Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 2 July 2020 at 12:30 – 15:30
Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Acting Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Conflicts of Interest		-		
1.4	Patient Story - Dexymethazone Trials for COVID	Senior Clinical Research Practitioner *Iram Ahmed*	Presen-tation	12:35	Note
1.5	Chief Executive Update	Chief Executive	3	12:50	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 4 June 2020	Acting Chair	7	13:00	Approve
2.2	Matters arising and actions from 4 June 2020	Acting Chair	19		Discuss
3.	**Governance**				
3.1	Board Assurance Framework	Deputy Chief Executive	21	13:05	Note
3.2	Integrated Audit Committee Assurance Report	Chair of Integrated Audit Committee	37	13:10	Note
4.	**High Quality Care**				
4.1	Covid-19 Update - Sustainability and Transformation Plan Update - ICS Recovery and Restore	Chief Executive/ Strategic Commander	41	13:15	Assure/ Note
4.2	Integrated Quality Performance Report	Deputy Chief Executive	57	13:25	Note
4.3	Quality Assurance Committee Assurance Report	Chair of Committee	87	13:35	Note
4.4	Safe Staffing Review	Interim Chief Nurse	91	13:40	Discuss/ Approve
5.	**Innovation**				
5.1	Trust Improvement Plan	Chief Executive/Improvement Director	107	13:50	Note/ Approve
5.2	Digital Strategy	Director of Transformation/IT	117	14:00	Discuss
6.	**Integrated Health Care**				
6.1	Communications and Engagement Report	Director of Coms and Engagement	159	14:10	Note

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Subject		Presenter	Page	Time	Action
7.	**Financial Stability**				
7.1	Finance Report - Month 2	Director of Finance	173	14:15	Note
7.2	Finance Committee Assurance Report	Chair of Committee	187	14:25	Note
8.	**Our People**				
8.1	Workforce Report	Director of HR and OD	190	14:30	Note
8.2	Workforce Race and Equality Standard Report to include; Workforce Disability Equality Report	Director of HR and OD	203	14:40	Approve
8.3	Freedom To Speak Up Update	Freedom To Speak Up Guardian	217	14:50	Note
9.	**For Approval/Review**				
9.1	Updating the Trust Constitution	Company Secretary	221	15:00	Note
10.	**Any Other Business**				
10.1	Council of Governors' Update	Lead Governor	Verbal	15:05	Note
10.2	BAF Reflection	Chair	Verbal	15:15	Discuss
10.3	Any other business	Chair	Verbal	15:25	Note
11.	**Date and time of next meeting: Thursday, 6 August 2020, 12:30 – 15:30**				

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – July 2020

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

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

In and around Medway

Our staff continue to work hard to deliver high-quality care for our patients whilst managing the continuing challenges of COVID-19 and progressing plans to resume routine clinical activity at the Trust. I would like to express my sincerest thanks for their hard work and dedication throughout this period; they continue to embody the very best of Medway.

I would also like to take this opportunity to thank our local community for their patience. As an organisation we have worked hard to continue to provide emergency care and a large number of virtual outpatient appointments throughout the pandemic, but we know that many patients have experienced cancellations; this has been typical in all NHS trusts across the country. This was the right thing to do to help reduce the spread of the virus and keep our community safe.

However, we know how upsetting it can be to have operations and appointments cancelled, especially for those who are worried or in pain. We are doing everything we can to resume elective surgery lists as quickly and as safely as possible, please do bear with us just a little while longer.

Temporary changes to the acute stroke service

All stroke services across Kent and Medway face some level of challenge recruiting and retaining specialist stroke staff. The Trust successfully retained sufficient numbers of specialist staff to deliver safe care for stroke patients up to the end of June. However, at this point, the number of stroke specialist nurses responsible for initial assessment of stroke patients and for providing vital clot-busting drugs, reduced from an original establishment of six to one.

Specialist stroke nurses are responsible for the initial assessment of stroke patients, alongside specialist doctors, and for administering vital clot-busting drugs.

The loss of these specialist nurses have made it impossible to maintain the necessary quality of stroke service at Medway Maritime Hospital, 24 hours a day, seven days a week. Despite the Trust's best efforts, it has not been able to recruit new appropriately trained and qualified specialist nursing staff to fill the soon to be vacant posts.

As a result, Medway NHS Foundation Trust and the Kent and Medway Clinical Commissioning Group (CCG) made the difficult decision to carry out an emergency temporary transfer of acute (urgent) stroke services out of Medway Hospital from 1 July 2020.

Suspected stroke patients from Medway and Swale are now taken by blue light ambulance directly to Maidstone Hospital or Darent Valley Hospital in Dartford (the majority will go to Maidstone). This emergency transfer of services will ensure the NHS can maintain ongoing safe and high-quality care of patients during the vital initial hours and days following a stroke.

Important changes for visitors to the hospital

In line with government recommendations, all visitors to the hospital are asked to wear a face covering at all times. Our staff are also following government guidance by wearing surgical masks when on-site.

While we ask visitors to wear face coverings in our hospitals for their protection and others, the guidance states that the following groups **do not** need to wear a face covering:

- Young children under the age of three
- Anyone with anatomical difficulties that would make wearing a face covering impossible or painful, for example facial injuries
- People with breathing difficulties
- Anyone who experiences severe discomfort or distress while wearing a face covering e.g. those with severe claustrophobia

We would like to thank all visitors for their cooperation in following this guidance.

Supporting BAME colleagues

As a Trust we promote a culture of equality and inclusion and aim to provide a working environment free from discrimination, harassment or victimisation. We have plans and policies in place to ensure we operate in line with equality and human rights legislation, and to meet the needs of our black, Asian and minority ethnic staff, as well as staff who fall under the nine protected characteristics.

We have many mechanisms in place to enable staff to speak up if they encounter any form of discrimination, and strongly encourage an environment where staff feel able to discuss matters of race and cultural identity free from fear of prejudice or discrimination.

I have written to all staff to offer my support during this very difficult period and as a Trust we were proud to join other trusts across Kent in pausing for two minutes to

support our BAME colleagues. Our strength is in our diversity and we must do all that we can to preserve and protect that diversity by standing by our colleagues from all communities and backgrounds.

Volunteers' Week

June marked the annual celebration of the contribution millions of people make across the UK through volunteering. We are particularly proud of our volunteers at Medway, and although many of them have had to change their working patterns and avoid visiting the hospital since the COVID outbreak, we must never forget all the years of service they have given to the Trust to help us deliver brilliant care to our patients. We look forward to many of them returning back to the hospital in the near future.

Congratulations to our Endoscopy team

I am very proud to say that our endoscopy unit has again successfully achieved JAG (Joint Advisory Group) accreditation following reassessment of the unit. This is formal recognition that our endoscopy service has demonstrated the competence to deliver against the measures in the endoscopy Global Rating Scale standards and demonstrates our commitment to providing high-quality, safe and appropriate endoscopy services.

The accreditation confirms that the team has met the best practice quality standards and means our patients are receiving the best possible care.

It is wonderful to be able to evidence the hard work that I know is carried out by teams across the Trust and this accreditation is an excellent example of this. Well done and congratulations to all involved.

Minutes of the Trust Board PUBLIC Meeting

Thursday, 4 June 2020 at 10:00 - 13:30, in the Trust Common Room and using MS Teams, Online Conferencing

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

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts to make the meeting whether it virtual or in the room. With the current government guidelines it has meant that some of the Board was able to meet safely on site whilst complying with social distancing rules. 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.

1.4 Chief Executive Update

James Devine, Chief Executive, gave an update to the Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. The Board was asked to note the content of this report.

1.4.1 James stated that although the CQC and Covid-19 work is covered elsewhere on the agenda but it would be remit of us not to mention the work that has happened over the last 10-12 weeks at the hospital and the management of this. The hospital is seeing a fairly consistent drop in the numbers of Covid cases confirmed, queried and in ICU. Earlier this week there was zero patients in ICU. However, the Trust is acknowledging that this may change over the next few weeks and months.

1.4.2 James wanted to thank Harvey McEnroe for his work as Strategic Commander and to Gary Lupton who deputised, plus thanks to Jane Murkin and David Sulch, the Trust has seen clinical leadership at its best, around the table, the care groups and its divisions.

1.4.3 Thank you to all of the Trust staff who have provided consistently good care to our patients not just those with Covid but those who have come into hospital with non-Covid related issues, especially with the constant challenge of ensuring that the Trust is following infection control procedures and ensuring that sufficient PPE is supplied/used. The processes in place have meant that the Trust reporting has been accurate. The Trust has measures in place to ensure that our staff are and are continued to be supported through this. The Trust knows that the winter period is difficult without Covid, so planning is in place to manage this time.

1.4.4 CQC report was published earlier this year and Jane Murkin has been leading on this and the development of the Trust CQC Action Plan which was submitted on 28 May 2020. James gave his thanks to Jane and the team for some good work. The important thing for the Trust now is to embed that work.

1.4.5 James welcomed Ian Renwick who is supporting the team with the Trust Improvement Plan. The plan is to share this with Trust staff June/July 2020. It will then come to the Board for approval thereafter. Staff involvement/feedback is important with the development of this plan.

1.4.6 In May the Trust celebrated International Day of the Nurse and Midwife. The community support is appreciated and the depth of the gratitude that our community has for them. James was extremely proud to see the outpouring of support in donations and on social media for our nurses and midwives at Medway, even more so in recent times.

1.4.7 It was International Clinical Trials Day in May 2020, which was a good opportunity for the Trust to recognise its achievements as well as a time to be grateful for the improvements that research has made to public health.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 12 May 2020 was reviewed by the Board. The minutes of the last meeting were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting

The action log was reviewed and the Board agreed to CLOSE the following actions: *TBPU/20/50, TBPU/20/59, TBPU/20/61, TBPU/20/62, TBPU/20/64, TBPU/20/68, TBPU/20/69, TBPU/20/70, TBPU/20/71, TBPU/20/72 and TBPU/20/73*

3 Governance

3.1 Board Assurance Framework

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

3.2 The paper detailed the changes. Chair stated that the BAF is a much improved and more usable document and thanked Gurjit et al for their work on this. The Board will reflect as usual at the end of the meeting.

4 High Quality Care

4.1 CQC Action Plan Update

James Devine explained that this plan is in response to the 'must dos and should dos' from the April 2020 CQC Report. Jane Murkin is lead on this and the detailed summary on the work to do.

4.1.1 Jane Murkin confirmed that this action plan is the formal response to the CQC Inspection Report and Letters of Intent. There has been significant progress with the plan and in its initial stages and going forward staff have been involved, at all levels.

4.1.2 The Trust's Quality Panel will oversee the must dos and should dos'. In addition to this the Executive Team are tracking the actions and have oversight on the overall plan. Louise Thatcher from the CQC has been a positive support in this work.

4.1.3 Jane informed the Board that an independent investigation of Dickens Ward has been commissioned, so the Trust understands why it happened and to provide assurance that it will not happen again, capturing the learning. Katy White will lead on this piece of work. Tony Ullman asked to see more information on this and suggested it is channeled through the QAC. **Action No: TBPU/20/74:** Jane Murkin to supply Tony Ullman/QAC with the Terms of Reference of this investigation of Dickens Ward.

4.1.4 Gary Lupton suggested that this investigative work should extend across the site, the Trust need to know that the same issues that happened on Dickens Ward could not be happening elsewhere.

4.1.5 James Devine confirmed that a response has been received informing the Trust that the NHSEI and CQC will not be taking any further regulatory action against the Trust arising from the inspection.

4.1.6 Chair thanked Jane and the team for their work on this and for the work happening on the ground.

4.2 Covid-19 Update

Harvey McEnroe, Chief Operating Officer, informed the Board that the submitted paper was to assure the Board on the update with Covid-19. The paper outlined:

a) The Trust's current response plans to Covid-19, focusing on the restore and recover programme as well as the wider work with system partners across the ICP and the ICS/STP.
b) The Trust's internal Covid-19 response plan and the proposed governance for the ICP C19 response plan.
c) The Trust's proposed model for the winter period in 2020.

4.2.1 Mark Spragg asked how senior level staff are keeping in touch with the teams such as Housekeeping and Infection Control etc. Management need to consider how top end decisions are filtered to the Frontline staff.

4.2.2 Harvey confirmed that the Tactical Groups have multi-disciplinary team representatives at the meetings. There have been a number of forums for staff to attend and ask questions and gather information. This involved the Medical Director and Chief Nurse (Interim) attending and facilitating 'Listening Events' for staff and specifically the consultant and nursing teams.

4.2.3 James Devine suggested that Housekeeping Audits would be a good measure as to whether or not the Trust is responsive. Gary Lupton confirmed the resource is there but will be measuring the outcome of this. Harvey added he would ensure this is tested.

4.2.4 Harvey confirmed the next step is for the Executive Team are to review the modelling for Ward Reconfiguration and bed numbers.

4.3 Safe Staffing Review

Jane Murkin, Interim Chief Nurse, informed the Board that the Safe Staffing Review has been robust but it needs more work and a reassessment to include post Covid-19 nursing. **Action No: TBPU/20/75:** Jane Murkin will submit to the July 2020 Board.

4.4 Integrated Quality Performance Report

Gurjit Mahil, Deputy Chief Executive, asked the Board to note the report and its new format. The refreshed version of the IQPR uses Statistical Process Control charts to display the data. This report informs Board Members of the quality and operational performance across key performance indicators for April 2020.

4.4.1 Safe: Our Infection Prevention and Control performance for April shows that the Trust has had 0 MRSA bacteraemia cases. 2019/2020 saw an improved performance against c-diff infection case numbers and this position has been maintained in April 2020. The updated January HSMR figure now sits at 99.1 (94.5 – weekday and 112.1 – weekend). The SHMI sits at 1.11

4.4.2 Caring: MSA continues to demonstrate an improvement; however in April, two breaches were recorded which is still higher than the national compliance levels. Electronic Discharge Notification (EDN) performance remains below trajectory, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system.

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

more work. He understands that there are different numbers of falls due to COVID. **Action No: TBPU/20/76:** David Sulch to bring back a piece on Fractured NOF to the QAC.

4.4.4 Responsive: The Trust saw a significant improvement to the 4 hour performance standard, reaching 92% for April 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with no 52 week breaches. Diagnostics has been recorded as 50.4%. Cancer 2 week wait performance for March continues to be above national standards at 94%. 62 day performance is recorded as 77.5%.

4.4.5 Well Led: The Trust has maintained compliance with targets for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for Month 1 of 2020/2021.

4.4.6 Mixed Sex Accommodation: There has been a significant reduction in breaches. This needs to be balanced due to the Covid crisis.

4.5 Quality Assurance Committee Assurance Report

Tony Ullman, Chair of the Quality Assurance Committee, took the paper as read and thanked Jane Murkin, Harvey McEnroe, David Sulch and the QAC for their hard work. The report detailed; Covid-19, CQC Improvement Plan, Quality Report, Refreshed IQPR, Horizon Scanning and the BAF – Quality. There were no further risks identified or escalations to the Board.

4.6 Mortality and Morbidity Update

David Sulch, Medical Director, asked the Board to note the paper, which was taken as read. The paper provided an update for the Board on the Trust's current mortality position. David discussed the key points as follows:

a) HSMR for the 12 months to January 2020 is 99.1, which is within the expected limits.
b) Weekend mortality remains raised at 112.1 for the same period. The changes to the GIM and frailty rotas introduced in January 2020, will have had minimal impact on the HSMR at this stage.
c) SHMI for the 12 months to November 2019 is 1.11: this has remained essentially unchanged over the last 12 months.
d) A review of deaths from cancer of the bronchus is planned in response to the raised SHMI for this condition seen in the last two datasets.
e) COVID-19 mortality has been just below 30%, comparable with the national picture reported in a study from Liverpool. There is no definitive evidence of an excess of mortality in any specific ethnic group.
f) A higher proportion of deaths from COVID-19 in the Medway & Swale system have occurred in hospital (rather than in care homes or hospices) compared to other systems such as West Kent and East Kent.
g) The Trust has appointed four new Medical Examiners; this will help with learning from deaths. Hayley Usmar is now the Medical Examiner Officer; this will all improve the Trust's responsiveness.

4.6.1 Chair asked whether the Mortality and Morbidity work be merged into the QAC Terms of Reference. **Action No: TBPU/20/77.** Tony Ullman said this was achievable and welcomed Ewan Carmichael's input with his experience on the Mortality and Morbidity Committee.

4.6.2 The Board asked that the QAC led by Tony Ullman would do a deep dive into the metric issues and bring back an update to the July Board. **Action No: TBPU/20/78.**

4.6.3 The Board **NOTED** the report.

5 Innovation

5.1 Trust Improvement Plan

Ian Renwick, Intensive Improvement Director, informed the Board that the paper provided an update on the development of the Trust's Improvement Plan and on progress with mobilisation against the key priorities. The report asked the Board to note progress on identifying the key corporate priorities included within the Plan, and in particular the process of engagement and consultation currently underway.

5.2 There has been good progress to date and good engagement with the Executive Team and SRO. The aim is to circulate the plan to the wider organisation to check that the priorities are correct.

5.3 The first meeting of the Trust Improvement Group was on 03 June 2020 and will be meeting bi-weekly going forward.

5.4 This is not the final and approved version but the Executive Team has had sight of this every other week at their group meeting.

5.5 Tony Ullman suggested adding the long term quality plans to the Improvement Plan. Chair suggested including; a look back, vision for the future and map it against the Quality Strategy and the 'Must Dos/Should Dos'. Chair suggested this is submitted to QAC with Jane Murkin. **Action No: TBPU/20/79.**

5.6 Ian stated that he would refresh the Improvement Plan in six to eight months' time.

6 Integrated Health Care

6.1 Communications and Engagement Report

Glynis Alexander asked the Board to note the update and the paper was taken as read.

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

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

6.4 Feedback from staff has indicated that they have felt well-informed about developments, including statistics relating to demand, and national guidance received. Updates have sought to provide information and reassurance about issues including PPE supplies and training. The team ran a Zoom engagement event with gave some interesting and valuable feedback. There are more engagement events to follow. Jenny Chong attended the session and thought it was a really positive exercise and will follow up with some feedback to Glynis.

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

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

7. Financial Stability

7.1 Finance Report

Richard Eley, Director of Finance (Interim), asked the Board to note the report which sets out the summary financial position to the end of March 2020.

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

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

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

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

7.1.5 22 June 2020 is the approval on the Board's behalf of the Trusts' Annual Accounts and Report at the Integrated Audit Committee.

7.1.6 Stock take could not be completed due to the Covid-19, because the Auditors could not physically attend. They were not satisfied with a virtual stock take.

7.1.7 NHSEI supports the going concern and has issued a report on this.

7.1.8 Cash is considerably better than plan, this is due to Finance not being able to complete all payments to suppliers, and therefore it will reduce to normal levels but will still be satisfactory.

7.1.9 Balance sheets; there has been a significant level of loans. NHSEI have decided that these long term loans will convert to Public Dividend Capital, they will not be completely written off. The Trust will need to pay a higher rate PDC dividend than was payable inspect o government loans.

7.2 Finance Committee Assurance Report

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

a) There is an improving position on the Cost Improvement Plan
b) The Finance Committee Work Plan was APPROVED
c) The Committee continues to have concerns with the levels of capital expenditure and investments. The Committee will tightly manage this over the course of the financial year.

8. Our People

8.1 Workforce Report

Leon Hinton asked the Board to note the content of the report. The report focusses on the core workforce risks, and looks to provide assurance robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The paper was taken as read.

8.1.1 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.

8.1.2 Trust turnover has decreased; sickness absence has increased and is above the Trust's tolerance level. Appraisal compliance has increased and is above the Trust target. Statutory and Mandatory training is at 88.3% and is meeting the Trust target of 85%.

8.1.3 The percentage of pay bill spent on substantive staff in April has increased compared to the month of March. The percentage of agency usage has increased compared to the month of March. The percentage of pay bill spent on bank staff remains unchanged.

8.1.4 James Devine stated that it is important that the Executives and NEDs ensure that their Stat /Man training is up to date. Mark Spragg asked that reminders are sent for training. **Action No: TBPU/20/80:** David Seabrooke to ensure this reminder is sent to the NEDs.

8.1.5 Jack Tabner suggested that more work is done on staff retention and how to develop an individual's career at the Trust and keep them at Medway. Leon confirmed this would be picked up at the new People Committee.

8.1.6 Ewan Carmichael asked whether the Trust had considered that international staff may want to travel abroad back to their homes post-Covid. Leon stated that feedback is being received at the moment on this, travel restrictions are currently stopping this but it is on the radar going forward. **Action No: TBPU/20/81:** Leon Hinton to write a piece on the retention of international staff and include it in the Workforce Report in July 2020.

8.2 Establishment of the People Committee

Leon Hinton, Director of HR and OD, stated that the Board has previously agreed to establish a new committee called the People Committee. The Board was asked to note the discussions that have taken place and discuss any further changes required.

8.2.1 The NED Chair of the Committee has been discussed and Sue Mackenzie has agreed to take on this role. Sue and Leon have worked on a first draft terms of reference.

8.2.2 The proposal is for the People Committee will meet on the same day as Nominations and Remuneration Committee and that all NEDs will be invited to attend.

8.2.3 The Board **NOTED** the paper and **AGREED** for this to progress.

[The Board took a break at 12:40 and reconvened at 13:05]

9 For approval

9.1 Health and Safety Six Month Report

Gary Lupton, Director of Estates and Facilities, informed the Board that the report aims to ensure the Chief Executive and the Board, are aware of the Trust activities relating to Health and Safety compliance in 2019/20. The Board was asked to note and approve the contents of this report and in addition asked to note the Health and Safety strategy. The paper was taken as read.

9.1.1 Tony Ullman asked if the CQC came in to the Trust today would it be compliant with the COSHH issues. Gary stated that it would be 68% compliant and there is improvement needed. James Devine is aware of this and has asked Gary to do more work on this to ensure that the Trust is compliant. Harvey added that COSHH products are being left out more frequently at the moment, due to the current Covid crisis. Gary stated that Housekeeping have minimised the variety of cleaning products needed.

9.1.2 Gary Lupton and Jane Murkin are implementing a series of walk rounds to oversee improvements. Tony Ullman suggested this could be a role for the NEDs when they are able to visit the site.

9.1.3 James Devine wanted to investigate further whether or not Datix captured the health and safety matters. **Action No: TBPU/20/82:** James Devine and Gurjit Mahil would investigate this further.

9.1.4 Chair suggested with this low level of assurance that the Board cannot wait for another six months for an update, so requested this to be submitted earlier. **Action No: TBPU/20/83:** Gary Lupton to provide a progress report in August 2020.

9.1.5 The Board **NOTED** the report

9.2 Trust Board Annual Planner 2020/2021

David Seabrooke, Interim Company Secretary, asked the Board to note the Annual Planner.

9.2.1 The paper and work plan submitted is currently set out for bi-monthly meetings, it gives an overview at topic level when each routine matter is due to come to the Board, and helps ensure that key developments are appropriately monitored and discussed. The programme is continually reviewed. A range of other factors, such as the Board Assurance Framework and the Action Log will also prompt agenda items, or will inform how particular topics are framed.

9.2.2 A separate planner operates for the Board Development.

9.2.3 Chair stated that the planner reflects the Board format as it was. The proposal is for the meetings to become monthly, a Board Development Programme is currently being reviewed and finalised. The planner will change going forward.

9.2.4 David stated that there was a number of Corporate Policies on the planner. Unless it is something exceptional, these policies can be approved by the Executive Team.

9.2.5 Strategies must continue to come to the Board.

9.2.6 Ewan Carmichael wanted the Board to note that the Voting members of the Board are also members of the Corporate Trustee. He would inform the Board when the Corporate Trustee needs to meet and expected this to be on an annual basis.

9.2.7 The Board **APPROVED** the Trust Board Annual Planner.

10 Any Other Business

10.1 Council of Governors Update

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

10.1.1 Social distancing has affected the Council of Governors but the regular updates from the Chief Executive, Chair and newsletters have assisted with keeping the communication lines open to what is happening in the hospital. The last COG meeting was on MS Teams and it was a success.

10.1.2 Governor Elections have been delayed until the end of June 2020, and the results announced in September 2020.

10.1.3 Glyn attended a Governor Workshop Webinar by NHSP on Zoom. It was a useful session, where they discussed Governor support, useful tools for the future.

10.1.4 Governors have continued to work in the community, but not in person.

10.1.5 The Membership Report has been updated

10.1.6 Governors have asked the Trust Communication team to assist them with an Engagement Webinar.

10.1.7 Questions from Governors:

a) The CQC Report; it was disappointing to hear that the 'Well Led' domain was reported to be down. The Governors would like to know what role they can play in this going forward and what input they can have.

Chair stated that this is an important point and there is a role for Governors in this and their input is welcomed. Chair asked that Glynis Alexander and Ian Renwick organise a presentation on the Trust Improvement Plan, at the next Council of Governors meeting in July 2020. **Action No: TBPU/20/84**

b) The Antibody testing; is this happening for staff yet?

Harvey McEnroe stated that this is happening but the priority is with certain frontline staff at present which will extend to others eventually.

10.2 BAF Reflection

10.2.1 *Investment for Capital Backlog:* the Board is not assured on this. It will take some time to do so but the right actions are in place through the Capital Group and with Richard Eley's input.

10.2.2 *CQC Process;* this has been discussed today but the Board cannot reduce the score as yet but the right actions are in place so that the team can work towards assurance.

10.2.3 Chair asked that Gurjit continue to lead on the BAF and remind the Executives on their risks. The Executive focus should be to reduce the red ratings and then work through the other scores.

10.3 There were no matters of any other business.

11. Date and time of next meeting

The next meeting will be held on Thursday, 2 July 2020, 12:30 - 15:30, location and type of meeting to be confirmed.

The meeting closed at 12:50

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 4 June 2020

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
05-Sep-19	TB/2019/030	**Patient Story** Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	03-Sept-20 ~~12-May-20~~ ~~5-Mar-20~~	David Sulch, Medical Director	Update to be submitted in September 2020	White
05-Mar-20	TBPU/20/60	**Integrated Quality and Performance Report (Item 4.2)** Write a report on the Trusts position on EDNs to go to the Executive Group, then to the QAC and later submit to Board.	02-Jul-20 ~~12-May-20~~	David Sulch, Medical Director	Update to be submitted in July 2020	White
04-Jun-20	TBPU/20/74	Supply Tony Ullman, Chair of QAC, the Terms of Reference for the independent review of Dickens Ward	ASAP	Jane Murkin, Interim Chief Nurse	Propose to close - complete	Green
04-Jun-20	TBPU/20/75	Re-submit Safe Staffing Review Paper to Board	02-Jul-20	Jane Murkin, Interim Chief Nurse	Propose to close - paper submitted in July 2020	Green
04-Jun-20	TBPU/20/76	Report on Fractured Neck of Femur to go back through QAC	ASAP	David Sulch, Medical Director	Propose to close - submitted to QAC for 21 July 2020	Green
04-Jun-20	TBPU/20/77	Merge the Mortality and Morbidity work into the QAC terms of reference. Work with Tony Ullman.	ASAP	David Sulch, Medical Director		
04-Jun-20	TBPU/20/78	Deep dive into the IQPR metrics issues with the QAC. *{Transferred to the QAC Action Log}*	ASAP	Gurjit Mahil, Deputy Chief Executive	This will be done through the Specific Dashboard for the QAC - will be an ongoing action - would suggest closure to be managed through QAC.	Green
04-Jun-20	TBPU/20/79	Quality Action Plan to include a look back, vision for the future and map it out against the Quality Strategy, submit to QAC	ASAP	Jane Murkin, Interim Chief Nurse		
04-Jun-20	TBPU/20/80	Stat Man Training reminders to be sent to the NEDs	ASAP	David Seabrooke, Interim Company Secretary		
04-Jun-20	TBPU/20/81	Retention of International Staff to form part of the next Workforce Report	02-Jul-20	Leon Hinton, Director of HR and OD	Propose to close - included in the Workforce Report	Green
04-Jun-20	TBPU/20/82	Investigate how the hospital picks up health and safety Datix reports. Work with James Devine.	02-Jul-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - On the Datix there are 2 questions that act as prompts: - Is this incident RIDDOR reportable? - Is Health & Safety a factor in this incident? In both cases, if either of the questions are answered with a 'yes', the Health and Safety Practitioner gets an automatic notification of the DATIX report. Answering the questions are not mandatory, therefore in order to ensure all incidents related to Health & Safety are looked into, a daily report is completed and each datix is reviewed.	Green

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
04-Jun-20	TBPU/20/83	Health and Safety Report Update to be submitted	06-Aug-20	Gary Lupton, Director of Estates and Facilities	Not due until August 2020	White
04-Jun-20	TBPU/20/84	Governors to be given a briefing session on the Trust Improvement Plan. Liaise with Ian Renwick.	22-Jul-20	Glynis Alexander, Director of Communications and Engagement	Propose to close - this is in the diary	Green

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Board Assurance Framework Update**	**Agenda Item**	3.1
Report Author	Gurjit Mahil, Deputy Chief Executive Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Resource Implications	None		
Quality Impact Assessment	Not required.		
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.		
	Approval ☒	**Assurance** ☒	**Discussion** ☒	**Noting** ☒
Appendices	Appendix 1 – Board Assurance Framework		

1 Integrated Healthcare

Executive Lead – Chief Operating Officer

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

No further changes.

2 Innovation

Executive Lead – Executive Director of Transformation and Digital

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

No further changes.

3 Finance

Executive Lead – Director of Finance

Risk	Initial Score	Current Score	Previous Month Score	Target Score
3a – Delivery of financial control total	4 x 4 = 16 (High)	**3 x 2 = 9 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 9 (Moderate)
3b – Capital Investment	4 x 4 = 16 (High)	**4 x 5 = 20 (High)**	4 x 5 = 20 (High)	4 x 3 = 12 (Moderate)
3c – Failure to achieve long term financial sustainability	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 4 = 16 (High)	4 x 3 = 12 (Moderate)
3d – Going concern	4 x 3 = 12 (Moderate)	**4 x 1 = 4 (Very Low)**	4 x 1 = 4 (Very Low)	4 x 1 = 4 (Very Low)

3a – Current risk rating decreased to 9 from 12 and target risk rating changed to 9.

3b – Renamed to Capital Investment.

3c – Current risk rating decreased to 12 from 16.

4 Workforce

Executive Lead – Executive Director of Human Resources and Organisational Development

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

No further changes.

5 Quality

Executive Lead – Chief Nurse

Risk	Initial Score	Current Score	Previous Month Score	Target Score
5a – CQC Progress	4 x 4 = 16 (High)	**4 x 4 = 16 (High)**	4 x 4 = 16 (High)	2 x 2 (Very Low)
5b – Failure to meet requirements of Health and Social Care Act	4 x 4 = 16 (High)	**4 x 4 = 16 (High)**	4 x 4 = 16 (High)	3 x 2 = 6 (Low)
5c – Patient flow – Capacity and demand	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
5d – Quality Governance	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	2 x 2 = 4 (Very Low)

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

5a - Has been updated with the relevant CQC action plans and improvement plan actions progress.

5b - has been updated to include progress on actions.

5c - has been updated to include the impact of Covid restart plan.

5d - No further changes.

Potential new risk to added regarding loss of or temporary moves of clinical services – to be agreed at the next QAC meeting.

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

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

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Executive Director of Finance										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a Delivery of Financial Control Total	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. If the STP does not meet its control total then the Trust will lose up to 50% of its FRF allocation, resulting in a variance to reported plan of up to £23.7m in 2020/21.	4 x 4 = 16 **Very High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. NHSE/I is providing funding to enable providers to achieve breakeven from 1 April 2020 to 31 July 2020. The eight CCGs in Kent have merged with effect from 1 April 2020, enabling them the scale and reach to support management of the system as a whole.		3 x 3 = 9 **Moderate May 2020** (Previous risk rating: April 2020 3 x 4 = 12 **High)**	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate)**	
			2. Programme Management Office and scrutiny by Financial Improvement Director to track operational delivery and financial consequences of those actions.	Financial improvement director in place.						
3b Capital Investment	If there is insufficient cash to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan.	4 x 4 = 16 **Very High**	1. Governed entirely by the availability of cash, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the STP and regulators unless affordable within the existing capital programme or through a revenue stream. (**Note**: Risk not fully mitigated from the Trusts perspective until it starts to generate a cash surplus).	Standard business case process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Capital Group, Finance Committee and Board.		1. Trust strategy for innovation together with Care Group /directorate strategies to be developed. 2. National shortage of capital funding recognised. Will potentially need some key choices to be made by the Board during 2020/21 3. Clarity and	5 x 4 = 20 **Extreme May 200** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 3 = 12 **High**	

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

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**
						"Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs."				

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

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

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

COMPOSITE RISK: Quality											
EXECUTIVE LEAD: Chief Nurse											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently achieve delivery of high quality care Failure to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Ineffective leadership , oversight and timely remedial action of the quality standards. 2. Lack of effective governance systems and processes. 3. Too much focus on flow versus quality standards. **Impact:** 1. Regulatory action by CQC &/ or NHSI 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. **4.** Inability to reduce avoidable harms to patients	**4 x 4 = 16 High**	1. CQC action plan developed and being implemented	Quality Panel Governance in place fortnightly meetings.	Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board	Internal Audit and External Quality Audit. IPAS Meetings (NHS I/E) CCG Quality Meetings CQC Engagement Meetings	Evidence sent thus far being quality assured	Complete QA process	**4 x 4 = 16 High** **June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented	Programme of continuous quality improvement: a. Improvement huddles b. Improvement Specialists c. Local improvement Projects	Quality Report and Accounts AGM to take place in September 2020.		CQI training paused since November 2019	Need to review CQI training			Partial
			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Quality strategy c. Ward to board assurance framework in development – currently a gap in control and assurance	New Scorecard developed. Quality strategy priorities reported to QAC	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board.		PRMs for 20-21 commenced 27 May 2020 Ward to board assurance framework in development – currently a gap in control and assurance	First PRM 27 May 2020. Ward to board assurance framework to be in place 30 June 2020			None at present
			4. Audit and review processes d. Clinical Audit programme and monitoring e. Daily MSA breach reporting and validation f. PLACE, COSHH and environmental audits	Revised Quality and Patient Safety Group Divisional Governance Boards	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial
			5. Central and local oversight of quality g. Complaints management h. Incident management, including Serious Incident (SI) processes and monitoring i. Compliance with Duty of Candour policy and training	Centralisation of the Divisional Quality Governance Teams	Regular reports to the Executive Group.		Compliance with 48 hour SI reporting to StEIS averaging 50%	Divisions have a plan in place to rectify.			Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	The result may be sub optimal outcomes and patient harm with potential regulatory action. Patients may be harmed	4x4 = 16 High	1. IPC Improvement plans	IPC policies, procedures and protocols in place Annual IPC work plan Mandatory IPC training Directorate and programme scorecards with key IPC indicators	Infection Control and Anti-Microbial Stewardship Group meeting (ICAS) Quality Assurance Committee	IPAS (I/E) meeting	Many IPC policies out of date IPC Committee met June 2020. 9 patients acquired C. Diff in May, No AMS audits for last three months due to audit lead long term sickness	Support secured from CCG to update all policies PIR's currently taking place. Medical Director to consider contingency plan	**4 x 4 = 16** **High** **June 2020**	**2 x 2 = 4** **Very Low**	Partial
5c There is a risk that poor patient flow and weak capacity and demand planning will fail to achieve the required performance standards (constitutional standards: 4 hour access, RTT, DM01 and Cancer)	Sustained failure to achieve constitutional standards may result in substantial delays to the treatment of patients, poor patient experience, potential patient harm and a possible breach of license. Impact on Trust Services and capacity if there is a second wave of the covid pandemic.	**3 x 4 = 12** **Moderate**	1. Integrated healthcare pillar of the Trust Improvement Plan including a Trust Delivery Board. 2. Future Hospital Reconfiguration Plan in development 3. Covid – Strategic Planning processes in place to monitor all hospital activity. a. Elective modelling underway to ensure backlogs are being reviewed. Private provider options being explored. b. Cancer pathways in place with Private providers. c. Outpatients with social distancing and virtual outpatients managed through strategic command. d. Restart programme is being managed through the System approach of restart alongside system partners. e. Outpatients and Elective day cases and IP will recommence on the 29th of June 2020 – with a stop/go assessment week commencing the 15th of June 2020. f. Elective and outpatient work will recommence based on the ability of the North Kent Pathology Services to make sure there are no delays in swab results.	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used.	External reviews by NHS I/E	Weekly Best Flow Programme Board has not met during COVID-19		**3 x 4 = 12** **Moderate** **June 2020**	**2 x 2 = 4** **Very Low**	Partial

			g. Social distancing policy being worked through in particular with potential impact to bed numbers.								
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5d If quality governance is not sufficiently understood or embedded there is a risk that the Trust may not deliver our quality priorities.	Risks to quality and safety of care may not be identified or controlled resulting in poor patient experience, sub optimal outcomes and patient harm with potential regulatory action.	**3 x 4 = 12 Moderate**	1. Quality ambitions a. Quality goals and priorities agreed for 2019/20 b. Quality Account	Quality governance groups established for delivery and monitoring quality Patient Safety Patient experience Clinical Effectiveness and Research Medicines Management Mortality Safeguarding	Executive Group and Quality Assurance Committee	IPAS (I/E) meeting	None	None	**3 x 4 = 12 Moderate** **June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Key leadership roles in place a. Corporate business critical posts in place providing governance, quality and safety leadership b. Directorate and programme clinical governance, quality and patient safety leads in place c. Quality Governance teams in place centrally and within directorates	Divisional Governance Boards in place	Executive Group	Internal and external audit reviews	New processes have not yet had a chance to embed	Maintain oversight of Divisional Governance effectiveness and provide support and training as required.			Partial
			3. Quality Governance monitoring a. CQC Assure b. Risk registers c. Quality Impact Assessments	Divisional and corporate risk meetings in place	Risk Assurance committee in place reporting to executive team.	CQC	CQC Compliance Framework not in place	CQC compliance framework being developed			Partial

Meeting of the Board of Directors in Public

Thursday, 02 July 2020

Assurance Report from Committees

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**3.2**
Committee Chair:	Mark Spragg		
Date of Meeting:	Monday 22 June 2020 and Wednesday 24 June 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Annual report and accounts The committee was taken through the highlights of the quality report and it was confirmed that the executive directors had seen an earlier draft; this version reflected the comments received. Subject to confirmation from the Trust executive that they are satisfied with this final version, the IAC **APPROVED** the quality report. Lengthy discussion was held with Grant Thornton (the external auditors) – see below. At the meeting on 22 June the IAC concluded that it could not yet approve the annual accounts and report until such time as assurance had been received from external auditors on completion of their procedures. A follow up meeting was therefore confirmed for 24	**Green**

June. At the meeting on 24 June the committee received assurance that audit procedures were now complete and there had been no material changes to the annual report and accounts. Under delegated authority from the Trust board, the committee therefore **APPROVED** the annual report and accounts for immediate signing. The committee thanked all those involved for their efforts in producing and finalising these documents.	
2. External audit Grant Thornton confirmed that the draft accounts were of a good quality and they had proposed no amendments that would have required a change to the reported deficit. Some amendments have been proposed and made in the notes/presentation of the accounts. The external auditors noted that the audit proved difficult due to this being the first year audit for Grant Thornton, coupled with the remote working requirements. AT its meeting on 22 June the committee was informed that the audit work was not yet complete; concern was raised by the committee Chair and assurance sought from Grant Thornton that the deadline (midday on Thursday 25 June) would be met. The Director of Finance noted that he had met separately with the auditors and expressed his disappointment. As noted above, given the audit was not complete by the meeting on 22 June the committee was unable to approve the accounts. Subject to completion of their work, Grant Thornton confirmed that: • They will be issuing a limitation of scope opinion on the accounts as a result of inventory being a material balance but no year-end inventory counts being held/attended as a consequence of the Covid lockdown and resulting operational pressures. The auditors confirmed that a number of other trusts across the NHS were also in this position. • Their audit opinion makes reference to the material uncertainty flagged by the valuers in their revaluation report and as has been disclosed in the accounts. • Their audit opinion references the extended going concern disclosure made in the accounts. • Their value for money opinion would have been unqualified but for the Trust reporting a deficit. The letter of representation presented to the committee and which requires signing at the same time as the annual report and accounts was **APPROVED**. At the follow up meeting on 24 June the auditors confirmed that their procedures were now complete and that they were closing down their file. No additional matters to note from the audit were raised. The audit partner confirmed that he would issue their audit opinion, as previously set out, in advance of the submission deadline.	**Amber/Green**
3. Internal audit KPMG confirmed that they had delivered 8 out of 11 reviews planned for 2019/20; one review was in the process of being finalised whilst the remaining two could not be undertaken due to Covid. However, they assured the committee that they had sufficient coverage to issue their	**Green**

Head of Internal Audit Opinion ("HOIAO"). The HOIAO is that there is significant assurance with minor improvements required; this is based on: the assurance outcomes from the reviews undertaken during the year; the number of high priority recommendations raised, and; the assurance outcomes on those key reviews. KPMG walked the committee through its testing plan for 20/21, noting a flexible approach has been adopted in respect of timing as a result of Covid. The Committee recommended that internal audit should support the audits of infection control and COSHH as required and aligned to the CQC findings report. It was suggested that the review into statutory and mandatory training could be removed to create capacity for these reviews as the Trust felt assured on this topic given current compliance rates. The review into gifts and hospitality was reported with a final rating of amber-red. The report into serious incidents has been updated and reissued to management for comment.	
4. BAF The updated BAF was presented to the committee and improvements acknowledged.	**Green**
5. Temporary SFI amendments The proposal to reduce those temporary uplift in approval limits - put in place as a result of Covid - back down to SFI levels were AGREED with immediate effect.	**Green**
Decisions made The quality account within the annual report was APPROVED at the meeting on 22 June. At its meeting on 24 June the committee – under delegated authority from the Trust board – did APPROVE the signing of the annual report and accounts. The letter of representation required by the external auditors was also APPROVED for signature alongside the annual report and accounts.	
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 removal of the temporary increases to the SFI delegated limits.	

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Board Update on Trust Response to Covid-19**	**Agenda Item**	4.1
Report Author	Harvey McEnroe – Strategic Commander – MFT and M&S ICP (Accountable Emergency Officer)		
Lead Director	Harvey McEnroe		
Executive Summary	This paper outlines the Trust's current response plans to C19, focusing on our restore and recover programme as well as our wider work with system partners across the ICP and the ICS/STP. This paper will outline the current status of the Covid19 response and what remains to be done regarding the recovery and restore work across the Trust and the wider health economy. This paper covers the following key updates: 1. MFT and the ICP restore and recover governance structure 2. Our current position on: a. Ward configuration b. Elective Care c. Urgent and Emergency Care d. Cancer and Diagnostics e. Covid19 Wave2 3. An update national guidance re face masks 4. MFTs response to BAME assessments 5. Waiting list backlog and management plans		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Date of approval:		
Executive Group Approval:	Date of Approval:		

National Guidelines compliance:	Does the paper conform to National Guidelines (please state):			
Resource Implications	Not at present			
Legal Implications/Regulatory Requirements	No			
Quality Impact Assessment	No			
Recommendation/ Actions required	This paper is for assurance and discussion			
	Approval ☐	**Assurance** ☒	**Discussion** ☒	**Noting** ☐
Appendices	None			

1 Executive Overview

1.1 The Trust has now entered the restore phase of the restart, restore and recovery programme. The current plans and restore work are being delivered via our internal and our external governance structures.

1.2 The attached Covid19 Strategic Incident Management Plan update outlines the oversight and governance structure for the restore programme across both MFT and the wider Integrated Care Provider (ICP).

1.3 The Trust is working closely with the ICP and the ICS (the newly formed single CCG across Kent and Medway) to ensure that our plans mirror those of the wider system and to ensure that we are in-sync with the regional and national asks on restore and recovery.

1.4 The Trust has supported the regional restore plan across the key priorities established (as set out in the attached Covid19 Strategic Incident Management Plan). Focusing on Elective Care, Urgent and Emergency Care, Primary and Community Care, Discharges and the Covid19/Winter preparedness planning. Our internal and ICP governance structure is established to operate in this way.

1.5 Emergency and urgent demand returned to 85% of previous activity to date, with admissions and conversion rates remaining below 70% of previous activity levels.

1.6 The elective care backlog for patients on the PTL is now at 20,200, which is a decrease 1,800 from January 2020. RTT performance is at 64% from 84.6% in March. The Trust is holding 22 52 week breaches.

1.7 In the Cancer care area the Trust has maintained its cancer pathways and is currently at 92.2% for Cancer 2ww pathways. This has been maintained thanks to the early efforts to use the independent sector and maintain urgent pathways in the Trust for Cancer treatment and early diagnostics. Endoscopy remains the biggest the challenge for the Trust and the wider ICS and there is work underway to resolve this at a Kent and Medway level, which the Trust Strategic Commander is leading for the region.

1.8 The Trust remains heavily focused on staff welfare and supporting our staff whilst we remain in incident management but also as we return to recovery and restore. As per the governance set out in the attached Covid19 Strategic Incident Management Plan, the Trust has established a core group to focus

on the issues of staff welfare and a Task and Finish Group to oversee staff swabbing and testing, a key function in the protection of our staff at this challenging time.

1.9 The Trust has worked to support the BAME staff group during the C19 response and has established a core group led by the Director of HR and OD to oversee staff work place assessments and the to ensure the support needed around returning to work is available. The Trust has established BAME network meeting weekly with BAME colleagues and has provided a robust support structure for staff that are at risks, this has included enhanced assessments, access to testing and swabbing but also support via the distribution of Vitamin D.

1.10 As part of the Trusts commitment to maintain safety for all staff and patients, all visitors and staff are now expected to have face masks on at all times.

2 Restore and Recover Plan – Current Status and next steps

2.1 The Trust has moved into Restore phase and has now commenced all services across elective and emergency care.

2.2 The Trust has now reconverted its theatres capacity back to general theatres, with 6 of 10 theatres now being used, with a further 4 coming on line week commencing the 22/06.

2.3 The Trust has reopened all outpatient services to 70% of previous capacity due to social distancing rules

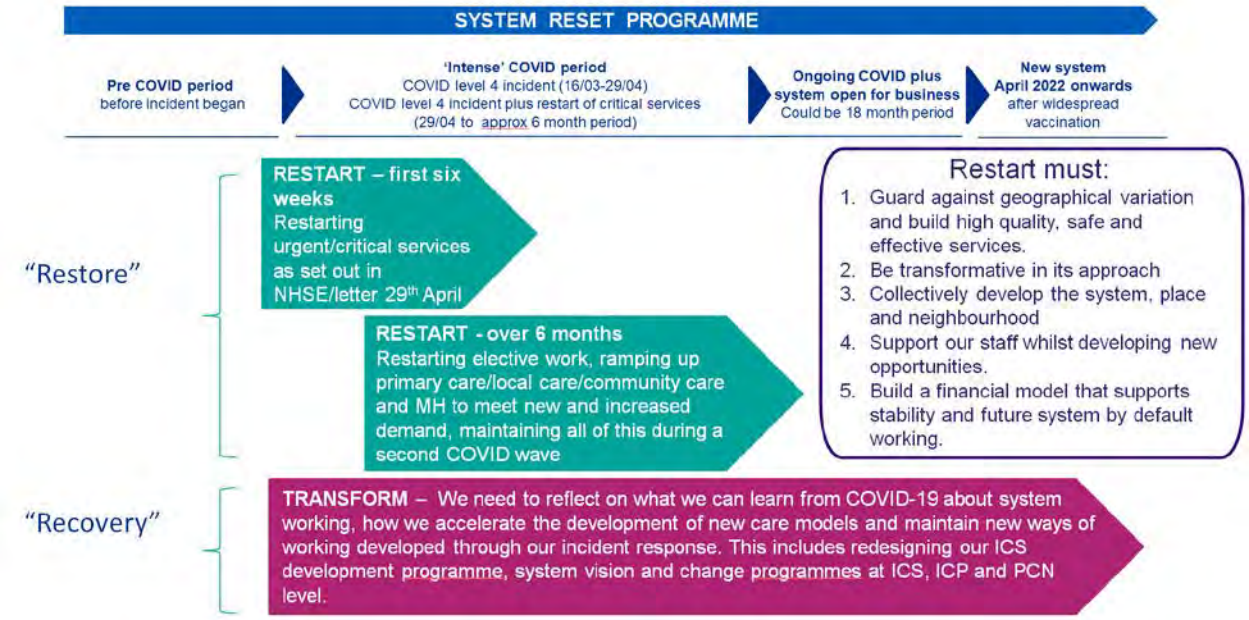
2.4 All diagnostics services are now open, again to 70% of previous capacity due to social distancing.

2.5 Access to urgent and emergency care is fully open though demand remains below previous activity levels for walk in patients (85%). Ambulance activity is back to previous levels.

2.6 Ward capacity remains at previous levels and the Trust has not at present moved to remove beds linked to social distancing, though modelling remains underway and the planning for this remains a key focus of the Trust and the ICP.

2.7 The overall planning and the current position of the Trust remain robust, but risks around elective care and access to ‘green’ ward capacity remain challenging. The conversion of two medicine wards to support the elective recovery plan in the coming 4-6 weeks will support the work on clearing the backlog and reducing the delay to our patients on elective care plans. We remain fully committed to the use of the Independent Sector (IS) to support our elective recovery plan, with 40 patients a week being treated in the IS.

2.8 The below graphic shows the system reset programme and outlines the stages of the recovery plans and the restore phase. MFT are on track with these plans at present and continue to work closely with the ICP and the ICS in the delivery of our restore and recover programme.



2.9 Whilst restore continues at pace, the Trust must maintain the ability to have 'red' C19 zones across urgent and emergency care, surgery wards and medicine wards. To this end the Trust maintains 3 medicine wards as C19 and 1 surgical ward (approximately 70 beds), which can serve as red and amber capacity. Red capacity is beds that are confirmed C19, amber being query C19 but with symptoms not yet confirmed from swabbing, green is no C19 and confirmed via swab. This flex capacity is vital to maintain safe, effective care and to ensure that the Trust can manage the changing demands of C19 as it occurs.

2.10 Clearly have 70 beds ring fenced for this purpose is putting strain of the acute bed base, and remains a risk should activity levels return to previous levels. Occupancy across the Trust remains below 90% at present.

3 Restoring Elective Care, Urgent and Emergency Care, Diagnostics and Cancer

3.1 **Elective Care** remains the key focus of the recovery and restore phase.

3.1.1 The reported April RTT position in May indicated RTT is April 72.6% compared to 80.5% in March 2020.

3.1.2 This is likely to have reduced further during April which will be seen on the next submitted return.

3.1.3 The number of incomplete pathways has remained stable throughout this period.

3.1.4 Only 4 52-week breaches reported in April although this is likely to be higher in May due to complex cases which cannot be undertaken at the IS provider sites and more likely to require critical care post-surgery.

3.1.5 There have been 20 52 week breaches validated in May.

3.1.6 The actions to mitigate the current elective care challenges:

- 5 theatres are opening on the MFT site before end of June
- 2 day surgery theatres will be utilised once current activity is relocated to main theatres.
- IS capacity is being maximised at IS Spire Alexander for Urology, Breast, ENT, gynaecology, pain management and by end of June – simple orthopaedics
- Major joint surgery will resume once community rehab available Outpatient plans in place to restore services – 80% news F2F and 80% Follow ups NF2F
- IS capacity to support outpatient activity as well as exploring system healthcare clinic space to move outpatients from MFT main site.
- HBS have re-engaged to provide MFT to support their recovery
- Modelling to identify gaps and recovery trajectories to be undertaken

3.2 **Diagnostics** is a key underpinning programme to support the work of the elective care pathway. The Trust is working across the wider system to support the programmes of recovery in the diagnostic area. The current position in the Trust on diagnostics is:

3.2.1 The reported April RTT position in May indicated RTT in April was 72.61% compared to 65.53% in March 2020.

3.2.2 This is likely to have deteriorated further during April due to diagnostics services being closed during the pandemic.

3.2.3 The actions to mitigate the current diagnostic backlog are:

- All diagnostic services have been re-opened.
- X-ray facilities have been re-opened in the MIUs in Swale
- The issues with spacing, timing and capacity have been a challenge to ensure patients are managed to minimise risk with social interaction with other patients as well as staff.
- At MFT they have introduced a diagnostics PTL and Diagnostics PTL meeting to systematically review each patient on the diagnostics waiting list, as well as continual validation.
- KIMS have been engaged to utilise their capacity for interventional cardiology for diagnostics and treatment – including angiograms, echo's and cardioversions which will support MFT recovery.
- MFT have plans in place to expand the use of their scanners so they are fully functional from 8-8pm 7 days a week. There are 2 scanners as "Cold" MRIs and 1 MRI is being kept as a "hot" scanner.
- Modelling to identify gaps and recovery trajectories to be undertaken

4 ICP governance and the system recovery plan

4.1 The below summary outlines the ICPs plan for recovery:

5 Conclusion and Next Steps

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

MFT **Covid19 Recovery**

Covid19 Strategic Incident Management Plan – Board Update July 2020

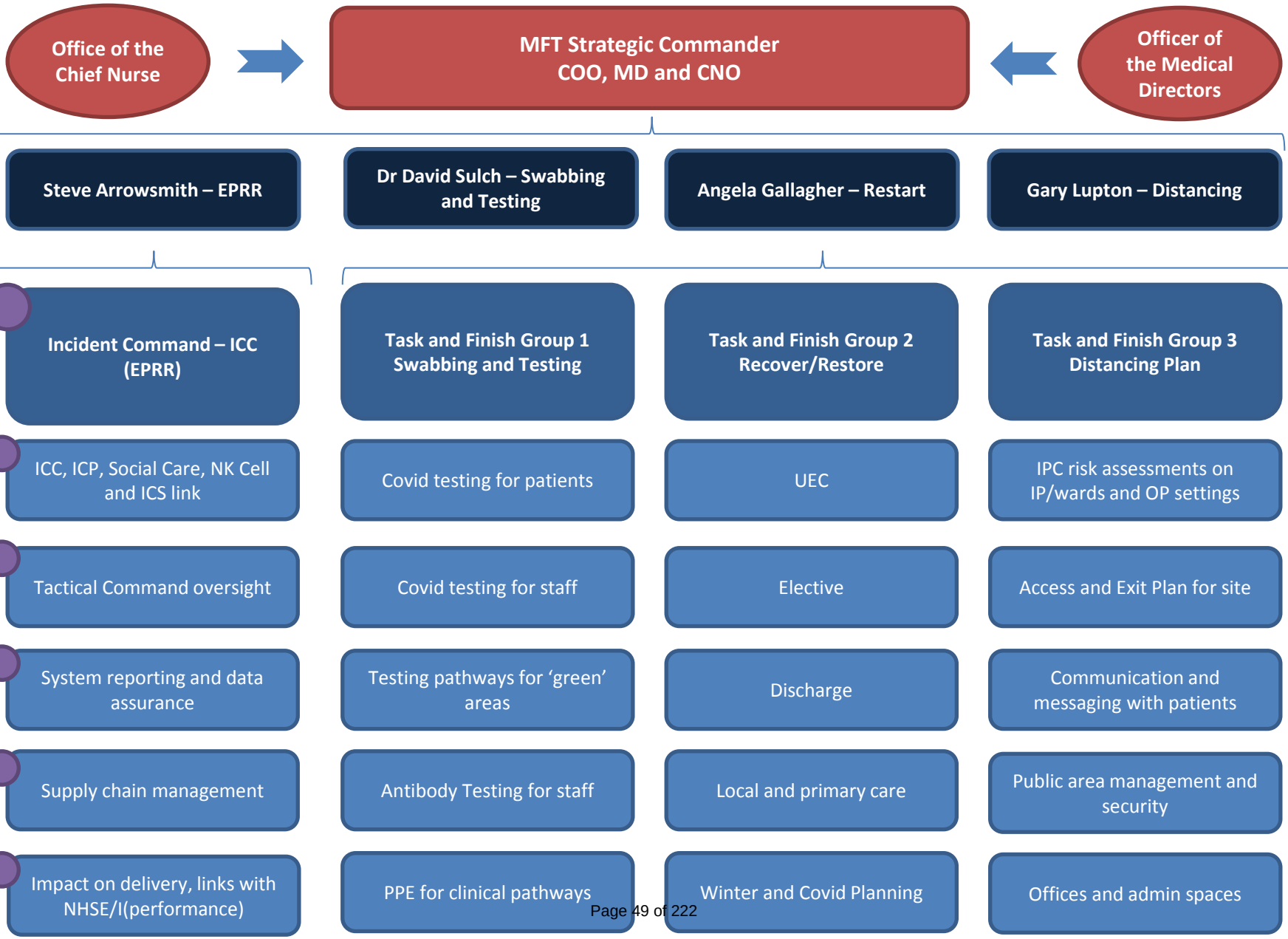
Harvey McEnroe
Strategic Commander

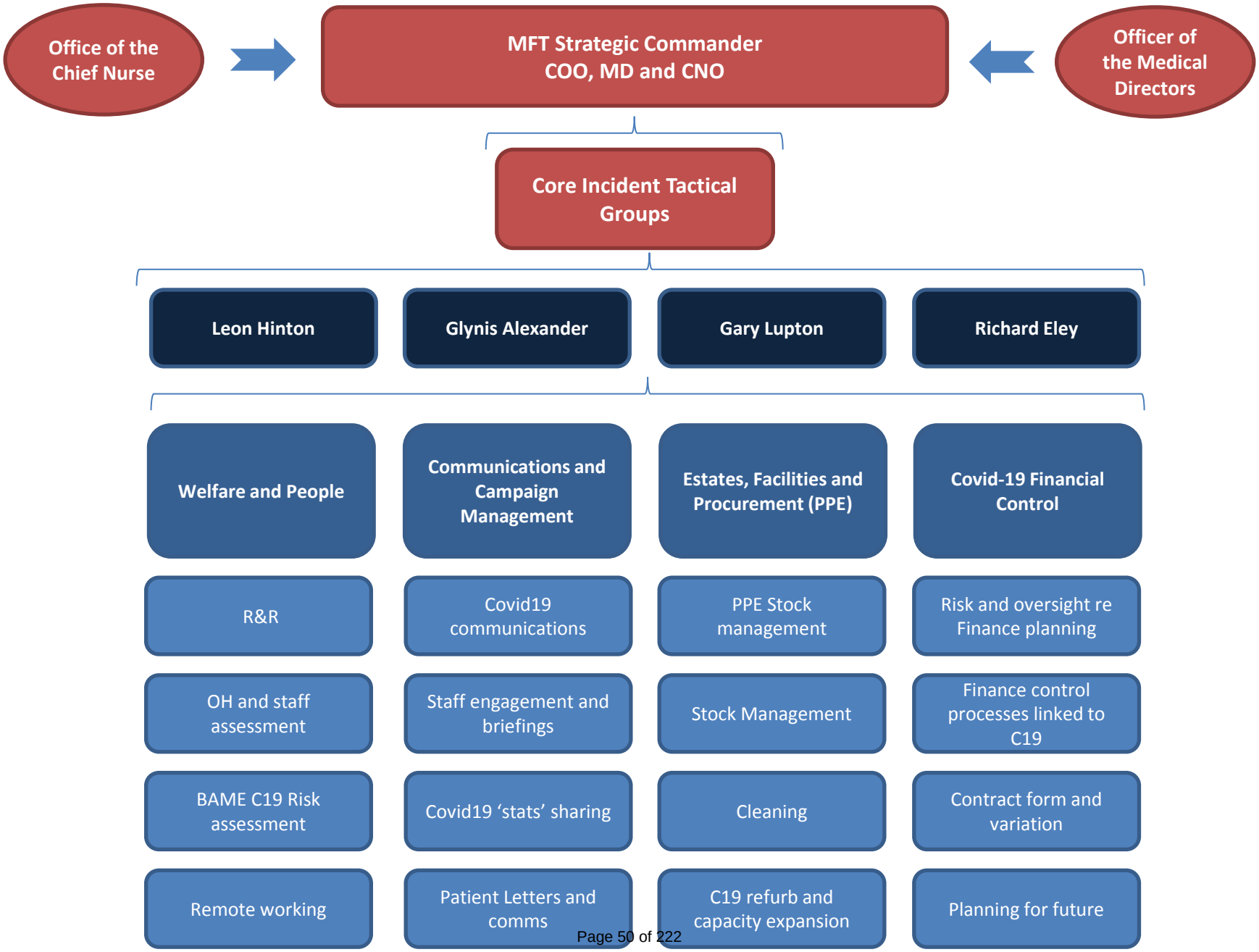
MFTs structure for C19 strategic response

- MFT has established a strategic response to C19 which was firstly established to respond to the incident, but which is now being converted to manage the restore and recover phase, as well as key aspects of swabbing and distancing.
- The MFT strategic response plan works to oversee incident management whilst we remain in level 4 major incident via a three times weekly strategic command structure, but also structures to oversee restore and recovery, with a twice weekly executive oversight structure.
- The executive oversight structure oversees three Task and Finish Groups:
  - Restore and Recover
  - Distancing and Home working
  - Swabbing and Testing
- The Restore and Recover T&FG is organised in the same structure of that of the ICP, thus ensuring that there is strong partnership working on restore plans between MFT and its partners across the ICP. This will be a system recovery and improvement plan.
- The next two slides outline the MFT T&FG structure and the core tactical group structure.

Denotes a formal function of EPRR

Covid19 Strategic Command Structure




Office of the Chief Nurse
MFT Strategic Commander
COO, MD and CNO
Officer of the Medical Directors
Core Incident Tactical Groups
Leon Hinton
Glynis Alexander
Gary Lupton
Richard Eley
Welfare and People
Communications and Campaign Management
Estates, Facilities and Procurement (PPE)
Covid-19 Financial Control
R&R
Covid19 communications
PPE Stock management
Risk and oversight re Finance planning
OH and staff assessment
Staff engagement and briefings
Stock Management
Finance control processes linked to C19
BAME C19 Risk assessment
Covid19 'stats' sharing
Cleaning
Contract form and variation
Remote working
Patient Letters and comms
C19 refurb and capacity expansion
Planning for future

Restore and Recover delivery plan

- The MFT R&R plan is aligned to the ICP plan which is aligned to the wider ICS plan. The plan focuses across five key areas:
  - Elective Care (including IS and Diagnostics)
  - Urgent and Emergency Care
  - Local and Primary Care
  - Discharges
  - Covid19 wave2 planning and Winter planning
- To ensure that the MFT plan is structured into the wider system plan, we have organised the internal restore and recover planning to mirror the ICP and the to work to the same objectives with partners from across the ICP supporting the internal MFT recovery plans.
- The next two slides outline the MFT and the ICP restore and recovery plans.

Medway NHS
NHS Foundation Trust

MFT internal Restart programme – designed to link into the wider ICP plan

System Restore and Recovery – Harvey McEnroe
Restore, Covid 19 Wave 2, Winter Planning, System bed reconfiguration

MFT – Restore/Recover Task and Finish – Angela Gallagher

Urgent and Emergency Care	Elective Care	Discharge	Local and Primary Care	Winter/ Covid Planning
Kevin Cairney	**Benn Best**	**Karen McIntyre**	**Simone Hay**	**Ben Stevens**
Med OCC Extended Hours 111/999 SDEC SEC Amb MH Crisis	Elective Access IS Providers Outpatients Hot Clinics System & Service redesign	Admission Avoidance MFFD Alternative pathways	Primary Care Hot Clinics/Sites Community Services Mental Health	Winter Planning Acute Bed Reconfiguration Covid19

Communication and Engagement with Partners, Staff, Service Users and the Public

Contracts and Performance
Contracts & Performance, Planning, Business Intelligence, Trajectories, Single PMO

Restart and recovery priorities for operational services across the ICP

System Restore and Recovery – Harvey McEnroe
Covid 19 Wave 2, Winter Planning, System bed reconfiguration

Urgent and Emergency Care	Elective Care	Discharge	Local and Primary Care
Nikki Teesdale	**Nikki Teesdale**	**Helen Martin**	**Tracy Rouse**
Med OCC Extended Hours 111/999 SDEC SEC Amb MH Crisis	Elective Access IS Providers Outpatients Hot Clinics System & Service redesign	Admission Avoidance MFFD Alternative pathways	Primary Care Hot Clinics/Sites Community Services Mental Health

Communication and Engagement with Partners, Staff, Service Users and the Public

Contracts and Performance
Contracts & Performance, Planning, Business Intelligence, Trajectories, Single PMO

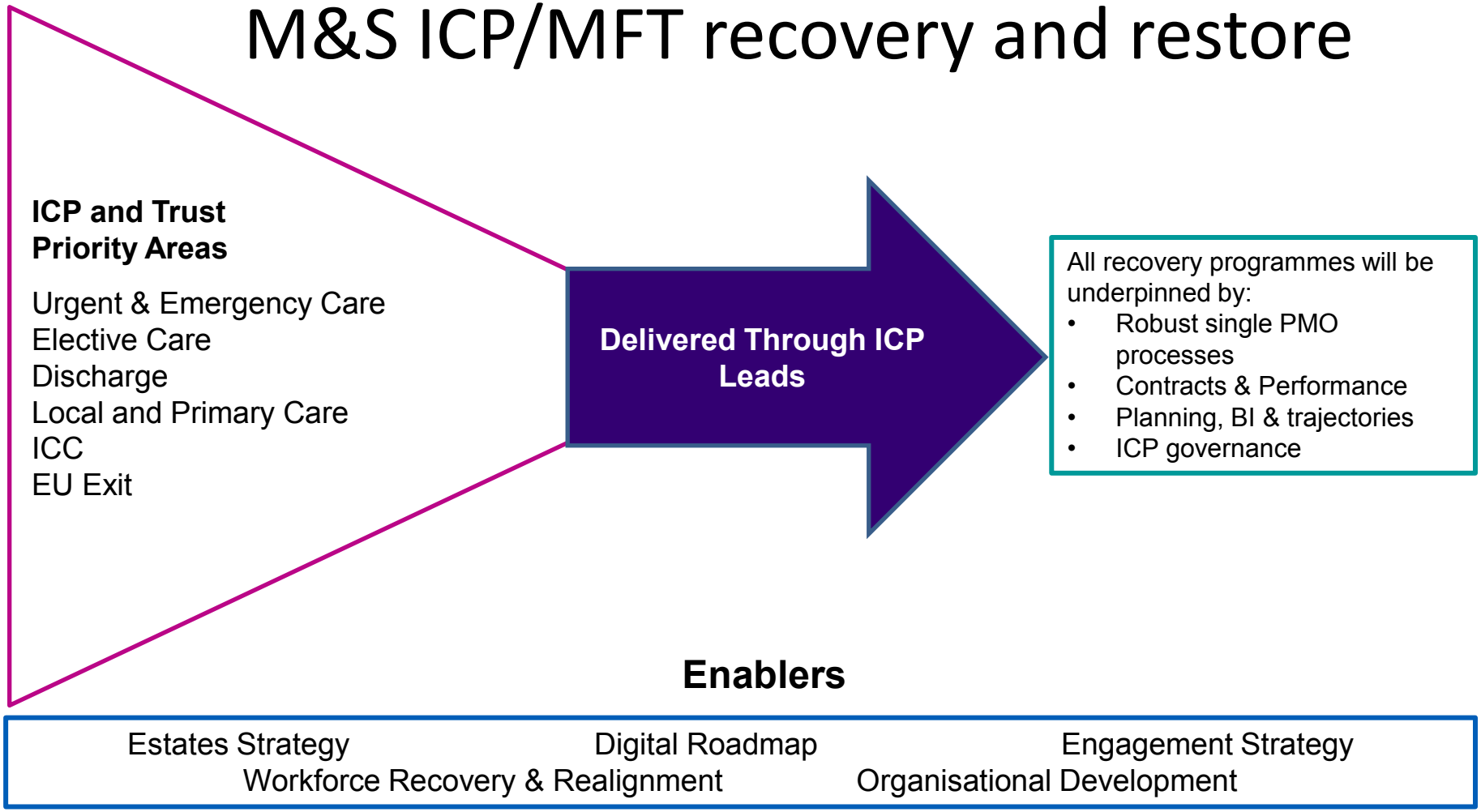
MFT and ICP recovery priorities

1. There will be a system-wide review of lessons learned. We will not automatically return to the ‘old way’ of doing things.
2. We will embrace developments implemented through COVID-19 related activity, and seek to incorporate these into clinical and operational strategies and service models.
3. Every service will develop a recovery plan to meet 'must dos’ including meeting a COVID second wave.
4. Recovery plans will demonstrate an awareness of impact of recovery actions on other parts of the health and social care system.
5. Organisations and services will own the issues in their recovery plan and avoid responsibility or cost shunting to other partners in the health and care system.
6. “System by Default” will be embedded locally, with 3 levels of leadership and recovery (Organisational, ICP and CCG/ICS).
7. There are likely to be multiple phases of recovery, but each phase will have an agreed target date.
8. Contracts will be used to support recovery, not as a punitive mechanism with contract monitoring focusing on delivery of recovery plans and trajectories.
9. Patient safety will always be non-negotiable, contract requirements and KPIs relating to safe care will remain in place.

ICP and MFT C19 strategy

- ICP Clinical Strategy including:
  - New model of primary care including separation of scheduled and unscheduled primary care
  - Stronger integration of primary and community services
  - Development of primary mental health services and stronger links between physical and mental health services
  - Population health management
  - Understanding and managing the long-term impacts of COVID 19, assessment of the harm which may have occurred during the pandemic due to lower thresholds and risk appetite.
  - Quality and safeguarding, acknowledging the risks and issues pre-covid and any additional risks and issues which occurred during the pandemic incident management.
  - Understand the new baseline as a result of the impact of Covid-19 and the changes implemented before standing up services and establishing the new business as usual.
- Engagement Plans:
  - Focused on robust communication and engagement with staff, services and the public and other stakeholders
- Robust organisational development plans for all partner organisations and the ICP:
  - Sustaining the changes to support transformation and to function effectively in a 'New Normal'.
  - Support staff resilience.
  - Impact on LTFM
- Agreement of MoUs that underpin the development of the ICP.
- Robust **management matrix approach** to co-ordinate recovery programmes across the ICP, ensuing we make the best use of available resources.

M&S ICP/MFT recovery and restore



Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.2
Report Author	Jane Murkin – Chief Nurse (Interim)		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	This is the refreshed version of the IQPR in using Statistical Process Control charts to display the data. This report informs Board Members of the quality and operational performance across key performance indicators for May 2020. **Safe** The Trust has had 9 c-difficile cases reported in May. Investigations are currently ongoing. Falls remains below the national average rate. The updated February HSMR figure now sits at 99.2 (95.4 – weekday and 109.8 – weekend), this is an improvement from the January position. The SHMI sits at 1.11 **Caring** MSA continues to demonstrate an improvement; however in May 2 breaches were recorded which is still higher than the national compliance levels. Electronic Discharge Notification (EDN) performance remains below trajectory at 77.3%, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system. **Effective** VTE performance for April sits at 94.3% against the 95% national target. Fractured NOF procedures within 36 hours performance shows a slight improvement moving from 68.4% to 72.7%. A number of different actions are in place to improve the experience for patients and the performance. **Responsive** The Trust saw a significant improvement to the 4 hour performance standard reaching 93% for May 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with four 52 week breaches, May is recording at 65.53% with twenty 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for May as 56.5%. Cancer 2 week wait performance for April continues to be achieving national standards at 93%, 62 day performance is recorded as 77.5%. **Well Led** We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 2 of 2020/2021.		

Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Resource Implications	None	
Legal Implications/Regulatory Requirements	State whether there are any legal implications	
Quality Impact Assessment	Not required.	
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.	

Approval	Assurance	Discussion	Noting
☒	☒	☒	☒

Appendices	Appendix 1 – IQPR – May 2020

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: May 2020

Guide to Statistical Process Control (SPC)

NHS Medway NHS Foundation Trust

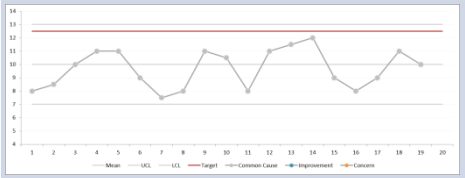
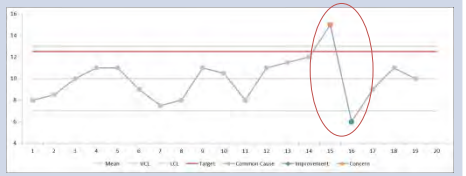
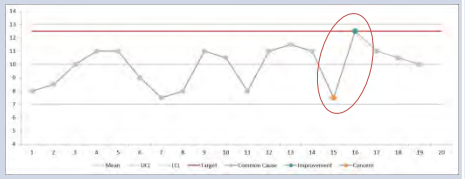
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

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

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

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

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

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

Guide to Statistical Process Control (SPC) Icons

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

Variation

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

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

Assurance

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

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

Executive Summary

Safe

Our Infection Prevention and Control performance for May. The Trust had 9 c-difficile cases reported in May. Investigations are currently underway .

Falls

The updated February HSMR figure now sits at 99.2 (95.4 – weekday and 109.8 – weekend), this is an improvement from the January position. The SHMI sits at 1.11

Caring

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

Electronic Discharge Notification (EDN) performance remains below trajectory at 77.3%, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system.

Effective

VTE performance for April sits at 94.3% against the 95% national target. Fractured NOF procedures within 36 hours performance shows a slight improvement moving from 68.4% to 72.7%. A number of different actions are in place to improve the experience for patients and the performance.

Responsive

The Trust saw a significant improvement to the 4 hour performance standard reaching 93% for May 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with 0 52 week breaches, May is recording at 65.53% with 20 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for May as 56.5%. Cancer 2 week wait performance for April continues to be achieving national standards at 93%, 62 day performance is recorded as 77.5%.

Well Led

We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 2 of 2020/2021.

Executive Dashboard

Current Month Overview of KPI Variation and Assurance Icons

NHS Medway NHS Foundation Trust

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

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

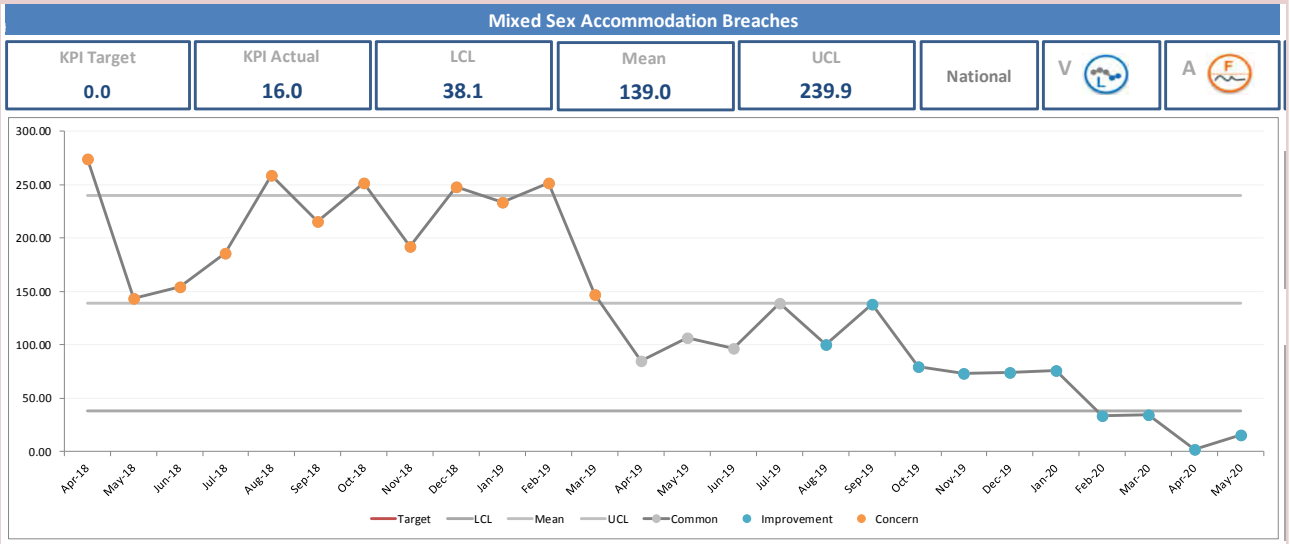
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	N	May-20	0	16	38	139	240	L	F
		MSA %	N	May-20	0%	0.1%	0.3%	0.9%	1.6%	L	F
		% of EDNs Completed Within 24hrs	N	May-20	100%	77.3%	69.9%	75.0%	80.0%		F
		Inpatients Friends & Family % Recommended	N	May-20	85%	88.6%	80.0%	86.2%	92.4%		?
		Inpatients Friends & Family Response Rate	N	May-20	22%	20.4%	15.8%	20.6%	25.4%		?
	ED Care	ED Friends & Family % Recommended	N	May-20	85%	88.1%	71.3%	78.2%	85.0%	H	F
		ED Friends & Family Response Rate	N	May-20	22%	18.3%	11.8%	14.4%	17.0%	H	F
	Maternity Care	Maternity Friends & Family % Recommended	N	May-20	85%	99.7%	96.9%	99.2%	100.0%		P
		Maternity Friends & Family Response Rate	N	May-20	22%	32.2%	10.6%	24.7%	38.8%		?
	Outpatient Care	Outpatients Friends & Family % Recommended	N	May-20	85%	90.4%	88.3%	90.5%	92.7%		P
		Outpatients Friends & Family Response Rate	N	May-20	22%	13.5%	11.9%	14.1%	16.4%		F

Domain: Caring Insights

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

NHS Medway NHS Foundation Trust

Indicator: Mixed Sex Accommodation Breaches



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low improving nature. Assurance indicates that the KPI is not consistently achieving the national target.

Actions:

- Single sex accommodation is provided where possible, using separate bays and side rooms.
- Breaches are discussed daily at ward level, at divisional safety huddles and site meetings. Breaches are reported on the twice daily site report as well as monthly data.

Outcomes:

- Significant reduction since Jan 2020, through tighter grip at ward level as well as support from executive level to prevent MSA. The majority of breaches are attributed to Critical Care due to delayed discharges once patients become able to step down.

Underlying issues and risks:

- During the covid-19 peak, there were issues in obtaining a suitable beds in covid-19 areas. For May 2020, 2 patients have awaited medical covid-19 beds for 2 days.
- As number of red and green beds fluctuate and increasing ED attendances, there is a risk that MSA rates will increase if others clinical pathways are given priority.

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

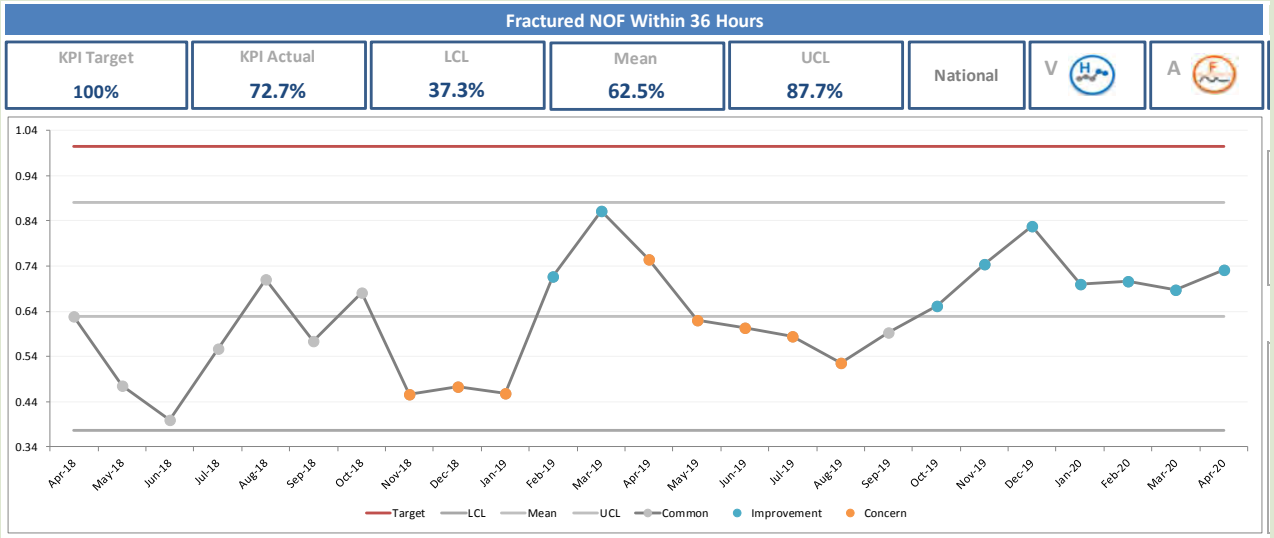
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	N	Apr-20	10%	8.5%	4.0%	5.4%	6.8%		
		30 Day Readmission Rate	N	Apr-20	10%	16.0%	8.8%	10.9%	12.9%		
		Discharges Before Noon	N	May-20	25%	12.9%	12.8%	15.1%	17.5%		
		Fractured NOF Within 36 Hours	N	Apr-20	100%	72.7%	37.3%	62.5%	87.7%		
		VTE Risk Assessment % Completed	N	May-20	95%	94.3%	72.0%	84.6%	97.3%		
	Maternity	Elective C-Section Rate	L	May-20	13%	16.2%	9.8%	13.1%	16.4%		
		Average occupancy	L	May-20	15%	18.7%	15.1%	18.9%	22.7%		
		Total C-Section Rate	L	May-20	28%	34.9%	27.5%	32.0%	36.5%		
		Number of Deliveries (Count of Mothers)	L	May-20		401	346	408	470		●
		12+6 Risk Assessment	N	Feb-20	90%	82.2%	77.2%	83.2%	89.2%		
	Stroke	Stroke SSNAP Rating *	N	Dec-19	B	D				●	●
		% of Pts Seen by Stroke Cons in 24 Hours *	N	Dec-19	95%	49.5%	32.1%	37.1%	42.1%		
		Stroke Pts Scanned Within 1 hour *	N	Dec-19	90%	40%	37%	44%	51%		

Domain: Effective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Fractured NOF Within 36 Hours



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Identify dedicated Trauma Surgeon availability
- Identify the additional theatre capacity required (to accommodate hip fractures and regular & specialty trauma)

Outcomes:

- Surgeon (hip fellowship trained) now available everyday from 8am. Immediate need met, but needs more sustained solution.
- Additional theatre capacity allocated weekly. This is for a minimum of one half-day (Theatre 7) every day. Immediate need met but needs sustained solution.

Underlying issues and risks:

- On-going Permanent dedicated resource to support additional Trauma capacity (trust consultant)
- Additional theatre capacity needs to be a permanent & protected allocation
- Challenging bed base , covid guidance limiting flexibility of bed base – red bed allocations.
- Resources to deliver 7 day therapy support

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

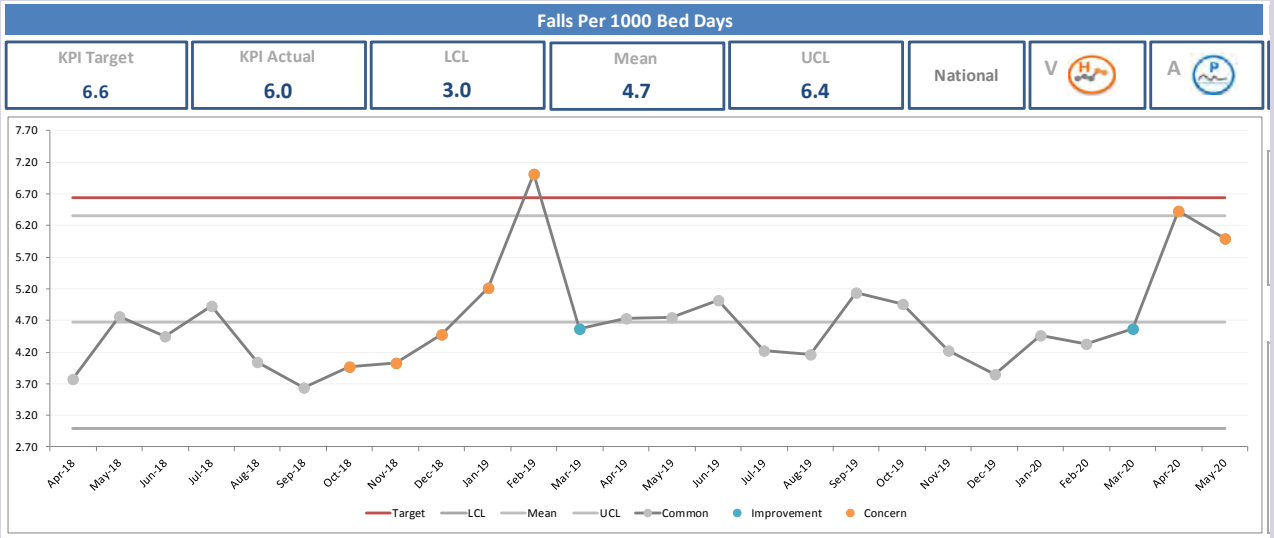
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	N	May-20	6.63	5.99	2.99	4.67	6.35	H	P
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	N	May-20	1.04	0.00	0.00	0.06	0.27		P
	Incident Reporting	Never Events	N	May-20	0.0	0.0	0.00	0.1	0.8		?
		No of SIs on STEIS	N	May-20	90	11	0	10	20		P
		% of SIs Responded To In 60 Days	N	May-20		100%	91%	98%	100%	H	●
	Infection Control	MRSA Bacteraemia (Trust Attributable)	N	May-20	5	1.00	0.00	0.62	2.96		P
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	N	May-20	43	9.0	0.00	3.0	10.0	H	P
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	N	May-20		3.0	0.00	1.6	5.7		●
		E-coli (Trust Acquired) Infections	N	May-20	30	4.0	0.00	4.6	10.6		P
	Mortality	Crude Mortality Rate	N	May-20	2.5%	3.32%	0.89%	1.58%	2.26%		P
		HSMR (All)	N	Feb-20	100%	99.2%	103.4%	107.1%	100.0%	L	F
		HSMR (Weekday)	N	Feb-20	100%	95.4%	100.0%	104.5%	100.0%	L	F
		HSMR (Weekend)	N	Feb-20	100%	109.8%	110.0%	114.5%	100.0%	L	F
		SHMI	N	Feb-20	1.0	1.11	1.06	1.09	1.11	H	F

Domain: Safe Insights

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

NHS Medway NHS Foundation Trust

Indicator: Falls Per 1000 Bed Days



Indicator Background:

The number of patient falls per 1000 bed days remains below the national average.

What the Chart is Telling Us:

The SPC data point is showing a reduction in falls per 1000 bed days compared to the previous month.

Actions:

- Work continues to support quality strategy pilot wards with improving the reliability of the processes known to reduce falls and mitigate risk of harm to patients by improving patient outcomes . Continue to perform weekly audits of falls CRASH bundle and support the implementation of the quality boards.
- Dignified Throne Project (reducing falls in toilets and bathrooms) commenced on Wakeley, Arethusa, Harvey and Byron during ward refurbishment.
- Lying and standing blood pressure, Neuro observations and post fall care training continues.

Processes & Outcomes:

- Weekly audit results of compliance and review of themes and trends to enable targeted support and training.
- All bathrooms will be refurbished with consideration of falls risk to make them as safe and patient friendly as possible
- Training being completed with ward staff one ward at a time

Underlying issues and risks:

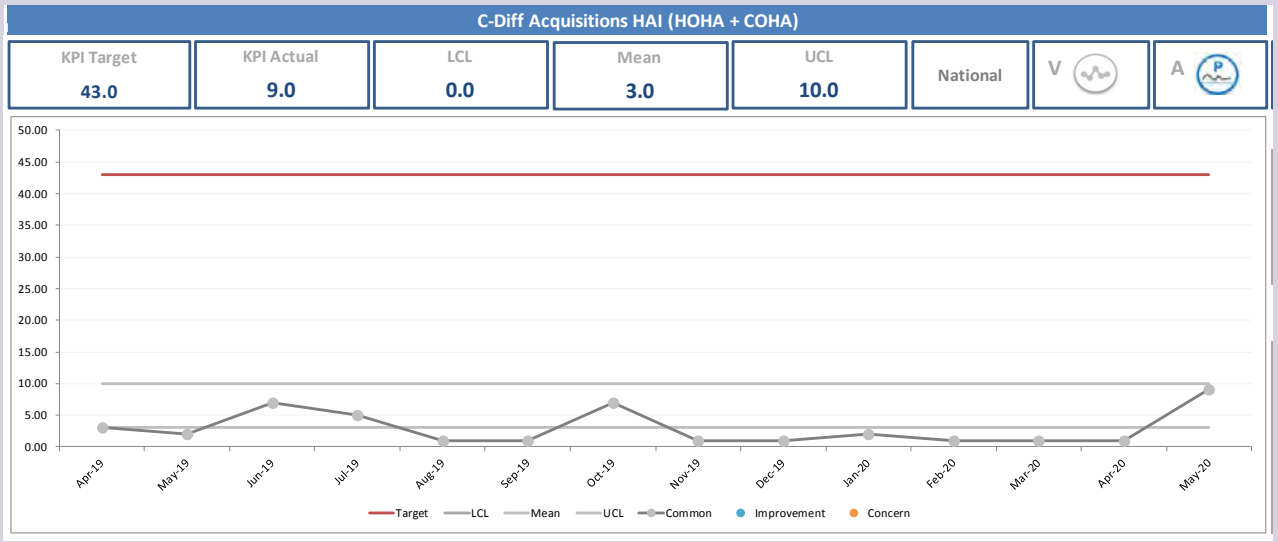
- The COVID 19 pandemic has contributed to an increase in falls In April, felt to be due to the increased infection control measures, with doors being closed, which reduced visual observation of patients and sounds of the alarms together with an increased time to get to the patient when needed, due to donning.

Domain: Safe Insights

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

NHS Medway NHS Foundation Trust

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



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Improvement plan has been written which captures the actions to improve upon rates of C.diff

Outcomes:

- Wards with cases of C.diff have been closely supported and monitored using the period of increased incidence

Underlying issues and risks:

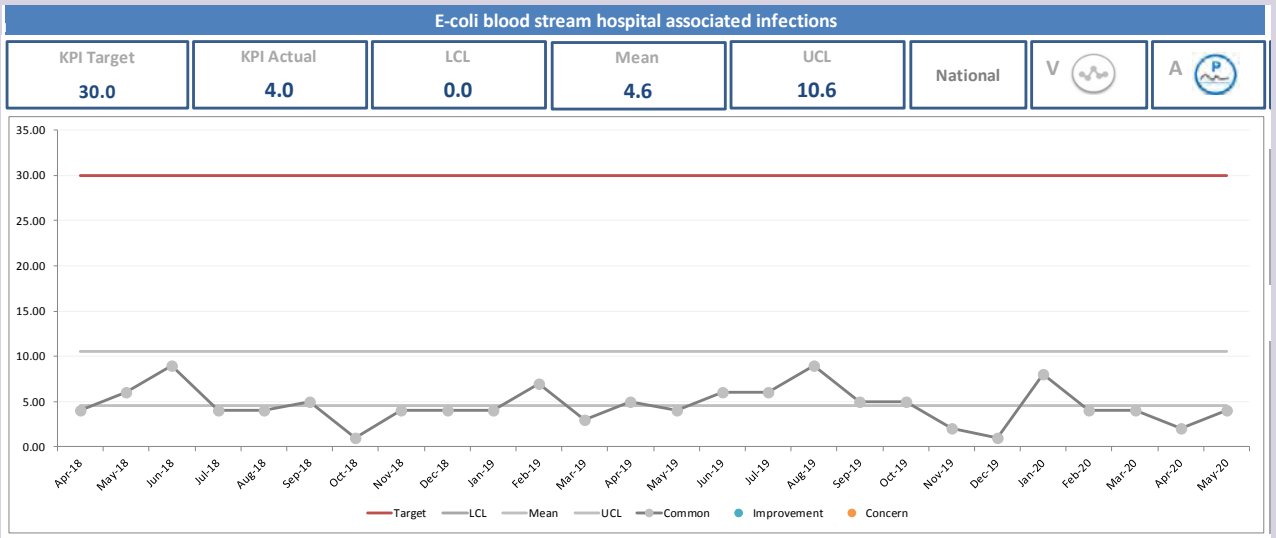
- Antimicrobial choices and durations of use, its also not always clear the indication for this

Domain: Safe Insights

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

NHS Medway NHS Foundation Trust

Indicator: E-coli blood stream hospital associated infections



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- The 2019/20 cases are being reviewed by DIPC to see if there is anything further that can be incorporated in to the Trust wide IPC action plan.

Outcomes:

- There is a high community prevalence of E.coli blood stream infection, compared to MFT. The top two sources are hepatobiliary and upper urine tract infection.

Underlying issues and risks:

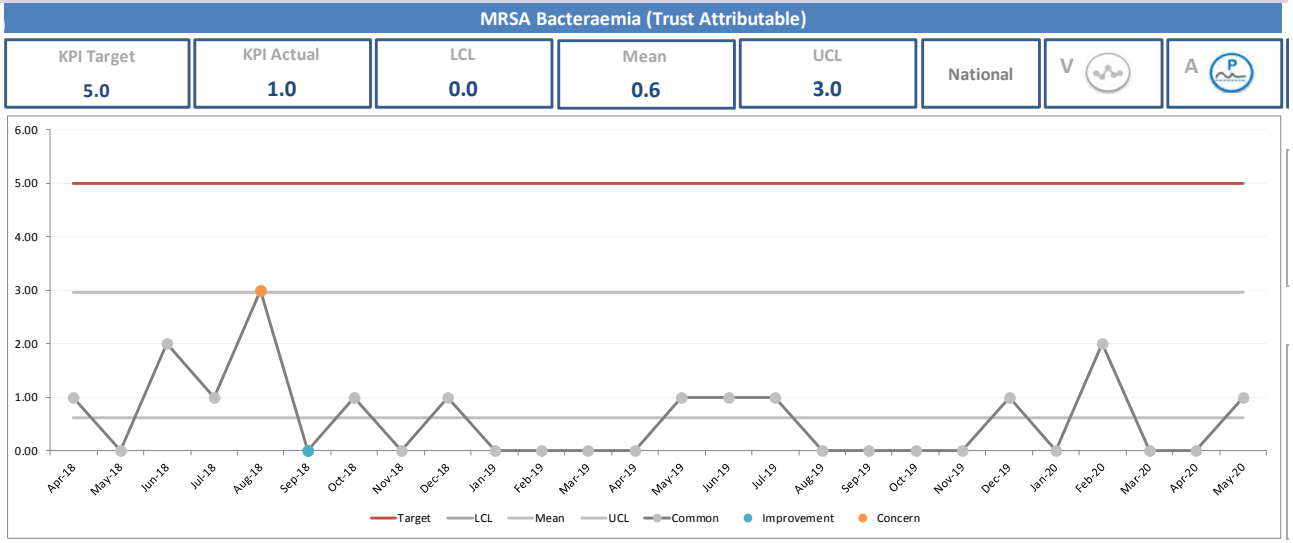
- There needs to be a system wide approach to GNBSI's to realise the reductions required

Domain: Safe Insights

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

NHS Medway NHS Foundation Trust

Indicator: MRSA Bacteraemia (Trust Attributable)



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Communications around preventative measures to take have been cascaded to clinical leads and heads of nursing
- Training plan has been developed for forward training.

Outcomes:

- Reduction of MRSA cases.

Underlying issues and risks:

- MRSA screening audit and feedback from this to drive improvements

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

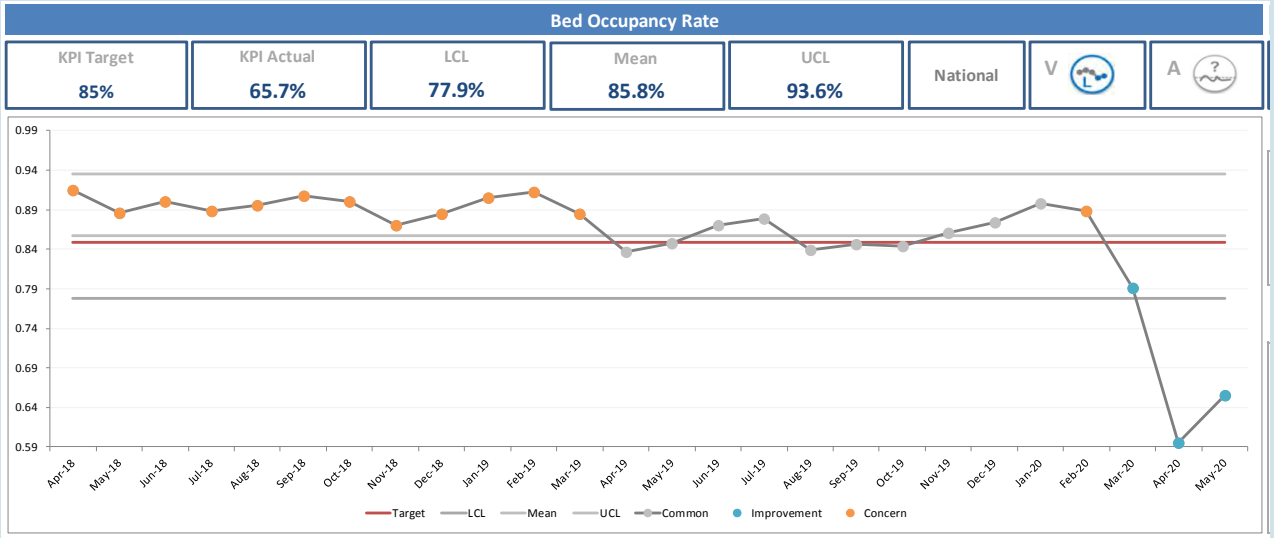
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Non Elective	Bed Management	Bed Occupancy Rate	N	May-20	85%	65.7%	77.9%	85.8%	93.6%		
		Average Elective Length of Stay	N	May-20	5	2.72	1.44	2.30	3.17		
		Average Non-Elective Length of Stay	N	May-20	5	11.17	7.30	8.71	10.13		
		% of Delayed Transfer of Care Point Prevalence in Month	N	Apr-20	3.5%	0.12%	0.48%	1.62%	2.75%		
		% Medically Fit For Discharge Point Prevalence in Month	L	May-20	7%	28.97%	14.76%	20.13%	25.49%		
	ED Access	ED 4 Hour Performance All Types	N	May-20	95%	93.0%	76.2%	83.2%	90.1%		
		ED 4 Hour Performance Type 1	N	May-20	95%	89.70%	66.53%	75.40%	84.27%		
		ED 12 hour DTA Breaches	L	May-20	0	0	0.00	14.27	54.81		
		60 Mins Ambulance Handover Delays	N	May-20	0	12	0	83	180		

Domain: Responsive – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Bed Occupancy Rate



Indicator Background:

The proportion of beds occupied at midnight.

What the Chart is Telling Us:

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

Actions:

- Number of patients arriving via Ambulance conveyance remains elevated (and system escalated) however is conversion to admission is currently at 21% (reflecting low acuity for our patients.).
- Operational line of sight on CQC plan & IPC plan via Site Operations and tactical structure.

Outcomes:

- Clinical involvement in operational flow which has reduced challenge of internal delays and challenges;
- Reduced number of medically fit for discharge (MFFD) patients has shown an improvement in the length of stay in Older Persons care.
- Patients maintained at centre of decision making and via Site Operations;

Underlying issues and risks:

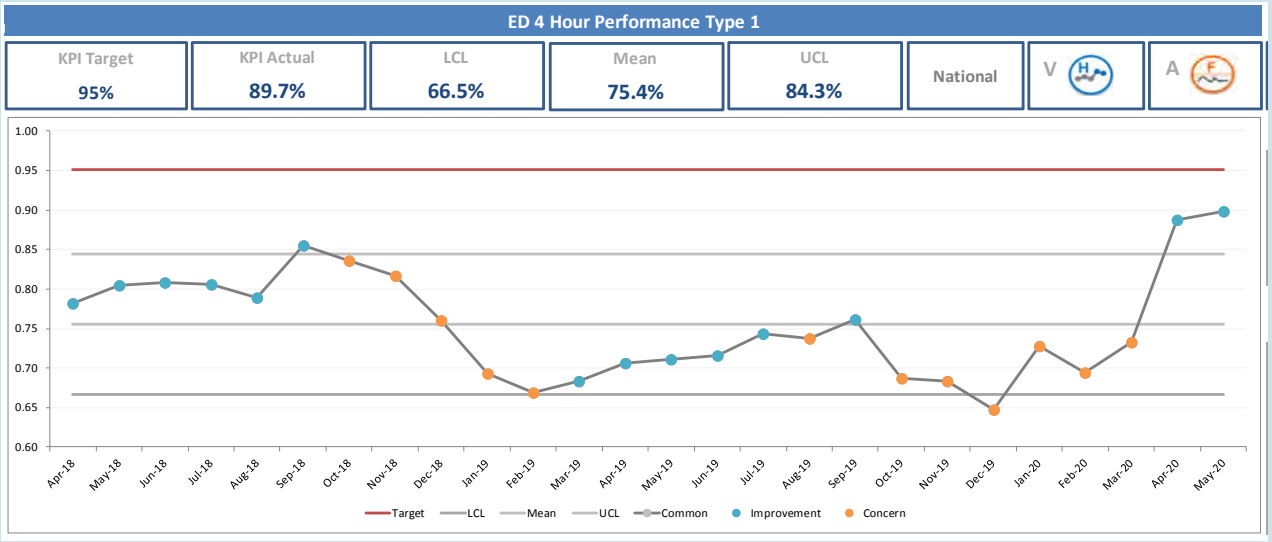
- Beds closed subject to CQC linked estates work. Monitored as part of Tactical Operations.
- Beds closed subject to IPC regulation. Monitored as part of Site Rhythm.
- Increasing bed occupancy in Planned Care with current beds closed / rising demand.

Domain: Responsive – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- OPEL 1 and 2 throughout M2;
- Patient flow co-ordinators remain in support of the clinical emergency team;
- Site rhythm deploys CSM1 in support of PFC;
- Amber patients (>3hrs) reviewed as part of site huddle. CSM and SMOC advised to report to DOC by exception over weekends;
- T1 Admitted performance >80%
- T1 Non-admitted performance >94%
- T3 and satellite performance >98%

Outcomes:

- OPEL monitored and no requirement for FCP actions as yet;
- PFC beginning to embed with operational and clinical support;
- Site rhythm policy escalated to COO to increase clinical involvement in flow;
- T1 admitted performance monitored via site operations & via new daily report from BI;
- T3 performance monitored by MCH;

Underlying issues and risks:

- Reduced CDU capacity as a result of phase 3 estates work (terminates M1 21/22);
- Incremental increase in bed occupancy from elective pathways through M3 onwards;
- Planned care bed capacity under review as part of RESTART programme;
- Weekend intervention and oversight of 4hr performance requires close senior operational support;
- Emergency care staffing remains under close surveillance (re: C19);
- SDEC utilisation at weekends requires intervention;

Domain: Responsive – Elective Dashboard

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

NHS Medway Foundation Trust Integrated Quality & Performance Report

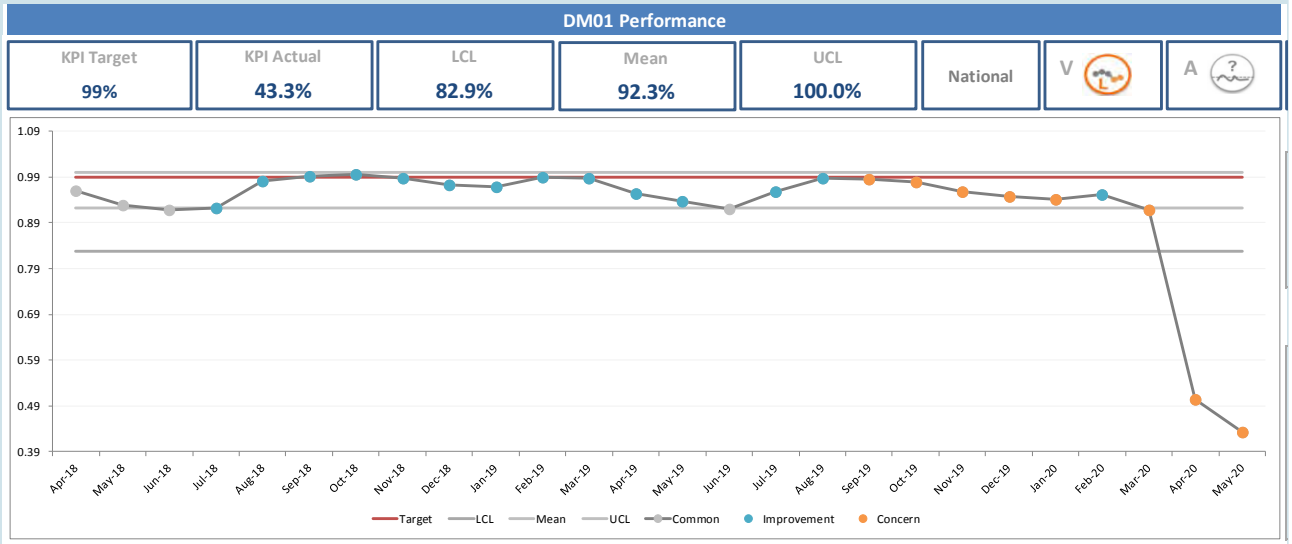
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Direct Access	DM01 Performance	N	May-20	99%	43.3%	82.9%	92.3%	100.0%	L	?
	Elective Access	18 Weeks RTT Incomplete Performance	N	May-20	92%	65.5%	77.5%	81.0%	84.5%	L	F
		18 Weeks RTT Over 52 Week Breaches	N	May-20	0	20.00	0.00	7.31	18.48	H	?
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	N	May-20	0	2.00	0.00	24.04	54.79		?
		Cancelled Operations Not Rescheduled < 28 days	N	May-20	0	0.00	0.00	5.54	14.16		?

Domain: Responsive – Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: DMO1 Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Endoscopy task & finish group implemented
- Endoscopy recovery plan developed
- In depth triaging of patients on waiting list by clinical team
- Reviewing possibility of using Independent Sector Provider for extra capacity as well as already utilised Will Adams Treatment Centre.

Outcomes:

- Triaging of waiting lists patients are being contacted and appropriate clinical decision is being made with regards to their care.
- Clear escalation process in place for imaging with regards to clinically reviewing patients.

Underlying issues and risks:

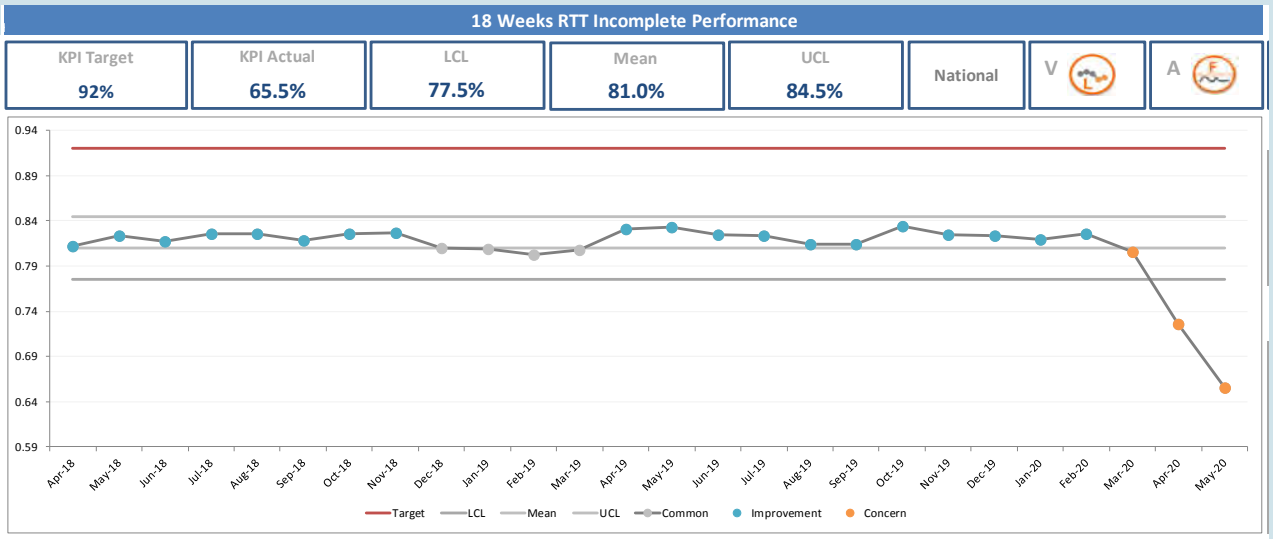
- Endoscopy capacity reduction causing delays in cancer and RTT patient pathways.
- Influx of requests, coming through to the diagnostic services, as we return to normal.

Domain: Responsive – Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Incomplete Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Restore & Recovery plans by speciality, are being implemented.
- Capacity modelling underway taking into account reduced capacity.
- Head of Access has commenced role within the Trust
- Focused PTL meetings on clinically urgent & longest waiter patients

Outcomes:

- Restore & recovery plans used to identify gaps in the services or where specific focus is required.
- Capacity modelling enables foresight on clinically urgent patients and long waiters.
- Head of Access will work closely with services to assist with recovery

Underlying issues and risks:

- Potential increase in long waiters due to capacity recovery plans being implemented.

Domain: Responsive – Cancer and Complaints Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

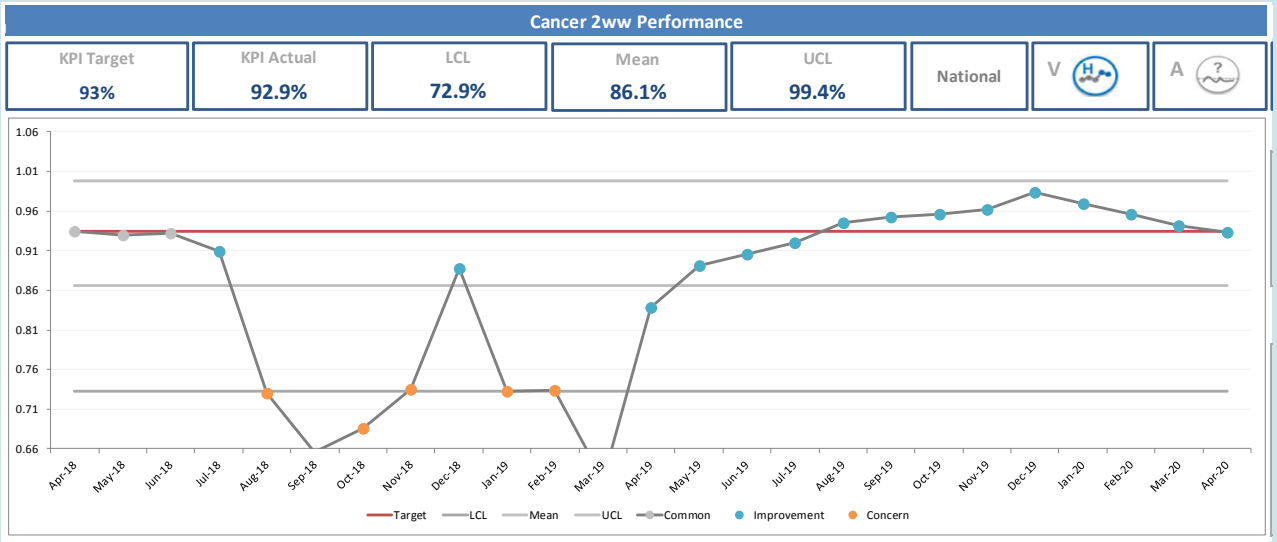
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	N	Apr-20	93%	93%	73%	86%	99%		
		Cancer 2ww Performance - Breast Symptomatic	N	Apr-20	93%	91%	44%	76%	100%		
		Cancer 31 Day First Treatment Performance	N	Apr-20	96%	97%	90%	96%	100%		
		Cancer 62 Day Treatment - GP Refs	N	Apr-20	85%	77%	66%	79%	92%		
		104 Day Cancer Waits	N	Apr-20	0	6	0.63	5.28	9.94		
	Complaints Management	Number of Complaints	N	May-20	41	14	30	62	95		
		% Complaints Responded to Within 30 Days	L	May-20	85%	62%	37%	66%	96%		

Domain: Responsive – Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- The April performance was vastly affected by the huge reduction in the number of referrals into the service reduced by 46% between March and April.
- Live 2WW Cancer performance is shared with all Staff in the Cancer Referrals Office so they are aware of performance in real time opposed to just retrospectively.
- Established better working relationships between CRO staff and tumour site service managers.
- The trust has centralised the booking of all 2WW OPA's (Excluding Lung and Haematology) .

Outcomes:

- Tumour site Service Managers are more reactive to capacity escalations made by the CRO team.
- Clear escalations set for each service allowing enough time for remedial actions to be implemented.
- CRO Booking team now proactively monitoring 2WW Performance throughout the month to maintain compliance against this performance indicator

Underlying issues and risks:

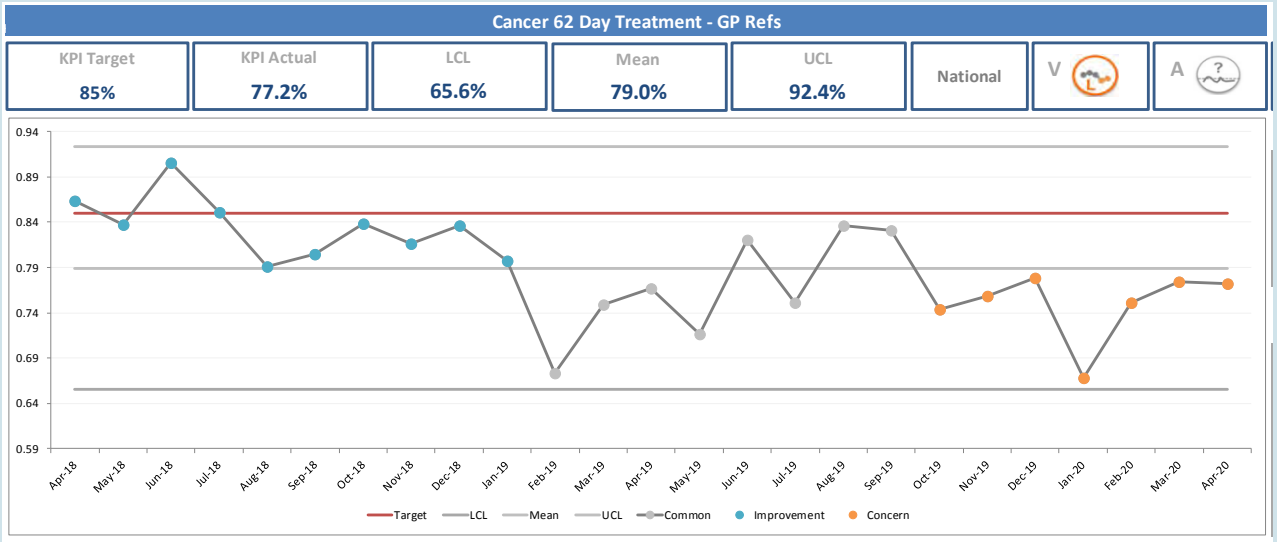
- The Volume of referrals into the service are picking up again post the 1st peak of the COVID 19 pandemic. It is well documented that some services I.E LGI will be able to cope with pre-COVID 19 referral levels and qFIT should have a positive impact in this area.
- COVID 19 could impact services due to capacity and change to how we deliver OPA's.

Domain: Responsive – Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- All 2WW patients who had been switched to alternative pathway have now been moved back onto the 62d PTL.
- Continued Focus on all 'Legacy Patients' (Patients beyond day 62) on PTL.
- Weekly performance updates now shared with Service Managers, General Managers and clinical leads each week, while a monthly trust table is shared so performance can be compared with other tumour sites.
- Weekly PTL figures shared with GM, SM MDT clinical lead and MDTC.

Outcomes:

- Focus on reduction in PTL numbers of patients beyond day 104.
- LGI are now reviewing patients 3x a week to expedite diagnosis treatment or discharge of patients who have undergone requested diagnostics.
- Patients that require clinical review are escalated with the relevant clinician and updated and progressed in a more timely fashion.

Underlying issues and risks:

- Capacity in Endoscopy continues to impact service. 71% of April breaches in GI services.
- 14% of April Trust breaches were in Lung this is due to patient choice, and complex diagnostic pathways 2 patients were discussed 3x times at MDT before starting treatment.
- Tumour Level plans for how to manage patients who Opt not to attend for OPA's and diagnostics to be finalised. Decisions must be patient specific and consultant led.

Domain: Well Led – Dashboard

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

NHS Medway Foundation Trust Integrated Quality & Performance Report

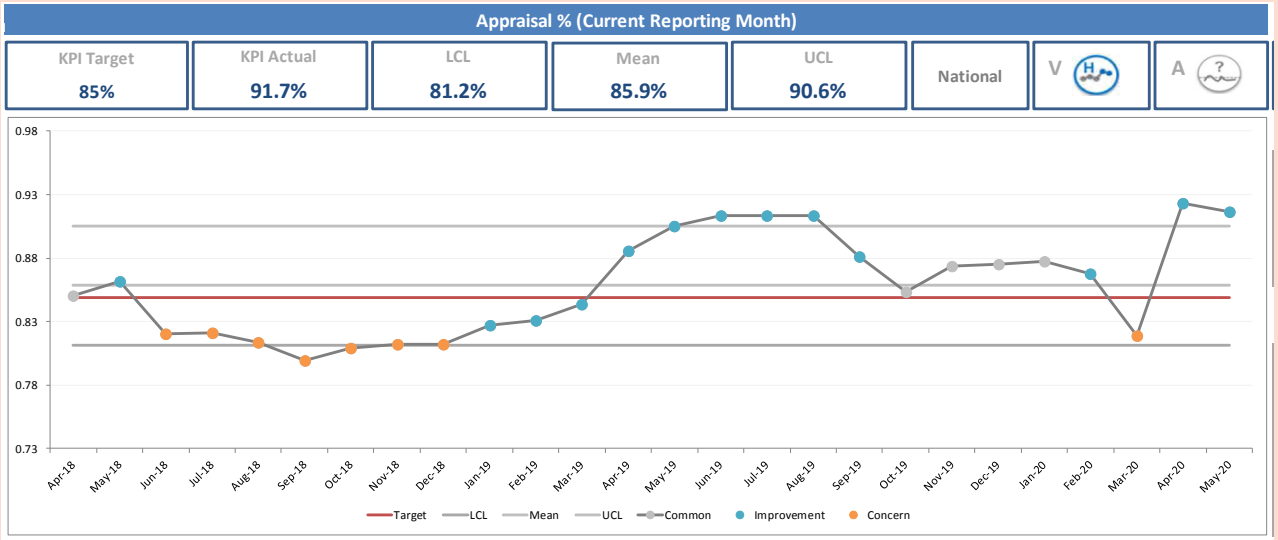
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	L	Sep-19	62%	51.4%	45.5%	49.2%	52.9%		
		Staff Friends & Family - Recommend Care of Treatment	N	Sep-19	79%	67.6%	65.0%	66.9%	68.9%		
	Workforce	Appraisal % (Current Reporting Month)	N	May-20	85%	91.7%	81.2%	85.9%	90.6%		
		Sickness Rate (Current Reporting Month, FTE%)	N	May-20	4%	4.4%	4.0%	4.2%	4.4%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	L	May-20	12%	12.4%	10.8%	12.0%	13.2%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	L	May-20		4,087	3,725	3,841	3,957		
		StatMan Compliance (Current Reporting Month)	N	May-20	85%	87.6%	57.0%	76.8%	96.6%		
		Agency Spend as % Paybill (Current Reporting Month)	L	May-20	4%	2.2%	2.1%	4.1%	6.1%		
		Bank Spend as % Paybill (Current Reporting Month)	L	May-20	9%	16.1%	8.5%	12.8%	17.2%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	L	May-20	75%	68.0%	64.9%	73.6%	82.4%		

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed the appraisal process.

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

- 3689 members of staff have an in-date appraisal with objectives and personal development plan outlined.

Underlying issues and risks:

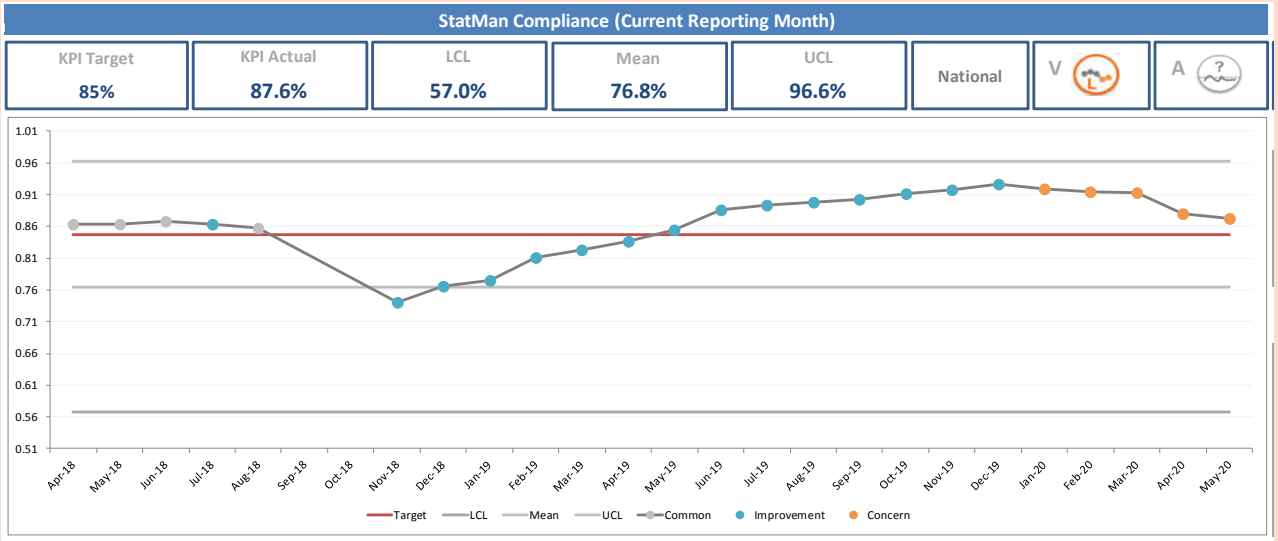
- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Failure to appraise staff timely reduces the opportunity to identify skills requirement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

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: StatMan Compliance (Current Reporting Month)



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

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

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

£k	In-month NHSE/I Baseline	In-month Actual	In-month Variance	YTD NHSE/I Baseline	YTD Actual	YTD Variance
Income	28,654	30,080	1,426	57,308	59,930	2,622
Pay	(18,216)	(19,866)	(1,650)	(36,432)	(38,047)	(1,616)
Total non-pay	(9,101)	(8,939)	162	(18,202)	(19,261)	(1,058)
Non-operating expense	(1,337)	(1,296)	41	(2,674)	(2,644)	31
Reported surplus/(deficit)	**(0)**	**(21)**	**(21)**	**(0)**	**(21)**	**(21)**
Donated asset deprecation	0	21	21	0	21	21
Control total	**(0)**	**0**	**0**	**(0)**	**0**	**0**

Indicator Background:

The Trust reports a £21k deficit position for May; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total.

What the Chart is Telling Us:

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

Actions:

- Deep dive reviews into staff costs to understand deployment of resources.
- CIP development and implementation of efficiencies within divisions.
- Financial modelling based on operational actions to “restore, recover, return”.

Outcomes:

- The Trust has met its control total, however this includes:
- Incremental costs associated with Covid-19 in month £2.3m (£4.0m year to date).
- In month “true-up” income accrued to achieve breakeven £2.0m (£3.6m year to date).

Underlying issues and risks:

- Clinical income on a cost and volume basis is £13.8m adverse to plan YTD (£6.1m adverse in-month). being the impact of reduced activity as a result of Covid.
- Gap between RAG rated CIP programmes and the draft budget requirement of £12m. Staff costs have continued to rise despite the significant reduction in activity during April and May.

Meeting of the Board of Directors in Public

Thursday, 02 July 2020

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.3**
Committee Chair:	Tony Ullman, Non-Executive Director		
Date of Meeting:	Tuesday, 16 June 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. Review of serious incidents The committee received a paper from David Sulch, Medical Director who undertook a review of Harms Resulting from Serious Incidents as an action from the previous meeting. The Chief Nurse had also contributed to the paper to setting out the background information and work the Trust had progressed to date to strengthen and improve the investigation and management of serious incidents. The review highlighted that the original harm rating recorded and included in the reporting had not subsequently been updated following any decisions to downgrade an SI following either closure of SIs at the external CCG panel. The Chief Nurse has requested the Associate Director of Quality & Patient Safety to address this matter and to ensure the final graded level of harm is included in future reports. As part of the reporting to QAC on patient safety and quality the committee requested a paper at a future meeting detailing a comprehensive analysis of the themes, lessons and learning from Serious Incidents including actions taken to mitigate risk of reoccurrence.	**Green**
2. COVID-19 The committee were updated on COVID by Harvey McEnroe, Chief Operating Officer who explained that the Trust has now moved into a restart recovery and restore following the	**Green**

response to COVID-19. This phase is about focusing on restarting elective care and ensuring sufficient capacity for the emergency care pathways. The Trust is compliant as an organisation for all staff, patients and visitors wearing face masks as per national guidance. Work will continue over the next few weeks on the recovery focused on the restructure of the bed base and emergency and elective pathway. Harvey advised the committee that he has briefed the Trust Board on the work last week. Harvey will provide updates to the committee. Jane Murkin, Chief Nurse (interim) explained that she had facilitated 3 listening events for nursing and midwifery staff that had been redeployed to other areas within the Trust during the COVID-19 response. The events were to seek feedback from staff about their experience, and to consider what actions the Trust can take in the ongoing professional development and in preparation of any future major incidents, winter planning issues or a second wave of COVID. Jane outlined that these were powerful events where staff had the opportunity to share their experiences, some of which were very emotional for the staff and identify lessons, themes and learning to be considered in any future requirements to redeployment of nursing staff and consideration of future professional development for the nursing and midwifery workforce. Jane outlined the ongoing work to support staff at this time. The committee discussed the Trust approach for supporting BAME staff and were advised of the process is in place and access to HR for one to one discussions with individuals about their fitness to work, and the additional risk assessments to support BAME staff. Harvey advised that there is also a priority task and finish group to focus on staff welfare. The committee also discussed the benefits of providing additional support for example offering vitamin D to BAME staff and or all staff and this could be financed by the hospital charity, Harvey will progress this with Leon Hinton, Director HR & OD.	
2. CQC progress update The committee was informed by Jane Murkin; Chief Nurse (interim), that the Trust has submitted a copy of the Trusts final CQC action plan and formal letter of response to the CQC on 28 May 2020. Jane outlined that the Trust had this week received a request for further evidence relating to the IPC action plan, IPC Board Assurance document and the COSSH action plan. Jane advised the committee that the High Quality Care Programme Board has now been established and is meeting later this month. The committee will continue to receive monthly updates on the progress on CQC.	**Amber/Green**
3. Quality Report The committee received the quality report which continues to report progress against the implementation quality strategy, SI reporting and quality matters. The committee will continue to receive the quality report on a monthly basis.	**Green**
4. IPC Framework The committee received the IPC Board Assurance Framework that has been completed by Esther Taborn and Ian Hosein. Jane stated that the framework has been shared with NHSEI in its draft format. Ian Hosein raised a risk relating to the concerns regarding swabbing, testing and laboratory processes at NKPS, as there is variation and issues and these do not provide assurance in relation to the results. Harvey reassured the committee that he has raised the concerns with NKPS and Ian in his role as DIPC will be providing support to NKPS via the newly formed Swabbing and Testing Care Group. The issues with NKPS will be added to the corporate risk register. The committee will receive progress updates against the IPC framework and on the improvements being made at NKPS.	**Amber/Green**
5. Best Flow Programme The committee received a presentation from Harvey McEnroe, Chief Operating Officer on	**Green**

best flow programme and the significant improvements that have been made by each of the eight workstreams on performance across the Trust. The committee felt reassured by the progress and improvements that have been made but questioned if we can maintain the Type 1 and A&E improvements as we go into 'restore' phase. The committee will receive updates on the restore phase from Harvey at a future meeting.	
6. Patient Experience Workshop Jane Murkin, Chief Nurse (interim) advised the committee of the work previously undertaken relating to the Trust Patient Experience Workshop held in November last year which was facilitated by Jane and Lesley Goodburn, National Lead NHSEI. The workshop was attended by staff and external stakeholders and was an opportunity to undertake an organisational assessment of patient experience within the Trust against the National Patient Experience Strategy. Jan outlined plans for the second workshop to complete the assessment process which will inform the development of the strategy and identify key actions the Trust will take to raise the profile and focus on patient experience. Jane also briefed the committee on plans to appoint an Associate Director of Patient Experience and have a senior professional lead to progress this work.	**Green**
7. IQPR The committee received an update on the refresh of the IQPR since the last meeting. Gurjit explained that the data has been linked and work is taking place to ensure the narrative is meaningful and statistical and completed by the services in a timely way. The committee discussed the reliability of the data and requested Gurjit work the Jack Tabner on how IT can support the data quality. The committee will receive the final IQPR at the July 2020 meeting.	**Amber/Green**
6. BAF – Quality The committee received the updated BAF on Quality which had been updated following the last committee meeting by Jane Murkin, Chief Nurse (interim) and Katy White. Supported by Gurjit Mahil as Lead Exec for the BAF. The committee discussed and reviewed each of the risks and asked that at the next meeting the BAF – quality comes with a trajectory to demonstrate a reduction in the risk score overtime. The committee discussed the addition of 5e relating to the impact of the loss of services to the Trust will have on quality and agreed for this to be added to the BAF. The Committee will continue to monitor the Quality BAF at future meetings.	**Amber/ Green**
7. Exception report from Quality and Patient Safety Group The committee received an exception report from the Quality and Patient Safety Group and also received its terms of reference for approval which Jane Murkin, Chief Nurse talked to. The committee was informed that this is a newly re-established group that has replaced the previous Quality Improvement Group and Patient Safety Group as part of the refreshed governance approach. The group has reviewed progress on delivery of the quality strategy, the back log of Datix and serious incidents and received key issues reports from its sub-groups. The Quality Assurance Committee will receive monthly exception reports.	**Green**
Further Risks Identified There were no further risks identified.	
Escalations to the Board or other Committee The quality assurance committee escalates the following issues to Trust Board 1) Concerns about lab capacity at NKPS 2) Incident reporting – work on the process 3) Impact of COVID on BAME staff	

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	Safe Staffing Nurse Establishment Review	**Agenda Item**	4.4
Report Author	Simone Hay, Divisional Director of Nursing Karen McIntyre, Divisional Director of Nursing Julie Murray Associate Director of Nursing		
Lead Director	Jane Murkin, Chief Nurse (Interim)		
Executive Summary	As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, provider Trust Boards are required to receive an annual review and approve any changes to nursing establishments. Therefore the purpose of this report is to focus solely on the adult in-patients ward nursing establishments as per the national requirement. In addition, as of April 2019, NHS providers are now assessed against the Workforce Safeguards Guidance (NHS Improvement (NHSI) 2018) to support the application of workforce planning and safe staffing decisions. NHSI has added a section to the Annual Governance Statement within the Annual Report and Accounts specifically about staffing governance processes. In response to this section, the Trust must describe or explain the extent of its compliance with the NQB guidance. This paper provides assurance to the Trust Board that nurse staffing levels on the in-patient wards at Medway NHS Foundation Trust have been reviewed in line with the Workforce Safeguards (NHSI October 2018), which incorporate the National Quality Board (NQB) standards. This nurse staffing review was carried out using the nationally recommended Safer Nursing Care Tool (SNCT) on 21 wards across the Trust with a six-month review. Prior to the implementation of any post COVID reconfiguration of wards services and changes, a further safe staffing review will be undertaken. The divisions commenced this annual review in October 2019. Following this a process was followed by which the Heads of Nursing validated the Safer Nursing Care Tool (SNCT) data by application of their professional judgement. Further application of professional judgement was carried out and challenged by the Divisional Directors of Nursing, who approved the proposed recommendations. The Chief Nurse endorsed the recommendations contained herein and presented this paper to the Executive Group on 15 April 2020 which the Executive Group approved. The Executive Group welcomed that the Chief Nurse will be undertaking a full and in-depth review of the nursing and midwifery workforce, which will include nursing standards and quality outcomes, and that the Chief Nurse had commissioned the Director of Finance to undertake a parallel financial review of the nursing and midwifery workforce costs. The Director of Finance has scrutinised the associated coasts contained within this paper.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐

(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)	**Finance:** We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Executive Group Approval:	Date of Approval: 15 April 2020	
National Guidelines compliance:	This paper conform to National Guidelines : National Quality Board (2016) Workforce Safeguards Guidance (NHS Improvement (NHSI) 2018)	
Resource Implications	The divisional finance teams have costed up the recommendations for additional posts in line with the 2020/21 business planning process. Based on the ward arrangements pre COVID, an additional 65.31FTE are required above the 19/20 in-patient ward nursing establishment, equating to an additional £2,083,401 (I.e. above the 2020/21 budget which is based on 2019/20 forecast outturn).	
Legal Implications/Regulatory Requirements	Failure to comply with validated safe staffing levels, in line with Royal College of Nursing (RCN) guidance, the National Institute of Clinical Excellence (NICE) guidelines, NHSI recommendations and Care Quality Commission Regulations, could lead to the Trust not meeting its terms of authorisation, resulting in breaches of regulations.	
Quality Impact Assessment	Not applicable for this report.	
Recommendation/ Actions required	The Board is recommended to: - Discuss the content of this review. - Endorse the decision of the Executive Group to support uplifting of the recommended Registered Nurse and Clinical Support Worker posts to support safe nurse staffing levels. - Delegate to the Executive Group to determine how this investment will be afforded, alongside the post COVID reconfiguration plan.	

Approval	Assurance	Discussion	Noting
X	☐	☒	☐

1. Introduction

1.1 The purpose of this paper is to provide the Trust Board with the annual safe nurse staffing review, carried out in line with the guidance and requirements as cited by the National Quality Board, Workforce Safeguards Standards, Lord Carter: Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, and the NICE approved Safer Nursing Care Tool (SNCT).

1.2. As such, this report focusses solely on the pre-COVID configuration of the adult in-patient ward nursing establishments as per the national requirement; however the Chief Nurse will be undertaking a broader nursing and midwifery workforce review, which will include nursing standards and quality outcomes, the outcome of which will be reported on in July 2020. The Finance Director has undertaken a parallel review of how much and where the nursing and midwifery money has been spent.

1.3. All Trust Boards have a duty to ensure that safe staffing levels are in place and that patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality.

1.4. In July 2016, the National Quality Board (NQB) published "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing". This safe staffing improvement resource provides an updated set of expectations for nursing and midwifery care staffing, to help NHS Trust Boards make decisions that will support the delivery of high quality care for patients within the available staffing resource. This resource:

1) sets out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric

2) identifies three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions; and

3) offers guidance for local providers on using other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care.

1.5. The Care Hours Per Patient Day (CHPPD) metric is a measure which shows on average how many hours of care time each patient receives on a ward/ department during a 24 hour period - this will vary across wards and departments based on the specialty, interventions, acuity and dependency levels of the patients being cared for. Enhanced Care (also known as specialling) occurs when patients in an area require more focused care than we would normally expect. In such circumstances extra, unplanned staff are assigned to support that ward. If enhanced care is required the ward may show shifts as being over filled. If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed. The NHS England guidance 'A Guide to Care Contact hours' (2014) recommends the inclusion of CHPPD by nursing and midwifery staff in establishment reviews.

1.6 Since April 2019 NHS provider boards have been assessed against NHSI guidance 'Developing Workforce Safeguards (NHS I 2018). By implementing this report's recommendations, the Executive and Trust Board can be assured that these workforce decisions will promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, NHSI Use of Resources assessment and the Board's statutory duties. The Executive Group is directed to note that NHSI has since added a section to the Annual Governance Statement within the Annual Report and Accounts specifically about staffing governance processes. In response to this section, the Trust must describe or explain the extent of its compliance with the NQB guidance.

1.7 In addition, the Nursing and Midwifery Council (NMC) sets out nursing and midwifery responsibilities in relation to safe staffing levels, and, demonstrating safe staffing is one of the standards that all healthcare providers must meet to comply with Care Quality Commission (CQC) regulations.

1.8 Evidence demonstrates that appropriate staffing levels and skill mix positively influences patient outcomes whereas poor nurse staff levels are attributable to increases in patient harm resulting in increased length of stay and incurring financial costs.

1.9 This paper is aligned to the Trusts five strategic priorities, High Quality Care, Integrated Healthcare, Innovation, financial stability and our people. Safe staffing will positively impact on the implementation of The Trusts Quality Strategy, People Strategy, Clinical Strategy and will support the delivery of safe, effective and person centred care. It is essential as an organisation that we have a stable and talented workforce; responsive to peaks in demand and able to deliver high quality health care.

1.10 This report outlines the pre-COVID ward configuration nursing establishments across all adult inpatient areas and makes recommendations on provision of safe nurse staffing levels. This investment will ensure sufficient substantive staff to deliver high standards of evidenced based care.

1.11 Based on an assessment of the areas of highest risk relating to the analysis of safe staffing requirements (section 5) and acknowledging that there are no plans to reduce the hospital bed base following the recovery and restart programme post COVID, work will be progressed in partnership with the Director of HR / OD to commence recruitment.

1.12 A phased approach to recruitment will take place and therefore the financial implications for this year will be reduced.

1.13 Specialist areas such as maternity, paediatrics, theatres, the emergency department and critical care are subject to separate specialist reviews and will be reported upon in July 2020.

2. Background

2.1. The Safer Nursing Care Tool (SNCT) is the NICE recommended tool and provides a standardised and systematic measure of nurse staffing levels at ward level, calculating adult inpatient ward staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guide Chief Nurses in their safe staffing decisions. The SNCT is in use across the inpatient wards of the Trust and allows nurses to take decisions on nurse staffing levels in line with patient acuity and dependency.

2.2. The SNCT acuity and dependency data collection is recorded at defined intervals throughout the 24-hour period. This allows for staff to be reallocated or additional staff to be requested to ensure that patient safety within the clinical areas is maintained according to acuity and dependency. There is a red flag process for staff to raise concerns to the senior nursing team.

2.3. The CHPPD data can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of the clinical support workers and dividing that by the total number of inpatients. Since collection of this data commenced in June 2016, there has been national variability in the data which has been captured, therefore it is not recommended that CHPPD data is used in isolation and must be used alongside the SNCT and the professional judgement of the senior nursing team.

3. Historical Establishment Review Process and Outcomes

3.1. Tables three and five at section five of this report show that in 2018 there was a reduction in the funded nurse establishment of 90.00 FTE. This was due to the Trust reporting CHPPD above the national average and was an outliner when compared to peer organisations. It should be noted at this point however that the 2018 review used patient acuity and CHPPD only and did not follow the national recommendation of application of SNCT to support setting of nurse establishments. The 2019 establishment reviews were undertaken using the SNCT, however it should be noted that these reviews were undertaken over a seven day period and not for the recommended 20 day census period. . Recommendations for an increase in nurse establishment were taken to the Board for a decision but the ensuing nurse establishments were funded on the outturn financial position and not on the recommendations presented. This left Planned Care with a shortfall of 16.19 FTE. It was agreed that the Planned Care Division should continue to staff to safe staffing levels, although this was not reflected in the budget and was added as a cost pressure for the division to fund within its Cost Improvement Plan (CIP).

3.2. In undertaking the 2020/21 nursing establishment review, the Chief Nurse is confident that this has been undertaken in line with all of the requirements set out within the guidance mentioned in section one.

4. Methodology

4.1. SNCT data was collected and recorded on each shift over a 20 day period in October 2019 by the nurse in charge of the shift.

4.2. Validation of the data was undertaken by the corporate nursing workforce team using the following principles:

1) The ward manager was to be in a supervisory role. The supervisory role facilitates the oversight of quality standards, management of complaints, incidents, staff management, supervision and appraisal and is recognised to be pivotal in supporting effective ward leadership.

2) The nurse in charge was to be outside of the clinical numbers

3) There must be a Band 6 registered nurse (RN) on each shift

4) The RN: CSW ratio had to be set at 60:40 ratio

5) A 22 percent uplift was applied in line with national guidance to allow cover for study leave, annual leave and sickness

4.3. Analysis of this data identified the adjustments needed to meet safe staffing.

4.4. The Heads of Nursing reviewed the analysis and applied professional judgement to validate the data which was then further challenged and corroborated by the Divisional Directors of Nursing. Professional judgement included an assessment of best practice standards and avoidance of harm to safeguard our patient.

4.5. These validated establishment recommendations were provided to the divisional finance teams who provided the detailed financial cost of the recommendations.

5. Analysis

5.1. Nationally, the Trust is the third quartile (between median and highest quartile) for spend on nursing per weighted activity unit (WAU) at £970 per WAU, the peer median is £858 per WAU (11.55% lower than existing Trust costs). In relation to this the Chief Nurse will be undertaking a Trust wide nursing and midwifery workforce review and continues to recruit to vacant substantive positions currently covered by bank and agency. Based on the methodology described above, the data in the tables below shows the Trust summary of adjustments needed to meet safe staffing against the previous year.

5.2. Table 1

	2019/20 FTE	2020/21 FTE Safer Staffing	Difference
Total	**801.36**	**866.68**	**65.31**
	2019/20 Annual Budget	**2020/21 Safer Staffing**	**Difference**
Total	**£30,990,110**	**£33,415,890**	**+ £2,425,780**

Table 2

	2020/21 Annual Budget based on 2019/20 FOT	2020/21 Budget Proposal for Safer Staffing	Difference
Base	**£31,090,176**	**£33,415,890**	**£2,325,714**
Adj for top of scale		**(£242,313)**	**(£242,313)**
Total requirement	**£31,090,176**	**£33,173,577**	**2,083,401**
Base costed additional staff at top of scale. Cost adjusted down to mean of scale.			

This is the full year cost of the proposal; the actual cost in 2020/21 will be less depending on when and at what rate the proposal is implemented.

Table 3

Ward	April 2018 FTE funded	April 2018 FTE change request	2019/20 FTE Current Budgeted	2020/21 FTE Proposed	Difference	Cost Implication (Diff from 2019/20 Budget)
Unplanned and Integrated Care						
Arethusa Ward	40.3	38.0	42.74	54.86	+12.12	£477,288
Bronte Ward	36.0	28.1	33.42	35.74	+2.32	£88,178
Byron Ward	42.9	35.6	37.32	42.58	+5.26	£155,244
Coronary Care Unity (CCU)		No change	13.22	14.25	+1.03	£27,713
Harvey Ward	40.3	38.3	43.75	46.75	+3.00	£123,050
Keats Ward	35.1	35.2	37.59	43.26	+5.69	£166,446
Lister (AMU)		No change	56.05	57.33	+1.28	£194,914**
Milton Ward	51.0	38.3	40.06	47.84	+7.78	£294,526
Nelson Ward	32.4	32.7	35.57	34.95	-0.62	-£23,142
Sapphire acute frailty unit		No change	40.57	37.82	-2.77	-£72,633
Tennyson ward	43.3	35.6	37.85	48.37	+10.53	£367,159
Wakeley ward	45.5	38.3	38.96	40.84	1.88	-£9,319**
Will Adams ward	35.1	35.2	37.57	43.26	+5.69	£168,032
Total	**401.9**	**355.3**	**494.67**	**547.85**	**+53.19**	**£1,957,457****

Table 4

Ward	2020/21 Draft Budget Based on 19/20 FOT	2020/21 Safer Staffing Proposal	Difference (from 2019/20 FOT)
Unplanned and Integrated Care Division			
Arethusa Ward	£ 1,603,760	£ 1,999,588	£ 395,828
Bronte Ward	£ 1,255,798	£ 1,296,539	£ 40,741
Byron Ward	£ 1,407,585	£ 1,496,845	£ 89,260
Coronary Care Unity (CCU)	£ 563,449	£ 556,764	-£ 6,685
Harvey Ward	£ 1,644,370	£ 1,658,693	£ 14,323
Keats Ward	£ 1,464,842	£ 1,518,823	£ 53,981
Lister (AMU)	£ 1,887,743	£ 2,228,997	£ 341,254
Milton Ward	£ 1,508,929	£ 1,708,760	£ 199,831
Nelson Ward	£ 1,325,853	£ 1,261,861	-£ 63,992
Sapphire acute frailty unit	£ 1,395,910	£ 1,352,611	-£ 43,299
Tennyson ward	£ 1,523,118	£ 1,720,299	£ 197,181
Wakeley ward	£ 1,415,266	£ 1,375,174	-£ 40,092
Will Adams ward	£ 1,536,867	£ 1,518,823	-£ 18,044
Total	**£ 18,533,490**	**£ 19,693,777**	**£ 1,160,287**

Table 5

Planned Care	April 2018 FTE funded	April 2018 Proposed Change	2019/20 FTE Current funded	2020/21 FTE Proposed	Difference	Cost implication
Kingfisher/SAU	48.0	42.9	43.76	43.76	0	0
Lawrence Ward	35.0	30.3	35.98	38.94	+2.97	£126,980
McCulloch	45.6	40.5	40.48	40.48	0	0
Ocelot		No Change	20.19	20.36	+0.17	£67,864**
Pembroke	50.8	40.5	45.73	50.98	+5.25	£166,482
Phoenix	50.8	40.5	40.48	44.22	+3.74	£106,997
Sunderland		No change	34.29	34.29	0	0
Victory ward	35.1	27.2	27.24	27.24	0	0
Total	**265.30**	**221.90**	**306.70**	**318.82**	**+12.12**	**£468,323****

Table 6

Ward	2020/21 Draft Budget Based on 19/20 FOT	2020/21 Safer Staffing Proposal	Difference (from 2019/20 FOT)
Planned Care			
Kingfisher Ward	£1,508,929	£1,708,760	£199,831
Lawrence Ward	£1,464,842	£1,518,823	£53,981
McCulloch Ward	£1,622,127	£1,747,946	£125,819
Ocelot Ward	£809,735	£895,348	£85,613
Pembroke Ward	£1,887,743	£2,228,997	£341,254
Phoenix Ward	£1,614,093	£1,816,802	£202,709
Sunderland Ward	£1,325,791	£1,362,177	£36,386
Victory Ward	£997,573	£1,181,398	£183,825
Total	**£12,566,686**	**£13,722,113**	**£1,165,427**

6. Unplanned and Integrated care Divisional Analysis

6.1. The adjustments in the nursing establishment required to meet the safe staffing recommendations within the Unplanned and Integrated Care Division is summarised in the table below and further expanded upon within the commentary against each ward.

	2019/20 FTE	2020/21 Safer Staffing FTE	Difference
Total	494.66	547.86	53.19

	2019/20 Annual Budget	2020/21 Annual Budget	Difference
Total	£17,736,320	£19,693,777	£1,957,457

	2020/21 Draft Annual Budget based on 2019/20 FOT	2020/21 Annual Budget Proposal for Safer Staffing	Difference
Total	£ 18,533,490	£ 19,693,777	£ 1,160,287

6.2. **Arethusa ward**

a) Arethusa is a short stay medical ward consisting of 27 beds; service reconfiguration requires the ward to change to an Acute Assessment ward, and therefore the recommended changes for nurse establishment reflect the increased complexity of patients. Going forward, where there are any significant changes to the functionality or activity of a clinical ward or department, then an associated Quality Impact Assessment will include a formal review of nurse staffing requirements to ensure safe staffing levels are provided.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £186, 047.89 attributed in year (April – Dec 2019).

c) Recommendation: increase the nursing establishment by 12.1 FTE to a total nursing establishment of 54.9FTE, thus allowing for an additional two RN each long day shift and one additional RN each night shift.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £395,828.

6.3. **Bronte ward**

a) Bronte' is a specialist respiratory ward consisting of 18 beds, SNCT data identifies that the ward has on average four level 2 patients per day requiring non-invasive ventilation (NIV). These patients require enhanced nursing care and staffing ratios to support a 1:2 RN: patient ratio for an initial period of 24hrs and then a 1:4 RN: patient ratio.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £82,240.64 attributed in year (April – Dec 2019).

c) Recommendation: Currently Bronte has one additional RN FTE over the winter period. The SNCT analysis suggests that this should be for the full 12 month period, which equates to 1.8 FTE uplift to the nursing establishment to cover one additional RN for each long day.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £40,741.

6.4. **Byron ward**

a) Byron is a specialist elderly care ward consisting of 26 beds. SNCT data analysis identified an increase in patient acuity and dependency on the ward. Within the census period four patients had falls on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £134,074.21 attributed in year (April – Dec 2019).

c) Recommendation: increase the nursing establishment by 5.3 FTE to a total nursing establishment of 42.6 FTE thus allowing for an additional CSW each long day shift.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £89,260

6.5. **Coronary Care Unit (CCU)**

a) The CCU is a specialist cardiac critical care unit of four beds and a cardiac pacing suite. Patients within the unit meet the criteria for level 2 critical care staffing of RN: patient ratio of 1:2. Currently there is CSW support for the early shift, however this does not allow for safe nursing care and on occasion the pacing room is used to support an additional in-patient requiring specialist cardiac care.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £50,070.38 attributed in year (April – Dec 2019).

c) Recommendation: increase nursing establishment by 1.0 FTE to a total nurse establishment of 14.2 FTE thus allowing for a CSW to work a long day shift rather than an early shift.

d) Budget setting from the 2019/20 outturn position is sufficient to fund safer staffing.

6.6. **Harvey ward**

a) Harvey is a specialist stroke ward consisting of 25 beds. These patients are highly dependent due to their clinical condition, often requiring two nurses for one patient to support the provision of the fundamental standards of care. SNCT data analysis shows an increase in patient acuity and dependency on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £284,786.05 attributed in year (April – Dec 2019).

c) Recommendation: increasing the nursing establishment by 3.0 FTE to a total nursing establishment of 46.7 FTE will allow for an additional RN each long day shift and one RN each long night shift. Additionally the ward requires one extra CSW each long day shift.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £14,323.

6.7. **Keats ward**

a) Keats ward is a specialist gastroenterology ward consisting of 26 beds. The speciality ward supports patients who are withdrawing from the effects of alcohol and drugs misuse. These patients can exhibit challenging clinical and emotional requirements requiring enhanced levels of nursing support. The SNCT data analysis shows an increase in both patient acuity and dependency on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £212,667 attributed in year (April – Dec 2019).

c) Recommendation: increasing the nursing establishment by 5.7 FTE to a total nursing establishment of 43.3 FTE will allow for one additional CSW each long day shift and one additional CSW each long night.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £53,981.

6.8. **Lister (AMU)**

a) Lister ward is an acute assessment ward consisting of 25 beds incorporating a GP assessment bay, however this is frequently used for additional inpatient capacity. Analysis of the SNCT data highlights that there has been an increase in patient acuity and dependency on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £387,204 attributed in year (April – Dec 2019).

c) Recommendation: increasing the nursing establishment by 1.3 FTE to a total nursing establishment of 57.3 FTE will provide safe staffing for the ward and to cover the GP assessment bay.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £341,254.

6.9. **Milton ward**

a) Milton ward is a 27 bedded elderly care ward incorporating a specialist dementia unit. These patients require enhanced care levels to support safe care. The SNCT data shows there has been an increase in both patient acuity and dependency on the ward.

b) The 2018 establishment review, referenced at section 3.1, saw the removal of 12.7 FTE from the nursing establishment.

c) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £162,530.65 attributed in year (April – Dec 2019).

d) Recommendation: by increasing the nursing establishment by 7.8 FTE to a total nursing establishment of 47.8 FTE will support two additional RN each long day shift and one additional RN and one additional CSW each long night shift.

e) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £199,831.

6.10. **Nelson ward**

a) Nelson ward is a 24 bedded coronary care ward incorporating nine telemetry cardiac monitoring beds. Analysis of the SNCT data identifies that the current nurse establishment is sufficient to deliver safe care.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £153,130.31 attributed in year (April – Dec 2019).

c) Recommendation: no change to the current nurse establishment.

d) Budget setting from the 2019/20 outturn position is sufficient to fund safer staffing.

6.11. **Sapphire Acute Frailty Unit (SAFU)**

a) SAFU is a 22 bedded acute frailty unit incorporating 3 outpatient clinic rooms on the ward. SNCT data analysis highlights that there has been a decrease in both patient acuity and dependency on the ward.

b) Recommendation: reduce the nursing establishment by 2.7 FTE to a total nursing establishment of 37.8 FTE. This will deliver a cost saving of £72,633.

c) Budget setting from the 2019/20 outturn position is sufficient to fund safer staffing.

6.12. **Tennyson ward**

a) Tennyson ward is a 27 bed elderly care ward. Analysis of the SNCT data identifies that there has been an increase in patient acuity and dependency on the ward.

b) The 2018 establishment review, referenced at section 3.1, saw the removal of 7.7 FTE from the nursing establishment.

c) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £162,831.63 attributed in year (April – Dec 2019).

d) Recommendation: increasing the nursing establishment by 10.5 FTE to a total nursing establishment of 48.4 FTE will support an additional RN and one additional CSW each long day shift and one additional RN and one additional CSW each long night shift. This is based on an average of four patients per 24 hours requiring enhanced care.

e) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £197,181.

6.13. **Wakeley ward**

a) Wakeley ward is a 25 bed ward for medically optimised patients awaiting transfer to a community setting. SNCT analysis identifies that there has been an increase in patient acuity and dependency on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £119,948.73 attributed in year (April – Dec 2019).

c) Recommendation: no change to nurse establishment.

d) Budget setting from the 2019/20 outturn position is sufficient to fund safer staffing.

6.14. **Will Adams ward**

a) Will Adams ward is a 26 bedded ward for general medical and endocrine patients. Analysis of the SNCT data identifies an increase in patient acuity and dependency on the ward.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £189,534.95 attributed in year (April – Dec 2019).

c) Recommendation: by increasing the nursing establishment by 5.7 FTE to a total nursing establishment of 43.3 FTE will support an additional CSW each long day shift and one additional CSW each long night shift.

d) Budget setting from the 2019/20 outturn position is sufficient to fund safer staffing.

7. Planned Care Divisional Analysis

The adjustments in the nursing establishment required to meet the safe staffing recommendations within the Planned Care Division is summarised in the table below and further expanded upon within the commentary against each ward. As referenced at section 3.2, the Planned Care Division budgeted nursing establishment in 2019 was not adjusted to reflect safe staffing requirements, therefore there was a shortfall of 8.67 FTE in the budgeted establishment.

	2019/20 FTE	2020/21 FTE	Difference
Total	306.70	318.82	12.12
	2019/20 Annual Budget	2020/21 Annual Budget	Difference
Total	£13,253,790	£13,722,113	£468,323
	2020/21 Draft Annual Budget based on 2019/20 FOT	2020/21 Annual Budget Proposal for Safer Staffing	Difference
Total	£12,556,686	£13,722,113	£1,165,427

7.1. **Kingfisher Ward/ Surgical Assessment Unit (SAU)**

a) Kingfisher ward is a 14 bedded ward for urology patients and incorporates eight trolleys as part of the SAU. Currently SAU functions during evenings, nights and weekends only, however plans are being formulated to convert SAU back to a 24/7 facility. A separate nursing establishment review will take place when the change of function of SAU is approved. Analysis of the SNCT data has identified that the current nursing establishment is sufficient to deliver safe care.

b) The budget for an additional waiting room RN and hot clinic nurse was transferred to SDEC when SDEC was opened, if SAU reverts to a 24/7 function then that budget will need to transfer back into Planned Care.

c) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £326,314.53 attributed in year (April – Dec 2019).

d) Recommendation: no change to the current nursing establishment.

e) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £199,831.

7.2. **Lawrence Ward**

a) Lawrence ward is a 19 bedded specialist ward for haematology and oncology patients. Analysis of the SNCT data has identified that there has been an increase in patient acuity and dependency on the ward due to the number of chemotherapy treatments administered.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £180,277.60 attributed in year (April – Dec 2019).

c) Recommendation: by increasing the nursing establishment by 2.97 FTE to a total nursing establishment of 38.94 FTE will support an additional RN on each long day shift.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £53,981.

7.3. **McCulloch ward**

a) McCulloch ward is a combined general surgery and ENT ward of 30 beds, incorporating an emergency ENT treatment room. Analysis of the SNCT data demonstrates that the current nursing establishment is sufficient to deliver safe care.

b) Recommendation: no change to the current nursing establishment.

c) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £125,819.

7.4. **Ocelot Ward**

a) Ocelot ward is a 12 bedded ward specialising in gynaecological surgery. The ward incorporates a gynaecology assessment unit (GAU) and an early pregnancy assessment unit (EPAU). SNCT data analysis identifies that the nursing establishment is sufficient to deliver safe care.

b) Recommendation: no change to the current nursing establishment.

c) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £85,613.

7.5. **Pembroke ward**

a) Pembroke ward is a 27 bedded orthopaedic trauma ward. The majority of patients are frail elderly with complex care needs. Analysis of the SNCT data shows that there has been an increase in patient acuity and dependency on the ward due to enhanced care needs. On average two patients each day required enhanced care over the 20-day census period.

b) Currently safe staffing is maintained by additional temporary staffing with a cost pressure of £298,330.60 attributed in year (April – Dec 2019).

c) Recommendation: by increasing the nursing establishment by 5.25 FTE to a total nursing establishment of 50.98 FTE will support an additional one CSW each long day shift and one additional CSW each long night shift.

d) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £341,254.

7.6. **Phoenix ward**

a) Phoenix ward is combined general surgery and vascular ward of 30 beds. SNCT data analysis identifies that there has been an increase in patient acuity and dependency on the ward due to enhanced care needs.

b) Recommendation: By increasing the nurse establishment by 3.7 FTE to a total nursing establishment of 44.2 FTE will support an additional CSW for a long day plus a CSW for each night shift.

c) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £202,709.

7.7. **Sunderland Day care centre**

a) Sunderland ward is a dedicated day care surgical unit**.** Due to challenges with capacity within the in-patients areas the unit has been open frequently overnight to provide flexible bed capacity. Surgical in-patients with no co-morbidities and an estimated stay of one or two nights are selected to be placed in this ward. Staffing is based on 1:8 ratio with a substantive RN on each shift. The division is required to staff the night shift substantively to support re-provision of 23hr stay ward.

b) Recommendation: no change to the current nursing establishment.

c) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £36,386.

7.8. **Victory ward**

a) Victory ward is a ring fenced elective orthopaedic ward of 18 beds. SNCT data analysis identifies that the current nursing establishment is sufficient to deliver safe care.

b) Recommendation: no change to the current nursing establishment.

c) Adjusting the budget setting from the 2019/20 outturn position to accommodate the safer staffing proposal will require an additional £183,825.

8. Conclusion

8.1. Inadequate nursing staffing levels impact on the nurse's ability to deliver safe high quality care. This places additional workload on our nursing teams and has an adverse impact on staff retention. It is imperative budgeted nurse establishments meet the defined requirements to deliver safe care as assessed by the safe nursing care tool.

8.2. As can be seen within the divisional analysis (sections 6 and 7) of this report, there are a number of wards (pre-COVID) where the currently funded nursing establishments do not meet the increasing acuity and dependency needs of the patients, or where there has been a change of function of the ward in the last year. This conclusion is based on the analysis of the correctly applied methodology of the SNCT and CHPPD rules and the professional judgement of the senior divisional nursing staff. The recommended nurse staffing numbers identified within this review are assessed by the Chief Nurse to be safety critical posts, subject to any post-COVID reconfiguration of ward services.

8.3. The corporate nursing workforce team continue to embed 'safe care' live monitoring across the Trust to allow real-time actions in response to nurse staffing variations.

8.4. The divisional senior nursing teams work with the 'healthroster' team to review roster templates and maintain efficient ward rosters.

8.5. The divisional senior nursing teams, with the support of the HR and OD teams, continue with nursing recruitment and retention plans to further reduce nurse vacancies and over-reliance upon temporary staff.

8.6. The Trust has an effective international recruitment programme in place that has enabled 189 nurses since 2018 to successfully register with the Nursing and Midwifery Council and subsequently supported the Trusts nurse recruitment programme. The current pipeline of nurses on the international recruitment programme scheduled to join the Trust is 164 nurses, however since January 2020, only two cohorts of 18 nurses have joined the Trust and the OSCE programme. A further 74 nurses were expected by December 2020. Unfortunately, the Government has suspended all international recruitment and as such this will impact on the recruitment to any vacancies

8.7. The Chief Nurse requires the corporate and directorate senior nursing team to review safe staffing six monthly, in line with national recommendations. A repeat establishment review using the SNCT, supported by the professional judgement of the senior divisional nurses will be undertaken post COVID implementation of any reconfiguration of services and changes towards a safe staffing review will be undertaken.

8.8. Where there are any significant changes to the functionality or activity of a clinical ward or department, then an associated Quality Impact Assessment will include a formal review of nurse staffing requirements to ensure safe staffing levels are provided.

8.9. The Chief Nurse has endorsed the recommendations contained herein and presented this paper to the Executive Group on 15 April 2020 which the Executive Group approved.

8.10. The Executive Group welcomed that the Chief Nurse will be undertaking a full and in-depth review of the nursing and midwifery workforce, following which will include nursing standards and quality outcomes, and that the Chief Nurse had commissioned the Director of Finance to undertake a parallel financial review of the nursing and midwifery workforce costs.

9. Recommendations

9.1. The Trust Board is recommended to:

1) Discuss the content of this review.

2) Endorse the decision of the Executive Group to support uplifting of the recommended Registered Nurse and Clinical Support Worker posts to support safe nurse staffing levels, subject to any ward reconfiguration post-COVID.

3) Delegate to the Executive Group to determine how this investment will be afforded.

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Improvement Plan Update**	**Agenda Item**	5.1
Report Author	Ian Renwick, Improvement Director		
Lead Director	Ian Renwick, Improvement Director		
Executive Summary	Provides an update to the Trust Board on the further development and mobilisation of the Trust's Improvement Plan, including on the process of engagement and consultation currently underway.		
Link to strategic Objectives 2020/21	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence			
Committee Approval:	Trust Board update 4 June 2020		
Executive Group Approval:	Regular updates have been presented to Executive Group and Planning and Delivery Board		
National Guidelines compliance:	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback.		
Resource Implications	The introduction of a standardised approach to Quality Improvement, and the development of a Trust-wide Organisational Development programme may have financial implications, although external funding may be available to support these costs.		
Legal Implications/Regulatory Requirements	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback The Improvement Plan and associated governance structures have been developed to ensure high level clinical involvement and engagement in its delivery.		
Quality Impact Assessment	QIA is not necessary for the Plan itself, but will be an integral part of its implementation		
Recommendation/	Note progress to date on the development of the Improvement Plan, and approve the Trust's improvement priorities contained within it.		

Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒
Appendices	Appendix 1 – Improvement Plan Workstreams: • High Quality Care • Our People • Integrated Care • Innovation • Financial Stability			

1 Executive Overview

1.1 This paper provides an update on the continued development and mobilisation of the Trust's Improvement Plan. It identifies the latest position on the key improvement priorities across each of the five domains (or 'pillars') of the Plan, and describes progress on the consultation and engagement process currently underway across the organisation as part of its finalisation.

2 Improvement Plan

2.1 As has been reported in previous months, the Trust's Improvement Plan has been developed across five pillars aligned to the Trust's existing corporate strategic priorities:

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

The key priorities have been developed to provide a balanced response to the challenges the Trust faces in the light of Regulatory and other feedback, set out across this and the following two financial years (subject to regular review and update). The latest version of the Trust's priorities across each of the pillars is shown at Appendix 1 to this report.

2.2 Since the last meeting, the improvement priorities have been mapped against the CQC Well Led Action Plan to ensure that all of those actions (as well as the Must Do/Should Do and other clinical priorities) are included in the Improvement Plan.

2.3 As has previously been reported, the implementation and sustainability of the single Improvement Plan will be supported by a number of enabling programmes. Particular attention is drawn to progress against two of these:

- *Standardised Approach to Quality Improvement*
  A costed proposal has now been received from NHS Elect/ACT Academy (part of NHSI) for the introduction of the NHS QSIR approach to QI within the Trust. This is a Programme designed and delivered for the NHS by the NHS, and is consistent with improvement methodology already used by key partners.

- *Organisational Development Programme*
  A proposal for a Board Development Programme has been received from NHS Providers and is under consideration to ensure that its brief addresses the findings and recommendations emerging from CQC Well Led inspection; the Deloitte Review of Board Effectiveness and the

recent Medway Talks staff feedback process as far as is practicable. Successful delivery of the Improvement Plan will also be under pinned by a num ber of enabling programmes and supporting services:

3 Mobilisation

3.1 The Trust's Improvement Board is now into the routine of meeting fortnightly, with the five Programme Boards providing updates on their Programme Brief via a structure moving towards risk-based 'highlight' reporting aligned to the CQC domains.

3.2 The process of engaging with staff across the organisation on the priorities identified within the Improvement Plan is now well underway:

- In early June the draft priorities were shared with Senior Managers across the Trust seeking their feedback on:
  - Whether the priorities within the plan are the right areas of focus;
  - How realistic the delivery of the priorities is;
  - Whether anything was missing from the draft at that stage.

  At the time of writing this process remains 'open' and an update will therefore be provided at the meeting.
- A session specifically to discuss the Improvement Plan with Clinical Council is scheduled for 24 June 2020;
- Two 'launch' sessions (both in virtual and s ocially distanced 'face to face' formats) are scheduled:
  - Senior Managers on 25 June 2020;
  - Other staff on 01 July 2020.
- A presentation to the Council of Governors is planned at its meeting on 22 July 2020.

4 Risks to Delivery

4.1 As the Improvement Plan infrastructure (including governance) becomes mobilised, a number of risks to delivery have already been identified, as highlighted below:

- **Key Roles** - A number of Clinical Lead roles do not, as yet, have names assigned to them. A process of seeking 'Expressions of Interest' is under development and we anticipate that this will complete before the next meeting.
- **NHSI Funding Bid** – The formal 'bid' to the NHSI Intensive Support Team for the development of NHS QSIR and the OD programme has not yet been s ubmitted. Work is underway to develop and finalise the brief/specification for the OD programme.
- **Development of IQPR** – SROs and the five Programme Boards will need to work up detailed implementation plans for each of the projects within the pillars at pace. The KPIs supporting the projects need t o be c ommunicated to the Business Intelligence and Analytics teams as quickly as possible to ensure that the IQPR is able to meet the reporting requirements.
- **Risk and Impact Assessment** – The Quality Impact Assessment process in place within the Trust was originally designed specifically around CIP projects, and is not, in its current state, fit for purpose for service improvement and transformation schemes. In line with best practice, it is suggested that a more comprehensive Impact Assessment (supported by a formal Policy) should be developed.

In light of the mitigating actions identified, the risk presented to the Plan as a whole is considered to be low at this stage.

5 Conclusions and Recommendations

5.1 Since the last meeting, further progress has been made on the development of the Trust's Improvement Plan, and on mobilising the supporting governance structures across the five 'pillars'. In addition, the process of wider engagement and consultation across the Trust is well underway as we look to finalise the Plan over coming weeks.

5.2 Board members are asked to:

- Note the further progress to date on the development of the Trust's Improvement Plan, and
- Note the key stages of engagement and consultation put in place as part of finalising the Plan.

Appendix 1 (i)

HIGH-QUALITY CARE

Mission 1: SAFE – Deliver Safe Care and Reduce Harm	Mission 2: EFFECTIVE – Reduce Variation and Create a Safety Learning Culture	Mission 3: PERSON-CENTRED – Transform the Patient Experience	Mission 4: Create the Conditions for Quality

DELIVER NOW [0-9 months]

Safeguarding:
- Review systems and processes
- Training to Level 5 (WL29)

Safe Ward Staffing (SD05)

Safe Staffing (OP, Theatres, Specialist Nurses and Corporate)

Serious Incident Review Framework:
- Develop a Serious Incidents Framework
- Thematic learning from Incidents and Complaints

(WL34, WL35, WL36)

Develop a Patient Experience Strategy including the use of Patient-Centred language (WL13/WL18)

Enhance Patient Experience:
- Review of Complaints

Reclaiming the Nursing Landscape:
- Improve Nursing & Midwifery governance (Ward to Board Assurance Framework)
- Nursing & Midwifery Leadership Development
- Develop a Nursing & Midwifery Strategy (including developing the workforce)
- Nursing Quality Standards

(WL07, WL24)

Infection Prevention and Control Action Plan

Design and implement a 'Business as Usual' Quality Assurance Peer Review Process

Fundamentals of Nursing Care:
Standardised* approach to:
- Pressure damage
- Nutrition and hydration
- Falls
- Delirium and Dementia

Quality Governance and Safety Learning Culture:
Standardised* approach to:
- Reducing SHMI and HSMR Variation
- Improve learning from Mortality Reviews

(WL28)

Improve Medical Leadership:
- Revised Professional Standards
- Develop Medical Leadership Programme

WORK TO IMPROVE [12-18 months]

***Standardised Approach:**
QI approach – PDSA/tests of change having established our baseline and encompassing a review:
- People/Structures/Reporting lines
- Training and education
- Governance and reporting
- Audit and Assurance
- Thematic learning
- Documentation and IT Systems

PLAN TO TRANSFORM [18-months+]

SUSTAIN AND EMBED IMPROVEMENTS

CONTINUE OUR QI JOURNEY USING DATA TO INFORM IMPROVEMENT IN PROCESSES AND PATIENT OUTCOMES

Appendix 1 (ii)

OUR PEOPLE

	Mission 1: *Best of People*	***Mission 2:*** *Best Culture*	***Mission 3:*** *Best Future*	***Mission 4:*** *Strategic Design of the Trust to be Well-led*
DELIVER NOW [0-9 months]	Local, National and International Recruitment Workforce Grip and Control (VCP)	Values, Behaviours and Tools – induction (YatD)	Talent Management and Succession Planning Apprenticeship alignment to Skills Demand	Ensuring corporate strategies have read across through Board and Executive reports (WL10)
	Performance Management processes to support High-Performing Teams			Executive presence in committees (WL22)
WORK TO IMPROVE [12-18 months]	Staff Retention and Stability Workforce Planning incorporating New Roles Equality and Inclusion Plans to narrow differentials WRES, WDES, GPG	Dovetail culture, OD with QSIR Staff Family and Friends Pulse Survey expansion Just Culture – Expansion beyond policy FTSU Strategy delivery (WL17, WL33)	Staff Survey 2020 (WL33) NHSEI Culture and Leadership Programme and Organisational Development delivery (WL14, WL16, WL32)	Executive Leadership Capability (WL01) Stability (WL02) Risk Visibility (WL03, WL20, WL21) Board Development (WL04) CoSec structure (WL05) NED Role (WL06) Strategy deployment (WL09) Executive Culture (WL14) Executive Visibility (WL15) Regulatory Requirements (WL19, WL31) Results-based Gemba (WL23) Corporate Risk Register (WL25) Risk Escalation (WL26) SI Management Process (WL27) Reporting Assurance (WL30) Executive Innovation (WL37) Board Effectiveness Assessment completed annually (WL06)
PLAN TO TRANSFORM [18-months+]	Remote and New Ways of Working: • Virtual Office • AI and Robotics			

Appendix 1 (iii)

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

Appendix 1 (iv)

INNOVATION

	Mission 1: Single EPR	Mission 2: User Experience	Mission 3: System by Design	Mission 4: Invisible IT	Mission 5: Supporting Evidenced Based Decision Making
DELIVER NOW [0-9 months]	Order Comms; EDRMS; Stabilise Extramed	CCIO & Clinical Advisory Group; Perfect Ward; Digital Dictation; Virtual Outpatients	ICP Digital Plan; Kent Data Sharing; Access Anywhere	Core IT Infrastructure; Telephony	IQPR (WL11)/ GIRFT; Business Intelligence Enablers; Data Accuracy - 'R.I.R.O.'
	Digital Strategy				
WORK TO IMPROVE [12-18 months]	PAS Upgrade; RPA; Vital Signs	Single Sign-On; Remote User Working	Patient Portal	Data Centre	
PLAN TO TRANSFORM [18-months+]	EPR	Natural Language Processing	Population Health		AI/ML

Appendix 1 (v)

FINANCIAL STABILITY

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

Meeting of the Trust Board
Thursday, 02 July 2020

Title of Report	Draft - Digital Strategy	Agenda Item	**5.2**
Lead Director	Jack Tabner – Exec Director of Transformation and IT		
Report Author	Michael Beckett – Interim Director of IT Jack Tabner – Exec Director of Transformation and IT		
Executive Summary	To support digital transformation at the Trust the organisation has commenced the development of a strategy, to set out our digital vision and roadmap over the next five years. The strategy will eventually aim to deliver a clear vision and roadmap, which supports the Trust's objective of making improvements to the way it cares for patients. Digital services are required to support the needs of our staff and patients, ensuring that IT enables our staff in providing the best possible patient care. This whilst also meeting the requirements of local and national strategies and drivers, along with consideration of how current and future technology could be used to the benefit future care and patient experience. The attached paper is the initial draft of this strategy which will aid the digital strategy agenda item at the Trust Board, which looks to discuss and input into the direction, focus and delivery of the strategy. This will be accompanied by a short presentation highlighting the key areas from the strategy document to support the discussion at the meeting. Following the presentation to the Board and the subsequent discussion, we will embark on a period of staff and stakeholder engagement with a target final publication in the Autumn. Our intention is to present this to the Board in September in a variety of formats e.g. technical appendices, patient and public accessible document.		
Committees or Groups at which the paper has been submitted	Planning and Delivery Group (Executive Team) 16 June 2020 Planning and Delivery Group (Executive Team) 2 June 2020		
Resource Implications	Finances and investments over the five year period of the strategy are described herein.		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to: • Provide feedback and the Draft Digital Strategy		

	• Use as supporting information during discussion on the agenda item			
	Approval ☐	Assurance ☐	Discussion ☒	Noting ☐
Appendices				

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.	

Digitally Enabled Care

Medway NHS Foundation Trust
Digital Strategy

2020-2025

Best of care
Best of people

Contents

Document History

Date	Version	Status	Comments
11/06/20	0.1	Draft	Initial Draft
16/06/20	0.2	Draft	Updates
17/06/20	0.3	Draft	Graphics
18/06/20	0.4	Draft	QA
18/06/20	0.5	Draft	Submitted to Board

1. Executive Summary

To follow

2. Introduction

Technology today has an ever-increasing impact on our everyday lives, with the use of smartphones, smart home devices, voice activated assistance devices and web apps just some of the new technology which has evolved over the last 10 years.

Digital solutions within the NHS including Medway NHS Foundation Trust (MFT) have not developed at this speed. Basic IT is a hinderance not a help to clinicians, systems cannot communicate with each other and utilisation of evolving technology has been slow. There is however an acceptance that digital transformation within the NHS has the potential to release front-line staff back to care, improve patient experience and advance clinical outcomes.

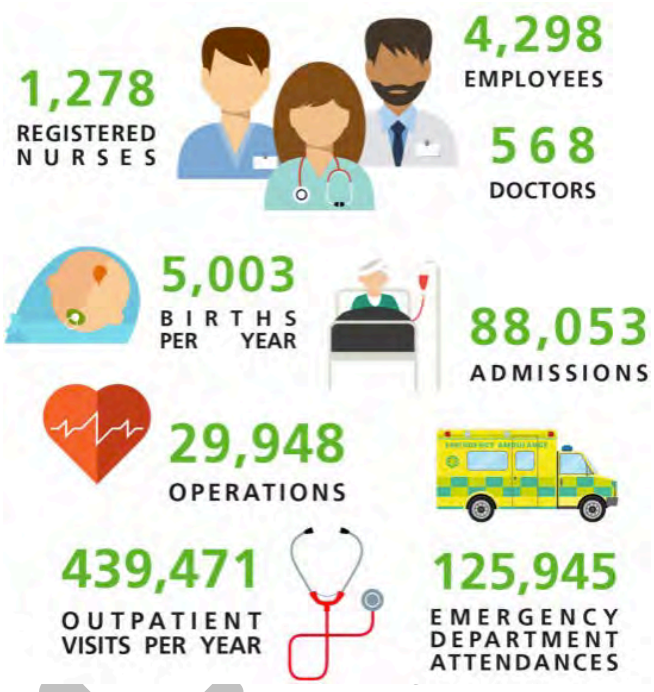
The strategy aims to deliver a clear vision and roadmap which supports the Trusts objective of making improvements to the way it cares for patients, aspiring to be the best. The strategy serves to ensure that digital services support the needs of the end-users to ensure that IT supports our staff in providing the best possible patient care. It must also ensure the Trust meets the requirements of local and national strategies and drivers, along with consideration of how current and future technology could be used to the benefit of the organisation.

This strategy sets our aims and objectives for the period 2020-2025 however we have attempted to articulate an ambitious vision for digital health and care services looking ahead 10-20 years.

3. Current Position

Medway NHS Foundation Trust is a single-site hospital based in Gillingham, serving a population of more than 424,000 across Medway and Swale.

From its site at Medway Maritime Hospital the organisation employees over 4,000 staff. The hospital provides clinical services to almost half a million patients a year, including more than 125,000 Emergency Department attendances, more than 88,000 admissions, more than 278,000 outpatients appointments and m ore than 5,000 babies born last year.



The Trust has achieved some successes with the introduction of departmental systems such as Safer Sleep for Anaesthetics and Metavision within ITU. However, the Trust has not built upon this work, with a lack of a clear vision on how to develop digital solutions to meet the Trust's needs.

Best of Breed IT Systems Approach

The Trust has focused on providing specialist applications within the Trust. However, this requires interfacing and users having to log into numerous systems every day. It has also led to systems being implemented in isolation to a wider plan for IT. This has impacted productivity and digital maturity.

Aging IT Infrastructure

There has been a lack of investment in IT infrastructure over the last 5 years which has led to IT issues effecting productivity and potential clinical risk within the organisation. However, the Trust has invested in network connectivity which does provide a good platform to build upon.

Engagement in STP Digital Programmes

The Trust has engaged with with Kent wide digital programmes and has successfully delivered the MIG and is currently working on interfacing with KMCR. However we need to ensure that these solutions are supporting our users.

Technical / Clinical Disconnected

Clinicians are willing to engage in Digital Transformation, however with no CCIO appointed or Clinical Advisory Group it is difficult to ensure the correct staff are involved at the right stages of strategy and project development.

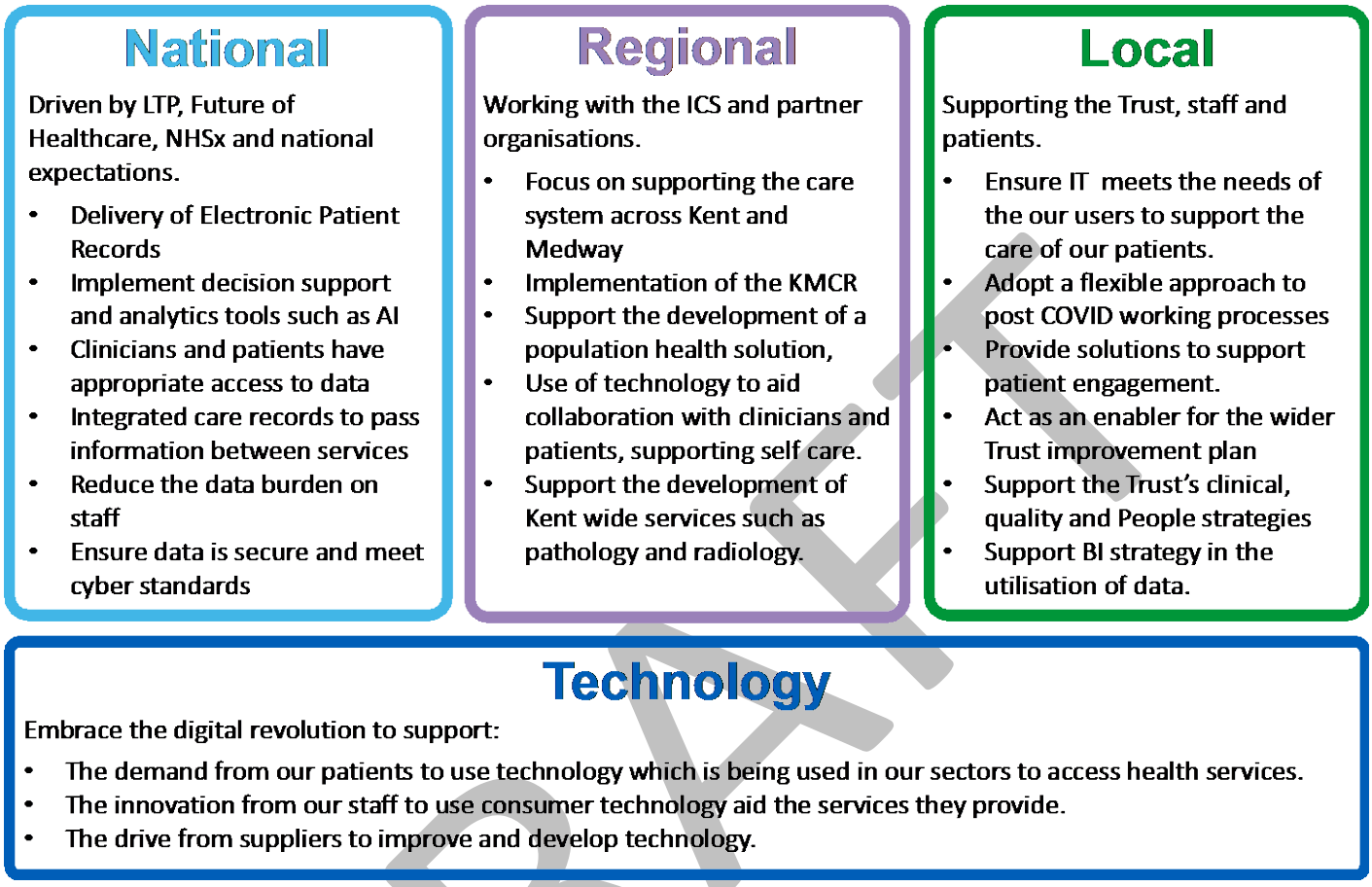
Lack of Clear Digital Strategy

Although the Trust has looked to improve IT within the organisation over the last 5 years this has been in isolated areas and not linked to a wider digital strategy, this has resulted in a delay to digital transformation within the organisation and a lack of central funding being secured.

During the development of this strategy, the following have been identified from engaging with Trust staff at all levels:

4. Strategic Drivers

The key drivers have been divided into four categories:



4.1. National Drivers

The government has set out a series of digital drivers and strategies for the NHS to achieve over the next five years which have been published in a series of papers, such as the 'Five year Forward View'[1], 'Personalised Health and Care 2020'[2], the 'Lord Carter Report'[3] and the 'Wachter Report'[4]. Most recently the latest NHS Strategy, the 'NHS Long Term Plan'[5] (LTP) and the Health Secretary's tech vision 'The Future of Healthcare'[6], also has a significant focus of digitally enabled care.

In January 2019 the LTP was published to provide a new service model for the 21st century as medicine advances, health needs change and society develops. It recognises that the

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] https://www.gov.uk/government/publications/personalised-health-and-care-2020
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
[4] https://www.kingsfund.org.uk/sites/default/files/media/T5_Bob_Wachter.pdf
[5] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[6] https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care

NHS has to move forward continually so that in 10 years' time we have a service fit for the future.
The LTP emphasises the importance of Integrated Care Systems (ICS) in engaging with all the healthcare organisations in the geography to ensure collaboration and integration of care. It recognises that technology underpins the future NHS setting out the critical priorities that will support digital transformation and provide a step change in the way the NHS cares for patients.

The LTP is devoted to making digitally enabled care mainstream across the NHS and specifically calls out offering patients the option of 'virtual' outpatient appointments with the intention of reducing face to face appointments by a third. This is expected to be delivered through mobile and telehealth technologies.

As a result, the digital strategy needs to ensure that it adopts and delivers against these national objectives.

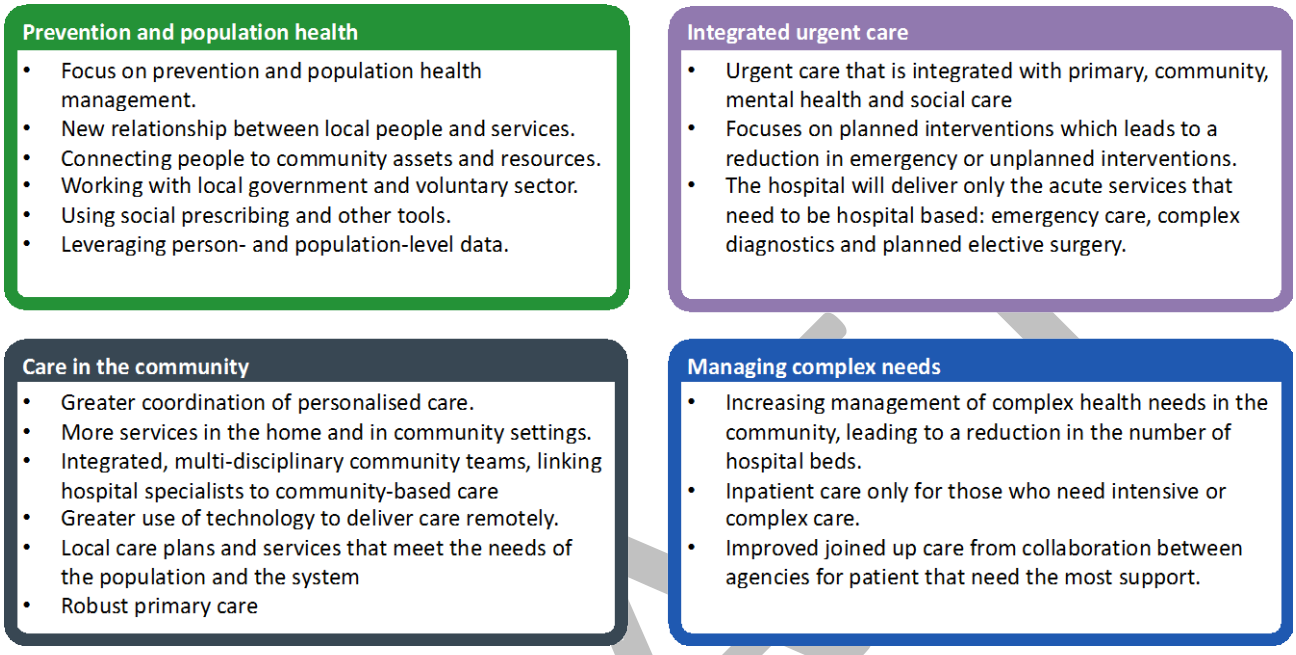
The key digital deliverables from these national agendas are as follows:

- Ensuring that an Electronic Patient Record solution is implemented within the organisation.
- Using decision support tools, including AI to help clinicians apply best practice, eliminate unwarranted variation, and support patients in managing their health and condition.
- Provide straightforward and secure digital access for patients to access and update their electronic records.
- Allowing engagement with services to help patients and cares manage their health.
- Ensure that clinicians can access patient records wherever they are.
- Reducing the burden on staff so they can focus on the patient.
- Integrated care records to pass information between services both in and out of the NHS.
- Enabling improved outcomes across the heath and care system.
- Use intuitive tools to capture data as a by-product providing more real-time information and reducing administrative burden.
- Adopt technology standards to ensure data is interoperable and accessible.
- Improvement of patient safety and quality of care, through the use of technology.
- Use predictive techniques to support local care systems to plan care for populations.

4.2. Regional Drivers

In 2014 the NHS Five Year Forward View set out a roadmap for the development of Integrated Care Systems across England, with MFT forming part of the Kent and Medway ICS. As the ICS and the Medway Integrated Care Partnership (ICP) develops, it is important that our digital solutions support this transformation.

4.2.1. What are the benefits of integrated care?



The Trust believes strongly that by working with our partner organisations across Kent and Medway can deliver better, more efficient care. MFT is already a partner in the Kent and Medway Care Record as part of the Kent and Medway Strategic Transformation Programme (STP) – now ICS, which will deliver information sharing on a new level. This will assist our staff to treat our patients wherever and whenever they need to

The digital priorities of the Kent and Medway ICS are as follows:

- Deliver system-wide service transformations such as the Kent pathology and radiology services.
- Support the development of the ICP within Medway and Swale.
- Support the transformation of services within the partnership through integration and digital innovation, while ensuring the improved utilisation of data to support population health.
- Enable wider management of patient flow across care settings to improve patient care and flow of patients through organisations. This will also include elements of decision support/system intelligence to aid process flow.
- Enable closer collaboration with GPs and the community trust to minimise length of stay in hospital, for instance through initiatives such as the 'virtual ward' will require IT support to make them work.

- Encourage a greater use of patient data to support population health data analysis, aiding further service transformation across the ICP and ICS.

4.3. Local Drivers

The Trust aspires for healthcare to be better for the population it serves, but are also clear that in some areas the services provided will need to be different in future, and there will need to be changes to the way we provide them. The Trust must also make sure the care provided by the organisation is sustainable for the future, in collaboration with the Kent and Medway ICS.

To support this delivery the Trust has developed a number of core strategies and the digital strategy is a key enabler:

4.3.1. Clinical Strategy

The ambitions of the Trust are to:

- Be recognised as one of the specialist emergency centres in Kent providing the highest standard of acute and emergency care

- Provide the highest quality of care by developing all our services based on the latest research and / or the best evidence of care provision that yields the best health outcomes for patients
- Achieve and surpass the constitutional, statutory and regulatory standards of the NHS for the care of our patients
- Work with our partners locally and across Kent and Medway to ensure patients receive the right care in the right place from the most appropriate healthcare professional to agree and subsequently meet their needs
- Continuously improve our efficiency and effectiveness in the interests of our patients

To support these objectives the strategy identifies that digital transformation is a key enabler, stating that is expected that the Trust will have a fully implemented an electronic patient record by 2025.

4.3.2. Quality Strategy

Quality Strategy will be delivered through three delivery domains:

Best Quality Design – We will undertake a systematic review of our core services using our 'designing for quality' assessment criteria, ensuring we check and adjust our quality position from board to ward. With Information and Technology has been identified as one of the five design which are required to ensure that the Trusts services are well led.

Best system – We will develop our staff and build their capability to deliver Quality Improvement throughout the organisation as daily business as usual and apply the concepts to improving quality in our services.

Best Delivery – We will have a continued and even more robust focus on delivery of our National and Local Quality Priorities with effective communication and dissemination across our organisation and a focus on joined up improvement.

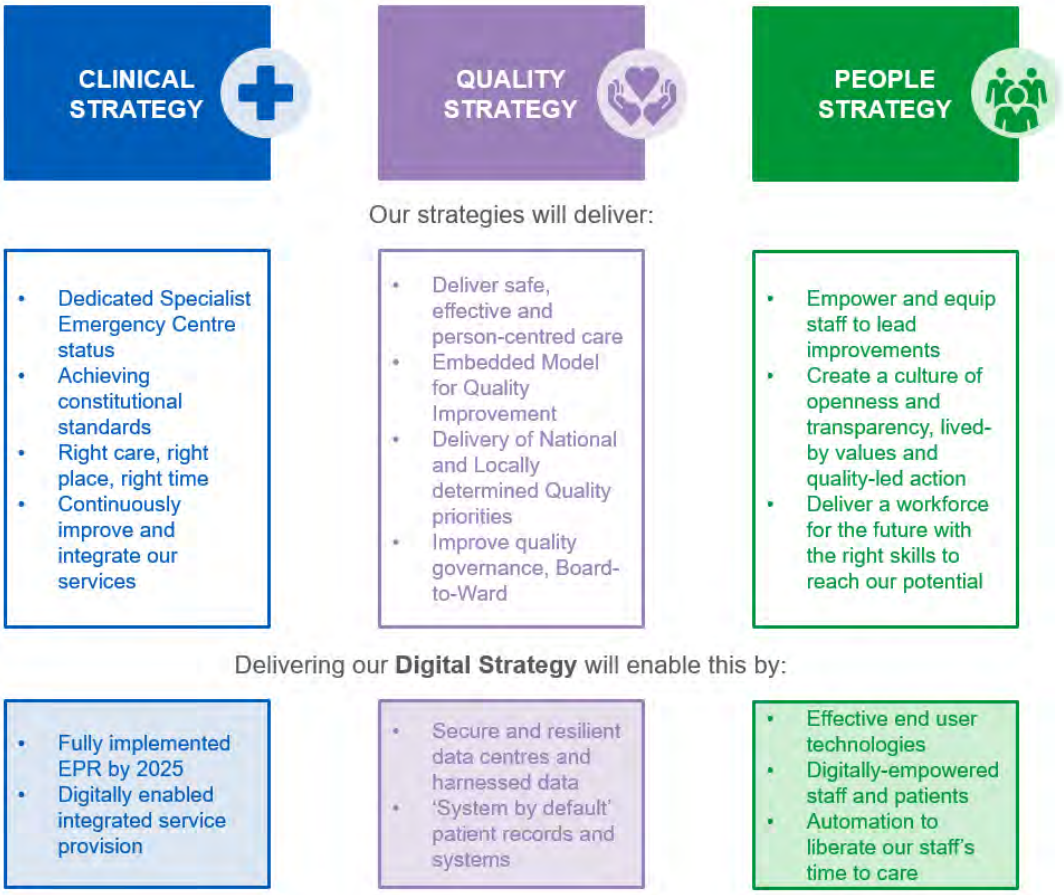
4.3.3. People Strategy

To become a brilliant organisation the Trust has set out three delivery plans:

Best of People – The Trust aim to transform ourselves through innovative staff-led improvements that meets the needs of our patients now and in the future. Two key areas of this plan which relate to digital are: Make quality, care and innovation core to staff-led improvements and Workforce productivity though utilisation of technology.
Best Culture – The Trust aim to have a culture of openness and transparency, lived- by values, quality-led actions across our entire workforce.
Best Future – The Trust will deliver a workforce for the future, supported with the right skills to allow us to reach our full potential.

The digital strategy must work to equip our people now and in the future with safe, resilient tools and the necessary skills to harness the power of digital technologies to improve patient care experience and outcomes. The workforce of the future is a 'digital first' one whereby intuitive and responsive technologies are the minimum expectation, and we must ready ourselves for this. Automation must liberate staff time to care for patients. Moreover, our patients are increasingly digitally mature and digitally literate. Our services must keep pace with these expectations.

In summary:


CLINICAL STRATEGY
QUALITY STRATEGY
PEOPLE STRATEGY
Our strategies will deliver:
• Dedicated Specialist Emergency Centre status
• Achieving constitutional standards
• Right care, right place, right time
• Continuously improve and integrate our services
• Deliver safe, effective and person-centred care
• Embedded Model for Quality Improvement
• Delivery of National and Locally determined Quality priorities
• Improve quality governance, Board-to-Ward
• Empower and equip staff to lead improvements
• Create a culture of openness and transparency, lived-by values and quality-led action
• Deliver a workforce for the future with the right skills to reach our potential
Delivering our Digital Strategy will enable this by:
• Fully implemented EPR by 2025
• Digitally enabled integrated service provision
• Secure and resilient data centres and harnessed data
• 'System by default' patient records and systems
• Effective end user technologies
• Digitally-empowered staff and patients
• Automation to liberate our staff's time to care

5. Our vision

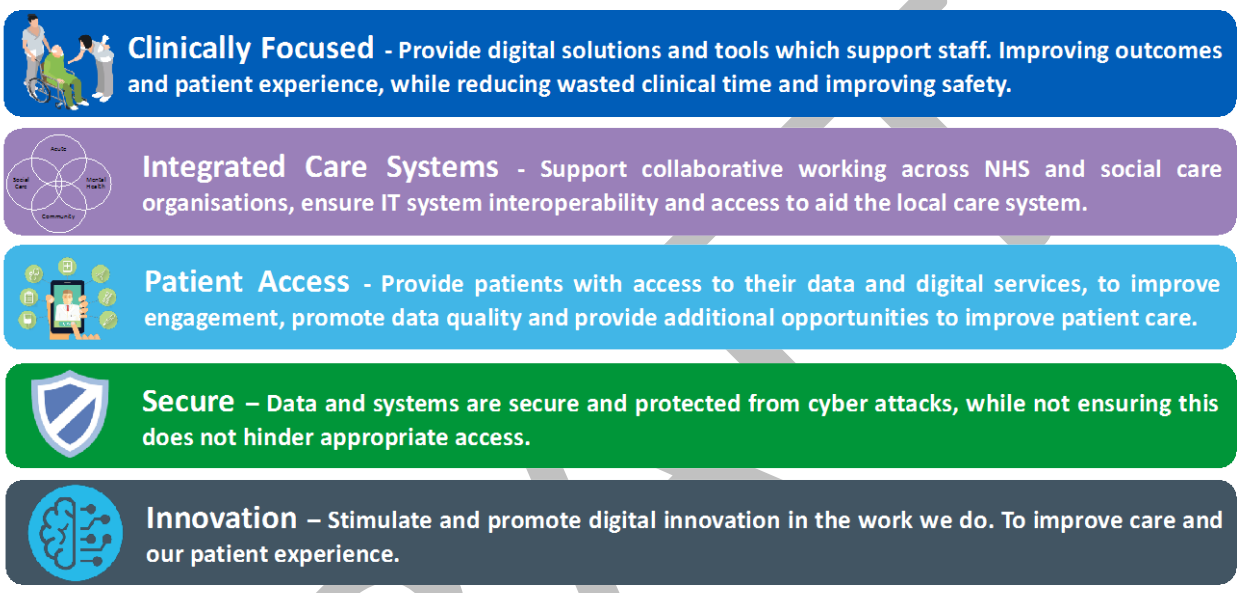
5.1. Mission Statement

The mission of those supporting the digital transformation of the Trust is:

"To provide digital solutions to empower our people to provide the best possible patient care experience and transform clinical outcomes."

5.1.1. Achieving Our Mission

To achieve this goal, we have set out five core missions:



5.2. Principles – healthcare of the future

Though this strategy sets our aims and objectives for the period 2020-2025, our vision for digital healthcare has to look beyond this. The below principles will be a guide for the work we do now to ensure we prepare for our workforce and our patients of the future.

5.2.1. Paperless

The Trust has fully deployed an Electronic Patient Record across the Trust, resulting in the organisation being fully paperless, clinical decision support tools being utilised to support prescribing, managing pathways, automating clinic outcomes and prioritising work, also this data will be further used to support service development within MFT. Integration will also be achieved with medical devices and point of care testing to further enrich the patient record, resulting in a direct impact on the quality of the clinical services we provide.

5.2.2. Personalised

Through a combination of AI/ML, utilisation of data being provided by the EPR, developments in biomechanics and genomics and personal data being provided by consumer products (e.g. apple watch) and patient portals we will be able to personalise

every patient's care. For example, this could lead to precision medicine through the use of genomics, we can also use AI and active monitoring to identify when patients with long term conditions require interaction with our teams. Reducing admissions and ens uring appointments are made at appropriate times.

Personalised care in action – here and now

Ampersand IBD case study to follow

5.2.3. Integrated

Data will be integrated between Acute, Community, Mental Health, GPs and S ocial Care, insuring that the full patient record is not only available for services to view but data integrates with the EPR to support wider analytics, and AI and decision support tools. There will also be complete integration between digital solutions across the organisations ensuring medical devices, wearables and IT systems are all working together.

Integrated care in action – here and now

KMCR case study to follow

5.2.4. Accessible

Both patients, carers and staff will be abl e to seamlessly access data, systems and tools from any location with devices fit for the services they are providing. Login times will be under 30 s econds, and the experience will be the same working from the hospital or remotely. Cyber security requirement will be met but not as a result of reduced user experience with face and voice recognition being used as a method of authentication.

5.2.5. Clinically Led

To ensure that the digital solutions implemented meet are clinicians needs and ensure that that the enable improvements in patient care clinicians will be at the forefront of design and decision making in implementing the digital strategy. With a CCIO (Chief Clinical Information Officer).

5.2.6. Innovative

We will look to adopt and utilise the latest technology if it offers the opportunity to improve services, reduce risk or adds to the patient experience. Whether it has been designed for health, another sector or the consumer we will in the future be a organisation which embraces technology.

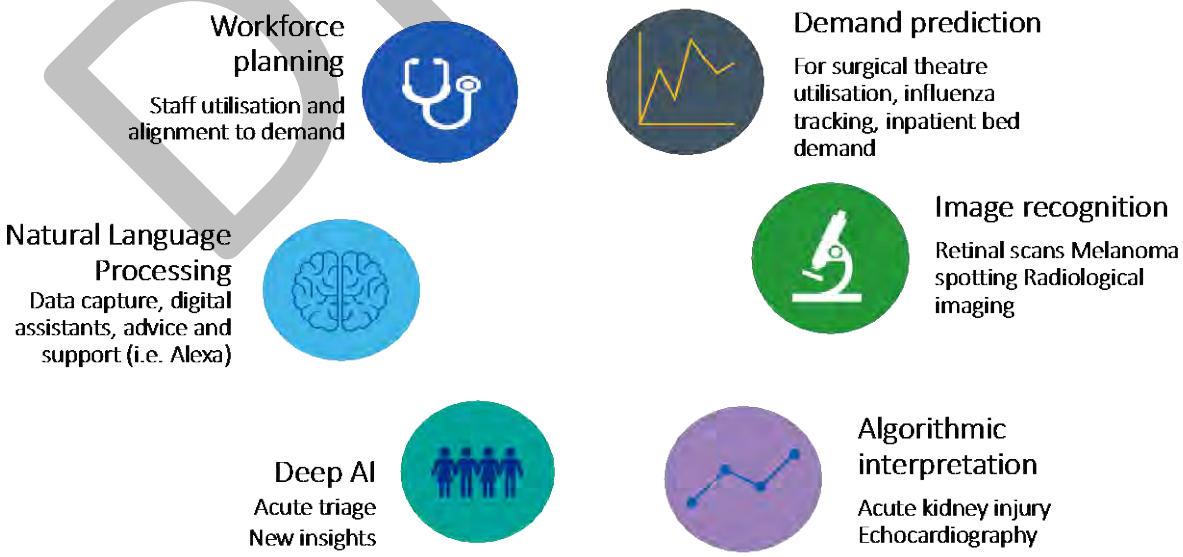
5.2.7. Flexible

COVID has shown us that we need to be flexible in our approach. In the future our systems should be designed in a way which makes it easy to develop and change a pass to support service transformation which takes place within the organisation.

5.3. Horizon-scanning

This strategy is designed to support the Trust to radically transform how digital supports the Trust to deliver on the strategic drivers. Although the strategy delivery plans only set out how we will make progress with this journey over the next 5 years; there are wider future considerations for how the Trust will continue to develop its digital maturity in the coming two decades.

Some of the technology the Trust will consider in the future are outlined in the diagram below:



Artificial Intelligence (AI): The Trust will look to implement AI algorithms which are able to mine medical records, design treatment plans or create drugs faster than through any current process, and with safety concerns being addressed this will have a significant impact on the future of healthcare services. One example of this has been achieved by Google's DeepMind, who recently created an AI for breast cancer analysis. The algorithm outperformed all human radiologists on pre-selected data sets to identify breast cancer, on average by 11.5%. However, to achieve this data is absolutely key. To support the Machine Learning and analytics big data within healthcare becomes essential. Hence the need over the next 5 years to collect this data which can support advancements such as this in the future.

Genomics: Another example is with Genomic tests. It is possible to establish valuable information about drug sensitivity, multifactorial or monogenic medical conditions and even family history. Moreover, there are already various fields leveraging the advantages of genome sequencing, such as nutrigenomics, the cross-field of nutrition, dietetics and genomics. At the present time, Genomics testing is expensive, but this will decrease over time, and the NHS and Trust should look to utilise this technology.

Natural Language Processing: The last example is with voice assistants; aiding patient engagement to support clinicians in outpatient rooms and during triage will develop using Natural Language Processing. Innovations in voice, such as Nuance Communications' virtual assistants and Cerner's voice solutions, provide ways to capture data to improve clinical documentation and remove the administrative burden on clinicians. Smart speakers are starting to support functions such as voice-based diagnosis which analyses changes in voice to detect illness or emotional state.

5.4. Medway Innovation Institute

The Trust's *Medway Innovation Institute* will seek to ensure our digital strategy is constantly looking beyond the immediate priorities and considering the technologies that can allow us to leapfrog many of the challenges our staff and patients face through the adoption of new and exciting technologies.

For more information on the *Medway Innovation Institute* and its role as a locus of quality improvement training and as a local innovation accelerator and incubator, click here [link to follow]:

6. Approach to delivery of the Digital Strategy

6.1. Digital transformation – getting it right across the many layers

Ensuring MFT is a digitally enabled organisation is not just about delivery on an Electronic Patient Record. Our strategy must address every aspect of digitally-enabled care, from the highly technical back-end infrastructure, through to how we work with our patients to adopt innovative tech that benefits patient care and clinical outcomes. It requires a concerted effort across a number of what we describe as 'layers' to enable a digital transformation at such a scale.

Each of these layers are defined in the sections below:

6.1.1. Back-end Infrastructure

Focused on services and solutions which are the backbone of our digital solutions. This includes servers, storage, user management tools, cyber security and network connective. All key components to delivering digital service which support clinical services and future technology.

6.1.2. End User Devices

End user devices are not just PCs and laptops. This includes smart phones, wearables and a whole host of other devices which are used by our staff and patients. We need to use the best of these to utilise the systems we have available and to support patient care.

6.1.3. Data Warehouse

Data's importance to providing healthcare will continue to grow as it is used to drive transformation, support population health and enable machine learning. One key component to this is how the data created from our IT systems feed the data warehouse, supporting future technology advances as well as the Trust's BI strategy. We also need to ensure that our infrastructure and warehousing design are are aligned to this vision and the Trust

6.1.4. Integration

With both the drive to see the complete patient within one view, medical device data being brought in to clinical systems and the development of integrated care across the NHS, the Trusts integration engine is key. We need to ensure data is interfaced correctly feeding the appropriate information in real-time.

6.1.5. Systems / Functionality

IT systems need to have the correct functionality to meet the clinical needs while having the flexibility to be localised. At present the Trust will have 150 unique systems. There is a need to understand how these all work together to meet our users and patients needs. While adapting to technology and transformational needs.

6.1.6. Collaboration

Lastly is the collaboration with staff, patients and partners to achieve the goals of the strategy. Without this engagement and support even the best solutions will fail. We need to have our users involved in the design and implementation of our digital solutions, understand how our partners can work with us to support our goals, while using 3rd parties to provide subject matter expertise to support our digital development. We also need to continuously improve the way we train and coach staff to use and refine digital health care, and to feel confident to innovate locally in partnership with our patients.

6.2. How we will organise ourselves to deliver

With the objectives of the Digital Strategy covering a broad area, we have broken down the plan to deliver the programme of work into four workstreams. The aim is to ensure focus on delivering key projects with clear benefits whilst ensuring these meet the aims of the Digital Strategy.

6.2.1. Electronic Patient Record

There is clear direction from National Strategies as well as support from the Trusts Clinical Strategy for an EPR. Although the Trust has adopted a best of breed approach to a patient record to date only a few applications could be considered best in class, and with limited integration between applications a single primary EPR system allows the Trust to achieve its vision at a faster pace.

Therefore, this workstream is focused on the development of an Electronic Patient Record (EPR) and how this data can support staff in providing better patient care while improving the flow of patients throughout the organisation.

More than any other IT system, an EPR will transform the way everyone at the Trust works, making sense of busy, complex health services, analysing information in clever ways and helping to manage many every-day tasks. This system will not only help to treat patients

more effectively by giving healthcare staff easier access to up-to-date information, it will also use this information to improve care, and give healthcare staff the tools needed to be safer and more efficient.

EPR goes beyond being a system for storing information. When patient records are stored on paper, the information can only be understood and analysed by staff reading through all of it every time they see a patient. EPR is capable of taking this information and applying the knowledge, intelligence and experience of a much wider network. This means the system is capable of suggesting plans of care, supporting clinical decision-making and acting as a double check.

The objective will be to consolidate the patient record into a single system. However, there will be a requirement for specialist department systems in some areas. Where this is required it is important to ensure that the objective of providing a complete electronic record is realised through the use of integrating these applications.

The Trust will look to integrate the EDRMS system already purchased to manage electronic access to paper records, reducing the risk of an extended period of time where paper and electronic records are in use.

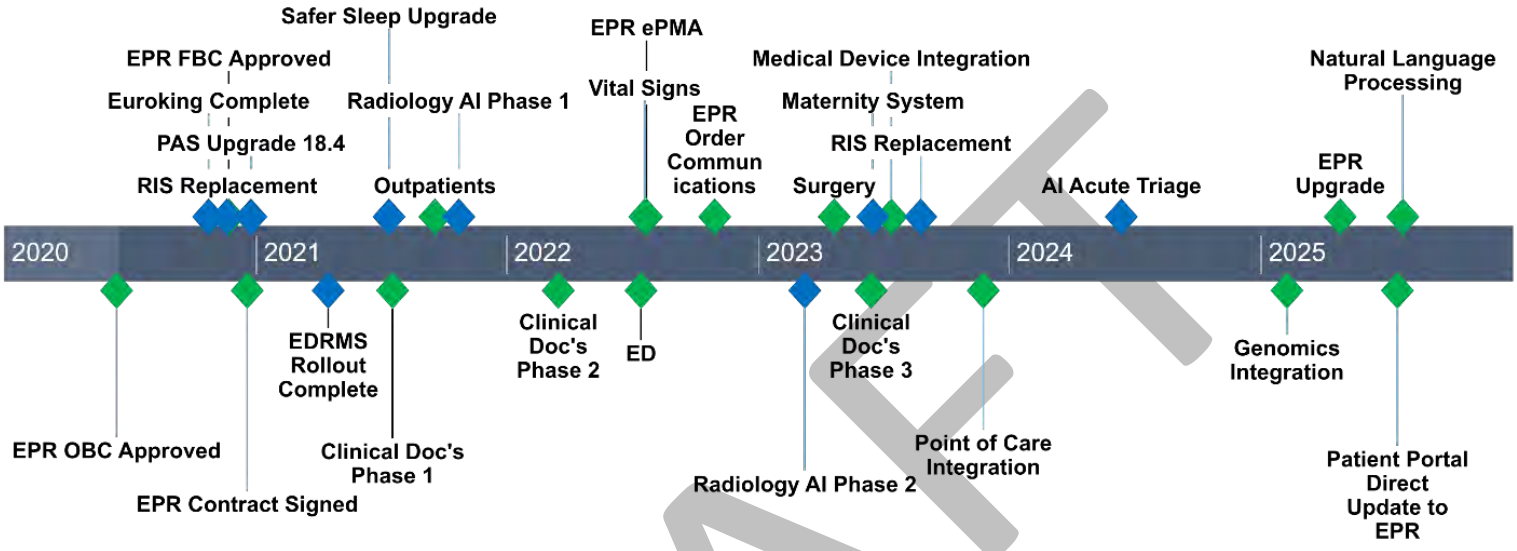
As technology evolves it is important to look at how EPR can be used to support clinical decisions and automate processes. This will start with areas such as ePMA but will be developed through technology such as AI.

The aim would be to complete the initial EPR core product implementation in Autumn 2021. This will be achieved by building upon the existing PAS (Patient Administration System) and starting with a small number of clinical documents. This small scope to beginning with will reduce the risk of early delay and allow the Trust to achieve some benefits at an earlier stage in the project. Following this emergency department functionality, order comms, electronic prescribing and theatres would follow over the next 2 years. However, there would be continuous growth in the use of the system over the duration of the next 10 years as technology develops and we look to adopt more and more functionality.

The workstream will also look to stabilise any existing systems to ensure they are supporting not hindering our users in the care they provide. Working with the Trust's Nursing Quality Group and CAG, any changes required to improve applications will be designed and implemented to improve services and meet agreed local and national standards, while ensuring patient safety and experience are always a focus.

Globally we are seeing companies such as IBM and Google continue to develop Artificial Intelligence (AI) functionality, with the benefits now starting to be utilised within healthcare. The Trust should look to adopt AI functionality to first act as a further decision support tool

for clinicians, automate management of patient pathways and support the Trust with process management, alerting, implementing optimal resolution plans and s upporting population health analytics. This would be integrated to the EPR to provide the biggest benefits, utilising the data which has been collected to support data driven care. However, AI would also be adopted into staff rostering and procurement processes to streamline and automate, as well as in areas Radiology and Pathology to aid diagnosis and natural language processing.



It is important that as an organisation MFT looks to support innovation in technology and integrates this into its digital vision to improve patient care. One example mentioned already which will h ave a significant impact on heal thcare moving forward is genomics'. Testing costs mean that utilisation of these services is currently limited. However, the benefits this will bring in the form of precision medicine and genetic mapping means that we should be ensuring that we are planning to ensure we are in a posi tion to utilise these services within our EPR in the form of prescribing, decision support, analytics, and results reporting.

Due to its nature, this workstream is more about the change it will bring to the organisation than the IT that is being implemented. As a result, this transformation will be clinically led.

Summary - EPR

By 2025 we will:

- [to follow – SMART objective]
- XXX
- XXX

6.2.2. End User Experience

At present, the limitations of technology can dictate how staff work. The aim is to ensure that the technology supports the workflows and processes of our staff, both now and in the future.

Not unreasonably, Trust staff increasingly expect the ease with which they use technology and data at home to be replicated within the NHS. The workstream will also look at how new technology can be adopted to the benefit of our users. Security and data protection will always be paramount when looking at new technology, but the Trust should adopt an attitude of embracing technology where possible, where it would aid our users.

Areas of focus:

- Ensuring we have the right end user devices to support our existing systems and how we can improve the overall experience by focusing on areas such as reducing logon times and steps.
- Support the development of the EPR and ensuring that we have the solutions in place to completement this increased digital way of working.
- Embrace technology outside of healthcare and future digital solutions to support our users, such as voice recognition and mobile tech.

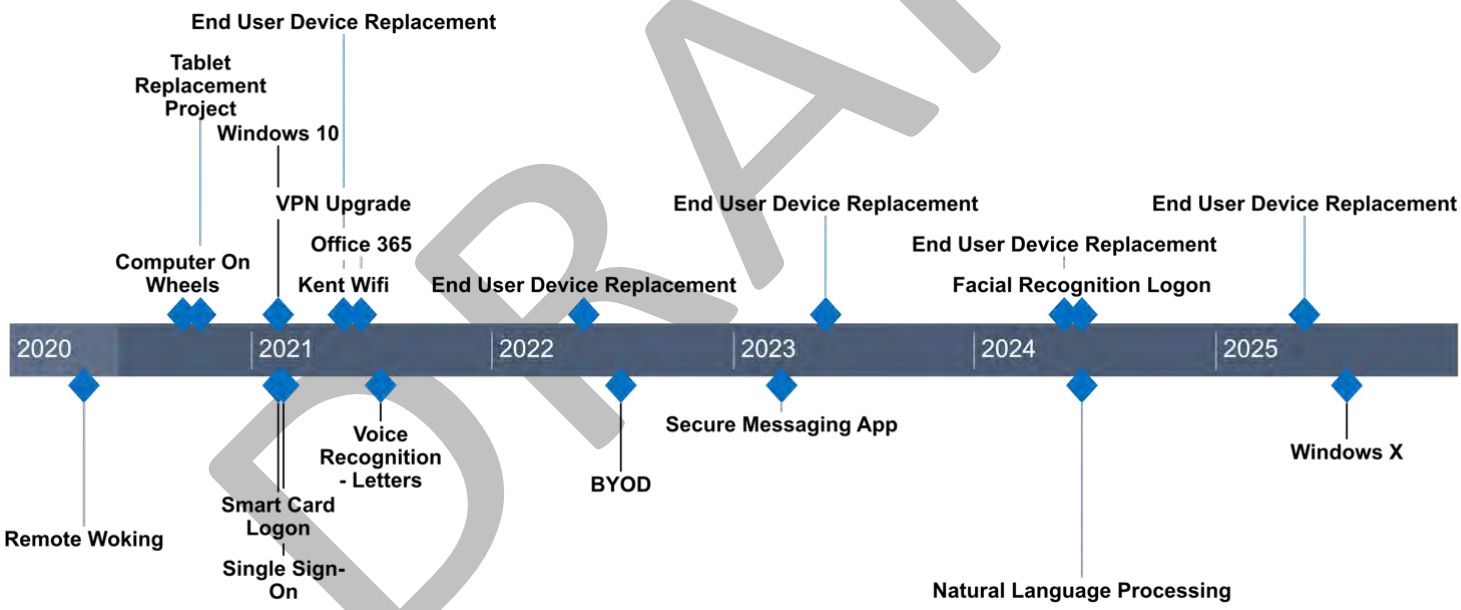
This workstream will look at not just improving the user experience regarding end user devices in isolation. All aspects need to be considered, from accessing Trust systems through to reduced logons and customised screens. This means that instead of just replacing devices like for like, we need to understand the change in working practices from adopting a paper lite approach as well as other service transformation work taking place. This may result different requirements for end user devices to support different working processes. As well as reviewing our needs, the Trust will review the NHS Global Digital Exemplars as well as other organisations globally to understand their approach to end user technology, as well as looking at innovative new technology that is coming to the market and how this can be used within the hospital, whilst allowing the device types and deployment approach to be driven by users through the newly established clinical advisory group.

Areas of focus will initially start with clinical areas to support current COVID work which directly supports patient care and act as an enabler for the future EPR programme. Example of improvements will be outpatient rooms, in 2020/21 additional screens will be added to make it easier to view data from different systems. Improvements in logon speeds and single sign-on to be adopted, which should lead to reduction in time it takes to access records. We are also increasing the amount of workstations on wheels (WOW's) in ward areas, and replacing tablet devices which have previously led to reliability issues. This will provide patient data being available during ward rounds, at the patient's bedside. As well these additional mobile PC's.

Following the introduction of Microsoft Teams during COVID this become a core application and shown the worth of virtual collaboration tools such as Teams. Moving forward the Trust will continue with Microsoft Teams but also adopt the full Microsoft 365 solution, utilising cloud based-storage for users, collaboration areas and SharePoint. This will support both remote working and multi-site access to date as the ICP develops.

Bring Your Own Devices (BYOD) offers the organisation the opportunity to provide users with the ability to utilise personal devices within the work place. The objective will be to make it easier for staff to securely access information, systems and data to support the jobs they do, while increasing the number of end user devices in operation around the organisation. BYOD will be introduced within the organisation 2022.

The Trust is also looking to adopt technology to improve productivity and in turn patient care. Examples of this include the introduction of voice recognition in addition to the digital dictation solution which is already being implemented for the creation of correspondents, reducing admin time for staff and should improve the turnaround time of letters within the Trust. Also, the introduction of video consultations and tele-medicine will be further deployed across the organisation following its successful deployment during COVID.



Instant messaging applications have become common with in everyday life, and are now becoming an important part of how our staff communicate with each other to manage operations. However, we are seeing examples of how these applications are being used to directly manage patient care. We need to ensure that me meet or information governance requirements in regards to patient date, however that should not mean that we reject communicating via this method. We will look to work with our preferred EPR supplier on solutions which are either built within the EPR or capable of integrating with it.

Finally, this workstream will constantly ensure we are focusing on the low cost solutions that can incrementally improve the care experience we provide, such as the introduction of patient-to-relative communications systems.

Summary – End User Experience

By 2025 we will:

- [to follow – SMART objective]
- XXX
- XXX

6.2.3. System By Default

As integrated care systems develop, there is an increasing need to collaborate with other care providers and the citizens we provide care for. This workstream focuses on how we ensure that we provide the correct digital solutions to meet this requirement.

As we move forward with Kent and Medway service redesign there is a drive to ensure that carers have access to the correct patient data to provide the best possible care, regardless of who holds the data and which provider the carer works for.

To further support multidisciplinary teams working across organisations and support the vision of the Integrated Case System (ICS), the Trust will be an active partner in the development of a Kent Care Record during its development over the next 1-3 years, with the aim of providing a clinical portal containing a complete care record across the county.

As the Medway and Swale Integrated Health Partnership (ICP) develops we will see a need to develop Integrated service models with the need to align clinical IT systems and IT infrastructure to support both our users in providing services which could be provided by multiple providers. The Trust will also see a greater need to utilise patient data to support population health data analysis and data driven care, aiding further service transformation across the ICP and increased personalised care for patients.

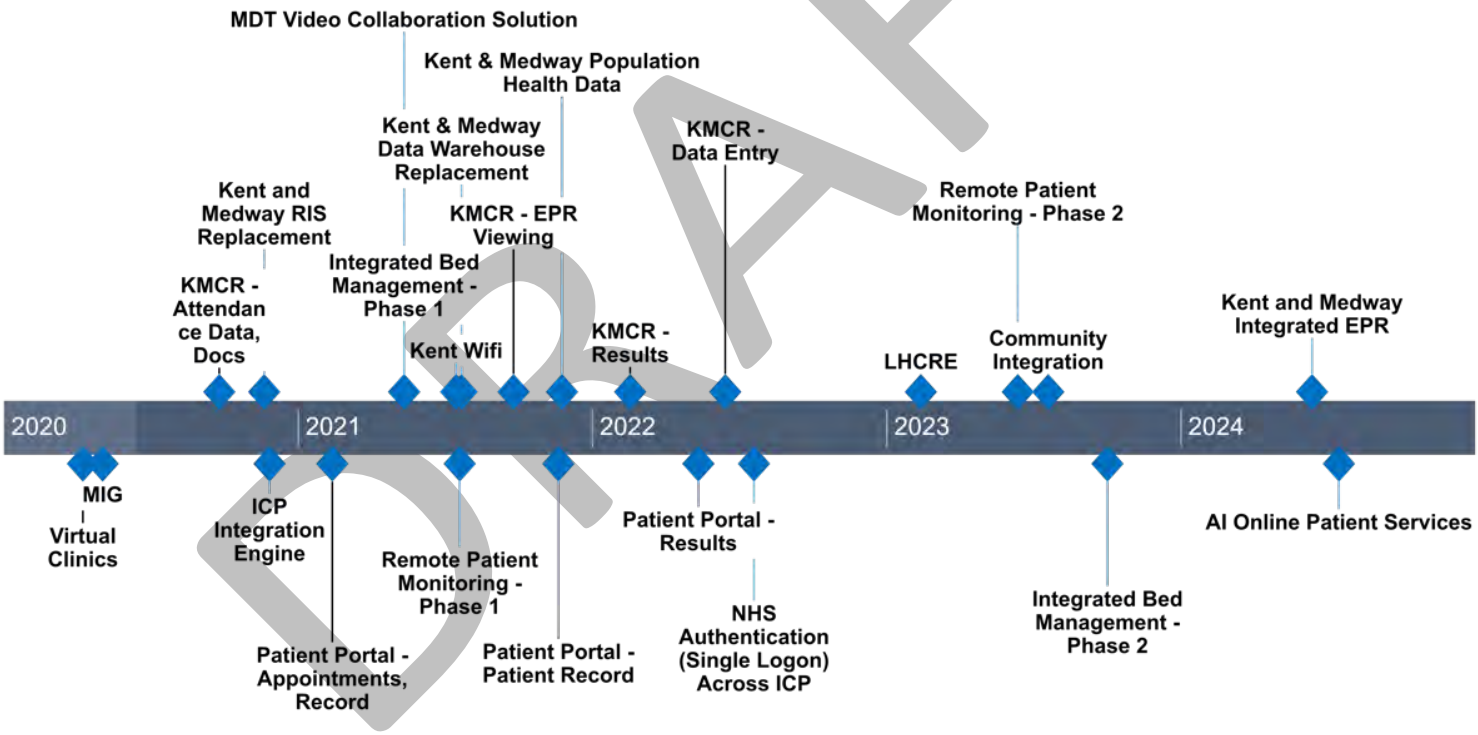
Due to this, the Trust will work with the other providers in developing a ICP integration engine, ensuring any data which flows between applications is managed by this one service. This approach will ensure that as the system develops data can be more easily managed and utilised. With MFT's integration engine being the most advanced in the region the Trust will look to utilise the solution already in place.

As part of the Trust BI strategy and working with the Invisible IT workstream we will also work to develop the Trust's data warehouses to ensure that the infrastructure is fit for purpose not just now but built and designed to deal with the requirements in future years. We also will ensure through this design phase with the information team that the solution supports collabration across the ICS to increase data anaylsis and quality. This would then support Medway capcity management, support service redesign and the development of population health data.

There is also a need to share data with our patients and their carers to both inform and support patient care. This will improve engagement with patients and their carers, promote data quality and provide additional opportunities to improve patient care. Providing access to Trust services via 'apps', accessing appointment information via email and video consultations are also key to improving patient interaction and providing improved services. This will be driven by the ICS's Kent and Medway Care Record programme with delivery over the next 3 years.

The Trust needs to ensure that its long term external patient interaction aligns with both the Kent and Medway ICS and NHSX in the form of building upon the KMCR and solutions such as the NHS App. However, in the interim we should look to embrace specialist products, working with suppliers to integrate and s hape these solutions to achieve our long-term strategy. Examples include patient appointment letters being replaced by electronic correspondents, patient record portals for long term condition management, allowing patients to enter in information on their condition which will aid their treatment. We will also see an i ncrease in video consultations as described within the Intuitive Technology workstream.

The Trust will also look to build upon its work with remote monitoring tools such as Current Health. Although these tools are being used within the hospital at present, the future of these solutions is for them to be monitoring patients at home and ensuring that this data is feed into the EPR and data warehouse to support proactive care and reducing ED admissions.



Summary – System by default

By 2025 we will:

- [to follow – SMART objective]
- XXX
- XXX

6.2.4. Invisible IT

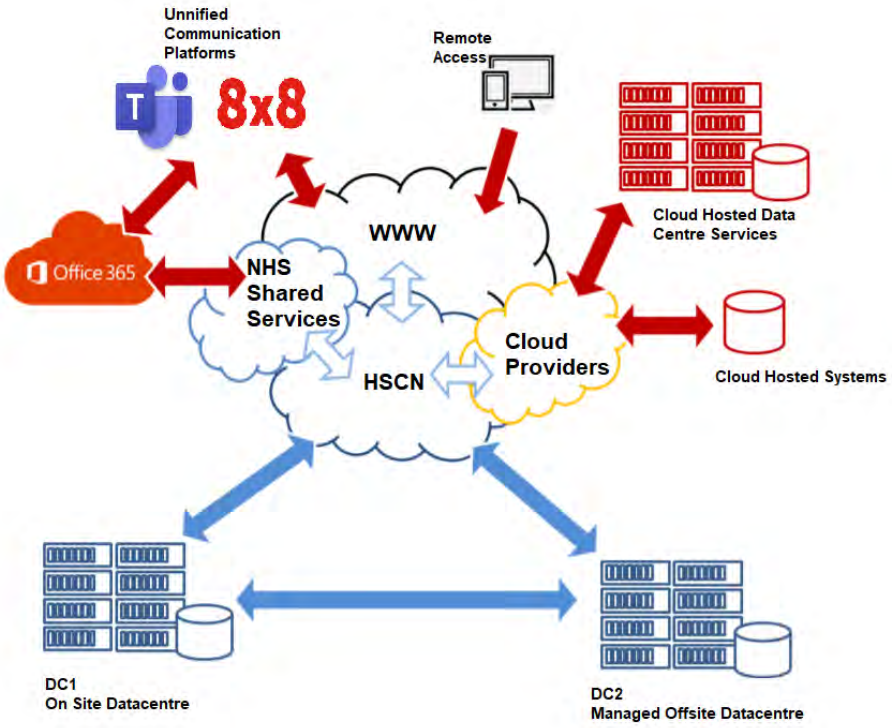
Focusing on ensuring the IT infrastructure in the Trust meets the needs of the organisation both now and in the future. This focuses on capacity, availability, speed and security. This includes projects such as increased storage, ability to provide more applications across the Trust and increase communications (voice, data, video) around the organisation.

The demands on IT infrastructure will continue to increase with the expectation that storage requirements for holding patient data will double every 73 days. It's key that the workstream ensures it understands the needs of the organisation to allow it to deliver the IT infrastructure needed. Ensuring the IT infrastructure in the Trust meets the needs of the organisation both now and in the future is key to achieving the objectives of the strategy.

It is essential that with the increased reliance on digital to support the organisation that our networks, servers and storage are resilient, flexible and able to meet the demands of our staff and patients. This will be achieved by working with partnership organisations and 3rd parties to provide the infrastructure to meet expectations.

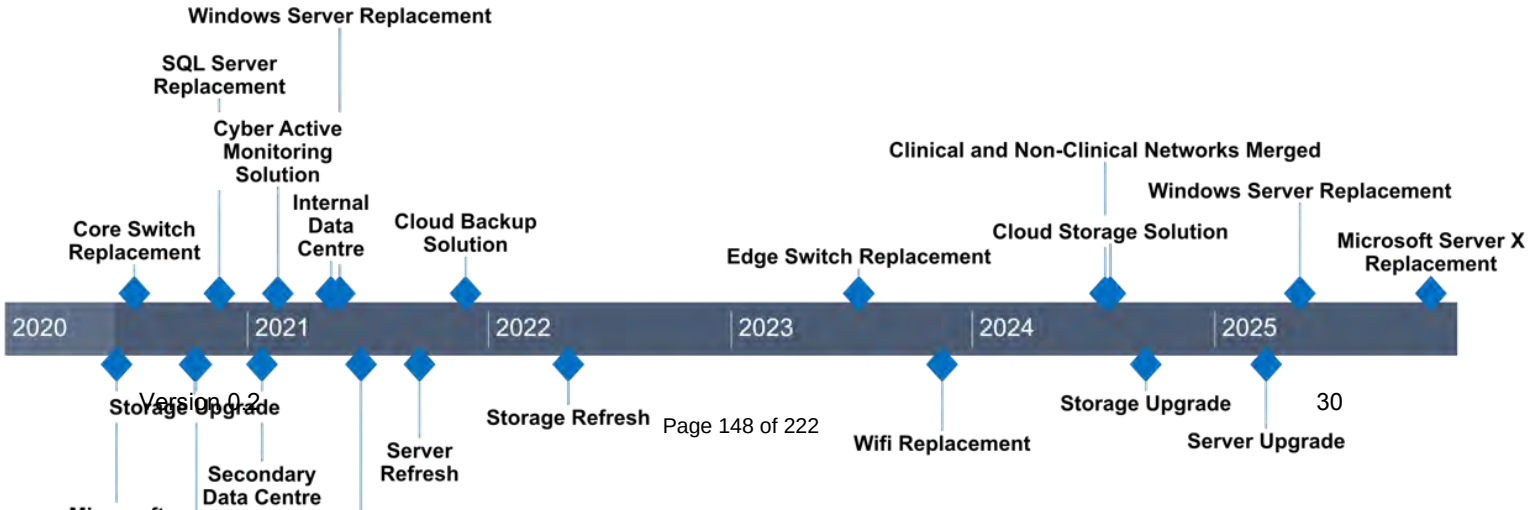
While some services will benefit from cloud based solutions, there will be a continued need to host our own systems locally for performance and cost reasons. We will take a pragmatic approach to our future infrastructure requirements and use a hybrid-cloud methodology accompanied by the need to maintain pace, security and supportability, wherever our systems are based. These programmes will be progressed with the intention of ensuring the updated IT Infrastructure is fully supported, flexible, scalable and capable of meeting the Trusts current and future IT needs, meeting the organisations data warehousing, which will be given dedicated resources to ensure that it supports the BI strategy. Investment in our infrastructure will continue to ensure that our solutions continue to be fit for purpose, adopting the latest technologies and ensuring the organisation does not revert back to the current position.

The below schematic of our recently deployed cloud-based telephony system is an example of this:



Whist updating the infrastructure to meet these needs in the first 2 years the organisation will also look at relocating its primary data centre to a specialist hosting supplier. As stated, the Trust will adopt a hybrid cloud solution, but it is important that are solutions which are locally hosted are still located within state of the art facilities, and working with partners is the best way to achieving this.

We also have a focus on cyber security, ensuring that all solutions have the latest security patches installed and being proactive in addressing new vulnerabilities, meeting the requirements set by NHS England. The Trust has already achieved Cyber Essentials accreditation however the NHS is seen as a target for cyber criminals and Trust must ensure a greater focus on Cyber. Cyber monitoring tools will be established as well as qualified cyber engineers to support our protection. However, the biggest impact in preventing a cyber attack is to ensure that the above projects are completed within the timescales set, ensuring all solutions are supported and patched correctly.

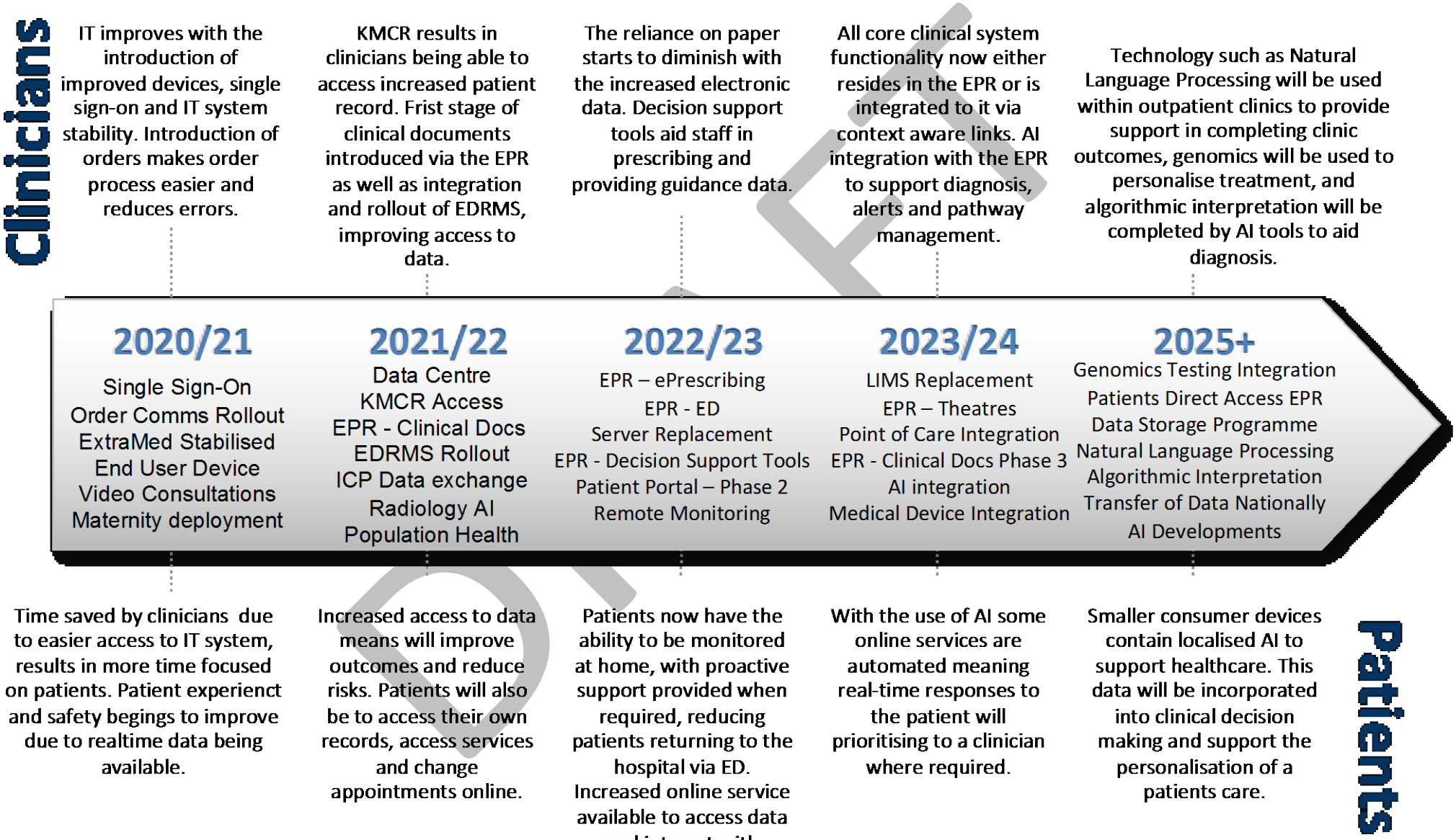


Summary – Invisible IT

By 2025 we will:

- [to follow – SMART objective]
- XXX
- XXX

6.3. What does this mean for the MFT clinician? And what does this mean for patients?



6.4. Finances and investment

To support the delivery of the strategy over the next 5 years a high-level plan is essential to ensure success. Within each of the workstream sections these plans have been shown in the form of a roadmap.

Although detailed planning has not been completed for all initiatives, we have considered the overall likely cost of delivering the programme to ensure the strategy does not put undue financial pressure on the organisation. However, we have also considered how quickly we could practically make improvements to the Trust's digital solutions – there are some urgent requirements to stabilise our services. A number of options have therefore been considered.

Although it is anticipated that Trust capital and revenue savings will support funding for the digital strategy, it would limit the pace of benefits being realised due to other costs pressures within the organisation. Therefore, although prioritisation should be given to these projects the Trust will be looking to secure funding via annual central funding programmes. These include Health System Led Investment (HSLI), ePMA Fund, Cyber Funding Project as well as future funds from NHSx. We are in regular discussion with our Regulators on the required funding for a strategy of such scale and ambition.

Where appropriate the Trust has and will continue to look at how these solutions are procured to spread costs to align to financial benefits.

As a result, the forecasted costs of delivering the strategy are as follows:

(£'000)		20/21		21/22		22/23		23/24		24/25		25/26	
Workstream	**Project**	**Cap**	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**	**Cap**	**Rev**
Invisible IT	Telephony system/ Pagers	290											
Invisible IT	Microsoft Licening - Server/	130	225		28		28		28	300	28		28
Invisible IT	Data Centre	500	15	500	35	500	40	500	40	500	40	1000	40
Invisible IT	Hardware Replacement	250		200		200		200		200		500	
User Expereince	End User Device Replaceme	400		400		400		400		500		500	
EPR	LIMS					400		1200	100		100		100
EPR	PACS/RIS			200		200	40		40		40		40
EPR	PAS Upgrade	150								400			
EPR	Departmental Systems	625		400	10	400	30	200	40	400	50	500	60
Invisible IT	Cyber Security	250		100		100		200		200		200	
System by Design	KMCR	190		100		100							
EPR	EPR	200		2000	700	2000	850	1000	1000	500	1000		1000
User Expereince	Single Sign On	300											
User Expereince	Microsoft Office 365	0	178		305		310		315		321		327
User Expereince	Voice Recognition/Natural	20	50		50		50	400	100		100	600	100
System by Design	NHS App/Patient Portal/Mc	0		100		200	50	100	50	200	50	400	50
EPR	AI Tools	0		100	25		60	250	100	500	150	500	150
EPR	EDRMS	400		1500		1000			150		150		150
System by Design	ICP Collabration - System Ir	0		100		400		1000		500			
System By Design	Patient Flow			500				200					
Capital		**3705**		**6200**		**5900**		**5650**		**4200**		**4200**	
Revenue			**468**		**1153**		**1458**		**1963**		**2029**		**2045**

The table above shows both the forecasted annual capital required in each year and the increased revenue cost pressure to the organisation to achieve the schemes identified within the stategy.

Central funding schemes have also been forecasted below but, these will be confirmed each financial year. These figures are currently based on what similar Trusts have received for the same projects over the last 3 years and programmes we expect to be initiated by NHSx/NHSE. However, it should be highlighted that these funds are a risk until confirmed by the central bodies.

(£'000)	20/21	21/22	22/23	23/24	24/25	25/26
KMCR	190	0	0	0	0	0
NHSE Cyber Programme	350	100	0	0	0	0
EPMA/EPR	200	1300	0	0	0	0
Digital Aspirants	0	0	0	0	0	0
HSLI	0	200	200	200	0	0
Other	250	0	400	1200	500	500

Financial benefits of each scheme are not included within the table but will be clearly identified in each business case. However, it is forecasted that over the term of the strategy the net revenue pressures will be covered by cash releasing benefits from the solutions deployed.

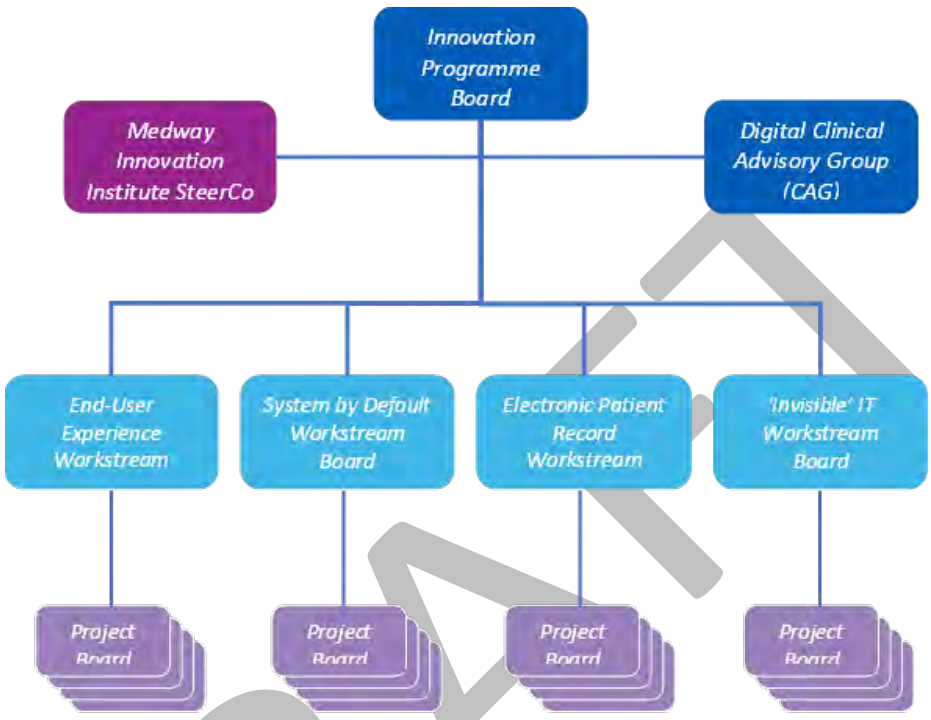
Based on the costed schemes and factoring in the potential central funding the forecast net position required to delivery the Digtial Strategy:

(£'000)	20/21	21/22	22/23	23/24	24/25	25/26
Revenue (Cumulative)	468	1153	1458	1963	2029	2045
Capital	2715	4600	5300	4250	3700	3700

6.5. Governance

6.5.1. Governance Model

The delivery of the digital strategy will be overseen within the governance of the Innovation Programme of the Trust's Improvement Plan (2020-2023) as depicted by the below governance model:



Programme Board - the purpose of the Programme Board will be to provide robust assurance and governance to support strategy delivery within the Trust. The board will ensure the programmes and pr ojects are managed with due regard to the delivery of transformation and the provision of systems and services that are fit for purpose, delivered on time and within budget. This board will support the overall delivery of Trust's objectives as described in this strategy.

Clinical Advisory Group – will be chaired by the CCIO and contain Clinical Digital Leaders, provide advise, guidance on clinical approval, and ensure clinical engagement for all digital programmes.

The Medway Innovation Institute SteerCo - will oversee the Institute's general course of operations – to stimulate and accelerate quality improvement and innovation at Medway

Delivery Workstreams - each workstream within the Innovation pillar will have a board. With the exception of the Invisible IT all boards will have a Clinician as SRO. The boards will be responsible for overseeing the delivery of their element of the Trusts Digital Strategy.

Project Boards - will be established for each deliverable with a clearly identified PID which has been agreed by the relevant programme board.

6.5.2. Programme Board Key Roles

Senior Responsible Owner
Ultimately accountable for the success of the workstream and is responsible for enabling the organisation to exploit the new environment resulting from the programme, meeting the new business needs and delivering new capabilities. It is proposed that given the scale of the programme, this role is undertaken by the Exec Director for Transformation and Digital.

Programme Manager
Responsible for delivery of the programme and the component projects. The Programme Manager is responsible for the effective co-ordination of the projects, their interdependencies, any risks and issues that may arise and for delivering the benefits of the programme.

Business Change and Benefits Leads
Responsible for defining the benefits, assessing progress towards realisation, transition and implementation of the new capabilities and achieving measured improvements.

Programme Management Office
Provides the information hub for the programme, covering tracking and reporting, information management, financial accounting, risk and issue monitoring, quality and change control, s upport and a dvice to projects, health checks and upwards reporting against strategic objectives and drivers.

6.5.3. Project Board Key Roles

Senior Responsible Owner
Ultimately accountable for the delivery of the project and responsible to the programme board for the project's contribution to enabling the organisation to exploit the new environment resulting from the programme, meeting the new business needs and delivering new capabilities.

Project Managers
Responsible for the day-to-day delivery of the project, the necessary activities and for managing members of the Trust and s upplier project teams. The Project Managers report progress, and are responsible to the Project Board.

Business Representatives

Responsible for having business awareness of why the project is being implemented and how a project will be implemented. Such representatives would generally become an expert in the functionality. A subject matter expert of the solution / functional specialist would often fulfil this role.

Clinical Representatives

Responsible for representing the users of the solution being implemented, guiding plans and acting as a champion amongst their peers and colleagues. Such representative would generally have a thorough understanding of the services being delivered within the clinical areas that would be impacted by the project.

Supplier Representatives

Responsible for representing the supplier(s) providing the key elements of the solution. This role is often fulfilled by the Supplier Project Manager where there is a single or prime supplier.

6.5.4. Benchmarking

The HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) is a global assessment tool, focused on benchmarking clinical system utilisation within an organisation. The model is an eight stage model (0-7) for provider organisations to demonstrate levels of digital maturity and excellence. For an organisation to achieve HIMSS stage 7, there is a requirement for universal levels of digital maturity across an organisation.

Although this does not cover all areas of digital maturity within a hospital it is a good benchmark to understand our current maturity, progress the organisation is making and targets over the coming years, with key assessments taking place at key milestones. Currently the organisation has been assessed to be at **stage 2** and the vision for this strategy is that we should achieve **stage 5 over the next 5 years**. Will will use the assessment over the period of the strategy to assurance on the progress which is being undertaken.

Stage 7
The hospital no longer uses paper charts to deliver and manage patient care and has a mixture of discrete data, document images and medical images within its EMR environment. Data warehousing is being used to analyse patterns of clinical data to improve quality of care and patient safety, and care delivery efficiency. Clinical information can be readily shared via standardised electronic transactions (i.e. CCD) with all entities that are authorized to treat the patient, or a health information exchange (i.e. other non-associated hospitals, ambulatory clinics, sub-acute environments, employers, payers and patients in a data sharing environment). The hospital demonstrates summary data continuity for all hospital services (e.g. inpatient, outpatient, ED and with any owned or managed ambulatory clinics).

Stage 6
Full physician documentation with structured templates and discrete data is implemented for at least one inpatient care service area for progress notes, consult notes, discharge summaries or problem list and diagnosis list maintenance. Level three of clinical decision support provides guidance for all clinician activities related to protocols and outcomes in the form of variance and compliance alerts. A full complement of radiology PACS systems provides medical images to physicians via an intranet and displaces all film-based images. Cardiology PACS and document imaging are scored with extra points.

Stage 5
The closed loop medication administration with bar coded unit dose medications environment is fully implemented. The eMAR and bar coding or other auto identification technology, such as radio frequency identification (RFID), are implemented and integrated with CPOE and pharmacy to maximise point of care patient safety processes for medication administration. The "five rights" of medication administration are verified at the bedside with scanning of the bar code on the unit dose medication and the patient ID.

Stage 4
Computerised Practitioner Order Entry (CPOE) for use by any clinician licensed to create orders is added to the nursing and CDR environment, along with the second level of clinical decision support capabilities related to evidence based medicine protocols. If one inpatient service area has implemented CPOE with physicians entering orders and completed the previous stages, then this stage has been achieved.

Stage 3
Nursing/clinical documentation (e.g. vital signs, flow sheets, nursing notes) is required and is implemented and integrated with the CDR for at least one inpatient service in the hospital; care plan charting is scored with extra points. The Electronic Medication Administration Record (eMAR) application is implemented. The first level of clinical decision support is implemented to conduct error checking with order entry (i.e. drug/drug, drug/food, drug/lab conflict checking normally found in the pharmacy information system). Medical image access from Picture Archive and Communication Systems (PACS) is available for access by physicians outside the radiology department via the organisation's intranet.

Stage 2
Major ancillary clinical systems feed data to a clinical data repository (CDR) that provides physician access for reviewing all orders and results. The CDR contains a controlled medical vocabulary, and the clinical decision support/rules engine (CDS) for rudimentary conflict checking. Information from document imaging systems may be linked to the CDR at this stage. The hospital may be health information exchange (HIE) capable at this stage and can share whatever information it has in the CDR with other patient care stakeholders.

Stage 1
All three major ancillary clinical systems are installed (i.e. pharmacy, laboratory, and radiology).

Stage 0
The organisation has not installed all of the three key ancillary department systems (laboratory, pharmacy, and radiology).

6.6. Delivery Approach

6.6.1. Programme Delivery

The programme will be delivered in line with the principles of the Managing Successful Programmes methodology and guidance.

6.6.2. Clinically Led

As a clinically lead organisation it is important that are digital programme is clinically led. The appointment of a CCIO is key to this, but clinical leaders will be needed for each project.

6.6.3. Project Delivery

Projects will be delivered in line with the principles of the Projects in Controlled Environments (PRINCE2) methodology and guidance.

6.6.4. Quality Management

Implementations of new solutions, and the management of change, will be delivered in line with the principles of Quality Service Improvement and Redesign (QSR) tools. Improvement will be delivered using the Plan, Do, Study, Act (PDSA) methodology and guidance.

6.6.5. Quality Impact Assessment

Implementations of new solutions, and the management of change, will be delivered only after the Integrated Quality Impact Assessment process has been completed. This is now built into all digital change projects and programmes as a core planning component.

6.6.6. Patient safety documentation

All IT changes will be contingent upon the completion of core IT Patient Safety documentation such as DCB0160, and require statutory sign-offs from key Trust representatives. E.g. Information Governance, Procurement, Information Security, MHRA – Medical Devices.

6.6.7. Risk and Issue Management

Risks and issues will be proactively managed throughout the delivery of the programme, both within each project as well as at programme-level, with appropriate detail.

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Communications and Engagement**	**Agenda Item**	6.1
Report Author	Glynis Alexander, Executive Director of Communications and Engagement		
Lead Director	Glynis Alexander, Executive Director of Communications and Engagement		
Executive Summary	This report provides an update on communications and engagement activity since the last Board meeting. Keeping staff informed about developments relating to COVID-19 has been our main priority, while at the same time communicating about the restart of other services, and the development of our Improvement Plan. Activity has included staff engagement, stakeholder relations and community communications.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	N/A		
Committee Approval:	N/A		
Executive Group Approval:	N/A		
National Guidelines compliance:	N/A		
Resource Implications	None		
Legal Implications/Regulatory Requirements	None		
QIA	N/A		
Recommendation/ Actions required	The Board is asked to note the report.		

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

1 Executive Overview

1.1 Keeping staff informed about developments relating to COVID-19 has been our main priority over the past month.

1.2 At the same time we have been communicating about the restart of other services, and engaging staff and stakeholders in the development of our Improvement Plan.

1.3 As always, we have used the full range of communications channels to reach as many people as possible, ranging from virtual workshops, to a new staff-only Facebook page.

2 COVID-19

2.1 Throughout June we have continued to ensure staff are kept informed about COVID-19 with daily statistics and dedicated bulletins three times per week.

2.2 Since the coronavirus began to spread we have work hard to keep staff informed and up-to-date with national guidance, as well as with local developments.

2.3 Most recently messaging has focused on the wearing of masks throughout the hospital, changes to access, and swabbing.

2.4 Screensavers and posters, along with our electronic displays in the hospital, have been updated regularly to reflect the changing situation and to ensure staff have sources of truth they can rely on.

2.5 We have been collating the personal experiences of staff during the COVID-19 pandemic, to share as blogs, under the banner Medway Moments. Unsurprisingly, the stories they share are great testament to the fantastic, caring approach our staff take, and often very moving.

2.6 We have also chronicled the work of our staff across the hospital in a series of photoboards with quotes from individuals.

2.7 We have been conscious of the need to support staff wellbeing, including setting up and equipping a wellbeing hub in the post graduate centre, with help from our charitable funds.

2.8 The generosity of our community, including residents and businesses, continues, with donations still flowing into the hospital.

3 TRUST IMPROVEMENT PLAN

3.1 Staff engagement on the draft Improvement Plan is underway, with three sessions to involve clinical leaders, senior managers and all staff.

3.2 The message has been that the development of the plan is clinically-led, and that all staff have an opportunity to feed back on the draft before it is finalised, adopted and launched in August.

3.3 Staff engagement activity builds on a programme of virtual workshops, a survey and interviews, commissioned to capture the views and perceptions of staff following the publication of our CQC report at the end of April.

3.4 A facilitated discussion has also been arranged for the Executive Team on 8 July to consider what we have heard from staff and to ensure we are responding to the findings.

3.5 Meanwhile, externally we have discussed the draft plan with stakeholders including the council's scrutiny committee, which received positive feedback. It is clear that we will need to continue to involve key stakeholders to ensure they have confidence in the delivery of the plan.

3.6 A range of materials will be produced to raise awareness of and communicate progress on the Improvement Plan. Traditional, digital and interactive channels will be used to create opportunities for meaningful engagement.

3.7 Some key areas of the Improvement Plan have already been the subject of engagement and campaign work. For example we have used screensavers and video animation to highlight the importance of infection prevention and control, and we have promoted the launch of the Innovation Institute website.

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

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

4 STAKEHOLDER ENGAGEMENT

4.1 In addition to engaging our external stakeholders about the COVID-19 and our draft improvement plan, we have held briefings with and sent updates to our five MPs and senior council representatives on other key issues.

4.2 In particular we have ensured they are aware of all we are doing (and have already done) in relation to our CQC action plan.

4.3 The chair and chief executive also took time to brief stakeholders about our stroke service, and the recommendation for a temporary move to Maidstone and Darent Valley in the interests of quality of care for patients.

4.4 We also held briefings with Healthwatch, who helped communicate the message to patients through their channels.

4.5 Our Community Engagement Officer has been reaching out to community groups to keep the Trust connected with our population.

4.6 She has also set up two virtual member events to support Governor engagement, one at the end of July focusing on our Improvement Plan, and the other to highlight infection prevention and control.

5 MEDIA AND SOCIAL MEDIA

5.1 Our local and regional media have covered a number of positive stories of patients who are recovering from COVID-19 and wanted to thank staff. This included one of our Care Support Workers, Cesar, who is now recovering at home after many weeks in the hospital.

5.2 Our social media channels have collectively reached well over a quarter of a million people in the last month, slightly down on the period when coronavirus was at its peak, but an increase on pre-COVID times.

5.3 In mid-June we launched a Facebook page for staff which quickly attracted 1,174 Trust employees. The page provides a forum to share Trust news and for staff to comment and raise questions.

NHS
Medway
NHS Foundation Trust

"Working in the ICU these past months has allowed us to see the devastating impact of COVID-19 but also the remarkable stories of recovery. We are proud to have played a part in keeping patients in touch with their loved ones during this difficult time."

Our Skype Angels Sharon and Mel

#MedwayCovidChronicles

Best of care
Best of people

NHS
Medway
NHS Foundation Trust

"I've been distributing hundreds of items across the hospital making sure all the generous donations from our community in Medway and Swale are reaching our staff who deserve them the most."

Cheryl, Fundraising Officer

Best of care
Best of people

#MedwayCovidChronicles

NHS
Medway
NHS Foundation Trust

"We've put our life on the line every day battling this terrible virus, but we are delighted that so many of our patients have managed to get better under our care."

Bernie, Associate Practioner

#MedwayCovidChronicles

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Best of people

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Medway
NHS Foundation Trust

"It's been a really busy period with all the extra stock that has come into the hospital, but as a team we've been determined to stand up to the challenge and deliver everything on time to help our colleagues and patients."

Dan, Head of Procurement

#MedwayCovidChronicles

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Best of people

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Medway
NHS Foundation Trust

"We've adapted our life-saving techniques during this unprecedented period to protect some of our most ill patients, like carrying out CPR in full protective equipment."

Rowena, Staff Nurse

Best of care
Best of people

#MedwayCovidChronicles

NHS
Medway
NHS Foundation Trust

"Despite the challenges of coronavirus, our priority has always been to serve staff and patients food that it is safe, nutritious and enjoyable. We couldn't feel prouder with the role we have played."

Justin, Catering Team

#MedwayCovidChronicles

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"The impact of this sudden pandemic affected everyone, but also brought us closer together as a team which helped us fight the peak of coronavirus."

Dr Safdar, Elderly Care

#MedwayCovidChronicles

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"Our doctors would not be able to care for patients safely without the help of unsung heroes like our housekeepers, who are on the frontline every day."

Wendie, Head of Housekeeping

#MedwayCovidChronicles

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"Our team worked together with calmness and flexibility to deal with this unprecedented situation - the actions of my colleagues were truly heroic."

Dr Hayden, Critical Care

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Best of people

#MedwayCovidChronicles

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NHS Foundation Trust

"We introduced a large selection of groceries and toiletries to save our clinical colleagues the stress of visiting the shops after they finished a long shift."

Scott, League of Friends Operation Manager

#MedwayCovidChronicles

Best of care
Best of people

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Medway
NHS Foundation Trust

"We proudly linked in with the community to arrange for their kind offers and donations to be delivered to wards and departments across the hospital."

Donna, Charity and Fundraising Manager

Best of care
Best of people

#MedwayCovidChronicles

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Finance Report**	**Agenda Item**	7.1
Report Author	Richard Eley, Director of Finance Paul Kimber, Deputy Director of Finance		
Lead Director	Richard Eley, Director of Finance		
Executive Summary	The Trust reports a deficit of £21k in month and year to date, which adjusts to breakeven against the NHSE/I Control Total.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: 25 June 2020		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
QIA	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance report and its appendices therein		

Finance report

For the period ending 31 May 2020

Contents

Appendices

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month (NHSE/I)	-	-	-	The Trust reports a £21k deficit position for May; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. In order to achieve breakeven the Trust accrued true-up income of £2.0m; Covid-19 expenditure in the month amounted to £2.3m.
YTD (NHSE/I)	-	-	-	
In-month (budget)	(5,182)	(21)	5,161	
YTD (budget)	(10,583)	(21)	10,562	
Forecast	-	-	-	
CIP				
In-month	210	210	-	Schemes delivered to date relate to procurement savings from nationally agreed prices and reduced external consultancy spend. The CIP forecast is currently as per budget although there is a £2.7m gap between this and plans at this time. Services continue to develop schemes to achieve the forecast total required.
YTD	420	420	-	
Forecast	12,000	12,000	-	
Capital				
In-month	(1,671)	(750)	921	Capital expenditure is currently behind plan. Orders of £6m have been raised and there is an expectation of delivering on plan as the year progresses.
YTD	(3,342)	(2,332)	1,010	
Forecast	(20,048)	(20,048)	-	
Cash				
Month end	19,018	47,496	28,478	Cash balances at 31 May were £28.5m higher than expected due to increased advance contract payments due to temporary COVID funding arrangements.

Activity is significantly below draft budgeted levels as a result of Covid	Clinical income based on the consultation tariff would have reported a year to date position of £26.2m, this being £13.8m adverse to the draft budget or 34% of the income target. (£6.1m adverse in-month or 30% of the income target). This reflects the impact that Covid has had on the performance of "routine" activity.
Pay costs are higher than expected	Divisions have been as ked/challenged to bear down on pay costs in June given the number of patients with Covid are low and the Trust has 109 beds closed.

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

£'000	In-month			Year-to-date		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	20,380	20,424	45	40,759	40,761	2
High cost drugs	1,876	1,644	(232)	3,752	3,452	(299)
Other income	1,982	1,534	(448)	3,964	3,179	(785)
FRF/MRET	4,417	6,478	2,061	8,834	12,538	3,704
Total income	**28,654**	**30,080**	**1,426**	**57,308**	**59,930**	**2,622**
Nursing	(5,927)	(6,326)	(399)	(11,854)	(12,362)	(508)
Medical	(5,640)	(6,461)	(821)	(11,280)	(12,397)	(1,117)
Other	(6,649)	(7,078)	(430)	(13,298)	(13,288)	9
Total pay	**(18,216)**	**(19,866)**	**(1,650)**	**(36,432)**	**(38,047)**	**(1,615)**
Clinical supplies	(3,774)	(3,515)	259	(7,548)	(6,839)	709
Drugs	(701)	(543)	158	(1,402)	(1,183)	219
High cost drugs	(1,925)	(1,637)	288	(3,850)	(3,446)	405
Other	(2,701)	(3,244)	(544)	(5,402)	(7,793)	(2,391)
Total non-pay	**(9,101)**	**(8,939)**	**162**	**(18,202)**	**(19,261)**	**(1,058)**
EBITDA	**1,337**	**1,275**	**(62)**	**2,674**	**2,623**	**(51)**
Depreciation	(834)	(788)	47	(1,668)	(1,570)	99
Net finance income/(cost)	39	13	(26)	78	11	(67)
PDC dividend	(542)	(522)	21	(1,084)	(1,085)	(1)
Non-operating exp.	**(1,337)**	**(1,296)**	**41**	**(2,674)**	**(2,644)**	**30**
Reported surplus/(deficit)	**-**	**(21)**	**(21)**	**-**	**(21)**	**(21)**
Adj. to control total	-	21	21	-	21	21
Control total	**-**	**-**	**-**	**-**	**-**	**-**

Key messages:

1. NHSE/I baseline budgets are calculated centrally and ar e based on av erage financial performance for defined periods during 2019/20, uplifted for inflation or known pressures where applicable.
2. The Trust has agreed with other providers in Kent to invoice one another using the same methodology applied by NHSE/I in calculating their baseline.
3. The "FRF/MRET" income in the baseline budget is the top-up income. The variance to actual reflects the additional "true-up" income required to achieve breakeven.
4. Total expenditure includes the incremental cost of Covid-19, being £2.3m; £0.9m of this is reported in non-pay and £1.4m in pay. Based on feedback from other providers within the STP this expenditure is not remarkable.
5. Further detail of incremental Covid-19 costs are included in Appendix 11.

2. Income and expenditure (reporting against draft budget)

£'000	In-month			Year-to-date		
	Budget	Actual	Var.	Budget	Actual	Var.
Clinical income	19,977	20,424	447	40,106	40,761	655
High cost drugs	1,881	1,644	(237)	3,829	3,452	(377)
Other income	2,091	1,534	(557)	4,182	3,179	(997)
FRF/MRET	769	6,478	5,709	1,538	12,538	11,000
Total income	**24,718**	**30,080**	**5,362**	**49,655**	**59,930**	**10,281**
Nursing	(5,963)	(6,326)	(363)	(11,953)	(12,362)	(408)
Medical	(5,589)	(6,461)	(873)	(11,179)	(12,397)	(1,218)
Other	(6,549)	(7,078)	(529)	(13,446)	(13,288)	158
Total pay	**(18,101)**	**(19,866)**	**(1,765)**	**(36,579)**	**(38,047)**	**(1,468)**
Clinical supplies	(2,957)	(3,515)	(558)	(5,937)	(6,839)	(902)
Drugs	(2,518)	(543)	1,975	(5,061)	(1,183)	3,878
High cost drugs	(2,461)	(1,637)	823	(3,767)	(3,446)	321
Other	(2,322)	(3,244)	(922)	(5,813)	(7,793)	(1,980)
Total non-pay	**(10,258)**	**(8,939)**	**1,319**	**(20,578)**	**(19,261)**	**1,317**
EBITDA	**(3,641)**	**1,275**	**4,916**	**(7,502)**	**2,623**	**10,124**
Depreciation	(958)	(788)	170	(1,915)	(1,570)	345
Net finance income/(cost)	(41)	13	54	(82)	11	93
PDC dividend	(542)	(522)	21	(1,084)	(1,085)	(1)
Non-operating exp.	**(1,541)**	**(1,296)**	**245**	**(3,081)**	**(2,644)**	**432**
Reported surplus/(deficit)	**(5,182)**	**(21)**	**5,161**	**(10,583)**	**(21)**	**10,562**

Key messages:

1. The Trust is currently maintaining internal budgets for probity. Divisions, care groups, specialties and cost centres will continue to be monitored against their agreed expenditure budget but not against income during the period of nationally executed contracting.

2. Total income is higher than the draft budget primarily as a result of the NHSE/I requirement to breakeven each month from April to July.

3. If income had been earned on a cost and volume basis in April and May (based on consultation tariff) the Trust would have reported clinical income of £26.2m, or £13.8m adverse to plan YTD (£6.1m adverse in-month). This reflects the impact that Covid has had on the performance of "routine" activity.

4. Non-pay expenditure includes incremental costs of c£0.9m in respect of Covid (£1.9m YTD).

5. Redeployment of staff to meet 7-day working and address acuity of payments is happening wherever possible. The demand on services to cover shifts through temporary staffing measures continues even though during May sickness levels reduced by 40%; pay costs did not reduce proportionately as annual leave increased significantly during the month (following requests to cancel all leave in April). For non-elective settings of care there is also a requirement to maintain staffing levels to ensure a state of readiness.

6. The incremental cost of Covid-19 on pay costs was £1.4m in May (£2.1m YTD).

2. Income and expenditure delegated budgets (NHSE/I: year to date)

£'000	Year to date								
	Income			Expenditure			Contribution		
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.
UIC									
Diagnostics & Clinical Support	3,156	2,953	(203)	(8,528)	(8,032)	496	(5,372)	(5,079)	293
Specialist Medicine	592	298	(294)	(4,521)	(3,909)	612	(3,929)	(3,611)	317
Therapies & Older Persons	6	16	9	(2,926)	(2,921)	5	(2,919)	(2,905)	15
Unplanned & Integrated Care	224	43	(181)	(2,296)	(4,184)	(1,888)	(2,072)	(4,140)	(2,068)
Urgent & Emergency Care	148	65	(84)	(4,457)	(2,163)	2,294	(4,309)	(2,098)	2,210
Sub-total	**4,127**	**3,375**	**(753)**	**(22,728)**	**(21,209)**	**1,520**	**(18,601)**	**(17,834)**	**767**
Planned care									
Cancer Services	706	795	89	(1,674)	(1,719)	(46)	(968)	(924)	43
Critical Care & Perioperative	326	-	(326)	(6,313)	(366)	5,947	(5,987)	(366)	5,621
Planned Care Infrastructure	113	121	8	(6,187)	(5,189)	998	(6,074)	(5,068)	1,006
Surgical Services	-	103	103	(420)	(5,859)	(5,439)	(420)	(5,756)	(5,336)
Women & Children	136	122	(14)	(6,060)	(6,235)	(175)	(5,924)	(6,113)	(189)
Sub-total	**1,281**	**1,141**	**(140)**	**(20,654)**	**(19,368)**	**1,286**	**(19,373)**	**(18,227)**	**1,146**
Corporate									
Communications	-	-	-	(75)	(71)	4	(75)	(71)	4
Exec & Board	-	-	-	(541)	(559)	(18)	(541)	(559)	(18)
Finance	8	8	-	(575)	(625)	(50)	(566)	(617)	(50)
Governance & Legal	-	-	-	(184)	(185)	(1)	(184)	(185)	(1)
Health Informatics	-	22	22	(623)	(670)	(47)	(623)	(648)	(25)
HR & OD	265	241	(24)	(777)	(726)	51	(512)	(485)	27
Medical Director	1,595	1,604	9	(903)	(865)	39	692	739	47
Nursing	-	3	3	(631)	(647)	(17)	(631)	(644)	(14)
PMO	-	-	-	(83)	(184)	(101)	(83)	(184)	(101)
Strategy and Partnerships	-	-	-	-	(315)	(315)	-	(315)	(315)
Sub-total	**1,868**	**1,877**	**10**	**(4,392)**	**(4,848)**	**(456)**	**(2,524)**	**(2,971)**	**(447)**
E&F									
E&F	**880**	**421**	**(459)**	**(3,846)**	**(3,814)**	**32**	**(2,966)**	**(3,393)**	**(427)**
Central									
Central	**49,152**	**53,121**	**3,969**	**(5,688)**	**(10,719)**	**(5,031)**	**43,464**	**42,403**	**(1,061)**
TOTAL	**57,308**	**59,930**	**2,622**	**(57,308)**	**(59,951)**	**(2,643)**	**-**	**(21)**	**(21)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**21**	**21**	**-**	**21**	**21**
Control total	**57,308**	**59,930**	**2,622**	**(57,308)**	**(59,930)**	**(2,622)**	**-**	**-**	**-**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

2. Income and expenditure delegated budgets (draft budgets: year to date)

Annual plan				Year to date								
				Income			Expenditure			Contribution		
Income	Exp.	Contr.	£'000	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
			UIC									
37,001	(53,285)	(16,285)	Diagnostics & Clinical Support	5,956	2,953	(3,003)	(8,782)	(8,032)	750	(2,826)	(5,079)	(2,253)
30,542	(26,742)	3,799	Specialist Medicine	4,899	298	(4,601)	(4,438)	(3,909)	529	461	(3,611)	(4,072)
9,505	(17,254)	(7,749)	Therapies & Older Persons	1,523	16	(1,508)	(2,876)	(2,921)	(45)	(1,352)	(2,905)	(1,553)
57,144	(26,196)	30,947	Unplanned & Integrated Care	9,161	43	(9,118)	(4,348)	(4,184)	165	4,813	(4,140)	(8,953)
1,237	(10,635)	(9,399)	Urgent & Emergency Care	198	65	(133)	(1,773)	(2,163)	(391)	(1,574)	(2,098)	(524)
135,428	**(134,113)**	**1,315**	**Sub-total**	**21,738**	**3,375**	**(18,363)**	**(22,217)**	**(21,209)**	**1,008**	**(479)**	**(17,834)**	**(17,355)**
			Planned care									
8,884	(10,357)	(1,473)	Cancer Services	1,424	795	(629)	(1,685)	(1,719)	(34)	(261)	(924)	(663)
1,800	1,392	3,192	Critical Care & Perioperative	300	-	(300)	(318)	(366)	(48)	(18)	(366)	(348)
65,145	(36,275)	28,870	Planned Care Infrastructure	10,444	121	(10,323)	(5,985)	(5,189)	797	4,459	(5,068)	(9,527)
12,791	(37,717)	(24,926)	Surgical Services	2,053	103	(1,951)	(6,225)	(5,859)	366	(4,171)	(5,756)	(1,585)
61,181	(38,046)	23,135	Women & Children	9,813	122	(9,691)	(6,313)	(6,235)	77	3,501	(6,113)	(9,614)
149,801	**(121,003)**	**28,798**	**Sub-total**	**24,035**	**1,141**	**(22,893)**	**(20,525)**	**(19,368)**	**1,157**	**3,509**	**(18,227)**	**(21,736)**
			Corporate									
-	(426)	(426)	Communications	-	-	-	(71)	(71)	(0)	(71)	(71)	(0)
-	(2,693)	(2,693)	Exec & Board	-	-	-	(449)	(559)	(111)	(449)	(559)	(111)
25	(3,744)	(3,719)	Finance	4	8	4	(620)	(625)	(5)	(616)	(617)	(1)
0	(1,044)	(1,044)	Governance & Legal	0	-	(0)	(174)	(185)	(11)	(174)	(185)	(11)
-	(3,989)	(3,989)	Health Informatics	-	22	22	(665)	(670)	(5)	(665)	(648)	17
1,452	(4,374)	(2,922)	HR & OD	242	241	(1)	(729)	(726)	3	(487)	(485)	2
9,641	(5,438)	4,203	Medical Director	1,607	1,604	(3)	(960)	(865)	96	646	739	93
202	(3,992)	(3,791)	Nursing	34	3	(31)	(665)	(647)	18	(632)	(644)	(13)
-	(832)	(832)	PMO	-	-	-	(192)	(184)	8	(192)	(184)	8
-	(1,819)	(1,819)	Strategy and Partnerships	-	-	-	(303)	(315)	(12)	(303)	(315)	(12)
11,319	**(28,352)**	**(17,033)**	**Sub-total**	**1,887**	**1,877**	**(9)**	**(4,829)**	**(4,848)**	**(19)**	**(2,942)**	**(2,971)**	**(29)**
			E&F									
5,334	**(23,613)**	**(18,278)**	**E&F**	**880**	**421**	**(459)**	**(3,933)**	**(3,814)**	**119**	**(3,053)**	**(3,393)**	**(340)**
			Central									
54,625	**(49,427)**	**5,198**	**Central**	**1,116**	**53,121**	**52,005**	**(8,734)**	**(10,719)**	**(1,984)**	**(7,618)**	**42,403**	**50,021**
356,508	**(356,508)**	**-**	**TOTAL**	**49,655**	**59,930**	**10,281**	**(60,238)**	**(59,951)**	**287**	**(10,583)**	**(21)**	**10,562**

The commissioner block income, top-up income and true-up income are all reported through "Central" during these Covid arrangements.

3. Forecast

No detailed forecast has been prepared at this time, principally because:

- No updated planning guidance has been received upon which to budget for the period August 2020 to March 2021;
- The period to 31 July 2020 will be funded by way of true-up income to allow the Trust to achieve a control total of breakeven;
- There remains significant uncertainty in respect of when and how the Trust returns to “normal business” and hence the financial modelling of these plans has not been possible.

The Trust remains committed to delivering a full year control total of breakeven and will work with its commissioners, partners and regulators through developments over the coming days, weeks and months.

4. CIP (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Mitigated target	Gap	Budget	Gap
Planned care	368	1,237	-	961	2,566	**5,100**	(2,534)	**4,682**	(2,116)
UIC	518	2,708	93	948	4,267	**5,505**	(1,238)	**4,253**	14
E&F	-	801	-	-	801	**800**	1	**661**	140
Corporate	363	-	-	-	363	**1,709**	(1,346)	**1,113**	(750)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	0
Total	**2,540**	**4,746**	**93**	**1,909**	**9,288**	**14,405**	**(5,117)**	**12,000**	**(2,712)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**210**	**210**	**-**	**420**	**420**	**-**	**12,000**	**12,000**	**-**

Process

1. CIPs are the responsibility of the budget holders.
2. The Improvement team supports the budget holders to deliver both quality and cost improvements.
3. The PMO oversees these programmes, supporting with PID writing/management and w orks to fill the programme.
4. The Finance department counts the extent to which the financial improvements have been made.
5. The Director of Finance and t he Director of Improvement monitor and work with budget-holders to achieve targets.

The total CIP included in the draft budget from March is £12m. Of this, the majority of CIPS are phased to be realised in the second half of the financial year.

An update to the programme reports that £7.3m of savings have been BRAG rated as blue or green and a further £2.0m as amber or red; the remaining £2.7m gap to achieve the NHSE/I plan are schemes in progress or yet to be identified. These savings are being developed through CIP panels and the QIA assessment process; however due to the change in activities and responding to Covid, some efficiency programmes have encountered delays.

The PMO team continue to work with Divisions and the Finance Business Partners to identify and quantify CIP schemes whilst working towards a stretch target of £14.4 million (this being 20% higher than the required CIP to mitigate the risk of individual scheme failure).

Delivery to date is £0.4m and as planned, this has mainly been achieved though procurement measures.

Further detail of CIP schemes by Division is presented in Appendix 6.

5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,790	**Non-current assets**	**215,996**	**205,548**	**(10,448)**
6,306	Inventory	7,400	5,950	(1,450)
36,687	Trade and other receivables	29,899	27,991	(1,908)
12,385	Cash	19,018	47,496	28,478
55,378	**Current assets**	**56,317**	**81,437**	**25,120**
(24,478)	Trade and other payables	(38,370)	(23,746)	14,624
(292,111)	Borrowings	(1,745)	(292,039)	(290,294)
(4,519)	Other liabilities	(23,337)	(32,160)	(8,823)
(321,108)	**Current liabilities**	**(63,452)**	**(347,945)**	**(284,493)**
(2,278)	Borrowings	(23,273)	(2,278)	20,995
(1,317)	Other liabilities	(900)	(1,317)	(417)
(3,595)	**Non-current liabilities**	**(24,173)**	**(3,595)**	**20,578**
(64,534)	**Net assets employed**	**184,688**	**(64,533)**	**(249,243)**
140,581	Public dividend capital	410,790	140,580	(270,209)
41,366	Revaluation reserve	47,336	41,366	(5,970)
(246,481)	Retained earnings	(273,438)	(246,502)	26,936
(64,534)	**Total taxpayers' equity**	**184,688**	**(64,533)**	**(249,243)**

Key messages:

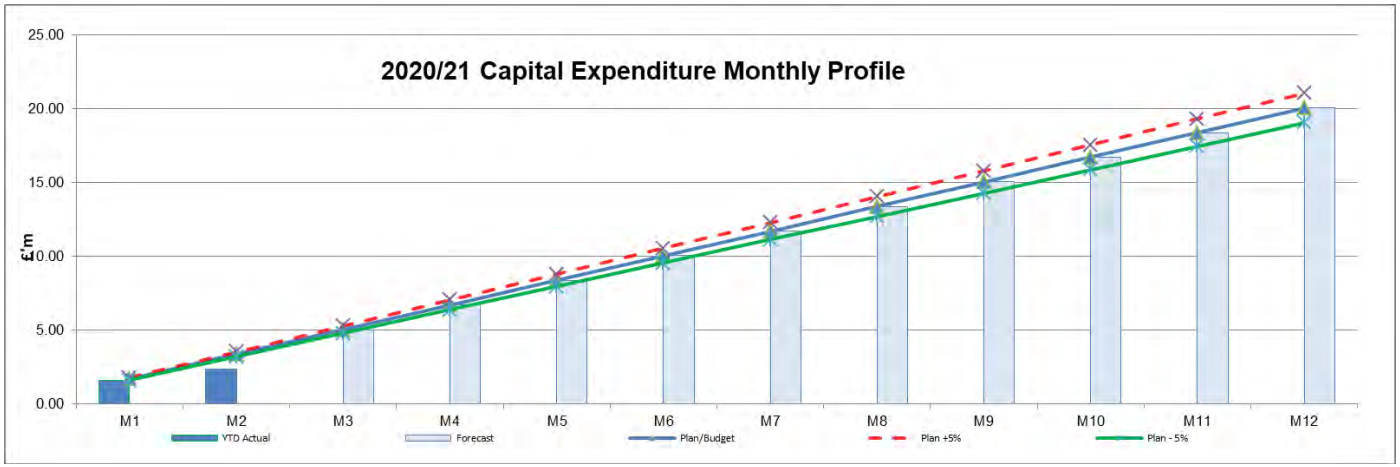
1. As part of the commissioning arrangements, the block income and top-up income for both April and May was paid to the Trust in April.

2. Where invoices are matched and approved, the Trust has paid its suppliers on immediate terms during the pandemic, rather than waiting for the normal credit period.

3. Following the guidance released at year end, the interim loans have been reclassified as due within one year; new PDC will be issued and the debt written off. The effective date of the transaction will be 30 September 2020 (assumed to be 1 April 2020 in draft plan). The value of loans originally thought to be eligible for this transaction was notably lower in our budget assumptions than we have now been informed.

6. Capital

£'000	In-month			Year To Date			Annual			Funding	
	Budget	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC
Backlog maintenance	290	76	214	580	465	115	3,473	3,473	-	3,473	-
Routine maintenance	27	91	(64)	54	99	(45)	326	326	-	326	-
Fire safety	416	259	157	832	675	157	4,991	4,991	-	0	4,991
IT	228	1	227	456	88	368	2,730	2,730	-	2,730	-
ED	320	(139)	459	640	(169)	809	3,835	3,835	-	835	3,000
Plant & equipment	390	462	(72)	780	1,174	(394)	4,693	4,693	-	3,589	1,104
COVID	-	-	-	-	-	-	-	-	-	-	-
Total	**1,671**	**750**	**921**	**3,342**	**2,332**	**1,010**	**20,048**	**20,048**	**-**	**10,953**	**9,095**



Capital expenditure to date is below plan. Capital allocations have now been finalised by the STP and a programme of work agreed at the Trust Capital Group. This will enable expenditure to accelerate in line with the plan.

As noted in a previous budget update to the Finance Committee, new financing requirements are typically expected to be funded through the issue of Public Dividend Capital rather than from loans or cash reserves.

7. Cash

13 Week Forecast	w/e																	
	Actual					Forecast												
£m	01/05/20	08/05/20	15/05/20	22/05/20	29/05/20	05/06/20	12/06/20	19/06/20	26/06/20	03/07/20	10/07/20	17/07/20	24/07/20	31/07/20	07/08/20	14/08/20	21/08/20	28/08/20
BANK BALANCE B/FWD	**53.65**	**37.89**	**37.44**	**62.07**	**57.85**	**47.48**	**45.98**	**41.65**	**66.27**	**53.57**	**43.02**	**40.65**	**67.27**	**54.57**	**44.02**	**41.33**	**65.82**	**61.61**
Receipts																		
NHS Contract Income	0.95	0.00	28.85	0.14	0.04	0.17	0.00	28.77	0.00	0.00	0.00	28.77	0.00	0.00	0.00	28.37	0.00	0.00
Other	0.35	0.07	0.61	0.45	0.09	1.29	0.59	0.32	0.28	0.28	0.59	2.97	0.28	0.28	0.28	0.59	0.28	0.28
Total receipts	**1.30**	**0.07**	**29.45**	**0.59**	**0.12**	**1.46**	**0.59**	**29.09**	**0.28**	**0.28**	**0.59**	**31.73**	**0.28**	**0.28**	**0.28**	**28.95**	**0.28**	**0.28**
Payments																		
Pay Expenditure (excl. Agency)	(8.13)	(0.44)	(0.32)	(9.60)	(8.22)	(0.35)	(0.35)	(0.35)	(9.56)	(8.22)	(0.35)	(0.35)	(9.56)	(8.22)	(0.35)	(0.35)	(0.42)	(9.49)
Non Pay Expenditure	(7.26)	(0.08)	(4.50)	(2.63)	(0.60)	(2.61)	(4.56)	(4.11)	(3.41)	(0.94)	(2.61)	(4.76)	(3.41)	(0.94)	(2.61)	(4.11)	(4.06)	(2.61)
Capital Expenditure	(1.67)	0.00	0.00	0.00	(1.67)	0.00	0.00	0.00	0.00	(1.67)	0.00	0.00	0.00	(1.67)	0.00	0.00	0.00	0.00
Total payments	**(17.06)**	**(0.52)**	**(4.82)**	**(12.23)**	**(10.49)**	**(2.96)**	**(4.91)**	**(4.46)**	**(12.97)**	**(10.83)**	**(2.96)**	**(5.11)**	**(12.97)**	**(10.83)**	**(2.96)**	**(4.46)**	**(4.48)**	**(12.10)**
Net Receipts/ (Payments)	**(15.76)**	**(0.45)**	**24.64**	**(11.64)**	**(10.37)**	**(1.50)**	**(4.33)**	**24.62**	**(12.70)**	**(10.55)**	**(2.38)**	**26.62**	**(12.70)**	**(10.55)**	**(2.69)**	**24.49**	**(4.21)**	**(11.82)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	5.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	2.31	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**7.41**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**37.89**	**37.44**	**62.07**	**57.85**	**47.48**	**45.98**	**41.65**	**66.27**	**53.57**	**43.02**	**40.65**	**67.27**	**54.57**	**44.02**	**41.33**	**65.82**	**61.61**	**49.79**

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	19,018	47,496	28,478

Following the nationally mandated contracting rules during the Covid pandemic, the Trust has been paid its April and May block commissioner contract and top-up payments in April. The income for June will be paid in May and those for July paid in June to ensure cash flow.
The value of contract income currently received in advance of delivery is £30,331k

Where the Trust has been able to match invoices to purchase orders and receipts, or where invoices have been separately approved, it has made immediate payment to suppliers in order to support their cash flows. This has meant that in some instances suppliers are paid before the normal credit term is taken, but is in keeping with the national guidance during this time.

8. Risks

Title	Description	£'000	Mitigation(s)	Lead(s)
2020/21 planning	No further guidance has been released at this time in respect of operating planning for 2020/21.	-	Current information indicates that national block contracting arrangements will continue until 31 October 2020.	Richard Eley
CIP (planning)	There remains a gap between RAG rated CIP programmes and the draft budget requirement of £12m.	£1,813	CIP meetings continue to be hel d by the Director of Improvement. Oversight moved from Transformation to Finance – fresh eyes from new directors. Return of CIP governance following pause during Covid pandemic.	Richard Eley, Mark Hackett
Staff costs	Staff costs have continued to rise despite the significant reduction in activity during April and May. Unchecked, this could drive a need f or additional CIP and/or additional true-up income from NHSE/I and/or the Trust missing its control total.	-	Deep dive reviews are underway at the time of writing to understand deployment of resources.	Divisional Directors
Safer staffing	The Trust is in the process of reviewing its safer staffing arrangements, which currently considers the acuity, bed occupancy and activity during the pre-Covid period.	£1,300	As Model Hospital suggests an ex pensive nursing cost per WAU compared to peers and nationally, nursing colleagues are asked to explore staffing levels in areas not covered through the safer staffing exercise. This exercise may be superseded as result of ward reconfigurations.	Richard Eley, Jane Murkin
Ward reconfiguration	As part of the restart planning wards will need to change at pace. T he changing nature, specialty and bed bas es could impact cost and efficiency.	TBC	Restart modelling is underway.	Richard Eley, Angela Gallagher, Mark Hackett
Microsoft licensing	The Trust was part of a government licensing arrangement for MS products. Li censing arrangements have subsequently changed and were originally intended to be addr essed as part of ITaaS.	£300	STP is seeking a c ollaborative and united approach for all providers.	Michael Beckett
Covid capital	Monies in respect of Covid capital claims are still unapproved from NHSE/I. T his is a national position.	c.£1,500	If not funded by NHSE/I this will need to be drawn from the Trust's capital allocation.	Richard Eley, Gary Lupton

9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £21k deficit (in-month and year to date), reducing to breakeven after removing the adjustment for donated asset depreciation. This financial performance is as per the NHSE/I control total. The position has been achieved through £2.0m of true-up funding being accrued after incurring £2.3m of incremental expenditure related to Covid.

Richard Eley
Director of Finance
June 2020

Meeting of the Board of Directors in Public

Thursday, 02 July 2020

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**7.2**
Committee Chair:	Jo Palmer		
Date of Meeting:	Thursday 25 June 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks The BAF was discussed and the current risk scores, mitigations and controls were accepted. The committee noted that risk 3b and the availability of capital investment funding remains at 20 (5-consequence, 4-likelihood.	**Amber/Green**
2. Risk register The risk register was noted. The Director of Finance confirmed that whilst progress had been made in respect of the CIP risk, there still remains a gap of £1.8m to reach the budgeted CIP total and £4.2m to reach a mitigated target.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
3. Finance report The Director of Finance took the committee through the report, noting key highlights as being: • The Trust is meeting its control total as set by NHSE/I; within this performance the Trust has incurred c£4m of incremental Covid expenditure and accrued £3.6m of true-up income. • CIP has been forecast to meet the budgeted level but this remains a risk given the gap as aforementioned. • Capital expenditure is behind plan but has an agreed programme which is expected to catch up. • Cash is notably higher than planned due to receipts in advance under current contracting arrangements. • Activity is significantly below planned levels and if the Trust were not on national contracting for Covid the cost and volume income would be £13.8m adverse. • The interim debt loans are due to be written off later in the year through the issuance of Public Dividend Capital ("PDC") and thus continue to be carried as a current liability. Financing through loans going forward is expected to be rare and will instead be done via PDC. • The PDC dividend expense is currently being reported in-line with budget, but subject to guidance there may be an opportunity here for a cost saving in 20/21. The committee expressed its concern that the Trust continues to see increases in its pay costs - noting these began during 2019/20 – particularly in light of reduced activity during the Covid pandemic. It was therefore **AGREED** that at its next meeting there would be a specific agenda item and report required on this topic.	**Amber/Red**
4. Budget setting update / "Restart" The Director of Finance and the Financial Improvement Director took the committee through the restart planning work to date, including the scenarios that will be modelled. It was noted that the Trust must make a return to the STP on 29 June setting out the activity it could undertake and the financial impacts of using current resources. There has been little/no guidance to support this work.	**Amber/Red**
5. Self-certification under licence condition FT4 The Interim Company Secretary presented the Trust's proposed annual self-certification response to its licence conditions. The committee **APPROVED** the self-certification.	**Green**
6. Kent pathology project The committee welcomed the Director of Finance from Dartford and	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Gravesham NHS Trust ("DGT") to the meeting to discuss the Kent pathology project. It was noted that the Trust and DGT are partners in the North Kent Pathology Services ("NKPS") and as such meet the national recommendation to form such an alliance. The STP is seeking to bring all NHS organisations within its boundaries onto a single Laboratory Information Management System ("LIMS"), operate across all sites with a single Managed Service Contract ("MSC") and unite the service management into a single model. Based on discussion and recommendation from the papers the committee **AGREED** that it would: • Support the proposed move to a single LIMS across Kent/the STP. • Support the proposed move to a MSC across the STP. • Not support a move to a single service management function across the STP in the short to medium term. These agreements were based on the Trust and NKPS being able to generate efficiencies and benefits from LIMS and MSC but with no evidentiary benefits noted at this time compared to its current partnership.	
7. Model Hospital The Director of Transformation took the committee through some of the recent updates made to Model Hospital. The committee emphasised that it is important to keep this as an agenda item for future meetings to understand progress being made by the divisions and services.	**Green**
Decisions made The committee APPROVED the self-certification of its licence conditions.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee The committee felt that the following were significant matters that the Board must be aware of/action: • There remains a significant risk in respect of the availability of capital funding and the programme of work that the Trust must undertake. • There remains a CIP between the value of identified CIPs and the budget requirement. • There is a significant piece of work requiring support from the Board to fully understand and evidence the causes of the increase in pay costs. • The Board will, in due course, be required to consider and opine on the merits of the Kent pathology project; the committee's recommendations to the Board are as set out in section 6.	

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Workforce Report**	**Agenda Item**	8.1
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Margaret Mcloughlin, Group Head of Human Resources; Lisa Webb, Group Head of Organisational Development		
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 668 candidates to date; 170 of these candidates have commenced in post since January 2019. Trust turnover has decreased to 12.33% (-0.18%) from 12.15%, sickness absence has decreased to 4.31% (+0.05%) compared to the month of April and is above the Trust's tolerance level of 4%. Appraisal compliance has decreased to 91.74% (-0.64% from 92.38%) and is above Trust target of 85%. Statutory and Mandatory training is at 87.59% (-0.71% from 88.3%) and is meeting the Trust target of 85%. The percentage of pay bill spent on substantive staff in May at 82% has decreased (-3%) compared to the month of April. The percentage of agency usage at 2% has remained unchanged compared to the month of April. The percentage of pay bill spent on bank staff at 16% has increased (+3%) compared to April.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		

Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators. • Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Update on medical and dental; allied health professional; and, scientific, technical and therapeutic professional recruitment. 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Work stream as part of the 2020/21 cost improvement programme			
Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to note the content of this report.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	None			

1 Introduction

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

Best of People

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

2 Recruitment and Retention

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During May 2020, 13 FTE registered/pre-registered nurses and midwives joined the Trust (net increase +7 FTE) on a substantive basis, alongside 3 FTE substantive clinical support workers/maternity care assistants (net increase +1FTE, table 2). In addition 21 Aspiring nurses and Aspiring Midwives joined the Trust to support the Trust during COVID-19.

2.2 As a result of COVID-19 the Trust had no international nurse arrivals May. To date a total of 199 international nurses have taken (OSCE) exam. The Trust has a first attempt pass rate of 82% and an overall success rate of 99%.

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

2.4 The Trust is also working with nine additional permanent nursing recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, MSI, Medline, Kate Cowhig, HealthPerm, Santuary Healthcare and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial year.

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

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

Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline
320 (189 in last 12 months)	186	696	Due to the closure of the OSCE test centres and no confirmed resumption date this is under review

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

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

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	29 (17 NHS Jobs/ open days & 12 international nurses via skype)	13	6
Clinical support workers/Maternity Care Assistants	1 (Clinical Support Worker)	3	2

(Table 2: Nursing starters and leavers May 2020)

2.6 During May a total of two medical staff joined the Trust. Focussed discussions on recruitment of medical staff takes place regularly within divisions during the vacancy control panel (VCP) meetings that are chaired by the divisional directors. At present consultant recruitment is taking place for the following specialities Acute Medicine, Cardiology, Gastroenterology, Geriatrics, Otolaryngology, Paediatrics and Haematology. As at end of May 2020 the Trust had 35.58 FTE vacant consultant posts and 28.81FTE vacant non-consultant posts.

Table 3 below summarises offers made, starters and leavers for the month of May 2020:

Role	Offers made in month	Actual starters	Actual leavers
Consultants	0	1	2
Junior doctors (including doctors in training)	94	1	1

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

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

Table 4 below summarises offers made, starters and leavers for the month of May2020.

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

(Table 4: AHP starters and leavers May 2020)

2.8 During May three Scientific, Technical and Therapeutic (ST&T) staff (including, but not limited to, Pharmacy staff, Operating Department Practitioners) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant practitioners especially when filling difficult to recruit to posts. Pharmacy department is currently in discussions with local community providers to develop joint rotational posts that will help fill some of the vacancies and providing learning in the different settings.

Table 5 below summarises offers made, starters and leavers for the month of May 2020:

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

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

2.9 During May three Scientific, Technical and Therapeutic (ST&T) staff (including, but not limited to, Pharmacy staff, Operating Department Practitioners) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant practitioners especially when filling difficult to recruit to posts. Pharmacy department is currently in discussions with local community providers to develop joint rotational posts that will help fill some of the vacancies and providing learning in the different settings.

3 International Recruitment and Retention (Nursing)

3.1 The Trust has been reasonably successful in recruiting international nurses. Continued proactive effort is required to sustain this position in order to ensure we have the right staff, in the right place, at the right time; and avoid recourse to expensive temporary staffing solutions. 251 international nurses have commenced in post since January 2018 and analysis of the turnover of the international nurses recruited shows a turnover rate of 7.57% (below the Trust target of 8% and actual turnover rate of 12.33%). As detailed in table 6 below the Trust has sourced nurses from a number of EU and non-EU countries and nurses recruited from the EU are more likely to leave within the first year of commencing in post. Of the 251 nurses recruited, 232 remain in post.

Nationality	No Starters	Left Within 1st Yr.	Left Within 2nd Yr.	Left Within 3rd Yr.	Still Employed	Overall Retention
Grand Total	**251**	**16**	**2**	**1**	**232**	**92.43%**

(Table 6: International starters and leavers)

3.2 A total of 19 international nurses have left the Trust since January 2018. Of those 16 resigned or were dismissed within 12 months of commencing in post (table 7). The majority of leavers that specified a destination on their leaver form moved to other NHS organisations (table 8)

Reasons for Leaving	Within 1st Yr.	Within 2nd Yr.	Within 3rd Yr.
Non-voluntary	4	0	0
Voluntary	14	2	1
Overall	**16**	**2**	**1**

(Table 7: Reason for leaving)

Destination on Leaving	Within 1st Yr.	Within 2nd Yr.	Within 3rd Yr.
Abroad - EU Country	1	0	0
NHS Organisation	3	2	1
- **Of which in Kent**	1	1	0
- **Of which in Surrey, Sussex**	0	0	1
- **Of which in London**	0	0	0
- **Of which elsewhere in UK**	2	1	0
No Employment	3	0	0
Unknown	8	0	0
Other Private Sector	1	0	0
Overall	**16**	**2**	**1**

(Table 8: Destination on leaving)

3.3 The Trust provides pastoral support to the overseas nurse throughout the recruitment journey and beyond. Preparatory information material is sent to international nurses to support them in readiness for their arrival to the UK which helps reduce some of the anxiety associated with relocating and working in a new country. In addition the Trust organises:

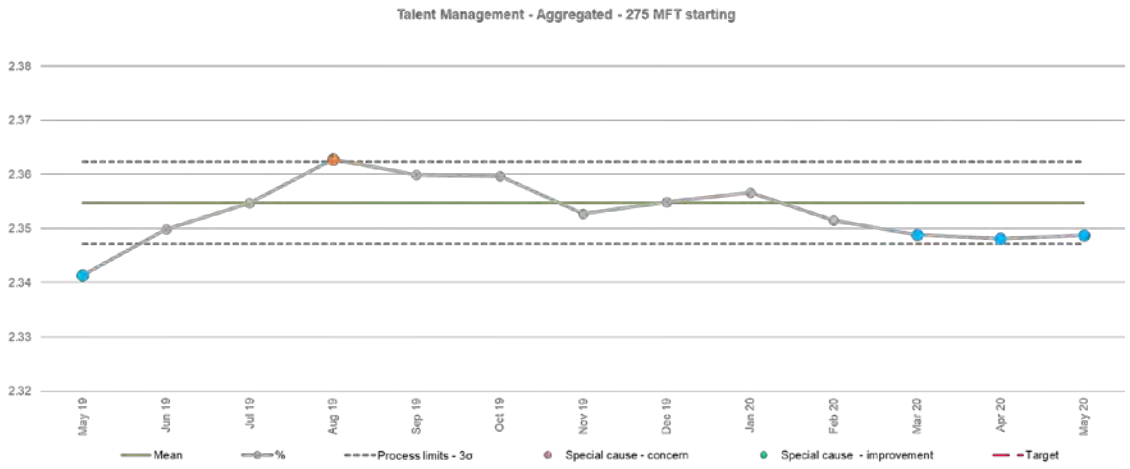
- An Airport meet and greet (met by our international agency partners);
- A welcome pack (tea, coffee basic staples etc.);
- Meet & Greet on arrival at the Trust (Resourcing and OSCE Team);
- Four-weeks paid accommodation;
- Assistance with opening a bank account;
- Financial Support on arrival and six weeks post arrival;
- A tea party to meet their future team and Trusts leaders;
- A point of contact details for any queries or issues.

3.4 The Trust provides peer support through a buddying system. Support from previously recruited overseas nurses helps new recruits with OSCE preparation, orientation and integration. Additionally, the resourcing team meet with the overseas nurse throughout the year at regular intervals in their first year of employment (Spirit of Medway) to obtain honest feedback and to ensure a positive experience during their time at MFT.

4 Trust and Divisional Metrics

4.1 The table below (table 9) shows performance across five core indicators by the divisions. Turnover, at 12.33% (+0.18 % from 12.15% in April), remains above the tolerance level of 8%. HR Business Partners work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results implementing service specific retention plans. Sickness absence at 4.31% is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

4.2 The Trust appraisal rate stands at 91.74% (+0.64% from 92.38% in April) and is above the Trust target of 85%. Estates and Facilities at 82.44% (-3.96% from 86.40%in April) failed to meet the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics. Chart 1 below demonstrates the aggregate appraisal score of performance and values over time. The appraisal scores are consistently passing target with a special cause of improving nature.



(Chart 1: Appraisal aggregate performance and values score)

4.3 Statutory and Mandatory training stands at 87.59% (-0.71% from 88.30% in April) and is meeting the Trust target of 85%. All divisions across the Trust are meeting the Statutory and Mandatory training target. Subject-matter experts (SMEs) provide sufficient capacity to provide face-to-face opportunities to meet the demand.

		MFT			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.00%	12.33%	▲		13.49%	▼		9.86%	▲		12.04%	▲		13.04%	▼	
Vacancy rate	12.00%	10.99%	▲		4.53%	▼		17.08%	▲		10.47%	▲		11.58%	▲	
Sickness rate (12-month rolling)	4.00%	4.31%	▼		2.54%	▼		6.49%	▲		4.63%	▼		3.89%	▼	
Statutory & Mandatory Training	85.00%	87.59%	▼		92.17%	▼		86.97%	▲		88.00%	▼		87.41%	▲	
Medway Appraisal	85.00%	91.74%	▼		90.56%	▼		82.44%	▼		95.08%	▲		90.92%	▼	
Agency costs (as % of total paybill)	11.00%	1.85%	▼		2.10%	▼		0.14%	▼		0.88%	▼		3.03%	▲	
Bank costs (as % of total paybill)		12.31%	▼		9.94%	▲		11.74%	▲		8.88%	▲		16.46%	▲	
Substantive costs (as % of total paybill)	89.00%	85.83%	▲		87.96%	▼		88.12%	▼		90.24%	▼		80.50%	▼	
Stability Index (12-month rolling, >12M)	85.00%	85.47%	▲													
Leavers citing "Work/Life Balance" 12m rolling	n/a	90.95	▲													

(Table 9: Key Workforce Metrics)

4.4 The table below (table 10) shows the compliance with StatMan on a divisional and care group basis:

Division >> Care Group	Compliance %		Compliance %
Corporate	92.90%	Planned Care	88.78%
Communications Directorate	96.30%	Cancer Services	90.33%
Finance	94.77%	Peri-operative & Critical Care	90.17%
Human Resources & Organisational Development	98.57%	Planned Care Infrastructure	78.92%
IT	90.54%	Surgical Services	85.72%
Medical Directorate	95.48%	Women's & Children's Health	89.43%
Nursing	86.47%	Unplanned and Integrated Care	87.79%
Strategy, Governance and Performance	93.90%	Diagnostics & Clinical Support Services	88.98%
Transformation	77.78%	Specialist Medicine	89.99%
Trust Executive & Board	90.43%	Therapies & Older Persons	88.81%
Facilities and Estates	86.88%		
Facilities and Estates Management	81.37%		
Hard FM	90.05%		
Soft FM	86.55%		

(Table 10: StatMan compliance profile)

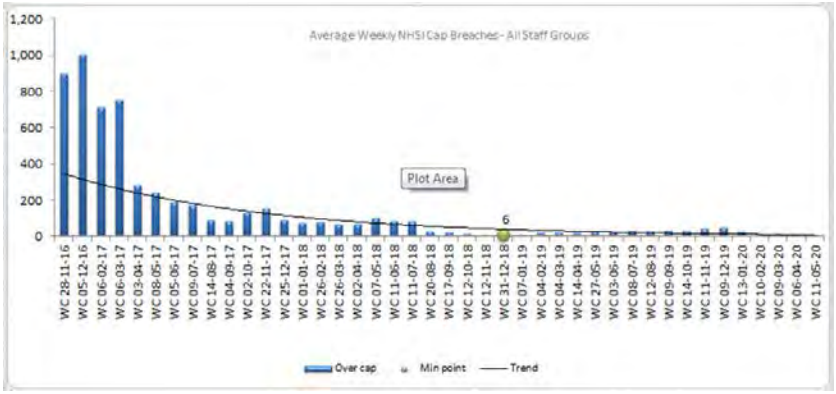
5 Temporary Staffing

5.1 Table 11 below demonstrates that temporary staffing expenditure increased in May 2020 compared to April 2020.

		Mar-17	Mar-18	Mar-19	Apr-19	Mar-20	2019/20 FYE	Apr-20	May-20
Spend	Agency	£3,890,198	£2,597,697	£783,127	£684,291	£28,843	£6,469,940	£393,932	£433,943
	Bank	£920,473	£2,329,768	£2,105,055	£2,267,819	£2,872,089	£28,031,242	£2,403,455	£3,182,476
	Substantive	£13,611,458	£13,542,990	£16,377,676	£14,152,087	£20,074,596	£181,825,421	£15,383,919	£15,383,919
% of pay bill	Agency	21%	14%	4%	4%	0%	3%	2%	2%
	Bank	5%	12%	11%	13%	13%	13%	13%	16%
	Substantive	74%	74%	85%	84%	87%	84%	85%	82%

(Table 11: Contractual profile)

5.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 2 below. During the month of May 2020 the Trust reported an average of 10 breaches per week across the month.



(Chart 2: NHSI cap breaches)

5.3 NHSEI has amended the financial agency spend ceiling (set at £17.8m for 2019/20) and replaced it with an 'Overall Agency Spend as a % of Total Spend' target. Agency staff costs if possible should be kept to a minimum and the benchmark figures for 2020/21 are set at the following values:-

- Green :0-5.5%
- Amber 5.5-8%
- Red: More than 8%

As illustrated in table 12 below, at month two the Trust's cumulative agency spend as a percentage of total pay bill was 2.18% (3.32% below NHSE/I national benchmark)

	Apr-20	May-20	% YTD Agency Spend
% Agency Spend	2.17%	2.18%	2.18%
% Target	≥ 5.5%	≥ 5.5%	≥ 5.5%
GREEN	0.00% - 5.50%		
AMBER	5.51% - 8.00%		
RED	Above 8.00%		

(Table 12: NHSI ceiling performance)

5.4 Temporary nursing demand decreased in May 2020 compared to April 2020 (6,885 shift requests in May 2020 compared to 8,546 shift requests in April 2020). The fill rate increased to 82% (+8% compared to April). Medical locum demand also decreased in May 2020 compared to April 2020 (1,470 shift requests in May 2020 compared to 1,700 shift requests in April 2020). The fill rate for medical locum increased to 89% (+3% compared to April).

Best Culture

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

6 Culture and Leadership Programme

6.1 Progress update

6.1.1 Our NHSEI Associate has now completed 1:1 calls with 53 staff who have expressed interest in being part of the Change Team. Whilst there are still some outstanding expression of

interest forms to be submitted with line manager approval sign off, the next stage of the process will begin as planned.

6.1.2 Dates have been scheduled for small group sessions with change team members through June and July for the Change Team and Ambassadors to explore the work that's already been done, reviewing results, actions and assumptions from the Discovery phase and how that can support the Design phase, and personal areas of interest on which those involved would like to focus.

6.1.3 We are aligning the work of the culture and leadership programme with that of the CQC engagement work currently being undertaken by the Public Engagement Agency (PEA), to ensure consistent messaging for staff.

7 Staff survey

7.1 Care group managers received a guided workbook detailing breakdown for their area thematically grouped to support the local action plan delivery to be written and owned locally.

7.2 HRBPs have now begun working with Care Group managers to formulate action plans having been delayed as a result of the Covid-19 response.

8 OD continued response to Covid-19

8.1 The Corporate and Clinical induction programme was converted to an online format in March, taking advantage of facilitated webinar technology and subsequently developing additional eLearning content at pace. Evaluation scores from participants continue to be generally positive (84%), when asked: "How likely is it that you would recommend this event to a friend or colleague? Predominant reasons for lower scores relate to connectivity and IT issues.

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

8.3 The conversion programme of Clinical Induction training is complete ensuring continuity of service of what was previously classroom based training to eLearning. The positive effect of this has to been to free up clinical staff that would have otherwise been used to facilitate training and making the training more easily accessible.

8.4 The conversion programme continues for the wider range of OD products and services with no cancellation of scheduled workshops or activities.

8.4.1 Whilst data are limited at this early stage evaluation scores are encouragingly positive at an average of 92%.

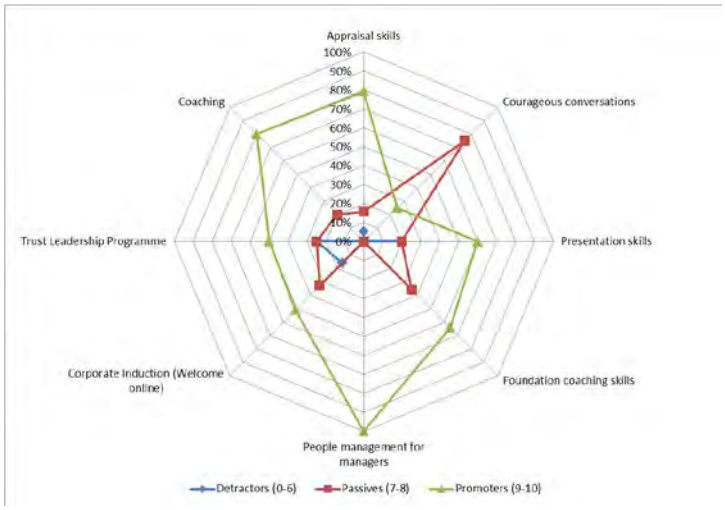


Figure 1: OD product recommendation scores on a scale of 0-10 (Positive: 7-10; Negative: 0-6; NPS (net promoter score) average: 55 (9-10))

8.5 OD services including coaching, support for apprenticeship learners and facilitated meetings have taken advantage of available technology to ensure continuity. The coaching offer has expanded with additional provision for leaders from partners including NHS Elect and HPMA.

8.6 Three staff completed training and are facilitating Leadership Support Circles (LSC) currently being provided as part of the national Our People programme. LSCs are short, themed, online sessions based on 10 evidence-based principles for leading compassionately during COVID-19. They are multi-disciplinary, interactive spaces for people managers at all levels to come together, share their experiences and be heard.

8.7 The work experience programme was postponed for summer placements and will be reviewed in September 2020 with the current aim of restoring work experience opportunities for young people in early 2021.

Best Future

We will deliver a workforce ready for the future, supported with the right skills to deliver quality care and to allow us to reach our full potential

9 Apprenticeships update

9.1 There has been limited disruption to apprenticeship programmes as a result of Covid-19

9.1.1 Providers are continuing to support learners with training and support sessions online

9.1.2 Some providers furloughed some staff and switched learner support to alternative personnel

9.2 There are currently 118 staff on apprenticeship programmes, of which 3 are paused for personal reasons and will restart at a later date. Clinical apprenticeships represent 50% of the total with 31% leadership apprenticeships and 19% (other) non-clinical. Of the 115 live apprenticeship programmes 56% relate to learners in clinical staff groups with the remainder from estates and admin & clerical.

Apprenticeships by category	Apprentices
Clinical	**59**
Healthcare support worker, Level: 2 (Standard)	4
Senior healthcare support worker, Level: 3 (Standard)	31
Children and Young People's Workforce: Children and Young People's Social Care, Level: 3	1
Nursing Associate (NMC 2018), Level: 5 (Standard)	11
Nursing Associate, Level: 5 (Standard)	10
Occupational Therapist, Level: 6 (Standard)	2
Leadership	**36**
Team leader / supervisor, Level: 3 (Standard)	1
Operations / departmental manager, Level: 5 (Standard)	9
Chartered manager degree apprenticeship, Level: 6 (Standard)	4
Senior Leader Master's Degree Apprenticeship, Level: 7 (Standard)	22
Non-clinical	**23**
Improving Operational Performance: Performing Engineering Operations, Level: 2	1
Business and Administration, Level: 2	1
Health Pharmacy Services, Level: 2	5
Pharmacy Services Assistant, Level: 2 (Standard)	1
Assistant accountant, Level: 3 (Standard)	1
Business and Administration, Level: 3	1
Business Administrator, Level: 3 (Standard)	3
Infrastructure technician, Level: 3 (Standard)	1
HR Support, Level: 3 (Standard)	1
Business and Professional Administration, Level: 4	1
Data analyst, Level: 4 (Standard)	4
HR Consultant / Partner, Level: 5 (Standard)	1
Digital and technology solutions professional, Level: 6 (Standard)	1
Healthcare Science Practitioner, Level: 6 (Standard)	1
Grand Total	**118**

Table 1: Apprenticeships by category May 2020

-END-

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Workforce Race Equality Standard**	**Agenda Item**	**8.2a**
Lead Director	Leon Hinton, Director of HR and OD		
Report Author	Alister McClure, Head of Equality and Inclusion		
Executive Summary	This report provides the annual Workforce Race Equality Standard summary (WRES) for 2020. This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater racial equality, as required by the Equality Act 2010. Under the NHS Standard Contract (schedule 6a) the Executive Group and Board are required to consider and approve the WRES report prior to publication by 31 July 2020, but extended this year to 31 August 2020 The performance is stable or improved compared to previous years. An action plan to address concerns and improve performance must be prepared and published by 31 October 2020.		
Link to strategic Objectives 2020/21 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group - 17 June 2020 Human Resources and Organisational Development Senior Team - 11 June 2020		
Resource Implications	None at this stage. The action must be produced within existing resources		
Legal Implications/ Regulatory Requirements	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Race. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on race equality in the form of the WRES summary		
Quality Impact Assessment	Not applicable		

Recommendation/ Actions required	To approve the publication of the Trust's Workforce Race Equality Standard Data Report			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix 1: charts and tables illustrating the performance Appendix 2: Background information The WRES Reporting Schedule (currently delayed by NHS Digital, is due imminently. If it is available, it will form Appendix 3)			

1 EXECUTIVE SUMMARY

1.1 The main purpose of the Workforce Race Equality Standard (WRES) is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

1.2 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 97.3%.

[For indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

1.3 Performance against most of the WRES indicators has stabilised or improved compared to previous years, with performance against indicators 2, 3 and 4 shows year on year improvement.

Indicator	Direction of Travel compared to: 2019	2018	2017
1 – Workforce Diversity	↔	↔	↔
2 - Recruitment	↑	↑	↓
3 – Formal Procedures	↑	↑	↔
4 – Training	↑	↑	↑

1.4 Normally Trusts are required to report on four Staff Survey indicators. However, reporting on those indicators has been excluded from the WRES this year. An analysis of these will be included in part of the development of this year's WRES Action Plan, which will be reported to the Executive Group and Trust Board later in the year.

1.5 It is a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WRES, including sign-off at Board level. Normally, this is before 31 July each year but in 2020 Trusts are required to publish their WRES data by 31 August and their WRES Action Plans by 31 October.

2 KEY FINDINGS

2.1 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are normally 9 performance indicators, but in 2020 Trusts are only to publish 4 performance indicators. [For indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

2.2 **Indicator 1 – Workforce Profile**

Staff in each of the Agenda for Change (AfC) Bands 1-9 and V SM (including Executive Group members) compared with staff in the overall workforce.

This information was required to be broken down not only by band, but also separating clinical, medical and dental and non-clinical staff. The data shows that there points in progression between grades where the proportion of BME staff in the workforce is lower than expected. For example, there is a dip in representation between Bands 5 and 6 in the non-clinical workforce, and progressively from Bands 5 through to 8a in the non-medical clinical workforce. Amongst consultants, 61% are from a BME background, yet only 1 out of 11 (9%) of senior medical managers are BME. The Trust's workforce is considerably more diverse than the local population, and the representation of staff for Black and Minority Ethnic (BME) backgrounds at all levels, except very senior management, has generally increased over time. There is significantly higher representation of people from BME backgrounds in medical and dental roles, which is reflective of the profile of their professions.

Tables illustrating the workforce profile can be found in Appendix 1.

2.3 **Indicator 2** - Relative likelihood of staff being appointed from shortlisting across all posts. **Performance in 2020: 1.1**

In 2015/16, white people shortlisted for interview were 2.58 times more likely than BME people to be appointed. By 2019 this gap narrowed to 1.30 times, and currently stands at 1.10 times. Whilst this is still an improvement on last year and a significant improvement on the situation in 2015/16, the reality is that white candidates still have a marginally greater likelihood of being appointed than candidates from BME backgrounds. Nevertheless, the Trust still aims for absolute equality of opportunity in the appointments process. As Indicator 1 illustrated, there is under representation of BME people at a number of pay bands, despite good performance on Indicator 2. This may be to do with an underrepresentation in applications from BME candidates, but further investigation into this is required.

2.4 **Indicator 3** - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **Performance in 2020: 0.59**

A statistically small number of individuals (1.59% of the whole workforce) have entered formal disciplinary procedures in the past year. White staff continue to be more likely to enter formal procedures than those from BME backgrounds. The proportion of both BME and white staff in formal procedures is falling. However, the small number of staff in these procedures means that changes from year are statistically insignificant. A table illustrating the performance over time is in Appendix 1.

2.5 **Indicator 4** - Relative likelihood of staff accessing non-mandatory training and CPD. **Performance in 2020: 0.98**

From 2019 onwards, NHS England's WRES team have asked all NHS organisations to explain their definition of non-mandatory training. As with previous years, this Trust defines access to non-mandatory training as being all training available via My ESR (the training platform that is part of the NHS Electronic Staff Record) with the exception of Statutory and Mandatory training courses under the Core Training Standards Framework. Continued Professional Development (CPD) is defined as

courses provided by Universities and other external providers. In house professional development specific to individual clinical disciplines and medical education are not included.

The data for this indicator shows that the performance on this indicator remains stable with a relative likelihood of uptake remaining at 0.98, and with staff from BME backgrounds still marginally more likely to access non-mandatory training, compared to their white colleagues. However, the uptake of non-mandatory training by white and BME employees has improved significantly year on year. A table illustrating performance over time is in Appendix 1.

3 Next Steps

3.1 The next steps fall into two categories: firstly, ensuring the publication of the WRES data summary on the NHS England WRES portal and the Trust's website by 31 August 2020; and secondly, developing an action plan for the Trust to implement to improve on the WRES indicators in future years, to be published on the Trust website by 31 October 2020

3.2 Further analysis of the WRES data and an action plan will be worked up by the Trust's Inclusion Steering Group, and considered by the Board of Directors in September 2020. These actions will be incorporated in the Trust's EDS2 (equality delivery system) action plan, which is published annually as a part of the Trust's management information on equality, diversity and inclusion.

3.3 The Action Plan will be developed in consultation with the Black, Asian and Minority Ethnic (BAME) Staff Network. Staff Networks exists across the NHS as part of staff engagement, in this instance with BAME staff across this Trust. The BAME Staff Network is an existing group, open to all BAME staff, with a core steering group. In addition to informing the WRES Action Plan, the network is also supporting the Trust in responding to current and ongoing priorities, such as the increased impact of Covid-19 on BAME Communities, and understanding the impact of systemic discrimination (i.e. biases in society that impact on the social and health outcomes for BAME communities)

3.4 BAME is a current preferred term, even though the WRES Data Reports, nationally, continue to use the term BME.

4 Recommendation

4.1 It is recommended that the Workforce Race Equality Summary Data be approved for submission to the NHS England WRES Portal and the Trust website.

Appendix 1 –PERFORMANCE CHARTS AND TABLES

Indicator 1 – WORKFORCE PROFILE

Chart 1: Ethnicity - Agenda for Change Non-Clinical Bands 2 to 9 and Very Senior Management, by proportion, showing headcount

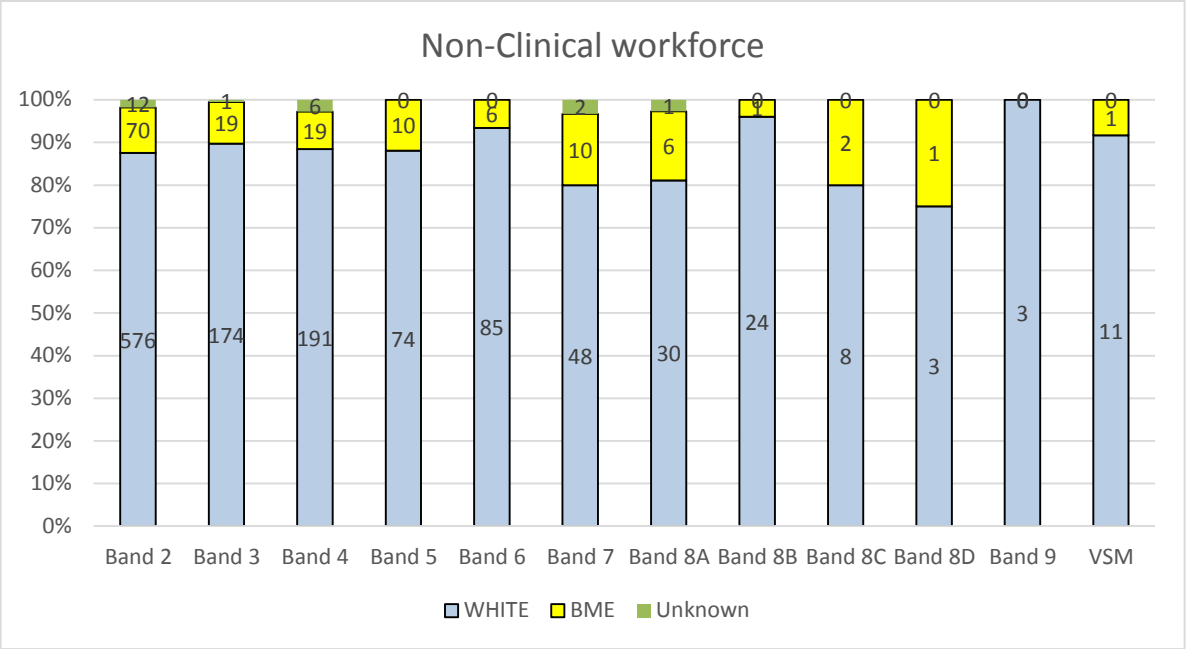


Chart 2: Ethnicity - Agenda for Change Clinical Workforce, non-medical, Bands 2 to 9 and Very Senior Management, by proportion, showing headcount

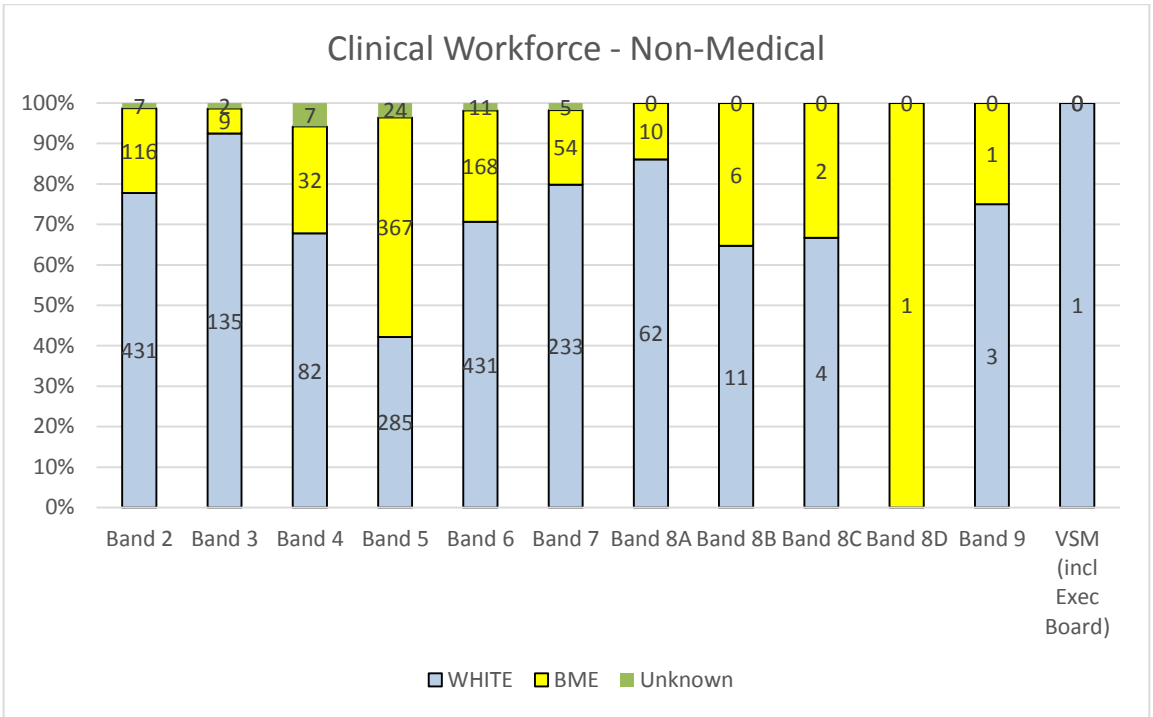
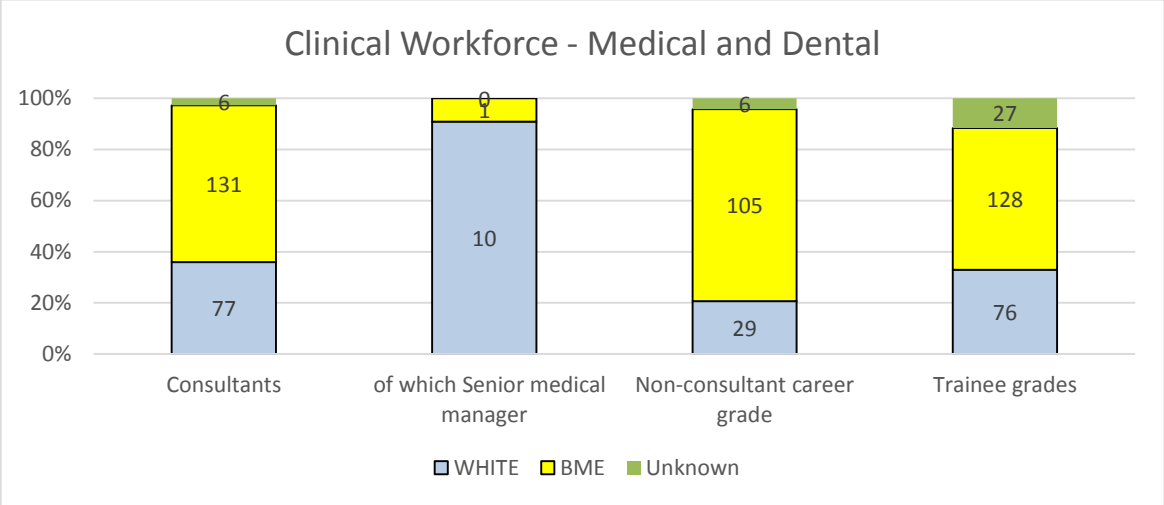


Chart 3: Ethnicity (Clinical Workforce, Medical and Dental by proportion, showing headcount)



Indicator 3 – FORMAL PROCEDURES

Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation			
WRES year	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
2020	1.53%	0.90%	0.59
2019	2.23%	1.25%	0.56
2018	3.58%	1.61%	0.45

Indicator 4 – NON-MANDATORY TRAINING

Likelihood of staff accessing non-mandatory training and CPD			
	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
2020	96%	98%	0.98
2019	70.04%	82.45%	0.85
2018	58.31%	68.68%	0.85

Appendix 2 - BACKGROUND INFORMATION

1 Originally launched in the Five Year Forward View a direction of travel was set out for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce. The evidence of the link between the treatment of staff and patient care is particularly well evidenced for Black and Minority Ethnic (BME) staff in the NHS, so this is an issue for patient care, not just for staff. The Equality and Diversity Council - representing the major national organisations in the NHS, proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

2 The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis. Medway NHS Foundation Trust produced its first WRES report in 2016, which formed the baseline against future years' assessments can be compared.

3 The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

4 It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WRES, including sign-off at Board level. Normally this is before 31 July each year but in 2020 Trusts are required to publish their WRES data by 31 August and their WRES Action Plans by 31 October.

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Workforce Disability Equality Standard**	Agenda Item	**8.2b**
Lead Director	Leon Hinton, Director of HR and OD		
Report Author	Alister McClure, Head of Equality and Inclusion		
Executive Summary	This report provides the second annual Workforce Disability Equality Standard summary (WDES). This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater disability equality, as required by the Equality Act 2010. Under the NHS Standard Contract (schedule 6a) the Executive Group and Board are required to consider and approve the WDES report prior to publication by 31 July each year, but extended to 31 August in 2020. Performance on the quantifiable indicators shows disabled people to be disadvantaged compared to non-disabled people in recruitment and senior representation. The staff perception indicators (drawn from the staff survey) consistently indicate that disabled employees are less satisfied than their non-disabled colleagues, but the direction of travel is both an improvement in the perceptions of disabled staff, and a narrowing of differentials between disabled and non-disabled staff.		
Link to strategic Objectives 2020/21 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group - 30 June 2020 Human Resources and Organisational Development Senior Team - 12 June 2020		
Resource Implications	None at this stage. The action plan, when complete will be met from existing resources		
Legal Implications/ Regulatory Requirements	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Disability. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on disability		

	equality in the form of the WDES summary			
Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	It is recommended that the Workforce Disability Equality data report be approved for submission to the NHS England WRES Portal and the Trust's website			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix 1 – Workforce profile charts and Staff Survey table Appendix 2 – Background information The WRES Data reporting template has been delayed by NHS Digital; if it becomes available it will form Appendix 3			

1 Executive Overview

1.1 The main purpose of the WDES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,
- to improve representation at the Board level of the organisation.

1.2 The WDES assessment has been prepared following technical guidance published by NHS England in 2019. Performance on two of the quantifiable indicators (1 and 2) shows disabled people to be disadvantaged compared to non-disabled people in recruitment and senior representation. However, on indicator 3 there were no disabled staff in capability procedures (not including sickness absence). The staff perception indicators (4 to 9) are drawn from the staff survey and consistently indicate that disabled employees are less satisfied than their non-disabled colleagues, but the direction of travel is both an improvement in the perceptions of disabled staff, and a narrowing of differentials between disabled and non-disabled staff.

1.3 This report is the second WDES report. Building on last year's baseline report, so longer term trends will not be known until later years. However, the assessment indicates that 3.5% of employees have declared that they are disabled, 78.5% have declared that they are not disabled, and 18% have not declared whether or not they are disabled. Just one employee on Agenda for Change band 8b or above has identified as disabled.

1.4 An action plan to address concerns and improve performance will be developed by the Trust's Inclusion Steering Group, by September 2020.

2 Key Findings

3.1 **Indicators 1 and 10: Disabled representation across the workforce**

The assessment indicates that just under 3.5% of employees have declared that they are disabled (a reduction from 5% last year), 78.5% have declared that they are not disabled, and 18% have not declared whether or not they are disabled. Just one employee on Agenda for Change band 8b or above has identified as disabled, although this is an increase from last year.

3.2 **Indicator 2 (Relative likelihood of appointment from shortlisting)**

The statistics show that non-disabled people were 1.22 times more likely than disabled staff to be appointed, which is deterioration from 2019, when the likelihood was 1.15. 17% of disabled people and 21% of non-disabled people were appointed after shortlisting. This is close to parity, but nevertheless shows a marginal disadvantage for disabled people, and is deterioration from last year.

3.3 **Indicator 3 (Relative likelihood of being in capability procedures, other than sickness absence)**

Just 12 people were involved in capability procedures, other than sickness absence, so it is not possible to consider the performance on Indicator 3 as statistically significant. However, no disabled people were in these procedures.

3.4 **Performance on the staff perception indicators.** Guidance is still awaited concerning the reporting of these indicators. Trusts have been advised not to report the Ethnicity staff survey results with the Workforce Race Equality Standard (WRES) in 2020, but guidance on the Workforce Disability Equality Standard is pending. The results are provided for information, and will be considered in the WDES Action Plan, which will be brought to the Board of Directors in September. However, if the guidance states these are not to be reported on the Data Return, this information will be withdrawn.

Staff survey data is reported retrospectively; therefore the WDES 2020 uses the Staff Survey data from 2019. For almost all of the perception indicators there has been an improvement in performance from the previous survey, and a narrowing of differentials between disabled and non-disabled staff. The notable exception is the marginal increase (0.2 percentage points) in the proportion of disabled staff reporting they have experienced harassment, bullying or abuse from other colleagues in the previous 12 months.

3 Next Steps

3.1 The next steps fall into two categories: firstly to ensure the publication of the WDES summary by 31 August 2020, on the NHS England WDES portal and the Trust website; and secondly to prepare an Action Plan for publication on the Trust's website before 31 October 2020.

3.2 These actions will be incorporated in the Trust EDS2 (equality delivery system) action plan, which is published annually as a part of the Trust's management information on equality, diversity and inclusion.

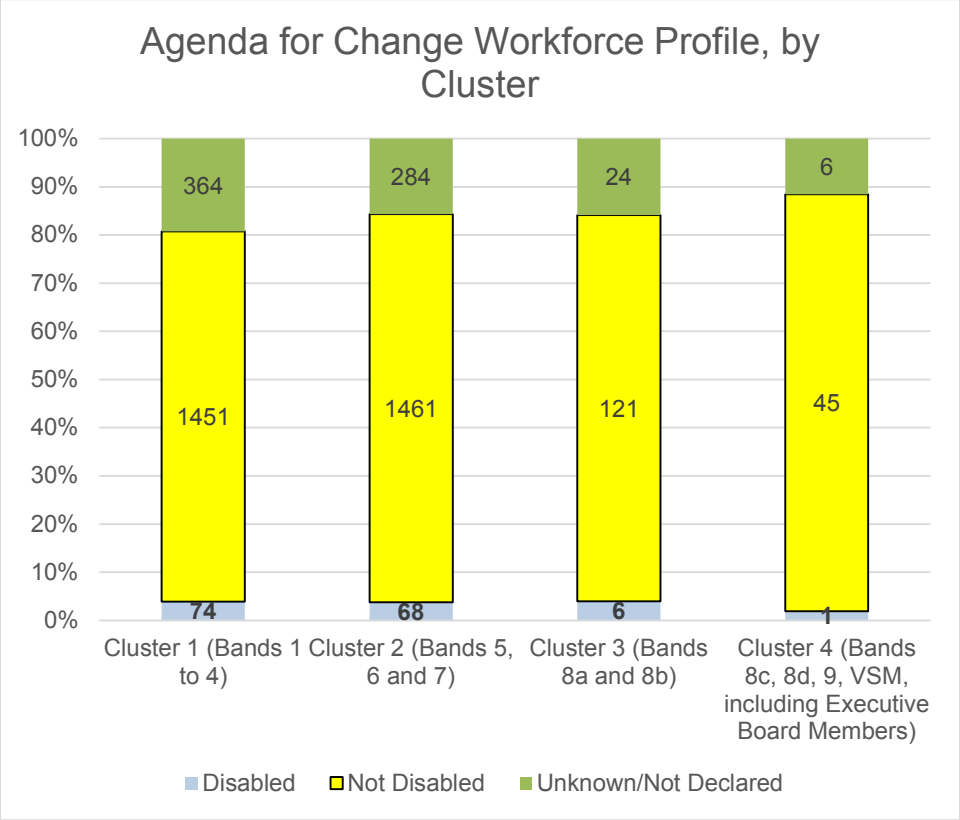
3.3 The Action Plan will be developed in consultation with the Disabled Staff Network. Staff Networks exists across the NHS as part of staff engagement, in this instance with disabled staff across this Trust. The Disabled Staff Network is an existing group, open to all disabled staff (including staff who are carers of disabled people), although is not currently meeting. It will be reconvened to consider and inform the WDES Action Plan, and current and ongoing priorities, such as the increased impact of Covid-19 on people with long term limiting illnesses.

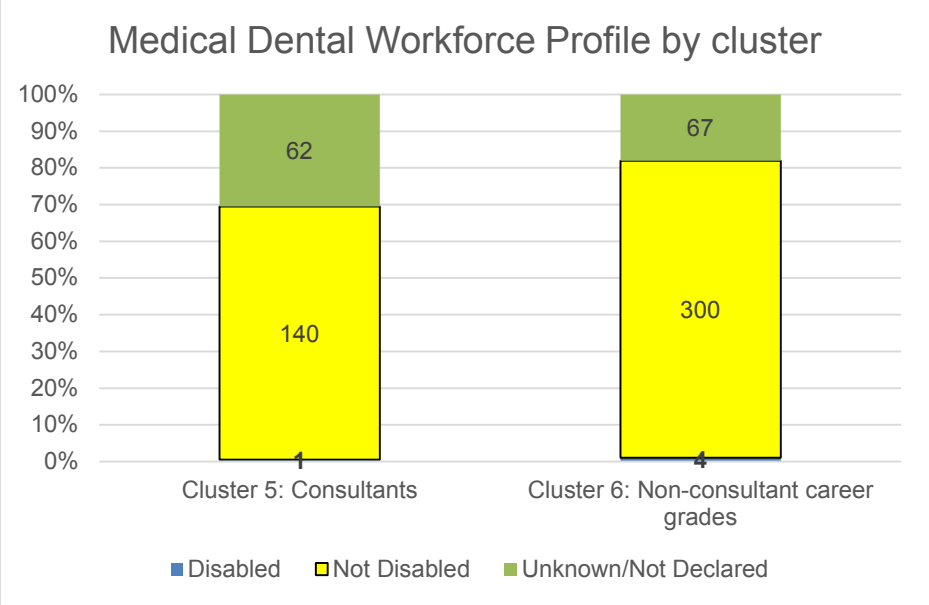
4 Recommendation

4.1 It is recommended that the Workforce Disability Equality Summary be approved for submission to the NHS England WRES Portal and the Trust's website.

Appendix 1 – CHARTS AND TABLES

Workforce profiles





WDES PERCEPTION INDICATORS

Staff Survey Question, 2019		Disabled		Non-disabled		Direction of Travel	
WDES Indicator	Staff Survey Question, 2019	2018	2019	2018	2019	For Disabled Staff	Gap between Disabled and Non-Disabled
4a	% of staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	37.6%	36.5%	28.5%	27.5%	Improvement	Narrowed
	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	29.2%	22.3%	18.2%	14.4%	Improvement	Narrowed
	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	29.9%	30.1%	21.5%	19%	Deterioration	Widened
4b	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	45.1%	47.3%	44.0%	45.6%	Improved Reporting Rate	Narrowed
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion.	66.3%	76.3%	76.8%	79.8%	Improvement	Narrowed
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	37.9%	33.2%	29.7%	24.7%	Improvement	Narrowed
7	% staff saying that they are satisfied with the extent to which their organisation values their work.	24.0%	35.1%	36.0%	43.6%	Improvement	Narrowed
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	60.1%		70.2%		Improvement	
9	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	5.8	6.5	6.5	7.1	Improvement	Narrowed

Appendix 2 – BACKGROUND INFORMATION

1 The NHS Workforce Disability Equality Standard (WDES) was made available to the NHS from December 2018, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WDES is included in the NHS standard contract, and this year's report forms the baseline assessment for the Trust.

2 The main purpose of the WDES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WDES indicators,
- to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,
- to improve representation at the Board level of the organisation.

3 It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WDES, including sign-off at Board level, before 31 July each year. The Trust must, therefore, publish its WDES following the Trust Board meeting on 3 July 2019. However in 2020, the data reporting deadline was extended to 31 August, and the action plan deadline was extended to 31 October.

Meeting of the Board of Directors in Public
Thursday, 02 July 2020

Title of Report	**Freedom to Speak Up Guardian Report Q3 and Q4 2019/2020**	**Agenda Item**	8.3
Report Author	Natasha Pritchard, Lead Freedom to Speak Up Guardian		
Lead Director	James Devine, Chief Executive		
Executive Summary	This report includes the progress of the Lead Guardian who commenced in post on the 31 July 2019 and is employed for 0.4 FTE. Previously in quarter 1 2019/2020, the Trust had 22 new concerns raised and in Q2 24 concerns were raised. In Q3 there were 17 concerns raised and in Q4 22 concerns were raised. Presently 12 cases remain open; these are being looked into by Executives and overseen by the Chief Executive. The Lead G uardian meets with the Chief Executive weekly and t he Chair monthly with ad-hoc meetings in between as required. Meetings with other Executives are arranged as required. The Trust has had 1 report of an individual experiencing detriment as a result of raising concerns. Unfortunately this person did not wish to pursue this.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Executive Group		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	A governmental response to Sir Robert Francis Report 2015 led to the introduction to the NHS Contract for 2016/17 requiring every NHS Trust to have a local FTSU guardian from 1 October 2016. Guidance for the appointment of a FTSU guardian was published in March 2016. • NHS Constitution and standard contract; • Public Interest Disclosure Act 1998; • Enterprise and Regulatory Reform Act 2013; • The Bribery Act; • Whistleblowing Arrangements; • Code of Practice		

Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to note the content of this report.			
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None			

1 Introduction

1.1 The Freedom to Speak Up Review undertaken by Sir Robert Francis and published in February 2015 was commissioned by the Secretary of State a result of the failings at Mid Staffordshire. The aim of the report was to provide advice and recommendations to ensure that NHS staff felt safe to raise concerns, were confident that they would be listened to and that concerns would be acted upon. The review identified concerns about the way NHS organisations dealt with concerns raised by NHS staff and the treatment of some of those who had spoken up.

1.2 From the evidence, the review identified five overarching themes as follows:

- need for culture change;
- need for improved handling of cases;
- need for measures to support good practice
- need for particular measures for vulnerable groups; and
- need for extending the legal protection.

As a result of this review the establishment of the National Guardian's Office as an independent non-statutory body was established and all NHS organisations are required to appoint a freedom to speak up (FTSU) guardian.

1.3 The Trust moved to an established lead guardian model (0.4 FTE) in January 2019.

2 Lead Guardian

2.1 The Trust's Lead Guardian position is filled by Natasha Pritchard who was previously a Sister in the Intensive Care Unit at Medway. To ensure concerns raised are listened to and dealt with, the existing guardian, meets with the Chief Executive weekly at present. If the Chief Executive is unable to meet an appointed Executive will meet in his stead.

2.2 The Trust remains up-to-date with its mandatory submissions to the National Guardian's Office following the submissions to the new reporting portal.

3 Strategy, Policy and Self-Assessment

3.1 The Trust's Freedom to Speak Up strategy was reviewed in February 2020 linking raising concerns to each of the Trust's strategies, namely quality, clinical, people and system financial recovery. The strategy determines the roles and responsibilities of the Lead Guardian, the guardians, the named Non-Executive Director and the Executives.

3.2 The Trust carried out a self-assessment in 2018 which reported on the progress made to address 33 partially met criteria and 11 unmet criteria (the process met 23 at the point of self-assessment). The updated self-assessment was reported to private Board in January 2020 which showed 25 fully met areas, 22 partial areas and 11 unmet areas around the self-assessment. The board are due to meet

separately to discuss how to provide the board with a variety of assurances about the effectiveness or the trusts strategy, policy and process.

4 Reported Cases

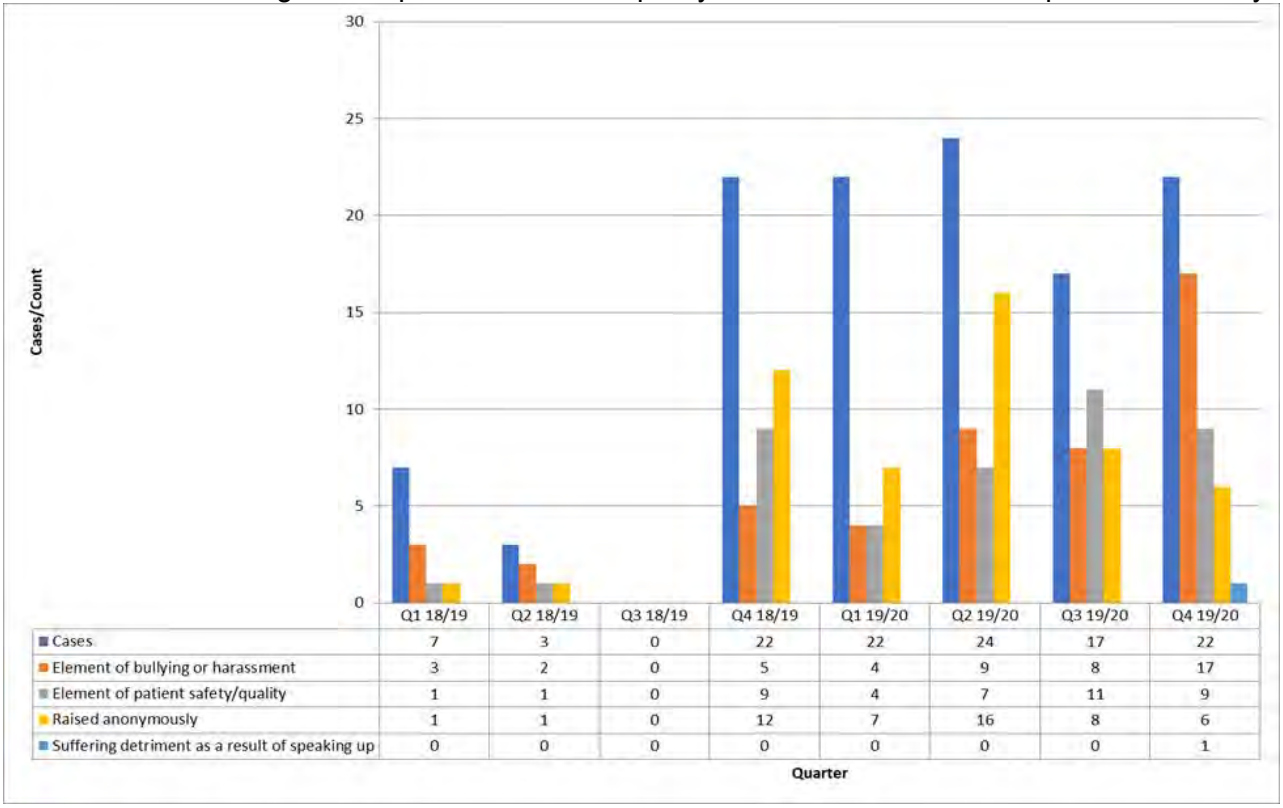
4.1 During Quarter 3 2019/20 a total of 17 concerns were raised of which 8 were anonymous, 11 included an element of patient safety/quality and 8 included an element of bullying or harassment. There were no reported incidents of people suffering detriment as a result of speaking up.

During Quarter 4 2019/20 a total of 22 concerns were raised of which 6 were anonymous, 9 included an element of patient safety/quality. 17 included an element of bullying or harassment. There was 1 reported incident of people suffering detriment as a result of speaking up. This individual did not wish to give further information on this.

4.2 Five more concerns were raised in Quarter 4 than Quarter 3. Anonymous cases have decreased by 2 in Quarter 4. There was also a decrease of 2 for elements of patient safety/quality. Bullying and harassment elements increased by 9.

4.3 It is clear that establishing a funded, dedicated Lead Guardian has significantly improved the confidence and accessibility to raise concerns across the organisation which has led to a stable jump to c.7-24 cases per quarter. Confidence to raise concerns without victimisation can be measured using the statistic of those cases raised anonymously (low anonymous rate may indicate confidence to raise concerns); however, this varies considerably between Q4 18/19 (12) down to 7 in Q1 19/20 but then rises again to 16 in Q2 19/20. Nationally (up to Q4 18/19 benchmarking data) the anonymous rate is c.11 -15% however the Trust is significantly higher than this and will require further work to understand the need to raise concerns anonymously.

4.4 Since the Freedom to Speak Up lead has come into post a year ago, the roles and responsibilities of champions has been revised and a flowchart explaining the investigation process is now available. There are now seven Freedom to Speak Up champions across the trust. Governance teams have been involved with ensuring data is protected and the policy is due to be revised and published in May 2022.



	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
Cases	7	3	0	22	22	24	17	22
Element of bullying or harassment	3	2	0	5	4	9	8	17
Element of patient safety/quality	1	1	0	9	4	7	11	9
Raised anonymously	1	1	0	12	7	16	8	6
Suffering detriment as a result of speaking up	0	0	0	0	0	0	0	1

4.5 Twelve cases remain open. Of these cases:

4.5.1 Four of these are from ED;

4.5.2 Two are from Therapies;

4.5.3 Two are bullying concerns in other departments from above;

4.5.4 One is an anonymous concern around shielding and social distancing;

4.5.5 One is from the community concerning behaviours of other staff;

4.5.6 One is asking for a Datix to be reviewed after concerns with the outcome;

4.5.7 One is around rumours that doctors were receiving additional pay during the peak of Covid 19.

~ End ~

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors
Thursday, 02 July 2020

Title of Report	**Updating the Constitution**	**Agenda Item**	9.1
Report Author	David Seabrooke, Interim Company Secretary		
Lead Director	David Seabrooke, Interim Company Secretary		
Executive Summary	A further review of the Constitution has been undertaken, following the completion of the 2017 review. The details will go to the July meeting of the Council of Governors for discussion. A number of suggested amendments have been identified and the significant cases are described below: At present, the Constitution prohibits directors and governors joining other trusts. The Trust may want to consider relaxing current prohibitions on individuals having roles on other Boards, or being governors on other foundation trusts (e.g. paragraph 16 of the governors' disqualification criteria; paragraph 30 for the Board). The Constitution should be clearer in respect of the appointment of a Vice Chairman. The Chairman should appoint the Vice-chairman and senior independent director, subject to consultation with the Council of Governors. (E.g. Annex 5 paragraph 2.5; Annex 6, paragraphs 2.4. and 2.5) An inconsistency in the process for the removal of a governor has been identified. This, should it ever be necessary, needs to be a function of the Council of Governors. Steps should be taken to avoid this happening, to investigate any disputed facts or circumstances, and to hear from the governor concerned before a decision is made by the Council. (Annex 8, paragraph 6)		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Executive Group Approval:	n/a		

Resource Implications	none			
Legal Implications/Regulatory Requirements	The Constitution gives effect to the legal requirements governing foundation trusts, mostly as set out in the National Health Service Act 2006. Other sources include the Code of Governance.			
Quality Impact Assessment	Not required.			
Recommendation/ Actions required	To note that the Council of Governors will consider these proposals later in July.			
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None			

Other points where amendments are proposed

For governor elections, the Trust's practice is to use the "first past the post" system (Model Election Rules)

The traditional requirement for the printing and posting of agenda papers is updated to reflect current on-line/electronic processes.

Annex 5 refers to governors as "members", which is considered to be ambiguous and has been changed throughout to "Governor."

Committees of the Council of Governors do not exercise delegated authority.