Medway NHS Foundation Trust

Papers for the Trust Board Meeting in Public

Wednesday, 03 July 2019 at 12.30pm

In the Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Windmill Road, Gillingham, Kent, ME7 5NY

Agenda

Trust Board Meeting in Public

Date: Wednesday, 03 July 2019 at 12.30pm – 3pm
Location: Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Item	Subject	Presenter	Page	Time	Action
1.	Patient Story	Director of Nursing	Verbal	12:30	Note
2.	**Preliminary Matters**				
2.1	Chair's Welcome and Apologies	Chairman	Verbal	12:45	Note
2.2	Quorum	Chairman	Verbal		Note

2.3	Conflicts of Interest:
	  i. Register of Interest
	  ii. Declaration of Interest
		Chairman	5
			Verbal
					Note

3.	**Minutes of the previous meeting and matters arising**				
3.1	Minutes of the previous meeting held on 2 May 2019	Chairman	9	12:50	Approve
3.2	Matters arising and actions from last meeting	Chairman	19		Discuss
4.	**Standing Reports and Updates**				
4.1	Chair's Report	Chairman	Verbal	12:55	Note
4.2	Chief Executive's Report	Chief Executive	21		Note

4.3	Strategy
	
	  i. System Transformation Partnership
	
	  ii. Transformation Programme Update
		
		Director of Strategy
		
		Associate Director of Transformation
			
			25
			
			75
					
					Approve
					
					Note

5.	**Quality**				
5.1	Integrated Quality and Performance Report	Director of Nursing/ Medical Director/ Chief Operating Officers	105	13:15	Discuss
5.2	Quality Assurance Committee Assurance Report	Non-Executive Director	137		Assurance
5.3	Learning from Deaths	Medical Director	141		Assurance
6.	**Finance and Performance**				
6.1	Finance Report - Month 2	Director of Finance	151	13:35	Note
6.2	Finance Committee Assurance Report	Finance Committee Chair	155		Assurance
6.3	Communications and Engagement Report	Director of Communications and Engagement	157		Note
6.4	7 Day Hospital Services Board Assurance Framework	Medical Director	161		Note

Best of care
Best of people

Agenda

7.	**People**				
7.1	Workforce Report	Director of HR and OD	173	13:55	Note
7.2	Workforce Race and Equality Standard Report	Director of HR and OD	185		Approve
7.3	Workforce Disability Equality Standard Report	Director of HR and OD	197		Approve
7.4	Safe Staffing (Inpatients) Review	Director of Nursing	205		Assurance
8.	**Governance and Legal**				
8.1	Board Assurance Framework	Company Secretary	213	14.20	Assurance
8.2	Integrated Audit Committee Assurance Report	Integrated Audit Committee Chair	235		Note
8.3	Freedom to Speak Up Update	Chief Executive	237		Note
9.	**Strategies**				

9.1	Core strategies:
	  i. Clinical Strategy
	  ii. People Strategy
	  iii. Quality Strategy
		Director of Strategy
		Director of HR and OD
		Director of Nursing
			243	14:40	Note

10.	**Annual Reports**				
10.1	Medical Education Annual Report	Medical Director	253	14:50	Note
10.2	Research and Innovation Annual Report	Medical Director	267		Note
11.	**Other Business**				
11.1	Council of Governors' Update	Governor Representative	Verbal	14:55	Note
11.2	Any other business	Chairman	Verbal		Note
11.3	Questions from members of the public	Chairman	Verbal		Discuss
12.	**Date and time of next meeting: 5 September 2019, 12.30pm-3.00pm, Trust Boardroom**				

MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS

JUNE 2019

Name	Position	Organisation	Nature of Interest
Stephen Clark	**Chairman**	Marshalls Charity	Chairman
		3H Fund Charity	Chairman
		Nutmeg Savings and Investments	Non-Executive Director
		Henley Business School	Member Strategy Board
		Access Bank UK Limited	Non-Executive Director
		Brook Street Equity Partner LLP	Chairman Advisory Council
		Medway NHS Foundation Trust	Chairman
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jon Billings	**Non-Executive Director**	Fenestra Consulting Limited	Director
		Healthskills Limited	Associate
		FMLM Applied	Associate
		University of Kent	Wife is Professor of Applied Health Research, Centre for Health Service Studies
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ewan Carmichael	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Karen Rule	**Executive Director of Nursing**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Dr David Sulch	**Executive Medical Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Executive Director of HR and OD**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Trust Board Meeting in Public

NHS Medway NHS Foundation Trust

Minutes of the Trust Board of Directors Meeting in Public

Thursday 2 May 2019 at 12.30pm, in the Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members	Name	Job Title
	Mr Stephen Clark	Chairman
	Ms Joanne Palmer	Non-Executive Director and Senior Independent Director
	Mr Jon Billings	Non-Executive Director
	Mr Mark Spragg	Non-Executive Director
	Mr Adrian Ward	Non-Executive Director
	Mr Ewan Carmichael	Non-Executive Director
	Mr James Devine	Chief Executive
	Mr Ian O'Connor	Director of Finance
	Ms Karen Rule	Director of Nursing
Attendees	Dr Diana Hamilton-Fairley	Director of Strategy
	Mr Gary Lupton	Director of Estates and Facilities
	Mr James Lowell	Director of Planning and Partnerships
	Ms Morfydd Williams	Director of IT Transformation
	Ms Gurjit Mahil	Chief Operating Officer - Planned Care
	Mr Harvey McEnroe	Chief Operating Officer - Unplanned and Integrated Care
	Dr Ghada Ramadan	Associate Medical Director
	Mr Jack Tabner	Associate Director of Transformation *(Item 4.3ii only)*
	Ms Elizabeth Nyawade	Deputy Director of HR and OD
	Mr Michael Addley	Head of Communications and Engagement
	Ms Brenda Thomas	Company Secretary (minutes)
	Ms Doreen King	Governor Board Representative
	Mr Alastair Harding	Lead Governor
	Mr Jim Gillies	Patient Story *(Item 1 only)*
	Ms Sakina Jaffery	Clinical Co-Director *(Item 1 only)*
	Mr Roberto Laza-Cagigas	Exercise Physiologist *(Item 1 only)*
	Mr Alastair Harding	Lead Governor
	Ms Jacqui McKenna	Quality Advisor
Apologies	Mr Leon Hinton	Director of HR and OD
	Dr David Sulch	Medical Director
	Ms Glynis Alexander	Director of Communications and Engagement
Observers	Two governors Two members of the public	

01/19   Patient Story

1.1   Karen Rule, Director of Nursing, introduced Mr Jim Gillies, one of the first patients to undergo surgery for renal cancer following his spell on the prehabilitation programme to get fitter for surgery. Surgery was the only option of treating the cancer, but his fitness levels at the time meant that there was a much higher risk of developing serious complications during and after surgery. He was therefore referred to the prehabilitation service, where personalised fitness programme which included exercise, nutrition and psychotherapy were offered to help preparation for surgery. Mr Gillies' lung capacity increased by 50% and his overall fitness increased just six weeks into the programme, allowing him to successfully undergo surgery.

1.2   The pre-habilitation unit which was developed, and is led by, Consultant Anaesthetist Dr Tarannum Rampal, with the support of her team, is first of its kind in the south east region. The unit is focused on preparing local patients both physically and mentally, typically between four to six weeks before surgery. This service which has had national interest and is supported by the League of Friends charity has been shortlisted for the Health Service Journal (HSJ) award, nominated for clinical support services.

1.3   The Chairman, on behalf of the Board thanked Mr Gillies and pre-habilitation team and wished Mr Gillies well for the future. He noted that the work of the pre-habilitation team is having a marked impact.

02/19   Preliminary Matters

2.1   Welcome and Apologies for absence

2.1.1   The Chairman welcomed everyone to the meeting and noted that this was Alastair Harding's last meeting as Lead Governor, as Alastair would not be standing a second term as governor for rest of England and Wales, due to family move.

2.1.2   Apologies for absence were received as recorded above. Dr Ghada Ramadan, Associate Medical Director was deputising for Dr David Sulch, Medical Director; Elizabeth Nyawade Deputy Director of HR and OD, deputising for Leon Hinton Director of HR and OD; and Michael Addley, Head of Communications, deputising for Glynis Alexander, Director of Communications and Engagement.

2.2   Quorum

2.2.1   The Chairman confirmed the meeting was quorate.

2.3   Register of Interests

2.3.1   There were no declarations of interest in relation to items on the agenda.

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

2.3.3   The Register of Interests was noted.

03/19   Minutes of the previous meeting and Matters Arising

3.1   Minutes of the previous meeting

3.1.1   The minutes of the previous meeting held on 7 March 2019 were **APPROVED** as an accurate record of the meeting.

3.2   Matters Arising and Action Log

3.2.1   Under matters arising, the Chairman reported that he had raised at the last Clinical Council meeting, senior consultants' buy-in/ full engagement on continuous improvement and their support to junior doctors.

3.2.2   The following actions on the action log that were proposed for closure were agreed to be closed: TB/2019/010, TB/2019/012 and TB/2019/013.

3.2.3   Updates were provided for the following actions:
    i.   TB/2019/008- Karen Rule reported that this feeds into the development of the Quality Strategy and the Trust's ambition for the first year. Agreed to close.
    ii.   TB/2019/009- This action has been addressed and was agreed to be closed.

04/19   Standing Reports and Updates

4.1   Chair's Report

4.1.1   The Chairman welcomed members of the public, press and governors and expressed thanks for taking a keen interest in the Trust's progress. He highlighted as follows:

   a) Following a challenging winter, improved performance across the Trust is beginning to be seen and staff are working hard to ensure this is sustained;
   b) The recent media coverage about the breast cancer two-week wait performance was disappointing. An independent review is underway and improvements have already been seen;
   c) Progress on the development of the Trust's clinical, quality and workforce strategies and a diverse range of staff led transformation projects, aiming for brilliant, would be communicated in due course;
   d) The patient story demonstrated how a staff led initiative on pre-habilitation is making a real impact to the local community, who deserve high quality and innovative care.

4.1.2   The Chairman was delighted to announce the appointment of James Devine as the substantive Chief Executive of the Trust, noting that James possesses the leadership skills and deep understanding of the healthcare environment and has already demonstrated an impressive commitment to driving improvement while maintaining a strong focus on quality. James was wished well for the future and was assured of the Board's support.

4.2   Chief Executive's Report

4.2.1   James Devine, Chief Executive, talked through his report, which was taken as read. He apologised on behalf of the Board and the cancer team to the patients affected by the poor breast cancer two-week wait performance, noting that the numbers are intolerable. He provided assurance that robust plans are now in place to prevent reoccurrence.

4.2.2   The following were highlighted from his report:

   a) Following the challenged winter period, staff who consistently go beyond the call of duty to provide the best of care were thanked for their hard work and dedication;
   b) This year's transformation project will focus on four key areas;
   c) Medway councillors have referred to the Secretary of State for Health and Social Care, the decision to exclude Medway in the preferred option for the location of hyper acute stroke units (HASUs) in Kent;
   d) The Trust discontinued the provision of dermatology service from 1 April 2019, prior to which notice was given to Medway Clinical Commissioning Group (CCG). Dermatology staff were thanked for their hard work over the years, whilst recognising that more work is required with the new partners, DMC Healthcare, to ensure safe transfer of patients;
   e) South East Coast Ambulance Service (SECAMB) has announced the appointment of Philip Astle, as the new chief executive to take up post in the near future;
   f) The Organ Donation (Deemed Consent) Bill received Royal Assent on 15 March 2019. It becomes the Organ Donation (Deemed Consent) Act 2019;
   g) A fifth strategic objective: high quality care has been created and was approved by the Board at its development session on 4 April 2019;
   h) The Chairman added that the Mayor of Medway opened the dementia therapy garden on 1 May 2019 and thanked those who were involved in this work.

4.2.3   Mr Devine thanked the Board for their support during his interim period as Chief Executive, assured the Board of his commitment to the Trust and noted his appointment as a privilege.

4.3   Strategy

4.3(i) Sustainability and Transformation Plan (STP) Update

4.3.1   Diana Hamilton-Fairley, Director of Strategy, presented the report which was taken as read. The current eight CCGs' commissioning function is to be replaced by a single strategic commissioner for Kent and Medway. The development of the integrated care partnerships (ICPs) and the primary care networks form a key platform for this work. The STP is continuing to progress the business plan for the stroke programme and implementation of the preferred option.

4.3.2   The OFSTED (Office for Standards in Education, Children's Services and Skills) SEND (Special Education Needs and Disabilities) report for Medway was similar in some areas with

Kent, though better. The STP has identified children's services as an area that requires the urgent development of a strategy to improve services. Roles and responsibilities across the system are being defined. The Month 10 Kent and Medway STP financial position for 2018/19 was a year-to-date (YTD) planned deficit of £75m. The YTD actual position was reported as £134m, £59m adverse to plan. This position has since changed and an updated position would be reported at the next Board meeting.

4.3.3 **The Board noted the STP update.**

4.3(ii) Transformation Programme Update

4.3.4 Jack Tabner, Associate Director of Transformation, presented the final report on the Cost Improvement Programme (CIP) for 2018/19 and a look ahead to the 2019/20 CIP. As at Month 12, YTD actual CIP delivery for 2018/19 was £21.0m (recurrent: £20.8m (against £15m target); non-recurrent: £0.2m (against £6m target)), achieving the target for the financial year.

4.3.5 The CIP target 2019/20 is £18.0m. As at 17 April, 93 schemes with a target value of £21.3m have been identified. A review of these schemes is being undertaken to ensure delivery. Six programmes have been prioritised for 2019/20, each with a Senior Responsible Officer (SRO) from the executive team. Harvey McEnroe, Chief Operating Officer- Unplanned and Integrated Care, talked through the ambition for the best flow programme, a key focus for 2019/20 and one of the largest improvement programmes ever undertaken at the Trust. The aim is to focus on quality improvement and address flow via a number of key initiatives, with flow ownership a key driver. Work is underway to link this programme with the Quality Strategy. Expert support to accelerate this work is being sought. Highlight reports from the core programmes would be submitted to the Trust Board to provide assurance of delivery against the agreed objectives.

4.3.6 James Devine assured the Board that the CIPs achieved was not at the expense of compromising the quality of patient care. Quality did not override savings, and is always at the forefront when new schemes are introduced. The Board was further assured that this program is about a tangible change and though challenging, there is clarity on expectation.

4.3.7 The Board:
   a) Felt assured that the tone was right and was encouraged by the stance;
   b) Discussed the robustness of the Quality Impact Assessment (QIA) process and requested that the terms of reference for the Quality Assurance Committee be reviewed to incorporate the review and robustness of the QIAs. **Action: TB/2019/014;**
   c) Commended the plan on a page;
   d) Queried the timeline for tangible changes to be seen.

4.3.8 The Chairman on behalf of the Board thanked Jack Tabner and the transformation team for an excellent work, noting that this was not about a cost-cutting exercise. All actions taken by the Trust is geared towards improving prospect for patient care and outcome.

4.3.9 The Board delegated authority to the Finance Committee to review and make a decision on the flow business case and report back to the Board. **Action: TB/2019/015.**

4.3.10 The Board noted the Transformation Programme update.

05/19 Quality
5.1 Integrated Quality and Performance Report
5.1.1 Karen Rule introduced the report, with input from the Chief Operating Officers and Associate Medical Director. The March report with February data was presented. The Board was assured that the executive team have agreed a new internal reporting timeline to ensure up to date information is presented going forward. The following were highlighted from the report, with indications from the March and April position, where available:
   a) Weekly performance meetings are now in place to ensure regular and constant tracking;
   b) Bed occupancy has been at above 100% for the last few months. Outputs of inpatient safe staffing review has been reviewed;
   c) Interventions put in place to reduce the number of patient falls have had positive impact, with falls decreased to pre-January levels. Falls action plan and CQUINs are in place;
   d) Though the Trust did not meet the infection prevention and control targets for the year, the Board was assured that infection is not widespread across the Trust and infection

prevention is being reviewed, with support from NHS Improvement (NHSI) for which feedback is awaited to further inform the improvement plan. The Quality Assurance Committee in April had an extended session on infection prevention and control;

e) A reduction was seen in the number of mixed sex accommodation (MSA) breaches in March, and early indicators suggest further decrease (below 100);

f) Hospital Standardised Mortality Ratio (HSMR) was noted as a long standing issue and actions have been taken on deaths in the community and palliative care coding to ensure accurate reporting. As a result, deaths are now being properly accounted for. A reduction has been seen in the HSMR figures; with the most up to date position at 105. A deep dive on pneumonia deaths was undertaken and a report was presented to the Mortality and Morbidity Committee. Jon Billings, Chair of the Quality Assurance Committee assured the Board that there is a more accurate reflection of the HSMR position and an understanding of the drivers for changes to inform target areas for intervention;

g) Performance against constitutional standards were highlighted and noted:

- Counting and coding changes associated with type three activity have now been facilitated into the Trust's IT system to ensure accurate validation and oversight. This was previously validated by the Medway Community Healthcare, which operate a different tracking system leading to inaccurate reporting. Early indicators show 10% deterioration with 8% deterioration in the Trust's overall position. Regulators have been informed of this position;

- Although the Trust did not achieve compliance against the trajectory and national standards for referral to treatment (RTT), targets were met for nine out of 12 months, a significant improvement compared to the previous 12 months;

- April data showed 81% was achieved for the cancer two week wait; and 69% for breast cancer. Improved performance has been seen on cancer, particularly breast. All affected breast cancer patients due to poor performance have now been seen, with patients being seen six days quicker than before and clinical harm reviews completed for all those patients. An independent review was commissioned and a number of interventions put in place to improve the position.

5.1.3 The Board queried the low staff appraisals figure and urged for actions to be taken for improvement. In addition, it was suggested that the plan for the cessation of the venous thromboembolism (VTE) task and finish group due to successful project outcomes is put on hold for another month or two to ensure improvement is maintained. In regards to the query on fractured neck of femur (FNoF), a plan of action was requested for the three to four quality indicators that have not improved as much, with tangible outputs over a short period of time (infection, FNoF, pressure ulcers, statutory mandatory training compliance - were suggested) **Action: TB/2019/016.**

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

5.2   Quality Assurance Committee Assurance Report
5.2.1 Jon Billings, Non-Executive Director and Quality Assurance Committee Chair, presented the report, which was taken as read. The Committee's updated terms of reference, which had been approved by the Committee at its meeting on 22 March were recommended for approval.

5.2.2 **The Board:**
  i.   **noted the Quality Assurance Committee Assurance Report; and**
  ii. **approved the terms of reference for the Quality Assurance Committee.**

06/19   Finance and Performance
6.1   Finance Committee
6.1.1 Joanne Palmer, Non-Executive Director and interim Finance Committee Chair, presented the report noting that:
  a) the Month 12 finance performance was reviewed, which showed £29.9m deficit was achieved against a planned deficit of £46.9million, after the Provider Sustainability Fund (PSF) reward of £8.3million. This showed significant improvement compared to the £62.4million deficit for 2017/18. The Committee was significantly assured of the financial position and thanks conveyed to the executive team;
  b) the CIP Plan for 2019/20 was reviewed;
  c) the draft financial plan for 2019/20 (£22.3m) was approved;

d) the Operating Plan reviewed and has been submitted to NHSI;

e) the tracking of urology robot cost has been transferred from the Integrated Audit Committee to the Finance Committee;

f) the Committee reviewed the risk register and was comfortable with the mitigations;

g) the Committee would be discussing the IT transformation plan and flow business case.

6.1.2 The Committee recommended for approval its terms of reference. There had been further discussions on the approval of business cases and it was agreed that the Board delegate authority to the finance committee to approve business cases up to the value of £2m and values of up to £250k to be approved by the Chief Executive, in line with the plan. Values above £2m would be referred to the Board.

6.1.3 **The Board:**
   i. **noted the Finance Committee Assurance Report; and**
   ii. **approved the terms of reference for the Finance Committee.**

6.2 Communications Report

6.2.1 Michael Addley, Head of Communications, presented the report which was taken as read. The Trust's internal communications continue to encourage engagement with the Trust's transformation programme and the many projects that are driving improvements at the hospital, with a range of communication methods to do this being used. Over the past three months the communications team dealt with more than 30 interactions with local, regional and national media. Record levels of engagement were seen on social media and the Trust remains the most followed Trust in Kent on Twitter. Community engagement continued, with stakeholders being kept informed of progress and governors and members supported.

6.2.2 **The Board noted the Communications Report**.

6.3 Membership Strategy

6.3.1 Michael Addley presented the refreshed Membership Strategy which had been approved by the Council of Governors in April 2019. He gave some context to its development and noted the purpose of the strategy is to outline how the Trust intends to build on membership recruitment and engagement activities; and how to support, sustain and communicate with the membership.

6.3.2 **The Board approved the Membership Strategy**.

6.4 Annual Health and Safety Report

6.4.1 Gary Lupton, Director of Estates and Facilities, presented the Health and Safety Annual Report, which covered the period 3 November 2017 to 31 March 2019. The report sought to provide assurance to the Board on how the management of health and safety is currently undertaken within the Trust, and the planned Health and Safety Strategy.

6.4.2 The Board:
   a) discussed onsite smoking, which has become more prevalent and was assured that plans are underway to re-establish the Smoking Group and take necessary actions to reinvigorate day-to-day focus to ensure non-smoking compliance;
   b) noted that the report presented the Health and Safety Committee as a Board committee. This was queried and would be reviewed. **Action: TB/2019/017;**
   c) requested a more regular reporting to the Board of health and safety issues, opposed to yearly, as per the report;
   d) queried whether fire safety training still incorporates fire warden training and ongoing support to fire wardens. Update to be included in the quarterly health and safety report.
   e) flagged that for all terms of reference, matrix to capture key issues within the monitoring section of the terms of reference should be set out. **Action: TB/2019/018;**
   f) raised as a concern, the non-compliance with personal protective equipment (PPE) or dosimetry badges by cardiologists and radiologists. This has been formally raised with the Medical Director and the Board flagged for this matter to be followed up as a matter of urgency. **Action: TB/2019/019.**

6.4.3 **The Board approved the Health and Safety Annual Report**.

07/19   People
7.1   Workforce Report
7.1.1   Elizabeth Nyawade, Deputy Director of HR and OD presented the workforce report which was taken as read. The report covered recruitment; staffing (permanent and temporary) - including turnover and sickness absence rate; appraisals and statutory mandatory training. Key highlights from the report:

  a) Turnover is linked to the Trust's Retention Strategy and is an area of focus. A number of retention initiatives have commenced, including holding sessions for new starters to feedback on their experiences and highlight areas for improvement. The YATD programme, which continues to make an impact, featured highly in these sessions;

  b) The Trust met both its statutory mandatory and staff appraisal targets at the end of March. The statutory mandatory training target was met for seven out of the 10 areas. Focus would be placed on the three non-compliant areas;

  c) In March 2019, 18 international nurses undertook the Objective Structured Clinical Examination (OSCE) exam with 17 passing at the first attempt. The Trust currently has a pass rate of 98%;

  d) Grip continues to be shown on agency spend, with the Trust achieving circa £6.7m below the NHSI agency ceiling for the period to March 2019.

7.1.2   A breakdown of NHSI retention collaborative for nursing was requested, including what the tangible outputs are and timeline for the stability index. **Action: TB/2019/020.** Furthermore, it was flagged that notwithstanding the Trust meeting the statutory mandatory training target which is an improvement, 85% was considered low as also noted by the last Care Quality Commission (CQC) report. It was requested that the next workforce report should include actions to be taken to get to 90%. **Action: TB/2019/021.**

7.1.3   Continued recruitment campaigns and retention initiatives are employed to fill vacancies and retain staff; this includes job offers being made to student nurses prior to completion of their courses. An analysis of the reasons for leavers per month was requested for the next meeting, to review trends (heat map versus turnover versus staff group, with reason for leaving). **Action: TB/2019/022.**

7.2   Staff Survey Result
7.2.1   Elizabeth Nyawade presented the 2018 staff survey results, which showed a slight increase in the Trust's response rate by 0.1% to 40.2% and reflected the opinions of 1595 employees. Reporting has changed significantly from key findings to themes, whilst allowing comparison to 2017. Across the staff survey themes for the entire Trust, six scores worsened (on a rating of one to 10), three remained the same and one was a new score. The main focus is on actions to be taken for improvement. The 2019/20 action plan with timescales, in addition to actions already being taken was noted. This action plan would be monitored monthly at the performance review meetings.

7.2.2   A six monthly review of progress against milestones per programme was requested. **Action: TB/2019/023.**

7.2.3   **The Board noted the staff survey results.**

08/19   Assurance Reports
8.1   **Integrated Audit Committee Report**
8.1.1   Jo Palmer, Non-Executive Director gave a verbal update of the proceedings of the meeting, due to timing and subsequent reporting.

  a) The internal auditors' and local counter fraud reports were discussed. Partial assurance on mortality review and significant assurance on research governance were given. Improving trend over the last 12 months on the overall performance on internal audit was noted. As a result, the Trust is expected to be issued with significant assurance on the annual accounts. Improved position on the counter fraud activities was also noted;

  b) The Internal Audit Plan and Local Counter Fraud Plan for 2019/20 were approved. The former to be revised to include the recently agreed fifth strategic objective and reviewed in light of the breast cancer issue. If there is need for the plan to be adjusted, this will be presented to the committee;

  c) The first draft of the annual report was reviewed;

d) The revised Conflicts of Interest Policy was reviewed and approved;
e) The Board was asked to delegate authority to the Integrated Audit Committee to approve the annual report and accounts on 23 May 2019.

8.1.2   Mark Spragg, Chair of the Integrated Audit Committee presented for approval the committee's terms of reference, which had been reviewed and approved by the Committee.

8.1.2   **The Board noted the Integrated Audit Committee report and delegated authority to the Committee to approve the 2018/19 Annual Report and Accounts.**

09/19   Policies and Strategies
9.1   The Board **approved** the following policies, following approval at the relevant committees and Executive Group, with the relevant changes highlighted:
1) Conflicts of Interest;
2) Consent;
3) Estates and Facilities;
4) Medicines Management; and
5) Safeguarding.

9.2   In relation to getting the message out to staff about the conflicts of interest policy, the Board requested Gurjit Mahil, Chief Operating Officer - Planned Care, to follow up with midwives and David Sulch to follow up with Consultants. **Action: TB/2019/024**.

10/19   Other Business
10.1   Trust Board Annual Planner
10.1.1   The Board noted the Trust Board Annual Planner for 2019/20.

10.2   Council of Governors' Update
10.2.1   Doreen King, Board Governor Representative congratulated James Devine on his appointment, noting that the Council of Governors unanimously approved the appointment which is a reflection from staff.

10.2.2   In relation to Doreen's query on emergency time, Harvey McEnroe provided assurance that the Trust is soon to go live with a new same day emergency care facility service, which would provide an additional 32 slots a day. Harvey to provide further information to Doreen outside of the meeting.

10.2.3   Alastair Harding, Lead Governor, thanked the Board for the time spent at the Trust, noting the progress made in a number of areas. He reiterated the positive appointment of James Devine.

10.3   Any Other Business
Financial position
10.3.1   Ian O'Connor, Director of Finance gave a verbal update on the financial position as the year end position was being finalised. The draft accounts were submitted to NHSI on 23 April 2019. He reiterated the earlier point made on the Month 12 finance position, which was £29.9m deficit achieved against a planned deficit of £46.9m, after the PSF reward and national bonus. Next year's target is £22.3m.

10.3.2   The Chairman reiterated the achievements are remarkable and thanked the executive team for a sterling job.

Director of Planning and Partnerships
10.3.3   James Devine, on behalf of the Board, bade farewell to James Lowell, Director of Planning and Partnerships, who would be proceeding on secondment to the ICP, as Director of System Transformation for Medway and Swale ICP. James was thanked for his contribution to the Trust and was wished well for the future.

10.4   Questions from members of the public
10.4.1   There were no questions from members of the public.

011/19 Date and time of next meeting

11.1   The next Board Meeting in Public will be held on Wednesday, 3 July 2019 at 12.30pm in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

11.2   The meeting closed at 15.02pm.

These minutes are agreed to be a correct record of the Trust Board Meeting in Public of Medway NHS Foundation Trust held on 2 May 2019
Signed ……………………………………….. Date ………………………………… Chair

Trust Board of Directors Meeting in Public
Action Log

Agenda Item: 3.2
Date: Wednesday, 03 July 2019

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
10-Jan-19	TB/2019/002	**Integrated Quality and Performance Report** Detailed discussion at the Quality Assurance Committee on the challenges of mixed sex accommodation and the way forward.	02-May-19	Karen Rule Director of Nursing	To be discussed at the Quality Assurance Committee development session on 28 June.	**Green**
07-Mar-19	TB/2019/007	**Action Log** Address the effects of pharmacy on patient flow for discharge	02-May-19	Harvey McEnroe Chief Operating Officer Integrated and Unplanned Care	New satellite pharmacy opening in emergency department and acute pharmacy service extended hours now in place.	Green
07-Mar-19	TB/2019/011	**Safe Working Hours Annual Report** Give consideration to producing a consolidated picture of the medical workforce to ensure that workforce is fit for purpose.	02-May-19	Dr David Sulch Medical Director	Report deferred to September.	Red
02-May-19	TB/2019/014	**Transformation Programme Update** Review terms of reference (ToR) for the Quality Assurance Committee to incorporate the review and robustness of the quality impact assessments (QIAs)	03-Jul-19	Karen Rule Director of Nursing	Already captured within the ToR approved by Board in May and has been included in the work plan to ensure oversight.	Green
02-May-19	TB/2019/015	**Transformation Programme Update** Authority delegated to the Finance Committee to review and make a decision on the flow business case and report back to the Board	03-Jul-19	Ian O'Connor Director of Finance	The Finance Committee held an extraordinary meeting on 2 May 2019, after the board meeting to review the flow business case. This was approved.	Green
02-May-19	TB/2019/016	**Integrated Quality and Performance Report** Produce plan of action for the three to four quality indicators that have not improved as much, with tangible outputs over a short period of time (infection, FNoF, pressure ulcers, statutory mandatory training compliance)	03-Jul-19	Karen Rule Director of Nursing	Improvement plans are in place for the suggested indicators, monitored via relevant sub-groups/ committees. Improvement plans and trajectories for statutory and mandatory training are owned by the corporate functions, programmes and directorates and monitored through programme and directorate boards and via PRMs with executive team.	
02-May-19	TB/2019/017	**Annual Health and Safety Report** Review Health and Safety Committee as a Board committee.	03-Jul-19	Brenda Thomas Company Secretary	The Health and Safety Committee has been deemed as a non-board committee. This committee will report directly into the Executive Group. The terms of reference will be revised to reflect this and the committee structure reflects this. Quarterly updates will however be provided to the Board.	Green
02-May-19	TB/2019/018	**Annual Health and Safety Report** Produce matrix to capture key issues within the monitoring section of the terms of reference .	03-Jul-19	Brenda Thomas Company Secretary	This will be produced for and monitored by the relevant committees.	Green

Trust Board of Directors Meeting in Public
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Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
02-May-19	TB/2019/019	**Annual Health and Safety Report** Follow up the non-compliance with personal protective equipment (PPE) or dosimetry badges by cardiologists and radiologists.	03-Jul-19	Dr David Sulch Medical Director	Update to be provided at the meeting	
02-May-19	TB/2019/020	**Workforce Report** Produce a breakdown of NHSI retention collaborative for nursing, including what the tangible outputs are and	03-Jul-19	Leon Hinton Director of HR and OD	Included in the Workforce Report.	Green
02-May-19	TB/2019/021	**Workforce Report** Include in the next workforce report actions to be taken to get to 90% statutory mandatory training compliance.	03-Jul-19	Leon Hinton Director of HR and OD	Included in the Workforce Report.	Green
02-May-19	TB/2019/022	**Workforce Report** Produce an analysis of the reasons for leavers per month to review trends (heat map versus turnover versus staff group, with reason for leaving).	03-Jul-19	Leon Hinton Director of HR and OD	Included in the Workforce Report.	Green
02-May-19	TB/2019/023	**Workforce Report** Produce six monthly review of progress against milestones per programme for the staff survey action plan.	05-Sep-19	Leon Hinton Director of HR and OD	Due in September	
02-May-19	TB/2019/024	**Conflicts of Interest Policy** Conflicts of interest policy - follow up with midwives and Consultants to ensure compliance with the policy.	03-Jul-19	Gurjit Mahil, Chief Operating Officer - Planned Care Dr David Sulch, Medical Director	Update to be provided at the meeting	

Chief Executive's Report – July 2019

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

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

In and around Medway

It has been another busy month across the hospital, and our focus has remained on improving the quality of care we provide, and our responsiveness in relation to the constitutional standards.   We know that we must get this right for our patients, which is why our staff are fully engaged with the Best Flow programme currently taking place. Through this work, we expect to see the improvements that our community deserve.

I am pleased to say that we have seen sustained improvement in relation to the breast cancer two-week wait standard; this was an area in which we had performed poorly in recent months. I would like to thank our cancer services staff for their drive and determination in putting things right for our patients.

Transformation

Work continues at pace to drive sustainable transformation at the Trust – enabling us to meet the future needs of our community.

We have developed a vision for the kind of hospital we need to be in future to best serve the health needs of the people of Medway and Swale. We want our staff – our 'best of people' – to provide the best of care to add life to years, not just years to life.

Our well-established values – Bold, Every Person Counts, Sharing and Open, and Together – underpin all that we do.

Four key documents, our Clinical Strategy, Quality Strategy, People Strategy, and Financial Recovery Plan, set out what we will do over the next three years to ensure we have the right services in the right place for our patients, with the appropriate resources and staff whose first priority is the quality of care they provide.

We have also agreed our six transformation programme priorities; these are flow, service transformation, systems financial recovery, quality improvement, theatres utilisation and support services efficiency.

We have a continuous improvement training programme – yellow belt and white belt – which is increasing the capability of our own staff to lead improvements and this is now seeing results.

Best Place to Work

Work continues to develop a new culture at the Trust, and our You are the Difference sessions are continuing to be held for new starters and existing staff alike. In conjunction with this, we have launched Best Place to Work – an online conversation with staff. This is not a one-off survey but an opportunity to start an ongoing conversation about how we can build on the successes we have achieved together and help make Medway the Best Place to Work.

Same Day Emergency Centre (SDEC)

I am pleased to announce that we have opened the first phase of our Same Day Emergency Centre; this is part of our work to improve patient experience and flow throughout the organisation. These initial changes will result in an improved waiting area for emergency care patients and a better environment for staff. They also form part of the wider plan to create an 'emergency floor' which incorporates the Emergency Department (ED) and the Urgent Treatment Centre (UTC).

Not Just A Number

I'm proud of the care we provide for our patients here at Medway and I know that our staff work hard to deliver safe and compassionate care every day.

A big priority for the Trust is to improve our performance against statutory targets. This isn't just about numbers, it's about getting the fundamental aspects of care right.

I do not want our staff to normalise poor performance, I want us to always remember that a percentage point on a spreadsheet represents a number of patients and their families that are not getting the care they deserve. I don't want that, and I know our staff don't either.

That's why last month we launched an awareness campaign called #NotJustANumber. It's a reminder to all our staff to take a moment and reflect on the person behind the numbers. It's about putting empathy at the heart of our care. It's about making Medway brilliant for our patients.

Rainbow badge scheme

We are proud to be one of the first NHS trusts in the south east to sign up to the Rainbow Badge scheme, with the eye-catching badges showing that we are a non-judgemental and inclusive place for people who identify as LGBT+.

This is a way for staff to show they are aware of issues that lesbian, gay, bisexual and trans (LGBT+) people face when accessing healthcare. The simple aim of the scheme is to make a positive difference by promoting a message of inclusion.

Our Best of People

It was a privilege to attend the Best of People Awards Ceremony last month. There was a buzz in the room as we took the opportunity to celebrate the very best people of Medway, with staff and volunteers receiving well-deserved recognition for their work and commitment. It was also very humbling to honour some of our longest serving staff members.

Volunteers' Week

Last month we celebrated National Volunteers' Week. Volunteers play a role which is vitally important to the NHS and particularly to us here at Medway. We are really fortunate to have hundreds of volunteers who give up their free time to support the delivery of the best care to our patients. They undertake a huge variety of vital roles and make a real difference to our

patients and their families 365 days a year. They really are the very heart of this organisation and I would like to take this opportunity to thank them for everything they do.

Chief Executive's Scholarship for Brilliance

I was delighted recently to launch this year's Chief Executive's Scholarship for Brilliance. This is the second year that we have offered the Scholarship and I am grateful to the Medway Hospital Charity for providing the funding. The purpose of the Scholarship is to celebrate innovation and excellence at Medway

Last year's joint winners, the Prehabilitation team and the Acute Medicine Team, visited centres of excellence in Canada and New Zealand respectively, and brought back a wealth of knowledge and new ideas to improve the care that we provide for our patients.

Making Medway Brilliant Conference

The Trust held a very successful staff conference which provided an opportunity to showcase the very best of this Trust and its staff. I strongly believe that to take a step forward we must reflect on the past, and it was clear from a number of marketplace stalls and presentations that we have achieved a great deal to improve the care for our patients. That's why it was so important to celebrate and reflect together on our achievements. The event also provided us with an opportunity to look to the future and the improvements we need to make in order to deliver consistently brilliant care for our patients.

Car Parking

We have relaunched our Trust's parking permit scheme for staff as we strive to utilise onsite parking much more efficiently, create a fairer and more transparent system, and reduce our reliance on the Dockside car park and shuttle bus service. Staff who do not wish to drive or who do not qualify for on-site parking can take advantage of sustainable travel options, such as cycling to work, season ticket loans for buses and trains, and car sharing.

Recognising our staff

Since my last report to the Board we have had considerable recognition for our staff on the national stage. This has included:

BMJ Awards 2019

Medical Training Initiative (MTI) for Overseas Physicians – **Dr Manisha Shah and Simulation Team** (Highly Commended)

HSJ Value Awards 2019 finalists

- Medical Training Initiative (MTI) for Overseas Physicians – **Dr Manisha Shah and Simulation Team**
- Launch of Prehabilitation Unit – **Dr Tara Rampal**
- Launch of Diabetes Specialist Nurse Professional Forum – **Amanda Epps**

Parliamentary Awards

Our local MP Rehman Chishti has nominated a number of staff for an NHS Parliamentary Award; these awards showcase the very best of the NHS, those who go above and beyond the call of duty to make the NHS a better service.

Our nominated colleagues are:

- Excellence in Healthcare – **Dr Tara Rampal and the Prehabilitation Service**
- Lifetime achievement – **Dr Diana Hamilton-Fairley**

Chief Executive's Report

- The Care and Compassion Award – **The Maternity Team**
- The Future NHS Award - **Amanda Epps**
- Wellbeing at Work Award – **The Simulation Department**

Healthcare People Management Association (HPMA) Excellence Awards 2019

On a personal note, I was very proud to win the award for HR Director of the Year at the HPMA awards. It's a special moment for me personally, but more importantly a real recognition of the fantastic Human Resources and Organisation Development Team who have worked alongside teams in the hospital to improve recruitment, culture, wellbeing and the development of our incredible workforce at Medway.

Further afield

KMPT appoints new chair

Julie Nerney has been appointed as Kent and Medway NHS and Social Care Partnership Trust's new chair. She takes over from Andrew Ling who is stepping down after eight years

Health Secretary orders review of NHS food

Matt Hancock has ordered an NHS food review following the recent listeria outbreak linked to hospital sandwiches and salads. We quickly were able to confirm that we had no contracts in place with the providers in question.

New NHS Chief Operating Officer

Amanda Pritchard, chief executive of Guy's and St Thomas', has been appointed as the NHS' Chief Operating Officer. She will take up the role on a secondment.

The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens and serves as a member of the combined NHS England/NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan.

Record figure for dementia diagnoses

Nearly half a million people aged 65 and over had a diagnosis of dementia last month, the highest monthly number on record, NHS England reports.

New data shows that the number of older people diagnosed by with dementia has increased by seven per cent in the past three years, with a record high 453,881 diagnoses in May this year, an increase of around 30,000 monthly diagnoses since June 2016, when there were 424,390 cases registered.

Interim NHS People Plan

NHS Improvement, NHS England and Health Education England have published an Interim NHS People Plan setting the national strategic framework for the workforce for the next five years. A final report will be published following the 2019 spending review. Our own People Strategy which has just been written makes reference to the national document.

- End

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	System Transformation Partnership update	**Agenda Item**	**4.3(i)**
Lead Director	Diana Hamilton-Fairley, Director of Strategy		
Report Author	Diana Hamilton-Fairley, Director of Strategy		
Executive Summary	The System Transformation Partnership is developing into an Integrated Care System (ICS) which is a complex change programme for all the current NHS structures and organisations. The Board has been asked to approve the Project Initiation Document which is attached to this report. A verbal update will be given from the proceeds of the System Transformation Partnership Programme Board: ▪ Estates strategy ▪ Development of Primary Care Networks ▪ Progress on the implementation of the local care model ▪ Financial position at year end 2018-19 and month 1 of 2019-20.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒	
	Finance: We will deliver financial sustainability and create value in all we do	☒	
	People: We will enable our people to give their best and achieve their best	☐	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒	
	High Quality Care: We will consistently provide high quality care	☒	
Committees or Groups at which the paper has been submitted	System Transformation Partnership Programme Board		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	None at present		
Quality Impact Assessment	Not required		
Recommendation/ Actions required	The Board is asked to approve the project initiation document for the development of the ICS and raise any issues they wish fed back to the STP/ICS Board.		

	Approval ☒	Assurance ☐	Discussion ☒	Noting ☐
Appendices	System Transformation Programme Project Initiation Document.			

System Transformation Partnership

Best of care
Best of people

1 Executive Overview

1.1 The System Transformation Programme (STP) Programme Board has agreed that the Kent and Medway system should become an Integrated Care System (ICS).

1.2 There will be three levels of partnerships within the ICS including;

1.2.1 A single strategic Commissioner for the whole of Kent and Medway

1.2.2 Four Integrated Care Partnerships (Medway and Swale, West Kent, North Kent, East Kent)

1.2.3 Primary Care Networks serving populations of 50-100,000 people.

1.3 The STP has written a Project Initiation Document (PID) to guide and implement this major transformation and each organisation and Clinical Commissioning Group (CCG) Governing Body is asked to approve the document.

1.4 It has been discussed and approved by the current governance processes within the STP.

2 Integrated Care System

2.1 The single strategic commissioner will be formed from the merger of the eight CCGs and the specialist commissioning functions of NHS England (South East).

2.2 The future functions and form of the ICS will be developed as part of this transformation project as described in the PID.

2.3 A new governance structure is proposed for the STP/ICS as the transformation occurs and will be in place from September 2019 to March 2020 when the ICS will be established.

3 Integrated Care Partnerships

3.1 The four Integrated Care Partnerships (ICPs) will be the providers of care across the geographies including the Acute, Community, Mental Health, Social Care and Primary Care networks.

3.2 The future functions and form of the ICPs will be developed as part of this transformation project as described in the PID.

4 Primary Care Networks

4.1 The proposal is that groups of Primary Care organisations – mostly GP practices – form into networks serving between 50 and 100,000 people in order to provide extended services to a local population to become Primary Care Networks (PCNs).

4.2 The future functions and form of the PCNs will be developed as part of this transformation project as described in the PID.

5 The Project Initiation Document

5.1 The PID outlines the changes to governance structures to verse the transformation, the pieces of work that need to be undertaken to create the new structures identifying the roles and responsibilities within the system. This will include the commissioning, providing and regulating roles and responsibilities to achieve the overarching aim of improving the health and wellbeing of the people of Kent and Medway.

5.2 The aim of the transformation outlined in the PID is as set out in Kent and Medway's clinical vision and strategy, '*Quality of life, quality of care'*, we want the population of Kent and Medway to be as healthy, fit (physically and mentally) and independent as possible; participating in their local economies and communities and able to access the right help and support when they need it.

6 Conclusion and Next Steps

6.1 The board is asked to sign the PID, noting it effectively forms a memorandum of understanding representing a commitment to work on this programme.

6.2 This request is recognised as materially different to a formal sign-off of the outputs of this programme of work and by signing this PID, organisations are only committing to proceed with the work outlined in this document and not to the service model or changes that may be proposed as a result of this work.

System transformation – cover paper/front-sheet content for the publication of the Programme Initiation Document (PID)

This content is for use within individual organisation meeting paper templates

As set out in Kent and Medway's clinical vision and strategy, 'Quality of life, quality of care', we want the population of Kent and Medway to be as healthy, fit and independent as possible; able to live their best life independently for as long as possible and to access the right treatment, care and support when they need it. However, the commissioning and provision of health and care across Kent and Medway continues to face significant challenges, such as scarcity of specialist workforce, rising quality standards, and the need to live within our allocated funding in a sustainable way. In addition, in too many areas commissioning and provision of care is fragmented and greater integration could bring about significant benefits to staff and patients alike. This coupled with changing population need, increased demand and rising expectation of health and care services means that responding to these challenges requires whole system transformation both in terms of the types of services provided to local people and how these services can be most effectively and efficiently organised.

The attached programme initiation document (PID) explains the direction and scope of the Kent and Medway system transformation programme, which focuses on the development of a county-wide integrated care system (ICS) over the next 21 months. The move towards creating an integrated care system across Kent and Medway is in line with the national ambitions set out recently in the NHS Long Term Plan. It builds on the achievements and working relationships developed through the county's Sustainability and Transformation Partnership (STP) – a collaborative of all the NHS and upper tier local authority organisations in Kent and Medway, working together to improve health and care across the county. The document is the reference document for the management and the assessment of the Programme. It outlines the objectives, benefits, scope, delivery method, structure and governance to deliver the proposed changes.

The PID has been developed over a number of months by various stakeholders from across the county, including GPs and members of our Patient and Public Advisory Group (PPAG), and focuses on making changes to enable improved health outcomes and improved

experience of health and care services for local people at its core. We are grateful for their input and look forward to continuing to work with them on this over the coming weeks and months.

The PID has been endorsed by the Kent and Medway Sustainability and Transformation Partnership (STP) Programme Board and is now being presented to all of the constituent organisations for discussion and formal sign-off. In considering the document, it should be noted that this is a major programme of work, which will continue to evolve. As such the PID and associated programme/project plans will be subject to regular review and updating throughout the programme.

To ensure local people, including our staff, are informed about the proposals, and able to comment on them, a summary document and set of frequently asked questions are being published. These set out why change is needed and the expected outcomes and benefits that local people, patients and health and care workers across Kent and Medway will experience as part of the system transformation programme and delivery of the NHS Long Term Plan.

ACTION: Following the STP Programme Board's endorsement of the PID at its June meeting, individual organisations are being asked to discuss this at their board meetings and sign-off the work programme, giving formal agreement to supporting this important area of work.

ENDS

Kent and Medway
System Transformation Programme

Programme Initiation Document (PID)
24/06/19

Document Control

a. Document Identification

Programme	System Transformation Programme
Author(s)	M. Ridgwell and I. Chana
Version	0.9
Status	Draft for discussion
Last updated	24/06/19
Approved by	STP Programme Board

b. Document History

Version	Date	Status	Author	Comment / Changes from Prior Version
0.0	13/03/19	Draft	M. Ridgwell	PID Framework
0.1	21/03/19	Draft	M. Ridgwell	PID Framework and system commissioner content
0.2	26/03/19	Draft	M. Ridgwell	PID overarching programme and system commissioner content
0.3	29/03/19	Draft	M. Ridgwell	PID overarching programme, system commissioner content and outline programme content
0.4	08/04/19	Draft	M. Ridgwell	Incorporates comments from SP and MG
0.5	14/04/19	Draft	M. Ridgwell	Incorporates comments from meeting with BB, RB, SP and MG
0.6	26/04/19	Draft	M. Ridgwell / I. Chana	Review of MG, RB and MR amends
0.7	01/05/19	Draft	M. Ridgwell / I. Chana	Review following meeting with ICP leads
0.8	24/05/19	Draft	M. Ridgwell / I. Chana	Following feedback from STP PB members and input from ICP Leads
0.9	24/06/19	Draft	M. Ridgwell / I. Chana	Final review following STP Programme Board

c. Document Purpose and Scope

The purpose of this document is to define the direction and scope of the Kent and Medway system transformation programme, which focuses on the development of a Kent and Medway Integrated Care System. This document is the reference document for the management and the assessment of this programme. It outlines the objectives, benefits, scope, delivery method, structure and governance in order to deliver the required changes.

Contents

1   EXECUTIVE SUMMARY

1.1   Vision

As set out in Kent and Medway's clinical vision and strategy, '*Quality of life, quality of care'*, we want the population of Kent and Medway to be as healthy, fit (physically and mentally) and independent as possible; participating in their local economies and communities and able to access the right help and support when they need it. We also know that a strong physical and mental health and social care system is pivotal to achieving our vision and that developing our workforce is critical. To help us do this, we want to promote Kent and Medway as a great place to live, work and learn, showcasing the benefits of joining our ambitious and forward-looking health and care system.

We want to develop and foster a vibrant voluntary sector and a strong sense of community in our towns and villages, where people feel connected and we support one another across the generations; and where we are in control of our health and happiness, feeling good and functioning well.

To achieve this vision and clinical strategy, we know that we will need to organise our system differently, seizing on opportunities to drive quality and reduce variation in outcomes, whilst ensuring a focus on 'place' and supporting a flexible approach to delivery. Our working proposal is to create a Kent and Medway integrated care system, which will include a system commissioner, four place-based integrated care partnerships and primary care networks to deliver improved quality and provision of care and patient outcomes for our population. The totality of this work is the Kent and Medway System Transformation Programme.

1.2   Case for change

The commissioning and provision of health and social care across Kent and Medway continues to face a number of strategic and operational challenges. In order to continue delivering services and for these services to be sustainable and responsive to the needs of the population, we need to change the way we do things. Responding to these challenges requires a whole system transformation of how we commission and deliver services. Future models need to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver safe and high quality care and, importantly, be responsive to the health and care needs of the population of Kent & Medway.

1.3   Overarching model

Becoming an integrated care system (ICS) will support the delivery of joined up personalised care and improve the quality of physical and mental health and care services across Kent & Medway; and we have already made significant progress in this regard. The ICS has the following key components:

- **Primary care networks (PCNs)**, as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support the delivery of primary care at scale, with expanded teams involving primary and community care, social care and voluntary sector partners. This will enable PCNs to be 'fit for the future' to discharge their new obligations.

- Four place-based **integrated care partnerships (ICPs)**, that are alliances of NHS providers working together to deliver care by collaborating within their local geography. They will determine and secure

the delivery of care through integrated working, operating across populations of around 250,000 to 700,000. The intention is to establish the following place-based ICPs will be established:

- East Kent Integrated Care Partnership

- Dartford, Gravesham and Swanley Integrated Care Partnership

- Medway and Swale Integrated Care Partnership

- West Kent Integrated Care Partnership

The system requirement for any at scale ICP will also be examined (e.g. to support more specialist mental health services).

- A single **system commissioner (SC)**, delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million. The new single CCG would not simply be a coming together of the current CCGs with the same responsibilities but would set strategic direction, establish the financial framework for the system and have an assurance function. Its focus would be on a much wider population needs basis as outlined in the table below and will contribute to and facilitate improvements in outcomes and patient experience.

This signals a significant transformation of health and social care commissioning and provision to support quality improvement, personalised care, and reduced variation. The development of strong relationships and partnerships across providers in different settings and sectors form a critical part of the success of delivering this change.

The ability to work as a whole system, both commissioning (including joint commissioning with our two local authority partners) and provision, will strategically strengthen the planning of services in response to population needs and expected outcomes, as well as the management of resources and their deployment. It is anticipated that the ability to work as a system will also offer opportunities to preside over key activities such as financial arrangements and incentives, in line with single system control totals.

1.4 High level programme plan

For the System Commissioner and Primary Care Network projects, the following high-level milestones will be kept under review (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document):

Milestone or Phase	Date
All PCNs submit registration information to CCGs	May 2019
Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner	May 2019
Establish leadership arrangements in transition for the four integrated care partnerships	May 2019
Integrated care partnerships outline development plans in place	May 2019
CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations	May 2019
Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review	July 2019

Primary care access extended contract DES live for 100% of country	July 2019
Development and sign off of a single primary care strategy with implementation plan, aligning with the response to the Long Term Plan	August 2019
Development and sign-off of any option for an at-scale integrated care partnership, to deliver Long Term Plan requirements for Mental Health Provider Collaboratives	August 2019
Submission of Kent and Medway response to the NHS Long Term Plan (anticipated date subject to guidance from NHS E)	August 2019
Agreement of Kent and Medway human resources, assurance and financial frameworks (to support development of system commissioner and integrated care partnerships)	September 2019
Governing bodies and GP Membership approve formal application for CCG merger – application to be submitted by no later than 30 September	September 2019
Appointment of CCG(s) permanent Accountable Officer	September / October 2019
Application to be considered by NHSE and formal notification of authorisation (with conditions)	October / November 2019
Assuming the Committee gives approval, the final detailed proposal on the proposed change submitted	January 2020
New system commissioner arrangements come into force	April 2020
National primary care network services start	April 2020

A range of early priorities (deliverables) have been identified which include:

   i.   Development of ICP project plans

   ii. Development of principles and the framework, including the assurance framework, that will cover the development of ICPs

   iii. Development of the outline ICP contract framework (recognising that initially the relationship between partners in the ICPs is likely to be based on a range of contractual agreements)

   iv. Launch of an analytics strategy, which includes details of population health management and segmentation that will be delivered at all levels of the ICS

   v.   The development of a range of expected outcomes for health and social care in order to move away from activity based accounting

   vi. Identification of current commissioning functions and an outline assessment of where these will be delivered within the future system architecture

   vii. A robust communications and engagement plan (covering all key stakeholders but particularly NHS boards, CCG governing bodies, GP member practices and local authorities)

   viii. Development of the draft constitution

   ix. A review of resource allocation to address inequalities and the wider determinants of health

1.5 Resourcing / costs

The following outlines the key resourcing requirements and at this point has a greater focus on the system commissioner project. It is recognised that there will be individual requirements for the four place-based ICPs dependent on the pace and rate of maturity. Identifying these requirements is work in progress and some initial thinking has been captured in the early draft ICP plans, although Section 3 of this document provides details of key senior roles aligned to the development of ICPs. Similarly, the Primary Care Board has been working on a single primary care strategy and PCN development and, as part of this, will make a case for any additional resource required. This work is currently resourced from within the existing STP team.

Role	Description	Resource
Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG)	Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group).	Existing CCG 0.4 WTE
Project Lead Director (Simon Perks, System Commissioner)	Chairs System Commissioner Working Group. Member of System Commissioning Executive Board. Provides executive leadership and oversight of the system commissioner programme through transition and up to planned 'go live' in April 2020. Responsible to AO and CCG Chairs for programme delivery.	Existing CCG 1 WTE
Director of Corporate Services, Mike Gilbert,	Provides day to day programme management and direction of system commissioner work programme. Responsible to Senior Sponsor and Clinical Chair for ensuring the programme successfully delivers agreed milestones. Professional responsibility for all aspects of governance surrounding the work programme and establishment of a single CCG	Existing CCG 0.7 WTE
System commissioner (including potential merger of the CCGs)	In recognition of the complexity and scale of the programme, additional programme management resources will also be required from CCGs: • 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, over-sight of programme risk management and co-ordination of core programme resourcing. • Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme's rigour, through monitoring and reporting of progress and overseeing all aspects of business support. • Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee	2 x AfC 8a 1 x AfC 7 1 x AfC 4
Overarching system transformation programme, and interim ICS operating model	Where appropriate existing programme management resources will be aligned from the STP to support the system transformation programme across the different core projects, including - Finance - Digital	From STP

	- Workforce / human resources	
	- Communications and engagement	
	- Business management support	
	Existing resource will be used more flexibly and rather than initiating new parallel workstreams the intent is to build upon and, where necessary, redirect existing STP workstreams.	

1.6 Initial assessment of risks

The following table provides an initial view on the key risks and issues associated with the System Transformation Programme:

Risk	Mitigation
Lack of a coherent and shared strategic vision across Kent and Medway	Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population health and wellbeing improvement. JSNA to inform resource prioritisation and integration of physical and mental health, primary and secondary and health and social care.
	Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits
	Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups
A lack of consistency across place-based ICPs that jeopardises the delivery of objectives or sees development adversely affected in one area compared to others	System Transformation Executive Board to manage interdependencies and individual developments of ICPs ensuring alignment to the entirety of the System Transformation programme and a clear governance framework within the STP/ICS
Lack of support for model from NHS England and Improvement	Early engagement on model with NHSE/I to ensure oversight of proposed plans
Lack of support for model from CCGs	Clinical leadership at the heart of the engagement approach with demonstrable and targeted programme of clinical engagement supported by the delivery of effective communications and engagement activities identified in the communications plan. Ensure two-way communication channels are in place for member practices and regular updates on progress to governing bodies through formal meeting papers and ad hoc briefings as required.
Lack of support of model from CCG member practices	As above
Lack of funding and resources for local authorities' impact on ability to support the emerging ICS	Early engagement with local authorities to help shape the direction of travel for the Kent and Medway Integrated Care System

Lack of support from provider organisations	Demonstrable and targeted programme of clinical and leadership engagement supported by the delivery of effective communications and engagement activities identified in the communications plan.
Limited resources to take forward programme including financial and workforce	Progress and risks to delivery to be managed by programme governance and into the STP programme board
Maintaining and improving quality and performance of services during a period of uncertainty and change	To be managed locally via statutory bodies
Maintaining and improving financial performance during a period of uncertainty and change	To be managed locally and via the STP Finance Group as per existing governance arrangements
Overall affordability given the challenged financial positions / the programme of work does not address the financial challenge faced by commissioners and providers	To be managed locally and via the STP Finance Group as per existing governance arrangements
Fragility of primary care impacts on delivery of the local care model, primary care networks and thus the viability of the ICPs	Interdependency to be managed via existing governance arrangements as well as System Transformation Executive Board
Timescales for PCN establishment lead to lack of effective representation of primary care within ICPs in the design phase	To be managed through both the Primary Care Board and the System Transformation Executive
Adherence to current rules on competition and regulation challenge the implementation of the ICP model (competition, choice and regulatory approval of options may delay or possibly prevent the implementation of the preferred options)	To be managed and worked on through early engagement with regulators and System Transformation Executive Board
Significant changes to working assumptions has potential to derail programme delivery in terms of progress against plan, finance and reputation	To be managed and worked on through early engagement with regulators and System Transformation Executive Board

2   PROGRAMME DEFINITION

2.1 System Vision

We want the population of Kent and Medway to be as healthy, fit (physically and mentally) and independent as possible, participating in their local economies and communities, and being able to access the right help and support. We also know that a strong physical and mental health and social care system is pivotal to achieving our vision and that developing our workforce is critical. We want Kent and Medway to be a great place to live, work and learn.

We want to create a vibrant voluntary sector and a strong sense of community in our towns and villages, where people feel connected and we support one another across the generations; and where we are in control of our health and happiness, feeling good and functioning well.

To achieve this, we have developed a clinical vision for Kent and Medway – *Quality of Life, Quality of Care* – comprising the following principles:

Quality of Life:

- Focusing on the whole person and what matters most to them
- Prevention as the starting point, for all people and pathways, recognising the greater scale of impact that we can have by avoiding ill health in the first place as well as preventing the development of secondary conditions
- Aspiring to protect the vulnerable and how best to access more geographically or culturally remote groups
- Caring for the person, not just the condition – applying interventions that address the interactions between mental and physical health, social and general wellbeing, and wider determinants of health (e.g., housing)
- Supporting people to maintain their physical and mental health, including promoting a healthy living environment and targeted support for people with complex or long-term conditions

Quality of Care

- Aspiring to ensure people can access care and support in the right place at the right time
- Striving to achieve the best outcomes and highest standards of care by adopting evidenced based practice, applying best practice guidelines and embracing research and development
- Continually assessing our performance, always learning (including from mistakes) and making changes to improve
- Embracing the use of technology and sharing information
- Equipping our workforce to provide the best quality of care, both in terms of numbers, training and support.

To achieve our vision and clinical strategy, we know that we will need to organise our system differently, seizing on opportunities to drive quality of care and reduce variation. Our working proposal is to create a Kent and Medway integrated care system, which will include a system commissioner, four place-based integrated care partnerships and developing our primary care networks (serving populations of 30,000 to 50,000). The totality of this work is the Kent and Medway System Transformation Programme.

2.2 Case for Change

The commissioning and provision of health and social care across Kent and Medway continues to face a number of strategic and operational challenges. In order to continue delivering services and for these services to be sustainable and responsive to the needs of the population, we need to change. Responding to these challenges requires a whole system transformation of how we commission and deliver services. Future models need to be financially sustainable, demonstrate operational effectiveness through improved outcomes, deliver safe and quality care and importantly, be responsive to the physical and mental health and care needs of the population of Kent & Medway.

Over the last four years, efforts to address the challenges outlined in the case for change have been focussed on promoting integration through new care and service models. More recently across Kent & Medway we have seen the benefits that integrated working brings to the care for the local population through outcomes, quality standards and operational efficiencies. At this stage of the transformation, it is

widely recognised that changes to how the system is structured, the redistribution of functions both locally and at a Kent & Medway level, through to more comprehensive integrated working will deliver benefits and improvements.

The publication of the national NHS Long Term Plan in January 2019 has further strengthened the need for integration and integrated care models with the expectation that current STP areas transition to Integrated Care Systems by April 2021. The development work to date across Kent and Medway meets this objective, putting us firmly on the path to establishing the system commissioning function. It also helps with the development of place-based Integrated Care Partnerships (ICPs), further aligning the local commissioning and provision of physical and mental health and social care based on local needs and in a way that is accessible and responsive. In addition to the ICPs, there will be other developments to support a more focused response to individuals needs such as the development of Primary Care Networks in increasingly aligning local health, social, community and primary care.

Our published case for change also shows that:

- **Every day 1,000 people (about 1 in 3 people in hospital at any one time) in Kent and Medway are stuck in hospital beds** when they could get the health and social care support they need out of hospital if the right services were available.

- **We need to focus more on supporting people so they don't get ill in the first place**: Around 1,600 early deaths each year could have been avoided with the right early help and support for example to help people maintain a healthy weight, stop smoking and drink responsibly.

- **GPs and their teams are understaffed, with vacancies and difficulties recruiting:** If staffing in Kent and Medway was in line with the national average there would be 245 more GPs and 37 more practice nurses.

- **The Care Sector in Kent and Medway has a recruitment and retention problem** which means that the Local Care intention of supporting people at home might not be possible for everyone.

- **Services and outcomes for people with long-term conditions are poor:** As many as four in 10 emergency hospital admissions could be avoided if the right care was available outside hospital to help people manage conditions they live with every day and to prevent them getting worse.

- **Some services for seriously ill people in Kent and Medway find it hard to run round-the-clock, and to meet expected standards of care:** All stroke patients who are medically suitable should get clot-busting drugs within 60 minutes of arriving at hospital. None of the hospitals in our area currently achieve this for all patients.

- **Planned care – such as going into hospital for a hip operation or having an x-ray – is not as efficient as it could be:** There is variation across Kent and Medway in how often people are referred to specialists and variation in the tests and treatments people get once they have been referred.

- **Cancer care does not always meet national standards**: waiting times for diagnostic tests, to see a specialist and for treatment, are sometimes longer than national standards.

- **People with mental ill health have poor outcomes:** the average life expectancy for people with severe mental illness is 15-20 years less than the average for other adults, due to being less likely to having physical health needs met.

- **We are not able to live within our means:** it is estimated that by the end of this financial year (2018/19) the NHS in Kent and Medway will have overspent its planned budgets by £75m, excluding

the benefit of non-recurrent support from the commissioner support fund and provider support fund, which reduces this overspend to circa £46m.

- **Services could be run more productively:** Around £190m of savings could be made if services were run as efficiently as top performing areas in England.

To address these challenges, we need to fundamentally look at how we commission and deliver care. We have started to do this through several approaches, including the Kent and Medway stroke review and East Kent Transformation Programme. However, we now need to look at some of the core principles that govern how care is delivered and support the integration of service provision to deliver a better patient experience, improved outcomes)and equity of outcomes for different population groups) and make best use of our scarce resources (not just in relation to the funding available to us but also in relation to making the best use of our staff, estates and other key enablers of high quality care).

2.3   Kent and Medway Integrated Care System model

This section details the overall ambition for the Kent and Medway Integrated Care System model that we are working to deliver. It does not cover the interim operating model which is detailed in Section 2.4

This ambition and future model often referred to as an 'end state' has a number of key components:

- **Primary care networks**, serving populations of 30,000 to 50,000, as outlined in the NHS Long Term Plan and enabled through the new GP contract, which support delivery of primary care at scale

- **Four place-based integrated care partnerships**, that determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000 (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document):

    - East Kent Integrated Care Partnership

    - Dartford, Gravesham and Swanley Integrated Care Partnership

    - Medway and Swale Integrated Care Partnership

    - West Kent Integrated Care Partnership

- **A single system commissioner**, delivered through the establishment of a single Kent and Medway CCG covering our population of circa 1.8 million (i.e. the number of people registered with our GP practices). The new single CCG would not simply be a coming together of the current CCGs with the same responsibilities. Its focus would be on a much wider population needs basis as outlined in the table below.

Programme Initiation Document (PID)

The following diagram outlines the future Kent & Medway Integrated Care System architecture:
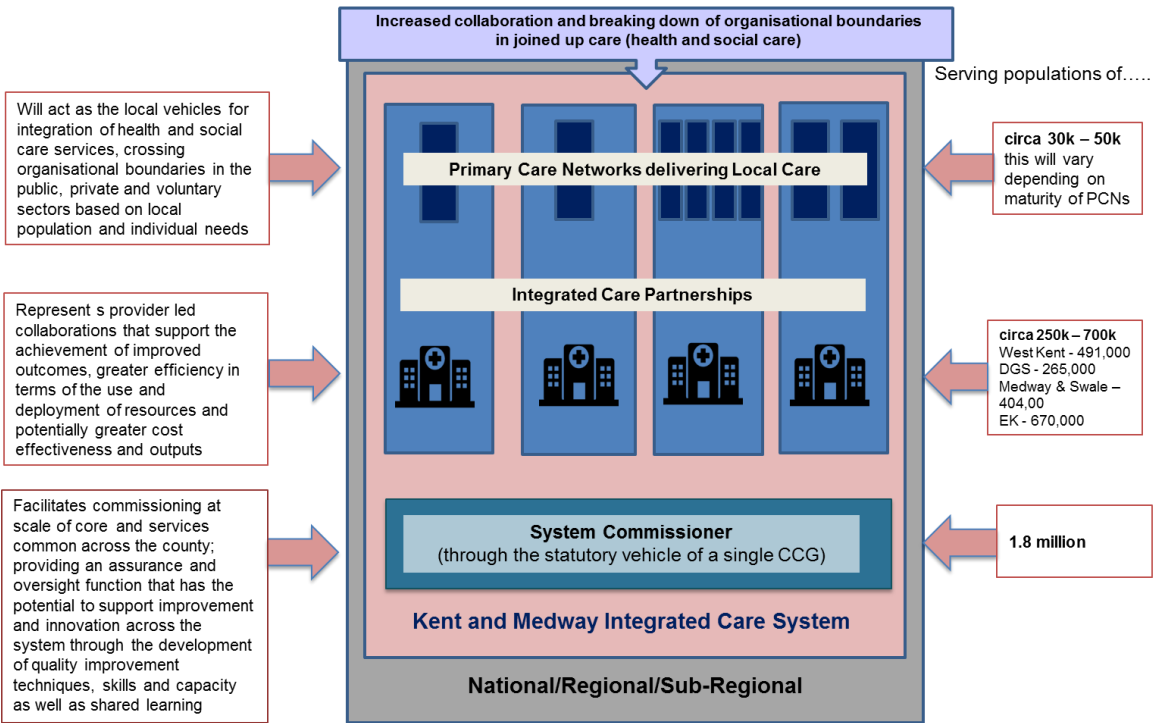
More information on these key building blocks is detailed below:

Primary Care Networks	Primary Care Networks have been an emerging concept over the last few years as part of the development of primary care, and more broadly local care provision at scale. PCNs are a group of practices working together locally in partnership with community services, social care, and other providers of health and care services which provides services that meets the needs of a neighbourhood with a population of 30k – 50k.
	The Long Term plan formalised the development of Primary Care Networks as a key function and way of further enhancing the integration of primary and community care, which we describe as local care. Primary Care Networks across Kent & Medway will act as the local vehicles for integration of health and social care services, crossing organisational boundaries in the public, private and voluntary sectors based on local population and individual needs. They will support the delivery of multidisciplinary services to meet the needs of the population as defined across the whole of Kent and Medway.
	The outline above, pending further development, discussion and agreement, signals a change to the way in which health and potentially social care services have been commissioned to date. Future commissioning and delivery will take advantage of models that:
	• Focus on and are responsive to the needs of the population of Kent & Medway
	• Seek to be sustainable in their delivery considering key factors such as workforce, standards of care, co-ordination of health and social care needs and financial affordability
	• Are forward looking and innovative and make improvement to the operational challenges facing current provision
	• Champion integration and focus on the patient experience and improved outcomes across health, social care and general wellbeing.

| Integrated Care Partnerships (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document) | Integrated Care Partnerships represent a provider led collaborative, operating most effectively across a population of 250,000 to 700,000. The logic behind this is the achievement of sufficient scale to collectively look at how services are provided and the benefits, in particular around collective working to offer existing and new models of care that are more effective in responding to people's needs. This use of new and alternative models including ways of working can also support the achievement of improved outcomes, greater efficiency in terms of the use and deployment of resources (e.g. workforce, estate, adoption of new technology) and potentially greater cost effectiveness and output that aligns to a single system control total. The working proposal for Kent & Medway based on population size, is for four place-based ICPs. These will be in East Kent, Dartford Gravesham and Swanley, Medway & Swale and West Kent.

Key functions of the place-based Integrated Care Partnerships include:

- Accountability for the physical and mental health of their whole population including development and delivery of care and well-being solutions to ensure this
- Focus on responding to population health needs and the provision of programmes that promote prevention and address health inequalities and inequality in health outcomes
- Ensure a focus on population health; more than the sum of individual care pathways
- Assure and oversee the quality of services and care provided. This assurance role will need further scoping in line with changes in NHS England and Improvement
- Support organisational development to enable cultural change and thus deliver integrated working at executive, managerial and practitioner level
- Local route for escalation and risk management within the system
- Local contract management and the increased use of alternative contract forms to support integrated delivery
- Taking account of and addressing the needs of their population, particularly in order to address the wider determinants of health, improve prevention and reduce health inequalities
- Designing pathways that both deliver the required outcomes and can be delivered within the particular ICP's circumstances. This design will be clinically and professionally led within the ICP and be able to demonstrate compliance with best practice and wide clinical, public and political engagement.
- Delivering care within the ICP's capitated budget
- Having aligned incentive contracts and sub-contracts which foster collaboration within and outside the ICP.
- Monitoring and achieving quality standards with robust measures to address failings
- Monitoring the care delivered and reporting on performance (including patient experience) compared to design. |
|---|---|
| The Kent and Medway System Commissioner | A single Clinical Commissioning Group (CCG) will be responsible for delivering a number of functions. As a system commissioner, it will be responsible for:

- Defining the needs of the population of Kent and Medway down to a population level of 30-50k
- Setting the outcomes to be delivered in addressing those needs, including emphasising prevention and addressing health inequalities and inequality in health outcomes
- Allocating capitated budgets within new financial frameworks that encourage Integrated Care Partnerships to focus on population health
- Providing oversight and offering strategic solutions to K&M wide functions such as Strategic Estates, Digital, Workforce, and Finance.
- Supporting and delivering the organisational development of providers to become members of |

	Integrated Care Partnerships.
	• Giving license to, and receiving assurance from, ICPs on the delivery of outcomes within budget
	• Acting as the point of escalation of dispute and risk in ICPs
	• Commissioning core services at scale.
	• Holding a single contract for larger (K&M) providers, whilst enabling and maintaining local flexibility
	• Holding contracts for some non-Kent and Medway tertiary and acute providers
	• Direct commissioning of rare and very expensive services
	• Providing high quality cost effective commissioning support and back office functions
	• Developing a Kent & Medway approach to service and quality improvement
	In addition to the commissioning of physical and mental health services, the establishment of a Kent & Medway system commissioner presents an opportunity to explore the potential for closer alignment or integration of health and social care commissioning in the future. Early conversations have been had with the two upper tier local authorities and there is willingness in principle to align first and explore practical ways of integrating health and social care commissioning.

The above components come together, with other elements, to form the Kent and Medway ICS. However, the ICS also operates within a wider context (e.g. the regulatory framework). An early priority will be development of the framework and principles within which the ICS, system commissioner and ICPs will develop. This work will be developed in partnership with stakeholders such as Local Authorities, not only including social care and public health, but also District Councils and voluntary sector to ensure person centred planning that supports the delivery of care and wellbeing solutions.

2.4   Interim Operating Model for 2019/20

As a working assumption during the 2019/20 transition period there will be a clear distinction between the role of the STP / ICS and the CCGs (or the CCG if the merger to create a single organisation is supported). These will be described in an interim operating model.

There are two key components to the interim operating model that will operate during 19/20:

a. A CCG joint committee to which CCGs, if supported by their governing bodies, can delegate a range commissioning functions and responsibilities

b. An interim STP / ICS operating model based on a range of delegated functions (this will see the STP / ICS focus on developing the system functions that will be required for an Integrated Care System, including those areas that have been directed for development by NHS England and Improvement).

A Kent and Medway Joint Committee has been established that will provide a vehicle during transition for the commissioning of a range of key services. This has been established by the CCGs with the intent of commissioning responsibilities being delegated to this in order to:

- Ensure consistency of approach across Kent and Medway

- Address a range of performance and quality challenges (recognising that some services are more optimally commissioned at a Kent and Medway level)

Programme Initiation Document (PID)

- To model Kent and Medway level working as a precursor to the formal establishment of the Kent and Medway System Commissioner

An interim STP / ICS operating model that will utilise the current programme governance structure to develop system functions. The scope of this programme will be driven by those areas identified by NHS England and Improvement for requiring a system approach. It is important to note that the interim operating arrangement does not supersede or undermine the role and accountability of individual organisations. Rather it reflects the need to collectively:

- Identify system priorities, including to:
    - provide a forum for partners to identify and address the critical strategic issues that will shape the planning and delivery of better health and care in the region
    - provide collective leadership and strategic oversight of areas of work that require a system approach
- Delivery of system priorities, including to:
    - target management, including clinical management, resources on the high priority (high risk) areas within the system.
    - oversee the implementation of the annual operating plans and mandated policy, interpreting the requirements to fit with the local challenges and circumstances of the system, ensuring that strategies, plans and work programmes are aligned to its delivery
    - ensure that the system makes best use of all appropriate tactics and levers available to support the delivery of national and local priorities for better health and health care. Best use of resources also?
    - Ensuring consistent and clear messaging with our internal and external stakeholders, including ensuring collective management and protection of our reputation
- Assurance and performance management, including to:
    - monitor performance and delivery
    - hold each other to account for delivery of strategies, policies and agreed targets
- Support service improvement, including capturing and disseminating best practice from within the system, nationally and internationally, challenging the whole system to improve aspirations, performance, capability and delivery

The interim operating model will need to recognise that the Integrated Care System will hold a number of assurance and oversight functions, alongside strategic planning functions, and these will be developed further as part of the programme of work outlined in this document, in a framework that covers:

- Annual planning
- Assurance and delivery
- Resilience (following the establishing of a system "winter function" in 18/19)
- Quality
- Strategic planning and programme delivery

Transitional arrangements will be kept under ongoing review and will be dynamic. This will include working with NHS England and Improvement to plan the delegation of a range of functions to the ICS.

2.5   Programme objectives

The System Transformation Programme aims to:
   a.   deliver improved quality and provision of care and patient outcomes for our population

   b.   improve the use of available resources (both financial and staffing)

In order to realise the above aims, the primary objective of the programme is to establish a Kent and Medway Integrated Care System, which will be achieved through the successful delivery of a number of core projects (the secondary objectives), namely:

   1.   Establishment of local primary care networks covering a registered patient population of 30,000 to 50,000.

   2.   Establishment of four place based Integrated Care Partnerships, similarly responsible for developing and implementing formal partnership arrangements that enable each to hold an appropriate contract and deliver integrated care services for their local population. The four ICPs will mature at different rates and as a result they will exercise different functions based on their levels of maturity.

   3.   Establishment of an interim operating model (transitional arrangements during 19/20) including:

      a.   CCG joint committee to which CCGs, if supported by their governing bodies, can delegate a range commissioning functions and responsibilities

      b.   An interim range of delegated functions to the Kent and Medway STP / ICS

   4.   Establishment of the Kent and Medway system commissioner (through the statutory vehicle of a single CCG achieved through the merger of eight CCGs to a single CCG, ideally by April 2020.

The constituent project groups and workstreams will develop or have assigned specific objectives (the deliverable for workstreams are outlined in this document at Section 3.3). A number of additional key enabling objectives for the programme, which support the overarching aims, have been identified:

   5.   Organisation (system) development plan to support the development of system leadership within PCNs, ICPs and the system commissioner, which recognises:

   • a move from competition to collaboration

   • the integration of health and social care

   • the integration of physical and mental health

   • the integration of commissioning and provision

   • the cultural changes that are needed to support the above

   • the importance of having the right people in the right roles

   6.   A revised financial framework that outlines how funding will flow through the whole system (supporting a move away from historic contracting arrangements that have been support by Payment by Results)

7. Development of a Kent and Medway approach to population health management

8. Robust communications and engagement plans and activities to support and facilitate understanding amongst key audiences and stakeholders.

It is recognised that these Kent and Medway system-wide objectives will exist alongside local objectives and priorities, which will be further developed by the emerging PCNs and ICPs.

2.6 Assumptions

It will be necessary to identify and adopt a range of assumptions to facilitate this significant programme of work to be taken forward. The range of assumptions that will be adopted will increase and change as the programme of work progresses. It is important that these are accurately recorded and continually tested to ensure they remain valid and are robust (i.e. are valid constructs that enable the programme to continue to be progressed). The following assumptions will also be reported as part of the overall risk management approach to delivery of the entirety of the System Transformation Programme.

The following provide an initial assessment of assumptions:

Assumption	Description
Support from CCGs and membership	Assumes there will be support for the proposed system model as outlined in this document
Support from Provider Organisations	Assumes there will be support for the proposed system model as outlined in this document
Support from NHS E / I	Assumes NHS England will support the development of a single CCG through their mandated process
Implementation timing	Assumes a single CCG will be implemented by April 2020. Assumes ICPs will start to evolve during 2019/20 but will take longer to develop and mature. Assumption is that all ICPs will be fully in place and holding contracts by 2021
Collaborative versus organisational focus	Assuming providers will support development of ICPs and that organisations will support place based working rather than a focus on their individual organisations, sharing clinical and business risk
Supporting from local authorities	Assuming LAs will support, including in relation to a Medway and Swale ICP
Delegation of function from NHS England	Assuming NHS E / I functions around local assurance and EPRR will be delegated to ICSs
The STP / ICS working alongside the CCC(s) during transition but acknowledge these functions are likely to come together as the ICS arrangements mature	As a working assumption during transition there will be a clear distinction between the role of the STP / ICS and the CCGs (or the CCG if the merger to create a single organisation is supported), which ascribes functions as follows: • CCCs (potentially in due course) - CCG functions other than those listed below • STP / ICS - Functions delegated or directed by NHS England (e.g. assurance, resilience planning) • STP / ICS - Over-arching strategic and programme planning

3 PROGRAMME GOVERNANCE

3.1 High-level Programme Structure

This programme consists of a number of core constituent projects, aligned to our system integration model and supported by a range of cross cutting work streams. This programme initiation document outlines these and their key deliverables and milestones. Within this programme we are utilising the following definitions:

Term	Definition
Programme	A group of related projects and change management activities that together achieve beneficial change for an organisation.
Project	A unique, transient endeavour, undertaken to achieve planned objectives, which could be defined in terms of outputs, outcomes or benefits. A project is usually deemed to be a success if it achieves the objectives according to their acceptance criteria, within an agreed timescale and budget
Workstream	Thematic portfolio of programmes or projects and processes that are strategically selected and managed to advance business goals

The core constituent projects and cross-cutting workstreams, that sit within the programme, are outlined in the diagram below:

| System Commissioner (inc. interim commissioning arrangements_ | WK ICP Steering Group | North Kent ICP Steering Group | Medway and Swale ICP Steering Group | EK ICP Steering Group | Interim system operating model |

HR & OD   Commissioning   Finance   BI / Population health / health needs assessment   Digital

Quality and Safety   Corporate Services   Comms and Engagement   Contracts   System functions

☐ = Constituent Project

▯ = Cross cutting workstream

Programme Initiation Document (PID)

The core constituent projects, as detailed above, will each require their own project plans, which will be developed alongside this document. These will be agreed, managed and coordinated through the programme governance structure detailed later in this document.

3.2   Overarching governance arrangements

The governance framework for the System Transformation Programme is outlined in the diagram below. The governance frameworks for the individual system commissioner and the four Integrated Care Partnership projects will be developed in more detail in their individual project plans but will exist and operate within the governance framework detailed below. The development of PCNs is led by the Primary Care Board and will report into the System Transformation Executive Board with progress against plan.
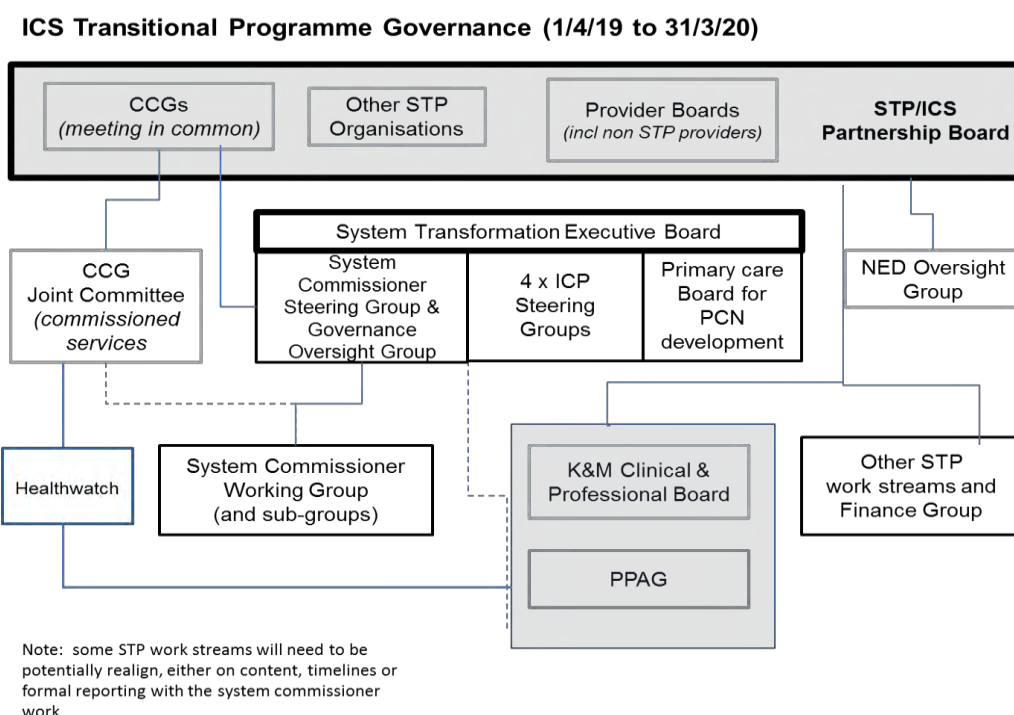
The following table outlines the role of each of the groups in the above diagram:

Group	Role	Frequency	Chair	Membership
STP Programme Board *(The renaming of this group to the ICS Partnership Board will be considered as part of the programme)*	Provides oversight of wider ICS development and the development and implementation of countywide programmes of work to deliver immediate and medium-term priorities. Programmes include productivity, local care, workforce, primary care and digital.	Bi-monthly	STP Chief Executive	Representation from all STP core partner organisations (see Section 12.3 for list)

Non-Executive Director (NED) Oversight Group	Provides independent scrutiny and oversight of the STP Partnership Board and its programmes of work, including development of the Integrated Care System.	Monthly	STP Chair	STP Chair, 2 x Provider NEDs, 2 x CCG independent members, 2 x Upper Tier LA elected Members
CCG Joint Committee(s)	• Delegated Authority from CCG governing bodies for a range of commissioning responsibilities (e.g. Stroke, Cancer and in due course: Children's services, Mental Health etc…) • Responsible for determining joint commissioning agenda and priorities	Monthly	Stroke: Independent Chair K&M Joint Committee - CCG Clinical Chair East Kent: Independent Chair	Representatives from each CCG Governing Body (incl AO, MDs, Clinical Chairs and independent lay members)
System Transformation Executive Board	• Responsible for the monitoring delivery of overall programme objectives • Designs principles and coordinates and supports the ICS development (spanning both the ICP and system commissioner development) • Ensures consistency of approach whilst also supporting local flexibility and autonomy • Provides senior executive leadership • Framework for ICP development • Development of an assurance and regulatory framework	Monthly	STP CEO / AO	STP CEO / CCG single accountable officer – Chair, STP Deputy CEO Senior sponsor, Chair of SCOG, senior sponsors for four ICP Steering Groups, CEO, KMPT Kent County Council lead director Medway County Council lead director Co-chair of Primary Care Board
System Commissioner Steering Group	Responsible for delivery of project objectives that include but not limited to: • Commissioning transformation and development of the System Commissioner • Merger of eight CCGs to form the single, Kent and Medway CCG as the system commissioner • Provides clinical leadership and endorsement of ICS development	Monthly	Bob Bowes, Clinical Chair, WK CCG	K&M Accountable Officer, CCG Clinical Chairs, Managing Director EK & MNWK, STP Deputy Chief Executive, Workstream team, Lay members for EK and MNWK and Lead Directors Kent County Council & Medway Council
System Commissioner Governance	To provide providing scrutiny, advice and guidance to the System Commissioner Steering Group	Monthly	Mike Gilbert, Director of Corporate	CCG Lay member (Governance Leads) and CCG Company

Programme Initiation Document (PID)

Oversight Group				Affairs	Secretary
ICP Steering Groups x 4 (place-based)	• Responsible for delivery of the ICPs and delivery of agreed system and local objectives • PCN development (working with the Primary Care Board) • Identification of priorities • Designing pathways that deliver required outcomes and can be delivered particular ICP circumstances (e.g. constraints on workforce, estates, etc…), clinically led in the ICP and demonstrate compliance with best practice and engagement with, clinicians, the public and politicians	As per local agreement	WK: Mile Scott, CEO MTW EK: Paul Bentley, CEO KCHFT North Kent: Louise Ashley, CEO, DGT Medway and Swale: James Devine, CEO, MFT	To be identified through individual ICP project plans (and recommended to include LMC representation to facilitate representation of general practice)
K&M Clinical and Professional Board	• Advises the STP Programme Board and CCG's Joint Committee on all clinically and professionally related matters • Provides collective clinical and professional leadership to the Kent and Medway system • Leads the development of the clinical and professional content of Kent and Medway level strategies • Oversee the work of the clinical and innovation workstreams	Monthly	CCG Clinical Chair / Provider Medical Director	Representation from all STP core partner organisations (see Section 8)
Primary Care Board (PCN Development)	• Provides strategic leadership to the Primary Care workstream • Ensures that the programme delivers its milestones and outcomes on time and to budget (based on agreed plan TBD) • Ensures that risks to implementation are identified and effectively managed • Ensures that the programme engages effectively with all necessary stakeholder groups in the development of proposals, including championing the programme across Kent and Medway	Monthly	Joint Chairs: one CCG Clinical Chair and one LMC Member	CCG, LMC, GP Federations, PCCCs, mental health, PPAG, NHSE
System Commissioner / Future Functions Working Group	Reports to System Commissioner Steering Group Responsible for developing and overseeing implementation of future	Monthly	System commissioner lead director	CCG Senior Managers and Subject Matter Experts

and work streams	system commissioner functions. 10 x cross cutting work streams: • Commissioning • Primary Care • Comms and Engagement • Contracting, performance management and business intelligence • Corporate Services/Governance • Digital • Finance • HR and Workforce and OD • Quality and Safety, safeguarding and CHC • population health management			SC Programme Director to chair work stream groups as appropriate

3.3 Cross cutting workstreams and deliverables

Based on the constituent projects, objectives and key deliverables outlined within this document, a number of cross-cutting workstreams are proposed. The following table outlines the proposed key workstreams. Membership will be determined by the Senior Sponsor for the constituent project in consultation with the System Commissioner, Executive, ICP Steering Groups and Primary Care Board.

Cross cutting workstream	ICS / SC / ICP / PCN	Lead	Deliverables
Human Resources & OD	ICS / SC / ICP / PCN	Becca Bradd, STP Workforce Programme Director	• Develop an HR Framework for bringing together commissioners and, in due course, any changes to providers around the development of ICPs and will see the transition of workforce from 8 existing CCGs into 4 ICPs and a single K&M CCG • Develop a programme that guides leadership development of ICPs and PCNs with a focus on population health (at all management and clinical levels) • Develop the OD programme for the ICS (all components) that promotes learning organisations / collaborations and recognises the evolutionary nature of system transformation • Design of the human resources function across the system • Design of the workforce planning function across the system
Commissioning	SC	Adam Wickings, Chief Operating Officer, West Kent / Lorraine	• Description of commissioning functions in each part of the new system model* • Identify areas of commissioning that need to be

		Goodsell, Deputy Managing Director, East Kent	undertaken jointly between health and local authorities (public health and social care) • Identify mechanisms for health and social care integrations and resource implications
Finance (via the existing K&M Finance Group)	SC	Reg Middleton, WK Director of Finance	• Description of commissioning functions in each part of the new system model* • Development of capitated (or other) budgetary framework • Framework that incentivises collaboration and is outcome focused with a shift to improving population health outcomes and improving inequalities (including to support benefits realisation)
Business Intelligence / Population segmentation / population health management / Health needs assessment	ICS / SC / ICP / PCN	Ivor Duffy, EK Director of Finance	• Develop needs assessment framework, including identifying wider determinants of health • Launch the analytics strategy and put in place resourcing and governance to ensure delivery • Describe and make available population down to PCN level • Define relationship and put on a more formal basis relationship between SC and HWBBs • Define outcomes based on identified priorities, including emphasising prevention and health inequalities • outcomes framework (including to support benefits realisation)
Digital	ICS / SC / ICP / PCN	Andrew Brownless, Chief Information Officer	• Digital strategy • Network model • Identify core systems / Integration / standardisation of core systems • At individual practitioner level provide tools to risk stratify and cohort patients • Link with Local Authorities digital strategies to create an integrated approach • Digital innovation approach through Innovation Collaborative
Communications and engagement	ICS / SC / ICP / PCN	Julia Rogers, K&M Director of Communications and Engagement	• System Transformation Communications and Engagement Plan including proactive approach to engagement with key audiences and stakeholders • Reactive responses against plan to media enquiries • Staff and stakeholder briefings • Design and implement effective strategic and operational communications and engagement function across the

			system (including co-production) • Working with the existing Patient and Public Advisory Group to co-design the new model of patient engagement across all levels of the future system architecture.
Contracts	ICS / SC / ICP / PCN	TBC	• Development of outcome-based contracts, including performance management and escalation framework • ICP MOU / contractual framework that focuses on wider determinants of health, prevention and outcomes framework, including framework for approval of sub-contacting that foster collaboration within and without of the ICP
Corporate services	ICS / SC / ICP / PCN	Mike Gilbert, STP / DGS CCG, Director of Corporate Services	• Describe corporate risk identification and escalation process • Indemnity framework, recognising the collaborative framework in which ICPs and PCNs will operate
Quality and safety	ICS / SC / ICP / PCN	Paula Wilkins, Director of Nursing, West Kent / Sarah Vaux, Director of Nursing, East Kent	• Best practice framework – process that drives optimum and innovative outcomes • Quality framework, including metrics and governance structure for oversight and route for clinical risk identification and risk escalation
System functions	ICS / SC	Michael Ridgwell, STP Deputy CEO	• Planning (including major service reconfigurations) • Resilience • Performance / assurance (including in relations to effectiveness of outcomes-based commissioning, and oversight of the best value test) • Assurance and license of system commissioner, ICPs and other constituent bodies • Service / System Improvement • Direct commissioned services and identify list of service that should be commissioned at a Kent and Medway level

3.4 Role descriptions

The following table provides a description of key roles within the programme:

Role	Responsibility
Senior sponsor	Executive level lead (normally a chief executive or clinical chair) who acts as the sponsor for a core project (noting the programme also has an overall senior sponsor) The sponsor is accountable for ensuring that the work is governed effectively and delivers the objectives that

	meet identified need. They are also responsible for championing the programme at a senior level to secure commitment and buy-in.
Project Lead Director	Responsible for the day-to-day delivery of their core constituent project or work area they are supporting, including achievement of key deliverables within the specified timeline
ICP GP Lead	A GP practicing in the ICP area who represents GPs and providers within discussions and acts as an interface with the emerging PCNs to ensure the system transformation programme is driven by and reflects general practice, the emerging PCNs and wider clinical considerations.
ICP non-executive lead	A non-executive director from one of the provider organisations that is a partner within the emerging ICP, responsible for representing non-executive board member, including liaising with their peers, and holding the programme to account for delivery of its strategic aims, ensuring value for money and that risks are being appropriately managed.
Workstream Lead	Thematic lead for a portfolio of projects and / or deliverables linked to one or more of the core constituent projects. The workstream lead is responsible for the day-to-day management of their workplan, including the coordination of projects and change management activities. They are responsible for identifying the resource needed to deliver identified benefits.

3.5 Key roles

The following table details the individuals who will be fulfilling the key roles for the constituent core projects:

Role	Lead
Overall senior sponsor for System Transformation Programme	• Glenn Douglas, STP Chief Executive / CCG Accountable Officer
System Commissioner (including interim CCG operating model)	• Senior sponsor: Dr Bob Bowes, Clinical Chair, WK CCG • Project Lead Director: Simon Perks, Director of System Transformation
West Kent ICP	• Senior sponsor: Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust • ICP GP lead: Dr Sanjay Singh • ICP non-executive lead: John Goulston, Chairman, Kent Community Health NHS Foundation Trust • Project lead director: Amanjit Jhund, Director of Strategy, Planning and Partnerships, Maidstone and Tunbridge Wells NHS Trust
East Kent ICP	• Senior sponsor: Paul Bentley, Chief Executive, Kent Community Health NHS Foundation Trust • ICP GP lead: Dr Sadia Rashid • ICP non-executive lead: Stephen Smith, Chairman, East Kent Hospitals University NHS Trust • Project lead director: Tbc
DGS ICP	• Senior sponsor: Louise Ashley, Chief Executive, Dartford, Gravesham and Swanley NHS Foundation Trust • ICP GP lead: Tbc • ICP non-executive lead: Tbc • Project lead director: Sue Braysher, Director of System Transformation, Dartford, Gravesham and Swanley NHS Foundation Trust / Dartford, Gravesham and Swanley CCG

Medway and Swale ICP	• Senior sponsor: James Devine, Chief Executive, Medway Foundation NHS Trust / Martin Riley, Chief Executive, Medway Community Healthcare • ICP GP lead: Tbc • ICP non-executive lead: Tbc • Project lead director: James Lowell, Director of Planning and Partnerships, Medway Foundation NHS Trust
Interim ICS operating model	• Senior sponsor: Michael Ridgwell, Deputy STP Chief Executive • Project lead director: Ravi Baghirathan

4   HIGH LEVEL PROGRAMME PLAN

For the System Commissioner and Primary Care Network projects, the following high-level milestones will be kept under review (individual ICP milestones are under development and will presented in their individual plans, which will supplement this document):

Milestone or Phase	Date
All PCNs submit registration information to CCGs	May 2019
Outline support from CCGs to continue to proceed with the establishment of a single CCG as the vehicle for the system commissioner	May 2019
Establish leadership arrangements in transition for the four integrated care partnerships	May 2019
Integrated care partnerships outline development plans in place	May 2019
CCGs confirm PCN coverage and approve GMS/APMS/PMS contract variations	May 2019
Governing Bodies agree Statement of Intent / outline application for CCG merger - to be submitted to NHSE Region for initial review	July 2019
Primary care access extended contract DES live for 100% of country	July 2019
Development and sign off of a single primary care strategy with implementation plan, aligning with the response to the Long Term Plan	August 2019
Development and sign-off of any option for an at-scale integrated care partnership, to deliver at Long Term Plan requirements for Mental Health Provider Collaboratives	August 2019
Submission of Kent and Medway response to the NHS Long Term Plan (anticipated date subject to guidance from NHS E)	August 2019
Agreement of Kent and Medway human resources, assurance and financial frameworks (to support development of system commissioner and integrated care partnerships)	September 2019
Governing bodies and GP Membership approve formal application for CCG merger – application to be submitted by no later than 30 September	September 2019
Appointment of CCG(s) permanent Accountable Officer	September / October 2019
Application to be considered by NHSE and formal notification of authorisation (with	October / November

conditions)	2019
Assuming the Committee gives approval, the final detailed proposal on the proposed change submitted	January 2020
New system commissioner arrangements come into force	April 2020
National primary care network services start	April 2020

However, a range of early priorities (deliverables) have been identified which include:

    i.   Development of ICP project plans

    ii.   Development of principles and the framework, including the assurance framework, that will cover the development of ICPs

    iii.   Development of the outline ICP contract framework (recognising that initially the relationship between partners in the ICPs is likely to be based on a range of contractual agreements between the ICPs and the system commissioner encompassing the services delivered by each ICP. This contract should include: activity; performance trajectories; quality measures; and financial values)

    iv.   Launch of an analytics strategy, which includes details of population health management and segmentation that will be delivered at all levels of the ICS

    v.   Identification of current commissioning functions and an outline assessment of where these will be delivered within the future system architecture

    vi.   A robust communications and engagement plan (covering all key stakeholders but particularly NHS boards, CCG governing bodies, GP member practices and local authorities)

    vii.   Development of the draft constitution

    viii. Plan for allocating resources based on population needs

    ix.   Continuing involvement with the Patient and Public Advisory Group to ensure patient voice is at heart of plans and embedded within new system

5   OVERALL RESOURCE REQUIREMENTS (RESOURCE PLAN)

The following outlines the key resourcing requirements and at this point has a greater focus on the system commissioner project. It is recognised that there will be individual requirements for the four ICPs dependent on the pace and rate of maturity. Identifying these requirements is work in progress although Section 3 of this document provides details of key senior roles aligned to the development of ICPs.

Role	Description	Resource
Clinical Chair (Bob Bowes, Clinical Chair, West Kent CCG)	Provides clinical leadership, direction and mentorship across the whole programme (including chairing the System Commissioner Steering Group).	Existing CCG 0.4 wte

Programme Initiation Document (PID)

Project Lead Director (Simon Perks, System Commissioner)	Chairs System Commissioner Working Group. Member of System Commissioning Executive Board. Provides executive leadership and oversight of the system commissioner programme through transition and up to planned 'go live' in April 2020. Responsible to AO and CCG Chairs for programme delivery.	Existing CCG 1 wte
Mike Gilbert, Director of Corporate Services	Provides day to day programme management and direction of system commissioner work programme. Responsible to Senior Sponsor and Clinical Chair for ensuring the programme successfully delivers agreed milestones. Professional responsibility for all aspects of governance surrounding the work programme and establishment of a single CCG	Existing CCG 0.7 wte
System commissioner (including potential merger of the CCGs)	In recognition of the complexity and scale of the programme, additional programme management resources will also be required from CCGs: • 2 x Programme Manager (Band 8a). Responsible for day to day co-ordination of the underpinning work streams, programme reporting, over-sight of programme risk management and co-ordination of core programme resourcing. • Business Support Manager – 1 wte (Band 7). Day to day support to System Commissioner Programme. The BSO will provide support to ensuring the programme's rigour, through monitoring and reporting of progress and overseeing all aspects of business support. • Administrative support – 1 wte (band 4). Provides dedicated day to day support of system commissioner programme including formal and informal reporting, diary management and support to the Steering Group and Joint Committee	2 x AfC8a 1 x AfC7 1 x AfC4
Overarching system transformation programme, and interim ICS operating model	Where appropriate existing programme management resources will be aligned from the STP to support the system transformation programme across the different core projects, including - Finance - Digital - Workforce / human resources - Communications and engagement - Business management support Existing resource will be used more flexibly and rather than initiating new parallel workstreams the intent is to build upon and, where necessary, redirect existing STP workstreams.	From STP
Patient involvement volunteers	Input from patient members of the Patient and Public Advisory Group including attendance at system transformation meetings and discussions within the main PPAG meetings	

6 PROGRAMME BENEFITS AND IMPACT

6.1 Benefits realisation

Inherent within the objectives of this programme of work is the intent to deliver a range of benefits, aligned to the two over-arching objectives of the system transformation programme, namely to:

a. Deliver improved quality and provision of care and patient outcomes for our population; and

b. Improve the use of available resources (both financial and staffing).

Before we start each stage of the transition, we aim to identify and quantify the intended benefits to patients, our teams and the system and track these through the programme. Any proposals that are identified will need to specify and quantify the anticipated benefits, how these will be delivered and monitored (e.g. a benefits realisation plan). It will also be necessary to be clear to whom any planned benefit will accrue to. To support these intentions we will deliver a clear outcomes framework for each of the above two over-arching objectives. Below is a high-level outline of our initial thinking on the benefits associated to our objectives, as follows:

Objective	Benefit (note this is not an exhaustive list and will be updated as the programme progresses)	Beneficiary	Measured through
Deliver improved quality and provision of care and patient outcomes for our population	• Improved outcomes against a range of indicators as outlined in the joint strategic needs assessment (JSNA) • Improved performance against NHS Constitution targets • Improved performance against NHS Long Term Plan priorities (recognising these include indicators within the JSNA and NHS Constitution target) • Improved self-management and prevention	Patient and local populations	Outcomes framework to be developed not only as part of the system transformation programme but linked to the long term plan and the JSNA

Deliver Improved use of available resources (both financial and staffing)	• Delivery of nationally mandated 20% reduction in management costs
	
	• Financial performance within the agreed system control total
	
	• Development of new workforce models to:
	  - address workforce shortages
	  - meet increasing demand
	  - support staff
	  - support service innovations
		Organisations
		
		Patients and public
		
		Staff
			Outcomes frameworks to be delivered in relation to:
			
			• Finance (as part of the long term plan)
			
			• Patient experience
			
			• Staff experience (e.g. as measured through staff surveys)

Alongside identifying the benefits of any proposed options, the cost of proposals will need to be quantified as part of a detailed options appraisal. Not only will the return on investment of any proposals need to be quantified but proposals will need to deliver the mandated management savings that CCGs and NHS England need to deliver, in order to increase investment in frontline services.

6.2 Programme Impact Assessment

This programme of work has the potential to have a significant impact on the delivery of local health and social care. As part of the programme any changes to the way care is delivered will be assessed to determine the impact on patients, particularly those with protected characteristics. The impact will be assessed against a range of domains, and the following provides an indicative list of the domains that will be considered:

Domain	Description
Safety	Rating the impact of the proposal on patient safety
Effectiveness	Rating the impact of the proposal on the clinical effectiveness of patient care
Experience	Rating the impact of the proposal on the patient experience of care delivery
Other impacts	Rating the impact of the proposal on other services, patient groups, staff or reputation of the organisations
Equality and diversity	Rating the impact on those in a specific group as outlined in the Equality Act 2010 and also including other hard to reach groups.
Prevention	Rating the impact of the proposal on the ability to deliver the prevention agenda

Any changes proposed around individual services may also require individual integrated impact assessments and if necessary public consultation.

7 RISKS AND ISSUES

7.1 Management of risk

A comprehensive risk register will be produced and the risks will be managed in accordance with recognised NHS risk management processes. A risk register will be developed and kept updated for the project. Risks will be identified and assessed using the following grid:

Risk score = Impact x Likelihood

	Likelihood				
	1	2	3	4	5
Impact	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Any risk red or amber rated risk of 8 or greater will be discussed at the following groups (see governance arrangements – Section 3.2):

    i.   System Transformation Executive Board

    ii.   System Commissioner Steering Group

    iii.   ICP Steering Groups

The above will support the mitigation of risks and escalate to individual organisations and the STP Programme Board as necessary. The register will also track risk in order that the above groups are able to determine the efficacy of the identified mitigations.

7.2   Initial assessment of programme risks

The following table provides an initial view on the key risks and issues associated with the System Transformation Programme.

Risk	Mitigation
Lack of a coherent and shared strategic vision across Kent and Medway	Development of a robust JSNA for Kent and Medway, which identifies the key priorities and actions required to effect population health and wellbeing improvement. JSNA to inform resource prioritisation and integration of physical and mental health, primary and secondary and health and social care.
	Robust communications and engagement with key stakeholders – members, governing bodies, provider boards, primary care etc. Development of narrative with consistent messages and tangible benefits
	Demonstrable programme of clinical and leadership engagement, supported by communications and engagement, with key stakeholders and audience groups
A lack of consistency across place-based ICPs that jeopardises the delivery of objectives or sees development adversely affected in one area compared to others	System Transformation Executive Board to manage interdependencies and individual developments of ICPs ensuring alignment to the entirety of the System Transformation programme and a clear governance framework within the STP/ICS
Lack of support for model from NHS England and Improvement	Early engagement on model with NHSE/I to ensure oversight of proposed plans
Lack of support for model from CCGs	Clinical leadership at the heart of the engagement approach with demonstrable and targeted programme of clinical engagement supported by the delivery of

	effective communications and engagement activities identified in the communications plan. Ensure two-way communication channels are in place for member practices and regular updates on progress to governing bodies through formal meeting papers and ad hoc briefings as required.
Lack of support of model from CCG member practices	As above
Lack of funding and resources for local authorities' impact on ability to support the emerging ICS	Early engagement with local authorities to help shape the direction of travel for the Kent and Medway Integrated Care System
Lack of support from provider organisations	Demonstrable and targeted programme of clinical and leadership engagement supported by the delivery of effective communications and engagement activities identified in the communications plan.
Limited resources to take forward programme including financial and workforce	Progress and risks to delivery to be managed by programme governance and into the STP programme board
Maintaining and improving quality and performance of services during a period of uncertainty and change	To be managed locally via statutory bodies
Maintaining and improving financial performance during a period of uncertainty and change	To be managed locally and via the STP Finance Group as per existing governance arrangements
Overall affordability given the challenged financial positions / the programme of work does not address the financial challenge faced by commissioners and providers	To be managed locally and via the STP Finance Group as per existing governance arrangements
Fragility of primary care impacts on delivery of the local care model, primary care networks and thus the viability of the ICP	Interdependency to be managed via existing governance arrangements as well as System Transformation Executive Board
Timescales for PCN establishment lead to lack of effective representation of primary care within ICPs in the design phase	To be managed through both the Primary Care Board and the System Transformation Executive
Adherence to current rules on competition and regulation challenge the implementation of the ICP model (competition, choice and regulatory approval of options may delay or possibly prevent the implementation of the preferred options)	To be managed and worked on through early engagement with regulators and System Transformation Executive Board
Significant changes to working assumptions has potential to derail programme delivery in terms of progress against plan, finance and reputation	To be managed and worked on through early engagement with regulators and System Transformation Executive Board

The above will be assessed and mitigations further developed as part of the programme risk register.

8 COMMUNICATION AND ENGAGEMENT

8.1 Communication and Engagement principles

In order to undertake large-scale transformation that affects staff, patients and the public alike, we need to ensure that we have developed a robust communications and engagement strategy, which is founded on the following principles:

- **Considered and accurate** – Good communications starts and ends with getting the basics right. We must make sure all communications consider the needs of the intended audience and deliver accurate and consistent messages to all group.

- **Targeted and tailored** – Consistent doesn't need to mean the same. There are a broad range of stakeholders in this project with different areas and levels of interest. We must make sure we target the right messages using the right channels for different audiences.

- **Inclusive and meaningful** – Staff and stakeholders affected by this programme are spread across a large geography, come from multiple organisations and diverse backgrounds. We need to ensure we have effective systems and channels in place to reach everyone. Seeking the views and involvement of staff and other stakeholders must have a purpose and offer a genuine opportunity for the views provided to shape the direction of the programme**.**

- **Timely** - Communications and engagement that is either premature or late loses impact; failing to deliver its objective and wasting resources. All communications and engagement activity must be delivered at a time that's appropriate for the message and the audience. Staff directly affected by the proposals should receive updates directly and ahead of external announcements.

- **Honest** – Linked to meaningful communications and engagement we need to be open and honest about progress of the program and the areas where people can genuinely influence the work. There will be many questions asked before we have definitive answers. We must be honest about what we can confirm or when we are likely to be able to provide clarity.

8.2 Key audiences and stakeholders

The communications and engagement function has undertaken stakeholder and audience mapping and analysis over the past two months and this will be subject to regular review. This work has identified the broad categories of key audiences and stakeholders outlined in the following table:

Key audience/stakeholder group	Rationale for engagement
Patients and the public	Patients and the public are likely to respond with greater interest when specific services or facilities are affected by change, however they are an important audience for this work as they can provide challenge, support and insight for how the new structures will operate most effectively for the populations they serve. We anticipate

	that engagement on the development of the five year plan will see greater levels of patient and public engagement with the aim of eliciting feedback and insight from those groups or individuals most impacted by the plans or who use services highlighted as priority areas e.g. Children's services, mental health, primary care, cancer.
	Our communications and engagement activity on system transformation should ensure that we are transparent, honest and present a 'case for change' that moves on from a description of challenges to a clear 'offer' for patients about how the new arrangements will benefit them.
	We should also be mindful of the fact that local campaigners and activists are showing a keen interest in other STP-related plans and workstreams and we must anticipate high levels of scrutiny from these groups and individuals as work progresses.
Staff across all commissioner and provider organisations including those outside of the traditional health economy in LAs, VCSE and private providers	Gaining buy-in and support for the future structure of health and care services is vital. Staff at all levels and within all organisation types need to feel that they have the opportunity to help shape the 'new world'.
	Within CCGs, CSU and the STP, shifts in organisational structures, specifically the creation of a single CCG, raise questions for staff who will be concerned about their future job role, place of work etc.
	At provider level, the development and implementation of ICPs may require staff to work differently and they will have questions about how change can benefit them and their patients and teams. They may be concerned about the future of their role or where they will work.
	VCSE, LAs and private providers all play an integral role in the delivery of care and with a greater drive towards integration, staff will need to understand and have the opportunity to shape the future structure of health and care services. Again, anxieties about job roles, location and security will need to be anticipated and addressed to ensure that these groups are supportive of future plans.
GP members	Reflecting the importance of primary care within the LTP and the growing role of PCNs in changing and improving the experiences and outcomes of people who are accessing care. We will make a concerted effort to offer opportunities and methods of engagement to ensure that GP members are reassured about the future and have their concerns listened to and understood.
	Gaining buy-in and support for the future structure of health and care services is vital. GP members need to feel that they have the opportunity to help shape the 'new world' and should be engaged in the process of shaping the future landscape.
Decision-makers	Within the scope of the new ICS including CCG governing bodies, provider boards – key groups who will be responsible for steering development of plans – especially those relating to the establishment of an ICS and its component parts – and who will give the go-ahead for changes to organisational structures
Politicians and elected representatives	Including MPs, county and district councillors, Health and Wellbeing Board Members, relevant oversight and scrutiny committees. Many of these groups are already engaged in the STP's work via existing channels and relationships including regular meetings, briefings and formal interactions at scrutiny boards and committees. We have provided new briefings on the system transformation work and will look to step up engagement on ICS, ICP and PCN development. These groups will also be engaged around local five year plan priorities and we will ensure that activity is aligned accordingly.

Professional bodies	LMC, BMA), staff-side representatives and organisation, trades unions – these groups have important insights about issues affecting workforce and are key influencers amongst staff groups and members. Engagement to understand concerns and anxieties about the future – as well as opportunities for meaningful engagement – will be scoped.
Regulators	We will continue to work with colleagues in NHSE/I to develop and refine our plans.
Community and patient voice	Including our local Healthwatch networks who already play an important part in shaping and informing our work and who have links to diverse and often overlooked groups and organisations. We also have ongoing relationships with other community groups, charities, patient voice organisations and social enterprises and will continue to engage with these groups so that our work has the breadth and depth required to ensure that the patient voice is enshrined at the heart of our plan development.

When the above broad categories of stakeholders are considered within the context of the Kent and Medway system this identifies the following list of key stakeholders;

ORGANISATION	ROLES	KEY ROLES FILLED BY
PPAG and local patient groups	STP Programme Board Non-Executive Director (NED) Oversight Group System Commissioner Steering Group Members Joint Committees Clinical and Professional Board East Kent ICP West Kent ICP DGS ICP Medway / Swale ICP	Nominated PPAG representatives
Dartford and Gravesham NHS Trust	STP Partnership Board DGS ICP Clinical and Professional Board	CEO Director of Transformation Trust Medical Director
East Kent Hospitals University NHS Foundation Trust	STP Partnership Board East Kent ICP Clinical and Professional Board	CEO Trust Chair Trust Medical Director
Kent County Council	STP Partnership Board System Commissioner Steering Group	Leader of the Council Cabinet Member for Social Care and Public Health Corporate Director Adult Social Care and Health Director of Public Health Corporate Director Adult Social Care and Health Director Strategic Commissioning

	Clinical and Professional Board	Directors of Partnerships, Adult Social Care and Health Corporate Director Elected Member of the Council
	Non-Executive Director (NED) Oversight Group	Director Public Health and Deputy Director Public Health
	Population Health Outcomes, Case for Change (JSNA) and Prevention workstream	
Kent and Medway CCGs	STP Programme Board	AO, MDs (Members)
	Non-Executive Director (NED) Oversight Group	2 x Independent Members
	System Commissioner Steering Group Members	CCG Chaired, 8 x CCG Clinical Chairs, 3 x Independent Members, AO and MDs CCG Chaired, 8 x CCG Lay Members for Governance
	System Commissioner Governance Oversight Group	CCG Chaired, 8 x CCG Clinical Chairs, AO, MDs and other CCG Governing Body Members
	Joint Committees	CCG Joint Chaired, 8 x CCG Clinical Chairs
	Clinical and Professional Board	CCG Joint Chaired, 8 x CCG Clinical Chairs
	East Kent ICP West Kent ICP DGS ICP Medway / Swale ICP	GP Representative GP Representative GP Representative GP Representative
Kent and Medway Community NHS Foundation Trust	STP Partnership Board	CEO
	East Kent ICP	CEO
	West Kent ICP	Trust Chair
	Clinical and Professional Board	Trust Medical Director
Kent and Medway NHS and Social Care Partnership Trust	STP Partnership Board	CEO
	Clinical and Professional Board	Trust Medical Director
	Non-Executive Director (NED) Oversight Group	Chair – Trust Chair
Kent and Medway Sustainability and Transformation Partnership	STP Partnership Board	Chair - STP CEO
	System Transformation Executive Steering Group	Chair STP CEO/AO

	Non-Executive Director (NED) Oversight Group	STP CEO
	CCGs Joint Committee	STP Deputy CEO
Maidstone and Tunbridge Wells NHS Trust	STP Partnership Board	CEO
	West Kent ICP	CEO
	Clinical and Professional Board	Trust Medical Director
	Non-Executive Director (NED) Oversight Group	Trust Chair
Medway Local Authority	STP Partnership Board	Leader of the Council
	Medway and Swale ICP	Tbc
	Clinical and Professional Board	Tbc
	Non-Executive Director (NED) Oversight Group	Elected Member of the Council
Medway NHS Foundation Trust	STP Partnership Board	CEO
	Medway & Swale ICP	Director of Strategy
	Clinical and Professional Board	Joint Chair - Trust Medical Director
NHS England / Improvement	STP Partnership Board	Dir of Strategy and Partnerships
	CCGs Joint Committee	NHSE Rep and Specialist Commissioning Rep
South East Coast Ambulance NHS Foundation Trust	STP Partnership Board	CEO
	Clinical and Professional Board	Trust Medical Director
Medway Community Healthcare	STP Partnership Board	CEO
	Medway ICP	CEO
	Clinical and Professional Board	MD
Virgin Healthcare	North Kent ICP	Tbc
District and Borough Councils	Through engagement processes, particularly focused around the development of the ICPs	As per local arrangements

8.3 Communication Tools

A range of communication and engagements approaches, and methods, will be used, which will be tailored to meet the specific requirements of the intended audience. The following provides an indication of the approaches that are either in place or under consideration:

Tool	Frequency	Responsible	Audience
Meeting minutes	Every decision making meeting	Meeting Lead	Working group members
Newsletters	Monthly	Communications and engagement	All stakeholders
Meeting Packs	Monthly	Meeting Lead	Steering Committee members
CCG AO report	Monthly	Meeting Lead	CCG Governing Bodies and members
Existing channels/tools/activity			
Web – partner organisations websites and the well-established STP website.	Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.	Communications and engagement	All stakeholders – we aim to publish as much material as possible on out websites in the interest of transparency. This has worked well during the stroke review and our work in east Kent, where we have also used various web presences to inform local audiences and stakeholders about forthcoming events and engagement opportunities and to host surveys and other feedback mechanisms.
Social media – at STP level we already utilise a wide variety of social media channels to engage with our audiences and stakeholders including Twitter, Facebook, YouTube and SoundCloud.	Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.	Communications and engagement	All stakeholders - as these channels appeal to a significant segment of our audiences and our approach is 'digital by default', we will continue to maximise these channels within our communications and engagement activities.
STP stakeholder Bulletin	Monthly	CCGs	Circulated to distribution list of stakeholders who have 'opted in' to receive the bulletin. (We continue to work to drive up recipients following the introduction of GDPR in May 2018.

CCG websites and social media channels	Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.	CCGs	All stakeholders.
Local and trade media	Ongoing – scheduled activity in response to specific announcements, plans and on a reactive basis.	Communications and engagement	All stakeholders. Traditional media including local media outlets (print, online and broadcast) – we have excellent, long-established relationships with local media groups and individuals who report on our work on a regular basis. We will also continue to seek opportunities for proactive work with trade and professional media outlets (HSJ, Municipal Journal, Pulse etc).
Face to face briefings and meetings within individual organisations	Tbc	Programme team and communications and engagement	Staff – we will harness established meetings and briefing sessions to engage with staff about developing plans.
Development and implementation of new visual identity to support ICS	In development	Communications and engagement	All stakeholders – although recommend that implementation is low key
Ensure that key messages are included in communications and engagement work relating to the 19/20 Operational Plan and five year plan engagement	Ongoing	Communications and engagement	All stakeholders as appropriate.
Development of FAQs for different stakeholder audiences	Ongoing	Communications and engagement with input from programme team	All stakeholders as appropriate.
Briefing materials including PowerPoint slides, core content and graphics, targeted updates for different stakeholder groups	Ongoing	Communications and engagement with input from programme team	All stakeholders as appropriate.
Potential new channels/tools/activity			

Programme Initiation Document (PID)

Facilitated workshop with eight CCG clinical chairs	Tbc	Programme team, communications and engagement	Clinical chairs with outputs communicated to GP members, CCG staff etc
Staff and GP member deliberative events and workshops on specific areas of focus	Tbc	Programme team, communications and engagement	Staff, GP members
Case studies developed and tailored for key audiences and stakeholders – for use in web publication, media work, staff engagement, public-facing communications.	Tbc	Programme team, communications and engagement	All stakeholders
Development of a dedicated briefing session for all local MPs in Summer 2019	Tbc	Communications and engagement	MPs and researchers.

9   PROGRAMME ACCEPTANCE SIGN-OFF

It is important that this PID is supported by organisations. It effectively forms a memorandum of understanding representing the stakeholder organisations commitment to work on this programme. This commitment to proceed is recognised as materially different to a formal sign-off of the outputs of this programme of work (e.g. by signing this PID organisations are only committing to proceed with the work outlined in this document and not to the service model or changes that may be proposed as a result of this work).

NAME OF ORGANISATION: Ashford CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Canterbury and d Coastal CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Dartford, Gravesham and Swanley CCG			
Name:		Date:	
Signature:			

Programme Initiation Document (PID)

NAME OF ORGANISATION: Dartford and Gravesham NHS Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: East Kent Hospitals University NHS Foundation Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Kent Community Healthcare Foundation Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Kent County Council			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Kent Community Healthcare Foundation Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Kent and Medway NHS and Social Care Partnership Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Maidstone and Tunbridge Wells NHS Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Community Healthcare			
Name:		Date:	
Signature:			

Programme Initiation Document (PID)

NAME OF ORGANISATION: Medway CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Council			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Medway Foundation NHS Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: South East Coast Ambulance Service NHS Foundation Trust			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: South Kent Coast CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Swale CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: Thanet CCG			
Name:		Date:	
Signature:			

NAME OF ORGANISATION: West Kent CCG			
Name:		Date:	
Signature:			

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Transformation Programme Update	Agenda Item	4.3 ii
Lead Director	James Devine, Chief Executive		
Report Author	Jack Tabner, Associate Director of Transformation		
Executive Summary	The portfolio of transformation programmes continues to gather pace across the Trust.		

Four core Trust strategies are nearing completion and publication, setting out the Trust's vision and priorities over the coming 5 years. These strategies include:

1. **Clinical strategy** – providing the Trust with clear direction in relation to our configuration of services, within the context of the changing Kent and Medway health system
2. **Quality strategy** – outlining the Trust's commitment to delivering high quality care for all as its central objective and planning delivery against the Trust's national and local quality improvement priorities (e.g. CQUIN)
3. **People strategy** – ensuring the Trust has a sustainable workforce, in terms of posts, roles and skills, necessary to meet the rising health and care service demand, and setting out our plans to improve the organisational culture
4. **Financial recovery plan** – setting out how the Trust will become more financially sustainable, address its underlying deficit, improve service productivity and efficiency, and make optimal use of its resources.

In order to translate the Trust's refreshed vision and values, and communicate clearly the way in which these strategies and priorities connect for staff, patients and public, a new set of graphics and visuals have been developed and shared. These visuals will be displayed throughout the Trust in the coming weeks.

The Transformation Operational Board, recently established, continues to oversee the delivery of the priority cross-hospital transformation programmes agreed by the Executive Team. This paper provides the following programme updates:

- **Cost Improvement Programme:** At the time of writing, the Cost Improvement Programme is favourable to plan by £74k. The Trust has delivered £2.25m in efficiencies in the first 2 months of the year.

- **BEST Flow Programme:** Alongside our external delivery partner, the initial diagnostic phase of the programme is nearing completion, known as our 'One Version of the Truth' (OVT). Alongside this, the

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Trust has progressed a number of operational improvements. These include *Patients At Risk of Increased Stay* (PARIS) reviews focusing on our patients who, without intervention, can wait for an unnecessary long period prior to discharge, and the development of the *Same Day Emergency Care* (SDEC) pathway.

- **Service Transformation and Access Review (STAR) Programme:** This is a newly scoped programme led by the Medical Director to improve the utilisation of our Outpatient clinics, largely through improving our Access services, diagnostic pathways and administrative systems and processes. Alongside this internally focused work, we are working jointly with Medway CCG to modernise the elective pathway generally and enhance the way GPs refer into the hospital.

- **Quality and Continuous Improvement Programme:** This is a newly scoped programme led by the Director of Nursing to deliver our national and local quality priorities. Continuous improvement methodology and improvement science continues to be embedded within the Trust through the improvement huddles and monthly Yellow Belt training.

Attached as separate appendices:
1. Up-to-date highlight reports on each transformation programme
2. A short pack of emerging insights from the BEST Flow Programme diagnostic – 'One Version of the Truth'.

Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	• Transformation Operational Board (fortnightly) • Transformation Assurance Group (fortnightly) • Finance Committee (monthly CIP report) • Clinical Council (bi-monthly)	
Resource Implications	Not applicable.	

Legal Implications/ Regulatory Requirements	Failure to deliver the Cost Improvement Programme target and the Trust's agreed financial control total could result in the Trust being placed in a Financial Special Measures regime.
Quality Impact Assessment (QIA)	Quality Impact Assessments (QIAs) must be completed for all change projects including individual Cost Improvement Programme schemes. The Medial Director and Director of Nursing are required to sign-off all QIAs. For significant projects, QIAs are subject to more detailed discussion and potentially review by the wider Executive Team.
Recommendation/ Actions required	The Board are asked to note the contents of this report.

Approval	Assurance	Discussion	Noting
☐	☒	☒	☒

Appendices	Appendix 1: Programme-level highlight reports Appendix 2: Outputs from BEST Flow Programme – 'One Version of the Truth' diagnostic.

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1 Executive Overview

1.1 The Trust's core strategies are near completion and publication, setting the Trust's strategic direction and vision for the coming 5 years.

1.2 The Portfolio and Programme Management infrastructure supporting the delivery of the transformation programme has been enhanced, namely with the establishment of the Transformation Operational Board. An update from the TOB is provided below, as are updates on each of the cross-hospital programmes of work.

1.3 At the time of writing, the Cost Improvement Programme is favourable to plan by £74k. The Trust has delivered £2.25m in efficiencies in the first 2 months of the year. However, there are some concerns with the number of Red-rated schemes within the plan and the level of Unidentified CIP within the Directorate plans – for immediate corrective action.

1.4 The Trust's flagship FY 2019/20 transformation programme, The BEST Flow Programme has successfully mobilised. The first diagnostic phase of the programme is on-track and near completion and will be shared with the system at the first System Summit on 21 June. Alongside this analytical work, significant operational improvement work is also underway e.g. PARIS reviews and the development of the SDEC pathway.

1.5 We have continued to embed continuous improvement methodology across the Trust through the roll-out of improvement huddles and the rolling training programme, Yellow Belt.

1.6 During the next few months, the transformation portfolio will focus intensively on programme delivery, while also focusing on business planning and CIP planning for next year.

2 Trust strategy

2.1 Four core Trust strategies are nearing completion and publication, setting out the Trust's vision and priorities over the coming 5 years. These strategies include:

2.1.1 **Clinical strategy** – providing the Trust with clear direction in relation to our configuration of services, within the context of the changing Kent and Medway health system

2.1.2 **Quality strategy** – outlining the Trust's commitment to delivering high quality care for all as its central objective and planning delivery against the Trust's national and local quality improvement priorities

2.1.3 **People strategy** – ensuring the Trust has a sustainable workforce, in terms of posts, roles and skills, necessary to meet the rising health and care service demand, and setting out our plans to improve the organisational culture

2.1.4 **Financial recovery plan** – setting out how the Trust will become more financially sustainable, address its underlying deficit, improve service productivity and efficiency, and make optimal use of its resources

2.2 In order to translate the Trust's refreshed vision and values, and communicate clearly the way in which these strategies and priorities connect for staff, patients and public, a new set of graphics and visuals have been developed and shared. These visuals will be displayed throughout the Trust in the coming weeks.

3 Transformation Operational Board (TOB)

3.1 **TOB:** The Transformation Operational Board (TOB), made up of the Executive Team, is now well-established and meets fortnightly to oversee the full portfolio of transformation programmes. TOB also considers the enabling initiatives required to deliver service changes at the required scale and pace, for example communications, estates, digital and data. Assurance is provided to the Transformation Assurance Group (TAG) which continues to meet fortnightly, chaired by the Trust Chairman.

3.2 **Programmes and enabling strategies:** 6 cross-hospital programmes and 7 enabling strategies have been formally agreed and tactical and strategic plans per programme are in development. The role of TOB is to manage any interdependencies and benefits realisation across the portfolio, as well as tackling more strategic issues facing the Trust. A cadence of highlight reports and flash reports of Key Performance Indicators (KPIs) is now established and SROs are asked for any items for escalations at each TOB. These highlights reports are provided as an Appendix.

3.3 **JPMO:** With a view to standardising this Portfolio and Programme methodology across the wider system, a (virtual) Joint PMO (JPMO) has been established to oversee the joint programmes of work, also governed through the Medway and Swale Transformation Board. Our documentation and project stage-gates have been standardised across the system to support effective cross-organisational planning and progress reporting.

3.4 **Medway Project Academy:** As part of the JPMO development, we have worked across the system with Medway CCG and Medway Community Healthcare to deliver x3 trainings for our Project Managers alongside NHS Right Care. In order to deliver complex, multi-organisational change across Medway and Swale, consistent project management and change management methodology is essential. The inaugural *Medway Project Academy* took place in late May and two further sessions were held in June for our first cohort of Project Managers. Each of the three sessions had a specific focus: *Diagnose, Develop, Deliver*.

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4 Cost Improvement Programme and System Financial Recovery

4.1 **Year-to-date position:** As at Month 2, the Cost Improvement Programme (CIP) has delivered £2.2m against an operational CIP plan of £2.1m, favourable to plan by £74k.
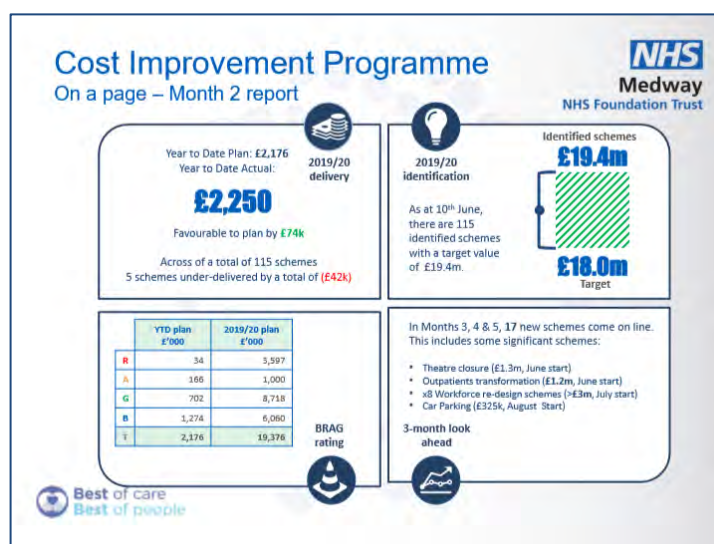
4.2 **Risk schemes:** As reported to Finance Committee, there is particular concern regarding the achievability of the CIP forecast for 2 key schemes:

    4.2.1 Theatres closure

    4.2.2 Outpatients Transformation

4.3 **Documentation:** In order to increase our ability to assure these schemes, there needs to be a significant increase to the pace and quality of the supporting planning documentation. Transformation Team and Finance Team colleagues are working collaboratively to support scheme owners.

4.4 **QIA panels:** In addition, and to further strengthen the existing QIA process, a weekly QIA Panel has been established which will be chaired by the Medical Director and Director of Nursing. This will be a face-to-face meeting where all new QIAs will be reviewed. For those with a "high risk" (scoring above 12 in the risk matrix) the Scheme Owner will be expected to present their QIA in person (or delegate to a suitably empowered representative). The Panel will also revisit QIA's throughout the year to ensure they remain safe and valid as each scheme develops.

4.5 **Pipeline:** A Pipeline of potential schemes to mitigate slippage, under-delivery and to fill the unidentified gap has been developed on the Aspyre system.

4.6 **Scheme identification:** At time of writing, a plan value of £19.4m has been identified for delivery in 2019/20, exceeding the target of £18.0m by £1.4m, comprising 115 schemes in total across the five Directorates.

4.7 **BRAG status:** Red-rated schemes represent the top risk schemes requiring further validation and/or support to deliver were presented to Finance Committee and Transformation Assurance Group. There are currently £3.597m in schemes marked as Red, meaning they lack basic assurance or documentation.

4.8 **Next year's CIP plan:** Focus on delivery continues throughout however, from August, Directorates should also be starting to consider CIPs for the next financial year (2020/21).

4.9 **Next steps:** The next steps for the Cost Improvement Programme:

4.9.1 Receive report from NHSI on CIP and PMO infrastructure

4.9.2 New PMO Officer starts on 24th June 2019

4.9.3 Conduct gap analysis with NHS Efficiency Map schemes – consult with Service Leads and present findings

4.9.4 Identifying schemes to a plan value of £24m – Target: Mid-July

4.9.5 Deliver a number of CIP Surgeries/Drop-in sessions for Scheme Owners – various sessions throughout July onwards

5 BEST Flow Programme

5.1 **BEST Flow:** The BEST Flow Programme is the flagship programme within the portfolio, central to the Trust's strategic ambition to become a designated Specialist Emergency Centre by 2020 and a key enabler in the Trust's ability to deliver against the emergency access constitutional standard. The Senior Responsible Officer (SRO) for the programme is the Chief Operating Officer for Unplanned and Integrated Care and the programme is currently in *Delivery* [PMO stage-gate].

5.2 The BEST Flow Programme represents one part of the wider Emergency Care Improvement Programme, ratified by the Regional Director of NHS Improvement/England, as depicted below.

5.3 **IST support:** The Intensive Support Team from NHS Improvement / England will be supporting the Emergency Care Improvement Programme, specifically on #2 Operational estates and service developments.

5.4 **OVT:** Alongside our external delivery partner, Transformation Nous, the initial diagnostic phase of the programme is nearing completion, known as our 'One Version of the Truth' (OVT). The OVT will be shared and discussed at the system summit on 21 June 2019.

5.5 **Key insights:** Key insights from the 'One Version of the Truth' diagnostic include:

5.5.1 MFT's conversion rate is very low at 18% and this has significant implications on its operations.

5.5.2 Admitted performance (adults) is where performance has dropped most year on year, specifically, mid-week performance has dropped significantly. This intra-week pattern is driven by specialist decision times, not by bed availability.

5.5.3 Patients are moved too many times. >16% of patients spend spells on 3+ locations

5.5.4 Increased number of ward moves correlates with a higher Average Length of Stay (ALOS). This is exacerbated by a high proportion of outlying patients (medical patients placed on surgical wards). Medicine patients who 'outlie' have a longer LoS, almost 2-days.

5.5.5 We have seen a significant drop in performance reported by MedOCC (the GP-run service hosted by Medway Community Healthcare) since April 2019. This relates to both Poor data quality but also poor actual performance.

5.6 **Ongoing operational improvements:** Alongside this analytical work, the Trust has already progressed a number of operational improvements. These include Patients At Risk of Increased Stay (PARIS) reviews focusing on our patients who, without intervention, can wait for an unnecessarily long period prior to discharge, and the development of the Same Day Emergency Care (SDEC) pathway. This new pathway will go live on 24th June 2019.
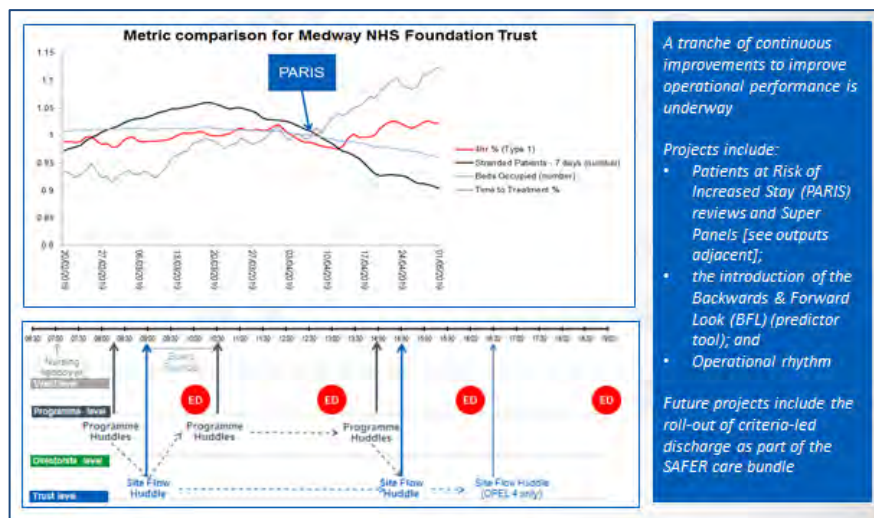
5.7 **Outcome measures:** Key outcome measures for the programme have been agreed by the Transformation Operational Board. Some KPIs will be confirmed following completion of the diagnostic.

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	Measure	Baseline	Q3	Q4	End of FY 19/20
Lead 1	Stranded patient beddays Number of beddays per month that are incurred for patients with a LOS >6	1,600	800	1,000	1,000
Lead 2	Zero LOS conversion 90% of [IC10 analysis] for potential SDEC patients	tbc	tbc	tbc	Tbc
Lead 3	Discharges before Noon % of patients discharged before noon	22%	30%	35%	37%
Lag t1	LOS- Average LOS for G&A patients	10.3	8.8	9.3	8.0
Lag t1	Bed Occupancy- G&A beds occupied vs agreed core G&A bed stock	104%	92%	95%	94%
Lag t2	Admitted Performance- Compliance with 4hr target for admitted patients	7%	67%	55%	70%
Lag t2	Type 1 Performance- Compliance with 4hr target for type 1 patients	69%	82%	80%	85%
Lag t2	ED Performance- Compliance with 4hr target for all ED patients	79%	92%	90%	95%
Lag t2	Ambulance Handover- Number of minutes lost per month in excess of 15 minutes	tbc	tbc	tbc	tbc
Lag t2	MSA- Number of MSA bed days	tbc	tbc	tbc	tbc
Lag t2	Outliers- Number of outlying bed days	tbc	tbc	tbc	tbc

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Note: TBC outcome measures / KPIs to be confirmed by OVT, June 2019

5.8 **Operational discipline:** In the coming weeks (at time of writing), the next phase of work will begin, focusing on day to day operational resilience and discipline. This will begin with ward-by-ward audits of Board Rounds. Process confirmation sheets will be completed every morning to ensure guidance is followed. These audits will identify areas of inconsistency or poor practice to correct, as well as good practice to share and replicate.

5.9 **System Summit:** On 21 June 2019, the Trust hosted the first BEST Flow System Summit. This convened colleagues from MFT as well as Medway and Swale CCGs, Medway Community Healthcare, and Medway Council. This summit will provide (at time of writing) an opportunity to reflect on the drivers of our current flow challenges, to understand what the blockages in our pathways are and to agree on ways forward to address these over the coming months, as a system.

6 Service Transformation and Access Review (STAR) Programme

6.1 **STAR Programme:** The Service Transformation and Access Review (STAR) Programme is a newly scoped programme led by the Medical Director as SRO to improve the utilisation of our Outpatient clinics, largely through improving our Access services, diagnostic pathways and administrative systems and processes. There will be significant interdependencies with ongoing digital transformation work e.g. EDRMS and digital dictation. This programme is at *Define* stage [PMO stage-gate]. The structure of the programme will mirror the structure adopted in the BEST Flow programme:

STAR programme

Operational improvement	One Version of the Truth	Leadership	Partnership working
• Redesign admin process (booking, clinic preparation, clinic outcomes) • Redesign diagnostic processes • Improve capacity management (clinic utilisation, job planning etc)	• Cancer Deep Dive • Mapping key admin processes • Understanding current working practices and data	• New Central Access Team • Service Manager fundamentals training programme	• Reset the parameters for joint working • Improve and standardise primary care's interactions with outpatients (GP referrals, pre-referral testing etc)

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6.2 **Service management fundamentals:** A significant component part of the programme will be improving the leadership and capability level amongst our operational leaders across the following 'fundamental' domains within the management of a service:
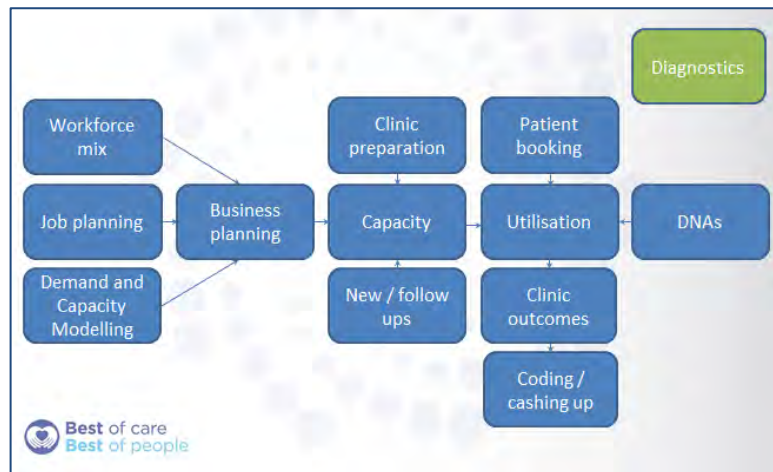
6.3 **Cancer deep dives:** This programme will also oversee the ongoing Cancer deep dives improvement work, prompted by recent Cancer performance concerns. The Intensive Support Team (IST) at NHS I/E have conducted a review and will provide ongoing support to this work as follows:
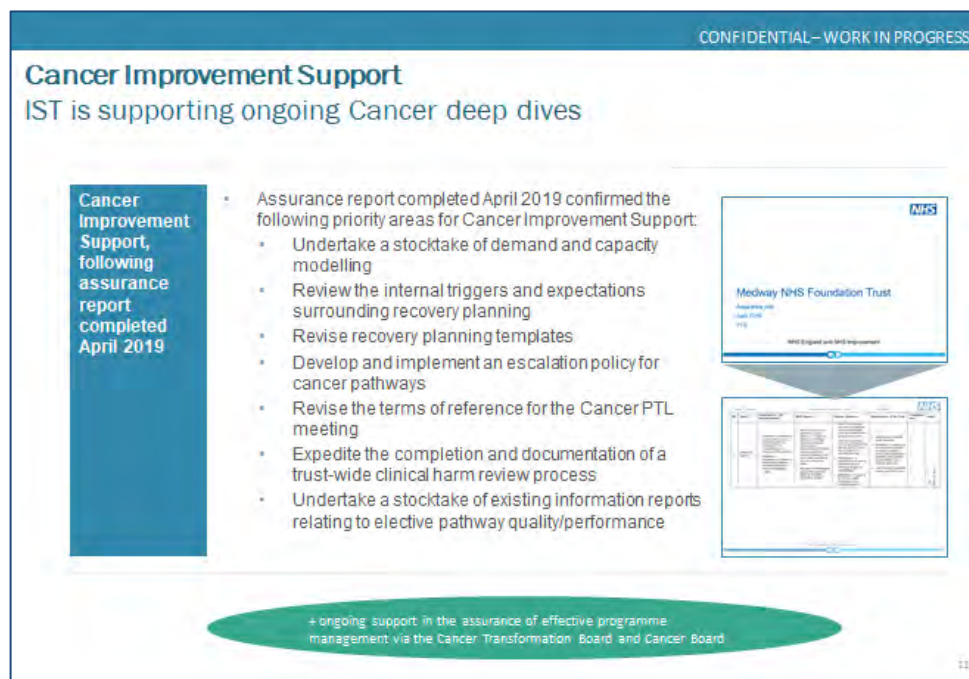
6.4 **Joint working with Medway CCG:** Alongside this internally focused work, we are working jointly with Medway CCG to modernise the elective pathway generally and enhance the way GPs refer into the hospital.

6.5 **Scope changes:** The second phase of the Portfolio of Services Review, analysing our non-core Specialist Emergency Centre services, has been commissioned as a separate deliverable by the Transformation Operational Board, out of the scope of this programme. Ongoing medicines optimisation work, specifically developing the case for central funding towards an Electronic Prescribing and Medicines Administration system has been moved out of the scope of this programme.

7 Quality and Continuous Improvement Programme

7.1 **QI Programme:** The Quality Improvement Programme is a newly scoped programme led by the Director of Nursing to deliver our national and local quality priorities. This programme is at *Define* stage [PMO stage-gate].

7.2 **CI methodology:** Continuous improvement methodology and improvement science continues to be embedded within the Trust through the improvement huddles and monthly Yellow Belt training.
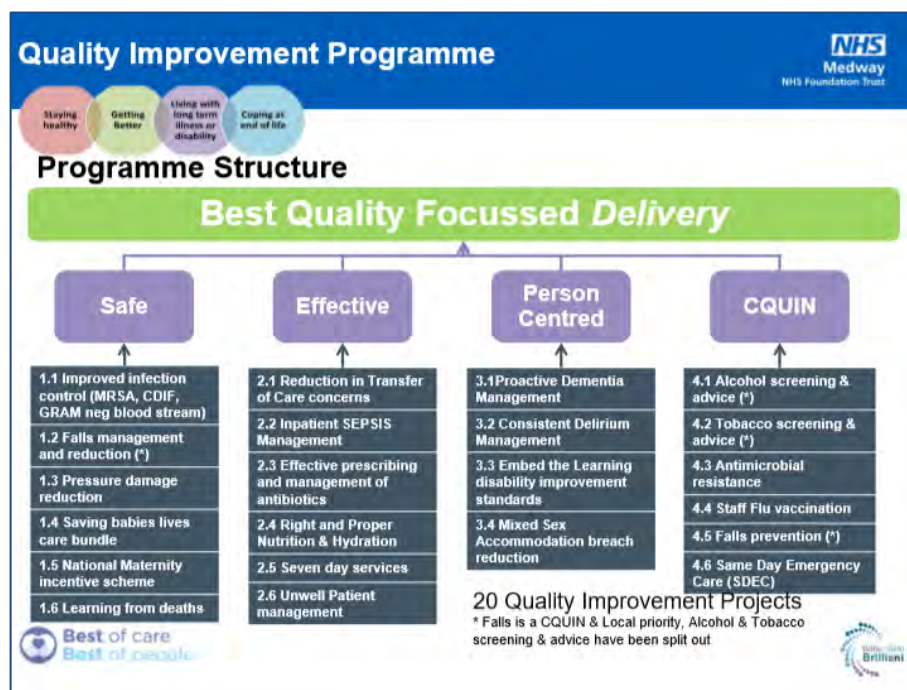
8 Conclusion and Next Steps

8.1 The transformation programme continues to gather pace across the Trust. There is an enormous amount of work happening within clinical and corporate teams to support the pace and scale of change required.

8.2 During the next few months, the transformation portfolio will focus intensively on programme delivery, while also focusing on business planning and CIP planning for next year.

8.3 The transformation team will also be deployed to support the CQC readiness and quality of care campaign, 'Going for Good'.

BEST Flow Programme Highlight Report

18th June 2019

Highlight report

Date: 18th June
Programme: Best Flow
Gateway: *Delivery*

SRO: Harvey McEnroe
RO: Kevin Cairney
TT Lead: Doug McLaren

Status: 🟢

NHS
Medway
NHS Foundation Trust

Activities since last update

- **External Provider on site** – OVT commenced, key introductions held and operationally set up
- **Senior Managers engagement –** Senior managers briefed and engaged with OVT outcomes to date
- **SDEC estate confirmed** – SDEC layout and estate mobilisation plan confirmed
- **Programme working group** – BEST flow working group established and meeting weekly
- **NHSi CAP –** Business case completed and subsequent meeting held with NHSi for consultancy appointment approval

Upcoming Milestones / Gateways

1. 18th June New site daily rhythm- 2 daily meetings supported by programme led huddles

2. 21st June First system 'summit' – engagement on SDEC, UTC, OVT

3. 24th June SDEC go live

Highest Risks

Risk in delay of moving services into area 1 and 2 for SDEC due to lack of assurance that outpatients have plans in place to move by 21st June. **Corrective action in place to mitigate this risk (Owner: KC)**

Highest Priority Actions

Surface MedOCC data quality and performance issues
Meeting fixed w/c 24th June (Owner: HMc)

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Risks | Low risk | Moderate risk | High Risk | Extreme Risk

Milestones/ Actions | Completed | On Track | Significant risk of delay

Project highlights

Date: 18th June
Programme: Best Flow
Gateway: *Delivery*

SRO: Harvey McEnroe
RO: Kevin Cairney
TT Lead: Doug McLaren

Status: 🟢

NHS Medway NHS Foundation Trust

	RAG	Narrative update	Top risks / issues
OVT *Lead: DS*	🟢	• On-track and near completion • System summit 21st June to share findings	• MedOCC data quality and performance issues
Operational Discipline *Lead: KC*	🟢	• PARIS, backwards and forward look, site operational rhythm – creating flow • Weekly calls ongoing with NHSI (Bernard Quinn) • IST support confirmed	• Rebuilding a consistently capable site team
Medical model *Lead: PK*	🟢	• SDEC go live 24th June on track • Medical WF recruitment is in progress • CIP documentation completed	• Establishing the estate for SDEC • National guidance is still progressing for SDEC causing a risk of misalignment
Engagement, Leadership & Capability *Lead: NC*	🟠	• First system summit on 21st June • Working groups progressing very well	• HoOP development programme now overdue

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🔴 *Intervention required*

🟠 *Further counter measures required*

🟢 *Risk mitigated*

Workplan

Date: 18th June 2019
Programme: Best Flow
Gateway: Delivery

SRO: Harvey McEnroe
RO: Kevin Cairney
TT Lead: Doug McLaren

Status: 🟢

NHS Medway NHS Foundation Trust

	Week 1 May	Week 2 May	Week 3 May	Week 4 May	Week 5 June	Week 6 June	Week 7 June	Week 8 June	Week 9 July	Week 10 July
	6 7 8 9 10	13 14 15 16 17	20 21 22 23 24	27 28 29 30 31	3 4 5 6 7	10 11 12 13 14	17 18 19 20 21	24 25 26 27 28	1 2 3 4 5	8 9 10 11 12

Oversight & Governance — SRO: HMc
- Award
- Panel

OVT — RO: DS
- Data gathering
- Analysis phase
- Key interviews and socialisation
- Refine and substantiate
- OVT draft 1
- OVT playback
- OVT playback
- Final OVT

Operational Discipline — RO: KC
- Ongoing PARIS reviews and super panels
- New site operational rhythm and BFL
- New Head of Site in post
- Board Round process confirmation

Medical Model — RO: PK
- Data gathering, CIP documentation
- SDEC Scoping
- SDEC go live
- Workplan subject to completion of the OVT and discussions with Delivery Partner

Engagement, Leadership & Capability — RO: NC
- Conclude listening events and synthesise themes
- Scoping
- External support begins →
- Develop HoOP Development Offer
- System summit

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- 🔷 Chair & CX briefing
- 🟢 Medway & Swale Transformation Board
- 🔴 Regulators' briefing
- 🔷 Best Flow Programme Board
- 🔷 Transformation Operational Board
- ⬜ Transformation Assurance Group

- 🟣 Key milestone
- 🔺 Key meeting/workshop
- ⭐ Key deliverable due

At the last Medway & Swale Transformation Board, SROs were asked to present the

OUTCOME MEASURES & KEY PERFORMANCE INDICATORS

Outcome measures – subject to change / confirmation following OVT

	Measure	Baseline	Q3	Q4	End of FY 19/20
Lead 1	Stranded patient beddays Number of beddays per month that are incurred for patients with a LOS >6	1,600	800	1,000	1,000
Lead 2	Zero LOS conversion 90% of [IC10 analysis] for potential SDEC patients	tbc	tbc	tbc	Tbc
Lead 3	Discharges before Noon % of patients discharged before noon	22%	30%	35%	37%
Lag t1	LOS- Average LOS for G&A patients	10.3	8.8	9.3	8.0
Lag t1	Bed Occupancy- G&A beds occupied vs agreed core G&A bed stock	104%	92%	95%	94%
Lag t2	Admitted Performance- Compliance with 4hr target for admitted patients	7%	67%	55%	70%
Lag t2	Type 1 Performance- Compliance with 4hr target for type 1 patients	69%	82%	80%	85%
Lag t2	ED Performance- Compliance with 4hr target for all ED patients	79%	92%	90%	95%
Lag t2	Ambulance Handover- Number of minutes lost per month in excess of 15 minutes	tbc	tbc	tbc	tbc
Lag t2	MSA- Number of MSA bed days	tbc	tbc	tbc	tbc
Lag t2	Outliers- Number of outlying bed days	tbc	tbc	tbc	tbc

Note: TBC outcome measures / KPIs to be confirmed by OVT, June 2019

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Patient At Risk of Increased Stay impacts

Metric comparison for Medway NHS Foundation Trust
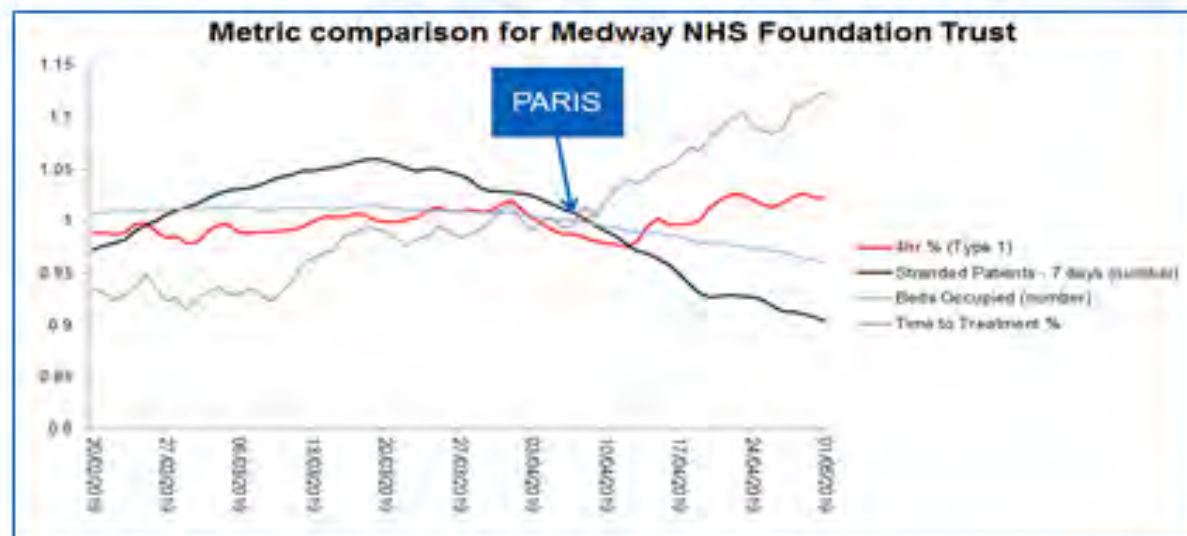
A tranche of continuous improvements to improve operational performance is underway

Projects include:

- Patients at Risk of Increased Stay (PARIS) reviews and Super Panels [see outputs adjacent];
- the introduction of the Backwards & Forward Look (BFL) (predictor tool); and
- Operational rhythm

Future projects include the roll-out of criteria-led discharge as part of the SAFER care bundle

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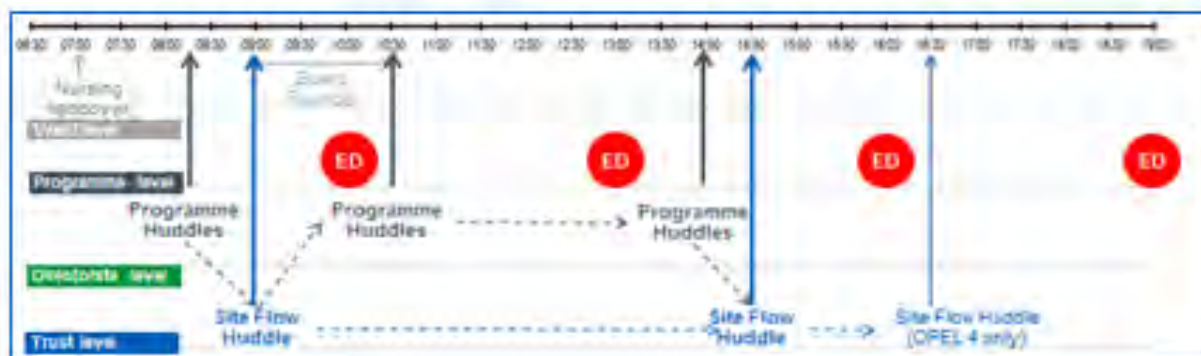
Immediate recovery plan – positive impact, now to embed the changes and sustain

w/c 2 June

w/c 9 June

Immediate recovery plan:

- ❑ Gone live with our new site operational rhythm (site meetings, huddles and ward rounds)
- ❑ Wrapped more structure and support around type 3 UTC patients, with enhanced Trust leadership support for our CCG commissioned UTC service
- ❑ Deployed early work on the new SDEC which formally opens on 24th June

Next steps:

- Full SDEC goes live next Monday
- New ambulance control process and FCP goes live in next 10 days
- LoS work on AMU and SAU underway
- UTC additional GP resource to be deployed from 27th June

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Appendix 2:
Early insights from BEST Flow Programme – 'One Version of the Truth' diagnostic

June 2019

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This is one programme of work and the Operational Discipline workstream is at the core

Operational Discipline

Preliminary listening events

OVT

Medical Model design

Engagement, Leadership, Capabilities
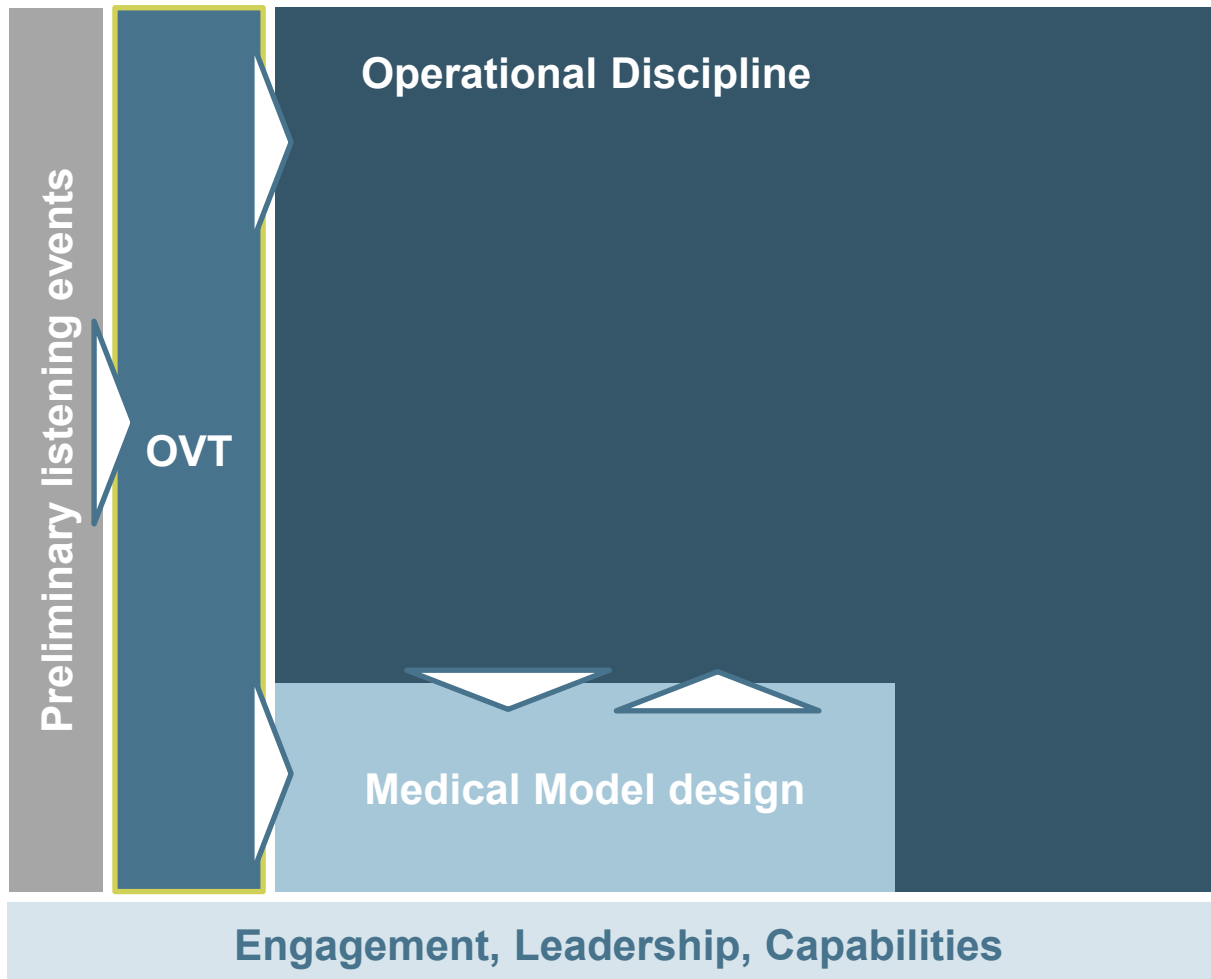
- The various parts are inextricably linked

- Operational Discipline is the part that will deliver the **desired step change** in:
  - Processes and systems
  - People, leadership, and capability

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Reminder: Overview of the Operational Discipline workstreams. We will work closely with your teams to tailor to MFT needs

INPATIENT TRANSFORMATION (Wards)

FOCUS:
- Implement SAFER
- Discharge targets
- Board rounds
- Discharge lounge
- Joint working

GOALS:
- Re-energise teams to increase number of discharges
- Increase proportion of pre-12pm discharges

REAL TIME SITE MANAGEMENT

FOCUS:
- Bed meeting
- Effective flow of information
- Use of queues
- Operational grip

GOALS:
- Right patient in the right bed
- Reduce time from DTA to admission into bed
- Improve operational grip, especially out of hours

ED INTERFACE WITH SPECIALTIES

FOCUS:
- Interface with AMU
- Referrals

GOALS:
- Improve response, esp. out of hours and without jeopardising conversion rate

ED OPERATIONS
- Flow co-ordination
- Staffing vs. flows
- Use of CDU

- Improve ED operations

CULTURAL SHIFT: CHANGING 'HEARTS AND MINDS'
- Instill the belief that improvement is still possible in the current climate
- Re-energise hospital teams to move to action
- Promote collaborative working towards a common goal

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Reminder: The programme aims to create a system that allows MFT teams to consistently deliver quality care. Some objectives include:

Right patient in the right bed
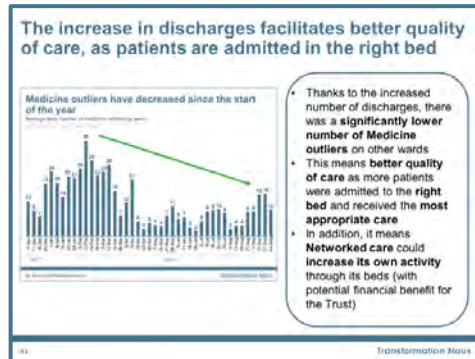
Reduced the number of outliers by 20-80% (eliminated at times at UHL)

Reduced time from DTA to admission
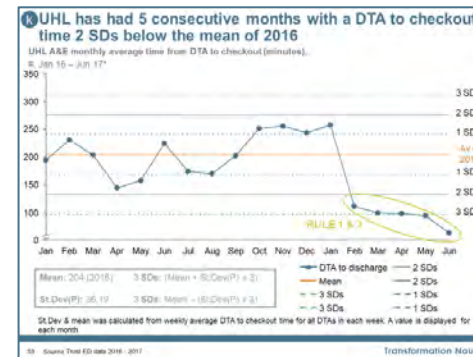
Reduced avg. time from DTA to admission by 30-50%

Reduced N of DTAs / lower occupancy
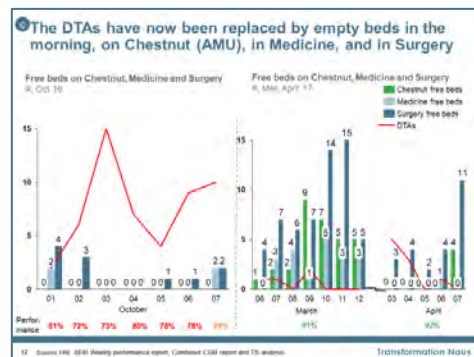
Significantly lower n of DTAs in ED at 3 sites

Sustained free beds in the am at 2 sites

Reduction in ambulance offload times
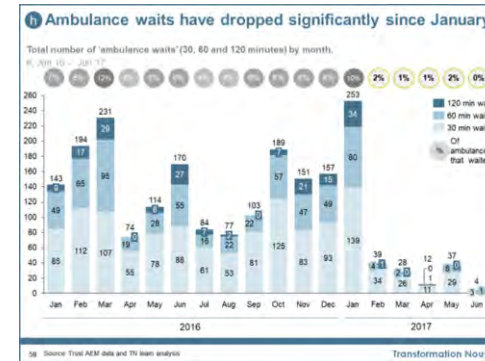
Reduction in 15' and 60' offload delays

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Best Flow

	2019								2020					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

OVT — (bar May–Jun 2019)

Medical model — (bar Jun–Jul 2019)

Operational discipline — (bar Aug 2019 – May 2020)
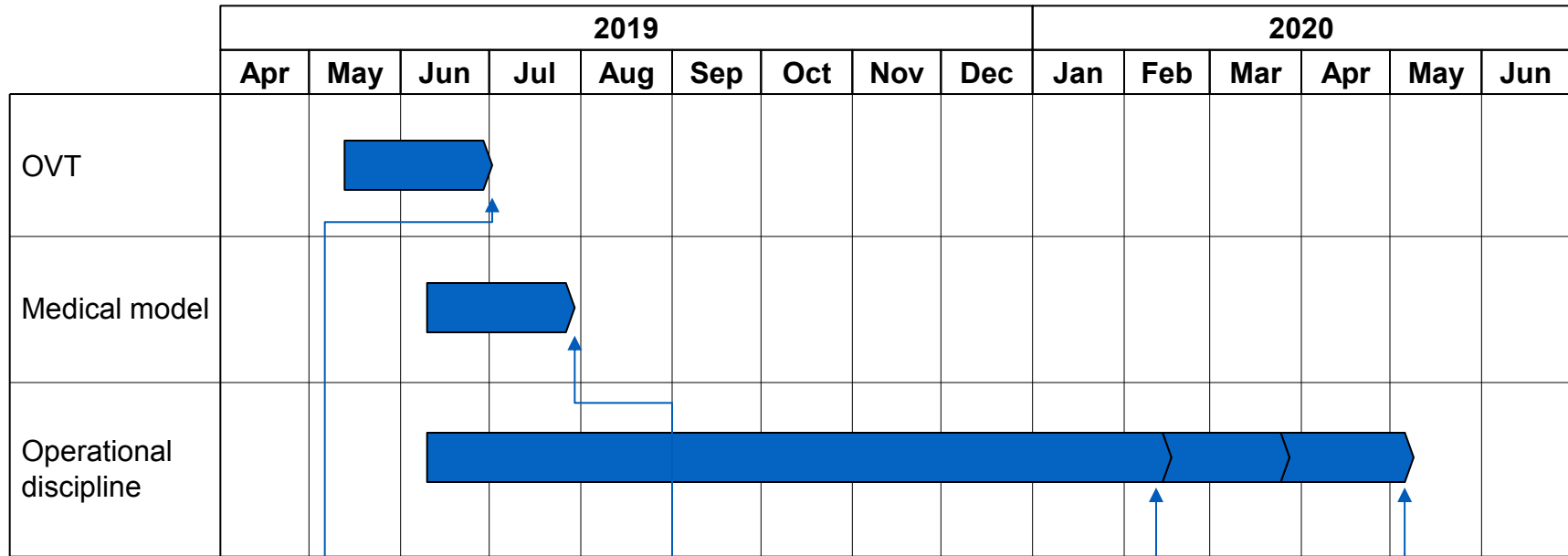
- Insights on root causes of performance by area of the pathway (see detail of chapters and progress by week on next page)
- Whole pathway and partners engagement
- Baseline of activity by specialty to be used as input for medical model work

- Agreed medical model, including:
  - Pathways (i.e.: what patients should go where and when, to be cared for by whom)
  - Bed base configuration to best accommodate activity
  - Assumptions of LoS for each step of pathway consistent with such bed base
  - Ways of working to achieve LoS: within teams and across teams
- Implementation plan, with process changes necessary

- Revised embedded new processes along the whole pathway (see next pages for more detail)

- Fully Trust-owned processes

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OVT Topics

OVT Topics:

1. Attendances	5. Assessment	10. Supported discharge
2. MedOCC	6. Outliers/Pathways	11. SITE
3. Process times	7. Frailty	12. Digital
4. Referrals and conversion rate	8. Ward processes/ALoS	13. Pathway performance
	9. Discharges	

Presented
To be presented

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13 4
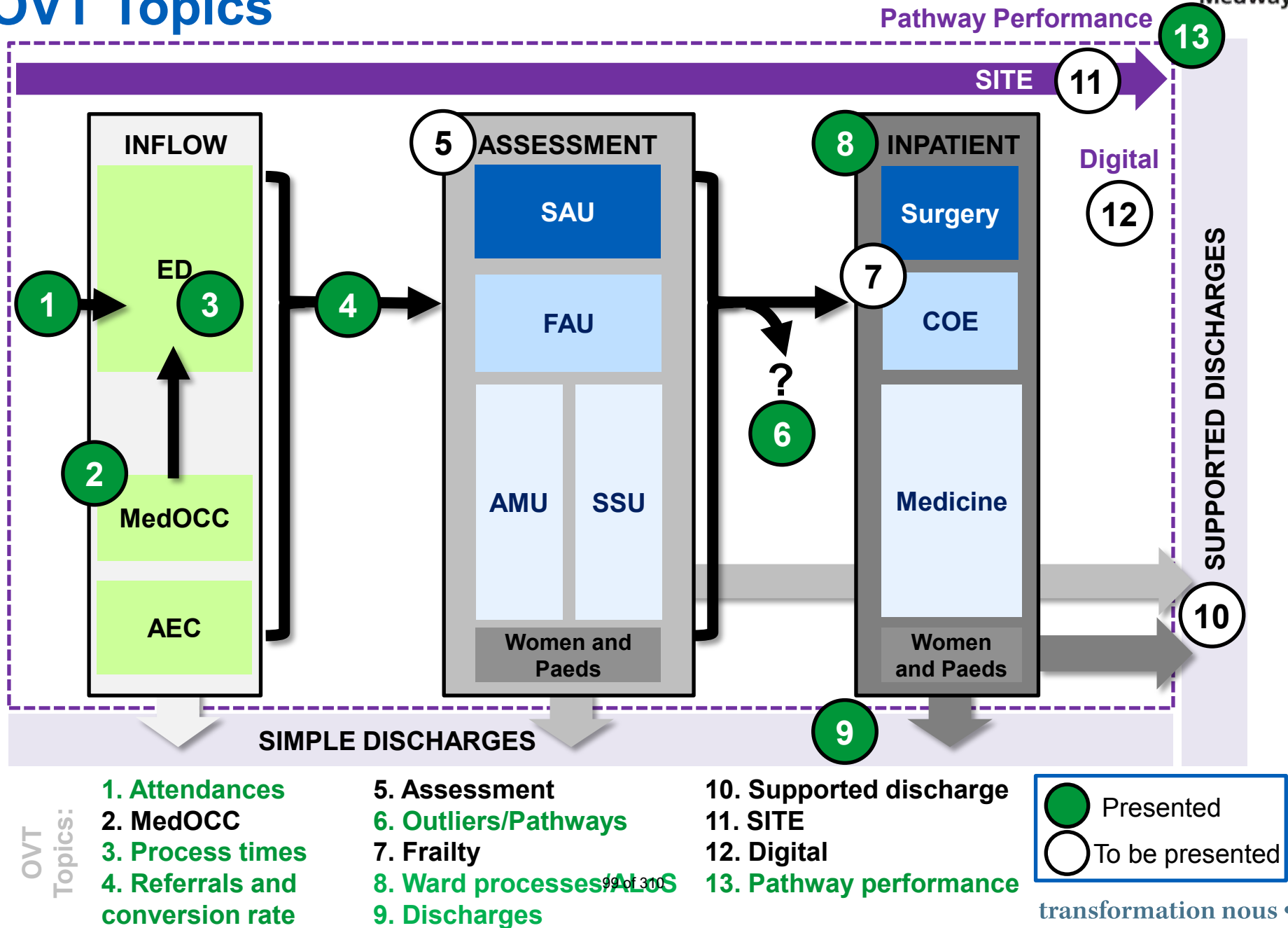
Key insights – performance and conversion rate
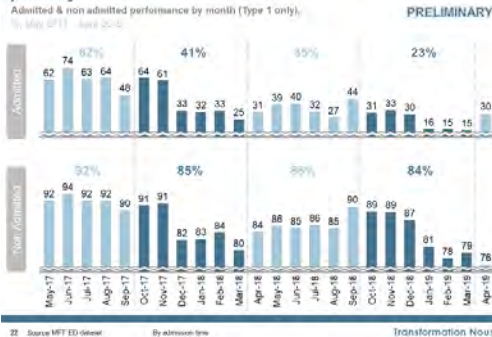
Adm. adults performance
Is where performance has dropped most year on year
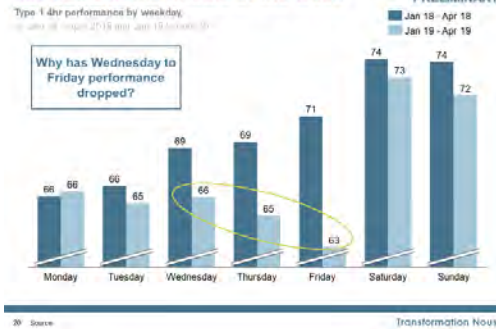
Mid-week performance has dropped significantly more…
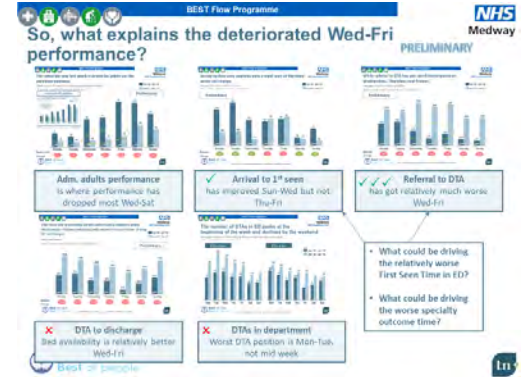
…and this intra-week pattern is driven by specialist decision times
Not by bed availability

MFT's conversion rate is very low at 18%...
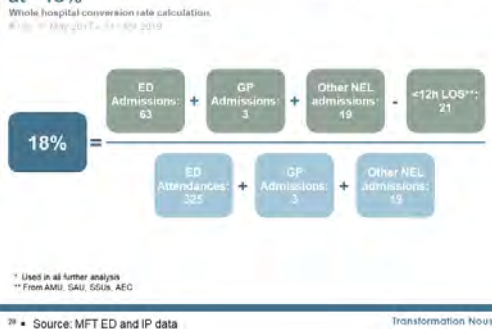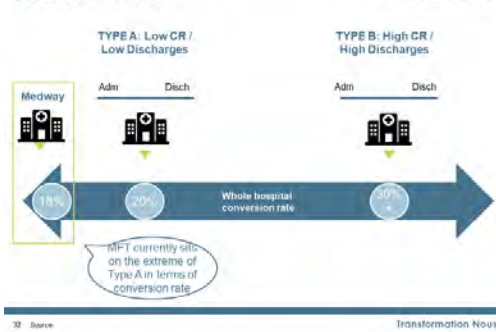
…and this has significant implications on its operations

- Patients are struggling to get into the hospital
- ED and Medicine are doing the "filtering"
- Risk of large swings in n of admissions when acuity peaks, with no "low hanging fruit" to discharge

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Key insights - Pathways and patient moves
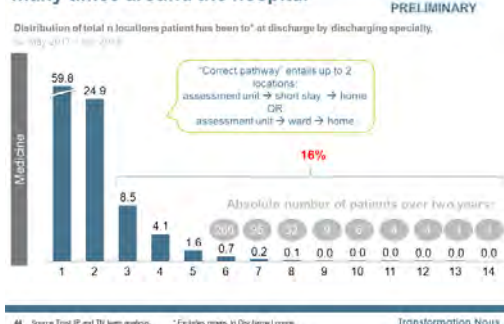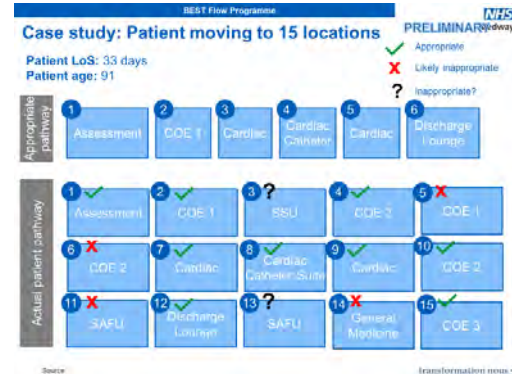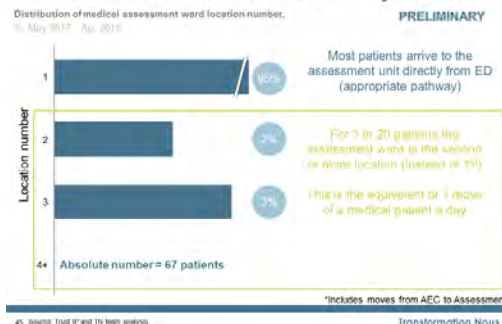
Patients are moved too many times
>16% of patients spend spell on 3+ locations

Some patients move "backwards" in the pathway
Back to assessment or to short stay

And there are extreme cases
Like one patient moving to 15 locations during 1 spell
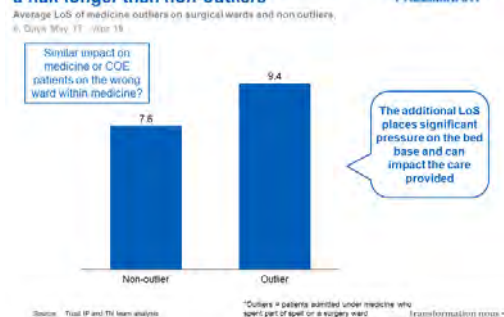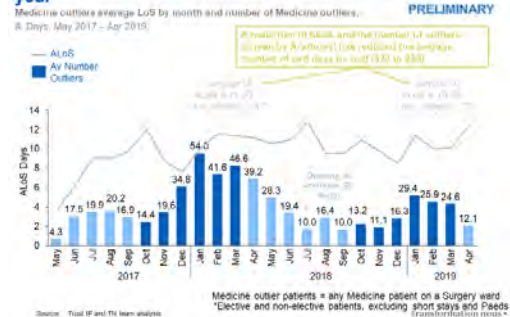
Medicine patients who outlie have much longer LoS
By almost 2dd

The number of outliers has come down
but only thanks to the revised bed base (Arethusa)

- There has been a vicious cycle between outlying patients and increasing the overall ALoS
- Medicine has been increasing its footprint
- There is a non insignificant number of very inappropriate patient moves

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Key insights – ALoS and Discharges trends
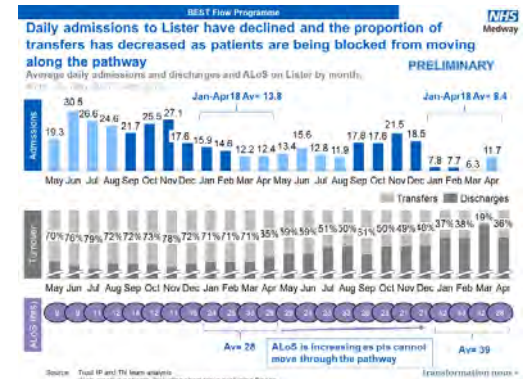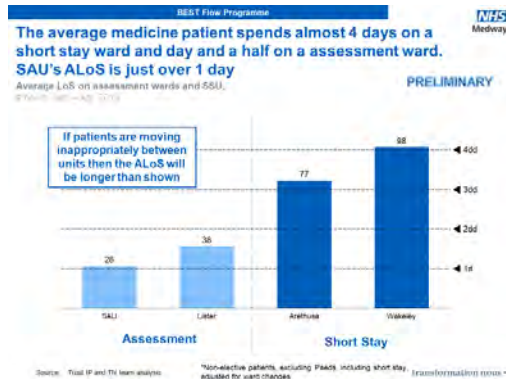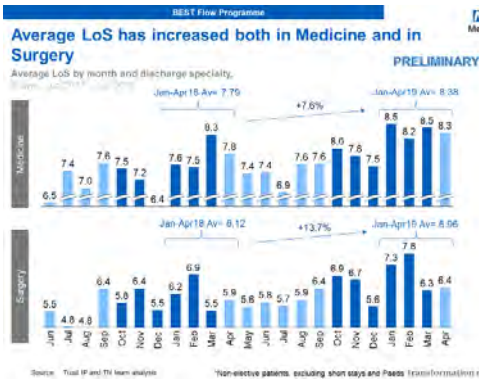
ALoS has increased for both Medicine and Surgery

Medicine assessment and SSU do not function as such
With too high ALoS

Lister's "churn" has more than halved
And the majority of its patients spend all their spell there
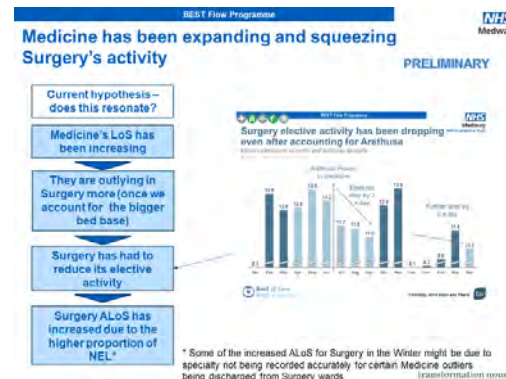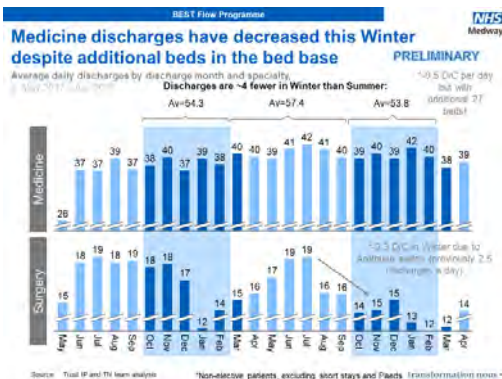
Medicine discharges have come down
Despite increased bed base

Medicine has been expanding
And squeezing Surgery's elective activity

- Surgery's increase in ALoS might be due to the higher % of NEL
- Another vicious cycle: assessment and SSU used inappropriately leading to higher LoS and more congested site
- Next step to investigate: Medicine specialties outliers

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③

Key insights - ED process times and specialty outcomes
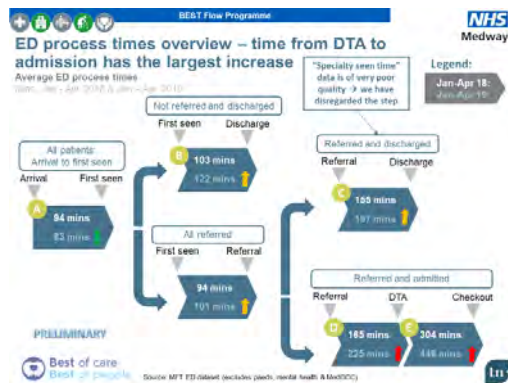
Process times in ED have all increased
Except time to 1st seen
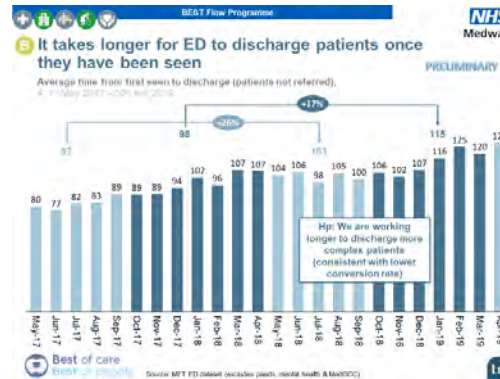
It takes longer to make a decision
Both by ED and then by specialties
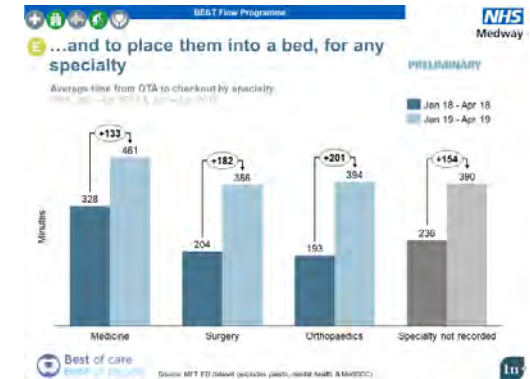
But most of all it takes much longer to admit them
With an average of 2-6 hours depending on specialty
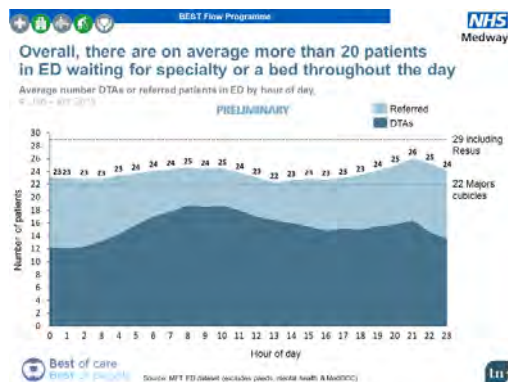
As a consequence ED is much more blocked
Throughout the day
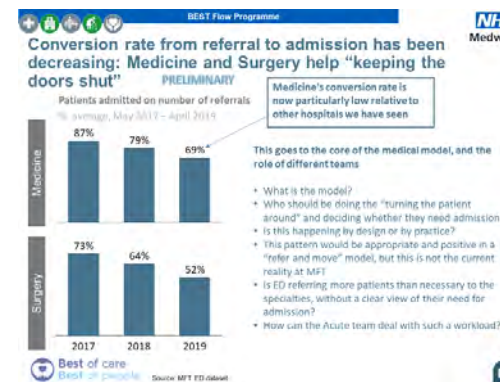
Conversion from referral to admission is relatively low
Potentially overloading assessment teams

- Decision times by specialties have increased – this might also be due to a change in mindset given blocked beds
- ED is performing well considering block
- Medical model will be key to address interface issues

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Key insights - MedOCC
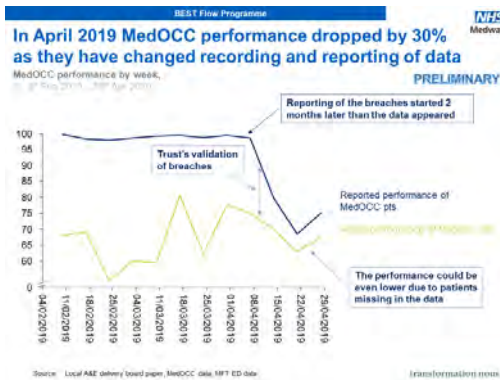
Significant drop in performance
Reported by MedOCC since April
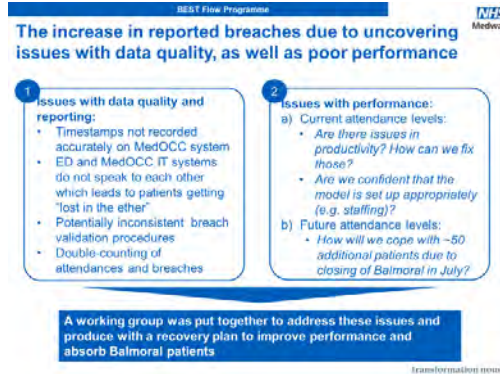
Poor data quality but also poor actual performance
Both issues need to be addressed
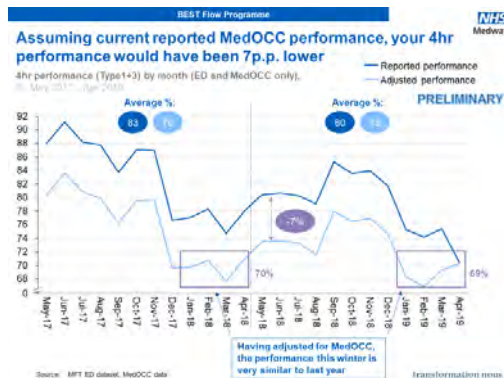
Adjusted Type 1+MedOCC performance would be ~7 points lower

- Poor performance was "under the radar". Should it have been identified earlier?
- The Trust is under considerable pressure by the Regulator to bring Type 3 performance up to acceptable standards
- Some pressure is expected to be relieved with opening of SDEC which should quickly receive referred patients, which take up significant GP time
- Still unclear whether the current model could deliver high performance once SDEC is online or if productivity improvements are also required
- MedOCC and CCG in discussions to agree funding plan also in consideration of additional activity from Balmoral

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Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Integrated Quality and Performance Report	**Agenda Item**	**5.1**
Lead Director	Karen Rule, Director of Nursing		
Report Author	Karen Rule, Director of Nursing Dr David Sulch, Medical Director Gurjit Mahil, Chief Operating Officer, Planned Care Harvey McEnroe, Chief Operating Officer, Unplanned Care Leon Hinton, Director of HR and OD		
Executive Summary	This report informs Board Members in the form of a dashboard report of May 2019 operational and quality performance across key performance indicators. May was again a busy month with bed occupancy regularly in excess of 100%. Staff continue to demonstrate commitment to maintaining patient safety by working flexibly as required however the overall need to flex nursing staff reduced as a result of improved staff fill rates. Performance against the constitutional targets was mixed. Of particular note the Trust did not meet the DM01 trajectory due to increased demand and loss of capacity. A revised performance trajectory has been agreed and a long term plan to support an increase in capacity is in place. Further detailed commentary can be found in the spotlight reports. The Unplanned and Integrated Care Directorate have continued to deliver improved falls performance, with a reduction in falls month on month for the past five months. This has been achieved through sustained support in a number of areas. The Trust is within trajectory for C.difficile with 5 cases reported for April and June. An improvement trajectory of no more than 5 cases has been agreed for MRSA Bacteraemia, this is a 50% reduction in reportable cases from 2018/19. To date the Trust has reported one case in May but this is being reviewed at the time of writing and may be considered for a downgrade. Two never events have been reported by the Trust, both events pertaining to retained foreign objects. Initial review of both events has identified aspects which may be considered as not meeting the Never Event criteria. A decision was made to report both events as never events and to await the outcome of the full investigations. Downgrade requests may be submitted if appropriate. Hospital Standardised Mortality Ratio (HSMR) is now within the expected range but the Medical Director continues with work to understand our outlier position for Pneumonia. Mixed Sex Accommodation (MSA) breaches increased by 22 in May. The focus of the improvement work remains in critical care and the need to step down patients into ward beds within four hours of the decision to 'step down'. There is good engagement from all staff with this work and the		

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targeted interventions alongside the Best Flow Improvement programme are expected to deliver further improvement in MSA performance.

The Trust remains challenged in delivering rapid improvement in Electronic Discharge Notification (EDN) performance despite a series of interventions. However an improved performance is reported in May.

Time to Surgery for Fractured Neck of Femur deteriorated in May following a month on month improvement for the past six months. An increased number of adult and child patients requiring surgery for non-hip fractures impacted on the ability to meet the time to surgery target. The Surgical Programme has implemented a number of actions to recover performance.

Performance against most of the HR metrics has remained static but of note is the Trust wide 85.81% compliance with the Statutory and Mandatory training target.

Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒

Committees or Groups at which the paper has been submitted	Executive team (content discussed, not entire report) Directorate and Programme leadership teams (content discussed, not entire report)
Resource Implications	Nil
Legal Implications/ Regulatory Requirements	Nil
Quality Impact Assessment	Not Applicable
Recommendation/ Actions required	The Board is asked to discuss and note the report.

Approval	Assurance	Discussion	Noting
☐	☐	☒	☒

Appendices	None

Integrated Quality and Performance Report

May 2019

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EXECUTIVE SUMMARY

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Constitutional Target Trajectories

		Apr-19	May-19
ED - 4 Hours Type 1	**Actual**	68.10%	68.88%
	Planned	68.13%	77.21%
	Variance	-0.03%	-8.33%
ED - 4 Hours All Types	**Actual**	79.66%	80.89%
	Planned	79.66%	83.05%
	Variance	0.00%	-2.16%

ED 4 Hour Trajectory Commentary:

Compared to 18/19 reporting period type 1 attends down by 365 (4.65%) in April and 645 (7.69%) and May with performance deteriorating by 1.6%. Type 1 non-admitted performance in region 89 – 92% with admitted performance 0-10%. Driver for deterioration in type 1 pathway is >100% bed occupancy driven by 65-70% stranded patient load (>7 days). Type 3 activity also reduced in April but attends increased in May by 313 attends (4.1%). Type 3 performance has deteriorated by 7% versus 18/19 reporting period. Satellite type 3 units at >99% with co-located MEDDOC facility now reporting regular <80% following revised validation process in M2 19/20

		Apr-19	May-19
RTT - 18 Weeks	**Actual**	83.08%	83.27%
	Planned	82.85%	84.98%
	Variance	0.23%	-1.71%
RTT - 52 Week Breaches	**Actual**	8	5
	Planned	27	6
	Variance	-19	-1

RTT Trajectory Commentary:

The Trust reported an overall performance of 83.08% which was 0.23% above the agreed trajectory. In addition the Trust reported 8 52 week breaches for the same period all of which have had a clinical review with no harm reported.

Constitutional Target Trajectories

		Apr-19
Cancer - 62 Days	Actual	76.69%
	Planned	77.10%
	Variance	-0.41%
Cancer - 2 Week Waits	Actual	83.39%
	Planned	87.10%
	Variance	-3.71%

Cancer Trajectory Commentary:

The Trust did not achieve the national standard and has recently submitted a full action plan to order to recover the position. The main areas of concern were lower GI and Breast.

		Apr-19	May-19
DM01- 6 Weeks	Actual	95.41%	93.72%
	Planned	99.20%	99.60%
	Variance	-3.79%	-5.88%

DM01 Trajectory Commentary:

The DM01 trajectory for April19 was not achieved – missed by 3.79%
Under performance was predominantly driven by Upper and Lower GI diagnostics continuing to experience challenges in rising demand and loss of capacity (ongoing at 3rd party and MFT); a plan, with suitable options for demand management and backlog clearance is in place, that also supports the sustainable position.
MRI has reported a worsening performance in April 19 due to a continuing increase in demand (mostly within cancer referrals, 50% increase) and loss of capacity due to machine outage; a revised trajectory with an increase in mobile capacity has been submitted and approved, alongside a long term plan for an increase in substantive capacity.

Safe

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Harm Free Care	Falls (moderate or severe harms and deaths)	0.0	#	1	0	1	2	1	2	4	3	4	3	2	4	27	
	Falls Per 1000 Bed Days	6.6	#	4.43	4.91	4.02	3.6	3.91	4	4.46	5.2	6.99	4.51	4.6	4.56	4.59	
	Pressure Injuries (Low Harm)	0.0	#	13	20	17	16	18	15	7	21	14	19	12	6	178	
	Pressure Injuries (Moderate and High Harm)	0.0	#	0	2	1	1	0	0	2	4	0	0	3	1	14	
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	-	#	0	0.13	0.06	0.06	0	0	0.12	0.24	0	0	0.19	0.06	0.07	
	Number of Medication Errors	0.0	#	1	0	1	0	4	1	0	0	1	2	1	0	11	
Incident Reporting	Never Events	0.0	#	0	0	0	0	0	1	0	0	0	0	0	2	3	
	Never Events - Incidence Rate	0.0	%	0	0	0	0	0	6.35	0	0	0	0	0	12.01	1.55	
	No of SIs on STEIS	0.0	#	12	13	15	4	10	6	6	7	6	4	5	18	106	
	% of SIs Responded To In 60 Days	-	%	100	100	100	100	100	93.33	100	100	100	100	100	100	99.07	
Infection Control	MRSA Bacteraemia (Trust Attributable)	0.0	#	2	1	3	0	1	0	1	0	0	0	0	1	9	
	C-Diff Acquisitions (Trust Attributable (Post 72 Hours)	19.0	#	3	0	2	4	4	1	3	3	0	2	3	2	27	
	C Diff Due to Lapses In Care	0.0	#	1	0	0	1	1	0	0	0	0	0	0	0	3	
	MSSA Surveillance (Trust Acquired)	0.0	#	1	3	1	1	3	3	2	2	0	2	0	1	19	
	E-coli (Trust Acquired) Infections	0.0	#	9	4	4	6	2	4	4	4	7	3	5	4	56	
Mortality	Crude Mortality Rate	2.5	%	1.49	1.46	1.31	1.44	1.41	1.35	1.14	1.29	1.51	1.92	1.71	-	1.47	
	HSMR (All)	100.0	%	111.01	113.3	113.89	115.59	112.7	110.73	108.73	106.28	103.25	-	-	-	110.71	
	HSMR (Weekday)	100.0	%	110.86	113.29	114.43	115.8	112.05	110.65	108.15	104.46	100.08	-	-	-	110.09	
	HSMR (Weekend)	100.0	%	110.77	113.09	111.79	114.43	113.96	110.22	109.29	110.31	111.7	-	-	-	111.75	
	SHMI	1.0	#	1.07	1.07	1.06	1.06	1.06	1.1	1.1	1.1	1.09	-	-	-		

Safe Commentary:

The Unplanned and Integrated Care (UPIC) Directorate reported a reduction in falls for the 5th consecutive month. A "Fall Down" Campaign led by the Senior Nursing team commenced in June. This is a similar approach as used for the "Hands Up" campaign which reached and trained Hand Hygiene competencies to 297 staff members in May. The MRSA bacteraemia is being considered for a downgrade pending the decision from the Post Infection review.

The two Never Events reported pertain to retained foreign objects post surgery. Both are currently under investigation.

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

Safe – Total HSMR Spotlight Report

Commentary, Risks & Mitigating Actions

The Trust's HSMR is now 'as expected' at **105.7**, and represents the fourth consecutive decrease. The Trust's HSMR data no longer includes community deaths, and this accounts for the dramatically lower HSMR figure (the HSMR figure released in March 2019 for the period January to December 2018 was 114.7; with the community deaths removed from the cohort, this is now being reported at 107.9).

The Trust continues to be an outlier for the Pneumonia diagnosis group, with an HSMR of 118.4, but this has decreased for the last two months. Currently, the Medical Director is reviewing the care of all patients with Pneumonia listed on part 1 of the Medical Certificate of Cause of Death; it is anticipated that patients who died in April and May will all be included in this review. In addition, the Trust continues to collate data for the national Community Acquired Pneumonia audit, which includes all patients with a Community Acquired Pneumonia (those that survived to discharge as well as those who died) with a particular focus on care metrics relevant to pneumonia.

Domain	KPI Name		Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19
Mortality	HSMR (All)	🟢	100.0	%	111.01	113.3	113.89	115.59	112.7	110.73	108.73	106.28	103.25
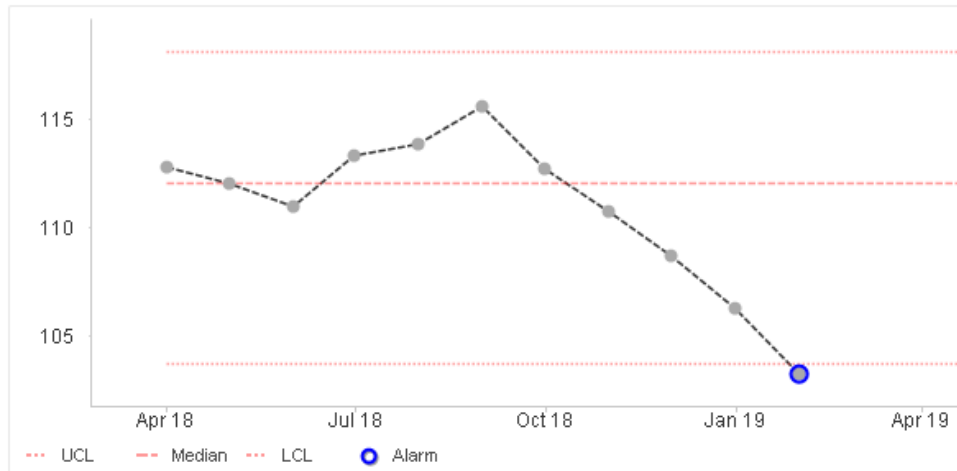
HSMR Total Definition:

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

Safe – Falls Per 1,000 Bed Days Spotlight Report

NHS Medway NHS Foundation Trust

Domain	KPI Name	● Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	4.43	4.91	4.02	3.6	3.91	4	4.46	5.2	6.99	4.51	4.6	4.56

Legend: UCL (dotted) — Median (dashed) — LCL (dotted) — ○ Alarm

Commentary

In May there were 76 in-patient falls. This is consistent with the average monthly fall rate. The total number of falls per occupied bed days remained below the national target.
There were 4 harms sustained from falls categorised as moderate or severe, including two within the emergency department. Root cause analysis is undertaken for all falls recorded as moderate or severe harm.
Falls with harm per occupied bed days went above the national target after remaining below the target since February 2019.

Risks & Mitigating Actions

The Falls team continue with monthly Trust wide audit on:
- Falls CRASH bundle
- Falls documentation (falls risk assessment and care plan)
- Bedrail assessment

The falls team aim to review all in-patients that fall and provide recommendations into reducing further incidents.

The Directorate teams are endorsing mini root cause analysis following in-patient falls to be performed by ward staff to improve immediate learning and this is being undertaken in the directorates with support from the falls team.

CQUIN falls data collection is underway and the team is on target to submit for Q1.

Falls Definition:

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

Safe – Pressure Ulcers Per 1,000 Bed Days Spotlight Report

NHS
Medway
NHS Foundation Trust

Domain	KPI Name	Target	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Harm Free Care	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	-	0	0.13	0.06	0.06	0	0	0.12	0.24	0	0	0.19	0.06

UCL ········ Median ─ ─ ─ LCL ········ Alarm ◯

Commentary, Risks & Mitigating Actions

There is not currently a national benchmark or target for pressure ulcer harm per 1000 OBD, however submission of a target against the Trust mean figure has been submitted for internal performance monitoring going forward.

There was 1 severe unstageable pressure ulcer acquired in May. Upon assessment it is thought that the pressure ulcer is likely to become a category 3 or 4 once the wound bed is visible. The pressure ulcer toolkit is being completed by the ward and directorate at the time of writing.

The tissue viability team continues to audit the wards monthly against the ASSKINg care bundle and to support staff with best practice.

The Unplanned and Integrated Care (UPIC) directorate working group continues to progress the Directorate TV improvement plan Actions include a Matron Campaign for " Get Moving" for August 2019.

Pressure Ulcer Definition:

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

CARING

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Caring

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	154	186	259	216	252	192	248	234	252	147	85	107	2332	
	MSA %	0.0	%	1.06	1.25	1.7	1.44	1.62	1.32	1.63	1.47	1.74	0.93	0.58	0.68	1.29	
	% of EDNs Completed Within 24hrs	100.0	%	50.16	49.32	48.11	49.44	49.12	49.71	49.86	46.59	47.35	47.54	49.46	49.83	48.88	
	Inpatients Friends & Family % Recommended	83.0	%	87.33	87.09	83.9	84.45	86.47	86.21	81.98	85.05	76.33	85.59	85.6	84.41	84.98	
	Inpatients Friends & Family Response Rate	25.0	%	22.33	21.84	21.71	22.55	21.54	22.7	19.45	19.69	12.1	20.64	15.83	18.51	20.01	
ED Care	ED Friends & Family % Recommended	65.0	%	78.92	78.44	77.03	80.65	80.48	78.86	71.97	72.05	72.18	75.56	73.34	73.14	76.24	
	ED Friends & Family Response Rate	25.0	%	15.8	14.95	14.08	15.58	14.14	13.94	14.01	13.99	13.23	13.42	10.64	12.35	13.85	
Maternity Care	Maternity Friends & Family % Recommended	79.0	%	97.74	100	99.26	98.82	100	100	95.19	97.64	99.6	99.66	100	100	99.01	
	Maternity Friends & Family Response Rate	25.0	%	30.15	28.93	28.32	17.67	22.71	23.62	28.15	32.81	38.67	31.78	29.77	28.88	28.41	
Outpatients Care	Outpatients Friends & Family % Recommended	83.0	%	89.85	90.7	89.91	89.12	89.93	90.93	91.63	90.28	89.48	91.14	89.23	89.77	90.18	
	Outpatients Friends & Family Response Rate	25.0	%	14.53	14.41	14.7	14.24	13.56	13.94	13.06	14.78	14.83	14.15	10.32	12.87	13.79	

Caring Commentary:

Significant improvement has been delivered for MSA compliance within Unplanned and Integrated Care Directorate. This has been achieved through a zero tolerance approach on wards, collaborative working and engagement by registered nurses and actively addressing potential breaches in critical care areas.

All areas for Friends and Family Test (FFT) have achieved the Trust target 'would recommend' rates. The focus going forward is to build on these scores and meet the national would recommend average performance for all areas. In relation to response rates in the Emergency Department, although appear to have not been achieved, frequently score above the national average each month.

Outpatient response rates are not measured nationally, however the measures being identified and put in place from the Inpatient task and finish group should be able to be replicated and influence and improve results in outpatients. Likewise, many of the improvements identified should also be able to be replicated for ED.

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

Caring – Mixed Sex Accommodation Spotlight Report

NHS Medway NHS Foundation Trust

Domain	KPI Name	● Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	154	186	259	216	252	192	248	234	252	147	85	107

UCL ···   Median ──   LCL ···

Commentary

The number of mixed sex breaches for May 2019 increased slightly to 107 total. As with April the breaches are predominantly in our critical care areas with two breaches occurring in our cardiac ward.

The Trust has launched the Best Flow transformation programme and mixed sex allocation will be included in the focus of the programme to ensure patients are allocated into the correct bed first time and to support reduction of delayed discharge from our critical care areas.

Risks & Mitigating Actions

Critical care discharges are being added to bed allocation profile and being picked up in the twice daily Trust clinical site meetings. Critical Care patients are being given equal priority with patients being admitted from our emergency department and assessment areas to ensure they are transferred to inpatient beds within four hours of decision to step down.

Accurate data is being recorded via the MSA application and nurses are validating information daily. Weekly validation continues to support link between wards and business intelligence to ensure record is accurate. Breaches are recorded on datix.

Mixed Sex Accommodation Definition:

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

EFFECTIVE

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Effective

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Best Practice	7 Day Readmission Rate	10.0	%	4.94	5.48	4.69	4.65	4.38	4.14	4.56	4.31	4.49	4.24	4.61	-	4.59	
	30 Day Readmission Rate	10.0	%	10.77	11.3	9.89	10	9.84	10.52	10.42	9.25	9.97	9.41	10.47	-	10.17	
	Discharges Before Noon	25.0	%	17.52	15.61	15.98	16.42	15.35	15.2	17.27	15.26	15.99	15.92	14.13	14.89	15.8	
	Fractured NOF Within 36 Hours	100.0	%	39.6	55.3	70.6	57.1	67.7	45.2	46.9	45.5	71.4	85.7	75	-	60	
	VTE Risk Assessment % Completed	95.0	%	86.3	78.3	66.98	59.98	55.6	58.19	50.57	74.73	89.29	90.61	95.31	90.52	74.04	
Maternity	Elective C-Section Rate	13.0	%	11.5	11.11	12.07	12.77	13.54	13.32	9.71	13.02	12.97	11.66	13.26	13.59	12.38	
	Emergency C-Section Rate	15.0	%	17	18.08	17.03	20.24	18.96	16.82	20.47	20.15	21.45	21.5	17	15.53	18.65	
	Total C-Section Rate	28.0	%	28.5	29.19	29.09	33.01	32.51	30.14	30.18	33.17	34.41	33.16	30.26	29.13	31.03	
	Number of Deliveries (Count of Mothers)	-	#	400	459	464	415	443	428	381	407	401	386	347	412	4943	
	12+6 Risk Assessment	90.0	%	79.35	84.04	81.4	81.58	83.33	83.84	85.19	82.52	82.47	-	-	-	82.65	
Stroke	Stroke SSNAP Rating *	B	-	E	E	E	E	E	E	E	D	D	D	-	-		
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	33.33	35.87	35.87	35.87	41.25	41.25	41.25	31.13	31.13	31.13	-	-	35.44	
	Stroke Pts Scanned Within 1 hour *	90.0	%	49.28	35.87	35.87	35.87	48.75	48.75	48.75	42.45	42.45	42.45	-	-	42.64	

Effective Commentary:

The Discharge before Noon performance has remained static over the last 12 months. The recently launched Best Flow Transformation programme is expected to deliver improved performance against this metric through the implementation of more effective patient pathways and improved discharge planning from the time of admission.

See spotlight report for commentary on fractured neck of femur.

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

Effective – Fracture Neck of Femur Spotlight Report

Commentary
Risks & Mitigating Actions

There was a dip in our time to surgery for the month of May 2019. This reflects the increased demand placed on trauma list due to increased number of patients and children with other non-hip fractures.

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Total Patients	31	41	33	34	33	37	47
Surgically treated or over 65	30	40	32	33	33	33	41
Surgery beyond 36 hours			12	9	8	6	19
Surgery within 36 hours			20	24	25	27	22
Surgery within 36 hours %	**40**	**42.5**	**59.3**	**72.72**	**75.7**	**81.81**	**53.65%**

Our performance for other BPT criteria

BPT Criteria	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Surgery within 36 hours %	40	42.5	59.3	72.72	75.7	81.81	53.65%
Pre-op AMTS			93.93	100%	100%	100%	100%
Ortho Geriatric review			100%	100%	100%	100%	95.12
Physio assessment within 24 hours			100%	100%	96%	96%	100%
4AT assessment			100%	100%	100%	100%	100%
MUST score (nutrition)			96%	100%	100%	100%	97.56
Falls assessment			100%	100%	100%	100%	100%
Bone protection			100%	100%	100%	100%	100%

Actions taken
1. We are constantly reviewing our data and performance. We have learnt from our performance in May 2019 and pre-emptively planned to create extra trauma lists/evening lists to accommodate hip and other fractures in forthcoming summer months
2. Transition of care from orthopaedics to Orthogeriatrician once surgically no concerns
3. Emphasis on optimisation of patients pre-operatively
4. Finalisation of the anti-coagulation pathway for hip fractures
5. Presentation in the orthopaedic departmental M&M meeting regarding our performance and steps taken to improve

Domain	KPI Name	● Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Best Practice	Fractured NOF Within 36 Hours	100.0	%	39.6	55.3	70.6	57.1	67.7	45.2	46.9	45.5	71.4	85.7	75

UCL ··· Median --- LCL ···
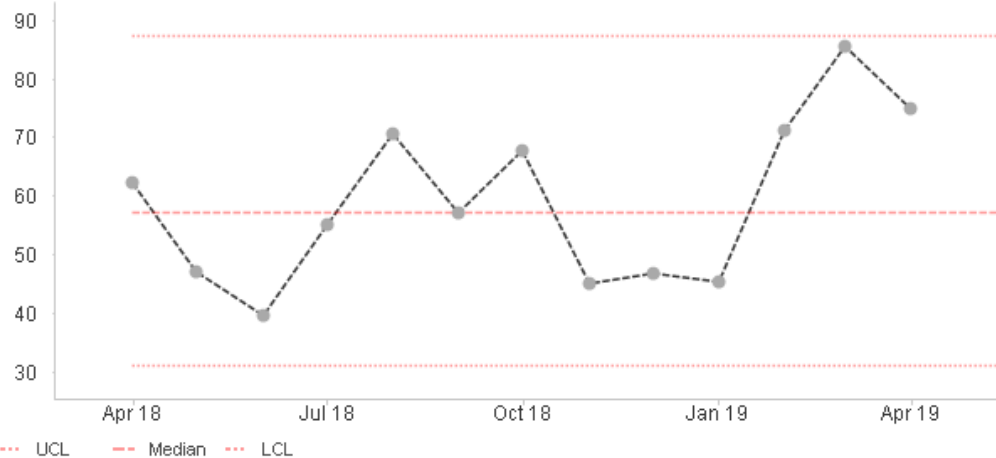
Fractured NOF in 36 Hours Definition:

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

Effective – VTE risk Assessment Spotlight Report

NHS Medway NHS Foundation Trust

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Best Practice	VTE Risk Assessment % Completed	95.0	%	86.3	78.3	66.98	59.98	55.6	58.19	50.57	74.73	89.29	90.61	95.31	90.52

Chart legend: UCL · Median · LCL
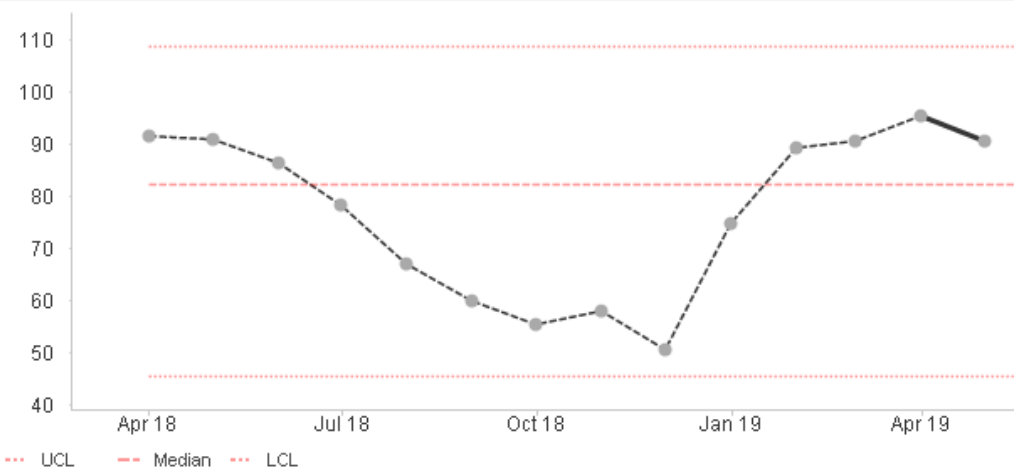
VTE Risk Assessment Definition:

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

Commentary	Risks & Mitigating Actions
In May we achieved 90.52% performance. Planned care achieved 92.91% and Unplanned and Integrated care achieved 88.8%. The main outlier for non compliance was Lister ward and the VTE nurse and management team are working together with the ward to improve this. Compliance with the target is expected to be met in June. The VTE nurse has worked with the paediatric team to ensure that patients who are 16 years and older on the paediatric wards are having a VTE assessment this will help raise compliance.	VTE nurse on Annual leave for July for 2 weeks – Bank cover is being requested through VCP. Non-compliance for June – meetings being held with Lister Management team and additional support provided by the clinical leads.

NHS
Medway
NHS Foundation Trust

RESPONSIVE

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Responsive – Non-Elective

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Bed Management	Bed Occupancy Rate	92.0	%	90.19	88.98	89.66	90.95	90.31	87.51	88.88	90.72	91.51	89.17	84.68	86.56	89.07	
	Average Elective Length of Stay	5.0	#	1.95	2.49	1.96	2.72	2.72	2.02	2.48	2.02	2.25	2.14	2.05	2.6	2.28	
	Average Non-Elective Length of Stay	5.0	#	8.02	7.68	8.25	8.43	8.5	8.33	8	9.23	8.79	8.7	8.64	8.8	8.44	
	Escalation Beds Open Point Prevalence in Month	0.0	#	61	123	331	327	775	750	373	775	700	775	750	775	6515	
	Delayed Transfer of Care Point Prevalence in Month	0.0	#	129	121	162	153	164	385	302	228	243	321	373	347	2928	
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	0.83	0.76	1	0.95	0.97	2.44	1.87	1.36	1.59	1.93	2.39	2.09	1.51	
	Medically Fit For Discharge Point Prevalence in Month	0.0	#	3266	3375	3465	3285	3234	3060	2991	3211	3345	3663	3379	3060	39334	
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	20.98	21.24	21.42	20.41	19.16	19.42	18.52	19.18	21.86	22.03	21.6	18.37	20.33	
ED Access	ED 4 Hour Performance All Types	95.0	%	86.88	87.06	85.92	90.2	88.77	88.95	87.34	83.03	77.29	78.04	79.66	80.77	84.51	
	ED 4 Hour Performance Type 1	95.0	%	74.27	73.7	71.79	80.32	77.24	77.63	74.42	65.94	64.76	66.1	68.09	68.87	71.91	
	ED 12 hour DTA Breaches	0.0	#	0	4	10	0	13	0	1	5	16	1	7	48	105	
	Median Time to ED Clinician (60mins)	60.0	#	44	42	35	33	36	36	40	48	53	48	37	38		
	Median Time to Ambulance Assessment (15mins)	15.0	#	3	4	4	3	4	3	3	3	4	4	4	4		
	ED Time to Specialty Review - Median	120.0	#	133	137	124	121	119	121	135	133	145	147	139	129		
	30 Mins Ambulance Handover Delays	0.0	#	492	620	455	321	332	261	315	364	449	423	346	408	4786	
	60 Mins Ambulance Handover Delays	0.0	#	51	80	54	17	18	8	72	192	212	133	105	98	1040	
	Number of ED arrivals by Ambulance	-	#	3098	3160	3018	2941	3124	3278	3500	3475	3088	3346	3391	3379	38798	
	ED Conversion Rate	20.0	%	25.86	26.74	25.36	25.48	25.71	23.06	24.74	22.15	20.3	21.78	24.73	24.78	24.22	

Responsive – Non-Elective Commentary:

General & Acute bed occupancy for April 2019 was regularly in excess of 100% (ECIST) with a static NEL LOS between 8.3 and 10.2 days. Stranded patient bed days in excess of 1800 per week with a noted reduction to 1427 following induction of PARIS (internal) and system super-panel sessions. This resulted in an improved weekly performance in early to mid-April in our type 1, admitted and ambulance handover profile. Internal ED clinical standards maintained with best regional performance in 60 minute TTT metric and conversion rate (all-types) around 19%. Ambulance attends increased by 6.57% against same reporting period 18/19 with ECDS indicating higher loading of category 3-4 (majors) patients and an age profile that is steadily increasing. <60 minute handover time has improved in April and May but we are off internal trajectory for 60 minutes. Ambulance >60 minutes and twelve hour breaches subject to internal rigour and medical re-modelling but are primarily linked to availability of beds in our assessment and specialty wards. This phenomenon occurs typically on a Monday + Wednesday alongside 11% higher activity.

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	61	123	331	327	775	750	373	775	700	775	750	775
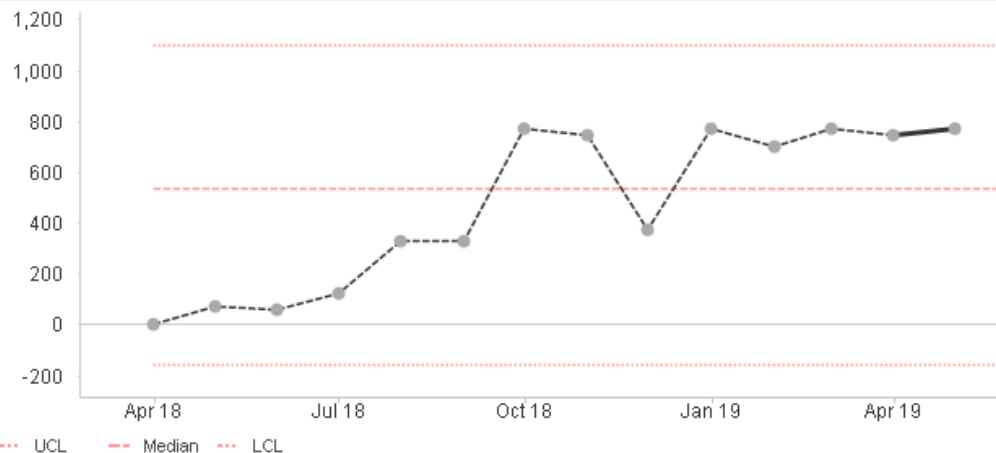
Escalation Beds Definition:

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

Commentary	Risks & Mitigating Actions
Bed occupancy regularly in excess of 100% not factoring in unplaced DTA within emergency care and assessment units.	Two units available for escalation. Dickens ward to 16 patients with a 1:8 nurse ratio. Sunderland Day Care (SDCC) to 20 patients with a similar ratio. Both utilised in Q4 (18/19) and sporadic deployment through April and May.
Regular cycles of CRITCON 1 requiring decompression of HDU.	Senior nursing and operational oversight to plan and close escalation areas given balance of risk to crowding, ambulance handover and CRITCON 1
Bed occupancy driven by high stranded patient volume for 7+, 14+ and 21+ including DTOC. 1800 bed days consumed by stranded patients (around 65% of operating G&A bed base is stranded)	Ongoing efforts to reduce LoS through Best Flow transformation, further reduce conversion using SDEC and evidence-based changes to Acute Medical model
Low discharge profile in Acute Medicine with critical mass of discharges from specialist and elderly programmes. Post-Take Ward Round (PTWR) in ED by specialties also discharges direct from ED.	Patient Flow policy developed in tandem with Best Flow programme and submitted via Unplanned Care governance.

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

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
ED Access	ED 4 Hour Performance All Types	95.0	%	86.88	87.06	85.92	90.2	88.77	88.95	87.34	83.03	77.29	78.04	79.66	80.77
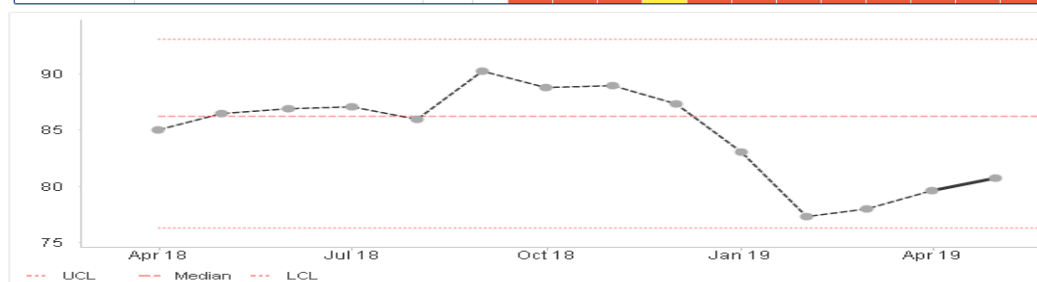
Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
ED Access	ED 4 Hour Performance Type 1	95.0	%	74.27	73.7	71.79	80.32	77.24	77.63	74.42	65.94	64.76	66.1	68.09	68.87
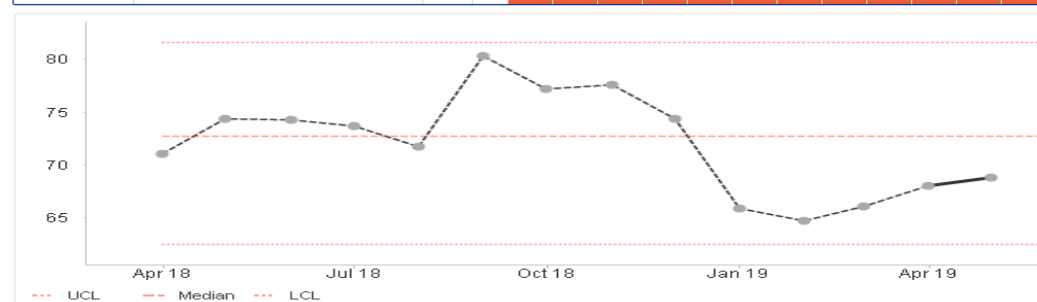
ED 4 Hr Performance Definition:

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

Commentary

Type 1 non-admitted in region of 88-92% despite significant crowding effects from admitted performance of 0-10%

TTT metric for type 1 remains a regional leader. >75% of patients are seen within 60 minutes by a decision maker.

Primary driver for type 1 deterioration is high bed occupancy and stranded patient metric

Streaming to MEDDOC or alternative care pathways remains in region of 27-39%

Type 3 performance has deteriorated by 7% driven by new validation of MEDDOC 4hr performance

Satellite type 3 is >99%.

Risks & Mitigating Actions

One Version of Truth (OVT) as part of Best Flow programme near completion. This will allow evidence-based operational intervention to target reduction in LoS and increase conversion to SDEC.

Primary intervention includes once weekly deployment of PARIS and system super panel to target stranded patients, including 21+ using system decision-makers;

Site management oversight of 4 and 12 hour flow has been revised including the induction of a new Site Lead. We have remodelled the site huddles to increase programme accountability

NHSI, MCH and MFT task and finish group with COO oversight now deploying plans re: type 3 performance. MFT will validate MEDDOC performance with adjusted policy. Emergency Floor Steering Group and Joint Management Board to provide governance for estate and pathway development for SDEC, UTC and ED.

Responsive – Elective

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Diagnostic Access	DM01 Performance	99.0	%	91.86	92.3	98.2	99.24	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72	96.54	
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	81.68	82.52	82.55	81.77	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27	81.88	
	18 Weeks RTT Over 52 Week Breaches	0.0	#	0	2	12	11	12	9	13	20	27	37	8	5	156	
	18 Weeks RTT Total Backlog	2,000.0	#	3807	3645	3693	3915	3803	3791	4111	4236	4425	4307	3407	3357		
	18 Weeks RTT Completed Admitted Performance	90.0	%	54.18	55.94	56.49	55.41	55.12	55.65	62.35	62.79	54.06	50.17	51.74	57.29	55.74	
	18 Weeks RTT Completed Non-Admitted Performance	95.0	%	82.32	82.42	81.5	81.27	81.01	79.96	78.57	78.6	81.19	79.77	82.32	81.17	80.85	
	Daycase Rate	85.0	%	65.22	66.94	65.71	64.69	66.02	63.48	63.54	67.61	68.61	65.88	65.85	66.27	65.82	
	DNA Rate	10.0	%	8.47	8.55	8.54	8.86	8.69	8.49	8.72	8.46	8	7.73	7.84	7.97	8.38	
	First to Follow Up Ratio	-	#	1.16	1.12	1.13	1.16	1.16	1.18	1.2	1.16	1.2	1.18	1.18	1.16	1.17	
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	21	19	11	17	29	24	52	46	51	14	41	15	340	
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	3	3	1	3	2	6	17	23	22	17	8	7	112	
	Urgent Operations Cancelled for the 2nd Time	0.0	#	0	0	0	0	1	1	0	0	0	0	0	0	2	
	Critical Care Occupancy Rate	92.0	%	91.61	92.66	94.44	90.69	96	94.02	94.55	99	94.95	95.88	84.83	89.21	93.17	

RESPONSIVE

Responsive – Elective Commentary:

The Trust continues to monitor its performance on a daily and weekly basis for all aspects of elective care. Our RTT performance is performing well against the overall Trajectory. Areas of concern for the reporting period are General Surgery, Neurology and Vascular. Our 52 week position has also seen significant improvement mainly down to the removal of the Dermatology service.

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

Responsive – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Diagnostic Access	DM01 Performance	99.0	%	91.86	92.3	98.2	99.24	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72

UCL — Median — LCL
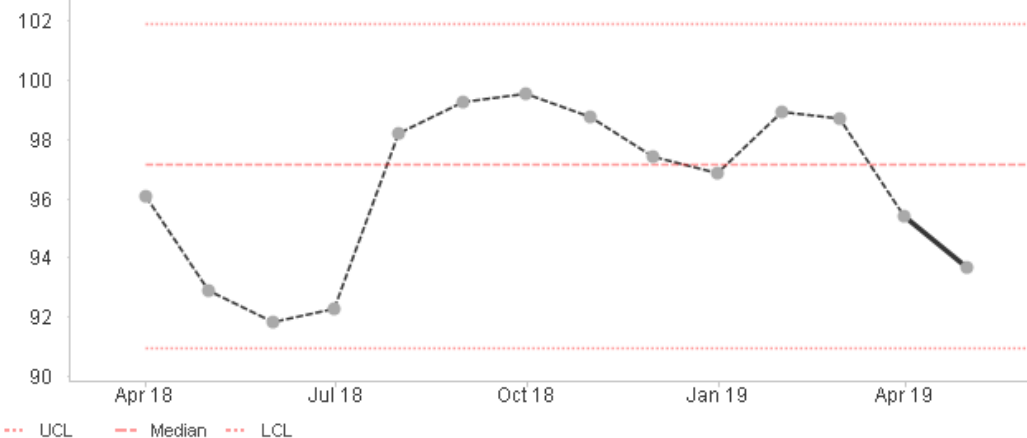
DM01 Performance Definition:

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

Commentary

DM01 performance fell in the latter half of the 18/19 year which has resulted in an lower than planned start of year position. This is driven predominantly by an increase in:

- MRI demand (clinically indicated)
- Changes to NICE guidance for imaging cancer
- Increase in Gastro scope demand
- Loss of third party provider capacity for scopes due to long term facilities issue

The DM01 & RTT meetings have now joined to ensure pathways are appropriately supported
Enhanced processes are being introduced as management of the performance standard of the DM01 matures e.g.:

- Weekly DM01 report for validation
- Monthly action report to action breeches with no less than 2 weeks notice of end of month
- Weekly Operational Performance Meeting (to evaluate and share performance within the organisation).

Risks & Mitigating Actions

Risks:
- Capacity (Routine)
  - MRI
  - Gastro (Upper and Lower GI)
- Consultant vacancy – Gastro (for diagnostics)
- Reporting capacity within Radiology
- NG12 clinical referral pathway
- MRI
  - Short term: Increase of mobile MRI van for 8 additional week (immediately placed)
  - Medium term: New tender for Mobile MRI – new contract & increase of capacity from 7 days to 14 days; purchase van allowing increase in capacity to 4 week
  - Long term: build and installation of MRI3/4
- Endoscopy
  - Short term: weekend lists running on site at MFT
  - Medium term: new contract for WATC
  - Long term: Build extension to Endoscopy unit at MFT, create 2 new room & repatriate activity

Responsive – RTT Performance Spotlight Report

Commentary	Risks & Mitigating Actions
52 week performance is reporting well vs overall trajectory. All 52 week breaches have had a clinical review and no harm reported.	Continue to monitor weekly.

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	0	2	12	11	12	9	13	20	27	37	8	5

UCL — Median — LCL   O Alarm

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	81.68	82.52	82.55	81.77	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27

UCL — Median — LCL
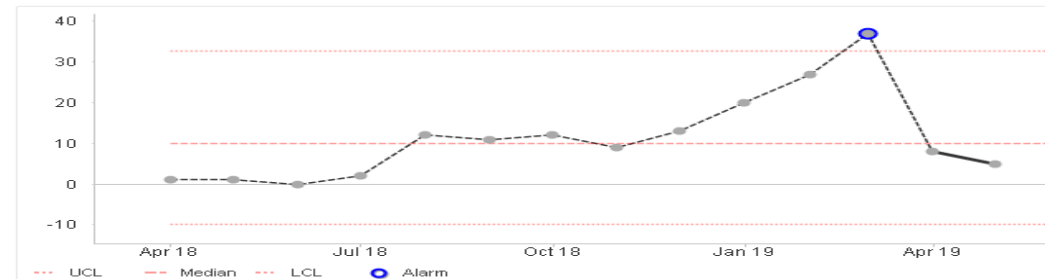
>52 Weeks Breaches Definition:

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

Responsive – Cancer & Complaints

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Cancer Access	Cancer 2ww Performance	93.0	%	92.76	90.44	72.61	65.19	68.13	73.11	88.35	72.87	73.01	61.66	83.39	-	76.05	
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	80	98.46	88.89	90.74	75.76	72	44.3	7.61	6.33	41.51	70.67	-	56.3	
	Cancer 31 Day First Treatment Performance	96.0	%	97.84	98.66	96.6	100	94.77	96.62	95.51	89.31	87.5	95.45	94.62	-	95.15	
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	95	96.43	100	95.24	92.59	89.66	89.47	75.76	75	73.91	82.61	-	87.6	
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	100	100	100	100	93.94	100	100	100	100	100	-	99.21	
	Cancer 62 Day Treatment - GP Refs	85.0	%	90.64	85.19	79.17	80.47	83.85	81.7	83.64	79.75	67.42	75	76.69	-	80.8	
	Cancer 62 Day Treatment - Screening Refs	90.0	%	94.44	86.21	81.13	89.13	83.33	63.41	71.79	51.52	42.86	92.31	94.59	-	77.84	
	Cancer 62 Day Treatment - Cons Upgrades	-	%	91.89	76.67	78.38	79.31	74.19	90.63	81.82	67.65	84.38	80.77	73.33	-	80.31	
	Cancer 62 Day Backlog Performance	0.0	#	18	20	24	22	24	21	21	20	26	21	23	-		
	104 Day Cancer Waits	0.0	#	2	5	7	4	4	3	6	3	5	9	5	-	53	
Complaints Management	Number of Complaints	45.0	#	75	62	64	51	65	57	64	67	69	71	57	81	783	
	Number of Complaints Returners	-	#	2	5	3	0	6	5	3	3	1	1	4	0	33	
	% Complaints Responded to Within 30 Days	85.0	%	51.61	64.18	50.88	75.51	87.18	68.89	84.48	94.83	98.08	65.52	56.86	71.19	71.76	

Responsive – Cancer & Complaints Commentary:

- 2WW performance has improved from previous month, but falls below national standards.
- The breast position has significantly improved from earlier this calendar year.
- 62 day performance has been affected by specific tumour groups in particular Breast and Lower GI. The Trust has also seen an increase in patients being referred into MFT from other Trusts which the teams are reviewing.

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

Responsive – 2 Week Wait Performance Spotlight Report

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Cancer Access	Cancer 2ww Performance	93.0	%	92.76	90.44	72.61	65.19	68.13	73.11	88.35	72.87	73.01	61.66	83.39
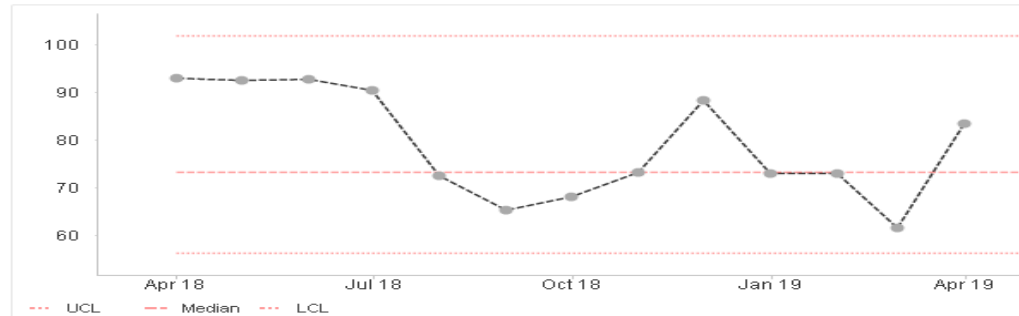
Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Cancer Access	Cancer 2ww Performance - Breast Symptomatic	93.0	%	80	98.46	88.89	90.74	75.76	72	44.3	7.61	6.33	41.51	70.67
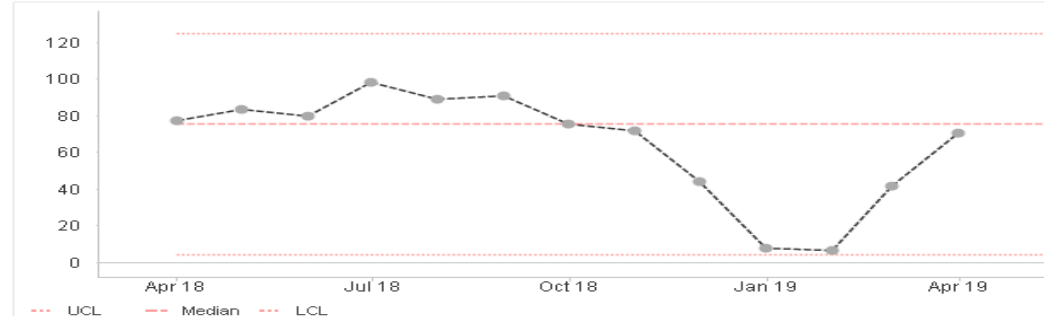
2 Week Wait Definition:
The percent of patients seen by a specialist within 14 days of an urgent GP referral for suspected cancer.

Commentary	Risks & Mitigating Actions
The Trusts 2ww position has improved for the month of April. Breast has improved significantly and offer a first appointment within 8-10 days. There are concerns in lower GI performance mainly due to Endoscopy availability.	Full action plans in place.

Responsive – 62 Day Wait GP Performance Spotlight Report

Commentary	Risks & Mitigating Actions
Although the 62 day position has improved on last months performance the Trust has failed to hit the standard.	Full action plans in place.

Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	90.64	85.19	79.17	80.47	83.85	81.7	83.64	79.75	67.42	75	76.69
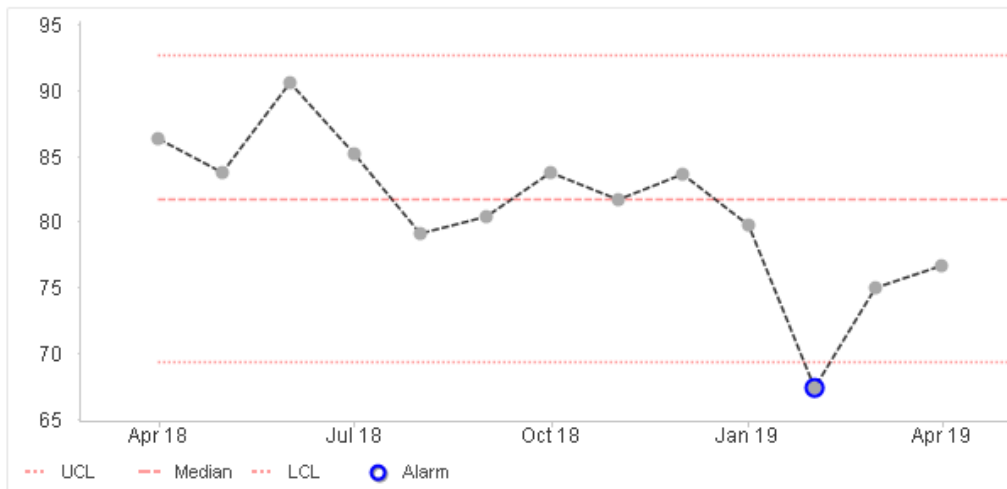
62 Day Wait GP Definition:

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

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Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	YTD	Trend
Financial Position	Variance from Plan	0.0	%	-	-	-	-	-	-	-	-	-	-	-	-		
	Liquidity Ratio (In Days)	-	#	-	-	-	-	-	-	-	-	-	-	-	-		
	Cash Actual	1,400,000.0	#	-	-	-	7400000	4400000	8600000	13700000	-	-	-	-	-		
	Overall Underlying Financial Surplus / Deficit	0.0	#	-	-	-	25.6	30	33	36.2	-	-	-	-	-		
	Capital Spend Vs Plan	95.0	%	-	-	-	-	-	-	-	-	-	-	-	-		
	Underlying Performance	0.0	#	-	-	-	-	-	-	-	-	-	-	-	-		
	Cost Improvement Plans (CIPS) - Var to Plan YTD	0.0	#	-	-	-	-	-	-	-	-	-	-	-	-		
Staff Experience	Staff Friends & Family - Recommend Place to Work	62.0	%	51.05	43.2	43.2	43.2	-	-	-	49.34	49.34	49.34	-	-	47.7	
	Staff Friends & Family - Recommend Care of Treatment	79.0	%	71.14	65.22	65.22	65.22	-	-	-	67.93	67.93	67.93	-	-	67.47	
Workforce	Appraisal % (Current Reporting Month)	85.0	%	82.12	82.19	81.47	80.01	81.01	81.3	81.3	82.8	83.2	84.43	88.66	90.59	83.19	
	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.07	4.06	3.96	4	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32	4.18	
	Short Term Sickness Rate (Current Reporting Month, FTE%)	3.0	%	2.03	2.02	1.97	1.98	2	2	1.97	1.96	1.98	1.93	1.93	1.93	1.97	
	Long Term Sickness Rate(Current Reporting Month, FTE%)	1.0	%	2.03	2.03	1.99	2.02	2.15	2.74	2.28	2.28	2.26	2.32	2.37	2.4	2.24	
	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	8.0	%	11.81	11.98	11.77	10.47	12.05	12.35	12.02	12.34	12.21	12.52	11.73	12.36	11.96	
	Contractual Staff in Post (FTE) (Current Reporting Month)	-	#	3819	3780	3761	3766	3595	3779	3768	3765	3798	3786	3681	3701		
	StatMan Compliance (Current Reporting Month)	85.0	%	87.17	86.65	-	-	-	74.3	76.88	77.75	81.32	82.55	83.96	85.81	82.05	
	Agency Spend as % Paybill (Current Reporting Month)	-	%	5.91	5	4.66	5.74	5.11	5.01	5.61	3.69	3.69	4.06	4	2.82	4.61	
	Agency Spend as % Paybill (Financial Year YTD)	-	%	6.08	5.05	4.78	4.46	4.52	4.04	4.63	5.68	5.5	5.37	5.29	5.11	5.04	
	Bank Spend as % Paybill (Current Reporting Month)	-	%	11.42	16.26	8.4	13.22	12.44	12.4	11.86	12.77	12.77	10.93	13.26	12.13	12.32	
	Bank Spend as % Paybill (Financial Year YTD)	-	%	11.66	16.43	8.45	13.19	12.57	12.4	12.34	11.95	12.03	12.15	12.88	12.54	12.38	
	Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	-	%	74	76	73	73	76	79	79	74	78	79	79	76	76.33	

Well-led:

Appraisal completion rate, at 90.59%, is up (1.93%) compared to April and is remains above the Trust's target (85%).
Overall Sickness absence rate at 4.32% has increased (0.2%) and is above the tolerance level of 4%. Short term sickness absence at 1.93% and Long term sickness absence, at 2.4%, remain static. The ratios of long-term sickness to short-term sickness remain broadly even.
Voluntary Turnover at 12.36% has increased (0.63%) compared to April and remains above the tolerance level of 8%.
StatMan compliance at 85.81% has increased and increased and now sits above the Trust's target of 85%
YTD Agency spend (as a percentage of pay bill) is 5%. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.
YTD Bank spend (as a percentage of pay bill) is 12.3%. Total YTD temporary spend sits at 17.72% which is above the Trust's target of 11.00%
Temporary staffing fill rate for Nurse and Midwifery at 79.00 remains static and is above YTD Average.

Well Led – Total Sickness Rate Spotlight Report

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Domain	KPI Name	Target		Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Workforce	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.07	4.06	3.96	4	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32

UCL ⋯⋯ — Median — ⋯ LCL

Commentary	Risks & Mitigating Actions
Overall Sickness absence rate at 4.32% remains static but remains above the Trust's tolerance level of 4%. Short term sickness absence remains at 1.93% whilst long term absence also remains static at 2.4%. The ratios of long-term sickness to short-term sickness remain broadly even.	Risks: Possibility of increased use of temporary staffing to backfill Possibility of impact on patient experience and care due to lack of continuity in care Mitigations: The Employee Relations team continue to focus on supporting the timely management of sickness absence cases across the organisation. Use of the reports from Healthroster platform that identify colleagues who have hit the trigger. Encouraging staff to take up flu vaccine especially at this time.

Sickness Rate Definition:

The *absence rate* is the *ratio* of workers with absences to total full-time wage and salary employment.

Safe Staffing

WARD	Day		Night		CHPDD
	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Overall
Arethusa Ward	82%	94%	100%	104%	6.61
Bronte Ward	99%	85%	99%	102%	7.66
Byron Ward	64%	129%	97%	129%	6.35
CCU	75%	61%	100%		14.68
Delivery Suite	100%	99%	100%	100%	25.15
Dickens Ward	26%	37%	61%	58%	7.88
Dolphin (Paeds)	93%	79%	108%	93%	12.84
ED Majors					
Harvey Ward	79%	90%	116%	77%	6.72
ICU	77%			80%	26.36
Keats Ward	72%	128%	108%	130%	6.71
Kent Ward	99%	100%	94%	98%	11.31
Kingfisher SAU	88%	111%	94%	126%	18.43
Lawrence Ward	89%	99%	96%	96%	7.95
Lister Assessment Unit	76%	85%	96%	77%	7.31
McCulloch Ward	76%	139%	99%	183%	7.22
Medical HDU	86%	100%	94%		18.31
Milton Ward	66%	116%	97%	157%	7.01
Nelson Ward	77%	94%	100%	104%	5.76
NICU	91%	67%	91%	25%	11.85
Ocelot Ward	94%	48%	101%	106%	7.01
Pearl Ward	100%	100%	101%	100%	8.07
Pembroke Ward	87%	161%	97%	202%	7.93
Phoenix Ward	85%	90%	95%	101%	5.90
Physiotherapy					
Sapphire Ward	88%	112%	97%	119%	5.90
SDCC	66%	76%	134%	127%	11.10
Surgical HDU	94%	89%	96%		15.55
Tennyson Ward	80%	111%	98%	125%	5.93
The Birth Place	100%	100%	100%	99%	22.65
Victory Ward	77%	82%	75%	94%	9.02
Wakeley Ward	81%	95%	100%	101%	6.12
Will Adams Ward	81%	112%	103%	144%	6.71
Trust total	**82.2%**	**97.8%**	**96.1%**	**113.6%**	8.58

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Assurance Report from Committees

Title of Committee:	Quality Assurance Committee	Agenda Item	5.2
Committee Chair:	Jon Billings, Non-Executive Director		
Date of Meeting:	Friday, 24 May 2019		
Lead Director:	Karen Rule, Director of Nursing		
Report Author:	Karen Rule, Director of Nursing		

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

Key headlines and assurance level	
Key headline	**Assurance Level** (use appropriate colour code as above)
1. Quality Dashboard Report The Committee discussed the progress report and data from April 2019: a) *Constitutional targets*: How it impacts on quality will be covered in the Directorate reports. b) *Falls*: Sustained the reduction in falls in April 2019 and the report now presents an improving performance since January 2019. c) *Low Harm Pressure Injuries*: there has been a reduction. d) *Never Events*: there were two reported in May 2019 – very unusual cases involving retained foreign objects. The committee received a detailed update and had assurance that the issues had been handled appropriately. e) *Mixed Sex Accommodation*: there has been a step change in	**White**

Key issues report to the Board

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engagement with non-clinical staff and operational team members; although it is still early days there is an improvement in this area. The positive change has been in cultural behaviour. There will be a critical care lead put in place to support further work to reduce breaches due to delayed 'step down' of care. This will be discussed further at the Clinical Council in June 2019. Benn Best confirmed there is a report which will be submitted to Executive Team and Clinical Council. Flow is a key part of quality, work is happening with the support of the Transformation Team. f) *Complaints*: there has been a small increase in complaint returners, which means that patients are not satisfied with the response they received. There has been a disappointing reduction in complaints being responded to within 30 days. g) *Safe staffing*: the fill rate and ward names will be added to this report. h) *VTE*: this is significantly improving, nearly 95% in April 2019. i) *Fractured NOF within 36 Hours*: two better months improved performance in February and March 2019. j) *Stroke*: this remains a challenge; data entry and flow are still the issues to be addressed. There has also been an impact on performance due to the senior staff retirement in April 2019. Finding a replacement has been made difficult by uncertainty over the future service.	
2. Mortality and Morbidity Report The Committee noted the updated report and commended David Sulch and team on the work that went into the HSMR report and the efforts to reduce the reported HSMR. The committee noted engagement with the mortality meetings process has improved but this remains an area of focus.	**Green**
3. Safeguarding Assurance Group (SAG) The Committee agreed the Non-Executive Director Lead for Safeguarding can be the chair of QAC. Going forward it will be a collective assurance from the Executive Team to the Quality Assurance Committee, then assurance can be given from the Committee to the Trust Board.	**Green**
4. Annual Research and Innovation Report The Committee reviewed and approved the report subject to a number of caveats prior to it being submitted to the Trust Board. The report has also been considered by the Research and Innovation Governance Group (RIGG).	**Green**
5. Quality Governance Audit Recommendations and Trust Response The Committee was asked to note the outcome of the audit and the Trust's responses to the recommendations. Assurance is rated at amber/green pending implementation of the recommendations.	**Amber/Green**
6. Quality Improvement – CQUINS CQUIN: The Committee was given an update on the CQUIN Achievement for 2018/19. 2018/19 CQUINS are being closed and currently 2019/20 are being opened. There are named leads in place for delivering these. Quality Improvement Plan 2019/20:	**White**

The Committee was given an update on the progress of the Trust's Quality Improvement Plan for 2019/20.

Duty of Candour Review 2017/18:

The Committee noted that Duty of Candour is a legal requirement. Across both Directorates there should be 100% compliance. It is moving in the right direction but work needs to be done to move up to the next level.

Decisions made

1) Approved the Annual Research and Innovation Report

2) Accepted that the chair of QAC could be named as the NED Safeguarding lead with Committee support on future assurances to the Trust Board.

Further Risks Identified

All risks are captured within the risk register and the BAF.

Escalations to the Board or other Committee

None

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Learning from Deaths	Agenda Item	5.3
Lead Director	Dr David Sulch, Medical Director		
Report Author	Hayley Usmar, Mortality and Effectiveness Manager Denise Thompson, Head of Clinical Effectiveness		
Executive Summary	This report provides assurance that Medway NHS Foundation Trust has a robust process in place for reporting, reviewing and learning from deaths. 1412 patients died in the Trust between 01 April 2018 and 31 March 2019. The care of 336 patients who died was reviewed using Structured Judgement Review methodology. Outlier groups highlighted through the Hospital Standardised Mortality Ratio have been reviewed and investigated. Pneumonia is an ongoing area of quality improvement work driven by the Respiratory Team. Whilst Other Perinatal Conditions has flagged as an outlier, investigation has shown that this is not an area for concern, as outlined in section 6.1 of the report. External metrics of mortality performance have identified that the Trust was within the expected range for the reporting period.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐	
	Finance: We will deliver financial sustainability and create value in all we do	☐	
	People: We will enable our people to give their best and achieve their best	☐	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐	
	High Quality Care: We will consistently provide high quality care	☒	
Committees or Groups at which the paper has been submitted	Mortality and Morbidity Group		
Resource Implications	Not Applicable		
Legal Implications/Regulatory Requirements	Failure to comply with national reporting requirements could result in regulatory action or a prosecution under the Care Quality Commission (Registration) Regulations 2009.		
Quality Impact Assessment	Not Applicable		

Recommendation/ Actions required	The Board is asked to review and note the Trust's progress regarding mortality and morbidity review and monitoring.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	N/A			

Learning from Deaths

Best of care
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1 Executive Overview

1.1 This report represents a summary of mortality metrics and mortality review activity between 01 April 2018 and 31 March 2019.

1.2 1412 patients died in the Trust during this period. Nine of these patients had learning disabilities and have been referred to the Learning Disabilities Mortality Review programme (LeDeR).

1.3 24% of patients who died in 2018/19 were subject to a Structured Judgement Mortality Review; nine reviewers indicated that the patient was more likely than not to have died due to problems in care. Following a review of the individual cases, only three patients had an overall care score of poor or very poor.

1.4 The Hospital Standardised Mortality Ratio (HSMR) for April 2018 to March 2019 was published on Thursday 20 June 2019. The Trust's HSMR for this period is 104.6; this is within the expected range.

1.5 The Summary Hospital-level Mortality Indicator (SHMI) for the period January to December 2018 was published on 16 May 2019. The Trust's SHMI for this period was 1.09, which is within the expected range. This metric includes deaths in hospital and those which occurred within 30 days of discharge from hospital.

2 Introduction

2.1 In March 2017, the National Quality Board published the National Guidance on Learning from Deaths. This document builds on the recommendations of the Care Quality Commission's (CQC) Learning, Candour and Accountability, published in December 2016, and provides guidance on how organisations should monitor, review, respond to and report death with a view to providing a more standardised approach across the NHS. The guidance aims to improve the quality of investigations and embed learning more effectively.

2.2 A key requirement of the Learning from Death framework is for Trusts to present mortality information at the Trust's Public Board meeting on a quarterly basis. This report outlines the Trust's position up to Quarter 4 of 2018/19.

2.3 In addition to local mortality monitoring and review, Medway NHS Foundation Trust reports two national mortality indicators: the Standardised Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). These indicators are risk-adjusted and provide a way to compare performance at different Trust's across the UK. As with all statistical indicators, they are not perfect, but do provide a measure of safe, high-quality care and a warning sign that things are going wrong.

3 Standardised Hospital-level Mortality Indicator (SHMI)

3.1 The SHMI is published quarterly, five months in arrears. This indicator was last published on 16 May 2019 with data from the period January – December 2018. The SHMI includes both patients who die in-hospital and those who die within 30 days of discharge. The benchmark is 1.00 – this would indicate that the same number of patients died as were expected to die – but to facilitate interpretation, NHS Digital places performance into bands: higher than expected, as expected and lower than expected.

3.2 The Trust's SHMI for the period January – December 2018 is 1.09. Since September 2016, Medway NHS Foundation Trust has been within the expected range for SHMI, as indicated in the table overleaf.

12 months to:	SHMI	Crude rate (%)	Observed		Expected	Trend
			in hospital	post discharge		
Mar-16	1.13	3.45	1960		1727.22	
Jun-16	1.1	3.42	1924		1746.85	
Sep-16	1.09	3.33	1892		1741.15	
Dec-16	1.09	3.44	1920		1759.24	
Mar-17	1.06	3.47	1885		1774.84	
Jun-17	1.07	3.48	1901		1775.33	
Sep-17	1.03	3.37	1867		1806.28	
Dec-17	1.03	3.33	1359	538	1846.89	
Mar-18	1.07	3.52	1445	583	1899.58	
Jun-18	1.06	3.53	1429	606	1915.54	
Sep-18	1.1	3.75	1445	636	1888.11	
Dec-18	1.09	3.5	1349	627	1814.04	

4   HSMR

4.1   The HSMR is published monthly, three months in arrears. This indicator was last published on 20 June 2019 with data from the period February 2018 – March 2019. The HSMR includes only in-hospital mortality. A benchmark of 100 indicates that the same number of patients died as were expected to die; the HSMR is also categorised in three bands: as expected, low and high.

4.2   The Trust's HSMR for the period April 2018 to March 2019 is 104.6.

4.3   The Trust's HSMR has been reported as high for most of 2018/19. Following extensive investigation and discussion with various stakeholders, it has been identified that two non-clinical factors have contributed to this elevation in HSMR: until February 2019, the HSMR for Medway NHS Foundation Trust included deaths in community care settings. In addition to this, the Trust has seen a gradual increase in the utilisation of the End of Life Care team, who provide advice and support for patients at the end of their lives who may not require input from a specialist palliative care team. Palliative care is one indicator of an increased mortality risk, and as the End of Life Care team saw increasing numbers of patients, the Trust's level of palliative care coding decreased, resulting in an increased HSMR. After discussion with NHS Improvement, NHS England and the CCG, the Trust began coding contact with the End of Life Care Team using the palliative care code in February 2019. The full impact of palliative care coding will not be seen until February 2020, when a full year's worth of data has been submitted; however, the table overleaf indicates that addressing these issues has resulted in the Trust's HSMR returning to the expected level.

Learning from Deaths

12 months to:	HSMR	Crude rate (%)	Observed	Expected	Trend
Apr 18	113.2	4.6	1328	1173.1	
May 18	112.5	4.1	1320	1173.5	
Jun 18	111.5	4.5	1311	1175.6	
Jul 18	113.9	4.6	1339	1175.9	
Aug 18	114.5	4.6	1333	1164.2	
Sep 18	116.3	4.7	1343	1155.1	
Oct 18	113.4	4.5	1302	1148.0	
Nov 18	111.5	4.4	1260	1130.0	
Dec 18	110.0	4.2	1209	1098.6	
Jan 19	107.5	4.0	1147	1067.1	
Feb 19	103.9	3.9	1128	1085.6	
Mar 19	104.6	4.0	1139	1088.7	

5   Outlier Groups: Pneumonia

5.1   The Trust has been an outlier for pneumonia for 12 consecutive months with an HSMR of 114.7 for the period April 2018 – March 2019. 254 patients admitted with a diagnosis of pneumonia died in 2018/19 (9 of these patients died following transfer to another provider).

5.2   An initial investigation of 15 patients with a low risk of dying as calculated for the HSMR revealed no obvious issues with the care of these patients.

5.3   In addition to mortality reviews, the Trust has also participated in the British Thoracic Society's Community Acquired Pneumonia national audit, which looks at care processes specific to the diagnosis and treatment of pneumonia. The national results of this audit are not yet available, but analysis of local data will be undertaken to provide insight whilst the national report is pending.

5.4   In view of the persistent elevation in HSMR for this diagnosis group, the Medical Director is personally reviewing the care of all patients who had pneumonia listed in Part I of the Medical Certificate of Cause of Death in the period April – May 2019.
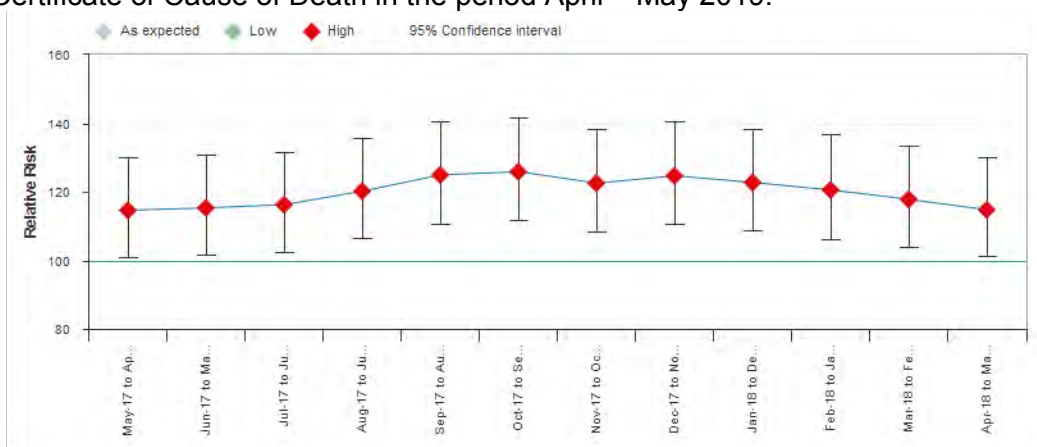
Figure 1: Pneumonia HSMR trend - 2018/19

5.5   It should be noted that the SHMI for Pneumonia remains in the As Expected band at 1.08.

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Learning from Deaths

6 Outlier Groups: Other perinatal conditions

6.1 The Trust has been an HSMR outlier for other perinatal conditions since August 2018, with an HSMR of 200.4 for the period April 2018 – March 2019. This diagnosis group includes stillbirths and early neonatal deaths; following discussion with Dr Foster, who provide the HSMR data, the Trust has identified that the elevated HSMR relates to a spike in observed deaths in this group in July 2018, when 4 deaths were recorded. Reviewing the last three years of data, the Trust has averaged between 0 and 2 deaths per month in this diagnosis group. Following discussion with the bereavement midwife, it was identified that these babies were not expected to survive after birth, and as the spike in deaths was an isolated anomaly, the Trust has been advised that the outlier status should not be a cause for concern at this time. It is anticipated that this diagnosis group will return to 'as expected' when the data for July 2019 is published.
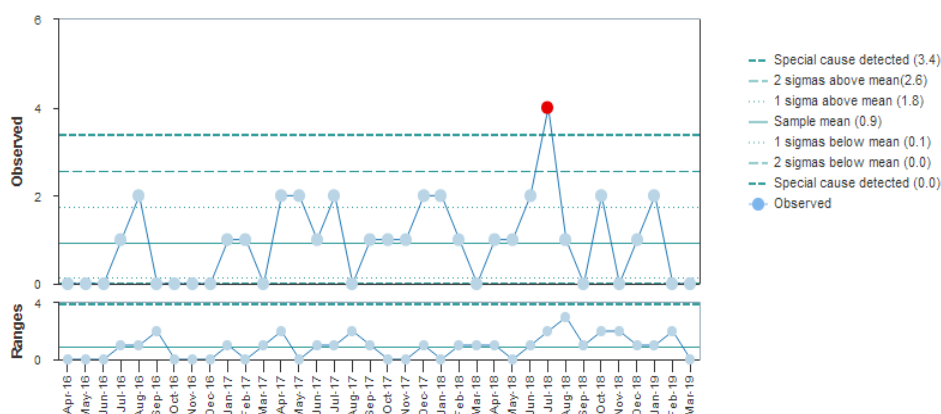
Figure 2: Other Perinatal Conditions - Observed Deaths since April 2016

7 Outlier Groups: SHMI

7.1 The Trust is not currently an outlier for any of the 10 diagnosis groups where a SHMI value is calculated.

8 Learning from Deaths

8.1. In line with the National Guidance for Learning from Deaths, all inpatient death and emergency department deaths in 2018/19 were screened against the following criteria:

- Was the case discussed with or reported to the coroner?
- Did the family/carers express any concerns about the patient's care?
- Were any concerns raised by members of staff?
- Did the patient have a learning disability?
- Did the patient have a severe mental illness?
- Did the patient die in an area where deaths are not expected (for example, day surgery)
- Did the cause of death in part I of the death certificate relate to a current Dr Foster alarm, red flag area, CQC / regulator concern or relate to an area where quality improvement work is being undertaken?
- Have any safeguarding concerns been raised?
- Is there any other reason why a mortality review should be undertaken?

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Learning from Deaths

If any of these criteria were met, a Structured Judgement Review was requested; this is a mortality review following a methodology developed by the Royal College of Physicians, where phases of care are reviewed, commentary is provided and a score out of 5 is awarded.

8.2. 1412 patients died in the Trust between April 2018 and March 2019. 9 of these patients had learning disabilities and have been referred to the Learning Disabilities Mortality Review programme (LeDeR).

8.3. 336 (24%) deaths were subject to a case record review. In 9 cases, the reviewing clinician indicated that the failings in care led to the patient's death; however, on review of these patients, 6 had an overall care score indicative of adequate, good or very good care. The wording of the question: "In your opinion, was the death more likely than not to have been due to problems in the care provided to the patient?" may have contributed to some confusion; from April 2019 this question has been revised and is now simplified to "In your opinion, did the patient die as a result of failings in care?".

8.4. Key themes identified during Quarter 4 included failure to initiate End of Life Care Pathways, issues with poor documentation and failure to complete Do Not Attempt Cardiopulmonary Resuscitation and Treatment Escalation Plans. All of these issues had already been identified by the Trust and are subject to individual quality improvement projects outside of the Mortality process.

Total number of deaths, deaths reviewed and deaths deemed avoidable (does not include patients with identified learning disabilities)			
2018/19	Total number of deaths	Total number of deaths reviewed	Total number of deaths judged more likely than not to be due to problems in care
Apr	114	52	0
May	113	53	2
Jun	105	49	0
Total Q1	332	154	2
Jul	118	32	2
Aug	107	26	1
Sep	104	42	1
Total Q2	329	100	4
Oct	94	17	0
Nov	108	21	2
Dec	118	17	0
Total Q3	320	55	2
Jan	152	8	0
Feb	118	8	1
Mar	148	6	0
Total Q4	418	22	1
TOTAL	1399	331	9

Learning from Deaths
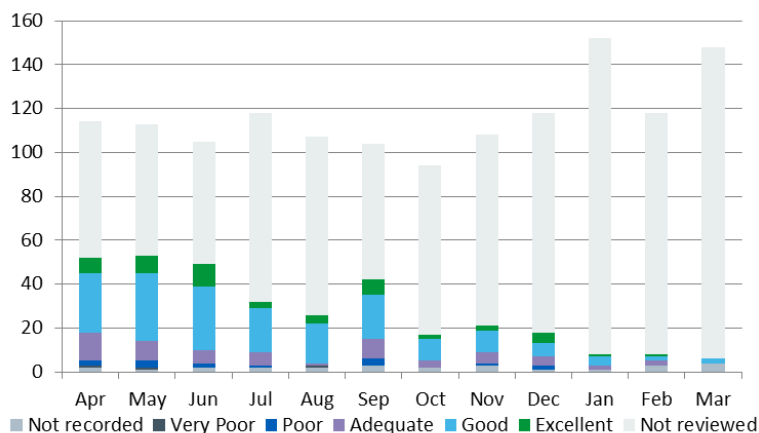
Figure 3: Patients whose care has been reviewed and the overall care score received.

Total number of deaths, deaths reviewed and deaths deemed avoidable for patients with identified learning disabilities			
2018/19	Total number of deaths	Total number of deaths reviewed	Total number of deaths judged more likely than not to be due to problems in care
Apr	0	0	0
May	0	0	0
Jun	0	0	0
Total Q1	0	0	0
Jul	1	1	0
Aug	0	0	0
Sep	0	0	0
Total Q2	1	1	0
Oct	1	0	0
Nov	2	1	0
Dec	2	1	0
Total Q3	5	2	0
Jan	0	0	0
Feb	1	0	0
Mar	2	1	0
Total Q4	3	0	0
TOTAL	9	3	0

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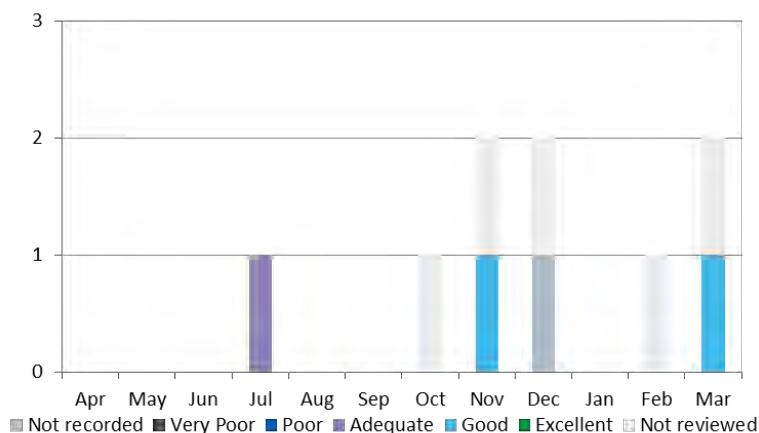
Figure 4: Patients with learning disabilities whose care has been reviewed using the local methodology and the overall care score received.

9   Conclusion

9.1.   The Trust's mortality for the 2018/19 financial year has been within the 'as expected' band according to the published mortality metrics (HSMR and SHMI). During this period, two HSMR diagnosis groups have flagged as outliers: Pneumonia and Other perinatal conditions, and the Trust has investigated deaths in these groups to ascertain what can be learnt about care of patients in these cohorts.

9.2.   Of the 1412 patients that died in 2018/19, 24% have been subject to a Structured Judgement Mortality Review. The care of 3 patients is felt to have been more likely than not to cause to their deaths, but the vast majority of patients experienced good or excellent care in their final admission.

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Learning from Deaths

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Finance Report May 2019	**Agenda Item**	6.1
Lead Director	Ian O'Connor, Director of Finance		
Report Author	Yasmin Ahmed, Deputy Director of Finance		
Executive Summary	This paper reports the May 2019 financial position for the Trust and delivery against financial targets.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐	
	Finance: We will deliver financial sustainability and create value in all we do	☒	
	People: We will enable our people to give their best and achieve their best	☐	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐	
	High Quality Care: We will consistently provide high quality care	☐	
Committees or Groups at which the paper has been submitted	Finance Committee 18th June 2019		
Resource Implications	Not Applicable.		
Legal Implications/ Regulatory Requirements	Month 2 year to date favourable to NHS Improvement control total by £970k.		
Quality Impact Assessment	Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established Quality Impact Assessment Framework.		
Recommendation/ Actions required	The Board is asked to note the financial position as at 31st May 2019 is a £970k favourable variance reported against the financial plan that adjusts to a £200k adverse variance when compared to the improvements expected against the current cost improvement plan.		

Approval	**Assurance**	**Discussion**	**Noting**
☐	☐	☐	☒

Appendices	Appendix 1: Dashboard

1   Executive Overview

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

1.2   The flash report detailing key performance indicators is attached at Appendix 1 and was circulated on 11th June. It sets out a series of individual metrics designed to show progress over time and assess the risks associated with operational performance and the impact on the Trust's financial position.

2   Income and Expenditure

2.1   To the end of May the Trust is reporting a year to date deficit of £8.3 million (excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). Operationally this is adverse to the current operational plan by £200k as shown in Table 1. Against the declared plan with NHSI the Trust is £970k ahead of plan. This will merge with the operational plan over the course of the year. The deficit arises as a result of non-delivery of baseline budgets with the cost improvement plan over-performing against the updated plans.

2.2   May's in month performance is a deficit of £3.7 million adverse to plan by £37,000.

2.3   Overall the forecast to the end of the year remains the delivery of the £22.3 million deficit.

2.4   PSF, MRET and FRP income in May is £1.8 million in line with the plan.

Table 1	Month 2			Year to Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Clinical Income	22,627	22,225	(402)	43,861	43,244	(617)
Other Income	1,939	2,053	114	3,870	4,006	136
Pay	(17,550)	(17,624)	(74)	(35,105)	(34,728)	377
Non –pay	(9,417)	(9,187)	230	(18,244)	(18,533)	(289)
EBITDA	**(2,401)**	**(2,533)**	**(132)**	**(5,618)**	**(6,011)**	**(393)**
Non Operating Expenses	(1,285)	(1,194)	91	(2,557)	(2,372)	185
Donations Adjustment	15	19	4	30	38	8
Surplus/(Deficit) before PSF/MRET/FRF	**(3,671)**	**(3,708)**	**(37)**	**(8,145)**	**(8,345)**	**(200)**
PSF/MRET/FRP	1,839	1,839	0	3,678	3,678	0
Operational Surplus/(Deficit)	**(1,832)**	**(1,869)**	**(37)**	**(4,467)**	**(4,667)**	**(200)**
CIP Rephasing	(409)		409	(1,170)		1,170
NHSI Reported Surplus/(Deficit)	**(2,241)**	**(1,869)**	**372**	**(5,637)**	**(4,667)**	**970**

3   Cost Improvement Programme

3.1   The targeted cost improvement programme overall is reported as £2.3 million achieved, ahead of plan at the end of May by £74,000.

4   Capital

4.1   Capital expenditure in month and year to date is £0.5m which is marginally above plan. As detailed schemes are finalised it is likely that the plan will need to be reprofiled but will remain within the overall annual plan of £23.7m as agreed and submitted to NHS Improvement.

Table 7	Month 2			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Backlog Maintenance	250	252	(2)	250	252	(2)
Routine	0	9	(9)	0	9	(9)
Plant/Equip/Trans/Fits/Other	0	116	(116)	0	116	(116)
Fire Safety	0	116	(116)	0	116	(116)
IT	200	0	200	200	0	200
New Build	0	26	(26)	0	26	(26)
Original Plan Total	**450**	**519**	**(69)**	**450**	**519**	**(69)**
IT- UEC	0	0	0	0	0	0
IT - EDRMS	0	0	0	0	0	0
Pharmacy -Define	0	0	0	0	0	0
WIFI Enhancements	0	0	0	0	0	0
Total	**450**	**519**	**(69)**	**450**	**519**	**(69)**

5   Working Capital

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

6   Recommendation

6.1   The Board is asked to note the financial position as at 31st May 2019 is a £970k favourable variance reported against the financial plan that adjusts to a £200k adverse variance when compared to the improvements expected against the current cost improvement plan.

APPENDIX 1 - Dashboard

I&E Deficit Excluding PSF / MRET / FRF £m

	Feb	Mar	Apr	May	RATING
Plan	(3.4)	(3.1)	(5.3)	(4.1)	
Actual	(1.6)	(3.1)	(4.6)	(3.7)	→
Variance	1.8	0.0	0.6	0.4	

The Trust has incurred a deficit of £3.7m for Month 2, excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds. This is favourable to plan by £0.4m in month as a result of earlier delvery of the cost improvement plan than was originally anticipated.

Capital Expenditure YTD (£m)

	Feb	Mar	Apr	May	RATING
Plan	(27.4)	(31.1)	0.0	(0.5)	
Actual	(7.3)	(11.4)	0.0	(0.5)	→
Variance	20.1	19.7	0.0	(0.0)	

19/20 Capital Expenditure is currently on plan.

CIP Delivery Current Plan £m

	Feb	Mar	Apr	May	RATING
Plan	2.6	2.7	1.3	0.9	
Actual	2.4	2.2	1.1	1.1	↑
Variance	(0.2)	(0.5)	(0.2)	0.2	

CIP Delivery is £1.1m in month and £2.2m year to date which is in line with plan year to date.

Cash Actual £m

	Feb	Mar	Apr	May	RATING
Plan	6.0	6.0	5.0	5.0	
Actual	8.2	10.8	17.0	29.2	↑
Variance	2.2	4.8	12.0	24.2	

The cash balance held at 31st May 2019 was £29.2m, £24.2m higher than plan. This is due to a revised payment profile with Commissioners which will defer the need for further borrowings until later in the financial year. This will save the Trust interest expenses and forms part fo the improvement plan.

Normalised Monthly Pay £m

	Feb	Mar	Apr	May	RATING
Plan	(15.9)	(16.0)	(17.5)	(17.6)	
Actual	(17.2)	(16.9)	(17.1)	(17.6)	↓
Variance	(1.3)	(0.9)	0.4	(0.0)	

Normalised pay expenditure in month is £17.6m this is in line with plan and it includes the cost of the 2019/20 pay award.

Normalised Monthly Agency Expenditure £m

	Feb	Mar	Apr	May	RATING
Plan	0.0	0.0	(0.7)	(0.7)	
Actual	(0.6)	(0.8)	(0.7)	(0.5)	↑
Variance	(0.6)	(0.8)	0.0	0.2	

Agency Spend is £0.5m, £0.2m favourable to plan.

Better Payment Practice Code (BPPC by Volume (%)

	Feb	Mar	Apr	May	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	43.00	46.00	43.20	55.00	↑
Variance	(52.0)	(49.0)	(51.8)	(40.0)	

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

All Aged Creditors 60+ Days (£m)

	Feb	Mar	Apr	May	RATING
Actual	4.6	2.4	4.4	3.4	→

Creditors balances in excess of 60 days have now reduced to 3.4m. £1.8m NHS, £1.6m Non NHS.
Whilst this has reduced it represents 54% of all creditors and the finance team continues to work with the operational teams to reduce this value.

All Aged Debtors 60+ Days (£m)

	Jan	Feb	Mar	Apr	RATING
Actual	18.4	13.6	14.3	13.2	→

Debtor balance in excess of 60 days has reduced to £13.2. £11.5m NHS including £2.3m WK CCG, £1.9m Swale CCG, £1.6m DGS CCG and various other Debtors with balances ranging from £20 to £750k
£1.7m Non NHS(£1m Medway Community Healthcare CIC).

Key:

(red)	Adverse to Plan
(green)	Favourable to Plan

Going in the right direction ↑

Going in the wrong direction ↓

Glossary of Terms:

I&E	Income and Expenditure
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
CIP	Quality Cost Improvement Programme
YTD	Year-to-Date

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Assurance Report from Committees

Title of Committee:	Finance Committee	Agenda Item	6.2
Committee Chair:	Joanne Palmer, Senior Independent Director		
Date of Meeting:	Thursday, 23 May 2019		
Lead Director:	Ian O'Connor, Director of Finance		
Report Author:	Ian O'Connor, Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** (use appropriate colour code as above)
1. Finance Month 1 Report The Committee discussed the Month 1 figures	**Green**
2. Finance Risk Register The Committee reviewed the Finance Risk Register and noted the risks and mitigations, together with current scores. Clarification needed on approach to invoicing.	**Amber**
3. Cost Improvement Programme (CIP) The Committee received a report on the month 1 CIP position, which shows CIP have delivered £1.140million (80 schemes) against an operational CIP plan of £1.462million – adverse to plan by a total of	**Amber**

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Key issues report to the Board

£322,000. Ongoing difficulties reconciling the Aspyre schemes to the ledger to be completed for Month 2. Committee stated that the priorities for focus are: theatre closure, out patients and workforce redesign. The Committee noted the RED schemes and that it has been a challenging start. There is time to get back on track but early action is required.	
4. Capital Plan 2019/20 The Committee was assured about the level of commitment to capital expenditure by the end of Month 1. The Committee raised concern about realistic time scales and giving assurance to the Board. The Committee requested an update once all tenders were in and the following had been considered: methodology for prioritisation, linking capital plan to CIP and achievability.	**Green**
5. Project Report Plan The Committee reviewed the timetable for plans submitted to the Committee and Executive leads.	**Green**
6. Project Updates – Support Service Productivity The Committee was shown a presentation 'Administrative Efficiencies'. The Committee agreed that it is a beneficial project for the Trust, it will be difficult but success is crucial. The Committee gave the team a number of suggestions to take away, for an update at a later date in June 2019.	**Green**

Decisions made 1) To accept the action from the Integrated Audit Committee for the International Financial Reporting Standards 16 (IFRS16) escalation.
Further Risks Identified All risks are captured within the risk register and the Board Assurance Framework.
Escalations to the Board or other Committee 1) IFRS16 has been raised as an action for the Finance Committee – this was later discussed at the Finance Committee meeting on the same day, 23 May 2019.

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Communications and Engagement	**Agenda Item**	**6.3**
Lead Director	Glynis Alexander, Director of Communications and Engagement		
Report Author	Glynis Alexander, Director of Communications and Engagement		
Executive Summary	This report details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	None		
Resource Implications	None		
Legal Implications/Regulatory Requirements	None		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The board is asked to note the report.		

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	None

Communications and engagement

1   Executive Overview

1.1   This report details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.

2   Engaging colleagues

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

2.2   We have developed an overarching communications plan and supporting materials for the next phase of the BBB improvement programme.

2.3   Members of the communications team are supporting the six transformation priority programmes with dedicated communications and engagement plans.

2.4   Work continues on the visual identity for the organisation, and vinyl displays defining our values and priorities are due to be installed in the coming weeks. More than 500 staff provided a photo for the staff mosaic that will be installed at the front entrance of the hospital.

2.5   The monthly team briefings with James Devine have continued with very good attendance and engagement from staff. Discussion topics have included transformation priorities, our new clinical, quality and people strategies, operational performance, staff award winners and car parking.

2.6   We have developed the Not Just A Number campaign as a reminder to all staff to take a moment and reflect on the person behind the numbers. It's about putting empathy at the heart of our care and remembering the human stories behind statutory targets. This campaign has been well received by staff, regulators and more widely on social media.

2.7   The 'Making a Difference' campaign, which offers staff the opportunity to 'bid' for funding to make small improvements to their working lives, has proved popular. There has been an excellent response from staff across the organisation and the requested items are beginning to be delivered to work areas.

2.8   The Best of People awards was a very successful event, showcasing the best of Medway, generating a positive atmosphere for staff and being celebrated outside the hospital.

2.9   We have continued to work with teams to promote the eDRMS project which will enable clinicians to see more patient information electronically and reduce paperwork.

2.10   The Making Medway Brilliant Staff Conference took place, with more than 100 staff celebrating achievements at the Trust, and looking to future priorities. Ninety-three per cent of staff rated the event as excellent, very good or good.

3   Media

3.1   Over the past two months the communications team has dealt with more than 20 interactions with local, regional and national media. These include reactive responses to media queries and proactive approaches by the team to promote good news stories.

3.2   Positive news included good coverage on James' appointment as Chief Executive and his recent award at the Healthcare People Management Association Awards, and reporting on work done by the research and innovation team. The Medway Messenger ran an eye-catching centre page spread on the Trust's Best of People Awards, and on our volunteers during Volunteers Week, as well as wide coverage on upcoming Trust fundraising events.

3.3   On a less positive note, local media have covered ongoing issues with the dermatology service after new providers took over the service.

3.4   In other news, there has been press coverage about the closure of the Balmoral GP walk-in centre in Gillingham and local Clinical Commissioning Group's public engagement about outpatients services. We have also responded to queries on nationally released data about causes of death at the hospital, smoking on site and car parking.

4   Social Media

4.1   Since the last update, Medway has continued to grow its following across all social media channels and has maintained its position as Kent's most-followed acute Trust on both Twitter and Instagram. The Trust's Twitter account is also closing in on the milestone 5,000 follower mark.

4.2   A range of key messages were shared widely across social media in this period, including James Devine's appointment as permanent Chief Executive; promotion of the Trust's superhero run and other charity events; and our #NotJustANumber campaign, which also received very good traction at national level.

4.3   Our regular, high-quality content received a sustained number of overall views throughout May and June – approximately 150,000 on Facebook and 185,200 on Twitter. This compared to 286,000 on Facebook (boosted by the knitted blankets campaign) and 67,100 on Twitter reported at the last update for March and April.

4.4   Medway's social media account followers now total 4,935 on Twitter (up from 4,732 at the last update), 6,957 on Facebook (up from 6,798) and 1,532 on Instagram (up from 1,363).

4.5   Some of our other most popular posts related to our awareness raising events – particularly Volunteers' Week 2019 – the opening of our Dementia Therapy Garden, our inaugural Making Medway Brilliant staff conference, national award nominations for our staff, and 'Best of People' annual staff awards ceremony.

5   Community engagement

5.1   Governors

5.1.1   In April 2019 we supported governors to engage with patient and the public at Sheppey Community Hospital.

5.1.2   Concerns focused on the challenges people experienced in accessing services for investigation and diagnosis, including booking appointments.

5.1.3 In May governors met members of the community in the Pentagon Shopping Centre. Concerns raised again centred on delays to accessing health care services across the board, with frustrations expressed about primary care.

5.1.4 Our Community Engagement Officer and Governor Lyn Gallimore were able to promote the Trust with interviews on Sheppey Community Radio.

5.1.5 They were able to speak about the governor role and encourage people to stand for governor in the current elections.

5.2 Since our last report we have also focused on engaging with older members of our population

5.2.1 Our May member event looked at Integrated Care for Older People. In response to Member feedback, this event was held during the daytime in Sittingbourne.

5.2.2 Attendees heard from staff from our Frailty team and members were able to gain a better understanding of the care provided for this group of patients.

5.2.3 The Frailty team also gave a presentation and met with Medway Pensioners Forum. Members said they found the session informative and had a better understanding of how the service is improving at the hospital.

5.2.4 The Trust held an engagement stand at MP Tracey Crouch's Pensioners' Fair when members of the public were able to ask questions and provide feedback on their experiences of the hospital.

5.2.5 Accessing healthcare services – in the community and through the hospital – is a common theme that continues to emerge through our engagement channels. We are addressing this through our improvement programmes internally, and also feeding into patient experience discussions with commissioners.

5.3 Other engagement

5.3.1 We continue to support Medway Clinical Commissioning Group to engage with patients and public at service redesign events.

5.3.2 Our Community Engagement Officer worked with our staff to ensure there was good representation from patients, families and their carers and encouraged them to be involved in the Respiratory, Urology and Cardiology outpatient services workshops.

5.3.3 In April we supported Dr Gill Fargher, Chair of the Trust's Organ Donation Committee to given a presentation to the Bengali Community. The event was well attended and attendees said they recognised the importance of becoming an organ donor.

5.3.4 Community members spoke about the barriers and fears that prevented them from registering for donation.

5.3.5 We met with staff at Sheppey Vocational College and plan to support their 'aspire' programme by inviting our clinicians to present to their students.

5.3.6 We supported our Prehab team to present their work on Diabetes to Medway Diversity Forum. Members reported that they found the presentation useful and informative and are keen for further engagement, as diabetes is prevalent among the BAME community.

5.3.7 Our Community Engagement Officer attended and met the Urology Support Group which is supported by our Urology Nurses.

5.3.8 We will be looking to see how we can increase the profile of this group so that more people can seek help and support.

Communications and engagement

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	7 Day Hospital Services Board Assurance Framework	**Agenda Item**	**6.4**
Lead Director	Dr David Sulch, Medical Director		
Report Author	Denise Thompson, Head of Clinical Effectiveness		
Executive Summary	The 7 Day Hospital Services Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.		

The 7 Day Hospital Services Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England.

This work is built on 10 clinical standards, four of which were prioritised for delivery to ensure that patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions and ongoing consultant directed review every day of the week.

Standard 2: Time to initial consultant review
Standard 5: Access to diagnostics
Standard 6: Access to consultant led interventions
Standard 8: Ongoing daily consultant-directed review

Delays in admission to hospital may actually improve compliance with Standard 2 – as many patients have their first consultant assessment prior to admission (while waiting for a bed in the emergency department). However audit demonstrates that despite this, the Trust was only compliant with the standard in 78% of a sample of 78 admissions from March 2019.

The process for obtaining cardiac pacing at the weekend is ad hoc but other consultant directed interventions are available.

There is a self-assessment for the remaining standards 1, 3, 4, 7, 9 and 10. We are fully compliant with standards 1,3, 7, 9 and 10. We are partially compliant with standard 4 regarding handover of patients, our move to electronic systems we allow us to be fully compliant.

Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐
	Finance: We will deliver financial sustainability and create value in all we do	☐
	People: We will enable our people to give their best and achieve their best	☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐
	High Quality Care: We will consistently provide high quality care	☒

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Committees or Groups at which the paper has been submitted	Executive Group
Resource Implications	As detailed within the report.
Legal Implications/Regulatory Requirements	Seven Day Service standards are regulated by NHS Improvement and form part of the Care Quality Commission assessment.
Quality Impact Assessment	The premise of 7 Day Hospital Services is to provide equitable healthcare access seven days a week to reduce variation
Recommendation/ Actions required	Note progress to date with implementing the Seven Day Service self-assessment framework and associated actions. Confirm support to receive bi-annual assurance reports against 7DS compliance.

	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒

Appendices	Appendix 1: 7 Day Hospital Services self-assessment.

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1 Executive Overview

1.1 The Seven Day Hospital Services (7DS) format of reporting on these standards has recently changed. In November 2018 NHS England (NHSE) and NHS Improvement (NHSI) released a joint briefing paper to state that between November 2018 and February 2019 they would be trialling a transition to a new board assurance framework to ensure that providers can produce a single consistent report for the dual purpose of assurance from their own boards and national reporting.

1.2 This means the autumn 2018 national 7DS survey has not taken place. Instead, all providers have been asked to complete the 7DS self-assessment template and to ask their boards to formally assure this assessment as an accurate and true reflection of delivery.

1.3 Medway NHS Foundation Trust (MFT) have not met the standard for initial consultant assessment (clinical standard 2) according to a recent audit. In the previous assessment MFT reported a 68% compliance rate. Since this assessment a variety of changes had been made to consultant working patterns both during the week and at weekends, including the extension of the medical consultant presence to 9pm and the introduction of a separate frailty take. It had been anticipated that these changes would have led to achievement of compliance with the standard. However achievement of the standard now sits at 78%. MFT reported compliance with access to consultant-directed diagnostics (clinical standard 5), and ongoing consultant-directed review (clinical standard 8). The Board Report now confirms compliance with Standard 6 (consultant directed interventions).

2 Introduction and Background

2.1 7DS is a nationally driven Quality Improvement initiative. It stems from an initial perspective that patients admitted over the weekend were at a greater risk of dying than patients admitted during the week. The evidence to support this theory is somewhat contradictory. Never the less the emphasis is now more about reducing variation in care over the seven days for better patient experience, reduced LOS (length of stay) and readmissions, and possibly improved patient outcomes such as mortality. The vehicle driving this improvement are the 7DS ten clinical standards described by Sir Bruce Keogh. Four clinical standards have been made priorities for delivery by NHSE and NHSI. The intention is to prevent variations in outcomes at the weekend with the aim that by 2020, 100% of the population will have the same access to consultant assessment and review, diagnostic tests and consultant-led intervention every day of the week. Whilst these standards refer to unplanned admissions to hospital there is an emphasis on a multi-agency response to 7DS especially with respect to standard 9.

2.2 To measure progress, NHSE and NHSI previously required Trusts to complete the 7DS Survey Tool (7DSAT) on a six monthly basis; the March / April 2018 audit was undertaken through a systematic review of the case notes. The trust is not required to produce any new audit data for the trial run of the board assurance process that was submitted February 2019.

2.3 The evidence submitted during this trial period will not be used for performance measurement. Instead NHSE/ NHSI will assess the information on delivery in the completed templates submitted to regional and national teams to ensure the new system is producing consistent measurement.

2.4   The new board assurance framework for 7DS is a self-assessment to be submitted in June 2019. Providers have been advised to use their latest data from March/April 2019 as the basis for their self-assessments.

2.5   The new self-assessment methodology does not rely solely on an audit process. Rather it encourages organisations to consider wider intelligence such as consultant job planning arrangements, patient experience data and targeted audits of performance as part of the Trust's continuous improvement activities.

2.6   In addition to the 7DS clinical standards for all emergency patients, there are five urgent network clinical services which have been given priority: hyper acute stroke, paediatric intensive care, STEMI heart attacks, major trauma and emergency vascular surgery. The Trust has reported on hyper acute stroke and Emergency Vascular Services. Other urgent networked clinical services are provided by other Trusts.

2.7   This paper summarises the self-assessment that was submitted in February 2019 with additional incorporation of an audit into Standard 2, and outlines the work undertaken at MFT in relation to 7DS and an overview from the NHSE and NHSI meeting October 2018, to enable the Trust Board to confirm their assurance of the assessment of delivery.

3   Priority 7DS clinical standards and how achievement is measured

3.1   The four priority standards ensure patients admitted in an emergency receive the same high quality care at any time of day on any day of the week by ensuring that patients have access to initial consultant assessment (clinical standard 2), access to diagnostics and interventions (clinical standards 5 and 6), and ongoing consultant-directed review (clinical standard 8).

3.2   Achievement of each standard requires meeting the level of care for at least 90% of patients admitted in an emergency. The self-assessment of achievement must be supported by local evidence, and be formally assured by the Trust Board.

3.3   An overview of the required sources of evidence for the priority clinical standards is provided below.

3.4   **Clinical standard 2**: First consultant review within 14 hours. Three sources of evidence:
   - Triangulation of consultant job plans to deliver 7DS
   - Local audits to provide evidence (case note review)
   - Reference to wider performance and experience measures.

3.5   **Clinical standard 5**: Access to consultant directed diagnostics - Assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by formal arrangement with another provider.

3.6   **Clinical standard 6**: Access to consultant-led - Assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, Interventions either on site or by a formal arrangement with another provider.

3.7   **Clinical standard 8**: Ongoing consultant-directed review. Four sources of evidence:

- Triangulation of consultant job plans to deliver 7DS
- Evidence of robust multi-disciplinary (MDT) and escalation protocols
- Local audits to provide evidence
- Reference to wider performance and experience measures

4   Medway NHS Foundation Trust Seven Day Services post-survey visit March/April 2018

4.1   The Trust had a post-survey meeting with NHSE and NHSI to discuss the results of the March/April 2018 audit results; they noted previous audits had shown that there has not been a consistent improvement in outcomes for Clinical Standard 2 and Clinical Standard 8. Clinical Standard 5 and 6 remain compliant.

4.2   For Clinical Standard 8, once daily review for weekdays is at 82% and twice daily at 100%. The Trust provides a range of consultant cover at weekends as additions to the admitting teams, including the presence of two acute physicians, a cardiologist, a respiratory physician (largely covering medical High Dependency Unit (HDU)), a gastroenterologist (largely covering endoscopy) and a discharge consultant. Not all of these sessions have been consolidated into job plans – some are being remunerated as additional sessions – but the Directorate has plans to bring this work into formal job plans before October.

4.3   Patient flow remains a significant challenge although a range of measures have been introduced to address this. These include the opening of the Acute Frailty Unit and the move to a more assessment based function (where space permits) for Lister Ward. The Best Flow programme will support further changes that are necessary. Poor flow in fact does not directly impact on the reported performance against the four key standards – and counterintuitively may actually improve performance against Standard 2 (see appendix 1 for more information).

5   Actions to meet the Seven Day Service standards

5.1   The Trust has recently undertaken a robust job planning round which has given senior operational and clinical leaders a clear baseline for current consultant working patterns. It is likely that the Best Flow programme will lead to adjustments to job plans and will see changes in patient flow which will have implications for working practices. A regular process of reviewing the impact of this programme on the 7DS standards, particularly at the weekend will be built into the project plan.

5.2   Specific discussions will be held to focus on areas where there is still a lack of clarity over the current service provision. The current position for cardiac pacing at the weekend – the service is available but in a rather ad hoc fashion – will be one area that will be discussed in more detail.

6   General Overview of Weekend Working

6.1   It is recognised that some processes within (and without) the organisation do not work as effectively at the weekend. This is to some extent inevitable given the significant difference in working patterns for all staff with the exception of ward nursing staff when weekdays are compared to weekends.

6.2   For example, the Trust employs a total of more than forty consultant physicians with bed holding responsibilities. At any one time approximately twenty of these are 'on the wards' with inpatients under their care. However at the weekend the number of physicians in the hospital reduces to nine. Six of these consultants are rostered to work via their regular job plan (the admitting general physician and geriatrician, one acute physician covering Ambulatory Emergency Care, and the on call cardiologist, respiratory / medical HDU consultant and gastroenterologist) and the other three of which (two acute physicians and one discharge consultant) are working via paid additional sessions.

6.3   The impact is that while essential and critical care to the seriously ill can be effectively delivered, care for those patients in the post-acute phase of their illness slows down. This manifests most clearly in the significantly lower discharge numbers on Saturday and Sunday – an issue which is aggravated by the reduction in capacity of many of the community services essential to discharge for the older population. Although a reduction in discharges on Saturday and Sunday is a national issue, the Get It Right First Time (GIRFT) Emergency Medicine review suggests that Medway has a greater proportionate reduction in weekend discharges (and takes longer to recover into the following week). Overall 16% of Medway patients are discharged on a Saturday and Sunday combined – lower than any other single day apart from Monday (15.1%). This has a resulting impact on waiting times for admission which are longest on a Monday and Tuesday.

6.4   The Best Flow programme will be specifically reviewing weekend working, maintenance of discharge profiles at the weekend and the recovery from weekends into the following week.

7   Audit Results

7.1   A case note review was undertaken by the Clinical Effectiveness team of a sample of 78 patients admitted during the week of 6-12 March. This sample was taken from a total of 481 patients admitted during the week. The notes were selected at random but the sample does include all main admitting medical and surgical specialities, as well as patients admitted via the emergency department (ED) and via the assessment units.

7.2   The initial results were validated by the Medical Director in the cases where the Clinical Effectiveness Team had found that consultant review was delayed to more than 14 hours after admission. This was in part to ensure the accuracy of the audit, and in part to review the circumstances which may have led to the delay in consultant assessment.

7.3   In total 61 of the 78 patients were definitely seen within 14 hours of admission, a total of 78%. Four more patients were judged as likely to have been seen within the appropriate timescales, but no time of the post take ward round was documented in the case notes. If these patients also met the standard, then the standard had been achieved in 82% of cases. This falls short of the 90% national target for this standard.

7.4   The 13 patients who were definitely not seen during the appropriate timescales can be further broken down as follows:

7.4.1   Seven patients admitted during the 'twilight' period (from around 7pm onwards) who were not seen on the day of admission and not seen until the late morning on the day after admission (three general medicine, one general surgery, one trauma and orthopaedics, one ear nose throat (ENT) surgery, one paediatrics)

7.4.2   One patient admitted via the Ambulatory Emergency Centre who was managed by the junior staff over a period of several hours before consultant advice was given to admit the

patient at around 8pm. The patient was not seen on the Post Take Ward Round (PTWR) until late the following day

    7.4.3   Two patients admitted via Surgical Assessment Unit during the late morning / early afternoon but who were not seen by a consultant until the following day (1 general surgery, 1 trauma and orthopaedics)

    7.4.4   One patient who was never seen by a consultant (urology – managed and discharged on the post take day by the specialist registrar)

    7.4.5   Two patients admitted in the late evening by medicine on March 7th who were not seen on the PTWR on March 8th. Both patients were eventually seen by a consultant on the morning of March 9th. The Directorate have been asked to investigate the circumstances of these omissions in care.

7.5   The twilight period has been recognised as a potential problem period for some years, but it was hoped that changes in the medical model (with a later finish and the introduction of the frailty service) would have mitigated these issues. However the audit clearly indicates the need for further work on this topic. In addition, the working patterns for the on call consultants in the surgical specialities need to be reviewed – it is likely that some patients are not seen promptly by a consultant because they are busy in theatre. This issue will be addressed with Planned Care and discussed as part of the forthcoming Job Planning review session.

8   Conclusion and Recommendations

8.1   The Trust self-assessed on the March submission as compliant for all priority standards initial consultant assessment (clinical standard 2), access to consultant-directed diagnostics (clinical standard 5), ongoing consultant-directed review (clinical standard 8), and for access to interventions (clinical standard 6).

8.2   However, subsequent audit work indicates that the Trust is in fact not compliant with standard 2, largely related to issues with the management of 'twilight' patients and with consultant availability in some surgical specialities. These two areas will be addressed via specific action plans following a more comprehensive audit.

8.3   The Executive Group will receive further updates against 7DS in July 2019 and 3-monthly thereafter until robust compliance with all standards can be demonstrated. The Board will be informed of the results of these reviews. It is recommended that a further formal report reviewing the position against the 7DS standards is brought to the Board in early 2020.

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7 Day Hospital Services Board Assurance Framework

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The March 2019 audit indicates that 78% of patients achieved this standard compared to a national compliance target of 90%. This is an improvement on the March 2018 audit, which demonstrated that 65% of patients achieved the standard. This standard does provide a difficult conundrum. The standard requires patients to be seen by a speciality consultant within 14 hours of admission (not arrival at hospital). The increasing delays in admission at MFT - as evidenced by the fact that over 50% of ED admissions wait more than 4 hours from a decision to admit to admission - actually means that a majority of speciality patients are now seen by the speciality consultant before admission (while the patient is waiting for a bed in the ED). This may therefore be expected to improve performance against this standard. Despite this the standard has not been achieved. This relates primarily to two issues - management of the 'twilight' cohort of patients (who arrive too late in the day to be seen by the consultant covering the day take) and some patients admitted under surgical specialities who miss out on a consultant review on the day of admission. The latter issue is likely to be because the consultants are busy in theatre. The Trust has developed systems across the whole week to improve consultant cover, including an extension in the medical consultant cover to 9pm (and often later depending on the pressure in the department) and the introduction of the acute frailty service. In essence the consultant staffing for all the admitting specialities is no different at the weekend than it is during the week.		No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Imaging: CT is available 24/7, 365 days a year (IP has 24/7 access, OP is Mon - Sun 0800 - 2000); MRI is available Mon-Sun 0800 - 2000 (MRI IP capacity at weekend is for emergency access only, but OP are scheduled 7 days per week); USS is available Mon - Sun (USS OP capacity is Monday to Friday 0800 - 1800, Sat/Sun 0900 - 1300 / USS IP capacity is Monday to Friday 0800 to 1800 , Sat/Sun 0900 - 1300). Echocardiography is provided for by IP and OP Monday to Friday 0900 - 1700 Microbiology has on site cover Monday to Friday 0900 - 1700, a robust oncall Microbiology service is provided	Echocardiography	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	**Standard Met**
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Critical Care access is 24/7 on site or via an on call service with a Senior House Officer available on site 24/7 with access via on call. IVR: an OP and IP IVR service is provided and offered Monday to Friday 0900 to 1700; a robust IVR oncall system is place, supported by Medical, Nursing and Radiographer which can be called in as needed - a shared care arrangement is also in place with EKHUFT in the event of an emergency and the lab is already in use or in rare occassion that the emergency oncall cannot be provided. Emergency/Interventional Endo: this service is available for both IP and OP (routine and emergency) Monday to Friday 0900 - 1700, outside of these hours, including weekends, a robust oncall system is in place for GI bleeds requiring intervention. PCI: is available Monday to Friday 0900 - 1700 for	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Provide a brief summary of performance against this standard, highlighting any areas for improvement in the case of non-compliance. Results from the previous seven day audit which took place in March 2018 indicate that overall the trust achieved 82% compliance for patients reviewed once every 24hrs, 92% for weekday review and 54% for weekend review and 100% ofr patients being reviewed twice daily. Further audit work is in progress to review the current performance. STROKE SERVICES: Patients are received with advance notice into the ED, with immediate assessment. Patients are immediately referred to the Stroke Clinical Nurse Specialist who will complete an immediate assessment and Thrombolysis assessment completed, following CT Head. Patients will be reviewed in the ED by the attending Stroke Consultant and transfered to the Acute Stroke Unit within 4 hours, whenever practicable. Ward and Board rounds are completed twice daily on the ASU, with Medical, Nursing and Therapist in attendance. Patients are reviewed, supported and treated 7 days per week by medical and therapy staff with once or twice daily reviews undertaken as needed, with assessments undertaken and referrals/transfers made as approriate and rehab bed availability. Fast acces to Neurosurgical input and advice is available 24/7 through a robust referral system and can be taken from both ED and ward. RESPIRATORY: patients have access to a 24/7 medic on site, in both the High Dependency Respiratory Unit (Medical HDU) and via an Inreach service - patients will be reviewed on both ward round and board round twice daily and further as required. A robust waiting list system is managed and reviewed daily with patients re/prioristed based on clinical need and urgency, supported further with a strong step down process in the unit. CCU: a dedicated CCU is available 24/7, 365. A medic is available on site 7 days per week 0800 - 2000, supported by Oncall Team and onsite Registrars over night - patients will be reviewed on both ward round and board round twice daily and further as required. A robust waiting list system is managed and reviewed daily with patients re/prioristed based on clinical need and urgency, supported further with a strong step down process in the unit.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	**Standard Met**

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10

Provide a brief overall summary of performance against these standards, highlighting areas where progress has been made since 2015

1. Patient Experience - CRITICAL CARE - Supports continuous improvement by appointing and training Advance Critical Care Practitioners (ACCP) who have enhanced the skill mix of the ward whilst improving patient experience and outcomes

3. MDT Review We have increased access to therapies at weekends and there is a plan to trial weekend pharmacy over the winter period.

4. Shift Handover – Consultant lead board rounds

7. Mental Health – Mental Health liaison service available 7DS.

9. Transfer to Community, Primary and Social Care - Services available during weekdays and weekends differ the trust is continually working with the CCG and MCH on the development of availability of services

10. Quality Improvement- Reviewed as part of the Trust Mortality Group with over 25% of deaths being reviewed as a SJR.

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7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Priority 7 day hospital services clinical standard

*information not visible on spreadsheet due to texts falling out (there is no provision to adjust spreadsheet once submitted to ensure all texts are seen)

Clinical Standard	Self-assessment of performance	Weekday	Weekend	Overall Score
Clinical Standard 5	Microbiology has on site cover Monday to Friday 0900 - 1700, a robust oncall Microbiology service is provided from Friday 1700 to Monday 0900 and every weekday night. Upper GI Endoscopy is provided for OP and IP Monday to Friday (on site for both IP and OP) 0900 - 1700 and off site Monday to Friday for OP only 0900 - 1700; a robust GI bleed oncall system is in place for Upper Endoscopy.			
Clinical Standard 6	Emergency/Interventional Endo: this service is available for both IP and OP (routine and emergency) Monday to Friday 0900 - 1700, outside of these hours, including weekends, a robust oncall system is in place for GI bleeds requiring intervention. PCI: is available Monday to Friday 0900 - 1700 for emergency, outside of these hours, patients are routed straight to EKHUFT or DVH. Cardiac pacing (temporary transvenous) is available 24/7 at Medway via the on call consultant cardiologist. Stroke Thrombolysis is provided on site Monday to Sunday 24/7, 365 days. Cardiac pacing is available via a mixture of external pacing, the consultant cardiologist on call and the PCI centre at Ashford but this is not a formally structured system. This only affects a very small number of patients (certainly less than one per month).			
Clinical Standard 8	CRITICAL CARE operate a AM and PM ward round everyday 7 days per week. Attended by Consultant, Nurse in charge and JR doctors.			

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Workforce Report	Agenda Item	7.1
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Elizabeth Nyawade, Deputy Director of HR and OD		
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 285 candidates to date – 11 candidates supplied to us by Cpl Healthcare and 55 candidates provided by HCL. Trust turnover has increased at 12.21% (+0.02%) from 12.19%, sickness absence at 4.30% (+0.01) compared to the month of April is above the Trust's tolerance level of 4%, and appraisal compliance has increased to 91.44% (+2.90% from 88.54%) and is above Trust target of 85%. Statutory and Mandatory training is at 88.64% (+3.01% from 85.63%) and is meeting the Trust target of 85%. The percentage of pay bill spent on substantive staff in May at (85%) increased (+1% from 84%) compared to the month of April. The percentage of agency usage at 3% decreased (-1%) compared to the month of April. The percentage of pay bill spent on bank staff at 12% (-1% from 13%) has decreased compared to April.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐	
	Finance: We will deliver financial sustainability and create value in all we do	☐	
	People: We will enable our people to give their best and achieve their best	☒	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐	
	High Quality Care: We will consistently provide high quality care	☐	
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		

Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators. • Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Work stream as part of the 2019/20 cost improvement programme
Quality Impact Assessment	Not applicable
Recommendation/ Actions required	The Board is asked to note the content of this report.

Approval	Assurance	Discussion	Noting
☐	☒	☐	☒

Appendices	None

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Workforce Report

1   Introduction

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

2   Recruitment

2.1   The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During May 2019, 21 full time equivalent (FTE) registered nurses and midwives joined the Trust on a substantive basis, alongside 4 FTE substantive clinical support workers/maternity care assistants.

2.2   In May 2019, 15 international nurses undertook the Objective Structured Clinical Examination (OSCE) exam with nine passing at the first attempt. The Trust currently has a pass rate of 90%. 15 International nurses commenced in post in the Trust in May 2019 and will be undertaking the OSCE programme over a six weeks' period.

2.3   Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Five Cpl international nurses have commenced in post, with 11 in the pipeline. 44 HCL nurses have also commenced in post. 55 HCL candidates remain in the pipeline with offers being processed.

2.4   The Trust is also working with 8 additional permanent recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, Medline, Kate Cowhig, HealthPerm, ILETS Medical and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial year 2019/2020.

2.5   To support the Trust in achieving its targets new international campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend, Kate Cowhig, Sanctuary Personnel and Cromwell Medical Recruitment. Table 1 below summarises the Trust's recruitment pipeline via all our partner agency providers.

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline	
Harvey Nash	7	0	213	0	(0%)
Cpl Healthcare	4	11	15	6	(33%)
HCL	44	55	99	25	(35%)
Person Anderson	28	0	28	0	(100%)
Cromwell Medical Recruitment	29	65	94	25	(45%)
MSI Group	3	0	8	0	(0%)
Xander Hendrix	4	8	12	4	(50%)
We Solutions	17	60	77	35	(45%)
Blue Thistle	0	8	8	0	(0%)
Medline	3	42	45	15	(35%)
HealthPerm	0	4	4	4	(100%)
IELTS Medical	0	0	0	0	-

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline	
Ascend International	8	19	27	10	(52%)
ESPN	1	0	1	0	(100%)
Sanctuary Personnel	0	1	1	1	(100%)
Kate Cowhig	0	12	12	8	(66%)
Total	133	285	665	108	

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

2.6 The Trust has also engaged with Health Sector Jobs recruitment agency to run targeted open days for qualified nurses and in the month of May 2019, 9 offers were made to candidates. Table 2 below summarises offers made, starters and leavers for May 2019.

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	74 (54 NHS Jobs/open days & 20 international nurses via skype)	21	17
Clinical support workers/Maternity Care Assistants	17 (Clinical Support Workers)	4	7

(Table 2: Nursing starters and leavers May 2019)

2.7 During May 16 medical staff joined the Trust; these included 13 junior doctors, 1 consultant in Neurology and 2 Radiology consultants.

3   Directorate Metrics

3.1 The table below (table 3) shows performance across five core indicators by the directorate. Turnover, at 12.21% (+0.02% from 12.19%), remains above the tolerance level of 8%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results to implement service specific retention plans. Sickness absence at 4.30% (+0.01 from 4.29%) is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 91.44% (+2.90% from 88.54%) and is above the Trust target of 85%, all directorates (Corporate, Planned, Unplanned and Estates & Facilities) are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics. Statutory and Mandatory training stands at 88.64% (+3.01% from 85.63%) and is meeting the Trust target of 85%. All directorates across the Trust are meeting the Statutory and Mandatory training target.

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Workforce Report

	Trust Target	Trust			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
		Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.0%	12.2%	▲		16.6%	▼		6.4%	▲		11.5%	▼		13.5%	▲	
Vacancy rate	12.0%	15.1%	▲		9.1%	▲		14.5%	▼		14.4%	▼		17.7%	▲	
Sickness rate (12-month rolling)	4.0%	4.3%	▲		2.7%	▼		6.5%	▲		4.3%	▼		4.1%	▲	
Statutory & Mandatory Training	85.0%	88.6%	▲		95.0%	▲		85.8%	▼		89.0%	▲		87.7%	▲	
Medway Appraisal	85.0%	91.4%	▲		91.1%	▲		90.6%	▲		95.3%	▲		87.1%	▲	
Agency costs (as % of total paybill)	11.0%	2.8%	▼		1.7%	▼		1.0%	▼		2.6%	▲		4.0%	▲	
Bank costs (as % of total paybill)		12.1%	▼		2.2%	▲		8.0%	▼		10.8%	▼		16.7%	▼	
Substantive costs (as % of total paybill)	89.0%	85.1%	▲		96.1%	▼		91.1%	▲		86.6%	▲		79.3%	▲	
Stability Index (12-month rolling, >12M)	TBC	81.7%	▲													
Leavers citing "Work/Life Balance" 12 month rolling	TBC	71	►													

(Table 3: Key workforce metrics)

3.3 Approximately 15,000 learning interventions need to occur during 2019/20 for the Trust to be compliant. These interventions occur across e-learning, classroom-based learning and also blended learning opportunities. SMEs provide sufficient capacity to provide face-to-face opportunities to meet the demand. The Trust's StatMan target across areas is 85% and is being met for conflict resolution; equality and diversity; health and safety, infection prevention and control, safeguarding children (level 1), safeguarding adults, fire and prevent. However, the minimum is not met for moving and handling (level 2, 3); resuscitation and safeguarding children (level 3).

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

Directorate >> Programme	Compliance %
Corporate	95.02%
>> Communications	100.00%
>> Governance & Legal	
>> Finance	95.04%
>> Human Resources & Organisational Development	97.68%
>> IT	98.15%
>> Medical Directorate	95.22%
>> Nursing Directorate	89.67%
>> Strategy & Planning	99.72%
>> Transformation	87.91%
Estates & Facilities	85.76%
>> Estates & Facilities Management	96.09%
>> Hard Facilities Management	96.21%
>> Soft Facilities Management	84.03%
Planned Care	88.96%
>> Cancer Services	91.51%
>> Perioperative & Critical Care	90.65%
>> Planned Care Infrastructure	94.12%
>> Surgical Services	84.41%
>> Women's & Children's Health	89.78%
Unplanned & Integrated Care	87.72%
>> Diagnostics & Clinical Support Services	89.88%
>> Specialist Medicine	88.70%
>> Therapies & Older Persons	89.80%
>> Unplanned & Integrated Care Management	89.97%
>> Urgent and Emergency Care	84.12%

4 Temporary Staffing

4.1 Table 4 below demonstrates that temporary staffing expenditure decreased in May 2019 compared to April 2019.

		Mar 17	Mar 18	Apr 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Spend	Agency	£3,890,198	£2,597,697	£943,419	£689,179	£1,095,639	£620,839	£783,127	£684,291	£497,825
	Bank	£920,473	£2,329,768	£2,307,191	£1,544,845	£2,227,879	£2,151,604	£2,105,055	£2,267,819	£2,136,062
	Substantive	£13,611,458	£13,542,990	£13,904,703	£14,092,671	£14,061,431	£14,072,139	£16,377,676	£14,152,087	£17,624,270
% of pay bill	Agency	21%	14%	5.5%	4%	6%	4%	4%	4%	3%
	Bank	5%	12%	13.5%	9%	13%	13%	11%	13%	12%
	Substantive	74%	74%	81%	87%	81%	83%	85%	84%	85%

4.2 The agency cap breaches across all staff groups continues to decrease as illustrated in chart 1 below. During the month of April 2019 the Trust reported an average of 25 breaches per week across the month.
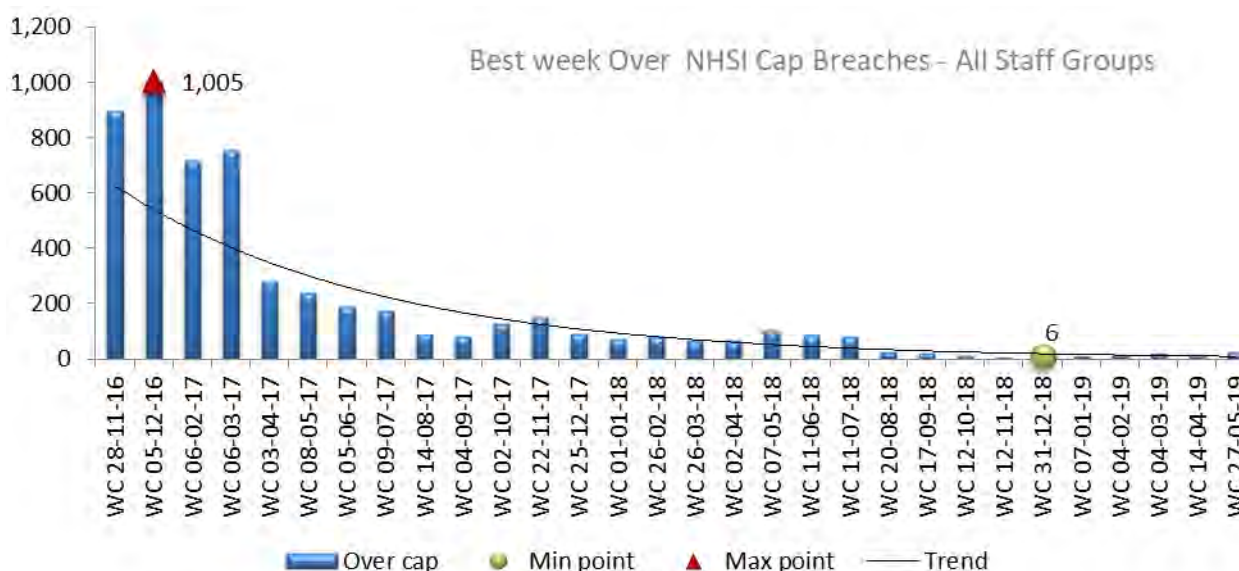
(Chart 1: NHSI cap breaches)

4.3 The Trust's NHS Improvement (NHSI) annual agency spend celling remains the same for 2019/2010 at £17.88m. Based on month 2 agency spend, the Trust is £1,182,116 below the NHSI agency ceiling cap target as illustrated in the chart and table below.
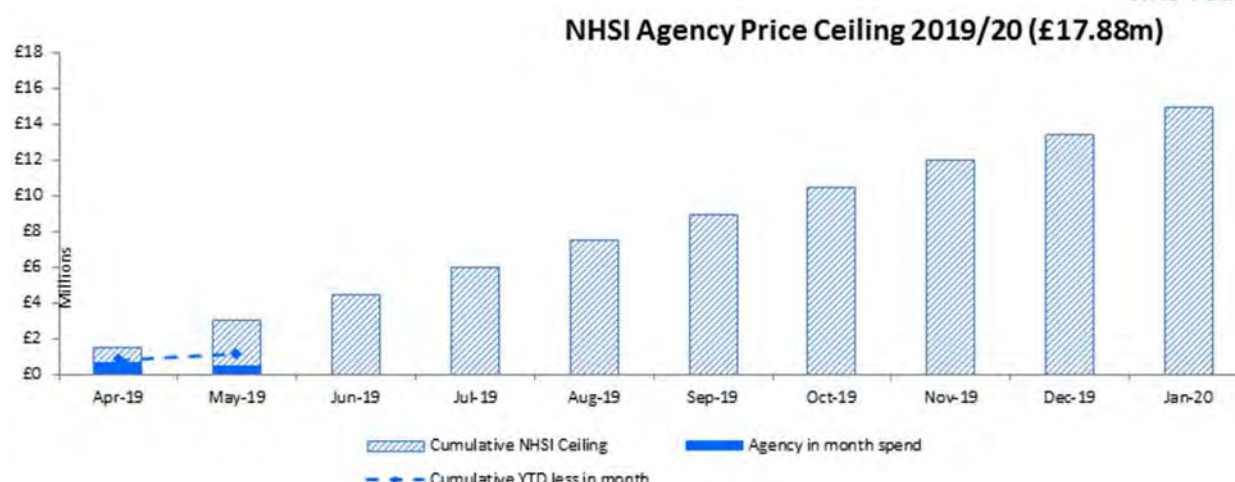
(Chart 2: NHSI agency ceiling)

Table 5 below shows NHSI agency ceiling performance:

	Oct-18	Nov-18	Dec-18	Jan-18	Feb-19	Apr-19	May-19
Cumulative NHSI ceiling target	£10,430,000	£11,920,000	£13,410,000	£14,900,000	£16,390,000	£14,490,000	£2,980,000
Agency in month actual spend	£881,163	£988,934	£689,179	£1,095,639	£620,839	£684,291	£497,825
Cumulative below ceiling	£6,988,224	£7,977,158	£8,666,337	£9,761,977	£10,382,817	£805,709	£1,182,116

4.4   Temporary nursing demand increased in May 2019 compared to April 2019 (8,711 shift requests in May 2019 compared to 8,044 shift requests in April 2019). The fill rate was 73%. Medical locum demand increased in May 2019 compared April 2019 (1,216 shift requests in May 2019 compared to 1,136 shift requests in April 2019). The overall fill rate for nursing and medical locum was 82%.

5   NHSI Nursing Retention

5.1   In 2018 the Trust successfully applied to be part of NHSI nursing retention direct support programme cohort 4. As part of this programme, the Trust has worked in partnership with NHSI to identify and implement a number of retention initiatives. The Executive Director of Nursing and Executive Director of HR & OD are sponsors of this programme and the Associate Director of Nursing and Deputy Director of HR & OD are supporting the delivery of the initiatives. A working group made up of the Head of Resourcing, Nursing and Midwifery Workforce Lead, Co-Clinical Directors, Matron, Ward Sisters and Charge Nurses is in place to support the implementation of the identified retention initiatives. The approach being taken is that this is a clinically-led programme.

5.2   Following a review of the data set provided by NHSI which included the Trust's retention rates, reasons for leaving and age profile, the organisation set up listening events led by NHSI support team. The purpose of the listening events was to identify the key issues for nursing staff within the Trust, to be used in shaping the retention initiatives. The outcome of listening events resulted in the following retention initiatives that will be implemented across this financial year for nursing staff; it is acknowledged that some of these retention initiatives will also be beneficial to other staff groups within the organisation.

5.2.1 Practice Development Nurse Support on all ward areas:

- The trust has achieved success with a number of ongoing recruitment campaigns; this means that a large number of the nursing workforce is relatively new and inexperienced. The main focus of practice development is the improvement of patient care through developing, supporting and engaging staff, most ostensibly within their own practice environment. Practice development allows Organisations to tackle inconsistencies by targeting areas requiring improvement and ensuring the correct message is shared throughout the whole Organisation.

- The staff listening events demonstrated the value of Practice Development Nurse Support across our ward areas with regards to pastoral care support and improvements in the quality of care provided. This has been achieved through facilitation and knowledge sharing.

- Our current service provision allows for Practice Development Nurse Support in specialist areas namely, ED, Critical Care, Theatres, Paediatrics, Haematology/Oncology, NICU and Midwifery. The Nurse Education Team within the Corporate Nursing Directorate provide Practice Development Nurse Support for all of the general ward areas. The current service provision is one Practice Development Nurse per every 5-6 general ward areas. The work being undertaken by the team has enabled identification of the areas of practice which the organisation needs to focus on to improve patient care, staff support and retention. However, in order to be the best we need to review the numbers of available Practice Development Nurses in order to develop our workforce.

5.2.2 Staff Support, Recognition and Health and Wellbeing support:

- The 'Spirit of Medway' sessions were launched in April 2019. These sessions are led by our Head of Resourcing and allow new starters the opportunity to let us know how their first few months at our Trust have been.

- The Director of Nursing, Matron, Ward Sister and Charge Nurse forums were launched in May 2019. These will be held monthly and will be led by the Director of Nursing.

- All international nurses receive a two week induction programme following completion of the OSCE programme. This allows for them to receive additional training and support prior to them commencing on the wards.

- A Preceptorship Programme was launched in June 2018 and is available for all new starters. This consists of six study days over a twelve month period. It also includes White Belt Training.

- Ongoing pastoral support for new starters and existing staff is provided by the Resourcing, Nursing Workforce and Nurse Education Team. This also includes Clinical Supervision, Coaching and Mentoring support.

- In collaboration with NHS Elect, The Director of Nursing and Head of Workforce Development and OD the Trust is developing a Senior Sister/Charge Nurse Leadership programme which will be launched in September 2019.

5.2.3 Flexible Retirement Options for nursing staff:

- Developing a standalone Flexible retirement policy by end of Q2 2019/20 aimed at tapping into this group of staff and encouraging a return to working in the Trust flexibly post retirement.

5.3   As part of monitoring the impact of retention initiatives, the Trust will start publishing Nursing Stability Index rate. The table and graph below shows nursing and midwifery stability index rate over the last 12 months. Overall, there is a significant and largely sustained and positive direction of registered nursing workforce stability. This will continue to be monitored and reported as part of the programme.
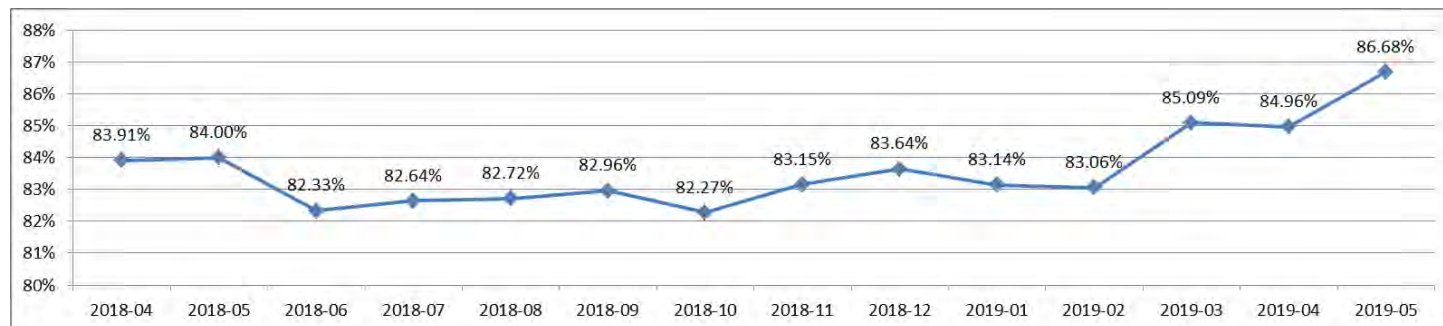
5.4   To investigate if there is a causal or correlation between leaving reason and staff survey results, an analysis has been undertaken. The results are shown below; however, there is no correlation between survey results and leaving reasons upon interrogation.
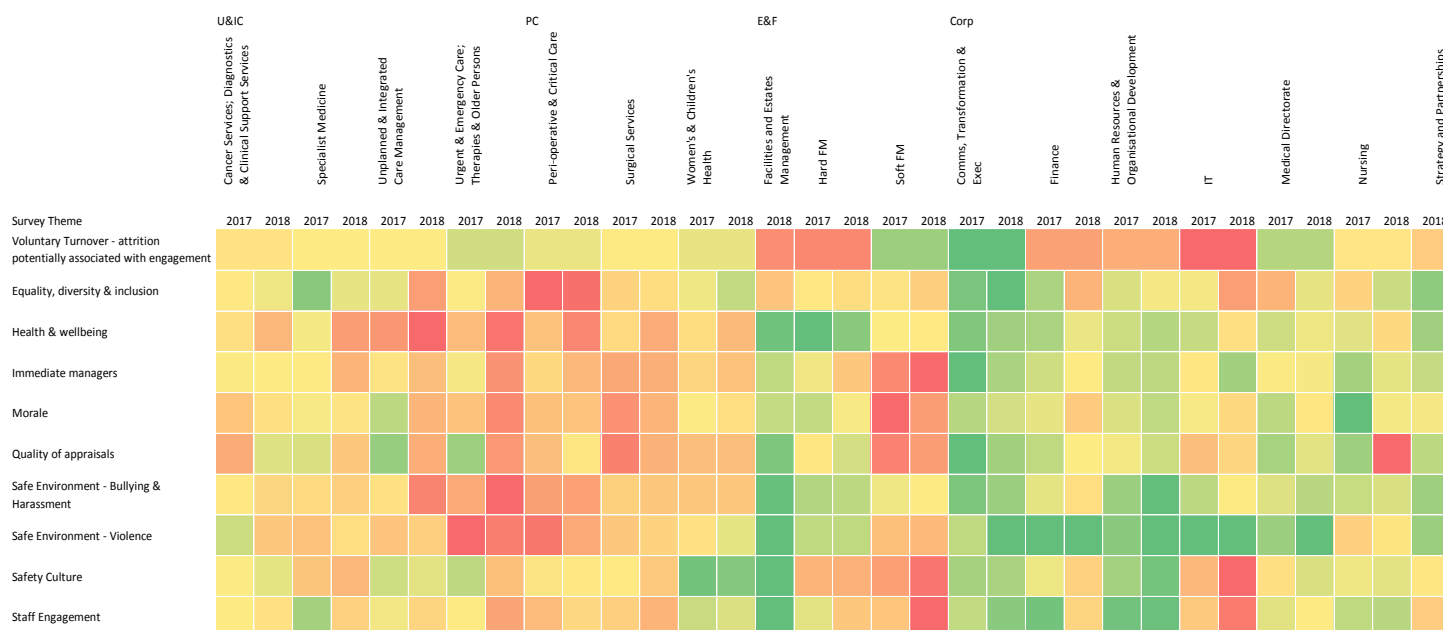
6   Best Place to Work

6.1   In conjunction with Health Education England (HEE) and Clever Together, Best Place to Work aims to build on the You Are The Difference (YATD) culture programme by looking in more detail about the experiences of staff at Medway.

6.2   The Making Medway Brilliant conference showcased examples of the best of Medway. But we know from feedback that we urgently need to make sure the best examples of leadership and management are felt consistently across teams and divisions. We know this from conversations with

staff as well as our analysis of staff survey which tells us that we are a long way from where we want or need to be.

6.3 Our Trust is embarking on a new way of engaging staff, so that we not only hear what we think needs to change, but also we can get ideas from staff about how we can change for the better. This month we will invite all staff to join a Trust-wide initiative with a difference:

6.3.1 It's a conversation NOT a survey – where you can say what you think and why you think it;

6.3.2 It's anonymised – we are collaborating with an independent partner, Clever Together who will ensure no personal data is shared with the trust and your ideas and comments are completely anonymous to the trust;

6.3.3 It's accessible – the platform will be open 24 hours a day for about two weeks and is available from any internet enabled device – PC, Laptop, mobile or tablet;

6.3.4 It's interactive – you can view the anonymised comments of your colleagues and comment on them or use voting buttons to indicate support or disagreement;

6.3.5 It's non-hierarchical – the ideas and comments will be judged by your colleagues on their merit, not on the basis of your grade, staff grouping or personal characteristic.

6.4 We are genuinely excited to understand better what staff think we as a Trust need to start doing, stop doing, or do differently to improve. We know we have some distance to travel but there is so much great work to build on and we know that the ambitious we have can only be met if we genuinely engage our staff, in a meaningful conversation like this.

6.5 The online conversation will close in July and Clever Together provides feedback and proposed immediate action areas to us by September once the analysis has been concluded.

7 Staff Survey Action Plans

7.1 The Human Resources Business Partners have been working with programmes to develop local action plans that will be owned and delivered locally.

7.2 Delivery plans and actions are based on programme-based survey breakdown exploring each of the survey themes and question breakdown to look at not only where the programme scores low, but also to identify its strengths and further develop these.

7.3 The action plans identify three key items per programme of focus and these are demonstrated below and reviewed at the programme review meeting on a monthly basis to monitor progress.

PLANNED CARE

PERI-OPERATIVE AND CRITICAL CARE	TIMESCALE
Drop in sessions with the triumvirate for all staff once a month	Immediately
Develop career pathways for staff to enable them to understand what development is required to enable them to progress at Medway	By the end of July
Increase utilisation of the YATD/Trust value recognition cards and continue to nominate staff for employee of the month every month	Immediately
WOMEN'S AND CHILDREN'S	
Purchase 2 banners promoting the RCM Midwifery Service of the Year so that they can be placed across the Trust highlighting the excellent service available to women	By end of April
Download Airwatch onto the Community Midwives smart phones to enable them to be used within the community setting	By the end May
Develop a transparent process for applying for/requesting training and development	By the end of July
SURGICAL SERVICES	
Nominate at least one member of staff for employee of the month within Surgical Services every month and ensure this is communicated to the member of staff	Immediately
Clinical Co-Director and Matrons will meet with new starters on the wards as part of their induction as a welcome	Immediately
Triumvirate open sessions with staff once a month and implementation of regular team meetings	Immediately
CANCER SERVICES	
Arrange for Gary Lupton and Gurjit Mahil to attend a team meeting to discuss the space issues and the Estates strategy for the whole programme	End of June 2019
Explore the opportunity of laptops and mobile phones for the team given the lack of space for working and confidential conversations for CNS team and resolve telephone issues in the referral office (i.e. through use of a splitter)	End of June 2019
Secure keypad for the door between Imaging and BSU to ensure safety of staff and patients	End of July 2019

UNPLANNED AND INTEGRATED CARE

THERAPIES AND OLDER PERSONS	
Quarterly listening events – enable drop in sessions with the "Quad" programme management team. Providing the opportunity of staff from nursing, medical and therapy departments to feedback thoughts, views and feelings on team performance, morale, frustrations and good news.	April onwards
Weekly programme Huddles - to review and ensure that all clinical areas are completing appraisals and ensuring that staff have the right skills and knowledge (Stat/Man training). Review sickness, vacancies and review how as a programme we can support our staff, to share good news stories and recognition of good work.	April onwards
Frailty Forum- a new forum to bring together all disciplines to share learning, knowledge and experience. A time to reflect on what hasn't gone so well and what has. An opportunity to share patient stories, learning from experience and case studies.	End of August
DIAGNOSTICS AND CLINICAL SUPPORT SERVICES	
Morale, Training & Development, Growth and Personal Development to be advertised and actively encouraged; Workforce Development Strategy for each service to be developed, shared and implemented	31.08.19
Delivery of structured and regular team meetings/huddles (to include feedback on learnings, internal adverts, H&WB)Departmental updates via email / paper	All services go live from July 2019
Staff engagement in Service Development Monthly Programme Triumvirate 'surgery' Ideas and suggestions by all at any time – reviewed at steering group led by HoOP and staff groups represented Engagement with Transformation Team when needed	Surgery go live June 19; Steering Group go live July 19
SPECIALIST MEDICINE	
Weekly staff drop in session with the programme management team	29 April onwards
Transformational Huddle Weekly Listening /improvement huddle (staff recognition, updates, new ideas, appraisals ,StatMan)	Immediate
Exit Interviews Every resignation to go the Clinical Co Director, face to face exit interviews to get the feedback for improvement	Immediate
URGENT AND EMERGENCY CARE	
Transformational Huddle Weekly Listening /improvement huddle (staff recognition, updates, new ideas, appraisals ,StatMan)	Immediate
Professional Development / career opportunities Training and development opportunities (Number/ % of staff trained in each ward/ area quarterly report to be submitted to programme boards)	Immediate
Exit Interviews Ward areas - every resignation to go the Clinical Co Director / Matron face to face exit interviews to get the feedback for improvement	Immediate

CORPORATE, ESTATES AND FACILITIES

TRANSFORMATION	
Hold 'Don't be a boiling frog!' team session and form Health & Wellbeing Action Plan	In June
Develop clearer policy on working from home for our team – supported by tools which facilitate effective flexible and remote working	July
Introduce new performance calendar and development infrastructure, bespoke for a transformation / improvement team	By August
SOFT FM	
Nominate at least one member of staff for internal employee of the month scheme in Soft FM	End of June
Head of Hotel Services told hold quarterly open forums for all staff to attend	End of July
Senior leadership team to attend improvement huddles once per month	
Improvement huddles to take place in each team	End of July
HARD FM	
Health & Safety presence at team meetings	End of June
Arrange for Toolbox Talks with all staff groups	End of July
Health & Safety to consult and discuss with Estates staff regarding lone working concerns	End of July
IT	
Making use of internal training opportunities for whole team.	12 months
Improve strategic planning and alignment across Transformation Team, IT and Trust.	12 months
Link with OL&D on the most beneficial way to support staff, so as to minimise stress and improve morale.	3 months
Arrange regular whole team meetings, with agenda, to ensure staff inclusion	1 month

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Workforce Report

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Workforce Race Equality Standard	**Agenda Item**	**7.2**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Alister McClure, Head of Equality and Inclusion		
Executive Summary	This report provides the annual Workforce Race Equality Standard summary (WRES) for 2019. This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater racial equality, as required by the Equality Act 2010. Under the NHS Standard Contract (schedule 6a) the Executive Group and Board are required to consider and approve the WRES report prior to publication by 31 July 2019. The performance is largely stable, compared to 2018, but still improved overall compared to 2016. A draft action plan to address concerns and improve performance is set out at section 5, which will be worked up in further detail by the Trust's Inclusion Steering Group before September 2019.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐	
	Finance: We will deliver financial sustainability and create value in all we do	☐	
	People: We will enable our people to give their best and achieve their best	☒	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐	
	High Quality Care: We will consistently provide high quality care	☐	
Committees or Groups at which the paper has been submitted	Human Resources and Organisational Development Senior Team Executive Group		
Resource Implications	None identified at this stage. Any actions should be achieved within existing resources.		
Legal Implications/ Regulatory Requirements	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Race. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on race equality in the form of the WRES summary.		

Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	To approve the publication of the Trust's Workforce Race Equality Standard Report.			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	The WRES Reporting Schedule (currently delayed by NHS Digital, but will be circulated).			

1 Executive Overview

1.1 The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and
- to improve BME representation at the Board level of the organisation.

1.2 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 98%.

[For indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

1.3 The performance has stabilised compared to 2018, and still an overall improvement compared to 2016. Further work is required to build performance back the levels reported in 2017; actions to do this are indicated in section 5 of the report.

1.4 Performance on indicator 3 (relative likelihood of staff being in formal procedures) shows that White staff continue to be more likely than BME staff to be in formal procedures. The national picture is the reverse, with BME staff being more likely to be in formal procedures. The number of staff in formal procedures, however, is falling.

1.5 Performance on indicator 4 (access to non-mandatory training and continued professional development) shows continued improvement, whilst indicators 5-7 (measured through the 2017 Staff Survey) have only stabilised compared to the previous year, and indicator 8 has also improved, with a smaller proportion of staff survey responses identifying discrimination at work).

1.6 An action plan to address concerns and improve performance is set out at section 5.

2 Background

2.1 The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce. The evidence of the link between the treatment of staff and patient care is particularly well evidenced for Black and Minority Ethnic (BME) staff in the NHS, so this is an issue for patient care, not just for staff. The Equality and Diversity Council - representing the major national organisations in the NHS, proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

2.2 The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis. Medway NHS Foundation Trust produced its first WRES report in 2016, which formed the baseline against future years' assessments can be compared.

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2.3   The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,

- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and

- to improve BME representation at the Board level of the organisation.

2.4   It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WRES, including sign-off at Board level, before 31 July each year. The Trust must, therefore, publish its WRES following the Trust Board meeting on 3 July 2019.

2.5   The WRES Summary assessment is attached with this paper [NB – we are still waiting for NHS England to publish the template – due w/c 17 June], and the key findings are set out below. The summary shows a generally stable performance compared to 2018, but still an overall improvement compared to 2016, and continued progress on indicator 3 (relative likelihood of white and BME staff being in formal procedures) and indicator 4 (access to non-mandatory training).

3   Key Findings

3.1   The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 98% (up 1.5 percentage points on 2018, where the self-declaration rate was 96.5%.)

[For indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

3.2   **Indicator 1** – **Workforce profile**

Staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including executive Board members) compared with staff in the overall workforce.

This information was required to be broken down not only by band, but also separating clinical, medical and dental and non-clinical staff. The data shows that there is an over-representation of White staff at Band 2 (non-clinical), although it is likely to be due to staff at lower pay bands and non-clinical roles being recruited more from the local community than higher bands and clinical roles. The Trust's workforce is considerably more diverse than the local population, and the representation of staff for Black and Minority Ethnic (BME) backgrounds at all levels, except very senior management, has increased from previous years.

There is significantly higher representation of people from BME backgrounds in medical and dental roles, which is reflective of the profile of their professions.

Table 1a: Ethnicity (Agenda for Change *Non-Clinical* Bands 2 to 9 and Very Senior Management, Headcount)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	VSM
WHITE	599	170	182	84	73	47	37	19	9	3	1	17
BME	67	19	15	13	8	5	6	1	3	2	1	1
ETHNICITY UNKNOWN/NULL	10	1	4	0	0	1	1	1	2	1	0	0
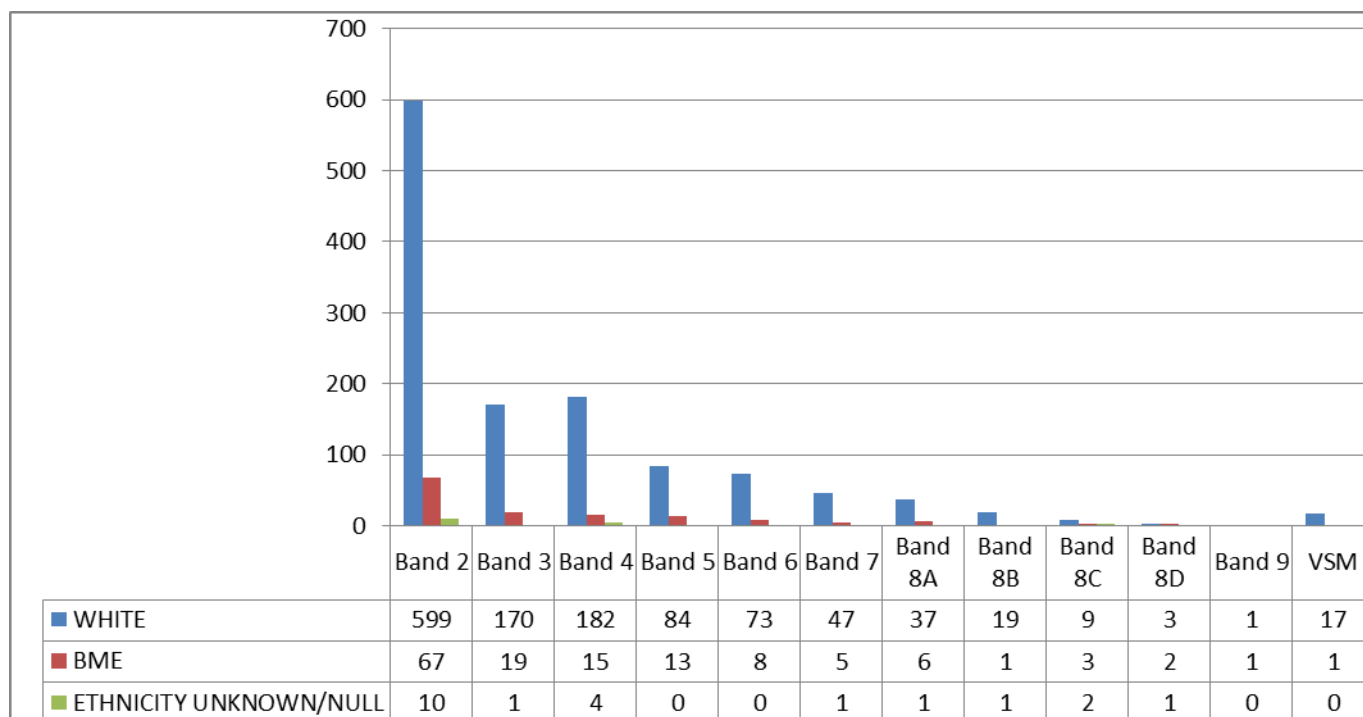
Table 1b: Ethnicity (Agenda for Change *Non-Clinical* Bands 2 to 9 and Very Senior Management, by proportion)
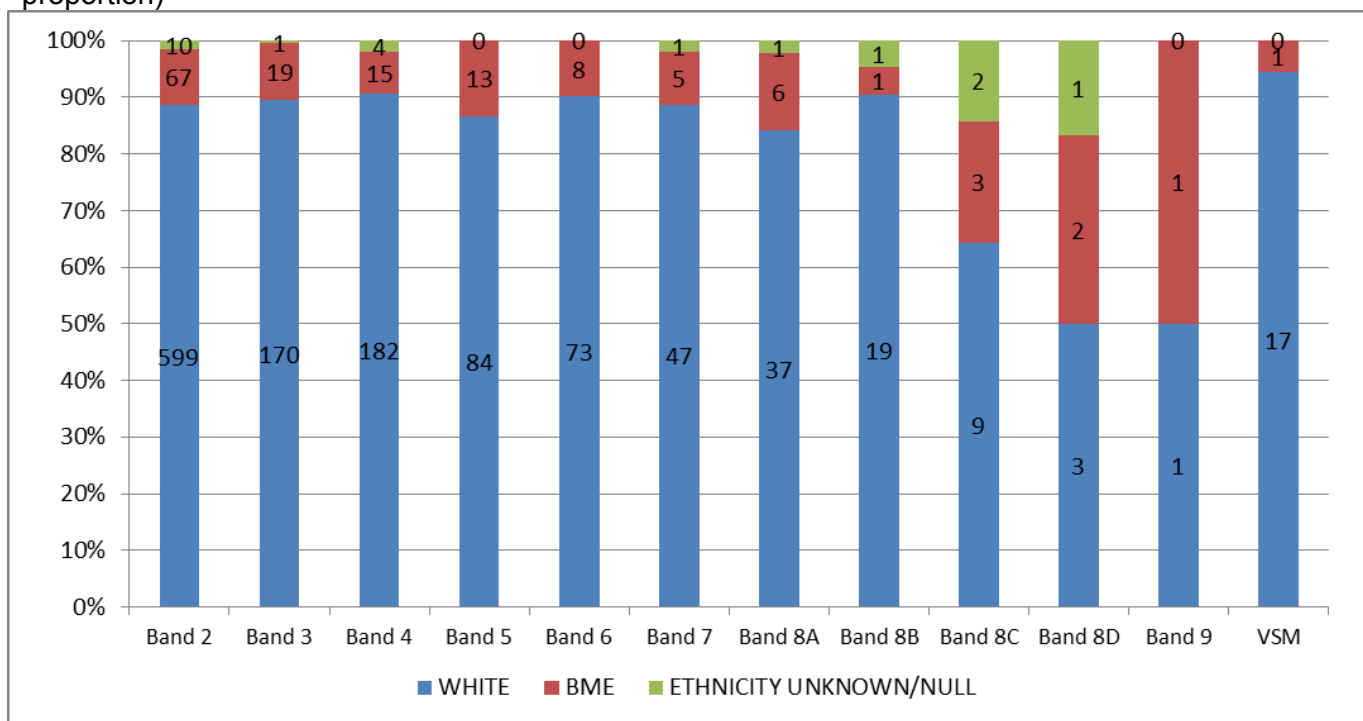
Table 2a: Ethnicity (Agenda for Change *Clinical* Bands 2 to 9 and Very Senior Management, Headcount)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	VSM (incl Exec Board)
WHITE	407	141	73	316	432	232	52	10	5	0	3	3
BME	81	8	33	281	141	44	8	6	2	0	1	1
ETHNICITY UNKNOWN/NULL	6	1	2	14	10	4	0	0	0	0	0	0
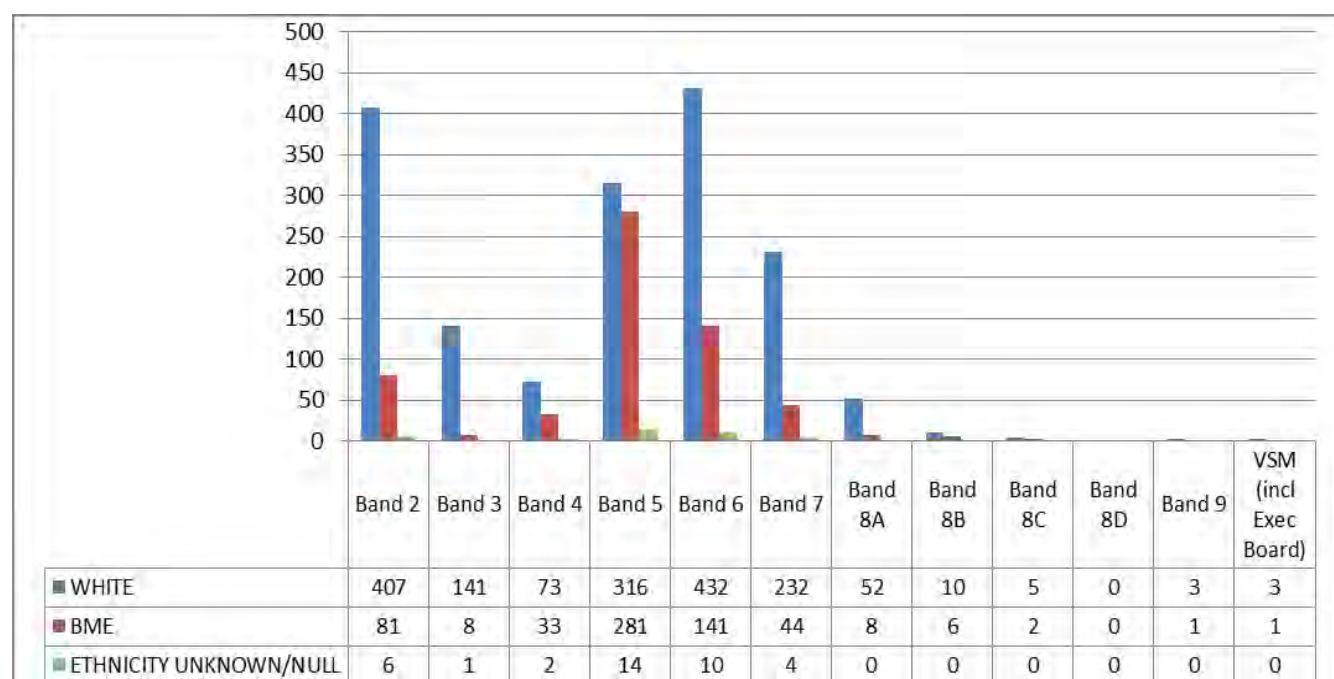
Table 2b: Ethnicity (Agenda for Change *Clinical* Bands 2 to 9 and Very Senior Management, by proportion)
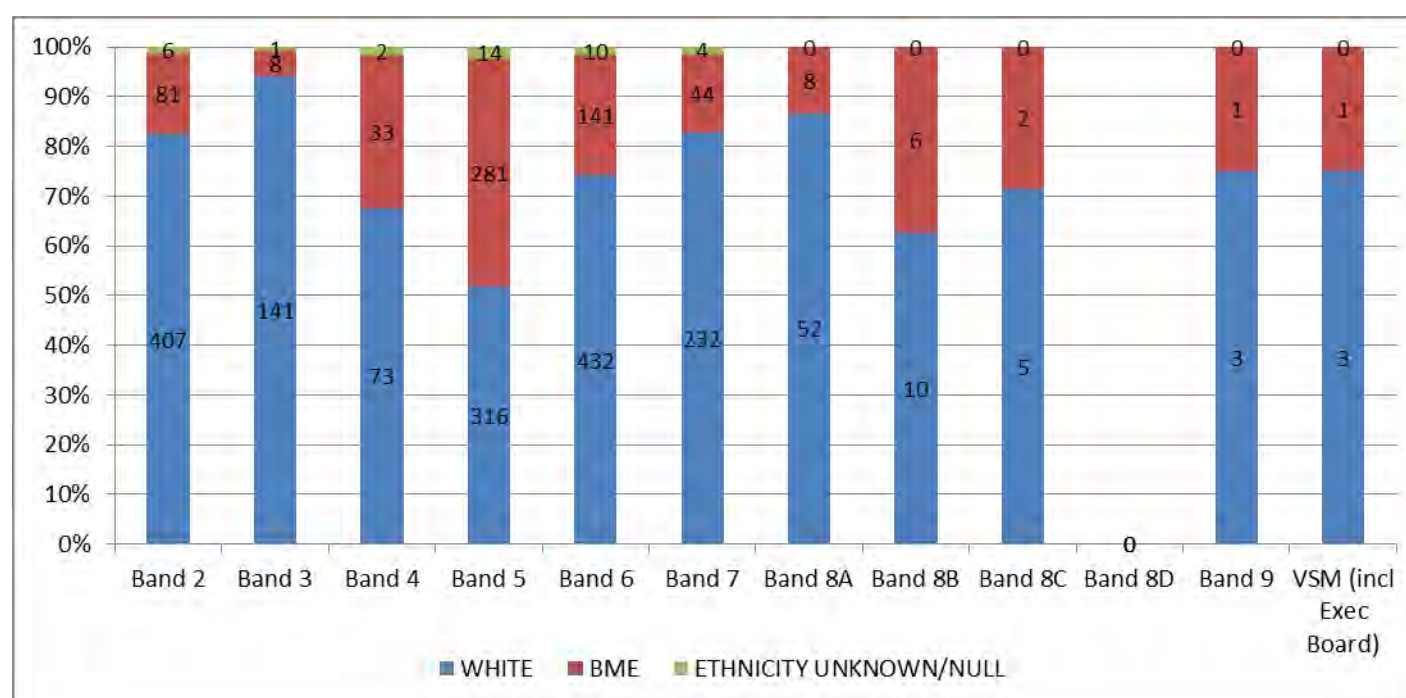
Table 3a: Ethnicity (Agenda for Change *All* Bands 2 to 9 and Very Senior Management, Headcount)

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	VSM
WHITE	1006	311	255	400	505	279	89	29	14	3	4	20
BME	148	27	48	294	149	49	14	7	5	2	2	2
ETHNICITY UNKNOWN/NULL	16	2	6	14	10	5	1	1	2	1	0	0
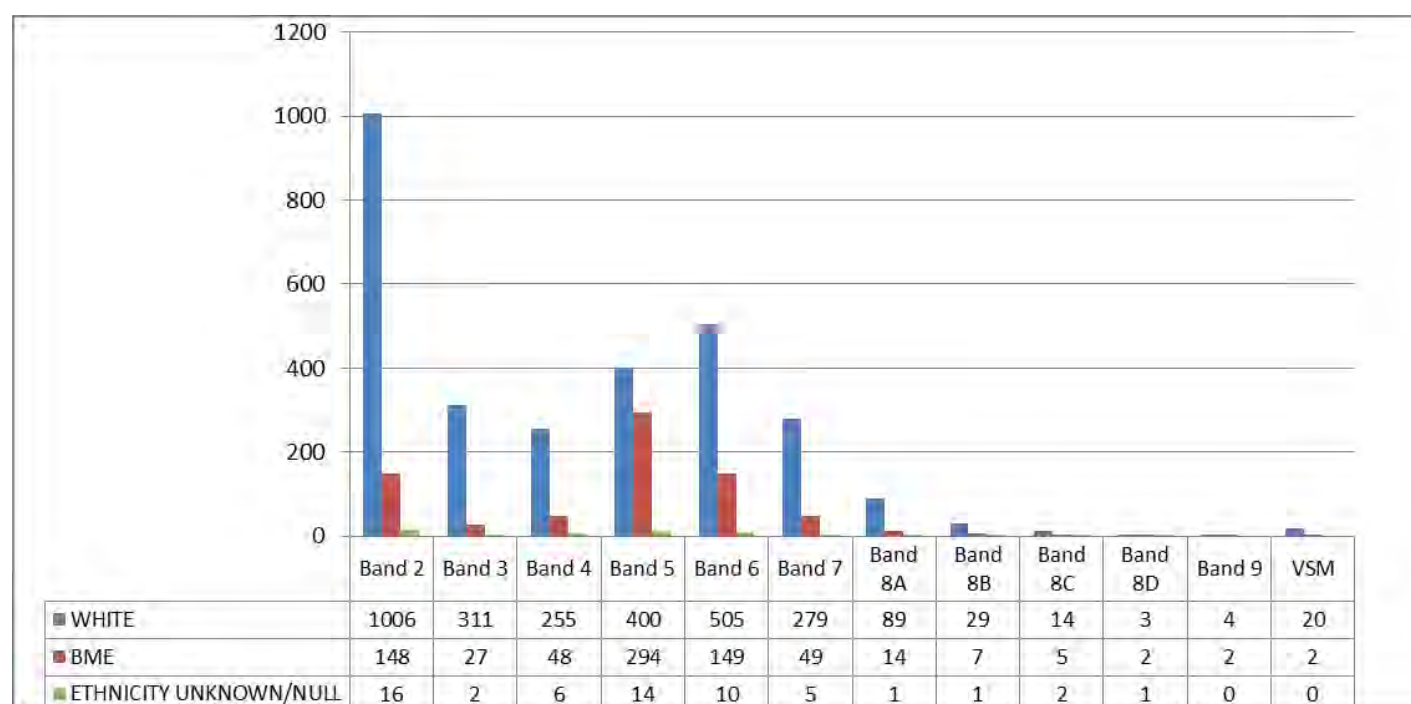
Table 3b: Ethnicity (Agenda for Change *All* Bands 2 to 9 and Very Senior Management, by proportion)

Workforce Race Equality Standard Report
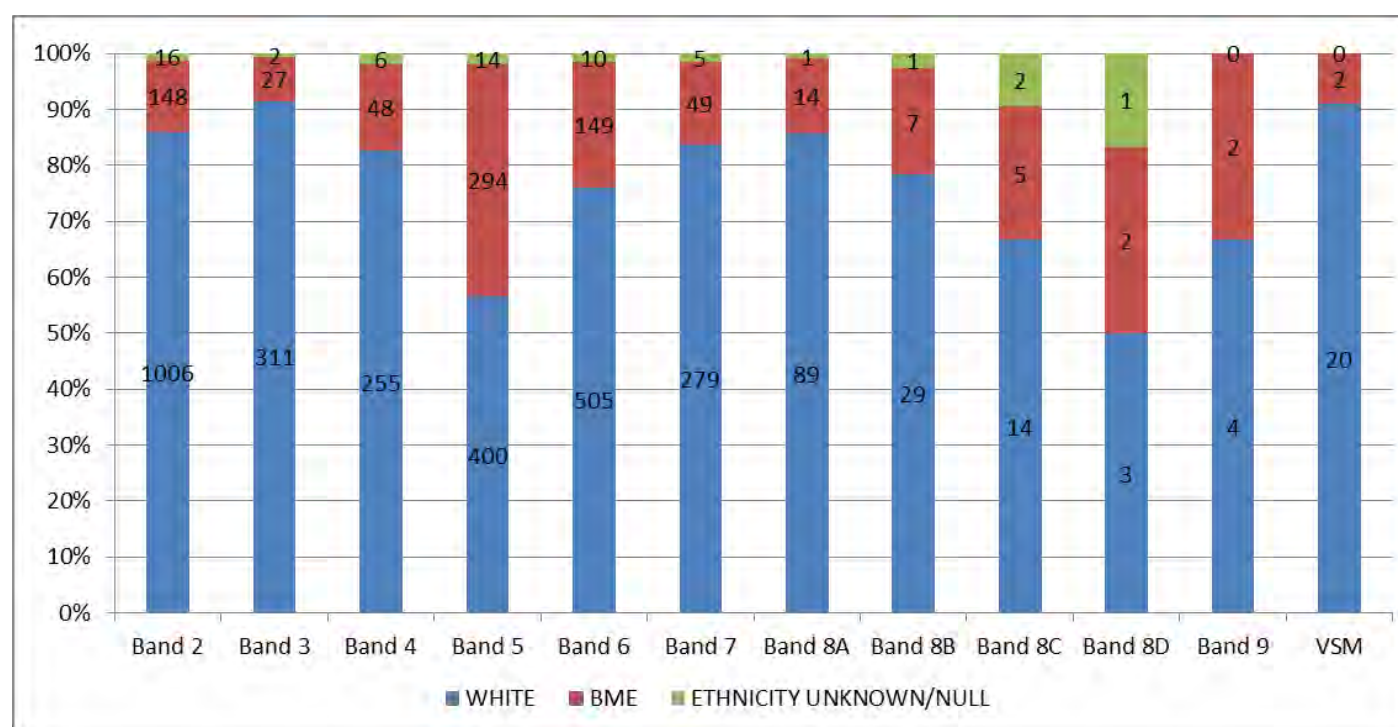
Table 4a: Ethnicity (Medical and Dental grades, Headcount)
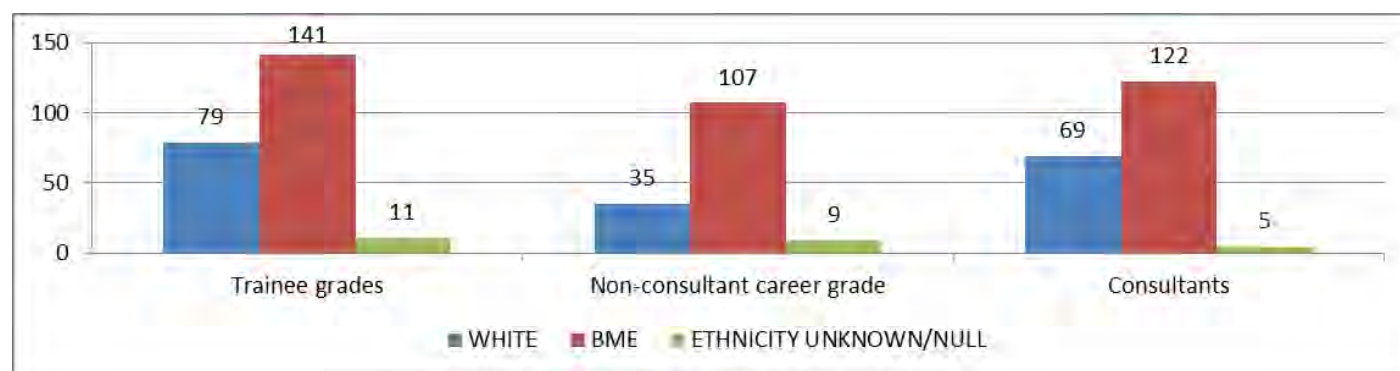
Table 4b: Ethnicity (Medical and Dental grades, by proportion)
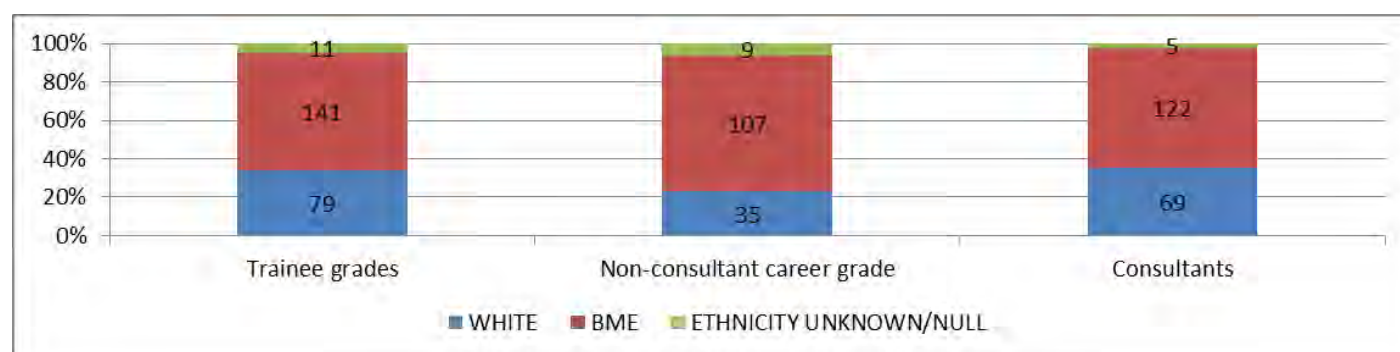
3.3 **Indicator 2** - Relative likelihood of staff being appointed from shortlisting across all posts.

In 2015/16, White people shortlisted for interview were 2.58 times more likely than BME people to be appointed. By 2018 this gap narrowed to 1.33 times, and currently stands at 1.30 times. Whilst this is still an improvement on last year and a significant improvement on the situation in 2015/16, the reality is that White candidates still have a greater likelihood of being appointed than candidates from BME backgrounds. [In 2018/19 the Trust appointed 26% of White candidates shortlisted, and 20% of BME candidates shortlisted.] Nevertheless, the Trust still aims for equality of opportunity in the appointments process, and has redesigned recruitment training to include training on unconscious bias and affinity bias.

3.4 **Indicator 3** - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

A statistically small number of individuals (1.98% of the whole workforce) have entered formal disciplinary procedures in the past year. White staff continue to be more likely to enter formal procedures than those from BME backgrounds. The proportion of BME staff in formal procedures is falling, whilst the proportion of White staff in formal procedures is increasing. However, the small number of staff in these procedures means that that changes from year are statistically insignificant.

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Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation			
WRES year	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
2019	2.23%	1.25%	0.56
2018	3.58%	1.61%	0.45
2017	1.22%	0.86%	0.71

3.5 **Indicator 4** - Relative likelihood of staff accessing non-mandatory training and CPD

From this year onwards, NHS England's WRES team have asked all NHS organisations to explain their definition of non-mandatory training. As with previous years, this Trust defines access to non-mandatory training as being all training available via MyESR (the training platform that is part of the NHS Electronic Staff Record) with the exception of Statutory and Mandatory training courses under the Core Training Standards Framework. Continued Professional Development (CPD) is defined as courses provided by Universities and other external providers. In house professional development specific to individual clinical disciplines and medical education are not included.

The data for this indicator shows that the performance on this indicator remains stable with a relative likelihood of uptake remaining at 0.85, and with staff from BME backgrounds still marginally more likely to access non-mandatory training, compared to their White colleagues. However, the uptake of non-mandatory training by White and BME employees has improved significantly.

Likelihood of staff accessing non-mandatory training and CPD			
	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
2019	70.04%	82.45%	0.85
2018	58.31%	68.68%	0.85

3.6 **Indicators 5-8** – National NHS Staff Survey indicators

The Trust is clear that harassment, bullying and abuse is not acceptable as it impacts on wellbeing, productivity, turnover and patient care. Whilst actions have been taken to address this, the indicators 5, 6 and 8 show deterioration from the previous year, and the Trust is performing at or below national average.

The indicators from the Staff Survey are:

- Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

- Indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

- Indicator 7 – Percentage believing that the trust provides equal opportunities for career progression or promotion.

- Indicator 8 – In the last 12 months have you personally experienced discrimination at work form manager/team leader or other colleagues?

For indicator 7 (Percentage believing that trust provides equal opportunities for career progression or promotion), the percentage of staff giving a positive answer has fallen, particularly amongst BME staff.

WRES Indicator	2017		2018		Direction of Travel
	White	BME	White	BME	
5	27.1%	29.1%	30.5%	28.0%	Stable
6	28.1%	31.8%	32.4%	31.8%	Stable
7	79.8%	67.3%	76.4%	69.1%	Stable
8	8.3%	16.2%	7.6%	14.6%	Improvement

There is now greater awareness in the Trust of equality and diversity (evidenced by increased compliance with mandatory training on equality and human rights and attendance at non-mandatory equality training), which may be contributing to greater awareness of potentially discriminatory practice. However, indication 8 (the only one of these indicators that relates to 'discriminatory practice') continues to improve, and to perform significantly better than the other 3 indicators.

3.7 **Indicator 9** - Percentage difference between the organisations' Board voting membership and its overall workforce

A marginal shift in this indicator is due only to a change in the size of the workforce. Given the low number of people involved, it is not appropriate to identify target dates for change, but the Trust will continue to identify action to encourage a wide range of suitable candidates at senior levels.

3.8 **Summary**

Performance against most of the WRES indicators has stabilised compared to 2018. Performance against indicators 3 and 4 shows year on year improvement, as does the Trust's performance on the proportion of staff who declare their ethnicity (now at 98%).

3.9 The most concerning indicators are those relating to the three of staff survey indicators (WRES Indicators 5 to 7). Performance on those indicators is poorer than those reported in the WRES in 2017 but have, on average, stabilised compared to those reported in 2018. The perceptions of White staff have worsened, but there are improvements in the perceptions of BME staff in all three of these indicators Indicator 8 (the proportion of staff reporting discrimination from managers or colleagues), has improved for both White and BME staff.

4   Next Steps

4.1 The next steps fall into two categories: actions for the Trust to implement to improve on the WRES indicators in future years; and ensuring the publication of the WRES summary by 31 July 2019. This must be on the NHS England WRES portal and the Trust's website.

4.2 Actions to improve performance must be published on the Trust website in September 2019. A summary of proposed actions is set out below (section 5), and will be worked up more fully by the Trust's Inclusion Steering Group. These actions will be incorporated in the Trust's EDS2 (equality delivery system) action plan, which is published annually as a part of the Trust's management information on equality, diversity and inclusion.

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5   Action Plan

	Direction of Travel compared to:			Action	Timeframe	Responsibility
	2018	2017	2016			
1 – Workforce Diversity	↔	↔	↔	Continue to promote ESR self-service	Current and ongoing	Workforce Intelligence
2 - Recruitment	↑	↓	↑	Continue to roll out the Recruitment Training for appointing managers, developed in 2018/19	Current and ongoing	Organisational Development and Head or Equality and Inclusion
3 – Formal Procedures	↑	↔	↑	Equality analysis of reasons for White staff being more likely to be in formal procedures	September 2019	Employee Relations
4 – Training	↑	↑	↑	Encourage all managers to use the Appraisal system to promote non-mandatory training and CPD	September 2019 and ongoing	Organisational Development and all managers
5-8 – Staff Survey	↔	↓	↔	Programme of staff engagement activity, including promotion of wellbeing opportunities and staff networks	Current and ongoing to October 2019	HR Business Development Manager, Head of Equality and Inclusion and Organisational Development
9 – Board Membership	↔	↑	↑	Review of methods and media for future recruitment of Non-Executive Directors and Senior managers	September 2019	HR&OD Senior Team

6   Recommendation

6.1   It is recommended that the Workforce Race Equality Summary be approved for submission to the NHS England WRES Portal and the Trust's website.

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Workforce Disability Equality Standard	**Agenda Item**	**7.3**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Alister McClure, Head of Equality and Inclusion		
Executive Summary	This report provides the first annual Workforce Disability Equality Standard summary (WDES). This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater disability equality, as required by the Equality Act 2010. Under the NHS Standard Contract (schedule 6a) the Executive Group and Board are required to consider and approve the WDES report prior to publication by 31 July 2019. As this is the first year of reporting, this report is a baseline assessment.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Human Resources and Organisational Development Senior Team Executive Group		
Resource Implications	None identified. Actions will be contained within existing budgets.		
Legal Implications/Regulatory Requirements	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Disability. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on disability equality in the form of the WDES summary.		
Quality Impact Assessment	Not applicable.		

Recommendation/ Actions required	It is recommended that the Workforce Disability Equality Summary be approved for submission to the NHS England WRES Portal and the Trust's website			
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1- The WDES Reporting Template.			

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1 Executive Overview

1.1 The main purpose of the WDES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the 10 WDES indicators,

- to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,

- to improve representation at the Board level of the organisation.

1.2 The WDES assessment has been prepared following revised technical guidance published by NHS England in 2018. There are 10 performance indicators (see spreadsheet). Performance on the quantifiable indicators (2, 3 and 10 shows disabled people to be disadvantaged compared to non-disabled people in recruitment, capability procedures and senior representation. The staff perception indicators (4 to 9) are drawn from the staff survey and consistently indicate that disabled employees are less satisfied than their non-disabled colleagues.

1.3 This report is a baseline report, so trends will not be known until later years. However, the assessment indicates that 5% of employees have declared that they are disabled, 77% have declared that they are not disabled, and 18% have not declared whether or not they are disabled. No employee on Agenda for Change band 8b or above has identified as disabled.

1.4 An action plan to address concerns and improve performance will be developed by the Trust's Inclusion Steering Group, by September 2019.

2 Background

2.1 The NHS WDES was made available to the NHS from December 2018, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WDES is included in the NHS standard contract, and this year's report forms the baseline assessment for the Trust.

2.2 The main purpose of the WDES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WDES indicators,

- to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,

- to improve representation at the Board level of the organisation.

2.3 It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WDES, including sign-off at Board level, before 31 July each year. The Trust must, therefore, publish its WDES following the Trust Board meeting on 3 July 2019.

2.4 The WDES Summary assessment is attached with this paper and the key findings are set out below.

3 Key Findings

3.1 Indicators 1 and 10: Disabled representation across the workforce

The assessment indicates that 5% of employees have declared that they are disabled, 77% have declared that they are not disabled, and 18% have not declared whether or not they are disabled. No employee on Agenda for Change band 8b or above has identified as disabled.

3.2 Performance on the quantifiable indicators (2 and 3) shows disabled people to be disadvantaged compared to non-disabled people in recruitment and capability procedures.

3.2.1 Indicator 2 (Relative likelihood of appointment from shortlisting)

The statistics show that non-disabled people were 1.15 times more likely than disabled staff to be appointed. 20% of disabled people and 23% of non-disabled people were appointed after shortlisting. This is close to parity, but nevertheless shows a marginal disadvantage for disabled people.

3.2.3 Indicator 3 (Relative likelihood of being in capability procedures)

It should be acknowledged that, as just 18 people were involved in capability procedures, it is not possible to consider the performance on indicator 3 as statistically significant.

3.3 Performance on the staff perception indicators (4 to 9), drawn from the staff survey, consistently indicate that disabled employees are less satisfied than their non-disabled colleagues. More work is needed to understand the reasons for this, and further engagement with disabled staff will take place in 2019/20.

Staff Survey Question, 2018	Medway FT		All Acute Trusts	
	Disabled	Non-disabled	Disabled	Non-disabled
Indicator 4a.i % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months.	37.6%	28.5%	33.8%	27.3%
Indicator 4a.ii % of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	29.2%	18.2%	20.8%	12.4%
Indicator 4a.iii % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	29.9%	21.5%	28.5%	19.0%
Indicator 4b % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	45.1%	44.0%	44.5%	44.4%

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Staff Survey Question, 2018	Medway FT		All Acute Trusts	
	Disabled	Non-disabled	Disabled	Non-disabled
Indicator 5 % of staff believing that the Trust provides equal opportunities for career progression or promotion.	66.3%	76.8%	77.4%	84.0%
Indicator 6 % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	37.9%	29.7%	34.1%	23.6%
Indicator 7 % of staff saying that they are satisfied with the extent to which their organisation values their work.	24.0%	36.0%	36.2%	48.0%
Indicator 8 % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	60.1%		72.1%	
Indicator 9 The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	5.8	6.5	n/a	n/a

4   Next Steps

4.1   The next steps fall into two categories: actions for the Trust to implement to improve on the WDES indicators in future years; and ensuring the publication of the WDES summary by 31 July 2019. This must be on the NHS England WDES portal and the Trust's website.

4.2   Actions to improve performance must be published on the Trust website in September 2019, and will be worked up by the Trust's Inclusion Steering Group. These actions will be incorporated in the Trust's EDS2 (equality delivery system) action plan, which is published annually as a part of the Trust's management information on equality, diversity and inclusion.

5   Recommendation

5.1   It is recommended that the Workforce Disability Equality Summary be approved for submission to the NHS England WRES Portal and the Trust's website.

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Appendix 1: Workforce Disability Equality Standard Reporting

METRIC	INDICATOR		Disabled	Non-disabled	Disability unknown	Total staff
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2019	1a) Non Clinical Staff				
		Cluster 1 (Bands 1 - 4)	4%	74%	22%	1067
		Cluster 2 (Band 5 - 7)	5%	82%	13%	231
		Cluster 3 (Bands 8a - 8b)	5%	88%	8%	65
		Cluster 4 (Bands 8c - 9 & VSM)	0%	81%	19%	26
		1b) Clinical Staff				
		Cluster 1 (Bands 1 - 4)	6%	76%	19%	743
		Cluster 2 (Band 5 - 7)	5%	77%	18%	1473
		Cluster 3 (Bands 8a - 8b)	3%	79%	18%	76
		Cluster 4 (Bands 8c - 9 & VSM)	0%	86%	14%	14
		Cluster 5 (Medical & Dental Staff, Consultants)	1%	65%	35%	200
		Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	3%	75%	22%	156
		Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	6%	88%	7%	232
2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff	1.15			
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	1.39			
4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	38%	29%		
		% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	29%	18%		
		% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	30%	22%		
		% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	45%	44%		
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	% of staff believing that the Trust provides equal opportunities for career progression or promotion.	66%	77%		
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	38%	30%		
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	% staff saying that they are satisfied with the extent to which their organisation values their work.	24%	36%		

METRIC	INDICATOR		Disabled	Non-disabled	Disability unknown	Total staff
8	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	60%			
9a	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	5.8	6.5		6.3
9b	**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)**	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)	Yes (see report)			
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** **• By Voting membership of the Board** **The data for this metric should be a snapshot as of 31st March 2019**	Total Board members - % by Disability	0%			
		Voting Board Member - % by Disability	0%			
		Non Voting Board Member - % by Disability	0%			
		Executive Board Member - % by Disability	0%			
		Non Executive Board Member - % by Disability	0%			
		Overall workforce - % by Disability	5%			
		Difference (Total Board - Overall workforce)	-5%			
		Difference (Voting membership - Overall Workforce)	-5%			
		Difference (Executive membership - Overall Workforce)	-5%			

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Safe Staffing- Inpatient Nursing, Midwifery and Care staff workforce review (inpatients) February/March 2019	Agenda Item	7.4
Lead Director	Karen Rule, Director of Nursing		
Report Author	Simone Hay, Deputy Director of Nursing- Planned care Karen McIntyre- Deputy Director of Nursing- Unplanned and Integrated Care Yasmin Ahmed, Deputy Director of Finance with Directorate Finance Business Partners.		
Executive Summary	The purpose of this paper is to present to the Board of Directors the outcome of the Inpatient Safe Staffing review and to provide assurance that the nursing establishments within inpatient areas are sufficient to provide safe care. The National Quality Board's (NQB) guidance on safe staffing (2016) states that providers: • must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively • should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times • must use an approach that reflects current legislation and guidance where it is available. The paper describes the process followed for the formal establishment reviews conducted within each of the directorates. Based on comparison data between October 2018 and April 2019 additional staffing resource identified from the review is an increase of 11.8 whole time equivalent (WTE). The paper also describes how the Planned Care Directorate will fund the additional staffing resource.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒

Committees or Groups at which the paper has been submitted	Directorate Management Board – Unplanned & Integrated Care and Planned Care Executive Group – 1 May 2019 and 15 May 2019.
Resource Implications	Planned Care Directorate requires additional £503k funding for nurse staffing. The Finance committee has been asked to note this cost pressure and to recognise that in the future there may be a request to support this from optimism bias however the first requirement is for the Directorate to resolve the cost pressure from elsewhere within their own delegated resource while maintaining the quality of care and the safety of patients.
Legal Implications/Regulatory Requirements	Meeting NQB's expectations helps providers comply with Care Quality Commission's (CQC) fundamental standards on staffing – for example, in the well-led framework and related legislation. The Trust must also ensure safe staffing levels in line with Royal College of Nursing (RCN) /Royal College of Midwifery (RCM) / National Institute for Health and Care Excellence (NICE) guidelines and NHS Improvement (NHSI) recommendations.
Quality Impact Assessment	Failure to provide safe staffing will detrimentally impact on safety, quality and flow. Agreement has been reached on funding source.
Recommendation/ Actions required	The Board is asked to note the content of the report and be assured the Trust has safe staffing levels in the inpatient areas.

Approval	**Assurance**	**Discussion**	**Noting**
☐	☒	☐	☐

Appendices	None

1 Executive Overview

1.1 Due to current challenges faced by the NHS both locally and nationally it is essential that we ensure as an organisation that we have a stable and talented workforce that is responsive and creative to peaks in demand and able to deliver high quality health care.

1.2 Evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, all of which align to the Trust priorities.

1.3 All Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality.

1.4 Trust Boards also have a duty to comply with the National Quality Board's guidance on safe staffing (2016) which states that providers:
    1.4.1 must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
    1.4.2 should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
    1.4.3 must use an approach that reflects current legislation and guidance where it is available.

1.5 The Nursing and Midwifery Council (NMC) sets out nurses and midwives responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the standards that all healthcare providers must meet to comply with Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2018).The NHS England guidance 'A Guide to Care Contact hours' (2014) recommends inclusion of contact time by nursing and midwifery staff in the establishment reviews. This is referred to as 'care hours per patient day' (CHPPD).

1.6 It is important to note the current staffing guidance is now supported by a further publication from NHSI 'Developing Workforce Safeguards'. It is the expectation that all Trusts will adopt and comply with this new guidance from April 2019 and therefore future reports will be based on this guidance.

1.7 The report focuses on the review of safe staffing across all adult inpatient areas excluding Maternity services and will include recommendations that enable safe staffing, which in turn will lead to improved outcomes and better care for all our patients.

1.8 The maternity unit completes the Birth Rate Plus acuity tool for the obstetric delivery suite and the Midwifery Led Unit four times a day. This is reviewed each day by the senior midwifery team and decisions are taken to ensure staffing reflects acuity.

2 Background

2.1 The safe care model has been in place across the organisation since March 2015. The purpose of this model is to work alongside the E-roster system. This enables flexibility and movement of staff to areas where there is an increase in activity or an increase in patient acuity.

It provides a systematic approach at ward level to ensure that patients receive the optimum nursing care they need regardless of the ward in which they are allocated, the time of day, or the day of the week.

2.2   The safe care acuity data collection is undertaken at intervals throughout a 24 hour period. This allows for staff to be reallocated or additional staff to be requested to ensure that patient safety within the clinical areas is maintained according to acuity and dependency. There is a clear escalation process for staff to raise concerns to the responsible matron or clinical site practitioners out of hours.

2.3   The Care Hours per Patient Day (CHPPD) data can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of the clinical support workers and dividing by the total number of inpatients. Since collection of this data commenced in June 2016, there has been variability in the data which has been captured. This has led to a need for further review in order to enable a standardised consistent approach to the assessment of acuity.

2.4   It is not recommended that CHPPD data is used in isolation and must be used alongside skill mix ratios, Safer Nursing Care Tool (SNCT) and the professional judgement of the senior team. Cole (2016). Independent review demonstrates that by using the CHHPD data triangulated with other quality measures allows for rich and meaningful data to be captured.

2.5   SNCT is the NICE recommended nurse staffing tool for establishment setting. This tool considers patient acuity and dependency and ward activity and used in conjunction with professional judgement allows staffing to be assessed and delivered to provide safe staffing ratios for care.

2.6   NHSI recommend that establishment reviews are undertaken every six months using a recommended tool such as the Safer Nursing Care Tool. Nursing establishments were reset in May 2018 following a safer staffing review. A further follow up audit was undertaken in October 2018 in line with this recommendation. This identified that some changes needed to be made to ward establishments which included an increase in establishments to Bronte, Pembroke and Surgical Assessment Unit (SAU). The data identified that no other changes were required at this time.

3   Principles of safe staffing review

3.1   The Executive Director of Nursing alongside the Deputy Directors of Nursing (DDoNs) and Workforce team agreed a set of principles to be followed in order to set the establishments using the evidence from the review.

3.2   The following principles for rebasing the establishments were agreed:

3.2.1   Band 7 senior sister to be in a supervisory role 100%. This is a nationally recognised staffing principle.

3.2.2   A Band 6 clinical sister on each shift, which will also include nights and weekends.

3.2.3   All staffing levels to be determined by demand and patient acuity as assessed via the safer nursing care tool.

3.2.4   Gold standard is a skill mix ratio of 65/35 where 65% of the care staff on duty are registered nurses and 35% are non-registered. Due to our current vacancy rate it is not possible to achieve the recommended standard of 65/35 therefore it has been agreed that 60/40 is acceptable.

3.2.5   Our current uplift remains at 22% for nursing (24% for maternity). This is in line with national guidance and allows for cover for study leave, annual leave and sickness.

3.2.6   In order to align our staffing ratios with the needs of our patients our acuity and dependency data will be aligned with establishments and will move away from the traditional 1 to 8 ratio.

4   Methodology

4.1   A full review of in patient wards was undertaken over a seven day period. This included the following:

4.1.1   A team of matrons including the Nursing workforce team collected acuity data twice a day for seven days.

4.1.2   Matrons did not review their own areas but peer reviewed each other.

4.1.3   The data was collected by the review team and discussed with the senior sisters or nurse in charge to validate the acuity data.

4.1.4   Once the data had been agreed the matron for that area inputted the data into the Safe Care tool.

4.1.5   Once the seven day census period had finished the Matron for Workforce reviewed all data submissions. This included reviewing the acuity levels of all in patient area submissions and calculating an average for each ward over the seven day period.

4.1.6   The data was then uploaded on to a database which is designed by the Shelford group and calculates the WTE required for each ward based on average acuity.

4.1.7   This information was uploaded on to a template provided by finance to calculate the cost and shared with the senior sisters, matrons, clinical co-directors, DDONs, Executive Director of Nursing and finance teams.

5   Summary of Directorate Reviews

5.1   Recommendations based on the outcome of the Safer Nursing Care results were presented, benchmarked against our peers and considered form a professional perspective by the senior teams. Each ward was discussed individually following submission of the SCNT data.

5.2   The tables below provide the summary position of the adjustments in establishment for Unplanned Care and Planned Care.

Planned Care Directorate - Safer Staffing Wards

	18/19 Total WTE	19/20 Total WTE	Wte Uplift	Full Cost for 19/20 £	19/20 budget allocated based on FOT £	Budget surplus / (deficit)	WTE Shortfall
Pembroke Wards	40.49	45.74	5.25	1,714,184	1,732,212	18,028	0.76
Kingfisher & SAU	40.37	43.11	2.74	1,550,605	1,538,304	(12,301)	(0.33)
Victory Ward	27.25	27.25	0.00	1,026,358	958,428	(67,930)	(1.77)
McCulloch Ward	40.49	40.49	0.00	1,512,725	1,667,544	154,819	4.04
Phoenix Ward	40.49	40.49	0.00	1,501,107	1,534,284	33,177	0.67
ICU	55.38	55.38	0.00	2,531,388	2,353,743	(177,645)	(3.58)
Trafalgar Ward	35.04	35.04	0.00	1,514,558	1,432,176	(82,382)	(1.87)
Medical HDU	24.63	24.63	0.00	1,059,043	974,404	(84,639)	(1.84)
SDCC Ward Nurses	34.48	34.48	0.00	1,245,541	961,104	(284,437)	(6.61)
	338.62	**346.61**	**7.99**	**13,655,509**	**13,152,199**	**(503,310)**	**(10.52)**

Unplanned Care Directorate - Safer Staffing Wards

	18/19 Total WTE	19/20 Total WTE	Difference	Full Cost for 19/20 £	19/20 budget allocated based on FOT £	Budget surplus / (deficit)	WTE Shortfall
AMU Lister	59.71	56.05	(3.66)	2,034,083	2,034,083	-	-
Arethusa	40.22	42.74	2.52	1,522,300	1,522,300	-	-
Wakeley	41.76	38.96	(2.80)	1,384,493	1,384,493	-	-
Will Adams	37.89	37.62	(0.27)	1,344,846	1,344,846	-	-
Keats Ward	37.76	37.63	(0.13)	1,346,039	1,346,039	-	-
Bronte Ward	30.89	35.58	4.69	1,208,360	1,208,360	-	-
CCU Ward	12.59	13.24	0.65	527,638	527,638	-	-
Nelson Ward	35.52	35.59	0.07	1,278,192	1,278,192	-	-
Harvey Ward	40.47	43.75	3.28	1,535,642	1,535,642	-	-
Byron Ward	37.58	37.34	(0.24)	1,341,601	1,341,601	-	-
Tennyson Ward	38.13	37.85	(0.28)	1,353,140	1,353,140	-	-
Milton Ward	40.87	40.06	(0.81)	1,414,234	1,414,234	-	-
SAFU	41.86	40.57	(1.29)	1,425,244	1,425,244	-	-
Lawrence Ward	32.27	36.06	3.79	1,288,261	1,288,261	-	-
Galton Ward	26.44	24.66	(1.78)	792,312	792,312	-	-
	553.96	**557.69**	**3.73**	**19,796,387**	**19,796,387**	**-**	**-**

6 Staffing adjustments – unplanned and integrated care directorate

6.1 An uplift in establishment is required on Bronte ward, Harvey Ward and Lawrence Ward. This uplift is offset by adjustments to staffing levels on other wards within the Directorate.

6.2 2019/20 Budgets have been set at M9 (2018/19) forecast outturn and are sufficient to fund the changes in establishments required.

7 Staffing adjustments – planned care directorate

7.1 Pembroke ward requires an increase in Clinical Support Worker (CSW) establishment of one for each shift to provide enhanced care for the high number of vulnerable patients cared for on the ward. The current review was undertaken during a week when the acuity was particularly high and indicated a requirement for additional four CSWs per shift, however the application of professional judgement

suggests this is inappropriate and 1 CSW will manage normal acuity demand. The recommendation is to uplift the establishment by 5.25WTE.

7.2   It is recommended the SAU incorporate a band 5 nurse Monday-Sunday from 10:00- 23:00 hours, in order to meet patient acuity, increased activity through the unit and to provide dedicated nursing care to patients in the waiting room and those receiving treatment. The recommendation is to uplift the establishment by 2.74WTE for Kingfisher and SAU.

7.1   It is recommended all other ward nurse establishments in Planned Care Directorate remain unchanged.

7.2   Although WTE establishment in Planned Care wards reflects the safer staffing uplift, due to the budget being set on 2018/19 outturn there is a shortfall of funding of £503k as per the table in 5.2. Planned care wards vacancies from 2018/19 are now being recruited to and therefore budget needs to be available to cover for these posts.

7.3   The requirement to staff at safe staffing levels is paramount. The Executive Group agreed to implement the safe staffing recommendations.

7.4   The need for the Trust to equally manage any cost pressures associated with maintaining these levels is equally important. A £0.5 million pressure has been identified. The Executive Group concluded that this will in the first instance be sought through further improvements within the Directorate.

7.5   The Finance committee has been asked to note this pressure and to recognise that in the future there may be a request to support this pressure from optimism bias however the first requirement is for the Directorate to resolve the pressure from elsewhere within their own delegated resource while maintaining the quality of care and the safety of patients.

8   Conclusion and Next Steps

8.1   All Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. Implementation of the recommendations presented in this report will ensure the Trust is able to fulfil its duty and maintain safe levels of nursing care.

8.2   Any significant changes to activity or speciality will trigger an establishment review and reviewed for accuracy six weeks after any change.

9.3   The Board of Directors are asked to note the outcome of the safe staffing review and be assured the Trust has safe staffing levels in the inpatient areas.

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Board Assurance Framework	**Agenda Item**	**8.1**
Lead Director	James Devine, Chief Executive		
Report Author	Brenda Thomas, Company Secretary		
Executive Summary	This report provides the Board with the Trust's Board Assurance Framework (BAF) aligned with the Trust's strategic objectives. The purpose of the BAF is to provide a structure and process that enables the Trust focus on those risks that might compromise achieving its strategic objectives; map out the key controls that should be in place to manage those risks and confirm that the Board has gained sufficient assurance about the effectiveness of the controls. Following approval by the Board of a fifth strategic objective: *High Quality Care - We will consistently provide high quality care*, new risks have been raised, taking the total risks on the BAF to 15, from the previous 11. All risks on the BAF have a threshold of 12 or higher.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	⊠	
	Finance: We will deliver financial sustainability and create value in all we do	⊠	
	People: We will enable our people to give their best and achieve their best	⊠	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	⊠	
	High Quality Care: We will consistently provide high quality care	⊠	
Committees or Groups at which the paper has been submitted	Executive Group, 5 June 2019		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The Board is responsible for ensuring that the Trust has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. The Board is also accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the Trust's objectives.		

Board Assurance Framework

Best of care
Best of people

Quality Impact Assessment	Not required.

Recommendation/ Actions required	The Board is asked to scrutinise and comment on the risk profile of the BAF and consider whether:
	  a. the risks identified reflect the most significant risks facing the Trust along with the risk ratings given to each risk.
	  b. the identified controls and assurances provide members with the necessary assurance that these risks are being managed effectively
	  c. the assurances give Board members the necessary confidence that the controls put in place to manage these risks are working effectively.

Approval ☐	**Assurance** ☒	**Discussion** ☒	**Noting** ☐

Appendices	Appendix 1 - BAF Highlight Report Appendix 2 - Board Assurance Framework Appendix 3 - BAF Heat Map Appendix 4 - Risk Matrix

1   Executive Summary

1.1   Following approval by the Board of a fifth strategic objective: *High Quality Care - We will consistently provide high quality care*, new risks have been raised, taking the total risks on the BAF to 15, from the previous 11.

1.2   All risks on the BAF have a threshold of 12 or higher.

2   Board Assurance Framework

2.1   At the Executive Group meeting on 5 June 2019, the following changes were approved:

Objective One: Integrated Health and Social Care

1) Composite risk title changed from '*System Integration to deliver sustainable future system model of care*' to '*Lack of System Integration to deliver sustainable future system model of care*'.
2) Framing of risk changed - articulated around the risk of not delivering for patients, rather the risk of not delivering collaboration.
3) Risk owner changed from *Director of Planning and Partnerships* to *Director of Strategy*.

Objective Two: Innovation

1) Risk 2a - risk title changed from *'Innovation'* to *'Digital Innovation'*
2) **Current and target risk ratings for digital innovation downgraded from 16 (4x4) and 12 (4x3) to 9 (3x3) and 6 (3x2) respectively**.
3) Risk description, key controls and gaps in controls for all risks have been revised.

Objective Three: Finance

1) Risk 3a - Delivery of financial control total: **Current risk rating downgraded from 20 (4x5) to 12 (4x3)**
2) Risk 3c - Failure to achieve longer term financial sustainability: **Current risk rating downgraded from 25 (5x5) to 16 (4x4)**
3) Risk 3d - Going Concern: **Current and target risk ratings downgraded from 8 (4x2) to 4 (4x1)**.

Objective Four: Workforce

All risk ratings remain unchanged.

Objective Five: Quality

Risk ratings, controls and assurances for the four risks raised were agreed.

2.2   **Appendix 1:** BAF risks - highlight report, presents a summary of the key updates, including new risk ratings since the BAF was last reviewed.

2.3   **Appendix 2** presents the risk heat map showing where risks are concentrated.

3   Conclusion and Next Steps

3.1   Executive directors will continue to review and monitor the strategic risks. The Integrated Audit Committee will scrutinise the BAF at every meeting.

Board Assurance Framework

Appendix 1: BAF Risks - Highlight Report June 2019

Strategic Objective	Risk Title	Risk Owner	Key Updates	2018 Current risk rating DEC	2019 Current risk rating JUN	Movement From Last Report	2018 Target risk rating DEC	2019 Target risk rating JUN
Objective One: Integrated Health and Social Care	1a - Lack of System Integration to deliver sustainable future system model of care	Director of Strategy	1. Amendment to objective, to read: *Integrated Health Care - We will work collaboratively with our system partners to establish an Integrated Care Partnership* 2. Risk title changed from 'System Integration to deliver sustainable future system model of care' 3. Framing of risk changed - articulated around the risk of not delivering for patients, rather the risk of not delivering collaboration 4. Risk owner changed from Director of Planning and Partnerships to Director of Strategy.	16 (4x4)	16 (4x4)	↔	6 (3x2)	6 (3x2)
Objective Two: Innovation	2a - Digital Innovation	Director of IT Transformation	1. Risk title changed from 'Innovation' to 'Digital Innovation' 2. Risk description reviewed 3. Current risk rating downgraded from 16 to 9 4. Target risk rating downgraded from 12 to 6	16 (4x4)	9 (3x3)	↓	6 (3x2)	6 (3x2)
	2b - Capability	Director of IT Transformation	Changes made include: 1. Target date moved from 31 March 2019 to 31 March 2020	12 (4x3)	12 (4x3)	↔	9 (3x3)	9 (3x3)
	2c - Funding	Director of IT Transformation	1. Target date moved from 31 March 2019 to 31 March 2020	9 (3x3)	9 (3x3)	↔	9 (3x3)	9 (3x3)
Objective Three: Finance	3a - Delivery of financial control total	Director of Finance	1. Current risk rating downgraded from 20 to 12	20 (4x5)	12 (4x3)	↓	12 (4x3)	12 (4x3)
	3c - Failure to achieve longer term financial sustainability	Director of Finance	1. Current risk rating downgraded from 25 to 16	25 (5x5)	16 (4x4)	↓	12 (4x3)	12 (4x3)
	3d - Going Concern	Director of Finance	1. Current and target risk ratings downgraded from 8 to 4	8 (4x2)	4 (4x1)	↓	8 (4x2)	4 (4x1)
Objective Four: Workforce		Director of HR and OD	No changes made			↔		
Objective Five: Quality	5a - Achieving required quality and safety standards and delivery of *Brilliant* care	Director of Nursing	New risks raised following approval by the Board of a fifith strategic objective: *High Quality Care - We will consistently provide high quality care*	N/A	16 (4x4)	N/A	N/A	4 (4x1)
	5b - Compliance with the statutory requirements of the Hygiene Code	Director of Nursing		N/A	16 (4x4)	N/A	N/A	6 (3x2)
	5c - Managing capacity and Demand	Director of Nursing		N/A	12 (4x3)	N/A	N/A	6 (3x2)
	5d - Quality Governance	Director of Nursing		N/A	12 (4x3)	N/A	N/A	4 (2x2)

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target ↔

Board Assurance Framework

The five Strategic Objectives of the Trust are as follows:

Objective One: Integrated Health Care - We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place

Objective Two: Innovation - We will embrace innovation and digital technology to support the best of care

Objective Three: Financial Stability - We will deliver financial sustainability and create value in all we do

Objective Four: Our people - We will enable our people to give their best and achieve their best

Objective Five: High Quality Care - We will consistently provide high quality care

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Lack of System Integration to deliver sustainable future system model of care
EXECUTIVE LEAD: Director of Strategy
LINKS TO STRATEGIC OBJECTIVE: One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 1a **TITLE:** Failure of partnership working to enable the design of future health and social care models with quality at its core across all systems partners. **CAUSE AND EFFECT:** There is a risk that the Medway and Swale system cannot enable true partnership working which designs a long term population based, integrated health and social care system with the patients at its centre. Thus leading to a failure to deliver systems integration, stability and better patient services via the enablement of clinically led patients centred system redesign. **IMPACT:** The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) and at a locality level within Medway and Swale that is based on a joint strategic needs assessment. We will therefore not leverage the ability to redesign the system for better quality of care to be provided to those we serve in the short and long term.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Establishment of monthly Medway and Swale Transformation Board. a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive. b. Membership is made up of executive from all provider and commissioning organisation c. System recovery is a standing agenda item. d. Cost Improvement Plan (CIP) and QIPP plans as well as commissioners key transformational programmes monitored via the Board. 2. Systems wide strategic vision written in partnership with all organisations. Agreed Intergraded Care Partnership (ICP) model in place with systems partners actively working to mobilise key collaborative elements. 3. A director of Systems Transformation is now in post to act as the programme manager for the formation of the Medway and Swale system. 4. A 10 year systems integration plan based on key population based outcome measures and underpinned with a long term financial management plan is being written in collaboration with all Medway and Swale systems partners.	1. Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement bi-monthly Assurance meetings. 2. Regular updates against milestones submitted to Executive and Board of Directors meetings. 3. Proposed governance arrangements for the Medway and swale system to be agreed with sovereign boards in the summer of 2019. 4. The Local system is working with the ICS management team to set up a framework to enable organisational collaboration within the umbrella of a 10 year population based health and social care contract. 5. The ICPs agreed ambition is as follows and will have detailed population health outcome measures developed as part of the multi-agency development work which will read across to the ICS and ICP Joint Strategic Needs Assessment work : a) Shifting the focus of care from treatment to prevention; b) Utilising evidence based interventions with clinically led service developments c) Support the delivery of highest quality primary, community and urgent care; d) Design and develop local care; e) Provider collaboration to deliver equality and efficiency; f) Mental health development to improve the overall value of care provided; g) Maximise value and patient outcomes from specialised commissioning; h) Establish a flexible and collaborative approach to workforce; i) Digital interoperability to improve information flow and efficiency.	1. Governance model in draft. 2. No ICP accreditation process established to follow and no 5 to 10 year ICS or ICP plan drafted as yet.. 3. Patient and staff side engagement strategy needs to be further developed.	**4 (major) X 3 (possible) = 12 [High]**	**3 (moderate) X 2 (unlikely) = 6 [Moderate]**	July 2019 to review progress against key milestones

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Innovation

EXECUTIVE LEAD: Director of IT Transformation

LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 2a **TITLE: Digital Innovation** **CAUSE AND EFFECT:** There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP and the organisation's role therein. **IMPACT:** Trust may slow down investment in digital innovation to keep to the pace of the STP.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Work with the STP to influence strategic direction and the digital agenda. 2. Establish Digital Delivery Group in the Trust which will also consider the wider interfaces to the STP and the emerging ICS and ICP. 3. Maintain priority and focus on the investment on digital technology within the Trust which supports the Trust wider transformation agenda.		1. Development of longer term Digital and I innovations Strategy 2. Agree Digital Governance 3. Establish Digital providers Forum	**3 (moderate) X 3 (possible) = 9 [High]**	**3 (moderate) X 2 (unlikely) = 6 [Moderate]**	01/07/2019
BAF Risk: 2b **TITLE: Capability** **CAUSE AND EFFECT:** There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology. **IMPACT:** Transformational change will be held back which may impact also quality improvements and meeting financial targets.	**3 (moderate) X 3 (possible) = 9 [High]**	1. Prioritisation of digital programmes to support key transformation deliverables. 2. Review and restructure IT Services department undertaking a capability and skills assessment 3. Seek private sector partners to support the delivery of foundation services		1. IT Services review 2. Foundation Services Plan	**4 (major) X 3 (possible) = 12 [High]**	**3 (moderate) X 3 (possible) = 9 [High]**	31/03/2020
BAF Risk: 2c **TITLE: Funding** **CAUSE AND EFFECT:** There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research. There is a risk that the Trust will be unable to secure sufficient capital to invest in the desired new technologies. **IMPACT:** The Trust may become less attractive for new medical and clinical staff The Trust may not deliver the transformation required at pace	**3 (moderate) X 3 (possible) = 9 [High]**	1. Trust investment in the R and D department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials. 2. Partnering arrangements being secured for managed services in a number of areas to enable cost of innovation to be spread over the life, as well as ensuring there is sufficient expertise for optimum implementation and adoption. 3. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released. 6. Work with the ICP, CCG and other external partners to secure funding to support collaborative working. 7. Agree the capital programme for the delivery of digital innovation and foundation IT services. 8. Ensure that best value is being delivered through current contracts.		Develop reporting mechanism to appropriate committees including: Transformation Assurance Group Clinical Council Digital Delivery Board Capital Group, Finance Committee	**3 (moderate) X 3 (possible) = 9 [High]**	**3 (moderate) X 3 (possible) = 9 [High]**	31/03/2020

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Finance

EXECUTIVE LEAD: Director of Finance

LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 3a **TITLE:** Delivery of financial control total **CAUSE AND EFFECT:** There is a risk that the Trust may be unable to establish financial sustainability within the required timeframe due to inability to realise efficiencies. **IMPACT:** This may lead to inability to return to balance position and deliver the financial control total leading to a reputational impact.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. agency usage has reduced and bank usage increased – continuing to focus on this, and to address bank rate differentials b. improving run rate during the year. c. live monitoring of cost improvement programme by TAG d. rebasing of directorate plans e. 12 monthly budgets 2. Establishment of Programme Management Office and appointment of Financial Improvement Director to track operational delivery and financial consequences of those actions. 3. Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board. Weekly performance overview meetings. Internal accountability framework at programme level. 4. Monitoring controls: Monthly reporting of actual v budget performance for review at PRMs and presented to the Board. Weekly performance overview meetings. Internal accountability framework at programme level. 5. Fortnightly system transformation meetings to look at strategy for efficiency across care pathways. 6. Monthly Integrated Assurance Meetings with regulators.	1. Heightened Grip and Control processes (Q4 2018/19) 2. monthly reporting 3. daily updates of agency expenditure 4. routine confirm and challenge sessions 5. report on cost centres adverse to plan a. in finance report b. to Directors	1. Establishment and prosecution of system wide recovery plan 2. Understanding of shifts in reference costs and model hospital between years 3. Assessing impact of quarterly spend and activity on reference costs	**4 (major) X 3 (possible) = 12 [High]**	**4 (major) X 3 (possible) = 12 [High]**	Establishment of system wide Recovery Plan: **30/09/2019** Prosecution of system wide Recovery Plan: **Dependent on the Plan** Assessing impact of quarterly spend: **2019/20**
BAF Risk: 3b **TITLE:** Investment **CAUSE AND EFFECT:** If there is insufficient cash to invest in new technologies, there is a risk to the transformation plan. **IMPACT:** Non-delivery of transformation plan.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Governed entirely by the availability of cash, obtaining loans for significant investment in new technologies will require business cases to be signed off by regulators unless affordable within the existing capital programme or through a revenue stream. (Note: Risk not fully mitigated from the Trusts perspective until it starts to generate a cash surplus).	1. Development of standard business case process (Q2 2019/20) 2. Project reviews by Finance Committee (Q1 2019/20).	1. Strategy for innovation in IT to be developed. 2. Assessment of methodology for IT delivery 3. National shortage of capital funding recognised. Will need some key choices to be made by the Board during 2019/20	**4 (major) X 3 (possible) = 12 [High]**	**4 (major) X 3 (possible) = 12 [High]**	**Once strategy is defined.**

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Finance

EXECUTIVE LEAD: Director of Finance

LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 3c **TITLE:** Failure to achieve longer term financial sustainability. **CAUSE AND EFFECT:** Achieving financial sustainability is a statutory responsibility. Improving the position will lead to enhanced reputation leading to an improved capability for recruitment into key roles. **IMPACT:** This may lead to further regulatory action.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Establishment of Transformation Operational Board with System Recovery as key cornerstone of the programme monitoring delivery and engaging with partners.	1. Development of longer term financial model based on impact of 2018/19 delivery on 5 year programme. 2. Reporting of identified pressures alongside CIP and budgetary delivery to Finance Committee on a regular basis (M8 2018/19 and ongoing). 3. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans). 4. Development of system wide financial narrative and joint plans with commissioners and other key stakeholders.	1. Better understanding of run rate and impact of changes. 2. Development of service line and Patient Level Information and Costing System (PLICs). 3. Closer scrutiny at PRMs 4. Programme for the development of service line information and its migration to service line management processes to be established (Q4 2018/19) for delivery by Q3 2019/20.	**4 (major) X 4 (likely) = 16 [Extreme]**	**4 (major) X 3 (possible) = 12 [High]**	
BAF Risk: 3d **TITLE:** Going Concern **CAUSE AND EFFECT:** There is a risk that the Trust's Going Concern assessment is at risk given the proportionality of the continued and sustained deficit. **IMPACT:** This could lead to further licence conditions and potential regulatory action.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Interaction with regulators for loans to support deficit and capital requirements has mitigated this risk. (**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).	1. Change would be required in national context		**4 (major) X 1 (rare) = 4 [Moderate]**	**4 (major) X 1 (rare) = 4 [Moderate]**	

COMPOSITE RISK: Workforce
EXECUTIVE LEAD: Director of Human Resources and Organisational Development
LINKS TO STRATEGIC OBJECTIVE: Objective Four - Our People: We will enable our people to give their best and achieve their best

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 4a **TITLE:** Staffing levels including recruitment and retention **CAUSE AND EFFECT:** There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function **IMPACT:** This may lead to an impact on patient experience, quality, staff morale and safety	**4 (major)** **X** **4 (likely)** **=** **16** **[Extreme]**	1. Strategy: Workforce Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	Workforce strategy in place from April 2018 to 31 March 2019. 2019/21 Workforce Strategy presented at April 19 development Board.	Talent management to support the Trust's successional planning process due to form part of revised Workforce Strategy alongside culture programme. [April 19]	**4 (major)** **X** **2 (unlikely)** **=** **8** **[High]**	**4 (major)** **X** **2 (unlikely)** **=** **8** **[High]**	**March 2020**
		2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Launch of retention programmes across Trust.	1. Trust vacancy rate at 18%. 2. Sickness rate 4.2% 3. Substantive workforce 85.1%				
		3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	1. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. 2. Temporary staffing and daily pressure/gap report in operation.				
		4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	1. Number of substantive nurses currently at highest point since 2015. C.450 international nursing offers in place.				
		5. Temporary staffing delivery: a. NHSI agency ceiling reporting to Board; b. Weekly breach report to NHSI; c. Reporting to Board of substantive to temporary staffing paybill.	1. £5.1m favourable to ceiling; 2. Averaging 20 breaches per week compared to c1000 in 2016 3. Agency workforce 5% 4. Bank workforce 12%				
		6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	84 apprentices of 101 target				
		7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	85% of operational HR KPIs met				

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Workforce
EXECUTIVE LEAD: Director of Human Resources and Organisational Development
LINKS TO STRATEGIC OBJECTIVE: Objective Four - We will enable our people to give their best and achieve their best

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 4b **TITLE:** Staff Engagement **CAUSE AND EFFECT:** Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	3 (moderate) X 4 (likely) = 12 [High]	1. Strategy: Workforce Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	1. Workforce strategy in place from April 2018 to 31 March 2019. 2019/21 Workforce Strategy presented at April 2019 development Board.	Local survey action plans to be developed and discussed through PRM processes. Pulse surveys to be implemented to enable continuous feedback. Values-based recruitment to be reviewed in March 2019.	3 (moderate) X 4 (likely) = 12 [High]	3 (moderate) X 2 (unlikely) = 6 [Moderate]	March 2021
		2. Culture Intervention: The Trust has engaged with specialist to deliver 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change.	1. You are the difference (YATD) commenced in Q2 18/19, Phase 2 implemented February 2019 2. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme.				

		3.Staff Communications:
		  a. Weekly Chief Executive communications email;
		  b. Monthly Chief Executive all staff session (December 2018 onwards);
		  c. Senior Team briefing pack monthly.
			Communications routes well-established in Trust.				

		7. Staff Survey results: Annual report to Board demonstrating:
		  c. Trust scores across key domains;
		  d. Comparative results from previous years and other organisations;
		  e. Heat maps for targeted interventions.
		  f. Local survey action plans to address key concerns.
			Survey 2018 staff engagement score, 6.4 – lower than average 7				

		8. Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 2018/19.				

		6. Policies, processes and staff committees in place:
		  a. Freedom to speak up guardian route to Chief Executive;
		  b. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours;
		  c. Respect: countering bullying in the workplace policy;
		  d. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.
			1. Freedom to speak up guardians in place;
			2. Promoting professional pyramid in place, training for peer messengers continuing;
			3. Respect policy in place;
			4. JSC and JLNC in place.				

		7. Well-being interventions in place:
		  a. Employee assistance programme and counselling;
		  b. Advice and health education programmes;
		  c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support.
			1. Employee assistance programme launched and live;
			2. Advice, education and Connect 5 programmes live.				

		8. Values embedded into the Trust and culture:
		  a. Values-based recruitment (VBR) in place for medical and non-medical positions;
		  b. Values-based appraisal in conjunction with performance.
			1. VBR in place since June 2018;
			2. Qualitative and quantitative values-based appraisal in place since April 2018.				

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Workforce
EXECUTIVE LEAD: Director of Human Resources and Organisational Development
LINKS TO STRATEGIC Objective Four - Our People: We will enable our people to give their best and achieve their best

| Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 4c **TITLE:** Best staff to deliver the best of care **CAUSE AND EFFECT:** Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 (moderate)** **X** **4 (likely)** **=** **12** **[High]**	1. Strategy: Workforce Strategy in place to address the underlying cultural issues within the Trust to deliver the 'Best Culture' with the best of people.	Workforce strategy in place from April 2018 to 31 March 2019. 2019/21 Workforce Strategy presented at April 2019 development Board.		**3 (moderate)** **X** **4 (likely)** **=** **12** **[High]**	**3 (moderate)** **X** **2 (unlikely)** **=** **6** **[Moderate]**	**March 2021**
		2. Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall StatMan (statutory and mandatory training) compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented)				

		3. Right attitude and values:
		   a. Values-based recruitment (VBR) in place for medical and non-medical positions;
		   b. Values-based appraisal in conjunction with performance;
		   c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours;
		   d. Respect – countering bullying in the workplace policy.
			1. VBR in place since June 2018;
			2. Qualitative and quantitative values-based appraisal in place since April 2018;
			3. Promoting professional pyramid in place, training for peer messengers continuing;
			4. Respect policy in place.				

		4. Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity:
		   a. Current contractual vacancy levels (workforce report)
		   b. Monthly reporting of vacancies and temporary staffing usage at PRMs;
		   c. Reporting to Board of substantive to temporary staffing paybill.
			1. Trust vacancy rate at 18%;
			2. Substantive workforce 85.1%;
			3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.				

		5. Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.				

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - June 2019

COMPOSITE RISK: Quality

EXECUTIVE LEAD: Director of Nursing

LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date

BAF Risk: 5a
 TITLE: Achieving required quality and safety standards and delivery of *Brilliant* care
 	
 CAUSE AND EFFECT: Since exiting special measures the Trust has maintained a CQC rating of 'Requires Improvement'. It needs to build momentum to progress towards a 'good' and 'outstanding' rating to ensure we do not fail to deliver sustainable change.
 	
 IMPACT: If this were to happen it may result in instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust's reputation and loss of staff. This will also impact on staff morale and patient confidence in the Trust.
	4 (major) X **4 (likely)** = **16** **[Extreme]**	1. CQC improvement plan in place
		 2. Annual quality goals and priorities agreed
		 3. Programme of continuous quality improvement
		    a. CI training (yellow belt, white belt)
		    b. Improvement huddles
		    c. Improvement Specialists
		    d. Local improvement Projects
		 4. Clinical policies, procedures, guidelines and SOPs
		 5. Quality metrics reported via
		    a. IQPR and directorate scorecards
		    b. harm free care monitoring via ward scorecards
		    c. Safety Thermometer
		 6. Regular schedule of meetings to review quality
		    a. Monthly Directorate Performance Review meetings
		    b. Weekly Trust Performance Review meeting
		 7. Audit and review processes
		    a. Clinical Audit programme and monitoring
		    b. Daily MSA breach reporting and validation
		    c. Ward Quality Review audits
		 8. Central and local oversight of quality
		    a. Complaints management
		    b. Incident management, including Serious Incident (SI) policy, processes and monitoring
		    c. Compliance with Duty of Candour policy and training
		 9. Regular Quality Groups
		    a. Patient Safety
		    b. Patient experience
		    c. Clinical Effectiveness and Research
		    d. Medicines Management
		    e. Mortality
		    f. Safeguarding
		 10. Participation in collaboratives (e.g. Medway and Swale End of life Care Programme Board).
			1. Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board
			
			 2. Regular performance review meetings with all programmes
			
			 3. NHSI Integrated Assurance meeting
			
			 4. Monthly CCG Quality Monitoring Group
			
			 5. Audit reports – compliance with policies and guidelines,
			
			 6. Regular reports from Quality Groups
			
			 7. SI panels with CCG
			
			 8. Referral process to professional regulatory bodies
			
			 9. Quarterly complaints and safeguarding reports
			
			 10. Quality Governance metrics reported (complaints, incidents, Duty of Candour)
				1. Overall CQC rating of 'Requires Improvement'- *delivery of Quality Improvement Plan (see below) and Quality Governance improvements (see quality risk 4) to close gaps in assurance.*
				
				 2. Draft overarching Trust Quality improvement plan in place - *'adoption' of Quality Improvement plan as a Trust Transformation programme in June 2019*
				
				 3. Absence of evidence of formal systemic 'Learning from Experience' – *Biannual 'Learning from Experience' report (complaints, claims, incidents, inquests)to be produced, first report (period Oct 2018 to Mar 2019) to be presented at Executive Group in June/July 2019*
				
				 4. Compliance with Duty of Candour – *Directorate trajectories in place to achieve 90% compliance*
				
				 5. The Quality Strategy is currently in draft – *approval of strategy by Trust Board in July 2019*
					4 (major) X **4 (likely)** = **16** **[Extreme]**	**2 (low)** X **2 (unlikely)** = **4** **[Low]**	March 2020 – overall Trust CQC rating of 'Good'

BAF Risk: 5b
 TITLE: Compliance with the statutory requirements of the Hygiene Code
 	
 CAUSE AND EFFECT: Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.
 	
 IMPACT: The result may be sub optimal outcomes and patient harm with potential regulatory action. Patients may be harmed
	4 (major) X **4 (likely)** = **16** **[High]**	1. Baseline assessment
		    a. Self-Assessment against Hygiene Code
		 2. IPC Improvement plans
		 3. Annual IPC workplan
		 4. Audit programme
		    a. Saving Lives
		    b. Environmental audits
		    c. PLACE inspections
		 5. IPC policies, procedures and protocols in place
		 6. Training
		    a. Mandatory IPC training
			1. Infection Control and Anti-Microbial Stewardship Group meeting (ICAS)
			 2. Monitoring of key IPC indicators at ICAS
			 3. IQPR
			 4. Directorate and programme scorecards with key IPC indicators
			 5. Annual IPC report
				1. NHIS IPC Review Report, poor compliance with Hygiene Code – *action plan to address IPC leadership, governance and practice*	**4 (major)** X **4 (likely)** = **16** **[High]**	**3 (moderate)** X **2 (unlikely)** = **6** **[Moderate]**	March 2020

COMPOSITE RISK: Quality
EXECUTIVE LEAD: Director of Nursing
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care

Risk Number/ Description	Initial Risk Rating	KEY Controls	KEY Assurances on Controls	Gaps in Controls and Actions to address	Current Risk Rating	Target Risk Rating	Target Date
BAF Risk: 5c **TITLE:** Managing capacity and demand **CAUSE AND EFFECT:** If we have poor patient flow and weak capacity and demand planning we will fail to achieve the required performance standards (constitutional standards: 4 hour access, RTT, DM01 and Cancer) **IMPACT:** Sustained failure to achieve constitutional standards may result in substantial delays to the treatment of patients, poor patient experience, potential patient harm and a possible breach of license.	3 (moderate) X 4 (likely) = 12 [High]	1. Best Flow Transformation Programme 2. Recovery plans including agreed trajectories for all constitutional standards 3. Capacity and demand improvement work	1. Weekly Trust Performance Review meeting 2. Weekly PTL for RTT and Cancer 3. IQPR 4. Directorate and programme scorecards 5. Directorate Management Board meetings 6. Monthly programme Performance Reviews 7. Biweekly Transformation Operational Board 8. Biweekly Transformation Assurance group 9. Reports to Executive group and Trust Board 10. NHSI Integrated Assurance meeting		3 (moderate) X 4 (likely) = 12 [High]	3 (moderate) X 2 (unlikely) = 6 [Moderate]	March 2020

BAF Risk: 5d **TITLE:** Quality Governance
 	
CAUSE AND EFFECT: If quality governance is not sufficiently understood or embedded we may not deliver our quality priorities.
 	
IMPACT: Risks to quality and safety of care may not be identified or controlled resulting in poor patient experience, sub optimal outcomes and patient harm with potential regulatory action.
	3 (moderate)
	X
	4 (likely)
	=
	12
	[High]
		1. Quality ambitions
		  a. Quality goals and priorities agreed for 2019/20
		  b. Quality Account
		2. Key leadership roles in place
		  a. Corporate business critical posts in place providing governance, quality and safety leadership
		  b. Directorate and programme clinical governance, quality and patient safety leads in place
		  c. Quality Governance teams in place centrally and within directorates
		3. Quality Governance monitoring
		  a. CQC compliance framework
		  b. CQC Assure
		  c. Risk registers
		  d. Quality Impact Assessments
		4. Quality governance groups established for delivery and monitoring quality
		  a. Patient Safety
		  b. Patient experience
		  c. Clinical Effectiveness and Research
		  d. Medicines Management
		  e. Mortality
		  f. Safeguarding
			1. Bi monthly Quality Assurance Committee (QAC) and bimonthly Trust Board
			
			2. Regular quality governance reports and IQPR presented to QAC and Trust Board
			  o Mortality reports
			  o Learning from Deaths reports
			  o Internal audit reports
			
			3. Internal Quality Governance monitoring
			  o Quality and Safety metrics reported via IQPR Trust
			  o directorate scorecards
			  o Quality Governance Scorecard - metrics reported for complaints, incidents, Duty of Candour
			
			4. CCG Quality Monitoring Group
				Quality Strategy drafted – *to be approved by Trust Board July 2019*
				
				External Audit, Directorate Quality Governance: partial assurance with improvements required – *action plan drafted to address recommendations of the audit.*
					3 (moderate)
					X
					4 (likely)
					=
					12
					[High]
						2 (low)
						X
						2 (unlikely)
						=
						4
						[Low]	

Appendix 3: BAF Heat Map

Appendix 4 - Guidance for Risk Rating
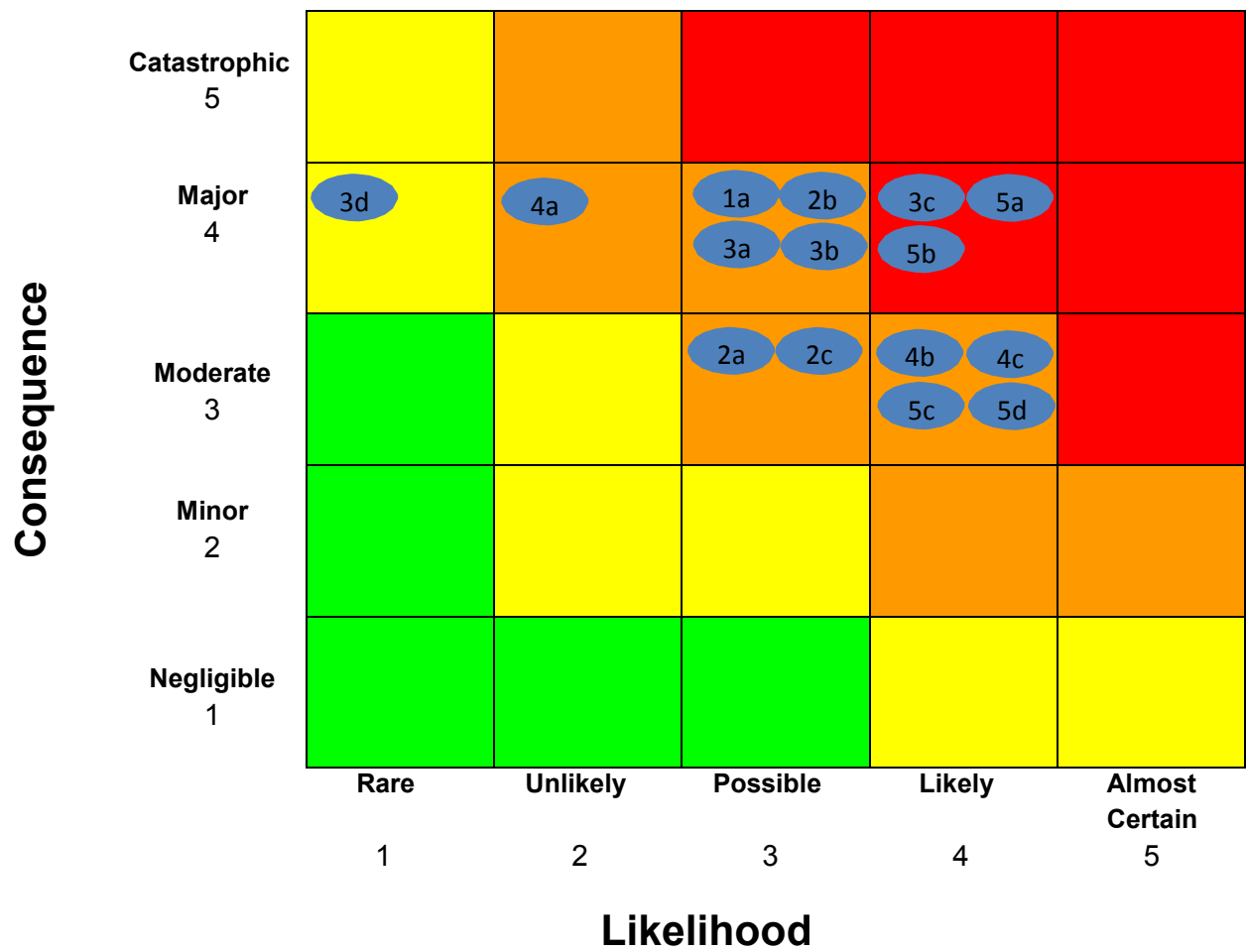
Risk Rating Guidance

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1** **Negligible**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
Impact on Safety of Patients, Staff, Visitors	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury/illness requiring minor intervention Time off work <3 days Increase in LOS by 1-3 days Affects 1-2 people	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay 4-14 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Affects (3-15) people	Major injury leading to long-term incapacity/disability >14 days off work Increase in LOS by >15 days Mismanagement of patient care with long term effects An event which impacts on moderate numbers (16-50)	Death Multiple permanent injuries or irreversible health effects An event which impacts on large numbers (>50)
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget	5-10% over budget	10-25% over budget	>25% over budget
Finance	Small loss <£1000	Loss of 0.1 -0.25 % of budget	Loss of 0.26-0.5% of budget	Loss of 0.51-1.0% of budget Uncertain delivery of key objectives Purchasers failing to pay on time	Loss of >1% of budget Non-delivery of key objectives Failure to meet specification/ slippage Loss of contract/service/payment by results

Best of care
Best of people

Appendix 4 - Guidance for Risk Rating

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1** **Negligible**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
Quality/Audit	Peripheral element or treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Noncompliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Complaints / Claims	Locally resolved complaint Potential for settlement /litigation <£500	Overall treatment /service substandard Formal justified complaint (stage 1) Claim <£10K	Justified complaint (stage 2, with potential to go to independent review) involving lack of appropriate care Claims between £10k - £100K	Multiple justified complaints Independent review Claim(s) between £100k - £1m	Multiple justified complaints Inquest (involving legal representation) ombudsman inquiry Multiple claims or single major claim Claim(s) >£1 million
Human resources	Low staff morale affecting one person	Low staff morale (1%-25% of staff)	Low staff morale (26%-50% of staff)	Very low staff morale (51%-75% of staff)	Very low staff morale >75%

Appendix 4 - Guidance for Risk Rating

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1** **Negligible**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
Organisational development /	Minor competency related failure reduces service quality <1 day	75% - 95% staff completing mandatory/key training	50% - 74% staff completing mandatory/key training	25% - 49% staff completing mandatory/key training	<25% of staff completing mandatory/key training
Staffing competence	Short term low staffing level temporarily reduces service quality (<1 day), Minor competency related failure reduces service quality <1 day	On-going low staffing level resulting in minor reduction in the quality of patient care, Unresolved trend relating to competency reducing service quality	Late delivery of key objective/service due to lack of staff, Unsafe staffing level > 1 day, Minor error due to ineffective training	Uncertain delivery of key objective/service due to lack of staff, Unsafe staffing level or competence (>5 days), Serious error due to ineffective training, Loss of key staff	Non-delivery of key objectives/service due to lack of staff, Ongoing unsafe staffing levels/competence, Loss of several key staff, Critical error due to insufficient training/competency
Compliance / Audit / Governance	Minor lapse in governance or process; affects one person; single instance of failure relating to human error with no patient harm; policy is out of date by < 1 month, minor non-compliance with standards/guidance	Non-compliance with policy or process in a single department; policy is out of date by < 2 months; affects up to 5 people but causes no patient harm; policy is out of date by < 2 months, Non-compliance with standards/guidance	Failure of governance/process impacting beyond a single department; policy out of date by 2-6 months; affects 5-20 people or results in patient harm; improvement or non-compliance notice received	Trust wide governance failure/multiple breaches; policy out of date > 6mths/non-existent; failure affects 20-50 people; Major non-compliance with core standards	Governance failure resulting in prosecution; gross failure in governance; significant patient harm and/or death, Prosecution, severely critical report, overall rating of inadequate against any of the CQC 5 questions

Appendix 4 - Guidance for Risk Rating

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1** **Negligible**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met	Local media coverage Long term reduction in public confidence	National media coverage < than 3 days Confidence on organisation undermined Use of services affected	National media coverage with > 3 days service well below reasonable public expectation MP concern (questions in house) Total loss of public confidence
Service / business interruption	Loss/interruption of >1 hour, no impact on delivery of patient care/ability to provide services	Loss/interruption of >8 hours	Loss/Interruption of > 1 day Disruption causes unacceptable impact on patient care	Loss/interruption of > 1 week Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service or facility Disruption to facility leading to significant knock-on effect across the local health economy
Environmental Impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Agreed Targets	Not Applicable for this Risk Type	1% off planned Fail to meet National target 1 quarter	2%-4% off planned Fail to meet National target 2 qtrs. Amber light	5%-10% off planned. Fail to meet National target > 2 quarters Red light	>10% off planned Failure to meet National target > 2 quarters, by more than 20%

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Appendix 4 - Guidance for Risk Rating

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1** **Negligible**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Catastrophic**
Fire Safety/General Security	Minor short term (<1day) shortfall in fire safety system Security incident no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc. (non-patient area) Security incident managed locally Controlled drug discrepancy accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety	Failure of multiple critical components of fire safety system (high risk patient area) Infant / young person abduction
Information Governance / IT	Breach of confidentiality – no adverse outcome. Unplanned loss of IT facilities < half a day Health records / documentation incident – no adverse outcome	Minor breach of confidentiality – readily Resolvable Unplanned loss of IT facilities < 1 day Health records incident / documentation incident – readily resolvable	Moderate breach of confidentiality – complaint initiated Health records documentation incident – patient care affected with short term consequence	Serious breach of confidentiality – more than one person Unplanned loss of IT facilities >1 day but less than one week Health records / documentation incident – patient care affected with major consequence	Serious breach of confidentiality – large Numbers Unplanned loss of IT facilities >1 week Health records / documentation incident – catastrophic consequence

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Appendix 4 - Guidance for Risk Rating

Table 2	Likelihood score
Level	**Description**
1 Rare	<3% probability. **Not expected to occur for years**, but may occur, but only in exceptional circumstances. • Loss, accident or illness could only occur under freak conditions • The situation is well managed and all reasonable precautions have been taken Ideally, this should be the normal state of the workplace
2 Unlikely	3%-10% probability. **Expected to occur at least annually**. The situation is generally well managed. However occasional lapses could occur. • This also applies to situations where people are required to behave safely in order to protect themselves but are well trained
3 Possible	11%-30% probability. **Expected to occur at least monthly**. • Insufficient or substandard controls in place • Loss is unlikely during normal operation, however, may occur in emergencies or non – routine conditions.
4 Likely	31%-90% probability. **Expected to occur at least weekly.** • Serious failures in management controls • The effects of human behaviour or other factors could cause an accident but is unlikely without this additional factor.
5 Almost Certain	>90% probability. **Expected to occur at least daily.** • Absence of any management controls • If conditions remain unchanged there is almost a 100% certainty that the hazard will be realised

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Appendix 4 - Guidance for Risk Rating

Table 3	Risk Matrix				
	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

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Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Assurance Report from Committees

Title of Committee:	Integrated Audit Committee	Agenda Item	8.2
Committee Chair:	Mark Spragg, Non-Executive Director		
Date of Meeting:	Thursday, 23 May 2019		
Lead Director:	Ian O'Connor, Director of Finance		
Report Author:	Ian O'Connor, Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** (use appropriate colour code as above)
Annual Report and Accounts 2018/19 The Committee discussed the following reports for approval, to be signed off for submission to NHS Improvement /England and Parliament.	**Green**
1. External Audit Report The Committee was asked to note that elements of the Trust's accounts were the best Deloitte have received. The quality of the presentation of the Accounts to the auditors has been excellent and the Committee commended the finance team. A full Site Valuation Report will be produced in 2019/2020 and updates provided to the Committee. Deloitte confirmed the overall opinion would be 'clean with no suggested changes'.	**Green**

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2. Annual Report With delegated authority from the Trust Board, the Committee signed off the final draft version of the 2018/19 Annual Report.	**Green**
3. Annual Accounts The Committee formally adopted the 2018/19 Accounts and agreed that they are ready for sign off by the Chief Executive and the Chairman.	**Green**
4. Quality Report The Committee signed off the Quality Report.	**Green**

Decisions made

1) The Committee signed off the Annual Report and Accounts 2018/19.

Further Risks Identified

All risks are captured within the risk register and the Board Assurance Framework.

Escalations to the Board or other Committee

1) International Financial Reporting Standards 16 (IFRS16) has been raised as an action for the Finance Committee – this was later discussed at the Finance Committee meeting on the same day, 23 May 2019.

Meeting of the Council of Governors in Public
Wednesday, 03 July 2019

Title of Report	Freedom to Speak Up Guardian Report Q4 2018/19	Agenda Item	8.3
Report Author	Leon Hinton, Executive Director of HR and OD		
Lead Director	James Devine, Chief Executive		
Executive Summary	This report includes the progress for the recruitment to the Lead Guardian position following the departure of the post holder in June 2019. During quarter 4 2018/19, the Trust had 22 new concerns raised following the appointment of a dedicated, funded lead guardian and successful integration of the guardian into the 'You are the Difference' programme and wider engagement interventions. Of the 22 new concerns raised, 21 have been closed and one is actively being responded to via a number of Executives overseen by the Chief Executive. The quarter 4 results show an increase of 22 concerns raised (from 0). The regular quarterly meeting between the guardians and the Chief Executive continue. Benchmarking of case type demonstrates that the Trust has lower concerns that have elements of patient quality/safety and/or bullying and harassment than other NHS acute organisations, but higher rates of anonymous concerns raised. The Trust has no reports of individuals experiencing a detriment as a result of raising concerns.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒	
	Finance: We will deliver financial sustainability and create value in all we do	☒	
	People: We will enable our people to give their best and achieve their best	☒	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒	
	High Quality Care: We will consistently provide high quality care	☒	
Committees or Groups at which the paper has been submitted	Executive Group		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	A governmental response to Sir Robert Francis Report 2015 led to the introduction to the NHS Contract for 2016/17 requiring every NHS Trust to have a local Freedom to Speak Up (FTSU) guardian from 1 October 2016.		

	Guidance for the appointment of a FTSU guardian was published in March 2016.
	- NHS Constitution and standard contract; - Public Interest Disclosure Act 1998; - Enterprise and Regulatory Reform Act 2013; - The Bribery Act; - Whistleblowing Arrangements; - Code of Practice
Quality Impact Assessment	Not applicable
Recommendation/ Actions required	The Board is asked to note the content of this report.

Approval ☐	Assurance ☒	Discussion ☐	Noting ☒

Appendices	None

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Freedom To Speak Up Update

1   Introduction

1.1   The Freedom to Speak Up Review undertaken by Sir Robert Francis and published in February 2015 was commissioned by the Secretary of State a result of the failings at Mid Staffordshire. The aim of the report was to provide advice and recommendations to ensure that NHS staff felt safe to raise concerns, were confident that they would be listened to and that concerns would be acted upon. The review identified concerns about the way NHS organisations dealt with concerns raised by NHS staff and the treatment of some of those who had spoken up.

1.2   From the evidence, the review identified five overarching themes as follows:

- need for culture change;
- need for improved handling of cases;
- need for measures to support good practice
- need for particular measures for vulnerable groups; and
- need for extending the legal protection.

As a result of this review the establishment of the National Guardian's Office as an independent non-statutory body was established and all NHS organisations are required to appoint a freedom to speak up (FTSU) guardian.

1.3   The Trust moved to an established lead guardian model (0.4 FTE) in January 2019.

2   Lead Guardian

2.1   The Trust's Lead Guardian position is currently vacant with interviews due to take place on 02 July 2019 to appoint to the 0.4 FTE band 6 position. The previous Lead Guardian, Chloe Saygili left the position on 16 June 2019, moving into a nursing position within the Trust.

2.2   To ensure concerns raised are listened to and dealt with, the existing guardians, as a group, meet with the Chief Executive on a quarterly basis.

2.3   The Trust remains up-to-date with its mandatory submissions to the National Guardian's Office.

3   Strategy, Policy and Self-Assessment

3.1   The Trust's Freedom to Speak Up strategy was launched in January 2019 linking raising concerns to each of the Trust's strategies, namely quality, clinical, people and system financial recovery. The strategy determines the roles and responsibilities of the Lead Guardian, the guardians, the named Non-Executive Director and the Executives.

3.2   The Trust carried out a self-assessment in 2018 and will similarly report on the progress made to address 33 partially met criteria and 11 unmet criteria (the process met 23 at the point of self-assessment). The updated self-assessment is due to be reported to private Board in September 2019.

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Freedom To Speak Up Update

4   Reported Cases

4.1   During quarter 4 2018/19, a total of 22 concerns were raised, of which 12 were raised anonymously, nine included an element of patient safety/quality, and five included an element of bullying or harassment. There were no reported incidents of people suffering detriment as a result of speaking up.

4.2   Quarter 4 was significantly higher than any other month previously reported to the guardian's office. This is largely due to having an established Lead Guardian position with the resources and dedicated time to make contact throughout the organisation, to establish themselves through communication routes and link into the 'You are the Difference' sessions. The trend for the previous year is shown below. It should be considered encouraging to see an increase with individuals feeling they can make their voices heard when they have concerns and, as a Trust, we will continue to encourage concerns being raised through this process. It should be noted however, that 12 concerns were raised anonymously – this should be considered a marker for trust in the organisation to be fair and transparent with individuals who raise concerns.

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
■ Cases	7	3	0	22
■ Element of bullying or harassment	3	2	0	5
■ Element of patient safety/quality	1	1	0	9
■ Raised anonymously	1	1	0	12
■ Suffering detriment as a result of speaking up	0	0	0	0
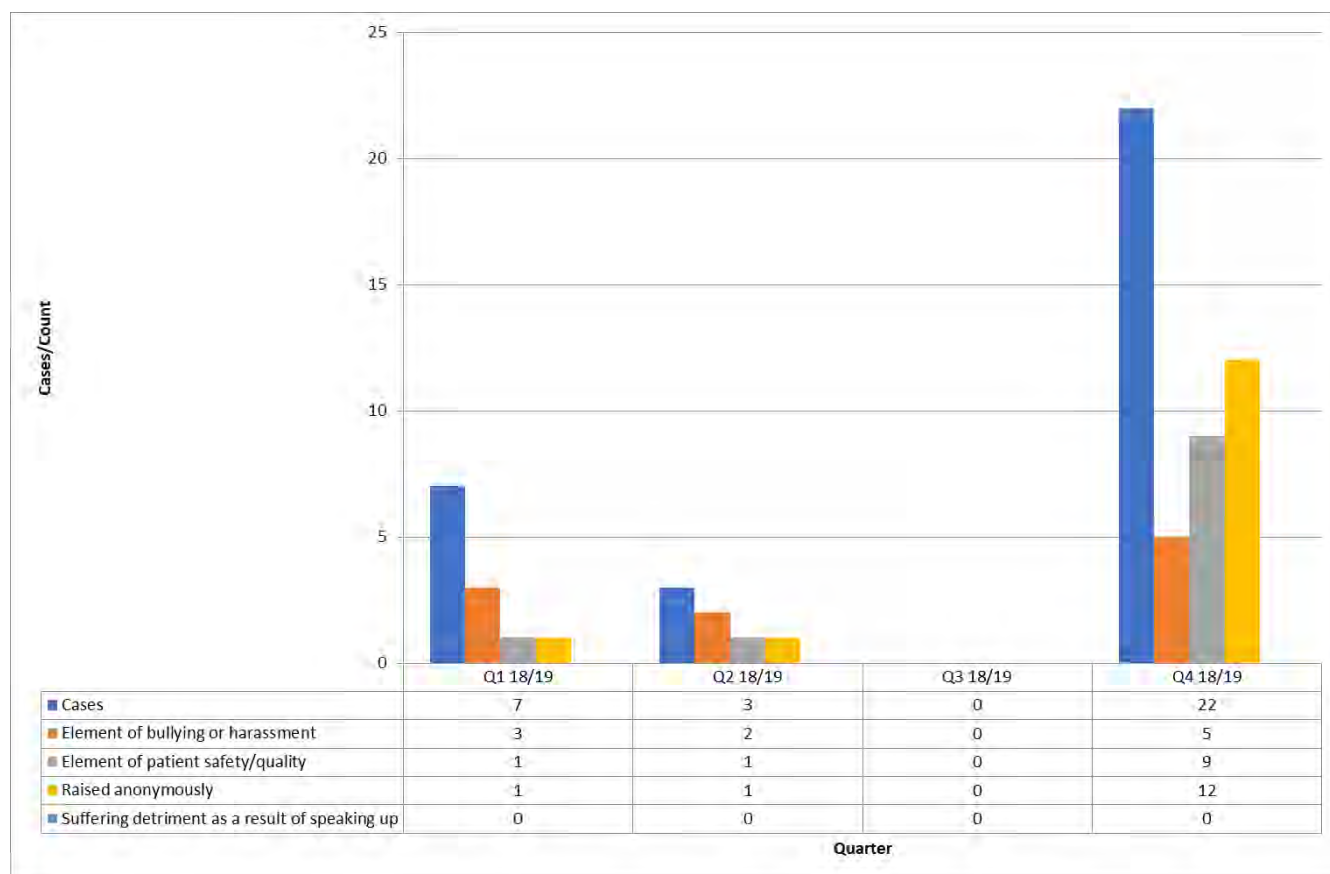
4.3   Of the 22 cases raised in quarter 4, 21 cases have been investigated and closed. One remaining case is open, has a number of different elements and is actively being actioned through the Chief Executive by the associated executives.

4.4 Comparison to our benchmark organisations (less than 5000 substantive employees, acute organisation) shows that there was a doubling of cases nationally in quarter 3 and 4 – the Trust's increase in quarter 4 of 22 cases (from nil to 22) should be considered in tandem with item 4.2. Across the benchmark group:

4.4.1 7% of individuals raising concern potentially suffered detriment as a result, versus the Trust's rate of 0% consecutively;

4.4.2 14% of individuals raised concerns anonymously versus the Trust rate of 25%;

4.4.3 36% of cases had elements of patient safety/quality versus 22% as reported for the Trust cases;

4.4.4 50% of cases had elements of bullying or harassment versus 33% as reported for the Trust cases.

- End

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Communicating our core strategies	Agenda Item	9.1
Lead Director	Glynis Alexander, Director of Communications and Engagement		
Report Author	Glynis Alexander, Director of Communications and Engagement		
Executive Summary	The Quality Strategy, Clinical Strategy, and People Strategy have been written with engagement from staff and stakeholders and have been discussed by Board members during their development. We have also been conscious of the local and wider context in which we are planning for the future of the hospital, including the Integrated Care Partnership, and the Sustainability and Transformation Partnership. They are therefore written through the lens of integrated planning and delivery with local health and social care partners. It is important now that the strategies are in place that we engage staff and stakeholders in the plans we have for the hospital over the next three years. This summary document, and accompanying interactive PDF version, will be used to communicate the key content of the three strategies with our staff, patients and stakeholders, encouraging conversations about how they will be delivered to meet the needs of our community in future. The summary document and PDF aim to provide a clear, brief summary of the content of the three strategies so that audiences gain a general understanding. The strategies themselves will be available for people who wish to read the full detail. The Board is asking to note the summary document and PDF.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒	
	Finance: We will deliver financial sustainability and create value in all we do	☒	
	People: We will enable our people to give their best and achieve their best	☒	
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒	
	High Quality Care: We will consistently provide high quality care	☒	
Committees or Groups at which the paper has been submitted	The strategies have been considered by: Executive Group Board development meeting 6 June 2019 Quality Assurance Committee		

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Resource Implications	None
Legal Implications/Regulatory Requirements	None
Quality Impact Assessment	Detailed within strategies.
Recommendation/ Actions required	The Board is asked to note the summary document which will be used to engage staff and stakeholders in the Trust's core strategies.

Approval ☐	Assurance ☐	Discussion ☐	Noting ☒

Appendices	Appendix 1: Strategies summary document.

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MEDWAY NHS FOUNDATION TRUST

OUR CORE STRATEGIES AT A GLANCE

2019 to 2020

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Strategies for the future at Medway

At Medway we want healthcare to be better for the population we serve, but we are also clear that in some areas the services we provide will need to be different in future, and there will need to be changes to the way we provide them. We must also make sure the care we provide is sustainable for the future. That is why we are working with our health and social care partners to transform care across the hospital, and in the community.

We have published four key documents – our **Clinical Strategy**, **Quality Strategy**, **People Strategy**, and **Financial Recovery Plan**. They set out what we will do over the next three years to ensure we have the right services in the right place for our patients, with the appropriate resources and staff whose first priority is the quality of care they provide.

These documents are linked, and are supported by a number of enabling initiatives which are essential to make the necessary changes and improvements to care for our patients. These include plans covering our estate (buildings and facilities), digital / technology, and culture. In all we do, we recognise that the patient is central to planning and delivering improvements, and listening to our community and service users is integral to developing services for the future.

The 'strategy pyramid' below shows how our strategies and enabling initiatives sit alongside our vision and values to provide us with direction for the future.
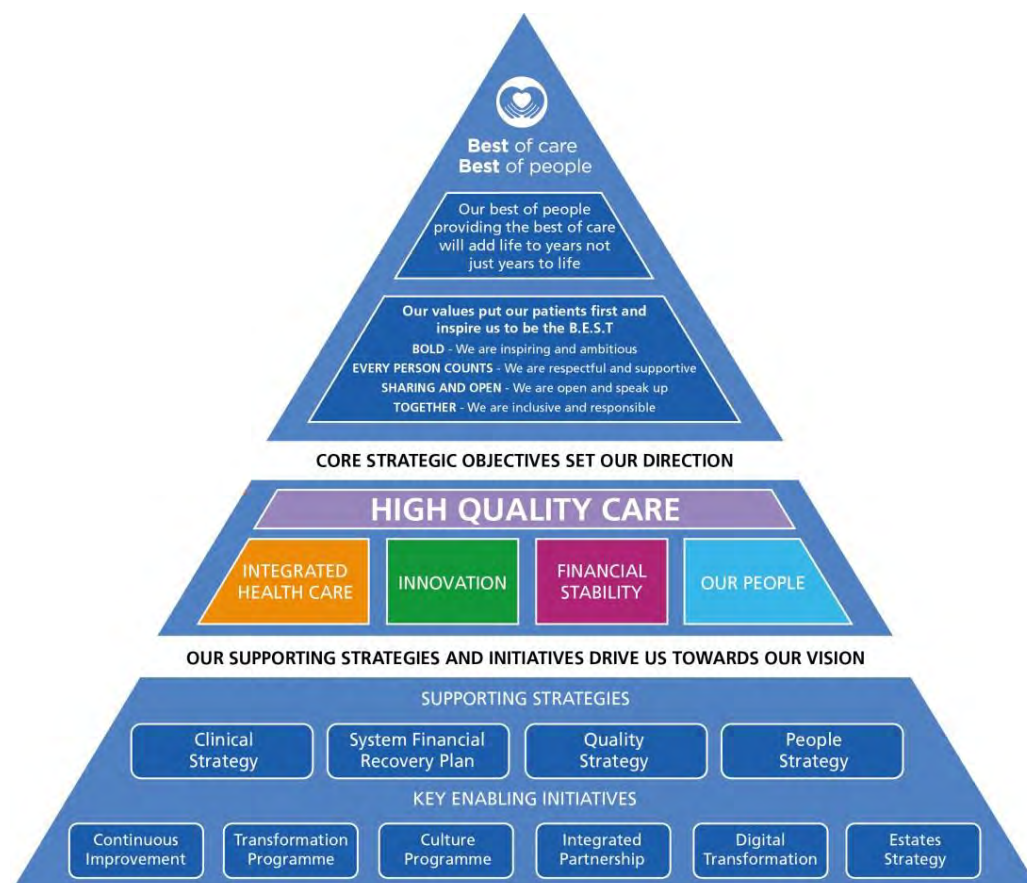
We have developed a vision for the kind of hospital we need to be in future to best serve the health needs of the people of Medway and Swale. We want our staff – our 'best of people' – to provide the best of care to add life to years, not just years to life.

Our well-established values – Bold, Every person counts, Sharing and open, and Together – underpin all that we do.

Our five objectives identify our priority areas of focus:

1. High quality care
2. Integrated healthcare
3. Innovation
4. Our people
5. Financial Stability

The patients we serve

Working closely with our health and social care partners, we understand our community, and the healthcare it needs for the future. Our strategies are aligned with these needs, based on knowledge about the local population as well as taking account of developments in healthcare.

We serve a population of over 405,000 in Medway and Swale

The proportion of older people experiencing income deprivation is 15.1 per cent.

1 in 4 people in Medway has a mental health problem.

Medway has high levels of excess weight, smoking prevalence and alcohol consumption.

Adult excess weight: With more than two thirds of adults aged 18 years and over in Medway being overweight or obese, more people are at increased risk of cardiovascular disease, diabetes, some cancers, and other health problems.

Smoking: 19 per cent of adults aged 18 years and over are current smokers. Smoking is the main cause of preventable death in Medway. Medway also has a high rate of pregnant women who smoke.

Alcohol: Alcohol is the leading cause of death among 15 to 49 year olds and heavy alcohol use has been identified as a cause of more than 200 health conditions. Research conducted in Medway shows that 15,000 men and 11,000 women (aged 18-65) are drinking at increasing risk levels, which increases the risk of developing a range of illnesses such as cancer, stroke, heart disease, liver disease and damage to the brain and nervous system.

Our Clinical Strategy

It is important that our clinical strategy takes account of changes being implemented over the coming months and years at a Kent and Medway level.

In future there will be one strategic commissioner for the county, replacing the current eight Clinical Commissioning Groups. This means some services, such as cancer care and services for children and young people will be planned on a county-wide level, while others such as care of the elderly are more likely to be commissioned locally, that is for Medway and Swale. Some services such as urgent and emergency care will probably be planned across part of the county, in our case for Medway, North and West Kent.

The chart below shows the challenges currently facing health and social care in Kent and Medway.

Current System Challenges in Kent and Medway

Staff Shortages

Ageing Estate

Ageing and Growing Population

Limited financial resource

Main challenges

Population Growth
MNWK has one of the highest predicted growth rate in E&W
The demand on hospital care already exceeds supply

Ageing Population
Increasing numbers with increasing complexity needs more specialist management
Inpatient hospital care is not the best management option for these patients

Cancer Care
We are not fulfilling
- Screening targets
- Targets for diagnosis and treatment
- High cost partic Haematology
- Poor outcomes
- capacity issues.

Emergency Care
Not achieving the 95% A&E target for the following reasons
- Increasing attendances
- Patient flow
- Workforce
- blocked Assessment and ambulatory areas

Elective Surgery
Failure to meet RTT targets
Cancellations on the day
Outsourcing
Poor productivity in theatres
Lower than average Day Surgery rates
Poor patient satisfaction
Frustrated surgeons

Children and Young People
Increasing young people in population
Currently below standards for;
- Emergency Services
- Community Services
- Teenage and Young Adult Services (13-25)
- Paediatric Surgery
- Cancer Services
- Children's Mental Health

Clinical Support Services
- Lack of imaging capacity at all sites
- Staffing shortages
- Increasing / changing technology
- Pathology services not Carter compliant
- Not meeting 7 day service provision in some support areas.

Specialist Services
Specialist service viability is questionable;
- Workforce Issues
- Access to Beds/Space/Equipment
- Access to support services
- Patient nos.
- In some circumstances this will be impacting patient outcomes.

Medway NHS Foundation Trust will provide high quality consultant-led services for the people of Medway and Swale as the major acute hospital in an integrated healthcare system.

Our ambitions are:

- To provide the highest standard of acute and emergency care and be recognised as one of the specialist emergency centres in Kent.
- To provide the highest quality of care by developing all our services based on the latest research and/or the best evidence or care provision that yields the best health outcomes for patients.
- To achieve and surpass the constitutional, statutory and regulatory standards of the NHS for the care of our patients.
- To work with our partners locally and across Kent and Medway to ensure patients receive the right care in the right place from the most appropriate healthcare professional to agree and subsequently meet their needs.
- To continuously improve our efficiency and effectiveness in the interests of our patients.

To achieve these ambitions we will focus on four priorities:

| Best Integrated Care | Best Emergency Care | Best Elective Care | Best Care for patients with multiple long-term conditions |
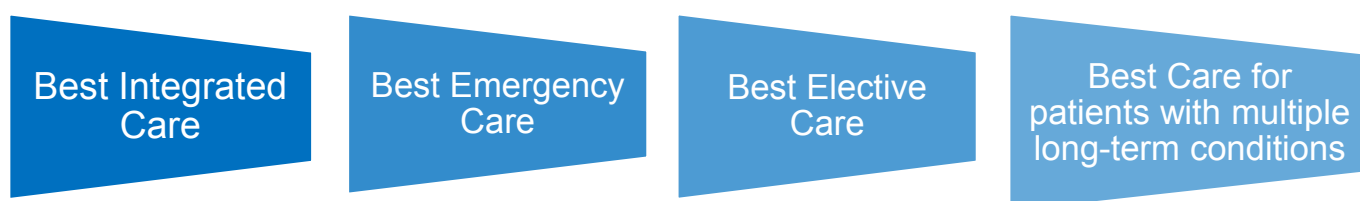
Clinical Goal 1: Best Integrated Care

- Developing an **Integrated Care Partnership** with community and mental health organisations, as well as networks of primary care, to provide care closer to home and in a more joined up way, reducing the need for patients to attend hospital.

Clinical Goal 2: Best Emergency Care

- Delivering the **Best Emergency Care** with an integrated pathway from the Urgent Treatment Centre / Emergency Department to consistently ensure the majority of patients are seen within four hours meeting the national 95 per cent target, with admission into the hospital or returning home.

Clinical Goal 3: Best Elective Care

- Providing **Best Elective Care** by redesigning care pathways with partner organisations to provide specialist advice and care closer to home. For patients needing surgery we will ensure that no operation is cancelled except for safety reasons.

Clinical Goal 4: Best Care for patients with multiple long-term conditions

- Providing the **Best Care for patients with multiple long-term conditions**, by grouping care for these patients in one area of the hospital.

Our Quality Strategy

The Trust has adopted **High Quality Care** as its first strategic objective, recognising the importance of this as a priority for everyone who works at the hospital.

To help maintain this focus we review our services against four domains to optimise people's quality of life – staying healthy, getting better, living with long term illness or disability, and coping at the end of life.

We have engaged with staff, patients, public and NHS partner organisations in developing this strategy. Through this process we have identified that quality in healthcare is not a single idea, but a series of ideas to describe the overall outcome and experience for patients, with criteria such as 'safe', 'effective' and 'person-centred' being useful ways to measure quality.

Our Quality Strategy will be delivered through three domains:

Best quality design	Best quality improvement system	Best quality focused delivery

Best Quality Design

Our core services will undergo a comprehensive review to ensure they are designed to provide the best possible quality of care to achieve the best possible outcome for the individual.

Best Quality Improvement System

We will develop our staff so that they can deliver continuous improvements as part of the daily work. We have expertise and methodologies to do this, and are already seeing practical, sustainable improvements as a result of supporting and training staff to lead projects to enhance care for our patients.

Best Quality Focused Delivery

We will have a continued focus on making sure we delivery on our quality priorities, some of which are identified nationally and some we have decided locally following engagement with staff, patients and stakeholders. These will be reviewed and refreshed each year.

Our People Strategy

The Trust's workforce has evolved significantly over the past two years to better fit the services we provide and to become more efficient. We now need to retain talent, and attract the best people as we continue to transform care for our patients.

We will enable our staff to achieve brilliant outcomes by:

- Offering an exciting and engaging career path, where different roles are equally valued;

- Becoming a recognised University Hospital, thereby expanding opportunities for our staff;

- Becoming an employer of choice through creating a brilliant all round offer for our people (including training and development, career development opportunities, and an attractive physical environment);

- Making sure we have the best mix of people with the skills to serve the local population's needs, within an integrated system of health and social care.

The Trust's vision and objectives can only be realised by engaging our people, our patients, our partners and our community and by promoting a culture of equality and inclusion.

We will deliver our People Strategy through three domains:

Best of People   Best Culture   Best Future

Best of People

We aim to transform ourselves through innovative staff-led improvements that meet the needs of our patients now and in the future.

Best Culture

We aim to have a culture of openness and transparency, values that staff live by, and quality-led actions across our entire workforce.

Best Future

We will deliver a workforce ready for the future, supported with the right skills to deliver quality care and to allow us to reach our full potential.

Next steps

We will engage our staff in delivering these strategies. We will also want to ensure that as we continue to transform care for our patients, we communicate with all stakeholders so that they understand our objectives and how we are delivering on our priorities, and are able to influence future improvements.

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Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Medical Education Report	**Agenda Item**	**10.1**
Lead Director	Dr David Sulch, Medical Director		
Report Author	Dr Janette Cansick, Director of Medical Education Carol Atkins, Medical Education Manager		
Executive Summary	To inform/advise the Board of: 1. The structure of Medical Education, with further reorganisation at Health Education Kent, Surrey and Sussex 2. Results of General Medical Council National Training Survey 2018 3. Update on Health Education Kent, Surrey and Sussex Quality Visit action plans 4. Medical Education strategy, with progress against objectives with current opportunities, focus for improvements and potential threats to delivery 5. Multi-professional working - Faculty of Education 6. Kent and Medway Medical School progress. Medway NHS Foundation Trust has one Director of Medical Education supported by two deputies and Medical Education Manager to oversee medical training, with leads within different programmes and specialties to oversee delivery. The Director of Medical Education is accountable to the Trust Medical Director and Health Education Kent Surrey Sussex Postgraduate Dean. Medical Education continues to work closely with Clinical Co-Directors and Directors of Operations, to improve patient safety and trainee experience. Notable improvements have been seen in both Emergency Medicine and Medicine. Another significant area of work has been the support of quality of pharmacy Education and Training, with successful re-allocation of Pre-Registration Pharmacists to Trust from August 2019. A Report is provided to show progress against our Medical Education Strategy. Particular priority has been given to the development of faculty, both Leads (college tutors) and Educational Supervisors. This is in line with requirements for General Medical Council appraisal and revalidation. Progress has also been made in obtaining oversight of the Postgraduate Medical Education budget. Further work is required to secure this.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐

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	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☐
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Local Academic Board and Executive Group	
Resource Implications	Not applicable.	
Legal Implications/Regulatory Requirements	Meeting the requirements of Health Education England is essential to maintaining our training posts with a financial and reputational risk if we have trainees removed.	
Quality Impact Assessment	Not required.	

Recommendation/ Actions required	The Board is requested to:
	 1. Understand the responsibilities of Medical Education to the Trust and Health Education England
	 2. Receive update on Health Education England Quality Visits, noting resolution of the majority of actions
	 3. Receive this paper as an update on medical education strategy
	 4. Be aware of the risks identified within training and their mitigation:
	   a. Rota gaps
	   b. Changes to training posts
	   c. Oversight of budget
	   d. Re-organisation at Health Education Kent Surrey Sussex.	

	Approval ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☒

Appendices	None

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1   Introduction

Health Education England (HEE) is committed to the provision of quality education and training for the development of healthcare professionals. Budget is allocated to every Local Education and Training Board (LETB) to fund specific education and training and to meet strategic education and training objectives. The Learning and Development Agreement (LDA) is a 3 year contract managed on behalf of HEE by Health Education Kent, Surrey and Sussex (HEKSS). Although HEKSS had merged with HEE London to become HEE London and South East (LaSE), the Quality function has transferred back to KSS as of 1 December 2018, with a plan for all areas of work except recruitment and trainee support to be transferred by November 2019. Links are being sought with HEE South. Foundation remains linked with London, as South Thames Foundation School.

HEE commissions a broad range of education and training services from a variety of Local Education Providers (LEPs, such as Medway NHS Foundation Trust (MFT)) with the expectation of provision of high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust. HEE expects the Trust to support national workforce priorities and those identified locally through HEKSS, and to make investment plans and decisions based on long-term workforce planning using local and national data sources including that currently produced by the Centre for Workforce Intelligence.

The Trusts have a duty to demonstrate that the quality of the education and training that they provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The Trust must identify an Executive Education Lead (EEL) at Board level (this is the Medical Director) who will form the main point of contact for the organisation with HEKSS on all matters involving workforce or education contained within the LDA. The expected outcome of quality placements and training is excellent patient care provided by competent and capable staff.

The Director of Medical Education (DME) is responsible for managing the KSS Contract on behalf of their LEP, within the national guidelines set out by the General Medical Council (GMC) and the medical Royal Colleges, and the regional systems set out in KSS Graduate Education and Assessment Regulations [GEAR]. This includes direct responsibility for:
1. Management, organisation and development of medical education
2. Financial management of tariffs – managerial oversight of all local PGMDE funding
3. Managing HEKSS Quality visits
4. Managing GMC annual surveys and ensuring outcomes are operationalised appropriately
5. Underpinning Director of Undergraduate Medical Education (DUME) including service increment for training (SIFT) monies
6. Coordinating library and knowledge services, and pharmacy education.

There are specific additional requirements which relate to medical, dental and pharmacy professions to ensure that education and training meets the requirements of the specific regulators and assures the LETB can quality manage the training programmes and environments for which they are responsible. Specific to medical training the annual GMC survey indicates areas required for improvement in the training of the Medical Doctors. The Trust must implement a remedial action plan and provide appropriate updates back to HEKSS where issues are identified. In addition HEKSS undertakes Quality Visits where needed. Where HEKSS determines there are instances of material non-compliance for all trainees whether medical, dental or pharmacy they will communicate with the Trust to seek a resolution. Both Parties will seek to resolve the issue within an eight week timescale. HEE is entitled to withhold up to 10% of monthly payments to the Trust after that or until the issue is resolved.

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Medical Education Report

Educational Infrastructure and Governance (set out in GEAR)
1. <u>Local Faculty Groups</u> (LFGs) – the first tier of local management at specialty / departmental level and are accountable for undergraduate and postgraduate medical education. LFGs review the progress of every trainee doctor and consider their educational development needs as well as the needs of their trainers.
2. <u>Local Academic Board</u> (LAB) – LFG specialties, including Pharmacy, Library, Simulation and Specialist and Associate Specialist (SAS) report into LAB. The LAB is responsible for signing off the satisfactory progress of trainee doctors, the learning needs of trainers, and is also the first point of contact between the Trust and HEKSS.
3. The DME is responsible for informing the Medical Director (MD) on any issues having a detrimental effect on trainees.

All trainees must have a named Educational Supervisor (ES) and the ES should meet regularly with the trainee to review educational progress and to encourage reflection and the collection of appropriate supporting information on all aspects of Good Medical Practice for Revalidation. The Responsible Officer for doctors in PG training is the HEKSS Postgraduate Dean. For every placement the doctor must have a named Clinical Supervisor (CS). In some instances this will be the same person as the ES. The CS should be involved with teaching and training the trainee in the workplace and should help with both professional and personal development.

HEKSS expects the quality of training to be maintained and improved in terms of: administrative support for Post Graduate Medical Education (PGME); clinical medical education; programmed activities and local course delivery; provision of library services and resources supporting IT access; provision of simulation facilities; and faculty development.

2   Structure of Medical Education at MFT

2.1   <u>Workforce</u> (see Figure 1)

- DME dually accountable in the Trust to Dr David Sulch, Medical Director, and at HEE to Dr Graeme Dewhurst, Postgraduate Dean. Dr Janette Cansick, DME meets with the MD at least twice a month to discuss medical education.
- Two deputy DMEs (Miss Ginny Bowbrick and Dr Rajesh Hembrom) – in process of restructure to one deputy.
- Medical Education Manager (Carol Atkins) is responsible to the DME. The MEM has an operations manager and team of (including the Undergraduate and Simulation team) six full time and one part-time administration staff as well as one full-time and one part-time clinical staff.
- LFG leads (College Tutors) in all clinical areas, Foundation Training Program Directors, DUME and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME.
- There are currently 127 Educational Supervisors with HEKSS approval and 10 Clinical Supervisors with local approval.
- In addition the quality of Pharmacy education and training is overseen by the DME.

2.2   <u>Educational Quality Governance</u>
- Trainee Voice
  - Trainee in Action groups in key areas of need (medicine, pharmacy)
  - Reps at LFG and LAB
  - Meetings with DME and MD

- - Junior Doctors' forum (contract issues)
- Local Faculty Groups (LFG, chaired by College Tutors) meet three times a year
- Local Academic Board (LAB) meets three times a year
  - reports from all areas of medical education, with joint learning
  - simulation, pharmacy and library reports
  - All LFG leads summarise improvements and any concerns arising
  - Trainee Representatives provide feedback, including patient safety concerns
  - GMC survey results and HEKSS visits are discussed.
  - All quality metrics are discussed.

Figure 1: Structure of Medical Education with links and reporting lines

Postgraduate and Patch Deans
Prof Graeme Dewhurst
Dr Ali Bokhari

MD - Exec
Dr David Sulch

Multiprofessional Education
- Lisa Webb (Head of ODP)
- Julie Murray (Nurse Education)

DME
Janette Cansick

Deputy DMEs
Ginny Bowbrick
Rajesh Hembrom

Medical Education Manager (MEM)
Carol Atkins
supported by Clinical & Admin team

College Tutors
Unplanned and Integrated Care Directorate
Dr Mandy Morrice – Emergency Medicine
Dr Paul Kitchen - Medicine

College Tutors
Planned Care Directorate
Miss Shirley Chan - Surgery
Dr Mali de Silva – Anaesthetics/ICU
Miss Padma Vankayalapati – O&G
Dr Palaniappan Sashikumar - Paediatrics

Director of Undergraduate Education
Helen Watson

F1 lead
Paul Williams

F2 lead
Naser
Ben Ramadan

GP TPDs

Simulation lead
Manisha Shah

Careers lead
Bov Jani

SAS tutors
Hany Wisa
Irfan Khan

Physicians Associates Champion (students and PAs)
Has Ahmed

Pharmacy Education and Training Lead
Nichola Baker

Library Services
Sue Kerslake

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3 Trainee Establishment

3.1 Development of training establishment

Key Changes to Medical Training Posts
Chief Registrar in medicine – the first appointment was made in October 2018 and has been very successful in supporting improvements in Medicine. There is support for further post in Medicine for 2019/2020 although 50% funding no longer available through HEKSS.

Following decommissioning of dermatology services, two Dermatology Specialist Registrar posts have been lost.

Internal Medicine Training (IMT)
In response to the recommendations set out in the Shape of Training Report, the Joint Royal Colleges of Physicians Training Board (JRCPTB) has developed a new curriculum for Internal Medicine (IM). The IM stage 1 will replace the current Core Medical Training (CMT) programme from August 2019.

The IM stage 1 programme will comprise the first three years post-foundation training, during which there will be increasing responsibility for the acute medical take and the MRCP (UK) Diploma will be achieved. It will include mandatory training in geriatric medicine, critical care, outpatients and ambulatory care. The new curriculum sets a minimum requirement of 10 weeks in no more than two blocks as well as providing guidance on the 'gold standard' of a three month Intensive Care Unit (ICU) placement which we already provide at MFT. There are some changes to our training programmes as each trainee is required to have a placement in Geriatric medicine as well as ICU. There may also be a risk to the medical rotas in IMT 3 due to the loss of 2 current ST3 posts to the programme.

Medical Training Initiative Schemes (MTIs)
MTIs are overseas doctors who are accepted on a fixed 2 year program through the Royal Colleges to be trained within the UK. We now have an agreed establishment in Medicine of 15 MTI doctors at any stage, who are rotating in a variety of sub-specialties at varying levels of competence (supporting the SHO or Registrar rotas accordingly). We are continuing to recruit, train and support this program.

Physicians Associates
Following success in a PA student program in Trust, in conjunction with Christchurch Canterbury University, we now have a number of PA interns particularly within Medicine. We have successfully recruited a senior PA in orthogeriatrics (Band 8A). We currently employ four at Band 7 and six at Band 6. In addition a third cohort of students is in training.
Two issues need resolution:
   a.   Each qualified PA needs an ES, with space in job plan
   b.   There is CEO support to increase the PA workforce but the Directorate budgets needs allocation; there is opportunity to offer these Band 6 interns substantive Band 7 posts.

Rota gaps and recruitment
HEKSS are responsible for the recruitment and allocation to the Trust training posts and programmes. HEKSS have been unable to fill all the training posts this academic year; in particular there have been significant gaps in the Foundation program (Junior Doctors). This situation has been compounded by poor communication from HEKSS during their restructuring with reduction in number and experience of staff.

4   Trainee Progression and Competency

Annual Review of Competence Progression (ARCP) - Outcomes Academic Year 2017-18

4.1   A review of all doctors in training occurs at least once a year to ensure that they are progressing satisfactorily through their training programme. This review is carried out at the ARCP panel and is based on the evidence within the e-portfolio, which confirms achievement of specified competences based on satisfactory assessment. In some specialties all trainee attend; in others selected trainees are invited.

4.2   Each of the specialist Royal Colleges organise the ARCP panels with the exception of the Foundation Training Programme which is organised at Trust level. 37 of the 41 FY1 posts and 38 of the 43 FY2 posts were filled in the 2017/18 academic year; all of these trainees had satisfactory outcomes at ARCP.

5   Funding

5.1   Medical Education in MFT oversees the funding and quality for the training programmes and posts in a wide variety of specialties in the Trust and community. The DME carries direct responsibility for the financial management of the tariffs which cover funding for all direct costs involved in delivering medical education and training by the Trust.

Undergraduates

Total of 44 teaching posts rotating in 6 week blocks. 22 Year 4 and 22 Year 5	
Income for 2018/2019	**£1,179,235**

Postgraduates

Total of 227 training posts (Foundation, GPVTS, Cores and Higher trainees) with 201 of these posts being in hospital placements, 8 in community posts and 18 in General Practice ST3 (employed and managed by MFT).	
159 posts are HEKSS funded – **50%** Salary cost + Tariff of £12,152 placement support uplifted by Market Factor Forces (MFF). This includes provision of ES time of 0.25 PA per trainee.	**£5,395,777**
Single Employer Contract provides funding for GP ST3 trainees, and out of hospital placements, including admin.	**£1,870,934**
F2 placements in General Practice – **100%** funded	**£266,200**
Other Education and Training (to include admin support for DME, CTs.) + Direct Allocations	**£36,000**
Less Than Full Time trainees attract additional payment when in slot shares (variable)	**£11,285**
Foundation Training Programme Directors and Administration support – calculated on 84 foundation doctors in trust.	**£50,400**
General Practice – Training programme and Administration support	**£16,400**
Total	**£7,646,996**

6 GMC National Trainee Survey 2018

6.1   The HEE Local Offices across London and the South East are required, by the GMC, to have in place suitable quality management mechanisms to respond to issues that are highlighted via the GMC National Trainee Survey. They send to us an excel workbook, and the action plans that are required to be completed by the trust, within it, fulfil part of the quality management processes required by the GMC.

6.2   The Trust received the following Patient Safety Concerns

1.   One Immediate: – in Trauma and Orthopaedics, with delays in theatre "to prevent patients operations" – investigated, not corroborated, theatre utilisation monitored.

2.   Five Non-immediate: - theme of lack of medical doctors especially Registrars, and support of medical outliers

6.3   There were no reported Undermining and Bullying Concerns.

6.4   <u>Highlights (green flags)</u>
Departments that have done exceptional well with many green flags reported are Emergency Medicine, 12 green flags across all programmes with no red/pink flags, and Obstetrics and Gynaecology with 7 green flags, 5 light green flags and no red/pink reported.

Out of the 23 programmes that deliver training in Medway, 14 programmes meet the national average score for overall satisfaction indicator receiving no flags. Emergency Medicine received green flags for the FY programme and a light green flag was received in GP Obstetrics and Gynaecology programme.
From a post speciality view of this year's results, special note to:
- Acute Internal Medicine, receiving 4 green flags with no red/pink flags; it has received green flags for local teaching for three consecutive years.
- Intensive Care Medicine, received 2 green flags (99% in Overall Satisfaction), 1 light green flag and 2 pink flags.

6.5   <u>Concerns (red flags)</u>
Most notable were red/pink outlier flags in both Foundation F1 and F2 programmes in both Medicine and Surgery, which required formal response to the GMC. The main causal factors for these were:
1. Winter pressures with extreme number of medical outliers with redeployment of surgical juniors to support medicine and
2. Very poor fill of the medical Registrar rota (less than 50% at worse). Rectification of both these issues has been prioritised over the last year, with significant improvements seen.

A further focus from Medical Education has been the observation of a few red flags across the Trust in teamwork (questions address multidisciplinary and across department culture) and supportive environment.

7 Quality Visits

7.1   <u>Medicine and Emergency Medicine</u>

Following significant concerns from HEKSS since February 2015, there have been several Quality visits and a senior leadership conversation in 2017 which saw closure of many actions. Since the last Quality Visit in May 2018, all Emergency Medicine actions have now been closed and at Local

Academic Board in December 2018 there was closure of all Medicine actions by the Patch Dean, with the exception of the action relating to the lack of progress in implementing Hospital at Night. These concerns were about out of hours working being unsafe with excessive workload. A major accomplishment, however, has been the establishment of a full middle grade rota, with MTI recruitment and training being a priority.

7.2   Pharmacy

Following an on-site Urgent Concern Review in July 2017, there was removal of Pre-Registration Pharmacists (PRPs). Significant work has been undertaken at many levels in the Trust, including from Medical Education, to ensure a change in culture, reduction in vacancies and turnover, and establish clear supervision and support structures. It was with delight that at the last Quality Visit in December 2018 that PRPs will be reintroduced to the Trust in 2019.

8   Awards
8.1   Undergraduate
- Excellence in teaching awards, administrator of the year Daniella James KCL Dec 2018
- Excellence in teaching award Dr Paul Kitchen KCL December 2018
- QIP projects medical student winners, Medway Maritime Student QIP presentations February 2019. (Last years QIPs were presented at various external conferences)
- Annual Education conference Kings December 2019.
- Lightening presentations:
  - Dr Manisha Shah 'Simulation for TTF1s'
  - Gemma Wrigton 'Simulation and Skills for 4th year medical students '
  - Gary Knowles 'Use of QR codes in feedback'
- Numerous letters of commendation from the Dean Kings college Medical school. Various members of staff.

Shortlisted for BMJ Awards and HSJ
Paediatrics
- '*Emergency Boxes for children with a Tracheostomy'* - Best poster presentation at the inaugural STRS and South Thames Paediatric Critical Care Network Best Practice Conference – awarded to Sarah Levitt, Gill Marshall and Ruth Casey – November 2018
Anaesthetics
- First Prize, Medilead Presentation 2017, *Dr Harpreet Sodhi, Anaesthetics Registrar*
- Accepted abstract – European Society of Regional Anaesthesia 2017, *Dr Harpreet Sodhi – Is the management of major chest trauma using thoracic epidurals at a major London Trauma Centre a Gold Standard?*
- Published article, '**Beyond tubes and cannulas**', *Dr Mikaela Nordblad, FY2, Dr Manisha Shah.*

9   Medical Education Strategy
Vision:
To design, develop and deliver the best education and training to enable and empower trainees to be the best doctors to deliver the best care to patients.

Purpose:
1. Support delivery of best education and training programmes in all departments and Directorates

2. Achieve high quality outcomes by improving links with Directorates, innovating through training leads and engaging trainees and trainers
3. Assess and respond to workforce requirements, to support service and provide best training opportunities
4. Empower trainers to perform their best in supervision and delivery of training
5. Enable and empower every trainee to be their best and achieve success

The working strategy has domains in line with responsibilities to HEE:
Management, organisation and development of medical education meeting standards required by GMC
1. Development of Educational Governance
2. Development of Trainers
3. Oversight and Provision of support, advice and guidance for Trainees in Difficulty
4. Effective Management of Education Centre and Facilities
5. Management of Education Tariff (PGME funding)

In addition there are specific areas which deserve individual focus:
Development of Learning and Development Resources including Library
1. Coordination of the Management of Pharmacy Training
2. Management of Undergraduate Medical Education
3. Facilitation of Education and Training within Primary Care
4. Facilitation of Education and Training within Psychiatric Care
5. Management of Simulation
6. Support of Educational Development of Doctors outside Tariff
7. Support of Educational Development of PAs and PA Students

Key Areas of Update against Strategy:

1) <u>Management, organisation and development of medical education meeting standards required by GMC</u>

<u>Induction</u>
Corporate Induction for doctors in training is reviewed annually for August induction to ensure the most up to date information is delivered. Numerous induction films have been created using extra HEKSS funding (£30k 2017; £7,600 2018). 16 were completed in 2017 and a further 4 this year. These are available on YouTube but only accessible to view via direct links provided with induction information.

ED: https://youtu.be/xZ-jrUNzc5w
Role of ART: https://youtu.be/_kdB7GktgCU

<u>Workload</u>
Previous serious trainee conerns about workload in Medicine have improved. Medical Education has worked closely with Service in particular with the following:
a. Recruitment of Medical Training Initiative (MTI) trainees leading to resolution of Registrar rota gaps in Medicine

A training lead for MTIs in Medicine was recruited in January 2018. The number of MTIs has increased from 4 to 11 of the agreed 15 establishment. A rotational program has been established to ensure competency and knowledge of NHS processes, followed by "Ready to be Registrar" simulation course. The MTI can then be placed on the Registrar rota usually after 6-12 months.

b. Winter Pressures working

Following significant disruption in junior doctors' placements, and therefore training, due to surgical juniors being redeployed to support Medicine outliers during winter 2016/17, clear guidance and plan was implemented leading to improvement over winter 2017/18. In total 17 Foundation trainees were affected (11 F1, 6 F2), with 10 redeployed for one day each, 5 on two days each, and 2 on three days each. Although morale is perceived as significantly better this year, a mapping of Medicine junior doctors is being undertaken to aim to decrease this to zero in 2018/19, as has been achieved by some other Trusts this year. This has been subject to an FOI request both to Trust and HEE.

c. Hospital at Night

Progress has been very limited in this area of Service development until recently. Having been prioritised by Clinical Council, there is now a clear action plan under the leadership of the MD.

Clinical Teaching Videos
An online library of GP and Foundation teaching sessions is being developed to enable trainees to access teaching which they have missed due to on call or leave. There are set hours of mandatory teaching they are required to attend face to face and this initiative is designed to support the remainder, along with e-learning. Filming and editing is in process.

Teamworking
As noted in the GMC training survey results, there were concerns about multidisciplinary and across department working. The Chief Registrar is leading on this work in consultation with one of the Deputy DMEs. A small focus group of trainees met in December and a Trust wide survey of trainees has been undertaken in relation to Rude, Dismissive and Aggressive Behaviour. This questioned whether specialties are working well together, the frequency of this behaviour and who it is most likely to be from. It also looked at the impact of this behaviour on the individuals. Working from this and in combination with the pre-existing Trust initiatives we will be meeting again to take this iniatiative forward. This remains a priority.

Undermining and Bullying
There have been a few episodes of undermining and bullying reported by trainees, which have been dealt with in conjunction with MD and HR as appropriate. There were no reports made in the 2018 GMC training survey.

New Junior Doctors' Contract – Exception Reports
The Junior Doctors' Forum is attended by the DME, MEM and representative for flexible training (deputy DME), and Medical Education continues to work closely with the Guardian of Safe Working. The vast majority of exception reports have been around hours and safe working. Only five education focussed reports have been submitted from 1st August 2018 to end of February 2019; these relate to missing teaching due to workload.

Medical Education Report

1. **Development of Educational Governance**

   A <u>Faculty of Multiprofessional Education</u> has been re-established, initially with a core group of DME, MEM, Head of Organisation and Professional Development (ODP), and Nurse Education. Positive working relationships have been established with agreed common purpose, and this will be developed into an Education Strategy. There is already good practice in Simulation and two multi-professional LFGs (Emergency Medicine and Obstetrics and Gynaecology).

   <u>Educational Website</u>
   A scoping exercise is being undertaken to develop a dedicated education website which will be accessible externally. It would initially be focusing on the Postgraduate Medical trainees but the vision is to roll this out to include Nursing education, Pharmacy education and any other allied health professions.

   <u>Trainee-in-Action groups</u> have been established in Medicine and Pharmacy. In addition focus groups for both PAs and MTIs have been introduced to support these particular members of staff.

2. **Development of Trainers**

   <u>Improvement in quality of educational supervision</u>

   Out of 127 Consultant Educational Supervisors (ES), 16 are new ES, with training completed. Out of the remaining 111 ESs, 66 have undertaken a half day workshop to provide update as a medical educator, thus supporting Trust appraisal and revalidation. An external provider was initially commissioned to deliver these workshops but going forward these ES Refresher workshops will be delivered by the DME and deputy. The remaining 45 will be targeted this year.

   In addition Medical Education has run the following half day workshops, with the aim of enhancing the skills of ESs and other training leads within the Trust:
   1. Trainees in Need of Support (previously known as Trainees in Difficulty)
   2. e-Portfolios and ARCP
   3. Well-being

   Further workshops are being developed including Mentoring and Coaching Skills, Trainer in Difficulty.

   <u>ARCP Feedback on Quality of ES Reports</u>
   Foundation ARCP occurs in Trust. In 2018 we introduced a form whereby the ARCP panel could provide qualitative feedback to ESs on their submitted reports on trainees' portfolios. This can then be used for reflection and feed into consultant appraisal as an Educator.

   <u>Supported Return to Training (SRTT)</u>
   HELKSS are developing a SuppoRTT Programme for all trainees absent for 3 months or more, regardless of reason. Those absent for less than 3 months can opt in. The programme will invole a series of guided meetings with the Educational Supervisor or Training Programme Director co-ordinated by the Trust SRTT Champion and School Appointed SRTT Lead. We are in the process of apppointing a Trust Champion and at Medway have the HEKSS School of Surgery and Emergency Medicine Leads (Shirley Chan and Mandy Morrice).

We were successful in our bids for financial support from HEKSS to set up two training days for College Tutors and also additonal funds in Simulation for returning trainees. The training days are planned for April and May.

3. **Oversight and Provision of support, advice and guidance for Trainees in Difficulty**

There is a confidential password-protected spreadsheet of all trainees in difficulty. The ES is the key person to work with the trainee, with support and advice from the LFG leads and DME. Liaison occurs with the Heads of Specialty School, Learning Support at LaSE and Occupational Health as appropriate according to need. In 2017/18 there were 11 trainees who were escalated from LFG leads to DME and MEM to discuss and provide further support. Currently there are 5 trainees actively being supported.

4. **Effective Management of Education Centre**

The oversight of the Postgraduate Education Centre rooms currently is provided by Recruitment function of HR. There have been significant concerns over this last year about the use of the Education Centre rooms. Moving forward, the following will occur.
   a. Once the non-education HR teams have been re-located out of Education Centre, Medical Education will directly own the oversight of the Centre, with report into the Faculty of Multi-professional Education.
   b. A new room booking system to be purchased.
   c. The current building will be developed to become an Education and Research Centre.

5. **Management of Education Tariff**
There has been clearer oversight of the postgraduate and undergraduate budgets with support from the management accountants in finance. Work is ongoing to align the income with all the budget reports for 2019/2020 both in undergraduate and postgraduate. All junior doctor salary income is being checked in Directorate establishments against the HEKSS post summary. The education tariff comprises of the educational supervision in job plans and direct teaching time within the departments.

6. **Kent and Medway Medical School**

HEE have now confirmed there will be a new Medical school at Universities of Kent at Canterbury and Canterbury Christchurch, the first Medical school in Kent. This will be supported by BSMS Brighton, acting as 'parent institution'. This is part of a government initiative to create 1,500 additional medical places by 2020. We have full representation at the Clinical Advisory Group chaired by Professor Chris Hollands the Founding Dean.
MFT anticipates being allocated up to 75 new medical students starting from September 2022. This represents a doubling of medical student numbers.
There is a core group working on this, and it will present to Board separately.

Meeting of the Board of Directors in Public
Wednesday, 03 July 2019

Title of Report	Research and Innovation Annual Report 2018-19	**Agenda Item**	**10.2**
Lead Director	Dr David Sulch, Medical Director		
Report Author	Professor Ranjit Akolekar, Research and Innovation Clinical Lead Dr Swapna Thomas, Research and Innovation Strategy and Operations Manager		
Executive Summary	The report outlines the research and innovation activities for the period 1st April 2018 until 31st March 2019.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Quality Assurance Committee Research and Innovation Governance Group		
Resource Implications	Not Applicable		
Legal Implications/ Regulatory Requirements	Not Applicable		
Quality Impact Assessment	Not required.		
Recommendation/ Actions required	The Board is asked to note the Research and Innovation Annual Report 2018/19.		

Approval	**Assurance**	**Discussion**	**Noting**
☐	☐	☐	☒

Appendices	Appendix A: Research Performance of Medway NHS Foundation Trust.

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Appendix B (i). The list of publications from the investigators within the Trust during the year.

Appendix B (ii):

a) Table 1 - List of Grants Submitted by Medway NHS Foundation Trust in 2018-19

b) Table 2 - List of Funding applications in Progress

c) Table 3 - List of Non-Portfolio projects in Pipeline.

Research & Innovation

Annual Report
2018-2019

TABLE OF CONTENTS

1.   Executive Summary

1.1.   Medway NHS Foundation Trust (MFT) is committed to Research and Innovation recognizing the benefits these bring to patient care, general public health, education, staff retention and development of the Trust.

1.2.   This report outlines progress and achievements over the last 12 months (1st April 2018 to 31st March 2019).

2. Performance

2.1. Research studies conducted at MFT

2.1.1 In 2018/2019, a total of 108 research studies were conducted at MFT. Compared to the previous report, the total number of studies has decreased slightly but this is a reflection of a relatively smaller number but more intensive interventional studies conducted in the recent years

2.1.2 This is reflected in a total of 10,038.5 weighted recruits against the predicted weighted recruits of 7,684.0, bringing the Value for Money (VFM), which is the cost per patient recruited, to £87.39.

2.1.3 Research in Reproductive Health and Childbirth, led by Professor Akolekar is by far the highest performing specialty and is supported by research midwives (Two Band 7 and one Band 6) funded by the National Institute of Health Research (NIHR).

2.1.4 Table 1 (Appendix A) presents the number of studies in each specialty.

2.1.5 Figure 2 (Appendix A) outlines the number of studies that MFT participated in over six years, from 1st April 2013 to 31st March 2019.

2.1.6 Figure 3 & 4 (Appendix A) demonstrate activity in 2018/19 and proposed activity for 2019/20 based on study-weighting and research specialty.

2.2. Recruitment in research studies

2.2.1 For a fifth consecutive year, MFT was the *highest* performing trust at recruiting patients into clinical Trials in Kent, Surrey and Sussex Clinical Research Network (CRN) (out of 20 member organisations).

2.2.2 In 2018/19, The Trust recruited 5,828 participants in total towards the target of 1,717 during the year 2018/19. The total recruitment of MFT to research studies was 339% against the agreed target with the NIHR.

2.2.3 Figure 1 (Appendix A) **re**presents the annual recruitment target and the actual number of patients at MFT recruited into the NIHR adopted studies over six year period, from 1st April 2013 to 31st March 2019.

2.3 Specialty and staff engagement

2.3.1 During 2018-19, approximately 90 clinical staff participated in the conduct of research approved by the Health Research Authority at MFT across 19 disease areas as well studies looking into Health Services Research.

2.3.2 In the period between 1st April 2018 and 31st March 2019 the Investigators at MFT published 90 articles (Appendix B).

3 The department's research and innovation strategy will be linked with the trust clinical strategy to bring in trust wide engagement in research and innovation finances

3.2 Funding support from National Institute of Health Research (NIHR)

3.2.1 The funding allocation to NHS trusts for any financial year is based on previous year's research activity (calculated as weighted recruits).

3.2.2 The total weighted recruits in a financial year are used to estimate the cost per case, which in turn allows the total research spent (£80-£100 per patient in 2017-2018, which is within the safe level).

3.2.3 The allocation of funding for 2019-2020 for MFT from NIHR was based on previous years activity and although despite our fantastic performance in recruitment to research studies, we did not qualify for an increase in NIHR funding but out funding support was maintained with no funding cuts to our research support from NIHR, unlike many neighboring trusts which have suffered reduction in funding support.

3.2.4 For the financial year 2019-2020, the NIHR allocation to MFT Research and Innovation (R&I) department based our research activity is a total of £942,890.

3.2.5 Table 2 presents expected core funding allocations to all partners within Kent Surrey and Sussex in 2019-20.

3.3 Investigators accounts

3.3.1 A total income of £389k is accumulated in the Investigator accounts. Although, there has been an increased reimbursement of clinician's time spent on research and funding of educational activities, a strategic planning is required in each specialty to spend the income from the investigator's account wisely and efficiently in research within the specialty under supervision of the Research and Innovation Governance Group (RIGG).

3.3.2 A Standard Operating Procedure (SOP) on distribution of research income and cost allocations recently approved by the Medical Director would facilitate transparency in research income distribution and efficient utilization of income for research purposes.

4   Research governance and safety

4.2   Research governance

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

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

4.2.3   Any research and/or innovation related incidences are reported to the RIGG which in turn gets reported to the Trust Executive Group.

4.2.4   To remind staff that no research and/or innovation should be conducted without Trust approval, the R&I Department continues to distribute reminders via Trust global newsletter.

4.2.5   An external audit was conducted on R&I by KPMG. The outcome of the Audit came with a rating of significant assurance with minor improvement opportunities recommending regular reporting to Trust Board (already implemented), dedicated research lead per department and standardized feedback to the departments through the departmental research leads (to be implemented)

4.3   Safety in research

4.3.1   The R&I Department completes a DATIX entry for each and every serious adverse events related to research.

4.3.2   The patients involved and engaged in research studies do suffer from critical illnesses and so the incidences are 'expected'.

4.3.3   Out of 60 incidences reported in 2018-19, 33 were Serious Adverse Events (SAEs), but none of these were a result of research practice.

4.3.4   Other reported incidences (27) relate to non-serious governance errors or operational issues such as flooding in Gate Lodge building where the delivery team are based.

4.3.5   Of all the reported incidences, 4 were deemed to be of low-harm and 56 to be of no harm.

4.3.6   All the reported incidences for 2018-19 were investigated and adequate measures put in place.

5   Academic activities and collaborations

5.2   University collaborations

5.2.1   A new jointly funded post of Senior Research and Innovation Officer (SRO) was created with the University of Kent (UoK) to support collaborative projects between the Trust and UoK.

5.2.2   There are collaborative projects underway with CCCU and discussions are in progress to develop collaborative research projects.

5.3   Research Grand Round

5.3.1   The R&I Department held a Research Grand Round on 02 November 2018 on 'Plans for the Medical School and impact on the Trust' with presentations from Professor Chris Holland, Dean of the Kent and Medway Medical School (KMMS) and Dr Peter Nicholls, Dean of Kent Health and Faculty of Sciences. There are plans for such regular Grand Round presentations to be arranged by R&I.

5.4   Research output

5.4.1   The following lists in the **Appendix B** will provided the details of applications at various stages.

- List of Grant Applications submitted

- List of Funding applications in Pipeline

- List of Non-Portfolio projects in Pipeline

6   Research priorities for 2019/2020

6.1   Kent and Medway Medical School (KMMS) and Trust University Status

6.1.1   With the Medical School being established at Kent and Medway in 2020, R&I is working with the Trust towards the possibility of attaining the University Hospital Trust status.

6.1.2   A letter with supporting evidence has been drafted to submit to Association of UK University Hospitals (AUKUH) with an aim for the Trust to achieve the University Hospital Status. With the support of the Dean of KMMS and Vice-Chancellor of Canterbury Christ Church University (CCCU), this will be submitted to AUKUH following the approval by the Trust Board in June 2019.

6.2   Kent and Medway Joint Research Office (JRO)

6.2.1   The possibility to establish a Kent and Medway Joint Research Office (JRO) to support the KMMS research activities is being explored by visiting JROs across the country.

6.2.2   Discussions are under way with the Trust Head of R&I, Director of R&I of East Kent Hospitals University NHS Foundation Trust and Peter Nicholls representing University of Kent and KMMS on the feasibility of JRO in Kent and Medway.

6.3   Trust Research and Education Centre

6.3.1   R&I Department in liaison with the Medical Education Department, is working towards the establishment of Research and Education Centre in the Trust at the location of current Postgraduate Centre building.

6.3.2   Several of these meetings have already taken place and work is underway to discuss logistics of staff, resources and infrastructure necessary for this to move forward.

6.4   Integrated Health Care

6.4.1   R&I will continue to collaborate with the Clinical Research Network Kent Surrey and Sussex (CRN KSS) to increase research activity and thus lowering the cost per patient recruited to the minimum and get increased funding.

6.4.2   R&I is working towards extending its activities to primary care thus integrating the healthcare services of the Trust. Discussions are under way with the Clinical Commissioning Group to come to an agreement about the provision and delivery of the required research services between MFT and the upcoming primary care network.

6.4.3   R&I collaborate with the Medway Innovation Hub (MiH) and thus develop the portfolio of innovation studies with primary care in Medway.

6.5 Trust-wide Engagement in Research and Innovation

6.5.1 Prof Ranjit Akolekar has been recently appointed as the Clinical Lead of R&I Department by the Trust. The Clinical Lead will play the key role in bringing Trust wide engagement in research and innovation and thus maximize the number of research active specialties within the Trust.

6.5.2 A Standard Operating Procedure outlining the procedure on how Consultants are awarded Support Programmed Activities (SPAs) for research and/or innovation has been approved by the Medical Director to improve the engagement of clinicians in research and innovation and encourage the current research active clinicians.

6.6 Public Awareness and Patient Engagement

6.6.1 The R&I Office will continue to collaborate with Patient Research Ambassadors appointed to improve patient engagement.

6.6.2 A Clinical Research Liaison Manager is appointed to plan training and events for the R&I Department. R&I actively participated in the 70th birthday celebrations of the NHS in July 2018 and will continue to promote research and innovation through public and Trust events.

6.6.3 International Clinical Trials Day will be celebrated by having a research stand at Hempstead Valley shopping centre, Chatham Dockside and Trust Foyer on various days of the week commencing 20 May 2019.

7   Appendices

7.1   Appendix A: Research Performance of Medway NHS Foundation Trust

Figure 1: Total number of research studies conducted at MFT between 2013- 2019
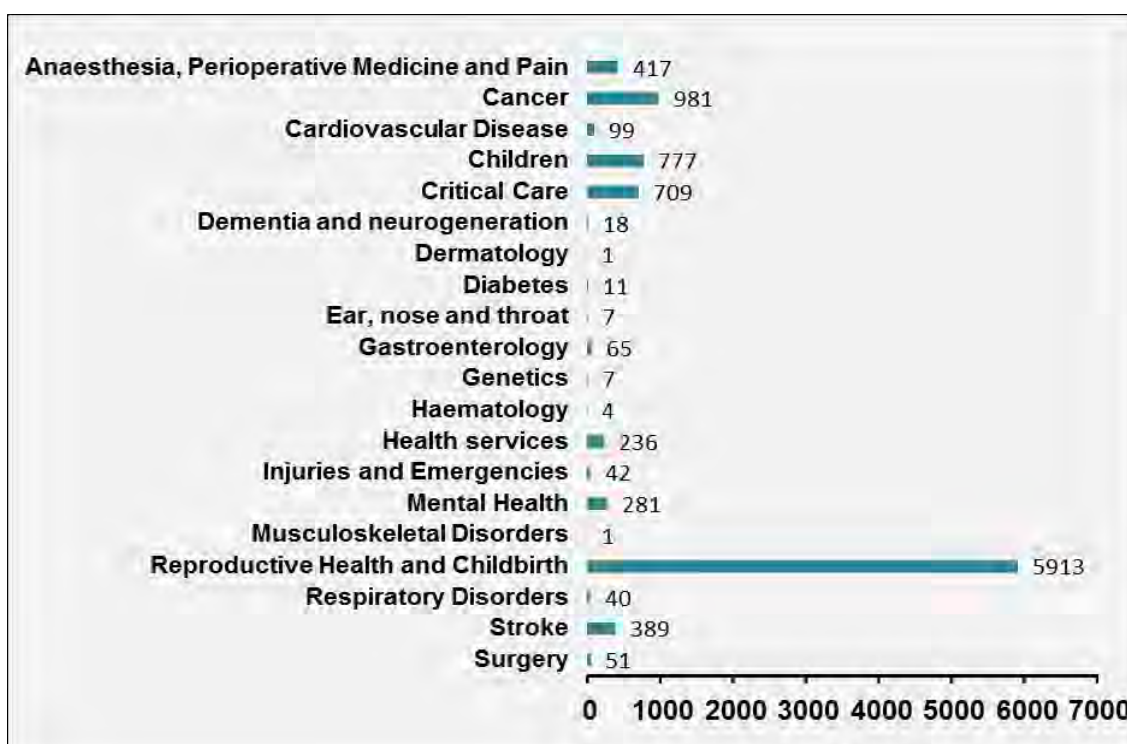
Figure 2: Total Research Activity of MFT in 2018-19
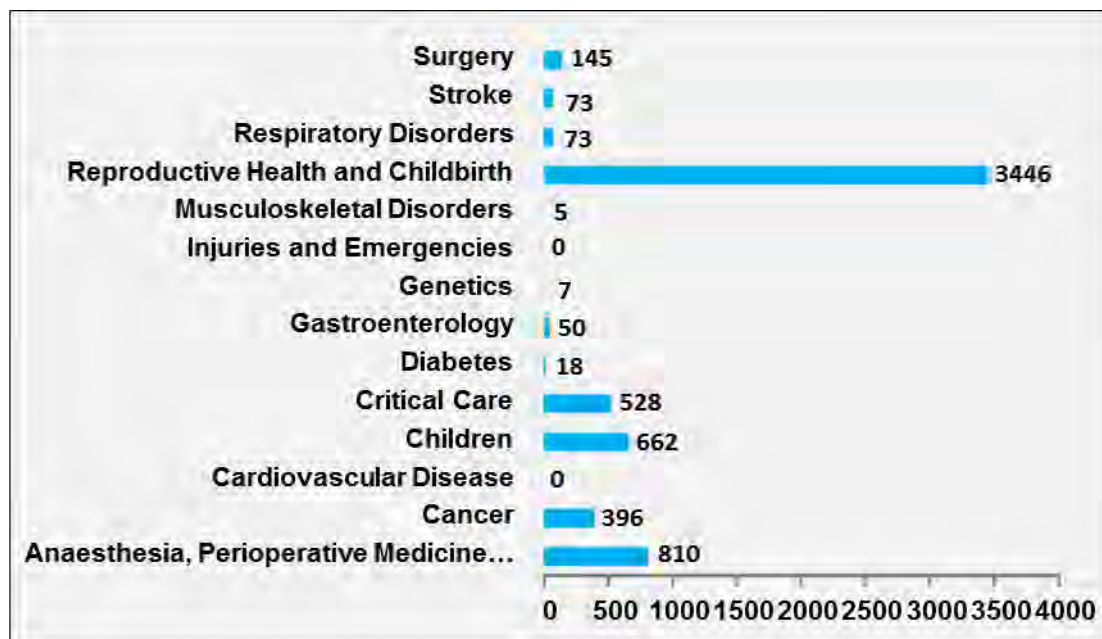
Figure 3: Planned Research Activity in 2019-20
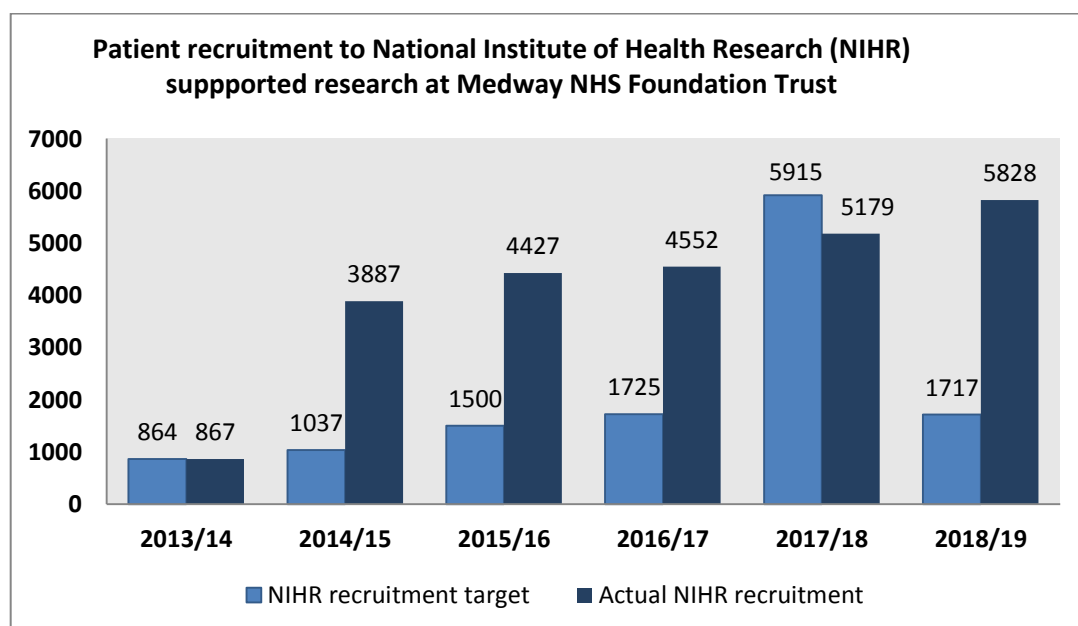
Figure 4: Annual recruitment target and the actual recruitment of patients into the NIHR adopted studies at MFT

Table 1: Total number of research projects per research speciality undertaken at MFT during 2018-19.

Number of Studies by Research Speciality	2018 - 2019
Anaesthesia and Perioperative Medicine	5
Cancer	32
Cardiovascular	6
Children	9
Critical Care	7
Dementias and neurodegeneration	4
Dermatology	1
Diabetes	1
Ear Nose and Throat	3
Gastroenterology	1
Health Services Research	7
Injuries and Emergencies	5
Mental Health	2
Metabolic and endocrine	1
Musculoskeletal	3
Other*	3
Renal Disorders	3
Reproductive health	9
Respiratory and Thoracic	5
Stroke	1

*Studies outside of clinical speciality for example educational studies or research into overall patient experience.

Table 2: Funding allocation of KSS-CRN Partners for 2019-20

TRUST	Baseline 18/19	2a RTT 17/18	17/18 VFM	VFM adjustment	capped/collar adjustment	Recurrent funding	19/20 funding	3% COL	Total
ASPH	£601,486.70	£0.00	£156.00	-£60,148.67	-£60,000.00		£541,486.70	£16,244.60	£557,731.30
BSUH	£1,627,308.74	£0.00	£66.00	£81,365.44	£60,000.00		£1,687,308.74	£50,619.26	£1,737,928.00
D&G	£372,251.38	-£18,612.57	£120.00	£0.00	-£18,612.57		£353,638.81	£10,609.16	£364,247.98
EKHUFT	£1,018,904.94	-£20,378.10	£120.00	£0.00	-£20,378.10		£998,526.84	£29,955.81	£1,028,482.65
ESH	£383,479.27	-£19,173.96	£87.00	£0.00	-£19,173.96		£364,305.31	£10,929.16	£375,234.47
FH	£671,862.24	-£13,437.24	£84.00	£0.00	-£13,437.24		£658,425.00	£19,752.75	£678,177.75
KMPT	£306,701.14	£0.00	£66.00	£15,335.06	£15,335.06		£322,036.20	£9,661.09	£331,697.28
KCHFT	£128,829.38	£0.00	£58.00	£12,882.94	£12,882.94		£141,712.32	£4,251.37	£145,963.69
MTW	£788,930.33	-£39,446.52	£144.00	-£78,893.03	-£60,000.00		£728,930.33	£21,867.91	£750,798.24
MFT	£877,267.15	£0.00	£90.00	£0.00	£0.00	£38,160.00	£915,427.15	£27,462.81	£942,889.96
QVH	£67,535.92	£0.00	£39.00	£6,753.59	£6,753.59	£93,000.00	£167,289.51	£5,018.69	£172,308.20
RSCH	£1,034,973.81	-£51,748.69	£109.00	£0.00	-£51,748.69		£983,225.12	£29,496.75	£1,012,721.87
SABP	£278,973.44	-£5,579.47	£33.00	£27,897.34	£22,317.88	£103,453.00	£404,744.32	£12,142.33	£416,886.64
SASH	£338,596.27	£0.00	£54.00	£33,859.63	£33,859.63	£40,680.00	£413,135.90	£12,394.08	£425,529.97
SCFT	£250,505.14	£0.00	£87.00	£0.00	£0.00		£250,505.14	£7,515.15	£258,020.29
SPFT	£729,477.50	£0.00	£68.00	£36,473.88	£36,473.88	£38,950.00	£804,901.38	£24,147.04	£829,048.42
WSHFT	£800,898.68	-£40,044.93	£146.00	-£80,089.87	-£60,000.00		£740,898.68	£22,226.96	£763,125.64
SECAMB	£40,401.65	£0.00	£8.00	£4,040.17	£4,040.17	£35,550.00	£79,991.82	£2,399.75	£82,391.57
Partner B	£914,955.03	-£18,299.10	NA	£0.00	-£18,299.10	£72,269.00	£968,924.93	£29,067.75	£997,992.68

Appendix B: Studies at Medway NHS Foundation Trust

1) The list of publications from the investigators within the Trust during the year is attached as Appendix B (i).

2) The details of the all the home grown studies at various stages of development is attached as Appendix B (ii):

   a) Table 1 - List of Grants Submitted by Medway NHS Foundation Trust in 2018-19

   b) Table 2 - List of Funding applications in Progress

   c) Table 3 - List of Non-Portfolio projects in Pipeline

MMH Publications April 2018-March 2019

Subject   Cardiology

Title   Atrial fibrillation screening in general practice by clinical pharmacists using pulse palpation and single-lead ECG during the influenza vaccination season: a multi-site feasibility study

Author/s   Savickas V, Stewart A, Mathie A, Bhamra S, Corlett S, Veale E

Reference   European Heart Journal, Aug 2018, 39/Supp 1

MMH Staff member/s   A Stewart

Subject   Cardiology

Title   Day case complex devices: the state of the UK

Author/s   Waight M, Elawady A, Adhya S

Reference   Open Heart, Mar 2019, E-pub

MMH Staff member/s   Michael Waight, Abdula Elawady, Shaumik Adhya

Subject	Cardiology
Title	Rationale and design of the randomized multicentre His Optimized Pacing Evaluated for Heart Failure (HOPE-HF) trial
Author/s	Keene D, Arnold A, Shun-Shin M, Howard J, Sohaib S, Moore P, Tanner M, Quereshi N, Muthumala A, Chandresekeran B, Foley P, Leyva F, Adhya S
Reference	ESC Heart Failure, Jul 2018/E-pub ahead of print
MMH Staff member/s	Shaumik Adhya

Subject	Dermatology
Title	A rare case of a tattoo-induced morphoea reaction
Author/s	Mehrtens S, Fleming A, Shall L
Reference	Clinical and Experimental Dermatology, Oct 2018/E-pub ahead of print
MMH Staff member/s	Sarah Mehrtens, Larry Shall

Subject	Dermatology
Title	Case of keratoacanthoma centrifugum marginatum treated with acitretin
Author/s	Mehrtens S, de la Hera I, Shankar S
Reference	BMJ Case Reports, Nov 2018/E-pub
MMH Staff member/s	Sarah Mehrtens, Inma de la Hera, Sonal Shankar

Subject	Dermatology
Title	Choosing an emollient
Author/s	Croney S
Reference	British Journal of Nursing, Jun 2018 27/11 (597-598)
MMH Staff member/s	Stacey Croney

Subject	Dermatology; Paediatrics
Title	A case of focal facial dermal dysplasia type 4
Author/s	Mehrtens S, Shankar S
Reference	Pediatric Dermatology, Jan/Feb 2019, 36/1 (e58-e59)
MMH Staff member/s	Sarah Mehrtens, Sonal Shankar

Subject	Diabetes
Title	Measurement of breath acetone in patients referred for an oral glucose tolerance test
Author/s	Andrews B, Denzer W, Hancock G, Lunn D, Peverall R, Ritchie G, Williams K
Reference	Journal of Breath Research, Apr 2018/E-pub ahead of print
MMH Staff member/s	Brian Terence Andrews, Karen Williams

Subject	Diabetes; Paediatrics
Title	Psychological spectrum in DM1
Author/s	Khanna A, Ranasinghe A
Reference	Endocrine Abstracts, Oct 2018 58 (PO73)
MMH Staff member/s	Ankit Khanna, Asankha Ranasinghe

Subject	Emergency Medicine; Cardiology
Title	Possible Holt-Oram Syndrome: missed prenatal diagnosis and sub-optimal management in a poor-resourced hospital
Author/s	Osonuga A, Arhin J, Okoye G, Da'Costa A
Reference	Balkan Medical Journal, Mar 2019, E-pub
MMH Staff member/s	Adebayo Da'Costa

Subject	Gastroenterology
Title	Malignant peritoneal mesothelioma: clinical aspects, and therapeutic perspectives
Author/s	Boussios S, Moschetta M, Karathanasi A, Tsiouris A, Kanellos F, Tatsi K, Katsanos K, Christodoulou D
Reference	Annals of Gastroenterology, Oct 2018, 31 (1-11)
MMH Staff member/s	Stergios Boussios, Afroditi Karathanasi

Subject	Gastroenterology; Oncology
Title	Factors affecting adenoma detection rate in a national flexible sigmoidoscopy screening programme: a retrospective analysis
Author/s	Bevan R, Blanks R, Nickerson C, Saunders B, Stebbing J, Tighe R, Veitch A, Garrett W, Rees C
Reference	The Lancet Gastroenterology & Hepatology, Mar 2019, 4/3, (239-247)
MMH Staff member/s	William Garrett

Subject	Haematology
Title	The impact of cytogenetics on duration of response and overall survival in patients with relapsed multiple myeloma (long-term follow-up results from BSBMT/UKMF Myeloma X Relapse [Intensive]): a randomised, open-label, phase 3 trial
Author/s	Cook G, Royle K, O'Connor S, Cairns D, Ashcroft A, Williams C, Hockaday A, Cavenagh J, Snowden J, Ademokun D, Tholouli E, Andrews V, Jenner M, Parrish C, Yong K, Cavet J, Hunter H, Bird J, Pratt G, Drayson M, Brown J, Morris T
Reference	British Journal of Haematology, Feb 2019, E-pub
MMH Staff member/s	Vivienne Andrews

Subject	Infection Control
Title	2019 update of the WSES guidelines for management of Clostridioides (Clostridium) difficile infection in surgical patients
Author/s	Sartelli M et al
Reference	World Journal of Emergency Surgery, Feb 2019, 14/8, E-pub
MMH Staff member/s	Shirley Chan

Subject	Medicine
Title	Overuse of antibiotics in acute pancreatitis: fighting resistance with education
Author/s	Knowles H, Khan A, Amin J, Harillingam M
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S64)
MMH Staff member/s	H Knowles

Subject	Midwifery
Title	Improving induction of labour for women through the development of a new pathway
Author/s	Wier J, Hinchey-Beer S, Walker L
Reference	Journal of Midwifery, Sep 2018, 26/9 (585-590)
MMH Staff member/s	Sonya Hinchey-Beer, Lyndsay Walker

Subject	Neonatology
Title	Antimicrobial resistance in UK neonatal units: neonIN infection surveillance network
Author/s	Cailes B, Kortsalioudaki C, Buttery J, Pattnayak S, Greenough A, Matthes J, Bedford Russell A, Kennea N, Heath P
Reference	Archives of Disease in Childhood: Fetal & Neonatal Edition, Sep 2018/E-pub ahead of print
MMH Staff member/s	Santosh Pattnayak

Subject	Neonatology
Title	Epidemiology of UK neonatal infections: the neonIN infection surveillance network
Author/s	Cailes B; Kortsalioudaki C; Buttery J; Pattnayak S; Greenough A; Matthes J, Bedford Russell A, Kennea N, Heath P
Reference	Archives of Disease in Childhood: Fetal and neonatal edition, Nov 2018, 103/6 (F547-F553)
MMH Staff member/s	Santosh Pattnayak

Subject	Neonatology
Title	Fetal Medicine Foundation fetal and neonatal population weight charts
Author/s	Nicolaides K, Wright D, Syngelaki A, Wright A, Akolekar R
Reference	Ultrasound in Obstetrics & Gynecology, Apr 2018, E-pub
MMH Staff member/s	Ranjit Akolekar

Subject	Neonatology
Title	Magnetic resonance spectroscopy assessment of brain injury after moderate hypothermia in neonatal encephalopathy: a prospective multicentre cohort study
Author/s	Lally P, Montaldo P, Oliveira V, Soe A, Swamy R, Bassett P, Mendoza J; Atreja G; Kariholu U; Pattnayak S; Sashikumar P, Harizaj H; Mitchell M; Ganesh V; Harigopal S; Dixon J; English P, Clarke P, Muthukumar P, Satodia P, Wayte S et al
Reference	Lancet Neurology, Jan 2019, 18/1 (35-45)
MMH Staff member/s	Aung Soe, Santosh Pattnayak, Palaniappan Sashikumar, Helen Harizaj, Martrin Mitchell, Vijayakumar Ganesh

Subject	Neonatology
Title	Residual brain injury after early discontinuation of cooling therapy in mild neonatal encephalopathy
Author/s	Lally P, Montaldo P, Oliveira V, Swamy R, Soe A, Shankaran S, Thayyil S
Reference	Archives of Disease in Childhood: Fetal and neonatal edition, Jul 2018, 103/4 (F383-F387)
MMH Staff member/s	Aung Soe

Subject	Neonatology
Title	Therapeutic hypothermia for mild neonatal encephalopathy: a systematic review and meta-analysis
Author/s	Kariholu U, Montaldo P, Markati T, Lally P, Pryce R, Teiserskas J, Liow N, Oliveira V, Soe A, Shankaran S, Thayyil S
Reference	Archives of Disease in Childhood: Fetal and neonatal edition, Dec 2018/E-pub ahead of print
MMH Staff member/s	Aung Soe

Subject	Neonatology
Title	Therapeutic hypothermia initiated within 6 hours of birth is associated with reduced brain injury on MR biomarkers in mild hypoxic-ischaemic encephalopathy: a non-randomised cohort study
Author/s	Montaldo P, Lally P, Oliveira V, Swamy R, Mendoza J, Atreja G, Kariholu U, Shivamurthappa V, Liow N, Teiserskas J, Pryce R, Soe A, Shankaran S, Thayyil S
Reference	Archives of Disease in Childhood: Fetal and neonatal edition, Nov 2018/E-pub ahead of print
MMH Staff member/s	Aung Soe

Subject	Neonatology
Title	Whole blood gene expression reveals specific transcriptome changes in neonatal encephalopathy
Author/s	Montaldo P, Kaforou M, Pollara G, Hervás-Marín D, Calabria I, Panadero J, Pedrola L, Lally P, Oliveira V, Kage A, Atreja G, Mendoza J, Soe A, Pattnayak S, Shankaran S, Vento M, Herberg J, Thayyil S
Reference	Neonatology, Oct 2018, 115 (68-76) E-pub ahead of print
MMH Staff member/s	Santosh Pattnayak, Aung Soe

Subject	Neonatology; Obstetrics & Gynaecology
Title	Prediction and prevention of small-for-gestational-age neonates: evidence from SPREE and ASPRE
Author/s	Tan M, Poon L, Rolnik D, Syngelaki A, de Paco Matallana C, Akolekar R, Cicero S, Janga D, Singh M, Molina F, Persico N, Jani J, Plasencia W;,Greco E, Papaioannou G, Wright D, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Apr 2018, E-pub
MMH Staff member/s	Ranjit Akolekar

Subject	Neurology
Title	Short-term memory impairment in vestibular patients can arise independently of psychiatric impairment, fatigue, and
Author/s	Smith L, Wilkinson D, Bodani M, Bicknell R, Surenthiran S
Reference	Journal of Neuropsychology, Apr 2018/E-pub
MMH Staff member/s	S Surenthiran

Subject	NHS Staffing
Title	Integrating physician associates into the health workforce: barriers and facilitators
Author/s	Szeto M, Till A, McKimm J
Reference	British Journal of Hospital Medicine, Jan 2019, 80/1 (12-17)
MMH Staff member/s	Matthew Szeto

Subject	Obstetrics & Gynaecology
Title	ASPRE trial: incidence of preterm pre-eclampsia in patients fulfilling ACOG and NICE criteria according to risk by FMF algorithm
Author/s	Poon L, Rolnik D, Tan M, Delgado J, Tsokaki T, Akolekar R, Singh M, Andrade W, Efeturk T, Jani J, Plasencia W, Papaioannou G, Blazquez A, Carbone I, Wright D, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Jun 2018, 51/6 (738-742)
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Case based discussion of surgical approach to deep infiltrating endometriosis
Author/s	Ahmed H
Reference	World Journal of Gynecology & Women's Health, Jan 2019, E-pub
MMH Staff member/s	Hasib Ahmed

Subject	Obstetrics & Gynaecology
Title	Extreme prematurity and perinatal management
Author/s	David A, Soe A
Reference	The Obstetrician & Gynaecologist, Apr 2018, 20/2 (109-117)
MMH Staff member/s	Aung Soe

Subject	Obstetrics & Gynaecology
Title	Fetal Medicine Foundation reference ranges for umbilical artery and middle cerebral artery pulsatility index and cerebroplacental
Author/s	Ciobanu A, Wright A, Syngelaki A, Wright D, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Oct 2018/E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Impaired placental perfusion and major fetal cardiac defects
Author/s	Fantasia I, Andrade W, Syngelaki A, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Oct 2018/E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Long-term outcomes of the Stop Traumatic OASI Morbidity Project (STOMP)
Author/s	Basu M, Smith D
Reference	International Journal of Gynecology and Obstetrics, Sep 2018, 142/3 (295-299)
MMH Staff member/s	Maya Basu, Dot Smith

Subject	Obstetrics & Gynaecology
Title	Management of complications arising from the use of mesh for stress urinary incontinence—International Urogynecology Association Research and Development Committee opinion
Author/s	Duckett J, Bodner-Adler B, Rachaneni S, Latthe P
Reference	International Urogynecology Journal, Mar 2019, E-pub
MMH Staff member/s	Jonathan Duckett

Subject	Obstetrics & Gynaecology
Title	Prediction of adverse perinatal outcomes by the cerebroplacental ratio in women undergoing induction of labour
Author/s	Fiolna M, Kostiv V, Anthoulakis C, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Nov 2018/E-pub ahead of print
MMH Staff member/s	Magdalena Fiolna, Vira Kostiv, Christos Anthoulakis, Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Prediction of small-for-gestational-age neonates at 35-37 weeks' gestation: contribution of maternal factors and growth velocity between 20 and 36 weeks
Author/s	Ciobanu A, Formuso C, Syngelaki A, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Feb 2019, E-pub
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Risk of miscarriage following amniocentesis and chorionic villus sampling: a systematic review of the literature
Author/s	Beta J, Lesmes-Heredia C, Bedetti C, Akolekar R
Reference	Minerva Ginecologica, Apr 2018, 70/2 (215-219)
MMH Staff member/s	Jaroslaw Beta, Cristina Lesmes-Heredia, C Bedetti, Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Routine assessment of cerebroplacental ratio at 35-37 weeks' gestation in the prediction of adverse perinatal outcome
Author/s	Akolekar R, Ciobanu A, Zingler E, Syngelaki A, Nicolaides K
Reference	American Journal of Obstetrics & Gynecology, Mar 2019, E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Routine first-trimester screening for fetal trisomies in twin pregnancies: cell-free DNA test contingent on results from the combined
Author/s	Galeva S, Konstantinidou L, Gil M, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Oct 2018/E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Routine first-trimester screening for fetal trisomies in twin pregnancy: cell-free DNA test contingent on results from combined test
Author/s	Galeva S, Konstantinidou L, Gil M, Akolekar R, Nicolaides K
Reference	International Journal of Gynaecology & Obstetrics, Feb 2019, 53/2 (208-213) E-pub
MMH Staff member/s	Slavyana Galeva, Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Routine ultrasound at 32 vs 36 weeks' gestation: prediction of small-for-gestational-age neonates
Author/s	Ciobanu A, Khan N, Syngelaki A, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Mar 2019, E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	Screening for pre-eclampsia by maternal factors and biomarkers at 11–13 weeks' gestation
Author/s	Tan M Y, Syngelaki A, Poon L, Rolnik D, O'Gorman N, Delgado J, Akolekar R, Konstantinidou L, Tsavdaridou M, Galeva S, Ajdacka U, Molina F, Persico N, Jani J, Plasencia W, Greco E, Papaioannou G, Wright A, Wright D, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Jun 2018/E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology
Title	The efficacy and safety of pharmacologic thromboprophylaxis following caesarean section: a systematic review and metaanalysis
Author/s	Yang R, Zhao X, Yang Y, Huang X, Li H, Su L
Reference	PLoS One, Dec 2018, 13/12 E-pub
MMH Staff member/s	Maya Basu is the Editor

Subject	Obstetrics & Gynaecology
Title	Ultrasonographic estimation of fetal weight: development of new model and assessment of performance of previous models
Author/s	Hammami A, Mazer Zumaeta A, Syngelaki A, Akolekar R, Nicolaides K
Reference	Ultrasound in Obstetrics & Gynecology, Apr 2018/E-pub ahead of print
MMH Staff member/s	Ranjit Akolekar

Subject	Obstetrics & Gynaecology; Oncology
Title	Large cell neuroendocrine carcinoma of the uterine cervix
Author/s	Habeeb A, Habeeb H
Reference	BMJ Case Reports, Jan 2019, 12/1 E-pub
MMH Staff member/s	Hany Habeeb

Subject	Obstetrics & Gynaecology; Urology
Title	Age, menopausal status and the bladder microbiome
Author/s	Curtiss N, Balachandran A, Krska L, Peppiatt-Wildman C, Wildman S, Duckett J
Reference	European Journal of Obstetrics & Gynecology & Reproductive Biology, Jun 2018/E-pub ahead of print
MMH Staff member/s	Natasha Curtiss, Aswini Balachandran, Jonathan Duckett

Subject	Oncology
Title	Antimicrobial prescribing in cancer patients with bloodstream infections
Author/s	Raja N, Umpleby H, Harwell S
Reference	Research.net, May 2018/E-pub
MMH Staff member/s	Nadeem Raja

Subject	Oncology
Title	Metastatic spinal cord compression: unraveling the diagnostic and therapeutic challenges
Author/s	Boussios S, Cooke D, Hayward C, Kanellos F, Tsiouris A, Chatziantoniou A, Zakynthinakis-Kyriakou N, Karathanasi A
Reference	Anticancer Research, Sep 2018, 38/9 (4987-4997)
MMH Staff member/s	Stergios Boussios, Deirdre Cooke, Catherine Hayward, Afroditi Karathanasi

Subject	Oncology
Title	Spinal Ewing sarcoma debuting with cord compression: have we discovered the thread of Ariadne?
Author/s	Boussios S, Hayward C, Cooke D, Zakynthinakis-Kyriakou N, Tsiouris A, Chatziantoniou, A, Kanellos F, Karathanasi A
Reference	Anticancer Research, Oct 2018 38/10 (5589-5597)
MMH Staff member/s	Stergios Boussios, Catherine Hayward, Deirdre Cooke

Subject	Oncology
Title	The developing story of predictive biomarkers in colorectal cancer
Author/s	Boussios S, Ozturk M, Moschetta M, Karathanasi A, Zakynthinakis-Kyriakou N, Katsanos K, Christodoulou D, Pavlidis N
Reference	Journal of Personalized Medicine, Feb 2019, 9/1 (e12)
MMH Staff member/s	Stergios Boussios, Afroditi Karathanasi

Subject	Oncology
Title	Thy 3F and 3a malignancy rate, a multisite regional retrospective case series
Author/s	Alexander V, Rudd J, Walker D, Wong G, Lunt A, Hamakarim Z, Bell S, Balfour A, Davis J, Pitkin L, Pelser A
Reference	Annals of the Royal College of Surgeons of England, Jul 2018/E-pub ahead of print
MMH Staff member/s	J Rudd

Subject	Oncology; Haematology
Title	Ovarian carcinosarcoma: current developments and future perspectives
Author/s	Boussios S, Karathanasi A, Zakynthinakis-Kyriakou N, Tsiouris A, Chatziantoniou A, Kanellos F, Tatsi K
Reference	Critical Reviews in Oncology/Hematology, Feb 2019, 134 (46-55)
MMH Staff member/s	Stergios Boussios, Afroditi Karathanasi

Subject	Orthopaedics
Title	Bone block procedures for glenohumeral joint instability
Author/s	Nzeako O, Bakti N, Bawale R, Singh B
Reference	Journal of Clinical Orthopaedics and Trauma, Mar-Apr 2019, 10/2 (231-235)
MMH Staff member/s	Obinna Nzeako, Nik Bakti, Rajesh Bawale, Bijayendra Singh

Subject	Orthopaedics
Title	Early versus delayed mobilization following rotator cuff repair
Author/s	Bakti N, Antonios T, Phadke A, Singh B
Reference	Journal of Clinical Orthopaedics and Trauma, Mar-Apr 2019, 10/2 (257-260)
MMH Staff member/s	Nik Bakti, Akshay Phadke, Bijayendra Singh

Subject	Orthopaedics
Title	Musculoskeletal injections: analysis of healthcare providers understanding of indications, risks, and rehabilitation
Author/s	Dhinsa B, Pillai D, Gulihar A, Kochhar T
Reference	International Journal of Clinical Practice, Jun 2018, 72/6 (e13100)
MMH Staff member/s	Dilip Pillai

Subject	Orthopaedics
Title	Role of platelet rich plasma in rotator cuff tendinopathy- clinical application and review of literature
Author/s	Phadke A, Singh B, Bakti N
Reference	Journal of Clinical Orthopaedics & Trauma, Oct 2018/E-pub ahead of print
MMH Staff member/s	Akshay Phadke, Bijayendra Singh

Subject	Orthopaedics
Title	Role of platelet rich plasma in rotator cuff tendinopathy- clinical application and review of literature
Author/s	Phadke A, Singh B, Bakti N
Reference	Journal of Clinical Orthopaedics and Trauma, Mar-Apr 2019, 10/2 (244-247)
MMH Staff member/s	Akshay Phadke, Bijayendra Singh, Nik Bakti

Subject	Orthopaedics
Title	Single vs double row repair in rotator cuff tears - a review and analysis of current evidence
Author/s	Khoriati A, Antonios T, Gulihar A, Singh B
Reference	Journal of Clinical Orthopaedics and Trauma, Mar-Apr 2019, 10/2 (236-240)
MMH Staff member/s	Bijayendra Singh

Subject	Orthopaedics; Surgery
Title	Metal ion levels comparison: metal-on-metal hip resurfacing vs total hip arthroplasty in patients requiring revision surgery
Author/s	Ahmed S, Bawale R, Jain S, Samsani S
Reference	Journal of Orthopaedics, Dec 2018, 15/4 (1013-1016)
MMH Staff member/s	Rajesh Bawale, Sunil Jain, Srinivasa Samsani

Subject	Paediatrics
Title	Improvement in confidence levels for the management of paediatric cardiac arrests in medical students following a training course
Author/s	Quraishi M, Umar - Khateeb H, Parmar R
Reference	Anaesthesiology & Pain Medicine, Apr 2018, 8/2 (e14867) E-pub ahead of print
MMH Staff member/s	Mohammed Kamil Quraishi

Subject	Patient Care
Title	Authors' reply to Montoya et al: Comment on: "Tools Measuring Quality of Death, Dying, and Care, Completed After Death: Systematic Review of Psychometric Properties"
Author/s	Kupeli N, Candy B, Tamura-Rose G, Schofield G, Webber N, Hicks S, Floyd T, Vivat B, Sampson E, Stone P, Aspden T
Reference	The Patient, Dec 2018/E-pub
MMH Staff member/s	Theodore Floyd

Subject	Patient Care
Title	Improving resuscitation decisions: a trust-wide initiative
Author/s	Fadel M, Parekh K, Hayden P, Krishnan P
Reference	BMJ Open Quality, Oct 2018/E-pub
MMH Staff member/s	Michael Fadel, Krishan Parekh, Paul Hayden, Priya Krishnan

Subject	Patient Care
Title	Patient-centered care must be measured through patient-centered means
Author/s	Zeina M, Collins A, Aghababaie A
Reference	Patient Preference and Adherence, Sept 2018, 12 (1897-1899)
MMH Staff member/s	Arameh Aghababaie

Subject	Patient Care
Title	Tools measuring quality of death, dying, and care, completed after death: systematic review of psychometric properties
Author/s	Kupeli N, Candy B, Tamura-Rose G, Schofield G, Webber N, Hicks S, Floyd T, Vivat B, Sampson E, Stone P, Aspden T
Reference	The Patient, Aug 2018/E-pub ahead of print
MMH Staff member/s	Theodore Floyd

Subject	Patient Care; Oncology
Title	Colorectal cancer diagnosis: How satisfied is your patient?
Author/s	Assaf N, Nagrecha R, Campbell-Smith, T, Chan S
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S50)
MMH Staff member/s	N Assaf, R Nagrecha, S Chan

Subject	Patient Safety; Management
Title	Improving the quality of operation notes with electronic proformas
Author/s	Whiting D, Mohamed M
Reference	Journal of Perioperative Practice, Oct 2018/E-pub ahead of print
MMH Staff member/s	D Whiting, M Mohamed

Subject	Patient Safety; Patient Care
Title	Treatment escalation and resuscitation decision-making at Medway Foundation Trust
Author/s	Graham A, Ellis J, Yogalingam S, Jeyabaladevan P, Rogers J, Fadel M, Krishnan P, Parekh K
Reference	BMJ Leader, Nov 2018, 2/Supp 1 (A23)
MMH Staff member/s	Michael Fadel, Priya Krishnan, Krishan Parekh

Subject	Physiotherapy
Title	Return to work following arthroscopic supraspinatus repair: a survey of current UK practice
Author/s	Rai J, Mackenzie T, Singh B, Swaine I
Reference	Physiotherapy, Jan 2019, 105/Supp 1 (e206)
MMH Staff member/s	Bijayendra Singh

Subject	Radiology; Orthopaedics
Title	Magnetic resonance imaging scans are not a reliable tool for predicting symptomatic acromioclavicular arthritis
Author/s	Singh B, Gulihar A, Bilagi P, Goyal A, Goyal P, Bawale R, Pillai D
Reference	Shoulder & Elbow, Oct 2018, 10/4 (250-254)
MMH Staff member/s	Bijayendra Singh, Abhinav Gulihar, Praveen Bilagi, A Goyal, P Goyal, Rajesh Bawale, Dilip Pillai

Subject	Respiratory
Title	EZPAP-a new adjunct for respiratory physiotherapy?
Author/s	Elliott S
Reference	Journal of the Intensive Care Society, May 2018, 19/2 (73)
MMH Staff member/s	Sarah Elliott

Subject	Respiratory
Title	The use of a hand held ventilator to supplement NIV for patients with ALS/MND with respiratory insufficiency
Author/s	Oliver D, Banerjee S, Vincent-Smith L, Kindred J, Martin K
Reference	Amyotrophic Lateral Sclerosis & Frontotemporal Degeneration, May 2018, 19/3-4 (313-314)
MMH Staff member/s	Sandip Banerjee, Lisa Vincent-Smith, Jane Kindred, Katharine Martin

Subject	Respiratory; Oncology
Title	Survival and pleurodesis outcome in patients with malignant pleural effusion – post-hoc analysis from the TIME-1 trial
Author/s	Hassan M, Mercer R, Maskell N, Pepperell J, Saba T, Ali N, West A, Miller R, Halifax R, Corcoran J, Asciak R, McCracken D, Bedawi E, Rahman N
Reference	Thorax, Dec 2018, 73/Supp 4
MMH Staff member/s	A West

Subject	Simulation; Education
Title	Working without worry: transition to foundation year 1 simulation training
Author/s	Arlidge J, Rampal T, Shah M
Reference	BMJ Simulation & Technology Enhanced Learning, Dec 2018/E-pub
MMH Staff member/s	James Arlidge, Tarannum Rampal, Manisha Shah

Subject	Surgery
Title	Case report: acute gastric necrosis; a rare complication of small bowel obstruction
Author/s	Assaf N, Andrews B, Rait J
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S30)
MMH Staff member/s	Nazrin Assaf, Brian Andrews, J Rait

Subject	Surgery
Title	Incidence and management of incidental spinal durotomies noticed during spinal surgery
Author/s	Grewal I S, Grewal U S, Eadsforth T, Barrett C, Pillay R
Reference	Open Orthopaedics Journal, Feb 2019, 13/1 (47-52)
MMH Staff member/s	Urpinder Singh Grewal

Subject	Surgery
Title	Laparoscopic cholecystectomy in acute gallstone pancreatitis: a case for operative urgency
Author/s	Knowles H, Khan A, Amin J, Harilingham M
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S64)
MMH Staff member/s	H Knowles

Subject	Surgery
Title	Pneumoparotid: an unusual case of intermittent unilateral cheek swelling
Author/s	Paterson T, Maini N, Ganesh V, Newman L
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S27)
MMH Staff member/s	Vijaykumar Ganesh

Subject	Surgery
Title	The role of diagnostic flexible sigmoidoscopy in investigation of lower gastrointestinal symptoms: a retrospective study
Author/s	Chang L, Jawad A, Mamidanna R, Gandhi P
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S47-S48)
MMH Staff member/s	L Chang, A M Jawad, R Mamidanna, P Gandhi

Subject	Surgery
Title	Use of patient focus groups to improve patient information in enhanced recovery in colorectal surgery
Author/s	Decker E, Williams S, Leong M, Hare S, Grimes C
Reference	International Journal of Surgery, Jul 2018, 55/Supp 1 (S46)
MMH Staff member/s	Emily Decker, S Williams, M Leong, Sarah Hare, Claire Grimes

Subject	Surgery; Gastroenterology
Title	Use of long saphenous vein graft in acute on chronic mesenteric ischaemia
Author/s	Fadel M, Andrews B
Reference	BMJ Case Reports, Sep 2018
MMH Staff member/s	Michael Fadel, Brian Andrews

Subject	Surgery; Patient Safety
Title	Building an effective and efficient theatre team and harnessing its power
Author/s	Bennett L, Ryan S, Walker L
Reference	Journal of Perioperative Practice, May 2018, 28/5 (123-127) E-pub
MMH Staff member/s	Laura Bennett, Shouphyna Ryan, Lisa Walker

Subject	Technology
Title	Reduction of electricity costs in Medway NHS by inducing pro-environmental behaviour using persuasive technology
Author/s	Taha A, Wu R, Emeakaroha A, Krabicka J
Reference	Future Cities and Environment, Sep 2018 4/1 (1–10)
MMH Staff member/s	Anthony Emeakaroha

Subject	Urology
Title	Managing nocturia: the multidisciplinary approach
Author/s	Robinson D, Suman S
Reference	Maturitas, Oct 2018, 116 (123-129)
MMH Staff member/s	Sanjay Suman

Subject	Urology; Obstetrics & Gynaecology
Title	Long-term rate of mesh sling removal following midurethral mesh sling insertion among women with stress urinary incontinence
Author/s	Gurol-Urganci I, Geary R, Mamza J, Duckett J, El-Hamamsy D, Dolan L, Tincello D, van der Meulen J
Reference	JAMA, Oct 2018, 320/16 (1659-1669) E-pub ahead of print
MMH Staff member/s	Jonathan Duckett

Subject	Urology; Oncology
Title	12 month results of CALIBER: a phase II randomised feasibility trial of chemoablation with MMC versus surgical management in low risk (LR) non-muscle invasive bladder cancer (NMIBC)
Author/s	Mostafid H, Porta N, Cresswell J, Griffiths T, Kelly J, Catto J, Davenport K, McGrath J, Cooke P, Masood S, Feber A, Knowles M, Knight A, Penegar S, Wiley L, Lewis R, Hall E
Reference	European Urology Supplements, Mar 2019, 18/1 (e762-e763)
MMH Staff member/s	Shikohe Masood

10 May 2019

Table1 List of Grant Applications submitted by Medway NHS Foundation Trust in 2018-19

Local R&I number	CI/PI Investigator	Ownership	Study title	Funder	Submission date	Total Project cost	Status
774	Dr Shaumik Adhya	Lead	Strengthening Exercises To Combat Hospitalisation (STRETCH) in Patients Diagnosed with Preserved Ejection Fraction Heart Failure (HFpEF): A	NIHR: Research for Patient Benefit	17/07/2018	£236,664	Unsuccessful
919	Dr Ghada Ramadan	Lead	Developing a Two-Way Audiovisual System and Evaluating Effectiveness on	Bliss	12/01/2018	£118,036	Unsuccessful
835	Dr Ruiheng Wu	Partner	Research of Microwave-based Bio-sensing Method for Non-invasive Blood Glucose	Diabetes UK: PhD Studentship	31/08/2018	£82,500	Unsuccessful
835	Dr Ruiheng Wu	Partner	Non-Invasive Blood Glucose Monitor	Innovate UK: Notification Digital health technology	18/04/2018	400,560	Unsuccessful
981	Dr Ghada Ramadan	Lead	The Promotion of Peer Support Using Practical Storytelling	Health Foundation: Q Exchange	18/06/2018	£20,932	Unsuccessful
N/A	Prof Ian Swaine (UoG)	Partner	Development of an exercise ball for NHS Patients	University of Greenwich Seedling	31/01/2018	£4,500	Successful
1006	Dr Tara Rampal	Partner	Personalised digital prehabilitation to improve wellbeing for the individual, leading to better surgical	Digital health technology catalyst round 3: collaborative R&D	31/10/2018	486,280	Unsuccessful
N/A	Dr Tara Rampal	Lead	Digital Advertising for Surgical Patient Education Programme	NIHR CRN Accelerating Digital Programme: Small	31/07/2018	3000	Unsuccessful
993	Ahmad Taha	Partner	Smart Energy System in the NHS	Innovate UK: Smart local energy systems: concepts	27/07/2018	£199,483	Ineligible

993	Ahmad Taha	Partner	Smart Energy System in the NHS	Innovate UK: Open grant funding	12/09/2018	£340,850	Unsuccessful
N/A	Ecole Nationale Supérieure des Arts et Industries Textile (ENSAIT)	Observer	INWeaReD:Development of an Intelligent Wearable System for Rehabilitation of Disabled people	Interreg	21/12/2018	£3,200,000	Recommended for 2nd Stage
1010	MFT/MCH/UoK	Partner	InjuryMap:Testing and development of digital health campaign – muscle and joint	Boost4Health	30/11/2018	14,500 euros	Successful
1006	Dr Tara Rampal	Partner	Personalised digital prehabilitation to improve wellbeing for the individual, leading to better surgical	Innovate UK: Notification Digital health technology catalyst round 2	09/04/2019	429,999	Awaiting Outcome
N/A	Dr Lex Mauger (UoK)	Observer	Can Infi-Tex smart-insoles detect changes in walking gait arising from MSK pain?	EIRA Research & Development Grant	07/04/2019	49,906	Awaiting Outcome
N/A	Dr Dennis Douroumis/ Dr Lisa Vincent-Smith	Observer	Trans-national implementation of a smart self-management e-health application to reduce the number and impact of exacerbations in patients with	InterReg	07/04/2019	Unknown	Awaiting Outcome

Appendix B (ii)

Table 2 - List of Funding Applications in Progress

Local R&I	Study Type	Sponsored/ Hosted	Funding Appplication	Short Study Title	Full Study Title	Stage
1018	non-commerical non-portfolio	Sponsored and Hosted	Yes	Reducing pain with Virtual Reality exercise for patients with Osteoarthritis	Reducing pain with Virtual Reality exercise for patients with Osteoarthritis: A Pilot	Protocol Development
TBC	non-commerical non-portfolio	Sponsored and Hosted	Yes	Prehab for IBD patients undergoing elective surgery	Does prehabilitation improve lean muscle mass, strength, performance and quality of life in Inflammatory Bowel Disease patients undergoing elective surgery? A pilot study	Protocol Development
TBC	non-commerical non-portfolio	Sponsored and Hosted	Yes (potentially)	Feasibility of adapted ERAS Protocol on EmLap outcomes	Outcomes after emergency laparotomy; are they improved with an adapted ERAS protocol: a feasibility study	Protocol Development
TBC	non-commerical non-portfolio	Sponsored and Hosted	Yes (potentially)	Prehab for EmLap	Rehabilitation: a prescribed program of rehab for emergency laparotomy patients	Protocol Development

List of Non-Portfolio Projects in Pipeline

Local R&I Number	Study Type	Sponsored/Hoste	Funding Appplication	Short Study Title	Full Study Title	Stage
998	non-commerical non-portfolio	Sponsored & Hosted	No	Psychosocial Screening for Young People in the Acute Setting: A community Perspective	Psychosocial Screening for Young People in the Acute Setting: A community Perspective	Completing IRAS to submit for HRA/REC approval
1036	non-commerical non-portfolio	Sponsored & Hosted	No	Attitudes towards a Paediatric Procedural Sedation	A qualitative study evaluating attitudes and views on the implementation of Paediatric Procedural Sedation (PPS) service in the Emergency Department	Protocol Development/preparation for HRA submission
TBC	non-commerical non-portfolio	Sponsored & Hosted	No	Natia	TBC	Protocol Development
TBC	Student	Hosted	No	Critical Care Dissertation (Chris Donnelly)	TBC	Protocol Development
TBC	Student	Hosted	No	Dementia PhD (Ree & David Larkai)	TBC	Passed onto Sittingbourne Memorial Hospital
TBC	Student	Hosted	No	Dementia Garden (April Thompson)	Physiotherapists perceptions of the facilitators and barriers to the longevity of therapeutic gardens in the acute hospital setting.	Awaiting UREC and Sponsorship documents
TBC	Student	Hosted	No	Prehab MSc Dissertation	TBC	Under discussion
TBC	Student	Hosted	No	Effect of special measures on nurse turnover (Muyunda Lifumbela Uok KBS)	Exploring the potential impact of special measures on nurses' psychological contracts and their turnover intentions: A case study of an acute NHS trust	Awaiting UREC and Sponsorship documents
TBC	non-commerical non-portfolio	Sponsored & Hosted	No	Use of Cardiac Output monitoring in Prehab	Evaluation of Non invasive cardiac output monitoring in Perioperative Medicine	Protocol Development