# Agenda

## Trust Board Meeting

**Date: Tuesday, 12 May 2020 at 11:00 – 12:30**

**Meeting via MS Teams**

| Subject | | Presenter | Page | Time | Action |
|---|---|---|---|---|---|
| **1.** | **Preliminary Matters** | | | | |
| 1.1 | Chair's Welcome and Apologies | Acting Chair | Verbal | 11:00 | Note |
| 1.2 | Quorum | | | | |
| 1.3 | Conflicts of Interest: | | - | | |
| *1.3a* | *Register of Interests* | | 3 | | |
| *1.3b* | *Declaration of Interests* | | Verbal | | |
| **2.** | **Minutes of the previous meeting and matters arising** | | | | |
| 2.1 | Minutes of the previous meeting held on 5 March 2020 | Acting Chair | 5 | 11:03 | Approve |
| **3.** | **Standing Reports** | | | | |
| 3.1 | Chair's Report | Acting Chair | Verbal | 11:05 | Note |
| 3.2 | Chief Executive's Report | Chief Executive | 21 | | Note |
| **4.** | **Governance** | | | | |
| 4.1 | Board Assurance Framework | Deputy Chief Executive | 25 | 11:20 | Note |
| **5.** | **High Quality Care** | | | | |
| 5.1 | Covid-19 Update, including:<br>- Business as Usual Planning<br>- Staffing; Challenges/Management of Re-deployment; annual leave<br>- Staffing Support<br>- IT Planning for remote working | Chief Executive/Chief Operating Officer | 37 | 11:30 | Note |
| 5.2 | CQC Action Plan Update | Chief Executive/Interim Chief Nurse | 59 | 11:45 | Note |
| 5.3 | Board Assurance – Finance Committee | Chair of Committee | 101 | 12:00 | Note |
| 5.4 | Board Assurance – Integrated Audit Committee | Chair of Committee | 103 | 12:10 | Note |
| 5.5 | Board Assurance – Quality Assurance Committee | Chair of Committee | 107 | 12:20 | Note |
| **6.** | **Other Business** | | | | |
| 6.1 | Any other business | Acting Chair | Verbal | 12:30 | Note |
| **7.** | **Date and time of next meeting: Thursday, 2 July 2020, 11:00 – 12:00 (Private) and 12:30 – 15:30 (Public), Trust Boardroom** | | | | |

NHS
Medway
NHS Foundation Trust

**MEDWAY NHS FOUNDATION TRUST**

**TRUST BOARD REGISTER OF INTERESTS**
**MAY 2020**

| Name | Position | Organisation | Nature of Interest |
|---|---|---|---|
| **Ewan Carmichael** | **Non-Executive Director** | Medway NHS Foundation Trust | Chair of Charitable Funds Committee |
| | | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Mark Spragg** | **Non-Executive Director** | Marcela Trust | Trustee |
| | | Sisi and Savita Charitable Trust | Trustee |
| | | Mark Spragg Limited | Director |
| | | Faculty of Medical Leadership and Management | Lay Trustee/ Director |
| | | Medway NHS Foundation Trust | Chair Integrated Audit Committee |
| | | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Adrian Ward** | **Non-Executive Director** | Award Veterinary Sciences Limited | Director |
| | | Nursing and Midwifery Council | Chair Fitness to Practice Panel |
| | | RCVS Preliminary Investigation Committee | Member |
| | | BSAVA Scientific Committee | Member |
| | | Medway NHS Foundation Trust | Member of the Quality Assurance Committee |
| | | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Joanne Palmer** | **Acting Chair** | Lloyds Gresham Nominee1 Limited | Director |
| | | Lloyds Gresham Nominee2 Limited | Director |
| | | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Rama Thirunamachandran** | **Academic Non-Executive Director** | Canterbury Christchurch University | Vice-Chancellor and Principal Director and Trustee |
| | | Universities UK | Director and Trustee |
| | | Million Plus (Lobby Group for HE) | Chair |

| | | | |
|---|---|---|---|
| **Jenny Chong** | **Associate Non-Executive Director** | Knightingale Consulting | Managing Partner |
| | | KogoPay | CTO, Head of Innovation |
| **Tony Ullman** | **Non-Executive Director** | Kent and Canterbury Hospital, East Kent NHS Foundation Trust | Partner is a part-time Specialty Dr |
| **James Devine** | **Chief Executive** | London Board for the Healthcare People Management Association | Member |
| | | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Dr David Sulch** | **Executive Medical Director** | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Leon Hinton** | **Executive Director of HR and OD** | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Sue Mackenzie** | **Non-Executive Director** | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Jane Murkin** | **Interim Chief Nurse** | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |
| **Richard Eley** | **Interim Director of Finance** | Medway NHS Foundation Trust Charitable Funds | Member of the Corporate Trustee |

# Minutes of the Trust Board PUBLIC Meeting

**Thursday, 5 March 2020 at 12:30 – 15:30, in the Trust Boardroom, Postgraduate Centre, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY**

| Members | Name | Job Title |
|---|---|---|
| **Voting:** | Stephen Clark | Chairman |
| | Jo Palmer | Deputy Chair and Senior Independent Director |
| | Adrian Ward | Non-Executive Director |
| | David Sulch | Executive Medical Director |
| | Ewan Carmichael | Non-Executive Director |
| | Ian O'Connor | Executive Director of Finance |
| | James Devine | Chief Executive |
| | Jane Murkin | Interim Chief Nurse |
| | Jon Billings | Non-Executive Director |
| | Leon Hinton | Executive Director of HR and OD |
| | Mark Spragg | Non-Executive Director |
| | Tony Ullman | Non-Executive Director |
| **Non-Voting:** | Gary Lupton | Executive Director of Estates and Facilities |
| | Glynis Alexander | Executive Director of Communications & Engagement |
| | Gurjit Mahil | Deputy Chief Executive |
| | Harvey McEnroe | Chief Operating Officer |
| | Jack Tabner | Executive Director of Transformation |
| | Jenny Chong | Associate Non-Executive Director |
| | Sue Mackenzie | Associate Non-Executive Director |
| **Attendees:** | Alana Marie Almond | Assistant Company Secretary (Minutes) |
| | Simon Brooks-Sykes | Kent and Medway Vascular Network |
| | Elisa Llewelyn | East Kent Hospitals University NHS FT |
| | Glyn Allen | Lead Governor |
| **Observing:** | Sheila Adam | NHSE/I |
| | Catherine McDonald | NHSE/I |
| | John Murray | Deloitte LLP |
| | Vicky Kidner | Patient Story – Staff |
| | Cathie Cooper | Patient Story – Staff |
| | Lyndsay Barrow | Patient Story - Patient Experience Manager |
| | Marion | Patient Story |
| | Two members of Public: | |

| | | |
|---|---|---|
| | - Wyn Roberts GRT Ltd (Pharmacy firm, interested in STP Plans)<br>- Vicky Morgan Liaison Workforce (IT, worked with James Devine in past) | |
| **Apologies:** | Rama Thirunamachandran | Academic Non-Executive Director |
| | Karen Rule | Director of Nursing |

**Patient Story**

The Patient Story and attendees was introduced by Jane Murkin, Interim Chief Nurse. Marion {the patient} actively sought breast screening and was unfortunately diagnosed with bilateral breast cancer last year. She underwent breast surgery and radiotherapy and considers the care she received to be excellent, which along with her positive attitude has helped her to recover.

Staff communicated well with Marion throughout the process and it was a collaborative approach to treatment and returning to fitness. When she initially had her diagnosis the nurses gave her positive encouragement and tried to comfort her by reassuring her not to be upset about it. Marion has a positive attitude and is proactive in her approach to staying healthy. This has helped to achieve a good outcome and is demonstrated as she continued to work during her radiotherapy.

Ewan Carmichael thanked Marion for her story as we do get a real mixture of stories and wondered if the nurse's positive encouragement at the start was of help to her? Marion confirmed it was positive comment of encouragement and it did comfort her.

Jo Palmer asked Marion how she felt about the Prehab and Marion said it was excellent and would go back if necessary. The Chairman confirmed that the Prehab work is now going out into the community.

The Board thanked Marion for her positive feedback, especially since she has had patient experience in a number of areas in the pathway. The Chief Executive went on to thank Marion for her twenty years of service at the Trust.

**1 Preliminary Matters**

1.1 *Chair's Welcome and Apologies*

The Chair welcomed all present especially to Sheila Adam, NHSE/I, Catherine McDonald and John Murray from Deloitte LLP who would be observing. 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. There was however a few typographical changes requested by Adrian Ward on his Register of Interest, as follows:

Nursing and Midwifery Council – Chair Fitness to Practice Panel
Award Veterinary Services Limited – Director

**2 Minutes of the previous meeting and matters arising**

2.1 The minutes of the last meeting, held on 8 January 2020 was reviewed by the Board.

a) Amend the attendee list on both Private and Public minutes: Tony Ullman is a Voting Member of the Board.

Subject to the above amendment the minutes of the last meeting, held on 8 January 2020 were **APPROVED** as a true and accurate record.

2.2 *Matters arising and actions from the last meeting*
The action log was reviewed and the Board agreed to **CLOSE** the following actions that were proposed for closure: *TB/2019/038, TB/2019/043, TB/2019/044, TBPU/20/47, TBPU/20/48, TBPU/20/49, TBPU/20/51, TBPU/20/52, TBPU/20/53, TBPU/20/54, TBPU/20/55, TBPU/20/56 and TBPU/20/57*

**3 Standing Reports**

**3.1 Chairman's Report**

Stephen Clark, Chairman, gave a verbal update to the Board.

3.1.1 Stephen advised the Board that the recruitment process for the next Chair has begun and Jo Palmer will be overseeing that process from the 31 March 2020. Stephen knows that the Board will give their full support in that role.

3.1.2 Stephen informed the Board of the outcome of the stroke judicial review, which was announced in the High Court recently. The judge ruled in favour of the Kent and Medway Stroke Programme Joint Committee of CCGs on all grounds.

It is now important that we move forward and deliver the configuration that has been agreed. David Sulch and the team are well prepared for this and will give continued support to the HASU Programme. It is important that service quality is kept to a high standard.

3.1.3 The Chairman extended his thanks to Trust Governor Chris Harvey who has stood down as the League of Friends representative. Chris has not only served the Trust as a governor but also as a nurse prior to her retirement, and she will be very much missed.

3.1.4 Stephen gave his thanks to Jon Billings who will be finishing his term of office on 31 March 2020. Jon has been with the Trust for three years and has made a significant contribution in chairing the Quality Assurance Committee and on the Board, through some pretty challenging times. The Board wishes him well for the future.

3.1.5 It is important through the current Covid-19 crisis that the Trust keeps public confidence up. In terms of what the Trust can do and how it can help people. With this in mind the Trust must keep the hospital working 'business as usual' as long as it can, with increasing pressures.

**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 This is the first formal Board meeting since the peak of the winter period (December/January) and James wanted to give sincere thanks to Trust staff for their dedication in providing care for our community during this very busy period.

Throughout the winter we saw the majority of those coming to our Emergency Department within four hours; however a small number of patients did experience longer waits than we would have liked. High quality care and best flow remain the priority for the Trust.

3.2.2 <u>NHS Staff Survey</u>
James was happy to inform the Board that the Trust has made some real progress with this year's survey and that according to staff feedback we have seen improvements in almost all

areas surveyed (ten out of the eleven), particularly in areas such as morale and engagement which is a really positive sign.

3.2.3 Corona Virus

As a Trust we have taken a number of steps to ensure we are informed and prepared, including daily huddles, a Coronavirus workshop, and the creation of priority assessment pods-for those with symptoms indicative of the infection. Advice for the public, should they have concerns that they may have been exposed to the virus, is to phone NHS111 and not attend the Emergency Department unless they are seriously ill.

Whilst the Trust does have to deal with this crisis over the coming weeks and months, the focus must be on 'business as usual' in our core services, even with these additional pressures.

3.2.4 Relaunch of our Trust values

This is not a relaunch but it is a refresh of our Trust Values. This was presented to staff at the briefing a few weeks prior to this meeting. These values are ones that are recognised and the presentation was well received by all.

3.2.5 CQC

James confirmed that the Trust has now had the draft report and the factual accuracy response has been submitted back to the CQC for their review on 2 March 2020. Publication date of the final report is currently the 20 March 2020; if the date does change the Board will be informed. Glynis Alexander is working on a Communications Plan both internally and externally.

3.2.6 Closure of Dickens Ward

As previously discussed and minuted, the Letters of Intent; Section 29a and 31 warning notices were issued and the Trust responded quickly to those letters. There were subsequent discussion with the CQC and James informed the Board that he and the Executive team took the decision to close Dickens Ward earlier than planned. This was largely because the team had significant concerns around the quality of care and did not feel that these concerns could be rectified in sufficient/preferred time.

Patients on the Ward at the time of closure were discharged safely to either a community setting or back to their care home. There were a small number of patients discharged from the ward back into the hospital bed space. Thanks to Trust partners, working with Harvey, Jane and David the turnaround on Dickens Ward was within 50 to 72 hours and each patient was risk assessed prior to moving.

3.2.7 Preparing our patients for discharge

The Trust nursing team has been working on an exciting new project with NHS Improvement and other partners to produce a discharge guide for our patients. The guide will be given to every single inpatient and will provide them with all the information they need to get ready for their discharge by midday. This is a really excellent piece of work and will greatly improve patient experience.

3.2.8 Finance director

This is the Trust's Finance Director, Ian O'Connor's last meeting. Thanks to Ian who has had a real impact in his time at Medway, overseeing a substantial reduction in our deficit, and improved contracting arrangements. Good luck with his new job at Dartford hospital.

3.2.9 Chairman's departure

Our Chairman, Stephen Clark will be leaving the Trust when his term of office comes to an end in March 2020. The Board gives a huge thank you to him; Stephen joined the Trust in 2016, when the Trust was in special measures. Under Stephen's leadership and his unforgiveness about delivering high quality care he has led Medway to see a number of improvements and embarked on a major transformation programme. James gave Stephen his thanks on behalf of the 600,000 people in the local community.

3.2.10 The Chairman stated that he knows the Board will give Jo Palmer its support in her role as Chair. Stephen wished the Board well, as it is a big responsibility to run a hospital. He also thanked the Board for its support to him as Chairman of the Trust and it has been a real privilege. There is no greater, more noble cause than Medway Maritime Hospital.

**4 High Quality Care**

**4.1 CQC Update**

James Devine, Chief Executive, gave the Board a brief summary of the current position the Trust is in with the CQC Inspection.

4.1a James brought the Inspection Timeline to the Boards attention within the submitted paper, which spans from the 3 December 2019 all the way through to January 2020. The Factual Accuracy Response was submitted on the 2 March 2020 that included three core areas; Well-Led, Clinical and Older Persons and Children and Younger Persons. There has been confirmation from the CQC that this has been received and the Trust now awaits the outcome.

4.1b James reiterated as he had done on several previous occasions, the Boards responsiveness to the CQC Inspection generally but more so the Letter of Intent and the Warning Notices. The Board is absolutely taking these matters seriously as the evidence of the subsequent actions shows. The Trust continues to take these issues seriously with Jane Murkin's leadership with the Quality Improvement Plan and with a close watch on the ongoing Governance mechanisms that are in place, are adhered to. This will give the Board assurance that these things are in place, they stay in place and they do have the correct output. The Trust are doing this not to satisfy the CQC but because it is the right thing to do for the patients and to maintain safety and high quality care across all of the Trust services. The Board has accepted the seriousness of the issues at both the Private and Public Board meetings.

4.1c Jane Murkin, Interim Chief Nurse gave a high level summary on some of the highlights from the paper and to give the Board assurance on the immediate actions that have been taken. Not just in response to the section notices but in responding to the initial inspection findings whilst the CQC were still on site.

4.1d The Inspectors raised their concerns in regards to COSHH and that same week the Trust issued an action plan to address those concerns. The key actions were progressed to respond to the concerns. Meetings with key staff and briefings across the organisation were had. Plus the estates team dealt with the fixing of the cupboard doors. These actions were added as 'immediate' into the overall plan, which Jane is overseeing.

4.1e The Inspectors also had concerns in regard to infection prevention control; patients in mixed sex accommodation breaches and the care of patients in recovery overnight. The Trust took immediate action to these concerns notwithstanding that some of these actions will have an ongoing nature.

4.1f There is established, an Oversight Panel that meets on a weekly basis which oversees the governance of the action plan, tracks reports and evidence plus it looks at findings that come from the actions. This Panel reports in to the Executive Group and to the Quality Assurance Committee.

4.1g To embed and sustain the actions the team are working with Sheila Adam, NHSE/I on the overarching quality improvement plan and the emerging themes of leadership, culture, governance and quality improvement. Plus it will take into account the must dos and should dos from the CQC Report that will come out later in March 2020.

4.1h Communications have included briefings to make staff aware of issues, to engage them and also to support them to resolve these issues. More importantly to help them understand that some of these issues that the Inspectors found are absolutely of an unacceptable nature and will not be tolerated. Staff will be held account to assist the Trust with delivery.

4.1i David Sulch, Medical Director, stated that the infection prevention control was already a concern prior to the inspection. He wanted to assure the Board that the action plan is now more robust than it was before. Going forward every piece of evidence will be triangulated, not only whether or not they have been completed but how effective they are.

4.1j James Devine asked David and Jane how they can ensure that hand hygiene is paramount now with the Covid-19 risk, when it has already been a concern. David confirmed that there are now extra recruits within the IPC team. Therefore more training will be given at Ward level. The Covid-19 risk may enhance people's thoughts on hand hygiene in general. Staff on site must lead by example and be seen to be using hand gels as they walk in. Jane confirmed that with the escalation of the role of the Matrons on site this will be carefully monitored. There will be 'secret shopper' style spot checks and more of the GEMBA walk rounds.

4.1k Harvey McEnroe, Chief Operating Officer, confirmed that the Trust carries an average of 98 medically fit for discharge patients through January and February. The Trust is working with partners at the A and E Delivery Board; a sub-group of the System Delivery Board; responsible for flow in the system. The Board has requested a System Plan, partner and provider; commissioner, mental health, acute and community care, to address the occupancy issue of the medically fit for discharge list and reduce it by 50 percent. That review includes out of hospital bed capacity, as well as a review of the integrated discharge function. This report is due back to the A and E Delivery Board at the end of March 2020, it forms part of an Urgent Care Improvement Plan, which needs to be submitted regionally and nationally. Harvey is working with NHSE/I on this and the pace will pick up now.
**ACTION NO: TBPU/20/59:** Harvey McEnroe, Chief Operating Officer to 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 in May 2020.

**4.1.1 Reclaiming the Nursing Landscape**

Jane Murkin, Interim Chief Nurse, informed the Board that this paper sets out the strategic priorities for nursing and midwifery at the Trust for this calendar year, setting these against the local context and national priorities. Jane asked that the Board discuss the content of this strategic report and support its delivery.

The implementation of a unique identifier Matron uniform has been agreed which will support visible leadership in clinical areas and raise the profile of the role of the Matron within the Trust. Roles and responsibilities will be understood and professional development opportunities will be offered.

Pride and empowerment needs to be instilled into staff, this will take time and support and staff need to believe that things will improve. Jane advised the Board that she will be working with Glynis Alexander on a communications plan to excite staff.

The Board **NOTED** the report.

**4.2 Integrated Quality and Performance Report**

Jane Murkin, Interim Chief Nurse, asked the members to note and discuss the report which informed the Board in the form of a dashboard report of January 2020 quality and operational performance across key performance indicators.

4.2.1 Jane informed the Board that the IQPR is currently being reviewed and refreshed with input from several of the Executive Team members.

4.2.2 The Chairman stated that it is not a job for the Board to review this paper. The Board should feel confident that the other sub-Board Committees and Groups have done this. The report that is submitted to Board should be a summary document with key highlights.

4.2.3 Jo Palmer asked the team to consider the following; When the Board can expect to see indicators moving to green? What is the forecast? When will the Trust get there? How is the Trust tracking this?

**ACTION NO: TBPU/20/60:** David Sulch, Medical Director, write a report on the Trust's position on EDNs to go to the Executive Group, then to the QAC and later submit to Board for the meeting in May 2020.

**ACTION NO: TBPU/20/61:** Harvey McEnroe, Chief Operating Officer to inform the Board what three areas will be focused on in terms of performance?

**ACTION NO: TBPU/20/62:** Gurjit Mahil, Deputy Chief Executive, to update the Board on the timeline for the development of the IQPR at the May 2020 meeting.

**4.3 Quality Assurance Committee Assurance Report**

Jon Billings, 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 meeting that happened in January 2020.

4.3.1 The report sets out the key areas that were focused on; one area to highlight was the extensive discussions on nutrition and hydration at the meeting. There was a good presentation given to the Committee and it informed the Committee on the importance of nutrition and hydration and how it can affect pressure area damage, general falls, recovery and other such things. The Committee understands the importance of this and patients will be assessed on their nutrition and hydration. It is also important that this area should be embedded especially into the nursing roles.

4.3.2 The most recent Committee meeting (February 2020) focused on a lot of the areas that the Board are discussing such as; CQC, IQPR, Mortality and Infection Prevention Control.

4.3.3 There is some consideration on how the Quality Assurance Committee functions going forward and how it gets it assurance.

**4.4 Mortality and Morbidity Update**

David Sulch, Medical Director, asked the Board to review the current position regarding mortality. HSMR remains within acceptable limits at 102.5 for the year to October 2019. Data for Q2 of 2019/20 indicates an improvement in the SHMI, which for July and August

2019 are 98.8. Initial feedback from the RCP Learning from Deaths review of the Trust's processes is included, with a more formal briefing on the full report to follow

4.4.1 This data and report was reviewed at the last Quality Assurance Committee and the Mortality and Morbidity Committee.

4.4.2 The Board **NOTED** the report and current position.

**4.5 Safeguarding Adults and Children Annual Report**

Jane Murkin, Interim Chief Nurse, advised the Board that the reports seek to provide assurance that Statutory Safeguarding duties have been executed in line with policy and procedures during 2018/19. The reports also demonstrate the growth of safeguarding activity, and provide a trend analysis of the three year period since the Trust was served a performance contract notification by the commissioners in 2016.

4.5.1 The Board was advised that these reports had been submitted to the Safeguarding Assurance Group, the Executive Group and the Quality Assurance Committee.

4.5.2 The Board **NOTED** the reports and was **ASSURED** that Statutory Safeguarding duties have been executed in line with policy and procedures during 2018/19.

**5 Innovation**

**5.1 Transformation Programme Update**

Jack Tabner, Director of Transformation, asked the Board to note the contents of the report which provides an update on the Trust's 'Better, Best, Brilliant' transformation portfolio. The report provides an update on progress across the Trust's transformation portfolio, including work during the previous period to align transformation efforts behind the Trust's Quality Strategy and the findings of the CQC.

5.1.1 Jack gave some further information on the large, cross-hospital transformation programmes. He stated that activity within the Trust's core transformation programmes continues to gather pace.

5.1.2 BEST Flow: The Programme, currently supported by change partners, Transformation Nous, now enters its final phase. During the previous period, work has focused on operational grip at each juncture of the emergency pathway in the face of well-publicised operational pressure and demand. The Board was advised that over the coming weeks, the team with support from Mark Hackett will oversee the 'handover' from TN to ensure we sustain and embed the improvements achieved to date. The Trust has commissioned an independent review of the programme to be led by our Financial Improvement Director as it gears up for further work on non-elective patient flow next year. Future work will focus barriers to and enablers of safe and effective flows within the hospital and also out into the community. Key achievements, challenges and next steps are provided in the appended highlight report.

5.1.3 BEST Access: This Programme continues to drive improvement across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management. The work has helped secure the Trust's contractual settlement with our commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year. Key achievements, challenges and next steps are provided in the appended highlight report.

5.1.4 The Cost Improvement Programme (CIP): As at Month 10, the Trust has delivered £15.0million in CIP. Year to date, this is adverse to the operational plan monitored internally

by £2.4million. The team is forecasting an outturn position of £16.5 - £18.2million against the Trust's requirement of £19.5million. The focus is now on next year's Cost Improvement Programme, working with clinical and operational teams to prioritise schemes which deliver efficiencies through improved care quality, patient safety and patient and staff experience. The team is working towards a challenging target of £12 - £14million to deliver the Trust's control total. The Divisions are getting support from the Transformation Team to assist with delivery.

**6. Integrated Health Care**

**6.1 Sustainability and Transformation Plan Update: Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24**

Gurjit Mahil, Deputy Chief Executive, informed the Board that in January 2018, the NHS published its Long Term Plan for the next 10 years. All systems across England were required to develop a local five year plan in response to the NHS Long Term Plan over the summer and autumn of 2019. The paper submitted to the Board is the draft Kent and Medway five year plan, subject to final discussion with NHS England/NHS Improvement. The plan sets out the continued transformation of the system, building on all of the work to date under the K&M Sustainability and Transformation Partnership. It sets out the Trust's commitment to become a high performing Integrated Care System, delivering high quality services, improving the overall health and wellbeing of the population, investing in prevention and embedding prevention through the ICS, and working to address health inequalities.

6.1.1 The plan was developed with widespread engagement of staff from across the system, discussed at our system forums and informed by four public engagement events. The plan is a technical document and once it has been finalised with NHS England/NHS Improvement, the Trust will publish a shorter more digestible public facing summary. Following the endorsement of plan at the STP/ICS Partnership Board on 4 November 2019, CCG Governing Bodies and provider Boards are asked to support and endorse the plan. Detailed implementation will be addressed through annual operational planning.

6.1.2 Delivery Priorities:

1) Implementing an ICS quality framework and quality priorities
2) Delivering more care outside of hospital including resilient primary care and community care
3) Addressing clinical and financial sustainability of acute services
4) Transforming urgent and emergency care
5) Transforming outpatients and ensuring timely planned care
6) Improving services and care outcomes for cancer, MH, maternity and neonatal, children and young people, LD and autism, stroke, CVD, diabetes, respiratory disease, end of life care

**ACTION NO: TBPU/20/63:** Alana Marie Almond, Assistant Company Secretary to invite James Lowell to present on this subject at the next Board Development Session . {Post meeting note: the April Board Development Session was cancelled due to Covid-19}

**ACTION NO: TBPU/20/64:** Harvey McEnroe, Chief Operating Officer to provide the Board with the reports on the work that the Trust is doing with locally with system partners via email.

6.1.3 The Board **SUPPORTED** the progress so far.

**6.2 Communications and Engagement Report**

Glynis Alexander, Director of Communications and Engagement, asked the Board to note the report which details some of the communications and activity since the last Board meeting. Glynis gave a few highlights from the report:

6.2.1 The Communications team have developed and launched a new look for our Trust Values featuring ambassadors for our organisation across many different disciplines. A suite of materials, including posters in corridors, screensavers and folding pocket cards have been rolled out across the hospital. It has been well received and been a worthwhile exercise.

6.2.2 The team is supporting the delivery of the quality agenda, ensuring that staff understand the role they can play in improving care for our patients. As part of this the Trust has replaced the Theme of the Week channel, with Theme of the Month. This gives a full month to focus on a key priority, and be able to assess to what extent activity has had the desired impact, and embedded the changes required. It is now very much an operational and clinically lead communication. Next steps; working with Jane Murkin on Reclaiming the Nursing Landscape.

6.2.3 Working closely with clinical colleagues the team has delivered communications relating to Covid-19 to both staff and the public. There has been close liaison with the local media to dispel rumours and reassure the public. Externally the Trust is reiterating the National messages. There have been numerous enquiries on pressure and the closure of Dickens Ward which are being dealt with.

6.2.4 Working with NHSE/I and the Trust's nursing team a project has started to produce a discharge guide for our patients. The guide will be given to every single inpatient and will provide them with all the information they need to get ready for their discharge. There are many campaigns now based around the quality priorities.

6.2.5 Preparation has begun for the release of the CQC Inspection Report.

6.2.6 The new Community Engagement Officer has been recruited and their role will be more evidence based work, relating to the Trusts quality strategy

6.2.7 Social Media coverage has increased with lots of good news stories such as; the staff hero story, prehab work, organ donation and the new patient menu are amongst some of the stories.

**7. Financial Stability**

**7.1 Finance Report – Month 10**

Ian O'Connor, Director of Finance, the Trust reports an in-month surplus of £6,000 and year-to-date surplus of £91,000 against the NHSI plan.

7.1.1 Year-to-date and forecast outturn remains in line with original control total although with little room for manoeuvre.

7.1.2 Resources are not being starved to front line provision. Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established QIA Framework.

7.1.3 The Board **NOTED** the report.

**7.2 Finance Committee Assurance Report**

Mark Spragg, Deputy Chair of the Finance Committee, submitted the report but gave no verbal update at the meeting. The report gave assurance in regard to the Finance Committee meeting held on the 27 February 2020.

## 8. Our People

### 8.1 Health Care Worker Flu Vaccination Self-Assessment Report

Leon Hinton, Director of HR and OD, informed the Board that the paper provides the outcome of the Trust's self-assessment against healthcare worker flu vaccination best practice management checklist for public assurance via Trust boards (see Appendix 1). A summary of the outcome on each measure is provided with mitigations where relevant.

8.1.1 Healthcare workers with direct patient contact need to be vaccinated to ensure protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. NHS organisations are being asked to identify the 'higher-risk' clinical areas and take more robust steps to limit exposure of patients to unvaccinated staff. In these higher-risk areas, Trusts are expected to take appropriate steps to maintain safety of the service including redeployment of staffing to maintain safe operation of the service.

8.1.2 The paper provides the outcome of the self-assessment which reveals that strong plans were in place on the following measures; Committed leadership, Communication plan and Incentives. Work continues to ensure Flexible accessibility to flu vaccinations is achievable. The Trust will use the findings from the self-assessment to support the 2020 flu vaccination programme. The Trust is currently achieving 73.5percent vaccination rate.

8.1.3 Going forward there is a need for more promotion around the flu vaccination and the Trust need to be ahead of this for next time.

8.1.4 The Board **NOTED** the report

### 8.2 Equality Delivery System 2

Leon Hinton, Director of HR and OD, EDS2 is a generic tool designed for both NHS commissioners and NHS providers. At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four Goals: Better health outcomes; Improved patient access and experience; A representative and supported workforce; and Inclusive leadership.

8.2.1 There are four possible grades for each outcome and goal. These are: Undeveloped; Developing; Achieving; Excelling.

8.2.2 The Trust undertook its first assessment against the EDS2 in September 2017, and set objectives against the EDS2 Goals. These objectives were incorporated into the Trust's Equality Strategy in July 2018, along with the implementation plans for the Workforce Race Standard and Gender Pay Gap.

8.2.3 Subsequent reviews, in January 2019 and January 2020, shows that performance against the EDS2 grades has improved with four of the EDS2 outcomes being assessed at Developing, and 14 at Achieving. None are now at Undeveloped.

8.2.4 Leon advised the Board that the submitted report also sets out the results of self-assessments and external assessment surveys.

8.2.5 The Trust is required to publish its EDS2 review on its website. The Board was asked to approve the publication of the EDS2 assessment and task the Equality and Inclusion Steering Group to oversee an action plan to take the Trust to 'Achieving' in 2020
**ACTION NO: TBPU/20/65:** Leon Hinton, Director of HR and OD to circulate the appendix of this paper to the Board and ask for comment via correspondence, prior to the deadline for upload to the Trust website by 31 March 2020.

8.2.6 The Board gave its thanks to Adrian Ward, NED, for his support with this.

**8.3 Gender Pay Gap Report**

Leon Hinton, Director of HR and OD, informed the Board that the report sets out the gender pay gap calculations and supporting statement for 2019. It is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust's mean gender pay gap is 32.63 percent and the median gender pay gap of 23.63 percent. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles.

8.3.1 The Board was asked to approve the publication of the Trust's Gender Pay Gap and supporting statement. Subject to the Board's approval today, the gender pay gap and supporting statement will be published on the Trust website and the Government portal before 31 March 2020.

It is recommended that:

1) The gender pay gap (section 4 of the report) together with the supporting statement (section 5), be approved for publication.
2) The Trust continues to work with partners across the NHS to develop a system-wide approach to the NHS gender pay gap.

**ACTION NO: TBPU/20/66:** Leon Hinton, Director of HR and OD to raise this subject/report at the People Committee.

8.3.2 The Board **APPROVED** this report subject to the above.

**8.4 Staff Survey Results**

Leon Hinton, Director of HR and OD, informed the Board that the Trust's response rate for the national staff survey 2019 increased to 43 percent and reflected the opinions of 1,828 employees. This report denotes the next steps to delivering genuine actions.

8.4.1 Thematic responses:
A new theme has been added to the survey; Team Working, which has been retrospectively determined for 2017 and 2018 results. Across the staff survey themes for the entire Trust, ten of eleven scores improved (of which eight were statistically significant improvements), one remained the same and zero deteriorated.

8.4.2 Individual questions:
Of the 90 staff survey questions, 79 had improved (based on positive scores), seven remained the same and four deteriorated. Significant improvements (of up to 12% improvements) were seen across all domains, but particularly the staff engagement (staff being able to suggest and make changes to own area) and morale scores.

8.4.3 The Board was informed that the Housekeeping Team is a particularly unhappy group within the Trust. Gary Lupton, Director of Estates and Facilities would like to use the Pharmacy model to grasp communications to staff and improve on this.
**ACTION NO: TBPU/20/67:** Leon Hinton, Director of HR and OD to raise this subject/report and complete a deep dive on this, at the People Committee

8.4.4 The Board **NOTED** the report and next steps.

**8.5 Workforce Report**

Leon Hinton, Director of HR and OD, informed the Board that this workforce report 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.

8.5.1 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.

8.5.2 Trust turnover has decreased to 11.85percent from 11.94percent, sickness absence at 4.08percent is the same compared to the month of December is above the Trust's tolerance level of 4percent, and appraisal compliance has increased to 87.86percent and is above Trust target of 85percent.

8.5.3 Statutory and Mandatory training is at 92.23percent and is meeting the Trust target of 85percent.

8.5.4 The percentage of pay bill spent on substantive staff in January remained the same compared to the month of December. The percentage of agency usage at 3percent has decreased compared to the month of December. The percentage of pay bill spent on bank staff at 14percent has increased compared to December.

8.5.5 The Board **NOTED** the content of this report.

**9. Governance**

**9.1 Board Assurance Framework**

Gurjit Mahil, Deputy Chief Executive, informed the Board that the refreshed BAF will be submitted back to the Board meeting in May 2020 after going to relevant committees. It is still a work in progress.

**9.2 Integrated Audit Committee Assurance Report**

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 last Committee meeting that happened in February 2020.

9.2.1 Mark confirmed that the Committee is working to its plan internal audit report and the main thrust was the external audit report for the year end. It seems to be going as well as can be expected. The Committee has reviewed their concerns.

9.2.2 Since the Committee meeting Mark confirmed that he and Ian have had a meeting with Jack from the NHS Counter Fraud team. Jack has nothing but praise for the way that the Trust deals with counter fraud. He acknowledged that KPMG had put the information on the wrong file.

**10. For approval**

**10.1 Kent and Medway Vascular Surgery Network Programme**

David Sulch, Medical Director, introduced the item to the Board and asked for its approval of the programme. The Chairman welcomed Simon and Elisa.

10.1.1 Vascular surgical services in Kent and Medway are currently provided by Medway Foundation NHS Trust (MFT) and East Kent Hospitals University NHS Foundation Trust at Kent and Canterbury Hospital (K&CH).

10.1.2 A number of reviews of vascular surgery have been undertaken since 2014, led by NHS England Specialised Commissioning. These reviews have concluded that an acute inpatient vascular service should be commissioned from one single acute Trust. In the interim, until

the longer-term transformation programme is delivered, all inpatient vascular surgery is to be centralised at the K&CH. This new model of care will mean that there will be no inpatient vascular surgical care provided at MFT.

10.1.3 Outpatient service provision, diagnostics for vascular surgery and day case surgery will remain unchanged in terms of their location but EKHUFT will become the host provider Trust for the Kent and Medway Vascular Surgical Service. The final location is yet to be decided.

10.1.4 David believes that this is the right thing to do and it would not work to have two sites, he was happy that quality will remain and confident that procedures are robust. There has been support from the public at engagement events.

10.1.5 Ewan Carmichael stated that there still needs to be a residual service at Medway Hospital. How can David assure the Board that quality remains in the service left here? There should be more than a report sent to the QAC.

10.1.6 Jon Billings stated that the governance around quality is important and agrees that there should be more than a report taken to the Quality Assurance Committee, David should establish a Steering Group for this work.

10.1.7 Jo Palmer suggested that based on the additional work required on this project that the Transformation Team should be involved with this.

10.1.8 The Board **SUPPORTED** the programme subject to the above report and steering group being established.

**10.2 Complaints Management Policy**

Jane Murkin, Chief Nurse, The policy has been updated to incorporate organisational changes relating to the divisions and job titles. There are no material changes to the policy content. This also includes the removal of the reference to the Quality Steering Group.

10.2.1 The Complaints policy went to the Executive Team in December 2019 and was approved. The Board was asked to approve the changes.

10.2.2 The Chairman raised the governance on the complaints system and the management of it. This must be looked at in detail. The Board stated that there needs to be support in place for staff in regard to complaints.

10.2.3 Jane confirmed that there will be a refreshed approach to the Patient Experience in May 2020 and policies will be reviewed after this.

10.2.4 The Board **APPROVED** the updated name changes and job titles only and await the refresh on the policy.

**11. Other Business**

**11.1 Council of Governors' Update**

Glyn Allen, Lead Governor, gave the Board a verbal update on the Council of Governors business.

11.1.1 Glyn informed the Board that since the last meeting the Council of Governors have had a number of extraordinary meetings, including one with Medway Council to understand what actions are being taken to address the forecast population growth in Medway and Swale, in terms of health care needs. The meeting was to address some concerns that had been

raised by the Governors and members of the public; it was a useful meeting and showed how healthcare would be transformed in the future by integrated care.

11.1.2 The Council of Governors would like to put on record their thanks to Jon Billings, for the work he has done for the Quality Assurance Committee and the way he has applied his expertise to that role, wishing him the best for the future.

11.1.3 The Council are pleased to approve the appointment of Mark Spragg for a second term as Non-Executive Director.

11.1.4 The Council welcomed Sue Mackenzie as a Non-Executive Director.

11.1.5 The Council gave their thanks to Ian O'Connor for his financial presentations during his time at the Trust giving facts and data to the Governors, wishing him the best for the future.

11.1.6 Finally, the Council are sorry that Stephen Clark will not be continuing at the Trust as Chairman. The Council really appreciates his dedication to the role and his commitment to ensure that patients are always put foremost of the Trusts agenda and activities. The Council gave their best for the future and will be supportive of Jo Palmer in her new role as Interim Chair.

11.1.7 Glyn asked how many pods had been used to date for Covid-19. Harvey McEnroe confirmed that to date there have been 58 patients self-present and 22 patients referred in the last 21 days. Of that cohort there have been no confirmed covid-19 cases. All patients have been swabbed and the majority of these patients left to self-isolate. There have been no inpatients under that pathway. There will be an increase in the number of pods, it is quite a complex plan to execute and Harvey McEnroe is lead on this with support from Gary Lupton.

11.1.8 The Chairman gave the Board's thanks to the Council of Governors and stated that it had been great to work with them all. Furthermore he gave his thanks and well wishes again to Jon Billings, NED and Ian O'Connor Director of Finance. Both of which would be leaving the Trust in the near future.

11.1.9 The Chairman closed by stating that the public confidence stance that the Trust takes is terribly important. He thanked the entire Board for their support and gave his best wishes and good luck for the future. He wished the Trust every success, for it to carry on and for it to achieve sustainability.

11.2 There were no further matters of any other business.
11.3 There were no questions from members of the public.

**12. Date and time of next meeting**

The next meeting will be held on Tuesday, 12 May 2020, 12:30 – 15:30, in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.
The meeting closed at 17:15

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 5 March 2020

Signed …….. Date ……
Chairman

NHS
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NHS Foundation Trust

**Chief Executive's Report – May 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.

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**In and around Medway**
We are currently living in unprecedented times as the entire world continues to battle the COVID-19 pandemic.

I wanted to take this opportunity to acknowledge the absolutely incredible efforts of our staff over the last couple of months.

They are all heroes to me because they have continued to deliver the very best of care for our patients. On our wards, in our hospital, every single day, they are saving lives, and offering dignity and compassion where lives can't be saved.

They have done an incredible job in ensuring we were able to deliver safe, effective and high-quality care as we saw the numbers of patients with COVID-19 symptoms rise day after day.

This pandemic has seen Medway at its very best; a team of people who have gone far beyond what could have ever been reasonably expected.

Many of our staff have made personal sacrifices to be at work and put our patients before being with their own families, spent many extra hours here looking after our patients, or investing their own time in ways that help their colleagues. It is nothing short of inspiring, and while we must never forget those who have sadly left us far too early as a result of COVID-19, we must also remember the way in which they have acted with selflessness, compassion, dignity and professionalism during this pandemic.

I had no doubt that they would rise to the challenge, and they haven't let me down – thank you.

**Protecting our staff during the COVID-19 pandemic**
The health and safety of our staff, as well as the care of our patients, is our primary concern and we quickly responded to the COVID-19 crisis with immediate measures to limit their risk and exposure to the virus. We also took steps to manage the demand on our services to ease the expected pressures on our staff. These included:

- Restricting access to wards to staff who are not directly involved in patient care or support of patient care.
- Cancelling all non-essential meetings and setting up video/dial in conferencing facilities so essential meetings could continue with minimal direct contact.
- Ensuring staff whose roles were appropriate to work from home had the kit and technology to enable them to do so.

- Limiting access to site to visitors (with some exceptions for patients with dementia, end of life patients and children) and external contractors.
- Moving outpatient appointments to phone/video appointments where possible.
- Making the early decision to postpone non-urgent and elective surgeries and procedures.

We are committed to ensuring that all staff have the appropriate equipment for the area they work in, and the risk they are exposed to.

Our Procurement team is working closely with local suppliers, as well as our regional and national colleagues, to ensure our supply chain remains strong. Thanks to their hard work we have not experienced a shortage of PPE, but we are keeping supplies under constant review in this fast-changing situation.

**Staff testing and support for our community partners**
To support our community health and social care partners, in April we expanded our staff COVID-19 staff screening programme to include workers from other health and social care organisations in Medway and Swale.

The service is available for staff who are self-isolating due to having COVID-19 symptoms or those who are self-isolating due to a household member having symptoms. Having access to this testing means more staff across the community are able to return to work more quickly, supporting the whole health and social care sector.

**Staff wellbeing**
We recognise that the current situation will take a toll on our staff's health and wellbeing and we have a wide range of support available to staff. This includes access to counselling and advice on financial matters.

Our Staff Wellbeing Operational Group, which is made up of multidisciplinary teams from across the Trust, meets twice a week (via video conference) to monitor and ensure our staff are receiving have access to, appropriate care and support during these difficult times.

We recently opened a Wellbeing Hub on the hospital site as a place for staff to escape from the pressures and enjoy a few moments of peace and tranquillity. The hub includes comfy sofas, bean bags, puzzle books, exercise yoga mats and much more. Yoga and meditation classes also take place at the Hub, in line with social distancing guidelines, or online courses.

We use our internal communications to regularly share the many offers of support and donations that we have received from the community.

We have several spaces around the hospital for staff to sit and take some time out including our Butterfly Garden which we have furnished with outdoor furniture, and we strongly encourage our staff to take regular breaks and use these spaces.

**Thanks to our community**
Local businesses and our community have been amazing and donated generously, ranging from equipment to meals for staff. A JustGiving appeal for our hospital charity has raised more than £12,000 which we are using to pay for care packs including toiletries and snacks, as well as chairs and soft furnishings so that staff can take a break. This support has meant so much to our staff.

**Trust maintains rating following CQC inspection**
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 was also recognised for the progress it has made in its 'use of resources', with the report noting improved productivity in clinical services, a significant reduction in its reliance on agency staff, and a reduction in the underlying financial deficit. The rating for 'use of resources' is raised from 'inadequate' to 'requires improvement'.

However, the report sets out where improvements are required in some services, particularly medical care, and the Trust will address these through a comprehensive action plan.

Our improvement plan covers all points raised in the report and will be closely monitored to ensure we are addressing areas where improvements are needed. We are also working with regulators to address their comments in the 'Well-led' report' and this programme is well-advanced. We accept that historic challenges and changes in leadership over the past few years have impacted in some areas, but 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.

**Karen Rule**
It was with great sadness that the Trust announced the death Executive Director of Nursing Karen Rule in April. 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 a wonderful, caring nurse, who always put our patients first, and was warmly regarded by all her colleagues on the Board and throughout the Trust.

She made a huge difference to our 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 we do.

She will forever be in our hearts and we will do everything we can to continue her legacy.

**A fond farewell**
In April, we bid farewell to our Chairman Stephen Clark. Stephen showed great commitment to improving the quality of care for our patients, and during his tenure has oversaw a number of notable achievements. I would like to thank him for all he has done for Medway, and to wish him well for the future. Jo Palmer will continue as our Acting Chair until a permanent appointment is made.

We 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 our patients.

**Approval of Annual Report and Accounts 2019/20**
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 to review the audited draft accounts on the Board's behalf.

NHS Medway NHS Foundation Trust

# Meeting of the Board of Directors in Public
# Tuesday, 12 May 2020

| | | | |
|---|---|---|---|
| **Title of Report** | **Board Assurance Framework Update** | **Agenda Item** | 4.1 |
| **Report Author** | Gurjit Mahil, Deputy Chief Executive Officer | | |
| **Lead Director** | Gurjit Mahil, Deputy Chief Executive Officer | | |
| **Executive Summary** | The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives.<br>The template has been updated in order to provide further assurance for the mitigations and controls identified for each risk.<br>Each objectives risk will then be discussed at the appropriate Board committee in order to provide the Board with overall assurance. | | |
| **Link to strategic Objectives 2019/20**<br><br>***(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: Date of approval: | | |
| **Executive Group Approval:** | Date of Approval: | | |
| **National Guidelines compliance:** | Does the paper conform to National Guidelines (please state): | | |
| **Resource Implications** | None | | |
| **Legal Implications/Regulatory Requirements** | | | |
| **QIA** | 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 |

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## 1. Integrated Healthcare

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

**The Integrated Healthcare risks will be discussed going forward at the Planning and Delivery Group.**

## 2. Innovation

| Risk | Initial Score | Current Score | Target Score |
|---|---|---|---|
| 2a – Future IT strategy | 4 x 4 = 16 (High) | 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) |
| 2c – Funding for investment | 3 x 3 = 9 (Moderate) | 3 x 3 = 9 (Moderate) | 3 x 3 = 9 (Moderate) |

**The Innovation risks will be discussed going forward at the Digital Delivery Group.**

## 3. Finance

| Risk | Initial Score | Current Score | Target Score |
|---|---|---|---|
| 3a – Delivery of financial control total | 4 x 4 = 16 (High) | 3 x 3 = 9<br>High | 3 x 3<br>High |
| 3b – Investment for backlog and EPR | 4 x 4 = 16 (High) | 5 x 4 = 20 (extreme) | 4 x 3 = 12 (high) |
| 3c – Failure to achieve long term financial sustainability | 4 x 4 = 16 (High) | 4 x 3 = 12 (High) | 4 x 3 = 12 (Moderate) |
| 3d – Going concern | 4 x 4 = 16 (High) | 4 x 1 = 4 (Very Low) | 4 x 1 = 4 (Very Low) |

**Finance risks were discussed in the April 2020 Finance Committee and changes were recommended to the scores for risk 3a (decrease) and 3b (increase). Further detail in the report; Appendix 1.**

## 4. Workforce

| Risk | Initial Score | Current Score | Target Score |
|---|---|---|---|
| 4a – Sufficient staffing of clinical areas | 4 x 4 = 16 (High) | 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 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) |

**The Workforce risks will be discussed going forward at the People Committee.**

## 5. Quality

| Risk | Initial Score | Current Score | Target Score |
|---|---|---|---|
| 5a – CQC Progress | 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) | 3 x 2 = 6 (Low) |
| 5c – Patient flow – Capacity and demand | 3 x 4 = 12 (Moderate) | 3 x 4 = 12 (Moderate) | 3 x 2 = 6 (Low) |
| 5d – Quality Governance | 3 x 4 = 12 (Moderate) | 3 x 4 = 12 (Moderate) | 2 x 2 = 4 (Very Low) |

**The Quality risks will be discussed going forward at the Quality Assurance Committee.**

| 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 |
| **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.<br>2. The ICP's agreed ambition is as follows and will have detailed population health outcome measures developed as part of the multi-agency development work which will read across to the ICS and ICP Joint Strategic Needs Assessment work :<br>a. Shifting the focus of care from treatment to prevention;<br>b. Utilising evidence based interventions with clinically led service developments<br>c. Support the delivery of highest quality primary, community and urgent care;<br>d. Design and develop local care;<br>e. Provider collaboration to deliver equality and efficiency;<br>f. Mental health development to improve the overall value of care provided;<br>g. Maximise value and patient outcomes from specialised commissioning;<br>h. Establish a flexible and collaborative approach to workforce;<br>i. Digital interoperability to improve information flow and efficiency. | Governance arrangements for the Medway and Swale system agreed<br>1. Monthly Medway and Swale System Delivery Board.<br>a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive.<br>b. Membership is made up of executive from provider and commissioning organisation<br>c. System recovery is a standing agenda item.<br>d. Cost Improvement Plan (CIP) and QIPP plans as well as commissioners key transformational programmes monitored via the Board. | 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 meeting every 6 weeks. | Patient and staff side engagement strategy needs to be further developed. | **4 x 3 = 12 Moderate** | **3 x 2 = 6 Low** | |

| 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 |
| **2a**<br>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<br>**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. | | Digital Delivery Group in place. Reporting to the Executive Team | | Development of longer term Digital and innovations Strategy<br><br>Agree Digital Governance<br><br>Establish Digital providers Forum | **3 x 3 = 9<br>Moderate** | **3 x 2 = 6 Low** | |
| | | | 2. Maintain priority and focus on the investment on digital technology within the Trust which supports the Trust wider transformation agenda. | | Reporting to the Executive Team every fortnight. | | | | | |
| | | | | | | | | | | |
| **2b**<br>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<br>**Moderate** | 3. Prioritisation of digital programmes to support key transformation deliverables.<br>4. Review and restructure IT Services department undertaking a capability and skills assessment<br>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. | Digital deliverables reported through the Transformation Governance structure and recorded at the Transformation Operations Board and the Transformation Assurance Group | | IT Services review<br><br>Foundation Services Plan | **4 x 3 = 12<br>Moderate** | **3 x 3 = 9<br>Moderate** | |
| | | | | | | | | | | |
| **2c**<br>There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research.<br><br>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<br><br>The Trust may not deliver the transformation required at pace | 3 x 3 = 9<br>**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.<br>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.<br>8. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released.<br>9. Work with the ICP, CCG and other external partners to secure funding to support collaborative working.<br>10. Agree the capital programme for the delivery of digital innovation and foundation IT services.<br>11. Ensure that best value is being delivered through current contracts. | | | | Develop reporting mechanism to appropriate committees including:<br>Transformation Assurance Group<br>Clinical Council<br>Digital Delivery Board<br>Capital Group, Finance Committee | **3 x 3 = 9<br>Moderate** | **3 x 3 = 9<br>Moderate** | |

| 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**<br>**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.<br><br>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<br>**Very High** | 1. Monthly reporting of financial position to finance committee and Board, demonstrating:<br>a. substantive fill rates are increasing with a decrease in bank and agency usage<br>b. improving run rate during the year<br>c. live monitoring of cost improvement programme<br>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.<br><br>NHSE/I is providing funding to enable providers to achieve breakeven from 1 April 2020 to 31 July 2020.<br><br>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. | | <u>Apr 2020</u><br>3 x 3 = 9<br>**High**<br><br><u>Mar 2020</u><br>3 x 4 = 12<br>**High** | <u>Apr 2020</u><br>3 x 3<br>**High**<br><br><u>Mar 2020</u><br>3 x 2<br>**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**<br>**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<br>**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.<br><br>(**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<br><br>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.<br><br>2. National shortage of capital funding recognised. Will potentially need some key choices to be made by the Board during 2020/21<br><br>3. Clarity and | <u>Apr 2020</u><br>5 x 4 = 20<br>**Extreme**<br><br><u>Mar 2020</u><br>4 x 4 = 16<br>**Extreme** | 4 x 3 = 12<br>**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**<br>**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<br>**Very High** | 1. Establishment of System Delivery Board with System Recovery as key cornerstone of the programme monitoring delivery and engaging with partners.<br><br>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.<br><br>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.<br><br>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<br>4 x 3 = 12<br>**High**<br><br>Mar 2020<br>4 x 4 = 16<br>**Extreme** | Apr 2020<br>4 x 1 = 12<br>**Moderate**<br><br>Mar 2020<br>4 x 3 = 12<br>**High** | |
| | | | | | | | | | | |
| **3d**<br>**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<br>**Very High** | 1. Interaction with regulators for Public Dividend Capital (and loans) to support deficit and capital requirements has mitigated this risk.<br><br>2. National policy in 20/21 to write-off all interim debt financing through issuance of Public Dividend Capital.<br><br>3. Management of cash reserves.<br><br>(**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.<br><br>STP and national regulatory bodies have not indicated intentions to divest services. | | Apr 2020<br>4 x 1 = 4<br>**Low**<br><br>Mar 2020<br>4 x 1 = 4<br>**Low** | 4 x 1 = 4<br>**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**<br>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<br>**Very 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 | 3 x 4 = 12<br>**High** | 3 x 2 **Moderate** | |
| | | | 2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating:<br>a. Current contractual vacancy levels (workforce report)<br>b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR))<br>Monthly reporting to services or all HR metrics and KPIs via HR Business Partners.<br>Retention programmes across Trust. | | KPI Board oversight<br>1. Trust vacancy rate at 12.2%.<br>2. Sickness rate 4.2%<br>3. Substantive workforce 83% | | | | | |
| | | | 3. Monitoring controls:<br>a. Monthly reporting of vacancies and temporary staffing usage at PRMs;<br>b. Daily temporary staffing reports to services and departments against establishment;<br>c. Daily pressure report during winter periods for transparency of gaps. | Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.<br><br>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:<br>a. NHSI agency ceiling reporting to Board;<br>b. Weekly breach report to NHSI;<br>c. Reporting to Board of substantive to temporary staffing paybill. | | Board reporting<br>1. £6m favourable to ceiling;<br>2. Averaging 30 breaches per week compared to c1000 in 2016<br>3. Agency workforce 2.5%<br>4. Bank workforce 14.5% | Agency reporting to NHSEI (Single oversight framework element) | | | | |
| | | | 6. Workforce redesign:<br>a. PRM review of hard to recruit posts and introduction of new roles;<br>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:<br>a. Operational KPIs for HR processes and teams reported monthly. | HR & OD performance meeting<br>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**<br>Staff engagement<br><br>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.<br><br>Pulse surveys to be implemented to enable continuous feedback.<br><br>Values-based recruitment to be reviewed in March 2020.<br><br>People Committee to commence. | 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<br>2. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme. | People Committee (to commence) | NHSEI Culture and Leadership programme update | | | | |
| | | | Staff Communications:<br>a. Weekly Chief Executive communications email;<br>b. Monthly Chief Executive all staff session (December 2018 onwards);<br>c. Senior Team briefing pack monthly. | Communications routes well-established in Trust. | | | | | | |
| | | | Staff Survey results: Annual report to Board demonstrating:<br>c. Trust scores across key domains;<br>d. Comparative results from previous years and other organisations;<br>e. Heat maps for targeted interventions.<br>f. Local survey action plans to address key concerns. | Survey 2019 staff engagement score, 6.8– lower than average 7 | People Committee (to commence) | National Staff Survey Centre annual reports | | | | |
| | | | Leadership development programmes:<br>a. Implemented to ensure leadership skills and techniques in place. | 1. Trust has become an ILM-accredited centre;<br>2. Programme in fourth year;<br>3. Henley Business School MA leadership programme launched in Q4 2018/19. | People Committee (to commence) | NHSEI Culture and Leadership programme update | | | | |
| | | | Policies, processes and staff committees in place:<br>a. Freedom to speak up guardian route to Chief Executive;<br>b. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours;<br>c. Respect: countering bullying in the workplace policy;<br>d. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce. | 1. Freedom to speak up guardians in place;<br>2. Promoting professional pyramid in place, training for peer messengers continuing;<br>3. Respect policy in place;<br>4. JSC and JLNC in place. | Freedom to speak up report to Board (as per work plan) | | | | | |
| | | | Well-being interventions in place:<br>a. Employee assistance programme and counselling;<br>b. Advice and health education programmes;<br>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;<br>2. Advice, education and Connect 5 programmes live. | People Committee (to commence) | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | Values embedded into the Trust and culture:<br>a. Values-based recruitment (VBR) in place for medical and non-medical positions;<br>b. Values-based appraisal in conjunction with performance. | 1. VBR in place since June 2018;<br>2. Qualitative and quantitative values-based appraisal in place since April 2018. | People Committee (to commence) | | | | | |
| | | | | | | | | | | |
| **4c**<br>Best staff to deliver the best of care<br><br>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.<br><br>**IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice. | This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice. | 3 x 4 = 12 (Moderate) | Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'. | 2019-22 People Strategy in place with monitored delivery plans. | People Committee (to commence) | | | 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).<br>1. StatMan compliance >88%<br>2. Appraisal rate 82% | People Committee (to commence) | | | | | |
| | | | Right attitude and values:<br>a. Values-based recruitment (VBR) in place for medical and non-medical positions;<br>b. Values-based appraisal in conjunction with performance;<br>c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours;<br>d. Respect – countering bullying in the workplace policy. | 1. VBR in place since June 2018;<br>2. Qualitative and quantitative values-based appraisal in place since April 2018;<br>3. Promoting professional pyramid in place, training for peer messengers continuing;<br>4. Respect policy in place. | People Committee (to commence) | | | | | |
| | | | Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity:<br>a. Current contractual vacancy levels (workforce report)<br>b. Monthly reporting of vacancies and temporary staffing usage at PRMs;<br>c. Reporting to Board of substantive to temporary staffing paybill. | 1. Trust vacancy rate at 12.2%;<br>2. Substantive workforce 83%;<br>3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing; | People Committee (to commence) | | | | | |
| | | | Leadership development programmes implemented to ensure leadership skills and techniques in place. | 1. Trust has become an ILM-accredited centre;<br>2. Programme in fourth year;<br>3. Henley Business School MA leadership programme launched in Q4 18/19. | People Committee (to commence) | | | | | |

| COMPOSITE RISK: Quality | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| EXECUTIVE LEAD: Acting 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** | **Actions to be Taken** | **Current Risk Rating** | **Target Risk Rating** | **Overall Assurance** |
| **5a** Since exiting special measures the Trust has maintained a CQC rating of 'Requires Improvement'. It needs to build momentum to progress towards a 'good' and 'outstanding' rating to ensure we do not fail to deliver sustainable change. | If this were to happen it may result in instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust's reputation and loss of staff. This will also impact on staff morale and patient confidence in the Trust. | **4 x 4 = 16 High** | 1. CQC improvement plan in place | Quality Panel meetings. | Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board | External Quality Audit.<br><br>IPAS Meetings (NHS I/E)<br><br>CCG Quality Meetings | | | **4 x 4 = 16 High** | 2 x 2 = 4 Very Low | |
| | | | 2. Annual quality goals and priorities agreed | AGM taken place.<br><br>Programme of continuous quality improvement:<br>a. CI training (yellow belt, white belt)<br>b. Improvement huddles<br>c. Improvement Specialists<br>d. Local improvement Projects | | | | | | | |
| | | | 5. Quality metrics reported via:<br>a. IQPR and directorate scorecards<br>b. harm free care monitoring via ward scorecards<br>c. Safety Thermometer | New Scorecard developed. | Updates to Executive Group, QAC and Trust Board. | | | | | | |
| | | | 6. Audit and review processes<br>e. Clinical Audit programme and monitoring<br>f. Daily MSA breach reporting and validation<br>g. Ward Quality Review audits<br>h. PLACE and environmental audits | | | | | | | | |
| | | | 8. Central and local oversight of quality<br>i. Complaints management<br>j. Incident management, including Serious Incident (SI) policy, processes and monitoring<br>k. Compliance with Duty of Candour policy and training | Centralisation of the Divisional Teams | Regular reports to the Executive Group. | | | | | | |

| | | | | 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** |
| **5b**<br>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 | | 1. IPC Improvement plans | IPC policies, procedures and protocols in place<br><br>Annual IPC work plan<br><br>Mandatory IPC training<br><br>Directorate and programme scorecards with key IPC indicators | Infection Control and Anti-Microbial Stewardship Group meeting (ICAS)<br><br>Quality Assurance Committee | IPAS (I/E) meeting | | | | |
| | | | | | | | | | | |
| **5c**<br>If we have poor patient flow and weak capacity and demand planning we will fail to achieve the required performance standards (constitutional standards: 4 hour access, RTT, DM01 and Cancer) | 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. Best Access Transformation Programme | Recovery plans including agreed trajectories for all constitutional standards<br><br>Weekly Best Flow Programme Board | Reviews and updates discussed at Executive Group, TAG and Board<br><br>National planning tools being used. | External reviews by NHS I/E | | **3 x 4 = 12 Moderate** | **3 x 2 = 6 Low** | |
| | | | | | | | | | | |
| **5d**<br>If quality governance is not sufficiently understood or embedded we 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<br>a. Quality goals and priorities agreed for 2019/20<br>b. Quality Account | Quality governance groups established for delivery and monitoring quality<br>Patient Safety<br>Patient experience<br>Clinical Effectiveness and Research<br>Medicines Management<br>Mortality<br>Safeguarding | Executive Group and Quality Assurance Committee | | | **3 x 4 = 12 Moderate** | 2 x 2 = 4 Very Low | |
| | | | 2. Key leadership roles in place<br>a. Corporate business critical posts in place providing governance, quality and safety leadership<br>b. Directorate and programme clinical governance, quality and patient safety leads in place<br>c. Quality Governance teams in place centrally and within directorates | | | | | | | |
| | | | 3. Quality Governance monitoring<br>a. CQC compliance framework<br>b. CQC Assure<br>c. Risk registers<br>d. Quality Impact Assessments | Divisional and corporate risk meetings in place | Risk Assurance committee in place reporting to executive team . | CQC | | | | |

# Meeting of the Trust Board
# Tuesday, 12 May 2020

| | | | |
|---|---|---|---|
| **Title of Report** | **Covid 19 Trust Board Update** | Agenda Item | **5.1** |
| **Lead Director** | Harvey McEnroe, Chief Operating Officer | | |
| **Report Author** | Harvey McEnroe, Chief Operating Officer and Strategic Commander for Covid19 | | |
| **Executive Summary** | To give a brief update to The Board on the current status of the Trust during COVID-19 including any escalations and risks | | |
| **Committees or Groups at which the paper has been submitted** | N/A | | |
| **Resource Implications** | N/A | | |
| **Legal Implications/ Regulatory Requirements** | N/A | | |
| **Quality Impact Assessment** | N/A | | |
| **Recommendation/ Actions required** | The Committee is asked to: state decision required i.e. review, approve, note. [For example: The Committee is asked to approve the Safeguarding Policy]. | | |

| Approval | Assurance | Discussion | Noting |
|---|---|---|---|
| ☐ | ☒ | ☐ | ☒ |

| | |
|---|---|
| **Appendices** | N/A |

| ***Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board*** | |
|---|---|
| The key headlines and levels of assurance are set out below: | |
| **No assurance** | Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans |
| **Partial assurance** | Amber/ Red - there are gaps in assurance |
| **Assurance** | Amber/ Green - Assurance with minor improvements required |

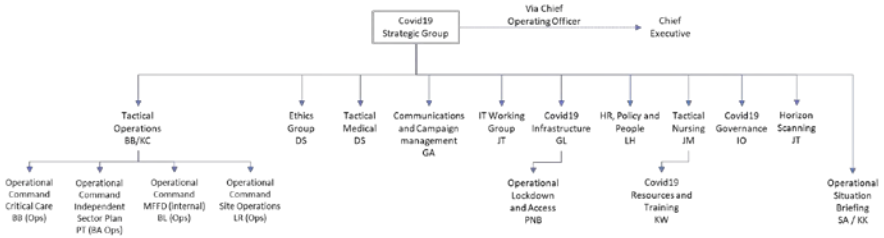
# Covid-19
# Trust Board update

**May 2020**

Harvey McEnroe
Chief Operating Office
COVID-19 Strategic Commander

# Our Trust Major Incident response

- The Trust formally stood up its incident level 3 response on 3 March 2020 in line with the regional ask. We stood up an incident control room and moved to EPRR management methodology with a central strategic command and a single tactical command via the DOC and SMOC rota.
- The Trust moved to incident level 4 on 11 March 2020, at this time we formally stood up the strategic command structure with formal tactical commands. The structure was oversee via the EPRR management model and reported to the AO via the emergency planning executive.




- Each Tactical Group manages a risk log and a single sheet reporting model which reports up daily into the Strategic Command Group.
- All tactical meetings should be logged and all meetings should have a formal action log and issues log.
- Once all reports are logged into Strategic Command, the Strategic Commander will brief the Chief Executive Officer daily.
- Once the CEO is briefed there will be a weekly briefing of the Board.

# The ‘holy trinity’ of hospital incident management

**Nursing Tactical – Led by Jane Murkin**

- Oversee quality and patient safety linked to C19.
- Manage Nursing welfare and PPE training.
- Engage with professional workforce up and out the Trust re nursing plan.

**Medical Tactical – Led by Dr David Sulch**

- Oversee medical response plan to C19 including rotas. Manage welfare of medical staff
- Led designs for ITU and critical care deployment plan.
- Engage with professional workforce up and out the Trust re medical plan.

**Ops Tactical – Led by Kevin Cairney**

- Implementation of medical and nursing plan.
- Operational management of site and ward plan.
- Work across the NK cell to manage the system links into MFT.

# Tactical Groups – how we micromanagement the incident

- **Communications Group**
  - Daily Bulletin to all staff
  - Daily stats outlining total cases and suspected along with deaths
  - Dedicated staff email address for all concerns/FAQs
  - Daily coffee break meeting with COO daily to discuss FAQs and concerns
- **Information Management Group**
  - Covid19 Systems Capacity Supply Sitrep
  - Bed Capacity Plan for independent sector
  - Daily issues Sitrep
  - NHSE/I C19 daily Sitrep
  - PHE C19 Hospital Episode Return
  - CPNS Death Submission
  - Oxygen Utilisation Submission
- **Ethical Group**
  - Using guidance from the Reference Group and other expert sources, formulate advice on the ethical issues arising from the management of C-19 within the Trust.
  - To support clinicians in decision-making based on ethical principles and reasoning in the context of the C-19 outbreak
  - To provide an ethical input into policy making, management and governance in the context of the C-19 outbreak
- **IT and Tech Group**
  - Service-desk Covid-19 kit request system and prioritisation criteria agreed. Proactive order of 500 laptops, due to be delivered on Wednesday and imaged by the end of this week. Mid-Kent College providing volunteers to support the build process
  - In addition, VPNs reviewed and re-allocated to priority staff. Additional tokens purchased with new laptops
  - Extra bandwidth to enable home working and remote outpatients commissioned
  - Telephony business case approved. 8x8 system enables call re-routing to support telephone outpatient consults
  - MS Teams deployed – user guides shared, Super User 'Team' mobilised, regular comms re: good practice and FAQs
  - Boards and sub-committees, EPRR groups, Virtual MDTs, ICU handover and >60 Teams set up via IT, Exec Team all trained
- **Procurement and E&F Group**
  - Daily reporting on PPE
  - Escalation for kit and PEE gaps
  - Estates response plan for extra weekend cover

# The EPRR incident response model we used to manage the C19 pandemic

- Under the Level 4 (Covid-19) Major Incident, The Trust formally delegated the role of MFT Strategic Commander to **Harvey McEnroe** as the named Accountable Emergency Officer. Harvey is responsible for overseeing the Trusts Strategic Command and the response to the Covid-19 incident on behalf of the Board and the Executive.
- The Strategic Command - has been established to oversee the multi-team response to Covid-19. This currently meets daily twice a day.
- The Strategic Command is made up of the Medical Director, Dr **David Sulch**; the Acting Chief Nurse, **Jane Murkin**; the Director of Estates and Facilities; **Gary Lupton**, the Director of Communications; **Glynis Alexander**, Trust EPRR lead; **Steve Arrowsmith** and IPC lead; **Ian Hosein**
- Strategic Command oversees the Tactical Command this layer has been established to oversee the multi-departmental tactical/operational response to Covid-19. This meets daily (virtually) and reports in to the Strategic Command. The Strategic Command is led by Tactical Commanders at Director and executive level including the **Divisional Directors of Operations**, **Divisional Directors of Nursing**, **Executive Directors of Workforce**, **IT**, **Finance** and **Governance**.
- Tactical Command leads the daily response to Covid-19 and coordinates the Operational teams. The Operational Command teams deliver the day to day functions of operations across planned care, unplanned care, critical care, emergency care and the wider corporate services.

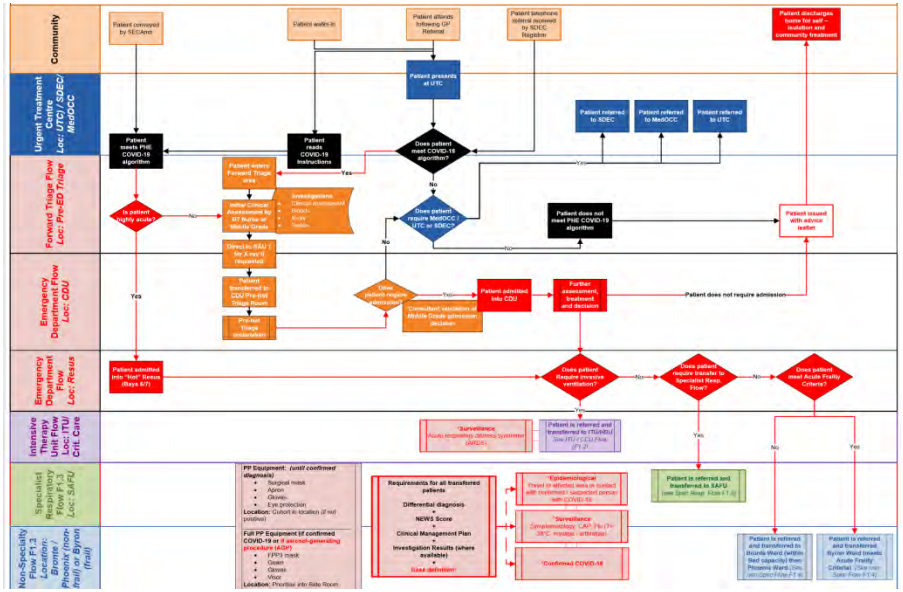
# Covid-19 role definition

- **Strategic Commander** - Responsible for overseeing the MFT response to the Covid-19 incident on behalf of the Trust. Attends Strategic Group meeting. Provides strategic leadership for the Incident Control Centre (ICC) and responsible for coordinating the various healthcare system and organisational responses to manage the incident.
- **Tactical Commander** – Responsible for the tactical group they oversee and ensure that strategic direction is deployed through this group and that escalation of issues is managed through the agreed governance to Strategic Command. Chairs the Tactical Command Group meetings. Provides tactical/operational leadership in managing the incident alongside other multi-agency partners and co-ordinates tactical response across the Trust.
- **Operational Commander** – Attends tactical meetings and actions the tactical plan, delivering the day to day management of the incident at department level, escalating issues to Tactical Command daily.

# Role of the Strategic Command, the Accountable Officer and the Board during the C19 response

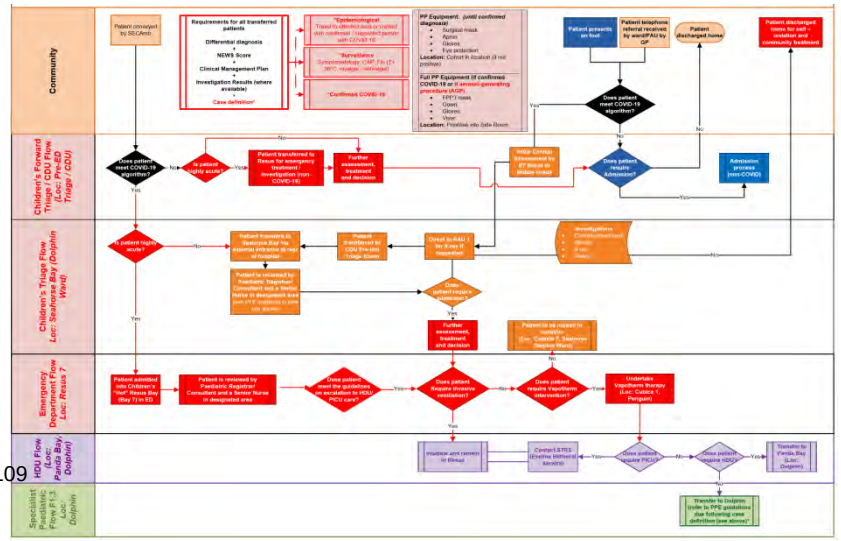
- Preserve life
- Minimise the risk to the public
- Minimise the risk to patients
- Minimise the risk to vulnerable persons through a coordinated partnership response
- Maximise the safety of partner agency staff
- Maintain the safe operation of services provided by partner Cat 1 & Cat 2 responders including support and voluntary agencies
- Ensure provision of non-directly affected services for as long as possible
- Develop information that enables partners to maintain their services to the public and restore normality as soon as possible
- Minimise disruption to local communities including local businesses
- Ensure a consistent multi-agency media response
- Manage any consequences of the disruption and agency response
- Maintain continuity of essential local services
- Facilitate a return to normality at the earliest opportunity

# Modifying the hospital bed base



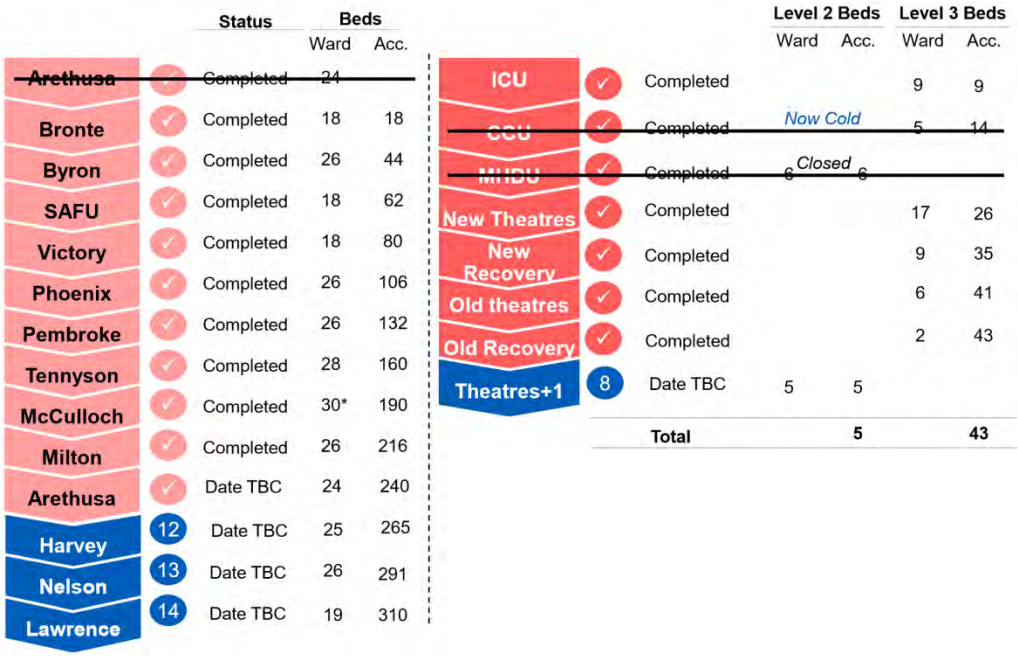

- In an attempt to facilitate an increased acuity in respiratory demand and a change to the ITU demand the Trust took steps to rearrange the bed base, with a plan to:
  - Establish a front triage model in resus and the emergency pathway
  - Establish up to 53 ITU beds (from 12)
  - Increased the medical HDU capacity
  - Open up to 250 general beds as C19 beds

- Whilst the above was required to facilitate the C19 the trust had to maintain;
  - A clean medicine ward function
  - Maternity services
  - A clean emergency access pathway
  - A non C19 stroke and cardiac bed base



# Creating C19 ward and ITU capacity

- Once the strategic command had agreed the potential ward reconfiguration to facilitate C19, we moved to deploy phase.
- As at 11 April 2020 the Trust had 216 bed converted to C19 – this was the peak of C19 conversion in general beds.
- By the Bank Holiday weekend the Trust had 240 beds converted to C19.
- At its maximum the Trust carried 43 critical care patients (ITU and HDU).

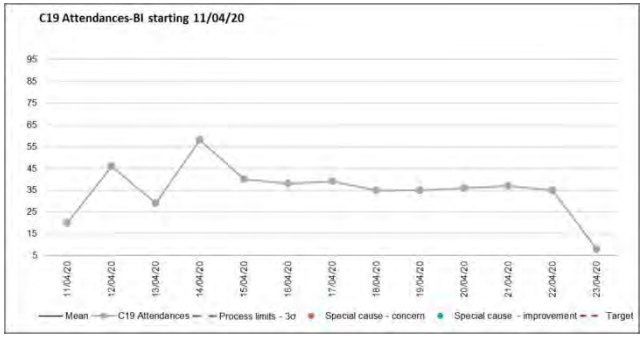


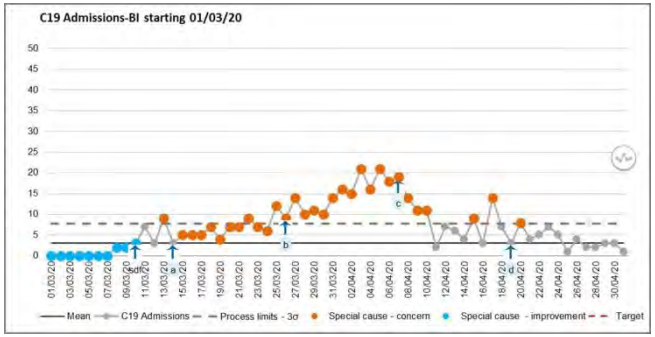
| | Status | Beds Ward | Beds Acc. |
|---|---|---|---|
| ~~Arethusa~~ | ~~Completed~~ | ~~24~~ | |
| Bronte | Completed | 18 | 18 |
| Byron | Completed | 26 | 44 |
| SAFU | Completed | 18 | 62 |
| Victory | Completed | 18 | 80 |
| Phoenix | Completed | 26 | 106 |
| Pembroke | Completed | 26 | 132 |
| Tennyson | Completed | 28 | 160 |
| McCulloch | Completed | 30* | 190 |
| Milton | Completed | 26 | 216 |
| Arethusa | Date TBC | 24 | 240 |
| Harvey | 12 Date TBC | 25 | 265 |
| Nelson | 13 Date TBC | 26 | 291 |
| Lawrence | 14 Date TBC | 19 | 310 |

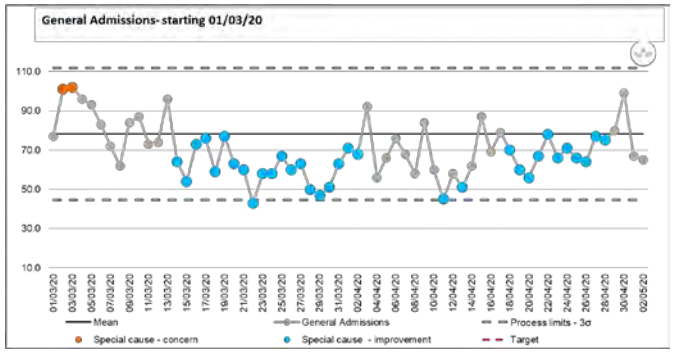
| | Status | Level 2 Beds Ward | Level 2 Beds Acc. | Level 3 Beds Ward | Level 3 Beds Acc. |
|---|---|---|---|---|---|
| ICU | Completed | | | 9 | 9 |
| ~~CCU~~ | ~~Completed~~ | *Now Cold* | | ~~5~~ | ~~14~~ |
| ~~MHDU~~ | ~~Completed~~ | ~~6~~ *Closed* | ~~6~~ | | |
| New Theatres | Completed | | | 17 | 26 |
| New Recovery | Completed | | | 9 | 35 |
| Old theatres | Completed | | | 6 | 41 |
| Old Recovery | Completed | | | 2 | 43 |
| Theatres+1 | 8 Date TBC | 5 | 5 | | |
| | **Total** | | **5** | | **43** |

# The Covid-19 demand profile

- The Trust saw a peak of C19 around 4 April 2020 which sustained to 8 April 2020. This was in keeping with the regional peak. There was a second peak on 16 April 2020, which again mirrored the regional peak data.
- During the same time, we saw a drop off in general attendances and general admissions. This activity profile was similar to the regional profile, though MFT remained twice as busy than are nearest provider trusts in North Kent and East Kent, seeing 100% more activity than DVH in this time and 50% more than MTW.



The next phase; debrief, support staff welfare and then….

# THE THREE R’S

# Exiting Major Incident response:

## Restore, Recover, Return to BAU

Debrief and Support Phase

### *Restore what was…*

- *Putting the aspects of the hospital back to as it was that can simply return to Business As Usual (BAU)*
- *Restart our core business for urgent and emergency care*
- *This aspect of work will be mainly applicable to the estate, workforce and rotas*
- *Communications re what is going back to 'normal' and by when*
- *Manage welfare and support staff*

***Indicative dates:***
*End of April – Mid/End May 2020*

***We are here***

### *Recover to a new normal*

- *Rebase line the performance plan*
- *Agree what the priority of performance recovery will be (e.g. urgent and cancer first)*
- *Clinically sign off recovery plan*
- *Agree the elective and cancer profile*
- *Agree mutual aid needs*
- *Agree the 'system' working plan*
- *Agree the regulator engagement plan*
- *Ensure we are 'system by default'*
- *Communicate what is going into BAU phase*
- *Independent Sector care model*
- *Agree data flows*

***Indicative dates:***
*Mid/End May – Mid June 2020*

### *Return to BAU post Wave 1*

- Establish full governance for new objectives and delivery plans
- Review and reflect phase
- Lessons learned and build into next phase planning
- Prep for wave2 and wave3 and winter planning

***Indicative dates:***
*End June – Mid July 2020*

# Ward and Clinical Reconfiguration

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

- **Immediate ward changes to safely manage the on-going 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 Acting 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 Acting Chief Nurse) supports governance, quality, safety and safeguarding requirements**
- **Development of Consultant working group from across the organisation (key stakeholders from medical and surgery)**

- **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)**

# Stepping down the incident and moving to wave2 and wave3 planning

- In the next four to six weeks, the C19 incident will be stepped down from a major incident, likely returning to a level 3.
- The Trust will set down its full EPRR, ICC response at this stage and will return to BAU.
- We will need to maintain a C19 cell within the operational team and a C19 response plan linked to the EPRR response plan.
- Wave2 and Wave3 will need to be planned for in line with regional and system partnership.
- It is the proposal of the Strategic command that this overseen via the EPRR team and linked into winter planning.
- The risk that second and third wave will have is yet to be measured, but we now have a clear plan for managing the hospital in C19 and have tested our capacity.

Known unknowns

# RISKS, OPPORTUNITIES AND FEARS

# Managing the hospital bed occupancy

- Using the historic trends of occupancy, non-elective activity and lengths of stay for the previous three Winters (defined as the period between December 1st and March 1st), and assuming a 2 short additional, 'flatter' peaks of CV19 cases, forecasting predicts that occupancy will peak at around 107%.
- A radical step-change will be needed across whole health economies to avoid hospital admissions and expedite discharges post-MO. Historically, these interventions have not kept pace with demand increases prompted by demographic and non-demographic growth.
- Ultimately, the system will need to think differently about the type of beds and the associated staffing model assuming that NHS workforce will be c.20% depleted when accounting for shielding restrictions, sickness and self-isolation measures.
- Using the currency of Occupied Bed days, the demand/capacity gap between a safe hospital bed occupancy (95%) and the forecast 107% is 59 beds i.e. the equivalent of 2 inpatient wards if we 'Do Nothing'.

Forecast Winter 2020 Occupancy:

**107%**

Number of occupied bed days (OBDs = beds x 365) needed to maintain safe occupancy-level of 95%:

**21,549**

Converted to G&A beds:

**59**

# A radical step-change in MO discharge expectations is needed to stay safe

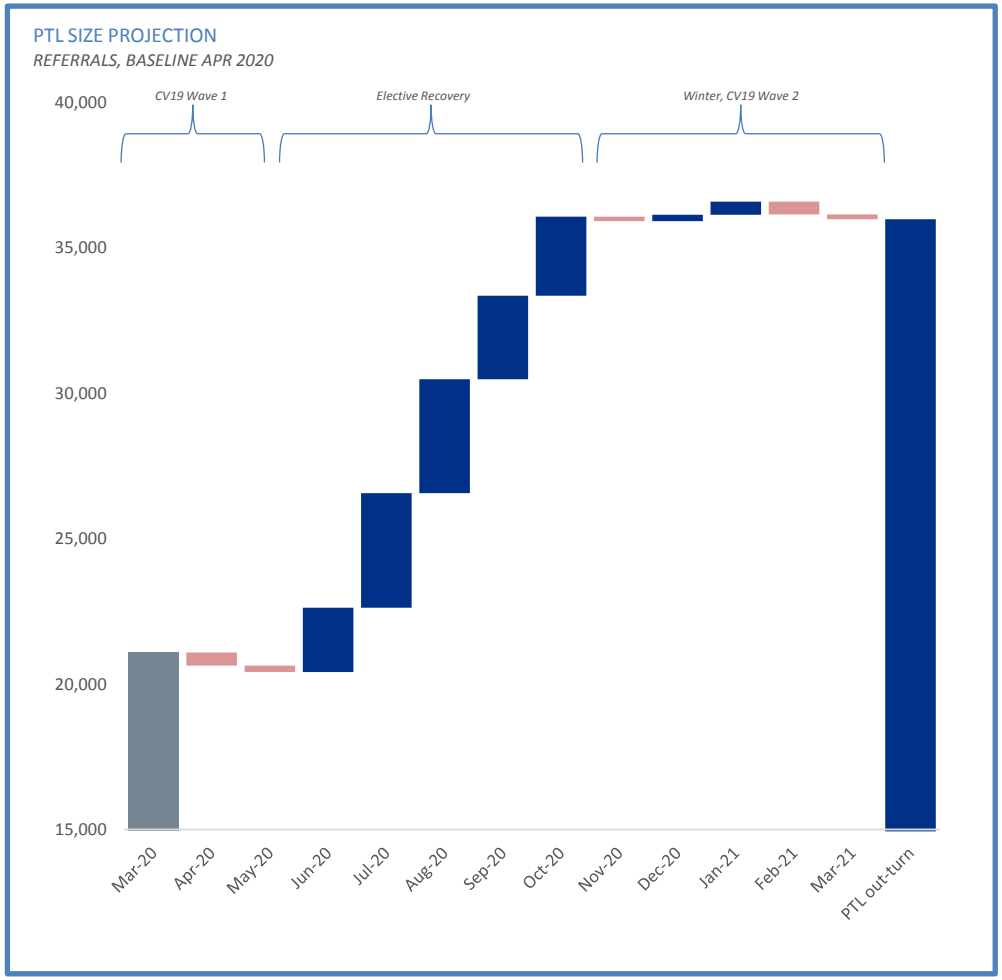
| | Supported Discharge KPIs | Pre-CV19 Target | CV19 Target |
|---|---|---|---|
| Discharges | Number of complex* discharges per weekday | +30% (in line with Trust target) | +50% |
| | Discharges achieved before noon | 35% | 40% |
| | Number of weekend discharges | 80% of weekday discharges | 100% of weekday discharges |
| | Average time from MO to discharge | 24h | 12h |
| LOS | Number of patients with LoS 14d+ | 50 | 30 |
| | Number of patients with LoS 21d+ | 30 | 10 |
| Process | Average time between admission and discharge plan being started | 24h | 12h |
| | Number of changes to discharge pathway | 0 | 0 |
| | The number of times patient becomes NMF after declared MF | 0 | 0 |

**<95% bed occupancy**

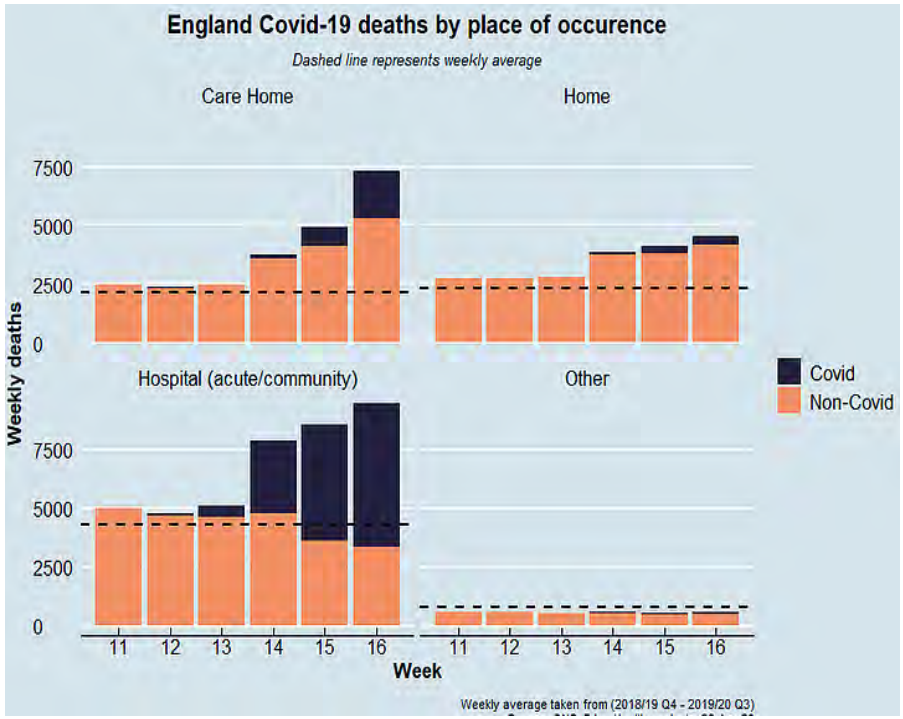
*Indicative SLA-able targets*

# Managing our PTL and the Elective Recovery Programme

- Working from an April 2020 PTL baseline, projecting the same historic patterns of activity, PTL removals and 'tip ins' from the previous 3-years, and assuming that General Practice capacity and referral patterns remain the same, we are forecasting a worrying PTL position in 12-months. Our 'Do Nothing' modelling assumes that an Elective Recovery programme will oversee a catch up over the next 5-months. With Winter pressures and potentially a second Wave of CV19 and the accompanying social distancing protocols, by April 2021, the hospital PTL will be >35,000 (currently c.20,000).
- This will mean:
  - A) the median waiting times will increase.
  - B) The Elective backlog will continue to grow – there are large cohorts of patients at between 12-18 weeks, currently waiting on the hospital's PTL that are ready to 'tip in' and patients between 1-10 weeks who will not have received a first appointment and as such be already delayed on a diagnostic pathway.
  - C) Some patients will die, or remain in chronic pain for long periods. National analysis and commentary is already referring to this vast waiting list as the second wave of indirect deaths attributable to CV19.



# Care Home capacity and deaths




- Excess deaths in care homes between the 30 March (week 14) and the 19 April were 9,600 - higher than the 9,400 in hospitals.
- The majority of excess care home deaths (6,500 of the 9,600) are not attributed to Covid-19, but this is misleading.
- Excess deaths at home jumped up in the week of the 30 March (week 14) by 1,000 (39%) and have only increased a bit over the last two weeks. These are presumably shielded or vulnerable people that are not using hospitals, but perhaps should.

# Other items....

- New IPC rules
- Adult Social Care occupancy
- Future CV-19 wave workforce resilience and community good will
- GP referral patterns
- Access to diagnostics
- Ending social distancing
- Regulatory expectations
- Delivering the CQC and Trust Improvement Plan alongside this

# Workforce

Wellbeing

- The Trust will be working to NHSEI's #HAY (how are you?) programme adapting methods used by the military across the 3Rs – this focuses across:
- Supporting staff with leave;
- Providing decompression/ wellbeing space (completed by Tara Rampal et al);
- Conduct wellbeing meeting (existing strategic moves to public);
- Provide Trauma Risk Injury (TRiM) support;
- Support our most vulnerable;
- Conduct check in/out;
- Coping strategies and resources (https://view.pagetiger.com/MFTBenefits/Covid-Support).

Deployments

- Nursing, Medical and Operational deployments have been managed by professional tactical group with phased approach (triggers) to next stage of deployment;
- Other deployment demands have been exceptionally low (<10 FTE);
- Deployments follow standard policy to assess (and mitigate) competence and suitability (adaptations).

# Meeting of the Board of Directors in Public
# Tuesday, 12 May 2020

| | | | |
|---|---|---|---|
| **Title of Report** | Draft CQC Improvement Plan | **Agenda Item** | 5.2 |
| **Report Author** | Philip Kemp, Associate Director Quality and Patient Safety (Interim) | | |
| **Lead Director** | Jane Murkin, Acting Chief Nurse | | |
| **Executive Summary** | This paper contains an updated copy of the CQC – High Quality Care Improvement Plan that was previously shared.<br><br>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.<br><br>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 & letter of intent Section 31.<br><br>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.<br><br>Louise Thatcher (CQC Specialist Advisor) has commenced work with the Central Team to oversee the delivery of the plan.<br><br>The next phase of work in further developing the content within the plan will include:<br>• 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)<br>• Progress and confirm the resourcing for the Quality PMO to support delivery of the plan and facilitate a workshop with identified staff<br>• Work with the Communications Team on producing a finished document.<br>• Prepare the draft plan for sharing with external partners | | |
| **Link to strategic Objectives 2019/20**<br><br>***(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 | | ☒ |

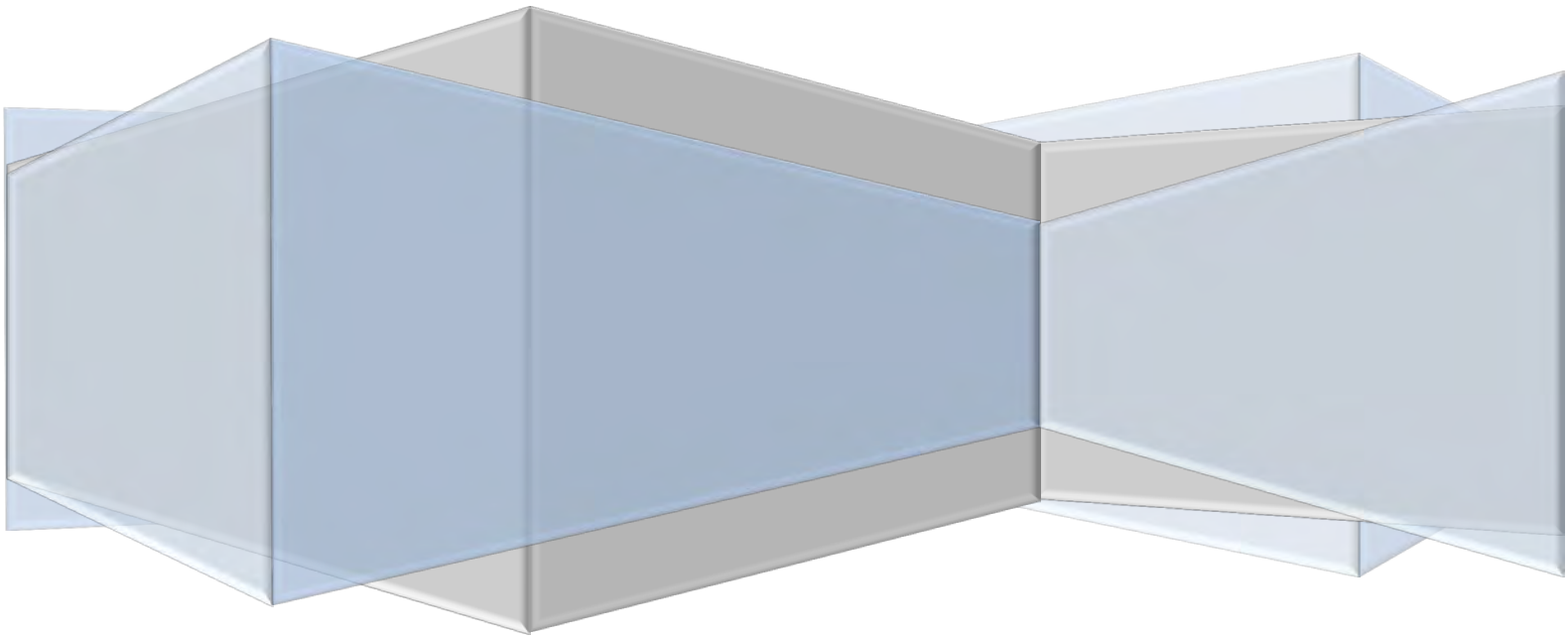
| | | |
|---|---|---|
| | **High Quality Care:** We will consistently provide high quality care | ☒ |
| **Due Diligence** | To give the Trust Board assurance, please complete the following: | |
| **Committee Approval:** | Name of Committee: Quality Assurance Committee, 28 April 2020<br>Date of approval: N/A in draft format – working document | |
| **Executive Group Approval:** | Date of Approval: 6 May 2020 | |
| **National Guidelines compliance:** | Does the paper conform to National Guidelines (please state): | |
| **Resource Implications** | A separate proposal has been made to resource the Quality PMO. | |
| **Legal Implications/Regulatory Requirements** | NHS I/E will expect the organisation to prepare, agree and resource an Improvement Plan which can be shared publicly. | |
| **Quality Impact Assessment** | State whether a Quality Impact Analysis has been undertaken or is proposed | |
| **Recommendation/ Actions required** | The Trust Board is asked to discuss the content of this report. | |

| **Approval** | **Assurance** | **Discussion** | **Noting** |
|---|---|---|---|
| ☐ | ☐ | ☒ | ☐ |

| | |
|---|---|
| **Appendices** | Appendix 1 – Draft CQC Improvement Plan |

NHS
Medway
NHS Foundation Trust

# CQC Improvement Plan
# March 2020



# Contents

# Executive Summary

Medway NHS trust comprises a single-site hospital based in Gillingham, Medway Maritime Hospital, which serves 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
- Clear 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, whilst the challenges we face are immense, I am confident we have the skills and desire to make Medway great again – and ultimately put us in a position to deliver Best of Care, Best of People.

I have been struck by how much good-will there is locally, and amongst 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 CQC Improvement Plan, aligned to our Trust Quality Improvement Plan which is aimed at delivery high quality care that is safe, effective and person centred.

Thank you

James Devine Chief Executive.

# High Quality Care

## Our CQC Improvement plan

The CQC Improvement Plan is aligned with the High Quality Care Pillar of the Trust overarching Quality Improvement Plan.
The first twelve months of this Improvement plan will focus on the delivery of the 24 must dos and the 19 should dos which derived from the December 2019/ 2020 inspection.
This plan provides the details of the improvement actions the Trust is taking forward to address the findings and demonstrate improvements with measures and metrics that will be tracked, monitored and reported to demonstrate achievement.
Including key areas such as:

- Infection prevention and control
- Basic nursing 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 yourselves 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 leads, timescales, milestones and objective measures to achieve improvement identified

The focus throughout the implementation of the improvement plan will demonstrate improvements in the safety and quality of care provided to our patients over the next 12 months, ensuring the focus is also on embedding changes in practice to ensure these are sustained long term.
The longer term focus of the improvement plan will include our quality strategy priorities and any other quality areas recognised as important areas of focus.

The approach taken will include:

- Building upon improvements made to date in addressing the inspection findings
- Building on the improvements that will be made following the first year of implementation of the plan
- Embedding and sustaining changes in practice which will continue to improve the quality and experience of care.
- Involving frontline teams and empowering them to identify, lead and implement changes for themselves
- Having a simple but comprehensive set of measures for improvement to demonstrate impact on the safety and quality of patient care and in everything we do.

# CQC Inspection Findings December 2019/January 2020

# CQC Inspection December 2019 / January 2020

During December 2019 the Care Quality Commission (CQC) undertook a planned inspection of the Trust in five Core Services.

Following the unannounced inspection on the 16 December 2019 the CQC confirmed that they had included medical care as the sixth core service review.

The following table indicates the dates of when CQC inspection occurred at the Trust and the type of inspection undertaken

| Inspection Visit | Date of inspection |
|---|---|
| Core Service Inspection involving the following five areas:<br>• Emergency Services<br>• Surgery<br>• Critical Care<br>• Children & Young People<br>• 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 the 17 December 2019 the Trust received a Possible Enforcement notice Section 31 letter of intent under the Health & Social Care Act. This related to the findings from the CQC unannounced inspection on the 16 December 2019. The letter raised concerns in regard to care of patients within Dickens Ward.

In responding to the concerns raised by the CQC the Trust provided a detailed response to the CQC and immediately developed an action plan to address the concerns. The Dickens action plan incorporated 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 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 & Social Care Act (Letter of Intent).

On the 19 December 2019 the Trust received a Section 29A Warning Notice

under the Health and Social Care Act 2008

**Governance Oversight**

All actions from the Section 31 and 29a letters and concerns raised in regard to COSHH have been combined into one single central overarching action plan.

This overarching plan is inclusive of the COSHH actions (from the 29a warning notice), IPC and MSA/recovery actions and the Trust action plan relating to COSHH.

Evidence process required to close each action is now clearly in place and once submitted is assessed by the central team.

A standardised measure of completion has also been applied (via the Trust's BRAG rating system) to ensure a consistent description of progress throughout.

Since this Inspection oversight of the each individual action plan has been reviewed.

An interim Associate Director of Quality & Patient Safety had been appointed to continue the work initiated by the Interim Chief Nurse.

In response to the Section 31 Letter of Intent the centralised action plan incorporated 29 Dickens Ward actions, on closure of the ward a number of these actions had been completed and evidence is being sort for those progressing or on track.

# Trust Ratings from the CQC 2019/20 Inspection

On April 2020, the Care Quality Commission (CQC) published its inspection report for Medway Maritime Hospital following a visit 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

## 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% 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.

## Negative Findings

- 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 Improvement Plan

As a result of the core service and well led inspection 2019/20 a CQC Quality Improvement Action Plan has been developed.

The work on the Improvement Plan has been led by the Associate Director of Quality & Patient Safety and overseen by the Chief Nurse as part of the organisations improvement work and supported by a member of staff from NHSI/E who is currently at the Trust as an Improvement Support Director.

All updates and evidence behind the plan are collated monthly. The improvement plan is subject to a robust monitoring arrangement both internally and externally; and will be submitted on a monthly basis to the CQC, NHS Improvement and Medway CCG

Our CQC Improvement Plan is not just a response to the Care Quality commission's (CQC) Inspection report of March 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, with an emphasis on continuously improving the safety, quality and experience 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.

A development proposal is in place to provide the provision of a skilled and experienced team to support the Trust with the development, tracking, reporting and implementation of the Trust's CQC Improvement Plan in response to the CQC's inspection findings. The additional staff will form a 'Quality PMO' integrated within the Central Quality & Patient Safety Team for a period of 18 months under the management of the Associate Director of Quality and Patient Safety and leadership of the Chief Nurse as the Executive Director for Quality and CQC

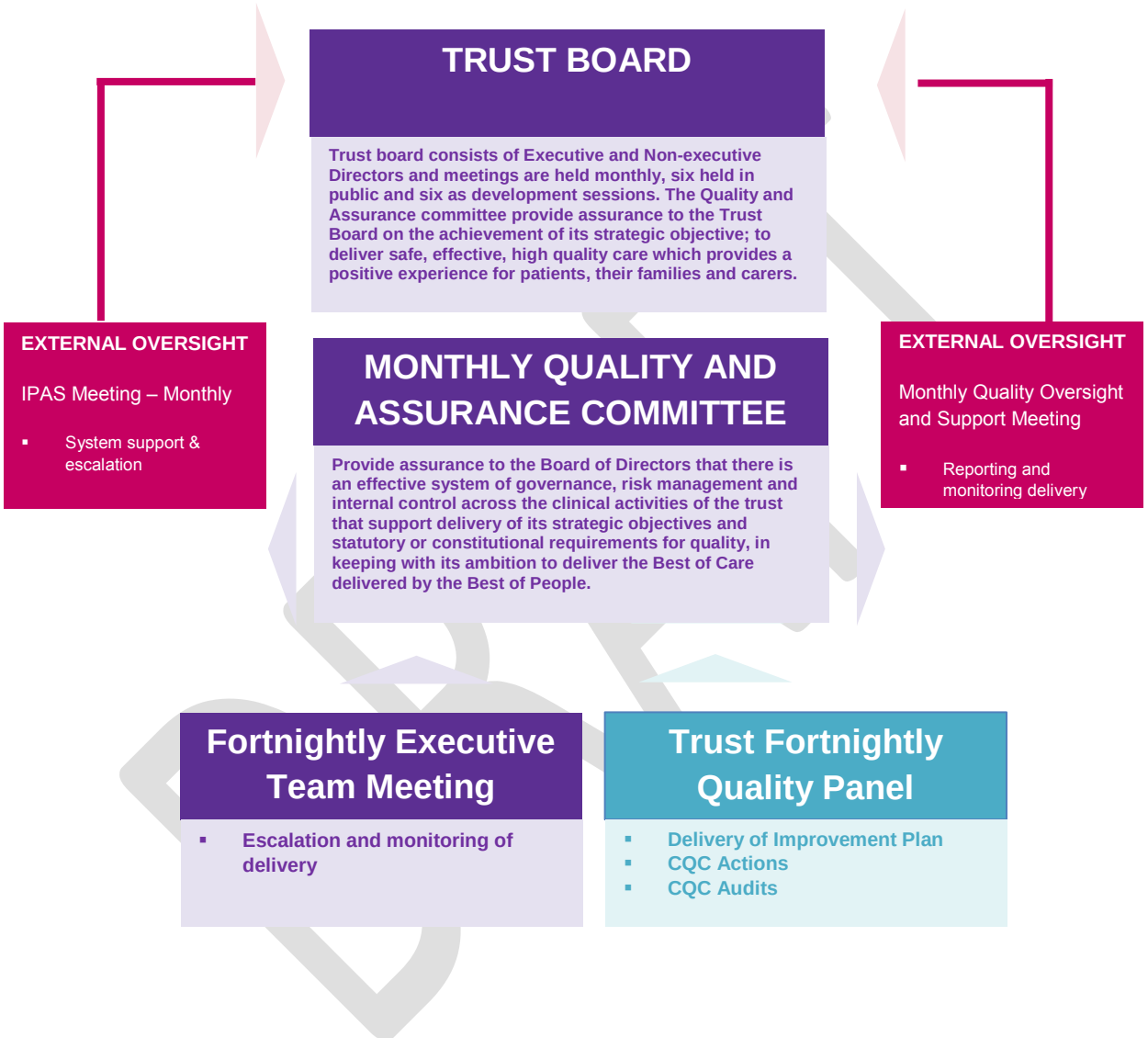
**The Central Quality PMO team will:**

- Support the Executive Director and Trust with the development, tracking, reporting and implementation of the Trusts Phase 2 Quality Plan
- Apply a robust programme and project management methodology to structure, track, monitor and report progress of the CQC Improvement Plan via the Quality panel as the approved governance structure

- To work with the Business Intelligence Team to develop a CQC Improvement plan performance dashboard to measure progress, delivery of actions and outcomes at both individual work stream / theme level and programme plan level
- To work as part of the Central Quality & Patient Safety Team and support the current staff working on CQC related work, providing an independent and objective assessment on the quality of evidence provided prior to actions being recommended for closure by the Quality Panel
- To support the Central Quality & Patient Safety Team in the annual programme of assurance to demonstrate the Trusts compliance with the Fundamental Standards and the implementation of a Trust wide programme of mock inspections
- To provide management and oversight supporting a robust schedule of formal reporting to the Quality panel as the governance mechanism overseeing this work
- Provide the Chief Nurse as the responsible CQC Executive Lead with regular progress reports and briefings including formal reporting to the Executive Team, Quality Assurance Committee and Trust Board

# CQC Improvement Plan – Governance Structure

To be updated to include the governance related within the Trust Quality Improvement Plan



# Implementing the CQC Improvement Plan

The delivery of our CQC Improvement Plan will maintain and build on our recent progress to ensure our actions will lead to measurable improvements in the quality and safety of care for our patients will involve patients in the design and delivery of our services so that we better understand what matters

The Chief Executive is ultimately responsible for implementing the CQC Improvement Plan. The Chief Nurse provides the leadership for the CQC Improvement Plan and the Medical Director provides leadership for Infection Prevention and Control.

Individual improvement programmes have been developed and will be led by our staff; clinical, operational, and corporate services will work together to ensure we provide high quality care and improved patient experience.

The Trust is also working closely with NHSI/E, through an Improvement Support Director who is supporting the Trust with the implementation of the CQC Improvement Plan.

To give confidence to our stakeholders, staff and patients that we are making continued improvements, the CQC Improvement Plan is underpinned by improvement milestones and metrics to ensure that we can effectively track our progress.

Our plan involves fundamental improvements to services, structures and systems to ensure we deliver the immediate changes required and position the organisation to be able to respond to the demands of the future.

# CQC Improvement Plan Delivery Framework

This will be amended and aligned to the Trust Quality Improvement Plan

| 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 | | | |
| | WARD TO BOARD (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 | |

# Fundamentals of Nursing Standards, Quality & Care

### Executive Lead: Jane Murkin, Chief Nurse (Interim)

### Operational Leads: Divisional Deputy Directors of Nursing Karen McIntyre & Simone Hay

### Aim:

- To consistently deliver the fundaments of nursing standards, quality and patient care to ensure patients receive safe, effective and person centred care and are not put at risk of avoidable harm.
- Monitor compliance with completion of early warning tool.
- Where relevant ensure all risk assessment and care plans are completed and that local and National agreed tools are used.

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

### Inspectors found:

- Services did not audit the Early Warning Score tool to ensure compliance.
- Staff did not always complete risk assessments for each patient on admission and arrival towards using recognised tools.
- The children's unit were at times taking patients up to the age of 19 and 20 years
- In Medical Care staff did not fully and accurately complete patient's 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.
- SD04 Ensure that risk assessments are updated, specifically in relation to nutrition and hydration.
- SD06 Ensure that the Planned Care Division monitor 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 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 & assurance Framework
- Ensure compliance with risk assessments and fundamentals of nursing care
- Implement a programme of nursing standard audits across the Trust
- Implement a weekly Matrons Quality report to Heads of Nursing
- Agree the role of perfect ward to support assurance audits
- Extramed – align to and reference the one page document from Jack
- Implement a Chief Nurse standards quality report from Divisional Director of Nursing
- Implement principles of nursing practice setting out what everyone, from nursing staff to patients, can expect from nursing.
- Ensure reliable completion of risk assessment for all patients
- Where relevant ensure all risk assessment and care plans are completed and that local and National agreed tools are used.
- including completion of risk assessments and care plane
- Ensure EWS 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: metrics to be defined

| Indicator | Successful when we achieve |
|---|---|
| Fall resulting in moderate or above harm | 0 |
| VTE risk assessment completed | 85% |
| Increase in compliance with EWS | 90% |
| Perfect Ward App - Where relevant audit to ensure all risk assessment and care plans are completed and that local and National agreed tools are used. | 85% |

# Infection Prevention Control

## Executive Lead: David Sulch, Medical Director

### 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 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 (including FIT testing for FFP3 masks).
- 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 hand hygiene best practices are in place
- Ensure all senior medical leaders undertake ward reviews focused specifically on infection prevention and control in their areas.
- Ensure PPE and BBE audits within the Perfect Ward App were undertaken supported 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 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% |
| Infection Control Mandatory and Statutory training (MAST) compliance | 90% |
| Clostridium difficile cases reported (yearly target) | 31 |
| MRSA bacteraemia reported | 0 |
| IPC Improvement Plan – Actions completed and assurance given according to declared timescales | 90% |

# Clinical Skills

## Executive Lead: Harvey McEnroe, Chief Operating Officer

### 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 person 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 clinical skills training, including safeguarding adult and children | 85% |
| Paediatric Life support training | 85% |

# Safeguarding MCA/DOLS

## Executive Lead: Jane Murkin, Chief Nurse (Interim)

## Operational Lead – Bridget Fordham

### Aim:

- Ensure there is no decision without the patient's or carer's involvement and the patient's wishes and values are at the centre of their care and treatment.

### 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.
- Patients were regularly being bought up 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.
- Staff did not change patient's positions regularly to reduce the risk of pressure damage.
- We received information that showed the senior leadership team were aware of the issues on Dickens, 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 following action appears within the Well Led section of the CQC Inspection Report and will be addressed by the Trusts Overarching Quality Improvement Plan:*

- WL29 Ensure relevant clinical staff are trained to level 5 for safeguarding vulnerable adults and children

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

| Indicator | Successful when we achieve |
|---|---|
| Compliance for safeguarding adult and children training | 85% |
| Completion of turn charts | Monthly audits |
| Compliance with COSHH audits | 90% |

# COSHH

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

## Operational Lead – Paul Norman-Brown

### 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.
- MD23 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.
- 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 |
|---|---|
| Compliance with COSHH training for all relevant staff | 85% |
| Compliance with COSHH audits | 90% |
| Compliance with COSHH spot checks | 90% |
| COSHH audits using Perfect Ward | 90% |

# End of Life Care

### Executive Lead: Jane Murkin, Chief Nurse (Interim)

### Operational Lead – Julie Murray

### 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 program 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 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 |
|---|---|
| Develop EoLC Training plan | **Deadline date to be added** |
| Implement EoLC Steering Group | **Deadline date to be added** |
| Compliance for EoLC training | **85%** |
| Compliance for mandatory training | **85%** |

# Surgery

## Executive Lead: Harvey McEnroe, Chief Operating Officer

### 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:

- 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 |
|---|---|
| Use of the Checklist is 100% | 100% compliance |

# Unplanned Care

## Executive Lead: Harvey McEnroe, Chief Operating Officer

### 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 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 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, 7 day a week. We also aim to move all our receiving teams to the ED to work alongside the ED team when reviewing patients for admissions, this will improve quality and safety in decision making for admission and will reduce the delay for a decision to admit.

### 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.

### 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.

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

| Indicator | Successful when we achieve |
|---|---|
| DTA to admission | <2 hours |
| SDEC usage (7 day services) | 30-40 pts per day |
| Triage to referral time | <1 hour |
| Use of CDU | 20-30 per pts per day |

# Access & Flow

## Executive Lead: Harvey McEnroe, Chief Operating Officer

### 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 the 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 the on the day or within 48 hours. All patients admitted to Dickens ward should be 'medically fit for discharge'. 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 4 hour waits, RTT and theatre utilisation)

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

| Indicator | Successful when we achieve |
|---|---|
| MSA | Zero variance against trajectory |
| Overnight recovery | Zero variance against trajectory |
| Use of day case | 20% improvement |
| MFFD | <30 |
| Time from DTA to admission | <2 hours |
| RTT standard | 82% |

# Complaints Management

### Executive Lead: Jane Murkin, Chief Nurse (Interim)

### Operational Lead – TBC

### 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 | **Deadline date to be added** |
| Patient feedback is displayed on all wards | **Deadline date to be added** |
| Evidence is available to demonstrate changes from lessons learnt and how services have improved | **Deadline date to be added** |
| Compliance within 10 working days complaint response for green complaints | **85%** |
| Compliance with 30 working day complaint response for all amber complaints | **85%** |
| Compliance with 60 working day complaint response for all red complaints | **85%** |
| Complaints that require a second response | **<8%** |
| Complaints upheld by the Parliamentary and Health Service Ombudsmen (PHSO) | **0** |

# Incident Management

## Executive Lead: Jane Murkin, Chief Nurse (Interim)

## Operational Lead: Cherrell Taylor

### 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 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 |
|---|---|
| Develop and implement an SI learning framework | **October 2020** |
| Relevant staff are trained in SI investigation management | **100%** |
| Duty of Candour completed for all incidents (as graded on Datix) at moderate harm and above | **100%** |
| Duty of Candour completed within 10 working | **100%** |
| Serious Incidents investigations >60 Days | **0** |
| Never Events declared | **0** |
| Staff who provide an informed response to the learning from incidents survey | **95%** |

# Clinical Records

**Executive Lead: Gurjit Mahil, Deputy Chief Executive**

## 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 |
|---|---|
| Number of outpatient appointments where clinical notes are not available | ? |
| Notes not securely stored on wards | <50 |
| Clinical records quality of meeting national standards | ? |

# Ward to Board

## Executive Lead: Gurjit Mahil, Deputy Chief Executive

- **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.
- SD16 The service should maintain their risk register, so it reflects when they last reviewed risks.
- 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 |
|---|---|
| Risks with no controls | 0 |
| Moderate/high/extreme risks | <6 per month |
| Moderate/high/extreme risks with overdue actions | 0 |
| Moderate/high/extreme risks with no actions | 0 |

# Estates & Infrastructure

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

## Operational Lead: Paul Vidler

### Aim:

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

### Inspectors Found

- There was 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 – specifically related to surgical wards.
- 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.
- SD10 The service should make sure the high dependency unit meet the minimum bed space dimensions as recommended in national guidance.
- 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 |
|---|---|
| MD04 Physical and administrative controls in place | **Access control system installed, commissioned and staff trained** |
| MD07 Refurbishment of Wakeley and Arethusa Wards' floors and walls | **Works completed and signed off.** |
| MD12 Compliant cleaning audits process in place for surgical wards | **Three months continual audit history** |
| MD18 Correct waste segregation in Phoenix Ward | **85% staff trained and successful compositional waste audit** |
| MD21 Adequate segregation between adults and children in place | **Physical or administrative separation achieved** |
| SD10 Proposal for recommended standards in HDU to be submitted for a capital bid | **Compliant bid submitted for consideration** |

# Executive Leadership

## Executive Lead: James Devine, Chief Executive

### 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 Chief Nurse 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 3 yearly by an external accountancy firm
- Ensure Board Development Programme in place

# Medical Leadership

## Executive 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.
- WL03 Medical leaders must ensure they are able to identify risk and issues described by staff
- 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 leadership within organisational structure | **June 2020** |
| Introduction of Medical Cabinet and refresh of Clinical Council | **May 2020** |
| Relaunch internal professional standards | **June 2020** |

# Nursing Leadership

## Executive Lead: Jane Murkin, Chief Nurse (Interim)

### Aim:

- To ensure our current and future nursing 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. Improve compliance with mandatory training.
- Effective nurse leadership is recognised as key in improving the safety and quality of patient care and outcomes.
- Good health and care outcomes are highly dependent on the professional practice and behaviours of nurses and midwives

### 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 Relaunch 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, 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
- Continue to implement the Ward Managers Leadership for Quality & Patient Safety programme for all Ward Managers across the Trust
- Revise the Matron job description

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

| Indicator | Successful when we achieve |
|---|---|
| Develop a programme of training to ensure all nursing staff are appropriately skilled for their role | Deadline date to be added |
| Commission and develop leadership programmes for all levels of nursing staff | Deadline date to be added |
| Implement reclaiming the Nursing Landscape | Deadline date to be added |
| Develop a Patient experience strategy | Deadline date to be added |
| Revisit the 'not just a number campaign' | Deadline date to be added |
| Review senior nursing management structure | Deadline date to be added |
| Roll out of training programme to develop senior nursing staff on recording and escalating risks | Deadline date to be added |
| Design, develop and implement a nursing strategy | Deadline date to be added |

# Engagement & Culture

## Executive Lead: Leon Hinton, Director of HR 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

- 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:

- SD05 The service should ensure that there are sufficient numbers of appropriately skilled staff to keep patients safe from avoidable harm
- 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 NHSEI 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 |
|---|---|
| Safe staffing ratios across staff groups and shifts | **?** |
| Safe staffing CHPPD per ward | **Against target** |
| 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 | |
| Freedom to speak up concerns – raised anonymously | |
| Freedom to speak up concerns – suffered detriment 0% | **0% (achieving)** |

# 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 eg: 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

Tuesday, 12 May 2020

## Assurance Report from Committees

| | | | |
|---|---|---|---|
| **Title of Committee:** | **Finance Committee** | **Agenda Item** | **5.3** |
| **Committee Chair:** | Jo Palmer | | |
| **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**<br>**(use appropriate colour code as above)** |
| **1. BAF and strategic risks**<br>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.<br>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**<br>The Committee noted that the Trust has achieved its control total for 2019/20 (being the second consecutive year).<br>The Committee was concerned about the continued increase in pay spend and has thus commissioned two pieces of work: | **Green** |

| | |
|---|---|
| i) To understand the drivers of the increase.<br>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**<br>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**<br>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.<br>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**<br>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.<br>The Committee noted the requirement to make submissions to NHSE/I in respect of Covid-19 revenue and capital expenditure.<br>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:<br>i) Those loans (c£291m) will now be classified as repayable within one year.<br>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**<br>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**<br>As noted. | |
| **Further Risks Identified**<br>All risks are captured within the risk register and the BAF. | |
| **Escalations to the Board or other Committee**<br>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). | |

# Meeting of the Board of Directors in Public

Tuesday, 12 May 2020

## Assurance Report from Committees

| | | | |
|---|---|---|---|
| **Title of Committee:** | **Integrated Audit Committee** | **Agenda Item** | **5.4** |
| **Committee Chair:** | Mark Spragg | | |
| **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**<br>**(use appropriate colour code as above)** |
| **1. Security of controlled drugs**<br>A report was presented by the Chief Pharmacist providing assurance over the controls and processes to safely manage controlled drugs and drugs liable for abuse. | **Green** |
| **2. Internal Audit Report and Local Counter Fraud Reports**<br>The counter-fraud self-assessment for 2019/20 has been made with an overall rating of amber. Whilst this remains the same as for 2018/19 there has been an improvement in the rating for "hold to account".<br>The internal audit plan for 2020/21 was presented and **APPROVED**.<br>Two new reports from reviews were presented: data security and | **Green** |

| | |
|---|---|
| protection toolkit has been rated as 'amber-red' whilst core financial systems are rated as 'amber-green'. Three further reports are expected to be ready in May although it was noted that sufficient work has been undertaken to allow KPMG to provide their Head of Internal Audit Opinion for the annual report and accounts. | |
| **3. External Audit Report**<br><br>Grant Thornton presented their External Audit Progress Report. They drew the Committee' attention to the following two matters:<br><br>i) Because 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.<br><br>ii) Inventory is material as at 31 March but, as previously agreed, the Trust did not conduct an inventory count due to operation pressures arising from Covid-19. This would require Grant Thornton to include a limitation of scope audit opinion (consistent with national practice under the same circumstances). Work is underway to determine if procedures can be applied to mitigate such an opinion being necessary.<br><br>It was also noted that given the current climate the audit would be undertaken remotely; the draft accounts and a number of working papers have been provided already. | **Amber/Green** |
| **4. Conflicts of interest policy**<br><br>This policy was reviewed as part of its normal cycle and was **APPROVED**. | **Green** |
| **5. Valuation report**<br><br>Further to the comments on the valuation report as referenced in the external audit report, the Trust has made the required disclosure in its accounts in respect of the material uncertainty on valuation.<br><br>The net revaluation is an increase of £6.7m. Of this, £6.1m is taken directly through the revaluation reserve, whilst £0.6m is taken through the income and expenditure (with no impact on control total). | **Green** |
| **6. 2019/20 Annual Accounts update and plan**<br><br>The Committee noted the extensions to the submission timetables; it was noted that the unaudited annual accounts were submitted in line with the original timetable and accordingly thanked the finance department.<br><br>It was noted that during 2020/21 the DHSC will write-off interim loan debt by issuing Public Dividend Capital. The consequences of this are that:<br><br>i) Those loans (c£291m) will now be classified as repayable within one year.<br><br>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.<br><br>The Committee noted that some annual report disclosure requirements | **Green** |

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| have been relaxed given the pressures arising from Covid-19, whilst implementation of 'IFRS 16 - Leases' has been deferred by a year to 1 April 2021. | |
| **7. Closure of Dickens ward**<br><br>The Committee noted the paper but asked that an update be provided at its next meeting to provide assurance that the opening and closing of wards has/follows a prescribed process. | **Amber/Green** |
| **8. Covid-19 governance**<br><br>The Committee noted a paper which set out the governance arrangements already in place together with any changes/assurance over the finance department response.<br><br>Temporary increases to the delegated limits of the Deputy Chief Executive, Associate Director of Procurement and Chief Operating Officer were agreed to be recommended to the Board. | **Green** |

**Decisions made**

As a result of current conditions and the extended timetable for the submission of the annual report and accounts, it was AGREED that the Committee meetings in May would be cancelled and new meetings diarised for 22 June and in July.

**Further Risks Identified**

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

**Escalations to the Board or other Committee**

It is 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.

| Role | From | To |
|---|---|---|
| Deputy CEO | £50k | £250k |
| AD procurement | £50k | £250k |
| COO | £25k | £250k |

# Meeting of the Board of Directors in Public

Tuesday, 12 May 2020

## Assurance Report from Committees

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| **Title of Committee:** | **Quality Assurance Committee** | **Agenda Item** | **5.5** |
| **Committee Chair:** | Tony Ullman, Non-Executive Director | | |
| **Date of Meeting:** | 27 March, 16 April and 28 April 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**<br>The committee have been receiving 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.<br>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.<br>Below outlines some of the key activities and actions reported to the committee:-<br>• Initiated a staff risk assessment tool which was deployed across the Trust.<br>• 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.<br>• The Chief Nurse led on the development and implementation of a COVID-19 quality | **Green** |

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| risk register to capture associated risks that COVID-19 could have on quality aligned to associated national risks and local issues such as PPE.<br>• The Chief Nurse initiated a weekly COVID related patient safety incident report that is reported to strategic group.<br>• 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.<br>• Excellent examples of medical and nursing leadership have been demonstrated throughout COVID-19 with a strong clinically led focus.<br>• 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.<br>• A daily safe staffing report was initiated and continues with monitoring, staff redeployed and moved as required with mitigations to maintain safe staffing.<br>• A PPE steward programme was initiated by the Chief Nurse providing advice and support across the Trust with PPE education, advice and guidance.<br>• 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.<br>• 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**<br>Following the update to the 16 April 2020 committee meeting, Jane Murkin, Chief Nurse provided a detailed report to the Committee in relation to the development of the CQC Quality Improvement 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 the actions from the phase one CQC action plan. The draft improvement plan was shared with the committee for their comments.<br><br>Jane outlined the next phase of work including working 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 and then work with communications team to have a document that will then be ready for external sharing as a working draft by the end of April.<br><br>The following phase of work will include staff and stakeholder engagement and consultation in 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 and ensure ownership of all staff in the work to support the delivery of the CQC report.<br><br>The committee was pleased with the improvement plan and was encouraged to hear that Louise Thatcher, CQC Lead Inspector has agreed to work with the Trust as a specialist advisor supporting the Central Quality Team with the development of the CQC improvement plan. This is a great opportunity for the Trust to have Louise's expertise and input to our improvement plan and will ensure by the time to document has been through the consultation period the Trust will have a robust plan that our external stakeholders and CQC will be satisfied with. | **Amber/Green** |
| **3. Workplan**<br>The committee approved its annual work plan on the basis it will need to be revisited post COVID-19 as the Trust goes back to business as usual. | **Green** |
| **4. Refreshed IQPR**<br>The committee were sighted of the first 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 requested to see the next iteration at a subsequent meeting. | **Amber/Green** |

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| **5. EDN back log**<br>The committee received assurance that David Sulch, Medical Director has undertaken a review of the backlog of EDN's. The committee were informed that a task and finish group was set up lead by Dr Sarah Hare, Clinical Director and included primary care doctors and junior doctors. The actions from the task and finish group have been delayed due to the response to COVID-19. These will be taken forward when we return to business as usual. David is undertaking a review of a sample number of patients to establish any level of harm resulting in the EDN not having been completed. David will further update the committee at the next meeting. | **Amber/Green** |
| **6. Dickens deaths review**<br>The committee received assurance from David Sulch, Medical Director on the review he has undertaken of the 7 deaths that occurred on Dickens ward. The patients had been deemed medical fit and were waiting for discharge. 4 of the patients were end of life patients who had been placed on the ward as it being a quieter, calmer and more dignified place to be rather than in the emergency department. The other 3 patients were in the midst of being discharge but experienced a prolonged period of waiting and deteriorated rapidly on the ward. There was no harm from being on Dickens ward but the prolonged wait for discharge relating to system wide care packages and complex discussions with families.<br><br>The committee acknowledged the need for the Trust to maintain the current flow of discharge that has been established during COVID-19. | **Green** |
| **Further Risks Identified**<br>There were no further risks identified. | |
| **Escalations to the Board or other Committee**<br>None | |