Medway NHS Foundation Trust
Papers for the Trust Board Meeting in Public
Thursday, 05 March 2020 at 12:30
In the Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust
Windmill Road, Gillingham, Kent, ME7 5NY
# Agenda

**Trust Board Meeting in Public**

**Date:** Thursday, 05 March at 12:30 – 15:30  
**Location:** Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

## Subject | Presenter | Page | Time | Action
---|---|---|---|---
**Patient Story** | Chief Nurse | Verbal | 12:30 | Note

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<th>1. Preliminary Matters</th>
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<th>2. Minutes of the previous meeting and matters arising</th>
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<th>6. Integrated Health Care</th>
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# Agenda

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<td>6.2</td>
<td>Communications and Engagement Report</td>
<td>Director of Communications and Engagement</td>
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<td>Financial Stability</td>
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<td>Finance Report - Month 10</td>
<td>Director of Finance</td>
<td>14:45</td>
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<td>7.2</td>
<td>Finance Committee Assurance Report</td>
<td>Chair of Finance Committee</td>
<td>15:00</td>
<td>Approve</td>
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<td>Our People</td>
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<td>8.1</td>
<td>Health Care Worker Flu Vaccination Self-Assessment Report</td>
<td>Director of HR and OD</td>
<td>15:00</td>
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<td>Equality Delivery System 2</td>
<td>Director of HR and OD</td>
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<td>Gender Pay Gap Report</td>
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<td>Staff Survey Results</td>
<td>Director of HR and OD</td>
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<td>Workforce Report</td>
<td>Director of HR and OD</td>
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<td>Governance</td>
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<td>Board Assurance Framework</td>
<td>Deputy Chief Executive</td>
<td>15:15</td>
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<td>Integrated Audit Committee Assurance Report</td>
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<td>For approval</td>
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<td>10.1</td>
<td>Kent and Medway Vascular Surgery Network Programme</td>
<td>Medical Director</td>
<td>15:25</td>
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<td>10.2</td>
<td>Complaints Management Policy</td>
<td>Chief Nurse</td>
<td>15:35</td>
<td>Approve</td>
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<td>11.</td>
<td>Other Business</td>
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<td>11.1</td>
<td>Council of Governors’ Update</td>
<td>Lead Governor</td>
<td>15:45</td>
<td>Note</td>
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<tr>
<td>11.2</td>
<td>Any other business</td>
<td>Chairman</td>
<td>15:55</td>
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<td>11.3</td>
<td>Questions from members of the public</td>
<td>Chairman</td>
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<td>Discuss</td>
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<td>12.</td>
<td>Date and time of next meeting: Thursday, 12 May 2020, 12:30 – 15:30, Trust Boardroom</td>
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<td>Name</td>
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<td>Stephen Clark</td>
<td>Chairman</td>
<td>Marshalls Charity</td>
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<td>Brook Street Equity Partner LLP</td>
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<td>Jon Billings</td>
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<td>Fenestra Consulting Limited</td>
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<td></td>
<td>University South Wales</td>
<td>Course tutor, PGDip/MSc Leadership in Healthcare</td>
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<td>University of Kent</td>
<td>Wife is Professor of Applied Health Research, Centre for Health Service Studies</td>
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<td>Mark Spragg</td>
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<td>Marcela Trust</td>
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<td>Joanne Palmer</td>
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<td>Lloyds Gresham Nominee1 Limited</td>
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<td>Lloyds Gresham Nominee2 Limited</td>
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<td>Rama Thirunamachandran</td>
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<td>Vice-Chancellor and Principal Director and Trustee</td>
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<td>Tony Ullman</td>
<td>Non-Executive Director</td>
<td>Kent and Canterbury Hospital, East Kent NHS Foundation Trust</td>
<td>Partner is a part-time Specialty Dr</td>
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<td>James Devine</td>
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<td>London Board for the Healthcare People Management Association</td>
<td>Member</td>
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<td>Essex Partnership Trust</td>
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<td>Karen Rule</td>
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**Minutes of the Trust Board PUBLIC Meeting**

**Wednesday, 8 January 2020 at 12:30 – 15:30, in the Trust Boardroom, Postgraduate Centre, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY**

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<thead>
<tr>
<th>Members</th>
<th>Name</th>
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<tr>
<td>Voting:</td>
<td>Stephen Clark</td>
<td>Chairman</td>
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<td>David Sulch</td>
<td>Executive Medical Director</td>
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<td>Ewan Carmichael</td>
<td>Non-Executive Director</td>
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<td>James Devine</td>
<td>Chief Executive</td>
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<td></td>
<td>Jane Murkin</td>
<td>Interim Chief Nurse</td>
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<td>Leon Hinton</td>
<td>Executive Director of HR and OD</td>
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<td>Non-Voting:</td>
<td>Gary Lupton</td>
<td>Executive Director of Estates and Facilities</td>
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<td></td>
<td>Glynis Alexander</td>
<td>Executive Director of Communications &amp; Engagement</td>
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<td>Gurjit Mahil</td>
<td>Deputy Chief Executive</td>
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<td>Harvey McEnroe</td>
<td>Chief Operating Officer</td>
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<td>Jack Tabner</td>
<td>Executive Director of Transformation</td>
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<td>Paul Kimber</td>
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<td>Rama Thirunamachandran</td>
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<td>Sue Mackenzie</td>
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<td>Tony Ullman</td>
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<td>Attendees:</td>
<td>Alana Marie Almond</td>
<td>Assistant Company Secretary (Minutes)</td>
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<td>Diana Hill</td>
<td>Governor</td>
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<td>Glyn Allen</td>
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<td>Katy White</td>
<td>Director of Nursing Quality &amp; Professional Standards</td>
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<td>Viv Boutell</td>
<td>Governor</td>
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<td>Observer:</td>
<td>Louise Thatcher</td>
<td>Inspection Manager CQC</td>
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<td>Heidi Jeffrey</td>
<td>Patient Story – Matron</td>
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<td>Lyndsay Barrow</td>
<td>Patient Story – Patient Experience Manager</td>
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<td>Phil and Eve Denyer</td>
<td>Patient Story</td>
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<td>Four members of Public</td>
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<td>Apologies:</td>
<td>Ian O’Connor</td>
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<td>Joanne Palmer</td>
<td>Non-Executive Director and Senior Independent Director</td>
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Patient Story
The Patient Story and attendees were introduced by Jane Murkin, interim Chief Nurse. Matron Heidi Jeffrey accompanied Mr and Mrs Denyer (son and daughter in law) who told Winifred and Kenneth’s story. Winifred and Kenneth, aged 93 and 91 respectively, had been married for more than 67 years. Winifred was brought into hospital by ambulance at the end of May with abdominal problems and was cared for on SAU/Kingfisher ward. She needed end of life care and Kenneth stayed at her bedside during her final days. During this time staff became worried for Kenneth’s health and he experienced episodes of delirium. Kenneth was seen by a doctor and a decision was made to admit him to hospital.

Staff focussed on both Kenneth and Winifred as a couple and identified a clinical area where they could be cared for together and not be separated during Winifred’s final days. Winifred and Kenneth were able to hold hands and comfort each other during this sad time. Winifred sadly passed away but this devastating event was made a bit easier by knowing that Kenneth and her family were able to be with her when she died.

The family felt that staff went ‘over and above their paid job’ to care for Winifred and Kenneth. This is perfect example of the kind of compassionate care seen all over the hospital. Staff made a real difference to this family, allowing Winifred to have a dignified death in the embrace of the man that she had loved for most of her life.

ACTION NO: TBPU/20/47: James Devine to communicate the family’s gratitude for everything in his ‘Weekly Message from the Chief Executive’ under the section ‘This Is Us’.

1 Preliminary Matters
1.1 Chair’s Welcome and Apologies
The Chair welcomed all present especially to the newly appointed NEDs; Rama Thirunamachandran, Tony Ullman and Sue Mackenzie. Welcome to Louise Thatcher of the CQC who was observing, Jane Murkin as Interim Chief Nurse, Paul Kimber deputising for Ian O’Connor and Alana Marie Almond as Assistant Company Secretary. Apologies for absence were noted as recorded above. Introductions around the table were made.

1.2 Quorum
The meeting was confirmed to be quorate.

1.3 Conflicts of Interest
There were no conflicts of interest in relation to items on the agenda.

2 Minutes of the previous meeting and matters arising
2.1 The minutes of the last meeting, held on 7 November 2019 were APPROVED as a true and accurate record.

2.2 Matters arising and actions from the last meeting

3 Standing Reports
3.1 Chairman’s Report
Stephen Clark, Chairman, gave a verbal update to the Board. 2019 was a busy year for the Trust at Medway. The new Same Day Emergency Care Centre opened, there was continued development of the Emergency Department, the Butterfly Garden opened, the Trust launched a number of innovative initiatives to improve care for patients and the Maternity Team was named the best in the country; the Trust even managed to squeeze in
a visit from royalty. There is much to be proud of. The team knows it still has more to do to provide consistent care, meet statutory targets and achieve financial sustainability but MFT are confident that the plans are in place to achieve this.

3.1.1 Having listened to the patient story, the Chairman said he was sure the Board would be delighted to hear of the fantastic care received by Winifred and Kenneth. It is true evidence of the type of compassionate care that the hospital can pride itself on. The Board gives its thanks to Mr and Mrs Denyer for attending and telling their family’s story. The Chairman informed those at their first Trust Board meeting that the patient story is not just an opportunity to give praise but for balance the Board also hears from patients with more negative experiences. It is through hearing first hand of such experiences that the team learns and implements change.

3.1.3 The Chairman on behalf of the Board expressed his gratitude to all staff that worked over Christmas and the busy winter this period. The Chairman walked around the hospital with the Deputy Chief Executive on Christmas morning and gave his thanks for her time; he also witnessed how Trust staff made it as pleasant an experience as possible for the patients. MFT commitment to the patients is deeply appreciated by us all. The whole community owes a real debt of gratitude to them for their compassion, commitment and tenacity.

3.1.4 As is to be expected at this time of the year, the Trust has been experiencing some significant operational pressures with a great deal of demand for acute hospital care and a challenging flow position. MedOCC is now a much more comfortable and nicer area since the building works are complete.

3.1.5 The Chairman closed with wishing the Board and its guests a happy new year for 2020.

3.2 Chief Executive’s Report
James Devine, Chief Executive, gave an update to the Board on a range of strategic and operational issues which were not due to be discussed on the agenda.

3.2.1 Over the winter at any Trust the winter period is an intense time. MFT had the highest number of patients in December 2019. The Staff have coped particularly well with the pressure. With bed occupancy levels being as high as 98 percent most days during this period, is a lot of pressure and to be able to treat and discharge patients as well and quickly as possible is a huge challenge. The team has done a great job to keep the flow going.

3.2.2 The Trust was happy to welcome the Care Quality Commission (CQC) back to the Trust in December to inspect the core services. It is fair to say that the hospital is still in inspection mode. There is still Phase 3 of the inspection to come, the ‘Well-Led’ review. They will return on 15 and 16 January to carry out their review of how well-led the Trust is which also contributes to the overall rating. The inspection does not end there it continues until the CQC Panel meet on 14 February 2020. The outcome will be announced a further two weeks from this date and will be published mid to late March 2020. The Trust has received initial feedback acknowledging how passionate the team is about improving care for patients.

However there were areas of serious concern raised formally and informally by way of notices given to the Trust. JD advised that JM would also detail these in her Quality update. In one area the concern was with quality and safety which was disappointing and significant. The challenge is how to deal with these situations, James was happy to report that Jane Murkin Harvey McEnroe and David Sulch have taken immediate action, to address some of the issues that were highlighted. The importance now is what has been discussed recently,
which is how to embed that change. The message and action is to “Consistently provide good levels of care”. James said that creating the action plan is the easy task, embedding the change is the hard task to consistently provide good levels of care. The Trust is doing this as it is the right thing to do for the benefit of the community and patients, by improving on quality and safety. The Trust will look forward to receiving the final CQC report.

3.2.3 Beginning of phase 2 in the clinical decision unit in the new emergency department has started. Thanks to Gary Lupton, Harvey McEnroe and Jack Tabner as this is a great step forward. As part of the continued focus on improving flow through the organisation, the Trust is delighted to launch the new Full Capacity Protocol. This is a really important step for patients and the resilience of the Trust when under pressure. This is good governance for the Trust to have an agreed protocol, with safety at the heart and it is maintained. The Best Flow and Best Access programmes remain the key transformation projects to improve care both now and for the longer term.

3.2.4 James confirmed that the NHS Staff Survey is now complete, the Trust are pleased to report that it achieved a 43 per cent response rate, which is an improvement on previous years. Initial indications are reasonably positive with an improvement noted within engagement. Full results will be in February 2020.

3.2.5 In December 2019 HRH the Princess Royal in December, it was a great afternoon for Medway and the Teams really showed her the best of the hospital, around the emergency care pathway and the maternity unit. It was here the Trust also welcomed the Chief Executive and President of The Royal College of Midwives. The plaque that was revealed by the Princess Royal in February 2001 was also shown to her.

3.2.6 The Chairman, Gray Lupton and CE have been working closely with the League of Friends on re-energising the front entrance by the coffee shop, by the old Out Patients area on the right hand side. At the beginning of December the Trust signed the ten year lease with the League of Friends. There has been a lot of hard work put in to this and it is an ongoing piece of work and securing long standing commitment from the League of Friends is important to the Trust. The aim is to open the new coffee shop July 2020.

The Chairman added how important the League of Friends group is to the Trust. The shop turnover is in excess of £2 million they have donated over £400,000 to the Trust. They are really responsive to donating towards equipment and soft furnishings within the hospital. They are truly committed group with 200 volunteers, some who are in the hospital every day, way finders and shop assistants. The group is thrilled to be able to be part of this new development. The Chairman and the Trust appreciate all of their hard work and ongoing commitment.

3.2.7 Congratulations to the Procurement Team who won the Hospital Procurement Award at the Health Business Awards alongside other nominations for other Medway teams. It is impressive and encouraging to see Medway on the national stage.

3.2.8 The Chief Executive and Chairman attended a few of the carol services. This year the Trust held a very successful Christmas Fair for staff, patients and community. James wanted to extend his thanks to all those involved in hosting stalls, plus Town Crier Mike Billingham, Hospital Radio Medway, Chatham Grammar Choir and the Rainham Ladies Choir for making it such a special event. The total raised was more than £1,500 for the hospital charity to be spent on improving the experience for patients.

3.2.9 There has been a launch of an innovative scheme for patients with Type 2 Diabetes. Led by Dr Tara Rampal and Amanda Epps, the ‘Perioperative Diabetes Optimisation Clinics’ will
provide patients with a personalised and integrated diabetes management plan, combining care from MFT’s brilliant pharmacy and prehabilitation teams.

3.2.10 In November the Trust launched the new electronic document and records management system (EDRMS). The system, named Cito, allows us to see more information electronically, including the digitisation of patient records. Initially the system is being piloted across the Sleep Service, before being rolled out fully next year. Although it is early days with the implementation, it is a positive step forward and shows commitment to leading the way in the use of innovative and digitally enabled technology to support the delivery of brilliant care.

3.2.11 The judicial review hearing into stroke services concluded at the beginning of December 2019, although a ruling was not made. The judge said they recognised the need to reach a quick resolution to the case, and the Trust could expect a ruling early in 2020.

4 High Quality Care
4.1 Integrated Quality and Performance Report
4.1.1 Jane Murkin, Interim Chief Nurse, asked the Board to note and discuss the report. The report advised the Board of the current position in the form of a dashboard report for November 2019 quality and operational performance across key performance indicators. Jane informed the Board that there has been positive reports in quality and negative in other areas. There is a robust action plan in place, led by Gary Lupton to address the issues raised by the recent CQC Inspection (December 2019).

4.1.2 David Sulch reported to the Board that the Trust’s Infection Prevention and Control performance for November shows zero MRSA bacteraemia cases since July 2019. There should always be zero cases reported. There is a MRSA improvement plan which is being worked through. The Trust is on trajectory for C. difficile infections and the antimicrobial stewardship group activity will assist in ensuring controls against this are effective.

4.1.3 Lessons have been learnt from the CQC feedback, especially with the assurances that were being given. There will be more surveillance from clinical leads, ward visits by Executives and others plus daily monitoring. Across teams at all levels there will be check and challenge and staff who do not comply will face consequences. The governance on these issues needs more work but we are in a better position now.

4.1.4 The Infection Prevention and Control performance for November shows that the Trust has had zero MRSA bacteraemia cases since July 2019. The Trust is on trajectory for C. difficile infections and the antimicrobial stewardship group activity will assist in ensuring controls against this are effective.

4.1.5 Jane advised the Board that there is a programme of work in regard to roles and responsibilities. The Transformation team is also assisting with the promotion of knowledge on this subject. Leaders will be clear on this education plus roles and responsibilities. Currently the team cannot give the Board a level of assurance of embedding this change as yet but it is being worked on. A report will be submitted to the Quality Assurance Committee prior to coming back to Board in March 2020. **ACTION NO: TBPU/20/48:** Jane Murkin, David Sulch and Harvey McEnroe to give the Board assurance on the Action Plan to embed quality, at any time, within the hospital.

4.1.6 The Board stated that leadership should be held to account. They must lead by example and it should be a team effort. Disciplinarians must work to the highest of standards prior to being able to enforce any action. The best of the best should be positioned in problem areas.
4.1.7 The Chief Executive confirmed that the triangulation of Jane Murkin, David Sulch and Harvey McEnroe on an integrated approach is working. The Quality Assurance Committee and the Trust Board gives its full support with disciplinary action being taken against staff who do not comply.

4.1.8 Harvey McEnroe, Chief Operating Officer talked through the report bringing to the Boards attention the information detailed under; ED Four Hour Performance, Bed Occupancy, Referral to Treatment, Cancer and Complaints, Best Access Programme and patients who are Medically Fit to Discharge.

4.1.9 Jon Billings informed the Board that the last Quality Assurance Committee was a focused formal group meeting instead of the Development session. Overall he believes there is good governance but there is a need for change. The messages are going through strongly. The focus at the December 2019 meeting was; Quality Strategy, Mortality and Morbidity, Infection Prevention Control, Electronic Discharge Notifications and Radiology Reporting Issue Update.

4.1.10 The Fractured Neck of Femur (NOF) performance has been impacted by another period of increased demand for trauma services and orthopaedic services. Plans are being implemented to create additional trauma lists and evening orthopaedic lists to meet demand. Jon Billings asked that this subject is discussed at the Quality Assurance Committee.

**ACTION NO: TBPU/20/49:** – David Sulch to submit a report on the performance in regard to fractured neck of femur to the next QAC meeting.

4.1.11 David Sulch informed the Board that the Electronic Discharge Notification (EDN) performance remains below trajectory, a review by the Medical Director and Deputy Chief Executive and a recent deep dive analysis with the teams has been completed and refreshed trajectories and resources have been clarified to ensure completion within 24 hours. A clinically led Task and Finish Group has also been set up to coordinate this work. The piece of work required will be focused but is a lengthy piece to do.

4.1.12 Jack Tabner stated that systems processes and staff need to be taken into consideration. The ICPR as a whole is being redeveloped by Jon Billings, Gurjit Mahil and Jack. The aim is to come away from just reporting figures. The new Business Intelligence Strategy is currently being taken through the Transformation Assurance Group and will be scrutinised by the Quality Assurance Committee.

4.2 Quality Assurance Committee Assurance Report

Jon Billings, Chair of the Quality Assurance Committee, gave the Board a verbal update, there was not a paper submitted this time.

4.2.1 The focus of the QAC is a lot of the same as what has been discussed already today, Jon wanted to confirm that the QAC and Board agendas are aligned and focus on quality is the same.

4.3 Infection Prevention and Control

David Sulch, Medical Director, asked the board to note the contents of this report and the Trust’s performance. NHS providers are obliged to ensure the Board is sighted on performance against Infection Prevention and Control within the Trust on at least a quarterly basis, this report is intended to address this. At the time of writing the report the data included for December 2019 was not validated.

4.3.1 The detail from this report was discussed under the IQPR section (Item 4.1) earlier in the meeting.
4.4 **Responding to Deaths**
David Sulch, Medical Director, gave the Board a verbal update. The updated August HSMR figure now sits at 102, which is not a national outlier. A further independent review will take place in November 2020 by NHSI. There are less people dying at Medway than there was last year. David has asked Dr Foster for some analysis and will report back at a later date.

4.5 **Safe Staffing Review**
Jane Murkin, Interim Chief Nurse, informed the Board that the briefing paper has been commissioned by the Director of Nursing, to provide the Board with a progress update in relation to the recent nurse establishment review using NHSI guidance.

4.5.1 The establishment review covers adult inpatient wards. A detailed report including nurse establishment recommendations will be presented to the Executive Team on 15 January 2020. This is a bi-annual review and it will be submitted to the Quality Assurance Committee prior to coming back to the Board. **ACTION NO: TBPU/20/50:** Jane Murkin to update the Board on progress at the next meeting in March 2020 via QAC.

5 **Innovation**

5.1 **Transformation Programme Update**
Jack Tabner, Director of Transformation, asked the Board to note the contents of the report which provides an update on the Trust’s ‘Better, Best, Brilliant’ transformation portfolio, including:

5.1.1 Large, cross-hospital transformation programmes. Activity within the Trust’s core transformation programmes continues to gather pace:

a) **BEST Flow**; the Programme has been re-focused on a set of simple activities and measures to support clinical and operational teams manage operational pressures throughout the busy winter period. The programme structure has been reviewed and changes have been made with Key Performance Indicators. This remains one of the big priorities; work will be done now on deciding where this programme goes in the future.

b) **BEST Access**; this programme, coordinating improvement work across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management, is now fully up and running. The work has helped secure the Trust’s contractual settlement with commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year. This programme links closely with the IT programme, so the IT and Transformation teams have been and will be more aligned over the coming months.

c) **Cost Improvement Programme**; as at Month 8, the Trust has delivered £11.4million in CIP. Year to date, this is adverse to the operational plan monitored internally by £1.3million. The forecast is an outturn position of £16.6million - £17.0million against the Trust’s requirement of £19.5million. There is not much more that can be done on this in this financial year. The focus will now be on next year’s CIP, working with clinical and operational teams to prioritise schemes that improve tax payer value for money and deliver efficiencies through improved quality, safety and experience. The target will be 4.4 percent of expenditure, £12million - £14million. **TAG will be used to do this work and will be plugged into quality.**

**ACTION NO: TBPU/20/51:** Jack Tabner to submit a report on what resources the Trust has on site in totality to work more as a composite team, to next meeting. Leon Hinton can assist with this.

d) **Delivering the quality strategy**; as part of the Trust’s Quality and People Strategies, there are over 100 trained staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Improvement projects are being delivered by frontline staff in 90 day cycles, which align directly to the Trust’s strategic objectives. Training pauses during the winter to allow staff to focus on core operations but coaching is always on offer from the Transformation Team. This will be tested through the TAG.
e) Development of an Innovation Institute; As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement. Led by three newly appointed Clinical Directors of Innovation and Improvement, this will create a ‘one stop shop’ for clinicians looking to conduct research studies and improvement projects. It will combine the best of the currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks and the local Universities.

5.1.2 The Board asked for more figures and information to be included in this report. Jack confirmed future reports would include this in the form of a summary.

6. Integrated Health Care
6.1 STP and ICP Update
Gurjit Mahil, Deputy Chief Executive, gave the Board a verbal update.

6.1.1 November 2019 held the first Integrated Care Partnership (ICP) meeting. The long term plan will be formed after the meeting on 14 January 2020. The STP gave positive feedback on the long term plan submission; MFT was one of only a few Trusts to receive such feedback. Jo Palmer is leading NED on this.

ACTION NO: TBPU/20/52: Gurjit Mahil to give an update to the Board at the next meeting in March 2020.

6.2 Communications and Engagement Report
6.2.1 Glynis Alexander, Director of Communications and Engagement, asked the Board to note the report which details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in the transformation programme. It also includes feedback from recent engagement with the community.

6.2.2 It is important that the Trust highlight areas of excellence alongside the negative feedback that can sometimes be reported on.

6.2.3 The November members’ event dedicated to the role of the pharmacy and medicines department was well attended and feedback has been excellent. Members learnt about medications, the operation of the pharmacy department and what goes on behind the scenes to ensure patients receive the medicines they need. The next member event will focus on Qualities Priorities and will be held on Wednesday 5 February 2019, 18:00 to 20:00 at the Postgraduate Medical Centre. The Board is more than welcome to attend.

6.2.4 Community Outreach and Patient Engagement has been proactive and positive.

7. Financial Stability
7.1 Finance Report – Month 8
Paul Kimber, Deputy Director of Finance, the Board is asked to note the financial performance to 30 November 2019, being £55,000 favourable against the financial plan.

7.1.1 The finance dashboard report sets out key performance indicators with a series of individual metrics designed to show progress over time, assessing the risks associated with operational performance and impact on the Trust’s financial performance and position.

7.1.2 To the end of November 2019 the Trust is reporting a year to date deficit of £34.4million, excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and
Financial Recovery Funds (FRF). This is favourable to the plan submitted to NHSI by £55,000 and the expectation is for the Trust to hit the control total by the end of the year.

7.1.3 Based on the agreement with local CCGs and the conclusion of the debates with specialist commissioners around the robot, the risk of failing to meet the control total in 2019/20 is maintained at moderate/low. This is expected to improve further in the event that further cost improvements come to fruition over the winter period and with closer control of pay costs.

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

7.1.5 Cash position remains strong. The cash held is managed by ensuring these funds are drawn in line with the planned deficit and that loans are not requested ahead of when the cash is needed. This follows a standard monthly cycle and is actively managed by the financial control team. The strategy of obtaining earlier payment of contracted values from the Clinical Commissioning Group (CCG) is yielding benefit.

7.1.6 Aged Debtors; outstanding trade receivables as at the 30 November 2019 are £19.5million, £16.7million – 86 percent is overdue for payment.

7.1.7 Chief Executive asked that there is not a distorted view on income going forward. There should not be more expenditure, on less hours and achieving less. The Chair asked that going forward there is a more integrated approach between Paul Kimber, Gurjit Mahil, Jack Tabner and Harvey McEnroe to ensure this is not the case in the future.

7.2 Finance Committee Assurance Report
The Chairman, asked the Board to note the report. In Jo Palmer’s absence the report was taken as read and noted. There were no further questions.

8. Our People
8.1 Workforce Report
Leon Hinton, Director of HR and OD, asked the Board to note the content of this report which focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust.

8.1.1 The Trust’s recruitment campaigns, including national, local and international have delivered 640 candidates to date; 211 of these candidates have commenced in post over the last 12 months.

8.1.2 The Trust’s turnover has decreased to 12.10 percent from 12.21 percent, sickness absence at 4.15 percent compared to the month of September is above the Trust’s tolerance level of 4 percent, and appraisal compliance has decreased to 88 percent and is above Trust target of 85 percent. Statutory and Mandatory training is at 92 percent and is meeting the Trust target of 85 percent.

8.1.3 The percentage of pay bill spent on substantive staff in October at 83 percent, decreased compared to the month of September. The percentage of agency usage at 4 percent increase compared to the month of September. The percentage of pay bill spent on bank staff at 13 percent has increased compared to September.
8.1.4 There was a 43 percent response to the Staff Survey. The raw data that has been reviewed so far shows positive responses. The final results will be reported to the next Trust Board.

8.1.5 The Board was informed that the Trust is not managing to spend its apprenticeship levy so it is losing money. The funds cannot be spent elsewhere they must be spent on apprenticeships. Leon continues to work with the STP to find a solution for this. 

ACTION NO: TBPU/20/53: Leon Hinton to investigate this issue further and report back to the next Board in March 2020.

ACTION NO: TBPU/20/54: Leon Hinton to investigate the vacancy and leaver rate for EU nurses of the last four quarters.

8.2 Inclusive Recruitment
Leon Hinton, Director of HR and OD, asked the Board to approve that the Board give approval to the Trust signing up to the Disability Confident and Valuable 500 schemes, as set out in Sections 4.2 and 5.2 of the paper.

8.2.1 Three additional opportunities that have arisen since the Trust published its Workforce Race (RES) and Disability Equality Schemes (DES) in July. These are: the NHS Inclusive Recruitment Toolkit; the Disability Confident scheme; and the ‘Valuable 500’, which provides organisations with resources, peer support and a community of practice to help Boards lead on disability inclusion. The latter two schemes require Board engagement as part of the eligibility criteria.

8.2.2 The Board APPROVED that the work proceeds.

9. Governance
9.1 Integrated Audit Committee Assurance Report
Mark Spragg, Chair of the Integrated Audit Committee, asked the Board to note the report which was taken as read.

9.1.1 The report details the assurances. Furthermore the Integrated Audit Committee decided it would be useful to have the Internal Auditor recommendations presented to the Executive Group on a monthly basis so they have them in mind. They were concerned that some of the time limits on the recommendations were too distant and some dates were being missed. The Committee has asked that the Executive set reasonable time limits for putting their recommendations into effect. The exception report recommendations will then come back to the Committee on a quarterly basis to keep an overview and to ensure they are put into effect.

9.2 Standing Financial Instructions
Paul Kimber, Deputy Director of Finance, asked the Board to approve the SFIs and delegate future authority for such approval to the Integrated Audit Committee. Assistant Company Secretary highlighted that the report stated the Finance Committee. Paul confirmed this is in the report erroneously and should state Integrated Audit Committee.

9.2.1 The annual review of the SFIs has been completed. There are some minor narrative changes together with an update to the scheme of delegation limits to reflect operational processes. The policy remains largely unchanged, limited principally to some wording and presentation refinement.

9.2.2 There is a significant proposed change to the Trust Scheme of Delegation. This has been amended to reflect the revised structure of the organisation and empower staff in the purchasing of goods and services where purchasing policies have been followed.
ACTION NO: TBPU/20/55: Confirm whether or not the Committee is Finance or Integrated Audit and whether or not the Board can delegate authority.

9.2.3 The Board APPROVED the Standing Financial Instructions subject to the above action being completed.

10. Policies for approval

10.1 Emergency Preparedness Resilience and Response Policy
Harvey McEnroe, Chief Operating Officer and lead on EPRR, asked the Board to review and approve the report. The EPRR Policy sets out the Trust arrangements for the management of EPRR and associated governance to ensure compliance with the regulations.

10.1.1 As a category 1 responder, as identified in the Civil Contingencies Act (2004), MFT has a responsibility to have comprehensive Business Continuity Plans in place to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable. Business Continuity Management (BCM), including processes for recovery and restoration, should be considered by NHS organisations as part of everyday business processes and should follow a designed programme of activity. This statement applies to Item 10.2.

10.1.2 The Board APPROVED the report.

10.2 Business Continuity Policy
Harvey McEnroe, Chief Operating Officer, asked the Board to review and approve the report. Both reports have been taken through the same due diligence (Item 10.1 and 10.2) by the Executive Group and the NHSE EPRR Framework under the Civil Contingencies Act (2004).

10.2.1 The Board APPROVED the report, subject to Executive revalidation. There will be no changes to the report after this approval.

10.3 Risk Management Policy and Strategy
Gurjit Mahil, Deputy Chief Executive, the Board was asked to review and approve the content. A full review of risk management has taken place. The procedure describes in full the management and escalation process. Risk pathways have been established for both corporate divisions and clinical divisions.

10.3.1 Board Assurance Framework will come back to the Board in March 2020.

11. Policies for approval

11.1 Emergency Preparedness Resilience and Response Annual Assurance Report
Harvey McEnroe, Chief Operating Officer, informed the Board that the report is presented for Assurance.

11.1.1 MFT is subject to an annual assurance process for Emergency Planning under the NHS England EPRR Framework as stipulated by the Civil Contingencies Act (2004). MFT was Assurance audited by NEL on behalf of Medway Clinical Commissioning Group.

11.1.2 The Board NOTED the report which followed the same due diligence as Item 10.1 and 10.2.

12. Other Business

12.1 Council of Governors’ Update
Glyn Allen, Lead Governor, gave the Board a verbal update on the Council of Governors business.
a) The have been a number of Governor Events recently, one worth noting was the Christmas Decoration Competition in the hospital. Glyn Allen and Vivien Boutell were the Governor Representative Judges for the competition. Glyn wanted to inform the Board and commend the enthusiasm they experienced from the Staff. It was an impressive effort from all.

b) Governor events:
- Monday 13 January 2020: Workshop organised by Medway and Swale Integrated Care Partnership, it is a public engagement event and the idea is to put people in the picture who use the services, as part of the plan. The Governors have been invited to attend.
- February 2020: Governors will attend a meeting to discuss the planning decisions that have been reached in terms of capacity requirements for the future, to discuss health demands. This meeting will also be attended by Medway Council.

**ACTION NO: TBPU/20/56:** Harvey McEnroe to provide Cllr John Wright (Governor) the date and time details for the meeting they have together on Social Services Release.

**ACTION NO: TBPU/20/57:** Harvey McEnroe to review the Cancer data that was provided to the CCG and what was submitted in the IQPR over the last three months to see if there are any discrepancies. Send to Lyn Gallimore and copy Stephen Clark and James Devine.

12.2 There were no further matters of any other business.

12.3 There were no questions from members of the public.

13. **Date and time of next meeting**
The next meeting will be held on Thursday, 5 March 2020, 12:30 – 15:30, in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

The meeting closed at 16:15

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday, 8 January 2020

Signed .................................................. Date ..............................................

Chairman
#### Board of Directors in Public Action Log

**Date: Wednesday, 08 January 2020**

Actions are RAG Rated as follows:

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Minute Ref / Action No</th>
<th>Action Description</th>
<th>Action Due Date</th>
<th>Owner</th>
<th>Current position</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>05-Sep-19</td>
<td>TB/2019/030</td>
<td><strong>Patient Story</strong></td>
<td>05-Mar-20</td>
<td>David Sulch, Executive Medical Director</td>
<td>Update in March 2020</td>
<td>White</td>
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<tr>
<td></td>
<td></td>
<td>Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.</td>
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<tr>
<td>07-Nov-19</td>
<td>TB/2019/038</td>
<td><strong>Chair's Report</strong></td>
<td>05-Mar-20</td>
<td>Leon Hinton, Executive Director of HR &amp; OD</td>
<td>Propose to close - complete</td>
<td>Green</td>
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<tr>
<td></td>
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<td>Creation of a People Committee to report into the Nominations and Remuneration Committee, to take forward the People Strategy</td>
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<tr>
<td>07-Nov-19</td>
<td>TB/2019/43</td>
<td><strong>Workforce Report</strong></td>
<td>08-Jan-20</td>
<td>Leon Hinton, Executive Director of HR &amp; OD</td>
<td>Forms part of the ICP reports Update: 08.01.20 - the discussion still needs to be had.</td>
<td>Red</td>
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<tr>
<td></td>
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<td>Discuss outside the meeting, temporary staffing including commissioned contract staff who do not feature in the care groups and safe staff numbers</td>
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<tr>
<td>07-Nov-19</td>
<td>TB/2019/44</td>
<td><strong>Workforce Report</strong></td>
<td>05-Mar-20</td>
<td>David Sulch, Executive Medical Director</td>
<td>Propose to close - complete</td>
<td>Green</td>
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<td>Review consultancy vacancies, with benchmarking highlighting gaps and actions to be taken to address the gaps - how many of those vacancies are needed and how many are covered with locum staff.</td>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/47</td>
<td><strong>Patient Story</strong></td>
<td>ASAP</td>
<td>James Devine, Chief Executive Glynis Alexander, Director of Communications and Engagement</td>
<td>Propose to close - complete</td>
<td>Green</td>
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<td></td>
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<td>Communicate the family’s gratitude, in the ‘Weekly Message from the Chief Executive’ under the section ‘This Is Us’.</td>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/48</td>
<td><strong>Integrated Quality and Performance Report (Item 4.1)</strong></td>
<td>05-Mar-20</td>
<td>Jane Murkin, Interim Chief Nurse David Sulch, Medical Director Harvey McEnroe, Chief Operating Officer</td>
<td>Update in March 2020</td>
<td>Green</td>
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<td>Give the Board assurance on the Action Plan to embed quality, at any time, within the hospital. Bring an update report to the next Board, report to go to QAC prior to March 2020.</td>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/49</td>
<td><strong>Integrated Quality and Performance Report (Item 4.1)</strong></td>
<td>24-Jan-20</td>
<td>David Sulch, Medical Director</td>
<td>Propose to close - complete</td>
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<td>Chair of QAC requested a report submitted on the performance in regard to fractured neck of femur, to the next QAC meeting.</td>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/50</td>
<td><strong>Safe Staffing Review (Item 4.5)</strong></td>
<td>05-Mar-20</td>
<td>Jane Murkin, Interim Chief Nurse</td>
<td>Update in March 2020</td>
<td>Green</td>
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<tr>
<td></td>
<td></td>
<td>Update the Board on progress at the next meeting in March 2020 via QAC.</td>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/51</td>
<td><strong>Transformation Programme Update (Item 5.1)</strong></td>
<td>05-Mar-20</td>
<td>Jack Tabner, Director of Transformation Leon Hinton, Director of HR and OD</td>
<td>Update in March 2020</td>
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<tr>
<td></td>
<td></td>
<td>CIP: submit a report on what resources the Trust has on site in totality, to work more as a composite team.</td>
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</table>
## Actions RAG Rated as follows:

### Meeting Date: Wednesday, 08 January 2020

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Minute Ref / Action No</th>
<th>Action</th>
<th>Action Due Date</th>
<th>Owner</th>
<th>Current position</th>
<th>Status</th>
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<tr>
<td>08-Jan-20</td>
<td>TBPU/20/52</td>
<td>STP and ICP Update (Item 6.1)</td>
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<td>Gurjit Mahil, Deputy Chief Executive</td>
<td>Propose to close - complete</td>
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<td>08-Jan-20</td>
<td>TBPU/20/53</td>
<td>Workforce Report (Item 8.1)</td>
<td>05-Mar-20</td>
<td>Leon Hinton, Executive Director of HR &amp; OD</td>
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<td>TBPU/20/54</td>
<td>Workforce Report (Item 8.1)</td>
<td>05-Mar-20</td>
<td>Leon Hinton, Executive Director of HR &amp; OD</td>
<td>Propose to close - complete</td>
<td>Green</td>
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<td>08-Jan-20</td>
<td>TBPU/20/55</td>
<td>Standing Financial Instructions (Item 9.2)</td>
<td>ASAP</td>
<td>Alana Marie Almond, Assistant Company Secretary</td>
<td>Delegated authority should be to the IAC. SFIs, Standing Orders and the Scheme of Delegation are usually reserved matters for Boards. It is usual for the Audit Committee to review the detail ahead of a Board meeting and recommend that the Board approves the changes.</td>
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<td>08-Jan-20</td>
<td>TBPU/20/56</td>
<td>Council of Governors Update (Item 12.1)</td>
<td>ASAP</td>
<td>Harvey McEnroe, Chief Operating Officer</td>
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<td>08-Jan-20</td>
<td>TBPU/20/57</td>
<td>Council of Governors Update (Item 12.1)</td>
<td>ASAP</td>
<td>Harvey McEnroe, Chief Operating Officer</td>
<td>Propose to close - complete</td>
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Chief Executive’s Report – March 2020

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

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

In and around Medway

As winter draws to a close I would like to thank our staff for their dedication in providing care for our community during this very busy period. Throughout the winter we saw the majority of those coming to our Emergency Department within four hours – however a small number of patients did experience longer waits than we would have liked. We would like to apologise and thank these patients for their patience and understanding.

Thank you also to those members of the community who played a role in helping us to manage winter pressures by ensuring that they choose the best place for their care (not always our Emergency Department) and had their flu vaccination.

Transformation

Our Best Flow and Best Access programmes remain the key transformation projects to improve care both now and for the longer term. We are seeing improvements as you will hear during the meeting, although we still have a long way to go.

Stroke review

The outcome of the Judicial Review into the stroke consultation was announced on 21 February. The appeal by campaigners was rejected meaning the move to three hyper acute stroke units for Kent and Medway can progress.

Although we had originally hoped that one of the HASUs would be sited at Medway, we accepted the outcome of the review and supported the creation of three HASUs (in Dartford, Maidstone and Ashford) as these will lead to better outcomes for stroke patients.

NHS Staff Survey

I am delighted to see that we have made some real progress in this year’s survey and that according to staff feedback we have seen improvements in almost all areas surveyed. I am particularly delighted that we have seen improvements in staff feeling that they are able to make suggestions to improve the work of their teams and department, and that they feel supported by their managers.

But this isn't just about percentage points. We know that behind these numbers are staff who are happier coming to work, feel more supported, have better development opportunities and feel that they make a difference to our patients. This is #NotJustANumber, it is a sign that as an organisation we are moving in the right direction; becoming an organisation where we
can all feel proud to work. We are not a silent organisation – we are an organisation who feels able to speak up, and does so. However, I am also conscious that we need to improve. I am disappointed to see that staff are still reporting that they have experienced discrimination and violence from patients and members of the public while going about their work. Sadly increasing violence to NHS staff is a theme that carries through the national results and we are working hard to eliminate these behaviours at Medway. We launched our “Here to help, not be hurt” campaign last year to get across the message that violence to our staff is absolutely not acceptable. We have much more to do to make Medway a brilliant place to work, but we are well on our way.

Coronavirus
As a Trust we have taken a number of steps to ensure we are informed and prepared, including daily huddles, a Coronavirus workshop, and the creation of priority assessment pods for those with symptoms indicative of the infection. Advice for the public, should they have concerns that they may have been exposed to the virus, is to phone NHS111 and not attend the Emergency Department unless they are seriously ill.

Relaunch of our Trust values
I was proud to launch the new look for our Trust values – Bold, Every Person Counts, Sharing and Open and Together. These are the values that bind us as an organisation – something we should all aspire to. I’m pleased to see so many familiar faces involved; they represent the very best ambassadors for our organisation across many different disciplines.
Closure of Dickens Ward

Dickens Ward, an escalation ward, was closed in January; it had always been our intention to close the ward imminently.

We primarily placed patients there who are ‘medically optimised’ (i.e. patients who no longer require acute hospital care but may require additional care, such as rehabilitation, before being safely discharged).

Following discussions with the CQC as part of their recent visit we reviewed the use of the ward. We took the decision to bring forward the closure so that patients are cared for in the most appropriate care setting which may be in another hospital ward or in the community with a care plan.

We have worked together with the support of our partners in the community and our commissioners to ensure patients who were fit to go home or to a community setting were able to do so in a timely way.

Chairman departure

Our Chairman, Stephen Clark will be leaving the Trust when his term of office comes to an end in March 2020.

Stephen joined the Trust in 2016, becoming Chair in April 2017, since when Medway has seen a number of improvements, and embarked on a major transformation programme. During this period the Trust has also reduced its financial deficit, delivering £21 million of efficiency savings last year, and helping put the hospital on a more sustainable footing.

Jo Palmer, as Deputy Chair, will take over the role while we recruit a permanent replacement.

Preparing our patients for discharge

Our nursing team has been working on an exciting new project with NHS Improvement and other partners to produce a discharge guide for our patients.

The guide will be given to every single inpatient and will provide them with all the information they need to get ready for their discharge. This is a really excellent piece of work and will greatly improve patient experience.

Finance director

It is inevitable that from time to time we will see changes in our Executive team, and I am genuinely sorry to say that our Finance Director, Ian O’Connor, will be leaving us in the spring to take up an appointment at Dartford which is closer to his home. Ian has had a real impact in his time at Medway, overseeing a substantial reduction in our deficit, and improved contracting arrangements.
Executive Overview

The CQC visited Medway NHS Foundation Trust in December 2019 and January 2020 as part of the Core Services announced and unannounced inspections. Separate reviews into the Use of Resources and Well Led inspection then contributed to the overall inspection process.

Concerns about the quality of care and safety issues were formally raised by the CQC through feedback the Trust received in December 2019 including numerous requests for further information.

This paper provides the Trust Board with a progress update on the CQC findings, what immediate actions the Trust took to address them and what ongoing actions are being taken in addressing the concerns raised over the next few months.

Inspection Table
Report to the Trust Board

### Inspection Visit

<table>
<thead>
<tr>
<th>Core Service Inspection involving the following five areas:</th>
<th>Date of inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency Services</td>
<td>3, 4, 5 December 2019</td>
</tr>
<tr>
<td>• Surgery</td>
<td></td>
</tr>
<tr>
<td>• Critical Care</td>
<td></td>
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<tr>
<td>• Children &amp; Young People</td>
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<td>• End of Life</td>
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<table>
<thead>
<tr>
<th>Unannounced Inspection (Medical Care core service)</th>
<th>16 December 2019</th>
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</thead>
<tbody>
<tr>
<td>Well Led Inspection</td>
<td>15 and 16 January 2020</td>
</tr>
<tr>
<td>Unannounced Inspection</td>
<td>29 January 2020</td>
</tr>
</tbody>
</table>

A total of 133 documentation requests were received post inspection— all were collated and submitted to the CQC within the allotted timeframe.

The Trust did receive positive feedback which included:

- It was evident that staff are passionate about wanting to improve patient care.
- Observation of compassionate care, patients involved in enhancing care and examples of good leadership.
- Staff were open and honest, and the majority of areas visited were calm and organised.
- CQC Hospital Inspector acknowledged that staff were very helpful throughout both inspections.
- Site pressures were recognised and acknowledged

### 1. Oversight and Management of Dickens Ward

The CQC raised a number of concerns about the nursing and medical leadership and quality of care on Dickens Ward.

Dickens ward was used as the Trust’s escalation or ‘winter pressures’, used to temporarily increase the number of beds during periods of high demand. Patients who were cared for there were Medically Fit for Discharge and did not need to be cared for in an Acute Hospital.

The CQC set out the following areas the Trust needed to address:

- Safe nursing staff numbers until planned closure in March 2020.
- Senior nursing oversight of patients and care on Dickens ward.
- Medical oversight and review of patients and their care.
- Escalation of patients whose discharge is delayed.
- Regular audit on quality and safety of care.
- Regular reviews of nursing care plans and action to address any shortfalls identified.

On the 17 December 2019 the Trust provided a detailed response to the CQC incorporating the immediate actions the Trust had taken to address the concerns relating to Dickens ward with assurance that the quality of care the Trust provides to the patients is our number one priority.
Report to the Trust Board

An action plan was developed in response to the letter and the Chief Nurse commenced a programme of regular ward visits which are collated into a weekly Chief Nurse Assurance report with any issues escalated in real time to the Chief Nurse, Medical Director or Chief Operating Officer.

Weekly reporting of the Chief Nurse Assurance report from the Divisional Director of Nursing and provided to the CQC commenced on 3 January 2020.

In responding to the concerns a range of activities and actions were taken and progress made with improvements noted and evidenced in relation to nursing standards. Positive progress was made in addressing the areas of concern raised by the CQC, however there was still variation in practice and further work was undertaken to ensure the standards for all patients including medical review were happening for every patient every day.

Chief Nurse Visits included attendance by the following external staff to the Trust, with positive feedback and acknowledgment of progress in addressing the issues raised:

- CQC - Louise Thatcher, Inspection Manager
- CCG – Paula Wilkins, Chief Nurse

The Chief Executive took the decision to bring forward the closure of the ward and so it was safely closed on 31 January 2020. In closing Dickens Ward the Chief Nurse requested that every patient on the ward received a full clinical review to ensure all risk assessments were completed and patients reviewed prior to the safe transfer of patients to an alternative ward or discharged to the community.

Given these patients were medically fit for discharge, we asked our local CCGs to support a system response to urgently find additional community capacity. The Regional Director at NHS Improvement /NHS England was also approached to assist with this process.

2. Care of Substances Hazardous to Health (CoSHH), Infection Prevention and Control, Mixed Sex Accommodation Breeches, Patients in Recovery Overnight

On 19 December 2019 the CQC expressed concerns that not all staff were following infection prevention and control practice, care of substances hazardous to health (CoSHH) were not securely stored; patients were not being cared for in single sex areas and the recovery bay in theatres was being used for overnight accommodation and issues pertaining to infection prevention and control.

In immediately responding to these concerns immediate actions were taken by the Trust which included:

- Ensuring the safe storage of substances hazardous to health an actions plan was developed on the week of the announced inspection when concerns
- A strategic action plan developed to oversee the implementation of actions to address the concerns
- Letters sent to all housekeepers regarding responsibilities to address issue and ensure compliance with COSHH
Report to the Trust Board

• Trust wide staff briefing for nursing staff and housekeepers
• Rectifications made to any areas found to be non-lockable and pins fitted.
• Trust wide compliance audit undertaken of all domestic cupboards to deem lockable and identify any areas of risk to be addressed.
• Actions taken to address patients in recovery overnight and Mixed Sex Accommodation breeches to ensure patient privacy and dignity is maintained

Good progress has been made with addressing all concerns relating to the issues raised. Further work is of an ongoing nature to address all actions and requirements.

3. Governance Process
All actions implemented in regard to COSHH, MSA an Infection Prevention and Control and patients in recovery overnight have been combined into one single strategic action plan which is overseen by a Quality panel chaired by the Chief Nurse and supported by the Medical Director and Chief Operating Officer.
Weekly Quality panel meetings commenced on 7 January and continue to review progress in completing the actions within plan.
Tracking and reporting progress both externally to CQC and internally to the CEO, Executive Team and to the Quality Assurance Committee has taken place and is continuing to ensure all actions are completed with any barriers to progress escalated for resolution.

4. CQC Draft Report
The Trust received the draft CQC Inspection Report on Monday 17 February 2020. An extraordinary Board meeting was held on Friday 28 February to discuss the draft report and factual accuracy checking process and feedback, coordinated by the CEO.
Feedback was submitted to the CQC by the CEO on 2 March 2020.

5. Next Steps
The final published report will be released mid-March 2020. The Trust is now working on the development of a Trust improvement plan to include longer term actions to address the CQC findings and ensure changes are embedded and sustained in practice with staff being clear on their role and responsibilities.
This work is being progressed with support from NHS E / I Improvement Director and will involve a process of staff and stakeholder consultation and engagement to ensure ownership of all staff across the Trust.
A working draft improvement plan will be available for sharing with external stakeholders in April and the Trust will consult with representatives of the local Clinical Commissioning Groups and NHS Improvement/ NHS England.
<table>
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<tr>
<th>Title of Report</th>
<th>Reclaiming the nursing landscape: a strategic plan for nursing and midwifery at Medway NHS FT January – December 2020</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>Lead Director</td>
<td>Jane Murkin, Chief Nurse</td>
<td></td>
</tr>
<tr>
<td>Report Author</td>
<td>Katy White, Director of Nursing Quality and Professional Standards</td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>This paper sets out the strategic priorities for nursing and midwifery at the Trust for this calendar year, setting these against the local context and national priorities</td>
<td></td>
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<tr>
<td>Committees or Groups at which the paper has been submitted</td>
<td>This report was presented to the Executive Group Meeting on Wednesday 19 February 2020</td>
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</tr>
<tr>
<td>Resource Implications</td>
<td>In implementing the priorities identified within this paper, there are resource implications to ensure delivery however these have not yet been fully costed.</td>
<td></td>
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<tr>
<td>Legal Implications/ Regulatory Requirements</td>
<td>Failure to implement these priorities this year could lead to regulatory action being taken by the Care Quality Commission and NHS E/I</td>
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<tr>
<td>Quality Impact Assessment</td>
<td>Not required</td>
<td></td>
</tr>
<tr>
<td>Recommendation/ Actions required</td>
<td>The Board is asked to discuss the contents of this report and support its delivery.</td>
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</tr>
<tr>
<td>Appendix 1. Priorities by theme</td>
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Reports to committees will require an assurance rating to guide the Committee’s discussion and aid key issues reporting to the Board

The key headlines and levels of assurance are set out below:

| Partial assurance                   | Amber/ Red – there are gaps in assurance                       |             |
Reclaiming the nursing landscape:

A strategic plan for nursing and midwifery at Medway NHS Foundation Trust

January – December 2020

Jane Murkin, Chief Nurse

and

Katy White, Director of Nursing Quality and Professional Standards

February 2020
1 NATIONAL CONTEXT

The National Strategy, NHS England/ Improvement (NHS E/I)

Upon her appointment in January 2019, the Chief Nurse Ruth May set out her vision for nursing and midwifery, stating that nursing, midwifery and care staff are leading transformational change across health and care and have a key contribution to delivering the NHS Long Term Plan. Complementary to the Long Term Plan, the Chief Nursing Officer (CNO) for England has set out three priorities:

A workforce that is fit for the future

Ensuring the right teams are in place is crucial to the delivery of the Plan. To achieve this, we need to:

- Recruit and retain enough people with the skills required.
- Build places of work that are rewarding, positive and filled with opportunity.
- Develop the quality of our management and leadership at every level.
- Tackle inequality and break down the barriers that are preventing too many from reaching their potential.
- Create an infrastructure that enables more volunteers to support our front-line staff.

Renew the reputation of our profession for the future

There is a need to firmly establish the value and highlight the importance of what the professions do and why. To tackle the embedded stereotypes about the roles, and raise the profile of the work nursing, midwifery and care staff do. The breadth of the role as nurses in prescribing, research and technical and clinical care is not understood enough. Nursing is a highly skilled, educated profession and includes extraordinarily skilled people and leaders.

#teamCNO – a collective voice that is powerful and heard

It is vital that nursing, midwifery and care professionals speak with confidence, understand their value and know that their contribution is important. This collective voice enables collective leadership and ensures the professions are heard and valued in all decision-making conversations.

2 LOCAL CONTEXT

In considering how the above resonated and related with nursing and midwifery locally at Medway NHS FT, the Chief Executive Officer (CEO) commissioned a report from NHS E/I in February 2019. The findings from that report identified recommendations for improving nursing and midwifery practice at the Trust, however the main focus of this related to nursing.

On receipt of the report in March 2019, the CEO appointed a Quality Advisor for a period of three months. The purpose of this appointment was twofold,

1. To provide experienced and senior professional leadership support for the Director of Nursing to improve nursing governance and drive forward improvements in practice, and
2. To provide assurance direct to the CEO that nursing leadership, governance and practice was of a good quality. Whilst initially there were some improvements made, such as a reduction in mixed sex accommodation breaches and infection prevention and control, these were not sustained.

In October 2019 the CEO again sought further assurance from two senior experienced nurses, both of whom identified some areas of good practice but also raised concerns, a number of which had also been identified by the Associate Director for Quality and Patient Safety. Concerns found included:

- The attendance at the trust wide nursing forums was poor, due to the reported perception by ward managers and matrons, that the organisational focus and prioritisation was on operational flow, and that these meetings were frequently cancelled.
- It was unclear how nursing indicators and outcomes were linked to the performance management and quality governance within the divisions and care groups, and of how and where senior nurses were held to account.
- There was lack of clarity and consistency regarding the Ward manager/ Senior Sister/ Charge Nurse role (even in use of the job title itself, however for the purpose of this report the title ward manager
will be used). Several ward managers expressed that they had not received any formal leadership development to enable them to fulfil the responsibilities of the role, they felt disempowered and did not have authority for decision making on their wards. Whilst ward managers are 100% supervisory, there does not appear to be a common agreement as to how they divide their time between the supervisory and leadership functions and undertaking ward management duties such as audit and appraisal.

- There was found to be a similar lack of clarity and consistency around the role and function of the Matron. Disparity was found, even within the same division, as to what levels of authority Matrons held - for example in approving off duty rosters. There was variation in how Matrons worked, with many citing that they did not have time to undertake teaching in clinical practice or assure themselves that nursing outcomes were good as they felt pulled into operational flow. Similar to the ward managers, Matrons also said that they had not had any leadership development and they felt that they were not fulfilling the role they thought they should be doing.
- Direct observations of ward routines and practices found distinct variations. Many areas appeared chaotic, cluttered and untidy, and were lacking in structure and routine. There was little or no oversight of fundamental care outcomes such as nutrition and infection prevention and control. Trust wide, most patients were found to be in bed – even at mealtimes, and there was poor compliance with the Trust Clinical Workwear Policy.
- Senior leaders were not fully sighted on ward safety risks that were reported and which were apparent when walking round ward areas.
- There was little or no ‘upward and outward’ facing, communication or sharing of nursing care and practices beyond the hospital.
- A number of the above issues were subsequently identified during the Care Quality Commission (CQC) Core Services reviews – planned and unannounced – and during the Well Led Review.

On 13 December 2019, in part due to the anticipated long-term sick leave of the substantive Director of Nursing, the CEO made some immediate changes to the Trust senior nursing leadership. The Associate Director of Quality and Patient Safety was appointed as the Chief Nurse (interim) and the position of a Director of Nursing Quality and Professional Standards was created to assist with addressing the related issues and concerns.

3 STRATEGIC APPROACH AND PRIORITIES FOR ACTION

Very quickly, the interim Chief Nurse and the Director of Nursing Quality and Professional Standards identified the strategic priorities and actions needed to address nursing related concerns and issues utilising the opportunity to reclaim the nursing landscape and set out the nursing priorities for the next 3, 6 and 12 months. This swift response will provide assurance to the Executive Team, the Trust Board, our regulators and stakeholders and regain confidence in the nursing leadership and delivery of high quality care and standards at the Trust. Whilst acknowledging that there are elements in need of development from a professional leadership position applicable across both nursing and midwifery, the clinical elements in need of improvement are more centred on the adult in patient wards.

The implementation of a unique identifier Matron uniform has been agreed which will support visible leadership in clinical areas and raise the profile of the role of the Matron within the Trust.

The following priority areas set out below and related actions are included in the attachment at appendix 1.

Nursing and Midwifery Leadership

Reviews and research have shown the importance of leadership within healthcare, linked to mortality, quality of care, patient experience and better staff wellbeing and morale. Good health and care outcomes are highly dependent on the professional practice and behaviours of nurses and midwives. The purpose of professionalism in nursing and midwifery is to ensure the consistent delivery of safe, effective and person centred care and achieving the best outcomes for people.

- Led by the Chief Nurse and the Director of Nursing Quality and Professional Standards, the priorities and responsibilities for the following pivotal nursing leadership groups i.e. Ward Managers,
Matrons and Heads of Nursing are being set out in revised job descriptions and the expectations and deliverables from these roles clarified, for example the time spent on clinical versus management duties will be clearly defined. The Matron and Head of Nursing job descriptions are being updated and revised with a launch date of March 2020. To ensure that Matrons are highly visible in clinical areas implementation of a unique identifier Matron uniform, these are red tunics/dresses and is anticipated will be available from April 2020.

• The primary focus for the next six months will be on developing the role of the matron and ward manager with an investment in their leadership development and an infrastructure of support. Reflecting on how the Matrons role has evolved since it was introduced in 2003, on 4 February 2020 the CNO for England launched the Matrons handbook. Several aspects remain the same: providing compassionate, inclusive leadership and management to promote high standards of clinical care, patient safety and experience; prevention and control of infections; and monitoring cleaning of the environment. However, the role has also grown significantly, to include: workforce management; finance and budgeting; education and development; patient flow; performance management; and digital technology and research. From this, the following key roles have emerged:

1. Inclusive leadership, professional standards and accountability.
2. Governance, patient safety and quality.
3. Workforce planning and resource management.
5. Performance and operational oversight.
6. Digital and information technology.
7. Education, training and development.
8. Research and development.
9. Collaborative working and clinical effectiveness.
10. Service improvement and transformation.

• A programme of monthly Matron Forums led by the Chief Nurse commenced in December 2019 and will continue throughout the year. These meetings will focus on our local priorities, supporting leadership development and a refocus on the ten ‘new’ key roles utilising a competency assessment which will be undertaken by the Care Group Heads of Nursing, Director of Nursing Quality and Professional Standards and overseen by the Chief Nurse.

• The Chief Nurse has commissioned a bespoke externally facilitated Matron Leadership Development Programme and will commence on 27 February 2020 until September 2020. Each Matron will have 1-1 shadowing by an experienced senior (external) nurse and a Myers-Briggs Type Indicator assessment; themes from the work shadowing will be fed back to the Chief Nurse and Masterclasses and coaching tailored accordingly. Matrons will attend a personalised diagnostic assessment centre and receive personalised feedback, followed by a programme of six master classes which will include: Personal Effectiveness, Performance Management and influencing and negotiating.

• In addition to the Leading for Quality and Safety Programme introduced by the Chief Nurse whilst in the Associate Director of Quality and Patient Safety role, a focused programme of Ward Manager forums commenced in December 2019 to revisit the ward manager role. Over the course of the year these meetings will include agreeing levels of authority and responsibilities to ensure clarity, and by being explicit in setting what the expectations of their roles are in leading quality, patient experience, standards and professional practice at ward level.

• It is expected that throughout 2020 all Ward Managers will have attended the Leadership for quality and safety programme already established. Cohort one have just completed this course and presented their projects on 10 February; these covered for example: ward leadership in the face of adversity, patient rehabilitation post critical care, consultant involvement in maternity safety huddles
and standardising the discharge process of patients undergoing urological surgery. These projects will be shared more widely at a Grand Round in March to share, celebrate achievements and learning. Cohort two commenced on 14 February. To date this programme has evaluated very positively.

- The above development programmes are aligned and integrated with other strategic priorities, primarily with the Quality Strategy which focuses on safe, effective and person-centred care, but also with the Best Flow programme and the unique contribution of what nursing can bring to that clearly defined. The CNO was explicit in the Matrons handbook that ‘…… leading services to improve the care pathway is a key component of ensuring care quality – the central point of the matron’s role. Designated professionals should take the lead on operational patient flow, which will free the matron’s time to focus on care quality’. We specifically request that our Matrons are released from operational flow to do exactly that.

- In addition Ward Managers need to be visible and focused in their wards directing care, ensuring fundamental standards are achieved, supporting the effective organisation and care delivery in the first two hours of their shift, therefor changing the times of the site bed management meetings has been critical to supporting this.

- Strategically the Chief Nurse in partnership with the Chief Operating Officer has agreed this refocus of the Ward Sisters and Matrons to ensure delivery of standards of care and to support effective discharge planning and improving patient’s outcomes.

- Heads of Nursing ought to provide strong, visible, professional leadership and focus for the delivery of the best of care throughout their Care Group. They are accountable for a range of services across their groups ensuring high quality, flexible and responsive service delivery and to plan, develop, coordinate and evaluate the services provided. However they have not had the leadership development to enable them to do this effectively. Similar to the Matrons leadership development programme, the Chief Nurse has commissioned a bespoke Heads of Nursing leadership development programme which will commence in May 2020. The programme will cover, for example, enriched political and self-awareness, greater confidence and self-belief and greater understanding and engagement in the National health agenda and will support raising the profile and effective delivery of patient care and outcomes across the Trust.

**Nursing and Midwifery Governance**

- A new nursing and midwifery standards, accountability and governance framework is currently being developed. Focussing on the Matron ten key roles, the quality and safety metrics for measuring and monitoring fundamental standards and demonstrating improvement and impact. This will be finalised by the end of February and implemented in March 2020. This will be supported by a standardised fortnightly Matrons quality report to their Head of Nursing and a monthly quality report generated from each Head of Nursing/ Midwifery to their Divisional Director of Nursing (DDON). Each DDON will then produce a divisional nursing and quality assurance report to the Chief Nurse. This mechanism will provide the Chief Nurse with assurance regarding the standards of patient care across the Trust.

- Wards will all have a quality and safety board which have been ordered and will be populated with data to enable the measurement of days between falls, pressure ulcers and other related nursing and patient indicators.

- A weekly senior nursing leadership meeting, with a structured agenda focused on these priorities and related actions to support delivery, was introduced by the Chief Nurse in December 2019.

- A programme of standardised bedside/ ward handover and re-establishing ‘the first two hours of a wards day’ will be role modelled and implemented across the Trust commencing with testing in February.

- Currently nursing staff are recording patient care assessment, planning, delivery and evaluation on both paper and electronic systems which has led to confusion for staff and duplication, this lack of standardisation is a risk to the organisation and urgent work is being progressed to address this. An ExtraMed four week task and finish group, supported by the Director of Transformation, is assisting with streamlining and standardising our processes.
• Currently Perfect Ward is being used to evaluate a range of care environment and nursing practices; however this is not being implemented in a standardised way at present with little assurance to be gained from the findings produced. Again, a four week task and finish group to review the use of Perfect Ward and clarify its role and function to support the auditing of standards across the Trust is underway.

• An external review of maternity services with a focus on reporting, investigating and learning form incidents and the governance to support is being commissioned by the Chief Nurse and will be undertaken in partnership with the CCG. This will provide assurances that our maternity services are safe, effective and person centred and where recommendations are made from this, these will be incorporated into our priorities.

Workforce and education

• Explicit criteria and a clear methodology for undertaking a nursing and midwifery workforce review, including an establishment review of both divisional and corporate nursing teams (including Clinical Nurse Specialists); and incorporating an education and training needs analysis review of current and future nursing and midwifery workforce requirements will be undertaken from the beginning of April, this will include a review of safe staffing, ward establishments, identification of workforce priorities as well as job planning for specialist nurses. Any subsequent role/ people changes will be made in keeping with the Trust policy on organisational change.

• The development of a nursing and midwifery workforce and education and training plan for the Trust is an area of priority which the Chief Nurse has identified. The appointment of a workforce lead will be pivotal to overseeing this work which will also focus on new and alternative roles with a focus on the identified areas of risk and priorities for the Trust to support.

• We are also conscious that the implementation of the national Care Certificate for our Clinical Support Workers has not progressed at the Trust, so currently we are reviewing the resource requirements needed to implement the Care Certificate from 30 March 2020 and the Chief Nurse has requested a paper setting out our strategic approach and plan to implement the Care certificate over the next 12 months.

Quality

• This prioritised work-plan will be an opportunity to ensure alignment and integration with strategic priorities, primarily the Quality Strategy which focuses on delivery of safe, effective and person-centred care, alongside other strategic priorities i.e. the Best Flow programme to confirm the unique contribution of nursing and ensure ward to Board visibility in support of the delivery of high quality care and nursing standards and practice.

• A programme of development relating to fundamental aspects of nursing care will be implemented and will include prioritising areas of risk: nutrition and hydration, pressure ulcers, falls, person centred care, discharge planning including a re-launch of ‘end pj paralysis’, documentation (particularly in relation to individual patient risk assessments and care planning), safeguarding, infection prevention and control and delivery of the quality strategy priorities on identified pilot wards. This programme will commence with a Trust-wide baseline audit of the fundamental standards of care that each of our patients can expect to receive, a trust wide nutrition and hydration audit and a trust wide patient dignity audit. This work will be completed in February and the outcomes from these audits will provide the Chief Nurse with a baseline position for the Trust and from which to determine the priority areas of focused improvement and next steps will be. Thereafter the findings will be shared at the Nursing and Midwifery Advisory Group meeting on 9 March, the Quality Assurance Committee on 27 March and at a multi-disciplinary Grand Round on 6 April 2020, Executive Team and Quality Assurance Committee.

Structure & Resources

• The appointment of a deputy Chief Nurse role to support the Chief Nurse is pivotal and is urgently required to ensure the Corporate Nursing infrastructure is sufficient in providing senior professional
nursing leadership to drive forward this significant programme of priority work. A revised job description has been approved and progress towards appointing on an interim basis initially, has commenced.

- Critical to supporting the nursing and midwifery workforce and education priorities, it is essential that a senior nurse workforce lead be created to lead on this important agenda and an identified lead for implementing the Care Certificate Programme.
- The introduction of joint monthly 2-2-1 meetings with the Chief Nurse, each Divisional Director of Nursing and the Chief Operating officer to ensure delivery of the strategic priorities is also being established.

4 CONCLUSION AND NEXT STEPS

- Strong, visible nursing and midwifery leadership and oversight, and driving implementation of quality and nursing standards, as set out above, is essential to ensuring the delivery of our local strategic quality and safety priorities and in turn regaining the confidence in nursing both internally and externally to the Trust. This will ensure nurse leaders and their nursing teams are accountable and responsible for patient care, delivery of the Chief Nurse for England’s vision and the Trusts Five Strategic Objectives:
  1. We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place.
  2. We will embrace innovation and digital technology to support the best of care.
  3. We will deliver financial sustainability and create value in all we do.
  4. We will enable our people to give their best and achieve their best.
  5. We will consistently provide high quality care.

- It is expected that the priorities set out in ‘Reclaiming the nursing landscape’ will be both welcomed and supported by the CEO, our Executive and senior nursing colleagues and the Trust Board.
- A monthly report on progress against these priorities will be presented to the Executive Group meeting by the Chief Nurse.
- We recognise that there is much more to do to strengthen nursing and midwifery leadership and effectiveness locally, however we are convinced that these are our priorities for the next 12 months. In order to deliver the scale and depth of priorities at pace will, at times, require a more transactional leadership approach to be taken. However to truly transform nursing and midwifery practices at the Trust, a three-year nursing and midwifery strategy will be developed in the summer and launched in the autumn of 2020.
- Such is our commitment to delivering on these priorities we will make the launch of this plan public by inviting the Chief Nurse for England and Regional Chief Nurse to meet with our senior nursing and midwifery leaders in support of this work.
- We will celebrate our achievements at Medway NHS FT by hosting a nursing and midwifery conference in November, whilst also celebrating the 200th birthday of the founder of modern nursing, Florence Nightingale and ‘2020 International Year of the Nurse and Midwife’ with a series of events scheduled to take place throughout the year.
<table>
<thead>
<tr>
<th>Date</th>
<th>Patient/ Clinical Care</th>
<th>Governance</th>
<th>Leadership</th>
<th>Operational</th>
<th>Workforce &amp; Education</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 16/12/20</td>
<td></td>
<td></td>
<td>Programme of weekly meetings commenced with Senior Nursing Leadership team</td>
<td></td>
<td></td>
<td>Draft ‘Reclaiming the nursing landscape</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Programme of monthly meetings commenced with Ward Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Programme of monthly meetings commenced with Matrons Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w/c 13/01/20</td>
<td></td>
<td></td>
<td>Facilitated Matron workshop</td>
<td></td>
<td></td>
<td>Scope nursing priorities for the next 3, 6 and 12 months to understand the scale and depth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unique identifier Uniform for Matrons agreed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w/c 20/01/20</td>
<td>First review of nursing quality and safety metrics</td>
<td></td>
<td>Programme of monthly meetings commenced with Heads of Nursing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>w/c 27/01/20</td>
<td>Undertake a patient by patient review of all patients on Dickens ward prior to being discharged or transferred</td>
<td></td>
<td>Matron to maintain a central log of all patient level risk assessments, as well as ensuring these are accurately recorded in the patient records.</td>
<td></td>
<td></td>
<td>Scope nursing priorities for the next 3, 6 and 12 months to understand the scale and depth</td>
</tr>
</tbody>
</table>
| w/c 03/02/20 | Determine the criteria and methodology for three Trust wide patient care audits  
  - Fundamentals of Care  
  - Nutrition and Hydration  
  - Dignity  
  This will provide a baseline position for the trust and will help to determine the next steps | Standardise a Ward Manager daily and weekly checklist | Revise Matron job description | Identify what needs to be put in place Trust wide to free up nurses from attending 8:15 and 8:30 site huddles, and Matrons from all bed meetings | Review resource requirements to implement the Care Certificate | Draft Nursing Quality Standards Improvement Framework |
| Roll out Theme of the month throughout February: Nutrition and Hydration | Weekly quality monitoring report for Matron escalation/assurance to HON  
  Develop monthly divisional nursing quality improvement and assurance report template | Professional Standards meeting with DDONs, HONs and Matrons | Review next four weeks of diaries of all Matrons and HONs to ensure only essential/appropriate meetings attended |  |
|  |
| w/c 10/02/20 | Matrons and corporate specialist nursing team to undertake a Trust wide patient level risk assessment audit | Commence Task and Finish Group (x4 weeks) to review form and function of Perfect Ward | Coproduction of externally facilitated HON development programme | Commence Task and Finish Group (x4 weeks) to review functionality and scope of Extramed | HR facilitated debrief for Dickens ward staff | Determine scope of Maternity services external review |
| Matrons and Ward Managers to conduct a Trust wide Dignity (patients in bed) audit | Ward Managers Leadership for Quality and Safety Cohort 1 – presentations |  |  | CSW open forum | Launch Principles of Nursing |
| Matrons and Ward Managers to conduct a Trust wide nutrition and hydration audit | Ward Managers Leadership for Quality and Safety Cohort 2 starts |  |  |  |  |
## Nursing and Midwifery priorities for the next 3, 6 and 12 months

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 17/02/20</td>
<td>Rollout ‘first 2 hours’ on first two pilot wards (x1 UPIC x1 PC) (2) and thereafter roll out to one ward per division every two weeks thereafter until 01/06/20</td>
</tr>
<tr>
<td></td>
<td>Determine the criteria, form and function of a Trust wide nursing and midwifery accountability panel. Each care group will present twice per year</td>
</tr>
<tr>
<td></td>
<td>Review HONs job description</td>
</tr>
<tr>
<td></td>
<td>Staff nurse open forum</td>
</tr>
<tr>
<td>24/02/20</td>
<td>Commence externally facilitated six month Matron development programme</td>
</tr>
<tr>
<td></td>
<td>Determine criteria and methodology to assess RN competence in patient level risk assessments</td>
</tr>
<tr>
<td></td>
<td>Present Reclaiming the nursing landscape to the Executive Group</td>
</tr>
<tr>
<td>02/03/20</td>
<td>Roll out Theme of the month throughout March: End PJ Paralysis</td>
</tr>
<tr>
<td></td>
<td>Commence monthly nursing and midwifery accountability panel – e.g. Surgical Services (1)</td>
</tr>
<tr>
<td></td>
<td>Launch of revised Matron JD and national Matron Handbook</td>
</tr>
<tr>
<td></td>
<td>Review form and function of Safer Nursing Care Tool/ Safe Care Live and Care Hours per Day and reporting</td>
</tr>
<tr>
<td>09/03/20</td>
<td>Nursing and Midwifery Advisory Group: sharing of Fundamentals of Care Audit findings</td>
</tr>
<tr>
<td></td>
<td>Trust wide CNS Forum</td>
</tr>
<tr>
<td>30/03/20</td>
<td>Roll out Theme of the month throughout April: TBC</td>
</tr>
<tr>
<td></td>
<td>Introduce monthly ‘breakfast with the Chief Nurse’ open forums</td>
</tr>
<tr>
<td></td>
<td>Commence roll out of Care Certificate for CSW</td>
</tr>
<tr>
<td></td>
<td>Determine criteria and methodology for undertaking workforce review, incl. establishment review of both divisional and corporate nursing</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>06/04/20</td>
<td>Grand Round: Presentation of Nutrition, Hydration and Dignity audits</td>
</tr>
<tr>
<td>04/05/20</td>
<td>Roll out Theme of the month throughout May: International Year of the Nurse and Year of the Midwife</td>
</tr>
<tr>
<td>18/05/20</td>
<td>Commence externally facilitated HON development programme</td>
</tr>
<tr>
<td>01/06/20</td>
<td>Roll out Theme of the month throughout June: TBC</td>
</tr>
<tr>
<td>29/06/20</td>
<td>Matrons and corporate specialist nursing team to undertake a 2&lt;sup&gt;nd&lt;/sup&gt; Trust wide patient level risk assessment audit</td>
</tr>
<tr>
<td></td>
<td>Matrons and Ward Managers to conduct a 2&lt;sup&gt;nd&lt;/sup&gt; Trust wide Dignity (patients in bed) audit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teams</th>
<th>Involving CNS; and incorporating education and training needs analysis review</th>
</tr>
</thead>
</table>

Commence the development of a Nursing and Midwifery Strategy 2020 – 2022

Give consideration to areas in which nursing research would be of benefit
## Nursing and Midwifery priorities for the next 3, 6 and 12 months

<table>
<thead>
<tr>
<th>Action</th>
<th>05/10/20</th>
<th>23/11/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matrons and Ward Managers to conduct a 2nd Trust wide nutrition and hydration audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate Director of Nursing to undertake a review of ‘First two hours’ to ensure embedded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Launch Nursing and Midwifery Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MFT 2020 International Year of the Nurse and Midwife Conference</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A revised nursing meeting programme commenced in December 2019.
Senior nursing team weekly meetings c. 16/12/19
Monthly Ward Managers forums
Monthly Matrons forums
Monthly HON/M forums
### Executive Summary

This report informs Board Members in the form of a dashboard report of January 2020 quality and operational performance across key performance indicators.

#### Safe:

We continue to see an improvement on key KPI metrics for pressure ulcers, patient falls and C-Diff. While the HSMR for patients admitted at the weekend has begun to indicate some improvements – with a reduction from 119.5 (for the 12 months to June 2019) to 115.9 (for the 12 months to October 2019), this improvement should be treated with caution as the observed deaths in this cohort has not changed significantly over the time period.

#### Caring:

Mixed Sex Accommodation Breaches have improved slightly but remain high at 76 breaches in January. These are related to Critical Care patients that are ready to step down from level 3 and 2 beds; an MSA action plan is in place and is currently being worked through with the Divisional Teams to ensure timely step downs. The Trust is expected to report to the CQC on actions taken by 20 March on concerns raised. The Trust continues to work through the Best Flow Programme to improve Flow within the Trust. EDN completion remains an issue. The Task and Finish Group set up to review the process has now ended and a report on the findings awaits. Following this an improvement trajectory will be created and against which performance will be measured.

#### Effective:

Discharges before noon remains static with the Trust averaging 14.67% in the last 12 months. With regard to the Maternity standards the total C-section rate has deteriorated from 30.49% in December 2019 to 37.05% in January 2020, the highest it has been all year. The reason for this has been requested from the service. For patients admitted with a Fractured Neck of Femur, 82.4% received surgery within 36 hours of admission, which is the best performance year to date. VTE assessment % has improved to 93.08% in January against 91.97% in December 2019, however remains below the 95% target.

#### Responsive:

The January 4 hour standard performance places the Trust at 78.98% for all
types with 34 patients breaching the 12 hour DTA standard due to continued late average time of day of discharge and increasing number of mental health attendances. CDU opened on 6 January with an average of 15 patients per day flowed from ED. The Best Flow programme continues to change the way of working within the Trust. The Best Access programme is reviewing the elective processes within the Trust. The RTT position for January is currently showing as 81.94%, which is a deterioration from 83.25% in December. There was one patient with a 52 week breach. Diagnostics position for the month is sitting at 94.22% against a 12 month average of 96.15%. Cancer – the position for the 2 week wait in January shows that 97.91% of patients were seen within 2 weeks, this is the best performance this year.

**Well Led:**
The Trust remains above the 85% appraisal standard at 87.86%. The Statutory and Mandatory training remains above the compliance standard at 92.23%.

<table>
<thead>
<tr>
<th>Committees or Groups at which the paper has been submitted</th>
<th>This report was presented to the Quality Assurance Committee on 28 February 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Implications</td>
<td>Nil</td>
</tr>
<tr>
<td>Legal Implications/Regulatory Requirements</td>
<td>Nil</td>
</tr>
<tr>
<td>Quality Impact Assessment</td>
<td>Not required</td>
</tr>
<tr>
<td>Recommendation/Actions required</td>
<td>The Board is asked to discuss this report</td>
</tr>
<tr>
<td>Approval</td>
<td>Assurance</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Appendices</td>
<td>Appendix 1. Integrated Quality Performance Report Dashboard</td>
</tr>
</tbody>
</table>

*Reports to committees will require an assurance rating to guide the Committee’s discussion and aid key issues reporting to the Board*

The key headlines and levels of assurance are set out below:

<table>
<thead>
<tr>
<th>Partial assurance</th>
<th>Amber/Red - there are gaps in assurance</th>
</tr>
</thead>
</table>

Committee report
Integrated Quality and Performance Report

January 2020

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Executive Summary  2
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Caring  9
Effective  13
Responsive  17
Well Led  27
Safe Staffing  30
Executive Summary

**Safe:**
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**Effective:**
Discharges before noon remains static with the Trust averaging 14.67% in the last 12 months. With regard to the Maternity standards the total C-section rate has deteriorated from 30.49% in December 2019 to 37.05% in January 2020, the highest it has been all year. The reason for this has been requested from the service. For patients admitted with a Fractured Neck of Femur, 82.4% received surgery within 36 hours of admission, and the best performance year to date. VTE assessment percent has improved to 93.08% in January against 91.97% in December.

**Responsive:**
The January 4 hour standard performance places the Trust at 78.98% for all types with 34 patients breaching the 12 DTA standard due to continued late average time of day of discharge and increasing number of mental health attendances. CDU opened on 6 January with an average of 15 patients per day flowed from ED. The Best Flow programme continues to change the way of working within the Trust. The Best Access programme is reviewing the elective processes within the Trust. The RTT position for January is currently showing as 81.94%, which is a deterioration from 83.25% in December. The was one patient with a 52 week breach. Diagnostics position for the month is sitting at 94.22% against a 12 month average of 96.15%. Cancer – Un-validated position for 2 week wait in January shows that 97.91% of patients were seen within 2 weeks, this is the best performance this year.

**Well Led:**
The Trust remains above the 85% appraisal standard at 87.86%. The Statutory and Mandatory training remains above the compliance standard at 92.23%.
The Trust remains within trajectory for C. difficile infections and the antimicrobial stewardship group meets regularly to approve and keep track of initiatives to provide controls around this. There have been four cases of MRSA this year in this reporting period. The Trust has an MRSA improvement plan under implementation phase.

<table>
<thead>
<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
<th>Aug 19</th>
<th>Sep 19</th>
<th>Oct 19</th>
<th>Nov 19</th>
<th>Dec 19</th>
<th>Jan 20</th>
<th>12M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm Free Care</td>
<td>Falls Per 1000 Bed Days</td>
<td>6.6</td>
<td>#</td>
<td>7</td>
<td>4.59</td>
<td>4.73</td>
<td>4.74</td>
<td>5.01</td>
<td>4.22</td>
<td>4.15</td>
<td>6.13</td>
<td>4.94</td>
<td>4.10</td>
<td>3.79</td>
<td>4.37</td>
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<tr>
<td></td>
<td>Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)</td>
<td>1.0</td>
<td>#</td>
<td>0</td>
<td>0</td>
<td>0.2</td>
<td>0.06</td>
<td>0</td>
<td>0</td>
<td>0.13</td>
<td>0</td>
<td>0.06</td>
<td>0.00</td>
<td>0.00</td>
<td>0.05</td>
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<tr>
<td>Incident Reporting</td>
<td>No of SSI on STEIS</td>
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<td>#</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>8</td>
<td>11</td>
<td>10</td>
<td>12</td>
<td>7</td>
<td>19</td>
<td>17</td>
<td>15</td>
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<tr>
<td></td>
<td>% of SSI Responded To in 60 Days</td>
<td>-</td>
<td>%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Infection Control</td>
<td>MRSA Bacteremia (Trust Attributable)</td>
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<td>1</td>
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<td></td>
<td>C. Diff. Acquisitions (Trust Attributable, Post 48 Hours)</td>
<td>43.0</td>
<td>#</td>
<td>-</td>
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<td>3</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>1</td>
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<td>C. Diff. Hospital Onset Hospital Acquired (HOHA)</td>
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<td>1</td>
<td>8</td>
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<td>4</td>
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<td>6</td>
<td>9</td>
<td>5</td>
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<tr>
<td>Mortality</td>
<td>Crude Mortality Rate</td>
<td>2.5</td>
<td>%</td>
<td>1.51</td>
<td>1.92</td>
<td>1.5</td>
<td>1.9</td>
<td>1.78</td>
<td>1.42</td>
<td>1.53</td>
<td>1.34</td>
<td>1.24</td>
<td>1.37</td>
<td>1.51</td>
<td>1.52</td>
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<tr>
<td></td>
<td>HSMR (All)</td>
<td>100.0</td>
<td>%</td>
<td>106.61</td>
<td>106.97</td>
<td>107.19</td>
<td>107.12</td>
<td>107.82</td>
<td>108.08</td>
<td>103.02</td>
<td>101.66</td>
<td>102.53</td>
<td>-</td>
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<td></td>
<td>HSMR (Weekday)</td>
<td>100.0</td>
<td>%</td>
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<td>103.76</td>
<td>103.25</td>
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<td>101.21</td>
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<td>95.53</td>
<td>97.69</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>HSMR (Weekend)</td>
<td>100.0</td>
<td>%</td>
<td>114.67</td>
<td>110.03</td>
<td>115.3</td>
<td>117.17</td>
<td>119.49</td>
<td>119.49</td>
<td>110.51</td>
<td>117.73</td>
<td>113.76</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td></td>
<td>SHMI</td>
<td>1.0</td>
<td>#</td>
<td>1.05</td>
<td>1.09</td>
<td>1.07</td>
<td>1.09</td>
<td>1.11</td>
<td>1.11</td>
<td>1.12</td>
<td>1.12</td>
<td>1.12</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>
Safe – Total HSMR
Spotlight Report

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

HSMR Total Definition:
The HSMR for the year to October 2019 was 102.5, representing a small rise over the 12 months to September 2019. A small increase in observed deaths during the year was also seen (from 1129 to 1141).

While the HSMR for patients admitted at the weekend has begun to indicate some improvements – with a reduction from 119.5 (for the 12 months to June 2019) to 115.9 (for the 12 months to October 2019), this improvement should be treated with caution as the observed deaths in this cohort has not changed significantly over the time period (climbing from 329 to 334).

The mortality for frail patients admitted at the weekend does appear to be improving: from a peak of HSMR (132.8) and observed deaths (213) in the 12 months to March 2019, the most recent data indicates an HSMR of 118.0 and observed deaths of 206.

Changes have been made to both the general medical and the frailty models of care for the weekend. Both systems have introduced additional consultant support for the acute take from January 2020. The weekend mortality will continue to be closely monitored to assess the impact of these changes, although it will be appreciated given the lag in reporting of HSMR that the benefits are unlikely to be apparent until data released in May 2020 at the earliest.

Weekend mortality is higher than weekday mortality for both Medway and Swale residents. However the difference remains much more marked for Swale residents. The HSMR for Medway residents is 94.7 for weekday admission and 110.8 for weekend admission, while the HSMR for Swale residents is 101.0 for weekday admission and 130.1 for weekend admission. This difference between the boroughs remains unexplained.
Safe – Falls Per 1,000 Bed Days
Spotlight Report

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

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

In January there were 77 in patient falls.

One patient had fallen 6 times. All prevention strategies were in place and were balanced with the patient’s rights to independence and choices about the risks he was prepared to take.

14 falls (18%) related to patients with a diagnosis of Dementia.

7 falls (9%) related to patients diagnosed with delirium.

7 falls (9%) related to patients with a history of alcohol excess.

No incidences of harm were sustained from falls categorised as moderate/severe harm or death.

The Trust has remained below the national mean rate for falls resulting in moderate/severe harm or death since June 2019.

In Quarter 3, the trust achieved 38% compliance for falls CQUIN.

The minimum compliance required to achieve CQUIN is 25%.

Focused improvement work to reduce falls in line with the Quality Strategy include:

- The completion of lying and standing blood pressure competencies on the pilot wards
- Additional training for new “Sure” falls alarms
- Trialling of low emergency trauma trolleys to reduce risk of patients falling from the trolley whilst in the Emergency Department
- Improving completion of an assessment of mobility within 24 hours.
Safe – Pressure Ulcers Per 1,000 Bed Days Spotlight Report

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

In January the total number of hospital acquired pressure ulcers was 15.

There was 1 moderate Harm in January for an acquired unstageable pressure ulcer.

Across both directorates there were a total of:
- 6 category 2 PU
- 5 Deep Tissue Injury PU
- 3 Unstageable PU
- 1 category 2 (d) PU (caused by a device)

In January our highest incident ward was Byron Ward.

There was a total of 22 lessons learnt across both directorates for pressure ulcers.

The Trust is below the occupied bed day target for this month

We are above our trajectory target by 30 Pressure ulcers

Tissue Viability continue to carry out a point prevalence and aSSKIng audit every month.

aSSKIng audit results in January were 76% - Target 95%

Training for pressure ulcer prevention and management is available on a monthly basis – Total of 10 members of staff attended in January.

Pressure ulcer panel meeting is carried out on a monthly basis, all pressure ulcers that have acquired that month are discussed with an overarching trust pressure ulcer improvement plan attached to this to discuss learning.
Caring

FFT response rates – the inpatients response rate remains a challenge and we are currently exploring ways to increase this with our current provider. The response rate for ED remains above the national average of 12% (Nov 19 – latest data). The maternity response rate has dipped and this is due in part to the paper survey method that is used and the data entry is not always timely. We are currently exploring introducing a digital response to replace paper surveys. There is no reportable national response rate captured for outpatients, however our provider suggests that we are above the UK average of 7.5%.

FFT would recommend rates - Maternity, outpatients and Inpatients achieve reasonable would recommend scores from patients but we are currently sit below the national average with the exception of maternity. Our ambition is to improve on these scores overall and build on the work that has already been undertaken.

### Caring Commentary:

FFT response rates – the inpatients response rate remains a challenge and we are currently exploring ways to increase this with our current provider. The response rate for ED remains above the national average of 12% (Nov 19 – latest data). The maternity response rate has dipped and this is due in part to the paper survey method that is used and the data entry is not always timely. We are currently exploring introducing a digital response to replace paper surveys. There is no reportable national response rate captured for outpatients, however our provider suggests that we are above the UK average of 7.5%.

FFT would recommend rates - Maternity, outpatients and Inpatients achieve reasonable would recommend scores from patients but we are currently sit below the national average with the exception of maternity. Our ambition is to improve on these scores overall and build on the work that has already been undertaken.

### Domain KPI Name | Target | Feb 19 | Mar 19 | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | 12M
---|---|---|---|---|---|---|---|---|---|---|---|---|---|---
Admitted Care | Mixed Sex Accommodation Breaches | 0.0 | # | 252 | 147 | 85 | 107 | 97 | 139 | 190 | 138 | 80 | 73 | 74 | 76 | 1368
| MSA % | 0.0 | % | 1.75 | 0.94 | 0.59 | 0.7 | 0.67 | 0.9 | 0.65 | 0.96 | 0.53 | 0.45 | 0.46 | 0.45 | 6.75
| % of EDNs Completed Within 24hrs | 100.0 | % | 75.56 | 75.53 | 75.95 | 77.5 | 74.93 | 73.19 | 70.64 | 74 | 74.57 | 73.97 | 88.55 | 85.81 | 73.23
Inpatients Friends & Family % Recommended | 65.0 | % | 76.33 | 65.59 | 85.6 | 94.41 | 63.66 | 68.01 | 65.25 | 66.55 | 65.97 | 66.16 | 67.67 | 57.03 | 85.86
Inpatients Friends & Family Response Rate | 22.0 | % | 12.1 | 20.94 | 15.03 | 16.51 | 20.65 | 20.72 | 22.07 | 22.04 | 22.96 | 21.55 | 20.19 | 19.07 | 19.85
ED Care | ED Friends & Family % Recommended | 65.0 | % | 72.16 | 75.56 | 73.34 | 73.14 | 72.56 | 72.9 | 77.85 | 84.65 | 79.14 | 77.72 | 77.96 | 30.94 | 77.01
| ED Friends & Family Response Rate | 22.0 | % | 13.23 | 13.42 | 10.64 | 12.35 | 13.45 | 12.06 | 15.3 | 14.38 | 14.23 | 13.86 | 14.43 | 15.06 | 13.85
Maternity Care | Maternity Friends & Family % Recommended | 85.0 | % | 99.96 | 99.96 | 100 | 100 | 99.96 | 99.77 | 99.44 | 99.85 | 99.19 | 99.46 | 99.16 | 93.48
| Maternity Friends & Family Response Rate | 22.0 | % | 38.67 | 31.78 | 29.77 | 26.88 | 21.01 | 23.56 | 18.51 | 19.65 | 22.77 | 20.58 | 8.6 | 15.29 | 29.94
Outpatients Care | Outpatients Friends & Family % Recommended | 85.0 | % | 89.48 | 91.14 | 89.23 | 89.77 | 89.42 | 89.9 | 91.51 | 91.2 | 90.96 | 91.33 | 92.02 | 91.17 | 99.86
| Outpatients Friends & Family Response Rate | 22.0 | % | 14.83 | 14.15 | 10.32 | 12.87 | 12.75 | 12.91 | 15.04 | 15.09 | 15 | 15.11 | 14.28 | 15.45 | 13.36

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
Caring – Mixed Sex Accommodation Spotlight Report

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

<table>
<thead>
<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
<th>Jan 19</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
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<th>Sep 19</th>
<th>Oct 19</th>
<th>Nov 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>MSA Breaches</td>
<td>0.0</td>
<td>252</td>
<td>147</td>
<td>65</td>
<td>107</td>
<td>97</td>
<td>138</td>
<td>0</td>
<td>158</td>
<td>80</td>
<td>73</td>
<td>74</td>
</tr>
</tbody>
</table>

Commentary

The validated position for January 2020 is 76, all for critical care. ICU 13, MHDU 26 and SHDU 37. Longest wait was 3 days on MHDU.

Exec support remains, and we have also started audit of patient who are staying in recovery and if they experience MSA.

MSA is a key issue discussed at all site meetings and safety breeches.

Risks & Mitigating Actions

MSA is avoided where possible using side rooms, annexes and bays. Step downs are identified at 8am daily. Extramed is viewed for a visual notification of males and females. 10am – HoN/Matron review patients on wards to instigate ‘umixing’ if possible. Bed requirements are escalated to site/surgical bed manager/care group as soon as required, as well as scheduled site meetings as 0830, 1100, 1400 and 1545 daily. Relevant care group duty manager is response for identifying an empty bed. MSA report is reviewed formally on a weekly basis with BI attendance. The CC representative is responsible for reviewing the MSA data on daily basis. The NIC of each area is responsible to answer any justified or unjustified breeches. The Critical Care Matron reviews the MSA report on a weekly basis and validates. BI is contacted should there be any errors or amendments required (this may take some time and multiple correspondence)

The CC rep is contacted when the bed is allocated, and they initiate the transfer between the relevant units. NHSi confirmed that time stamp for MSA restarts at 7am, providing a 4 hour window to step patients out. This has been amended on the reporting tool. Position for 14/02/202 13 for ICU, 9 MHDU and ZERO for SHDU.
Caring – Electronic Discharge Notification (EDN) Spotlight Report

Commentary
Risks & Mitigating Actions

Task and finish group now completed and closed.

Recommendations, made by a multidisciplinary stakeholder group consisting of GPs, Pharmacy, BI, IT, Junior Doctors, have been made as requested. These recommendation will need to be actioned if eDN quality and completion are to be improved and any improvement is to be sustained.

Of note, the data being provided needs to be analysed more closely as its accuracy may be questionable.

Recommendations are as follows:

• Reduce the eDN dataset to contain only the necessary information relevant, to achieve safe, timely and effective handover of care from the hospital teams to primary care teams
• Provide useful focussed education in the form of face to face quick fire sessions, at induction, to junior doctors about how to write a high quality discharge summary
• Streamline the drugs list and pharmacy section to reduce the risk of error and time taken to complete
• Improve the mechanics of completion of an eDN to – time of day, location, passwords
• Provide protected eDN completion time for junior doctors
• There must be a useful monitoring process that is accessible and relevant to all involved in the process
• There should be regular, close monitoring of the success of the project, owned by a member of executive with clear ownership of the eDN process.

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

The Trust’s readmission rate is not a national outlier according to the Dr Foster metrics. The relative risk of readmission on Dr Foster is 99.2 for the year to July 2019, with a crude rate of 12.9% for that period. The apparent rise in crude rate noted in the table above will be kept under close review.

The time to theatre for patients with fractured neck of femur has improved since August 2019 (from 52.2% to 74.1%) but further review is required to ensure that the improvements are sustained. Issues with theatre time availability, particularly when patients with fractures arrive in batches is a key underlying issue.

There are no improvements in the SSNAP rating: the Trust continues to work to support the stroke service pending the outcome of the Judicial Review and the Independent Review Panel.
Effective – Fracture Neck of Femur Spotlight Report

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

Fractured NOF in 36 Hours Definition:

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

Commentary
Risks & Mitigating Actions

The time to theatre for patients with fractured neck of femur has improved since August 2019 (from 52.2% to 74.1%) but further review is required to ensure that the improvements are sustained. Issues with theatre time availability, particularly when patients with fractures arrive in batches is a key underlying issue.
Effective – VTE risk Assessment Spotlight Report

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

Performance within VTE compliance through the first quarter of 2020 is relatively stable. This is due to constant monitoring, reviews and flexing of processes to amend issues as they arise.

The VTE nurse continues her efforts to improve the performance and try to hit the 95% compliance rate. January and February just shy of that.

Examples of Improving Practices:
Due to the current VTE nurse leaving us from the end of March 2020, the service has been discussed and a new structure has been decided on. The band 7 VTE nurse will now work alongside a band 2 admin Clerk which should help increase the rate of compliance for the service. Through this we hope to see improvement across the board including the more difficult areas, such as paediatrics.

Risks:
• Paediatric Ward engagement continues to be an issue.
• 0% compliance for Dec19/Jan20
• Opening of escalation areas affect the VTE compliance.
• VTE nurse leaving in March for a new role
• Contingency plan for service during the interim of VTE vacancies.

Mitigations/actions taken:
• Redesign of the VTE role creating a band 2 assistant role to facilitate the collection and inputting of VTE assessments
• Training sessions have been delivered for all Ward Managers and Ward Clerks for the completion & entry of VTE risk assessments
• Specific training sessions have been completed on both Lister and on the Paediatric wards
• VTE nurse is working hard on maintaining performance in areas where staffing is limited
Responsive – Non-Elective

Medically fit patients in the Trust peaked at 153 in early Jan in addition delayed transfers of care were also at the highest level this year, leading to an increased average LOS. 12hr breaches were also the highest of the year due to continued late average time of day of discharge and increasing number of mental health attendances.

Conversion rate was at the highest of the year due to increase acuity.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients “boarded” on an escalation ward are more likely to have poorer experience and high delays in discharge. These wards are not funded and staffed from a planned annual budget.
Responsive – ED 4 Hr Performance All Types and Type 1 Spotlight Report

**Commentary**

Admitted performance was 1.89%, non-admitted 87.37%. Admitted performance in the 3rd week of the month was relatively strong at 16%+ in contrast to a usual run rate of 0-2%.

Focus and additional resourcing for the medical take has reduced waiting times to under an hour on weekdays with further work needed on nights.

CDU opened on 6th Jan with an average of 15 patients a day flowed from ED with an estimated 2.5-3% improvement in 4hr performance.

4.41% of patients were turned around at the front door with a further 1.58% STREAMed to SDEC.

**Risks & Mitigating Actions**

- Increasing CDU throughput to 25 patients a day to further reduce type1 breaches
- Developing a plan to mitigate against the closure of the CDU estate in March
- Continued focus on delivery of BEST Flow objectives to improve admitted performance
- Decision and action relating to DTA upon referral
- Development of live breach validation process to provide better intelligence of breach reduction opportunities

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**ED 4 Hour Local Trajectory**

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Responsive – Elective

### Responsive – Elective Commentary:

The Trust failed to hit the constitutional standards for the month of December for both RTT 18 weeks and the diagnostic DM01 performances. The Trust is reported zero 52 week waits and a positive DNA rate of 7.88% for the month of January. The number of patients cancelled on the day dropped to 20 from 44 largely due to a reduction in the elective programme due to winter pressures.

### Responsive – Elective

<table>
<thead>
<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
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<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
<th>Aug 19</th>
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<th>Jan 20</th>
<th>12M</th>
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</thead>
<tbody>
<tr>
<td>Diagnostic Access</td>
<td>DM01 Performance</td>
<td>99.0%</td>
<td>98.92</td>
<td>98.7</td>
<td>95.41</td>
<td>93.72</td>
<td>92.03</td>
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<td>92.0%</td>
<td>60.25</td>
<td>60.75</td>
<td>63.06</td>
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<td>62.25</td>
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<td></td>
<td>18 Weeks RTT Over 52 Week Breaches</td>
<td>0.0%</td>
<td>#</td>
<td>27</td>
<td>37</td>
<td>6</td>
<td>5</td>
<td>3</td>
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<td>Daycase Rate</td>
<td>85.0%</td>
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<td>65.17</td>
<td>65.31</td>
<td>65.75</td>
<td>66.06</td>
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<td>First to Follow Up Ratio</td>
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<td>1.19</td>
<td>1.18</td>
<td>1.19</td>
<td>1.15</td>
<td>1.14</td>
<td>1.14</td>
<td>1.18</td>
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<td>0.0%</td>
<td>#</td>
<td>51</td>
<td>14</td>
<td>41</td>
<td>15</td>
<td>29</td>
<td>26</td>
<td>11</td>
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<td>17</td>
<td>6</td>
<td>7</td>
<td>2</td>
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<td>Critical Care Occupancy Rate</td>
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<td>95.44</td>
<td>84.33</td>
<td>86.99</td>
<td>89.54</td>
<td>86.21</td>
<td>84.09</td>
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<td>88.21</td>
<td>85.17</td>
<td>90.66</td>
<td>90.43</td>
<td>88.84</td>
</tr>
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</table>
DM01 performance steadily declined over the third quarter of 2019/20 and into quarter four, driven predominantly due to and continuing increase in demand, winter pressures commencing and lack of matching capacity, resulting in OP being displaced to accommodate IP requests.

The number of MRI requests has seen a sharp increase in volume, driven chiefly by one referring location only and a change in their referring criteria & process – waits are not at 6+ weeks.

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

All other reportable areas within the DM01 remain compliant.

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

- Weekly DM01 report for validation for undated/ forecastable breaches + joint PTL meeting + weekly Exec Review Meeting
- Monthly action report for breeches < 2 weeks notice of end of month
- Best Access Programme responsible for the performance, delivery and mitigating actions of the DM01, linked to the OP improvement plan and RTT improvement plan
- Work Stream leads in place for all areas for improvement: Endoscopy (gastro) & Imaging (and Cancer)
- All services to regularly update the IST D&C modelling and identify actions to enable interventions to be completed and realised (quarterly)

<table>
<thead>
<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
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<th>Dec 19</th>
<th>Jan 19</th>
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<tbody>
<tr>
<td>Diagnostic Access</td>
<td>DM01 Performance</td>
<td>99.0%</td>
<td>98.90%</td>
<td>98.70%</td>
<td>98.60%</td>
<td>98.40%</td>
<td>98.20%</td>
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<table>
<thead>
<tr>
<th>DM01 - 6 Weeks</th>
<th>Actual</th>
<th>Planned</th>
<th>Variance</th>
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<td>Apr-19</td>
<td>95.41%</td>
<td>99.20%</td>
<td>-3.79%</td>
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<tr>
<td>May-19</td>
<td>93.72%</td>
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<td>99.80%</td>
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<td>99.80%</td>
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<td>Nov-19</td>
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<td>99.20%</td>
<td>-3.32%</td>
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<td>99.20%</td>
<td>-4.32%</td>
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<tr>
<td>Jan-19</td>
<td>94.68%</td>
<td>98.30%</td>
<td>-5.08%</td>
</tr>
</tbody>
</table>

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

**Mitigations/Actions:**
- A review and refresh of interventions as per IST model in all specialties for 19 - 21, in line with clinical strategy and RTT for each DM01 area
- Increase of MRI Van capacity mobile from 7 to 14 days (contract to commence Jan 20) / purchase of mobile MRI
- Source NHS Locum Gastroenterologist to undertake lists OOH / undertake clinics to release substantive Consultants to complete lists
- Advertise and recruit Consultant Radiologists (Locum & Perm)
- Lower GI amending triage and acceptance criteria at WATC
- Colorectal amending STT pathway/triage process – this may impact other diagnostic & RTT performance
- UIC division to review cost pressures of delivering 6 week performance in MRI and NOUS and approve interventions
- Implementation of Diagnostics T&F group, led by CCG
Responsive – RTT Performance Spotlight Report

The Trust reported an overall RTT 18 week performance of 82.34% for the month of December with zero 52 week breaches for the same period. The total waiting list size did reduce during December to 22,477 patients.

Best Access continues to monitor and mitigate with an overall trajectory of 88% by end of March 2020.

Best Access continues to focus on Outpatients, Cancer, Theatres, engagement and digital to improve the constitutional standards within the Trust.

Services at risk of not hitting the trajectory are:

- NEUROLOGY 40.38%
- ORTHODONTICS 63.04%
- VASCULAR 67.04%
- SLEEP 77.17%

There has been a significant reduction in uncashed clinics, reduced total PTL size and less patients waiting longer than 26-weeks.

Pages 69 of 431
The Trust hit the cancer 2WW performance for 5th month in a row but failed to meet the operational standard of 93% for Breast symptomatic with a performance of 92.54% in December. The Non compliance was caused by 5 breaches within the service. The breaches attributed to Symptomatic Breast were due to patient choice beyond target, and a delay to patient receiving offer for appointment.

The Trust reported a position of non compliance against the 31 day subsequent surgery standard in December with performance of 90% this was against 10 treatments 9 compliant and 1 breach, the subsequent surgery breach was in the Urology tumour group.

The trust was non compliant against the 62 day treatment target with performance in December with performance of 77.87% against the operational standard of 85%. The Trust has failed to meet the 62 day standard from GP referral with 13.5 breaches. Breaches were attributed to: Breast x1, H&N x1.5, LGI 7.5, Lung 1.5, UGI x1, Urology x1. The reasons for the breaches were as follows. 8.5 breaches were attributed to delays in endoscopy, 1 breach was due to medical reasons (Patient declared unfit on the day), 2 breaches were due to patient choice beyond target wait, 2 breaches were due to complex diagnostic pathways.

There were 6 breaches over 104 days, 1 breach in Urology caused by a complex diagnostic pathway (patient required numerous biopsies, 2 breaches in H&N 1 caused by patient choice beyond target wait(Holiday), the other caused by complex diagnostic pathway (Multiple tumour sites), 3 breaches in LGI caused by delays to Endoscopic procedure.

Responsive – Cancer & Complaints Commentary:

The Trust hit the cancer 2WW performance for 5th month in a row but failed to meet the operational standard of 93% for Breast symptomatic with a performance of 92.54% in December. The Non compliance was caused by 5 breaches within the service. The breaches attributed to Symptomatic Breast were due to patient choice beyond target, and a delay to patient receiving offer for appointment.

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There were 6 breaches over 104 days, 1 breach in Urology caused by a complex diagnostic pathway (patient required numerous biopsies, 2 breaches in H&N 1 caused by patient choice beyond target wait(Holiday), the other caused by complex diagnostic pathway (Multiple tumour sites), 3 breaches in LGI caused by delays to Endoscopic procedure.
Responsive – 2 Week Wait Performance Spotlight Report

**Commentary**

The Trust was compliant with 2WW performance for the 5th consecutive month.

Breast symptomatic 2WW performance was 92.54% in December which was below the operational standard of 93%.

The Breast Screening service saw 67 patients in December with 62 of these being seen within 14 days. Of the 5 patients who breached the Standard 4 were as a result of patient choice beyond target wait, 1 breach was as a result in delay to patient receiving their appointment letter.

**Risks & Mitigating Actions**

**Risks**

The trust will need to develop its own internal 1st OPA standard to facilitate delivery of the 28d FDS. Seeing a new 62d patient for the first time on day 14 would make it very difficult to then achieve the 28d FDS.

**Mitigating Actions**

The trust will be working to an internal target of 7 days, with aspirations to get this to day 4 or below.

---

**2 Week Wait Definition:**

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

Cancer Local Trajectory:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Cancer Access</td>
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<td>92.14</td>
<td>75.21</td>
<td>63.7</td>
<td>70.43</td>
<td>76.06</td>
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<td>Cancer - 62 Days Actual</td>
<td>76.86%</td>
<td>71.67%</td>
<td>82.14%</td>
<td>75.21%</td>
<td>83.70%</td>
<td>74.94%</td>
<td>83.16%</td>
<td>74.94%</td>
<td>74.58%</td>
<td>77.87%</td>
<td>77.37%</td>
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<td>Planned</td>
<td>77.10%</td>
<td>77.80%</td>
<td>86.50%</td>
<td>81.40%</td>
<td>76.60%</td>
<td>74.80%</td>
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<td>-0.41%</td>
<td>-6.13%</td>
<td>-4.36%</td>
<td>-6.19%</td>
<td>5.10%</td>
<td>8.36%</td>
<td>-0.76%</td>
<td>-6.42%</td>
<td>-2.53%</td>
<td>-3.71%</td>
<td>-3.03%</td>
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</table>

| Cancer - 2 Week Waits Actual | 83.39%  | 88.69% | 90.12% | 91.61% | 94.09% | 94.86% | 95.18% | 95.71% | 97.91% |
| Planned        | 87.10%  | 89.10% | 93.90% | 93.80% | 93.00% | 88.90% | 85.90% | 89.90% | 91.30% |
| Variance       | -3.71%  | -0.41% | -3.76% | -2.19% | 1.09%  | 9.96%  | 9.28%  | 5.61%  | 6.61%  |

Commentary

The Trust failed to meet the 62 day target with performance in December being 77.87% against the operational standard of 85%.

The Trust had 13.5 breaches in December.

8 Tumour sites recorded 62d activity in December of which 4 failed to meet the 85% standard. The tumour sites that were below the standard where H&N on 62.50% (4 treatments/1.5 breach), LGI 11.76% (8.5 treatments/7.5 Breaches), Lung 50% (3 treatments/1.5 breaches) UGI 33.33% (1.5 treatments/1 Breach)

Risks

There are still over 139 patients (Not all Confirmed Ca) beyond day 62 currently on the PTL. This cohort of patients can negatively impact performance as whenever they are treated this will pull down performance. The trust does not have the throughput of 62d CA treatments each month to offset any additional breaches.

The clearing of the 62d Endoscopy backlog will continue to impact the service as some of these patients will have a confirmed malignancy and require treatment. In December GI (upper & Lower) breaches attributed to 13.93% of activity.

Mitigating Actions

There is now a weekly LGI PTL that reviews the entire PTL to ensure that patients are tracked in as close to real time as possible and to also ensure remedial actions can be taken to prevent breaches.
Well Led:

Appraisal completion rate, at 87.86% has increased for a fourth consecutive month and remains above the Trust’s target (85%).

Overall Sickness absence rate at 4.07% has increased (+0.01%) and remains above the tolerance level of 4%. Short term sickness absence at 1.88% has increased (-0.01%). Long term sickness absence, at 2.20% has increased (+0.04%). The ratios of long-term sickness to short-term sickness remain broadly even.

Voluntary Turnover at 11.93% has increased (+0.12%) compared with November and remains above the tolerance level of 8%

StatMan compliance at 92.23% has decreased slightly and remains above the Trust’s target of 85%

YTD Agency spend (as a percentage of pay bill) is 4.05%. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive or bank assignments continues.

YTD Bank spend (as a percentage of pay bill) is 12.43%. Total YTD temporary spend sits at 16.48% which is above the Trust’s target of 11.00%

Temporary staffing fill rate for Nurse and Midwifery remains constant at 72.00% which is above the YTD average
Well Led – Total Sickness Rate Spotlight Report

Commentary

Overall Sickness absence rate at 4.07% has decreased but remains above the Trust’s tolerance level of 4%.

Short term sickness absence has decreased to 1.88% whilst long term absence has increased to 2.20%

The ratios of long-term sickness to short-term sickness remain broadly even.

Risks & Mitigating Actions

Sickness Rate Definition:
The absence rate is the ratio of workers with absences to total full-time wage and salary employment.
## Safe Staffing

### CHPDD SAFE CARE WARD CC

<table>
<thead>
<tr>
<th>WARD</th>
<th>Day</th>
<th>Night</th>
<th>CHPDD</th>
<th>SAFE CARE</th>
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<td>Average fill rate - care staff (%)</td>
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<td>Escalations</td>
<td>RN</td>
<td>CSW</td>
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**Trust total**

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<th>Overall</th>
<th>Escalations</th>
<th>RN</th>
<th>CSW</th>
</tr>
</thead>
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<tr>
<td>96%</td>
<td>90.35%</td>
<td>89.82%</td>
<td>113.23%</td>
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Meeting of the Board of Directors in Public
Thursday, 05 March 2020

Assurance Report from Committees

<table>
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<tr>
<th>Title of Committee:</th>
<th>Quality Assurance Committee</th>
<th>Agenda Item</th>
<th>4.3</th>
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<tbody>
<tr>
<td>Committee Chair:</td>
<td>Jon Billings</td>
<td></td>
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</tr>
<tr>
<td>Date of Meeting:</td>
<td>Friday, 24 January 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Jane Murkin, Chief Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author:</td>
<td>Katy White, Director of Nursing Quality and Professional Standards</td>
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The key headlines and levels of assurance are set out below, and are graded as follows:

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<thead>
<tr>
<th>Assurance Level</th>
<th>Colour to use in ‘assurance level’ column below</th>
</tr>
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<tbody>
<tr>
<td>No assurance</td>
<td>Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans</td>
</tr>
<tr>
<td>Partial assurance</td>
<td>Amber/Red - there are gaps in assurance</td>
</tr>
<tr>
<td>Assurance</td>
<td>Amber/Green - Assurance with minor improvements required</td>
</tr>
<tr>
<td>Significant Assurance</td>
<td>Green – there are no gaps in assurance</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>White - no assurance is required</td>
</tr>
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</table>

Key headlines and assurance level

<table>
<thead>
<tr>
<th>Key headline</th>
<th>Assurance Level</th>
</tr>
</thead>
</table>
| 1. CQC Progress Update  
Following her update to the December committee meeting, Jane Murkin, Chief Nurse provided a detailed report to the Committee in relation to the inspection findings from both the CQC Core Service Inspection undertaken on 3, 4 and 5 December 2019 and the unannounced inspection undertaken on 16 December 2019. The paper outlined immediate actions the Trust had taken to address the inspection findings and concerns raised, including progress to date and work underway in responding to the concerns and issues identified. An early feedback update was also provided in relation to the Well Led inspection which took place on 15 and 16 January 2020. The committee was pleased to hear that Infection Prevention and Control mandatory training now has good compliance rates, however this has not yet translated into improvements in practice therefore the committee is not assured that there is pace, grip and urgency in driving the IPC improvement plan. | Red |
| 2. Quality Strategy Priority No. 3 Nutrition and Hydration                 | Amber/Red       |
| The committee received a detailed report and presentation on the current                                                                                     |               |

Key issues report to the Board
position relating to nutrition and hydration across the Trust. The committee was disappointed to hear of the low levels of patient nutritional screening and assessment and sought clarity on what immediate actions were in place to address this. The committee was advised that 1) a refreshed Nutrition Steering Group was in place, chaired by the Director of Nursing Quality and Professional Standards, and had set out the priorities for the next three to six months, 2) a new menu was being introduced on 24 February 3) Throughout February the Theme of the Month would be nutrition and hydration focussed 4) Increasing the number of volunteers to help patients with eating and drinking 5) The Chief Nurse had held a meeting with ward sisters the day before to talk about them owning what happens on their wards and their accountability for standards of care and quality of care for patients under their care. The committee will receive an update in three months.

3. Mortality and Morbidity Report
The Committee was informed that overall the HSMR is decreasing (101.1). The SHMI for the period August 2018 – July 2019 is 1.12 and within the ‘expected’ range. It was noted that the attendance at and evidence of the Mortality and Morbidity meetings needs to improve and the administration could be better. Paul Kitchen and David Sulch will investigate why attendance at the Mortality and Morbidity meetings has declined. All committee members are to be written to by the medical director to remind them of the importance of attending committee meetings.

4. Best Flow Interventions
The committee heard that the acute medical working group for best flow is in the middle of a 10 week recovery programme to increase flow to the Same Day Emergency Centre (SDEC), and to reduce clerking time from 7.5 hours to target time of 60 minutes. SDEC has gone from 30 patients per day at the end of November 2019 to 65 patient per day which has allowed us to contain the growth on type one demand at the front door and has also had an impact on type one performance, we are one of the higher performers in the South East region using the length of stay metric. We discharge more patients within 24 hours (38%) and we are PDSing in acute medicine flow we have gone from an aggregate of 7.5 hours to 70 minutes, this is the lowest take wait in 2 years which is significant progress. The committee has asked for a presentation on the impact of this on quality and safety to be given at the February QAC.

5. Annual Safeguarding Report 2018/19
The Committee approved the report for onward sighting at the Trust Board. The committee was assured that the Trust has met the statutory duties set and provided evidence to both the Kent and Medway Safeguarding Adult Board and the Medway Safeguarding Children Board through the reporting and self-assessment frameworks. Throughout 2018-2019 the safeguarding team ensured that the multi-agency working and attendance at partnership meetings was maintained and thus provided a visible and audible presence of the Trust externally.

Further Risks Identified
All risks are captured within the risk register and the BAF however due to time constraints the item on the BAF was deferred to the February meeting.

Escalations to the Board or other Committee
None
Meeting of the Board of Directors in Public
Thursday, 05 March 2020

<table>
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<tr>
<th>Title of Report</th>
<th>Mortality and Morbidity Update</th>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>Lead Director</td>
<td>Dr David Sulch, Medical Director</td>
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</tr>
<tr>
<td>Report Author</td>
<td>Dr David Sulch, Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>The Board are asked to review the current position regarding mortality. HSMR remains within acceptable limits at 102.5 for the year to October 2019. Data for Q2 of 2019/20 indicates an improvement in the SHMI, which for July and August 2019 are 98.8. Initial feedback from the RCP Learning from Deaths review of the Trust’s processes is included, with a more formal briefing on the full report to follow.</td>
<td></td>
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</table>

Link to strategic Objectives 2019/20

(Please choose ALL that applies - this could be more than one)

- Innovation: We will embrace innovation and digital technology to support the best of care
- Finance: We will deliver financial sustainability and create value in all we do
- People: We will enable our people to give their best and achieve their best
- Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership
- High Quality Care: We will consistently provide high quality care

Due Diligence

To give the Trust Board assurance, please complete the following:

Committee Approval:
- Name of Committee: Quality Assurance Committee
- Date of approval: February 2020

Executive Group Approval:
- Date of Approval: Mortality Committee – January 2020

National Guidelines compliance:
- Does the paper conform to National Guidelines (please state):

Resource Implications
- None

Legal Implications/Regulatory Requirements
- None

QIA
- Approval
- Assurance ☒
- Discussion ☒
- Noting □
Executive Summary

1.1 This report will update the Trust Board on the latest information relating to mortality and morbidity. The data quoted covers the year to October 2019; there will be a verbal update for refreshed data to November 2019 available for the meeting.

HSMR and SHMI

2.1 HSMR for the year to October 2019 was 102.5, representing a small rise over the 12 months to September 2019. A small increase in observed deaths during the year was also seen (from 1129 to 1141). The fluctuations in HSMR are shown on the attached graph.

2.2 The Committee will recall that at the peak of mortality in September 2018 the HSMR was 115.9, and observed deaths totalled 1343.

2.3 While the HSMR for patients admitted at the weekend has begun to indicate some improvements – with a reduction from 119.5 (for the 12 months to June 2019) to 115.9 (for the 12 months to October 2019), this improvement should be treated with caution as the observed deaths in this cohort has not changed significantly over the time period (climbing from 329 to 334).

2.4 The mortality for frail patients admitted at the weekend does appear to be improving: from a peak of HSMR (132.8) and observed deaths (213) in the 12 months to March 2019, the most recent data indicates an HSMR of 118.0 and observed deaths of 206. The graphs below show overall weekend mortality, and frailty weekend mortality.
2.5 Changes have been made to both the general medical and the frailty models of care for the weekend. Both systems have introduced additional consultant support for the acute take from January 2020. The weekend mortality will continue to be closely monitored to assess the impact of these changes, although it will be appreciated given the lag in reporting of HSMR that the benefits are unlikely to be apparent until data released in May 2020 at the earliest.

2.6 Weekend mortality is higher than weekday mortality for both Medway and Swale residents. However the difference remains much more marked for Swale residents. The HSMR for Medway residents is 94.7 for weekday admission and 110.8 for weekend admission, while the HSMR for Swale residents is 101.0 for weekday admission and 130.1 for weekend admission. This difference between the boroughs remains unexplained.

2.7 Mortality for pneumonia and for acute cerebrovascular disease, both formerly of major concern is no longer an outlier. The HSMR for pneumonia for the 12 months to October 2019 is 108.9, while the
HSMR for acute cerebrovascular disease is 93.6. While the change in palliative care coding will have had some impact, it should also be noted that the crude mortality for both conditions has also significantly improved. The crude mortality for pneumonia has reduced from 16.3 percent to 13.2 percent over the last 12 months, while the crude mortality for acute cerebrovascular disease has reduced from 19.2 percent to 15.1 percent over the same time period.

2.8 The SHMI for the 12 months to July 2019 has shown a small improvement to 110.5. The overall trend is downward as shown in the following graph, which displays the SHMI by quarter for the last three years. It will be noted that the SHMI for Q2 of 2019-20 (for which only two months of data are available) is 98.8. This compares to 113 for Q1 of 2019-20 and 123 for Q4 of 2018/19.

![SHMI trend for all activity across the last available 3 years of data](image)

2.9 The Committee will recall that the overall SHMI data had indicated a reduction in observed deaths, but a greater than expected reduction in expected deaths. Dr Foster have analysed the data underlying the SHMI, but have not been able to draw any clear conclusions regarding the change in expected mortality.

2.10 While the figures for Q2 of 2019/20 are reassuring, it has been decided by the Mortality Committee that deaths occurring within two weeks of hospital discharge (these contribute to the SHMI but not the HSMR) will be subject to screening and structured judgement review as necessary to assess for any issues particularly at the time of discharge (for example, whether patients were sent home prematurely, or whether any problems arose with arrangements for follow up or community care). Specialities are currently reviewing how to conduct these reviews, as the SHMI cohort adds a significant number of patients to those already being reviewed as part of the current inpatient learning from deaths process.

2.11 The issue of palliative care coding has been discussed at the Systems Assurance Meetings, and the CCG have been asked to assure them that the current coding process is appropriate.

3 Royal College Review

3.1 A review of 40 deaths was carried out on 6 and 7 February 2020 by Andrew Gibson, Clinical Director for the RCP’s ‘Learning from Deaths’ programme and a team of reviewers. The review was arranged in response to concerns regarding the Trust’s mortality for pneumonia.

3.2 The reviewers assessed 20 sets of notes for patients dying with pneumonia, and 20 sets of notes for patients dying with septicaemia. The initial review focused on the care given to the patients, but the
reviewers will go on to compare their findings with the Trust’s own conclusions from our internal Learning from Deaths review process. It is anticipated that this will provide external assurance over the robustness of the Trust’s internal review processes.

3.3 In addition the reviewers will consider whether any obvious differences in pre-hospital care are apparent when comparing Medway and Swale residents.

3.4 The formal report from this review is due to be available by the end of February. However, the reviewers were able to share some initial impressions with the Trust at the end of the review period.

3.5 The Acute Response Team’s input into the care of the patients reviewed was described as ‘outstanding’ and ‘the glue that held the care together’.

3.6 Communication between teams and access to speciality reviews as needed was felt to be good.

3.7 Early antibiotic treatment in the Emergency Department was given very promptly – often within 15 minutes of a patient’s arrival at hospital. However on occasion there was a delay noted in following up the initial antibiotic with the prescription and administration of the ongoing course of treatment.

3.8 Concerns were expressed over the calculation of NEWS scores, which were sometimes overestimated and sometimes underestimated.

3.9 Further feedback will be provided to the Committee if the formal report has been received by the time of the meeting.

4 Other Issues

4.1 The Trust advertised for Medical Examiners in January. Unfortunately no applications were received. The Medical Director has explored the reasons for this with possible candidates and the posts have now been re-advertised externally.

Dr David Sulch
Medical Director
February 2020
<table>
<thead>
<tr>
<th><strong>Title of Report</strong></th>
<th>Trust Safeguarding Annual Report 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prepared By:</strong></td>
<td>Bridget Fordham - Head of Safeguarding</td>
</tr>
<tr>
<td><strong>Lead Director</strong></td>
<td>Jane Murkin – Interim Chief Nurse</td>
</tr>
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| **Committees or Groups who have considered this report** | Safeguarding Assurance Group  
                          Executive Group  
                          Quality Assurance Committee |

**Executive Summary**

This report seeks to provide assurance that Statutory Safeguarding duties have been executed in line with policy and procedures during 2018-2019. This report demonstrates the growth of safeguarding activity and provides a trend analysis of the 3 year period since the Trust was served a performance contract notification by the commissioners in 2016.

**Resource Implications**

There are legislation changes and growth in the national safeguarding picture for both safeguarding children and safeguarding adults both in 2018-2019 and 2019 -2020. There is a need to review the team resource to ensure that there is sufficient resource to meet the growing statutory duties placed upon the Trust.

**Risk and Assurance**

The Trust has met the statutory duties set and provided evidence to both the Kent and Medway Safeguarding Adult Board and the Medway Safeguarding Childrens Board through the reporting and self-assessment frameworks. Throughout 2018/19 the safeguarding team ensured that the multi-agency working and attendance at partnership meetings was maintained and thus provided a visible and audible presence of the Trust externally.

**Legal Implications/Regulatory Requirements**

**The Care Act: safeguarding adults**

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Local authorities have new safeguarding duties. They must:

- **lead a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens
- **make enquiries, or request others to make them**, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
• **establish Safeguarding Adults Boards**, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy

• **carry out Safeguarding Adults Reviews** when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them

• **arrange for an independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Any relevant person or organisation must provide information to Safeguarding Adults Boards as requested.

**CQC regulation 13** – Safeguarding service users from abuse and improper treatment states that, “Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors.

Abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint…….. Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider.”

**The Children Act 2004**

Section 11 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

These organisations and agencies should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

• a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children

• a senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation’s/agency’s safeguarding arrangements

• a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services

• clear whistleblowing procedures, which reflect the principles
in Sir Robert Francis’ Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed

- clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies
- arrangements which set out clearly the processes for sharing information, with other practitioners and with safeguarding partners
- safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check
- appropriate supervision and support for staff, including undertaking safeguarding training
- creating a culture of safety, equality and protection within the services they provide

**Working Together to Safeguard Children 2018** – has clear statutory duties for local authorities, the police and employers in regards to People In Positions of Trust (PiPoT). These include, “Employers, school governors, trustees and voluntary organisations which should ensure that they have clear policies in place setting out the process, including timescales for investigation and what support and advice will be available to individuals against whom allegations have been made. Any allegation against people who work with children should be reported immediately to a senior manager within the organisation or agency. “

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**CORPORATE POLICY: Safeguarding**

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<th>Safeguarding Team</th>
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<td>Head of Safeguarding</td>
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<tr>
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<td>2</td>
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Medway NHS Foundation Trust
Safeguarding Policy

Document Control / History

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<th>Revision No</th>
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<tr>
<td>1</td>
<td>New high level document combining adults and children</td>
</tr>
<tr>
<td>2</td>
<td>Review and changes to include legislation and new document links</td>
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Consultation

Executive Group
Trust Board

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**Table of Contents**

TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS. 4

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7 EQUALITY IMPACT ASSESSMENT STATEMENT & TOOL 10

9 REFERENCES 10
Medway NHS Foundation Trust
Safeguarding Policy

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 The Safeguarding policy provides an overarching framework to co-ordinate, lead and develop services to prevent harm occurring and protect the most vulnerable adults and Children, embracing both the acute and community services provided by the Trust. i.e. COAST (community outreach and specialist team)

2 Purpose / Aim and Objective

2.1 Safeguarding children, young people and adults is everyone’s business, however specialist safeguarding staff are employed in dedicated roles, and we have clear safeguarding structures within the Trust. These staff, with executive support will embed and drive the safeguarding agenda forward, provide a framework that supports best practice and allows the Trust to fulfil its statutory responsibilities.

2.2 All Trust business and activity relating to safeguarding will follow the Trust’s governance processes for oversight and monitoring purposes.

2.3 The Policy framework ensures that key compliance areas sets out how we will improve services in five key domains:

- Effective safeguarding structures and governance.
- Mainstream safeguarding children, young people and adults into everyday business
- Working in partnerships
- Learning through experience and the development of knowledge and skills for staff
- Engaging with service users

2.4 The Medway NHS Foundation Trust (MFT) Safeguarding Assurance Group will provide assurance to the Trust Board via an annual report that there are robust and effective safeguarding measures in place to execute statutory safeguarding duties.

2.5 The Trust aims to ‘Be the BEST’ in everything it sets out to do, and this extends to embedding safeguarding at the heart of how it protects and manages vulnerable patients.

3 Policy Framework
3.1 **Medway NHS Foundation Trust** is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

**Adult**
- **The Care Act**
- **GUCPCM001 - Safeguarding Vulnerable Adults**
  - This document then has been developed to meet and work within the safeguarding adult lawful requirements set out within the Care Act 2014; it’s supporting Statutory Guidance and the associated Schedules and Regulations.
- **SOP0194 - Safeguarding Adults - Making Safeguarding Referrals**
  - Explains how to make a safeguarding referral.
- **SOP0195 - Safeguarding Adults - Process for Applying for a Deprivation of Liberty Safeguards - DoLS**
  - Explains how to apply for a Deprivation of Liberty Safeguards – DoLS.
- **STRCPCM001 - Safeguarding and Protecting Children Training Strategy (1 attachment)**
  - Training required to ensure all staff in the Trust understand their role in safeguarding children and can recognise when a child is at risk and know what to do if they are concerned about a child.

**Children**
- **POLCPCM055 - Kent & Medway Safeguarding Procedures**
  - Joint procedures that reflect the level of cross boundary work undertaken by many of the agencies and organisations who use the procedures. They reflect those local procedures that relate only to Kent or Medway.
- **POLCPCM027 - Safeguarding and Protecting Children Policy**
  - Local policy document used in conjunction with Kent and Medway procedures.
- **SOP0053 - Safeguarding Children - Raising Concerns**
  - Provides guidance on how to raise a concern about children.
- **SOP0051 - Safeguarding Children - Child Abuse Neglect Sexual Exploitation and trafficking**
  - This guidance is to support staff in the management of children who are at risk of abuse or where abuse has been identified.
- **SOP0050 - Safeguarding Children - Community**
  - This document is produced to assist staff working in the community to fulfil their
safeguarding responsibilities.

<table>
<thead>
<tr>
<th>SOP0054 - Safeguarding Children - Interagency Working</th>
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<tr>
<td>This document ensures all staff know what is expected in their role particularly when working with partner agencies.</td>
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<tr>
<th>SOP0052 - Safeguarding Children - Female Genital Mutilation - FGM</th>
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<td>Local guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.</td>
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<tr>
<th>GUDNM228 - Safeguarding Children - Kent and Medway Female Genital Mutilation</th>
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<td>Kent and Medway guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.</td>
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<th>SOP0055 - Safeguarding Children - Looked After Children - Consent</th>
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<tbody>
<tr>
<td>Explains how to obtain consent for Looked After Children.</td>
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<tr>
<th>SOP0117 - Safeguarding Children - In the Emergency Department including gangs</th>
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<tr>
<td>Principles of safeguarding children in ED and information on gangs.</td>
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<tr>
<th>SOP0060 - Safeguarding Children - Useful Contacts</th>
</tr>
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<tbody>
<tr>
<td>Supplies staff with contact details of safeguarding teams both in and out of the Trust to support their work in safeguarding children.</td>
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<table>
<thead>
<tr>
<th>PROCPCM001 - Safeguarding Children - Responding to Child Death Procedure</th>
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<tbody>
<tr>
<td>Describes the mandatory process that must be followed when a child dies.</td>
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<th>GULPCM202 - Safeguarding Children - Safeguarding Children who may have been trafficked - HM Government</th>
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<td>Home office guidance for trafficked children</td>
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<th>GUDNM231 - Safeguarding Children on the Neonatal Unit - Neonatal Nursing</th>
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<tr>
<td>Local guidance for the Neonatal Unit.</td>
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<tr>
<th>SOP0483 - Identifying and Supporting Vulnerable Families within the Maternity Setting New Team Connect for Safeguarding in Maternity</th>
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## 4 Roles and Responsibilities

### 4.1 Trust Board

#### 4.1.1 The Care Act 2014 provides a clear legal framework for how all healthcare organisations will work in partnership with other public services, to protect adults at risk. As a statutory partner of the Kent and Medway Safeguarding Adult Board (SAB) and Medway Safeguarding Children’s Board, (MSCB) and Kent Safeguarding Children’s Board (KSCB), Medway NHS Foundation Trust (MFT) has corporate commitment to safeguard our patients and our local community.
4.2 Chief Executive

4.2.1 The Chief Executive devolves the responsibility for compliance and monitoring to the Director of Nursing

4.3 Board Leads for Safeguarding

4.3.1 The Executive Board Lead is the Director of Nursing whose role it is to provide executive level leadership for safeguarding, ensuring the Trust is represented at the Safeguarding Boards across Kent and Medway.

4.3.2 The Executive Board lead will be responsible for senior strategic leadership and decision making on behalf of the Trust and will report to the Trust Board on safeguarding arrangements within the Trust.

4.3.3 The Executive Board Lead will also provide reassurance to the Board that we meet our statutory requirements.

4.3.4 The Non Executive Board lead will work with the Safeguarding Assurance Group to ensure that the Trust fulfils its statutory and legislative responsibilities, whilst prioritising patient care supporting the governance and strategic development of safeguarding across the Trust, offering collaborative challenge and advice.

4.4 Head of Safeguarding

4.4.1 Work at a strategic level across the health and the social care community, fostering and facilitating multi-agency working and training in respect of Safeguarding Adults and Children.

4.4.2 To be the strategic lead within the Trust for safeguarding of adults and children

4.4.3 To facilitate policies and procedures related to safeguarding adults and children

4.4.4 Providing assurance reports for the Executive Lead on Safeguarding Adult and Children legal compliance.

4.5 MFT Safeguarding Assurance Group

4.5.1 MFT has an established multidisciplinary Safeguarding Assurance Group which provides strategic direction to safeguarding activities across the Trust. The membership of the Safeguarding Assurance Group includes representatives from local Clinical Commissioning Groups and Local Authority.

4.5.2 The Safeguarding Assurance Group provides assurance to both the Trust Board (via the Quality Assurance Committee) and the Commissioners via the Kent and Medway Safeguarding Adults Board and Children’s Board.

4.6 The Safeguarding Group
4.6.1 The Children and Adult Safeguarding Group provides an operational overview to influence our strategic aims for Safeguarding services at Medway Foundation Trust. This group will share information in relation to their work plans and representation at multi-agency meetings and learning events. The group will also discuss operational issues and concerns in relation to their specific area of work, identify solutions and support mechanisms required to ensure that actions are taken to lead and execute safeguarding practices across Medway Foundation Trust.

4.7 Lead Nurse Safeguarding Children

4.7.1 The Lead Nurse will undertake the duties of the Named Nurse under the leadership of the Named Professional, (Head of Safeguarding) and will provide leadership at an operational level to all staff within the Trust.

4.7.2 The Lead Nurse will ensure the Trust is compliant with its duties and ensure policies are in place and up dated and available for all staff.

4.7.3 The Lead Nurse will ensure processes to safeguard children and young people are in place and that staff at the frontline are supported in their day to day work.

4.7.4 The Lead Nurse will represent the Trust at the Safeguarding Boards’, subgroups ensuring there is good participation and information sharing when contributing to Multi agency audits.

4.7.5 The Lead Nurse ensures there is a robust training programme in place to support staff in their understanding of safeguarding children and young people.

4.7.6 The Lead Nurse will provide supervision and support to staff at the frontline on a day to day basis.

4.7.7 The Lead Nurse ensures there are processes in place to collect data as required by the safeguarding children boards and the CCG.

4.7.8 The Lead Nurse works closely with external partners sharing information and contributing to assessments of risk to vulnerable children and young people.

4.8 Named Midwife for Safeguarding

4.8.1 The Named Midwife is responsible for the coordination of all cases where there are vulnerable babies.

4.8.2 The Named Midwife works closely with the frontline midwives in both the community and on the maternity wards, providing supervision and support on any difficult cases.

4.8.3 The Named Midwife works closely with external partners ensuring information sharing is provided in the best interest of the babies.

4.8.4 The Named Midwife contributes to assessments when a vulnerable woman or young person is pregnant.
4.8.5 The Named Midwife coordinates the maternity hub where vulnerable cases are discussed.

4.8.6 The Named Midwife provides information to the MARAC process when vulnerable pregnant women are discussed.

4.9 **Line Managers**

4.9.1 Line managers are responsible for ensuring that the Safeguarding Policies are implemented within their programmes and directorate.

4.10 **All Staff**

4.10.1 All staff are responsible for adhering to the policy and fulfilling mandatory training requirements.

5 **Monitoring and Review**

<table>
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<tr>
<th>What will be monitored</th>
<th>How/Method / Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/ gaps Recommendation s and actions</th>
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<tr>
<td>Policy review</td>
<td>Annually</td>
<td>Head of Safeguarding</td>
<td>Director of Nursing</td>
<td>Where gaps are recognised action plans will be put into place</td>
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<td>Mental Capacity and Deprivation of Liberty (DoLS)</td>
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<td>Head of Safeguarding / Director of Nursing</td>
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<td>Kent and Medway Self-Assessment Framework for the KMSAB</td>
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<td>Adult Safeguarding Lead</td>
<td>Head of Safeguarding / Director of Nursing / KMSAB</td>
<td>Where gaps are recognised the Assurance Group to decide remedial actions required</td>
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<td>S11 Self-assessment document of compliance to the Children Act.</td>
<td>Bi annually for Kent LSCB and Medway LSCB. These are completed alternately annually</td>
<td>Named Nurse for Children</td>
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<td>Ensure that in discharging their functions staff have regard to the need to safeguard and promote the welfare of children.</td>
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<td>KMSAB Self-assessment framework</td>
<td>Annually</td>
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<td>Director of Nursing / KMSAB</td>
<td>Where gaps recognised the Assurance Group to decide remedial actions required</td>
</tr>
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</table>

6 **Training and Implementation**

6.1 To support the implementation and embedding of the Safeguarding policy and procedures;
6.1.1 Mandatory training to all staff;
6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

7.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to “set out arrangements to assess and consult on how their policies and functions impact on race equality.” This obligation has been increased to include equality and human rights with regard to disability, age and gender.

7.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This document was found to be compliant with this philosophy.

7.3 Equality Impact Assessments will also ensure discrimination does not occur on the grounds of Religion/Belief or Sexual Orientation in line with the protected characteristics covered by the existing public duties.

9 References

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<td>See framework</td>
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END OF DOCUMENT
Safeguarding Adult Policy

To be read in conjunction with the Safeguarding Children Policy, Domestic Abuse SOP, Managing Allegations Against Staff SOP

<table>
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<th>Bridget Fordham</th>
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<td>Head of Safeguarding</td>
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<th>Edition No</th>
<th>Reason for change</th>
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<tr>
<td>Edition 2</td>
<td>Increased requirements detailed within the revised NHSLA Risk Assessment Standards and new legislation pertinent to the activity of safeguarding. Addition due to best practice and NHSLA requirements.</td>
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<tr>
<td>Edition 5</td>
<td>Multi-Agency Safeguarding Adults Policy and Protocols and Practitioner Guidance for Kent and Medway utilised as key point of reference</td>
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<td>Edition 7</td>
<td>Trust Policy updated to reflect the implementation of the Care Act 2014 and Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway</td>
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Click on the following link for further information and resources in relation to the Care Act (2014. Chapter 14 relates to Safeguarding)


## Consultation

Safeguarding group; Safeguarding Assurance Group

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TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS.

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APPENDIX 1 - SAFEGUARDING ADULT CONCERN REFERRAL PROCESS

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APPENDIX 3 - EQUALITY IMPACT ASSESSMENT
Introduction

1.1 The Care Act 2014 provides a clear legal framework for how all healthcare organisations will work in partnership with other public services, to protect adults at risk. As a statutory partner of the Kent and Medway Safeguarding Adult Board (SAB), Medway NHS Foundation Trust (MFT) has corporate commitment to safeguard our patients and our local community.

1.2 The Trust is committed to working in partnership with Kent and Medway Safeguarding Adult Board to help protect adults who are at risk from abuse, harm and neglect (adults at risk) and have in place systems and processes to support the Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway to ensure that all adult patients deemed to be at risk will receive appropriate protection whilst under the care of the Trust.

1.3 The Trust recognises that its first priority should always be to ensure the safety, wellbeing and protection of adults at risk in its care and that the responsibility of all staff working with patients is to act on any suspicion or evidence of abuse or neglect, and to report their concerns to their line manager and adult safeguarding team.

1.4 This policy applies to the activities of all personnel employed by MFT, including staff from agencies, contractors, volunteers and students during their clinical placements.

Purpose / Aim and Objective

2.1 The aim of this policy is to provide staff with guidance on who might be adults at risk, indicators of abuse, harm and neglect and processes for responding to and reporting adult safeguarding cases. It clarifies the responsibilities of all Trust staff in relation to safeguarding adults and aims to ensure consistency of approach across MFT.

2.2 This policy is aligned with the Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway and demonstrates commitment to working with other agencies to ensure that people within all services are appropriately safeguarded.

2.3 This policy also provides information regarding the requirement for mandatory training and awareness raising requirements of the Trust to various staff groups.

Definitions

3.1 Adult at Risk

The Care Act refers to all adults aged 18 and over who:

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1 Care Act 2014. Chapter 14 relates to Safeguarding)

2 Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway available at:

Edition No: 7 Safeguarding Adult Policy
3. Has need for care and support (whether or not the Local Authority is meeting any of those needs)
• Is experiencing or at risk of abuse or neglect
• As a result of those needs is unable to protect himself or herself against the abuse or neglect or risk from it.

3.2 Abuse can be:

• A single act or repeated acts;
• an opportunistic act or a form of serial abusing where the perpetrator seeks out and “grooms” individuals;
• an act of neglect or a failure to act;
• multiple in form (many situations involve more than one type of abuse); deliberate or the result of negligence or ignorance;
• Abuse may be: a crime.

3.3 Categories of abuse

This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern, as set out in the Care and Support Statutory Guidance document (DoH 2014):

• Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

• Domestic abuse – including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence. Domestic abuse is not only about intimate partners, but can involve other family members as well and therefore much safeguarding work that occurs at home is, in fact is concerned with domestic abuse. Age range is now extended down to 16 years.

• Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

• Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

• Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

• Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal
to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home.

- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

- **Self-neglect** – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.

Further information regarding types of abuse and possible indicators can be found using the following link: https://www.scie.org.uk/publications/ata-glance/69-adults-safeguarding-types-and-indicators-of-abuse.asp

### 4 (Duties) Roles & Responsibilities

#### 4.1 Trust Board

The Trust Board has a responsibility to ensure that there is an overall policy and procedure in place to protect adults at risk under the Care Act 2014.

#### 4.2 Chief Executive

The Chief Executive devolves the responsibility for compliance and monitoring of Safeguarding procedures to the Director of Nursing.

#### 4.3 Director of Nursing

The Director of Nursing is the Executive Lead for Safeguarding at MFT and is responsible for ensuring that the Trust upholds the principles of the Safeguarding Adult Policy when dealing with patients and their families / carers.

The Director of Nursing has responsibility for providing advice and support to the Trust Board in relation to Safeguarding and for assuring the Board that MFT has the correct processes in place to protect adults at risk and for ensuring that appropriate policies and procedures are developed, maintained and communicated throughout the organisation and that those policies and procedures are developed and implemented in co-ordination with other relevant organisations and stakeholders.
The Director of Nursing is the named contact for at the Kent and Medway Safeguarding Adults Board.

4.4 Head of Safeguarding

The Head of Safeguarding has responsibility to:

- Work at a strategic level across the health and the social care community, fostering and facilitating multi-agency working and training in respect of Safeguarding Adults and children.
- To have management responsibility for and to provide leadership for the corporate safeguarding team.
- To facilitate policies and procedures related to safeguarding adults
- Providing assurance reports for the Executive Lead on Safeguarding Adult compliance.

4.5 Adult Safeguarding Lead

The Adult Safeguarding Lead is the operational lead for adult safeguarding within the Trust and will support the Safeguarding team in providing a Trust wide overview of all adult safeguarding matters. They are responsible for:

- Training staff with a basic awareness of safeguarding adult protection policies and procedures within the Trust
- Liaising with Social Services to ensure that allegations of abuse are followed up and investigated, as appropriate
- Attending and contributing to sector wide safeguarding adult forums and contributing to local borough safeguarding adult subgroups and partnership meetings
- Being accessible to front line staff for advice and guidance within the multi-agency guidelines and MFT’s Safeguarding policy.

4.6 Deputy Directors of Nursing

Deputy Directors of Nursing are responsible for ensuring that the requirements of MFT’s Safeguarding Adult Policy are effectively managed within their Directorate’s and that their staff are aware of, and implement, those requirements. They will ensure that staff within their sphere of responsibility are aware of and comply with the local safeguarding adults procedures and that they receive the level of training appropriate to their role.

4.7 Matrons

Matrons are the nominated professionals who coordinate the response within the Directorates and work with Adult Safeguarding team and other agencies to coordinate the follow up and enquiry processes for Safeguarding Adult concerns and subsequent enquiries. They are responsible for attending relevant safeguarding adult training to a level commensurate with their role and:

- Contributing to on-going or further enquiries and consulting with other professional colleagues disciplines where their input is required
- Attending Safeguarding enquiry / outcome meetings as required
• Monitoring of recommendations arising from investigations and ensuring that any actions required are followed up and implemented.

4.8 Departmental and Ward Managers

Departmental and Ward Managers are responsible for:

• Ensuring that staff adhere to this policy
• Ensuring the alleged victim is made safe and protected whilst in MFT’s care
• Managing any immediate protection issues
• Ensuring that Safeguarding concerns are reported through Medway’s Datix Incident Reporting system
• Ensuring that Safeguarding concerns are recorded on Adult social care safeguarding alert form and sent to the relevant Local Authority (copied to the Safeguard Adult Team via email: met-tr.safeguardingadults@nhs.net)
• Ensuring that the requirements of Making Safeguarding Personal (MSP) are met

4.9 All staff

All staff employed by the Trust have a duty to act promptly and report concerns if they think that a patient in their care is being abused, or that their concerns about standards of care suggest there is a risk of abuse or neglect to adults using the service. The seriousness, or the extent of the abuse, is often not clear. It is therefore important that staff report incidents immediately so that the matter can be investigated further and that staff approach such allegations with an open mind.

It is the responsibility of the staff caring for the patient to ensure there is no immediate danger. If deemed necessary, the medical team caring for the patient may be required to examine the patient and instigate any clinical investigations needed.

Trust staff must make sure that they assure the person raising the concerns that their concerns will be taken seriously and that they, and the Trust, have a duty to report incidents of this nature. It should be explained to the person raising the concern that in order to safeguard an individual information will need to be shared with others, or with safeguarding teams, who have a part to play in protecting them. Do not give promises of complete confidentiality.

4.10 Organisational and Professional Development Team

The Organisational and Professional Development Team are responsible for ensuring that Safeguarding Adult, Mental Capacity Act, Deprivation of Liberty Safeguards, Prevent, Learning Disability and Domestic Violence training is available, accessible and deliverable to all MFT staff.

The Organisational and Professional Development Team will maintain training records for every member of staff employed by MFT and supply data on compliance with training requirements for Safeguarding Adult training from ESR.

4.11 MFT Safeguarding Assurance Group
Medway NHS Foundation Trust has an established multidisciplinary Safeguarding Assurance Group which provides strategic direction to safeguarding activities across the Trust. The membership of the Safeguarding Assurance Group includes representatives from local Clinical Commissioning Groups and Local Authorities.

In terms of governance, the Safeguarding Assurance Group provides assurance to both the Trust Board (via the Quality Assurance Committee) and the Commissioners via the Kent and Medway Safeguarding Adults Board.

## Procedure

### 5.1 The Care Act 2014

The Care Act 2014 is legislation that requires all agencies to have Safeguarding policies and procedures in place to effectively respond to known or suspected abuse. This policy reflects and compliments the Safeguarding processes of the Kent and Medway Safeguarding Adult Board.

### 5.2 General principles of Safeguarding Adults procedures

The Trust will adhere to the agreed safeguarding principles that provide a basis to achieve good outcomes for patients:

- **Principle 1 – Empowerment**
  Presumption of person led decisions and consent
- **Principle 2 – Protection**
  Support and representation for those in greatest need
- **Principle 3 – Prevention**
  Prevention of neglect, harm and abuse is the primary objective
- **Principle 4 – Proportionality**
  Proportionality and least obtrusive response to the risk presented
- **Principle 5 – Partnership**
  Local solutions through services working in their communities
- **Principle 6 – Accountability**
  Accountability and transparency in delivering safeguarding.

### 5.3 What is an adult safeguarding concern?

An adult safeguarding concern is any allegation about an adult who has or appears to have care and support needs that they may be subject to, or who may be at risk of abuse and neglect and may be unable to protect themselves against this. A concern may be raised by anyone, and can be:

- An active disclosure of abuse by the adult, where the adult tells a member of staff that they are experiencing abuse and/or neglect
- A passive disclosure of abuse where someone has noticed signs of abuse or neglect, for example clinical staff who notice unexplained injuries
- An allegation of abuse by a third party, for example a family/friend or neighbour who have observed abuse or neglect or have been told of it by the adult
- A complaint or concern raised by an adult or a third party who doesn't perceive that it is abuse or neglect. Complaint officers should consider whether there are safeguarding matters
5.4 Responsibility of the alerter

An "Alerter" is anyone who suspects that a patient or other adult is at risk, is being or has been abused, harmed or neglected.

The responsibility to report an adult at risk, where there is cause for concern, rests with the individual who identifies that concern regardless of their status in the organisation. Safeguarding adults from abuse is the responsibility of all staff.

Depending on the nature of the concerns or how this is disclosed, sometimes immediate steps will need to be taken. These include:

- Making an immediate evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
- Do not disturb or move articles that could be used in evidence, and secure the scene, for example, by locking the door to a room
- Contact the lead nurse for safeguarding children or the paediatric liaison nurse if a child is also at risk
- If possible, make sure that patients / other service users are not at risk.

All staff are expected to adhere to the guidance set out in this Policy. Whenever it is known, or suspected, that an adult has been abused, it is the responsibility of staff member to report this concern directly to the appropriate senior member of staff and to:

- Follow the flow chart (see Appendix 1) for assistance on how to respond to, report and refer cases of suspected or actual abuse.
- Complete datix incident report
- Access the Trust Intranet Safeguarding Adults page and complete Safeguarding Adult referral
- Email the completed Safeguarding Adult referral form to the Local Authority where the patient resides and copy the Trust Safeguarding Adult team on email: met-tr.safeguardingadults@nhs.net

There may be some occasions when the adult at risk does not want to pursue a referral to the Local Authority. Where it is a personal matter and may cause family disharmony, if possible the adult at risk’s wishes should be respected and other ways of ensuring the adult’s safety explored. Where there is a potentially high risk situation, staff should be vigilant of possible coercion and the emotional or psychological impact that the abuse may have had on the adult.

Decision makers also need to take account of whether or not there is a public or vital interest to refer the concern to the Local Authority. Where there is a risk to other adults, children or young people or there is a public interest to take action because a criminal offence had occurred and the view is that it is a safeguarding matter, the wishes of the individual may be
overridden. Where the sharing of information to prevent harm is necessary, lack of consent to information sharing can also be overridden. In the event that people lack the capacity to provide consent, action should be taken in line with the Mental Capacity Act 2005. Where a possible crime has been committed the victim should always be encouraged to report the matter to the police.

5.5 Patient and family / carer involvement

The Care Act (2014) recommends ‘making safeguarding personal’ therefore where possible gaining consent for referrals and listening to and recording the views of patients and those involved in their care is important.

Patients, patients’ family / carer’s should be involved where appropriate in safeguarding procedures, their views considered and they may be invited to meetings as part of the investigation process.

Staff should discuss their concerns with the patient/ and or their family/carer ensuring adequate provision is made to meet communication and advocacy needs and request permission to refer the concerns via the Safeguarding Adults Process.

5.6 Capacity, consent and decision making

The consideration of capacity is crucial at all stages of Safeguarding Adults procedures. For example, determining the ability of an adult at risk to make lifestyle choices, such as:

- choosing to remain in a situation where they risk abuse
- determining whether a particular act or transaction is abusive or consensual: or
- determining how much an adult at risk can be involved in making decisions in a given situation.

All adults should be deemed to have capacity unless there has been a formal capacity assessment to indicate otherwise in line with the Mental Capacity Act 2005.

Should that patient/service user refuse intervention and is deemed to have capacity, the practitioner should document this discussion appropriately and seek further advice from the Safeguarding Team. Where safe to do so, staff should also discuss with the individual and their family/carer their views and desired outcomes of safeguarding procedures and document these within the clinical record or safeguarding referral.

5.7 Situations where the adult risk does not have capacity

If it is decided that the adult at risk does not have capacity then staff should act in the best interests of the person, and do what is necessary to promote health or wellbeing or prevent deterioration.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect adults at risk who are not able to make their own decisions and is underpinned by five key principles:
Safeguarding Adults Policy

- A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- Individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests – anything done for or on behalf of people without capacity must be in their best interests.
- Least restrictive intervention - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a “decision specific” test. No one can be labelled “incapable” as a result of a particular medical condition or diagnosis.

The Act makes it clear that a lack of capacity cannot be established merely by reference to a person’s age, appearance, or any other condition or aspect of a person’s behaviour which might lead others to make unjustified assumptions about capacity. A person lacks capacity in relation to a specific matter if he/she is unable to:

- Make a decision for him/herself in relation to the matter because of impairment or a disturbance in the functioning of the mind or brain [Mental Capacity Act 2005].
- Understand the information relevant to make the decision
- Retain the information
- Use or weigh that information as part of the process of making the decision
- Communicate their decision, whether by talking, using sign language or any other means [Mental Capacity Act 2005].

The Mental Capacity Assessment form can be found on the hospital intranet.

A copy of the assessment should be kept in the patient hospital record.

5.8 Advocacy (Independent Mental Capacity Advocates)

IMCAs must be instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person, but may also be instructed in other circumstances. They advocate for patients where appropriate, especially where there are potential issues relating to capacity and consent. Staff will need to consider when an independent advocate is best suited to meet the needs of the patient or for those who may lack capacity, the instruction of an Independent Mental Capacity Advocate.

5.9 Process for responding to safeguarding concerns raised against MFT.

Please see Appendix 2 for process flowchart for responding to safeguarding concerns raised against MFT. In summary:
• The Local Authority Social Services Team will forward the concern to the Safeguarding team.
• The Safeguarding team will record an incident on the Trust Datix Incident Reporting system and request a concise review from the responsible matron
• The Datix incident raised will be reviewed at the directorate governance meeting.
• The Matron will complete a 72 hour report and attend any Local Authority Enquiry meetings, if required
• A copy of the investigation report should be sent to the Adult Safeguarding Team, so that this can be shared with the Social Worker assigned to follow up by the Local Authority Safeguarding Team.

Please refer to the Trust ‘Management of Allegations against Trust staff involving a Vulnerable Adult or Child SOP’ if the concern relates to a member of staff working at the Trust.

6 Monitoring and Review

6.1 The effectiveness of this policy will be monitored through reports to the MFT Safeguarding Assurance Group and will provide assurance to the Trust Board via the Quality Assurance Committee (QAC).

6.2 The Trusts MFT Safeguarding Assurance Group meets quarterly and reports to the Quality Assurance Committee as well as providing an Annual Report to the Trust Board.

6.3 Monitoring will also occur through the Medway and Kent Safeguarding Adults Boards and by the Clinical Commissioning Groups.

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How/Method/Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/gaps Recommendations and actions</th>
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<td>Adult Safeguarding Team</td>
<td>MFT Safeguarding Assurance Group</td>
<td>Where gaps are recognised action plans will be put into place</td>
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<td>MFT Safeguarding Assurance Group</td>
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What will be monitored | How/Method/ Frequency | Lead | Reporting to | Deficiencies/gaps Recommendations and actions
--- | --- | --- | --- | ---
Compliance with Policy | An annual audit will be undertaken in relation to staff compliance with Safeguarding Adult procedures | Adult Safeguarding Team | MFT Safeguarding Assurance Group | Training for areas which are not compliant

### 7 Training and Implementation

7.1 The Care Act 2014 and Care and Support Statutory Guidance identifies that safeguarding adults training is required for all staff and volunteers and that different levels of training are required depending on staff groups’ roles and responsibilities.

7.2 The Trust has a Safeguarding Adults Training Strategy which outlines training requirements for different groups of staff:

**Level 1**: All newly appointed staff will receive Safeguarding Adults awareness training as part of the Trust Induction programme. All staff, including non-clinical and administrative staff are required to complete face to face training for Adult Safeguarding.

**Level 2**: All clinical staff are required to complete the Level 2 Adult Safeguarding training provided via the Trust Adult Safeguarding Team. This includes Bank and Agency staff.

**Level 3**: Named adult and identified safeguarding leads/practitioners are required to attend Level 3 multi-agency training provided by the Local Authority.

7.3 Staff who might undertake Safeguarding Adults investigations can attend the required multi-agency training provided by the Local Authority. Each Local authority provides multi-agency adult safeguarding training in addition to the Trust’s Safeguarding Adults training.

7.4 The Prevent Duty guidance for England and Wales requires that healthcare workers are trained to recognise signs where people may be vulnerable to being drawn into terrorism. Staff should also be trained to be aware of and locate available support, including the Channel programme where necessary.

7.5 Prevent awareness training is provided for all Trust staff at induction and in mandatory update training. Specific staff groups are identified to attend the WRAP workshop based on the competency framework and home office/NHS England guidance.

7.6 Please see Safeguarding Adults Training Strategy for further details of training competencies requirements for individual staff groups.
8 Equality Impact Assessment Statement & Tool

8.1 The Equality Act 2010 became law in October 2010 and covers the same equality strands that were protected by previous equality legislation, but extends some protections to groups not previously covered, and also strengthens particular aspects of equality law. It replaced previous legislation (such as the Race Relations Act 1976 and the Disability Discrimination Act 1995) to ensure consistency in what employers need to do to make an organisation compliant with the law.

8.2 This policy was screened for impact on equality in February 2017. As a result of this screening, it has been decided that a full equality impact assessment is not required. Please refer to Appendix 3 for the Equality Assessment Screening Tool.

9 References

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<td>Department of Health - Care Act 2014 Chapter 23</td>
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<td>Kent and Medway Safeguarding Adults revised 2017 - Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway available at:</td>
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<td>Department for Constitutional Affairs 2017 – Mental Capacity Act 2005 Code of Practice</td>
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<td>Ministry of Justice 2008 – Deprivation of Liberty Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice</td>
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<td>Kent and Medway Domestic Abuse Strategy Group – Domestic Abuse Support Services in Kent and Medway</td>
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<td>Safeguarding Adult Strategy 2016 - 18</td>
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<td>Policy/Procedure</td>
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<td>Prevent Guideline GUDLS003 - Prevent Guideline (1 attachment)</td>
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Appendix 1 – Safeguarding Adult Concern Referral Process

Abuse discovered / suspected / a disclosure made to you

Person has capacity to understand concerns and consents to a safeguarding referral?

Yes - but refuses referral

Yes

No - refer in the patients Best Interest to the Local Authority where the patient resides.

Accept unwise decision. No further action to be taken if no one else is at risk of harm. Document in patient records.

Consent can be overridden if there are concerns that a serious crime may have been committed or that the person or someone else such as a child or other vulnerable person is at serious risk of harm (public interest).

1. Ensure patient’s safety.

2. If advice is required please contact the Trust Adult Safeguarding team by telephone on ext 5524. Out of hours contact your line manager / the bleep holder.

3. Contact Children’s Social Care if a child in the home is also at risk.

4. Notify the police (999) if the patient is at risk of immediate harm or a crime has been committed.

5. Preserve any evidence e.g. clothing, objects. Prepare a body map and arrange medical illustrations (photography) as appropriate.

6. Complete datix incident.

7. Complete Safeguarding Adult notification form and send to the appropriate Local Authority and copy by email to the Trust Safeguarding team (email met-tr.safeguardingadults@nhs.net)

8. Fully document concerns in patient records as this information may be required for further investigations.

Local Authority progresses enquiry and requests further information if required.

Useful Contacts

Kent Local Authority: centralDutyTeam@kent.gcsx.gov.uk

Medway Local Authority: s.accessandinfo@medway.gov.uk

Patient has complex issues (no abuse) and may require support, additional assessments (from specialist services e.g. mental health, alcohol team, homeless team). Refer to the Integrated Discharge Team.
Appendix 2 - Process for responding to Safeguarding concerns raised against MFT

SAFEGUARDING CONCERN RAISED AGAINST TRUST BY EXTERNAL ORGANISATION / FAMILY OR CARE PROVIDER

Safeguarding concern / alert form received in generic Safeguarding Group email from Local Authority with notification about description of the alleged abuse or incident.

Safeguarding Adult Team to add incident on Datix and email relevant Directorate Matron with web reference number, requesting a concise review.

Concise review discussed at Incident review meeting to determine whether it meets the criteria for a Serious Incident.

No. Incident does not meet criteria for Serious Incident investigation.

Concise report submitted to Lead Social Worker who determines whether the Safeguarding enquiry needs to be progressed further and whether it meets the criteria outlined in Section 42 of the Care Act 2014.

Statutory Section 42 Enquiry progressed.

Enquiry Officer (EO) appointed to undertake enquiry (required with 20 working days).

EO / Investigating Officer to attend Case Conference to present findings of Section 42 Enquiry

Yes. Incident meets criteria for Serious Incident investigation.

Serious incident reported on STEIS and duty of candour procedure followed

Investigating Officer assigned and Serious Incident Root Cause Analysis (RCA) Report Investigation requested by Patient Safety Team.

Serious Incident report and recommendations / action plan completed within 60 days and report shared with family and Adult Safeguarding Team

Protection plan agreed and closed to safeguarding.

Outcome of enquiry recorded on Datix and incident closed

No further action required by Trust – safeguarding closed

Serious Incident report outcome, recommendations / action plan shared with Social Services to provide assurance that investigation has been completed and shared with patient / family or nominated representative.

Non Statutory Safeguarding Enquiry progressed.

Edition No: 7 Safeguarding Adult Policy
**Appendix 3 - Equality Impact Assessment for Safeguarding Adult Policy**

<table>
<thead>
<tr>
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<th>Yes/No</th>
<th>Comments</th>
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<tr>
<td>1. **</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
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<td></td>
<td>• Age</td>
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<td></td>
<td>• Disability</td>
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<td></td>
<td>• Gender Reassignment</td>
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<td>• Sexual Orientation including lesbian, gay and bisexual people</td>
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## Safeguarding Adults Policy

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<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>Yes</td>
<td>Specific Safeguarding Adult Policy</td>
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<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>Yes</td>
<td>Care Act 2014 stipulates that there should be specific guidance for persons who are 18 years and over.</td>
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<td>4. Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
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<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
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<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
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<td>7. Can we reduce the impact by taking different action?</td>
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## Document Control / History

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<th>Date</th>
<th>Reason for change</th>
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<tr>
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<td>Reviewing policy</td>
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## Consultation

Safeguarding Group; Safeguarding Assurance Group

© Medway NHS Foundation Trust [2019]
# Table of Contents

TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS.

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To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 The policy has been written for health professionals and other staff, who are working directly or indirectly with families and children. They are to be used in conjunction with Kent & Medway Safeguarding Children Safeguarding Procedures which can be found at [https://www.medwayscp.org.uk/mscb/](https://www.medwayscp.org.uk/mscb/).


1.3 All healthcare professionals/Trust Employees, including those who work primarily with adults have a professional responsibility and duty to safeguard and promote the welfare of children and must familiarise themselves with the Trust and wider Kent and Medway Policies. These procedures give specific instruction and guidance for best practice in child protection, but they cannot cover every eventuality and they do not remove or minimise professional responsibility and accountability.

1.4 Health professionals within their roles are also able to identify children in need, children who are suffering or at risk of suffering significant harm, and refer to a statutory agency if appropriate. It is also her/his responsibility to participate in discussions with statutory agencies i.e. Social Workers and Police, and contribute to plans and assessments in order to meet the needs of children or protect them from significant harm.

1.5 The Children Act 1989 continues to provide the framework for the care and protection of children, and applies to all children and young people up to the age of 18. Section 11 of The Children Act 2004 has placed a duty on all key agencies to ensure they safeguard and promote the welfare of children which is defined as:

1.6 Protecting children from maltreatment; preventing impairment of children’s health or development; ensuring that they are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully.

1.7 The following fundamental principles contained within the Children Acts 1989 and 2004, and Working Together to Safeguard Children 2018, governs the actions of agencies engaged in protecting children. They are:

1.8 The Child’s welfare is paramount.

1.9 Working in partnership with parents. Consent for any intervention or to share information must be requested from parents. However as the safety of the child is paramount there may be occasions when disclosure of information without consent may be required.
1.10 Health professionals are major contributors to the inter-agency care of children.

1.11 Co-operation with other agencies i.e. Children Social Care, Police and Education, as well as other relevant health professionals is essential.

1.12 Any decision or service provision will take full regard of the child’s ethnicity, culture, language, religion, gender and any disability.

1.13 All services offered will be on the basis of equal opportunity.

1.14 The right to confidentiality for parents, carers and children will be respected and any information shared will only take place in the interests of the child or where required by law.

2 Purpose / Aim and Objective


When to Suspect Child Maltreatment: https://www.nice.org.uk/guidance/cg89


The NSPCC guide to spotting signs and symptoms of abuse: https://www.nspcc.org.uk/preventing-abuse/signs-symptoms-effects/

Information sharing advice: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

2.2 Advice should be sought from the Safeguarding Team – contact Lead Nurse for Safeguarding children on ext. 5166, Named midwife for safeguarding on ext. 5834 or Paediatric Liaison Nurse on ext. 5759

2.3 Staff should make every effort to work openly and honestly with parents and carers, and where appropriate involve them in all discussions around concerns and decision making. Where involving the parents/carers may place the child or yourself at further risk then a decision will can be made to withhold discussions with parents/carers. This must be fully documented on the referral form with a rationale why a discussion has not taken place.

2.4 Staff should ensure that all parents/carers and children are informed that confidentiality may not be maintained if the withholding of information will prejudice the welfare of the child.

2.5 All observations and explanations involving concerns should be recorded contemporaneously in the healthcare records and should include the following :
• All children who are seen in the Emergency Department (ED) must have a safeguarding assessment completed before discharge
• Who has Parental Responsibility (PR) for the child
• Information on the child’s appearance and behaviour
• Any views/comments/wishes and feelings expressed by the child
• Attitude of the parents and interaction with the child
• Details of any injury and the use of a body map OTLPCM039 should be completed where appropriate.
• Detailed, factual, contemporaneous, signed, record keeping is essential (POLCGR059). All records must be signed, dated and timed

2.6 Staff can contact Children’s Specialist Services at any time for a consultation if they have concerns about a child; advice should be sought from the Safeguarding Team prior to any consultation if available

2.7 Consent from parents/carers must be sought to make an Early Help or Child in Need referral. Consent is not mandatory for a referral where ‘significant harm’ is suspected. If consent is declined then a referral can still be made but the referral must be explicit as to why consent has not been obtained.

2.8 All children who are subject to a Child Protection Plan, Child in Need Plan or discussed at/known to the Multi Agency Risk Assessment Conference (MARAC), Risk and Vulnerabilities group or the Adolescent Risk Management (ARM) Panel will have an alert placed on their records; any unborn child will have an alert placed on the mother’s healthcare records which will be transferred to the child’s healthcare records once born.

2.9 Where English is not the first language of the child concerned (or there are other communication difficulties e.g. a hearing impaired child or parent/carer) and communication is necessary for the purposes of safeguarding and promoting the child’s welfare, the use of an interpreter must be considered. If an interpreter is not utilised, the reasons for this must be recorded in the child’s records.

3 Safeguarding Children in the Community

3.1 If a child is in need of urgent medical attention, the community staff must make every effort to persuade the parents/carers to take the child immediately to the Accident & Emergency department.

3.2 If necessary dial 999 for an ambulance.

3.3 In the event of parental refusal, (or if there are serious concerns) contact the police and Children’s Social Care and advise them of the emergency.

3.4 Once the immediate emergency has been dealt with, make a telephone referral to Children’s Social Care in Medway (01634 334466) or the Central Referral Unit for the Kent area (including Swale) (CRU 03000 411111). Out of hours contact is 03000 419191. The Named Nurse Safeguarding Children should then be informed of the
referral (Ext: 5166 internal or 01634 825166 External). A message can be left on the answer phone).

3.5 Physical injuries must be documented using a body map (Appendix 2) and this must be completed immediately. It must be dated and timed as to when injuries were seen and recorded.

3.6 Following the telephone referral to Children’s Social Care, a follow-up referral must be made in writing using the online form described in section 23 of this document. In the event of any child death please follow Child Death Process SOP PROCPM001

4 Management of suspected abuse in the Emergency Department (ED) of hospital

4.1 All children seen in the ED must have a safeguarding assessment completed and must not be discharged until this has been completed. If there are safeguarding concerns the child must have an assessment of concerns initiated and a Safeguarding care plan commenced OTLPCM040.

4.2 Full demographic details of the child must be obtained including who has Parental Responsibility for the child, who accompanied the child to the ED and whether they have a Social Worker or an Early Help plan.

4.3 If there is a suspicion the information provided is not accurate the staff member should contact the Trust’s safeguarding team so Trust IT systems and Framework I (Medway Social care) can be checked. The safeguarding team should contact Kent Social Care directly for Kent children.

5 Assessment of suspected Non-Accidental Injury (NAI)

5.1 When a child is referred with an injury following an allegation of abuse, or where this is suspected following initial assessment, the child should be urgently referred to the duty Paediatric Consultant for a formal child protection assessment including a physical examination. If the child is seen by the Senior Registrar the on call Consultant Paediatrician must always be notified about the child. For physical examinations a chaperone should be present in addition to parent/carer. If appropriate (taking into account age, cognition and developmental stage) consent for examination should be obtained from the child. If the child refuses and is competent or is assessed to have capacity under the Mental Capacity Act 2005 then the examination cannot take place. If the child is not competent and/or parents refuse examination this should be discussed urgently with Children’s Social Services.

5.2 Detailed documentation of history and examination should be recorded together with use of body maps OTLPCM039. Where concerns regarding significant harm/likelihood of significant harm are confirmed a child protection referral to Children’s Social Services should be made promptly. Consent is not needed for this referral.
5.3 If a child requires a skeletal survey for a suspected Non Accidental Injury (NAI) (please refer to the Skeletal Survey Guidance 2017 and the Royal College Paediatrics and Child Health Guidelines 2008) then the child should not be discharged until the report from the expert radiologist has been received. If clinically fit, discharge to a place of safety should only take place with agreement from Children's Specialist Services and Safeguarding Children’s team.

5.4 All non-mobile children who present with a fracture, burn or bruise must be reviewed by the on call Consultant Paediatrician or Senior Registrar. Any child under 3 years old with a long bone fracture must also be reviewed by the on-call Consultant Paediatrician.

5.5 Children should only be admitted to hospital as a place of safety after discussions with Children’s Specialist Services and Named Doctor for Safeguarding Children and/or Children’s Safeguarding Team.

5.6 If a child is assessed to be in immediate danger and there is no cooperation from parents then advice should be sought immediately from both Children's Specialist Services and the police; a Police Protection Order or Emergency Protection Order may be arranged.

5.7 In the event of parent / carers removing the child from the ED or hospital, Police and Social Services must be contacted immediately by the person in charge of the clinical area. The person in charge must inform all agencies involved in any incident of this type of the outcome of the incident and record that this has been done in the healthcare records; the manager for the appropriate clinical area must also be informed and this must be documented in the healthcare records.

6 Admission to hospital

6.1 All children admitted to a Medway Foundation NHS Trust Paediatric bed will be under the responsibility of the duty Consultant Paediatrician.

6.2 The named Social Worker must be informed of any admission for children subject to a Child Protection Plan, Child in Need Plan or a looked after child.

6.3 Any child aged between 16 and their 18th birthday who is admitted to an adult ward will be afforded the same safeguarding protection as younger children on a Paediatric ward. The adult ward must inform the safeguarding team of the admission.

6.4 All documentation to be completed on admission with details of the child’s parents/carers and who has Parental responsibility for that child.

6.5 Contact should be made with the Health Visitor or School Nurse team responsible for the child/family who may be able to provide staff with more information.

7 Discharges from hospital

7.1 Where there are Safeguarding concerns a child may only be discharged with the agreement of the Consultant Paediatrician, Safeguarding Children’s team and Local
authority (if appropriate). A multi-agency discharge planning meeting must take place.

7.2 Any follow up plan must be recorded in the healthcare records

7.3 The paediatric liaison nurse will inform the Social Worker, Health Visitor or School Nurse team that child has been discharged

7.4 Particular attention is required in the discharge planning of babies from neonatal Intensive Care Units, since these babies are at high risk of re-admission to hospital. These children will need a coordinated programme of follow-up, with special attention to vision, hearing, developmental progress and immunisations.

7.5 No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP. The Consultant under whose care the child has been admitted is responsible for ensuring this happens. If unable to obtain a GP when the child is fit for discharge, the child must remain in hospital until one is obtained.

7.6 Transfer of care for children (including unborn children) about whom there are concerns - If a child is transferred to another hospital or area of the country, professionals caring for that child must ensure that care is transferred appropriately. There should be verbal handover of care followed by written documentation of concerns to the receiving practitioner. The Named Nurse for Safeguarding Children must be contacted in order to hand over to relevant Designated/Named Nurses in that area.

8 **Referrals for a Child Protection Medical (Not Child Sexual Abuse Medical)**

8.1 All Referrals/Requests to be made to the Safeguarding Children Co-ordinator by telephoning 01634 840774 or 01634 830000 Ext 5308 between the hours of 08.15 and 4.30 p.m. Monday to Friday. Outside of Office hours the Voicemail redirects the caller to contact Switchboard for the On Call Paediatrician.

8.2 Requests are only accepted from Social Care or the Police. On receipt of the request the Co-ordinator will process the relevant information and ensure the request for the medical is appropriate and fits the required criteria. The Co-ordinator will then contact the on–call Paediatrician to discuss the details and if the examination is agreed, an appointment will be allocated for the child. Examinations take place on Penguin Assessment Unit (PAU) and are generally undertaken following completion of the Ward round between the hours of 11.30 and 4.00 p.m. The Consultant is unlikely to examine a child after 4.00 p.m. due to the imminent handover.

8.3 The Co-ordinator will contact the Referrer to share the appointment details, it is expected that the Social Worker or a Police Officer will accompany the child to the examination and the Co-ordinator will ensure the relevant Consent is available for the child to be examined.

8.4 The Co-ordinator will contact PAU and inform them of the details and request that a set of temporary Hospital notes including Body Maps are prepared and also email a
copy of the Referral details and any other relevant information, i.e. Care Plan/Minutes if the child is already known to the Safeguarding Team. Safeguarding Databases will be updated with the relevant information and on receipt of the Medical Report from the Consultant a copy is scanned into the record.

9 Child Sexual Abuse (CSA) Medicals

9.1 CSA damages the child emotionally, even when physical signs are absent. The evidence for CSA depends, in the majority of cases, on the child’s disclosure or on observations of the child’s behaviour, and, rarely on the findings of the medical examination alone. Delay in responding to an allegation of CSA may lead to –

- Silencing of the child
- Loss of forensic or other evidence
- Absconding of the alleged perpetrator
- Loss of the child’s trust and confidence in the adult and agency
- Further harm to the child

9.2 The primary focus is the welfare of the child and this may mean that any action taken and discussion with other agencies may take place without the knowledge or consent of the parents/carers

9.3 Following any disclosure a referral must be made to Children's Specialist Services and a strategy meeting held in a timely manner

9.4 The Kent and Medway Sexual Assault Referral Centre (SARC) at Beech House in Maidstone offers care and support to men, women and children who have experienced rape or sexual assault.

9.5 Contact details (24 hour call centre): 0800 133 7432 or weekdays 9:00 -17:00 01622 726461. Email address: bh.admin@nhs.net

The Kent and Medway CSA pathway should be followed. Available online from: https://www.medwayscp.org.uk/mscb/info/4/advice-resources-professionals/18/child-sexual-abuse


9.9 Young people under the age of 13 cannot lawfully consent to sexual activity and such cases must be discussed with a nominated child protection lead (Named Nurse or Named Doctor) and MUST be referred to Children’s Social Services. There should be no delay in referral to children’s social care if the named nurse or doctor cannot be contacted especially out of hours.
10 Exploitation of children

10.1 Child sexual exploitation is defined as – Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

10.2 Children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. They are likely to be in need of welfare services and - in many cases - protection under the Children Act 1989. Often children and young people who are victims of sexual exploitation do not recognise that they are being abused. There are a number of warning signs that can indicate a child is being groomed for sexual exploitation and behaviours that can indicate that a child is being sexually exploited.

10.3 Clinicians who are concerned about a young person who may be at risk of sexual exploitation must undertake a risk assessment to help them decide on what the concerns are and what their next step of action will be. The CSE risk assessment tool can be found online here: [https://www.medwayscp.org.uk/mscb/downloads/file/183/cse-toolkit-kent-and-medway---september-2017](https://www.medwayscp.org.uk/mscb/downloads/file/183/cse-toolkit-kent-and-medway---september-2017)

10.4 Children and young people can also be exploited by gang activity. Over recent years there has been an increase in the incidents of young people carrying knives. The average age of a gang nominal operating in Kent and Medway is 15, but extremely young children can be targeted and groomed by gangs – the youngest reported Kent and Medway is 10 years old.

10.5 If a child or young person presents in ED with knife injuries or gunshot injuries due to reported gang activity the police must be informed via operation Raptor and a referral must be made to Children's social care. As per Kent and Medway Safeguarding Children Procedures. Available online. Please find a link: [https://www.proceduresonline.com/kentandmedway/chapters/p_gangs.html?zoom_highlight=gang](https://www.proceduresonline.com/kentandmedway/chapters/p_gangs.html?zoom_highlight=gang)


10.7 This group may include children who have been sexually abused through the misuse of technology, coerced into sexual or gang activity by criminal gangs or the victims of trafficking. Any child who discloses, or where there are suspicions that they may be a victim of child exploitation, should have a risk assessment completed using the Medway Safeguarding Children Partnership Child Sexual Exploitation toolkit. This will act as an aide memoire for staff and provide guidance as to whether a referral to Medway Social care is appropriate; if in doubt contact the Safeguarding Team.
10.8 Kent has a dedicated Child Sexual Exploitation Team (CSET) based at Kent Police HQ. Any intelligence around Child Sexual Exploitation can be shared with CSET via the Safeguarding Team. Please contact the Named Nurse for Safeguarding Children for advice and support or use the following link to share information: http://www.kscb.org.uk/guidance/sexual-abuse-and-exploitation

10.9 For any information or soft intelligence on the exploitation of children please use the online reporting form to the police. The E-intel form can be found here: https://www.qes-online.com/Kent/elintel/Live/m/eintel/public/index

10.10 The Kent and Medway Risk Threats and Vulnerability checklist can be used on any child where there are exploitation concerns, including when a child’s internet use may be putting them at risk of harm. The online tool can be found here: https://www.kscmp.org.uk/guidance/sexual-abuse-and-exploitation

11 Modern Slavery and Trafficking

11.1 Child trafficking and modern slavery is child abuse. Children are recruited, moved or transported and then exploited, forced to work or sold. Children can be trafficked into the UK from abroad and be trafficked from one town to another within the United Kingdom. Please see the quick reference guide from Medway Safeguarding Children Partnership https://www.medwaysscp.org.uk/mscb/downloads/file/198/trafficked-people---quick-reference-guide Or the Medway Safeguarding Children Partnership Safeguarding Trafficked Children Toolkit here: https://www.medwaysscp.org.uk/mscb/downloads/file/196/abbreviated-safeguarding-trafficked-children-toolkit

12 Online Safety

12.1 Online Safety or "E-Safety" is not just an IT issue; it is about safeguarding young people in the digital world as part of our safeguarding responsibilities. The focus should be on building children and young people's resilience to online risk so they can be safe and confident online.

12.2 Child Exploitation and Online Protection (CEOP) command have useful information for staff and parents to keep children and young people safe online. This can be found here: https://www.ceop.police.uk/safety-centre/

12.3 The Kent Safeguarding Children Multi Agency Partnership has produced guidance for agencies professionals working with children and young people that may need to respond to sexting incidents or youth produced sexual imagery- this can be found via the following link - http://www.kscb.org.uk/guidance/online-safety

12.4 Please see point 2.59 for the 2.59 The Kent and Medway Risk Threats and Vulnerability checklist can be used on any child where there are exploitation concerns, including when a child’s internet use may be putting them at risk of harm.
13 Fabricated or Induced Illness (FII)

13.1 There are three main ways in which a parent or carer may fabricate or induce an illness in a child -

13.2 Fabrication of signs and symptoms, which may include past medical history

13.3 Falsification of hospital charts and records, letters and documents, specimens of body fluids

13.4 Induction of illness by a variety of means

13.5 If there are any concerns in relation to fabricated or induced illness, it is imperative that these concerns are not discussed either with the parent/carer or the child themselves.

13.6 Advice should be sought immediately from the Safeguarding Team and/or the Paediatric Consultant on call. Further advice should be sought from Children’s Social Services.

13.7 It is vital that all information and concerns should be documented in the child’s healthcare records in a contemporaneous manner, without the knowledge of the parent/carer.

13.8 Guidance is available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf This should be read in conjunction with the Working Together Guidelines (2018).

14 Children who have self-harmed or taken a deliberate overdose

14.1 All children who have self-harmed or taken a deliberate overdose attending the ED at Medway NHS Foundation Trust must be referred to, and seen by, the on-call Psychiatric Liaison team prior to discharge. A care plan must be agreed which may involve a referral to the Child and Adolescent Mental Health Service (CAMHS).

14.2 The Safeguarding Team must liaise with the relevant School Nurse Team to share any concerns about the child.

15 Management of adults who present where domestic abuse, mental health or substance abuse is known or suspected

15.1 Research has shown that these issues, known as the Trio of Vulnerabilities (previously known as the 'Toxic Trio') can have a serious impact on the health, development and safety of a child (born or unborn). All staff have a responsibility to respond to any disclosures of domestic abuse and safety planning is always the priority.

15.2 Any adult who presents with any of the above must be asked if they have any children they are responsible for – if they have then full demographic details of
children should be obtained (name, date of birth etc.). It must be documented where the children are and who is looking after them.

15.3 If staff are not trained in using a domestic abuse tool (Domestic Abuse Risk Assessment DARA or DASH) professional judgement should be used to refer to Multi Agency Risk Assessment Conference (MARAC) if appropriate. Staff should seek advice from the Safeguarding Team.

15.4 Staff should refer to the Medway Foundation NHS Trust Domestic violence standard operating procedure SOP0351 and read in conjunction with the NICE Domestic Abuse Guidelines Available online: [https://www.nice.org.uk/guidance/ph50](https://www.nice.org.uk/guidance/ph50)

15.5 Referral to services for domestic abuse can be made using the current referral pathways. Medway available online [https://choicesdaservice.org.uk/mdas.html](https://choicesdaservice.org.uk/mdas.html) Kent available online: [http://www.domesticabuseservices.org.uk/](http://www.domesticabuseservices.org.uk/)

### 16 Honour based abuse (HBA) and forced marriage

16.1 Honour based abuse is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community and is a fundamental abuse of Human Rights under Human Rights Act 1998.

16.2 HBA is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

16.3 Honour based abuse can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members. Such crimes cut across all cultures, nationalities, faith groups and communities. They can transcend national and international boundaries.

16.4 Staff should be aware that adults in forced marriages can experience psychological, physical, sexual and financial violence.

16.5 Staff should be alert to signs and symptoms of adults in forced marriages which may include deliberate self-harm, depression, anxiety, and substance misuse; adults may seek professional advice for an unrelated issue but may mention some ‘family problems’.

16.6 Staff should refer to the national guidelines for advice and contact the Safeguarding Team. Available online from: [http://safelives.org.uk/sites/default/files/resources/Spotlight%20on%20HBV%20and%20forced%20marriage-web.pdf](http://safelives.org.uk/sites/default/files/resources/Spotlight%20on%20HBV%20and%20forced%20marriage-web.pdf)

16.7 When a disclosure of potential forced marriage is made staff should:

- Take any disclosure seriously and not dismiss the need for immediate protection nor assume that someone else is dealing with situation
- Not contact the family
Use careful questioning to establish the full facts

16.8 Offer advice and provide the person with information about specialist advice and information services. Karma Nirvana is a charitable organisation that provides support for HBA and forced marriage. Their website can be found here: https://karmanirvana.org.uk/

16.9 Share information with the Children’s Specialist Services and police as appropriate

16.10 If a child makes a disclosure the appropriate Safeguarding procedures will need to be followed; Safeguarding Adult procedures may need to be followed if an adult makes a disclosure

16.11 Advise the adult that a breach in confidentiality may be necessary in order to ensure their safety.

16.12 Maintain accurate records and record all information in the healthcare records

17 Female Genital Mutilation (FGM)

17.1 Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is illegal in the UK (Female Genital Mutilation Act 2003) as is taking a child out of the UK to have FGM performed on them. New guidelines were published in 2016 which guide policy and practice. Please also refer to the Trust Female Genital Mutilation SOP0367.

17.2 From the 31st October 2015 all healthcare professionals have a mandatory duty to report all known or suspected cases of FGM in those aged under 18 to the police (via 101) and Children's Specialist Services. For all cases where a child is deemed at risk of FGM this also falls within the threshold of significant harm and a referral to Children's Specialist Services is mandatory.

17.3 Any concerns must be raised with the Safeguarding Team. As an organisation the Trust reports quarterly to the Clinical Commissioning Group, Medway Safeguarding Children’s Partnership on FGM prevalence figures. FGM is also reportable to the Department of Health.

18 Prevent and the Channel process

18.1 Prevent is part of the governments counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism.

18.2 Within Kent and Medway there is a process for identifying at risk individuals and referring them to the Channel Panel. This is a multi-agency panel which assesses the risk that an individual may pose and develops a safety plan to protect the individual and the community. Guidance is available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf

18.3 Any concerns should come through the Safeguarding Team and information will be shared with Operation Dovetail, the Home Office process used in Kent and Medway.
19 **Missing children**

19.1 Any child reported missing from Medway NHS Foundation Trust premises should be reported to the police and Children’s Specialist Services. Please refer to the Medway NHS Trust Infant Abduction Policy and Procedure POLDNM002 and the current Kent and Medway Safeguarding Children procedures (which follow national guidelines). They can be found here: [https://www.proceduresonline.com/kentandmedway/chapters/contents.html](https://www.proceduresonline.com/kentandmedway/chapters/contents.html)

20 **Concern for the unborn child and pregnant woman**

20.1 All health professionals involved in providing maternity care (including midwives, obstetricians, paediatricians and sonographers) should be aware of the support services offered by the local authority for children and families in need. These professionals also need to be aware of what action to take should they identify any children at risk of harm – including the unborn. Their duty is no different than that for a child as above. Advice must be sought from the Named Midwife or Team Connect. In their absence the Safeguarding Children team must be contacted.

20.2 The Maternity Safeguarding Hub provides a forum for a multidisciplinary discussion around vulnerable families to ensure that at the earliest opportunity, families within Medway and Swale are accessing the right service at the right time and identifies those families who may be currently receiving support or who will require support from specialist Children Services during pregnancy. Hub referrals should be completed at the earliest opportunity with the consent of both parents and sent to the Named Midwife for Safeguarding who will review the identified concerns and to ensure the referral is appropriate. Actions, referrals or signposting to other services will be determined and identified by the Safeguarding Hub professionals in an attempt to support the women and their families during pregnancy and address the needs of their vulnerabilities. Feedback from the meeting will be given to the referring Midwife and the completion of actions, referrals or signposting remains the responsibility of the Named Midwife for the mother.

20.3 Team Connect aim to provide women centred, specialised care that is individually tailored to the needs and vulnerabilities during the antenatal and postnatal period. Team Connect will provide continuity of antenatal and postnatal care and work closely with other healthcare professionals, Children Services and agencies in supporting the woman and her family.

20.4 The Maternity Support form should be completed by 16 weeks gestation or on identification of concerns or vulnerabilities and uploaded to the relevant patient record within Euroking, a copy of this should be sent electronically and securely using NHS mail to the Health Visiting Team and General practitioner. Updates to the Maternity Support Form should be shared again with the General Practitioner and Health Visiting Team again at 28 weeks, 36 weeks and upon discharge.

20.5 Staff must be aware that they have a duty to safeguard not only the unborn but also any family member. The professional who identifies the risks, or needs, in a family
has the responsibility to act on their concerns and complete a maternity support form; it must be uploaded to the woman’s electronic records.

20.6 Pre-birth planning should be completed for all women and families who are subject to a Child Protection Plan or a Child In Need Plan by 36 weeks gestation. Team Connect will generate and upload the plan to the relevant patient record within Euroking. The Pre-birth plan will be clear and concise in order to guide the staff on the unit.

20.7 Discharge notification in the Antenatal or Postnatal period where concerns or vulnerabilities have been identified and allocated to Team Connect should be sent to the maternity safeguarding and the community team email addresses. Please see Identifying and supporting vulnerable families within the Maternity setting SOP0483

21 Child death reporting


21.2 Every child death is a tragedy and all enquiries should balance the forensic and medical requirements and supporting the family. The Local Safeguarding Children Partnership is responsible for ensuring that a review of each death of a child in their area is undertaken by the Child Death Overview Panel (CDOP).

21.3 An online notification should be completed as soon as possible to alert CDOP there has been a child death. The online form is available at - https://www.medwayscp.org.uk/mscb/info/4/advice-resources-professionals/68/child-death-overview-process

21.4 The Safeguarding Children’s team must be informed of all child deaths on the Trust premises - Contact number – Ext. 5166, Ext. 6722 or Ext. 5759

21.5 The Child Death service can be contacted on – kent.cdr@nhs.net  Telephone number 03000 42 11 26 (main office)

21.6 When a child dies, several investigative processes may be instigated, particularly when abuse or neglect is a factor. All professionals involved with a child who dies unexpectedly (before and/or after the death) must collaboratively respond to the child’s death. The local Designated Paediatrician for Child Deaths (or the nominated substitute when she/he is unavailable) should coordinate the work of the team convened in response to a child’s death.

21.7 Please see Child Death Process SOP PROCMP001 for further information.

22 Where a child is considered to be in immediate danger of harm

22.1 Trust staff should seek urgent medical attention and advice. The Consultant Paediatrician on call and the Safeguarding Children’s team should be contacted immediately; Children's Specialist Services (via the Central duty Team) should be contacted by phone.
22.2 In circumstances when parental/carer/child co-operation is lacking and as a consequence the child is placed at immediate risk, the police should be contacted in order to help manage the situation and to protect the child. Police Protection may be necessary and Children's Specialist Services will advise and work together with Health and the Police. Please contact the Trust Security Team for advice and support.

22.3 In the event of parent / carers removing the child from the department, Police and Social Services must be contacted immediately by the person in charge, who will also inform the manager for the appropriate clinical area, the on call Consultant Paediatrician and the Safeguarding Children Team.

22.4 The person in charge must inform all agencies involved in the incident of the outcome and record that this has been done. A DATIX report should be raised.

23 Referral to Children's Social Care

23.1 The safety and welfare of the child (and/or unborn child) is paramount and must be the first consideration of all staff. Staff must remember to keep the child in focus when working closely with parents and to avoid any undue risk to the child (or unborn child), in the form of collusion. Staff are expected to work in partnership with statutory and voluntary agencies to protect children and to make referrals to Children's Specialist Services. Staff are also expected to listen to the child and document their feelings and wishes and observe the interaction between child and parent or carer.

23.2 The responsibility of safeguarding children investigations lies with the statutory agencies, i.e. Children's Specialist Services and Police. Health professionals must not investigate the incident but they have a duty to assist the local authority during any inquiry (Section 47 Children Act 1989).

23.3 Any member of staff must report immediately to the nurse or person in charge of the clinical area if there is any suspicion or concern in relation to a child’s welfare.

23.4 However it is the responsibility of the practitioner who has the concern to act on that concern. Under no circumstances should any member of staff assume that a concern has been acted on if there is no evidence to prove otherwise.

23.5 A discussion should take place between all staff caring for the child and a subsequent management plan decided. This must also involve the person in charge of the relevant area and the safeguarding team and/or duty consultant paediatrician.

23.6 The Named Doctor, Nurse or Midwife can be contacted via switchboard. Any advice given by the Safeguarding team will be emailed to the relevant practitioner and must be saved in the child’s healthcare record. Staff should establish whether there is a flag on the system or on the records for child or family. The safeguarding team are able to access limited information on Framework I (Medway Social care’s ITsystem) to establish whether the family are known to Medway Social Care.

23.7 Practitioners can discuss safeguarding concerns with Children's Specialist Services before making a referral. If a referral is not appropriate Children's Specialist Services
will discuss an appropriate plan with the practitioner. Prior to contacting Children's Social Care, staff should discuss the concerns with the Trust Safeguarding Children Team or on call Consultant Paediatrician. Consent is not required from parents to discuss concerns with Children's Specialist Services. Information can be found in Kent and Medway Safeguarding Children procedures. Available online here: https://www.proceduresonline.com/kentandmedway/chapters/p_referrals.html?zoom_highlight=consultation

23.8 Medway Children’s Social Care have a Threshold criteria to help and support practitioners with their decision making process. The threshold criteria can be found online: https://www.medwayscp.org.uk/mscb/downloads/file/64/medway-threshold-criteria-for-children-in-need

23.9 Kent has a new process for referring a child to Children's Social Care. This is known as a Request for Support. Guidance on levels of support (previously known as thresholds) is available to aid practitioners to ensure that the correct level of support is provided at the right time. This is available online: https://www.kscmp.org.uk/guidance/kent-support-levels-guidance

23.10 Advice must be sought from the Safeguarding team (if available) prior to submitting a Referral. The Medway link to the online referral form can be found via the following link: https://www.medwayscp.org.uk/info/200170/children_and_families/600/worried_about_a_child/1

23.11 The Kent link to the form and upload platform can be found via the following link: http://www.kscb.org.uk/procedures/child-in-need-chin

23.12 Telephone contact for Medway Children’s Social Care is 01634 334466. Kent Children’s social care can be contacted on 03000 411111 (office hours) or Kent and Medway out of hours telephone number is 03000 419191.

23.13 A copy of the referral must be placed in the child’s current healthcare record and sent to the Safeguarding Team at: met-tr.mftsafeguardingc@nhs.net

23.14 Parent/carers and if appropriate the child, should be consulted and informed about concerns. Consent should be sought from parents to make a referral and evidenced on the referral form. If consent not sought or obtained this must be evidenced again.

23.15 Staff must keep legible contemporaneous healthcare records which are written, signed and dated, that demonstrate the events and all details, decision and actions taken. Full details of the concern or injury, action taken, other professionals involved and any relevant history should be documented.

23.16 All doctors involved in the care of a child about whom there are concerns about possible deliberate harm, must provide Children’s Social Services with a written statement of the nature and extent of their concerns. A Child Protection Medical should be completed at the earliest opportunity if appropriate. If a misunderstanding of medical diagnosis occurs, these must be corrected at the earliest opportunity, in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood.
23.17 The referring practitioner should follow up the outcome of the referral within 48 hours (or deputise to another member of staff); all decisions should be documented.

24 Disagreements between professionals

24.1 If for any reason there is a disagreement with the decisions made by Children's Specialist Services it is incumbent on all practitioners to challenge this. There are clear procedures for this which can be found in the current Kent and Medway Safeguarding Procedures via the following link http://www.proceduresonline.com/kentandmedway/chapters/p_resolution.htm

24.2 Should there be a disagreement between the health professional referring and Children’s Social Care or another agency, this should be resolved using the process described in the Medway Safeguarding Partnership’s policy. This is online and available from; https://www.medwayscp.org.uk/mscb/downloads/file/111/mscb-challenge-and-escalation-policy

In Kent the professional disagreement process can be found online from https://www.proceduresonline.com/kentandmedway/chapters/p_resolution.html?zoom_highlight=escalation

24.3 Please liaise with the Safeguarding Team if you wish to challenge any decisions.

24.4 Differences of clinical opinion may occur between health professionals in relation to the management or diagnosis of a child about whom there are concerns. When this occurs in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion. If this is still unresolved the Trust Named Doctor and/or Nurse must be informed to assist in working towards a resolution. If this is not possible, the local CCG Designated Doctor/Nurse for Safeguarding Children should be involved.

24.5 Accurate documentation of differences and subsequent resolutions is imperative.

25 Flagging system for children with Child Protection Plans or Looked after Children

25.1 Children’s Specialist Services share information about children subject to child protection plans with agreed contacts within each Health organisation. This information is added to the Trust hospitals IT systems on the children’s records to inform staff. For unborn children the information is placed on the mother’s records and transferred to the child’s records at birth. It is known as Child Protection information System (CP-IS)

25.2 CP-IS provides practitioners with data as to whether a child is subject to a Child Protection Plan or is a Child in Care. It also provides contact details of the child’s Social Worker. In Maternity, ED and children’s ward areas all males up to 19 years and all females up to 55 years are checked on the CP-IS system. This provides
clinicians with information on the date the plan was commenced and ended. It will also state which local authority is responsible for the identified child. In addition CP-IS will send an automatic notification to the responsible local authority of the attendance. This allows the front line clinicians to focus more on the child and the child’s needs rather than notifying social care of attendances. However, if there are safeguarding concerns with the attendance, relevant information should be shared with the child’s Social Worker. Out of working hours health professionals should refer to the Out of Hours Social Services team if the concerns are urgent and immediate (03000 419191). Information will also be shared with the relevant Health Visitor and School Nurse Teams.

26 Early Help

26.1 The aim of the Early Help and Preventative Service is to help identify and address, at the earliest opportunity, the risks and needs of children and young adults (from pre-birth to age 25) and their family to improve the outcomes for these children, young people and their families. The aim is to provide timely and co-ordinated support to meet those needs so that they are safeguarded, their educational, social and emotional needs are met and they achieve good outcomes so as to reduce the demand for social care services.

26.2 It provides a consistent approach throughout Kent and Medway so as to ensure effective decision making and allocation to appropriate advice and support – the right support at the right time

26.3 It reduces the workload of statutory services and can help to step down services from Children’s Specialist Services

26.4 Early Help Coordinators will work with schools, health professionals and other practitioners in agencies to support families in Kent and Medway. These families have met level 3 in the threshold criteria document (see point 2.135 and 2.136). Early Help can provide a range of services to meet the educational, social and emotional needs of children, young people and families in Kent and Medway through partner organisations. Consent from the family or young person will be required for Early Help services.

26.5 The online referral form in Medway can be found here: https://www.medwayscp.org.uk/xfp/form/194

26.6 In Kent Early Help can be accessed via the single request support form from: https://www.kscmp.org.uk/guidance/child-in-need-chin

27 Was not Brought or Did Not Attend Appointment

27.1 If a child or adult has not attended an appointment because the parent or carer failed to bring them; the term ‘Was Not Brought’ must be recorded in the adult or child’s records and in all correspondence.
27.2 If a young person chooses not to attend their appointment; consideration must be
given whether the young person is putting themselves at risk of significant harm.

27.3 Consideration should be given to Gillick competencies (see paragraph 2.189) if the
young person is below the age of 16. Does the child have the ability to make a
decision? Do they have a level of maturity, knowledge and understanding regarding
the implications of their decision?

27.4 If a child has failed or continues to fail to attend a scheduled appointment the
responsible practitioner should consider if the child’s health needs are being
neglected; the child’s record must be reviewed to have an overview of appointments
missed and those cancelled by the parent or carer.

27.5 Each case needs to be considered individually and a decision made based on
analysis of the case, consideration of the risk to the child or adult based around the
professional judgement of the practitioner and in discussion with other relevant
professionals. The assessment should include consideration of risk to any other
person living with the child. Please see Elective Access policy POLCOM018 and
Was Not Brought Guidance (awaiting ratification).

28 Safeguarding Supervision

28.1 The Trust places the highest priority on safeguarding all children who come into
contact with the Trust. The Trust expects all staff to meet their statutory
responsibilities and comply with best practice guidance. The child’s welfare is
paramount and staff will ensure that the child’s safety and welfare is their first
concern (including those not yet born).

28.2 Effective and accessible supervision is essential to help practitioners cope with the
emotional demands of work with children and their families and to help to put in
practice the critical thinking required to understand cases holistically, complete
analytical assessments, and provide an intervention.

28.3 The national requirement for staff supervision where children are considered to be at
risk of significant harm is well documented and has been a recommendation in
recent Safeguarding Review Practice (formally known as Serious Case Review).

28.4 Regular safeguarding supervision will promote monitoring of quality and lead to
improved outcomes for children, their families and vulnerable adults,

28.5 The needs of the child are paramount. The process of supervision is underpinned by
the principle that every member of staff remains accountable for their own practice.
The supervisor is accountable for the advice they give and action they take.

28.6 Please see Medway Foundation NHS Trust policy of Safeguarding supervision
POLCPCM056
The Mental Capacity Act (MCA) 2005 and consent


29.2 The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA covers children aged 16 and 17 who also fall within the jurisdiction of the Children Act 1989.

29.3 The MCA does not generally apply to people under the age of 16 except where the Court of Protection is making a decision regarding a child’s property and finance, or, where there has been an offence committed of ill treatment or wilful neglect; this will apply equally to a person under the age of 16.

29.4 Capacity - (or lack of capacity) refers specifically to a person’s ability to make a particular decision or provide informed consent at the time it needs to be made. See

29.5 If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent – especially if a person with parental responsibility wishes to give consent on the young person’s behalf. The Family Division of the High Court can hear cases where there is disagreement.

29.6 People/staff carrying out acts in connection with the care or treatment of a child aged 16 to 17 who lacks capacity to consent will generally have protection from liability as long as the person carrying out the act -

- has taken reasonable steps to establish that the young person lacks capacity
- reasonably believes that the young person lacks capacity and,
- it is established that the act is in the young person’s best interests, and follows the Act’s principles.

29.7 When assessing what is in the young person’s best interests, the person providing care or treatment must consult with those involved in the young person’s care and anyone interested in their welfare – if it is practical and appropriate to do so. This may include the young person’s parents. Care should be taken not to unlawfully breach the young person’s right to confidentiality.

29.8 Sometimes there will be disagreements about the care, treatment or welfare of a young person aged 16 or 17 who lacks capacity to make relevant decisions. Depending on the circumstances, the case may be heard in the family courts or the Court of Protection. Any concerns around disagreements on care and treatment must be referred to the on call Consultant Paediatrician, Named Nurse Safeguarding Children and the Trust Legal Services.
30 Fraser Guidelines and Gillick Competencies

30.1 Gillick competencies are used with children under the age of 16 to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

30.2 Fraser Guidelines apply specifically to contraceptive advice in children under the age of 16 years.

30.3 Staff working with children in any context need to consider how to balance children’s rights and wishes with their responsibility to keep children safe. Key issues to bear in mind include: The child’s safety is paramount. Child protection concerns must always be shared with the relevant agencies, even if this goes against the child’s wishes. Underage sexual activity is a possible indicator of child sexual exploitation and children who have been groomed may not realise they are being abused. Sexual activity with a child under 13 is a criminal offence and should always result in a child protection referral. Further information can be found on NSPCC fact sheet available online: https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

30.4 Please see Standard Operating Procedure for Consent Procedure SOP0131 and Obtaining Consent for a Looked after Child PROLGR011

31 Private fostering

31.1 Private fostering is an informal arrangement whereby a child is living with a family or adult who has no family ties to that child. A child may be privately fostered for a number of reasons including accessing education or their own family are living abroad.

31.2 A privately fostered child is defined as a - Child under the age of 16 (or 18 if disabled) who is cared for and accommodated by someone who does not have parental responsibility for them, or is not a close relative, for 28 days or more. Close relatives include grandparents, siblings, aunts/uncles, or cousins.

31.3 Any member of staff who suspects or has reason to believe that a child is being privately fostered must – Seek advice from the Safeguarding Team

31.4 Ensure that the carer is aware of their statutory duty to refer the situation to Children's Specialist Services

31.5 The staff member must inform Children's Specialist Services if they believe that a child is being privately fostered. Guidance available via the following link – https://www.medway.gov.uk/info/200248/types_of_foster_care

32 Child Protection Conference and Strategy Meeting

32.1 Following a Request for Support to Children's Specialist Services the Local Authority will reach a decision on the outcome of the referral. If the threshold for ‘significant
harm’ is reached the Local Authority is mandated to investigate and make enquiries regarding the child and their family and formalise a plan on the way forward.

32.2 A Strategy Meeting may be held to plan the investigation. All staff who submit a referral are expected to take part in any initial Strategy Meeting alongside the Lead Nurse Safeguarding Children (or their nominated deputy) usually via a conference call. Other staff involved with the child (including a Consultant Paediatrician and the Named Doctor for Safeguarding Children) are expected to share information they hold on the child/family to inform the Strategy Meeting. Staff have a duty to cooperate with the investigation under Section 47 Children Act 1989. Support will be available at all times.

32.3 Minutes from all meetings will be held in the current healthcare record and with the Safeguarding Team.

32.4 Child Protection Conference – it is the responsibility of the local authority to decide whether to convene a Child Protection Conference. Where a decision is taken to not convene a Child Protection Conference this can be challenged by any professional involved with that child and the Safeguarding Children team. Staff should contact the Safeguarding Children team for advice.

32.5 All staff attending a Child Protection Conference are expected to produce a report to share with and inform the conference members. Reports should be completed on the approved Medway pro-forma. This can be found here: https://www.medwaysscp.org.uk/mscb/downloads/file/265/child-protection-conference-report-template

32.6 Kent Safeguarding Children Board pro-forma for case conference reports can be found via the following link http://www.kscb.org.uk/guidance/child-protection-conferences-and-plans/child-protection-conference

32.7 These forms should be used for both initial and review Child Protection Conferences and should be submitted to the Child Protection Conference Chair at least 48 hours prior to the conference. A copy of the report must be placed in the healthcare record and sent to the Safeguarding Team. Support is available to all staff should they require it. It is expected that all reports will be shared with parents prior to the conference. If this is not possible the rationale must be documented.

32.8 Any staff member who is required to attend Child Protection Conferences, Strategy Meeting’s or planning meetings will have the support of their line manager or the Named Nurse; midwives will have the support of the Named Midwife, Team Connect or Named Nurse. This should including debriefing and supervision if required. It is entirely appropriate to ask for professional support at the conference.

32.9 Each individual has a right to make their contribution and give their point of view. Any staff member who attends a Child Protection Conference has the right to have their opinion recorded by the conference chair; this will be reflected in the minutes. If any staff member disagrees with a decision of the conference this must be recorded at the time of the conference. Conference minutes and subsequent action plans should be checked carefully on receipt for any discrepancies and copies placed in the kept in the child’s healthcare record. All minutes will be held by the Safeguarding Team. In cases where concerns have been raised during pregnancy, all information will be
held in the mother’s healthcare records. Following the birth of the baby all information will be transferred immediately into the baby’s hospital healthcare record.

33 Information sharing and confidentiality

33.1 Please use the following link for up to date advice: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

33.2 Sharing information amongst professionals working with children and their families is essential for the purposes of safeguarding and promoting the welfare of children. It is often only when information from a range of sources is put together that a child can be seen to be in need or at risk of serious harm. Staff are mandated to cooperate with any enquiries by Children’s Specialist Services under Section 47 Children Act 1989. GDPR is not a barrier to information sharing.

33.3 The duty of confidentiality owed to children is that same as that for adults. Any disclosure must be justifiable and staff must weigh up the child/young person’s right to privacy and the degree of current or likely harm. It must always be made clear that confidentiality may not be maintained if the withholding of information will prejudice the welfare of a child.

33.4 Professionals work in partnership with parents and or carers and it is good practice to gain their consent (and that of the child) for sharing information. Where there are specific concerns that informing the parent/carer that information is to be shared may place the child (ren) at further risk then parents/carer(s) would not be informed. The law will not prevent a practitioner from sharing information with others if consent has been obtained.

33.5 The public interest in safeguarding a child’s welfare overrides the need to maintain confidentiality

33.6 Information is being shared to inform an assessment being undertaken by social services. The Children Act 1989 places an obligation on health professionals to share information when a s47 assessment is being undertaken.

33.7 Disclosure is required under a court order or other legal obligation. If you are required by a court order to provide a statement or report please contact your line manager and the legal team who will guide you through the process. The Safeguarding Team can also provide support.

33.8 Information should not be shared with parents in cases of FII or if the sharing of information would be likely to contaminate evidence in further investigations such as in sexual abuse, female genital mutilation or forced marriage allegations.

33.9 Professionals must exercise caution when asked for information over the telephone. The caller’s identity must always be verified and a work telephone number or work email address established. Do not share information via a mobile phone. Information may be shared by email via an nhs.net email account only to a secure email account. Telephoning the parents back on their work number is recommended.
34 Sharing of records

34.1 There may be a request from other organisations (Children's Specialist Services, Police etc.) to share the contents of healthcare record or the records themselves. The Trust has clear policies for sharing confidential information. Do not photocopy and share any records with any outside agency without prior agreement. Please seek advice from your line manager and the Trust Legal Team; the Trust's Safeguarding Children team and the Caldicott Guardian can provide advice.

34.2 Any information shared must be documented accurately with the reason given for disclosure and to whom the disclosure is made. All staff must ensure that the records are signed and dated/timed contemporaneously.

35 Learning and improvement

35.1 Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.

35.2 Good practice should be shared so that there is a growing understanding of what works well. Conversely when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

35.3 These processes should be transparent with findings of reviews shared publically and nationally. Everyone has an interest in understanding both what works well and also why things go wrong.

35.4 Safeguarding Children Partnerships have a duty to review cases regularly to ensure that lessons are learnt about how organisations work together to safeguard and promote the welfare of children. Cases which do not meet the criteria for a statutory review but may highlight good practice or valuable lessons around working together are pivotal in ensuring a clear understanding of what is or is not good practice.

35.5 The Trust has a duty to cooperate in these reviews to highlight any areas for improvement but also to ensure we as an organisation are working to the highest standards.

35.6 13.1 There are different types of reviews; If the threshold for a Child Safeguarding Practice Review (CSPR) has been met a Rapid Review Panel will be convened within 15 days of receiving the referral to consider multi agency information. The decision to undertake a CSPR ultimately rests with the MSCP executive. Decision making will be overseen by the independent scrutineer.

35.7 Where the threshold for undertaking a CSPR is not met, but where an incident has occurred and there are concerns about multi-agency working to safeguard children and promote their welfare, then the Rapid Review Panel will consider the need or a lessons learned review or single agency review and refer it to the MSCP Learning Lessons Subgroup/ Case File Audit group or Learning Lessons panel. For example, where a child has died of natural causes, but multi-agency working has been found
to be a cause for concern and the review required is more extensive than the Child Death Overview.

35.8 A Lessons Learned Review is completed with the same approach to CSPRs. Each agency concerned may be asked to complete an Individual Management Review that will feed into an overview report. The learning and actions from these reviews will be disseminated through practitioner events and the action plans monitored by the MSCP Learning Lessons Subgroup.

35.9 A case file audit is a multi-agency review of the case file of the child/ren at a themed prescheduled regular quarterly meeting using the MSCP case file audit tool. The tool addresses why a child/family is known, the concerns relating to the child, what needs to happen and what progress is being made.

35.10 Good/Practice Review is where a professionals forum will be called on an ad hoc basis to consider the practice in individual cases to identify examples of practice in need of improvement, ongoing challenges for professional practice and examples of good practice.

35.11 A single agency completes a report as per the Lesson’s Learned Review approach where multiple agencies will be required to complete an Individual Management Review.

35.12 Whilst the referee is invited to identify what type of review the case warrants, the final decision rests with the Learning Lessons Subgroup, unless a CSPR is indicated and the Rapid Review Panel will be convened.

36 **Allegations against staff**

36.1 The Trust is committed to listening to children especially when they are expressing concerns about either their own or another child’s welfare. Parents and children are able to make complaints via the Trust PALS Service. Any disclosure of concerns over a child’s welfare must be brought to the attention of the Safeguarding Team.

36.2 Allegations of abuse against any member of staff must be dealt with quickly and consistently in a way that provides effective protection for the child and supports the person who is the subject of the allegation.

36.3 Anyone receiving allegations about staff must report the concerns to their manager and not make an early decision about whether the allegation is true. If the allegation is made against a senior manager, it should be reported to an alternative senior manager.

36.4 An allegation may require consideration from any of the following three inter-related perspectives.

- Child protection enquiries by Children’s Social Services
- Criminal investigation by the police
- Staff disciplinary procedures

36.5 The Local Area Designated Officer (LADO) must be informed of any allegation of abuse against staff. The LADO can consult or refer to police and/or social services.
36.6 Medway Safeguarding Children Partnership advice on managing allegations against staff can be found via the following link: [https://www.medwayscp.org.uk/mscb/downloads/file/243/professionals-referral-form](https://www.medwayscp.org.uk/mscb/downloads/file/243/professionals-referral-form)

36.7 It is recommended that Police and Social Services investigations are completed before any disciplinary process can be concluded. However these may run concurrently.

36.8 Consideration must be given to support mechanisms for staff during a period of exclusion e.g. occupational health and Human Resources should be informed.

36.9 If a member of staff has concerns about malpractice, illegal acts or omissions at work of colleagues relating to the care of a child, the Trust’s Freedom to Speak Up at Work Policy POLCHR014 should be used in order to protect the child.

### 37 Definitions

37.1 Child - a child is defined as anyone who has not yet reached their 18th birthday

37.2 Young Person/People – a child aged 16 - 17

37.3 NAI – Non-Accidental Injury - any abuse purposefully inflicted on a person; this abuse can be physical or emotional

37.4 MARAC – Multi-Agency Risk Assessment Conference - a multi-agency meeting where information is shared on the highest risk domestic abuse cases

37.5 Emergency Protection Order (EPO) - Under Section 44 of the Children Act 1989, a local authority can apply for an Emergency Protection Order (EPO) where there are reasonable grounds for believing there is an immediate risk of Significant Harm to a child. Applications will usually be made to the Family Proceedings Court.

37.6 Honour Based Abuse/Violence (HBV) - a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code which it refers to is set at the discretion of male relatives and women who do not abide by the ‘rules' are then punished for bringing shame on the family.

37.7 The Children Act 1989

- Section 1 – The welfare of the child is paramount. A child is defined as being any person who has not yet reached their eighteenth birthday

- Section 17 – a Child is defined as being in need when they are unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled

- Section 47 – Introduces the concept of ‘Significant Harm’ as the threshold for compulsory intervention in a child’s life; it establishes a duty on local
authorities to make enquiries regarding a child once significant harm is suspected and for agencies to ‘cooperate’ with these enquiries

- The Children Act 2004 – establishes duties on all agencies to cooperate with any investigation and to share information to safeguard the welfare of a child or children

37.8 Safeguarding – this is the action taken to promote the welfare of children and protect them from harm; it is everyone’s responsibility and everyone has a duty to cooperate (HM Government 2018). Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing the impairment of their health and development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

37.9 Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm as a result of abuse or neglect.

37.10 Abuse and neglect: a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children (Working Together Guidelines 2018)

37.11 **Categories of abuse – Definitions from Working Together to Safeguard Children 2018**

37.12 **Physical abuse**

- Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

37.13 **Emotional abuse**

- Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development.

- It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person

- It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate
• It may feature age or developmentally inappropriate expectations being imposed on children
• These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction
• It may involve seeing or hearing the ill-treatment of another
• It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children
• Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone

37.14 **Sexual abuse**

• Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse.

• Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children

• Children who are victims of child sexual exploitation are also suffering sexual abuse and require careful assessment of their needs. Staff should refer to the Kent and Medway Safeguarding Children Procedures; in particular the use of the MSCP Child Sexual Abuse Pathway found here: [https://www.medwayscp.org.uk/mscb/info/4/advice-resources-professionals/18/child-sexual-abuse](https://www.medwayscp.org.uk/mscb/info/4/advice-resources-professionals/18/child-sexual-abuse)

37.15 **Neglect**

• Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

• Once a child is born, neglect may involve a parent or carer failing to -
Policy

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment
- It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

37.16 Child in need

- A child is defined as being in need when they are unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled

37.17 Significant harm

- This is the threshold that justifies compulsory intervention in a child’s life. When this threshold has been reached the Local Authority is under a duty to investigate, or make enquiries when it has reasonable cause to suspect that a child is suffering, or at risk of suffering significant harm.
- Harm is defined as the ill treatment of a child or the impairment of their health and development.

38 (Duties) Roles & Responsibilities

38.1 Head of Service for Safeguarding

- The Head of Service for Safeguarding will represent the Trust at the Safeguarding Children Board in Medway and the Health Safeguarding Group in Kent.
- The Head of Service will be responsible for senior strategic leadership and decision making on behalf of the Trust and will report to the Trust Board on safeguarding arrangements within the Trust.
- The Board Lead will also provide reassurance to the Board that we meet our statutory requirements.

38.2 Lead Nurse Safeguarding Children

- The Lead Nurse will provide leadership at an operational level to all staff within the Trust.
The Lead Nurse will ensure the Trust is compliant with its duties and ensure policies are in place and up to date and available for all staff.

The Lead Nurse will ensure processes to safeguard children and young people are in place and that staff at the frontline are supported in their day to day work.

The Lead Nurse will represent the Trust at the Safeguarding Boards’, subgroups ensuring there is good participation and information sharing when contributing to Multi agency audits.

The Lead Nurse ensures there is a robust training programme in place to support staff in their understanding of safeguarding children and young people.

The Lead Nurse will provide supervision and support to staff at the frontline on a day to day basis.

The Lead Nurse ensures there are processes in place to collect data as required by the safeguarding children boards and the CCG.

The Lead Nurse works closely with external partners sharing information and contributing to assessments of risk to vulnerable children and young people.

**Named Midwife for Safeguarding**

- The Named Midwife is responsible for the coordination of all cases where there are vulnerable babies.
- The named Midwife works closely with the frontline midwives in both the community and on the maternity wards, providing supervision and support on any difficult cases.
- The named midwife works closely with external partners ensuring information sharing is provided in the best interest of the babies.
- The named midwife contributes to assessments when a vulnerable woman or young person is pregnant.
- The named midwife coordinates the maternity hub where vulnerable cases are discussed.
- The named midwife provides information to the MARAC process when vulnerable pregnant women are discussed.

**All staff**

- Any member of staff within the Trust, irrespective of their area of work may come into contact with children, young people and their families, and so they therefore need to be alert to the possibility that a child is or is likely to suffer significant harm. Where there are concerns or suspicions that a child has been abused or due to parental concerns this is likely to happen, these
suspicions must be discussed with their line manager, senior person on duty or Named Nurse safeguarding children. All staff should:

- Consider the welfare of the child as paramount at all times.
- Be vigilant as to the possibility of abuse.
- Be objective in the assessment of signs or symptoms of possible abuse.
- All health staff, whether senior or junior, should be aware that it is their professional responsibility to report any concerns regarding possible child abuse or neglect to an ‘authorised’ agency i.e. Children’s Social Care and/or the police.
- All staff must be prepared to fully co-operate with children’s social care (and police) in cases of possible abuse, which are being investigated.
- All health staff should be conversant with, and have access (in their place of work) to The Kent Safeguarding Children Multi Agency Partnership and Medway Safeguarding Children’s Partnership Safeguarding Procedures https://www.proceduresonline.com/kentandmedway/

39 Monitoring and Review

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How/Method/ Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/ gaps Recommendations and actions</th>
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<tbody>
<tr>
<td>Policy review</td>
<td>To be reviewed and updated as required</td>
<td>Author</td>
<td>Safeguarding Assurance Group</td>
<td>Where gaps are recognised action plans will be put into place</td>
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<tr>
<td>Compliance with documentation on children’s records/notes</td>
<td>An annual audit will be undertaken</td>
<td>Named Nurse Safeguarding Children.</td>
<td>Quality and Risk Committee</td>
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<tr>
<td>Case notes following criteria set by the Quality Review Group of the safeguarding Board</td>
<td>Multi-agency audit in conjunction with partner agencies from the Medway safeguarding i.e. police, social care, Primary Care Trust and Education.</td>
<td>Safeguarding team to represent the Trust but the group is lead by children social care.</td>
<td>Quality Review group of the Medway Safeguarding Children Partnership and the Quality and Risk Committee of</td>
<td></td>
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</table>
### Policy

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How/Method/ Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/ gaps Recommendations and actions</th>
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<tbody>
<tr>
<td>Compliance with our duties under section 11 of the Children Act 2004</td>
<td>The Kent and Medway Safeguarding Children Boards’ audit on an annual basis</td>
<td>Lead Nurse Safeguarding Children</td>
<td>the Trust</td>
<td>The Kent and Medway Safeguarding Children Partnerships. This audit will also be reported on at the Trust’s Strategic group and included in the quarterly reports to the Trust’s Quality and Risk committee.</td>
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</tbody>
</table>

#### 40 Training and Implementation

40.1 Please refer to the Safeguarding and Protecting Children Training Strategy - STRCPCM001

40.2 An annual report will be submitted to the Trust Board

40.3 Evidence will be collated quarterly on training compliance and referrals made to Children's Specialist Services

40.4 The Lead Nurse for Safeguarding Children will ensure that all Trust staff are informed of any procedural or statutory changes in a timely manner

40.5 Quarterly data will be submitted to the Kent Safeguarding Children Board to provide assurance that the Trust is fulfilling its statutory obligations

40.6 A Section 11 audit will be completed every 2 years and submitted to Medway Safeguarding Children Partnership

#### 41 Equality Impact Assessment Statement & Tool
All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”.

The policy owner must insert here a statement to summarise how they have assessed the policy for impact on the protected characteristics under the Equality Act 2010. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment [AGN00168 - Equality Impact Assessment guidance note]. Key issues to include are:

- An assessment of how relevant the policy is to equality and diversity
- The key informants (e.g. data and/or consultees) of the assessment
- What, if anything, was learnt, and any actions that need to be taken to ensure that the policy can be delivered equitably.
- Where the impact assessment can be located (e.g. available from the document author)

42 References

<table>
<thead>
<tr>
<th>Document</th>
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<tr>
<td>Brook Sexual Behaviours Traffic Light Tool</td>
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<td>Channel Duty Guidance</td>
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<td>Children Act 1989 and 2004</td>
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<td>Children and Social Work Act 2017</td>
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<td>Child Exploitation and Online Protection command</td>
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<td>Choices Domestic Abuse Service</td>
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<td>Domestic Abuse Service</td>
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<td>Human Rights Act 1998</td>
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<td>Information Sharing Advice for Safeguarding Practitioners 2015</td>
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<td>Karma Nirvana support for honour based violence and forced marriage</td>
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<td>Kent and Medway Child Sexual Abuse Pathway</td>
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<tr>
<td>Kent and Medway Child Sexual Exploitation Risk Assessment tool</td>
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<td>Kent and Medway Gang Strategy</td>
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<td>Kent and Medway Child Death Review Partners Arrangements</td>
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<td>Kent and Medway Risk Threats and Vulnerability Checklist</td>
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<td>Kent and Medway Safeguarding Children Procedures [online]</td>
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<td>Kent Safeguarding Children Multi Agency Partnership Guidance for online safety</td>
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<td>Medway Safeguarding Children Partnership Child Sexual Abuse Pathway</td>
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<td>Medway Safeguarding Children Partnership Challenge and Escalation Policy</td>
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<td>Medway Safeguarding Children Partnership Safeguarding Trafficked Children Toolkit</td>
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<td>Medway Safeguarding Children Partnership Trafficked People Quick Reference Guide</td>
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### Policy

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<td>Mental Capacity Act 2005</td>
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<tr>
<td>NICE Domestic Abuse Guidelines</td>
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<tr>
<td>NSPCC Guide to spotting signs and symptoms of abuse</td>
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<td>Safeguarding Children in Whom Illness is Fabricated or Induced Illness</td>
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<tr>
<td>Safelives resources on Honour Based Violence and Forced Marriage</td>
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<tr>
<td>What to do if you’re worried a child is being abused</td>
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<td>When to Suspect Child Maltreatment</td>
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<tr>
<td>Working Together to Safeguard Children 2018</td>
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<td>Working with Sexually active young people toolkit</td>
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#### Trust Associated Documents:

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<tr>
<td>Body Maps</td>
<td>OTLPCM039</td>
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<td>Child Death Process SOP</td>
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<td>Consent Procedure</td>
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<td>Domestic Abuse SOP</td>
<td>SOP03.51</td>
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<td>Elective Access policy</td>
<td>POLCOM018</td>
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<td>Female Genital Mutilation SOP</td>
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<td>Managing Allegations Against Staff</td>
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<td>Obtaining Consent for LAC</td>
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<td>Safeguarding Care Plan</td>
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<td>Safeguarding Supervision Policy</td>
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<tr>
<td>Supporting Vulnerable families within the maternity setting SOP</td>
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Executive Summary

The report provides an update on progress across the Trust’s transformation portfolio, including work during the previous period to align transformation efforts behind the Trust’s Quality Strategy and the findings of the CQC.

**Large, cross-hospital transformation programmes.**

Activity within the Trust’s core transformation programmes continues to gather pace:

**BEST Flow:** The Programme, currently supported by change partners, *Transformation Nous*, enters its final phase. During the previous period, work has focused on operational grip at each juncture of the emergency pathway in the face of well-publicised operational pressure and demand. Over the coming weeks, we will oversee the ‘handover’ from TN to ensure we sustain and embed the improvements achieved to date. We have commissioned an independent review of the programme to be led by our Financial Improvement Director as we gear up for further work on non-elective patient flow next year. Future work will focus barriers to and enablers of safe and effective flows within the hospital and also out into the community. Key achievements, challenges and next steps are provided in the appended highlight report.

**BEST Access:** This Programme continues to drive improvement across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management. The work has helped secure the Trust’s contractual settlement with our commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year. Key achievements, challenges and next steps are provided in the appended highlight report.

**The Cost Improvement Programme (CIP).**

As at Month 10, the Trust has delivered £15.0m in CIP. Year to date, this is adverse to the operational plan monitored internally by £2.4m. We are forecasting an outturn position of £16.5m - £18.2m against the Trust’s requirement of £19.5m. We focus efforts now on next year’s Cost Improvement Programme, working with clinical and operational teams to prioritise schemes which deliver efficiencies through improved care quality, patient safety and patient and staff experience. We are working towards a challenging target of £12m - £14m to deliver the Trust’s control total.

**Delivering the quality strategy.**

Led by the Chief Nurse, we are increasingly working to align our improvement and transformation efforts behind the Trust’s Quality Strategy. The CQC inspection report also provides a set of ‘must do’ quality improvement priorities, and highlights some long-standing cultural challenges we must address. We have honed our method for improvement in recent weeks and the
next phase of the Trust’s QI programme will launch in Q1 of the next Financial Year. During the previous period, we have worked with a small creative agency to create an ‘Improvement & Innovation’ sub-brand: a ‘one stop shop’ for quality improvement (QI) to improve staff access to, and engagement with support, coaching and resources for their quality improvement projects.

**Improving data confidence.**

During the previous period, we have mobilised work to improve the Trust’s data confidence i.e. the quality and validity of the data and information we report, and how effectively this is prioritised to help make decisions, and how this information flows from Ward-to-Board. This includes a review and overhaul of the Trust’s Integrated Quality and Performance Report (IQPR).

<table>
<thead>
<tr>
<th>Link to Strategic Objectives 2019/20</th>
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<tr>
<td><strong>Innovation:</strong> We will embrace innovation and digital technology to support the best of care</td>
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<td><strong>Finance:</strong> We will deliver financial sustainability and create value in all we do</td>
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<tr>
<td><strong>People:</strong> We will enable our people to give their best and achieve their best</td>
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<tr>
<td><strong>Integrated Health Care:</strong> We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
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<td><strong>High Quality Care:</strong> We will consistently provide high quality care</td>
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<table>
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<th>Due Diligence</th>
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<td>To give the Trust Board assurance, please complete the following:</td>
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<tr>
<td>Committee Approval:</td>
<td>TAG fortnightly: 11 February and 25 February 2020</td>
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<tr>
<td>Executive Group Approval:</td>
<td>19 February 2020</td>
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<td>National Guidelines compliance:</td>
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<td>Resource Implications</td>
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<td>Quality Impact Assessment</td>
<td>QIAs must be completed for all change projects including individual Cost Improvement Programme schemes.</td>
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<td>Recommendation/Actions required</td>
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<tbody>
<tr>
<td>Appendix 1: Best Flow, Best Access &amp; Digital highlight reports</td>
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Executive Overview

1.1 The report provides an update on progress across the Trust’s transformation portfolio, including work during the previous period to align transformation efforts behind the Trust’s Quality Strategy and the findings of the Care Quality Commission (CQC).

1.2 Large, cross-hospital transformation programmes. Activity within the Trust’s core transformation programmes continues to gather pace:

1.2.1 BEST Flow: The Programme, currently supported by change partners, Transformation Nous, enters its final phase. During the previous period, work has focused on operational grip at each juncture of the emergency pathway in the face of well-publicised operational pressure and demand. Over the coming weeks, we will oversee the ‘handover’ from TN to ensure we sustain and embed the improvements achieved to date. We have commissioned an independent review of the programme to be led by our Financial Improvement Director as we gear up for further work on non-elective patient flow next year. Future work will focus barriers to and enablers of safe and effective flows within the hospital and also out into the community. Key achievements, challenges and next steps are provided in the appended highlight report.

1.2.2 BEST Access: This Programme continues to drive improvement across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management. The work has helped secure the Trust’s contractual settlement with our commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year. Key achievements, challenges and next steps are provided in the appended highlight report.

1.3 The Cost Improvement Programme (CIP). As at Month 10, the Trust has delivered £15.0m in CIP. Year to date, this is adverse to the operational plan monitored internally by £2.4m. We are forecasting an outturn position of £16.6m - £18.2m against the Trust’s requirement of £19.5m. We focus efforts now on next year’s Cost Improvement Programme, working with clinical and operational teams to prioritise schemes which deliver efficiencies through improved care quality, patient safety and patient and staff experience. We are working towards a challenging target of £12m - £14m to deliver the Trust’s control total. As reported through Finance Committee, the process to validate schemes is proving challenging and we are behind our internal targets for achieving a ‘Green’-rated plan at the time of writing.

1.4 Delivering the quality strategy. Led by the Chief Nurse, we are increasingly working to align our improvement and transformation efforts behind the Trust’s Quality Strategy. The CQC inspection report also provides a set of ‘must do’ quality improvement priorities, and highlights some long-standing cultural challenges we must address. We have honed our method for improvement in recent weeks and the next phase of the Trust’s QI programme will launch in Q1 of the next Financial Year. During the previous period, we have worked with a small creative agency to create an ‘Improvement & Innovation’ sub-brand: a ‘one stop shop’ for quality improvement (QI) to improve staff access to, and engagement with support, coaching and resources for their quality improvement projects.

1.5 Improving data confidence. During the previous period, we have mobilised work to improve the Trust’s data confidence i.e. the quality and validity of the data and information we report, and how effectively this is prioritised to help make decisions, and how this information flows from Ward-to-Board. This includes a review and overhaul of the Trust’s Integrated Quality and Performance Report (IQPR).

BEST Flow

2.1 Programme overview aims and objectives: Mobilised in May 2019, the BEST Flow programme is a large-scale transformation programme to improve patient flow through each step of the emergency access and inpatient pathways. This represents the Trust’s flagship transformation programme in 2019/20, as well as a key system priority as outlined in the local economy’s System Recovery Plan. We have therefore partnered with expert operational improvement consultancy, Transformation Nous, to support this work. In the last update to the Board, we reported that the Trust was awarded the Patient Flow Programme of the Year 2019, out of 70 Trusts nationally who submitted an application. Best Flow’s objective is to enable the Trust to deliver improved 4hr ED waits performance. We recognise that
Transformation update

2.2 **Programme activity during the previous period**: The recent operational pressures on emergency care regionally and nationally have been well-publicised. These pressures have been intensified by Coronavirus referrals and the decision to close Dickens Ward in January. The programme has therefore continued to focus on improvements to operational grip at every juncture of the emergency pathway:

2.2.1 This has included improvements to the efficacy of crucial meetings e.g. the 0830 site meeting: a critically important forum for managing the day and prioritising early decision-making across the bed-base, and ED multi-disciplinary safety huddles, led by the ED Nurse-In-Charge.

2.2.2 The programme has also supported the work to finalise the Trust's Full Capacity Protocol – a crucial document for managing the site safely and effectively when at maximum capacity and detailing the key actions and triggers during OPEL 3 and 4.

2.2.3 The Clinical Decision Unit opened in January. The unit provides a much improved, modern environment for our patients, especially those who are waiting for speciality reviews and outcomes of investigations. It also helps to reduce crowding in our Emergency Department (ED) and encourages better flow throughout the department and beyond. This helps us to ensure that quality and safety are our top priorities and that ED capacity is prioritised for those who most need it.

2.2.4 A recent development has been the creation of a Site Director role, the glue to maintaining consistent operational grip throughout the day and from one day to another. Though in its early stages, this role has proved very valuable as an “on-the-ground” leader to support the problem-solving of issues, with a clear mandate to make operational decisions on behalf of the senior team.

2.2.5 Finally, the programme has also delivered a refreshed set of ‘Role Cards’ for ED Nurse in Charge, ED Majors Co-Ordinator, ED Flow Co-Ordinator, ED Duty Manager to clarify roles and responsibilities within the teams.

2.3 Type 1 ED performance has been improving in relative rankings throughout the programme, from 112th nationally in March 2019 (=bottom quartile of Trusts) to 59th (=national median) in January 2020:
2.4 A crucial part of sustaining the improvements lies in training and capability-building. In April, we will formally launch the Best Flow Academy: a series of modular trainings for staff involved in the emergency pathway, focusing on the soft and hard skills required to enable safe patient flow, for instance, Board rounding effectively, weekend planning, completing electronic Discharge Notifications.

2.5 Up to this point, the Programme has been supported by change partners, Transformation Nous. This work is entering its final phase. Over the coming weeks, the Programme Management Office will oversee the ‘handover’ from TN to ensure we sustain and embed the improvements achieved to date. We have commissioned an independent review of the programme to be led by our Financial Improvement Director as we gear up for further work on non-elective patient flow next year. Future work will focus barriers to and enablers of safe and effective flows within the hospital and also out into the community. Key achievements, challenges and next steps are provided in the appended highlight report.

3 BEST Access

3.1 Programme overview aims and objectives: The overall aim of this programme is to build and sustain operational resilience to deliver safe services, improve quality and patient experience in Cancer Care, Outpatient Services, Diagnostics and Elective Surgery (Inpatient and True Day Case), ensuring economy and efficiency. The programme is resourced by an internally established Delivery Unit. This is a co-sourced, high-performing internal consultancy, established to support the Trust’s most pressing and complex problems. The programme’s key objective is to ensure compliance with all Cancer, RTT, DM01 Constitutional Standards, including the incoming 28 day FDS for Cancer.

3.2 Programme activity during the previous period: This Programme continues to drive improvement across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management. The work has helped secure the Trust’s contractual settlement with our commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year. Workstream updates are as follows:
3.2.1 **Cancer services**: We achieved a performance improvement in 2 week wait referrals for December, up to 97.91% (+2.23% from November’s reported position). The incoming 28 day FDS for GP Referrals and Screening, from April 2020, shows that the Trust is compliant with all new standards set at 70%, against 80% level of data completeness (data completeness compliance data will be available from March 2020). A full breach avoidance programme is now operational across Cancer services. New support mechanisms have seen the full resolution of the endoscopy Cancer backlog at the end of January. Patients on the Cancer Pathway awaiting endoscopy are now all being scheduled within the target of 14 days.

3.2.2 **Outpatients and Referral to Treatment (RTT)**: The programme has delivered steady improvements in key areas of RTT performance with the embedding of the re-structured RTT Patient Tracking List (PTL) meetings, improved validation of patient pathways, timely completion of outpatient clinic procedures, improved clinic utilisation and clinic space allocation. We have also deployed a targeted programme relating to the scheduling and administration function (including patient correspondence). The embedding of clinical triage, additional clinical activity and insourcing in some key specialties will improve the RTT position further. The volume of patients waiting more than 26 weeks has reduced by more than 400 in the past four weeks across all specialties and remains on a downward trajectory.

3.2.3 **Diagnostics and DM01 standard**: The programme has re-structured the weekly Diagnostics PTL. Issues remain within MRI and Endoscopy and we are insourcing at pace to meet this demand. Business cases are developed to provide medium-term solutions including the procurement of replacement and additional MRI scanning capacity. All other Diagnostic specialties are performing at the required standard.

3.2.4 **Theatres**: Delivery against the theatre productivity target [20% of the identified opportunity] has been exceeded: 25% of the opportunity has been delivered under cases completed for week ending 9th February. This has been achieved by optimising our patient call-outs process to reduce non-attendance rates down to less than 2% for 10 consecutive weeks. In-theatre optimisation has also been achieved and we continue to monitor average cases per session and theatre ‘touchtime’.

### 4 Cost Improvement Programme & Model Hospital

4.1 **Year-to-date delivery, 2019/20**: Our current plan for FY 2019/20 comprises 80 efficiency schemes which have collectively delivered £15m of cost improvements as at Month 10. This is against our Trust operational plan of £17.4m i.e. adverse to plan by £2.4m.

4.2 Our year end forecast is a delivery of between £16.5m-£18.2m. The best case delivery relies on all red and amber schemes delivering alongside the existing green rated schemes. The worst case scenario assumes no change to the current delivery profile. Based on a profile maintained in line with PMO assurance processes, the mostly likely outcome is circa £17.8m.

4.3 Controlled use of planned contingencies means that we remain confident in our ability to deliver to the control total deficit position for 2019/20.

4.4 **Planning for 2020/21**: The Trust plan for 2020/21 is confirmed at £12m, with internal targets pushing out to £14.4m. To date, the outline draft plan comprises £2.5m in full year effect schemes from last year as well as a further 71 new ‘ideas’. These ideas have been generated by clinical and operational teams, as well as by non-clinical areas using benchmarking tools (GIRFT, Model Hospital, NHS Benchmarking). 35 of these schemes target an estimated value of £6.9m and a further 36 are being worked up through the Programme Management Office (PMO) pipeline.

4.5 For every CIP scheme, the approval process is robust and was audited externally by NHS Improvement in June 2019. Scheme owners are required to complete a suite of CIP documentation which passes through a series of internal stage-gates before final approval is sought at formal panels. For this year’s round of CIP planning, Executive-led Quality Impact Assessment (QIA) and Project Initiation Document (PID) approval panels comprise senior leaders within the Trust, including the Director of Nursing, the Medical Director, the Chief Operating Officer and the Director of Transformation to stress-test the
worthiness and feasibility of every scheme. This stringent approach means that when a scheme is considered ‘Green’, we are confident that the scheme is well thought-through and that sufficient planning evidence has been provided.

4.6 As reported at Finance Committee, the process to validate schemes is proving challenging and we are behind our internal targets for achieving a ‘Green’-rated plan at the time of writing.

4.7 2020/21 will mark the 3rd year of an ambitious cost reduction programme which, at 2017/18 outturn, sought to reduce one of the largest deficits in the country (as a proportion of expenditure). This means that efficiencies will increasingly be rooted in transformational change more so than transactional savings. We are working with staff to consider where quality of care improvements and improvements to staff and patient experience can drive out waste and reduce duplication; therein lays efficiency.

4.8 **Model Hospital:** In late February, the national data refresh of the Model Hospital benchmarking tool was completed, giving the Trust renewed insights into our efficiency and productivity. The tool now uses largely data from FY 2018/19 and the key opportunities are depicted below:
### 5 Delivering the quality strategy

5.1 Led by the Chief Nurse, we are increasingly working to align our improvement and transformation efforts behind the Trust’s Quality Strategy. The CQC inspection report also provides a set of ‘must do’ quality improvement priorities, and highlights some long-standing cultural challenges we must address.

5.2 We have honed our method for improvement in recent weeks and the next phase of the Trust’s QI programme will launch in Q1 of the next Financial Year. During the previous period, we have worked with a small creative agency to create an ‘Improvement & Innovation’ sub-brand: a ‘one stop shop’ for quality improvement (QI) to improve staff access to, and engagement with support, coaching and resources for their quality improvement projects. This sub-brand will be launched in April alongside a revamped modular training/capability building programme and a micro-site for staff to access contacts and resources for their improvement work.

### 6 ‘Plot the dots’ – analytics and insights improvements

6.1 **Integrated Quality and Performance Review (IQPR):** At the request of the Quality Assurance Committee, we have undertaken a review of the current Integrated Quality and Performance Review (IQPR). We have reviewed the product itself and also the way the information is used, challenged and actioned. This review has led to a wider data-driven assessment on how the trust uses insight and information more generally: a) to support the delivery of its strategic and operational objectives; and b) to take assurance in the safety, quality and effectiveness of services.

6.2 In the previous period, the Trust has re-designed the current IQPR ‘look and feel’ to include statistical process control (SPC) methodology and move away from the traditional Red-Amber-Green (RAG) rated indicators. This in line with the national directive to deploy a method known as ‘Plot the dots’, which has been proven to improve Board-level decision-making and scrutiny through improved data visualisation and more statistically rigorous understanding of variation.
6.3 This work forms part of a Business Intelligence Transformation Strategy which has been refreshed in the previous period. This document sets out the core objectives needed to transform the function and mature the Trust’s ability to promote and embed a data-driven culture that is linked from Board-to-Ward.

6.4 **Deep dives into our clinical systems and data confidence:** Included within the Business Intelligence strategy is a series of structured deep dives into our data quality to instil greater confidence in the data we report and use to make decisions. Specifically, we are reviewing the ‘inputs’ to and ‘outputs’ from our core clinical systems and applications. The first of these systems to undergo a 4-week deep dive are:

6.4.1 *Perfect Ward* – the Trust’s audit assurance application which allows Ward Managers to self-assess completion of core safety and quality audits, inspections and bundles; and

6.4.2 *ExtraMed* – the Trust’s bed management system, which also has functionality to record digitally Nursing clinical observations

6.5 Adopting a Quality Improvement approach (define the problem, agree the aims and measures, make small-scale tests of changes), the deep dives led by the Director of Transformation will assess how the systems are configured as well as highlight and address certain behavioural barriers to effective use in
practice. At the end of 4-weeks, each multi-disciplinary deep dive group will draw its conclusions and publish a series of prioritised recommendations to be taken forward by the Quality Panel and the Executive Team. The first of these deep dives will conclude at the end of March.

7 **Conclusion and Next Steps**

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

7.2 The Board is also asked to note that the CQC inspection report will identify a ‘must do’ priority list, behind which our transformation efforts will need to align.
Activities Since Last Update

- Focus on Outpatient Productivity – less than 7 day cancellation by hospital and patient reason; cashing up of appointment slot delays; under booking of clinics; DNA rates and PTL validation all profiled in weekly PTL and action log generated to manage by specialty.

- Commencement of focused redesign of processes from referral management, scheduling and patient pathway management. Outpatient clinic utilisation now being captured using new timetabling system. New business intelligence data is supporting visibility of this activity. Overall patient numbers on the PTL are reducing with a significant proportion of these being patients waiting >26 weeks.

- Insourcing commenced in key areas of Neurology and ENT.

- Further re-structure of Cancer PTL to prioritise breach avoidance programme focusing on maintaining compliance achieved against future 28 FDS and improving performance against current 62 day treatment standard. 2WW performance reported for December 2019 shows sustained compliance and a formal escalation pathway mapped between Endoscopy and Upper/Lower GI for the management of Cancer Patients.

- Above trajectory for theatre optimisation. Cases completed for week ending 09/02/20 were at 25% (of 50% opportunity). Trajectory expected at 20%, DNA rates at <2% for 10 weeks and average cases/session monitoring and theatre touchtime monitoring now fully embedded.

- Physical mapping of outpatient areas to ensure full usage of rooms with appropriate clinical occupancy – digital map to follow.

- Continued Breach Avoidance Programme within Cancer, RTT and Diagnostics.

- Further adjustments to the DM01/Diagnostics PTL Structure and information sets to align with the other PTL’s and ensure greater visibility on performance and productivity.

Upcoming Milestones / Gateways

- Agreement to relocate Best Access into its own Hub within the hospital. This is essential to support focus and cohesion of all initiatives.

- Continued improvements in RTT performance around outpatients (90% of the opportunity in non-admitted pathway) to reduced 26 week waits.

- Implementation of Demand Management methodology across Diagnostics with specific focus on MRI and Endoscopy.

- Options appraisal of digital tools to support Outpatient and Theatre scheduling, booking and patient communications.
### Highest Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical capacity (internal or insourced) within key specialities to support reduction in &gt;26 week patients. Issues due to illness, Pension legislation and availability of suitably skilled resource.</td>
<td>Continual review and refresh of Outpatient infrastructure including clinical and operational processes and resources to mitigate known inconsistencies in Outpatient and Cancer Care</td>
</tr>
<tr>
<td>MRI capacity causing delays across organisation – 12 weeks to routine scan and 6 weeks to report</td>
<td>Internal and external demand management programme within Imaging (MRI) and Endoscopy, including the acquisition of additional capacity, supported by Medical Director / Clinical Leads</td>
</tr>
<tr>
<td>Existing structure of clinical and operational staff in Cancer Services does not support cohesive working</td>
<td>Develop Site Hub for Best Access</td>
</tr>
<tr>
<td>Internal endoscopy capacity. Resolution required to ensure sustainability of recent improvements due to operator availability for Gastro</td>
<td>Restructure of Cancer Services within the Trust, taking account of regional developments. NHSE/I and Cancer Alliance supporting discussions</td>
</tr>
<tr>
<td>Capacity within Business Intelligence to support the development of further monitoring tools and dashboard to improve visibility of performance for operational and clinical teams</td>
<td>Prioritisation of applications of digital solutions to manage outpatient, diagnostic and theatre processes, in collaboration with Trust IT and Clinical Systems teams</td>
</tr>
<tr>
<td>Capacity within MTW Cancer Hub and tertiary treatment centres (GSTT, KCH) to diagnose and/or treat Medway patients within the required timescales to ensure optimal patient outcomes</td>
<td>Agree Bite Size Training under Engagement and Leadership Work stream.</td>
</tr>
<tr>
<td>Rota management not stable for all specialities</td>
<td>Finalise turnaround times with NKPS and MTW for histopathology.</td>
</tr>
<tr>
<td>Timeliness of OrderComms clinical sets ahead of Go Live in April 2020.</td>
<td>Broadening the range of specialties completing full of clinical triage at point of referral</td>
</tr>
<tr>
<td></td>
<td>Embed breach avoidance within Cancer Care to support new 28 day FDS</td>
</tr>
</tbody>
</table>
**Activities since last update**

- New site SOP launched to work with reclaiming nursing landscape initiative
- **Best flow academy** – First two best flow academy workshops held on board rounds
- **Weekend preparation** – Agreed weekend preparation meeting to be held on Fridays and chaired by COO, DoN, etc
- **Weekend operations** – Agreed and began rolling out pink for system for specialty and frailty wards to facilitate weekend discharge and effective ward rounds on Monday

**Highest Risks**

<table>
<thead>
<tr>
<th>Risks</th>
<th>Milestones/Actions</th>
</tr>
</thead>
</table>
| New 830 bed meeting – teams need to commit to the compromised solution with DMs bring accurate information, discussion of queries by exception and allocation of patients | Site:  
- Agree site direction function  
- Executive team and leads to support the embedding on new site SOP (830 meeting and new bed meeting times)  
- Continue to improve 1545 site meeting |
| The scheduled closure of CDU will have a negative impact on 4hr performance – what is the mitigation? | Agree solution to mitigate impact of CDU closing |
| Acute & ED: Team continue to push for change and see opportunities for improvement (this week there has not been sufficient senior input into ward ops (Board rounds) | Embed improvements in acute medicine (currently fluctuate)  
- Maintain & continue to reduce response & decision times  
- Continue to reduce number of medicine pts waiting for review handed over from day to night |

**Highest Priority Actions**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Milestones/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>Agreement on solution for site director role/ function</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>Surgery pathways and bed modelling to be presented to programme boards and then the execs on the 26th Feb</td>
</tr>
<tr>
<td>High risk</td>
<td>Approve site direction function</td>
</tr>
<tr>
<td>Extreme risk</td>
<td>Agree solution to mitigate impact of CDU closing</td>
</tr>
</tbody>
</table>

**Upcoming Milestones / priorities**

- Agreement on solution for site director role/ function
- Surgery pathways and bed modelling to be presented to programme boards and then the execs on the 26th Feb
Weekly performance and attendances

4hr Performance (T1)

4hr Performance (all T3)

Attendances (T1)

Attendances (T3)

Source: Trust IP and ED dataset, DSIT report
Update on other core KPIs (1/2)

DTAs 8am/8pm

- The DTAs at 8am and 8pm have decreased in the last week
- Hours lost to ambulance delays have increased since last week but still lower than the weeks in December
- DTA to checkout time has increased to over 7 hours again

Source: Trust IP and ED dataset, SECAMB
Update on other core KPIs (2/2)

**Comments:**
- **ALoS on Lister** is just under 2 days this week, while Arethusa has increased to 49 hrs.
- The number of **medicine outliers** is continuing to decline.
- The number of **stranded and super stranded** is continuing to decline, but is still higher than required.

**Source:** Trust IP and ED dataset

Note: data on this page updated to week of 10/02 as PAS data is not reliable for more recent period.
MFT performance all types

Monthly / weekly performance by type, %, 1st Apr 2018 – 2nd Feb 2020

Source: MFT DSIT reports, National Data
Since June 2019 Type 1 performance has been improving in relative rankings. The step change in January brought us into the middle of the pack.

Trust Type 1 performance rankings by month, #, Jan 2019 – Jan 2020

Relative rank (out of 120)

*Jan numbers from UEC dashboard, rough estimate only (average of weekly averages)
We have made progress on 0830 meeting agenda, but more focus is required in improving the accuracy of information.

Examples of good practice:

- Significantly improved coordination and leadership of the meeting on some days.
- Push for specific actions, time for completion and personal accountability:
  - “This patient needs to be priority on the OGD list this morning, could you let me know by 10am that this has happened.”
- Improved allocations on some days:
  - A brief discussion today on clinical priority between HoN and Flow Nurse to allocate into a definite on Bronte.
- Clear identification of priorities regarding patient moves:
  - ITU then recovery then CDU and ED.
- Following up on some actions / plans:
  - “Yesterday we agreed we will provide senior support to the wards until 1000, this has not happened in your care group. Can we make sure to do this today.”

Improvement opportunities:

- The information on discharges is not accurate / actionable:
  - Tennyson had 3 queries at 0830 today, none of them are queries at 0900 BR
  - No discharges identified on multiple wards
  - This leads to drop in confidence of the bed managers’ to allocate patients early
- Not enough focus on 4hrs:
  - ‘Red patients’ not discussed despite prompting because ‘it’s already been done’
- Inconsistency in the leadership of the meeting (and therefore outcomes):
  - Leads to inconsistent follow through and push on accountability.
830 huddle struggled to identify specific patient-level actions and allocate patients which delays patient access to care

Insufficient discharge details provided limiting MDT members to action discharges

No live allocations of DTAs or definites

No actions specified to execute 7 definite discharges and 44 queries

No actions identified for CDU & ED

Delay in:
- Patient care & needs
- Getting patients home timely

Blocking patient flow

Compromising quality of care
Site Director is the glue to maintaining consistent operational grip throughout the day and from one day to another.

### Bed meeting agenda

**Location / time:** Site room, 0830, 1000, 1100, 1300, 1400, 1545  
**Attended by:** Head of Site, CSMs, DMs, GMs and HOts (at OPEL 4), bed managers, Ward NIDs and Ward Managers (ad hoc for training & overnight), DGSS rep, ED rep, senior ops support

1. **Review of progress since last meeting**  
   - Recap of actions  
   - Discussion of new breaches & reasons for them

2. **Current position:**  
   - ED update: Performance patients in the department, DTAs, wait times, biggest OPEL / clinical risk  
   - “Red patients,” line-by-line review of patients 3-4 hrs in ED and create a plan to avoid breaches  
   - CDU update: N of patients, DTAs  
   - Medical / surgical wait

3. **Care group updates - Patient-level update for each ward incl:**  
   - Ward metrics: START, infection control, MIA, 111, DCGS, etc  
   - Confirmed and potential discharges, and specific actions required to expedite discharge  
   - Abolish list into each definite discharge and agree specific times for the moves considering +1  
   - Summarise: the bed position against the target for each care group

4. **Summarise the bed position for the Trust and key actions of focus**

### Highlights of the role:

- Leads the daily 0830 and 1545 meetings  
- Sets consistent meeting agenda  
- Identifies key operational risks and priorities  
- Identifies actions to create flow or resolve operational issues within a specific timeframe

- Spends 75% of the role “on-the-ground” to maintain the overview of the emergency pathway and key operational risks, and provide support and challenge

- Problem solves issues, and has a mandate to make operational decisions on behalf of the senior team

- Hold the owners to account throughout the day
Surgery Pathways & Bed Modelling

Achievements this week
- Sign-off achieved by surgical operational teams within surgery board meeting on 19th Feb
- Agreement of next steps to commence execution plan

Next steps
- Present pathways & modelling to execs on 26th Feb
- Achieve agreement of execs
- Agree on operational and clinical responsibility to execute pathways
- Create a project plan/execution plan to implement pathways with set timelines
Patient utilisation of CDU

CDU throughput (Avg daily)

<table>
<thead>
<tr>
<th>Week</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 13-Jan</td>
<td>16</td>
</tr>
<tr>
<td>w/c 20-Jan</td>
<td>15</td>
</tr>
<tr>
<td>w/c 27-Jan</td>
<td>17</td>
</tr>
<tr>
<td>w/c 3-Feb</td>
<td>14</td>
</tr>
<tr>
<td>w/c 10-Feb</td>
<td>12</td>
</tr>
</tbody>
</table>

CDU Outflow (Avg daily)

<table>
<thead>
<tr>
<th>Week</th>
<th>Transferred</th>
<th>Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 13-Jan</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>w/c 20-Jan</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>w/c 27-Jan</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>w/c 3-Feb</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>w/c 10-Feb</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

CDU Length of Stay (Avg hours by adm date/time)

<table>
<thead>
<tr>
<th>Week</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/c 13-Jan</td>
<td>7.0</td>
</tr>
<tr>
<td>w/c 20-Jan</td>
<td>6.1</td>
</tr>
<tr>
<td>w/c 27-Jan</td>
<td>6.8</td>
</tr>
<tr>
<td>w/c 3-Feb</td>
<td>8.1</td>
</tr>
<tr>
<td>w/c 10-Feb</td>
<td>10.4</td>
</tr>
</tbody>
</table>

Last week (w/c 12th Feb):

- Decreased number of patients using CDU
- Greater number of patients being admitted from CDU to wards
- Average LoS in CDU has increased to 10 hours

Conversion rate:

17% 13% 14% 12% 15%

Source: Manual data collection from CDU log book
ED Priorities

1. ED huddles
   - Maintain/standardise quality of ED huddles by building capability among NiCs to lead huddles – *John to provide 1-to-1 coaching*
   - Embed huddles during evenings and weekends – *John to put out comms to nursing staff*
   - Ensure consistent attendance from Take Consultant – *David/Paul to reiterate expectation*

2. CDU usage
   - Maintain a daily CDU throughput of 25 patients
   - Develop a plan for staffing the CDU to full capacity consistently – *Doug*
   - Socialise CDU SOP among ED and Acute staff

3. Role Cards
   - Finalise role cards for ED NiC, ED Majors Co-Ordinator, ED Flow Co-Ordinator, ED Duty Manager – *Claire*
   - Communicate role cards to staff and train as necessary – *Claire*
   - Clarify escalation pathways and embed
### Executive Summary

In January 2018, the NHS published its Long Term Plan for the next 10 years. All systems across England were required to develop a local five year plan in response to the NHS Long Term Plan over the summer and autumn of 2019. Attached for information is our draft Kent and Medway five year plan, subject to final discussion with NHS England/NHS Improvement. Our plan sets out the continued transformation of our system, building on all of the work to date under the K&M Sustainability and Transformation Partnership. It sets out our commitment to become a high performing Integrated Care System, delivering high quality services, improving the overall health and wellbeing of our population, investing in prevention and embedding prevention through the ICS, and working to address health inequalities.

Our plan was developed with widespread engagement of staff from across our system, discussed at our system forums and informed by four public engagement events.

The plan is a technical document and once it has been finalised with NHS England/NHS Improvement, we will publish a shorter more digestible public facing summary. Following the endorsement of plan at the STP/ICS Partnership Board on 4th November, CCG Governing Bodies and provider Boards are asked to support and endorse the plan. Detailed implementation will be addressed through annual operational planning.

### Link to strategic Objectives 2019/20

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<td>We will embrace innovation and digital technology to support the best of care</td>
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<td><strong>Finance</strong></td>
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<tr>
<td>We will deliver financial sustainability and create value in all we do</td>
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<td><strong>People</strong></td>
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<td>We will enable our people to give their best and achieve their best</td>
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<td><strong>Integrated Health Care</strong></td>
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<tr>
<td>We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
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<td>We will consistently provide high quality care</td>
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1 Introduction

Three years ago, the Kent and Medway Sustainability and Transformation Partnership was created, bringing together over 19 partners from health, local authorities, voluntary sector and patient groups across Kent and Medway to work together to transform and improve services. The vision for ‘Quality of Life, Quality of Care’ is the driver behind all of our transformation and improvement initiatives. The STP is pleased that the ethos of the NHS Long Term Plan is firmly reflected in this vision. The vision is informed by the Joint Health and Wellbeing Strategies of our two authorities Kent County Council and Medway Council.

2 Objectives and Delivery Priorities

1. Improving Care Quality and Experience
   a) This strategic objective covers a wide range of delivery priorities including developing our ICS accountability framework for quality and Delivering integrated care closer to home (expanded primary care and community care services). We are transforming urgent and emergency care to ensure that A&E is only used for serious urgent care needs and emergencies. We also know that resolving a number of structural challenges that impact the clinical and financial sustainability of our services is critical. Lastly, this objective includes a number of specific priorities to improve care and outcomes for a number of clinical and service areas.
   b) Delivery Priorities:
      i. Implementing an ICS quality framework and quality priorities
      ii. Delivering more care outside of hospital including resilient primary care and community care
      iii. Addressing clinical and financial sustainability of acute services
      iv. Transforming urgent and emergency care
      v. Transforming outpatients and ensuring timely planned care
      vi. Improving services and care outcomes for cancer, MH, maternity and neonatal, children and young people, LD and autism, stroke, CVD, diabetes, respiratory disease, end of life care

2. An Increased Focus on Population Health and Prevention
   a) This strategic objective includes developing our approach to population health management to improve overall population outcomes. Prevention will be embedded throughout the ICS and at the start of every care pathway. Our approach to prevention follows the life course as well as targeted actions on priority areas of smoking, obesity, alcohol, MH, health protection, cancer and other major conditions.
   b) Delivery Priorities:
i. Implementing population health management (PHM) including a K &M outcomes framework informed by this Strategy Delivery Plan

ii. Developing capacity and capabilities for PHM

iii. Embedding prevention throughout the system and in every pathway

iv. Supporting more people to stop smoking and preventing children and young people from ever starting to smoke

v. Taking a place based approach to tackle obesity

vi. Identifying people at risk of alcohol and substance misuse in the community and supporting them with targeted interventions

vii. Tackling health inequalities at a place based level

3. **Driving Financial Balance, Efficiency and Productivity**
   a) This strategic objective covers our actions to address our financial challenges including meeting the government’s four tests for best use of taxpayers’ investment in the NHS.
   b) Delivery Priorities:
      i. Deliver against financial trajectories for the 5 year period
      ii. Achieve success in bidding for targeted funding from national bodies to support the delivery of our plan
      iii. Deliver c12m productivity savings in 19/20
      iv. Continue to explore opportunities to delivery productivity savings of c£53-90m by 23/24 through areas such as:
         v. Continued implementation of best practice processes *(GIRFT, Right Care, Model hospital)*
      vi. Delivering a single
      vii. pathology service for Kent
      viii. & Medway
      ix. Developing a collaborative ‘bank’ for medical and nursing staff across K&M

4. **Transformation of our Workforce and Infrastructure**
   a) This strategic objective starts with our Workforce Transformation Strategy and the actions being taken to address our workforce challenges. Digital transformation is a critical enabler to improving care quality and transformation and to providing the infrastructure to support population health management. Our estates strategy is aligned to our clinical strategies to deliver a fit for purpose estate for the future, with a significant capital requirement.
   b) Delivery Priorities:
      i. Implementing the K&M Workforce Transformation Strategy
      ii. A step change in digitally enabled care including online guidance to support self-care
      iii. Creating the infrastructure to enable integrated datasets
      iv. Implementation of the K&M Shared Care Record
      v. Completing and implementing the K&M analytics strategy
      vi. Delivery of our K&M estates strategy including success in national bidding rounds for funding

5. **A New Integrated Care System Delivery Model**
   a) This strategic objective is about a new way of organising ourselves, in line with national policy that will better enable integration of services, put an end to unwarranted variation and drive a focus on population health.
   b) Delivery Priorities:
      i. A system commissioner to commission at scale and drive a focus on population health
      ii. Development of Integrated Care Partnerships to deliver high quality integrated care and tackle local health inequalities
      iii. Development of Primary Care Networks to create a resilient primary care and expanded community care delivering personalised anticipatory care
      iv. Development of innovation, research, and quality improvement
v. Expanded joint working between the NHS, local authorities, voluntary sector, and wider partners

3 Monitoring Implementation

The Kent and Medway Sustainability & Transformation Partnership (STP) currently has an established system governance to support delivery of our STP Programmes and provide the foundation for delivery of the Strategy Delivery Plan. In 2018, the STP refreshed the system governance with individual Programme Boards set up to support delivery, and a Non-Executive Director Group established with membership from NHS commissioners and providers as well as the Local Authorities to support oversight and connection to statutory organisations and their Boards and Committees.

As the move to become an Integrated Care System takes place there will need to be a transition to a new set of ICS governance arrangements, ascertaining what is required at the system level and what will need to operate at the level of the Integrated Care Partnerships.

In the immediate future, the existing STP governance, individual organisational governance, and ICP partnership boards will remain in place. The existing arrangements are already changing incrementally to support the move to an ICS, for example with the STP Programme Board evolving into an ICS Partnership Board. Alongside the creation of new governance for a single CCG, a wider governance review will be instigated to look at the levels of accountability between the CCG and the ICPs including where accountabilities sit for quality governance and quality assurance.

Additionally, a key focus of the new governance arrangements will be the importance of clinical leadership, GP representation and patient representation. It is likely that we will need to develop and evaluate a series of options for the future ICS arrangements.
Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.
Foreword (1/2)

I am delighted to present this five year **Strategy Delivery Plan** for the health and care system in Kent and Medway. This plan describes our priorities and actions over the next five years to continuously improve the health and wellbeing of our population, and to address the challenges of our health and care system. We have engaged widely in developing this plan, focusing on what matters most to local people. However, this plan reflects the current status of our system and over the next six to nine months, there will be significant changes in the way that services are organised, not least the merger of our existing eight Clinical Commissioning Groups to form a single CCG for Kent and Medway. Such changes will prompt us to reflect on this Plan and to launch a refreshed vision and strategy as we move closer to becoming an Integrated Care System.

In the summer of 2018, the government announced increased funding for the NHS in England resulting in the publication of a **Long Term Plan for the NHS** in January 2019; setting out guidelines for how the increased investment should be spent in local systems. The Plan signals a need for more integrated services, an increased focus on prevention and more targeted action on the biggest killers and disablers of our population. We welcome this set of national priorities as it accords with our own in Kent and Medway.

We are a system comprised of partners from across the NHS, local authorities, the voluntary sector and patient groups with a shared goal of achieving ‘**Quality of Life, Quality of Care’**. By providing high quality personalised care we will support people to live their best lives - helping people to look after their physical health, mental health and wellbeing; preventing avoidable illness; and supporting people with complex needs to best manage their health and look after their independence.

In Kent and Medway, we have a number of **structural challenges** with the way our services are organised and delivered, impacting both clinical and financial sustainability. We are working together as a system to implement long term solutions to these challenges, in a phased approach. In 19/20, we launched our system wide Workforce Transformation Strategy which aims to **make Kent and & Medway a great place to live, work and learn**. This has seen the creation of the Kent and Medway Medical School, an exciting collaboration of partners that will attract and train future doctors from 2020. We are also developing the Kent and Medway Academy for Health and Social Care to focus on system wide solutions to strategic challenges such as creating fulfilling lifelong careers in health and care.

Our first clinical priority area is the development of a network of hyper acute stroke units to ensure that providers can consistently deliver high quality services. This will result in more people surviving a stroke and improved quality of life and independence for people who have had a stroke. At a place level, our East Kent transformation programme is assessing two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.
Foreword (2/2)

Over the next five years we will look at options in relation to vascular and other more specialist services as well as looking at the options to improve care through networking of services across Medway, North Kent and West Kent.

Since the creation of the K&M Sustainability and Transformation Partnership in 2016 we have made great strides in integration including the implementation of system wide programmes for transforming primary care, creating multi-disciplinary teams to support people with complex needs, and prevention across the life course. In September 2019, our CCGs unanimously agreed to merge to become a single CCG across K&M in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation.

This plan includes explicit commitment of all partners to invest in population health and prevention, ensuring that prevention is part of every single health and care pathway. Across the system we are tackling the underlying drivers of health inequalities. By taking positive action on underlying issues, such as smoking, obesity and alcohol consumption, we will reduce deaths and disability caused by cardiovascular disease, stroke, diabetes, respiratory disease and some cancers such as lung and colon. We know that the burden of issues such as smoking and obesity does not affect our population equally and that in areas of deprivation these issues contribute to inequalities. Additionally, we know that feeling lonely has a major impact on both our physical and mental health. Together, we need to do more to tackle deprivation and social isolation.

In this plan, you will see our priorities and actions to improve outcomes for all major conditions. This is underpinned by an overriding principle that our care pathways focus on the person and their needs and goals, not just a condition. This plan includes also explicit commitments to:

- Continue to improve our cancer services and ensure that more cancers are diagnosed earlier at stages 1 and 2 and that more people survive cancer
- Focus on our population’s mental health, expand mental health services and better look after the physical health of people with severe mental illness
- Ensure that children, young people and adults with SEND, Learning Disabilities and autism and their families and carers receive the care and support they need and deserve

This plan is a call to arms for a fundamental change in the way that care is delivered in Kent and Medway and that enables all of us to lead our best lives.

Glenn Douglas
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Section one

Introduction
Introduction continued

Our vision for Kent and Medway

Three years ago, we created the Kent and Medway Sustainability and Transformation Partnership, bringing together over 19 partners from health, local authorities, voluntary sector and patient groups across Kent and Medway to work together to transform and improve services. Our vision for ‘Quality of Life, Quality of Care’ is the driver behind all of our transformation and improvement initiatives. We are pleased that the ethos of the NHS Long Term Plan is firmly reflected in our own vision. Our vision is informed by the Joint Health and Wellbeing Strategies of our two authorities Kent County Council and Medway Council*.

In Kent and Medway, we want to create a population where people are supported to live well and stay well, recognising that our health is impacted by everything around us – our living environment, our working environment, our families and communities – and that good health is a combination of good physical health, good mental health and our overall wellbeing. We want to create vibrant, strong communities where people support one another across the generations.

Over the summer of 2019, our Sustainability and Transformation Partnership has been working across the Kent and Medway system with staff, clinicians and our population to develop this five year Strategy Delivery Plan. Our Plan sets out the strategic objectives and priorities for Kent and Medway and how we will implement the NHS Long Term Plan locally. The Long Term Plan itself was developed with extensive engagement of the people who know best what needs to change – with staff and patients from across the county.

Delivering this plan over the next five years and beyond requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year’s operational and financial planning. We also have a significant need for capital investment and will continue to work closely with national bodies on how this requirement will be met.

Introduction continued

Our approach to developing this plan

The Kent and Medway Strategy Delivery Plan 19/20-23/24 has been developed in collaboration with a wide network of local experts from across health and social care. Every stage of its creation has been clinically led, with contributions from a range of GPs and clinical specialists. Our system wide STP Clinical and Professional Board have provided input to the plan at their meetings in August, September and October. Additionally, we have utilised a range of system forums and boards to discuss and develop the proposals in this plan (see right).

Whilst this is a Kent and Medway level plan setting out system level ambitions, work has been performed with colleagues in our localities to ensure the plans are locally owned. We have brought together clinicians, commissioners, service managers and finance professionals to discuss the proposals as they have developed and to ensure that they are underpinned by realistic finance and workforce assumptions.

The plan builds on the progress and achievements of the Kent & Medway Sustainability and Transformation Partnership over the past three years, recognising that we have already made significant progress in areas such as the plans for reconfiguration of stroke services to improve outcomes for people who have had a stroke, the East Kent transformation programme to develop a system for East Kent that will consistently deliver high quality care into the future, collective commitment across all partners to implement more joined up care closer to home in ‘Local Care’, fewer people smoking than ever before, and improved performance against cancer waiting standards. Our plan builds on this strong foundation, using the NHS Long Term Plan as a helpful framework against which to review our progress to date and to identify additional areas of focus.

Most importantly of all, we have held four engagement events across Kent and Medway to discuss our NHS Long Term Plan response and test our thinking with the public, as well as undertaking targeted engagement activity on specific priority areas, including surveys and focus groups with seldom-heard groups. As well as these events, we have conducted staff briefings, and discussed the plan as it progresses with wider stakeholders, for example district and borough councils, MPs, and Health and Wellbeing Boards for Kent and Medway.
Introduction continued

Implementing this strategy delivery plan

Delivering through our new Integrated Care System framework

We will become an Integrated Care System by 2021 which will enable us to go further and faster in areas such as making decisions collectively and driving integration. In September 2019, our Clinical Commissioning Groups unanimously agreed to merge to become a single CCG across Kent and Medway in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation. The merger was approved by NHS England and NHS Improvement on 21st October 2019.

Our Integrated Care Partnerships, comprising Primary Care Networks, will be empowered to design and deliver their local services in a way that achieves improved outcomes for local people. Our Primary Care Networks are bringing together GP practices and developing expanded primary care teams to build a resilient primary care for the future and provide more community-based care.

This new way of organising ourselves, to drive integration and a focus on population health, is a very different landscape. We recognise that the governance arrangements of the Sustainability and Transformation Partnership need to change as we move to become an Integrated Care System with a more formal set of structures than have existed under the STP. We will initiate a governance review working with system partners on the principles to guide the development of options and recommendations for ICS governance, including the arrangements for clinical and patient representation, accountabilities for quality governance, patient safety and outcomes. We will need to look at the accountabilities that should reside with Integrated Care Partnerships (ICPs) and the accountability relationship between the single CCG and the ICPs.

Keeping our strategy live

In Kent and Medway, we believe it is important that this strategy remains a live, dynamic process. This Strategy Delivery Plan has been prepared according to a national timetable for all systems across England to prepare five year plans in response to the national NHS Long Term Plan by Autumn 2019. We recognise that the contents of this plan reflect a point in time and that the coming year will see significant change for Kent and Medway as we make further strides in becoming an Integrated Care System, including the planned merger of our CCGs by April 2020, accelerated development of our four Integrated Care Partnerships and the bedding down of our 42 Primary Care Networks (PCNs). We have developed a Primary Care Strategy led by Primary Care professionals and we recently held our first conference of the Clinical Directors of the 42 PCNs. Over the next 6 to 12 months our ICPs and PCNs will develop considerably in their leadership and working arrangements including partnership working.

As such, we are proposing to develop a refreshed vision for our Integrated Care System in spring/summer 2020. This will be part of a wider Organisational Development programme which we will start to implement now to support us in the changes we need to make to become an Integrated Care System by 2021. We will also need to produce a commissioning strategy for the new Kent and Medway single CCG. Additionally, our ICPs will be developing, for the first time, their operational plans in early 2020. Consequently, we intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to Kent and Medway to support the implementation of the Long Term Plan.

We will monitor whether the priorities and actions set out in this plan are having the intended impact on our patients and our population. We will identify the interventions which have greatest impact and we will ensure that they are implemented across our geography.
Section two

Summary of our Strategy Delivery Plan
Needs of our population

In summer 2019, Kent County Council and Medway Council jointly produced a Kent and Medway Health Needs Assessment, the results of which have directly informed the setting of priorities in this plan. We have unacceptable differences across Kent and Medway in the underlying drivers of poor health (such as smoking and obesity) which results in health inequalities. There is a clear link between health inequalities and deprivation and that as a system we need to do more to tackle deprivation.

Causes of preventable ill-health

**Smoking** - 15% of people in Kent and 14.7% of people in Medway smoke, which is higher than the national average.

**Obesity** – Obesity is rising and directly contributes to many serious illness, such as diabetes. In Medway, obesity levels are higher than the national average for both adults and reception year children. While in Kent, levels are similar to the national average, we have high levels of obesity in Thanet and Dover.

**Alcohol and substance misuse** – There are an estimated 17,053 dependent drinkers across Kent and Medway, approximately 378,000 adults who drink more than 14 units a week, contrary to department of health guidelines, and approximately 7000 opiate and/or crack cocaine users. Rates of death and harm linked to alcohol and substance misuse are generally higher in areas of deprivation.

Major health conditions

Smoking, obesity and alcohol and substance misuse directly impact on the levels of death and disability caused by major health conditions such as cardiovascular disease, stroke and diabetes.

- The estimated prevalence of cardiovascular disease in K&M is lower than the national average but it is still a significant cause of disability
- There are at least 123,000 people with diabetes of which around 90% are adults with type 2 diabetes which is amenable to actions on diet and physical activity
- Stroke prevalence is around the national average although rates are higher in some areas. Stroke is the largest cause of severe disability
- Rates of respiratory disease are generally lower than national average but we have pockets where under 75s mortality due to respiratory disease is significantly higher – in Dover, Thanet, Swale and Medway
- The number of people over the age of 65 with a diagnosis of dementia in Kent and Medway is estimated to be 23,375, with 14,298 (61.17%) having a confirmed diagnosis. Some dementia is preventable, with good management of cardiovascular health.

To improve the health of our population against these major conditions, our plan includes both preventative actions and targeted interventions delivered in Primary Care aimed at people at high risk.

In 2017, 4,893 people died from cancer in Kent and Medway, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening, and earlier diagnosis. Continued action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer.

Multi-morbidity and frailty

Approximately 20% of the Kent and Medway population have more than one long term condition, known as ‘multi-morbidity’, rising to 40% in over 50s and 70% in over 85s. There is a strong link between multi-morbidity and deprivation, with around 21% of people living in the most deprived areas having multiple conditions compared to 16% in the most affluent areas.

People with multiple conditions are more likely to become frail – and frailty doesn’t just affect the elderly. Identifying frailty risk early enables earlier intervention and maximises quality of life and independence.

In Kent & Medway, we are taking a population health approach to identifying the overlap between frailty and multi-morbidity by identifying people at risk and supporting them with integrated multi-disciplinary teams.
Needs of our population

Mental health

We all have mental health and we will all experience challenges with our mental health at some point in our lives. Since 2014, rates of severe depression have increased in Kent and Medway and suicide rates are higher than both the national average and regional neighbours, particularly in men. The co-existence of mental health problems like depression or anxiety with other problems such as obesity, smoking, alcohol misuse and poor self-care is also increasing. People with severe mental health illness are more likely to have a physical health condition and die on average 15 years earlier than people with no mental illness.

There is an urgent need to take a population health approach to looking after the mental health and emotional wellbeing of our population. We need targeted action on expanding services and ensuring that people can access the right support. We need to focus on improving the physical health of people with mental illness and recognise that good health is a combination of physical health, mental health and wellbeing.

Dementia

Currently, only just over 61% of individuals over the age of 65 in Kent and Medway suspected to have dementia have a diagnosis. We need to ensure that people receive a timely diagnosis and receive the appropriate support to ensure they remain as independent as possible, for as long as possible.

Healthy start in life

Obesity in pregnancy, low birth weight and rates of breastfeeding are amongst some of the most relevant issues in Kent and Medway where we could have a positive impact on giving babies a healthier start in life.

One in five pregnant women in Kent and one in four pregnant women in Medway were obese in 2017, a 1% and 2% increase from 2015. 3% of pregnant women in K&M were morbidly obese.

Low birth weight is associated with a number of different factors, one of which is smoking. While the rate of smoking in pregnancy has been falling, there is more to do to reduce from the current rate of 14.2% to the Local Maternity System (LMS) target of 6% by 2022.

• Rates of breastfeeding in the first 48 hours of life differ significantly across Kent and Medway, with Maidstone and Tunbridge Wells NHS Trust reporting highest rates and Dartford and Gravesham NHS Trust reporting the lowest.

Children and young people

There are a wide range of needs for children in Kent and Medway:

• Around 13% of children and young people aged 5 to 19 years are estimated to have a mental health condition and there is particular concern for looked after children.
• 1 in 5 primary school children are obese or overweight.
• The rate of teenage pregnancies is above regional average.
• Children in early years do not have adequate vaccination coverage.
• The number of children with life-limiting conditions has increased in recent years, while the rate of deaths is declining owing to advances in diagnosis and care. The need for palliative and end of life care is growing year on year.
• Rate of children with SEN type autism is higher than national average.
• Rate of children and adults with SEND, LD or autism receiving physical health checks varies significantly across Kent and Medway and this unwarranted variation must be reduced.
• In early 2019, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of services for children and young people in Kent with special educational needs and/or disabilities (SEND) which identified a number of weaknesses. Kent County Council and the NHS are committed to working together to address these weaknesses.
Summary of our population needs

What people have told us

In developing our plan we have drawn on extensive previous engagement with local people, as well as carrying out specific and targeted engagement activity to inform the development of the strategic priorities set out in this document. You can read all about these events in our Strategy Delivery Plan Engagement Document. In summary terms, here are main things that local people want to see in their services:

For prevention
- Helping people improve their health and make healthier lifestyle choices
- Recognising and tackling the wider determinants of health
- Making the most of community resources to improve health and wellbeing

For mental health
- Improving quality and how care is organised, including communication between different services and with patients
- Making it easier to access care, including improving awareness among all NHS staff and having more mental health staff in front-line services
- NHS, schools, employers and councils and communities working together to raise awareness of mental health problems and to improve mental health and wellbeing

For Dementia
- Better information about post diagnostic services, activities and carer support
- Better access to technology that could give reminders and provide additional security and peace of mind
- Access to a wider range of activities and activities which are aimed specifically at men

For cancer
- Improving how cancer services are currently organised
- Getting a quick referral and diagnosis
- Communication within the NHS and with patients and their families, and raising awareness to support earlier diagnosis and help prevent cancer

For primary and community based care
- Getting enough of the right staff, with the right skills in primary and community care
- Making it easier to access the right care quickly and close to home
- Making sure primary and local care is well planned, consistent and joined up

For children and young people
- Improving current services and communication within the NHS and with social care
- Working with parents, families and schools to raise awareness of and prevent mental health problems and to better support children with mental health needs
- Taking a more proactive approach to targeting families who don’t take up vaccinations, working with them to understand and overcome concerns

For digital transformation
- Encouraging and helping people to use digital technology, including NHS staff, where appropriate, without losing face to face contact
- Making better use of digital technology to improve health and quality of care
- Making better use of digital technology to connect different health and care services
Our system challenges

Geographical and demographic challenges

Kent and Medway is a large geographical area (1,368 square miles) including many towns, villages and rural areas, surrounded on three aspects by water and in close proximity to London. The county has a very long coastline particularly in the south and east of the county; and more urban and light industrial towns in the north and west. It is a major transitory route for the continent through the port of Dover and the Channel Tunnel in Folkestone. Transport across the county can be challenging both by road and public transport. We have pockets of high levels of deprivation, particularly in our coastal areas and in parts of Medway, driving significant differences in health outcomes as referenced earlier in our description of population needs. Close proximity to London has an impact on our ability to recruit and retain staff. Adopting a range of approaches to tackle this and to make K&M a great place to live, work and to learn is a pivotal strand of our Workforce Transformation Strategy (see right for more detail on workforce challenges).

The population of Kent and Medway in 2018 was estimated to be approximately 1.85 million people, an increase of 0.8% from the previous year. Most of this growth was from the Kent area, where growth was higher than both the national average and that of the South East. The population is expected to increase to 2.1 million by 2031 with local authority housing forecasts indicating that some 178,600 housing units are planned by 2031. In north Kent, there will be significant concentrated population growth from the Ebbsfleet Healthy New Town, with 15,000 new homes including a high number of young families. Whilst the significant population growth in Kent increases demand for services, it also provides an opportunity to recruit and train more people in health and care skills.

As with the rest of England, we also have an ageing population. The number of older people is growing quickly. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care, for example, there are currently around 14,000 people living with dementia in K&M.

Workforce challenges

It is recognised by national regulators that Kent and Medway has some of the most difficult workforce challenges across the South East and that we have made significant progress since the inception of the Kent and Medway STP to tackle these issues. We have developed a system wide Workforce Transformation Strategy and underpinning the Strategy is a set of plans for short, medium and long term solutions, recognising that growing future workforce supply to the numbers required is a long term endeavour.

We have shortages in general practice that are amongst the worst in the country. This is exacerbated by the age profile of our staff with 25% of GPs and 55% of general practice nurses approaching retirement. Transforming out of hospital care including implementing new models of community based care is a significant strand of our long term strategy and this will require us to address challenges in community staffing including in community nursing and Allied Health Professionals. We have shortages of key mental health professional workforce including psychiatrists and nurses. There are specific concerns in relation to the cancer workforce required by 2022 including specific gaps in gastroenterology, histopathology, and clinical and diagnostic radiology. There are shortages of skilled social care workforce providing direct care and support in our local communities, with over half of all vacancies in Kent and Medway being within social care. These shortages can directly impact the quality of care that is provided to patients as well as increasing the workload and strain for our staff.

We are tackling our workforce challenges through implementation of a system wide strategy, working at a system level on areas best addressed collectively (for example, by promoting life long careers and attracting young people into health and care professions) as well as working at an organisational level on targeted local recruitment, retention and best place to work schemes aligned to system wide principles. We will adopt system ways of working to ensure that all components of the system work together collaboratively to grow our workforce for the future.
Our system challenges

Acute services sustainability

Across Kent and Medway we have a number of structural challenges with how our services are organised and delivered which can impact the quality of our services. Resolving these structural challenges is also the key to long term clinical and financial sustainability of our services, alongside actions to build the workforce for the future and to deliver streamlined and efficient services.

These challenges need to be addressed in a phased approach and our first clinical priority has been to implement a new model for stroke services in response to our providers continuously struggling to meet quality standards. Following a review of services in 2014, a proposal was developed to establish a network of hyper acute stroke units and acute stroke units operating 24 hours a day, 7 days a week. This change will mean that more people survive a stroke and, for those who have had a stroke, improved quality of life and independence. Over the next five years, we will look at the case for change for other specialist services, starting with vascular services. Our goal will be to identify where services are not consistently delivering high quality care, to assess the case for change and to develop a set of options for change which will be rigorously analysed and subjected to engagement with our population.

At a place level, the delivery of services in East Kent is not sustainable. In 2016, clinicians and leaders in East Kent published a case for change setting out the reasons why change is needed – long waits to see a GP, long waits in A&E, challenges with attracting and retaining enough staff to deliver services and the need to deliver services differently moving more care closer to home. Our East Kent transformation programme was established to steer the work to develop new models of care in East Kent and a series of options for the future configuration of urgent, emergency and acute medical care. Through an appraisal process, this has resulted in the shortlisting of two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.

The capital requirements in East Kent are a pressing cause for concern, with significant backlog maintenance to ensure that conditions for patients and staff are safe and appropriate. Regardless of which option is the confirmed option, the issues of the current hospital estate will need to be addressed.

The implementation of Local Care has been continuing at pace in East Kent and this will be a key part of the solution for East Kent; under either option. Local Care teams are providing joined up, personalised care close to home which focuses on keeping people well, avoiding unnecessary hospital admissions, and maintaining wellness and independence.

Whilst we do not believe major service reconfiguration is required in the same way as is being pursued in East Kent, in our other areas – West Kent, Medway & Swale, Dartford, Gravesham and Swanley – we need to conduct a needs assessment of the services that require more networking between acute providers or consolidation in order to ensure services are sustainable and able to deliver the best outcomes. In Medway and Swale specifically, we will utilise the newly formed Integrated Care Partnership to look at the clinical and financial viability of services into the longer term.

You can read more about our approach to challenges of acute services sustainability in Section 3
Our system challenges

Diagnostic services

Improving diagnostics in healthcare is a global objective of effective healthcare systems. We need to continuously improve how quickly and accurately we diagnose conditions and illnesses. In Kent and Medway, we have particular challenges affecting our diagnostics capacity and processes associated with both workforce challenges and availability of diagnostic equipment.

In particular, shortages of radiologists impact our diagnostic services. However, our broader workforce challenges impact the availability of our consultants and other clinical professionals to support diagnostics.

There are examples across K&M of patients requiring diagnostic support via an emergency admission but not being able to access an MRI, CT or ultrasound in the evenings/weekends as well as long waits for particular types of investigations such as neurological investigations.

In East Kent, our transformation programme is tackling challenges of access to diagnostics. This will also need to be considered as part of the work that needs to be undertaken in other parts of the county as we look at the need to network services between hospitals or to consolidate provision of services. Additionally, within our cancer programme we are implementing a range of improvements to support early diagnosis.

However, the work on diagnostics now needs to span beyond East Kent and cancer to a wider diagnostics review that will encompass both a speciality view and a geographical view.

Options will need to include consideration of networked models as well as the potential major diagnostic centre in the Kent and Medway geography. Digital will need to play a significant role in the transformation of diagnostic services, with increasing levels of automation to speed up processes and free up staff time as well increased use of artificial intelligence to support earlier and more accurate diagnosis.

Quality challenges

All of the challenges described - workforce, acute system sustainability and diagnostics – are all inextricably linked and all compound to affect the quality of our services at times. Quality services are services that are safe, effective, and provide as positive a patient experience as possible.

Two of the acute trusts have been in special measures for quality in recent years and as a system we struggle to meet the constitutional targets of A&E four hour waiting times, cancer waiting times, and 18 week referral to treatment standard. Some of our acute trusts still report higher than expected cases of MRSA and C difficile. Many of our patients receive excellent care, but there are also examples of where care has fallen short of the required standard. It is this variation in quality of care that our five year plan will tackle.

Despite support and continued improvement projects, the quality of care across the Kent and Medway geography remains challenged. The only solution is to work together as a system to enhance the care for our population in relation to both prevention and intervention and prioritise the development of new models of care to keep people well for longer.

We also know that we need a greater focus on recognised Quality Improvement methodologies and a cultural change in the way we approach improvement. Quality Improvement must be at the heart of system and organisational culture, with a focus on identifying the root causes of issues, improving processes, measuring and sustaining that improvement.
Our system challenges

Financial position and investment

Delivering this plan requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year’s operational and financial planning.

Kent and Medway is a financially challenged system, and as previously described in this chapter, some of the key reasons for this include growing demand for services combined with how some of our services are currently configured. By ensuring that our services are both clinically and financially sustainable we will drive a route to long term financial balance. Additionally, we also know that there are significant opportunities for productivity and efficiency across Kent and Medway, for example, in pathology, back office functions and our use of temporary staffing. In terms of care delivery, by reducing unwarranted variation and streamlining care pathways to remove unnecessary delays we will both improve patient outcomes and experience while also releasing valuable staff time to reinvest in the improvements set out in this plan.

You can read about more about our approach to driving efficiency and productivity in section 5.

We have a significant need for capital investment. Whilst we are doing all that we can to utilise existing estate and to move care closer to home, there remain instances where we will require new buildings and where we need to maintain our current buildings. The investment required for the East Kent transformation and to implement our Local Care model of care closer to home is a significant element of our capital requirement. We will continue to work with national bodies as to how this requirement will be met to support delivery of this plan.

You can read about our estates strategy in section 6.
Our five strategic objectives

To meet the needs of our population and to address our system challenges we will focus on five strategic objectives:

1) **Improving care quality experience** - This strategic objective covers a wide range of delivery priorities including developing our ICS accountability framework for quality and *Delivering integrated care closer to home* (expanded primary care and community care services). We are *transforming urgent and emergency care* to ensure that A&E is only used for serious urgent care needs and emergencies. We also know that resolving a number of *structural challenges* that impact the clinical and financial sustainability of our services is critical. Lastly, this objective includes a number of *specific priorities to improve care and outcomes* for a number of clinical and service areas.

2) **An increased focus on population health and prevention** - This strategic objective includes developing our approach to population health management to improve overall population outcomes. Prevention will be embedded throughout the ICS and at the start of every care pathway. Our approach to prevention follows the life course as well as targeted actions on priority areas of smoking, obesity, alcohol, MH, health protection, cancer and other major conditions.

3) **Driving financial balance, efficiency and productivity** – This strategic objective covers our actions to address our financial challenges including meeting the government’s four tests for best use of taxpayers’ investment in the NHS.

4) **Transformation of our workforce and infrastructure** – This strategic objective starts with our Workforce Transformation Strategy and the actions being taken to address our workforce challenges. Digital transformation is a critical enabler to improving care quality and transformation and to providing the infrastructure to support population health management. Our estates strategy is aligned to our clinical strategies to deliver a fit for purpose estate for the future, with a significant capital requirement.

5) **A new Integrated Care System delivery model** – This strategic objective is about a new way of organising ourselves, in line with national policy, that will better enable integration of services, put an end to unwarranted variation and drive a focus on population health.

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**What our K&M Health Needs Assessment says**

- **Cancer** is the number one cause of premature death
- **Cardio Vascular Disease** is the biggest cause of disability
- **Stroke** is the single largest cause of complex disability
- 90% of adults with **diabetes** have preventable type 2 diabetes
- Higher levels of **respiratory disease** in areas of deprivation
- **Frailty** and **multi-morbidity** are rising
- **Health inequalities** between most and least deprived areas

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**What people have told us they want to see**

**Prevention** – healthier lifestyle choices

- **MH** – quality and ease of access to services
- **Cancer** – increased efforts to raise awareness to prevent and diagnose cancer earlier as well as quicker referral and diagnosis

**Children and Young People** – better support for children and young people with MH problems as well as improving vaccination rates

- **Primary and community care** – easier access to the right staff and bringing care closer to home

**Digital transformation** – Better use of digital services to connect health and care services and improve health and quality of care.

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**Our system challenges**

- Long coastline and proximity to London
- Workforce challenges particularly in primary care, social care, mental health and cancer
- Acute services sustainability challenges
- Quality challenges
Our strategic planning framework has been informed by our STP programmes, the Kent and Medway Health Needs Assessment, listening to what local people want, and the national priorities as set out in the NHS Long Term Plan.

### Principles cutting across our strategic objectives
- A relentless focus on driving out unwarranted clinical variation
- Adopting a ‘health in all policies’ approach across all partners in the development of new policies to consider the impact on population health
- Promoting self management, self care and citizen activation

<table>
<thead>
<tr>
<th>Strategic objectives</th>
<th>Delivery Priorities</th>
</tr>
</thead>
</table>
| 1. Improving care quality and patient experience | • Implementing an ICS quality framework and quality priorities  
• Delivering more care outside of hospital including resilient primary care and community care  
• Addressing clinical and financial sustainability of acute services  
• Transforming urgent and emergency care  
• Transforming outpatients and ensuring timely planned care  
• Improving services and care outcomes for cancer, MH, maternity and neonatal, children and young people, LD and autism, stroke, CVD, diabetes, respiratory disease, end of life care |
| 2. Increased focus on population health and prevention | • Implementing population health management (PHM) including a K&M outcomes framework informed by this Strategy Delivery Plan  
• Developing capacity and capabilities for PHM  
• Embedding prevention throughout the system and in every pathway  
• Supporting more people to stop smoking and preventing children and young people from ever starting to smoke  
• Taking a place based approach to tackle obesity  
• Identifying people at risk of alcohol and substance misuse in the community and supporting them with targeted interventions  
• Tackling health inequalities at a place based level |
| 3. Driving financial balance, efficiency and productivity | • Deliver against financial trajectories for the 5 year period  
• Achieve success in bidding for targeted funding from national bodies to support the delivery of our plan  
• Deliver c12m productivity savings in 19/20  
• Continue to explore opportunities to delivery productivity savings of c£53-90m by 23/24 through areas such as:  
  o Continued implementation of best practice processes (GIRFT, Right Care, Model hospital)  
  o Delivering a single pathology service for Kent & Medway  
  o Developing a collaborative ‘bank’ for medical and nursing staff across K&M |
| 4. Transformation of our workforce and infrastructure | • Implementing the K&M Workforce Transformation Strategy  
• A step change in digitally enabled care including online guidance to support self-care  
• Creating the infrastructure to enable integrated datasets  
• Implementation of the K&M Shared Care Record  
• Completing and implementing the K&M analytics strategy  
• Delivery of our K&M estates strategy including success in national bidding rounds for funding |
| 5. A new integrated care system delivery model | • A system commissioner to commission at scale and drive a focus on population health  
• Development of Integrated Care Partnerships to deliver high quality integrated care and tackle local health inequalities  
• Development of Primary Care Networks to create a resilient primary care and expanded community care delivering personalised anticipatory care  
• Development of innovation, research, and quality improvement  
• Expanded joint working between the NHS, local authorities, voluntary sector, and wider partners |

**By doing all of this we will achieve for the population:**
- Increase in healthy life expectancy
- Improved wellbeing and resilience
- Reduced health inequalities
Our priorities for the population of Kent and Medway by 2023/24

By delivering the priorities across our five strategic objectives, we will deliver improved outcomes and benefits for the population. The below is a set of priorities for the population that have been identified through the development of this plan. This will be supplemented with a K&M Population Health Outcomes Framework to be developed in early 2020. *Please note that the below is not exhaustive and does not cover all of the benefits and outcomes described in this plan – you will find these within individual chapters.*

<table>
<thead>
<tr>
<th>A good start in life for babies, children and young people</th>
<th>Good health and wellbeing for working age adults</th>
<th>Good health and wellbeing for people who are frail and/or have multiple conditions conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Less than 6% of women will smoke during pregnancy</td>
<td>• Even more people will have received psychological therapies for common MH problems (c60,000)</td>
<td>• More people with complex needs (including people with MH conditions and people with complex LD or autism) will have been supported by a multi-disciplinary team, supporting them to stay well</td>
</tr>
<tr>
<td>• Increased breastfeeding rates by providing more support for more women who choose to breastfeed and through promotion of benefits</td>
<td>• A reduction in the age incidence of stroke</td>
<td>• Some 30,000 people will have benefited from a social prescribing referral</td>
</tr>
<tr>
<td>• Some 2000 women will receive perinatal MH support</td>
<td>• More people will survive stroke and those who do will have better quality of life and independence</td>
<td>• At least 30,000 people will have benefited from a care and support plan</td>
</tr>
<tr>
<td>• Increase vaccination uptake</td>
<td>• Around 6,500 people will have been supported by the Diabetes Prevention Programme</td>
<td>• Incidence of falls in older people and frail people will reduce</td>
</tr>
<tr>
<td>• Around 16,000 children and young people accessing mental health services</td>
<td>• A lower rate of diabetic complications</td>
<td>• Reducing levels of premature mortality for people with mental health conditions and for people with LD or autism</td>
</tr>
<tr>
<td>• Reduced gap in rates of obesity for reception year children between the most and least deprived areas</td>
<td>• A lower rate of premature mortality and disability from CVD</td>
<td>• More people with LD or autism will receive community based care</td>
</tr>
<tr>
<td>• Reduced waiting times for children and their families for autism spectrum disorder assessments</td>
<td>• Less than 12% of population will smoke</td>
<td>• More people will receive a timely diagnosis for dementia and be guided to the right care and support</td>
</tr>
<tr>
<td>• Children with complex needs will be supported by a community based multi-disciplinary team</td>
<td>• A reduced gap in obesity levels between the most and least areas</td>
<td>• Nearly 80% of people with LD and autism will have had a physical health check</td>
</tr>
</tbody>
</table>

**Across our population**

- c61% of cancers will be diagnosed earlier at stages 1 and 2 leading to more people surviving cancer
- 70% to 100% of our general hospitals with a major ED will have liaison psychiatry services in place to support people with a mental health need
- Following a successful Mental Health Wellbeing campaign, more people will know their ‘five a day’ for the mind
- More people will report that they feel comfortable discussing mental health and that they have been able to access the right services through a ‘no wrong door’ approach
- Suicide will reduce by 10%
- More people will have received urgent care and advice outside of A&E settings
- Almost all of our population will have been able to access online consultations
- Carers will report they feel better supported by a range of different resources
Our strengths and opportunity areas

We have set strategic objectives and priorities to address our challenges and the needs of our population. It is important to recognise that in delivering on our strategic objectives and priorities, we will build and capitalise on our key strengths and achievements including:

• Our GP leaders unanimously voting to merge our existing CCGs to create a single CCG across K&M to commission at scale, put an end to unwarranted variation and drive population health management
• Our ambitious and driven Primary Care Network clinical directors
• Our commitment to meeting the national investment standard in Mental Health and the progress in achieving parity of esteem between physical and mental health
• Our improved cancer performance for treating patients within 62 days of referral, taking us to the second best performing cancer alliance in the country for this standard.
• Our commitment to embedding prevention throughout the ICS and in every pathway
• Our work on the Kent Integrated Dataset which has enabled us to develop a detailed understanding of our population
• Our track record of coming together to agree future direction, for example, our collective commitment to the Local Care model and our Primary Care strategy owned and led by Primary Care professionals
• Our track record of partnership working with the STP comprising over 19 partnership organisations – see slide 98 for list of members

As we continue to implement our strategic objectives and priorities, we will actively target themes where we know that there are opportunities to be further exploited including:

• Further development of our long term digital strategy including the role that digital will play in transforming how people look after their health and wellbeing and in transforming how care is delivered and experienced. We recognise that we have many pockets of innovation and excellence across Kent and Medway. We now need to develop a long term strategy which drives consistent application of high impact digital tools and solutions
• A greater focus on identifying and spreading innovation, irrespective of which part of the system is the instigator. This will be reliant on the ability to evaluate impact effectively and to adopt a change management model which enables innovation to be swiftly implemented and spread
• Further integration of our primary and community care strategies via joined up implementation plans, with a focus on the overall population health outcomes to be achieved
• Further integration of mental health services into our care models for prevention, PCN working and community based care, urgent and emergency care and planned care – this will ensure that mental services are not seen and experienced as standalone services but are integrated with services for physical health
• A focus on developing capacity and capability for quality improvement within our Integrated Care Partnerships, including Primary Care Networks, such that we continuously improve our care delivery
• Opportunities to ‘build for health and wellbeing’ from the outset in the context of Ebbsfleet Healthy New Town. This exciting development provides opportunities to innovate and to learn from this experience for the wider benefit of Kent and Medway.

These areas will be revisited as part of our strategy refresh in 2020.
Section Three

Strategic Objective 1) – Improving care quality and patient experience
Section Three

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality
Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality

A single national definition of what we mean by ‘quality’ was first introduced following Lord Darzi’s review of the NHS in 2008/09 - care that is safe, clinically effective, and that provides as positive an experience for patients as possible. All three dimensions must be present to deliver a high quality service. This is the definition adopted in Kent & Medway.

Developing a system approach to quality

We are developing an ICS quality framework to enable organisations to have a common definition and approach to quality, with shared and aligned programmes to achieve quality improvement and prevent duplication. This chapter sets out the guiding principles to the approach whilst the strategy is developed across the ICS. The quality framework will be overseen by the Kent and Medway Clinical and Professional Board.

A significant step in system working for quality is the establishment of a new Nursing and Clinical forum to bring together the senior nursing leaders from providers, commissioners and education across Kent and Medway. The forum is currently defining its purpose but aims to provide nursing and clinical advice and guidance to the Clinical and Professional Board. The forum will provide strategic direction to areas such as workforce and quality strategy as well as supporting the transitional arrangements and developments as the system establishes an Integrated Care System and Integrated Care Partnerships. This strategy recognises that Primary Care Networks (PCNs) are at differing levels of maturity and therefore the quality support offered needs to flex and be tailored to their individual needs. An Allied Health Professional Cabinet has also been set up to look at the priorities across AHP disciplines.

Our proposed strategic quality priorities for the next five years

• We will implement new ICS governance arrangements for quality assurance which will include safeguarding, Infection prevention and control (IPC) and patient safety
• We will invest in developing our capacity and capabilities for quality improvement across the system, utilising recognised Qi methodologies to continually drive improvement
• We will further develop our quality framework to increase the focus on early warning signs
• We will work both within and across ICPs to support quality improvement by learning from complaints and incidents and to identify and spread good practice
• We will invest in developing our workforce, introducing new roles as well as ensuring a culture that allows the leaders of the future to be identified, developed and supported to achieve
Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

K&M Quality Priorities for 19/20 and 20/21

The below priorities have been developed and signed off the Nursing and Clinical Forum:

- To ensure clinical quality, leadership and accountability are clearly understood across all commissioned services
- To ensure mechanisms are in place and working well to provide assurance on the quality of all commissioned services, ensuring local needs and variations are addressed
- To promote an open and transparent culture between commissioners and provider organisations across each ICP and the ICS to identify and implement areas of best practice and learning
- To support the care sector improving the quality of care delivered
- To ensure that people have a positive and safe experience of care and that the individual is at the centre of care
- To ensure that a competent workforce is in place to deliver the transformations both in and out of hospital
- To reduce variation in all aspects of quality including outcomes related to premature deaths in both physical and mental health settings
- To ensure robust Quality Assurance and Improvement Framework developed to support emerging Primary Care networks and new models of care

As a result of adopting the Darzi definition of quality, our priorities are necessarily broad and span areas outside of the scope of traditional CCG quality functions. Delivering on these quality principles will require actions from functions and organisations across the system; in particular there is a significant role for digital transformation and workforce transformation to drive quality. Our ICPs will need to be at the forefront of driving continuous improvement in services and using evidence and data effectively.

Safety

In order to achieve our priorities we will need to ensure that we foster a standardised process across the system in safeguarding, care planning, investigating and quality assurance to reduce risk to patients and enable comparison of themes, trends and promote shared learning. Providers across K&M have described the following areas for action to directly improve clinical outcomes:

- Reducing falls, ensuring the 3 high impact interventions are carried out
- Reducing the number of pressure ulcers that are acquired whilst under our care
- Ensuring nutritional assessments are embedded reducing concerns and incidents relating to nutrition and hydration optimising health for recovery

In addition there are work streams across providers aimed at

- Ensuring that healthcare associated infections are reduced, including the prescribing and management of antibiotics and promoting good antimicrobial stewardship
- Prioritising the reduction to the length of stay and support the prevention of re admissions
- Improved quality of care for the deteriorating patient, promoting early recognition, response and appropriate escalation in all areas of care; including the sepsis pathway. All stakeholders in the systems are working to create a safety culture that embraces ‘lessons learned’ and recognises human factors that influence clinical practice and decision making. In order to achieve this there will need to be good governance and peer review of serious incidents to seek assurance that learning has embedded, by reviewing progress of completion and effectiveness of actions. Primary care will be support to adopt safety tools such as ECLIPSE live and PINCER.
- We will ensure Quality Impact/Combined Impact assessments are completed and reviewed when implementing change including monitoring of potential risks.
Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

Safety continued

- Develop digital ways of working to improve the interoperability between the systems to ensure seamless data sharing which will support more time to care and reduce risk (see digital chapter)
- Support leadership and quality development in the care sector
- Deliver the Kent and Medway workforce Plan as an integral part of safety

Actions to ensure compliance with National Patient Safety Strategy

The strategy aims to commit to a continuous improvement of person/patient safety by building on the foundations of a patient safety culture and patient safety system. This includes the delivery of three strategic aims: Insight, Involvement and Improvement.

We will:
- Provide leadership to local systems and within 5 years we will have created a coalition of resources to support the ICPs to have developed, implemented plans and evaluated outcomes aligned with the NHS Long Term Plan. This will include leadership support to the care sector
- Set the ambition for delivering the strategy locally to ensure alignment with regional priorities and have delivered these within the 5 years
- Ensure the establishment of acute trust-based medical examiner scrutiny of all deaths in acute hospitals by April 2020, and all deaths by April 2021
- all deaths in acute settings are scrutinised by medical examiners by
- Support work with the emerging PCNs to develop their role in safety improvement, with a fully matured system within 5 years
- Ensure that delivery of the strategy achieves the right balance between assurance and improvement within ICP and Care settings.
- Encourage uptake of the new patient safety curriculum and training with this being fully embedded within 5 years
- Encourage the implementation of early warning systems and within 5 years have an established system that recognises these and is able to respond to prevent poor quality
- Incorporate insights from pilot site systems into plans to implement the awaited Patient Safety Incident Response Framework (PSIRF) by summer 2021
- Improve patient involvement in patient safety by ensuring that patient representatives are members of safety-related committees throughout the system by April 2021

At a strategic level the system commissioner will:

- Support STP/ICS across Kent and Medway to implement features of the NHS Patient Safety Strategy with it being fully embedded by 21/22
- Share learning within and across the systems including non-NHS providers and the Care Sector; escalating concerns from PSIRF

The system commissioner will work with regulators to:

- Encourage contribution to the patient safety specialist network
- Deliver the Patient Safety Improvement programme through the improvement programmes for maternity and neonatal safety, medicines safety and mental health safety improvement programme
- Support the replacement of the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) with the new Patient Safety Management System (PSIMS) by March 2021
Strategic Objective 1) – Improving care quality and patient experience

Our approach to Quality continued

**Effectiveness**

To ensure that care is effective we will need to continue to work to improve the flow of patients through whichever pathway of care best meets their needs, with effective and seamless transfer and care across and between providers, delivering timely and safe treatment through both emergency and planned pathways. There will need to be continued work to reduce mortality rates; improve the care and treatment patients receive following a stroke and to see this reflected in the published national data (HSMR, SHIMI, SSNAP). There will be work to develop and expand shared care protocols and improved drug monitoring, including medicines management in the care sector.

To improve outcomes for women and babies the achievement of the Better Births agenda will be prioritised and the outcomes monitored. So that the system is better enabled to identify and evidence improvements in outcomes of care, quality improvement methodologies and digital solutions will be adopted.

**Experience**

We will ensure that there are excellent public and patient engagement plans to improve the way we engage and receive feedback from patients ensuring vulnerable groups and those with complex needs are given the opportunity to respond. The intelligence gathered from all groups will be utilised in the co-design and co-production of patient pathways across the system through the use of the ESTHER philosophy as set out in the Workforce plan.

To directly improve the experience for the person /patients we will:

- Improve the transition of care for children and young people to adult services
- Ensure timely decision making for the provision of End of Life Care
- Make personalised care a priority, including consent and capacity assessments to ensure collaborative decision making and the use of ESTHER cafes to include the person’s experience in MDTs, risk assessment, and focus on the patients’ needs
- To support the experience for patients we will ensure that staff feel valued through good staff engagement and appraisals and learning from new models of care. We will support the development of staff to strengthen the NHS, social care and care sector pool of talent, develop new and enhanced roles to improve pathways of care and raise staff morale and encourage retention and progression. It is our aim to improve the staff survey results to reflect that staff want to work for the NHS, social care and the care sector and for organisations to be recognised as outstanding employers.
**Strategic Objective 1) – Improving care quality and patient experience**

**Quality Governance**

As we transition towards a system commissioner as part of the ICS with four ICPs across Kent and Medway, the current governance arrangements will need to develop. Specific attention is being given how the care sector and non-NHS providers are involved and represented, they are part of the emerging quality structures of all four ICPs. Recruitment to a single Chief Nurse across the system commissioner will commence following the appointment of the Accountable Officer in late 2019. This post will be crucial to the design and development of the new governance arrangements.

The Nursing and Clinical and Professional forum will be instrumental in identifying the appropriate soft and hard intelligence required to develop datasets, dashboards, thresholds and statistical analysis tools that are used across the system. It is envisaged that the current routes for quality escalation of concerns to the K&M Quality Surveillance Group will be replaced with a quality oversight group which will include all key stakeholders will review emerging safety concerns.

Safeguarding teams across K&M are working collaboratively across the ICS footprint to ensure there is sufficient expert capacity to effectively safeguard both children and adults. The collaborative approach to safeguarding is delivered through each member of the team leading on portfolios that align to national safeguarding directives, legislative requirements and local need.

Operational safeguarding will be delivered from within the ICPs (including the PCNs and Social Care) achieving the frontline objectives of the Kent and Medway Boards & Partnerships, providing performance, audit & experiential data as evidence of achievement & sustainability.

Designated nurses/professionals within the system commissioner will provide a strategic overview of the safeguarding governance of the ICPs and provide a valuable expert resource to the system and partners to ensure that learning is shared and that national programmes are appropriately delivered at the local level. External scrutiny will be achieved through the national safeguarding team and the local safeguarding boards and partnerships.

**Quality assurance**

We will take an approach to quality assurance that focuses on an objective overview of how well the whole system operates in order to prioritise activity and identify gaps, weaknesses and strengths against known risks. This approach, embedded in a culture of mutual respect, will allow partners to hold each other to account on the evidence available, and support the ongoing development of a culture of constructive challenge and improvement. Benchmarking tools and audits will be used to help identify areas for improvement.

By adopting the “Three Line of Defence” methodology used in a range of national and local assurance models, our approach focuses on developing assurance across partnerships that supports the management of risk and provides an understanding of both the operational delivery of services and the effectiveness of the system in meeting the needs of our population.

This methodology will provide a balance between the frontline, the organisational and the system oversight, using early warning indicators and a dashboard to help us to identify and track good or poor system performance and focus on new issues or risks. Success and the impact will be measured against defined outcome measures which will be developed during 2020/21.
Strategic Objective 1) – Improving care quality and patient experience

Quality Assurance continued

The **first** tier of assurance will take place at the local ICP operational level, coming from those delivering the frontline services, assuring that performance is monitored, risks identified and addressed, and objectives are achieved.

- Development of dashboards that incorporate an early warning mechanism
- System/peer assurance process, shared quality committee process
- Agreed escalation process and threshold
- Consistency of approach (policy, process, procedure) within the system
- ICP and safeguarding quality forums
- Care Sector Registered Managers Network to develop quality improvement mechanisms supported by the Design and Learning Centre (DLC) Learning
- Hub feeding back into the Local Workforce Action Board.

The **second** tier of assurance will be at a strategic level via the Clinical Commissioning Group and giving an overview of the activity and quality of care being delivered to the population, including that care is delivered in line with set expectations and standards.

- Agreed system quality metrics and KPIs
- Adapted QSG approach to strategic system assurance
- Consistency of approach (policy, process, procedure) across ICPs
- Agreed escalation process and threshold

The **third** tier of assurance will be of an independent nature and will provide assurance of the whole system, highlighting gaps, weaknesses and strengths. This assurance approach will be in development during 2019/20 and fully embedded in 2020/21

Quality Improvement

There is commitment across our system to embed quality improvement in how we manage change, and organisations have trained staff in a variety of complementary methodologies including Quality, Service Improvement and Redesign (QSIR), Lean / Six Sigma, Dartmouth Clinical Microsystems, and General Practice Improvement Leaders (GPIL).

As we develop our integrated care system we will build on this capacity and capability across all settings of health and social care, ensuring that more people are trained and empowered to take forward these evidence-based approaches to continuous improvement.

Embedding QI is a critical part of the development of our ICPs, where we aim to build teams that can support this work across their locality with a range of skills including data and analysis, change management and quality improvement. The care model framework set out in our clinical and professional vision takes exactly this approach, starting with understanding the needs of a particular cohort, designing and testing interventions to meet these needs, and evaluating the impact. These approaches will help us address our unwarranted variation alongside programmes such as GIRFT and RightCare.

The impact of any planned service change or improvement will be assessed by the application of a Combined Impact Assessment. This tool, which will be agreed for use across Kent and Medway, will combine an assessment on quality alongside our obligations under the Equality Act (2010) to undertake impact assessments against the protected characteristics.
Section three

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Primary and community based care

Our approach to transforming out of hospital and expanding primary and community based care is made up of three strands: building a resilient Primary Care, implementing our Local Care model of multi-disciplinary team working and investing in our Community services. None of these areas are exclusive of the others and over time we see the boundaries between these areas blurring even further. We are organising ourselves around the person and their needs, rather than around organisations and services. By bringing together all of these strands in how we deliver care, we will deliver care that is more anticipatory and personalised. We are implementing specific initiatives to support personalised care, in line with national policy, but personalised care in Kent and Medway is a consistent ethos that underpins our strategies and plans for primary care, wider community services and Local Care – and indeed more broadly across all of the clinical and service areas outlined in this plan. It means focusing on the whole person and their needs and goals, focusing on ‘total health’ - physical health, mental health and wellbeing, supporting people to look after their health and wellbeing, and empowering people in decisions about their health and care. By doing this, we will fundamentally change patient experience and long term outcomes. The creation of a single CCG across Kent and Medway will create further opportunities to strengthen the delivery of personalised care through new commissioning strategies.

Primary Care – We are investing in primary care through delivery of our primary care strategy, including strengthening core general practice, and the development of 42 Primary Care Networks across K&M, implementing new roles and digitally innovations to meet our workforce challenges. Over time, PCNs will take on increasing responsibilities for improving the overall health of local populations.

Community services – We are investing in community services to ensure that more people receive the right care they need at home with multi-disciplinary teams providing crisis response and reablement. We are rolling out the renowned Buurtzorg model of self-managed teams, proven to focus on the needs of the patient.

Local Care - We are completing the roll out of MDTs for adults and older people with complex needs across Kent and Medway, utilising the successful MDT principles we have developed locally. MDTs span competences from across health, social care and voluntary sector. Over the next five years, we will roll out MDT working for children with complex needs, people with co-occurring conditions, and for people with learning disabilities and autism.

Mental health support and services span all strands, however, we recognise that we have more to do to integrate our mental health pathways and ensure ‘no wrong door’ for access MH support services.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Primary and community based care

One of the five major practical changes set out in the NHS Long Term Plan is to “boost out-of-hospital care, and finally dissolve the historic divide between primary and community health services.” The 2016 Kent & Medway Case for Change set out the challenges facing out-of-hospital care, including:

• 30% of patients in acute hospital beds would be better looked after in an alternative setting
• 12% of admissions through A&E are avoidable through more consistent decision making at the front door, or through better health and social care provision in the community
• 25% of community hospital patients would be better cared for at home or in other community setting
• There is wide variation in whether people would recommend their GP practice to a friend – between 68% and 84% (national average 78%)

The 2018 Case for Change refresh supported this stating, ‘that a priority area for focus is avoiding hospital admissions for people with long term conditions and supporting their carers’.

Additionally, we know that primary care is the bedrock of out of hospital care and that we have significant workforce challenges in primary care in K&M. Our shortages in GPs are amongst the worst in the country and we have a significant volume of GPs approaching retirement.

This has led to the dedicated establishment of programmes across Kent and Medway for Primary Care and Local Care.

Our primary care strategy

We have undertaken significant engagement and co-design to develop a single primary care strategy for Kent and Medway, led in partnership with the Kent Local Medical Committee. This strategy is owned by primary care, including our new PCN Clinical Directors, with a commitment from all partners to ensure that we deliver it.

Our vision for primary care is to have healthy people, happy communities, and valued colleagues. We have set out what we hope primary care will look like in five years time, and a realistic set of phased improvement priorities over the next five years to achieve this. We have undertaken detailed work to understand the affordability of these and where we need to make further investment as a system to deliver them.

Our priority themes are based on what we heard from primary care:

• Care redesign for patients and communities
• Workforce and workload
• Digital
• Estates
• Finance and contracts
• Communications and engagement
• Primary care networks
• Measurable implementation plans

You can read more in our Primary Care Strategy
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Development of primary care networks

Our development of primary care networks (PCNs) begins with stabilising core general practice, the bedrock of PCNs, and this is a focus in our primary care strategy. It then builds on what local areas have already been doing to support primary care at scale – we are not starting from scratch. Building successful PCNs means creating expanded primary and community care teams. As part of our primary care strategy, we have co-designed a consistent support offer for our PCNs. This is being coordinated centrally but delivered locally, maximising the resource that we already have in the system.

In September 2019 we brought all of our PCN Clinical Directors together to discuss this support offer, their development, and allocation of the PCN Development Funding that we have been given as a system. These Clinical Directors have also contributed directly to the phasing of priorities for primary and local care. Our PCN development offer builds on the national maturity matrix and will enable everyone working in a PCN to be able to do four things:

• Take care of you e.g. personal leadership development
• Take care of your colleagues e.g. developing effective teams
• Take care of your community e.g. care transformation projects, population health management
• Get the basics right e.g. IT, governance, financial flows

Our commitment to additional investment in primary and local care means that PCNs will be able to access significant support to put them in the best position to deliver all of the national requirements across the next five years, as well as work in partnership across their ICP on our wider ambitions for local care and improved population health.

As they evolve, ICPs are working with their PCNs to develop plans for what can be done in partnership, which includes the involvement of community providers. This year, we have allocated funding to PCNs for three things:

• Clinical Director leadership development: we are excited by the number of new leaders who have chosen to step up as Clinical Directors, and will ensure they get significant individual support to develop in these roles. In addition to funding, Clinical Directors have access to support from our Training Hubs who are running dedicated programmes, as well as coaching and mentoring

• Primary care network development: every PCN has received some funding for development and delivery of a local plan that helps build network maturity, backed by dedicated support from local CCG teams. We have not been prescriptive on what we expect from these plans, allowing networks the freedom and headspace to work on local priorities in partnership

• Service improvement projects: in 19/20 we are focusing on improving data quality and coding to enable PCNs to have an accurate baseline for improvement. In addition to this, we are providing access to support from central teams trained in quality improvement methodology. Through this we will build the capacity and capability to run service improvement projects targeted at improving on system priorities where we know we have significant unwarranted variation; or targeted at areas that will put PCNs in a stronger position to deliver the new service specifications

Our PCN leaders are visionary and ambitious, however we must recognise that there is a gap between what they are currently able to deliver with the resources and time that they have had available, and the much wider five year vision. More funding is part of the solution, but is not the only thing we need to do to bridge this gap. In partnership with the Kent Local Medical Committee (LMC), we will continue to provide backfill to release clinical time for all of our Clinical Directors to come together and work with us on designing the future.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

Our Local Care model has been the cornerstone of our STP since its creation. Our Multi Disciplinary Team (MDT) model of personalised care ensures that the needs and preferences of the individual are honoured for optimal functional health and quality of life. We have been rolling out MDTs across Kent & Medway for adults and older people with complex needs and frailty, aligned to the 42 Primary Care Networks. Our agreed ‘MDT Framework for Primary Care Networks ensures consistency and quality of the delivery of personalised care across all 42 PCNs.

Some considerable engagement with a range of stakeholders has led to the development of eight key interventions which will deliver holistic personalised care, and align to the national Universal Personalised Care agenda:

- Care and support planning with community navigation and case management
- Self-care and management
- Healthy living environment
- MDTs, integrated coordinated as close to home as possible
- Single point of access
- Rapid response
- Discharge planning and reablement
- Access to expert opinion and timely access to diagnostics

By doing this, we are intending to have a positive impact on the following:

- Unnecessary A&E attendances and patient admissions
- Reducing long length of stay
- Positive outcomes for patient activation, independence and wellbeing

We have made significant progress on this ambition and have MDTs in place within each PCN to deliver integrated health and care services close to where people live. This is something we must continue to drive; integrated working at scale and pace to make personalised care the norm.

Over the next five years we will deliver an integrated health and social care model of personalised care to all frail elderly patients and adults with complex needs that focuses on delivering high quality, outcome-focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting.

We will transform local services to deliver proactive care and support, focused on promoting health and wellness rather than care and support that is solely reactive to ill health. Core to the model of care is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and, where appropriate, independent sector services to deliver the right care, in the right place, at the right time.

Over the next five years the MDT approach will expand to provide services for children with complex needs and people with learning disabilities and autism. These MDTs will include a broader range of staff than those already in place, be aligned to the PCNs and comprise of staff working across health, local authority, voluntary and care sectors.

Extensive engagement has been undertaken across the system to develop an agreed ‘MDT Framework for Primary Care Networks’, including links to our ‘top tips’ for MDT working.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

The Multi-Disciplinary Team (MDT)

The concept is to prevent duplication from multiple services, prevent the patient having to repeat themselves, to co-ordinate the patient’s care, to put the patient at the very centre of their care, to identify any unmet need gaps and work as a team to address the patient in a cohesive way.

The patient is at the centre of the plan of care and is involved in the decision making process and the planning of their anticipatory care management plan.

Social prescribing

About 30% of the referrals from the MDT meetings are for social prescribing, as a way to improve outcomes for people; keeping people well, independent and resilient by connecting them to community based support, services, resources and assets. Across K&M we have agreed a set of principles for rolling out social prescribing and community-based support to meet the needs of local populations. We are developing a business case for a single IT platform to facilitate better coordination of social prescribing.

By 23/24 some 30,000 people will have benefited from a social prescribing referral.

Care planning

Our model of integrated case management (ICM) supports shared decision making and care planning. The focus is to drive personalisation, help people to maintain independence, provide care closer to home and build community resilience. Our ICM approach aims to build relationships between health and social care professionals to improve health and wellbeing outcomes for patients at high risk of future emergency admission to hospital.

ICM is initially aimed at the top 3% of the population with the highest risk stratification scoring or severe frailty. The service aims to reduce unnecessary hospital admissions, reduce avoidable A&E attendance, and facilitates early discharge from in-patient beds.

By 23/24, at least 30,000 people will have benefited from a care and support plan.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

While our Local Care model is the heart of out of hospital services, there is a significant transformation agenda taking place within community services more broadly.

Of note is our implementation of the Buurtzorg model of care. Founded in the Netherlands in 2006/07, Buurtzorg is a unique district nursing system and involves small teams of nursing staff and other community staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. The model has garnered international acclaim for being entirely nurse-led with both the RCN and The King’s Fund welcoming the remarkable success of the Buurtzorg model. A significant reason why Buurtzorg has managed to provide excellent patient-centred care been due to its approach of putting patient self-management at the heart of its operation.

The model focuses on personalisation; it starts from the patient perspective, and works outwards to create solutions that enable improved independence and quality of life. The model empowers individuals and encourages self-reliance. There’s an emphasis on small teams of staff working with each individual and their families and carers to access all the resources available in their social networks and neighbourhood to support them to be more independent. The nursing teams have a flat management structure, working in ‘non-hierarchical self-managed’ teams. This means they make all the clinical and operational decisions themselves. Aspects of the Buurtzorg model are in stark contrast to historical provision in England where ‘health’ and ‘social care’ have typically been provided by two entirely separate teams. People requiring care at home are often seen by multiple staff members on a given day and may not see the same care worker or nurse again. The Buurtzorg model provides continuity of staffing.

The types of benefits to patients of this care model include increased levels of wellbeing and independence; more confidence to self care with less reliance on health and social care services. Patients feel more empowered, supported and reassured through continuity of staff and wider engagement with their local communities.

The types of benefits to staff include higher levels of job satisfaction through deeper more meaningful relationships with both patients and colleagues as well as a sense of trust, autonomy and control.

Kent County Council, Kent Community Health NHS Trust and Medway Community Healthcare are now implementing the Buurtzorg model across Kent and Medway through the Transforming Integrated Community Care (TICC) project, a four year health and Europe research project that that aims to create systemic change in health & social care, providing services better suited to our ageing population and addressing holistic needs.

TICC will enable us to implement new ideas and practice quickly; increase staff productivity, recruitment, retention creating a blueprint for successful transfer of social innovative service models in health and social care from one country to another benefitting all public/private services. We have an ambitious roll out plan across the County starting with our test and learn community nursing team s in Ashford, Charing, Edenbridge and Medway and a domiciliary-care led team of occupational therapists, enablement support and care workers based in the Ashford town area.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Key progress to date

Significant progress has been made across K&M in the delivery of our local care model to support all 42 PCNs; with each one having an aligned multi-disciplinary team, working to deliver integrated case management, for adults with complex needs and frailty. To date, all are achieving their agreed trajectories of personalised anticipatory care plans, helping individuals to stay well and supported in the community.

To augment this ‘Frailty Pathways’ have been developed including bespoke frailty units to support ‘hot frailty clinics’ for step up step down crisis care; we are working with our NHSE/I lead to ensure links with the reconfiguration of 111 in terms of a seamless crisis response and single point of access.

Consistency in delivery and quality

For 2019/20 we have an agreed deliverables framework for local care. Across local and primary care we are presently working on an aligned outcomes framework.

Our ‘Primary Care Strategy’ has been well received, having been co-designed with primary care colleagues. It also includes an agreed support offer for PCN development.

To ensure consistency and quality we have worked with key stakeholders across the system to develop an ‘MDT Standards Framework for PCNs’, including ‘top-tips’ for MDTs, which we have now shared both locally and nationally (mentioned on page 28).

We have also agreed a K&M ‘Quality Standard’ for Primary Care; a set of consistent local enhanced services for key delivery priorities.

Social prescribing

There has been an additional investment of £15m, across health and local authority into social prescribing in 2019/20. There is a collective agreement, longer term, to align contracts and link with the new social prescribing posts within each PCN.

To support this we have agreed to move to a full business case for the provision of one social prescribing platform across K&M.

Supporting carers

This has also been a key focus and we have engaged a wide range of stakeholders to co-design an ‘app’ to support anyone in a caring role (paid or unpaid); building on the award winning ‘Stop Look Care’ booklet from Brighton and Hove CCG. Stage 1 of the development provides the fundamental elements in caring for someone and also how to access support for the individuals who care. Stage 2 will provide a comprehensive directory of services and access for on-line training resources, free of charge, to all care agencies.

We are pleased the app is in the final stages of the NHS Digital Pathfinder programme, hoping for national roll out.

Sharing learning

To date we have hosted two K&M wide conferences for local care in 2018 and 2019 (the 2019 conference was attended by 200 people across 45 different health and care organisations). We also held a K&M wide conference for PCN Clinical Directors in September 2019 to co-design our support offer to PCNs.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Transforming urgent and emergency care

Nationally, and across Kent and Medway (K&M), we have an urgent and emergency care (UEC) system under significant pressure, but also one in the midst of profound change. The Long Term Plan sets out actions to ensure patients get the care they need, fast, and to relieve pressure on Emergency Departments (ED) New service channels such as Urgent Treatment Centres (UTCs) are being designated across England.

For those that do need hospital care, emergency admissions are increasingly being treated through same day emergency care (SDEC) without need for an overnight stay. This model will be rolled out across all acute hospitals and nationally the ambition is to increase the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on hospitals’ success in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. In partnership with local councils’ further action to cut delayed hospital discharges will help free up pressure on hospital beds.

In Kent and Medway, delivery against the four hour A&E standard is challenged. We have a specific set of priorities for transforming UEC (see right) that are complimented by our work to create a resilient primary care for the future and to implement our Local Care model. The transformation of UEC in Kent and Medway is dependent on all of these transformations coming together in a whole system approach to materially change how and where patients receive care. This level of change will take time to realise its full impact and is affected by the scale of workforce challenges across K&M. However, we are making good progress and our plans are supported by national bodies.

Urgent and Emergency Care will be led by the four Local A&E Delivery Boards (LAEDBs) geographically based around the four Integrated Care Partnerships in Kent.

Our strategic priorities for UEC are:
• **Urgent Treatment Centres (UTCs)** that are primary care led, open at least 12 hours per day every day, offering appointments that can be booked through 111 or GP referral, and are equipped to diagnose and deal with the most common ailments for which people attend ED
• **High Intensity User (HIU) services** will support patients who frequently attend A&E to resolve the reasons for their attendances, linking in with existing networks of support service including those from the third sector
• **Same Day Emergency Care (SDEC) units** will support each ED by providing rapid assessment and care to allow the majority of patients to return home the same day
• **Reducing delayed transfers of care (DTOC) and length of stay (LOS)** – improved hospital flow will have a positive impact on ED. Ensuring appropriate LOS and avoiding DTOCs involves a multi-faceted, system wide approach, working with primary care, community care and local authorities
• **Quality improvement initiatives in ED** aimed at streamlining processes and ensuring good access to expert opinion and diagnostics. Additionally, quality improvement initiatives aimed at improving flow throughout a hospital can help to release clinician time to support ED.
• **Embed a single multidisciplinary Clinical Assessment Service** within the newly commissioned 111 service to provide specialist services from a range of different professionals, encompassing physical and mental health
• **Developing our emergency care pathways for Mental Health**, including alternatives to ED such as crisis cafes and sanctuaries

Taking these actions will stem the rising increase in demand in EDs and ensure that EDs deliver safe and effective services, however, as a system it will remain challenging to consistently meet the four hour waiting standard over the five year period.
Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Improving planned care

Delivery across Kent & Medway against the national referral to treatment time standard has been challenged through 2018-2019. Recruitment and retention of key clinical staff has been, and remains, a critical challenge.

Delivery of reduced waiting times and improved pathways of care are key priorities shared by all partners within Kent & Medway. Providers and commissioners are working together to achieve national Referral to Treatment (RTT) expectations and those outlined in the national Long Term Plan. Delivery in ICPs will be enabled by key shared work across workforce, digital development and estates. ICPs will agree jointly-owned demand and capacity plans, incorporating utilisation of Independent Sector (IS) capacity. Continuous improvement in Emergency and Non-Elective Care management across Kent will enable more effective, planned and reliable use of NHS and IS Elective Care capacity.

In this context, CCGs and Trusts in Kent & Medway have been increasingly looking to work more collaboratively using a mix of approaches. These have varied across ICPs, from using new contract models such as an Aligned Incentives Contract (AIC) or large-scale Prime Provider contracts, to developing joint plans between CCGs and providers for outpatient transformation. Local partners are continuing to use these contract models and plans to focus on redesign of whole clinical pathways, better use of technology and expansion of collaborative contract models that encourage joint working. All four ICP areas have plans, agreed by providers and the CCGs, focused on the key Elective Care aims across Kent & Medway:

- Improving performance against 18 week Referral to Treatment (RTT), including working towards the utilisation of capacity alerts and the delivery of the 26 week programme
- Reducing the inconsistencies
- Addressing workforce pressures
- Ensuring the application of the Kent and Medway Referral and Treatment criteria (RATC) is applied consistently across all providers

Aside from speciality specific approaches, there are three main areas where we are working as a system:

**Workforce** - In each ICP, providers will cease to compete with one another for key clinical staff but will act collaboratively. Furthermore, providers across the ICS will recruit on consistent rates for permanent, temporary and locum staff.

**Transforming outpatients** - ICPs are working with local providers to manage waiting lists through their Transforming Outpatients workstreams which have seen the introduction of a number of one stop shop approaches and an increase in non-face to face follow-up clinics to improve use of capacity. In support of this a number of telephone clinics, nurse led clinics and the introduction of virtual clinics utilising Skype and video technology have been introduced. ICPs will also look to maximise their approach to offering advice and guidance functionality.

**Right Care and Getting It Right First Time (GIRFT)** - All the ICP systems are working collaboratively to agree opportunities identified through these national programmes and through Outpatient Transformation projects to ensure that shared, jointly-owned delivery projects are established. The opportunities, areas of focus and projects are specific to ICPs. ICPs are reviewing speciality patient pathways across a spectrum of planned care areas including, Ear, Nose and Throat (ENT), Neurology, Urology, Gynaecology and Gastroenterology.

Despite taking these actions, our performance against referral to treatment times and diagnostic waiting times remains challenged over the five year period. We intend to re-cast our diagnostic waiting times projection as part of a dedicated diagnostics review across Kent and Medway, which will drive up performance. In terms of referral to treatment time, we will initiate further work at both a system and an ICP level to identify further local opportunities as well as system level opportunities to treat patients across ICP areas. This will require system level oversight and assurance to track delivery and impact of initiatives.
Section Three

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability
Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

East Kent Transformation Programme

We are working with our patients, public and other stakeholders to look at how we develop local care and options for changing the way our hospitals in east Kent are organised (covering a broad range of services including emergency care, planned care, outpatients). The four East Kent CCGs have delegated authority for taking forward the transformation programme to a joint committee, which is supported by a robust programme infrastructure. We are taking forward this change programme because:

• We know that the way that our acute hospitals in East Kent are set up makes it difficult to provide consistently good care. For example people spending too long waiting in A&E and waiting too long for treatment. The current configuration of services is also not financially sustainable. By making changes we can improve the quality of care and establish a more sustainable model of care.

• We also know many people, including complex elderly frail patients, are often treated in the acute hospital setting when their needs are better met in an alternative setting of care. Both data analysis and bed audits undertaken by clinical teams have identified that this could be as many as one in three acute hospital beds being used to support individuals whose needs could be met through an alternative care model.

• We expect GPs, community staff, mental health, social care and other professionals to be working together in local teams everywhere in East Kent to provide more joined-up care for people with complex health needs. This is facilitated by the development of Primary Care Networks and the East Kent Integrated Care Partnership. In terms of acute care, all three main hospitals in East Kent are equally important for future care and need to be used so they provide care by working together, not as separate entities.

In order to achieve this change, we identified a long list of possible options for the roles of the three hospitals and assessed these against hurdle criteria, which were developed with clinicians, patients and the public, and other stakeholders. This resulted in two options emerging for the reconfiguration of hospital services as a medium list:

• Option 1: A major emergency centre at the William Harvey Hospital in Ashford, an emergency centre at the Queen Elizabeth the Queen Mother Hospital in Margate, and an integrated care hospital at the Kent and Canterbury Hospital.

• Option 2: A major emergency centre at the Kent and Canterbury Hospital with the other two hospitals becoming integrated care hospitals.

The detailed evaluation of the above two options is now in the process of being finalised. Both options were considered against five criteria:

• Clinical sustainability
• Accessibility
• Strategic fit
• Ease of implementation
• Financial sustainability.

The outcome of the evaluation will be presented to NHS England in a pre-consultation business case, seeking approval to move to public consultation in February. Ahead of submitting the business case, the proposal will be submitted in November to the South East Coast Clinical Senate for their consideration in order to inform NHS England’s assurance process.
Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

Stroke services

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme (SSNAP). Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway. We have significant challenges in workforce and our stroke services are not configured in line with evidence based national best practice.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person’s outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, both hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was, therefore, to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and have improved quality of life and independence.

Following the development of options, options appraisal and public consultation, the Joint Committee for stroke agreed that three HASU/ASUs would be established at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. We are committed to the proposals agreed by the joint committee following consultation and we are endeavouring to implement these proposals as soon as possible, pending the outcome of legal challenges.

Vascular

Approximately 13,000 patients in Kent and Medway receive vascular treatment each year, (about 2,600 specialised and 11,400 non-specialised) currently delivered by six hospitals, of which only two are specialised vascular centres providing the full range of complex vascular care.

The national standards state there should be 24-hour access to specialist care and a minimum catchment population of 800,000 to ensure doctors treat enough different types of vascular cases to remain expert. However, there is only a small pool of the specialist surgeons and interventional radiologists available and neither of our 2 vascular centres have sufficient skilled staff. Both centres serve a population of less than 800,000 as patients from Tunbridge Wells and Dartford, Graveshams and Swanley access services in London.

A long list of possible options has been considered for Vascular services in K&M. A clinical review of those options has been undertaken and the recommended option is for a single vascular arterial centre supported by other non arterial sites in K&M. The single arterial centre would be located at one of the two current vascular centres in east Kent and Medway.

Activity numbers are being finalised and will be presented to commissioners and the Joint Health Overview and Scrutiny Committee (JHOSC) A formal consultation is being planned for early 2020. This will also be linked to the wider reconfiguration work being undertaken in East Kent.
Section Three

Strategic Objective 1) – Improving care quality and patient experience

Delivering the NHS Long Term Plan in clinical and services areas
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer

The NHS Long Term Plan sets two bold ambitions nationally for improving cancer outcomes – that by 2028:

- 55,000 more people each year will survive cancer for five years or more
- 75% of people will be diagnosed at an early stage (stage one or two)

In 2017, 4,893 people died from cancer in Kent and Medway. The mortality rate from all cancers has been falling over time locally and nationally. However, cancer remains the leading cause of premature death in Kent and Medway, accounting for 29% of all deaths and 40% of deaths in those aged under 65-years in 2017. There were 10,359 new cases of cancer registered in 2016/17, the majority of which were in people under 75 years of age. This is a 13.5% rise from 9,127 in 2011/12.

In Kent & Medway, our overall 1-year survival rate across all tumours is 71.7% which is below the national average, and our 5-year survival rate is 46.7% also below the national average (CADEAS, 2019). The key to improved survival rates is to diagnose cancer earlier and, in Kent and Medway, our current early stage diagnosis rate is 51.8% with the expectation nationally that we achieve 75% by 2028.

The Kent and Medway Cancer Alliance brings together clinicians and managers from health, social care and other services to transform the diagnosis, treatment and care for cancer patients. These partnerships enable care to be more effectively planned across local cancer pathways. In advance of the anticipated establishment of a single CCG from April 2020, our existing CCGs have set-up a joint committee of clinical commissioning groups (JCCCG) to make joint decisions. It is the publicly-accountable governance forum driving forward our collective strategy for improving cancer care and outcomes.

Since the first meeting of the Joint Committee in March 2018, the following progress and improvements have been made:

- Significant improvement with 62 day cancer performance across K&M – the Cancer Alliance position has moved from 19 out of 19 alliances to 2nd out of 19 alliances for the latest reported month August 2019 (83.8%)
- Progress with implementation of streamlined diagnostic pathways in line with national recommendations for lung, colorectal and prostate Cancer which means patients are getting diagnosed faster
- Initiated a pilot in Dartford in July 2019 to support patients presenting with vague and indeterminant symptoms accessing diagnostic tests quicker
- In partnership with the South East London Cancer Alliance, we are working to improve cross-boundary issues and tertiary referrals to ensure safer and faster diagnosis for patients in the transfers of care
- As a result of the alignment of the STP with the Cancer Alliance, we have established a clear reporting and governance structure to ensure that timely decisions and clinical priorities are discussed appropriately
- Focused work with clinicians in our priority Tumour Site Specific Groups (TSSGs) to streamline patient pathways and improve services for our patients
- Agreed stratified pathway protocols for breast, prostate and colorectal cancer to support the personalised care agenda
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer continued

Our strategic priorities for improving cancer care and outcomes are:

- **Prevention** – as over half of cancers can be prevented, prevention is a critical focus of our cancer strategy, with a focus on smoking prevention, diet, obesity, alcohol consumption, and HPV vaccination.

- **Screening** – we will focus on increased uptake of screening programmes to support early diagnosis, in particular bowel due to the current variation across our CCG geographies and the strong evidence base that early diagnosis of bowel cancer has a significant impact on survival rates.

- **Earlier and faster diagnosis** – we have a multi-faceted approach including awareness campaigns, a primary care education strategy, reviewing and improving our diagnostic service provision (for both cancer and diagnostics broadly, recognising that issues with diagnostics do not just impact patients with cancer but with a wide range of conditions).

- **Treatment and care** – our strategy includes a number of strands to ensure that patients can access appropriate and specialist treatment, including specialised surgical care available alongside modern radiotherapy and chemotherapy services.

- **Personalised care and support** – we will ensure that all patients have access to personalised care including a care plan, access to health and wellbeing information and support, stratified pathways of care, and provision of psychological support.

By 2023/24, Kent and Medway will have:

- Significantly increased uptake and coverage of the National Cancer Screening Programmes.

- Networked Diagnostic Services for streamlined turnaround and reporting of tests.

- Implemented the Faster Diagnosis Standard so that patients get a diagnosis of cancer within 28 days of referral by a GP (85%).

- Implemented Targeted Lung Health Checks based on national piloting and recommendations.

- Established a Radiotherapy Network with colleagues at Guys & St Thomas’s NHS Trust which has fully implemented the new national service specifications.

- Ensured that all cancer patients will have access to personalised care, including needs assessment, a care plan and health and wellbeing support and provision.

- Extensive genomic testing available to patients who are newly diagnosed with cancers.

- Developed plans with ICPs to improve early cancer diagnosis of patients in their localities and significantly increased the number of people diagnosed at stages 1 & 2 – by 23/24 c61% of cancers will be diagnosed at stages 1 & 2.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health

We all have mental health and, just like our physical health, our mental health goes up and down over time. We experience different things in life, our circumstances change, and we move through different stages of life. In fact, over half of us will have a problem with mental health during our lifetime and about a quarter of us do at any one time. So, just like we look out for our body, we need to look out for our mind.

Common mental health problems, such as depression and anxiety, are increasing both nationally and here in Kent and Medway. The co-existence of mental health problems with other issues such as smoking and alcohol misuse is also increasing. People with a serious mental health illness die on average 25 years earlier than people without a mental illness.

Prevention, early diagnosis and support for children is essential, because half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s. Our work to help prevent MH problems in children and provide earlier diagnosis and support, needs to be linked to a wider set of actions on deprivation, adverse childhood events and other risk factors for MH problems in children. The NHS and education will need to work even more closely in the future, including mental health support teams in schools.

In Kent and Medway, specialist mental health services for adults and older people are delivered by Kent and Medway NHS and Social Care Partnership Trust (KMPT) and for children and young people by North East London NHS Foundation Trust (NELFT). Additionally, KCC and Medway Council provide MH social work and AMHP provision, as well as commissioned social care mental health services. We also have a range of IAPT providers and additional primary care mental health practitioners. These providers are coming together to form a K&M Mental Health Collaborative.

Since 2016, we have had in place a system programme for Mental Health within our Kent and Medway Sustainability and Transformation Partnership. This programme has focused on delivering the Five Year Forward View for Mental Health, promoting mental wellbeing, and integrating physical and mental health care. Our Mental Health Workstream Oversight Group meets monthly and comprises a wide range of partners including Healthwatch, CCG commissioners, Local Authority social care mental health and public health representatives, KMPT and NELFT.

Progresses and successes to date include:

• A reduction in the rate of death by suicide
• A higher than the national target number of CYP with a diagnosable mental illness accessing specialist mental health services
• We significantly expanded specialist community perinatal mental health services, serving pregnant women and new mums
• A higher than the national expected proportion of people recovered after receiving IAPT / primary care psychological therapies
• Nearly ¾ of people referred with suspected first episode of psychosis engaged with the Early Intervention in Psychosis service within two weeks of referral
• All adults who were acutely unwell were placed in local acute inpatient mental health beds, except women needing psychiatric intensive care
• All CCGs met the Mental Health Investment Standard for 2019/20
• We have secured so far in 2019/20 c£5m Central Transformation Funding for local community crisis care services, Liaison Mental Health Services, and schools-based Mental Health Support Teams
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health continued

Our Plan

We will support Kent and Medway’s population to have good habits for looking after our minds as a normal part of living a healthy life. Where children, young people and adults have problems with their mental health or a mental health illness, we will ensure that the right mental health care is simple to access, close by. Our overriding principle for mental health support is ‘no wrong door’ – that staff across health and social care will feel comfortable talking to a person about mental health and be able to signpost to the right care and support.

We are taking up the big challenges to give mental health equal priority to physical health, address equity of health outcomes for people with a mental illness, reduce the treatment gap in mental health care, and have excellent mental health services.

Our strategic priorities are:

• Improving the mental health and wellbeing of the population including developing resilience – we will implement a Mental Health Wellbeing Campaign
• Ensuring ‘no wrong door’ for accessing mental health support – through partnership working and integration we will ensure that anyone who needs support for their mental health needs will be able to access it
• Developing a working collaborative of K&M Mental Health service providers to optimise the mental health contribution to PCNs and ICPs
• Developing and implementing a Mental Health Impact Assessment to carve mental wellbeing into local NHS policy, pathways redesign and complex change delivery at the outset

• Increasing the proportion of children and young children accessing timely support for their mental health or in relation to a mental illness
• Improving mental health service outcomes for young people aged 18-25 years
• Working to increase and sustain positive outcomes for people with common mental health illness
• Transforming core community mental health services so that people with lived experience report them as ‘services without borders’
• Addressing the inequity in health outcomes for people with severe mental illness, especially targeted actions for improved physical health
• Enhancing urgent and emergency pathways for people with a mental illness, including community-based alternatives to A&E and more tailored NHS 111 and Ambulance services
• Ensuring that 75% to 100% of our general hospitals with an A&E department have on-site liaison mental health services that satisfy national ‘Core 24’ standards
• Improving dementia diagnosis rates and the range of services available to support people with dementia and their families and carers
• Increasing community support (including out of hours) to ensure that people with dementia can remain in their usual place of residence at a time of crisis. This will include support to care homes

To support the transformation of mental health services, CCG planned investment this year is £278m and will continue to meet Mental Health Investment Standard in future years.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal

Giving babies and children a healthy start in life is one of our key priorities. Our approach to maternity and neonatal care includes a focus on prevention and promoting healthy behaviours, continuously improving neonatal care, and supporting women during pregnancy and beyond.

• The rate of smoking in pregnancy in Kent and Medway is 14.2%, with the aim to reduce this to 6% by 2022. Stopping smoking is the single most important change a woman can make to avoid unnecessary complications. Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birthweight and sudden unexpected death in infancy. It also increases the risk of infant mortality by 40%

• One in five pregnant women in Kent and one in four in Medway were obese in 2017, a 1% and 2% increase from 2015. Obesity during pregnancy impacts on the infant’s weight in childhood and increases the infant’s predisposition to type 2 diabetes in childhood.

• Infant mortality has been decreasing in Kent and Medway over the past 15 years, however, over the last six years in Kent this has increased from 3.5 per 1000 to 3.8 per 1000 while rates in Medway remain unchanged at 3.7.

• 1 in 3 women will experience urinary incontinence after childbirth, 1 in 10 faecal incontinence, and 1 in 12 pelvic organ prolapse. Physiotherapy is the most cost effective intervention for preventing and treating these conditions. There is a commitment across Kent and Medway to improve access to postnatal physiotherapy, ensuring that all women have access to multidisciplinary pelvic health clinics and clear referral pathways when required.

• UK breastfeeding rates at 6-8 weeks compare unfavourably with other countries in Europe. In Kent and Medway we have variation in breastfeeding rates across the county. We will develop and implement a tailored breastfeeding strategy to ensure that women have the advice, information and support they need, when they need it, and ultimately improve local rates of breastfeeding initiation and continuation. Improving the UK’s breastfeeding rates would have a profoundly positive impact on child health.

In February 2016 the national Better Births Maternity Review* set out a compelling future for maternity services: we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care. Achieving this requires local leadership and action and this is achieved by commissioners, providers and service users coming together to create a Local Maternity System (LMS) to deliver local transformation. The LMS is a collaborative of organisations and partners. The LMS Maternity System Transformation plan has been approved by the NHSE Regional Team and was endorsed by the K&M STP prior to submission. In addition, the 0-25 Health and Wellbeing Board in Kent and the Health and Wellbeing Board in Medway also endorsed the plan as the respective Boards are committed to improving health in pregnancy and early childhood.

Our strategic priorities for the next five years are:

• Safer maternity care
• Tackling smoking in pregnancy
• Delivering continuity of carer
• Improving perinatal mental health services
• Access to maternity records and digital support

* https://www.england.nhs.uk/mat-transformation/
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal continued

Safer maternity care

The second version of the national care bundle includes a greater emphasis on continuous improvement and addresses variation by bringing together five key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. The priorities for the Kent and Medway LMS are:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
- Raising awareness of reduced foetal movement (RFM)
- Effective foetal monitoring during labour
- Reducing preterm birth from 8% to 6% by 2025

There is significant commitment in this second version of the Saving Babies’ Lives Care Bundle to meet the national ambition of 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025.

Smoking during pregnancy

The new Tobacco Control Plan 2017-2022 defines an ambition to achieve a ‘tobacco free generation’ by 2022. To realise this vision, we must harness our efforts to ensure babies and children are not exposed to tobacco use. The Tobacco Control Plan seeks to further reduce maternal smoking in England to 6% or less by 2022. Our work will involve working with Public Health colleagues and our STP Prevention Programme on smoking cessation during pregnancy. We will target interventions in communities with the highest maternal rates.

Delivering of continuity of carer

Continuity of carer is associated with significant improvements in the safety, personalisation and experience of maternity care including:

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks.
- 24% less likely to experience pre-term birth
- 15% less likely to have regional analgesia and 16% less likely to have an episiotomy

In K&M, the LMS are working to ensure that most (>51%) women are receiving continuity of carer by March 2021. All Trusts are developing and implementing Continuity of Carer pathways.

Perinatal mental health services

The NHS Long Term Plan includes a commitment to establish Maternity Outreach Clinics to integrate maternity, reproductive health, and psychology therapy for women experiencing mental health difficulties. This community based model of care will compliment specialist inpatient services and psychological therapy services. The LMS in K&M is bidding to national bodies to be an early implementer for this new community based care. By 23/24, some 2,000 women will receive perinatal MH support.

Access to maternity records and digital support

Three of our four Trusts have received funding from NHS Digital to enable women access to their own maternity records. The LMS is funding the development of electronic personal health records at the remaining Trust to ensure that all women have this option. The LMS will be participating in work at the level of Kent, Surrey and Sussex clinical network to ensure that women are guided to a small number of recommended apps to form their digital toolkit. Via this toolkit, women will be able to express their choices and receive personalised care.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Children and young people (CYP)

Across Kent and Medway, whilst there are some exemplar services in place for CYP, there is not yet an over-arching strategic plan for the commissioning and delivery of Children’s Services. As a result, the level of service delivery and clinical/care outcomes vary considerably and are a material contributory factor to the inequalities children and young people experience across the county.

Current challenges

- The recent CQC/Ofsted Inspection of services for children with Special Educational Needs and Disabilities in Kent identified areas of significant weakness. Medway’s inspection also identified similar challenges
- There is a high number of women who smoke during their pregnancy (13.8% in Kent and 17.1% in Medway)
- Children in their early years do not have adequate vaccination coverage
- 1 in 5 primary school children are obese or overweight
- The rate of teenage pregnancies is above the regional average in Kent and Medway
- Around 10% of children and young people have a mental health issue and there is a particular concern for looked after children
- 12% of children in Kent and 17% of children in Medway have a special educational need
- There is minimal local provision of cancer care and hospice care for children

Action taken to date

A Joint Committee of K&M CCG’s has been established to oversee improvements. The Joint Committee supported the immediate priorities to oversee the delivery of the Kent and Medway SEND action plans including the imminent Medway re-inspection and to support the development a Kent and Medway multi-agency plan for Children and Young People (0-25). They recognised that this will identify further system priorities and will be developed in line with the Long Term Plan.

We have produced SEND Improvement Plans which are agreed with CQC and Ofsted which focus on 5 areas of improvement:
1. Parental confidence, engagement and coproduction
2. Inclusive practice, outcomes, progress and attainment of children and young people
3. Quality of education, health and care plans
4. Joint commissioning and governance
5. Service provision

Next Steps

The development of a system-wide priorities document by December 2019 which will describe system:
- Principles
- Priorities
- Strategic Aims and Objectives
- Success Measures
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism

The rate of children with the autism in Kent and Medway is significantly higher than the England average. It is also higher than Kent’s statistical neighbour Essex. The rate of children with ASD known to schools is 19.7 per 1,000 in Kent and 20.5 per 1,000 in Medway. The prevalence of the primary SEN type ASD is much greater amongst children and young people with SEN support (9.7% in Kent, 5.7% in England) and amongst children and young people with an Educational Health Care Plan (EHCP) at 39.7% in Kent, and 28.2% in England. We also know that 24.5% of the 14-18 year olds with a Learning Disability are prescribed hypnotic medication without having a diagnosis of a serious mental health disorder and 15.7% are prescribed anti-psychotics.

In February 2018, an analysis of Autism & ADHD data confirmed, within the adult population of Kent, 14,600 people are estimated as being undiagnosed for Autism (7,118) and or ADHD (7,482). Medway data for these cohorts showed within the adult population of Medway 8,061 people are estimated as being undiagnosed for Autism (1,001) and or ADHD (7,060).

Kent & Medway adult’s data evidences a significant undiagnosed population when compared to expected prevalence rates for this cohort. Therefore, the demand for adult diagnostic service provision is unlikely to diminish over the next 5-10 years.

Only around 40% of our learning disability population across Kent and Medway, registered with a GP and aged over 14, years are accessing annual health checks and for our adults, aged 19 and older, 20.8% with a Learning Disability are prescribed a hypnotic without having a diagnosis of a serious mental health disorder and 25% prescribed anti-psychotics.

Our service model for LD & Autism

Commissioning

Learning Disability services for Kent and Medway have been commissioned via a Section 75 Partnership Agreements between all Kent CCGs and Kent County Council, and between Medway Council and Medway CCG. There is also an established Integrated Commissioning Team for Kent Learning Disability, and an integrated Pooled Budget, which are hosted by Kent County Council. From 1st April 2019 the scope for the Kent Partnership Agreement was expanded to include Autism, and it was clarified that the current Section 75 Agreement is not age limited. We have also developed and agreed a plan to stop the over medication of people with a learning disability (STOMP).

Kent and Medway health and social care are currently working together to review and jointly commission a co-designed neuro developmental pathway, recognising the gaps in community service provision for people with autism that result in poorer outcomes for individuals and their families and have adverse economic consequences for the health and social care system.

For clients across Kent and Medway with Learning Disability or autism who are currently accessing in-patient care and are part of the previously named Transforming Care programme, there is a dedicated programme, with a system wide SRO to focus on recovery of the current inpatient numbers. Whilst the numbers of CYP inpatients is within acceptable limits, improvements to the admission and discharge processes are being made with specific reference to reducing both the number of inpatients and out of area admissions. The numbers for adult inpatients are far in excess of that expected for our population and a recovery plan is in place which focuses on discharge planning to deliver the 19/20 trajectory of 63 adults, reducing long lengths of stay and out of area placements, mobilisation and delivery of community and the forensic infrastructure business case and CTR/CeTR assessment capacity.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism continued

Learning disability and autism services are currently provided by a range of providers including:

- Kent & Medway NHS & Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Medway Community Healthcare
- East Kent Hospitals NHS Foundation Trust
- North East London NHS Foundation Trust
- Kent County Council has a well-established specialist adult social care ‘Autistic Spectrum Conditions’ (ASC) team covering Kent. Providing statutory assessments, care and support packages for those eligible under the Care Act 2014. The ASC team has recently redesigned its service in preparation for integration with health in 2020 and it is anticipated that the service will expand its specialisms to include other neurodevelopmental conditions such as ADHD. Medway have already changed their social care model of delivery to a generic function but retains specialisms amongst its workers
- The inpatient secure and non-secure capacity is provided by a range of NHS and private specialist providers. In addition, the PBS Framework enables access to 14 Providers who successfully showed, through the tender process, that they have, or are, developing the right approaches, competencies and capability to support people with the most complex needs. Providers with the right skills and organisational infrastructure are key to co-producing solutions for people with complex needs, particularly those with learning disability and/or autism within the remit of need defined by the Transforming Care Programme

Priorities for improvement

- To review and co-design a new neuro developmental pathway for Kent & Medway by April 2020
- To ensure people with Learning Disabilities access annual health checks and screening to support improved physical health by December 2020 with 80% people receiving
- To eliminate the back log of Learning Disabilities Mortality Reviews and to ensure learning informs future commissioning plans by October 2020
- To ensure the appropriate prescribing of anti-psychotic medications for people with Learning Disabilities by April 2020. The current uptake is low with the NHS plan target being 75%
- Provide more community based and forensic support for people with LD & autism who are at risk of, or are, accessing inpatient secure care by December 2020
- To significantly reduce the number of CYP and adults requiring in-patient secure care by 2025 in line with national expectations
- To better develop the specialist community care market via the PBS framework which is ongoing
- To ensure K&M delivers the necessary CTR/CeTR capacity
- To develop host commissioner arrangements for secure inpatient facilities by April 2020
- Provide more personalised care for people with LD & autism and their families, listening to their care needs and their life goals by working with clients and families with learned experience
- To work specifically with main stream education providers to enable them to provide timely support to people with autism and ADHD
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

**Stroke**

Stroke prevalence across Kent and Medway is around the national average of 1.7% with some areas of higher prevalence. It is estimated that there are currently nearly 1.2 million adults across the area that have two or more unhealthy lifestyle behaviours, such as smoking and obesity, which increase their risk of avoidable disease and disability such as stroke. Each year, an average of 3,054 strokes are treated for patients in the Kent and Medway catchment area. Stroke care accounts for about 4.5% of total spending on healthcare in Kent and Medway with an average of £7,000 per year spent on people who have had a stroke, (compared to an average £2,700 per year for those who have not).

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme. Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person’s outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was therefore to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and with improved quality of life and independence.

Our five year strategic priorities for Stroke include:

- Taking a range of preventative actions on diet, physical exercise, obesity and smoking as outlined in section 5 of this plan
- Implementing targeted interventions in primary care such as detection and monitoring of Atrial Fibrillation (AF) to reduce the number of AF related strokes
- Developing a stroke prevention business case, that will incorporate both of the above
- Implementing the model of hyper acute stroke units and acute stroke units across K&M, in line with national policy
- Support the development and delivery of an intra-arterial thrombectomy centre for stroke patients within Kent and Medway (currently, thrombectomy is not consistently available and there is a need to travel outside of the county for intervention compromising the benefits associated with early recanalisation)
- Developing a rehabilitation business case to ensure that community services meet the national and local specifications and to reduce variation
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Diabetes

In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% are adults are living with Type 2 diabetes. Approximately 75% of people with diabetes go on to develop cardiovascular disease. Prolonged exposure to raised blood glucose levels can also damage the eyes, kidneys and nerves. Diabetes is the leading cause of blindness in people of working age, the largest single cause of end stage renal failure and the second most common cause of lower limb amputation. This places a significant burden on health and social services. Life expectancy is reduced, on average, by more than 20 years in people with Type 1 diabetes and by up to 10 years in people with Type 2 diabetes. More recently, a greater number of children are being diagnosed with Type 2 diabetes, as a secondary condition to being overweight. Increasing physical activity, maintaining good diet and reducing the obesogenic environment are key strands of our prevention strategy (see section 4). These preventative actions will be critical to reducing the number of people who develop diabetes.

Current service provision

Historically, variation has existed in the commissioning arrangements for diabetes services across Kent and Medway which has led to variation in care and outcomes for people with diabetes. A key priority is addressing this variation in diabetes prevention, management, treatment and care/support, with a focus on achieving the three nationally recommended treatment targets. Addressing variation and meeting the national standards is the purpose of the Diabetes Oversight Group. This group membership comprises of STP diabetes Leads including Clinical, STP Prevention leads, 8 CCG commissioning leads, acute provider and community provider leads in diabetes, Public Health, Diabetes UK, voluntary sector and patient representative. The purpose of the group is to oversee the implementation of the NHS Long Term Plan for diabetes.

Our five year priorities

Kent and Medway’s ambition for diabetes can be broken down into three overarching priorities:

• Prevention of type 2 diabetes – Increase referrals and attendance at the National Diabetes Prevention Programme (NDPP). We will work with practices and all partners across the STP to ensure there is sustained referrals and understand the barriers/issues to referral rates and subsequent attendance. We will also develop the opportunities to improve referrals through the Primary Care Networks. By 23/24, some 6,500 people will have been supported by the Diabetes Prevention Programme.

• Reduce the variation in commissioning – A Kent and Medway CCG would set Integrated Care Partnerships with clear standards to be achieved supplemented with national pathways and support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools. This will include expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes. We will procure a K&M Diabetes Education Service that will increase access and attendance to structured education programmes

• Reconfigure diabetes services – Developing primary care/community services, improving interfaces between primary/community and secondary care ensuring resource/work force are aligned accordingly and developed and ensure diabetes alignment with the wider CVD LTP deliverables. We will enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices to minimise their risk of future complications
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan in clinical and service areas

Cardiovascular disease (CVD)

The NHS Long Term Plan identifies cardiovascular disease as a clinical priority and the single biggest condition where lives can be saved by the NHS over the next 10 years. The Plan sets the ambition for the NHS to help prevent over 150,000 heart attacks, strokes and dementia cases over the next 10 years and outlines how we, and partners in the voluntary and community sector and in other national organisations, will meet this.

The national CVD Prevention programme has been set up to develop targeted interventions to optimise care by maximising diagnosis and treatment to minimise both individual risk factors, and population risk.

In K&M, although prevalence of CVD is lower than the England average, it is the biggest cause of premature mortality and a significant cause of disability in K&M. The number of hospital admissions in K&M for heart failure is increasing, particularly in Medway where the gap to England is also increasing.

Our five year priorities

1) A step change in our prevention efforts including rolling out the national CVDPrevent initiative

The chapter on prevention outlines our ambitions and plans to prevent or mitigate some of the risk factors for cardiovascular disease, smoking, obesity, alcohol, lack of activity and high salt consumption. Our aim is to ideally prevent bad habits forming but also to identify people whose habits or behaviours would benefit from and be amenable to an intervention that will decrease their future risks. Our approach is to work with people to understand their personal risks and what could be done to reduce these, taking a holistic person centred approach

2) Identification of patients at risk followed by targeted interventions

We will be supporting the HealthChecks programme to both ensure that it is being accessed and is accessible to those most at risk, and that those identified risks are then acted upon. We will also be working with pharmacists and pharmacies to support them in identifying patients at risk, for AF though the use of AliveCor, for BP through the use of BP monitoring and for Cholesterol through point of care screening.

We are already piloting an audit in primary care to support the CVDPrevent initiative in some parts of Kent & Medway. This provides prompts in the patients’ clinical record which are visible during a consultation, reports at a practice level identifying individual patients and reports at a system level showing performance at a practice level. The plan is to have this aligned to the CVDPrevent rules once they are finalised and role out this support to primary care across the whole of Kent and Medway.

3) Monitoring the impact of interventions

The primary care CVDPrevent audit will also help us improve identification and management of patients with risk conditions, and allow us to monitor near real time improvements and the impact of interventions. We would use the Kent Integrated Dataset (KID) as a means of monitoring this on a near real time basis, and identifying where interventions should be targeted.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Respiratory disease
Respiratory disease affects one in five people in England and is the third biggest cause of death, with hospital admissions for respiratory disease remaining a major factor in the winter pressures faced by the NHS.

Nationally, there is a correlation between incidence and mortality for respiratory disease with social deprivation due to higher levels of smoking, poor housing, and higher levels of air pollution. Kent and Medway is recognised as having several areas of high deprivation.

One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. For under-75 mortality due to respiratory disease, Kent on average, fares better than England, though areas such as Thanet and Medway are comparatively worse.

The three cornerstones of the Long Term Plan for respiratory are:

- Prevention
- Earlier diagnosis
- Pulmonary rehabilitation

Community Respiratory services are provided across Kent and Medway (with the exception of Dartford, Gravesham and Swanley) delivering care at home, in community clinics and in acute hospitals dependent on need. They also provide an "unwell service" which offers, where appropriate, same day appointment, helping to treat acute episodes promptly and preventing unnecessary admission to hospital.

There is some inconsistency in provision across Kent and Medway, for example community respiratory as above. There are also challenges in workforce, with a lack of staff and poor retention. There is a lack of access to smoking cessation services and poor standardisation and interpretation of spirometry.

Our ambition for respiratory

Key actions to achieve the ambitions for respiratory:

*Reduction in smoking rates across all categories* – including children, pregnant women, and older age, through better education to prevent initiation of smoking and improvement in smoking cessation services

*Improvement in diagnosis and identification of respiratory disease* by case finding, improvement in spirometry services and interpretation, as well as encouraging ‘at risk but well’ patients to engage with opportunistic spirometry, brought in via community screening sessions

*Improved access to pulmonary rehabilitation services* by increasing referral rates, including through QOF, increasing places for pulmonary rehabilitation courses and working towards alternative means of engaging patients who work or who are otherwise unable to attend courses

*Ensuring 100% of patients within K&M are able to access community respiratory services*, including during exacerbations, providing long-term management, psychological support, education and palliative care in addition to smoking cessation, pulmonary rehabilitation and pharmacological treatment.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care in Kent and Medway

We live in an ageing society. In England around 500,000 people die each year. This will increase by 15% by 2035. The number of people with long term conditions (LTCs) is rising (by 2025 number of people with at least one LTC will rise from 15 million to 18 million; those with two or more LTCs will rise from 5 million to 6.5 million), leading to more complex end of life care for some of these patients.

In 2017, 46% of people died in hospital in England and 68% were admitted to hospital in the last 90 days of their life, with 7.4% of those having 3 or more admissions. Whilst data for Kent and Medway shows a downward trend with 43% dying in hospital, admittance to hospital in the last 90 days of life was higher than the national average in 6 out of 8 Kent and Medway CCGs.

End of Life and palliative care in Kent and Medway is provided by a variety of specialist, acute, community, primary care, and voluntary sector organisations. There are eight specialist hospices. Six of these (Pilgrims Hospice Canterbury, Pilgrims Hospice Margate, Pilgrims Hospice Ashford, Heart of Kent hospice, Hospice in the Weald, and Wisdom hospice) provide services solely for adults. Ellenor Hospice provides services for all ages and Demelza Hospice is a specialist children’s hospice. Community care is provided by a range of NHS and voluntary organisations, and includes community nurses, district nurses, specialist nurses, health care and therapy assistants.

Our ambition is for everyone approaching end of life to receive high quality care that reflects their individual needs, choices and preferences. We strive to provide high quality and equitable end of life and palliative care to everyone, regardless of their life limiting condition, care setting, social circumstances, lifestyle choices, culture or religion.

Challenges for End of Life Care

The challenges in Kent and Medway reflect many of those experienced nationally. A lack of standardised care planning documentation and shared IT platforms can result in confusion among providers about treatment plans and ceilings of care, potentially leading to patients receiving poor care and ultimately a negative experience. Similar issues occur through the lack of a standardised electronic care record. There is a lack of standardised documentation both nationally and at a system level. This can create difficulties for patients and their carers, particularly at points of transfer of care. Patients at end of life frequently transfer between acute, primary and community sector as well as care homes and hospices.

There is a challenge to ensure all staff are adequately trained to enable them to identify and care for patients approaching the end of life and to ensure there is an understanding that end of life treatment encompasses the last 12 months of a person’s life, rather than the last few weeks or days. In order to support this, it is vital end of life care is embedded into primary and community care. We need to address inequalities in end of life care, for those with learning disabilities, working with specialist commissioning to support prisoners, travellers, LGBTQ+ and the homeless.

End of Life care for children and Young People

Rates of life limiting and life threatening conditions (LLCs) amongst children and young people have significantly increased in K&M since 2014/15 whilst death rates from LLCs have been declining since 2008. The need for services is growing year on year owing to advances in diagnosis and management of LLCs. The national picture can also be seen in Kent and Medway where a complex and fragmented system is sometimes ill equipped to cope with this, particularly in the provision of 24 hour EOL care.
Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care continued

Our priorities for the next five years

We recognise the need for a strategy and implementation plan for Kent and Medway and will be working with colleagues to establish this. In the development of the strategy we will consider the following areas:

• Expansion of services for children with life limiting conditions and terminal illness, in line with the national priority of the LTP and as indicated by our K&M Health Needs Assessment, reducing unwarranted variation and the delivery of care closer to or in the child’s home

• Review of provision of home based EoL care, reflecting our commitment to support people to be cared for and die in their preferred place including support for their informal carers

• Standardisation of care and support planning and documentation across providers and wider organisations involved in a person’s end of life care to include advance care planning and tools such as RESPECT

• Working more closely with voluntary sector to maximise the value that they can bring to EoL and bereavement care
Section Four

Strategic Objective 2) – An increased focus on population health and prevention
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health

Population Health is an approach aimed at improving the health of an entire population. The concept of population health is not new: there is existing knowledge across the system and specific expertise within our Public Health teams. However, the term ‘population health’ helps to create a collective sense of responsibility across partner organisations and individuals, in addition to public health professionals. Population health management (PHM) uses data to guide the planning and delivery of evidence-based interventions to achieve maximum improvement of population health within the resources available.

The King’s Fund defines population health as having four key pillars rooted in what drives our health, and what can improve and maintain it over time. Population health can only be delivered through a coherent, joined up system. A population health system recognises the interconnectedness of the four pillars of population health management, maximising the activity in the overlapping areas, as well as ensuring a balance of activity across the four pillars.

Defining population health management in Kent and Medway

The Kent and Medway system have been working on aspects of PHM for a number of years, such as the Kent Integrated Dataset (KID). This work has been further supported by the STP. However, a programme to develop a Roadmap for Population Health Management in Kent and Medway has now been established as part of the development towards an Integrated Care System. The programme will involve all parts of the Integrated Care System, including commissioners, ICPs, PCNs, upper tier Local Authorities as well as Public Health England and the Kent, Surrey and Sussex Academic Health Science Network.

Case studies from the NHSE/I Population Health Development Programme show that one of the first steps on the roadmap to embedding a PHM approach is to develop a consistent understanding and vision of PHM across place and system leadership. Nationally, PHM is defined as improving population health by “…data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactibility modelling to identify local ‘at risk’ cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.”

Locally, we aim to develop a simplified definition that resonates with our stakeholders, patients and the public, and broaden its scope, recognising that clinical care and health behaviours account for only 50% of health outcomes. Our Kent and Medway definition, agreed with our local stakeholders, will reflect our collaborative approach to PHM, explicitly incorporating prevention and improving well-being. This definition will be underpinned by a vision and values statement, articulating our aims for PHM and aspirational future state.
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health continued

Maturity and progress to date

An initial assessment against the population health management maturity matrix indicates that overall, Kent and Medway’s arrangements are ‘Developing’ against the infrastructure, intelligence and interventions domains. In some areas of the Intelligence domain, we are ‘Maturing’, for example: the development of the Kent and Medway Care Record using linked data to segment and stratify the local population starting to map and understand the system’s analytical workforce.

There is the potential to rapidly move to ‘Maturing’ overall once specific Infrastructure and Intelligence elements are agreed or established, e.g., joint data controller arrangements, linking remaining care datasets within Kent Integrated Dataset or its successor. As part of the programme, we will also consider the development of system-wide leadership behaviours (i.e. supporting action across the four pillars of population health) and workforce development requirements.

The maturity assessment will be adapted and continue to be tested with stakeholders to ensure that it accurately reflects our progress, in order to helpfully inform the development of our PHM arrangements.

Kent and Medway is one of the most advanced areas in the country in linking longitudinal patient and social care user data across a number health and care settings. This gives us an opportunity to understand in depth the health of the Kent and Medway population, including an ability to segment and stratify our population to identify "at risk" cohorts and assess the impact of proposed strategies. Whilst we have developed a range of leading edge approaches around the capture and linking of data we are yet to fully optimise the benefits and impact of these approaches. As part of becoming an Integrated Care System with a focus on population health management, we will need to develop and maximise our infrastructure and system architecture to enable full realisation of person level linked data.

Support for Primary Care Networks

The 2019/20 planning guidance states that ‘STPs/ICSs must ensure that Primary Care Networks (PCNs) are provided with primary care data analytics for population segmentation and risk stratification…to allow Primary Care Networks to understand in depth their populations’ needs for symptomatic and prevention programmes including screening and immunisation services’. Kent and Medway’s Public Health Teams are in the process of drafting PCN health profiles to support local understanding of health and care needs. Medway Council’s Public Health team is also producing PCN-level children and young people’s profiles to support work on developing a system-wide, intelligence-led children and young people’s strategic plan.

Next steps

By April 2020, we plan to have an agreed Population Health Management Strategic Plan in place, which outlines our PHM arrangements at each level of the system, the infrastructure, intelligence and intervention capabilities that will support these arrangements and how we will continue to strengthen and enhance population health management during the lifetime of this Strategy Delivery Plan to become a ‘thriving’ population health system.

Our immediate priorities for 2019/20 are to:

Q3:
• Agree local PHM definition and supporting vision and values statement
• Establish population health management as a system-wide work programme, with agreed governance arrangements and dedicated resources
• Agree Analytics Strategy
• Complete PCN-level health and children & young people’s profiles

Q4:
• Run further stakeholder workshops to inform strategic plan development
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention

The importance of prevention in impacting health and wellbeing

The Kent and Medway Health Needs Assessment, produced jointly by Kent County Council and Medway Council, sets out a compelling case for the role of prevention in supporting the needs of our population.

There are many major health conditions that are preventable and amenable to targeted interventions, particularly those that are linked with smoking, diet (including salt consumption), obesity, alcohol and substance misuse, and air pollution. Some headlines from the K&M Health Needs Assessment from a prevention perspective are shown below:

- **Cancer** - Cancer remains the leading cause of premature death in K&M. In 2017, 4,893 people died from cancer in K&M, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening and earlier diagnosis. Continued preventative action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer.

- **Cardio Vascular Disease (CVD)** - CVD causes a quarter of all deaths in the UK and is the largest cause of premature deaths in deprived areas. It is the single biggest area where the NHS can save lives as CVD is largely preventable through lifestyle changes, particularly diet and exercise. The estimated prevalence of CVD in people of all ages is 9.9% in Kent and 8.3% in Medway and, although this is lower than the England average (9.5%), CVD is still the biggest cause of premature mortality and a significant cause of disability in Kent and Medway.

- **Respiratory disease** - One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. There is a significant link between respiratory disease and deprivation, associated with smoking, poor living environments and air quality. While K&M fares better than England as a whole, we have pockets where under 75 mortality due to respiratory disease is significantly higher than the England average - in Dover, Thanet, Swale, and Medway.

- **Stroke** is the fourth single leading cause of death and the single largest cause of complex disability. There is a strong evidence base for the case finding of atrial fibrillation and subsequent anti-coagulation treatment in the prevention of stroke. Unhealthy lifestyle choices such as smoking and obesity increase the risk of stroke.

- **Type 2 diabetes** is increasing in prevalence and is often associated with being overweight. It can have devastating effects on the eyes, kidneys, nerves, and limbs. In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% of adults with Type 2 diabetes.

- **Mental Health** – there is a strong case for prevention in Mental Health. Half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s. Efforts to positively impact the mental health and wellbeing of children need to considered alongside wider actions relating to deprivation and adverse childhood events such as family breakdown. Suicide rates in K&M are higher than the national average, particularly in men, and there are large co-occurrences with substance misuse and self-harm.

- **Frailty and multi-morbidity** – Frailty doesn’t just affect the elderly and having more than one long term condition increases a person’s risk of becoming frail. Additionally, ageing does not necessitate becoming frail. Therefore, targeted action on maintenance of wellbeing and independence is essential. There also needs to be a greater alignment between interventions for frailty and dementia.
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Health Inequalities in Kent & Medway

Health inequalities are avoidable differences in the health and wellbeing of individuals due to factors such as, where they live and whether they have good quality employment. The past decade has seen mortality falling across Kent and Medway, however, the gap in deaths between the most and least deprived areas continues to increase, i.e. there are widening health inequalities. For example, over the last five years in Medway, life expectancy has increased by 2.6 years in Cuxton and Halling, while it has only increased by 0.3 years in Chatham Central, leading to an increase in the gap in life expectancy from 5.1 years to 7.4 years. In Kent, over a six-year period, female life expectancy has decreased by 0.5 years in Folkestone and Hythe and increased by 1 year in Sevenoaks. Male life expectancy in Canterbury has not changed, whilst male life expectancy in Thanet has improved by 1 year over the same time period.

In Kent and Medway, men living in the most deprived areas have, on average, a 7 to 8 year life expectancy gap when compared with men living in the least deprived areas. While the trend is similar for women, the absolute gap is smaller (4.4 years for Kent and 5.4 years for Medway). Cancer is the largest cause of premature mortality overall. But in the more deprived areas, an increasing proportion of deaths are caused by cardiovascular, respiratory and gastrointestinal (GI) disease.

Many inequalities are amenable to being reduced through earlier detection of disease and preventative measures, such as lifestyle modification and management of long-term health risks.

The causes of health inequalities are many and complex and although many of the wider determinants of health can be addressed at a strategic level, via national and regional interventions, there is a compelling argument for designing interventions at a local level where they can be informed by the local communities and local services. This is the reason for the utilisation of the Integrated Care Partnerships in addressing health inequalities. These new partnerships present a bridge between work at the individual level and at the regional and national level.

Profiles have been created for each of the Integrated Care Partnerships (ICPs) in the Kent and Medway Integrated Care System (ICS). The aim of the profiles is to allow comparison between each of the ICPs and identify priority areas to focus work.
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

More action on prevention

A critical overarching theme throughout our five year plan is the importance of more action on prevention. To deliver prevention at scale, the NHS needs to work with other local partners, specifically local government, to maximise the use of resources to deliver better outcomes. Local government has a strong role to play to create the physical and cultural environment in which health can be protected and improved. In K&M, we have a compelling vision for joined up action on prevention between the NHS, local authorities, the voluntary sector and our communities. Prevention is everyone’s responsibility and it is never too early or too late in the life cycle to focus on prevention.

The K&M Health Needs Assessment stresses the importance of these factors and the critical role of prevention in positively impacting outcomes. This has driven our proposed prevention strategic priorities:

**Prevention across the life course:**
- A strong start in life
- Working age adults
- Ageing well

**Prevention across the system**
- Reducing health inequalities
- Tackling modifiable disease risk factors by:
  - Stopping smoking
  - Reducing obesity
  - Reducing alcohol consumption
- Protecting health
  - Improved screening
  - Improved vaccination
  - Improved infection control
  - Reducing antimicrobial resistance (AMR)
- Improving chronic disease management and secondary prevention
  - Cardiovascular disease/stroke, respiratory disease, diabetes
- Improving mental health
- Improving air quality

Embedding Prevention across the system

Extending the reach of prevention across the system through all levels and in all pathways will be a priority over the 5 years of the strategic plan. Alongside the work on population health management, there is a clear opportunity to set clear ambitions and scope of work. To ensure consistency and consensus, a set of principles have been developed which are being proposed for the ICS as a commitment to drive prevention across the system:

- Prevention will be owned by the whole Kent and Medway system. All partners have a clear understanding of prevention and of their role within the system
- Prevention and its role in reducing health inequality and variation will be a priority across the system, making the best use of a proportionate approach
- All clinical pathways will begin with prevention
- Tackling prevention as an system will be a whole system approach. The wider determinants of health will be tackled alongside clinical health in a partnership approach making the most of partner specialisms
- There is parity in the importance of good physical health alongside mental wellbeing
- The system will take a life course approach embedding prevention alongside all life events. It’s never too early or too late for prevention.
- Children and young people will be a priority, embedding prevention at the earliest opportunity. Schools and other education settings will be fully involved to shape the future of children and young people
- Systems thinking will underpin all work, using an intelligence led, evidence based approach to developing and evaluating interventions
- Interventions will be implemented at scale in a coherent and consistent way across the system to achieve the best outcomes
- Services will be co-commissioned to ensure prevention is fully embedded across the system. Every commission must be published with a section on
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Current delivery priorities for 1920 into 2021

• **NHS Health Check**: The NHS Health Check outreach programme introduced in 2019/20 is designed to increase the number of patients diagnosed with hypertension through a specific programme focused on vulnerable members of the population of Kent and Medway. This programme will overlap into the early stages of 2021 and will enable identification of risk factors particularly for CVD

• **Obesity**: Kent and Medway provide a range of well established weight management services through ‘OneYou Kent’ and ‘A Better Medway’ respectively. Obesity prevalence is heavily influenced by the wider determinants of health and for this reason tackling obesity involves changing a complex system of interrelated factors and relationships at multiple levels for interventions to be effective. Equally, as is demonstrated in the data, prevalence of obesity is higher in disadvantaged communities leading to health inequality and the requirement for a place-based approach. In light of the publication of the guidance on the Whole Systems Approach to Obesity, the Prevention Workstream is currently reviewing the opportunity to embed the whole systems approach in our work to tackle obesity across K&M

• **Smoking cessation**: Services for smoking cessation are well developed across Kent and Medway and offer services to support people to quit smoking through the ‘OneYou Kent’ offer and the ‘A Better Medway Programme’. The range of services available are designed to offer the service in a way that suits the needs of individuals. Services include digital and online services, face to face and telephone support. There is public facing ‘walk in’ provision in both central Chatham and Ashford offering convenient and approachable support. The number of adults across Kent and Medway who smoke continues to fall and the current trajectory will need to be maintained to meet the aspiration set out in the Tobacco Control Plan of 12% or less adults who smoke by 2022

• **Smokefree environments**: Achieving a Smokefree environment at each of our Trust sites is a key focus in 2019/20. Trusts have come together to develop consistency in policy and actions to facilitate full implementation of their Smokefree commitment. Actions are being implemented including wording in appointment letters, signage and speaker systems

• **Smoking during pregnancy**: Specialist smoking cessation midwives in each of the acute trusts have supported pregnant women in Kent to quit smoking since 2016. STP funding in the financial year 2019/20 has enabled extension of this service to Medway. Smoking cessation midwives have a key role in ensuring carbon monoxide testing of pregnant women at the time of booking and making referrals to stop smoking services as appropriate. The latest data for 2018/19 shows that 14.2% of women across Kent and Medway smoke during pregnancy, although this is falling, there is a steep trajectory to reach the Local Maternity System Target of 6% by 2022. It is intended that the work of the specialist midwives will continue into 2020/2021 alongside a range of services provided by Kent and Medway Public Health Teams

• **Reducing alcohol consumption**: Reducing alcohol consumption services across Kent and Medway fall under the following main areas
  - Identification and brief advice - Know your score (‘OneYou Kent’ campaign) and lower your drinking (‘A Better Medway’ campaign)
  - Making Every Contact Count training for frontline staff
  - The Blue Light project in Medway supports those facing severe and multiple disadvantage (substance misuser, involvement in the criminal justice system and homelessness) by way of a multi-agency team
  - Moving forward into 2021 the Kent and Medway aspiration is to create better links between hospitals and treatment services and to ensure vulnerable dependant drinkers have access to MDT teams via local care
Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Current delivery priorities for 1920 into 2021

- **Air Quality**: The Kent and Medway Energy and Low Emissions Strategy Consultation sets out a clear vision for reducing emissions and, therefore, improving air quality across the footprint. The aim of the strategy is that by 2050 emissions in the county of Kent have been reduced to Net-Zero and it is benefiting from a competitive, innovative and resilient low carbon economy, where no deaths are associated with poor air quality. The outcome of the consultation and the strategy will guide the ongoing work through the lifetime of the plan.

- **Health Protection (including antimicrobial resistance)**: The scope of the STP Prevention Workstream has been extended to include Health Protection. This strand of work includes oversight of antimicrobial resistance (AMR), outbreak control, infection prevention and control, sexual health and immunisation and screening (non-cancer). A Task and Finish Group has been set up to develop a work plan to guide the work of this strand through the period of the plan.
Section five

Strategic Objective 3) – Driving efficiency and productivity
Strategic Objective 3) – Driving financial balance, efficiency and productivity

Investing in the delivery of the Long Term Plan

Kent & Medway has been allocated £166m of Long Term Plan fair share funding over the five years. The categories of spend for each of these categories of investment are set out at high level in the table below. Throughout the development of this Strategy Delivery Plan, we have brought together clinicians, service managers, subject matter experts and finance professionals to continue to stress test the affordability of plans at a high level. Work will continue on this with each year’s operational and financial planning to ensure that funding is allocated to the commitments outlined in this plan. Where required, the STP/ICS will make decisions regarding the prioritisation of initiatives.

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The NHS Long Term Plan implementation framework states that targeted funding will be available for selected systems to act as pilot or test sites in implementing certain aspects of the LTP earlier than other systems. The system is actively bidding for targeted funding in relation to a number of areas. These include PCN development, new Local Care models, diabetes, mental health, and Cancer innovation fund. Ageing Well funding will be applied to deployment of home-based and bed-based elements of the Urgent Community Response model, development of Community Teams, and Enhanced Health in Care Homes. ‘Other’ covers the LTP funding available to support implementation of the LTP for Prevention, CVD, Stroke & Respiratory, CYP & maternity, Learning Disabilities and Autism.

This does not represent the total funds that K&M will invest in these areas, as we anticipate receiving additional targeted funding through successful bids to national bodies as well as re-prioritising our baseline budget according to the priorities outlined in this plan. This will see a shift in investment over the next five years to prevention, out of hospital services and integrated care. Prioritisation and impact on other services will continue to be assessed through the 20/21 operational planning process.
Strategic Objective 3) – Driving financial balance, efficiency and productivity

Delivering finance balance

The five year projections have been prepared with acknowledgement to financial improvement trajectories. Separate work is ongoing in respect of medium to long term financial planning to deliver long term clinical and financial sustainability through a range of measures including transforming out of hospital care, managing demand, reducing unwarranted variation, driving efficiency and productivity and making best use of capital. K&M STP has made significant progress in addressing a 19/20 £479m do-nothing financial challenge presented in October 2017. The current forecast is for a £135m net deficit in 19/20 (after sustainability funding). All organisations are forecasting financial balance against their trajectories for the 3 year period 2021/22 to 2023/24. However Dartford & Gravesham Trust and East Kent Hospitals Trust are currently forecasting plans adverse to their trajectories for 2020/21. To balance the system this pressure manifests in a £6m additional QIPP requirement in CCG plans and therefore delivering collectively above the expected trajectories by the £6m for the CCGs. Finance leaders have agreed to share this additional challenge across the system and have agreed to develop an appropriate approach to this. Through our Finance Group and Finance & Activity Modelling Group (FAM Group) we will conduct an exercise to confirm the £6m position and to understand the key opportunities across all four Integrated Care Partnerships. Additionally, work has been initiated to develop proposals for how income will be apportioned across the system for 20/21 and how we will move to alliance based contracts.

<table>
<thead>
<tr>
<th>Aggregate Plan Position vs Trajectory (£m)</th>
<th>19/20 PLAN</th>
<th>19/20 FOT</th>
<th>20/21 PLAN</th>
<th>21/22 PLAN</th>
<th>22/23 PLAN</th>
<th>23/24 PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner Underspend / (Deficit) excluding CSF</td>
<td>38.90</td>
<td>38.90</td>
<td>20.68</td>
<td>18.56</td>
<td>15.11</td>
<td>12.71</td>
</tr>
<tr>
<td>Provider Plan excluding PSF, FRF, including MRET</td>
<td>96.12</td>
<td>96.72</td>
<td>85.11</td>
<td>70.60</td>
<td>61.12</td>
<td>53.31</td>
</tr>
<tr>
<td>Combined position</td>
<td>135.02</td>
<td>135.62</td>
<td>105.79</td>
<td>89.16</td>
<td>76.23</td>
<td>66.02</td>
</tr>
<tr>
<td>Aggregate Trajectory</td>
<td>117.82</td>
<td>117.82</td>
<td>106.68</td>
<td>89.87</td>
<td>77.38</td>
<td>66.78</td>
</tr>
<tr>
<td>Combined distance to trajectory</td>
<td>17.20</td>
<td>17.80</td>
<td>0.89</td>
<td>0.71</td>
<td>1.15</td>
<td>0.76</td>
</tr>
</tbody>
</table>

The table and graph show the trajectory of the system is moving towards financial balance over the five year period. Contingent on achievement of agreed trajectories, the receipt of Financial Recovery Funding of £107.7m in 20/21 would take the system to an aggregate surplus position which continues through to 2023/24. In line with the long term plan expectations, the number of organisations in deficit within Kent and Medway reduces over the planning period from 10 to 8 (of 12) organisations before FRF and from 3 to 0 after the application of FRF with all organisations planning to be in surplus from 2022/23 after FRF. Work is continuing across the system to the ambition of a quicker trajectory to financial balance.

<table>
<thead>
<tr>
<th>Number of Deficit Organisations</th>
<th>Before FRF</th>
<th>After FRF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCGs</td>
<td>Prov</td>
</tr>
<tr>
<td>2019/20</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2020/21</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2021/22</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2022/23</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2023/24</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

The K&M Productivity programme was established in 2016. The programme has focused on delivering efficiencies that are enabled by working in partnership at a ‘system level’. A ‘Productivity Executive Board’ and ‘Working Group’ governance structure have been set up with finance and subject matter expert leads assigned to each workstream embedding a collaborative culture and ownership to deliver. A clear reporting structure and governance has been created with an Executive SRO. This programme has delivered savings of £1.2m in 2017/18, £2.9m in 2018/19, and forecast delivery of £11.67m of saving in 2019/20.

The key areas of focus for 19/20 delivery are:

- £8.99m in Bio-Similar switching
- £250k in continence formulary
- £1.86m in Temporary Staffing
- £555k in Pathology

These programmes of work align with the Carter Efficiency Guidance and the NHS Long Term Plan (LTP).

The STP will follow due process for "stress-testing" of all programmes ensuring the assumptions underpinning them are credible and the outcomes are deliverable.

The plans for 19/20 and the forward planning for the next 5 years, in line with the LTP, will support a trend towards achievement of financial balance. Model Hospital is supporting the STP to realise an opportunity of c£53m to c£90m over 5 years. Teams are completing a desktop exercise with Model Hospital against internal datasets to confirm a degree of confidence with the opportunity.

The Model Hospital opportunities include:

- **Developing a workforce to deliver 21st century healthcare** - This workstream focuses on maintaining agency staff in accordance with NHSI cap rates for Nursing, AHP and Admin staff and working in partnership with agencies for Medical locums making Kent & Medway NHS the best place to work. Alongside this, K&M STP are driving forward a technology driven collaborative bank system which embeds with existing banks systems. This will enable K&M to develop a new operating model for workforce which will override all workforce gaps and costs. Model Hospital demonstrates workforce holds an opportunity of c£16m - £26m.”

- **By 2023, K&M will align with the diagnostic imaging networks vision** - to enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. The programme is currently undertaking a diagnostic review and will develop the initiatives in collaboration with the Cancer Alliance plan and the Elective Care Transformation and Digital plans.

- **Tackle clinical variation across health improving providers’ financial and operational performance** – Kent & Medway recognises that further unwarranted clinical variation exists, particularly within Geriatric Medicine, Emergency Medicines and Orthopaedic & Spinal Surgery with an opportunity of c£11m – c£13m, c£10m- c£14m and c£8m – c£14m respectively. Kent & Medway have plans in place by utilising Rightcare, Model Hospital and GIRFT data and support from local and central NHSE/I to deliver opportunities where they exist.

- **Estates and Facilities is a key priority with opportunity ranging from c£8.2m - £23.4m** - This workstream holds plans for a review of Linen & Laundry, Medical Records Storage and Transport. These plans are a stepping stone towards maximising best value within K&M’s existing Estate. Capital planning has started and in many places is already in progress with regards to prioritisation, improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency and all leasing properties now needed to support the government’s target of building new homes.
Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

- **Further efficiencies in NHS admin costs across providers and commissioners both nationally and locally** - Productivity will be part of this priority which sits with CCG and Providers at tackling reducing management costs. The STP recognises efficiency in consolidating corporate services, thereby reducing the cost and improving the quality of services. Focus areas are currently within scope; temp staffing such as developing a Collaborative Bank and reviewing structures across organisations such as HR and Legal. Further plans will include standardisation of internal procedures/processes (to reduce variation and enable prospects of pooling/sharing of resources) and pooling of high cost/specialist resource within a system to maximise utilisation.

Areas which Model Hospital exclude but where the STP will realise opportunity are:

- In the future, a **single pathology service in Kent and Medway** will be established with a single Laboratory Information Management System, Managed Service Contract, referred diagnostic contract and standardised operating procedures; which, together with potential efficiency gains through strategic partnership/s and management/workforce redesign. This workstream is well established and a final business case (FBC) is currently being developed. The potential annual saving for this initiative across Kent and Medway is **£5.6 million annual saving** on current costs.

- **Delivering value from the £16bn spend on medicines** - Kent & Medway Medications Optimisations Group have agreed a set of priorities which will deliver ‘system level’ working and ‘local level’ working for the next 5 years. The focus points are Workforce, System Aseptic Review, Dispensing, Medicines Information, Centralised Stock Holding, ‘Direct to ward’, Vaccination Supply & Management and a centralised admin function, whilst other priorities will be maintained at a local partnership level such as Clinical Services, Educational & Training and Governance.

- **Improved efficiency in community health, mental health and primary care through integrated care models** – productivity opportunity will hold a wider ‘lens’ focusing on the improved efficiency in the new partnership ways of working model. Keys focus points will be on supporting all Community staff, Primary Care Networks and Mental Health. The collaborative working of these priority STP workstreams will model and track the changes to ensure we are measuring improved productivity at a wider level.

- **Engage with local intelligence at a population health level** - Kent & Medway is committed to **achieving cash releasing productivity growth**. Productivity will continue to plug into national support and datasets and initiate further work with Public Health Intelligence to gain a niche understanding of the population needs. By triangulating all of these sources, productivity growth will accelerate and impact benefits realisation in specific areas of deprivation.
Strategic Objective 3) – Driving financial balance, efficiency and productivity

Reducing growth in demand through integration and prevention

We have set out in sections 3 and 4 of this plan our plans for prevention and integrated services. The full financial impact of these new models of care is not yet fully quantified, in line with the LTP implementation framework statement that all not systems will be in a position to quantify this as part of the Strategy Delivery Plan. Understanding the impact of prevention and integration on the cost of services is necessarily complex. Work has started across our ICPs to understand the medium term cost impact of key interventions being taken in Local Care and Primary Care (i.e. integrated care). However, more work is required on this. Understanding the impact of prevention would need to be evaluated over a longer term timeframe (potentially in excess of 10 years). We will look to learn from NHSE/I and more advanced Integrated Care Systems as to the most appropriate method for long term financial planning of this nature.

Making best use of capital investment

The K&M Estates Strategy contains 117 projects, with capital investment values varying from under £500k to £363m. The suite of projects totals £821m. The STP have an agreed assurance and governance process for the Programme Management of all Capital projects. The STP has initiated programme management of the disposals programme with regular reporting from the property owners and escalation of blockers and issues. The estates workstream is embedded as an enabler into all other workstreams – including the Estate/Capital requirement to deliver the services.

Please see Section 6 for details of our estates strategy

Achieving cash-releasing productivity growth of at least 1.1% per year

Through all of the efficiency and productivity schemes, the organisations within Kent and Medway are planning on delivering in excess of 1.1% cash releasing productivity growth. The profiling of the efficiencies required and planned show the higher ask in the first two years of the plan.
Section Six

Strategic Objective 4) – Transformation of critical enablers
Strategic Objective 4) – Transformation of our workforce and infrastructure

Making K&M a great place to live, work and learn

In Kent and Medway, we know that at the heart of our health and care services are our people and that is why we are committed to making Kent and Medway a great place to live, work and learn. The workforce transformation strategy focuses on our commitment to work together to prioritise actions that will have the biggest impact on addressing our workforce challenges. We strongly believe this focus will support the system-wide transformation needed to provide the people of Kent and Medway with a better quality of life and a better quality of care. We have developed the strategy with the aims for our:

**Workforce** to work together across health and social care, enjoy their work, learn in their jobs and be empowered, engaged and developed to be good at what they do.

**Employers** to work together to attract and retain the right supply of health and social care workforce through talented and capable leadership and the offer of attractive, flexible and interesting careers.

**Population** to have the skills and support to help them manage their own health and care with confidence and, where needed, with the right support to achieve their health, social and community outcomes and goals.

To deliver this ambition and address critical workforce challenges we will develop a Kent and Medway Academy for Health and Social Care working collectively to:

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

As set out in the interim NHS People Plan, and aligned to our transformation plan, we need more staff working across health and social care over the next five years; system actions identified in our strategy will both address existing shortages and deliver the improvements set out in the Long Term Plan.

**Our workforce context**

In Kent and Medway we employ around 78,141 FTE workforce across Kent and Medway in over 350 careers across health and social care organisations.

<table>
<thead>
<tr>
<th>Workforce (FTE)</th>
<th>March 19 (actual)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>18,960</td>
</tr>
<tr>
<td>Community</td>
<td>5,372</td>
</tr>
<tr>
<td>Mental health</td>
<td>3,175</td>
</tr>
<tr>
<td>Primary care</td>
<td>4,030</td>
</tr>
<tr>
<td>Ambulance (Total SECAMB)</td>
<td>3,427</td>
</tr>
<tr>
<td>CCG (* 19/20 FOT)</td>
<td>619</td>
</tr>
<tr>
<td>Social care (* 2018)</td>
<td>31,700</td>
</tr>
<tr>
<td>Pharmacy (* 2017)</td>
<td>2,012</td>
</tr>
<tr>
<td>Dentistry</td>
<td>1,086</td>
</tr>
<tr>
<td>Ophthalmology (* 2018)</td>
<td>414</td>
</tr>
<tr>
<td>Vacancies</td>
<td>7,346</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78,141.</strong></td>
</tr>
</tbody>
</table>

It is recognised that across K&M, there have been long term workforce challenges with workforce supply for most staff groups being behind national growth averages, except for pharmacists and health visitors.
Strategic Objective 4) – Transformation of our workforce and infrastructure

Some of workforce challenges include:

- Limited pipeline of skilled and qualified workforce in Kent and Medway
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies
- Trust shortage of key specialty workforce and staff groups including consultants (61.79 FTE by 20/21), adult, community and mental health nursing, junior doctors and allied health professionals
- Shortage of GP and primary care workforce is exacerbated by the primary care age profile – 25% of GPs and 55% of general practice nurses approaching possible retirement. In order to meet the retirement gap, we would need to increase the GP workforce to 222.4 full-time equivalent (FTE) and grow our nursing workforce to 287.9 FTE
- Not enough stroke workforce to provide hyper acute stroke services on the current sites. The revised workforce gap analysis across the preferred sites will require an estimated additional 135.5 FTE to 264 FTE staff, including the filling of a range of new and enhanced roles
- Shortages of key mental health professional workforce including, psychiatrists and nurses, and a required total growth in the mental health practitioner workforce by 2024 of 1577 FTE
- Significant unregistered and non-statutory workforce for intellectual disabilities supporting a complex and extremely diverse group of people with support required being highly individualised with the potential for variability in terms of workforce engagement and development support
- A 90 FTE gap between forecast supply and demand in cancer workforce by 2022. Particular areas of concern are: Gastroenterology, histopathology, clinical and diagnostic radiology amounting to 84% of the identified gap.
- Shortage of skilled social care workforce providing direct care and support in local communities, with over half of all vacancies in Kent and Medway within social care – estimated vacancy rate of 8.7%.

The Kent and Medway Local Workforce Board (LWAB) which oversees the delivery of the workforce transformation Board (LWAB) which oversees the delivery of the workforce transformation plan have identified five key strategic system workforce risks:

- Collective inability to attract, recruit and retain sufficient numbers of high quality staff may result in a continued dependency on temporary staff and unsafe staffing levels, affecting quality of care, costs and may also impact on the health and wellbeing of staff
- Limited national and regional supply of workforce will not meet demand in Kent and Medway which may result in an increased vacancies now and in the future
- Reliance on temporary staffing may lead to quality issues and impact on the improvement plan for financial sustainability
- Lack of consistent funding alignment for growth in workforce expected may result in not achieving expected growth in workforce
- Should there be a deterioration of staff engagement due to lack of workforce confidence, this may lead to worsening morale and subsequent increase in turnover.
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies

The Workforce Transformation plan aims to mitigate these risks and address our system wide workforce challenges. Key actions include activities to attract, recruit and retain the right staff, actions to maximise current supply through workforce redesign, using digital and new and enhanced roles, investment in cross sector apprenticeships, a collaborative approach for harmonising temporary staffing costs and agency conversion, working with our partners to identify recurring workforce funding streams.

We have been working together as a workforce board to understand the collective challenges and opportunities in Kent and Medway. We successfully supported our universities to campaign for a medical school for Kent and Medway to increase our supply of potential doctors and attract wider professionals into the county.
Our Transformation Strategy

To deliver our ambition and address critical workforce challenges we will develop a Kent and Medway Academy for Health and Social Care working collectively to:

- **Promote Kent and Medway** as a great place to work through social media, a dedicated website, and recruitment campaigns for roles such as GPs and primary care. We are developing a joint attraction offer and will undertake joint international recruitment activities; maximising the use of apprenticeships including health and care rotations and streamlining the recruitment process through the implementation of staff passports.

- **Maximise supply** of health and social care workforce acknowledging that we have a limited workforce supply. We will launch a Kent & Medway Academy and introduce a Kent & Medway Medical School in 2020, undertake redesign through competency workforce planning, maximise the use of current skills through new and enhanced roles such as care navigation and through the use of social prescribing, introduce a skills hub and improve the digital capability of our staff.

- **Create lifelong careers** in health and social care by providing work experience, pre-employment health and care courses, promoting careers through school and employment events. We are also supporting flexible and part time working and using new technologies to support staff such as our Help4Carers app.

- **Develop our system leaders** and encourage culture change. We have been working together to introduce an OD toolkit for local care team collaboration, introducing a Kent and Medway Talent Board for hard-to-recruit roles and senior roles across health and social care, developing our own leaders of the future from the existing workforce, and equip current leaders with the skills they need to help transform our local systems. These actions will be supported by the introduction of a system OD strategy later this year.

- **Improve workforce wellbeing, inclusion and address workload** to increase retention through Best Place to work retention programmes, by developing programmes which support staff with health and wellbeing activities, staff resilience projects, professional development and retirement planning. We are working on the implementation of an inclusion strategy and improving rostering in all our organisations.

Our workforce transformation strategy provides an overview of our work to date including:

- A Kent and Medway Medical School which will have 500 students by 2025, with a focus on growing our future workforce aligned to our care models.
- Kent and Medway social care recruitment campaign.
- Launching the 'Take a Different View' website and social campaign for hard to recruit roles.
- Upskilling education programmes for health and care in the community.
- Supported 237 individuals through pre-employment and Prince Trust courses and engaged with 8900 individuals through careers activities.
- Launched an OD toolkit for multidisciplinary team working.
- Invested in system leadership development programmes.
- Investment in retention programmes for GPs.

Our workforce transformation plan identifies key activities that are being undertaken between 19/20 to 21/22 for our STP priority areas. These include:

- Ensuring cross system placement readiness for the Kent and Medway Medical School, with 100 medical students starting in September 2020.
- Working with education partners to increase the number of trainee placements.
- Working with PCNs and ICPs to undertake localised workforce planning and redesign including promotion of career development and new and enhanced roles.
- Developing our health and social care staff to be digitally ready through training, access to education platforms and use of digital champions.
- Working together to recruit a number of international doctors enrolling onto the Kent and Medway Global Learners Programme by March 2021. This would make a difference to hard to recruit areas such as interventional radiology, surgery, Anaesthetics, ED and Elderly Care including Stroke.
Strategic Objective 4) – Transformation of our workforce and infrastructure

• Implementation of our primary care workforce plan through our Training Hubs with a focus on developing multidisciplinary learning and working within PCNs, retention of our workforce (at all career stages), workforce redesign including introduction of new roles, OD and leadership development and primary care recruitment campaigns
• Working with providers to implement the stroke workforce plan including actions on recruitment, workforce redesign, introduction of new and enhanced roles and upskilling through the stroke competency framework and education programme and retention
• Growing the mental health workforce with an expansion target for growing the workforce by 2021 of 498 WTE - we are currently over performing and would meet this target
• Investment in community learning disability and neuro-developmental teams, introduction of a Positive Behaviour support team and attractive pay rates for providers on the PBS framework
• Co-production of a Kent and Medway workforce plan, building on sessions being run to identify key actions to address the shortage of hard to recruit roles and a Kent and Medway recruitment campaign
• Social care sector recruitment campaign, continued sector engagement and events to develop a care sector workforce strategy, rollout of ESTHER coaching, supporting new roles including apprenticeships and introduction of the Help4Carers app.

Delivery of the Workforce Transformation plan is monitored through the Workforce Board with progress reported to the Partnership Board. The Workforce Board has four key workstream groups which include engagement from primary care, social care, HR Directors and Directors of Nursing. The implementation plan is being updated to include actions up to 23/24 with a revised workforce monitoring dashboard.

Responding to the Interim People Plan

In Kent and Medway we recognise the importance of the national, regional, local system and organisational actions needed to address the workforce challenge and welcome the recommendations made as part of the Interim People Plan, focused on four key themes of:
• Making the NHS the best place to work
• Improving leadership culture
• Holistic approach to workforce transformation and workforce growth – ‘more people, working differently’
• Changing the workforce operating model within the context of ICS working

We have reviewed our transformation plan against the key local system recommendations from the Interim People Plan and are encouraged that these recommendations, in the most part, are already underway or planned as part of our activities.

Making the NHS the best place to work to improve workforce wellbeing, inclusion and address workload.

We have a number of organisational and system initiatives to improve retention including two Trust providers on the Best Place to Work scheme and a number undertaking the NHSE/I retention programmes, Training Hubs leading retention initiatives for the ‘First Five, Last Five’ programmes for primary care (£192,850 awarded by NHSE/I) and local authorities working with the care sector to develop a workforce strategy for the wider care sector utilising support and expertise from Skills for Care. Shared inclusion and health and wellbeing commitments and activities will be further developed using best practice from our organisations and from the wider health and care systems.
Strategic Objective 4) – Transformation of our workforce and infrastructure

Improving leadership culture to Develop our system leaders and encourage culture change. We have programmes underway to support the leadership development within primary care, social care providers and system leaders through Practice Manager and Registered Manager development programmes, Leading through Kent and Medway system leadership programme and the development of Communities of Practice. Clinical Director and PCN development offers are planned for later this year.

- We are developing an ICS OD strategy, including working with our system leaders to develop shared values and behaviours and bring together the system plans and actions.

Holistic approach to workforce transformation and workforce growth – ‘more people, working differently’, alignment to promote Kent and Medway and maximise supply. Working together to grow the workforce supply by promoting Kent and Medway whilst also using our current workforce differently. Examples of this include:

- Buurtzorg community teams
- Local and system workforce redesign (using competency based system workforce planning)
- Upskilling current staff (for example, care navigation and stroke competency framework)
- Maximising new and enhanced roles (such as Nurse Associates, apprenticeships, Advanced Clinical Practitioners, Physician Associates)
- Digital (upskilling, improved rostering, shared systems and use of telecommunications to reduce inefficiency)
- Empowering our population and their carers to self-care and self-management through the use of technology such as the Help4Carers app and training and support for self-monitoring

- Changing the workforce operating model within the context of ICS working- including the development of a Kent and Medway Academy for health and social care to create lifelong careers in health and social care. In Kent and Medway we have been developing our operating model for workforce for the future including the development of a Kent and Medway Academy and Workforce Board.

- We have been working together to develop our strategic approach to key challenges in primary care, social care and, more recently, the nursing challenge, led by senior system leaders from health and social care and overseen by LWAB. The Academy will build on the workforce transformation plan and the good relationships we have with partners such as HEE and NHSE/I. There will be a focus on workforce planning, career development, work experience, engagement with education, role development and redesign, and workforce assurance. The Academy will also play a key role in engagement and development of a network of volunteers and peer support.

- Part of our evolving governance arrangements will be localising workforce activities where these are best undertaken at an integrated care partnership, primary care network or organisational level whilst continuing to share learning and best practice.
Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation

Digital must be regarded as a golden thread running throughout our plan. This includes utilising digital technology to enable service transformation, to harness the power of modern technology and approaches to allow health and care to be delivered in new ways not previously possible. Delivery needs to be enacted through a strong and mature platform that keeps our data both secure and accessible. We need to ensure that digital care delivery is safe and seamless as we become ever more reliant on technology for both every day delivery of health and care and long term strategic planning. We can use digital to keep our population healthier for longer, intervene earlier when needed and to enable the use of our NHS resources more effectively in caring for our population.

Kent and Medway is committed to learning from best practice from other areas and to gain maximum advantage from national products and solutions, such as the NHS App and NHS Login. For example, the STP is linked into the Global Digital Exemplar (GDE) and local health care record programmes and is seeking to apply learning from the GDE blueprints, where appropriate, to STP priorities.

The Kent and Medway digital strategy has the ambition to help people achieve the best possible health and well-being outcomes, living independent and fulfilling lives in their own homes and communities by using digital innovation and technology. The digital workstream aims to co-design solutions; working proactively with all relevant stakeholders to deliver the right solutions and outcomes. The Kent and Medway digital strategy contains seven core components as detailed in the table opposite.

<table>
<thead>
<tr>
<th>Digital strategy core components</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal care record</td>
<td>Health and care professionals have immediate access to all relevant information about a patient’s care, treatment, diagnostics and previous history, for all patients across Kent &amp; Medway, with each digital footprint area determining their own delivery approach. This will be delivered through the Kent and Medway Care Record (More information on slide 74)</td>
</tr>
<tr>
<td>Universal Care Professional Access</td>
<td>Health and care professionals can operate in the same way independent of their geographic location. This is the infrastructure layer and includes providing HSCN connections to all sites with GovRoam access to support sharing of information, and meeting cybersecurity standards</td>
</tr>
<tr>
<td>Universal transactional services (eCare Navigation)</td>
<td>Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway</td>
</tr>
<tr>
<td>Shared management information</td>
<td>Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets</td>
</tr>
<tr>
<td>Online patient services</td>
<td>Patients can access their own medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question.</td>
</tr>
<tr>
<td>Expert systems</td>
<td>Health and care professionals and patients have access to knowledge bases to support the care processes</td>
</tr>
<tr>
<td>Personal digital healthcare</td>
<td>Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management</td>
</tr>
</tbody>
</table>
Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation continued

This strategy is delivering:

- A digital infrastructure based on care/clinical themes and their associated outcome measures (cross reference to clinical transformation sections)
- County wide processes for sharing data safely and securely
- Focus on data quality and consistent coding

The development of digital maturity with care provider organisations is based on creating core capabilities across the organisation covering:

- Administration
- Records Assessments and Plans
- Transfers of Care
- Medicines management
- Order communications and results management
- Remote and assistive care
- Decision support
- Clinical and business intelligence
- Asset & resource optimisation

Our actions for the next five years cover three broad categories:

1) Deliver today’s requirements
2) Transformation to support tomorrow
3) Underpin the future

Kent and Medway Care Record

We are developing the Kent and Medway Care Record (KMCR) to achieve the following:

- Enable health and care professionals involved in an individual’s care to view near real-time electronic patient records currently held in numerous Provider point of care systems. A view of an individual’s KMCR will be accessed via an integrated solution
- Enable a citizen to access their own consolidated record and to receive support and guidance to promote self-care
- Support the use of the rich dataset to drive intelligence, both in terms of near real time operational management of the Health and Social Care system plus longer term strategic planning and population health management (utilising depersonalised subset of data)

KMCR facilitates the NHS Long Term Plan aspiration to provide a Local Health Care Record for Kent and Medway. Subject to business case approval, the Kent and Medway Care Record will deliver a significant transformational change for the health and social care system in terms of shared information between providers and with citizens. This will provide a better patient experience and improve clinical safety as all relevant information will be available in one place. KMCR will also provide a platform for Kent and Medway citizens to access their health and care records and provide a consolidated platform to support population health intelligence.

The KMCR will initially prioritise the needs of Urgent and Emergency Care settings where patient data is required instantaneously, then extend to other areas including care homes. The development of specific KMCR requirements, including design and mobilisation, will be led by our Citizen User Group and Clinical Reference Group.

The specification that has underpinned the KMCR procurement has been based on national best practice. We continue to discuss our plans for the KMCR with NHSE/I to ensure that all national best practice is utilised.
Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Future digital structures and priorities

The merger of our CCGs provides an opportunity to review and invest in digital leadership through the establishment of a Chief Information Officer (CIO) at a system level. This role is key in reviewing and agreeing a refreshed digital strategy and implementation plans for K&M. With the imminent merger of the eight CCGs, there is an opportunity to develop extended capability in a range of functions including digital. We are moving to develop integrated management structures in order to streamline, remove duplication and pool talent.

It is suggested that Kent and Medway needs to improve its digital planning and delivery capability to ensure that digital developments are able to support strategic and delivery aspirations. The new leadership and management structures would be pivotal to this. Guidance from NHSE/I emphasises the need to establish either Chief Clinical Information Officers (CCIO) or Chief Information Officers (CIO) as board level appointments. Regardless of the specific approach adopted, both clinical and technical leadership is required.

Through this approach we need to focus on:

- **Oversight of the system architecture:** Ensure oversight and coherence of enterprise architecture services, solutions architecture and design, application and data architecture, architecture and information governance, and assurance and consulting
- **Strategic development and planning:** Understanding the challenges, issues and opportunities of the emerging digital landscape in Kent and Medway and developing system strategies and associated plans that align opportunities to local requirements
- **Technology Architecture:** Ensuring focused Information Management & Technology (IM&T) expertise and advice is in place to ensure all significant IT investments have a solid business case and are consistent with established IT architectural standards

- **IM&T Programme & Project Management:** Scalable and adaptable delivery of digital initiatives to ensure significant commitments are delivered within time and budget constraints and to agreed specification. This can be through delivery of an intelligent customer role linked to the commissioning of external support or through the direct management of internal resources as agreed with the CCG or system
- **Digital Procurement, Contract & Vendor Management Services:** Managing 3rd party suppliers end-to-end to ensure high quality and compliant service provision as well as ongoing value for money
- **Systems Accreditation & Testing:** Providing assurance that updated or new externally provided systems meet the business / contractual specifications and that the inter-operability of systems is assured
- **Information governance and cyber security:** Strengthen our resilience and ensure the ongoing safeguarding of data
- **Business Intelligence:** Our system has a strong focus on population health intelligence and we are developing a K&M health and care analytics strategy to build on our extensive experience with linked data sets, most notably the Kent Integrated Data set (KID). The strategy is due for completion in autumn 2019 and will cover the following themes:
  - Understanding and predicting the health needs of the population and understanding the impact of interventions on population health, reducing health inequalities, improving patient experience, efficiency, and workforce wellbeing
  - Examining the wider determinants of health and the impact of work across the system
  - Supporting the shift from reactive care to anticipatory care
  - Providing information and intelligence for our citizens
  - Driving innovation by working with research and industry partners
  - Developing whole system demand and capacity intelligence for integrated care management
  - Developing intelligent business support for clinicians and care teams
Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Across Kent and Medway we harnessing technology to transform services and personalise care. We have outlined some examples of the innovations being tested, piloted and implemented across Kent and Medway. Through our Digital Transformation Group we will evaluate the cost and benefits of various innovations and we will look to spread the most impactful innovations.

Supporting cancer diagnosis using technology

Darent Valley Hospital are harnessing machine learning and use of artificial intelligence (AI) software to identify abnormal chest x-rays. If an abnormality is detected AI will be able to detect this within 40 seconds allowing patients requiring further investigations to be fast tracked for a CT scan.

There is opportunity to adopt AI supported diagnostic technology for other tumour groups as this area of work develops. Using AI we can ensure that we can support early diagnosis through a more efficient turnaround of x-rays for those patients on a cancer pathway. We will evaluate the impact of this pilot and consider its further application across Kent and Medway.

Kent and Medway is the only cancer alliance nationally that has a networked cancer information system across all of its providers, the next phase of this journey is to develop a integrated cancer care record for patients in Kent and Medway. The benefit of this solution would mean that no matter which hospital, GP surgery or clinic you are at, your full care record relating to your cancer diagnosis and treatment will be available to the relevant clinician. The system will draw a diagnostic scan, blood tests and reports from the various local systems through IT interfaces to allow it to be seen in one place.

We are currently looking to implement a network diagnostic service where scans can be reported by a clinician remotely irrespective of where a scan was performed, removing unnecessary delays.

Unlocking the future of digital primary care

Kent and Medway is embarking on an exciting period of change with additional digital functionality being made available for practices and patients.

Over the next few years we will be embarking on a transformational change in how patients service their primary care needs:

- Underpinning online consultations as a core element of the primary care offer, enabling patients to access primary care at their convenience, and where deemed clinically appropriate, rollout of these services will start in 2019 / 20.
- Using digital technology to enable practices to operate at scale and develop patient facing models of care that are utilising technology such as apps an wearables.
- Wider integration between providers and system suppliers to join up pathways and patient journeys. Creating seamless and safe handoffs between systems allowing patients to flow between care settings.

There is significant investment that is being made in primary care and a fundamental change in the way we are harnessing technology to improve patient access and experience.
Digital Primary Care First East Kent Digital First Unscheduled Care Accelerator

Moving to a digital based primary care sector is a key aspiration of the STP and we are fortunate to have one of the national digital accelerator projects within the county: the East Kent Digital First Unscheduled Care Accelerator (EK UCA). This will deliver agreed outcomes within our unscheduled care pathways. This will ensure patients and professionals can access appropriate services in a timely and consistent manner, reducing unwarranted variation around experience (patient and professional). It is expected that the solutions that are being implemented in East Kent will be extended to the rest of the county.

East Kent was awarded accelerator funding due to two specific challenges:

- **GP to patient ratio** – East Kent has some of the lowest GP to patient ratios in England, currently 1:2520 in Thanet. The NHSE mean is 1:1724.

- **Significantly higher ageing and associated acuity** in the Thanet locality, which places additional unscheduled demand pressure on the unscheduled care pathway, particularly around care homes.

**Phase 1:** Funding will develop and test new ways of working enabled by Digital First solutions. Margate Primary Care Network (PCN) (4 GP Practices / 17 Care Homes) and Hythe (8 GP Practices) will be our original test of change sites. East Kent will adopt a Quality Improvement Making Data Happen approach and focus on three areas of the unscheduled care pathway:

- **Patient access (on the day primary care demand)** - Ensuring patients flow down the right channels via the NHS App (where possible) to the appropriate whole system professional in a safe and timely manner

- **Digitally enabling Care Homes** – Ensure a more proactive approach with rapid response by appropriate professionals delivered in a more effective manner, reducing GP visits enabling GPs to have more capacity for continuity of care around complex patients. This will also ensure the right step up in care – when required.

- **UEC/111 interoperability** – The ability to ensure that professionals can have safe and timely access to almost real time information to make the right pathway decisions. The ability to directly book patients to the appropriate professional e.g. GP practice or Urgent Treatment Centre

We will build on learning from our online consultation partner eConsult around efficient delivery of ‘on the day’ GP services, a PCN hub based approach to maximise on efficient and effective use of GP time. The aim being that GPs focus on the patients that need their expertise – between 20-30% of daily demand. The other 70% channel shifting to administration support, social prescribing, practice pharmacists and nursing staff. This will also impact positively on Emergency Department walk-ups.

**Our core aim is to:**

**Enable the East Kent Unscheduled Care system to use their time more effectively to reduce unwarranted variation in health outcome and patient, carer and workforce experience.**

A core requirement is to blueprint our approach and spread it in a prioritised manner – based on findings from our QI Making Data Happen platform for example conveyance (over 75s) rate per 1000 GP practice patients or demand and capacity work using operational data to both baseline the current position and measure improvement.

We fully understand that this system transformation requires appropriate levels of business change management and programme management. This is not about product – it’s about digitally enabling new models of care that can spread and sustain on a local and national basis.
Unlocking the future of digital mental health care

The future of Mental Health provision will benefit from digital technology and solutions in a number of areas, these include:

- The adoption of a population health intelligence approach to looking at the mental health and emotional well-being of our population
- The provision of online services to support direct access to a range of IAPT services
- Making crisis care plans available to care professionals that need them across the urgent care pathway
- Supporting the “no wrong door” aspiration through the provision of a shared care record (KMCR) Patient access to their records, including their care plan, is expected to become available in year two of this development and will facilitate the provision of data by patients from wearables, home hospital devices, and Internet of Things (IoT) devices.
- Provision of online advice and guidance between care professionals
- The use of video-conferencing as an option for consulting with patients
- We have identified a range of artificial intelligence applications covering patient engagement, administration support, alert management, coding and classification, predictive forecasting, record summarisation, and information governance. There is much work still to do on this agenda but already we can see opportunities and benefits across the board from patient safety, through quality improvement, clinical outcomes, productivity, satisfaction, and sustainability.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Avoiding unnecessary visits to hospital by channel shifting

There are a number of pilot solutions in place across Kent & Medway to utilise video conferencing solutions to provide virtual consultations, including the Attend Anywhere project at Maidstone & Tunbridge Wells.

It is our ambition to extend these pilots across the whole of Kent and Medway leading to the provision of up to 30% of follow-up outpatient appointments virtually by the end of the long term plan period.

- Use of online advice and guidance services to provide specialist clinical advice to generalists
- The use of remote monitoring telehealth devices to support safe, early discharge
- Supporting self-care by the provision of online information to patients, removing the need for unnecessary follow-up appointments
Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Supporting digital maternity

Better Births Maternity Review set out a digitally enabled future for the provision of maternity services and it is our ambition to meet this aspiration by providing every woman with access to her personal health record to support her through her pregnancy. We anticipate that this will be delivered through the citizen access component of the Kent and Medway Care record and will be accessed through the NHS App utilising NHS Login.

We will further support this by the provision of apps to provide targeted and relevant information to women throughout their pregnancy.

Through the Local Maternity System (LMS) maternity services will be well represented within web resources for Kent & Medway, providing a single point of access and directory of services for women and families accessing maternity and neonatal services. The first iteration of this website is planned to go live in April 2020, and development of the resource to meet the needs of a modern maternity service will be ongoing, with innovation, development and maintenance being handed over as business as usual by March 2021.

East Kent Hospitals University Foundation Trust have an advancing digital maternity transformation programme underway, with colleagues from maternity, IT and business intelligence working well together to deliver benefits for the service. Kent & Medway LMS will support the spreading of this best practice across the footprint. The MOMA app being developed in East Kent will be developed and adopted across Kent & Medway in line with the Better Births vision for women to have a digital tool for maternity. This work also forms part of the personalisation and choice workstream as the app becomes a digital Personal Health and Support Plan for the maternity journey. It will enable clinicians to tailor care to each woman based on what is important for her.

Community Services

Supporting the wider partnership arrangements for the delivery of health and social care services to patients, we will develop digital solutions in the following areas:

- Preventing ill health:
  - Signposting patients to information via smartphone apps and other digital resources
  - Supporting patients with self management of long-term conditions through wearable technology, online support services and tailored apps

- Integrating services:
  - Sharing patient data and information across the care management team through the KMCR and supporting technologies
  - Providing online support, guidance and training for clinicians on condition specific issues

- Delivering high quality care at home and in the community:
  - Providing teams with live, interactive resourcing tools that will allow teams to respond to real-time patient demands
  - Supporting teams to undertake remote consultations and liaison with patients and carers

- Developing sustainable services:
  - Provide digitally enabled services to remove duplication, speed patient access to services and reduce complexity
  - Supporting digital access for clinicians and patients to clinical information and service access points
**Strategic Objective 4) – Transformation of our workforce and infrastructure**

**Our estates strategy**

The Kent & Medway STP (K&M STP) fully acknowledge the importance of having the right estate to deliver its clinical aspirations and intentions. This includes ensuring the estate is future proofed to meet the demands of the large housing growth which will occur over the next 10 years within Kent and Medway resulting in an additional c. 400,000 or c.23% increase in population by 2031 according to Kent & Medway Growth & Infrastructure Plan 2018.

This population growth, combined with the aging population within Kent and Medway will have a significant impact on the demand for services, the location the services are required to be delivered from and how the services are delivered. In response to this, the system submitted a forward thinking Estates Strategy in July 2019 to NHS I focusing on how the estate will be an enabler to the K&M STP objectives, how the accessibility of the estate will improve to the benefit of the patient and how we will ensure that the estate is fit for purpose and future proofed. Following a review and roundtable discussion with NHS I, the Estates Strategy for Kent and Medway has now been rated as ‘Good’.

The Strategy focuses on the transformation of how the estate is viewed and used – to shift perspective from individually owned properties to a shared, co-located estate which can be used by all organisations within the STP. This alignment of the estate will focus primarily on opportunities that will benefit the patient, by making the services more accessible and in fit-for purpose facilities. Through shared costs and improved utilisation of the estate – paying particular adherence to the Carter Metrics and ERIC/model hospital data - it is hoped that revenue saved can be re-invested either into the estate to improve its condition and capacity and/or patient services.

Within the Primary/Local estate, the system will undertake locality reviews to seek to utilise the existing estate to its full potential – by reducing void spaces and increasing shared desk spaces, open to all organisations, including the Local Authorities. Through working with the digital workflows and the Kent and Medway Care Record, we will seek to improve connectivity within all buildings regardless of organisation – to allow more time spent on work productivity and less time on travelling to siloed office locations.

We will also be working closely with the new ICP’s in their development of Primary Care Networks, and with the Acute Trusts as clinical service requirements and locations are agreed for out of hospital services to best serve patient needs. An example of which may be Cancer or Integrated Urgent Care Services, as the locations to deliver these will impact on the development of the PCN’s, the size of the estate necessary and any requirements on the accessibility of the estate. Emphasis will be on utilising the existing estate in the most efficient way to reduce void costs, with shared clinical service space throughout the day wherever possible to reduce the amount of void space/redundant rooms when a service is not running.

As demonstrated in the Estates Checkpoint Submission contained within the appendices, the K&M STP have a robust disposals pipeline working towards the £85.4m Naylor Fair Share target that was allocated. Currently, organisations within K&M have delivered £51m of receipts, with an additional £28m of properties on our disposals pipeline to be delivered within the Naylor timescales. Through the locality reviews that are being undertaken, it is expected that currently unknown disposal opportunities will arise from a reduction in void spaces/improved utilisation within the current estate – which will enable other properties to be sold.
Strategic Objective 4) – Transformation of our workforce and infrastructure

Our estates strategy continued

Although the existing estate will be used whenever possible, there will also be instances where a new build is required, or significant capital required to tackle backlog maintenance issues to ensure continuity of services. Therefore, we will continue to work on developing its capital projects pipeline and prioritisation of projects for different funding amounts. By regularly updating and understanding the priority of each project, resources and internal assurance can be given to business cases to be developed in line with strategic need or greatest impact. This will ensure that they are available or close to completion for future capital bidding rounds as they become available, and that the capital expenditure is efficiently targeted to projects with the best return to the system.

A high level summary of our mid/long term capital investment requirement broken down per STP clinical initiative shows investment of:

- Stroke services Reconfiguration - £27.7m
- East Kent Acute Redesign - Option 1 = £351m, Option 2 = £363m Acute bids - £224m (excluding the EK Redesign)
- Local Care including primary care
- £211m Mental Health - £31m

Without this integrated health system approach and without additional capital investment, there is a risk that the current estate may not able to meet the patient needs now and also in the future, which will have an impact on the patients health and wellbeing. It is imperative that the K&M Estate has sufficient pro-active investment to the housing and population growth, so it has the resilience to provide the additional clinical services that will be required, as well as appropriate environments for staff to deliver services from before and during the housing growth, not after.
Section Seven

Strategic objective 5) A new Integrated Care System delivery model
Strategic objective 5) A new Integrated Care System delivery model

An Integrated Care System for Kent and Medway

To achieve ‘Quality of Life, Quality of Care’ we know that we need to organise our system differently to remove duplication and enable collaboration and integration. We are creating an Integrated Care System to support the delivery of joined up and personalised care, to drive consistency of services, and to address unwarranted variation.

- **Primary care networks (PCNs):** GP practices working as networks, as outlined in the NHS Long Term Plan and enabled through the new GP contract. PCNs will enable delivery of primary care at scale, with an extended primary care team. We will have 42 Primary Care Networks in K&M, all of which have a Clinical Director who is responsible for leading the PCN’s development.

- **Four integrated care partnerships (ICPs):** Partnerships of NHS providers and other key partners working together to deliver joined up care by collaborating within their local geography. They will determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000. Our four ICPs are:
  - East Kent Integrated Care Partnership
  - Dartford, Gravesham and Swanley Integrated Care Partnership
  - Medway and Swale Integrated Care Partnership
  - West Kent Integrated Care Partnership

- **One Single system commissioner:** The establishment of a single K&M CCG covering our population of circa 1.8 million. A single CCG would not simply be a coming together of the current CCGs with the same responsibilities but would set strategic direction, establish the financial framework for the system and have an assurance function. Its focus would be on population needs as outlined in the table below.

This signals significant transformation of health and social care commissioning and provision to drive collaboration and integration. The development of strong relationships and partnerships across providers in different settings and sectors form a critical part of the success of delivering this change. The ability to work as a whole system, both commissioning and provision, will strategically strengthen the planning of services in response to population needs and expected outcomes, as well as the management of resources and its deployment. It is anticipated that the ability to work as a system will also offer opportunities to preside over key activities such as financial arrangements and incentives, in line with single control totals.

**Benefits for patients arising from Primary Care Networks:**

- Extended access to primary care at different practices/facilities outside of traditional opening hours and with more care, advice and support offered outside of the GP’s consulting room
- Patients discover a new confidence in primary care teams – recognising that sometimes the most effective help and support is found outside of the consulting room and with a pharmacist, social prescriber, nurse or mental health professional
- You’ll only need to tell your story once – shared records will mean that patients no longer have to tell their story to multiple individuals or teams
- Prevention and early intervention are key drivers to help people stay well, prevent avoidable illness, and to make the right decisions for their health and wellbeing
- Joined-up care for those with complex conditions, treating the whole person and what’s important to them will be the cornerstone of care
- By creating bigger, more integrated teams allows professionals to work under the primary care ‘umbrella’, rather than in isolation, offering more holistic and personalised care. With other highly qualified health professionals able to focus on care and support to patients, GPs will have more time to deal with the complex cases that need their attention and focus on bringing their medical knowledge and expertise where it is most needed.
Strategic objective 5) A new Integrated Care System delivery model

Benefits of creating Integrated Care Partnerships

- ICPs will work together rather than in competition with each other to deliver local care. We expect their role will include:
  - Focusing on the specific health needs and challenges of their local population and developing and delivering services that improve the health and wellbeing of local people
  - Driving integration by breaking down barriers between organisations, enabling more joined-up working, less duplication and a more seamless experience for patients
  - Assuring and overseeing the quality of care and services that local people receive, reporting on performance and ensuring that the highest quality standards are adhered to
  - Local clinicians and teams at the forefront of designing and delivering patient pathways that deliver the highest quality care and best patient outcomes with the support of local people
  - Making best use of available budget and managing contracts with local providers to ensure that care and support represents true integration and value for money.

Benefits of creating a Kent and Medway CCG

- The Kent and Medway CCG would focus on health needs of the whole population and would set out what integrated care partnerships need to do to meet them
- The CCG could also commission some specialist services for the whole of Kent and Medway, for example, cancer care and children’s services
- The CCG would set the standard of what we want to see for everyone in Kent and Medway, how funding flows and hold the whole system to account

To achieve ICS status by April 2021, we need to deliver the following:

Key actions for remainder of 19/20

- Develop ICS system model and governance structure for transition including the agreement of ICS system functions and interim operating model
- Confirm future ICS leadership arrangements that includes the appointment of the permanent Accountable Officer and senior management team for single CCG, building upon current joint working arrangements
- Confirm future functions and roles across ICPs, CCG and ICS responsibilities.
- Appoint Independent Chair for ICS and CCG Clinical Chair
- Develop the Medium Term Financial strategy across K&M system (links to merger application)
- Approval of the K&M Analytics Strategy

Actions for 20/21

Merger of 8 CCGs into single CCG by April 2020

- Further development of future financial allocations
- Develop a long term strategic approach to embedding prevention in all policy, commissioning and delivery of services
- An agreed Population Health Management Strategy outlining our PHM arrangements at each levels of the system, including the infrastructure, intelligence and intervention capabilities

The table overleaf shows our K&M position against the key national components of an integrated Care System.
<table>
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<tr>
<th>Key requirements for an ICS from the LTP implementation framework</th>
<th>Kent and Medway current position</th>
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| A partnership board, representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, voluntary and community sector and other partners | • Recently undergone a major STP/ICS Partnership Board governance refresh, resulting in the streamlining of our governance ensuring alignment to clinical forums and Health and Wellbeing Boards  
• System Transformation Executive Board will oversee the delivery of the system commissioner, ICPs and PCNs across Kent and Medway and has broad representation from across the sectors  
• Developed, and have in place, joint working relationships with both of our upper tier Local Authorities and we are continuing to develop our ways of working with the voluntary sector |
| A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/governing bodies | • A NEDs Oversight Group that sits alongside the STP/ICS Partnership Board and successfully received funding from NHS Confederation to be a pilot site for effective NED / Lay member engagement  
• A System Commissioner Governance Oversight Group made up of CCG Lay members to oversee the development of a single CCG. The STP currently has an interim chair and we will recruit a permanent independent chair for the ICS |
| Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes | • A clear system transformation infrastructure in place with good clinical leadership and close working with Local Govt  
• A single Accountable Officer structure across the 8 CCGs with direct reports holding portfolios with shared responsibility  
• Shared leadership by way of a senior management team across the 8 CCGs to enable joint working  
• Dedicated PMO capacity within the STP working on large scale change programmes across the system  
• We will be appointing a Kent and Medway Chief Nursing Officer and Chief Financial Officer |
| Full engagement with primary care, including through a named accountable Clinical Director of each primary care network | • Developed primary care strategy that is owned by primary care professionals, including our PCN Clinical Directors.  
• We have worked directly with the Clinical Directors through surveys, workshops and 1:1s to understand what support they want and need to develop their roles within ICPs and the ICS, as well as to develop their own PCN. This directly contributed to how we allocated our PCN development funding and to the design of our support offer, which is centrally coordinated but delivered within ICP footprints  
• Appointed a Senior Primary Care Advisor to sit on our System Transformation Executive Board to support the design and development of PCN representation |
| Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, ICSs and Health and Wellbeing Boards will also work closely together | • An established Clinical and Professional Board (CPB) has a specific mandate through its terms of reference to promote clinical and professional engagement and leadership in the delivery of STP programmes and the transition to an integrated care system  
• Each of the four ICPs has established local clinical and professional boards to build on this model and lead the delivery of our clinical and professional vision. As we transition to an ICS we will use the CPB to support the development of these local arrangements as well as advising on the design of an ICS that remains as firmly clinically and professionally led as our STP has been since its inception. This will ensure that we continue to provide care model frameworks and support and challenge at system level, while enabling local programmes and pathways to be developed within ICPs  
• Through the Kent and Medway Cancer alliance (which is already coterminous with our STP), we have a strong focus on improving cancer performance against national standards and preparing to meet new standards for faster diagnosis and diagnosis at stages 1 & 2 |
Strategic objective 5) A new Integrated Care System delivery model

The case for a K&M system commissioner through a single Clinical Commissioning Group

Our eight clinical commissioning groups (CCGs) have successfully applied to become a single commissioner with effect from 1 April 2020. This will enable the NHS in Kent and Medway to build on, and accelerate, joint working to address some of our key local challenges, unlocking short and long term benefits for the people who use our services and for our workforce.

A single clinical commissioning group will:

- Free up staff and GP time to improve care for local people
- Have less complex structures and a clearer framework for clinical decision making
- End duplication of committees, meetings and effort, saving time and money, not just for the clinical commissioning group, but also the for the NHS trusts and other organisations that provide NHS services and partners, such as social care
- Enable faster decision making, meaning improvements to patient care can happen sooner
- Agree health outcomes for Kent and Medway, reducing unacceptable difference in health and life expectancy – these will be delivered by integrated care partnerships and will be tailored to their local populations
- Use detailed data to achieve a bird’s eye view of the health of specific groups or communities, underpinning the development of health outcomes
- Reduce the number of buildings needed for staff in the longer term and IT running costs
- Improve staff recruitment and retention through a joined-up approach to workforce issues and opportunities
- Use its substantial buying power to increase value for money for the taxpayer
- Continue to involve local people in shaping health and care services
- Accelerate clinically-led innovation

The GPs who chair the current CCGs led the drive to create a single CCG, after rigorously assessing all the possible options for a system commissioner. They undertook extensive engagement including with the GPs who make up our current CCGs, staff, patients, the public, health and social care partners, local authorities and MPs.

A recurring theme has been concern about the potential loss of local input into a single CCG. To address this concern, the following has been integral to the proposed design of a single CCG:

- The new CCG will always be GP-led, with a GP governing body majority including a GP from each current CCG until at least April 2022 and clinical representation or leadership as appropriate on all committees
- A full and robust development programme for primary care networks enabling effective leadership within the emerging integrated care system
- Strong local patient and public representation running from the CCG governing body to individual primary care networks, linking all patient and public involvement forums, and creating a citizens’ panel and an insight bank, to significantly strengthen the use of patient experience and insight across the system
- GP members and governing bodies of the existing eight CCGs all approved the merger. NHSE/I approved the merger application in October 2019
- We have also developed a ‘One Team’ model which sets out how health and social care will work together in a more joined-up way, drawing expertise together from across organisations to address the key challenges, and improve quality of life and quality of care for patients
ICS Organisational Development

We have been working as a system to develop our organisational development (OD) approach through our System Leadership and OD group. We have developed a set of OD activities to support PCNs and to enable our CCG teams to transition to a single system commissioner. We are scoping the OD needs of our ICPs. An OD strategy that brings these elements together to support Kent and Medway to transition to an ICS is to be developed, building on current and future system OD needs, activities and actions. This will support us as a system to have an agreed set of system priorities, a common language, development of our system leaders to lead this change and a shared OD methodology to transform our system. As the new system will be evolving over the next five years, with different parts developing at different rates, this strategy itself is emergent and will adapt and change as new elements of the system develop and mature.

Immediate priorities are focused on the development of the ICS OD strategy, transition plan for the system commissioner, and the clinical leadership and development offer for the PCNs.

- Development of the ICS OD strategy
- Undertaking development of our senior leaders with the objective of co-producing a vision, values, behaviours and strategic direction and prioritising strategic activities for the ICS
- Implement the senior leadership structure that is aligned to the delivery of the vision of the ICS including appointment to the permanent AO/system leader
- Developing cohorts of leaders (including clinical leaders) in system working, building on the Leading across Kent and Medway pilot
- Implement the Workforce and OD plan for the CCG
- Rollout of the PCN development offer including clinical leadership development, rollout of the OD toolkit to support team collaboration
- Scoping of OD needs with ICPs
- Develop new models of care that work effortlessly across boundaries

ICS Operating Model

As the Integrated Care System develops, there will be a number of functions that we will need to operate at a system level. These functions will include:

- **System Planning**: This year has seen the development of a System Operating Plan for 19/20 and the creation of this five year Strategy Delivery Plan 19/20 to 23/24. There is further work to do on our long term outcomes and benefits, linked with future operational planning at all levels of the ICS
- **System Resilience**: In 18/19, Kent and Medway were asked to provide some support to winter planning at a system level; this was expanded to also lead on EU Exit planning for the system. We have established a team at a Kent and Medway level to lead on system resilience and planning
- **Assurance and delivery**: With the changes at NHSE/I, and the expectation that ICSs will take more of a responsibility for assurance, STPs/ICSs will be invited to join the regulators’ system assurance meetings and Intensive Support work with ICPs in 19/20
- **Quality**: The NHSE/I feedback on the SOP noted the lack of a Quality strategy at a Kent and Medway level. We have set out in Chapter 4a) Our approach to quality how this is being addressed

NHSE/I will be rolling out a “one team” approach with STPs/ICSs on delivering national programmes in 19/20. In some areas, the STP has pre-existing programmes and already works with NHSE/I, but STPs/ICSs will take on more responsibility for overseeing national programmes across systems. This will include Primary Care, Cancer, Mental Health, Continuing Healthcare, Maternity, Learning Disabilities and Autism, Digital, Diabetes, Variations and New Pathways, Urgent and Emergency Care, Elective.

In Kent and Medway, we have developed an interim operating model which describes the integrated working arrangements across the emergent ICS and outlines the key relationships between commissioners, healthcare providers (including PCNs) and local authorities - the key partner organisations within the new system. It reflects the need to focus on the system and sub-systems rather than the individual organisations, drawing expertise together from across organisations in order to address the key challenges, and realise opportunities for patient through integration of care delivery.
Strategic objective 5) A new Integrated Care System delivery model

Specialised commissioning

As we move to become an Integrated Care System, we will continue to work with NHSE/I to plan and deliver specialised services as locally as possible and to join up care pathways from primary care through to specialised services with the overall goal of improving patient outcomes and experience. We will work with NHSE/I to understand the national parameters within which ICS can take on more responsibility and the associated resource implications.

We will support NHSE/I to repatriate services that are currently being provided outside of the South East where it is in the best interests of patients and supports sustainability of South East providers. This will be in support of the drive to move care closer to home.

We will work with NHSE/I on the implementation of Long Term Plan commitments as outlined elsewhere in this plan:
- Improving bowel, breast and cervical screening uptake
- Implementing the HPV vaccination programme for boys
- Roll out of FIT 120
- Roll out of HPV Primary Screen in the cervical screening programme
- Taking forward the findings of Sir Mike Richards review into Cancer screening
- Designing screening and vaccination programmes to support a reduction in health inequalities
- Improvements in child immunisation levels
- Implementation of the digital child health record ‘e-book’

Specific areas for Kent and Medway include:

- **Mechanical Thrombectomy** – the geography of Kent makes it important to have a mechanical thrombectomy centre in Kent to ensure equitable access. Currently it is envisaged that it will be at William Harvey site based on analysis conducted by NHSE/I. It is important looking ahead that there is a joined up approach to planning all vascular intervention which would include thrombectomy for stroke and vascular services

- **Kent and Medway Vascular Network** – continuing to drive the establishment of a vascular network across Kent and Medway to secure the long-term provision of vascular services and support equity of access for all patients in Kent and Medway (as outlined earlier in this plan on page 41)

- **Clinical Frailty** – East Kent have successfully achieved a place in the National Clinical Frailty Pilot for Vascular services. The improvement work developed at this site will be used as an exemplar for other specialised service teams to improve their services for people with frailty, as well as shaping national policy

- **Cardiology** – We will work closely with specialised commissioning colleagues to establish an appropriate network to improve the outcomes and experience of people accessing these services and ensure fast access to life-saving stroke treatments

- **Enhanced Supportive Care** - Promote the expansion of Enhanced Supportive Care, and take a leadership role in sharing learning, to enable patient choice and informed decision-making. Specialised Commissioning have pump-primed investment in Maidstone and Tunbridge Wells NHS Trust to achieve this.
Strategic objective 5) A new Integrated Care System delivery model

Innovation

As we move to become an ICS, we will need to consider where leadership and capability for research and innovation should sit, with a need to consider innovation alongside our approach to quality improvement and digital given the close interactions between these areas.

In order to spread innovation faster and wider, Kent and Medway STP supported the establishment of the Innovation Collaborative. The collaborative consists of the Kent Sussex and Surrey AHSN, and the Design and Learning Centre who have a remit to accelerate the uptake of health and social care innovations in Kent and Medway. The Design and Learning Centre was initially developed as part of the NHS Integrated Care Pioneer Programme which aimed to explore new and innovative ways of delivering health and social care in an integrated way. The Innovation Collaborative seeks to identify, select and support the adoption of innovations that improve clinical outcomes, deliver better patient experiences, drive down the costs of care and stimulate wealth creation locally and regionally.

In line with the ambitions of the Long Term Plan, the Kent and Medway STP Clinical and Professional Board (C&PB) set a challenge for the collaborative to find new and innovative ways to support people with a number of conditions including asthma, cardio vascular disease, chronic obstructive pulmonary disease and diabetes. The group will report back to the Clinical and Professional Board during Q4 of 2019/20.

Key deliverables for the Innovation Collaborative in 19/20 are:

- Organising user / citizen innovation sessions to support programmes such as Local Care and Digital
- Evaluation and Research Network supporting the Clinical & Professional Board including the link with ARC and the Health Analytics Board
- ESTHER training and briefing sessions for Dartford Gravesham and Swanley and Swale
- ESTHER and Buurtzorg: EU management and implementation of the new models of care
- Care Sector Workforce: facilitating conferences and engagement
- Medication Innovation programme: digital MAR sheets and joint pharmacy programme
- International and national funding applications including for the Innovation Lab, Workforce Academy, Digital innovation supporting health and social care

Future arrangements for innovation will be considered as part of the wider ICS operating model design.
Strategic objective 5) A new Integrated Care System delivery model

The role of the voluntary sector and volunteers

In Kent and Medway, we are committed to working closely with the voluntary sector, recognising the invaluable and under exploited role of the voluntary sector to support new models of care.

Social isolation has a major impact on both physical and mental health and as a system we are committed to working with our communities, with the voluntary sector, volunteers and local businesses to continue to find new and innovative ways to tackle loneliness and isolation. We also recognise that there is a significant role for business, community, voluntary sector organisations and volunteers to support prevention. As we embed prevention across all of our pathway, we will actively consider new and expanded ways of working with these organisations and individuals.

As part of the Kent and Medway STP, the local care model for older people and adults with long-term conditions has been developed. Through this new model, new roles for care navigators, case managers and peer supporters are being developed. Peer supporters will usually be volunteers, with similar conditions or challenges to give the patient the support they need. They might also act as mediators. Some of our volunteers already provide a sign-posting role by staffing information desks, but the new local care model provides opportunities for the role of peer supporters to be further developed and recruited.

Through the Home First scheme, the NHS and social care in Kent is working more closely together to get more people home from hospital safely and sooner. Part of this involves commissioning and partnering with organisations, such as Age UK, to provide a meet and greet service for patients returning home from hospital. We will explore opportunities for volunteers to form part of a befriending scheme to help tackle social isolation among patients who are returning home from hospital and support sign-posting as part of the multidisciplinary team.

Befriending services are in place across much of our geography, mainly for isolated older people, delivered by local organisations including Age UK, carers’ organisations, volunteer bureaux and community groups. Most are specific to a geographical location such as isolated rural areas or to a specific client group, for example phone befriending for carers, or visits to people with dementia. Arrangements for funding of befriending services by KCC are moving from grants to contracts and as a result, a number of befriending services are forming a Kent-wide consortium to tender for this work. We will explore way of working with any future consortium to help build befriending into our care pathways. We will support promotion of the befriending scheme to increase referrals from our staff.

We will utilise local business and community networks to promote volunteer recruitment and create corporate fundraising and volunteering opportunities for local businesses. A good example of where this has already worked well is where Maidstone Lions supported Kent Community Health Foundation Trust’s charity ‘i care’ to launch a sensory room in Maidstone.

Volunteers make a unique and valuable contribution to patients, carers, visitors and staff. As well as having a positive impact on healthcare services and the volunteer, volunteering is widely recognised as a powerful tool for promoting healthy communities. Volunteers are an essential resource in helping us achieve our vision.

In Kent and Medway we recognise that volunteering can help to:

- Improve quality of life: The Royal Voluntary Service, in May 2012, found volunteering in later life decreased depression and social isolation and boosted quality of life.
- Improve an individual’s ability to cope with ill health: Volunteering can help people come to terms with their illness and provide a form of distraction to one’s own problems.
Strategic objective 5) A new Integrated Care System delivery model

- Lead a healthier life: Smokers who volunteer in stop-smoking services, often give up and students who binge-drink, drink less when volunteering.

- Improve mental health: Volunteering helps people to improve self-esteem and gives a sense of purpose. This can be vital for people who might be isolated.

Across Kent and Medway, provider Trusts utilise the valuable service of volunteers in over 37 different types of roles many of which are patient focused including volunteers who assist with mealtimes, ward exercise rehabilitation, ward trolley rounds, reception and admin support, hospital shops, and governors. Additionally, we have a vibrant network of volunteers in primary care carrying out activities such as volunteer driving.

We are developing and innovative and integrated youth volunteering offer in partnership with Pears Foundation and NHSI/E during 20/21 and 21/22 that increases the number of young people aged 16-25 actively participating in volunteering within the sector and widens the breadth of volunteering opportunities available to young people, building a cross sector network that works together to embed this work within the wider health and care volunteering and career development system. We are also working in partnership with the Princes to Trust to support Young People aged 16-30 yrs old into health and care careers and planning to expand these type of employability model with other voluntary sector organisations to widen participation and diversify our workforce.

As we become an Integrated Care System, there is an opportunity to look at ways of engaging and partnering with business, community, and voluntary sector organisations as a system, to support and augment the work that is happening with individual organisations and at a local level.
Section Eight

Monitoring delivery of this plan
Monitoring delivery of this plan

Governance

Our Kent and Medway Sustainability & Transformation Partnership (STP) has established system governance to support delivery of our STP Programmes and provide the foundation for delivery of the Strategy Delivery Plan (see governance structure right). In 2018, the STP refreshed the system governance with individual Programme Boards set up to support delivery, and a Non-Executive Director Group established with membership from NHS commissioners and providers as well as the Local Authorities to support oversight and connection to statutory organisations and their Boards and Committees.

However, as we move to become an Integrated Care System, we will need to transition to a new set of ICS governance arrangements, ascertaining what is required at the system level and what will need to operate at the level of the Integrated Care Partnerships.

In the immediate future, we will continue to utilise our existing STP governance, individual organisational governance, and ICP partnership boards. Our existing arrangements are already changing incrementally to support the move to an ICS, for example with the STP Programme Board evolving into an ICS Partnership Board.

Alongside the creation of new governance for a single CCG, a wider governance review will be instigated to look at the levels of accountability between the CCG and the ICPs including where accountabilities sit for quality governance and quality assurance (as outlined in section three of this plan on ‘Our approach to Quality’). Additionally, a key focus of the new governance arrangements will be the importance of clinical leadership, GP representation and patient representation. It is likely that we will need to develop and evaluate a series of options for the future ICS arrangements.

Once new arrangements are agreed, we will ensure a smooth transition from the existing legacy STP arrangements to the ICS governance model.
Monitoring delivery of this plan

Supporting delivery

The established system governance and programme delivery is supported by a PMO team that has been set up as part of the STP team, and has been in place since 2017. The PMO team lead the management of the STP programmes with SROs and workstream leads and ensures an appropriate programme management approach is used. The PMO team also manage the system governance to support the focus on delivery and oversight. As we move to become an ICS, the emergent Integrated Care Partnerships will provide the infrastructure for partners to work together on delivery as well as the local governance to track progress with the delivery of plans.

Assurance

Kent and Medway’s vision for an Integrated Care System will support delivery and ensure appropriate monitoring across the different levels of the system. NHSE/I are supporting this model with assurance focusing on the ICP level in 2019/20 with the STP invited to attend assurance discussions. The Single Oversight Framework for providers and the CCG Improvement and Assessment Framework are also being brought together to support the move to partnership working. To support further integration, NHSE/I are also inviting STP and ICS leaders to join their South East region Senior Leadership Team meetings every quarter. These are complemented by six-monthly meetings with each STP or ICS leadership team. NHSE/I are also establishing a “One Team” approach with STPs/ICSs for national programmes that will provide a direct linkage between national and STP programmes and an operating model that supports a whole system approach.

Risk management

The STP has established a risk management approach that is led by programmes and tracked and monitored through the STP. Every STP workstream has a programme board that manages programme risk or escalates to our STP/ICS Partnership Board where required.

As part of our ICS development we are designing a new approach to monitoring system risks across Primary Care Networks, Integrated Care Partnerships and across K&M as a system. This will build on the STP risk management policy that has been signed off by all organisations for monitoring the STP programme. We will report on these risks in our 20/21 System Operating Plan and individual ICP and organisational plans.
Monitoring delivery of this plan

Future engagement on our plans

The STP has engaged with patients, public, and a range of partners and stakeholders to develop and deliver plans since 2016. Our approach was to build on the extensive engagement work already undertaken, which gives us a good understanding of local issues, attitudes, and concerns and has informed our work. To support the development of the Strategy Delivery Plan, listening events were held in each of the ICP areas, as well as targeted engagement with seldom heard groups.

The Kent and Medway STP’s Patient and Public Advisory Group (PPAG) has been regularly involved in the development of engagement plans, as well as playing an important role in co-producing and critiquing the actual plans. PPAG members sit on existing STP workstreams representing the patient voice and feed into the co-design of the plans from those workstreams.

As the STP evolves into an ICS, and to support the delivery of plans, we have co-designed a new model of patient and public involvement to ensure that patients continue to have a voice at every level. This includes the creation of a new patient group, supplemented by patient, client and carer-led task and finish groups. These will be drawn together for time-limited focused pieces of work as the workstreams and overall programme of transformation require.

In addition, two new systems will be set up to support these groups. We will launch a virtual citizen’s panel - a network of people representative of the Kent and Medway population to ensure a public perspective can be sought on all work programmes. Plus an insight bank to collate and link all the existing intelligence on patient experience gathered by NHS trusts, Healthwatch Kent and Healthwatch Medway, CCG, ICPs and local authorities. Supplementary groups are also being established at ICP and PCN level to ensure patients have a voice at every level.

While not losing the range of groups and mechanisms we have to support our engagement, we will be using these new groups to facilitate and help monitor our progress. We will continue to share our progress against the ambitions we have set out with our audiences and seek their views on how effective we are being and where we can improve so that the voice of patients and the public remains at the heart of everything we do.
Monitoring delivery of this plan

Next steps

The Strategy Delivery Plan builds on the work of the STP as well as the System Operating Plan for 19/20 to provide a plan for the next five years for Kent and Medway. Following approval of Kent and Medway’s Strategy Delivery Plan, we will ensure that this is comprehensively built into programmes with the appropriate governance in the system to monitor progress and support delivery. This will also be hardwired into the development plan for the Integrated Care System in Kent and Medway. Detailed actions for the coming year will be set out in the System Operating Plan for 20/21, which will provide further granularity on plans in the next financial year.

The development of Kent and Medway’s plans do not stop with our Strategy Delivery Plan. Significant pieces of strategy and plans in development include a shared children’s plan, a system wide analytics strategy, a refreshed Digital strategy and an End of Life Care strategy and implementation plan. Additionally, we know that the creation of a single CCG and the development of our Integrated Care Partnerships, including our Primary Care Networks, creates an opportunity to refresh our system vision.

We intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. Additionally, we will develop a commissioning strategy for the new single Kent and Medway CCG. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to K&M to support the implementation of the Long Term Plan.
Annex 1 – STP partners
Members of STP Programme Board

1. Ashford CCG
2. Canterbury and Coastal CCG
3. Dartford and Gravesham NHS Trust
4. Dartford, Gravesham and Swanley CCG
5. East Kent Hospitals University NHS Foundation Trust
6. Kent and Medway NHS and Social Care Partnership Trust
7. Kent Community Health NHS Foundation Trust
8. Kent County Council
9. Maidstone and Tunbridge Wells NHS Trust
10. Medway CCG
11. Medway Community Healthcare CIC
12. Medway Council
13. Medway NHS Foundation Trust
14. South East Coast Ambulance Service NHS Foundation Trust
15. South Kent Coast CCG
16. Swale CCG
17. Thanet CCG
18. West Kent CCG
19. Healthwatch Kent and Medway
### Executive Summary

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

### Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

<table>
<thead>
<tr>
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### Committees or Groups at which the paper has been submitted

None

### Resource Implications

None

### Legal Implications/Regulatory Requirements

None

### Quality Impact Assessment

Not applicable

### Recommendation/Actions required

The board is asked to note the report.

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<th>Approval</th>
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### Appendices

None
1 EXECUTIVE OVERVIEW
1.1 This report details some of the communications and engagement activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our improvements.
1.2 It also includes feedback from recent engagement with our community.

2 ENGAGING COLLEAGUES;
2.1 We have continued to engage staff in our key transformation programmes – Best Access and Best Flow, through regular updates and our Making Medway Brilliant newsletter. These programmes remain an integral part of ensuring that we deliver the very best care to our patients.

2.2 The Communications Team is supporting the delivery of the quality agenda, ensuring that staff understand the role they can play in improving care for our patients. As part of this we have replaced our Theme of the Week channel with Theme of the Month. This gives us a full month to focus on a key priority, and be able to assess to what extent activity has had the desired impact, and embedded the changes required.

2.3 We worked with NHS Improvement and our nursing team on a project to produce a discharge guide for our patients. The guide will be given to every single inpatient and will provide them with all the information they need to get ready for their discharge.

2.4 We were proud to develop and launch a new look for our Trust values featuring ambassadors for our organisation across many different disciplines. A suite of materials, including posters in corridors, screensavers and folding pocket cards have been rolled out across the hospital.

2.5 We delivered communications announcing the Chairman’s departure when his term of office comes to an end on 31 March.

2.6 We have worked closely with clinical colleagues to deliver communications relating to Covid-19 to both staff and the public; we have also liaised closely with our local media to dispel rumours and reassure the public.

2.7 The team worked closely with colleagues in HR and OD to ensure staff were fully aware of the results of the NHS Staff Survey.

2.8 The Team has begun preparation for the release of the CQC’s inspection report.

3 MEDIA
3.1 The communications team has dealt with nearly 40 interactions with local, regional and national media since the last board report, with a balance between proactive and positive reporting, less positive stories and neutral coverage.

3.2 The beginning of the year saw the anticipated enquiries about winter pressures and waiting times in the emergency department. We also responded to an enquiry about referral to treatment times from figures reported in October, where we were able to demonstrate an improvement in performance since the reported figures in our response.

3.3 We issued communications about the outcome of the stroke Judicial Review and the departure of the Chair at the end of his term of office.

3.4 There was extensive local and national coverage for an off-duty member of staff who saved the life of a man who had collapsed in the street.
3.5 A press release about changes and improvements made to the quality and choice of meals for patients, visitors and staff led to an interview with our Head of Catering on BBC Radio Kent, while a clip of a video we produced of a group of our cancer nurses was featured in a video published by World Cancer Day in a round-up of events from around the world to mark World Cancer Day.

3.6 Other positive stories generated from press releases included a feature on New Year’s Day babies, advice to the public on staying well in winter and various charity events and thanks for donations.

3.7 We also facilitated an interview with the Chair of our Organ Donation Committee to raise awareness of the change in the law around organ donation due in the spring.

3.8 Less positive stories were published about a recent financial settlement from an historic case and the early closure of our escalation ward.

3.9 The COVID-19 virus has kept the team particularly busy these last few weeks with responses to media queries about the Trust’s preparedness to deal with an outbreak, advice and reassurances to the public.

4 SOCIAL MEDIA

4.1 The Trust remains as Kent’s most-followed acute Trust on both Twitter and Instagram, and has passed the 2,000 follower mark on the latter platform since the last update.

4.2 Medway’s social media channels were used to share key information and updates, including improvements by the Catering Team to the quality and choice of meals for patients, visitors and staff; the special event hosted by staff to mark World Cancer Day 2020; and alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure. Elsewhere, the channels are also being used proactively to support national messaging around the COVID-19 virus and advice to the public on staying well during winter.

4.3 Videos produced in-house by the Communications Team were seen by almost 30,000 social media users, with the story about a patient whose life was saved in the street by an off-duty Trust employee proving most popular.

4.4 Since the last update, posts across our channels reached an increased number of users – approximately 310,4860 on Facebook and 240,200 on Twitter, compared to 130,600 and 161,300 respectively last time. (Significantly higher figures due to better user engagement and a shorter reporting period for the last report)

4.5 Medway’s social media followers continue to grow steadily and now total 5,693 on Twitter (up from 5,478 at the last update), 7,736 on Facebook (up from 7,467) and 2,013 on Instagram (up from 1,866).

5 STAKEHOLDER ENGAGEMENT

5.1 Governors

5.1.1 Governors have continued to meet constituents to listen to patients’ feedback about their experiences at the hospital.

5.1.2 On 13 February there was a Governor engagement event at Hoo Leisure Centre when Diana Hill and Victoria Bean met local residents. This proved to be a good venue to engage with people living in this area.
5.1.3 The next Governor engagement session will be at Rochester Healthy Living Centre from 10am on 10 March.

5.2 Community and patient engagement

5.2.1 At the beginning of January our Community Engagement Officer gave a presentation on the Trust’s progress to the Sunlight Rotary Club. This was well received.

5.2.2 We attended the launch of the Rochester Neuro Café organised by the Medway Neurological Network – a group which takes a keen interest in the hospital.

5.2.3 We supported a diabetes focus group, led by our consultant Dr Tara Rampal, to engage with BAME residents with diabetes.

5.2.4 In early February we organised for an external speaker to give a training presentation to staff on working with the Gypsy and Traveller community.

5.3 Member engagement

5.3.1 Our member event at the beginning of February focused on our quality priorities for the coming year.

5.3.2 A roomful of interested members of the public heard an excellent presentation by Katy White, the Trust’s Quality Standards and Governance Improvement Director. This was followed by a workshop session in which attendees recorded their views and feedback on the proposed feedback.

5.3.3 The next scheduled member event is from 2pm to 4pm on 20 May when the subject will be infection prevention and control. This will be the first time we have held an afternoon member event; this is being trialled in response to a survey which indicated some people would prefer an earlier time.
# Finance Report for January 2020

**Title of Report**: Finance Report for January 2020

**Agenda Item**: 7.1

**Report Author**: Ian O’Connor, Director of Finance, Paul Kimber, Deputy Director of Finance, Matthew Chapman, Head of Operational Finance, Cleo Chella, Associate Director Income & Contracts, Isla Fraser, Financial Controller

**Lead Director**: Ian O’Connor, Director of Finance

**Executive Summary**: The Trust reports an in-month surplus of £6,000 and year-to-date surplus of £91,000 against the NHST plan.

**Link to strategic Objectives 2019/20**

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**Due Diligence**

**Committee Approval**: To give the Trust Board assurance, please complete the following:

- **Name of Committee**: Finance Committee
- **Date of approval**: 27 February 2020

**Executive Approval**: Date of Approval: N/A

**National Guidelines compliance**: Does the paper conform to National Guidelines (please state): Yes

**Resource Implications**: None

**Legal Implications/Regulatory Requirements**: Year-to-date and forecast outturn remains in line with original control total although with little room for manoeuvre.

**Quality Impact Assessment**: Resources are not being starved to front line provision. Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established QIA Framework.

**Recommendation/Actions required**: The Board is asked to note the financial performance.

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Finance Report
January 2020

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Forecast ......................................... 13
Balance Sheet 2020/21 .................... 16
Conclusions & Recommendations .... 20
Appendices .................................... 21-23
1 Executive Summary

1.1 The report sets out the summary financial position to the end of January 2020 and includes:

- A review of the year to date position incorporating a deep dive into pay costs and reported monthly activity
- An assessment of the most likely year end outturn position
- A description of year to date delivery of the cost improvement programme
- The balance sheet and its component parts
- An assessment of 2020/21 and planning

1.2 To the end of January the Trust is reporting a cumulative deficit of £19.38 million against an expected £19.47 million deficit as declared in its financial plan; this is a favourable variance to plan of £91k. Deficits in operational Divisions continue against delegated plans offset by improvements developed centrally. Where appropriate underspending corporate budgets have been devolved to operational areas in 2019/20. In the final forecast analysis the budgetary position will be offset by the contingency reserve and fortuitous underspends in corporate areas.

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<td>1,193</td>
<td>221,023</td>
<td>222,216</td>
</tr>
<tr>
<td>Pay</td>
<td>(16,788)</td>
<td>(170,809)</td>
<td>(175,112)</td>
<td>(4,303)</td>
<td>(170,809)</td>
<td>(175,112)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(9,500)</td>
<td>(96,657)</td>
<td>(94,938)</td>
<td>1,719</td>
<td>(96,957)</td>
<td>(94,938)</td>
</tr>
<tr>
<td>Non Operating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td>(1,337)</td>
<td>(13,024)</td>
<td>(11,542)</td>
<td>1,482</td>
<td>(13,024)</td>
<td>(11,542)</td>
</tr>
<tr>
<td>Control Total</td>
<td>(957)</td>
<td>(19,467)</td>
<td>(19,375)</td>
<td>91</td>
<td>(19,467)</td>
<td>(19,375)</td>
</tr>
<tr>
<td>18/19 PSF Gain</td>
<td></td>
<td></td>
<td>580</td>
<td>580</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ledger</td>
<td>(957)</td>
<td>(19,467)</td>
<td>(18,795)</td>
<td>671</td>
<td>(19,467)</td>
<td>(18,795)</td>
</tr>
</tbody>
</table>

1.3 The Cost Improvement plan is likely to undershoot its adjusted cost improvement requirement of £19.5 million and will be offset through the application of the contingency reserve.
Based upon continuing income and expenditure patterns and basing the forecast on a number of different scenarios, the forecast for 2019/20 remains that the £22.3 million deficit will be achieved with a narrowing of the current range between £21.2 and £22.5 million.

An emerging risk surrounds the transparency of outsourced activity and the expected RTT performance to achieve the 88% required by the CCG as agreed within the agreement at £202.0 million block contract.

<table>
<thead>
<tr>
<th>£'000</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Month</td>
<td>957</td>
<td>951</td>
<td>6</td>
</tr>
<tr>
<td>Cumulative</td>
<td>19,467</td>
<td>19,375</td>
<td>91</td>
</tr>
<tr>
<td>Forecast</td>
<td>22,201</td>
<td>22,201</td>
<td>0</td>
</tr>
</tbody>
</table>

**Income and Expenditure**

The Trust continues to benefit from the £202 million full and final settlement from commissioners with actual activity running £1.8 million below planned levels.

Based upon existing expenditure and patterns of income with other commissioners, the level of risk in achieving the forecast is considered low.

**Divisional Detail**

Despite activity at levels lower than plan, pay costs continue to rise implying lower levels of overall productivity since the beginning of the financial year. A more detailed evaluation of pay spend compared to weighted activity is included in this report.

Vacancies in corporate divisions are providing benefit as well as favourable conclusions to contract negotiations with local CCGs and specialist commissioners affecting the improvements against central financial plans.
Cost Improvement

Increases in the cost improvement plan to support Flow and additional costs of planned care nursing establishment are unlikely to be delivered.

<table>
<thead>
<tr>
<th>£'000</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Month</td>
<td>2,305</td>
<td>1,621</td>
<td>(684)</td>
</tr>
<tr>
<td>Cumulative</td>
<td>17,347</td>
<td>14,999</td>
<td>(2,348)</td>
</tr>
<tr>
<td>Forecast</td>
<td>18,024</td>
<td>18,207</td>
<td>183</td>
</tr>
</tbody>
</table>

Capital

Capital Expenditure is marginally ahead of plan representing a significant slow-down in spend compared to plan. Individual projects expected for 2020/21 are being accelerated in order to ensure expenditure matches the outturn plan.

The forecast reflects slippages on some projects mitigated by the acceleration of other projects to achieve the capital control total.

Risk of non-delivery is heightened.

<table>
<thead>
<tr>
<th>£'000</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Month</td>
<td>2,830</td>
<td>1,048</td>
<td>(1,782)</td>
</tr>
<tr>
<td>Cumulative</td>
<td>16,539</td>
<td>16,288</td>
<td>(251)</td>
</tr>
<tr>
<td>Forecast</td>
<td>23,713</td>
<td>23,713</td>
<td>0</td>
</tr>
</tbody>
</table>

Cash

Cash continues to be higher than plan as a result of NKCCG advances of cash in April and October. Cash is expected to improve to plan in February with loans for the revenue deficit and capital plan taken in March. Work continues with credit control.

<table>
<thead>
<tr>
<th>£'000</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 31/01/20</td>
<td>5,000</td>
<td>33,312</td>
<td>28,312</td>
</tr>
</tbody>
</table>
2 Run Rates

Clinical Income (Excl HCD)

The January income position has reduced compared to December mainly driven by lower activity in month for Elective Day cases and Elective inpatients. This is due to cancellation of day case procedures as a result of shortages of beds. The beds were occupied by emergency patients as expected during winter months.

There isn’t a corresponding increase in non-elective emergency income because the length of stay is longer for these patients and income will be recognised when they are discharged.

Pay

Monthly pay spend continues to increase as the costs of the Clinical Decisions Unit nursing staff and S DEC medical staffing impact on the position.

When comparing other pay expenditure pressures to the average of the previous 9 months, pay costs have increased by (£483k). This increase is across both substantive staff (£222k) and temporary staffing (£261k). The demand for temporary staff continues to cover vacancies, winter pressures, specialist nursing and activity within the clinical divisions. Finance Business Partners continue to work with Divisions to gain insight into recruiting plans and gain control against pay overspending.

A deeper analysis is provided later in this report.
Non-pay expenditure in January has decreased as the optimism bias reserve provision has been utilised. This has been necessary as pay costs continue to increase and the Cost Improvement Programme is adverse to plan. The release of the optimism bias reserve this month is £1.2 million bringing the total value of the reserve used in the reported position to £1.5 million.
### 3 Income and Expenditure

#### 3.1 Income

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>Plan</td>
</tr>
<tr>
<td>Clinical Income</td>
<td>19,139</td>
<td>19,576</td>
</tr>
<tr>
<td>High Cost Drugs</td>
<td>2,243</td>
<td>2,341</td>
</tr>
<tr>
<td>Other Income</td>
<td>2,020</td>
<td>2,104</td>
</tr>
<tr>
<td>Central Funds</td>
<td>3,266</td>
<td>3,266</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>26,668</td>
<td>27,287</td>
</tr>
</tbody>
</table>

Clinical income performance is a result of agreeing a block contract with our local commissioners for 2019/20. The block value has been agreed at £202 million with North Kent CCGs and represents a benefit of £1.8 million at Month 10.

An independent consultant was engaged to review MFT data and calculate the value of the North Kent CCGs contract for 19/20 based on M1-6 actual activity.

The draft report has now been issued in which the calculated value of the contract for 19/2020 is given as £202.1 million before CQUIN. MFT have requested some changes to the calculation however the outcome of the report has still to be concluded with the CCG.
### 3.2 Pay

#### 3.2.1 Year to Date

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £'000</td>
<td>Actual £'000</td>
</tr>
<tr>
<td>Substantive</td>
<td>(14,532)</td>
<td>(14,885)</td>
</tr>
<tr>
<td>Bank</td>
<td>(1,689)</td>
<td>(2,446)</td>
</tr>
<tr>
<td>Agency</td>
<td>(567)</td>
<td>(616)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(16,788)</strong></td>
<td><strong>(17,946)</strong></td>
</tr>
</tbody>
</table>

Monthly pay spend continues to increase and is the subject of a deeper dive into productivity later in this report. Analysing different pay groups then we can see the predominant adverse variances arising from the use of Nursing and Medical staff.

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £'000</td>
<td>Actual £'000</td>
</tr>
<tr>
<td>Medical</td>
<td>(5,305)</td>
<td>(5,521)</td>
</tr>
<tr>
<td>Nursing</td>
<td>(5,497)</td>
<td>(5,894)</td>
</tr>
<tr>
<td>Other</td>
<td>(5,987)</td>
<td>(6,533)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(16,788)</strong></td>
<td><strong>(17,946)</strong></td>
</tr>
</tbody>
</table>

*Medical*

There are currently vacancies in the junior doctor's rota; these require temporary staffing cover to meet demand needs as well as the on call rota. This is expected to continue for the next three months of this rotation.

The overall adverse variance is due to high level of spending in the clinical divisions to meet an increase in demand, SDEC and CDU.
**Nursing**

The in-month nursing staff adverse variance position has deteriorated further, with clinical divisions relying further on bank and agency staff to meet the demands on the services and backfill vacant posts (mainly in Obstetrics and Theatres, by 7.04 WTE). Costs associated with the Clinical Decision Unit totalling £47k and 6.24 WTE have contributed to the cost increase for January.

Divisions are addressing the new budgets for service developments and safer staffing levels through business planning for 2020/21.

**Other Staff**

Substantive staff favourable variance is due to vacant posts within the Planned Care Division, Facilities & Estates as well as Corporate services. This has increased the demand for bank and agency staff to cover the vacancies. Unplanned Care division is reporting an adverse variance mainly driven by unfound efficiencies within their CIP programme.
3.2.2 Relative Pay Efficiency

The Finance committee asked for a review of relative pay efficiency assessing pay costs against activity. It is recognised that outpatient activity and inpatient activity is difficult to compare and so income has been used as a proxy for work done.

Based on the activity and costs shown in the tables opposite the reduction in overall productivity is stark with weighted activity flat or on a decreasing trend with pay costs increasing. The correlation across each area is shown in the table below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Pay</th>
<th>WTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust total</td>
<td>-0.25</td>
<td>-0.44</td>
</tr>
<tr>
<td>Planned care</td>
<td>-0.30</td>
<td>-0.28</td>
</tr>
<tr>
<td>Unplanned care</td>
<td>-0.48</td>
<td>-0.51</td>
</tr>
</tbody>
</table>

The above table shows the correlation coefficient between pay/WTE and activity. The closer to +1.0 the stronger the correlation between a linear relationship; the closer to -1.0 the stronger the correlation of an inverse relationship.

The closer the coefficient is to zero the less correlation exists.

As shown in this table and can be seen in the graphs, an inverse relationship has developed through the course of the year. This means that services are less efficient, i.e. more staff for less activity per staff member.

This has been explored further at a care group level on the following page.
It is worth noting that there are some inherent limitations and assumptions that are made in the collation of this data however the general point is that in many areas there is a lack of correlation between activity and pay costs.

Information up to and including month 9 has been used – flex and freeze movements could impact months 8 and 9 activity values.

Activity combines a mixture of currencies, e.g. attendance, outpatient, day case, inpatient, and so income has been used as a proxy for weighting activity. High cost drugs activity is excluded.

Trust wide, corporate divisions pay spend and WTE are included in the Trust total position.

<table>
<thead>
<tr>
<th>Planned care</th>
<th>Pay</th>
<th>WTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Paediatrics</td>
<td>0.25</td>
<td>0.26</td>
</tr>
<tr>
<td>Anaesthetics/Pain</td>
<td>0.16</td>
<td>-0.50</td>
</tr>
<tr>
<td>Audiology</td>
<td>-0.04</td>
<td>0.13</td>
</tr>
<tr>
<td>Cancer</td>
<td>-0.16</td>
<td>0.48</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>0.39</td>
<td>0.03</td>
</tr>
<tr>
<td>ENT</td>
<td>-0.55</td>
<td>-0.42</td>
</tr>
<tr>
<td>General Surgery</td>
<td>0.19</td>
<td>-0.68</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>-0.57</td>
<td>-0.76</td>
</tr>
<tr>
<td>ICU</td>
<td>-0.18</td>
<td>-0.70</td>
</tr>
<tr>
<td>Neonatology</td>
<td>-0.59</td>
<td>0.16</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>-0.11</td>
<td>-0.17</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>0.28</td>
<td>0.12</td>
</tr>
<tr>
<td>Orthotics</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>-0.04</td>
<td>-0.52</td>
</tr>
<tr>
<td>Pre-assessment</td>
<td>-0.42</td>
<td>-0.30</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Urology</td>
<td>0.22</td>
<td>-0.22</td>
</tr>
<tr>
<td>Vascular</td>
<td>-0.58</td>
<td>-0.47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UIC</th>
<th>Pay</th>
<th>WTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>0.15</td>
<td>-0.07</td>
</tr>
<tr>
<td>Care of the Elderly/Frailty</td>
<td>-0.01</td>
<td>-0.60</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.32</td>
<td>0.22</td>
</tr>
<tr>
<td>Diabetes/Endocrine</td>
<td>-0.45</td>
<td>-0.28</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>-0.58</td>
<td>-0.41</td>
</tr>
<tr>
<td>Gastrology</td>
<td>-0.29</td>
<td>-0.36</td>
</tr>
<tr>
<td>General Medicine</td>
<td>-0.08</td>
<td>0.66</td>
</tr>
<tr>
<td>Haematology</td>
<td>-0.56</td>
<td>-0.73</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>-0.21</td>
<td>0.11</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.48</td>
<td>-0.02</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>-0.70</td>
<td>-0.78</td>
</tr>
<tr>
<td>Pathology</td>
<td>-0.47</td>
<td>-0.39</td>
</tr>
<tr>
<td>Radiology</td>
<td>0.15</td>
<td>-0.21</td>
</tr>
<tr>
<td>Respiratory</td>
<td>0.20</td>
<td>0.16</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0.78</td>
<td>0.64</td>
</tr>
<tr>
<td>Therapies</td>
<td>-0.03</td>
<td>0.48</td>
</tr>
</tbody>
</table>

Notwithstanding the above caveats, with the exception of Rheumatology, none of the care groups demonstrate a medium-strong correlation between pay/WTEs and activity.

There are significantly more inverse relationships than positive linear relationships in the data; most notably, gynaecology and nuclear medicine are particular outliers.

Finance business partners are working with the care groups using this information to determine the individual drivers of the deterioration in efficiency that this highlights. This in turn will be used as part of the benchmarking for CIP development.
### 3.3 Non Pay

<table>
<thead>
<tr>
<th></th>
<th>Current Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £'000</td>
<td>Actual £'000</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>(3,666)</td>
<td>(3,814)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(548)</td>
<td>(773)</td>
</tr>
<tr>
<td>High Cost Drugs</td>
<td>(2,186)</td>
<td>(2,360)</td>
</tr>
<tr>
<td>Other</td>
<td>(3,100)</td>
<td>(2,213)</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>(9,500)</td>
<td>(9,160)</td>
</tr>
<tr>
<td>Non-Operating Expenditure</td>
<td>(1,337)</td>
<td>(1,132)</td>
</tr>
<tr>
<td>Total</td>
<td>(10,837)</td>
<td>(10,292)</td>
</tr>
</tbody>
</table>

Clinical supplies adverse variance includes T&O insourcing costs in the Planned Care Division of £1.2 million. Drugs expenditure is higher than budget mainly due to higher non-elective activity than planned.

Capital projects are currently reported as “assets under construction” and hence generate no depreciation charge; this is currently being reviewed and this timing issue is expected to be redressed by year end. A provision is held to address any variance.
## Cost Improvement Programme

The cost improvement programme is discussed in more detail in the report from the Transformation team. Based on the current trajectory, cost improvements in the region of £18.2 million by the end of the financial year are expected. Performance against each of the operational and corporate areas is set out in the tables below.

### Planned Care

<table>
<thead>
<tr>
<th></th>
<th>Year To Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Urology Robot</td>
<td>975</td>
<td>975</td>
<td>975</td>
<td>0</td>
</tr>
<tr>
<td>Procurement</td>
<td>559</td>
<td>559</td>
<td>559</td>
<td>0</td>
</tr>
<tr>
<td>CNST</td>
<td>250</td>
<td>306</td>
<td>306</td>
<td>56</td>
</tr>
<tr>
<td>Other</td>
<td>3,726</td>
<td>2,560</td>
<td>2,560</td>
<td>(1,166)</td>
</tr>
<tr>
<td>PbR Total</td>
<td>5,510</td>
<td>4,400</td>
<td>4,400</td>
<td>(1,110)</td>
</tr>
</tbody>
</table>

### Unplanned Care

<table>
<thead>
<tr>
<th></th>
<th>Year To Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Bank And Agency Reduction</td>
<td>1,505</td>
<td>1,033</td>
<td>1,033</td>
<td>(472)</td>
</tr>
<tr>
<td>Rheumatology repatriation</td>
<td>382</td>
<td>382</td>
<td>382</td>
<td>0</td>
</tr>
<tr>
<td>Deep Dive</td>
<td>458</td>
<td>456</td>
<td>456</td>
<td>(2)</td>
</tr>
<tr>
<td>Other</td>
<td>2,875</td>
<td>2,388</td>
<td>2,388</td>
<td>(487)</td>
</tr>
<tr>
<td>PbR Total</td>
<td>5,220</td>
<td>4,259</td>
<td>4,259</td>
<td>(961)</td>
</tr>
</tbody>
</table>

### Corporate

<table>
<thead>
<tr>
<th></th>
<th>Year To Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>STP Reduction</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>Senior Positions</td>
<td>132</td>
<td>132</td>
<td>132</td>
<td>0</td>
</tr>
<tr>
<td>Consultancy</td>
<td>65</td>
<td>70</td>
<td>70</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>534</td>
<td>280</td>
<td>280</td>
<td>(254)</td>
</tr>
<tr>
<td>PbR Total</td>
<td>931</td>
<td>682</td>
<td>682</td>
<td>(249)</td>
</tr>
</tbody>
</table>

### Estates and Facilities

<table>
<thead>
<tr>
<th></th>
<th>Year To Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Car Parking</td>
<td>231</td>
<td>50</td>
<td>50</td>
<td>(181)</td>
</tr>
<tr>
<td>Senior Management review</td>
<td>120</td>
<td>124</td>
<td>124</td>
<td>4</td>
</tr>
<tr>
<td>18/19 Linen</td>
<td></td>
<td>120</td>
<td>120</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>762</td>
<td>736</td>
<td>736</td>
<td>(26)</td>
</tr>
<tr>
<td>PbR Total</td>
<td>1,113</td>
<td>1,030</td>
<td>1,030</td>
<td>(83)</td>
</tr>
</tbody>
</table>

### Central

<table>
<thead>
<tr>
<th></th>
<th>Year To Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Productivity Gain</td>
<td>2,170</td>
<td>2,170</td>
<td>2,170</td>
<td>0</td>
</tr>
<tr>
<td>Income</td>
<td>830</td>
<td>830</td>
<td>830</td>
<td>0</td>
</tr>
<tr>
<td>Mars</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>828</td>
<td>828</td>
<td>828</td>
<td>0</td>
</tr>
<tr>
<td>PbR Total</td>
<td>4,628</td>
<td>4,628</td>
<td>4,628</td>
<td>0</td>
</tr>
</tbody>
</table>
5 Forecast

Using the reported position for January, the following scenarios have been assessed to forecast how the Trust will perform financially. These have been calculated using known pieces of information and objective assessments of outcomes that will impact on the final position.

In assessing the forecast from a top down perspective four main scenarios have been considered, each assume the application of the entirety of the optimism bias reserve.

**2019/20 Forecast (M10)**

Based on 4 different scenarios assuming:

- Average income continues
- Pay spend either continues at current levels or based on an average of the last three months
- Marginal increases in depreciation
- Additional expenditure on RTT, SDEC and further winter pressures
- £0.5 million available for out of hospital support

Scenarios range from £21.1 million to £22.3 million with an absolute worst case scenario at £22.7 million. Three of the four scenarios coalesce around the £22.2 to £22.3 million year end deficit. A prudent view of provisions continues to be made and valuations at year end are sufficient to address any variation to plan.

**Risk**

The Finance Committee is aware that the settlement of the £202.0 million expected the Trust to deliver a referral to treatment waiting time above 18 weeks at 88%, that there would be nobody waiting more than 26 weeks and the Trust would be left with a waiting list size of no more that around 20,000 patients.
The Finance Committee is also aware that achieving above 88% attracts additional revenue of £100,000 for every 0.1% above the trajectory. This represents about 25 patients and would provide scope to improve performance against the deficit. On the opposite side not achieving 88% (and this is not assured) and committing revenue to exceed 88% provided pressure since there would be no income to support the outsourced activity.
6 Balance Sheet

### Assets

<table>
<thead>
<tr>
<th>£m</th>
<th>As at 31 Jan 20</th>
<th>As at 31 Mar 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Current Assets</td>
<td>193.1</td>
<td>185.2</td>
</tr>
<tr>
<td>Inventory</td>
<td>6.2</td>
<td>5.9</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>37.6</td>
<td>39.1</td>
</tr>
<tr>
<td>Cash</td>
<td>33.3</td>
<td>10.8</td>
</tr>
<tr>
<td><strong>PbR Total</strong></td>
<td><strong>270.2</strong></td>
<td><strong>241.0</strong></td>
</tr>
</tbody>
</table>

The high cash balance held has resulted from an agreed re-profiling of monthly contract income from the North Kent CCG group. This has provided advances in May and October delaying the need for the Trust to access deficit support borrowings until Q4. The Trust is actively pursuing all debts to their fullest to generate further cash reserves and regardless intends to draw deficit support funding at the maximum level available as this is only available during the year deficit occurs. Cash balances will be utilised fully to repay liabilities where possible.

**Trade and other receivables** include £14.0 million of sales invoices outstanding net of credit loss provision, £17.3 million of income accruals, £4.5 million of prepayments (goods that have been paid for in advance of receipt).

### Liabilities

<table>
<thead>
<tr>
<th>£m</th>
<th>As at 31 Jan 20</th>
<th>As at 31 Mar 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borrowings</td>
<td>(168.3)</td>
<td>(127.1)</td>
</tr>
<tr>
<td>Trade and Other Payables</td>
<td>(36.2)</td>
<td>(23.8)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>(37.7)</td>
<td>(3.0)</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td><strong>(242)</strong></td>
<td><strong>(154)</strong></td>
</tr>
<tr>
<td>Borrowings</td>
<td>(95.9)</td>
<td>(137.5)</td>
</tr>
<tr>
<td>Other Long term liabilities</td>
<td>(0.9)</td>
<td>(0.9)</td>
</tr>
<tr>
<td><strong>PbR Total</strong></td>
<td><strong>(96.8)</strong></td>
<td><strong>(138.4)</strong></td>
</tr>
</tbody>
</table>

Total Borrowings as at 31st January are £264.2 million, all with the Department of Health. This includes £14.0 million of long term capital borrowings, £230.3 million of planned deficit support for 2014/15 to 2018/19 and £19.9 million of additional support provided. The Trust has not yet borrowed any additional funds in 19/20 but has a board resolution to draw revenue support up to the value of the planned deficit and capital loans as planned.

**Trade and other payables** include £12.2 million of invoices received, £16.0 million of expenditure accruals and £7.9 million employers payroll costs previously paid in advance, payment has reverted back in order to maintain sufficient cash balance in February. Balances are forecast to be in line with prior year at year end.

**Other liabilities** include £36.5 million of deferred income which relates to the income received in advance in May and October and general provisions. Provisions were reassessed in month 9 and increased by £1.6 million due to a number of legal cases, dilapidations and an onerous...
### Taxpayers equity

<table>
<thead>
<tr>
<th>£m</th>
<th>As at 31 Jan 20</th>
<th>As at 31 Mar 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dividend Capital</td>
<td>138.9</td>
<td>138.9</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(244.0)</td>
<td>(225.2)</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>35.0</td>
<td>35.0</td>
</tr>
<tr>
<td>Taxpayers equity</td>
<td>(70.1)</td>
<td>(51.3)</td>
</tr>
</tbody>
</table>

Pre-approved capital investment PDC of £2.7 million is planned for quarter 4.

### Fixed Assets

<table>
<thead>
<tr>
<th>£'000</th>
<th>Year To Date</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>4,500</td>
<td>2,932</td>
<td>(1,568)</td>
</tr>
<tr>
<td></td>
<td>Plant and Equipment</td>
<td>2,040</td>
<td>520</td>
<td>(1,520)</td>
</tr>
<tr>
<td></td>
<td>Fire Safety</td>
<td>5,948</td>
<td>5,575</td>
<td>(373)</td>
</tr>
<tr>
<td></td>
<td>IT</td>
<td>1,800</td>
<td>2,758</td>
<td>958</td>
</tr>
<tr>
<td></td>
<td>ED</td>
<td>2,000</td>
<td>4,562</td>
<td>2,562</td>
</tr>
<tr>
<td></td>
<td>PbR Total</td>
<td>16,288</td>
<td>16,347</td>
<td>59</td>
</tr>
</tbody>
</table>

Spend year to date largely on plan yet slowing. Increased risk of undershooting control total managed through bringing forward spend from 20/21.
## Aged Debt

### Trade Debt Age Profile

<table>
<thead>
<tr>
<th>Debtor Category</th>
<th>Current Month Total Debt</th>
<th>31 to 60 Days</th>
<th>61 to 90 Days</th>
<th>91 to 180 Days</th>
<th>6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£m</strong></td>
<td><strong>£m</strong></td>
<td><strong>£m</strong></td>
<td><strong>£m</strong></td>
<td><strong>£m</strong></td>
<td><strong>£m</strong></td>
</tr>
<tr>
<td>NHS FTs</td>
<td>2.41</td>
<td>0.26</td>
<td>0.08</td>
<td>0.09</td>
<td>0.57</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>2.16</td>
<td>0.21</td>
<td>0.51</td>
<td>0.11</td>
<td>0.41</td>
</tr>
<tr>
<td>DH</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Public Health England</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Health Education England</td>
<td>(0.01)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>CCGs and NHS England</td>
<td>8.24</td>
<td>0.79</td>
<td>0.59</td>
<td>1.04</td>
<td>1.43</td>
</tr>
<tr>
<td>Special Health Authorities</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>NDPBs</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Other DH bodies</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total NHS Debtors</strong></td>
<td>12.80</td>
<td>1.26</td>
<td>1.18</td>
<td>1.24</td>
<td>2.41</td>
</tr>
<tr>
<td>Other WGA bodies</td>
<td>0.01</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>0.08</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>3.80</td>
<td>0.39</td>
<td>0.16</td>
<td>0.19</td>
<td>0.77</td>
</tr>
<tr>
<td><strong>Total Non NHS Debtors</strong></td>
<td>3.89</td>
<td>0.39</td>
<td>0.16</td>
<td>0.19</td>
<td>0.77</td>
</tr>
<tr>
<td><strong>Total Current Month Debtors</strong></td>
<td>16.69</td>
<td>1.65</td>
<td>1.34</td>
<td>1.43</td>
<td>3.18</td>
</tr>
<tr>
<td>Provision for credit losses</td>
<td>(2.70)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Debtors</strong></td>
<td>13.99</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total debt totals £16.7 million for which £2.7 million is provided. All other debt is considered recoverable. £16.7 million equates to around 70% of a typical months income. £15 million is overdue with the majority provided in other NHS organisation accounts.

### Other WGA bodies

- **£7.4 million relates to overdue CCG and NHS England debt**
  - Overdue high cost/homecare drug debt is £3.4 million, of which £0.2 million relates to prior years.
  - Overdue NCA debt is £1.8 million, of which £1.2 million relates to prior years.
  - Overdue clinical contract and other debt is £2.2 million, of which £1.8 million relates to prior years, mostly with West Kent. Finance is liaising to finalise disputes.

### Other DH bodies

- **£4.1 million relates to overdue Provider to Provider debt**
  - £3.2 million across 3 local Trusts relating to Clinical and Non clinical SLA’s
  - The finance team continually works with all NHS debtors to assist and respond to queries and disputes in relation to these debts. 2 national agreement of balances exercise are taking place between January and April where all intra group debts are matched and agreed.

### Non NHS Debt

- £1.8 million relates to debt with Medway Community Healthcare, A meeting has now taken place with progress being made.
£0.9 million overseas debtors: this has increased in-year as the Trust is now able to identify more cases and bill up to 3 years after the
treatment has taken place. Unfortunately due to the nature of the debtor if identified retrospectively the probability of recovering the debt is low.
For this reason credit losses at 50% are recognised for all debts of this type. The other 50% risk should be covered by the CCG.
The remaining £0.8 million relates to various other non-clinical services, patient and staff related debts.
Finance actively pursues all debts, refreshed commercial debt recovery training has recently been provided to increase expertise in this area
and the service of external debt recovery are utilised where debts required a more formal approach.
In accordance with IFRS9 non NHS debt lifetime expected credit losses have been reassessed, as a result the credit loss (bad debt)
provision has been increased from £1.9 million to £2.7 million therefore 73% of non NHS debt is currently covered.
7 Conclusions and Recommendations

The Finance Committee is asked to note the attached report with particular reference to:

- Continued delivery against monthly control totals
- The expectation that the deficit control total will be delivered for 2019/20
- Increasing pay costs in operational areas relative to weighted activity
- The risk associated with RTT delivery above 88%
- Continuing issues with credit control

Ian O’Connor
Director of Finance
February 2020
Appendix 1 – Flash Report

I&E Deficit EXCLUDING PSF YTD (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>0.8</td>
<td>0.7</td>
<td>1.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Actual</td>
<td>1.7</td>
<td>1.3</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Variance</td>
<td>0.9</td>
<td>0.6</td>
<td>0.1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

The Trust delivered a breakeven variance for Month 10 on a planned deficit of £1.0 million. It has been necessary to increase the use of the contingency reserve to cover adverse variances in SDEC, CDU, Surgical Services and unfind CIP; utilisation of the reserve is £1.4 million. The year to date provision for optimism bias is £1.6 million.

Cash Actual £m

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Actual</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Variance</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

The Trust cash balance at month 10 is £33.3m. Still ahead of plan due to a revised payment profile agreed with the main commissioners. Contract payments will not be received from these commissioners in February and March. As a result cash balances are expected to reduce from month 11 although capital loans for Fire and ED are to be drawn in M11 and revenue support loans in M12 ensuring the Trust has more than sufficient cash cover for trade payables for remaining part of the year.

Better Payment Practice Code (BPPC by Volume (%))

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td>Actual</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td>Variance</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Non NHS BPPC compliance continues to improve slowly. As aged creditors are resolved this rating will improve further over the coming months, the expectation is for 20/21 to see a significant improvement.

All Aged Creditors 60+ Days (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>5.5</td>
<td>6.1</td>
<td>6.2</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Over 60 day aged Creditors has decreased slightly due to £1.2m invoices from a capital contractor being on hold whilst the certification of work is verified.

All Aged Debtors 60+ Days (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>12.3</td>
<td>12.9</td>
<td>13.6</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Over 60 day debt remains at the same level as the previous month. This is expected to improve in the coming months as commissioners clear balances. Finance continues to work with debtors to resolve queries to clear these long standing debts.

Capital Expenditure YTD (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Actual</td>
<td>1.7</td>
<td>1.3</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Variance</td>
<td>0.6</td>
<td>0.0</td>
<td>0.4</td>
<td>0.7</td>
</tr>
</tbody>
</table>

19/20 Capital Expenditure is now on plan. Achievement of the annual target for the 19/20 Capital Programme will now represent a challenge given emerging slippages on some projects which include Breast Screening, Orthodontics, Fluoroscopy and SDEC. However in mitigation a range of other projects are being accelerated with the aim of achieving the capital control total for the current year.

CIP Delivery YTD (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>46.1</td>
<td>44.5</td>
<td>39.3</td>
<td>39.8</td>
</tr>
<tr>
<td>Actual</td>
<td>46.9</td>
<td>50.6</td>
<td>55.1</td>
<td>56.2</td>
</tr>
<tr>
<td>Variance</td>
<td>(4.8)</td>
<td>[4.4]</td>
<td>[3.9]</td>
<td>[3.9]</td>
</tr>
</tbody>
</table>

CIP delivery is £1.6 million and adverse to plan at £0.7 million. The reduction in delivery compared to the previous month is caused by Cancer MDT £300k being reported in December, taking the normalised delivery in the previous month to £1.7 million. The CIP plan includes the impact of the unidentified balances that were phased into the final 6 months of the year.

Normalised Monthly Pay

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>16.7</td>
<td>16.6</td>
<td>16.7</td>
<td>16.8</td>
</tr>
<tr>
<td>Actual</td>
<td>16.7</td>
<td>16.6</td>
<td>16.7</td>
<td>16.8</td>
</tr>
<tr>
<td>Variance</td>
<td>(0.0)</td>
<td>(0.0)</td>
<td>(0.0)</td>
<td>(0.0)</td>
</tr>
</tbody>
</table>

Normalised pay expenditure in month is £17.9 million and is £1.2 million adverse to plan. The £0.1 million increase in cost since December is mainly due to an increase in costs for CDU and SDEC Medical Staffing in the Unplanned Care Division. Included within the adverse position are the CIP schemes relating to pay reductions that have not been achieved.

Normalised Monthly Agency Expenditure (£m)

<table>
<thead>
<tr>
<th></th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>(0.5)</td>
<td>(0.6)</td>
<td>(0.6)</td>
<td>(0.6)</td>
</tr>
<tr>
<td>Actual</td>
<td>(0.6)</td>
<td>(0.7)</td>
<td>(0.7)</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Variance</td>
<td>(0.1)</td>
<td>(0.1)</td>
<td>(0.1)</td>
<td>(0.1)</td>
</tr>
</tbody>
</table>

Agency Spend in Month 10 have reduced by £0.1 million to £0.6 million and breakeven to plan. Spend over the last four months has been reasonably constant.

<table>
<thead>
<tr>
<th>&amp;E</th>
<th>Income and Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA</td>
<td>Earnings Before Interest, Tax, Depreciation and Amortisation</td>
</tr>
<tr>
<td>CIP</td>
<td>Quality Cost Improvement Programme</td>
</tr>
<tr>
<td>YTD</td>
<td>Year-to-Date</td>
</tr>
</tbody>
</table>

Key:
- Going in the right direction
- Going in the wrong direction
- Adverse to Plan
- Favourable to Plan
## Appendix 2 – Cash Flow Forecast

### 13 Week Forecast

<table>
<thead>
<tr>
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*Pages 315 of 431*
### Appendix 3 – Loan Schedule

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<tr>
<td>30</td>
<td>Revenue Support</td>
<td>November deficit support</td>
<td>1.50%</td>
<td>Dec 2021</td>
<td>5,568</td>
<td>5,568</td>
<td>5,568</td>
<td></td>
<td>5,568</td>
</tr>
<tr>
<td>31</td>
<td>Revenue Support</td>
<td>December Deficit support</td>
<td>1.50%</td>
<td>Jan 2022</td>
<td>2,956</td>
<td>2,956</td>
<td>2,956</td>
<td></td>
<td>2,956</td>
</tr>
<tr>
<td>32</td>
<td>Revenue Support</td>
<td>January deficit support</td>
<td>1.50%</td>
<td>Feb 2022</td>
<td>2,281</td>
<td>2,281</td>
<td>2,281</td>
<td></td>
<td>2,281</td>
</tr>
<tr>
<td>33</td>
<td>Revenue Support</td>
<td>February deficit support</td>
<td>1.50%</td>
<td>Mar 2022</td>
<td>2,269</td>
<td>2,269</td>
<td>2,269</td>
<td></td>
<td>2,269</td>
</tr>
<tr>
<td>34</td>
<td>Revenue Support</td>
<td>March defect support</td>
<td>1.50%</td>
<td>Mar 2023</td>
<td>10,001</td>
<td>10,001</td>
<td>10,001</td>
<td></td>
<td>10,001</td>
</tr>
</tbody>
</table>

Total: £264,066, 0, -991, 263,075
Meeting of the Board of Directors in Public
Thursday, 05 March 2020

Assurance Report from Committees

Title of Committee: Finance Committee
Committee Chair: Mark Spragg (Deputy)
Date of Meeting: Thursday, 27 February 2020
Lead Director: Ian O’Connor, Director of Finance
Report Author: Paul Kimber, Deputy Director of Finance

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

<table>
<thead>
<tr>
<th>Assurance Level</th>
<th>Colour to use in ‘assurance level’ column below</th>
</tr>
</thead>
<tbody>
<tr>
<td>No assurance</td>
<td>Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans</td>
</tr>
<tr>
<td>Partial assurance</td>
<td>Amber/Red - there are gaps in assurance</td>
</tr>
<tr>
<td>Assurance</td>
<td>Amber/Green - Assurance with minor improvements required</td>
</tr>
<tr>
<td>Significant Assurance</td>
<td>Green – there are no gaps in assurance</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>White - no assurance is required</td>
</tr>
</tbody>
</table>

Key headlines and assurance level

<table>
<thead>
<tr>
<th>Key headline</th>
<th>Assurance Level (use appropriate colour code as above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Finance Report Month 10</td>
<td>Green</td>
</tr>
<tr>
<td>The Committee discussed the Month 10 financial performance for the Trust, specifically pay costs in the clinical divisions where there appears to be a growing inefficiency compared to activity.</td>
<td></td>
</tr>
<tr>
<td>2. Finance Risk Register</td>
<td>Green</td>
</tr>
<tr>
<td>The Committee reviewed the Finance Risk Register and noted the risks and mitigations, together with current scores within the papers.</td>
<td></td>
</tr>
<tr>
<td>3. Cost Improvement Programme</td>
<td>Amber/Red</td>
</tr>
<tr>
<td>The Committee received a report on the month 10 CIP position; there remains concern at the £2.4m adverse variance to plan for the year. PMO continues to actively monitor and support this work.</td>
<td></td>
</tr>
</tbody>
</table>
The Committee was given an update on the Capital programme for 2019/20. This included the following: current status of capital expenditure; progress against key projects, and; next steps.

The Committee noted that the programme is accelerating some schemes originally planned for 2020/21 in order to meet the current year target, following slippage against some schemes in-year.

5. Budget Setting 2020/21
The Committee received an update on 2020/21 budget setting and acknowledged the revised control total of break-even (after receipt of £47.4m of Financial Recovery Fund (“FRF”) central support) following release of the operating plan guidance from NHSI/E.

A “top down” process combined with a “bottom up” review was noted, including areas of potential cost pressure arising.

The plan requires delivery of a £12m / 4.3% CIP in 2020/21, of which approximately £2.5m is currently green rated. It was noted that the bar for schemes to be green rated is higher this year than before and that the divisions have a pipeline of over 70 schemes that are under development.

The Committee was informed of changes arising from the release of the operating plan guidance, including:

- Conversion of the deficit loan funding (balance sheet liability) into Public Dividend Capital (taxpayers' equity). This eliminates the interest payable on the loans (at 1.5%) but introduces a dividend payable (at 3.5%).
- The Trust FRF in 2019/20 was solely based on delivery of its control total; in 2020/21 half of this sum is based on delivery against its own control total with the other half dependent upon delivery of the ‘system’ control total.

6. Model Hospital
The Committee was shown the Model Hospital tool where the 2018/19 reference cost data had now been uploaded. This showed that the Trust has improved since the previous release in it ‘cost per WAU’ and was now the median Trust in the country.

7. Committee Work Plan
This was approved by the Committee.

Decisions made

Further Risks Identified
All risks are captured within the risk register and the BAF.

Escalations to the Board or other Committee
None
# Health Care Worker Flu Vaccination Self-Assessment Report

## Executive Summary

This paper provides the outcome of the Trust’s self-assessment against healthcare worker flu vaccination best practice management checklist for public assurance via Trust boards (see Appendix 1). A summary of the outcome on each measure is provided with mitigations where relevant.

Healthcare workers with direct patient contact need to be vaccinated to ensure protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. NHS organisations are being asked to identify the ‘higher-risk’ clinical areas and take more robust steps to limit exposure of patients to unvaccinated staff. In these higher-risk areas, Trusts are expected to take appropriate steps to maintain safety of the service including redeployment of staffing to maintain safe operation of the service.

This paper provides the outcome of the self-assessment reveals that there are strong plans were in place on the following measures – Committed leadership, Communication plan and Incentives. Work continues to ensure Flexible accessibility to flu vaccinations is achievable. The Trust will use the findings from the self-assessment to support the 2020 flu vaccination programme.

The Trust is currently achieving 73.5 percent vaccination rate.

## Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

- **Innovation:** We will embrace innovation and digital technology to support the best of care
  - □
- **Finance:** We will deliver financial sustainability and create value in all we do
  - □
- **People:** We will enable our people to give their best and achieve their best
  - ☒
- **Integrated Health Care:** We will work collaboratively with our system partners to establish an Integrated Care Partnership
  - □
- **High Quality Care:** We will consistently provide high quality care
  - ☒

## Committees or Groups at which the paper has been submitted

- Executive Group – 19 February 2019
  - Human Resources and Organisational Development Senior Team.

## Resource Implications

Any actions should be achieved within existing resources.

## Legal

Possible risks include:
Introduction

The importance of healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu is widely known. The focus this year (winter of 2019-20) is to achieve 100% of healthcare workers with direct patient contact being vaccinated. This winter Trusts’ are required to use the quadrivalent (QIV) vaccine for the broadest protection.

The Trust is currently achieving 73.5% vaccination rate.

Healthcare workers with direct patient contact need to be vaccinated to ensure protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. NHS organisations are being asked to identify the ‘higher-risk’ clinical areas and take more robust steps to limit exposure of patients to unvaccinated staff. In these higher-risk areas, Trusts are expected to take appropriate steps to maintain safety of the service including redeployment of staffing to maintain safe operation of the service.

To help organisations achieve the highest possible numbers of staff vaccinated this winter, 2019-20, NHS England and NHS Improvement (NHSEI) has provided the best practice management checklist for healthcare worker vaccination asking Trusts to carry out a self-assessment against measures provided with a requirement to publish outcome in board papers.

This paper provides the outcome of the Trust’s self-assessment on healthcare worker flu vaccination best practice management against the following four measures – Committed leadership, Communications plan, Flexible accessibility and Incentives (see Appendix 1). The audit shows strong plans are in place on the following measures – Committed leadership, Communication plan and Incentives. Work continues to ensure Flexible accessibility to flu vaccinations is implemented.

Outcome Of Healthcare Worker Flu Vaccination Best Practice Management Checklist

The Trust has completed the self-assessment of the healthcare worker flu vaccination best practice management checklist against the four measures – Committed leadership, Communications plan,
Flexible accessibility and Incentives. A summary of the outcome of the audit is provided below by the areas of measures:

2.1.1 Committed Leadership Measure

The Executive Director of Nursing is the named board champion and the required vaccine is available. A task and finish group with senior leadership membership and representation across both divisions meets bi-weekly to evaluate progress, discuss challenges and put in place required mitigations. A dedicated team from Occupational Health is used to cover all areas across the Trust. Higher risk areas were targeted as part of ensuring high compliance and mitigating risk to patients.

2.1.2 Communications Plan Measure

The Trust has a robust communication strategy of the flu campaign in place in line with learning from previous years. Posters and screensaver flu campaign messages have been rolled out. Social media avenues including twitter is also being used to drive uptake. Directors have had their flu vaccinations with photographs shared with staff via the weekly global message.

2.1.3 Flexible Accessibility Measure

The self-assessment outcome on this measure revealed that, this is an area of work in progress resulting in an amber rating/partial. Given competing interests, it remains a challenge for staff to be released from clinical areas to attend the flu drop in clinics and for peer vaccinators to focus on flu campaign. In mitigation, the flu campaign teams led by Occupational Health nursing staff will be attending all clinical areas.

2.1.4 Incentives Measure

The Trust has plans in place to incentivise uptake of the flu vaccination which have encouraged take-up including pens and confectionery. Success and progress communications is central to our communications strategy.

-End
## Appendix I: Healthcare worker flu vaccination best practice management checklist

<table>
<thead>
<tr>
<th>A</th>
<th>Committed leadership</th>
<th>Trust self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1</strong></td>
<td>Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.</td>
<td>Full</td>
</tr>
<tr>
<td><strong>A2</strong></td>
<td>Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers</td>
<td>Full</td>
</tr>
<tr>
<td><strong>A3</strong></td>
<td>Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt</td>
<td>Full</td>
</tr>
<tr>
<td><strong>A4</strong></td>
<td>Agree on a board champion for flu campaign</td>
<td>Full</td>
</tr>
<tr>
<td><strong>A5</strong></td>
<td>All board members receive flu vaccination and publicise this</td>
<td>Partial</td>
</tr>
<tr>
<td><strong>A6</strong></td>
<td>Flu team formed with representatives from all directorates, staff groups and trade union representatives</td>
<td>Partial</td>
</tr>
<tr>
<td><strong>A7</strong></td>
<td>Flu team to meet regularly from September 2019</td>
<td>Full</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Communications plan</th>
<th>Trust self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B1</strong></td>
<td>Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions</td>
<td>Full</td>
</tr>
<tr>
<td><strong>B2</strong></td>
<td>Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper</td>
<td>Full</td>
</tr>
<tr>
<td><strong>B3</strong></td>
<td>Board and senior managers having their vaccinations to be publicised</td>
<td>Full</td>
</tr>
<tr>
<td><strong>B4</strong></td>
<td>Flu vaccination programme and access to vaccination on induction programmes</td>
<td>Full</td>
</tr>
<tr>
<td><strong>B5</strong></td>
<td>Programme to be publicised on screensavers, posters and social media</td>
<td>Full</td>
</tr>
<tr>
<td><strong>B6</strong></td>
<td>Weekly feedback on percentage uptake for directorates, teams and professional groups</td>
<td>Full</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Flexible accessibility</th>
<th>Trust self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong></td>
<td>Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered</td>
<td>Partial</td>
</tr>
<tr>
<td><strong>C2</strong></td>
<td>Schedule for easy access drop in clinics agreed</td>
<td>Full</td>
</tr>
<tr>
<td><strong>C3</strong></td>
<td>Schedule for 24 hour mobile vaccinations to be agreed</td>
<td>Partial</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Incentives</th>
<th>Trust self-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1</strong></td>
<td>Board to agree on incentives and how to publicise this</td>
<td>Partial</td>
</tr>
<tr>
<td><strong>D2</strong></td>
<td>Success to be celebrated weekly</td>
<td>Full</td>
</tr>
</tbody>
</table>
### Executive Summary

EDS2 is a generic tool designed for both NHS commissioners and NHS providers. At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four Goals: Better health outcomes; Improved patient access and experience; A representative and supported workforce; and Inclusive leadership.

There are four possible grades for each outcome and goal. These are: **Undeveloped; Developing; Achieving; Excelling**.

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

Subsequent reviews, in January 2019 and January 2020, shows that performance against the EDS2 grades has improved with 4 of the EDS2 outcomes being assessed at Developing, and 14 at Achieving. None are now at Undeveloped.

The report also sets out the results of self-assessments and external assessment surveys.

The Trust is required to publish its EDS2 review on its website. The report recommends that the Equality and Inclusion Steering Group oversee the development of an action plan to take the Trust to achieving.

### Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

- **Innovation**: We will embrace innovation and digital technology to support the best of care
- **Finance**: We will deliver financial sustainability and create value in all we do
- **People**: We will enable our people to give their best and achieve their best
- **Integrated Health Care**: We will work collaboratively with our system partners to establish an Integrated Care Partnership
- **High Quality Care**: We will consistently provide high quality care

- ☐
- ☐
- ☒
- ☒
- ☒

### Committees or Groups paper has been submitted

Executive Group – 19 February 2020
HR and OD Senior Team
### Executive Overview

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

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

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

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

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

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

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

1.6 Subsequent reviews, in January 2019 and January 2020, show that performance against the EDS2 Grades has improved as follows:
<table>
<thead>
<tr>
<th>EDS2 Grade across all four Goals</th>
<th>2017</th>
<th>2018</th>
<th>2020</th>
<th>Direction of Travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undeveloped</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>Stable</td>
</tr>
<tr>
<td>Developing</td>
<td>12</td>
<td>13</td>
<td>4</td>
<td>Improvement</td>
</tr>
<tr>
<td>Achieving</td>
<td>0</td>
<td>5</td>
<td>14</td>
<td>Improvement</td>
</tr>
<tr>
<td>Excelling</td>
<td>0</td>
<td>0</td>
<td>No change</td>
<td></td>
</tr>
</tbody>
</table>

## 2 METHODOLOGY

Amber / Green

2.1 This assessment of the Trust’s progress on EDS2 builds on the initial assessment conducted in 2017, which included information from stakeholders, such as commissioners, partner organisations and Healthwatch. For the assessments conducted both in 2017 and at the end of 2018, a survey was sent to commissioners and partners, and in January 2019 and January 2020, and an internal self-assessment survey was sent to clinical managers across the Trust during 2019.

2.2 In both all three assessments, the Head of Equality and Inclusion has examined a range information and data sources, including:

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

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

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

## 3 Key Findings

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

3.2 It is important to remember, however, that the EDS2 scoring measures whether there is evidence of equitable outcomes for each protected characteristic, but not necessarily the quality of the outcome. And further work is required on that.

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

<table>
<thead>
<tr>
<th>EDS2 Grade across all four Goals</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Direction of Travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undeveloped</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>Stable</td>
</tr>
<tr>
<td>Developing</td>
<td>12</td>
<td>13</td>
<td>4</td>
<td>Improvement</td>
</tr>
<tr>
<td>Achieving</td>
<td>0</td>
<td>5</td>
<td>14</td>
<td>Improvement</td>
</tr>
<tr>
<td>Excelling</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDS2 Improvements for each goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Direction of Travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1 Better health outcomes</td>
<td>4x developing</td>
<td>5x developing</td>
<td>4x achieving</td>
<td>Improvement</td>
</tr>
<tr>
<td></td>
<td>1x undeveloped</td>
<td>1x developing</td>
<td>1x developing</td>
<td></td>
</tr>
<tr>
<td>Goal 2 Improved patient access</td>
<td>3x developing</td>
<td>4x developing</td>
<td>3x achieving</td>
<td>Improvement</td>
</tr>
<tr>
<td>and experience</td>
<td>1x undeveloped</td>
<td>1x developing</td>
<td>1x developing</td>
<td></td>
</tr>
<tr>
<td>Goal 3 A representative and</td>
<td>3x developing</td>
<td>4x achieving</td>
<td>5x achieving</td>
<td>Improvement</td>
</tr>
<tr>
<td>supported workforce</td>
<td>3x undeveloped</td>
<td>2x developing</td>
<td>1x developing</td>
<td></td>
</tr>
<tr>
<td>Goal 4 Inclusive leadership</td>
<td>2x developing</td>
<td>1x achieving</td>
<td>2x achieving</td>
<td>Improvement</td>
</tr>
<tr>
<td></td>
<td>1x undeveloped</td>
<td>2x developing</td>
<td>1x developing</td>
<td></td>
</tr>
</tbody>
</table>

3.4 The key learning from the survey with commissioners and partners (four returns) was generally positive, with the responses to most questions about health outcomes and patient experience being graded as mainly met. Little feedback has been received on the quality of outcomes, in terms of equality and diversity. For 2020, it is proposed that more work be done with commissioners, partners, members and governors, to get a wider representation of input into the EDS assessment.

3.5 The key learning from the self-assessment surveys (conducted earlier in 2019), in terms of protected characteristics, at least two thirds of respondents considered that the Trust performs well or adequately on all nine protected characteristics, none considered that the Trust performs poorly. A third of respondents could not say how the Trust performs in relation to the protected characteristics. Respondents were asked to identify what the Trust does well and could do better in relation to equality and inclusion. The results were:

<table>
<thead>
<tr>
<th>Does Well</th>
<th>Could be improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Training</td>
<td>• Information made accessible and in different</td>
</tr>
<tr>
<td>• Follows guidelines to deliver equity and</td>
<td>languages</td>
</tr>
<tr>
<td>fairness</td>
<td>• Greater awareness of cultural backgrounds, in</td>
</tr>
</tbody>
</table>
3.6 One of the key challenges of the Trust is that the use of patient demographic data to inform service design and delivery has been very limited, and more work is needed to ensure consistent use of patient demographic data to inform equality analysis.

4 CONCLUSION

4.1 Taking together the EDS2 review (set out in appendix I) and the feedback from the surveys, the Trust has improved its performance since September 2017, and has moved overall to ‘Achieving’. This assessment does not take into consideration how well the Trust performs against each protected characteristic in terms of the quality of outcome, but simply on whether or not work on all protected characteristics can be evidenced in each of the 18 outcomes. The Trust is not yet ‘Excelling’ against any of the outcomes, and further work is required on the quality of outcomes.

4.2 The report illustrates that further work is needed to elevate the assessment from ‘Achieving’ to ‘Excelling’. This includes:

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

5 PUBLICATION

5.1 Subject to approval by the Trust Board at its meeting on 5 March 2020, the EDS2 Report, including the attached assessment, will be published on the Trust website before 31 March 2020.

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

-End-
<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Gender Pay Gap</th>
<th>Agenda Item</th>
<th>8.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Director</td>
<td>Leon Hinton, Executive Director of Human Resources and Organisational Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author</td>
<td>Alister McClure, Head of Equality and Inclusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>This report sets out the gender pay gap calculations and supporting statement for 2019. It is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust’s mean gender pay gap is 32.63 percent and the median gender pay gap of 23.63 percent. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to strategic Objectives 2019/20</td>
<td>Innovation: We will embrace innovation and digital technology to support the best of care</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finance: We will deliver financial sustainability and create value in all we do</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>People: We will enable our people to give their best and achieve their best</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High Quality Care: We will consistently provide high quality care</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Committees or Groups at which the paper has been submitted</td>
<td>Executive Group 20 February 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR and OD Senior Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Implications</td>
<td>None – can be managed within existing resource.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Implications/ Regulatory Requirements</td>
<td>The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires the Trust to publish its gender pay gap.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Impact Assessment</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation/ Actions required</td>
<td>To approve the publication of the Trust’s Gender Pay Gap and supporting statement (as set out is section 5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval ☒</td>
<td>Assurance ☐</td>
<td>Discussion ☐</td>
<td>Noting ☐</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pages 329 of 431
1 Executive Overview

1.1 This report sets out the gender pay gap calculations for 2019, together with a supporting statement. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

1.2 The Trust’s mean gender pay gap is 32.63% and the median gender pay gap of 23.63%. This is a deterioration from the position in 2018, but close to the gender pay gap in 2017. From September 2019, quarterly monitoring has taken place, and improvements have been made within the year, and the gender pay gap is on target for a marginal improvement in 2020. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. The Trust’s official reporting figure must not separate Agenda for Change (AfC) from medical pay bands, but informal analysis shows that the AfC average (mean) gender pay gap is 6.20%, while the gender pay gap for medical and dental staff is 19.04%; and since medical and dental pay averages at a higher rate compared to AfC, this aggregates to the overall gender pay gap of 32.63%. There is some evidence that this pattern is repeated in many other Trusts across the NHS, and relates to professional career paths.

2 BACKGROUND

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

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

2.3 The difference between the gender pay gap and equal pay

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

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

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

3 REPORTING REQUIREMENTS

3.1 Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions,
medical staff and very senior managers. All calculations must be made relating to the pay period in which the snapshot day falls. For this year, this will be the pay period including 31 March 2019.

3.2 Employers must:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls;
- calculate the differences between both the median and mean hourly rate of ordinary pay of male and female employees;
- calculate the difference between the median (and mean) bonus pay paid to male and female employees. For the NHS, bonus payments are defined as: clinical excellence awards; long service awards (monetary vouchers); workplace vouchers in addition to salary; recruitment bonuses; and relocation costs in excess of expenses. [The following are not to be considered as either pay or bonuses: salary sacrifice schemes, benefits in kind (e.g. NHS discounts); and the reimbursement of expenses.]
- calculate the proportions of male and female employees who were paid bonus pay;
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

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

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

4 GENDER PAY CALCULATIONS

4.1 Mean and Median Hourly Rates (All staff groups)

4.1.1 As at 31 March each year:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average (mean) Hourly Rate</th>
<th>Median Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22.99</td>
<td>21.82</td>
</tr>
<tr>
<td>Female</td>
<td>15.48</td>
<td>14.82</td>
</tr>
<tr>
<td>Difference</td>
<td>7.50</td>
<td>7.00</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>32.63%</td>
<td>32.09%</td>
</tr>
<tr>
<td>Direction of travel</td>
<td>Deterioration</td>
<td>Deterioration</td>
</tr>
</tbody>
</table>
4.1.2 As at 31 March, 30 September and 31 December 2019:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average (mean) Hourly Rate</th>
<th>Median Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec 19</td>
<td>Sep 19</td>
</tr>
<tr>
<td>Male</td>
<td>23.27</td>
<td>23.57</td>
</tr>
<tr>
<td>Female</td>
<td>15.83</td>
<td>15.95</td>
</tr>
<tr>
<td>Difference</td>
<td>7.44</td>
<td>7.62</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>31.98</td>
<td>32.32</td>
</tr>
<tr>
<td>Direction of travel within year</td>
<td>Improvement</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

4.2 Number and Percentage of employees per quartile

4.2.1 Number of employees per quartile:

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2019</td>
<td>2018</td>
</tr>
<tr>
<td>1 (lower)</td>
<td>863</td>
<td>882</td>
</tr>
<tr>
<td>2 (lower middle)</td>
<td>857</td>
<td>899</td>
</tr>
<tr>
<td>3 (upper middle)</td>
<td>884</td>
<td>887</td>
</tr>
<tr>
<td>4 (upper)</td>
<td>637</td>
<td>691</td>
</tr>
</tbody>
</table>

4.2.2 Percentage of employees per quartile:

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female %</th>
<th>Male %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2019</td>
<td>2018</td>
</tr>
<tr>
<td>1 (lower)</td>
<td>84.2</td>
<td>84.97</td>
</tr>
<tr>
<td>2 (lower middle)</td>
<td>83.35</td>
<td>85.13</td>
</tr>
<tr>
<td>3 (upper middle)</td>
<td>86.16</td>
<td>84.96</td>
</tr>
<tr>
<td>4 (upper)</td>
<td>62.03</td>
<td>65.75</td>
</tr>
</tbody>
</table>

4.3 Bonus Payments

4.3.1 There is no comparator for 2017, as bonus payments (CEAs, i.e. clinical excellence awards) in that year were incorporated into pay. As there was comparatively small number of CEAs, the impact on the mean and median pay rates was statistically negligible. Changes in 2018 to the award of CEAs have resulted in significant improvement.

4.3.2 Mean and Median Bonus Rates (2018 and 2019 only):

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average (mean) Hourly Rate</th>
<th>Median Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019</td>
<td>2018</td>
</tr>
<tr>
<td>Male</td>
<td>53.62</td>
<td>61.10</td>
</tr>
<tr>
<td>Female</td>
<td>53.29</td>
<td>49.90</td>
</tr>
<tr>
<td>Difference</td>
<td>0.33</td>
<td>11.2</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>0.61</td>
<td>18.37</td>
</tr>
<tr>
<td>Direction of Travel</td>
<td>Improvement</td>
<td>Improvement</td>
</tr>
</tbody>
</table>
4.3.3 Number of Employees paid bonuses per quartile:

<table>
<thead>
<tr>
<th>Year</th>
<th>Female 2019</th>
<th>Female 2018</th>
<th>Male 2019</th>
<th>Male 2018</th>
<th>Female % 2019</th>
<th>Female % 2018</th>
<th>Male % 2019</th>
<th>Male % 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>6</td>
<td>13</td>
<td>13</td>
<td>23.53</td>
<td>31.58</td>
<td>76.47</td>
<td>68.42</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>4</td>
<td>12</td>
<td>15</td>
<td>33.33</td>
<td>21.05</td>
<td>66.67</td>
<td>78.95</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>6</td>
<td>15</td>
<td>12</td>
<td>11.76</td>
<td>33.33</td>
<td>88.24</td>
<td>66.67</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>4</td>
<td>12</td>
<td>17</td>
<td>33.33</td>
<td>19.05</td>
<td>66.67</td>
<td>80.95</td>
</tr>
</tbody>
</table>

4.3.4 Percentage of Employees paid bonuses:

<table>
<thead>
<tr>
<th>Year</th>
<th>Female 2019</th>
<th>Female 2018</th>
<th>Male 2019</th>
<th>Male 2018</th>
<th>Total 2019</th>
<th>Total 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>3241</td>
<td>3359</td>
<td>865</td>
<td>830</td>
<td>4106</td>
<td>4189</td>
</tr>
<tr>
<td>2019</td>
<td>18</td>
<td>20</td>
<td>52</td>
<td>57</td>
<td>70</td>
<td>77</td>
</tr>
<tr>
<td>2019</td>
<td>0.56%</td>
<td>0.59%</td>
<td>6.01%</td>
<td>6.87%</td>
<td>1.70%</td>
<td>1.84%</td>
</tr>
</tbody>
</table>

5 **SUPPORTING STATEMENT**

5.1 The headline calculations for this Trust are a Mean gender pay gap of 32.63% and a Median gender pay gap of 23.63%. It is evident that the proportion of men in the workforce increases in the upper quartile, compared to quartiles 1 to 3.

5.2 When calculating the pay gap separately for medical and dental, and non-medical staff, the mean reduces for both groups, and the median reduces for non-medical staff. Indeed, the mean pay gap for non-medical staff (chiefly AfC pay bands) there is very little variation in the mean, at 6.2%, and the median is 1.2%.

5.3 The gender pay gap issue for the Trust comes when we combine medical and non-medical grades, as the number of men in the medical workforce, particularly consultants, is significantly higher than the number of women. Amongst medical consultants, men comprise over 75% of the workforce. In Agenda for Change (AfC) pay bands, women form over 80% of the workforce. This means that, compared to women, a greater proportion of men are in higher paid roles. Another potential matter to consider is the fact that the Trust has not outsourced some services, such as catering and housekeeping, which have a higher proportion of women in lower pay bands. A current externally managed study of organisational culture and gender pay may help the trust identify the reasons for apparent glass ceilings of women, and what practical actions can be taken to address these.

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

5.5 Further work is needed to understand the reasons for the differences in progression for men and women, especially in medical and dental roles. There is also little that the Trust can do in the short term to remove the gender pay gap, precisely because the issue affects professions that have long term career pathways.
5.6 The important issue with gender pay gap analysis is not only to know the data and understand the reasons for the gaps, but to be able to develop plans to address the gap. Noting that the gender pay gap issue is common to many other acute trusts across the NHS, it will be important to continue to explore with partners across the NHS what practical changes can be made. Ideas currently under consideration include:

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

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

6 PUBLICATION

6.1 Subject to approval by the Trust Board at its meeting in March 2020, the gender pay gap and supporting statement will be published on the Trust website and the Government portal before 31 March 2020.

6.2 It is recommended:

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

6.2.2 that the Trust continues to work with partners across the NHS to develop a system-wide approach to the NHS gender pay gap.
<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Staff Survey 2019</th>
<th>Agenda Item</th>
<th>8.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Director</td>
<td>Leon Hinton, Executive Director of HR and OD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author</td>
<td>Lisa Webb, Group Head of Organisational Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>The Trust’s response rate for the national staff survey 2019 increased (+3%) to 43% and reflected the opinions of 1828 employees. Thematic responses: A new theme has been to the survey - Team working – which has been retrospectively determined for 2017 and 2018 results. Across the staff survey themes – for the entire Trust, ten of eleven scores improved (of which eight were statistically significant improvements), one remained the same and no deteriorated. Individual questions: Of the 90 staff survey questions, 79 had improved (based on positive scores), seven remained the same and four deteriorated. Significant improvements (of up to 12% improvements) were seen across all domains, but particularly the staff engagement (staff being able to suggest and make changes to own area) and morale scores. This briefing report denotes the next steps to delivering genuine actions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to strategic Objectives 2019/20</td>
<td>Innovation: We will embrace innovation and digital technology to support the best of care</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finance: We will deliver financial sustainability and create value in all we do</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>People: We will enable our people to give their best and achieve their best</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High Quality Care: We will consistently provide high quality care</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Committees or Groups at which the paper has been submitted</td>
<td>Executive Group 19 February 2020 Human Resources and Organisational Development Senior Team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Implications</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Implications/Regulatory Requirements</td>
<td>NHS organisations are required to undertake the annual staff survey and report to Board.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Impact Assessment</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation/</td>
<td>The Board is asked to note the content of this report and next steps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions required</td>
<td>Approval</td>
<td>Assurance</td>
<td>Discussion</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Appendices</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Best Culture**

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

### 1 Response rate

1.1 The response rate for the Trust increased to 43% (1828 responses) in 2019 against an average national response for acute Trusts at 47%. The response rate per directorate is as follows:

- Planned Care – 40%
- Unplanned & Integrated Care – 40%
- Estates & Facilities – 38%
- Corporate – 73%

1.2 Response rate for clinical directorates varied between high of 77% (Unplanned & Integrated Care Management) and low of 31% (Urgent and Emergency Care). A structured and implemented plan helped increase the response rate of the survey. Anecdotally, resistance to completion of the survey largely included privacy concerns that surveys could be traced back, a message that numerous communications attempted to dispel. In addition, an incentive scheme was introduced this year for individuals to win a voucher or a tablet, on the basis of completing and submitting the survey. The winners were randomly selected by the survey company.

### 2 Changes to the Staff Survey

2.1 A new theme has been to the survey - Team working – which has been retrospectively determined for 2017 and 2018 results. The eleven themes are:

- Equality, diversity and inclusion;
- Health and wellbeing;
- Immediate managers;
- Morale;
- Quality of appraisals;
- Quality of care;
- Safe environment – bullying and harassment;
- Safe environment – violence;
- Safety culture;
- Staff engagement;
- Team working.
3 Survey findings

3.1 The organisational heat map is shown in table 1 (below) and shows graphically the higher scoring elements (positive) of the organisation (towards green) versus the lower scoring elements (negative) of the organisation (towards red). The change in colours also denote comparative improvement (towards green) or deterioration (towards red) against 2018.
3.2 Across the staff survey themes – for the entire Trust, ten of eleven scores improved (of which eight were statistically significant improvements), one remained the same and none deteriorated. The results are shown below:

<table>
<thead>
<tr>
<th>Theme</th>
<th>2018 score</th>
<th>2018 respondents</th>
<th>2019 score</th>
<th>2019 respondents</th>
<th>Statistically significant change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, diversity &amp; inclusion</td>
<td>8.8</td>
<td>1573</td>
<td>8.9</td>
<td>1792</td>
<td>Not significant</td>
</tr>
<tr>
<td>Health &amp; wellbeing</td>
<td>5.3</td>
<td>1591</td>
<td>5.6</td>
<td>1809</td>
<td></td>
</tr>
<tr>
<td>Immediate managers</td>
<td>6.2</td>
<td>1596</td>
<td>6.6</td>
<td>1810</td>
<td></td>
</tr>
<tr>
<td>Morale</td>
<td>5.4</td>
<td>1584</td>
<td>5.8</td>
<td>1789</td>
<td></td>
</tr>
<tr>
<td>Quality of appraisals</td>
<td>5.5</td>
<td>1248</td>
<td>5.7</td>
<td>1518</td>
<td>Not significant</td>
</tr>
<tr>
<td>Quality of care</td>
<td>7.0</td>
<td>1342</td>
<td>7.4</td>
<td>1580</td>
<td></td>
</tr>
<tr>
<td>Safe environment - Bullying &amp; harassment</td>
<td>7.4</td>
<td>1584</td>
<td>7.8</td>
<td>1797</td>
<td></td>
</tr>
<tr>
<td>Safe environment - Violence</td>
<td>9.4</td>
<td>1581</td>
<td>9.4</td>
<td>1788</td>
<td>Not significant</td>
</tr>
<tr>
<td>Safety culture</td>
<td>6.1</td>
<td>1577</td>
<td>6.4</td>
<td>1800</td>
<td></td>
</tr>
<tr>
<td>Staff engagement</td>
<td>6.4</td>
<td>1609</td>
<td>6.8</td>
<td>1821</td>
<td></td>
</tr>
<tr>
<td>Team working</td>
<td>6.1</td>
<td>1573</td>
<td>6.6</td>
<td>1799</td>
<td></td>
</tr>
</tbody>
</table>

3.3 There was a significant increase in Morale (4% thematic swing/6% improvement on positive scores) and Staff engagement (4% thematic swing/7% improvement on positive scores), which were target areas for improvement across the Trust following the 2018 staff survey (having both reported as some of the lowest scores in the NHS), between 2018 and 2019 with the greatest improvement being 12%. The results are shown below:
3.4 There has been a statistically significant improvement in reducing harassment and bullying compared to 2018 staff survey (+4% improvement to score) which is corresponding to improvement across line management relationship scores, working as a team and improvement communication with senior management.

4 Areas of concern

4.1 Four questions deteriorated (as positive score), two were directly related to experiencing physical violence or experiencing discrimination from patients/service users or their relatives (2% decrease across both questions). In August 2019, the Trust launched a zero tolerance campaign to tackle treats of violence, abuse or harassment against staff – this was to raise awareness to the public, and also to help staff understand that violence and abuse against them or colleagues is not tolerated – a review of incidents will be carried out to understand the impact. There was a 1% increase in the numbers of staff witnessing errors, near misses or incidents that could have hurt staff in the last month. There was a 2% increase in the number of staff reporting they were working additional paid hours beyond their contracted; however this is not mirrored across bank/overtime reports.

4.2 Staff recommending their organisation as a place to receive treatment has significantly improved since the 2018 staff survey (+7%) at 54%; however, remains as one of the lowest across acute providers nationally. The same question is asked as part of the quarterly staff family and friends test and regularly reports c.68%. The organisation will need to understand the rationale and pattern for the reporting of this metric. The questions used as part of the family and friends test will be extended from quarter 4 2019/20 to include five key driver questions to form a more regular ‘pulse’ survey approach to staff engagement, morale and safety culture and its links to the question determining staff’s recommending the organisation as a place to receive treatment.
Learning from the staff survey

5.1 The Trust has seen a remarkable improvement in scores associated with the staff survey as a result of several interventions including a continuous uptake of the ‘you are the difference’ programme; quality improvement methodology and intensive organisational development programmes. Learning from this shift will be utilised for other interventions.
6 **Next steps**

6.1 The 2019 NHS staff survey results were released nationally on 18 February 2020. Continuing from the progress made in 2018’s approach to translating the survey results into dynamic local action plans, each care/corporate group will receive a guided workbook detailing breakdown for their area thematically grouped to support the local action plan delivery to be written and owned locally. The results for divisions and programmes will be shared via HR Business Partners highlighted areas to celebrate and those for improvement.

6.2 Furthermore, the staff survey action plans forms a key component of the divisional performance review meetings (PRM) on a monthly basis to monitor progress against plan, celebrate success and test assumptions. A key element of this strategy has been to move the approach of staff survey from a one-off activity and event through to business as usual ongoing monitoring and review with oversight through PRM.

6.3 Actions taken during and following the staff survey fieldwork period included:

- The Integration of Best of Care, Best of People sessions into our “You Are the Difference” programme. The sessions include the following:
  - The Medway Way: Best of Care, Best of People helping staff understand and link our values to the desired culture here at Medway;
  - A Cultural Diverse and Aware Medway, helping all staff gain cultural competence to enable the development of an effective and harmonious working environment;
  - Promoting Professionalism here at Medway: Helping staff reinforce professional conduct expectations within the Trust;
  - You are the Difference programme.

- Bespoke OD interventions;
- Development and implementation of Talent management system;
- NHSEI Culture and Leadership Programme;

6.4 To enable Medway to address areas to:

- Re-inforce an inspiring vision;
- Promote staff health and wellbeing;
- Listen and involve staff at all levels;
- Ensure staff feel safe, supported, respected and valued;
- Give constructive feedback and celebrate successes;
- Address system-level problems;
- Develop and actively model good teamwork;
- Develop delivery and actions plans from the Reports produced by the Clever Together online conversation forum;

7 **Conclusion**

7.1 The Trust will continue to build on and embed some of the initiatives that are already in place to increase staff engagement, improve clinical quality and safety outcomes, and increase communication between staff and senior management team and to empower staff. These include:

- Continue running phase 3 of YatD programme that has now been embedded in the Trust Induction programme to include Doctors induction;
• Continue to conduct listening sessions to help develop programme plans that prioritise areas for action in clinical and non-clinical areas;
• Gemba walks;
• QI programme rolled out across the Trust with a view to embedding quality improvement initiatives and making these part of business as usual;
• Appointment of the Freedom to Speak Up Guardian and recruitment of 6 champions;
• We are working on retaining our best staff at the trust with a number of initiatives including:
  o NHSEI– we have subscribed to cohort 4 of the retention direct support programme;

7.2 The 2019 staff survey results have improved significantly compared to 2018. The next steps reflect the need for continual organisational spotlight on actions aligned to engaging and supporting our staff over a period of time where change management is increasing, and financial pressures continue.

-End-
### Executive Summary

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

The Trust’s recruitment campaigns, including national, local and international have delivered 668 candidates to date; 302 of these candidates have commenced in post over the last 12 months.

Trust turnover has decreased to 11.85% (-0.09%) from 11.94%, sickness absence at 4.08% is the same compared to the month of December is above the Trust’s tolerance level of 4%, and appraisal compliance has increased to 87.86% (+0.25% from 87.61%) and is above Trust target of 85%. Statutory and Mandatory training is at 92.23% (-0.71% from 92.94%) and is meeting the Trust target of 85%.

The percentage of pay bill spent on substantive staff in January at (83%) remained the same compared to the month of December. The percentage of agency usage at 3% (-1%) has decreased compared to the month of December. The percentage of pay bill spent on bank staff at 14% (+1) has increased compared to December.

### Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

<table>
<thead>
<tr>
<th>Innovation: We will embrace innovation and digital technology to support the best of care</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance: We will deliver financial sustainability and create value in all we do</td>
<td>☐</td>
</tr>
<tr>
<td>People: We will enable our people to give their best and achieve their best</td>
<td>☒</td>
</tr>
<tr>
<td>Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
<td>☐</td>
</tr>
<tr>
<td>High Quality Care: We will consistently provide high quality care</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Committees or Groups at which the paper has been submitted

Executive Group
Human Resources and Organisational Development Senior Team.

### Resource Implications

Not applicable
Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.

- Nurse Recruitment
- Temporary Staffing Spend

The following activities are in place to mitigate this through:
1. Targeted campaign to attract local and national nurses
2. Update on overseas campaign
3. Update on medical and dental; allied health professional; and, scientific, technical and therapeutic professional recruitment.
4. Ensuring a robust temporary staffing service
5. Review of temporary staffing usage, particularly agency usage, currently in use at Medway
6. Agency/Temporary Staffing Work stream as part of the 2019/20 cost improvement programme

Quality Impact Assessment
Not applicable

Recommendation/ Actions required
The Board is asked to note the content of this report.

<table>
<thead>
<tr>
<th>Approval</th>
<th>Assurance</th>
<th>Discussion</th>
<th>Noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

Appendices
None

1 Introduction

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

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

2 Recruitment

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During January 2020, 26 FTE registered nurses and midwives joined the Trust (net increase +14 FTE) on a substantive basis, alongside 16 FTE substantive clinical support workers/maternity care assistants (net increase +11 FTE, table 2).

2.2 In January 2020, 19 international nurses arrived in the Trust. To date a total of 180 international nurses have taken (OSCE) exam. The Trust has a first attempt pass rate of 82% and an overall success rate of 99%.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Ten Cpl international nurses
commenced in post, with 10 nurses remaining in the pipeline. 53 HCL nurses have also commenced in post. 4 candidates remain in the pipeline with offers being processed.

2.4 The Trust is also working with nine additional permanent nursing recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, MSI, Medline, Kate Cowhig, HealthPerm, Santuary Healthcare and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial years 2019/2020 and 2020/2021.

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

Table 1 below summarises the Trust's nursing recruitment pipeline as at end of January 2020:

<table>
<thead>
<tr>
<th>Commenced</th>
<th>Pipeline</th>
<th>Agency total</th>
<th>Anticipated new starters over the next 12-months from pipeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>302</td>
<td>189</td>
<td>668</td>
<td>156</td>
</tr>
</tbody>
</table>

(Table 1: Nurse recruitment pipeline as of January 2020)

Table 2 below summarises offers made, starters and leavers for the month of January 2020:

<table>
<thead>
<tr>
<th>Role</th>
<th>Offers made in month</th>
<th>Actual starters</th>
<th>Actual leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses &amp; midwives</td>
<td>50 (36 NHS Jobs/open days &amp; 14 international nurses via skype)</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Clinical support workers/Maternity Care Assistants</td>
<td>11 (Clinical Support Workers)</td>
<td>16</td>
<td>5</td>
</tr>
</tbody>
</table>

(Table 2: Nursing starters and leavers January 2020)

2.6 During December a total of six medical staff joined the Trust. Focused discussions on recruitment of medical staff takes place regularly within divisions during the vacancy control panel (VCP) meetings that are chaired by the divisional directors. Out of the 12 medical staff leavers in January, six were junior doctors in training taking up placement posts in other NHS Trusts. At present consultant recruitment is taking place for the following specialities Acute Medicine, Cardiology, Gastroenterology, Geriatrics, Otolaryngology, Paediatrics and Haematology. As at end of January 2020 the Trust had 41 FTE vacant consultant posts and 53 FTE vacant non-consultant posts.

Table 3 below summarises offers made, starters and leavers for the month of January 2020:

<table>
<thead>
<tr>
<th>Role</th>
<th>Offers made in month</th>
<th>Actual starters</th>
<th>Actual leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Junior doctors (including doctors in training)</td>
<td>22</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

(Table 3: Medical staff starters and leavers January 2020)

2.7 During December two Allied Healthcare Professionals (AHP) (Physiotherapists, Occupational Therapists, Radiographers and Dieticians) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant physiotherapy/occupational therapy especially when filling difficult to recruit to posts.
Table 4 below summarises offers made, starters and leavers for the month of January 2020:

<table>
<thead>
<tr>
<th>Role</th>
<th>Offers made in month</th>
<th>Actual starters</th>
<th>Actual leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapists</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Therapy Assistant Practitioner</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dieticians</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Radiographers</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sonographer</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

(Table 4: AHP starters and leavers January 2020)

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

Table 5 below summarises offers made, starters and leavers for the month of January 2020:

<table>
<thead>
<tr>
<th>Role</th>
<th>Offers made in month</th>
<th>Actual starters</th>
<th>Actual leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Technicians</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacy Assistant</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Operating Theatre Practitioners / Theatre Nurses</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Anaesthetic Assistant</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assistant Practitioner (Theatres)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Table 5: ST&T starters and leavers January 2020)

3 Trust and Divisional Metrics

3.1 The table below (table 6) shows performance across five core indicators by the divisions. Turnover, at 11.85% (-0.09% from 11.94%), remains above the tolerance level of 8%. HR Business Partners work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let’s work together commissioned by Health Education England) and staff survey results implementing service specific retention plans. Sickness absence at 4.08% is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 87.86% (+0.25% from 87.61%) and is above the Trust target of 85%, all divisions are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

3.3 Statutory and Mandatory training stands at 92.23% (-0.71% from 92.94%) and is meeting the Trust target of 85%. All divisions across the Trust are meeting the Statutory and Mandatory training target. Approximately 15,000 learning interventions need to occur during 2019/20 for the Trust to be compliant. These interventions occur across e-learning, classroom-based learning and also blended learning...
opportunities. SMEs provide sufficient capacity to provide face-to-face opportunities to meet the demand.

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

<table>
<thead>
<tr>
<th>Division &gt;&gt; Care Group</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>275 Corporate</td>
<td>95.77%</td>
</tr>
<tr>
<td>275 Communications Directorate</td>
<td>97.53%</td>
</tr>
<tr>
<td>275 Finance</td>
<td>97.71%</td>
</tr>
<tr>
<td>275 Human Resources &amp; Organisational Development</td>
<td>99.43%</td>
</tr>
<tr>
<td>275 IT</td>
<td>97.05%</td>
</tr>
<tr>
<td>275 Medical Directorate</td>
<td>94.53%</td>
</tr>
<tr>
<td>275 Nursing</td>
<td>92.43%</td>
</tr>
<tr>
<td>275 Strategy, Governance and Performance</td>
<td>98.21%</td>
</tr>
<tr>
<td>275 Transformation</td>
<td>91.67%</td>
</tr>
<tr>
<td>275 Trust Executive &amp; Board</td>
<td>83.42%</td>
</tr>
<tr>
<td>275 Facilities and Estates</td>
<td>91.06%</td>
</tr>
<tr>
<td>275 Facilities and Estates Management</td>
<td>85.71%</td>
</tr>
<tr>
<td>275 Hard FM</td>
<td>94.26%</td>
</tr>
<tr>
<td>275 Soft FM</td>
<td>90.71%</td>
</tr>
<tr>
<td>275 Planned Care</td>
<td>92.16%</td>
</tr>
<tr>
<td>275 Cancer Services</td>
<td>93.09%</td>
</tr>
<tr>
<td>275 Peri-operative &amp; Critical Care</td>
<td>92.85%</td>
</tr>
<tr>
<td>275 Planned Care Infrastructure</td>
<td>89.36%</td>
</tr>
<tr>
<td>275 Surgical Services</td>
<td>89.54%</td>
</tr>
<tr>
<td>275 Women's &amp; Children's Health</td>
<td>93.03%</td>
</tr>
<tr>
<td>275 Unplanned and Integrated Care</td>
<td>90.78%</td>
</tr>
<tr>
<td>275 Diagnostics &amp; Clinical Support Services</td>
<td>92.73%</td>
</tr>
<tr>
<td>275 Specialist Medicine</td>
<td>91.96%</td>
</tr>
<tr>
<td>275 Therapies &amp; Older Persons</td>
<td>91.17%</td>
</tr>
<tr>
<td>275 Unplanned &amp; Integrated Care Management</td>
<td>84.89%</td>
</tr>
</tbody>
</table>

(Table 7: StatMan compliance profile)
4 Temporary Staffing

4.1 Table 8 below demonstrates that temporary staffing expenditure increased in January 2020 compared to December 2019.

<table>
<thead>
<tr>
<th></th>
<th>Mar 17</th>
<th>Mar 18</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>Oct 19</th>
<th>Nov 19</th>
<th>Dec 19</th>
<th>Jan 20</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>£3,890,198</td>
<td>£2,597,697</td>
<td>£783,127</td>
<td>£684,291</td>
<td>£634,482</td>
<td>£876,962</td>
<td>£871,691</td>
<td>£615,767</td>
<td>£5,837,220</td>
</tr>
<tr>
<td>Bank</td>
<td>£920,473</td>
<td>£2,329,768</td>
<td>£2,105,055</td>
<td>£2,267,819</td>
<td>£2,371,903</td>
<td>£2,291,922</td>
<td>£2,368,729</td>
<td>£2,445,677</td>
<td>£22,427,921</td>
</tr>
<tr>
<td>Substantive</td>
<td>£13,611,458</td>
<td>£13,542,990</td>
<td>£16,377,676</td>
<td>£14,152,087</td>
<td>£14,756,923</td>
<td>£14,628,175</td>
<td>£14,738,766</td>
<td>£14,884,893</td>
<td>£146,847,033</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Agency</th>
<th>Bank</th>
<th>Substantive</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pay bill</td>
<td>21%</td>
<td>5%</td>
<td>74%</td>
</tr>
<tr>
<td>Agency</td>
<td>14%</td>
<td>11%</td>
<td>85%</td>
</tr>
<tr>
<td>Bank</td>
<td>4%</td>
<td>13%</td>
<td>84%</td>
</tr>
<tr>
<td>Substantive</td>
<td>4%</td>
<td>13%</td>
<td>83%</td>
</tr>
</tbody>
</table>

(Table 8: Contractual profile)

4.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 1 below. During the month of January 2020 the Trust reported an average of 23 breaches per week across the month.

(Chart 1: NHSI cap breaches)

4.3 The Trust’s NHSI annual agency spend ceiling remains the same for 2019/2020 at £17.88m. Based on month 10 agency spend, the Trust is £8.9m below the NHSI agency ceiling cap target as illustrated in the chart and table below.
Chart 2: NHSI agency ceiling

Table 9 below shows NHSI agency ceiling performance in the month of January 2020:

<table>
<thead>
<tr>
<th>Month</th>
<th>Cumulative NHSI Ceiling</th>
<th>Agency in month actual spend</th>
<th>Cumulative below ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-19</td>
<td>£1,490,000</td>
<td>£684,291</td>
<td>£805,709</td>
</tr>
<tr>
<td>May-19</td>
<td>£8,940,000</td>
<td>£506,702</td>
<td>£5,073,562</td>
</tr>
<tr>
<td>Jun-19</td>
<td>£10,430,000</td>
<td>£634,482</td>
<td>£5,801,300</td>
</tr>
<tr>
<td>Jul-19</td>
<td>£11,920,000</td>
<td>£676,962</td>
<td>£7,248,820</td>
</tr>
<tr>
<td>Aug-19</td>
<td>£13,410,000</td>
<td>£671,691</td>
<td>£8,067,129</td>
</tr>
<tr>
<td>Sep-19</td>
<td>£14,900,000</td>
<td>£615,767</td>
<td>£8,941,362</td>
</tr>
</tbody>
</table>

4.4 Temporary nursing demand increased January 2020 compared to December 2019 (9,578 shift requests in January 2020 compared to 9,292 shift requests in December 2019). The fill rate decreased to 70%. Medical locum demand decreased in January 2020 compared to December 2019 (1,115 shift requests in January 2020 compared to 1,183 shift requests in December 2019). The fill rate for medical locum was 88%.

5 **NHSI Nursing Retention**

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

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

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

6.1 The Trust is continuing to provide support to EU and EEA nationals given the UK leaving the European Union. In the run-up to leaving the EU, EU and EEA nationals were invited to a group meeting led by an immigration lawyer to provide information on the legal position in relation to Settled Status, and the process of application. This was followed by direct email briefings to each individual identified as those who need to apply for the Settled Status or Pre-Settled Status. This information was also sent out through the Weekly Staff Bulletin, and on an Intranet page dedicated to EU/EEA Settlement.

6.2 Practical support remains on offer and includes the opportunity to talk through concerns with the Head of Equality and Inclusion. The Trust has also set aside a dedicated Android smartphone (to enable staff without that technology to be able to access the application process).

6.3 Staff have been reminded to ensure that their employment records are updated once they receive Settled Status, or Pre-Settled Status, or if they obtain UK Citizenship. Table 11 below shows the number of EU and EEA nationals broken down by staff groups.
EU Staff Tracker

<table>
<thead>
<tr>
<th></th>
<th>Qtr1</th>
<th>Qtr2</th>
<th>Qtr3</th>
<th>Qtr4</th>
<th>Qtr1</th>
<th>Qtr2</th>
<th>Qtr3</th>
<th>Qtr4</th>
<th>Qtr1</th>
<th>Qtr2</th>
<th>Qtr3</th>
<th>Qtr4</th>
<th>Qtr1</th>
<th>Qtr2</th>
<th>Qtr3</th>
<th>Qtr4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff in Post FTE</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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Meeting of the Board of Directors in Public  
Thursday, 05 March 2020  
Assurance Report from Committees

<table>
<thead>
<tr>
<th>Title of Committee:</th>
<th>Integrated Audit Committee</th>
<th>Agenda Item</th>
<th>9.2</th>
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<tbody>
<tr>
<td>Committee Chair:</td>
<td>Mark Spragg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td>Thursday 27 February 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Ian O’Connor, Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author:</td>
<td>Paul Kimber, Deputy Director of Finance</td>
<td></td>
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The key headlines and levels of assurance are set out below, and are graded as follows:

<table>
<thead>
<tr>
<th>Assurance Level</th>
<th>Colour to use in ‘assurance level’ column below</th>
</tr>
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<tbody>
<tr>
<td>No assurance</td>
<td>Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans</td>
</tr>
<tr>
<td>Partial assurance</td>
<td>Amber/ Red - there are gaps in assurance</td>
</tr>
<tr>
<td>Assurance</td>
<td>Amber/ Green - Assurance with minor improvements required</td>
</tr>
<tr>
<td>Significant Assurance</td>
<td>Green – there are no gaps in assurance</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>White - no assurance is required</td>
</tr>
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</table>

Key headlines and assurance level

<table>
<thead>
<tr>
<th>Key headline</th>
<th>Assurance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Internal Audit Report and Local Counter Fraud Reports</td>
<td>Green</td>
</tr>
<tr>
<td>Three new recommendations were raised since the last Committee meeting on 28 November 2019; currently there are fifteen overdue, which are being followed up.</td>
<td></td>
</tr>
<tr>
<td>Trust executives present committed to swifter action to implement recommendations in line with agreed deadlines.</td>
<td></td>
</tr>
<tr>
<td>RAG Ratings:</td>
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</tr>
<tr>
<td>Board Assurance Framework: amber/green</td>
<td></td>
</tr>
<tr>
<td>2. External Audit Report</td>
<td>Green</td>
</tr>
<tr>
<td>Grant Thornton presented their External Audit Report. They confirmed that progress to date was in line with expectations and that the key risks</td>
<td></td>
</tr>
</tbody>
</table>
they would seek assurance over as part of their work were:

- Management override of controls
- Revenue recognition
- Transfer of financial information to the new general ledger
- Valuation of property, plant and equipment
- Going concern

The Committee also approved its response to the auditor’s queries in respect of processes in place to prevent and detect fraud and to ensure compliance with law and regulation.

<table>
<thead>
<tr>
<th>3. 2019/20 Annual Accounts Plan</th>
<th>Green</th>
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</thead>
<tbody>
<tr>
<td>The Committee received an update on the progress made in respect of changes to accounting for leases (effective from 1 April 2020) and following appointment of Montagu Evans (who are undertaking the revaluation of the Trust estate). The Committee noted the going concern assessment and advised of current known amendments that will be required when this is updated at the point the annual report and accounts are signed.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Losses and Special Payments</th>
<th>Green</th>
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</thead>
<tbody>
<tr>
<td>The Committee noted the report which identified losses and special payments to date of £12,107.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>5. Annual Work Plan and Terms of Reference</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee received a draft of its Annual Work Plan and has requested minor amendments before this is submitted to the Board for approval. The Terms of Reference for the Committee were APPROVED.</td>
<td></td>
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</tbody>
</table>

**Further Risks Identified**

All risks are captured within the risk register and the BAF.

**Escalations to the Board or other Committee**

None
# Executive Summary

Vascular surgical services in Kent and Medway are currently provided by Medway Foundation NHS Trust (MFT) and East Kent Hospitals University NHS Foundation Trust at Kent and Canterbury Hospital (K&CH).

A number of reviews of vascular surgery have been undertaken since 2014, led by NHS England Specialised Commissioning. These reviews have concluded that an acute inpatient vascular service should be commissioned from one single acute Trust. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery is to be centralised at the K&CH. This new model of care will mean that there will be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery will remain unchanged in terms of their location but EKHUFT will become the host provider Trust for the Kent and Medway Vascular Surgical Service.

### Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Mark</th>
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<tbody>
<tr>
<td>Innovation: We will embrace innovation and digital technology to support the best of care</td>
<td>☐</td>
</tr>
<tr>
<td>Finance: We will deliver financial sustainability and create value in all we do</td>
<td>☐</td>
</tr>
<tr>
<td>People: We will enable our people to give their best and achieve their best</td>
<td>☒</td>
</tr>
<tr>
<td>Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td>
<td>☒</td>
</tr>
<tr>
<td>High Quality Care: We will consistently provide high quality care</td>
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### Due Diligence

To give the Trust Board assurance, please complete the following:

<table>
<thead>
<tr>
<th>Committee Approval:</th>
<th>Name of Committee: No</th>
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</thead>
<tbody>
<tr>
<td>Date of approval:</td>
<td>No</td>
</tr>
</tbody>
</table>

| Executive Group Approval: | Date of Approval: Planning and Delivery Board on 19 February 2020 |

<table>
<thead>
<tr>
<th>National Guidelines</th>
<th>Does the paper conform to National Guidelines (please state): Yes – complies</th>
</tr>
</thead>
<tbody>
<tr>
<td>compliance:</td>
<td>to the Vascular Society for Great Britain and Ireland guidance, with the National Service Specification for Specialised Vascular Services and with NHS England Specialist Commissioning requirements</td>
</tr>
<tr>
<td>Resource Implications</td>
<td>The proposed recommendation will not have any additional resource implications</td>
</tr>
<tr>
<td>Legal Implications/Regulatory Requirements</td>
<td>The proposed reconfiguration of acute inpatient vascular surgical services will require a formal public consultation to be undertaken. This will be led by NHS England Specialised Commissioning in partnership with the CCGs and the provider Trusts and is scheduled to commence in late April 2020 for a 6 week period. The current vascular surgical team at MFT will also transfer to EKHUFT under TUPE arrangements. This process will commence post public consultation.</td>
</tr>
<tr>
<td>Quality Impact Assessment</td>
<td>A Quality Impact Assessment has been completed by NHS England Specialised Commissioning and forms part of the business case appendices</td>
</tr>
<tr>
<td>Recommendation/Actions required</td>
<td>The Board is asked to approve the programme</td>
</tr>
<tr>
<td></td>
<td>Approval ☒</td>
</tr>
<tr>
<td>Appendices</td>
<td>The business case has a large number of appendices attached. These are listed at the end of the business case</td>
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**SERVICE DEVELOPMENT BUSINESS CASE**

<table>
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<tr>
<th>Title:</th>
<th>Kent and Medway Vascular Surgery Programme</th>
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<td>Care Group:</td>
<td>Surgery and Anaesthetics Care Group</td>
</tr>
<tr>
<td>Specialty/Department:</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Project Manager:</td>
<td>Simon Brooks-Sykes</td>
</tr>
<tr>
<td>Financial Lead:</td>
<td>Elisa Llewelyn</td>
</tr>
<tr>
<td>HR Partner:</td>
<td>Karl Woods</td>
</tr>
</tbody>
</table>

*ALL SECTIONS MUST BE COMPLETED*

### Section 1 - Executive Summary

1. **What is the issue/s that needs to be resolved? (Include Timescales)**

Vascular Surgical services in Kent and Medway are currently provided by two NHS Trusts: Medway Foundation NHS Trust and East Kent Hospitals University NHS Foundation Trust.

In March 2013, the National Service Specification (NSS) for Specialised Vascular Services was issued for adoption from October 2013. The report states "There is a strong evidence base that suggests that mortality from elective aneurysm surgery is significantly less in centres with a high caseload than in units that perform a lower number of procedures".

In December 2014, NHS England Specialist Commissioning initiated a review of the vascular service provided by the current providers in Kent and Medway. This was followed by the publication of a detailed Case for Change for Vascular Surgery in Kent and Medway§ which articulated the need to reconfigure the local vascular services across Kent and Medway in order to meet the NSS and Vascular Society’s Provision Of Vascular Surgery standards (VS POVs).

The main issues that were identified by the review included:

- The lack of a vascular network across Kent and Medway.
- The number of people served by both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) is below the 800,000 minimum which is recommended by the Vascular Society. MFT serves around 450,000 and EKHUFT serves around 720,000.
- At both trusts, the total number of some of the core index procedures is either borderline or below the recommended numbers.
- The number of consultants is currently lower than required. Consequently there is concern about being able to staff the vascular surgical and interventional radiology rotas 24/7 at both sites.

Neither hospital was able to fully meet the service specification criteria or achieve the requirements of the VS POVs on its own.

---

§ See appendix 1
In early 2015, NHS England South (South East) granted derogation (a temporary exemption) to both Kent and Medway Trusts so that they could continue to provide vascular surgical services even though they did not fully meet the national specification (EKHUFT now treats the minimum number of core index procedures). Both Trusts were tasked with working together to find a sustainable, efficient and effective longer-term solution for vascular surgical services.

In 2015/16, further work was undertaken as part of the Kent and Medway Sustainability and Transformation Partnership to plan for the longer-term future of vascular surgical services. This work concluded that in the longer-term (as part of the STP) a single inpatient vascular centre should be created in east Kent. Such a centre would serve a population of over 1.4 million, would allow the consolidation of skilled staff and resources to achieve the requirements of the national specification and would enable the service to meet the needs of the VS POVs.

In July 2018, NHS England led a further review of vascular services in Kent and Medway and recommended that the arterial hub should be located at Kent and Canterbury Hospital in Canterbury ahead of its final location being determined under the East Kent STP. The GIRFT vascular lead and the Vascular Society of Great Britain and Ireland agreed with this recommendation.

In March 2019, the South East Regional Medical Director and Chief Clinical Information Officer (CCIO) also concluded that the arterial hub should be established at Canterbury. It was acknowledged that whilst the future location of the unit will be determined through the East Kent transformation programme this should not detract from the need to ensure delivery of a high quality, sustainable service in the interim.

It is NHS England’s intention to implement the recommendations of this review and to commission acute inpatient vascular services in the interim period from a single inpatient arterial hub in Kent and Medway (located at the Kent and Canterbury Hospital) by the end of 2019/20. The longer-term future of the service would be determined by the east Kent STP and under the two shortlisted options it would either remain at K&C or relocate to the William Harvey Hospital in Ashford.

EKHUFT has been supporting MFT’s inpatient vascular surgical services over recent months as MFT has been unable to provide sustainable on-call rotas within the service. In January 2020, MFT implemented an emergency move of all elective and non-elective AAA surgery to Kent and Canterbury Hospital. This emergency move remains in place and therefore no AAA surgery can be undertaken at MFT.

This business case articulates the reason why the preferred option for the interim arterial centre should be located at Kent and Canterbury Hospital until such time as the longer-term transformational programme is implemented.

### 2. What are the options to address the issue/s?

A number of possible options have been evaluated and this produced a short-list of two options. Following extensive public and patient engagement a detailed options appraisal was undertaken to produce a recommended preferred option. Details of each of the options and the preferred option are outlined in section 3 of this business case.

### 3. What is the financial impact of the Options?

It is assumed that the clinical and operational model of both options, namely whether the services were based at EKHUFT or MFT would be broadly similar and therefore it is likely that the revenue costs of providing the model would not vary significantly between the options. However, Medway Maritime Hospital does not have the capacity to take over the provision of all vascular inpatients for Kent and Medway therefore a significant additional build would be required to enable this to happen.

The estimated impact of the service moving to EKHUFT has the following impact on each Trusts
bottom line. This modelling assumes that EKHUFT will be paid MFT’s Market Forces Factor for all the transferred patients. But does not take into account any additional capital costs that would be required by MFT in order to accommodate the service.

<table>
<thead>
<tr>
<th></th>
<th>EKHUFT</th>
<th>MFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£4,439,295</td>
<td>-£4,439,295</td>
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<tr>
<td>Expenditure</td>
<td>£4,362,116</td>
<td>-£3,564,127</td>
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<tr>
<td>Change in Trust Position</td>
<td>£77,179</td>
<td>-£875,168</td>
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</table>

The above table has assumed the likely amount of pay and non-pay cost MFT will be able to avoid through TUPE, staff redeployment, reduction in agency nursing and allied health professionals and reductions in variable non-pay expenditure. However, it should be noted that MFT will be left with stranded costs which will deteriorate the financial position of the Trust and commissioners are asked to support the Trust through this transition (typically 3 years). EKHUFT financial position is estimated to be a small improvement in its bottom line.

4. What are the details of the preferred option?

The preferred option is a network model that works across a number of sites with a single acute inpatient arterial centre supported by an enhanced non-arterial centre and a number of outpatient sites.

The model will be structured as follows:

- **Single Arterial Centre (Hub)** – This will be located at the Kent and Canterbury Hospital in Canterbury, East Kent. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year-round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. The Arterial Centre will also fulfil all the components of care available in an enhanced non-arterial vascular centre. This reflects the national recommendation for best practice. All vascular inpatient care will take place in the single Arterial Centre, this will include recovery from surgery until the patient is fit to either return home or to be transferred to rehabilitation care closer to their place of residence. This is mainly the case for patients requiring amputations although some other North Kent patients may wish to return to Medway Hospital for further rehabilitation closer to home. The Arterial Centre will also provide a comprehensive vascular diagnostic and outpatient ambulatory care service for the local population.

- **Enhanced non-arterial vascular centre (Enhanced Spoke)** - Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service.

- **Non-enhanced non-arterial hospitals (Spokes)** -Locally across Kent and Medway, the Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site
vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals’ buildings at these sites. These hospital sites, which include Maidstone Hospital, Sheppey Hospital, William Harvey Hospital, Queen Elizabeth The Queen Mother Hospital and Dover Hospital will deliver a range of services that seek to keep care as close to home as possible for patients and will include:

- Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
- Pre- and post-operative care;
- Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
- Diagnostics and tests; and
- Day surgery where appropriate

In summary therefore, the preferred option would see EKHUFT becoming the host provider Trust for the Kent and Medway Vascular Surgical Service. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery would be centralised at the Kent and Canterbury Hospital in Canterbury. There would be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery would remain unchanged in terms of their location but EKHUFT will become the provider of all of those services.

The vascular surgical team who are currently employed by Medway Hospital NHS Foundation Trust will all transfer over to East Kent Hospitals University NHS Foundation Trust under TUPE arrangements. This includes 4 consultant vascular surgeons, 1 ST Registrar, 2 Vascular Nurse Specialists and 3 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements. Details of staff transferring and their clinical commitments are provided at Appendix 2.

Some members of Medway Hospital’s anaesthetic team and interventional radiology team have expressed a desire to continue to participate in the provision of vascular surgical care at K&CH but do not wish to formally transfer their employment to K&CH. Arrangements are being made for those staff to participate in the vascular network using honorary contracts and service level agreement to remunerate them for their time. All appropriate clinical governance arrangements have been set in place to support this activity.

At Maidstone Hospital, outpatients and diagnostic services will continue to be provided as at present. The hospital will have access to Vascular Consultant opinion with consultant presence 2 days per week. A Vascular Consultant will also be available on a planned ad-hoc arrangement to support with elective gynaec-oncology, orthopaedic and obstetric surgical cases where it is considered necessary to have a vascular specialist on site. The current Service Level Agreements that exist between MTW and MFT will be transferred to EKHUFT and will be reviewed after the Network has been operational for 6 months.

The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.

The two Venn diagrams below show the scale of the proposed changes.
Under the preferred option, EKHUFT will become the lead provider organisation for all vascular services in Kent and Medway.
Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care. The proposed move of all inpatient vascular surgical activity under the preferred option will therefore impact around 400 inpatient cases per year.

Outpatient activity will continue to be provided in its current locations.

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<thead>
<tr>
<th>Site</th>
<th>OP New</th>
<th>OP Follow Up</th>
<th>Grand Total</th>
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<td>MFT</td>
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<td>MTW</td>
<td>1,856</td>
<td>1,816</td>
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<tr>
<td>Total</td>
<td>6,955</td>
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**Outpatient activity at MFT, MTW and EKHUFT**

Detailed Financial Analysis

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<th>Impact on EKHUFT</th>
<th>Impact on Medway FT</th>
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<tbody>
<tr>
<td>Income</td>
<td>Income</td>
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<tr>
<td>Activity</td>
<td>Income</td>
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<td>Adult Critical Care</td>
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<td>Daycase</td>
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<td>Elective Inpatient</td>
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<td>OP FA</td>
<td>2,942</td>
</tr>
<tr>
<td>OP FU</td>
<td>2,548</td>
</tr>
<tr>
<td>OP Procedure</td>
<td>799</td>
</tr>
<tr>
<td>Stents</td>
<td>£597,035</td>
</tr>
<tr>
<td>Unbundled Radiology</td>
<td>803</td>
</tr>
<tr>
<td>Total Income</td>
<td>£8,493</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Costs</td>
<td>Pay Costs</td>
</tr>
<tr>
<td>WTE</td>
<td>Expenditure</td>
</tr>
<tr>
<td>Admin &amp; Management</td>
<td>8.50</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1.00</td>
</tr>
<tr>
<td>Admissions Area</td>
<td>4.80</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>0.24</td>
</tr>
<tr>
<td>Critical Care Nurses</td>
<td>10.84</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>7.00</td>
</tr>
<tr>
<td>SCP</td>
<td>1.00</td>
</tr>
<tr>
<td>Sonographer</td>
<td>1.00</td>
</tr>
<tr>
<td>Remove Locum Sonographer</td>
<td>-2.23</td>
</tr>
<tr>
<td>Specialist Nursing</td>
<td>5.26</td>
</tr>
<tr>
<td>Theatre</td>
<td>0.46</td>
</tr>
<tr>
<td>Ward</td>
<td>17.80</td>
</tr>
<tr>
<td>Travel Costs</td>
<td>-£77,060</td>
</tr>
<tr>
<td>Total Pay Costs</td>
<td>£643.36</td>
</tr>
<tr>
<td>Variable Non Pay Costs</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>£120,215</td>
</tr>
<tr>
<td>Other Non Pay Costs</td>
<td>£649,917</td>
</tr>
<tr>
<td>Pathology</td>
<td>£1,385</td>
</tr>
<tr>
<td>Radiological Services</td>
<td>£6,828</td>
</tr>
<tr>
<td>Supplies</td>
<td>£724,942</td>
</tr>
<tr>
<td>MTW Outpatient Clinic Recharges</td>
<td>£100,950</td>
</tr>
<tr>
<td>Medway FT Outpatient Clinic Recharges</td>
<td>£150,500</td>
</tr>
<tr>
<td>Total Non Pay Costs</td>
<td>£1,175,450</td>
</tr>
<tr>
<td>Additional Support Services Costs</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>£20,282</td>
</tr>
<tr>
<td>Pathology</td>
<td>£30,559</td>
</tr>
<tr>
<td>Radiology</td>
<td>£13,125</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1.00</td>
</tr>
<tr>
<td>Total Support Services Costs</td>
<td>1.00</td>
</tr>
<tr>
<td>Equipment</td>
<td>75,000</td>
</tr>
<tr>
<td>Total Costs</td>
<td>£4,352,116</td>
</tr>
<tr>
<td>Profit (Loss)</td>
<td>£77,179</td>
</tr>
</tbody>
</table>
Implementation plan and timescales

The proposed reconfiguration of vascular services in Kent and Medway constitutes a significant change in the delivery of services and therefore a public consultation is required to seek the views and opinions of our stakeholders. The pre-consultation business case is being prepared by NHS E South East Spec Comm and this is required to be approved prior to commencement of a public consultation. This assurance process can only commence once the provider organisations are signed up to the business case and agree on the preferred option. Once all NHS providers and NHS E agree with the proposals set out in this business case the Programme Management Team will secure the agreement of the Kent County Council Health Overview and Scrutiny Committee and of the Medway Health Overview and Scrutiny Committee. This will enable a proposed six-week public consultation to commence (currently scheduled for April and May 2020). Analysis of the consultation feedback and responses will then be undertaken to allow the NHS organisations to make an informed decision on their proposals for the reconfiguration of vascular services in Kent and Medway. The current programme of work shows that the Kent and Medway Vascular Network could go live in the summer of 2020 subject the NHS England Specialised Commissioning approval.
Section 2 - Case for Change Summary

1. What is the issue/s that needs to be resolved?

1.1 Introduction

Vascular Surgical services in Kent and Medway are currently provided by two NHS Trusts: Medway Foundation NHS Trust and East Kent Hospitals University NHS Foundation Trust. However, the current configuration of specialised vascular surgery across Kent and Medway is not sustainable and needs to change.

The NHS England service specification which references the recommendations of the Department of Health, VSGBI, the Royal College of Radiologists, NCEPOD and NICE recommends a minimum population of 800,000 in order to maintain safe activity levels stating that “vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on-call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.”

The review of vascular service in 2015/16 led by the South East Regional Medical Director, recommended that the arterial centre should be located at Kent and Canterbury Hospital in Canterbury ahead of its final location being defined and coming to fruition under the East Kent STP. Professor Mike Horrocks (GIRFT vascular lead) and Jonothan Earnshaw (VSGBI) agree with this recommended model.

In March 2019, the South East Regional Medical Director and Chief Clinical Information Officer (CCIO) also concluded that the arterial centre should be established at Canterbury². He acknowledged that the future location of the unit will be determined through the East Kent transformation programme but this should not distract from the need to ensure delivery of a high quality, sustainable service in the interim. It was therefore NHS England’s intention to implement the recommendations of the review and to commission vascular services from a single inpatient arterial hub in Kent and Medway.

1.2 What are specialist vascular services?

Vascular disease affects veins and arteries. It may cause blood clots, artery blockages and bleeds which can lead to strokes, amputations of limbs and conditions that might threaten life if left untreated.

NHS England South (South East) commission (plan and pay for) specialised treatment in Kent and Medway, Surrey and Sussex.

NHS England has led a review to look at this small but very important part of specialised services in Kent and Medway. Specialised vascular services are types of treatment for:

- aortic aneurysms – a bulge in the artery wall that can rupture (treatment may be planned or as an emergency)
- carotid artery disease, which can lead to stroke
- arterial blockages, which can put limbs at risk

The types of treatment that might be required include:

- complex and potentially high risk bypass surgery to the neck, abdomen or limbs
- balloon or stent treatment to narrowed or blocked arteries
- blood clot dissolving treatments to the limbs
- stent grafts of varying complexity to treat aneurysms.

All these treatments are highly specialised and need a skilled team available 24 hours a day, every day.

² Please see Appendix 4
of the year, to provide this service and support patients.

The review looked at both emergencies and planned specialist vascular treatment. It included both patients treated in Kent and Medway hospitals and people living in Kent and Medway who go to London for their treatment. This review did not look at varicose vein surgery, heart disease, heart surgery or the management of the common types of stroke.

1.3 Why has NHS England reviewed specialist vascular services in Kent and Medway?

Vascular services are a specialised area of healthcare which, evidence has shown, will benefit from organisation into larger centres covering a population that is big enough for there to be significant volumes of activity in all areas of service, with a robustly staffed workforce able to deliver services 24 hours a day, 365 days of the year.

There is an opportunity in Kent and Medway to ensure that excellence in patient care and outcomes can be provided and that resource is always available for the vascular service to continue to improve on the type and standards of care provided.

Establishing a vascular service of excellence will offer the opportunity for a much improved and comprehensive service to patients. In particular, the right model of care could deliver more local care to Kent and Medway residents and the type of care could include more complex procedures. Such a centre will be better able to embrace new technology and innovation in practice. A regional centre of excellence is most likely to be the place that patients would choose for their specialist care and where other clinicians are most likely to refer their patients to. Such centres are most likely to be able to attract the highest calibre workforce and offer sustainability.

The training boards will look to centres of excellence to be involved in training the future generation of vascular clinicians. This not only benefits the service but invests in the future provision of excellence in patient care. Suitably sized centres with the appropriate population could offer opportunity for quality audit and research.

The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that offers all of these benefits.

2. How frequently does the issue occur?

Vascular surgical services in Kent and Medway have been the focus of intensive reconfiguration works for the past 6 years. The services do not comply with the national service specification or meet the needs of the VS POVs. Kent and Medway is three or four years behind many other parts of the country where vascular services have already been reconfigured to achieve compliance and deliver more sustainable care.

Based on the activity for 2018/2019 and the 2019/20 year to date activity, the following conclusions can be drawn about the expected levels at the single arterial inpatient centre. The data used comes from the NAC Dataset provided by NHSE using the Total Sum of Unique Patients.

<table>
<thead>
<tr>
<th>Total All Activity</th>
<th>2019/20 (Full Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated Inpatient Procedures</td>
<td>814</td>
</tr>
<tr>
<td>Other IP Procedure 107 Activity</td>
<td>292</td>
</tr>
<tr>
<td>EKHFUFT Validated DC Procedures</td>
<td>8</td>
</tr>
<tr>
<td>Other EKHFUFT DC Procedure 107 Activity</td>
<td>28</td>
</tr>
<tr>
<td>MFT Validated DC Procedures</td>
<td>14</td>
</tr>
<tr>
<td>Other MFT DC Procedure 107 Activity</td>
<td>8</td>
</tr>
<tr>
<td>Total Activity</td>
<td>1,164</td>
</tr>
</tbody>
</table>
There are a further 440 non-validated day cases within the dataset that are not included in the above table. Under the preferred option, the growth in inpatient activity (from present state) is shown in the table below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>2018/19</th>
<th>2019/20 (FYE)</th>
<th>Total (12-month average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT Current Total</td>
<td>680</td>
<td>740</td>
<td>700</td>
</tr>
<tr>
<td>EKHUFT New Total</td>
<td>1066</td>
<td>1142</td>
<td>1091</td>
</tr>
<tr>
<td>% Change</td>
<td>57%</td>
<td>54%</td>
<td>56%</td>
</tr>
</tbody>
</table>

**Procedures**

The table below shows the total number of inpatient procedures that took place in 2019/20 at EKHUFT and at MFT. The activity undertaken at MFT includes patients admitted from the Maidstone catchment area.

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>EKHUFT 2019/20 (Full Year)</th>
<th>MFT 2019/20 (Full Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Aortic Aneurysm</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>EVAR Aortic Aneurysm</td>
<td>54</td>
<td>20</td>
</tr>
<tr>
<td>Subclavian Artery</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Lower Limb - Reconstruction Surgery</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Lower Limb - Amputation (Major)</td>
<td>78</td>
<td>66</td>
</tr>
<tr>
<td>Lower Limb - Amputation (Minor)</td>
<td>70</td>
<td>98</td>
</tr>
<tr>
<td>Emergency Femoral Artery</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Elective Iliac Artery Ops</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>IR - Angioplasty</td>
<td>270</td>
<td>94</td>
</tr>
<tr>
<td>Renal Access</td>
<td>128</td>
<td>46</td>
</tr>
<tr>
<td>Total inpatient activity</td>
<td>736</td>
<td>398</td>
</tr>
</tbody>
</table>

Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care.

**Outpatients**

The following data from 2018/19 is for Vascular Outpatients, split by New and Follow Up. It also shows the breakdown by each site where activity has been delivered.

<table>
<thead>
<tr>
<th>Site</th>
<th>OP New</th>
<th>OP Follow Up</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT</td>
<td>3,641</td>
<td>3,651</td>
<td>7,294</td>
</tr>
<tr>
<td>MFT</td>
<td>3,314</td>
<td>2,886</td>
<td>6,200</td>
</tr>
<tr>
<td>Total</td>
<td>6,955</td>
<td>6,537</td>
<td>13,494</td>
</tr>
</tbody>
</table>

*Table 7 Outpatient activity at MFT and EKHUFT*

In 2018, Maidstone and Tunbridge Wells NHS Trust approached EKHUFT with an invitation to provide
vascular surgical services across west Kent. Following discussions with west Kent CCG, this development has been temporarily been put on hold pending the outcomes of the EKHUFT and Medway Vascular Network. If the network achieves the aims and objectives that have been set out then MTW may look to join the Kent and Medway Vascular Network.

3. **What is the severity of the issue - Strategically? (Scope & Risk)**

1.4 **Vascular Society of Great Britain and Ireland (VSGBI)**

In 2012 VSGBI published a series of recommendations describing how vascular services should be organised to deliver the best outcomes for patients (Provision of Vascular Services, 2012). VSGBI quality improvement frameworks (QIFs) are also in place for both abdominal aortic aneurysm (AAA) repair and lower limb amputation. The NHS AAA Screening Programme has made adopting the AAA QIF mandatory for providers treating patients referred from the programme.

In light of these recommendations NHS England, as the commissioners of specialist vascular services, published a national service specification for the provision of vascular services in July 2013. This specification sets out both the essential components of a specialist vascular service and the clinical outcomes that the service should achieve. A clinical reference group, chaired by Professor Matt Thompson, has developed the national service specifications. Reporting outcomes of all vascular surgical procedures to the new National Vascular Registry has been mandatory since April 2015.

The national service specification, the Vascular Society guidance and a range of research papers culminate in the conclusion that to achieve the best outcomes for patients an arterial centre needs to provide complex aortic endovascular procedures from a dedicated vascular hybrid theatre. This must be supported by 24/7 vascular surgery and 24/7 interventional radiology, bringing together the expertise and experience of key clinicians in these techniques to provide both elective endovascular procedures and emergency procedures such as endovascular repair for ruptured abdominal aortic aneurysm.

Indeed being able to perform interventional radiology procedures in a dedicated hybrid theatre has the potential to significantly reduce the length of recovery and the risk of surgical complications and lower the risk of mortality compared to conventional open repairs.

To achieve the guidance and to deliver resilient and sustainable vascular services NHS England are re-organising vascular services into networks.

Since the publication of the national service specification NHS England, South-South East have been reviewing vascular services across Kent, Surrey and Sussex to determine the work needed to ensure local vascular providers comply with the best practices outlined in the service specification. The key elements of which are that providers of vascular services should:

- Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures.
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency.
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists (individually undertaking a minimum number of interventions).
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures.
- Provide a dedicated vascular ward and nursing staff.
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other.

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3. A copy of the national service specification for vascular services can be found at:
http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a04/
specialties to provide a comprehensive multi-disciplinary service.

- Care of patients will be managed through regular multi-disciplinary team meetings, which will occur at least once a week.
- Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres by 2015.

Central to national recommendations is the requirement for arterial surgery to be delivered out of fewer, higher volume specialist arterial surgical centres to improve clinical outcomes (in particular mortality rate) and deliver a range of other benefits to patients.

The emphasis on high volume specialist units particularly relates to concerns regarding the risks or poorer outcomes associated with a low numbers of cases each year. Hence there has been national recognition of the need for reconfiguration proposals to deliver sufficient activity per consultant to maintain the highest surgical standards.

Medway Foundation Trust and East Kent Hospitals University Trust are the two current arterial centres in Kent and Medway. However only one, the Kent and Canterbury Hospital, is currently able to meet the service specification criteria.

In January 2020, MFT's vascular surgical services were extremely fragile and it was becoming increasingly difficult to run robust on-call rotas for AAA Surgery. This had been an ongoing issue which EKHUFT had been supporting with since August 2019. On the 6th January 2020, MFT implemented an emergency move of all elective and non-elective AAA surgery to Kent and Canterbury Hospital. This has helped stabilise the vascular surgical services at MFT and was the first step towards consolidation of inpatient vascular surgical services in Kent and Medway.

1.5 Kent and Medway Health Needs Assessment

The current K&M population is 1,817,400. (2016 ONS Data). The population of Kent is projected to increase by 125,800 by 2026 and will grow by around 14% by 2035. The population of Medway is projected to increase by just under 15%, reaching around 317,529 by 2035. This represents an increase of just over 40,500 people.

Kent and Medway faces a number of demographic challenges these include pockets of significant growth in over 65 year olds in some areas (by 2035 the ONS thinks over 65s will make up more than a quarter of the area's residents), areas of deprivation and a significant variation of mortality across its wards.

Cardio Vascular Disease (CVD) is a key cause for premature death in Kent and Medway. Key concerns are the high prevalence of diabetes, hypertension, obesity and smoking. The non-modifiable factors for CVD relate to;

- Age
- Male gender
- Ethnicity
- Family History.

The modifiable features include;

- Diabetes
- Smoking
- Hypertension
- Obesity
- Physical Inactivity
- Cholesterol levels
- Alcohol.

Across Kent and Medway, the highest prevalence for hypertension is in South Kent Coast and Thanet
CCGs followed by Dartford/Swanley & Gravesham (DGS) CCG. Diabetes prevalence is highest in Swale and Thanet CCGs followed by South Kent Coast and Medway CCGs. Medway CCG has the highest level of obesity followed by Swale CCG.

As noted there is a variance across Kent and Medway in relation to deprivation with key pockets across the North Kent and East coastal areas in particular South Kent Coast, DGS, Thanet and Swale. There are however specific wards in CCG areas with high levels of deprivation including Medway and West Kent CCGs.

In Kent and in Medway, about 1,200 people need specialist acute inpatient vascular care each year.

1.6 Kent and Medway Clinical Commissioning Groups
There are two main local authorities serving Kent and Medway, these are:
- Kent County Council; and
- Medway Council

The recommended population base (National Service Specification and Vascular Society guidance) needed for an adequate number of cases for a viable centre is 800,000.

If all the Kent population’s vascular surgery requirements were cared for within Kent and Medway (i.e. including the population currently flowing into London from west and north Kent) then the total network population would exceed 1,600,000 and so would be enough to support two vascular arterial centres i.e. 800,000 per centre. However, the population flowing into London for vascular surgery equates to almost 50% of the West Kent population and 94% of the North Kent population (Dartford and Graveshem). As a consequence, the population data illustrates that the current combined catchment area for EKHUFT and MFT vascular surgical services is around 1.4 million.
1.7 Specification Standards

The National Specification for Vascular services notes that the overarching aim of elective and 24/7 emergency vascular services is to provide evidence-based models of care that improve patient diagnosis and treatment and ultimately improve mortality and morbidity from vascular disease. Key features of the national specification include:

- All Trusts delivering vascular services must belong to a provider vascular network
- Arterial surgery should be delivered in an arterial centre
- The pathway for vascular services to include: Diagnosis /Assessment /Outpatient activity / Inpatient activity / Day case activity / Rehabilitation care.
- Non-arterial surgery and day care should receive specialist vascular care locally with agreed protocols including emergency transfers to the arterial centre.
- Adequate population volumes; A minimum population of 800,000 but for a world class service a larger catchment area will be required.
- Adequate volumes of core Vascular procedures. ( > 60 AAA procedures, > 50 Carotid Endarterectomies and commensurate lower limb procedures)
- 24/7 arterial surgery
- 24/7 Interventional radiology available
- Acceptable on call rota requirements, i.e. consultants being on call no more frequently than every six weeks.
- A minimum of six Arterial surgeons and six Interventional radiologists.
- Provision of Vascular surgery by specialist vascular surgeons.
- Provision of Vascular Interventional Radiology by specialist IR consultants.
- Provision of Vascular service by a specialist multi-disciplinary team (MDT).

The following table represents the status of the current services measured against the national specification of Medway Foundation Trust, East Kent Hospitals University Foundation Trust and Guys and St. Thomas' Hospitals Trust (the main London provider for K&M).

<table>
<thead>
<tr>
<th>Required</th>
<th>Medway FT</th>
<th>East Kent Hospitals</th>
<th>St Thomas' Hospital</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 MDT</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>6 vascular surgeons. On call rota (1:6)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>1:10</td>
</tr>
<tr>
<td></td>
<td>1:5*</td>
<td>1:4</td>
<td>1:10</td>
<td>*includes a locum</td>
</tr>
<tr>
<td>On call Vascular Interventional radiology</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</td>
<td>*Recruitment underway</td>
</tr>
<tr>
<td>AAA screening</td>
<td>Through K&amp;M screening programme</td>
<td>EKHUFT delivers the K&amp;M screening programme</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Outpatient assessment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>In patient non arterial services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Elective and emergency arterial services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Table 3 Status of the current services measured against the national specification

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day case surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td>505,569</td>
<td>682,106</td>
<td>450,687</td>
</tr>
<tr>
<td>Population currently served;</td>
<td>505,569</td>
<td>682,106</td>
<td>450,687</td>
</tr>
<tr>
<td>Kent Population treated in London: 450,687</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kent population treated outside Kent or London: 86,417</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk adjusted Mortality rates; AAA/CE (NVR data September 15)</td>
<td>4.6% / 4.0%</td>
<td>1.1% / 1.0%</td>
<td>0.6% / 3.5%</td>
</tr>
<tr>
<td>All within national tolerance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Details of the current clinical pathways for patients requiring vascular treatment are provided at Appendix 1.

1.13 The Vascular Society

The Vascular Society published guidance on the Provision of Vascular services (2012). The primary objective of the society guidance is to “provide all patients of vascular disease with the lowest possible elective and emergency morbidity and mortality rates in the developed world. This will be achieved by modernising services to deliver world class care from a smaller number of high volume hospital sites.”

Key recommendations of the Vascular Society guidance include:

- Recognition that it is no longer acceptable:
  1. For emergency vascular care to be provided by generalists who do not have a specialised elective vascular practice.
  2. To provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.
  3. For the vascular specialist to be providing emergency general surgical cover. In addition, vascular surgeons should not be expected to provide elective general surgical services. (N.B. Occasionally some surgeons will undertake specific procedures to maintain competencies directly related to local service needs, but this should be the exception.)
- Networks, involving arterial intervention at more than one site, often result in a reduction in the quality of care and increased mortality for patients in out of business hours. For this reason, current strategies for the provision of vascular care require that all arterial interventions should be performed on a larger volume hospital site, with intervention provided at these hospitals by vascular surgeons and interventional radiologists from both the central and network hospital sites. This allows for 24/7 patient care and the timely treatment of any complications, which may occur.
- Services should be organised in a model that allows reasonable elective activity alongside acceptable on call consultant arrangements. This should result in small units creating a modern clinical network where a designated single centre performs all elective and emergency arterial interventions.
- Facilities must be set up for 24/7 provisions, supported by 24/7 critical care, dedicated vascular wards and endovascular theatre.
- Minimum procedure volumes are recommended; > 60 AAA procedures per unit with a minimum population of 800,000. Minimum 10 per surgeon.
- Hospitals providing vascular services should know and audit their AAA mortality aiming for elective mortality of 3.5% (by the end of 2013) and should regularly review the mortality morbidity rates of

4 The full document can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf
Specialists undertaking aortic interventions should submit their activity to the National Vascular Register.

Specialist vascular centres should provide dedicated nursing care of vascular in-patients, combining aspects of general surgical nursing, critical care, limb and wound assessment, tissue viability, wound care, rehabilitation, care of the disabled and care of the elderly.

This care should be provided in a ward dedicated to the care of vascular patients is essential to ensure an appropriate skill mix of nurses who have been specially trained in the care of vascular patients.

Emergency assessment and treatment should be available within one hour of travel to a recognised vascular unit in most locations in the UK. 95% of patients should be triaged, referred and have arrived at the vascular unit within two hours arrival at the spoke hospital.

Vascular services are a specialised area of healthcare, which evidence has shown, will benefit from organisation into larger centres covering a population that will facilitate significant volumes of activity in all areas of service with a robustly staffed workforce able to deliver services 24/7, 365 days of the year. The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that will deliver all of this.

1.14 Aims and Objectives

The overarching aim of this programme is to provide evidence-based models of care that improve patient diagnosis and treatment, and ultimately improve mortality and morbidity from vascular disease. The service will deliver this aim by:

- Improving the patient experience, providing equality of access to the full range of vascular diagnostics and interventions and ensuring that patients are receiving a high quality of service, with access to the most modern techniques;
- Developing and sustaining the resilience of vascular services and the workforce providing those services;
- Improving mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation;
- Improving complication rates following a vascular admission (short and long term);
- Reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma;
- Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease;
- Supporting other services to control vascular bleeding and manage vascular complications; and
- Working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss and prevent amputation.

1.15 Travel Times Analysis

The Vascular Society recommends that services should be arranged to minimise transfer times and to transfer vascular emergencies to the vascular unit without delay. The key priority is to transfer the patient to a vascular unit, even if the travel time is beyond the hour, as evidence shows that this improves patient outcomes.

In January 2015, a detailed travel analysis was commissioned as part of the vascular service review in Kent & Medway (see appendix 5 for the detailed report). The results of the report showed the travel time to Medway Maritime and Kent & Canterbury hospitals and concluded that:

- Medway Maritime is the most accessible site within 30 minutes to the population of Kent and Medway
- Medway Maritime and Kent & Canterbury are equally accessible within 45 minutes
- London hospitals are accessible within 60 minutes by ambulance only to areas in the western quarter of Kent.
- A service centred on Medway Maritime would be slightly over 60 minutes by ambulance (62
minutes) from the east coast around Thanet which has a high number of admissions of circulatory disease (n = 1,699).

- A service centred on Kent & Canterbury would be over 60 minutes by ambulance from Tunbridge Wells, but this area has lower number of admissions than around Thanet (n = 796).

A further analysis of vascular patient travel times was also undertaken by Carnell-Farrar in July 2017\(^5\). The analysis showed that 100% of patients from across Kent and Medway are currently able to access vascular services provided at either MMH or K&CH within 60 minutes.

<table>
<thead>
<tr>
<th>Configuration</th>
<th>% population able to access vascular services within 60 minutes</th>
<th>Maximum travel time for K&amp;M population (PEAK)</th>
<th>% population within 60 minutes access time (PEAK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>As is:</td>
<td>100%</td>
<td>61 mins</td>
<td>99.9%</td>
</tr>
<tr>
<td>Vascular services offered at MMH and K&amp;C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 1a:</td>
<td>99.9%</td>
<td>61 mins</td>
<td>99.9%</td>
</tr>
<tr>
<td>Vascular services offered at WHH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 1b:</td>
<td>100%</td>
<td>59 mins</td>
<td>100%</td>
</tr>
<tr>
<td>Vascular services offered at KCH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 1c:</td>
<td>75.7%</td>
<td>78 mins</td>
<td>25.7%</td>
</tr>
<tr>
<td>Vascular services offered at QEQMH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 2:</td>
<td>95.3%</td>
<td>67 mins</td>
<td>85.3%</td>
</tr>
<tr>
<td>Vascular services offered at MMH</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The analysis also showed that having the Single Arterial Centre located at QEQMH would provide poor access for patients requiring vascular surgery. If the Centre was located at QEQMH then around 25% of the Kent and Medway population would fall outside of the 60-minute travel time window. As a result, around 5% of the population would be transferred to one of the London tertiary centres for the care.

Travel time analysis that has been undertaken has demonstrated that establishing the Vascular Centre at WHH or at K&CH would allow the best access for patients from across Kent and Medway allowing 99.9% and 100% of the population able to reach these respective sites within 60 minutes.

Having the Single Arterial Centre located at Medway Maritime Hospital would provide slightly lower levels of access; allowing 96.5% of the population to reach the centre within 60 minutes.

4. **What is the severity of the issue - Financially? (Scope & Risk)**

The financial impact of maintaining the current clinical and operational model is difficult to cost due to the number of unknown variables which will arise from the deterioration of vascular services on each site due to the unsustainable pressures currently experienced by the services with staff stretched across unsustainable rota schedules. However it is likely that services would lose substantive medical staff who would be replaced by expensive locums and so ultimately the do nothing option will increase...
Costs in both organisations with no corresponding improvement in patient care.

5. **What are the risks to the Trust of maintaining the current position – Qualitative?**

<table>
<thead>
<tr>
<th>There are many risks associated with maintaining the status quo. The service would continue to be unsustainable and this would threaten the viability of the existing vascular services. These sustainability issues relate to the fragility of specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multi-disciplinary team) being spread too thinly across the county and having insufficient patients to treat. In turn, this means that our staff become less skilled and less experienced in treating sufficient numbers of patients to maintain competencies. Maintaining the status quo also means that having 24/7 on site vascular surgery and interventional radiology on-call rotas staffed by the right number of staff continues to be impossible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We would continue to be unable to have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service. Staying as we are also means that staff are also unable to develop their skills and expertise and this impacts on the ability to manage patients’ conditions and recovery.</td>
</tr>
<tr>
<td>Having services fragmented as they are at present means that services are less productive and less efficient as there is unnecessary duplication and waste. It also inhibits opportunities for training, research and innovation and this all impacts on patient care.</td>
</tr>
<tr>
<td>Although K&amp;C has a dedicated vascular ward and nursing staff, this is not the case in Medway where vascular patients are cared for on general surgical wards. Under the status quo this would continue. Patients requiring major amputations should be treated in arterial centres that have all the necessary skills and resources to manage their care. As there is no single arterial centre in place for Kent and Medway currently, at times patients do not receive a consistently high quality service, with access to the most modern techniques. It is also difficult to make improvements to mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation in the way services are currently configured. Making improvements to complication rates following a vascular admission (short and long term) is also extremely difficult.</td>
</tr>
<tr>
<td>Staying as we are would also mean that reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma is almost impossible. Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease and supporting other services to control vascular bleeding and manage vascular complications also continues to be extremely difficult and fragile.</td>
</tr>
<tr>
<td>Maintaining the status quo would also mean that working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss, prevent amputation, standardise methods and promotion of best practice across the clinical teams continues to be challenging.</td>
</tr>
<tr>
<td>It also means that opportunities to reduced length of stay for patients and improving pathway links with community providers to support timely repatriation of patients following surgery remains almost impossible.</td>
</tr>
<tr>
<td>In summary therefore, if the status quo continues there is a real risk that Kent and Medway’s vascular surgical services fall over and patients would have to travel to London to receive all of their vascular care. The risk associated with this is that the London providers would be unable to cope with the additional demand and patients would suffer.</td>
</tr>
</tbody>
</table>
Section 3 – Option Appraisal

The outputs from the Review clearly demonstrated that there is a need to address the provision and configuration of the Vascular services in Kent and Medway to ensure sustainable and quality service accessible to all Kent and Medway residents.

The scope for the scheme is to reconfigure the existing Specialised Commissioned in-patient vascular services in Kent and Medway. With this in mind, an original long list of seven options was generated using the options framework.

Option 1 – Two Kent and Medway Hubs with Current London Pathway
No Change to the current configuration and patient flows. Kent and Medway surgical services provided at East Kent Hospitals University NHS FT (EKHUFT) and Medway Foundation Trust (MFT) and Guy's and St Thomas' NHS Foundation Trust (GSTH).

Option 2 – No Kent and Medway Hubs
No arterial surgical centre in Kent and Medway. All arterial surgery takes place in London. All Kent and Medway providers are network spokes.

Option 3 – Two Kent and Medway Hubs without London
The two vascular surgery centres in Kent and Medway become hub centres and no patients are referred to GSTH, expect for highly specialised procedures.

Option 4 – One Kent and Medway Hub, no London Pathway
One vascular surgery centre in Kent and Medway becomes the hub centre and no patients are referred to GSTH, expect for highly specialised procedures.

Option 5 – One Kent and Medway Hub with London Pathway
One vascular surgery centre in Kent and Medway becomes the hub centre. Patients continue to be referred to GSTH.

Option 6 - Networked Kent and Medway Hubs, no London Pathway
The two current vascular surgery centres provided all arterial surgery for Kent and Medway with no referral to GSTH, except for highly specialised procedures. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

Option 7 - Networked Kent and Medway Hubs with London Pathway
The two current vascular surgery centres provided arterial surgery for Kent and Medway with the current referral pathway to GSTH remaining. The two surgical and IR teams network to provide Hub services including surgical cover at both sites 24/7.

The Vascular Review Programme Board formally agreed the scope of the reconfiguration and noted that this would not include the current patient flows into GSTT (July 2016). Patient and Clinical choice will remain for both GSTT and the new proposed K&M collaboration.

The options appraisal tested each option against a set of criteria from the national specification and the Vascular Society Provision of Vascular Services. These included:

a. Minimum population volumes;
b. Minimum procedures undertaken;
c. Minimum staffing numbers for consultant surgeons and interventional radiologist;
d. Specialist facilities including dedicated hybrid theatres and wards;
e. Targets for key outcomes measures; and
f. To work within a network, using a hub (in-patient unit) and spoke (out-patient and diagnostic units) delivery model.

The ability to meet the aforementioned criteria and the quality and safety issues of each option was reviewed within the context of:
a. Delivering a safe sustainable staffing rota and availability;
b. Travel Times;
c. Essential co-dependencies; and
d. Current activity and possible impact of future population growth

Short-listed options

The option appraisal process was agreed through the Programme Advisory Board and undertaken by the Clinical Reference group. The Clinical Reference Group appraised the long list of options and determined that two options should be short listed:

- **Option 5** – One Kent and Medway Hub with London Pathway
- **Option 7** – Networked Kent and Medway Hubs with London Pathway

These two options were reviewed in detail against the national specification and Vascular Society guidance. The review was undertaken by the Clinical Reference Group and included consideration for workforce, job planning, travel times, patient transfers, emergency and non-emergency take and patient safety and experience.

Further analysis identified that Option 7 would:
- not deliver the required volume of activity at the two arterial centres
- not resolve the derogation or deliver the national specification in a sustainable manner; and would
- require the closure of in-patient support at one site on certain periods potentially leaving post-surgical patients without consultant cover.

Option 5 was assessed as being the only option able to deliver the national specification requirements and was the only option able to create a sustainable centre of excellence in Kent and Medway. To achieve this, the clinical model will operate as a network across Kent and Medway with a single arterial centre (hub) and a more diverse, multi-site model for non-arterial centres. One of the non-arterial centres would become an enhanced non-arterial centre providing mainly outpatient and day-case services for the local population. Under this option, appropriate patients will continue to be referred from Kent and Medway to GSTH.

This preferred model for the future of vascular services in Kent and Medway required further clarification in relation to which hospital site becomes the single arterial centre (hub) and which site becomes the non-arterial centre.

Medway Foundation Trust has a single inpatient site, however in East Kent there were three possible sites that could potentially host either an AC or an Enhanced NAC: QEQM, WHH and K&C.

A site-based analysis was therefore undertaken to ascertain which of the East Kent Hospital sites would be most suited to become a Vascular Centre (either AC or NAC). This analysis considered:
- Whether the site has the necessary clinical adjacencies to support either an AC or a NAC;
- Existing estates constraints specific to the site in question
- Any possible flows of activity that may result from creating either an AC or a NAC at that site.

Following completion of the analysis of the long-listed options and the subsequent identification of the short-listed options, the options for more detailed analysis were as follows:

**Option 5A** - Single Arterial Centre at Kent and Canterbury Hospital and Enhanced Non-Arterial Centre at MFT

**Option 5B** - Single Arterial Centre at Medway, and Enhanced Non-Arterial Centre at EKHUFT

Under both short-listed options, patients would still have the opportunity to access the London tertiary
centres for their treatment under patient choice.

In order to take forward the development of the recommendation and model of care, the Chief Executive Officers at EKHUFT and MFT worked together to agree the Kent and Medway Vascular Clinical Network arrangements\(^6\). This formal collaboration agreed the development of the Network through a Network Board with a number of key work streams and sub-groups.

The purpose of the sub-groups was to develop the clinical model and the governance arrangements (both clinical and information governance). The Finance work stream group provided the overarching support for the development of this business case as part of a Network solution. This group provided on-going financial and information support as required once the Network was up and running.

The Network solution has been jointly developed by the clinicians from MFT and EKHUFT in accordance with the national specification and Vascular Society guidance. It seeks to deliver the ambition providing world class vascular services across Kent and Medway which is both clinically and financially sustainable for the future. The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.

Further development of the Vascular Surgical model will take place alongside the Kent and Medway Sustainability and Transformation Partnership (STP). The permanent solution for the Vascular Surgical model will form part of the business case for the STP once the Pre-Consultation Business Case has been approved and the Public Consultation for the STP has been completed. However, the East Kent Transformation Programme is likely to take around 5 years to deliver therefore NHS England has recommended that an interim arterial hub should be located in Canterbury at the Kent and Canterbury Hospital until such time as the longer-term transformation programme materialises as this site has the necessary resources to accommodate the additional inpatient activity.

Numerous Public and Patient Engagement events have been held over the last four years and the information gathered from the Events has been used to help inform these decisions. See Appendices 7 & 8

Details of the two preferred options for the interim arterial network model are now provided below alongside the do-nothing option.

### Short-listed Options

<table>
<thead>
<tr>
<th>Do nothing</th>
<th>Maintain the current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Option</td>
<td>Under this option acute inpatient vascular surgical services would remain as they currently are, provided at both Medway Maritime Hospital in Gillingham and at Kent and Canterbury Hospital in Canterbury. Neither hospital would become a single arterial centre for Kent and Medway.</td>
</tr>
<tr>
<td>Activity Impact</td>
<td>Under this option neither acute inpatient hospital site would serve the minimum population levels and therefore both hospitals would struggle to treat sufficient number of clinical cases required by the national service specification. Consequently, both Trusts would remain under Commissioner derogation. This is not a position that NHS England is prepared to let continue.</td>
</tr>
<tr>
<td>Workforce Impact</td>
<td>The workforce would continue to be split across two inpatient sites with Medway Hospital not seeing the necessary levels of activity. This option also does nothing to improve the current intensity of on-call commitments and consequently does nothing to improve the recruitment opportunities. Consultants will continue to have to cover unsustainable on-</td>
</tr>
</tbody>
</table>

\(^6\) See Appendix T
call rota commitments. At Medway Hospital, the Vascular surgical service will continue to struggle to secure junior doctors support (Jnr Doctors have been temporarily removed from the service due to lack of supervision and oversight. These have been replaced by substantive doctors to support the service for the immediate future).

### Income Impact
None – although income may decrease if substantive staff are lost

### Cost Impact (Revenue)
Likely increase in costs due to loss of substantive staff as a result of unsustainable rota scheduling

### Benefits of Implementation
NHS England, the Vascular Society and GIRFT have all concluded that this option is not sustainable and must not continue. There are no benefits to maintaining the status quo.

### Quality & Safety Impact
This option will not support the sustainable delivery of evidence-based models of care that aim to improve patient diagnosis and treatment. Ultimately there will be no ability to improve mortality and morbidity from vascular disease across Kent and Medway. The way vascular surgical services are currently configured in Kent and Medway is inconsistent with the need to deliver services as part of a vascular network. This option would mean that arterial surgery would not be delivered in an arterial centre serving a large enough population. As a consequence, clinicians would not undertake adequate volumes of core Vascular procedures to maintain their skills. Consultants would continue to have to participate in unacceptable on call rotas, which is unsustainable.

### Risks of Implementation
NHS England, the Vascular Society and GIRFT have all concluded that this option is not sustainable and must not continue. There are no benefits to maintaining the status quo.

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### Option 5A
Preferred Option:
Single Arterial Centre at Kent and Canterbury Hospital and Enhanced Non-Arterial Centre at MFT

#### Summary of Option
Under this option, the single Arterial Centre will be based at the Kent and Canterbury Hospital in Canterbury, East Kent. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network.

Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service.

The Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular
centre for 24/7 support for vascular advice and patient management. These sites, which include Maidstone Hospital, William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals’ buildings at these sites. These hospital sites will deliver a range of services that seek to keep care as close to home as possible for patients and will include:

- Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
- Pre- and post-operative care;
- Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
- Diagnostics and tests; and
- Day surgery where appropriate

Patients would still have the opportunity to access the London tertiary centres for their treatment under patient choice.

Activity Impact
(Demand & Capacity)

The clinical model will see the creation of a vascular network across Kent and Medway with a single arterial inpatient centre (hub) at K&CH, an enhanced non-arterial centre at MFT providing outpatient, day-case surgery and diagnostic services, and a number of supporting sites that will provide outpatient services and diagnostics for their local population.

Based on the activity for 2018/2019 and the 2019/20 year to date activity, the following conclusions can be drawn about the expected levels at the single arterial inpatient centre.  

<table>
<thead>
<tr>
<th>Total All Activity</th>
<th>2019/20 (Full Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated Inpatient Procedures (K&amp;CH &amp; MFT)</td>
<td>814</td>
</tr>
<tr>
<td>Other IP Procedure 107 Activity (K&amp;CH &amp; MFT)</td>
<td>292</td>
</tr>
<tr>
<td>EKHUFT Validated DC Procedures</td>
<td>8</td>
</tr>
<tr>
<td>Other EKHUFT DC Procedure 107 Activity</td>
<td>28</td>
</tr>
<tr>
<td>MFT Validated DC Procedures</td>
<td>14</td>
</tr>
<tr>
<td>Other MFT DC Procedure 107 Activity</td>
<td>8</td>
</tr>
<tr>
<td>Total Activity</td>
<td>1,164</td>
</tr>
</tbody>
</table>

There are a further 440 non-validated day cases within the dataset that are not included in the above table.

All inpatient procedures that will be undertaken at K&CH once the network goes live

Under the preferred option, the growth in inpatient activity (from present state) is shown in the table below. The day case activity shown above will stay in its current location. It will not all move to K&C.

<table>
<thead>
<tr>
<th>Activity</th>
<th>2018/19</th>
<th>2019/20 (Full Year Effect)</th>
<th>Total (12-month average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT Current Total</td>
<td>680</td>
<td>740</td>
<td>700</td>
</tr>
<tr>
<td>EKHUFT New Total</td>
<td>1,066</td>
<td>1,142</td>
<td>1,091</td>
</tr>
<tr>
<td>% Change</td>
<td>57%</td>
<td>54%</td>
<td>56%</td>
</tr>
</tbody>
</table>

7 The data used comes from the NAC Dataset provided by NHSE using the Total Sum of Unique Patients.
The figure of 1,091 (in the above table) has been used to calculate the theatre capacity required in the future.

Procedures

The number of procedures shown in the table below have been agreed by NHS England Specialised Commissioning working in conjunction with the Business Intelligence Team and Consultants at EKHUFT. The table shows the number of procedures undertaken at EKHUFT and MFT in 2019/20.

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>EKHUFT 2019/20 (Full Year)</th>
<th>MFT 2019/20 (Full Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Aortic Aneurysm</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>EVAR Aortic Aneurysm</td>
<td>54</td>
<td>20</td>
</tr>
<tr>
<td>Subclavian Artery</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Lower Limb - Reconstruction Surgery</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Lower Limb - Amputation (Major)</td>
<td>78</td>
<td>66</td>
</tr>
<tr>
<td>Lower Limb - Amputation (Minor)</td>
<td>70</td>
<td>98</td>
</tr>
<tr>
<td>Emergency Femoral Artery</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Elective Iliac Artery Ops</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>IR - Angioplasty</td>
<td>270</td>
<td>94</td>
</tr>
<tr>
<td>Renal Access</td>
<td>128</td>
<td>46</td>
</tr>
<tr>
<td>Total inpatient activity</td>
<td>736</td>
<td>398</td>
</tr>
</tbody>
</table>

The total number of procedures figure does not match the figure shown for inpatient activity because a number of patients will have had more than one procedure during their inpatient stay.

Detailed analysis of the activity data has produced a definitive set of procedures which relate to inpatient care. The proposed move of all inpatient vascular surgical activity from MFT to K&CH will therefore impact around 400 cases per year.

Beds

At K&CH, the number of occupied bed days has risen to a high of nearly 6,000 bed days in 2018/19. This means on average the vascular surgical inpatient activity occupied around 20 beds (at 85% occupancy).

The demand and capacity modelling shows that the move of 400 inpatient vascular cases per year from MFT to K&C. Working on 85% bed occupancy this activity would require around 11 beds. Therefore, the proposed arterial hub at Kent and Canterbury Hospital will require a total of 31 inpatient beds.

<table>
<thead>
<tr>
<th>Current funded beds at K&amp;C</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional beds needed</td>
<td>11</td>
</tr>
<tr>
<td>Total beds required (85% occupancy)</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 4 Vascular inpatient bed current and future required

The current dedicated Vascular inpatient ward at Kent and Canterbury Hospital is Kent Ward. Kent Ward currently has 20 funded inpatient beds and 3 unfunded inpatient beds.
It also has a 6 bedded area which is currently allocated for day case surgery and admissions. In the future, these 6 beds would become inpatient beds dedicated for inpatient Vascular Surgery and the unfunded beds would be appropriately funded taking the total number of funded inpatient beds from 20 to 29.

It is recognised that the LOS at Medway is higher than that of EKHUFT, as such it is not expected that the gap in beds required will be sought through efficiencies in the system. It is unknown at present if the increased requirement for repatriation or the growth in amputations requiring 2 beds spaces will affect EKHUFT LOS. As such, the business case is looking to fund converting the 6 bedded trolley bay on Clarke (adjacent ward) into an inpatient space to accommodate peaks in demand.

The 12 trolley bay spaces will be re-provided in the former Ambulatory Care area located between the Urgent Treatment Centre and the Radiology department.

The graph below shows the average length of stay for vascular patients at MFT and at EKHUFT. Average length of stay for Medway patients is around 2 days longer than for patients at K&CH.

EKHUFT will be looking to repatriate patients that have had a major limb amputated back to MFT for their ongoing rehabilitation once they no longer need to be under the direct care of the Vascular surgical team. The clinical pathway for these patients enables them to be repatriated under Medway Hospital’s diabetic team. This would also help to free up inpatient bed capacity at the arterial centre. A robust process must be in place to ensure the timely transfer of these patients.

The demand and capacity modelling uses the following data and assumptions:

- Data taken from NHSE NAC dataset.
- Theatre and bed capacity provided internally and using the same totals as the initial internal piece of work.
- Percentages of theatre splits from the initial internal work.
- The additional demand and capacity is based on the methodology used in the initial work using an ‘as is percentage growth’ method.

**Theatres**

Table below shows the theatre capacity required for all vascular activity. Currently weekly theatre capacity equates to 7 sessions and in the future the service will require 11 sessions. These additional 4 sessions will be provided through the move of some general surgical main theatre sessions from the K&C site to QEQM (2.5 sessions). The additional IR theatre sessions will be created with the opening of the second IR theatre. The capacity will temporarily be created through elongated days until both theatres are in use.

<table>
<thead>
<tr>
<th>Main Theatre</th>
<th>Sessions$^8$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current annual Capacity</td>
<td>364</td>
</tr>
<tr>
<td>Current weekly Capacity</td>
<td>7</td>
</tr>
<tr>
<td>Capacity Growth (annual)</td>
<td>203.49</td>
</tr>
<tr>
<td>New Total Capacity required (annual)</td>
<td>567.49</td>
</tr>
<tr>
<td>New Total Theatre capacity Required (per week)</td>
<td>4</td>
</tr>
<tr>
<td>Weekly Total sessions required</td>
<td>11</td>
</tr>
</tbody>
</table>

$^8$ Activity modelling assumptions:
That all sessions have been entered onto Theatreman. That all activity under IR and Vascular that currently takes place in KCH theatre 6 is appropriate. An all-day session counts as two sessions. This does not include cancelled sessions. This is an average figure and it is assumed variation can be absorbed within operational working practices.
Theatre 6 (EVT) and Interventional Radiology

<table>
<thead>
<tr>
<th></th>
<th>Theatre 6 (Joint Vascular and IR)</th>
<th>Theatre 6 (Vascular-related IR)</th>
<th>Theatre 6 (IR)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current annual utilisation</td>
<td>104</td>
<td>139.88</td>
<td>358.8</td>
<td>602.68</td>
</tr>
<tr>
<td>Current weekly capacity</td>
<td>2</td>
<td>2.69</td>
<td>6.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Capacity annual growth</td>
<td>58.14</td>
<td>30.23</td>
<td>-</td>
<td>88.37</td>
</tr>
<tr>
<td>New total annual capacity required</td>
<td>162.14</td>
<td>170.11</td>
<td>-</td>
<td>332.25</td>
</tr>
<tr>
<td>New weekly total capacity required</td>
<td>3.13</td>
<td>3.27</td>
<td>-</td>
<td>6.4</td>
</tr>
<tr>
<td>Weekly capacity Gap to fill</td>
<td>1.13</td>
<td>0.58</td>
<td>-</td>
<td>1.71</td>
</tr>
</tbody>
</table>

Table 6 Theatre 6 and Interventional Radiology

According to the theatre utilisation dashboard, K&C theatre six (EVT) was used on average 2 sessions a week for vascular activity. Interventional Radiology activity used 6.9 (7) sessions a week, of which 2.69 sessions was Vascular-related IR activity. Rounding up, therefore theatre six (EVT) was utilised for a total of 8.9 (9) sessions a week. The unused sessions is for MDT and is used ad-hoc when required.

The analysis shows that 2 (1.71) extra sessions will be needed in theatre six to accommodate activity which will be moving from MFT. Therefore an average of 10.61 sessions a week will be needed to accommodate all activity from EKHUFT and MFT. Of course, a proportion of that activity will be done either at weekends or out of hours.

ITU / Critical Care
HDU bed activity is not indicated separately on the Trusts PAS system. It is anticipated that an additional 2 HDU beds are required. There is sufficient bed space for 2 additional beds in critical care which will be funded as part of this business case.

Outpatients
The following data from 2018/19 is for Vascular Outpatients, split by New and Follow Up. It shows the breakdown by Trust of where OPD activity has been delivered. This outpatient activity will continue to be provided in its current locations and it will not change as a result of the creation of the Kent and Medway Vascular Network model.

Table 7 Outpatient activity at MFT and EKHUFT

<table>
<thead>
<tr>
<th>Site</th>
<th>OP New</th>
<th>OP Follow Up</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT</td>
<td>3,641</td>
<td>3,861</td>
<td>7,292</td>
</tr>
<tr>
<td>MFT</td>
<td>1,458</td>
<td>1,270</td>
<td>2,728</td>
</tr>
<tr>
<td>MTW</td>
<td>1,856</td>
<td>1,616</td>
<td>3,472</td>
</tr>
<tr>
<td>Total</td>
<td>6,955</td>
<td>6,537</td>
<td>13,492</td>
</tr>
</tbody>
</table>

---

9 weekly data between week commencing 31/12/18 and 30/12/2019 (53 weeks)
10 The OPD data has come from the Dr Foster
The vascular surgical team who are currently employed by Medway Hospital NHS Foundation Trust will all transfer over to East Kent Hospitals University NHS Foundation Trust under TUPE arrangements. This includes 4 consultant vascular surgeons, 1 ST Registrar, 2 Vascular Nurse Specialists and 3 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements. Details of staff transferring and their clinical commitments are provided at Appendix 2.

Some members of Medway Hospital’s anaesthetic team and interventional radiology team have expressed a desire to continue to participate in the provision of vascular surgical care at K&CH but do not wish to formally transfer their employment to K&CH. Arrangements are being made for those staff to participate in the vascular network using honorary contracts and service level agreements. All appropriate clinical governance arrangements have been set in place to support this activity.

### Income Impact

As the service is embedded there should be an increase in the volume of patients seen and treated as waiting lists are reduced to expected levels. This is not expected to result in a material increase in cost to commissioners on an annual basis. However, MFT are left with considerable stranded costs which commissioners are asked to fund.

### Overall Service Level Impact (SLR Profitability)

<table>
<thead>
<tr>
<th></th>
<th>EKHUFT</th>
<th>MFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£4,439,295</td>
<td>-£4,439,295</td>
</tr>
<tr>
<td>Expenditure</td>
<td>£4,362,116</td>
<td>-£3,564,127</td>
</tr>
<tr>
<td>Change in Trust Position</td>
<td>£77,179</td>
<td>-£875,168</td>
</tr>
</tbody>
</table>

### Benefits of Implementation

Under this option, service would become sustainable and viable. The specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multi-disciplinary team) will all be located on a single site meaning that they will have sufficient patients to maintain their specialist skills. There would be 24/7 on site vascular surgery rotas staffed by the right number of specialist staff.

The option will enable the service to have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.

Staff will be better able to develop their skills and expertise. Productive and efficiency will improve as there will be less duplication and waste. It also supports opportunities for training, research and innovation and this all impacts on improvements in patient care.

### Quality & Safety Impact

All vascular inpatients will be treated on a dedicated vascular ward by dedicated vascular nursing staff.

Patients requiring major amputations will be treated in this single arterial centre which will have all the necessary skills and resources to manage their care and access to the most modern techniques. There will also make it easier to make improvements to mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation.

The preferred option will also enable early intervention and treatment to achieve regional
reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease.

The preferred option also will enable working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss, prevent amputation, standardise methods and promotion of best practice across the clinical teams. It also means that opportunities to reduced length of stay for patients and improving pathway links with community providers to support timely repatriation of patients following surgery will be more possible.

The above costing also includes a number of service enhancements that will improve the service offering to patients in Kent and Medway and ensure that services are more timely and sustainable. The Vascular Nurse Practitioners are vital to the running of the Vascular services across Kent and Medway. The VNP deliver independent clinics alongside the vascular surgeon teams, support the vascular doctors and ward staff. The team are responsible for delivering a large amount of the vascular outpatient activity, pre-assessment, supporting inpatients and the emergency pathways. The teams are skilled in the assessment of the acute and chronic vascular patients. This includes undertaking a physical assessment, recording of a health history, interpretation of Doppler assessments and planning appropriate treatment. The current VNP teams are at risk of losing their workforce over the next 2-5 years through retirement with no clear plan on training and replacing the highly skilled staff. The business case included the funding to support recruitment for two full time band 6 in a development posts to train up with the required competencies to become a band 7 in the future.

The EKHUFT Vascular Department currently pay an agency sonographer to run an all-day clinic once a week at KCH. The role is highly specialised and we do not currently have the skills within the Trust to support this activity. The vascular team often require specialist ultrasound scans at other times through the week but are unable to access them. The business case includes the funding to recruit a full-time vascular sonographer to the department. This removes the agency costs of £426 per day which is currently paid. The sonographer would run all day clinics at WHH, QEQM and K&C. The clinics would comprise of the routine vascular scans, AAA surveillance patients and inpatients awaiting scans which often see delays to their treatment and/or discharge. This post will also support a reduction to the departmental costs. Ultrasound scans can be carried out on some patients post EVAR surgery instead of CT scans. The reduction in CT scans is likely to be around 10 per month. This also provides a health benefit to the patient as they will not be exposed to further radiation. There is a potential to develop a peripheral arterial duplex scan service, similarly a specialist post carotid surgery scan service. The Vascular service will see a reduction of trainee doctors over the coming years due to the changes in the training programme. As a Vascular hub we must ensure there is a safe, stable and sustainable workforce in place to deal with the demand. The addition of two Associate Specialist posts will future proof the on-call and activity required of the middle grade doctor tier. This will also guarantee the service does not need to use high cost locums at times of trainee shortages.

The current outpatient waiting times at Medway for Vascular services are at unsustainable levels in order to achieve 18weeks. By combining resources, we will be able to address the long waiting times and improve the referral to treatment performance.

Inpatient services will need to be reconfigured on the K&C site in order to support the increase in vascular inpatient activity. Kent ward will remove the trolley bay to create an additional 6 beds, the space is currently used for vascular theatre admissions. Clarke ward will also lose their Urology admission area to facilitate another additional 6 beds required for vascular inpatients. The expansion of the bed base must be supported by a new admissions area on site for Vascular and Urology patients. This admission unit will
create streamlined processes for theatre admissions, reducing delays to theatres, improved communication pathways and saves time for medical teams as patients are all in one place. This will allow the ward staff to concentrate on high acuity patients on the ward and discharges.

**Risks of Implementation**

MFT staff choose not to TUPE resulting in EKHUFT having to employ costly locum and agency staff.

<table>
<thead>
<tr>
<th>Option 5B</th>
<th>Single Arterial Centre at Medway, and Enhanced Non-Arterial Centre at K&amp;CH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Option</strong></td>
<td>Under this option, the single Arterial Centre will be based at Medway Hospital. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year-round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. Under this option, Kent and Canterbury Hospital will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service. The Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals’ buildings at these sites. These hospital sites will deliver a range of services that seek to keep care as close to home as possible for patients and will include:</td>
</tr>
<tr>
<td></td>
<td>• Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;</td>
</tr>
<tr>
<td></td>
<td>• Pre- and post-operative care;</td>
</tr>
<tr>
<td></td>
<td>• Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;</td>
</tr>
<tr>
<td></td>
<td>• Diagnostics and tests; and</td>
</tr>
<tr>
<td></td>
<td>• Day surgery where appropriate</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>The vascular surgical team who are currently employed by EKHUFT will all transfer over</td>
</tr>
</tbody>
</table>
### Impact

To Medway NHS Foundation Trust under TUPE arrangements. This includes 3 consultant vascular surgeons, 2 ST Registrar, 5 Vascular Nurse Specialists and 6 supporting administrative staff. Other teams that provide a supporting service for the vascular surgical service will continue to provide these services under a number of service level agreements.

### Income Impact

Additional cost to commissioners of MFT providing service due to higher MFF = £250k

### Overall Service Level Impact (SLR Profitability)

Data not available
Section 4 Options scoring process

A set of Evaluation Criteria was developed as part of the STP against which all future proposed clinical models are being and will be evaluated. The full evaluation criteria were developed by the STP hospital care work-stream. These have built on patient, public and carer insight over recent years around what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some on-going testing and discussion with wider stakeholder audiences and groups across Kent and Medway.

The development and progress of the design phase for the evaluation criteria has regularly been reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board.

The evaluation criteria model consisted of 6 elements, each with a set of sub-criteria against which each of the short-listed options were evaluated. The evaluation criteria were used to evaluate the two shortlisted options for Vascular Surgical services in Kent and Medway.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evaluation question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Quality of care for all</td>
<td>Does the option provide improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, comparison of current clinical quality of sites? Which option would provide a better experience for patients using patient experience surveys and looking at the quality of the buildings and facilities? What are the clinical co-located services required for vascular and other services that required vascular inputs? Which option would provide a better clinical outcomes for patients using mortality rate and readmission rates? What is the expected impact on access mortality, serious unward incidents and patient harm?</td>
</tr>
<tr>
<td>2 Access to care for all</td>
<td>Do any options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car at off-peak and peak times and public transport? What is the ability of model to facilitate 7 day services and improved access to care out of hours? Which options would give people in Kent the greatest choice of hospitals for each service under consideration across the greatest number of trusts?</td>
</tr>
<tr>
<td>3 Profit/loss</td>
<td>What is the Profit/Loss of the options?</td>
</tr>
<tr>
<td>Affordability and value for money</td>
<td>What is the affordability to commissioners?</td>
</tr>
<tr>
<td>Capital cost to the system</td>
<td>Which options would have the lowest capital costs (cost of buildings and equipment)?</td>
</tr>
<tr>
<td>Meet license conditions</td>
<td>Does the option meet regulatory requirements e.g. surplus generated by each Foundation Trust?</td>
</tr>
<tr>
<td>4 Workforce</td>
<td>What is the potential impact on current medical and non medical staff and retraining / relocation required? What is the likelihood of each option to be sustainable from a workforce perspective, facilitating 7 day services and taking into account recruitment challenges and change in what work force does i.e. ability to ensure sufficient people with the right skills in the right places? What is the potential impact on staff attrition due to change?</td>
</tr>
<tr>
<td>5 Sustainability</td>
<td>How easy will it be to deliver change in 3-5 years?</td>
</tr>
<tr>
<td>Impact on local workforce</td>
<td>How well does each align with other strategic changes and provide a flexible platform for the future?</td>
</tr>
<tr>
<td>6 Research and Education</td>
<td>Which options best fit with current research and education to minimise disruption in these areas?</td>
</tr>
<tr>
<td>Support current &amp; future education &amp; research delivery</td>
<td>Which options best support current and developing research and education?</td>
</tr>
</tbody>
</table>

Table: Evaluation criteria used to evaluate the short-listed options

On 15th August 2017 an evaluation process was undertaken to appraise the remaining two options using the evaluation criteria. The evaluation process was undertaken by the following representatives from MFT and EKHUFT:

- K&M Lead Vascular consultant
- Deputy Chief Executive and the Director of Strategic Development and Capital Planning - EKHUFT
- Director for Surgical Services MFT
- Medical Director MFT
- Consultant Interventional Radiologist and Deputy Vascular Network Lead MFT
- Divisional Director for Surgical Services EKHUFT
Case Ref:

- Senior Strategic Development Manager and Programme Manager for the Kent and Medway Vascular Network – EKHUFT
- Deputy Chief Nurse and Deputy Director of Quality EKHUFT
- General Manager Surgery – EKHUFT
- General Manager for Emergency Surgical Services – MFT

The evaluation criteria were examined to allow a comprehensive evaluation of the two options enabling the team to score each of the options against the criteria. The analysis for each option was completed by analysing each evaluation criteria in details through the sub-criteria which were measured via specific evaluation questions.

The outputs of the option evaluation process are shown in the table below.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
<th>OPTION A</th>
<th>OPTION B</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care for all</td>
<td>Clinical effectiveness and responsiveness</td>
<td>+2</td>
<td>+2</td>
<td>Clinical effectiveness, patient experience and clinical outcomes were not clear differentiators between the two options even when compared as part of the National Vascular Registry. The GIRFT report did not highlight patient experience as an issue so is also not a differentiator. Creating the single arterial centre would improve all of these metrics regardless of which option was implemented.</td>
</tr>
<tr>
<td></td>
<td>Patient experience</td>
<td>+1</td>
<td>+1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>+2</td>
<td>+2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical co-dependencies</td>
<td>+2</td>
<td>0</td>
<td>Clinical co-dependencies at EKHUFT would be better under the STP plans and it was felt that clinical outcomes could also be improved if the Centre was in East Kent due to having all the correct clinical adjacencies present.</td>
</tr>
<tr>
<td></td>
<td>Clinical outcomes</td>
<td>+2</td>
<td>+1</td>
<td></td>
</tr>
<tr>
<td>Access to care for all</td>
<td>Distance and time to access services</td>
<td>0</td>
<td>-1</td>
<td>It was felt that having the centre at MFT would provide slightly poorer access for patients than at present. Having the centre in East Kent would not improve or worsen distance and access times.</td>
</tr>
<tr>
<td></td>
<td>Service operating hours</td>
<td>0</td>
<td>0</td>
<td>Service operating hours would be improved regardless of which option was selected.</td>
</tr>
<tr>
<td></td>
<td>Patient choice</td>
<td>+1</td>
<td>+1</td>
<td>Patient choice was not considered to be a differentiator between the two options.</td>
</tr>
<tr>
<td>Affordability and value for money</td>
<td>Profit/Less</td>
<td>-2</td>
<td>-2</td>
<td>It was agreed that further work needed to be undertaken on the affordability elements of the business case.</td>
</tr>
<tr>
<td></td>
<td>Affordability to commissioners</td>
<td>+1</td>
<td>0</td>
<td>A lower EKHUFT Market Forces Factor was considered to be beneficial against affordability to commissioners.</td>
</tr>
<tr>
<td></td>
<td>Capital cost to the system</td>
<td>-1</td>
<td>-1</td>
<td>Capital cost to the system was the same for both options and therefore not a differentiator</td>
</tr>
<tr>
<td></td>
<td>Meet license conditions</td>
<td>0</td>
<td>0</td>
<td>Neither option would make meeting the license conditions any easier or worse.</td>
</tr>
</tbody>
</table>
### Table: Scoring of the short-listed options using the evaluation criteria

The conclusion from the options appraisal process identified Option 5A as the preferred option - Single Arterial Centre at the Kent and Canterbury Hospital with an Enhanced Non-Arterial Centre at MFT.

<table>
<thead>
<tr>
<th>Workforce</th>
<th>+1</th>
<th>+1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainability</td>
<td>+2</td>
<td>+2</td>
</tr>
<tr>
<td>Impact on local workforce</td>
<td>-1</td>
<td>-1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverability</th>
<th>+1</th>
<th>+1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected time to deliver</td>
<td>+2</td>
<td>+1</td>
</tr>
<tr>
<td>Co-dependencies with other strategies</td>
<td>-1</td>
<td>-1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research and Education</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disruption to education &amp; research</td>
<td>+2</td>
<td>+2</td>
</tr>
<tr>
<td>Support current &amp; future education &amp; research delivery</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total scores**

<table>
<thead>
<tr>
<th>Option A</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option B</td>
<td>9</td>
</tr>
</tbody>
</table>

**CONCLUSION** - Option A scores higher than Option B.

The preferred option is therefore to create a single Arterial Centre at a site in East Kent identified as the Major Emergency Centre (MEC) with specialist services, and to create an Enhanced Non-Arterial Centre at MFT.
Section 5  Travel impact on affected patients under the preferred option

A travel analysis has been undertaken using the postcodes of patients currently accessing inpatient vascular care at Medway Hospital. Postcodes have been taken from the dataset provided by NHS England Specialised Commissioning.

Patients that currently receive inpatient care at Medway Hospital will, in the future, need to travel further to receive their inpatient care at Kent and Canterbury Hospital.

The table below shows the difference in travel times for this group of patients. The analysis shows the average time it currently takes for vascular inpatients to access Medway hospital alongside the average travel time for the same patients (from the postcodes of Medway patients) to access Kent and Canterbury Hospital.

<table>
<thead>
<tr>
<th>Travel Time Analysis</th>
<th>Average Time (minutes)</th>
<th>Min Time (minutes)</th>
<th>Max Time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFT Driving AM Peak Time</td>
<td>21.95</td>
<td>3.49</td>
<td>90.55</td>
</tr>
<tr>
<td>K&amp;CH Driving AM Peak Time</td>
<td>43.87</td>
<td>16.11</td>
<td>88.49</td>
</tr>
</tbody>
</table>

For the group of patients analysed (patients who are currently accessing inpatient vascular care at Medway Hospital) the average travel time will increase from 22 minutes to 44 minutes.

Patients are currently spending between 3 minutes and 91 minutes (the range) travelling to Medway Hospital in peak time for their inpatient vascular care. Using the same set of patients, the travel time range would be between 16 minutes and 88 minutes to travel to K&CH.

Currently, patients from the Maidstone area of west Kent that require vascular surgical care receive their care at Medway Maritime Hospital. The average travel time for those patients to access MFT is around 32 minutes. Under the preferred option, these patients will have an average travel time of around 53 minutes.

The map below shows that not all of these patients originate from the Medway area. There are 7 patients whose postcodes are closer to Canterbury than Medway therefore the time taken for these patients to get to Medway is currently longer than it would be for them to get to Canterbury in the future.
In the future, 60% of the patients’ postcodes (from those patients currently receiving inpatient care at MFT) will be able to access K&CH in under the 43 minutes average travel time.

<table>
<thead>
<tr>
<th>Distance data</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Analysis</td>
<td>Average Distance</td>
</tr>
<tr>
<td>MFT Driving Distance</td>
<td>14.7 km</td>
</tr>
<tr>
<td>K&amp;CH Driving Distance</td>
<td>48.3 km</td>
</tr>
</tbody>
</table>

The average distance travelled by patients who are currently accessing their inpatient vascular care at Medway is currently 14.7 km. Some patients are travelling 69 km for their care whilst others travel just 5.8 km.

In the future, the average distance that patients will need to travel to access inpatient care at Canterbury is 48.3 km.

The analysis of the current patient data (patients who are currently accessing their inpatient vascular care at Medway) shows that the maximum travel distance would be 91.7 km and the minimum distance would be 8.9 km. There are 7 postcodes that are closer to K&C than they are to Medway and for these patients the travel distance would be much shorter than at present.

It is important to note that the majority of the cohort of patients on which this analysis focuses are predominantly patients who are currently accessing vascular inpatient care at their local hospital in Medway. It is therefore only natural that the distance and time taken to travel to K&C in the future will be longer (as it is not their local hospital).

Heatmap

The heatmap below provides information about the number of patients that are currently accessing their vascular inpatient care at Medway.
Map 2  Heatmap showing originating postcodes of patients accessing MFT for their inpatient vascular treatment (2018/19)
Section 6 – Workforce requirement and support

This section gives an overview of the combined workforce demand for the vascular service upon go live. Vacancies at the time of this report are highlighted alongside recruitment strategies to support supply of labour to deliver the service. In line with Our NHS People plan we will support all affected colleagues to ensure achievement of the best place to work now and as part of a new model.

Risks and issues are included in this section for consideration and readiness. An engagement plan is proposed to support the transition and integration of staff in both organisations. Timescales to support the transfer are provided to address the preferred and minimum legislative requirements for transfer of service.

Table 1a below shows the TUPE workforce for go-live:

<table>
<thead>
<tr>
<th>Consultant</th>
<th>Current Employing Organisation</th>
<th>Staff Group</th>
<th>Band</th>
<th>weekly hours</th>
<th>Service</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>Consultant</td>
<td>47.392</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td>2</td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>Consultant</td>
<td>48.012</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td>3</td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>Consultant</td>
<td>46.844</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td>4</td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>Consultant</td>
<td>48.392</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td>5</td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>Consultant-recharge GS</td>
<td>48.368</td>
<td>Vascular 50% and Surgery 50%</td>
<td>MMH</td>
</tr>
<tr>
<td></td>
<td>MFT</td>
<td>Medical and Dental</td>
<td>STR Higher</td>
<td>40</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td></td>
<td>MFT</td>
<td>Nursing and Midwifery (Registered)</td>
<td>AfC 8a</td>
<td>37.5</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td></td>
<td>MFT</td>
<td>Nursing and Midwifery (Registered)</td>
<td>AfC 7</td>
<td>37.5</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td></td>
<td>MFT</td>
<td>Administrative and Clerical</td>
<td>AfC 4</td>
<td>37.5</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
<tr>
<td></td>
<td>MFT</td>
<td>Administrative and Clerical</td>
<td>AfC 4</td>
<td>37.5</td>
<td>Vascular</td>
<td>MMH</td>
</tr>
</tbody>
</table>
Possible implications associated with TUPE:

1. Change of base/location – this will attract a four-year excess mileage payment (where applicable); at the time of writing and based on the current information available this will amount to circa £77,000 over the four years (high level assumptions made).

2. Both organisations operate on national terms and conditions and there is no impact on pay on either side.

3. Both organisations are Foundation Trusts with freedoms to set Supporting Programme Activity (SPA) outside national terms and conditions of service.

4. Some consultants at MFT have additional programmed activities (APA) – discussion on how this will be treated should be considered; it is therefore recommended that timescales for TUPE activities detailed in the key stages of the consultation process are observed.

5. Assess impact of on-call service – identify all rotas that eligible staff participate in on-call duties especially those outside vascular service, if applicable.

6. The job planning cycle for MFT runs from Nov/Dec for a 12-month period therefore this means that current job plans have been agreed until Nov/Dec 2020; however job planning is an activity that can be reopened when required.

7. Deanery doctors’ placements will be transferred to EKHUFT following liaison with Kent, Surrey and Sussex Health Education England deanery (KSSHEE) – one-post at Specialty Registrar (Higher) level (StR H).

8. Administrative and clerical staff currently in scope for TUPE will need the proposed base/location assessed to determine if TUPE falls within the test of suitable alternative employment. For clarity, if the chosen base/location remains MFT then all admin staff will TUPE if the base is to transfer to Kent and Canterbury Hospital (KCH) then assessment of return mileage from current home addresses to KCH needs to be considered to determine if TUPE applies.

9. Organisational Development package to support staff transferring: it is recommended that a supportive bespoke organisational development programme is put in place prior to the transfer to align cultural approach. This programme should commence ahead of the consultation exercise and continue during this challenging period for staff and also include the onboarding upon transfer – estimated costs circa £5k. To be delivered by an external party.

Recruitment Strategies:

A number of strategies will be deployed to address existing vacancies identified in the table above. These will include targeting potential candidates locally, nationally and internationally. Some of the existing routes at present include:

1. Use of existing NHS Jobs platform, advertising on BMJ;

2. Working alongside Sustainability and Transformation Partnership (STP) to tap into the Global Learners Initiative to source candidates internationally;

3. Other international recruitment avenues – Medical Training Initiative (MTIs), Trust Clinical Fellow (CTFs);
4. Recruitment and retention initiatives to be considered;

5. EKHUFT will advertise for Vascular consultation posts ahead of TUPE transfer; current MFT employees are welcome to apply ahead of TUPE if preferred.

Key stages of the consultation process:

The two proposed timescales below meet legislative timescale requirements; however, the preferred timescale outline mitigates potential liabilities associated with Programmed Activity (PA) change.

<table>
<thead>
<tr>
<th>PREFERRED TIMESCALES</th>
<th>MINIMUM TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go live minus 6 months</td>
<td>Go live minus 3 months</td>
</tr>
<tr>
<td>• Receipt of decommissioning letter;</td>
<td>• Receipt of decommissioning letter;</td>
</tr>
<tr>
<td>• Receipt of letter of measures;</td>
<td>• Receipt of letter of measures;</td>
</tr>
<tr>
<td>• Notification of and engagement with relevant unions/staff side colleagues;</td>
<td>• Notification of and engagement with relevant unions/staff side colleagues;</td>
</tr>
<tr>
<td>• With the above 2 in place launch consultation for 30 calendar days;</td>
<td>• With the above 2 in place launch consultation for 30 calendar days;</td>
</tr>
<tr>
<td>• All activities associated with consultation to be completed (Outcome, 1-2-1 meetings etc.).</td>
<td></td>
</tr>
</tbody>
</table>
Possible Risks:

High-level risks associated with the delivery of the vascular service post go-live are provided below along with possible mitigations.

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In the event that EKHUFT advertise for vascular consultant posts ahead of TUPE and current MFT consultants apply and are successful, the service at MFT may be at risk given reduced capacity; alternatively if applicants are external to MFT then consideration needs to be given to avoid a possible situation of having excess vascular consultants in post for the network – this may result in a possible redundancy situation.</td>
<td>Monitor vacancies detailed in tables above on a monthly-basis to help inform recruitment strategies.</td>
</tr>
<tr>
<td>2</td>
<td>In the event that the letter of measures informs that APAs will not be accommodated, some consultants may find this unattractive resulting in a decision to resign (and therefore not TUPE).</td>
<td>Early discussion with stakeholders on how APAs will be treated ahead of TUPE.</td>
</tr>
<tr>
<td>3</td>
<td>In the event that the base/location for administrative staff changes from MFT there is a possibility that this staff group may not TUPE on the grounds of it not being considered suitable alternative employment.</td>
<td>The base/location for admin staff to remain MFT, this will allow for service continuity from this staff group.</td>
</tr>
<tr>
<td>4</td>
<td>There is a possibility that none of the staff eligible for TUPE transfers across to EKHUFT (through resignations). Under TUPE legislation employees may choose to resign from their current post at any time including a day before the date of TUPE transfer. The network needs to bear this in mind in planning for the service delivery.</td>
<td>The network needs to work up a scenario with this possibility. Consideration may also be given to explore temporary workforce in readiness for this eventuality.</td>
</tr>
<tr>
<td>5</td>
<td>Recruitment strategies deployed may not yield candidates.</td>
<td>Exploration of temporary workforce should be considered by host/employing organisation and associated funding included in the business case.</td>
</tr>
<tr>
<td>6</td>
<td>Lack of frequent communication to staff directly affected, resulting in dis-engagement and possible resignations.</td>
<td>Robust communication and organisational development supportive programme throughout process.</td>
</tr>
</tbody>
</table>
The preferred option is a network model that works across a number of sites with a single acute inpatient arterial centre supported by an enhanced non-arterial centre and a number of outpatient sites.

The model will be structured as follows:

- **Single Arterial Centre (Hub)** – This will be located at the Kent and Canterbury Hospital in Canterbury, East Kent. The Arterial Centre will be the single hospital within the network that provides all inpatient care for both elective and emergency vascular surgery, providing all types of vascular surgery and vascular interventional radiology. This Arterial Centre will be the only hospital in Kent and Medway that has on site a 24/7, full, year-round specialist vascular team to manage all acute inpatient elective and emergency vascular surgery. The Arterial Centre will also be the managerial centre for the Kent and Medway Vascular Network. The Arterial Centre will also fulfil all the components of care available in an enhanced non-arterial vascular centre. This reflects the national recommendation for best practice. All vascular inpatient care will take place in the single Arterial Centre, this will include recovery from surgery until the patient is fit to either return home or to be transferred to rehabilitation care closer to their place of residence. This is mainly the case for patients requiring amputations although some other North Kent patients may wish to return to Medway Hospital for further rehabilitation closer to home. The Arterial Centre will also provide a comprehensive vascular diagnostic and outpatient ambulatory care service for the local population.

- **Enhanced non-arterial vascular centre (Enhanced Spoke)** - Medway Hospital (MFT) will be the Enhanced non-arterial vascular centre and will form an integral part of the Networks solution model of care. This will be resourced to provide local vascular services that do not require a 24/7 workforce presence and inpatient based vascular interventions. It will have an enhanced weekday presence of a specialist vascular team to support other acute services within the hospital. This hospital will have interventional radiology (IR) services to support day case vascular interventions. This IR service will also support the IR needs of non-vascular services. Day-case services will be provided to support activity within the vascular network e.g. renal access surgery and on-going fistula management support interventions and it will offer a comprehensive vascular diagnostic and outpatient ambulatory care service.

- **Non-enhanced non-arterial hospitals (Spokes)** - Locally across Kent and Medway, the Network model will be supported by Non-enhanced non-arterial hospitals. Hospitals that provide acute care services (typically medicine, surgery, obstetrics), that at times will require on site vascular advice and will require direct contact links to the arterial vascular centre for 24/7 support for vascular advice and patient management. These sites will not have a daily specialist vascular presence, however, the ability to offer full vascular diagnostics and outpatient services for the local population will be available. The Non-enhanced non-arterial hospitals will deliver all out of hospital care and will be delivered through the existing Kent and Medway hospitals’ buildings at these sites. These hospital sites, which include Maidstone Hospital, Sheppey Hospital, William Harvey Hospital, Queen Elizabeth The Queen Mother Hospital and Dover Hospital will deliver a range of services that seek to keep care as close to home as possible for patients and will include:
  - Outpatients clinics; i.e. multi-disciplinary clinics, condition specific clinics, one stop shop clinics, nurse led and consultant clinics;
  - Pre- and post-operative care;
  - Ongoing monitoring and management of vascular conditions e.g. Peripheral vascular disease;
  - Diagnostics and tests; and
  - Day surgery where appropriate
The preferred option would see EKHUFT becoming the host provider Trust for the Kent and Medway Vascular Surgical Service. In the interim, until the longer-term transformation programme is delivered, all inpatient vascular surgery would be centralised at the Kent and Canterbury Hospital in Canterbury. There would be no inpatient vascular surgical care provided at MFT.

Outpatient service provision, diagnostics for vascular surgery and day case surgery would remain unchanged in terms of their location but EKHUFT will become the provider of all of those services.

At Maidstone Hospital, outpatients and diagnostic services will continue to be provided as at present. The hospital will have access to Vascular Consultant opinion with consultant presence 2 days per week. A Vascular Consultant will also be available on a planned ad-hoc arrangement to support with elective gynaecology, orthopaedic and obstetric surgical cases where it is considered necessary to have a vascular specialist on site. The current Service Level Agreements that exist between MTW and MFT will be transferred to EKHUFT and will be reviewed after the first 6 months of the Network go-live date. All costs for diagnostics undertaken on vascular patients at Maidstone Hospital by the Kent and Medway Vascular Network will need to be charged to EKHUFT.

The detailed clinical model and clinical pathways have been produced and formally approved by the Network Steering Group and can be found at Appendix 3.
### Section 8 – Benefits Summary of Options

<table>
<thead>
<tr>
<th>Target Indicator</th>
<th>Option</th>
<th>Option 5A</th>
<th>Option 5B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do Nothing</td>
<td>Preferred</td>
<td>Alternative</td>
<td></td>
</tr>
</tbody>
</table>

**SERVICE DELIVERY**

The expected benefits that have been identified will be achieved through the delivery of this vision for Vascular Surgery across Kent and Medway and include:

- Development of skills and expertise so that patients are better able to manage their condition and recovery;  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- Improved access to outpatient clinics at non-enhanced non-arterial centres;  
  - Option: No  
  - Option 5A: No  
  - Option 5B: No
- Improved sustainability of the existing vascular services;  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- A sustainable specialist workforce (Consultant surgeons, IR Consultants and specialist nurses and the wider multidisciplinary team);  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- A more productive and efficient service (minimisation of duplication and waste);  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- Improved opportunities for training, research and innovation;  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency.  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists (individually undertaking a minimum number of interventions).  
  - Option: No  
  - Option 5A: Yes  
  - Option 5B: Yes
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic...  
  - Option: Yes  
  - Option 5A: Yes  
  - Option 5B: Yes
- Provide a dedicated vascular ward and nursing staff.
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialties to provide a comprehensive multi-disciplinary service.
- Care of patients will be managed through regular multi-disciplinary team meetings, which will occur at least once a week.
- Provider networks will work towards the aim of all leg amputations being undertaken in arterial centres.
- Improving the patient experience, providing equality of access to the full range of vascular diagnostics and interventions and ensuring that patients are receiving a high quality of service, with access to the most modern techniques;
- Developing and sustaining the resilience of vascular services and the workforce providing those services;
- Improving mortality and morbidity rates for people with vascular disease and improving survival rates following hospitalisation;
- Improving complication rates following a vascular admission (short and long term).
- Reducing mortality rates by preventing death from ruptured abdominal aortic aneurysm, stroke, lower limb ischaemia and vascular trauma;
- Providing early intervention and treatment to achieve regional reductions in the incidence of stroke due to carotid artery disease and leg amputation due to peripheral arterial disease;

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Only at 1 site</th>
<th>Difficult and costly to deliver due to estate pressures</th>
</tr>
</thead>
<tbody>
<tr>
<td>•</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>•</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>•</td>
<td>No</td>
<td>Yes</td>
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<td>•</td>
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<td>Yes</td>
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<td>•</td>
<td>No</td>
<td>Yes</td>
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<td>•</td>
<td>No</td>
<td>Yes</td>
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<td>•</td>
<td>No</td>
<td>Yes</td>
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<td>•</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>•</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>•</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>•</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>


**Supporting other services to control vascular bleeding and manage vascular complications; and**
- Yes
- Yes
- Yes

**Working jointly with the diabetic and podiatry service to optimise care, minimise tissue loss and prevent amputation.**
- Yes
- Yes
- Yes

## QUALITY INDICATORS

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continued improvement of the clinical outcomes, in particular lower limb amputation, working towards achieving the best rather than average performance;</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Standardised methods and promotion of best practice across the clinical teams</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Clear lines of accountability and clinical governance across the network that puts clinicians and patients at the heart of performance monitoring and service development;</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>The creation of a transparent and effective vascular network, that benefits from shared clinical expertise and clear effective pathways of care;</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC BENEFIT

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduced length of stay for patients and more effective pathway links with community providers to support timely repatriation of patients following surgery.</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures.</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Case Ref:</td>
<td>Affordability for Commissioners</td>
<td>Yes</td>
<td>Yes</td>
<td>No as MFT has a higher MFF which Commissioners would need to pay for all EKHUFT activity</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>OTHER</td>
<td>Distance to access services</td>
<td>Yes</td>
<td>Yes</td>
<td>No (Medway arterial centre would provide poorer access for some of the population)</td>
</tr>
</tbody>
</table>
Section 9 Equality analysis

The NHS England Specialised Commissioning team has undertaken a high level analysis of the equality impact that changes to the provision of vascular surgical services will have.

People with diabetes are at a higher risk of vascular disease. Prevalence of diabetes is caused by a number of factors such as an ageing population, obesity and low levels of activity.

Another important factor for diabetes is the changing ethnic mix of the population. People from black and minority ethnic communities are six times more likely to develop the disease, suffer from a 50% increased risk of heart disease and have much higher levels of kidney disorders. The care of people with diabetes can also be complex with 25% of people suffering from three or more other long-term conditions.

NHS England now has an accessible information standard which needs to be considered/adhered to in the engagement

<table>
<thead>
<tr>
<th>Group</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Patients using vascular services tend to be older. Although there is an increasing prevalence of older people using online services it will be important for the communications and engagement process to consider the needs of older people by producing some documentation in print/large print to allow for age-related changes in vision.</td>
</tr>
</tbody>
</table>
| Disability                        | • Because a proportion of patients accessing vascular services have diabetes it is likely that some will have visual impairment beyond the usual age-related changes in vision. This means that the consultation will need to be available in alternative formats. These patients may be unable to drive and may have difficulties accessing public transport, consideration needs to be given to whether they will be able to attend meetings.  
  • Arterial disease in some patients requires lower limb amputation which will also affect accessibility to attend meetings  
  • Patients with chronic mental health problems and learning disability (particularly Down’s syndrome) are at increased risk of diabetes and arterial disease. There will be a requirement for easy read versions of documentation |
| Gender reassignment (including transgender) | No impact                                                                                                                                   |
| Marriage and civil partnership     | No impact                                                                                                                                   |
| Pregnancy and maternity            | No impact                                                                                                                                   |

### Race
Diabetes is more common in people of South Asian origin with earlier onset of significant arterial complications. People of Afro-Caribbean origin are more prone to high blood pressure which may be more difficult to control than in other groups, hence increased incidence of renal disease and stroke. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design. It will also be appropriate to make translations available for people whose first language is not English.

### Religion or belief
Patients whose religion or belief does not allow blood transfusion or particular blood products will have complications relating to accessing vascular services.

### Sex
Vascular disease is more likely to affect men than women. Narrative content of the communications does not need to be adjusted but appropriate images this group can identify with should be used in any design.

### Sexual orientation
No impact

### Carers
As vascular patients tend to be older and may already have disabilities (or develop a disability as a result of vascular surgery/amputation) they may already have a carer or may need the support of a carer.

The consultation will seek to engage with carers to understand the impact of the proposals and possible solutions such as community transport for visitors.

### Other identified groups.
Parts of Medway CCG have areas of socio economic deprivation. Smoking, obesity and low levels of activity are more common in areas that have socio economic deprivation. As these lifestyle risk factors are also linked to prevalence of diabetes (and therefore risk of vascular disease) the communications and engagement must consider the communications needs of this group. A review by Ofcom indicates that socio economic deprivation influences access to ICT (put in full) which can itself be a form of social exclusion.

However, more recent research by Public Health England for the One You campaign shows people aged 40-60 in lower socio economic groups are heavy users of mobile communications including text messaging and digital social media such as Facebook. The mix for the campaign needs to take these preferences into account.
**Section 10 – Implementation Plan**

The Kent and Medway Vascular Surgery Network Programme has been led and Programme Managed by NHS England South East Specialised Commissioning.

The detailed analysis of the activity data highlighted that only a small proportion of the vascular activity that is undertaken at MFT and EKHF is commissioned by Specialised Commissioning and, indeed, that a large proportion of the activity is commissioned by the Clinical Commissioning Groups across Kent and Medway. Nevertheless, NHS England South East Specialised Commissioning have confirmed that they wish to continue to lead the proposed reconfiguration of vascular services in Kent and Medway and the CCGs have confirmed that they are happy for NHS E to do so.  

These commissioning arrangements are important as the NHS must abide by NHS England’s Assurance Processes as set out in “Planning, assuring and delivering service change for patients (March 2018)”. This assurance process requires commissioners and their local partners to develop clear, evidence based proposals for service change and to undertake assurance to ensure they can progress with due consideration for the government’s four tests of services change and NHS England’s test for proposed bed closures. The service change process has several phases as shown in the diagram below.

![Service Change Process Diagram](image)

*Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority.*

The proposed reconfiguration of vascular services in Kent and Medway constitutes a significant change in the delivery of services and therefore a public consultation is required to seek the views and opinions of our stakeholders. The pre-consultation business case is being prepared by NHS E South East Spec Com and this is required to be approved prior to commencement of a public consultation. This assurance process can only commence however once the provider organisations are signed up to the business case and agree on the preferred option. Once all NHS providers and NHS E are in agreement with the proposals set out in this business case the Programme Management Team will secure the agreement of the Kent County Council Health Overview and Scrutiny Committee and of the Medway Health Overview and Scrutiny Committee. This will enable a proposed six week public consultation to commence (currently scheduled for April and May 2020). Analysis of the consultation feedback and responses will then be undertaken to allow the NHS organisations to make an informed decision on their proposals for the reconfiguration of vascular services in Kent and Medway.

The current programme of work shows that the Kent and Medway Vascular Network could go live in the summer of 2020 subject the NHS England Specialised Commissioning approval.

---

12 See Appendix 9
Section 11 – Recommendations

1. It is recommended that approval is given for the preferred option to be implemented.

Section 12 – sign off

EKHUFT Sign-Off

<table>
<thead>
<tr>
<th>Group</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Investment Group</td>
<td></td>
</tr>
<tr>
<td>CEMG</td>
<td></td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
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### Executive Summary

The policy has been updated to incorporate organisational changes relating to the divisions and job titles. There are no material changes to the policy content. This also includes the removal of the reference to the Quality Steering Group. The Complaints policy went to the Executive Team in December 2019 and was approved.

#### Link to strategic Objectives 2019/20

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)

- **Innovation:** We will embrace innovation and digital technology to support the best of care
- **Finance:** We will deliver financial sustainability and create value in all we do
- **People:** We will enable our people to give their best and achieve their best
- **Integrated Health Care:** We will work collaboratively with our system partners to establish an Integrated Care Partnership
- **High Quality Care:** We will consistently provide high quality care

### Due Diligence

To give the Trust Board assurance, please complete the following:

- **Committee Approval:**
  - Name of Committee: N/A
  - Date of approval:

- **Executive Group Approval:**
  - Date of Approval: 12 December 2019

- **National Guidelines compliance:**

- **Resource Implications**
  - State if the paper will have additional resource implications

- **Legal Implications/Regulatory Requirements**
  - The Trust is required to comply with the local authority social services and NHS Complaints Regulations 2009.

- **Quality Impact**
  - None

### Recommendation/Actions required

The Board is asked to approve the updated name changes and job titles.

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### Appendices

- Complaints Management Policy
# CORPORATE POLICY: Complaints Management

<table>
<thead>
<tr>
<th>Author:</th>
<th>Ann Bushnell Head of Quality Governance</th>
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<tr>
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<td>Lyndsay Barrow Patient Experience Manager</td>
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<td>Implementation Date:</td>
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### Complaints Management Policy

#### Document Control / History

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<td>1</td>
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<td>4.1</td>
<td>Insert new section - Complaints Requiring Reimbursement</td>
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<td>Review &amp; update following KMPG Audit</td>
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<tr>
<td>9.0</td>
<td>General Review and update – to be reviewed in 6 months due to new management of team</td>
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#### Consultation

- Director of Nursing
- Head of Patient Experience
- Division Governance Leads
- Executive Group
- Chief Executive

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TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS.  

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1 Introduction

1.1 This Policy outlines the Trust’s commitment to dealing with complaints about its services and provides information on how we manage, respond to and learn from complaints made about our services.

1.2 The Trust’s Policy on complaints management is to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 - Statutory Instrument 2009/309 (“the Regulations”), conform to the NHS Constitution and reflect the recommendations from the Francis Report (2013).

1.3 The Trust will treat complaints seriously and ensure that complaints, concerns and issues raised by patients, relatives and carers are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with resulting actions will be explained to the complainant.

1.4 The Trust’s policy is to follow the “Good Practice Standards for NHS Complaints Handling” (Sept 2013) outlined by the Patients Association:

1.4.1 Openness and Transparency – well publicised, accessible information and processes, and understood by all those involved in a complaint;

1.4.2 Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints;

1.4.3 Logical and rational in our approach;

1.4.4 Systematically respond to complaints and concerns in appropriate timeframes;

1.4.5 Provide opportunities for people to offer feedback on the quality of service provided;

1.4.6 Provide complainants with support and guidance throughout the complaints process;

1.4.7 Provide a level of detail appropriate to the seriousness of the complaint;

1.4.8 Identify the causes of complaints and take action to prevent recurrences;

1.4.9 Effective and implemented learning – use “lessons learnt” as a driver for change and improvement;

1.4.10 Ensure that the care of complainants is not adversely affected as a result of making a complaint;

1.4.11 Ensure that Medway NHS Foundation Trust meets its legal obligations;

1.4.12 Act as a key tool in ensuring the good reputation of Medway NHS Foundation Trust.
1.5 The complaints system also incorporates the Parliamentary and Health Service Ombudsman’s ‘Principles of Good Complaints Handling, Principles of Good Administration and Principles for Remedy’ which include:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

2 Purpose / Aim and Objective

2.1 The purpose of this Policy is to provide a framework for dealing with complaints relating to services provided by Medway NHS Foundation Trust and to ensure that patients, relatives, carers and all other users of services have their complaints and concerns dealt with in confidence and impartiality, with courtesy and empathy in a timely and appropriate way.

2.2 The aim of the policy is to ensure that all complaints (formal or informal) are treated in a courteous and sympathetic manner by any person to whom the complaint is made.

2.3 It is also intended for distribution to patients and members of the public who require more detailed information than that contained in the Trust's leaflet ‘How to make a complaint’

2.4 It is intended that the Trust’s complaints procedures:

2.4.1 Provide a single process which deals with complaints

2.4.2 Provide a flexible approach to investigating complaints locally and to providing people with a rapid, open, and honest response

2.4.3 Are fair to staff and complainants alike.

2.4.4 Enable the Trust to use the information it receives from patients’ complaints to improve its services for patients.

2.4.5 Use complaints as an opportunity to gain insight into the patient experience and improve the quality of care and treatment and overall experience.

2.4.6 Complaints between NHS bodies, providers and local authorities may require a collaborative response covering all complaints across health and social care, including primary, secondary and tertiary health care. The investigation may involve colleagues in other NHS Trusts or agencies. In negotiation with the other organisations involved, a single trust should lead and co-ordinate the response. In these circumstances any response that we provide to another organisation should be signed off by the CEO in the usual
way. Equally where we are leading, the final response should be sent to other organisations involved.

3 Definitions

3.1 A complaint or concern is an expression of dissatisfaction about an act, omission or decision, either verbal or written, and whether justified or not, that requires a response. Patients may not always use the word "complaint." They may offer a comment or suggestion which can be extremely helpful but it is important to recognise those "comments" which are really complaints and need to be handled as such.

3.2 Regulations - Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 - Statutory Instrument 2009/309. The Regulations set out the statutory framework that the Trust follows including

- 3.2.1 Persons who can make complaints
- 3.2.2 Duty to handle complaints
- 3.2.3 Complaints about the provision of health services
- 3.2.4 Complaints not required to be dealt with
- 3.2.5 Duty to co-operate
- 3.2.6 Time limit for making a complaint
- 3.2.7 Procedure before investigation
- 3.2.8 Investigation and response
- 3.2.9 Forms of communication, Publicity, Monitoring, Annual Reports
- 3.2.10 Full details of the Regulations are available via: http://www.legislation.gov.uk/uksi/2009/309/contents/made

4 (Duties) Roles & Responsibilities

4.1 Trust Board

- 4.1.1 Responsible for approving the Trust’s Corporate Policy for complaints management.
- 4.1.2 Responsible for reviewing and approving the annual report to the Board on complaints.
- 4.1.3 Responsible for understanding the statutory framework for management of complaints and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

4.2 Chief Executive

- 4.2.1 In accordance with the Regulations the Chief Executive is the designated “Responsible Person”.

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Page 6
4.2.2 Overall accountability for ensuring the Trust’s Corporate Policy for complaints management meets the statutory requirements as set out in the Regulations.

4.2.3 Responsible for approving and signing complaints response letters. Regulation 4 (2) of the Regulations allows the functions of the Responsible Person to be performed by any person authorised by Medway NHS Foundation Trust to act on the Responsible Person’s behalf. Accordingly, Medway NHS Foundation Trust has delegated responsibility for signing of complaints within the parameters set out in appendix 1.

4.3 **Head of Quality Governance**

4.3.1 Is responsible for complaints management and is the designated “Complaints Manager” required by the Regulations. Complaints management is managed operationally by the Central Complaints Team.

4.4 **Central Complaints Team**

4.4.1 Is responsible for the implementation and co-ordination of the Trust's complaints policy.

4.4.2 Is responsible for ensuring all complaints are read and recorded.

4.4.3 Is responsible for the collation and submission of any returns required in relation to complaints e.g KO41.

4.4.4 Is responsible for the preparation of the annual report in relation to complaints.

4.4.5 Is the Systems Manager for the Trust’s complaints management system with responsibility for ensuring the correct usage and application of the system and the extraction of data to meet reporting requirements.

4.5 **Chief Operating Officer**

4.5.1 The Chief Operating Officer has operational responsibility to ensure that the Divisions have adequate procedures and resources for investigating and responding to complaints in accordance with the requirements of the Regulations.

4.5.2 They also have responsibility for ensuring that there are effective Division governance processes for reviewing and embedding the learning from complaints.

4.6 **Division Governance Lead**

4.6.1 Has responsibility for following the Trust procedure for managing and reviewing the complaints it receives; the focus of which will be to review and, where necessary, change practice, develop learning outcomes and improve the quality of patient care.

4.6.2 Division reports will be provided for review through the division’s governance structure detailing the work being undertaken to learn from complaints. Good practice initiatives will be shared across the organisation and issues of
Concern will be addressed through the Trust's governance and performance process.

4.6.3 Has responsibility for allocating complaints to an Investigating Manager and ensuring that they respond in accordance with the established procedures.

4.6.4 Has responsibility to ensure complaint responses are coordinated and completed within the given deadlines.

4.6.5 Where recommendations or action plans are produced by the Parliamentary and Health Service Ombudsman following their investigations, it is the responsibility of the Division Governance Lead to implement and monitor these recommendations and plans. All Parliamentary and Health Service Ombudsman recommendations will be reported through the Division Governance Lead.

4.6.6 The Division Governance Lead is responsible for identifying when an action plan is required and ensuring actions are completed and monitored and uploaded to datix.

4.7 Division Governance Facilitators/Administrators

4.7.1 In circumstances whereby a local resolution meeting with division staff members is required, division governance staff will coordinate the meeting arrangements in a timely manner and ensure that a record of the meeting is taken (this may be written or recorded) and that notes of the recording are uploaded onto Datix.

4.7.2 Are responsible for ensuring that all evidence relating to the complaint and its investigation is uploaded onto Datix ensuring the integrity of the audit trail and completeness of the complaint record on Datix. On some occasions, an internal high level review or serious incident will be necessary as part of the complaint and these documents must be scanned into Datix.

4.7.3 Are responsible for providing a complaints management service to the Division Care Group, including the analysis of the complaint, setting up meetings, gathering of information required to respond to the complainant, ensuring that the complaint is responded to within the specified timeframe.

4.7.4 Collate and analyse patient experience data both quantitative and qualitative (complaints, PALS, surveys, Friends and Family etc.) identifying emerging and consistent themes and trends. Provide patient experience reports at both speciality and Care Group level.

4.7.5 Co-ordinate the Duty of Candour process, ensuring that outcomes are communicated and recorded and included within complaint responses.

4.8 Investigating Manager

4.8.1 Has a responsibility to thoroughly investigate the concerns raised in each complaint. Statements will be gained from the relevant staff involved. All statements and supporting information will be forwarded to the Division Governance team for uploading onto Datix, which is the Trust’s complaints database.
4.9 Complaints Direct to CEO Office

- Complaint received direct to CEO and/or medical director from MP or complainant
- Acknowledged by CEO Executive Assistant
- CEO Executive Assistant sends to CCT
- CCT acknowledges & requests consent where required
- CCT log compliant and allocate to division
- Complaint will then follow trust process OTCGR187 - Complaints - Process Flowchart

4.10 Staff

4.10.1 Staff and managers on the wards, in clinics and at reception desks are those most likely to receive verbal concerns or complaints. The first responsibility of anyone who receives a complaint or concern is to ensure that the immediate health care needs of the patient concerned are being met. This may require urgent action before any matters relating to the complaint are tackled. The recipient should then seek a full understanding of the complaint, including any aspects which might not be immediately apparent. This needs to be undertaken with tact and sensitivity. Complainants should be encouraged to speak openly and freely about their concerns and be assured that whatever they say will be treated in confidence. Staff should refer to the procedures in SOP0219 - Complaints - Handling Verbal Concerns for further guidance.

4.10.2 The aim should always be to satisfy the complainant that his or her concerns are being treated seriously, to offer an apology and an explanation and to take the necessary action to resolve the complaint. Any response given to a complainant which refers to matters of clinical judgement must be agreed by the clinician concerned and, in the case of medical care, by the consultant concerned. A record of such complaints should be made and managed within the division.

4.10.3 All staff should feel empowered to manage a complainant’s concerns, however it is recognised that this will not always be the case. If the member of staff feels they cannot help the complainant further they should contact their immediate line manager. The manager should make the complainant a priority and should try to allay all fears and put the situation right. This may or may not be followed up in writing or with a telephone call; this is dependent on the situation. If the complainant remains dissatisfied and wishes to pursue it further then the complainant will be advised of the formal complaint process and provided with the Trust’s complaints leaflet.

4.11 Patient Advice and Liaison Service (PALS)

4.11.1 Is responsible for promoting their service across the organisation to patients, and acting as the first point of contact for complainants as it is the right of every member of the public to contact them to help them resolve a situation.
5.1 Medway NHS Foundation Trust is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

**SOP0190 - Complaints Procedure**
This procedure outlines the process for how we deal with complaints received.

**GUCGR026 - Complaints - Responding to Letters of Complaint**
This document provides guidance on how to respond positively to complaint letters allowing staff to apologise to our patients if something has gone wrong.

**OTCGR187 - Complaints - Process Flowchart**
A flowchart detailing the process from the beginning to end including timeframes.

**Complaints Patient Information Leaflets**

**PIL00001114 - Complaints - Easy Read**
How to make a complaint
A leaflet for patients that tells them our process for making a complaint.

**Complaints – Supporting Procedures**

**SOP0219 - Complaints - Handling Verbal Concerns**

**SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints**

**SOP0235 - Complaints - Datix Web**

6.1 When responding to complaints, the Trust will comply with the requirements of The Accessible Information Standard, which aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. The Standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in accessible formats.

6.2 The Standard also tells organisations how they should make sure that people get support from a communication professional if they need it, and about changing working practices to support effective communication. By law (section 250 of the Health and Social Care Act 2012), all organisations that provide NHS care or adult social care have been required to follow the Standard in full from 31 July 2016 onwards.
6.3 The Standard says that patients, service users, carers and parents with a disability or sensory loss should:

6.3.1 Be able to contact, and be contacted by, services in accessible ways, for example via email, text message or Text Relay.

6.3.2 Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print.

6.3.3 Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter.

6.3.4 Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid.

7 Principles underpinning complaints handling

7.1 People complain for many different reasons. The vast majority of people receiving NHS services do not set out to become complainants, so when they do express a concern, or raise a complaint, we recognise that it is usually a significant thing for them to do.

7.2 When members of the public raise matters with the Trust if things have gone wrong we commit to:

7.2.1 Signposting them to the relevant organisation if responsibility for dealing with the complaint does not rest with the Trust;

7.2.2 Inviting the complainant to have a say in how the case is handled and how things are to be put right;

7.2.3 Providing an honest and open response to all the concerns;

7.2.4 Providing a thorough and detailed explanation concerning events leading up to the complaint;

7.2.5 Providing an apology where things have gone wrong;

7.2.6 Providing a response in a timely manner adhering to Trust response deadlines

7.2.7 Providing an explanation to the complainant concerning what the organisation will learn from this experience, with the reassurance that other patients will have a better outcome as a consequence;

7.2.8 Consider making a financial contribution to the complainant if they have suffered a financial loss as a direct consequence.

7.3 No one should be discriminated against or treated badly as a result of making a complaint or raising a concern. Where the complainant is a patient, it is important that their right to quality care is not compromised by their complaint and that they are not treated adversely.
7.4 It is important to listen and react appropriately when patients, carers or relatives express a concern or make a complaint. Not everything that patients, relatives and carers raise as a concern is necessarily a “complaint”. Most complaints and concerns can and should be resolved informally by the people to whom they were addressed or by their immediate manager. All possibilities should be explored in an attempt to resolve the complaint positively.

7.5 Where patients find it difficult to complain, or are unable to complain, the Trust will welcome complaints from a close family member or a patient advocate in appropriate circumstances. When someone complains on behalf of a patient, the organisation will need to satisfy itself that the patient has agreed to their information being shared for the purposes of investigation and resolution of the complaint.

7.6 Information received from a complainant will remain confidential and be communicated only to those people who need to know. Specific patient information will be anonymised wherever possible.

7.7 The Trust's complaints leaflet will be published on the Trust’s website and be available to patients upon request.

7.8 If the complainant is dissatisfied with the final response of the Trust, s/he has the right to take their complaint to the Parliamentary and Health Service Ombudsman.

8  Entitlement to complaint documentation

8.1 The Freedom of Information Act, provides a right to access official information. Under the Freedom of Information Act the complainant will have the right to request any recorded information held by a public authority. The complainant can ask for any information they think the public authority may hold. The Act only covers recorded information which includes information held on computers, in emails and in printed or handwritten documents as well as images, video and audio recordings. The complainant should identify the information required as clearly as possible. The request can be in the form of a question, rather than a request for specific documents, but the authority does not have to answer this question if it would mean creating new information or giving an opinion or judgment that is not already recorded. Some information may not be given because it is exempt, for example because it would unfairly reveal personal details about somebody else. Further information can be located on the following link: https://ico.org.uk/your-data-matters/official-information/

9  Complaints & Serious Incidents

9.1 On receipt of a complaint that is already recorded as a serious incident, the complaint will be logged onto datix and linked to the serious incident. The complaint response due date will be the same target date set for the serious incident and the complainant will be notified of this date and of the existing investigation.
10 Matters Excluded from the NHS Complaints Procedure and this Policy

10.1 The following complaints are excluded from the scope of the NHS Complaints Procedure:

10.1.1 A complaint made by a Trust employee about any matter relating to their contract of employment;

10.1.2 A complaint made by another NHS body which relates to contractual arrangements with the Trust;

10.1.3 A complaint which is or has been investigated by the Parliamentary and Health Service Ombudsman;

10.1.4 A complaint relating to a failure to comply with a request for information under the Freedom of Information Act 2000;

10.1.5 An oral complaint which is resolved to the complainant’s satisfaction although understanding that feedback about the service can help continuous improvement;

10.1.6 A matter that has already been investigated under the complaints regulations;

10.1.7 A matter arising out of an alleged failure to comply with a data subject request under the General Data Protection Regulations 2018;

10.1.8 If a complaint is also part of an ongoing police investigation or legal action it will be discussed with the relevant police authority or legal advisor and only continue as a complaint if it does not compromise the police or legal action.

10.2 The Trust will write and explain the reasons for not dealing with the complaint.

11 Who may Complain and Timescales for Complaints

11.1 The Trust will act on complaints from people who are receiving, or have recently received, the services which it provides. People may complain on behalf of existing or former patients, where this is the explicit wish of the patient and consent has been given. They may also complain on behalf of a patient who is not competent to give consent, for example because he or she is too ill at the time or because they have parental responsibility or for a patient who has died. The Trust will establish that the person is able to act on behalf of the patient. Particular attention will be given to the need to respect the confidentiality of the patient and any known wishes expressed by the patient before death.

11.2 A complaint should always be made as soon as possible after the incident in question. The Trust will not normally investigate a complaint which is made more than 12 months after the event giving rise to it. The Trust may use its discretion to extend the time limit in cases where, for example, the complainant has suffered particular distress or trauma which prevented him or her from complaining earlier, where it is still possible to investigate the complaint effectively and efficiently.
11.3 The target response time for all complaints is 30 working days. For complex complaints or those where a Serious Incident investigation is required the complainant will be informed the Trust will require 60 working days to allow sufficient time for the investigation and resulting report. The target for a response to a complaint relating to two or more agencies is likely to be longer than 30 working days, the complainant will be notified of the timeframe. The response should include information on what action the complainant should take if they remain dissatisfied with the response. Where it is not possible to provide a full reply within 30/60 working days, contact should be made with the complainant by the division explaining the reason for the delay and the anticipated timescale for resolution. The Trust aims to answer 85% of complaints within 30 working days.

11.4 The Trust leaflet entitled ‘How to make a complaint’ giving guidance on the complaints procedure will be made freely available in all patient areas. Complainants will also be advised that written complaints may be sent via email directly to the Complaints Team. The original communication method i.e. letter or email will be the route in which the Trust will enter into corresponding with the complainant. The leaflet provides details of advocacy services that can support people in making a complaint.

11.5 The Trust recognises the role mediation and conciliation can play in resolving complaints. If a complaint warrants mediation or conciliation in order to resolve matters, this should be discussed with the Chief Operating Officer. The use of external mediation services will be considered on a case by case basis.

12 Complaints Requesting Reimbursement

12.1 Complaints may contain an explicit request for reimbursement of costs incurred for travelling or parking when travelling to hospital for clinic appointments that are cancelled without prior notification. In cases such as these the Chief Operating Officer will consider the request made by the complainant and include the decision on reimbursement in their response including the rationale for the decision taken. Funds for reimbursement will be paid from division funds. This is in conjunction with the Parliamentary and Health Service Ombudsman’s Principles for Remedy. This is only appropriate for patients undergoing care and treatment provided by Medway NHS Foundation Trust. In the case of a complaint where another organisation is involved reimbursement must be considered separately by that specific organisation.

12.2 Where a request is made for reimbursement of onsite parking costs due to cancelled clinic appointments, or cancelled treatment, the Chief Operating Officer will consider reimbursing the costs in full only if no attempt was made to contact the patient to warn them of the cancellation. It is reasonable to expect that contact should be made by the most appropriate means in the circumstances such as by text, mobile phone, email or letter. Additional parking costs incurred for late running clinics will not be reimbursed.

12.3 No other costs (eg. salary, petrol) will be reimbursed. This is recognising that the NHS has finite resources that must be prioritised on patient care.
12.4 Patients remain responsible for their personal belongings whilst on Trust premises. Therefore, requests for reimbursement of lost property will not be considered further unless the items were handed over to the Trust for safekeeping and a receipt issued by the Trust. Patients will be signposted to their home insurers for reimbursement.

13 Complaints and Legal Action

13.1 Where the complaint is made concurrently with a legal claim or shortly after the legal claim has already been notified to the Trust, the Central Complaints Team will take legal advice from the Trust’s Legal Services Team, who in giving that legal advice shall have regard to the current law and guidance which is relevant, about whether the complaint should be dealt with at that time or whether it should be put into abeyance pending resolution of the legal claim.

13.2 The default position is that the Chief Operating Officer will ensure they investigate the complaint concurrently with the Legal Team. Actual or intended litigation will not be a barrier to the processing or investigating of a complaint.

14 Parliamentary and Health Service Ombudsman Procedure

14.1 Where a complainant is dissatisfied with the response received from the Trust and the outcome of any further attempts to resolve the complaint locally has not been accepted, he or she may make a request to the Parliamentary and Health Service Ombudsman for review of the complaint. Any requests received by the Trust must be forwarded to the Ombudsman within the timescales specified.

14.2 The information produced by the Parliamentary and Health Service Ombudsman describing its role, should be made available to complainants on request – [link](http://www.ombudsman.org.uk/make-a-complaint/how-to-complain)

14.3 The Trust will respond promptly to the Parliamentary and Health Service Ombudsman, and in accordance with any targets set by them. All correspondence and records which are requested for their investigation will be coordinated through the Central Complaints Team.

15 Disruptive and unreasonably persistent complainants

15.1 There are a small number of complainants who, because of the frequency of their contact with the Trust, hinder the Trust’s consideration of their, or other people’s, complaints. We refer to such complainants as ‘persistent complainants’ and, in exceptional cases, where this contact is unreasonable, we will take action to limit their contact with the Trust.

15.2 The decision to restrict access to our service is taken at a senior executive level and any restrictions imposed are appropriate and proportionate.

15.3 In all cases we will write to tell the complainant why we believe their behaviour falls into this category, and request that they change it.
15.4 If the behaviour continues, we will write to the complainant explaining that we are limiting their access to the Trust. We will also tell them how they can complain if they disagree with that decision.

15.5 Advice for staff on handling unreasonable, regular or persistent complainants is found in a separate SOP - [SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints](https://www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf)


### 16 Monitoring and Review

<table>
<thead>
<tr>
<th>What will be monitored</th>
<th>How/Method/ Frequency</th>
<th>Lead</th>
<th>Reporting to</th>
<th>Deficiencies/ gaps Recommendations and actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy review</td>
<td>Annually</td>
<td>Executive Director for Complaints Team</td>
<td>Executive Group / Board</td>
<td></td>
</tr>
<tr>
<td>30 working day response target</td>
<td>DATIX table demonstrating the status of complaints / Monthly</td>
<td>Division Governance Manager</td>
<td>Deputy Director of Nursing</td>
<td>Where gaps are recognised, action plans will be put into place by each division governance lead</td>
</tr>
<tr>
<td>Complaints analysed and trends identified</td>
<td>Monthly via DATIX and reports to PRMs</td>
<td>Division Governance Team</td>
<td>Division Governance groups</td>
<td></td>
</tr>
<tr>
<td>Overdue complaints and division response times</td>
<td>Division Governance Team liaise with the appropriate specialty where matters of concern arise</td>
<td>Division Governance Manager</td>
<td>Deputy Director of Nursing</td>
<td>Review DATIX fields and tables</td>
</tr>
<tr>
<td>Turnaround times regarding collaboration with external organisations (joint responses)</td>
<td>Monthly</td>
<td>Division Governance Manager</td>
<td>Deputy Director of Nursing External organisations</td>
<td>Review DATIX fields and tables</td>
</tr>
<tr>
<td>The number of Ombudsman requests</td>
<td>Monthly</td>
<td>Central Complaints Team (CCT)</td>
<td>Quarterly complaints report</td>
<td></td>
</tr>
<tr>
<td>Changes as a result of formal complaints</td>
<td>Changes in practice discussed at monthly division and governance meetings</td>
<td>Division Governance Manager Deputy Director of Nursing</td>
<td>Division Management Board</td>
<td>Each Division will demonstrate learning and where necessary a change of practice</td>
</tr>
</tbody>
</table>
## 17 Training and Implementation

### 17.1 Staff Training

17.1.1 The Head of Quality Governance is responsible for ensuring that the training requirements for staff are identified and met.

17.1.2 Division Governance Leads will be responsible for ensuring that all staff receive the relevant training in complaint management provided by the Trust in order to address their specific needs.

17.1.3 All staff need to know how to react and what to do if someone makes a complaint as the initial response may either help resolve the situation on the spot or provide the complainant with the reassurance that their concerns will be treated appropriately.

17.1.4 The Trust will provide training and support for all staff required to deal with complaints from or on behalf of the Trust.

## 18 References

<table>
<thead>
<tr>
<th>Reference</th>
</tr>
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<tbody>
<tr>
<td>POLCGR005 - CORPORATE Complaints Management Policy</td>
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<tr>
<td>OTCGR187 - Complaints - Process Flowchart</td>
</tr>
<tr>
<td>SOP0190 - Complaints Procedure</td>
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<tr>
<td>GUCGR026 - Complaints - Responding to Letters of Complaint</td>
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<tr>
<td>SOP0235 - Complaints - Datix Web</td>
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<tr>
<td>SOP0219 - Complaints - Handling Verbal Concerns</td>
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<tr>
<td>SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints</td>
</tr>
<tr>
<td>PATIENT INFORMATION LEAFLETS</td>
</tr>
<tr>
<td>PIL00001114 - Complaints - Easy Read</td>
</tr>
</tbody>
</table>
### Appendix 1

<table>
<thead>
<tr>
<th>Initial assessment of complaint</th>
<th>Type of complaint</th>
<th>Level of investigation, response period and signatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low level (Green) - formal complaint</td>
<td>Simple, non-complex complaints e.g. Cancelled outpatient appointment/admission Waiting time, Car Parking</td>
<td>Simple investigation required. Response may be provided verbally or in writing by the Matron/Service Manager, with the complainant’s agreement. Response period – Within 10 working days from date complaint opened or when consent received. Alternatively a written response can be signed by the Chief Operating Officer or Deputy Director of Nursing.</td>
</tr>
</tbody>
</table>
| Medium level (Amber) – formal complaint | May be several issues and/or involve clinical care | More detailed investigation involving clinical matters. Response to be signed by Chief Operating Officer unless:  
- Complaint crosses more than one division – in which case either the Director of Nursing or Medical Director can sign; a judgment will need to be made as to which of these is most appropriate in light of the complaint issues  
- Investigation results in initial assessment changing from amber to red  
- Is subject to an incident / Serious Incident investigation  
Response period – within 30 working days from date complaint opened or when consent received. |
| High level (Red) – formal complaint | Complex complaint involving several Divisions or more than one organisation. Issues may have been investigated as a Serious Incident (or need to be) or may have the potential for legal action. | Detailed investigation with option to obtain advice from Associate Medical Director/Lead Clinician. Response to be signed by Chief Executive. Response period within 60 working days from date complaint opened or when consent received. |
| High level (Blue) – formal complaint | MP’s involvement Solicitor’s involvement | Response period – within 30 working days from date complaint opened or when consent received. Response to be signed by Chief Executive |