# Agenda

NHS Medway NHS Foundation Trust

## Public Trust Board Meeting

**Wednesday, 01 February 2023 at 12:30 – 15:30 in the Trust Boardroom and via MS TEAMS**

| Item | Subject | Presenter | Page | Time | Action |
|---|---|---|---|---|---|
| **Opening Matters** | | | | | |
| **1.** | Chair's Welcome and Apologies | Chair | Verbal | 12:30 | Note |
| **2.** | Quorum | | Verbal | | Note |
| **3.** | Declarations of Interest | | Verbal | | Note |
| **4.** | Minutes of the last meeting held on 15 December 2022, and matters arising/actions | | 3 and 15 | | Approve |
| **5.** | Chair's introduction and update | | Verbal | | Note |
| **6.** | Chief executive update | CEO | 17 | 12:45 | Assurance |
| **Patient and Staff Experience** | | | | | |
| **7.** | Clinical Presentation – Hydration and Nutrition. | Associate Director of Patient Experience | 23 | 12:50 | Note |
| **8.** | Council of Governors Update | Lead Governor | Verbal | 13:00 | Note |
| | **Wellbeing Break** | | | | |
| **Assurance Items** | | | | | |
| **9.** | Committee updates:<br>• Quality and Assurance (Dec 22, and Jan 23)<br>• Finance, Planning and Performance | Non-Executive Chairs of each Committee | 33<br>47 | 13:20 | Assurance |
| **10.** | Annual Business Plan (23/24) development update | CFO/COO | 55 | 13:35 | Assurance |
| | **Wellbeing Break** | | | | |
| **Escalation or Decision Items** | | | | | |
| **11.** | Finance Report | CFO | 61 | 13:50 | Approve |
| **12.** | Integrated Quality performance Report | COO, CNO, CMO | 77 | 14:00 | Approve |
| **13.** | Audit and Risk Committee Terms of Reference (revised) | Company Secretary | 124 | 14:20 | Approve |
| **Closing Matters** | | | | | |
| **14.** | Questions from the public | Chair | Verbal | 14:25 | |
| **15.** | Any other business | Chair | Verbal | 14:30 | Note |
| **16.** | Board review of meeting | | | | |

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|---|---|
| **17.** | Date and time of next meeting: 29 March 2023 – Formal Trust Board |

**Additional documents circulated for information and note:**

- (Annual) Emergency Planning Resilience and Response – Page 137
- (Annual) Research and Innovation – Page 145

NHS Medway NHS Foundation Trust

# Minutes of the Trust Board PUBLIC Meeting

**Thursday, 15 December 2022 - 12:30pm to 3.30pm**

**Hybrid Meeting with TEAMS and Trust Boardroom**

| Members | Name | Job Title |
|---|---|---|
| **Voting:** | Adrian Ward | Non-Executive Director |
| | Alison Davis | Chief Medical Officer |
| | Annyes Laheurte | Non-Executive Director |
| | Jayne Black | Chief Executive |
| | Leon Hinton | Chief People Officer |
| | Mandy Woodley | Chief Operating Officer (Interim) |
| | Mark Spragg | Non-Executive Director |
| | Evonne Hunt | Chief Nursing Officer |
| | Alan Davies | Chief Financial Officer |
| | Paulette Lewis | Non-Executive Director |
| | Jo Palmer | Trust Chair |
| **Non-Voting:** | Glynis Alexander | Director of Communications and Engagement |
| | Jenny Chong | Associate Non-Executive Director |
| | Rama Thirunamachandran | Academic Non-Executive Director |
| **Attendees:** | Dan Rennie-Hale | Director of Integrated Governance, Quality and Patient Safety |
| | Alison Herron | Director of Midwifery |
| | Cllr David Brake | Lead Governor |
| | Emma Tench | Assistant Company Secretary (Minutes) |
| | Matt Capper | Company Secretary (Interim) |
| | Emma Coutts | Lead Nurse Acute Response Team |
| | Amanda Cameron | Senior Acute Response Team Sister |
| | Charlotte Barnett | Student Midwife at Canterbury Christ Church Uni. |
| | Cllr Angela Harrison | Governor |
| | Jignesh Patel | Governor |
| | Jennifer Teke | Research Nurse |
| | Stergios Boussios | Consultant Oncologist |
| | Tracy Kelly | Deputy Head of Corporate Governance and Legal |
| | Adebayo Da-Costa | Staff Governor |
| | Olaide Kazeem | Governor |

| | | |
|---|---|---|
| | Nitesh Mathai | Staff Governor |
| **Apologies:** | Sue Mackenzie | Non-Executive Director |

**Minutes**
**Opening Matters**

1. **Chair's Welcome and Apologies**
   In the absence of the Trust Chair Jo Palmer, Mark Spragg, (Senior Independent Director) acted in the capacity of Chair for the Public Trust Board.
   The Chair welcomed all present and apologies were given as listed above.

2. **Quorum**
   The meeting was confirmed to be quorate.

3. **Declarations of Interest**
   There were no conflicts of interest raised.

4. **Minutes of the previous meeting and matters arising/actions**
   The minutes of the last meeting, held on 5 October 2022 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.
   Action log: reviewed and updated.

5. **Chairs Introduction and Update**
   Mark Spragg, Non-Executive Director, updated the board on the following;

***a)*** *Winter has hit hard this week, and I would like to take this opportunity to thank colleagues who have continued to provide the best of care to our patients in spite of the disruption caused by the ice and snow.*

***b)*** *We have started to feel the impact of the colder weather, with an increase in respiratory illnesses including flu and COVID-19 and anticipate this will continue well into the New Year.*

***c)*** *Careful planning by colleagues has ensured we are in the best possible position to manage the demand we will see over the coming weeks.*
*This has included a Breaking the Cycle week, which aimed to ensure patients are discharged in a timely way, avoiding delays for those patients needing to be admitted for care.*

***d)*** *We are also very conscious of the need to support our teams, and encourage colleagues to take advantage of facilities on offer to help with their wellbeing.*

**e)** *This week we are, of course, getting ready for Christmas, and it has been lovely to see the hospital getting into the festive spirit, with some of the celebrations reintroduced after a break due to the pandemic.*

6. **Chief Executive Update**
   Jayne Black, Chief Executive highlighted the following from her update:

***a)*** *With winter likely to see a rise in cases of COVID-19 and seasonal flu in our community. Members of our community encouraged to have their vaccinations when invited;*

***b)*** *Last month saw the launch of our new acute medical model at the Trust. The initiative is supported by NHS England and brings a new model to the Trust for patients with an acute medical need. We hope it will play a major part in tackling winter pressures and reducing*

*ambulance handover times, as it brings a far more comprehensive approach to managing patients on a same day basis.*

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

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

***e)*** *A special event to mark the fifth anniversary of robotic surgery at the Trust in November.*
*We were ahead of the robotic curve when we introduced the programme in 2017 and we were one of the early adopters of the da Vinci Xi technology. Since its arrival, the minimally invasive surgery tool has revolutionised the care we provide to patients.*
*I'm proud to say that the da Vinci robotic training pathway has recently been accredited by the Royal College of Surgeons as one of the safest and most effective robotic training pathways. The team here at Medway has completed this training pathway and is now helping to teach teams at other Trusts along with Intuitive.*
*In addition, the Trust has also been recognised by NHS England for offering gold standard treatment to urology patients by using the robotic system.*

***f)*** *Last month we shared the good news that we are creating capacity to care for frail Swale patients closer to home. We have been working with partners to find ways of providing this much-needed service, and to create more beds within our own hospital for planned operations and treatment.*
*With funding from NHS England, we will use vacant space in Sheppey Community Hospital, creating a frailty ward, primarily for patients living in Swale. The ward will be staffed by a clinical and support team employed by the Trust.*

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

***h)*** *Thank you to members of our community who have taken the time to nominate our colleagues for a Hospital Hero award, which is a part of our annual staff awards.*
*The awards are a lovely way for the Trust to recognise and reward staff who have gone that extra mile or have shown great passion and commitment to improving the working environment for their colleagues and patients.*
*Award winners will be announced at a special event in the New Year.*

**Patient and Staff Experience**

**7. Patient Story – Call for Concern**

Emma Coutts, Lead Nurse Acute Response Team and Amanda Cameron, Senior Acute Response Team Sister presented the Board with the Call for Concern presentation.

Emma Coutts highlighted the following points:

- The Call for Concern initiative is an open, Acute Response nurse-led, programme aimed at supporting the hospital to proactively manage deteriorating patients. The initiative will include the family voice, research has shown us that it is often the family who are able to identify subtle changes in their loved one and raise issues of clinical concern faster than a visiting clinical team.

- The Teams number will be advertised around the Trust and is available 24/7, 365 days a year.
- This initiative has seen a good response in other trusts.
- As well as improving the responsiveness of the team the initiative should improve complaint rates.

**a)** Mark Spragg enquired how much time this approach takes to give each patient sufficient attention. Emma Coutts advised this would depend on the clinical need but approximately one to two hours, a total of three hours a month, based on other trusts.

**b)** Paulette Lewis, Non-Executive Director, commented on the 30 per cent clinical concerns rate, asking what were the key issue or themes. Emma Coutts advised the contact themes were wide ranging.

**c)** Paulette Lewis asked if the clinical concerns will be reviewed. Emma Coutts confirmed every single patient will be audited, looking at themes and trends, breaking down data with an aim for prevention.

**d)** Alison Davis, Chief Medical Officer, commented the Acute Response Team is an integral part of the Patient First Breakthrough Objective for avoiding 2222 (Cardiac Arrest) calls; this links into patients who are deteriorating and clinical concerns, all interwoven.

The Chair thanked Emma and Amanda for a very interesting and insightful presentation.

**8. Council of Governors Update**

David Brake updated the Board on Governor Engagement since October 2022 and outlined a series of interesting events enjoyed by all attending.

David Brake thanked Kim Willsea, Sophie Cawsey and Glynis Alexander for their continued support.

**9. Questions from the Public**

No questions from the public had been received for this meeting.

**Assurance Items**

**10. Board Assurance Framework**

Dan Rennie-Hale, Director of Integrated Governance, Quality and Patient Safety, updated the Board on the Board Assurance Framework (BAF). The Trust has redesigned the BAF and aligned it to the revised Risk Management Framework.

The previous risks have been reviewed and updated to reflect the Patient First True North Domains and Breakthrough Objectives. The paper provides the outcome of the review of the previous BAF and the current proposed risks.

Once approved the BAF will be monitored via the relevant Board Committees. In addition, work is also required to review all risks on the Trust Risk Register scoring less than 15 (as described in the risk management framework) which may impact on the True North Domains.

**a)** Mark Spragg asked which of the Executive groups will review and take action. Dan Rennie-Hale explained how each area will be covered by new Executive Groups reporting into the relevant Board Committees, which will then provide the Board with assurance (either positive or negative), with the full pack coming to the Board every six months.

**b)** Paulette Lewis, Non-Executive Director, commented on the Quality aspect of the BAF, in particular the risk description which refers to timely escalation. Paulette felt it would it be helpful to have a description of how the risk was reduced to give further assurance. For example did the 'call for concern' help with clinical escalation. Dan Rennie-Hale advised the breakdown detail will be included once the Board has approved the new template. The score has been reduced from 25 to 20 due to a reduction in 2222 calls. This is a cautious amendment.

The Board **APPROVED** the new Board Assurance Framework, and noted this will be monitored via the relevant Board Committees.

**11. Trust Risk Register**

Dan Rennie-Hale updated the Board on the content of Trust Risk Register which describes risks for November 2022. The report described the new risks added and the movement of existing risks. The Risks are monitored and actioned by the Executive Committees. More information (deep dive) will be given to those risks that have increased or remained static for a prolonged period.

The Trust Risk Register now has 224 risks. Two risks have been closed down and one reduced to a rating of 12 from the previous month.
Two new risks rated 15 plus have been identified and a decision to approve them will be made at the Risk Compliance and Assurance Group (RCAG) before being added to the Trust Risk Register.

**a)** Mark Spragg congratulated Dan Rennie-Hale on the work to date and asked how we (the board) stand if a Board committee asks for a deep dive in practice. Dan Rennie-Hale advised as the new Quality Integrated Governance Structure is implemented then the Execs will take a more proactive approach and start the work before it is requested.

**b)** Mark Spragg asked how we will address working across Board Committees. Dan Rennie-Hale advised the Integrated Governance Team will be attending with a business partner model that will be managed centrally to look at trends and issues early and reduce duplication.

**c)** Angela Harrison, Governor, asked if there is a programme of internal audit that would complement the deep dives. Mark Spragg commented as Audit and Risk Committee Chair that the Trust has internal auditors who have an agreed annual work plan, they carry out programmed audits and additional audits if required.

The Board **NOTED** the Trust Risk Register.

**12. Committee updates**

**a) Audit and Risk**

Mark Spragg delivered the Assurance report to the Trust Board from the Audit and Risk Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.

**b) People**

Leon Hinton delivered the Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee meeting held 24 November 2022. Leon provided an update on the preparedness for any Strike Action.

**c) Quality Assurance**

Assurance report to the Trust Board from the Quality Assurance Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.

**d) Finance, Planning and Performance**

Alan Davies, Chief Financial Officer presented the report setting out the key discussions held at the Finance, Planning and Performance Report. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts and the operational performance report.

Annyes Laheurte, Non-Executive Director, added a note on the discussion of format of committee paper from Healthcare Financial Management Association (HFMA).

**13. Finance Report**

Alan Davies, Chief Financial Officer, updated the Board on the month 7 Finance Report. The Trust reported a deficit for the year to date (YTD) at the end of October of £7.5m. The planned deficit at this date was £1It was explained that the £6.5m adverse position is largely as a result of unbudgeted escalation capacity remaining open to meet activity demands, however other factors include overspends against medical staffing, clinical supplies and drugs (associated with activity and demand) together with underperformance against the efficiency programme.

The Trust is working with its system partners on a robust forecasting exercise to set out whether we believe we can achieve our control total for the year. This is particularly risky given the YTD performance and ongoing pressures faced.

**a)** Jayne Black, Chief Executive, commented it has been an extremely difficult period, but the Trust is now clear what the deficit drivers are. The *"breaking the cycle"* was an important initiative in addressing the financial position. As an example the Trust closed17 escalation beds during the initiatives' period, although it was noted that these had to be reopened due to heightened activity levels.

Jayne Black also commented that there remained a large number of medically fit for discharge patients in the hospital. The Trust has been working with community and local authority

colleagues to identify the additional capacity needed to improve discharge rates. The resultant schemes will go to ICB this week.

**14. Annual Business Plan (23/24) Development Update**

Many Woodley, Interim Chief Operating Officer, presented the report. The Trust made an early start with its internal business planning, with first draft plans due in 16 December 2022. The plans cover activity, workforce, budgets and strategic priorities.

There has been no national guidance issued at the time of writing. Upon its release the Trust will review and update its own guidance as applicable.

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

**a)** Annyes Laheurte commented, with regards to the Efficiency Programme, it would be good to see that divisions have *"sign-up"* to deliver on the plan and are held accountable.

Jayne Black confirmed the divisions and care groups need to sign their elements of the plan off, with the support of the finance team. They will set targets in terms of their efficiencies.

**15. Edenfield Update**

Evonne Hunt, Chief Nursing Officer, presented the work undertaken by the Trust following the BBC Panorama programme 'Edenfield Secure Mental Health Hospital Review'.

Mark Spragg thanked Evonne Hunt for the report and the assurance to the Board.

**16. Maternity Safety Update**

Alison Herron, Director of Midwifery, highlighted the following reports to the Trust Board:

**a) Kirkup Report**

The report provides an overviewof the recent publication (19 October 2022) of the Dr Bill Kirkup Independent Investigation report of maternity and neonatal services in East Kent Foundation Trust, titled "Reading the Signals".

This overview describes the key recommendations within the Kirkup report for maternity services to review in relation to maternity care provided at Medway NHS Foundation Trust.

An update on the Medway maternity leadership initial review of the Kirkup report and their preliminary priority areas for further deep dive and potential areas of improvement within our services.

- Paulette Lewis, Non-Executive Director, commented, in regards to student concerns raised from a listening event facilitated by the Nursing and Midwifery Council (NMC) .The hospital would be advised to consider culture and behaviour, impacting on delivered care. Information breakdown of the issues raised is needed to triangulate Clinical Negligence Scheme for Trusts (CNST) Kirkup and Ockenden in terms of impact on outcomes for our women in cultural behaviour. How do we reach the population we serve in terms of engaging with the community? In terms of hearing the voice of our senior and junior staff, is this from freedom to speak up and safe areas to speak? Cultural transitioning, we in the organisation need to understate the culture and diversity of those coming into our organisation. It would be good to see retrospective surveys to compare and see improvements.

- Jayne Black commented these are all very good points. The work Alison Herron and her team are doing is incorporating these areas and will need to be reflected.

- Mark Spragg commented it is important to get people to speak honestly and feel safe in doing so, using the correct questioning and that work was currently being undertaken to get to this position.

**b) Clinical Negligence Scheme for Trusts (CNST) Assurance Report**

The report provides an update to the Trust Board on the Maternity Service's progress against compliance with the 10 Safety Actions for CNST Year 4. Maternity had self-certified compliance with all ten Safety Actions. An inspection by Local Maternity and Neonatal Systems (LMNS) quality team had gone through the standards presented, and agreed with us that all 10 had been satisfied and this was concluded in the letter of assurance. Mark Spragg commented that this was an enormous piece of work for Alison Herron, Kate Harris and the Team and a great outcome and the Board expressed its thanks to the Team.

The Board was requested to note the assurance and give approval for the Trust to submit a declaration of full compliance to all 10 CNST standards, to NHS Resolution, by 2 February 2023.

The Board **APPROVED** submission to NHS Resolution.

**c) Ockenden Assurance Report**

This report provides an update to the Trust Board on the Maternity Service's progress against compliance with the initial seven Immediate and Essential Actions (IEAs) from the preliminary findings Ockenden report (2020) along with the 15 IEAs from the final Ockenden report (2022).

- Mark Spragg enquired, why the shortage of Occupational Health nurses noted as a risk in the Risk Register is not included.

- Leon Hinton, Chief People Officer, advised there had been capacity issues with conducting pre-employment checks for nurses and midwives but this has been rectified and is no longer an issue. Leon committed to update the Risk Register to reflect the new position.

**d) Perinatal Quality Surveillance Tool Report – December 2022**

The report provides an update and assurance to the Trust Board on the quarterly Perinatal Surveillance Data. The Care Quality Commission (CQC) arrived last Monday, with five inspectors and held interviews on Friday with senior staff. The findings from the visit are awaited. (Approx. eight weeks.)

The Board thanked Alison Herron and her team for the work they had undertaken to get Medway Maternity to where it is currently.

**17. Infection, Prevention and Control Update**

Evonne Hunt, Chief Nursing Officer, presented the report to the Board.

NHS England (NHSE) introduced the BAF to support Infection Prevention and Control (IPC) improvements and changes during the COVID pandemic. The version that the Trust developed as an IPC Improvement plan was published on 24 December 2021.

Subsequently NHSE released a revised guidance following the *"Living with COVID"* measures to continue and support service recovery: Issued 28 September 2022 published 15 October 2022.
The changes identified would be consolidated with the existing improvement plan.
There were 216 actions identified within the Trust's 2021 IPC improvement plan. To date, 159 actions have been fully implemented, 57 remain overdue awaiting full implementation.
Following the consolidation of the 2021 improvement plan with the September 2022 publication, the Trust now has a total of 145 actions, 38 remain overdue awaiting full implementation. These have been broken down against the Trust's Patient First True North Domain.

The update has been agreed at IPC Group and Quality and Patient Safety Sub-committee.
Work has already started on completing the overdue actions as for the actions to be completed in November and December 2022

**a)** Angela Harrison, Governor, commented, as there is no requirement for people to test for Covid before entering the hospital, could the hospital state this as a statutory requirement, setting reasonable rules.

Evonne Hunt confirmed the hospital continue to follow NHSE guidance, in line with *"living with Covid"*. The hospital continues to encourage individuals to wear masks in clinical areas, this is a requirement for clinical staff.

**Quality, Performance and Items for Escalation or Decision**

**18. Integrated Quality Performance Report (IQPR)**

Mandy Woodley, Interim Chief Operations Officer, Evonne Hunt, Chief Nursing Officer and Alison Davis, Chief Medical Officer presented the IQPR to the Board for their subsequent areas.

**a)** Jo Palmer enquired about the number of 40 week patients. Mandy Woodley advised that the pathway has been reviewed and improved and is positively managed. Following the review some patients were reduced down as the 40 week was not an accurate picture. There have been some delays in workforce and community services.

**b)** Jo Palmer commented on the Patient Harm Review. Mandy Woodley confirmed a review has taken place by the hospital and Community Health. The results have been reported to both organisations.

**c)** Mark Spragg commented on the c-section rates increasing and asked what had happened to the work being undertaken to get to the root cause of the increase. Evonne Hunt confirmed this will be followed up and a review to go to the Quality Assurance Committee (QAC).

**d)** Jo Palmer commented the IQPR was reviewed at QAC, and agreed this would be the last time seeing the old format. The IQPR will be reviewed quarterly by the Trust Board. The Board Committee will review the IQPR for monthly monitoring.

The Board **APPROVED** the new format and frequency for Monitoring and Review.

**e)** Paulette Lewis, Non-Executive Director, commented on the work to address pressure ulcers. Evonne Hunt advised the hospital continues to work with the Health and Care Community involving GPs – some promotional work still needs to be done.

**f)** Paulette Lewis noted the raise in hypoxia, relating back to ED.

**19. Winter Plan/ Nursing and Midwifery Safer Staffing**

Jayne Black highlighted the following aspects of the report:

- Series of workshops to review and predict the activity levels for this winter
- There are a number of elements that need to pull out around demand and capacity monitoring.
- Medically fit and initiatives working with the system to reduce bed occupancy to 92%.
- Schemes and plans in place – Sheppey Frailty Unit (Minster ward), virtual wards, acute medical model.
- Pieces around mental health and support given within community setting.
- Risk and mitigations – workforce, industrial action
- Care providers area  risk with capacity – system work taking place
- Ambulance handovers – improvements to maintain.
- Protect Cancer and Emergency patients.
- Being reviewed on a daily/weekly basis.

**20. Business Case Sheppey Ward**

The report was presented by Alan Davies, Chief Financial Officer.  Owing to a challenging project timeline this paper was presented and approved at an extraordinary Board meeting on 9 November 2022 and is brought to this meeting as the first opportunity to present the paper and decision to the  Public Board.

The report sets out the business case and strategic plan for the relocation of the Harvey ward on the Medway Maritime Hospital site to Sheppey Community Hospital (Minster Ward).

This would involve a “lift and shift” of the current Harvey ward with staff and support services providing care at Minster, with a view to eventually taking direct from the Emergency Department to avoid admission into the acute trust.

An illustration of finance and activity are presented through this Business Case and the project plan will be updated with opportunities(including NHS Property Services plans).

**a)** Mark Spragg asked about page 2 of the report stating on the 20 September 2022 version 0.9 was presented to the Exec Management Board but declined. Alan Davies advised the proposal had gone through various further amendments and was subsequently approved; the Executive Management Board was assured all financial areas have been reviewed and completed.

**b)** Post Meeting: the table was updated with the dates of approval by exec management boards. **ACTION TB/010/2022:** Date of when the subsequent approval for the business case was received to be added to the business case review – and minuted for this meeting.

**c)** Jayne Black commented on the good initiative for the hospital, especially for frailty patients, which complements and extends the frailty model. The initiative has been delayed until January 2023, however the staffing review has been completed. To note, the process to identify funding to open the ward on the Medway site for elective capacity is to be worked through with the ICB.

**d)** Angela Harrison, Governor, said that this was on her “patch” and that she had received great feedback from her constituents about the initiative which was really welcomed.

The Board **RATIFIED** the Business Case for Sheppey Frailly Unit.

## Closing Matters

### 21. Any Other Business

Mark Spragg advised the Board of the two reports presented for information only:

- Organ and Tissue Donation Annual Report 2021-22 and strategy 2022-23
- Medical Education Annual Report.

**a)** Jo Palmer advised the Organ and Tissue Donation report had been scrutinised in detail at the Quality Assurance Committee.

Alison Davis commented the report was a huge amount of work; a complex area with a lot of challenges.

**b)** Alison Davis advised the Medical Education report had been through the People Committee; to note the hard work from Medical Education and collaborative work to give students the best possible learning opportunities.

**c)** Jayne Black advised the Board, Mandy Woodley will be leaving the hospital on 6 January 2023 as Interim Chief Operations Officer. The Board will be updated, in due course, on a replacement. The Board thanked Mandy for her work during her Interim position at the hospital.

**22. Board Review of Meeting**

- Approved submission of full compliance for all 10 CNST standards to the NHSR
- Approved new format and monitoring frequency for IQPR – Agenda Item 18
- Approved of Business Case for Sheppey Frailty Unit – Agenda Item 20

**23. Date of next meeting: 01 February 2023**

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 15 December 2022

Signed …….. Date …….

# Board of Directors in Public
# Action Log

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

**Actions are RAG Rated as follows:**

| Meeting Date | Minute Ref / Action No | Action | Action Due Date | Owner | Current position | Status |
|---|---|---|---|---|---|---|
| 15.12.2022 | TB/010/2022 | Add date of Exec team approval for Sheppey Business case to business case review and minute at next board meeting. | 01.02.2023 | Company Secretary | Completed | Green |
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NHS
Medway
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## Chief Executive's Report – February 2023

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.

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This is the first board meeting of 2023, which feels like an appropriate moment to reflect on the last 12 months.

We are proud to be at the centre of our community and throughout 2022 our hard-working colleagues continued to serve the residents of Medway and Swale with great professionalism and compassion. I would like to thank all our staff for their outstanding commitment to providing care of the highest quality to our patients.

It was an extremely busy year at the Trust, and during the year we provided 553,000 outpatient appointments, 87,000 inpatient admissions, cared for more than 144,000 patients in our Emergency Department, performed more than 3.8 million scans and delivered more than 4,600 babies.

I would also like to take this opportunity to thank our community for their ongoing support and patience – we've asked a lot of them over the last year. Thank you to patients and visitors for helping us to keep our hospital safe by following infection control measures on our site, for understanding when we had to make the difficult decision to bring in visiting restrictions, and for being patient when at times the waits for care were longer than any of us would have liked.

### Pressure on hospital services

For a number of weeks, we have experienced significant demand for our services and challenges with discharging medically fit patients, plus an increase in the number of patients with flu, COVID-19 and other respiratory conditions.

This led to us taking the very difficult decision to declare a Critical Incident at the end of last year. Thanks to the incredible efforts of staff we were able to stand this down quickly. I would like to thank patients, who had appointments cancelled, for their understanding during this very challenging time.

## Recent media coverage

In recent weeks the Trust has been the focus of media coverage relating to long patient waits and incidences where patient care has not been to the level we would wish to provide. I would like to apologise to any patients who have received care that is not to our usual standard.

Patient safety is always paramount and where we have provided care to a lesser standard, no matter what the extenuating circumstances, we will learn from these patient experiences. Our patients have every right to expect the highest level of care, and our staff are working hard to provide that.

There is no doubt it has been an incredibly busy time at the Trust, and I would ask our community to continue to support us by choosing the most appropriate location for their care, ensuring that we can keep the Emergency Department free for our most acutely unwell patients.

## Providing care closer to home for frail patients in Sheppey

I'm delighted to say that the Sheppey Frailty Unit is now beginning to care for patients closer to their homes.

We have used vacant space in Sheppey Community Hospital, to create a frailty unit, primarily for patients living in Swale. The unit is staffed by a clinical and support team employed by the Trust. Most patients who live in Medway and need care within a specialised frailty setting will continue to be looked after at Medway Maritime Hospital.

Creating beds in Sheppey also helps us to free up capacity within Medway enabling us to allocate further beds for planned operations and treatment.

## The next steps for Patient First

We are now preparing to roll out the next wave of Patient First in the coming weeks. Our focus will be on increasing the number of discharges that take place before noon, reducing the number of patients waiting for their first appointment at the hospital and reducing overspend in departmental budgets.

In response to feedback from the first wave, we are taking a different approach to the training and coaching that needs to be undertaken in preparation for using Patient First. We have recognised that classroom-based sessions can be difficult to coordinate and commit to, so this time we will be offering a more condensed package that comprises fewer classroom sessions and introduces digital learning that can be accessed in a more flexible way.

We are confident this will make the experience easier for all and it will of course mean more teams can get on board more quickly, so Patient First will roll out at a faster pace across the Trust than we originally planned. This is an exciting time and I look forward to welcoming our new cohorts.

## Makeover for ward

At the end of December, we were delighted to begin caring for patients in our new and improved Keats Ward, which has undergone a £1.4million makeover.

The 26-bedded ward provides a clinically suitable and comfortable environment for patients to receive acute inpatient care and treatment. The staff working on the ward also benefit from a modern, clean and organised workspace to deliver the best of care to patients, as well as a designated well-equipped staff area for colleagues to enjoy refreshments during break times and rest periods during busy shifts.

## Trust launches new patient safety initiative

A new patient safety initiative to help prevent the clinical deterioration of patients on wards, has been launched by the Trust.

Call 4 Concern (C4C) enables inpatients staying at the hospital and their friends and family, to call a dedicated number 24/7 for immediate help and advice, directly from a member of the Trust's Acute Response Team, if they still have ongoing concerns about a patient's changing condition despite raising their concerns with the nurse in charge or doctor.

A member of the team will then visit the patient on the ward to discuss any concerns and assess the situation before liaising with the patient's medical team and other healthcare professionals as needed, to discuss further treatment options. A note of the C4C intervention will then be logged in the patient's notes summarising the concern raised and any actions taken.

Our staff work extremely hard to provide the very best of care to our patients, but we also recognise that at times the patient or a close friend or loved one can see that something is wrong before we can.

While we already have robust systems and processes in place to detect when a patient's condition worsens, Call 4 Concern is another layer of reassurance for our patients and their families and shows our commitment to providing safe, compassionate and joined up care.

## Changes to vascular surgery approved

A public consultation was held last year on plans to provide a safe and sustainable vascular service across Medway, east Kent and Maidstone in the medium term.

The feedback from the public consultation showed a clear mandate for change and broad support for a single vascular inpatient centre at Kent and Canterbury Hospital in Canterbury.

Those plans have now been approved by NHS commissioners, provider trusts and Kent and Medway's joint health scrutiny committee which means all vascular surgery requiring an overnight stay in hospital will move to Kent and Canterbury Hospital early next year. Day surgery will continue here at Medway and also at Kent and Canterbury Hospital.

Outpatient appointments and diagnostic tests will continue here at Medway as well as hospitals in Ashford, Canterbury, Margate, and Maidstone.

Vascular services reconstruct, unblock or bypass arteries and are often one-off specialist procedures to reduce the risk of sudden death or amputation and prevent stroke.

Evidence shows that patients who need vascular treatment receive better care and have a better chance of survival when they are treated by a team of vascular surgeons, interventional radiologists, nurses, and therapists, who treat large numbers of these patients.

In January 2020 abdominal aortic aneurysm (AAA) surgery temporarily moved to Kent and Canterbury Hospital to ensure the service could remain safe and sustainable. The rest of the inpatient vascular service will transition to Kent and Canterbury Hospital from Medway in a phased way this year.

**Maternity Patient Survey**

Last month the Care Quality Commission (CQC) published the results of the Maternity Survey for 2022.

Medway is one of 65 organisations that took part in the annual survey. It captures the views of people who gave birth during February 2022 and asks about all aspects of their maternity care experience from the first time they saw a clinician or midwife, during labour and birth, through to the care provided at home in the weeks following the arrival of their baby.

I'm pleased to say that the Trust has improved in 12 areas in comparison to the previous year. Our results showed that our positive response rate was better than the national average in 22 areas and that we'd stayed the same in 10 areas compared to the 2021 results.

Our maternity services team is currently working through an action plan to address some of the areas where the Trust didn't score as highly as it would have liked.

Thank you to the team for their continuing commitment to providing a safe and caring environment for everyone who accesses our maternity services.

**Communicating with colleagues and the community**

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

## Photo gallery




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# Communications update

February 2023

**140,000**
*total social media impressions*

**340**
*media mentions*


Best of care
Best of people

# Meeting of the Public Committee/Trust Board
# Thursday, 19 January 2023

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Nutrition and Hydration presentation | | **Agenda Item** | 7 |
| **Author** | Eilidh Smith – Lead Nutrition Nurse<br>Amelia Lythgoe – Lead Dietician<br>Nikki Lewis – Associate Director of Patient Experience | | | |
| **Lead Executive Director** | Evonne Hunt, CNO | | | |
| **Executive Summary** | 1. To note that the steering group work was paused during the long period of business continuity<br>2. Actions and countermeasures remain static since November, however work has commenced on the trial for NGPOD<br>3. Weekly MUST scores and compliance with Protected mealtimes have improved in the last reporting period based on the documented audits<br>4. MUST scores on admission and care plan actions / interventions are static<br>5. A training needs analysis is required for all grades of clinical staff. Work is to commence with the newly appointed DCMO to provide a work plan to resolve training and competency<br>6. Risks include prolonged business continuity and housekeeping staff issues | | | |
| **Proposal and/or key recommendation:** | | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | X | Approval | |
| | Noting | X | Discussion | X |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | Patient Experience Group<br>Quality and Patient Safety Committee | | | |

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

| | | | | | |
|---|---|---|---|---|---|
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: X | Effective: X | Caring: X | Responsive: | Well-Led: |
| **Identified Risks, issues and mitigations:** | • Prolonged period of business continuity led to the rescheduling of the proposed meetings to progress work and actions<br>• Activity pressures within trust impacting on performance.<br>• Dietetic staffing on risk register<br>• Reduced time by dietetic lead / nutrition nurse to analyse / theme and action DATIX reports | | | | |
| **Resource implications:** | n/a | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | n/a | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ Not applicable (*please indicate why an equality assessment was not required)* | | | | |
| **Legal and Regulatory implications:** | | | | | |
| **Appendices:** | | | | | |
| **Freedom of Information (FOI) status:** | State either:<br><br>This paper is disclosable under the FOI Act | | | | |
| **For further information or any enquires relating to this paper please contact:** | Nikki Lewis<br>Nicola.lewis18@nhs.net | | | | |
| **Reports require an assurance rating to guide the discussion:** | | | | | |
| | No Assurance | | There are significant gaps in assurance or actions | | |
| | Partial Assurance | x | There are gaps in assurance | | |
| | Assurance | | Assurance minor improvements needed. | | |
| | Significant Assurance | | There are no gaps in assurance | | |
| | Not Applicable | | No assurance required. | | |

**Meeting:** Public Board **Agenda Item 7**

**Date:** 01/02/2023

**Title:** Nutrition and Hydration presentation

## Introduction

This presentation reports on information gathered from audit data and experience in relation to nutrition and hydration outcomes from in-patients at Medway NHS Foundation Trust based on the National Institute of Clinical Excellence (NICE) guidance and Care Quality Commission (CQC) regulatory requirements as follows:

Screening, care planning, guidance on food and beverage services, monitoring arrangements for food and drinks provision, observing protected mealtimes, training and competencies for all staff, food and hydration provision out of hours, nutrition and hydration policy and frameworks safe delivery and provision of food and drinks and a Multi-disciplinary team (MDT) approach to improvements.

The aim is for Malnutrition Universal Screening Tool (MUST) score completion more than 95%. Reduction in Nasogastric (NG) feed delays and related incidents to less than 10%. Improvement in Friends and Family test (FFT) and survey feedback. To reduce incidents of nasogastric feed (NG) related never events to 0. To evidence compliance with all elements with the CQC 10 core standards.

## Current Status

The data to support the current status can be found in the A3 project document which is included in the presentation.

## Goal / Aims

The aim is for Malnutrition Universal Screening Tool (MUST) score completion more than 95%. Reduction in nasogastric feed delays and related incidents to less than 10%. Improvement in friends and family test and survey feedback. Reduce incidents of nasogastric feed related never events to 0. To evidence compliance with all elements with the CQC 10 core standards.

## Countermeasures

1. Weekly visits from Catering teams to identify and rectify quick wins. Review of housekeeping procedures and communication.
2. To commence digital food ordering, education and training for housekeepers and ward staff in regards to documentation / fluid charts
3. Trial to commence for ‘NGPOD’ to accurately test pH on the gastroenterology ward
4. Bespoke training to be delivered on each ward by the dietetics team and newly recruited international nurses

5. To implement mandatory training and a delivery plan for MUST, NG placement, Testing with the support of the Deputy Chief Nursing Officer
6. Review and development of Care support workers and Registered Nurses Nutrition and Hydration competencies

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# Nutrition and Hydration

## December 2022

**Amelia Lythgoe, Eilidh Smith, Nikki Lewis**

Patient FIRST

# Executive Summary

- To note that the steering group work was paused during the long period of business continuity
- Actions and countermeasures remain static since November, however  work has commenced on the trial for NGPOD
- Weekly MUST scores and compliance with Protected mealtimes have improved in the last reporting period based on the documented audits
- MUST scores on admission and care plan actions / interventions are static
- A training needs analysis is required for all grades of clinical staff. Work is to commence with the newly appointed DCMO to provide a work plan to resolve training and competency
- Risks include prolonged business continuity and housekeeping staff issues

# Title: Nutrition and Hydration

**SRO Nikki Lewis**

NHS Medway NHS Foundation Trust

## 1) Problem Statement

**Patients are not provided or receiving all 10 aspects of good nutrition and hydration whilst in our care at MFT. The 10 characteristics set out by NHSE include;**

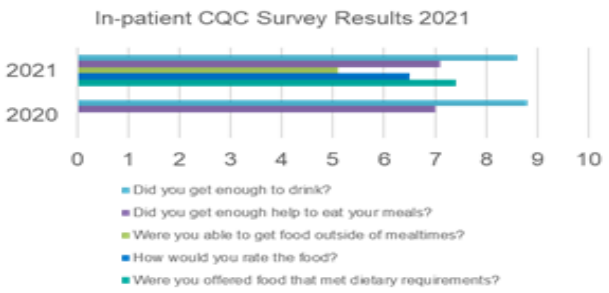
**Screening, care planning, guidance on food and beverage services., monitoring arrangements for food and drinks provision, observing protected mealtimes, training and competencies for all staff, food and hydration provision out of hours, nutrition and hydration policy and frameworks safe delivery and provision of food and drinks, MDT approach to improvements.**

**EPR and EPMA changes since implementing the system has highlighted incomplete documentation and risk assessment associated with Nutrition and Hydration. Malnutrition universal screening tool (MUST) is used for assessing patients who may be at risk to identify any interventions required.**

## 2) Current Situation

December 2022

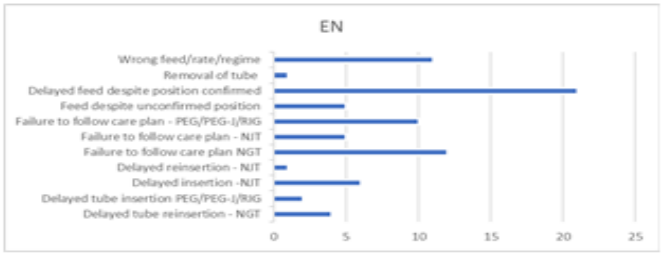

- Reduction in MUST score assessment compliance
- Increase in weekly MUST monitoring
- Large increase in the compliance with protected mealtimes




High rate of poor experiences in relation to

- choice
- access
- Assistance

This is based on the feedback from the 2021 CQC in-patient survey



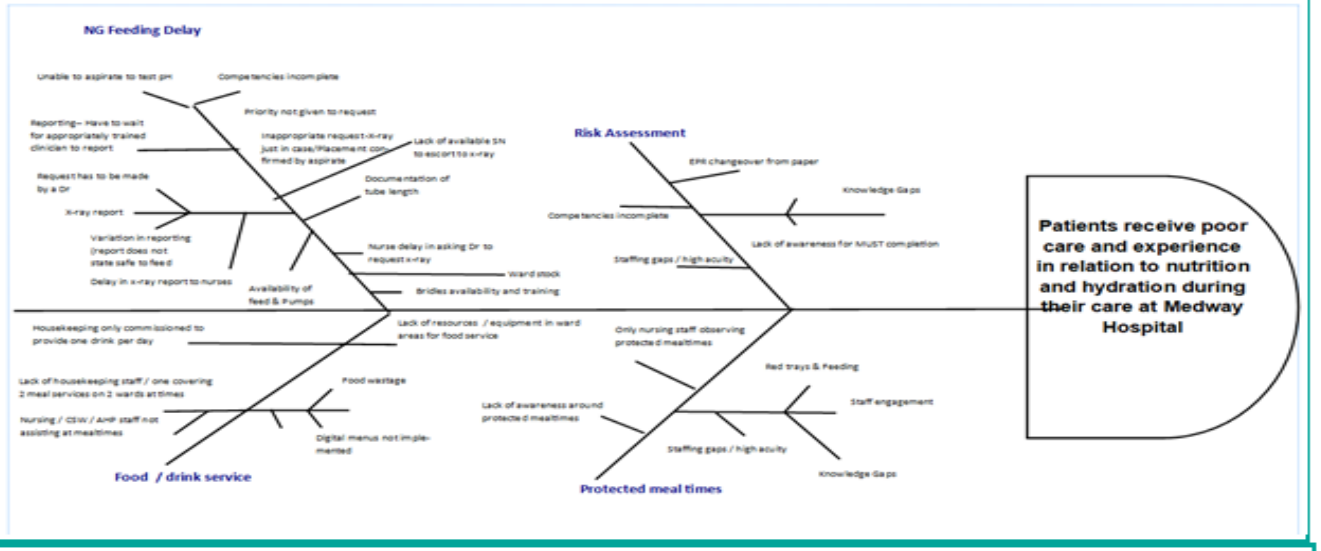

Incidents attributed to delays in NG feeding. The largest contributors are;

- Delay despite position confirmed
- Wrong feed / rate / regime
- Failure to follow care plan

## 3) Vision / Goals

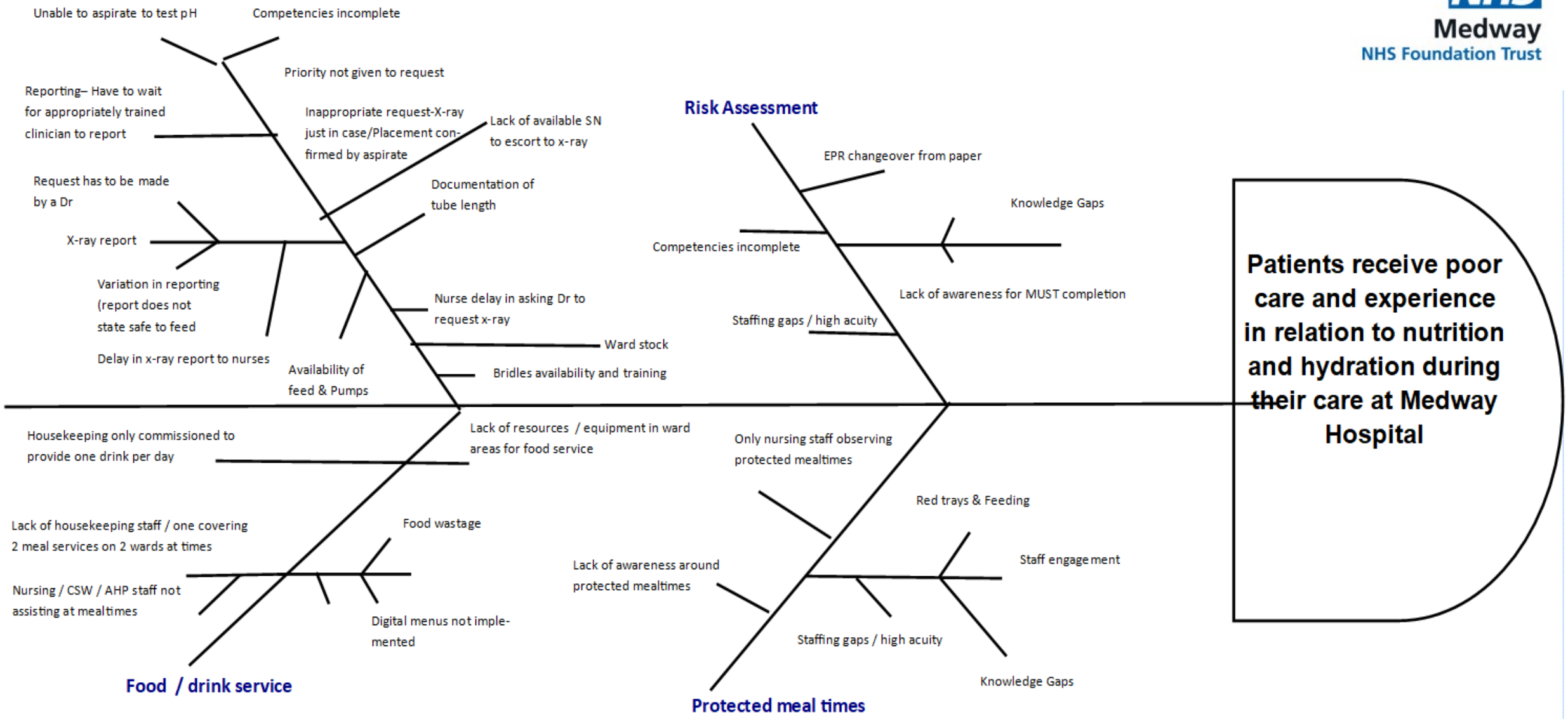
MUST score completion >95%. Reduction in NG feed delays & related incidents to less than 10% . Improvement in FFT and Survey feedback. Reduce incidents of NG related never events to 0. To evidence compliance with all elements with the 10 NHSE core standards

## 4) Root Cause



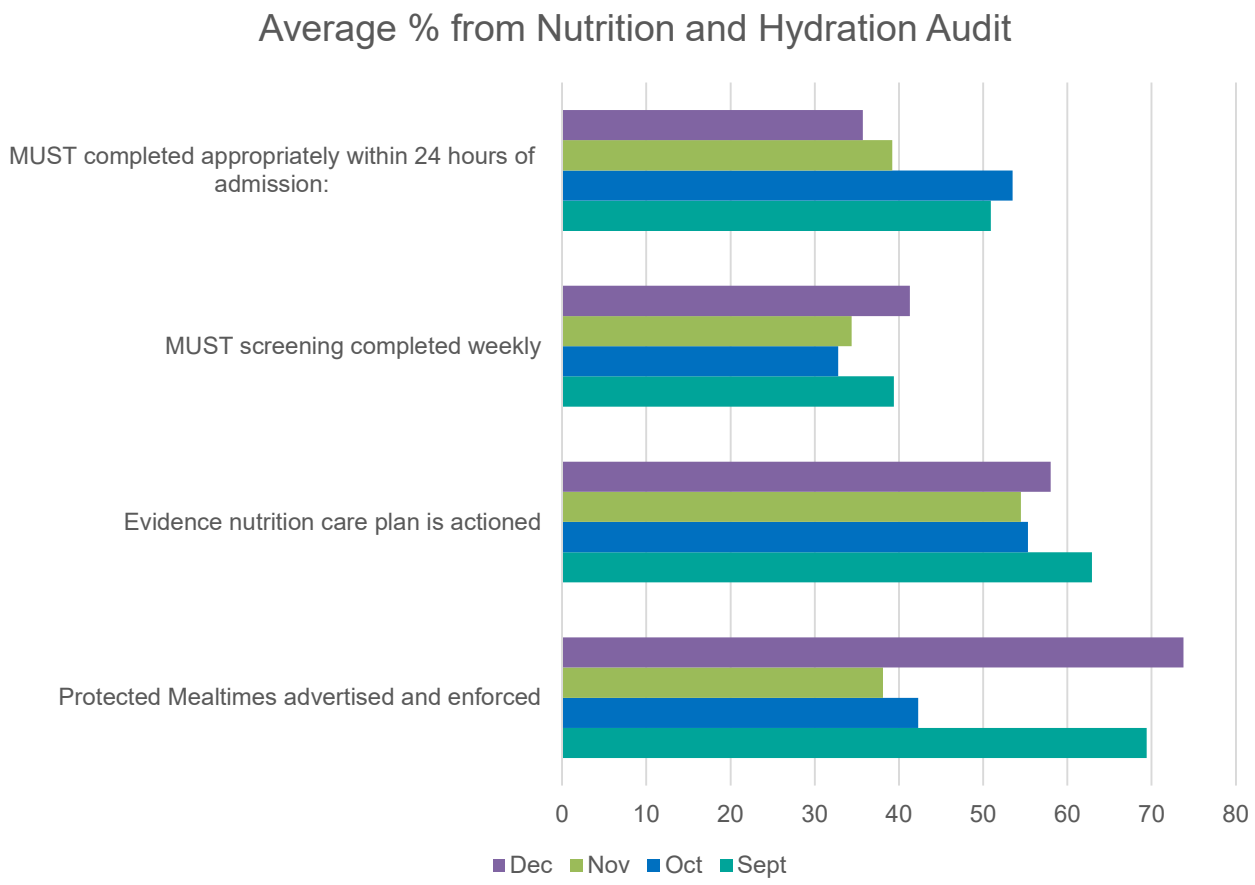

## 5) Countermeasures

| Action Date | Root Cause | Countermeasure | By Who | Status | Comments/ |
|---|---|---|---|---|---|
| Nov 22 | Inconsistent food service & lack of equipment | Weekly visits from Catering teams to identify and rectify quick wins. Review of housekeeping procedures and communication . | Catering | Ongoing | Improve |
| Nov 22 | Unable to quantify consumption meals / drinks | To commence digital food ordering, education and training for housekeepers and ward staff in regards to documentation / fluid charts | Catering / housekeepers / wards teams | In progress | Improve |
| Dec 22 | Delay in NG Tube Placement | Trial to commence for NGPOD to accurately test pH on the gastroenterology ward | ES | In-progress | Action |
| Dec 22 | Compliance with MUST scores poor | Bespoke training to be delivered on each ward by the dietetics team and newly recruited international nurses | Dietetics | Ongoing | Improve |
| Jan 22 | Scattergun approach with training and education | To implement mandatory training and a delivery plan for MUST, NG placement, Testing with the support of the DCNO | NL | Outstanding | Action |
| Jan 22 | Poor oversight for staff competency | Review and development of CSW & RN Nutrition and Hydration competencies | NL/ES/AL | Outstanding | Action |


Unable to aspirate to test pH
Competencies incomplete
Priority not given to request
Reporting– Have to wait for appropriately trained clinician to report
Inappropriate request-X-ray just in case/Placement con-firmed by aspirate
Lack of available SN to escort to x-ray
Request has to be made by a Dr
Documentation of tube length
X-ray report
Variation in reporting (report does not state safe to feed
Nurse delay in asking Dr to request x-ray
Delay in x-ray report to nurses
Ward stock
Availability of feed & Pumps
Bridles availability and training
Housekeeping only commissioned to provide one drink per day
Lack of resources / equipment in ward areas for food service
Lack of housekeeping staff / one covering 2 meal services on 2 wards at times
Food wastage
Nursing / CSW / AHP staff not assisting at mealtimes
Digital menus not imple-mented
Food / drink service
Risk Assessment
EPR changeover from paper
Knowledge Gaps
Competencies incomplete
Lack of awareness for MUST completion
Staffing gaps / high acuity
Only nursing staff observing protected mealtimes
Red trays & Feeding
Staff engagement
Lack of awareness around protected mealtimes
Staffing gaps / high acuity
Knowledge Gaps
Protected meal times
Patients receive poor care and experience in relation to nutrition and hydration during their care at Medway Hospital

# Nutrition and Hydration

**Ambition:** Improvement in Nutrition and Hydration standards in Trust
**Goal:** 95% patients screened for malnutrition risk within 24 hours of admission




## Key Messages:

- Current standards below recommended standards as per CQC regulation 14, Hospital Food Standards, NHS England 10 key characteristics good nutrition care, NICE CG32

## Issues, Concerns & Gaps:

- MUST screening 38%, target 95%, Care plan to be actioned- current 41%, protected mealtimes enforced in 64% of wards, target 100%
- Business continuity has halted the progress of the steering group
- Staffing within the hostesses team

## Actions & Improvements:

- Work streams as part of Nutrition and Hydration group working in these 3 areas (screening, implementing nutritional care plans, food and drink provision). Due to business continuity not met in Dec 22
- Nutrition Nurse is working with Procurement to commence a trail for NG pH testing

# SIOR

Nutrition and Hydration

NHS Medway NHS Foundation Trust

## Successful Deliverables

- MUST training and feeding tube care training delivered to all International nurses
- Bespoke ward training delivered on 3 wards last month
- Monthly GTHR audits to capture data
- MUST completion scores ~stable,

## Identified Challenges

- Priority of nutritional screening with high work loads.
- Competency and confidence of staff to manage artificial feeding tubes.
- Staffing levels for hostess / catering teams

## Opportunities

- MDT working to improve nutrition and hydration through N&HSG and A3 projects
- Improvement in recruitment but newly qualified/ international / return to practice staff needing supervision until able to work independently.
- More dietetic support for the 3 work streams as part of A3

## Risks

- Improvement work delayed due to bed pressures
- Dietetic staffing numbers low
- Reduced time by dietetic lead / nutrition nurse to analyse themes and issues

| |
|---|
| **Meeting: Quality Assurance Committee**<br><br>**Date:** Tuesday, 20 December 2022 |
| **Title:** Assurance Report |
| **Introduction** |
| Update from QAC meeting held 20 December 2022.<br><br>Assurance report gives key headlines from the meeting with rag rated assurance levels.<br><br>The report gives details of escalation comments to the Trust Board. |
| **Current Status** |
| N/A |
| **Goal / Aims** |
| To give the Board assurance the QAC is fulfilling its responsibilities and designated authorities |
| **Countermeasures** |
| Escalations to the Board |

# Committee Assurance Report – agenda item: 9

# Meeting of the Trust Board (Public)
# Wednesday 1st February 2022

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Quality Assurance Committee – Assurance Report | | **Agenda Item** | 9 |
| **Author** | Joanne Adams, Business Support Manager | | | |
| **Lead Executive Director** | Evonne Hunt, Chief Nursing Officer | | | |
| **Executive Summary** | Assurance report to the Trust Board from the 20 December 2022, Quality Assurance Committee, ensuring all nominated authorities have been reviewed and approved.<br>The report includes key headlines from the Committee, and papers to be escalated to the Board. | | | |
| **Proposal and/or key recommendation:** | The Committee approved the following papers for onward sharing with Trust Board:-<br><br>The Committee inform the Board on the following points:- | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | X | Approval | |
| | Noting | | Discussion | |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | N/a | | | |

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

| | |
|---|---|
| **Identified Risks, issues and mitigations:** | NIL |
| **Resource implications:** | NIL |

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

| Key headlines | Assurance Level (use appropriate colour code as above) |
|---|---|
| **1. Research and Innovation Annual Report**<br>The committee received the research and innovation annual report. The report provided an update on the performance of research and innovation for the period 1 April 2021 to 31 March 2022.<br>The report provided details of research trials, impact of research and changes to practice and patient care, funding and joint activity with Canterbury Christ Church University, University of Greenwich and Kent Medical School, engagement in the local community and the plans for the Trust working to achieve University status.<br>The committee was pleased to see such a diverse portfolio of research with the trust amongst the top 10 NHS organisations for research, for last year out of 850 research active trusts, Medway was ranked 81st and in terms of patient recruitment the trust was amongst the top 4%. The trust is the top recruiter for the eighth consecutive year in recruitment to cancer research. The trust has more than 182 research staff and more than 23 specialties involved in research.<br>The committee was informed of future research plans for next year and the annual research and innovation conference. | Green |
| **2. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report**<br>The committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Wednesday 14 December 2022.<br>The committee was assured by the report which provided a summary of the discussions, the things QPSSC is assured about and those where further work is required. | Green |
| **3. Integrated Quality Performance Report (IQPR)**<br>The committee received the integrated quality performance report in its new format.<br>The committee expressed its concern that the report provided was incomplete and had been circulated on the morning of QAC.<br>The committee raised an action to formally escalate its concern to the Business Intelligence Team on how the IQPR is produced along with the | Red/Amber |

| | |
|---|---|
| timeframes for data being approved and narrative submitted to Quality and Patient Safety Sub-Committee as the first point of validation along with Trust Management Board.<br><br>The committee noted that there is further work required to develop the IQPR in terms of setting targets and reporting metrics. | |
| **4. Quality Account Update**<br>The committee received the quality account update paper which sets out the timeline for the production of the quality account.<br><br>The committee was informed that following a change last year foundation trusts are required to produce a separate quality account in the past it formed part of the annual report.<br><br>The committee was advised that NHS England will confirm the process and data dictionary for what is required in the report and there is also no requirement for external assurance of the quality account.<br><br>The committee was informed that additional papers to provide assurance on legal compliance with the quality account will be submitted to Audit and Risk Committee.<br><br>The committee **APPROVED** the quality account update paper. | Green |
| **5. 8x8 Dropped Calls**<br>The committee received and discuss the 8x8 dropped calls paper which had been requested following an increase in call volume in the PALs and Complaints team and through Switchboard from the introduction on the 8x8 telephony system.<br><br>The committee was informed that the project for 8x8 was disbanded in May 2021 and 8x8 phone system was handed over as business as usual. However there is no monitoring of performance and ownership is required.<br><br>The committee agreed that the 8x8 paper should be taken to the Trust Management Board for a decision of where this sits in the organisation for oversight and monitoring of performance.<br><br>The committee acknowledged some actions from the project group are outstanding and recognised that staff may need training to gain confidence in answering phone calls and the potential for dealing with difficult conversations.<br><br>The Chief Medical Officer will take the paper to the Trust Management Board. | Red/Amber |
| **6. Risks and Escalations to Board**<br>The quality assurance committee escalates the following matters to Board:-<br>• No new risks identified | |

| | |
|---|---|
| • 8x8 abandoned calls to be discussed at TMB for a decision on ownership of monitoring phone call performance.<br>• Timely production of the IQPR report<br>• On-going work to address increase to HSMR and SHIMI | |

# Committee Assurance Report – agenda item 9

**Meeting: Quality Assurance Committee**

**Date:** Tuesday, 24th January 2023

**Title:** Assurance Report

## Introduction

Update from QAC meeting held Tuesday, 24th January 2023.

Assurance report gives Key Headlines from the meeting with rag rated assurance levels.

The report gives details of escalation comments to the Trust Board.

## Current Status

N/A

## Goal / Aims

To give the Board assurance the Quality Assurance Committee is fulfilling its responsibilities and designated authorities

## Countermeasures

Escalations to the Board

# Meeting of the Trust Board (Public)
# Wednesday 1st February 2022

| | | | |
|---|---|---|---|
| **Title of Report** | Quality Assurance Committee – Assurance Report | **Agenda Item** | 9 |
| **Author** | Joanne Adams, Business Support Manager | | |
| **Lead Executive Director** | Evonne Hunt, Chief Nursing Officer | | |
| **Executive Summary** | Assurance report to the Trust Board from the Quality Assurance Committee held on Tuesday 24th January 2023, ensuring all nominated authorities have been reviewed and approved.<br><br>The report includes key headlines from the Committee, and papers to be escalated to the Board. | | |
| **Proposal and/or key recommendation:** | The Committee approved the following papers for onward sharing with Trust Board:-<br>• Maternity Digital Strategy<br><br>The Committee inform the Board on the following points:-<br>• Data issue for whole trust<br>• HSE notice<br>• Potential CQC visit<br>• Backlog of SARs and FOI<br>• 2013 Sharps directive<br>• timeliness of reporting RIDDOR<br>• impact of business continuity on meetings and mandatory training | | |

| | | | | |
|---|---|---|---|---|
| **Purpose of the report (tick box to indicate)** | Assurance | √ | Approval | |
| | Noting | | Discussion | |

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

| | | | | | |
|---|---|---|---|---|---|
| **Committee/Group at which the paper has been submitted:** | N/a | | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) √ | Priority 4: (Quality) √ | Priority 5: (Systems) |

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

| Key headlines | Assurance Level (use appropriate colour code as above) |
|---|---|
| **1. Assurance and Escalation report from Quality and Patient Safety Sub-Committee (QPSSC)**<br>The committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Thursday 19 January 2023.<br>The committee was informed of the discussions taken place at QPSSC about the impact of business continuity when stepping down meetings and mandatory training, this had been escalated from the assurance and escalation reports from Safeguarding Assurance Group, Nutrition and Hydration and Patient Experience Group. The committee will escalate to Board.<br>QPSSC escalated:<br>• Risk of sharps management.<br>• Likelihood of a CQC inspection following an increase in CQC enquiries.<br>• Impact of business continuing on standing down meetings and cancelling mandatory training.<br>The committee were assured by the report which provided a summary of the discussions, the things QPSSC are assured about and those where further work is required. | Green |
| **2. Integrated Quality Performance Report (IQPR)**<br>The committee was advised that the IQPR is not correct, some data and reporting metrics were not included and some of the information is un-validated. The IQPR was not discussed due to these issues.<br>The committee expect to receive a full validated report at the next meeting. | Red |
| **3. Quality Risk Register**<br>The committee received the quality risk register paper which provided a status position of risks that have been categorised as having an impact on our quality or our patient safety.<br>There are 115 risks with some dating back to 2019 and 2020 and these risks will be reviewed to see if they are still risks.<br>The committee will receive the Quality Risk Register for review on a monthly basis. | Amber |
| **4. Quarter 3 Integrated Quality Performance Report**<br>The committee received and discussed the quarter three integrated quality | Amber |

| | |
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| performance report which provided an update on performance against the hospital's key quality metrics, including:<br>• Patient Safety.<br>• Quality Assurance and Compliance.<br>• Clinical Effectiveness.<br>• Mortality and Morbidity.<br>• Risk & Policy Management.<br>• Legal and Information Governance.<br><br>The committee noted the levels of falls and pressure ulcers which need improvement.<br><br>The committee was informed the trust received a notice in contravention from the HSE in relation to the delay in report RIDDOR incidents which is a breach of regulation and prevents early intervention. The trust has responded with an action plan and the notice has been closed by the HSE. An A3 thinking exercise is planned in order to identify barriers.<br><br>The committee was informed there is potential for the trust to be inspected by HSE in relation to Sharps Management as part of their 2022-23 inspection schedule. This is an outstanding action for the trust and work is continuing with procurement, infection control and occupational health to replace devices currently used.<br><br>The committee was advised there is a backlog of SARs and FOI requests, a business case has been written for additional staffing to support the service.<br><br>The committee was partially assured by the content of the quarter three quality performance report. | |
| **5. Patient Experience Update**<br>The committee received the Patient Experience update which provided an update on:<br>• Falls and pressure ulcers<br>• Enhanced care team<br>• VTE<br>• Integration of the End of Life Care, Bereavement Team and MCH Palliative Care Team and plans to provide a 7 days service.<br>• First trust to appoint a Namaste Clinical Practitioner which integrates compassionate nursing care with physical activities for patients with advanced dementia.<br>• Friend and Family test survey increase to response rate and 'would recommend'<br>This report is presented to Board. | Green |
| **6. Maternity Digital Strategy**<br>The committee received and discussed the maternity digital strategy and Approved for onward approval at Trust Board. | Green |

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| This report is presented to Board. | |
| **7. CQC Maternity Picker Survey 2022**<br>The committee discussed the CQC maternity picker survey 2022 results. It was noted that the survey was sent by the CQC in June to ladies who had given birth in February.<br><br>The report was received by the trust in November/December and has just been published in the public domain.<br><br>The report is a snapshot of where the trust was in February 2022 with some of the subsequent actions having been completed and addressed as part of Ockenden and CNST.<br><br>The committee was advised the action plan from the survey will be monitored by the Patient Experience Group. | Amber/Green |
| **8. Nutrition and Hydration Presentation**<br>The committee received an update on nutrition and hydration and the improvement projects that have been identified by carrying out A3 methodology.<br><br>The improvement projects have been split into three work streams: assessments, implementation and catering.<br><br>The work on the improvements has been impacted by business continuity with staff working clinically and not being able to carry out training and review of datix. This has been added to the nutrition and hydration risk register.<br><br>This report will be presented to Board. | Amber/Green |
| **9. Infection Prevention and Control BAF (IPC BAF)**<br>The committee received the Infection Prevention and Control BAF and were advised the document is a consolidation of the 2021 IPC improvement plan and NHSE guidance 'living with COVID' measures issued in September 2022.<br><br>The committee was informed that a gap analysis of the two versions has been completed. Following this gap analysis the trust has 148 actions, 39 remain overdue waiting full implementation. There is a trajectory for the actions to be completed and this is measured monthly.<br><br>The committee receive an update on the IPC BAF on a bi-monthly basis. | Amber |
| **Risks and Escalations to Board**<br>The quality assurance committee escalates the following matters to Board:-<br><br>• Data issue for whole trust.<br>• HSE notice. | |

| | |
|---|---|
| • Potential CQC visit.<br>• Backlog of SARs and FOI.<br>• 2013 Sharps directive.<br>• Timeliness of reporting RIDDOR.<br>• Impact of business continuity on meetings and mandatory training compliance. | |

# Meeting of the Trust Board
# Wednesday, 01 February 2023

| | | | |
|---|---|---|---|
| **Title of Report** | Finance, Planning and Performance Committee Assurance Report | **Agenda Item** | 9 |
| **Author** | Matthew Chapman – Head of Financial Management | | |
| **Lead Executive Director** | Alan Davies, Chief Financial Officer<br>Annyes Laheurte, Non-Executive Director | | |

**Executive Summary**

The enclosed report sets out the key discussions held at the Finance, Planning and Performance Committee held on 19 January 2023. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts and the operational performance report.

The headline financial performance at month 8 (November) is as follows:

| £m | In-month | | | Year to date (YTD) | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Var. | Budget | Actual | Var. |
| Surplus / (deficit) | (0.1) | (4.2) | (4.1) | (1.2) | (11.7) | (10.5) |
| Efficiencies | 1.2 | 0.6 | (0.6) | 6.5 | 4.5 | (2.0) |
| Capital spend | 1.0 | 1.2 | 0.2 | 6.2 | 5.2 | (1.0) |

The key drivers of the overspend against the surplus/(deficit) control total continue to be:

- Open escalation capacity that was not budgeted
- Underperformance against the efficiency programme, including theatres and outpatients productivity
- Use of bank and agency medical staffing to support the escalation capacity, but also additional costs in respect of vacancies and rota gaps, together with activity/acuity pressures.
- Overspends against drugs and clinical supplies due to activity and inflationary pressures.

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| **Proposal and/or key recommendation:** | The Trust Board is asked to note this report. |

**Purpose of the report (tick box to indicate)**

| | | | |
|---|---|---|---|
| Assurance | | Approval | |
| Noting | X | Discussion | |

| | | | | |
|---|---|---|---|---|
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | The report summarises the Finance, Planning and Performance Committee meeting on 22 December. | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | |
| | Priority 1: (Sustainability) X | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | |
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: X |
| **Identified Risks, issues and mitigations:** | The Committee noted the key risk that the Trust may not meet its control total. | | | |
| **Resource implications:** | The report sets out the use of financial resources. | | | |
| **Sustainability and /or Public and patient engagement considerations:** | The report sets out the financial performance and hence the sustainability. | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ Not applicable | | | |
| **Legal and Regulatory implications:** | The Trust has a statutory duty to breakeven – the discussions held indicated that the Trust has a high risk of this not being achieved in 2022/23. | | | |
| **Appendices:** | See enclosed report | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | | |
| **For further information or any enquires relating to this paper please contact:** | Alan Davies, Chief Financial Officer alan.davies13@nhs.net<br>Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net | | | |
| **Reports require an assurance rating to guide the discussion:** | | | | |
| | No Assurance | | There are significant gaps in assurance or actions | |
| | Partial Assurance | | There are gaps in assurance | |
| | Assurance | | Assurance minor improvements needed. | |

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

**Meeting:** Finance, Planning & Performance Committee

**Date:** 22/12/2022

**Title:** Finance Report – Month 8

## Introduction

The overall plan for the year is a breakeven position; there is a high degree of risk in delivering this control total in 2022/23 and work is taking place both internally and with system partners in respect of mitigating actions, intervention requirements and deliverability. The Trust continues to work with the Kent and Medway Integrated Care Board to produce a revised system position, this will be agreed across all providers prior to being reported to NHS England.

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

The meeting had two non-executive directors and one executive director present, which confirmed the meeting was not quorate. The Trust had declared a critical incident and apart from the Chief Finance Officer there were not any other Executive Directors available. It was decided to proceed for information purposes.

## Current Status

- The Trust is reporting a £4.2m deficit position in month and £11.7m year to date (YTD), this being £10.5m adverse to the final plan submitted to NHSE/I in June.
- As with the previous month, the main drivers of the adverse position remain, these include escalation capacity remaining open, medical staff pay pressures including additional locums in the emergency department, premium cost of temporary staffing, drugs & clinical supplies price and volume increases, unidentified and undelivered efficiencies.
- Capital expenditure is reporting £0.9m under plan YTD due to the timing of schemes becoming live.
- Delivery of efficiencies is £2.0m behind plan YTD, with achievement YTD of £4.5m.
- An updated forecast position as at month 8 is £25m; however this is still being analysed prior to agreeing a final position with the ICB.

## Goal / Aims

Further scrutiny of the financial forecast is ongoing, along with discussions with ICB partners regarding the forecast outturn for 2022/23. This is includes a diagnosis of why the Trust is performing off plan, non-recurrent actions included to date and a detailed discussion of further mitigating interventions.

The efficiency programme continues to be prioritised with more project management resource made

available. Services continue to identify and develop more schemes, some of which will be implemented for 2023/24.

## Countermeasures

Current financial performance is £11.7m adverse to plan YTD. Additional controls have been implemented and work to determine a realistic, robust forecast is progressing.

# Meeting of the Board (Public)
# Wednesday, 01 February 2023

| | | | |
|---|---|---|---|
| **Title of Report** | Financial forecast | **Agenda Item** | 9 |
| **Author** | Paul Kimber, Deputy Chief Financial Officer | | |
| **Lead Executive Director** | Alan Davies, Chief Financial Officer | | |
| **Executive Summary** | The Finance, Planning and Performance Committee received a briefing at its December meeting on the National guidance released which sets out the process to be followed when an organisation and/or system report a change in their forecast outturn from control total.<br><br>The Kent and Medway system is proposing to change its forecast from break-even to a stretch target deficit target in M10 (February). The Trust proposes a reforecast outturn deficit of £15m as part of this target deficit.<br><br>The Finance, Planning and Performance Committee has scrutinised the proposed approach to achieve this target and recommends that the Board agree to the approach.<br><br>Delivery of the system stretch target has risks which are actively being managed by the system, but they have not been fully mitigated against. Specific risks for the Trust include delivery of the enhanced controls over elective activity, greater scrutiny of vacancies and agency staffing, closure of escalation capacity and resolution of debt disputes in our favour. However, there are a number of areas where the Trust has greater certainty of delivery, including a review of credit note provisions and accruals, together with additional funding for winter/discharge.<br><br>The ICB and the wider system have undertaken the necessary steps as per the Protocol to amend its 22/23 forecast position.<br><br>Work is underway to support system partners to achieve their component of the revised stretch target deficit to enable the system to be able to deliver. Revising the system forecast is in line with the discussions had by the ICB with NHS England.<br><br>In addition to the Trust position the finance committee will continue to receive, at future meetings, an updated system forecast, an update on the risks to delivery and the monthly financial performance. | | |

| | |
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| | The focus now by all system partners is delivering the agreed deficit trajectory.<br><br>The Finance, Planning and Performance Committee has **approved** the Trust reforecast position of £15m deficit. |
| **Proposal and/or key recommendation:** | The Board is asked to ratify the recommendation from the Finance Committee. |

| **Purpose of the report (tick box to indicate)** | | | | |
|---|---|---|---|---|
| | Assurance | | Approval | X |
| | Noting | | Discussion | |

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

| | |
|---|---|
| **Committee/Group at which the paper has been submitted:** | The forecast has been discussed with the Trust Executive team and will be required to be approved by the Trust Board. |

| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | | |
|---|---|---|---|---|---|
| | Priority 1: (Sustainability)<br><br>X | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |

| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
|---|---|---|---|---|---|
| | Safe: | Effective: | Caring: | Responsive: | Well-Led: X |

| | |
|---|---|
| **Identified Risks, issues and mitigations:** | The Trust does not propose to meet its statutory breakeven duty, even after mitigating actions. The proposed deficit forecast position is accepted by the ICB and NHSE but there remains risk in delivering this as an outturn. |
| **Resource implications:** | There are no immediate resource implications from this report, although additional capital in 2023/24 will be made available to the system if the ICB meets its overall target.<br>However, it is noted that the additional governance process implemented by the ICB will require Trust staff to divert their time towards this purpose over and above their existing responsibilities. |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |

| | | | |
|---|---|---|---|
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes<br>☑ Not applicable | | |
| **Legal and Regulatory implications:** | The Trust has a statutory duty to breakeven. | | |
| **Appendices:** | Reforecast presentation pack enclosed. | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | |
| **For further information or any enquires relating to this paper please contact:** | Alan Davies, Chief Financial Officer alan.davies13@nhs.net<br>Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | **Assurance** | **X** | **Assurance with minor improvements needed.** |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

# Meeting of the Trust Board
# Wednesday, 01 February 2023

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Annual Business Plan 2023/24 – update | | **Agenda Item** | 10 |
| **Author** | Paul Kimber, Deputy Chief Financial Officer | | | |
| **Lead Executive Director** | Alan Davies, Chief Financial Officer | | | |
| **Executive Summary** | The Trust issued its internal planning guidance in September 2022, with a deadline for draft plans of 16 December 2022. Owing to operational pressures across the trust few of these plans have currently been received; the CFO is following up with each division/directorate to provide these ahead of the March 2023 deadline.<br><br>The executive team and their deputies have been asked to review the business plans upon receipt, with the Trust Management Board to be used for these to be presented by the divisions and feedback given.<br><br>National guidance has been released, with clarity provided on the national operating priorities for 2023/24. Signed and triangulated plans are expected via the ICB by the end of March 2023, with further details to follow on this process. | | | |
| **Proposal and/or key recommendation:** | The Trust Board is asked to note this update and next steps. | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | | Approval | |
| | Noting | X | Discussion | |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | An update was presented at the executive meeting in the w/c 9 January and to the Finance, Planning and Performance Committee on 26 January. | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Patient First Domain/True North** | Tick the priorities the report aims to support: | | | | |
| | Priority 1: (Sustainability) | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |

| | | | | | |
|---|---|---|---|---|---|
| **priorities (tick box to indicate):** | X | X | X | X | X |
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: X | Effective: X | Caring: X | Responsive: X | Well-Led: X |
| **Identified Risks, issues and mitigations:** | Not all business plans have been received at the time of writing. | | | | |
| **Resource implications:** | The business plans set out the requested resources; if these are not appropriately identified then budgets and operational performance may be adverse. | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | None at this time | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes<br>☑ Not applicable at this time | | | | |
| **Legal and Regulatory implications:** | Subject to the content of the business plans there could be legal and regulatory implications, e.g. balanced budget, constitutional standards performance, etc. | | | | |
| **Appendices:** | Included within the paper:<br>Appendix 1 – National NHS Objectives 2023/24<br>Appendix 2 – High-level internal business planning timetable<br>Appendix 3 – HFMA summary of national planning guidance | | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | | | |
| **For further information or any enquires relating to this paper please contact:** | Alan Davies, Chief Financial Officer alan.davies13@nhs.net<br>Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net | | | | |
| **Reports require an assurance rating to guide the discussion:** | No Assurance | There are significant gaps in assurance or actions | | | |
| | **Partial Assurance** | There are gaps in assurance | | | |
| | Assurance | Assurance with minor improvements needed. | | | |
| | Significant Assurance | There are no gaps in assurance | | | |
| | Not Applicable | No assurance required. | | | |

# 1 Executive Overview

1.1 The Trust issued its internal planning guidance in September 2022, with a deadline for draft plans of 16 December 2022. Owing to operational pressures across the trust few of these plans have currently been received; the CFO is following up with each division/directorate to provide these ahead of the March 2023 deadline.

1.2 The executive team and their deputies have been asked to review the business plans upon receipt, with the Trust Management Board to be used for these to be presented by the divisions and feedback given.

1.3 National guidance has been released, with clarity provided on the national operating priorities for 2023/24. Signed and triangulated plans are expected via the ICB by the end of March 2023, with further details to follow on this process.

# 2 Background

White

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

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

# 3 Regional and National Guidance

White

3.1 The national operating planning guidance was issued on 23 December 2022; the key priorities (in addition to the long-term plan) are included in appendix 1.

3.2 NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity.

3.3 The default national position is that systems will operate block contracts; however, elective activity that has been subject to the Elective Services Recovery Fund ("ESRF") targets to date will now fully operate on a payment by results ("PbR") basis.

3.4 Agency expenditure is expected to reduce to 3.7% of the total pay bill.

3.5 Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300m nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.

3.6 System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023. NHS England will separately set out the requirements for plan submission.

3.7 The HFMA summary of the planning guidance is included as an appendix to this report.

3.8 At the time of writing there has been no formal guidance from the ICB.

# 4 Timetable

Amber /Red

4.1 The high level timetable for draft business plans is set out in appendix 2. Draft plans were due by 16 December; this deadline was set in consultation with clinical divisions.

4.2 As at 18th January 2023, business plans had been received from the following:

- Finance
- CMO's office
- Planned care – overview presentation and care group plans
- UIC – care group plans

However, it is noted that many of the individual care group plans are incomplete; no review of the quality of the content has been undertaken at the time of writing.

4.3 Reminders were sent by the CFO prior to Christmas requesting all other business plans from the corporate areas.

4.4 Whilst business plans were provided for some care groups, others remain outstanding across both clinical divisions. Furthermore, the planning guidance was clear in its request for a single business plan for each clinical division which focused on the divisional priorities and challenges.

# 5 Conclusion and next steps

5.1 The deadline for draft business plans has not been met. The CFO is following up on those outstanding plans.

5.2 The executives (or their deputies on their behalf) are asked to read and provide feedback comments on the business plans; the clinical divisions are asked to present their plans at the Trust Management Board on 1 February, where feedback/facilitative challenge will be provided.

5.3 Subject to the significance of budget/challenge/risk, corporate directorates will be asked to present their plans; all directorates will be provided with feedback regardless.

5.4 "Final" plans are due in the first week of March; this fits with the national timetable to have all plans agreed with the ICB by the end of March. We await further guidance form the system at the time of writing.

5.5 Following receipt of the national planning guidance the internal business plans will need to ensure they address our approach to any of the additional key priorities.

# Appendix 1: National NHS Objectives 2023/24

**National NHS objectives 2023/24**

| | Area | Objective |
|---|---|---|
| Recovering our core services and improving productivity | Urgent and emergency care* | Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 |
| | | Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 |
| | | Reduce adult general and acute (G&A) bed occupancy to 92% or below |
| | Community health services | Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard |
| | | Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals |
| | Primary care* | Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need |
| | | Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 |
| | | Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 |
| | | Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels |
| | Elective care | Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) |
| | | Deliver the system- specific activity target (agreed through the operational planning process) |
| | Cancer | Continue to reduce the number of patients waiting over 62 days |
| | | Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days |
| | | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 |
| | Diagnostics | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% |
| | | Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition |
| | Maternity* | Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury |
| | | Increase fill rates against funded establishment for maternity staff |
| | Use of resources | Deliver a balanced net system financial position for 2023/24 |
| | Workforce | Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise |
| | Mental health | Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) |
| | | Increase the number of adults and older adults accessing IAPT treatment |
| | | Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services |
| | | Work towards eliminating inappropriate adult acute out of area placements |
| | | Recover the dementia diagnosis rate to 66.7% |
| | | Improve access to perinatal mental health services |
| | People with a learning disability and autistic people | Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 |
| | | Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit |
| | Prevention and health inequalities | Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 |
| | | Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% |
| | | Continue to address health inequalities and deliver on the Core20PLUS5 approach |

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

# Appendix 2: High-level internal business planning timetable

| Date | Event | Expected outcome/milestone |
|---|---|---|
| **By 16-Sep** | TMB / Trust Executive | Approve business planning guidance |
| **19-Sep** | Business planning guidance released | Issued business planning guidance |
| **From 19-Sep** | Roadshows | Run c4-6 weeks of events to explain the business planning guidance and take questions from divisional, care group and directorate teams |
| **19-Sep to 28-Oct** | Demand and capacity planning | Build the D&C models on a service-by-service basis |
| **25-Nov** | Rollover budgets issued | Issue standing budgets for 23/24 on a rollover basis, incorporating the full year effect of approved investments, etc. |
| **28-Nov to 9-Dec** | Proposed budget changes identified | Building on the rollover budgets issued, identify further proposed and requested changes to budgets for 23/24 and beyond |
| **3-Oct to 16-Dec** | Capital pipeline | 5-year capital programme and master list to be reviewed for completeness and content |
| **w/c 12-Dec** | Triangulation | Exercise to ensure alignment between D&C, activity, workforce and budgets |
| **16-Dec** | Draft business plans | Completion of 1st draft plans by Clinical Divisions |

# Meeting of the Trust Board
# Wednesday, 01 February 2023

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Financial report – month 9 | | **Agenda Item** | 11 |
| **Author** | Matthew Chapman, Head of Financial Management<br>Cleo Chella, Associate Director Income and Contracts<br>Isla Fraser, Financial Controller | | | |
| **Lead Executive Director** | Alan Davies, Chief Finance Officer | | | |
| **Executive Summary** | The Trust reports a £2.2m deficit for month 9, this being £2.1m adverse to the final plan submitted to NHSE, and £12.6m adverse YTD. The underlying run rate has reduced by £2.0m which is mainly due to the previous month including the adverse impact of £0.7m for GRNI and credit note adjustments; in month 9 favourable movements include additional income from NHSE £0.6m for ERF activity, income for Sheppey Ward £0.2m, reduced independent sector costs £0.3m and a reduction on pay costs of £0.5m.<br><br>The Trust continues to work with system partners to agree a revised forecast position. | | | |
| **Proposal and/or key recommendation:** | The Trust Board is asked to note the financial performance for the year to date (YTD). | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | | Approval | |
| | Noting | X | Discussion | |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | The report was presented at the Finance, Planning and Performance Committee meeting on 24 November. An assurance report form that Committee is included on the Trust Board agenda. | | | |
| **Patient First Domain/True North priorities (tick box to indicate):** | Tick the priorities the report aims to support: | | | |
| | Priority 1: (Sustainability)<br><br>X | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems) |
| | Tick CQC domain the report aims to support: | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Relevant CQC Domain:** | Safe: | Effective: | Caring: | Responsive: | Well-Led: X |
| **Identified Risks, issues and mitigations:** | There is a risk that the Trust does not meet its control total in 2022/23. | | | | |
| **Resource implications:** | The report sets out the use of financial resources. | | | | |
| **Sustainability and /or Public and patient engagement considerations:** | The report sets out the financial performance and hence the sustainability. | | | | |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes<br>☑ Not applicable – this reports the financial performance of the Trust and not the service provision. | | | | |
| **Legal and Regulatory implications:** | The Trust has a statutory duty to breakeven – the report indicates that the Trust has a high risk of this not being achieved in 222/23. | | | | |
| **Appendices:** | None | | | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act | | | | |
| **For further information or any enquires relating to this paper please contact:** | Alan Davies, Chief Financial Officer alan.davies13@nhs.net<br>Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net | | | | |

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

# Finance report

## For the period ending 31 December 2022

### Contents

# 1. Executive summary

| £'000 | Budget | Actual | Var. | |
|---|---|---|---|---|
| **Trust surplus/(deficit)** | | | | |
| In-month | (106) | (2,202) | (2,096) | The Trust reports a £2,202k deficit position for December; decreasing to £2,190k after making the technical adjustments for donated assets, this being £12,553k adverse to the submitted plan year to date. The reported position includes Elective Services Recovery Funding (ESRF) income of £7.5m year to date. The improvement in the run rate of £2.0m is mainly due to additional income from NHSE £0.6m for ERF activity, income for Sheppey Ward £0.2m, reduced independent sector costs £0.3m and a reduction on pay costs of £0.5m. |
| Donated Asset Depreciation | 13 | 12 | (1) | |
| **In-month total** | **(93)** | **(2,190)** | **(2,097)** | |
| **YTD total** | **(1,359)** | **(13,912)** | **(12,553)** | |
| **Efficiencies Programme** | | | | |
| In-month | 1,104 | 789 | (315) | The delivered efficiency programme position of £5.3m includes £3.1m of the approved cross cutting themes and £0.2m full year effect of schemes continuing from 2021/22. The adverse £2.3m adverse variance to plan includes £0.4m the 0.5% stretch target that was included for the second half of the financial year. The remaining efficiencies continue to be predominantly from the Corporate functions £0.4m, Facilities and Estates £0.7m as well as the Unplanned Care division £0.9m. |
| YTD | 7,593 | 5,299 | (2,294) | |
| **Capital** | | | | |
| In-month | 1,048 | 1,210 | 161 | Since M8 the £5,608k of additional capital funding in the pipeline has increased by £3,653k to £9,261k:<br>- On review of the Endoscopy project achievability has been assessed as £2.1m, therefore £2,000k of PDC funding has been added back and agreed.<br>- Additional system capital of £1,653k has been agreed to fund the purchase of a new gamma camera (£1,000) and partially fund the PDC shortfall for EPR. In accepting the funds for the camera the trust is committing to funding enabling works in 23/24 but as the camera is 32 years old this is a priority for our patients.<br>Risks associated with capital are;<br>- Urgent diagnostics equipment MRI replacement (risk score 25), 28 year old Gamma camera (risk score 16), 18 year old CR rooms (risk score 20). As above the Trust has been allocated £1,000k additional funding in December to purchase the camera and recently NHSE have potentially proposed funding for a replacement MRI, although this is still under review.<br>- Assets under construction (AUC), current balance is £16,542k, this is a potential risk to the I&E position as these assets are not yet being depreciated if found to be in use.<br>- 23/24 capital need is approx. £47,500k, ICS have confirmed funding to be £13,019k. Total shortfall = £34,481k. Planning is in progress to review and prioritise need. |
| YTD | 7,132 | 6,990 | (142) | |
| System Annual | 10,970 | 10,970 | 0 | |
| Total Annual | 20,731 | 20,731 | 0 | |

# 1. Executive summary (continued)

| Cash | | | | |
|---|---|---|---|---|
| Month end | 27,799 | 28,704 | 905 | The Trust cash balance is £905k higher than plan. This is not as high as expected in the cash maximisation strategy due to £2,096k of PDC capital expenditure being incurred in advance of the cash drawdown and the deterioration in the financial position of the Trust and Expenditure and therefore cash outflow continues to be a pressure. £1,850k of the above mentioned PDC cannot be drawn until the MOU has been issued by NHSE. |

# 2. Income and expenditure (reporting against NHSE plan)

| £'000 | In-month | | | Year-to-date* | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Var. | Plan | Actual | Var. |
| Clinical income | 27,881 | 29,147 | 1,265 | 250,935 | 256,447 | 5,512 |
| High cost drugs | 1,888 | 2,356 | 468 | 16,990 | 18,496 | 1,506 |
| Other income | 2,500 | 2,695 | 195 | 22,263 | 22,356 | 92 |
| Donated Asset Adjustment | - | 1 | 1 | - | 17 | 17 |
| **Total income** | **32,269** | **34,198** | **1,929** | **290,189** | **297,316** | **7,127** |
| Nursing | (8,764) | (8,820) | (55) | (79,186) | (80,099) | (913) |
| Medical | (6,624) | (7,409) | (785) | (60,768) | (64,414) | (3,646) |
| Other | (5,088) | (6,028) | (941) | (46,703) | (50,942) | (4,239) |
| **Total pay** | **(20,476)** | **(22,257)** | **(1,781)** | **(186,657)** | **(195,455)** | **(8,798)** |
| Clinical supplies | (3,968) | (4,619) | (651) | (33,797) | (37,172) | (3,375) |
| Drugs | (632) | (1,168) | (536) | (5,688) | (9,185) | (3,497) |
| High cost drugs | (1,888) | (2,102) | (214) | (16,990) | (18,434) | (1,444) |
| Other | (3,538) | (4,433) | (894) | (31,546) | (34,322) | (2,777) |
| **Total non-pay** | **(10,026)** | **(12,321)** | **(2,295)** | **(88,021)** | **(99,114)** | **(11,093)** |
| **EBITDA** | **1,767** | **(381)** | **(2,148)** | **15,511** | **2,747** | **(12,764)** |
| Depreciation | (1,253) | (1,294) | (41) | (11,276) | (11,643) | (367) |
| Donated asset adjustment | (13) | (12) | 1 | (120) | (16) | 104 |
| Net finance income/(cost) | 0 | 91 | 91 | (5) | 469 | 474 |
| PDC dividend | (607) | (607) | 0 | (5,469) | (5,469) | 0 |
| **Non-operating exp.** | **(1,873)** | **(1,821)** | **52** | **(16,870)** | **(16,659)** | **211** |
| **Reported surplus/(deficit)** | **(106)** | **(2,202)** | **(2,096)** | **(1,359)** | **(13,912)** | **(12,553)** |
| **Adj. to control total** | **13** | **12** | **(1)** | **120** | **16** | **(104)** |
| **Control total** | **(93)** | **(2,190)** | **(2,097)** | **(1,239)** | **(13,896)** | **(12,657)** |

1. Block funding arrangements for the full year 2022/23 were agreed with the Kent & Medway CCG and included in the June plan submission.
2. Clinical income favourable variance includes the extra £4.0m pay award funding not in the submitted plan, as well as £0.6m of the £0.8m additional funding agreed with NHSE and £0.2m Sheppey Ward income.
3. Other income includes £1.1m of recharges for pass through clinical supplies costs and drugs, these costs are recorded in the relevant non-pay category. Also included are the NHS provider to provider contracts, car parking income, F&E retail income and medical education contribution to overheads.
4. The ESRF income year to date included is £7.5m with associated cost to independent sector healthcare providers and additional consultant sessions of £2.8m. The risk of the 75% clawback due to under performance against the ESRF plan is covered by NHSE for the full year.
5. Pay budgets are reporting a £8.8m adverse position YTD, this position includes £4.5m benefit from the non-recurrent release of accruals, and the adverse impact of the pay award (£4.0m) offset by the clinical income favourable variance.
6. The overall reported deficit position continues to be driven by unbudgeted escalation capacity, premium costs for junior doctors to cover vacancies within the medical rota, staff sickness, temporary theatres staff, drugs costs, clinical supplies and non-delivery of the efficiency programme.
7. Escalation capacity in PAHU, ADL and SDEC overnight stays, additional beds on McCulloch & Emerald wards as well as Will Adams ward (previously known as Jade) remain open. The escalation capacity cost pressure is c£4.4m YTD.
8. Covid costs have remained constant at £0.1m in month following executive action to control spend.

# 3. SLA Activity and Income

| POD Group | Planned care YTD Plan £'000s | Planned care YTD Actual £'000s | Planned care YTD Variance £'000s | Unplanned & Integrated Care YTD Plan £'000s | Unplanned & Integrated Care YTD Actual £'000s | Unplanned & Integrated Care YTD Variance £'000s | Totals YTD Plan £'000s | Totals YTD Actual £'000s | Totals YTD Variance £'000s |
|---|---|---|---|---|---|---|---|---|---|
| A&E | - | - | - | 13,010 | 13,578 | 568 | 13,010 | 13,578 | 568 |
| Adult Critical Care | 7,652 | 7,137 | (515) | - | - | - | 7,652 | 7,137 | (515) |
| Block Contracts | 1,281 | 1,281 | - | 1,027 | 1,027 | - | 2,308 | 2,308 | - |
| Chemotherapy | 1,552 | 1,748 | 196 | 0 | 68 | 68 | 1,552 | 1,816 | 264 |
| Day Cases | 11,638 | 11,264 | (373) | 6,125 | 5,148 | (977) | 17,763 | 16,412 | (1,351) |
| Direct Access | 1,068 | 580 | (488) | 6,482 | 8,703 | 2,222 | 7,550 | 9,283 | 1,734 |
| Elective Inpatient | 16,065 | 13,248 | (2,817) | 738 | 506 | (232) | 16,803 | 13,754 | (3,049) |
| Excess Bed Days | 1,231 | 1,857 | 626 | 1,446 | 3,675 | 2,229 | 2,677 | 5,531 | 2,855 |
| Excluded Devices | 322 | 183 | (139) | 1,309 | 1,339 | 30 | 1,631 | 1,522 | (109) |
| HCD | 4,801 | 4,978 | 177 | 12,051 | 13,454 | 1,402 | 16,990 | 18,496 | 1,506 |
| Maternity Pathway | 8,531 | 9,084 | 554 | - | - | - | 8,531 | 9,084 | 554 |
| Neonatal Critical Care | 7,737 | 8,547 | 809 | - | - | - | 7,737 | 8,547 | 809 |
| Non Elective Inpatient | 42,679 | 42,289 | (390) | 46,133 | 39,349 | (6,784) | 88,812 | 81,638 | (7,174) |
| Other cost per case | 2,167 | 1,909 | (258) | 1,055 | 1,303 | 248 | 3,222 | 3,212 | (10) |
| Outpatients | 20,645 | 21,550 | 905 | 17,514 | 14,546 | (2,968) | 38,159 | 36,096 | (2,063) |
| Paediatric Critical Care | 512 | 210 | (303) | - | - | - | 512 | 210 | (303) |
| | **127,883** | **125,866** | **(2,017)** | **106,890** | **102,696** | **(4,194)** | **234,911** | **228,627** | **(6,284)** |
| | | | | | | | | | |
| Cancer Drug Fund | | | | | | | (1,267) | (1,684) | (417) |
| Block Adjustment K&M ICB | | | | | | | 35,039 | 44,926 | 9,887 |
| Block Adjustment SEL ICB | | | | | | | (66) | (426) | (359) |
| Block Adjustment Spec Comm | | | | | | | (113) | 109 | 222 |
| Block Adjustment NHSE Other | | | | | | | 757 | 124 | (633) |
| Block Adjustment LVA | | | | | | | (749) | (3,164) | (2,415) |
| **Total Block Adjustments** | **-** | **-** | **-** | **-** | **-** | **-** | **33,601** | **39,885** | **6,284** |
| | | | | | | | | | |
| **Total Block Income** | **127,883** | **125,866** | **(2,017)** | **106,890** | **102,696** | **(4,194)** | **268,512** | **268,511** | **(0)** |

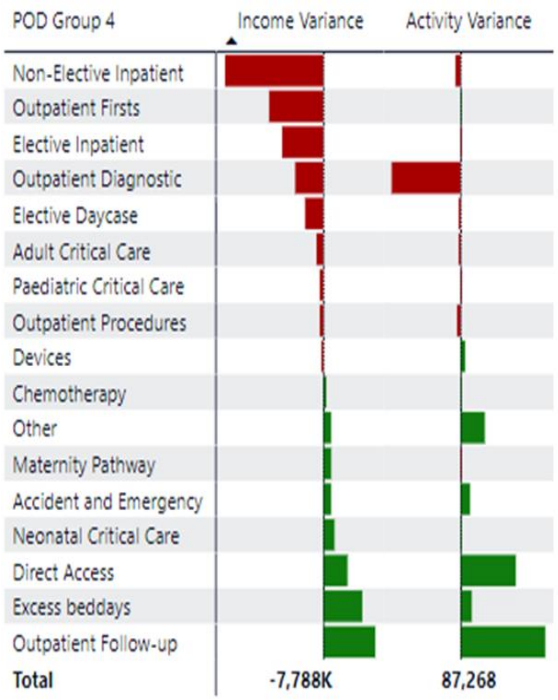
Providers have been funded on block contracts for 22/23 for most services except for elective patient care. Elective patient care is funded as part of the Elective Services Recovery Fund (ESRF) based on the national tariff.

The table sets out the income and activity performance for the Trust at point of delivery (POD) as at month 9. The Trust is below plan by £6.3m overall including HCD.

- In 22/23 all clinical income has been devolved to divisions based on activity plans priced at national tariff (or local prices in the absence of a national tariff).
- MFT receives a benefit of £45m in its year to date budget compared to funding activity on national tariff. £40m of the benefit is related to the annual top-up income of £53m
- Planned Care division is £2m below plan driven by underperformance in elective inpatients of £2.8m, £0.4m in day cases and £0.5m in Adult critical care. This is largely offset by over performance in Neonatal critical care of £0.9m and Outpatients of £1m.
- Unplanned care is £4.2m below plan, driven by non-elective underperformance £6.8m and outpatients of £3m. This is offset by over performance in excess bed days of £2.2m, direct access of £2.2m and HCD of £1.5m.

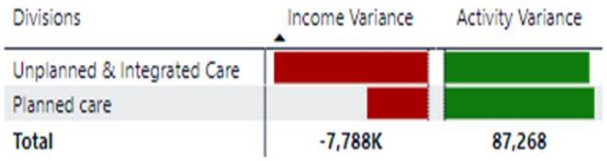
# M9 Income and activity by POD (excl. HCD)

The estimated value of the underperformance in M9 for the SLA income based on national tariff is £7.8m YTD (excluding high cost drugs).



| POD Group 4 | Income Variance | Activity Variance |
|---|---|---|
| Non-Elective Inpatient | | |
| Outpatient Firsts | | |
| Elective Inpatient | | |
| Outpatient Diagnostic | | |
| Elective Daycase | | |
| Adult Critical Care | | |
| Paediatric Critical Care | | |
| Outpatient Procedures | | |
| Devices | | |
| Chemotherapy | | |
| Other | | |
| Maternity Pathway | | |
| Accident and Emergency | | |
| Neonatal Critical Care | | |
| Direct Access | | |
| Excess beddays | | |
| Outpatient Follow-up | | |
| **Total** | **-7,788K** | **87,268** |

| POD Group 4 | Income Plan | Income Actual | Income Variance | Activity Plan | Activity Actual | Activity Variance |
|---|---|---|---|---|---|---|
| Non-Elective Inpatient | £88,812K | £81,638K | -7,174K | 39211 | 35034 | -4,177 |
| Outpatient Firsts | £16,005K | £11,990K | -4,015K | 76031 | 77176 | 1,145 |
| Elective Inpatient | £16,803K | £13,754K | -3,049K | 4054 | 3584 | -470 |
| Outpatient Diagnostic | £6,108K | £3,999K | -2,109K | 94334 | 39089 | -55,245 |
| Elective Daycase | £17,763K | £16,412K | -1,351K | 20567 | 18354 | -2,213 |
| Adult Critical Care | £7,652K | £7,137K | -515K | 7004 | 5909 | -1,094 |
| Paediatric Critical Care | £512K | £210K | -303K | 693 | 285 | -408 |
| Outpatient Procedures | £6,357K | £6,091K | -266K | 32177 | 29474 | -2,703 |
| Devices | £1,631K | £1,522K | -109K | 51236 | 54826 | 3,590 |
| Chemotherapy | £1,552K | £1,816K | 264K | 10171 | 11149 | 978 |
| Other | £6,844K | £7,365K | 521K | 59672 | 79346 | 19,674 |
| Maternity Pathway | £7,373K | £7,911K | 537K | 4024 | 3915 | -109 |
| Accident and Emergency | £13,010K | £13,578K | 568K | 66801 | 73915 | 7,114 |
| Neonatal Critical Care | £7,737K | £8,547K | 809K | 8021 | 8559 | 538 |
| Direct Access | £7,550K | £9,283K | 1,734K | 1851476 | 1895373 | 43,896 |
| Excess beddays | £2,677K | £5,531K | 2,855K | 8155 | 17022 | 8,867 |
| Outpatient Follow-up | £9,533K | £13,348K | 3,814K | 90558 | 158444 | 67,886 |
| **Total** | **£217,921K** | **£210,133K** | **-7,788K** | **2424185** | **2511453** | **87,268** |



| Divisions | Income Variance | Activity Variance |
|---|---|---|
| Unplanned & Integrated Care | | |
| Planned care | | |
| **Total** | **-7,788K** | **87,268** |

| Divisions | Income Plan | Income Actual | Income Variance | Activity Plan | Activity Actual | Activity Variance |
|---|---|---|---|---|---|---|
| Unplanned & Integrated Care | £94,839K | £89,245K | -5,594K | 2174600 | 2217449 | 42,849 |
| Planned care | £123,082K | £120,888K | -2,194K | 249585 | 294004 | 44,420 |
| **Total** | **£217,921K** | **£210,133K** | **-7,788K** | **2424185** | **2511453** | **87,268** |

# M9 Income and activity by POD (excl. HCD)

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

- The main underperformance is within elective, day cases, non-elective inpatients and outpatient first attendances.
- Non-elective underperformance is £7.1m of which £5.9m is in General Medicine driven by a lower than planned case mix in Respiratory cases and infectious diseases. The underperformance is also driven in part by Stroke inpatient activity (£1.8m). Stroke services have moved to MTW and DVH but the activity and income remains within the budgets for MFT. The funding is covering costs in other areas, work will be done with commissioners to reallocate this funding to other services. Other underperformance is sitting in Paediatric Surgery £1.1m, Respiratory Medicine £1m and Midwife Episodes £1.3m. There is offsetting over performance in A&E short stay admissions of £2.3m and activity over performance of 1,997 spells. This activity of a lower case mix is the reason for low activity underperformance despite the high financial adverse variance. There is another £2.3m over performance in Obstetrics.
- Elective inpatients and day cases are £4.4m below plan and was mainly driven reduced surgical activity due to the lack of anaesthetists and cancellation of some planned work due to winter pressures during December. T&O is below plan by £1.5m, ENT £0.8m, colorectal surgery 0.9m and vascular £0.6m.
- Outpatient's income for first attendances is below plan of £4m YTD mainly driven by low activity in General Medicine £1.8m, Gynae £0.8m and ENT £0.8m. The underperformance in General medicine is a result of coding all outpatient activity as follow up. This is currently being worked on by BI and will be corrected.
- Outpatient's income for follow up attendances is significantly above plan of £3.8m YTD mainly driven by high virtual activity in General Medicine. Coding of some of the FUP activity is being reviewed and will be re-coded as Firsts once the work is completed.
- Chemotherapy treatments are above the activity and financial plan of £264k YTD.
- Direct access activity is above plan especially for MRIs £548k and x-rays £447k however there is offsetting underperformance in Outpatients unbundled radiology.
- Neonatal cot days are above plan and resulting in a favourable income of £1m YTD.

# M9 YTD Year on Year activity comparison by POD

The table compares activity performance for 21/22, 22/23 and 19/20. This comparisons provides a view of recovery of services to pre-pandemic levels. The aggregate PODs are as below.

| POD Group | M9 19-20 activity | M9 21-22 activity | M9 22-23 activity | 21/22 to 19/20 % Growth | 22/23 to 19/20 % Growth | 22/23 to 21/22 % Growth |
|---|---|---|---|---|---|---|
| Accident and Emergency | 67,049 | 68,428 | 73,915 | 2% | 10% | 8% |
| Adult Critical Care | 7,086 | 5,406 | 5,909 | -24% | -17% | 9% |
| Chemotherapy | 10,041 | 9,970 | 11,149 | -1% | 11% | 12% |
| Devices | 571 | 52,686 | 54,826 | 9127% | 9502% | 4% |
| Direct Access | 1,858,594 | 1,843,627 | 1,895,373 | -1% | 2% | 3% |
| Elective Daycase | 19,846 | 16,168 | 18,354 | -19% | -8% | 14% |
| Elective Inpatient | 4,006 | 3,264 | 3,584 | -19% | -11% | 10% |
| Excess beddays | 5,266 | 11,399 | 17,022 | 116% | 223% | 49% |
| Maternity Pathway | 4,024 | 4,070 | 3,915 | 1% | -3% | -4% |
| Neonatal Critical Care | 7,961 | 7,296 | 8,559 | -8% | 8% | 17% |
| Non-Elective Inpatient | 37,908 | 38,768 | 35,034 | 2% | -8% | -10% |
| Other | 74,878 | 70,103 | 79,346 | -6% | 6% | 13% |
| Outpatient Diagnostic | 78,727 | 43,918 | 39,089 | -44% | -50% | -11% |
| Outpatient Firsts | 65,971 | 74,920 | 77,176 | 14% | 17% | 3% |
| Outpatient Follow-up | 105,345 | 175,879 | 158,444 | 67% | 50% | -10% |
| Outpatient Procedures | 56,259 | 29,729 | 29,474 | -47% | -48% | -1% |
| Paediatric Critical Care | 809 | 953 | 285 | 18% | -65% | -70% |
| **Grand Total** | **2,404,341** | **2,456,584** | **2,511,453** | **2%** | **4%** | **2%** |

- A&E activity is above pre pandemic levels by 10% which is higher than the activity last year by 8% however conversion rates in admissions have fallen from 24% to 21.5% compared to same period last year.
- Day cases are below 19/20 levels by 8% but 14% higher than the activity delivered at this time last year.
- Elective Inpatients are below pre-pandemic levels by 11% but have improved over last year's activity by 10%
- Non elective current year performance is below 19/20 levels by 8% and below the activity delivered last year by 11%. The activity for last year exceeded 19/20 by 2%
- Outpatient First attendances are above the level delivered in 21/22 by 4% but still below the pre-pandemic level by 2%
- OP Follow up activity is higher than 19/20 by 50% but less than last year's activity by 10%.

# 4. Efficiency programme (status and summary)

| Status £'000 | Blue | Green | Amber | Red | Cross Cutting Schemes | Sub-total Identified | Over Identified / (Unidentified) | Plan Target | YTD Plan | YTD Delivery | Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned care | 10 | 735 | 84 | 0 | 1,593 | 2,422 | (1,203) | 3,625 | 2,719 | 510 | **(2,209)** |
| UIC | 144 | 658 | 0 | 321 | 3,000 | 4,124 | 893 | 3,231 | 2,206 | 2,321 | **115** |
| E&F | 89 | 833 | 0 | 0 | 0 | 922 | 236 | 686 | 649 | 656 | **7** |
| Corporate | 42 | 540 | 0 | 0 | 156 | 738 | 115 | 623 | 533 | 428 | **(105)** |
| Central | 0 | 47 | 0 | 0 | 1,419 | 1,466 | 0 | 1,466 | 1,067 | 1,384 | **318** |
| **Sub Total** | **284** | **2,814** | **84** | **321** | **6,168** | **9,670** | **39** | **9,631** | **7,174** | **5,299** | **(1,875)** |
| **Stretch target 0.5%** | | | | | | **0** | **(851)** | **851** | **419** | **0** | **(419)** |
| **Total for 22/23** | **284** | **2,814** | **84** | **321** | **6,168** | **9,670** | **(812)** | **10,482** | **7,593** | **5,299** | **(2,294)** |

| Summary £'000 | In-month | | | Year-to-date | | | Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Var. | Budget | Actual | Var. | Budget | Forecast | Var. |
| Trust total | **1,104** | **789** | **(315)** | **7,593** | **5,299** | **(2,294)** | **10,482** | **7,136** | **(3,347)** |

**Process**

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

The delivered efficiency programme position of £5.3m includes £3.1m from 8 of the cross cutting schemes, the length of stay efficiency scheme to close Nelson Ward has fully delivered; in addition, corporate functions have delivered a total of £0.5m and F&E £0.6m, this includes the additional staff car parking charges. The position includes £0.4m impact from the stretch target in H2; other under delivery includes Jade Ward length of stay cross cutting efficiency £0.7m although offset by additional efficiencies delivered within the Unplanned Care divisions; in Planned Care outpatients including virtual clinics £0.2m, and theatres redesign following the review with independent consultants £0.4m and unidentified schemes against the target £1.2m.

The efficiency programme continues to be prioritised with more project management resource made available. Services continue to identify and develop more schemes, some of which will be implemented for 2023/24. Further detail is provided within the Efficiencies Report.

# 5. Balance sheet summary

| Prior year end | £'000 | Month end actual | Var on PY. |
|---|---|---|---|
| **240,295** | **Non-current assets** | **237,439** | **(2,856)** |
| 5,996 | Inventory | 6,299 | 303 |
| 13,889 | Trade and other receivables | 19,454 | 5,565 |
| 33,455 | Cash | 28,704 | (4,751) |
| **53,340** | **Current assets** | **54,457** | **1,117** |
| (136) | Borrowings | (281) | (140) |
| (28,147)) | Trade and other payables | (37,499) | (9,352) |
| (2,116) | Other liabilities | (3,987) | (1,871) |
| **(30,399)** | **Current liabilities** | **(41,767)** | **(11,368)** |
| (2,025) | Borrowings | (2,829) | (803) |
| (1,248) | Other liabilities | (1,248) | 0 |
| **(3,273)** | **Non-current liabilities** | **(4,076)** | **(803)** |
| **259,963** | **Net assets employed** | **246,053** | **(13,910)** |
| 461,656 | Public dividend capital | 461,656 | 0 |
| (245,218) | Retained earnings | (259,128) | (13,910) |
| 43,525 | Revaluation reserve | 43,525 | 0 |
| **259,963** | **Total taxpayers' equity** | **246,053** | **(13,910)** |

**Key messages:**

1. Receivables have increased by £5.6m from the prior year The current balance represents approximately 61% of one month's average turnover (£32.2m).

2. Payables have increased by £9.3m from the prior year, £1.8m relates to PDC which is only collected by DH in M6 and M12. Current payables balance represents 116% of one month's average turnover.

3. Total Trust borrowings (current and non-current) are £3.1m, £1.0m higher than the prior year. This is due to the implementation of IFRS16.

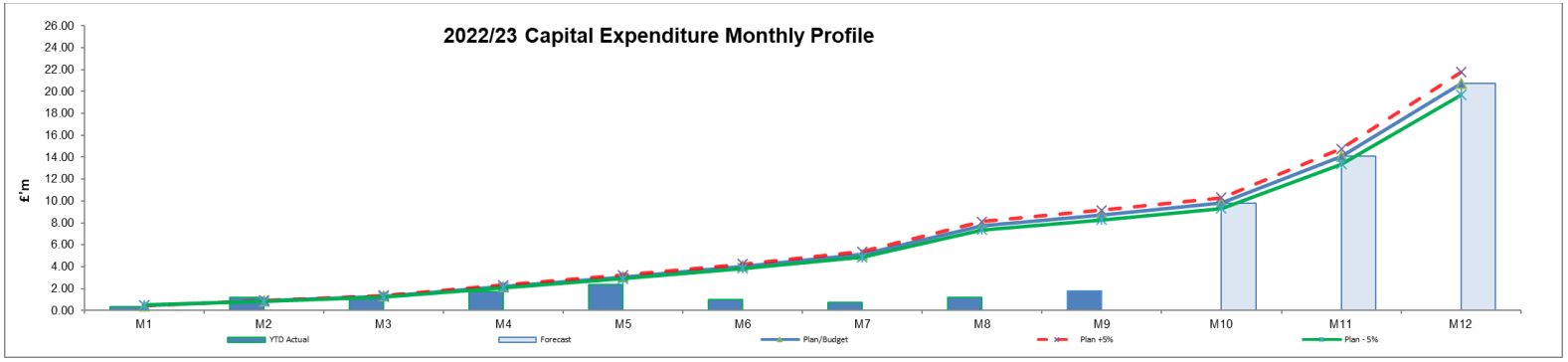
4. Other Liabilities are deferred income and have increased by £1.9m from the prior year. This is due to the nature of the transactions. In year we receive income in advance but only minimal income is paid in advance of a financial year.

# 6. Capital

## 2022/23 Capital Expenditure

| £'000 | In-month | | | Year To Date | | | Annual | | | | | | Funding | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var. | Plan | Actual | Var. | NHSI Plan | Revised Trust Plan | Forecast | Var on revised Trust plan | Real Forecast | Variance on revised plan | Internal (system capital) | PDC | OTHER |
| Backlog Maintenance | 423 | 280 | (142) | 1,462 | 1,199 | (263) | 2,954 | 2,675 | 2,675 | 0 | 2,750 | 75 | 2,675 | 0 | 0 |
| Emergency Department | 30 | 97 | 67 | 45 | (386) | (431) | 0 | 74 | 74 | 0 | (228) | (302) | 74 | 0 | 0 |
| Fire Urgency Works | 397 | 204 | (193) | 1,150 | 453 | (697) | 0 | 2,100 | 2,100 | 0 | 2,101 | 1 | 2,100 | 0 | 0 |
| Information Technology | 220 | 314 | 94 | 1,006 | 717 | (289) | 2,619 | 1,220 | 1,220 | 0 | 1,213 | (7) | 1,220 | 0 | 0 |
| Medical and Surgical Equipment Programme | 357 | 90 | (267) | 952 | 85 | (867) | 1,086 | 1,394 | 1,394 | 0 | 1,324 | (70) | 1,394 | 0 | 0 |
| Routine Maintenance | 90 | 0 | (90) | 230 | 52 | (178) | 500 | 435 | 435 | 0 | 338 | (97) | 435 | 0 | 0 |
| Service Developments | (331) | 329 | 660 | 1,547 | 1,284 | (263) | 3,811 | 3,072 | 3,072 | 0 | 2,224 | (848) | 3,072 | 0 | 0 |
| Unfunded projects | 0 | (20) | (20) | 0 | 34 | 34 | 0 | 0 | 0 | 0 | 34 | 34 | 0 | 0 | 0 |
| Phasing Adjustment to align to NHSI Plan* | (299) | 0 | 299 | 517 | 0 | (517) | | | | | | 0 | | | |
| **Total System Capital** | **886** | **1,294** | **408** | **6,909** | **3,438** | **(3,471)** | **10,970** | **10,970** | **10,970** | **0** | **9,756** | **(1,214)** | **10,970** | **0** | **0** |
| UTC | 0 | 0 | 0 | 0 | 181 | 181 | 500 | 500 | 500 | 0 | 500 | 0 | | 500 | 0 |
| Unspecified PDC Schemes | 0 | 0 | 0 | 0 | 0 | 0 | 80 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 |
| **Total Planned Additional Capital** | **0** | **0** | **0** | **0** | **181** | **181** | **580** | **500** | **500** | **0** | **500** | **0** | **0** | **500** | **0** |
| **Total Planned Capital** | **886** | **1,294** | **408** | **6,909** | **3,619** | **(3,290)** | **11,550** | **11,470** | **11,470** | **0** | **10,256** | **(1,214)** | **10,970** | **500** | **0** |
| EPR - PDC | 0 | 0 | 0 | 0 | 1,850 | 1,850 | 0 | 1,850 | 1,850 | 0 | 1,850 | 0 | | 1,850 | 0 |
| EPR - Additional System Capital | 0 | (88) | (88) | 0 | 1,173 | 1,173 | 0 | 593 | 593 | 0 | 800 | 207 | 593 | 0 | 0 |
| Ultrasound | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 90 | 90 | 0 | 90 | 0 | | 90 | 0 |
| PACS/RIS (Image sharing) | 54 | 4 | (51) | 109 | 240 | 131 | 0 | 272 | 272 | 0 | 272 | 0 | | 272 | 0 |
| Endoscopy | 1,626 | 0 | (1,626) | 0 | 6 | 6 | 0 | 2,160 | 2,160 | 0 | 2,160 | 0 | | 2,160 | 0 |
| Gamma Camera | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,000 | 1,000 | 0 | 1,000 | 0 | 1,000 | 0 | 0 |
| Defibrillators | 102 | 0 | (102) | 102 | 102 | 0 | 0 | 102 | 102 | 0 | 102 | 0 | | 0 | 102 |
| Irefer | 6 | 0 | (6) | 12 | 0 | (12) | 0 | 29 | 29 | 0 | 29 | 0 | | 29 | 0 |
| CDC Business Case | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,165 | 3,165 | 0 | 3,165 | 0 | | 3,165 | 0 |
| **Total Additional Capex** | **1,788** | **(85)** | **(1,873)** | **223** | **3,371** | **3,148** | **0** | **9,261** | **9,261** | **0** | **9,468** | **207** | **1,593** | **7,566** | **102** |
| **Slippage - to be reassigned** | | | | | | | | | | | **1,007** | **1,007** | | | |
| **Total Capex** | **2,674** | **1,210** | **(1,465)** | **7,132** | **6,990** | **(142)** | **11,550** | **20,731** | **20,731** | **0** | **20,731** | **0** | **12,563** | **8,066** | **102** |

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



# 6. Capital (continued)

6.1 **System Capital**: **Annual Plan £10,970k; Reported Annual Forecast £10,970k = CRL target met**

System capital is funded from internal depreciation of £15,033k. In the past the Trust would have been able to re-invest all depreciation but due to the national regime the Trust is now only able to re-invest the CRL as set by NHSI and then distributed by the ICS. For 2022/23 this is £4,063k less, which means the Trust less funding to replace assets or invest in developments, with potential risks to the Trust.

Year to date system capital expenditure is £3,471k behind plan including £724k of EPR expenditure originally planned for additional PDC funding. The slippage is entirely due to the late approval of the plan which delayed the start of most programmes and access issues due to the unprecedented pressures in clinical areas for the last couple of months. Annually the NHSE reported forecast is to recover this slippage and meet the CRL of £10,970k which is a financial requirement for the Trust. However there is £1,007k of slippage forecast on planned schemes which will need to be reallocated in order to achieve this. This is likely to be achieved with revenue to capital transfers and bringing forward EPR work from 23/24 if necessary to aid next years plan.

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

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

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

6.3 **Additional Capital, as agreed in year** £9,268k additional capital funding is in the pipeline, £3,653k more than what was presented at M8. The increase relates to

6.3.1 £2m Endoscopy funded by PDC, in M8 the plan for Endoscopy was under review so was held at a nominal value of £100k

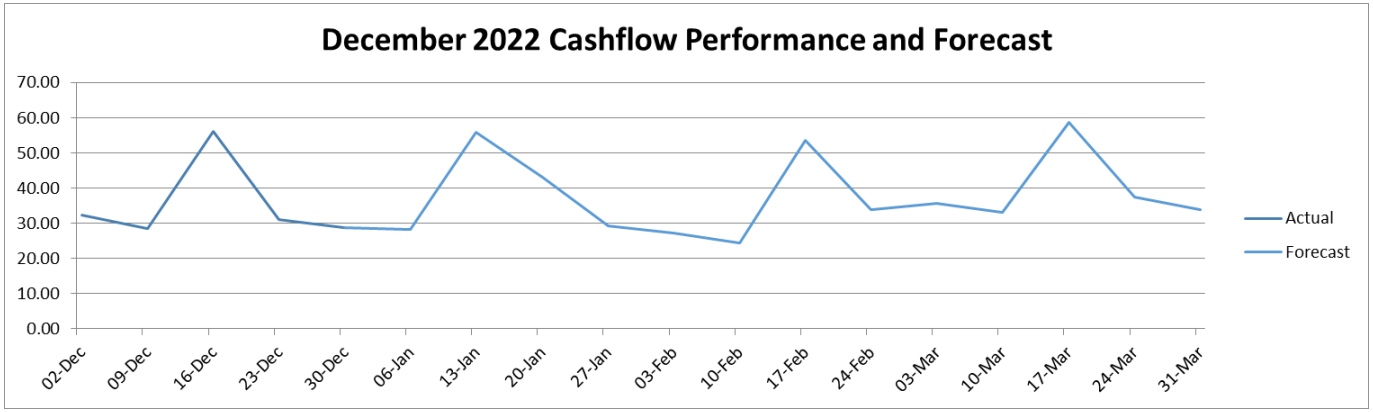
6.3.2 £1m additional system capital to enable the Trust to replace its 32 year old Gamma Camera. There are some concerns over how long enabling works will take which may put purchase of the camera in 22/23 at risk. This is a high priority risk to the Trust as at 32 years old it well past it useful life which means there is high risk of failure and image quality is materially impacted.

6.3.3 £593k additional system capital to part fund the £800k EPR national funding shortfall, leaving £207k to be funded from system capital slippage.

# 7. Cash

**13 Week Forecast** w/e

| £m | Actual 02/12/22 | 09/12/22 | 16/12/22 | 23/12/22 | 30/12/22 | Forecast 06/01/23 | 13/01/23 | 20/01/23 | 27/01/23 | 03/02/23 | 10/02/23 | 17/02/23 | 24/02/23 | 03/03/23 | 10/03/23 | 17/03/23 | 24/03/23 | 31/03/23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BANK BALANCE B/FWD** | **34.41** | **32.24** | **28.58** | **56.09** | **31.13** | **28.68** | **28.30** | **55.92** | **42.96** | **29.20** | **27.23** | **24.25** | **53.63** | **33.75** | **35.68** | **33.00** | **58.55** | **37.30** |
| **Receipts** | | | | | | | | | | | | | | | | | | |
| NHS Contract Income | 0.04 | 0.06 | 30.32 | 0.10 | 0.00 | 0.02 | 30.95 | 0.30 | 0.00 | 0.00 | 0.00 | 31.13 | 0.00 | 0.00 | 0.00 | 31.13 | 0.00 | 0.00 |
| Other | 0.69 | 0.24 | 0.33 | 0.12 | 0.30 | 0.21 | 0.18 | 0.63 | 0.25 | 0.57 | 0.63 | 5.00 | 0.25 | 0.25 | 0.63 | 0.51 | 0.38 | 0.25 |
| **Total receipts** | **0.73** | **0.29** | **30.65** | **0.21** | **0.30** | **0.23** | **31.13** | **0.93** | **0.25** | **0.57** | **0.63** | **36.13** | **0.25** | **0.25** | **0.63** | **31.64** | **0.38** | **0.25** |
| **Payments** | | | | | | | | | | | | | | | | | | |
| Pay Expenditure (excl. Agency) | (0.41) | (0.44) | (0.40) | (20.80) | (0.02) | (0.61) | (0.45) | (9.17) | (11.31) | (0.44) | (0.41) | (3.55) | (16.93) | (0.44) | (0.41) | (3.55) | (16.93) | (0.44) |
| Non Pay Expenditure | (2.44) | (3.41) | (2.66) | (3.55) | (2.59) | 0.22 | (2.83) | (4.50) | (2.48) | (2.98) | (2.98) | (0.27) | (0.98) | (2.18) | (2.05) | (4.76) | (4.48) | 3.09 |
| Capital Expenditure | (0.06) | (0.09) | (0.09) | (0.82) | (0.15) | (0.22) | (0.23) | (0.22) | (0.22) | (0.22) | (0.22) | (2.94) | (2.22) | (0.72) | (0.85) | (0.22) | (0.22) | (6.49) |
| **Total payments** | **(2.90)** | **(3.94)** | **(3.14)** | **(25.17)** | **(2.75)** | **(0.61)** | **(3.51)** | **(13.89)** | **(14.01)** | **(3.64)** | **(3.61)** | **(6.75)** | **(20.13)** | **(3.34)** | **(3.31)** | **(8.52)** | **(21.63)** | **(3.84)** |
| **Net Receipts/ (Payments)** | **(2.17)** | **(3.65)** | **27.50** | **(24.96)** | **(2.45)** | **(0.38)** | **27.62** | **(12.96)** | **(13.76)** | **(3.06)** | **(2.98)** | **29.38** | **(19.88)** | **(3.09)** | **(2.68)** | **23.12** | **(21.25)** | **(3.59)** |
| **Funding Flows** | | | | | | | | | | | | | | | | | | |
| PDC Capital | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.09 | 0.00 | 0.00 | 0.00 | 5.01 | 0.00 | 6.09 | 0.00 | 0.00 |
| Dividend payable | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | (3.65) | 0.00 | 0.00 |
| Total Funding | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **1.09** | **0.00** | **0.00** | **0.00** | **5.01** | **0.00** | **2.44** | **0.00** | **0.00** |
| **BANK BALANCE C/FWD** | **32.24** | **28.58** | **56.09** | **31.13** | **28.68** | **28.30** | **55.92** | **42.96** | **29.20** | **27.23** | **24.25** | **53.63** | **33.75** | **35.68** | **33.00** | **58.55** | **37.30** | **33.72** |




| Prior year end | £'000 | Month end actual | Var. |
|---|---|---|---|
| 33,455 | Cash | 28,704 | (4,751) |

The overall cash balance has decreased by £4.0m in December

**£31.5m of cash was received in month**

£30.5m NHS contract income for the month and £1.0m cash receipts in relation to trading activities and settlement of prior period sales invoices.

**£35.5m of cash was paid out by the Trust in month**

£12.6m (34%) in direct salary costs to substantive and bank employees.
£9.4m (27%) employer costs to HMRC and NHSP - now paid as due rather than prepaid.
£13.5m (38%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

# 8. Conclusions

The Finance Committee is asked to note the report and financial performance, which is £2,190k deficit in-month, £13,912k deficit year to date; this is £12,553k adverse to the YTD plan submitted to NHSE and the Kent & Medway ICS in June 2022. The overall plan for the year is a breakeven position; there continues to be a high degree of risk in delivering this control total in 2022/23 and work is ongoing both internally and with system partners in respect of mitigating actions, intervention requirements and deliverability. The Trust continues to work with the Kent & Medway ICB to produce a revised system position, this will be agreed across all providers prior to being reported to NHSE and will be reported to the committee when available.

The current efficiency programme is £2.3m adverse to plan, with a delivery of £5.3m year to date; the plan includes £0.4m of the stretch target. ESRF income of £7.5m has been included at a cost of £2.8m for activity delivered by the independent sector and additional consultant sessions; the risk of repaying the ESRF income has been mitigated by NHSE and the ICB for the full year.

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

**Alan Davies**
Chief Financial Officer
January 2023

# Meeting of the Board (Public)
# Wednesday, 01 February 2023

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Integrated Quality and Performance Report | | **Agenda Item** | 12 |
| **Author** | Simon Bailey, Director of BI, Planning and Performance | | | |
| **Lead Executive Director** | Alan Davies, Chief Finance Officer | | | |
| **Executive Summary** | The monthly Integrated Quality and Performance Report | | | |
| **Proposal and/or key recommendation:** | To review and approve | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | | Approval | X |
| | Noting | | Discussion | |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: | Staff Confidentiality: | Commercially Sensitive: | Exceptional Circumstances: |
| **Committee/Group at which the paper has been submitted:** | Finance, Planning and Performance Committee | | | |

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

| | | | | | |
|---|---|---|---|---|---|
| **Relevant CQC Domain:** | Tick CQC domain the report aims to support: | | | | |
| | Safe: X | Effective: X | Caring: | Responsive: X | Well-Led: X |

| | |
|---|---|
| **Identified Risks, issues and mitigations:** | Related to performance risks described in the report. |
| **Resource implications:** | N/A |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |

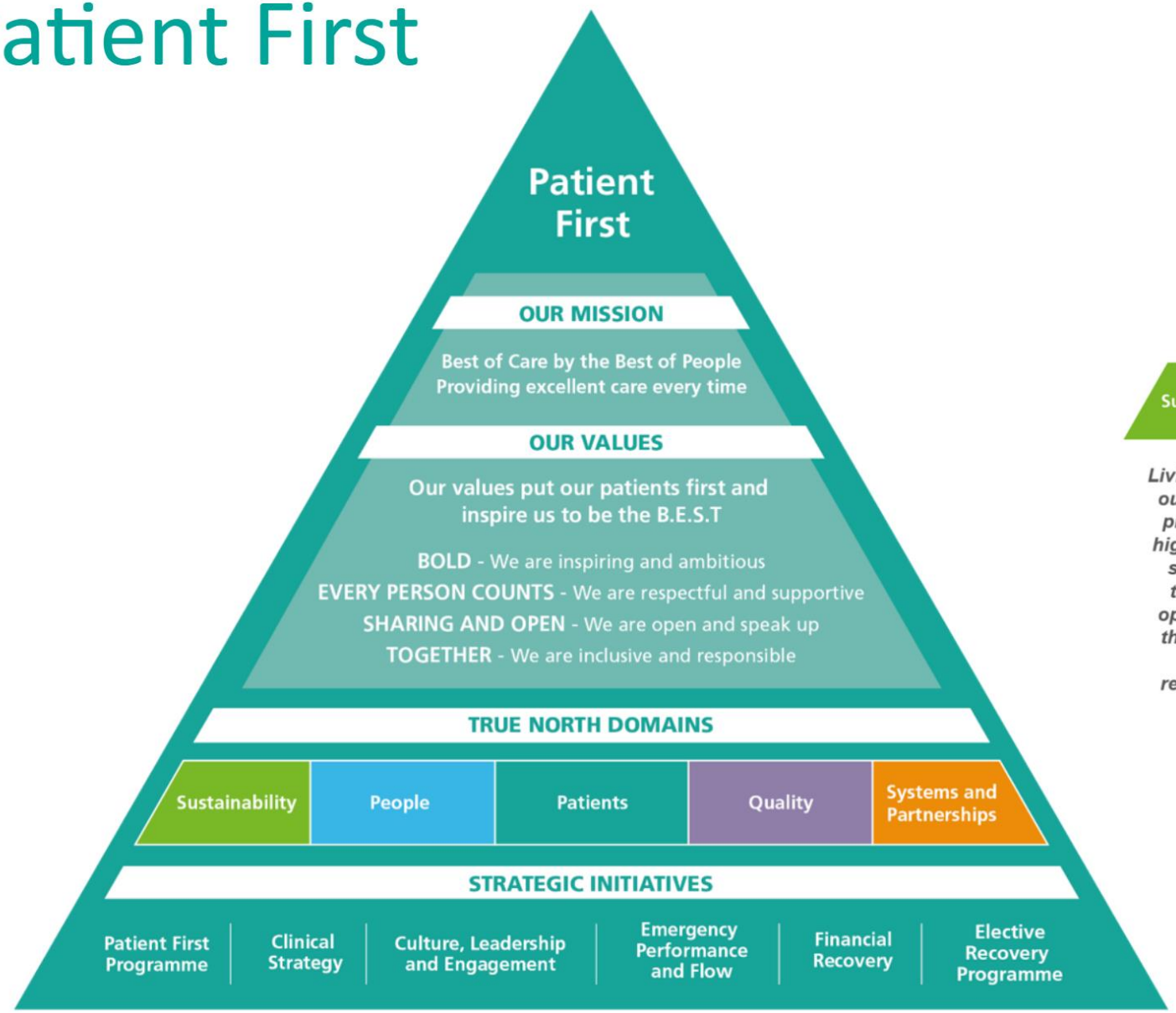
| | | | |
|---|---|---|---|
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☐ Not applicable (*please indicate why an equality assessment was not required)* | | |
| **Legal and Regulatory implications:** | It is a contractual requirement to produce and publish quality and performance data. | | |
| **Appendices:** | The IQPR Report | | |
| **Freedom of Information (FOI) status:** | This paper is disclosable under the FOI Act, | | |
| **For further information or any enquires relating to this paper please contact:** | Simon.bailey2@nhs.net | | |
| **Reports require an assurance rating to guide the discussion:** | Insert Tick | | |
| | No Assurance | | There are significant gaps in assurance or actions |
| | Partial Assurance | | There are gaps in assurance |
| | Assurance | X | Assurance minor improvements needed. |
| | Significant Assurance | | There are no gaps in assurance |
| | Not Applicable | | No assurance required. |

NHS
Medway
NHS Foundation Trust

# Integrated Quality & Performance Report

December - 2022

# Patient First




| Sustainability | People | Patients | Quality | Systems and Partnerships |
|---|---|---|---|---|
| *Living within our means providing high quality services through optimising the use of our resources* | *To be the employer of choice and have the most highly engaged staff within the NHS* | *Providing outstanding, compassionate care for our patients and their families, every time* | *Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have* | *Delivering timely, appropriate access to acute care as part of a wider integrated care system* |

# SIOR

## Executive Summary

**Jayne Black**

***Chief Executive***

## Successful Deliverables

- The Trust has received £825k additional income for the year from NHSE specialised commissioning team, under the Elective Recovery Fund.
- Continued improvement to substantive staffing profile (improved and sustained vacancy and turnover), driving reduction in bank and agency spend in Planned Care
- Reduction in open Serious Incidents with ICB & Self assessment tool rolled out to speciality to assess areas in need of support.
- The performance in cancer 31day, 31 sub treatment, 62 day screening, 28 day were all compliant for the last reported period (November).
- Phase One of the Acute Medical Model continues to enable significant improvements in ambulance handover.
- Statistically, there was a high level of positive variation shown within the Workforce sub-domain

## Identified Challenges

- The key challenges in delivery against the balanced financial plan primarily relate to the key drivers of the deficit, including unbudgeted escalation capacity, medical staffing, drugs, clinical supplies and shortfall against the efficiencies target.
- Domestic skills shortage across all clinical professions continues dependency on international recruitment.
- Trust entered into internal business continuity for a period between Christmas, New Year & into January.
- SJR reporting- currently there is no reporting database for SJRs making analysis around themes and trends challenging.
- As a result of the elective pause at the end of Q3, to support non-elective surge, the non-admitted 52 week patient backlog has now increased to 634 however no 78 week breaches at this point. The main area of concern remains in ENT.
- Release CDU capacity for ambulatory patients

## Opportunities

- The Trust has identified a number of mitigating actions to reduce the monthly overspend with a plan to contain the year end deficit within the agreed revised target of £15m deficit
- Further development of our international recruitment across other clinical specialties
- Roll out plan of 'you said, we did' posters in all areas
- Governance staff moving into new roles within central team gives an opportunity to review, revise and update processes and procedures
- The Trust is exploring potential additional capacity for endoscopy with a neighbouring NHS Trust.
- To implement the Second Phase of the Acute Medical Model for direct access to Frailty, SAU, GEC/EPAC.
- Data Assurance Committee involved in looking at Data Quality for ED

## Risks

- The key risks to delivery of the financial mitigation plan and operational delivery will be closely monitored through to year end, and include delivery of the bed de-escalation plan and of further non-recurrent financial mitigations
- Organisational capacity and staffing pressure due to ongoing or prolonged industrial action
- Data quality issues.
- The lack of capacity in the breast unit could lead to a deterioration in overall performance of the 2WW standard, which would in turn impact the 62-day standard over the remaining quarter.
- The continuing high MFFD number will have a direct impact on ED performance due to lack of flow (DTA's awaiting beds).

# Executive Summary

| True North | Sub Domain | Variation | | | Assurance | | |
|---|---|---|---|---|---|---|---|
| | | | H/L | H/L | P | F | ? |
| Patients | Experience | 6 | 2 | 7 | 1 | 5 | 6 |
| People | Workforce | 8 | 4 | 2 | 1 | 4 | 5 |
| Quality | Harm | 19 | 3 | 7 | 0 | 1 | 8 |
| | Mortality | 2 | 0 | 5 | 1 | 2 | 4 |
| Sustainability | Financial Position | 8 | 1 | 2 | 0 | 0 | 6 |
| Systems & Partnerships | Access | 11 | 4 | 10 | 3 | 4 | 11 |
| | Emergency Care | 3 | 2 | 6 | 1 | 2 | 6 |

| Variation | | | Assurance | | |
|---|---|---|---|---|---|
| | H/L | H/L | ? | P | F |
| Common cause – no significant change | Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or lower pressure due to (H)igher or (L)ower values | Variation indicates inconsistently hitting passing and falling short of the target | Variation indicates consistently (P)assing the target | Variation indicates consistently (F)alling short of the target |

**Variation icons:** **Orange** indicates concerning **special cause variation** requiring action; **Blue** indicates where improvement appears to lie, and grey indicates no significant change (**common cause variation**).

**Assurance icons:** **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

# Sustainability

NHS Medway NHS Foundation Trust

Patient FIRST

# Sustainability

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

## Financial Position

### Breakeven Revenue Budget (£)

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | £0 | H | ? | 0.06m | -0.54m | 0.36m | 0.55m | 0.45m | 0.43m | 0.21m | 1.19m | 1.65m | 3.04m | 4.18m | 2.20m |

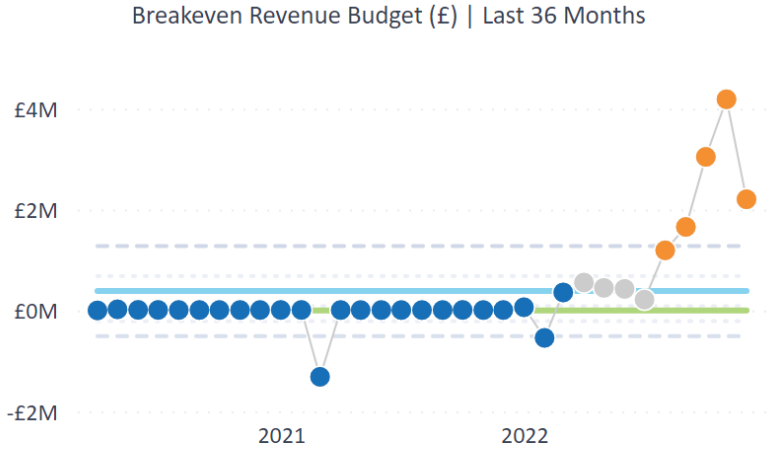
True North Domain: **Sustainability**

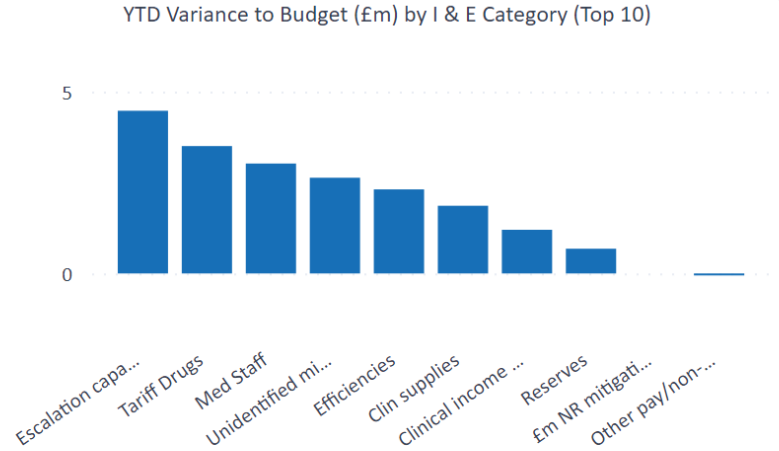
KPI Target: £0

Sub Domain KPIs: 11

Variation Summary:

| | | | | |
|---|---|---|---|---|
| | L | H | L | H |
| 8 | 0 | 2 | 0 | 1 |




## Key Messages

The Trust's financial performance in month 9 was a deficit of £2.2m (£2.1m adverse to plan), increasing the YTD deficit to £13.9m (£12.6m adverse).
The Trust has followed the NHSE protocol with the ICB to develop a revised forecast outturn, setting out the drivers of the deficit and mitigations, in order to deliver a revised year end target deficit of £15m. The Reforecast Protocol is being presented to FPPC on 25th January for agreement and recommendation to the Board for approval.
The adverse financial performance means that the Trust currently remains in SOF4.

## Issues, Concerns & Gaps

Reporting a deterioration in the forecast against our control total is a breach of the Trust's statutory duty and has triggered the requirement for the Reforecast report.
The overspending is primarily driven by the unbudgeted cost of escalation capacity, overspendings on medical staff, drugs and clinical supplies and shortfall against efficiencies target, together with unidentified mitigations of £3.5m for the year (see graph above right).

## Actions & Improvements

The 'control of overspending' breakthrough huddle has launched and concerted efforts and counter measures are under development and implementation with regards to medical pay costs, drugs expenditure and clinical supplies expenditure.
A range of other mitigating actions have been agreed by the Executive Team to reduce the monthly level of overspend, which is set out in the Reforecast Protocol Report, with the aim to mitigate the deficit to £15m as agreed with the ICB.

# SIOR

## Financial Position

**Alan Davies**

***Chief Financial Officer***

## Successful Deliverables

The level of overspend in month 9 (December) was lower than that in the previous two months, primarily due to the reduction in the pay run rate in Planned Care and additional income of £825k for the year from NHSE specialised commissioning under the Elective Recovery Fund. The Trust has identified a plan to mitigate the year end deficit to £15m, as set out in the Reforecast Protocol Report, albeit delivery of this plan contains risk.

## Identified Challenges

The key challenges in delivery against the balanced financial plan primarily relate to the key drivers of the deficit, i.e.:

- Unbudgeted escalation capacity requiring to be open due to operational pressures and high numbers of medically fit patients
- Full identification and delivery against the efficiency programme
- Overspending and over-establishment against the medical staff budget
- Overspending against the drugs budget
- Overspending against the clinical supplies budget

## Opportunities

The Trust has identified a number of mitigating actions to reduce the monthly overspend.
Those matters that have been decided already and implemented include enhanced controls applicable at the Trust's Vacancy Control Panel. Further details are set out in the Reforecast Protocol Report.
Further opportunities are being identified through the work of the Breakthrough Objective for Sustainability, in relation to Medical Staff, Medicines and Clinical Supplies. These are set out in more detail in the Reforecast Protocol Report. Weekly Huddles are underway, led by the CFO with support from other Execs, Divisional leadership and subject matter leads. This work is being fed through the Divisional and Care Group Strategic Deployment Review meetings and will feed in to Business Planning and the Efficiencies Programme for 2023/24.
The Trust is finalising the bed de-escalation plan which will begin to mitigate the overspend attributable to this driver.
Planning for the Efficiencies Programme for 2023/24 is underway with a draft plan by the end of February (further details in Efficiencies Report to FPPC)

## Risks

The key risks to delivery of the mitigation plan with be closely monitored through to year end. These are described in more detail in the Reforecast Report, but include:

- Delivery of bed de-escalation plan, with delivery of the System schemes funded by the Discharge Fund a key enabler, as well as virtual wards and Sheppey Frailty Unit.
- Delivery of further non-recurrent financial mitigations
- Final agreement of funding of £1.8m for two wards for medically fit patients at MFT
- Ensuring ongoing control of recruitment, agency spend, additional sessions and discretionary non-pay.

Other risks include:

- A harsh winter that overloads the emergency department and other services, severely impacting patient flow through the hospital.
- Further strike action negatively impacting the Trust's performance and finances.
- A rise in the number of Covid patients requiring reintroduction of infection prevention and control measures.

# Sustainability

## Financial Position - KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sustainability | Financial Position | | | Breakeven Revenue Budget (£) | £0 | H | ? | 0.06m | -0.54m | 0.36m | 0.55m | 0.45m | 0.43m | 0.21m | 1.19m | 1.65m | 3.04m | 4.18m | 2.20m |
| | | | | Agency Spend % | 2.0% | | ? | 0.4% | 2.4% | 3.9% | 3.3% | 3.7% | 2.6% | 3.7% | 3.5% | 3.0% | 3.1% | 3.1% | 2.8% |
| | | | | Bank Spend % | 10.0% | | ? | 14.0% | 11.8% | 17.2% | 14.0% | 9.8% | 16.6% | 13.8% | 13.4% | 10.2% | 11.9% | 12.2% | 11.2% |
| | | | | Agency Spend (£) | - | | | 0.08m | 0.52m | 0.72m | 0.67m | 0.76m | 0.52m | 0.75m | 0.77m | 0.76m | 0.71m | 0.70m | 0.63m |
| | | | | Income (£) | - | | | -31.60m | -32.35m | -47.74m | -31.59m | -33.15m | -31.95m | -32.48m | -32.62m | -35.65m | -32.64m | -33.03m | -34.20m |
| | | | | Income (£) vs Budget | £0 | | ? | 0.34m | -1.17m | -16.55m | 0.34m | -1.31m | 0.86m | -0.29m | -0.42m | -3.26m | -0.41m | -0.69m | -1.93m |
| | | | | Total Pay Spend (£) | - | | | 20.37m | 21.41m | 32.15m | 20.39m | 20.25m | 19.85m | 20.09m | 21.91m | 25.22m | 22.74m | 22.74m | 22.26m |
| | | | | Total Pay Spend (£) vs Budget | £0 | | ? | 0.70m | 1.72m | 12.47m | -0.18m | -0.25m | -0.64m | -0.33m | 1.49m | 2.42m | 2.28m | 2.22m | 1.78m |
| | | | | Total Non-Pay Spend (£) | - | H | | 9.84m | 9.51m | 13.12m | 10.07m | 11.50m | 10.77m | 10.35m | 10.03m | 10.23m | 11.19m | 12.65m | 12.32m |
| | | | | Total Non-Pay Spend (£) vs Budget | £0 | | ? | -0.98m | -0.54m | 2.91m | -0.01m | 1.56m | -0.08m | 0.28m | -0.08m | 3.32m | 1.20m | 2.61m | 2.30m |
| | | | | Establishment WTE | - | H | | 4,831.75 | 4,827.52 | 4,983.58 | 4,870.10 | 4,722.18 | 4,989.22 | 4,934.96 | 4,935.05 | 4,911.91 | 4,952.63 | 5,017.52 | 5,001.50 |

# People

NHS Medway NHS Foundation Trust

Patient FIRST

# People

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

## Workforce

### National Staff Engagement Score

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|
| | 7.30 | | F | 6.50 | 6.50 | 6.50 |

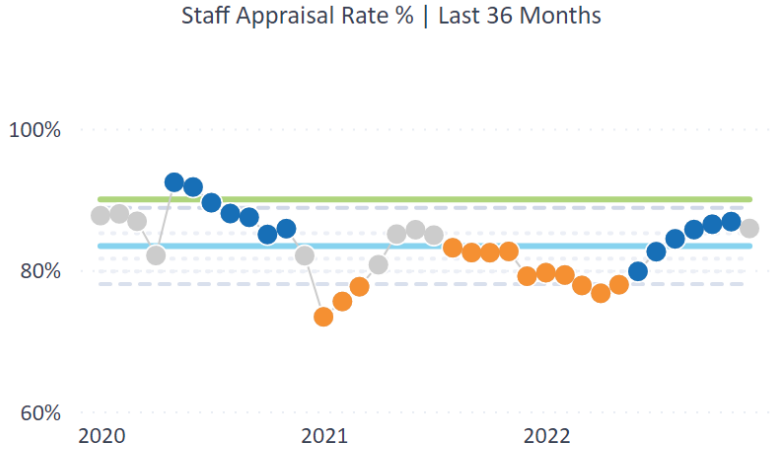
True North Domain: **People**

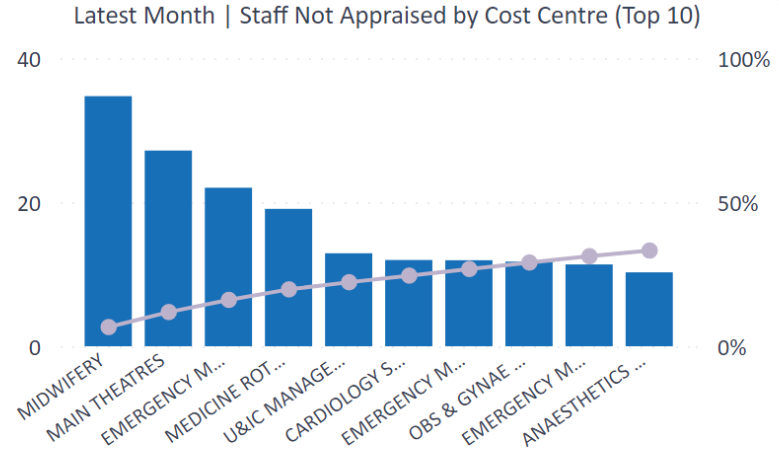
KPI Target: 7.30

Sub Domain KPIs: 14

Variation Summary:

| | L | H | L | H |
|---|---|---|---|---|
| 8 | 1 | 1 | 2 | 2 |




## Key Messages

Staff survey (engagement score) likely to be finalised and reported from January 2023;
Voluntary turnover (annual) continues to reduce; however remains above 12%;
Appraisal and wellbeing conversation (breakthrough) reporting first decrease in month since April 22.
Sickness rate spikes in December 2022 due to cold/flu and Covid absence.

## Issues, Concerns & Gaps

Domestic skills shortage across all clinical professions continues dependency on international recruitment;
Band 6 nursing, clinical support workers, radiographers, ENT consultants remain the highest vacancy levels;
Profile indicates lower proportional diversity at senior levels;
Staff engagement scores only collected annually (at representational levels of response).

## Actions & Improvements

Workforce Race and Disability Equality Standards actions (anti-discrimination draft statement January 2023) and strategy (focus events – racial justice, LGTBQIA+ and disability completed, women's network in Q4 22/23);
Reducing clinical vacancies task and finish group (A3).

# SIOR

## Workforce

**Leon Hinton**

***Chief People Officer***

## Successful Deliverables

- Draft anti-discrimination policy under review by networks and equality and inclusion group through January 2023.
- Continued improvement to substantive staffing profile (improved and sustained vacancy and turnover)
- Working group to focus on clinical vacancies in place using patient first methodology;
- Sustained appraisal rate over target for planned care.

## Identified Challenges

- Domestic skills shortage across all clinical professions continues dependency on international recruitment;
- Band 6 nursing, clinical support workers, radiographers, ENT consultants remain the highest vacancy levels;
- Profile indicates lower proportional diversity at senior levels;
- Staff engagement scores only collected annually (at representational levels of response);
- Effects of ongoing industrial action within Trust and the wider system on capacity.

## Opportunities

- Renewal of StatMan working group to innovatively address competencies with lower than target rates – delivery of classroom-based competencies and assessment;
- Further development of our international recruitment across other clinical specialties;
- Task and finish group for line-by-line review of agency and long-term bank assignments to ensure recruitment plan in place and effectiveness review.

## Risks

- Underutilisation of apprenticeship levy (moderate), although meeting headcount number, spend is lower than 100%. The Trust is supporting the Health and Care Partnership through sharing levy;
- Organisational capacity due to ongoing or prolonged industrial action. The Trust has completed and will monitor the impact assessment and effectiveness of its internal business continuity planning whilst liaising with unions.

# People

## Workforce – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People | Workforce | | | National Staff Engagement Score | 7.30 | | F | 6.50 | 6.50 | 6.50 | | | | | | | | | |
| | | | | Staff Appraisal Rate % | 90.0% | | F | 79.6% | 79.3% | 77.8% | 76.7% | 77.9% | 79.8% | 82.6% | 84.4% | 85.7% | 86.5% | 86.9% | 85.9% |
| | | | | Staff in Post (FTE) | - | H | | 4,282.79 | 4,297.98 | 4,322.01 | 4,334.73 | 4,344.55 | 4,374.26 | 4,389.40 | 4,407.90 | 4,424.08 | 4,460.50 | 4,506.19 | 4,543.50 |
| | | | | Staff Leavers (FTE) | - | | | 61.47 | 60.27 | 85.08 | 51.04 | 56.88 | 48.35 | 88.85 | 161.34 | 84.08 | 76.49 | 46.88 | 48.66 |
| | | | | Staff Starters (FTE) | - | | | 65.53 | 63.64 | 94.15 | 71.53 | 64.35 | 63.95 | 39.24 | 190.11 | 82.31 | 113.06 | 81.27 | 43.99 |
| | | | | Vacancy Rate % | 9.0% | L | F | 10.3% | 10.0% | 9.7% | 12.7% | 12.6% | 12.4% | 12.1% | 11.5% | 11.0% | 9.9% | 9.1% | 9.4% |
| | | | | Voluntary Turnover % | 8.0% | H | ? | 12.1% | 12.5% | 12.8% | 12.8% | 13.1% | 12.8% | 13.2% | 13.0% | 13.3% | 12.9% | 12.4% | 12.1% |
| | | | | Staff Fill Rate - Total % | 85.0% | | ? | 78.3% | 77.5% | 77.8% | 81.3% | 83.1% | 83.0% | 79.9% | 79.7% | 84.3% | 81.9% | 83.7% | 81.1% |
| | | | | Staff Fill Rate % (Total) - Registered Nurse | - | | | 76.7% | 75.6% | 75.0% | 79.3% | 83.0% | 81.6% | 78.5% | 77.7% | 82.1% | 81.8% | 82.0% | 80.0% |
| | | | | Care Hours per Patient Day (CHPPD) | 9.50 | L | ? | 8.21 | 8.35 | 8.03 | 8.44 | 8.59 | 8.50 | 8.12 | 8.25 | 8.29 | 7.81 | 8.02 | 8.33 |
| | | | | Sickness Absence Rate - Total % | 4.0% | | ? | 6.0% | 5.2% | 5.6% | 4.9% | 4.3% | 4.6% | 6.0% | 4.5% | 4.5% | 5.0% | 4.6% | 5.5% |
| | | | | Sickness Absence Rate - Short Term % | 2.0% | | ? | 3.5% | 2.8% | 3.6% | 2.8% | 2.2% | 2.6% | 3.8% | 2.3% | 2.5% | 3.1% | 2.5% | 3.4% |
| | | | | Sickness Absence Rate - Long Term % | 2.0% | L | F | 2.5% | 2.4% | 2.1% | 2.1% | 2.1% | 2.0% | 2.2% | 2.2% | 2.0% | 1.9% | 2.1% | 2.0% |

# People

## Workforce – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People | Workforce | | | StatMan Training Compliance % | 85.0% | | | 86.1% | 86.2% | 83.3% | 85.0% | 85.3% | 85.0% | 85.3% | 85.9% | 86.3% | 86.3% | 86.9% | 87.2% |

# Patients

NHS Medway NHS Foundation Trust

Patient FIRST

# Patients

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

## Experience

### Inpatients FFT Recommend %

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 95.0% | | F | 78.7% | 76.6% | 81.3% | 74.1% | 73.2% | 83.5% | 65.8% | 75.6% | 75.6% | 70.3% | 90.7% | 86.0% |

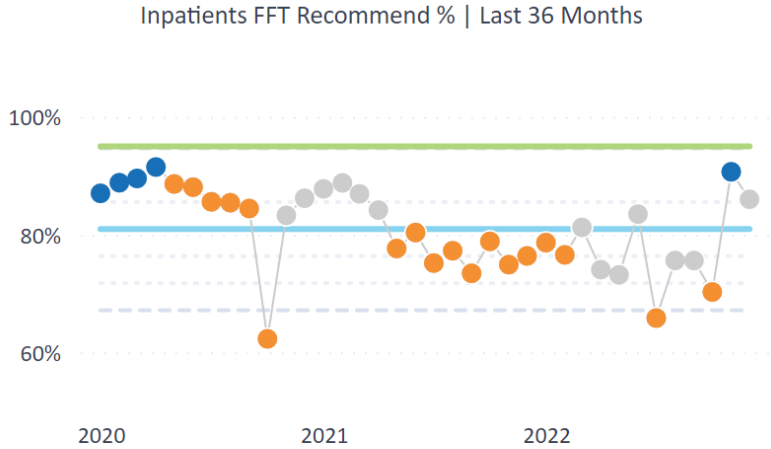
True North Domain: **Patients**

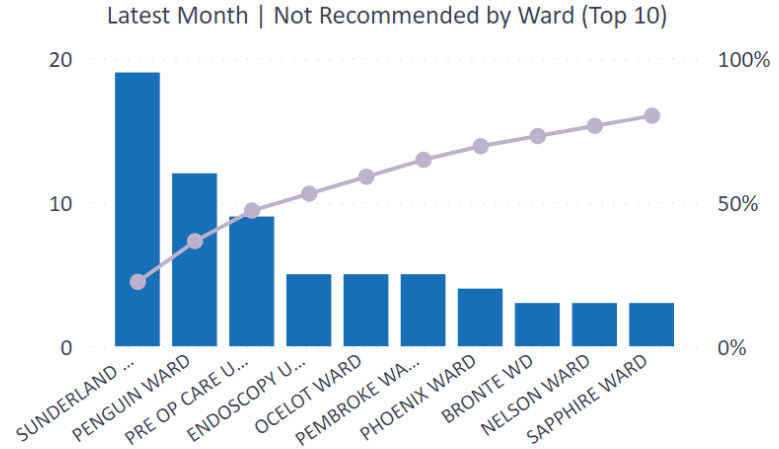
KPI Target: 95.0%

Sub Domain KPIs: 15

Variation Summary:

| | L | H | L | H |
|---|---|---|---|---|
| 6 | 4 | 3 | 2 | 0 |




## Key Messages

Overall experience of care / recommend rate remains high, although the Trust has seen a slight decline in recommend rate when compared to the previous month.

Reporting for themes and trends established via Gather to enable actions to be identified for QI.

## Issues, Concerns & Gaps

Driver huddles stood down during prolonged period of internal business continuity and FFT not sustained as BAU

FFT rates in maternity dropped significantly, this is due to the change in data gathering approach and faults identified with the QR codes / surveys.

## Actions & Improvements

Text message approach is going to be rolled out across the Trust with a focus on maternity areas.

# SIOR

## Experience

**Evonne Hunt**

***Chief Nursing Officer***

## Successful Deliverables

- Transition complete from Envoy to Gather which will enhance systems and processes
- Huddles ongoing in patient first roll out areas to improve performance against the True North Objective
- Recommend rate improvement from previous month, but requires ongoing monitoring through patient first methodology
- Improved staff FFT engagement
- Positive themes emerging from feedback through Gather which can be used to feed into the Patient Experience Academy

## Identified Challenges

- Trust entered into internal business continuity measures which has impacted on patient experience (especially within ED/SDEC) and led to the cancellation of Area/ward patient first huddles
- Electronic devices / Wi-Fi issues have impacted on the ability to collect responses
- Further work is required for the thematic analysis of data collected and the development of actions for improvement based on feedback
- Some areas are still collecting surveys on paper which creates a resource challenge to ensure data is uploaded in a timely way
- Further development of the dashboard on early warning card is required
- Complaints 3 day acknowledgement rate below expected target
- Breached Complaints peaked in December, and have now begun to reduce in January
- Mixed sex breaches continue to be of concern

## Opportunities

- Teaching on the gather system to further enhance its usability across the Trust and access to data for staff
- Text messaging opportunities to be reviewed and costed to ensure the Trust use all available methodologies for the collection of data to improve response rates
- Scrutinising the opened vs unopened links in each area to understand missed opportunities
- Forward action planning on Gather system to develop the 'you said we did' element of feedback
- Roll out plan of you said we did posters in all areas and move towards BAU
- Transition and re-alignment of complaints processes to improve the delivery of the complaint 3 days acknowledgement target
- Further work is required to understand data quality issues around mixed sex breach reporting

## Risks

- Trust entering into internal business continuity measures results in patient experience activities being stopped. This will impact on the continuity of the roll out of patient experience improvement initiatives, study days, etc.

# Patients

## Experience – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | Experience | | | Inpatients FFT Recommend % | 95.0% | | F | 78.7% | 76.6% | 81.3% | 74.1% | 73.2% | 83.5% | 65.8% | 75.6% | 75.6% | 70.3% | 90.7% | 86.0% |
| | | | | Inpatients FFT Response Rate % | 18.0% | L | ? | 18.0% | 19.1% | 19.7% | 18.9% | 18.2% | 21.2% | 17.2% | 19.3% | 15.8% | 18.8% | 10.3% | 14.7% |
| | | | | Emergency Care FFT Recommend % | 70.0% | L | ? | 79.1% | 74.0% | 71.4% | 70.8% | 69.2% | 65.1% | 66.5% | 52.6% | 70.9% | 61.3% | 66.8% | 67.3% |
| | | | | Emergency Care FFT Response Rate % | 18.0% | L | F | 14.3% | 14.9% | 14.2% | 14.3% | 14.2% | 14.0% | 13.8% | 15.0% | 12.3% | 12.7% | 8.4% | 9.0% |
| | | | | Outpatient FFT Recommend % | 70.0% | | P | 89.8% | 89.2% | 89.1% | 89.3% | 89.5% | 88.4% | 88.0% | 88.9% | 88.5% | 89.7% | 90.0% | 90.3% |
| | | | | Outpatient FFT Response Rate % | 18.0% | | F | 7.9% | 7.6% | 7.4% | 6.7% | 7.4% | 8.1% | 8.3% | 8.1% | 8.0% | 8.5% | 7.5% | 10.5% |
| | | | | Complaints | 0 | | F | 30 | 23 | 49 | 37 | 39 | 38 | 28 | 49 | 39 | 50 | 37 | 36 |
| | | | | Complaints Acknowledged Within 3 Working Days % | 95.0% | | ? | 93.3% | 91.3% | 83.7% | 100.0% | 92.3% | 100.0% | 96.4% | 93.9% | 100.0% | 92.0% | 94.6% | 94.4% |
| | | | | Complaints Breached % | 85.0% | L | ? | 86.7% | 69.6% | 77.6% | 83.8% | 41.0% | 44.7% | 67.9% | 65.3% | 76.9% | 82.0% | 64.9% | 19.4% |
| | | | | Patient Advice and Liaison Service (PALS) Concerns | - | H | | 367 | 416 | 501 | 419 | 460 | 418 | 440 | 467 | 405 | 468 | 507 | 366 |
| | | | | Parliamentary and Health Service Ombudsman (PHSO) Cases | - | L | | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | Parliamentary and Health Service Ombudsman (PHSO) Cases - Month End | - | | | - | - | - | - | - | - | - | - | - | - | - | - |
| | | | | Mixed Sex Accommodation (MSA) Compliance % | 0.0% | H | ? | 0.6% | 0.7% | 1.0% | 0.4% | 0.5% | 0.4% | 0.5% | 0.8% | 0.8% | 1.2% | 2.0% | 9.2% |

# Patients

## Experience – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients | Experience | | | Mixed Sex Accommodation Breaches | 0 | H | ? | 103 | 109 | 165 | 67 | 92 | 69 | 93 | 140 | 139 | 211 | 346 | 1,649 |
| | | | | EDNs Completed Within 24hrs % | 90.0% | L | F | 67.3% | 69.4% | 67.4% | 69.1% | 69.5% | 68.7% | 69.1% | 68.3% | 61.2% | 18.3% | 28.2% | 57.1% |

NHS
Medway
NHS Foundation Trust

# Quality

# Quality

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

## Harm

### Incidents with Harm

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | | F | 13 | 14 | 13 | 14 | 7 | 10 | 8 | 9 | 13 | 22 | 19 | 20 |

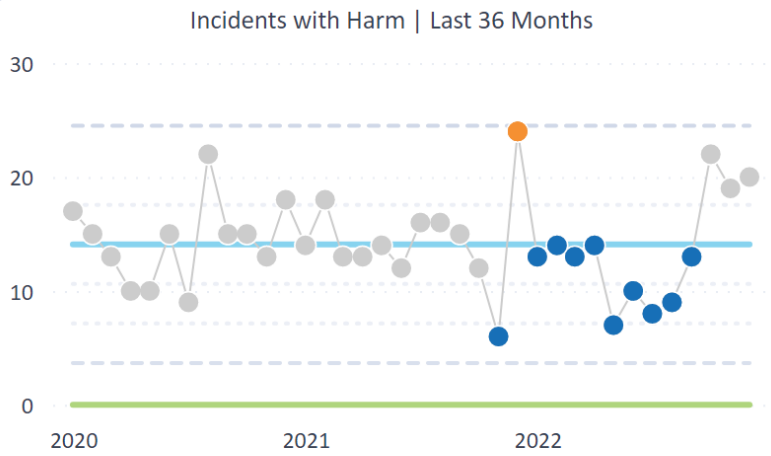
True North Domain: Quality

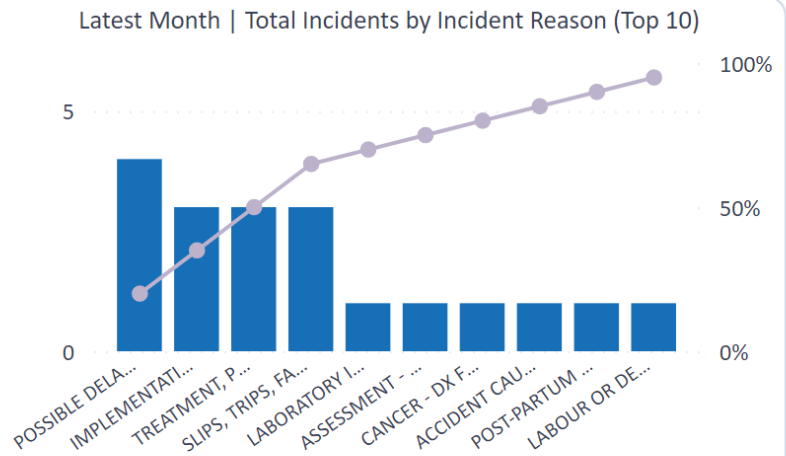
KPI Target: 0

Sub Domain KPIs: 29

Variation Summary:

| | L | H | L | H |
|---|---|---|---|---|
| 19 | 1 | 6 | 2 | 1 |




## Key Messages

- Incident reporting has increased over the previous quarter in line with internal business continuity.
- Whilst the graph suggests an increase in harm reporting – this needs to be considered in context with overall reporting across the Trust.
- Moderate and above harm remain consistent at less than 2% of total reporting in line with previous months.

## Issues, Concerns & Gaps

- With increased reporting, and decreased resources due to Trust bed status, investigations are not as timely or thorough as required. This can cause a loss of confidence in reporting and poor learning outcomes from investigations.

## Actions & Improvements

- New Datix form launched in early December. This will allow better data validation and collection, including data surrounding 2222 calls.
- Daily validation to categorise incidents provides greater assurance of emerging themes within the incidents reported.

# SIOR

## Harm

**Alison Davis**

***Chief Medical Officer***

## Successful Deliverables

- Reduction in open Serious Incidents with ICB, with an improved closure rate achieved due to enhancement and development of the Serious Incident Review Group and Incident Review Group systems and processes.
- Datix reporting increasing month on month without notable increase in percentage of harms seen, which demonstrates a good and open reporting culture.
- New Datix form launched for simpler reporting.
- No grade 3 pressure ulcers for 4 consecutive months.
- No never events for 4 consecutive months.
- 12 hour breach harm review migrated to Datix to ensure easy capture of themes

## Identified Challenges

- internal business continuity reducing staff ability to investigate and close opened datix incidents, which remain above the agreed 10% of the number of incidents reported.
- Redesigned form will need to change with introduction of LFPSE in September 2023
- Team capacity to complete daily cleanse as number of incidents increases
- 12 hour breaches, pressure ulcers on admission and implementing ongoing monitoring and escalation remain the top three most reported incident types.
- Delayed reporting of RIDDOR incidents remains an ongoing issue as identified by the HSE.

## Opportunities

- Staff moving into new roles within central team gives and opportunity to review, revise and update processes and procedures, and continue to build upon successes in changes to systems and process.
- Continued work around 72 hour reporting of incidents.
- Opportunity to review how learning outcomes and good practise is shared across the Trust, and the team will be looking to introduce a centralised action database to ensure the ability to target quality improvement work.

## Risks

- Risk of non-compliance with upgrade to LFPSE compatible system by national deadline of March 2023 due to server upgrades required
- Risk of non-compliance with duty of candour legislation
- Risk of decreased staff engagement if incidents are not investigated in a thorough, timely manner
- Risk of regulatory action by HSE as a result of late RIDDOR submissions.

# Quality

## Harm – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | Harm | | | Incidents with Harm | 0 | | F | 13 | 14 | 13 | 14 | 7 | 10 | 8 | 9 | 13 | 22 | 19 | 20 |
| | | | | Total Incidents | - | H | | 835 | 838 | 1,044 | 954 | 1,158 | 955 | 1,117 | 1,029 | 1,157 | 1,489 | 1,312 | 1,405 |
| | | | | Falls - Total | - | H | | 90 | 83 | 91 | 94 | 81 | 77 | 82 | 84 | 78 | 103 | 97 | 96 |
| | | | | Falls - Low Harm | - | H | | 18 | 20 | 25 | 30 | 18 | 28 | 19 | 27 | 26 | 27 | 19 | 23 |
| | | | | Falls - Moderate Harm | - | | | 2 | 3 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | 1 | 5 | 2 |
| | | | | Falls - Severe Harm | - | | | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 2 | 1 | 2 | 1 |
| | | | | Falls Resulting in Death | - | | | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| | | | | Falls per 1,000 Bed days | - | | | 6.19 | 6.10 | 6.08 | 6.48 | 5.46 | 5.37 | 5.58 | 5.67 | 5.42 | 6.78 | 6.57 | 6.22 |
| | | | | Pressure Ulcers - Grade 1 | - | H | | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| | | | | Pressure Ulcers - Grade 2 | - | | | 4 | 2 | 8 | 8 | 7 | 5 | 4 | 6 | 6 | 5 | 14 | 6 |
| | | | | Pressure Ulcers - Grade 3 | 0 | | ? | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| | | | | Pressure Ulcers - Grade 4 | 0 | | ? | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 |
| | | | | Pressure Ulcers - Unstageable | - | H | | 4 | 10 | 9 | 8 | 9 | 4 | 7 | 4 | 10 | 12 | 15 | 11 |

# Quality

## Harm – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | Harm | | | Pressure Ulcers - Deep Tissue Injury | - | | | 5 | 5 | 5 | 7 | 10 | 6 | 4 | 6 | 7 | 6 | 15 | 10 |
| | | | | Pressure Ulcers per 1,000 Bed Days | - | | | 1.24 | 1.69 | 1.47 | 1.59 | 1.75 | 1.05 | 1.02 | 1.15 | 1.60 | 1.65 | 3.05 | 2.33 |
| | | | | Serious Incidents | - | L | | 5 | 10 | 12 | 8 | 3 | 1 | 4 | 5 | 8 | 14 | 12 | 10 |
| | | | | Serious Incidents Responded to Within 60 Days % | 95.0% | H | ? | 20.0% | 70.0% | 16.7% | 0.0% | 0.0% | 0.0% | 0.0% | 40.0% | 12.5% | 50.0% | 91.7% | 90.0% |
| | | | | Open Incidents | - | H | | 4 | 0 | 4 | 2 | 2 | 4 | 8 | 10 | 13 | 35 | 72 | 489 |
| | | | | Open Incidents - Month End | - | L | | 483 | 595 | 659 | 732 | 686 | 524 | 791 | 755 | 897 | 1,093 | 830 | 1,080 |
| | | | | Never Events | 0 | | ? | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| | | | | Medication Errors - Total | - | | | 43 | 56 | 77 | 54 | 88 | 64 | 66 | 68 | 77 | 98 | 83 | 64 |
| | | | | IPC Incidents | - | | | 36 | 19 | 56 | 42 | 36 | 27 | 31 | 23 | 42 | 26 | 15 | 21 |
| | | | | C-Diff Cases - Hospital Acquired Total | - | | | 1 | 3 | 2 | 3 | 3 | 4 | 3 | 4 | 5 | 2 | 5 | 2 |
| | | | | C-Diff Cases - Hospital Acquired (HOHA) | - | | | 1 | 1 | 1 | 2 | 3 | 4 | 3 | 3 | 5 | 2 | 5 | 2 |
| | | | | E.coli Cases - Hospital Acquired | 5 | | ? | 2 | 3 | 2 | 6 | 3 | 5 | 2 | 3 | 2 | 2 | 2 | 2 |
| | | | | MRSA Cases - Hospital Acquired | 0 | | ? | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

# Quality

## Harm – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | Harm | | | MSSA Cases - Total | - | | | 41 | 37 | 51 | 36 | 50 | 40 | 36 | 44 | 47 | 35 | 48 | 40 |
| | | | | Covid-19 Diagnosed - Total | 0 | | | 835 | 409 | 698 | 549 | 139 | 105 | 430 | 133 | 106 | 237 | 55 | 134 |
| | | | | VTE Risk Assessment Completed % | 95.0% | | | 95.0% | 94.4% | 94.5% | 95.2% | 94.4% | 89.1% | 94.4% | 92.6% | 87.9% | 72.3% | 94.0% | 82.7% |

# Quality

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

## Mortality

Crude Mortality Rate %

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1.3% | | | 2.1% | 1.4% | 1.5% | 1.9% | 1.5% | 1.5% | 1.8% | 1.3% | 1.1% | 1.7% | 1.7% | 2.0% |

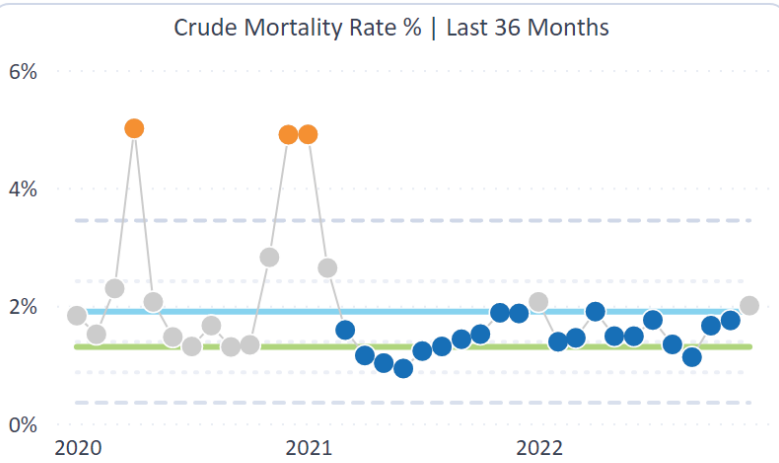
True North Domain: Quality

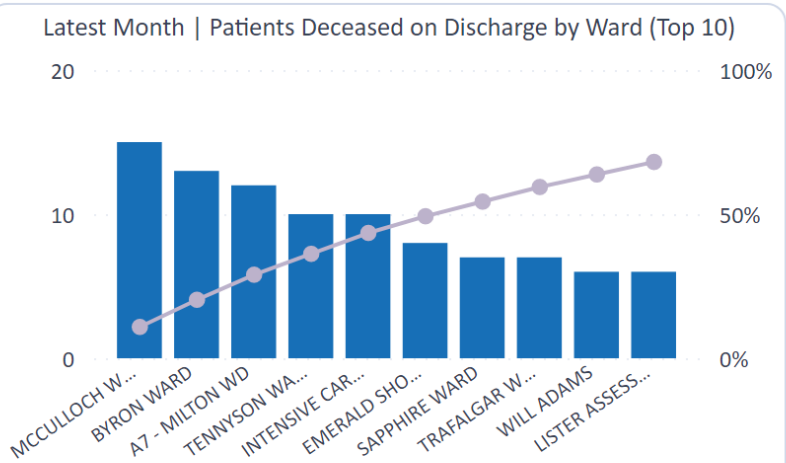
KPI Target: 1.3%

Sub Domain KPIs: 7

Variation Summary:

| | L | H | L | H |
|---|---|---|---|---|
| 2 | 0 | 5 | 0 | 0 |




## Key Messages

- Rolling crude rate continues to rise while the expected rate continues to fall which explains why HSMR is deteriorating.
- Emergency weekday HSMR is now 'higher than expected' with Monday increasing and all other days remaining 'as expected'.
- SHMI is 1.10 and within the expected banding.
- To date, the indicators are not indicative of quality of care. So far, all clinical reviews undertaken in deep dives have not revealed any failings in care.

## Issues, Concerns & Gaps

- There has been a reduction in volume and rate of palliative care reported which will have an impact of the expected rate
- FCE- where there are changes in diagnosis between dominant episode and last episode, crude rate is higher. This links to clinical certainty/wording for the Primary diagnosis
- Wording used in documentation will have an impact on the level of risk of a patient. Terms used such as 'query' or 'possible' cannot be coded and thus the true severity of a patient will not be reflected which will in turn, impact HSMR.

## Actions & Improvements

- Learning from Deaths Lead attended Diabetes M&M around the issues to documentation.
- Coding will also attend speciality M&Ms to present the impact of wording on coding/mortality starting with Acute Med and ED in January.
- Deep dives initiated to explore potential drivers for rise in HSMR: Saturday short stay, low risk and low comorbidity with Respiratory as speciality at discharge linking to potential FCE issues. Deep dives on 'other infections including parasitic' which links to low risk diagnosis with high risk mortality outcomes.

# SIOR

## Mortality

**Alison Davis**

***Chief Medical Officer***

## Successful Deliverables

- New speciality M&M template has been circulated, with rota for speciality leads to attend MMSG.
- Self assessment tool rolled out to speciality to assess weaker areas in need of support.
- Learning from Deaths Lead attended Diabetes M&M and coding attended Respiratory M&M to discuss issues of wording in documentation and impact on coding/mortality indicators. Plan to attend all specialities with ED and Acute Medicine as a priority.

## Identified Challenges

- There is currently no patient identifier on Dr Foster allowing the identification of patients for deep dive review. This makes identifying the patients using dates of admission, death, age, sex, diagnosis group coding lengthily and sometimes, inaccurate. Dr Foster is currently liaising with BI around getting this reinstated.
- Admin support for M&M meetings- some teams have responded to the new M&M template forms that there is a lack of admin support within the department to complete more thorough reviews.
- SJR reporting- currently there is no reporting database for SJRs making analysis around themes and trends challenging. Discussions with potentially moving this to Datix are ongoing as part of the merge between Patient Safety and Mortality.

## Opportunities

- The message around the importance of documentation of comorbidities and primary diagnosis to be presented to all specialties via their M&M meetings by the Clinical coding and Learning from Deaths Lead.
- Meeting with the clinical coding team at Maidstone who implemented EPR earlier than Medway to discuss documentation issues and how they approached the challenges.
- SJR / mortality review training to be considered for current reviewers and to widen the pool of reviewers

## Risks

- Patients listed under the incorrect consultant on PAS and transferred, rather than corrected, will have an impact on the FCE (finished consultant episode) and overall HSMR.
- Documentation- steps need to be taken to improve the terminology for coding purposes. The Trust is currently higher than the national average for % of provider spell with a primary diagnosis of symptom and signs. During the deep dive reviews, a theme of the use of 'query' or 'possible' was noted, which are not code-able terms. If all comorbidities are not documented throughout the admission, the HSMR model will not be able to adjust or reflect the true severity of patients. Ultimately, there should be no 'new' conditions listed on the death certificate that have not been documented throughout the admission. Clinical certainty, where possible, in documentation will improve this.
- HSMR is currently on the 98$^{th}$ centile. If the current trajectory persists, the Trust will move out of the expected range,.

# Quality

## Mortality – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | Mortality | | | Crude Mortality Rate % | 1.3% | | | 2.1% | 1.4% | 1.5% | 1.9% | 1.5% | 1.5% | 1.8% | 1.3% | 1.1% | 1.7% | 1.7% | 2.0% |
| | | | | Avoidable Cardiac Arrest Calls (2222) | 16 | H | P | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| | | | | HSMR (All) | 1 | H | | 0.99 | 0.97 | 0.97 | 1.01 | 1.04 | 1.06 | 1.11 | 1.13 | | | | |
| | | | | HSMR - Weekday | 1 | H | | 0.96 | 0.94 | 0.93 | 0.98 | 1.01 | 1.03 | 1.08 | 1.10 | | | | |
| | | | | HSMR - Weekend | 1 | H | F | 1.09 | 1.06 | 1.07 | 1.09 | 1.15 | 1.18 | 1.21 | 1.23 | | | | |
| | | | | SHMI | 1 | H | F | 1.06 | 1.06 | 1.05 | 1.05 | 1.07 | 1.09 | 1.10 | | | | | |
| | | | | Fractured NOF Within 36 Hours | 92.0% | | | 60.0% | 46.7% | 72.7% | 68.2% | 78.1% | 69.2% | 52.2% | 71.9% | 55.0% | 79.3% | 73.0% | |

NHS
Medway
NHS Foundation Trust

# Systems & Partnerships

Patient FIRST

# Systems & Partnerships

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

## Access

### RTT Incompletes Performance %

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 92.0% | L | F | 62.1% | 61.6% | 62.3% | 61.4% | 63.6% | 62.6% | 61.7% | 61.9% | 60.9% | 61.5% | 62.3% | 60.0% |

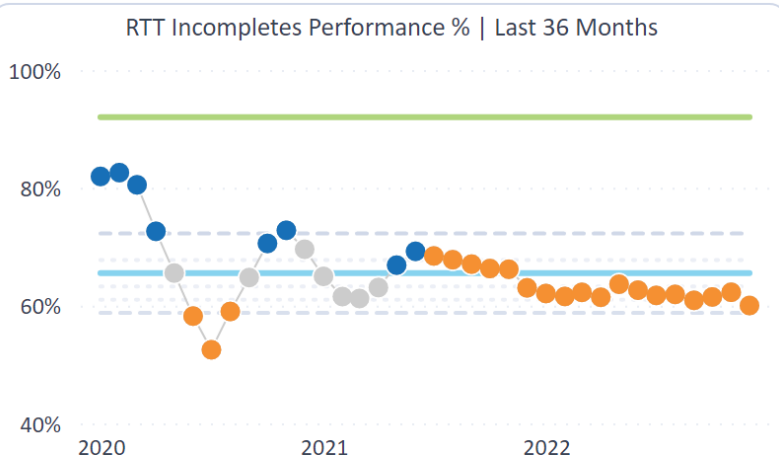
True North Domain: **Systems & Partnerships**

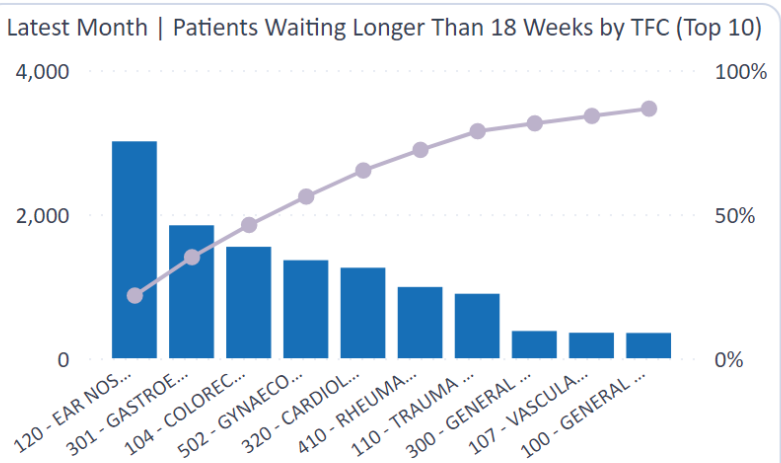
KPI Target: 92.0%

Sub Domain KPIs: 25

Variation Summary:

| | | | | |
|---|---|---|---|---|
| 11 | 3 | 7 | 0 | 4 |




## Key Messages

RTT 52 weeks is now at 600 patients. Percentage stays at circa 60%

## Issues, Concerns & Gaps

ENT remains the biggest concern. Cardiology and Gastroenterology also remain a concern.

## Actions & Improvements

De-escalation of bedded capacity will support a return to business as usual which will in turn fully restart the day surgery elective programme.

# SIOR

## Access

**Gavin MacDonald**

***Chief Operating Officer***

## Successful Deliverables

The performance in cancer 31day, 31 sub treatment, 62 day screening, 28 day were all compliant for the last reported period (November).

The Trust is reporting no 78 week breaches for the last reported position that are not patient choice.

The DMO1 is currently performing at 78% with most modalities now reporting at above 90% with the exception of endoscopy.

## Identified Challenges

Breast, 2 week wait (WW) is the greatest challenge within the elective programme achieving 81% for November and is likely to deteriorate over the following months.

Because of the elective pause at the end of Q3, to support non-elective surge, the non-admitted 52 week patient backlog has now increased to 634 however no 78 week breaches at this point. The main area of concern remains in ENT.

## Opportunities

Breast unit have plans to increase capacity within the unit by insourcing over the coming months.

Due to non-elective pressures, the Sunderland Day Care Centre was closed to elective activity at the end on Q3. As we recover over the start of Q4, the unit is slowly returning to normal activity.

The number of clinic cancelations increased over the last month this has dropped and normal outpatient activity has increased.

Additional capacity has been secured and work commenced to reduce the ENT backlog.

The Trust is exploring potential additional capacity for endoscopy with a neighbouring NHS Trust.

## Risks

With the lack of capacity in the breast unit, there will be a deterioration in overall performance of the 2WW standard, which will in turn impact the 62-day standard over the remaining quarter.

# Systems & Partnerships

## Access – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Systems & Partnerships | Access | | | RTT Incompletes Performance % | 92.0% | L | F | 62.1% | 61.6% | 62.3% | 61.4% | 63.6% | 62.6% | 61.7% | 61.9% | 60.9% | 61.5% | 62.3% | 60.0% |
| | | | | RTT 40+ Week Waiters | - | H | | 1,468 | 1,436 | 1,663 | 2,186 | 2,310 | 2,188 | 2,336 | 2,175 | 2,135 | 1,935 | 1,930 | 2,258 |
| | | | | RTT Waiting List Size | - | H | | 28,897 | 29,447 | 30,391 | 31,154 | 31,687 | 32,075 | 32,675 | 33,076 | 33,936 | 34,347 | 34,433 | 34,615 |
| | | | | RTT 52 Week Breaches | 0 | H | F | 112 | 114 | 162 | 187 | 158 | 202 | 271 | 383 | 422 | 504 | 567 | 603 |
| | | | | OP Average Time to First Appointment (days) | 60 | H | F | 80.10 | 80.79 | 75.10 | 67.95 | 76.48 | 80.39 | 83.51 | 94.09 | 90.35 | 91.72 | 96.37 | 89.83 |
| | | | | Outpatient DNA Rate % | 10.0% | H | P | 8.1% | 8.1% | 8.4% | 8.6% | 7.7% | 8.0% | 8.2% | 7.7% | 7.7% | 7.8% | 7.5% | 8.6% |
| | | | | OP First to Follow Up Ratio | - | | | 2.30 | 2.28 | 2.24 | 2.22 | 2.19 | 2.11 | 1.89 | 1.93 | 1.96 | 1.83 | 1.82 | 1.85 |
| | | | | Operations Cancelled by Hospital on Day | 0 | | ? | 10 | 7 | 8 | 11 | 5 | 5 | 17 | 3 | 13 | 10 | 18 | 19 |
| | | | | Cancelled Operations Not Rescheduled < 28 Days % | - | | | 0.0% | 0.0% | 0.0% | 0.0% | 20.0% | 0.0% | 0.0% | 33.3% | 15.4% | 20.0% | 0.0% | 5.3% |
| | | | | Urgent Operations Cancelled for 2nd Time | 0 | | ? | 1 | 5 | 6 | 1 | 3 | 5 | 7 | 2 | 4 | 12 | 5 | 9 |
| | | | | Day Case Rate % | - | H | | 21.1% | 28.8% | 28.0% | 25.9% | 27.8% | 27.0% | 28.2% | 28.2% | 29.3% | 32.0% | 30.2% | 26.0% |
| | | | | Average Elective Length of Stay (days) | 3 | | P | 0.29 | 0.25 | 0.42 | 0.36 | 0.35 | 0.35 | 0.32 | 0.39 | 0.30 | 0.33 | 0.38 | 0.32 |
| | | | | Average Non-Elective Length of Stay (days) | 10 | H | P | 4.16 | 4.48 | 4.21 | 4.48 | 4.04 | 4.26 | 4.29 | 4.75 | 4.48 | 4.71 | 4.64 | 4.57 |

# Systems & Partnerships

## Access – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Systems & Partnerships | Access | | | 104 Day Cancer Waits | - | H | | 2 | 2 | 3 | 3 | 1 | 2 | 4 | 5 | 7 | 4 | 5 | |
| | | | | Cancer 2ww Performance % | 93.0% | L | ? | 96.3% | 96.9% | 96.7% | 93.3% | 96.3% | 95.6% | 95.0% | 93.2% | 95.4% | 93.3% | 89.6% | |
| | | | | Cancer 2ww Performance - Breast Symptomatic % | 93.0% | | ? | 88.8% | 92.1% | 93.2% | 78.6% | 93.2% | 85.7% | 93.1% | 88.1% | 85.7% | 80.0% | 74.3% | |
| | | | | Cancer 31 Day First Treatment Performance % | 96.0% | | ? | 97.0% | 99.2% | 100.0% | 99.3% | 100.0% | 96.9% | 97.2% | 96.7% | 98.2% | 96.4% | 98.1% | |
| | | | | Cancer 31 Day Subsequent Treatments - Drugs % | 98.0% | | ? | 95.9% | 95.5% | 95.8% | 95.5% | 100.0% | 100.0% | 100.0% | 100.0% | 93.3% | 100.0% | 100.0% | |
| | | | | Cancer 31 Day Subsequent Treatments - Surgery % | 94.0% | | ? | 100.0% | 87.0% | 94.1% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 90.9% | 100.0% | 89.5% | |
| | | | | Cancer 62 Day Treatment - GP Refs % | 85.0% | H | ? | 76.9% | 89.9% | 88.7% | 86.7% | 88.0% | 84.9% | 82.1% | 82.5% | 85.6% | 85.0% | 80.6% | |
| | | | | Cancer 62 Day Treatment - Cons Upgrades % | 50.0% | | ? | 60.9% | 35.3% | 63.2% | 70.8% | 70.6% | 53.3% | 44.7% | 61.3% | 76.2% | 76.7% | 80.0% | |
| | | | | Cancer 62 Day Treatment - Screening Refs % | 90.0% | H | ? | 95.9% | 67.6% | 97.1% | 79.5% | 85.0% | 87.0% | 88.9% | 90.0% | 88.0% | 75.0% | 90.9% | |
| | | | | Cancer 28 Faster Diagnosis % | 75.5% | H | ? | 74.2% | 85.3% | 77.1% | 79.2% | 79.8% | 76.9% | 81.8% | 77.4% | 74.5% | 71.5% | 71.8% | |
| | | | | Cancer 28 Faster Diagnosis Screening % | - | | | 17.1% | 56.3% | 20.0% | 50.9% | 65.9% | 73.4% | 40.5% | 45.3% | 24.2% | 40.0% | 60.5% | |
| | | | | DM01 Performance % | 99.0% | L | F | 75.8% | 81.6% | 81.4% | 78.1% | 75.8% | 72.7% | 66.7% | 67.4% | 71.7% | 77.9% | 78.0% | 73.3% |

# Systems & Partnerships

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

## Emergency Care

### Total EC 4 Hour Performance %

| Type | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 95.0% | L | F | 74.3% | 73.6% | 70.5% | 70.6% | 69.6% | 68.6% | 67.6% | 71.0% | 69.1% | 62.1% | 61.0% | 57.3% |

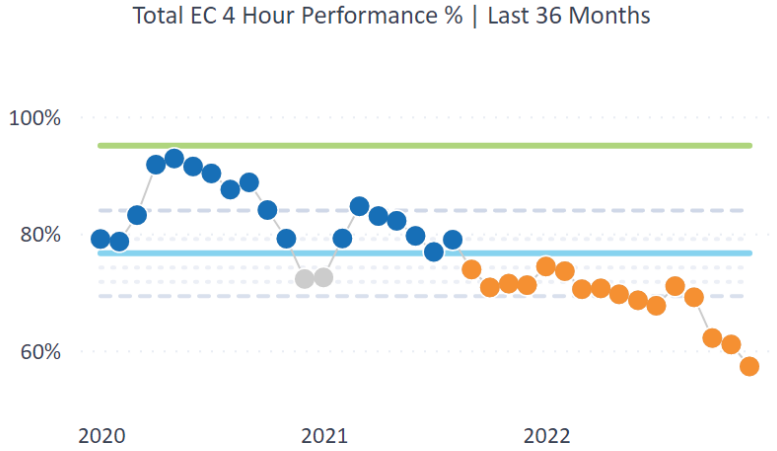
True North Domain: **Systems & Partnerships**

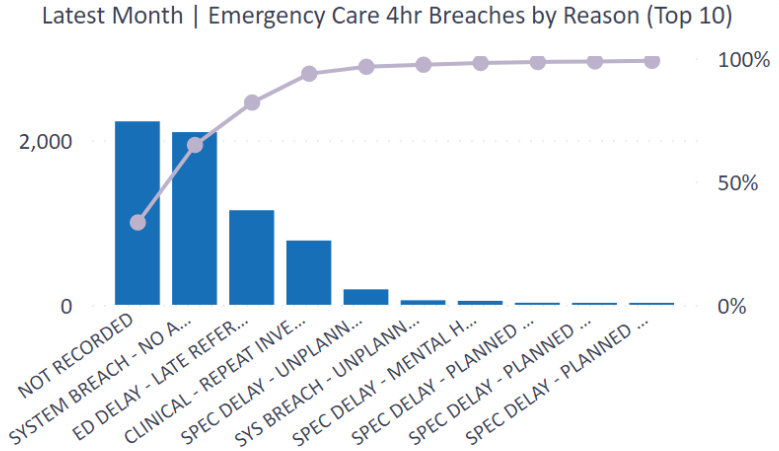
KPI Target: 95.0%

Sub Domain KPIs: 11

Variation Summary:

| | | | | |
|---|---|---|---|---|
| | L | H | L | H |
| 3 | 2 | 4 | 2 | 0 |




## Key Messages

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

## Issues, Concerns & Gaps

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

The increase in activity in Paediatric ED due to Strep A media coverage continues to have an significant impact on non-admitted performance.

## Actions & Improvements

- Project to relocate mental health patients away from CDU
- ChED operational model improvement programme
- Improvement project for ED non-admitted 4-hr performance
- Successful implementation of Acute Medical Model
- Implementation of Phase II of Acute Medical model
- Increased front-door access to Frailty (EAU), SAU, GEC/EPAC
- Opening of Frailty capacity at Sheppey
- Ongoing focus on EPR issues and optimisation.

# SIOR

## Emergency Care

**Gavin MacDonald**

***Chief Operating Officer***

## Successful Deliverables

- Phase One of the Acute Medical Model continues to enable significant improvements in ambulance handover.
- Ambulance handover continues to show significant improvements in 30 and 60 minute delays.
- New Service Manager for ED joined in December, a post which had previously been vacant.

## Identified Challenges

- Release CDU capacity for ambulatory patients
- Improved communication and escalation and adherence to processes
- Results in first two weeks show reduction in aggregated patient delays of approximately 2 hours, and reduction in average LOS in department of 5 hours
- Right care, right place, improved patient pathways
- Limit Frailty admissions via ED
- Improved flow, increased discharges, reduced MFFD
- Significant reduction in Type 3 performance.
- Ongoing issues with ED EPR system.
- Increase in Paediatrics patients waiting over 4 hours due to Streptococcus A

## Opportunities

- To implement the Second Phase of the Acute Medical Model for direct access to Frailty, SAU, GEC/EPAC.
- Improved capacity within the department to see and treat more patients following release of CDU area.
- ChED operational and improvement model meetings have started.
- To have the Right Care/Right Place and improved patient pathways
- Ongoing collaborative working with partners to deal with the increased service demands of Paediatrics.
- Data Assurance Committee involved in looking at Data Quality for ED
- Opening of Sheppey Frailty Unit, Streaming patients from the front door

## Risks

- Physical capacity on site, delays to works required, competing demands for space
- High MFFD number has a direct impact on ED performance due to lack of flow (DTA's awaiting beds).
- Sustaining of improvements beyond intervention
- industrial action and operational impact
- De-escalation of bedded escalation capacity

# Systems & Partnerships

## Emergency Care – KPI Scorecard

| Domain | Sub Domain | Type | BO | Key Performance Indicator | Target | V | A | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Systems & Partnerships | Emergency Care | | | Total EC 4 Hour Performance % | 95.0% | L | F | 74.3% | 73.6% | 70.5% | 70.6% | 69.6% | 68.6% | 67.6% | 71.0% | 69.1% | 62.1% | 61.0% | 57.3% |
| | | | | IP Discharged Before Noon % (Inc transfers to ADL) | 40.0% | | F | 14.5% | 13.8% | 15.5% | 14.3% | 16.0% | 14.2% | 13.6% | 15.8% | 14.9% | 15.0% | 13.4% | 13.5% |
| | | | | Type 1 EC 4 Hour Performance % | 75.0% | L | ? | 65.3% | 64.5% | 60.2% | 58.6% | 59.8% | 58.5% | 56.9% | 57.3% | 54.2% | 45.4% | 48.3% | 46.5% |
| | | | | Total EC 12 Hour Breaches | 0 | H | ? | 73 | 25 | 75 | 84 | 40 | 23 | 139 | 148 | 166 | 420 | 263 | 561 |
| | | | | Average Time in EC Department (mins) | 200 | H | ? | 211.91 | 267.20 | 283.06 | 290.35 | 287.30 | 289.12 | 315.73 | 270.23 | 272.14 | 371.21 | 338.37 | 374.25 |
| | | | | Number of ED Arrivals by Ambulance | - | L | | 3,189 | 2,878 | 3,109 | 2,988 | 3,252 | 2,980 | 2,975 | 2,963 | 2,922 | 2,940 | 2,350 | 2,984 |
| | | | | Ambulance Handover Delays (> 30 mins) | - | | | 390 | 340 | 543 | 431 | 530 | 424 | 653 | 446 | 512 | 679 | 150 | 277 |
| | | | | Ambulance Handover Delays (> 60 mins) | 0 | | ? | 171 | 83 | 187 | 162 | 172 | 136 | 260 | 151 | 242 | 304 | 10 | 37 |
| | | | | Bed Occupancy - General & Acute % | 80.0% | H | ? | 86.3% | 88.8% | 89.9% | 89.4% | 89.4% | 90.1% | 90.9% | 91.2% | 91.2% | 92.2% | 91.5% | 91.8% |
| | | | | Medically Fit for Discharge Patients % | 9.0% | H | P | 0.3% | 6.0% | 7.9% | 10.3% | 9.5% | 11.5% | 10.3% | 10.2% | 10.0% | 9.3% | 9.9% | 10.1% |
| | | | | 30 Day Readmission Rate | 13.0% | L | ? | 13.3% | 10.4% | 10.1% | 11.8% | 10.4% | 10.4% | 10.3% | 10.1% | 10.0% | 8.5% | 8.6% | 9.7% |

NHS
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# Useful Information

Patient FIRST

# Patient First - Guidance

## Patient First - Metric Types

| | | |
|---|---|---|
|  | True North Metric | • The measures that form the whole focus of improvement with regards to Patient First |
|  | Driver Metric | • The measure you will choose to actively work on to 'drive' improvement.<br>• This is typically selected as areas that have the highest impact on True North domain. |
|  | Watch Metric | • Watch metrics will be monitored monthly<br>• We will watch for adverse trends (i.e. more than 4 months) in performance, at which time we may decide to actively work to improve it |
|  | Breakthrough Objective | • A metric that is targeted for significant improvement (30+%).<br>• It is selected on the evidence base of what will impact True North domain the most. |

## RAG Status & Targets

For every Key Performance Indicator, each monthly position is given a Red/Green status based on performance vs the relevant agreed target. If a target has not been set or is not required, then no Red/Green status will be applied to the monthly values and the target will show as -

## Patient First - Business Rules

| No. | Rule Description | Expected Actions |
|---|---|---|
| 1 | Driver is **green** for latest reporting period | Share success and move on |
| 2 | Driver is **green** for 6 reporting periods | • Switch to watch metric<br>• Increase target |
| 3 | Driver is for **red** latest reporting period | Share top contributing reason and the amount this contributor impacts the metric |
| 4 | Driver is for **red** for 2 reporting periods | Produce countermeasure summary performance report |
| 5 | Watch is **green** for latest reporting period | Continue too maintain performance |
| 6 | Watch is a **concern** for latest reporting period | Share top contributing reason (e.g special / significant event) |
| 7 | Watch is **red** for 4 reporting periods | • Switch to driver metric (replace existing driver metric and amend to a watch metric)<br>• Review Thresholds |
| 8 | Specific Watch is **above or below 1 standard deviation** in latest reporting month | Share top contributing reason (e.g special / significant event) |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Patients | Experience | | Inpatients FFT Recommend % | IP Friends and Family Test Score |
| Patients | Experience | | Inpatients FFT Response Rate % | The proportion of Inpatients who responded to the Friends and Family Test (FFT) |
| Patients | Experience | | Emergency Care FFT Recommend % | EC Friends and Family Test Score |
| Patients | Experience | | Emergency Care FFT Response Rate % | The proportion of Emergency Care patients who responded to the Friends and Family Test (FFT) |
| Patients | Experience | | Outpatient FFT Recommend % | OP Friends and Family Test Score |
| Patients | Experience | | Outpatient FFT Response Rate % | The proportion of Outpatients who responded to the Friends and Family Test (FFT) |
| Patients | Experience | | Complaints | The total number of complaints received |
| Patients | Experience | | Complaints Acknowledged Within 3 Working Days % | The percentage of complaints acknowledged within 3 working days of the opened date |
| Patients | Experience | | Complaints Breached % | % of Complaints which have breached |
| Patients | Experience | | Patient Advice and Liaison Service (PALS) Concerns | The total number of PALS received |
| Patients | Experience | | Parliamentary and Health Service Ombudsman (PHSO) Cases | The total number of PHSO Cases |
| Patients | Experience | | Parliamentary and Health Service Ombudsman (PHSO) Cases - Month End | The total number of PHSO Cases Open at Month End |
| Patients | Experience | | Mixed Sex Accommodation (MSA) Compliance % | Mixed Sex Accommodation (MSA) Compliance % |
| Patients | Experience | | Mixed Sex Accommodation Breaches | The total number of Mixed Sex Accommodation (MSA) breaches |
| Patients | Experience | | EDNs Completed Within 24hrs % | % of EDNs Completed Within 24hrs |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| People | Workforce | | National Staff Engagement Score | National Staff Engagement Score |
| People | Workforce | | Staff Appraisal Rate % | The proportion of staff that has completed the appraisal process |
| People | Workforce | | Staff in Post (FTE) | Staff in Post (FTE) |
| People | Workforce | | Staff Leavers (FTE) | Staff Leavers (FTE), in month position |
| People | Workforce | | Staff Starters (FTE) | Staff Starters (FTE), in month position |
| People | Workforce | | Vacancy Rate % | Vacancy Rate % |
| People | Workforce | | Voluntary Turnover % | Workforce Voluntary Turnover %, shown as a 12-Month Rolling Average |
| People | Workforce | | Staff Fill Rate - Total % | Staff Fill Rate % (Day & Night) for Registered Nurses and Care Staff combined |
| People | Workforce | | Staff Fill Rate % (Total) - Registered Nurse | Staff Fill Rate % (Day & Night) for Registered Nurses |
| People | Workforce | | Care Hours per Patient Day (CHPPD) | Number of Care Hours per Patient Day to monitor staffing levels in relation to patient numbers on an inpatient ward. |
| People | Workforce | | Sickness Absence Rate - Total % | Short & Long Term Sickness Absence Rate % |
| People | Workforce | | Sickness Absence Rate - Short Term % | Sickness absence rate - Short Term (%) |
| People | Workforce | | Sickness Absence Rate - Long Term % | Sickness absence rate - Long Term (%) |
| People | Workforce | | StatMan Training Compliance % | Statutory & Mandatory Training Compliance % |
| Quality | Harm | | Incidents with Harm | Incidents with Harm (Moderate, Severe, Death) |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Quality | Harm | | Total Incidents | Total Incidents recorded on Datix |
| Quality | Harm | | Falls - Total | The total number of Falls recorded on Datix |
| Quality | Harm | | Falls - Low Harm | The total number of Falls recorded on Datix with Low Harm |
| Quality | Harm | | Falls - Moderate Harm | The total number of Falls recorded on Datix with Moderate Harm |
| Quality | Harm | | Falls - Severe Harm | The total number of Falls recorded on Datix with Severe Harm |
| Quality | Harm | | Falls Resulting in Death | The total number of Falls recorded on Datix that resulted in death |
| Quality | Harm | | Falls per 1,000 Bed days | The number of falls per 1,000 bed days |
| Quality | Harm | | Pressure Ulcers - Grade 1 | The total number of Grade 1 Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers - Grade 2 | The total number of Grade 2 Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers - Grade 3 | The total number of Grade 3 Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers - Grade 4 | The total number of Grade 4 Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers - Unstageable | The total number of Unstageable Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers - Deep Tissue Injury | The total number of Deep Tissue Injury (DTI) Pressure Ulcers recorded on Datix |
| Quality | Harm | | Pressure Ulcers per 1,000 Bed Days | The total number of Pressure Ulcers per 1,000 bed days |
| Quality | Harm | | Serious Incidents | The total number of Serious Incidents as recorded on Datix |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Quality | Harm | | Serious Incidents Responded to Within 60 Days % | % of Serious Incidents Responded to in 60 Days (DATIX) |
| Quality | Harm | | Open Incidents | The total number of Open incidents as recorded on Datix |
| Quality | Harm | | Open Incidents - Month End | The total number of Open incidents as recorded on Datix at Month End (Snapshot) |
| Quality | Harm | | Never Events | The total number of Never Events as recorded on Datix |
| Quality | Harm | | Medication Errors - Total | The total number of medication errors recorded on Datix |
| Quality | Harm | | IPC Incidents | Total Incidents recorded on Datix relating Infection Control |
| Quality | Harm | | C-Diff Cases - Hospital Acquired Total | The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated & Community Onset Hospital Associated) |
| Quality | Harm | | C-Diff Cases - Hospital Acquired (HOHA) | The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated) |
| Quality | Harm | | E.coli Cases - Hospital Acquired | The number of E.coli cases - Hospital Acquired (Blood Culture Only) |
| Quality | Harm | | MRSA Cases - Hospital Acquired | The number of MRSA cases - Hospital Acquired (Blood Culture Only) |
| Quality | Harm | | MSSA Cases - Total | The number of MSSA cases - Total |
| Quality | Harm | | Covid-19 Diagnosed - Total | The number of Covid-19 Inpatients |
| Quality | Harm | | VTE Risk Assessment Completed % | The proportion of patients risk-assessed for Venous Thromboembolism (VTE) |
| Quality | Mortality | | Crude Mortality Rate % | Crude Mortality Rate |
| Quality | Mortality | | Avoidable Cardiac Arrest Calls (2222) | Avoidable Cardiac Arrest Calls (2222) |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Quality | Mortality | | HSMR (All) | HSMR (All) |
| Quality | Mortality | | HSMR - Weekday | HSMR (Weekday) |
| Quality | Mortality | | HSMR - Weekend | HSMR (Weekend) |
| Quality | Mortality | | SHMI | SHMI |
| Quality | Mortality | | Fractured NOF Within 36 Hours | Fractured NOF Within 36 Hours |
| Sustainability | Financial Position | | Breakeven Revenue Budget (£) | Breakeven Revenue Budget Position |
| Sustainability | Financial Position | | Agency Spend % | Percentage of total spend with regards to Agency staff |
| Sustainability | Financial Position | | Bank Spend % | Percentage of total spend with regards to Bank staff |
| Sustainability | Financial Position | | Agency Spend (£) | Agency Spend £ (Finance Ledger) |
| Sustainability | Financial Position | | Income (£) | Income £ (Finance Ledger) |
| Sustainability | Financial Position | | Income (£) vs Budget | Income £ (Finance Ledger) |
| Sustainability | Financial Position | | Total Pay Spend (£) | Total Pay spend |
| Sustainability | Financial Position | | Total Pay Spend (£) vs Budget | Total Pay spend |
| Sustainability | Financial Position | | Total Non-Pay Spend (£) | Total Non-Pay Spend |
| Sustainability | Financial Position | | Total Non-Pay Spend (£) vs Budget | Total Non-Pay Spend |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Sustainability | Financial Position | | Establishment WTE | Establishment WTE (Finance Ledger) |
| Systems & Partnerships | Access | | RTT Incompletes Performance % | The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for less than 18 weeks from referral. |
| Systems & Partnerships | Access | | RTT 40+ Week Waiters | The number of patients on the RTT waiting list waiting 40 weeks or more at month end |
| Systems & Partnerships | Access | | RTT Waiting List Size | RTT Waiting List Size |
| Systems & Partnerships | Access | | RTT 52 Week Breaches | The number of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for over 52 weeks. |
| Systems & Partnerships | Access | | OP Average Time to First Appointment (days) | OP Average Time to First Appointment (Days), excluding diagnostic imaging and ward attenders |
| Systems & Partnerships | Access | | Outpatient DNA Rate % | The percentage patients failing to attend their Outpatient appointment (DNA - Did not Attend) |
| Systems & Partnerships | Access | | OP First to Follow Up Ratio | Outpatient First Attendance to Follow Up Attendance Ratio |
| Systems & Partnerships | Access | | Operations Cancelled by Hospital on Day | Operations Cancelled By Hospital on Day |
| Systems & Partnerships | Access | | Cancelled Operations Not Rescheduled < 28 Days % | The Percentage of Cancelled Operations Not Rescheduled < 28 Days for Non-Clinical Reason |
| Systems & Partnerships | Access | | Urgent Operations Cancelled for 2nd Time | Cancelled Urgent Procedure For 2nd Time For Non-Clinical Reason |
| Systems & Partnerships | Access | | Day Case Rate % | Day Case % Rate - where National_POD = 'DC' / All Spells (%) |
| Systems & Partnerships | Access | | Average Elective Length of Stay (days) | Average Elective (EL, DC, RDA) Length of Stay |
| Systems & Partnerships | Access | | Average Non-Elective Length of Stay (days) | Average Non-Elective Length of Stay |
| Systems & Partnerships | Access | | 104 Day Cancer Waits | 104 Day Cancer Waits |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Systems & Partnerships | Access | | Cancer 2ww Performance % | The proportion of patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral. |
| Systems & Partnerships | Access | | Cancer 2ww Performance - Breast Symptomatic % | The proportion of Breast Symptomatic patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral. |
| Systems & Partnerships | Access | | Cancer 31 Day First Treatment Performance % | The proportion of patients who had their first definitive treatment within 31 days from their decision to treat. |
| Systems & Partnerships | Access | | Cancer 31 Day Subsequent Treatments - Drugs % | The proportion of patients who had their subsequent anti-cancer drug treatment within 31 days from their decision to treat. |
| Systems & Partnerships | Access | | Cancer 31 Day Subsequent Treatments - Surgery % | The proportion of patients who had their subsequent surgical treatment within 31 days from their decision to treat. |
| Systems & Partnerships | Access | | Cancer 62 Day Treatment - GP Refs % | The proportion of patients urgently referred by GPs/GDPs for suspected cancer and had first definitive treatment within 62 days from referral. |
| Systems & Partnerships | Access | | Cancer 62 Day Treatment - Cons Upgrades % | The percentage of patients upgraded by a consultant for cancer and had first definitive treatment within 62 days from referral. |
| Systems & Partnerships | Access | | Cancer 62 Day Treatment - Screening Refs % | The proportion of patients referred by the national screening programme and had first definitive treatment within 62 days from referral. |
| Systems & Partnerships | Access | | Cancer 28 Faster Diagnosis % | The proportion of patients referred for suspected cancer that are informed if they do or do not have a cancer diagnosis within 28 days |
| Systems & Partnerships | Access | | Cancer 28 Faster Diagnosis Screening % | Cancer 28 Faster Diagnosis Screening |
| Systems & Partnerships | Access | | DM01 Performance % | The proportion of patients that are currently waiting for a diagnostic test for less than 6 weeks from referral. |
| Systems & Partnerships | Emergency Care | | Total EC 4 Hour Performance % | Percentage of patients treated within 4 in Emergency Care |
| Systems & Partnerships | Emergency Care | | IP Discharged Before Noon % (Inc transfers to ADL) | Percentage of patients discharged from hospital before noon (between 06:00:00 and 11:59:59 - Including transfers to the discharge lounge before noon) |
| Systems & Partnerships | Emergency Care | | Type 1 EC 4 Hour Performance % | Performance against the national 4 hour target (Type 1 departments only) - The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours |
| Systems & Partnerships | Emergency Care | | Total EC 12 Hour Breaches | The number of patients with total LOS of greater than 12hrs in EC Department (Type 1 & 3 departments combined) |

# KPI Glossary

| True North Domain | Sub Domain | Type | Key Performance Indicator | KPI Description |
|---|---|---|---|---|
| Systems & Partnerships | Emergency Care | | Average Time in EC Department (mins) | Average Time in EC Department (Mins) |
| Systems & Partnerships | Emergency Care | | Number of ED Arrivals by Ambulance | Number of ED Arrivals by Ambulance (Ambulance Handovers) |
| Systems & Partnerships | Emergency Care | | Ambulance Handover Delays (> 30 mins) | The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 30 minutes. |
| Systems & Partnerships | Emergency Care | | Ambulance Handover Delays (> 60 mins) | The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 60 minutes. |
| Systems & Partnerships | Emergency Care | | Bed Occupancy - General & Acute % | The proportion of beds occupied at midnight (General and Acute beds only) |
| Systems & Partnerships | Emergency Care | | Medically Fit for Discharge Patients % | % Medically Fit for Discharge (MFFD) Patients |
| Systems & Partnerships | Emergency Care | | 30 Day Readmission Rate | 30 Day Readmission Rate |

# Meeting of the Trust Board
# Wednesday, 01 February 2023

| | | | | |
|---|---|---|---|---|
| **Title of Report** | Terms of Reference Review | | **Agenda Item** | 13 |
| **Author** | Matthew Capper, Interim Company Secretary | | | |
| **Lead Executive Director** | Jayne Black, Chief Executive | | | |
| **Executive Summary** | It is good practice to review committee terms of reference annually to ensure they are still fit for purpose. Reviewed and approved at the Audit and Risk Committee held 4 December 2022. | | | |
| **Proposal and/or key recommendation:** | It is proposed that the Trust Board ratify the draft revised terms of reference. | | | |
| **Purpose of the report (tick box to indicate)** | Assurance | ☐ | Approval | ☒ |
| | Noting | ☐ | Discussion | ☐ |
| **(If appropriate) state reason for submission to Private section of Board:** | Patient Confidentiality: ☐ | Staff Confidentiality: ☐ | Commercially Sensitive: ☐ | Exceptional Circumstances: ☐ |
| **Committee/Group at which the paper has been submitted:** | Audit and Risk Committee on 4 December 2022 | | | |

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

| | |
|---|---|
| **Identified Risks, issues and mitigations:** | No risks associated with this item. |
| **Resource implications:** | N/A |
| **Sustainability and /or Public and patient engagement considerations:** | N/A |
| **Integrated Impact assessment:** | **Please tick** the correct box and provide required information.<br>Has the quality and equality assessment been undertaken?<br>☐ Yes (*please attach the action plan to this paper*)<br>☒ Not applicable (*please indicate why an equality assessment was not required)* |
| **Legal and Regulatory implications:** | It is a legal requirement for the Trust Board to establish and operate an Audit Committee and to appoint an independent Non-Executive with specific focus on Audit. These terms of reference support this. |
| **Appendices:** | • Draft Terms of reference |
| **Freedom of Information (FOI) status:** | State either:<br><br>This paper is disclosable under the FOI Act, or |
| **For further information or any enquires relating to this paper please contact:** | Matthew Capper, Interim Company Secretary<br>m.capper@nhs.net |

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

# Audit and Risk Committee Terms of Reference

## 1. Introduction

1.1. The Audit and Risk Committee ("the Committee") is established in accordance with the NHS Medway Foundation Trust ("MFT") Constitution, Standing Orders and Scheme of Reservation and Delegation ("SORD") . These Terms of Reference set out the remit, responsibilities, delegated authority, membership and reporting arrangements of the Committee.

1.2. The Committee is a non-executive committee, accountable to the MFT Board ("the Board") and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of MFT.

1.3. The Committee is authorised by the Board to act within its Terms of Reference. All employees and individuals appointed by MFT are directed to co-operate with any request made by the Committee.

1.4. The Committee will liaise with and function as a resource for other MFT committees and forums, where specific matters are most appropriately considered by the Committee in line with its responsibilities.

1.5. Where MFT Board scrutiny or decision is required for related matters, the Committee will consider these in advance and act as the sponsor for any recommended action/decision required by the Board.

1.6. The remit of the Committee is outlined below. The nature of how these are delivered will be determined by the Committee Chair in discussion with the relevant lead executive officer of MFT.

## 2. Purpose

2.1. To contribute to the overall delivery of MFT objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and finance and internal control processes within MFT.

2.2. The duties of the Committee will be driven by MFT's strategies, objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year. This will be flexible to new and emerging priorities and risks.

2.3. The Committee has no executive powers, other than those delegated in the SORD and specified in these terms of reference.

## 3. Responsibilities

3.1. The Committee's duties can be categorised as follows.

*Integrated governance, risk management and internal control*

3.2. To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of MFT's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board through MFT's Board Assurance Framework.

3.3. To ensure that financial systems and governance are established which facilitate compliance with the national Accounting Manual.

3.4. To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of MFT's objectives, the effectiveness of the management of principal risks.

3.5. To have oversight of system risks where they relate to the achievement of MFT's objectives.

3.6. To ensure that MFT acts consistently with the principles and guidance established in HMT's "Managing Public Money".

3.7. To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.8. To identify opportunities to improve governance, risk management and internal control processes across MFT.

*Internal audit*

3.9. To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring duplication between internal and external audit is kept to a minimum and that the work programme is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work, including the Head of Internal Audit Annual Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

*External audit*

3.10. To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the audit reports issued and the findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

*Other assurance functions*

3.11. To review the findings of assurance functions in MFT, and to consider the implications for the governance of MFT.

3.12. To review the work of other committees in MFT, whose work can provide relevant assurance to the Committee's own areas of responsibility.

3.13. To review the assurance processes in place in relation to financial performance across MFT including the completeness and accuracy of information provided.

3.14. To review the findings of external bodies and consider the implications for governance of MFT. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g., National Audit Office, Select Committees, NHS Resolution, CQC (Care Quality Commission)
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges and accreditation bodies)

*Counter fraud*

3.15. To assure itself that MFT has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

3.16. To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

3.17. To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

3.18. To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

3.19. To report concerns of suspected fraud, bribery and corruption in accordance with the MFT policy on counter fraud.

Freedom to Speak Up

3.20. To review the adequacy and security of MFT's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

Information Governance (IG)

3.21. To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

3.22. To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

3.23. To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

3.24. To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting

3.25. To receive and review the assurances from the Finance, Planning and Performance Committee about budgetary control mechanisms, application and effectiveness of finance policy and decision-making and the completeness and accuracy of the information provided

3.26. To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Unadjusted mis-statements in the Financial Statements
- Significant judgements and estimates made in preparing of the Financial Statements

- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting

Conflicts of Interest

3.27. The chair of the Committee will be the nominated Conflicts of Interest Guardian.

3.28. The Committee shall satisfy itself that MFT's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with MFT policy and procedures relating to conflicts of interest.

Management

3.29. To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.30. The Committee may also request specific reports from individual functions within MFT as they may be appropriate to the overall arrangements.

3.31. To receive reports of breaches of policy and normal procedure or proceedings, including suspensions of MFT's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

3.32. To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally as required.

## 4. Authority

4.1. The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of MFT (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by MFT for obtaining legal or professional advice
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish

sub-groups in accordance with MFT's constitution, standing orders and SORD but may/ not delegate any decisions to such groups

4.2. For the avoidance of doubt, the Committee will comply with the MFT Standing Orders, Standing Financial Instructions and the SORD, other than where there has been an explicit agreement made by the Board

## 5. Membership and Attendance

Membership

5.1. The Committee members shall be appointed by the Board in accordance with the MFT Constitution.

5.2. The Board will appoint at least three members of the Committee who are Independent Non-Executive Members of the Board.

5.3. Neither the Chair of the Board, nor employees of MFT will be members of the Committee.

5.4. Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to MFT's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and vice chair

5.5. In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge, skills, and experience, making them suitable to chair the Committee.

5.6. The Chair of the Committee shall be independent and therefore must not chair any other committees and, as far as it is possible, they will not be members of any other committee.

5.7. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

5.8. Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Chief Finance Officer or their nominated deputy
- Executive Director with a Corporate remit or equivalent
- Chief Nursing Officer

- The Trust Company Secretary
- Representatives of both internal and external audit
- Individuals who lead on risk management and counter fraud matters

5.9. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.10. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions.

5.11. The Chief Executive has a standing invitation to attend the Committee, with a minimum expectation that they will attend annually

5.12. The Chair of MFT may also be invited to attend to gain an understanding of the Committee's operations and where necessary, may be included to reach quoracy.

Attendance

5.13. Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access

5.14. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Committee.

## 6. Meetings, Quorum and Voting

6.1. The Audit and Risk Committee will normally meet five/four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

6.2. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

6.3. The Board, Chair or Chief Executive of MFT may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

Quorum

6.4. For a meeting to be quorate a minimum of two independent non-executive members of the Board are required, including the chair of the Committee.

6.5. If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual

shall no longer count towards the quorum.

6.6. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6.7. Virtual attendance by means of teleconference or other media shall count towards the quorum as long as the member has appropriate access to all papers and is able to contribute as if they were physically in the meeting.

Decision making and voting

6.8. Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. If this is not possible the Chair may call a vote.

6.9. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.10. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6.11. If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

Other arrangements

6.12. Meetings of the Committee will not be open to the public as this would inhibit the free and frank provision of advice or exchange of views that would prejudice the effective conduct of public affairs.

6.13. Papers and minutes of Committees meetings will be subject to the Freedom of Information Act and disclosable to the public where appropriate under the Act.

## 7. Accountability and reporting

7.1. The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities. The minutes of the meetings or a summary of the minutes shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

7.2. The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

7.3. The Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements
- The robustness of the processes behind the quality accounts

## 8. Notice of Meetings

8.1. Notice of any Committee meeting must indicate:

- Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)
- Where it is to take place
- An agenda of the items to be discussed at the meeting and any supporting papers
- If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting

## 9. Policy and best practice

9.1. The Committee will be conducted in accordance with the MFT policy on Standards of Business Conduct, specifically:

- There must be transparency and clear accountability of the Committee.
- The Committee will hold a members Register of Interests which will be presented to each meeting of the Committee
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take. This may include requesting that individuals withdraw from any discussion/voting until the matter(s) is concluded

9.2. Members of the Committee should aim to attend all scheduled meetings.

9.3. Committee members and participants must maintain the highest standards of personal conduct and in this regard must comply with:

- The laws of England and Wales
- The spirit and requirements of the NHS Constitution
- The Nolan Principles
- Any additional regulations or codes of practice relevant to the Committee

## 10. Secretariat

10.1. The MFT company secretaries' team will provide secretariat arrangements to the Committee. The duties of the secretariat include but are not limited to:

- Agreement of the agenda with the Chair together with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward

10.2. Before each Committee meeting an agenda and papers will be sent to every Committee member no less than five (5) business days in advance of the meeting, unless the meeting has been convened at short notice, in which case papers will be sent at the earliest opportunity.

10.3. If a Committee member wishes to include an item on the agenda, they must notify the Chair no later than ten (10) business days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) business days prior to the meeting. The decision as to whether to include the agenda item is at the discretion of the Chair.

## 11. Confidentiality

11.1. Members of the Committee shall respect the confidentiality requirements set out in the MFT's Standing Orders, relevant corporate policies, and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

11.2. Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

## 12. Review

12.1. The Terms of Reference of the Committee shall be reviewed by members of the Committee annually, or as required in line with any developments or changes to the MFT constitution, national guidance, or feedback from auditors, with recommendations made to the MFT Board for approval.

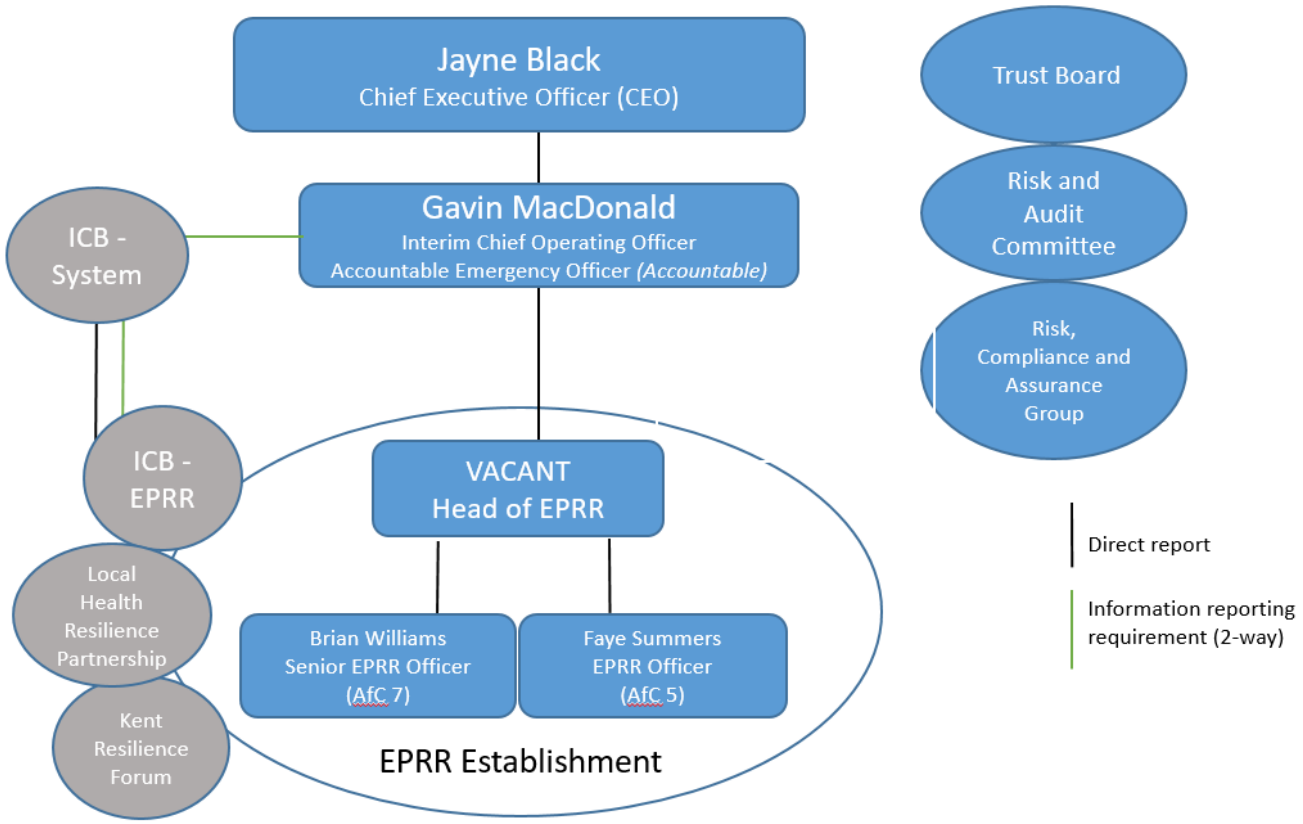
The chair of the Committee and internal and external auditors will undertake an annual effectiveness review of the Committee annually. This review will take place without management.

# Meeting of the Trust Board
# Wednesday, 01 February 2023

| | | | |
|---|---|---|---|
| **Title of Report** | **EPRR Report Update 2023** | Agenda Item | X |
| **Lead Director** | Gavin MacDonald, Chief Operating Officer | | |
| **Report Author** | Brian Williams, Senior Emergency Preparedness, Resilience and Response officer | | |
| **Executive Summary** | This report provides the Trust Board with:<br>• an overall update on progress against the EPRR Core Standards annual assurance improvements,<br>• the work plan for 2023<br>• Current risks and threats. | | |
| **Committees or Groups at which the paper has been submitted** | Trust Management Board – January 2023 | | |
| **Resource Implications** | EPRR Resource required within its agreed Trust establishment – recruitment to one Band 8a Head required. | | |
| **Legal Implications/ Regulatory Requirements** | The Civil Contingencies Act 2004, CCA 2004(Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022.<br>All acts place EPRR duties upon the NHS in England.<br>Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework (2022) | | |
| **Quality Impact Assessment** | N/A | | |
| **Recommendation/ Actions required** | **N/A.** | | |
| | Approval ☐ | Assurance ☒ | Discussion ☐ | Noting ☒ |
| **Appendices** | A) EPRR Work plan for 2022/2023<br>B) EPRR Core Standards Improvement plan | | |

## 1.0 Trust EPRR Governance and Accountability

1.1 The current Trust EPRR establishment and accountability is represented below:




1.2 The trust is currently recruiting to the position of Head of the EPRR team. The vacancy is currently being covered by the senior EPRR Officer under the supervision of the Chief Operating Officer.

1.3 The previous governance for EPRR in the Trust has been recently reconfigured and now reflects in new reporting structures. There is a Trust 'EPRR group', chaired by the delegated AEO for the Trust and is established to assist the Trust Board in fulfilling organisational responsibilities in relation to the Civil Contingencies Act 2004. The Group has a new Terms of Reference, in keeping with the new reporting structures, membership and responsibility for maintenance and oversight of: all Trust EPRR plans, EPRR Risk register, EPRR Training and Exercising programme, Incident records management and retention and all lessons identified from debriefing post-exercises and incidents. The Group reports to the Risk, Compliance and Assurance Group.

## 2.0 NHS EPRR Core Standards – Annual Assurance process improvements plan

2.1 The ability of the Trust to remain resilient and responsive to emergencies and incidents which disrupt day to day operations, over a sustained period, is due to our collective commitment to Emergency Preparedness, Resilience and Response (EPRR).

2.2 NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process with providers submitting a self-assessed view of compliance against a set of 68 Core standards: NHS England » Emergency preparedness, resilience and response: core standards

2.3 The overall EPRR assurance rating is based on the percentage of core standards the organisation assesses itself as being compliant with, from being non-Compliant through to Fully Compliant – MFT after review stood at **SUBSTANTIAL**:

| Overall EPRR assurance rating | Criteria |
|---|---|
| Fully | The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards |
| Substantial | The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards |
| Partial | The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards |
| Non-compliant | The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards |

| 100% | 99-89% | 88-77% | 76% or less |
|---|---|---|---|
| Number of fully compliant core standards to achieve the percentage | | | |
| 64 | 63-57 | 56-49 | 48 |

### 3.0 Trust EPRR Core Standards Position Statement 2022

3.1 The Trust Board are asked to note the EPRR resource is still currently depleted. The work programmes which wrap around these 64 core standards and 13 in the deep dive, were supported by 1 member of staff. A new Band 7 has been appointed but with the loss of the Head of EPRR the team are still one short against the agreed required establishment and not near equivalent to the neighbouring Trusts, to lead and deliver this work.

3.2 The fully compliant scoring of **58**, means the Trust has a self-assessed compliance level of **'Substantial'** for the year 2022/23.

3.4 The Domains where improvements are required to achieve full compliance for 2023, are detailed in the EPRR Core Standards Assurance Improvements plan 2022-23, in Appendix c.

3.6 The 'Deep dive' standards table and associated evidence required, has also been submitted along with the evidence collated for each standard, in the table below. Any non or partial compliance with these deep dive standards, will also be acknowledged in the improvements plan 2022 – 2023.

### 4.0 Annual EPRR Assurance Improvements plan

This action plan was agreed by the Trust Board in October, following the 2022 EPRR Core Standards Assurance self-assessment, which requires improvements to obtain 'Full Compliance' for 2023. Progress with these improvements are detailed below. All actions currently in progress, have been included in the overall EPRR team work plan for 2023.

**Ref 5)** Is fully complete with both these EPRR posts now fully recruited and inducted into the EPRR establishment.

**Ref 24)** The EPRR Training and Exercising Prospectus for 2023 is in development. Once this has been agreed at the next EPRR group, work with Organisational Development will take place to align training access and competencies to ESR for improving the uptake and reporting of staff completing EPRR training data.

**Ref 46)** The Trust Business Impact Analysis will be undertaken by a Senior representation task and finish group convened by the EPRR team, in the new year. This will prioritise and identify the Trust's essential services; all process, activities and interdependencies to plan solutions for and enable the continuity of Essential services during a period of disruption - caused by the pre-defined risks within the NHS Business Continuity Framework.

**Ref 47)** The new Senior EPRR Officer has now completed the Business Continuity Institute Certification and is able to provide training and advice for all service leads reviewing their Business Continuity Plans. A Trust Business Continuity Network will be formed aligned to the Business Continuity Framework 2022 and Business Continuity Terms of Reference 2022 in the New Year.

**Ref 51)** The Recommendations directly related to Business Continuity arrangements, from the KPMG audit 2021, requiring EPRR action have been completed. The residual actions are now dependant on service lead staff time to develop their Business Impact Analysis and review service level Business Continuity Plans – with support and advice from the EPRR team where needed.
Training packages are available to be delivered and this will be coordinated through the new Trust BC Network when convened. KPMG Actions update embedded here.

**Ref 58)** The Trust remains in a vulnerable but a much improved position, with 50% of ED staff, 2 Site Team and several divisional staff now competent in CBRN response. This training has been outsourced over a period of 6 months, to MTW colleagues trained to deliver this CBRN training, to an agreed Local Health Resilience Partnership standard. There are plans in place for this support to continue from March 2023, until the ED quota reaches 80% and the MFT EPRR team are able to confidently supply and deliver this independently to staff.

**5.0 Summary of recent Incidents**

5.1 The incidents below, required emergency responses to mitigate impacts to the safety and security of patients, staff and visitors in the Trust. Following each event, an Incident debrief in accordance with the NHS EPRR framework, was undertaken with staff involve, to identify lessons and improve response plans and processes for the 'next eventuality'.

5.2 The external incidents were monitored by the EPRR team for any impacts to the Trust, via links into the Kent Resilience Forum and Local Health Resilience Partnership colleagues and multi-agency meeting groups.

5.3 Internal incidents
Severe Weather – Commencing 4/12/22
Pre Amber alert – National Platelet Shortage – 14/12/22 > 29/12/22
Critical Incident – 22/12/2022
A structured response to the incident with some praise from the ICB around reporting and appropriate escalation.

5.4 External Incidents - with potential impacts to the Trust
Small boat refugee incident – Channel – 14/12/2022
East Kent Water loss incident 19/12/2022 > 23/12/2022
Oxygen Cylinder Shortage, National – 30/12/2022 > 11/01/2022

**5.0 Summary of 2022 EPRR Training, Exercising and meetings**

5.1 Attendance to EPRR Training was managed by the EPRR lead. This now is led by the band 5 EPRR Officer by advertising training to appropriate staff, sourcing/delivering the training and then recording on a central EPRR Training Register, linked to an EPRR Training needs analysis for Trust Staff. This has not historically linked to ESR for automation of booking attendance, compliance uptake or attendance recording; this will be progressed as part of the 2023 EPRR work plan.

5.2 EPRR Training compliance data is currently recorded by the EPRR team for the following modules**:**

Command Training – All SMoC and DoC staff (2 year refresher)

CBRN Response – ED staff, Heads of Nursing and Matrons across divisions and Site team staff
Initial Operating Response – frontline reception, security and admin staff
Loggist training – PA's, administrative staff, EPRR team, Site team staff
METHANE reporting training – all Site Team staff, switchboard operators and ED Resus/Majors staff
EPRR Group Meetings attendance – as per its Terms of Reference
LHRP Delivery and Executive Group meetings attendance – MFT Accountable Emergency Officer

5.3 Attendance and participation in EPRR Training, Exercises and relevant meeting groups are recorded for this year, as part of the schedule described below. The 2 areas of weakness currently are the CBRN and Loggist training, both addressed in the Action Plan for 2023 with work already progressing this year to greatly improve current levels of compliance by end of 2022.

### MFT EPRR Group Meetings

| Date | Time | Location |
|---|---|---|
| Thursday 12th January 2023 | 10 – 11.30am | MS Teams |
| Thursday 16th March 2023 | 10 – 11.30am | MS Teams |
| Thursday 18th May 2023 | 10 – 11.30am | MS Teams |
| Thursday 20th July 2023 | 10 – 11.30am | MS Teams |

### Live Exercises

| Date | Time | Subject | Location |
|---|---|---|---|
| March 2023 | TBC | Ward Evacuation | Sunderland |

### Live Exercises

The planning for undertaking a 'live exercise' during 2022 were postponed due to 'real life' incident response for the Level 4 Heatwave which required Command, Control and Coordination establishment and replaced the formal requirement for a Live Exercise as part of the Assurance for 2022. However in preparation for furture assurance we were able to complete a live exercise in main theatres.

**Exercise Bazelgette** was a live simulation exercise held in December, to test the Evacuation procedures and assembly points identified in the draft version of the Main Theatres Fire Evacuation plan. Due to the Trust Fire Response plan outstanding its review with EPRR principles and processes and not being fully embedded with staff, the exercise was instead based on a non-Fire scenario, to prompt the Theatres evacuation. The Trust's Hospital Evacuation plan and the draft Theatres Fire Evacuation plan were tested and the exercise was successful in achieving its aim and objectives overall. Using a hot and cold debrief process, the embedded report here outlines the learning and recommendations to improvements required overall. The risk remains that inefficiencies in planning, staff training and regular exercising is a concern, if a Fire was to cause evacuation from this area of the site specifically.

There is a view to plan and action a further exercise with the Sunderland Unit in the New Year.

### Communications Exercises

| Date | Location | Subject |
|---|---|---|
| February 2023 | SECAmb, ICB, MFT (Ex Alert 2) | Testing the alerting for 'communication alerting notification' in and between organisations. |

The above exercise will assist in have fulfilling the ongoing requirement to undertake 2 x 6 monthly communications exercises.

### Loggist Training

| Date | Time | Location |
|---|---|---|
| 28th and 29th September | am / pm on each day | EPRR Office, MFT |

There is currently a low uptake of staff wanting to do be trained in the Loggist role. There is a plan to issue a communications drive to encourage uptake and for training sessions (TBC) to be made accessible for staff to attend.

### Emergency Response CBRN Training (ED staff inc. CSWs)

| Date | Time | Location |
|---|---|---|
| 27/03/2023 | 09.00am – 4pm | Education Centre meeting room - MFT |
| 03/04/2023 | 09.00am – 4pm | Education Centre meeting room - MFT |
| 24/04/2023 | 09.00am – 4pm | Education Centre meeting room - MFT |
| 22/05/2023 | 09.00am – 4pm | Education Centre meeting room - MFT |

We have 125 staff on role for Emergency Department Staffing, suitable to undertake this training.
There are currently 56.8% of ED staff competently trained, to respond to a CBRN incident.
That leaves a gap of 23.2%, equating to 29 people.

Several non-ED staff have also recently been trained and further staff are booked to attend future sessions, which elevates the % to the wider staffing groups, compliance figures.

Overall: There are currently 35 ED staff and 8 non-ED staff fully competent in CBRN response. There are an additional 71 ED staff and 17 non-ED staff booked to attend further training sessions up until November 2022.

### Initial Operating Response Training – Front of house staff
### NaCTSO ACT training – Front of house staff (and open to all)

| Date | Time | Location |
|---|---|---|
| Online training sent to leads for ED admin team, Reception, Switchboard, Housekeeping, Security and Site team. | Available all year round for any new staff who join front of house roles. | Training Video, links to e-learning and hard copy materials made available via the EPRR office |

### METHANE Alerting and Escalation training

| Date | Time | Location |
|---|---|---|
| Staff in ED Resus/Majors team, Switchboard and Site team. | Available all year round. Training provided to these teams in June 2022 | In Person. Handouts of the METHANE form are provided |

### Incident Commander Training Programme for On Call staff

All new staff at Senior Manager and Director level, who are required to partake in the On Call rotas, have attended the Incident Commander training, as a requirement before undertaking such duties.

Incident Commander Training dates are being arranged in the updated Training Portfolio – Delivery maybe challenged until Vacancy in EPRR team filled.

| | | | |
|---|---|---|---|
| Incident Command | TBA | | |

**6.0 Lessons Identified – Quality Improvements**

6.1 Each Incident and/or Exercise that occurs in the Trust, requires a structured debrief with the staff involved, to ensure that lessons are identified and translated into recommended actions informing quality improvements to plans, processes, access to resources and identify training requirements. A tangible example of this would be the recent establishment of a Trust-wide Incident Response WhatsApp group following the foul water leaks incidents, which has improved the timely escalation and alerting and coordinated response to incidents on site.

6.2 This year, the following debrief reports have been developed and submitted to Trust Management Board and the Risk Compliance and Assurance Group for endorsement of actions.

- Exercise Bazellgette – LI report

**7.0 EPRR Risks and process for management**

7.1 The Trust EPRR risk register is managed by the Head of EPRR (Currently vacant). This is representative of risks input into the DATIX system by staff across the Trust, which require appropriate management and ownership and risks which are identified through debriefs post incident and exercises.

7.2 Other external EPRR risks are included from the Kent Resilience Forum Community Risk Register as well as local risks reported via the Local Health Resilience Partnership, chaired by the Kent and Medway ICB.

7.3 EPRR risks are represented on the Trust Risk Register as they score appropriately according to the criteria. This coming year will see more intervention being requested to manage Climate Change and adaptation planning risks to the Buildings and infrastructure.

**8.0 ICC Relocation project**

8.1 The Trusts' Incident Coordination Centre (ICC) has now been established in a new location – Residence 13a, East Wing room. It is operational but requires Estates support for full completion.

8.2 This move is a requirement towards achieving the ICC relocation proposal agreed earlier this year, to improve the Trust's physical space and capabilities towards effective and coordinated Incident Response, bringing this in line with the national NHS EPRR standards.

8.3 The Training room in the Post Graduate centre will be the new 'back-up' location for an ICC and will be established as such, in the new year.

**9.0 Next steps – Quality Improvements for 2023 Assurance compliance**

9.1 The Action plan detailing improvements required against this year's EPRR Core Standards Compliance report 2022, can be found appended to this report. The actions directly relate to the domain areas in which the Trust were unable to provide substantial evidence to be 'fully compliant' with, this year.

9.2 The progress of this Improvements plan will be monitored by the MFT EPRR group and its members who will be allocated ownership of appropriate actions. This will be overseen by the Risk, Compliance and Assurance Group by way of regular KPIs reporting from the EPRR group chair. Completion of all actions within the Improvements plan is expected to ensure the Trust reaches 'Full compliance' with the NHS EPRR Core Standards Assurance for 2023.

# Meeting of the Board (Public)
# Wednesday, 01 February 2023

| | | | |
|---|---|---|---|
| **Title of Report** | Research & Innovation (R&I)<br>Annual Report 2021-2022 | **Agenda Item** | X |
| **Report Author** | Dr Edyta McCallum, Head of R&I | | |
| **Lead Director** | Dr Alison Davis, Chief Medical Officer | | |
| **Executive Summary** | The report outlines research and innovation performance for the period 1st April 2021 until 31st March 2022. | | |
| **Due Diligence** | To give the Trust Board assurance, please complete the following: | | |
| **Committee Approval:** | Name of Committee: Quality and Patient Safety Sub-Committee<br>Date of approval: 14th December 2022 | | |
| **Executive Group Approval:** | n/a | | |
| **National Guidelines compliance:** | Does the paper conform to National Guidelines (please state): Yes | | |
| **Resource Implications** | N/A | | |
| **Legal Implications/Regulatory Requirements** | N/A | | |
| **Quality Impact Assessment** | N/A | | |
| **Recommendation/ Actions required** | Review and approval. | | |
| | **Approval** ☒ | **Assurance** ☐ | **Discussion** ☐ | **Noting** ☒ |
| **Appendices** | n/a | | |

# 1. Executive Summary

1. Medway NHS Foundation Trust (MFT) is committed to Research & Innovation (R&I) recognizing the benefits these bring to patient care, general public health, education, staff retention and development of the Trust.
2. This report outlines progress and achievements over the last 12 months (1st April 2021 to 31st March 2022) and provides some up-to-date information.

# 2. Performance

## 2.1. Performance in research studies

2.1.1 In 2021/2022, a total of 94 research studies were conducted at MFT.

2.1.2 Out of these 50 were National Institute for Health and Care Research (NIHR) open recruiting studies, ranging from large-scale, observational, interventional and commercial.

2.1.3 The highest number of studies were conducted on Cancer (15), followed by Children (10), and Reproductive Health and Childbirth (9).

2.1.4 Nationally (England only), amongst 850 research-active trusts, MFT was in position 81, therefore, making it within the top 10%.

2.1.5 The highest in England was Cambridge University Hospitals NHS Foundation Trust delivering 371 studies.

2.1.6 **Figure 1** (**Appendix A**) presents the total number of studies in each speciality.

2.1.7 **Figure 2** (**Appendix A**) outlines the number of studies that MFT participated in from 1st April 2013 to 31st March 2022.

## 2.2. Performance in patient participation in research studies

2.2.1 In 2021/2022, 6,948 patients consented to the NIHR studies, against the target of 3,782 (187%).

2.2.2 The Trust held to its reputation for the eighth consecutive year as being best in the number of patients participating in clinical research, amongst 20 member organisations within Kent, Surrey and Sussex Clinical Research Network (CRN).

2.2.3 Nationally (England only), amongst 850 research-active trusts, MFT was in position 33, therefore well within the top 4% (highest in England was the Southern Health NHS FoundaTrust with 27,641 participants).

2.2.4 Research in Reproductive Health and Childbirth, led by Professor Akolekar continues to be the highest-performing speciality in terms of recruitment numbers. The study First-trimester cfDNA Testing alone consented 3,304 pregnant ladies.

2.2.5 Other specialities have lower recruitment numbers but are highly intensive in terms of delivery and safety and that is reflected in the weighting allocated by the NIHR (Large scale studies = 1 point; Observational studies = 3.5 points and interventional studies = 11 points).

2.2.6 Currently, the Trust has 5 COVID-19-related studies open which are comparable to the height of the pandemic when there were in excess of 10.

2.2.7 **Table 1 (Appendix A)** outlines COVID-19 studies currently conducted at MFT.

2.2.8 **Figure 3** (**Appendix A**) represents the annual recruitment target and the actual number of patients at MFT recruited into the NIHR-adopted studies from 1st April 2013 to 31st March 2022.

## 2.3 Staff engagement in research

2.3.1 During 2021/22, approximately 182 clinical staff participated in the conduct of research approved by the Health Research Authority (HRA) across 23 disease areas as well as studies looking into Health Services Research.

2.3.2 In the period between 1st April 2021 and 31st March 2022, the Investigators at MFT declared 56 published articles to the Trust Knowledge and Library Services.

2.3.3 **Table 2** (**Appendix A**) lists publications in 2021/2022.

## 2.4 R&I Specialty Roles

2.4.1 Research is recognized only in some job plans, and the feedback from Clinicians is that due to clinical demands, the majority of the work is completed in their spare time.

2.4.2 To help manage the growing R&I portfolio and ensure safe delivery of trials, a business case to support the appointment of Speciality Clinical Leads for R&I (£100K) was submitted and approved by the Project Review Group in April 2021.

2.4.3 The funding was allocated in April 2022 and 12 Clinicians have been recruited into the R&I Speciality Lead roles (Cancer, Haematology, Urology, Cardiovascular, Neonatology, Rheumatology, Perioperative Medicine, Anaesthesia & Pain Management, Critical Care, Injuries and Emergencies, Reproductive Health & Childbirth, and Paediatrics).

2.4.4 Individual meetings with Specialty Leads took place and objectives tailored to the current performance of a speciality in research have been agreed upon. Regular, quarterly reviews continue.

2.4.5 In addition to the core objectives of growing the portfolio, Specialty Leads are encouraged to develop home-grown studies and apply for funding grants.

## 2.5 Examples of research MFT has been involved in that has changed practice

2.5.1 The CfDNA ( Clinical Implementation of Cell Free DNA Testing in Maternal Blood in the First-trimester of Pregnancy ) trial has led to national guidelines to include the availability of Non invasive prenatal testing (NIPT) for women deemed high risk for chromosomal abnormalities at combined screening. When this was only available privately before about 2 years ago.

2.5.2 The TOGTHER project which was a trial to assess a communication tool for pregnancy women with learning disabilities. The change in practice is currently being developed but includes education for midwives, alterations to our electronic maternity records to better capture the right information to identify women and provide links for support. It is also leading to policy change and collaborative working with local learning disability services.

2.5.3 ASPREE trial - This has resulted in national guidelines change to recommend women are screened for early onset preeclampsia and those high risk prescribed aspirin. This is now routine practice.

2.5.4 GenOMICC ( Genetics of susceptibility and mortality in critical care )
Majority of knowledge about host genetics in Covid severity comes directly from GenOMICC trial, including multiple therapeutic targets under active investigation. This is from the 4 publications since covid, the trial is ongoing. Here is the link to the last manuscript accepted for publication.
https://www.dropbox.com/sh/cq6mhk40sdv7cyi/AADEWH5nzv4PLArwW35mLAn3a?dl=0

2.5.5 REMAP-CAP (Randomized, Embedded, Multifactorial, Adaptive Platform trial for Community-Acquired Pneumonia). A trial that uses a novel and innovative adaptive trial design to evaluate a number of treatment options simultaneously and efficiently. The trial showed that tocilizumab and a second drug called sarilumab - have a significant impact on patient survival, **reducing mortality by 8.5%**.

2.5.6 Randomised Evaluation of COVID-19 Therapy (RECOVERY) – This is a global clinical trial which aims to identify treatments that may be beneficial for adults hospitalised with confirmed COVID-19. The results so far has changed practice in that Baricitinib and Dexamethasone is now used as standard care, Tocilizumab is also used asstandard of care in highly inflamed patients.
However, high dose Dexamethasone is shown to be harmful in less ill covid patients, therefore not in use.

# 3 Finance

## 3.1 Funding support from the National Institute for Health and Care Research (NIHR)

3.1.1 The Clinical Research Network Kent Surrey and Sussex (CRN KSS) receives its annual funding allocation from the National Institute for Health and Care Research (NIHR), which in turn is funded by the Department of Health and Social Care (DHSC).

3.1.2 The CRN KSS makes funding allocations based on the agreed funding model with the partners. It is linked to the previous year's research activity (calculated as weighted recruits).

3.1.3 The **core** funding allocation by the NIHR to the CRN KSS in **2021/2022** was £14,205,553.00 and by the CRN KSS to the Trust £979,663.

3.1.4 The **core** allocation from the NIHR to the CRN KSS in **2022/2023** is £15,982,245 and by the CRN KSS to the Trust £1,034,234.

3.1.5 The R&I Department has applied and was awarded an additional £182,194 to support costs associated with research devliery (total funding as of 31st March 2021 £1,161,857).

3.1.6 The additional bids included: £38,400 pump prime for COVID-19 VACC Maternal Immunisation; £1,965.04 towards staff maternity leave; £30,462.58 additional uplift; £7,169.58 for REMAP CAP and CCP studies; £38,777.10 to support reopening of studies post COVID; £13,365 round 3 managed recovery; £5,598 for pharmacy, £13,365 to support neonatology deparment; £29,389.88 3% uplift; £3701.82 for specialty lead.

3.1.7 **Table 3** (**Appendix B**) presents core funding allocations to all partners within KSS in 2021/2022.

## 3.2 Investigators accounts

3.2.1 A total income of £462,261 is accumulated in the investigator's accounts as of 30th September 2022.

3.2.2 A Standard Operating Procedure (SOP) for the distribution of research income and cost allocations has been implemented. It facilitates transparency in research income distribution and efficient utilization of income for research purposes, outlining how funds can be spent in operation.

3.2.3 Where possible, the Investigator's accounts are used as the primary source of funding to support research activities.

3.2.4 R&I income and outgoings are monitored by the Research & Innovation Governance Group (RI GG) which reports to the Clinical Effectiveness and Outcomes Group (CEOG).

3.2.5 **Table 4** (**Appendix B**) provides details of the exact balance in each Principal Investigator (PI) account.

# 4 Research Governance and Safety

## 4.1 Research governance

4.1.1 All research carried out at the Trust must be in accordance with the principles set in the UK policy framework for health and social care research and the Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006.

4.1.2 Health Research Authority (HRA) Approval is required for all project-based research involving the NHS and Health and Social Care that is being led from England.

4.1.3 It brings together the HRA's assessment of governance and legal compliance with the independent ethical opinion of a Research Ethics Committee (REC).

4.1.4 R&I Governance Team ensures that any research project conducted within the Trust has the required approvals (HRA approval and any other regulatory approvals as required) in place prior to providing the local R&I approval for the conduct of the study.

4.1.5 Any research and/or innovation-related incidents are reported to the Research and Innovation Governance Group (RI GG) which in turn reports to the Clinical Effectiveness and Outcomes Group (CEOG).

## 4.2 Update on R&I internal audit 2020/2021

4.2.1 R&I carried out an internal audit on NIHR portfolio open and recruiting clinical research studies, during the financial year 2020/2021. The focus of this audit was to assess the compliance when receiving informed consent from participants.

4.2.2 As a result of the audit findings **(Appendix C)**, which related mostly to missing documentation, a number of corrective actions were taken including re-training of all Clinical Research Practitioners in Valid Informed Consent, and the creation of guideline documents.

4.2.3 Following the implementation of the corrective actions, an audit spot-check was conducted on documentation on a random cross-section of patients who were consented to clinical trials during a 30 day period.

4.2.4 Results from the spot-check indicated an improvement from the main audit and there were no critical findings. To continue this improvement, further in-house training for all Principal Invesitgators (PI's) was suggested, with sessions running 1-2 times per week. It was also suggested that R&I provide a check list for PI's and this document was approved at the Research & Innovation Governance Group (RIGG).

4.2.5 A further spot-check was carried out in November 2022 with no findings.

4.2.6 Assuming further progress has been made, the theme for the next audit will be decided at the RIGG in January 2023.

## 4.3 DATIX review

4.3.1 A total of 30 governance-related incidences were submitted on DATIX in the financial year

2021/2022.

4.3.2 All were investigated in detail and improvements were implemented and shared with relevant teams.

4.3.3 Amongst these, two incidences were of particular concern as they had direct impact on patients and required senior management input:

4.3.3.1 **COPE trial (R&D No:1081)**

Two patients were administered medication that has undergone temperature excursion (fridge temperature *below* acceptable norm). No patients were harmed. The study was put on hold until all corrective measures were put in place. New fridges were purchased and Clinical Trial Pharmacy Team conducted a full review of storage and operational procedures. The Rapid Review Form was completed. The study, after Sponsor's site visit and agreement, including MHRA, has now been reopened.

4.3.3.2 **RECOVERY trial (R&D No: 1096)**

The patient was due to receive a second dose of convalescent plasma but was administered fresh frozen plasma instead. The patient was not harmed. The error was traced back to the lab - a staff member who issued fresh frozen plasma placed it in a yellow convalescent plasma trial bag. Corrective actions included the relocation of convalescent plasma stock, 'incident reflective training' with the blood transfusion team and the introduction of additional checks.

## 4.4 Electronic Patient Record (EPR)

4.4.1 The R&I Team liaised with the EPR team to explain the importance of having a research section within the system.

4.4.2 The EPR team allocated a Business Analyst to incorporate the research section.

4.4.3 The R&I Team was then informed that the project was postponed until the last phase of EPR implementation. This is due to other activities taking priority.

4.3.4 The R&I Department is currently waiting for further instructions and is reassured that they are on the list for implementation.

# 5 Academic activities and collaborations

## 5.1 Development of a 'home grown' portfolio

5.1.1 For the Trust to achieve its ambition of becoming a 'University Trust', it must establish a portfolio of its own research (so-called 'home grown').

5.1.2 The portfolio has to include projects that are nationally/internationally recognized and have been granted funding through a competitive process.

5.1.3 At the moment, majority of the research projects delivered at the Trust are from the NIHR portfolio.

5.1.4 Developing a home grown portfolio is more challenging mainly because clinical delivery takes priority and staff have little/no time to realize their own ideas.

5.1.5 To address the difficulties, R&I team developed number of schemes such as recruitment of dedicated facilitators to help write protocols or undertake a literature review, delivery of specialized courses, networking with the Academic Health Science Network (AHSN) or Academic Research Collaborative (ARC).

5.1.6 The schemes enabled expansion of the home grown portfolio.

5.1.7 Between 1st April 2021 and 31st March 2022, there were 31 active home grown projects. Out of these:

- 6 were fully delivered (from concept to outcome)
- 17 are ongoing
- 8 were put on hold (1 Chief Investigator left the Trust and the other 7 stopped responding to any form of communication)

5.1.8 3 funding applications were submitted (totalling £63,200) and a total of £61,300 was granted.

5.1.9 **Figure 4 (Appendix D)** presents the number of studies from November 2020 until now. The figure indicates an upward trend in the number of home grown studies conducted at the Trust.

5.1.10 **Table 5** (**Appendix D**) provides detailed information on funding applications and their outcomes submitted between 1st April 2021 and 31st March 2022.

## 5.2 Kent and Medway Joint Research Collaborative (KM JRC)

5.2.1 MFT continues to support development of the KM JRC, set up by the MFT Head of R&I, Dr Edyta McCallum in 2020.

5.2.2 The JRC partners include acute trusts, community care, primary care, public health, academia (Kent and Medway Medical School, University of Kent, Canterbury Christ Church University and the University of Greenwich), and local authorities (both Kent and Medway).

5.2.3 The main purpose of the JRC is to (similarly to the concept of the Integrated Care Systems (ICS)) through an integrated and collaborative approach advance investigator-led research and innovation within the region, provide evidence to transform services and improve health outcomes for communities, and to inform the future direction of local healthcare, social care, prevention of ill health, health inequalities and health education.

5.2.4 KM JRC is expected to contribute to the ICS strategy, especially since recently published guidance by the Department of Health & Social Care Services (Guidance on the preparation of integrated care strategies) includes a section as to how partners will collaborate on R&I, and adopt and spread proven innovation to address population needs and reduce disparities in access, outcomes and experience within the region.

## 5.3 Joint R&I Strategy with the Canterbury Christ Church University (CCCU)

5.3.1 In April 2021, the Trust approved Joint Research Strategy with the CCCU 2021-2024.

5.3.2 The strategy underpins the Trust's long-term ambition of becoming a University Trust.

5.3.3 Appointment of the Speciality Clinical Leads for R&I will support implementation of the strategy as it will allow the creation of interest groups and the finalisation of honorary contracts and other employment opportunities between the two institutions.

5.3.4 A number of collaborative projects have already begun such as the Virtual and Augmented Reality (VARE) Enhanced Healthcare Education where Trust Consultants contribute to the development of education programme using VARE equipment; 'The only Diabetes Specialist Nurse in the village' pilot which concluded that having DSN in surgeries improved patient outcomes and experience, or the Un-banding project which was initiated by our Chief Nursing Officer Evonne Hunt.

5.3.5 R&I are working closely with CCCU to develop a closer working relationship regarding ethics and ethical applications from staff and students. Several R&I members have been invited to be on the ethical review committee.

## 5.4 Collaboration with the University of Greenwich (UoG)

5.3.1 The UoG is another local university that the Trust has a close working relationship on research and innovation.

5.3.2 Number of academics and students were provided with honorary contracts with the Trust to enable:

- Placement of nutrition students at the diabetes department (collaboration between Prof Nazanin Zand, Prof in Food and Nutrition and Dr Sameer Sighakoli, Trust Diabetes Consultant).
- Analysis and research of the TriNetx global health data that the Trust has access to.

## 5.5 Collaboration with the Kent and Medway Medical School (KMMS)

5.5.1 The R&I Department is working closely with R&D Directors at the KMMS on developing joint research projects.

5.5.2 One such initiative is the development and delivery of research ideas provided by the MFT staff.

5.5.3 The KMMS students will have one year to develop ideas into a comprehensive research project (2022/2023) and one year to deliver these (2023/2024).

5.5.4 At the last count, 3 ideas had been submitted to KMMS by Trust staff. This is now closed as of 31/08/2022.

## 5.6 Collaboration with the MFT Education Department

5.6.1 The R&D Department is supporting the education team in the delivery of Quality Improvement Projects (QIPs) by the Kings College Students (KCL).

5.6.2 The R&I team approached R&I Specialty Leads to identify suitable projects and supervisors.

5.6.3 Arrangements such as relevant HR clearance and access to medical systems were also addressed prior to students arriving on site thus enhancing student experience.

## 5.7 Patient Public Involvement and Engagement (PPIE)

5.7.1 The R&I Department were successful in obtaining funding from the CRN KSS to establish dedicated Patient Public Involvement and Engagement (PPIE) Facilitator for R&I.

5.7.2 The funding enabled to release one of the Senior Clinical Trial Practitioners (SCRP) from research delivery to lead on the ‘underserved’ project i.e. to reach out to communities that are currently not benefiting from participation in research.

5.7.3 That includes liaison with community organisations and groups to explain about benefits of clinical research and provide information about current opportunities.

5.7.4 As part of the initiative, the PPIE Facilitator initiated MFT's own Research Friends initiative i.e. created a database of patients and public members who are interested in engaging in research activities such as the development of protocols or attendance at meetings to provide lay member perspective.

5.7.5 PPIE Facilitator is also closely monitoring the results of the Patient Research Experience Survey (PRES) and helps to address any areas that require improvement.

## 5.8 Engagement of Nurses and Allied Health Professionals in research

5.8.1 'We know that being involved in research improves patient outcomes and staff retention. However, not all patients and members of the public are offered opportunities to be involved in research studies. […] Hence it is essential nurses know about studies taking place in their area of work and can support people who want to join studies (Making Research Matter. Chief Nursing Officer for England's strategic plan for research. Version 2 November 2021. https://www.england.nhs.uk/wp-content/uploads/2021/11/B0880-cno-for-englands-strategic-plan-fo-research.pdf )

5.8.2 To realise the ambition, R&I Department is attending the Nurses and Midwifery AHP Board to provide an update on research initiatives, PhD, and MSc opportunities and to support the development of research culture within this professional group.

5.8.3 The R&I Department is also looking to appoint R&I Nurse/AHP Speciality Lead.

## 5.9 Development of R&I Website

5.9.1 To enhance communication about research opportunities, the R&I Department invested in a new R&I website that provides background information, reports about current projects, upcoming events, funding opportunites and invitation to commercial companies.

5.9.2 The link to the website can be found at https://medwayresearchandinnovation.co.uk/

## 5.10 Update on the Medway Innovation Institute (MII)

5.4.1 This year (2021-2022) the MII was closed and incorporated into the Transformation Team that leads the Patient First initiative.

5.4.2 The R&I Department worked closely with the MII and the aim is to foster new working relationships with members of the Transformation Team in order to continue to develop and encourage research, quality improvement and service evaluation projects around the trust.

# 6 Plans for 2022/2023

6.1 There are 3 key areas that the R&I Department will concentrate on in the upcoming year:

1. Development of new Strategy for 2023/2026. This will require broad stakeholder engagement, alliance with the Clinical Strategy currently under development and Patient First Initiative.
2. Expansion of the 'home-grown portfolio'. Focusing on funding applications.
3. Development of research portfolio in underperforming specialities. Mainly delivered through liaison with the R&I Specialty Leads.

6.2 Number of events are planned to promote R&I in 2022/2023, these include:

- Your Path in Research campaign [November 2022]
- R&I Annual Conference with the theme "Research at Medway; past, present and future" [March 2023]
- R&I Awards [March 2023]
- International Clinical Trial Day Celebration [May 2023]

# 7 Appendices

## Appendix A

**Figure 1.** Presents the total number of studies in each speciality from 1st April 2021 until 31st March 2022.

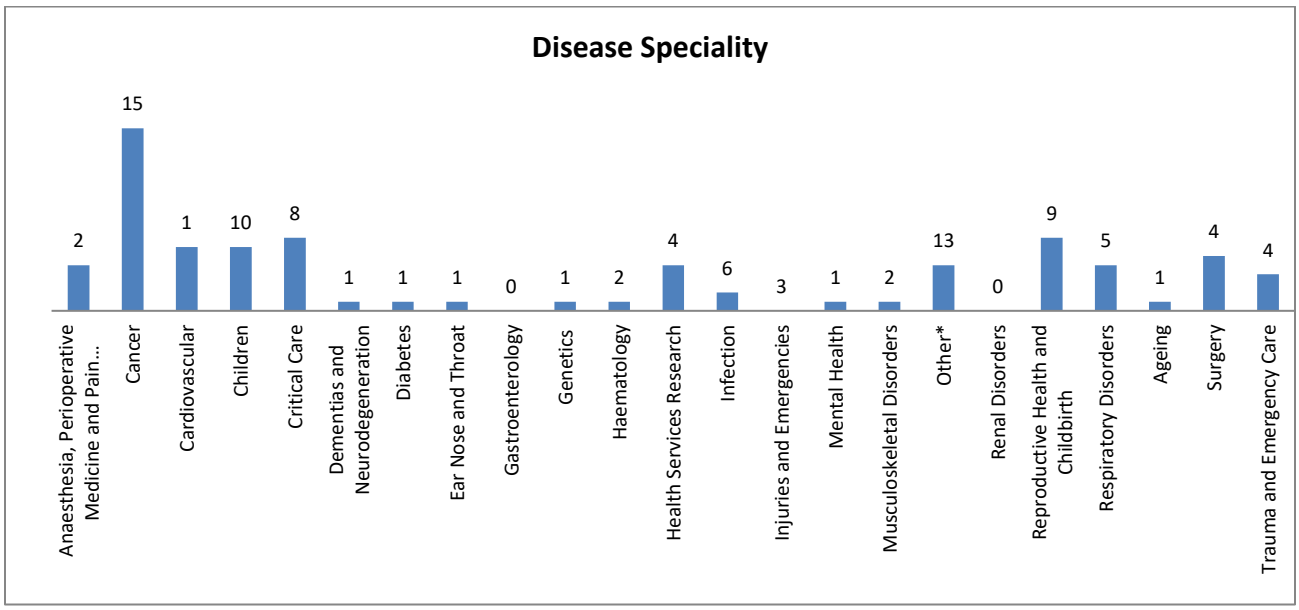



**Figure 2**. Outlines the number of studies that MFT participated in from 1st April 2013 to 31st March 2022.

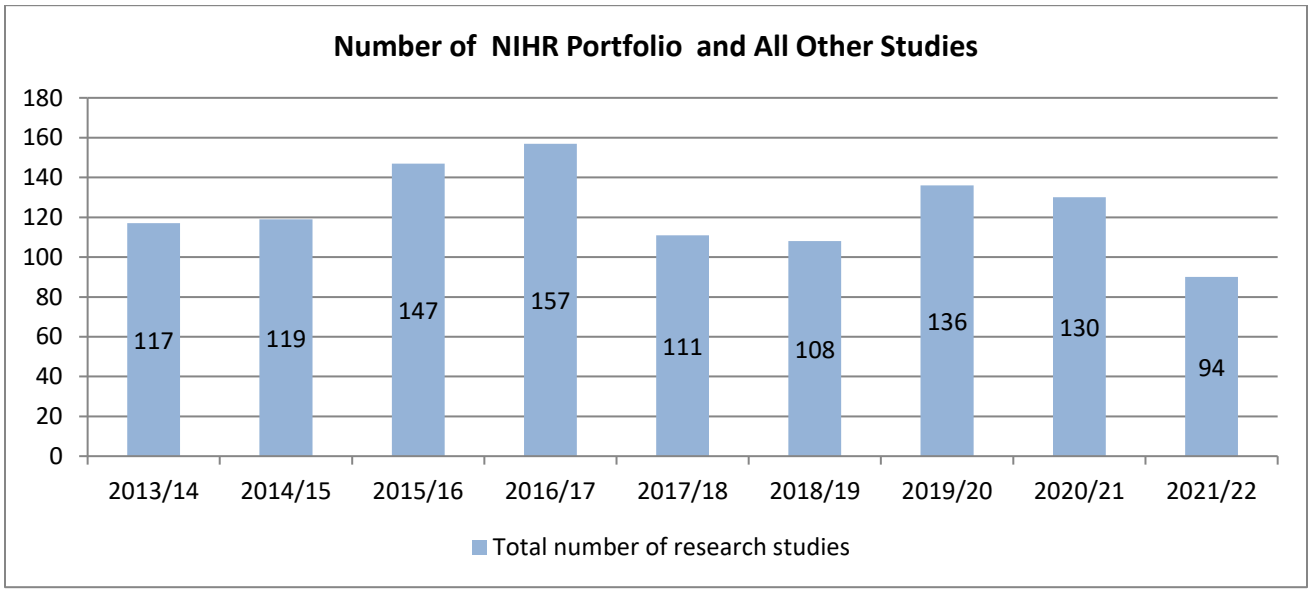


**Table 1.** Description of COVID-19-related studies currently delivered at MFT.

| Study Name / Acronym | Description |
|---|---|
| **Clinical Characterisation Protocol for Severe Emerging Infection** | Infectious disease is the single biggest cause of death worldwide. New infectious agents, such as the SARS, MERS and other novel coronaviruses, novel influenza viruses, viruses causing viral haemorrhagic fever (e.g. Ebola), and viruses that affect the central nervous system (CNS) such as TBEV require investigation to understand pathogen biology and pathogenesis in the host. Even for known infections, resistance to antimicrobial therapies is widespread, and treatments to control potentially deleterious host responses are lacking. In order to develop a mechanistic understanding of disease processes, such that risk factors for severe illness can be identified and treatments can be developed, it is necessary to understand pathogen characteristics associated with virulence, the replication dynamics and in-host evolution of the pathogen, the dynamics of the host response, the pharmacology of antimicrobial or host-directed therapies, the transmission dynamics, and factors underlying individual susceptibility. The work proposed here may require sampling that will not immediately benefit the participants. It may also require analysis of the host genome, which may reveal other information about disease susceptibility or other aspects of health status. This study, while not a study of medicine, may involve additional procedures (some minimally invasive), the retention of genetic material, the collection of personal data and additional follow-up. The ISARIC consortium is keen that this protocol serves as a generic template for the adoption of this study in other countries and similar studies in the future. ISARIC also intend that this protocol and supporting documents can be used to support or run alongside future intervention studies. For these reasons, we aim to fulfil the standards of consent required by Medicines for Human Use (Clinical Trials) Regulations 2004 and NHS NPSA NRES Guidance for Researchers & Reviewers (May 2009). This protocol as now amended is designed to enrol patients with proven infection by Influenza A/H5N1, A/H7N9, MERS-CoV, SARS-CoV-2, viral haemorrhagic fever, TBEV, any infection on the PHE/DHSC high consequence infection list (see PHE website), and any other pathogen of public health interest as yet unspecified. |
| **GenOMICC Genetics of susceptibility and mortality in critical care** | Our genes determine how susceptible we are to life-threatening infections. When a patient is already sick, different genetic factors determine how likely they are to survive. The GenOMICC (Genetics of Susceptibility and Mortality in Critical Care) study will identify the specific genes that cause some people to be susceptible to specific infections and the consequences of severe injury. Our hope is that identifying these genes will help us to use existing treatments better, and to design new treatments to help people survive critical illnesses. To do this, we will compare DNA and cells from carefully selected patients with samples from healthy people. Susceptibility to COVID-19 is almost certainly, in part, genetic. GenOMICC can find the genes that cause susceptibility, which may help us to prioritise treatments to respond to the global crisis. GenOMICC was designed for this crisis. Since 2016, the open, global GenOMICC collaboration has been recruiting patients with emerging infections, including COVID-19. All patients with confirmed COVID-19 in critical care are eligible for GenOMICC. |

| Study Name / Acronym | Description |
|---|---|
| **HEAL-COVID trial HElping Alleviate the Longer-term consequences of COVID-19 (HEAL-COVID): a national platform trial** | COVID-19 is the disease caused by SARS-CoV-2. Despite unprecedented public health measures, SARS-CoV-2 has rapidly spread across the world. Though much is now known about the virus and the short-term effects of the disease it causes; the longer-term complications associated with COVID-19 are only starting to become apparent. We do not yet have full information on the longer-term outlook from COVID-19, but as many as 1 in 4 survivors still experience significant symptoms some weeks after the initial illness and 1 in 10 die within the first 3 months. This study will assess several different treatments that may be of benefit in reducing or preventing the complications that patients with COVID-19 are reporting after their acute illness.<br>HEAL-COVID is a large platform clinical trial designed to assess whether several different treatments are better than the current "standard of care" (the best available evidence-based treatment). In practice, this means the study will be flexible enough to include new treatments not specified at the start of the trial as our understanding of COVID-19 changes.<br>Participants will be recruited from hospitals in the UK. Adults, with SARS-COV-2 infection-associated disease, hospitalised with an expected hospital discharge within 5 days will be eligible to participate in the study. Participants will be randomly assigned to one of the study treatments or standard of care and will be followed up for 12 months. Information will be collected from their routinely collected health records (mortality and subsequent hospitalisations) to minimise the burden on study participants, alongside a collection of remotely entered patient-reported data (online portal or smartphone app) and quality-of-life assessments.<br>The trial is funded by the National Institute for Health and Care Research (NIHR) |
| **RECOVERY trial Randomised Evaluation of COVID-19 Therapy.** | In early 2020, as this protocol was being developed, there were no approved treatments for COVID-19, a disease induced by the novel coronavirus SARS-CoV-2 that emerged in China in late 2019.<br>A range of potential treatments have been suggested for COVID-19 but nobody knows if any of them will turn out to be more effective in helping people recover than the usual standard of hospital care that all patients will receive. The RECOVERY Trial tests some of these suggested treatments. |
| **SI SARS-CoV-2 Infection in NEonates or in Pregnancy: Outcomes at EighTeen months NEPOST study** | Two large ongoing studies, the UK Obstetric Surveillance System (UKOSS) and the British Paediatric Surveillance Unit (BPSU) identified 3000 pregnant women and 100 newborn babies who were hospitalized with the Coronavirus (SARS-CoV-2 or COVID-19) infection so far. Most of these pregnant women gave birth at term (at 37 weeks of gestation or more) and most of the newborn babies who had Coronavirus infection were also born at term. Almost all of these babies were well or were only mildly affected by the virus shortly after birth. Recent research shows that Coronavirus infection in children and adults may affect the brain. Since the development of term-born babies is not routinely checked by health professionals, we will not know whether Coronavirus infection during pregnancy or shortly after birth will affect their development as they grow.<br>From May 2021 to October 2022, this study will check the development of babies exposed to Coronavirus infection and compare it with the development of babies who |

| Study Name / Acronym | Description |
|---|---|
| | did not have Coronavirus infection to find out if there are any lasting effects. The aim is to enrol 200 children who were exposed to COVID-19 during pregnancy, 120 children who have COVID-19 shortly after birth and 200 children without COVID-19. Parents will complete a questionnaire when their child is 18 months old regarding their child's development. The study results will help the NHS develop guidance for pregnant women and parents of newborn babies about the effects of COVID-19. |

**Figure 3. T**he annual recruitment target and the actual number of patients at MFT recruited into the NIHR adopted studies from 1st April 2013 to 31st March 2022.

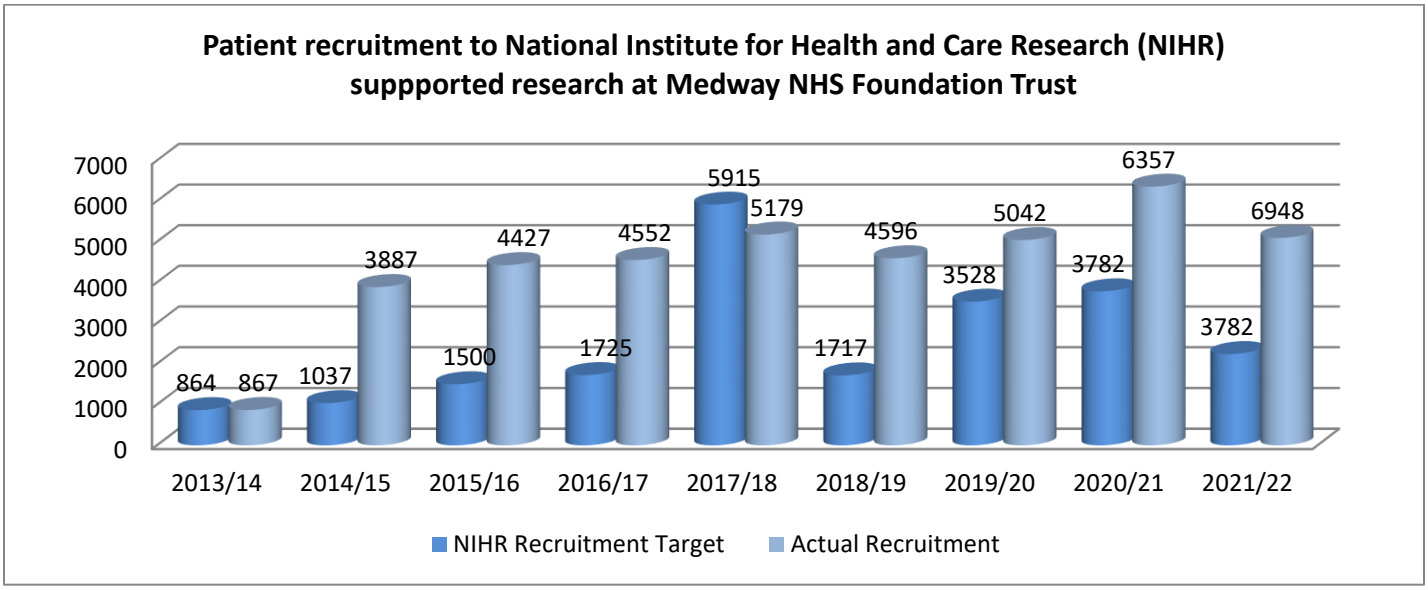



**Table 2.** In the period between 1st April 2021 and 31st March 2022, the Investigators at MFT declared 56 published articles to the Trust Knowledge and Library Services.

| Principle Investigator | Publication | Research Specialty |
|---|---|---|
| **Mr Ibrahim Ahmed** | **British Journey of Surgery, Oct 2021** A quality improvement project: engaging and educating our thyroidectomy patients | Cancer |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, July 2021** Second trimester contingent screening for small gestational age neonates | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Ultrasounds in Obstetrics & Gynaecology, April 2021** Cell-free | Fetal & Maternal Medicine |

| | | |
|---|---|---|
| | DNA testing of maternal blood in screening for trisomies in twin pregnancy: cohort study at 10-14 weeks and updated meta-analysis | |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, May 2021** Fetal loss after chorionic villus sampling in twin pregnancies | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, May 2021** Perinatal outcome of pregnancies with a prenatal diagnosis of vasa previa: a systematic review and meta-analysis | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **BJOG, April 2021** Evaluation of the RCOG guideline for the prediction of neonates that are small for gestational age and comparison with the competing risks model | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **BJOG, 2021** Predictive performance for placental dysfunction related stillbirth of the competing risks model for small-for-gestational-age foetuses | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Journal of Obstetrics and Gynaecology, May 2021** Kielland's rotational forceps delivery: comparison of maternal and neonatal outcomes with pregnancies delivered by non-rotational forceps | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, Dec 2021** Estimated fetal weight at mid-gestation in the prediction of pre-eclampsia in singleton pregnancies | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, Sept 2021** STATIN trial: predictive performance of a competing-risk model in screening for pre-eclampsia at 35-37 weeks gestation | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Circulations, Aug 2021** Pravastatin versus placebo in pregnancies at high risk of term preeclampsia | Fetal & Maternal Medicine |
| **Professor Ranjit Akolekar** | **Ultrasound in Obstetrics & Gynaecology, Oct 2021** Development and validation of a model for prediction of placental dysfunction-related stillbirth from | Fetal & Maternal Medicine |

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| | maternal factors, fetal weight and uterine artery Doppler at mid-gestation | |
| **Dr Nikhil Bhatia** | **Human Genetics, Jan 2022** Common, low-frequency, rare and ultra-rare coding variants contribute to COVID-19 severity | Infection |
| **Professor Stergios Boussios** | **BMJ Case Reports, Mar 2022** Case of cerebral venous thrombosis on a patient with a background of nephrotic syndrome | Oncology |
| **Professor Stergios Boussios** | **International Journal of Molecular Sciences, Nov 2021** BRCA mutations in prostate cancer: assessment, implications and treatment considerations | Oncology |
| **Professor Stergios Boussios** | **Diseases, May 2021** Cancer-associated thrombosis: new light on an old story | Oncology |
| **Professor Stergios Boussios** | **Diagnostics, July 2021** Unravelling the wide spectrum of melanoma biomarkers | Oncology |
| **Professor Stergios Boussios** | **Clinical & Translational Oncology, Nov 2021** Comparative genomic characterisation of melanoma of known and unknown primary | Oncology |
| **Professor Stergios Boussios** | **Cancer Epidemiology, Dec 2021** The outcome of patients with serous peritoneal cancer, fallopian tube cancer and epithelial ovarian cancer by treatment eras: 27 years data from the SEER registry | Oncology |
| **Professor Stergios Boussios** | **Cancer Treatment Review, Feb 2022** Systematic review of fetal and placental metastases among pregnant patients with cancer | Oncology |
| **Professor Stergios Boussios** | **International Journal of Molecular Sciences, Sept 2021** Angiogenesis and anti-angiogenic treatment in prostate cancer: mechanisms of action and molecular targets | Oncology |
| **Professor Stergios Boussios** | **International Journal of Molecular Sciences, Sept 2021** Genetic aberrations of DNA repair pathways in prostate cancer: translation to the clinic | Oncology |

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| **Professor Stergios Boussios** | **International Journal of Environmental Research and Public Health, Jan 2022**Non-epithelial ovarian cancers: how much do we really know? | Oncology |
| **Professor Stergios Boussios** | **Expert Opinion on Therapeutic Targets, June 2021** Aberrations of DNA repair pathways in prostate cancer: a cornerstone of precision oncology | Oncology |
| **Professor Stergios Boussios** | **International Journal of Molecular Sciences, Special Issue, Forthcoming 2022** State-of-the-art molecular oncology in the UK | Oncology |
| **Professor Stergios Boussios** | **The Lancet, Dec 2021** Abiraterone acetate and prednisolone with or without enzalutamide for high-risk non-metastatic prostate cancer: a meta-analysis of primary results from two randomised controlled phase 4 trials of the STAMPEDE platform protocol | Oncology |
| **Miss Shirley Chan** | **British Journal of Surgery, Oct 2021** Supporting surgeons in their return to training | Surgery |
| **Mr Adebayo Da-Costa** | **BMC Emergency Medicine, Jan 2022** Point-of-care testing in paediatric settings in the UK and Ireland: a cross-sectional study | Paediatrics |
| **Sarah Elliott** | **Intensive Care Medicine & Anesthesiology, Oct 2021** Implementation of the ABDEF bundle for critically ill ICU patients during the COVID-19 pandemic: a multi-national 1-day point prevalence study | Critical Care |
| **Miss Caris Grimes** | **Clinical Nutrition ESPEN, Oct 2021** The role of exclusive enteral nutrition in the pre-operative optimisation of adult patients with Crohn's disease: a systematic review | Gastroenterology |
| **Miss Caris Grimes** | **Clinical Nutrition ESPEN, Aug 2021** Does exclusive enteral nutrition reduce the rate of stoma formation in patients requiring ileocolic resection for Crohn's disease? A single-centre experience | Nutrition |

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| **Miss Caris Grimes** | **Nutrients, Dec 2021** Current use of EEN in pre-operative optimisation in Crohn's disease | Surgery |
| **Miss Caris Grimes** | **Tropical Doctor, May 2021** Living with a hernia: A qualitative study of patient experience of abdominal wall hernias in Ndola, Zambia | Surgery |
| **Dr Sarah Hare** | **Techniques in Coloproctology, Apr 2021** The management of adult appendicitis during the COVID-19 pandemic: an interim analysis of a UK cohort study. | Surgery |
| **Dr Sarah Hare** | **World Journal of Surgery, May 2021** Guidelines for perioperative care for emergency laparotomy Enhanced Recovery After Surgery (ERAS) Society Recommendations: Part 1 – Preoperative: diagnosis, rapid assessment and optimisation | Surgery |
| **Dr Paul Hayden** | **Case Reports in Infection Diseases, 2021** Rapid whole genome sequencing of Serotype K1 Hypervirulent Klebsiella pneumonia from an undocumented Chinese migrant | Infection |
| **Mr Martin Mitchell** | **Radiography, May 2021** Concordance between a neuroradiologist, a consultant radiologist and trained reporting radiographers interpreting MRI head examinations: an empirical study | Radiology |
| **Dr Ghada Ramadan** | **ADC Education & Practice, Jan 2022** Fifteen-minute consultation: Is this umbilical venous catheter safe to use? | Fetal Medicine |
| **Dr Ghada Ramadan** | **Ultrasound in Obstetrics & Gynaecology, May 2021** Perinatal outcome of pregnancies with a prenatal diagnosis of vasa previa: systematic review and meta-analysis | Fetal Medicine |
| **Dr Thomas Sanctuary** | **Diagnostics, Nov 2021** Volumetric imaging of lung tissue at micrometre resolution: clinical applications of micro-CT for the diagnosis of pulmonary diseases | Respiratory |
| **Dr Rahul Sarkar** | **medRxiv, Jan 2022** An ML prediction model based on clinical parameters | Infection |

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| | and automated CT scan features for COVID-19 patients | |
| **Dr Rahul Sarkar** | **Free Radical Biology and Medicine, Oct 2021** FDA-approved L-type channel blocker Nifedipine reduces cell death in hypoxic A549 cells through modulation of mitochondrial calcium and superoxide generation | Infection |
| **Dr Rahul Sarkar** | **American Journal of Respiratory & Critical Care Medicine, May 2021** Performance of calibration of performance model scores in a large single-centre database | Critical Care |
| **Dr Rahul Sarkar** | **The Lancet. Digital Health April 2021** Performance of intensive care unit severity scoring systems across different ethnicity in the USA: a retrospective observational study | Critical Care |
| **Professor Bijay Singh** | **Journal of Clinical Orthopaedics & Trauma, June 2021** Proximal ulna fractures in adults: a review of diagnosis and management | Orthopaedics |
| **Professor Bijay Singh** | **Postgraduate Medical Journal, Feb 2022** Orthopaedic surgical prioritisation: can it be made fairer to minimise clinical harm? | Orthopaedics |
| **Professor Bijay Singh** | **Injury, Dec 2021** The use of Nottingham Hip Fracture score as a predictor of 1-year mortality risk for periprosthetic hip fractures | Orthopaedics |
| **Professor Bijay Singh** | **Journal of Ultrasounds, Sept 2021** Experience of an isolated use of low-intensity pulsed ultrasound therapy on fracture healing in established non-unions: a prospective case series | Radiology |
| **Professor Bijay Singh** | **Journal of Ultrasound, Sept 2021** Experienced an isolated use of low-intensity pulsed ultrasound therapy on fracture healing in established non-unions: a prospective case series | Radiology |
| **Professor Bijay Singh** | **Lung India, July 2021** Should COVID-19 vaccination be made mandatory? | Infection |
| **Professor Bijay Singh** | **British Journal of Surgery, Oct 2021** The global impact of COVID-19 on surgeons and team members (GlobalCOST) study | Surgery |

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| **Professor Bijay Singh** | **Journal of Clinical Orthopaedic & Trauma, June 2021** Proximal ulna fractures in adults: a review of diagnosis and management | Orthopaedics |
| **Professor Bijay Singh** | **Postgraduate Medical Journal, Feb 2022** Orthopaedic surgical prioritisation: can it be made fairer to minimalise clinical harm? | Orthopaedics |
| **Professor Bijay Singh** | **Injury, Dec 2021** The use of Nottingham Hip Fracture score as a predictor of 1-year mortality risk for periprosthetic hip fractures | Orthopaedics |
| **Dr Aung Soe** | **BJOG, Feb 2022** Immediate birth for women between 34-37 weeks' gestation with preterm prelabour prolonged rupture of membranes and vaginal or urine GBS detection: an economic evaluation | Obstetrics & Gynaecology |
| **Professor Henk Wegstapel** | **British Journal of Surgery, Oct 2021** Robot-assisted colorectal surgery: short-term outcome of first 70 cases at different time-intervals along the learning curve | Surgery |

**Appendix B**

**Table 3.** Funding allocation by the CRN KSS to partners in 2021/2022.

| PARTNER | 2021/22 ALLOCATION |
|---|---|
| ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST | £579,482.51 |
| BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST | £1,805,707.19 |
| DARTFORD AND GRAVESHAM NHS TRUST | £342,028.87 |
| EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST | £1,068,593.84 |
| EAST SUSSEX HEALTHCARE NHS TRUST | £371,106.43 |
| FRIMLEY HEALTH NHS FOUNDATION TRUST | £704,626.94 |
| KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST | £361,218.03 |
| KENT COMMUNITY HEALTH NHS FOUNDATION TRUST | £151,656.60 |
| MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST | £780,079.12 |
| MEDWAY NHS FOUNDATION TRUST | £979,662.71 |
| QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST | £187,643.41 |
| ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST | £1,052,218.16 |
| SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST | £474,834.29 |
| SURREY AND SUSSEX HEALTHCARE NHS TRUST | £484,678.67 |
| SUSSEX COMMUNITY NHS FOUNDATION TRUST | £268,082.78 |
| SUSSEX PARTNERSHIP NHS FOUNDATION TRUST | £921,380.87 |
| WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST | £831,044.21 |
| SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST | £93,844.49 |
| MEDWAY COMMUNITY HEALTH | £119,548.94 |
| **Partner A total** | **£11,577,438.07** |

**Table 4.** Details of the exact balance in each Principal Investigator (PI) account as of 30th September 2022

| Study Title | Amount | Study Area |
|---|---|---|
| 649 Radi CRT | (1,994) | Cardiovascular |
| 690 Respire - commercial | (1,822) | Cardiovascular |
| 711 Astral - Commercial | (4,274) | Haematology Oncology |
| 609 SWIFFT | (1,778) | Musculoskeletal |
| 349 Calories | (3,967) | Critical Care |
| 661 POPPI (feasibility) | (3,301) | Critical Care |
| 696 Accupass - commercial | (4,293) | Critical Care |
| 686 Leopards | (3,480) | Critical Care |
| 171 ADHD | (5,543) | Children |
| 605 EPOCH | (2,990) | Anaesthesia, Perioperative & Pain Management |
| 452 TAPPS | (1,920) | Lung Cancer |
| 750 Regn 2222 | (4,297) | Children |
| 712 Respite | (1,440) | Reproductive Health & Childbirth |
| 447 Cromis-2 | (2,304) | Stroke |
| 503 ROSE | (2,430) | Haematology |
| 697 EUROPA - commercial | (1,559) | Renal |
| 615 PFIZER 1022 | (441) | Cardiovascular |
| 620 PFIZER 1038 | (3,240) | Cardiovascular |
| 499 Onset 1 - commercial | (36,786) | Diabetes |
| 408 Address 2 | (900) | Diabetes |
| 183 Badbir | (7,245) | Dermatology |
| 597 Planet-2 - listed under Dr | (4,929) | Neonatology |
| 38 INOT | (32,038) | Neonatology |
| 455 ACT-TAPER | (15,980) | Rheumatology |
| 382 MTO4 | (1,726) | Dermatology |
| 657 AB1-2003 Masitinib in pros | (1,102) | Urology Oncology |
| 444 Bumpes | (1,156) | Reproductive Health & Childbirth |
| 394 RA-Proactive - commercial | (757) | Rheumatology |
| 500 impress | (326) | Infection |
| 741 River | (7,520) | Stroke |
| 579 Caliber | (564) | Urology Oncology |
| 201 TOPKAT | (850) | Musculoskeletal |
| 842 Sanofi & D | (252) | Diabetes |

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|---|---|---|
| 861 AD Genetics | (842) | Dementia & Neurodegeneration |
| 875 Amore Study | (4,112) | Gastroenterology |
| 480 Vue Study | (200) | Reproductive Health & Childbirth |
| 851 ExPEC | (7,561) | Renal |
| 866 - Galactic - HF (AMGEN) | (6,193) | Cardiovascular |
| 764 Strive - HF | (2,102) | Cardiovascular |
| 955 Optalyse PE | (10,980) | Cardiovascular |
| 953 CALLS Trial | (2,681) | Haematology Oncology |
| 758 OPTIMA | 964 | Breast Oncology |
| 966 Ascribed Trial | (2,244) | Trauma & ED |
| 949 Flight | (166) | Haematology |
| 938 65 Trial | (8,950) | Critical Care |
| 935 Penthrox Survey | (3,617) | Trauma & ED |
| 934 Penthrox Pass | (18,266) | Trauma & ED |
| 894 Probit | (2,407) | Reproductive Health & Childbirth |
| 892 NICHI IKO | (3,516) | Musculoskeletal |
| 891 Astral 111 | (13,025) | Haematology Oncology |
| 751 HIPvac | (406) | Infection |
| 978 Soul | (1,104) | Diabetes |
| 980 MPP VARR | (64) | Cardiovascular |
| 960 NeoART | (70) | Surgery |
| 766 TICH 2 | (225) | Stroke |
| 990 Prepare ABC | (318) | Colorectal Cancer |
| 1017 NeoClear | (5,074) | Children |
| 951 Quota | (6,528) | Mental Health |
| 1012 Poise-3 | (13,057) | Anaesthesia, Perioperative & Pain Management |
| 790 Baby Oscar | (2,475) | Neonatology |
| 1029 Empress | (11,232) | Critical Care |
| 1041 SCIENCE KIDS | (100) | Trauma & ED |
| 1016 ALLEGRO | (4,355) | Anaesthesia, Perioperative & Pain Management |
| 968 FLO-ELA | (1,400) | Anaesthesia, Perioperative & Pain Management |
| 570 ROSCO | (32) | Breast Oncology |
| 982 DIAPASS | (193) | Children |
| 1009 LORIS | (751) | Breast Oncology |
| 780 MCL-Biobank | (55) | Cancer |
| 1044 KNOCOUT | (8,147) | Cardiovascular |

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|---|---|---|
| 722 ADD-Aspirin | (53) | Cancer |
| 847 Statin | (422) | Reproductive Health & Childbirth |
| 895 PROMIS | (4,378) | Respiratory |
| 729 Cardamon | (716) | Haematology Oncology |
| 824 EVENTS | (518) | Reproductive Health & Childbirth |
| 1032 CONVINCE | (157) | Stroke |
| 1031 DNA Lacunar 2 | (70) | Stroke |
| 334 STAMPEDE | (205) | Urology Oncology |
| Pharmacy HRA | (37,005) | |
| 957 STROLLERS | (267) | Stroke |
| 1134 AZTEC | (15,558) | Neonatology |
| Dr Sameer Sighakoli | (2,876) | |
| Dr Caris Grimes | (10,000) | |
| 1037 The A-Stop Study | (350) | Critical Care |
| 1158 SurfON | (3,378) | Neonatology |
| 1153 CBYL719C2401 | (4,121) | Breast Oncology |
| 1144 ARCADIA | (5,098) | Diabetes |
| 1131 ILIAD 7 | (7,657) | Critical Care |
| 1081 COPE | (861) | Reproductive Health & Childbirth |
| 1089 ACCURE UK 2 | (971) | Surgery |
| 1069 MK6482 | (12,091) | Urology Oncology |
| 1071 neoAMRO | (72) | Neonatology |
| 1084 CCP Isaric | (14,721) | Infection |
| 1099 RECOVERY RS | (525) | Respiratory |
| 1132 WHITE-9 | (92) | Trauma & ED |
| 1150 FALCON C-19 | (1,068) | Infection |
| 1178 Redhill ABC | (4,679) | Infection |
| 1185 HEAL-COVID | (112) | Infection |
| R&I Pathology | (840) | |
| 1169 OHANA | (4,145) | Reproductive Health & Childbirth |
| 1179 COVID-19 Vaccine Maternal | (10,195) | Reproductive Health & Childbirth |
| 1186 UK-ROX | (350) | Critical Care |
| 1196 PARADIGM | (245) | Urology Oncology |
| 1176 periCOVID UK | (6,197) | Reproductive Health & Childbirth |
| 1205 SIGNET | (76) | Critical Care |
| 1078 BICS | (578) | Respiratory |
| 1182 DAPA-MI Study | (6,929) | Cardiovascular |
| | **(462,261)** | |

**Appendix C**

| Category | Main Findings | Recommendations |
|---|---|---|
| **Critical** | Patient Information Sheets (PIS) and Informed Consent Forms (ICF)<br>• Incorrect versions<br>• No evidence of consent process<br>• No documentation to suggest patient received copies of PIS/ICF<br>• No consent forms in patient notes<br>• No consent forms in ISF's<br>• Reaffirming consent is not always documented in patient notes | Incorrect versions of PIS/ICF's<br>• Correct utilisation of Amendment Workflow on EDGE<br>• Key Staff member responsible for amendments, including superseding previous versions, removing old versions from circulation including all locations such as a document box, ISF and Shared Drive, along with any other location study documentation is stored. (Ante-Natal Clinic etc)<br>No evidence of consent process<br>• This is gold standard practice; this is basic and should be the practice for every participant of any study.<br>• Information in notes as a minimum; eligible for study, PIS version given, discussion had with patient, questions answered, consent version signed.<br>• Utilise Consent Process Proforma (one currently on EDGE which can be adapted and updated)<br>• In order to be delegated to a consenting role – complete GCP training, complete Valid Informed Consent Training including clinicians receiving consent as well as research staff.<br>• EDGE training levels 1-10<br>• Potential to request a Research divider in medical records OR all (S)CRP's file research paperwork in the same way and in the same section of notes i.e. in the front of the correspondence section.<br>PIS & ICF not in notes<br>• Copy of PIS should always be in medical notes for other clinicians information (as it may be required) |

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| | | • Copy of ICF in notes should be standard practice, hence the need for consent training. |
| **Major** | No evidence of GP letters being sent to GP's | Utilise participant entry pro-forma on EDGE or use a checklist. GP letters should be in patient notes also as evidence of sending and filed in the correspondence section. This is only required if requested by the sponsors. If there is no GP letter, participation to be included on the discharge summary as a copy of this is also sent to the GP. |
| **Major** | Staff member receiving consent have not completed consent competencies within the first 6 months of employment – 3 out of the 4 studies audited had no proof of Valid Informed Consent training in the Investigator Site File (ISF) or saved on the shared drive. | The (Senior) Clinical Research Practitioners (S/CRP's) should ensure along with their line manager that the Induction Framework for Clinical Research Staff (Version 5.0 – June 2019) is completed within the first 6 months of their employment. This is to be part of the local induction for new starters and included on the new starter checklist. Staff training records and Valid Informed Consent Certificates to be saved on the shared drive. |
| **Major** | No Valid Informed Consent Certificates present in the Site File or Trial Master File. 3 out of 4 studies audited had no proof of Valid Informed Consent training in the ISF. | Whilst it is not standard practice for certificates to be in the ISF and they are not generally requested by the sponsors, it is good practice for all staff undertaking the consent process to complete this training. Therefore, all staff should complete this training and renew this periodically. |
| **Other** | No evidence of project specific training in receiving consent in the ISF or Trial Master File. | There should be a training log for each trial as standard practice. If there is no training log provided, then R&I template should be used and detail that no training log was provided. |
| **Other** | Good Clinical Practice (GCP) certificates in ISF do not cover all staff for the full period of the Delegation Log, along with | Regular maintenance of the ISF is required by the CRP's and this needs to be scheduled into calendars to check along with the training and delegation logs. Monthly emails are now sent out to those whose GCP's are expiring or have expired. |

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| | expired or missing certificates. | |

**Appendix D**

**Figure 4.** The number of active home grown studies from November 2020 until now.

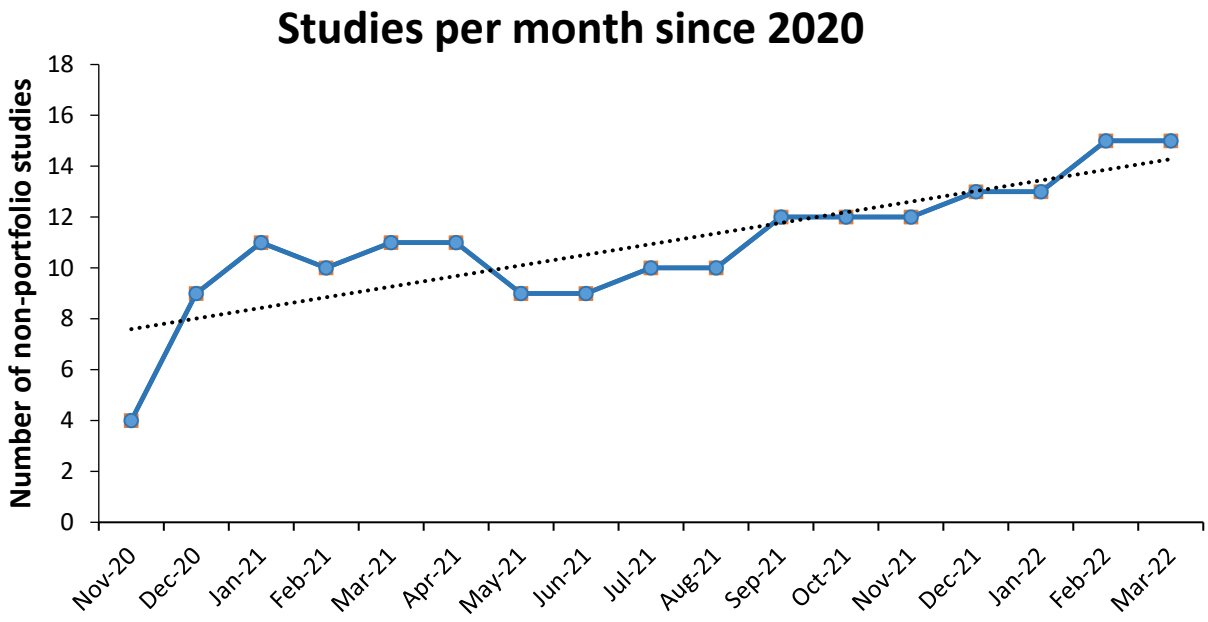


**Table 5.** Funding applications and outcomes between 1st April 2020 and 31st March 2021.

| Project title | Key project members | Amount applied for (£) | Amount granted (£) | Source of funding | Outcome of funding application | Year | date |
|---|---|---|---|---|---|---|---|
| Virtual and Augmented Reality (VARE) Enhanced Healthcare Education | Prof Hatzidimitriadou | 18200 | 18200 | MII | Approved | 2021 | 29/04/2021 |
| Individualised antimicrobial stewardship | Dr Zak Fang | 25000 | 23100 | Pfizer | Approved | 2021 | 04/10/2021 |
| Individualised antimicrobial stewardship | Dr Zack Fang | 20000 | 20000 | Manerini | Approved | 2021 | 09/12/2021 |