Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 03 September 2020 at 12:30 – 17:30

Meeting via MS Teams

	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Acting Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Conflicts of Interest		-		
1.4	Chief Executive's Update	Chief Executive	3	12:35	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 06 August 2020	Acting Chair	7	12:45	Approve
2.2	Matters arising and actions from: 06 August 2020	Acting Chair	17		Discuss
3.	**Speciality Presentation**				
3.1	Respiratory Medicine (*Presented by Jay Hettiarachchi*)	Medical Director	Verbal	13.00	Note
4.	**Governance**				
4.1	Board Assurance Framework (P*resented by David Seabrooke*)	Deputy Chief Executive	19	13:30	Note
4.2	Integrated Audit Committee Assurance Report	Chair of Committee	35	13:50	Note
4.3	Updating the Constitution (*Constitution sent separately to pack*)	Company Secretary	37	14:05	Approval
5.	**Trust Board Business**				
5.1	Covid-19 Update/Restore and Recovery	Strategic Commander/ Chief Operating Officer	39	14:15	Assurance
5.2	Sustainability and Transformation Update	Strategic Commander	45	14:25	Note
5.3	Integrated Quality Performance Report	Deputy Chief Executive	49	14:35	Assurance
5.4	Quality Assurance Committee Assurance Report	Chair of Committee	79	14:50	Assurance
	Screen Break 15:00				
5.5	Dermatology Service Update	Chief Nurse	85	15:15	Note
5.6	Annual Medical Appraisal and Revalidation Report (*Presented by Kirtida Mukherjee*)	Medical Director	93	15:25	Assure/ Approve
5.7	Rare Diseases Update	Medical Director	113	15:35	Note/ Discuss
5.8	Annual Medical Education Report (Presented by *Ginny Bowbrick*)	Medical Director	119	15:50	Note
5.9	a) Fire Update b) Health and Safety Update	Director of Estates and Facilities	191 195	16:00	Note Approve
5.10	Committee Effectiveness Reviews 2020	Company Secretary	Verbal	16:15	Note
5.11	EPRR BC Policy	Chief Operating Officer	201	16:16	Approve
6.	**Innovation**				
6.1	Trust Improvement Plan - Monthly Update: IPC and CoSHH	Chief Executive/ Chief Nurse	225	16:20	Approve

Agenda

	Subject	Presenter	Page	Time	Action
7.	**Financial Stability**				
7.1	Finance Report - Month 4	Director of Finance	237	16:35	Note
7.2	Finance Committee Assurance Report	Chair of Committee	253	16:45	Assurance
8.	**Our People**				
8.1	People Committee Assurance Report	Chair of Committee	257	16:50	Assurance
9.	**Any Other Business**				
9.1	Council of Governors Update	Lead Governor	Verbal	17:00	Note
9.2	BAF Reflection	Chair	Verbal	17:10	Discuss
9.3	Questions from the Public	Chair	Verbal	17:20	Discuss
9.4	Any Other Business	Chair	Verbal	17:25	Discuss

NHS
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Chief Executive's Report – September 2020

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

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

In and around Medway

COVID-19

Over a number of weeks now we have seen the number of patients with COVID-19 down to single figures, which is extremely good news. As the level of infection has greatly reduced we have been able to allow visitors to return, albeit in a limited way at this stage. This is a significant step as we recognise that for patients and their loved ones, visiting provides a good deal of comfort.

I am also delighted to say a number of our volunteers are also now back with us, providing a warm welcome on site, and offering support around the hospital in a number of different ways.

We continue to maintain areas for the care of patients with the virus, and closely monitor statistics to ensure we are able to safely manage any increase.

Restart and recovery

Senior leaders have been focused on restarting our services, so that people waiting for surgery or diagnostics receive their appointments, and I pleased to say this work was progressed quickly and smoothly to minimise the disruption to our patients.

Part of the restart programme involves a detailed project to return or move wards following the changes made during the pandemic, ensuring we have areas where COVID-19 patients are treated, and areas that are kept free of the infection. This is a complex exercise, and I have been impressed with the way teams have approached it. Recovering our performance in relation to waiting times will take some months, and we will keep the Board updated.

Planning for winter

In parallel with the restart programme, we are well advanced with winter plans so that we are in the best possible position for an increase in demand, which we see each year, and also for any second or subsequent waves of COVID-19.

The NHS is good at planning for an increase in demand, and we have well-rehearsed procedures. However, the pandemic presented us with unprecedented challenges and we

do not know what lies ahead, so we are, rightly, preparing for best, worst and most likely scenarios, and these plans will be tested ahead of winter.

We will shortly be launching our campaign to encourage staff to have the flu vaccination, which plays a vital role in protecting our patients and staff from flu over winter. This year, more than ever, it will be important for as many staff as possible to have the vaccination.

We continue our communications to remind colleagues, patients and visitors of the importance of hand hygiene, face masks and social distancing, which all help reduce the spread of infection, not just for COVID-19, but for all infections.

Trust Improvement Plan

Following the Board's approval of the Trust's Improvement Plan at our last meeting, we have been implementing projects across the five pillars – High Quality Care, Integrated Health Care, Our People, Innovation and Finance.

Some projects were already underway, and others are just beginning or due to start. We know that it will take time to achieve all the improvements we are keen to see, but the important thing is that we have the commitment and engagement of our clinical colleagues who will be instrumental in improving the experience for our patients.

We have shared the plan widely and begun regular communications about progress. On 10 September we are having an event where staff can find out more about each of the pillars; ongoing updates will demonstrate the difference we are making across all areas.

As well as working closely with our colleagues who are delivering the plan, we are also liaising with partners in the health and care system, and other stakeholders who have a keen interest in the Trust, such as councillors and local MPs.

Staff networks

Staff networks are important forums for connecting with colleagues across the Trust, gaining insight and providing support.

Following the successful relaunch of the Black, Asian and Minority Ethnic Staff Network earlier this year, the Trust is now working towards the relaunch of the Staff LGBTQI* Network (*representing lesbian, gay bisexual, transgender, intersex and other minority genders/sexual orientations), and the Staff Disability Network.

I am pleased to say discussions are taking place with people interested in being part of these networks and helping to increase the voice and representation of disabled and LGBTQI people at work.

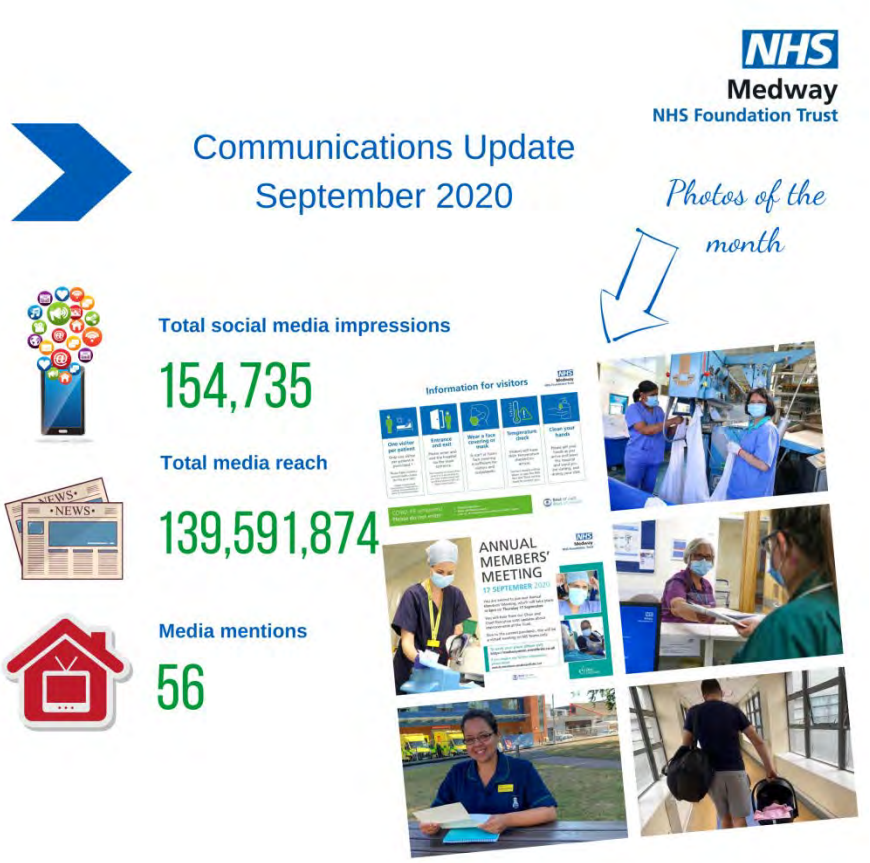
Communicating with colleagues and the community

While engaging colleagues and local residents in the work of the Trust has been more challenging during the pandemic, we have held some virtual events which have been well received.

We held an online engagement event for members, discussing our improvement plan, look forward to the next one. We have also had the opportunity to engage with a number of

community groups, and have been invited to speak at several meetings, including a presentation to a patient group by our Director of Infection Prevention and Control, Dr Ian Hosein.

As always, there has been plenty for us to communicate about through our regular newsletters, the media and social media – the graphic below gives a flavour.



Minutes of the Trust Board PUBLIC Meeting

Thursday, 06 August 2020 at 10:00 – 13:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Acting Chair
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	Adrian Ward	Non-Executive Director
	David Sulch	Medical Director
	Ewan Carmichael	Non-Executive Director
	James Devine	Chief Executive
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Director of HR and OD
	Richard Eley	Interim Director of Finance
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Interim Company Secretary
	Glyn Allen	Lead Governor
	Ian Renwick	Intensive Improvement Director NHSEI
Observing:	Ann Utley	NHS Providers
Apologies:	Gurjit Mahil	Deputy Chief Executive (Business Course)
	Harvey McEnroe	Strategic Commander (Annual Leave)
	Jack Tabner	Director of Transformation/IT (Annual Leave)

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts to make the meeting on MS Teams and for the Board's flexibility in using the technology to enable it to conduct its business. Whilst the threat of Covid-19 remains, the Board must do all that it can to adhere to government guidance on social distancing. Thanks extended to the Governors and local community for continued support. Apologies for absence were noted as recorded above.

1.2 The Board has often recognised how amazing Trust staff have been during the pandemic. It has been physically and emotionally draining for many colleagues, and it is important that as many as possible are able to take some leave during the summer to relax and refresh. The Chair would encourage all staff to ensure they take some time to enjoy a well-earned break.

1.3 Chair congratulated Jane Murkin on her appointment as Chief Nursing and Quality Officer and thanked James Devine for leading on this.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Conflicts of Interest

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

1.4 Chief Executive Update

James Devine, Chief Executive, gave an update to the 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 was asked to note the content of this report.

1.4.1 The Trust quickly responded to the NHS England letter issued by Simon Stevens and Amanda Pritchard on 29 April 2020 requiring all Trusts to begin to safely reintroduce services and facilities. The Trust immediately started on plans and actions to restart and restore the routine elective surgeries, outpatients and diagnostic services safely, while continuing to manage the Covid-19 challenge. The Trust will ensure that it learns from the lesson during the Covid pandemic in future planning.

1.4.2 An update on Recover and Restore work was given to the Council of Governors in July 2020.

1.4.3 James gave his thanks to colleagues for their continued hard work and efforts, not just during Covid but now with the reconfiguration of hospital wards and the recovery and restore phase. The Trust is ensuring it is prepared and is planning well in advance of the winter period.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 02 July 2020 was reviewed by the Board. The minutes of the last meeting were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting

The action log was reviewed and the Board agreed to CLOSE the following actions:
TBPU/20/77, 86, 87, 89, 90, 91, 92, 93, 94, 95, 96 and 97

Update on Action No: TBPU/20/88: Jane Murkin, Chief Nursing and Quality Officer, gave the Board an update the action plan and analysis report was presented to the QAC, there is progress on the must dos and should dos. The QAC had some concerns in the report and have asked that it is re-submitted to the next QAC meeting and will come back to Board in October 2020.

3 Governance

3.1 Board Assurance Framework

David Seabrooke, Company Secretary (Interim) presented on behalf of Gurjit Mahil, Deputy Chief Executive, and asked the Board to note the discussions that have taken place and discuss any further changes required on the BAF. The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well

as the trust. It helps to clarify what risks will compromise the achievement of the Trust's strategic objectives. The report was taken as read.

3.1.1 No further changes to Integrated Healthcare and Innovation

3.1.2 Finance BAF; the following changes have been made:
a) Independent assurance levels updated
b) Actions identified for 3b and 3c

3.1.3 Workforce BAF; the following changes have been made:
a) All risks have updated assurances and actions

3.1.4 Quality BAF; the following changes have been made:
a) The Quality risks have been reviewed and updated to ensure controls are clear and appropriate.
b) 5a and 5b - Further controls, assurances and actions identified.
c) 5b - has been updated to include progress on actions.
d) 5c - has been updated to include the impact of Covid restart plan.
e) 5d - Oversight functions updated (Partial assurance)
f) Potential new risk (5e) to be added regarding loss of or temporary moves of clinical services; to be agreed at the next QAC meeting.
g) Action plans being created for high risks.

3.1.5 Chair stated that there is a generally improving trend in the Trust's risk profile; however, there are risks that need continued focus, such as IPC and CoSHH. Chair proposed there to be a monthly update on IPC and CoSHH. Alana Almond added to work plan. In addition there should be monthly updates on financial stability, quality and digital strategy as the Board works through the Improvement Plan.

3.1.6 James Devine supports the Chair on this. He attended a meeting on 05 August in regard to IPC and CoSHH. Jane Murkin was tasked to brief on the actions to the QAC and later to the Board in September 2020.

3.1.7 The BAF has been reviewed by the Executive team and nominated leads. There has been some challenge and robust debate on the risk ratings. The ratings will not be reduced unless the evidence collation is robust.

3.1.8 James is confident that the Trust is on track with CQC actions, however the evidence collation needs strengthening.

Action No: TBPU/20/98: Gurjit Mahil, Deputy Chief Executive, to review risk ratings and inform the Board when it can expect to see a reduction in ratings, with the actions and mitigations in place.

Action No: TBPU/20/99: Gurjit Mahil, Deputy Chief Executive, to add a timeline graph to the BAF to see how the risks are changing and to give assurance that the risks are being managed.

4 High Quality Care

4.1 Covid-19 Update

Angela Gallagher, Chief Operating officer presented on behalf of Harvey McEnroe, Strategic Commander asked the Board to note and discuss the paper.

4.1.1 The paper outlined the Trust's current response plans to the Covid19 pandemic and the subsequent work of the restore and recovery programme. The restore and recovery programme has progressed in line with regional and national expectations focused on the four core areas of recovery:

1) Urgent and Emergency Care
2) Elective Care
3) Community and Primary Care
4) Discharges

4.1.2 Chair stated that recovery and restart is going well and there is good engagement across the system. Harvey McEnroe is working with the ICP and will give more detail at the next Board meeting. Angela Gallagher is working on the Medway Winter Plan, which will detail how to manage safe and effective flow.

4.1.3 James Devine confirmed that there is a weekly ICP meeting. There are still several unknown risks. No one knows if there will be a second wave or how severe it will be. Reinforcing some of the measures already in place will help, such as combining second wave and winter planning plus the flu jab would assist. A second wave would impact on the restart programme, there is still anxiety about patients coming back into hospital so they are delaying coming in for their treatment.

4.1.4 There is an ICP Board meeting on 11 August 2020, where the system plans are being discussed, Harvey McEnroe is attending.

4.1.5 David Sulch said that he believes going forward there will be more localized outbreaks rather than a second wave. There are excellent surveillance updates from the CCG on information coming in from 111. The situation in Kent is looking promising, as most of the cases are now in hospital rather than in the community. The limiting factor is availability of anesthetists not so much capacities. Covid-19 remains a dynamic situation and is hard to predict, the Trust is taking learning from the first wave to help if there is another outbreak. CCG data is useful as it shows a gradual increase in figures. The Medical Tactical groups are still running and the BI team is sending out data. There is a range of streams in intelligence to warn the Trust if there is a resurgence, which will trigger the incident response. David will update the Board on any emergent risks.

4.1.6 Chair congratulated the team on figures of cases reducing. Has the Trust considered weekly testing of staff for Covid? Angela Gallagher stated that it was considered for staff who were patient facing, however the Kent and Medway Director was clear that this was not a policy to follow. They said that PPE and social distancing is the method to use, so staff swabbing was not introduced. The introduction of staff swabbing would also have an effect on the turnaround in the pathology labs and results waiting time.

4.1.7 Chair raised a concern about the ethics of some of the decisions between treating Covid and things such as cancer. The Board needs to consider the ethics on these decisions. It is important that this is on record.
Action No: TBPU/20/100: David Sulch, Rama Thirunamachandran, Tony Ullman to discuss ethics around decisions made during the Covid crisis. Contact University to see if the Ethics Group can assist with this, bring back to the September Board.

4.2 Integrated Quality Performance Report
Jane Murkin, David Sulch and Angela Gallagher presented on behalf of Gurjit Mahil, Deputy Chief Executive, and asked the Board to note the report and discuss the content. The refreshed

version of the IQPR uses Statistical Process Control charts to display the data within the report. The report was the refreshed version of the IQPR in using Statistical Process Control charts to display the data. The report informed the Board of the quality and operational performance across key performance indicators for June 2020.

4.2.1 Safe: Our Infection Prevention and Control performance for June shows that the Trust has had 0 MRSA bacteraemia cases and 2 C-diff cases. Good results with the post infection review process.

4.2.2 Mortality: The updated March HSMR figure now sits at 98.6 (94.5 – weekday and 110.3 – weekend). The SHMI sits at 1.11. Chair commented on how well the team is doing.

4.2.3 Caring: Mixed Sex Accommodation continues to demonstrate an improvement; however in June 6 breaches were recorded which is still higher than the national compliance levels. Falls the Trust remains below the national average, the team is mitigating the risks in regard to falls. Pressure ulcers have reduced since last year.

4.2.4 Electronic Discharge Notification (EDN): Performance remains below trajectory at 77.7%, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system. David and the team are working on ensuring that the data is accurate.

4.2.5 Effective: VTE performance for June sits at 93.6% against the 95% national target. The performance of Fractured NOF procedures within 36 hours remains at 72.7%. A number of different actions are in place to improve the experience for patients and the performance.

4.2.6 Responsive: Bed Occupancy; still working on emergency pathways and trying to safely manage this. ED performance, Angela is working with the team to improve on its performance. Diagnostic performance decreased during Covid but has increased again since June 2020. The Trust saw the 4 hour performance standard reaching 87.1%. Trust have restarted everything and working in business as usual in diagnostic. More work needed in breast screening, will be back to pre-Covid number within the next month or so. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for June is recorded at 80.5%, with twenty 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for June as 91.8%. Cancer 2 week wait performance for May continues to be achieving national standards at 98.5%; 62 day performance is recorded as 70.6%. Structure is now all in place for elective care, now the trust is ramping up on this. Orthopaedics will be back on track by next week.

4.2.7 James Devine stated that he hoped that the CCG would have shared their paper on Dermatology services by now. **Action No: TBPU/20/101:** Jane Murkin to bring back an update on dermatology to September Board.

4.2.8 Well Led: We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 3 of 2020/2021. Chair mentioned this as it is a positive story to tell.

Action No: TBPU/20/102: David Sulch, Medical Director, to supply data from the transferred Stroke Service, include in the IQPR going forward.

Action No: TBPU/20/103: Gurjit Mahil to ensure that the IQPR is only one month in arrears, plus to add dates and trajectories against the actions in the report.

4.2.9 The Chair gave thanks on the report.

4.3 Quality Assurance Committee Assurance Report
- Control of Substance Hazardous to Health (CoSSH)

Tony Ullman, Chair of the Quality Assurance Committee, gave the Board an update on the Committee meetings held on Tuesday, 28 July 2020. The paper was taken as read.

Key highlights and concerns on risk for escalation to the Board:

1) CoSHH
2) Cancer rates – on 2 week waits, however service has been back on track
3) Stroke – David did update QAC on the transfer of service

4.3.1 Stroke: David Sulch informed the Board, that it was a smooth transfer of services across; there are local meetings to keep an oversight on this. There has been good support from SEECAM, plus the Dartford, Gravesham and Maidstone CCG has been exemplary. It is a good indication of how all partners can work together to make something happen in a much shorter time frame when we work together.

4.3.2 CoSHH: Gary Lupton informed the Board that levels of improvement have been seen in certain areas of the Trust. There are areas within the hospital that still need significant improvement. Housekeeping trolleys being left out unattended. The solution is to replace with lockable trollies (on order) and training for staff as to what not to do. There are some areas where washing up liquids are being left out on the sides. The team is looking for replacement products, in addition to ensuring they are locked away.

There is a technological solution for the door locking issues called; Aeroscout Door Contact Alarms. The Stanley Aeroscout system is providing monitoring for drug fridges across the site, and has been shown to be effective in dealing with drug fridge issues related to temperature. This has been hugely successful for fridges. The same system can be used to monitor critical doors and the development of the system to do this is underway. The cost of the solution is tens of thousands to procure the kit. It will alarm staff when the cupboards are left open audibly and it will flash up on the Ward Clerk's screen, the escalation will go through to Switchboard if the alarm is not noticed. Gary will also receive a report as to where the failings are.

4.3.3 Training on CoSHH is being reinforced. The Estates audit will also assist with this.

4.3.4 James Devine thanked Gary for his work and Jane on the CoSHH compliance with the matrons. James stated that this matter is being taken very seriously and he would consider disciplinary action for continued failings associated with CoSHH breaches.

4.3.5 Chair thanked Tony Ullman on behalf of the Board for his work with the QAC. The improvement on the work from QAC is excellent. The IPC and CoSHH update will be added to the work plan by Alana Almond.

4.4 Referral to Treatment – Current Position

Angela Gallagher, Chief Operating Officer, asked the Board to discuss the content of the report which provided the Board with the following information, most of which was covered earlier in the meeting under Agenda Item 4.2 (IQPR):

a) A summary of the Trusts Referral to Treatment (RTT) performance prior to the onset of the Covid-19 pandemic
b) An update on the current RTT position for the Trust overall and major specialties

c) An update on the restart of elective activity (Outpatients and Inpatients)
d) Work to date in developing a trajectory for improved performance including non-admitted, admitted and patients waiting over 52 weeks and then moving to 40 weeks. Performance is monitored on a weekly basis at the PTL meetings.

4.4.1 Angela stated that it is a work in progress and will keep the Board updated on this and the trajectories set.

[Screen Break at 12:15 to reconvene at 12:45]

5 Innovation

5.1 Trust Improvement Plan

James Devine, Chief Executive, asked the Board to approve the Trust Improvement Plan, noting the process of engagement and consultation with staff and partners. The paper described the background to the Plan, and the process of engagement and consultation undertaken to include the views of staff and partners in the final version.

5.2 James stated that the timeline was set out in February 2020 and the team wanted to ensure that there was good engagement with staff and stakeholders. The plan was set to be written in such a way that colleagues could understand with ease and engage fully. There has been good feedback but the plan has been met with some skepticism. The challenge is how to make this one different to previous improvement plans. The Trust used St Georges' improvement plan as a guide and James has spoken with their Chief Executive to understand how they delivered their plan which led to them coming out of special

5.3 Time has been invested with individuals and teams informally and formally. The plan must be clinically led; details must be included on who is leading the work and who is leading the design. The plan is the final version for board comment and approval.

5.4 The engagement has been structured based on the CQC well led comments; there has been an independent facilitated session to gain feedback. There was limited confidence to start with, people did not recognise members of the team and there was not a feeling of engagement. The biggest issue was for staff to understand the plan. The Council of Governors has been presented to and feedback was given.

5.5 The latest version presented was part online and part in the Hospital restaurant. There were strong indicators that the Trust is looking at the right things. The other feedback was that the plan must be written in the way that everyone can relate to. The report has been finessed further so we are clear on what the aim of the plan is and what an individual's role is expected to be.

5.6 Timescales to highlight:

1) What the Trust will deliver now
2) What the Trust will deliver in 12 to 18 months
3) What the Trust will deliver 18 months and beyond

Within the timescales are the areas of focus.

5.7 The governance framework around the plan is that there are fortnightly Improvement Board meetings chaired by James Devine and supported by Ian Renwick Intensive Improvement Director. This meeting is an opportunity for people to report progress, whether or not the plan is on track and what is coming up over the next month. The aim is to keep people motivated and to show that improvements are being made to build confidence.

5.8 The Board positively commented on how much the plan had improved since the last submission and thanked the team for their efforts. The Board gave the following comments for amending or addition:

1) Contents page the titles need reviewing.
2) Page 27; table references ED 4 hour performance, it is currently 92% are we aiming for a different % for next year?
3) Current Measures are in quote marks; explain why they are in quote marks or remove them.
4) Page 42; Innovation, how we are making progress section – should it say 'less than' rather than 'more than 1,000?
5) Acronyms should be spelt out and then the acronym in brackets.
6) Be good to see feedback from stakeholders
7) Integrated Care; where does the Trust sit in local system, its role with the ICP etc. Need more information on how the Trust links with its partners.

5.9 Glynis Alexander confirmed that the comments would be actioned with the Communications team. There has not been any Stakeholder feedback, the closing date has passed. This document is not the public facing version; there will be a summary document put together which will; give the spirit and sense of the plan. There is a supporting communications plan, including videos, a focused launch, dedicated bulletins etc.
Action No: TBPU/20/104: Glynis Alexander and Coms Team to work through the feedback from the Board and amend as necessary.

5.10 Ian Renwick gave his thanks to the teams for their engagement. He gave the Board assurance that there is a very robust plan in place in regard to CQC and Well Led report and also the Trust's own targets. There is extensive internal and external feedback process and the team has been able to take some of the negative feedback into positive plans. Despite the skepticism, the staff are supportive of their link to good quality patient care.

5.11 Chair on behalf of the NEDs thanked Ian for his support, for the work of the team, their willingness to engage and for listening to feedback even though sometimes difficult to hear. It is commendable work and a terrific plan, the Trust now has to deliver it.

5.12 The Board **APPROVED** the draft Improvement Plan.

6. Financial Stability

6.1 Finance Report – Month 3

Richard Eley, Director of Finance (Interim), asked the Board to note the report which sets out the summary financial position to the end of June 2020. The paper was taken as read.

6.1.1 The Trust reports a deficit of £11k in month and £33k year to date, which adjusts to breakeven against the NHSE/I control total. The Trust reports an £11k deficit position for June; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total.

6.1.2 CIP: Schemes delivered to date relate to the full year effect of 2019/20 schemes as well as procurement savings from nationally agreed prices and reduced external consultancy spend. The CIP forecast is currently as per budget although there is a £2.6m gap between this and plans at this time. Over achievement against plan is due to timing differences of schemes delivered.

6.1.3 Capital: Capital expenditure is currently behind plan year to date, although that gap has reduced in month. Contractor workforce restrictions in relation to the pandemic have impacted on

building projects. As those staff return to work, these projects are expected to catch up and deliver on plan by year end. £18million was released for backlog maintenance. Gary Lupton confirmed that there are detailed plans emerging to ensure that the Trust hits the capital target and additional funding.

6.1.4 Cash: Cash balances held at 30 June were £19.5m in excess of the plan. This is due to temporary COVID related changes to contract payment profiles. Additional contracts have been received one month in advance and monthly top up funding received in replacement of quarterly FRF and MRET payments.

6.1.5 Activity: This is significantly below draft budgeted levels as a result of Covid. Clinical income based on the consultation tariff would have reported a year to date position of £40.4m, this being £20.9m adverse to the draft budget or 34% of the income target. This reflects the impact that Covid has had on the performance of "routine" activity. This is not something to currently be concerned about.

6.1.6 Debt: This has improved overall. The team is trying to reduce the debt in this period; there will be money in from the Centre.

6.1.7 There is a surplus on stroke service at the moment and discussions are being have on what impact the loss of this will have on the Trust. It will need careful management. Transitional funding is being considered.

6.1.8 Covid Capital Funding: NHSEI is asking for the Trust to resubmit. This is a significant risk because if the Trust does not get the additional funding it will go to the Capital budget. Gary Lupton is working with Richard on this.

6.1.9 The Trust will be working on a STP basis, a Partnership Board will be established and the Trust will be represented on the Board. The funding envelope will be by system rather than by Trust. Richard believes that the Trust may have to bid on what it believes it can achieve. The restart targets are challenging.

6.1.10 The board **NOTED** the report.

6.2 Finance Committee Assurance Report

Jo Palmer, Chair, took the paper as read and informed the Board of the following key issues and concerns to note:

1) Capital
2) Long and Medium Term Financial Stability
3) Cost Improvement Programmes; particularly how the Trust will be able to break even with Covid-19 still being a risk. This will remain a risk over the next few financial years.

6.2.1 The board **NOTED** the report.

7. Our People

7.1 People Committee Assurance Report

Sue Mackenzie, Chair of the People Committee, gave the Board an update on the Committee meeting held on Tuesday, 21 July 2020. The paper was taken as read.

7.2 Sue Mackenzie informed the Board that the first People Committee was held in July 2020. There is a lengthy list of areas that should be covered by the Committee, so the Committee now meets monthly instead of quarterly to be able to provide assurance on these areas. The

frequency of the meetings will be reviewed end of the year. The first agenda was deliberately busy which filled the two hour meeting. There was good engagement and feedback. The NEDs asked for further assurance.

7.4 The Committee Work Plan is still in progress, Sue, Leon Hinton and David Seabrooke will be reviewing further. The next meeting is on 18 August 2020.

7.5 Sue gave her thanks to Leon Hinton, David Seabrooke and Alana Almond for their work on the establishment of this Committee.

7.6 Chair gave thanks to Sue and Leon for their work as it is important for the Trust governance.

8 Any Other Business

8.1 BAF Reflection

The Chair stated that there are the areas that need highlighting are as follows and the actions from today will take us forward with the risk ratings:

1) Infection Prevention Control: There will be a monthly update to the Board on this risk.
2) CoSHH: There will be a monthly update to the Board on this risk; the presentations from the specialtys at Board will support the Improvement Plan on CoSHH and IPC.
3) Capital Investment: This risk needs a lot of attention over course of next few months with budget setting
4) Long Term Financial Stability: Chair and James Devine will address the long term position for the Trust.
5) Track trajectory on risk over time: this is a useful suggestion for Gurjit Mahil.
6) Review risk rating on elective capacity and whether or not we have risk at the right level. Angela Gallagher will review this as we go into winter period.

8.2 Any Other Business

There were no matters of any other business. The Chair thanked the Board for their time and efforts.

9. Date and time of next meeting

The next meeting will be held on Thursday, 03 September 2020, 12:30 – 15:30.

The meeting closed at 13:40

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 06 August 2020

Signed …….. Date ……
Chair

Board of Directors in Public
Action Log

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

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
05-Sep-19	TB/2019/030	Patient Story; Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	03-Sept-20 ~~12-May-20~~ ~~5-Mar-20~~	David Sulch, Medical Director	Update to be submitted in September 2020	White
05-Mar-20	TBPU/20/60	IQPR; Write a report on the Trusts position on EDNs to go to the Executive Group, then to the QAC and later submit to Board.	01-Oct-20 ~~06-Aug-20~~ ~~02-Jul-20~~ ~~12-May-20~~	David Sulch, Medical Director	This action can be closed once the report has been submitted to the Executive Group/QAC. Need to sort data issues - will take to QAC September 2020 and then include in the Board assurance report in October.	White
04-Jun-20	TBPU/20/83	Fire, Health and Safety Report Update to be submitted	03-Sep-20	Gary Lupton, Director of Estates and Facilities	Not due until September 2020	White
02-Jul-20	TBPU/20/85	MFT Research Project Report	01-Oct-20	Iram Ahmed, Senior Clinical Research Practitioner	Not due until October 2020	White
02-Jul-20	TBPU/20/88	Submit an action plan and analysis report regarding the outcome of the investigation on the Inpatient Survey and letter from CQC (25 June 2020). Submit to the Exec. Team, QAC, then to Board.	01-Oct-20 ~~06-Aug-20~~	Jane Murkin, Chief Nurse	Update on position at October meeting - JM to bring action plan and analysis report after submission to Execs and QAC	White
06-Aug-20	TBPU/20/98	BAF: Review risk ratings and inform the Board when it can expect to see a reduction in ratings, with the actions and mitigations in place.	03-Sep-20	Gurjit Mahil, Deputy Chief Executive	Propose to close. Update: - Quality red risks reduced - Capital risk remains red - actions in place	Green
06-Aug-20	TBPU/20/99	BAF: Add a timeline graph to the BAF to see how the risks are changing.	01-Oct-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - in progress	Green
06-Aug-20	TBPU/20/100	Covid-19 Update: To discuss ethics around decisions made during the Covid crisis. Contact University to see if the Ethics Group can assist with this, bring back to the September Board.	03-Sep-20	David Sulch, Medical Director Rama Thirunamachandran, NED Tony Ullman, NED	Propose to close - undertaking an internal review as part of a Covid debrief session held at Clinical Council on 09.09.20. Awaiting feedback from RT in regard to an external review/input from the University.	Green
06-Aug-20	TBPU/20/101	IQPR: Update on dermatology to September Board.	03-Sep-20	Jane Murkin, Chief Nurse	Propose to close - on the agenda	Green
06-Aug-20	TBPU/20/102	IQPR: Supply data from the transferred Stroke Service, include in the IQPR going forward.	03-Sep-20	David Sulch, Medical Director	Propose to close - DS asked stroke leads at Maidstone and Dartford to supply SSNAP data for Medway and Swale patients who are treated on the stroke units in those hospitals. The Trust wants specific Medway & Swale data to make sure that our local residents are not disadvantaged in terms of thrombolysis, LOS etc. Will be included in quarterly data in the IQPR.	Green

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
06-Aug-20	TBPU/20/103	IQPR: Ensure that the IQPR is only one month in arrears, plus add dates and trajectories against the actions in the report.	03-Sep-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - Reviewing of all cut off dates for data in progress to ensure one month in arrears.	Green
06-Aug-20	TBPU/20/104	Trust Improvement Plan: work through the feedback from the Board and amend as necessary. Confirm at the next meeting this has been actioned. Alana Almond sent notes to GA on 06.08.20.	03-Sep-20	Glynis Alexander, Director of Communications and Engagement	Propose to close - comments noted and amendments made, complete	Green

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Board Assurance Framework Update**	**Agenda Item**	4.1
Report Author	Gurjit Mahil, Deputy Chief Executive Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives.		
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		☒
Resource Implications	None		
Quality Impact Assessment	Not required.		
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.		
	Approval ☒	**Assurance** ☒	**Discussion** ☒	**Noting** ☒
Appendices	Appendix 1 – Board Assurance Framework		

1 Integrated Healthcare

Executive Lead – Chief Operating Officer

Risk	Initial Score	Current Score	Previous Month Score	Target Score
1a – Failure of system integration	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 3 = 12 (Moderate)	3 x 2 = 6 (Low)

No further changes.

2 Innovation

Executive Lead – Executive Director of Transformation and Digital

Risk	Initial Score	Current Score	Previous Month Score	Target Score
2a – Future IT strategy	4 x 4 = 16 (High)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 2 = 6 (Low)
2b – Capacity and Capability	3 x 3 = 9 (Moderate)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)
2c – Funding for investment	3 x 3 = 9 (Moderate)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)

No further changes.

3 Finance

Executive Lead – Director of Finance

Risk	Initial Score	Current Score	Previous Month Score	Target Score
3a – Delivery of financial control total	4 x 4 = 16 (High)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)
3b – Capital Investment	4 x 4 = 16 (High)	**5 x 4 = 20 (High)**	5 x 4 = 20 (High)	4 x 3 = 12 (Moderate)
3c – Failure to achieve long term financial sustainability	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 3 = 12 (High)	4 x 3 = 12 (Moderate)
3d – Going concern	4 x 3 = 12 (Moderate)	**4 x 1 = 4 (Very Low)**	4 x 1 = 4 (Very Low)	4 x 1 = 4 (Very Low)

No further changes.

4 Workforce

Executive Lead – Executive Director of Human Resources and Organisational Development

Risk	Initial Score	Current Score	Previous Month Score	Target Score
4a – Sufficient staffing of clinical areas	4 x 4 = 16 (High)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
4b – Staff engagement	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
4c – Best staff to deliver the best care	3 x 4 = 12 (Moderate)	**3 x 2 = 6 (Low)**	3 x 2 = 6 (Low)	3 x 2 = 6 (Low)

All risks have updated assurances and actions.

5 Quality

Executive Lead – Chief Nurse

Risk	Initial Score	Current Score	Previous Month Score	Target Score
5a – CQC Progress	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 4 = 16 (High)	2 x 2 (Very Low)
5b – Failure to meet requirements of Health and Social Care Act	4 x 4 = 16 (High)	**3 x 3 = 9 (Moderate)**	4 x 4 = 16 (High)	3 x 2 = 6 (Low)
5c – Patient flow – Capacity and demand	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
5d – Quality Governance	3 x 4 = 12 (Moderate)	**3 x 3 = 9 (Moderate)**	3 x 4 = 12 (Moderate)	2 x 2 = 4 (Very Low)
5e - Loss or temporary moves of key clinical services off the MFT site.	5 x 4 = 20 (High)	**2 x 3 = 6 (Low)**	5 x 4 = 20 (High)	2 x 2 = 4 (very Low

The Quality risks have been reviewed and updated to ensure controls are clear and appropriate.

5a – Risk reduced from 16 to 12.

5b – Risk reduced from 16 to 9.

5c – Has been updated to include the impact of Covid restart plan.

5d – Risk reduced from 12 to 9.

5e – New risk added regarding loss of or temporary moves of clinical services – Risk reduced from 20 to 6.

COMPOSITE RISK: Lack of System Integration										
EXECUTIVE LEAD: Chief Operating Officer										
LINKS TO STRATEGIC OBJECTIVE: 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										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance Full, Partial, None**
1a 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.	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 x 4 = 16 High**	1. 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. 2. Current work through Covid structures is placing a key focus on the system partnerships to ensure timely decision making, for example the reduction in MFFD patients.	Governance arrangements for the Medway and Swale system agreed. Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways.	Regular updates against milestones submitted to Executive and Board of Directors meetings.	Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement Integrated Performance Assurance		**4 x 3 = 12 Moderate**	**3 x 2 = 6 Low**	Partial
			3. 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 .	1. Monthly Medway and Swale System Delivery 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 provider and commissioning organisation						

COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Director of Transformation										
LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
2a 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.	Trust may slow down investment in digital innovation to keep to the pace of the STP.	4 x 4 = 16 **High**	1. Establish Digital Delivery Group in the Trust which will also consider the wider interfaces to the STP and the emerging ICS and ICP. 2. Maintain priority and focus on the investment on digital technology within the Trust which supports the Trust wider transformation agenda.	Senior IT and Transformation Team Weekly CIO call with all provider Trusts.	Digital Delivery Group in place. Reporting to the Executive Team Reporting to the Executive Team every fortnight.	NHS X / E/I, and NHS Digital reviews.	Development of longer term Digital and innovations Strategy Agree Digital Governance	**3 x 3 = 9 Moderate**	**3 x 2 = 6 Low**	Partial
2b There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology.	Transformational change will be held back which may impact also quality improvements and meeting financial targets.	3 x 3 = 9 **Moderate**	3. Prioritisation of digital programmes to support key transformation deliverables. 4. Review and restructure IT Services department undertaking a capability and skills assessment 5. Seek private sector partners to support the delivery of foundation services	IT services have undertaken a skills review with a proposed new structure, further work with HR required deploying.	Trust Improvement Board – Innovation Pillar	NHS X / E/I, and NHS Digital reviews.	Development of longer term Digital and innovations Strategy System approach to IT services	**4 x 3 = 12 Moderate**	**3 x 3 = 9 Moderate**	Partial
2c 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.	The Trust may become less attractive for new medical and clinical staff The Trust may not deliver the transformation required at pace	3 x 3 = 9 **Moderate**	6. 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. 7. 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. 8. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released. 9. Work with the ICP, CCG and other external partners to secure funding to support collaborative working. 10. Agree the capital programme for the delivery of digital innovation and foundation IT services. 11. Ensure that best value is being delivered through current contracts. 12. New IT solutions in place during Covid lockdown. a. MS Teams b. Virtual outpatients	Senior IT and Transformation Team	Trust Improvement Board – Innovation Pillar	NHS X / E/I, and NHS Digital reviews.	On-going discussions with I/E regarding funding.	**3 x 3 = 9 Moderate**	**3 x 3 = 9 Moderate**	Partial

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										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a **Delivery of Financial Control Total**	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. If the STP does not meet its control total then the Trust will lose up to 50% of its FRF allocation, resulting in a variance to reported plan of up to £23.7m in 2020/21.	4 x 4 = 16 **Very High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. NHSE/I is providing funding to enable providers to achieve breakeven from 1 April 2020 to 31 July 2020. The eight CCGs in Kent have merged with effect from 1 April 2020, enabling them the scale and reach to support management of the system as a whole.		3 x 3 = 9 **High** (Previous risk rating: Mar 2020 3 x 4 = 12 **High)**	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate)**	
			2. Programme Management Office and scrutiny by Financial Improvement Director to track operational delivery and financial consequences of those actions.	Financial improvement director in place.						
3b **Capital Investment**	If there is insufficient cash to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan.	4 x 4 = 16 **Very High**	1. Governed entirely by the availability of cash, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the STP and 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).	Standard business case process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Capital Group, Finance Committee and Board.		1. Trust strategy for innovation together with Care Group /directorate strategies to be developed. 2. National shortage of capital funding recognised. Will potentially need some key choices to be made by the Board during 2020/21 3. Clarity and	5 x 4 = 20 **Extreme** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 3 = 12 **High**	

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										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
							support from STP is required for capital prioritisation / funding from 20/21.			
3c **Failure to achieve long term financial sustainability**	If the Trust does not achieve financial sustainability could lead to reputational damage, difficulty in recruitment into key roles, further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Establishment of System Delivery Board with System Recovery as key cornerstone of the programme monitoring delivery and engaging with partners. 2. Multi-year control total agreement with NHSE/I that does not require return to financial breakeven without national support.	Development of longer term financial model based on impact of 2019/20 delivery on 5 year programme, including sensitivity analysis. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans).	Reporting of identified risks and pressures alongside CIP and financial performance to Finance Committee regularly.	Current national policy is to provide Financial Recovery Fund support to achieve breakeven for those organisations with an agreed deficit. NHSE/I have in principal set an agreed deficit control total up to and including 2023/24 with FR funding to support a breakeven position.	Development of system wide financial narrative and joint plans with commissioners and other key stakeholders.	4 x 3 = 12 **High** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 1 = 4 **Moderate** (Previous target risk rating: Mar 2020 4 x 3 = 12 **High)**	
3d **Going concern**	If the Trust is unable to improve on the proportionality of the continued and sustained deficits there is a risk that it could lead to further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Interaction with regulators for Public Dividend Capital (and loans) to support deficit and capital requirements has mitigated this risk. 2. National policy in 20/21 to write-off all interim debt financing through issuance of Public Dividend Capital. 3. Management of cash reserves. (**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).		Considered by the Integrated Audit Committee and by the Board as part of the annual report and accounts approval.	Change would be required in national context. STP and national regulatory bodies have not indicated intentions to divest services. A statement from NHSE/I on 27 May 2020 in light of Covid contracting arrangements it stated:		4 x 1 = 4 **Low**	4 x 1 = 4 **Low**	

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										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
						"Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs."				

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										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16** **High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting)	2019-22 People Strategy in place with monitored delivery plans. (People Committee)		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Staff networks are further developed, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 21] To review actions following the publication of the NHS People Plan 2020/21 (due August 2020).	**3 x 4 = 12** **Moderate**	**3 x 2 = 6** **Low**	
			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. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 13%. 2. Sickness rate 4.2% 3. Substantive workforce 85%					
			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.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. 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.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					
			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.		People Committee reporting 1. £6m favourable to ceiling; 2. Averaging 30 breaches per week compared to c1000 in 2016 3. Agency workforce 4% 4. Bank workforce 11%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 117 apprentices of 101 target	People Committee					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						

				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4b Staff engagement 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	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	**3 x 4 = 12 (Moderate)**	Strategy: People 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'.	2019-22 People Strategy in place with monitored delivery plans.	People Committee		Local survey action plans to be developed and discussed through PRM processes. March 2020-August 2020 Delivery of Freedom to Speak Up strategy [Mar 21] To review actions following the publication of the NHS People Plan 2020/21 (due August 2020).	**3 x 4 = 12 (Moderate)**	**3 x 2 = 6 (Low)**	
			Culture Intervention: The Trust has embedded the delivery of '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.						
			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.						
			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						
			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.						
			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.						
			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.						

			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.						
4c Best staff to deliver the best of care 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.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People 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'.	2019-22 People Strategy in place with monitored delivery plans.	People Committee		Delivery of Freedom to Speak Up strategy [Mar 21] To review actions following the publication of the NHS People Plan 2020/21 (due August 2020).	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			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). 1. StatMan compliance >92% 2. Appraisal rate >88%						
			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.						
			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 13%; 2. Substantive workforce 85%; 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing;						
			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.						

COMPOSITE RISK: Quality											
EXECUTIVE LEAD: Chief Nursing and Quality Officer											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently achieve delivery of high quality care. Failure to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Ineffective leadership, oversight and timely remedial action of the quality standards. 2. Lack of effective governance systems and processes. 3. Too much focus on flow versus quality standards. **Impact:** 1. Regulatory action by CQC &/ or NHSI 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. **4.** Inability to reduce avoidable harms to patients	**4 x 4 = 16 High**	1. CQC action plan developed and being implemented 2. Programme of ward assurance visits commenced , 2 wards per week 3. Associate Director of Patient Experience recruited, to commence October 20204. Review of Dickens ward undertaken – report being written.	Quality Panel Governance in place fortnightly meetings.	Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board CQC Evidence panel in place. High Quality care Programme Board established. Ward Assurance Visits in place.	Internal Audit and External Quality Audit. IPAS Meetings (NHS I/E) CCG Quality Meetings CQC Engagement Meetings	Evidence sent thus far being quality assured	Complete QA process Report on the first eight ward visits completed to be undertaken by end of August	**4 x 3 =12 Moderate August 2020** **4 x 4 = 16 High June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented Matrons Development Programme in place Heads of Nursing Development Programme in place	Programme of continuous quality improvement: a. Improvement huddles b. Improvement Specialists c. Local improvement Projects	Quality Report and Accounts AGM to take place in September 2020.		CQI training paused since November 2019	Need to review CQI training Aspirant ward managers programme being developed			Partial
			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Quality strategy c. Ward to board assurance framework approved by Executive Group 15/07/2020 d. Quality boards on wards piloted. Now being rolled out across all areas. Launch 1 September 2020 e. 'Big room' event held on 17 July in partnership with the Innovation Institute celebrating improvements in pressure ulcer reduction. f. Second 'big room' event planned for 18 September with a focus on nutrition	New Scorecard developed. Quality strategy priorities reported to QAC Fortnightly Matron assurance reports Monthly Heads of Nursing Assurance Report Monthly DDON assurance reports to the Chief Nursing and Quality Officer	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board. High Quality care Programme Board		PRMs for 20-21 commenced 27 May 2020 Ward to board assurance framework approved by Executive Group 15/07/2020	First PRM 27 May 2020. Ward to board assurance framework to be in place 30 June 2020 – Completed Second 'big room' event planned for 18 September with a focus on nutrition			Partial
			4. Audit and review processes d. Clinical Audit programme and monitoring e. Daily MSA breach reporting and validation f. PLACE, COSHH and environmental audits g. Timetable of audits to support CQC action plan in place and being implemented	Revised Quality and Patient Safety Group Divisional Governance Boards	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial
			5. Central and local oversight of quality h. Complaints management i. Incident management, including Serious Incident (SI) processes and monitoring j. Compliance with Duty of Candour policy and training Refreshed SI Framework being developed.	Centralisation of the Divisional Quality Governance Teams Divisional Governance Boards	Regular reports to the Executive Group. Quality and Patient Safet Group		Compliance with 48 hour SI reporting to StEIS averaging 50% Maternity services review scoped and TOR	Divisions have a plan in place to rectify.			Partial

			Complaints review process approved and to be undertaken in September. Safeguarding review currently underway				agreed, date to be confirmed				

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	The result may be sub optimal outcomes and patient harm with potential regulatory action. Patients may be harmed	4x4 = 16 High	1. IPC Improvement plans	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual adopted by MFT, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan rewritten and forms basis for ongoing work. Mandatory IPC training compliance at over 95% for the majority of the last several months. First draft of practical ward based training plan completed. Directorate and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Panel: Evidence review panel in place and considered IPC evidence on 13/08/20 High Quality Care Programme commenced of which IPC is within Mission 1. Safe Care Quality Assurance Committee	IPAS (I/E) meeting Oversight from system DIPC	The total number of all key hospital acquired infections (MRSA bacteremia, C difficile, gram negative blood stream infections) is lower for Apr-Jul 2020 than for the corresponding period in 2019. MFT has had no outbreaks of hospital acquired COVID-19. 18 IPC policies currently undergoing review. Resumption of antimicrobial audits in June 2020Review of IPC team structure under way – Associate Director role being introduced. Decontamination group to restart in August 2020	Support secured from CCG to update all policies PIR's completed. Medical Director to consider contingency plan	**3 x 3 = 9 Moderate August 2020 4 x 4 = 16 High June 2020**	**2 x 2 = 4 Very Low**	Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5c There is a risk that the Trust processes as well as the clinical and managerial leadership regarding patient flow are not sufficiently developed to manage the emergency demand effectively through the available capacity. This subsequently impacts on the elective capacity reducing the level of planned operations and procedures that can take place. poor patient flow and weak capacity and demand planning will fail to achieve the required performance standards (constitutional standards: 4 hour access, RTT, DM01 and Cancer)	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 x 4 = 12 Moderate**	1. The restart programme has included a refresh of the demand and capacity across all specialties. 2. Pathways have been reviewed to ensure patients receive their care in the most appropriate settings including non-face to face, independent setting and at MFT. 3. Emergency pathways have been further developed to include the range of assessment options through frailty, acute assessment and Same Day Emergency Care (SDEC). 4. A bed reconfiguration programme has been undertaken to profile the planned and unplanned beds based on expected demand & full ring-fencing of elective capacity. 5. The Trust has a renewed focus on length of stay to ensure that patients get the most effective care during as short a stay in hospital as is appropriate for their care. 6. In summary: a. Elective, Outpatients & cancer care modelling underway to ensure patients with a prolonged wait for treatment are appropriately managed and that the new physical distancing and pre-hospital preparations are clear. b. The recovery programme is being managed through the System approach to ensure that all out-of hospital capacity ad opportunities are highlighted and used appropriately.	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used.	External reviews by NHS I/E	Weekly Best Flow Programme Board has not met during COVID-19		**3 x 4 = 12 Moderate** **June 2020**	**2 x 2 = 4 Very Low**	Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5d If quality governance is not sufficiently understood or embedded there is a risk that the Trust may not deliver our quality priorities.	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 x 4 = 12 Moderate**	1. Quality ambitions a. Quality goals and priorities agreed for 2019/20 b. Quality Account	Quality governance groups established for delivery and monitoring quality Patient Safety Patient experience Clinical Effectiveness and Research Medicines Management Mortality Safeguarding	Executive Group and Quality Assurance Committee Risk Assurance Group in place	IPAS (I/E) meeting	None	Ensure full embedding of the RAG processes.	**3 x 3 = 9 Moderate August 2020** **3 x 4 = 12 Moderate June 2020**	**2 x 2 = 4 Very Low**	Partial
			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	Divisional Governance Boards in place	Executive Group	Internal and external audit reviews	New processes have not yet had a chance to embed	Maintain oversight of Divisional Governance effectiveness and provide support and training as required.			Partial
			3. Quality Governance monitoring a. CQC Assure b. Risk registers c. Quality Impact Assessments	Divisional and corporate risk meetings in place	Risk Assurance committee in place reporting to executive team.	CQC	CQC Compliance Framework not in place	CQC compliance framework being developed			Partial
5e **Loss or temporary moves of key clinical services off the MFT site.**	The risk to clinical services and interdependencies with other clinical risks. Risks to quality and safety of patients and teams effected. (Stroke and Vascular)	**5 x 4 = 20 High**	1. Key strategic decisions being made around clinical services are discussed at Clinical Council, Executive, Board and System levels. 2. This is to ensure that there is no disruption to the services and to ensure safety. 3. Clear links with neighbouring Trusts to ensure patient safety and Programme Board meetings are in place for key services.	Executive Group	Quality Assurance Committee and Trust Board	IPAS (I/E) Meeting		Maintain oversight on patients that are transferred.	**2x 3 = 6 Low July 2020** **5 x 4 = 20 High June 2020**	**2 x 2 = 4 Very Low**	Full

Meeting of the Board of Directors in Public

Thursday, 03 September 2020

Assurance Report from Committees

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**4.2**
Committee Chair:	Mark Spragg		
Date of Meeting:	Thursday, 27 August 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

The key headlines and levels of assurance are set out below, and are graded as follows:	
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**
1. Internal audit The Committee welcomed Richard Hewes as the new internal audit partner to the Trust and thanked Fleur Nieboer as the departing partner. KPMG presented their 'Serious incidents' report, noting that there had been progress in this area, albeit the rating awarded is "partial assurance with improvements required". The counter-fraud progress report was presented to and noted by the committee. This highlighted the proactive and reactive work being undertaken.	**Green**
2. External audit Grant Thornton noted that their audit plan for the 2020/21 audit is expected to be presented at the February 2021 meeting. The external auditors stated that they had conducted debrief sessions	**Amber/Green**

with the finance team including the CFO. It was noted that this was an extraordinary year (as a result of Covid and restrictions thereon) and a number of areas for improvement were noted on both sides. An additional audit fee has been agreed between the Trust and Grant Thornton. The committee requested that planning work be undertaken now to allow a smooth year end and audit process for 2020/21 on the assumption that some of the Covid restrictions may still be in place. This work should also consider the learning and feedback from the debrief sessions held. It was also noted that because the audit opinion was qualified due to a limitation of scope on inventory, the 2020/21 opinion will also need to be qualified; this is on the basis that the opening position/comparator financials will retain that limitation. Grant Thornton noted this was not due to a lack of financial control at the Trust but as a result of the circumstances at the year end.	
3. BAF The BAF extract was presented to the committee.	**Green**
4. Review of the closure of Dickens ward It was noted that the executive team has now approved a standard operating process for opening and closure of wards. It was stated that the Dickens ward closure was made based on agreement between a number of executives and with the CCG. All 16 patients on the ward were assessed before closure. A report is under preparation.	**Amber/Green**
Decisions made None.	
Further Risks Identified None.	
Escalations to the Board or other Committee It is recommended that the Board is made **AWARE** that the external audit opinion on the 2020/21 annual accounts will be qualified on the basis of a limitation of scope; this arises because the inventory in the opening balance sheet/comparators has been qualified on this same basis.	

Meeting of the Board of Directors
Thursday, 03 September 2020

Title of Report	**Updating the Constitution**	**Agenda Item**	4.3
Report Author	David Seabrooke, Interim Company Secretary		
Lead Director	David Seabrooke, Interim Company Secretary		
Executive Summary	A further review of the Constitution has been undertaken, following the completion of the 2017 review. The details were reviewed by the July meeting of the Council of Governors and there are no matters to report. A number of suggested amendments have been identified and the significant cases are described below: The Trust should consider relaxing current prohibitions on individuals having roles on other Boards, or being governors on other foundation trusts (e.g. paragraph 16 of the governors' disqualification criteria; paragraph 30 for the Board). The Chairman should appoint the Vice-chairman and senior independent director, subject to consultation with the Council of Governors. (E.g. Annex 5 paragraph 2.5; Annex 6, paragraphs 2.4. and 2.5) The process for the removal of a governor becomes a function of the Council of Governors, assisted by the Company Secretary.		
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		☐
Executive Group Approval:	n/a		
Resource Implications	none		
Legal Implications/Regulatory Requirements	The Constitution gives effect to the legal requirements governing foundation trusts, mostly as set out in the National Health Service Act 2006. Other sources include the Code of Governance.		
Quality Impact Assessment	Not required.		

Recommendation/ Actions required	To approve the updated Constitution.			
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	None			

Other points where amendments are proposed

- For governor elections, the Trust's practice is to use the "first past the post" system (Model Election Rules)
- The traditional requirement for the printing and posting of agenda papers is updated to reflect current on-line/electronic processes.
- Annex 5 refers to governors as "members", which is considered to be ambiguous and has been changed throughout to "Governor."
- Committees of the Council of Governors do not exercise delegated authority.

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Covid-19 Board Update/Restore and Recovery**	**Agenda Item**	5.1
Report Author	Mr Harvey McEnroe Regional Strategic Commander and Winter Director		
Lead Director	Mr Harvey McEnroe Regional Strategic Commander and Winter Director		
Executive Summary	This report provides the Trust Board with an update on the Covid19 response and next steps linked to the Phase 3 letter.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☐
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: n/a Date of approval: n/a		
Executive Group Approval:	Date of Approval: n/a		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state):		
Resource Implications	n/a		
Legal Implications/Regulatory Requirements	n/a		
Quality Impact Assessment	n/a		
Recommendation/ Actions required	This update is for Board assurance.		
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☐
Appendices	None		

1 Executive Overview

1.1 This report provides the Trust Board with an update on the Covid19 response and next steps linked to the Phase3 letter

2 Restore and Recovery Programme

2.1 **Urgent and local care**

The main driver for the urgent and emergency care workstream is to work together as system partners to provide patients with a service which is responsive to meeting the emergency care standards in an environment which meets new infection control measures. The ambulance service, Medway NHS Foundation Trust, Medway Community Healthcare, mental health, social care and the CCG are working closely.

2.2 The key workstreams to support pathways ensure patients are seen by the right team are:

2.2.1 **Direct Access Booking from 111** into the emergency department, same day emergency care and the urgent treatment centre. We are working to introduce direct access booking into Medway NHS Foundation Trust by September 2020.

2.2.2 **Direct communication between paramedics and ED consultants.** We are exploring the use of a digital solution for paramedics to dial in to gain consultant advice on whether the patient needs to be directed to ED or an alternative urgent care environment.

2.2.3 **Maintaining improved flow of hospital beds while adhering to infection prevention and control regulations.**

2.3 **Elective Care**

The focus for the elective care workstream has been to restore elective services for patients at both Medway Maritime Hospital and independent sector hospitals so patients can confidently attend clinic appointments, attend their diagnostic procedures and be admitted for elective surgery.

2.4 Collectively the teams have worked together undertaking risk assessments, redesigning pathways, changing working patterns and set patient way finders to services throughout the hospital. Under the guidance of clinical, quality and infection control measures patients can now attend outpatients, diagnostics and attend for surgery within the acute hospital.

2.4.1 **Outpatients**

- Outpatient appointments during the coronavirus pandemic Medway NHS Foundation Trust introduced a virtual outpatient appointment process to enable patients, where appropriate, to continue to have their outpatient appointments with the clinical teams. Since the end of June, following completion of all necessary changes within the outpatient department areas, patients have attended face to face appointments. Marshalls at the front entrance of the hospital and in clinical areas welcome and signpost patients, minimising crossover of patients and staff walking around the hospital. Additionally extra capacity has been created outside of the hospital to hold outpatient appointments for some specialties where required.

2.4.2 **Diagnostics**

- Medway NHS Foundation Trust has restarted all diagnostic and imaging services for elective patients.

2.5 Local and Primary Care

2.5.1 The Medway and Swale Local and Primary Care teams are focused on six areas:

- Early cancer diagnosis

- Population Health Management
- Meeting health inequalities
- Improve access to services for patients
- Supporting the development of Primary Care Networks
- Early cancer diagnosis

3 Phase 3 – Sir Simon Stevens letter

3.1 Accelerating the return to near normal levels of non-Covid health services

3.1.1 This work focuses on the efforts to reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels. MFT is now open to all Cancer services back to pre-pandemic levels

3.2 Winter preparation and Covid wave2

3.2.1 See below for the key headlines on winter planning.

3.3 Lessons learnt and maintaining benefits from news ways of working

3.3.1 Whilst the pandemic has had a terrible impact on so many people, we believe that a range of new ways of working which the NHS had to introduced in response to the pandemic have benefitted patients and our teams. Where this benefit can be maintained we will be looking to retain these new ways of working as normal practice in the future. The clearest example has been the rapid increase in the use of telephone and video consultations across primary, community, hospital and mental health services. Maintaining high levels of phone and video consultation are specific requirements set out in the national priorities for NHS recovery.

3.3.2 However, we recognise that telephone/video consultations will not be right for some people and some types of appointment. They would not replace the ability to see a clinician face to face but they are offering more convenience and flexibility for people and reducing the need for people to travel to healthcare settings.

3.3.3 With any plans for restart that may involve adopting new ways of working we will be considering patient and public engagement requirements to ensure the views of local people have shaped our plans.

4 Winter planning

4.1 The Trust has commenced its winter plan for winter 2020.

4.2 The winter plan will include:

4.2.1 The surge planning for winter pressure

4.2.2 The Covid wave2 impact plan

4.2.3 The EU transition plan

4.2.4 The PHE surge plan and incident response plan

4.3 The national team via the Kent and Medway ICS have requested that the Trust and the ICP winter plan consider options on the following, which will feature in our Winter Plan:

4.3.1 Deliver a very significantly expanded seasonal flu vaccination programme the Department of Health and Social Care (DHSC) determined priority groups, including providing easy access

for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

4.3.2 Expanding the 111 ‘First Offer’ to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty ‘hot’ clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed A&E capital to help offset physical constraints associated with social distancing requirements in Emergency Departments.

4.3.3 Systems should maximise the use of ‘Hear and Treat’ and ‘See and Treat’ pathways for 999 demands, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

4.3.4 Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St Johns Ambulance which is set to be renewed.

4.3.5 Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies

5 Covid19 Wave2 planning

5.1 Working with the regional and national teams across the NHS and PHE the Trust is well underway on its Covid second wave impact plan.

5.2 The wave2 plan will focus on three regional scenarios, working from the reasonable worst case through to the reasonable best case.

The Covid wave two plan will pull upon the lessons learned from wave one and will pull in all partners

5.3 Our wave two plan will incorporate:

5.3.1 Acute staffing plan

5.3.2 Our ward configuration plan for COVID and non COVID wards

5.3.3 Our ITU bed plan

5.3.4 Our swabbing and testing plan

5.3.5 Our elective and diagnostic ‘green’ plan

5.3.6 Our homeworking plan and remote/distancing plan

5.3.7 Our links to the wider system plan and oversight

5.4 A first draft of this plan will be ready for 14.09.20 with executive review on 17.09.20.

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Sustainability and Transformation Update**	**Agenda Item**	5.2
Report Author	Harvey McEnroe – Regional Strategic Commander and Winter Director		
Lead Director	Harvey McEnroe – Regional Strategic Commander and Winter Director		
Executive Summary	This report provides an update to the MFT Trust Board on the STP and its transition into the ICS. The report provides a summary on: • Update on STP transition to ICS • STP/ICS Vision Summary • ICS executive structure		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	No		
Executive Group Approval:	No		
National Guidelines compliance:	n/a		
Resource Implications	n/a		
Legal Implications/Regulatory Requirements	n/a		
Quality Impact Assessment	n/a		
Recommendation/ Actions required	The Board is asked to note the update.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

1 Updated on the STP transition to the ICS

1.1 Kent and Medway is on the journey to becoming an integrated care system (ICS) to support the delivery of joined up and personalised care and to drive consistency of outcomes across Kent and Medway.

1.2 The STP is aiming to achieve ICS accreditation in December 2020, which means they will start the process with a submission in September (currently underway).

1.3 A workshop was held on 20 July 2020 with members of the System Transformation Executive Board and guests to consider the vision and principles for Kent and Medway ICS.

2 STP vision summary

2.1 Discussion at the extended System Transformation Executive Board (STEB) indicated that the following things were important to the system leaders present:

2.1.1 The vision should be a small number of points that relate to the population and our system intentions rather than a single short, generic statement;

2.1.2 We need to recognise place and purpose to reflect where people live but also what might bind them in respect of, for example, disease orientated groups.

2.1.3 The vision statements should be ambitious but mindful that we may be starting from a more challenging place post Covid.

2.1.4 We must talk about people and not patients.

2.1.5 We must use the word 'partnership' in our vision statements and purpose. Reducing health inequalities must be visible in our statements.

2.1.6 We must be clear that our vision spans physical and mental health.

3 STP/ICS COVID19 RESPONSE

3.1 All critical services identified as part of the national priority areas have been restored with the exception of Breast and Bowel screening which have plans in place to address capacity issues.

3.2 Demand and capacity across the system are both being modelled at provider and CCG levels with initial capacity outputs being available for the Acute and Mental Health providers as of the W/C 13 July.

3.3 The first cut of capacity modelling for other workstreams will be available in a phased manner during July and August 2020.

3.4 All restart plans are, to varying degrees, constrained by a common set of factors: Workforce (incl. wellbeing), Estates, IPC measures, availability of PPE and drugs.

3.5 Both capital and revenue pressures are being quantified and will cause system / regional pressure as the restart plans mature

4 ICS Executive Structure

4.1 This structure brings together the Executive function into one Kent and Medway team.

4.2 The aim of the structure is to build system leadership capability to lead and influence the Kent and Medway system to become a high performing system, delivering Quality of Care, Quality of Life to our communities. All whilst supporting the Governing Body to fulfil the CCG organisational ambition to improve the health and wellbeing of Kent and Medway's communities and the need to discharge its statutory accountabilities (cover the functions expected of a CCG).

Director	Initial responsibilities
Chief Nurse **Paula Wilkins**	Leading on development of a ICS quality and safety framework Lead with Clinical Chair from the CCG on the Clinical & Professional Board
Director of Health Improvement **Caroline Selkirk**	Lead for the Restart programme Leading on the refresh of the primary care and local care strategies Lead from the CCG on health improvement Lead from the CCG for the Joint Health and Wellbeing Board/HOSC/HASC
Director of Strategy and Population Health **Rachel Jones**	Leading on the development of the ICS strategy, vision and priorities Lead for the Transform programme Lead from the CCG for the Partnership Board
Director of System Development and Assurance **Lisa Keslake**	Lead for ICS, ICP and PCN development and assurance framework Lead for the system performance framework Lead from the CCG for the STEB
Chief Finance Officer **Ivor Duffy**	ICS financial strategy and ICS budget CCG lead for ICP contracting arrangements Lead for the ICS Finance Group
Director of Corporate Affairs **Mike Gilbert**	ICS governance arrangements and review Lead from the CCG for the Non-Executive Group
Director of People and Organisational Development **Becca Bradd**	Lead for ICS organisational development, workforce and communications & engagement Lead from the CCG on the ICS OD, comms & engagement and workforce strategies Lead for the ICS Workforce Group
Director of Digital Transformation Appointment to follow	Lead for ICS digital strategy and transformation Lead of the ICS Digital Group

Executive team portfolios – CCG responsibilities

Director	Responsible for
Chief Nurse **Paula Wilkins**	Quality assurance; patient safety; safeguarding; Looked After Children and SEND; primary care quality; special assessment placement team; infection and prevention control; personalised care; medicines optimisation
Director of Health Improvement **Caroline Selkirk**	Restart programme; commissioning functions including: cancer; children; mental health; LD and autism; stroke; primary care; ICP facing teams; 3rd sector; joint commissioning with local authorities; annual operating plan; health improvement
Director of Strategy and Population Health **Rachel Jones**	Transform programme; East Kent, Long Term Plan, population health management development
Director of System Development and Assurance **Lisa Keslake**	System role
Chief Finance Officer **Ivor Duffy**	CCG strategic financial planning; financial governance of the CCG transformation programme; contracting; audit ICP facing financial business partnering; estates
Director of Corporate Affairs **Mike Gilbert**	Corporate governance; Information governance; Emergency Preparedness, Resilience and Response (EPRR); complaints and Freedom of Information; SIRO, CCG governance and constitutional matters, risk management and legal services
Director of People and Organisational Development **Becca Bradd**	CCG HR; CCG organisational development; CCG and system communications and engagement; freedom to speak up; equality and diversity
Director of Digital Transformation Appointment to follow	CCG information management; data analytics and information systems

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	5.3
Report Author	Jane Murkin – Chief Nursing and Quality Officer David Sulch – Medical Director Angela Gallagher – Chief Operating Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators for July 2020. **Safe** Our Infection Prevention and Control performance For June shows that the Trust has had 0 MRSA bacteraemia cases and 2 C-diff cases. The March HSMR figure now sits at 98.6 (94.5 – weekday and 110.3 – weekend). The SHMI sits at 1.11 **Caring** MSA continues to demonstrate an improvement; however in July 7 breaches were recorded in Critical Care areas, which is higher than the national compliance levels. The Friends and Family response rates varies across the Trust from 13.7% to 36.2%. The recommended rates remain close or above the national standard of 85% (Inpatients: 88.1%, ED: 84.3%, Maternity: 99.4%, Outpatients: 89.2%) **Effective** VTE performance for July sits at 94.1% against the 95% national target. Fractured NOF procedures within 36 hours performance remains at 72% and 7 day readmission rates remain below the a national standard (10%) at 6.5%. **Responsive** The Trust saw the 4 hour performance standard reaching 90.7% for July 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for July is recorded at 52.5%, with 95 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for July as 73.04%. Cancer 2 week wait performance for June continues to be achieving national standards at 98.05%, 62 day performance is recorded as 61.76%. **Well Led** We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also achieved the control total for month 4 of 2020/2021, exceeding the CIP target but behind on capital expenditure with clear actions to address.		
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	☒
Resource Implications	None	
Legal Implications/Regulatory Requirements	State whether there are any legal implications	
Quality Impact Assessment	Not required.	
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.	

Approval	Assurance	Discussion	Noting
☐	☒	☒	☒

Appendices	Appendix 1: IQPR - July 2020

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: July 2020

Guide to Statistical Process Control (SPC)

NHS Medway NHS Foundation Trust

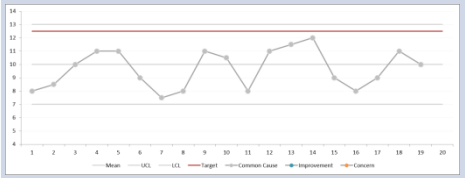
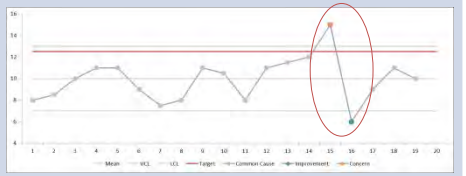
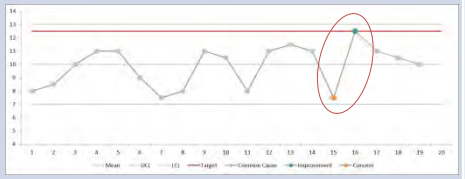
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

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

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

NHS Improvement have published two documents '**Making Data Count**' which will provide further information on SPC. Please click on the More Info box in the bottom right hand corner to access the documents.

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

Common cause	7 consecutive points above mean	7 Consecutive points below mean	Astronomical points outside CL
			
7 consecutive descending	**7 consecutive ascending**	**2 out of 3 sigma points**	**More Info Click here**
			NHS Improvement 'Making data count'

Guide to Statistical Process Control (SPC) Icons

Extract of how the SPC Icons have been included into the IQPR

Variation

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

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

Assurance

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

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

Executive Summary

Safe

Our Infection Prevention and Control performance For June shows that the Trust has had 0 MRSA bacteraemia cases and 2 C-diff cases.

The March HSMR figure now sits at 98.6 (94.5 – weekday and 110.3 – weekend). The SHMI sits at 1.11

Caring

MSA continues to demonstrate an improvement; however in July 7 breaches were recorded in Critical Care areas which is higher than the national compliance levels.

The Friends and Family response rates varies across the Trust from 13.7% to 36.2%. The recommended rates remain close or above the national standard of 85% (Inpatients: 88.1%, ED: 84.3%, Maternity: 99.4%, Outpatients: 89.2%)

Effective

VTE performance for July sits at 68.7% against the 95% national target. Fractured NOF procedures within 36 hours performance remains at 72% and 7 day readmission rates remain below the a national standard (10%) at 6.5%.

Responsive

The Trust saw the 4 hour performance standard reaching 90.7% for July 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for July is recorded at 52.5%, with 95 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for July as 73.04%. Cancer 2 week wait performance for June continues to be achieving national standards at 98.05%, 62 day performance is recorded as 61.76%.

Well Led

We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also achieved the control total for month 4 of 2020/2021, exceeding the CIP target but behind on capital expenditure with clear actions to address.

	Variation					Assurance			
Trust Domains									
Caring									
Admitted Care	2	0	0	1	2	0	3	2	0
ED Care	0	0	0	2	0	0	1	1	0
Maternity Care	2	0	0	0	0	1	0	1	0
Outpatients Care	2	0	0	0	0	1	1	0	0
Effective									
Best Practice	1	1	2	1	0	1	2	2	0
Maternity	5	0	0	0	0	0	2	2	1
Stroke	0	2	0	1	0	0	2	0	1
Safe									
Harm Free Care	1	0	0	0	1	2	0	0	0
Incident Reporting	0	0	2	1	0	1	0	1	1
Infection Control	4	0	0	0	0	3	0	0	1
Mortality	0	0	2	0	3	0	3	2	0
Responsive									
Bed Management	1	0	0	0	4	2	2	1	0
Cancer Access	1	1	0	2	1	0	1	4	0
Complaints Management	0	1	0	0	1	0	0	2	0
Diagnostic Access	0	1	0	0	0	0	0	1	0
ED Access	2	0	0	2	0	0	2	2	0
Elective Access	0	1	1	0	0	0	1	1	0
Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Well Led									
Staff Experience	2	0	0	0	0	0	2	0	0
Workforce	1	0	2	2	3	0	0	7	1

Domain: Caring Dashboard

Executive Lead: Jane Murkin – Chief Nurse
Operational Lead: N/A
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

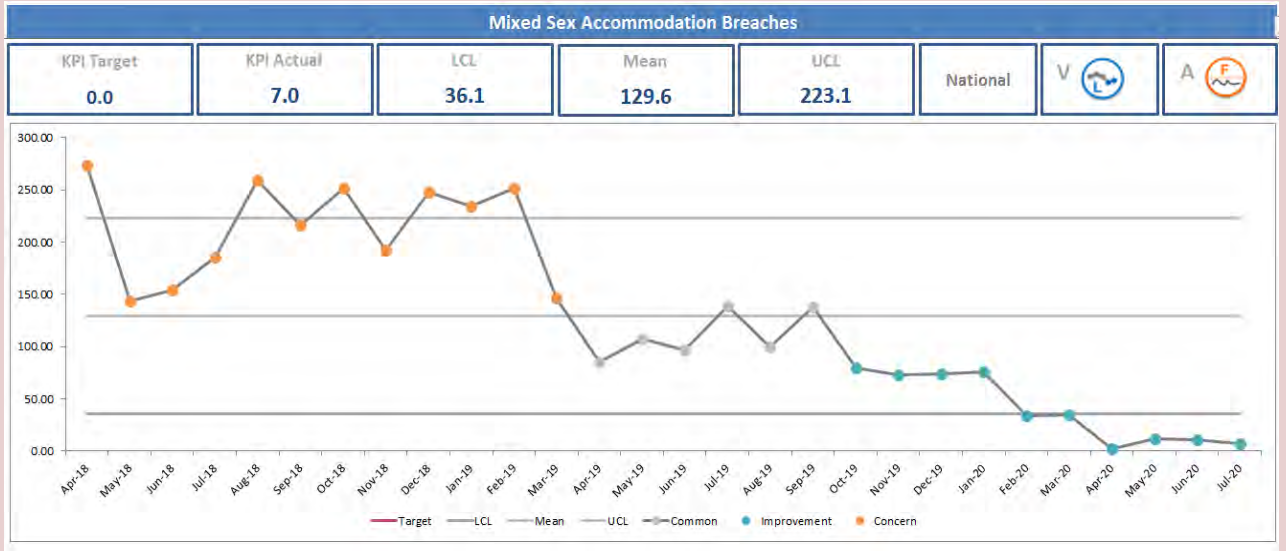
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	N	Jul-20	0	7	36	130	223		
		MSA %	N	Jul-20	0%	0.1%	0.2%	0.9%	1.5%		
		% of EDNs Completed Within 24hrs	N	Jul-20	100%	85.7%	69.9%	75.4%	80.9%		
		Inpatients Friends & Family % Recommended	N	Jun-20	85%	88.1%	80.3%	86.3%	92.3%		
		Inpatients Friends & Family Response Rate	N	Jun-20	22%	21.4%	16.0%	20.7%	25.4%		
	ED Care	ED Friends & Family % Recommended	N	Jun-20	85%	84.3%	71.4%	78.4%	85.3%		
		ED Friends & Family Response Rate	N	Jun-20	22%	16.9%	11.8%	14.5%	17.1%		
	Maternity Care	Maternity Friends & Family % Recommended	N	Jun-20	85%	99.4%	97.0%	99.2%	100.0%		
		Maternity Friends & Family Response Rate	N	Jun-20	22%	36.2%	11.2%	25.1%	39.1%		
	Outpatient Care	Outpatients Friends & Family % Recommended	N	Jun-20	85%	89.2%	88.2%	90.4%	92.7%		
		Outpatients Friends & Family Response Rate	N	Jun-20	22%	13.7%	12.0%	14.1%	16.3%		

Domain: Caring Insights

Executive Lead: Jane Murkin – Chief Nurse
Operational Lead: Simone Hay – Divisional Director of Nursing
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: Mixed Sex Accommodation Breaches



Indicator Background:

The number of patient breaches by day of mixed-sex accommodation (MSA)

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low improving nature. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

Actions from previous are consistent. Datix submission in real time is being embedded.

Outcomes:

The MSA breaches in July all occurred in critical care on 7 occasions. This affected 1 patient for 3 days in ICU awaiting a general Surgical bed, and 4 patients for 1 day each in HDU, awaiting 3 general surgical and 1 general medical bed. Review of data indicates the majority of breaches occur on Fridays.

Underlying issues and risks:

Review of MSA breeches show majority occur on Fridays.

Patient transfer from ED frequently takes priority, resulting in delayed discharges, OOH discharges and MSAs

Domain: Effective Dashboard

Executive Lead: Jane Murkin – Chief Nurse
David Sulch – Medical Director
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

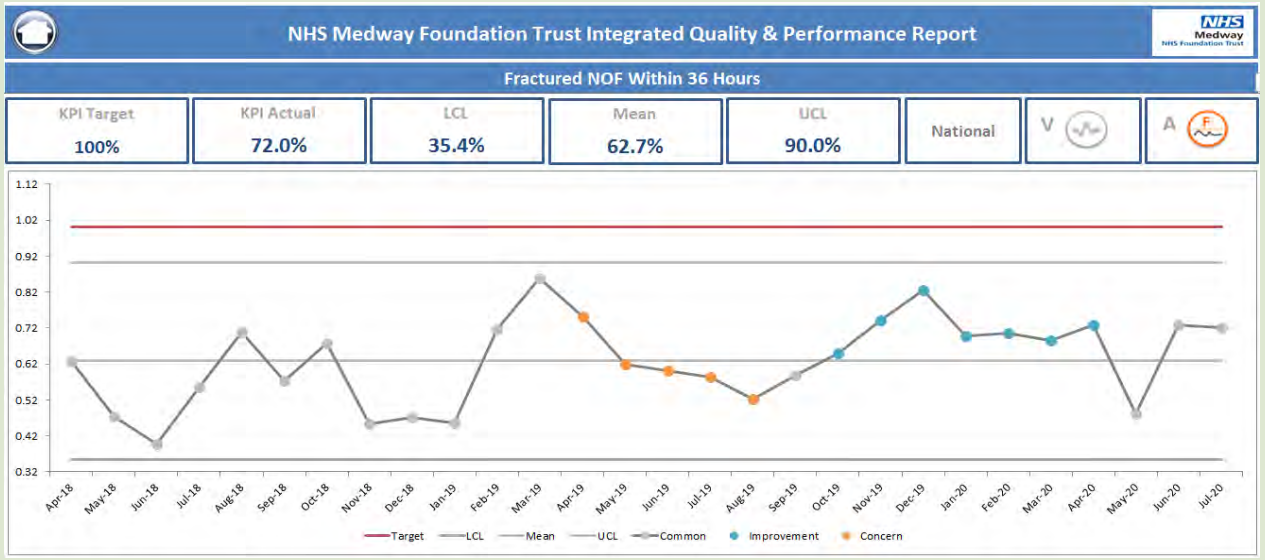
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	N	Jun-20	10%	6.5%	4.0%	5.6%	7.2%		
		30 Day Readmission Rate	N	Jun-20	10%	13.8%	9.0%	11.2%	13.3%		
		Discharges Before Noon	N	Jul-20	25%	17.3%	12.1%	15.1%	18.0%		
		Fractured NOF Within 36 Hours	N	Jul-20	100%	72.0%	35.4%	62.7%	90.0%		
		VTE Risk Assessment % Completed	N	Jul-20	95%	68.7%	70.2%	84.4%	98.7%		
	Maternity	Elective C-Section Rate	L	Jul-20	13%	12.9%	9.7%	13.1%	16.5%		
		Average occupancy	L	Jul-20	15%	19.4%	15.2%	18.9%	22.6%		
		Total C-Section Rate	L	Jul-20	28%	32.3%	27.7%	32.1%	36.4%		
		Number of Deliveries (Count of Mothers)	L	Jul-20		104	308	398	488		
		12+6 Risk Assessment	N	Mar-20	90%	81.6%	77.3%	83.1%	88.9%		
	Stroke	Stroke SSNAP Rating *	N	Mar-20	B	D					
		% of Pts Seen by Stroke Cons in 24 Hours *	N	Mar-20	95%	40.0%	32.0%	37.4%	42.9%		
		Stroke Pts Scanned Within 1 hour *	N	Mar-20	90%	40%	38%	43%	49%		

Domain: Effective Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Dr Graeme Sanders & Mr Neil Kukreja
Sub Groups : Orthopaedics, Anaesthesia, Orthogeriatrics

NHS Medway NHS Foundation Trust

Indicator: Fractured NOF Within 36 Hours



Indicator Background:

The proportion of patients admitted with fractured neck of femur (NOF) and had surgery within 36 hours of admission.

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

An extra half day trauma theatre has been sporadically provided Mon-Fri since the beginning of July 2020. This has been made regular since August 2020.

Revamp of orthopaedic staffing underway. Need to employ two more surgeons on a permanent basis.

Outcomes:

No impact on NOF within 36-hours pathway, but other frailty trauma has been operated on earlier.

Business case for new consultants in progress by Mr Cottam.

Underlying issues and risks:

Two orthopaedic surgeons have been shielding.
Lack of trauma theatre capacity.
High volumes of sub-specialty frail non-NOF trauma, equally deserving prompt surgery.

Domain: Safe Dashboard

Executive Lead: Jane Murkin – Interim Chief Nurse
David Sulch – Medical Director
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

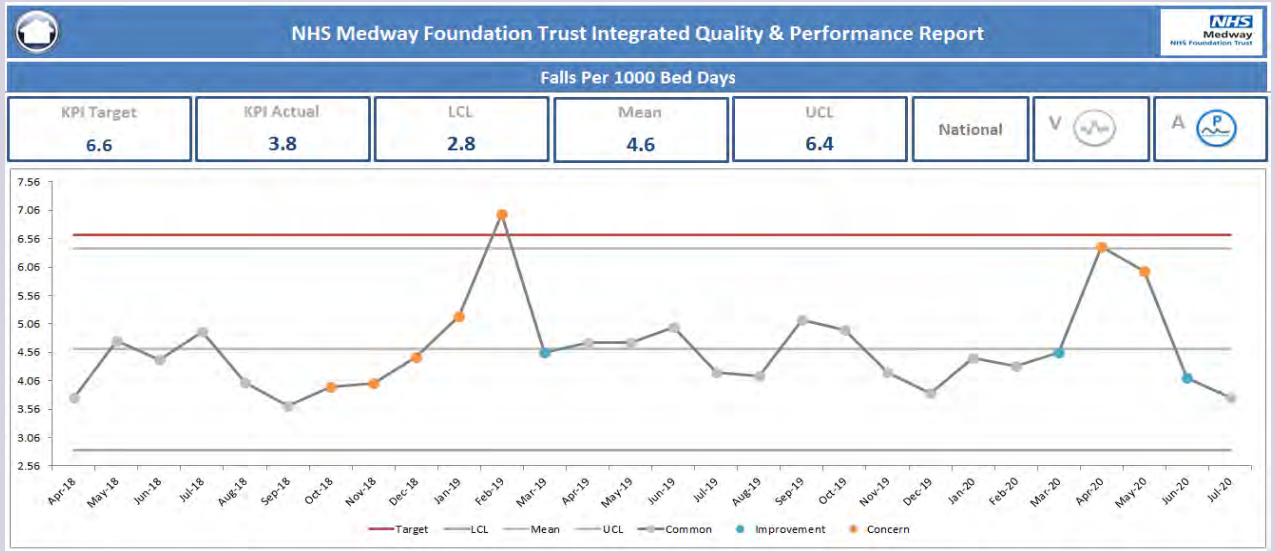
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	N	Jul-20	6.63	3.77	2.85	4.62	6.40		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	N	Jul-20	1.04	0.00	0.00	0.06	0.25		
	Incident Reporting	Never Events	N	Jul-20	0.0	0.0	0.00	0.1	0.9		
		No of SIs on STEIS	N	Jul-20	90	18	1	11	21		
		% of SIs Responded To In 60 Days	N	Jul-20		100%	92%	98%	100%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	N	Jun-20	0	0.00	0.00	0.59	2.95		
		C-Diff Acquisitions HAI (HOHA + COHA)	N	Jun-20	0	2.0	0.00	2.9	10.3		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	N	Jun-20		0.0	0.00	1.5	5.8		
		E-coli blood stream hospital associated infections	N	Jun-20	0	3.0	0.00	4.6	0.0		
	Mortality	Crude Mortality Rate	N	Jun-20	2.5%	1.48%	0.51%	1.67%	2.83%		
		HSMR (All)	N	Mar-20	100%	98.6%	102.9%	106.5%	100.0%		
		HSMR (Weekday)	N	Mar-20	100%	94.5%	99.6%	103.8%	100.0%		
		HSMR (Weekend)	N	Mar-20	100%	110.3%	109.6%	114.0%	100.0%		
		SHMI	N	Apr-20	1.0	1.11	1.07	1.09	1.11		

Domain: Safe Insights

Executive Lead: Jane Murkin – Chief Nurse
Operational Lead: Kerry O'Neill
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: Falls Per 1000 Bed Days



Indicator Background:

The number of patient falls per 1000 bed days.

What the Chart is Telling Us:

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

Actions:

Pilot ward staff are receiving knowledge questionnaires and surveys to ascertain barriers and challenges to implementing falls prevention strategies. Results will guide focused improvement work including individualised training requirements.

Need to purchase additional sensor pads to meet demand.

Outcomes:

0 patients were COVID positive
4 patients (8%) had a confirmed diagnosis of Dementia
11 incidents (22%) involved patients with increased alcohol consumption
16 patients (31%) had confirmed Delirium
There were no incidents moderate harm and above in July

Underlying issues and risks:

Ensuring patients are well hydrated especially during recent hot weather to avoid falls related to dehydration.

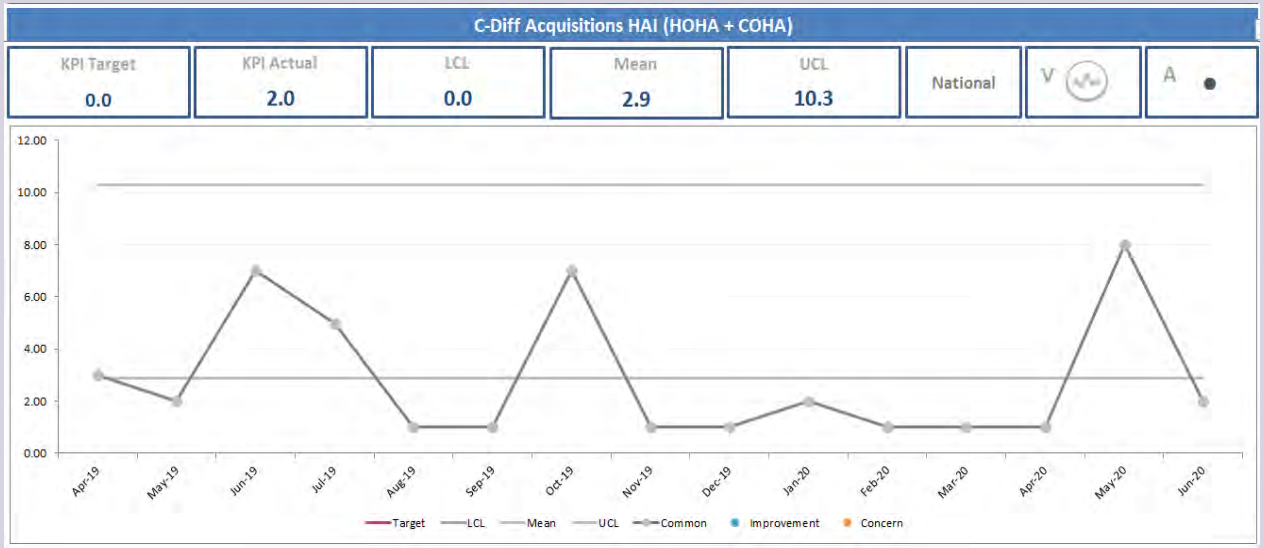
Patients with delirium have use of falls sensor pad and not clip and cord in the delirium pathway. Increased patients with delirium challenged current available stock.

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Ian Hosein
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: C-Diff Acquisitions HAI (HOHA + COHA)



Indicator Background:

The number of Clostridium difficile (C-Diff) cases.

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently achieving target.

Actions:

Areas with previous occurrences have undergone periods of enhanced focus and inspections, with marked improvements and shared learning

Outcomes:

0 occurrence HOHA C-Diff in June, down from 4 occurrences in May.

Underlying issues and risks:

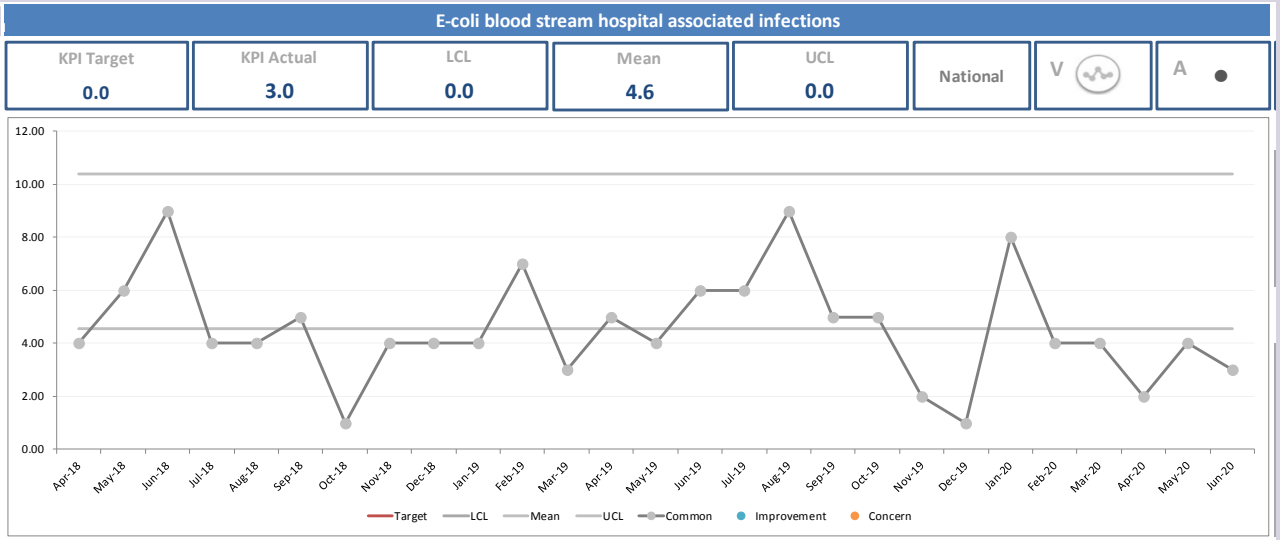
Hand gel availability

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Ian Hosien
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: E-coli blood stream hospital associated infections



Indicator Background:

The number of Escherichia coli (E. coli) cases.

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently achieving target.

Actions:

Areas with previous occurrences have undergone periods of enhanced focus and inspections, with marked improvements and shared learning

Outcomes:

1 occurrence on Phoenix and 1 on Delivery Suite

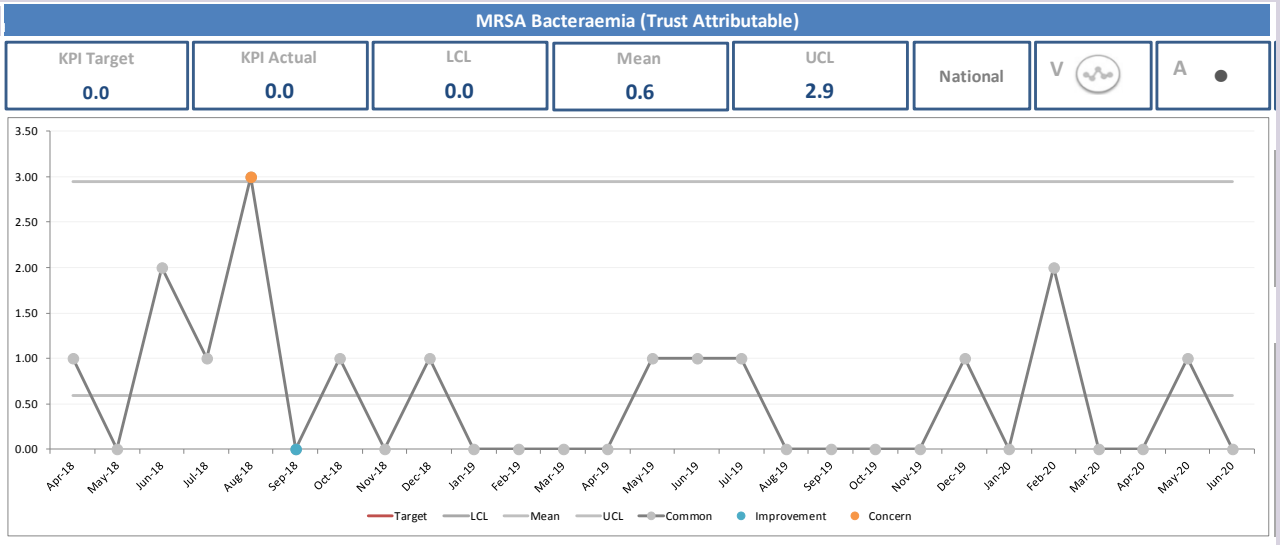
Underlying issues and risks:

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Ian Hosien
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: MRSA Bacteraemia (Trust Attributable)



Indicator Background:

The number of Meticillin-resistant Staphylococcus aureus (MRSA) cases.

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently achieving target.

Actions:

Areas with previous occurrences have undergone periods of enhanced focus and inspections, with marked improvements and shared learning

Outcomes:

No cases of MRSA Bacteraemia since March 2020

Underlying issues and risks:

Aware of audit of MRSA screening and will be working with IPC to improve compliance.

Domain: Responsive – Non Elective Dashboard

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

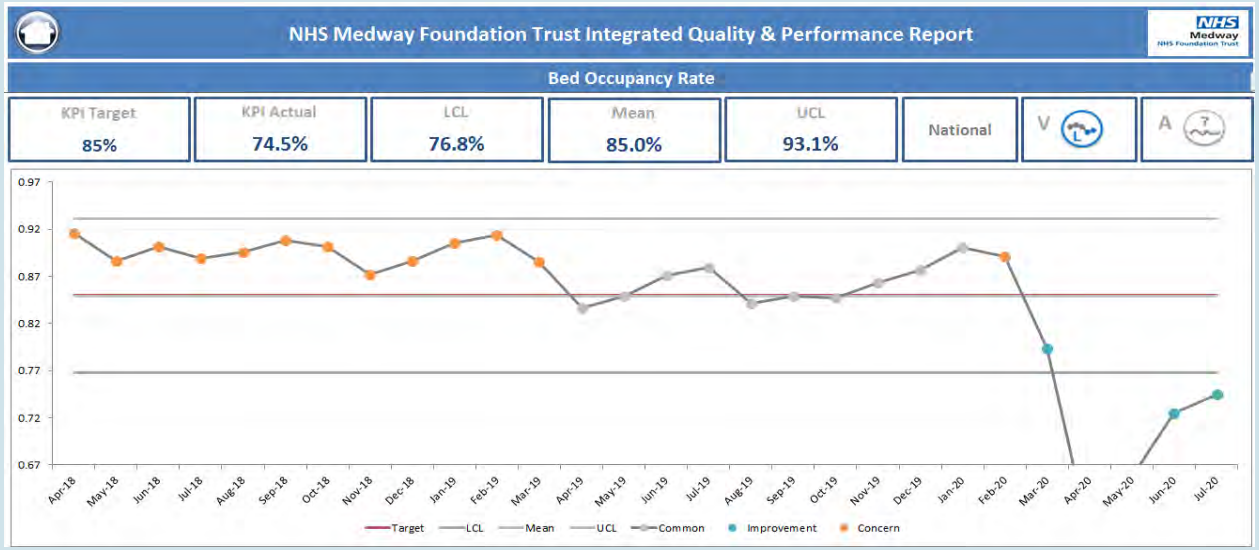
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Non Elective	Bed Management	Bed Occupancy Rate	N	Jul-20	85%	74.5%	76.8%	85.0%	93.1%	L	?
		Average Elective Length of Stay	N	Jul-20	5	2.13	1.42	2.31	3.21		P
		Average Non-Elective Length of Stay	N	Jul-20	5	7.81	7.28	8.49	9.71	L	F
		% of Delayed Transfer of Care Point Prevalence in Month	N	Jun-20	3.5%	0.01%	0.36%	1.52%	2.68%	L	P
		% Medically Fit For Discharge Point Prevalence in Month	L	Jul-20	7%	10.15%	15.19%	18.78%	22.37%	L	F
	ED Access	ED 4 Hour Performance All Types	N	Jul-20	95%	90.7%	77.1%	83.8%	90.4%	H	F
		ED 4 Hour Performance Type 1	N	Jul-20	95%	85.89%	67.60%	76.19%	84.78%	H	F
		ED 12 hour DTA Breaches	L	Jul-20	0	0	0.00	13.25	50.79		?
		60 Mins Ambulance Handover Delays	N	Jul-20	0	1	0	78	172	L	?

Domain: Responsive – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Kevin Cairney, Director of Operations, UIC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Bed Occupancy Rate



Indicator Background:

The proportion of beds occupied at midnight.

What the Chart is Telling Us:

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

Actions:

The reconfiguration of wards and the implementation of clean pathways together with ongoing division of covid and non covid wards has meant not all beds can be accessed for all types of patients. resulting in beds being left empty.
Current IPC guidance requires in some beds to be closed follow discharge until complete bays can be cleaned.

Outcomes:

The overall occupancy will be reduced as a result of the actions listed.
The overall bed base will need to be adjusted to reflect current working practise.

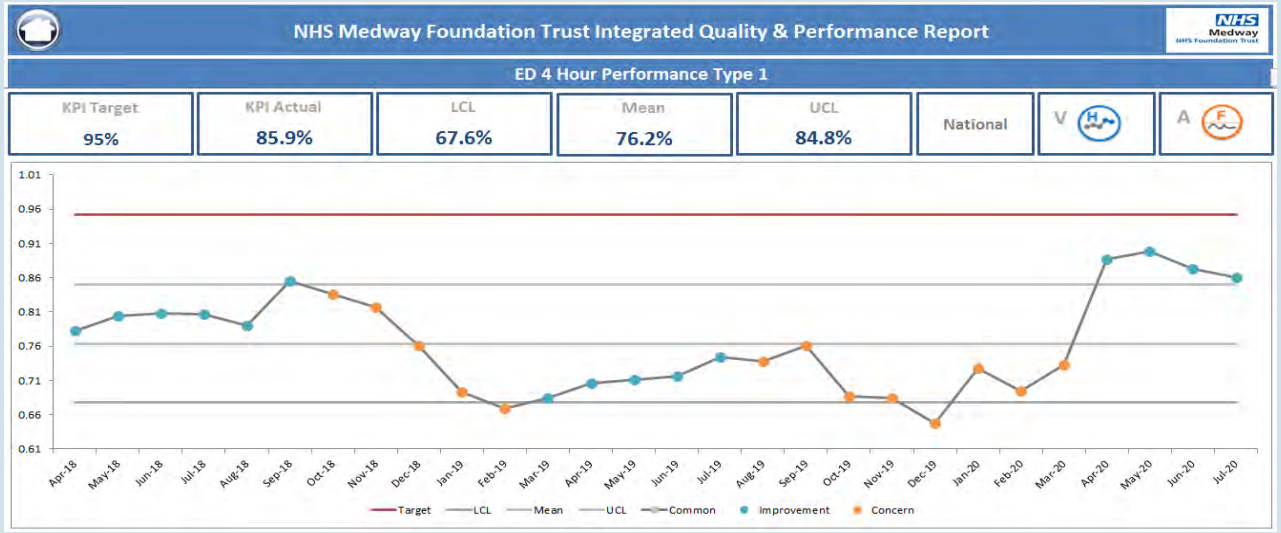
Underlying issues and risks:

Domain: Responsive – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Kevin Cairney, Director of Operations, UIC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 4 hours of arrival.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high improving nature. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

- End to end review of Emergency Department processes , roles and responsibilities.
- Continuous review of assessment capacity, bed capacity and acute demand.

Outcomes:

Improvements in compliance for ambulant patients attending the UTC were seen as the new model continues to embed with compliance of 98%.
Overall performance was impacted by admitted pathways with an increase in ED LOS of admitted patients.

Underlying issues and risks:

- ED processes, roles and responsibilities.
- Day to day trust wide management of LOS and patient flow.
- Difficulty of bed configuration post covid, resulting in a number of empty beds on occasion.

Domain: Responsive – Elective Dashboard

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

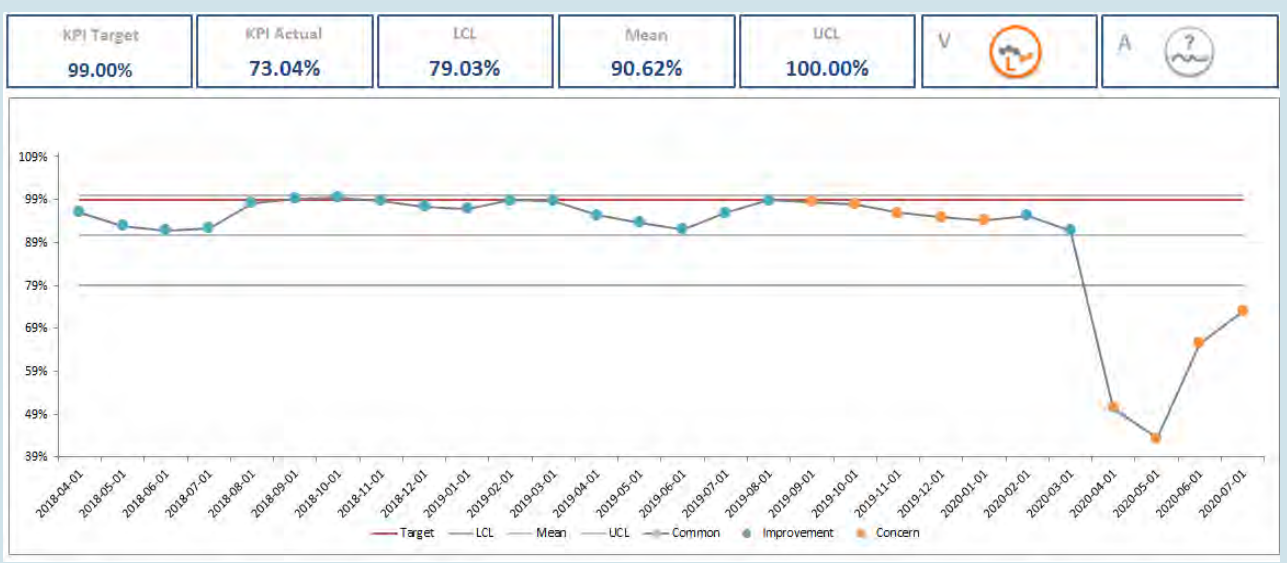
TRUST										
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Diagnostic Access	DM01 Performance	Jul-20	99%	73.04%	79.03%	90.62%	100.00%		
	Elective Access	18 Weeks RTT Incomplete Performance	Jul-20	92%	52.50%	74.62%	79.15%	83.68%		
		18 Weeks RTT Over 52 Week Breaches	Jul-20	0	95.00	0.00	11.93	29.66		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Jul-20	0	11.00	0.00	22.89	52.25		
		Cancelled Operations Not Rescheduled < 28 days	Jul-20	0	2.00	0.00	5.21	13.39		

Domain: Responsive – Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Kevin Cairney, Director of Operations, UIC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: DMO1 Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

DM01 performance has been adversely effected by the covid pandemic. We are bring services back to as near pre covid levels as possible. as part of the restart programme the monitoring meeting has undergone a change of format and chair.

Outcomes:

The trajectories have been revisited and weekly monitoring is ongoing with actions allocated in week to address either by insourcing or reprioritising resources.

Underlying issues and risks:

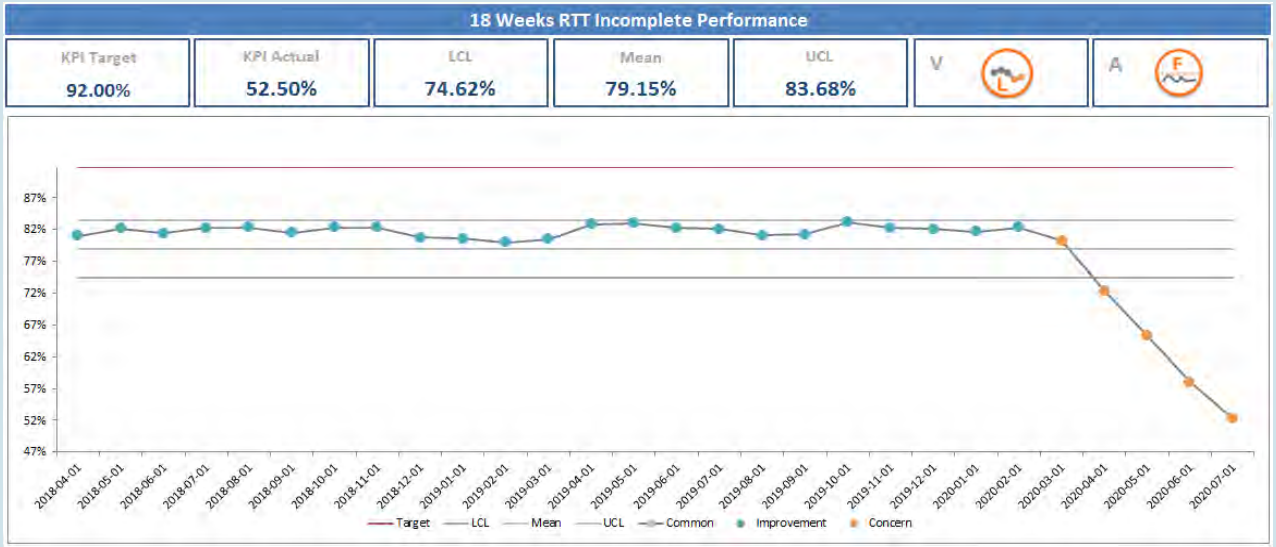
Heavily reliant on additional workforce to deliver key modalities.
Social distancing has limited capacity, which is being mitigated by increased hours of operation for some areas at additional cost.

Domain: Responsive – Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Incomplete Performance



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for less than 18 weeks from referral.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

- Deliver the elective restart programme in full across all specialties
- Bed-in the Green Zone to maintain patient and staff safety in relation to elective activity .
- Produce and manage a revised trajectory that outlines our specialty level plan to reduce all capacity related 52 week breaches by end November and achieve a max wait of 40 weeks by the end of March 2021.
- Review and produce a plan to deliver the phase 3 letter requirements.

Outcomes:

Trajectories being set inline with national requests.

Internal targets – Zero 52 week breaches at the end of November that are capacity related.

Concentration on patients over 40 weeks

Underlying issues and risks:

Delay in agreeing Orthopaedic elective ward due to complexities of post-covid ward configuration.

Domain: Responsive – Cancer and Complaints Dashboard

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

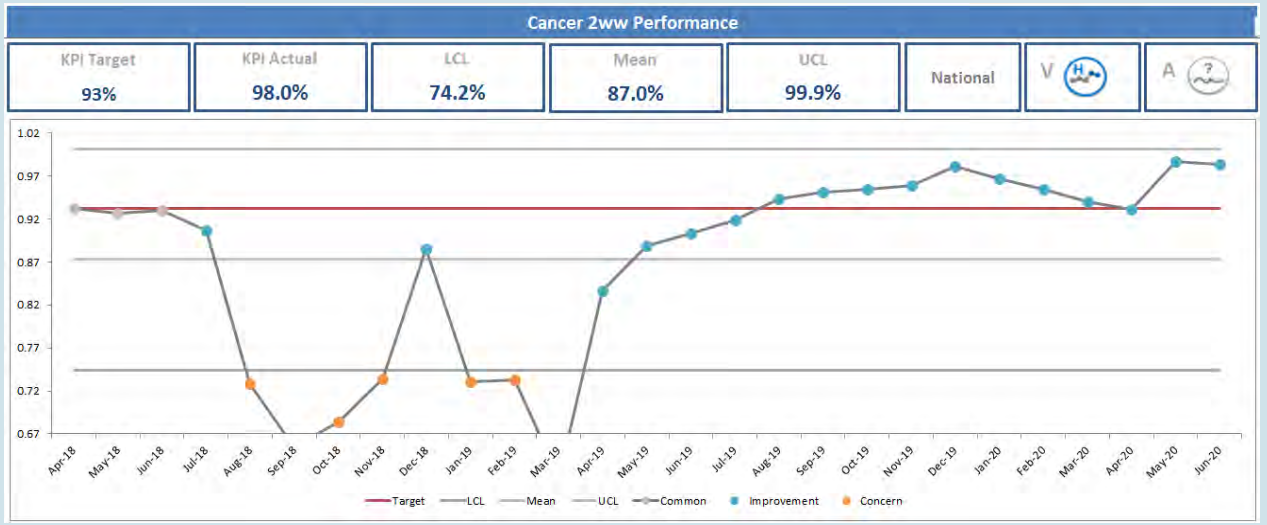
TRUST									
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assuranc
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Jun-20	93%	98.05%	74.16%	87.03%	99.91%		
		Cancer 2ww Performance - Breast Symptomatic	Jun-20	93%	98.44%	47.37%	77.84%	100.00%		
		Cancer 31 Day First Treatment Performance	Jun-20	96%	97.14%	89.55%	96.25%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Jun-20	85%	61.76%	64.10%	78.03%	91.96%		
		104 Day Cancer Waits	Jun-20	0	8.00	0.00	5.22	10.75		
	Complaints Management	Number of Complaints	Jul-20	41	59.00	26.63	61.11	95.59		
		% Complaints Responded to Within 30 Days	Jul-20	85%	83.33%	37.36%	66.89%	96.41%		

Domain: Responsive – Cancer and Complaints Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high improving nature. Assurance indicates that the KPI is Inconsistently achieving target.

Actions:

The Trust has implemented several process changes that have allowed it to remain consistently compliant against this KPI these include: Working to an internal Stretch Target of 7 Days. Any service unable to facilitate 1st OPA in 7 days or less will be escalated to the Service manager and if required the General Manager for that Service. Cancer Booking Office receive regular real time updates on Performance. Weekly referral numbers and day of booking shared with each service, allowing them to address capacity issues in real time. Work continues to reduce the polling range for 1st 2WW OPA's down to 7 days. Regular meetings with service managers to ensure that there is adequate capacity to manage demand.

Outcomes:

The Trust consistently hit this target and have been compliant with this KPI since August 2019. The trust has reported compliance in 10 of the last 11 months (the 1 month where we uploaded a position of non-compliance (April 20) was as a result of a data validation issue that has since been rectified this should show compliance once updated at quarter end)

Underlying issues and risks:

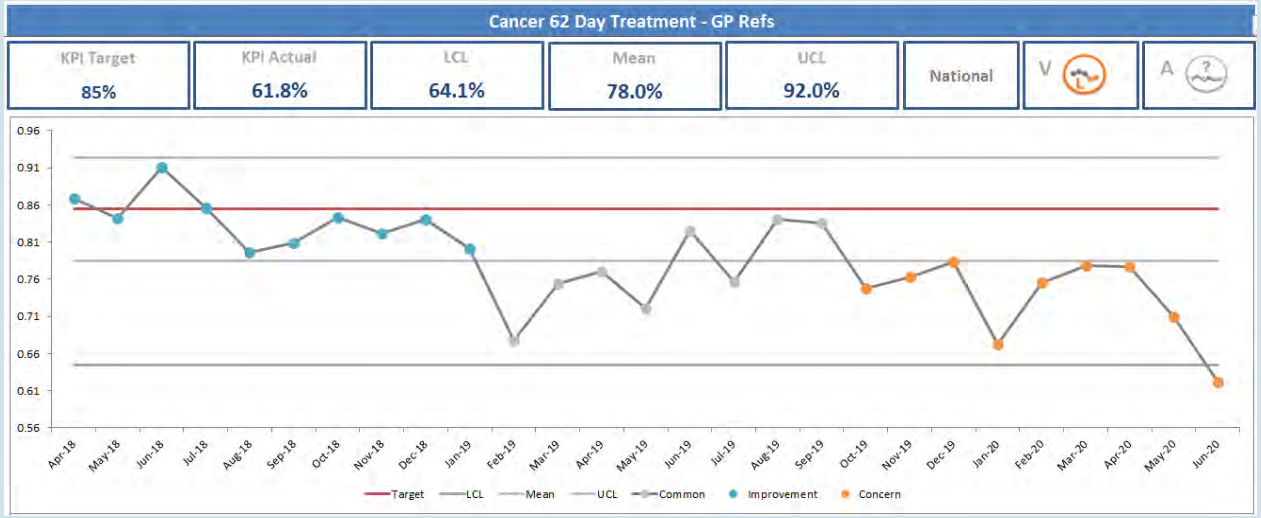
Potential for increased referral s in Q3 & Q4 as primary care resumes normal services.

Domain: Responsive – Cancer and Complaints Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Clear escalation points to be introduced for all CWT KPI's to support trusts Zero tolerance on breaches.

Individual patient level reviews for all patients in the 85-104 and 62-85 day cohort.

Outcomes:

The provisional performance (un-validated) for July is 80.36%. We forecast compliance with this standard from October 20. T

he trust has reduced the number of patients waiting above 104 days by 92% since 23/06/2020. Best in class

Underlying issues and risks:

- Endoscopy capacity in the medium and long term.
- Trust –wide focus on the cancer PTL at specialty level.

Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Director of HR & OD
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

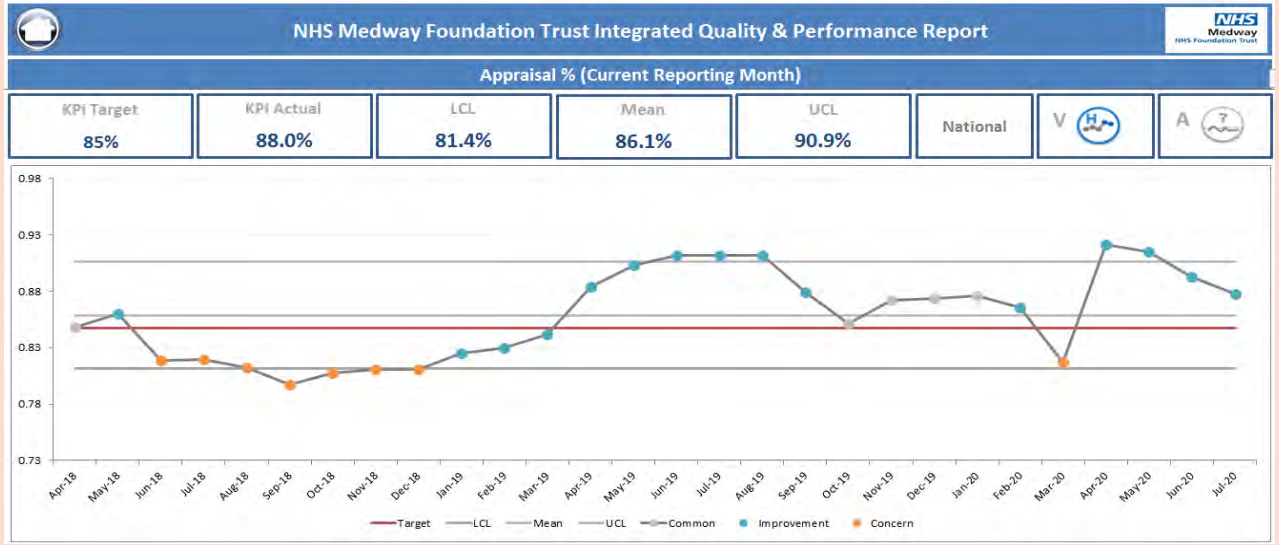
NHS Medway Foundation Trust Integrated Quality & Performance Report

CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	L	Mar-20	62%	56.8%	46.6%	50.5%	54.4%		
		Staff Friends & Family - Recommend Care of Treatment	N	Mar-20	79%	69.0%	65.4%	67.3%	69.1%		
	Workforce	Appraisal % (Current Reporting Month)	N	Jul-20	85%	88.0%	81.4%	86.1%	90.9%		
		Sickness Rate (Current Reporting Month, FTE%)	N	May-20	4%	4.4%	4.0%	4.2%	4.4%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	L	Jul-20	12%	12.1%	10.8%	12.0%	13.2%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	L	Jun-20		4,113	3,737	3,851	3,966		
		StatMan Compliance (Current Reporting Month)	N	Jul-20	85%	89.3%	59.2%	77.7%	96.2%		
		Agency Spend as % Paybill (Current Reporting Month)	L	Jun-20	4%	0.0%	1.8%	3.9%	6.1%		
		Bank Spend as % Paybill (Current Reporting Month)	L	Jun-20	9%	0.0%	6.5%	12.4%	18.2%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	L	Jun-20	75%	0.0%	55.5%	70.9%	86.3%		

Domain: Well Led – Workforce - Insights

Executive Lead: Leon Hinton – Director of HR & OD
Operational Lead: Ayesha Feroz, Unplanned Care, Temi Alao, Planned
Sub Groups : N/A

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed the appraisal process.

What the Chart is Telling Us:

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

Actions:

Weekly reporting in place;
Automated reminders in place;
Weekly and monthly progress to form actions with care group leaders in place;
Matrons, senior sisters and line managers required to build appraisal trajectory to correct current position (recovery plans);
Appraisal workshops provided with good uptake;
Pay progression policy linked to appraisal completion in place (nationally suspended due to Covid)

Outcomes:

- 3695 members of staff have an in-date appraisal with objectives and personal development plan outlined.

Underlying issues and risks:

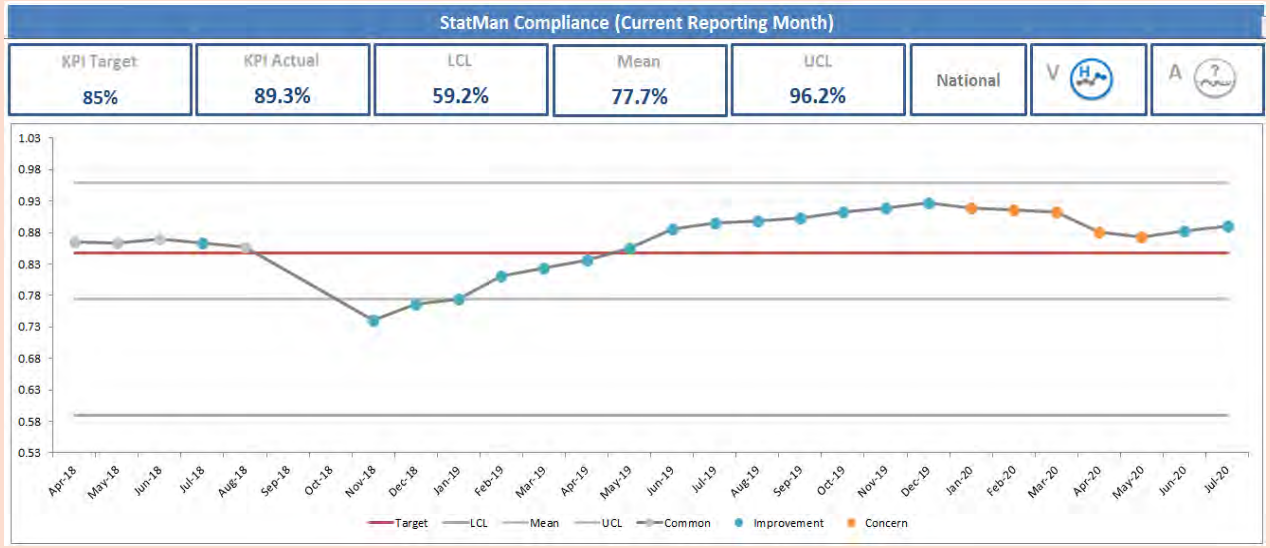
- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Failure to appraise staff timely reduces the opportunity to identify skills requirement for development, succession planning and talent management. Low appraisal rate are linked to high turnover of staff, low staff engagement and low team-working.

Domain: Well Led – Workforce - Insights

Executive Lead: Leon Hinton – Director of HR & OD
Operational Lead: Ayesha Feroz, Unplanned Care, Temi Alao, Planned
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: StatMan Compliance (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed their appropriate training to comply with their statutory and mandatory requirements.

What the Chart is Telling Us:

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

Actions:

- Weekly reporting in place;
- Automated reminders in place;
- Weekly and monthly progress to form actions with care group leaders in place;
- Matrons, senior sisters and line managers required to build appraisal trajectory to correct current position (recovery plans);
- Significant number of classroom-based learning events moved to webinar or video to support remote working and flexible access to StatMan content due to Covid. Reviewing the impact of quality and learning post-covid – and delivery of course content in future.
- Pay progression policy linked to StatMan completion in place (nationally suspended due to Covid)

Outcomes:

- Competencies, on average, being met (>85%) includes conflict resolution; equality and diversity; health and safety; infection, prevention and control (L1, 2); moving and handling (L1); information governance; prevent (basic, WRAP); safeguarding children (L1,2); safeguarding adults (L1,2)
- Competencies, on average, not being met (<85%) includes fire; safeguarding children (L3), resuscitation (L2,3 adult, L2,3 paediatrics, L2 newborn); moving and handling (L2); MCA/DoLS.

Underlying issues and risks:

- Current COVID-19 is interrupting clinical staff's capacity to carry out StatMan in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect StatMan completion for clinical areas.
- Uneven StatMan renewal cycles can impact on the training capacity thereby limiting the availability for timely compliance.
- Failure for staff to be compliant with StatMan can negatively affect staff and patient safety, patient quality and experience and clinical skills.
- Low StatMan compliance can be linked to higher number of incidents and negatively impacts a safety culture.

Domain: Well Led - Financial Position

Executive Lead: Richard Eley
Operational Lead: Paul Kimber – Deputy Director of Finance
Sub Groups : Finance Committee

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £'000	In-month			YTD		
	Baseline	Actual	Variance	Baseline	Actual	Variance
Income	28,654	29,843	1,189	114,617	119,416	4,799
Pay	(18,216)	(18,294)	(78)	(72,863)	(75,001)	(2,138)
Non-pay	(9,101)	(10,179)	(1,078)	(36,405)	(38,946)	(2,541)
Non-operating expenses	(1,337)	(1,381)	(44)	(5,349)	(5,512)	(163)
Reported surplus/(deficit)	-	(11)	(11)	-	(43)	(43)
Donated asset depreciation	-	11	11	-	43	43
Control total	-	-	-	-	-	-

Other Financial Stability metrics	In-month			YTD		
	Baseline	Actual	Variance	Baseline	Actual	Variance
CIP	463	474	11	1,093	1,626	533
Capex	1,671	1,385	(286)	7,170	5,612	(1,558)

Indicator Background:

The key indicator for the Trust is whether it meets its statutory control total, of which CIP delivery is an integral component.
It is also vital that the Trust delivers against its capital programme.

What the Chart is Telling Us:

The Trust has met its control total target, is exceeding its CIP target but is behind against its capital expenditure plans.

Actions:

- Financial modelling based on operational actions to "restore, recover, return".
- Continued work with divisions to assess the financial impact of revised ward configuration
- CIP development and implementation of efficiencies within divisions.

Outcomes:

The Trust has met its control total, however this includes:

- Incremental costs associated with Covid-19 in month are £1.2m (£7.1m year to date).
- In month "true-up" income accrued to achieve breakeven is £1.2m (£6.5m year to date).

Underlying issues and risks:

Clinical income on a cost and volume basis is £21.8m adverse to plan YTD (although only £0.1m adverse in-month) this being the impact of reduced activity as a result of Covid.
The gap in the £12m CIP programme is £0.7m.
Capacity together with additional funding awards are putting pressure on delivery of the capital programme.

Meeting of the Board of Directors in Public

Thursday, 03 September 2020

Assurance Report from Committee

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**5.4**
Committee Chair:	Tony Ullman, Non-Executive Director		
Date of Meeting:	Tuesday, 18 August 2020		
Lead Director:	Jane Murkin, Chief Nursing and Quality Officer		
Report Author:	Joanne Adams, Business Support Manager		

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 headlines	**Assurance Level**
1. Electronic Discharge Notifications (EDN) backlog David Sulch, Medical Director advised the committee that there is a misalignment between the EDN system and reported performance David advised the committee that the Business Intelligence team are undertaking an audit and he will be able to provide the committee of a more informed position on the backlog at the September meeting.	**Amber/ Red**
2. COVID-19 The committee agreed that COVID-19 was no longer required as a separate standing item on the agenda as this will be included in the Restore and Recovery updates. Harvey McEnroe, Trust Strategic Commander explained to the committee how this forms part of the strategic planning for Winter and will produce a closing paper to the committee on COVID-19 for the next meeting.	**Green**
3. CoSHH Gary Lupton, Director of Estates and Facilities joined the committee for this update. The trust continues to work to improve its current performance in relation to the management of COSHH products. The physical infrastructure is being enhanced with additional controls around locks and alarms when doors are left open, staff behaviour and understanding need to be improved at pace to ensure long term sustained changes are implemented, recent evidence suggests some	**Amber/ Red**

improvements and additional planned physical controls should greatly contribute to improving the results. The improvements will continue to be measured from these key areas; routine monthly H&S team led auditing, training of local H&S link workers, local monitoring and guidance from ward leadership / departmental Health and Safety link workers on each ward undertaking regular audits. Housekeeping supervisors to include auditing of COSHH into daily routine. The Chief Nursing and Quality Officer has implemented a programme of joint ward visits with the Executive Director of Estates and Facilities at which compliance with IPC and COSHH is assessed, any issues immediately dealt with and results fed back to the ward and any additional environmental actions agreed with the Estates Team The committee will escalate CoSHH to the Trust Board.	
4. Quality Strategy Implementation and next steps The committee received the Quality Strategy Implementation report which contained an update on the position of the completion of the CQC Must do / Should do actions: 79% were on track or completed. Actions were agreed at the evidence panel to address the issues, and will follow up with operational and executive leads to address the red rated status The report also provided an update on the results of the in-patient hospital survey. The 2019 National Inpatient Survey in which Medway Foundation Trust was identified as being 'worse than expected' and significantly below the Trust average for similar organisations. The following actions have been progressed: • In depth analysis of the survey results with comparisons against previous years and benchmarked against other organisations which was presented to the Executive Team and Quality Assurance Committee • Successful recruitment to the Associate Director of Patient Experience role to support the Trust with taking a refreshed and energised approach to Patient Experience and strengthen the leadership and oversight of this pivotal agenda. Karen McIntyre, Senior Nurse / Divisional Director of Nursing has been appointed and a start date is currently being negotiated. • A senior nursing leadership meeting to discuss the findings, themes and identify key actions and progress the development of an improvement plan to address the poor scoring areas with targeted areas for improvement. • Facilitated discussion at Clinical council and identification of actions to be progressed at care group, and divisional level that will feed into the improvement plan A short life working group led by the Deputy Chief Nurse to oversee the development of the plan to address findings has been initiated. **Key Successes and Achievements** • The Trust has continued to remain below the national mean rate for total number of falls per occupied bed days • Increases in days between hospital acquired pressure ulcers on pilot wards. • In December 2019 there were 31 hospital acquired pressure ulcers and in June 2020 • a successful multidisciplinary Pressure Ulcer `Big Room Event' was held with Pilot wards and key stakeholders to share their successes and achievements to date and learning from improving key processes known to impact on patient outcomes and reduce the number of hospital acquired pressure ulcers in the Trust. • Increase in number of pilot wards consistently sustaining over 95% reliability in the falls CRASH bundle and ASSKINg bundle for prevention of pressure ulcers Improvement in MUST scoring and a nutritional care plan implemented • Successful pilot of the quality and safety boards on the pilot wards • E- Learning package being developed for SEPSIS 6	**Green**

• Patient activity packs created • Improvement in every patient living with a Learning Disability will have a Passport in place if required and having a “Flag” added to the Bed Management system • Difficulties encountered in monitoring original pilot wards and the impact on data collection with some ward teams who had received focused Quality improvement interventions have now moved to a different named ward. The committee requested a more detailed paper on patient experience	
5. Quality and safety implications and risks associated with restart and recovery and delivery on constitutional standards Angela Gallagher, Chief Operating Officer (interim) updated the committee on the work of restart and recovery. The key issues and actions to support quality and safety (for both patients and staff) identified from this work included: • Comprehensive mapping exercise for all specialities of patient and staff flows through the hospital • Improved wayfinding for patients visiting for outpatient and diagnostics • Specific zones and entrances/exits for patients and staff to minimise risk • Staff at patient entrances are present to support with directions and to issue face coverings • Creation of a ‘Green Zone’ (Covid-19 free) for patients having elective surgery including the reconfiguration of ward areas • Reinstatement of the Sunderland day Unit as a dedicated Day Surgery centre • Changes in our communication with patients regarding their appointments in line with Covid-19 guidelines • Development of a Swabbing Pathway for patients undergoing elective surgery • Development of a new Theatre Template to allow for the booking of inpatient and day case procedures from 03 August 2020 • Reinstatement of the DM01 PTL meeting for the monitoring of diagnostic performance • Development of diagnostic recovery plans (by individual modality) The Trust is moving from restarting elective care to re-establishing pre-covid or near pre-covid levels of activity, as set out in the recent Phase Three letter from NHS England. Whilst good progress is being made, the potential risks to achieving this level of activity include: • A local or national increase in the prevalence of Covid-19 that slows or stops elective activity • Shortages of PPE • Limited availability of staff due to the need to shield or self-isolate • Difficulty scheduling patients for diagnostics and treatment due to requirement for self-isolation and patients fears of coming to a hospital site • Diagnostic backlogs • Winter bed pressures • Testing and reporting delays in the Swabbing Pathway The committee noted the particular risks to the unplanned care system, especially as we move into Winter and requested a report on Winter planning for the next meeting.	**Amber/ Green**
6. Board visits to wards and clinical areas The committee received a paper setting out how Board visits to wards and clinical areas can be re-established as the Trust moves into ‘business as usual’ post COVID. Members of the Executive Team have regularly visited wards and clinical areas for assurance purposes as part of their role. Structured Gemba visits have also taken place several times a year for a number of years, providing opportunities for Executives to undertake visits themed around particular issues, logging observations, supporting staff with a coaching style, and feeding back on highlights of the visit as well as areas for improvement.	**Green**

The Chief Nursing and Quality Officer has also instigated a programme of ward visits and will also be implementing a programme of spending time working in clinical wards and departments over the next 12 months. Feedback from our last CQC visit indicated that neither the ward visits nor the Gemba walkabouts were working in the way intended, with room for improvement in the effectiveness of both. A new structure for visits is proposed by way of Patient safety leadership visits these visits will be a way of ensuring that Executives and Non Executives are informed first-hand regarding the safety concerns of frontline staff. They also help demonstrate visible commitment to leadership attention, and a focus on patient safety and quality through listening and supporting staff when issues of safety are raised. These visits can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation. Visits will be organised to facilitate conversations between staff and Executives and Non-Executive Directors. An assigned scribe will ensure any issues raised are logged, tracked and followed-up, with actions and outcomes fed back to the ward or clinical area. Themes will be collated and analysed and shared with the Board through reporting at the Quality Assurance Committee. Governors will be invited to join the visits on a rota basis. Visits will be held bi-monthly and will last for around an hour. A schedule drawn up by the central team will ensure all wards and clinical areas are included and visited at least twice a year. Colleagues in those areas will be notified in advance. Executives and Non-Executive Directors will be asked to join visits at agreed times, and once the schedule is published attendance will be expected unless there are exceptional circumstances. It is essential that colleagues feel this is important to Board members, and cancellations could undermine this. Discussions with colleagues in clinical area will focus on exploring how safety can be improved. The committee agreed with this approach and asked about being able to ask patients questions during the visits and recommended the board were sighted of the paper for noting at the next board meeting.	
7. Assurance framework for specialties at MFT David Sulch, Medical Director explained the assurance framework for specialties stating that the framework is structured in six key domains, and includes an edited version (or 'heat map') which can quickly be produced from known, easy to access data and from local intelligence. This will inform the sequence in which deeper dives into specialities will be carried out. The committee were happy with the proposal and agreed the first speciality to use the assurance frame work in relation to fractured neck of femur.	**Green**
8. Dermatology briefing paper Following the identification of concerns relating to a significant number of patients waiting for urgent procedures, approximately 1800 patients and approximately 7500 patients on a backlog waiting list who had waited over and above NHS mandated waiting times for routine and urgent treatment. The Board has a substantive agenda item on this issue. The committee requested a further paper on the impact on the Trust of the closure of local GP Practices provided by DMC.	
9. BAF – Quality and integrated healthcare The committee received the BAF on Quality which had been updated following the last committee meeting. The committee noted the proposed changes in the BAF, and were pleased to see reduction in risk levels in a number of areas, specifically in 5a and 5b of the BAF which reflected the work and focus which has been put in on these areas. The Committee will continue to monitor the Quality BAF at future meetings.	**Amber/ Green**

10. IQPR The committee received the refreshed IQPR containing the July data and discussed each of the sections and associated metrics. Jane explained that work continues with the business intelligence team on changes required to metrics and the final IQPR will be available for the September meeting.	**Green**
11. Independent sector Jeremy Davis, ENT Consultant attended the committee meeting to discuss the governance of how the patients have been looked after in the independent sector during COVID-19. Jeremy explained that clear governance was needed to cover all aspects of patients being treated at independent providers this included ensuring patients could be looked after as an in-patient and complex pathways were developed and reviewed and agreed by all stakeholders. Lead surgeon or anesthetist were available to be contacted if needed and Jeremy as a back up to approach MFT for cover. Patient notes were tracked to Spire, KIMS or Will Adams and transported using our hospital transport, copies of the patient record for the procedures were kept at the relevant facility and all electronic communication was carried out by NHS mail. Service managers at MFT are monitoring the generic NHS email address and have an excel spreadsheet with patient details to ensure follow up appointments are arranged as necessary. IST sign off where appropriate by clinical director or divisional director by region or commissioner, these are live documents and are updated as issues changed.	**Green**
12. Review of community deaths during COVID-19 James Williams, Director of Public Health, Medway Council joined the committee to provide a presentation on the impact of COVID-19 on deaths in the community. Report can be provided upon request by the Company Secretary. James explained that the first COVID-19 deaths were recorded in week 13 in March 2020 and spoke to each of the slides attached with the key points listed below: • The pattern of COVID-19 deaths in Medway and Swale is broadly similar to that seen in other areas. • A higher proportion of deaths took place in the acute hospital in Medway and Swale ICP than in other ICPs, probably due to different responses by care homes in the areas. • Currently the number of deaths seen (in total) per week is lower than would normally be expected at this time of year.	**Green**
13. Quality Assurance Committee work plan The committee were informed that the work plan for the quality assurance committee will be reviewed by Tony and Jane and brought back to the September meeting for agreement. Jane explained that although the work plan had been approved COVID-19 and additional agenda items have impacted upon the schedule. This needs to be amended from governance prospective to ensure the committee is meeting deadlines for the work plan.	**Amber/ Green**
Further Risks Identified There were no further risks identified.	
Escalations to the Board or other Committee The quality assurance committee escalates the following issues to the Trust Board: 1) assurance framework has been reviewed and agreed 2) risk to urgent care as we move towards Winter. 3) continued focus on CoSHH and Infection Prevention and Control 4) Progress with CQC recommendations and actions	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Dermatology Briefing Paper – Quality of Care Concerns relating to Dermatology Services provided by DMC Healthcare for Medway patients.**	**Agenda Item**	5.5
Report Author	The attached report has been written by the Assistant Director Secondary Care from the CCG and provided at the request of the Chief Nursing and Quality Officer to the Chief Nurse from the CCG (Paula Wilkins).		
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Executive Summary	Following the identification of concerns relating to a significant number of patients waiting for urgent procedures, approximately 1800 patients and approximately 7500 patients on a backlog waiting list who had waited over and above NHS mandated waiting times for routine and urgent treatment. The dermatology service for Medway patients was prior to its suspension of contract provided by DMC Healthcare. The Chief Executive and Chief Nursing Officer for MFT formally contacted the CCG Accountable Officer and Chief Nurse to raise their concerns relating to the dermatology service and the impact of the delays on the quality of care for patients, including the significant number of patients that might have a potential cancer diagnosis. On 22 June 2020 the DMC dermatology contract was formally suspended by Kent and Medway Clinical Commissioning Group (CCG) due to serious concerns regarding patient care. This paper provides the background information, relevant details and actions taken to ensure an effective interim service is in place. The attached paper has been provided to the Chief Nursing and Quality Officer by the Chief Nurse from the CCG (Paula Wilkins) and will be presented to the Health and Adult Social Care Overview and Scrutiny Committee. This report was an agenda item at the Quality Assurance Committee on 18 August 2020.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐

	High Quality Care: We will consistently provide high quality care	☐
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Quality Assurance Committee Date of approval: 18 August 2020	
Executive Group Approval:	Date of Approval: No	
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): n/a	
Resource Implications	None	
Legal Implications/Regulatory Requirements		
Quality Impact Assessment	A quality impact assessment has **not** been undertaken.	
Recommendation/ Actions required	The Board is asked to note the current performance for COSHH audits and the positive actions either started or planned.	

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

Appendices	None

Medway Council
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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 18 AUGUST 2020

DERMATOLOGY BRIEFING

Report from: Caroline Selkirk, CCG Executive Director of Health Improvement

Author: Nikki Teesdale, CCG Assistant Director Secondary Care

Summary

DMC Healthcare has been providing dermatology services to Medway patients since April 2019.

On 22 June 2020 the DMC dermatology contract was formally suspended by Kent and Medway Clinical Commissioning Group (CCG) due to serious concerns regarding patient care. This paper provides the background information and details the action the CCG has taken to ensure an effective interim service is in place.

The Committee is asked to NOTE this briefing

1. Budget and policy framework

1.1. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Dermatology services

Background

2.1. Dermatology is the medical term for the treatment or management of skin conditions which can include rashes, lesions, lumps on the skin, changes to moles and skin cancer.

2.2. DMC Healthcare has been providing dermatology services since April 2019. During the 14 months of contract delivery the CCG has been increasingly concerned about the underlying quality and capability of the care provided by DMC. An informal Contract Performance Notice (CPN) was issued in November 2019 with a formal one issued on 5th February 2020. The main areas of concern at this point were:

- The lack of management of Patient Tracking List (PTL) information
- Lack of reliable reporting and assurance against constitutional standards and key performance indicators in line with contract specifications
- A lack of assurance around Serious Untoward Incident (SUI) reporting
- Lack of organisational governance and clinical accountability
- Concern over the compliance and management of patients receiving pharmacological biological treatments

2.3. The follow through of the CPN was delayed until May due to the Covid-19 response. When the process was recommenced with weekly meetings between the CCG and DMC, there was a continued lack of delivery of a clear Remedial Action Plan (RAP) which could provide the CCG with assurance that services were able to operate safely. This lack of formal progress led to further formal action.

Contract Suspension

2.4. Data submitted to the CCG on 17 June 2020 showed 1855 patients waiting for urgent procedures and approximately 7500 patients on a backlog waiting list. There was a significant number of high risk patients who had waited over and above NHS mandated waiting times for routine and urgent treatment. This was reviewed by senior clinicians within the CCG and external professionals. They shared significant concern regarding the content and on-going delivery of service, given the large backlog that had accumulated and the risk of harm.

2.5. As a result, the North Kent Dermatology contract provided by DMC Healthcare was formally suspended on 22 June 2020 by the CCG due to the significant concerns that patients may be placed at risk of harm should the service continue in its current state; DMC were contacted on 19 June to advise of the suspension. They were requested to cancel all clinics and share the lists of the cancelled clinics with the interim provider being put in place in order not to delay treatment. The suspension took account of emerging evidence of inadequate care that had

been delivered to patients since DMC took over the service from Medway Foundation Trust (MFT) on 1st April 2019.

2.6. Under the terms of the suspension DMC were permitted to continue to care and treat a limited number of patients receiving on-going biologic medication treatment.

2.7. The CCG has ensured open communication with NHS England, the CQC and the GMC as regulatory bodies.

2.8. The decision to suspend was in accordance with General Condition (GC) 16 of the NHS Standard Contract under which the service operates. Under this there is the presumption that the provider works with the CCG to remedy the areas of operation that were considered of such a substandard nature, that a suspension of the service was an appropriate and proportionate step. Prior to, and in the period since suspension, the CCG has been meeting with DMC on a weekly basis to go through the remedial action plans that the provider has submitted. These have been targeted to address the areas causing the suspension. The CCG team has remained of the opinion that the service should continue to be suspended. In addition, in early July further evidence of inadequate processes relating to pharmacy management for patients on long term therapy came to the attention of commissioners. In response to this evidence the CCG suspended the service in full on 15 July 2020.

Interim service

2.9. Sussex Community Dermatology Service (SCDS) had an existing contract with Kent and Medway CCG covering west Kent and non-contracted activity with the north Kent locality.

2.10. An emergency short term contract was awarded to SCDS with support from 18 Week Support who specialise in supporting NHS Trusts to clear waiting lists and have capacity to see high volumes of patients in short periods. SCDS have maintained an effective service history in providing dermatology levels 1 to 4, which includes cancer pathways, to patients in west Kent and a proven track record with close links to Queen Victoria Hospital (QVH) plastic surgical unit and Maidstone oncology service. They also hold a lead role in the Kent and Medway specialist skin multidisciplinary team, with one of their consultants as lead for the skin tumour group who works in close partnership with the cancer alliance.

2.11. Introduction of an interim service has required a complete start from the basics including sourcing facilities, equipment and pharmacy support to deliver care with respect to a mobilisation of the contract. In addition care pathways, including

pathology and onward referral to specialist services and oncology pathways have needed to be clinically determined to ensure safety.

2.12. Concerns were also raised in relation to the data held by DMC Healthcare; as such the CCG has commissioned a data validation company to transfer the data to SCDS under the emergency contract. This is a manual process, and cases have been prioritised in relation to the urgency of referrals.

2.13. Since taking over the emergency contract, SCDS have effectively set up community capacity with clinics commencing within 2 weeks of contract award. These are fully consultant led comprising of 4 Consultant Dermatologists, 1 Associate Specialist in Dermatology, 3 Plastic Surgeons, 5 Specialist Nurses, and Healthcare Assistants to cover the north Kent and Medway localities.

2.14. Phase 1 of the mobilisation of service was to ensure all patients requiring urgent or cancer treatments were seen and treated and we now have in place a 2 week-wait service, urgent diagnostics, booked cancer surgery, and one-stop services. This has already stabilised the new patient cancer service and we have clinical availability to see and treat all patients within 3-weeks of referral meeting all cancer targets in a very short time interval. The surgical facilities and equipment are now all in place and have worked effectively to deliver a modern high throughput service.

2.15. All patients that require discussion at a multidisciplinary (MDT) skin specialist forum have all been discussed, with the first clinic taking place on the day of the original suspension to ensure no further delays were encountered for this high risk group. Patients needing clinical surveillance for monitoring of cancer and high risk conditions are actively being booked for scans, ultrasounds and are being managed by the SCDS team. The cancer pathway is clearly defined and is working well between SCDS and QVH clinical consultants across the Kent and Medway area. The cancer service for new and existing active cancer patients is safe clinically.

2.16. More than 80% of the patients being treated for long term conditions with biologic medications have been transferred and are being actively managed by experienced Consultant Dermatologists, all of whom are used to running biologics clinics. The remaining patients are being transferred. The data transfers have been completed in a priority order depending on dates that medication reviews are required.

2.17. The identification of patients unseen and not treated has gradually emerged through analysis of the DMC database. These patients are being transferred onto the SCDS systems, so that patients can be tracked through the system more accurately. This process is nearly complete and there are approximately 3500

follow-up patients and 1800 surgical cancer waits. Access to DMC Healthcare data has proven challenging and medical notes are not readily interpreted with few patient time lines identified to prioritise care.

2.18. The long-term non-urgent follow-up patients will be provided with care in Phase 2 of the mobilisation. At the time of writing this report over 1000 patients have been seen; this includes patients on the urgent lists as well as new patients on a 2 week wait cancer pathway. The trajectory with current clinical capacity is for a further 4084 patients to be seen during August, although this will be adjusted as further clinical capacity becomes available during phase 2 of mobilisation. Clinics are currently being held 7 days a week from the Rochester Healthy Living centre, Rainham Healthy Living centre and Fleet Health campus.

2.19. Due to concerns with DMC data the CCG requested that local GPs go back through their records and re-refer directly to SCDS any patient who was originally referred on a 2 week pathway, urgent or with a potential condition that could deteriorate if left untreated. As a result of this instruction referrals went up by 450% in July compared to referrals in January and although we would expect to see a rise in summer months this is un-proportionate to other areas particularly with Covid influencing patient behaviours: west Kent for example has seen a significant reduction in numbers. All the referrals have been processed, with urgent and cancer pathways treated. The doubling up of patients will cause some interim data issues as we will have patients being moved over from DMC Healthcare to the SCDS database that have already been treated; we will not be able to fully validate this and have a complete 'clean' waiting list until this process has been completed. It is important to note that this will not cause any additional delays to patient care; this is a back office function impact.

2.20. A helpline has been commissioned for patients both current and previously treated by DMC for dermatology conditions. This is being manned by the organisation IC24, Monday to Friday 9.00am to 6.00pm. Call handlers are not clinicians but are following a prepared script in order that the correct disposition can be reached for each patient. Calls in the main are in relation to appointment details. Any calls that relate to potential harm or complaints are being collated by the CCG quality and safety team and investigated in line with CCG policy.

2.21. All patients referred to DMC Healthcare dermatology services that have been waiting for longer than 52 weeks for treatments and those waiting for longer than 104 days for definitive cancer treatments will have a clinical harm review undertaken. All other patients who have been transferred to SCDS for their dermatology assessment and treatment will have a view taken by their treating clinician and those where there is a suspicion that an extended wait may have caused harm will also have a full clinical harm review. The findings of these reviews will be moderated by a panel with agreed terms of reference. DMC

Healthcare patients that fall outside of these categories that are deemed to have come to harm will be escalated through the serious incident reporting process mandated by NHS England Serious Incident Framework (2015). The CCG patient safety team will be collating all the findings of the harm reviews and the serious incidents so that patients learning and recommendations can be identified. These will be reported through the quality safety and safeguarding committee at the CCG. All patients will have a full duty of candour undertaken.

2.22. The CCG is collating complaints and these are being dealt with as per CCG policy. In some cases the complaints are being referred into the harm review process and will therefore follow an alternative timeline for a response.

Future of the Contract

2.23. DMC Healthcare and the CCG have agreed in principle to a mutual termination of the dermatology contract. At the time of writing this report the CCG is unable to comment as to the future of the service but will provide a verbal update at the meeting.

3. Risk management

3.1. The management of risk to patient care and clinical outcomes is detailed in the above report. There are no material risks arising from this report that will impact on the Council's ability to achieve its strategic objectives.

4. Financial implications

4.1 There are no financial implications to Medway Council arising directly from this report.

5. Legal implications

5.1. There are no legal implications to Medway Council arising directly from this report.

6. Recommendations

6.1. The Committee is asked to NOTE the briefing

Lead Officer Contact:

Nikki Teesdale, Assistant Director, Secondary Care
Kent and Medway CCG
Nikkiteesdale@nhs.net

Meeting of the Board of Directors in Public

Thursday, 3rd September 2020

Title of Report	**Medical Appraisal and Revalidation Annual report**	Agenda Item	**5.6**
Report Author	Dr Kirti Mukherjee, Deputy Medical Officer and Deputy Responsible Officer		
Lead Director	Dr David Sulch, Medical Director and Responsible Officer		
Executive Summary	• Medway NHS Foundation Trust has **402** doctors connected as on 31st March 2020. **363(90.2%)** of the Doctors have completed an appraisal for the reporting year. **36(8.9%)** of the Doctors had an approved missed or incomplete appraisal for the reporting year. **3(0.8%)** had unapproved missed appraisals. • For the year ending 31 March 2020, there were **109** doctors due to revalidate. **103** Doctors received a positive recommendation for revalidation, 10 doctors received recommendation for deferral, out of which 5 doctors were revalidated within the mentioned appraisal year (these have been counted in the figure above). The trust made a non-engagement recommendation for 2 doctors, who subsequently engaged. • External Quality Assurance Review of Appraisal Portfolios (conducted by MIAD HealthCare) was commissioned in January 2020 which concluded that the output for the appraisers working with Medway NHS Foundation Trust DB during 2019-20 appraisal year is of a very high and consistent standard. Several recommendations have been made to further improve the quality of appraisals which will be fed back to the doctors and included in the internal quality check.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Committee assurance, please complete the following:		
Committee Approval:	Name of Committee: People Committee Date of approval: Tuesday, 18 August 2020		
Executive Group Approval:	05 August 2020		

National Guidelines compliance:	Regulatory requirements -The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).			
Resource Implications	No new additional resources required.			
Legal Implications/ Regulatory Requirements	The purposes of this report are: • To provide assurance to the Board as part of the Responsible Officer's Regulations. • To seek approval of the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the regulations.			
Quality Impact Assessment	None			
Recommendation/ Actions required				
	Approval ☒	Assurance ☒	Discussion ☐	Noting ☐
Appendices	Appendix 1 – Appraisal and Revalidation Report (NHS England Format) Appendix 2- External Quality Assurance Review of Appraisal Portfolios (conducted by MIAD HealthCare). Appendix 3 – Standard Operational Policy for Managing Late Appraisals			

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
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
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.	

1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2019-20 reporting year. It covers the progress made in implementing medical revalidation and the improvements planned for this year. This report is a required item of assurance, and we are also required to submit a compliance statement, signed off by or on behalf of the Board.

We are able to positively respond to all assurance statements as we are compliant with all regulatory requirements.

2 Background

The GMC's aims for medical revalidation are that it:

1) Is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

2) Supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession.
3) Facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body that monitors and assures their practice. MFT is a Designated Body for 402 doctors and this report is about them. .

3 List of Attached Documents

Appendix 1 – Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2019-20.

Appendix 2- External Quality Assurance Review of Appraisal Portfolios (conducted by MIAD HealthCare).

Appendix 3 – Standard Operational Policy for Managing Late Appraisals

4 Conclusion and Next Steps

Overall, MFT achieved 90.2% appraisal completion for the doctors in spite of Covid-19 outbreak which saw postponement of the appraisals which were due in February/March 2020. A total of 102 doctors were revalidated by GMC during the reporting year.

Appraisals and Revalidation process was on hold from March 2020 but the appraisal and revalidation process has been restarted in June 2020.

General review of last year's actions

Completed Actions:

1) 17 New appraisers trained
2) Yearly update to current appraisers completed.
3) Running sessions for doctors "new to UK" facilitated by GMC Liaison Officer
4) Running regular session for new doctors to further their understanding about the appraisal process.

Actions still outstanding

1) To strengthen information flow about starters and leavers list of doctors.

Current Issues:

1) In spite of tightening the process of information flow from Medical staffing, we are made aware of some doctors later than usual turnaround time of one month.

New Actions:

1) To provide training for new appraisers.
2) Restart Patient feedback process for individual doctors.
3) To develop "help guides" on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.
4) Audit of appraisal output summary and give One to one formative feedback to at least 40% appraisers on their appraiser performance.

Overall conclusion:

a) We have continued to strengthen our appraisal and revalidation process.
b) There is overall good engagement from our doctors.
c) A Commissioned External Quality Assurance Review of Appraisal Portfolios in January 2020 has confirmed that the output for the appraisers working with Medway

NHS Foundation Trust DB during 2019/20 appraisal year is of a very high and consistent standard.

Appendix 1

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors. GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**
  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report
Section 1 – General:

The board / executive management team of **Medway NHS Foundation Trust** can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: No submission

Action from last year: No actions were identified.

Comments:

NHS England did not require submission of AOA for 2019 – 2020 due to Covid-19 pandemic. Medway NHS Foundation Trust has **402** doctors connected as on 31st March 2020.

1. **363(90.2%)** of the Doctors have completed an appraisal for the reporting year.
2. **36(8.9%)** of the Doctors had an approved missed or incomplete appraisal for the reporting year.

2.1. 19 Doctors had approved missed appraisal due to the Covid-19 Pandemic.
2.2. 10 Doctors started working in the trust during January 2020 – March 2020 and were new to UK practice and were not required to complete an appraisal before 31st March 2020.
2.3. 4 Doctors were on maternity leave during this reporting year.
2.4. 1 Doctor was on a career break.
2.5. 1 Doctor was working abroad.
2.6. 1 Doctor's appraisal was delayed due to sickness of appraiser.

3. **3** (0.7%) Doctors have unapproved or missed appraisals

Action for next year: To continue to submit the AOA as per NHS England directive.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Dr Kirti Mukherjee stepped down from the Responsible Officer Role on 30th September 2019. Dr David Sulch was appointed as Responsible Officer with effect from1st October 2019.

Comments: Dr David Sulch meets all the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely he is a medical practitioner and has been continuously registered as medical practitioner for the previous 5 years.

Action for next year: None required.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Appraiser Refresher Training for current appraisers and an Appraiser training session to recruit new appraisers to be arranged.

Comments: Designated body (MFT) provides sufficient funds and resources to carry out RO responsibilities. The Responsible Officer is supported by Deputy Responsible (Deputy Medical Director), a senior medical appraiser and an administrative team. The Trust has an electronic appraisal system in place (L2P).

The appraiser refresher training was arranged via MIAD Health Care on an e-learning platform to be completed by all appraisers at the beginning of 2020.

The trust held an appraiser training session in November 2019 and trained seventeen new appraisers.

Action for next year: Funding will be available to complete a new appraiser training session in November 2020 to replace those who have retired or who wish to step down as an appraiser.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To tighten the process of recruitment to ensure the Revalidation Team is aware of Doctors' employment history in relation to start date and leaving date.

Comments: The Human Resources Department/Medical Staffing provides the Medical Director's office with a weekly list of all new non-training grade doctors, together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC connection list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. Despite the Standard Operating Procedure (SOP) in place for information flow for starter and leavers list, 1% of Doctors slipped through the net, particularly those Doctors that left training grade but continued at MFT on the bank and the doctors that go from a bank posting to a substantive posting or in a training grade post.

Action for next year: The Revalidation team will now receive monthly reports for staff in post, weekly medical induction training report, weekly starters' lists, and also working with temporary staffing to contact doctors leaving the training programme in August 2020, so that Revalidation team can maintain accurate records.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Appraisal and Revalidation of Medical Staff policy to be updated.

Comments: The updated policy was agreed with the Local Negotiation Committee and the updated policy is now in use since January 2020.

Action for next year: None required.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Higher Level Responsible Officer (HLRO) Quality Review (formally Independent Verification Visit) to be planned for 2019-20.

Comments: HLRO Quality review could not be arranged but an External Quality Assurance Review of Appraisal Portfolios was commissioned and review carried out in January 2020 by MIAD Health Care, an independent external company.

30 appraisal folders were quality checked against set criteria for both appraisal input and Appraisal output summary.

The review has confirmed that the output for the appraisers working with Medway NHS Foundation Trust DB during 2019-20 appraisal year is of a very high and consistent standard.

The full report is enclosed as Appendix 2.

Action for next year: Several recommendations were made both for appraisers and appraisees to further improve the quality of appraisals.

Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary by using an appraisal output quality tool. This will be done on 40% of the current appraisers within the trust for 2020-21 year and one to one feedback will be provided on their performance as a Medical Appraiser. The aim will be to give individual feedback to all appraisers over a period of next 2-3 years.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Nil

Comments:

Non-training grade Trust doctors and doctors working on MFT employment bank follow the same process as everyone else - they are expected to undertake an Annual appraisal. All doctors with a prescribed connection to MFT as Designated body are connected on GMC Connect and added to MFT appraisal system L2P.

New doctors are invited to the appraisal training and are sent all the necessary information for them to carry out an appraisal. Regular appraisee training sessions are provided by Deputy Responsible Officer/Senior Appraiser and 1:1 sessions if needed, to all doctors new to UK and any doctor who is new to the appraisal system. Revalidation team also offer all the support needed for completion of appraisals, including facilitating collection of patient and colleague feedback. The Revalidation administrator receives a monthly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role.

For Agency doctors who are connected to their Agency RO - only agencies, where the trust has assurance of appraisal and revalidation processes, are used to source agency locum doctors.

All Doctors are encouraged to attend their own directorate governance meetings with attendance to be recorded within their CPD diaries. All short term placement doctors receive a Study Leave entitlement. All doctors are also encouraged to attend grand rounds, local tutorials/teaching sessions as appropriate.

MFT currently offer in house sessions “Welcome to UK practice” delivered by GMC’s *Regional Liaison Adviser (South East)* for those doctors who are new to UK practice and who did not attend this session during the GMC registration programme.

Action for next year: To develop “help guides” on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor’s whole practice, which takes account of all relevant information relating to the doctor’s fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: None identified.

Comments: All Doctors are required to complete an appraisal every year containing supporting evidence on their full scope of work. If a doctor works outside MFT in any capacity as a medical doctor, the doctor is required to complete an Annual Declaration form duly signed and confirmed by RO/hospital Director from the Private Hospital or other organisations where they practice.

The revalidation manager receives a monthly report from the Governance team from both Planned and Unplanned and Integrated Care Divisions which contains all SIs / complaints logged on Datix in relation to a Doctors practice. The doctor is required to declare all SIs/complaints in their appraisal document with their reflections and learning.

The Revalidation team send out HES data reports taken from Dr Foster to all Doctors, where available, for inclusion in their appraisal supporting documentation.

Action for next year: To continue reviewing the SIs and complaints to ensure relevant complaints / SI are included in appraisals. To continue to send HES data reports, taken from Dr Foster, to relevant Doctors.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Introducing Standard Operating Procedure (SOP) to increase the number of doctors fully completing their appraisal in scheduled month.

Comments: If a doctor does not expect to complete an appraisal during their scheduled appraisal month, a postponement request form is required to be submitted to RO who will agree or disagree with the postponement request.

If a doctor is repeatedly reminded to complete an appraisal and has still not begun to upload evidence or arrange a meeting two weeks after the scheduled appraisal month, a meeting with Responsible Officer is arranged and the reasons for non-completion is discussed along with a date by which appraisal must be completed. Failure to comply after this date will result in a referral for non-engagement being sent to the GMC. In 2019 – 2020, one doctor was referred to the GMC for an early concern of non-engagement, who then complied with completion of appraisal. Two doctors had non-engagement recommendations made to GMC as they were under notice for Revalidation. Both cases have now been resolved and the doctors have engaged in the appraisal process

Action for next year: To continue to monitor timely completion of appraisals. Due to the Covid-19 pandemic, the GMC has postponed all revalidations which were due between March 2020 to March 2021 for further one year from their due date. Revalidation recommendations can still be made if all supporting evidence is available including previous satisfactory appraisals in the last 5 years.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: To update and review the "Appraisal and Revalidation of Medical Staff policy" which was coming to the end of review period.

Comments: The updated policy was agreed with the Local Negotiation Committee and the updated policy is now in place from January 2020.

Action for next year: None identified. None identified.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To provide new appraiser training in the reporting period 2019-2020.

Comments: 17 new appraisers were recruited and given training to act as medical appraisers in November 2019. The Trust had 110 trained appraisers on 31st March 2020.

In 2019 – 2020, a total of 19 appraisers from MFT ceased to be appraisers due to retirement, leaving the trust or stepping down from the role. There is a prediction that similar number of appraisers will be lost in 2020 – 2021. In order to mitigate this, new Appraisers will be continued to be recruited.

Action for next year: To provide New Appraiser Training in November 2020, with an aim to recruit up to 15 new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To provide appraiser refresher training.

Comments: An appraiser e-learning refresher was commissioned from MIAD in February 2020 and appraisers were asked to complete the e-learning.

The majority of appraisers have completed the e-learning and a few were delayed during the Covid-19 pandemic and now in the process of completing the training.

Regular appraisal feedback reports are provided to the individual appraisers, based on the feedback questionnaire completed by each appraisee once the appraisal process is complete,

A help guide sheet has been developed with suggestions as to what kind of supporting evidence appraisers can submit within their own appraisal, for their role as a Medical appraiser under their full scope of practice.

External Quality Assurance Review of Appraisal Portfolios was commissioned and carried out in January 2020 by MIAD Healthcare (Report received in March 2020- see Appendix 2)

Action for next year: Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 40% of appraisers within the trust for the 2020-21 year.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Nil

Comments: All appraisals are checked by the Deputy Responsible Officer/ senior appraiser and a final sign off of appraisals is undertaken once all the required supporting information is checked to be present. If not ready for 'sign off' the appraisals are sent back to the doctor to upload required or missing information.

The yearly appraisal and Revalidation Report is first presented to the Executive Group of the Board and once ratified by the Executive members, the report presented to the Trust Board. This report will also be presented to Peoples' Committee this year before presenting to Trust Board.

Action for next year: To continue presenting yearly report to Board for compliance.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action from last year: None identified.

Comments: For the year ending 31 March 2020, there were 109 doctors due to revalidate. 103 Doctors received a positive recommendation, 10 doctors received a defer recommendation in which 5 were revalidated within the mentioned appraisal year, these have been counted in the figure above. The trust made a non-engagement recommendation for 2 doctors, 1 of these Doctors had also previously been deferred which has been counted in the figures above. Both non-engagement recommendation cases were investigated by the GMC and have now been closed. However, in one case, one Doctor did have the potential to lose their medical licence as decided by the GMC.

Action for next year: To continue with the correct processes in place to support Revalidation Recommendations.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None identified.

Comments: All Doctors are contacted by the Revalidation team four months prior to a submission date to discuss any outstanding areas and the type of recommendation which can be sent. Once a recommendation has been sent to the GMC, confirmation is communicated to the doctor on the day the recommendation is sent. If a non-engagement or deferral recommendation is sent to the GMC, the Doctor is made aware of this and notified as to the reasons of these recommendations. Before any non-engagement recommendation is sent to the GMC, a Standard Operating Procedure is followed (appendix 3).

Action for next year: To continue with the correct processes in place to support Revalidation Recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None identified.

Comments: Assurance and performance in this area are reported through the Quality Assurance Committee to our Trust Board, chaired by Non-executive Director. Key aspects of clinical governance for the RO are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems.

The Revalidation team will continue to work with the Governance teams in the organisation to provide information on complaints, involvement in incidents and similar items for the medical appraisal process.

All Consultants, Specialty Doctors and doctors (not in a formal training programme) are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a regular basis by the Revalidation team to ensure that progress in meeting these deadlines is being maintained.

Action for next year: The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None Identified

Comments: Revalidation Team receives a monthly report, which contains all SI's / complaints logged on Datix in relation to a Doctors practice for both Planned and Unplanned Care Divisions. Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. The team receives regular requests from Private Practices to complete Practicing Privileges references and share relevant information to the RO of the organisation where a doctor works.

Any conduct or capability issues are triangulated from information received from HR processes, complaints/SIs/Never Events and regular weekly meetings of Medical Director with Deputy and Divisional Medical Directors.

All doctors are required to include reports of any SIs/Datix/Complaints in which they were involved during the appraisal year, with appropriate reflections and learning.

All doctors are required to undergo formal Multisource feedback both from Colleagues and Patients once in the 5 yearly revalidation cycle. All doctors are encouraged to share and reflect any compliments received (including thank you cards and feedback received from patient experience team) during every appraisal discussion.

Training grade Doctors have Postgraduate Dean at Health Education Kent, Surrey and Sussex (HEKSS) as their Responsible Officer. While they are working in MFT, the Doctors have regular work placed based assessments by their named Educational and Clinical supervisors and their performance discussed and documented in the quarterly Local Faculty Group and Local Academic Board meetings. Any identified concerns are flagged up to HEKSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at HEKSS.

Action for next year: We will strengthen the process of identifying early conduct and performance issues and monitor regularly in biweekly meeting with HR.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Identified

Comments: The Medical Director / Responsible Officer chairs the Decision Making Group, which meets bi-weekly to review all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the

GMC as required in each case. The Deputy Responsible Officer and a member from HR attend this meeting.

Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified, these are then managed under the appropriate Trust policy.

Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy.

The trust has 18 trained Case Investigators and 8 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed.

All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance.

As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate.

Action for next year: None identified.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Nil

Comments

A senior team including the Medical Director (RO), Deputy Medical Director, Deputy Director of Human Resources and Head of MD services meets on a biweekly basis to review concerns about doctors and decide on appropriate action. Investigations where required, are undertaken under MHPS guidelines, using appropriately trained Case Manager and Case Investigators.

Doctors in training have their RO at the Health Education Kent, Surrey and Sussex (HEKSS) and any concerns are flagged up to RO at HEKSS via Director of Medical Education.

The following table outlines the number and outcome of cases reviewed by the Decision Making Group in the reporting year.

	Figures in brackets are the proportion of the medical workforce (only non-training doctors) as a whole in the protected	White 27%	BAME 73%	Male 70%	Female 30%	TOTAL

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

	characteristic					
Conduct/Capability	Outcome					
4	Reviewed and no case to answer	2	2	3	1	**4**
4	Reviewed and advice given regarding future conduct	3	1	2	2	**4**
2	Formal MHPS investigation carried out leading to agreed Behavioural contract and action plans	0	2	2	0	**2**
5	Referred to GMC, by external organisation/patients	2	3	5	0	**5**
	Figures in brackets are the Proportion within protected characteristic	7 (47%)	8 (53%)	12 (80%)	3 (20%)	15

Action for next year: To continue with the present format.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None identified.

Comments: Upon connecting a Doctor to the designated body, an RO to RO reference request is sent to the previous designated body. Dependent on the information shared, more details may be requested which can result in an RO to RO conversation to elaborate further.

All doctors who work in other places are required yearly to produce a signed form from RO/Hospital Director of the other organisation (s) about their practice and any concerns regarding their practice. This form is uploaded to their medical appraisal every year.

For doctors connected elsewhere but working in MFT fall under two categories:

Training grade doctors who are regularly monitored by their educational supervisors and any concerns raised are dealt with through the Local faculty groups chaired by the specialty College Tutors and the Local Academic Board chaired by the Director of Medical Education and escalated to RO of HEKSS and the RO at MFT is updated immediately for any necessary actions.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Other groups of doctors who may work in MFT could be bank doctors or contracted through agencies and have their own RO. The Revalidation team would contact their designated body if any concern arises.

Action for next year: To continue with the current process set in place.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Comments: All processes for responding to concerns are managed according to our Trust Policy (Disciplinary and Capability Procedures for Medical and Dental Staff) which is consistent with MHPS. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced.

Action for next year: Nil

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None identified.

Comments: All doctors employed by MFT are subject to NHS mandatory recruitment pre-employment checks. To ensure compliance with pre-employment checks, a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.

Action for next year: To continue to monitor compliance.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall, MFT achieved 90.2% appraisal completion for the doctors in spite of Covid-19 outbreak which saw postponement of the appraisals which were due in February/March 2020. A total of 102 doctors were revalidated by GMC during the reporting year.

Appraisals and Revalidation process was on hold from March 2020 but the appraisal and revalidation process has been restarted in June 2020.

General review of last year's actions

- **Completed Actions:**
  - 17 New appraisers trained
  - Yearly update to current appraisers completed.
  - Running sessions for doctors "new to UK" facilitated by GMC Liaison Officer
  - Running regular session for new doctors to further their understanding about the appraisal process.
- **Actions still outstanding**
  - To strengthen information flow about starters and leavers list of doctors.
- **Current Issues:**
  - In spite of tightening the process of information flow from Medical staffing, we are made aware of some doctors later than usual turnaround time of one month.
- **New Actions:**
  - To provide training for new appraisers.
  - Restart Patient feedback process for individual doctors.
  - To develop "help guides" on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.
  - Audit of appraisal output summary and give One to one formative feedback to at least 40% appraisers on their appraiser performance.

Overall conclusion:

- We have continued to strengthen our appraisal and revalidation process.
- There is overall good engagement from our doctors.
- A Commissioned External Quality Assurance Review of Appraisal Portfolios in January 2020 has confirmed that the output for the appraisers working with Medway NHS Foundation Trust DB during 2019-20 appraisal year is of a very high and consistent standard.

Appendix two – External Quality Assurance Review of Appraisal Portfolios

Medway Hospitals Trust report final July

[Please ask the Company Secretary Office to provide the Appendix]

Appendix three – Standard Operational Policy for Managing Late Appraisals

appraisal SOP Dec 2019 FINAL.pdf

[Please ask the Company Secretary Office to provide the Appendix]

Section 7 – Statement of Compliance:

The Board / executive management team of ***Medway NHS Foundation Trust*** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman)

Official name of designated body: **Medway NHS Foundation Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Rare Diseases – An Update**	**Agenda Item**	5.7
Report Author	Dr David Sulch, Medical Director		
Lead Director	Dr David Sulch, Medical Director		
Executive Summary	The Trust Board heard a patient story at the September 2019 meeting from Armaan Jameel and his mother. Armaan told the Board about his experiences living with a rare disease – beta-thalassemia major – and the challenges this posed when he was admitted to Medway NHS Foundation Trust for treatment. The Board asked for more information on how the Trust should approach the process of care for patients with rare diseases and what improvements could be made.		
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		☒
Committee Approval:	This paper is written in response to questions at the Trust Board and has not been considered elsewhere. A more comprehensive discussion regarding the Trust's obligations in this area will be scheduled for the Executive Group.		
National Guidelines compliance:	This paper considers the UK Rare Diseases Strategy (published in 2013) and subsequent related publications.		
Resource Implications	None identified at present		
Legal Implications/Regulatory Requirements	NHS organisations were originally intended to comply with the commitments in the 2013 Rare Diseases Strategy by the end of 2020, but this timeline may have been delayed by the coronavirus pandemic.		
Quality Impact Assessment	A quality impact is proposed for specific actions once these have been defined.		
Recommendation/ Actions required	The Board is asked to note and discuss the paper.		
	Approval ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☒
Appendices	None		

1 Executive Overview

1.1 The Trust Board received a patient story in September 2019 from Armaan Jameel, an 11 year old boy with beta thalassemia major. Armaan spoke eloquently of some of the problems he had faced during episodes of care at Medway. Key among these were a reluctance by junior medical staff to admit a lack of knowledge, a disinclination from the same group to listen to the expert views of Armaan and his family, and some issues with liaison and coordination of care with specialist centres.

1.2 The Board were interested to learn more about the approach at the Trust to rare diseases, and how this related to the agreed national strategy.

2 Rare Diseases – an overview

2.1 The European Union defines a rare disease as one which is life-threatening or chronically debilitating, that affects 50 people or fewer in 100,000 and that requires special, combined efforts to enable patients to be treated effectively. The number of patients affected refers to the prevalence (the number of people living with the condition at any point in time), not the incidence (the number of new diagnoses every year)

2.2 Many rare diseases are much less common than this. Only 60 of the most common rare diseases have a prevalence of as many as 10 cases per 100,000 people: there will be fewer than 50 cases in the population served by Medway NHS Foundation Trust for all other rare diseases.

2.3 However, while the prevalence of an individual disease is small, the prevalence of all rare diseases is not. The current estimate is that approximately 3 million people in the UK are living with a rare disease. Between 4000 and 6000 rare diseases in total have been described in the UK population.

2.4 Rarity depends on geographical location. Beta thalassemia major is a rare condition in the UK: under 1000 patients are currently registered on the National Haemoglobinopathy Registry. However, even within Europe it is much commoner in Mediterranean countries – such as Cyprus and Greece, where the prevalence may be more than ten times greater.

2.5 80% of rare diseases are inherited genetically. Excluding those conditions which are diagnosed at or soon after birth, 50% of rare diseases are diagnosed in childhood.

2.6 37% of rare diseases are compatible with a normal life expectancy. 36% of rare diseases lead to a reduced life span for those who survive to beyond the age of 5. The remaining 27% of rare diseases are lethal before the age of 5.

3 The UK Strategy

3.1 It has long been recognised that people with rare diseases require a focused and individualised approach to their care. The complex nature of many such diseases, the lack of widespread knowledge regarding symptoms and complications, and the paucity of treatment options (only 400 rare diseases have had specific treatments identified as being of benefit) are all key issues to consider.

3.2 As a result the Government published the UK Rare Diseases Strategy in 2013. The strategy discussed a national approach to developing services for patients with rare diseases, and supported the discussion with a series of 51 commitments which were planned to be delivered by the end of 2020.

3.3 The 51 commitments were split into five key categories:

- 3.3.1 making sure patients and their families and carers have the information they need, are listened to and consulted
- 3.3.2 developing better methods of identifying and preventing rare diseases
- 3.3.3 improving diagnosis and earlier intervention for those with a rare disease
- 3.3.4 developing better coordination of care for those with a rare disease, including joined up consultation and treatment schedules

3.3.5 building on research to improve personalised approaches to healthcare for those with a rare disease

3.4 Most of the commitments related to national initiatives around disease registry, the Genome Project and research, along with a process for developing and improving specialist services and patient pathways. There was not a strong focus on the care provided for people with rare diseases within general secondary care services.

3.5 However, a number of key issues do apply to the approach taken at Medway NHS Foundation Trust regarding such patients. I would regard the three most critical areas on which to focus as the following:

3.5.1 Improving awareness of rare diseases and therefore accelerating the recognition of such conditions, facilitating earlier diagnosis

3.5.2 Empowering patients and their families, recognising their status as the true local experts on their condition and ensuring that their views are sought and listened to by all healthcare providers involved in their care

3.5.3 Enhancing communication between the Trust and the relevant specialist care centre to improve the coordination of care and the provision of advice during acute unplanned episodes of care at Medway.

4 The Scale of the Challenge

4.1 It is critical to understand that while many diseases meet the definition of ‘rare’, this does not mean that medical practitioners at the Trust have not heard of them.

4.2 The commonest rare diseases in a pan European study of prevalence are listed below:

Disease name	Estimated prevalence (/100 000)
Brugada syndrome	50
Protoporphyria, erythropoietic	50
Guillain-Barre syndrome	47,5
Melanoma, familial	46,8
Autism, genetic types	45
Tetralogy of Fallot	45
Scleroderma	42
Great vessels transposition	32,5
Focal dystonia	30
Marfan syndrome	30
Non-Hodgkin malignant lymphoma	30
Retinitis pigmentosa	27,5
Gelineau disease	26
Myeloma, multiple	26
Alpha-1 antitrypsin deficiency	25
Diaphragmatic hernia, congenital	25
Juvenile arthritis, idiopathic	25
Neurofibromatosis type 1	25
Oesophageal atresia	25
Polycythemia vera	25
Charcot-Marie-Tooth disease	24
Polycystic kidney disease, recessive type	23
VATER association	23
Coffin-Lowry syndrome	22,5
Rendu-Osler-Weber disease	21,25
Dermatitis herpetiformis	20,2
Atresia of small intestin	20
Duodenal atresia	20
Ehlers-Danlos syndrome, classic type	20
Hirschsprung disease	20
Microdeletion 22q11	20
Spherocytosis hereditary	20

4.3

4.4 These diseases fall into three main categories:

4.4.1 Diseases which although rare are well known by doctors because of their importance in relation to the emergency medical take (such as Guillain Barre syndrome, non-Hodgkin lymphoma and myeloma)

4.4.2 Diseases which are extensively taught at medical school as examples of congenital or developmental disorders (such as Tetralogy of Fallot, transposition of the great vessels and gut atresia)

4.4.3 Diseases which are well known by trainee physicians because of their frequent appearance in postgraduate examinations (such as Charcot Marie Tooth disease, Rendu-Osler-Weber disease, dermatitis herpetiformis and Ehlers Danlos syndrome)

4.5 Many much rarer diseases are also very familiar to medical practitioners. For example, diseases with a prevalence of less than one in 100,000 in the European study include Creuzfeldt Jakob disease, hypokalemic periodic paralysis and Bartter's syndrome.

4.6 Thus while the knowledge base can always be improved, total lack of familiarity or of understanding of these diseases is unlikely to be an issue. Indeed, although beta thalassemia major is very rare in the UK (affecting one in 60,000 people), the principles of the condition are extensively taught in medical courses.

4.7 A more significant issue is the application of knowledge. Two key issues require further attention. Firstly, there is a tendency – observed frequently by the author during his clinical work – for busy and over pressed staff to consider common conditions to the exclusion of alternative diagnoses, despite evidence that may support the alternative. The overdiagnosis of community acquired pneumonia, or of urosepsis in older confused patients is an example.

4.8 Secondly there is also a tendency for some healthcare professionals to assume that their knowledge of certain conditions is always superior to that of the patient or their family, or to not admit to a lack of knowledge about an unusual disease. This is a particular issue when dealing with a rare disease, and was highlighted in the story told by Armaan last September.

4.9 The failure of Trust staff to fully engage with, listen to and empower patients and their families is not an unusual theme in complaints and in clinical incidents. In more general terms it is very commonly a feature of cases which result in legal claims. The approach of Trust staff to patients with rare diseases, if improved can act as an exemplar for the approach to all patients treated by the Trust.

4.10 The issue of coordination of care with specialist centres is one that cannot be solved by the Trust alone. The Rare Diseases Strategy contains a significant range of commitments which were expected to be delivered by specialist units by the end of 2020, but as previously mentioned this is likely to have been delayed by the coronavirus pandemic. It is suggested that the Trust should focus on a small number of pathways initially – perhaps those affecting the greatest number of patients in the Medway and Swale population – and work on improving links with the relevant specialist unit. Initiatives such as shared patient held records and advice lines should be considered as part of this work.

5 Conclusion and Next Steps

5.1 Medway NHS Foundation Trust needs to play its part in delivering the ambitions of the UK Rare Diseases Strategy to benefit the population of Medway and Swale.

5.2 This paper identifies the background to the Strategy, the applications locally and some basic principles that could be addressed in ensuring that people with rare diseases have the best possible experience of care when attending Medway NHS Foundation Trust.

5.3 It is suggested that the Medical Director takes up a further discussion with the clinical leaders, and that a small number of key diseases are identified to develop pilot work aimed at improving the local experience for patients, and the links with specialist units.

6 References

1. The UK Strategy for Rare Diseases 2013 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/260562/UK_Strategy_for_Rare_Diseases.pdf

2. The 51 Commitments from the 2013 Strategy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/285770/rare-disease-commitments.pdf

3. The 2020 Update on progress against the strategy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/867940/dhsc-2020-update-to-the-rare-diseases-implementation-plan-for-england.pdf

4. Rare Diseases in Numbers (European data) https://ec.europa.eu/health/archive/ph_threats/non_com/docs/rdnumbers.pdf

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Medical Education Report**	**Agenda Item**	5.8
Report Author	Ginny Bowbrick, Acting Director of Medical Education Carol Atkins, Head of Medical Education Services		
Lead Director	David Sulch, Medical Director		
Executive Summary	To inform/advise the Board of: 1. The structure of Medical Education 2. Medical Education strategy, with progress against objectives with current opportunities, focus for improvements and potential threats to delivery 3. Medical Education response to and experience of COVID19 4. Update on HEKSS Quality Visit action plans 5. Educational Supervision 6. KMMS progress MFT has one Director of Medical Education supported by one Deputy Director of Medical Education and Medical Education Manager to oversee medical training, with educational leads within different programmes and specialties to oversee delivery. The DME is accountable to the Trust Medical Director and Health Education Kent Surrey Sussex Postgraduate Dean. At present Medical Education is being hampered by the lack of progress over our budget discussions with the Finance Department. Any provision for improvements whether that is related to the Medical Education Centre, teaching or association with KMMS is at present suspended until this can be resolved.		
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		☒
Executive Group Approval:	Date of Approval: Executive Group, 19 August 2020		
National Guidelines compliance:	GMC Promoting Excellence: Standards for Medical Education & Training GMC Generic Professional Capabilities Framework GMC Excellence by Design: Standards for Postgraduate Curricular Gold Guide		

Resource Implications	Risk of loss of funding streams from HE KSS, KMMS and GKT
Legal Implications/Regulatory Requirements	Health Education Kent, Surrey and Sussex, Learning Development Agreement (Contract)
Quality Impact Assessment	Quality and delivery of Education and Training to Medical workforce and through Simulation the wider clinical workforce
Recommendation/ Actions required	The Board is requested to: 1) Be aware of the risks identified within Medical Education: a. Delayed configuration of the Medical Education Centre b. Oversight of budget 2) Receive an update on Medical Education's response to COVID19 3) Receive an update on HEEKSS Quality Visits 4) Receive an update on Educational Supervision in the Trust

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	Appendix 1 – Finance 2020 Appendix 2 – Executive Group 12.12.19 Centre Development Appendix 3 – Business Case Medical Education – April 2019 Appendix 4 – KSS LO Report 2019 – Medway Appendix 5 – Final Report – Medway 06 March 2020 Appendix 6 – GMC Trainer Trust Board Results 2019 Appendix 7 – GMC Outlier by Trust Board 2019

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).

HEE commissions a broad range of education and training services from a variety of Local Education Providers (LEPs, such as MFT) with the expectation of provision of high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust. HEE expects the Trust to support national workforce priorities and those identified locally through HEKSS, and to make investment plans and decisions based on long-term workforce planning using local and national data sources including that currently produced by the Centre for Workforce Intelligence.

The Trusts have a duty to demonstrate that the quality of the education and training that they provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The 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 GMC and the medical Royal Colleges, and the regional systems set out in KSS Graduate Education and Assessment Regulations.

HEKSS expects the quality of training to be maintained and improved in terms of: administrative support for PGME; clinical medical education; programmed activities and local course delivery; provision of library services and resources supporting IT access; provision of simulation facilities; and faculty development.

2. Structure of Medical Education at MFT

Workforce (see Figure 1)

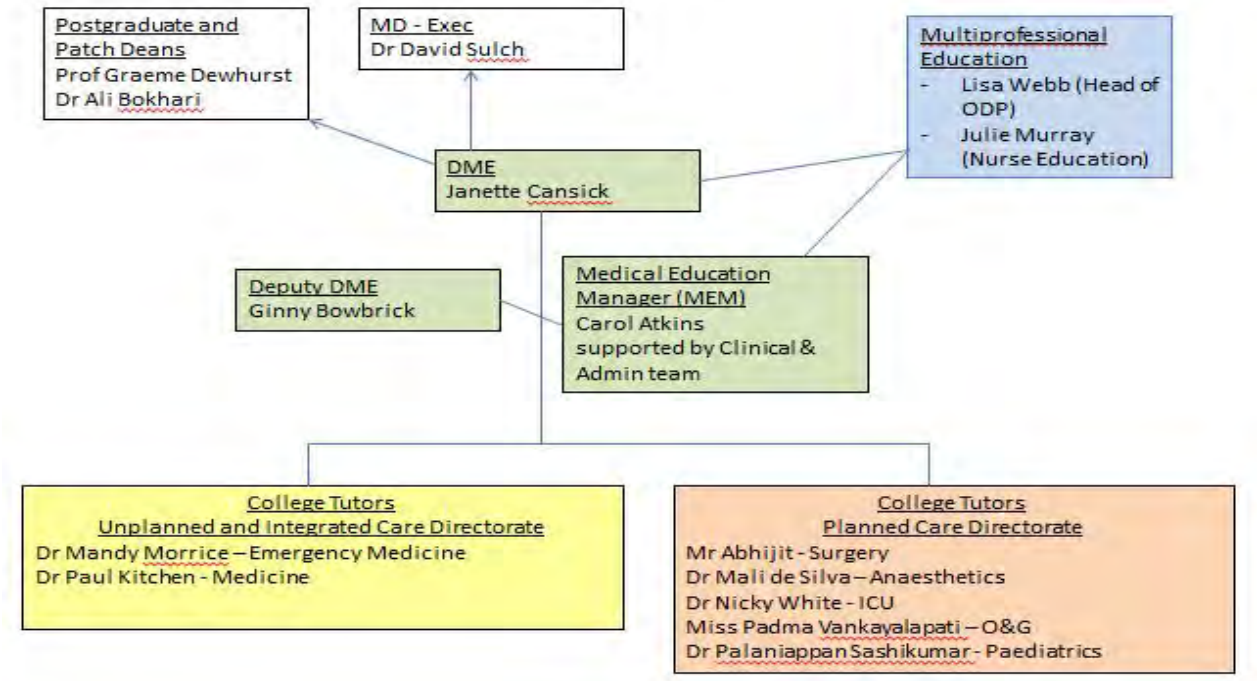
- DME dually accountable in the Trust to Dr David Sulch, Medical Director (MD), and at HEE to Prof. Graeme Dewhurst, Postgraduate Dean. Dr Janette Cansick, DME meets with the MD at the weekly MD Operational Meeting.
- One Deputy DME (Miss Ginny Bowbrick)
- Medical Education Manager (Carol Atkins) is responsible to the DME. The MEM has an operations manager and admin team (including the Undergraduate & Simulation team).
- LFG leads (College Tutors) in all clinical areas, Foundation Training Program Directors, Director of Undergraduate Medical Education (DUME) and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME.
- There are currently 132 Educational Supervisors with HEKSS approval and 4 Clinical Supervisors with local approval.
- In addition the quality of Pharmacy education and training is overseen by the DME.

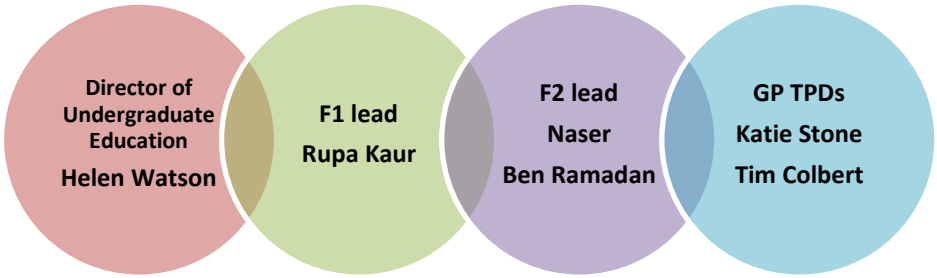
Educational Quality Governance

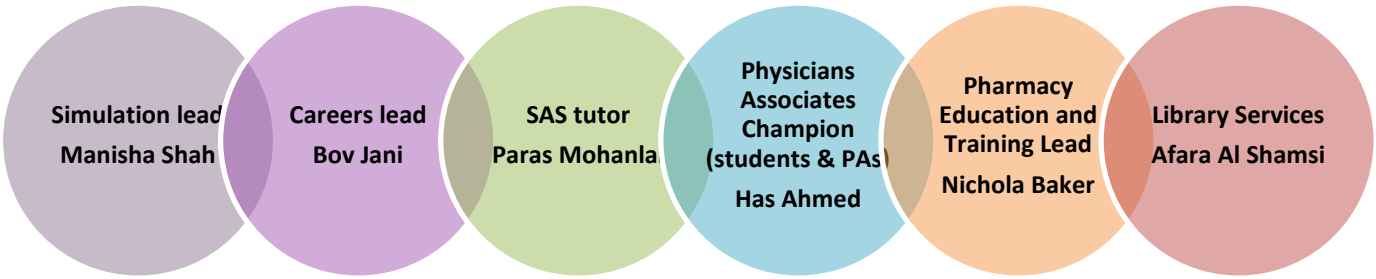
- Trainee Voice
    - Trainee in Action groups in key areas of need (medicine, pharmacy)
    - Reps at LFG and LAB
    - Meetings with DME and MD
    - Junior Doctors' forum (contract issues)

- 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







3. Update on Trainee Establishment

1) Chief Registrar in Medicine – the first appointment was made in October 2018 with a subsequent appointment in 2019. These posts have been very successful in supporting quality improvements in Medicine; of note the current Chief Registrar has had significant involvement in the development of the Hospital at Night and Medical Award Ceremony for Excellence in Training. Unfortunately no appointment has been made for 2020/2021 due to concerns about funding. The current Chief Registrar is fully funded by the Trust and we hope that the Directorate of Unplanned Care will resolve this issue so that a Chief Registrar can be appointed for 2021/2022.

2) Decommissioning of Stroke Services - three geriatric Specialist Registrar posts have been maintained within Frailty with Deanery approval.

3) 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) developed a new curriculum for Internal Medicine (IM) to replace the current Core Medical Training (CMT) programme which commenced in August 2019. As part of this new curriculum the IMTs have to undertake 80 supervised clinics over their three year training. This has proved difficult particularly with the move to virtual/telephone clinics and was discussed with the Patch Dean at the last LAB. It was agreed that the trainees could undertake telephone clinics with their Educational or Clinical Supervisor present using a speaker telephone. However due to the new telephone system this cannot be initiated until the system has been installed and will remain a serious training issue.

5) Rota gaps and recruitment - HEKSS are responsible for the recruitment and allocation to the Trust training posts and programmes. This year we have one vacancy at F1 level with four at F2 and two at GP ST1 levels. This is a significant improvement on previous years.

6) Foundation Priority Programme - Foundation Priority Programmes (FPP) have been developed and initiated in August 2020 to support specific areas of the UK that have historically found it difficult to attract and retain trainees through the foundation and specialty recruitment processes. The main aim is to maximise the opportunity for applicants who wish to be located in less popular areas and therefore improve supply for specialty training and beyond. Every FPP enrolls in a PGCert and remains at the Trust for both Foundation years. At MFT we have welcomed four FPPs this August; two in Education and two in Leadership.

7) Physicians Associates - Two issues need resolution:
   a. Each PA requires an annual appraisal and at present there is nobody identified in Trust to undertake this since the Band 8a PA resigned.
   b. There is MD support to increase the PA workforce but the Directorate budgets needs allocation; at present the Trust is training PA students but is unable to offer them employment after graduation.

4. Finance

Medical Education in MFT oversees the funding and quality for the training programmes and posts in a wide variety of specialties in the Trust and community. The DME carries direct responsibility for the financial management of the tariffs which cover funding for all direct costs involved in delivering medical education and training by the Trust. The funding breakdown for 2019/2020 is attached in Appendix 1.

Management of Finances and Redevelopment of Education Centre:
A proposal was presented at the Meeting of the Executives in December 2019 for the redevelopment of the Education and Research Centre (Appendix 2). A Business Case (Appendix 3) was also submitted to the Executive Group in September 2019 and agreed in principle. Unfortunately there has been no progress in this

direction since this partly due to COVID19 and partly due to ongoing discussions with the Finance department which have stalled.

There has been oversight of the postgraduate and undergraduate budgets with support from the management accountants in finance. However there remains an unresolved issue regarding the use of the Tariff (clinical placement fee). Tariff is paid by HEKSS as payment for the ES's PAs in their job plans and direct teaching time, facilities and provision within the departments and Education Centre. The Finance department is currently not authorising the budget cases as they have not clearly defined the Tariff to be used by us and are instead using it for service provision which we believe to be incorrect. This is a view shared by HEKSS Dean when we discussed this matter with him. Our accounts appear in deficit which has prevented us from proceeding with our Business Case and redevelopment plans.

Non-education HR teams have been re-located out of the Education Centre. We own oversight of the Centre by default although currently do not have access to our budget to make improvements or correctly staff the Centre to manage it. No agreement has been reached of the utilisation of the space as the planned redevelopment cannot advance. This is impacting on the Research and Innovation Team as well as the planned intake of KMMS medical students in 2022.

5. Medical Education response to and experience of COVID

Medical Education was proactive at an early stage in the pandemic as education and training was suspended to support front line care; the team supported the redeployment of trainees across the Trust including the repatriation of trainees from the community back into Trust. We also employed 24 final year medical students from a number of medical schools who were deployed to support the front line. This cohort graduated whilst at MFT and continued to work into July 2020 as interim F1s. 3 PA students were also employed to on B4 fixed term contracts to enable required curriculum clinical hours to be met.

The Simulation department was key to the training response during COVID19 for donning and doffing, patient proning and fit mask testing throughout the Trust.

In June we completed all of the foundation ARCPs which was within the necessary timescale. We have reconfigured the Medical Education Centre to allow for social distancing and have been able to restart teaching for junior doctors face to face and virtually. It is a national priority to restart training and teaching sessions to minimise the long term impact of COVID19 on trainees.

We have just completed the August Induction successfully which was undertaken in a different format with some training face to face and some virtual. This received universal positive feedback and we will be using this format in our next Induction in October although we will be looking to improve our equipment throughout the Centre to facilitate this.

<u>Trainee Survey:</u>

Dr Nik Bhatia (Deputy College Tutor Medicine) undertook a survey of all doctors in training posts (including interim F1s) at MFT in July 2020 requesting qualitative and quantitative data on the COVID19 experience between March and June 2020.

74 responses were received, with the highest number from frontline trainees and psychiatry trainees. Within this cohort 92% had managed patients with COVID19.

Main themes:

a) Anxiety levels were understandably high however improved as the period progressed
b) Stress related to workload was bad at some points however again did improve
c) 23 doctors had developed COVID-19 and 40 responded they had not
d) Doctors had been made anxious by issues relating to PPE, fear of dying, BAME risk, and uncertainty of

when to escalate to HDU

e) COVID-19 affected practice with changes to rotas, increased weekend working, PPE and cancelled rotations
f) Confidence and skills increased for Foundation doctors working in Respiratory and ICU and there was support and guidance from Educational Supervisors. Learning took place and 18% felt it did not affect their training.
g) Some trainees felt they were there only for service provision and they were unhappy with missed rotations and lack of teaching
h) 62 trainees felt there was good support in ICU, Anaesthetics, Respiratory and ED
i) However, more guidance was needed with regard to PPE. Fit mask testing issues had caused anxiety.
j) Belittling – doctors who made a decision early to wear face masks felt the culture was against this practice and a DATIX was even raised at one stage
k) Doctors would like more engagement in changes of ward and additional work payments were not clear. More swabbing of staff.
l) The issue of infection control was raised and the fact there was a definite lack of presence on the wards from the Infection Control Team.

Positive responses included:

a) Staffing levels were good
b) There were daily updates and communication was good.
c) Exceptional support from ICU and Anaesthetics
d) PPE provision was better than in other Trusts.

This survey was discussed at LAB in July 2020 at which the Medical Director was present. This has given the Trust an insight into improvements to consider in a potential second wave particularly with regards to escalation policy, swabbing and PPE.

The trainees should be commended for their flexibility and calm whilst working during difficult times.

6. GMC National Trainee Survey 2019

The 2020 survey is currently still open but is in a different format this year and is not mandatory. The Trust received HEKSS Local Office Report from the Quality Department last August for the 2019 GMC survey (see Appendix 4).

In 2019 the Trust received five Patient Safety concerns. These were related to staffing levels, rota gaps and lack of rest facilities at the hospital. Since the report was published the Trust was awarded £30000 by the British Medical Association as part of a national initiative to establish rest facilities for trainees and two rest rooms were completed in March 2020.

There was one reported Undermining and Bullying concern. This was related to a surgical trainee's experience in the Emergency Department of inappropriate referrals. The report was investigated but could not be substantiated due to lack of information from the respondent. However no concerns have been raised before either through the GMC survey or Surgery LFG and the trainees have been asked to raise any concerns if this occurs in the future.

<u>Overall satisfaction:</u>
Overall satisfaction in 2019 improved from 2018 (77.09 from 75.64).

Green flags in specialties were seen in workload in Haematology and Urology, clinical supervision out of hours in Neonatology and feedback in Anaesthetics.

Sadly we saw an increase in the number of red and pink flags across the survey in 2019 compared to 2018; notably in Gastroenterology and Geriatrics which triggered a Quality Visit on 6 March 2020 by the Deanery.

Across the specialties there were a large number of red and pink flags for reporting systems and teamwork.

7. Quality Visits

Gastroenterology, Geriatrics and Core Medical Training:
Following the 2019 GMC survey, there was a Risk Based Review by HEKSS to Gastroenterology, Geriatrics and Core Medical training on 6 March 2020 (Appendix 5)

The review team noted several areas that were working well including induction, simulation, access to endoscopy and ward experience.

Areas of concern included unsupervised clinics and opportunities to attend clinic, Emergency Department triage, lack of support from the on call consultant, staffing levels, workload on call, departmental training sessions and implementation of Hospital at Night.

The Deanery required that unsupervised registrar clinics ceased as an immediate mandatory requirement and this was actioned. The formal response to the outstanding concerns is required by 30th September 2020 and is being actioned by the Deputy DME and Medicine College Tutor.

8. Educational Supervision

The GMC defines an Educational Supervisor (ES) as "a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a clinical training placement or series of placements."

The ES is responsible for:

1) Ensuring safe and effective patient care through training
2) Establishing and maintaining an environment for learning
3) Teaching and facilitating learning
4) Enhancing learning through assessment
5) Supporting and monitoring educational progress
6) Guiding personal and professional development
7) Continuing professional development as an educator

The GMC publishes information about trainers on the medical register, including doctors who have been recognised as a named postgraduate educational supervisor or named postgraduate clinical supervisor. Doctors who hold either of these roles have a note on the medical register entry to say, "This doctor is a trainer recognised by the GMC".

Each trainer is expected to undergo an initial training course with three yearly refresher courses, undertake Education CPD, complete an Education section in their annual appraisal and attend or participate in LFGs. In return they receive 0.25 PA per trainee to a maximum of four trainees per ES in their job plan.

Experience of MFT Trainees and Supervision levels:
At MFT we have 132 ESs. We report to the GMC annually in regards to numbers of ES's, their training and appraisal from the database we hold. Without our recommendation the ES would have their trainer citation removed from the GMC register to no longer be recognised as a trainer and could no longer act as an ES.

GMC Trainer Survey 2019 (Appendix 6):

MFT had a response rate from 39% of trainers with overall satisfaction of 75.29. Support for trainers was at 73.17 and time for training at 68.59. There were no red or pink flags on the overall ratings with one green flag for curriculum coverage.

GMC Trainee Survey 2012 - 2019 (Appendix 7):

The results for Educational Supervision in 2019 was 85.17, in 2018 83.86 and in 2017 86.08. Looking back to 2012 this has been consistent with no red or pink flags.

Therefore we can see from the GMC trainer and trainee surveys that the experience at MFT for Educational Supervision is satisfactory. Our goal should be to improve these scores to achieve light green or green flags. In respect to trainers there is always the issue of service commitment competing with finding time to train. In Medical Education we have pushed to ensure that all ES's have 0.25 PA in their job plan for each trainee that they supervise. In addition we support our ES's with their CPD by running internal workshops covering a range of educational topics which are well subscribed and consistently receive positive feedback.

Overall we have an enthusiastic group of ES's who are compliant with their CPD with many attending regional or national committees and National Selection/Recruitment for specialties. The Trust should be commended on its willingness to release trainers to participate in these activities. If the time or ability of ES's to train and supervise is improved then the trainee experience will inherently also improve.

ES's are also required for medical students, PA students and CTFs within the Trust and consultant job plans should also reflect this. The planned increase in numbers of medical students at MFT will therefore also require an increase in ES numbers which is being reviewed by the DUME.

9. Kent & Medway Medical School

KMMS are due to take their first intake of 100 students in September 2020 but it is unclear as to whether the curriculum will be delivered face to face or virtually at present. MFT is due to take KMMS medical students from 2022. The tariff for these students will commence in September 2022 with no priming.

The Medical School is asking us to commit to the number of students we can take via a survey. Also in the questionnaire, we have to provide information on accommodation, Medical Centre facilities, Simulation and skills, number of consultants who have teaching PAs and the number of ES's. Miss Helen Watson (DUME) is assessing our flexibility and what we can provide for approximately 20-25 students per year with the anticipation of eventually accepting a total of 60-75 students across years 3, 4 and 5. We need to review what they will be studying in these years whilst ensuring we do not compromise the quality of education provided for GKT students.

The deadline for providing this information is the end of August 2020.

Appendix 1 - Funding Streams

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 2019/2020	**£1,057,198**

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	**£3,355,913**
Tariff (Clinical placement fee)	**£1,985,570**
Single Employer Contract provides funding for GPST3 trainees, and out of hospital placements, including admin.	**£2,002,070**
Study Leave payments	**£134,262**
Specialty Training Programme Directors & Foundation Training Programme Directors and Administration support – calculated on 84 foundation doctors in trust.	**£70,400**
Other Education and Training (to include admin support for DME, CTs.) + Direct Allocations	**£36,000**
Project and SuppoRTT Champions	**£75,000**
SAS funding	**£17,879**
Less Than Full Time trainees attract additional payment when in slot shares (variable)	**£25,377**
Total funding streams relating to Medical Education	**£6,774,099**

Appendix 2 - Meeting of the Execs
Thursday, 12 December 2019

Title of Report	**Redevelopment of Education and Research Centre**	Agenda Item	X
Lead Director	Dr David Sulch, Medical Director		
Report Author	Dr Janette Cansick, Director of Medical Education Miss Helen Watson, Director of Undergraduate Medical Education Carol Atkins, Head of Medical Education Services Edyta McCallum, Head of Research and Innovation		
Executive Summary	The current Education centre is inadequate to meet the current Education and Training needs of the Trust. It is an LDA requirement to maintain adequate centre for medical education. Development is required to cater for KMMS students arriving in Trust September 2022. Furthermore colocation of Education and Research is required for establishing academic centre fit for proposed University Status Health Education, Kent Surrey & Sussex (HEKSS) are commissioners of education and provide clear funding steams in excess of £10M to MFT (tariffs per student, trainee and training) through the Learning Development Agreement (LDA). There are also separate funding streams for the General Practice medical education support and HEKSS projects within quarterly payments to Trust. Currently the Medical Education team underspends budget. In addition, there are Undergraduate monies to ensure training facilities for Kings medical students. The Trust prides itself on being research active and innovative and the proposal offers opportunity to realise the vision and support long term strategy. This paper outlines the current situation, progress and challenges relating to the Education centre, and outlines proposals to design and develop a new Education and Research Centre		
Committees or Groups at which the paper has been submitted	KMMS Steering group - core group extraordinary meeting		
Resource Implications	• External funding (Dinwoodie, other) • Trust capital investment. • Funding investment by the Clinical Research Network Kent Surrey and Sussex (CRN KSS). • Commercial research income.		

Legal Implications/ Regulatory Requirements	The Learning Development Agreement (LDA) between the Trust and Health Education England Kent, Surrey & Sussex (HEKSS) requires the Trust to "make available appropriate access to premises and facilities to support learners" and that education and training "will have priority in the use of those facilities". The General Medical Council (GMC) regulates the training posts through HEKSS and this LDA contract. Potential breach of contractual agreement with the National Institute for Health Research (NIHR), signed by the Trust CEO. The contract specifies that the subcontractor (the Trust) will ensure facilities, materials and Health and Safety at Work etc. Act 1974 are satisfied to carry out agreed Work Programme.
Quality Impact Assessment	University status application Kent and Medway Medical School (KMMS) GKT – Kings medical school LDA with HEKSS GMC National Institute for Health Research (NIHR) Clinical Research Network Kent Surrey & Sussex (CRN KSS)
Recommendation/ Actions required	The Committee is asked to support and approve the process of Education and Research Centre rebuild by: 1. Approval for new room booking system 2. Trust commitment to prioritise this project 3. Decide which option to proceed on 4. Approve proceeding to next stage with architect 5. Approve appointment of fixed term project manager 6. Agree to receive regular updates at Board bimonthly.

Approval	Assurance	Discussion	Noting
☒	☒	☒	☐

Appendices	

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

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

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

Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.

Executive Overview

1.1 Introduction

1.1.1 The training rooms available in the Education Centre are insufficient in size and number to meet the demands of the current Trust multi-professional Education and Training (E&T) needs. Furthermore, there is increasing demand for use of rooms for non-training purposes.

1.1.2 Room bookings are often taken several months in advance, and results in changes and cancellations when rooms are required for E&T. A new booking system is required.

1.1.3 It is already agreed that Medical Education will run Education centre once HR has moved in January. Education Centre manager on business case, already approved by Execs and awaiting finance committee sign off.

1.1.4 The Trust has requirement from Health Education England Kent, Surrey & Sussex (HEKSS) through the Learning Development Agreement (LDA)

- to "make available appropriate access to premises and facilities to support learners"
- to ensure that education and training "will have priority in the use of those facilities".

1.1.5 Research and Innovation Department are currently housed in inadequate premises.

1.1.6 Clinical Research Network Kent Surrey and Sussex (CRN KSS) asked the Trust to host the Network. It is a privilege and exceptional reputation and income opportunity (the CRN KSS wishes to cover hosting fees).

1.1.7 It is logical to co-locate Education and Research

1.1.8 Further expansion is required to accommodate additional KMMS students from September 2022 (additional 75 medical students – 25 in each of 3 year groups)

1.1.9 The current build is not of quality fit for University status

1.1.10 The Faculty of Education (medical education, nurse education, OPD) with R&I meet as KMMS steering group monthly. Finance and Estates join alternate months.

1.2 Aim

The aim is to design, refurbish and build a joint Education and Research Centre to provide up to date facilities fit for a Trust of University Status, with timescale for completion for first KMMS students arriving September 2022.

1.3 Purpose of Paper

To inform Execs of the

- Current plans for Education Centre refurbishment and use
- Current plans for Education Centre management

- Plans for future development, with identification of different possibilities
- Proposed funding sources
- The urgency of decisions given timescale for probable building works

1.4 Current Centre and Management

1.4.1 Vacation of Education centre by HR

- Gundolf ward to be refurbished to accommodate all of HR faculties except OPD (plan January 2020) (Estates monies)
- HR to move to Gundolf ward (January 2020)

1.4.2 Decoration and IT infrastructure to support R&I to relocate – to be co-located with OPD (from January 2020) (Estates monies)

1.4.3 Booking system to be in place (Medical Education monies)

1.4.4 Education centre manager – awaiting business case from Medical Education to be approved (Medical Education monies)

1.4.5 Oversight of room bookings by Faculty of Education

1.5 Design and rebuild of Education and Research Centre – progress to date

1.5.1 Medical education and KMMS Steering group have had provisional meetings with Director of Estates and Architect to provide headlines and estimates of rebuild

1.5.2 Identification of space requirements for each of the services to be housed in Education and Research Centre: R&I; OPD; Nurse Education; Medical Education (postgraduate and undergraduate); Simulation.

1.5.3 Initial conversation with Director of Transformation to support in recruitment of Project Manager

1.5.4 Scoping of funding possibilities

- Dinwoodie Trust
- Trust capital investment
- Funding investment by the Clinical Research Network Kent Surrey and Sussex (CRN KSS).
- Commercial research income.

1.5.5 Major project to take this forward …..

1.6 **Timeline** up to deadline of September 2022 (KMMS students arrive) puts us already out of schedule (timescales as outlined by Estates)

1.7 SWOT Analysis

1.7.1 Successes

- CEO and Directors – Estates, Transformation, Medical - broadly in agreement with the vision for Education and Research Centre
- Clear focus from both Education and Research teams
- Collaborative working of Faculty of Education and Research
- Strong KMMS-Trust working relationships

  - Trust appointments to KMMS leadership team.

  - Medical Education staffs are taking part in the Multiple Mini Interviews process for the intake of students.
- Head of R&I is in discussion with local NHS partners in creating a Joint Research Office for Kent & Medway (first workshop planned on 11th February 2020).

1.7.2 Weaknesses

- Delays in refurbishment of Gundolf ward
- Difficulties in communication across many services
- Current oversight by KMMS steering group where expertise of such a project does not currently exist
- Needs clear ownership by Executive team
- Requires experienced project manager with designated time and responsibilities to coordinate and be accountable on timings
- Proposed plan needs agreement with sign off on design
- Applications for funding need design agreement
- No estate proposal outlined to the CRN KSS.

1.7.3 Opportunities

- CEO and Chair support, along with Executive Board
- Trust reputation for Education and Research
- Excellence in E&T with consequent improved patient safety
- Experience of students and staff
- Retention of staff
- Exemplary cohesive working pathways
- Alignment of Education and Research departments with new proposal for Innovation Hub / Institute.
- Commercial income
- Research funding

- CRN KSS investment
- Career development opportunities
- Quality Improvement through research and innovation
- Links with the academia
- Positive regulatory inspections (CQC, MHRA, HEE etc.)

1.7.4 **Threats**

- Needs close working of stakeholders at all levels in Trust
- Loss of Trust reputation as good educator – HEE, GMC
- Loss of Trust reputation to be available to provide good quality of research

1.8 Proposals for New Education and Research Centre

1.8.1 Do nothing

- This is not viable in terms of size and facilities
- This does not account for Research activity being accommodated
- This does not meet need for expansion for training of KMMS students

1.8.2 Refurbish existing premises

- This will upgrade existing facilities but will not provide expansion needed as described in 1.8.1

1.8.3 Education Centre only

- With HR moving, refurbishing existing facilities would enable enough space for E&T activities (but very costly – see below)
- BUT no other Trust activity would be able to be accommodated
- BUT R&I department currently in condemned accommodation and would need alternative site

1.8.4 Extend and update current premises

- This is the most expensive option
- The current “Nurse Education” centre has a significant backlog of work needing to be done

1.8.5 New build on current “Nurse Education” site, New Build Element – 1512m² @ 3k – 3.5k per m²

- This would cost £4,920,500

1.8.6 Refurbishment of existing Education centre – 2815m² @ 2k – 2.5k per m²

- £6,333,750

BUSINESS CASE PROCESS

Summary Business Case - APPENDIX 3

Title:	Medway Postgraduate and Undergraduate Education Delivery		
Division:	Medical Director's	**Speciality:**	Medical Education
Author:	Carol Atkins	**Contact Number:**	Ext 8252

Key issue to be addressed: (*Please outline the main reason for the development of this business case proposal*)

A Business Case for workforce restructuring to provide service delivery

Health Education, Kent Surrey & Sussex (HEKSS) are commissioners of education and provide clear funding steams in excess of £10M to MFT (tariffs per student, trainee and training) through the Learning Development Agreement (LDA). There are also separate funding streams for the General Practice medical education support and HEKSS projects within quarterly payments to Trust.

1. The medical education department is going to accept management responsibility of the education centre, currently managed by HR workforce. This additional responsibility cannot be accommodated within the current medical education department workforce structure.

2. Currently MFT hosts 44 Kings medical student placements during the year. This involves 4th and 5th years rotating through MFT specialties on 6 to 12 week programmes to include inductions at every stage. With the implementation of the new Kent & Medway Medical School (KMMS), a further 75 medical student placements are expected at MFT by 2025. Workforce planning has already begun for the first cohort (25 students) in 2022 and this has impacted on the current undergraduate workforce structure.

3. The current Simulation resources will need to increase considerably to accommodate the extra training requirements from internal and external factors. This includes continuing to support the recruitment of overseas nurses with induction and clinical upskilling, which is unstainable in its current form. Also, the additional KMMS placements will more than double the current Simulation service requirements.

Brief outline of proposal:

To meet the demands of all the increased activity from internal and external stakeholders, there are now significant gaps in workforce which needs to be addressed. The current service structure needs to be redesigned by adding additional posts and uplifting current banding of posts to implement the proposed changes.

The additional medical student placements and increased Simulation training activity will

support MFTs application for University Trust status.

With the requested additional resources in regard to the reassignment of the centre management, this will enable the medical education department to deliver a high quality service to the Trust and our external partners. This will enhance reputation and attract high quality doctors and allied health professionals.

Please outline the Impact of not developing this case: *(Do nothing option)*

If the proposed restructure is not approved then there is a significant risk to future income from HEKSS and damage to organisational reputation.

Outline project timescales: *(Please give planned dates for case approval, build competition, appointment to posts, case completion etc.)*

The Centre management was scheduled for April 2019.
The Simulation activity has been scoped and planned for April 2019 start. HEKSS funding is in place for agreed delivery of courses.
The work has already began for the new medical school with various team members attending working groups/meeting and external events. The new post for the undergraduate team is required immediately so that the current workload/funding stream is not diluted or lost.

Expected source and value of required funding:	***Refer Financial Proforma Working Paper A1(Section 8 below)*** ***HEKSS Tariff*** ***Trust Investment***	**Estimated Activity p.a.:**	***Refer Financial Proforma Working Paper A2***
Estimated Income p.a.:	***Refer Financial Proforma Working Paper A2***	**Estimated Cost Savings p.a.:**	***Refer Financial Proforma Working Paper A3***

Please detail any accommodation or equipment requirements: *(Please include estimated cost, useful economic life and what it replaces where appropriate)*

N/A

Please detail any other cost implications:

Refer Financial Proforma Working Paper A1and provide a summary here

Please Describe any Changes to Existing Resources :*(For example reduction in existing staff, changes to clinical times/activity, change in use of existing clinical space/equipment, etc.)*

Refer Financial Proforma Working Paper A1and provide a summary here

The LDA funding streams are secured with further opportunities to secure additional funding for projects throughout the year – see Q5 payment 2018/2019 as evidence. We do, however, have to be able to deliver on these projects for HEKSS.

There is £65,723 uplift on **Total Medical Payments** due to the tariff transition deductions and with the changes to the HEKSS study leave budget, this has given our service a real opportunity to evolve what we offer to our students, trainees and trust staff. We have secured over £51,000 of funding for courses that will be delivered through the 2019 academic year.

The Undergraduate tariff income has still not been completely utilised for current workflow.

Table 1 below shows the level of investment for the new posts and uplifts (all have been costed at top of scales with 20% on costs, this is a 3-5 year investment plan) to meet the current and future needs of the service.

Table 1

Funding Income	2019/2020	Changes	Cost
LDA	£6,460,169	**Undergraduate** Uplift from B5 – B6 New Band 4 (WTE 1.0)	 £8,555 £28,513
		Simulation 1 x New Post B6 (WTE 0.6) 1 x Extra hours B6 (WTE 0.2) Uplift from B3 – B4	 £26,800 £17,866 £3,559
		Postgraduate Uplift from B6 – B7 Uplift from B4 – B5 Uplift from B2 – B3	 £7,859 £7,599 £2,130
		Centre Management & Medical Education Admin Support New Post B5 (WTE 1.0) 2 x New Posts B2 (WTE 1.0)	 £36,112 £45,648
		Totals	**£184,641**

Establishment

The Director of Medical Education (DME) and deputy (funded separately from tariff – see LDA Q1, point 7) oversee the teams and work streams below with supporting tutors/leads and Clinical Education Supervisors. The Medical Education Manager (MEM) Band 8a (with the DME) looks after the strategic, financial and quality reviews and represents the Trust to HEKSS for the reporting and governance systems (MEM funding comes out of tariff).

For establishment purposes – the roles have been defined as below, however from 2018 the teams have been cross working and supporting each other with the varying work streams/projects.

Simulation Team

Multi-professional education and training – this small team drives forward the Trust strategy and the LDA remit for mandatory simulation and clinical skills training.

Current posts –
Clinical Simulation Operational Manager, B7, Full-time.

Band 6 (currently WTE 0.4 – requesting an additional 0.2 WTE) – Clinical skills trainer **rebranded to Clinical Simulation and Skills' Practitioner.**

New Band 6 (WTE 0.6) – Clinical Simulation and Skills' Practitioner. This new role with the current member of staff will be required to work with the Simulation Operational Manager to devise, develop and deliver a simulation based education and clinical skills programme for all clinical years now and in the future (with KMMS) at MFT.

Band 3 uplift to Band 4 Technician - required to lead in the technical equipment within the depts. This post is now called upon to cover IT filming service, management of expensive manikins and with the new design of the centre, more technical equipment will need to be brought under the direction of this role. This role is a valued member of the current faculty for all training/recruitment events.

New Band 2 (Education Centre) to support – see below

Undergraduate Team

44 Kings medical student placements with group changeovers every 5/6 weeks throughout the academic year and additional transitional Foundation placements in May/June.

Band 5 uplift to Band 6 Undergraduate Manager - the current Band 5 is an administration post (0.8 WTE). This post will change in reporting structure and directly report to the Strategic MEM. They will lead on the new processes ready to receive the new students in MFT from Kent & Medway medical school (2019). They will line manage the new B4 post below, train, develop and support this post with some of the current Kings medical students.

New Band 4 (WTE 1.0)

This post would be able to income generate with the elective programme of overseas students, therefore covering the cost of the post.

New Band 2 (Education Centre) to support basic admin – see below

Postgraduate Team

228 HEKSS/GMC approved posts for training. The team oversee the quality and management of these training posts and associated education programmes for the trainees to progress to the Annual Review Competence Progression (ARCPs).

Band 6 uplift to B7 (1.0 WTE) – **Medical Education Manager Operational** – This post manages the day to day work streams, oversees the running of the education programmes, Education and Clinical Supervisors, medicine programmes and Regional programmes. This post deputises at meetings for the Strategic MEM. This post will now oversee the running of the Education Centre functions and directly line manages the new Centre Manager post.

Band 5 (1.0 WTE), Medical Education Faculty Registrar (education governance), LAB, LFGs and projects.

Band 4 uplift to Band 5 (1.0 WTE) – Foundation Programme Manager. This post will take full responsibility for all Foundation programmes (years 1 & 2) work streams. Currently the workload is shared with the faculty B5 post; however this is unsustainable as HEKSS are devolving foundation responsibilities.

Band 4 (1.0 WTE) – All Medicine programmes, EM, Pharmacy LFGs, TiAs and general postgraduate work streams.

Band 4 (1.0 WTE) (Job share) – General practice work stream, funded separate to tariff (invoice raised to HEKSS) (0.6 WTE) - (0.2 WTE), LDA tariff – Inductions, Physicians Associates.

Band 2 uplift to Band 3 (1.0 WTE) – this post will be responsible for implementing the new study leave process. This work stream has now been completely devolved to the Trusts from HEKSS and monthly reporting is essentially to gain the income back to Trust. This post will form part of the Education Centre Team.

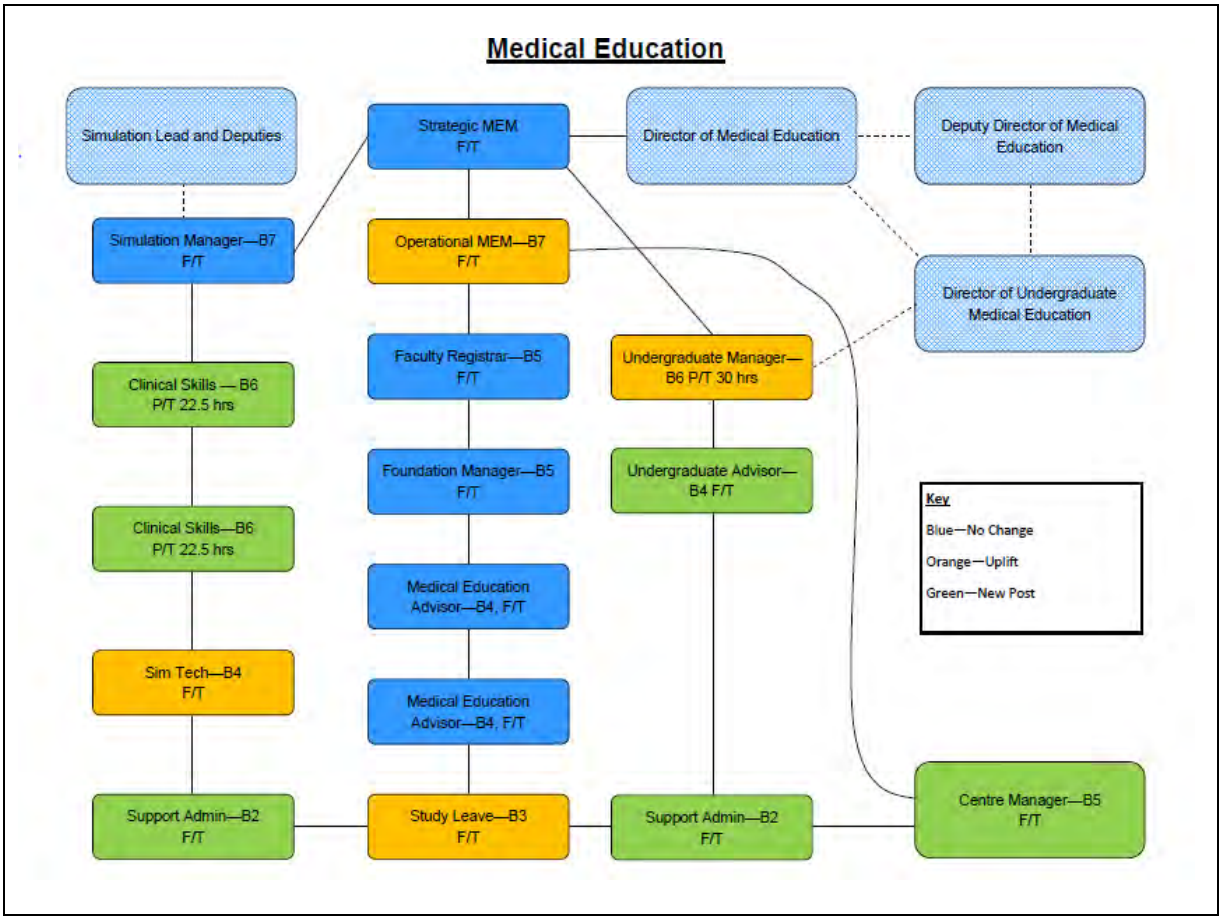
Education Centre Team

New Post Band 5 - Centre Manager (1.0 WTE) – This new post is an events management post and will ensure that plans are in place to make sure that the facilities in the Education Centre are developed. They will be responsible for all the functions that take place in the and look at the future direction of the facilities to support these events.

2 x New Posts Band 2 (2 x 1.0 WTE) – These two new posts will primarily support the education centre functions. They will take their administration duties from the above teams.

To summarise, I am requesting **£184,641** of the medical education tariff to support the development of the Education Centre and the growth in medical education services. This restructure of the service into teams will enable the smooth running of current work flow and help establish resources for the new work streams coming from trust (Centre management), the new KMMS and HEKSS.

BUSINESS CASE PROCESS



Please Detail any Impact on Other Departments or Directorates:
Medical Education is delivered across the trust in a variety of settings.

Please Give a Brief Outline of the Implementation Plan:
As above

Please Give a Brief Outline of the Key Benefits and Risks:	
Benefits • Improvement in the delivery of medical education and training opportunities • Establishment of fully functional education centre with opportunities for income generation • Development of an effective service • Support for clinical and international nurse/medical education/workforce	**Risks** • Study leave funds • More Quality visits • Loss of trainees • Cohesive programmes

plan • Restructure providing more effective use of existing resources • Improvement in Governance and Quality objectives • Extra funded projects awarded from HEKSS	

Does it meet Divisional Objectives and Priorities	Yes
Is it within the Division Business Plan?	Yes
Does the proposal resolve an issue identified within the Risk Register?	No
If yes is the risk identified in both the Trust and Divisional Annual Plan?	Yes/ No
Is the primary concern for the case to improve Patient Safety?	Yes
Is the primary concern for the case to improve Staff Safety?	Yes
Is the primary concern of the case to meet NHS set national quality targets?	Yes
Does the case address issues to maintain or ensure accreditation?	Yes
Does the case identify a more efficient method of service delivery?	Yes
Does the case contribute to the Division improvement programme?	Yes
Can the level of activity provided in the last 12 Months continue to be provided with or without this case being approved?	No
Is this case required to meet increased capacity requirements or demand growth?	Yes
Does the case involve the repatriation of activity from other providers?	No
If so has this been agreed and formally confirmed by the commissioner	Yes/ No
Does this case represent an agreed service development to be offered by the Trust?	Yes
Have all potentially affected Support Services (Clinical & Non-Clinical) been consulted and have the forecast impacts been formally recognised and agreed	Yes / No
Is this case related to a service change or investment requested by the commissioner?	Yes/ No
Has an existing divisional budget been identified in order to fund the required investment?	Yes/ No

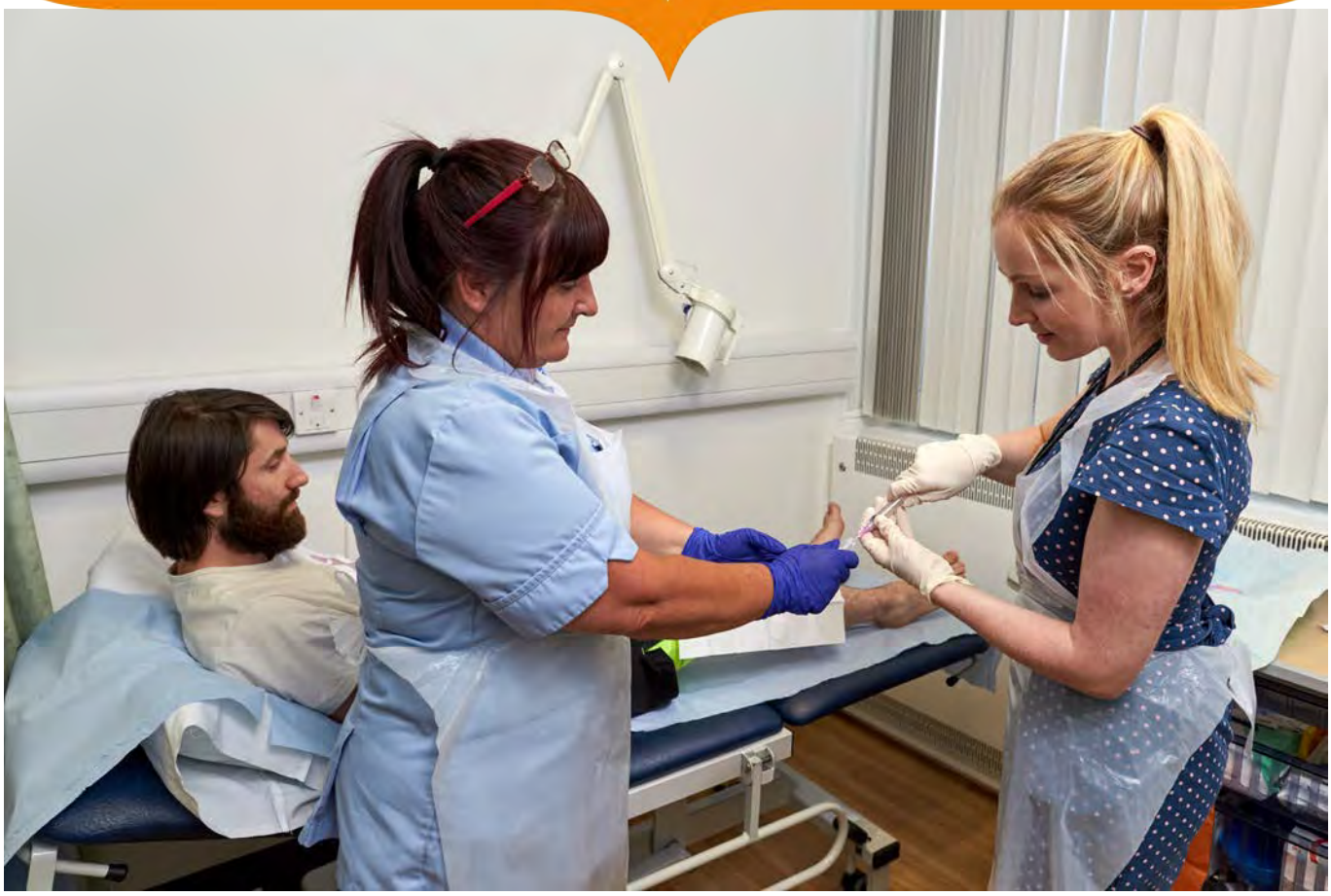
Certification, Clinical aspects reviewed
Certified Name Position

BUSINESS CASE PROCESS

Certification, Financial and Workforce resource requirements reviewed	
Finance Certified Name Position	**Human Resources** Certified Name Position

NHS
Health Education England

Kent, Surrey and Sussex Local Office Report



Medway NHS Foundation Trust 2019

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Contents

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Executive Summary

I am pleased to introduce this report for the local office with our results and would like to take this opportunity to thank all our partners working in trusts and in education for helping us to deliver the survey and for supporting trainees in these challenged times.

2019 has been a year of change with the Kent, Surrey and Sussex Quality team established from December 2018, managing and analysing the General Medical Council (GMC) National Training Survey (NTS) for the first time.

I am very pleased to say we achieved a 99.8% response rate for the trainee survey which was the third highest in HEE and the highest level in England. This reflects a well-managed transition from London and gives us a high degree of confidence in the reliability in the results. The trainer survey response rate was 48% which is a slight increase on previous years.

Our overall ranking has fallen since last year although the indicators do not show a significant reduction with the majority decreasing by fewer than two points. Our results also include those from the Foundation school for the first time as these were previously all placed in the London Deanery results and this may account for some of the change, with Overall Satisfaction from trainees decreasing from 6th to 15th place in the national rankings. The Overall Satisfaction from trainers has increased slightly from 12th to 11th place.

We have seen improvements in the trainees' survey in Local Teaching, Regional Teaching and in Rota Design and improvements in the trainers' ranking of a number of indicators including Supportive Environment, Curriculum Coverage and Educational Governance.

Our national ranking for Overall Satisfaction by programme group was in the top four for six of our programmes, namely:

- Core surgical training
- Genito-urinary medicine
- Oral and maxilla-facial surgery
- Otolaryngology
- Core psychiatry training, and
- Neurology.

We also have 13 programmes in the bottom four for Overall Satisfaction nationally and will be considering how we can work with our partners to improve on this in the coming year.
We received fewer comments from trainees about bullying and undermining and about patient safety than in recent years and will work with the trusts to address any issues raised.
I would like to thank you for taking the time to look through our results and look forward to working with you over the coming year. We are determined to work with you, your clinicians and our trainees to improve our results so as to develop KSS as the best place to train and the best place to work longer term - for the benefit of all of our patients.

Professor Graeme Dewhurst
Regional Postgraduate Dean for South East England

Introduction

The purpose of this report is to provide an overview of the 2019 GMC National Training Survey (NTS) results for trainees and trainers working across Health Education England Kent Surrey and Sussex. The results are analysed at local office, Programme and Trust Level. In addition, feedback and intelligence from other professions has been included at trust level.

In December 2018 the Kent, Surrey and Sussex (KSS) Quality Team was formed. For the 2019 GMC NTS, we have worked with and shadowed the London Quality, Patient Safety and Commissioning Team (QPSC) to take over responsibility for NTS processes for KSS. We achieved a completion rate of 99.8% for the trainee survey and were placed 3rd nationally for response rates. HEE Local Offices are required, by the GMC, to have in place suitable quality management mechanisms to respond to issues that are highlighted via the NTS. The local processes in place for KSS are detailed below.

Quality Management and Interventions

The KSS Quality Team's processes are based upon the principles in the HEE Quality Framework. We use the HEE Intensive Support Framework to categorise all concerns and decide on the best method to address and support improvement of them.

Governance of quality interventions and risk rating is via the multi professional Quality Management Oversight Group. Escalation is via the KSS Senior Leadership Team and Regional Quality Team.

Following the release of the 2019 NTS results, the KSS Quality Team have worked with the Postgraduate Dean, County Deans, Associate Dean (Quality) and Heads of School to analyse the results and determine any areas of concern where a quality intervention may be required. This analysis considers the NTS results, any patient safety and bullying and undermining comments raised by trainees throughout the survey and local intelligence (including other healthcare professions). A report for each Head of School was written which looks in detail at the results by school to inform their work for the year as well as where quality intervention may be required. These reports also summarised intelligence we hold on the specialties within their school.

An overview of the quality management plan put in place for each Trust can be found at the end of each Trusts section within this report.

The steps taken to form each quality intervention plan are detailed below:

1.	Initial review of 2019 results.
2.	Report for each Head of School produced.
3.	Detailed look at below outliers by programme group.
4.	Feedback from Heads of School.
5.	Head of School feedback collated.
6.	Meeting with Postgraduate Dean, County Deans, Associate Dean (Quality), KSS Workforce Transformation, Dean of Pharmacy.
7.	Quality Interventions 2019-20 Planning Meeting.
8.	Planned Quality Interventions 2019-20 list confirmed and prioritised.

Table 1: KSS Quality Team process to form 2019 – 20 Quality Inventions List.

In addition to planning any quality interventions, we will ask trusts to provide feedback to detail how they will investigate concerns and improve any programmes which have four or more red outliers at site level. They will also have to provide feedback on any red outliers in any of the four key indicators; overall satisfaction, educational supervision, clinical supervision and clinical supervision out of hours (this practice follows that previously used by the London HEE team in recent years) and where we require more details to look into a particular issue. The feedback will be reviewed by the County Deans, and if any actions are required these will be issued to the trust and added to the action plans for monitoring. Feedback from trusts will be presented at Quality Management Oversight Group (QMOG) which will manage the overall governance of risks identified.

Patient safety and bullying and undermining comments made by trainees throughout the survey were all sent to Trusts for their response, and all responses have been reviewed by the County Deans. Any that remain an area of concern will be added to Trust action plans, and the Trusts will continue to provide HEE with updates until we are satisfied that reasonable, and sustainable measures have been put in place to address any concerns. Comments that remain a concern have specific actions against them, this will help the trusts to provide us with the evidence that is required to address and close them.

Overview of the National Training Survey

Conducted annually, the GMC NTS gathers feedback from trainees undertaking postgraduate medical training in order to monitor the quality of medical education and training in the UK. Its purpose is to gain a comprehensive snapshot of the quality of training environments across the UK. The trainee survey consists of around 85 questions and the trainer survey around 80 questions (see briefing note 3 for the questions) which are linked to the following indicators listed below. Indicators which appear in both trainee and trainer surveys are highlighted in blue:

Overall satisfaction	Handover	Educational supervision
Clinical supervision	Supportive environment	Feedback
Clinical supervision out of hours	Induction	Local teaching
Reporting systems	Adequate experience	Regional teaching
Work load	Curriculum coverage	Study leave
Teamwork	Educational governance	Rota design

Table 2: GMC NTS Trainee Survey Indicators

Overall satisfaction	Curriculum coverage	Resources for trainers
Work load	Educational governance	Support for trainers
Handover	Time for training	Trainer development
Supportive environment	Rota design	

Table 3: GMC NTS Trainer Survey Indicators

The indicators are given a mean which are compared to a benchmark group. From this, outliers are identified in the various reports. A key to the colours used for the indicators can be found below:

GREEN **Above outlier**	Report group mean is in top 25% and **confidence is high.**	Report group mean is higher than the benchmark group interquartile range 3 (Q3) ***and*** the report group lower confidence level is higher than the benchmark group upper confidence level.
Light Green **Within quartile 3, but not an above outlier**	Report group mean is in top 25% but **confidence is variable.**	Report group mean is higher than the benchmark group interquartile range 3 (Q3) ***and*** the report group lower confidence level is *lower* than the benchmark group upper confidence level.
WHITE **Within the inter-quartile range**	Report group mean is in interquartile range.	Report group mean is higher than the benchmark interquartile range 1 (Q1) ***and*** lower than the benchmark group interquartile range 3 (Q3).
PINK **Within quartile 1, but not a below outlier**	Report group mean is in bottom 25% nationally and **confidence is variable.**	Report group mean is lower than the benchmark group interquartile range 1 (Q1) ***and*** the report group upper confidence level is *higher* than the benchmark group lower confidence level.

RED **Below outlier**	Report group mean is in bottom 25% nationally and **confidence is high.**	Report group mean is lower than the benchmark group interquartile range 1 (Q1) ***and*** the report group upper confidence level is *lower* than the benchmark group lower confidence level.
Grey	Less than three trainees, results not published.	
Yellow	No responses, no result.	

Table 4: Key to GMC NTS Indicator colours.

This report contains the 2019 results for your school by Programme Group and by Post Specialty, please see the definitions below for the differences between the two:

Programme Group:	Programme Group is the programme specialty for the overall training programme that the doctor is completing. This provides data for trainees in a department broken down by their training grade/programme; for example, a programme group report labelled 'Anaesthetics' would comprise data only from specialty Anaesthetics ST3+ trainees.
Post Specialty:	Post Specialty is the post that the doctor was in when they completed the survey, it combines the data from all trainees regardless of training grade/programme. For example, a post specialty report labelled 'Anaesthetics' would comprise data from all Anaesthetics F2, ACCS, Core anaesthetics, Anaesthetics ST3+ who were in an anaesthetics post. Post specialty reports are useful if looking at small units/departments which otherwise would not have enough trainees at each programme level to generate a result.

Table 5: Definitions of Programme Group and Post Specialty.

Results by local office

KSS Overall Results

The following tables compare the KSS mean scores in each indicator to national averages and shows the statistical range of the responses within KSS. As a local office overall, no above or below outliers were identified in either trainee or trainer surveys.

Trainee Survey

Indicator	2019 KSS mean	2019 national mean	UK ranking (/18)	KSS mean change since 2018	UK ranking change since 2018(/19)
Overall satisfaction	78.78	79.45	15	↓ 1.29	↓ 9
Clinical supervision	89.38	90.13	13	↓ 2.20	↓ 10
Clinical supervision out of hours	86.62	87.56	14	↓ 2.69	↓ 11
Reporting systems	73.63	74.61	16	↓ 1.08	↓ 7
Work load	48.23	49.22	12	↓ 0.39	↓ 3
Teamwork	72.72	74.20	14	↓ 1.33	↓ 7
Handover	64.99	65.82	15	↓ 0.83	↓ 10
Induction	79.60	79.15	7	↓ 0.43	↓ 3
Adequate experience	79.03	79.72	14	↓ 0.34	↓ 6
Curriculum coverage	77.11	77.53	13	↓ 0.56	↓ 8
Supportive environment	71.93	72.36	12	↓ 1.85	↓ 8
Educational governance	72.56	72.85	14	↓ 1.52	↓ 8
Educational supervision	84.49	84.69	11	↓ 0.87	↓ 6
Feedback	75.66	75.00	7	↓ 1.90	↓ 2
Local teaching	71.93	71.78	9	↓ 1.59	↑ 6
Regional teaching	64.65	67.31	14	↓ 1.20	↑ 2
Study leave	62.42	63.73	13	↑ 0.26	↓ 4
Rota design	57.26	58.42	13	↓ 1.04	↓ 9

Table 6: KSS trainee mean scores compared nationally.
Source: NTS Reporting Tool; Report by Deanery/HEE Local Office

The highest-ranking indicators for KSS are Induction and Feedback. However, the mean scores for Induction and Feedback have both decreased slightly from 2018. This would suggest changes to national trends in responses compared to 2018.
One indicator has increased mean score from 2018 (Study Leave).
Two indicators have moved up the UK ranks from 2018 (Local Teaching and Regional Teaching).

KSS achieved mean scores above the national UK average in 3 of the 18 indicators and the remaining 15 out of 18 indicators are lower than the national UK average.

The variance between KSS mean and national mean is minimal; the greatest difference is 2.66 under the national mean for Regional teaching.

The 2019 data for KSS includes Foundation trainees. For the previous two years this data has been reported under HEE South London but this year it was decided that the data should be split across the two regions, so trainees working in a trust within KSS were allocated to KSS. This is worth noting as the addition of Foundation trainees to the KSS data will have an effect.

Trainer Survey

Indicator	2019 KSS mean	2019 national mean	UK ranking (/18)	KSS mean change since 2018	UK ranking change since 2018(/19)
Overall satisfaction	71.53	71.88	11	↑ 0.90	↑ 1
Work load	43.08	43.62	10	↓ 1.09	↓ 4
Handover	68.37	68.50	10	↑ 0.24	No change
Supportive environment	72.52	66.73	7	↑ 0.38	↑ 5
Curriculum coverage	75.51	72.43	7	↑ 0.68	↓ 1
Educational governance	67.73	67.34	7	↑ 2.42	↑ 6
Time for training	56.23	57.12	12	↓ 0.70	↓ 3
Rota design	60.89	62.18	12	↑ 2.17	↑ 2
Resources for training	67.25	69.47	14	↓ 0.74	↓ 1
Support for trainers	67.81	68.52	13	↑ 0.32	↓ 2
Trainer development	70.52	71.36	13	↑ 1.98	↓ 1

Table 7: KSS trainer mean scores compared nationally.
Source: NTS Reporting Tool; Report by Deanery/HEE Local Office

The highest-ranking indicators for KSS are Supportive environment, Curriculum coverage and Educational Governance. Supportive environment has also gone up by 5 places in the UK ranks, and Educational governance has gone up 6 places. Curriculum Coverage has gone down by one place from 2018 which would suggest changes to the national trend.
Four indicators have moved up in the national ranking from 2018, whilst six have gone down.

KSS achieved mean scores above the national UK average in 3 of the 18 indicators.
Again, the variance between KSS mean and national mean is minimal, the greatest difference is 2.42 over the national mean for Educational governance.

KSS Overall Satisfaction

For trainees, the overall satisfaction indicator combines general questions about the quality and usefulness of the training post to provide a single satisfaction score. For trainers, the indicator focuses on the experience of being an educator.

The tables below compare overall satisfaction within KSS to the rest of the UK.

Trainee Survey

Local office/Deanery	Mean	Rank
Pharmaceutical Deanery	84.62	1
North East	81.64	2
Defence Deanery	81.30	3
Wessex	80.95	4
South West	80.61	5
Wales	80.38	6
Scotland	80.34	7
North West London	80.26	8
North Central & East London	80.24	9
Northern Ireland	79.75	10
South London	79.73	11
North West	79.15	12
Thames Valley	79.11	13
West Midlands	78.83	14
Kent, Surrey and Sussex	78.78	15
Yorkshire and the Humber	78.07	16
East of England	77.98	17
East Midlands	77.38	18
National Mean	**79.45**	

Trainer Survey

Local office/Deanery	Mean	Rank
North East	74.61	1
South West	74.43	2
South London	72.91	3
Northern Ireland	72.80	4
North West	72.80	4
Thames Valley	72.70	6
Wessex	72.54	7
West London	72.16	8
Pharmaceutical Deanery	72.01	9
Scotland	71.89	10
Kent, Surrey and Sussex	71.53	11
Wales	71.34	12
East of England	71.25	13
North Central & East London	70.94	14
West Midlands	70.90	15
Yorkshire and the Humber	69.52	16
East Midlands	69.21	17
Defence Deanery	48.75	18
National Mean	**71.88**	

Table 8: Overall Satisfaction scores by local office.
Source: NTS Reporting Tool; Report by Deanery/HEE Local Office (trainee and trainer reports used).

The ranking for KSS in the trainee survey has decreased from 6th in 2018 to 15th for overall satisfaction. The ranking in the trainer survey has improved by one to 11th since 2018 for overall satisfaction.

The national mean for overall satisfaction has increased slightly in both the trainee and trainer surveys for overall satisfaction.

Results by Programme

This section looks at the results by programme group at local office level to give an overview of how individual programmes within KSS are performing.

Overall Satisfaction by programme group – local office level

Of the 38 programmes in KSS for which a score was identified, (an additional one had less than three trainee responses and therefore the results were not published), there are six ranked in the top four of their programme group and eight in the bottom four nationally for overall satisfaction.

Trainee Survey

Ranked in the top four of programme group

Programme	National Mean	HEE KSS Mean	UK ranking	Denominator	UK ranking change since 2018
Core Surgical Training	77.52	80.07	2	17	↑ 6
Genito-urinary medicine	81.45	93.20	2	11	↓ 1
Oral and maxillo-facial surgery	81.45	91.70	2	12	No change
Otolaryngology	81.45	90.37	3	15	↑ 1
Core Psychiatry Training	77.52	84.10	4	17	↓ 1
Neurology	81.45	84.60	4	15	↑ 2

Table 9: Top overall satisfaction scores by programme group.
Source: NTS Reporting Tool, Report Programme Type by Deanery/HEE Local Office.

No above outliers were identified at programme type by HEE Local Office level.
No KSS programmes were ranked first for overall satisfaction, down from 2018 when two programmes were ranked first. Genito Urinary Medicine was 1st in 2018 and has dropped to 2nd in 2019.
Renal Medicine was 1st in 2018 but has dropped to 15th in 2019.
Below outliers were identified for Gastroenterology and Respiratory Medicine (highlighted in table below).

Ranked in the bottom four of programme group

Programme	National Mean	HEE KSS Mean	UK ranking	Denominator	UK ranking change since 2018
Gastroenterology	81.45	68.51	16	16	↓ 2
Respiratory medicine	81.45	69.48	17	17	↓ 5
Renal medicine	81.45	72.46	15	16	↓ 14
Dermatology	81.45	76.00	15	15	↓ 2
Intensive Care Medicine	8145	71.22	13	13	No change
Medical Microbiology	81.45	76.00	11	11	No change
Rheumatology	81.45	76.54	15	16	↓ 1
General surgery	81.45	80.10	15	17	↓ 7
Clinical radiology	81.45	82.30	14	17	↓ 5
Child and adolescent psychiatry	81.45	83.75	14	15	No result in 2018

Programme	National Mean	HEE KSS Mean	UK ranking	Denominator	UK ranking change since 2018
Combined Infection Training	81.45	81.00	10	13	No result in 2018
Paediatrics	81.45	79.08	13	16	No change
Vascular Surgery	81.45	80.71	13	14	↓ 8

Table 10: Bottom overall satisfaction scores by programme group.
Source: NTS Reporting Tool, Report Programme Type by Deanery/HEE Local Office.

Please note: the national mean is an average of the scores for all specialties at the same training level, rather than a score for a single programme specialty. For example: General Psychiatry ST3+ and Cardiology ST3+ are both benchmarked against the national mean for all ST3+ trainees.
This is how a programme may rank in the bottom three when compared nationally with the same programme in other regions, yet still have a score higher than the national mean.

Trainer Survey

Of the 47 trainer specialties in KSS for which a score was identified (a further 11 had less than three trainer responses and therefore the results were not published), there are four which were ranked in the top three, of their programme group and seven in the bottom three nationally for overall satisfaction.

Ranked in the top four of trainer specialty

Programme	National Mean	HEE KSS Mean	UK ranking	Denominator	UK ranking change since 2018
General psychiatry	71.88	78.04	3	16	No change
Clinical oncology	71.88	72.50	4	16	↑ 4
Haematology	71.88	72.00	4	16	↑ 8

Table 11: Top Overall satisfaction scores by Trainer specialty
Source: NTS Reporting Tool, Report Trainer Specialty by Deanery/HEE Local Office.

No above outliers were identified.

Ranked in the bottom four of trainer specialty

Programme	National Mean	HEE KSS Mean	UK ranking	Denominator	UK ranking change since 2018
Vascular surgery	71.88	56.00	13	14	↓ 4
Cardiology	71.88	58.75	16	16	↓ 3
Genito-urinary medicine	71.88	63.75	13	13	↓ 2
Endocrinology and diabetes mellitus	71.88	65.00	16	16	↓ 6
Obstetrics and gynaecology	71.88	68.90	15	16	↓ 2
Rheumatology	71.88	70.00	14	16	↓ 3
Anaesthetics	71.88	71.54	15	16	No change

Table 12: Bottom Overall satisfaction scores by Trainer specialty
Source: NTS Reporting Tool, Report Trainer Specialty by Deanery/HEE Local Office.

Below outliers were identified for Vascular surgery and Cardiology.

Comparing Overall satisfaction between trainee and trainer surveys

Rheumatology is in the bottom four nationally for overall satisfaction in both the trainee and trainer surveys.

Genito-urinary Medicine in the top four for overall satisfaction in the trainee survey but is in the bottom four for trainer overall satisfaction.

Results by Trusts

This section looks at results at trust level to give an overview of how trusts within KSS are performing (details for each trust separately are included from page 20). This section aims to give the headlines to enable benchmarking when looking at the individual trust sections.

Outliers by trust overall

The table below gives an indication of how well a Trust is performing overall for an indicator, based on the data collected from all trainees and trainers within a Trust, compared against national benchmarks. Above outliers are presented in green, and below outliers in red.

Trust	Trainee Survey	Trainer survey
Ashford and St Peter's Hospitals NHS Foundation Trust		
Brighton and Sussex University Hospitals NHS Trust		Educational Governance Resource for trainers
Dartford and Gravesham NHS Trust		
East Kent Hospitals University NHS Foundation Trust		Curriculum Coverage
East Sussex Healthcare NHS Trust	Curriculum Coverage Educational Supervision	
Frimley Health NHS Foundation trust (Frimley Park Hospital only)		Supportive environment
Kent and Medway NHS and Social Care Partnership Trust		Overall Satisfaction Handover Supportive environment Curriculum Coverage Educational governance Resource for trainers Support for trainers Trainer development
Maidstone and Tunbridge Wells NHS Trust		
Medway NHS Foundation Trust	Teamwork	Curriculum coverage
Queen Victoria Hospital NHS Foundation Trust	Clinical Supervision out of hours Teamwork	
Royal Surrey County Hospital NHS Foundation Trust		
Surrey and Borders Partnership NHS Foundation Trust	Work Load	Overall satisfaction Resource for trainers Trainer development
Surrey and Sussex Healthcare NHS Trust		
Sussex Community NHS Foundation Trust	Work Load Teamwork Regional Teaching Rota Design	Curriculum Coverage
Sussex Partnership NHS Foundation Trust		Curriculum Coverage
Western Sussex Hospitals NHS Foundation Trust		Curriculum Coverage

Table 13: Outliers at trust level
Source: NTS Reporting Tool, Report by Trust/Board Trainee, Report by Trust/Board Trainer.

Outliers by Programme Group/Specialty – Trust Level

The below data shows trainee programme groups and trainer specialties within Trusts for which multiple above or below outliers were identified. This have been looked at by Trust level (site level detail can be found within each trusts section).
The data displayed from the trainee survey are programmes with four or more outliers out of 18 indicators, and for the trainer survey with three or more outliers out of 11 indicators. The programmes with the greatest number of outliers in each table are highlighted.
Also included are any that have an outlier in Overall satisfaction, Clinical supervision, Clinical supervision out of hours or Educational supervision. This is indicated next to the number of outliers (Key: OS = Overall satisfaction, CS = Clinical Supervision, CS OOH = Clinical Supervision Out of Hours, ES = Educational supervision).

Trainee survey (by programme by trust)

The table below shows programmes with multiple **above** outliers (four or more greens) and programmes that have an **above** (green) outlier in one of the four key indicators.

Trust	Programme Group	No. of ABOVE outliers
Ashford and St Peter's Hospitals NHS Foundation Trust	Anaesthetics F1	**8** (OS)
	Core Surgical Training	**7** (CS, CS OOH)
Brighton and Sussex University Hospitals NHS Trust	Cardiology	**1** (CS OOH)
	Emergency Medicine F1	**2** (CS OOH)
	Endocrinology and diabetes mellitus	**1** (CS OOH)
	GP Prog - Emergency Medicine	**9** (OS, CS)
	Genito-urinary medicine	**5**
	Otolaryngology	**9** (OS)
	Paediatrics	**1** (CS OOH)
	Psychiatry F1	**5** (CS)
	Renal medicine	**1** (CS OOH)
	Trauma and orthopaedic surgery	**4**
	Urology	**4**
Dartford and Gravesham NHS Trust	Core Surgical Training	**5** (CS, CS OOH)
	Obstetrics and gynaecology	**8** (OS, CS, CS OOH)
East Kent Hospitals University NHS Foundation Trust	Anaesthetics	**4**
	Anaesthetics F1	**3** (CS)
	Neurology	**5**
East Sussex Healthcare NHS Trust	Obstetrics and gynaecology	**4**
	Ophthalmology	**8** (CS OOH)
Frimley Health NHS Foundation Trust (Frimley Park Hospital only)	Anaesthetics	**3** (OS)
	Emergency Medicine	**2** (CS OOH)
	GP Prog - Paediatrics and Child Health	**8** (OS, CS, CS OOH)
	Obstetrics and gynaecology	**11** (OS, CS, CS OOH)
	Ophthalmology	**1** (CS OOH)

Trust	Programme Group	No. of ABOVE outliers
Maidstone and Tunbridge Wells NHS Trust	Anaesthetics F1	**11** (OS, ES)
	Clinical radiology	**3** (CS OOH)
	GP Prog - Surgery	**6** (OS)
Queen Victoria Hospital NHS Foundation Trust	Anaesthetics	**3** (OS)
	Core Surgical Training	**9** (OS, CS, CS OOH)
Royal Surrey County Hospital NHS Foundation Trust	GP Prog - Obstetrics and Gynaecology	**3** (CS OOH)
Surrey and Sussex Healthcare NHS Trust	Core Surgical Training	**7** (OS, CS)
	GP Prog – Medicine	**3** (CS)
	Medicine F2	**6** (CS)
Sussex Community NHS Foundation Trust	Paediatrics	**5**
Western Sussex Hospitals NHS Foundation Trust	Core Surgical Training	**1** (CS)
	Emergency medicine	**5**
	GP Prog - Emergency Medicine	**4** (OS)

Table 14: Programmes with four or more above outliers or an above outlier in a key indicator.
Source: NTS Reporting Tool, Report by Programme Group by Trust/Board.

The table below shows programmes with multiple **below** outliers (four or more reds) and programmes that have a **below** (red) outlier in one of the four key indicators.

Trust	Programme Group	No. of BELOW outliers
Ashford and St Peter's Hospitals NHS Foundation Trust	GP Prog- Medicine	**7** (OS)
Brighton and Sussex University Hospitals NHS Trust	Acute Internal Medicine	**4** (OS)
	Clinical radiology	**2** (OS)
	Gastroenterology	**3** (ES)
	Medical microbiology	**4**
	Surgery F1	**3** (CS, CS OOH)
	Surgery F2	**6** (OS)
Dartford and Gravesham NHS Trust	Emergency Medicine F2	**6** (CS, CS OOH)
	GP Prog - Emergency Medicine	**4** (OS, CS)
East Kent Hospitals University NHS Foundation Trust	ACCS	**3** (CS)
	GP Prog - Emergency Medicine	**4** (CS, CS OOH)
	GP Prog – Medicine	**2** (CS OOH)
	Obstetrics and Gynaecology F2	**2** (CS)
East Sussex Healthcare NHS Trust	Anaesthetics	**3** (OS)
	Clinical radiology	**1** (CS OOH)
	Core Medical Training	**2** (ES)
	Emergency Medicine	**1** (ES)
	Emergency Medicine F2	**4** (OS)
	GP Prog - Medicine	**7** (OS)
	Surgery F1	**1** (CS)

Trust	Programme Group	No. of BELOW outliers
	Surgery F2	**4** (OS, CS)
	Urology	**1** (CS OOH)
Frimley Health NHS Foundation Trust (Frimley Park Hospital only)	Emergency Medicine F1	**2** (OS)
	Medicine F2	**7** (OS, CS, CS OOH)
Maidstone and Tunbridge Wells NHS Trust	Core Medical Training	**1** (ES)
	General Practice F2	**1** (CS OOH)
	Surgery F1	**2** (CS)
Medway NHS Foundation Trust	Geriatric medicine	**4** (CS OOH)
Royal Surrey County Hospital NHS Foundation Trust	Emergency medicine	**3** (CS)
	GP Prog - Medicine	**9** (OS, CS OOH)
	Trauma and orthopaedic surgery	**2** (CS OOH)
Surrey and Borders Partnership NHS Foundation Trust	Psychiatry F1	**2** (ES)
Surrey and Sussex Healthcare NHS Trust	Emergency medicine	**5** (OS)
	Emergency Medicine F2	**2** (ES)
	Geriatric medicine	**3** (CS OOH)
	Paediatrics	**6** (OS)
Sussex Partnership NHS Foundation Trust	Psychiatry F2	**4** (CS OOH)
Western Sussex Hospitals NHS Foundation Trust	Geriatric medicine	**2** (CS OOH)
	GP Prog - Paediatrics and Child Health	**5** (CS)

Table 15: Programmes with four or more below outliers or a below outlier in a key indicator.
Source: NTS Reporting Tool, Report by Programme Group by Trust/Board.

Trainer survey (by trainer specialty by trust)

The table below shows trainer specialties with three or more **above** (green) outliers and specialties that have an **above** (green) outlier in overall satisfaction.

Trust	Trainer Specialty	No. of ABOVE outliers
Ashford and St Peter's Hospitals NHS Foundation Trust	General Surgery	**6** (OS)
Dartford and Gravesham NHS Trust	Paediatrics	**3**
	Urology	**6** (OS)
East Kent Hospitals University NHS Foundation Trust	Respiratory Medicine	**3** (OS)
East Sussex Healthcare NHS Trust	Acute Internal Medicine	**3**
	Paediatrics	**4**
Frimley Health NHS Foundation Trust (Frimley Park Hospital only)	Otolaryngology	**3**
Kent and Medway NHS and Social Care Partnership Trust	General psychiatry	**5**
	Old age psychiatry	**6** (OS)
Maidstone and Tunbridge Wells NHS Trust	Anaesthetics	**3** (OS)
	Obstetrics and gynaecology	**1** (OS)
	Ophthalmology	**8** (OS)
Medway NHS Foundation Trust	Emergency medicine	**3**
	Urology	**3** (OS)
Surrey and Borders Partnership NHS Foundation Trust	Child and adolescent psychiatry	**5**
	General psychiatry	**4** (OS)
Surrey and Sussex Healthcare NHS Trust	General surgery	**3**

Table 16: Trainer specialties with three or more above outliers or an above outlier for overall satisfaction.
Source: NTS Reporting Tool: Report by Trainer Specialty by Trust/Board

The table below shows trainer specialties with three or more **below** (red) outliers and specialties that have a **below** (red) outlier in overall satisfaction.

Trust	Trainer Specialty	No. of BELOW outliers
Ashford and St Peter's Hospitals NHS Foundation Trust	Anaesthetics	**2** (OS)
	Paediatrics	**3**
Brighton and Sussex University Hospitals NHS Trust	Clinical radiology	**4** (OS)
	Gastroenterology	**4**
	Geriatric medicine	**4**
	Obstetrics and gynaecology	**4** (OS)
East Kent Hospitals University NHS Foundation Trust	Trauma and orthopaedic surgery	**4**
East Sussex Healthcare NHS Trust	Obstetrics and gynaecology	**3**
Frimley Health NHS Foundation Trust (Frimley Park Hospital only)	Anaesthetics	**5** (OS)
	Respiratory medicine	**4** (OS)

Trust	Trainer Specialty	No. of BELOW outliers
Maidstone and Tunbridge Wells NHS Trust	Cardiology	**3**
	Trauma and orthopaedic surgery	**4**
Surrey and Sussex Healthcare NHS Trust	Cardiology	**9** (OS)
	Paediatrics	**3**
Western Sussex Hospitals NHS Foundation Trust	Endocrinology and diabetes mellitus	**6** (OS)
	Geriatric medicine	**7** (OS)

Table 17: Trainer specialties with three or more below outliers or a below outlier for overall satisfaction.
Source: NTS Reporting Tool: Report by Trainer Specialty by Trust/Board

Trends by Programme Group/Trainer Specialty

The tables within this section look at outlier trends over the past eight GMC surveys for trainees and the past four years for trainers.

Trainee survey – Above outlier Trends

The table below shows programmes in which an indicator has been identified as an **above** outlier for at least three years. There are 13 programmes for which this has been identified.

Programme group	Trust	Indicator	No of years
GP Prog - Psychiatry	Kent and Medway NHS and Social Care Partnership Trust	Work Load	6
GP Prog - Psychiatry	Sussex Partnership NHS Foundation Trust	Work Load	6
Anaesthetics F1	East Kent Hospitals University NHS Foundation Trust	Work Load	5
Cardiology	Brighton and Sussex University Hospitals NHS Trust	Clinical Supervision out of hours	4
Psychiatry F1	Brighton and Sussex University Hospitals NHS Trust	Work Load	4
Clinical radiology	East Kent Hospitals University NHS Foundation Trust	Work Load	4
Clinical oncology	Maidstone and Tunbridge Wells NHS Trust	Supportive environment	4
GP Prog - Surgery	Maidstone and Tunbridge Wells NHS Trust	Work Load	4
General Practice F2	Brighton and Sussex University Hospitals NHS Trust	Feedback	3
Genito-urinary medicine	Brighton and Sussex University Hospitals NHS Trust	Reporting systems	3
Genito-urinary medicine	Brighton and Sussex University Hospitals NHS Trust	Teamwork	3
Genito-urinary medicine	Brighton and Sussex University Hospitals NHS Trust	Supportive environment	3
Genito-urinary medicine	Brighton and Sussex University Hospitals NHS Trust	Educational Governance	3
Paediatrics	Brighton and Sussex University Hospitals NHS Trust	Clinical Supervision out of hours	3
General Practice F2	East Kent Hospitals University NHS Foundation Trust	Work Load	3
Psychiatry F1	East Kent Hospitals University NHS Foundation Trust	Work Load	3

Programme group	Trust	Indicator	No of years
Psychiatry F2	East Kent Hospitals University NHS Foundation Trust	Work Load	3
Emergency Medicine F2	Maidstone and Tunbridge Wells NHS Trust	Study Leave	3
Anaesthetics	Queen Victoria Hospital NHS Foundation Trust	Work Load	3
CST	Queen Victoria Hospital NHS Foundation Trust	Work Load	3

Table 18: Above outliers for three or more years (trainee survey).
Source: NTS Reporting Tool, Report by Programme Group by Trust/Board year-on-year comparison.

Trainee survey – Below outlier trends

The table below shows programmes in which an indicator has been identified as a **below** outlier for at least three years. There are six programmes for which this has been identified.

Programme group	Trust	Indicator	No of years
Anaesthetics	East Sussex Healthcare NHS Trust	Adequate Experience	5
General Surgery	Frimley Health NHS Foundation Trust (Frimley Park Hospital)	Work Load	4
Clinical oncology	Brighton and Sussex University Hospitals NHS Trust	Local Teaching	3
Gastroenterology	East Kent Hospitals University NHS Foundation Trust	Study Leave	5
Surgery F1	Brighton and Sussex University Hospitals NHS Trust	Clinical Supervision out of hours	3
Surgery F2	Brighton and Sussex University Hospitals NHS Trust	Overall Satisfaction	3

Table 19: Below outliers for three or more years (trainee survey).
Source: NTS Reporting Tool, Report by Programme Group by Trust/Board year-on-year comparison.

Trainer survey – Above outlier Trends

The table below shows specialties in which an indicator has been identified as an **above** outlier for at least three years. There are 15 programmes for which this has been identified.

Trainer Specialty	Trust	Indicator	No of years
Anaesthetics	Medway NHS Foundation Trust	Curriculum Coverage	3
Child and adolescent psychiatry	Sussex Partnership NHS Foundation Trust	Curriculum Coverage	3
Emergency medicine	East Sussex Healthcare NHS Trust	Curriculum Coverage	3
Emergency medicine	East Sussex Healthcare NHS Trust	Educational Governance	3
General psychiatry	Kent and Medway NHS and Social Care Partnership Trust	Curriculum Coverage	3
Histopathology	Royal Surrey County Hospital NHS Foundation Trust	Supportive environment	3
Obstetrics and gynaecology	Frimley Health NHS Foundation Trust	Handover	3
Obstetrics and gynaecology	Western Sussex Hospitals NHS Foundation Trust	Handover	3
Paediatrics	Dartford and Gravesham NHS Trust	Trainer Development	3
Paediatrics	East Sussex Healthcare NHS Trust	Educational Governance	3

Trainer Specialty	Trust	Indicator	No of years
Respiratory medicine	East Kent Hospitals University NHS Foundation Trust	Educational Governance	3
Urology	Dartford and Gravesham NHS Trust	Educational Governance	3
Urology	Dartford and Gravesham NHS Trust	Overall Satisfaction	3
Urology	Dartford and Gravesham NHS Trust	Rota Design	3
Urology	Dartford and Gravesham NHS Trust	Supportive environment	3

Table 20: Above outliers for three or more years (trainer survey).
Source: NTS Reporting Tool, Report by All results by trainer specialty by trust/board

Trainer survey – Below outlier trends

The table below shows specialties in which an indicator has been identified as a **below** outlier for at least three years. There are 13 programmes for which this has been identified.

Trainer Specialty	Trust	Indicator	No of years
Paediatrics	Ashford and St Peter's Hospitals NHS Foundation Trust	Supportive environment	4
Geriatric medicine	Western Sussex Hospitals NHS Foundation Trust	Curriculum Coverage	3
Anaesthetics	Brighton and Sussex University Hospitals NHS Trust	Educational Governance	3
Geriatric medicine	Brighton and Sussex University Hospitals NHS Trust	Educational Governance	3
Paediatrics	Brighton and Sussex University Hospitals NHS Trust	Educational Governance	3
Clinical radiology	Brighton and Sussex University Hospitals NHS Trust	Overall Satisfaction	3
Gastroenterology	Brighton and Sussex University Hospitals NHS Trust	Rota Design	3
Obstetrics and gynaecology	East Sussex Healthcare NHS Trust	Rota Design	3
Clinical radiology	Brighton and Sussex University Hospitals NHS Trust	Support for trainers	3
Gastroenterology	Brighton and Sussex University Hospitals NHS Trust	Supportive environment	3
Trauma and orthopaedic surgery	East Kent Hospitals University NHS Foundation Trust	Supportive environment	3
Clinical radiology	Brighton and Sussex University Hospitals NHS Trust	Time for training	3
Paediatrics	Ashford and St Peter's Hospitals NHS Foundation Trust	Time for training	3

Table 21: Below outliers for three or more years (trainer survey).
Source: NTS Reporting Tool, Report by All results by trainer specialty by trust/board

Patient Safety and Bullying and Undermining Comments

Trainees were able to comment on any Patient Safety and Bullying and Undermining concerns throughout the survey. These are free text comments and based on the post the trainee is in as of the start date of the survey. We monitored the comments that came in and rated them each day. The comment ratings were reviewed by the Postgraduate Dean, Associate Dean (Quality) and County Deans. Any immediate comments were shared with the trust on the same day and a response requested within 10 working days or 48 working hours if the comment related to clinical or educational supervision. Non-immediate comments were shared with trusts half way through the survey and at the end of the survey. The process used for handling the Patient Safety and Bullying and Undermining Comments will be reviewed with changes implemented in 2020.

A total of 55 comments were received in 2019. The table below shows the number of patient safety and bullying and undermining comments and compares to previous years.

	2017	2018	2019
Patient Safety	47	42	40
Bullying and Undermining	12	10	9

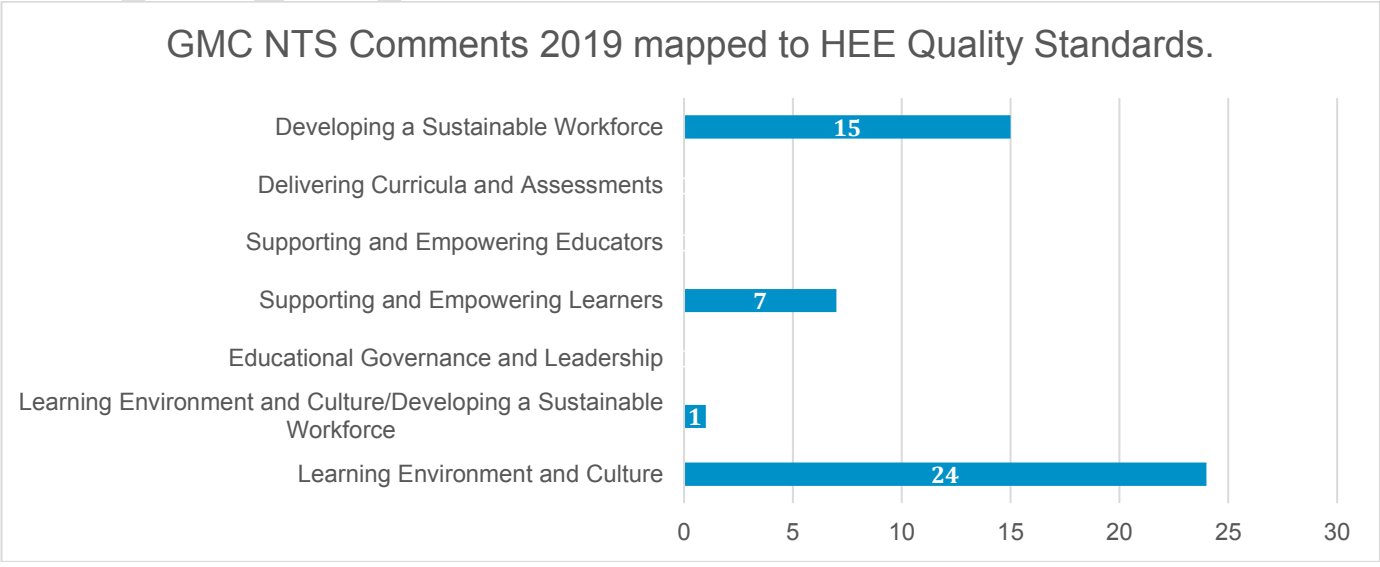
Table 22: Summary of 2019 NTS Comments

Please note that one of the comments received in 2019 related to the GMC (a bullying and undermining comment) and a further five (one bullying and undermining and four patient safety) were for a site within a KSS trust which the KSS Quality Team does not support. Two trainees filled in the comments section but did not write a comment. This left a total of 47 comments relating to concerns/issues within KSS trusts.

When categorising the comments as immediate or non-immediate, we also looked at HEE Quality Framework Quality Standards and which of the six domains the comments fell within. The six domains used for standard of quality are:

1. Learning Environment and Culture
2. Educational Governance and Leadership
3. Supporting and Empowering Learners
4. Supporting and Empowering Educators
5. Delivering Curricula and Assessments
6. Developing a Sustainable Workforce

The domains that the comments fell within can be seen in the graph below.



Results by Trusts in Detail

This section looks in detail at each trust within KSS, considering the following:

- HEE Quality Interventions that have taken place over the last year.
- CQC Inspections and Ratings data.
- HEE Reporting – this will include anything that we are monitoring through the Deans Report, Enhanced Monitoring, and the HEE Reporting Register (see below for further information).
- GMC NTS Results.
- Patient Safety and Bullying and Undermining Comments.

Each Trusts section ends with our Quality Management plans for the trust over 2019-20.

Deans Report
The Deans Report is an online system through which we report on concerns to the GMC, focusing on key areas where improvement is needed to maintain standards. The GMC use the system to monitor concerns highlighted through HEE quality management processes. We risk rate all concerns that are raised (e.g. through quality interventions that take place) using the Intensive Support Framework and any items graded two or above are reported to the GMC via the Deans Report. Please note that current items on the Deans Report are historical and have been inherited from the London QPSC Team. We will provide the GMC with updates for all concerns on the Deans Report over the next few months and work towards closing them where possible or updating them on a regular basis.

Enhanced Monitoring
Enhanced Monitoring is a GMC process, whereby the GMC provides support to Deaneries to improve the quality of training where normal Deanery processes alone are unlikely to enable sites to meet the requirements of the GMC standards. There are two main elements of the Enhanced Monitoring process:

1) More frequent review of the data, information and intelligence relating to the training.
2) More frequent Quality Management - Quality Improvement visits (usually 6-12 monthly) with a panel that often includes representatives from the GMC.

HEE Reporting Register
The HEE Reporting Register is our internal system of sharing and escalating concerns from Kent, Surrey and Sussex programmes. Any concerns with an Intensive Support Framework (Appendix 1) grading of two or above are recorded on the HEE Reporting Register, this then feeds up to the whole of the South and HEE. The concerns that are logged on this register are also reported to the relevant Quality Surveillance Group (Surrey and Sussex, or Kent and Medway) and reviewed at the Quality Management Oversight Group.

GMC NTS Results
This part of each Trusts section details the following:

- Graphs showing the number of outliers identified for the entire trust, showing 2017, 2018 and 2019 for comparison, by Programme Group and by Post Specialty.
- Table detailing what we have identified from the 2019 results by Programme Group.
- Table detailing what we have identified from the 2019 results by Post Specialty.

Within the two tables, the indicators have been shortened. Please find a key below:

Overall satisfaction = OS Clinical supervision = CS Clinical supervision out of hours = CS OOH Reporting systems = RS Work load = WL Teamwork = TW	Handover = HO Supportive environment = SE Induction = Ind Adequate experience = AE Curriculum coverage = CC Educational governance = EG	Educational supervision = ES Feedback = Fb Local teaching = LT Regional teaching = RT Study leave = SL Rota design = RD

Medway NHS Foundation Trust

Quality Interventions in the last year

Date	Specialty	Type of Intervention
13 December 2018	Pharmacy	On-site risk review

CQC Inspection/Rating

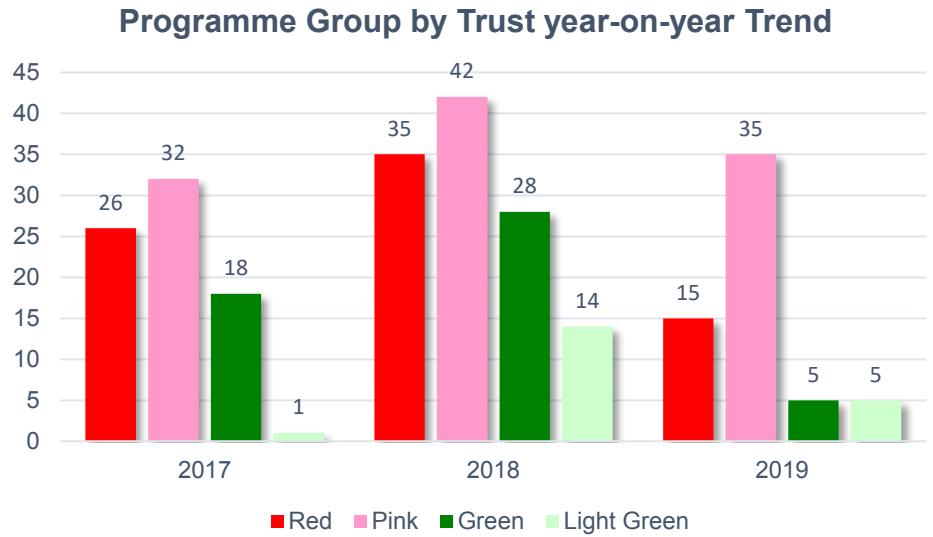
Latest CQC Inspection Report Date:	Trust Overall Rating:
26 July 2018	Requires improvement

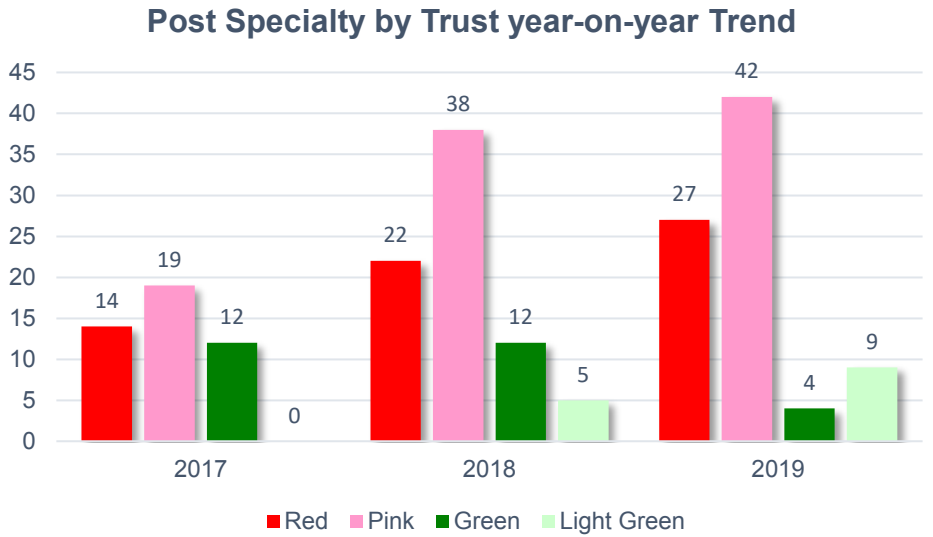
HEE Reporting

Specialty/Profession	Details of Intelligence
Medicine	This is on the HEE Reporting Register. This is on the Deans Report.

GMC NTS 2019 Results

The below graphs show the number of outliers identified for the entire trust for the past three years, by programme group and by post specialty.





Please note that the number of outliers may change when looking at results by site level. In 2017 there was one less indicator (Rota Design was added in 2018).

The table below details the programme groups that we have identified within this trust from the GMC NTS results, it includes programmes that we have identified for good feedback and programmes that we identified as areas for improvement. Comparison to previous year's results has also been included.

Programme Group	2019 Result	Comparison to previous results
Geriatric Medicine	4 reds (CSOOH, SE, SL, RD), 8 pinks (CS, TW, HO, Ind, AE, ES, Fb, RT).	In 2018 there were no results for this programme. In 2017 there were 2 reds (WL, HO) and 1 pink (TW) and the remaining indicators were white.
GP Prog - Medicine	3 reds (WL, SE, SL), 7 pinks (OS, CS, TW, HO, Ind, CC, EG).	In 2018 this programme had 1 red (RT) and 1 pink (Ind) plus 1 light green (RS) so the programme has deteriorated over the year.

The table below details the post specialties that we have identified within this trust from the GMC NTS results, it includes post specialties that we have identified for good feedback and specialties that we identified as areas for improvement. Comparison to previous year's results has also been included.

Post Specialty	2019 Result	Comparison to previous results
Cardiology	1 red (WL), 5 pinks (TW, HO, Ind, AE, RD).	In 2018 there were 3 pinks.
Gastroenterology	10 reds (OS, CS, RS, WL, Ind, AE, ES, Fb, LT, SL), 6 pinks (CS OOH, TW, SE, CC, EG, RD).	In 2018 no results were available as there were less than 3 trainees.
Intensive Care Medicine	3 reds (CS OOH, RS, Ind), 5 pinks (TW, EG, ES, Fb, RD).	In 2018 there were 2 pinks, 2 greens and 1 light green.
Paediatrics	1 red (HO), 5 pinks (CS, CS OOH, RS, SE, CC).	In 2018 there were 4 pinks and 1 light green.

The following specialties have not been included in the above table, to avoid duplication, as they show similar results to those in the Programme Group table: Geriatric Medicine

2019 Patient Safety and Bullying and Undermining Comments

Patient Safety	Five comments were received.	Comments related to staffing levels, rota gaps and lack of rest facilities at Medway Maritime Hospital.
Bullying and Undermining	One comment was received.	The comment was raised by a trainee in General surgery in relation to the Accident and Emergency department.

Quality Management Plan

Specialty/ties	Type of Intervention	Reason
Medicine Core Medical Training, Gastroenterology and Geriatric Medicine	Full Review	Due to the number of below outliers when looking at results by post specialty.
Surgery – Vascular Surgery	Education Lead Conversation	The trust has relocated trainees in response to a bullying and harassment issue in the department.

Conclusion

We will be contacting each of our trusts to give them a summary of their individual results as well as these being available through the GMC website at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports.

Our individual contact with trusts will include details of any planned quality interventions in the coming year.

Health Education England

Medway NHS Foundation Trust

Risk based review

Gastroenterology, Geriatric Medicine and Core Medical Training

Quality Review report

6th March 2020

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	The risk-based review to Medway NHS Foundation Trust following the results of the 2019 National Training Survey (NTS). Red outliers for gastroenterology appeared within overall satisfaction, clinical supervision, reporting systems, workload, induction, adequate experience, educational supervision, feedback, local teaching and study leave. Red outliers for geriatric medicine appeared within clinical supervision out of hours, supportive environment, study leave and rota design. Red outliers for core medical training appeared within reporting systems and teamwork.
Training programme / learner group reviewed	Higher trainees in gastroenterology and geriatric medicine. Core and internal medicine trainees within medicine.
Number of learners and educators from each training programme	Data was gathered through a pre-review survey of 11 trainees across those specialties under review, feedback from two higher trainees who finished their rotations at the Trust within these specialties in September 2019, and trainees attending feedback sessions during the visit. The review team met with the following trainees during the review visit: Five higher trainees across both gastroenterology and geriatrics. Five core and internal medicine trainees in general medicine.
Review summary and outcomes	The review team would like to thank the Trust for accommodating the review and extend their thanks to all those who attended. The review team were pleased to note the following areas that were working well: • The core trainees reported that their senior colleagues were supportive and highlighted that the higher trainees taught at every opportunity. • The respiratory and intensive care department inductions were singled out by the trainees for praise. • Ward experience, when this occurred, was generally reported as very good. • Trainees reported that the breadth and depth of clinical opportunities at the Trust is favourable. • All trainees reported that the handover meeting at night has significantly improved. • The new simulation programme was highlighted for praise by the trainees. • The dedicated endoscopy list for gastroenterology trainees was highlighted as a significant improvement. • Higher trainees were positive about the increase in clinic opportunities and weekly teaching in geriatrics. However, the review team also noted a number of areas which required improvement:

	• Higher gastroenterology trainees reported instances where they were being expected to run clinics without consultant supervision. • Concerns were raised by both core and higher trainees about triage in the Emergency Department. Trainees had concern for patient safety, citing knowledge of when the triage had resulted in inappropriate pathways of care. • Trainees reported a lack of feedback from incidents which they had reported via Datix. • Trainees reported a lack of support and oversight of the on-call team by a consultant. • The review team heard concerns from the trainees about consultant leadership on Keats Ward, and trainees having the appropriate level of responsibility. • Medical trainees reported an imbalance of on-call work and ward work within their rota, with a very intense two-week acute block on-call. Trainees were concerned about the impact of this on their wellbeing and their ability to attend mandatory training. • Trainees reported insufficient medical staffing levels on both the wards and on-call rota. • Some trainees reported inadequate departmental induction, which was provided after they started in their post. • Trainees told the review team that the number of patients handed over from the night on-call to the day on-call can sometimes be high. • Core trainees reported that they were not always able to attend clinics because of staffing levels on the wards. When they did attend clinics, they were not always prepared, and learning opportunities were not maximised. • Higher trainees in geriatric medicine reported difficulty fulfilling specialty specific training requirements away from the ward due to rota gaps. • Higher trainees in gastroenterology told the review team that they did not get the opportunity to see patients presenting with gastroenterological bleeds. They also did not have the opportunity to deal with referrals with consultant supervision, which they felt was a missed learning opportunity. • Gastroenterology trainees reported inconsistency in the availability of weekly departmental training sessions. • Core trainees reported that, whilst rotating through Intensive Care, they were unable to attend clinics which form part of their curriculum requirements. • Hospital at Night has been implemented but is yet to be refined and embedded.

Quality Review Team			
HEE Review Lead	Professor Nik Patel, Head of School for Medicine	**County Dean (Kent)**	Professor Ali Bokhari
Training Programme Director for Gastroenterology	Dr Fergus Chedgy, Consultant Gastroenterologist	**Training Programme Director for Geriatric Medicine**	Dr Iain Wilkinson, Consultant Geriatrician

Training Programme Director for Core Medical Training	Dr Burhan Khan, Consultant Physician in General and Respiratory Medicine	**Trainee Representative for Gastroenterology**	Dr Mohammed Aamir Saifuddin, ST6 in Gastroenterology
Trainee representative for Geriatric Medicine	Dr Leon Campbell, ST4 in Geriatric Medicine	**Trainee Representative for Core Medical Training**	Dr Phoebe Cheng, CT2 Medicine
Lay Representative	Jane Gregory	**HEE Representative**	Hayley Kenway, Quality Project Officer
HEE Quality Manager	Bridget Kelly		

Educational overview and progress since last visit – summary of Trust presentation

The medical education leadership team highlighted a selection of recent training improvements that have been made. Grand round attendance has improved, and there is zero tolerance for not presenting. An internal medicine training (IMT) simulation project has been mapped to the IMT curriculum; this is a three-year programme. Improvements have been made to induction, which include an additional 'winter pressures' induction. The local faculty group (LFG) meetings are now completely trainee centred. Medical Training Initiative (MTI) doctors now have a training programme in place over their first five months in post which means they are able to go on and support the on-call rota.

Service improvements, which impact on the learning opportunities for trainees, were also shared. Following concerns about medical outliers and how this group of patients were managed, the Trust has taken steps to pair medical and surgical wards and decreased the number of medical outliers so far this year. There has also been an increase in allocation of junior doctors to wards with a high intensity of medical outliers. Further, the Trust is implementing the Royal College of Physicians (RCP) guidance on safe medical staffing. As a result, they have identified vacancies and begun to fill them. Of the 16 vacancies in 'tier one' staffing, nine have been recruited to in anticipation that they will commence in May 2020. Recruitment to the remaining posts continues. The nine posts that have been recruited to are currently being filled with locum staff; the Trust reported that six of the nine vacancies are usually filled. The Trust also commented that they may require higher numbers than the RCP recommend as their MTI trainees may not be familiar with the service and require additional support. The Trust also reflected upon 'tier two' doctors (higher trainees), and that their time on the ward is currently suboptimal because of low staff numbers.

The Trust highlighted that they have recently worked to reduce the number of 'unclerked' medical patients handed over at night as a result of placing the acute medical team in the emergency department and rapid assessment unit; the waiting time for patients to see the medical team is reported to be down from hours to minutes. This has been facilitated by the flow transformation programme, and the exclusive use of a workstation in the emergency department by the acute medical team. To achieve this, locum staff have been used. The Trust stated that they have set a budget for this and incorporated it into their business model during their current business planning in order to make this improvement sustainable.

The Trust continues to develop and implement their Hospital at Night programme. It has been in place since December 2019. The Trust reported that bleep filtering is getting better but that there are still improvements to be made. The 'task list' for the night remains a paper-based system; the Trust identified that information technology will be an important factor in the continued development of hospital at night.

Improvements in gastroenterology teaching were highlighted. Teaching sessions take place on a Monday; if a trainee misses a session, they are able to stay updated through documents available online. There is now a dedicated endoscopy training list. It was also reported that higher trainees run clinics with a supervising consultant. The Trust shared that there are now two higher trainees on call throughout the day and night.

Improvements within the core and internal medical training at the Trust included more robust and protected teaching, a specialty in-reach standard operating procedure and same day emergency care (SDEC) pathways.

Geriatric medicine improvements were reported by the Trust. The rota has now fallen under the remit of human resources. The rotations within geriatric medicine are now four months rather than two, allowing for continuity.

The Trust also highlighted that as consultant morale is quite low at present, and that it likely to be filtering down to trainees. Workforce numbers and winter pressures were identified as contributory factors.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
CGG 1.1	**Patient safety** The review team heard concern from both core and higher trainees about the triage system in place in the emergency department. They explained that upon triage by a nurse in the emergency department, which was based upon the patient's modified early warning score (MEWS), the patient would be allocated a pathway through one of three channels; the Emergency Department, the onsite GP led service (MEDOC), or the Same Day Emergency Care centre (SDEC). The trainees highlighted that patients were sometimes placed on an incorrect pathway, identifying that it could take 12 to 16 hours for the patient to be clerked by the appropriate medical team as they would have to be transferred between pathways. The higher trainees elaborated and gave examples of at least two serious incidents where patients had been incorrectly allocated a pathway. They also perceived there to be a high number of peri-arrest and arrest calls to the MEDOC department. It was highlighted by the higher trainees that the triage criteria utilised the MEWS and did not utilise clinical red flags. The supervisors stated that they felt the pathways would be safe if they were adhered to. Core trainees told the review team of instances where medical outliers on their wards had not be seen by their team; the site team had to be made aware that the patients were there in order that the specialty team review them. When asked, the trainees reported that it was clear at the weekends which ward patients were the most 'poorly'. Further, the trainees stated that there were clear paths of escalation for these patients.	

	Higher trainees highlighted their concern about the possibility of risk to patient safety and suboptimal care as a result of inadequate junior doctor staffing numbers. They explained that there had been times when the on-call registrar had covered both the medical take and the wards. The review team heard that the gastroenterology ward is led by a different consultant each week, but that there is no handover from one consultant to the next.	Yes, please see requirement 1.6b below
CGG 1.2	**Serious incidents and professional duty of candour** When asked whether they have received responses to any incidents they have reported on Datix, the trainees shared mixed experiences; some had received feedback and others had not. Most trainees stated that they report on Datix and feel able to escalate patient safety concerns. However, one of the trainees identified that at the end of their shift they are often too tired to file a Datix report, particularly when on-call.	Yes, please see requirement CGG 1.2 below
CGG 1.3	**Appropriate level of clinical supervision** Higher trainees reported concerns about support from consultants, particularly when on-call. They described how the day shift often started quiet, but the intensity would build up throughout the day. They perceived there to be no oversight or support from the senior medical team. This was in stark contrast to the Trust presentation where the review team were advised that a consultant acute physician was based in the Emergency Department, leading the take. Higher trainees told the review team that they usually run the on-call shift, but without any authority. They described that junior doctors vary in the number of patients they are able to see during an on-call shift; as a result of the lack of oversight this is something which does not get challenged or addressed. The supervisors identified that there was a consultant on-call until 9pm, though they had stayed ad hoc if it was busy. When asked whether there was an escalation policy pertaining to this, the supervisors advised the review team that they believed there was, but as they had not needed to initiate the policy in the last 18 months, they were not certain. The supervisors stated that higher trainees are allocated a supervising consultant in gastroenterology clinics and can discuss patients with them as needed. However, the gastroenterology trainees shared a number of instances where they had attended clinic and found the consultant absent. They reported that the service managers had oversight of clinic rotas and felt disappointed that they had been allocated on days where there was no supervision. The review team heard that the service manager would try to find a consultant to be in the area. The trainees stated that there had been times when they refused to run the clinics in the absence of a consultant. The review team heard that gastroenterology trainees often do not get the opportunity to discuss their patients with the consultant at the end of the clinic, and sometimes have to do this via email. They raised concerns about the imbalance in covering the service and taking up training opportunities.	Yes, please see requirement CGG 1.3 below Yes, please see Immediate Mandatory Requirement CGG 1.3 below.
CGG 1.4	**Responsibilities for patient care appropriate for stage of education and training** The review team heard concerns from trainees about a lack of consultant leadership on Keats Ward. They reported that consequently, even locums were fearful of covering the ward, so it was often understaffed. As a result, there had been instances where junior trainees had been left to make decisions beyond their scope,	Yes, please see requirement CGG 1.4 below.

	such as do not attempt resuscitation agreements. The trainees also highlighted that in these instances they had escalated to an appropriately senior colleague.	
CGG 1.5	**Taking consent** No issues were raised to the review team regarding consent by the trainees.	
CGG 1.6	**Rotas** Core trainees said that the rota impacts greatly on their ability to engage in learning opportunities. One of the trainees identified that at least 62 per cent of their time had been spent on-call. Consequently, there are limitations to the continuity of care that they can provide, and the exposure they get to clinical learning opportunities with their consultants. The core trainees are not involved in the generation of rotas. The review team heard that the core trainee on-call rota was exhausting, A week of 71.5 hours followed by a week of 69.5 hours was considered by the trainees to be detrimental to their well-being. The trainees reported that they had shared their concerns about the disproportionate time spent on-call versus covering the ward at the local faculty group (LFG), but had received no response. They said that they have now been made aware that changes will take place in August 2020 but they have not been told what the changes will be. The core trainees told the review team that they had looked at the rota design together and identified possible solutions. They had escalated these solutions to the rota co-ordinator but had not had a response. One of the core trainees also reported discussing the solutions with their educational supervisor but felt that no notice was taken of this issue. Further, core trainees reported that the on-call team is not always fully staffed. This results in the more experienced core trainees 'acting up' to fulfil registrar roles. The Trust shared their recent work to implement the RCP guidelines on minimum staffing levels. However, the core trainees told their review team that it had not yet been implemented. The number of junior doctors allocated to the wards was perceived by trainees to be at the ward's discretion, with a sense that the consultants have authority to determine staffing levels. Trainees reported having to come in on their 'audit day' to fill shortages and having to move from ward to ward to ensure service provision. They voiced concerns about the impact that staff shortages have on patient flow, continuity of care, and the delay to patient care. The supervisors acknowledged the rota being problematic for the trainees. They highlighted the higher trainee's rota can be fragmented; on-call days can mean lieu days mid-week which had an impact on their ability to take up training opportunities.	Yes, please see requirement CGG 1.6a below. Yes, please see requirement CGG 1.6b below.
CGG 1.7	**Induction** Core trainees reported the Trust induction to be very good, however departmental induction was varied. Some trainees reported no departmental induction, whilst others had high praise for intensive care induction, medical high dependency unit induction and respiratory induction. Another trainee reported that the induction was covered in a departmental teaching, however they had started working on the ward before this took place. The educational and clinical supervisors told the review team that geriatric medicine induction usually occurs within the trainees' first week in post. If this does not fall on their first day, their consultant will explain what is expected of them at the morning 'board round'.	Yes, please see requirement CGG 1.7 below.

	The medicine induction was reported by the supervisors to happen every four months, lasting half a day. The gastroenterology supervisors were unable to comment on what induction was available to their trainees. When asked whether the Deanery induction films were used by the Trust, the supervisors advised the review team that they were not.	
CGG 1.8	**Handover** The Trust's medical educational leadership team identified recent measures to reduce the number of patients requiring clerking that are handed over from the day on-call team to the night on-call team. Locating an acute physician within the emergency department, and a higher trainee within the rapid assessment unit had reportedly had a positive impact. However, both core and higher trainees were unaware of the resident acute physician within the emergency department. Further, they attributed the reduction in patients requiring clerking at handover with the significantly increased allocation of junior doctors to the clerking function. They perceived this to have had a negative impact on ward cover, with fewer staff available. Higher trainees identified that there may also be fewer patients for handing over from the day to night team as a result of them being triaged out of the medicine pathway upon presentation at the Emergency Department. The trainees also reported an increase in the number of patients being handed over from the night to the day team. Core trainees reported a culture where it is not acceptable to hand over jobs from a night shift to a day shift. This was further compounded by the night on-call team's absence at the day on-call handover in the morning. The review team heard from the trainees that Hospital at Night had resulted in a robust handover from the day team to the night team. They reported that medicine attended, alongside site practitioners and the acute response team. This had not yet extended to include surgery.	Yes, please see requirement CGG 1.3 below Yes, please see requirement CGG 1.8 below.
CGG 1.9	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The educational and clinical supervisors reported that trainees were receiving good training opportunities. They felt that general medicine experience was particularly strong. Core trainees reported an excellent exposure to a variety of clinical experiences. However, they also reported that staffing levels on the wards were inadequate to allow them the opportunity to attend clinics, as they would potentially be leaving a foundation doctor unsupervised to manage a ward of patients. This was echoed by the supervisors. When staffing levels did permit core trainees to attend clinic it was ad hoc and therefore unprepared. There were often no clinic rooms available to accommodate them. Further, if there was a room, the consultant may not be prepared to set the trainee up as it caused a delay in the running of the clinic. Core trainees reported raising this at their LFG, but no changes had been made. The review team heard from the core trainees that, when working on the wards, the consultants make a point to teach. In geriatric medicine it was reported that the higher trainees tend to do most of the teaching. They also stated that the higher trainees are good at supporting learning opportunities when on-call. The supervisors told the review team that the more experienced higher trainees would find the on-call work enjoyable, though the less experienced would likely find it challenging.	Yes, please see requirement CGG 1.9a below.

	The review team heard that higher trainees in geriatric medicine find it challenging to take up learning opportunities specific to their specialty training needs; in some instances, annual leave was taken in order to attend training. They also stated that staff shortages result in them feeling unable to leave the ward, particularly when facilitating core and foundation trainees to fulfil their training. Rota gaps also impede their ability to schedule learning opportunities away from the ward, such as those based in the community or at the hospice. Trainees reported that this was not exclusive to the geriatric specialty in medicine. The geriatric medicine clinical supervisor also shared concerns that there was not sufficient time in the rota to facilitate any specialty training requirements. They commented that such training opportunities had to be organised so that they do not impact the general medicine rota. The review team heard concerns from the clinical supervisors that trainees had less time on the geriatric medicine wards. It was also highlighted by one of the educational leads that new hot clinics for registrars will commence from August/September 2020. Trainees are to be supervised by consultants in these clinics, as they are reported to have been to date. Gastroenterology trainees reported access to specific training lists, which they found very useful. Opportunities to access gastroenterological bleeds was reported as poor by the trainees. They stated that such patients often present in the morning and as this is the busiest time on the wards, they were not able to leave to attend an interesting case. Within gastroenterology, trainees reported that consultants took the responsibility for accepting referrals as part of the in-reach service. They highlighted that this was an excellent training opportunity for them, but they were unable to pursue it because of a lack of consultant support. Further, the review team heard that consultants are often reluctant to accept referrals, and that the time window for referrals each day was very short. The educational and clinical supervisors identified that the gastroenterology ward was very busy, with many outliers. Despite this, they reported that the trainees had ample opportunities to see interesting cases. They said that, because of the intensity of ward work, there was not always the opportunity for trainees to discuss patients with the consultant immediately after ward rounds. However, they reported that the gastroenterology consultants are supportive and that the on-call gastroenterologist will be receptive to requests for support throughout the day.	Yes, please see requirement CGG 1.9b below. Yes, please see requirement CGG 1.9c below. Yes, please see requirement CGG 1.9d below.
CGG 1.10	**Protected time for learning and organised educational sessions** The educational and clinical supervisors stated that there was a weekly departmental training session for gastroenterology. The review team heard that, historically, these sessions were often missed by trainees if there was a high workload on the wards. The supervisors also reported that consultants had not always prepared teaching for the sessions. They told the review team that there was a schedule in place. However, the trainees reported that teaching sessions were often cancelled. The review team also heard from the educational and clinical supervisors that the weekly geriatric medicine teaching sessions are protected. The Trust medical education leadership team said that exception reporting took place, with the majority of reports pertaining to service rather than training. They advised the review team that protected teaching, such as the grand round, does not get cancelled.	Yes, please see requirement CGG 1.10 below
CGG 1.11	**Adequate time and resources to complete assessments required by the curriculum**	

	Supervised learning events (SLEs) were reported positively by core trainees. The supervisors reported that it was a challenge to sign off trainees on the IMT curriculum as their time on the wards was fragmented. One clinical supervisor highlighted that they only really got to know their trainee when on-call with them.	
CGG 1.12	**Access to simulation-based training opportunities** Core trainees complimented the new simulation programme, reporting that the sessions they had attended were very good.	
CGG 1.13	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** All of the trainees reported that they knew their educational supervisors.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

CGG 2.1	**Effective, transparent and clearly understood educational governance systems and processes** This was not discussed at the review.	
CGG 2.2	**Impact of service design on learners** This was not discussed at the review.	
CGG 2.3	**Appropriate system for raising concerns about education and training within the organisation** This was not discussed at the review.	
CGG 2.4	**Organisation to ensure time in trainers' job plans** This was not discussed at the review.	
CGG 2.5	**Systems and processes to make sure learners have appropriate supervision** This was not discussed at the review.	

CGG 2.6	**Systems to manage learners' progression** This was not discussed at the review.	
CGG 2.7	**Organisation to ensure access to a named clinical supervisor** All trainees reported having a named clinical supervisor.	
CCG 2.8	**Organisation to ensure access to a named educational supervisor** All trainees reported having a named educational supervisor.	
CGG 2.9	**Systems and processes to identify, support and manage learners when there are concerns** The supervisors reported that there was a detailed process and system in place for identifying and supporting trainees in difficulty.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

CGG 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** This was not discussed at the review.	
CGG 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** One of the trainees reported an occasion where they had experienced undermining and had escalated it to their clinical supervisor. They said they received feedback and were satisfied that it was dealt with appropriately. The Trust medical education leadership team shared their 'You are the difference' programme. The Trust anticipated that this would improve and embed a respectful culture. The review team were advised that there was weekly sharing of information between the Director of Medical Education (DME) and Medical Director (MD) and any issues on bullying and undermining are raised, with agreement on action to address the situation. The Trust recently received their National Education and Training Survey (NETS) comments and were in the process of reviewing them.	Yes, please see recommendation CGG 3.2 below.
CGG 3.3	**Shadowing for medical students transitioning to foundation training** This was not discussed at the review.	
CGG 3.4	**Timely and accurate information about curriculum, assessment and clinical placements** This was not discussed at the review.	

CGG 3.5	**Academic opportunities** This was not discussed at the review.	
CGG 3.6	**Less-than-full-time training** This was not discussed at the review.	
CGG 3.7	**Access to study leave** Core trainees reported that, when scheduled to be on-call, they were unable to attend regional training days. However, they were supported to do so when scheduled to be covering the ward. Trainees identified that this limited their access to training days, but also depleted their time on the wards even further.	
CGG 3.8	**Regular, constructive and meaningful feedback** Trainees reported a mixed response by senior clinicians to quality improvement work, citing that only a small number were open and supportive. They perceived the senior clinicians to be overstretched. Trainees identified a lack of support and leadership for improvement and change. When asked by the review team how trainees can feed in change, the supervisors reported that there were trainee in action forums. The review team heard that trainees were encouraged to attend these forums; issues raised here were taken to local faculty group (LFG) meetings for discussion. The supervisors acknowledged the efforts of the Chief Registrars and the changes that they had made. The review team heard from the higher trainees that there was a lack of recognition of workload and efforts, particularly when on-call. Trainees perceived this to be underpinned by a lack of senior clinical leadership.	Yes, please see requirement CGG 3.8 below. Yes, please see recommendation CGG 3.2 below.

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

CGG 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** Support for the upskilling of educational supervisors and clinical supervisors was reported by the medical education leadership team as strong, with access to post graduate certificates in education and Masters level education opportunities. However, the review team heard that investment for additional posts within the medical education team remained a challenge. It was further reported that allocating resource was difficult as the educational leadership team do not have oversight of the tariff money, so are unable to allocate it appropriately. The supervisors told the review team that they were supported in their development and encouraged to pursue educational qualifications. They reported that the yearly training programme for educational and clinical supervisors kept them up to date. The review team heard from supervisors that stand alone, three yearly educational appraisals had not been implemented at the time of the visit.	Yes, please see recommendation CGG 4.1 below. Yes, please see requirement CGG 4.1 below.

CGG 4.2	**Sufficient time in educators' job plans to meet educational responsibilities** Educational and clinical supervisors reported having enough time in their job plans for their educational responsibilities. However, they highlighted that they would like to see their trainees on the wards more. The gastroenterology supervisors advised the review team that they feel supported, but that there are time constraints because of the workload on the wards and sometimes the clinics. The remaining supervisors stated that they feel well supported. However, they also stated that their trainees are perhaps supervised so tightly that they do not have room to make decisions.	
CGG 4.3	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** This was not discussed at the review.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

CGG 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** This was not discussed at the review.	
CGG 5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** Core trainees reported that, whilst rotating through intensive care, they were unable to attend clinics. They said that they had been able to achieve their clinic attendance requirements through the utilisation of the same day emergency care (SDEC) department. However, it was highlighted to them by the training programme director, that this can only represent 25 per cent of their clinic requirements. Consequently, trainees felt concerned that they would not meet this curriculum requirement.	Yes, please see requirement CGG 5.2 below.
CGG 5.3	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** This was not discussed at the review.	
CGG 5.4	**Opportunities to develop clinical, medical and practical skills and generic professional capabilities through technology-enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation**	

	This was not discussed at the review.	
CGG 5.5	**Opportunities for interprofessional multidisciplinary working** The Trust highlighted the recent implementation of Hospital at Night. Bleep filtering was considered by the core trainees to be ineffective; trainees reported that it was dependent on the site practitioner that was on duty and their competencies. Core trainees were unaware of the clinical support worker on the Hospital at Night team and higher trainees reported a concern about the lack of team working within this service. When asked whether alternative members of the workforce had been considered, the Trust medical education leadership team reported that they had a small number of physician associates working within the Emergency Department where they were being embraced by the rest of the team. The Trust said that this role worked best in small specialist areas.	Yes, please see requirement CGG 5.5 below.
CGG 5.6	**Regular, useful meetings with clinical and educational supervisors** This was not discussed at the review.	
CGG 5.7	**Appropriate balance between providing services and accessing educational and training opportunities** Please see CGG 1.9.	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

CGG 6.1	**Appropriate recruitment processes** This was not discussed at the review.	
CGG 6.2	**Learner retention** This was not discussed at the review.	
CGG 6.3	**Progression of learners** This was not discussed at the review.	

CGG 6.4	**Transition to employment** This was not discussed at the review.	

Good Practice and Requirements

Good Practice
The core trainees reported that their senior colleagues were supportive and highlighted that the higher trainees taught at every opportunity.
The respiratory and intensive care department inductions were singled out by the trainees for praise.
Ward experience, when this occurred, was generally reported as very good.
Trainees reported that the breadth and depth of clinical opportunities at the Trust is favourable.
All trainees reported that the handover meeting at night has significantly improved.
The new simulation programme was highlighted for praise by the trainees.
The dedicated endoscopy list for gastroenterology trainees was highlighted as a significant improvement.
Higher trainees were positive about the increase in clinic opportunities and weekly teaching in geriatrics.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CGG1.3	HEE heard that higher trainees in gastroenterology were often being expected to run clinics without consultant supervision.	Clinics are not to be undertaken by trainees without direct on-site supervision, without exception. Prospective audit data to be collected and presented to HEE as evidence of compliance. Please also provide feedback from trainees via minutes of the Medicine Trainees in Action Group meeting, and the Local Faculty Group Meeting. Please provide an initial response by 13th March 2020.	R1.8

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CGG 1.2	The Trust must ensure that there are adequate governance systems in place to process Datix reports and ensure any patient safety issues are adequately identified and fedback to the reported to maximise learning from incidents.	Please provide evidence of the process followed to ensure that patient safety issues are identified through Datix reporting. Please also provide evidence of how feedback is provided to trainees who have reported incidents via Datix, and the	R1.3

		systems in place to maximise learning from incidents. Please provide this evidence by 30th September 2020.	
CGG 1.3	The Trust must ensure that there is appropriate supervision and oversight of the on-call team by a consultant. There must be a clear route of escalation when additional support is needed by trainees.	Please provide evidence showing the composition of the on-call team, In addition, please confirm the role the Acute Medical Physician is playing in the Emergency Department including how they supervise and support medical trainees undertaking on-call and clerking. Evidence to be provided via trainee feedback at LFG and Acute Physician (placed in the Emergency Department) rota. Please provide HEE with the policy which evidences the escalation system to support trainees on-call. Please provide evidence that all trainees are informed of it at regular induction. Pease provide evidence that trainees are satisfied that they are in receipt of the escalation policy at induction via LFG minutes. Please provide this evidence by 30th September 2020.	R1.8
CGG 1.4	The Trust must ensure appropriate consultant leadership on Keats Ward. There must be adequate supervision of trainees to ensure their responsibilities are appropriate for their stage of education and training.	Please provide evidence of a review of medical staffing levels on Keats Ward and a plan to ensure adequate supervision of trainees. Please provide evidence, via LFG minutes that trainees responsibilities on Keats Ward are appropriate to their stage of education and training. Please provide this evidence by 30th September 2020.	R1.7 R1.9
CGG 1.6a	The Trust must ensure an appropriate balance of on-call work and ward work for medical trainees within their rota. The rota should address the intensity of two 'acute' weeks and the impact of this on trainee's wellbeing. It should also facilitate trainees to attend mandatory training sessions, regional training days and specialty-based training requirements. The Trust should ensure trainee representation in the development of the rota.	Please provide details of the proposed rota changes that the Trust eluded to. Please also provide assurance of the intended implementation date. Please provide evidence that demonstrates trainee involvement in the development of the rota. Please provide this evidence by 30th September 2020. Once the rota is implemented, please provide evidence that trainees are able to attend mandatory, regional and required specialty training. Please provide this evidence three months after the new rota starts.	R1.12 R3.12
CGG 1.6b	The Trust is to ensure adequate medical staffing levels on the wards and the on-call rota (in accordance with the Royal College	Please provide evidence of medical staffing levels on the wards and the on-call rota, and how this compares with the Royal	R1.7

	of Physicians safe staffing guidance) to ensure both patient safety and the availability of trainees to take up clinical learning opportunities (such as clinics etc.).	College of Physicians safe staffing guidance. This should include the Trust staffing model, recruitment plans and recruitment against the plan. Please provide evidence of reduced movement of trainees from ward to ward. Please provide this evidence by September 2020.	R1.15
CGG 1.7	The Trust is to ensure that core trainees receive adequate, timely and consistent general internal medicine induction and departmental induction.	Please provide evidence that core trainees receive timely induction at next rotation. Please provide evidence of the content of core trainee departmental inductions. Following the next round of induction, please provide evidence of feedback from the trainees regarding the adequacy of their induction. Please provide this evidence by 30th September 2020.	R1.13
CGG 1.8	The Trust is to audit the number of patients handed over from the night on-call to the day on-call and respond to reduce it when necessary.	Please provide audit data which evidences the number of patients handed over from the day team to night team and night on-call to the day on-call team. Please provide evidence of the Trusts response to reduce it if necessary. Please provide this evidence by 30th September 2020.	R1.14
CGG 1.9a	The Trust is to ensure that core trainees are allocated protected opportunities to attend clinics. These opportunities should be adequately prepared to maximise the learning experience for the trainees.	HEE recommend a review of the rota to facilitate protected time for core trainees to attend clinics. Please provide evidence of core trainee outpatient clinic attendance. Please provide this evidence by 30th September 2020.	R1.18
CGG 1.9b	The Trust is to ensure that rota gaps are addressed in order that higher trainees in geriatric medicine may fulfil their specialty specific training requirements away from the ward. The Trust should also ensure that higher trainees in other medical specialties are able to fulfil their specialty specific training requirement away from the ward.	Please review the rota and provide short term and long-term plans to fill rota gaps in geriatric medicine. Please provide evidence that geriatric medicine trainees have been able to fulfil their specific training requirements. Please provide evidence that higher trainees across all medical specialties have been asked whether they are able to fulfil their specialty based training requirements away from the ward; and that action has been planned to address any issues. Please provide this evidence by 30th September 2020.	R1.12
CGG 1.9c	The Trust should ensure that higher trainees in gastroenterology have adequate exposure to the management of gastrointestinal bleed cases.	Please provide evidence that higher trainees in gastroenterology are contacted to attend bleed cases.	R1.15

		Please provide this evidence by 30th September 2020.	
CGG 1.9d	The higher trainees in gastroenterology should be afforded the opportunity to review inpatient gastro-intestinal (GI) referrals under consultant supervision. This should incorporate a regular and structured process for patient referral, review and discussion.	Please provide evidence that higher trainees in gastroenterology are afforded the opportunity to review GI referrals, with the appropriate level of supervision. Please provide evidence of the process for patient referral, review and discussion. Please provide this evidence by 30th September 2020.	R1.15
CGG 1.10	The Trust should ensure that gastroenterology trainees have access to weekly departmental training sessions.	Please provide higher trainee attendance records at weekly departmental training sessions in gastroenterology, and a schedule of planned sessions. Please provide this evidence by 30th September 2020.	R1.16
CGG 3.8	The Trust should ensure that trainees are supported to carry out quality improvement work.	Please provide evidence of the quality improvement projects within Medicine, by department. Please identify which are trainee led. Please provide this evidence by 30th September 2020.	R1.22
CGG 4.1	The review team heard that three yearly educational appraisals had not been implemented at the time of the visit.	The Trust must ensure that appraisals fully consider the supervisors' educational and supervisory roles and the GMC requirements for supervisors.	R4.1
CGG 5.2	The Trust should ensure that core trainees rotating through intensive care have the opportunity to attend clinics in order to meet their curriculum requirements.	Please provide evidence of attendance by core trainees working within intensive care at clinics. Please provide this evidence by 30th September 2020.	R1.18
CGG 5.5	The Trust has an open IMR from a previous visit regarding Hospital at Night. This action will remain open. The Trust is to ensure that this continues to be managed and implemented.	The Trust is to continue management and implementation of its Hospital at Night service, and update HEE with evidence according to their action plan.	R1.17

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
CGG 3.2	HEE recommend that the Trust continue its programme of work to embed a respectful culture within the Trust.	Provide details of the plan and its action/outcomes	R3.3
CGG 4.1	HEE recommend that the Trust ensure that the DME and MEM have access to tariff monies and are able to use it to improve education and training	Provide access to tariff monies to the DME and MEM and evidence its use for improvements to education and training.	R2.1

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility
Concerns were raised by both core and higher trainees about triage in the Emergency Department. Trainees had concern for patient safety, citing knowledge of when the triage had resulted in inappropriate pathways of care. These pathways should be reviewed urgently.	The HEE Quality team will pass this concern onto the Quality Surveillance Group for the area.

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Professor Nik Patel. Professor Ali Bokhari.
Date:	20/04/2020

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.

Trust Board Filters

and Trust / Board is equal to **Medway NHS Foundation Trust**
and Survey Year is equal to **2019**
and GEO Deanery/HEE local office is equal to **Health Education Kent, Surrey and Sussex**

Trust / Board	Response Rate	Overall Satisfaction	Work Load	Handover	Supportive environment	Curriculum Coverage	Educational Governance	Time for training	Rota Design	Resources for trainers	Support for trainers	Trainer Development
Medway NHS Foundation Trust	39%	75.29	42.23	67.88	61.06	77.01	69.86	68.59	67.87	71.51	73.17	71.63

Report By is equal to / is in **Trust/Board**

and Indicator is equal to **Feedback** , **Clinical Supervision out of hours** , **Educational Governance** , **Local Teaching** , **Overall Satisfaction** , **Rota Design** , **Study Leave** , **Reporting systems** , **Adequate Experience** , **Clinical Supervision** , **Handover** , **Induction** , **Supportive environment** , **Educational Supervision** , **Regional Teaching** , **Work Load** , **Curriculum Coverage** , **Teamwork**

and Trust / Board is equal to **Medway NHS Foundation Trust**

and GEO Deanery/HEE local office is equal to **Health Education Kent, Surrey and Sussex**

Trust / Board	Indicator	2012	2013	2014	2015	2016	2017	2018	2019
Medway NHS Foundation Trust	Overall Satisfaction	75.73	78.48	78.17	81.67	77.07	79.64	75.64	77.09
	Clinical Supervision	86.43	86.20	85.89	88.00	87.15	90.07	88.13	88.34
	Clinical Supervision out of hours				86.12	84.05	88.49	82.25	85.17
	Reporting systems					67.65	72.59	70.01	70.20
	Work Load	39.23	37.40	38.88	45.68	41.04	42.29	44.20	48.58
	Teamwork						69.03	65.28	65.78
	Handover	64.30	65.33	71.27	80.47	68.48	65.25	60.21	61.15
	Supportive environment				75.11	72.26	71.36	67.20	67.27
	Induction	77.59	76.70	80.57	83.31	78.44	80.74	76.63	75.08
	Adequate Experience	77.93	81.44	79.25	83.45	78.69	80.60	77.12	79.14
	Curriculum Coverage						77.06	74.86	77.42
	Educational Governance						71.13	68.40	70.91
	Educational Supervision	84.60	86.67	89.16	89.41	90.13	86.08	83.06	85.17
	Feedback	66.99	69.39	71.50	72.83	69.48	74.30	71.57	72.19
	Local Teaching	60.48	61.13	61.44	66.34	62.09	66.05	72.53	69.36
	Regional Teaching	66.52	67.36	65.99	66.56	68.24	66.47	64.29	63.59
	Study Leave	59.02	59.37	59.85	65.98	62.68	56.72	58.10	57.87
	Rota Design							51.13	56.04

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	Fire Safety Improvement - Performance Report	**Agenda Item**	**5.9a**
Lead Director	Gary Lupton, Executive Director of Estates and Facilities		
Report Author	Paul Norman-Brown, Head of Health & Safety / Compliance		
Executive Summary	The Trust Board has extensively kept under review fire safety risks at Medway Maritime Hospital. The Trust Board recognise improvements in fire safety are required and has committed to putting these in place, ensuring that capital funding is ring-fenced in order to do this. The Fire Assurance Group undertook monitoring on behalf of the Trust Board until the completion of the cladding replacement project. This assurance will now come from the Fire Safety Capital Programme Board via the Strategic Health and Safety Committee. The key improvements made to date include:- • Internal plaster boarding completed in 474 rooms. • Cladding replacement Completed, project wrap up in process. • Installation of a permanent platform lift enabling bed and incubator evacuation without the need to transfer patients across the roof of Arethusa between level 4 Green Zone, and Level 5 Red Zone. • Installation of a network of Advance fire alarm panels across the site and connections made to areas undergoing refurbishment. • Investment in the existing fire alarm system to maintain its functionality during the replacement project. • Commencement of a lift refurbishment programme, including increasing the provision of lifts with dual supplies. A further £7.44m bid for capital was submitted due to a level of previously underestimated costs and additional works identified. In lieu of this funding, the trust Board has committed to ring fence monies from future capital allocations to ensure the projects continue.		
	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	n/a
Resource Implications	Resource implications are addressed through ring-fenced capital budget to pay for the improvement works and associated professional fees. Project and programme management is to be resourced from the in house projects team. New appointments are currently being made.
Legal Implications/Regulatory Requirements	The Trust is required to comply with the Regulatory Reform (Fire Safety) Order 2005; the Fire Safety Improvement Programme is intended to move the Trust to an improved position. Whilst no legal advice has been taken in preparing this report, failure to improve the Trust's state of compliance is considered very likely to leave the Trust with compliance risk.
Quality Impact Assessment	Not Required at this stage
Recommendation/ Actions required	The Board is asked to note the performance reported and consider as is appropriate.

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

Appendices	Appendix 1 Schedule of Capital costs

1 Executive Overview

1.1 The Trust Board has extensively considered the fire safety risks at Medway Maritime Hospital. Since June 2017 the Trust has been in regular contact with, and reacting to advice and instruction provided by NHS Improvement (NHSI) and a significant number of actions have been enacted and capital investment made to reduce the risk of fire and/or impact of any fire incident.

1.2 The largest project, which was the life cycle replacement of the external cladding, afforded the Trust the opportunity to ensure that the exterior cladding, the structure and fire stopping behind it were fully compliant with all relevant standards and did not compromise the fire safety of the building on the external elevations. The Chief Executive established the Fire Assurance Group to provide oversight and obtain assurance that the building was kept in a safe condition throughout. The contractor recently finished on site and the Trust is now in the process of concluding the final account and drawing together all the certificates and warranties necessary to provide a comprehensive document trail for the future. In line with its original terms of reference, the executive Fire Safety Assurance Group has now been stood down and replaced by a Fire Safety Capital Programme Board, which will continue to manage the delivery of the remaining fire safety improvement schemes, providing assurance to the Board via the Strategic Health and Safety Committee.

1.3 The Trust Board has shown its commitment to fire safety by ring-fencing some of the annual capital allocation for fire safety projects, whilst also bidding for additional capital from central funds.

1.4 This report provides an update on the fire safety programme, highlighting progress made and identifying the general approach as to how the remaining projects will be delivered.

2 Programme status update

2.1 The Fire Assurance Group were regularly updated on the progress of seven particular areas. The Fire Safety Capital Programme Board will be overseeing and reporting on an additional three areas; the fire alarm replacement programme, compartmentation and replacement emergency lighting:

- Fire Boarding (plaster boarding)
- Cladding replacement
- Fire Strategy
- Communications Plan
- Replacement Lifts and New Lifts
- Fire Door replacement
- Emerald Ward
- Fire Alarm Replacement
- Compartmentation
- Emergency Lighting Improvements

2.2 The work on plaster boarding was reported as 100% complete in January 2020.

2.3 The replacement external cladding was recently completed. The Trust and its professional advisors are concluding the post project account, receiving and r eviewing the certificates and w arranties and ensuring the project is fully documented. The newly established Fire Safety Programme Board will be reviewing the impact of this project on the Trusts fire risks, which should then be reduced.

2.4 Following the conclusion of the cladding project the Trust's new AE provider BB7, will continue to work with the Trust, updating the strategy and advising on the remaining fire safety capital projects.

2.5 The communication plan will continue with staff being informed of works in their areas with a particular focus on maintaining patient privacy & dignity.

2.8 The replacement of the current 10 lifts across the site started September 2019 with a rolling programme over 3 years. Incorporated within the lift refurbishment project is the installation of dual power supplies to lifts 1, 3, 5, 8 and 10, improving vertical evacuation provision across the main building. Lifts 2 and 4 are now complete and the Trust is exploring whether Lift 5 can be brought forward in the programme to improve the resilience of the lifts in red Zone.

2.9 An order for £600k to replace fire doors has been placed to enhance protection in the highest risk areas and this has recently resumed on site following a hiatus caused by the COVID lockdown.

2.10 Emerald Ward refurbishment will enable the site to increase its bed numbers to create the capacity of a decant ward, this means the move of a ward currently in accommodation not of the standard we would expect for a modern hospital. This means it enables us to decant wards and undertake routine maintenance, part of these works will be the full replacement of the current alarm system and emergency lighting, and other environmental improvements will also be made. It is anticipated that work on Emerald will be completed by the end of October. Thereafter we anticipate trying to refurbish 4-6 wards per annum subject to availability of capital.

2.11 The Trust has invested in a network of Advance fire alarm panels across the hospital. This enables areas undergoing refurbishment, and the new lifts, to be upgraded and connected to a modern addressable system as part of the process of replacing the alarms site wide. The programme to date has been opportunistic, using refurbishment projects to make progress. Once the decant ward is available the project can move into a planned programme. In the interim £60k has been invested in the existing fire alarm system to ensure it remains operational. The new alarm system will provide greater reliability, have more functionality, and be significantly easier to maintain than the current system which is at the end of its design life. This is the most complex of all the fire safety projects as it requires the Trust to transition between two systems in all areas whilst ensuring full coverage.

2.12 Investment has been made in internal fire compartmentation, and remedial works have been undertaken along the hospital street as well as during refurbishment projects. A comprehensive survey is required across the site to record all findings on a computer based system to enable penetrations through fire compartment lines to be monitored and managed correctly.

2.13 Emergency lighting improvements are underway with self-testing fittings being used helping to ensure the Trust is meeting statutory obligations whilst also reducing the man-hours required to do so.

3 Conclusion & Next Steps

3.1 The Trust Board is asked to note progress on the programme of projects, and be assured that a robust governance process remains in place to track actions, and maintain safety.

~ End ~

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Health and Safety Update**	**Agenda Item**	5.9b
Report Author	Louise Furlong, Health and Safety Practitioner		
Lead Director	Gary Lupton, Executive Director of Estates and Facilities		
Executive Summary	This report, aims to ensure the Chief Executive and the Board, are updated of the Trust activities relating to Health & Safety compliance during the period of 04 June 2020 and 03 September 2020		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	N/A		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Health & Safety Strategic Committee plays a key role in monitoring the Trust's compliance with current legislation and the requirements of the Health and Safety Executive (HSE).The Health and Safety at Work Act 1974 (HASAWA), places a duty on employers to ensure so far as is reasonably practicable, the health, safety and welfare at work of all their employees. A breach of the Act could give rise to prosecution, financial implications, civil claims and reputational damage.		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to note and approve the contents of this report.		

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

Appendices	N/A

1 Executive Overview

1.1 In accordance with the Health and Safety at Work Act 1974, supporting regulations and all other associated approved codes of practice (ACOPS), this report looks to:

- Provide an update to the Board on Health & Safety matters for the period of 04/06/2020-03/09/2020, and
- To provide a snapshot of Health & Safety performance YTD in comparison to previous years.

1.2 The Safety Team continues to be supported by volunteers within the Trust, undertaking roles such as Keyworkers for Health & Safety or Moving & Handling, or Fire Wardens.

2 Training

2.1 Since 01 June 2020, an e-learning module for COSHH awareness has formed part of the statutory & mandatory Health, Safety & Welfare training for all staff.

Table 1 details the current compliance figures for the COSHH Awareness module (as taken on 14/08/2020):

Table 1

Directorate	Compliance
Trust	35.91%
Unplanned & Integrated Care	34.94%
Planned Care	26.67%
Estates & Facilities	73.61%
Corporate	39.07%

2.2 **Table 2** shows the compliance figures YTD for Health, Safety & Welfare training as of the statutory and mandatory report (as taken on 14/08/2020), in comparison to the compliance figures for 2019/20. The overall slight reduction in performance might be due to recent operational pressures as results were lower during Covid.

Table 2

Directorate	2019/20 Compliance	2020/21 YTD Compliance
Trust	94%	92%
Unplanned and Integrated Care	93%	90%
Planned Care	96%	92%
Estates and Facilities	85%	95%
Corporate	97%	95%

2.3 An additional 7 Health & Safety Keyworkers have been appointed since 04/06/2020, from 64 to 71. This is an increase of 11%, and overall an increase of 20% from the same month in 2019/20 (59 to 71).

2.4 Keyworker development sessions continue to be facilitated with the use of MS Teams.

Since 04/06/2020, 9 sessions have taken place, to focus solely on COSHH compliance. Future sessions planned look to build competence in workplace inspections, risk-assessing skills and incident investigation.

2.5 Participation at keyworker development sessions continues to be low; as of 14/08/2020, only 8 keyworkers participated across 6 sessions, equating to 0.75hours dedicated time per keyworker from the Health & Safety Team. The Executive team recently provided their support for ensuring keyworkers were released from duties to fulfil the annual commitment of a minimum 37.5hrs per annum being dedicated to H&S related matters.

3 Incident Reporting

3.1 The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 2013, require employers to report and keep record of certain incident types. The submissions are made directly to the HSE via the Health & Safety Team.

3.2 The number of RIDDOR submissions since the last board report on 04/06/2020 totals 6. A total of 7 RIDDOR submissions have been made YTD.

3.3 **Table 3** shows the number of RIDDOR submissions for the last 3 financial years, compared to 2020/21 YTD.

Table 3

Financial Year	No. of RIDDOR Submissions
2017-18	16
2018-19	35
2019-20	16
2020-21 (YTD)	7

3.4 **Table 4** shows a summary of the 7 incidents reported to the HSE in line with RIDDOR in 2020/21 YTD.

Table 4

Incident Type	Reporting Criteria	Summary
Injury preventing the injured person from working for more than 7 days.	Slip, Trip Fall	A member of staff fell from a chair whilst attempting to retrieve an item from under her desk– resulting in more than 7 days absence from work.
Accidental Release or escape of substance liable to cause harm.	Ingestion of a hazardous substance.	2 members of the catering team ingested a residual amount of a hazardous substance following de-scaling of a hot-water boiler. The 2 staff members affected suffered minor ill-health effects and are now fully recovered.
Injury preventing the injured person from working for more	Injury caused by physical	A staff member on Keats Ward was assaulted by a patient who

than 7 days	assault.	lacked capacity, resulting in more than 7 days absence from work.
Release or escape of biological agent.	Contaminated needle-stick injury.	A staff member sustained a needle stick injury. The needle was contaminated at the time of the incident, by a confirmed HIV positive patient.
Injury preventing the injured person from working for more than 7 days	Moving & Handling injury.	A staff member was absent from work for 8 days due to an injury sustained whilst collecting samples from a local GP practice.
Injury to member of the public taken directly to hospital	Fall from height.	2 members of the public fell into a lift from approx. 30cm height due to the lift failing to level correctly. The female attended ED and received treatment for her injuries – although the level of treatment given is not yet known.
Release or escape of biological agent	Contaminated needle-stick injury.	A staff member sustained a needle stick injury. The needle was contaminated at the time of the incident, by a confirmed HIV positive patient.

3.6 The Health & Safety Team have conducted full investigations into each of the incidents reportable under RIDDOR, in association with the relevant specialists. Advice has been provided to the departmental lead of the area as to what actions should be taken to prevent future similar incidents occurring. All incidences of RIDDOR are discussed at the H&S Operational group meetings.

3.7 **Table 5** shows the breakdown of RIDDOR submissions by directorate for the both current and previous financial year/s.

Table 5

Directorate	2018/19 RIDDOR Submissions	2019/20 RIDDOR Submissions	2020/21 RIDDOR Submissions (YTD)
Unplanned & Integrated Care	8	1	0
Planned Care	16	8	4
Estates & Facilities	6	5	2
Corporate	2	1	0
Injuries to members of the public	3	1	1
TOTAL	**35**	**16**	**7**

3.7 **Table 6** shows the breakdown of RIDDOR submissions by accident type for both the current and previous financial year.

Table 6

Injury Type	2018/19 Number of Submissions	2019/20 Number of Submissions	2020/21 YTD Number of Submissions
Crush Injury	1	1	0
Fall from Height	1	0	1
Formalin Spill	2	1	0
Incorrect Use of Equipment	3	2	0
Inoculation Injury	2	0	2
Moving & Handling Injury	8	2	1
Slip, Trip & Fall	12	6	1
Struck By Object	3	1	0
Violence & Aggression	1	2	1
Work-Related Dermatitis	2	0	0
Exposure to Hazardous Substance	0	0	1

3.8 The Health & Safety Team rely on staff using the internal incident reporting system (DATIX) in order to identify trends.

4 Enforcement Notices

4.1 The Trust has not been subject to any enforcement notices from the HSE since December 2017. Inspectors and local authority officers prioritise the highest risks and those businesses which fail to manage health and safety properly.

4.2 Inspectors have the right of entry to Trust premises as well as the right to talk to employees and safety representatives, and exercise powers to help them fulfil their role

An inspector's role is to:

- Investigate (when accidents have happened or a complaint is made) whether people are at risk.
- Require action to be taken to control risks properly if not already complying with the law.
- Take appropriate enforcement action in relation to any non-compliance, ranging from advice on stopping dangerous work activities, to potentially taking prosecutions where people are put at serious risk
- Provide advice and guidance to help you comply with the law and avoid injuries and ill health at work

5 Conclusion and Next Steps

5.1 The management of Health and Safety remains a key priority for the Trust with appropriate resources being provided to manage this within the organisation.

5.2 The Trust continues to improve both the incident reporting culture and the systems within which the data is captured. Further work is required to improve staff training for DATIX, to ensure data is captured correctly.

5.3 In 2019/20 The Trust saw an increase in the number of incidents reported as shown in **Table 7**. However YTD for 2020/21 shows a decrease across all incident types if compared to the same month in the previous year. This may be due to decreased footfall on-site or reduction in reporting:

Table 7

Incident Type	2018/19	2019/20	2020/21 YTD
Slips, Trips & Falls	53	64 (+21%)	11 (-42%)
Moving & Handling Injuries	21	23 (+10%)	5 (-50%)
Struck By or Against an Object	47	55 (+17%)	15 (=)
Sharps & Contamination Injuries	136	167 (+23%)	60 (-7%)

In response to the increase in sharps and contamination injuries, the occupational health team have implemented venepuncture and cannulation refresher training every 2 years – which was previously only completed upon induction.

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Emergency Preparedness, Resilience and Response and Business Continuity Policy**	**Agenda Item**	5.11
Report Author	Steve Arrowsmith, Head of Emergency Preparedness, Resilience and Response		
Lead Director	Angela Gallagher, Chief Operating Officer		
Executive Summary	A combination of the EPRR Policy and the BC Policy and an expansion on both previous versions to include; • Mandatory training for staff groups • Specific section that addresses funding • Risk Assessment		
Link to strategic Objectives	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: EPRR Group Date of approval: 30 July 2020		
Executive Approval:	Date of Approval: 05 August 2020		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): NHS E EPRR Standards		
Resource Implications	n/a		
Legal Implications/Reg. Req.	n/a		
QIA	n/a		
Recommendation/ Actions required	The Board is asked to approve the policy.		

Approval	Assurance	Discussion	Noting
☒	☐	☐	☐

Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

Author:	Head of EPRR
Document Owner:	Chief Operating Officer
Revision No:	8.1
Document ID Number	POLCOM045
Approved By:	Divisional Management Boards
Implementation Date:	July 2020
Date of Next Review:	July 2022

Policy

Document Control / History		
Revision No	**Date**	**Reason for change**
1.0		Detail the arrangements of the Trust in relation to the Local Health Resilience Partnership (LHRP) and Kent Resilience Forum (KRF).
2.0		Reference to include National Risk Register 2014
3.0		Change of Organisational leads.
4.0		Streamlined into Corporate Trust Policy for Board approval. Responsibilities of the Board and EPRR Group added. References to supporting documents added.
5.0		Change of author, owner, Accountable Executive and update of Trust Logo
6.0		Role and Responsibility of Non-Executive Director with EPRR Portfolio Trust Annual Report requirement
7.0	August 2019	Revision of terminology in line with the NHS England EPRR Standards and update of roles in place. Critical Plan referenced superseding the Significant Incident Plan, Structure
8.0	July 2020	Combination of EPRR and Business Continuity Policy into one document

Consultation
Divisional Management Boards (Planned and Unplanned)

Table of Contents

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

1 Introduction

1.1 Medway NHS Foundation Trust have a duty to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

1.2 Under the Civil Contingencies Act (2004) the Trust, as a Category One responder has special duties and standards which need to be met in relation to Emergency Preparedness, Resilience and Response (EPRR).

1.3 As an NHS funded organisation the Trust must be able to demonstrate that it can deal with an incident whilst maintaining services to patients.

1.4 This Policy ensures that the Trust is compliant with the Civil Contingencies Act (2004), and the NHS England EPRR Framework (2015), outlining objectives, processes and Governance to facilitate this compliance.

2 Purpose / Aim and Objective

2.1 The purpose of this policy is to provide assurance that the framework is in place to enable the Trust to prepare, respond and recover from incidents or emergencies.

2.2 The Civil Contingencies Act (2004)

- The Civil Contingencies Act (2004) and accompanying non-legislative measures, deliver a single framework for civil protection in the United Kingdom capable of meeting the challenges of the twenty-first century. The Act is separated into two substantive parts: local arrangements for civil protection (Part 1) and emergency powers (Part 2).
- Part 1 of the Act and supporting Regulations and statutory guidance Emergency Preparedness establish a clear set of roles and responsibilities for those involved

in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each.

- Those in Category 1 are those organisations at the core of the response (e.g. emergency services, local authorities, NHS bodies).

2.3 The Civil Contingencies Act (2004), requires Category 1 responders to:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- co-operate with other local responders to enhance co-ordination and efficiency
- provide advice and assistance to businesses and voluntary organisations about business continuity management (local authorities only)

2.4 NHSE Emergency Preparedness Resilience and Response Framework (2015)

The Trust Policy is to ensure the requirements set out in the NHS England EPRR Framework are met.

NHS funded organisations are required to submit evidence of their conformity to the required EPRR standards via the completion of a pro-forma template and the provision of a statement of EPRR Conformity. The Trust Board is responsible for reviewing and approving the submission annually.

2.5 The National Health Service Standard Contract.

SC30 – Service Matters, require that the Trust have a clear reporting process and assess the impact and recovery of Elective Care in relation to Major Incident.

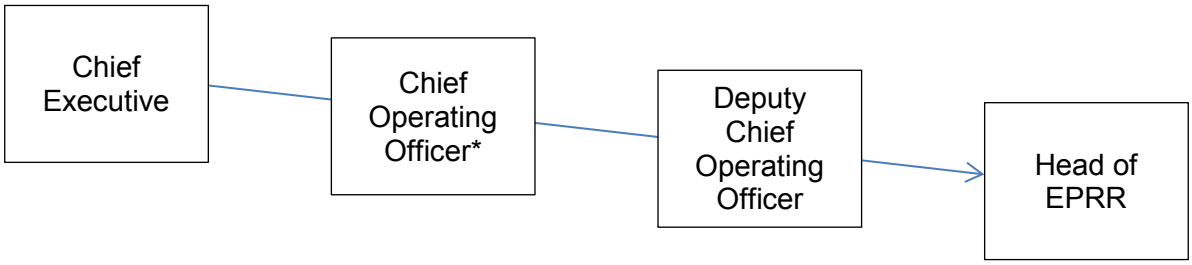
2.6 Business Continuity

The Trust Policy is to ensure that business continuity arrangements are aligned to ISO 22301. This International Standard specifies requirements for setting up and managing an effective Business Continuity Management System (BCMS) thereby;

- Understanding the organisation's needs and the necessity for establishing business continuity management policy.
- Implementing and operating controls and measures for managing an organisation's overall capability to manage disruptive incidents
- Monitoring and reviewing the performance and effectiveness of the BCMS
- Continual improvement.

2.7 Trust Objectives

EPRR supports the Trust objectives by ensuring the continuous improvement and rolling programme of Business Continuity and Emergency Preparedness across the



**Holds the role of Accountable Emergency Officer*

organisation and at all appropriate levels of staffing by ensuring that its people are trained and exercised in EPRR best practice with the support to carry out the skills required when required.

2.8 On Call

Medway NHS Foundation Trust ensures it can receive notifications relating to business continuity incidents, critical incidents and major incidents by employing a resilient and dedicated on-call mechanism, which is supported by the Head of EPRR.

This function has both 24/7 senior manager and director level robust availability and capability. On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer. The Identified Individuals;

- Are trained according to the NHS England EPRR competencies (National Occupational Standards).
- Can determine whether a Major, Critical or Business Continuity incident has occurred
- Has a specific process to adopt during decision making
- Is aware of who should be consulted and informed during decision making
- Should ensure appropriate records are maintained throughout

2.9 Testing and Exercising

Exercising schedule should incorporate the response needed for Major, Critical and Business Continuity Incident, whilst considering local risks and meeting the needs of the organisation in the form of;

- Six-monthly communications cascade test
- Annual Table top
- Live Exercise; and a
- Command post exercise

2.10 Incident Control

The Incident Control Centre currently resides on the second floor at the front of the hospital (next to the Site Office) during an incident it will function side by side with the site office to manage the incident as well as the rest of the Hospital.

The completion of incident SitReps can be found as an appendix to the Major Incident Plan on Q-Pulse.

A list of trained Loggists sits with switch board who can be contacted 24/7.

2.11 Business Continuity Management System (BCMS)

The organisation has a system to evaluate BCMS and this is part of the 2020/22 programme of work which will include the monitoring and evaluation of Business Continuity arrangements against KPIs, Support arrangements and Emergency Ward boxes for Critical Hospital Functions.

3 Definitions

3.1 **Business Continuity Management (BCM)** identifies critical activities and highlights potential impacts that could threaten an organisation. It provides a framework for building resilience and the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities

3.2 **Category 1 responders.** Core responders, as defined by the Civil Contingencies Act (2204), to emergencies and are responsible for carrying out the legislation set down by the Act.

3.3 **Critical Activity.** An activity which an organisation needs to ensure its continuity, in order to meet business objectives.

3.4 **Critical Incident.** Any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical functions,

patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

3.5 **Emergency Preparedness, Resilience and Response (EPRR)** - A programme of work which prepares and responds to a wide range of emergencies and incidents that could affect health or patient care.

3.6 **Incident -** An event that causes disruption to the organisation.

3.7 **Local Health Resilience Partnership (LHRP) -** Group representatives at Executive level from local health sector organisations. A forum for joint working in EPRR.

3.8 **Local Resilience Forum -** Multiagency partnership made up of representatives from category 1 and 2 responders.

3.9 **Major Incident -** An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.

4 (Duties) Roles & Responsibilities

4.1 Trust Board

Responsible for;

- Approving the Trust's Corporate Policy for EPRR.
- Reviewing and approving the annual report to the Board on EPRR arrangements.
- Understanding the statutory framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.
- Supporting the delegated responsibility of Command and Control during an incident that requires such processes to be implemented.

4.2 Chief Executive

Department of Health Guidance (2005) dictates the Chief Executive is named as the person accountable for Emergency Preparedness, Resilience and Response. To support this arrangement the chief Executive;

- is responsible for designating the responsibility of EPRR as a core part of the organisation's governance and operational delivery programmes
- Is aware of the factors within the organisation which could negatively impact on public protection within their health community as a result of a major incident
- Is aware of their legal duty to respond to a major incident
- Is responsible for nominating an Accountable Emergency Officer

4.3 Non-Executive Director

The Trust has an identified, active Non-executive Director representative who formally holds the EPRR portfolio for the organisation.

The Non-executive Director Representative will;

- Be publicly identified via the public website and annual report
- Be a regular and active member of the Board/Governing Body
- Be briefed via a formal and establish process on the progress of the EPRR work plan outside of Board meetings.
- Attend EPRR Group meetings, be familiar with the minutes and engage in current EPRR issues as required.

4.4 Chief Operating Officer

The Chief Operating Officer is the designated Executive for EPRR and the delegated Accountable Emergency Officer with responsibility to ensure;

- that the Trust has Resources committed and funds available to the EPRR Function,

- that Plans and policies are in place to fulfil the requirements of the statutory framework;
- Commitment from staff and Senior Leadership towards Emergency Planning, Business Continuity and Training and Exercising
- The Chief Executive and the Trust Board are provided Assurance that the organisation is meeting its obligations in respect to EPRR and relevant statutory obligations under the Civil Contingencies Act (2004)
- The organisation is properly prepared and resourced to respond

They will;

- Attend the Local Health Resilience Partnership Group,
- Discharge their responsibility to provide EPRR reports to the board no less frequently than annually, the reports must go to board, and as a minimum, include an overview on;
  - Training and exercising undertaken by the organisation
  - Summary of any business continuity, critical incidents and major incidents
  - Summary of lessons identified from Incidents and exercises
  - The organisations compliance position in relation to the latest NHS England EPRR Assurance process

4.5 Emergency Preparedness, Resilience and Response Group

This group is established to assist the Trust Board in fulfilling its responsibilities in relation to the Civil Contingencies Act 2004. It will fulfil its purpose by having responsibility for oversight of the Trust EPRR Policies, documentation, and learning from exercises and incidents.

The group must address issues regarding EPRR and providing assurance in relation to governance to the board.

4.6 Head of Emergency Preparedness Resilience and Response

The Head of EPRR is responsible for;

- Reviewing and facilitating Emergency plan updates through the correct Trust procedure.
- ensuring the EPRR corporate responsibilities are met in line with NHS England Core Standards for EPRR (2020 – 2022)
- training and exercising resilience response plans throughout the Trust
- representing the Trust at local sub groups related to EPRR and the LRF
- coordinating a post incident debrief and using lessons learnt to improve existing plans
- Supporting the accountable Emergency Officer in providing assurance to the Trust Board regarding EPRR.
- Preparing assurance reports to relevant Committees and Boards.
- Carrying out and documenting risk assessments in relation to national and local risk.

4.7 Directors, General Managers and Heads of Department

Directors, General Managers, Service Managers, Heads of Departments (including Nursing) will;

- Agree the Trust Core Functions and Critical Dependencies for their areas and undertake detailed Service and IT System Business Impact Assessments following the Trust Management of Business Continuity Policy,
- Be responsible for ensuring that their appropriate departments comply and engage in EPRR and support the Accountable Emergency Officer in providing assurance to the Trust Board
- Ensure that business continuity plans and arrangement are in place which are agreed and remain as live documents.
- In line with the EPRR Training Needs Analysis release staff accordingly for training and ensure they are fully compliant with EPRR training within the Trust.
- Release staff (including those that are, but not limited to, Medical, Nursing and Operational) to undertake Exercises to test EPRR Plans.

- Directors, General Managers and Heads of Department who are aligned to the Trust on call Rota's will evidence attendance against the agreed EPRR training programme ensuring an up to date EPRR portfolio is kept
- Directors, General Managers and Heads of Department must ensure they are accessible and are fit to carry out their duties at all times whilst on call and have access to the required information, policies and communications

4.8 Service Leads

Service leads;

- Must ensure that their departments/areas have comprehensive Service Level Business Continuity Plans (BCP) in place
- Are responsible for reviewing and updating plans
- Are responsible for ensuring that all relevant staff are aware of the service plan and have received instruction in the use of the plan
- Must collaborate with the Head of EPRR to exercise service level BCPs once a year.

4.9 Communications Team

The communications Team are responsible for Trust Communications during an incident and liaison with external communication partners

4.10 Head of Infection Control

The Head of Infection Control is responsible for supporting the EPRR agenda via communications with and direction from the Health Protection Agency or other Agencies as required.

4.11 The Head of IT

The Head of IT will;

- ensure that there is a Disaster Recovery Plan (Covering loss of physical assets and recovery with a recovery time objective)

- ensure that the Trust can demonstrate Cyber Security (as outlined within https://www.gov.uk/government/publications/10-steps-to-cyber-security-advice-sheets

4.12 Associate Director of Procurement

The Associate Director of Procurement will ensure that a system is in place to risk assess, request and obtain business continuity plans from providers that the organisation commissions and any sub-contractors have arrangements in place.

4.13 Switchboard Supervisor

The Switchboard Supervisor will maintain the contact details of staff on 'on-call rotas' Will assist with the testing of the Incident Response cascade at least 6 monthly.

4.14 Consultant Nuclear Medicine

The Consultant Nuclear Medicine will ensure that the Radiation Monitoring Devices based in the Emergency Department (RAMGENE) are adequately assured on an annual basis via an approved appointed person.

4.15 Chemical, Biological, Radioactive and Nuclear (CBRN) Leads of the Emergency Department.

The CBRN Leads of the Emergency Departments will be responsible for maintaining the CBRN Standards (LHRP, 2013) covering:

- Risk Assessment.
- Equipment
- Training
- Management of CBRN and Radiation Monitoring trained Staff.

4.16 In response to any EPRR incident, which requires activation of an emergency plan and/or the command and control structure, the Senior Manager on Call and Director on call have a duty to assume the relative command position. The SMOC will assume the role of the Tactical Commander and the Director on Call will become the Strategic Commander. This policy permits those commanders the authority to act

outside of their normal scope of duties in direct response to an evolving incident in order to promote or save life, reduce humanitarian suffering but within keeping with the Trust's vision and values.

5 Business Continuity Management

5.1 Business Continuity Management (BCM) identifies critical activities and highlights potential impacts that could threaten an organisation. It provides a framework for building resilience and the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value creating activities.

5.2 BCM Planning

Effective programme management will ensure capability is established and maintained within the Trust

5.2.1 Step 1 – Understanding the organisation

Business Impact Analysis (BIA) identifies and documents key services and critical activities required to deliver them, the impact of a disruption and the resources required to recover.

5.2.2 Step 2 – Determine the BCM Strategy

Identify actions to maintain the critical activities.

5.2.3 Step 3 – Developing and Implementing BCM response

The development and implementation of appropriate plans and arrangements to ensure management of an incident and continuity as well as recovery of critical activities.

5.2.4 Step 4 – Exercising, Maintaining and Reviewing

Ensure the BCM arrangements are validated by exercising and reviewed according to policy and revised accordingly.

The BCM will be reviewed to ensure that it is effective. Peer review and internal audit process will facilitate BCMS review.

5.3 BCM Scope

Business Continuity Plans relate to all health care services provided in the inpatient, outpatient and community settings.

5.4 BCM Ownership

5.4.1 Plans (including BIAs) will be kept up to date in line with current legislation, guidance and good practice.

5.4.2 Directorates and departments will produce and maintain a business continuity plan (with the included BIA). These plans will be kept locally within the directorates and on Q-Pulse.

5.5 Business Continuity Plans of Commissioned Suppliers and Providers

5.5.1 Business Continuity Plans of commissioned suppliers and providers need to be assessed to ensure they are in place and dovetail with Trusts plans and critical activities.

5.5.2 These activities can be managed through the procurement contractual process and the Head of EPRR working with service leads in the commissioning and implementation phases. BCPs for services commissioned by the CCG for multiple organisations, such as patient transport, equipment providers and NHS 111 will be assessed by the CCGs. Business Continuity plans should be tested with multiple providers as part of the exercising programme.

5.6 EPRR Plans

5.6.1 The Head of EPRR is responsible for developing, maintaining, reviewing and revising emergency resilience plans including;

- MFT EPRR and Business Continuity Policy
- MFT Major Incident Plan
- MFT Mass Casualty Plan
- MFT Infant Abduction Plan
- MFT Incident Response Plan
- MFT Heatwave Plan
- MFT Winter Plan
- MFT Critical Incident Plan
- MFT Pandemic Flu Plan
- MFT Evacuation Plan

5.6.2 EPRR plans will be written and revised in consultation with key stakeholders both internally and external to the organisation. This will be documented on the plans' version control.

5.6.3 Plans are ratified through the EPRR Group and relevant other committees. Emergency resilience plans will be available to all staff via the Trust's Intranet. Paper copies of the plans will be held in key locations across the Trust including the Incident Control Centre.

6 Key Performance Indicators

6.1 Clinical Groups will be measured against Key Performance Indicators for EPRR and reported biannually through the EPRR Group and annually through the EPRR Report.

7 Work Plan

7.1 An annual EPRR Work Plan, which includes the annual exercise plan, will be submitted to the EPRR Group at the end of the previous calendar year. The work plan outlines the proposed schedule of work in relation to plan development, EPRR logistics, training and exercises

7.2 The work programme to be delivered will be to:

- Meet statutory requirements
- Address lessons learnt from incidents and exercises
- Identify risks
- Identify outcomes of assurance and audit processes

7.3 The work and exercise plan may be influenced by arising risks as well as local and national agendas throughout the year

8 Training and Exercising

8.1 The Head of EPRR is responsible for coordinating and facilitating the EPRR training and exercise programme for the Trust

8.2 Training

8.2.1 Mandatory Emergency Resilience Training is required every 2 years for;

- Matrons/ward sisters including midwifery (band 6 and above)
- Allied Health Professionals (Band 7 and above)
- Operational Service Managers (Band 7 and above)

Records of Training will be recorded on ESR.

8.2.2 Senior Managers and Directors who carry out an on call role must take part in the Commander training programme and maintain a portfolio in line with National Occupational Standards.

8.2.3 Records of training will be recorded by the Head of EPRR. The Head of EPRR will also provide non mandatory training to other staff groups through local arrangements, staff development days and staff meetings.

8.2.4 Training sessions will incorporate National Occupational Standards as best practice.

8.2.5 CBRN training is facilitated in partnership with Acute Trusts across Kent to ensure a system-wide consistency. The training is essential for all Emergency Department staff but the courses are open to all Trust staff.

8.3 Exercising

8.3.1 The Trust has a legal obligation under the Civil Contingencies Act (2004) to carry out regular exercising of resilience arrangements.

8.3.2 The Trust must carry out;

- A Live Exercise every three years
- A Table top exercise every year

- Communications exercises at least every 6 months

8.3.3 The Head of EPRR will coordinate these exercises. These exercises may be run in conjunction with partnership organisations including Kent Fire and Rescue, Kent Police and South East Coast Ambulance.

8.3.4 All Trust Emergency Exercising carried out should be both proposed into and agreed by the EPRR Group, and exercising report should then be presented to the group within 1 month of the exercise, This includes (but is not limited to) any Emergency Simulation exercises, Security or Fire response Exercises. This allows the organisation to coordinate and ensure that the quality of participation is effective and safe.

8.3.5 The Head of EPRR and other operational staff will endeavour to participate in external exercises facilitated by other Category One and Two responders to support interoperability. The Head of EPRR will make available opportunities for other staff to take part in multiagency exercises not only in the incident response but in surge capacity and winter planning.

8.3.6 The Head of EPRR is responsible for ensuring that the lessons learnt and recommendations are gathered and actioned following exercises or real incidents. This information will be presented at the next EPRR Group, risks will be assessed and mitigated where possible and when the risk cannot be mitigated, reported to the Executive Group.

8.3.7 A record of all lessons learnt and recommendations is maintained by the Head of EPRR.

9 Funding

9.1 The Head of EPRR will have control and hold the Emergency Preparedness, Resilience and Response budget. This will be set each year with the Chief Operating Officer and The Chief Executive.

9.2 Each department will fund the costs of staff going on training and exercises and any resilience equipment required within its department.

9.3 In the event of a Major Incident all departments must keep a record of additional expenditure and forward this to Divisional Finance Business Partners, so that where possible reserves can be allocated by the Director of Finance however the costs of responding to a major incident rest with the directorate concerned. In the event of a large scale incident, costs will be met through Trust reserves.

10 Risk Assessment

10.1 The Head of EPRR will develop and maintain the Emergency Resilience Risk Register in line with National and the Kent Community Risk Register. This is the External Factors EPRR Risk Register which is reviewed every two years, after an external risk register publication or significant change in risk.

10.2 EPRR risks will be reviewed as a standing item at the EPRR Group

11 Assurance and Governance

11.1 The EPRR Group will provide assurance to the Executive Group that the resilience programme is being developed and maintained and that EPRR and Business Continuity Issues are being addressed within the Trust.

11.2 The Head of EPRR will submit an annual report to the Executive Group and the Trust Board regarding EPRR. Additional exception reports may be required for assurance purposes.

11.3 The Head of EPRR will complete the annual NHS E/I Core Standards for EPRR self-assessment as required. The outcome will be submitted to the Trust board through an exception report.

12 Information Sharing

12.1 Under the civil contingencies act 2004 (CCA), Category 1 and 2 responders have a duty to share information with other Category 1 and 2 responders. This is required

for those responders to fulfil their duties under the CCA. Information sharing is also encouraged as being good practice.

12.2 To allow appropriate information sharing to take place, Trust Commanders must ensure that the following legislation has been considered:

- Freedom of Information Act 2000
- General Data Protection Regulation 2018
- Data Protection Act 2018

12.3 Trust Commanders must follow the organisational policies and seek guidance if unsure if the information can be shared.

12.4 Data Protection legislation requires all organisations which handle personal information to comply with a number of principles regarding privacy and disclosure.

12.5 It is important that emergency response is not hampered by organisations or individual's reluctance to share information which could be deemed confidential.

13 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Chief Operating Officer	Where gaps are recognised action plans will be put into place
NHS EPRR framework – compliance with the core standards	EPRR Group – Each meeting	EPRR Manager	Executive Group, Trust Board	Where gaps are recognised, action plans will be put into place
EPRR work plan	EPRR Group – Each meeting	EPRR Manager	Executive Group	Where gaps are recognised, action plans will be put into place
Learning from exercises	EPRR Group – Each meeting	EPRR Manager	Executive Group	Where gaps are recognised, action plans will be put into place

14 Training and Implementation

14.1 A training needs analysis is prepared as part of the annual work plan and its adequacy is reviewed by the EPRR Group.

15 Equality Impact Assessment Statement & Tool

15.1 Public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]".

15.2 The policy owner must insert here a statement to summarise how they have assessed the policy for impact on the protected characteristics under the Equality Act 2010. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment [AGN00168 - Equality Impact Assessment guidance note]. Key issues to include are:

- An assessment of how relevant the policy is to equality and diversity
- The key informants (e.g. data and/or consultees) of the assessment
- What, if anything, was learnt, and any actions that need to be taken to ensure that the policy can be delivered equitably.
- Where the impact assessment can be located (e.g. available from the document author)

16 References

Document	Ref No
References:	
Civil Contingencies Act 2004 Part 1 and 2	
Emergency Preparedness, Resilience and Response Framework (NHS England, 2015)	
NHS England Core Standards for Emergency Preparedness, Resilience and Response (NHS England, 2015)	

The Health and Social Care Act, 2012	
Trust Associated Documents:	
Major Incident Plan	
Chemical, Biological, Radiological and Nuclear CBRN Incident Plan	
Kent and Medway – Information Sharing Agreement	
Kent and Medway Local Health Resilience Partnership – Mutual Aid Agreement	

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	Trust Improvement Plan - Control of Substances Hazardous to Health (CoSSH) and Infection Control Update	**Agenda Item**	**6.1**
Lead Director	Gary Lupton, Executive Director of Estates and Facilities, David Sulch Medical Director		
Report Author	Gary Lupton, Executive Director of Estates and Facilities, David Sulch Medical Director		
Executive Summary	The trust continues to work to improve its current performance in relation to the management of COSHH products. The physical infrastructure is being enhanced with additional controls around locks and alarms when doors are left open, staff behaviour and understanding need to be improved at pace to ensure long-term sustained changes are implemented, recent evidence suggests some improvements and additional planned physical controls should greatly contribute to improving the results. The improvements will continue to be measured from these key areas; routine monthly H&S team led auditing, training of local H&S link workers, local monitoring and guidance from ward leadership / departmental Health and Safety link workers on each ward undertaking regular audits. Housekeeping supervisors to include auditing of COSHH into daily routine. Management involvement is critical to making these changes, they will need to actively drive the completion of training and make staff available to undertake the role of the Health and Safety link worker for their area.		
	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 Quality Assurance Committee continues to scrutinise CoSSH and infection control performance.		

Resource Implications				
Legal Implications/Regulatory Requirements	Infection Control performance and CoSSH compliance are both key regulatory concerns.			
Quality Impact Assessment	Not Required at this stage			
Recommendation/ Actions required	The Board is asked to note the performance reported and consider as is appropriate.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☐
Appendices	1. COSHH Spot Check Audit: Overall Compliance Results (2020) 2. Aeroscout Door Contact Alarms:			

1 Audit Results

Amber /Red

1.1 The Health & Safety team undertakes a monthly audit across all accessible wards to check that there are secure areas to keep COSHH products in and that staff are using them. The audit questions are to establish if the basic rule 'keep COSHH products secure' is being followed. These audits have been reported separately to all other COSHH audits undertaken and therefore are only a reflection of that time and day these audits are undertaken. However having reviewed all the other audits undertaken these confirm consistently the problems around kitchens especially but does expand the lack of compliance to all staff groups not meeting the required standards as staff wash up their own cutlery for example, all staff groups in addition to housekeeping need to be tackled.

1.2 Four monthly rounds of auditing have now been completed (Appendix1) and the results show an improved position from that reported last month.

- 1.2.1 68% in May
- 1.2.2 86% in June
- 1.2.3 16% in July
- 1.2.4 54% August

The target in the CQC action plan is 95%, however an expectation of 100% compliance is the only way we can ensure the safety of all our patients.

1.3 Eleven of 24 wards failed on the August audit, with Housekeeping products remaining the main area of concern: washing up liquid and dishwasher chemicals account for the significant number of the failures identified. The relevant managers have been made aware of the audit results and issues are raised with the senior manager on the ward at the time.

1.4 The clear objective is to get staff to keep all COSHH products secure at all times when not actually in use and supervised.

1.5 We also need staff to develop the awareness to ensure all doors that should be kept secure are locked, including storage cupboards, staff rooms and any other areas where there is a risk to patients, irrespective of them being in common or ward areas.

2 Training Trajectory

Red

2.1 Keeping COSHH products secure is one aspect of ensuring staff and patient safety. Staff awareness and understanding of what COSHH products are and how they should be used is critical if we are to prevent accidents when the products are in use.

2.2 On the 1st June the Trust implemented a COSHH training e-learning package for all staff to supplement the Health Education England approved statutory 'Health, Safety and Welfare' module. The training is more detailed and tests the staff members understanding of the topic.

2.3 It is still a local responsibility to ensure employees are trained in the specific COSHH products used in their workplace as each product will have specific usage instructions and emergency procedures associated with it.

2.4 The training objective to achieve 95% of all staff by September 2020 with the following trajectory.

Table 1:

	June	6th July	27th July	August to-date	September
Target	**10%**	**65%**		**85%**	**95%**
Organisation	**8.98%**	**14.31%***	**26.33%**	**35.91%**	**-**
Corporate	-	*20.37%*	*32.49%*	*39.07%*	
E&F	-	*6.98%*	*65.00%*	*73.61%*	
Planned	-	*12.22%*	*18.78%*	*26.67%*	
Unplanned	-	*14.31%*	*22.19%*	*34.94%*	

2.5 Organisation Development will provide two weekly reporting for divisions and departments. The granular report is now developed.

2.6 Whilst E&F compliance remains higher than other areas of the organisation it is evident when looking at the latest audit failures, the majority of failures remain attributed to housekeeping services.

3 Health and Safety Keyworkers

Amber /Red

3.1 Ward and department managers are responsible for identifying Health and Safety link workers to help them fulfil their responsibilities under the Health and Safety Policy, and for allocating time within working hours for them to be able to meet their responsibilities.

3.2 Health and Safety link workers are there to assist the managers with; mandatory risk assessments, workplace health and safety audits, quarterly workplace inspections, providing low risk health and safety advice and maintaining the health and safety folder.

3.3 In order to gain greater assurance and behavioral change, it is important that the Health and Safety link workers are used to provide more frequent (weekly/daily) audits on COSHH safety. This will improve the level of assurance to the organization, and locally as opposed to the monthly audits undertaken by the Health and Safety team.

3.4 At present there continues to be an insufficient number of link workers nominated. Currently five wards are still without a named link worker. Of those who are appointed, only limited numbers of ward based link workers have attended the COSHH training despite numerous e-mail reminders sent for attendance, three further training sessions have been set.

3.5 The Health and Safety team can then monitor the link worker audits and pick up on any exceptions, and on a monthly basis look more deeply into the local management arrangements on each ward. The link workers can then be used to facilitate any improvements.

4 Conclusion and Next Steps - CoSHH

4.1 At present the Trust is not meeting its target COSHH audit score of 95% and training is behind trajectory.

4.2 In order for the Trust to improve its performance, all ward and department managers need to ensure that three objectives are met:

- COSHH products are kept secure.

- Employees complete their COSHH training.
- Link workers are appointed and trained.

4.3 Health and Safety link workers need to be identified and trained quickly as they are the means of providing local capacity for weekly / daily auditing and resolving issues identified in the audits. This needs to be achieved in the in-patient areas first, but must extend to the remainder of the organisation.

4.4 The Health and Safety team can provide independent assurance of COSHH safety and support to link workers in each ward or department.

4.5 The following risks need to be managed:

- Doors to be closed and locked
- Unattended COSHH products must be removed and secured safely
- Online training compliance levels too low

4.6 The following additional actions are now being progressed – electronic door monitoring via a small device (Aeroscout) (Appendix 2) fitted on the door linked back to a central system which monitors and alarms when the doors are open. The first order of these products have been delivered and are being fitted and tested, a daily report is being created and this will need to have parameters set in terms of what an acceptable time is for a door to remain open. As part of this roll out, all door self-closers will be checked and latch mechanisms to be disabled where possible. Where latches cannot be disabled a plan to replace all locks will be generated and orders for replacement locks raised.

4.7 Replacement of 60 housekeeping cleaning trolleys with lockable versions – 35 have been delivered and deployed. No reportable failures in the recent audit highlighted unattended or trolleys with products accessible to the public/patients.

4.8 In terms of washing up liquid, no non-COSHH products have been identified to date, therefore the decision has been made to modify how this liquid is dispensed. This will be achieved by a hand pump being fitted to the top of the sink with the liquid stored in a container fitted inside the locked cupboard.

4.9 The Chief Nursing and Quality Officer has implemented a programme of joint ward visits with the Executive Director of Estates and Facilities at which compliance with IPC and COSHH is assessed, any issues immediately dealt with and results fed back to the ward and any additional environmental actions agreed with the Estates Team.

5 Work to date and actions taken to address risks relating IPC

5.1 On 19 December 2019 the Trust received a Section 29A Warning Notice under the Health and Social Care Act 2008. This raised significant concerns relating to Infection, Prevention & Control (IPC); Care of Substances Hazardous to Health (CoSHH) and mixed sex accommodation.

5.2 **Immediate actions for IPC included:**

- The Divisional Medical Directors spoke with doctors regarding personal IPC standards.
- All Theatre staff were informed they must be bare below the elbows with no jewellery, including fit bits with notices displayed confirming this. Scrubs only to be worn.
- Wards were visited by the Matrons and Heads of Nursing to discuss the issues raised.
- IPC was also added to the discussion at safety huddles.

- The Chief Nursing and Quality Officer implemented a weekly Matrons report on nursing fundamental standards and risk assessments which is reported through to the Divisional Directors of Nursing (DDoNs) as part the approach to provide assurance from ward to board.
- Observational audits and spot checks continue to be undertaken by the Matrons, Heads of Nursing and Divisional Directors of Nursing and reported in an assurance report to the Chief Nursing and Quality Officer.
- All nursing observations and IPC care plans were kept on ExtraMed IPC which flags infection status, including influenza and includes care plans for infections.

5.3 A combined CoSHH / IPC action plan was developed and supported by the central quality team to co-ordinate responses and progress on actions.

5.4 A number of information requests from the CQC relating to Infection Control and CoSHH were received by the Trust and responded to in a timely manner. These were:

Date	Source of Request	Full details	Date submitted	Information provided
17/12/19	Section 31 Enforcement Action	Staff IPC processes	19/12/2019	Email letter to Inspection manager as part of larger request
16/12/19	Unannounced inspection 16/12//19	IPC Action Plan	23/12/19	Email letter to Inspection manager with IPC Action plan as part of a larger request
23/12/19	Section 31 & 29A letter	Update on the actions to address Section 29A	24/01/20	24/1/20 email letter to Inspection Manager relating to the actions raised in section 29A for IPC.
11/06/20	CQC Information request	IPC team structure, up to date IPC action plan, IPC BAF & CoSHH Action Plan	17/06/20	Email letter to Inspection Manager with: CEO response, including IPC Board Assurance Framework

The Chief Nursing and Quality Officer, has recently submitted further evidence to the CQC Inspection team in July which included:

- **Governance -** Quality Panel agendas, minutes and two examples of completed templates that are submitted to the panel by operational leads. Copy of letter sent to Executive and Operational Leads from the Chief Nurse and CEO.
- **Reporting** – Copies of reporting on the Trusts action plan to the Executive Team, Quality Assurance Committee and Trust Board.
- **Implementation of Trust wide Quality assurance visit process** – Presentation to the quality panel and template
- **Evidence Panel** – This has recently been implemented, agenda from first meeting

- **Audit template** – Flow chart reviewed and approved at the Quality panel
- **IPC & COSHH** –action plans, evidence of audits, draft IPC education strategy
- **Nursing standards** – Nursing and Midwifery Assurance Framework and daily standards and practice report

5.5 Over this period of time 54 of the 62 actions contained in the CoSHH/ IPC action plan were completed and closed. Remaining actions were then transferred into the Trust's CQC Action Plan.

6.6 Executive and operational leads provide updates and evidence of progress via a standardised reporting template developed by the central quality team and to assess the RAG status of their related Must do and Should do actions plan.

6.7 Actions relating to both areas contained within the Trust's CQC action plan include the following:

Infection Prevention and Control (IPC)
Actions being taken
▪ MD01 RAG status has moved from RED to Amber – 'Actions on Track' (and will be Green following the transfer to the new BRAG status) reflecting the work and progress described below.
▪ The Trust wide IPC Improvement Plan has undergone a major redraft by Dr Ian Hosein, Director of Infection Prevention and Control. This plan forms the basis for agendas and actions from the Infection Prevention and Control Committee (IPCC).
▪ High level metrics identify that the Trust remains on target for infection control standards. The numbers of patients developing hospital acquired infections are lower in 2020-21 (April to July) for every key infection when compared to 2019-20. In July the Trust had zero MRSA and one C-diff case. The rate of hospital acquired E coli blood stream infections has more than halved compared to 2019-20 (13 cases versus 28 cases).
▪ The Trust has had no outbreaks of hospital acquired COVID-19 infection. The rates of definite or probable hospital acquired COVID-19 remains below the regional mean (8.8% vs 12%) with two cases reported in July.
▪ Post infection reviews are carried out in a timely manner and have broad attendance from the clinical teams. All cases of MRSA bacteraemia, C difficile and hospital acquired COVID-19 occurring before the end of July have undergone a PIR and key learning has been publicised in the Divisions.
▪ Level 2 Mandatory Training compliance for both clinical divisions has remained at close to (or greater than) 95% since a major drive to ensure compliance was undertaken in the summer of 2019.
▪ ED medical staff and pharmacists have been given job specific infection control update training.
▪ A review of pre-admission MRSA swabbing has been undertaken identifying 54% compliance. IPC

will now develop a plan to address this for presentation at the next IPC Committee.
▪ PPE and BBE audits are now being undertaken monthly and show good compliance.
▪ The Associate Director of Quality & Patient Safety has met with the Director of Infection Prevention and Control (DIPC) again to confirm the process by which the Central Team will receive weekly data on identifiable target organisms, monthly audit results for hand hygiene and personal protective equipment and to changes to the IPC Improvement Plan

Additional Actions being taken
▪ All of the outstanding IPC policies have been updated after the department adopted the Scottish government's national IPC overarching policy and organism specific appendices.
▪ Six wards have now been reviewed as part of the Quality Assurance Visit programme and a paper will be presented to QAC next month on themes and trends. This month Theatres will be reviewed along with the effectiveness of the high risk cleaning.
▪ Plans will now be developed to standardise the Trust's equipment on vascular line insertion and work with the Procurement Team to reduce the product variety of stock available to staff.
▪ The IPC project plan for the High Quality Care was presented to August's Programme board and will be amended to include a total of 5 key projects including those mentioned above.

Appendix 1

COSHH Spot Check Audit: Overall Compliance Results (2020)

Spot check audit Criteria	May	Jun	Jul	Aug	Sept	Oct	
Total Number of Wards	27	28	28	28	0	0	YTD Trend Analysis
Total Number of Wards Available	19	23	19	24	0	0	77%
Number of Wards Audited	19	23	19	24	0	0	100%

	Target %	May	Jun	Jul	Aug	Sept	Oct	YTD Trend Analysis
Are locks fitted to cleaners stores?	100%	100%	100%	100%	100%	0%	0%	100%
Are the locks in use and all products not in use secured?	100%	95%	95%	68%	100%	0%	0%	90%
Do the sluice rooms have a lockable cupboard/s?	100%	100%	100%	100%	100%	0%	0%	100%
Are the locks in use and all products not in use secured?	100%	95%	100%	79%	92%	0%	0%	92%
Do the kitchens have a lockable cupboard/s?	100%	100%	100%	100%	100%	0%	0%	100%
Are the locks in use and all products not in use secured?	100%	74%	95%	63%	75%	0%	0%	77%
Are all other rooms/cupboards that are required to be kept secure, shut and locked?	100%	79%	95%	68%	83%	0%	0%	81%
Compliance Rate	100%	68%	86%	16%	54%	0%	0%	56%

Ward Overall Compliance results	Target	May	Jun	Jul	Aug	Sept	Oct	YTD Trend Analysis
Bronte Ward	100%	0%	0%	0%	0%	0%	0%	NA
Byron Ward	100%	71%	0%	0%	100%	0%	0%	NA
Keats Ward	100%	100%	100%	100%	100%	0%	0%	100%
Tennyson Ward	100%	100%	0%	0%	100%	0%	0%	NA

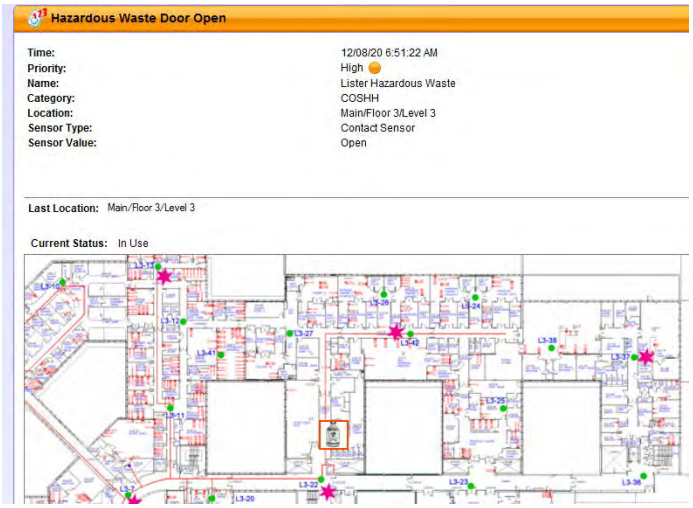
Milton Ward	**100%**	100%	100%	86%	86%	0%	0%	**93%**
Sapphire (SAFU)Ward	**100%**	86%	100%	71%	100%	0%	0%	**89%**
Wakeley Ward	**100%**	0%	100%	86%	100%	0%	0%	**NA**
Nelson Ward	**100%**	0%	100%	0%	86%	0%	0%	**NA**
Harvey Ward	**100%**	100%	100%	100%	0%	0%	0%	**NA**
Dickens Ward	**100%**	0%	0%	0%	0%	0%	0%	**NA**
Lawrence Ward	**100%**	100%	100%	0%	100%	0%	0%	**NA**
Ocelot Ward	**100%**	86%	86%	86%	100%	0%	0%	**89%**
Dolphin Ward	**100%**	100%	100%	86%	100%	0%	0%	**96%**
Lister Ward	**100%**	71%	100%	71%	86%	0%	0%	**82%**
Arethusa Ward	**100%**	0%	0%	86%	86%	0%	0%	**NA**
Pembroke Ward	**100%**	100%	100%	71%	86%	0%	0%	**89%**
Kent Ward	**100%**	100%	100%	57%	86%	0%	0%	**86%**
Birthplace	**100%**	100%	100%	71%	100%	0%	0%	**93%**
Pearl Ward	**100%**	100%	100%	71%	71%	0%	0%	**86%**
Oliver Fisher	**100%**	100%	100%	100%	100%	0%	0%	**100%**
Delivery Suite	**100%**	100%	100%	86%	86%	0%	0%	**93%**
Kingfisher Ward	**100%**	100%	100%	86%	86%	0%	0%	**93%**
McCulloch Ward	**100%**	0%	100%	0%	0%	0%	0%	**NA**
Trafalgar Ward	**100%**	0%	100%	86%	86%	0%	0%	**NA**
Victory Ward	**100%**	71%	86%	86%	100%	0%	0%	**86%**
Phoenix Ward	**100%**	57%	86%	86%	100%	0%	0%	**82%**
ICU/CCU	**100%**	0%	100%	0%	86%	0%	0%	**NA**

Appendix 2

Aeroscout Door Contact Alarms:

The Stanley Aeroscout system is providing monitoring for drug fridges across the site, and has been shown to be effective in dealing with drug fridge issues related to temperature. The same system can be used to monitor critical doors and the development of the system to do this is underway.

The system uses door contacts similar to those used in burglar alarms, and a small box containing the transponder to the Aeroscout system via the Trust's WiFi system. Each time the critical door is opened, the system logs this and this data can be turned into reports and, more importantly, alarms as it does with the drug fridges. These alarms can be sounded at the nurse's station or other relevant terminal, in the same way the drug fridges do.



The pictures above show the contacts and the transponder, also shown is the instant notification seen at the user's terminal.
It is currently in a 'proof of concept' state, and is fitted to three doors identified in the last CQC report as an issue when left open. The system is generating alerts and is reporting daily on breaches. Underway is the configuration of the system from the collected data it has generated to create meaningful warnings and reports and also to map their destination.
50 Transponders have been purchased at a cost of £8,721, including licences. A further 100 tags are required to ensure that all critical doors for COSHH and hazardous waste are monitored.
Further developments of the system would include baby and mother separation, panic alarm and patient tracking.

Meeting of the Board of Directors in Public
Thursday, 03 September 2020

Title of Report	**Finance Report – Month Four**	**Agenda Item**	7.1
Report Author	Richard Eley, Director of Finance Paul Kimber, Deputy Director of Finance		
Lead Director	Richard Eley, Director of Finance		
Executive Summary	The Trust reports a deficit of £10k in month and £43k year to date, which adjusts to break even against the NHSE/I control total.		
Link to strategic Objectives	**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		☐
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday, 23 July 2020		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
QIA	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	Finance report

Finance report

For the period ending 31 July 2020

Contents

Appendices

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month (NHSE/I)	-	-	-	The Trust reports a £10k deficit position for July; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total.
YTD (NHSE/I)	-	-	-	
In-month (budget)	(3,327)	(10)	3,317	
YTD (budget)	(6,006)	(43)	5,963	
Forecast	-	-	-	

	£'m
Covid spend	**1.2**
Base overspend	**0.5**
True-up income accrued	**(1.2)**
Other adjustments	**(0.5)**
Reported against control	**-**

CIP				
In-month	463	474	11	Schemes delivered to date relate to the full year effect of schemes from 19/20, efficient use of theatres, as well procurement and pharmacy savings from nationally agreed prices. The CIP forecast is currently as per budget, the gap at the end of July to the total plan has reduced to £0.7m. Over achievement against plan is due to timing differences of schemes delivered.
YTD	1,093	1,626	533	
Forecast	12,000	12,000	-	
Capital				
In-month	1,671	1,385	(286)	Capital expenditure is currently behind plan YTD due to contractor delays and reprioritisation of schemes. R ecently the Trust has been awarded a f urther £4.3m of PDC from the national Critical Infrastructure Fund (CIF) and this is reflected in the forecast. Since the month end a further £0.9m has been awarded for ED projects, but this is not yet reflected in the forecast.
YTD	7,170	5,612	(787)	
Forecast	24,414	24,414	-	
Cash				
Month end	21,242	50,154	28,912	Cash balances held at 31 July were £28.9m in excess of the plan. This is mainly due to temporary COVID related changes to contract payment profile and delays in the capital programme. Additional contracts have been r eceived one month in advance and monthly top up f unding received in replacement of quarterly FRF and MRET payments.

Activity is below draft budgeted levels as a result of Covid	Clinical income based on the consultation tariff would have reported a year to date position of £61.0m, this being £21.5m adverse to the draft budget. In month performance excluding high cost drugs is £20.9m compared to a Q1 monthly average of £13.4m; this is a significant improvement following the restart programme and in-month is under performing against plan by 4%.
Pay costs are higher than expected	Pay costs have reduced by £0.5m in month as the pay reserve was released into the position but still remain adverse to plan by £0.3m.

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

£'000	In-month			Year-to-date		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	20,380	19,753	(626)	81,518	81,212	(307)
High cost drugs	1,876	2,586	710	7,502	7,464	(38)
Other income	1,982	1,880	(102)	7,928	6,576	(1,352)
Top-up income	4,417	4,417	-	17,668	17,668	-
True-up income	-	1,207	1,207	-	6,497	6,497
Total income	**28,654**	**29,843**	**1,189**	**114,617**	**119,416**	**4,800**
Nursing	(5,927)	(6,912)	(985)	(23,708)	(29,922)	(6,214)
Medical	(5,640)	(6,006)	(366)	(22,560)	(24,242)	(1,682)
Other	(6,649)	(5,376)	1,273	(26,595)	(20,837)	5,758
Total pay	**(18,216)**	**(18,294)**	**(78)**	**(72,863)**	**(75,001)**	**(2,138)**
Clinical supplies	(3,774)	(3,239)	535	(15,097)	(13,747)	1,350
Drugs	(701)	(568)	133	(2,804)	(2,458)	346
High cost drugs	(1,925)	(2,586)	(660)	(7,701)	(7,468)	234
Other	(2,701)	(3,786)	(1,085)	(10,802)	(15,274)	(4,472)
Total non-pay	**(9,101)**	**(10,179)**	**(1,078)**	**(36,405)**	**(38,946)**	**(2,541)**
EBITDA	**1,337**	**1,371**	**34**	**5,349**	**5,469**	**120**
Depreciation	(834)	(827)	7	(3,337)	(3,313)	23
Net finance income/(cost)	39	(12)	(51)	156	(31)	(187)
PDC dividend	(542)	(542)	0	(2,168)	(2,168)	0
Non-operating exp.	**(1,337)**	**(1,381)**	**(43)**	**(5,349)**	**(5,512)**	**(163)**
Reported surplus/(deficit)	**-**	**(10)**	**(10)**	**-**	**(43)**	**(43)**
Adj. to control total	-	10	10	-	43	43
Control total	**-**	**-**	**-**	**-**	**-**	**-**

Key messages:

1. NHSE/I baseline budgets are calculated centrally and are based on average financial performance for defined periods during 2019/20, uplifted for inflation or known pressures where applicable.
2. The Trust continues to invoice other provider organisations in Kent using the same methodology applied by NHSE/I in calculating their baseline.
3. The top-up and true-up income are reported under "FRF/MRET" income in the table on the following page.
4. Total expenditure includes the incremental cost of Covid-19, being £1.2m in-month; £0.4m of this is reported in non-pay and £0.8m in pay (£3.1m and £3. 9m YTD respectively). Further work is ongoing with other provider trusts to compare levels of Covid expenditure.
5. Further details of incremental Covid-19 costs are included in Appendix 11.

2. Income and expenditure (reporting against draft budget)

£'000	In-month			Year-to-date		
	Budget	Actual	Var.	Budget	Actual	Var.
Clinical income	22,040	19,753	(2,287)	83,341	81,212	(2,129)
High cost drugs	2,107	2,586	479	7,960	7,464	(497)
Other income	2,110	1,880	(230)	8,382	6,576	(1,806)
FRF/MRET	769	5,624	4,855	14,914	24,165	9,251
Total income	**27,026**	**29,843**	**2,817**	**114,597**	**119,416**	**4,819**
Nursing	(7,278)	(6,912)	366	(29,183)	(29,922)	(739)
Medical	(5,583)	(6,006)	(423)	(22,319)	(24,242)	(1,923)
Other	(5,136)	(5,376)	(240)	(20,905)	(20,837)	67
Total pay	**(17,997)**	**(18,294)**	**(297)**	**(72,407)**	**(75,001)**	**(2,594)**
Clinical supplies	(3,199)	(3,239)	(40)	(12,237)	(13,747)	(1,510)
Drugs	(2,782)	(568)	2,214	(10,518)	(2,458)	8,060
High cost drugs	(2,070)	(2,586)	(515)	(7,828)	(7,468)	360
Other	(2,764)	(3,786)	(1,022)	(11,450)	(15,274)	(3,824)
Total non-pay	**(10,815)**	**(10,179)**	**636**	**(42,033)**	**(38,946)**	**3,086**
EBITDA	**(1,786)**	**1,371**	**3,157**	**158**	**5,469**	**5,311**
Depreciation	(958)	(827)	131	(3,832)	(3,313)	518
Net finance income/(cost)	(41)	(12)	29	(164)	(31)	133
PDC dividend	(542)	(542)	-	(2,168)	(2,168)	-
Non-operating exp.	**(1,541)**	**(1,381)**	**160**	**(6,164)**	**(5,512)**	**652**
Reported surplus/(deficit)	**(3,327)**	**(10)**	**3,317**	**(6,006)**	**(43)**	**5,963**

Key messages:

1. The Trust is continues to maintain internal budgets for probity. Divisions, care groups, specialties and cost centres are being monitored against their agreed expenditure budget but not against income during the period of nationally executed contracting.

2. Total income YTD is higher than the draft budget primarily as a result of the NHSE/I requirement to breakeven each month from April to July.

3. If income had been earned on a cost and volume basis (based on consultation tariff), excluding high cost drugs the Trust would have reported clinical income of £20.9m in month; this is £7.5m higher than the monthly average of the first quarter and 4% underperformance to plan in month. This reflects the impact of increased patient activity following the restart of services.

4. Total expenditure includes the incremental cost of Covid, this being £1.2m in month and £7.1m year to date.

5. Safer staffing increased establishments totalling £1.3m per annum have been approved and are included from 1st August.

2. Income and expenditure delegated budgets (NHSE/I: in-month)

£'000	In-month								
	Income			Expenditure			Contribution		
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.
UIC									
Diagnostics & Clinical Support	1,578	2,433	855	(4,264)	(5,241)	(977)	(2,686)	(2,808)	(122)
Specialist Medicine	296	278	(18)	(2,261)	(1,852)	409	(1,964)	(1,573)	391
Therapies & Older Persons	3	7	4	(1,463)	(1,431)	32	(1,460)	(1,424)	36
Unplanned & Integrated Care	112	72	(40)	(1,148)	(1,069)	79	(1,036)	(997)	39
Urgent & Emergency Care	74	31	(43)	(2,229)	(2,169)	60	(2,154)	(2,138)	17
Sub-total	**2,064**	**2,822**	**758**	**(11,364)**	**(11,762)**	**(398)**	**(9,301)**	**(8,940)**	**361**
Planned care									
Cancer Services	353	436	83	(837)	(880)	(43)	(484)	(443)	40
Critical Care & Perioperative	163	-	(163)	(3,157)	(169)	2,987	(2,994)	(169)	2,824
Planned Care Infrastructure	56	92	36	(3,093)	(2,778)	315	(3,037)	(2,686)	351
Surgical Services	-	33	33	(210)	(2,804)	(2,594)	(210)	(2,770)	(2,560)
Women & Children	68	123	55	(3,030)	(3,213)	(183)	(2,962)	(3,090)	(129)
Sub-total	**640**	**684**	**44**	**(10,327)**	**(9,844)**	**483**	**(9,686)**	**(9,160)**	**527**
Corporate									
Communications	-	-	-	(38)	(45)	(8)	(38)	(45)	(8)
Finance	4	-	(4)	(287)	(230)	57	(283)	(230)	53
HR & OD	132	167	35	(388)	(443)	(54)	(256)	(276)	(20)
IT	-	3	3	(311)	(324)	(13)	(311)	(321)	(10)
Medical Director	797	834	37	(452)	(431)	21	346	404	58
Nursing	-	24	24	(315)	(341)	(26)	(315)	(317)	(2)
Strategy, Governance & Perform	-	-	-	(252)	(253)	(1)	(252)	(253)	(1)
Transformation	-	-	-	(42)	(98)	(56)	(42)	(98)	(56)
Trust Executive & Board	-	-	-	(271)	(267)	3	(271)	(267)	3
Sub-total	-	-	-	(38)	(45)	(8)	(38)	(45)	(8)
E&F									
E&F	**440**	**269**	**(171)**	**(1,923)**	**(2,012)**	**(89)**	**(1,483)**	**(1,743)**	**(260)**
Central									
Central	24,576	25,040	464	(2,844)	(3,803)	(959)	21,732	21,236	(496)
TOTAL	**28,654**	**29,843**	**1,189**	**(28,654)**	**(29,853)**	**(1,199)**	**-**	**(10)**	**(10)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**10**	**10**	**-**	**10**	**10**
Control total	**28,654**	**29,843**	**1,189**	**(28,814)**	**(29,843)**	**(1,029)**	**-**	**-**	**-**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

2. Income and expenditure delegated budgets (NHSE/I: year to date)

£'000	Year to date								
	Income			Expenditure			Contribution		
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.
UIC									
Diagnostics & Clinical Support	6,312	6,509	197	(17,056)	(17,390)	(333)	(10,744)	(10,880)	(136)
Specialist Medicine	1,185	724	(461)	(9,043)	(7,539)	1,503	(7,858)	(6,815)	1,043
Therapies & Older Persons	13	23	11	(5,851)	(5,759)	93	(5,839)	(5,736)	103
Unplanned & Integrated Care	448	170	(278)	(4,592)	(4,232)	360	(4,144)	(4,062)	82
Urgent & Emergency Care	297	115	(182)	(8,914)	(8,467)	447	(8,617)	(8,352)	266
Sub-total	**8,255**	**7,542**	**(713)**	**(45,457)**	**(43,387)**	**2,070**	**(37,202)**	**(35,845)**	**1,357**
Planned care									
Cancer Services	1,412	1,632	220	(3,348)	(3,494)	(147)	(1,936)	(1,862)	73
Critical Care & Perioperative	652	-	(652)	(12,627)	(673)	11,954	(11,975)	(673)	11,302
Planned Care Infrastructure	225	306	80	(12,373)	(10,679)	1,694	(12,148)	(10,374)	1,775
Surgical Services	-	174	174	(840)	(11,332)	(10,492)	(840)	(11,158)	(10,318)
Women & Children	273	283	11	(12,120)	(12,591)	(471)	(11,848)	(12,308)	(460)
Sub-total	**2,562**	**2,395**	**(167)**	**(41,307)**	**(38,769)**	**2,538**	**(38,746)**	**(36,374)**	**2,371**
Corporate									
Communications	-	-	-	(151)	(168)	(17)	(151)	(168)	(17)
Finance	17	-	(17)	(1,149)	(914)	235	(1,132)	(914)	219
HR & OD	529	500	(29)	(1,554)	(1,474)	79	(1,024)	(974)	50
IT	-	27	27	(1,245)	(1,395)	(150)	(1,245)	(1,369)	(123)
Medical Director	3,190	3,253	64	(1,806)	(1,761)	46	1,383	1,492	109
Nursing	-	29	29	(1,261)	(1,322)	(61)	(1,261)	(1,293)	(32)
Strategy, Governance & Perform	-	-	-	(1,009)	(995)	14	(1,009)	(995)	14
Transformation	-	-	-	(166)	(383)	(217)	(166)	(383)	(217)
Trust Executive & Board	-	-	-	(1,083)	(1,054)	29	(1,083)	(1,054)	29
Sub-total	**3,735**	**3,808**	**73**	**(9,423)**	**(9,465)**	**(42)**	**(5,688)**	**(5,657)**	**31**
E&F									
E&F	**1,760**	**927**	**(833)**	**(7,692)**	**(7,916)**	**(224)**	**(5,932)**	**(6,989)**	**(1,057)**
Central									
Central	**98,304**	**104,744**	**6,440**	**(10,736)**	**(19,922)**	**(9,186)**	**87,568**	**84,822**	**(2,746)**
TOTAL	**114,617**	**119,416**	**4,800**	**(114,616)**	**(119,459)**	**(4,843)**	**-**	**(43)**	**(43)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**43**	**43**	**-**	**43**	**43**
Control total	**114,617**	**119,416**	**4,800**	**(114,616)**	**(119,417)**	**(4,800)**	**-**	**-**	**-**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

2. Income and expenditure delegated budgets (draft budgets: in-month)

£'000	In-month								
	Income			Expenditure			Contribution		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
UIC									
Diagnostics & Clinical Support	3,240	2,433	(807)	(4,506)	(5,241)	(736)	(1,265)	(2,808)	(1,543)
Specialist Medicine	2,687	278	(2,409)	(2,229)	(1,852)	378	458	(1,573)	(2,031)
Therapies & Older Persons	837	7	(830)	(1,437)	(1,431)	6	(600)	(1,424)	(824)
Unplanned & Integrated Care	109	72	(37)	(919)	(1,069)	(150)	(810)	(997)	(187)
Urgent & Emergency Care	5,032	31	(5,000)	(2,167)	(2,169)	(2)	2,865	(2,138)	(5,003)
Sub-total	**11,905**	**2,822**	**(9,083)**	**(11,258)**	**(11,762)**	**(504)**	**648**	**(8,940)**	**(9,588)**
Planned care									
Cancer Services	782	436	(346)	(868)	(880)	(12)	(85)	(443)	(358)
Critical Care & Perioperative	150	-	(150)	(359)	(169)	190	(209)	(169)	40
Planned Care Infrastructure	5,752	92	(5,660)	(2,903)	(2,778)	125	2,848	(2,686)	(5,535)
Surgical Services	1,140	33	(1,106)	(2,737)	(2,804)	(67)	(1,597)	(2,770)	(1,173)
Women & Children	5,404	123	(5,281)	(3,123)	(3,213)	(90)	2,281	(3,090)	(5,371)
Sub-total	**13,228**	**684**	**(12,544)**	**(9,991)**	**(9,844)**	**147**	**3,237**	**(9,160)**	**(12,397)**
Corporate									
Communications	-	-	-	(44)	(45)	(1)	(44)	(45)	(1)
Finance	-	-	-	(234)	(230)	4	(234)	(230)	4
HR & OD	230	167	(63)	(480)	(443)	37	(250)	(276)	(26)
IT	-	3	3	(332)	(324)	8	(332)	(321)	11
Medical Director	827	834	7	(481)	(431)	51	346	404	57
Nursing	7	24	17	(324)	(341)	(16)	(318)	(317)	1
Strategy, Governance & Perform	0	-	(0)	(245)	(253)	(8)	(245)	(253)	(8)
Transformation	-	-	-	(96)	(98)	(2)	(96)	(98)	(2)
Trust Executive & Board	-	-	-	(224)	(267)	(43)	(224)	(267)	(43)
Sub-total	**1,064**	**1,028**	**(36)**	**(2,461)**	**(2,432)**	**29**	**(1,397)**	**(1,404)**	**(7)**
E&F									
E&F	**449**	**269**	**(179)**	**(2,032)**	**(2,012)**	**20**	**(1,584)**	**(1,743)**	**(159)**
Central									
Central	**381**	**25,040**	**24,659**	**(4,612)**	**(3,803)**	**808**	**(4,231)**	**21,236**	**25,467**
TOTAL	**27,026**	**29,843**	**2,817**	**(30,353)**	**(29,853)**	**500**	**(3,327)**	**(10)**	**3,317**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

2. Income and expenditure delegated budgets (draft budgets: year to date)

Annual plan				Year to date								
				Income			Expenditure			Contribution		
Income	Exp.	Contr.	£'000	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
			UIC									
37,001	(53,181)	(16,181)	Diagnostics & Clinical Support	12,325	6,509	(5,816)	(17,723)	(17,390)	333	(5,398)	(10,880)	(5,482)
30,542	(26,536)	4,005	Specialist Medicine	10,173	724	(9,448)	(8,861)	(7,539)	1,322	1,311	(6,815)	(8,126)
9,505	(17,500)	(7,994)	Therapies & Older Persons	3,166	23	(3,143)	(5,749)	(5,759)	(10)	(2,583)	(5,736)	(3,153)
1,237	(11,025)	(9,789)	Unplanned & Integrated Care	412	170	(242)	(3,675)	(4,232)	(557)	(3,263)	(4,062)	(799)
57,144	(26,368)	30,776	Urgent & Emergency Care	19,033	115	(18,917)	(8,631)	(8,467)	163	10,402	(8,352)	(18,754)
135,428	**(134,611)**	**817**	**Sub-total**	**45,108**	**7,542**	**(37,566)**	**(44,638)**	**(43,387)**	**1,252**	**470**	**(35,845)**	**(36,314)**
			Planned care									
8,884	(10,344)	(1,459)	Cancer Services	2,959	1,632	(1,327)	(3,427)	(3,494)	(68)	(467)	(1,862)	(1,395)
1,800	(854)	946	Critical Care & Perioperative	600	-	(600)	(844)	(673)	171	(244)	(673)	(429)
65,191	(35,700)	29,491	Planned Care Infrastructure	21,713	306	(21,408)	(11,929)	(10,679)	1,250	9,785	(10,374)	(20,158)
12,837	(36,628)	(23,791)	Surgical Services	4,276	174	(4,102)	(12,117)	(11,332)	786	(7,842)	(11,158)	(3,316)
61,242	(37,959)	23,283	Women & Children	20,398	283	(20,115)	(12,608)	(12,591)	17	7,790	(12,308)	(20,098)
149,955	**(121,484)**	**28,471**	**Sub-total**	**49,946**	**2,395**	**(47,551)**	**(40,925)**	**(38,769)**	**2,155**	**9,022**	**(36,374)**	**(45,396)**
			Corporate									
-	(447)	(447)	Communications	-	-	-	(163)	(168)	(5)	(163)	(168)	(5)
-	(2,805)	(2,805)	Finance	-	-	-	(935)	(914)	21	(935)	(914)	21
1,778	(4,780)	(3,002)	HR & OD	593	500	(93)	(1,593)	(1,474)	119	(1,001)	(974)	26
-	(3,989)	(3,989)	IT	-	27	27	(1,330)	(1,395)	(66)	(1,330)	(1,369)	(39)
9,930	(5,839)	4,091	Medical Director	3,310	3,253	(57)	(1,989)	(1,761)	228	1,321	1,492	172
82	(3,897)	(3,815)	Nursing	29	29	(1)	(1,301)	(1,322)	(21)	(1,272)	(1,293)	(21)
0	(2,936)	(2,936)	Strategy, Governance & Perform	0	-	(0)	(979)	(995)	(16)	(979)	(995)	(16)
-	(832)	(832)	Transformation	-	-	-	(384)	(383)	1	(384)	(383)	1
-	(2,693)	(2,693)	Trust Executive & Board	-	-	-	(898)	(1,054)	(156)	(898)	(1,054)	(156)
11,790	**(28,217)**	**(16,428)**	**Sub-total**	**3,932**	**3,808**	**(124)**	**(9,571)**	**(9,465)**	**106**	**(5,639)**	**(5,657)**	**(18)**
			E&F									
5,359	**(24,552)**	**(19,192)**	**E&F**	**1,781**	**927**	**(854)**	**(8,201)**	**(7,916)**	**285**	**(6,420)**	**(6,989)**	**(569)**
			Central									
53,976	**(47,644)**	**6,332**	**Central**	**13,830**	**104,744**	**90,915**	**(17,268)**	**(19,922)**	**(2,654)**	**(3,438)**	**84,822**	**88,260**
356,508	**(356,508)**	**-**	**TOTAL**	**114,597**	**119,416**	**4,819**	**(120,603)**	**(119,459)**	**1,144**	**(6,006)**	**(43)**	**5,963**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

3. Forecast

Further discussions have taken place within the ICS, however no detailed forecast has been prepared at this time, principally because:

- The planning guidance has not been received upon which to budget for the period August 2020 to March 2021;
- The period to 31 July 2020 will be funded by way of true-up income to allow the Trust to achieve a control total of breakeven;
- The Trust is undertaking a number of ward reconfigurations which, until finalised, create uncertainty in forecasting veracity.

The Trust remains committed to delivering a full year control total of breakeven and will work with its commissioners, partners and regulators through developments over the coming days, weeks and months.

4. CIP (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Mitigated target	Gap	Budget	Gap
Planned care	446	2,225	71	759	3,501	**5,100**	(1,599)	**4,682**	(1,181)
UIC	500	3,243	944	230	4,917	**5,505**	(588)	**4,253**	664
E&F	-	801	-	-	801	**800**	1	**661**	140
Corporate	363	107	-	323	793	**1,709**	(916)	**1,113**	(320)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	0
Total	**2,600**	**6,375**	**1,015**	**1,312**	**11,303**	**14,405**	**(3,102)**	**12,000**	**(697)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**463**	**474**	**11**	**1,093**	**1,626**	**533**	**12,000**	**12,000**	**-**

Process

1. CIPs are the responsibility of the budget holders.
2. The Improvement team supports the budget holders to deliver both quality and cost improvements.
3. The PMO oversees these programmes, supporting with PID writing/management and w orks to fill the programme.
4. The Finance department counts the extent to which the financial improvements have been made.
5. The Director of Finance and t he Director of Improvement monitor and work with budget-holders to achieve targets.

The total CIP included in the draft budget from March is £12m. Of this, the majority of CIPS are phased to be realised in the second half of the financial year.

At the end of July £9.0m of savings have been BRAG rated as blue or green, this is an increase of £0.4m from the end of June. A further £2.3m of schemes are assessed as amber or red; the remaining £0.7m gap to achieve the NHSE/I plan are schemes in progress or yet to be identified.

CIP schemes are being developed through CIP panels and the QIA assessment process. Due to the change in activities and the Covid response, some savings programmes continue to encounter delays; the plan is regularly updated.

The PMO team continue to work with Divisions and the Finance Business Partners to identify and quantify CIP schemes whilst working towards a stretch target of £14.4 million (this being 20% higher than the required CIP to mitigate the risk of individual scheme failure). Delivery to date is £1.6m and favourable to plan by £0.5m; this over achievement has mainly been achieved through the full year effect of 19/20 schemes for agency rate reductions, as well as procurement and pharmacy national pricing measures exceeding the original plan £0.5m. This is expected to be a timing difference only.

Further detail of CIP schemes by Division is presented in Appendix 6.

5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,790	**Non-current assets**	**217,212**	**207,089**	**(10,123)**
6,306	Inventory	7,400	5,911	(1,489)
36,687	Trade and other receivables	31,549	22,903	(8,646)
12,385	Cash	21,242	50,154	28,912
55,378	**Current assets**	**60,191**	**78,968**	**18,777**
(24,478)	Trade and other payables	(38,369)	(23,639)	14,730
(292,111)	Borrowings	(1,569)	(292,054)	(290,485)
(4,519)	Other liabilities	(24,027)	(31,316)	(7,289)
(321,108)	**Current liabilities**	**(63,965)**	**(347,009)**	**(283,044)**
(2,278)	Borrowings	(23,273)	(2,278)	20,995
(1,317)	Other liabilities	(900)	(1,317)	(417)
(3,595)	**Non-current liabilities**	**(24,173)**	**(3,595)**	**20,578**
(64,534)	**Net assets employed**	**189,265**	**(64,547)**	**(253,812)**
140,581	Public dividend capital	410,790	140,613	(270,177)
41,366	Revaluation reserve	47,336	41,366	(5,970)
(246,481)	Retained earnings	(268,861)	(246,524)	22,337
(64,534)	**Total taxpayers' equity**	**189,265**	**(64,547)**	**(253,812)**

Key messages:

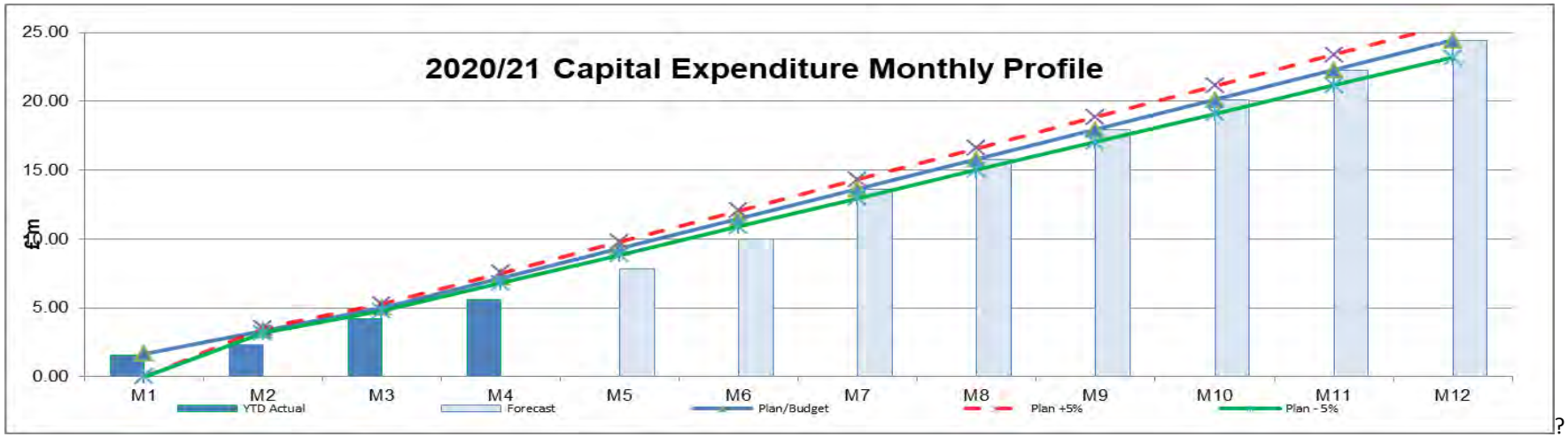
1. Cash and other liabilities are impacted by the revised commissioning arrangements; block income and top-up income (replacing FRF and MRET) for both April and May was paid to the Trust in April and continues to be paid monthly in advance.
   The plan only expected advance payments from North Kent and quarterly payments of FRF. This has resulted in a significantly higher cash balance and levels of deferred income.
   The advance payments are not expected to unwind until March so these balances are expected to remain high for the remainder of the year.

2. Where invoices are matched and approved, the Trust continues to pay suppliers on immediate terms and will do so whilst cash balances remain high.

3. Following the guidance released at year end, the interim loans have been reclassified as due within one year; new PDC will be issued and the debt written off. The effective date of the transaction will be 30 September 2020 (assumed to be 1 April 2020 in draft plan). The value of loans originally thought to be eligible for this transaction was notably lower in our budget assumptions than we have now been informed.

6. Capital

£'000	In-month			Year To Date			Annual			Funding		
	Budget	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	230	1,248	(1,018)	1,245	2,849	(1,604)	5,671	5,671	0	690	0	4,981
Routine Maintenance	87	(576)	663	348	60	288	1,046	1,046	0	691	0	355
Fire Safety	476	168	308	1,904	774	1,130	5,720	5,720	0	366	4,252	1,102
IT	228	64	164	912	160	752	2,730	2,730	0	2,730	0	0
ED	320	2	318	1,441	(142)	1,583	5,283	5,283	0	835	3,000	1,448
Plant & Equipment	330	479	(149)	1,320	1,911	(591)	3,964	3,964	0	2,860	1,104	0
COVID	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1,671**	**1,385**	**286**	**7,170**	**5,612**	**1,558**	**24,414**	**24,414**	**0**	**8,172**	**8,356**	**7,886**



Capital expenditure to date is below plan. This is mainly due to delays in the ED, Fire projects, impacted by contractors working restrictions in relation to the pandemic and a reassessment of operational priorities. The Trust is expecting to recover this variance by the end of the financial year.

The Trust has increased its Annual Plan due to the allocation of the Critical Instructure Fund. £7.9m of PDC has been allocated to fund backlog maintenance, £3.6m for planned schemes from the original £20m plan and £4.3m to accelerate projects planned for next year.

7. Cash

13 Week Forecast w/e

	Actual					Forecast												
£m	03/07/20	10/07/20	17/07/20	24/07/20	31/07/20	07/08/20	14/08/20	21/08/20	28/08/20	04/09/20	11/09/20	18/09/20	25/09/20	02/10/20	09/10/20	16/10/20	23/10/20	30/10/20
BANK BALANCE B/FWD	**52.94**	**43.82**	**42.90**	**71.63**	**59.62**	**50.10**	**48.27**	**74.87**	**71.20**	**59.26**	**48.59**	**46.11**	**65.75**	**52.30**	**41.64**	**39.16**	**72.33**	**58.88**
Receipts																		
NHS Contract Income	0.79	0.12	32.32	0.09	0.06	0.06	29.41	0.00	0.00	0.00	0.00	27.57	0.00	0.00	0.00	27.17	0.00	0.00
Other	0.68	1.97	0.41	0.31	0.56	0.35	2.72	0.25	0.25	0.25	0.56	0.30	0.25	0.25	0.56	2.99	0.25	0.25
Total receipts	**1.47**	**2.10**	**32.73**	**0.40**	**0.62**	**0.40**	**32.14**	**0.25**	**0.25**	**0.25**	**0.56**	**27.87**	**0.25**	**0.25**	**0.56**	**30.16**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(8.29)	(0.32)	(0.41)	(9.76)	(7.95)	(0.33)	(0.35)	(0.42)	(9.49)	(8.21)	(0.35)	(0.34)	(9.56)	(8.21)	(0.34)	(0.34)	(9.55)	(8.20)
Non Pay Expenditure	(0.41)	(2.72)	(3.60)	(2.65)	1.33	(1.90)	(5.19)	(3.50)	(2.70)	(1.16)	(2.70)	(4.20)	(4.15)	(1.16)	(2.70)	(4.20)	(4.15)	(1.16)
Capital Expenditure	(1.89)	0.00	0.00	0.00	(3.51)	0.00	0.00	0.00	0.00	(1.54)	0.00	0.00	0.00	(1.54)	0.00	0.00	0.00	(1.54)
Total payments	**(10.59)**	**(3.05)**	**(4.01)**	**(12.41)**	**(10.14)**	**(2.23)**	**(5.54)**	**(3.92)**	**(12.19)**	**(10.91)**	**(3.05)**	**(4.55)**	**(13.71)**	**(10.91)**	**(3.04)**	**(4.54)**	**(13.70)**	**(10.90)**
Net Receipts/ (Payments)	**(9.12)**	**(0.95)**	**28.72**	**(12.01)**	**(9.52)**	**(1.83)**	**26.60**	**(3.67)**	**(11.94)**	**(10.66)**	**(2.49)**	**23.32**	**(13.46)**	**(10.66)**	**(2.48)**	**25.61**	**(13.45)**	**(10.65)**
Funding Flows																		
PDC Capital	0.00	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	291.00	0.00	0.00	0.00	7.56	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(291.42)	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.25)	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.03**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(3.67)**	**0.00**	**0.00**	**0.00**	**7.56**	**0.00**	**0.00**
BANK BALANCE C/FWD	**43.82**	**42.90**	**71.63**	**59.62**	**50.10**	**48.27**	**74.87**	**71.20**	**59.26**	**48.59**	**46.11**	**65.75**	**52.30**	**41.64**	**39.16**	**72.33**	**58.88**	**48.23**

Cash Flow, 12 months ahead

	Actual				Forecast											
£m	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
BANK BALANCE B/FWD	**12.37**	**37.58**	**47.48**	**43.46**	**50.11**	**50.21**	**44.61**	**48.26**	**44.59**	**37.99**	**37.09**	**35.47**	**6.83**	**41.00**	**41.16**	**38.87**
Receipts																
NHS Contract Income	45.11	22.70	24.52	22.99	22.58	22.52	22.52	22.52	22.52	22.52	22.52	0.70	53.95	27.12	28.94	26.94
NHS Top Up	8.84	6.28	2.39	10.15	6.42	4.82	4.42	4.42	4.42	4.42	4.42	4.42	0.00	0.00	0.00	0.00
Other	4.66	1.56	1.53	3.65	4.10	1.69	4.38	1.64	1.64	4.33	1.64	1.74	4.23	1.46	1.30	4.52
Total receipts	**58.61**	**30.54**	**28.44**	**36.79**	**33.10**	**29.03**	**31.32**	**28.58**	**28.58**	**31.27**	**28.58**	**6.86**	**58.18**	**28.58**	**30.24**	**31.46**
Payments																
Pay Expenditure (excl. Agency)	(18.79)	(18.57)	(18.58)	(18.76)	(18.46)	(18.46)	(18.78)	(18.42)	(18.73)	(18.39)	(18.37)	(18.35)	(19.68)	(19.05)	(18.91)	(19.54)
Non Pay Expenditure	(13.03)	(8.73)	(11.99)	(7.90)	(13.00)	(10.96)	(14.91)	(12.21)	(14.91)	(12.43)	(11.15)	(13.15)	(13.36)	(8.37)	(12.70)	(14.77)
Capital Expenditure	(1.58)	(0.75)	(1.89)	(3.51)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(0.92)	(0.92)	(0.92)	(0.92)
Total payments	**(33.40)**	**(28.05)**	**(32.46)**	**(30.17)**	**(33.00)**	**(30.96)**	**(35.23)**	**(32.17)**	**(35.18)**	**(32.36)**	**(31.06)**	**(33.04)**	**(33.96)**	**(28.34)**	**(32.53)**	**(35.23)**
Net Receipts/ (Payments)	**37.58**	**40.07**	**43.46**	**50.08**	**50.21**	**48.28**	**40.70**	**44.67**	**37.99**	**36.90**	**34.61**	**9.29**	**31.05**	**41.24**	**38.87**	**35.10**
Funding Flows																
DOH - FRF/Revenue Support	0.00	5.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.95	0.00	0.00	9.95
PSF	0.00	2.31	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.03	0.00	291.00	7.56	0.00	0.00	0.19	0.86	0.80	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	(0.08)	0.00	0.00	0.00	(291.42)	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	(3.25)	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**7.41**	**0.00**	**0.03**	**0.00**	**(3.67)**	**7.56**	**(0.08)**	**0.00**	**0.19**	**0.86**	**(2.46)**	**9.95**	**(0.08)**	**0.00**	**9.95**
BANK BALANCE C/FWD	**37.58**	**47.48**	**43.46**	**50.11**	**50.21**	**44.61**	**48.26**	**44.59**	**37.99**	**37.09**	**35.47**	**6.83**	**41.00**	**41.16**	**38.87**	**45.05**

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	21,242	50,154	28,912

Cash balances held are in excess of the plan due to £6.5m of additional commissioning advances and £12.6m of block top up payments in advance of FRF/MRET payments expected. Opening cash was also higher than originally planned; this plan was due to be refreshed to reflect outturn numbers in April which would have closed the gap by £7.3m. A delay in the capital programme has also impacted cash,
Whilst cash balances remain high the trust continues to pay all suppliers on invoice approval instead of contractual payment terms. Unfortunately there are many delays in invoice approval as detailed in the payables preventing benefit maximisation of the cash position and payment discounts that often come with early payment.

8. Risks

Title	Description	£'000	Mitigation(s)	Lead(s)
Loss of stroke service	The Trust has agreed to transfer its stroke activity to other providers given the local issues. Current indications are that this could leave a contribution gap of up to £1.8m (FYE).	£1,325	Work with the STP is underway to validate the budgeted and actual income, expenditure and activity of the service.	Richard Eley
CIP (planning)	There remains a gap between RAG rated CIP programmes and the draft budget requirement of £12m.	£697	CIP meetings continue to be held by the Director of Improvement. Oversight moved from Transformation to Finance. Return of CIP governance following pause during Covid pandemic.	Richard Eley, Mark Hackett
Staff costs	Staff costs remain high; unchecked, this could drive a need for additional CIP and/or additional true-up income from NHSE/I and/or the Trust missing its control total.	-	Deep dive paper submitted to the July Finance Committee meeting.	Divisional Directors
Ward reconfiguration	As part of the restart planning wards will need to change at pace. The changing nature, specialty and bed bases could impact cost and efficiency.	TBC	Restart modelling is underway.	Richard Eley, Angela Gallagher, Mark Hackett
Microsoft licensing	The Trust was part of a government licensing arrangement for MS products. Licensing arrangements have subsequently changed and were originally intended to be addressed as part of ITaaS.	£300	STP is seeking a collaborative and united approach for all providers.	Michael Beckett
Covid capital	Monies in respect of Covid capital claims are still unapproved from NHSE/I. This is a national position.	c.£1,500	If not funded by NHSE/I this will need to be drawn from the Trust's capital allocation.	Richard Eley, Gary Lupton

9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £10k deficit in-month and £43k deficit year to date, reducing to breakeven after removing the adjustment for donated asset depreciation. This financial performance is as per the NHSE/I control total. The in-month performance has been achieved through £1.2m of true-up funding being accrued after incurring £1.2m of incremental expenditure related to Covid.

Richard Eley
Director of Finance
August 2020

Meeting of the Board of Directors in Public

Thursday, 03 September 2020

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**7.2**
Committee Chair:	Jo Palmer		
Date of Meeting:	Thursday, 27 August 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

The key headlines and levels of assurance are set out below, and are graded as follows:	
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**
1. BAF strategic risks The BAF was discussed and the current risk scores, mitigations and controls were accepted. The Chief Finance Officer noted that a national letter had now been issued setting out the contractual funding for the remainder of the year and as a result the score of the "delivery of financial control total" may need to change; this will be reviewed as more information becomes available. The "capital investment" remains unchanged but it was noted that the value of backlog maintenance has now decreased; national funds have also been made available to the Trust to address this further in 2020/21.	**Amber/Green**
2. Risk register The risk register was noted. The CIP risk was scored at 12 on the basis that the Trust had been moving towards the target set. However, in the last few days a risk in unplanned care was emerging.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level**
3. Finance report The Director of Finance took the committee through the report, noting key highlights as being: • The Trust is meeting its control total as set by NHSE/I; the incremental Covid expenditure in-month was £1.2m and true-up income of £1.2m was also accrued. • The Trust has an underlying underspend year to date (i.e. excluding Covid) which is annualised at approximately £10m; however this is lower than fellow provider organisations in Kent. Conversely our Covid expenditure does appear to be notably lower than those providers. • The Chief Finance Officer noted that activity had significantly increased in July following "restart" work. • CIP is currently ahead of plan but the emerging issue on the forecast was noted. • Capital expenditure is behind and it is noted that we have been awarded additional funding/equipment, including addressing critical infrastructure, emergency department and breast screening. A final Covid capital funding request has also been made which would add to the forecast expenditure this year. • Cash is notably higher than planned – underlying sums are c£12m, £25m cash advances have been received due to national contracting arrangements, capital expenditure is behind plans at this time and our receivables position has improved (reduced). The Trust will continue to monitor these sums. • The Trust has received formal notification from DHSC confirming issuance of Public Dividend Capital in order to repay c£290m of loans. Discussion was held in respect of the patient backlog and the work the Trust is undertaking to "restart". It was noted that this is being carefully planned and managed in an effort to maximise the number of patients we can safely see, ensuring that appropriate infection prevention and control procedures were in place as a result of Covid. The Board has received reporting on the estimated trajectories of the activity.	**Amber/Green**
6. Budget setting update / "Restart" Additional nursing budgets of c£0.9m as a part year effect are included in budgets from 1 August 2020. The committee heard that national guidance released since the paper was written has confirmed that from month 6 (September 2020) activity will be paid based on the 2020/21 tariffs. The activity targets will be based on activity performed in months 6-12 in 2019/20; provisionally the Trust believes this will be slightly lower than the levels set in budgets, although the Trust has set aside c60 beds for Covid which will impact on capacity. Actual activity performed below the target levels will have 20-25% deduction on tariff, whereas activity performed above the target levels will be paid at 70-75% of tariff. The Chair and Chief Finance Officer confirmed that the activity targets are to be managed across the system as a whole.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
7. Capital plans The Executive Director of Estates and Facilities welcomed the additional funding being made available for capital projects but noted that this of course needs to be carefully planned and managed to deliver in the financial year. Despite being behind plan at this time – mainly due to the ED project - the Trust has a number of schemes in the pipeline that have been risk assessed and could be brought forward; the key concern noted was the speed at which these could be mobilised. The Chair set out a vision for the Trust to push out its planning horizon to 3-5 years; this would allow in-year delivery to be flexed upwards/downwards as required to respond to challenges faced. The committee considered the risks - to the capital programme, the Trust and patients – of supplier concentration, i.e. using a narrow range of contractors. It was **AGREED** that the Trust would as a matter of urgency seek to achieve greater contractor diversity to secure that no individual contractor delivers more than 30% of on-site works.	**Amber/Green**
8. "Best Flow" project evaluation The Director of Financial Improvement presented the paper and noted that whilst the project did not deliver the financial benefits the business case set out, it did make improvements in a number of operational and other areas, noting that some of these fully delivered whilst others again did not. The paper made a number of recommendations and points of learning for implementation; it was **AGREED** that these will be taken through the Trust Improvement Board.	**Green**
9. National cost collection pre-submission report The committee was informed that it is a requirement for this report to be presented to the committee. The committee **APPROVED** the methodology as set out in the paper.	**Green**
11. Model Hospital The General Manager for medical and clinical oncology presented a report which set out how the Model Hospital data was being used as a means to improve efficiency. A number of visits to other provider organisations have been held/arranged to better understand how those Trusts may be delivering a more efficient/cost effective service.	**Green**
12. Self-assessment – review of effectiveness The Trust Secretary noted that an assessment must be made and this will be circulated shortly.	**Green**
Decisions made It was **AGREED** that with immediate effect the Trust would implement guidelines such that no individual contractor could/should be appointed to deliver more than 30% of works on-site. It was noted that advice would be sought confirming legality of this position. It was **AGREED** that the recommendations made in the post project evaluation of the "Best Flow" will be	

Key headlines and assurance level	
Key headline	**Assurance Level**
taken through the Trust Improvement Board. The committee **APPROVED** the methodology for the national cost collection exercise as set out in that paper.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee There are no matters to escalate.	

Meeting of the Board of Directors in Public

Thursday, 03 September 2020

Assurance Report from Committee

Title of Committee:	**People Committee**	**Agenda Item**	**8.1**
Committee Chair:	Sue Mackenzie		
Date of Meeting:	Tuesday, 18 August 2020		
Lead Director:	Leon Hinton, Director of Human Resources and Organisational Development		
Report Author:	Leon Hinton, Director of Human Resources and Organisational Development		

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Medical Appraisal and Revalidation Paper The Committee was ASSURED on the progress made in implementing medical revalidation and the improvements planned for this year. The Committee APPROVED the report for onward assurance to the Board as part of the Responsible Officer's Regulations. The Committee APPROVED the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the regulations.	**Green**
2. IQPR – People KPIs The report was the refreshed version of the IQPR in using Statistical Process Control charts to display the data. The committee has requested that the Executive reviews the target for staff turnover/stability. There are no other matters to report.	**Amber/Red**
3. HR Resourcing Dashboard The Committee NOTED the progress made with recruiting to substantive vacancies. The paper was the revised resourcing dashboard and provided an overview of: a) Nursing and midwifery recruitment; b) Medical and dental recruitment. Key highlights for the Committee: The top five specialties with highest consultant vacancies demonstrates progress to recruit to all posts in acute medicine (1.32 FTE post pipeline hires); 0.65 FTE emergency medicine; nil vacancies in obstetrics and gynaecology. Significant vacancies remain in ENT (3.5 FTE) and respiratory (1.96 FTE). Mitigations to current vacancies are reported as part of the dashboard. The Committee asked for the report to include Nursing Support (clinical	**Green**

support workers, nursing associates etc) as part of the report.	
4. Trust Improvement Plan – Our People Programme Update The Committee NOTED the progress to date and the forthcoming actions. The highlight report provided an update of the key project initiatives within the 'Our People Programme' and in conjunction with the People Strategy which was implemented in April 2019. The main focus of the update referred to the three strands of the People Strategy which are: Best People, Best Future, Best Culture	**Amber/Green**
5. Board Assurance Framework and Risk Register – Workforce The BAF was discussed and the current risks, mitigations and controls were accepted; actions required to be updated in line with the People Improvement Programme. The Committee NOTED that the Workforce risks had been reviewed and assurances had been updated in order to provide further assurance for the mitigations and controls identified for each risk. No changes had been made to the current risk score for the BAF items. Actions to be taken have been mapped from the Trust's Improvement Plan (People Programme). The Committee was informed that within the report was all workforce-related risks that scored 12 or greater. One risk is currently rated at 16 (stroke service workforce) and six risks score between 12 and 15.	**Green**
6. CQC Report - Well Led The Committee NOTED the verbal update, which informed the Committee of progress with the Executive development programme. A full written update is to be provided for the next committee.	**Amber/Green**
7. We Are The NHS: People Plan for 2020/21 – Action For Us All – Executive Summary The Committee NOTED the summary of the People Plan and SUPPORTED the works over the next seven to eight months. The 'We are the NHS: People Plan for 2020/21 – action for us all' (the "People Plan") was published on 30 July 2020 by NHS England and NHS Improvement (NHSEI) and serves to add to the previous iteration of the interim NHS People Plan. The People Plan contains 92 deliverable actions/products, with a number with prescribed deadlines. Three of the 92 actions are not applicable to acute Trusts and will not attract actions directly by the Trust. The remaining 89 actions are split across four mission commitments: 1) Looking after our people 2) Belonging in the NHS 3) New ways of working and delivering care 4) Growing for the future The agreed governance is for the People Plan actions to be integrated into the Our People improvement programme and reported to the People Committee and the Improvement Board.	**Green**
Decisions made: none to report	
Further Risks Identified: none to report	
Escalations to the Board or other Committee: none	