Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting

Date: Thursday, 4 June 2020 at 10:00 – 13:30
Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Acting Chair	Verbal	10:00	Note
1.2	Quorum				
1.3	Conflicts of Interest		-		
1.4	Chief Executive Update	Chief Executive	3		
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 12 May 2020 - Trust Board in Public	Acting Chair	5	10:05	Approve
2.2	Matters arising and actions from 12 May 2020	Acting Chair	15		Discuss
3.	**Governance**				
3.1	Board Assurance Framework	Deputy Chief Executive	17	10:10	Note
4.	**High Quality Care**				
4.1	CQC Action Plan Update	Chief Executive/Interim Chief Nurse	31	10:20	Note
4.2	Covid-19 Update	Chief Executive/Chief Operating Officer	75	10:30	Discuss
4.3	Safe Staffing Nursing Review	Interim Chief Nurse	Verbal	10:45	Approve
4.4	Integrated Quality Performance Report	Deputy Chief Executive	88	10:50	Note
4.5	Quality Assurance Committee Assurance Report	Chair of Committee	119	11:00	Note
4.6	Mortality and Morbidity Update	Medical Director	123	11:05	Note
5.	**Innovation**				
5.1	Trust Improvement Plan	Intensive Improvement Director	135	11:15	Note/ Approve
6.	**Integrated Health Care**				
6.1	Communications and Engagement Report	Director of Coms and Engagement	145	11:30	Note
7.	**Financial Stability**				
7.1	Finance Report - CIP Update	Director of Finance	149	11:40	Note
7.2	Finance Committee Assurance Report	Chair of Committee	167	11:55	Discuss

Agenda

NHS Medway NHS Foundation Trust

Subject		Presenter	Page	Time	Action
8.	**Our People**				
8.1	Workforce Report	Director of HR and OD	169	12:00	Note
8.2	Establishment of the People Committee	Director of HR and OD	177		Note
9.	**For approval**				
9.1	Health and Safety Six Month Report	Director of Estates and Facilities	179	12:30	Approve/ Note
9.2	Trust Board Annual Planner	Company Secretary	189	12:45	Note
10.	**Any Other Business**				
10.1	Council of Governors' Update	Lead Governor	Verbal	12:55	Note
10.2	BAF Reflection	Chair	Verbal	13:05	Discuss
10.3	Any other business	Chair	Verbal	13:20	Note
11.	**Date and time of next meeting: Thursday, 2 July 2020, 12:30 – 15:30, Trust Boardroom**				

Chief Executive's Report – June 2020

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

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

In and around Medway

Over the last month staff at the Trust has continued to rise to the challenge of the COVID-19 pandemic – providing high quality, compassionate care in very challenging circumstances.

I am pleased to say that we are seeing a consistent fall in the number of patients in the hospital with COVID-19, which is really encouraging. We are, of course, watching the numbers carefully, conscious of a potential rise as lockdown restrictions begin to ease.

I am pleased to say we have not had any issues with PPE shortages and our strategic and tactical structure continues to ensure the incident is well managed.

Meanwhile, we are progressing plans to return to a 'new normal', as we consider how and when we will bring patients back for appointments.

Supporting our staff

We do not underestimate the effects that this time of prolonged stress and a new way of life can have on the health and wellbeing of our staff.

That is why we have made many offers, interventions and opportunities available to support their mental health and wellbeing during COIVD-19 and beyond. Support and services available include access to counselling, information on self-help apps and guides and many resources from mental health charities, public health and other national bodies.

We see our staff as members of our family, and we will do absolutely everything we can to provide the support that they require.

Looking to the future

Work is currently underway across the organisation to develop our CQC Improvement Plan and overarching Trust Improvement Plan and we have already made some excellent progress.

Our aim is to ensure that staff and stakeholders are involved in the next stages of development of the plan. This has already begun with a number of staff engagement sessions taking place across the organisation; these have seen good attendance and some good healthy and robust discussion.

Celebrating our nurses and midwives
We were delighted to celebrate our nurses and midwives in May as part of the International Day of the Nurse and Midwife.

We have so much to thank our nurses and midwives for – now more than ever – and while we were sadly unable to come together to celebrate International Day of the Nurse as we would have done under normal circumstances, I hope that all our nursing and midwifery staff know how much they are appreciated and the depth of the gratitude that our community has for them. I was very proud to see the outpouring of support on social media for our nurses and midwives at Medway.

International Clinical Trials Day
It was International Clinical Trials day last month which was a good opportunity for us to recognise our achievements as well as a time to be grateful for the improvements that research has made to public health.

The Research and Innovation team is currently running 136 trials, including six COVID-19 research studies. Three of these are studies which assess interventions and treatments for COVID-19, and this research is so crucial to improving the outcomes for our patients.

Medway joins the world of TikTok
I was pleased to see our communications portfolio increased last month as the Trust officially joined TikTok – the world's fastest growing social media platform. We know how important social media is right now for sharing up-to-date and accurate information about the Trust, and this latest update will help to do exactly that.

Hospital Heroes Lockdown Run
Our charity's annual Hospital Heroes Run at the Great Lines was due to take place in May; however, this had to be cancelled due to the COVID-19 outbreak. So, instead of running as a group, individuals were encouraged to take part in a socially distanced lockdown run.

Despite COVID-19 doing its best to scupper the day, the socially distanced runners (or in some cases walkers!) still managed to raise an incredible £3,000 for charity. We continue to be deeply appreciative of the generous support from our community.

Minutes of the Trust Board PUBLIC Meeting

Tuesday, 12 May 2020 at 11:00 - 12:30, using MS Teams, Online Conferencing

Members	Name	Job Title
Voting:	Jo Palmer (Chair)	Acting Chair
	Adrian Ward	Non-Executive Director
	David Sulch	Medical Director
	Ewan Carmichael	Non-Executive Director
	James Devine	Chief Executive
	Jane Murkin	Interim Chief Nurse
	Leon Hinton	Director of HR and OD
	Mark Spragg	Non-Executive Director
	Richard Eley	Interim Director of Finance
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Gurjit Mahil	Deputy Chief Executive
	Harvey McEnroe	Chief Operating Officer
	Jack Tabner	Director of Transformation
	Jenny Chong	Associate Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Interim Company Secretary
Observing:	Glyn Allen	Lead Governor
	Ian Renwick	NHSEI
	Nye Harries	NHSEI
Apologies:	Rama Thirunamachandran	Academic Non-Executive Director

1 Preliminary Matters

1.1 *Chair's Welcome and Apologies*

The Chair welcomed all present. Apologies for absence were noted as recorded above.

1.2 *Quorum*

The meeting was confirmed to be quorate.

1.3 *Conflicts of Interest*

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

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 5 March 2020 was reviewed by the Board. The minutes of the last meeting were **APPROVED** as a true and accurate record.

Page 17 – Paragraph 9 – John Mitton is the name not Jack – Mark will send over an amendment via email to Alana Almond. {*Post meeting note:* minutes amended 12.05.20}.

Chair informed the Board that David Seabrooke is reviewing/streamlining the Committee and Board attendance. There will be interim changes whist there is an acting Chair. David has also reviewed the roles and responsibilities of Board attendees and has detailed this in the document circulated with the papers for this meeting.

Chair congratulated Mark Spragg on his recent appointment as Deputy Acting Chair and Senior Independent Director. Chair welcomes his support and input.

3 Standing Reports

3.1 Chair's Report

Jo Palmer, Acting Chair, gave a verbal update to the Board.

a) Chair thanked the Board for joining this meeting on MS Teams. It is important for the Board to adhere to Government guidance on social distancing, so making the best use of technology is appropriate on this occasion. The Board wants to ensure there is transparency and the public have been welcomed to the meeting upon request and Glyn Allen, Lead Governor has joined us.

b) Following discussions with the Chief Executive, the Chair decided the Board would have a slimmed down agenda for this meeting, in the hope that it will return to the more comprehensive format in the near future.

c) Chair stated that during this unprecedented COVID-19 situation that every effort has been made to keep Board members up to date about the Trust's strategic incident and how it is being managed to provide assurance about the quality of care being provided to the community. This has included how the hospital is coping in relation to important issues such as critical care capacity, supplies of PPE, screening, and also the statistics of admissions and positive cases, critical care beds, and, more positively, discharges.

d) Chair shared how impressed she and the entire Board have been by the level of leadership shown by James Devine as Chief Executive, Harvey McEnroe as Strategic Commander plus the support from the entire team. It has been an exemplary response to the crisis.

e) Chair asked that an enormous thank you is on record for all staff in the hospital, whether in frontline clinical roles or vital support staff such as porters, housekeepers and catering teams. They have done an amazing job and the local community and entire team recognises and appreciates them. Chair asked for Gary Lupton to pass on the thanks to the teams.

f) Now the team needs to focus on what is next and work to return the hospital to providing surgical and diagnostic services in a managed way. Harvey McEnroe will discuss this today. This also links to the Trust Improvement Plan currently being developed. Ian Renwick is attending today to discuss the framework of improvement. A significant part of the plan relates to the response to the recent inspection by the Care Quality Commission and the report published on 30 April 2020. Chair thanked James Devine and Glynis Alexander on their work on the communications of this.

g) Further to this a thank you to Jane Murkin, our Interim Chief Nurse, for the 'Outstanding' rating for critical care and improvements in other areas. A real achievement and the Board

would like to see this is all areas going forward. Whilst the Board acknowledges there is much to do in many areas, there is so much for the Trust to be proud of too. Well done to those teams whose excellence was noted in the report.

h) David Seabrooke informed the Board on the governance work that had been completed in regard to the Board, its members (voting/non-voting), attendees and observers. David shared the attendance list which set out the roles of each individual. Chair stated that it is important to recognise who makes decisions at meetings. Ewan Carmichael thanked David for the work he is doing and asked that for future development that he explores the addition of the Committee Chairs on to the document. James will share some work that was done recently with David. **Action No: TBPU/20/68:** David Seabrooke to explore the addition of Committee Chairs on the document. James Devine to supply David, with the work completed recently which outlines the structure.

3.2 Chief Executive's Report

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.

3.2.1 James wanted to note the incredible job Trust staff has done, ensuring that the hospital is able to deliver safe, effective and high-quality care, as the country saw the numbers of patients with COVID-19 symptoms rise day after day. The pandemic has seen Medway at its very best; a team of people who have gone far beyond what could have ever been reasonably expected. Currently James, Gurjit and David, are working on how to recognise the contribution staff have made and of course those the Trust and Trusts across Kent, have sadly lost to Covid along the way. The Trust must remember the way in which staff acted with selflessness, compassion, dignity and professionalism during this pandemic. James wanted to thank Ewan Carmichael for his contribution into the planning for staff; his knowledge from his military background has assisted the Trust greatly in these unprecedented times.

3.2.2 James wanted to acknowledge the work of the Charity, not just from a communications perspective but from the Charity team and their interaction with the community. The JustGiving page in a short time has received donations of over £12,000, which has allowed the Trust to buy things such as care packages for staff and also 'essentials' for discharged patients to have when they get home. All these small gestures make such a big difference and the support from the community means so much to staff.

3.2.3 Last month, the Care Quality Commission (CQC) published a report based on its inspection of Medway Maritime Hospital in December 2019 and January 2020. The report rated the Trust as 'requires improvement' – the same as at the last, but with Critical Care raised to Outstanding, and the rating for End of Life Care lifted to Good. The Trust are confident that we now have a strong, talented Executive team working with high calibre Non-Executive Directors to provide the leadership the Trust needs, leading up to the next CQC Inspection.

3.2.4 It was with great sadness that the Trust announced the death Executive Director of Nursing Karen Rule in April 2020. Karen had been a member of the Medway family since October 2014 when she was appointed Deputy Chief Nurse; she then went on to take up the role of Executive Director of Nursing in October 2015. Karen was warmly regarded by all her colleagues on the Board and throughout the Trust. She made a huge difference to the patients and community, playing a key role in helping to bring the Trust out of special

measures and putting quality at the centre of all that the Trust does. She will forever be in our hearts and we will do everything we can to continue her legacy.

3.2.5 In March, the Trust bade farewell to our Chairman Stephen Clark. Stephen showed great commitment to improving the quality of care for patients, and during his tenure oversaw a number of notable achievements. James wanted to thank him personally and on behalf of the Trust and Board, for all he has done for Medway, and wish him well for the future. Jo Palmer will continue as our Acting Chair until a permanent appointment is made.

The Trust also said farewell to one of our Non-Executive Directors, Jon Billings who also came to the end of his term. Those of you that know Jon will be aware that he has been a real advocate for safe, effective and person-centred care, and has been unfaltering in his drive to support the hospital in improving quality of care to the patients. Stephen and Jon were both very passionate in their work for the Trust.

3.2.6 It has been the Board's practice in recent years to entrust the approval of the Annual Report and Accounts to the Integrated Audit Committee. Because of the coronavirus crisis, the Annual Report and Accounts submission dates have been moved back from May into June and the Integrated Audit Committee will be meeting on 22 June 2020, to review the audited draft accounts on the Board's behalf, led by Mark Spragg.

4 Governance

4.1 Board Assurance Framework

Gurjit Mahil, Deputy Chief Executive, explained that the Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives. The Board was asked to note the discussions that have taken place and discuss any further changes required.

4.2 The template has been updated in order to provide further assurance for the mitigations and controls identified for each risk. Each objectives risk will then be discussed at the appropriate Board committee in order to provide the Board with overall assurance.

4.3 Tony Ullman suggested that the BAF be reviewed post Covid. The Board agreed. **Action No: TBPU/20/69:** Gurjit Mahil said that the BAF will be reviewed with her through the Quality Assurance Committee.

4.4 James Devine confirmed that the Business Continuity Plan is being reviewed post Covid. It is a work in progress for Harvey McEnroe but should be complete by the next Board meeting for an update to be given.

4.5 Jack Tabner suggested that the individual BAF risks should be reflected on at the end of each meeting. The Board agreed. Gurjit confirmed that she monitors the deadlines for actions, which are picked up at the appropriate Committee meetings with the Executive Lead.

4.6 The Board NOTED the discussions that have taken place.

5 High Quality Care

5.1 Covid-19 Update

Harvey McEnroe, Chief Operating Officer and Covid-19 Strategic Commander, presented to the Board.

5.1.1 Chair informed the Board that she has asked Harvey to focus on the forward planning at today's meeting; this is not taking anything away from the huge effort that has happened as the work to date has been extraordinary and exemplary. James Devine added that the briefing from the Prime Minister on Sunday 10 May 2020 was likely to impact on how the Trust plans and works going forward.

5.1.2 Harvey McEnroe wanted to thank the Board and entire team for the support he has received; it has been extremely encouraging and kept him positive.

5.1.3 Harvey discussed the content of the paper, with a focus on 'The Three R's' (Page 48 of the pack). Harvey informed the Board on the Exiting Major Incident Response: Restore, Recover, Return to Business As Usual.

5.1.4 James Devine stated that the Winter Planning will have a refreshed approach since the Covid crisis. **Action No: TBPU/20/73:** Harvey will bring this back to the next Board meeting.

5.1.5 Tony Ullman asked as the Trust moves to BAU, there will be a significant amount of in-hospital activity being dealt with elsewhere. How can the Board be assured that the care of the people who are the Trust's responsibility but outside of our care, are still getting high quality care. This issue can be tracked through the Quality Assurance Committee.

5.1.6 Harvey brought to the Board's attention the Ward and Clinical Reconfiguration slide (Page 50 of the pack). This is an ongoing piece of work, by Thursday 14 May 2020 there will be further detail on the options the Trust has going forward. Chair asked that this comes to the Board Covid-19 Update on 28 May 2020. Later it should be submitted to the Quality Assurance Committee for formal approval. It will need sign off by the Estates team and possibly the Finance Committee. **Action No: TBPU/20/72:** Harvey McEnroe to follow this up. Jane Murkin said it would have a quality risk approach to this and NHSEI are supporting the team on this piece of work.

5.1.7 David Sulch informed the Board that 3 – 22% Covid-19 cases have been developed in hospital. The 2 metres social distancing in hospital is harder to achieve with patients beds being so close together. This is a consideration for the reconfiguration; it could mean there is a loss of beds going forward. It is a complex piece of work which requires careful consideration and accurate answers.

5.1.8 Harvey discussed the how the Trust needs to be able to deliver high quality care in a more complex system with several unknowns at this stage. Considerations need to be made whether or not the elective programme is delivered at the hospital or externally and the care home challenge being a risk. Other areas to consider are:

a) New IPC rules
b) Adult Social Care occupancy
c) Future Covid-19 wave workforce resilience and community good will
d) GP referral patterns
e) Access to diagnostics
f) Ending social distancing
g) Regulatory expectations
h) Delivering the CQC and Trust Improvement Plan alongside this work

5.1.9 Harvey will assure the Board at a later date on these areas of consideration. Chair offered the NED input and support to Harvey on this when there are Board Covid updates. Harvey will also populate with the most current data.

5.1.10 Chair asked that the budgets are considered in health and social care, how will these issues be resolved. The care home capacity and deaths are a real concern. A piece of work is needed to demonstrate the challenge in care homes and that patients are not being discharged too quickly. Care Home staff must have the right training and the correct equipment to handle infection.

5.1.11 David Sulch confirmed that a piece of work is being submitted to the Mortality and Morbidity Committee on 15 May 2020 and will be submitted to the Quality Assurance Committee. James Devine added that he needs to start to overlay the SHMI data.

5.1.12 Chair thanked Harvey for his ongoing efforts, she asked that Harvey keep being honest and open about the uncertainties and what needs to be done so the Board can support.

5.2 CQC Action Plan Update

5.2.1 Ian Renwick, Improvement Director, gave an introduction to the improvement plan presentation to give some context on the CQC Improvement Plan. {*Post meeting note:* The presentation was circulated to the Board on 12.05.20}

5.2.2 Jane Murkin, Interim Chief Nurse, informed the Board that the paper contained an updated copy of the CQC – High Quality Care Improvement Plan that was previously shared. The approach taken in developing this draft plan has been structured based on the St Georges Improvement Plan which was recommended by Executive Team members. The draft plan includes the 24 'Must Dos and 19 Should Dos' from the 2020 CQC report, and ongoing actions from the Phase 1 CQC action plan and responses to the Warning Notice Section 29a and Letter of Intent Section 31. The Trust Board was asked to discuss the content of this report.

5.2.3 Meetings have taken place with each responsible Executive Director and relevant responsible leads to further develop and approve the content within the plan and to discuss and define proposed metrics and outcomes. Louise Thatcher (CQC Specialist Advisor) has commenced work with the Central Team to oversee the delivery of the plan. This plan is in draft but the final document will be completed by the end of May 2020. The final version will be submitted to the Board for final sign off at a later date.

5.2.4 The next phase of work to further develop the plan is as follows:

a) Meeting with Divisional triumvirate to share and discuss the plan and ascertain subject matter experts to support delivery of the plan (meeting scheduled for the 6 May 2020)
b) Progress and confirm the resourcing for the Quality PMO to support delivery of the plan and facilitate a workshop with identified staff
c) Work with the Communications Team on producing a finished document.
d) Prepare the draft plan for sharing with external partners

5.2.5 Tony Ullman asked for some clarification to be added to the document which makes a distinction between the 'action plan' and the 'improvement plan', also to understand where the action plan sits in the overall planning.

5.2.6 James Devine confirmed that the aim is to finalise the high level plan then share it with staff so they have input and genuinely are involved in the improvements in their areas.

5.3 Board Assurance – Finance Committee

Jo Palmer, Chair of the Finance Committee, asked the Board to note the report which was taken as read. She gave a verbal update to the Board in regard to the Committee meeting that happened in April 2020.

5.3.1 BAF and strategic risks: The Committee revisited the financial risks at the end of the meeting to determine the extent to which the meeting addressed them. A number of amendments were noted as being required; specifically, the investment risk was felt to be potentially understated, it remains a concern although good progress has been made. The Committee asked that it is noted at the Board.

5.3.2 Cost Improvement Programmes: The Committee noted that there remains a gap to target for 2020/21. The team would normally be further along with this work. CIP planning work was requested to resume following the passing of the peak of the pandemic and it was noted that further operating plan guidance for 2020/21 is awaited.

5.3.3 Committee Work Plan: The Finance Committee Work Plan was reviewed with some amends to be made. It will be signed off at the May 2020 Committee meeting.

5.3.4 Escalation to the Board: The Committee asked for the Capital Investment issue to be escalated to the Board. It will remain an issue for the Board going forward. James Devine informed the Board that Gary Lupton had discussed this with him today and a paper is being drafted for the next Committee meeting in May 2020, which will include the risk of not doing some of those capital investments.

5.3.5 The Board NOTED the report

5.4 Board Assurance – Integrated Audit Committee

Mark Spragg, Chair of the Integrated Audit Committee, asked the Board to note the report which was taken as read. He gave a verbal update to the Board in regard to the Committee meeting that happened in April 2020.

5.4.1 Annual Report and Accounts: Mark informed the Board that the Committee meetings in May 2020 had been cancelled and a meeting to sign off the Annual Report and Accounts is now in the diary for the 22 June 2020.

5.4.2 Valuation Report: Montagu Evans has made reference to a material uncertainty in its valuation report (related to Covid-19) the Trust must provide a disclosure to this effect. The audit opinion on the annual accounts will therefore contain an emphasis of matter referencing this disclosure. This applies to all Trusts nationally. It was confirmed that the valuation remains the best estimate of professionals and is not incorrect.

5.4.3 Stock Take: the Auditors have not been able to present in the hospital so are currently reviewing how assured they can be to sign off the stock levels.

5.4.4 Escalations to the Board: It was recommended that the Board APPROVE the temporary increases to the delegated limits of the Deputy Chief Executive, Associate Director of Procurement and Chief Operating Officer until 31 July 2020. The Board asked why the

amount had been increased by five times the original amount. Mark confirmed that it was due to the availability of people during the pandemic, the temporary increased limits would reduce end of July 2020.

5.4.5 The Board **APPROVED** the short term delegated authority and NOTED the report.

5.5 Board Assurance – Quality Assurance Committee

Tony Ullman, Chair of the Quality Assurance Committee, asked the Board to note the report which was taken as read. He gave a verbal update to the Board in regard to the Committee meetings that happened in March and April 2020.

5.5.1 Tony gave his thanks to Jane Murkin, David Sulch and Harvey McEnroe for keeping the work of the Committee ongoing during the crisis and to others involved. Tony informed the Board that the Committee are complimenting not duplicating the work of the Board.

5.5.2 The Committee are currently concentrating on two things:

1) Return to 'Business As Usual' Phase and how the Trust ensures quality through this process.
2) Impact of the work being taken into the independent sector and ensuring high quality care continues through the system.

5.5.3 EDN Backlog has an amber green rating; there is a need for a robust approach for how this is monitored. James Devine asked the Committee to pick this up at its meeting later today.
Action No: TBPU/20/70: David Sulch to raise this with the Committee

6 Reflection and Any Other Business

6.1 BAF Reflection:
Chair stated the following in regard to the BAF:

a) Add elective work to the backlog
b) Add Covid to the BAF
c) Add Capital position to the BAF
d) Add the Improvement Plan to the BAF and review both the negative and positive effects.
Action No: TBPU/20/71: Gurjit Mahil to update the BAF with these additions and review Item 16, which the Board agreed should be increased from a red rating.

6.2 Glyn Allen, Lead Governor, did not have an update at this meeting but would attend the 4 June 2020 to do so. The Governors wanted it noted that they send their sincere gratitude and thanks to the staff at this time and the level of care they are giving. The Governors and local community are very grateful.

6.3 Chair wished 'Happy Nursing Day' to all the frontline nursing team, it is a well-deserved celebration and they have done an amazing job. Jane Murkin confirmed that all the nursing staff has been given a thank you card and candle to mark the occasion.

6.4 James Devine wanted to note that the IT and Staffing Welfare although not discussed today are included in the papers for this meeting. The Board was content with this.

6.5 There were no further matters of any other business.
6.6 There were no questions from members of the public.

12. Date and time of next meeting

The next meeting will be held on Thursday, 4 June 2020, 09:30 – 13:30, location and type of meeting to be confirmed. The next Trust Board Covid Update will be on Thursday, 28 May 2020, 13:15 – 14:00.

The meeting closed at 12:50

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Tuesday, 12 May 2020

Signed …….. Date …….
Chairman

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
05-Sep-19	TB/2019/030	**Patient Story** Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	03-Sept-20 ~~12-May-20~~ ~~5-Mar-20~~	David Sulch, Medical Director	Update to be submitted in September 2020	White
08-Jan-20	TBPU/20/50	**Safe Staffing Review (Item 4.5)** Update the Board on progress at the next meeting, via Exec and QAC.	04-Jun-20 ~~12-May-20~~ ~~5-Mar-20~~	Jane Murkin, Interim Chief Nurse	Propose to close - paper submitted to Board in June 2020	Green
05-Mar-20	TBPU/20/59	**CQC Update (Item 4.1)** Provide out of site bed capacity information to the Board ASAP, plus bring back a report to the next meeting on the Urgent Care Improvement Plan.	04-Jun-20 ~~12-May-20~~	Harvey McEnroe, Chief Operating Officer Jane Murkin, Interim Chief Nurse	Update at meeting	
05-Mar-20	TBPU/20/60	**Integrated Quality and Performance Report (Item 4.2)** Write a report on the Trusts position on EDNs to go to the Executive Group, then to the QAC and later submit to Board.	02-Jul-20 ~~12-May-20~~	David Sulch, Medical Director	Update to be submitted in July 2020	White
05-Mar-20	TBPU/20/61	**Integrated Quality and Performance Report (Item 4.2)** Inform the Board what three areas will be focused on in terms of quality and performance.	04-Jun-20 ~~12-May-20~~	Harvey McEnroe, Chief Operating Officer	Propose to close	Green
05-Mar-20	TBPU/20/62	**Integrated Quality and Performance Report (Item 4.2)** Update the Board on the timeline for the development of the IQPR at the May 2020 meeting.	04-Jun-20 ~~12-May-20~~	Gurjit Mahil, Deputy Chief Executive	Propose to close - on the agenda	Green
05-Mar-20	TBPU/20/64	**STP Update (Item 6.1)** Provide the Board with the reports on the work that the Trust is doing with locally with system partners via email.	ASAP	Harvey McEnroe, Chief Operating Officer	Propose to close - paper submitted	Green
12-May-20	TBPU/20/68	**Chair's Report (Item 3.1)** Add further information to the attendee list for Board (Committee Chairs etc). James Devine to supply David, with the work completed recently which outlines the full structure.	04-Jun-20	David Seabrooke, Company Secretary Interim	Propose to close - complete	Green
12-May-20	TBPU/20/69	**Board Assurance Framework (Item 4.1)** BAF to be reviewed with post Covid, through the Quality Assurance Committee.	04-Jun-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - Covid to be added throughout the BAF for each objective risk. Covid is on Corporate Risk Register and a separate risk register is in place.	Green
12-May-20	TBPU/20/70	**Board Assurance – Quality Assurance Committee (Item 5.5)** EDN Backlog to be discussed at the Quality Assurance Committee on 12 May 2020	02-Jul-20	David Sulch, Medical Director	Update to be submitted in July 2020	White
12-May-20	TBPU/20/71	**BAF Reflection (Item 6.1)** Update the BAF with additions as discussed (see minutes) and review Item 16, which the Board agreed should be increased from a red rating.	04-Jun-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - complete	Green

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Board Assurance Framework Update**	**Agenda Item**	3.1
Report Author	Gurjit Mahil, Deputy Chief Executive Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	n/a		
Executive Group Approval:	n/a		
National Guidelines compliance:	n/a		
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 – Board Assurance Framework		

1 Integrated Healthcare

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

1a has been updated to include the system partnership work that has been done throughout the current Covid pandemic.

2 Innovation

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

2a/b/c – All assurance levels (1, 2, 3) have been reviewed and updated.

3 Finance

Risk	Initial Score	Current Score	Previous Month Score	Target Score
3a – Delivery of financial control total	4 x 4 = 16 (very High)	3 x 3 = 9 (high)	3 x 4 = 12 (high)	3 x 3 = 9 (high)
3b – Investment for capital for backlog maintenance and EPR	4 x 4 = 16 (very High)	4 x 5 = 20 (High)	4 x 4 = 16 (High)	4 x 3 = 12 (high)
3c – Failure to achieve long term financial sustainability	4 x 4 = 16 (very High)	4 x 3 = 12 (High)	4 x 4 = 16 (high)	4 x 1 = 4 (moderate)
3d – Going concern	4 x 4 = 16 (very High)	4 x 1 = 4 (Very Low)	4 x 1 = 4 (Very Low)	4 x 1 = 4 (Very Low)

BAF risks reviewed in Finance Committee – no further changes.

4 Workforce

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

4a and 4b updated actions with timeframes.

5 Quality

Risk	Initial Score	Current Score	Previous Month Score	Target Score
5a – CQC Progress	4 x 4 = 16 (High)	4 x 4 = 16 (High)	4 x 4 = 16 (High)	2 x 2 (Very Low)
5b – Failure to meet requirements of Health and Social Care Act	4 x 4 = 16 (High)	4 x 4 = 16 (High)	4 x 4 = 16 (High)	2 x 2 (Very Low)
5c – Patient flow – Capacity and demand	3 x 4 = 12 (Moderate)	3 x 4 = 12 (Moderate)	3 x 4 = 12 (Moderate)	2 x 2 = 4 (Very Low)
5d – Quality Governance	3 x 4 = 12 (Moderate)	3 x 4 = 12 (Moderate)	3 x 4 = 12 (Moderate)	2 x 2 = 4 (Very Low)

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

5a has been updated with the relevant CQC action plans and improvement plan actions.

5b has been updated to include to the support secured from the CCG to update all policies.

5c has been updated to include the impact of Covid on the elective flow for our patients.

5d has been updated to include reference to the newly established Risk Assurance Group.

COMPOSITE RISK: Lack of System Integration										
EXECUTIVE LEAD: Deputy CEO and Chief Operating Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance Full, Partial, None**
1a There is a risk that the Medway and Swale system cannot enable true partnership working which designs a long term population based, integrated health and social care system with the patients at its centre. Thus leading to a failure to deliver systems integration, stability and better patient services via the enablement of clinically led patients centred system redesign.	The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) and at a locality level within Medway and Swale that is based on a joint strategic needs assessment. We will therefore not leverage the ability to redesign the system for better quality of care to be provided to those we serve in the short and long term.	**4 x 4 = 16 High**	1. Systems wide strategic vision written in partnership with all organisations. Agreed Intergraded Care Partnership (ICP) model in place with systems partners actively working to mobilise key collaborative elements. 2. Current work through Covid structures is placing a key focus on the system partnerships to ensure timely decision making, for example the reduction in MFFD patients.	Governance arrangements for the Medway and Swale system agreed. Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways.	Regular updates against milestones submitted to Executive and Board of Directors meetings.	Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement Integrated Performance Assurance		**4 x 3 = 12 Moderate**	**3 x 2 = 6 Low**	Partial
			3. The ICPs agreed ambition is as follows and will have detailed population health outcome measures developed as part of the multi-agency development work which will read across to the ICS and ICP Joint Strategic Needs .	1. Monthly Medway and Swale System Delivery Board. a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive. b. Membership is made up of executive from provider and commissioning organisation						

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

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

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

COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Director of Human Resources and Organisational Development										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16** **High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting)	2019-22 People Strategy in place with monitored delivery plans. (Board)		Talent management to support the Trust's successional planning process in early adoption March 2021	**3 x 4 = 12** **Moderate**	**3 x 2 = 6** **Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 13%. 2. Sickness rate 4.2% 3. Substantive workforce 85%					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	Board workforce 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.		Board reporting 1. £6m favourable to ceiling; 2. Averaging 30 breaches per week compared to c1000 in 2016 3. Agency workforce 4% 4. Bank workforce 11%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 117 apprentices of 101 target	Board workforce report – apprenticeship progression and spend					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						

				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4b Staff engagement Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans.	People Committee to commence.		Local survey action plans to be developed and discussed through PRM processes. March 2020-August 2020 People Committee to commence. Quarter 2 2020	**3 x 4 = 12 (Moderate)**	**3 x 2 = 6 (Low)**	
			Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change.	1. You are the difference (YATD) commenced in Q2 18/19, Phase 2 implemented February 2019 2. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme.						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session (December 2018 onwards); c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: c. Trust scores across key domains; d. Comparative results from previous years and other organisations; e. Heat maps for targeted interventions. f. Local survey action plans to address key concerns.	Survey 2018 staff engagement score, 6.4 – lower than average 7						
			Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom to speak up guardian route to Chief Executive; b. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; c. Respect: countering bullying in the workplace policy; d. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place; 4. JSC and JLNC in place.						
			Well-being interventions in place: a. Employee assistance programme and counselling; b. Advice and health education programmes; c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support.	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live.						

			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018.						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans.				**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall StatMan (statutory and mandatory training) compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented). 1. StatMan compliance >92% 2. Appraisal rate >88%						
			Right attitude and values: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance; c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; d. Respect – countering bullying in the workplace policy.	1. VBR in place since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018; 3. Promoting professional pyramid in place, training for peer messengers continuing; 4. Respect policy in place.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.	1. Trust vacancy rate at 13%; 2. Substantive workforce 85%; 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing;						
			Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.						

COMPOSITE RISK: Quality											
EXECUTIVE LEAD: Chief Nurse											
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 being developed	Quality Panel Governance in place fortnightly meetings.	Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board	Internal Audit and External Quality Audit. IPAS Meetings (NHS I/E) CCG Quality Meetings CQC Engagement Meetings	Action plan not yet implemented	Being developed	**4 x 4 = 16 High**	2 x 2 = 4 Very Low	Partial
			2. Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented	Programme of continuous quality improvement: a. Improvement huddles b. Improvement Specialists c. Local improvement Projects	Quality Report and Accounts AGM to take place in September 2020.		CQI training paused since November 2019	Need to review CQI training			Partial
			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Quality strategy c. Ward to board assurance framework in development – currently a gap in control and assurance	New Scorecard developed. Quality strategy priorities reported to QAC	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board.		PRMs for 20-21 not yet taken place Ward to board assurance framework in development – currently a gap in control and assurance	First PRM 27 May 2020. Ward to board assurance framework to be in place 30 June 2020			None at present
			4. Audit and review processes d. Clinical Audit programme and monitoring e. Daily MSA breach reporting and validation f. PLACE, COSHH and environmental audits	Revised Quality and Patient Safety Group Divisional Governance Boards	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial
			5. Central and local oversight of quality g. Complaints management h. Incident management, including Serious Incident (SI) processes and monitoring i. Compliance with Duty of Candour policy and training	Centralisation of the Divisional Quality Governance Teams	Regular reports to the Executive Group.		Compliance with 48 hour SI reporting to StEIS averaging 50%	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	IPC policies, procedures and protocols in place Annual IPC work plan Mandatory IPC training Directorate and programme scorecards with key IPC indicators	Infection Control and Anti-Microbial Stewardship Group meeting (ICAS) Quality Assurance Committee	IPAS (I/E) meeting	Many IPC policies out of date IPC has not met during COVID-19, although IPC discussions taking place in daily Strategic meetings.	Support secured from CCG to update all policies	**4 x 4 = 16** **High**	2 x 2 = 4 Very Low	Partial
5c There is a risk that 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. Integrated healthcare pillar of the Trust Improvement Plan including a Trust Delivery Board. 2. Future Hospital Reconfiguration Plan in development 3. Covid – Strategic Planning processes in place to monitor all hospital activity. a. Elective modelling underway to ensure backlogs are being reviewed. Private provider options being explored. b. Cancer pathways in place with Private providers. c. Outpatients with social distancing and virtual outpatients managed through strategic command.	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used.	External reviews by NHS I/E	Weekly Best Flow Programme Board has not met during COVID-19	Executive to consider if this risk better fits with Integrated Care as per the Trust Improvement Plan	**3 x 4 = 12** **Moderate**	2 x 2 = 4 Very Low	Partial
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	IPAS (I/E) meeting	None	None	**3 x 4 = 12** **Moderate**	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

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	CQC Action Plan & Must Do Should Do Recording Template	**Agenda Item**	4.1
Report Author	Philip Kemp, Associate Director of Quality and Patient Safety (interim)		
Lead Director	Jane Murkin, Chief Nurse (Interim)		
Executive Summary	This paper updates the Trust Board on the progress on the development of the CQC action plan to address the CQC Report published on 30 April 2020. Attached is also the working draft evidence document representing the Must Do and Should Dos and is the formal document for tracking and monitoring progress against via the Quality panel. It also provides the Trust Board with an update on what evidence had been provided and the how many of the Must Dos and Should Dos have been completed so far. The paper also highlights the first date by which the Trust must provide the first update to the Care Quality Commission about the progress taken.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Quality Assurance Committee Date of approval: 26 May 2020		
Executive Group Approval:	Date of Approval: 20 May 2020		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): CQC regulations		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	State whether there are any legal implications		

Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to note the content of this report.			
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices				

1. Executive Summary

This paper updates the Trust Board on the development of the Trust's CQC Action Plan in response to their published inspection report of 28 April 2020.

It also provides the Trust Board with a high level overview of progress to date completion of many of the Must Dos and Should Dos since the inspections in December and a status update on the collation of evidence.

The paper also highlights the first date by which the Trust must provide the first update to the Care Quality Commission about the progress taken.

Development of the CQC Action Plan

In December 2019 and January 2020 the Care Quality Commission (CQC) conducted of an announced and unannounced inspection. The report was published on 28 April 2020.

In responding to the concerns raised the Trust immediately developed an action plan, known as Phase 1 in responding to and in addressing the immediate concerns raised. This included providing a detailed response to the CQC on the immediate actions the Trust had taken to address the safety concerns and provide assurance that the quality of care the Trust provides to the patients is our number one priority.

Subsequently following the Trusts response to the formal warning notices the CQC confirmed no further regulatory action would be taken.

Whilst the initial priority was placed on delivery of the immediate concerns and the must do and should do the focus and approach set out in the CQC action plan will ensure that the changes implemented are embedded into practice to ensure changes are sustained in practice.

Organisations have 28 days to reply to the CQC's findings and in relation to the Regulatory Notices issued. This period expires on 28 May 2020 and a report and response is currently being prepared for the Chief Nurse to review prior to submission following approval by the CE.

2. CQC Action Plan Development

This version is the third draft CQC action plan that has been shared with the Executive Team and has been further developed over the past two weeks. Attached today is also the working draft evidence document representing the Must Do and Should Dos and is the formal document for tracking and monitoring progress against via the Quality panel.

The CQC Action Plan describes:

a) When the inspections took place and the areas which were inspected.
b) What the CQC findings were and actions taken to address immediate concerns including what actions are required to address the concerns raised.

c) These are stated in the form of Must Dos and Should Dos
d) The aims and metrics against each must do and should do
e) The stated aims of the organisation with regards to our CQC improvement journey.
f) The accountable Executive and operational lead
g) The leadership, governance and reporting mechanisms

3. Leadership, Governance Future Actions for Monitoring & Governance

1) The Quality Panel, Chaired by the Chief Nurse is the governance group that will and oversee and monitor the delivery of the CQC Action Plan and will report progress against completion to the Quality Assurance Committee, Trust Board and High Quality Care Programme Board once established, by early June.
2) It will agree the reporting requirements and the monitoring process for business as usual, in addition to agreeing the evidence needed for each of the actions.
3) The Chief Nurse will be writing to Executive colleagues and the Divisional Management teams setting out the reporting requirements against the Must do and Should dos contained within the action plan and evidence requirements for reporting purposes to the Quality Panel.
4) It is anticipated these will include minutes of Divisional Governance Programme board, IPC committee meetings; Divisional Management Team meetings where the CQC action plan related Must dos and Should dos are discussed as formal agenda items, reported on and monitored. This will include evidence of audits, spot checks and quality rounds are discussed.
5) A mock inspection programme will be developed over the next three months to become part of BAU process and will be implemented by the Central Quality & Patient Safety Team CQC team via a series of audits and mock inspections. This is to ensure the adoption of a consistent and regular approach is adopted over time.

4. Summary

1) A final working draft action plans to address the CQC's report findings, including the Must do and should dos has been further developed.
2) Governance and oversight of the delivery of the action Plan is via the Quality Panel Chaired by the Chief Nurse.
3) The working draft evidence document has been developed representing the Must Do and Should Dos and is the formal document for tracking and monitoring progress against via the Quality panel
4) Executives are required to confirm any outstanding operational lead names to enable the plan to be finalised prior to reporting to the next Quality panel meeting.
5) Executives are to ensure the CQC action plan and related Must dos and Should dos are formally reported through divisional governance meetings and other related committees i.e. IPC Committee and Health & Safety.
6) Operational leads for each of the projects will be expected to submit evidence in standardised format on a monthly basis to the panel.
7) The Trust and CQC will receive regular reports on the progress of the Plan.
8) Work is progressing to share the one page projects contained within the plan and the CQC action plan with relevant subject matter experts, divisional leadership teams and other staff across the Trust

NHS
Medway
NHS Foundation Trust

CQC Action Plan

MARCH 2020

Our Medway

Best of care
Best of people

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Executive summary

Medway NHS Foundation Trust comprises a single-site hospital based in Gillingham, Medway Maritime Hospital, serving a population of more than 424,000 across Medway and Swale who rely on the hospital and community services we provide each year. With over 4,400 dedicated staff, we are one of four acute hospital trusts in Kent and Medway.

High quality care is one of the Trust's five strategic objectives set out within our Quality Strategy. The strategic priorities within our Quality Strategy aim to provide consistent high quality care, with an emphasis on continuously improving the safety, quality and experience and ensuring that the care patients receive is evidence based and reliable. Designing quality into every aspect of our services will support the achievement of our quality goals and are a key component of the Trusts quality improvement plan.

Quality at the Trust is defined by the domains of:

- services are safe,
- effective
- person-centred
- while promoting better health and well-being.

To achieve a culture of high quality care we have incorporated five enablers which run through our Quality Strategy:

- An inspirational vision of high quality care
- Clearly aligned goals at every level
- Employee engagement
- Continuous learning and quality improvement
- Team working, cooperation and integration.

A message from James Devine, Chief Executive

As Chief Executive, I see every day the positive impact we have on patients and the communities we serve. This is down to the 4,400 staff who work across our hospital and many community services.

I joined the Trust in 2017 and, while the challenges we face are immense, I am confident we have the skills and desire to make Medway brilliant – and ultimately put us in a position to deliver Best of Care, Best of People.

I have been struck by how much goodwill there is locally, and among the communities we serve, for Medway to succeed. This includes our patients, but also the many partner organisations we work with; this inspires me, and re-emphasises the importance of delivering the improvements we want to make.

Great organisations never think they have reached their goals – they always want to strive to continually improve care. This is the type of organisation I want us to be here at Medway.

This document represents our response to the inspection findings in an action plan aimed at addressing the 'must do' and 'should do' actions. This action plan forms part of the High Quality Care pillar of the Trust's improvement plan aimed at delivering care that is safe, effective and person centred.

Thank you

James Devine
Chief Executive

About the CQC action plan

The plan is the Trust's response to the inspection findings published in the CQC report in April 2020.

The first 12 months of this action plan responds to and will focus on delivery of the 24 must dos and the19 should dos. This plan provides the progress to date and details of the actions the Trust has been taking, in responding to the concerns raised following the inspections and sets out the planned improvement work.

This includes priority areas such as:

- Infection prevention and control
- Nursing standards and practices
- Escalation procedures and processes to ensure patient safety, including the opening and use of escalation areas/wards
- Governance and assurance processes in place to assure ourselves and others of a safe standard of care
- A demonstration of the leadership understanding of the significance and seriousness of the concerns raised
- Clear improvement planning with named leads, timescales, milestones and objective measures to achieve the improvement identified.

While priority is placed on delivery of the immediate concerns and the must do and should do actions, the focus and approach will ensure that the changes implemented are embedded into practice to ensure changes are sustained. The approach and methodology taken will include:

- Building upon the improvements made to date in addressing the immediate concerns raised by the CQC implementing, embedding and sustaining changes which will make the biggest impact in improving the quality and experience of care.
- Involving, and empowering frontline teams to identify, lead and implement changes that will demonstrate improvement
- Having a simple set of measures for improvement to demonstrate impact.

CQC inspection findings December 2019/January 2020

CQC inspection December 2019 / January 2020

During December 2019 the Care Quality Commission (CQC) undertook a planned and two unannounced inspections of the Trust in six Core Services.

The following table indicates the dates of when the CQC inspections occurred at the Trust.

Inspection Visit	Date of inspection
Core Service Inspection involving the following five areas: • Emergency Services • Surgery • Critical Care • Children & Young People • End of Life	3,4,5 December 2019
Unannounced Inspection (medical care core service)	16 December 2019
Well Led Inspection	15 & 16 January 2020
Unannounced Inspection	29 January 2020

Following the unannounced inspection on 17 December 2019 the Trust received a Letter of Intent, Section 31 possible Enforcement notice under the Health and Social Care Act. This related to the findings from the CQC unannounced inspection on the 16 December 2019. The formal letter of intent raised concerns in relation to the care of patients within Dickens Ward.

In responding to and addressing the concerns raised, the Trust immediately developed an action plan. This included providing a detailed response to the CQC on the immediate actions the Trust had taken to address the safety concerns and provide assurance that the quality of care the Trust provides to the patients is our number one priority.

Dickens ward was an escalation ward with patients primarily placed there who were deemed 'medically fit for discharge' (patients who no longer required acute hospital care but may have required additional care, such as rehabilitation, before being safely discharged).

In January 2020 the Trust took the decision to close Dickens Ward and in doing so the Chief Executive and Chief Nurse ensured that patients were safely transferred to an alternative ward or discharged from the hospital.

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

After closure of the ward the CQC did not issue the Trust with the Enforcement Action Section 31 of the Health and Social Care Act (Letter of Intent).

On 19 December 2019 the Trust received a Section 29A Warning Notice under the Health and Social Care Act 2008.

Trust ratings from the CQC 2019/20 inspection

On 30 April 2020, the Care Quality Commission (CQC) published its inspection report for Medway Maritime Hospital following visits to the Trust in December 2019 and January 2020. The CQC disappointingly found a number of significant issues that resulted in an overall rating of 'Requires Improvement' for the services we provide.

Summary and full CQC reports can be found on the CQC website: https://www.cqc.org.uk/provider/RPA

Our ratings for Medway NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency care Services	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020
Medical Care (Including older peoples care)	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Inadequate ↓ Mar 2020	Inadequate ↓↓ Mar 2020	Inadequate ↓↓ Mar 2020
Surgery	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020
Critical Care	Good ↑ Mar 2020	Good →← Mar 2020	Outstanding ↑ Mar 2020	Good ↑ Mar 2020	Outstanding ↑↑ Mar 2020	Outstanding ↑↑ Mar 2020
Maternity and Gynaecology	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Services for Children and Young People	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020
End of Life Care	Good →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020
Outpatients	Good Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Diagnostic Imaging	Requires improvement Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall trust	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020

Our overall rating for Medway Foundation Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Inadequate ↓ Mar 2020	Requires improvement →← Mar 2020

CQC inspection report findings December 2019 / January 2020

In responding to the findings and publication of the report it is important to acknowledge the successes and achievements as well as the areas that require focused improvement work to address the concerns.

Positive findings

- The trust had implemented recruitment and training initiatives to address the lack of medical and nursing staff which meant staffing levels met national guidelines in most areas.
- The services provided mandatory training in key skills to all staff and checked staff completed it. Overall, the majority of staff completed this training.
- The trust employed staff competent to perform their roles and ensured they maintained competency in specialist areas. Most staff had a completed appraisal and met the trust target of 85 per cent for appraisal completion.
- Doctors, nurses and other healthcare professionals generally worked together as a team to benefit patients. They supported each other to provide care.
- Patients, families and carers were generally positive about the care received and we observed compassionate and courteous interactions between staff and patients. In some areas there was a strong, visible person-centred culture. Staff took time to interact with people who used those services and those close to them in a respectful and considerate way, despite pressures in the services.
- Critical care service leaders had an inspiring shared purpose, strived to deliver and motivated staff to succeed. The service had comprehensive and successful leadership strategies to ensure they delivered and developed the desired culture.

Areas for improvement

- The CQC inspection report identified 24 ‘must do’ actions and 19 ‘should do’ actions.
- Action the trust MUST take is necessary to comply with its legal obligations and indicates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust received a Section 29A Warning notice and seven Requirements notices in response to breaches of the following regulations in a number of core services:
- Regulation 10 – Dignity and Respect
- Regulation 12 – Safe care and Treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 14 – Meeting nutritional and hydration needs
- Regulation 15 – Premises and Equipment
- Regulation 17 – Good Governance
- Regulation 18 – Staffing
- Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or improve services.

Developing our CQC action plan

As a result of the core service and well led inspection 2019/20 and in responding to the findings, this CQC action plan has been developed under the leadership of the Chief Nurse, supported by the Associate Director of Quality and Patient Safety. The action plan is subject to robust monitoring arrangements internally by the Quality Panel.

Our CQC action plan is not just a response to the Care Quality Commission's (CQC) Inspection report of April 2020. It also includes the actions that we feel are necessary to provide the communities we serve with safe, effective, and person centred care.

High Quality Care is Medway's fifth core strategic objective set out within the Quality Strategy.

The strategic priorities within the Quality Strategy aim to provide consistent high quality care. The emphasis is on continuously improving the safety, quality and experience of care and ensuring that the care patients receive is evidence based and reliable.

Quality Strategy Domains

☐**Safe** – We will learn when things go wrong and reduce the incidence of hospital acquired harm, creating a culture of safety.

☐**Effective** – We will ensure the right patient is in the right place receiving the best of care and their care is safely transferred between care providers. This will be based on evidence based best practice.

☐**Person Centred Care** – Patients, carers and families will be listened to and supported to meet their needs. Best experiences of care for every person – 'doing with' and not too patients, families and carers.

Leadership and governance oversight of the CQC action plan

The Chief Nurse established the Quality Panel in January to oversee delivery of the immediate actions and the phase one action plan.

Quality Panel aims

- Oversee delivery of the strategic CQC action plan relating to findings from the announced and announced CQC visits and related enforcement notices under Section 29a and Section 31 Letter of Intent.
- Oversee actions related to recovery plans, progress on delivery and hold people to account.
- Tracking and reporting progress both externally to CQC and internally to the Chief Executive, Executive Team and to the Quality Assurance Committee (QAC), a sub-committee of the Trust Board.
- Attendees are divisional leaders, corporate and senior owners of actions and executives as invited.
- The panel has the delegated authority of the Executive Group.

The panel membership includes Executive Leads, Divisional Management Teams, Governance colleagues and external partners.

Our leadership, governance and oversight arrangements of the CQC plan are to ensure the right people take the right actions at the appropriate time.

Phase 1 action plan

In January 2020 all actions originating from the inspection findings, letter of intent Section 31 and 29a Warning notices issued by the CQC were combined into one single central overarching action plan known as the phase one action plan. Delivery of the immediate actions and the action plan was overseen by the Quality Panel chaired by the Chief Nurse.

Phase two CQC action plan

The next phase of our improvement journey has begun with the development of the CQC action plan which will be overseen by the Quality Panel, chaired by the Chief Nurse.

The tracking and monitoring of progress against delivery of the ‘must do’ and ‘should do’ actions will use a standard measure of assessment for each action using a red, amber, green or ‘RAG’ rating system. This will ensure a consistent approach to the tracking and reporting of the overall plan within the Trust and with external partners.

Governance and oversight

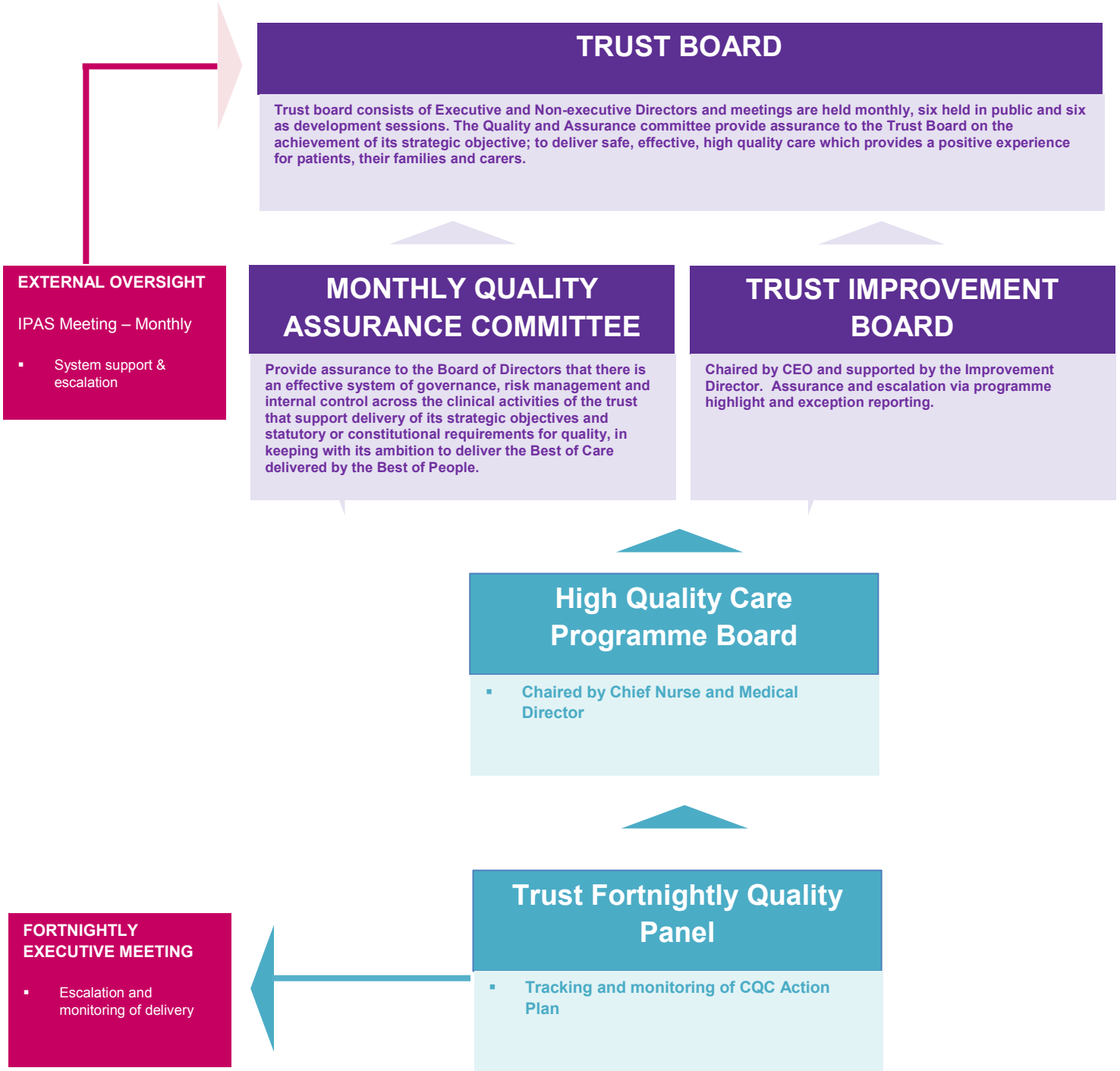
The Quality Panel will continue to meet fortnightly to monitor and oversee the delivery of the CQC action plan and will report progress into the High Quality Care Board (HQCB). The HQCB is one of five programmes that sit within the overarching Trust Improvement Plan.

The following Divisional and organisational groups and committees will also be expected to monitor and track progress against delivery of the CQC action plan

- Divisional Governance Board
- Divisional Management Team
- Trust Infection Prevention and Control Committee
- Health and Safety Committee.

Executive Directors will oversee their operational owners, providing a formal report to the Quality Panel using a standardised template, which will be quality reviewed by the Central Quality Team with a quality assurance assessment of the evidence provided prior to formal reporting to the panel.

Governance structure



Implementing our CQC action plan

The delivery of our CQC action plan will maintain and build on the progress to date in addressing the inspection findings and will ensure the actions will lead to measurable improvements in the quality and safety of care for our patients. Where relevant we will involve patients in the design and delivery of our services so that we better understand what matters to them.

The Chief Executive is ultimately accountable for the implementation of the CQC action plan. The Chief Nurse provides the executive leadership and oversight for the action plan and the Medical Director provides executive leadership for Infection Prevention and Control and will support the Chief Nurse with the delivery of High Quality Care.

This plan will be led by our staff; clinical, operational and corporate services, who will work together to ensure we implement the changes and actions and demonstrate improvements in the safety and quality of patient care.

The Trust is also working closely with NHS Improvement/England through an Improvement Support Director who is supporting the Trust with the implementation of the Trust's Improvement Plan.

To give confidence to our stakeholders, staff and patients that we are making continued improvements, this action plan is underpinned by improvement milestones and metrics to ensure that we can effectively track, monitor and demonstrate progress.

Our plan involves fundamental improvements to services, systems, and processes to ensure we deliver and ensure that we embed and sustain the changes in practice.

CQC action plan Delivery Framework

PROGRAMMES	WORKSTREAMS	PROJECTS			
SAFE & EFFECTIVE CARE	FUNDAMENTALS OF NURSING STANDARDS QUALITY & CARE (MD06, 11, 22, SD04, 06, 07, 08, 17, 18, 19)	Reclaiming Nursing Landscape - Nursing & Midwifery	Pressure Damage	Patient Risk Assessments	
	INFECTION PREVENTION CONTROL (MD01)	Infection Prevention Control			
	CLINICAL SKILLS (MD08, MD24,SD02)	Clinical Skills			
	SAFEGUARDING MCA/DOLS (MD05,WL29)	Safeguarding / MCA / DOLS Compliance	Improvements to Process and Quality		
	COSHH (MD03, MD23)	COSHH Safety			
	EOLC (SD13,SD14,SD15)	EOLC Training	Access to EOLC Specialist		
	SURGERY (SD09)	WHO Checklist			
FLOW & CLINICAL TRANSFORMATION	UNPLANNED CARE (SD01)	ED Majors Patients	Discharge & Process MFFD		
	ACCESS & FLOW (MD02, MD10, MD12, MD14, MD16, MD17)	RTT Performance	Patients in Recovery & Theatre Flow	MSA	Right Patient Right Ward
QUALITY, RISK AND GOVERNANCE	COMPLAINTS MANAGEMENT (SD03)	Improvement to process, Quality & Response Rate			
	INCIDENT MANAGEMENT (WL27,28, 34, 35, 36, 37)	Learning from Deaths	Establish & Sustain Best Practice	Improvement to process, Quality & learning for SI's & Never events	
	CLINICAL RECORDS (MD13, MD19)	Safe, Secure Storage of Records			
	RISK AND CORPORATE GOVERNANCE (MD20,SD16,WL11, 20, 21,25,30)	Corporate Governance	Data / IQPR		
ESTATES & INFRASTRUCTURE	ESTATES & INFRASTRUCTURE (MD04, 07, 15, 18, 21, SD10, WL12)	Estates Strategy	Improve Environment for staff and Patients	Cleaning and Waste Management	
ENGAGEMENT & LEADERSHIP	EXECUTIVE LEADERSHIP (MD09, WL01,02,03,04, 05, 06, 07, 09, 13, 14, 15, 18, 19, 23, 24, 26, 31)	Medical Leadership	Nursing Leadership		
	ENGAGEMENT & CULTURE (SD05, WL10, 16, 17, 22, 33)	Recruitment & Development	Executive Development		
		Exec / Senior Management Engagement	Staff Engagement	Staff Development	

Fundamental Nursing Standards and Quality of Care

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Leads: Karen McIntyre and Simone Hay, Divisional Directors of Nursing

Aim:

- To ensure all patients consistently receive high quality, safe, effective and person-centred care and are not put at risk of avoidable harm.
- To promptly identify changes in a patient's condition and take appropriate action.
- Where relevant ensure all risk assessment and care plans are completed and that local and nationally agreed tools are used.

Standards of care in nursing are important because they recognise the trusted role that a nurse plays. These standards are considered the baseline for quality care.

Inspectors found:

- Services did not audit the National Early Warning Score (NEWS2) tool to ensure compliance.
- Staff did not always complete risk assessments for each patient on admission and arrival to a ward using recognised tools.
- The children's unit was at times taking patients up to the age of 19 and 20 years
- In Medical Care staff did not fully and accurately complete patients' fluid and nutrition charts where needed.
- In Surgery the service did collect safety thermometer data; however, we did not see it displayed on wards or departments.
- On McCulloch ward we saw nine patients did not have their call bell within reach.
- Children's services did not use a nationally recognised tool to monitor children and young people at risk of malnutrition
- The children's unit did not follow the Royal College of Nursing (RCN) guidance for Standards for assessing, measuring and monitoring vital signs in infants, children and young people
- Areas missing within the pre-written care plans used within Dolphin ward. Staff did not complete all care plans on admission and they were dated a few days after the patient had been admitted onto the ward. Evidence found that fluid balance and cannula insertion charts had not been fully completed.

We will:

- MD06 Ensure that risks to patients are identified, documented and regularly reviewed to ensure patients are safe from avoidable harm.
- MD11 Ensure that systems and processes are established and operated effectively to enable the trust to assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity.
- MD22 Ensure there is a clear policy as to the maximum age of young people admitted onto the unit and complete a risk assessment for a young person above the age of 17 admitted onto unit.
- MD23The trust must ensure the doors to the kitchen area on the children's

ward are kept closed at all times and only staff should be able to access the kitchen

- SD04 Ensure that risk assessments are updated, specifically in relation to nutrition and hydration.
- SD06 Ensure that the Planned Care Division monitors compliance with the national early warning score tool.
- SD07 Ensure patient safety information is displayed for patients and visitors to see.
- SD08 Ensure all patients have their call bell within reach.
- SD17 Patients should be assessed by a paediatric dietician and nutritional assessments in place for all patients.
- SD18 Ensure that there is record patient's height and weight on admission to the ward
- SD19 Ensure all staff complete all care plans, assessments and charts in patient records.
- Implement quality and safety Boards on every ward
- Put in place a Ward to Board Quality Standards Improvement and Assurance Framework
- Ensure compliance with risk assessments and fundamentals of nursing care
- Implement a programme of nursing standards audits across the Trust
- Implement a bi-weekly Matrons Quality report to Heads of Nursing/ Midwifery
- Implement a monthly Heads of Nursing/ Midwifery Quality report to the Divisional Directors of Nursing
- Agree the role of perfect ward to support assurance audits
- Implement a monthly Chief Nurse standards quality report from Divisional Directors of Nursing
- Implement the principles of nursing practice setting out what everyone, from nursing staff to patients, can expect from nursing.
- Where relevant ensure all risk assessment and care plans are completed and that local and National agreed tools are used.
- Ensure NEWS 2 audits achieving 90% compliance of audit undertaken
- Ensure robust governance and processes are in place to proactively manage risk assessments.

We will be using a range of indicators to measure this including:

Indicator	Successful when we achieve
Compliance with Nursing Quality audits Year 1 Year 2	 85% 95%
Timely completion of patient level risk assessments and care planning, including the use of 'turn charts'	90%
NEWS 2 audit compliance and appropriate actions taken	90%
Develop and implement a policy as to the maximum age of young people admitted onto the unit and complete a risk assessment for a young person above the age of 17 admitted onto unit	July 2020
Quality Boards will be visible on every ward	August 2020
A Paediatric Dietician will be recruited	September 2020
Nutritional risk assessments will be undertaken for all paediatric In-patients	90%
All patients will have a call bell within reach.	100%
Implement the Royal College of Nursing (RCN) guidance for Standards for assessing, measuring and monitoring vital signs in infants, children and young people	July 2020
Nursing care plans, assessments and charts within the paediatric ward will always be held within in patient records.	90%
All patients (adult and children) who require fluid balance monitoring will have this completed accurately	90%

Infection Prevention and Control

Executive Lead: David Sulch, Medical Director

Operational Lead: Ian Hosein, Director of Infection Prevention and Control

Aim:

- To reduce hospital acquired infections and prevent the spread of infections within the Trust. As part of our everyday duty of care to ensure that no harm is done to patients, visitors or staff.

Inspectors found:

- The service did not control infection risk in line with best practice. Staff did not use equipment and control measures to protect patients, themselves and others from infection
- Staff routinely did not always clean their hands, use personal protective equipment correctly, such as gloves and aprons, manage linen or were bare below the elbows (BBE) in clinical areas in line with trust policy and national guidance.

We will:

- MD01 Ensure all staff are compliant with infection prevention and control practices and procedures, including hand hygiene, and correct use of personal protective equipment PPE.
- Introduce a practical Mandatory Training module to complement the current e-learning module, with each to be taken once every two years.
- Update and implement the existing Infection Prevention and Control Improvement Plan
- Ensure all senior medical leaders undertake ward reviews focused specifically on infection prevention and control in their areas.
- Ensure PPE and BBE audits are undertaken by the Infection Prevention and Control Team.
- Implement the IPC champion initiative Trust wide
- Ensure that IPC audit/assessments and Post Infection Reviews are completed in a timely manner.
- Ensure robust governance and processes are in place to proactively manage IPC processes.
- Ensure that the actions in the IPC Improvement Plan are delivered on time, and that assurance is subsequently obtained to demonstrate that the actions have had the desired effect.

We will use a range of indicator measure this including:

Indicator	Successful when we achieve
Hand Hygiene Audit compliance	**95%**
IPC Improvement Plan – Actions completed and assurance given according to declared timescales	**100%**
Update and implement the Trust IPC improvement Plan	**July 2020**

Clinical Skills

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best and Kevin Cairney Divisional Directors of Operations

Aim:

- Embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training
- Ensure staff complete paediatric life support training

Inspectors found:

- In medical care the 85% target was met for one of the nine mandatory training modules for which medical staff were eligible.
- Paediatric life support training was below the trust target of 85% in children's and young people's services
- In urgent and emergency care
  - 85% target was met for four of the ten mandatory training modules for which medical staff were eligible.
  - 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.
  - 85% target was met for two of the four safeguarding training modules for which medical staff were eligible.

We will:

- MD08 The trust must embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse.
- MD24 Ensure all staff complete paediatric life support training.
- SD02 The Emergency service should ensure that staff are compliant with mandatory training and improve compliance in safeguarding and Mental Capacity Act training
- Monitor compliance of mandatory training via Trust Workforce Reports.
- Achieve 85% compliance in paediatric life support training

We will be using a range of indicators to measure this including:

Indicator	Successful when we achieve
Compliance for all clinical skills training, including safeguarding adult and children, Mental Capacity Act for all relevant staff	85%
Paediatric Life support training	85%
An effective system for monitoring compliance with mandatory training will be embedded	July 2020

Safeguarding

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Bridget Fordham, Head of Safeguarding

Aim:

Patients will be protected from avoidable harm and abuse and statutory safeguarding requirements will be met.

- All staff will receive training on how to recognise and report abuse at the level expected of their roles, as set out by the intercollegiate documents and be able to apply it in practice.
- All staff will understand how to protect patients from abuse and will engage in the necessary safeguarding processes to remove or reduce risk of abuse or neglect.
- Patients will be protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.
- Safeguarding champions will be developed across the Trust, supporting the embedding of safeguarding practices in all areas.

Inspectors found

- The trust failed to notify the Care Quality Commission of safeguarding incidents, where the police had been called.
- Areas around medical care services were unlocked and contained cleaning products hazardous to health, which could be accessed. This is a safeguarding matter however actions pertaining to the safety of products are addressed through COSHH.
- Patients were regularly being brought from the emergency department to wards and placed in a corridor while waiting for their allocated bed to become available and those patients could not call nursing staff for help or have access to drinks. This will be monitored via the Access and Flow one pager.
- Staff did not change patients' positions regularly to reduce the risk of pressure damage. This will be monitored via the Fundamental Nursing Standards and Quality of Care one pager.
- We received information that showed the senior leadership team were aware of the issues on Dickens Ward, including those we identified. These issues had been raised with the senior leadership team in June and July 2019

We will:

- MD05 Ensure that systems and processes are established and operated effectively to prevent abuse of service users.
- The Chief Nurse will commission a Trust wide review of safeguarding
- Ensure that there are robust policies and procedures in place to support and inform staff.
- Ensure that people who use our services are at the centre of safeguarding and are protected from discrimination.
- Ensure that staff have received up-to-date training in all safeguarding subjects, including Prevent and MCA, at levels appropriate to role.
- Ensure that safeguarding adults, children and young people at risk is given sufficient priority in the Trust by ensuring that there are strong governance and reporting structures in place.
- Ensure that staff will take steps to prevent abuse or discrimination that might cause avoidable harm, responding appropriately to any signs

or allegations of abuse and work effectively with others, including people using the service, to agree and implement protection plans.

- Longer term, ensure that there is active and appropriate engagement in local safeguarding procedures and multiagency working such as the Kent and Medway Safeguarding Adults Board, Medway Safeguarding Children's Partnership and the Kent Safeguarding Children's Partnership, PREVENT Boards, MARAC and Community Safety Partnerships
- Ensure that Safeguarding supervision is available for all staff involved in safeguarding cases across the Trust.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Implement systems and processes to prevent abuse of service users	**Sept 2020**
Compliance for safeguarding adult and children training	**85%**
Updated policy and procedure	**Annually with regular review for changes in national policy**
Commission a review of safeguarding	**July 2020**

COSHH

Executive Lead: Gary Lupton, Executive Director of Estates and Facilities

Operational Lead: Paul Norman-Brown, Head of Health and Safety and Compliance

Aim:

- To ensure that premises used by the service provider for the care of patients are safe to use for their intended purpose.
- Ensure that all staff are aware of the need to keep hazardous substances secure and the where relevant all cupboards and doors must be locked to prevent the public from accessing hazardous materials, such as blood and body fluids and chemicals.

Inspectors found:

- Hazardous substances and waste were not stored in line with regulations. Not all areas of the hospital were secure.

We will:

- MD03 Ensure all substances hazardous to health are stored and managed in line with regulations.
- Ensure that all cleaning cupboards, linen stores, sluice rooms and kitchens where relevant are secure.
- Ensure all COSHH products are stored securely
- Ensure education and training is in place informing, instructing and training employees about risks and precautions to be taken
- Ensure that the Trust as an effective procedure and policy
- Ensure effective monitoring/auditing of COSHH compliance is in place

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
All substances hazardous to health are stored in line with regulations	90%

End of Life Care

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Julie Murray, Associate Director of Nursing

Aim:

- Continue to improve the experience for patients and their loved ones at the end of their life.
- Improve compliance with End of Life Care training.

Death and dying are inevitable. The quality and accessibility of this care will affect all of us. Personalised care at end of life will result in a better experience, tailored around what really matters to the person.

Inspectors found:

- End of life care staff said their current arrangement for medical cover worked however a dedicated specialist palliative care consultant would help the service continue improving.
- The service provided training for ward staff in end of life care however, over the past year this had been more limited than the service would have liked.
- The service provided end of life care training in the trust wide induction programme so that all staff had at least an outline of end of life care.
- It is felt due to pressures on the trust as a whole this resulted in a poor attendance at training sessions for end of life care.
- The trust had link nurses and link clinical support workers for end of life care on each ward. Link staff would like more formal training to be able to support their wards more effectively.

We will:

- SD13 Improve greater access to a specialist palliative care consultant.
- SD14 Improve the capacity for delivering end of life care training for staff across the trust.
- SD15 Increase staff attendance at end of life care training courses.
- Ensure all relevant staff are prepared to care for patients at end of life
- Develop and implement a Trust end of life care education and training plan
- Reduce variation and inequalities in end of life care
- Improve outcomes and patient experience for patients at end of life
- Ensure the care people receive, reaching the end of their life, is aligned to their needs and preferences.
- Implement a Trust wide EOL Steering group and work with partners across the system to improve end of life care taking a whole system approach
- Ensure delivery of excellent end of life care
- Monitor compliance of mandatory training via Trust Workforce Reports
- Monitoring compliance with EoLC training for staff across the Trust.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
SLA in place for palliative care (post currently vacant)	August 2020
Develop and implement EoLC Training plan	August 2020
The service will maintain its risk register, so it reflects when risks were last reviewed	May 2020
Compliance for EoLC training	85%

Surgery

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best, Divisional Director of Operations and Simone Hay, Divisional Director of Nursing

Aim:

- To apply the WHO checklist recommendations and the full checklist process and a standard operating process. This will be clinically led and will be overseen via the Divisional governance process.

Inspectors found

- Audit data provided from the briefing and de-briefing stages of the WHO Safer Surgery Checklist only showed data collected from October 2019.

We will:

- MD20 - Introduce systems and processes to proactively identify and address risks to the service.SD09 Ensure compliance with the briefing and de-briefing stages of the World Health Organisation Safer Surgery Checklist.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
The **briefing and de-briefing stages of the World Health Organisation Safer Surgery Checklist** will be consistently applied	**100% compliance**
Observational Audit of WHO checklist practice	**100%**
Review systems and process for identifying risk	**August 2020**
Review and update risk register	**August 2020**

Unplanned Care

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Lead: Kevin Cairney, Divisonal Director of Operations

Aim:

- We aim to reduce the delay for patients who are on admitted pathways in the emergency access pathway. Through a combined programme of work with partners and within the Trust we aim to reduce the aggregated patient delay from decision to admit (DTA) to admission for all medical, surgical and mental health pathways. This will be through the effective use of assessment areas and non-admission pathways, taking full advantage of the Same Day Emergency Care (SDEC) and short stay assessment models at the Trust. We aim to enhance the offer of our SDEC so this runs 12 hours a day, seven day a week. We also aim to move all our receiving teams to the Emergency Department (ED) to work alongside the ED team when reviewing patients for admissions; this will improve patient quality and safety in decision making for admission and will reduce the delay for a decision to admit.
- We aim to ensure the endoscopy unit has the correct numbers of staff to avoid staff working extra hours.

Inspectors found

- During our inspection, multiple patients were receiving treatment, trying to sleep or waiting within the majors waiting area.
- We observed one patient had been in the majors waiting area for over 20 hours and another for 14 hours awaiting specialist review.
- Patients had spent the night in the 'majors lite' waiting room sat on a chair beneath bright hospital lighting.
- The endoscopy unit had 17 members of staff (15 whole time equivalent). This included 14 registered nurses and three clinical support workers. The planned number of staff in the endoscopy unit had not always been achieved, which led to staff having to work extra hours. Staff classified the extra hours worked as 'time off in lieu', however staff reported they had not been able to take back any time, due to the unit being continually short staffed. We looked at the extra hours accrued by 14 of the 17 nursing staff, which ranged from 30 minutes to 27 hours 15 minutes and totalled 169 additional hours that staff had worked. We also noted the senior sister for the unit had worked an additional 70 hours. Working excessive hours can have a detrimental effect on staff physical and mental well-being.

We will:

- SD01 The service should consider how to reduce the length of time patients wait in the majors waiting area, awaiting specialist review or admission.
- SD05 The service should ensure that there are sufficient numbers of appropriately skilled staff to keep patients safe from avoidable harm
- The service will review how best to reduce the length of time patients wait in the majors waiting area, awaiting specialist review or admission.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Reduce the length of time patients wait in majors area awaiting specialist review for admission	July 2020
DTA to admission	**<2 hours**
SDEC usage (7 day services)	**30-40 pts per day**
Triage to referral time	**<1 hour**
Use of Clinical Decision Unit	**20-30 per pts per day**
There are sufficient number of appropriate skilled staff to keep patients safe from avoidable harm	**October 2020**

Access and Flow

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best and Kevin Cairney, Divisional Directors of Operations

Aim:

- Improve the quality of services provided to patient and outcomes for patients by ensuring that delays in the elective and emergency access pathway are addressed through improvements in discharge planning across all inpatient areas, reduction in the delay of admission and improvements in the use of day case.
- By effectively leading this work we will ensure that we reduce harm and improve patient experience, specifically in the areas of Mixed Sex breaches and improvements in patient dignity, which is one of the biggest drivers for flow improvement.

Inspectors found

- Patients are sharing sleeping accommodation with others of the opposite sex. We requested the trust's standard operating procedure for using recovery as an area for escalation. The policy recognised that by nursing patients in a recovery, that patients remain in a mixed sex area, and curtains around bed space to remain pulled if patient prefers and safety allows. The trust has reported no mix sex breaches for the last 12 months for this area. Patients' dignity and respect was compromised when in recovery overnight because of the other patients recovering from surgery in the same room.
- We looked at the patient flow policy (June 2019), which says that patients transferred to Dickens ward should be discharged from there on the day or within 48 hours. All patients admitted to Dickens ward should be 'medically fit for discharge' (MFFD). On the day of inspection, we found patients that had been on Dickens ward for two weeks.
- From October 2018 to September 2019, the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently worse than the England average.
- Between September 2018 and November 2019, 418 patients were in recovery after midnight. The trust target was zero.
- Between September 2018 and November 2019 theatre utilisation for the day surgery theatres was 75% which was less than the trust target of 85%. In the same period, the average theatre utilisation for main theatres was equal to the trust target of 85%.

We will:

- MD02 Ensure we meet the Department of Health and Social Care's standard on eliminating mixed sex accommodation, except where it is in the overall best interests of the patient or reflects the patient's choice.

- MD10 Ensure we have an effective system to ensure only clinically suitable patients were cared for in the escalation areas.
- MD12 Ensure it has effective systems and processes to assess and monitor the risk of harm to patients because of waiting times from referral to treatment and arrangements to admit, treat and discharge patients.
- MD14 ensure that all reasonable steps are being taken to improve the quality of service, specifically in relation to access to treatment and waiting times.
- MD16 Ensure that all reasonable steps are being taken to improve the quality of service, specifically in relation to access to treatment and waiting times.
- MD17 The trust must consider ways to improve patient flow within theatres and recovery.
- SD11 Patient discharges should not be delayed once they are deemed medically ready to transfer to a ward.
- SD12 Out of hour discharges should be avoided in line with the Guidelines for the Provision of Intensive Care Services, 2015.
- Monitoring of Mixed Sex Accommodation Breaches month by month including trajectory
- Graphical and numerical data showing trust performance against constitutional standards.
- Monitoring of Recovery Breaches month by month including trajectory
- Monitoring of Access Performance targets (eg four-hour waits, RTT and theatre utilisation)

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Eliminate MSA	Zero variance against trajectory
Avoid patients staying overnight in recovery	Zero variance against trajectory
Effective systems and processes to assess and monitor the risk of harm to patients because of waiting times from referral to treatment and arrangements to admit, treat and discharge patients will be in place	July 2020
Patient discharges from theatre will not be delayed once they are deemed medically ready to transfer to a ward	June 2020
Out of hours discharges from Critical Care areas will be avoided	Zero variance against trajectory
Use of day case.	20% improvement
MFFD	<30
Time from Decision to Admit to admission	<2 hours
RTT standard	8Ph

Complaints Management

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Philip Kemp, Associate Director of Quality and Patient Safety

Aim:

- Place the patient first and ensure the Trust has a patient friendly complaints process which complies with national guidance.
- Ensure that complaints are responded to in a timely manner, investigated thoroughly and that feedback effectively and systematically for and learning from complaints informs improvement in patient experience.
- Take a person centred approach to complaints management

Patient experience is positive when staff give care that is compassionate, involves patients in decision-making and provides them with good emotional support

Inspectors found:

- From September 2018 to August 2019, the trust received 147 complaints in relation to medicine at the trust (19.3% of total complaints received by the trust). The trust took an average of 35 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be closed within 30 working days.

We will:

- SD03 the Unplanned Care Division should implement an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy. Identify a way to process complaints that improves quality and effectively responds within agreed timeframes
- Undertake a Trust wide review of complaints management across the Trust
- Put the patient first and take a patient friendly and person centred approach to complaints management
- Implement real time patient feedback
- Ensure real time patient experience and feedback is displayed on all wards and clinical areas
- Improve our systems and processes to ensure the Trust has an effective and efficient complaint management service
- Analyse and triangulate complaints data with other quality measures.
- Create a culture of ensuring lessons are learnt from complainants feedback and this is used to improve services
- Ensure that there is evidence to demonstrate that practice has changed following complaints
- Patients are given information about the range of ways they can provide feedback

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Undertake Trust wide review of complaints management	**September 2020**
The Unplanned Care Division will have an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy, including identifying a way to process complaints that improves quality and effectively responds within agreed timeframes	**September 2020**
Patient feedback is displayed on all wards	**September 2020**
Evidence is available to demonstrate changes from lessons learnt and how services have improved	**November 2020**
Compliance with 40 working day complaint response for all amber complaints	**85%**

Incident Management

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Cherrell Taylor, Head of Patient Safety

Aim:

- To ensure that learning from incidents is implemented to reduce the risk of reoccurrence and that lessons and learning is disseminated and shared across the Trust.

- Identifying incidents, recognising the needs of those affected, examining what happened to understand the causes and responding with action to mitigate risks remain essential to improving the safety and quality of patient care in Medway.

Inspectors found:

- There was minimal evidence of learning and reflective practice.
- There was limited assurance that incidents were being reported at all or in a timely manner.
- Evidence demonstrated incidents were not being responded to in a timely way and there was a large backlog of incidents which had not been reviewed.
- There was sporadic innovation or service development, limited application of improvement methodologies, and improvement was not a priority among staff and leaders.

We will:

- WL27 Embed the Serious Incident Management process, including Never Events, to implement a learning and improvement framework.
- WL34 Implement a process of learning and reflective practice from incidents/never events
- WL35 Ensure incidents are reported in a timely manner and responded to promptly
- WL36 Ensure a process is in place to address the incident backlog and monitor and sustain this going forward. Improve analysis of incidents to allow for thematic analysis and identification of recurrent themes
- Develop and implement a Serious Incident and learning framework aligned to national policy by October 2020
- Review current practice and establish minimum standards for low and high level incident reporting and distribution, with improved communication to staff
- Ensure timely investigation of incidents and ensure that the quality of investigations is of a high standard and meets nationally recommended principles
- Design systems to support the needs of those affected from patient safety incidents
- Ensure patients and families are offered the opportunity to participate in SI investigations or share their story and experience
- Take a risk based proportionate approach to investigation of patient safety incidents
- Ensure lessons and learning is disseminated across the Trust
- Ensure all actions from serious incident investigations are completed with evidence provided

- Facilitate a programme of staff forums to share lessons and learning from incidents, investigations and near misses
- Ensure there is a robust process in place to support analysis of incidents and develop thematic divisional reports to inform improvement actions
- Implement a training programme in serious incident investigation management to ensure the Trust has a highly skilled investigation team within the Trust

The following actions appear within the well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

- WL37 The executive team must take a proactive approach to innovation and improvement

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
The Serious Incident Management process, including Never Events, to implement a learning and improvement framework will be embedded	**September 2020**
A process of learning and reflective practice from incidents/never events will be implemented	**July 2020**
Incidents will reported in a timely manner and responded to promptly	**July 2020**
A process is in place to address the incident backlog and monitor and sustain this going forward	**May 2020**
Analysis of incidents to allow for thematic analysis and identification of recurrent themes will be improved.	**June 2020**

Clinical Records

Executive Lead: Gurjit Mahil, Deputy Chief Executive

Operational Lead: Karen Persad, General Manager

Aim:

- To ensure patient care is not impacted by storage, completion or accessibility of clinical records.
- To ensure that staff meet the quality standards so we are able to support safe and effective care.

Inspectors found

- Patients medical care records were stored in trolleys with locks; however, they were found not locked during the inspection. On the surgical assessment unit, 18 sets of patient records were found in an unlocked office. On the post-operative care unit, pre-assessment unit Pembroke ward and McCulloch wards records were within trolleys, but the trolleys were unlocked. In addition, on McCulloch ward records were found left on top of and next to the trolley.

We will:

- MD13 Ensure that medical records and confidential patient information are stored securely to ensure patient confidentiality.
- MD19 Protect our patients by ensuring that records relating to the care and treatment for each patient are kept securely and are an accurate and complete record
- Ensure records are accessible to authorised staff in order that they may deliver, to people, care and treatment in a way that meets their needs and keeps them safe.
- Identify areas of non-compliance for clinical record storage and barriers to compliance
- Review capacity of corporate secure record storage facilities
- Review the audit process for clinical records to improve the quality of clinical records
- Identify training needs for clinical groups and identify feedback forums to support learning
- Agree national and local quality standards so we can track our performance
- Develop action plan for remedial action at area level to enable compliance
- Review the temporary notes process.
- Link in with the Digital strategy for EPR.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Medical records and confidential patient information are stored securely to ensure patient confidentiality.	90%
Records relating to the care and treatment for each patient are kept securely and are an accurate and complete record	90%

Risk and Corporate Governance

Executive Lead: Gurjit Mahil, Deputy Chief Executive

Operational Leads: Gemma Brignall and David Seabrooke

- **Aim:** To handle risk throughout the organisation through effective systems and processes that are used and understood by our staff.
- To ensure that information is provided to our Board to assure them we are operating effectively and our patients and staff are being well cared for.

Inspectors found:

- The risk register did not accurately reflect all the risks we identified.
- The service monitored a range of performance and outcome measures each month. However, we could not always see where action had been taken to address poor performance.
- The End of Life care services risk register showed that one of the three risks had not been reviewed since 2016; however this we did see that this risk that related to staff training had been discussed at the service governance meetings.

We will:

MD20 - Introduce systems and processes to proactively identify and address risks to the service. This is address through the Surgical Project page.

- SD16 The service should maintain their risk register, so it reflects when they last reviewed risks. This is address through the End of Life Care project page.
- Continue to monitor compliance with the risk management policy
- Review all risk register controls and RAG ratings
- Introduce a refreshed version of the Trust Integrated Quality and Performance Report (IQPR) will be available at the May 2020 Board.
- Arrange for regular executive review of risk registers will commence from April 2020. Enable the Board to confirm its current risk appetite at its May 2020 meeting
- Organise monthly executive corporate risk register review meetings first meeting on the 17th of April 2020. The group is to provide oversight to the Executive Group about the effectiveness of corporate compliance and risk management arrangements. Divisional teams will also be required.
- Commence a review of the Board Assurance Framework
- Undertake a review of the Corporate Governance Team Structure

The following actions appear within the well led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality improvement Plan.

- WL11 Review of IQPR
- WL20 Ensure there is a process in place for the board to receive risks/issues and reports on significant information
- WL21 Ensure emerging themes and trends from top risks are presented to the board
- WL25 Ensure corporate risk register is presented to the board on a monthly basis
- WL30 Ensure information used in reporting and performance management is accurate, valid, reliable, timely and relevant

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
WL11 Review of IQPR	**June 2020**
WL20 There is a process in place for the board to receive risks/issues and reports on significant information	**July 2020**
WL21 Emerging themes and trends from top risks are presented to the board	**June 2020**
WL25 Ensure corporate risk register is presented to the board on a monthly basis	**June 2020**
WL30 Information used in reporting and performance management is accurate, valid, reliable, timely and relevant	**Sept 2020**

Estates and Infrastructure

Executive Lead: Gary Lupton, Executive Director of Estates and Facilities

Operational Lead: Paul Vidler, Deputy Director of Estates and Facilities

Aim:

- To address issues with the estate and facilities services to ensure patient and staff safety

Inspectors found

- There were no key coded or swipe access doors to access places other than the paediatric section within the urgent and emergency care department. This meant unauthorised personnel could access all areas.
- Flooring, walls, fixtures, and fittings were not intact on some of the wards visited.
- The trust did not meet National Specifications for Cleanliness in the NHS regarding the frequency of audits in theatres.
- Equipment was not always stored in a way to minimise the risk of cross infection.
- Staff in theatres did not always clean equipment after patient contact to ensure it was safe to use.
- Staff did not always dispose of body fluids quickly to minimise the risk of cross infection.
- The hospital did not have a dedicated paediatric operating theatre or recovery area.
- The design of the medical high dependency unit did not follow national guidance.

We will:

- MD04 Ensure access to the adult emergency department is restricted to only those authorised.
- MD07 Ensure the flooring and walls on medical wards (Wakeley and Arethusa) meet the Department of Health and Social Care Health Building Note 00-09.
- MD15 Ensure they meet with the national specifications for cleanliness on the frequency of cleaning audits carried out in all high-risk areas.
- MD18 Ensure waste is handled in line with national guidelines – relating to Phoenix ward as used disposal gloves in waste bin. Staff understanding of waste segregation. MD21 Ensure children in recovery are not placed next to adults with only a curtain for privacy. Paediatric Strategy currently being developed by Planned Care
- SD10 The service should make sure the high dependency unit meet the minimum bed space dimensions as recommended in national guidance. Part of clinical strategy.
- We will use competent persons to devise and implement compliant solutions for the 'must do' actions, and will address the 'should-do' and 'would-like to do' actions as far as is reasonably practicable.

The following action appears within the Well Led section of the CQC Inspection Report and will be addressed by the Trusts Overarching Quality Improvement Plan:

- WL12 The trust must ensure there is a current Estates Strategy

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Physical and administrative controls in place (two stage strategy is currently being implemented)	Access control system installed, commissioned and staff trained
Refurbishment of Wakeley and Arethusa Wards' floors and walls	Works completed and signed off.
Compliant cleaning audits process in place for theatres	Three months continual audit history
Correct waste segregation in Phoenix Ward	85% staff trained and successful compositional waste audit
Adequate segregation between adults and children in place	Physical or administrative separation achieved
Options appraisal to be undertaken to meet standards in HDU	**Options appraisal completed and considered**

Executive Leadership

Executive Lead: James Devine, Chief Executive

Supported by Ian Renwick, Improvement Director

Aim:

- To ensure our current and future Executive Team and Board are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

We will:

- WL01 All Executive leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL02 The Trust must ensure there is stability in the Executive leadership team
- WL03 Executive leaders must ensure they are able to identify risk and issues described by staff
- WL04 Ensure a programme of board development is in place
- WL05 The Trust must ensure they recruit a company secretary
- WL06 Ensure Non-Executive Directors have a good understanding of their roles and responsibilities
- WL09 Ensure all staff are aware of trust strategies and how their role contributes to achieving the strategy
- WL14 Ensure Executive Team complies with the Trust culture of fairness, openness, transparency, honesty, challenge and candour.
- WL15 Ensure visibility of the Executive Team
- WL19 Ensure the Executive Team are aware of the significance of the regulatory requirements of care and their duty to report significant incidents to the CQC
- WL20 Ensure there is a process in place for the board to receive risks/issues and reports on significant information
- WL23 Ensure Gemba Walkabouts are effective and identify where poor-quality care is being delivered. Ensure results are acted upon and evidenced
- WL25 Ensure corporate risk register is presented to the board on a monthly basis
- WL26 Ensure Executive Team and senior leaders are aware of the process of escalating risks onto the corporate risk register
- WL27 Ensure that the Trust embeds the serious incident management process, including Never Events, to implement a learning and improvement framework
- WL30 Ensure information used in reporting and performance management is accurate, valid, reliable, timely and relevant
- WL31 Ensure data or notifications where required are consistently submitted to external organisations

- WL37 The Executive Team must take a proactive approach to innovation and improvement
- Board effectiveness assessment completed internally by the Trust on a yearly basis and three-yearly by an external accountancy firm
- Ensure Board Development Programme in place

Medical Leadership

Executive and Operational Lead: David Sulch, Medical Director

Aim:

- To ensure our current and future medical leaders are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

We will:

- WL01 All medical leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL14 Ensure that all medical staff adhere to a Trust culture of fairness, openness, transparency, honesty, challenge and candour
- WL28 Ensuring a consistent approach across specialities from learning from deaths
- Development of the Clinical Engagement Strategy with a specific focus on how organisational structures can empower and enhance clinical leadership
- Implantation of Leadership Development Programme
- Reorganise operational structure to ensure that each Division, Care Group and speciality has a single named clinical lead
- Review the results of the recent Medical Engagement Scale exercise and address accordingly
- Develop Clinical Advisory Groups for all critical Trust committees
- Facilitate leadership training both externally and internally for key medical leaders

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Completed and approved Clinical Engagement Strategy	**July 2020**
Medical leadership development programme and strategy	**August 2020**
Review of medical leadership within organisational structure	**June 2020**
Introduction of Medical Cabinet and refresh of Clinical Council	**May 2020**
Relaunch internal professional standards	**June 2020**
There will be a consistent approach across specialities from learning from deaths	**July 2020**

Nursing Leadership

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Katy White, Director of Nursing Quality and Professional Standards

Aim:

- To ensure that the Trust has in place highly visible experienced, empowered, knowledgeable, confident, competent and compassionate nursing and midwifery leaders at all levels, and across all wards, departments, care groups and divisions.
- To ensure that the Trust has nursing and midwifery leaders who can inspire and effectively lead our nurses to deliver consistently high quality care to patients and their loved ones.

Inspectors found:

- Not all nursing and midwifery staff have completed the necessary competency training for their roles.

We will:

- MD09 Ensure nursing staff are appropriately skilled and competent to carry out their roles, to provide safe care, in the medical care.
- WL01 All Nursing leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL07 Launch and implement the Reclaiming Nursing Landscape
- WL13 The trust must ensure there is a current Patient Experience Strategy
- WL18 Ensure patients are referred to by name and not bed numbers or clinical conditions
- WL24 Ensure visibility of Senior Nursing Staff on wards
- WL26 Ensure senior nursing leaders are aware of the process of escalating risks on to the risk registers
- Design and implement a Ward to Board Nursing and Midwifery Assurance Framework
- Design, develop and implement a Nursing Strategy
- Strengthen nursing and midwifery leadership across the Trust
- Renew the reputation of our profession
- Commission and implement a Matron leadership development programme
- Commission and implement a Heads of Nursing leadership development programme
- Implement a Matron unique identifier uniform to support visible leadership
- Ensure all our nurses, midwives and care support staff have a voice and are empowered and enabled to be heard
- Implement a programme of senior nurse forums
- Have a workforce that is fit for the future through the development of a nursing and midwifery workforce, education and training plan which includes roll out of the care certificate for nursing and midwifery support staff
- Continue to implement the Ward Managers Leadership for Quality & Patient Safety programme for all Ward Managers across the Trust
- Revise the Matron and Head of Nursing job descriptions

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Develop a programme of education and training to ensure all nursing and midwifery staff are appropriately skilled for their role	September 2020
Commission and develop leadership programmes for all levels of nursing and midwifery staff in leadership roles	November 2020
Implement Reclaiming the Nursing Landscape	March 2020
Develop a patient experience strategy	Sept 2020
Revisit the 'not just a number campaign'	July 2020
Review the senior nursing and midwifery management structure	Sept 2020
Roll out of training programme to develop senior nursing and midwifery staff on identifying, recording, managing and escalating risks	August 2020
Senior leaders will have ward visits built into their job plans	July 2020

Engagement and Culture

Executive Lead: Leon Hinton, Executive Director of HR & OD

Operational Lead: Lisa Webb, Head of Leadership and OD

Aim:

- To ensure all staff live by our values of being bold; that every person counts; to be sharing and open; and being together through being inclusive and responsible.
- That these values are embedded in our culture, our language, how we carry out our roles, and our behaviours to one another and to our patients.

Inspectors found

- Staff did not feel all leaders where visible accessible and approachable and not all staff felt respected supported and valued.
- Not all services had a culture that provided high quality sustainable care. Services were not always focused on the need of the patients receiving care.
- The Trust strategy had not been translated into meaningful and measurable meaningful plans at all levels of the Trust.

We will:

- Develop our existing leaders with a key focus on developing the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Monitor safe staffing numbers and ensure correct resources demand for skills are met.
- Ensure governance processes are in place to enable progress against delivery of strategies. The CQC highlighted the People Strategy as best practice in layout and the indication of its governance process and measurements. Develop a process whereby all strategies follow this example, this will ensure our strategies dovetail into the CQC Action Plan.
- Measurements of the Trust's culture will be addressed through the Executives and Trust Board meetings. The following areas will be monitored:
    - Staff survey theme progress;
    - Staff Friends and Family Test (FFT);
    - Response rates to the staff survey and the FFT.
- Ongoing and regular review of the culture programmes which have now been running in the Trust since April 2019.
- Monitoring of the engagement of staff attending the NHS England/Improvement culture and leadership programme workshops and listening events.
- Monitoring of the number of staff who anonymously contact the freedom to speak up guardians.
- The introduction of ground rules at start of meetings, this should be a standard agenda item. Stating that only emergency calls can be

answered, behaviours and expectations of the group.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

- WL10 The Trust must ensure progress against delivery of the strategies must be consistently monitored/reviewed and evidence sourced
- WL14 Ensure a Trust culture of fairness, openness, transparency, honesty, challenge and candour.
- WL16 The trust must eliminate silo working across the organisation
- WL17 Ensure all staff are aware of the freedom to speak up guardians and how to contact them
- WL22 Ensure senior leaders are engaged at meetings and not distracted by choosing to read and respond to emails on mobile phones
- WL33 Ensure concerns raised by staff are dealt with especially around bullying and harassment

We will use a range of indicators to measure this including

Indicator	Successful when we achieve
Trust Board, Executive, Divisional reports and papers demonstrate consistency and alignment to relevant strategies	**All papers demonstrate consistent alignment to core strategy delivery**
Trust strategies have clear, defined delivery plans	**Delivery plans in place**
Staff survey score – Equality, Diversity and Inclusion (2019 8.9)	**9**
Staff survey score – Health and Wellbeing (2019 5.6)	**5.9**
Staff survey score – Immediate Managers (2019 6.6)	**6.8**
Staff survey score – Morale (2019 5.8)	**6.1**
Staff survey score – Quality of Appraisals (2019 5.7)	**5.6 (achieving)**
Staff survey score – Quality of Care (2019 7.4)	**7.5**
Staff survey score – Safe environment – bullying and harassment (2019 7.8)	**7.9**
Staff survey score – Safe Environment - Violence (2019 9.4)	**9.4 (achieving)**
Staff survey score – Safety Culture (2019 6.4)	**6.7**
Staff survey score – Staff Engagement (2019 6.8)	**7**
Staff survey score – Team Working (2019 6.6)	**6.6 (achieving)**
Staff survey response rate (2019 41%)	**44%**
Staff FFT recommend as place to work (2019/20 Q4 59%)	**63%**
Staff FFT recommend as place for treatment (2019/20 Q4 68%)	**72%**
Staff FFT response rate	
Staff engagement at NHSEI culture and leadership events	**60%**
Freedom to speak up concerns – raised anonymously	
Freedom to speak up concerns – suffered detriment 0%	**0% (achieving)**
Our existing leaders will be supported to develop the following the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills	**September 2020**

How we will communicate our CQC Improvement Plan achievements

Communications and engagement

Building support for the CQC Improvement Plan requires a genuine culture change. Executive, managerial and clinical engagement and ownership are crucial elements to support successful implementation. Communications to engage all stakeholders in the importance of quality, patient safety and the priorities within this plan must be well conceived and consistently repeated across the organisation with all staff actively involved and engaged in the implementation phase. It will also be important to engage external audiences in progress. The programme will require us to maximise the potential of existing communications channels and create new and bespoke communications and engagement platforms.

Internal Core Channels

- Senior manager briefings
- All staff briefings by the chief executive
- Chief Executive's weekly message
- Staff app
- Monday bulletin to all staff
- News@Medway
- Intranet
- Social media staff groups
- Theme of the Month

External channels

- Community engagement events
- News@Medway magazine
- Member events programme
- Governor engagement opportunities in the community
- Presentations to key stakeholders e.g. local authority scrutiny committees
- MP and councillor briefings
- Media briefings
- Social media
- website

Bespoke and new opportunities

- New branding and strapline to promote the improvement plan
- Suite of materials to engage staff
- Collateral to support external stakeholder engagement
- Website presence
- Greater use of social media channels, beyond Twitter
- Dedicated stakeholder bulletin

Progress as of May 2020

- Scoping of communications strategy to support improvement plan underway
- Branding and strapline options being drawn up.

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Board Update on Trust Response to Covid-19**	**Agenda Item**	4.2
Report Author	Harvey McEnroe – Chief Operating Officer (Accountable Emergency Officer, Trust Strategic Commander – C19 and ICP ICC Strategic Commander – C19)		
Lead Director	Harvey McEnroe – Chief Operating Officer/Strategic Commander		
Executive Summary	- This paper outlines the Trusts current response plans to C19, focusing on our restore and recover programme as well as our wider work with system partners across the ICP and the ICS/STP. - This paper outlines the agreed governance for the Trusts internal C19 response plan and the proposed governance for the ICP C19 response plan, - This paper outlines the proposed model for winter 2020 oversight.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	N/A		
Executive Group Approval:	N/A		
National Guidelines compliance:	N/A		
Resource Implications	Not at present		
Legal Implications/Regulatory Requirements/QIA	N/A		
Recommendation/ Actions required	This paper is to assure the Board and for discussion.		
	Approval ☐	**Assurance** ☒	**Discussion** ☒	**Noting** ☐
Appendices	N/A		

1 Executive Overview

1.1 As the Trust moves to its 'Recovery, Restore and Return' phase of the C19 incident we have taken steps to reconfigure the Trust strategic command structure and the tactical level groups which sit to support the Trust in managing C19.

1.1.1 In line with the ICP, ICS and the STP the Trust has now moved formally to a recovery level which in summary means:

- The restart of elective care
- The restart of diagnostic care
- The restart all cancer pathways
- The reintroduction of face to face outpatient care

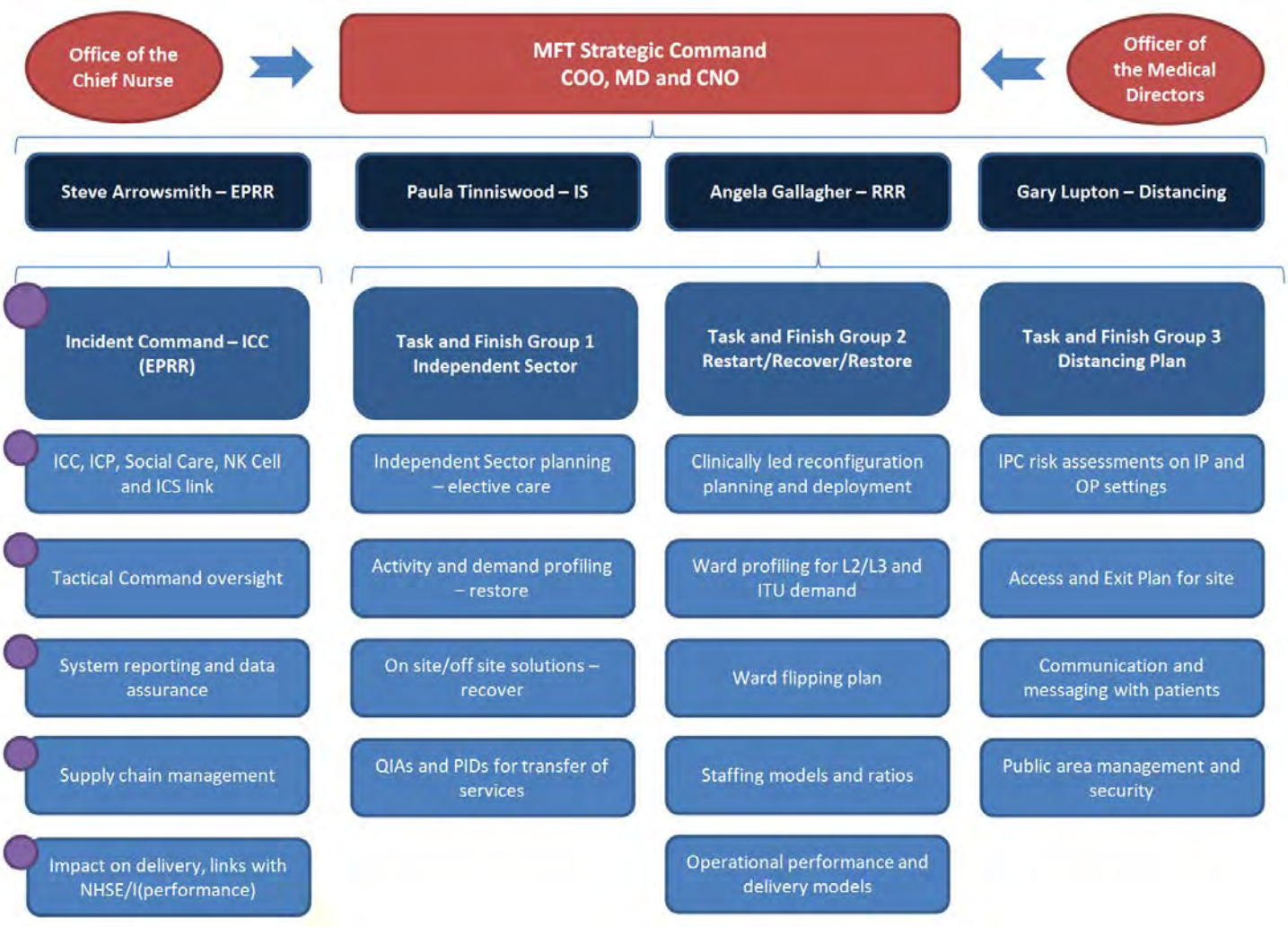
1.2 As we move to the recovery phase and restart the essential services of the Trust, we must also ensure that we manage the C19 incident and the planning for Wave2 and Wave3, along with ensuring that our Trust is compliant with the IPC guidance re; distancing, isolation and swabbing pre elective care.

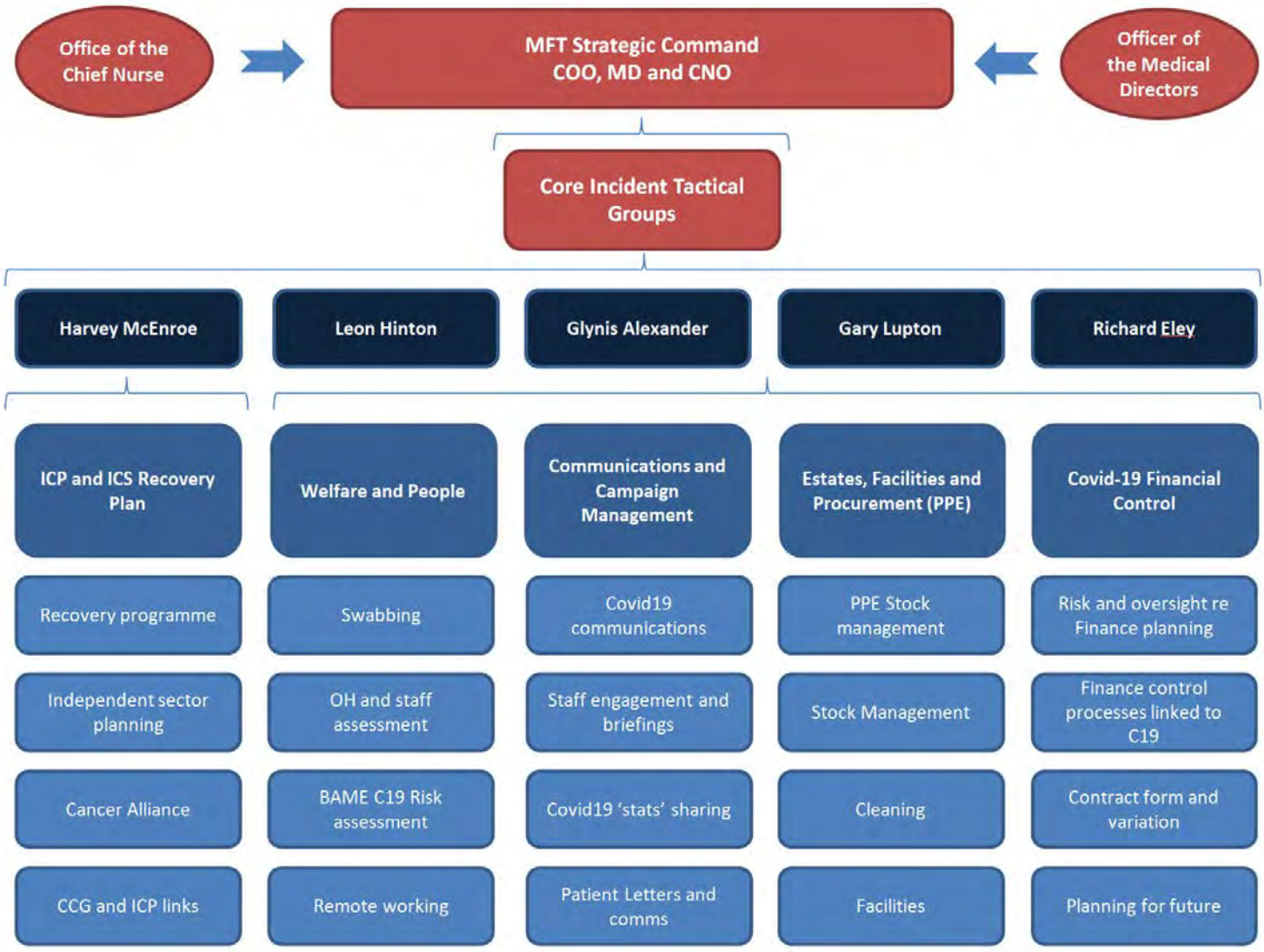
1.2.1 To respond to this complicated set of priorities the Strategic Command is rearranging its focus to work across four key areas of planning and delivery, these being:

- Incident Management in line with EPRR
- The Independent sector plan
- The Recover, Restore and Return plan across emergency care, elective care, cancer care and diagnostics
- The Distancing Plan to move to 2mtr distances for emergency, inpatient and outpatient care

1.3 In addition to these four key focus areas, we will also maintain a set of 'core' tactical groups, which will continue to work across the C19 brief but will not formally report via strategic command moving forward (unless we move back into full incident management).

1.4 The following two diagrams outline the Trusts Covid19 Strategic command structure and the Tactical oversight structure:





2 Recover and Restore Plan – Trust Oversight

2.1 The Trust has established a Task and Finish structure to oversee the recovery and restore phase of the C19 plan. These Task and Finish groups (as outlined above in the executive summary) report formally into the Trusts Strategic Command structure.

2.2 The three T&FGs are:

- The Independent sector Task and Finish Group
- The Recover, Restore and Return Task and Finish Group
- The Distancing Task and Finish Group

2.3 Each group is chaired by a director and has co clinical chair.

2.4 The groups meet a minimum of three times a week and reports into the strategic group via a formal action log. Decision making for action and delivery is delegated to the T&FG chairs and is outlined in the TOR of each group.

2.5 The below diagram outlines the specific areas of focus overseen by each T&FG

2.6 As we design our recovery plan we are considering the impact of our new distancing policies and the impact these distancing rules will have on capacity.

2.7 The 2 meter distancing impact will see approximately 129 beds coming out of the acute site footprint. As at today we are undertaking a full risk assessment of this plan and reviewing how this will impact the Trusts ability to deliver our RTT plan, the Cancer Recovery Plan and our Diagnostics plan. There is also a clear impact on the emergency care pathway ad the flow of patients out of the emergency department which must be considered in the assessment of this plan and the risks therein.

2.8 The RRR T&FG is focused on assessing the operational recovery plan and the ward reconfiguration plan, linked to the distancing policies coming on line via the IPC team. The operational teams are working closely with Angela Gallagher in resetting the operational delivery of our constitutional standards. To date we have not yet agreed what the new trajectories and baseline performance will be, this work is underway with our regulators and the regional ICP team and the CCG

3 Ward Reconfiguration

3.1 The Trust has undergone a full system review of the ward plan, post the C19 closure and compression model was put in place to allow for the growth in Critical Care beds and the reduction in standard attendances.

3.2 The below summary provides a brief update on the position to date (note this is not yet completed and is linked to the above Task and Finish structure)

Phase 1: Hospital Footprint
(28 days – 6 months)

- **Immediate ward changes to safely manage the ongoing COVID demand**
- **Focus on safety, quality and patient experience and what is in the best interests of patients**
- **Ward reconfiguration to build in a residual COVID pathway** alongside Planned & Unplanned Care, including:
  - Patient focus and segmentation
  - Supporting and ensuring safe staffing levels
  - Redeployment of corporate and specialist nursing teams back to pre-COVID roles
  - All ward moves and changes approved by the senior nurse leaders and endorsed by Chief Nurse
  - Adapting the inpatient footprint to seasonal pressures
  - Ward reconfiguration will also need to take account of the following:
    - CQC recommendations and 'must do's' (adhering to advised timelines)
    - Ward refurbishment plans
    - Pre-COVID planned ward/clinic moves e.g. Cath lab, consolidating the HDUs
- **Clarifying the clinical and operational processes** of new pathways, to include robust supporting pathology. Review existing pathology arrangements.
- **Working with community partners** to define the Medically Fit threshold and commit to maintaining this number
- **Using private providers for urgent work during COVID** (e.g. Spire for cancer services, Will Adams for endoscopies, KIMS for cardiology services)
- **Ensure nursing model approved by Chief Nurse) supports governance, quality, safety and safeguarding requirements**
- **Development of Consultant working group** from across the

Phase 2: Patient Focused - Redesigning and improving patient pathways + Innovation
(6 months initial recovery,
up to 24 months full stabilisation)

- **Continued cohesive and collaborative working with the private sector over the coming months, in line with the STP to negate the backlog of routine work (RTT)**
- **Improving patient experience and moving services closer to home**
- **Reducing footfall in outpatient services by 60-80%**
  - Building IT framework to increase virtual outpatient appointments (Attend Anywhere)
  - Rollout of OrderComms to support robust Demand Management programme in line with streamlined pathways and reduced footfall
- **Improve patient flow and reduce hospital occupancy to 92%**
  - To define clinical pathways with community partners to ensure that all diagnostic options are enhanced before referral into the acute setting (e.g. qFIT-endoscopy)
- **Redesigning cancer services** to include placement of a PET-CT scanner on site

Phase 3: Service Transformation
(up to 24 months)

- **Establishing a new GP practice** at periphery of MFT to support patients in the locality, negating the need for non-acute patients to attend MedOCC or ED
- **Establishing partnerships with community providers to host services**, e.g. osteoporosis, frailty (MCH)

3.3 The key priorities established for the recon work, designed by the medical and nursing tactical teams were:

3.3.1 Maintenance of close links between critical care and respiratory medicine in anticipation of further waves of COVID-19

- Long-term footprint of Respiratory services
- How Critical Care and Respiratory will work together to look after a greater number of patients requiring intensive care

3.3.2 Colocation of specialty wards:

- Critical care: ITU & HDUs
- Cardiology: Inpatient ward, CCU, Cath Lab & diagnostic areas
- Respiratory: Inpatient ward, MHDU & diagnostic areas
- Surgery: Inpatient wards & Theatres
- Front door: ED, Assessment wards & Investigative areas

3.3.3 Provision of mixed-sex wards for Diabetes / Endocrinology and Gastroenterology

3.3.4 Preservation of SAFU for use as a swing ward to permit ward refurbishment work (as per CQC recommendations)

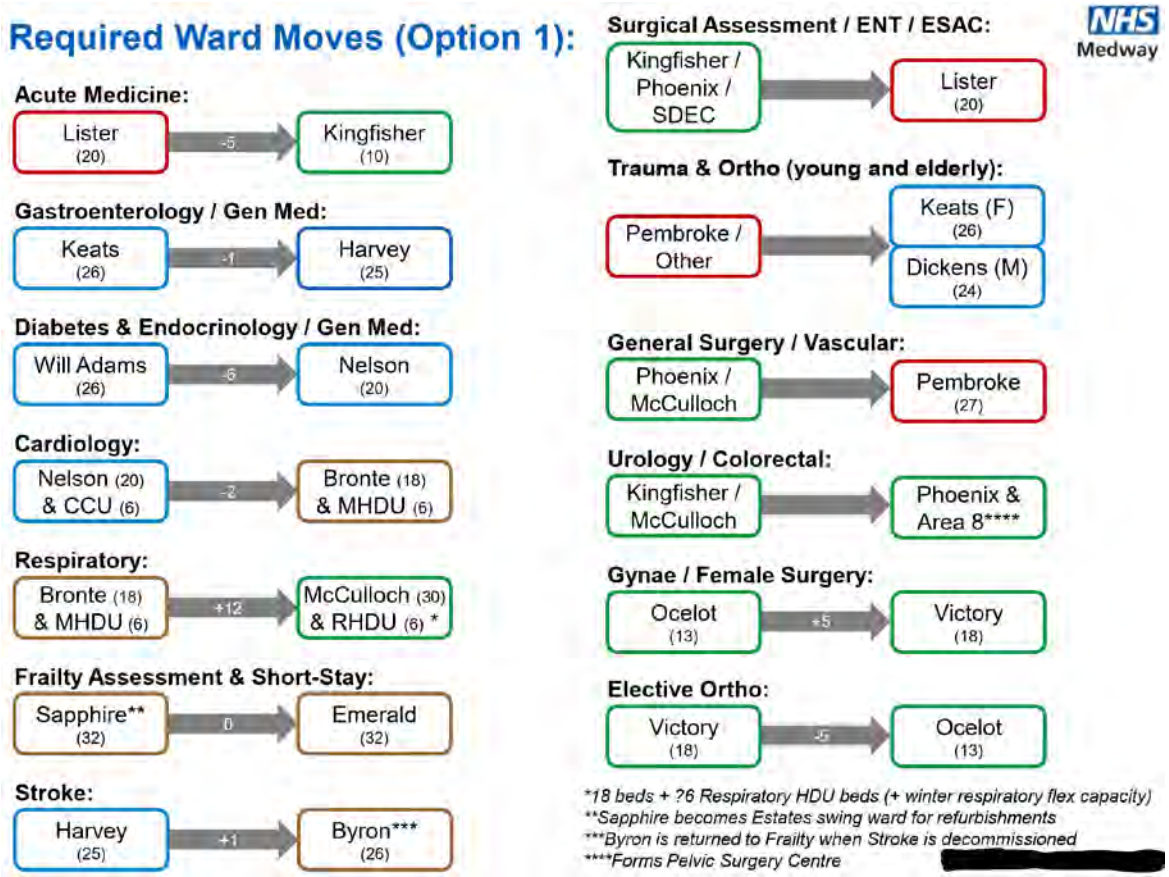
- Initially: Wakeley, Arethusa and Harvey (MDs from CQC)

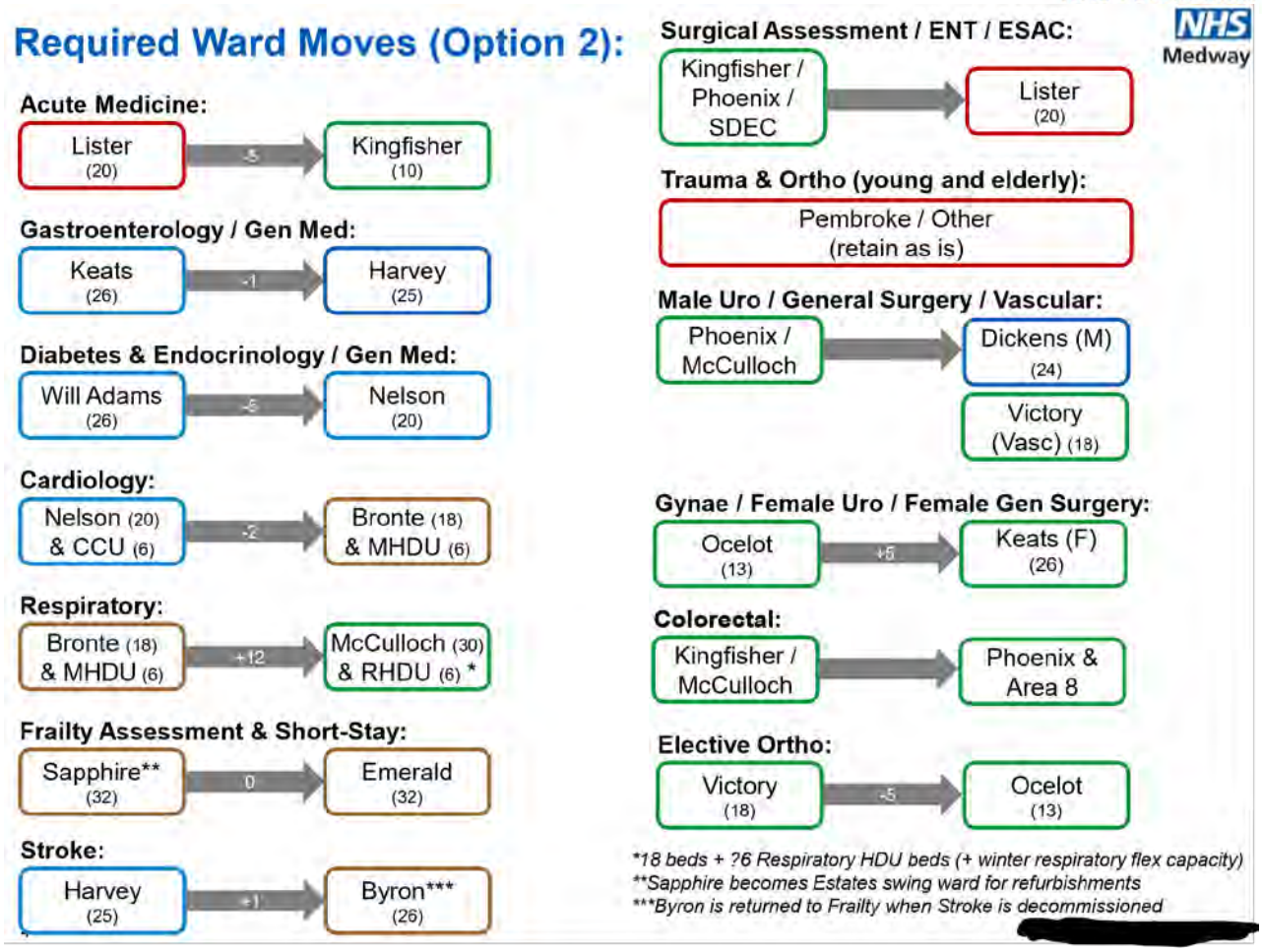
- Longer terms: All wards for fire system remedial work (Estates ambition)

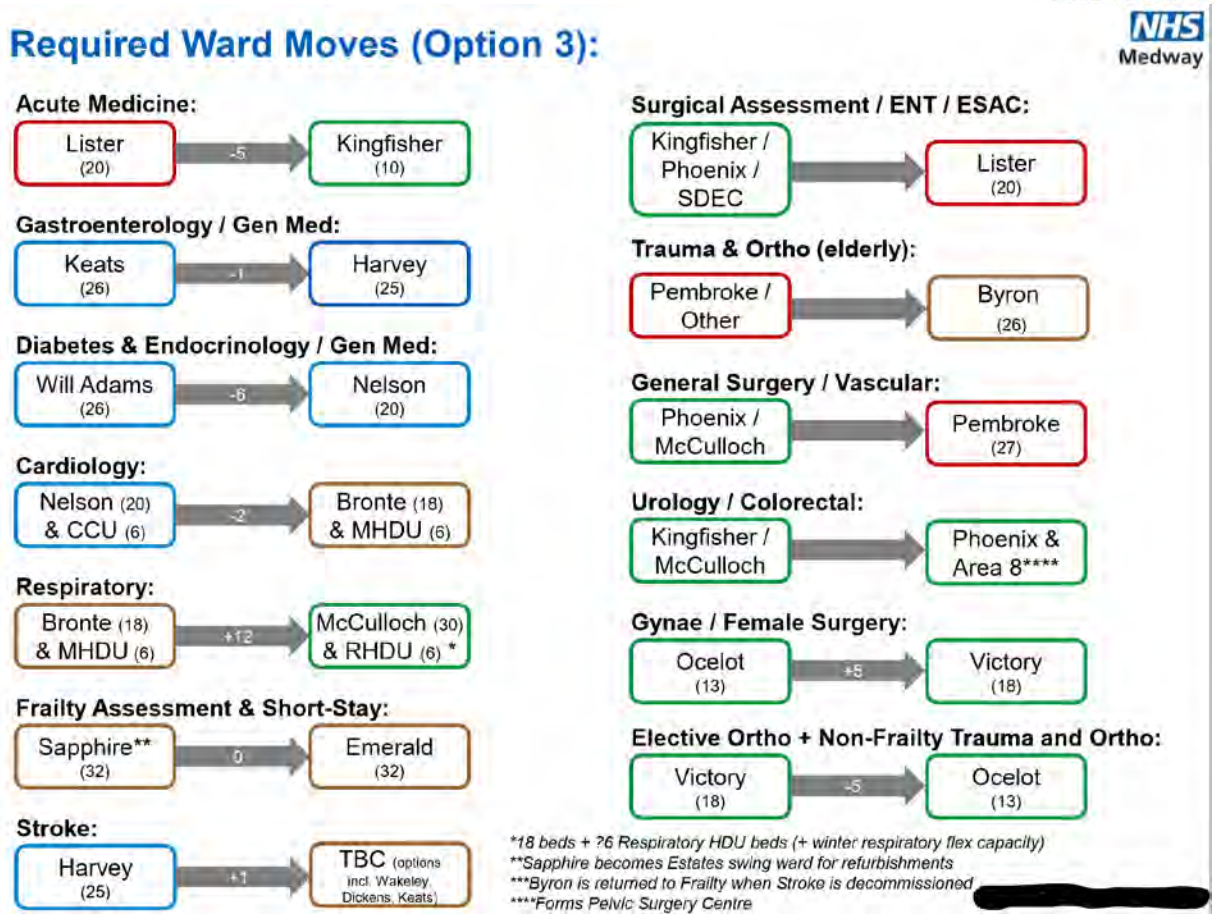
3.3.5 5. Establishment of a residual COVID pathway

- Agree whether the COVID bed base will be concentrated within dedicated hot wards or as hot bays within wards

3.4 The phase 1 plan was presented to the clinical teams and the divisional MDTs for review and refinement. We are now on model 4.1 on the ward recon plan and the current plan is outlined as follows, broken down into three main options (this is for noting as this is currently approved):




Required Ward Moves (Option 2):
Acute Medicine:
Lister (20)
-5
Kingfisher (10)
Gastroenterology / Gen Med:
Keats (26)
-1
Harvey (25)
Diabetes & Endocrinology / Gen Med:
Will Adams (26)
-6
Nelson (20)
Cardiology:
Nelson (20) & CCU (6)
-2
Bronte (18) & MHDU (6)
Respiratory:
Bronte (18) & MHDU (6)
+12
McCulloch (30) & RHDU (6) *
Frailty Assessment & Short-Stay:
Sapphire** (32)
0
Emerald (32)
Stroke:
Harvey (25)
+1
Byron*** (26)
Surgical Assessment / ENT / ESAC:
Kingfisher / Phoenix / SDEC
Lister (20)
Trauma & Ortho (young and elderly):
Pembroke / Other (retain as is)
Male Uro / General Surgery / Vascular:
Phoenix / McCulloch
Dickens (M) (24)
Victory (Vasc) (18)
Gynae / Female Uro / Female Gen Surgery:
Ocelot (13)
+5
Keats (F) (26)
Colorectal:
Kingfisher / McCulloch
Phoenix & Area 8
Elective Ortho:
Victory (18)
-5
Ocelot (13)
*18 beds + ?6 Respiratory HDU beds (+ winter respiratory flex capacity)
**Sapphire becomes Estates swing ward for refurbishments
***Byron is returned to Frailty when Stroke is decommissioned
NHS
Medway



4 ICP governance and the system recovery plan

4.1 The below summary outlines the ICPs plan for recovery:

4.1.1 There will be a system-wide review of lessons learned. We will not automatically return to the ‘old way’ of doing things.

4.1.2 We will embrace developments implemented through COVID-19 related activity, and seek to incorporate these into clinical and operational strategies and service models.

4.1.3 Every service will develop a recovery plan to meet 'must dos’ including meeting a COVID second wave.

4.1.4 Recovery plans will demonstrate an awareness of impact of recovery actions on other parts of the health and social care system.

4.1.5 Organisations and services will own the issues in their recovery plan and avoid responsibility or cost shunting to other partners in the health and care system.

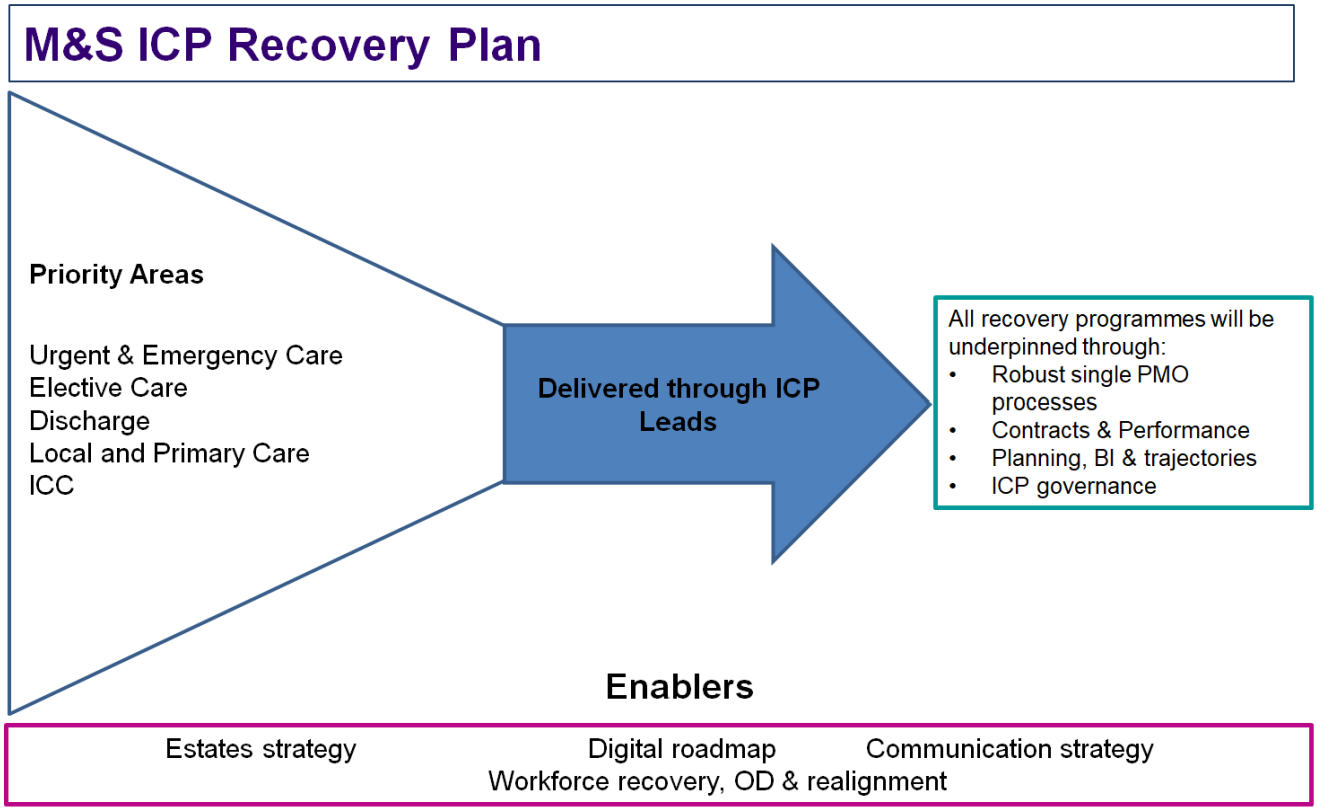
4.1.6 “System by Default” will be embedded locally, with 3 levels of leadership and recovery (Organisational, ICP and CCG/ICS).

4.1.7 There are likely to be multiple phases of recovery, but each phase will have an agreed target date.

4.1.8 Contracts will be used to support recovery, not as a punitive mechanism with contract monitoring focusing on delivery of recovery plans and trajectories.

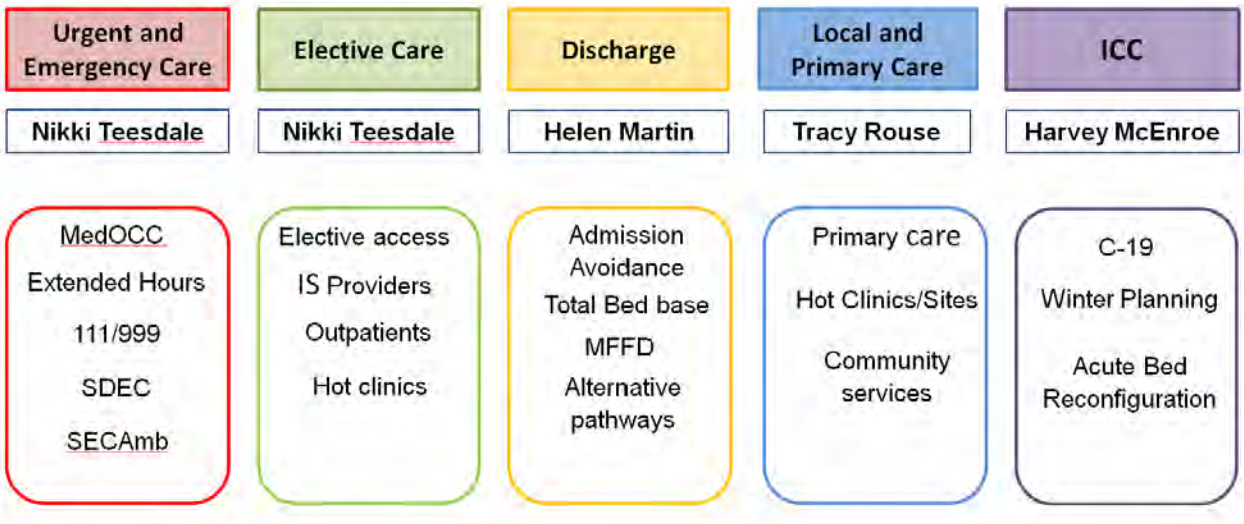
4.1.9 Patient safety will always be non-negotiable, contract requirements and KPIs relating to safe care will remain in place.

4.2 The ICP have established a set of key priorities which have been influenced by the Trust via close working between the SROs. The below diagram outlines the key priorities established for the ICP:



4.3 Similar to the model established within the Trust, the ICP will have a set of Task and Finish structures, which will work closely across the ICP and the Trust structures.

4.4 The ICP and the Trust have established co-chair functions across the four key recovery plans and the Trust and the ICP have agreed a single Incident Control process for the ongoing management of Covid19 and the wider planning for new waves and winter. The below diagram outlines the governance of the new structure:



4.5 The ICP (with Trust engagement) has established a recovery matrix, which is being used by the ICP Board to oversee the delivery of the recovery plans. In summary these are:

4.5.1 The teams will explore how to integrate existing work programmes building on existing programmes which had been jointly developed with key stakeholders and define with their team's new ways of working.

4.5.2 Recognise how the rapid changes which were implemented during Covid-19 and not revert back to old ways of working.

4.5.3 The ICP leads will need to set up their programmes to support agile working, flexibility, and proportionate to the change and outcomes.

4.5.4 Each programme area will need to identify the interdependencies between programme areas as well as the additional key areas outlined below:

4.5.4..5 Diagnostics

4.5.4..6 Rehabilitation

4.5.4..7 Care Homes

4.5.4..8 ILRs

4.5.4..9 End of Life

4.5.4..10 Cancer

4.5.4..11 Mental Health

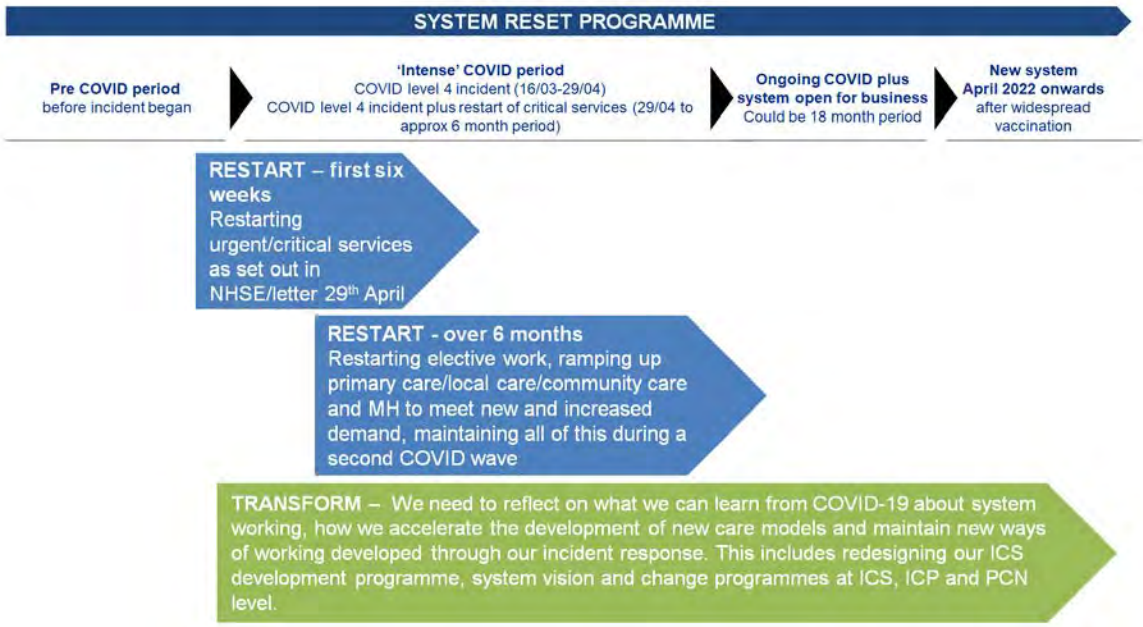
4.5.4..12 LD

4.5.4..13 Vulnerable and shielded patients

4.5.4..14 Integrating therapies (building on the outcomes from the current pilot)

4.6 The ICP recovery plan links to the wider ICS plan and the STP regional recovery plan. The governance of this is established via the STP Partnership Board, and the ICP Delivery Board. The Chief Executive serves as a representative on the STP PB and is co-chair of the ICP Board. The COO serves a ICP ICC Strategic Command and ICP Winter lead.

4.7 The wider ICS structure and the STP oversight is established to ensure that there is parity and co design across the Kent and Medway region. The below diagram outlines the ICS/STP recovery model:



Role of the ICS programme for restart

- NHSE/I interface – system level view
- Identify key risks and issues that may required system discussion and system solutions
- Guard against geographical variation in restarting/ramping up services

4.8 The ICS into the ICP has established a set of key priority areas in addition to and in support of the four we have established locally as a Trust/ICP. These are as follows (with our leads named for context):

Workstream	Programme Lead	ICP Leads	
Elective Care	Karen Benbow	DGS: EK:	M&S: Harvey McEnroe WK:
Cancer and Diagnostics	Ian Vousden	DGS: EK:	M&S: Harvey McEnroe WK:
Mental Health	Adam Wickings	DGS: EK:	M&S: WK:
Radiology	Karen Benbow	DGS: EK:	M&S: Harvey McEnroe WK:
Endoscopy	Ian Vousden	DGS: EK:	M&S: Harvey McEnroe WK:
Children	Oliver McKinley	DGS: EK:	M&S: WK:
LD and Autism	Oliver McKinley	DGS: EK:	M&S: WK:
Small Providers	Oliver McKinley	DGS: EK:	M&S: WK:
111 and Urgent Care	Stuart Jeffrey	DGS: EK:	M&S: Harvey McEnroe WK:
Primary Care and Local Care	Faye Rye Cathy Bellman	DGS: EK:	M&S: Chris McKenzie WK:
Community Care	Faye Rye Cathy Bellman	DGS: Debbie Stock EK: Oena Windibank	M&S: Tracey Rouse WK:

5 Wave2 and Wave3 planning and Winter 2020

5.1 The Trust has established a Winter Planning team, which will work across the Trust and the wider ICP to plan for winter 2020 impacts taking into account a possible Wave2 and Wave3 impact.

5.2 The Trust COO will take the lead for winter planning across the Medway and Swale footprint and will serve as strategic command across the ICC for the ICP and the Trust, which will ensure joined up management across primary, secondary, community and mental health provision.

5.3 The Winter Planning programme will be supported by an internal MDT team from MFT across finance, planning, EPRR, IT and the divisions to ensure that we have a robust winter plan alongside a clear incident control process for Covid19. At present there isn't a clear impact plan for Covid19 and winter, but this is being worked up presently and for the next board the COO and CEO will be able to outline the roadmap for winter and the wider C19 impact plan.

6 Conclusion and Next Steps

6.1 The Trust is responding well to the C19 impact and is working closely with system partners.

6.2 The Trust has established its recovery plans post the acute impact of C19, and whilst there remains many 'known unknowns', the Trust is moving ahead with its restore plans at good pace. The next stage for the strategic command, via the T&FG for the coming four weeks will be to:

- 6.2.1 Continue to map the major disruptions and assess the impact on patients / local people and identify any potential risk of harm that might have resulted
- 6.2.2 Restart urgent/critical/essential services over the next 4 weeks that have either been identified as a national priority or driven by our local assessment of risk of potential harm
- 6.2.3 Reconfigure the wards and clinical areas to be compliant with ICP guidance and to meet the needs of C19 demand and the elective and emergency care pathway, post detailed risk assessment on this topic.
- 6.2.4 Restart all non-urgent services over a 3 to 6 month period in line with the wider ICP and ICS plan

6.3 In the coming 4-6 weeks the Trust will support the wider ICP and ICS/STP ask regarding:

- 6.3.1 The reset of the operational trajectories and the wider system 'must dos' regarding performance and delivery.
- 6.3.2 Reflecting on what we can learn from COVID-19 about system working, including what we don't want to go back to
- 6.3.3 Redesigning an ICP/ICS development programme, system vision, and associated change programmes at ICS, ICP, PCN and provider level.

6.4 The Trust will continue to focus on building its recovery plan, linked to NHSE/I ad system programmes of work, with specific focus on

- 6.4.1 Delivery of high quality care in the 'new normal'
- 6.4.2 Develop new ways of working that are informed by the system plan
- 6.4.3 Plan for staff returning to new offices and increased virtual working

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.4
Report Author	Jane Murkin – Chief Nurse (Interim)		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	This is the refreshed version of the IQPR in using Statistical Process Control charts to display the data. This report informs Board Members of the quality and operational performance across key performance indicators for April 2020. **Safe** Our Infection Prevention and C ontrol performance for April shows that the Trust has had 0 M RSA bacteraemia cases. 2019/2020 saw an improved performance against c-diff infection case numbers and this position has been maintained in April 2020. The updated January HSMR figure now sits at 99.1 (94.5 – weekday and 112.1 – weekend). The SHMI sits at 1.11 **Caring** MSA continues to demonstrate an improvement; however in April 2 breaches were recorded which is still higher than the national compliance levels. Electronic Discharge Notification (EDN) performance remains below trajectory, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system. **Effective** VTE performance for April sits at 93.3% against the 95% national target. Fractured NOF procedures within 36 hours performance remained in line with the previous 2 months at 68.4%. A number of different actions are in place to improve the experience for patients and the performance. **Responsive** The Trust saw a significant improvement to the 4 hour performance standard reaching 92% for April 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with 0 52 week breaches, Diagnostics has been recorded as 50.4%. Cancer 2 week wait performance for March continues to be above national standards at 94%, 62 day performance is recorded as 77.5%. **Well Led** We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 1 of 2020/2021.		

Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Due Diligence	To give the Trust Board assurance, please complete the following:	
Committee Approval:	Name of Committee: Executive Group on the 03 June 2020 Date of approval: 03 June 2020	
Executive Group Approval:	Date of Approval: 03 June 2020	
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): NA	
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 – April 2020

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: April 2020

NHS
Medway
NHS Foundation Trust

Topic	Page
Statistical Process Control (SPC) Guide	3
Executive Summary	5
Caring	7
Effective	9
Safe	11
Responsive	16
Well Led	25

Guide to Statistical Process Control (SPC)

NHS Medway NHS Foundation Trust

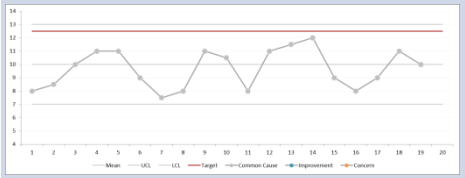
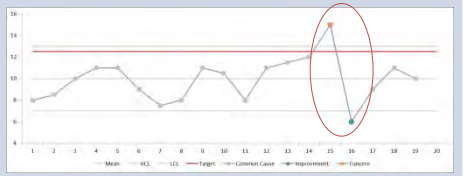
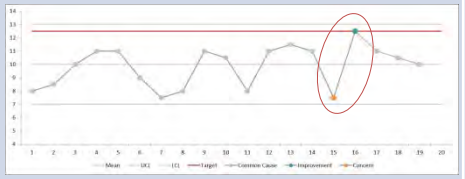
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

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

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

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

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

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

Guide to Statistical Process Control (SPC) Icons

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

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe

Our Infection Prevention and Control performance for April shows that the Trust has had 0 MRSA bacteraemia cases. 2019/2020 saw an improved performance against c-diff infection case numbers and this position has been maintained in April 2020.

The updated January HSMR figure now sits at 99.1 (94.5 – weekday and 112.1 – weekend). The SHMI sits at 1.11

Caring

MSA continues to demonstrate an improvement; however in April 2 breaches were recorded which is still higher than the national compliance levels.

Electronic Discharge Notification (EDN) performance remains below trajectory, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system.

Effective

VTE performance for April sits at 93.3% against the 95% national target. Fractured NOF procedures within 36 hours performance remained in line with the previous 2 months at 68.4%. A number of different actions are in place to improve the experience for patients and the performance.

Responsive

The Trust saw a significant improvement to the 4 hour performance standard reaching 92% for April 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with 0 52 week breaches, Diagnostics has been recorded as 50.4%. Cancer 2 week wait performance for March continues to be above national standards at 94%, 62 day performance is recorded as 77.5%.

Well Led

We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 1 of 2020/2021.

Executive Dashboard

Current Month Overview of KPI Variation (Trend) and Assurance (Target) Icons

NHS Medway NHS Foundation Trust

Trust Domains	Variation					Assurance			
		L	H	L	H	P	F	?	●
Caring									
Admitted Care	2	0	0	1	2	0	3	2	0
ED Care	0	0	0	2	0	0	2	0	0
Maternity Care	1	1	0	0	0	1	0	1	0
Outpatients Care	1	1	0	0	0	1	1	0	0
Effective									
Best Practice	1	1	2	1	0	1	2	2	0
Maternity	3	0	2	0	0	0	2	2	1
Stroke	1	1	0	1	0	0	2	0	1
Safe									
Harm Free Care	0	0	2	0	0	2	0	0	0
Incident Reporting	2	0	0	1	0	1	0	1	1
Infection Control	4	0	0	0	0	3	0	0	1
Mortality	1	0	1	0	3	1	4	0	0
Responsive									
Bed Management	2	0	1	0	2	2	2	1	0
Cancer Access	2	0	1	2	0	0	1	4	0
Complaints Management	1	0	0	0	1	0	0	2	0
Diagnostic Access	0	1	0	0	0	0	0	1	0
ED Access	1	0	0	2	1	0	2	2	0
Elective Access	0	1	0	0	1	0	1	1	0
Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Well Led									
Staff Experience	2	0	0	0	0	0	2	0	0
Workforce	2	0	2	2	2	0	1	6	1

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

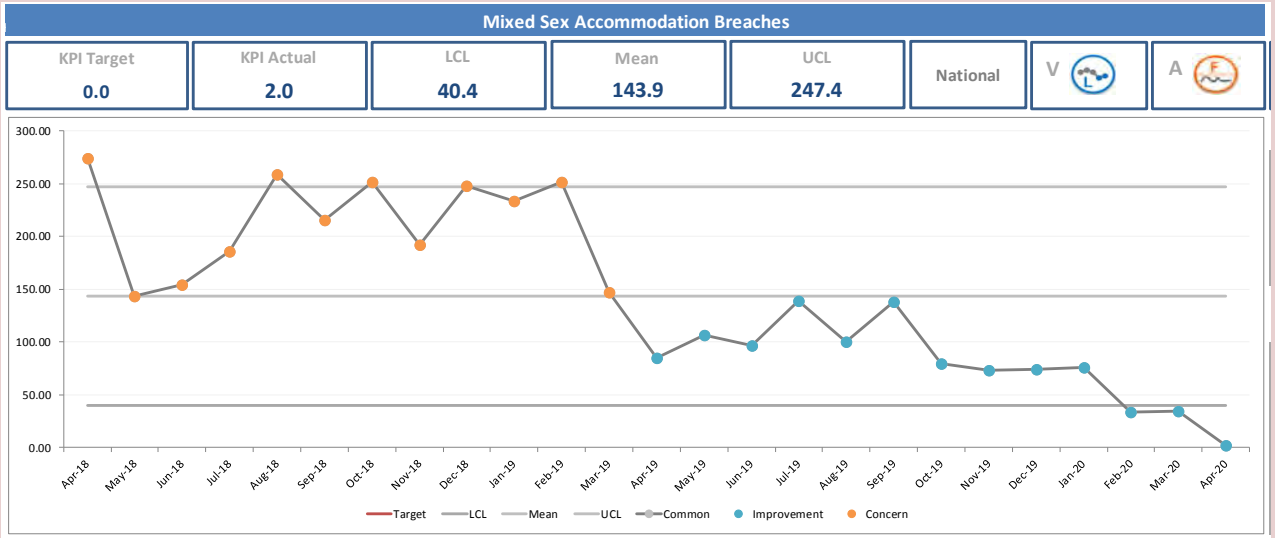
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	N	Apr-20	0	7	41	144	247		
		MSA %	N	Apr-20	0%	0.1%	0.3%	1.0%	1.6%		
		% of EDNs Completed Within 24hrs	N	Apr-20	100%	74.8%	69.9%	74.9%	79.9%		
		Inpatients Friends & Family % Recommended	N	Apr-20	85%	91.5%	80.0%	86.1%	92.2%		
		Inpatients Friends & Family Response Rate	N	Apr-20	22%	18.9%	15.8%	20.6%	25.5%		
	ED Care	ED Friends & Family % Recommended	N	Apr-20	85%	90.6%	70.9%	77.8%	84.6%		
		ED Friends & Family Response Rate	N	Apr-20	22%	17.5%	11.6%	14.2%	16.9%		
	Maternity Care	Maternity Friends & Family % Recommended	N	Apr-20	85%	100.0%	96.9%	99.2%	100.0%		
		Maternity Friends & Family Response Rate	N	Apr-20	22%	18.1%	11.3%	24.4%	37.5%		
	Outpatient Care	Outpatients Friends & Family % Recommended	N	Apr-20	85%	90.0%	88.2%	90.5%	92.7%		
		Outpatients Friends & Family Response Rate	N	Apr-20	22%	12.8%	11.9%	14.2%	16.4%		

Domain: Caring Insights

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

NHS Medway NHS Foundation Trust

Indicator: Mixed Sex Accommodation Breaches



Indicator Background:

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

What the Chart is Telling Us:

There continue sot be a reduction in MSA. However current performance is higher than the national target of 0.

Actions:

Trust wide approach to prioritising MSA breaches.
Critical care have adopted a proactive approach to managing same sex accommodation and move patient to avoid breaches occurring.
Privacy and dignity is maintained in the wards at all times, by use of curtains and ensuring patients are dressed when able to do so.

Outcomes:

2 breaches Same Sex accommodation reported April 2020 compared to 30 in March.
Breaches occurred in High Dependency Unit with one patient waiting two days for a respiratory specialist bed.

Underlying issues and risks:

Whilst this is the best position since SSA reporting started this was facilitated by reduced bed occupancy across the Trust allowing prompt placements of patients able to be stepped down to ward based care. As the Trust returns to normal activity there must be a continued focus on supporting prompt discharge from critical care units.

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

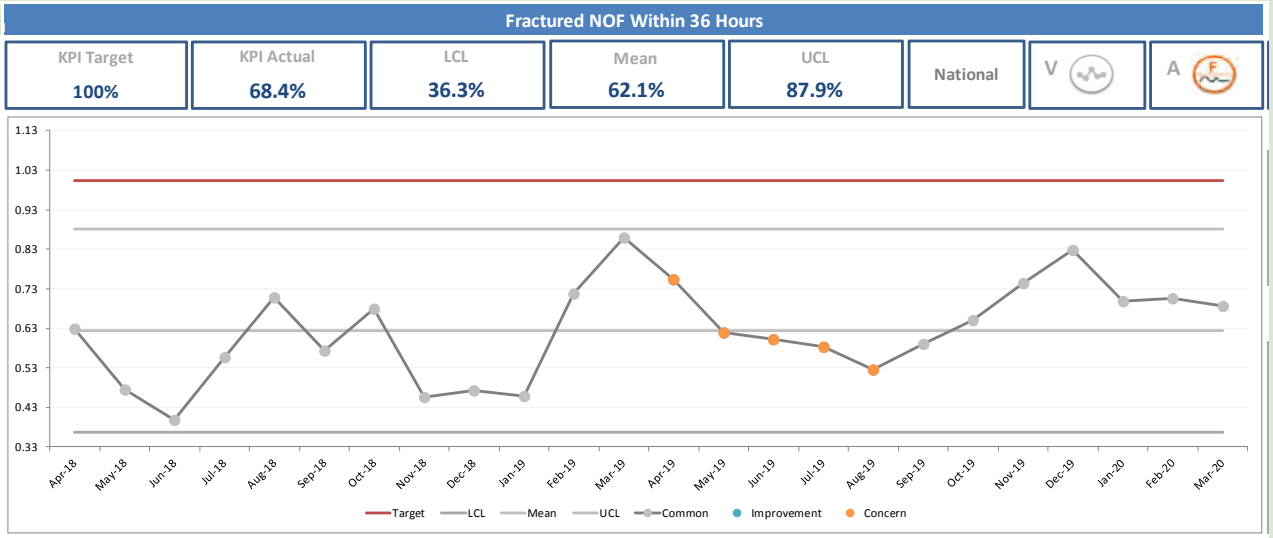
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	N	Mar-20	10%	6.2%	4.1%	5.3%	6.5%	H	P
		30 Day Readmission Rate	N	Mar-20	10%	11.6%	9.1%	10.7%	12.3%	H	?
		Discharges Before Noon	N	Apr-20	25%	14.3%	12.9%	15.3%	17.6%	L	F
		Fractured NOF Within 36 Hours	N	Mar-20	100%	68.4%	36.3%	62.1%	87.9%		F
		VTE Risk Assessment % Completed	N	Apr-20	95%	93.3%	71.4%	84.1%	96.9%	H	?
	Maternity	Elective C-Section Rate	L	Apr-20	13%	13.6%	9.8%	13.0%	16.2%		?
		Average occupancy	L	Apr-20	15%	22.1%	15.3%	18.9%	22.5%	H	F
		Total C-Section Rate	L	Apr-20	28%	35.6%	27.2%	31.9%	36.6%	H	?
		Number of Deliveries (Count of Mothers)	L	Apr-20		389	344	408	472		●
		12+6 Risk Assessment	N	Jan-20	90%	82.2%	76.9%	83.2%	89.5%		F
	Stroke	Stroke SSNAP Rating *	N	Dec-19	B	D				●	●
		% of Pts Seen by Stroke Cons in 24 Hours *	N	Dec-19	95%	49.5%	32.1%	37.1%	42.1%	H	F
		Stroke Pts Scanned Within 1 hour *	N	Dec-19	90%	40%	37%	44%	51%	H	F

Domain: Effective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Fractured NOF Within 36 Hours



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Appoint a new Orthopaedic Lead Clinician.
Ensure that there is a trauma theatre slot every day for fractured NOF (potentially with an 8:00 a.m. start).

Outcomes:

New Lead Clinician appointed on 19/06/20.

Underlying issues and risks:

Not all orthopaedic surgeons are operating on these patients (e.g. some upper limb specialists).
Time from arrival in ED to getting to ward is prolonged.
Early identification of those patients in whom palliative care is most appropriate.

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

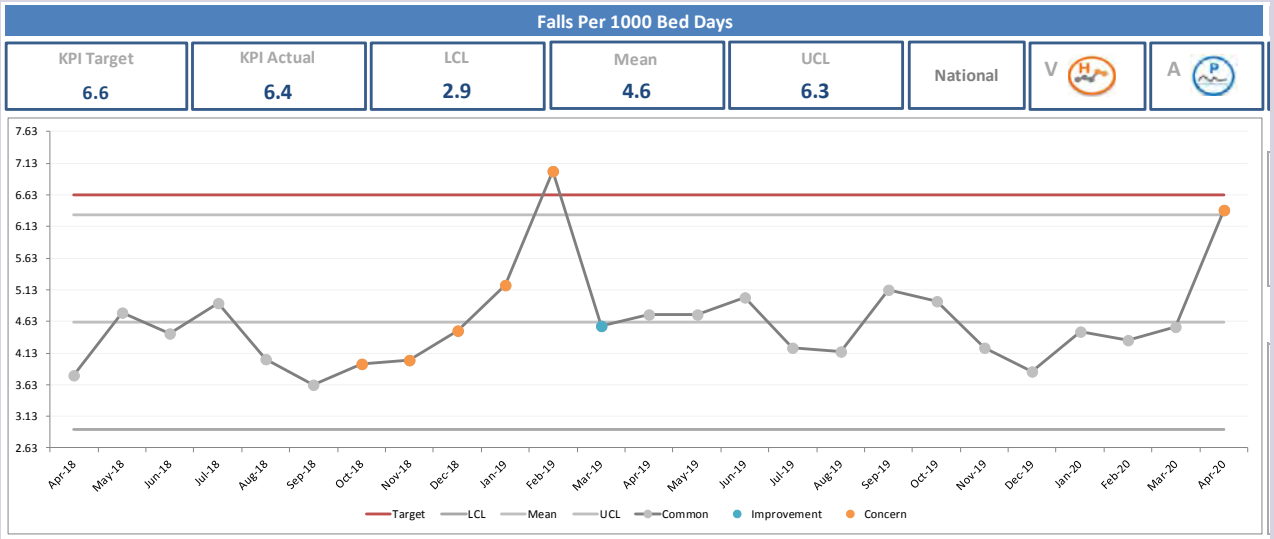
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	N	Apr-20	6.63	6.38	2.92	4.62	6.32		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	N	Apr-20	1.04	0.34	0.00	0.07	0.29		
	Incident Reporting	Never Events	N	Apr-20	0.0	0.0	0.00	0.1	0.8		
		No of SIs on STEIS	N	Apr-20	90	11	0	10	21		
		% of SIs Responded To In 60 Days	N	Apr-20		100%	91%	98%	100%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	N	Apr-20	0	0.00	0.00	0.60	0.00		
		C-Diff Acquisitions HAI (HOHA + COHA)	N	Apr-20	0	1.0	0.00	2.5	8.3		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	N	Apr-20		1.0	0.00	1.5	5.5		
		E-coli blood stream hospital associated infections	N	Apr-20	0	2.0	0.00	4.6	0.0		
	Mortality	Crude Mortality Rate	N	Mar-20	2.5%	1.68%	1.01%	1.50%	1.99%		
		HSMR (All)	N	Jan-20	100%	99.1%	103.8%	107.7%	100.0%		
		HSMR (Weekday)	N	Jan-20	100%	94.5%	100.5%	105.0%	100.0%		
		HSMR (Weekend)	N	Jan-20	100%	112.1%	110.5%	114.8%	100.0%		
		SHMI	N	Jan-20	1.0	1.11	1.06	1.09	1.11		

Domain: Safe Insights

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

NHS Medway NHS Foundation Trust

Indicator: Falls Per 1000 Bed Days



Indicator Background:

The number of patient falls per 1000 bed days. The Trust performs well on a nationally.

What the Chart is Telling Us:

The SPC data point is showing special cause variation .April data point highlights the opportunity for review of the Falls cases to assess any changes

Actions:

To provide additional assurance and monitor quality and safety during the COVID-19 pandemic, CRASH bundle audits were performed weekly on the Pilot Wards
Falls team continued to review every patient who fell to provide advice and support to ward.
Opportunity to commence Dignified Throne Project during any ward refurbishment

Outcomes:

- 15 patients (21%) were COVID positive
- 13 patients (18%) had a confirmed diagnosis of Dementia
- 8 patients (11%) had increased alcohol consumption
- 6 patients (8.5%) had confirmed Delirium

3 Moderate Harm falls/ 1 Severe harm fall

Underlying issues and risks:

Additional COVID-19 impact identified since last report

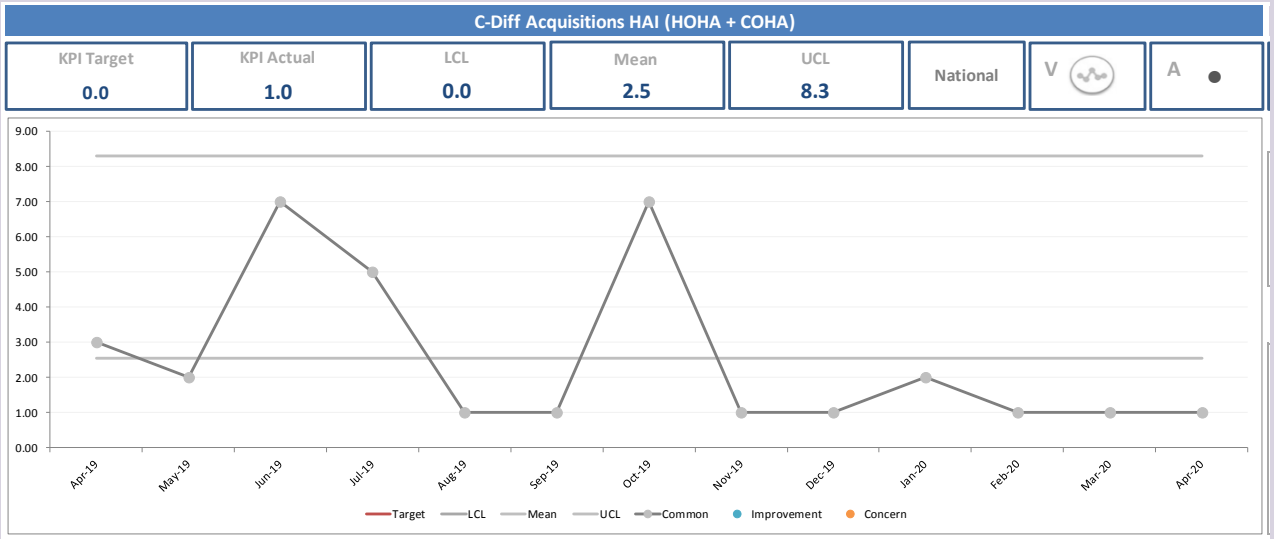
- Difficulty in hearing falls alarms (doors shut)
- Delay in reaching patients whilst donning appropriate PPE
- Redeployed staff from non ward background not competent in equipment choice/selection available

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

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



Indicator Background:

2019/20 the Clostridium difficile (C-Diff) cases metric was changed to HOHA+COHA = HAI. 2020/21 CDI objective has not been released by NHSI/E. Until advised MFT has continued to use the 2019/20 metrics.

What the Chart is Telling Us:

2019/20 saw improved performance against CDI case numbers for the first time in 5 years. April this position has been maintained.

Actions:

MFT needs to continue the work against antimicrobial stewardship compliance

Prescribing audits need to have input from doctors and feedback used to empower changes in ritualistic prescribing

Dr's need to complete the E-learning on ESR for AMR/AMS.

Outcomes:

E-Learning was launched in March for doctors to raise awareness of antimicrobial resistance and the prudent prescribing within formulary.

Underlying issues and risks:

We have a number of cases which are COHA – c.diff positive within 28 days post discharge.

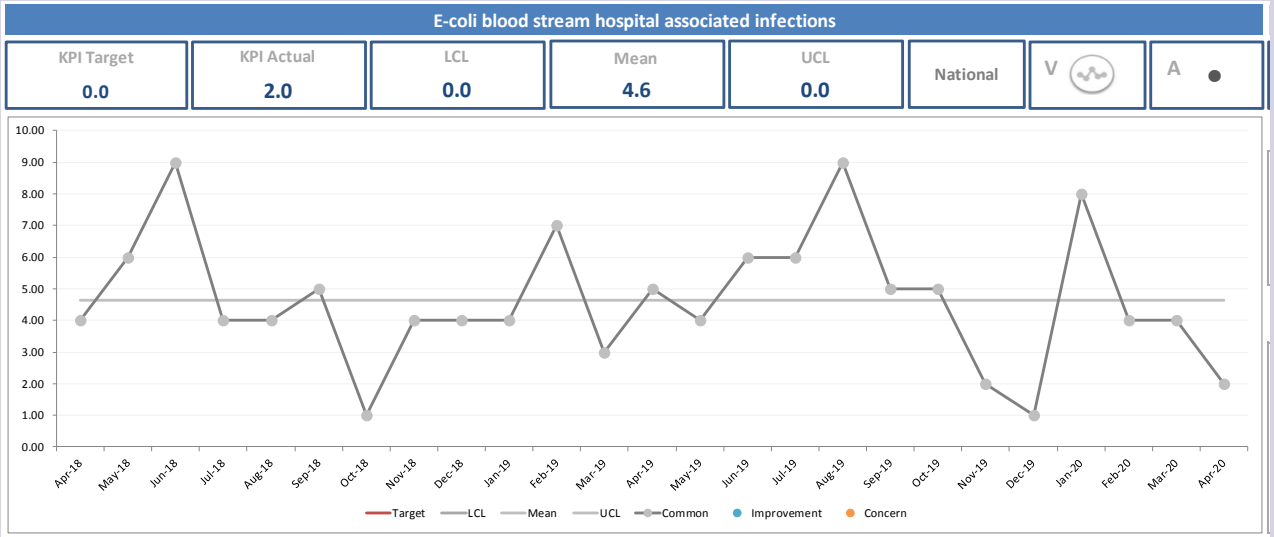
Our HOHA rate could be improved by prompt sampling of patients when required when loose stool develops and infection is suspected.

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: E-coli blood stream hospital associated infections



Indicator Background:

The number of Escherichia coli (E. coli) cases should be deceased by 15% each year over four year period of 2017-18 to 2021.

What the Chart is Telling Us:

MFT continue to have cases of E.coli Blood stream infection (BSI), no drop in rate of infection.

Actions:

Catheter care and maintenance needs further investment and a programme of work with the clinical areas ; this could be of benefit

Form on EDN should be approved for catheters but disagreed at IT programme board

Outcomes:

Between 2017 and 2019 no substantial progress was made on E.coli BSI reduction, last year 10 % reductions were realised through projects on hydration and raised awareness of our local sources of infection, commencing work with community continence teams

Underlying issues and risks:

Lack of continence resource in the Trust, only Urology team in place, they don't cover continence workloads

Catheter passport was launched and used with EDN there is no form for catheter so breakdown in communication flows

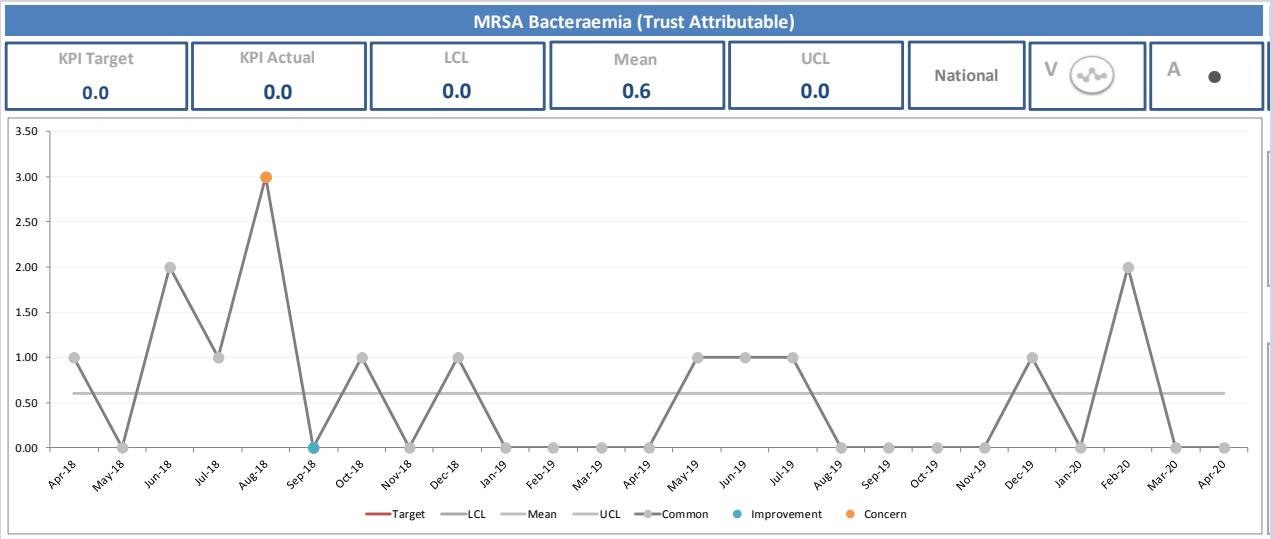
TWOC is difficult in community but recommended on discharge actions for follow up

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: MRSA Bacteraemia (Trust Attributable)



Indicator Background:

There should be a zero tollerance to Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection cases. MFT managed in 2019/20 to halve the number of cases (6) compared to 2018/19 (12)

What the Chart is Telling Us:

MFT continue to have peaks of cases in quarters 1 and 4 of the year

Actions:

All cases have been declared as an SI and thoroughly investigated post infection

Policy is being reviewed

Environmental contribution is being reviewed and actions in place to reduce this as a source

Outcomes:

Wash bowls have all been changed to single use pulp product to stop cross contamination from plastic bowls

Underlying issues and risks:

Data on screening results is not used with the data on patient admission system (PAS) to provide an audit of screening rates and reduce colonisation rates that maybe impacting on BSI incidence.

Domain: Responsive – Non Elective Dashboard

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

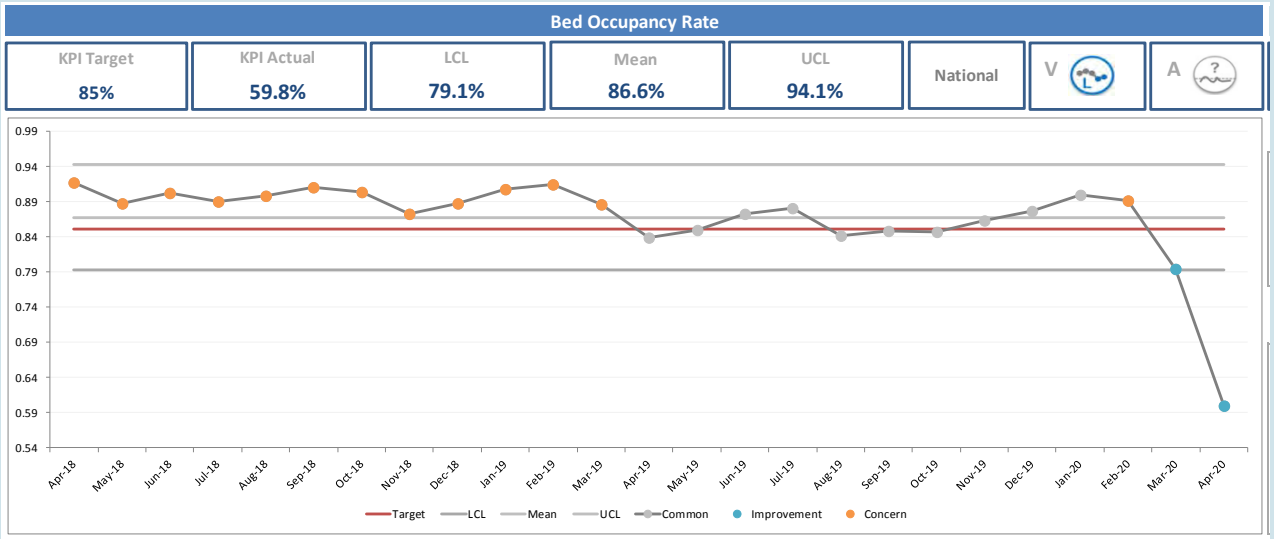
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Non Elective	Bed Management	Bed Occupancy Rate	N	Apr-20	85%	59.8%	79.1%	86.6%	94.1%		
		Average Elective Length of Stay	N	Apr-20	5	2.47	1.56	2.29	3.02		
		Average Non-Elective Length of Stay	N	Apr-20	5	8.41	7.47	8.61	9.74		
		% of Delayed Transfer of Care Point Prevalence in Month	N	Mar-20	3.5%	1.85%	0.69%	1.68%	2.67%		
		% Medically Fit For Discharge Point Prevalence in Month	L	Apr-20	7%	42.66%	15.74%	21.02%	26.30%		
	ED Access	ED 4 Hour Performance All Types	N	Apr-20	95%	92.0%	75.7%	82.8%	89.9%		
		ED 4 Hour Performance Type 1	N	Apr-20	95%	88.63%	65.72%	74.84%	83.95%		
		ED 12 hour DTA Breaches	L	Apr-20	0	0	0.00	14.84	57.07		
		60 Mins Ambulance Handover Delays	N	Apr-20	0	29	0	86	185		

Domain: Responsive – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Bed Occupancy Rate



Indicator Background:

The proportion of beds occupied at midnight.

What the Chart is Telling Us:

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

Actions:

- Temporary pause of non-urgent and non-cancer elective surgery;
- MFFD clearance under NHSE L4 conditions has mobilised better clearance of refractory MFFD lists;
- Compliance with flow metrics through acute medicine and improving SDEC flow;
- Low conversion of ambulances to DTA;
- 1000hrs nursing staff huddles temporarily paused with IPC guidance;

Outcomes:

- IS plan mobilised to maintain element of elective work. Currently undergoing RESTART review;
- MFFD clearance strategy continues under strategic leadership of DCEO and tactical leadership of HoT. Aim <20 green / <30 amber;
- Sentinel type 1 emergency conditions under attended in M1 but will rebound;
- Site operations continue to deploy core site rhythm without nursing huddles;

Underlying issues and risks:

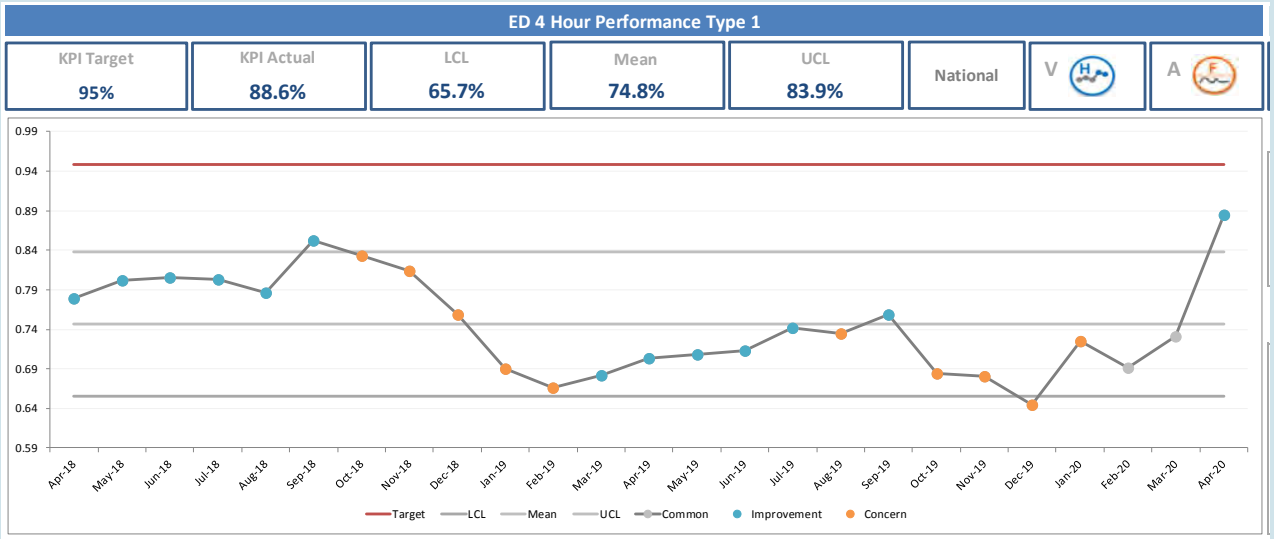
- Bed occupancy rising through M2. LoS noted in older persons and respiratory. 119 beds closed secondary to CQC, estates plan and IPC conditions – all being monitored through Site Operations;
- MFFD clearance plan (and funding) must continue to support increasing type 1 demand;
- Wave2 demand is unknown but being monitored with IPC support;

Domain: Responsive – Non Elective Insights

Executive Lead: Harvey McEnroe – 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:

Enhanced system working through NHSE L4 COVID9 response has released acute care capacity for type 1 flow through MFFD clearance. Despite pathway challenges posed by IPC, we have managed to increase admitted performance and suppress APD to record low levels. Non-admitted consistenly >94%. Good use of CDU function and loading of T3 and SDEC pathways throughout. PFC embedding in practice with good coverage of Duty Manager.

Outcomes:

- Bed occupancy <80% in-month;
- MFFD clearance excellent. Starting most mornings <15 patients;
- Type 1 admitted performance >80%;
- Non-admitted 94%;
- APD <8hrs per day;
- Ambulance conversion to DTA <21%
- Mental health 4hr performance <65%

Underlying issues and risks:

- Ambulance demand has been persistently >100 per day and is now subject to NK Cell escalation;
- Mental Health LoS has resulted in x3 SI and is subject to NK Cell escalation;
- LoS increase noted in Older Persons and Respiratory Medicine;
- Unable to return to pre-C19 operational policy for site rhythm;
- Phase 3 ED estates initiation / loss of CDU capacity;

Domain: Responsive – Elective Dashboard

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

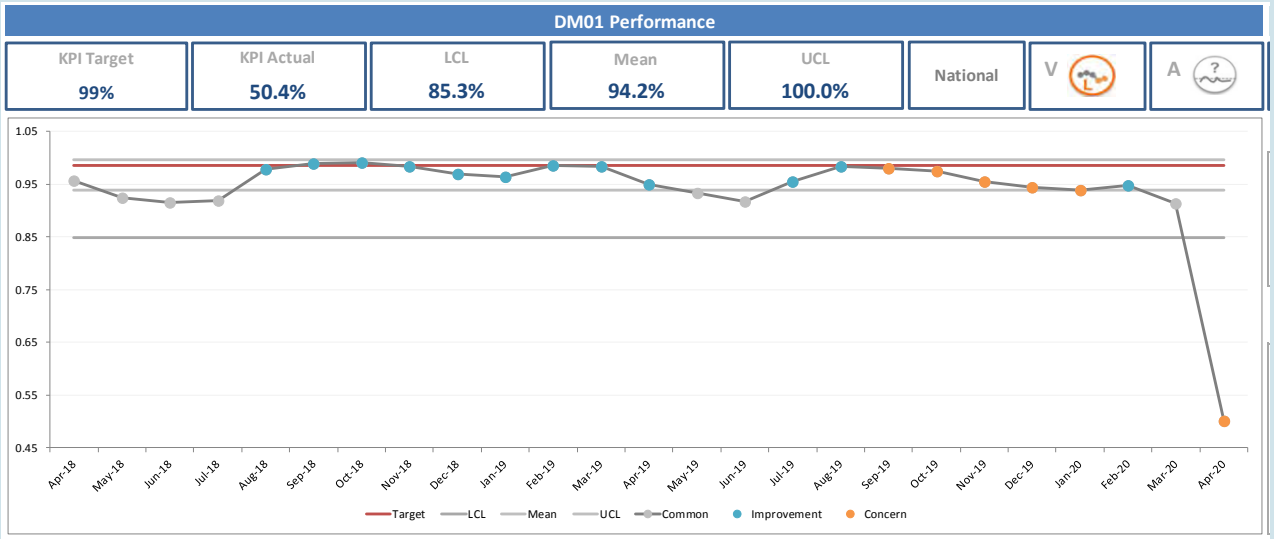
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Direct Access	DM01 Performance	N	Apr-20	99%	50.4%	85.3%	94.2%	100.0%		
	Elective Access	18 Weeks RTT Incomplete Performance	N	Apr-20	92%	72.6%	78.7%	81.6%	84.5%		
		18 Weeks RTT Over 52 Week Breaches	N	Apr-20	0	4.00	0.00	6.80	16.66		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	N	Apr-20	0	4.00	0.00	24.92	56.73		
		Cancelled Operations Not Rescheduled < 28 days	N	Apr-20	0	10.00	0.00	5.76	13.63		

Domain: Responsive – Elective Insights

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: DMO1 Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- DM01 Meetings to re-start
- Plans required for commencing routine procedures.
- Endoscopy triaging patients to ensure urgent patients booked accordingly.

Outcomes:

- Ensure all patients are tracked and traced
- Return to electives
- Patients treated in clinical order

Underlying issues and risks:

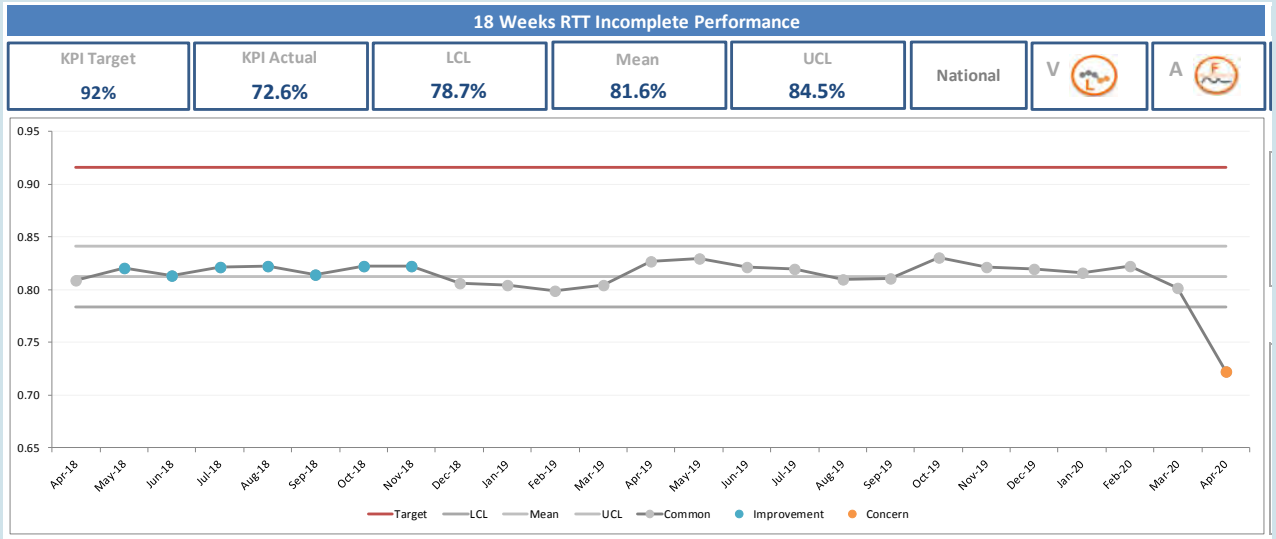
- COVID 19 and a potential 2nd wave
- Decrease in capacity in endoscopy again due to infection control
- Only urgent procedures undertaken in imaging with a plan to return to electives ASAP
- Patients choice declining appointments

Domain: Responsive – Elective Insights

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Incomplete Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Service teams switching to virtual clinics
- Processes being put in place for admitted patients to attend safely
- Improved triage of new referrals to ensure appropriateness
- Clinically lead triage of current patients to ensure patients are safe and assessing clinical urgency

Outcomes:

- Increase in clinic capacity
- Patients remain safe when visiting
- Patients treated in clinical order
- Prevent wasted slots

Underlying issues and risks:

- COVID
- Reduced theatre capacity
- Reduced outpatient capacity
- Patients cancellations for both theatre & outpatients
- Increase in referrals

Domain: Responsive – Cancer and Complaints Dashboard

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

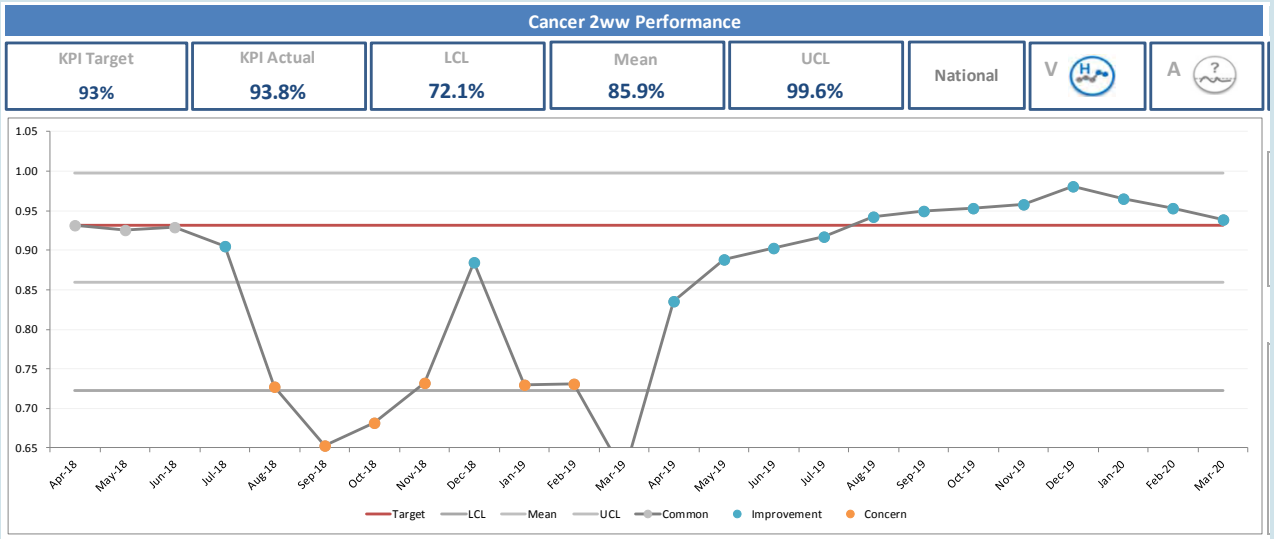
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	N	Mar-20	93%	94%	72%	86%	100%		
		Cancer 2ww Performance - Breast Symptomatic	N	Mar-20	93%	96%	43%	76%	100%		
		Cancer 31 Day First Treatment Performance	N	Mar-20	96%	97%	90%	96%	100%		
		Cancer 62 Day Treatment - GP Refs	N	Mar-20	85%	77%	65%	79%	93%		
		104 Day Cancer Waits	N	Mar-20	0	10	0.86	5.25	9.64		
	Complaints Management	Number of Complaints	N	Apr-20	41	5	32	64	97		
		% Complaints Responded to Within 30 Days	L	Apr-20	85%	60%	36%	67%	97%		

Domain: Responsive – Cancer and Complaints Insights

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- The Trust has maintained compliance against this KPI since August (8 consecutive months)
- The Cancer Referral Office escalate any capacity issues in real time.
- Will be implementing a more digital phone system to optimise efficiencies within the CRO
- The Booking team are working to an internal stretch target of 7 days.

Outcomes:

- Outpatient Capacity issues are escalated in real time allowing issues to be resolved before they impact performance.
- Services have taken more accountability for ensuring that there is sufficient capacity within their services to accommodate 2WW demand.
- With the exception of Haematology and Lung all booking for services are now centralised through CRO .

Underlying issues and risks:

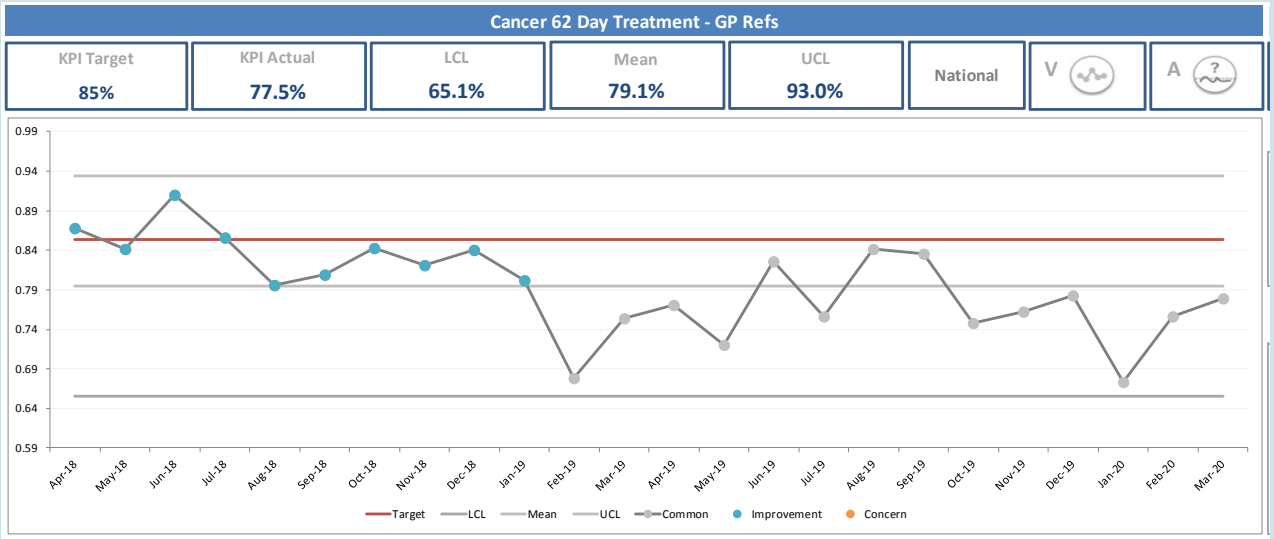
- Large volumes of LGI 2WW referrals into the trust continue to be a problem as Endoscopy has struggled to meet the demand, qFIT testing should be rolled out in Primary Care by the end of May which should have a positive impact on the volume of 2WW's into the trust.
- COVID 19 could impact the performance as some patients may prefer not to attend due to fear or anxiety.

Domain: Responsive – Cancer and Complaints Insights

Executive Lead: Harvey McEnroe – 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 high improving nature. Assurance indicates that the KPI is Inconsistently achieving target.

Actions:

- All MDTC posts have been recruited into Have now implemented permanent MDTC's in all tumour sites.
- Tumour site and Trust performance shared with each MDT team each week to provide live updates.
- Have introduced a buddy system to offer more stability in times of A/L or sickness

Outcomes:

- Increased Focus on all 'Legacy Patients' (Patients beyond day 62) on PTL.
- Clinical/MDT leads are now more engaged with breach avoidance.
- MDT leads meeting with Cancer GM to discuss solutions to pathway bottlenecks.

Underlying issues and risks:

- GI Breaches attribute 59% of total MFT breaches in March 2020. Endoscopy capacity is increasing as we begin to move towards pre-Covid activity levels.
- Patients put on Alternative pathway are now being reviewed and will be pulled back onto the PTL this will impact performance as where a CA is diagnosed and treated it will result in a breach.

Domain: Well Led – Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

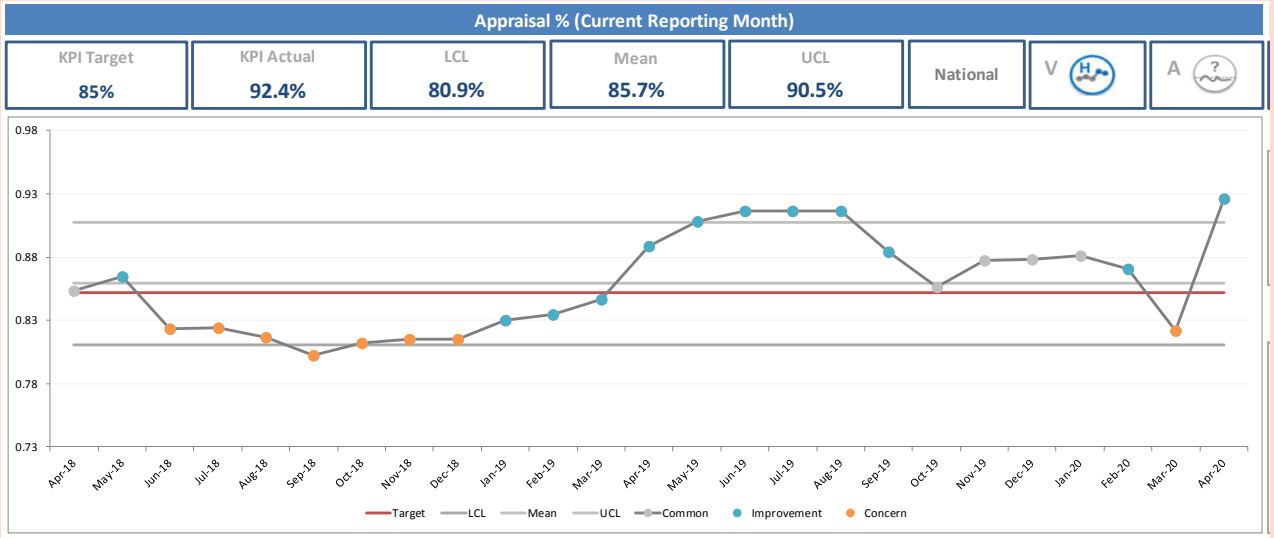
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	L	Sep-19	62%	51.4%	45.5%	49.2%	52.9%		F
		Staff Friends & Family - Recommend Care of Treatment	N	Sep-19	79%	67.6%	65.0%	66.9%	68.9%		F
	Workforce	Appraisal % (Current Reporting Month)	N	Apr-20	85%	92.4%	80.9%	85.7%	90.5%	H	?
		Sickness Rate (Current Reporting Month, FTE%)	N	Apr-20	4%	4.1%	4.0%	4.2%	4.3%		F
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	L	Apr-20	12%	12.3%	10.7%	12.0%	13.3%		?
		Contractual Staff in Post (FTE) (Current Reporting Month)	L	Apr-20		4,006	3,719	3,831	3,943	H	●
		StatMan Compliance (Current Reporting Month)	N	Apr-20	85%	88.3%	55.8%	76.4%	96.9%	H	?
		Agency Spend as % Paybill (Current Reporting Month)	L	Apr-20	4%	2.2%	2.1%	4.2%	6.3%	L	?
		Bank Spend as % Paybill (Current Reporting Month)	L	Apr-20	9%	13.2%	8.5%	12.7%	16.9%	H	?
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	L	Apr-20	75%	54.0%	66.3%	73.8%	81.4%	L	?

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The percentage of staff that have an in-date appraisal.

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 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:

- 3697 members of staff have an in-date appraisal with objectives and personal development plan outlined.

Underlying issues and risks:

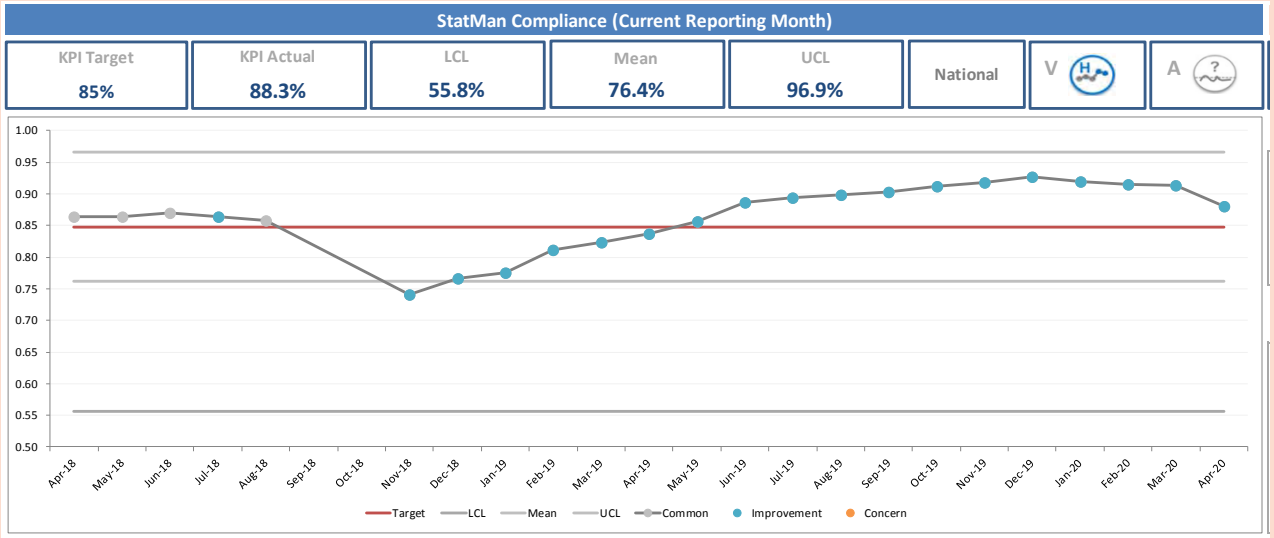
- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Failure to appraise staff timely reduces the opportunity to identify skills requirement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

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: StatMan Compliance (Current Reporting Month)



Indicator Background:

The percentage of staff that have an in-date competency meeting the appropriate statutory and mandatory training, in line with their post's training needs analysis.

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

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

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

£'000	In-month		
	Baseline	Actual	Var.
Income	28,654	29,856	1,202
Pay	(18,216)	(18,181)	35
Non-pay	(9,935)	(11,109)	(1,174)
Non-operating exp.	(503)	(566)	(63)
Control total	-	-	-

Indicator Background:

Trusts Financial Performance for April 2020 (Month 1).

What the Chart is Telling Us:

The Trust is reporting breakeven against a control total for the month of breakeven.

Actions:

Grip on cost control and value to be tightened.
CIP development and implementation.
Financial modelling based on operational actions to "restore, recover, return".

Outcomes:

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

- £1.7m of incremental costs associated with Covid
- £1.6m of "true-up" income accrued to achieve breakeven

Underlying issues and risks:

Income on a cost and volume basis is c.£7m lower than the draft budget as submitted to NHSE/I in early March, being the impact of reduced activity as a result of Covid.
CIP planning, development and implementation requires reinvigorating.
Uncertainty over operational planning and national contracting guidance post-Covid remain risks.

Meeting of the Board of Directors in Public

Thursday, 04 June 2020

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.5**
Committee Chair:	Tony Ullman, Non-Executive Director		
Date of Meeting:	12 May 2020 and 26 May 2020		
Lead Director:	Jane Murkin, Chief Nurse (Interim)		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. COVID-19 The committee continues to receive fortnightly updates on the Trust's response to managing COVID-19 to receive assurance on the decisions and actions the Strategic command under EPR and tactical groups are making. The tactical groups are planning, preparing and managing COVID-19 across the Trust, ensuring patient and staff safety, safe staffing levels and necessary training and equipment for PPE is in place, decisions are clinically led and any risks mitigated. Below outlines some of the key activities and actions reported to the committee:- • Initiated a staff risk assessment tool which was deployed across the Trust. • An Ethics Committee is in place, led by senior medics and nursing staff to consider and agree any ethical decision making processes should pressure on available resources require difficult decisions relating to prioritisation under these extreme conditions. • The Chief Nurse led on the development and implementation of a COVID-19 nursing	**Green**

and quality risk register to capture associated risks that COVID-19 could have on both nursing, safe staffing and quality aligned to associated national risks and local issues such as PPE. • The Chief Nurse initiated a weekly COVID related patient safety incident report that is reported to strategic group. • The horizon group was initiated to focus on business as usual for the Trust that will happen again once COVID-19 activity begins to wind down. • Excellent examples of medical and nursing leadership have been demonstrated throughout COVID-19 with a strong clinically led focus. • Weekly Chief Nurse drop in sessions continue and act as a mechanism to listen to staff concerns and queries and offer any additional advice and support alongside daily staff briefings. • A daily safe staffing report was initiated by the Chief Nurse and continues with monitoring, staff redeployed and moved as required with mitigations to maintain safe staffing. • A PPE steward programme was initiated by the Chief Nurse providing advice and support across the Trust with PPE education, advice and guidance. • Quality and nursing related risks continue to be mitigated through a range of activates and actions which includes a daily report to the Chief Nurse to provide assurance at this time. • The planning and decision making for the conversion of wards to COVID-19 wards and overseeing the re-direction of other patients and services that are being stopped such as elective surgery, maternity, cancer treatment and out-patients	
2. CQC Improvement Plan Jane Murkin shared the draft CQC action plan stating that the draft improvement plan for safety and quality contains all of the CQC must do and should do's from the CQC inspection findings and incorporates any of the outstanding actions from the phase one CQC action plan and work to address the warning notices and letter of intent. Jane explained that work has taken place with executives to populate each of the one page documents and confirm the specific actions required to achieve the must do and should do's, identify operational leads and then work with communications team to have a finalised document. The Quality panel is the governance committee that oversees the delivery of the action plan document and will track and monitor progress with delivery including any escalation of risks. Jane will meet with James Devine, Chief Executive to review any final documents prior to submission to the CQC. The next phase of work has included broader staff and stakeholder engagement and consultation throughout May and early June to make sure we consult and engage with as many staff as possible on the actions and identify any additional ideas for improvements. This will ensure ownership of all staff in the work to support delivery of the CQC report. The committee was pleased with the draft CQC action plan and will be sighted of the final document that will be submitted to the CQC.	**Amber/Green**
3. Quality report The committee received a first example of the quality report that briefs the QAC on the Quality Strategy implementation and other quality and safety priorities. The strategic priorities within the Quality Strategy aim to provide high quality care that is safe, effective and person centred care, with the emphasis on continuously improving the safety, quality and experience of care and ensuring that the care patients receive is evidence based and reliable. The Quality Strategy is one of the strategies for the Trust and sets out areas where we will focus on improving patient care. Work continues to support the pilot teams in progressing	

work to improve the processes and outcomes on the following areas: Falls, Pressure Ulcers, Dementia and Delirium. During the COVID-19 pandemic it is understood that Quality improvement work may encounter disruptions. Activity has focused on supporting staff in keeping patients safe, therefore work has focused on this aspect of care, alongside the nursing and quality risk register produced in managing COVID 19 and previously reported to the committee. Jane advised that the going forward once the refreshed quality IQPR has been finalised this report will sit alongside the metrics, graphs and data displayed using statistical process control charts.	
4. Refreshed IQPR The committee were sighted of the second draft of the refreshed Quality IQPR which uses statistical process control charts to measure and report the data, which was recognised as best practice. The committee noted the progress and was positive on the refreshed approach and will receive the final version at the next meeting on the 16 June 2020.	**Amber/Green**
5. Horizon scanning The committee have been discussing areas that will require consideration and monitoring as the Trust moves to business as usual focusing on the impact of quality and safety to our patients: • contracted out services, and how we are assured of quality, given that the Trust retains overall responsibility for these patients • the re-configuration plans as part of returning to the new normal • how do we assure ourselves of the quality of care provided to patients during the response period, such as discharge, decisions, care homes, difficult questions. Do we think the pause on normal activity will this impact – national steer but we should review locally, if we get 2nd wave, we need to have debriefed on patients with COVID-19 and elective • what has happened to emergency patients that have not been coming to the Trust. David is speaking to colleagues at Medway Council and public health, and will bring a report to a future meeting.	**Amber/Green**
6. BAF – Quality - The committee received the updated BAF – quality and were disappointed that the risk rating for 5a and 5b were still showing as red. - The committee were advised that the document is a live working document and that the risk rating for 5a will change once the CQC action plan has been signed off and submitted to the CQC. - David Sulch, Medical Director provided assurance that the risk rating for 5b is a realistic assessment of where the Trust is, however, good progress is being made in a number of areas but infection figures continue to be a concern as there have been a number of C.Diff cases, which he explained is not unexpected or unusual given the amount of antibiotics that have been administered during COVID-19. - Jane Murkin, Chief Nurse described that as progress against delivery of the CQC action plan reports the risk for 5a will be reviewed and updated. - The Trust continues to receive support from Esther Taborn, NHSE and Joanne Green, CCG with IPC. - The Committee will receive a further update on the BAF – quality at a future meeting to monitor progress.	**Green**
Further Risks Identified There were no further risks identified.	
Escalations to the Board or other Committee None	

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Mortality and Morbidity Update**	**Agenda Item**	4.6
Report Author	Hayley Usmar, Mortality Manager David Sulch, Medical Director		
Lead Director	David Sulch, Medical Director		
Executive Summary	This paper provides an update for the Board on the Trust's current mortality position. Key points to note are as follows: • HSMR for the 12 months to January 2020 is 99.1, which is within the expected limits. • Weekend mortality remains raised at 112.1 for the same period. The changes to the GIM and frailty rotas introduced in January 2020 will have had minimal impact on the HSMR at this stage. • SHMI for the 12 months to November 2019 is 1.11: this has remained essentially unchanged over the last 12 months. • A review of deaths from cancer of the bronchus is planned in response to the raised SHMI for this condition seen in the last two datasets. • COVID-19 mortality has been just below 30%, comparable with the national picture reported in a study from Liverpool. There is no definitive evidence of an excess of mortality in any specific ethnic group. A higher proportion of deaths from COVID-19 in the Medway & Swale system have occurred in hospital (rather than in care homes or hospices) compared to other systems such as West Kent and East Kent.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Mortality and Morbidity Committee Date of approval: May 15 2020		
Executive Group Approval:	Not applicable		

National Guidelines compliance:	Not applicable			
Resource Implications	None			
Legal Implications/Regulatory Requirements	None			
Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	This paper is to assure the Board, be noted and for discussion.			
	Approval ☐	**Assurance** ☒	**Discussion** ☒	**Noting** ☒
Appendices	Mortality Report and COVID-19 Mortality Review			

Mortality Report: April 2020

Overview

218 patients died in the Trust in April 2020. As a result of the ongoing SARS-CoV2 / COVID-19 pandemic, mortality reviews have been suspended during this period.

The HSMR for the period February 2019 – January 2020 was published on 27 April 2020. The Trust has an overall HSMR of 99.1 for this period, which is within the expected limits. For the same period, weekend HSMR is 112.1 (compared to a weekday HSMR of 94.5) and an outlier; however, the lower 95% confidence interval is 100.5 suggesting that this is moving in the right direction.

The following diagnosis groups are have been flagged as outliers for the period February 2019 – January 2020: 'Other perinatal conditions'; 'Short gestation, low birth weight, and fetal growth retardation'; 'Spondylosis, intervertebral disc disorder, other back problems', 'Open wounds of extremities'. Of these, only 'Other perinatal conditions' is statistically significant, having been an outlier for 18 consecutive months based on the most recent data release; however, no deaths were recorded in this diagnosis group in December 2019 or January 2020.

The SHMI for the period December 2018 – November 2019 is 1.11 and within the 'expected range'. SHMI data for 10 diagnosis groups is also provided. The Trust has been listed as having a higher than expected SHMI for 'Cancer of bronchus; lung' with a SHMI value of 1.44; at this juncture, this is not statistically significant. Information about the patients included in this cohort has been collated in preparation for further review should this diagnosis group remain an outlier.

SARS-CoV2 / Covid-19

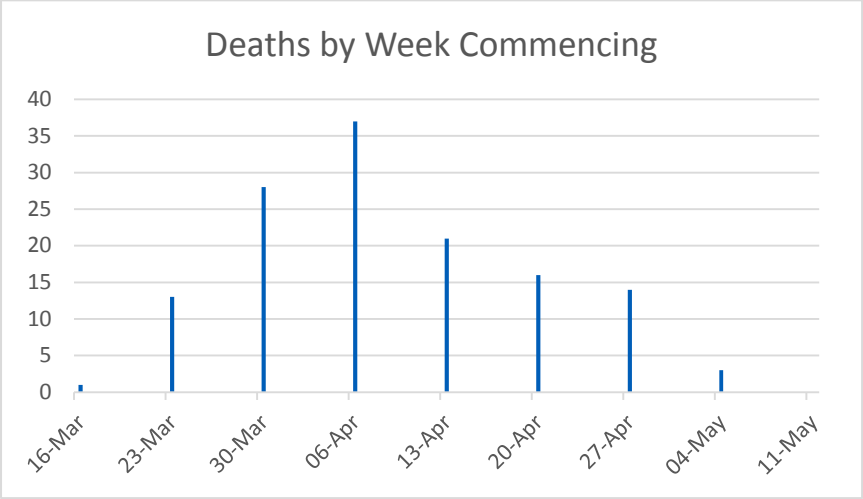
WHO declared Covid-19 a global pandemic on 10 March 2020, and the Trust announced our first Covid-19 death on 20 March 2020. As a result of the pandemic, non-essential meetings have been cancelled, including mortality and morbidity meetings. In addition, the usual cycle of casenote reviews has been interrupted. The Trust will develop a plan to address the backlog of reviews in due course.

COVID-19 MORTALITY - INITIAL REVIEW

Total deaths (to date) 133

Total positive inpatients 449

Mortality rate 29.6% (national data: 33%)



Analysis of first 105 hospital deaths:

Gender:	Male 59 (56%)	Female 46 (44%)	
Age:	<65	20	19%
	65-74	15	14%
	75-84	31	30%
	85+	39	37%
Ethnicity:	White British	93.3%	(89%)
	White Other	0.9%	(2.9%)
	Asian	1.9%	(3.8%)
	Black African	3.8%	(2.0%)

The table above compares the ethnicity of the patients dying from COVID-19 with the overall ethnicity profile of MFT's catchment population.

Domicile:	Medway Towns	61%
	Hoo Peninsula	7%
	Swale	30%
	Other	2%

29 of the deaths had not had an MCCD issued at the time of the data cut (6 of these had been referred to the coroner)

Of those with an MCCD four had no mention of COVID-19 on the certificate and appear to have died 'with COVID' rather than 'from COVID'. Their cause of death was given as:

- Alcoholic liver disease
- Ca pancreas
- Primary intracerebral haemorrhage
- MI / IHD

Of the 72 patients who were certified as having died from COVID, five had no co-morbidities listed on their MCCD. Three of these died in ITU: the other two died on Victory (62 year old woman) and on Milton (86 year old man). Review of decision making around access to higher dependency care would be appropriate for both these patients.

43 of the 105 patients had no previous admission in the last 12 months: of this group, 28 also had no ED attendance in the last 12 months.

16 of the deceased patients were residents in care homes

A wide range of co-morbidities were listed on the MCCD's and probably reflect the general prevalence of medical conditions in the local population. Common co-morbidities listed (many of which have been recognised to be associated with an increased risk from COVID-19) are as follows (the number given is the total number of records across the 72 certificates, not a percentage)

Hypertension	24
Diabetes Mellitus	23
Frailty	16
Atrial Fibrillation	15
Cardiac Failure	11
Chronic Kidney Disease	10
COPD	8
Stroke / Cerebrovascular disease	8
Dementia	7
Ischaemic heart disease	6
Solid organ cancers	5
Haematological cancer	4

Many patients had multiple co-morbidities with predictable combinations (eg hypertension with diabetes mellitus).

Obesity was mentioned on one certificate. One patient had Down's syndrome and one patient was listed as 'learning difficulties' without a clear diagnosis of the cause.

Community Deaths

The MCCD's of 24 patients who died from COVID-19 infection in the community have been reviewed (information for all community deaths is shared with Hayley Usmar as part of our planned work to begin to review deaths within 28 days of discharge).

Of these, 16 died in care homes, 5 at Wisdom Hospice and 3 in their own homes. 14 of the 16 deaths were in three care homes (with one home registering nine deaths among its residents, and one of the other homes also being the normal residence of one of the patients who died at Wisdom Hospice).

8 were men and 16 were women.

The age range was 60 to 100, with 21 of the patients being aged over 75 (and 14 being aged 85+). The patients who died in their own homes were aged 79, 87 and 90.

22 of the patients were White British and two were White Other. There were no BAME patients among this cohort.

All the MCCD's mentioned COVID-19 with one exception (a patient with known COVID-19 infection certified as dying from congestive cardiac failure due to ischaemic heart disease). Two patients had known malignancy (one metastatic breast cancer and one renal cancer). These three patients died at Wisdom Hospice.

Four patients died following a recent discharge from MFT: abbreviated timelines are listed in the table below. Review of these notes would be helpful in respect of decision making around discharge.

Patient	Admitted	Discharged	Died	Ward	Place of Death	Days DC to Death
77F	3/4	9/4	13/4	Byron	NH	4
77F	31/3	7/4	25/4	Phoenix	Hospice	18
90F	5/4	10/4	25/4	Pembroke	Home	15
93F	23/3	1/4	5/4	Byron	NH	4

The quality of the MCCD's for the community patients was surprisingly poor – although some of the certificates mentioned disease processes such as pneumonia (as associated with COVID-19) the vast majority did not mention any co-morbidities, even for those patients who were resident in care homes and (presumably) had other important diagnoses which would be relevant for inclusion on an MCCD. This lack of information also risks affecting nationally collated data on COVID-19 and the factors associated with deaths from the condition.

April 2020

Dashboard

SHMI	HSMR – Overall	HSMR – Weekend	Crude Mortality
1.11 As expected band Dec 18 – Nov 19	**99.4** 93.6 – 105.0 95% confidence interval Feb 19 – Jan 20	**112.7** 96.6 – 130.8 95% confidence interval Feb 19 – Jan 20	**218** patients died in the Trust in April 2020; **5** had Learning Disabilities

Outlier diagnosis groups

HSMR Outliers

	Relative risk (95% CI)	Observed	Expected	Cohort	
Other perinatal conditions	250.3 (133.1 – 428.0)	13	5.2	564	
Short gestation, low birth weight and fetal growth retardation	196.0 (107.0 – 328.8)	14	7.1	281	
Spondylosis, intervertebral disc disorder, other back problems	278.6 (101.7 – 606.4)	6	2.2	1521	
Open wounds of extremities	*374.8 (100.8 – 959.6)*	*4*	*1.1*	*169*	

SHMI Outliers

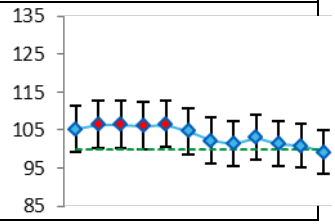
	SHMI	Observed Inpatient	Observed Post-discharge	Total	Expected	Cohort	
Cancer of bronchus, lung	1.44	24	34	58	40	105	

Performance against published mortality indicators

Hospital Standardised Mortality Ratio (HSMR)

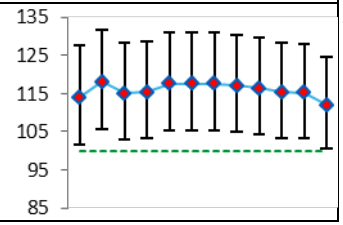
Overall

Key: ◆ As expected ◆ Low ◆ High

12 months to:	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Trend
HSMR	105.17	106.36	106.37	106.02	106.49	104.67	102.24	101.41	102.98	101.28	100.88	99.15	
Crude rate (%)	3.95	4.00	4.05	4.05	4.08	4.01	3.94	3.90	3.97	3.93	4.00	3.99	
Observed	1130	1145	1165	1162	1170	1154	1138	1131	1151	1148	1177	1183	
Expected	1074.43	1076.57	1095.19	1096.01	1098.68	1102.56	1113.10	1115.25	1117.74	1133.45	1166.77	1193.16	

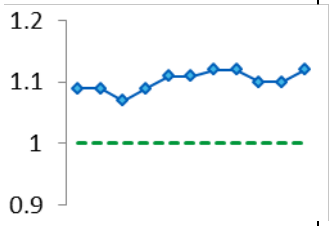
Weekend

Key: ◆ As expected ◆ Low ◆ High

12 months to:	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Trend
HSMR	113.99	118.13	115.13	115.42	117.65	117.54	117.57	117.07	116.48	115.36	115.15	112.09	
Crude rate (%)	5.82	6.05	6.01	6.16	6.32	6.30	6.35	6.33	6.33	6.18	6.30	6.20	
Observed	307	320	321	323	329	330	334	336	338	334	343	342	
Expected	269.33	270.89	278.82	279.85	279.64	280.75	284.10	287.00	290.19	289.53	297.88	305.11	

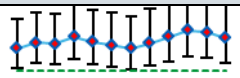
Summary Hospital-level Mortality Indicator (SHMI)

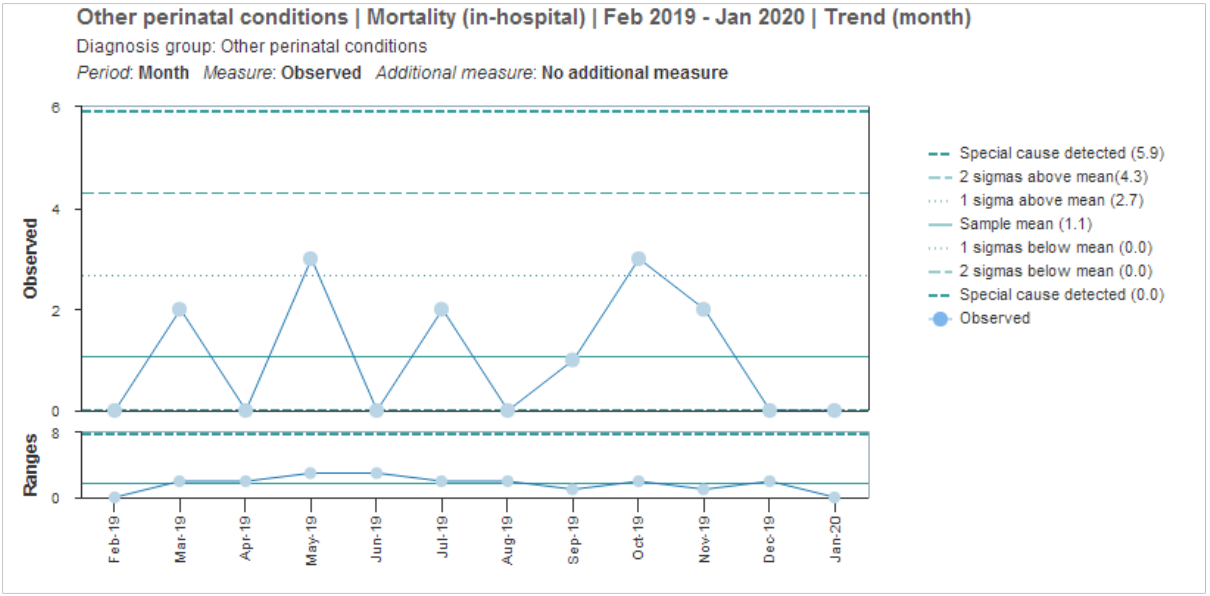
Key: ◆ As expected ◆ Lower than expected ◆ High

12 months to:	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Trend
SHMI	1.09	1.09	1.07	1.09	1.11	1.11	1.12	1.12	1.10	1.10	1.12	1.11	
Observed (in hospital)	1349	1292	1276	1295	1315	1310	1325	1320	1310	1310	1335	1335	
Observed (post-discharge)	627	618	611	610	620	610	600	605	590	590	590	585	
Expected	1815	1755	1760	1740	1745	1730	1725	1715	1720	1725	1725	1725	

Analysis of Outlier HSMR Diagnosis Groups

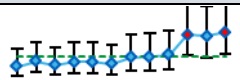
HSMR outliers are calculated based on diagnosis at admission; details of current outliers are provided below.

Relative Risk	Rolling 12 Month Trend	Lower CI	Upper CI	Total Observed	Expected	Consecutive outlier months
Other perinatal conditions						
250.3			133.1	428.0	13	5.2	18



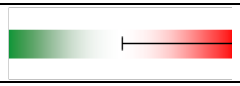
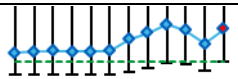
This diagnosis group includes stillbirths and early neonatal deaths, and Dr Foster therefore advises reviewing crude numbers to ensure that there is no prolonged trend of higher numbers of deaths in a month than average. The outlier status has probably been triggered by the two months with three deaths recorded in this diagnosis group, May 2019 and October 2019.

Of the thirteen deaths in this cohort, three relate to late terminations of pregnancy, eight were stillbirths and two related to babies transferred from the neonatal unit to a tertiary centre, where they subsequently died.

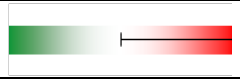
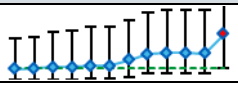
Relative Risk	Rolling 12 Month Trend	Lower CI	Upper CI	Total Observed	Expected	Consecutive outlier months
Short gestation, Low birth weight, Fetal growth retardation						
196.0			107.0	328.8	14	7.1	1

All of these deaths will be subject to the Child Death Review process; five of these babies died on the Oliver Fisher Neonatal Unit and nine were early neonatal deaths of babies born extremely prematurely at less than 23 weeks' gestation.

Relative Risk	Rolling 12 Month Trend	Lower CI	Upper CI	Total Observed	Expected	Consecutive outlier months
Spondylosis, intervertebral disc disorders, other back problems						

Relative Risk		Rolling 12 Month Trend	Lower CI	Upper CI	Total Observed	Expected	Consecutive outlier months
278.6			101.7	606.4	6	2.2	1

Four of the cases in this group have been reviewed and have received an overall care score of good or very good. Reviews of the remaining two cases will be requested. At this point, this outlier group is not statistically significant.

Relative Risk		Rolling 12 Month Trend	Lower CI	Upper CI	Total Observed	Expected	Consecutive outlier months
Open wounds of extremities							
374.5			*100.8*	*959.6*	*4*	*1.1*	*1*

Two of the cases in this group have been reviewed and have received an overall care score of good. Reviews of the remaining two cases will be requested. At this point, this outlier group is not statistically significant.

SHMI by Diagnosis Group

12 months to:	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Trend
Acute bronchitis	1.26	1.19	1.11	1.14	1.12	0.57	1.11		0.99	0.62	0.92	0.9	
Acute myocardial infarction	1.05	1.03	1.1	0.87	0.79	1.11	0.88		1.03	1.08	1.1	1.14	
Cancer of bronchus; lung	1.12	1.13	1.13	1.22	1.28	1.16	1.33	0.92	1.36	1.09	1.39	1.44	
Fluid and electrolyte disorders	1.09	0.94	0.91	0.97	0.91	0.94	0.94		0.81		0.79		
Fracture of neck of femur (hip)	0.89	0.9	0.86	0.9	0.86	1.3	0.88	0.65	0.95	1.18	0.94	0.96	
Gastrointestinal haemorrhage	1.15	1.12	1.1	1.09	1.11	0.99	0.93	0.97	0.81	0.77	1.09	1.12	
Pneumonia (excluding TB/STD)	1.09	1.09	1.09	1.09	1.13	0.94	1.12	0.65	1.12	0.88	1.1	1.09	
Secondary malignancies	1.05	1.01	0.99	1.05	1.06	0.88	1.05	0.67	1.11	0.84	1.06	1.04	
Septicaemia (except in labour), shock	1.12	1.11	1.09	1.13	1.17	1.14	1.10	1.14	1.06	0.85	1.02	1.01	
Urinary tract infections	0.82	0.87	0.86	0.91	0.81	0.74	0.89	0.59	1.03	0.91	1.04	1.11	

Outlier SHMI Diagnosis Groups

	SHMI	Observed Inpatient	Observed Post-discharge	Observed Total	Expected	Cohort	Consecutive outlier months
Cancer of bronchus, lung	1.44	24	34	58	40	105	2

Glossary

HSMR – The Hospital Standardised Mortality Ratio (HSMR) is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group.

Weekend HSMR – This is the HSMR for patients who were admitted on a Saturday or a Sunday; there is documented evidence that patients who are admitted at the weekend have a greater risk of mortality.

SMR – The Standardised Mortality Ratio (SMR) is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100).

SHMI – The Summary Hospital-Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Episode – The period of care that an individual receives in one hospital under the care of one consultant, if the care of a patient is transferred from one consultant to another then a new episode of care will start.

Spell – The period of care of an individual in one hospital which could include a group of episodes linked together to form a set of multiple consultant episodes, if a patient is transferred to another hospital then a new spell of care will start.

Superspell – The entire period of care a patient receives. This could include multiple consultant episodes and spells of care at multiple hospitals; alternatively, a superspell could contain only one episode of care at one hospital.

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Improvement Plan Update**	**Agenda Item**	5.1
Report Author	Ian Renwick, Improvement Director		
Lead Director	Ian Renwick, Improvement Director		
Executive Summary	Provides an update to the Trust Board on the development of the Trust's Improvement Plan and on progress with mobilisation against the key priorities. The report asks the Board to note progress on identifying the key corporate priorities included within the Plan, and in particular the process of engagement and consultation currently underway.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence			
Committee Approval:	Initially presented to Trust Board on 12 May 2020		
Executive Group Approval:	N/A		
National Guidelines compliance:	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback.		
Resource Implications	The introduction of a standardised approach to Quality Improvement, and the development of a Trust-wide Organisational Development programme may have financial implications, although external funding may be available to support these costs.		
Legal Implications/Regulatory Requirements	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback The Improvement Plan and associated governance structures have been developed to ensure high level clinical involvement and engagement in its delivery.		
Quality Impact Assessment	QIA is not necessary for the Plan itself, but will be an integral part of its implementation		
Recommendation/	Note progress to date on the development of the Improvement Plan, and		

Actions required	approve the Trust's improvement priorities contained within it.			
	Approval ☒	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1 – Improvement Plan Workstreams: • High Quality Care • Our People • Integrated Care • Innovation • Financial Stability Appendix 2 – Key Roles			

1 Executive Overview

1.1 Over recent weeks, significant progress has been made on the development of a single Improvement Plan for the Trust (of which its response to the findings of the CQC Inspection Report published on 30 April 2020 forms part).

1.2 Building on the presentation provided at the Board meeting last month, the key priorities across each of the five domains (or 'pillars') of the Plan have now been finalised by the Senior Responsible Officers (SROs). These are now the subject of a wider process of consultation and engagement across the organisation, and as such are presented here for the Board's information.

2 Improvement Plan

2.1 The Improvement Plan has been developed across five pillars aligned to the Trust's existing corporate strategic priorities:

Improvement Plan Domain	Senior Responsible Officers
High Quality Care	David Sulch Jane Murkin
Our People	Leon Hinton
Integrated Care	Harvey McEnroe
Innovation	Jack Tabner
Financial Stability	Richard Eley

The priorities across each of these pillars are shown at Appendix 1 to this report. These provide a balanced response to the challenges the Trust faces in the light of Regulatory and other feedback, set out across this and the following two financial years (subject to regular review and update).

2.2 Underpinning the development and implementation of the Improvement Plan, efforts have been made to strengthen clinical engagement and involvement in, and leadership and ownership of, the Improvement Plan. This includes the identification of Clinical Leads within each of the pillars. Details of the key roles across the Implementation Plan are attached at Appendix 2.

2.3 Successful delivery of the Improvement Plan will also be underpinned by a number of enabling programmes and supporting services:

- A standardised, Trust-wide approach to Quality Improvement (NHS QSIR);
- Development of a 'Board to Ward' Organisational Development programme;
- Further development of the Trust's Integrated Quality and Performance Report (IQPR);
- Introduction of a Portfolio Management Office;
- Finance;

- Information Technology;
- Estates.

3 Mobilisation

3.1 The first meeting of the Trust's Improvement Board (chaired by the Chief Executive) was held on 3 June 2020. Because of the timetable of meetings, an update on the key issues discussed at the Improvement Board will be provided verbally at the Trust Board meeting.

3.2 SROs will be available at the meeting to provide updates regard to specific pillars.

4 Conclusion and Next Steps

4.1 Significant progress has been made over recent weeks on the development of the Trust's overall Improvement Plan. This sets out the Trust's key improvement priorities over the next three years. However, for the Plan to be successful it needs to become embedded and sustained within the organisation; clinical leadership and engagement will be central to achieving this. To that end, a process of engagement and consultation is underway to 'test' the draft priorities and ensure that they resonate across the organisation as a whole.

4.2 Board members are asked to:

4.2.1 Note progress to date on the development of the Trust's Improvement Plan, and

4.2.2 Note the engagement and consultation process currently underway as part of finalising the key improvement priorities within the Plan.

Appendix 1 (i)

HIGH-QUALITY CARE	***Mission 1:*** ***SAFE*** *– Deliver Safe Care and Reduce Harm*	***Mission 2:*** ***EFFECTIVE*** *– Reduce Variation and Create a Safety Learning Culture*	***Mission 3:*** ***PERSON-CENTRED*** *– Transform the Patient Experience*	***Mission 4:*** *Create the* ***Conditions for Quality***
DELIVER NOW [0-9 months] 	**Fundamentals of Ward-based Quality** Standard approach to: • IPC • Pressure damage • Nutrition and hydration • Falls • Deteriorating patient **Safeguarding:** • Review • Legislation • Training to Level 5 Deployment of the **Nursing Assurance Framework**	**Quality Governance and Safety Learning Culture** Standard approach to: • Complaints, PALS • Serious Incidents/Never Events (Datix) • FTSU • Clinical audit • CNST • Coroner's inquiries	**Devise and Deliver Year 1 Priorities within a Patient Experience Strategy:** • Address the PE structure and colocation of patient experience teams • Implement 'what matters to me' • Thematic learning from incidents and complaints etc. in relation to PE • Patient-centred vocab / compact	Re-claiming the Nursing landscape including Role-specific **Nursing Leadership Development Programme** **Care Certificate** **EOLC** **Safe Ward Environment** – including Estates-related CQC findings: • COSHH • HDU bed dimensions Devise and deploy a programme for CQC as Business As Usual Nursing and Midwifery Workforce and Training Plan Devise and consult upon a **Nursing and Midwifery Strategy**
WORK TO IMPROVE [12-18 months] 				
PLAN TO TRANSFORM [18-months+]				

Appendix 1 (ii)

OUR PEOPLE

	Mission 1: *Best of People*	***Mission 2:*** *Best Culture*	***Mission 3:*** *Best Future*	***Mission 4:*** *Strategic Design of the Trust to be Well-led*
DELIVER NOW [0-9 months]	Safe Staffing (Wards) SD05 Workforce Grip and Control (VCP) Safe Staffing (Outpatients, Theatres, Specialist Nurses and Corporate) Local, National and International Recruitment	Values, Behaviours and Tools – induction (YatD) Staff Family and Friends Pulse Survey expansion Just Culture – Expansion beyond policy	Talent Management and Succession Planning Apprenticeship alignment to Skills Demand Performance Management processes to support High-Performing Teams	Ensuring corporate strategies have read across through Board and Executive reports (WL10) Executive presence in committees (WL22) Executive Leadership Capability (WL01) Stability (WL02) Risk Visibility (WL03, WL20) Board Development (WL04) CoSec structure (WL05) NED Role (WL06) Strategy deployment (WL09) Executive Culture (WL14) Executive Visibility (WL15) Regulatory Requirements (WL19, WL31) Results-based Gemba (WL23) Corporate Risk Register (WL25) Risk Escalation (WL26) SI Management Process (WL27) Reporting Assurance (WL30) Executive Innovation (WL37) Board Effectiveness Assessment completed annually
WORK TO IMPROVE [12-18 months]	Staff Retention and Stability Workforce Planning incorporating New Roles Equality and Inclusion Plans to narrow differentials WRES, WDES, GPG	QSIR FTSU Strategy delivery (WL17, WL33)	Staff Survey 2020 (WL33) NHSEI Culture and Leadership Programme and Organisational Development delivery (WL14, WL16)	Trust improvement Plan Executive Walkarounds
PLAN TO TRANSFORM [18-months+]	Remote and New Ways of Working: • Virtual Office • AI and Robotics			

Appendix 1 (iii)

INTEGRATED CARE

	Mission 1: *Safely Deliver 92% Occupancy*	***Mission 2:*** *Improve Cancer Outcomes*	***Mission 3:*** *Transform Outpatients Pathways*	***Mission 4:*** *Work as a "System by Default" in a Clinically-led Way*
DELIVER NOW [0-9 months]	Demand and Capacity Internal Discharge Delivery Flow and Site Ops WHO Checklist	Demand and Capacity PTLs Cancer Booking Process 62 day Breach avoidance	Demand and Capacity OP areas Estate	ICP/ System Engagement
WORK TO IMPROVE [12-18 months]	12 hr, 7 Day SDEC Admission Avoidance MFFD , Stranded and SS	Access to Diagnostics Tumour-Site Specific Groups 28-Day Standard		Parity of Esteem
PLAN TO TRANSFORM [18-months+]	UEC, 111, Comm. Pharmacy Integrated Discharge Hot/Cold Elective Care	Work w/ Cancer Alliance	Virtual outpatients (Attend Anywhere)	

Appendix 1 (iv)

INNOVATION

	Mission 1: *Single EPR*	***Mission 2:*** *User Experience*	***Mission 3:*** *System by Design*	***Mission 4:*** *Invisible IT*	***Mission 5:*** *Supporting Evidenced Based Decision Making*
DELIVER NOW [0-9 months]	Order Comms; EDRMS; Stabilise Extramed	CCIO & Clinical Advisory Group; Perfect Ward; Digital Dictation; Virtual Outpatients	ICP Digital Plan; Kent Data Sharing; Access Anywhere	Core IT Infrastructure; Telephony	IQPR/ GIRFT; Business Intelligence Enablers; Data Accuracy - 'R.I.R.O.'
	Digital Strategy				
WORK TO IMPROVE [12-18 months]	PAS Upgrade; RPA; Vital Signs	Single Sign-On; Remote User Working	Patient Portal	Data Centre	
PLAN TO TRANSFORM [18-months+]	EPR	Natural Language Processing	Population Health		AI/ML

Appendix 1 (v)

FINANCIAL STABILITY

	Mission 1: *Achieve Financial Targets – 'Getting to Zero'*	**Mission 2:** *Improve Value for Tax Payers' Money*	**Mission 3:** *Plan our Investments Efficiently*	**Mission 4:** *System Working*
DELIVER NOW [0-9 months]	Full Reimbursement of COVID Costs Management of Staff Costs Deliver I&E and Capital Targets	Deliver CIP Benchmarking of Services Commercial Plan Product Standardisation	Business Cases for Quality and Operational improvements Plan to recover Backlog Equipment and Maintenance	Review Portfolio of Services
WORK TO IMPROVE [12-18 months]	Deliver I&E and Capital Targets Long-Term Financial Plan to deliver future sustainability	Model Hospital, GIRFT Virtual outpatients Deliver CIP	Plan to implement an EPR	ICS Financial Plan Shared Provision Shared Control Totals
PLAN TO TRANSFORM [18-months+]	Deliver I&E and Capital Targets	Review Back Office Functions Deliver CIP		

Appendix 2

Key Roles

NHS Medway NHS Foundation Trust

	Executive Accountable	Support Directors	Clinical Leads	Portfolio Manager	Assurance
Improvement Board	James Devine	Ian Renwick	David Sulch & Jane Murkin	Linda Longley	Trust Board

	SRO	Support Directors	Clinical Leads	Programme Manager	Assurance
1 **High-Quality Care**	Jane Murkin & David Sulch	Katy White	DMDs DDoNs	Phillip Kemp & Jacqui Lesley	QAC
2 **Our People**	Leon Hinton	Nye Harries	**TBC**	Deputy Director Of HR/OD	People Committee (to be set up)
3 **Integrated Care**	Harvey McEnroe	Angela Gallagher	Paul Kitchen & Simone Haye	Paula Tinniswood Ian Stafford Jodie Taggart	QAC
4 **Innovation**	Jack Tabner	Michael Beckett	Sunil Jain	Kerensa De Roberto	Digital Delivery Group (to be set up)
5 **Financial Stability**	Richard Eley	Mark Hackett	**TBC**	Paul Kimber	Finance Committee

Best of care
Best of people

Meeting of the Trust Board in Public
Thursday, 04 June 2020

Title of Report	**Communications and Engagement**	**Agenda Item**	6.2
Report Author	Glynis Alexander, Executive Director of Communications and Engagement		
Lead Director	Glynis Alexander, Executive Director of Communications and Engagement		
Executive Summary	March, April and May have been a period of intense activity to ensure staff, patients and stakeholders have been kept informed about how the hospital is dealing with the coronavirus pandemic. Communications was an important element of the strategic and tactical response, with the Director of Communications working closely with the incident strategic commander and workstream leads. Feedback from staff has indicated that they have felt well-informed about developments including statistics relating to demand, and national guidance received. Updates have sought to provide information and reassurance about issues including PPE supplies and training. Meanwhile, during the same period a detailed communications plan was implemented in response to the CQC report publication. In spite of the necessary focus on COVID-19, it was essential that staff were aware of the findings of the report and engaged in improvements. The next phase will require a clear narrative about what the 'new normal' means for services and patient experience, while an engagement programme will ensure staff, patients and stakeholders are involved in the Trust-wide improvement plan.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	N/A		
Committee Approval:	N/A		
Executive Group Approval:	N/A		
National Guidelines	N/A		

compliance:				
Resource Implications	None			
Legal Implications/Regulatory Requirements	None			
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to note the report.			
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None			

1 Executive Overview

1.1 March, April and May have been a period of intense activity to ensure staff, patients and stakeholders have been kept informed about how the hospital is dealing with the coronavirus pandemic.

1.2 Communications was an important element of the strategic and tactical response, with the Director of Communications and Engagement working closely with the incident strategic commander and workstream leads.

1.3 Feedback from staff has indicated that they have felt well-informed about developments including statistics relating to demand, and national guidance received. Updates have sought to provide information and reassurance about issues including PPE supplies and training.

1.4 Meanwhile, during the same period a detailed communications plan was implemented in response to the CQC report publication. In spite of the necessary focus on COVID-19, it was essential that staff were aware of the findings of the report and engaged in improvements.

1.5 The next phase will require a clear narrative about what the 'new normal' means for services and patient experience, while an engagement programme will ensure staff, patients and stakeholders are involved in the Trust-wide improvement plan.

2 COVID-19

2.1 Since the coronavirus began to spread we have work hard to keep staff informed and up-to-date with national guidance.

2.2 Early on we developed a daily bulletin to ensure staff received a steady stream of information about changes to wards, PPE, social distancing, and support for their wellbeing.

2.3 The bulletin was produced seven days a week, dropping to three times a week towards the end of May as cases began to reduce.

2.4 We have also produced daily emails updating staff on the numbers of patients testing positively and other useful statistics. These continue to be issued every day, including weekends.

2.5 The bulletins and emails are supplemented with screensavers and posters, along with our electronic displays in the hospital.

2.6 There have also been regular opportunities for engagement with senior leaders to support staff – for example Harvey McEnroe and Jane Murkin have held coffee break chats and drop-in sessions which have been welcomed by staff.

2.7 Messages from the chief executive have been issued, encouraging and thanking them throughout this period, and other Executives, Non-Executives, and Governors have also written to staff.

2.8 Initiatives to support staff wellbeing have included a wellbeing hub established in the post graduate centre.

2.9 Our community, including residents and businesses, have been incredibly generous in providing donations, which have been co-ordinated and distributed by the hospital charity team.

2.10 Media and social media activity has largely focused on good news stories about patients recovering from COVID-19.

2.11 The deaths from COVID-19 were reported of an agency nurse who had served many shifts at the Trust, and a community-based Occupational Therapist who had previously worked at the Trust and been a staff governor. Tributes were paid by the Trust in both cases.

3 CQC REPORT

3.1 A comprehensive communications and engagement plan was implemented following the publication of the Trust's CQC report on 30 April 2020.

3.2 This included making staff aware of the content of the report, briefing stakeholders, and commenting through the media.

3.3 During May nine staff engagement sessions were organised on the Zoom platform which were well attending by a good spread of clinical and non-clinical staff.

3.4 An independent facilitator was engaged to encourage staff to discuss how they felt about the report and their views on future improvements. Most staff were keen to contribute their views. A poll showed that almost all staff were aware of the findings of the report, while there was more of a mixed picture in relation to people's optimism about achieving the improvements needed.

3.5 At the time of writing a staff questionnaire was being created to seek staff opinions on the findings of the CQC report and the culture of the organisation.

3.6 Further phases of the staff engagement plan will follow to ensure the views of staff help inform the wider improvement plan.

4 TRUST IMPROVEMENT PLAN

4.1 A communications and engagement plan is being developed in parallel with the Trust improvement plan with the aim of ensuring staff, patients, stakeholders and the wider public understand the objectives and are able to contribute to projects that enhance the experience of patients.

4.2 Existing communications channels are being reviewed to ensure they are effective in reaching each of the Trust's audiences.

4.3 Traditional, digital and interactive channels will be used to raise awareness of the plan and create opportunities for meaningful engagement.

4.4 We will also work collaboratively partners within the Medway and Swale Integrated Care Partnership and other community and voluntary organisations, including Healthwatch.

4.5 Communications will be evaluated throughout the process to measure impact.

4.6 Communications and engagement activity will work in conjunction with the Trust's culture and leadership programmes, and in support of clinical engagement and leadership.

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Finance Report**	**Agenda Item**	7.1
Report Author	Richard Eley, Director of Finance Paul Kimber, Deputy Director of Finance		
Lead Director	Richard Eley, Director of Finance		
Executive Summary	The Trust reported an unaudited final performance of £22.0m deficit; this is a £274k favourable variance to the NHSE/I Control Total.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 28 May 2020		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total in its unaudited position.		
QIA	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

Finance Report

March 2020

Contents

Executive summary
Run-rate
Income & expenditure
CIP
Balance sheet
Conclusions and recommendations
Appendices

1 Executive Summary

1.1 The report sets out the summary financial position to the end of March 2020.

	Current Month			Year To Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Income	26,653	36,917	10,264	312,993	325,673	12,680
Pay	(16,646)	(23,076)	(6,429)	(204,153)	(216,427)	(12,274)
Non-pay	(9,457)	(13,234)	(3,777)	(115,371)	(116,413)	(1,042)
Non-operating expenditure	(1,343)	(877)	466	(15,670)	(13,834)	1,836
Ledger	**(793)**	**(270)**	**523**	**(22,201)**	**(21,001)**	**1,200**
Control Total Adjustments						
18/19 PSF gain	-	-	-	-	(580)	-
Impairment Reversal	-	(585)	(585)	-	(585)	-
Donated Asset Adj.	15	(51)	(66)	-	146	-
Control total	**(778)**	**(906)**	**(128)**	**(22,294)**	**(22,020)**	**274**

1.2 The Trust is reporting a cumulative deficit of £22.0m against an agreed control total of £22.3m as declared in its financial plan, this being a final position (subject to audit) favourable variance of £274k for 2019/20. The Trust has therefore met it`s Control total and for the second year. The Capital budget was also fully spent with a £20k under-spend, thus staying within the capital limit.

1.3 The impact of Covid-19 costs of £1.8m are included in the position along with the equal and opposite additional income provided to fund these.

1.4 The Cost Improvement Plan achieved for 2019/20 was £18.2m, this is £0.2m higher than the submitted NHSE/I plan. The revised plan set internally of £19.5m to support patient flow and additional costs of planned care nursing establishment was not delivered as expected; the undershoot being offset through the application of the contingency reserve and general reserves.

1.5 In accordance with accounting policy the Trust estate was subject to a full revaluation at 31 March 2020, which was conducted by an external valuation service. As a result the land, buildings and dwellings increased in value by £6.7m; £12.7m of this is an upwards revaluation with a net £6.0m impairment. Within the impaired estate £0.6m resulted in an impairment reversal which has been credited to expenditure.

£'000	Plan	Actual	Variance
Current Month	(793)	(270)	523
Cumulative	(22,201)	(21,001)	1,200
Forecast	(22,201)	(21,001)	1,200

Income and Expenditure

The Trust has improved against its control total of £22.3m for 2019/20, achieving the Control total for the year.

The table shows the position on t he financial ledger including adjustments that are not part of the control total; these being a benefit from 18/19 PSF funding £580k, as well as £585k reversal from the revaluation reserve, and r emoving the donated asset depreciation charge £146k.

The Trust has reported a benefit of £1.8m from the £202m full and final settlement from commissioners. This change in the position reported at month 11 is due to a reduction in activity across all points of delivery as a result of the Covid 19 pandemic.

Divisional Detail

The planned care adverse performance is due t o significant overspending against pay and non -pay as a r esult of unbudgeted outsourcing activities as well as unfound efficiencies in the division. Income underperformance this month is £1.9m as elective procedures have reduced significantly as the services prepare for the impact of Covid-19.

UIC continues to make marginal improvements in its run-rate, although income is adverse to plan as non-elective activity has reduced as the division focuses on the impact of Covid-19.

Central reserves and accounting adjustments continue to be employed to manage the Trust's overall position.

£'000	Plan	Actual	Variance
Planned	27,261	17,518	(9,743)
Unplanned	(951)	(6,367)	(5,416)
Corporate	(16,001)	(15,825)	177
Estates and Facilities	(17,350)	(17,642)	(292)
Central	(15,159)	1,314	16,473
	(22,201)	**(21,001)**	**1,200**

£'000	Plan	Actual	Variance
Current Month	2,170	1,618	(552)
Cumulative	18,024	18,181	157

Cost Improvement

The Trust delivered £18.2m of efficiencies against its original CIP plan submitted to NHSE/I of £18.0m. The increased target of £19.5m to support patient flow and additional nursing establishment was not delivered as expected.

Capital

The Trust delivered a large scale programme of capital work in 2019/20 to safeguard patients and staff, together with delivering a number of developments. Fire safety and ED programmes continue into 2020/21.

£0.1m COVID-19 capital expenditure is included in the outturn for which retrospective additional funding is expected in 2020/21.

The delayed UTC project – for which PDC funding has been agreed and was over and above the plan – has been deferred to 2020/21.

£'000	Plan	Actual	Variance
Current Month	(4,745)	(4,861)	(116)
Cumulative	(23,713)	(23,693)	20

£'000	Plan	Actual	Variance
Balance at 31 Mar	5,135	12,385	7,250

Cash

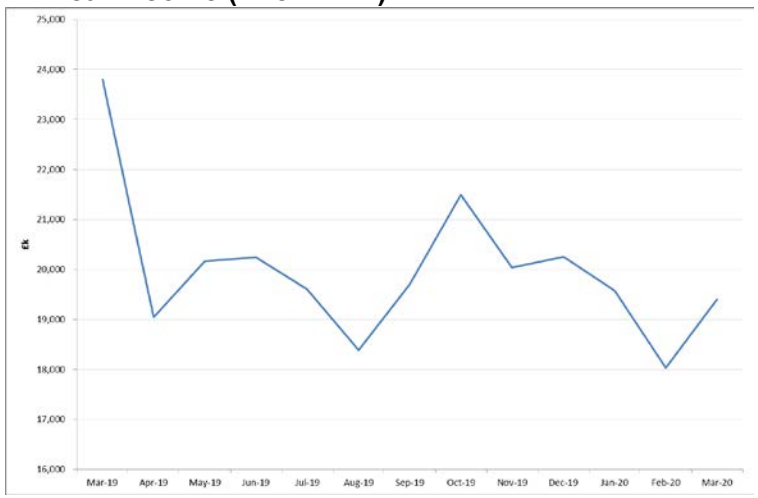
The cash balance at 31 March 2020 was £12.4m, £7.3m higher than planned. This represents a net increase in actual cash terms of £1.6m on the 2018/19 year-end balance.

Cash payments of £37m to staff and creditors were made in March, £8m more than the average for the 2019/20. £17m of this was in relation to substantive and bank staff costs and £20m to suppliers.

Revenue support loans of £19.6m were received in March.

2 Run Rates

Clinical Income (Excl. HCD)



Underlying income based upon c ost and volume of activity has remained at similar levels to recent months, however because the North Kent CCGs income is now on a year end fixed sum and we are tracking this to original plan phasing, the amount recognised is capped.

There has been underperformance across all PODs in month 12 due to Covid 19 which has meant that the Trust is a net beneficiary of this year end fixed sum.

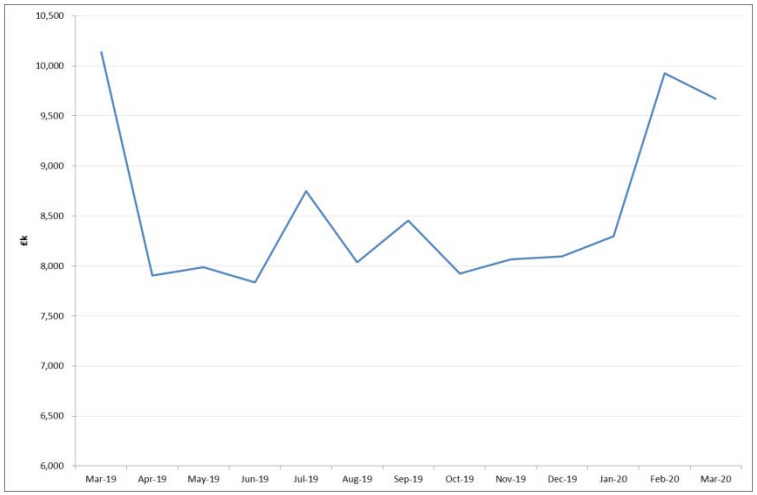
Pay

Total pay costs have remained static compared to February. The March figure has been adjusted for the benefit of reserves as well as increased pensions costs of 6.3 percent equating to £8.2m that have been pro-rated across the year to enable comparison with run rate of previous months. The adjusted total figure in the graph is therefore different to the table above.

- Higher temporary staffing costs across the Trust associated with absence cover due to sickness or self-isolating as a consequence of Covid-19 totals £885k. There is additional income included in the position to cover these costs.
- Excluding the Covid-19 impact on staff expenditure, total cost has reduced across the divisions as efforts focus on freeing up bed capacity in preparation for Covid-19 patients.

Finance Business Partners continue to work with Divisions to gain insight into recruiting plans and ensure the impact of Covid-19 on pay overspending is reported correctly.

Non Pay (Excl. HCD)



Underlying non-pay expenditure in March has decreased mainly in the Planned Care division as last month reported a catch up of costs associated with RTT work (£0.2m). The trend line included in the graph excludes the benefit of the contingency reserve and any remaining Trust reserves; it is therefore different to the figure included in the finance table above.

3 Income and Expenditure

3.1 Income

	Current Month			Year To Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Add Pension Cont - Cent Fund	-	8,189	8,189	-	8,189	8,189
COVID Funding	-	1,863	1,863	-	1,863	1,863
Clinical income	19,045	19,397	352	231,455	235,935	4,480
High cost drugs	2,358	1,781	(577)	27,146	23,274	(3,872)
Other income	1,983	2,420	437	23,764	25,204	1,440
Central Funds	3,267	3,267	-	30,628	31,208	580
Total Income	**26,653**	**36,917**	**10,264**	**312,993**	**325,673**	**12,680**

	Year To Date		
£'000	Plan	Actual	Variance
A&E	15,508	13,848	(1,660)
Adult Critical Care	11,035	9,795	(1,239)
Neonatal Critical Care	9,735	9,664	(71)
Elective Days Case	18,495	20,696	2,201
Elective In Patient	18,837	16,233	(2,604)
Non Elective In Patient	92,531	95,937	3,406
Maternity	10,464	9,911	(553)
Out Patient First	41,459	39,212	(2,247)
PbR Total	**218,064**	**215,296**	**(2,768)**
Direct Access	9,109	9,150	42
Devices	1,116	848	(268)
OP Ratio	(3,762)	(3,117)	645
Other	6,928	13,758	6,830
Non PbR Total	**13,391**	**20,639**	**7,248**
Clinical Income	**231,455**	**235,935**	**4,480**

Clinical income performance reflects the agreed block contract with our local commissioners for 2019/20. NKCCG have underperformed in month by £1.9m and the YTD performance is below the block contract. This is due to closure of theatres and cancellation of clinics and pl anned procedures due t o Covid 19. Activity in A&E has also been s ignificantly low in Month 12.

Discussions have continued with the CCGs to review and agree the findings and recommendations of the report issued by an i ndependent consultant on the value of the 19/20 contract. This is happening as part of the discussions to agree contract values for 2021.

3.2 Pay

	Current Month			Year To Date		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Substantive	(14,531)	(20,075)	(5,544)	(176,794)	(181,825)	(5,031)
Bank	(1,482)	(2,972)	(1,490)	(19,897)	(28,131)	(8,234)
Agency	(633)	(29)	604	(7,462)	(6,470)	992
Total	**(16,646)**	**(23,076)**	**(6,429)**	**(204,153)**	**(216,427)**	**(12,274)**

Medical	(5,225)	(7,224)	(1,999)	(64,105)	(69,203)	(5,099)
Nursing	(5,473)	(5,644)	(171)	(65,702)	(67,940)	(2,239)
Other	(5,949)	(10,208)	(4,260)	(74,347)	(79,283)	(4,936)
Total	**(16,646)**	**(23,076)**	**(6,429)**	**(204,153)**	**(216,427)**	**(12,274)**

£'000	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Planned	7,367	7,402	7,295	7,325	7,502	7,885	7,595	7,510	7,603	7,573	7,911	7,745
Unplanned	6,723	6,807	6,857	6,757	6,862	7,356	7,189	7,126	7,311	7,384	7,467	7,232
Corporate	1,686	1,713	1,693	1,684	1,655	1,723	1,659	1,730	1,654	1,785	1,689	1,766
Estates and facilities	1,046	1,030	1,027	1,029	1,039	1,036	1,043	1,030	1,010	1,080	1,049	998
Sub-total	**16,822**	**16,952**	**16,872**	**16,795**	**17,057**	**18,000**	**17,486**	**17,396**	**17,578**	**17,823**	**18,116**	**17,740**
Central	282	672	201	385	385	(398)	278	201	201	124	123	5,335
Total	**17,104**	**17,624**	**17,073**	**17,180**	**17,442**	**17,602**	**17,763**	**17,597**	**17,779**	**17,946**	**18,239**	**23,076**

Monthly pay spend has decreased across clinical divisions as the services focus on freeing up capacity to cope with Covid-19 patients. Staffing costs incurred to care for patients presenting or diagnosed with Covid-19 are captured in the Central Division and recovered from a central government funding mechanism. Also included in Central is the impact of the increased 6.3 percent pension cost, this is covered by additional income.

In month sickness absence increased by 16.2 percent, totalling 6,553 days. Temporary staffing costs across the divisions increased by £285k, this being an 8.8 percent increase. Permanent staff costs reduced by £339k and the number of vacancies moved slightly to 462 WTE vacant substantive posts.

Finance Business Partners continue to work with the Transformation Team and Divisions to identify areas of efficiency for 2020/21, as well as calculating and monitoring the impact of safer staffing establishments required on the budgets.

3.3 Non Pay

	Current Month			Year To Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Clinical Supplies	(3,644)	(5,127)	(1,483)	(43,605)	(47,113)	(3,508)
Drugs	(580)	(765)	(185)	(6,447)	(7,794)	(1,347)
High Cost Drugs	(2,280)	(1,739)	541	(26,676)	(22,785)	3,891
Other	(2,953)	(5,603)	(2,650)	(38,643)	(38,722)	(79)
Total Operating Expense	**(9,457)**	**(13,234)**	**(3,777)**	**(115,371)**	**(116,413)**	**(1,042)**
Non-operating Expenditure	(1,343)	(877)	466	(15,670)	(13,834)	1,836
Total	**(10,800)**	**(14,111)**	**(3,311)**	**(131,041)**	**(130,248)**	**793**

The clinical supplies adverse variance includes T&O insourcing costs in the Planned Care Division; there has additionally been an increase for Covid-19 consumables, PPE, medical equipment and training. Expected stock count adjustments have not been actioned due to current working conditions and ability to test the reliability of stock takes. In total, other non-pay is reporting a benefit following use of reserves to manage the Trust position.

£'000	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Planned	2,485	2,575	2,470	2,811	2,396	2,827	2,841	2,518	2,497	2,694	3,109	2,456
Unplanned	3,805	3,681	4,017	3,966	4,046	3,647	3,677	3,883	3,487	4,290	4,367	4,268
Corporate	506	529	498	553	545	559	580	568	576	569	733	691
Estates and facilities	763	828	746	770	805	925	781	824	872	890	957	910
Sub-total	**7,558**	**7,613**	**7,731**	**8,100**	**7,793**	**7,958**	**7,878**	**7,793**	**7,432**	**8,443**	**9,165**	**8,326**
Central	2,964	2,769	3,417	2,699	2,902	2,573	3,866	1,958	3,184	1,849	492	5,785
Total	**10,522**	**10,381**	**11,148**	**10,799**	**10,695**	**10,531**	**11,744**	**9,751**	**10,616**	**10,292**	**9,657**	**14,111**

The table above details the run rate of non-pay for all divisions. Central includes the impact of Covid-19 costs and reserve movements.

4 Cost Improvement Programme

The total efficiencies delivered during 2019/20 was £18.2m. Performance against each of the operational and corporate areas is set out in the tables below. The Transformation Team report provides further detail about CIP for 20/21.

Planned Care	Year To Date		
£'000	Plan	Actual	Variance
Urology Robot	1,169	1,169	-
Procurement	671	671	-
CNST	375	432	57
Other	5,019	3,054	(1,964)
Total	**7,234**	**5,326**	**(1,909)**

Unplanned Care	Year To Date		
£'000	Plan	Actual	Variance
Bank And Agency Reduction	1,993	1,313	(680)
Rheumatology repatriation	451	451	-
Deep Dive	590	588	(2)
Other	3,766	2,945	(820)
Total	**6,800**	**5,297**	**(1,502)**

Corporate	Year To Date		
£'000	Plan	Actual	Variance
STP Reduction	181	240	59
Senior Positions	128	132	4
Consultancy	79	84	5
Other	780	383	(397)
Total	**1,168**	**839**	**(329)**

Estates and Facilities	Year To Date		
£'000	Plan	Actual	Variance
Car Parking	325	50	(275)
Senior Management review	166	148	(18)
18/19 Linen	0	144	144
Other	933	866	(67)
Total	**1,424**	**1,208**	**(216)**

Central	Year To Date		
£'000	Plan	Actual	Variance
Productivity Gain	2,600	2,600	-
Income	1,000	1,000	-
Mars	954	954	-
Other	956	956	-
Total	**5,510**	**5,510**	**-**

Total	Year To Date		
£'000	Plan	Actual	Variance
Income	1,813	6,633	4,820
Pay	11,559	6,225	(5,334)
Non Pay	4,652	5,323	671
Total	**18,024**	**18,181**	**157**

5 Balance sheet

Assets

£m	As at 31 Mar 20	As at 31 Mar 19
Non-current assets	204.3	184.9
Inventory	6.3	5.9
Trade and other receivables	36.7	39.1
Cash	12.4	10.8
Total	**55.4**	**55.8**

Non-current assets represent capital expenditure net of depreciation and revaluation. The Trust delivered a £23.7m programme of work in 2019/20, with a net upwards revaluation of £6.7m.
It should be noted that the total net increase of £19.4m will give rise to additional depreciation and PDC dividends in 2020/21.
Cash balances have increased by £1.6m on the prior year and includes receipt of £31.4m of PDC and loans. Loans have continued to be drawn to maintain the cash balance to ensure the £15.4m of yet to be invoiced expenditure is partially covered.
Trade and other receivables include £13.6m of sales invoices outstanding, net of credit loss provision, £18.5m of income accruals and £3.4m of prepayments (goods that have been paid for in advance of receipt).

Liabilities

£m	As at 31 Mar 20	As at 31 Mar 19
Borrowings	(292.1)	(127.1)
Trade and other payables	(24.5)	(23.8)
Other liabilities	(4.9)	(2.9)
Current liabilities	**(321.5)**	**(153.9)**
Borrowings	(3.3)	(137.5)
Other long term liabilities	(0.9)	(0.9)
Total	**(3.2)**	**(138.4)**

Total borrowings as at 31 March are £293.8m shown at £294.4m amortised cost (principal plus current interest payable), all with the Department of Health and Social Care.
This is an increase of £29.8m in year; £19.6m revenue support and £10. 2m capital (£11.7m additional borrowing, net of £1.5m repayments).
£291m of the existing revenue and capital loans are categorised as interim loans which DHSC intends to write off in 2020/21 by way of issuing PDC. Whilst this is positive, the write off will take the Trust back into a net asset position giving rise to annual PDC dividend payments (3.5% of relevant net assets) in place of loan interest charges(1.5-2.6%).
Trade and other payables include £8.3m of invoices received, £15.4m of expenditure accruals, and £0.8m of contractual payables, i.e. employer costs.
Other liabilities of £5.8m include £2.7m of deferred income, which remains at the same level as prior year for Maternity Pathway and Research Funds.
£3.1m of provisions, increasing by £2m on the prior year. This is due to new dilapidations, onerous contracts and disputes being recognised.

Taxpayers equity

£m	As at 31 Mar 20	As at 31 Mar 19
Public Dividend Capital	140.6	138.9
Retained Earnings	(246.5)	(225.2)
Revaluation Reserve	41.4	35.0
Taxpayers equity	(64.5)	(51.3)

Public Dividend Capital has increased in month by £0.59m in relation to funds for LED and pharmacy projects. The Trust has received a total of £1.69m PDC in year.
The revaluation reserve has increased in line with the revaluations conducted as at 31 March 2020.

Aged Debt

Debtor Category	Current Month Total Trade Debt	Trade Debt Age Profile				
		Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
	£m	£m	£m	£m	£m	£m
NHS FTs	**2.34**	0.29	0.16	0.07	0.36	1.46
NHS Trusts	**2.30**	0.25	0.09	0.05	0.71	1.20
DH	**0.00**	0.00	0.00	0.00	0.00	0.00
Public Health England	**0.00**	0.00	0.00	0.00	0.00	0.00
Health Education England	**0.10**	0.10	0.01	0.00	0.00	(0.01)
CCGs and NHS England	**6.72**	0.81	1.05	0.56	0.81	3.49
Special Health Authorities	**0.00**	0.00	0.00	0.00	0.00	0.00
NDPBs	**0.00**	0.00	0.00	0.00	0.00	0.00
Other DH bodies	**0.00**	0.00	0.00	0.00	0.00	0.00
Total NHS Debtors	**11.46**	**1.45**	**1.31**	**0.68**	**1.88**	**6.14**
Other WGA bodies	**0.02**	0.00	0.00	0.00	0.00	0.02
Local Authorities	**0.09**	0.01	0.00	0.00	0.00	0.08
Bodies external to Government	**3.95**	0.39	0.23	0.28	0.39	2.66
Total Non NHS Debtors	**4.06**	**0.40**	**0.23**	**0.28**	**0.39**	**2.76**
Total Current Month Debtors	**15.52**	**1.85**	**1.54**	**0.96**	**2.27**	**8.90**
Provision for credit losses	*(3.20)* *					
Total Debtors	**12.32**					
Total Prior Month Debtors	**18.07**	**2.34**	**1.46**	**1.29**	**3.14**	**9.84**
Movement on Prior Month	**(2.55)**	**(0.49)**	**0.08**	**(0.33)**	**(0.87)**	**(0.94)**

*Full provision is £3.6m but £0.4m relates to Injury Cost Recovery debtors not in trade debtors analysis)

£15.6m is owed to the Trust from third parties.

£11.5m owed by other NHS organisations.

£4.0m owed by non-NHS debtors, for which a £3.2million credit loss provision has been recorded. This does not mean this is the value of debt deemed irrecoverable as under IFRS9 we are required to provide for inherent risk in addition to signs of impairment.

NHS Debt £11.5m; £10.0m overdue

£6.0m of overdue debt is with CCG's and NHS England, whilst £4.0m relates to overdue Provider to Provider debt. In line with current guidance, organisations have been instructed to settle this timely. (A significant value has been agreed but due to year end rules in respect of cut-off dates for payment these were not paid prior to the year end.)

£3.8m is outstanding across five local Trusts relating to clinical and non-clinical SLA's. much of which relates to estimated pathology billing and is currently being finalised.

Non NHS Debt

£1.8m relates to debt with Medway Community Healthcare, a meeting has now taken place with progress on some debts.

£1.0m overseas debtors: this has increased in-year as the Trust is now able to identify more cases and bill up to three years after the treatment has taken place. Unfortunately due to the nature of the debtor if identified retrospectively the probability of recovering the debt is low. For this reason credit losses at 50% are recognised for all debts of this type. The other 50% risk should be covered by the CCG.

6 Conclusions and recommendations

The Finance Committee is asked to note the attached report with particular reference to:

- The financial position as at 31st March 2020 is favourable than the control total by £274k.

Richard Eley
Director of Finance
April 2020

Appendix 1 – Flash Report

Key Financial Metrics

I&E Deficit EXCLUDING PSF YTD (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	(1.9)	(1.0)	(2.0)	(0.5)	
Actual	(1.9)	(1.0)	(1.9)	(0.3)	
Variance	0.0	0.0	0.1	0.2	

The Trust delivered a favourable variance for Month 12 on a planned deficit of £0.8 million. The remainder of the contingency reserve and general reserves have been used to cover adverse variances in income, SDEC, CDU, Surgical Services and unfound CIP.

Capital Expenditure YTD (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	(13.5)	(16.3)	(19.0)	(23.7)	
Actual	(15.5)	(16.5)	(19.2)	(23.7)	
Variance	(2.0)	(0.3)	(0.3)	0.0	

19/20 Capital Expenditure is on plan at £23.7m; this includes normal capex plus a small amount of unplanned COVID-19 expenditure which will be funded centrally.

CIP Delivery YTD (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	2.0	2.1	2.1	2.2	
Actual	2.0	1.6	1.6	1.6	
Variance	0.0	(0.4)	(0.5)	(0.6)	

CIP Delivery is £1.6 million and adverse to plan by £0.6 million. CIP performance over the last 4 months has been consistent (the December figure includes Cancer MDT £300k being reported in month), taking the normalised delivery of £1.7 million. The CIP plan includes the impact of the unidentified balances that were phased into the final 6 months of the year.

Cash Actual (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	5.1	5.1	5.1	5.1	
Actual	31.7	33.3	16.2	12.4	
Variance	26.5	28.2	11.1	7.3	

The Trust cash balance at 31st March 2020 is £12.4m, this is favourable to plan as higher levels of debt have been recovered from our debtors and slow invoicing from suppliers, this is particularly in relation to capital.

Monthly Pay (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	(16.7)	(16.8)	(16.7)	(16.6)	
Actual	(17.8)	(17.9)	(18.2)	(23.1)	
Variance	(1.1)	(1.2)	(1.5)	(6.4)	

Pay expenditure in month is £23.1 million and is £6.4 million adverse to plan. The position includes the impact of COVID-19 spend and the additional 6.3% pension costs that are funded centrally, as well as any remaining pay reserves.
The normalised pay spend figure excluding these adjustments is £17.9 million as services free up beds to cope with COVID-19 pressures.

Monthly Agency Expenditure (£m)

	Dec	Jan	Feb	Mar	RATING
Plan	(0.6)	(0.6)	(0.6)	(0.6)	
Actual	(0.7)	(0.6)	(0.6)	(0.0)	
Variance	(0.1)	(0.0)	(0.0)	0.6	

Agency Spend in Month 12 includes the benefit of the pay reserves for agency costs, excluding these the normalised position remains at £0.6m.

Better Payment Practice Code (BPPC by Volume (%)

	Dec	Jan	Feb	Mar	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	55.1	56.2	56.2	57.0	
Variance	(39.9)	(38.8)	(38.8)	(38.0)	

Non NHS BPPC continues to gradually improve. As aged creditors are resolved this rating will improve further over the coming months, the expectation is for 20/21 to see a significant improvement.

All Aged Creditors 60+ Days (£m)

	Dec	Jan	Feb	Mar	RATING
Actual	6.2	5.3	5.9	4.4	

Over 60 day aged Creditors has decreased, Finance and Operational teams continue to work together to resolve and clear aged balances.

All Aged Debtors 60+ Days (£m)

	Dec	Jan	Feb	Mar	RATING
Actual	13.6	13.7	14.3	12.2	

Over 60 day debt has decreased in March due to some clearance of aged CCG invoices.

Key:

	Adverse to Plan
	Favourable to Plan

Going in the right direction

Going in the wrong direction

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

Appendix 2 – Cash Flow Forecast Requested

13 Week Forecast	w/e																	
	Actual					Forecast												
£m	06/03/20	13/03/20	20/03/20	27/03/20	03/04/20	10/04/20	17/04/20	24/04/20	01/05/20	08/05/20	15/05/20	22/05/20	29/05/20	05/06/20	12/06/20	19/06/20	26/06/20	03/07/20
BANK BALANCE B/FWD	**16.20**	**15.76**	**15.31**	**40.43**	**25.31**	**35.58**	**35.19**	**61.36**	**49.60**	**40.17**	**37.74**	**58.44**	**45.79**	**36.08**	**33.67**	**31.40**	**51.19**	**40.24**
Receipts																		
NHS Contract Income	1.28	1.22	3.15	0.27	23.92	0.00	29.40	0.00	0.00	0.00	24.35	0.00	0.00	0.00	0.00	24.35	0.00	0.00
Other	0.21	0.96	0.46	0.55	0.50	2.91	0.78	0.28	0.40	0.28	0.66	0.28	0.22	0.40	0.53	0.40	0.53	0.53
Total receipts	**1.50**	**2.17**	**3.62**	**0.83**	**24.42**	**2.91**	**30.18**	**0.28**	**0.40**	**0.28**	**25.01**	**0.28**	**0.22**	**0.40**	**0.53**	**24.75**	**0.53**	**0.53**
Payments																		
Pay Expenditure (excl. Agency)	(0.38)	(0.45)	(0.40)	(9.13)	(7.87)	(0.40)	(0.40)	(9.07)	(7.52)	(0.40)	(0.40)	(9.07)	(7.52)	(0.40)	(0.40)	(0.40)	(9.07)	(7.59)
Non Pay Expenditure	(1.56)	(2.18)	(2.25)	(7.38)	(5.28)	(2.91)	(3.61)	(2.96)	(0.66)	(2.31)	(3.91)	(3.86)	(0.76)	(2.41)	(2.41)	(4.56)	(2.41)	(2.41)
Capital Expenditure	0.00	0.00	0.00	0.00	(1.00)	0.00	0.00	0.00	(1.65)	0.00	0.00	0.00	(1.65)	0.00	0.00	0.00	0.00	0.00
Total payments	**(1.94)**	**(2.62)**	**(2.66)**	**(16.51)**	**(14.14)**	**(3.31)**	**(4.01)**	**(12.03)**	**(9.83)**	**(2.71)**	**(4.31)**	**(12.93)**	**(9.93)**	**(2.81)**	**(2.81)**	**(4.96)**	**(11.48)**	**(10.00)**
Net Receipts/ (Payments)	**(0.44)**	**(0.45)**	**0.96**	**(15.69)**	**10.28**	**(0.40)**	**26.17**	**(11.75)**	**(9.43)**	**(2.43)**	**20.70**	**(12.66)**	**(9.71)**	**(2.41)**	**(2.28)**	**19.80**	**(10.95)**	**(9.47)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	19.64	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
MRET	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
PSF	0.00	0.00	1.98	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
DOH/FTFF - Capital	0.00	0.00	3.99	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	0.57	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
Loan Repayment/Interest payable	0.00	0.00	(1.44)	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	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**24.16**	**0.57**	**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**
BANK BALANCE C/FWD	**15.76**	**15.31**	**40.43**	**25.31**	**35.58**	**35.19**	**61.36**	**49.60**	**40.17**	**37.74**	**58.44**	**45.79**	**36.08**	**33.67**	**31.40**	**51.19**	**40.24**	**30.77**

Appendix 3 – Loan Schedule

Loan	Loan Type	Loan Purpose	Interest %	Principal Repayment date	Amount	Balance @ 1st April 2019	Loans Received	Loans Repaid	Balance @ 31st March 2020
					£000	£000	£000	£000	£000
1	Capital investment	Gamma Camera	0.82%	Oct 2019	1,600	230		(230)	0
2	Capital investment	£2.7m PAS, £1,8m MRI, £0.9m IT IFRASTRUCTURE	1.26%	Sep 2020	5,400	1,255		(835)	420
3	Capital investment	Winter capacity, Keogh and CQC recommendations	1.26%	Nov 2038	3,100	2,531		(126)	2,405
4	Revenue Support	2014/15 deficit support	1.50%	Sep 2020	22,500	22,500			22,500
5	Revenue Support	2015/16 deficit support	1.50%	Sep 2020	56,800	56,800			56,800
6	Revenue Support	2016/17 deficit support	1.50%	Jul 2020	21,300	21,300			21,300
7	Revenue Support	2016/17 deficit support	1.50%	May 2020	5,070	5,070			5,070
8	Revenue Support	2016/17 deficit support	1.50%	Jun 2020	4,609	4,609			4,609
9	Revenue Support	2016/17 deficit support	1.50%	Jul 2020	6,268	6,268			6,268
10	Revenue Support	2016/17 deficit support	1.50%	Aug 2020	3,249	3,249			3,249
11	Revenue Support	2016/17 deficit support	1.50%	Sep 2020	5,141	5,141			5,141
12	Revenue Support	2017/18 deficit support	1.50%	Jun 2020	5,860	5,860			5,860
13	Revenue Support	2017/18 deficit support	1.50%	Jul 2020	3,100	3,100			3,100
14	Capital investment	£2.3 ED and £1.4m various other	1.59%	Feb 2036	3,700	3,320		(195)	3,125
15	Revenue Support	2017/18 deficit support	1.50%	Aug 2020	5,128	5,128			5,128
16	Revenue Support	2017/18 deficit support	1.50%	Sep 2020	7,493	7,493			7,493
17	Revenue Support	2017/18 deficit support	1.50%	Oct 2020	4,326	4,326			4,326
18	Revenue Support	2017/18 deficit support £5.9m/£4.1m Additional Cash Support	1.50%	Nov 2020	10,015	10,015			10,015
19	Revenue Support	2017/18 deficit support	1.50%	Dec 2020	4,865	4,865			4,865
20	Revenue Support	2017/18 deficit support	1.50%	Jan 2021	3,615	3,615			3,615
21	Capital investment	ED Project - £2.79m Jan 18/£3m Feb 18	2.57%	Feb 2043	8,790	5,790	3,000	(240)	8,550
22	Revenue Support	2017/18 March deficit support £15.5m/Additional Cash Support £15.76m	1.50%	Mar 2021	31,260	31,260			31,260
23	Capital investment	Fire Safety	2.57%	Feb 2043	10,548	1,800	8,748		10,548
24	Revenue Support	2018/19 Deficit Support	1.50%	Apr 2021	4,400	4,400			4,400
25	Revenue Support	2018/19 Deficit Support	1.50%	Jun 2021	5,312	5,312			5,312
26	Revenue Support	2018/19 Deficit Support	1.50%	Jul 2021	4,054	4,054			4,054
27	Revenue Support	2018/19 Deficit Support	1.50%	Aug 2021	5,532	5,532			5,532
28	Revenue Support	2018/19 Deficit Support	1.50%	Sep 2021	3,244	3,244			3,244
29	Revenue Support	2018/19 Deficit Support	1.50%	Oct 2021	2,458	2,458			2,458
30	Revenue Support	2018/19 Deficit Support	1.50%	Nov 2021	5,568	5,568			5,568
31	Revenue Support	2018/19 Deficit Support	1.50%	Dec 2021	2,956	2,956			2,956
32	Revenue Support	2018/19 Deficit Support	1.50%	Jan 2022	2,747	2,747			2,747
33	Revenue Support	2018/19 Deficit Support	1.50%	Feb 2022	2,269	2,269			2,269
33	Revenue Support	2018/19 Deficit Support	1.50%	Mar 2022	10,001	10,001			10,001
33	Revenue Support	2019/20 Deficit Support	1.50%	Mar 2023	19,635		19,635		19,635
						264,066	**31,383**	**-1,626**	**293,823**

Meeting of the Board of Directors in Public

Thursday, 04 June 2020

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**7.2**
Committee Chair:	Jo Palmer, Chair		
Date of Meeting:	Thursday 30 April 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF and strategic risks The revised BAF format was noted. The Committee returned to the risks at the end of the meeting to determine the extent to which the meeting addressed them. A number of amendments were noted as being required; specifically, the investment risk was felt to be potentially understated and that this should be raised at the Board.	**Amber/Red**
2. Finance Report Month 12 The Committee noted that the Trust has achieved its control total for 2019/20 (being the second consecutive year), subject to audit. The Committee was concerned about the continued increase in pay	**Green**

spend and has thus commissioned two pieces of work: i) To understand the drivers of the increase. ii) To produce a financial sensitivity analysis of operational scenarios to move from current state to a reopening of services at the Trust.	
3. Finance Risk Register The Committee reviewed the Finance Risk Register and noted the risks and mitigations, together with current scores within the papers.	**Green**
4. Cost Improvement Programme The Committee received a report on the month 12 CIP position, noting that the Trust has realised over £18 million in 2019/20 in addition to the £21 million in 208/19. The Committee noted that there remains a gap to target for 2020/21 full year values per the draft plan. CIP planning work was requested to resume following the passing of the peak of the pandemic and it was noted that further operating plan guidance for 2020/21 is awaited.	**Amber/Green**
5. Budget Setting 2020/21 update The Committee received an update on 2020/21 budget setting; this confirmed that expenditure budgets have been signed off but that in the period up to 31 July 2020 there are nationally mandated commissioning arrangements. The Committee noted the requirement to make submissions to NHSE/I in respect of Covid-19 revenue and capital expenditure. It was also noted that during 2020/21 the DHSC will write-off interim loan debt by issuing Public Dividend Capital. The consequences of this are that: i) Those loans (c£291m) will now be classified as repayable within one year. ii) As the interest on loans of 1.5% is lower than the dividend rate payable (3.5%) there will be higher revenue costs going forward, albeit these are being funded by FRF.	**Green**
6. Committee Work Plan A number of changes were required to the work plan and as such this would be brought back to the May meeting.	**Amber/Red**
Decisions made As noted.	
Further Risks Identified All risks are captured within the risk register and the BAF.	
Escalations to the Board or other Committee BAF risk '3b Investment' was considered to be higher risk than currently shown as a result of a number of large projects on the horizon, most notably an EPR. The Board is therefore asked to consider this risk and its impact on the Trust (should funding not be made available).	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 4 June 2020

Title of Report	**Workforce Report**	**Agenda Item**	8.1
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Margaret Mcloughlin, Group Head of Human Resources; Lisa Webb, Group Head of Organisational Development		
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 668 candidates to date; 302 of these candidates have commenced in post over the last 12 months. Trust turnover has decreased to 12.15% (-0.33%) from 11.94%, sickness absence has increased to 4.36% (+0.2%) compared to the month of March and is above the Trust's tolerance level of 4%. Appraisal compliance has increased to 92.38% (+10.42% from 81.96%) and is above Trust target of 85%. Statutory and Mandatory training is at 88.3% (-0.24% from 88.45%) and is meeting the Trust target of 85%. The percentage of pay bill spent on s ubstantive staff in April at 85% has increased (+1%) compared to the month of March. The percentage of agency usage at 2% (+2%) has increased compared to the month of March. The percentage of pay bill spent on bank staff at 13% has remained unchanged.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators. • Nurse Recruitment		

	• Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Update on medical and dental; allied health professional; and, scientific, technical and therapeutic professional recruitment. 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Work stream as part of the 2020/21 cost improvement programme
Quality Impact Assessment	Not applicable
Recommendation/ Actions required	The Board is asked to note the content of this report.

Approval	Assurance	Discussion	Noting
☐	☒	☐	☒

Appendices	None

1 Introduction

1.1 This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that there are robust plans in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The report to Board is aligned to the objectives and deliveries associated with the Trust's People Strategy.

Best of People

We aim to transform ourselves through innovative staff-led improvements that meet the needs of our patients now and in the future

2 Recruitment

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During April 2020, nine FTE registered nurses and midwives joined the Trust (net decrease -2 FTE) on a substantive basis, alongside 11 FTE substantive clinical support workers/maternity care assistants (net increase +9 FTE, table 2).

2.2 Due to COVID-19 the Trust had no international nurse arrivals in April. To date a total of 180 international nurses have taken (OSCE) exam. The Trust has a first attempt pass rate of 82% and an overall success rate of 99%.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Ten Cpl international nurses have commenced in post, with 10 nurses remaining in the pipeline. 53 HCL nurses have also commenced in post. 4 candidates remain in the pipeline with offers being processed.

2.4 The Trust is also working with nine additional permanent nursing recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, MSI, Medline, Kate Cowhig, HealthPerm, Santuary

Healthcare and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial year.

2.5 To support the Trust in achieving its recruitment targets, new international campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend, Kate Cowhig, Sanctuary Personnel, MSI and Cromwell Medical Recruitment.

Table 1 below summarises the Trust's nursing recruitment pipeline as at end of April 2020:

Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline
320 (189 in last 12 months)	183	692	156

(Table 1: Nurse recruitment pipeline as of April 2020)

Table 2 below summarises offers made, starters and leavers for the month of April 2020:

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	27 (20 NHS Jobs/ 0 open days & 7 international nurses via skype)	8	10
Clinical support workers/Maternity Care Assistants	8 (Clinical Support Workers)	11	2

(Table 2: Nursing starters and leavers April 2020)

2.6 During April a total of six medical staff joined the Trust. Focussed discussions on recruitment of medical staff takes place regularly within divisions during the vacancy control panel (VCP) meetings that are chaired by the divisional directors. At present consultant recruitment is taking place for the following specialities Acute Medicine, Cardiology, Gastroenterology, Geriatrics, Otolaryngology, Paediatrics and Haematology. As at end of April 2020 the Trust had 32.98 FTE vacant consultant posts and 25.61 FTE vacant non-consultant posts. Table 3 below summarises offers made, starters and leavers for the month of April 2020:

Role	Offers made in month	Actual starters	Actual leavers
Consultants	2	3	1
Junior doctors (including doctors in training)	11	3	1

(Table 3: Medical staff starters and leavers April 2020)

2.7 During April four Allied Healthcare Professionals (AHP) (Physiotherapists, Occupational Therapists, Radiographers and Dieticians) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant physiotherapy/occupational therapy especially when filling difficult to recruit to posts. Table 4 below summarises offers made, starters and leavers for the month of April 2020.

Role	Offers made in month	Actual starters	Actual leavers
Physiotherapists	0	1	1
Therapy Assistant Practitioner	1	0	0
Occupational Therapists	0	0	0
Dieticians	1	1	0
Radiographers	1	2	2
Sonographer	0	0	0

(Table 4: AHP starters and leavers April 2020)

2.8 During April one Scientific, Technical and Therapeutic (ST&T) staff (including, but not limited to, Pharmacy staff, Operating Department Practitioners) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and

new roles including assistant practitioners especially when filling difficult to recruit to posts. Pharmacy department is currently in discussions with local community providers to develop joint rotational posts that will help fill some of the vacancies and providing learning in the different settings. Table 5 below summarises offers made, starters and leavers for the month of April 2020:

Role	Offers made in month	Actual starters	Actual leavers
Pharmacy Technicians	0	0	1
Pharmacy Assistant	1	0	0
Pharmacists	3	1	1
Operating Theatre Practitioners / Theatre Nurses	0	0	0
Anaesthetic Assistant	0	0	0
Assistant Practitioner (Theatres)	0	0	0

(Table 5: ST&T starters and leavers April 2020)

3 Trust and Divisional Metrics

3.1 The table below (table 6) shows performance across five core indicators by the divisions. Turnover, at 12.15% (-0.33% from 12.48% in March), remains above the tolerance level of 8%. HR Business Partners work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results implementing service specific retention plans. Sickness absence at 4.38% is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 92.38% (+10.42% from 81.96% in March) and is above the Trust target of 85%, all divisions are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

3.3 Statutory and Mandatory training stands at 88.30% (-0.24% from 88.54%) and is meeting the Trust target of 85%. All divisions across the Trust are meeting the Statutory and Mandatory training target. SMEs provide sufficient capacity to provide face-to-face opportunities to meet the demand.

		MFT			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.00%	12.15%	▼		13.79%	▲		9.54%	▼		11.43%	▼		13.23%	▼	
Vacancy rate	12.00%	10.99%	▼		4.53%	▼		17.08%	▲		10.47%	▼		11.58%	▼	
Sickness rate (12-month rolling)	4.00%	4.36%	▲		2.60%	▼		6.45%	▼		4.69%	▼		3.93%	▲	
Statutory & Mandatory Training	85.00%	88.30%	▼		92.55%	▼		86.55%	▼		88.75%	▼		87.37%	▼	
Medway Appraisal	85.00%	92.38%	▲		91.93%	▲		86.40%	▲		94.94%	▲		91.43%	▲	
Agency costs (as % of total paybill)		2.17%	▼		3.82%	▼		0.17%	▼		1.08%	▼		2.38%	▼	
Bank costs (as % of total paybill)	11.00%	13.22%	▼		3.34%	▼		9.44%	▼		7.99%	▼		14.57%	▼	
Substantive costs (as % of total paybill)	89.00%	84.61%	▲		92.84%	▲		90.39%	▲		90.93%	▲		83.05%	▲	
Stability Index (12-month rolling, >12M)	85.00%	85.06%	▼													
Leavers citing "Work/Life Balance" 12m rolling	n/a	85.75	▲													

(Table 6: Key Workforce Metrics)

3.4 The table below (table 7) shows the compliance with StatMan on a divisional and care group basis:

Division >> Care Group	Compliance %
Corporate	**92.28%**
Communications Directorate	97.22%
Finance	93.95%
Human Resources & Organisational Development	99.26%
IT	89.81%
Medical Directorate	95.43%
Nursing	87.00%
Strategy, Governance and Performance	91.55%
Transformation	**83.33%**
Trust Executive & Board	**84.57%**
Facilities and Estates	86.77%
Facilities and Estates Management	**84.52%**
Hard FM	91.13%
Soft FM	86.26%
Planned Care	88.71%
Cancer Services	**90.43%**
Peri-operative & Critical Care	88.71%
Planned Care Infrastructure	85.06%
Surgical Services	86.86%
Women's & Children's Health	89.64%
Unplanned and Integrated Care	87.72%
Diagnostics & Clinical Support Services	**89.18%**
Specialist Medicine	89.37%
Therapies & Older Persons	87.90%
Unplanned & Integrated Care Management	**82.05%**

(Table 7: StatMan compliance profile)

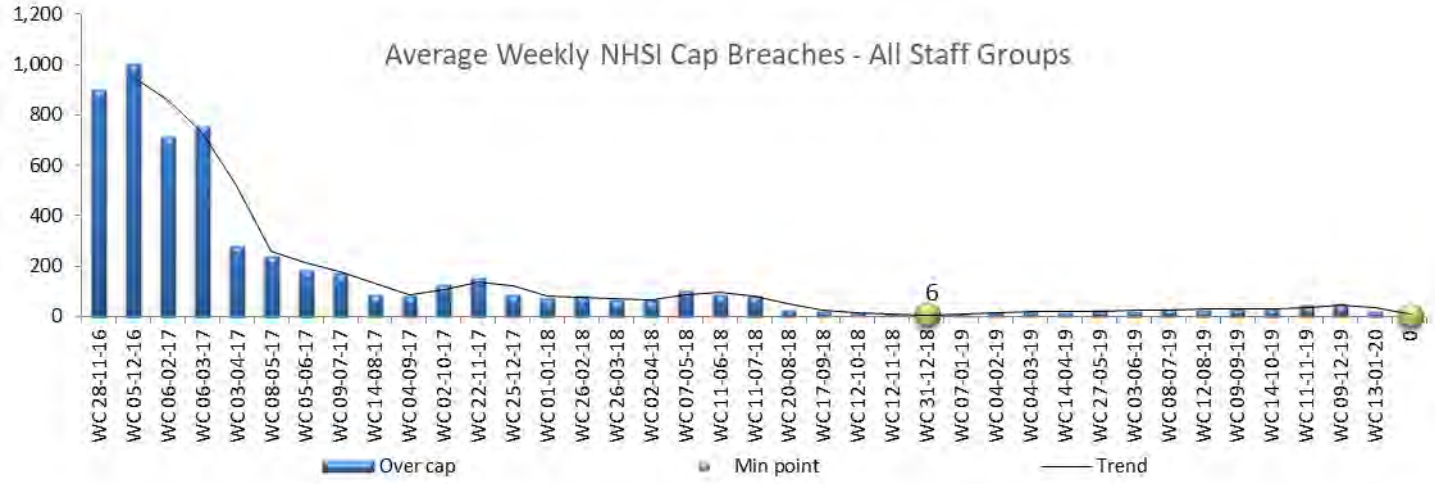
4 Temporary Staffing

4.1 Table 8 below demonstrates that temporary staffing expenditure increased in April 2020 compared to March 2020.

		Mar-17	Mar-18	Mar-19	Apr-19	Oct-19	Jan-20	Mar-20	2019/20 FYE	Apr-20
Spend	Agency	£3,890,198	£2,597,697	£783,127	£684,291	£634,482	£615,767	£28,843	£6,469,940	£393,932
	Bank	£920,473	£2,329,768	£2,105,055	£2,267,819	£2,371,903	£2,445,677	£2,872,089	£28,031,242	£2,403,455
	Substantive	£13,611,458	£13,542,990	£16,377,676	£14,152,087	£14,756,923	£14,884,893	£20,074,596	£181,825,421	£15,383,919
% of pay bill	Agency	21%	14%	4%	4%	4%	3%	0%	3%	2%
	Bank	5%	12%	11%	13%	13%	13%	13%	13%	13%
	Substantive	74%	74%	85%	84%	83%	84%	87%	84%	85%

(Table 8: Contractual profile)

4.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 1 below. During the month of April 2020 the Trust reported an average of 25 breaches per week across the month.



(Chart 1: NHSI cap breaches)

4.3 As Detailed in table 9, The Trust was £11.41m below its annual target NHSI Agency ceiling target for 2019/2020 (set at £17.88m). The Trust's agency spend for 2019/20 was £11.41m below the ceiling.

	Apr-19	Sept-19	Nov-19	Jan-20	March
Cumulative NHSI ceiling target	£1,490,000	£8,940,000	£11,920,000	£14,900,000	£17,880,000
Agency in month actual spend	£684,291	£506,702	£676,962	£615,767	£28,843
Cumulative below ceiling	£805,709	£5,073,562	£7,248,820	£8,941,362	£11,410,060

(Table 9: NHSI ceiling performance)

4.4 Temporary nursing demand decreased in April 2020 compared to March 2020 (8,546 shift requests in April 2020 compared to 10,770 shift requests in March 2020). The fill rate decreased to 64% (-5% compared to March). Medical locum demand also decreased in April 2020 compared to March 2020 (1,439 shift requests in April 2020 compared to 1,671 shift requests in March 2020). The fill rate for medical locum increased to 86% (+3% compared to March).

Best Culture

We aim to have a culture of openness and transparency, values that staff live by, and quality-led actions across our entire workforce

5 Culture and Leadership Programme

5.1 Programme phase status: This programme commenced in April 2019 and is the vehicle to bring all culture, leadership and wellbeing work together. The programme is a three-phase process:

- Discover - diagnosing the culture using a range of six elements, including focus groups, interviews and surveys, building understanding of the strengths and where the gaps are. This stage is complete.
- Design - agreeing a clear Leadership Strategy to deliver priorities over a three-year period
- Deliver - implementing the strategy across a broad range of disciplines and departments.

5.2 The impact of the Culture and Leadership programme to date

5.2.1 The Culture and Leadership dashboard is populated by NHSEI as part of the programme and is an extrapolation of results from the national staff survey, where it shows our overall position compared to other Trusts in the same category. In Aug 2019, based on 2018 staff survey results, MFT was ranked 84 out of 89 acute Trusts. This position improved in 2019 to a ranking of 64 of 88 Trusts.

Figure 1 (top): Comparison of overall position based on 2018 to 2019 staff survey results;
Figure 2 (bottom): Comparison of culture dimension position based on 2018 to 2019 staff survey results

5.2.2 Following a targeted invitation approach to staff representing bands 3-5, we have had over 40 members of staff express interest in being part of the Change Team; a far larger number than originally envisaged. People have volunteered from all around the Trust including clinicians, managers, staff running our retail services and people from across IT, HR, Finance and Estates. We also have people from a range of different bands, including people at bands 2 and 3 who will not only be able to provide real insight into how our culture translates into front-line services, but who may well also be our leaders of the future. There are people who were involved in the original 'You are the Difference' Ambassadors programme alongside people who have signed up more recently.

We now have a timetable for building on the Diagnostic element of the Programme. This illustrates that we will keep up a steady flow of activity between now and the end of the calendar year, so that there is no chance of the Programme slipping from view. The aim is to have this element completed at the beginning of 2021, so that we can then proceed to the next phases. In building on the Diagnostic phase, we will draw on, and incorporate, the outcomes from previous Focus Groups and surveys, and also the findings from the Staff Engagement Sessions in relation to the recent CQC report, so that we draw everything together in a single thread.

6 Staff survey

6.1 The 2019 NHS staff survey results were released nationally on 18 February 2020. Care group managers received a guided workbook detailing breakdown for their area thematically grouped to support the local action plan delivery to be written and owned locally.

6.2 Action planning with staff has been delayed as a result of the Covid-19 response where the focus of attention, in the context of staff engagement, has been on the provision of health and well-being support and resources.

7 OD response to Covid-19

7.1 With an average in excess of 20 new staff joining the Trust each week the immediate priority was to ensure induction programmes could continue to be delivered in a safe manner. To that end Corporate and Clinical programmes were converted to an online format in the first week, taking advantage of facilitated webinar technology and subsequently developing additional eLearning content at pace.

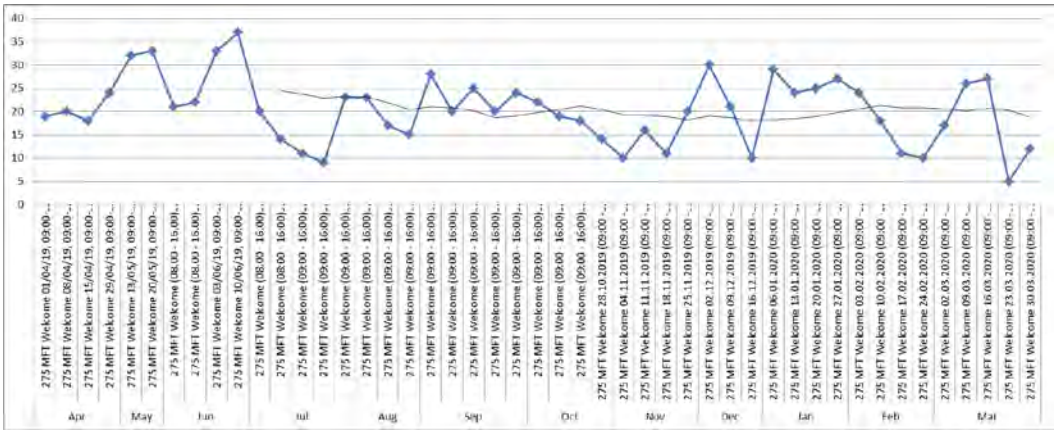
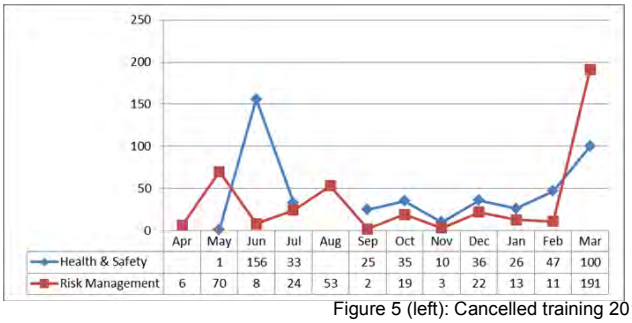


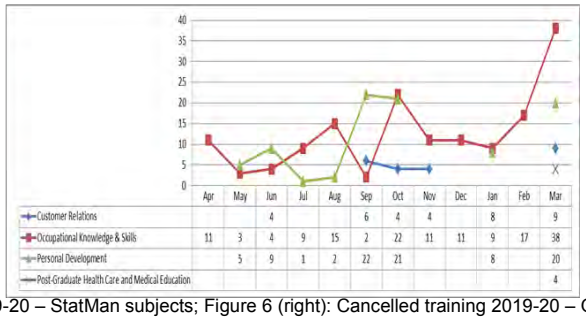
Figure 4: MFT Corporate Welcome attendance 2019-20

7.2 With the exception of the practical assessment elements of resuscitation and manual handling training, which continued in their usual small group format and taking into account social distancing, all elements of induction programmes have transitioned to online delivery. Evaluation scores have moved from 80% positive in week 1 to the current 89%.

7.3 Class room based training was initially cancelled as part of the Covid-19 response affecting six StatMan classes and 12 related to other subjects. Where national eLearning products were available StatMan subjects were immediately moved from classroom based training to online.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health & Safety		1	156	33		25	35	10	36	26	47	100
Risk Management	6	70	8	24	53	2	19	3	22	13	11	191



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Customer Relations			4			6	4	4		8		9
Occupational Knowledge & Skills	11	3	4	9	15	2	22	11	11	9	17	38
Personal Development		5	9	1	2	22	21			8		20
Post-Graduate Health Care and Medical Education												4

Figure 5 (left): Cancelled training 2019-20 – StatMan subjects; Figure 6 (right): Cancelled training 2019-20 – Other subjects

7.4 A rolling conversion programme was implemented to ensure continuity of service of what was previously classroom based training, beginning with Fire Safety and a range of clinical subjects, to facilitated online learning or eLearning where appropriate.

7.5 OD services including coaching, support for apprenticeship learners and facilitated meetings have taken advantage of available technology to ensure continuity.

7.6 A wider conversion programme continues for the entire range of OD products and services.

~ END ~

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

Title of Report	**Formation of People Committee**	**Agenda Item**	8.2
Report Author	David Seabrooke, Interim Company Secretary		
Lead Director	Leon Hinton, Director of HR and OD		
Executive Summary	The Board has previously agreed to establish a new committee called the People Committee. A first draft terms of reference has been produced, outlined here and a NED Chair of the committee has been discussed. It is envisaged that the People Committee will meet on the same day as Nominations and Remuneration Committee and that all NEDs will be invited to attend.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Executive Group Approval:	n/a		
Resource Implications	The overhead in supporting the new committee, which is expected to be quarterly, will be met from existing resources.		
Legal Implications/Regulatory Requirements	none		
Quality Impact Assessment	Not required.		
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	none		

1 Executive Overview

1.1 The detail of the terms of reference of the proposed People Committee will be discussed at the first meeting of the committee if this report is approved.

1.2 It is envisaged that the committee will support and challenge the Director of HR and OD in delivery of this portfolio. The regular and "guest" attendance from within the organisation will be discussed by the committee and will form part of the terms of reference.

1.3 Areas likely to form part of the committee's remit:

- support the monitoring of the Trust Improvement Plan and the associated workforce plan review workforce KPIs, such as for staff satisfaction, training and appraisal
- provide a forum for equalities and freedom to speak up
- review the relevant part of the Board Assurance Framework
- oversee the delivery of the People strategy
- support the recruitment of staff
- receive reports from aligned internal groups

2 Conclusion and Next Steps

2.1 If the Board is content to approve the committee being established then an inaugural meeting will be scheduled to discuss the terms of reference and work plan and seek necessary board approval.

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 04 June 2020

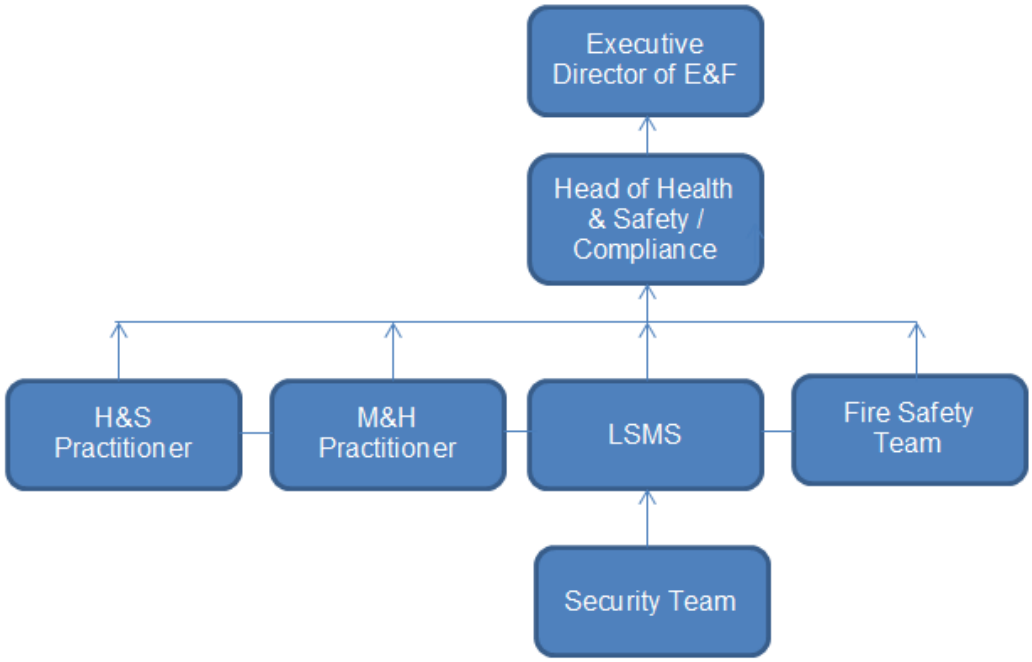
Title of Report	**Annual Health & Safety Report**	**Agenda Item**	9.1
Report Author	Paul Norman-Brown, Head of Health, Safety and Compliance		
Lead Director	Gary Lupton, Executive Director of Estates and Facilities		
Executive Summary	This report, aims to ensure the Chief Executive and the Board, are aware of the Trust activities relating to Health & Safety compliance during the period of 01 April 2019 to 31 March 2020		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Health and Safety Strategic Committee, 17.03.2020		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Health & Safety Strategic Committee plays a key role in monitoring the Trust's compliance with current legislation and the requirements of the Health and Safety Executive (HSE). The Health and Safety at Work Act 1974 (HASAWA), places a duty on employers to ensure so far as is reasonably practicable, the health, safety and welfare at work of all their employees. A breach of the Act could give rise to prosecution, financial implications, civil claims and reputational damage.		
QIA	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to note and approve the contents of this report. The Board is asked to note the Health and Safety strategy.		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1: Health & Safety Strategy		

1 Executive Overview

1.1 In accordance with the Health and Safety at Work Act 1974, supporting regulations and all other associated approved codes of practice (ACOPS), this report looks to provide assurance to the Board on how the management of Health and Safety is currently undertaken within the Trust and the planned Health & Safety Strategy going forward.

2 Structure

2.1 The structure of the Safety Team has been revised, and no longer includes the provision for Emergency Preparedness, Resilience and Response (EPRR). As such, the structure is now as shown below:



2.2 The Safety Team is further supported by volunteers within the Trust, undertaking roles such as Keyworkers for Health & Safety or Moving & Handling, or Fire Wardens.

2.3 The Head of Health & Safety and Compliance was appointed in May 2019. This role was created to bring together individual safety related disciplines, in order to coordinate these resources, create synergies and improve resilience. The role also incorporates the function of providing assurance on the estate.

3 Training

3.1 Health & Safety training within the Trust currently consists of 2 levels of training:

1. **Health, Safety and Welfare** training at induction with a renewal period of 3 years. At renewal, training can be undertaken as either face to face session or via a national e-learning package.
2. **Health & Safety Keyworker** training, delivered as a 1-hour induction session, followed by subsequent monthly 'development sessions'.

   This training aims to provide the required skill set to nominated individuals from service areas in order for them to take an active role in the Health & Safety management within their area. This is inclusive of completing risk assessments and workplace inspections, being able to provide low-level

Health & Safety advice to colleagues, and also be a central point of communication for the Health & Safety team to ensure key messages are communicated effectively.

The Trust currently has 64 trained keyworkers, an increase of 31% from 2019/20.

3.2 **Table 1** shows the current compliance figures for Health, Safety & Welfare training as of the statutory and mandatory report released on 24/02/2020.

Table 1

Directorate	Compliance
Trust	94%
Unplanned and Integrated Care	93%
Planned Care	96%
Estates and Facilities	85%
Corporate	97%

3.3 There is an identified need for a suite of bespoke Health & Safety Training to be available to staff, such as Breakaway Training for a select number of staff, COSHH Awareness Training, Confined Space, etc. To-date the Executive team have approved the need for COSHH awareness training to be mandated, software has been procured and training will be rolled out during 2020.

4 Incident Reporting

4.1 The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 2013, require employers to report and keep record of certain incident types. The submissions are made directly to the HSE via the Health & Safety Team.

4.2 The number of RIDDOR submissions since the last board report in April 2019 totals 15.

4.3 **Table 2** shows the number of RIDDOR submissions over the last 3 financial years.

Table 2

Financial Year	No. of RIDDOR Submissions
2017-18	16
2018-19	35
2019-20 (YTD)	15

4.4 For 2018-19, data submitted for the ERIC return (Estates Returns Information Collection), suggests for Medium Acute Trusts, an average of 7.34 RIDDORS were submitted for the Estates and Facilities Division.

4.5 **Table 3** shows the breakdown of RIDDOR submissions by directorate for the current financial year.

Table 3

Directorate	No of RIDDOR submissions
Unplanned & Integrated Care	1
Planned Care	8
Estates & Facilities	4
Corporate	1
Injuries to members of the public	1
TOTAL	**15**

4.7 **Table 4** shows the breakdown of RIDDOR submissions by accident type for the current financial year.

Table 4

Injury Type	Number of Submissions
Crush Injury	1
Formalin Spill	1
Incorrect Use of Equipment	2
Moving & Handling Injury	2
Slip, Trip & Fall	6
Struck By Object	1
Violence & Aggression	2

4.8 The Health & Safety Team rely on staff using the internal incident reporting system (DATIX) in order to identify trends.

5 Enforcement Notices

5.1 Over the last 5 years, the Trust have received the below 2 enforcement notices from the HSE. Both notices were in relation to the category level 3 (CL3) containment facilities within microbiology, which has now been taken out of service since the introduction of the North Kent Pathology Service;

Type of Notice	Date Received	Details
Prohibition Notice	February 2014	No thorough examination and check on LEV - persons liable to be exposed to substances hazardous to health. i.e. Hazard Group 3 biological agents such as mycobacterium tuberculosis because the HEPA filter used to filter extracted air from the CL3 laboratories had not been subject to thorough examination in preceding 14 months.
Improvement Notice	December 2017	MHSWR 1999, Reg 5(1), inadequate health and safety management arrangements for the planning, organisation, monitoring and review of work with biological agents.

5.2 Following a visit by the Care Quality Commission in November 2019, the trust was issued with a Warning Notice under Section 29A which, among other things, raised concerns with the securing of areas accessible to patients, especially where COSHH products were stored. A task and finish project was carried out to address the concerns in the notice and longer term controls have been implemented to monitor these areas.

6 Conclusion and Next Steps

6.1 The management of Health and Safety remains a key priority for the Trust with appropriate resources being provided to manage this within the organisation.

6.2 The Trust must work to improve both the incident reporting culture and the systems within which the data is captured. Further work is required to improve staff training for DATIX, to ensure data is captured correctly.

6.3 The Trust has seen an increase in the number of incidents reported in relation to:

- Slips, trips and falls (+17%)
- Moving & handling injuries (+17%)
- Struck by or against an object (+20%)
- Sharps and contamination injuries (+29%)

6.4 Assaults on staff, and work-related stress remain widely reported, with slips, trips and falls incidents having the highest number of RIDDOR reported incidents to the HSE.

6.5 Work will need to focus on these key areas, and those identified by the CQC, to address the risks, and also to embed a culture where the focus is on prevention and learning.

~ END ~

Appendix 1

Health & Safety Strategy

Author:	Head of Health, Safety & Compliance
Document Owner	Executive Director of Estates and Facilities
Revision No:	1
Document ID Number	STRCS015
Approved By:	Health & Safety Strategic Committee
Implementation Date:	April 2020
Date of Next Review:	April 2023

Strategy

Document Control / History	
Revision No	**Reason for change**
1	New document

Consultation
Health & Safety Operational Group
Health & Safety Strategic Committee

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1 Introduction

1.1 Effective health and safety management supports Medway NHS Foundation Trust by preventing adverse and avoidable incidents from impacting on the delivery of its objectives.

1.2 The aim of this document is to provide a strategic direction to all Trust departments, to enable a shared vision for the full and effective integration of health & safety management into operational practices.

1.3 This strategy has been endorsed by the Health & Safety Strategic Committee, which reports directly to the Trust's executive team and board.

2 Where We Are Now (Current Position)

2.1 The Trust has appointed competent persons for health and safety.

2.2 The Trust has a governance structure in place, comprising of the Health & Safety Operational Group and Health & Safety Strategic Committee.

2.3 The Trust Board and Executive team members are aware of their responsibilities and attend annual training focused on 'leadership in safety'.

2.4 The Trust has a network of keyworkers across various departments, with the aim of assisting their managers on health and safety matters.

2.5 The Trust has an incident reporting system; however its use and application requires improvement.

2.6 There is a lack of structured training available to staff in relation to risk assessing, risk management, reporting of incidents and incident investigation.

3 Where We Want To Be (The Vision)

3.1 To improve the health and safety cultural maturity of the organisation to one of 'Excellence' as defined by the Health and Safety Laboratories[1] in which:

- Health & Safety becomes integral to business activities
- Routine and visible senior leadership
- Strong partnership working
- Anticipation of safety issues
- Investigation of root cause

[1] Risk Management Maturity Model – RM3 *Health and Safety Laboratories*

4 How We Get There (Priorities for Strategic Change)

4.1 Fundamental Principles

- The Health and Safety Executive (HSE)[2] recognises good health and safety management comes from a continuous cycle of improvement. This strategy commits to continually improve the management of health and safety by adopting the Plan, Do, Check, Act model.
- Decision making and the monitoring of performance requires accurate and timely information. This strategy commits to measure the right things in the right way; continually improving the quality, quantity, speed and efficiency of data collection to ensure that decisions and corrective actions are appropriate and timely.

4.2 Moving towards Excellence

- Integrating health and safety into business practices – to work with managers to improve their understanding of how health and safety incidents impact on day to day business and how to manage risks, and to ensure health and safety risks are considered when planning change.
- Routine and visible senior leadership – to work with the executive team to ensure that health and safety is considered at a strategic level, divisions are coordinated, and initiatives are promoted, poor performance challenged and successes celebrated.
- Strong partnership working – to work with staff, partners and contractors to develop solutions and ways of working that ensure the health and safety of all who are affected by the Trust's activities.
- Anticipation of safety issues – to ensure the organisation is managing its current health and safety risks, whilst monitoring emerging issues with a view to mitigating them early.
- Investigation of root causes – to ensure that incidents and near misses are correctly reported in a timely fashion; that managers have the skills, knowledge and experience to investigate incidents and identify the root causes and that the organisation is effective in implementing the recommendations.

5 Governance Overview

5.1 The Health & Safety Operational Group is chaired by the Head of Health, Safety & Compliance, with key-issues escalated to the Health & Safety Strategic Committee.

5.2 The Health & Safety Strategic Committee is chaired by the Executive Director of Estates & Facilities, with key issues escalated to the Executive Group.

5.3 The Trust has both an Executive Director and a Non-Executive Director appointed to oversee the Management of Health & Safety, with onward reporting to the Executive Group and Trust Board.

[2] Managing for Safety (HSG65) - *Health and Safety Executive*

5.4 The purpose of the governance structure is to ensure assurance is provided to the Trust Board; specifically in relation to risk management and internal control across the health and safety activities of the Trust.

6 Values and Principles

6. 1 Implementation of the strategy will aim to support the key leadership values in relation to health and safety as recognised by the Board:

- Building and promoting a shared vision,
- Being considerate and responsive,
- Providing support and recognition,
- Promoting fairness and trust in relationships with others,
- Encouraging improvement, innovation and learning.

7 Financial Implications

7.1 The Trust has an existing provision for internal health and safety advice.

7.2 The strategy will be delivered using existing resources and coordination of activities between key stakeholders.

7.3 Achieving the strategic goals will enable the Trust to reduce; the costs of absenteeism as a result of work-related injury or ill-health; the likelihood of receiving financial penalties from regulatory bodies; the costs associated with employer and public liability claims.

4 References

Document	Ref No
People Strategy	
Clinical Strategy	
Quality Strategy	
Corporate Health & Safety Policy	POLCS005
Risk Management Standard Operating Procedure	SOP0064

~ END OF DOCUMENT ~

Meeting of the Board of Directors
Thursday, 04 June 2020

Title of Report	**Board of Directors agenda plan 2020/21**	Agenda Item	**9.2**
Lead Director	Interim Company Secretary		
Report Author	Interim Company Secretary		
Executive Summary	Currently set out for bi-monthly meetings, the agenda plan for the Trust Board provides gives an overview at topic level when each routine matter is due to come to the Board, and helps ensure that key developments are appropriately monitored and discussed. The programme is continually reviewed. In practical terms, the planner forms a start-point for the drafting and discussion of the agenda in the weeks leading up to the meeting. A range of other factors, such as the Board Assurance Framework and the action tracker will also prompt for agenda items, or will inform how particular topics are framed. A separate register operates for board development.		
Committees or Groups at which the paper has been submitted	None		
Resource Implications	State if the paper will have additional resource implicationsNone		
Legal Implications/ Regulatory Requirements	The agenda planner helps ensure the Trust addresses legal or regulatory requirements in a timely way.		
Quality Impact Assessment	None		
Recommendation/ Actions required	To NOTE the agenda planner for 2020/21		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices	Agenda plan 2020/21		

Amber/ Green - Assurance with minor improvements required

Trust Board in Public Planner 2020/2021

Agenda Item	Presenter	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Standing Items												
Chair's Report	Chair	x		x		x		x		x		x
Matters Arising and Action Log	Chair	x		x		x		x		x		x
Minutes of the Previous Meeting	Chair	x		x		x		x		x		x
Register of Interests	Chair	x		x		x		x		x		x
Welcome and Apologies for Absence, Quorum	Chair	x		x		x		x		x		x
Chief Executive's Report	Chief Executive	x		x		x		x		x		x
Patient Experience Story	Interim Chief Nurse	x		x		x		x		x		x
Questions from the Public	Chair	x		x		x		x		x		x
Finance Report	Director of Finance	x		x		x		x		x		x
Integrated Quality and Performance Report (IQPR)	Director of Nursing	x		x		x		x		x		x
Transformation Update	Director of Transformation	x		x		x		x		x		x
Workforce Report	Director of HR and OD	x		x		x		x		x		x
Communications Report	Director of Communications and Engagement	x		x		x		x		x		x
Sustainability and Transformation Plan	Deputy Chief Executive	x		x		x		x		x		x
Committee Assurance Reports	Committee Chairs	x		x		x		x		x		x
Council of Governors' Update	Governor Representative	x		x		x		x		x		x
Any Other Business	Chair	x		x		x		x		x		x
BAF Reflection	Chair	x		x		x		x		x		x
Quarterly/ Regular Reports												
Board Claims Report	Head of Corporate Governance and Legal			x						x		
Board Assurance Framework	Deputy Chief Executive	x		x		x		x		x		x
Emergency Planning, Resilience and Response	Chief Operating Officer			x								
Freedom to Speak Up Update	Freedom to Speak Up Guardian			x						x		
Mortality and Morbidity Update	Medical Director			x				x				x
Health and Safety Six Month Report	Director of Estates and Facilities	x						x				
Annual												
Annual Business Plan	Deputy Chief Executive	x										
Annual Report and Accounts - Timeline	Deputy Chief Executive							x				
Annual Report and Accounts	Chief Executive/Director of Finance											x
Amendment to Trust Constitution (as and when required)	Company Secretary			x								
Scheme of Delegation (as and when required)	Director of Finance											
Standing Financial Instructions (as and when required)	Director of Finance											
Trust Board Annual Planner	Company Secretary	x										
Membership Strategy	Director of Communications and Engagement	x										
Board Effectiveness Review	Company Secretary					x						
Committee Effectiveness Reviews	Company Secretary					x		x				
PLACE Annual Report	Director of Estates and Facilities					x						
Equality and Inclusion Report	Director of HR and OD							x				
Equality Delivery System 2	Director of HR and OD									x		
Gender Pay Gap Report	Director of HR and OD									x		
Workforce Race and Equality Standard Report	Director of HR and OD			x						x		
Workforce Disability Equality Report	Director of HR and OD			x						x		
Quality Account	Chief Nurse			x								
Annual Infection Prevention and Control Report	Chief Nurse					x						
Safe Staffing Review	Chief Nurse			x						x		
Safeguarding Adults and Children Annual Report	Chief Nurse									x		
Emergency Planning Resilience and Response Annual Report	Chief Operating Officer			x						x		
Fire, Health and Safety	Director of Estates and Facilities	x										
Annual Research and Innovation Report	Medical Director			x								
Integrated Audit Committee Annual Report to the Board	Director of Finance					x						
Complaints Report	Chief Nurse					x						

Health Care Worker Flu Vaccination Self-Assessment Report	Director of HR and OD							x				
Sustainability Report	Director of Estates and Facilities							x				
Annual												
Staff Survey result	Director of HR and OD	x										
Annual Report Medical Appraisal and Revalidation	Medical Director					x						
Annual Report Medical Education	Medical Director			x								
Safe Working Hours Annual Report	Medical Director									x		
Claims Report	Medical Director			x								
Skills Matrix	Director of HR and OD							x				
Policies and Strategies												
Quality Strategy	Interim Chief Nurse			x								
Estates Strategy	Director of Estates and Facilities			x				x				
IT Strategy	Deputy Chief Executive			x								
Clinical Strategy	Medical Director			x								
People Strategy	Director of HR and OD			x								
Freedom to Speak Up Strategy	Freedom to Speak Up Guardian											x
Risk Management Policy and Strategy	Director of HR and OD					x						
Corporate Policy - Medicines Management	Chief Pharmacist	x										
Corporate Policy - Modern Day Slavery	Director of HR and OD					x						
Corporate Policy - Human Resources and Organisational Development	Director of HR and OD							x				
Corporate Policy - Information Governance and Framework	Director of HR and OD							x				
Corporate Policy - Consent	Deputy Chief Executive	x										
Corporate Policy - Serious Incident	Interim Chief Nurse							x				
Corporate Policy - Safeguarding	Interim Chief Nurse	x										
Corporate Policy - Duty of Candour	Interim Chief Nurse							x				
Corporate Policy - Complaints Management	Interim Chief Nurse											x
Corporate Policy - Estates and Facilities	Director of Estates and Facilities	x										
Corporate Policy - Health and Safety	Director of Estates and Facilities	x										
Corporate Policy - Fire Safety	Director of Estates and Facilities					x						
Corporate Policy - Emergency Planning Resilience and Response	Chief Operating Officer					x						
Corporate Policy - Conflicts of Interests	Company Secretary	x										
Corporate Policy - Violence and Agression	Director of Estates and Facilities	x										