Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 04 March 2021 at 13:00 – 15:30

Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	13:00	Note
1.2	Quorum				
1.3	Declarations of Interest - Register Update: *Jenny Chong, Tony Ullman*		3		
1.4	Chief Executive Update	Chief Executive	5	13:05	Note
1.5	Patient Story	Chief Nursing and Quality Officer	Present-ation	13:15	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 04.02.21	Chair	9	13:40	Approve
2.2	Matters arising and Action Log: 04.02.21	Chair	19		Discuss
3.	**Governance**				
3.1	Board Assurance Framework Review	Deputy Chief Executive	21	13:45	Note
3.2	IAC Assurance Report. Meeting on 25.02.21 - Delegation of approval of Annual Report and Accounts	Chair of Committee Chief Finance Officer	43	13:55	Assure
3.3	Wellbeing Guardian – Introduction and Nomination	Chief People Officer	47	14:05	Note/ Discuss
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNQO, CMO	51	14:15	Note
4.2	Quality Assurance Committee Assurance Report. Meeting on 16.02.21	Chair of Committee/ Chief Nursing and Quality Officer	77	14:30	Assure
4.3	Ockenden Response	Chief Nursing and Quality Officer	81	14:40	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 10	Chief Finance Officer	87	14:50	Note
5.2	Finance Committee Assurance Report. Meeting on 25.02.21	Chair of Committee/ Chief Finance Officer	105	15:00	Note
6.	**Innovation**				
6.1	Trust Improvement Plan - Patient First Focus	Chief Operating Officer (Interim)	109	15:10	Note
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	15:20	Note
7.2	Questions from the Public	Chair	Verbal		Note
7.3	Any Other Business	Chair	Verbal		Note
7.4	Date and time of next meeting: Thursday 15 April, 12:30 – 15:30				

NHS
Medway
NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS
FEBRUARY 2021

Name	Position	Organisation	Nature of Interest
Joanne Palmer	**Chair**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Sutton Valence School	Governor
Ewan Carmichael	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi and Savita Charitable Trust	Trustee
		Mark Spragg Limited	Director
		Faculty of Medical Leadership and Management	Lay Trustee/ Director
		Medway NHS Foundation Trust	Chair Integrated Audit Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Adrian Ward	**Non-Executive Director**	Award Veterinary Sciences Limited	Director
		Nursing and Midwifery Council	Chair Fitness to Practise Panel
		RCVS Preliminary Investigation Committee	Member
		BSAVA Scientific Committee	Member
		Medway NHS Foundation Trust	Member of the Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Tony Ullman	**Non-Executive Director**	Kent and Canterbury Hospital, East Kent NHS Foundation Trust	Partner is a part-time Specialty Doctor
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Sue Mackenzie	**Non-Executive Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Rama Thirunamachandran	**Academic Non-Executive Director**	Canterbury Christchurch University	Vice-Chancellor and Principal Director and Trustee
		Universities UK	Director and Trustee
		Million Plus (Lobby Group for HE)	Chair
Jenny Chong	**Associate Non-Executive Director**	Knightingale Consulting	Managing Partner
		KogoPay	CTO, Head of Innovation
		Imperial College London	Advisor to IVMS (Imperial Venture Mentoring Service) and ITES (Imperial Technology Experts Service)
		The Design Museum	Co-opted Member of the Finance & Operations Committee
		Egypt Exploration Society	Co-opted Member of the Collections Committee
		Business of Data	Global Advisory Board Member
James Devine	**Chief Executive**	London Board for the Healthcare People Management Association	Member
		Medway Health and Well-Being board	Member
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
David Sulch	**Chief Medical Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Chief People Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jane Murkin	**Chief Nursing and Quality Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Alan Davies (*30.10.20 start date*)	**Chief Finance Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Richard Eley (01.11.20 left MFT)	***Chief Finance Officer Interim***	*Medway NHS Foundation Trust Charitable Funds*	*Member of the Corporate Trustee*

Chief Executive's Report – March 2021

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.

COVID-19

It is clear that the combination of the national lockdown and the most ambitious mass vaccination programme this country has ever seen is beginning to have an impact on the pandemic.

Here at Medway, I am delighted to say that the number of patients requiring inpatient care for COVID-19 has reduced significantly, and we have been able to return some of our temporary COVID wards to their original function.

Our Vaccination Hub continues to go from strength to strength and this month we celebrated the 10,000th COVID vaccination which was given to a nurse from Medway Community Healthcare, one of the partner organisations we are supporting with our vaccination programme. We have extended our vaccination programme to include eligible members of the public, in support of the community vaccination programme.

After a number of months battling the COVID-19 pandemic, it certainly feels like a corner has been turned and our focus must now turn to returning our services to normal.
At the end of 2020 we had to take the very difficult decision to postpone and cancel some services at the Trust in order to be able to manage the surge in emergency requirements, additional critical care services and other services related to the COVID-19 pandemic.

We know how difficult it is for patients who have had procedures delayed due to the pandemic and are therefore keen to resume these services as soon as possible. However, this requires careful transition to ensure we maintain capacity for COVID-19 patients, as well as preventing the spread of infection, in the interests of patients and staff.

We are fully committed to bringing all our services back to full capacity as quickly, and as safely as possible. We are extremely grateful for the support of our community and thank them for their continued patience and understanding

CQC inspection of the Emergency Department

Last month the Care Quality Commission published a report following an inspection of the Emergency Department at Medway Maritime Hospital on 14 December 2020.

The report acknowledges a number of positive observations about the care that staff provide for patients needing urgent and emergency care, but also highlights where improvements are needed.

Following feedback from the visit, Medway NHS Foundation Trust immediately took steps to address concerns raised, including measures to reduce waiting times, and to ensure patients do not deteriorate while waiting in ambulances or within the department.

Keeping patients and staff safe is always our priority. Our staff have worked incredibly hard throughout the COVID-19 pandemic to care for patients, and when the visit took place it was at the height of the second wave. But we fully accept that there is more we must do to ensure that robust processes are followed at all times to keep patients safe.

The CQC rated the urgent and emergency care service 'good' for being caring and effective, but unfortunately ratings for being safe, responsive and well-led were reduced to 'inadequate', meaning the overall rating for the ED has also been reassessed as 'inadequate'.

We have implemented an improvement plan that supports our clinical leaders to ensure we are consistently providing safe, high quality patient care.

Since the inspection, we have:

- Worked with health partners on a collaborative approach to managing demand on our Emergency Department, leading to a reduction in the number of patients waiting in ambulances for longer than 60 minutes.
- Put processes in place to quickly identify patients who are deteriorating in ambulances so they can be prioritised.
- Increased reviews of patients waiting to be admitted resulting in greatly reduced waiting times.
- Opened an additional 20 beds in order to cope with the demand.
- Launched a nationally recognised Patient First programme to enhance safe care in the Emergency Department.
- Instigated a multi-agency approach to increase timely discharge for patients who do not need to be in the hospital.
- Put plans in place to improve medical and nursing staff in the Emergency Department.
- Introduced a tailored development programme to improve leadership and culture.

Trust Improvement Plan
Last year we launched 'Our Medway', a major improvement programme to advance the quality of care for our patients. Clinically led and placing patients at its heart, this has helped to improve patient experience, reduce length of stay, increase our use of digital technology, and develop stronger relationships with our partners in community health, GPs, mental health and social care.

Although there is still much work to do to combat the COVID-19 pandemic, we must also to look to the future. This means building on the successes of the first phase of 'Our Medway' as we move into the next phase. We will be providing more information on this in the coming months.

National Apprenticeship Week 2021
In February we marked the annual week-long celebration of apprenticeships, shining a light on the amazing work being done by employers and apprentices across the country.
This includes our very own apprenticeship team and all the apprentices here at Medway who have continued to succeed despite the challenges they have faced in the last year. We are proud to have more than 150 apprentices at Medway offering several pathways in both clinical and non-clinical roles from level 2 to level 7 (equivalent to a degree).
This can be such an important route in to the NHS – in fact it is how I started my NHS journey 25 years ago this year. And it was here at Medway! One of the many reasons why this hospital will always hold a special place in my heart.

LGBT+ History Month
February marked LGBT+ history month and remembering the history of the LGBT+ community is to realise that we've come a long way. Being homosexual, for example, was a crime in the UK until 1967. We have only got to where we are today thanks to the fights of previous generations – their stories are an inspiration for the movements of today.

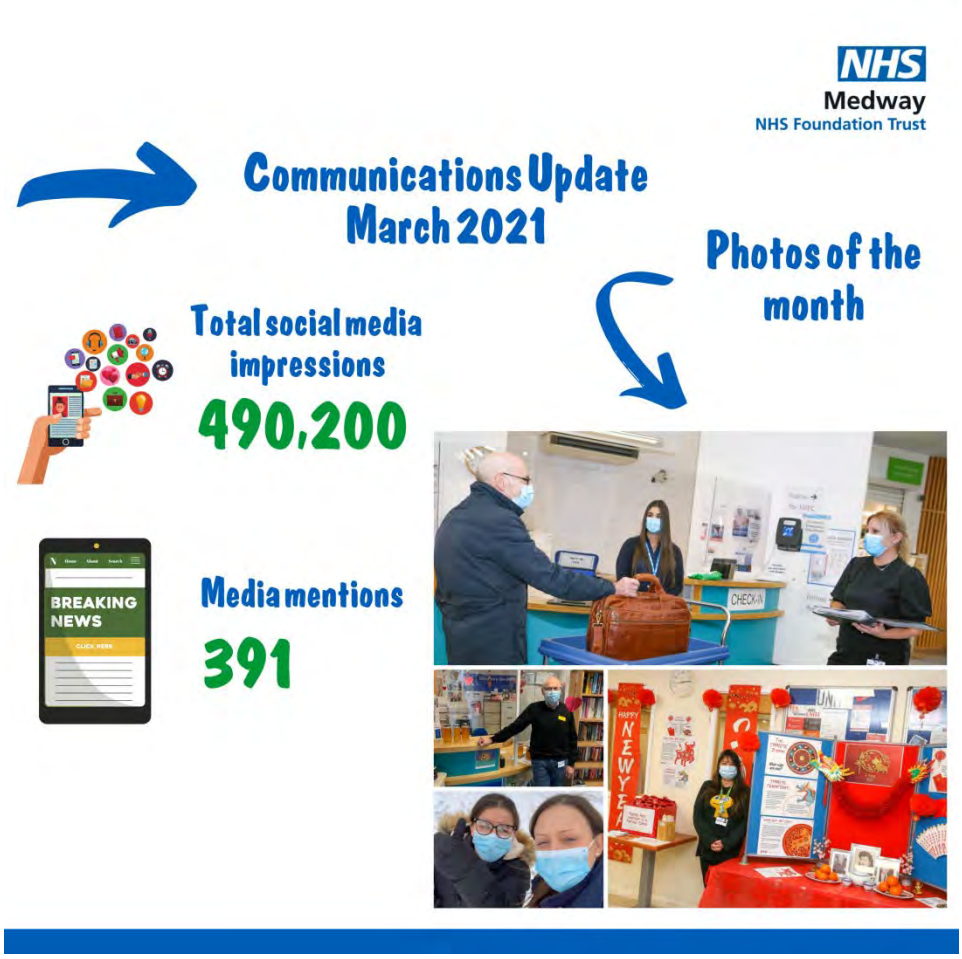
Members of the LGBT+ community:

- Are more likely to experience a range of mental health problems such as depressions and suicidal thoughts
- Are at greater risk of experiencing hate crime compared to heterosexual people, with certain LGBT+ groups found to be at particular risk including gay men, young people and those identifying as LGBT from black and minority ethnic groups.

We are proud to have an LGBT network at Medway and we will continue to work hard to support, and be allies for, the LGBT+ community.

Communicating with colleagues and the community

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



Minutes of the Trust Board PUBLIC Meeting

Thursday, 14 January 2021 at 12:30 – 15:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	David Sulch	Chief Medical Officer
	Ewan Carmichael	Non-Executive Director
	James Devine	Chief Executive (Excused at 13:20, returned 13:40)
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Chief People Officer
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer (Interim)
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Gurjit Mahil	Deputy Chief Executive
	Harvey McEnroe	Strategic Commander/Winter Director
	Jack Tabner	Director of Transformation/IT
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director (Excused at 14:00)
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Company Secretary
	Glyn Allen	Lead Governor
	Nye Harries	NHSEI Improvement Director
	Paula Tinniswood	Chief Staff Officer (Interim)
Observing:	John Wright	Partner Governor
	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
	Temi Alao	HR Business Partner

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts and patience as they continue to use MS Teams for these meetings. Chair welcomed the Board guests; John Wright,

Partner Governor, Katie May Nelson, Local Democracy Reporter from Kent Online, and Temi Alao, HR Business Partner from the Trust, who are observing the meeting.

a) Since the last meeting, when we were experiencing the peak of the second Covid-19 wave, the hospital has been under significant pressure, Chair extended the Board's thanks to Trust colleagues, whose commitment has been unstinting, and care for patients has been outstanding.
b) Chair was pleased to say that over recent weeks the Hospital has started to see the number of admissions due to Covid fall, albeit gradually, reflecting the lower transmission rate within the communities. We hope this continues to be the case.
c) The Trust is proud to see the success of the vaccination programme, with all staff being offered a first dose of the vaccine, along with care home staff, patients aged over 80, and colleagues from other health and care organisations. Despite these encouraging steps, Chair asked residents for their help so that the Hospital can continue to see the numbers of cases reduce. Her message was to please ensure that the community continues to use emergency services appropriately and continues to follow the government guidance on Covid-19. Together, as a community, the Chair believes that we can all work together to protect services and see the end of this terrible virus.
d) Chair closed by saying that the Trust is looking forward to a time in the not-so-distant future when it can return to some level of normality, in particular restarting elective surgery and other services it has had to pause whilst going through the peak of wave 2, but also being able to meet in person rather than virtually. We are not too far from that point.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Conflicts of Interest

The Board received an updated Register of Interest up to the end of January 2021. The Board **APPROVED** the updated register.

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, which provided a high level summary of the past month within the hospital. He drew particular attention to a number of salient points for the Board:

a) James gave his thanks to the Board and welcomed guests to the meeting. The Trust has had a further period of pressure in the hospital, as felt by most of the NHS in the December/January period. Thankfully the Trust has begun to see a decline in the numbers of covid presentation in the ED but equally have seen an increase in non-covid patients. It is an encouraging sign and the Trust is planning its approach to getting its services back to normal over the coming weeks and months, as it heads into brighter times.
b) James extended his thanks to Steve Cook and Gemma Nauman for their work at the Vaccination Hub, supporting colleagues, the community, care home workers and funeral directors to obtain their Covid-19 vaccinations. The Trust will continue to support public health with the vaccination programme. Again this is an encouraging sign but Covid-19 is still prevalent in the community, so we all must remain vigilant. It is not yet time to relax and it is still an extremely busy hospital.
c) James thanked teams across the hospital; it has now been an extremely long period in a difficult time. He also thanked non-clinical colleagues and those working in ITU, ED and the Mortuary, continuing to work which such respect to patients and their families.

d) The Board was previously made aware of the CQC Visit on 14 December 2020. The outputs for this were discussed at the January 2021 Board meeting. The Trust was issued with a Section 29a Warning Notice, which focused on delays at the hospital during ambulance handovers to ED and delays in admitting patients into the main bed base. The Trust receives upwards of 112,000 patients per year, which is extremely high; however, the Trust does not condone delays. Jane Murkin is addressing the immediate concerns and the hospital is already seeing improvements. The Trust will continue to provide safe and caring responses to its patients. Angela Gallagher stated that she is really pleased the Trust has improved on delays and have eliminated 60 min delays. The improvements can be seen during January and into February 2021. The team is still managing a critical incident but she continues to meet with the teams on a daily basis to monitor delays and the ED as a whole.

e) The Trust Improvement Plan is continuing to progress and James was pleased to say that the hospital has had some wards that have gone 900 days without infection. He gave his thanks and congratulations to the teams, where strong leadership has given excellent results. This is a strong and positive message to our Community.

f) Finance position; the Trust is on plan to hit its control total for the third successive year in 2020/21. James thanked the Finance and operational teams for managing quality and cost, both are important factors.

g) Staff wellbeing is something of great significance as the Trust heads into the coming months. The hospital is dealing with an extremely tired workforce. The restore and recovery work is in progress plus the requirement for getting patients back in for their elective and cancer care, whilst also supporting the workforce is being led and carefully managed by Angela Gallagher and Leon Hinton.

h) James gave his sincere apologies to members of the Community who have waited so patiently for their hospital care, especially with elective and cancer care. James wanted to reassure the Community that the hospital is getting those services back to 'normality' and strives to do this in the most efficient and safest way as possible.

i) James closed by thanking the Community for their ongoing support during this time, including their generous donations to the hospital charity. He also wanted to thank the Community for their letters of thanks he receives. The Trust will safely get back to normal as soon as possible it is aware of the impact it has on its patients and families.

j) Chair asked Glynis Alexander to continue with the approved messaging to the Community and to keep it as live as possible. The regular newsletters are of benefit and James being able to give interviews to local media is a positive action.

k) Chair stated that this has been a difficult and busy period for the hospital and she gave her sincere thanks to Angela and the teams for making significant improvements.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 14 January 2021 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record with the following amends;

a) James Devine asked the Company Secretary to review the factual accuracy on Page 1 of the minutes, relating to voting rights.

b) Item 5.1 – Alan Davies confirmed that it was Month 8 not 7.

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/20/107

3 Governance

3.1 Integrated Care System Update

James Devine, Chief Executive gave the Board a verbal update on the current position, for noting.

a) The ICS is heading towards formal accreditation, expected in April. James confirmed that he is the SRO on the ICP work.
b) The Trust has been working on the ICP Strategy, which is mainly focused on integration. The local community was asked for feedback to assist with this work. Some of the feedback included; the requirement for services closer to where people live, accessibility for non-urgent treatments, parking and other historical issues.
c) There is more work to be done but there will be a report to Board at a later date on the progress and the strategy.

4 High Quality Care

4.1 Integrated Quality Performance Report

The Board was asked 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 informed Board Members of the quality and operational performance across key performance indicators.

a) Angela Gallagher stated that Emergency Department performance overall was 73% in November 2020, although this is not delivering to the expected standard. There has been a reduction in discharges due to their acuity. Ambulance delays have reduced now and will be reported on at the next Board meeting. Priorities are now in the restart work and reconfiguration. There is a level of refurbishment that needs to be built into this so it will be a busy summer.
b) Jane Murkin stated that the focus is now on safe staffing and patient flow and breaches. There has been on 'never event' which is being investigated by the Serious Incident Team, with immediate actions taken.
c) David Sulch stated that the mortality rate is sitting below 100 at 98.9 and the hospital has seen improvements in some of the sub sets such as weekend mortality. An audit was taken prior to Wave 2 and results from that will be submitted to the Mortality and Morbidity Committee in March 2021.
d) Ewan Carmichael asked for Angela to pass on the thanks to the Housekeeping/Cleaning teams.
e) Chair asked if there was an indication as to when cancer and other patients will be able to come back in for treatment. Angela confirmed that the plan is for this to start on 22 February 2021, when the capacity is increased in the Green Zone for cancer and clinically urgent. It will be the 22 March for the long waiting patients.

4.2 Quality Assurance Committee Assurance Report: Meeting on 15 December 2020

Tony Ullman, Chair of Committee, gave the Board an update on the Committee meeting held on Tuesday, 19 January 2021. The paper was taken as read and noted. The Quality Assurance Committee escalated the following matters to the Trust Board:

a) Impact of operational pressures on the Trust as escalated by the quality and patient safety group, including an increase in serious incidents relating to 12 hour breaches and delays in reporting, potential impact on quality of care and patient safety. Discussed earlier in the meeting.
b) CQC notice section 29a and report received noting assurance that the key metrics are going in the right direction relating to ambulance hand over and decision to admit times; close monitoring by the committee will continue. Discussed earlier in the meeting.
c) Recommendations contained within the complaints review, and the decisions made. The Committee will review progress implementation going forward. There was a good discussion at the Committee and Tony expects improvements going forward the robust plan with this will deal with complaints in a much improved way.

4.3 Nurse Safe Staffing Review – Update

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board. The Board was asked to, note the content of the report, acknowledge the impact of Covid -19 pandemic on safe

staffing levels and to note the plan to undertake the annual safe staffing review post ward confirmed changes alongside reviews of other clinical areas, such as the Emergency Department.

a) As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, provider Trust Boards are required to receive an annual review and six monthly update on nursing establishments.
b) The annual review of nursing staffing levels was presented by the Chief Nursing and Quality Officer to the Board in July 2020 with the recommendation to increase the existing nurse establishment by an additional 65.31 FTEs above the 2019/20 inpatient ward nursing establishment. The paper provided assurance to the Trust Board that nurse staffing levels on the in- patient wards at Medway Foundation Trust had been reviewed in line with the Workforce Safeguards (NHSI October 2018), which incorporate the National Quality Board (NQB) standards.
c) The Trust Board approved the additional posts to ensure the Trust had sufficient resource to provide safe nurse staffing levels across its inpatient wards.
d) The paper provided an update outlining the progress with recruitment to the additional posts and work undertaken to ensure safe nurse staffing across its inpatient wards.
e) In responding to and managing the coronavirus pandemic/Covid-19 a nursing and midwifery redeployment plan was implemented to support safe staffing due to high levels of absences due to the pandemic.
f) The Trust have continued to progress with its recruitment and reconfiguring established budgets for the divisions. Jane stated that there has had to be a certain level of flexibility with the requirements from the last report due to Covid-19 pressures whilst also ensuring safe staffing. If Jane considered that levels are unsatisfactory, there have been actions taken to mitigate this.
g) The review for 2021/22 will include other areas such as ED, ITU and Neonatal. Jane stated that the Trust takes this matter seriously and she is ensuring that safe staffing levels are maintained.
h) Leon Hinton stated that following the report the Trust has managed to improve the recruitment pipeline. Originally there were difficulties with international recruitment due to the restrictions the Government put in place on travel because of Covid-19. In January 2021 the Trust has effectively managed to recruit 26 international and another 18 in February. The Trust is 54 staff behind but it is getting back on track, there is no way it can get this shortfall in any quicker.
i) Chair informed the Board that the phrase 'International Staff' is used only during the recruitment process to differentiate the cohort as there are specific requirements for this group in travelling into the UK. When they are working at the Trust there should be no differentiation in how nurses are described or identified.

4.4 Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Assurance Report

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board. The Board was asked to, note compliance and review the evidence provided. The report provided assurance to the Board that the Maternity Service is progressing reviewing and compiling evidence to demonstrate compliance with the Safety Actions as part of the CNST MIS. The detailed evidence for submission was submitted in the Appendix.

a) Following the 2 December 2020 meeting of the Trust Board, the Board requested detailed assurance reports to demonstrate compliance with CNST were presented to QAC for oversight and scrutiny this happened in January 2021. QAC will then provide key issue reports to the Board. To support these key issue reports, essential reporting and evidence will also be presented to the Board, in line with the NHSR technical guidance and requirements of CNST. The schedule for reporting was included in the report, for nothing and as follows:

1) Safety Action 1, 2 and 3 – Full report to QAC by Maternity Services January 2021, Key issues from QAC and Essential Reporting by Maternity Services to Trust Board February 2021

2) Safety Action 4, 5 and 6 – Full report to QAC by Maternity Services March 2021, Key issues from QAC and Essential Reporting by Maternity Services to Trust Board April 2021
3) Safety Action 7, 8, 9 and 10 – Full report to QAC by Maternity Services May 2021, Key issues from QAC and Essential Reporting by Maternity Services to Trust Board June 2021

b) Sue Mackenzie asked Jane for a comparison to other hospitals for numbers of deaths. Jane Murkin agreed to bring this information to the March Board. **Action No: TBPU/21/114**

4.5 CoSHH Update

Gary Lupton, Director of Estates and Facilities, presented the paper to the Board, which aimed to ensure the Chief Executive and the Board, are aware of the progress in meeting compliance for COSHH. The Board was asked to, note and be assured of the contents of the report.

a) Chair thanked Gary for his time on the report it is an important update for the Trust and the Board.
b) Gary confirmed the two key areas of highlight are that:
    1) Monthly audit results are positive; these ensure that the Trust has implemented change.
    2) CoSHH training compliance has improved.
c) Gary confirmed that the team continues to review progress. Louise Thatcher stated at the Quality Panel that she is content and that the improvements mean that the risk rating has improved from 'Amber' to 'Green'. Gary plans to keep monitoring progress for a few more months and the audits will continue to ensure that changes are embedded. Gary uses the feedback from the audits as to where action needs to be taken; he gave the Board assurance on the process.
d) Jane Murkin thanked Gary and his team for the work they have done, it is pleasing to see such improvements. Jane confirmed that with the spot checks in place the Trust is no longer seeing the concerns from the CQC Inspection. It is important to continue to embed change.
e) Gary confirmed that to help improve the CoSHH StatMan Training compliance levels, there would be further messaging on this to hospital colleagues. He will be working with Glynis Alexander on the messaging and will engage with the Executive team to filter the messaging through to the teams. Gary will be setting some milestones over the next three months in terms of compliance.

5 Strategy and Resilience

5.1 Emergency Planning Resilience and Response Annual Report

Harvey McEnroe, Strategic Commander, presented to the Board, under the NHSE EPRR Framework, there is a requirement as a minimum of yearly to report on the EPRR activities within the Trust. The Board was asked to, approve the EPRR update.

a) The Chief Executive ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board/Governing Body, no less frequently than annually. The paper included a summary of the Training, Exercising and Incidents from the previous year's programme.
b) The Board was asked to note that due to the Pandemic the majority of the programme has been cancelled and training has been focused towards preparing for and supporting the Pandemic Response.
c) A deep dive into the organisation's EPRR arrangements was not carried out as part of the 2020 annual assurance process, the CCG instead focused on gaining assurance that Pandemic Wave-2 and EU Transition preparation was in place.
d) Harvey asked the Board to note the training exercise undertaken by the organisation as listed in the report.
e) He also asked the Board to note the incidents that have been dealt with during 2020, not relating to the Covid-19 as listed in the paper.
f) The Trust is currently compliant and Harvey gave the Board assurance.

g) The Board oversight for EPRR is with Harvey and Ewan Carmichael, NED, it has been a daily review but this will now reduce to weekly.
h) Chair asked Harvey to ensure that the cancelled training exercises, due to the pandemic, are rescheduled and that there are no gaps. Harvey confirmed that due to the table top exercises the Trust has been able to accredit itself but will ensure that exercises are rescheduled and will update the Board in March 2021. **Action No: TBPU/21/115**
i) The Board gave their thanks to Steve Arrowsmith and the EPRR team.

6 Financial Stability

6.1 Finance Report – Month 9

Alan Davies, Chief Finance Officer, asked the Board to note the report which sets out the summary financial position to the end of December 2020. The paper was taken as read.

a) The Trust reports a deficit of £8k in month and £85k year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 01 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level.
b) Surplus: The Trust reports a £8k deficit position for December; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. In-month due to higher incremental Covid costs, £0.3m of the agreed Covid income has been brought forward to fund the increase. The forecast outturn position remains at breakeven after being updated using the December position.
c) CIP: Year to date performance reports an over achievement against plan due to timing differences of schemes delivered. The forecast position of actual delivery has been updated with the scheme owners identifying £9.0m of the £12m plan; this is the same as November.
d) Capital: Alan was cautiously optimistic on delivery of this, Gary and his team is working hard to deliver. Gary stated that the impacts of Covid-19 have made it a difficult task but the team are chasing through on every project twice a week. There was 50% extra capital provided late in the year and there are some reserve ideas. There may be some potential spend from next year, in this year so updates are live.
e) Activity is below draft budgeted levels as a result of Covid-19.
f) Pay costs are higher than expected.
g) Business planning: the team are reviewing budgets and planning for next year.
h) Forecast run rate: a first draft of this is being reviewed week commencing 08.02.21
i) The divisions have been tasked with a target of mid-March 2021 with their business planning. The finance team is working closely with them in performance management meetings.
j) Angela Gallagher confirmed she is working on the capacity plan during the coming months.
k) Harvey McEnroe confirmed that this work ties in with the strategy intent of the ICS.

6.2 Finance Committee Assurance Report: Meeting on 28 January 2021

Jo Palmer, Chair, took the paper as read and informed the Board of the following key issues from the Finance Committee meeting of Thursday, 28 January 2021 for the Board to note. The paper was taken as read and noted.

a) There were no escalations to the Board or other Committee.
b) Chair confirmed that there was an excellent presentation on Model Hospital Data by Gary Lupton. It was a good example of how to challenge yourself in cost management, including the trajectories and challenges over the year. Chair extended her thanks to Gary and the team for the real difference they have made to the running of Estates and Facilities.
c) The Committee discussed the Capital Plan.
d) Cardiac Catheter Case was resubmitted. The Committee had approved this business case in December 2020 but with outstanding questions, answers of which were brought back to the

January Committee. The Committee received confirmation that the Trust will be using the independent sector capacity whilst the construction work at the hospital is completed and new equipment is installed. This patient group will be serviced outside for the first part of the year. Angela Gallagher has not yet finalised when this will be.

e) Gary Lupton gave the Board a brief presentation on the Model Hospital Data presentation he gave to the Finance Committee. In summary Gary stated that every year a return needs to be submitted from Estates and Facilities. Submitted in the return is the size, age and profile of the estates, it happens at the end of the financial year. Gary needed a baseline position as to where estates were to start with, which gives an indicator of where the Trust sits against its peers locally and nationally. The Trust previously sat in the bottom quartile. This helped Gary to focus as to where the Trust needed improvements and where to make savings. There is more work to be done but now he is able to triangulate work back to the quality metrics.

7 Innovation

7.1 Trust Improvement Plan

Gurjit Mahil, Deputy Chief Executive, took the paper as read and asked the Board to note the current position for assurance. This paper provided the Board with an update on the progress against the Trust Improvement Plan's five pillars in the Executive Summary.

a) 0 – 9 month deliverables are: 39 green 38 amber 8 in red
b) The completed list of deliverables was brought to the attention of the Board
c) Gurjit confirmed that the team is looking at Phase 2 deliverables now, there will be a refresh on this after the next meeting week commencing 08 February 2021.
d) The paper showed progress on each of the other areas; it is a system piece of work to ensure that all partners are working together.
e) Tony Ullman asked that this item becomes a standing item at the QAC; Trust Improvement Plan - 'Patient First Update'. [*Post meeting note: Alana Marie Almond added to the Committee Work Plan*]
f) Chair thanked Gurjit for the report it is really well presented.

8 Our People

8.1 People Committee Assurance Report: Meeting on 18 January 2021

Sue Mackenzie, Chair of Committee, gave the Board an update on the Committee meeting held on Monday, 18 January 2021. The paper was taken as read and noted. Sue gave the following key highlights:

a) There were no escalations to the Board or other Committee.
b) The Committee discussed sickness rates and impacts on staffing. Leon Hinton confirmed to the Board that the Trust has had one of the highest sickness rates through December 2020. Half of that was Covid-19 related sickness. The spike happened in November 2020 and continued into December. There has been an elevated level of mental illness as a reason for sickness, this has been since March 2020, directly related to covid-19.
c) Leon stated that due to the sickness rates there have been higher temporary staffing costs to fill gaps and to resource the hospital to be able to open more bed capacity.
d) The Trust is working with KMPT to put psychological interventions in place and there is a well-being hub giving support to colleagues. The Trust will align demand for well-being where it is needed within the hospital, staff resilience is so important.
e) Ewan Carmichael wanted to extend his thanks and encouragement to Sue and Leon as Lead Executive of the Committee. The Committee is filling an important gap and is giving the Board invaluable data. It is a useful and well run Committee.

9 Any Other Business

9.1 Council of Governors Update

Glyn Allen, Lead Governor gave the Board an update on the Council of Governors to note.

a) The second session of 'Meet the Governors' went well, with twelve members of the public joining. The next meeting is in March 2021 and the format will be reviewed going forward.
b) The new NED position is vacant but there have been a number of applicants. Interviews will be held on 16 February 2021.
c) During such challenging times Glyn and the Governors wanted to send their sincere thanks to the Board and all staff at the Trust, the Governors are most grateful.

9.2 Questions from the Public

There were no questions from the public submitted to the Board.

9.3 Any Other Business

There were no matters of any other business.

9.4 Date and time of next meeting

The next meeting will be held on Thursday, 04 March 2021, 12:30 – 15:30.

The meeting closed at 14:15

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 04 February 2021

Signed …….. Date ……
Chair

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
14-Jan-21	TBPU/21/112	**Item 4.1 - Integrated Quality Performance Report:** - Provide some clarity to see what areas may deteriorate, where we may see changes. - How can the team quantify the indicators that may go off track with Covid. - Add a specific metric in the IQPR for the Emergency Department	04-Mar-21 ~~04-Feb-21~~	Jane Murkin, Chief Nursing and Qaulity Officer David Sulch, Chief Medical Officer Anglea Gallagher, Chief Operating Officer (Interim) Leon Hinton, Chief People Officer	**Update at the March Board**	Amber
04-Feb-21	TBPU/21/114	**Item 4.4 - Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Assurance Report:** information on the number of deaths in comaprison to other hospitals.	04-Mar-21	Jane Murkin, Chief Nursing and Qaulity Officer		
04-Feb-21	TBPU/21/115	**Item 5.1 - Emergency Planning Resilience and Response Annual Report:** ensure that the cancelled training exercises, due to the pandemic, are rescheduled and that there are no gaps.	04-Mar-21	Harvey McEnroe, Strategic Commander		

Meeting of the Public Board
Thursday, 04 March 2021

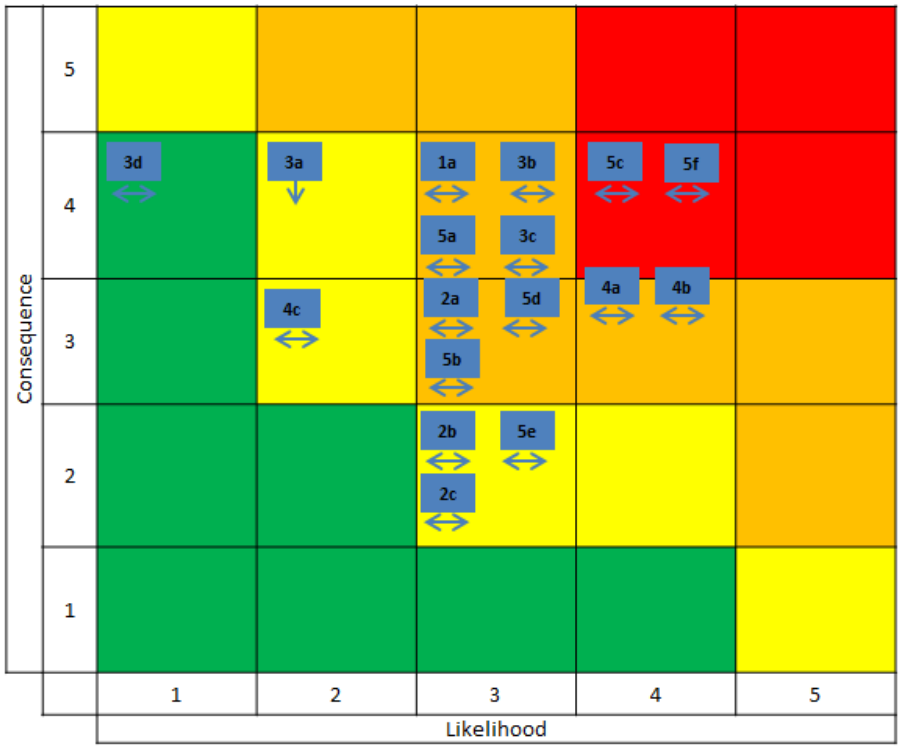
<table>
<tr><td>Title of Report</td><td colspan="2">Board Assurance Framework</td><td>Agenda Item</td><td>3.1</td></tr>
<tr><td>Report Author</td><td colspan="4">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="4">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="4">A summary of the BAF as of the 18 February 2021 is presented in this paper.

The Trust's principle risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Nov-20</th><th>Dec-20</th><th>Jan-21</th><th>Feb-21</th></tr>
<tr><td>5c - Patient flow – Capacity and demand</td><td>6</td><td>12</td><td>9</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>5f - Covid 19</td><td>4</td><td>20</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
</table>
</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="4">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="4">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="4"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="4">N/A</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="4">The Board is asked to note the report for assurance regarding the processes in place around risk management.
<table>
<tr><th>Approval</th><th>Assurance</th><th>Discussion</th><th>Noting</th></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☒</td></tr>
</table>
</td></tr>
</table>

1 Board Assurance Framework

Integrated Healthcare	1a. Failure of system integration	↔
Innovation	2a. Future IT Strategy	↔
	2b. Capacity and Capability	↔
	2c. Funding for investment	↔
Finance	3a. Delivery of financial control total	↓
	3b. Capital investment	↔
	3c. Long term financial sustainability	↔
	3d. Going Concern	↔
Workforce	4a. Sufficient staffing – clinical areas	↔
	4b. Staff engagement	↔
	4c. Best staff to deliver best care	↔
Quality	5a. CQC progress	↔
	5b. Health and Social Care Act requirements	↔
	5c. Patient flow	↔
	5d. Quality governance	↔
	5e. Impact of Covid 19	↔

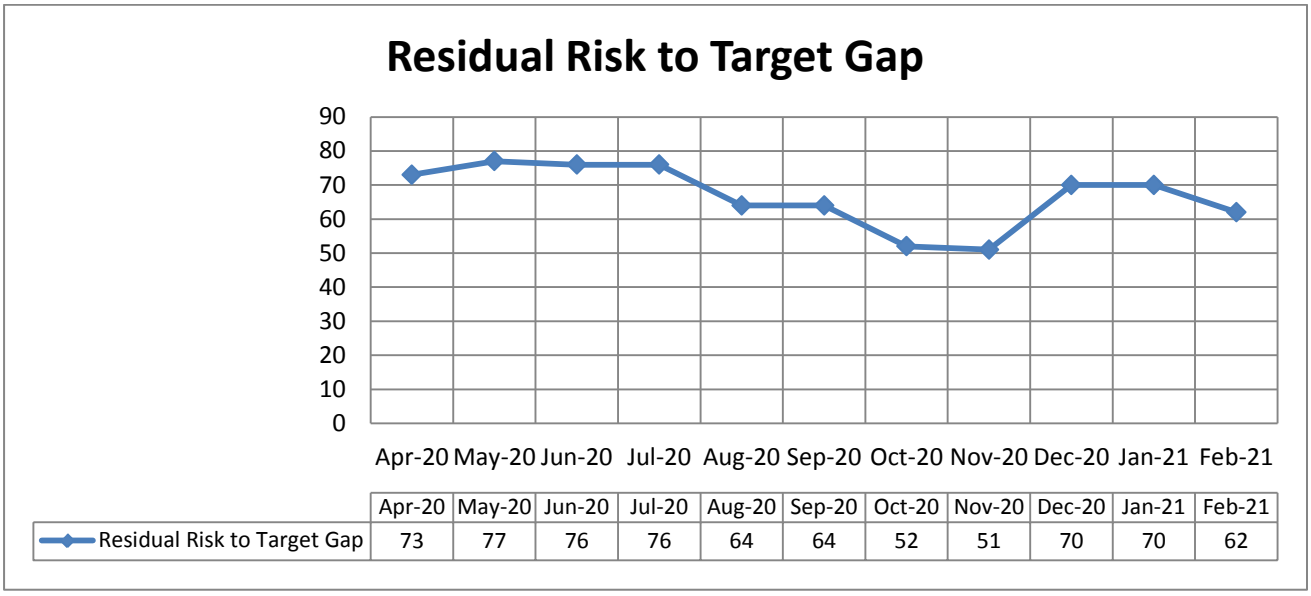


In the current reporting period the Trust has seen the reduction of one risk, deliver of the financial control total. This has been reduced to a moderate risk from a high risk due to the current forecast position.

There are two principles risks that are rated as high, 5c – Patient flow and 5e – Impact of covid-19, mitigations and actions are in place however these still remain high.

		Target Score	Initial Score	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Integrated Healthcare	1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12	12	12
Innovation	2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9	9	9
	2b. Capacity and Capability	9	9	12	12	12	12	12	12	6	6	6	6	6
	2c. Funding for investment	9	9	9	9	9	9	9	9	6	6	6	6	6
Finance	3a. Delivery of financial control total	9	16	6	6	9	9	9	9	9	16	16	16	8
	3b. Capital Investment	12	16	20	20	20	20	20	20	20	12	12	12	12
	3c. Failure to achieve long term financial sustainability	4	16	16	16	12	12	12	12	12	12	12	12	12
	3d. Going concern	4	12	4	4	4	4	4	4	4	4	4	4	4
Workforce	4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	12	12	12	12	12
	4b. Staff engagement	6	12	12	12	12	12	12	12	12	12	12	12	12
	4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	6	6	6	6
Quality	5a. CQC Progress	4	16	16	16	16	16	12	12	12	12	12	12	12
	5b. Failure to meet requirements of Health and Social Care Act	6	16	12	16	16	16	9	9	9	9	9	9	9
	5c. Patient flow – Capacity and demand	6	12	12	12	12	12	12	12	9	9	16	16	16
	5d. Quality Governance	4	12	12	12	12	12	9	9	9	9	9	9	9
	5e. Loss or temporary moves of key clinical services off the MFT site.	4	16					6	6	6	6	6	6	6
	5f. Covid 19	4	20									16	16	16
	Total Risk Score	105	242	170	174	173	173	165	165	153	152	175	175	167
	Residual Risk to Target Gap		137	73	77	76	76	64	64	52	51	70	70	62

Table 1.1 – Summary of BAF



1.1

Figure 1.2: Residual risk to target gap

1.2 Figure 1.2 (above), shows the residual risk to target score gap. The target score is based on the trigger levels for each of the risk domains and the residual risk is based on the gap between the residual risk score and the target score.

1.3 The reduction in the residual gap between January 2021 and February 2021 was due to the reduction of scoring in risk 3a.

COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Director of Transformation/IT										
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/ICS and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace with new technologies, other organisations locally and the ICP and ICS/STP.	4 x 4 = 16 **High**	1. Author a Digital Strategy that is well socialised across the region and well engaged with by teams internally. 2. Develop a roadmap to a single Electronic Patient Record. 3. Focus initially on key projects and investments to stabilise IT services (telephony, networks, end user devices, licenses, systems upgrades, service desk). This will provide a strong technology and information foundation to build upon: EPR, innovation, whole system analytics, specialist services. 4. Seek Regulator support for IT investments and longer-term Digital Strategy	Director of Transformation and Digital, CIO and Senior Digital Team Weekly CIO call with all Kent & Medway provider Trusts	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Reporting to Finance Committee as part of Committee work plan	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X	Formally publish Digital Strategy and EPR business case, ratified by Board Participate well in ICP Digital Strategy Group Form Digital First Team Appoint CCIO Re-launch Digital/IT team Continue to work closely with Regulators	**3 x 3 = 9 Moderate**	**3 x 2 = 6 Low**	P
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**	5. Deploy an Electronic Patient Record – to reduce the paper burden on the organisation and consolidate the number of IT systems 6. Appoint a Director of IT 7. Work in collaboration with neighbouring providers (MTW, EKHUFT) where necessary and to support infrastructure convergence 8. Complete IT team recruitment drive to substantiate bank/agency staff 9. Work more proactively with suppliers 10. Train and upskill Digital teams – closely align Digital with Transformation 11. Pursue PoCs and pilots via the Medway Innovation Institute to evidence benefits of key technologies on a small scale	Director of Transformation and Digital, CIO and Senior Digital Team	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Medway Innovation Institute Steering Committee	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X	Progress Electronic Patient Record FBC Confirm plans for IT leadership structure Form Digital First Team Appoint CCIO Re-launch Digital/IT team Continue to work closely with Regulators	**2 x 3 = 6 Low** **(October – was 3x3=9)**	**3 x 3 = 9 Moderate**	F

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
2c There is a risk that the Trust will be unable to secure sufficient funding for investment in new technologies and clinical research. Specifically, 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**	12. Develop longer-term [3-5 year] capital and investments plan, aligned to Digital Strategy and EPR deployment plan. 13. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released e.g. HSLI, EPMA, Cyber. Horizon scan for any new funding avenues e.g. GDE becoming Digital Aspirants. 14. Investment in the R&I 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. 15. Continue to develop Medway Innovation Institute for Proof of Concepts and to attract external funding and investment. 16. Close working with innovation hubs and accelerators for potential funding routes e.g. Academic Health Science Networks	Director of Transformation and Digital, CIO and Senior Digital Team	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Capital and Investments Group Reporting to Finance Committee as part of Committee work plan R&I Annual Report to Trust Board Medway Innovation Institute Steering Committee	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X NIHR Clinical Research Network Joint Research Office (Kent, Surrey Sussex) KSS AHSN	Progress EPR FBC ICS and HSLI funding discussions ongoing EPMA bid ongoing Adopting Innovation bid ongoing	**2 x 3 = 6** **Low** **(October – was 3x3=9)**	**3 x 3 = 9** **Moderate**	F

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
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.) Under 20/21 contracting arrangements the STP must meet its control total. Given the uncertainty of Covid, our cost response during wave one, CIP delivery risks and the removal of true-up income from months 7-12 of 2020/21, there is a very high risk of the Trust not meetings its control total.	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 30 September 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. STP has allocated funds to manage the system performance.	STP plan submission for months 7-12 2020/21 has been made – effectively requires the Trust to meet its budget.	4 x 2 = 8 **High** (Previous risk rating: Jan 2021 4 x 4 = 16 **Very 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	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	4 x 3 = 12 **High** (Previous risk rating: Oct 2020 5 x 4 = 20 **Extreme)**	4 x 3 = 12 **High**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
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**
			perspective until it starts to generate a cash surplus).				funding recognised. Will potentially need some key choices to be made by the Board during 2020/21 3. Clarity and 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.		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		4 x 1 = 4 **Low**	4 x 1 = 4 **Low**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
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**
			(**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).			divest services. A statement from NHSE/I on 27 May 2020 in light of Covid contracting arrangements it stated: "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) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		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]	**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 11.4%. 2. Sickness rate 4.4% 3. Substantive workforce 83.6%					
			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 3% 4. Bank workforce 13%					
			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 131 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. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Refresh of Freedom to Speak Up strategy [Apr 21] Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] Working across the STP to implement TRiM (Trauma and Injury Management) processes in the Trust as part of #HAY [Dec 21]	**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. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.	1. You are the difference (YATD) embedded in induction 2. NHSEI Culture, Engagement and Leadership Programme Board						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session; c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: a. Trust scores across key domains; b. Comparative results from previous years and other organisations; c. Heat maps for targeted interventions. d. 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. Respect: countering bullying in the workplace policy; c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Respect policy in place; 3. 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. d. National #How are you (HAY) wellbeing framework implemented	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. #HAY implemented and monitored						
			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 Qualitative and quantitative values-based appraisal						
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. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Refresh of Freedom to Speak Up strategy [Apr 21]	**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 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 >89% 2. Appraisal rate >85%						
			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 Qualitative and quantitative values-based appraisal in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place. 4.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and	1. Trust vacancy rate at 11.4%; 2. Substantive workforce 83.6%; 3. Monthly PRM including discussion on workforce, vacancies,						

			temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.	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 2020 4. Review of Dickens ward undertaken – report being written. 5. Substantive Associate Director of Quality and Patient Safety recruited, to commence in January 2021. 6.Terms of Reference for Maternity Services Review agreed and draft KLOE 7. Terms of Reference in final revision and date for commencing in negotiation with CCG. 8. Substantive Deputy Chief Nurse recruited – to commence in February 2021. 9. Phase one – document review of Maternity Service Review conducted on 29 October 2020. Phase two – staff interview dates being confirmed. 10. Action plan developed and actions progressed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A 15. Implementation of Patient First programme	Quality Panel Governance in place fortnightly meetings. CQC Evidence panel in place with fortnightly meetings. Daily senior ops 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. Programme of Matron competence assessment being implemented Report on the first twelve ward assurance visits completed and report produced for September and November Executive Group meetings and QAC	Internal Audit and External Quality Audit. CCG Quality Meetings CQC Engagement Meetings Safeguarding Review completed and draft report received. Complaints Review completed and draft report received Single Item Multi-Agency meetings	Evidence sent thus far being quality assured As a result of increasing operational pressures due to the change of red to amber wards during wave 2/3 of COVID-19, there is a risk that some of the ED CQC MDSD actions with regard to patient flow may not meet the date set for completion.	Complete QA process for all future evidence submitted Winter Plan and Watchtower plan being prepared. Joint senior medical and nursing tactical meetings have been established with the COO in attendance.	**4 x 3 =12 Moderate**	**2 x 2 = 4 Very Low**	Partial

			Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented cohort 3 being recruited to. Cohort three now midway through their programme. Once this has been completed all ward managers will have been through this programme Matrons Development Programme in place February – September 2020. Programme currently being evaluated. Heads of Nursing Development Programme in place May – November 2020. Aspiring ward leaders programme commissioned commenced 1 October 2020 Aspiring Clinical Leads programme to commence in January 2021 for AHPs Leadership development programme for specialist nurses being commissioned and to commence April 2021 Trust wide Matron Leadership Roles implemented for nursing fundamentals and quality priorities QI Development session held with Matrons 4 September 2020	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. AMM held on MS Teams		Aspiring Ward Leaders programme, Aspiring Clinical Leads Programme and CNS Leadership development programmes postponed until April 2021	Reflection and Recognition event for Matrons and Heads of Nursing planned for 27 November 2020. Rescheduled to 5 March 2021 due to Covid-19 and lockdown			Full
			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. Quality and Safety Boards now on all adult in-patient wards f. 'Big room' event held on 17 July in partnership with the Innovation Institute celebrating improvements in pressure ulcer reduction. g. Second multidisciplinary 'big room' event held on 18 September with a follow up on pressure ulcers and a focus on nutrition. Increasing numbers of 'days between' pressure ulcer acquisition on a number of wards	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 Sapphire Ward awarded a gold star by the Chief Nursing & Quality Officer and the Chief Executive for 239 days between the last pressure ulcer acquired on the ward. Eight other wards achieved bronze stars (achieving 50 days with no pressure ulcer) these will be presented by the matrons.	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 well attended			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 The newly implemented mechanical interventions are having the most positive impact on COSHH compliance which should show a significant improvement in the November COSHH audit. 50% of staff	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial

				compliant with COSHH training however there is an issue with accessing & capturing, Chief People Officer to re-circulate instructions to Staff.							
			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, development workshop planned for 12 October 2020 Complaints review process approved and in progress. Safeguarding review currently underway	Centralisation of the Divisional Quality Governance Teams Divisional Governance Boards Phase one – document review of Maternity Service Review conducted on 29 October 2020. Phase two – staff interview dates being confirmed. Complaints review completed, draft report with the Chief Nursing and Quality Officer for review. Draft report to Execs on 6 January 2021 Safeguarding review completed final report with the Chief Nursing and Quality Officer for review. Final report to Execs on 6 January 2021	Regular reports to the Executive Group. Quality and Patient Safety Group		Compliance with 48 hour SI reporting to StEIS deteriorating. Further process mapping of the issue underway. Maternity services review scoped and TOR agreed, commenced 29 October 2020	Divisions have a plan in place to rectify.			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**
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 2. Infection Control Action Plan developed in response to NHSE/I visit in November and being implemented 3. IPC Intensive Support programme supporting the Trust 4. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 5. Senior IPC nursing advisory function and support received from NHSI 6. Trust improvement plan reviewed and updated with short, medium and long term goals 7. IPC BAF reviewed, updated and presented to QAC in January and externally shared with regulators	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 Decontamination Group in place .	IPAS (I/E) meeting Oversight from system DIPC	The total number of all key hospital acquired infections (MRSA bacteraemia, C difficile, gram negative blood stream infections) is lower for Apr-Jul 2020 than for the corresponding period in 2019. MFT had no outbreaks of hospital acquired COVID-19 in wave 1 however there have been two outbreaks in wave 2. Updated position paper going to QAC on 19 January 2021 18 IPC policies currently undergoing review. Resumption of antimicrobial audits in June 2020. Review of IPC team structure under way – Associate Director role appointed to – commencing March 2021. Covid BAF update to be undertaken and presented to February 2021 QAC	Support secured from CCG to update all policies PIR's completed. Medical Director to consider contingency plan IPC Governance Review underway	**3 x 3 = 9 Moderate August 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. 7. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board Weekly ED performance review Daily check points for activity & flow Trajectories for all constitutional standards in place.	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used. System calls in place to ensure escalations. Progress against action plan will be overseen by Quality Panel c. 13 January 2021	External reviews by NHS I/E Single Item Multi-Agency meetings Response on current progress to CQC on 4 January 2021	Weekly Best Flow Programme Board has not met during COVID-19	Wave 3 planning Further response to CQC on 2 February 2021	**4x4 = 16 Dec 2020 High** (3 x 4 = 12) Moderate **(September 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	90 Day forum	None	Ensure full embedding of the RAG processes. Plans to meet with members to identify 2021/22 quality priorities scheduled for 24/02/21	**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.	**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	90 Day Forum		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

				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**
5f **Covid 19** (Revised February 2021)	The Trust has been under severe pressure from the delivery of its Covid response and required to manage multiple risks with very little contingency. A dedicated register monitors the range of operational risks that arise from this and reports on mitigations.	**4 x 5 = 20 High**	Regular System calls in place daily to escalate any further support required from partners Use of the strategic structures for planning 3-4 weeks ahead.	Operational Command and Control (OCC) arrangement e- 4 times a day and site meetings 4 times a day feeding into the 3 strategic meetings.	Regular review by Strategic Command and NED calls	Regular discussion with system partners and region		Mitigations are in place as described below. Actions to be reviewed and mitigations to be assessed.	**4 x 4 = 16 High**	**2 x 2 = 4 Very Low**	
Three main risk areas are identified:	1 & 2. The Trust will be unable to sustain its response to pressures arising from Covid:										
	-If it cannot maintain safe staffing levels in relation to open capacity		Plan implemented to redeploy nurses to support safe staffing. Daily safe staffing meeting System partners have been approached to provide Safe staffing resources Use of military personnel in some areas to provide additional support Staff redeployed from other areas to ensure an appropriate ratio. Mutual aid also in place to support ITU level 3 transfers where clinically appropriate.	Operational Command and Control (OCC) arrangement e- 4 times a day and site meetings 4 times a day feeding into the 3 strategic meetings.	Regular review by Strategic Command and NED calls	Regular discussion with system partners and region		Regular monitoring through Strategic structures and daily escalations in place.			
	-If it cannot control staff shortages arising from Covid prevalence in the community										
	-If it is not sufficiently supported financially by NHS E/I		Being tracked through by Divisional Finance Business Partners.	Managed through corporate tactical and strategic.	Review by the Finance Committee	Regular discussion with system partners and region					
	3. In order to extend capacity to match the numbers of patients requiring life-saving treatment, the Trust risk assessed the level of quality that it is possible to provide at this time. There is an increased likelihood of poor patient experience because for example patients cannot be turned as frequently as normal or there is no visiting in most clinical areas.		Plan for staffing regularly reviewed to ensure safe opening of the ward. Virtual Bed Bureau now in place to ensure factual accuracy of the systems Daily trust wide safe staffing reviews undertaken by DDON/ HON with escalation to CN&QO Senior IPC nursing advisory function and support received from NHSI Daily reports on PPE and Oxygen availability	New openings area managed through the OCC and Strategic structure. Daily senior operational meetings Daily nursing tactical meeting at 8am Monday – Friday Executive Group	Regular review by Strategic Command and NED calls	Regular discussion with system partners and region		Revisit the visiting policy in line with national recommendations as covid activity reduces. Actions in place for escalations.			

				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**
	The delivery of elective activity has been severely disrupted since the first wave of Covid in April 2020. Under national guidance, the Trust reduced activity to emergency cases, e.g. on the cancer pathway. If the community measures to control the spread of Covid are not sufficiently effective then Covid cases will not reduced and there will be further delay to elective cases.		As and when Covid cases reduce, the Trust will step back its Covid response, re-instating day case and inpatient areas to elective cases and well resume regular outpatients sessions – virtually where clinically appropriate. However there is a risk that delays to treatment starting will mean patient outcomes will be poorer. Where possible, cases are taken by private providers	Planned through and strategic command at this stage.	Monitoring of quality outcomes by QAC	Reporting to CQC and the region regarding PTL and trajectories.		Key milestones have been identified and appropriate operational/clinical meetings in place to review the status of restart on a weekly basis. Trajectories to be realigned in line with the planned elective activity.			

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 March 2020**	**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						

Meeting of the Board of Directors in Public

Thursday, 04 March 2021

Assurance Report from Committees

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**3.2**
Committee Chair:	Mark Spragg, Non-Executive Director		
Date of Meeting:	Thursday 25 February 2021		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Paul Kimber, Deputy Chief Financial Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Internal audit KPMG presented their audit summary and noted those reports that were now complete, where work is underway and where it is yet to be started. It was noted that the intention is to bring these reports to an April meeting. The 'Pharmacy Stock Management' report was presented, which had an improved rating of 'significant assurance with minor improvement opportunities'. The counter fraud progress report was presented to and noted by the committee. This highlighted the proactive and reactive work being undertaken, including raising awareness and communication at the Trust.	**Amber/Green**

2. External audit Grant Thornton presented their audit plan to the Committee, highlighting those areas of risk where procedures will be focussed. It was noted that it is their intention to attend an inventory count at the year end. The Committee **AGREED** that the Chair would issue a letter to the host of the financial ledger seeking a service organisation control report. The increased fees proposed in the audit plan were noted as arising due to the enhanced procedures required in respect of the Value for Money audit opinion. It was **AGREED** that Grant Thornton would provide a summary paper that can be shared with the Trust Governors.	**Amber/Green**
3. BAF The BAF extract on 'Quality' was presented to the Committee by the Chief Nursing and Quality Officer, focussing on the actions, control and governance in place to manage these items.	**Amber/Green**
4. National data security and protection toolkit The Deputy CEO presented this report to the Committee noting that 22 of the 27 standards that were not being met have now been addressed; work is ongoing on the remaining 5 standards. The next submission is due by the end of June 2021 and all matters are expected to be compliant at that time.	**Amber/Green**
5. Losses and special payments The report was presented by the Chief Financial Officer, who noted the two large items as being in respect of the bank mandate fraud and the write-off of a bad debt (which had been provided against previously). The report did not currently include the loss arising from the IT theft but would do in due course.	**Amber/Green**
6. Standing Financial Instructions (SFIs) The revised SFIs were presented by the Chief Financial Officer, who noted the key amendments made were: - To reflect correct job titles - To update the process applicable to tendering, namely the use of an electronic portal rather than hard copy submissions - To reflect the governance process for investments in the scheme of delegation. Discussion was held around whether it was appropriate to include a % cap for work conducted by/reliance on a single supplier and it was concluded that the SFIs were not right place for such an operational matter. It was **AGREED** that any such benchmark should be included in the business case policy and the terms of reference of the Trust's investment governance groups.	**Amber/Green**
7. Internal audit contract Due to KPMG's contract expiring in October 2021 and the risks associated with a change of internal auditors part way through the year, the Committee **APPROVED** the extension the contract to the end of the financial year (including delivery of the head of internal audit opinion for 2021/22).	**Green**
8. Single tender waivers (STWs) The Chief Financial Officer presented the report on STWs issued during	**Amber/Green**

the financial year. Audit colleagues noted that the Trust did not appear to be an outlier.	
9. Annual accounts planning The report noted the timetable for the production of the 2020/21 annual report and accounts; this included the extension from 15 June to 29 June that had been applied for and approved for submission of the audited version. Future Committee meetings will be scheduled to accommodate this timing. It was noted that following a full revaluation of the Trust land and buildings in 2019/20 a simpler desktop exercise will be undertaken for 2020/21. The Committee **AGREED** that it is appropriate to consider the Trust as a going concern for the purpose of the accounts.	**Green**
10. Claims report It was noted that this report had been presented to the Trust Board in January and was presented here for assurance.	**Amber/Green**
11. Risk policy It was noted that this report had been presented to the Trust Board in January and was presented here for assurance.	**Green**
12. IT theft report The Director of Transformation and IT presented the report and outlined the actions taken since the thefts to mitigate the risk of future incidents.	**Amber/Green**
Decisions made It was **AGREED** that the Committee Chair would issue a letter to the host of the financial ledger seeking a service organisation control report. It was **AGREED** that Grant Thornton would provide a summary paper that can be shared with the Trust Governors which outlines the additional procedures required to give the Value for Money opinion. It was **AGREED** that any benchmarks around % of work with a single supplier should be included in the business case policy and the terms of reference of the Trust's investment governance groups. The Committee **APPROVED** the extension of the internal audit contract with KPMG from October 2021 to the end of the financial year (including delivery of the head of internal audit opinion for 2021/22). The Committee **AGREED** that it is appropriate to consider the Trust as a going concern for the purpose of the accounts.	
Further Risks Identified None.	
Escalations to the Board or other Committee The Board is asked to delegate authority to the Committee to approve the Annual Accounts for 2020-2021 on its behalf.	

Meeting of the Board of Directors in Public
Thursday, 04 March 2021

Title of Report	**Wellbeing Guardian – Introduction and Nomination**	**Agenda Item**	3.3
Lead Director	Leon Hinton, Chief People Officer		
Report Author	Leon Hinton, Chief People Officer		
Executive Summary	The NHS People Plan 2020/21 sets out national health and wellbeing policy ambitions to enable us to create a culture of wellbeing, where our NHS people are cared for. One of the key new roles introduced through the plan is the Wellbeing Guardian who strategically steers and holds the organisation to account for the wellbeing of its employees. The Wellbeing Guardian is supported by an assurance mechanism through nine board principles as documented in this report. It is proposed that a Non-Executive Director is nominated to act in the capacity of the Wellbeing Guardian for the Board, to receive quarterly assurance reports, gaps and risks through the People Committee (item 3.1). It is proposed that the Trust undertakes an annual self-assessment of the implementation of the principles as part of its assurance mechanisms (item 3.2).		
Committees or Groups at which the paper has been submitted	- Executive Group - Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Recommendation from the NHS Staff and Learners Mental Wellbeing commission (Health Education England, 2019); NHS People Plan requirement, 2020.		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The Board is asked to note the requirements of the Wellbeing Guardian and are asked to nominate a Non-Executive Director for this brief.		
	Approval ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☒

1 Background and purpose

1.1 The NHS People Plan 2020-21 sets out national health and wellbeing policy ambitions to enable us to create a culture of wellbeing, where our NHS people are cared for. One of the key new roles introduced through the plan is the Wellbeing Guardian:

1.1.1 Wellbeing Guardians: Board members who strategically steer and hold the organisation to account for the wellbeing of its employees.

1.2 The concept of the Guardian arose through the national NHS Staff and Leaders' Mental Wellbeing Review (HEE, 2019) and identified a lack of uniformity in board-level leadership around the wellbeing of our NHS People.

1.3 The purpose of the Guardian is that the Wellbeing Guardian is a board-level role that provides oversight, assurance and support to the NHS Board to fulfil their legal responsibility in ensuring the health and wellbeing of our NHS people. The Guardian should feel confident in questioning decisions that could impact on the wellbeing of our NHS people and challenging behaviours that are likely to be detrimental to others. Where organisations have non-executive directors (NEDs) in post, it is likely that one of these colleagues will be appointed as the Wellbeing Guardian.

2 The nine board principles supported by the wellbeing guardian

2.1 **Principle one:** The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.

2.2 **Principle two:** Where an individual or team is exposed to a particularly distressing clinical event, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.

2.3 **Principle three:** Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') are being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.

2.4 **Principle four:** The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.

2.5 **Principle five:** The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.

2.6 **Principle six:** The NHS will ensure that all our NHS people and learners have an environment that is both safe and supportive of their mental and psychological wellbeing, as well as their physical wellbeing.

2.7 **Principle seven:** The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.

2.8 **Principle eight:** The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).

2.9 **Principle Nine:** The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment.

3 Assurances

3.1 It is recommended that a dedicated assurance report is provided by the Chief People Officer, through the People Committee, across all nine principles, to the Wellbeing Guardian on a quarterly basis.

3.2 An annual checklist against maturity of the principles is carried out with a gap analysis and associated plan, risks and mitigations – with the Wellbeing Guardian and other Non-Executive Directors at the People Committee. The reported status will then be reported to Board as per the current status recommendations of:

3.2.1 **Phase 1 status** - Health and wellbeing has limited coverage at board level:

a) Undertake NHS Health and Wellbeing Diagnostic to assess current health and wellbeing performance and identify priority activities (Principle 1).

b) Identify a wellbeing guardian.

c) Agree the priority actions to be included in the wellbeing guardian role description and how the nine principles will be phased in.

3.2.2 **Phase 2 status -** Principles of wellbeing guardian role are largely embedded:

a) Wellbeing guardian role is established and functioning well within the board.

b) Most of the nine principles are routinely evidenced at board meetings.

c) A holistic health and wellbeing strategy is in place (either standalone or as part of a wider people strategy) and being delivered.

d) Staff experience measures indicate a compassionate culture is in place or being created.

3.2.3 **Phase 3 status** - Health and wellbeing is routinely considered and included in board activity:

a) All board members routinely consider the holistic health and wellbeing of our NHS people in their strategic and operational plans and performance reporting.

b) The board regularly hears feedback in the from staff stories.

c) All nine principles are being delivered.

d) The NHS Health and Wellbeing Diagnostic Tool dashboard is green.

Meeting of the Board of Directors in Public
Thursday, 04 March 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Jane Murkin – Chief Nursing and Quality Officer David Sulch – Chief Medical Officer Angela Gallagher – Chief Operating Officer (Interim)		
Lead Director	Jane Murkin – Chief Nursing and Quality Officer Gurjit Mahil – Deputy Chief Executive		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for December shows that the Trust has had 0 MRSA bacteraemia cases and 3 hospital acquired C-diff cases. Whilst, October's overall HSMR rate is 98.79 and below the national threshold, the weekend HSMR rate is at 104.95 and links to risks during the weekends with Bed Occupancy and MSA also increasing. **Caring** Unfortunately, whilst MSA had shown improvement in previous months, January has seen that 452 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates remain close or above the national standard of 85% (Inpatients: 80.72%, ED: 89.02%, Maternity: 100%, Outpatients: 90.45%). Whilst Inpatients remains relatively static, improvements have been seen in ED, Maternity and Outpatients. **Effective** Discharges before Noon, whilst close to the Mean are still below at 14.21% and significantly below the Target of 25%, this is being reviewed through the Patient First work. **Responsive** Unfortunately, due in part to the lower discharges before noon rate and the pause in elective work the 18 weeks Referral to treatment (RTT) performance for January is recorded at 64.96%, with 345 +52 week breaches, clinical harm reviews have been completed for these patients. Additionally, the Trust has seen 2 Operations cancelled by the hospital on the day. . ED (Type 1) 4 hour performance as a result of site pressures reported 57.32% in January. Additionally, the Trust saw 363 Ambulance Handover delays of +60mins.		

	However, DM01 Diagnostics performance is at 81.81% for December. **<u>Well Led</u>** We have seen a reduction in appraisal rates at 75.56% however the Trust has maintained compliance statutory and mandatory training. To note: • The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay. • The SHMI data is currently showing August – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing October data, this is reliant on D r Foster and this is 3 to 4 months in arrears. • The bed oc cupancy includes all beds within the Trust including maternity and paediatrics.
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 – Reporting Period: January 2021

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: January 2021

What is Statistical Process Control (SPC)?

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 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.

The main aims 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.

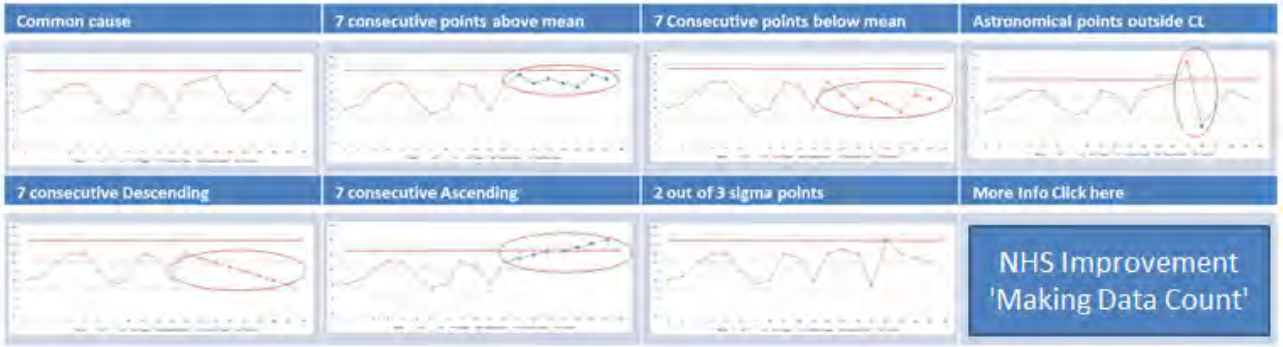
Key Facts about a SPC Chart:

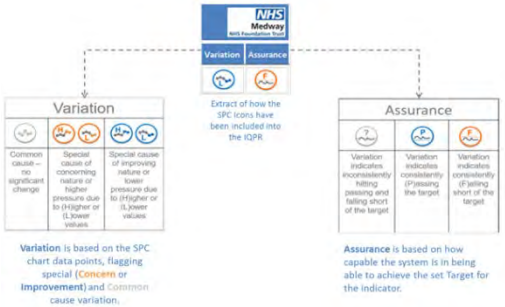
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

Contains two types of trend variation: Special Cause (Concern or Improvement) and Common Cause.

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





NHS
Medway
NHS Foundation Trust

Topic	Overview	Deep Dive
Executive Summary	4	5
Caring	7	7
Effective	8	9
Safe	10	11
Responsive	13	15
Well Led	21	22

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls) & Mortality Rates	• ED & Flow
Caring	• The Friends and Family recommended rates for Maternity services and Outpatients remain above the national standard of 85%. ED FFT has also improved in month.	• High number of breaches in Mixed Sex Accommodation continues into January • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set
Effective	• VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement • Fractured NOF, whilst under target, has improved in month and is above the Mean	• Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • The overall HSMR levels have dropped to 98.8, now below the national threshold (100)	• Infection data shows spikes in E-Coli and C-Diff cases throughout December
Responsive	• Cancer 2ww Performance has exceeded the target in Dec-20 • Whilst still significantly above UCL's, +60Min Ambulance Handover delays are down from levels seen in Dec-20, as to are +12 Hour DTA Breaches in ED	• DM01 Diagnostics performance has dropped. • ED 4 hour performance remains under LCL • RTT Incomplete Performance decreased in Dec-20 and is again slightly below LCL. +52wk breaches has seen an increase above UCL in Jan-21.
Well Led	• Maintained compliance with Trust target for StatMan Compliance • Whilst CIP savings are just under planned position in month, YTD shows actuals are above planned levels	• Sickness Rate above target and average (continuous area of increase) • Appraisal % has continued to fall below target and is now below the LCL position

Executive Summary

NHS Medway NHS Foundation Trust

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

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

NHS Medway NHS Foundation Trust

Safe			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Dec-20	3	3	43	27		
S2	Number of C-diff (HAI)	Dec-20	0	5	0	22		-
S3	MRSA Bacteraemia (Trust Attributable)	Dec-20	0	0	5	1		
S4	E-coli (Trust Acquired)	Dec-20	2	7	30	32		
S5	Falls per 1000 bed days	Jan-21	6.63	4.66	6.63	5.28		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Jan-21	1.04	0.2	1.04	0.03		
S7	Never Events	Jan-21	0	0	0	2		
S8	% of SIs responded to in 60 days	Jan-21	100%	100%	100%	100%		-
S9	HSMR (overall)	Oct-20	100	98.79	100	98.92		
S10	HSMR (weekday)	Oct-20	100	96.65	100	95.7		
S11	HSMR (weekend)	Oct-20	100	104.96	100	108.07		
S12	SHMI	Aug-20	1	1.07	-	-		

Caring			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Jan-21	0	452	0	1030		
C2	New Complaints	Jan-21	41	45	-	450		
C3	% Complaints responded to within target	Jan-21	85%	57.78%	85%	69.7%		
C4	% EDNs completed within 24 hours	Jan-21	100%	63.13%	100%	70.79%		
C5	Inpatients Friends and Family Response rate	Jan-21	22%	19.56%	22%	19.2%		
C6	Inpatients Friends and Family % recommended	Jan-21	85%	80.72%	85%	82.3%		
C7	ED Friends and Family Response rate	Jan-21	22%	16.06%	22%	15.98%		
C8	ED Friends and Family % recommended	Jan-21	85%	89.02%	85%	84.6%		
C9	Maternity Friends and Family Response rate	Jan-21	22%	24.17%	22%	32.21%		
C10	Maternity Friends and Family % recommended	Jan-21	85%	100%	85%	99.61%		
C11	Outpatients Friends and Family Response rate	Jan-21	22%	11.26%	22%	12.5%		
C12	Outpatients Friends and Family % recommended	Jan-21	85%	90.45%	85%	89.0%		

Responsive - Non-Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Jan-21	85%	83.37%	85%	80.19%		
R2	Average Length of stay (Non-elective)	Jan-21	5	9.43	5	8.17		
R3	Average Length of stay (Elective)	Jan-21	5	3.01	5	14.82		
R4	% of Delayed Transfers of Care	Jan-21	4%	0.27%	4%	0.47%		
R5	% Medically Fit For Discharge	Jan-21	7%	8.55%	7%	10.27%		
R6	ED 4 hour performance (All)	Jan-21	95%	85.61%	95%	72.63%		
R7	Ed 4 hour performance (Type 1)	Jan-21	95%	57.32%	95%	76.98%		
R8	ED 12 hour DTA Breaches	Jan-21	0	452	0	1030		
R9	Ambulance Attendances	Jan-21	-	3,117	-	32,194		
R10	60 minute handover delays	Jan-21	0	363	0	2,037		

Effective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Dec-20	5%	6.83%	5%	6.97%		
E2	30 day readmission rate	Dec-20	10%	12.7%	10%	13.46%		
E3	Discharges before noon	Jan-21	25%	14.21%	25%	14.46%		
E4	Fractured NOF within 36 hours	Jan-21	100%	88.00%	100%	72.45%		
E5	VTE risk assessment % completed	Jan-21	95%	91.69%	95%	94%		
E6	Elective C-section rate	Jan-21	13%	14.21%	13%	14.43%		
E7	Total C-Section rate	Jan-21	28%	40.21%	28%	36.29%		
E8	Average Occupancy (maternity)	Jan-21	15%	26%	15%	21.8%		
E9	12+6 risk assessments	Oct-20	90%	89.58%	90%	88%		
E10	Number of deliveries	Jan-21	-	373	-	3,865		-

Responsive - Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Dec-20	99%	81.81%	99%	70.96%		
R12	18 weeks RTT Incomplete Performance	Jan-21	92%	64.96%	92%	64.98%		
R13	18 Weeks over 52 week breaches	Jan-21	0	345	0	1238		
R14	Operations cancelled by hospital - on the day	Jan-21	0	2	0	104		
R15	Cancelled operations not rescheduled <28	Jan-21	0	10	0	26		
R16	Cancer 2ww performance	Dec-20	93%	95.23%	93%	97%		
R17	Cancer 2ww performance - breast symptomatic	Dec-20	93%	91.49%	93%	94.84%		
R18	Cancer 31 day first definitive treatment	Dec-20	96%	98.04%	96%	97%		
R19	Cancer 62 day treatment - GP referrals	Dec-20	85%	81.66%	85%	76.18%		
R20	104 day cancer waits	Dec-20	0	3	-	11		

Well Led			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	Dec-20	0	8	0	85	-	-
W2	CIP savings	Dec-20	£1,521k	£851k	£5,978k	£6,306		
W3	Appraisal %	Jan-21	85%	75.56%	85%	85.37%		
W4	Sickness Rate	Jan-21	4%	5.09%	4%	4.78%		
W5	Turnover rate	Jan-21	12%	12.25%	12%	12%		
W6	StatMan compliance	Jan-21	85%	88.47%	85%	88.66%		
W7	Contractual staff in post	Jan-21	-	4115.48	-	-		-
W8	Agency spend as % pay bill	Jan-21	4%	2.20%	4%	1.83%		
W9	Bank spend as % pay bill	Jan-21	9%	15.90%	9%	16.37%		
W10	Overall safe staffing fill rate	Dec-20						

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	Jan-21	0	452.00	23.21	136.06	248.91		
		MSA %	Jan-21	0%	2.84%	0.18%	0.92%	1.65%		
		% of EDNs Completed Within 24hrs	Jan-21	100%	63.13%	68.42%	73.66%	78.89%		
		Inpatients Friends & Family % Recommended	Jan-21	85%	80.72%	77.73%	84.43%	91.13%		
		Inpatients Friends & Family Response Rate	Jan-21	22%	19.56%	15.26%	20.19%	25.09%		
	ED Care	ED Friends & Family % Recommended	Jan-21	85%	89.02%	72.09%	79.45%	86.81%		
		ED Friends & Family Response Rate	Jan-21	22%	16.06%	12.15%	14.67%	17.20%		
	Maternity Care	Maternity Friends & Family % Recommended	Jan-21	85%	100.00%	97.45%	99.32%	100.00%		
		Maternity Friends & Family Response Rate	Jan-21	22%	24.17%	12.05%	26.87%	41.68%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Jan-21	85%	90.45%	87.40%	90.09%	92.79%		
		Outpatients Friends & Family Response Rate	Jan-21	22%	11.26%	11.48%	13.68%	15.87%		

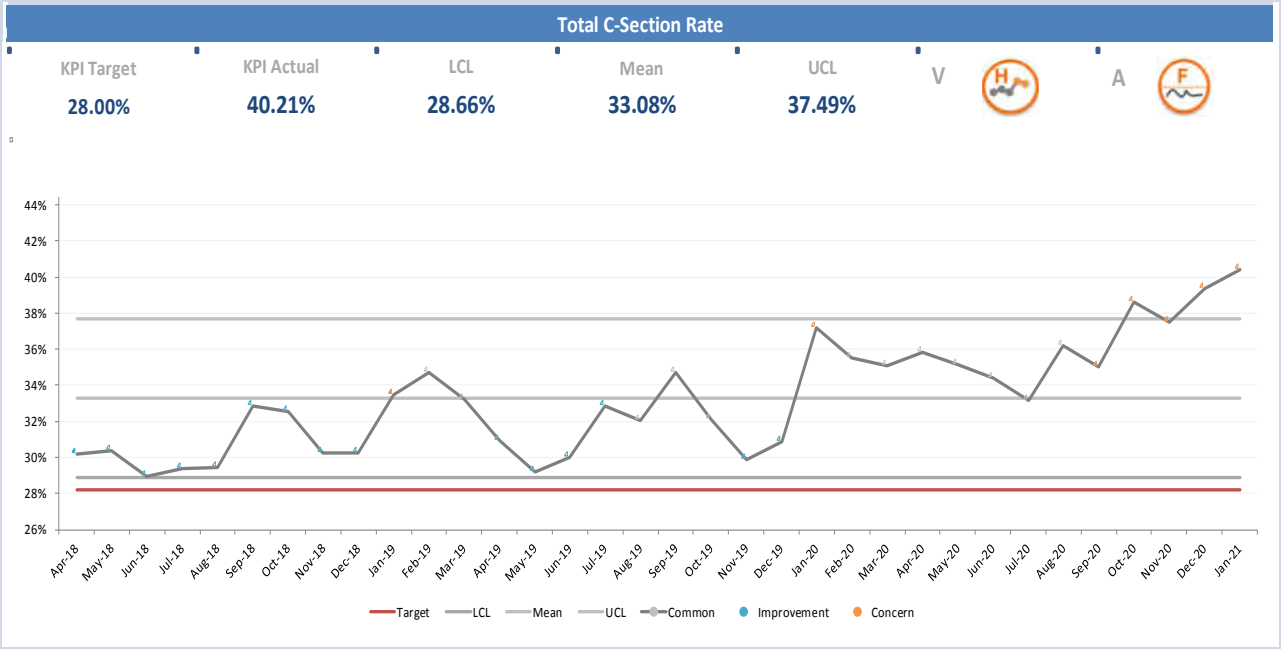
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	Dec-20	5%	6.83%	4.31%	5.77%	7.23%		
		30 Day Readmission Rate	Dec-20	10%	12.70%	9.40%	11.46%	13.52%		
		Discharges Before Noon	Jan-21	25%	14.21%	12.35%	14.93%	17.51%		
		Fractured NOF Within 36 Hours	Jan-21	100%	88.00%	35.28%	65.13%	94.98%		
		VTE Risk Assessment % Completed	Jan-21	95%	91.69%	76.64%	86.79%	96.95%		
	Maternity	Elective C-Section Rate	Jan-21	13%	14.21%	10.01%	13.38%	16.75%		
		Emergency C-Section Rate	Jan-21	15%	26.01%	15.49%	19.68%	23.87%		
		Total C-Section Rate	Jan-21	28%	40.21%	28.66%	33.08%	37.49%		
		12+6 Risk Assessment	Oct-20	90%	89.58%	60.25%	81.31%	100.00%		

Effective: Total C-Section Rate
Aim: TBC
Latest Period: January – 2021

Executive Lead: Jane Murkin – Chief Nursing & Quality Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate



What changes have been implemented and improvements made?

The elective and emergency caesarean rates must be considered on their own merit. Clinical decision making and counselling in an acute situation must be responsive to the emerging risk to mother and baby. This graph clearly illustrates that the total caesarean section rate is influenced by the rise in the emergency section rate. The details of these cases will be understood following the planned case review, which will be shared and an appropriate action plan agreed.

What do the measures show?

The % of births that were elective or emergency c-sections.

There has been a gradual rise in caesarean section rates since September 2020, with an increase noted in December . Following which the Chief Nurse has requested a review into caesarean section rates, which is currently in progress.

This may be reflective of the national ambition to reduce stillbirths by 50%, resulting in an increased induction of labour rate.
The graph illustrates that the total caesarean section rate is influenced by the rise in the emergency section rates.
The emergency rate should be considered along side the MBRRACE reported stillbirth rate, which is below national average.

Domain: Safe Dashboard

Executive Lead: Jane Murkin – Chief Nursing & Quality Officer
David Sulch – Chief Medical Officer
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

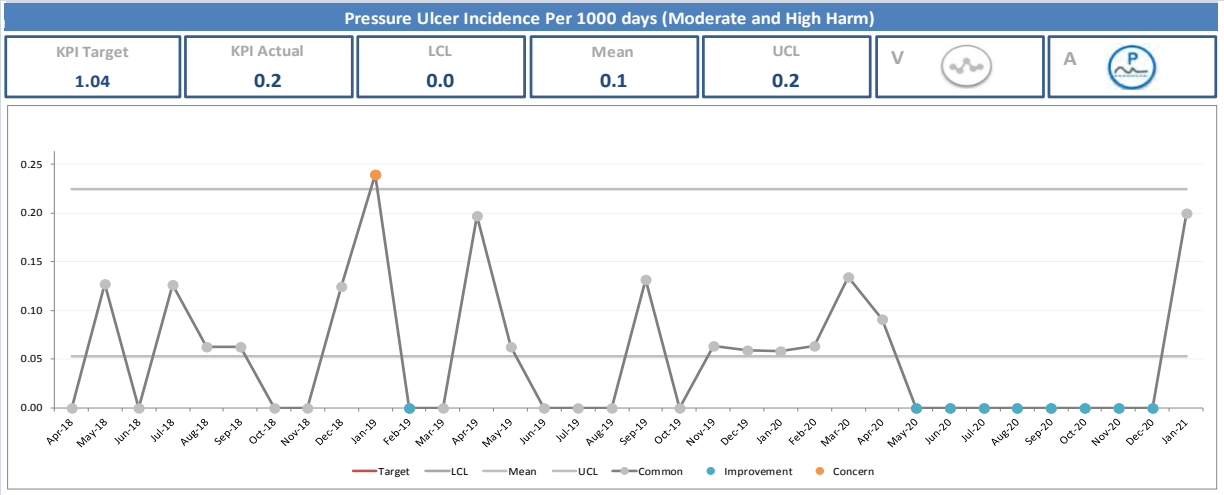
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Jan-21	6.63	4.66	2.90	4.75	6.61		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Jan-21	1.04	0.20	0.00	0.05	0.22		
	Incident Reporting	Never Events	Jan-21	0	0.00	0.00	0.15	0.95		
		No of SIs on STEIS	Jan-21	90	32.00	0.00	13.26	27.69		
		% of SIs Responded To In 60 Days	Jan-21	0%	100.00%	93.23%	98.33%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Dec-20	5	0.00	0.00	0.48	2.40		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Dec-20	43	2.00	0.00	2.71	8.97		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Dec-20	0	3.00	0.00	1.86	6.65		
		E-coli (Trust Acquired) Infections	Dec-20	30	7.00	0.00	4.42	10.49		
	Mortality	Crude Mortality Rate	Dec-20	3%	4.88%	0.46%	1.77%	3.08%		
		HSMR (All)	Oct-20	100	98.80	93.00	104.63	105.11		
		HSMR (Weekday)	Oct-20	100	96.65	90.00	101.78	103.87		
		HSMR (Weekend)	Oct-20	100	104.97	92.95	112.47	117.90		
		SHMI	Aug-20	1	1.07	0.78	1.01	1.24		

Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: January – 2021

Executive Lead: Jane Murkin – Chief Nursing & Quality Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)



What changes have been implemented and improvements made?

Focus continues on improving the reliability of the process through implementation of the ASSKING bundle.
Learning from the first wave of COVID , patients in the intensive care unit in the prone position sustained facial pressure ulcers. TVN sourced and implement mattresses that allow specific distribution of pressure to ensure the face is no longer compromised. Since use of the mattress there has been no facial pressure ulcers from COVID.

What do the outcome measures show?

The Quality strategy aim to reduce hospital acquired pressure ulcer incidents by 10% continues to show progress towards being achieved with increasing days between PU in pilot wards.
In December 2020 there was 26 hospital acquired pressure ulcers, the highest number of incidents in 2020. 15 of these are related to COVID and the patients acuity.

What do the process measures show?

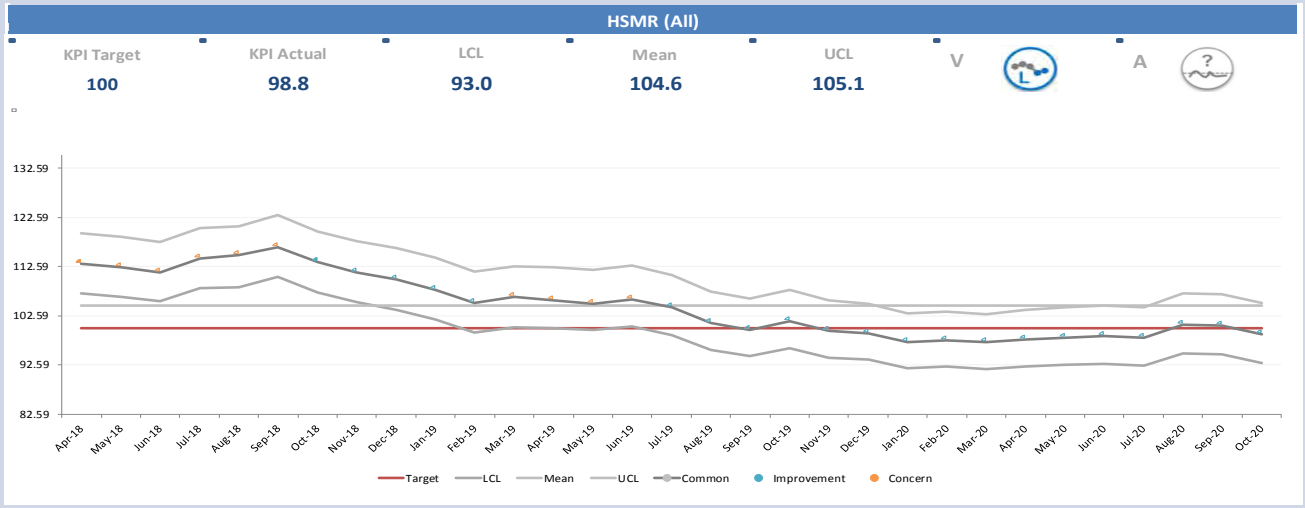
The focus to is on achieving a 95 % reliability in ASSKING care bundle process which in turn will Increase the days between Pressure ulcer incidents per ward

Safe: Mortality
Aim: TBC
Latest Period: September- 2020

Executive Lead: David Sulch – Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Mortality - HSMR



What changes have been implemented and improvements made?

Changes in the medical model at the weekend include the splitting of the weekend take between a general medical consultant and an acute physician. This essentially splits the entire take into three at the weekend (the GIM take, acute medicine take and frailty take), whereas one consultant was responsible for the entire take prior to the change in the medical model in June 2018.

The difference between the mortality for Medway and Swale patients observed particularly at the weekend, but also to a lesser extent during the week is being investigated via a prospective audit from the Frailty and Acute Medicine teams. This audit will report initial findings to the September meeting of the Mortality and Morbidity Committee.

What do the measures show?

HSMR continues to show an encouraging trend, with the steady reduction in the level being mirrored by a fall in observed deaths within the Trust. The difference between weekday and weekend mortality continues to be addressed via alterations to the medical take process for the weekends: the current position shows a reduction in weekend mortality.

The SHMI has not shown a similar reduction, although the level remains within the accepted confidence intervals. In fact the SHMI has worsened over the last year – this is because a reduction in observed deaths (of around 150 in the last year) has been outstripped by a greater reduction in expected deaths. The reasons for this are under investigation.

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

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Jan-21	85%	83.37%	81.29%	88.42%	95.54%		
		Average Elective Length of Stay	Jan-21	5	14.82	0.94	2.73	4.52		
		Average Non-Elective Length of Stay	Jan-21	5	9.43	7.33	8.48	9.64		
		% of Delayed Transfer of Care Point Prevalence in Month	Jan-21	4%	0.47%	0.35%	1.32%	2.30%		
		% Medically Fit For Discharge Point Prevalence in Month	Jan-21	7%	8.55%	14.25%	17.62%	20.99%		
	ED Access	ED 4 Hour Performance All Types	Jan-21	95%	72.63%	76.10%	83.25%	90.39%		
		ED 4 Hour Performance Type 1	Jan-21	95%	57.32%	64.88%	74.88%	84.89%		
		ED 12 hour DTA Breaches	Jan-21	0	57.00	0.00	22.94	78.40		
		60 Mins Ambulance Handover Delays	Jan-21	0	363.00	0.00	122.41	259.93		

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

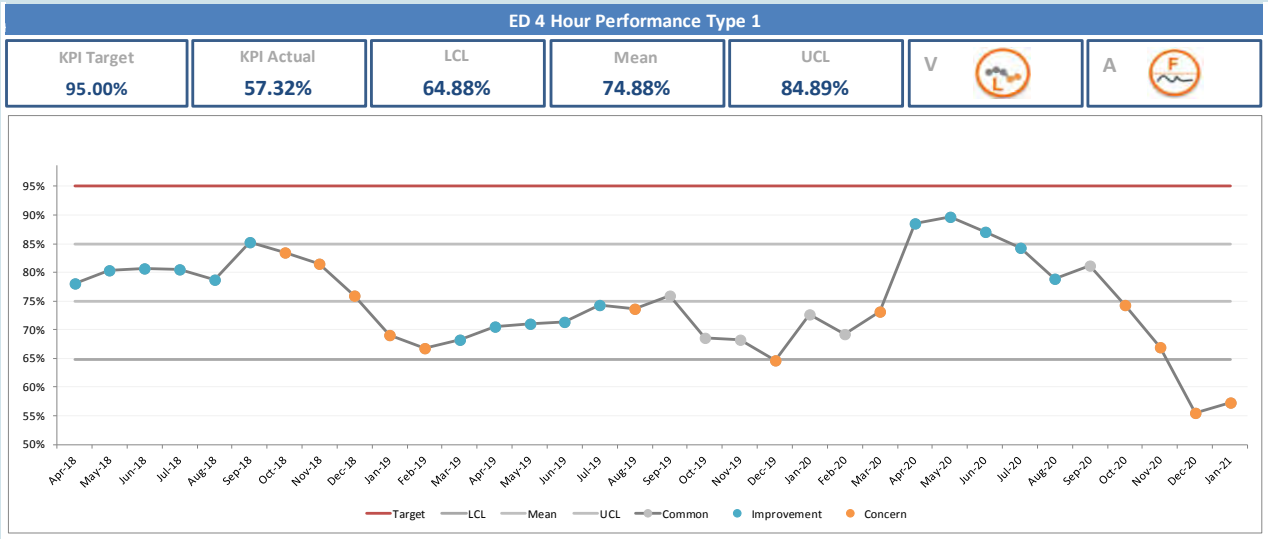
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Diagnostic Access	DM01 Performance	Dec-20	99%	81.81%	77.68%	89.96%	100.00%		
	Elective Access	18 Weeks RTT Incomplete Performance	Jan-21	92%	64.97%	71.03%	77.00%	82.97%		
		18 Weeks RTT Over 52 Week Breaches	Jan-21	0	345.00	0.00	41.29	90.46		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Jan-21	0	2.00	0.00	21.26	50.04		
		Cancelled Operations Not Rescheduled < 28 days	Jan-21	0	0.00	0.00	4.71	13.17		
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Dec-20	93%	95.23%	78.01%	88.78%	99.55%		
		Cancer 2ww Performance - Breast Symptomatic	Dec-20	93%	91.49%	50.66%	80.50%	100.00%		
		Cancer 31 Day First Treatment Performance	Dec-20	96%	98.04%	90.35%	96.46%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Dec-20	85%	81.67%	62.46%	78.03%	93.60%		
		104 Day Cancer Waits	Dec-20	0	3.00	0.00	2.18	5.42		
	Complaints Management	Number of Complaints	Jan-21	41	45.00	18.14	60.38	102.62		
		% Complaints Responded to Within 30 Days	Jan-21	85%	57.78%	38.88%	68.85%	98.81%		

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:

- To reduce LOS in ED waiting for Critical Care and Respiratory beds additional AGP bays were planned to be opened from early Jan;
- SDEC has supported emergency care flow through mitigating against blockages in SAU and stretched criteria to accept medical Take admissions, many on admission pathways; Sporadic use of Clinical Decision Unit pending workforce; Inconsistent application of swabbing protocol and TAT in laboratory has increased LOS for admitted patients

Outcomes:

- Demand is reduced by 6% with ambulances reduced by 2%;
- Admitted performance in M9 ranged 2-7%;
- Non-admitted performance circa 86%;
- Close correlation between trends in admitted and non-admitted performance due to excess LOS in ED reducing access to type 1 cubicles;
- CDU utilisation has reduced from 18 per day in M7 to less than 5 per day in M9;
- TTT metric remains RCEM compliant at 74%;

Underlying issues and risks:

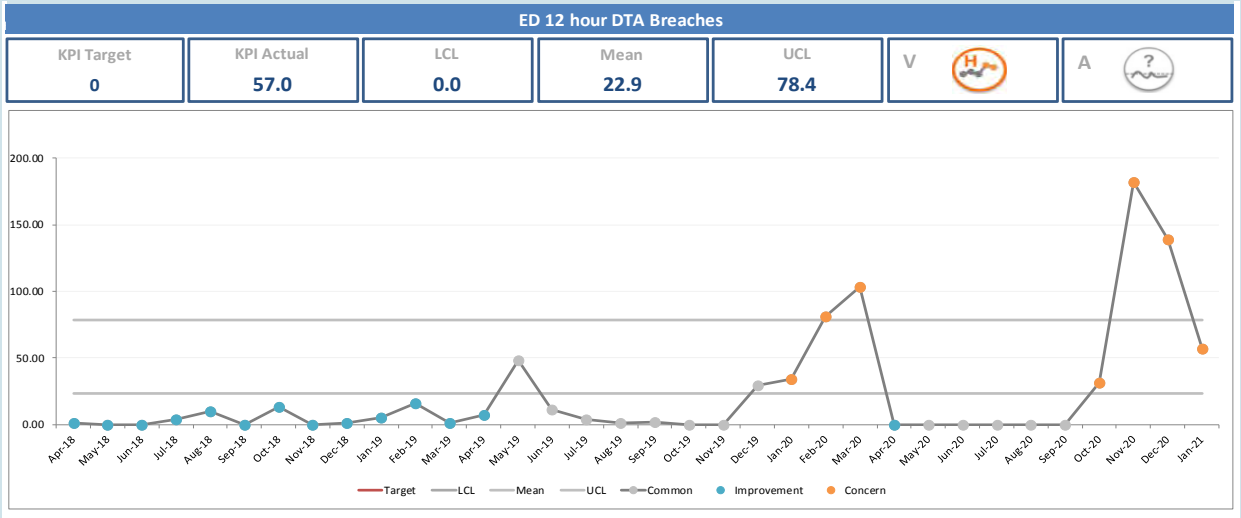
- Workforce gaps in acute medicine has meant increased LOS for referred patients. This wouldn't be a problem if we had Refer and Move capacity available on Lister. AAU capacity reduced by 50% in M9;
- Intermittent availability of SAU pathways as a failure to empty. Medical outliers consistently >30 (was >60 in M10 2020); Excess admitted and non-admitted breaches between 2100 – 0300. ED have re-introduced night MG position though uptake % is sporadic;

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 12 hour DTA Breaches



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 12 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:

- To reduce risks to patient safety, ED has increased the use of physical beds in the department for extended LOS patients;
- MADE is now led weekly by the ACOO focusing on areas with elevated >14 days LOS. This aims to reduce inpatient occupancy to reduce the risk of prolonged stay in ED;
- The submission of 12 hour breaches remains as per operational validation policy. The Associate Director of Quality has oversight on the liaison with CCG re: learning process;

Outcomes:

- Despite the increased LOS in ED of specialty patients, we are assured that our Quality & Safety plans provide patients with a standard of ward based care; Bed occupancy is reducing however access to beds remains limited due to IPC guidelines. Admitted performance remains <12% with bed occupancy at <90% in NEL for latter part of M10;
- Covid19 linked AGP, mental health and frailty have remained the highest risk of 12 hour DTA breaches in M10. Moving to M11 it is now patients within standard surgical & medical paths;

Underlying issues and risks:

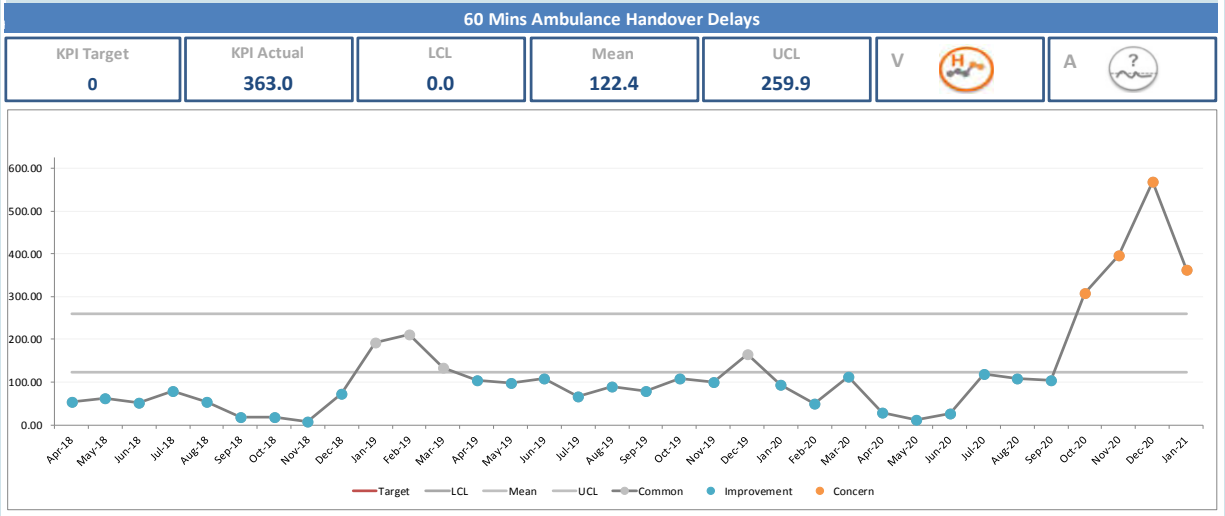
- AGP capacity has improved in terms of availability. Still requires admission after PTWR which can be delayed; Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity. Ocelot decommissioned at end of M10 however tactical re-opening of beds has continued under DCOO;
- There is a significant resource requirement to manage the governance around 12hr breaches and complete value adding investigations that are system linked. This is now acknowledged by ADQ;
- Reconfiguration of beds now ongoing alongside estates programme to ensure fir for future;

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: 60mins Ambulance Handover Delays



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 12 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:

- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways due to clinically significant exit-block (induced by occupancy and slow process);
- RAU process remains effective in terms of pre-arrival streaming and Fit2Sit. ECIST support continues;
- Inconsistent decompression into CDU during peak load surge. SOP formalised to establish risk mitigated corridor care;
- Downward trend noted as occupancy reduction continues.;
- Revision of ED real-estate ongoing a s per intelligence;

Outcomes:

- Hear and treat / see and treat pathways from SECAMB have improved utilisation in M8 and M9 and now into M10;
- Actions to monitor and respond to patient deterioration are improved and refined under CQC reporting conditions;
- Dynamic conveyancing has reduced through the M10 period as ICS starting to recover from C19;
- RAU remains at N=8 cubicles with Covid19 pathway specification ;

Underlying issues and risks:

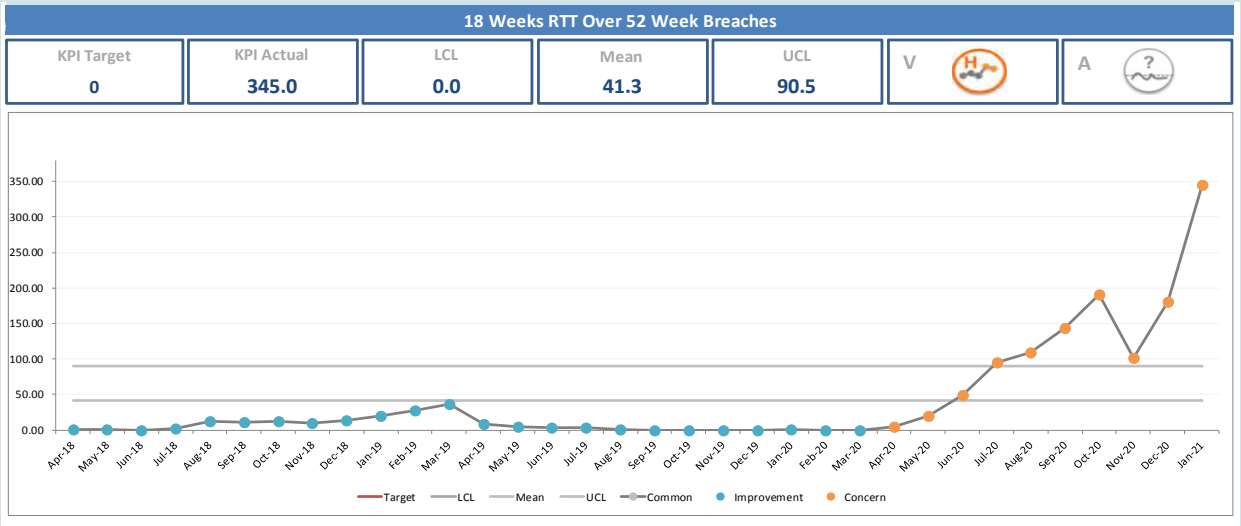
- Reverse triage (FCP action) carries a risk to quality and dignity of care for type 1 patients;
- On platform clinical assessment agreed by Chief Medic and ED Consultants following escalation of concern;
- Care Group led and clinically-led solution for internal ED decompression during surge required to compliment operational oversight;

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 Over 52 Week Breaches



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:

- Restart plan is currently being worked through.
- Clinical harm reviews being completed for all patients waiting over 52 weeks.
- RTT PTL meetings are back in place to manage all long waiting patients.
- Independent sector work is still in place.
- Virtual outpatients still in place.

Outcomes:

- Trajectories will be recalculated as part of the Restart 2.0 programme
- Recovery plans have been developed to deliver the zero trajectory
- Increased 'Green Zone' Elective capacity in the Independent Sector

Underlying issues and risks:

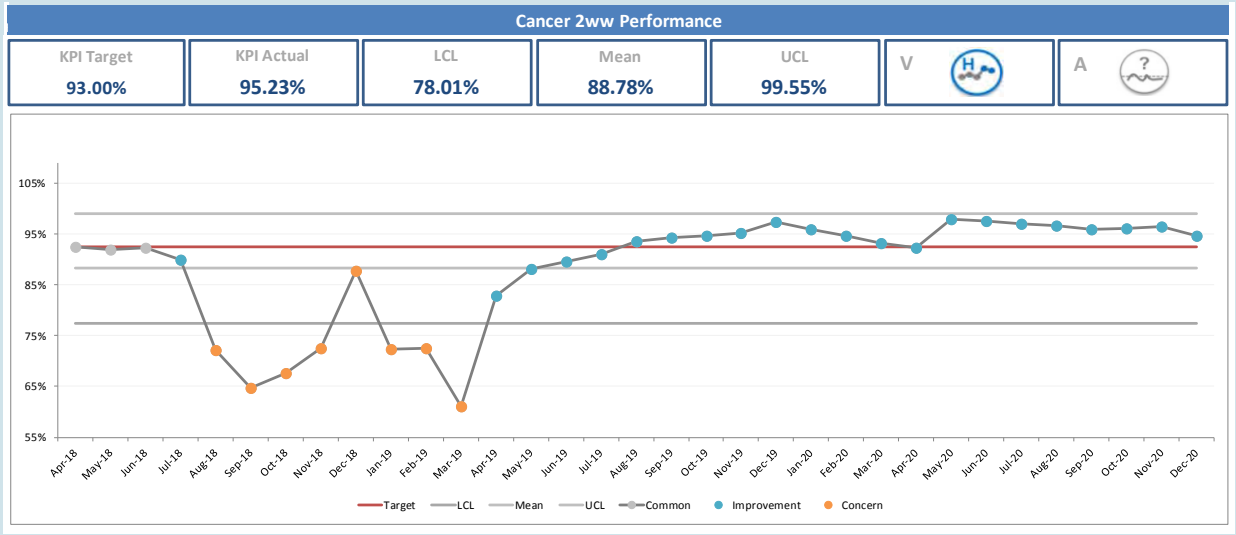
- Impact of covid wave 2
- Impact of current staffing levels from an absence and shielding point of view.

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:

- Working to an internal stretch target of 7 Days
- Providing regular real time updates on performance to CBO
- Escalations made to all services at risk of breaching 14 Day target
- Services failing 14 day target escalated to Divisional Director.
- Weekly referral numbers and day of OPA shared with each service.
- Services now using combination of Virtual (where appropriate) and F2F (some at IS sites) clinic formats to ensure that services remain compliant through the Pandemic.

Outcomes:

- Trust has remained compliant with this KPI since August 2019 (17 Consecutive Months)
- Daily escalations allow remedial action to be taken allowing service to remain compliant.
- Better working relationships between CRO and service managers .
- Regular meetings with Service Managers ensure that there is adequate capacity to facilitate demand.

Underlying issues and risks:

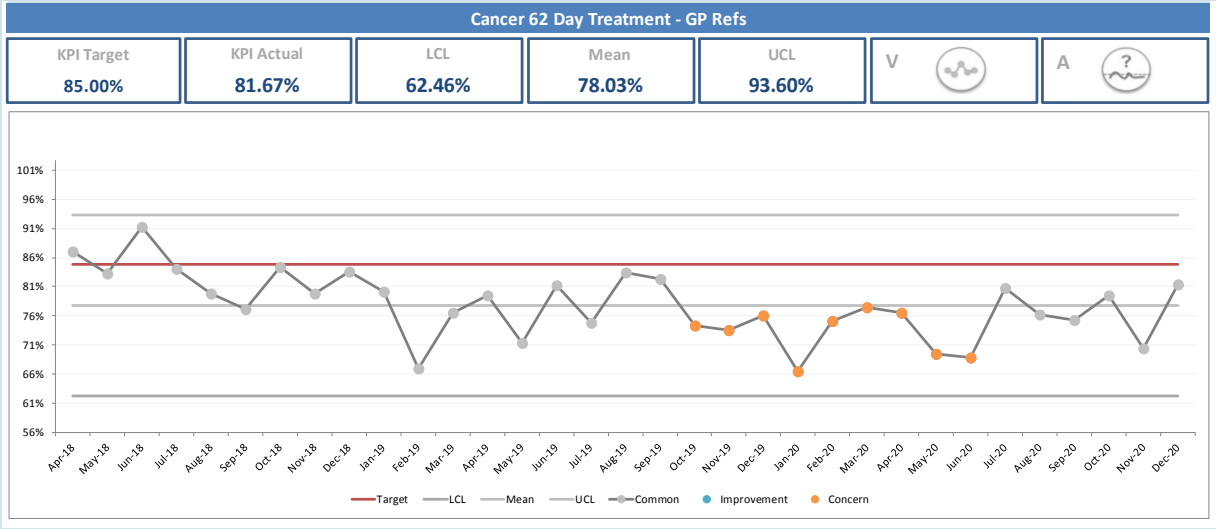
- Internal Stretch target of 7 Days is now being achieved by 2 services Urology & H&N
- 7/9 Services booking at day 14 or under.
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic Capacity could challenged as the trust pushes ahead with restart.

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:

- Weekly PTL chaired by Cancer GM and supported by tumour site service managers, now attended by MDT coordinator, Navigator and tracker to ensure detailed feedback provided.
- Weekly PTL now highlights potential Cancers earlier to promote referral to tertiary centre before day 38 also added 38 Day IPT target on MDT list allowing the service to work more towards delivery of this target.
- Full time support for LGI MDTC has begun to support PTL.
- Cancer Pathway Manager working with challenged tumour sites to ensure patients tracked and progressed along pathway in timely fashion.

Outcomes:

- Confirmed Cancer patients are being identified on the PTL much earlier.
- UGI Service has managed to send over more patients within 38 day IPT target.
- Dedicated tracking support for LGI has improved performance though not yet compliant with operational standard has facilitated highest performance in tumour site for over 13 months.
- More clinical lead engagement with tumour specific challenges to find solutions.

Underlying issues and risks:

- Inappropriate prioritisation – Increase in 2ww referrals
- Services currently competing for limited HDU capacity.
- Patient engagement is causing some issues as patients are worried and at times reluctant to attend for diagnostics or treatment.
- Post 2nd wave peak influx of referrals could overwhelm current capacity

Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-20	62%	56.84%	13.11%	37.86%	62.61%	H	?
		Staff Friends & Family - Recommend Care of Treatment	Mar-20	79%	68.97%	18.62%	50.46%	82.30%		?
	Workforce	Appraisal % (Current Reporting Month)	Jan-21	85%	75.56%	80.39%	85.40%	90.42%	L	?
		Sickness Rate (Current Reporting Month, FTE%)	Jan-21	4%	5.09%	4.06%	4.28%	4.50%	H	F
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Jan-21	12%	12.30%	10.92%	12.08%	13.23%		?
		Contractual Staff in Post (FTE) (Current Reporting Month)	Jan-21	0	4115.48	3794.01	3895.89	3997.76	H	●
		StatMan Compliance (Current Reporting Month)	Jan-21	85%	88.47%	64.36%	79.64%	94.91%	H	?
		Agency Spend as % Paybill (Current Reporting Month)	Jan-21	4%	1.84%	2.02%	3.74%	5.45%	L	?
		Bank Spend as % Paybill (Current Reporting Month)	Jan-21	9%	16.37%	8.69%	13.04%	17.39%		?
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Dec-20	75%	41.15%	60.80%	72.65%	84.49%	L	?

Domain: Well Led - Financial Position

Executive Lead: Alan Davies – Chief Financial Officer
Operational Lead: Paul Kimber – Deputy Chief Financial Officer
Sub Groups : Finance Committee

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month NHSE/I Baseline	In-month Actual	In-month Variance	YTD NHSE/I Baseline	YTD Actual	YTD Variance
Income	30,057	31,156	1,099	291,868	300,169	8,301
Pay	(19,332)	(20,078)	(746)	(186,415)	(191,135)	(4,720)
Total non-pay	(9,351)	(9,708)	(357)	(91,936)	(95,395)	(3,458)
Non-operating expense	(1,374)	(1,379)	(5)	(13,517)	(13,733)	(216)
Reported surplus/(deficit)	**(0)**	**(9)**	**(9)**	**(0)**	**(93)**	**(93)**
Donated asset deprecation	0	9	9	0	93	93
Control total	**(0)**	**0**	**0**	**(0)**	**0**	**0**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	1,823	812	(1,011)	7,801	7,118	(683)	12,000
Capital	(2,157)	(1,005)	1,152	(20,112)	(14,576)	5,536	(31,659)

Indicator Background:

The Trust reports a £9k deficit position for January; after adjusting for donated asset depreciation the Trust reports breakeven in line with the revised plan control total.

What the Chart is Telling Us:

The Trust is reporting breakeven against its control total. CIP is adverse to plan as schemes planned for the 2nd half of the year have not delivered. The forecast CIP for 20/21 is £8.9m, £3.1m adverse to the £12.0m plan. Capital programme is underspent, mainly due to a delay in planned schemes.

Actions:

- Monitoring of forecast outturn; currently a contingency of £1.1m has been identified.
- Business Planning for 2021/22 across all services including corporate, ensuring establishments, budgets and activity plans are developed in the divisions.
- CIP development with focus now on schemes for 2021/22.

Outcomes:

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

- Incremental costs associated with Covid-19 of £14.8m year to date. An additional £2.5m income has been secured for Covid; the total income for Oct-Mar is £10.1m.
- Of the Kent & Medway STP deficit for Oct-Mar, £3.7m is due the Trust's annual leave carry forward accrual.
- 20/21 forecast outturn for the Trust is breakeven excluding annual leave accrual.

Underlying issues and risks:

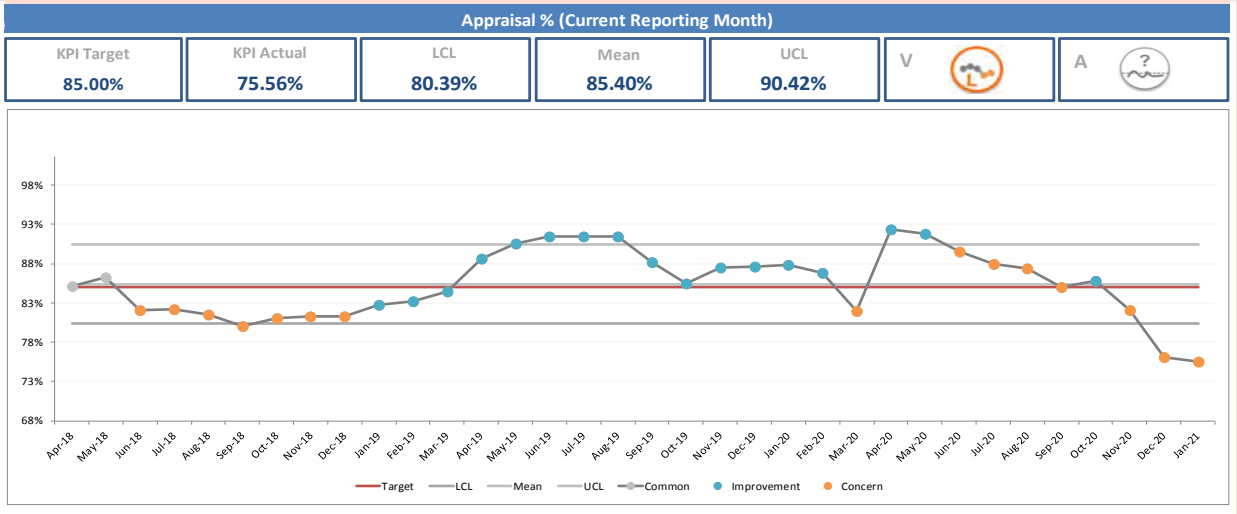
Following a revised plan submission, new arrangements came into force from 1 October with control of top-up, Covid and growth monies now held at STP level.
Staff costs remain adverse to budget and £0.7m adverse to the Oct-Mar plan mainly due to increased bed capacity and continued high levels of Covid activity.
CIP forecasts are £3.1m below the £12.0m plan, this is £0.1m less than December.
Capex is behind plan and the Trust has also received significant new funding streams for additional projects. This is expected to recover.

Well Led: Workforce - Insights

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: Ayesha Feroz, Unplanned Care, Temi Alao, Planned
Sub Groups : N/A

NHS Medway NHS Foundation Trust

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:

3090 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4058).

Underlying issues and risks:

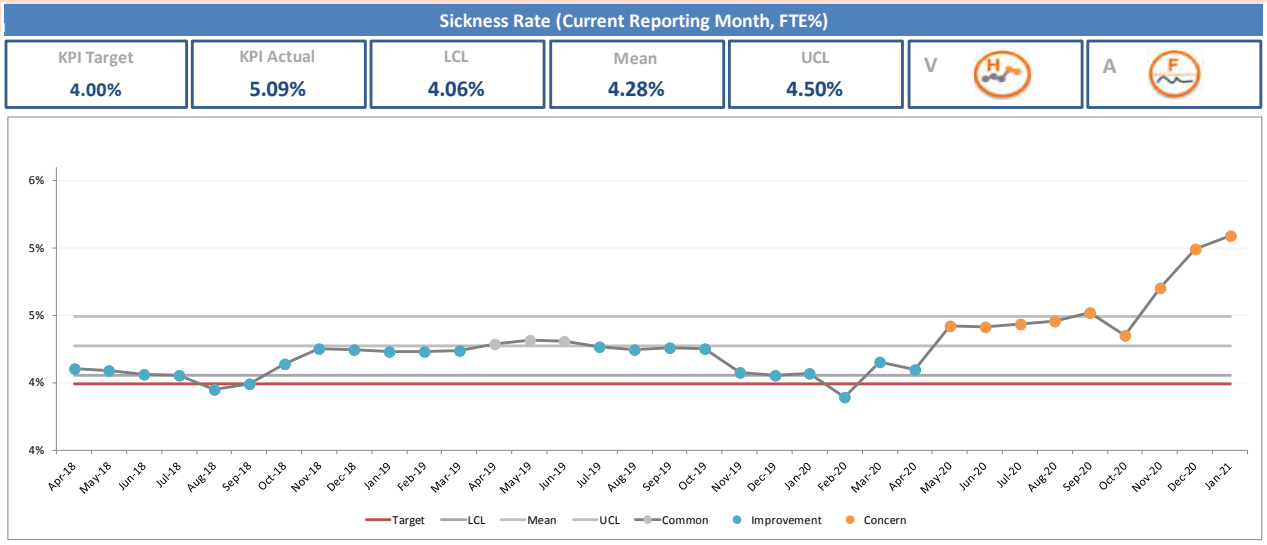
- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Failure to appraise staff timely reduces the opportunity to identify skills requirement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

Well Led: Workforce - Insights

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: Ayesha Feroz, Unplanned Care, Temi Alao, Planned
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Sickness Rate (Current Reporting Month, FTE%)



Indicator Background:

The proportion of staff (FTE) that are on sick leave

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:

- Monthly reporting in place;
- Draft wellbeing strategy to support employees and psychological wellbeing under consultation;
- Dedicated, aligned HR manager to support line manager with application of policy;
- Temporary application of national policy that covid-related sickness is not managed as per absence policy (temporary suspension of policy);
- MSK referral pathway implemented;
- Employee Assistance Programme (EAP) with counselling services in place with staff physio service;
- #HAY elements used to support staff through Covid.

Outcomes:

- Underlying sickness reasons for flu and musculo-skeletal in line with seasonal patterns
- Underlying stress/anxiety/depression/other psychological issues remain elevated at 1-1.2% throughout the covid period (dating back to March 20) and is c.0.4% higher than normal – to be supported through links with KMPT, psychological support access and facilitation.

Underlying issues and risks:

- Highest sickness reasons continue to be stress, anxiety and psychological; followed by musculoskeletal;
- Continued COVID-19 disruption is likely to continue to negatively affect sickness rates for all areas.
- High sickness rates can negatively affect staff and patient safety, patient quality and experience and clinical skills.
- High sickness rates can be linked to higher number of incidents and negatively impacts a safety culture.

Meeting of the Board of Directors in Public

Thursday, 04 March 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4-2**
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 16 February 2021		
Lead Director:	Jane Murkin, Chief Nursing and Quality Officer		
Report Author:	Niloufar Hajilou , Associate Director of Quality & Patient Safety 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 headline	**Assurance Level** (use appropriate colour code as above)
1. Quality Report: Progress on CQC Emergency Department Action Plan Trust CQC action plan: Positive progress continues with more actions moved to a closed status with only one action remaining rated red relating to Paediatrics Life Support training, with actions to progress and monitored by the paediatric team. Several actions have now been moved to complete and monitoring through business as usual processes, for example monitored through the IQPR, PIRM and the Divisional daily operational oversight on patient flow. The report highlighted the need for improved divisional oversight and accountability of	**Green**

regular monitoring of all CQC actions going forward. The report also highlighted progress with delivery of the ED CQC action plan which has progressed with positive improvements noted. It was also reported that weekly progress updates are provided to CQC since 14th of January and the draft report gone through Factual Accuracy and submitted to CQC. The central quality team are currently working on a CQC preparation plan which will include a divisional self-assessment, quality assurance visits and next steps for our next inspection. Safe: The report included a high level summary relating to patient safety and reporting of serious incidents including the initial learning from the Never Event which is currently being investigated. The findings and learning will be reported to a future meeting once completed. Backlog of Datix: The report highlighted progress made with reducing the back log of outstanding reported incidents around 80% and the importance of improved divisional oversight and ownership to reduce and maintain performance, and ensure learning is embedded across the organisation.. It was confirmed that the central team are undertaking an end to end process map of the incident management process which will highlight gaps and areas for improvement, and improve 48 hour reporting. Duty of Candour: The report highlighted that there has been improvement within Planned Care which is 100% in January. However, the overall Trust position remains 'Red' due to low performance within Unplanned Care division. It is important to acknowledge that this is in a backdrop of pressures relating to the management of COVID 19 pandemic. The report highlighted the work to address areas of low compliance alongside an audit to identify any gaps and areas to be strengthened, findings of which will be brought back to a future QAC meeting.	
2. Infection Prevention and Control Progress Update and IPC BAF The Chief Nursing & Quality Officer report highlighted the current state assessment in relation to infection prevention and control which had recently been reported at the Executive team meeting. The report outlined progress to date in addressing the issues identified following the national team visit in November and the work to develop the IPC improvement plan with short medium and longer term actions. The Committee were provided with the updated IPC Board assurance framework and self-assessment of compliance with PHE and other COVID-19 related infection prevention and control guidance with actions to address gaps. The organisation has been assessed against the parameters within the BAF to clearly demonstrate where the Trust is compliant; however there are a number of areas which will require further work to ensure the organisation is compliant with all the requirements from PHE and NHSE guidance and gaps have been identified which have required immediate remedial action to ensure compliance with National Guidance and statutory requirements. a) There are identified gaps in governance surrounding the provision of IPC. The Chief Nursing & Quality Officer has commissioned a review of IPC governance which is underway. **b)** The BAF will be updated prior to it being submitted to the Trust Board in March	**Amber/Red**
3. Review of the Top Risks of Covid-19 A verbal update on the top risks of COVID 19.was provided following the report JM provided to the Board and further work being progressed by David Sulch and Angela Gallagher to broaden the report to cover medical staffing and operational risks, and will be reported at the March meeting.	**Amber/Green**

4. Learning from Reg 28 Child Death The report highlighted that the Coroner has announced her intention to issue the Trust with a Regulation 28 Prevention of Future Deaths notice in relation to the care provided to L, a nine year old boy treated at the Trust in December 2019. The Coroner raised the concerns which were mainly in regard to issues that were specific to Patient L. There were some issues relating to care such as; handover with specific communications, reaction to early paediatric scores, a reluctance to giving enough fluids, effectiveness and supervision within the HDU. The Committee was appraised of the current position regarding this particular incident, and more generally with regard to the management of seriously unwell children by the paediatrics department and the overall approach to the surveillance of action plans relating to Serious Incidents within the Trust.	**Amber/Green**
5. Review of C-Section Rate The paper highlighted the interim positon on the review of caesarean sections commissioned by the Chief Nursing and Quality Officer following the increase in rates noted in December 2020. The work progressed relating to the maternity patient safety review, Ockenden review and caesarean sections will be presented as a broader Maternity paper to the March meeting.	**Green**
6. Clinical Negligence (CNST) The report provided by the Chief Nursing & Quality Officer highlighted the progress an evidence relating to compliance with the Maternity CNST Safety Actions 1, 2 and 3.	**Green**
7. Quality and Patient Safety Group Highlight Report The committee received a report highlighting current status and the concerns highlighted by its subcommittees. The Chair of the Medicines Management Group (MMG) has highlighted a marked decrease in the number of incidents reported on DATIX during the month of December and suspected that this was due to COVID19 pressures. A Task and Finish group has been set up to address gaps in the current process. It was recommended to the committee to review the number and frequency of meetings reported to the Quality and Patient Safety group with a view to streamlining and reducing clinical time invested in the meetings. Reducing these would not affect the Trust's compliance. .	**Amber/green**
8. Patient First The presentation included the following highlights: a) Emergency Flow – Acute Care Transformation b) Flow and Discharge c) Site Management d) Workforce and Organisational Development The patient first work is progressing with weekly meetings in place and immediate improvements in care within ED noted. Ambulance hand over was a key risk for the Trust, this was triggered by the spike in Covid-19 cases and the inability in ED to offload and maintain good IPC compliance. The Trust is on Day 7 of no 60 minute breaches. 30 to 60 minute breaches are also reducing. Further work to support effective management of discharges is underway and will support patient flow across the Trust..	**Amber**

9. Changes to Bed Base The paper set out the key changes to the current bed base in response to increasing demand for capacity on hospital beds. -Changes have been introduced to improve flow, reduce handover delays and waits in the Emergency Department and to ensure colleagues can safely place patients according to their Covid status. -The work has been done in conjunction with the clinical and operational response to discharge planning, which is a key area of focus to ensure good flow. -It is anticipated that further changes to the bed base will be required according to demand (volume and type). All such changes are subject to a thorough risk assessment and approved via the Strategic Command structure.	**Green**
10. End of Life Care Quarterly Report The quarterly report provided progress on the delivery of the End of life Care Service provided by the specialist team and builds on the findings from the December 2019 CQC review of End of Life Care Service, rated "Good" in all five domains, the previous rating being "Requires Improvement". Work is progressing well to date but Covid-19 has created challenges with the service provision impacted by the pandemic. The executive lead has initiated a Strategic End of Life Care Group, to work in partnership across the hospital and the system to lead further improvements in relation to end of life care for patients across the Trust supporting patients to die in their preferred place.	**Green**
11. Committee Business There was a decision to review future dates for QAC to ensure they are aligned with monthly Trust Board meetings and reporting cycles. Dates from July onwards would be tentative for now and updated shortly.	
Decisions made- N/A	
Further Risks Identified- N/A	
Escalations to the Board or other Committee- N/A	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 04 March 2021

Title of Report	**Ockenden Assurance Tools**	**Agenda Item**	4.3
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Executive Summary	This report to the Trust Board provides an overview the Medway Foundation Trusts position in response to the findings and recommendations of the Ockenden review. Donna Ockenden's first interim report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts were published on 11 December 2020. The report identified seven Immediate and Essential Actions (IEAs) for Trusts with a number of requirements for each IEA. On 14 December a letter was sent to all Trust Chief Executives who provide maternity services outlining the twelve Urgent Clinical Priorities (UCPs) from the IEAs. Chief Executives were required to confirm their Trust's position against the urgent clinical priorities by 21 December 2020 and a formal response was provided by the Trust. Further to the response the Trust was requested to undertake a self-assessment against the 7IEAs, linking with the 12 Urgent Clinical Priorities and requirements of the Clinical Negligence Scheme for Trusts (CNST) Safety Actions. The maternity service completed the attached assurance and workforce tool benchmarked against the findings of the Ockenden review as requested by the Regional Chief Midwifery Officer. The Trust was requested to complete the assurance tool and submit by 15 February, with a requirement for this to be reviewed by the Trust Board and Local Maternity System, and approved by the Chief Executive Officer and Local Maternity System Senior Responsible Officer. The Chief Nursing and Quality officer presented the Ockenden assurance and workforce tool to the Executive Team prior to submission following approval of the CEO, which is now being formally reported to the Trust Board. In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust(SaTH). This interim report on the first 250 cases including those of the initial two cases sets out "local actions for learning" and "immediate and essential actions" (IEA's).		

	The Ockenden assurance and workforce benchmarking tools illustrate the status of Medway Foundations Trust's compliance to the recommendations of the IEA's which are: 1. Enhanced Safety 2. Listening to Women and Families 3. Staff Training and Working Together 4. Managing Complex Pregnancy. 5. Risk Assessment Throughout Pregnancy 6. Monitoring Fetal Wellbeing 7. Informed Consent **Workforce** - Trust Boards confirm that they have a plan in place to the Birth-rate Plus (BR+) standard.
Committees or Groups at which the paper has been submitted	Quality Assurance Committee - 19 January 2021 Executive Group - 28 January 2021
Resource Implications	**Dedicated Non-Executive Director** The Chief Nursing and Quality officer has discussed the NED for Maternity with the Chief Executive and shared the national NHS JD. **Maternity Workforce** The Chief Nursing and Quality Officer will present the Maternity Establishment Review at the March 2021 Executive Group meeting, prior to being presented to the Trust Board.
Legal Implications/Regulatory Requirements	Nil
Quality Impact Assessment	NA
Recommendation/ Actions required	The Board is asked to NOTE the report

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	Appendix 1 Ockenden Assurance Tool Appendix 2 Workforce Tool

STANDARD **Medway Maternity services assessment and assurance tool**

IEA REQUIREMENT 1 (ENHANCED SAFETY): **Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**	**What do we have in place currently to meet all requirements of IEA 1?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Ockenden safety requirement Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Awaiting development of LMS Dashboard The LMS have confirmed that they will immediately implement a system for SIs to be reviewed 3 monthly within the existing CCG nursing and quality structure to meet the recommendations of the report. Maternity SIs currently reported to Trust Board via QAC.	Awaiting next LMS Executive Board discussion and confirmation on the LMS dashboard and SI reporting plan.	Awaiting next LMS Executive Board discussion and confirmation on the LMS dashboard and SI reporting plan.	Discuss with LMS a shared approach to SI investigations (e.g.. Share responsibility for investigating SIs). To present at next LMS Safety Meeting. RE to raise at next meeting.	Patient Safety Lead, January 2021	To be identified by the LMS.	Continue with current local arrangements, reporting, investigating and ratifying SIs through MFT Patient Safety and SI Framework.
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Currently reporting all eligible cases MBRRACE via PMRT. Compliance monitored. Data gaps identified in MSDSv2. Appropriate actions identified to resolve issues. 100% of cases reported to HSIB and NHSR for 19/20.	We are participating in the national reporting for MBRRACE for shared national learning, and PMRT supports the ongoing action plan for improving outcomes for mothers and babies. Maternity Service is working with BI to respond to data gaps ahead of the CNST MIS submission in July 2021. Maternity Service supports investigations by	MBRRACE national reports demonstrate improvements for Medway's mortality rates. MBRRACE and HSIB national reports underpin Local guidelines and training including Multidisciplinary CTG training and guidance for Skin to Skin	PMRT - Review and refresh Membership and TOR for Stillbirth review meeting. MSDS - Continue to work with BI and EuorKing to ensure all data is available prior to submission. HSIB - Continue to participate in HSIB investigations.	PMRT - Lead Clinician for fetal medicine MSDS - BI and Digital Team: 28 February 2021 HSIB - Risk and Patient Safety Leads : Ongoing	Substantive Quality and Safety Manager	MSDS - if any data gaps identified in December 2020 data set plan will need to be implemented to pull data manually for submission.
Link to urgent clinical priorities (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	The LMS have confirmed that they will immediately implement a system for SIs to be reviewed 3 monthly within the existing CCG nursing and quality structure to meet the recommendations of the report.	Awaiting next LMS Executive Board discussion and confirmation on the LMS dashboard and SI reporting plan.	Awaiting next LMS Executive Board discussion and confirmation on the LMS dashboard and SI reporting plan.	Continue to work with the LMS to implement the Perinatal Clinical Quality Surveillance Model.	ASAP	To be identified by the LMS.	Continue with current local arrangements, reporting, investigating and ratifying SIs through MFT Patient Safety and SI Framework.
IEA REQUIREMENT 2 (LISTENING TO WOMEN & FAMILIES): **Maternity services must ensure that women and their families are listened to with their voices heard.**	**What do we have in place currently to meet all requirements of IEA 2?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Ockenden Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	This role is currently undertaken in part by the MVP Chair. MVP Chair in place and funded by the LMS and covers Medway. Independent Advocate Role as recommended by the report is not yet in place. The Trust has been advised that the advocate role will be established on a National Level by Maternity Transformation, inlcuding JD, training and funding. Non-Executive Director currently attends Maternity Transformation and Assurance Board. Role requires review in light of newly shared Role Description.	MVP Chair participation for service and guideline development along with helping the service to understand women's experience during the Covid-19 pandemic. Independent Advocate role requires development at national level. Non-Executive Director Role requires review.	Maternity service regularly reviews women's feedback as provided by Friends and Family Tests, MVP and Picker Surveys along with complaints and PALS contacts. Maternity service also offers Debrief Service for women.	Chief Nursing and Quality officer and Trust Secretary to confirm formally identified NED to take up the role in Maternity, in order that an annual work plan can be implemented. Quarterly Report from MVP Chair to provide assurance. Trust to work with the LMS to appoint an independent advocate role.	Chief Nursing and Quality Officer & Trust Secretary - February 2021 MVP Chair - Ongoing Advocate Role - Maternity Transformation - National Initiaive	Formally appointed NED for Maternity. Advocate Role appointed.	MVP is currently being utilised by women to provide feedback. Trust Board Safety Champion supporting QI developments and chairing MTAB with attendance by provisional NED.
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	PMRT being used to review eligible deaths. MVP established, service user feedback gathered. Evidence of coproduced services provided. Safety Champion meetings established monthly.	We are participating in the national reporting for MBRRACE for shared national learning, and PMRT supports the ongoing action plan for improving outcomes for mothers and babies. MVP supported the development of BAME SOP during Covid-19 and plan for future activity i.e. "1S Steps" and "Whose Shoes" when onsite activities can resume. Board Level Safety Champion meetings with Local Safety Champions to review and promote QI initiatives.	MBRRACE national reports demonstrate improvements for Medway's mortality rates. MBRRACE national reports underpin Local guidelines and training including Multidisciplinary CTG training and guidance for Skin to Skin Maternity service regularly reviews women's feedback as provided by Friends and Family Tests, MVP and Picker Surveys along with complaints and PALS contacts. Maternity service also offers Debrief Service for women. MFT participates in kSS MATNEO and the LMS Safety Forum to share safety and QI projects.	Quarterly Report from MVP Chair to provide assurance. Reinstate onsite visits by MVP once Covid-19 restrictions are lifted. Support NED Ward visiting once role is implemented in full.	MVP Chair - Quarterly Reporting MVP Visits - HOM NED Visiting - Board Level Safety Champion and HOM	Formally appointed NED for Maternity.	Continue to maintain contact with MVP via virtual meetings. Professional Midwife Advocate support women through Birth Reflections (Debrief)
Link to urgent clinical priorities (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	As above re. MVP and NED	MVP established. Family and Friends Test Established. Take part in Picker Surveys.	As above re. MVP and NED	As above re. MVP and NED	As above re. MVP and NED	As above re. MVP and NED	As above re. MVP and NED
IEA REQUIREMENT 3 (STAFF TRAINING & WORKING TOGETHER): **Staff who work together must train together**	**What do we have in place currently to meet all requirements of IEA 3?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	MDT PROMPT and CTG training is in place. Not currently presented to LMS for external validation. 8:30 and 13:00 ward rounds currently attended by consultants. CNST monies have been previously used for CIP. Some were allocated to training. LMS monies allocated for Maternity and Neonatal Training have been ring-fenced.	PROMPT training utilises previous cases as part of the learning package to improve shared learning and future outcomes. Ward rounds are used for identifying red flags in care delivery and to improve MDT clinical decision making and communication. Supporting engagement with Continuity of Carer agenda, Human Factors and Obstetric Emergency and CTG to improve patient experience and safety.	Annual Safety Events with the LMS were SIs are shared, including those used for training. GMC and Trust Staff Survey reviewed to understand staff's feedback on training and MDT learning opportunities. Staff complete study day evaluation forms to inform improvements to training courses. Best practice and guidelines shared with LMS to improve quality and standardisation across the system - e.g.. CTG guidelines and BAME SOP	Further discussion at next LMS Safety meeting required. To propose process of validation with LMS. Patient Safety Lead to propose 5pm Board Round at Consultants Meeting. Requirement to attend Ward Rounds to be reiterated. Review electronic system MOSOS to see if a means of recording attendance/ward round detail is possible.	Patient Safety Lead, January 2021	Support of Trust Board and Division to allocated CNST monies to maternity Safety/training	Continue with agreed training curriculum and utilisation of CPD money for training.
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Action 4: Rotas support appropriate levels of clinical workforce planning. Action plans in place as per CNST requirements. Action 8: Working to achieve 90% compliance for staff groups.	Ensuring that we have the appropriate number of appropriately skilled staff to ensure safe clinical decision making and support. Ensuring all relevant staff are appropriately trained to respond to obstetric emergencies and improve patient safety and outcomes.	Monitoring and reduction in Avoidable Term Admission. Monitoring of clinical incidents reported via Datix with regards to themes and trends.	Action 8: Continue to monitor compliance and utilise e-learning as required.	Clinical Education Team	No additional resource required.	Daily review of rotas to ensure safe medical staffing cover.
Link to urgent clinical priorities (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	MDT PROMPT and CTG training is in place. As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)	
IEA REQUIREMENT 4 (MANAGING COMPLEX PREGNANCY): **There must be robust pathways in place for managing women with complex pregnancies**	**What do we have in place currently to meet all requirements of IEA 4?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Trust employs a visiting Obstetric Physician who attends onsite once per week to manage complex cases. Appropriate referral pathways to tertiary centres in place e.g. Cardiology. High-risk/complex pregnancies are managed in a consultant clinic. Formal risk assessment at booking and 28 weeks. Women referred to MCU/Triage if problems arise during pregnancy which would then result in referral if required. Fetal Monitoring form in labour prompts risk assessment.	Appropriate and timely referral to ensure best outcomes to mother and baby.	Monitoring of themes and trends of reported incidents. Review and monitoring of outcomes reported through MBRRACE	Lead Midwife for Fetal Medicine to review clinic allocation document and update as evidence of consultant lead clinics.	Lead Midwife for Fetal Medicine, February 2021.		
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Progress against compliance being monitored via CNST Task and finish Group. Appropriate steps have been taken to mitigate any gaps in assurance.	Reporting identifies any gaps for further service development and training that may be required. E.g. Maternity Service purchased new computerised CTGs to ensue all women who present with Reduced Fetal Movements have an appropriate CTG monitoring using antenatal criteria.	Monitoring of themes and trends of reported incidents. Compliance with SBLCBv2	Ensuring that we are able to utilise the Maternity IT System to capture the relevant data to demonstrate evidence of compliance.	Fetal Wellbeing Midwife and HOM to monitor compliance - July 2021.	Fetal Wellbeing midwife to be funded as a substantive role by the Trust if LMS funding does not continue.	Manual audit of compliance with any elements of SBLCBv2 that cannot be pulled from the Maternity Information System.

Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	All women with complex pregnancies have a consultant lead. In response to Ockenden report we are reviewing the mechanism for audit. Continue to work with the LMS to achieve a system wide approach to support the implementation of maternal medicine centre in Kent and Medway.	Appropriate and timely referral to ensure best outcomes to mother and baby.	Monitoring of themes and trends of reported incidents. Working with the LMS to achieve a system wide approach to Maternal Medicine.	Currently reviewing the mechanism for audit. Expectation that this can be monitored via Maternity Information System (EuroKing). An audit schedule will be established. Working with the LMS to achieve a system wide approach to Maternal Medicine.	Work with Digital Midwives and Euroking to ensure appropriate data can be extracted from EuroKing and establish audit schedule. - March 2021 LMS to determine schedule for Maternal Medicine Centre.	Substantive Digital Midwife Position. Trust support for Business case resulting from LMS plans for Maternal Medicine Centre.	Continue local policy of risk assessment and referral. Continue to utilise visiting maternal medicine physician. Implement audit plan.
IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY): **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**	**What do we have in place currently to meet all requirements of IEA 5?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Formally risk assessed at booking, 28 weeks and risk assessment tool when admitted labour. Every contact is a risk assessment - movements, blood pressure, urine etc. checked. Place of birth is not finalised to 36 weeks.	To maintain standardised approach to risk assessment and referral for complex pregnancies. 36 week appointment used to develop birth plan with mother, including place of birth, in response to clinical need to maintain patient safety. Risk assessment tool undertaken on the commencement of labour and throughout to ensure appropriate transfer to obstetric led care when appropriate.	Monitoring of themes and trends of reported incidents.	To ensure the new electronic patient records support evidence of personalisation of choice and risk assessment.	Digital Midwives to ensure compliance in the roll out of EuroKing 1.7 by December 2021.	Substantive Digital Midwife Position.	Continue with paper based risk assessments and tools.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Progress against compliance being monitored via CNST Task and finish Group. Appropriate steps have been taken to mitigate any gaps in assurance.	Reporting identifies any gaps for further service development and training that may be required. E.g. Maternity Service purchased new computerised CTGs to ensue all women who present with Reduced Fetal Movements have an appropriate CTG monitoring using antenatal criteria.	Monitoring of themes and trends of reported incidents. Compliance with SBLCBv2	Ensuring that we are able to utilise the Maternity IT System to capture the relevant data to demonstrate evidence of compliance.	Fetal Wellbeing Midwife and HOM to monitor compliance - July 2021.	Fetal Wellbeing midwife to be funded as a substantive role by the Trust if LMS funding does not continue.	Manual audit of compliance with any elements of SBLCBv2 that cannot be pulled from the Maternity Information System.
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	In response to Ockenden report working on how we would provide a robust audit plan for compliance.	To maintain standardised approach to risk assessment and referral for complex pregnancies. 36 week appointment used to develop birth plan with mother, including place of birth, in response to clinical need to maintain patient safety. Risk assessment tool undertaken on the commencement of labour and throughout to ensure appropriate transfer to obstetric led care when appropriate.	Monitoring of themes and trends of reported incidents.	Lead Midwife for Fetal Medicine to work with Community Matron to review how data regarding risk assessments can be audited.	Lead Midwife for Fetal Medicine to work with Community Matron to review how data regarding risk assessments can be audited., July 2021	No additional resource required.	Continue with risk assessments at each contact. Continue to review cases and monitor compliance.
IEA REQUIREMENT 6 (MONITORING FETAL WELLBEING): **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	**What do we have in place currently to meet all requirements of IEA 6?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Lead Midwife in post (funded by LMS) until early 2021. Have been advised that this funding will cease. Plan to use CNST monies to fund this role in the future. CTG programme currently funded. Lead Clinician not currently in post. CTG meetings run on Monday. Evidence provided by Fetal Wellbeing Midwife to demonstrate attendance and case details. Face to face and MS Teams utilised. CTG training ongoing and being monitored.	Fetal Wellbeing midwife have adapted fetal monitoring training to reflect local themes and identified care concerns. Weekly CTG meeting has been reinstated to include virtual attendance. Fetal Wellbeing midwives lead on Baby Born in Poor Condition review group which supports the ATAIN action plan and shares MDT learning.	Shared learning from CTG meetings. Fetal wellbeing midwives network within the region to share learning.	Lead Clinician to review Job plans and allocate Lead Obstetrician for Fetal Wellbeing. Continued funding for Fetal Wellbeing Midwife	Lead Clinician	Support of the Trust to allocate CNST monies to support the lead roles.	External company supporting CTG training and this has been procured. LMS currently funding Fetal Wellbeing midwife until March 2021.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Progress against compliance being monitored via CNST Task and finish Group. Appropriate steps have been taken to mitigate any gaps in assurance. MDT training in place and compliance monitored.	Reporting identifies any gaps for further service development and training that may be required. E.g. Maternity Service purchased new computerised CTGs to ensue all women who present with Reduced Fetal Movements have an appropriate CTG monitoring using antenatal criteria.	Monitoring of themes and trends of reported incidents. Compliance with SBLCBv2	Ensuring that we are able to utilise the Maternity IT System to capture the relevant data to demonstrate evidence of compliance. Continue to monitor training and utilise e-learning if required.	Fetal Wellbeing Midwife and HOM to monitor compliance - July 2021. Education Team - Ongoing	Fetal Wellbeing midwife to be funded as a substantive role by the Trust if LMS funding does not continue.	Manual audit of compliance with any elements of SBLCBv2 that cannot be pulled from the Maternity Information System. Continue to monitor and offer MDT training.
Link to urgent clinical priorities a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Lead Midwife in post (funded by LMS) until early 2021. Have been advised that this funding will cease. Plan to use CNST monies to fund this role in the future. CTG programme currently funded. Lead Clinician not currently in post.	As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)	As above (Row 11)
IEA REQUIREMENT 7 (INFORMED CONSENT): **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	**What do we have in place currently to meet all requirements of IEA 7?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	In light of Ockenden report website reviewed and ensure appropriate information is linked on website. Links to national guidelines and advice. Translators, Open access appointments, demonstrable consent processes. Review of Women's choices via Friends and Family, Complaints review and Picker Survey.	Website developed in collaboration with MVP and therefore reflective of service user needs. Continue to seek feedback from MVP and service users.	Digital midwives work with colleagues from other Trusts to ensure website reflects best practice and up to date information.	Consider sharing local patient information leaflets/guidelines. Ask MVP to review website to see if any additional information/accessibility options. Formal guideline/SOP required for informed choices. Thematic review of complaints to ensure women's choices are being resepected.	HOM to review patient information on website with MVP. MVP/Lead Midwife for Fetal Medicine /Community Team Leader to review/develop guideline to ensure that women's involvement in decision making. Matron to request thematic review of complaints by Governance Team.	Substantive Digital Midwife Position IT Support and response to change as required.	Digital Midwife in post currently funded by IT. recently reviewed and updated.
CNST Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	MVP established, service user feedback gathered. Evidence of coproduced services provided.	MVP supported the development of BAME SOP during Covid-19 and plan for future activity i.e. "15 Steps" and "Whose Shoes" when onsite activities can resume.	Maternity service regularly reviews women's feedback as provided by Friends and Family Tests, MVP and Picker Surveys along with complaints and PALS contacts. Maternity service also offers Debrief Service for women.	Quarterly Report from MVP Chair to provide assurance. Reinstate onsite visits by MVP once Covid-19 restrictions are lifted.	MVP Chair - Quarterly Reporting MVP Visits - HOM	No additional resource required.	Continue to maintain contact with MVP via virtual meetings. Professional Midwife Advocate support women through Birth Reflections (Debrief)
Link to urgent clinical priorities a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Website provides information on all aspects of care so that women can make informed decisions. Links to national information provided in electronic notes including screening of baby, monitoring baby movements, personalised care plan	Website developed in collaboration with MVP and therefore reflective of service user needs. Continue to seek feedback from MVP and service users.	Digital midwives work with colleagues from other Trusts to ensure website reflects best practice and up to date information.	Consider sharing local patient information leaflets/guidelines. Ask MVP to review website to see if any additional information/accessibility options. Formal guideline/SOP required for informed choices. Thematic review of complaints to ensure women's choices are being resepected.	HOM to review patient information on website with MVP. MVP/Lead Midwife for Fetal Medicine /Community Team Leader to review/develop guideline to ensure that women's involvement in decision making. Matron to request thematic review of complaints by Governance Team.	Substantive Digital Midwife Position IT Support and response to change as required.	Digital Midwife in post currently funded by IT. recently reviewed and updated.
NICE GUIDANCE RELATED TO MATERNITY	**What do we have in place currently to meet all requirements of IEA 1?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	NICE Guidelines managed by Central Clinical Effectivness team and overseen by Governance team. Guidelines are reviewed at sub-speciality and speciality meetings. All new and updated guidelines are reviewed by the appropriate clinician and local guidelines are adjusted to reflect NICE and RCOG recommendations accordingly.	Supports evidence based practice and best practice approaches to clinical care.	All datix and incidents are investigated to ensure that local and national guidelines have been followed. Audit of compliance is undertaken e.g. management of PPH.	Improved audit programme based on practices in line with National Guideance.	Audit Lead and Patient Safety Lead, April 2021	Funding for audit and QI Midwife	Sharing learning from incidents and complaints with reference to National Guidelines to support professional development.

MATERNITY WORKFORCE PLANNING -	What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Can you demonstrate an effective system of clinical workforce planning to the required standard?	CNST Safety Action 4 - Action plan in place following identified rota gaps leading to missed educational opportunities in GMC Survey of 2019	Issues with rota gaps were addressed prior to publication of GMC report. Additional middle grades recruited to as demonstrated by the rota. Action plan used as a tool for monitoring rota and training opportunities. Friday teaching sessions in place.	Monitor and review of Action plan at CNST T&F Group and Speciality Governance.. Sign-off by Trust Board and submission to RCOG Review Action plan and feedback at Consultant meeting and local faculty group.	Continue to seek feedback from trainees.	Trainee Lead/Clinical Lead	Trust Participation in GMC Survey	Continue to seek feedback from trainees to ensure training gaps are not lost. Daily review of rotas to mitigate any gaps and prioritise training where appropriate.
Can you demonstrate an effective system of midwifery workforce planning to the required standard?	CNST Safety Action 5 - Birth Rate Plus review undertaken in 2020. Identified adequate staffing for traditional model/ratio. Review demonstrated not compliant with non-clinical/specialist roles requiring additional staffing of 9.14 WTE to support this requirement. In order to support the continuity of carer model, which is a requirement of CNST, an additional 13 WTE Band 3-6 are required.	Workforce review and analysis has been based on the Birthrate Plus Tool along with the clinical judgement of the senior midwifery team. A Task and Finish Group has been established to monitor progress against Continuity of Carer. A workforce review paper has been prepared by the HOM for Executive Group review and scrutiny to achieve the recommendations of Birth Rate Plus.	Review of Workforce paper by Executive Group and Trust Board along with Divisional Review. Ongoing monitoring of CoC compliance via Task and Finish Group and Escalation to Division and Board Level Safety Champion as required by CNST.	Present Workforce paper to Trust Board. Trust support for additional midwifery roles. Further Birth Rate Plus Review in October 2021 to ensure continued compliance with ratio in light of new models of care.	Trust Board/Executive Group HOM 2021	Funding to repeat October 2021 Birth Rate + Review.	Continue to progress CoC Action plan to achieve compliance with Better Births. Continue to monitor and review staffing and staffing red flags to ensure safe delivery of care.
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	CNST Safety Action 5 - Workforce paper completed and sent to Deputy Chief Nursing Office 11/1/21. Paper proposes plan to meet the gap identified by Birthrate Plus and requires review by Executive Group and Trust Board.	Workforce review and analysis has been based on the Birthrate Plus Tool along with the clinical judgement of the senior midwifery team. A Task and Finish Group has been established to monitor progress against Continuity of Carer. A workforce review paper has been prepared by the HOM for Executive Group review and scrutiny to achieve the recommendations of Birth Rate Plus.	Review of Workforce paper by Executive Group and Trust Board along with Divisional Review. Ongoing monitoring of CoC compliance via Task and Finish Group and Escalation to Division and Board Level Safety Champion as required by CNST.	Present Workforce paper to Trust Board. Trust support for additional midwifery roles. Further Birth Rate Plus Review in October 2021 to ensure continued compliance with ratio in light of new models of care.	Trust Board/Executive Group HOM 2021	Funding to repeat October 2021 Birth Rate + Review.	Continue to progress CoC Action plan to achieve compliance with Better Births. Continue to monitor and review staffing and staffing red flags to ensure safe delivery of care.

MIDWIFERY LEADERSHIP (RCM Manifesto standards)	What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Director of Midwifery in every trust: Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	Director of Midwifery not part of leadership structure. The Chief Nursing and Quality Officer is progressing a review of the Head of Midwifery role in support of uplifting this to Director of Midwifery.	This approach meets the recommendations of the RCM Manifesto standards and aligns MFTs leadership with other services within the LMS and region.	The Chief Nursing and Quality Officer will work with HR, Organisational Development and Director of Finance.	To review the Head of Midwifery Job Description against the Director of Midwifery national profile.	Chief Nursing and Quality Officer, April 2021	Financial uplift to Maternity workforce budget.	Continue with Head of Midwifery role.
Regional & national lead midwives: A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	The Trust is working collaboratively with the regional Chief Midwifery Officer to support patient safety and service development in line with national policy.	N/A	N/A	N/A	N/A	N/A	N/A
More consultant midwives: We would like to see at least one consultant midwife in every maternity unit. For those responsible for providing services in remote and rural areas, one option could be to appoint a consultant midwife across more than one trust / health board, providing consistency and clarity of professional guidance for this very specific kind of midwifery service.	Consultant midwife not part of establishment. Maternity workforce review recommends uplift of senior structure which provides an opportunity to support the role of consultant midwife.	This approach meets the recommendations of the RCM Manifesto standards and strengthens maternity's ability to develop quality, evidence based services, in line with national policy.	The Chief Nursing and Quality Officer will work with HR, Organisational Development and Director of Finance.	Finalise and agree the senior midwifery structure in line with the October 2020 Birth Rate Plus review.	Chief Nursing and Quality Officer, April 2021	Financial uplift to Maternity workforce budget.	Utilise current matron and specialist roles with an understanding of the limitations of this approach to ongoing development of the service.
Specialist midwives in every trust: A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specialist substance misuse mental health specialist	Birthrate plus review has been completed identifying the shortfall in specialist roles. The subsequent workforce review has recommended an uplift of 9 WTE to support the addition of key roles to support the national maternity agenda e.g.. Fetal Wellbeing Midwife, Quality Improvement and Bereavement Midwife	This approach meets the recommendations of the RCM Manifesto standards and strengthens maternity's ability to develop quality, evidence based services, in line with national policy.	The Chief Nursing and Quality Officer will work with HR, Organisational Development and Director of Finance.	Finalise and agree the senior midwifery structure in line with the October 2020 Birth Rate Plus review.	Chief Nursing and Quality Officer, April 2021	Financial uplift to Maternity workforce budget.	Utilise LMS funding for Fetal Wellbeing role which ceases on 31 March 2021. Other specialist services are supported by clinical midwives with limitations.
Strengthening midwifery leadership in education & research: Lead Midwives for Education (LMEs) are experienced, practising midwife teachers who lead on the development, delivery and management of midwifery education programmes 13. They help to ensure high standards in midwifery education and are a vital intermediary between the professional regulator (the Nursing and Midwifery Council) and the universities.	Midwifery education team well established who lead on development, delivery and management of midwifery education programmes, working with the NMC and universities.	Practice Development Midwife has supported Higher Education Institute in the review and development of the Midwifery Standards of Education. The NMC audit has confirmed the quality of student experience at Medway is to a high standard. The preceptorship programme has been strengthened by the support of the clinical skills facilitators providing robust consolidation for post-registration midwives.	Student midwife feedback, essential skills evaluation, compliance with CNST Safety Action 8.	Continue to work closely with HEI partners and develop learning curriculum to meet the findings of clinical incidents and recommendations of national reports and policy.	Practice Development Midwife and Trust Education Lead and Learning and Development Team, Ongoing.	Allocation of training time appropriately built in to WTE uplift.	N/A
Fund ongoing midwifery leadership development: A commitment to fund ongoing midwifery leadership development.	The Chief Nursing and Quality Officer is fully engaged and committed to nursing and midwifery leadership with ongoing programmes in place.	Staff feedback on learning, staff retention.	Ongoing commitment to ring-fenced funding midwifery training. Utilise training opportunities on offer from professional and education bodies.	Review HEE training budget to incorporate leadership development along with further opportunities for MA apprenticeship.	Chief Nursing and Quality Officer, L&D and OD, April 2021	Allocation of training time and adequate funding to support leadership development.	Internal management programmes.
Professional input into the appointment of midwife leaders: Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into the right jobs.	To date, all Heads of Midwifery posts have Regional Chief Midwifery Officer, HIE and Chief Nursing and Quality Officer on the interview panel.	N/A	N/A	N/A	N/A	N/A	N/A

Meeting of the Board of Directors in Public
Thursday, 04 March 2021

Title of Report	**Finance Report – Month 10**	**Agenda Item**	5.1
Report Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Finance Officer		
Executive Summary	The Trust reports a deficit of £9k in month and £94k year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 1 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday, 25 February 2021		
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.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report – Month 10		

`

Finance report

For the period ending 31 January 2021

Contents

`

1. Executive summary

£'000	Budget	Actual	Var.
Trust surplus/(deficit)			
In-month (NHSE/I)	-	-	-
YTD (NHSE/I*)	-	-	-
In-month (budget)	(3,648)	(9)	3,639
YTD (budget)	(5,660)	(94)	5,565
Forecast	-	-	-

* Months 1-6 are per the NHSE/I baseline which reported breakeven budget and actual. Months 7-12 are per the October plan.

The Trust reports a £9 k deficit position for January; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. Incremental Covid costs have continued at similar levels to December. An additional £2.5m of Covid income has been agreed with the STP to fund the increase above the original plan; total income for October to March is £10.1m. The forecast outturn position remains at breakeven after being updated using the January position.

	£'m
Covid spend	**2.5**
Base overspend	**0.0**
Covid Income	**(2.5)**
Non-recurrent adjustments	**0.0**
Reported against control total	**0.0**

CIP				
In-month	1,823	812	(1,011)	Schemes delivered so far in the year mainly relate to the full year effect of schemes from 19/20, efficient use of theatres, reduced orthopaedic insourcing, as well procurement and ph armacy savings from nationally agreed prices. Year to date performance reports an under achievement against plan as savings identified to happen in the later part of the financial year have not delivered. The forecast position of actual delivery has been updated with the scheme owners identifying £8.9m of the £12m plan; this is £0.1m less than December.
YTD	7,801	7,118	(683)	
Forecast	12,000	8,853	(3,147)	

Capital				
In-month	2,157	1,005	(1,165)	The 2020/21 capital plan includes £24.4m STP capital allocation plus additional business cases and COVID. The agreement with the STP to underspend by £1.3m has been revisited, commissioners have approved acceleration of the EPR to utilise the funds in Medway. Additional PDC funding of £0.827m has been agreed by NHSI since month 9. However the UTC scheme planned for 2020/21 has not been submitted or approved by NHSI removing that scheme from the plan for this year. The Capital Resource Limit (CRL) has therefore changed from £31.833m to £31.659m, from which £31.350m is expected to be spent. The Trust Capital COVID bid has been approved by NHSI. Capital Expenditure is currently well below the CRL, IT schemes and building works are expected to rapidly accelerate throughout February and March.
YTD	20,112	14,576	(5,643)	
Forecast	31,659	31,350	(309)	

`

1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	33,853	52,942	19,089	The favourable variance this month relates to additional income received in advance of contract, a timing variance on PDC dividend payments, capital expenditure slippage and fluctuations in working balances.
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 £169.8m, this being £36.9m adverse to the draft budget. In month performance excluding high cost drugs is £15.3m compared to a M1 to M9 average of £17.2m, lower by £1.9m.
Pay costs are higher than expected				Total pay costs have increased in month by £0.4m to £20.1m. The rise in cost is driven by the increased in-patient capacity, recruitment of overseas nurses and the impact of clinical excellence awards (CEA) £0.4m. The position is adverse to budget by £2.4m, of this £1.5m is due to incremental Covid costs, the remainder is predominantly a consequence of non-achievement of CIP plans where budget has been removed from the divisions and the CEA awards that were not budgeted for.

`

2. Income and expenditure (reporting against NHSE/I baseline)

£'000	In-month			Year-to-date*		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	26,973	27,662	688	229,885	228,740	(1,145)
High cost drugs	1,613	1,809	196	17,706	18,645	939
Other income	1,471	1,685	214	17,775	16,576	(1,199)
Top-up income	-	-	-	26,502	26,517	15
True-up income	-	-	-	-	9,690	9,690
Total income	**30,057**	**31,156**	**1,099**	**291,868**	**300,168**	**8,300**
Nursing	(7,855)	(7,755)	100	(66,839)	(75,477)	(8,638)
Medical	(6,221)	(6,796)	(575)	(58,685)	(62,567)	(3,881)
Other	(5,256)	(5,526)	(271)	(60,890)	(53,091)	7,799
Total pay	**(19,332)**	**(20,078)**	**(746)**	**(186,415)**	**(191,135)**	**(4,721)**
Clinical supplies	(3,399)	(3,542)	(143)	(36,229)	(36,094)	135
Drugs	(553)	(793)	(240)	(6,418)	(6,090)	328
High cost drugs	(1,613)	(1,784)	(171)	(18,005)	(18,645)	(641)
Other	(3,786)	(3,588)	198	(31,284)	(34,564)	(3,280)
Total non-pay	**(9,351)**	**(9,708)**	**(357)**	**(91,936)**	**(95,394)**	**(3,457)**
EBITDA	**1,374**	**1,370**	**(4)**	**13,517**	**13,639**	**122**
Depreciation	(829)	(834)	(5)	(8,323)	(8,283)	39
Net finance income/(cost)	(2)	(2)	(0)	226	(25)	(251)
PDC dividend	(542)	(543)	(1)	(5,420)	(5,425)	(5)
Non-operating exp.	**(1,374)**	**(1,379)**	**(5)**	**(13,517)**	**(13,733)**	**(216)**
Reported surplus/(deficit)	**-**	**(9)**	**(9)**	**-**	**(94)**	**(94)**
Adj. to control total	-	9	9	-	94	94
Control total	**-**	**-**	**-**	**-**	**-**	**-**

*** Months 1-6 are per the NHSE/I baseline which reported breakeven budget and actual. Months 7-12 are per the October plan.**

Key messages:

1. NHSE/I baseline budgets covering months 1-6 are calculated centrally and are based on av erage financial performance for defined periods during 2019/20, uplifted for inflation or known pressures where applicable. For months 7-12 the plan has been forecast and ag reed with the STP for funding.

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 months 1-6 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 £2.4m in-month; £1.5m of this is reported in pay and £0.9m in non-pay (£9.2m and £5 .6m YTD respectively). Excluding the impact of Covid, the pay and non-pay variances would improve in month by these amounts. The favourable income variance would reduce by £1.1m as additional income was required to cover higher costs.

`

2. Income and expenditure (reporting against draft budget)

£'000	In-month			Year-to-date		
	Budget	Actual	Var.	Budget	Actual	Var.
Clinical income	20,532	27,662	7,129	209,265	228,740	19,475
High cost drugs	1,900	1,809	(91)	19,367	18,645	(722)
Other income	2,212	1,685	(528)	21,342	16,577	(4,765)
FRF/MRET	769	-	(769)	43,204	36,207	(6,997)
Total income	**25,414**	**31,156**	**5,742**	**293,178**	**300,169**	**6,991**
Nursing	(7,473)	(7,755)	(282)	(73,957)	(75,477)	(1,520)
Medical	(5,588)	(6,796)	(1,208)	(55,815)	(62,567)	(6,752)
Other	(4,599)	(5,526)	(927)	(50,189)	(53,091)	(2,902)
Total pay	**(17,660)**	**(20,078)**	**(2,418)**	**(179,961)**	**(191,135)**	**(11,174)**
Clinical supplies	(3,744)	(3,542)	201	(38,154)	(36,095)	2,059
Drugs	(661)	(793)	(132)	(6,737)	(6,090)	647
High cost drugs	(1,923)	(1,784)	139	(19,600)	(18,645)	954
Other	(3,535)	(3,588)	(54)	(38,986)	(34,566)	4,420
Total non-pay	**(9,862)**	**(9,708)**	**154**	**(103,477)**	**(95,395)**	**8,081**
EBITDA	**(2,108)**	**1,370**	**3,478**	**9,740**	**13,638**	**3,898**
Depreciation	(958)	(834)	124	(9,582)	(8,283)	1,299
Net finance income/(cost)	(39)	(2)	37	(393)	(25)	368
PDC dividend	(543)	(543)	-	(5,425)	(5,425)	-
Non-operating exp.	**(1,540)**	**(1,379)**	**161**	**(15,400)**	**(13,733)**	**1,667**
Reported surplus/(deficit)	**(3,648)**	**(9)**	**3,639**	**(5,660)**	**(94)**	**5,565**

Key messages:

1. The Trust 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. If income had been earned on a cost and volume basis (based on consultation tariff), excluding HCD the Trust would have reported clinical income of £15.3m in month; this is £1.9m lower than the monthly average for the first 9 months and 28.8% underperformance to plan in month.

3. Total expenditure includes the incremental cost of Covid, this being £2.4m in month and £14.8m year to date.

4. Excluding Covid costs, expenditure budgets are breakeven in month.

`

2. Income and expenditure delegated budgets (NHSE/I: in-month)

£'000	In-month								
	Income			Expenditure			Contribution		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
UIC									
Diagnostics & Clinical Support	1,614	1,605	(10)	(4,355)	(4,333)	22	(2,741)	(2,729)	12
Specialist Medicine	147	260	113	(1,921)	(1,980)	(59)	(1,774)	(1,720)	54
Therapies & Older Persons	5	8	3	(1,425)	(1,303)	123	(1,420)	(1,295)	125
Unplanned & Integrated Care	52	54	2	(1,154)	(1,178)	(24)	(1,102)	(1,124)	(22)
Urgent & Emergency Care	43	37	(6)	(2,275)	(2,373)	(97)	(2,232)	(2,335)	(103)
Sub-total	**1,861**	**1,964**	**103**	**(11,130)**	**(11,166)**	**(36)**	**(9,269)**	**(9,203)**	**66**
Planned care									
Cancer Services	408	454	46	(886)	(877)	10	(479)	(423)	56
Critical Care & Perioperative	43	79	36	(3,069)	(2,625)	443	(3,026)	(2,546)	480
Planned Care Infrastructure	-	-	-	(147)	(165)	(18)	(147)	(165)	(18)
Surgical Services	100	105	6	(2,770)	(2,596)	174	(2,670)	(2,490)	180
Women & Children	111	115	4	(3,257)	(3,267)	(10)	(3,146)	(3,152)	(6)
Sub-total	**661**	**753**	**92**	**(10,129)**	**(9,530)**	**599**	**(9,468)**	**(8,776)**	**691**
Corporate									
Communications	2	2	-	(40)	(32)	8	(39)	(30)	8
Finance	1	1	0	(214)	(232)	(17)	(213)	(230)	(17)
HR & OD	109	124	15	(362)	(339)	23	(253)	(215)	39
IT	2	2	-	(404)	(343)	61	(402)	(342)	61
Medical Director	849	712	(137)	(473)	(482)	(9)	376	230	(146)
Medway Innovation Institute	-	-	-	-	-	-	-	-	-
Nursing	-	3	3	(348)	(342)	5	(348)	(340)	8
Strategy, Governance & Perform	-	-	-	(330)	(238)	92	(330)	(238)	92
Transformation	-	-	-	(273)	(46)	226	(273)	(46)	226
Trust Executive & Board	962	-	(962)	(2,444)	(272)	2,173	(1,482)	(272)	1,210
Sub-total	**1,924**	**843**	**(1,081)**	**(4,889)**	**(2,327)**	**2,562**	**(2,964)**	**(1,484)**	**1,480**
E&F									
E&F	**274**	**214**	**(60)**	**(2,074)**	**(2,209)**	**(135)**	**(1,800)**	**(1,995)**	**(195)**
Central									
Central	**26,299**	**27,380**	**1,081**	**(2,798)**	**(5,932)**	**(3,134)**	**23,501**	**21,448**	**(2,053)**
TOTAL	**31,019**	**31,154**	**135**	**(31,019)**	**(31,164)**	**(144)**	**-**	**(9)**	**(9)**
Donated Asset Adjustment			**-**		**9**	**9**	**-**	**9**	**0**
Control total	**31,019**	**31,154**	**135**	**(31,019)**	**(31,154)**	**(135)**	**-**	**-**	**-**

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									YTD contribution variance	
	Income			Expenditure			Contribution				
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.	M1-6	M7-12
UIC											
Diagnostics & Clinical Support	15,925	16,605	679	(43,005)	(43,161)	(156)	(27,079)	(26,556)	523	(298)	822
Specialist Medicine	2,365	1,567	(798)	(21,247)	(20,164)	1,083	(18,882)	(18,597)	285	967	(682)
Therapies & Older Persons	38	57	18	(14,478)	(14,141)	337	(14,440)	(14,085)	355	326	29
Unplanned & Integrated Care	880	445	(435)	(11,325)	(10,374)	951	(10,445)	(9,929)	516	111	405
Urgent & Emergency Care	618	405	(213)	(22,472)	(22,413)	59	(21,854)	(22,008)	(154)	100	(254)
Sub-total	**19,827**	**19,078**	**(749)**	**(112,527)**	**(110,253)**	**2,274**	**(92,701)**	**(91,176)**	**1,525**	**1,205**	**320**
Planned care											
Cancer Services	3,749	4,177	429	(8,566)	(8,850)	(284)	(4,818)	(4,673)	145	94	51
Critical Care & Perioperative	1,150	-	(1,150)	(31,214)	(1,881)	29,333	(30,064)	(1,881)	28,183	16,961	11,223
Planned Care Infrastructure	338	921	583	(19,149)	(27,558)	(8,409)	(18,811)	(26,637)	(7,826)	2,463	(10,289)
Surgical Services	398	483	84	(12,339)	(29,457)	(17,117)	(11,941)	(28,974)	(17,033)	(16,011)	(1,022)
Women & Children	852	716	(135)	(31,207)	(32,280)	(1,073)	(30,355)	(31,564)	(1,209)	(1,045)	(164)
Sub-total	**6,487**	**6,298**	**(189)**	**(102,476)**	**(100,026)**	**2,449**	**(95,989)**	**(93,729)**	**2,260**	**2,461**	**(201)**
Corporate											
Communications	7	18	11	(387)	(408)	(21)	(380)	(390)	(10)	(26)	46
Finance	30	22	(8)	(2,581)	(2,464)	117	(2,551)	(2,442)	109	185	(6)
HR & OD	1,228	1,219	(8)	(3,778)	(3,668)	110	(2,550)	(2,449)	101	70	(127)
IT	7	37	30	(3,484)	(3,612)	(128)	(3,477)	(3,574)	(97)	(171)	(352)
Medical Director	8,180	8,268	88	(4,601)	(4,466)	135	3,578	3,802	223	178	906
Medway Innovation Institute	-	-	-	-	(6)	(6)	-	(6)	(6)	-	4,825
Nursing	-	9	9	(3,282)	(3,511)	(229)	(3,282)	(3,502)	(220)	(92)	5,336
Strategy, Governance & Perform	-	-	-	(2,163)	(2,484)	(321)	(2,163)	(2,484)	(321)	31	46
Transformation	-	-	-	(1,339)	(677)	663	(1,339)	(677)	663	(244)	(6)
Trust Executive & Board	3,849	-	(3,849)	(11,402)	(2,738)	8,664	(7,553)	(2,738)	4,815	(10)	(127)
Sub-total	**13,301**	**9,573**	**(3,728)**	**(33,018)**	**(24,033)**	**8,984**	**(19,717)**	**(14,460)**	**5,257**	**(80)**	**(352)**
E&F											
E&F	**3,735**	**2,431**	**(1,303)**	**(19,833)**	**(20,398)**	**(565)**	**(16,098)**	**(17,967)**	**(1,868)**	**(1,516)**	**(353)**
Central											
Central	**252,368**	**262,785**	**10,417**	**(27,863)**	**(45,548)**	**(17,685)**	**224,505**	**217,237**	**(7,268)**	**(2,132)**	**(5,137)**
TOTAL	**295,717**	**300,165**	**4,448**	**(295,717)**	**(300,259)**	**(4,543)**	**-**	**(94)**	**(94)**	**(60)**	**(34)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**94**	**94**	**-**	**94**	**94**	**60**	**34**
Control total	**295,717**	**300,165**	**4,448**	**(295,717)**	**(300,165)**	**(4,448)**	**-**	**-**	**-**	**-**	**-**

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	3,040	1,605	(1,435)	(4,411)	(4,333)	77	(1,371)	(2,729)	(1,358)
Specialist Medicine	2,500	260	(2,240)	(2,160)	(1,980)	180	340	(1,720)	(2,060)
Therapies & Older Persons	778	8	(770)	(1,500)	(1,303)	197	(722)	(1,295)	(573)
Unplanned & Integrated Care	101	54	(47)	(910)	(1,178)	(268)	(809)	(1,124)	(315)
Urgent & Emergency Care	4,676	37	(4,639)	(2,185)	(2,373)	(188)	2,492	(2,335)	(4,827)
Sub-total	**11,095**	**1,964**	**(9,132)**	**(11,165)**	**(11,166)**	**(1)**	**(70)**	**(9,203)**	**(9,133)**
Planned care									
Cancer Services	727	454	(273)	(859)	(877)	(17)	(132)	(423)	(290)
Critical Care & Perioperative	1,051	79	(972)	(3,025)	(2,625)	400	(1,973)	(2,546)	(573)
Planned Care Infrastructure	150	-	(150)	92	(165)	(257)	242	(165)	(407)
Surgical Services	5,335	105	(5,230)	(2,904)	(2,596)	308	2,431	(2,490)	(4,922)
Women & Children	5,013	115	(4,898)	(3,192)	(3,267)	(75)	1,821	(3,152)	(4,973)
Sub-total	**12,277**	**753**	**(11,523)**	**(9,888)**	**(9,530)**	**358**	**2,388**	**(8,776)**	**(11,165)**
Corporate									
Communications	2	2	-	(37)	(32)	5	(36)	(30)	5
Finance	-	1	1	(234)	(232)	2	(234)	(230)	3
HR & OD	148	124	(24)	(401)	(339)	62	(253)	(215)	38
IT	-	2	2	(347)	(343)	4	(347)	(342)	5
Medical Director	827	712	(116)	(462)	(482)	(20)	366	230	(136)
Medway Innovation Institute	-	-	-	-	-	-	-	-	-
Nursing	0	3	2	(349)	(342)	7	(349)	(340)	9
Strategy, Governance & Perform	0	-	(0)	(243)	(238)	5	(243)	(238)	5
Transformation	-	-	-	(62)	(46)	15	(62)	(46)	15
Trust Executive & Board	-	-	-	(255)	(272)	(16)	(255)	(272)	(16)
Sub-total	**978**	**843**	**(135)**	**(2,390)**	**(2,327)**	**63**	**(1,413)**	**(1,484)**	**(72)**
E&F									
E&F	**437**	**214**	**(223)**	**(2,194)**	**(2,209)**	**(15)**	**(1,757)**	**(1,995)**	**(238)**
Central									
Central	**628**	**27,380**	**26,752**	**(3,425)**	**(5,932)**	**(2,507)**	**(2,797)**	**21,448**	**24,246**
TOTAL	**25,414**	**31,154**	**5,740**	**(29,062)**	**(31,164)**	**(2,101)**	**(3,648)**	**(9)**	**3,639**

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									
37,078	(53,197)	(16,118)	Diagnostics & Clinical Support	30,920	16,605	(14,315)	(44,339)	(43,161)	1,178	(13,419)	(26,556)	(13,137)
30,542	(26,313)	4,228	Specialist Medicine	25,470	1,567	(23,903)	(21,986)	(20,164)	1,822	3,484	(18,597)	(22,081)
9,505	(17,894)	(8,389)	Therapies & Older Persons	7,927	57	(7,870)	(14,894)	(14,141)	753	(6,967)	(14,085)	(7,118)
1,237	(10,941)	(9,704)	Unplanned & Integrated Care	1,031	445	(587)	(9,121)	(10,374)	(1,253)	(8,090)	(9,929)	(1,839)
57,144	(26,012)	31,131	Urgent & Emergency Care	47,655	405	(47,251)	(21,643)	(22,413)	(770)	26,013	(22,008)	(48,021)
135,505	**(134,357)**	**1,148**	**Sub-total**	**113,004**	**19,078**	**(93,926)**	**(111,983)**	**(110,253)**	**1,730**	**1,021**	**(91,176)**	**(92,196)**
			Planned care									
8,884	(10,380)	(1,496)	Cancer Services	7,409	4,177	(3,232)	(8,649)	(8,850)	(201)	(1,240)	(4,673)	(3,433)
12,837	(36,485)	(23,648)	Critical Care & Perioperative	1,500	-	(1,500)	(1,179)	(1,881)	(702)	321	(1,881)	(2,202)
1,800	(866)	934	Planned Care Infrastructure	54,367	921	(53,446)	(29,585)	(27,558)	2,027	24,782	(26,637)	(51,418)
65,191	(35,407)	29,784	Surgical Services	10,705	483	(10,223)	(30,418)	(29,457)	961	(19,713)	(28,974)	(9,262)
61,242	(38,098)	23,144	Women & Children	51,073	716	(50,356)	(31,706)	(32,280)	(575)	19,367	(31,564)	(50,931)
149,955	**(121,237)**	**28,718**	**Sub-total**	**125,054**	**6,298**	**(118,756)**	**(101,537)**	**(100,026)**	**1,511**	**23,517**	**(93,729)**	**(117,246)**
			Corporate									
21	(499)	(478)	Communications	18	18	-	(425)	(408)	17	(407)	(390)	17
4	(2,957)	(2,953)	Finance	4	22	18	(2,490)	(2,464)	26	(2,486)	(2,442)	44
1,778	(4,787)	(3,009)	HR & OD	1,482	1,219	(262)	(3,986)	(3,668)	317	(2,504)	(2,449)	55
-	(4,198)	(4,198)	IT	-	37	37	(3,505)	(3,612)	(107)	(3,505)	(3,574)	(70)
9,930	(5,554)	4,376	Medical Director	8,275	8,268	(7)	(4,630)	(4,466)	164	3,645	3,802	157
-	(6)	(6)	Medway Innovation Institute	-	-	-	(6)	(6)	(0)	(6)	(6)	(0)
4	(4,193)	(4,189)	Nursing	4	9	6	(3,495)	(3,511)	(17)	(3,491)	(3,502)	(11)
0	(2,921)	(2,921)	Strategy, Governance & Perform	0	-	(0)	(2,434)	(2,484)	(50)	(2,434)	(2,484)	(50)
-	(855)	(855)	Transformation	-	-	-	(743)	(677)	66	(743)	(677)	66
-	(3,074)	(3,074)	Trust Executive & Board	-	-	-	(2,563)	(2,738)	(175)	(2,563)	(2,738)	(175)
11,737	**(29,045)**	**(17,308)**	**Sub-total**	**9,782**	**9,573**	**(208)**	**(24,276)**	**(24,033)**	**242**	**(14,494)**	**(14,460)**	**34**
			E&F									
5,238	**(25,055)**	**(19,817)**	**E&F**	**4,364**	**2,431**	**(1,933)**	**(20,598)**	**(20,398)**	**200**	**(16,233)**	**(17,967)**	**(1,733)**
			Central									
54,112	**(46,852)**	**7,259**	**Central**	**40,974**	**262,785**	**221,810**	**(40,444)**	**(45,548)**	**(5,104)**	**530**	**217,237**	**216,706**
356,547	**(356,547)**	**-**	**TOTAL**	**293,179**	**300,169**	**6,986**	**(298,838)**	**(300,259)**	**(1,421)**	**(5,660)**	**(94)**	**5,565**

`

3. Forecast

Further discussions have taken place within the ICS with activity and financial plans for October to March being submitted to the STP.

- The system plan for October to March identified a £36.9m deficit; the MFT pan included a deficit of £3.6m arising solely to the inclusion of an increased annual leave accrual in month 12. These plans were finalised and agreed by the STP and NHSE/I.

- Positive confirmed Covid cases continue to rise across the Trust. This creates an amount of uncertainty in the forecast plan due additional shifts being booked to cover staff sickness, self-isolation and patient acuity.

- For the period of October to March, £7.6m of funding to cover incremental Covid costs has been approved. Of this, £4.1m has been required from October to December, this being £0.3m above the agreed allocation to date.

- The forecast position has been updated using the December financial position. Non-pay spend is forecast to reduce as December includes £0.6m drugs adjustment as well as impact of GRNI £0.3m. The Trust continues to forecast compliance with our control total, this is summarised in the following table.

Summary Forecast October - March £'m	Oct'20 Actual	Nov'20 Actual	Dec'20 Actual	Jan'21 Actual	Feb'21 Forecast	Mar'21 Forecast	Oct - Dec Total
Income	29.0	30.3	31.2	31.2	30.4	30.6	**182.6**
Pay	(19.0)	(18.9)	(19.7)	(20.1)	(19.8)	(19.9)	**(117.5)**
Non-pay	(8.6)	(10.0)	(10.1)	(9.7)	(9.1)	(9.4)	**(56.9)**
EBITDA	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	**(8.3)**
Surplus / (Deficit)	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**0.1**	**(0.1)**	**(0.1)**
* Includes the impact of donated asset depreciation							
Covid Costs included in the Forecast	(0.6)	(1.1)	(2.5)	(2.3)	(1.8)	(1.8)	(10.1)

Key forecasting assumptions

1) Covid costs run at an average of £2.0m per calendar month in Q4.
2) Clinical Income as per block contract arrangements.
3) Other income and expenditure continues at run-rate.
4) No additional CIP schemes expected to be implemented.
5) £0.3m additional cost of opening bed capacity on Ocelot and Emerald (excluding Frailty SDEC).
6) Restart of elective activity in February 2021.
7) The forecast assumes a contingency of £1.1m.

Risks to the Forecast	£'m
Loss of stroke services	0.3
CIP - Current schemes stop delivering	1.7
North Kent Pathology Service (NKPS)	0.6
Ward reconfiguration / bed capacity	0.3
Total	**2.9**

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	Budget	Gap	Mitigated target	Gap
Planned care	446	2,199	359	-	3,005	**4,682**	(1,677)	**5,100**	(2,095)
UIC	501	2,119	15	195	2,831	**4,253**	(1,422)	**5,505**	(2,674)
E&F	-	591	211	-	801	**661**	140	**800**	1
Corporate	589	184	91	61	925	**1,113**	(188)	**1,709**	(784)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	-
Total	**2,827**	**5,094**	**676**	**256**	**8,853**	**12,000**	**(3,147)**	**14,405**	**(5,552)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**1,823**	**812**	**(1,011)**	**7,801**	**7,118**	**(683)**	**12,000**	**8,853**	**(3,147)**

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 January the total forecast CIP has reduced slightly by £0.1m to £8.9m, this leaves a gap of £3.1m to the original CIP Plan as some savings programmes continue to encounter delays due to the operational pressures experienced across the Trust.

During the year, a revised stretch target of £14.4m was set, this being 20% higher than the required CIP to mitigate the risk of individual scheme failure. The PMO team continue to work with Divisions and the Finance Business Partners to identify and quantify CIP schemes as well as assess schemes for the new financial year along with any that did not deliver being carried forward and implemented. Delivery to date is £7.1m, this is adverse to plan by £0.7m and as forecast in December.

The main efficiencies have been achieved from the full year effect of 19/20 schemes for agency rate reductions, as well as lean use of theatres and procurement and pharmacy national pricing measures exceeding the original plan.

`

5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,791	**Non-current assets**	**216,426**	**211,153**	**(5,273)**
6,307	Inventory	7,400	6,403	(997)
36,686	Trade and other receivables	22,000	21,397	(603)
12,385	Cash	33,853	52,942	19,089
55,378	**Current assets**	**65,477**	**84,044**	**18,567**
(292,111)	Borrowings	(77)	(132)	(55)
(24,478)	Trade and other payables	(19,000)	(29,308)	(10,308)
(4,519)	Other liabilities	(30,573)	(32,585)	(2,012)
(321,108)	**Current liabilities**	**(49,740)**	**(65,149)**	**(15,409)**
(2,278)	Borrowings	(2,278)	(2,151)	127
(1,317)	Other liabilities	(1,317)	(1,317)	0
(3,595)	**Non-current liabilities**	**(3,595)**	**(3,468)**	**127**
(64,534)	**Net assets employed**	**226,434**	**226,402**	**(32)**
140,581	Public dividend capital	431,609	431,610	1
(246,481)	Retained earnings	(246,541)	(246,574)	(33)
41,366	Revaluation reserve	41,336	41,366	-
(64,534)	**Total taxpayers' equity**	**226,434**	**226,402**	**(32)**

Key messages:

1. Current net assets are £226.4m, unchanged from month 9.
   This is a material change from the prior year when the Trust operated with net liabilities due to the level of deficit support borrowings from the Department of Health in prior years.

   A national initiative converted all Trust emergency borrowings to PDC (funding) in this financial year which was effectively a write off of the loans.

   Whilst this is a positive move for the financial position of the Trust it does have an I&E impact as interest on borrowings was significantly less than the 3.5% dividend now payable on 'relevant net assets'.

2. Payables are £10.3m adverse to plan due to increases in expenditure accruals which includes PDC dividends payable(£4.6m)

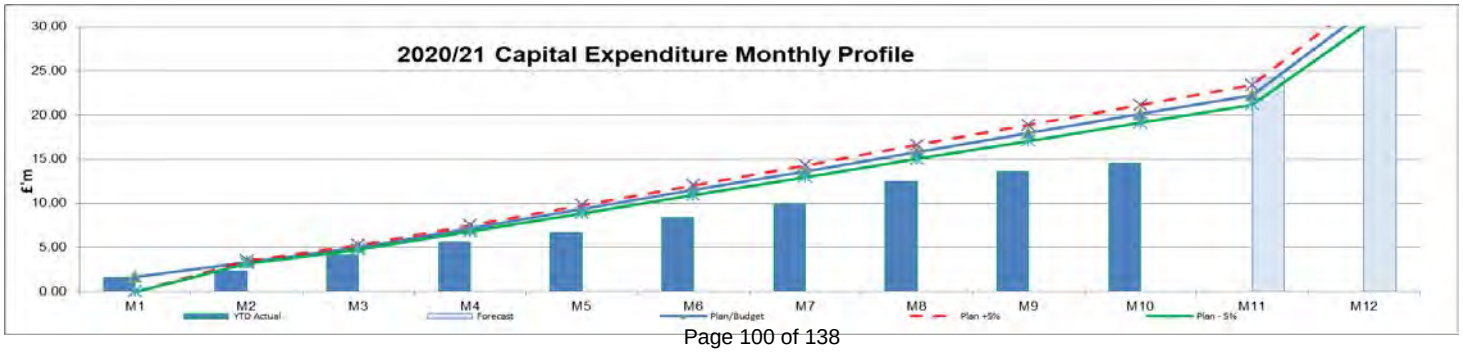
3. Other Liabilities are £2.0m adverse to plan due to additional cash advances from Commissioners for COVID.

`

6. Capital

£'000	In-month			Year To Date			Annual			Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	555	55	500	4,575	3,621	954	5,671	5,671	0	690	0	4,981
Routine Maintenance[1]	87	380	(293)	870	1,103	(233)	1,049	1,026	(23)	671	0	355
Fire Safety	476	269	207	4,760	4,173	587	5,720	5,720	0	366	4,252	1,102
IT[2]	228	591	(363)	2,280	1,618	662	4,130	4,130	0	4,130	0	0
New Build - Inc ED	481	423	58	4,327	570	3,757	5,283	5,283	0	835	3,000	1,448
Plant & Equipment	330	(736)	1,066	3,300	1,417	1,883	2,664	2,664	0	2,664	0	0
Total Planned Capex	**2,157**	**982**	**1,175**	**20,112**	**12,502**	**7,610**	**24,517**	**24,494**	**(23)**	**9,356**	**7,252**	**7,886**
COVID*	0	10	(10)	0	1,967	(1,967)	1,967	1,967	0	8	1,928	0
IT MOU	0	8	0	0	84	0	190	190	0	0	190	0
A&E MOU	0	0	0	0	0	0	857	548	(309)	0	548	0
Diagnostic equipment(breast) MOU	0	0	0	0	0	0	1,186	1,186	0	0	1,186	0
UTC MOU	0	5	0	0	23	0	0	23	23	23	0	0
Adopt & Adapt MOU	0	0	0	0	0	0	630	630	0	0	630	0
EPMA MOU	0	0	0	0	0	0	1,485	1,485	0	0	1,485	0
Diagnostic Equipment Replacement MOU	0	0	0	0	0	0	277	277	0	0	277	0
Secure Boundary MOU	0	0	0	0	0	0	50	50	0	0	50	0
HSLI EPR MOU	0	0	0	0	0	0	500	500	0	0	500	0
Total Additional Capex	**0**	**23**	**(10)**	**0**	**2,074**	**(1,967)**	**7,142**	**6,856**	**(286)**	**31**	**7,134**	**0**
Total Capex	**2,157**	**1,005**	**1,165**	**20,112**	**14,576**	**5,643**	**31,659**	**31,350**	**(309)**	**9,387**	**14,386**	**7,886**

[1] £12k Salix Grant added to Internal Funds
[2] £1,400k EPR Project added utilising previously agreed underspend



`

6. Capital (continued)

Capital expenditure consists of:

• Planned YTD expenditure of £12.502m, £7.61m behind plan.
All programmes except routine maintenance are currently behind plan, although IT, ED and backlog maintenance are materially behind plan. Work on the ED project has been affected by COVID working restrictions and resource shortages but is now picking up.
IT schemes are planned to accelerate in the next quarter. A recent scheme by scheme forecast undertaken by programme leads predicts all projects accelerating in the coming months and delivering on plan by 31st March.
An agreement with the STP to underspend by £1.3m has been revisited since December, funding has been returned to the Trust in order to accelerate the EPR project.

• £1.967m of unplanned YTD expenditure in relation to April to July COVID schemes, of which only £1.928m has approved funding
The Trust had been advised of a national shortfall in funding but Medway's schemes were seen as a priority.

Further capital expenditure in relation to COVID projects continues to be incurred by the Trust but as there is no mechanism to bid for additional funding this has had to be absorbed within the current Capital Resource Limit.

• A number of other 'funding' applications as listed in the table above have been approved by NHSI.
Since last month PDC for Diagnostic Equipment Replacements (£277k), IT secure Boundary project (£50k) and HSLI EPR (£500k). As with all current Trust PDC awards these funds must be drawn and spent by 31st March 2021, if this does not happened the Trust will be in breach of the funding agreement and funds will have to be returned.

The Trust CRL will increase in line with the PDC issued and annual dividends of 3.5% (i.e. £35k pa for every £1m granted) will be payable, PDC issued for COVID related assets do not attract this charge. In the last few years this has not been applicable to Medway as dividends are only payable by organisations with relevant net assets. Medway has held net liabilities due to the level of revenue borrowings which have now converted to PDC, bringing the Trust back to a net asset position.

`

7. Cash

Cash Flow, 12 months ahead

				Forecast											
£m	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
BANK BALANCE B/FWD	**45.45**	**55.94**	**59.21**	**52.84**	**48.51**	**23.18**	**57.35**	**57.51**	**55.22**	**61.40**	**57.99**	**51.41**	**57.62**	**54.23**	**47.81**
Receipts															
NHS Contract Income	22.74	22.55	22.88	22.39	0.20	53.95	27.12	28.94	26.94	26.94	26.94	26.94	26.94	26.94	26.94
NHS Top Up	17.17	8.08	1.30	5.72	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	1.51	4.43	1.26	1.71	4.48	4.23	1.46	1.30	4.52	1.69	1.75	4.46	1.69	1.69	4.35
Total receipts	**41.42**	**35.06**	**25.44**	**29.82**	**4.68**	**58.18**	**28.58**	**30.24**	**31.46**	**28.63**	**28.69**	**31.40**	**28.63**	**28.63**	**31.29**
Payments															
Pay Expenditure (excl. Agency)	(18.40)	(19.10)	(20.35)	(19.77)	(19.77)	(19.68)	(19.05)	(18.91)	(19.54)	(18.90)	(18.87)	(19.45)	(18.80)	(19.36)	(18.74)
Non Pay Expenditure	(10.52)	(10.48)	(10.69)	(10.65)	(21.74)	(13.36)	(8.37)	(12.70)	(14.77)	(12.22)	(12.22)	(14.77)	(12.22)	(14.77)	(12.22)
Capital Expenditure	(1.17)	(2.21)	(0.77)	(3.73)	(4.50)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)
Total payments	**(30.09)**	**(31.79)**	**(31.81)**	**(34.15)**	**(46.01)**	**(33.96)**	**(28.34)**	**(32.53)**	**(35.23)**	**(32.04)**	**(32.01)**	**(35.14)**	**(31.94)**	**(35.05)**	**(31.88)**
Net Receipts/ (Payments)	**56.78**	**59.21**	**52.84**	**48.51**	**7.18**	**47.40**	**57.59**	**55.22**	**51.45**	**57.99**	**54.67**	**47.67**	**54.31**	**47.81**	**47.22**
Funding Flows															
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	9.95	0.00	0.00	9.95	0.00	0.00	9.95	0.00	0.00	9.95
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	21.74	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00
Dividend payable	(0.76)	0.00	0.00	0.00	(5.74)	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00	0.00	0.00	0.00
Total Funding	**(0.84)**	**0.00**	**0.00**	**0.00**	**16.00**	**9.95**	**(0.08)**	**0.00**	**9.95**	**0.00**	**(3.26)**	**9.95**	**(0.08)**	**0.00**	**9.95**
BANK BALANCE C/FWD	**55.94**	**59.21**	**52.84**	**48.51**	**23.18**	**57.35**	**57.51**	**55.22**	**61.40**	**57.99**	**51.41**	**57.62**	**54.23**	**47.81**	**57.17**

13 Week Forecast

w/e

	Actual					Forecast												
£m	01/01/21	08/01/21	15/01/21	22/01/21	29/01/21	05/02/21	12/02/21	19/02/21	26/02/21	05/03/21	12/03/21	19/03/21	26/03/21	02/04/21	09/04/21	16/04/21	23/04/21	30/04/21
BANK BALANCE B/FWD	**71.13**	**59.23**	**58.35**	**76.12**	**64.08**	**52.86**	**52.65**	**49.14**	**72.62**	**48.52**	**43.67**	**61.38**	**54.02**	**35.07**	**22.40**	**20.88**	**67.05**	**53.96**
Receipts																		
NHS Contract Income	0.10	0.00	23.85	0.64	0.12	0.14	0.00	28.30	0.00	0.00	0.00	0.43	0.00	0.00	0.00	50.72	0.00	0.00
Other	0.36	0.06	0.45	0.18	0.15	0.25	0.59	0.28	0.28	0.25	0.56	3.05	0.25	0.25	0.58	0.30	0.25	0.25
Total receipts	**0.46**	**0.06**	**24.30**	**0.81**	**0.27**	**0.39**	**0.59**	**28.57**	**0.28**	**0.25**	**0.56**	**3.47**	**0.25**	**0.25**	**0.58**	**51.02**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(7.96)	(0.94)	(0.46)	(9.88)	(9.07)	(0.49)	(0.49)	(0.49)	(18.31)	(0.49)	(0.49)	(0.49)	(9.89)	(8.91)	(0.49)	(0.49)	(9.89)	(8.91)
Non Pay Expenditure	(3.25)	(0.01)	(5.53)	(2.98)	(2.18)	(0.11)	(3.61)	(4.61)	(2.33)	(4.61)	(4.11)	(4.61)	(9.31)	0.49	(1.61)	(4.36)	(3.46)	(3.46)
Capital Expenditure	(1.15)	0.00	(0.53)	0.00	(0.24)	0.00	0.00	0.00	(3.73)	0.00	0.00	0.00	0.00	(4.50)	0.00	0.00	0.00	0.00
Total payments	**(12.35)**	**(0.95)**	**(6.52)**	**(12.86)**	**(11.49)**	**(0.59)**	**(4.10)**	**(5.10)**	**(24.37)**	**(5.10)**	**(4.60)**	**(5.10)**	**(19.20)**	**(12.92)**	**(2.10)**	**(4.85)**	**(13.35)**	**(12.37)**
Net Receipts/ (Payments)	**(11.90)**	**(0.88)**	**17.78**	**(12.05)**	**(11.22)**	**(0.21)**	**(3.51)**	**23.48**	**(24.10)**	**(4.85)**	**(4.04)**	**(1.62)**	**(18.95)**	**(12.67)**	**(1.52)**	**46.17**	**(13.10)**	**(12.12)**
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	21.74	0.00	0.00	0.00	0.00	0.00	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	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(5.74)	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**21.74**	**(5.74)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**59.23**	**58.35**	**76.12**	**64.08**	**52.86**	**52.65**	**49.14**	**72.62**	**48.52**	**43.67**	**61.38**	**54.02**	**35.07**	**22.40**	**20.88**	**67.05**	**53.96**	**41.84**

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	33,853	52,942	19,089

Cash balances held are in excess of the plan mainly due to:

- 1st instalment of PDC was taken at £0.7m, much lower than expected due to relevant net asset calculation omitting restatement of loan conversion. £4.1m planned PDC dividend remains unpaid is not expected to be taken until on/after Q4.
- £5.6m capital expenditure slippage
- £30.9m of cash received in advance of costs being incurred

`

9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £9k deficit in-month and £94k deficit year to date, reducing to breakeven after removing the adjustment for donated asset depreciation. This financial performance is as per the plan submitted to the Kent & Medway STP.

The year to date CIP programme delivery is £0.7m adverse to plan; this is mainly due to pressures caused by Covid affecting the delivery of planned efficiencies in the second half of the year. The total schemes identified are £10.2m of these it is that £8.9m will be delivered, this being £3.1m adverse to the target £12.0m.

Alan Davies
Chief Financial Officer
February 2021

Meeting of the Board of Directors in Public

Thursday, 04 March 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Jo Palmer		
Date of Meeting:	Thursday 25 February 2021		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Paul Kimber, Deputy Chief Financial Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks The BAF scores remain unchanged from prior month for all items except for "3a. Delivery of financial control total". The risk score was reduced from 16 to 8 on the basis of greater assurance of control total delivery, including additional funding being made available via the STP in 2020/21. The Committee **AGREED** the score change.	**Amber/Green**
2. Risk register The risk register score for CIP remained unchanged from prior month and was considered appropriate.	**Amber/Green**
3. Finance report	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
The Chief Financial Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total in month 10 and year to date. The forecast is that we will meet our control total for the full year. • The Covid expenditure remained high in January at £2.4m and is offset by Covid income. Covid income recognised in the second half of the year is £6.5m against the total six-month allocation of £7.6m; however, the STP has confirmed additional Covid funding available to the Trust. • CIP has now fallen behind plan on a year to date basis, although the forecast outturn value remains unchanged at £9m. This value is included in our overall forecast in meeting the Trust control total. • Capital expenditure was noted as still being behind plan; there are plans to largely catch up by the year end but this is not without risk given the volume of work required in the final two months of the year. • Cash remains strong, although the block contract sums paid in advance are expected to unwind (i.e. no payment) in March. • Pay was noted as exceeding £20m for the first time, and it was **AGREED** that further analysis will be presented at future meetings.	
4. Annual plan and budget setting 2021/22 The Chief Financial Officer presented the paper updating on planning work to date and noted that there had been good engagement from divisions in taking this forward, including CIP identification. It was noted that national guidance is expected in March with a firm view that there will be interim arrangements in Q1 with "usual" arrangements thereafter. Accordingly, there is an anticipation that draft interim budgets will be available for the next Finance Committee and full year budgets during Q1 of 2021/22.	**Amber/Green**
5. Model Hospital – corporate benchmarking The Costing and SLR manager – who is also the Model Hospital Ambassador - presented a report which set out some of the key opportunities, particularly in HR. The Committee was keen to ensure that the Trust set itself stretching targets, particularly as the corporate services are not patient facing and hence may prove easier to transform, including working across the system.	**Amber/Green**
6. Cardiac catheter suite business case update The updated business case was presented following feedback at the last meeting; the case was **APPROVED**.	**Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Decisions made The Committee **AGREED** to the reduction in BAF score (from 16 to 8) for item "3.a Delivery of financial control total". It was **AGREED** that more detailed analysis on pay costs would be presented at the next meeting. The revised cardiac catheter suite business case was **APPROVED**.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee No further matters to note.	

Meeting of the Trust Board in Public
Thursday, 04 March 2021

Title of Report	**Patient First Programme- Operational Update**	Agenda Item	**6.1**
Lead Director	Angela Gallagher, Chief Operating Officer (Interim)		
Report Author	Keith Soper, Deputy Chief Operating Officer		
Executive Summary	This paper and the accompanying slides provide a progress update on three key and interrelated elements of our Patient First programme. This work is rightly targeting regulatory requirements and is supported by the Emergency Care Intensive Support Team (ECIST). There has been good engagement in the programme, with a number of areas in development. For each element we have agreed metrics to track our work and the impact of interventions and changes – these are reported via the Trust Improvement Board. But it is important also to understand how we are performing now against key indicators, since the programme has both a direct and indirect influence on our overall performance.		
Committees or Groups at which the paper has been submitted	- Trust Improvement Board, 10 February 2021 - Quality Assurance Committee, 16 February 2021; reviewed the slide pack attached.		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	NA		
Recommendation/ Actions required	The Board is asked to NOTE the report and progress made		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒

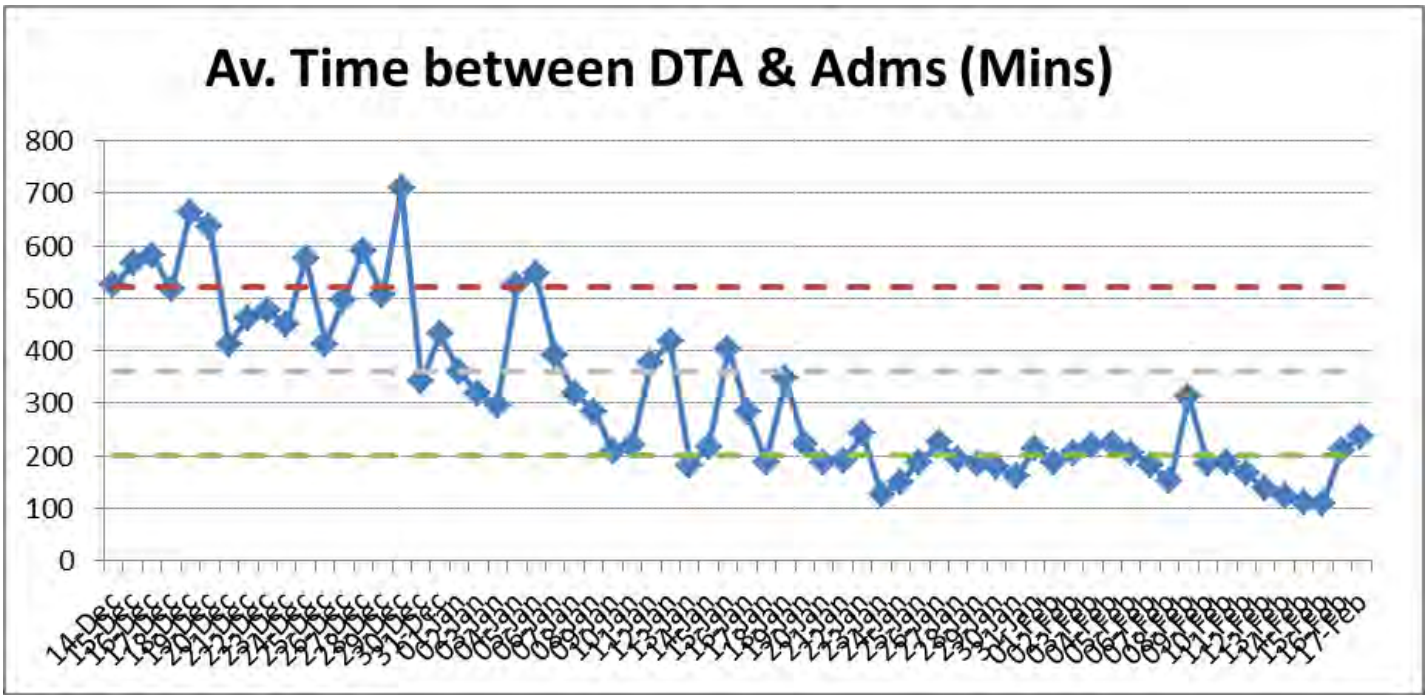
Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current 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

1 Executive Overview

1.1 This briefing describes at a headline level the progress made and references our improving performance.

2 Effective Site Management

2.1 It is acknowledged that good site management is an enabl er to performance and as such the Effective Site Management programme is focusing on timely, accurate information, appropriate and meaningful escalation and a richer discussion within the existing site meetings to move from reporting to problem solving and support. We have seen improvements in the time between the decision to admit and entry to a bed (see below) and we have started to reach the position at the end of the day of having good bed av ailability (both Red and Amber), with the Site Team overseeing the de-escalation of five wards from Red to Amber.



2.2 Our priorities for the next month include:

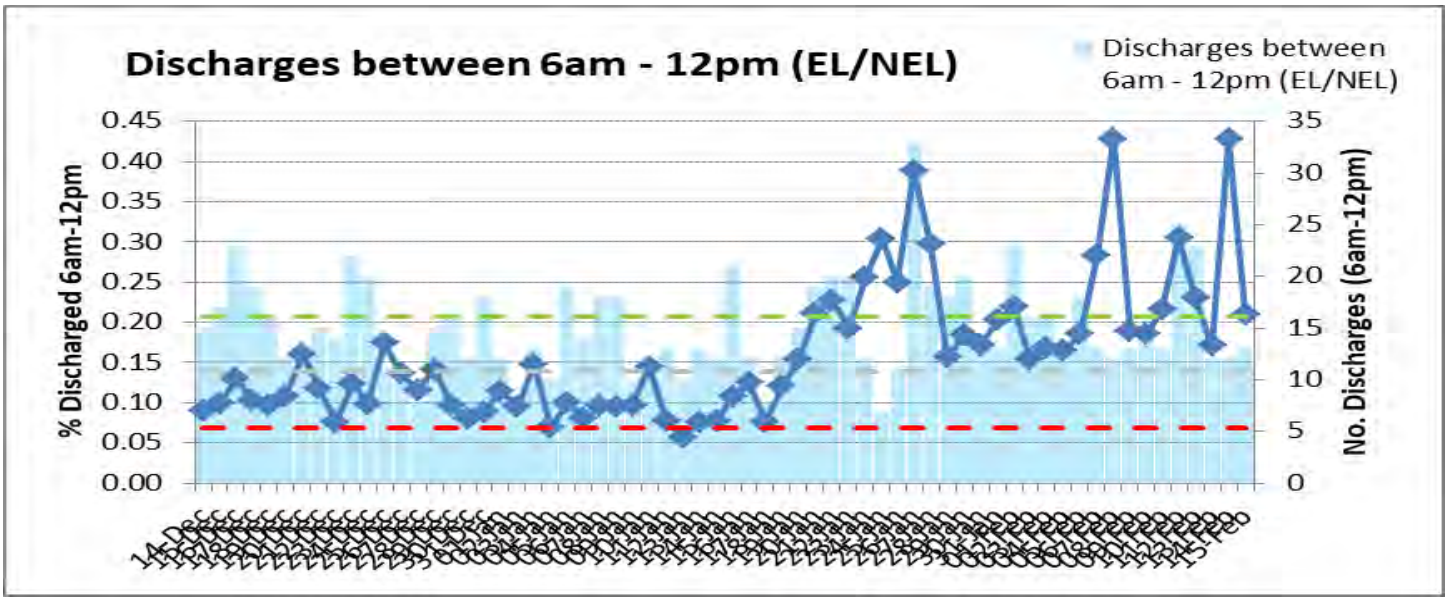
- Revise Trust Escalation documents and action cards with ECIST support and agree with clinical and operational leads, utilising SHREWD where possible
- Revise Standard Operating Procedures within the Site Office and Site Team.
- Modernise Site Office following receipt of an Innovation Fund Grant to enable live data feeds from Clinical Systems and provide a better physical working environment.
- Redefine attendance at Site Meetings to include senior decision-making capacity (operations, clinical, nursing).
- Development of clinical / operational dashboards with Clinical Systems and B I that support Site requirements (in conjunction with ACT and Flow and Discharge work streams)
- Work towards improved 24 hour site management and improving the on-call manager experience via the introduction of a trial twilight shift within the site team.

3. Flow and Discharge

3.1 The Flow and Discharge programme has been separated out into the following four key areas with a view to improving process and outputs:

- Clarifying roles and responsibilities
- Effective Board rounds
- Use of clinical systems
- Improved Out of hospital care and capacity.

3.2 It is acknowledged that the process can be unwieldy and that it is often unnecessarily administratively heavy. We are seeking to make this better for all involved in discharge planning and want to see more consistency in our process and more patients being discharged when they are ready and earlier in the day when they are due to go.

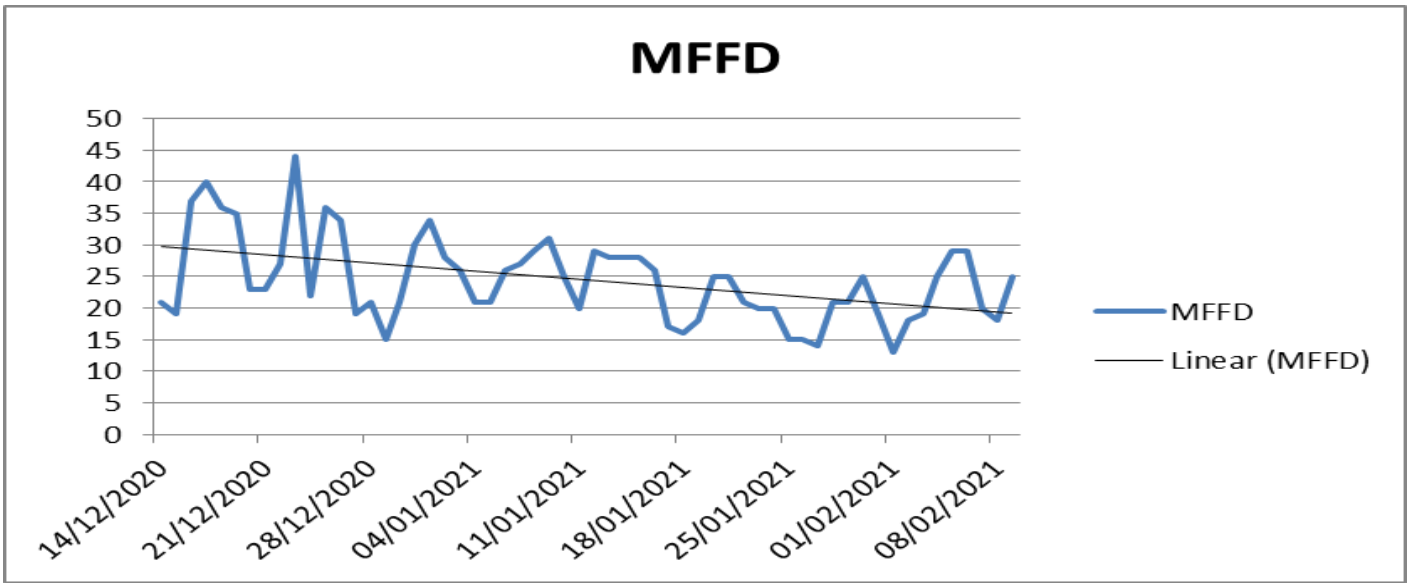


3.3 We have been running mini-MADEs (Multi Agency Discharge Events) for the last five weeks across two or three days per week. The events have been run over MS Teams with MDT partners. This has enabled us to pilot a Virtual Board Round (VBR) and assess the sound, view and accessibility. The MADE team join the board round remotely and support the ward by taking away actions or offering solutions to discharge barriers. Recently the manager from the Virtual Bed Bureaux (VBB) has joined the board round to collate and follow up actions and update Estimated Discharge Dates (EDDs) live on Extramed, and a dedicated Progress Chaser has followed up actions to support discharges not just for that day, but for those planned. This has seen recent very good discharge levels at the weekend.

3.4 Colleagues from our Transformation Team have joined the VBRs to support us with auditing the process against the SAFER principles. ECIST have also joined some of these VBRs and provided constructive feedback on the process. The feedback is being collated and will be presented alongside a best practice SAFER board round illustration. The key themes from the audit will be used to develop the improvement plan.

3.5 We are moving on to process map various elements of the discharge process. These events include representatives from our clinical teams as well as dependent partners. The aim is to ensure the new process is clinically informed and led and that the ward teams are engaged with the whole process. Once these process maps are completed we will be working with the Therapies and Older People Care Group to operationalise the new board round, one ward at a time, coupled with live Extramed updating particularly with EDDs following the clinical discussion at the board round. This then enables the pre-planning of discharge activities including EDN completion, TTOs and discharge dependent referrals

and diagnostics to be completed in advance of the proposed MFFD status of the patient. This will improve our pre-noon discharges and use of the discharge lounge to improve flow earlier in the day.



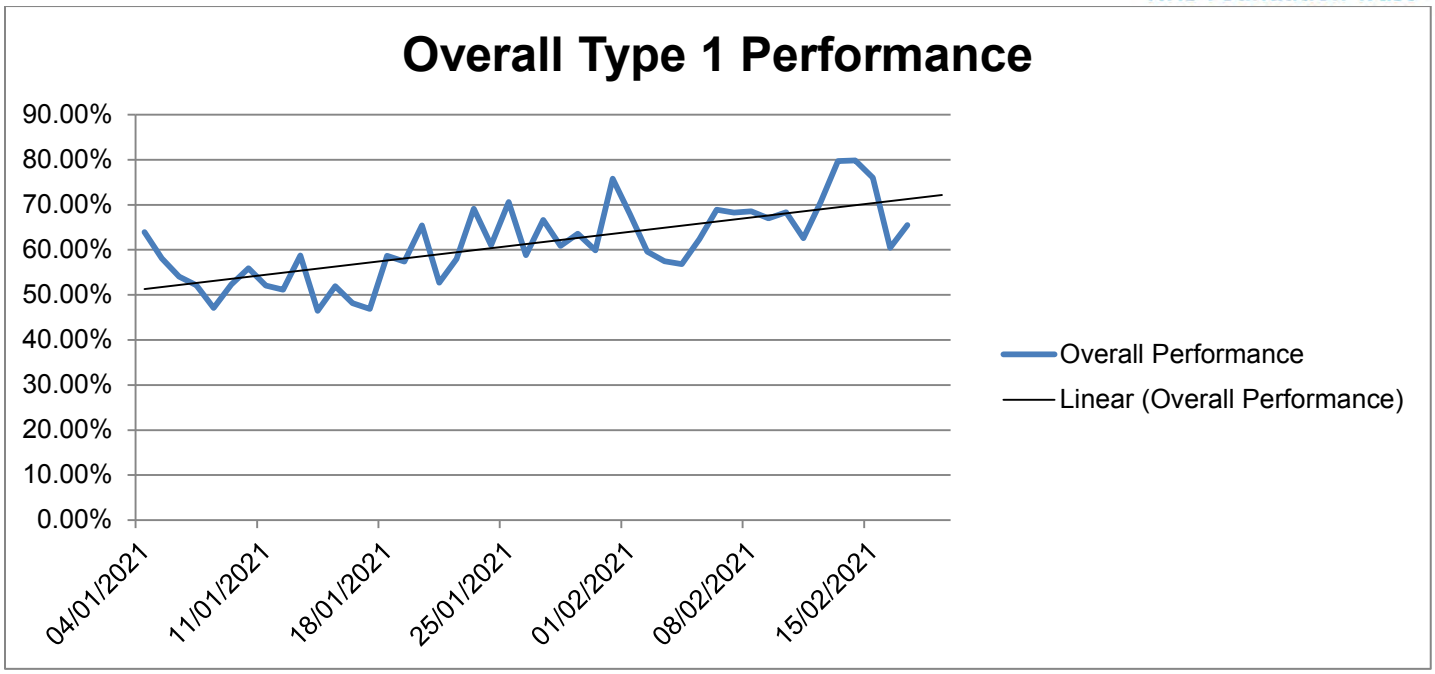
3.6 Our Business Intelligence team is supporting the development of metrics to further demonstrate improvements and outcomes from this programme of work, including:

- Improved patient flow through all wards
- Compliance with using clinical systems
- Appropriate updating of EDD to support and plan discharges
- Measure of EDDs against actual day of discharge
- Completion of EDNs in line with EDDs,
- Improvement on pre-noon discharges
- Utilisation of the discharge lounge
- Increased utilisation of early supported discharge pathways including home first and voluntary sector

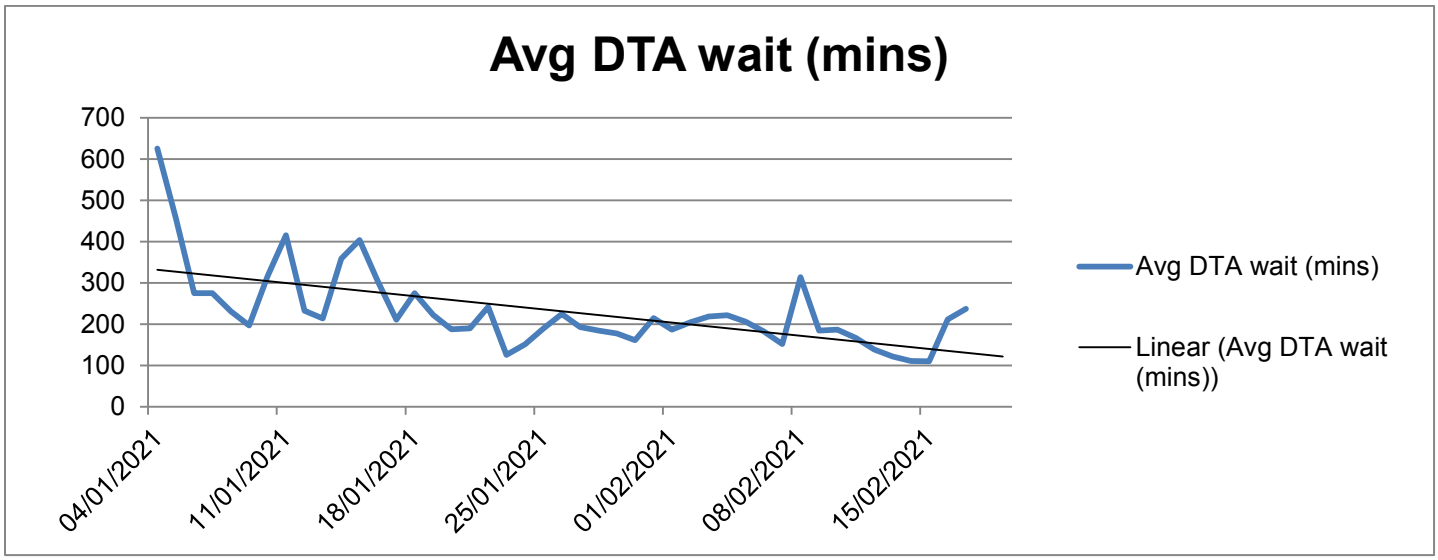
There will also be patient experience and quality metrics as part of the outcome measures.

4. Acute Care Transformation

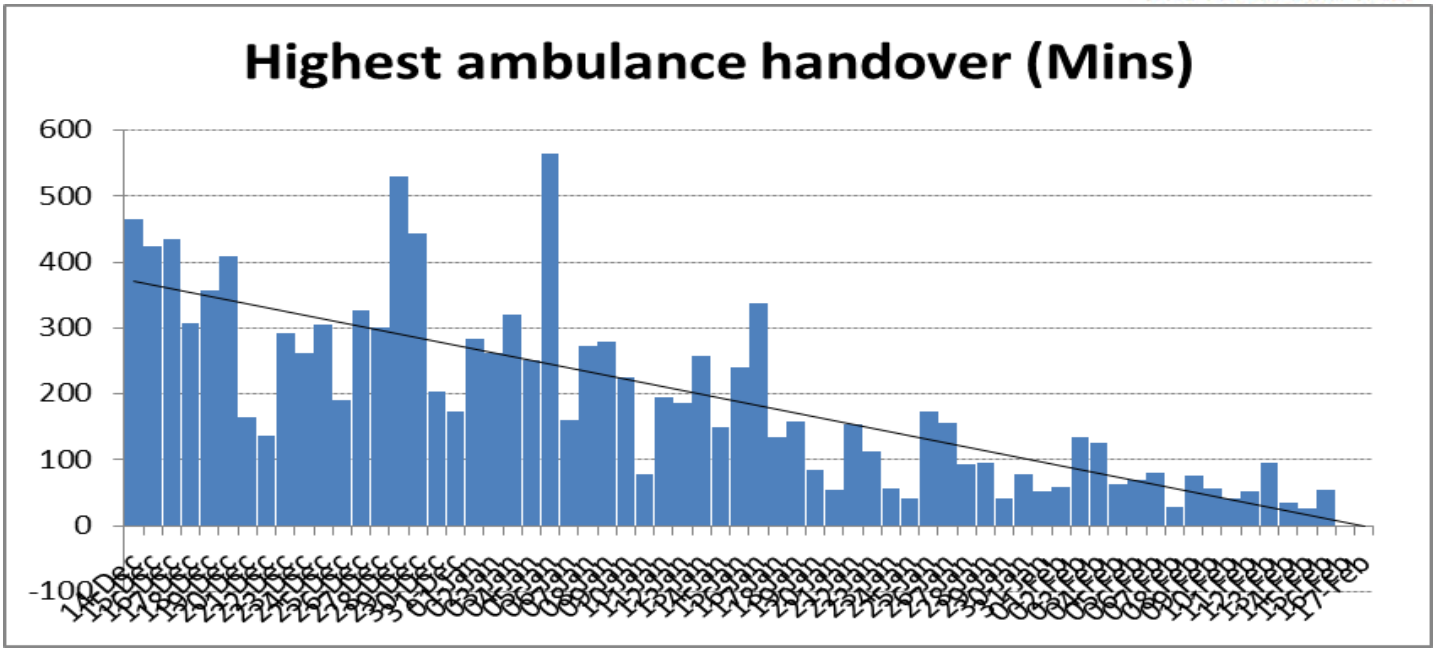
4.1 The work of the Acute Care Transformation programme links closely to our Care Quality Commission action plan. At its heart the programme is striving to ensure safe access and initial assessment for all patients and to minimise delays at every step of the ED journey. The programme is building metrics for the three stems (Frailty, Acute and Emergency) and once baselines are agreed we will be asking for monthly improvement markers over a 16 week phase and a plan to sustain and embed. These will support and drive further improvement through the main performance indicators, where there is a positive trend developing.



4.2 This is supported by a reduction in the average waiting time for a decision to admit. This is even more important at a time where our medical assessment unit is unable to churn as it normally would due to the safeguards in place to limit clinically unnecessary moves and reduce the risk of hospital acquitted Covid-19 infection and the impact this has on closed and blocked beds. Through the programme, and as levels of the virus and the risk changes, we want to re-energise the assessment process in line with infection prevention and control guidelines.



4.3 We are continuing to focus on reducing ambulance handover delays, and the trend is encouraging. Long handover delays are now unusual, but when we have experienced them this has generally been part of wider system pressure and we have been able to recover quickly. During February 2021 we have been in the position of offering mutual aid through ambulance diverts and this has been welcomed and acknowledged.



5. In conclusion the approach has been to integrate the work of the Patient First Programme into the daily, weekly and monthly priorities of our clinical operations activities and to use a set of daily metrics to monitor progress and ensure that the key issues were being addressed and showing consistent improvement. The Trust is benefitting from the experience and practical interventions from the Emergency Care Improvement Support Team which is targeted at our key priority areas. Future work will reflect the need to undertake further system-wide actions to manage the demand and capacity for emergency and non-elective activity within Medway and Swale and the additional opportunities available to address these.

6. Slide Pack presented at Quality Assurance Committee to follow this paper.

PATIENT FIRST

Quality Assurance Committee
Update Paper

1. EMERGENCY FLOW (ACUTE CARE TRANSFORMATION)

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Kevin Cairney, Dr Ashike Choudhury, Dr Ashraf Syed, Dr Sanjay Suman,
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart + ECIST

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Aims of the work

- Safe access and initial assessment for patients conveyed by ambulance;
- Increase direct ambulance conveyance to SDEC, SAU and Frailty;
- Re-introduce the 'refer and move' flow principle to surgical, frailty and medical assessment areas;
- Ensure that ED Internal Professional Standards are monitored and we are responsive to exceptional variation in activity;
- Validate Trust Internal Professional Standards in response to emergency referral and flow;
- Increase the number of patients who access zero LOS clinical pathways across surgery, medicine and frailty;
- Minimise delays at every step of the ED journey;

Short-term tests of change (PDSA cycles)

30, 60, 90 days

- ED patient safety checklist content aligned to ED Nursing documentation (30D)
- Time stamping the Emergency care, assessment and ambulatory pathways in line with IPS (90D with dependency on Symphony into SDEC, FAU, SAU and AAU);
- Business intelligence suite that informs our clinical leaders and operational teams of pathway performance and flows directly Site;
- Frontline staff are contributing to lean process mapping and quality improvement cycles;

Long-term priorities and key deliverables

- Symphony upgrades and accurate real-time analytics;
- Proactive and Trust-owned escalation to mitigate emergency pathway exit block;
- Commitment to IPS as a vehicle for improved clinical and quality outcomes for our patients across all pathways;
- Realisation of our Trust vision to become an emergency centre of excellence for our local community;

How will we know we are successful – and by when (measures and timeframes)

Outcome measures

- Mean ambulance handover time;
- ED & Trust IPS compliance;
- Emergency care type 1 standard;
- Assessment & ambulatory pathway response;
- Assessment & ambulatory pathway utilisation;
- Reduction in type 1 adult LOS in ED;

Process measures

- Refer & move procedure (DTA by exception);
- Direct conveyance to assessment areas;
- CDU utilisation & pathways;
- Patient FFT
- Learning from failure;

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Kevin Cairney, Dr Ashike Choudhury, Dr Ashraf Syed, Dr Sanjay Suman,
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Validate Trust Internal Professional Standards in response to emergency referral and flow and implement across all pathways; • Safe access and initial assessment for patients conveyed by ambulance; • Optimise direct ambulance conveyance to SDEC, SAU and FAU; • Re-introduce the 'refer and move' flow principle to surgical, frailty and medical assessment areas; • Ensure that ED Internal Professional Standards are monitored and we are responsive to exceptional variation in activity in line with Trust Escalation processes; • Increase the number of patients who access zero LOS clinical pathways across surgery, medicine and frailty; • Support the development and implementation of non-conveyance pathways with system partners	30 Days • ED patient safety checklist content aligned to ED Nursing documentation (30D) • Frontline staff are contributing to lean process mapping and quality improvement cycles; 60 Days • Business intelligence suite that informs our clinical leaders and operational teams of pathway performance • Time stamping the Emergency care, assessment and ambulatory pathways in line with IPS and the introduction of Symphony across the "emergency floor" • Symphony upgrades within the current IT / BI workplan for implementation • Proactive and Trust-owned escalation to mitigate emergency pathway exit block; • Commitment to IPS as a vehicle for improved clinical / quality outcomes for our patients across all pathways; 90 Days • Development of accurate real-time analytics, in conjunction with Site; • Realisation of our Trust vision to become an emergency centre of excellence for our local community;	• Mean ambulance handover time; • ED & Trust IPS compliance; • Emergency Care type 1 standard; • Assessment & ambulatory pathway utilisation; • Assessment & ambulatory pathway response; • Reduction in type 1 adult LOS in ED; • Refer & move procedure (DTA by exception); • Direct conveyance to assessment areas; • CDU utilisation & pathways; • Patient Experience

Measures

- Ambulance Handover
- Type 1 LOS (Adult)
- ED Internal Professional Standards, including F/SDEC
- CDU Utilisation
- Direct conveyance to assessment areas
- Emergency Care Professional Standards (Acute Medicine / Surgery / Frailty)
- Patient FFT

Internal Professional Standards									
	METRIC	Div RO	GREEN	AMBER	RED	BLACK			Live
AMB1	Mean handover time (all)	Kevin	<15	>15	>30	>45	Mins	Median	Y
Stream 1	UTC disposition (all type 1)	Kevin	>35	>30	>25	<25	%		Y
Stream 2	Initial Assessment (adult all)	Alice	<15	<20	<25	>25	Mins	Median	Y
RCEM 1	Time to Treatment (adult all)	Paul	<60	<90	<120	>120	Mins	Median	Y
ED IPS 1	Time to referral (adult referred)	Paul	<120	<150	<180	>180	Mins	Median	Y
MFT IPS 2	Specialty response to decision	Paul	<60	<80	<100	>100	Mins	Median	Y
MFT IPS 2	DTA to admission	Keith	<30	<50	<60	>60	Mins	Median	Y
ED IPS 2	CDU utilisation (per type 1) adult (P3)	Alice	>10	<10	<8	<5	%		
MFT NOF	LoS NOF ED	Dan	<150	>150	>180	>240	Mins	Mean	Y
MFT ECS	Type 1 performance (adult)	Kevin	>90	<90	<85	<80	%		Y
MFT ECS 1	Admitted performance (adult)	Keith	>85	<85	<75	<65	%		Y
MFT ECS 2	Non-admitted performance (adult)	Kevin	>95	>90	>85	<85	%		Y
Acute 1	AAU discharge from bedbase	Paul	>35	<35	<30	<25	%		Y
Acute 2	0 LOS on AAU	Paul	>10	<10	<5	<2.5	%		Y
Acute 3	AAU Transfer to Specialty	Paul	>35	<35	<30	<25	%		
Acute 4	LoS AAU	Paul	<72	>72	>84	>96	Hours	Median	Y
Acute 5	Number of >72hr breaches AAU	Paul	<5	>5	<10	>10	Number		Y
Acute 6	Refer and move admitted performance	Paul	>75	<75	<65	<55	%		Y
Acute 7	Consultant PTWR within 12hrs of admit	Paul	>95	<95	<90	<85	%		
SDEC 1	45 hot patients per weekday	Paul	>45	>40	>35	<35	N=	Mean	Y
SDEC 2	20 hot patients weekend	Paul	>20	<20	<15	<10	N=	Mean	Y
SDEC 3	Follow-up <10 per day	Paul	<10	<12	<15	<18	N=	Mean	Y
SDEC 4	LoS in SDEC	Alice	<4	<5	<6	<7	N=	Mean	Y
SDEC 5	Conversion rate	Paul	<15	<20	<25	>25	%	Mean	Y
SDEC 6	Initial Assessment	Alice	<15	<20	<25	>25			
SDEC 7	Time to Treatment	Paul	<60	<90	<120	>120			
AFU 0	CFS ED compliance >70 years	Alice	>90	<90	<85	<80	%	Mean	
AFU 1	Emerald discharge from bedbase	Paul	>20	<20	<15	<10	%	Mean	Y
AFU 2	Emerald LoS	Paul	<3	>3	>4	>5	N=	Mean	Y
AFU 3	Number of >72 hour breaches	Paul	<3	>3	>5	>6	N=	Mean	Y
AFU 4	Refer and move frailty	Paul		75	<75	<65	<55	%	Mean	Y
AFU 5	Direct conveyance (phase 1) per day	Paul		4	<4	<3	<2	N=	Mean	Y
FSDEC1	CGA within 60 minutes of arrival	Paul	>90		<90	<80	>80	%	Mean	
FSDEC 2	Conversion rate	Paul	<30		<40	<50	>50	%	Mean	Y
FSDEC 3	LoS	Paul	<4		<5	<6	<7	N=	Mean	Y

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Kevin Cairney, Dr Ashike Choudhury, Dr Ashraf Syed, Dr Sanjay Suman,
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Activities completed in last 2 weeks	Activities planned for next 2 weeks
▪ ED high level 'as is' process maps completed ▪ Governance defined and mapped with RO. Clinical and Operational Leads identified ▪ Draft ED Internal Professional Standards (IPS) ▪ Draft Emergency Care Standards and thresholds for escalation published ▪ Draft ED Dashboard development aligned to ED IPS ▪ Engagement with ECIST support to align priorities and resourcing ▪ Project mobilisation for Symphony implementation across the "emergency floor" (ED, SDEC, FSDEC, AAU and FAU)	▪ Mobilise Acute Care Transformation project structure with RO / clinical leads ▪ Complete ED process maps (detailed) ▪ Complete data entry check-points and mapping ▪ Patient experience measures co-design ▪ Progress Symphony implementation project to include SAU ▪ Re-establish ED Consultant Connect with CCG Project Lead ▪ Finalise ED IPS and Emergency Care Standards (UIC) ▪ Draft Emergency Care Standards (PC – Surgery)
Needs & Dependencies	**Risks, Issues & Blockers**
▪ Activity related to development of the ED workforce model to reflect professional standards and national guidance throughout the emergency pathway (support from Workforce stream) Dependencies: ▪ Symphony upgrade, including the implementation into SDEC / FAU ▪ Clinical Summit outcomes alignment into the project plan (Summit date: 05/02/20) ▪ ICP-led Ambulance handover group	Risks ▪ Integrating Emergency Surgical Care Standards promptly to minimise impact on timescales for the delivery of the Symphony mobilisation project ▪ Integration with other plans / deliverables and reporting structures focussed on Emergency Care (including ICP, CQC and other plans)

2. FLOW AND DISCHARGE

Work stream: Discharge & Flow (admission to discharge)
Clinical and operational leads: Tracy Stocker (Ops) & Alison Burrell / Dan West / AHP
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Aims of the work

- Deliver consistent, standardised twice daily inpatient board rounds to optimise acute care for patients who need it (criteria to reside / SAFER) over 7 days and prioritise "day before" and early discharges preparations
- Develop and monitor internal and professional standards to optimise length of stay, timely discharge, including criteria-led discharge (CLD)
- Inform, influence and support out of hospital care, including CoVID Virtual Ward, early supported discharge (RPM, D2A) pathways and admission prevention pathways

Short-term tests of change (PDSA cycles)

30, 60, 90 days

- SAFER Board Round auditing, actions and tests of change including criteria to reside and the optimisation of the principles "home first" and third sector support services (30D)
- Pilot virtual board rounds across Medical, Frailty, Surgical bed base with community partners including IDT (30D)
- Finalisation of pathway and referral process for CVW (30D)
- Extramed optimisation and dashboard development: EDD management, consistent use of clinical / pathway flags, inpatient reports – criteria to reside, medically optimised, discharge pathway (incl. CLD, ESD pathways)(90D)

Long-term priorities and key deliverables

- Clarity of patient pathways from point of admission
- Standardised, improved and clinically-led twice-daily Board Rounds supported with continuous improvement approaches including Red 2 Green, CLD
- Truly integrated discharge services which support effective transfers of care, virtual patient care and prevention of re-admission
- 7 day clinical/operational working across the ICP

How will we know we are successful – and by when (measures and timeframes)

Outcome measures

- Criteria to reside (no. & %)
- Reduction in Acute LoS (G&A / CoVID) including 7D, 14D, 21D+ occupancy
- Overall bed occupancy
- Readmission rates %
- Avoidable harm measures
- Compliance monitoring of internal metrics and professional standards

Process measures

- Outlying patient no.
- Pre-noon discharge %
- Criteria-led discharges%
- Twice daily BR compliance
- Medically optimised no. & %
- Early Supported Discharge (ESD) pathways utilisation (no. & %)

Work stream: Discharge & Flow (admission to discharge)
Clinical and operational leads: Tracy Stocker (Ops) & Alison Burrell / Dan West / AHP
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart

MEDWAY INNOVATION INSTITUTE

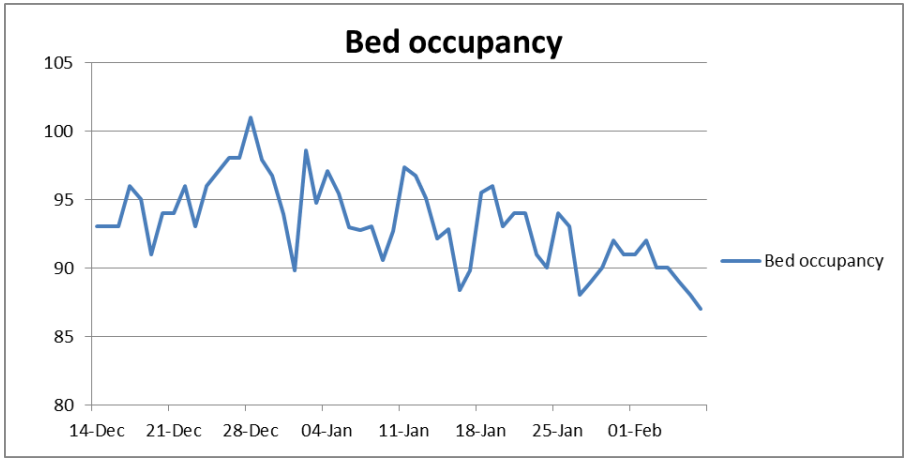
NHS Medway NHS Foundation Trust

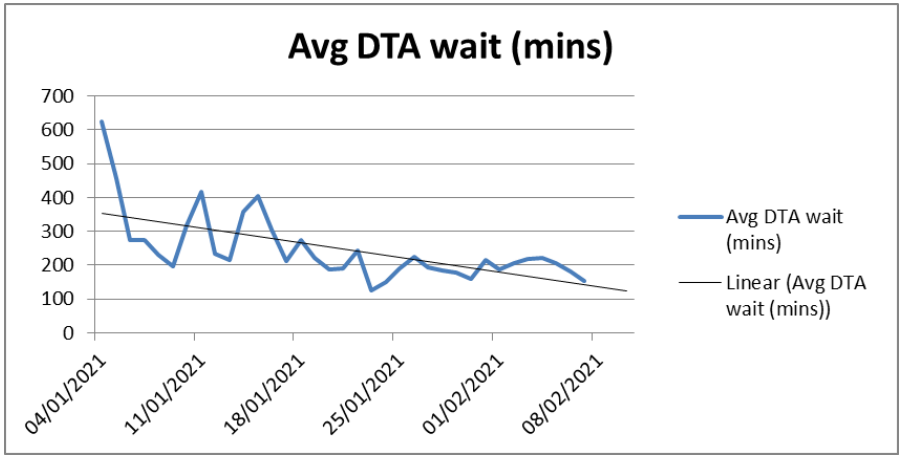
Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Optimise the flow of patients from assessment > inpatient areas as early in the day as possible to reduce pressure and improve patients' experience of care; • Deliver consistent, standardised twice daily inpatient board rounds to optimise acute care for patients who need it (criteria to reside / SAFER) over 7 days and prioritise "day before" and early discharges preparations; • Develop and monitor internal and professional standards to ensure safe, timely discharge (pre-noon where possible), including CLD and ESD pathways; • Improve data completion and quality rates through realignment of roles, virtual BR support and clinical leadership and engagement; • Support the delivery of high quality clinical care with a reduction of outlying patients	• SAFER Board Round auditing, actions and tests of change including criteria to reside and the optimisation of the principles "home first" and third sector support services (30D) • Pilot virtual board rounds across Frailty bed base with community partners including IDT (30D) • Finalisation of pathway and referral process for CVW (30D) • Extramed optimisation and dashboard development: EDD management, consistent use of clinical flags, inpatient reports – criteria to reside, discharge pathway (incl. CLD), IPC status (60 - 90D) • Clarity of patient pathways from point of admission • Standardised, improved and clinically-led Board Rounds supported with continuous improvement approaches including Red 2 Green • Truly integrated discharge services which support effective transfers of care, virtual patient care and prevention of re-admission • 7 day clinical/operational working across the ICP	• Pre-noon discharge % • Criteria-led discharges% • Twice daily BR compliance • Medically optimised no. & % • Early Supported Discharge (ESD) pathways utilisation (no. & %) • Criteria to reside (no. & %) • Reduction in Acute LoS (G&A / CoVID) including 7D, 14D, 21D+ occupancy • Overall bed occupancy • Readmission rates % • Avoidable harm measures • Compliance monitoring of internal metrics and professional standards • Outlying patient no.

Measures

- % Pre-noon discharges
- % Criteria-led discharges
- Medical / Frailty Outliers
- 2 x daily Board Round compliance rates (Measure SAFER)
- Early Supported Discharge (ESD) Pathway utilisation (Homefirst / CVW / RPM) (Pathway 0,1,2,3 flagged on ExtraMed)
- % bed occupancy overall and by no. and % 7D,14D and 21D + (G&A / CoVID)
- Acute LOS by Specialty / Ward linked to Nursing Quality metrics (Harm-free)
- Criteria to reside (no. & %)
- MFFD / Medically optimised (no. & %)
- Complaints, PALS reporting (themes) and learning from incidents

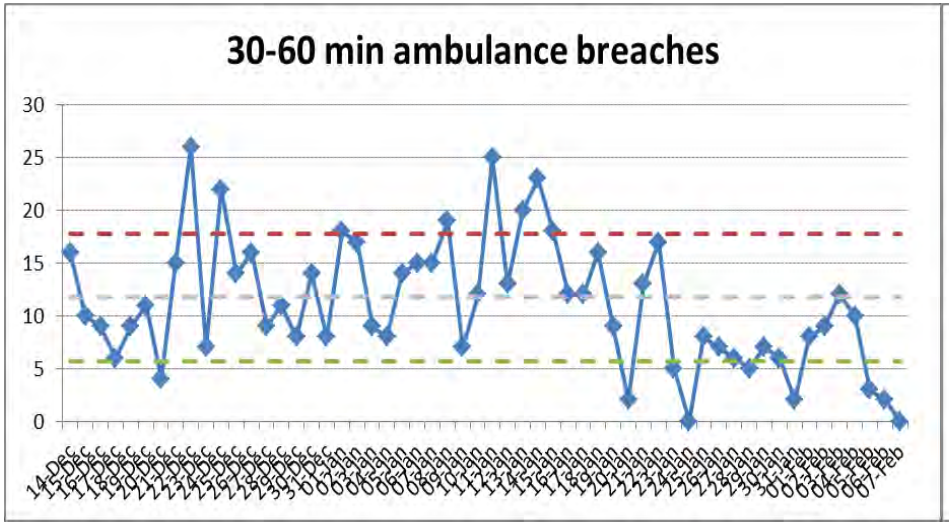
Measures

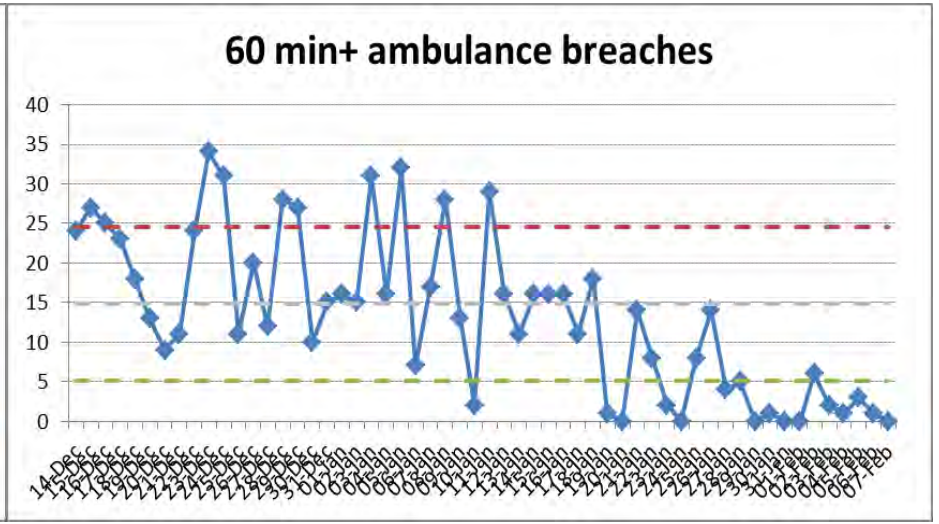




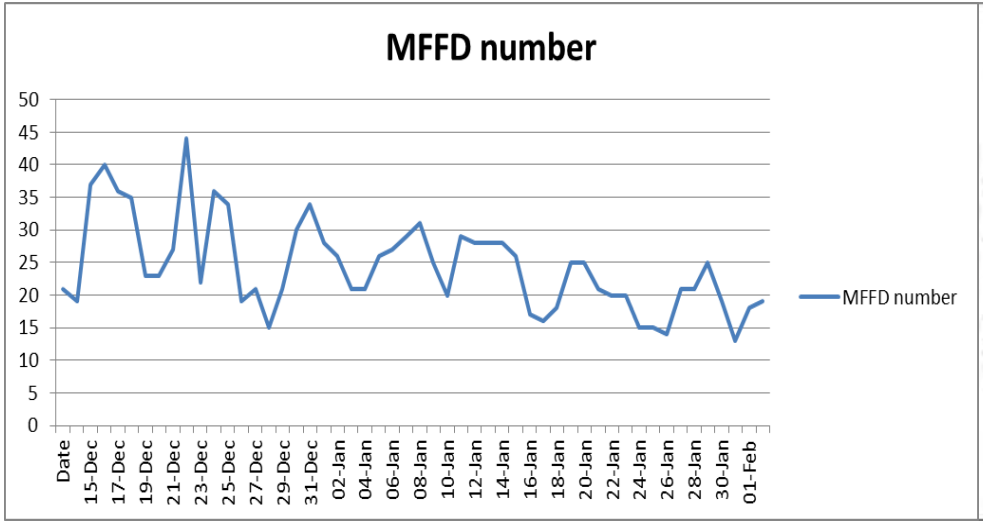
The decrease in bed occupancy has led to a decrease in Decision to admit delays and improved handover delays.

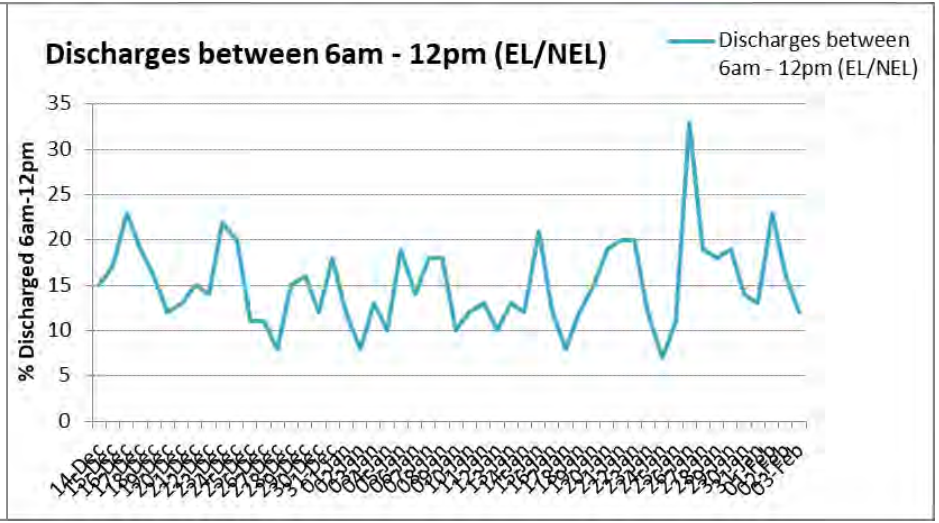
Measures


30-60 min ambulance breaches
30
25
20
15
10
5
0


60 min+ ambulance breaches
40
35
30
25
20
15
10
5
0

Measures


MFFD number
50
45
40
35
30
25
20
15
10
5
0
Date
15-Dec
17-Dec
19-Dec
21-Dec
23-Dec
25-Dec
27-Dec
29-Dec
31-Dec
02-Jan
04-Jan
06-Jan
08-Jan
10-Jan
12-Jan
14-Jan
16-Jan
18-Jan
20-Jan
22-Jan
24-Jan
26-Jan
28-Jan
30-Jan
01-Feb
MFFD number


Discharges between 6am - 12pm (EL/NEL)
Discharges between 6am - 12pm (EL/NEL)
% Discharged 6am-12pm
35
30
25
20
15
10
5
0
14-Dec
03-Feb

Work stream: Discharge & Flow (admission to discharge)
Clinical and operational leads: Tracy Stocker (Ops) & Alison Burrell / Dan West / AHP
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Activities completed in last 2 weeks

- Virtual Board Round (VBR) Audits & mini-MADE events underway
- VBR survey issued to clinical and operational staff to further develop effectiveness of remote attendance
- ECIST support, information gathering and resource alignment
- Clinical System reporting prompt sheets to support improvements in data completion rates
- CoVID Virtual Ward clinical criteria developed and fed into ICP T&F Group
- Draft metrics for improvement developed

Activities planned for next 2 weeks

- Mobilise Flow and Discharge project structure with RO, clinical leads and system partners (use existing ICP structures where relevant)
- Metrics for improvement finalised and mapped to systems, prioritising 'criteria to reside' requirements.
- Report SAFER / Virtual Board Round auditing and agree improvement actions with clinical and operational leads
- Implement Clinical Systems prompt sheets in pilot areas to improve data completion rates
- COVID Virtual Ward review and early successes / improvements
- Define roles and embed Progress Chasers, Virtual bed bureau/ward clerks to support Board Rounds and discharge
- ExtraMed training review and refresh with IT /Clinical Systems support
- Clinical system process mapping guide

Needs & Dependencies

Needs:
- Refreshed Clinical Systems training and support for inpatient teams
- Database development to support CVW activity Dependencies
- ICP working group plans for CVW mobilisation
- Extramed functionality to support IP dashboard for Site

Dependencies:
- On-site / workforce capacity to support SAFER Board Rounds
- System activity on ESD pathways

Risks, Issues & Blockers

- Clinical capacity to engage in board rounds which support pre-noon discharge and day-before preparation
- Capacity to support real-time clinical systems entry from a systems access, hardware and workforce perspective

3. SITE MANAGEMENT

Work stream: Site Management
Clinical and operational leads: Keith Soper (Ops) and Lesley Roberts (Clinical)
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart + ECIST

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Aims of the work

- Define the functions and roles within site management
- Reduce reliance on paper and people through the optimisation of real time clinical systems information
- Develop real-time analysis of the Site flow through the optimisation of dashboards, analysis and senior decision-making in Site meetings
- Demonstrate effective use of the Trust Escalation processes to identify flow pressures and enact clear actions of de-pressurise affected clinical areas
- Support safe, timely flow of patients across the hospital along defined clinical / CoVID pathways
- Optimise VBB and Ward Clerks to ensure real-time bed occupancy positions and utilisation of the Discharge Lounge

Short-term tests of change (PDSA cycles)

30, 60, 90 days

- Revise Trust Escalation documents and action cards with ECIST support and agree with clinical and operational leads (30D)
- Revise Standard Operating Procedures (SOP) within Site (30D)
- Modernise Site Office to enable live data feeds from Clinical Systems
- Redefine attendance at Site Meetings to include Senior decision-making capacity at all Site Meetings (60D)
- Development of clinical / operational dashboards with Clinical Systems and BI that support Site requirements (to be done in conjunction with ACT and Flow and Discharge PF workstreams) (60D).
- Revised site rhythm to prioritise “planning for tomorrow” (90D)

Long-term priorities and key deliverables

- Effective use of the bed management systems to flow patients correctly, optimising LOS and reducing inappropriate or unnecessary ward moves
- Comprehensive site management run via a Command and Control structure encompassing the clinical, operational, estates and support services functions

How will we know we are successful – and by when

Outcome measures

- Senior decision-making attendance at Site Meetings

Process measures

- CoVID Pathway bed downtime
- Non-CoVID Pathway bed downtime
- Time between “time to proceed” and admission to a bed - pending outcome of National Clinical Review of Standards (CRS)

Work stream: Site Management
Clinical and operational leads: Keith Soper (Ops) and Lesley Roberts (Clinical)
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart + ECIST

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Define the functions and roles within site management • Review of Trust Escalation processes, Site Management SOP to establish fitness for purpose • Redefine Site Meeting roles and attendance to ensure senior decision-making is available at all meetings • Systems review and the priorities to enable decision-making within Clinical, Operational, Systems and Estates site management • Safe, timely flow of patients across the hospital along defined clinical / Covid pathways • Optimise VBB and Ward Clerks to ensure real-time bed occupancy positions and utilisation of the Discharge Lounge	30 Days • Upgrade IT equipment and reconfigure Site Office • Audit VBB and Ward-based Ward Clerks to ensure coverage across all relevant clinical areas • Revision of Escalation and Operational policies (Trust-wide and Site management specific) • Improve data completion / accuracy rates in clinical systems to feed the development of clinical / operational dashboards that support Site requirements 60 Days • Redefine roles of Site Meeting attendees to optimise senior decision-making capacity with ECIST-supported workshops • Operationalise Revised Site Management dashboards 90 Days • Revised site rhythm to prioritise “planning for tomorrow”	• CoVID Pathway bed downtime • Non-CoVID Pathway bed downtime • Time between “time to proceed” and admission to a bed - pending outcome of National Clinical Review of Standards (CRS) • Senior decision-making attendance at Site Meetings

Measures

Hot (CoVID) Bed downtime (turnover)

Cold (non-CoVID) Bed downtime (turnover)

Time between “time to proceed” and admission to a bed (defined following national Clinical Review of Standards = CRS)

Senior decision-making attendance at daily Site Meetings

Work stream: Site Management
Clinical and operational leads: Keith Soper (Ops) and Lesley Roberts (Clinical)
Improvement resource: Jacqui Leslie, Charlene Hogg, Jodie Taggart + ECIST

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Activities completed in last 2 weeks	Activities planned for next 2 weeks
▪ Specification of IT hardware and software upgrades completed and underway with IT/ Clinical Systems ▪ ECIST engagement in virtual Site Meetings ▪ Review of paper based/board data and development of electronic documentation ▪ ECIST support, information gathering and resource alignment into project	▪ Additional IT hardware and software installed into site office ▪ Internal site office reconfiguration ▪ Replacement of COVID bed status board with screen ▪ ECIST baselining of current escalation and Site operational processes and appreciative enquiries completed with key stakeholders ▪ Mobilise Site Management project structure with RO / Clinical Lead
Needs & Dependencies	**Risks, Issues & Blockers**
Needs ▪ SAFER Board Round compliance and improvements in data completion rates (Discharge & Flow) ▪ Virtual Bed Bureau review (Discharge & Flow) ▪ BI Dashboard development support aligned to revised escalation processes Dependencies ▪ Emergency Care Standards finalisation and implementation (ED / Ambulance handover) ▪ Symphony upgrades (SDEC / AAU / SAU / FAU)	▪ Data completion and accuracy rates within Clinical Systems to inform site management functions ▪ Capacity within Site Team to engage with project and change fatigue ▪ Role definition and clarity for Clinical Site Management Team ▪ SAFER Board Round compliance and management of criteria to reside

4. WORKFORCE & ORGANISATIONAL DEVELOPMENT

Workstream: Workforce & Organisational Development

Clinical and operational leads: David Hurrell, Clive Evans, Clare Hughes, Ashike Choudhury, Doug McLaren, Ayesha Feroz

Improvement resource: Alex Hayes

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Aims of the work

- Ensure patient-centred care is at the heart of decision making
- Strengthen improvement methodology and management skills to support sustainable change.
- Ensure workforce model reflects professional standards and national guidance throughout the emergency pathway.
- Ensure all colleagues feel valued, empowered and supported to provide safe, high quality care.

Short-term tests of change (PDSA cycles)

30 days

- Agree staff engagement approach for all Patient First workstreams via an agreed engagement plan
- Create Health & Wellbeing Plan specifically for ED
- Review opportunities for professionally qualified staff to work a higher proportion of time at the top of their licence
- Trouble-shoot Band 7 Senior Nurse retention

60 days

- Facilitate staff engagement sessions
- Review practice development support to aid retention
- Review and start implementation of changes so that emergency pathway staffing meets national effectiveness standards
- Begin developing current quality improvement capability
- Support clinical leaders to evaluate past improvement campaigns and lessons learnt
- Instigate monthly staff open forums

60 days+ Long-term priorities and key deliverables

- Benchmarking of workforce development in other Trusts
- Update and refresh workforce strategy for ED

How will we know we are successful – and by when

(measures and timeframes)

NHS Staff Survey

- % confirming frequent opportunities to show initiative in their role
- % confirming able to make suggestions to improve the work of their team / department
- % confirming able to make improvements happen in their area
- % confirming trust definitely takes positive action on health & wellbeing

[2020 results to inform quarterly KPI]

Repeat of B7 Nurse questionnaire

- Do you see the Emergency Department as being Clinically led?

Outputs

- Staff in post in line with national effectiveness standards [Jul 2021]
- Number of engagement sessions – monthly

Workstream: Workforce & Organisational Development
Clinical and operational leads: David Hurrell, Clive Evans, Clare Hughes, Ashike Choudhury, Doug McLaren, Ayesha Feroz
Improvement resource: Alex Hayes

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Engagement/Comms Plan for ED	• 30 Days – by end February 2021	• % said they have frequent opportunities to show initiative in their role.
• Create Health & Wellbeing Plan specifically for ED	• 30 Days – by end February 2021	• % said they are able to make. suggestions to improve the work of their team / department.
• Review the “Managing Your Mind” initiative as a resource for ED.	• 30 Days – be end February 2021	• % said their trust definitely takes positive action on health & wellbeing.
• Engagement events for /Listening Session with Band 7, facilitated by OD.	• 60 Days - by end of March 2021	
• Develop ‘healthy workplace allies’ within existing workforce	• 60 Days – by end of March 2021	
• Support Clinical Leaders in reviewing past improvement campaigns and review QI capability within the department.	• 60 Days – by end March 2021	• % said they are able to make improvements happen in their area of work.
• Review staffing model in ED (in relation to variation in demand and for the opening of new capacity)	• 60 Days – by end March 2021	
• Update and refresh workforce strategy for ED	• 90 Days – by end April 2021	

Best of care Best of people

Our Medway

Measures

The Workforce & Organisational Development workstream will be working with BI to establish appropriate representation of the data to support the measures.

Workstream: Workforce & Organisational Development

Clinical and operational leads: David Hurrell, Clive Evans, Clare Hughes, Ashike Choudhury, Doug McLaren, Ayesha Feroz

Improvement resource: Alex Hayes

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

Activities completed in last 2 weeks	Activities planned for next 2 weeks
• Nursing establishment review in line with national effectiveness standards and for Majors extension • Weekly workstream meetings set up with ED to discuss and gather information about requirements as part of the Patient First initiative include Operational and Care Group leads. • Identification of immediate escalation issues i.e. Band 7 recruitment and retention. • 1:1 meetings with Director of Ops for Unplanned Care to better understand some key issues.	• Draft business case for revised nursing establishment in line with national effectiveness standards and for Majors extension • Agree dates for staff engagement events along with Exec sponsor • Wider comms/engagement plan for ED • Development of a Health and Wellbeing 'local' plan for ED. • Culture & Leadership change team member(s) involvement. • Review of "Managing Your Mind" initiative.
Needs & Dependencies	**Risks, Issues & Blockers**
• HR & OD resource supported by Transformation Programme Manager. • Understanding of the work of the other Patient First workstreams to ensure a consistent and transparent approach in meeting the programme approach and resulting interdependencies.	• Difficulty in achieving staff engagement due to operational pressures. • Awareness and avoidance of duplication of initiatives within the other Patient First workstreams. • Cross over with Trust Improvement Plan programmes of work.