Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

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

Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Conflicts of Interest				
1.4	Chief Executive Update	Chief Executive	3	12:35	Note
1.5	Clinical Presentation – Neonatal Unit by Ghada Ramadan, Speciality Lead for Neonatal Services	Chief Medical Officer	Verbal	12:50	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 02.12.20	Chair	7	13:10	Approve
2.2	Matters arising and Action Log: 02.12.20	Chair	17		Discuss
3.	**Governance**				
3.1	Integrated Audit Committee Assurance Report: Meeting on 07 January 2021	Chair of Committee/ Chief Finance Officer	19	13:20	Note
3.2	Risk Management Policy and Strategy	Deputy Chief Executive	21	13:30	Approve
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNQO, CMO	39	13:40	Note
4.2	Quality Assurance Committee Assurance Report: Meeting on 15 December 2020	Chair of Committee/ Chief Nursing and Quality Officer	61	13:55	Note
4.3	Board Assurance Framework	Deputy Chief Executive	77	14:05	Note
4.4	Risk Register Quarterly Review	Deputy Chief Executive	99	14:15	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 8	Chief Finance Officer	107	14:25	Note
5.2	Finance Committee Assurance Report: Meeting on 22 December 2020	Chair of Committee/ Chief Finance Officer	125	14:40	Note
6.	**Innovation**				
6.1	Trust Improvement Plan	Deputy Chief Executive	129	14:50	Note
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	15:10	Note
7.2	Questions from the Public	Chair	Verbal		Note
7.3	Any Other Business	Chair	Verbal		Note
7.4	Date and time of next meeting: Thursday, 4 February 2021, 12:30 – 15:30				

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – January 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.

I would like to start this month's message, by paying our respects to colleagues who have sadly passed away in December 2020.

Angela Holmes died after developing COVID-19. Angela was a Vascular Pathway-Co-ordinator and had worked for the Trust for more than a decade.

Sarah Montgomery sadly also passed away due to cancer at the end of the year. Sarah had worked at the Trust for nine years as an emergency department practitioner

It is incredibly sad to lose colleagues, and I would like to offer our sincere condolences to Angela's and Sarah's family, friends and colleagues. I would also like to say thank you to those colleagues who despite grieving, have continued to come to work to care for our patients.

<u>COVID-19</u>

Needless to say that the winter period has been exceptionally busy, with particularly high demand for our emergency, frailty and intensive care services being in excess of that we experienced in the first wave of the pandemic. This has meant that we have temporarily converted many of our wards to care for patients with coronavirus, and reduced the level of elective and outpatient activity.

We have continued to undertake some elective and cancer work, but recognise the impact on our patients that any delay in care can have on their physical and mental health. We continue to work with our clinical colleagues in managing the risks associated with these decisions, and I am grateful for their candour and advocacy on behalf of our patients at all times.

We have seen high prevalence of the virus within the communities across Medway and Swale, and it has been well publicised that until recently, Medway and Swale had the highest level of infection per 100,000 residents that anywhere else in the Country. It is so vitally important that continue to reinforce the message about good infection control practice, wearing of face masks, and social distancing, both within the hospital, and in the community.

Last month, we were very proud to become one of the first hospitals in the country to begin administering COVID-19 vaccinations to priority groups, specifically patients over 80, care home staff, and hospital colleagues. I would like to thank our teams for their incredible efforts, not just for the planning and preparation involved in getting the vaccine ready for distribution but for the care they have provided to our patients throughout this pandemic.

The vaccine is certainly an encouraging step toward some degree of normality, but we are still a long way from this pandemic being over and we are reminding our colleagues, patients and public about actions they can take to help support the hospital during winter.

We are also helping to keep our colleagues and patients safe by providing lateral flow test kits for all staff. These kits enable colleagues to test themselves twice per week for COVID infection; we also held a mass testing event for all asymptomatic staff which was kindly supported by the Department of Health and Social Care.

We would like to thank our community for their support and patience; we know that cancelling operations or having long waits in the Emergency Department is far from ideal and we are doing absolutely everything we can to minimise their disruption faced by our patients during this unprecedented time.

Supporting discharge

Last month, teams across the hospital were involved in a Multi-Agency Discharge Event (MADE) over a one-week period. The MADE brought together colleagues across the system to help get as many patients as possible home for Christmas.

Increasing the safe discharges of those who no longer require our care also helped to create much needed space and assist with better patient flow throughout the hospital.

On average we discharged an additional five patients each day, including the patient with the second longest length of stay in the hospital.

Thanks to those who took part in the event and helped to make it a success for our patients and colleagues.

Christmas at Medway

I would like to thank all our staff who spent Christmas away from home in order to care for patients. They always go above and beyond to bring some Christmas cheer to those unfortunate enough to be unwell at Christmas and this year was no exception.

We wanted to make Christmas feel as normal for colleagues this year as possible – holding a Christmas Tree Festival, offering a free Christmas Day lunch and delivering chocolates, pizza and hampers to colleagues in their work areas. Despite everything else going on, it really did feel very festive in the hospital. We very much hope that next year we can once again look forward to ‘normal’ Christmas celebrations on site.

Improvement Plan

While much of our effort has been focussed on managing the demands of the pandemic, I am pleased to say that we have continued to make progress on our improvement plan.

We have progressed our business case on the electronic patient record, and saw further improvements across our wards in relation to milestones for the number of days without infection and pressure ulcers. There is much more to do, but these are encouraging signs that we are improving the quality of care we provide, and focussing our efforts on the long term future of the hospital.

Our financial position remains on plan at month eight, but will require prudent management as we head towards the end of the financial year; notwithstanding the need to invest in the resource to manage to provide safe, effective and person centered care.

We have been grateful to our system partners for their support over recent months, as we move toward working as a truly integrated care system.

Communicating with colleagues and the community

Despite the challenges, we have continued to engage with our community by way of newsletters and social media. We also facilitated, as part of the ICP, an engagement event with our community to hear feedback on how they wanted to shape future services across Medway and Swale.

The graphic below gives a flavour.

Finally, I want to wish our community a Happy New Year. I genuinely hope that 2021 brings much joy and happiness, and a return to some degree of normality.

Minutes of the Trust Board PUBLIC Meeting

Wednesday, 02 December 2020 at 12:30 – 14:00

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	David Sulch	Chief Medical Officer
	Ewan Carmichael	Non-Executive Director
	Gurjit Mahil	Deputy Chief Executive
	James Devine	Chief Executive
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Chief People Officer
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer (Interim)
	Glynis Alexander	Director of Communications and Engagement
	Harvey McEnroe	Strategic Commander/Winter Director
	Jack Tabner	Director of Transformation/IT
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Company Secretary
	Glyn Allen	Lead Governor
	Natasha Pritchard	Freedom to Speak Up Guardian (Presenting Item 1.5)
	Nye Harries	NHSEI Improvement Director
Observing:	Ann Utley	NHS Providers
	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
	Niloufar Hajilou	Head of Quality and Safety, Moorfields Eye Hospital NHS FT
	Temi Alao	HR Business Partner
	Justine Wood	Business Support Manager to Chief Executive and Chair
Apologies:	Gary Lupton	Director of Estates and Facilities

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts to make the meeting on MS Teams and for the Board's flexibility in using the technology to enable it to conduct its business especially during this second lockdown period. There were no apologies sent prior to the meeting.

1.1.1 Today you will hear more about the challenges being faced within the hospital as a result of this second wave of Covid-19. As in the first wave, the Trust's incredible colleagues have stepped forward during a very difficult time to help those most in need. On behalf of the Trust Board, Chair thanked all colleagues at the Trust for the incredible care, compassion and commitment they are showing in caring for patients during this second wave of the Covid-19 pandemic. The pandemic has impacted so many colleagues, both professionally and personally, and despite this they continue to deliver the highest levels of care.

1.1.2 Chair stated that like everyone else in the Trust she was devastated to hear of the death of Hannah Jackson, one of the Trust's nurses, who died last week after developing Covid. Chair offered her sincere condolences to Hannah's family; may she rest in peace. Chair thanked the local community for their kind words about Hannah and for the support and patience they are showing at this time.

1.1.3 The Trust is humbled to have been able to return patients back to their families and saddened for the families who have lost loved ones to covid.

1.1.4 The Board meeting today was shortened to give the team as much time to focus on the hospital as possible.

1.1.5 Chair asked for colleagues and local residents to remember to have the flu vaccination and continue to follow the 'hands-face-space' guidance. These basic measures will help prevent the spread of infection which is so important to bring the rate down in our community and to help colleagues at the hospital bring down the infection rates.

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

1.4.1 It has been a busy and challenging month again for the Trust, especially since there has been an increase in patient admissions for Covid-19 and increased staff absence.

1.4.2 James asked the Board to join him in paying respects to Hannah Jackson and her family. Hannah was one of the Trust's surgical nurses and joined the Trust in April 2019. James and Jane Murkin spent considerable time with colleagues last week following the sad news of Hannah's death. It would be right that the Trust pays its respects to Hannah in the most appropriate way once it is able to do so. James sincerely thanked Hannah's colleagues who

despite hearing news of their friend continued in the following days to care for patients, despite their evident grief. It is a real testament to the Hospital's nursing colleagues.

1.4.3 The Board will hear more on the current processes in regard to Covid-19 today by Harvey McEnroe, as there has been significant demand for the Trusts services in November 2020. James went on to thank other hospitals in Kent for their ongoing support and mutual aid, not just physically but for the Chief Executive, Chief Operating Officer, Strategic Command and SECAmb discussions to ensure that the risk is shared across a wider Kent system and that all parties are more dynamic in their work together. James also thanked the CCG and regulator colleagues for their continuing support the Trust are pleased to have it. There is a lot more work to do in the coming months but with this welcome support the Trust can deliver.

1.4.4 The Board will also be informed today on the current Response Strategy. Particularly to provide some assurance around the Strategic Command Structure, this remains in place. James gave the Board assurance that the governance processes are working well, it is a collaborative and risk assessed process. This will ensure that the Board will continue to have oversight at the weekly NED Briefings but also through the Quality Assurance Committee.

1.4.5 James informed the Board that he has asked Jane Murkin through the Quality Assurance Committee, has been asked to review the risks around the decisions made over the past few weeks and will continue to scrutinise multiple times throughout every day.

1.4.6 Today the nation was informed of the approval of the Covid-19 vaccination. The Trust continues to encourage colleagues and the community to have their flu vaccine. The Trust will await the national guidance on communications on the Covid-19 vaccine but will share with colleagues upon receipt.

1.4.7 The Trust has started the Lateral Flow testing (staff testing), this is will support the work on nosocomial rates within the hospital but more so the community prevalence of Covid-19.

1.4.8 Over the last few days there has been a reduction in admissions and a reduction in nosocomial rates.

1.4.9 James stated that he with the Chair has seen the operational structure first hand and it continues to be well led by Harvey McEnroe et al and the resilience of the team should be noted.

1.4.10 James wanted to inform the Board on how seriously he and the entire Executive team take their responsibilities on all matters relating to Covid; especially on workforce, infection control, finance and most importantly quality of care.

1.4.11 Work continues on the development of the ICP Strategy and hopeful by Mid-December that the Trust will have its strategic intent document for the ICP. This is being completed in parallel with the ICS Accreditation.

1.4.12 James stated that Natasha Pritchard, Freedom to Speak Up Guardian, has done a fantastic job during her time at Medway. This will be her last meeting, so James asked for it to be recorded that the Board thanks Natasha for her work and how she has progressed the Freedom to Speak Up culture within the Trust, with such commitment and passion.

1.4.13 James stated within the IQPR today there will be an executive position given on operational performance. He assured the Board that whilst the Trust deals with the current

pressures/challenges, that the focus is firmly on safe, effective and person centred care. There are some difficult decisions being made and they are not taken lightly.

1.4.14 Staffing absence has been a particular challenge for the Trust this month. The Trust continues to ensure that colleagues are well supported.

1.4.15 Costs of Covid cannot be ignored, the issues around this will be detailed later on today. There is a gap but James wanted to thank colleagues across the hospital for their efforts in trying to bridge the financial gap.

1.4.17 James gave his thanks to the Community was given for their support and their commitment to 'hands, face and space'. James asked for their ongoing support as the country heads into higher restrictions in Medway and Swale. These simple but effective national guidelines will support to reduce infection rates.

1.4.18 James gave a huge thank you to all colleagues across the hospital who continue to provide care whether that is directly or indirectly to patients, with such passion and dedication. James ended by giving a final thanks to the Board and the Executive team for their support, challenge and guidance over the last year, it has been unfaltering. James gave a fond farewell as the last Board meeting of 2020 and hopes for a more encouraging 2021.

1.4.19 Chair thanked James for his report to the Board.

1.5 Freedom To Speak Up Update

Natasha Pritchard, Freedom to Speak Up Guardian, gave the Board an update on the progress of Freedom To Speak Up (FTSU).

1.5.1 Previously in Q3 2019/20 there were 17 concerns raised and in Q4 2019/20 22 concerns were raised. In Q1 2020/21 21 concerns were raised and in Q2 28 concerns were raised. Presently 21 cases remain open; these are being looked into by Executives and overseen by the Chief Executive.

1.5.2 Natasha has been working with the Chief People Office and the Deputy Director of HR and OD on supporting colleagues who fear repercussions on speaking up. More work on this will roll out after Christmas.

1.5.3 FTSU Month was successful; there was plenty of communications around this, in addition to social media posts and an event held in the Hospital Restaurant. The event attendance was impacted by Covid and the need to socially distance but was well attended under the circumstances.

1.5.4 Natasha has continued to work with NHSEI and regular meetings are scheduled. The HR team are working on areas that have themes occurring.

1.5.5 Natasha informed the Board that due to personal circumstances she will be leaving the Trust but one of the FTSU Champions would be looking after her role whilst a new Freedom to Speak Up Guardian is recruited to ensure continuity. Natasha thanked the Board, Chair and Chief Executive for all of their support during her time at the Trust.

1.5.6 Chair stated that it has been an absolute pleasure to work with Natasha and she has made a palpable difference to the Trust which is demonstrated in the numbers. The Trust is in a much better position than it has been in the past. The Board thanked Natasha for promoting and

embedding change and it has assisted the NEDs to be able to do their jobs and inspired colleagues.

1.5.7 James Devine stated that in terms of the report the Board can see an encouraging decrease in bullying and harassment issues. He thanked Natasha for asking the right questions and her work with colleagues has been excellent building trust and relationships wioth all. James gave her a huge thank you from the Trust and she will be greatly missed, wishing her all the best with her career at Southampton Hospital.

1.5.8 Leon Hinton congratulated Natasha for her work and the FTSU month. The feedback has been really positive and the message has reached areas the Trust did not reach before. The actions for FTSU will be governed through the People Committee. There is work to do on detriment alongside other areas and some work to complete prior to the refresh of the strategy.

1.5.9 Mark Spragg thanked Natasha for her hard work and asked if she felt that there had been a cultural change in the Trust. Natasha believes that there has been and as her job is also clinical she has seen both sides of working. She believes that colleagues are more aware of organisational development and of what is happening within the Trust. Networking events and triangulating information has helped, there is a much more joined up approach now within the Trust. Her successor will be able to measure where themes and concerns are going forward.

1.5.10 The Board asked that the People Committee review the measurement of cultural change due to FTSU. **Action No: TBPU/20/106**

1.5.11 Adrian Ward is the Non-Executive FTSU Guarding prior to Natasha starting and has seen an organisational awareness change and Natasha has successfully raised the profile of FTSU. He wished Natasha the best for the future and hoped that her successor brings the same amount of drive as she has.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 05 November 2020 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

Tony Ullman asked that the Board should note that due to Covid, the previous minutes referenced the November Quality Assurance Meeting. This meeting was shortened and business deferred to be formally held in December 2020.

2.2 Matters arising and actions from the last meeting
There were no matters arising or live actions on the log to address.

3 High Quality Care

3.1 Integrated Quality Performance Report

The Board was asked to note the report and discuss the content. The refreshed version of the IQPR uses Statistical Process Control charts to display the data within the report. The report informed Board Members of the quality and operational performance across key performance indicators.

3.1.1 Angela Gallagher, Chief Operating Officer (Interim) talked through the figures in the report. Responsive; Unfortunately, due in part to the lower discharges before noon rate and the pause in elective work the 18 weeks Referral to treatment (RTT) performance for September is recorded at 64.7%, with 144 +52 week breaches, clinical harm reviews have been completed for these patients. Additionally, the Trust has seen 31 Operations cancelled by the hospital on the

day. Continued site pressures, due to COVID increases, has also seen Bed Occupancy challenges, reported at 82.7% for October.
ED (Type 1) 4 hour performance as a result of site pressures reported 74.38% in October.
Additionally, the Trust saw 309 Ambulance Handover delays of over 60 minutes.
However, DM01 Diagnostics performance is continuing to improve at 87.5% for September.

3.1.2 James Devine confirmed that a further review is being completed on the bed base, led by Angela. The review on the bed base should be submitted to Quality Assurance Committee and then back to Board in February 2021. **Action No: TBPU/20/107**

3.1.3 Jane Murkin, Chief Nursing and Quality Officer stated that safety and quality care is a priority for the Trust. With over half of the bed base with Covid or query Covid status, the team remains extremely vigilant with the oversight on this. Jane is mitigating the risk of hospital acquired infection (HAI). The best outcome for care depends on having the right levels of care in the right places.

3.1.4 David Sulch, Chief Medical Officer, stated that the outbreaks in hospital are due to the increase in community rates, patients incubate covid and then it comes out once they are in hospital. To help reduce the HAI and risk the following actions are being taken:

a) Patients are tested on day three and day six to see if there are any developments.
b) Bed moves are only happening if absolutely necessary
c) Lateral Flow staff test kits are being rolled out, frontline staff testing twice a week, with a 30 minute test result. Regulators have been clear that the Lateral Flow test is designed for staff testing not patients, as it is only 70% effective. It is not part of the national testing strategy at the moment.
d) Samba machines started to be used this week which gives 90 minute results for admitted patients. Currently the number of patients tested is 50 per day but this will increase over next few weeks with extra machines and cassettes being supplied. David has had discussions with regulators over the supply of these being re-routed from Surrey and Sussex who currently require less. James stated that to have insufficient cassettes for the machines has an impact so this risk is being escalated as it severely limits the team to be able to test patients.
e) Robust management tactical cell and strategic meetings are established on a daily basis. There is a strong oversight of the hospital operations and this issue is being taken extremely seriously.

3.1.5 James stated that although significant progress has been made with mixed sex accommodation breaches, reducing falls and pressure ulcers, there may be a rise in breaches over the coming months due to the pressures in the hospital. There are real time risk assessments in place and teams need to be cognizant. Jane Murkin confirmed that she has grip on these issues and with a reduction in admissions the risk of these breaches would fall.

3.1.6 James stated that there is a similar situation in the breaches in ED. The Executive team and SECAmb have discussed the issues and have a plan going forward. Medway receive more ambulances than any of the other multi use sites. The Trust do not want patients to experience long delays, so sharing the workload and risk across other sites would alleviate pressure and reduce risk.

3.1.7 James stated that the Trust is seeing a decline in the numbers of appraisals and stat man training. He asked that the People Committee review this and take learning from other Trusts to improve on this when there has been a reduction in admissions and pressures. How can the Trust improve the percentage of colleagues completing their training? He asked that the Committee look at how the Trust can be more agile and find a more creative way to do training. **Action No: TBPU/20/108**

3.1.8 Leon Hinton, Chief People Officer, stated that on top of the self-isolating and sick staff there is also clinically vulnerable staff on top of time pressures on the Trust as a whole. The HR team are bolstering reporting processes in the system and this is being reviewed twice daily, which reports into the strategic group. The team is ensuring that with redeployment, that the right skills are in the right place at the right time. The tactical actions are being monitored to ensure that staffing is safe.

3.1.9 Tony Ullman asked that through Jane Murkin, could she ask that Karen McIntyre completes some analysis on complaints and report to the Quality Assurance Committee. **Action No: TBPU/20/109**

3.1.10 Harvey McEnroe, Strategic Commander, stated that the Trust receives approximately 130 ambulances per day, which is 30 – 40 more ambulances than other local hospitals, such as Maidstone and William Harvey. The Trust is on day three of Dynamic Conveyancing to understand pressures and redirect patients to other sites. Ambulances will take patients to sites where there is the least amount of delay, whilst risk assessing their condition and location. It is a good move toward safe care; it will benefit all parties and will support the Trust as it is under extreme pressure. It is not without its own risks but it will help reduce long delays. Harvey will keep the Board informed on this. There are difficult decisions being made on a daily basis but all decisions are being logged through the tactical/strategic meetings.

3.1.6 The Board was asked to specifically note in the paper:

1) The maternity 12+6 indicator currently shows July 2020 data, this is because NHSI/E/D calculates this indicator and is currently working three months in arrears.
2) The SHMI data is currently showing April 2020 – this is reliant on NHSI/E/D and is three to four months in arrears.
3) The HSMR is currently showing July data, this is reliant on Dr Foster and this is three to four months in arrears.
4) The C-diff, E Coli and RSA data is reliant on the Trust's internal infection prevention control sources and data is available from the 13th working day of the month.

4 Financial Stability

4.1 Finance Report – Month 7

Alan Davies, Chief Finance Officer, asked the Board to note the report which sets out the summary financial position to the end of October 2020. The paper was taken as read. The Trust reports a deficit of £8k in month and £69k year to date, which adjusts to breakeven against the NHSEI control total. New arrangements came into force from 01 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level. This is the first month of the revised plan. Alan gave the Board the following key highlights from the report:

4.1.1 Trust Surplus; The Trust reports a £8k deficit position for October; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. In-month non recurrent adjustments include (£0.8m) drugs accrual reduction and an increase to the contingency of £0.3m.

4.1.2 CIP; this remains a risk and teams are looking to close the gap. Schemes delivered to so far in the year mainly relate to the full year effect of schemes from 2019/20, efficient use of theatres, reduced orthopaedic insourcing, as well procurement and pharmacy savings from nationally agreed prices. Year to date performance reports an over achievement against plan due to timing differences of schemes delivered. The forecast position of actual delivery has been updated with the scheme owners identifying £10.3m to achieving the £12m plan, this being an increase in month of £0.5m.

4.1.3 Capital; this remains a risk in delivering the forecast. Alan is working with Gurjit on grip and control through the organisation and panels to review the issues. The capital plan of £24,414k has increased to £29,705k when factoring in all new monies expected. The Trust has agreed with the STP to underspend against this plan by £1.3m so monies can be reallocated to priority schemes in other Trusts which have not received CIF funding.

4.1.4 There is a risk around £3,071k of the additional funds: UTC business case (£1,104k) is still under consideration with NHSEI but is not expected to be a problem; Covid Capital funding (£1,967k) is however a significant risk. Due to a shortfall in national funds, NHSEI are reviewing all bids and it is highly likely that at least 50% will not be granted causing a pressure on the current programme.

4.1.5 James Devine thanked Alan for his work to date at the Trust; it has been a difficult time to join during the pandemic. He asked that the Finance Committee to complete a deep dive on the Covid-19 Expenditure and the effect it will have on the control total. **Action No: TBPU/20/110**

4.2 Finance Committee Assurance Report

Jo Palmer, Chair, took the paper as read and informed the Board of the following key issues from the Finance Committee meeting of Thursday, 26 November 2020 for the Board to note. The following escalations were submitted to Board:

1) The Committee recommended approval of the Electronic Patient Record (EPR) business case to the Trust Board, subject to the caveats as noted.

4.2.1 Chair stated that the Committee accepted the monthly Finance Report and meeting was shortened due to the pressures in the Hospital.

4.2.2 This was the second review of the EPR and as per the Assurance Report there were three more items for the team to take away to look at.

4.2.3 The Board was asked to give the Finance Committee delegated authority to sign off on the business case with the detailed caveats as the team would like to continue to make progress.

4.2.4 Chair added that the additional CIP savings would equate to half a percent on the Trust revenue. The Committee thought it was reasonable to achieve over time but is an additional stretch. Chair has met with Jack Tabner, who is lead on the project and suggested that Jack and his team make other savings to mitigate the revenue risk and update the Board on these savings. **Action No: TBPU/20/111**

4.2.5 Jenny Chong gave a short presentation on her thoughts and offered her expertise in this area and would give her input to Gurjit Mahil on information governance issues.

4.2.6 The Board **APPROVED** the business case and for the Finance Committee to have delegated authority ahead of the contract signing.

5 Innovation

5.1 Trust Improvement Plan

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

5.1.1 Gurjit confirmed that 26 of the actions are now green. The regular meetings chaired by James Devine, are still in place but are currently reduced to 30 minute sessions due to the pressures in the hospital.

5.1.3 The zero to nine month reviews will evidence that the team are doing what they say they are which can be show to colleagues.

5.1.4 The Board suggested that the RAG Ratings and delivery dates are reviewed and also for Gurjit to note what will not be delivered in the next nine months to be authentic to the Board and colleagues. **Action No: TBPU/20/112**

5.1.5 The Board liked the format of the report and asked Gurjit to keep pressure on and continue to make progress. The Board **NOTED** the report

6 Our People

6.1 People Committee Assurance Report

Sue Mackenzie, Chair of the People Committee, gave the Board an update on the Committee meeting held on Monday, 23 November 2020. The paper was taken as read and noted.

8.1.1 The following items were given as escalations to the Board:

1) EU Exit; The Board is asked to note the EU Exit risk to the Workforce. It needs to be amended on the Corporate Risk Register and BAF to be reviewed on a more regular basis. David Seabrooke, Company Secretary to ensure this is raised.

7 Any Other Business

7.1 Council of Governors Update

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

7.1.1 The Governor Coffee Morning event was held last week virtually and overall was a positive meeting. Any queries that were unable to be answered at the time have been logged and will be answered outside of the meeting. It was useful to have input from Karen McIntyre and Mohamed Mohamed at the meeting. The next Governor Coffee Morning will be held in January 2021.

7.1.2 The appointment has started for the new Non-Executive Director. The recruitment process will be handled in-house and supported by the NEDs.

7.1.3 Glyn had been asked to raise a concern from the Council. This had been submitted to the Chair, Company Secretary and Director of Communications and Engagement prior to the meeting. The matter concerned related to a person having to wait four weeks for a death certificate for his wife, due to a delay in the availability of a doctor to sign the certificate, which was eventually carried out by the medical examiner.

7.1.4 Lyndsay Barrow, Patient Experience Manager has been made aware of the concern and has advised that a new process has been put in place to prevent delays. All parties involved understand the current challenges due to Covid and the impact that has on the processes within the hospital.

7.1.5 David Sulch confirmed that there have been challenges to ensure that the certificates are completed in the appropriate time. Due to the current pressures the Medical Examiner can now complete the certificate themselves, which has helped to expedite the process. It also assists the Bereavement team to be able to process documentation and ultimately supply this to the

family. The Mortality and Morbidity Committee are aware of the challenge and the change which should accelerate the process.

7.1.6 James Devine and the Board gave their sincerest of apologies to the family that was affected by the delay in issuing the certificate. Chair thanked Glyn and the Council for raising this to the Board as it is so important that the Trust hears from its patients.

7.2 Questions from the Public

There were no questions from the public submitted to the Board

7.3 Any Other Business

Chair wished the Board a merry Christmas and hopes that 2021 is better for us all.

There were no matters of any other business.

7.4 Date and time of next meeting

The next meeting will be held on Thursday, 14 January 2020, 12:30 – 15:30.

The meeting closed at 14:10

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 05 November 2020

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

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

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
02-Dec-20	TBPU/20/106	**Item 1.5 - Freedom To Speak Up Update:** the People Committee to review the measurement of cultural change due to FTSU	14-Jan-21	Leon Hinton, Chief People Officer	Propose to close - Will be reviewed on 18 January 2021	Green
02-Dec-20	TBPU/20/107	**Item 3.1 - Integrated Quality Performance Report:** a review to be completed on the Hospital Bed Base, to be taken to QAC and then back to Board in February 2021	04-Feb-21	Angela Gallagher, Chief Operating Officer (Interim)	Not due until February 2021	White
02-Dec-20	TBPU/20/108	**Item 3.1 - Integrated Quality Performance Report:** the People Committee review appraisals and stat man training; how to improve the percentage of staff completing appraisals/training and take learning from other Trusts.	14-Jan-21	Leon Hinton, Chief People Officer	Update at meeting	Green
02-Dec-20	TBPU/20/109	**Item 3.1 - Integrated Quality Performance Report:** Jane Murkin, to work with Karen McIntyre on completing analysis on complaints and report to the Quality Assurance Committee.	14-Jan-21	Jane Murkin, Chief Nuring and Quality Officer	Update at meeting	
02-Dec-20	TBPU/20/110	**Item 4.1 - Finance Report - Month 7:** the Finance Committee to complete a deep dive on the Covid-19 Expenditure and the effect it will have on the control total.	14-Jan-21	Alan Davies, Chief Finance Officer	Update at meeting	
02-Dec-20	TBPU/20/111	**Item 4.2 - Finance Committee Assurance Report (EPR):** the team are to make other savings to mitigate the revenue risk (0.5%) and update to the Board on these savings.	14-Jan-21	Jack Tabner, Director of Transformation/IT	Update at meeting	
02-Dec-20	TBPU/20/112	**Item 5.1 - Trust Improvement Plan:** RAG Ratings and delivery dates to be reviewed and note what will not be delivered in the next nine months to be authentic to the Board and colleagues.	14-Jan-21	Gurjit Mahil, Deputy Chief Executive	Update at meeting	

Meeting of the Board of Directors in Public

Thursday, 14 January 2021

Assurance Report from Committee

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**3.1**
Committee Chair:	Mark Spragg, Non-Executive Director		
Date of Meeting:	Thursday, 07 January 2021		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Paul Kimber, Deputy Chief Finance Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Internal audit KPMG presented their audit summary and noted that fieldwork continues to be mindful of operational pressures. It was noted that work is progressing and no issues are anticipated in being able to provide a Head of Internal Audit Opinion for the Annual Report. The Committee asked for the due dates on all overdue recommendations to be reviewed and revised with realistic timeframes given current conditions. The 'Bank and Agency Staffing' report was presented, which had an improved rating of 'significant assurance with minor improvement opportunities'. The counter fraud progress report was presented to and noted by the committee. This highlighted the proactive and reactive work being undertaken, particularly in raising awareness at the Trust. The	**Amber/Green**

Committee was keen that proactive work moving forward includes greater focus on cyber. It was noted that an external investigation report into a breach of financial controls resulting in a loss would be shared with the Board. The committee confirmed that the operation of the controls in place had been reviewed by management. It was **AGREED** in principle that any changes in supplier bank details should be approved by the CFO or CEO. It was also **AGREED** that the CFO would speak with the Chief People Officer with regard to policies that cover failures of internal control processes.	**Amber/ Red**
2. External audit Grant Thornton presented their update paper to the Committee. It was noted that mitigations to physical attendance at an inventory count are being pursued. It was also highlighted to the Committee that there are significant changes to the audit requirements to be able to opine on value for money, being more onerous than previous years. It was also noted that audit requirements for the Quality Report remain unclear; the Committee was reminded that such requirements were withdrawn for 2019/20 as a result of the operational pressures caused by the pandemic.	**Amber/Green**
3. BAF The BAF extract on 'Innovation' was presented to the Committee by the Executive Director of Transformation and IT.	**Amber/Green**
4. Data security protection toolkit The Deputy CEO presented this report to the Committee. This document was noted, including the progress being made towards meeting the 2020/21 criteria. Further updates would be presented to future meetings.	**Amber/Green**
Decisions made It was **AGREED** that the CFO would review the process of changes in supplier bank details with a view to permitting only the CFO or CEO to have the authority to approve. It was **AGREED** that the CFO would speak with the Chief People Officer with regards to policies that cover failures of internal control processes.	
Further Risks Identified None.	
Escalations to the Board or other Committee The bank mandate fraud report from KPMG will be circulated to Trust Board members.	

Meeting of the Trust Board in Public
Thursday, 14 January 2021

Title of Report	**Corporate Risk Management Strategy, Policy and Risk Appetite**	Agenda Item	**3.2**
Lead Director	Gurjit Mahil, Deputy Chief Executive		
Report Author	Julie Wilson, Risk Manager Tracy Kelly, Assistant Head of Corporate Governance and Legal and Paul Mullane, Head of Corporate Governance and Legal		
Executive Summary	The Trust Board are requested to discuss and agree the following: • The Corporate Risk Management Strategy and Policy		
Committees or Groups at which the paper has been submitted	Executive Group with final ratification by the Trust Board		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to APPROVE the strategy and policy.		
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix 1 – CORPORATE – Risk Management Strategy and Policy		

1 Executive Overview

1.1 The Corporate Risk Management Strategy and Policy is presented at appendix 1 and is due for review in January 2021.

1.2 The strategy and policy fundamentally stay the same but changes made to the risk appetite have been made.

1.3 The Risk Appetite outlines the risk tolerances for various areas of the organisation's business. The Board are required to agree the proposed Risk Appetite target scores – appendix 3 within the policy.

2 Risk Management Strategy and Policy

Amber / Green

2.1 The policy outlines the roles and responsibilities for all staff and the collective responsibility for the management of all risks across the Trust.

2.2 The monitoring and review table outlines what will be monitored, by whom and how often.

2.3 Training for all staff is outlined.

3 Risk Appetite

Amber / Green

3.1 Trust Board members reviewed the risk appetite at a training session held in February 2020.

3.2 The Risk Appetite is defined as "The levels and types of risk the Organisation is prepared to accept in pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks".

3.3 The risk appetite statement will define the Executive Groups appetite for each risk identified to the achievement of strategic objectives for the financial year in question. Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

3.4 The review is carried out on an annual basis and the Trust will publish its risk appetite statement covering the overarching areas of:

- 3.4.1 Finance
- 3.4.2 Compliance and Regulation
- 3.4.3 Innovation
- 3.4.4 Reputation
- 3.4.5 Quality and Patient Safety
- 3.4.6 Workforce
- 3.4.7 External Stakeholders

3.5 The Board to approve the appropriate risk trigger levels across the above domains as show below:

Domain	Appetite	Range	Score (trigger level)
Quality and Patient Safety	Very Low	1-4	4
Compliance and regulation	Very Low	1-4	4
Reputation	Low	5-8	8
Digital	Low	5-8	8
Financial/Value for money	Moderate	9-15	9
Workforce	Moderate	9-15	9

External Stakeholders	Moderate	9-15	9
Estates/Infrastructure	Moderate	9-15	9
Innovation	High	16-25	16

4 Risk Assure

Amber / Green

4.1 We have changed the way we manage risks on Risk Assure. Changes made are as follows:

4.1.1 All risk registers appear in one place, the Corporate Risk register sits at the top of the list.

4.1.2 Several new registers have been created under Operations:

- COVID-19
- Winter Pressures
- EU Transition

4.1.3 Relevant risks must be placed within these folders.

4.2 Risk trigger levels dictate the movement of risks up and down the registers as follows;

Risk Appetite	Trigger Up	Trigger Down	Register
Very Low	4	n/a	Care Group Level / Department Registers
Low	8	n/a	Care Group Level / Department Registers
Moderate	9	8	Divisional Register
High	16	15	Corporate Register

4.3 Reporting has been updated to enable risks from all registers to appear on the weekly status reports sent out to the divisions to enable them to have oversight of all their risks on one report.

5 Conclusion and Next Steps

5.1 The Risk Assurance Group will continue to provide scrutiny, oversight and management of risks to ensure they are adequately described and mitigated.

5.1.1 All risks will be challenged and evidence will need to be provided.

5.1.2 All risks will be moved onto correct registers according to the new trigger levels.

5.1.3 Review dates will be reviewed to ensure they fall in line with the new timeframes set.

5.1.4 Review risks with no movement.

5.1.5 Review of all risks closed in the last six months.

5.2 A Risk Learning Group has been set up to look at linking risks to claims, incidents, SI's etc and to ensure learning has taken place.

Medway NHS Foundation Trust
Corporate Risk Management Strategy and Policy

Author:	Julie Wilson, Risk Manager Tracy Kelly, Assistant Head of Corporate Governance and Legal Paul Mullane, Head of Corporate Governance and Legal
Document Owner	Gurjit Mahil, Deputy Chief Executive
Revision No:	10
Document ID Number	POLCGR028
Approved By:	Executive Group and Trust Board
Implementation Date:	January 2021
Date of Next Review:	January 2022

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Document Control / History	
Revision No	**Reason for change**
7	Combined Risk Strategy & Policy
8	Page 8 - Detail added regarding training levels across the Trust
9	Reviewed – more detail added regarding reporting structures
10	Reviewed – Job titles and risk appetite statement updated, Risk Assurance Group and Risk Manager details added.

Consultation
Executive Group, Trust Board

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Table of Contents

Medway NHS Foundation Trust
Risk Management Strategy and Policy

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 All activities contain inherent risks. Risk management and internal control is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. Medway NHS Foundation Trust (MFT) will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

1.2 Although the key strategic risks are identified and monitored by the Trust Board, operational risks are managed on a day-to-day basis by staff throughout the organisation. In order that progress in managing all risks can be acknowledged, the Trust has a Standard Operating Procedure in place for Risk management (SOP0064), enabling provision of a record of all risks to the organisation via an electronic platform RiskAssure.

1.3 At the heart of the Trust Risk Management Strategy and Policy is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate, changes will be made to the Trust's systems to enable this to happen.

2 Purpose / Aim and Objective

2.1 **Risk Management Strategy and Policy Statement** Risk management is the key system through which strategic, clinical (Quality & Safety), operational, corporate and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. It is through this system of internal control and accountability the Chief Executive fulfils their responsibility as accountable officer and the Board fulfils its responsibility of stewardship. Key systems will be fully embedded at every level of the organisation and will ensure compliance with current and future risk management related standards and legislation; these systems are described within SOP0064 Standard Operating Procedure for Risk Management.

2.2 Assurances will be provided to the Trust Board through an agreed scheme of delegation according to principles and systems which will allow the Board to be able to make accurate judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. This Board Assurance Framework will contribute to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Account and it is through this process MFT monitors adherence to the requirements of the Care Quality Commission and other regulators. SOP0165 Medway NHS Foundation Trust Procedure for the Board Assurance Framework describes the assurance process.

3 Definitions

3.1 **Risk** is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.

3.2 **Risk management** is the assessment, analysis and management of risks. It is a way of recognising which events (hazards) may lead to harm in the future and minimising their potential consequence(s) and likelihood of occurrence.

3.3 **Risk Appetite** - The levels and types of risk the Organisation is prepared to accept in pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks.

4 (Duties) Roles & Responsibilities

4.1 **The Trust Board** is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives. The Board Assurance Framework (BAF) is described in a Standard Operating Procedure SOP0165.

4.1.1 The Board will receive a Corporate Risk Register for consideration and adoption, as recommended by the Integrated Audit Committee & Performance Committee every six months. The Board will also receive a quarterly Board Assurance Framework, proposed by the Trust Secretary. The Board will use both of these documents to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources.

4.1.2 To this end, both the Corporate Risk Register and the BAF will be sent to

4.1.2.1 the Finance Committee to inform financial decision making and budget setting

4.1.2.2 the Integrated Audit Committee to inform the planning of audit activity

4.1.2.3 the People Committee to inform human resources and training and development decisions

4.2 **Non-Executive Directors** have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical). This supports the achievement of quality and the organisation's objectives. Members of the Integrated Audit Committee will review the adequacy of the Risk Management Strategy, Policy and procedures and receive regular monitoring information against the management of risks judged as significant and provide verification to the Trust Board through the Board Assurance Framework on the systems in place for the management of risk within the Trust.

4.3 **The Chief Executive** is the Accountable Officer and is accountable for ensuring:

- The Trust's Principal Strategic Objectives are agreed.
- Sound systems of internal control exist, which are based on an ongoing management process designed to identify the principal risks to the achievement

of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically.

- Systems of internal control exist which are underpinned by compliance with the core controls assurance standards of Governance, Financial Management and Risk Management.
- Internal Audit Plans are aligned to risk areas and review the effectiveness of the system of internal control

The Trust Board Sub Committees are the principal means by which these responsibilities are discharged and through which effectiveness of risk management systems is monitored.

4.4 **The Deputy Chief Executive** is the Executive with responsibility for ensuring that the Trust has robust risk management resources and systems. They are responsible for ensuring that mechanisms for risk management are robust so as to assure the Trust Board that risks are being managed and that the Trust complies with the risk management standards.

4.5 **The Trust Secretary** has the responsibility for developing and implementing the Board Assurance Framework.

4.6 **The Head of Corporate Governance and Legal** reports to the Deputy Chief Executive and is responsible for overseeing the development and implementation of a robust Risk Management Strategy and Framework; working with Executive Directors, Chief Operating Officer and Divisional Governance Managers to embed good practice at all levels of the Trust and ensure that the Trust's commitment to managing risk is co-ordinated, systematic, transparent and evident.

4.7 **The Assistant Head of Corporate Governance & Legal** assists in the review of the Strategy, Policy and SOP, supporting the Risk Manager in their role and is a key member of the Risk Assurance and Risk Learning Groups.

4.8 **The Risk Manager** is responsible for the management and training of managers on the Trust's electronic Risk Management platform – RiskAssure. Works closely with the Executives and all management levels across the Divisions supporting them to maintain the corporate risk register and divisional risk registers. Ensures that processes are developed and maintained to support the organisations system of internal control; processes will include risk profiling, risk appetite statement, evidence based assurance processes supporting the corporate governance framework; development of an evidence based annual governance statement. Design and deliver a comprehensive risk management training package and develop and embed the Risk Management Strategy and policy across the Trust to ensure there is an effective Risk management System in place.

4.9 **The Chief Finance Officer** is accountable to the Trust Board and Chief Executive for the Trust's financial risk management activities and has close working arrangements with other Executive Directors with regard to ensuring that Financial Planning and Financial Risk Management integrates with the Trust's Clinical and

Organisational Risk Management activities, and is closely involved in consideration of the recommendations of the Integrated Audit Committee and the Quality Assurance Committee. The Chief Finance Officer seeks the Internal Auditor's Opinion on the effectiveness of Internal Control and Internal Financial Control.

4.10 **The Chief Medical Officer and Chief Nursing and Quality Officer** has responsibility for identifying with the principal risks to the Clinical Governance arrangements and through working with the appropriate Directors of Clinical Operations, Clinical Directors, Clinical Leads, senior managers and clinicians, ensures risks identified through risk profiling / assessment are effectively managed, eliminated or reduced. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate

4.11 **The Chief People Officer, The Director of Communications and Engagement, Director of Transformation, and the Trust Secretary** are responsible for the management of risks within their areas of operational responsibility. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities.

4.12 **The Chief Operating Officer and The Director of Estates and Facilities** are responsible for ensuring that the Trust's risk management processes are fully implemented within their services, risk registers are maintained and ensuring that principal risks to the Trust's objectives are systematically managed i.e. identified, evaluated, eliminated or reduced. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities

4.13 **The Divisional Governance Teams** - are responsible for managing their Divisional Risk register, utilising the agreed process and methodology, ensuring that it is regularly reviewed in appropriate governance meetings across the divisions and at the Divisional Management Board meetings.

4.14 **Risk Assurance Group (RAG)** - Ensures that the Clinical and Corporate Divisions are identifying and reviewing risks at all levels across the Trust and taking appropriate action to mitigate these, and have robust governance arrangements in place to manage this with evidence. Escalate risks to the Executive Group particularly when a risk or group of risks is escalating and has potential to affect the delivery of the annual or strategic plans and objectives. Ensure the Trust Risk Management Policy is reviewed annually and there are robust systems in place for identifying, managing and mitigating risk with a clear escalation process in place. To review all risks with no movement over four months.

4.15 **The Integrated Audit Committee** has a responsibility to provide to the Board assurance that in respect of Governance, Risk Management and Internal Control,

effective systems across the whole of the organisation's activities (both clinical and non-clinical), support the achievement of the organisation's objectives.

4.16 **Executive Committee / Quality Assurance / Nominations and Renumeration/ Financial and Sub Board Committees**

4.16.1 **All committees** have a responsibility to provide to the Board assurance that in respect of Risk Management and Internal Control, effective systems across the whole of the organisation's activities (both clinical and non-clinical), support the achievement of the organisation's objectives and report to the Board.

4.16.2 **All to ensure they act on lessons learnt from risks incidents and they review the risk reports on a quarterly basis.**

4.17 **Wards and Departments**

4.17.1 To identify, assess and monitor risks as they arise or are anticipated in accordance with the Risk Assessment Procedure (SOP0186). Risks may be identified as a result of

4.17.1.1 Incidents

4.17.1.2 Complaints

4.17.1.3 Claims

4.17.1.4 Serious Incidents Requiring Investigation and Never Events

4.17.1.5 Risk Assessments

4.17.1.6 External and internal reviews, inspections and assessments

4.17.1.7 External and internal audit activity

4.17.2 All such risks will be referred to and recorded on Care Group or Divisional Risk Registers, which will then be used to ensure the effective management of those risks.

4.18 **All Trust Staff** - Risk management is everyone's responsibility and it is important that potential risks are identified within all levels of the organisation; however it is also important that risks are articulated, recorded and acted upon appropriately and systems have been put in place to facilitate this as described in the Risk Management Standard Operating Procedure (SOP0064) which all staff are required to abide by.

5 Risk Appetite

5.1 See Risk appetite statement – Appendix 1

5.2 Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

5.3 Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take.

5.4 The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

5.5 Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

5.6 The Trust's risk appetite is expressed in two key ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

5.7 The Trust uses a risk matrix which is common across the NHS and globally recognised standard for risk measurement and management.

5.8 Good Governance Institute – Risk Appetite Descriptions – see appendix 2

5.9 Risk Appetite Summary Table – see appendix 3

6 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Every year	Head of Corporate Governance & Legal	Executive Group and Trust Board Risk Assurance Group	Where gaps are recognised action plans will be put into place
Compliance with the Trust's Risk Management standard operating procedure.	Managed via the outputs of the divisional governance groups monthly	Divisional Governance Teams	Executive Group and Trust Board Risk Assurance Group	Where gaps are recognised action plans will be put into place

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
The Integrated Audit Committee	Oversight of Risk Management and systems of control every six months	Chair of the Audit Committee	Trust Board	Where gaps are recognised action plans will be put into place
A review of all risks with no movement	Every four months	Chair of Risk Assurance Group	Executive Group	Where gaps are recognised action plans will be put into place
A review of closed risks	Every six months	Chair of Risk Assurance Group	Executive Group	To ensure learning is take place, where gaps are recognised action plans will be put into place

7 Training and Implementation

7.1 To support the implementation and embedding of the risk management policy and procedures the following training is available.

7.1.1 Every two years Risk Management training is provided by an external company to the Board.

7.1.2 A more in depth risk training presentation, Risk Management for Governance Staff, is delivered by the Risk Manager for staff in Governance roles.

7.1.3 As a result of in depth Risk Register Reviews by the Risk Manager, bespoke training is available to all staff teams, tailored to their specific needs and includes advice and guidance on the management of risk in their area and support with development of risk registers.

8 Equality Impact Assessment Statement & Tool

A screening process has been carried out and this policy does not require a full impact assessment.

9 References

Document	Ref No
References:	
Trust Associated Documents:	
SOP0064 - Risk Management Standard Operating Procedure (1 attachment)	SOP0064
SOP0165 - Board Assurance Framework (1 attachment)	SOP0165
SOP0166 - Producing Risk Register Reports from RiskAssure (1 attachment)	SOP0166
SOP0186 - Risk Assessment Procedure (1 attachment)	SOP0186

SOP0039 - Serious Incident SI - Procedure (1 attachment)	SOP0039

10 APPENDIX 1 - Risk Appetite Statement

The Trust Board has considered and agreed the principles regarding the risks that Medway NHS Foundation Trust is prepared to seek, accept or tolerate in the pursuit of its objectives.

The Trust Board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality and patient safety, compliance and regulation, reputation, workforce and external stakeholders.

In recognition of a challenging financial climate, the Trust Board has taken a view to reduce its risk appetite for financial controls.

In all these areas the Trust expresses a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

Alternatively, the Trust Board has set a high appetite for innovation, indicating an open approach and willingness to consider all potential delivery options while also providing an acceptable level of reward, (value for money).

This Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds therefore supporting delivery of the Trust's Risk Management Strategy and Policy.

The Board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas. The Trust's risk management framework requires that where the Trust's risk appetite is exceeded the risk review governance process includes:

- scrutinising the adequacy of mitigating actions and controls
- agreeing the timeline for bringing the risk within the acceptable risk tolerances
- monitoring progress
- determining any further actions and escalation routes if needed

Quality and Patient Safety

The Trust is responsible for ensuring the quality and safety of services it delivers. The provision of high quality services is of the utmost importance to the Trust and the Trust has low appetite for risks that impact adversely on quality of care. The Trust is strongly adverse to risks that could result in non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. The Trust has low appetite for options that impact on patient safety, the Trust will avoid taking risks that will compromise patient safety.

Compliance and Regulation

The Trust has been, and continues to be under regulatory scrutiny, having been rated "Requires Improvement" by the Care Quality Commission. The Trust is keen to move at pace on its "Better Best Brilliant" Programmes of improvement, as this is key to optimising quality and financial sustainability and the Trust takes a minimal or avoidance approach to

risks that will compromise this.

The potential for non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Trust and therefore the Trust has minimal appetite in relation to these risks. The Trust has a preference for safe delivery options rather than risk breaching legislative and regulatory obligations.

Reputation

The Trust recognises that patient confidence and trust in the organisation is important for good outcomes. The Trust therefore has a moderate appetite for risks that may cause reputational damage and undermine public and stakeholder confidence. The Trust's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of **significant** repercussions for the organisation.

The Trust will maintain high standards of conduct, ethics and professionalism and will not accept risks or circumstances that could cause reputational damage to the Trust and/or the wider NHS.

Finance

Until such times as financial sustainability is re-established, the Trust's strategy will be based mainly on low-risk opportunities and on a highly controlled basis. The Trust is cautious in accepting the possibility of some limited financial loss. Value for money is still a primary concern.

Workforce

The Trust will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual or a team's competence to perform roles or tasks safely, nor any incidents or circumstances, which may compromise the safety of any staff member or group.

The Trust will only tolerate lower substantive staffing levels where there is visible competent leadership, a robust management plan is in place and prevailing shortages of staff are supported by trained and competent temporary staffing to keep within safe staff numbers.

For patient safety, quality care and service and financial sustainability reasons the Trust is willing to consider risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.

External Stakeholders

The Trust has a greater appetite to seek out opportunities and take greater inherent risks for higher rewards in pursuit of partnership development and collaborative working where this is considered advantageous to the Trust or wider health economy through implementing sustainability and transformation plans.

Innovation

The Trust has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be

anticipated and it supports the use of systems and technology developments within service delivery. The Trust is eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risks). The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of information and patient management systems and technological developments being used to enhance operational delivery of current operations.
The Trust will consider risks associated with innovative technology and research and development approaches to enable the integration of care, development of new models of care and improvements in clinical practice to support sustainability.

11 APPENDIX 2 - Good Governance Institute – Risk Appetite Descriptions

Appetite Level	Described as:
None (0)	**Avoid**: the avoidance of risk and uncertainty is a Key Organisational objective.
Very Low (1-4)	**Minimal** (as little as reasonably possible): the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Low (5-8)	**Cautious**: the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Moderate (9-15)	**Open**: willing to consider all potential delivery options and choose, while also providing an acceptable level of reward (and Value for Money).
High (16-25)	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

12 APPENDIX 3 - Risk Appetite Summary Table

The diagram below summarises the Trust's risk appetite across these domains.

Domain	Appetite	Range	Score (trigger level)
Quality and Patient Safety	Very Low	1-4	4
Compliance and regulation	Very Low	1-4	4
Reputation	Low	5-8	8
Finance	Moderate	9-15	9
Workforce	Moderate	9-15	9
External Stakeholders	Moderate	9-15	9
Innovation	High	16-25	16

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 14 January 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Gurjit Mahil, Deputy Chief Executive Jane Murkin, Chief Nursing and Quality Officer David Sulch, Chief Medical Officer Angela Gallagher, Chief Operating Officer (Interim)		
Lead Director	Jane Murkin – Chief Nursing & Quality Officer		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for November shows that the Trust has had 0 MRSA bacteraemia cases and 2 hospital acquired C-diff cases. Whilst, August's overall HSMR rate is currently at 100.95 and below the national threshold, the weekend HSMR rate is at 109.67 and links to risks during the weekends with Bed Occupancy and MSA also increasing. **Caring** Unfortunately, whilst MSA had shown improvement in previous months, November has seen that 197 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates remain close or above the national standard of 85% (Inpatients: 72.42%, ED: 84.47%, Maternity: 99.64%, Outpatients: 88.21%). Whilst Inpatients remains relatively static, improvements have been seen in ED, Maternity and Outpatients. **Effective** VTE performance has seen an improvement from October recording at 90.15% against a target of 95% in November. Additionally, Discharges before Noon, whilst close to the Mean are still below at 15.30% and significantly below the Target of 25%. **Responsive** Unfortunately, due in part to the lower discharges before noon rate and the pause in elective work the 18 weeks Referral to treatment (RTT) performance for November is recorded at 72.79%, with 101 +52 week breaches, clinical harm reviews have been completed for these patients. Additionally, the Trust has seen 27 Operations cancelled by the hospital on the day. . ED (Type 1) 4 hour performance as a result of site pressures reported 67.00% in November. Additionally, the Trust saw 396 Ambulance Handover delays of		

	+60mins. However, DM01 Diagnostics performance is continuing to improve at 92.29% for November. **Well Led** We have seen a reduction in appraisal rates at 82.03% however the Trust has maintained compliance statutory and mandatory training. To note: • The maternity 12+6 indicator is now showing in real time. This indicator is calculated by NHS I/E/D and was previously reporting 3 months in arrears. • The SHMI data is currently showing August – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing August data, this is reliant on Dr Foster and this is 3 to 4 months in arrears. • Bed occupancy as reported in the IQPR relates to all inpatient beds within the Trust including Maternity and Paediatrics, the General and Acute bed occupancy for all patient pathways is recorded as 94%. • The Cancer metrics are reported one month in arrears as per the national guidance.
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 – November 2020

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: November 2020

What is Statistical Process Control (SPC)?

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

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

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

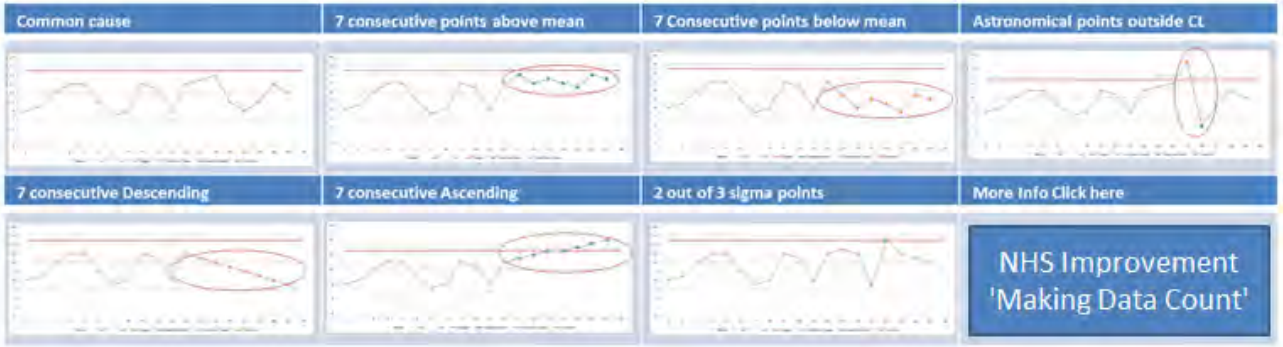
Key Facts about a SPC Chart:

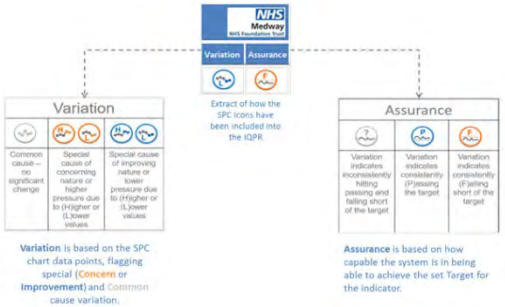
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





NHS
Medway
NHS Foundation Trust

Topic	Overview	Deep Dive
Executive Summary	4	6
Caring	7	8
Effective	9	10
Safe	11	11
Responsive	12	14
Well Led	19	19

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Patient Satisfaction/Care & Staffing	• ED & Flow
Caring	• The Friends and Family recommended rates (excluding Inpatients) remain close or above the national standard of 85% • Number of complaints received is below the mean and is under the target rate	• Whilst MSA had shown improvement in previous months, October & November have seen high numbers of breaches recorded • EDNs completed within 24hrs is now below LCL's, has continuously decreased and not met the target set
Effective	• VTE Risk Assessment % Completed, whilst still under target, has shown continuous improvement.	• Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Fractured NOF compliance is below mean levels and target
Safe	• Falls per 1,000 Bed Days remains below national average. • 0 Never Events reported	• Overall HSMR rate has risen slightly to just above the national threshold at 100.93 (but still below mean & UCL) • SHMI has also risen, for latest reporting period in July-20, to 1.05, over the national threshold of 1.
Responsive	• DM01 Diagnostics performance is continuing to improve at 92.46% for October-20 • Cancer 2ww Performance exceeded mean levels and target, showing continuous improvement	• ED 4 hour performance reported 79.4% for November, with 182 +12 Hour DTA Breaches in ED and 396 Ambulance Handover delays of +60mins. • RTT Incomplete Performance dropped below LCL in October, at 70.6% with 191 +52 week breaches
Well Led	• Maintained compliance with Trust target for StatMan Compliance • Agency Spend % is below LCL and target, showing continuous improvement	• Sickness Rate above target and average • Appraisal rate below target & average

Executive Summary

NHS Medway NHS Foundation Trust

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

Variation

	(H) (L)	(H) (L)
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

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Nov-20	3	2	43	24		
S2	Number of C-diff (HAI)	Nov-20	0	1	0	17		-
S3	MRSA Bacteraemia (Trust Attributable)	Nov-20	0	0	5	1		
S4	E-coli (Trust Acquired)	Nov-20	2	5	30	25		
S5	Falls per 1000 bed days	Nov-20	6.63	6.12	6.63	4.99		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Nov-20	1.04	0	1.04	0.03		
S7	Never Events	Nov-20	0	0	0	1		
S8	% of SIs responded to in 60 days	Nov-20	100%	100%	100%	100%		-
S9	HSMR (overall)	Aug-20	100	100.93	100	98.26		
S10	HSMR (weekday)	Aug-20	100	97.82	100	94.7		
S11	HSMR (weekend)	Aug-20	100	109.67	100	108.35		
S12	SHMI	Jul-20	1	1.05	-	-		

Caring		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Nov-20	0	197	0	342		
C2	New Complaints	Nov-20	41	40	-	359		
C3	% Complaints responded to within target	Nov-20	85%	85%	85%	72%		
C4	% EDNs completed within 24 hours	Nov-20	100%	65.58%	100%	73%		
C5	Inpatients Friends and Family Response rate	Nov-20	22%	20.04%	22%	20%		
C6	Inpatients Friends and Family % recommended	Nov-20	85%	72.42%	85%	83%		
C7	ED Friends and Family Response rate	Nov-20	22%	14.65%	22%	16%		
C8	ED Friends and Family % recommended	Nov-20	85%	84.47%	85%	85%		
C9	Maternity Friends and Family Response rate	Nov-20	22%	35.77%	22%	34%		
C10	Maternity Friends and Family % recommended	Nov-20	85%	99.64%	85%	99.6%		
C11	Outpatients Friends and Family Response rate	Nov-20	22%	11.96%	22%	13%		
C12	Outpatients Friends and Family % recommended	Nov-20	85%	88.21%	85%	89%		

Responsive - Non-Elective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Nov-20	85%	79.53%	85%	80%		
R2	Average Length of stay (Non-elective)	Nov-20	5	8.57	5	7.9		
R3	Average Length of stay (Elective)	Nov-20	5	2	5	2.54		
R4	% of Delayed Transfers of Care	Nov-20	4%	0.52%	4%	0.99%		
R5	% Medically Fit For Discharge	Nov-20	7%	10.48%	7%	10.71%		
R6	ED 4 hour performance (All)	Nov-20	95%	79.36%	95%	88%		
R7	Ed 4 hour performance (Type 1)	Nov-20	95%	67.00%	95%	81%		
R8	ED 12 hour DTA Breaches	Nov-20	0	182	0	213		
R9	Ambulance Attendances	Nov-20	-	3,240	-	26,129		
R10	60 minute handover delays	Nov-20	0	396	0	1,105		

Effective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Oct-20	5%	6.69%	5%	6.93%		
E2	30 day readmission rate	Oct-20	10%	12.93%	10%	14%		
E3	Discharges before noon	Nov-20	25%	15.30%	25%	14%		
E4	Fractured NOF within 36 hours	Nov-20	100%	58.80%	100%	69.57%		
E5	VTE risk assessment % completed	Nov-20	95%	90.15%	95%	94%		
E6	Elective C-section rate	Nov-20	13%	15.92%	13%	15%		
E7	Total C-Section rate	Nov-20	28%	37.40%	28%	35%		
E8	Average Occupancy (maternity)	Nov-20	15%	21.49%	15%	21%		
E9	12+6 risk assessments	Nov-20	90%	92.46%	90%	88%		
E10	Number of deliveries	Nov-20	-	377	-	3,126		-

Responsive - Elective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Nov-20	99%	92.29%	99%	76%		
R12	18 weeks RTT Incomplete Performance	Nov-20	92%	72.79%	92%	69%		
R13	18 Weeks over 52 week breaches	Nov-20	0	101	0	714		
R14	Operations cancelled by hospital - on the day	Nov-20	0	27	0	97		
R15	Cancelled operations not rescheduled <28	Nov-20	0	3	0	25		
R16	Cancer 2ww performance	Oct-20	93%	96.62%	93%	97%		
R17	Cancer 2ww performance - breast symptomatic	Oct-20	93%	100.00%	93%	96%		
R18	Cancer 31 day first definitive treatment	Oct-20	96%	97.26%	96%	97%		
R19	Cancer 62 day treatment - GP referrals	Oct-20	85%	78.88%	85%	76%		
R20	104 day cancer waits	Oct-20	0	0	-	3		

Well Led		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	Nov-20	0	0	0	0	-	-
W2	CIP savings	Nov-20	£1,119k	£908k	£4,457k	£5,455		
W3	Appraisal %	Nov-20	85%	82.03%	85%	88%		
W4	Sickness Rate	Nov-20	4%	4.18%	4%	4%		
W5	Turnover rate	Nov-20	12%	12.53%	12%	12%		
W6	StatMan compliance	Nov-20	85%	88.78%	85%	89%		
W7	Contractual staff in post	Nov-20	-	4061.34	-	-		-
W8	Agency spend as % pay bill	Nov-20	4%	1.54%	4%	2%		
W9	Bank spend as % pay bill	Nov-20	9%	1.30%	9%	7%		
W10	Overall safe staffing fill rate	Nov-20						

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

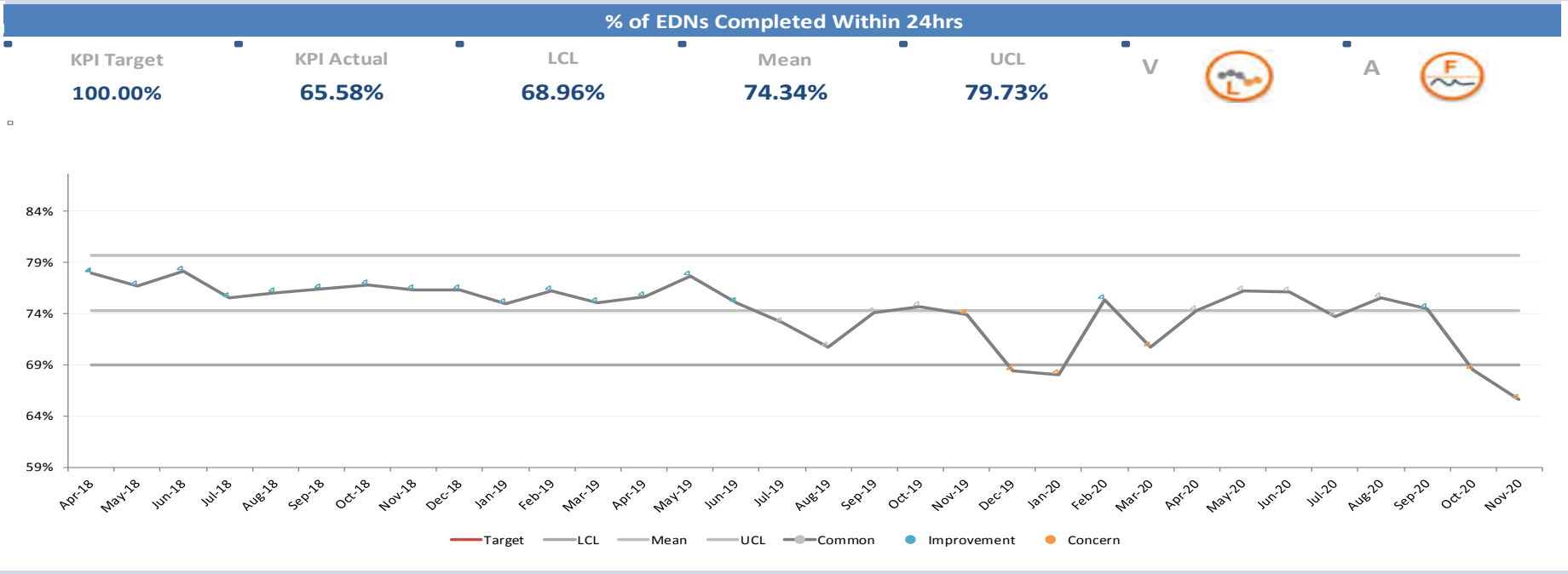
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	Nov-20	0	197.00	24.81	123.06	221.31		
		MSA %	Nov-20	0%	1.47%	0.16%	0.83%	1.49%		
		% of EDNs Completed Within 24hrs	Nov-20	100%	65.58%	68.96%	74.34%	79.73%		
		Inpatients Friends & Family % Recommended	Nov-20	85%	72.42%	78.37%	84.79%	91.21%		
		Inpatients Friends & Family Response Rate	Nov-20	22%	20.04%	15.84%	20.35%	24.86%		
	ED Care	ED Friends & Family % Recommended	Nov-20	85%	84.47%	72.39%	79.12%	85.86%		
		ED Friends & Family Response Rate	Nov-20	22%	14.65%	12.03%	14.60%	17.16%		
	Maternity Care	Maternity Friends & Family % Recommended	Nov-20	85%	99.64%	97.32%	99.28%	100.00%		
		Maternity Friends & Family Response Rate	Nov-20	22%	35.77%	12.24%	27.02%	41.79%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Nov-20	85%	88.21%	87.45%	90.12%	92.80%		
		Outpatients Friends & Family Response Rate	Nov-20	22%	11.96%	11.82%	13.87%	15.92%		

Caring: EDNs Completed
Aim: TBC – Currently Under Development
Latest Period: November - 2020

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

NHS Medway NHS Foundation Trust

Outcome Measure: % EDNs completed within 24 hours



What changes have been implemented and improvements made?

- The SPC data point is showing special cause variation of a low improving nature. Assurance indicates that the KPI is consistently failing to achieve target.
- Same sex accommodation breaches are highlighted at thrice daily site meetings with the expectation placement of these patients is prioritised alongside patients being admitted to the wards.
- Privacy and dignity maintained within critical care and information provided to patients.
- Main occurrences of breaches are in high dependency unit and at weekend periods where bed occupancy within the organisation was high.
- Bed occupancy high presenting challenges to step down patients from critical care units into ward based care.
- Increase in emergency surgical admissions and the requirement to maintain red and green pathways for elective and emergency surgical patients placed further pressure with patient placement.

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	Oct-20	5%	6.69%	4.22%	5.69%	7.16%		
		30 Day Readmission Rate	Oct-20	10%	12.93%	9.23%	11.39%	13.55%		
		Discharges Before Noon	Nov-20	25%	15.30%	12.36%	14.96%	17.57%		
		Fractured NOF Within 36 Hours	Oct-20	100%	58.80%	37.26%	63.00%	88.74%		
		VTE Risk Assessment % Completed	Nov-20	95%	90.15%	75.80%	86.44%	97.08%		
	Maternity	Elective C-Section Rate	Nov-20	13%	15.92%	9.93%	13.34%	16.75%		
		Average occupancy	Nov-20	15%	21.49%	15.25%	19.31%	23.37%		
		Total C-Section Rate	Nov-20	28%	37.40%	28.22%	32.67%	37.11%		
		Number of Deliveries (Count of Mothers)	Nov-20	0	377.00	345.03	405.09	465.16		
		12+6 Risk Assessment	Nov-20	90%	92.42%	55.68%	76.14%	96.59%		

Effective: Discharges before Noon
Aim: TBC
Latest Period: November - 2020

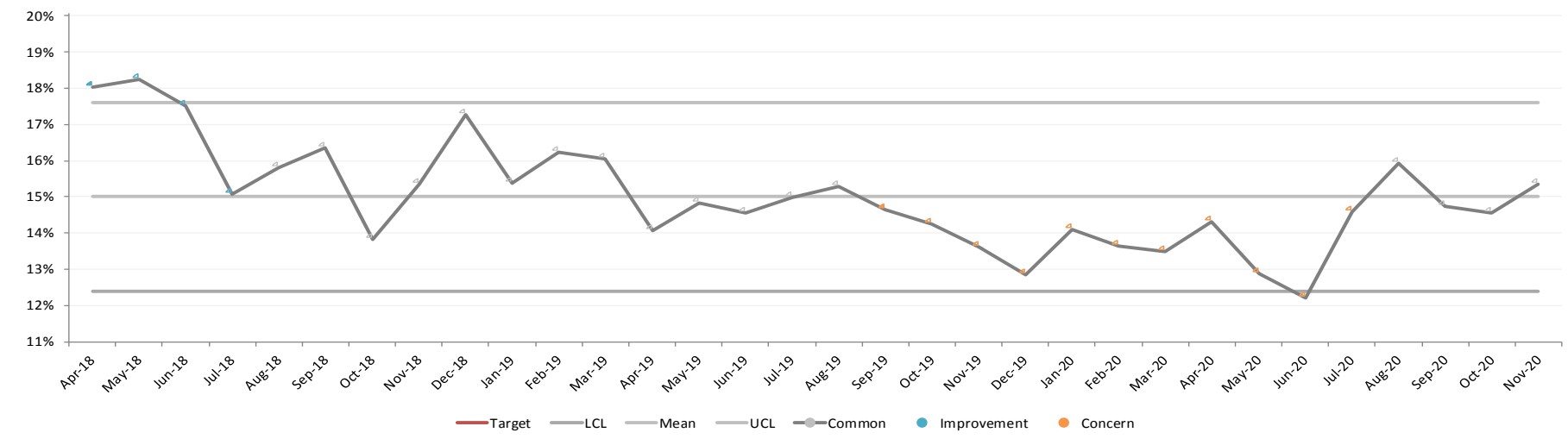
Executive Lead: David Sulch – Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Discharges before Noon

Discharges Before Noon

KPI Target	KPI Actual	LCL	Mean	UCL	V	A
25.00%	15.30%	12.36%	14.96%	17.57%		F



What changes have been implemented and improvements made?

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Oct-20	6.63	5.04	2.87	4.71	6.54		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Oct-20	1.04	0.00	0.00	0.05	0.22		
	Incident Reporting	Never Events	Nov-20	0	0.00	0.00	0.13	0.81		
		No of SIs on STEIS	Nov-20	90	19.00	1.36	11.31	21.27		
		% of SIs Responded To In 60 Days	Nov-20	0%	100.00%	92.79%	98.23%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Oct-20	5	0.00	0.00	0.52	2.56		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Oct-20	43	3.00	0.00	2.84	9.34		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Oct-20	0	7.00	0.00	1.79	6.22		
		E-coli (Trust Acquired) Infections	Oct-20	30	0.00	0.00	4.32	10.17		
	Mortality	Crude Mortality Rate	Oct-20	3%	1.34%	0.55%	1.64%	2.72%		
		HSMR (All)	Aug-20	100	100.93	95.14	104.80	107.36		
		HSMR (Weekday)	Aug-20	100	97.82	91.24	101.87	105.21		
		HSMR (Weekend)	Aug-20	100	109.67	97.51	112.68	122.78		
		SHMI	Jul-20	1	1.05	0.78	1.01	1.24		

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

TRUST										
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Nov-20	85%	79.53%	82.02%	88.92%	95.82%		
		Average Elective Length of Stay	Nov-20	5	2.70	1.48	2.34	3.21		
		Average Non-Elective Length of Stay	Nov-20	5	8.57	7.28	8.44	9.60		
		% of Delayed Transfer of Care Point Prevalence in Month	Sep-20	4%	0.18%	0.41%	1.44%	2.48%		
		% Medically Fit For Discharge Point Prevalence in Month	Nov-20	7%	10.48%	14.75%	18.18%	21.62%		
	ED Access	ED 4 Hour Performance All Types	Nov-20	95%	79.36%	76.92%	83.91%	90.91%		
		ED 4 Hour Performance Type 1	Nov-20	95%	67.00%	66.52%	76.04%	85.55%		
		ED 12 hour DTA Breaches	Nov-20	0	182.00	0.00	18.25	66.56		
		60 Mins Ambulance Handover Delays	Nov-20	0	396.00	0.00	100.94	214.80		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

TRUST										
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Elective	Diagnostic Access	DM01 Performance	Oct-20	99%	92.46%	78.00%	90.15%	100.00%		
	Elective Access	18 Weeks RTT Incomplete Performance	Oct-20	92%	70.56%	72.09%	77.76%	83.44%		
		18 Weeks RTT Over 52 Week Breaches	Oct-20	0	191.00	0.62	25.10	49.57		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Nov-20	0	27.00	0.00	22.41	51.07		
		Cancelled Operations Not Rescheduled < 28 days	Nov-20	0	2.00	0.00	4.66	12.12		

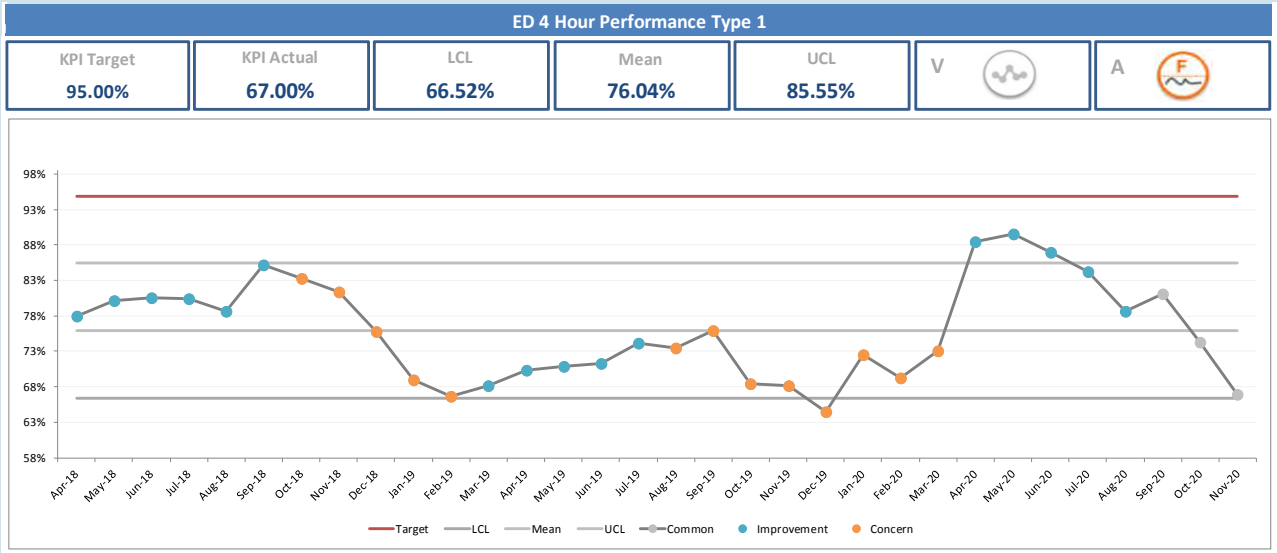
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Oct-20	93%	96.62%	77.00%	88.31%	99.63%		
		Cancer 2ww Performance - Breast Symptomatic	Oct-20	93%	100.00%	48.63%	79.71%	100.00%		
		Cancer 31 Day First Treatment Performance	Oct-20	96%	97.26%	90.32%	96.45%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Oct-20	85%	78.88%	63.38%	78.12%	92.86%		
		104 Day Cancer Waits	Oct-20	0	0.00	0.00	2.06	5.08		
	Complaints Management	Number of Complaints	Nov-20	41	40.00	16.95	61.31	105.67		
		% Complaints Responded to Within 30 Days	Nov-20	85%	85.00%	39.78%	69.34%	98.90%		

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Admitted performance driven by bed occupancy and potential increased LoS.
Divisions managing this through FCP 4 actions on a daily basis.
Current strategic command structures ensure oversight of all patient pathways within the Trust at number of strategic meetings throughout the day.

Outcomes:

All types performance for M8 is 79.34%.
Type 1 performance is 67%;
Type 3 performance is >99%;
QTD performance is 79.25%;

Underlying issues and risks:

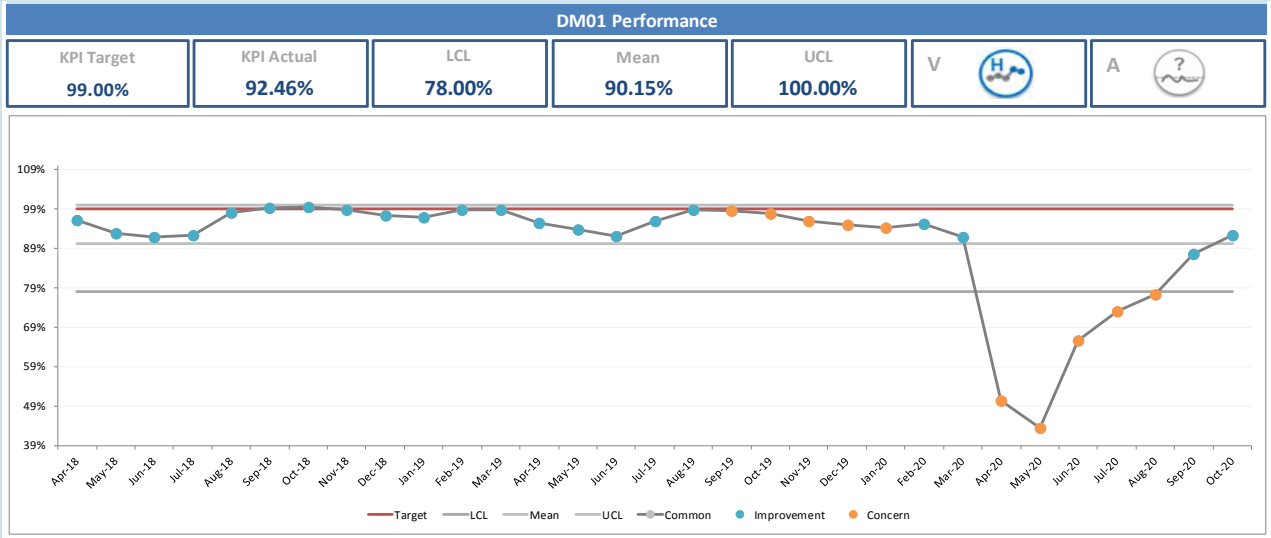
Covid19 and standard acuity attends expected to increase exponentially
Ambulance demand is increasing exponentially.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: DMO1 Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

DM01 PTL Meetings are held weekly to provide support and control for all DM01 modalities.
Recovery trajectories for diagnostic modalities are being monitored in the PTL meeting with any actions tracked weekly.
Endoscopy plan continues using insourcing and outsourcing capacity

Outcomes:

Improvements in DM01 performance and support for any operational/system issues.
Oversite of recovery plan allows for support for modalities.
Increase in Endoscopy capacity is supporting improvements in Cancer and Upper/Lower GI performance

Underlying issues and risks:

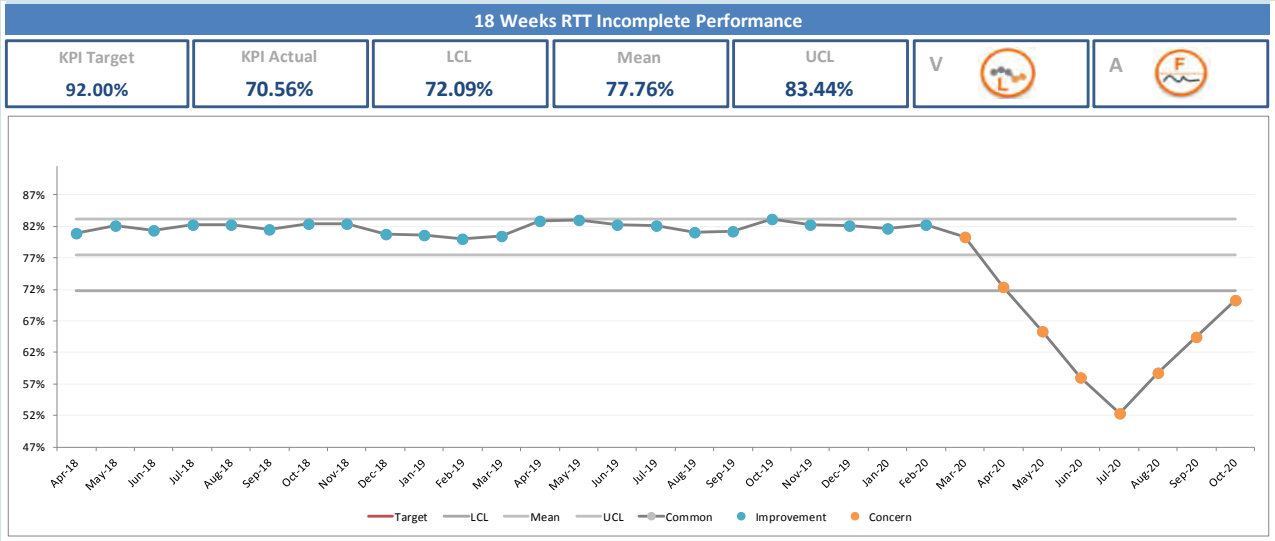
Potential impact of second Covid-19 surge on diagnostic capacity Endoscopy capacity limitations for patients not suitable for IS Provider

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Incomplete Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Elective outpatient activity for all specialities continues.
Weekly PTL meetings to provide oversight and support of all specialities
Review of the capacity available in the Independent Sector.

Outcomes:

Increased capacity to see new referrals and manage any remaining non-admitted backlogs.
Recovery plans developed for services at risk.
Service level support for specialities

Underlying issues and risks:

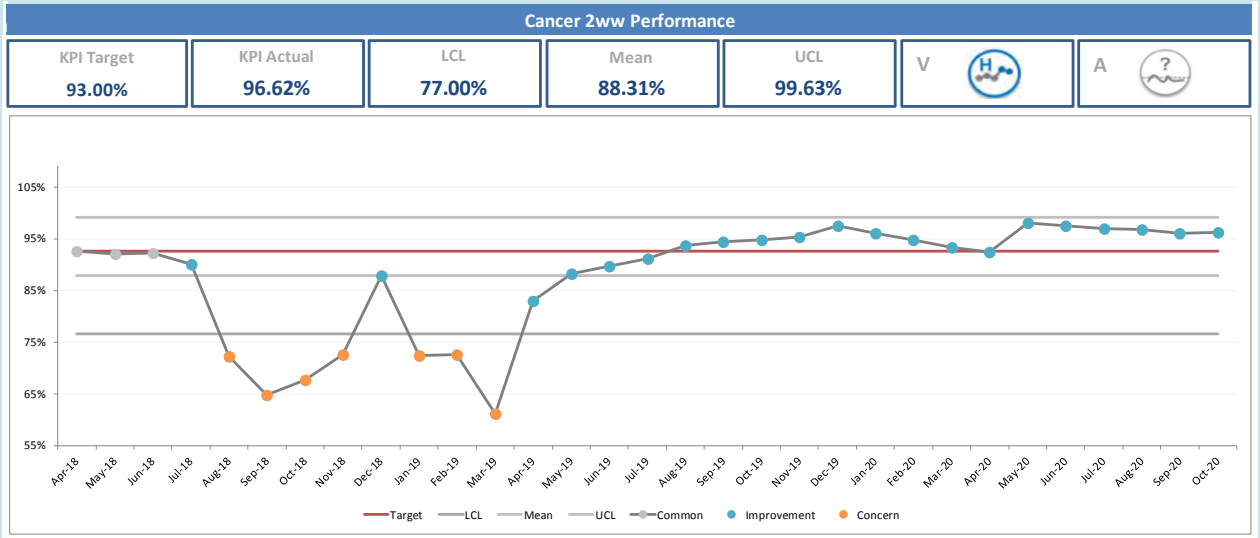
Potential impact of second Covid-19 surge on elective activity.
Patients choosing to delay treatment due to concerns over Covid-19.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

The trust is working to an internal Stretch Target of 7 days. Any service unable to facilitate 1st OPA in 14 days or less will be escalated to the Service manager and if required the General Manager for that Service. Real time performance is shared with the Referral booking office allowing them to take remedial action where necessary to remain compliant with the KPI. Weekly referral numbers and day of booking shared with each service, allowing them to flex capacity in response to demand in real time. Regular meetings with service managers to ensure that there is adequate capacity to manage demand and that clinic templates are reflective of demand on each service

Outcomes:

The Trust has been compliant with the operational Standard of 93% for 2 week wait first OPA for 12 consecutive months. The service is now more responsive to peaks in demand for OPA's and will flex capacity to accommodate peaks as they occur.

Underlying issues and risks:

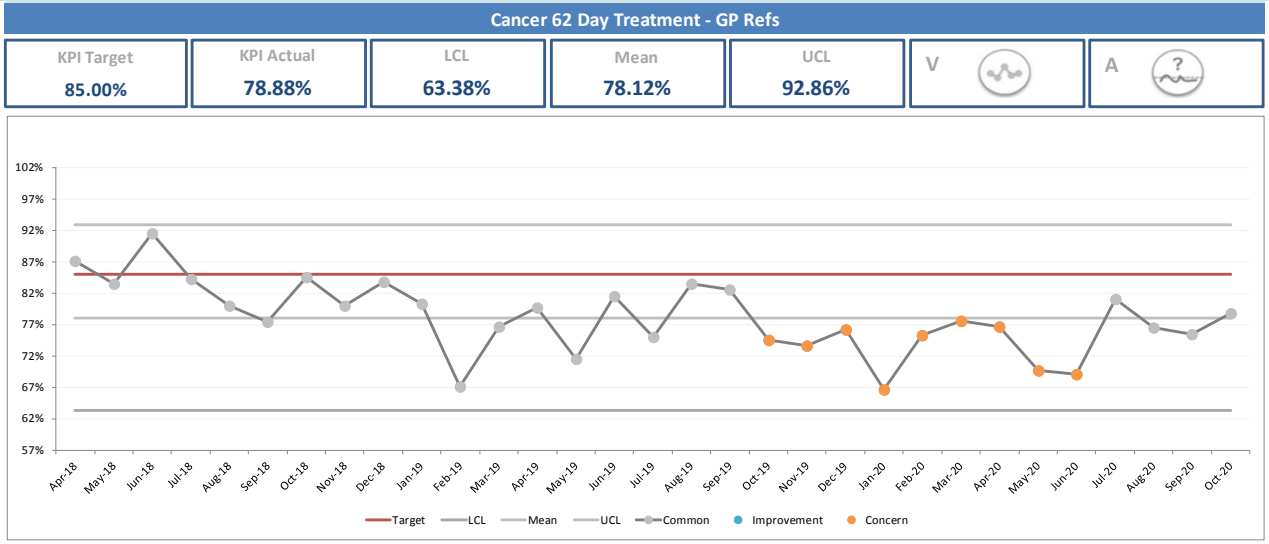
Due to social distancing measures combined with referral numbers slowly returning to pre-COVID levels delivering on the 7 day target is difficult to adhere to with the current levels of covid during wave 2.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

Cancer work is still being undertaken in the Trust and work within the independent sector will continue in January 2021.
PTL meetings are now being held with these services in order to ensure that any issues/bottlenecks in the pathway are identified and resolved in real time thus preventing breaches where possible.

Outcomes:

The performance against this KPI was 78.88% in October 2020.

Underlying issues and risks:

Potential impact of second Covid-19 surge on elective activity.
Patients choosing to delay treatment due to concerns over Covid-19.

Domain: Well Led – Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-20	62%	56.84%	13.11%	37.86%	62.61%		
		Staff Friends & Family - Recommend Care of Treatment	Mar-20	79%	68.97%	18.62%	50.46%	82.30%		
	Workforce	Appraisal % (Current Reporting Month)	Nov-20	85%	82.03%	81.22%	86.00%	90.78%		
		Sickness Rate (Current Reporting Month, FTE%)	Nov-20	4%	4.18%	3.18%	4.08%	4.98%		
		Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Nov-20	12%	12.53%	10.86%	12.06%	13.26%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Nov-20	0	4061.34	3780.85	3883.98	3987.11		
		StatMan Compliance (Current Reporting Month)	Nov-20	85%	88.78%	62.85%	79.07%	95.30%		
		Agency Spend as % Paybill (Current Reporting Month)	Nov-20	4%	1.54%	1.76%	3.79%	5.81%		
		Bank Spend as % Paybill (Current Reporting Month)	Nov-20	9%	1.30%	6.08%	11.22%	16.36%		
		Temp Staffing Fill Rate - Nurse & Midwifery (Current Reporting Month)	Nov-20	75%	0.01%	56.29%	71.51%	86.72%		

Meeting of the Board of Directors in Public

Thursday, 14 January 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.2**
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 15 December 2020		
Lead Director:	Jane Murkin, Chief Nursing and Quality Officer		
Report Author:	Joanne Adams, Business Support Manager		

Key headlines and assurance level

Key headlines	**Assurance Level**
1. Quality report Jane presented the quality report highlighting to the Committee that there has been a robust review of the well led evidence with a further 13 actions closed. Louise Thatcher, Head of Quality Assurance, Regulation and Compliance is currently reviewing all core services actions and supporting evidence for the next submission to the CQC. Further work has been progressed to address actions and since the report was written one red rated action has been closed with now only one red rated action with plans in place to address. The KPMG report actions are being progressed with an update to the executive group next week. The Trust continues to address issues relating to noncompliance for 48 hour reporting of Serious Incidents with actions progressed with divisional governance leads to achieve improvement , noting a slight improvement over last month . A task and finish group has been initiated to address any outstanding back log of incidents on Datix. The Committee were advised that a deep dive into compliance with NICE guidance has been completed and trajectories set to bring this back on track. The Committee were informed of a visit to the Trust by the national IPC team, findings and actions progressed following the visit. The Committee held a robust discussion regarding the findings along with the challenges the trust is facing with increase patient flow including the rise in COVID patients, bed capacity at the trust and potential options available to increase bed capacity and system support from partners. Jane briefed the Committee on an unannounced CQC inspection to the emergency care pathway that took place yesterday 14th December 2020. Action has been taken on the immediate findings from the inspection and the Trust awaits formal feedback. The Committee and Trust Board will up kept up to date on the outcome.	**Amber/Green**
2. COVID Outbreak Update Jane advised the Committee that this paper was due to be presented at the November Committee meeting which was truncated due to site pressures. The thematic analysis paper has since been to the Trust Board and reviews the findings, lessons and learning	**Amber**

from the initial outbreak of hospital acquired COVID, stating that the lessons and learning has also been shared at several other forums.	
3. Patient First – surge plan for Winter The Committee agreed that the patient first – surge for Winter presentation within the papers had already been discussed at Clinical Council and Trust Board. The Committee were assured that the work links internally on site for flow and has clinical input and leads for each project and is being progressed. The EDN template being used is from the first wave and is much shorter and there are 7 progress chasers supporting wards to ensure patients are discharged in a timely way, the watchtower data is being looked at on site and work is underway on a data pack for overview on flow and will be shared with the executive team each Tuesday and Friday.	**Amber**
4. Learning from Reg 28 The Committee received a verbal update from the Chief Medical Officer on learning from the incident and Regulation 28 relating to a case of the death of a child. The child was admitted with gastroenteritis but died from inadequate attention to fluid replacement and replacement of potassium as this was very low when the patient was admitted; this is an issue with children with muscular dystrophy. There were issues with communication between junior staff and senior medical staff and identification of abnormal results and handover from shifts. Jane confirmed that the organisational critical review huddle initiated last year was enacted within 24 hours of the incident to ascertain organisational risks, early intervention and actions to be progressed including the review of the SI. At the huddle immediate actions and any urgent risks were discussed and addressed. David further informed the Committee that he chaired an audit session last week which was attended by Dr Riphagen, Children's Consultant, specialist retrieval from Guy's & St Thomas'. The audit highlighted that the Trust does not always escalate unwell children quickly enough to the retrieval team who take acutely unwell children to the Evelina Children's hospital in London for more intensive treatment / care. The audit also highlighted that actions from a previous similar incident have not been embedded in the care group. The Committee requested a paper at the January meeting.	**Amber / Red**
5. Mortality and Morbidity Quarterly Report The Committee received the Mortality and Morbidity Quarterly Report. Mortality data to the end of July 2020 shows a continued reduction in HSMR both overall (to 98.8) and in key subgroups including those patients admitted at the weekend (to 109.3) and those patients who are resident in Swale (101.8). The rebase of Dr Foster to allow for the first wave of COVID-19 has now occurred. COVID-19 patients are excluded from the HSMR but included in the Standardised Mortality Ratio (SMR). The Trust's SMR to the end of July 2020 is 102.6. However the relative risk of death in the subcategory of patients including COVID-19 is above the 95th centile at 125.7. Further review of this information and also of mortality in patients treated during the first wave who did not have COVID-19 is now possible, and will be presented to the Mortality Committee for scrutiny in December. The Committee asked about the Dr Foster information on non-COVID mortality. Acute Myocardial Infarction has flagged as an outlier for the last four months of data, this looks like the first part of data with COVID showing issues with patients not presenting to hospital. David advised the Committee that the trust stopped activity in the first wave of COVID and saw a reduced number of patients presenting with heart and stroke issues; and there was a concern that this would reflect patients not presenting sooner than they required or not presenting at all. The Cardiology Department are reviewing the priority patients during wave one of COVID, particularly looking at the patients that have died to see if there were factors that were relevant; this is work in progress alongside wave one comparison with wave two and will be reviewed in more detail. David advised that Dr Foster information is	**Amber**

produced nationally and compared to the national baseline.	
6. Infection Prevention and Control – visit by National Team Jane advised the Committee that the National Infection Prevention and Control team visited the Trust on the 26th November, which identified key findings and themes to be addressed. Following the visit and in responding to the concerns Jane developed a draft IPC action plan, with further work progressed to finalise the action plan on receipt of the report from the national team visit; and confirming named responsible officers and deadlines for delivery. The Committee thanked Jane for the action plan and noted the challenges and lack of capacity of the IPC team. The Committee requested the action plan to go to the Trust Board in January for the Board to be sighted and to have ownership of the IPC plan. The Committee offered its support to Jane with leading and progressing the work to address the visit findings and IPC.	**Amber**
7. Safeguarding Assurance Group Highlight Report The Chief Nursing and Quality Officer updated the committee on the review of safeguarding she had commissioned which is nearing completion; and, once finalised later this month, will come to a future Committee meeting. Bridget Fordham, Head of Safeguarding spoke to the Safeguarding Assurance Group highlight report and advised the Committee that for the period during COVID there had been limited safeguarding cases and referrals; and that this represented the national picture, and could be a potential cause for concern. Bridget added that during lockdown there were concerns relating to domestic abuse victims not being able to make contact with services or support. The trust has a domestic abuse advisor on site, and her contact has increased as the Emergency Department are now seeing people presenting with symptoms and injuries consistent with domestic abuse. The Committee will receive a further update from the Safeguarding Assurance Group after its next meeting.	**Green**
8. Thematic Review of Learning from Deaths of Patients with Learning Disabilities Bridget Fordham, Head of Safeguarding and Eloise Brett, Learning Disability Liaison Nurse presented the thematic review of learning from deaths of patients with learning disabilities to the Committee. They explained that during 2020 the Trust had experienced twice as many deaths of patients with a learning disability in comparison to previous years, with 13 deaths within 2020 compared to 7 deaths in 2019. The thematic review was commissioned by the Chief Nursing and Quality Officer, following identification of an unusual number of patients with a learning disability dying whilst in hospital between 1 March 20 June 2020;which coincided with the COVID-19 pandemic. The review identified that there was no evidence of delay in care, treatment or decision making that may have contributed to the deaths, and no significant commonalities were identified. The majority of patients with learning disabilities who have been admitted to hospital have recovered from their illness and been discharged home, this includes a patient with complex learning disabilities who spent 6 weeks in hospital, treated for COVID which included admission to ICU. The committee noted the report and thanked Jane, Bridget and Eloise for this work.	**Green**
9. Quality and Patient Safety Group Highlight Report The Committee noted the Quality and Patient Safety Group highlight report and were advised that a review of the terms of reference and membership of the group had been undertaken. It was noted that the attendance at the meetings by senior nurses and doctors has improved, although this will continue to be monitored. The Quality and Patient Safety Group escalated operational pressures to the Committee.	**Green**
10. Maternity Transformation Assurance Board Highlight Report	**Green**

The Committee noted the Maternity Transformation Board Highlight Report with the following key highlights: • A CNST map and gap report has been presented to the Trust Board • A patient safety review of maternity services has been completed and a report of findings will follow. • The terms of reference for the Maternity Transformation Assurance Board have been updated and were provided to the Committee for information.	
11. Patient Experience Karen McIntyre, Associate Director of Patient Experience presented the Patient Experience report, which provided an update on work to date and set out the approach and plan to co-design and develop the Trust's patient experience strategy. This will be based on co-design principles and methodology as well as learning from best practice and leading national and international healthcare systems and other industries and organisations in excellent customer experience. The timelines in the report were discussed to ensure a robust consultation and engagement phase, with a draft strategy available for initial review by the Chief Nursing and Quality officer by April 2021. Jane acknowledged the work undertaken to date since Karen started in post, adding that Karen has stepped into the role and supported the testing of the 'What matters to you' boards, to support patient experience. The boards had received positive feedback from both staff and patients, alongside a range of other initiatives being progressed at this time. Jane acknowledged and thanked Karen for her leadership and work thus far and reinforced the importance of this work to ensure patient experience was given the same priority as other quality matters across the Trust; and the strategy development was an exciting time for MFT. The Committee will receive further updates on patient experience and the patient experience strategy when finalised next year.	**Green**
12. Ethical Framework for Decision Making The Committee were informed of the discussions that have taken place between David Sulch, Chief Medical Officer and Tony Ullman, Non-Executive Director and external colleagues including in Manchester and and at Canterbury Christchurch University regarding ethical decision making during the pandemic. The Committee were advised that further work is required on this topic and a more detailed report will be presented at a future meeting.	**Amber**
13. Quality IQPR and Board Assurance Framework – Quality Risks The Committee noted that the Quality IQPR and BAF-Quality were not included in the papers, and asked for the IQPR to be reviewed and circulated to the Committee. The Committee acknowledged the availability of data and turnaround of papers and were advised by the Company Secretary that meeting dates for the new financial year will be reviewed and moved to accommodate the timely production of data. The Committee requested that the BAF-quality be reviewed, in particular 5c relating to patient flow at the trust and consideration to be given to a new risk of 5f relating to COVID. The Committee were advised that the trust has an IPC COVID BAF that is owned by the Trust Board, and agreed for COVID related issues to be sighted on the COVID BAF.	**Amber/Green**
Further Risks Identified There were no further risks identified.	
Escalations to the Board or other Committee The Quality Assurance Committee escalates the following issues to the Trust Board: • Pressure on the emergency pathways due to COVID 19 • Infection Prevention and Control visit by the National Team and the Intensive Support Programme, and delivery of the Trust's action plan in response to the visit findings	

- Unannounced inspection to ED by the CQC on 14 December 2020
- Hospital acquired COVID acquisition and the importance of embedding lessons and learning from thematic review
- Mortality report and effect on COVID and non-COVID deaths

Key
Red – Action off track
Amber – Action in progress
Green – Action completed

Actions to Address Findings from National Team IPC Visit November 26th 2020

Aim – Reduce Hospital Acquired Infections

	Identified Issue	Finding	Action	Update of Action	Responsible Officer	By When	RAG
Leadership	1. IPC Leadership & Capacity	• Opportunity to Review Key Roles & Responsibilities	1. Review of current arrangements and strategic oversight by CEO supported by CNQO & CMO: specifically reviewing the DIPC role and Exec responsibility for IPC	• Initial review undertaken and CEO asked CNQO to take on role of Executive Lead& DIPC from December 14th 2020	CEO	30 Dec 2020	
			2. Additional resources being sourced by CNQO to bolster IPC Team whilst awaiting appointment of Associate Director of IPC.	• Interim support in the form of additional IP&C expertise commenced E. Taborn from NHSI/E and two days a week from Jo Green from CCG. • Interim Senior Nurse / Matron for IPC appointed on short term contract and commenced 14/12/20 • Interim Senior IPC Nurse interviewed and waiting confirmation of start date	CNQO	30th Dec	
			3. Recruitment process to be reviewed and shortened If possible by arranging early release from existing role of new Associate Director of IPC	• CNQO has contacted applicant and asked for earlier start date • CNQO to speak to originating organisation and request early release of staff member to take up post at MFT.	CNQO	20 Dec	
			4. Review of IPC Team to be undertaken to strengthen IPC Team	• Team strengthened in short term as per action 2	E. Taborn & DIPC	30 Jan 2020	
			5. Chief Nurse to be appointed as	• Chief Nursing & Quality Officer	CEO	30 Dec	

			DIPC	appointed as DIPC as of December 14th			
			6. Deputy Chief Nurse to be requested to provide day to day leadership and oversight of IP&C Team	• As requested by CNQO Deputy Chief Nurse now providing day to day leadership oversight & management of the team in absence of AD	CNQO	30 Dec	
			7. Roles and responsibilities of team to be reassessed and provide clarity of function	• Action links with Action 4 – review of IPC Team • Role and responsibilities of team members have initially been reviewed by Senor NHSI IPC Expert to ensure appropriate cover and advice is available to the wards and clinical areas. • Jo Green and E. Taborn supporting current staff with providing visible presence and advice in ward and clinical areas	DIPC/DCN	30 Jan 2021	
			8. Appointment of IP&C Matron to provide advice and monitor appropriate IPC Practice on wards and clinical areas.	• IPC Senior Nurse / Matron appointed and currently working with the team to provide support and advice to the wards and clinical areas	CNQO	30 Dec	
			9. Confirm in writing to all Senior Managers & Consultants a change in responsibility as Executive Lead for IPC and notification of the new DIPC	• Comms currently working on appropriate written statement to notify all officially of the change in DIPC. Notification has already been made during the nursing and medical clinical council.	CNQO/Coms	30 Dec	
			10. Support from Improvement Director as required	• Weekly IPC leadership meetings initiated by CNQO with first meeting held week 16th December. • Weekly meetings planned going	CNQO & Improvement Director	30 Dec	

				forward • CNQO & Improvement Director to agree any key actions for ID to support progress forward			
	2. Visibility of IPC Team	• Low visibility of the IPC Team was noted in clinical areas	1. Improve and increase daily visibility of IP&C Team on wards and clinical areas to provide assurance of good IP&C Practice.	• IPC team (Matron and IPC Nurse) have been given a daily schedule of ward visits to increase visibility. • Advice, support and mentoring provided by E. Taborn and J. Green	DIPC/DCN	30 Dec	
			2. Divisional Matrons to provide leadership oversight, monitoring and provide assurance during the regular ward quality rounds.	• CNQO has reinforced the role of the Divisional Matrons and informed them of the importance of their leadership role and responsibility for overseeing and monitoring IP&C standards of care and to ensure any compliance issues are dealt during this time • A formal letter from the CNQO setting out these expectations will be sent to Matrons	Divisional Directors of Nursing DCN	30 Dec 2020 30 Dec	
			1. Communication video from new DIPC providing consistent clear advice on IPC	• Video to be produced by Communication team and currently working on narrative for DIPC	DCN	Jan 15	
			3. Initiate Regular DIPC Blog to ensure all staff has access to clear accurate and up to date advice and support.	• Blog currently in preparation	DCN Comms Team	Dec 30	
			2. The new DIPC to Chair the next IP&C Committee (22nd December) to set out new strategic direction and Vision for IP&C moving forward.	• New DIPC diarised to chair the next IP&C Committee	DIPC	22 Dec 2020	
Prevention of	1. PPE		1. Launch remobilisation guidance	• Mobilisation guidance re launched and	DIPC/DCN	16 Dec	

Transmission & Prevention of Infection	• Overuse of PPE observed in ED department and Wards – including Doctors double gloving, wearing foot shoes, hats and suits. • Several staff were seen to be going from bay to bay and not changing their PPE • The use of visors was found to be unclear in several areas		and ensure all staff are aware of the current guidelines https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control	shared in formal CNQO and daily briefing comms aligned to pathways week commencing 16th Dec • IP&C Committee on 22nd December to discuss guidance and identify any further actions • Widespread sharing of documents and contents and reinforced through divisional governance mechanisms and staff meetings		2020	
			• Guidance to be sent to all senior nurses and Clinical Directors in the Trust to provide a readily available resource for information and guidance.	• Mobilisation guidance sent out to all Senior Nursing Teams for further distribution across the organisation. • Guidance sent to Chief Medical Officer for distribution down through medical workforce.	DCN	16 Dec 2020	
	2. COVID Pathways	• Language of pathways was felt to be confusing to staff- red, green, hot, cold and warm. • Staff were not clear on what PPE they should be wearing • Staff not clear	1. Initiate new Communication strategy relating to the current and appropriate guidance for all matters on infection Prevention & Control.	• CNQO briefing week of 16 Dec shared remobilisation guidance aligned to pathways • All communications relating to IP&C matters to be authorised by the DIPC prior to distribution across the organisation. • Communication team working with new DIPC to ensure all communications are clear and reflect and provide the necessary up to date national advice and guidance .	DIPC/Comms Team	30 Jan 2020	

		on understanding of and rationale for cohorting patients					
			1. Revisit the remobilisation national guidance and clarify pathways using agreed national terminology.	• Mobilisation guidance already reviewed and changes to pathways communicated and implemented • Refreshed signage displayed on wards to ensure clear signage on red amber and green departments aligned to pathways and refreshed PPE	DIPC / DCN	Dec 30 2020	
			2. Ensure appropriate terminology to be used in all communications with staff.	• All communication is to be signed off and authorised by the DIPC and checked for appropriate use of terminology aligned to national policy.	IPC Team	Dec 2020	
	3. Clinically Led Bed Moves	• Concerns raised as to why bed moves are not always clinically led	1. Strategic oversight of bed moves to be provided by DDoNs by attending the twice daily Site/bed meetings including ad hoc decision meetings when the site becomes busy.	• All bed moves coordinated through the bed /site team with oversight provided by the Senior Nurse/DDoN. • DDoNs attending site meetings to ensure appropriate movement of patients • All bed moves related to outbreaks to be reviewed and approved via IPC Team and outbreak management meeting and oversight	DDoNs Head of Site	17 Dec 2020	
	4. Nightingale Wards - Bed Spacing	• Unable to meet bed spacing requirements in wards of greatest risk from Hospital Acquired COVID - (Nightingale Wards)	1. All nightingale wards to be converted into hot wards to prevent transmission in the initial phase.	• With the support and advice of the NHSE/I Senior IPC Lead all nightingale wards have been converted to hot /red wards and are kept under review daily.	COO/DIPC	30 Dec 2020	
			1. Director of Estates to undertake an urgent review of all Nightingale Wards to identify opportunities to improve the	• Director of Estates to review nightingale wards looking to identify improvements which could support IP&C	Director of Estates/CMO /CNO	30 Dec 2020	

			ward infrastructure in partnership with CNQO & CMO				
			2. Consider closure of one Nightingale ward to facilitate better staffing on McCulloch ward (bed shortfall compensated by the opening of Emerald Ward).	• Currently under consideration however relates to bed capacity and patient flow	DIPC/COO/ CMO	30 Dec 2020	
	5. Social distancing	• Staff were found not to be adhering to social distancing in staff and doctors rooms	1. Reduce number of chairs in staff and doctors rooms.	• Chairs in staff rooms, offices and doctors rooms currently being reviewed by the IP&C team as they review each clinical area on a daily basis. • Senior Managers and clinical leads advised on the importance of adherence to this and management oversight	IP&C Team	30 Dec 2020	
			2. Each office room within the Trust to have clear signage indicating the maximum number of staff who can be in the room at one time.	• Office space under review			
			3. Estates to review available office space in the light of increased home working to provide alternative space for clinical teams to carry out administrative work	• This action is currently in progress as the IP&C Team work with clinical colleagues	Director of Estates /Team		
			4. IT to review access to Trust systems via virtual networks on staff's personal computers	• IT has a process in place to review virtual networks and provide additional network access with appropriate	Director of IT/Team		

			(appropriately protected and with safe storage at work provided)	safeguards in place for all staff where it is deemed they need to work off site			
	6. Signage	• Signage for toilets relating to high or medium risk status not in place. • Signage in all clinical areas indicating level of risk i.e. Red or Green	1. Review all patient toilet facilities to ensure correct signage relating to COVID risk status. 2. Ensure appropriate signage in all clinical areas indicating clearly the level of Covid risk status (Red/Amber/Green)	• All signage is currently part of the daily review by IP&C nurses and where changes are necessary signage is changed. • Temporary signage has already been produced to help and support staff and patients with clearly identifying the appropriate clinical area. Printed more substantial signage is currently on order.	IP&C Team IP&C Team	30 Dec 2020	
IPC Governance	1. IPC Governance	• Concerns raised relating to governance for IPC	1. Review of Ward to Board governance in relation to IP&C with support from NHSE/I	• To be reviewed with a focused session in January to undertake a high level review and identify the process and next steps to strengthen governance • This will be support of NHSE/I Senior IPC Lead & Improvement Director	DIPC/NHSE/I Improvement Director	30 Jan 2021	
	2. IPC BAF	• The IPC BAF has not been updated since May	1. IPC BAF to be urgently updated and reviewed by Chief Nursing & Quality Officer & Chief Medical Officer	• BAF currently in progress of being updated • High level update provided by CMO • Further review required to identify gaps and present to Januarys QAC	DCN & CNQO/CMO	30 Jan 2021	
			1. Updated IPC BAF to be reported at Exec Team, QAC and Trust Board monthly with associated action plan to address gaps in assurance.	• IPC BAF and associated action plans will be reported at the appropriate meetings going forward and scheduled for January QAC meeting	CNQO/CMO	30 Jan 2021	
	3. Outbreak Management	• Concerns raised	1. COVID data provided to CNQO & CMO prior to daily outbreak	• Covid 19 data is provided by	Deputy Director of	14 Dec 2020	

		relating to effective grip of outbreak management and decision making relating to patient, ward and bed moves • Concerns raised relating to escalation of COVID positive patients and use of data to inform decision making • Concerns raised that not all decisions made are clinically led	meetings	Business intelligence on a daily basis prior to outbreak meetings	Business Intelligence DIPC		
			1. Outbreak management overseen by responsible Exec (at present the CMO)	• Outbreak management currently overseen by CNQO as DIPC to provide executive leadership		14 Dec 2020	
			2. COVID outbreak policy to be virtually approved by Executive (approval from IPC Tactical team already obtained) and introduced into routine practice.	• Outbreak policy to be presented to Executive for approval?	DIPC/ Executive Team	30 Dec 2020	
			2. CMO and CNQO to provide professional oversight to ensure decisions and bed moves are clinically led.	• CMO and CNQO currently provide executive oversight through the DDoNs and Clinical Directors and all areas needing further decision making are brought to the attention of the CMO	CMO/CNQO	14 Dec 2020	

				/CNQO			
			3. Data collection process is governed by existing SOP's and guidance.	• Data collection is already governed by existing SOP's and guidance • Reviewof process to ensure effectively working and clarity of data submisisons and roles and responsibilities	Deputy Director of Business Intelligence	Feb 20 2021	
Infrastructure	1. 7 day IPC Services	Unable to currently demonstrate a robust IPC 7 day service to ensure effective IPC management, advice and guidance	1. Review to be undertaken as part of the review of the IPC Team and its current resources.	Review of IPC Team as per leadership section action 4	DIPC/DCN	30 Jan 2021	
	2. ADL Repurpose & Surge Capacity	Concerns relating to the opening of additional capacity meeting IPC requirements	1. All proposed repurposed and surge environments to be IPC compliant	• All clinical areas proposed for use as surge or any area to be repurposed will have risk assessment to ensure they are all IP&C compliant and formal approval by DDON and CNQO prior to opening .	DIPC/IP&C Team IP&C Team	Dec 2020	
			1. IP&C team to review additional capacity or surge environments to provide assurance appropriate mechanism and systems are in place to reduce and prevent transmission.	• IP&C Team have undertaken a review of the current change of purpose clinical area (Christina Rossetti) to ensure it was IP&C complaint before use.		Dec 30	
			2. DIPC to have oversight of any additional capacity or surge environments to ensure	• DIPC has reinforced the importance of being informed of any proposed changes of clinical environment before	DIPC & CMO	Dec 2020	

			appropriate risk assessments have been completed and signed off.	plans are put in place to make changes including IPC review and risk assessment to be completed. • Changes to be set out in risk assessments with an IPC review prot to formal sign off			
	3. Communications & Messaging	• Concerns relating to the effectiveness of COVID / PPE communications and key messaging at the frontline	1. Communications from Board to Ward to be revisited to ensure frontline clinicians receiving effective and up to date guidance	• All communications form ward to Board are now to be approved by the DIPC prior to release to ensure correct and appropriate information is being shared. • DIPC will also produce a regular blog of updates so staff can refer back for advice.	DIPC/Comms Team	30th Jan 2021	
	4. Preventative Estates Work	• Query raised relating to the programme of preventative estates work to support IPC regulations and compliance	• Programme of preventative IPC Estates work to be reviewed by DIPC in conjunction with Director of Estates.	• Any preventative IPC Estates work will be discussed with the DIPC prior to any changes being made. • The Director of Estates has been reminded of the DIPC's need to sign off any work from an IPC perspective.	Director of Estates/DIPC	30th March 2021	
			Clear programme of improvements to be provided and agreed to reduce transmission	• Director of Estates to review all opportunities where it may be possible to make improvements to reduce transmission and will discuss these with the DIPC for approval.	Director of Estates/DIPC	30th March 2021	

Meeting of the Public Board
Thursday, 14 January 2021

<table>
<tr><td>Title of Report</td><td colspan="2">Board Assurance Framework</td><td>Agenda Item</td><td>4.3</td></tr>
<tr><td>Report Author</td><td colspan="4">Gurjit Mahil – Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="4">Gurjit Mahil – Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="4">A summary of the BAF as of 23 December 2020 is presented in this paper.

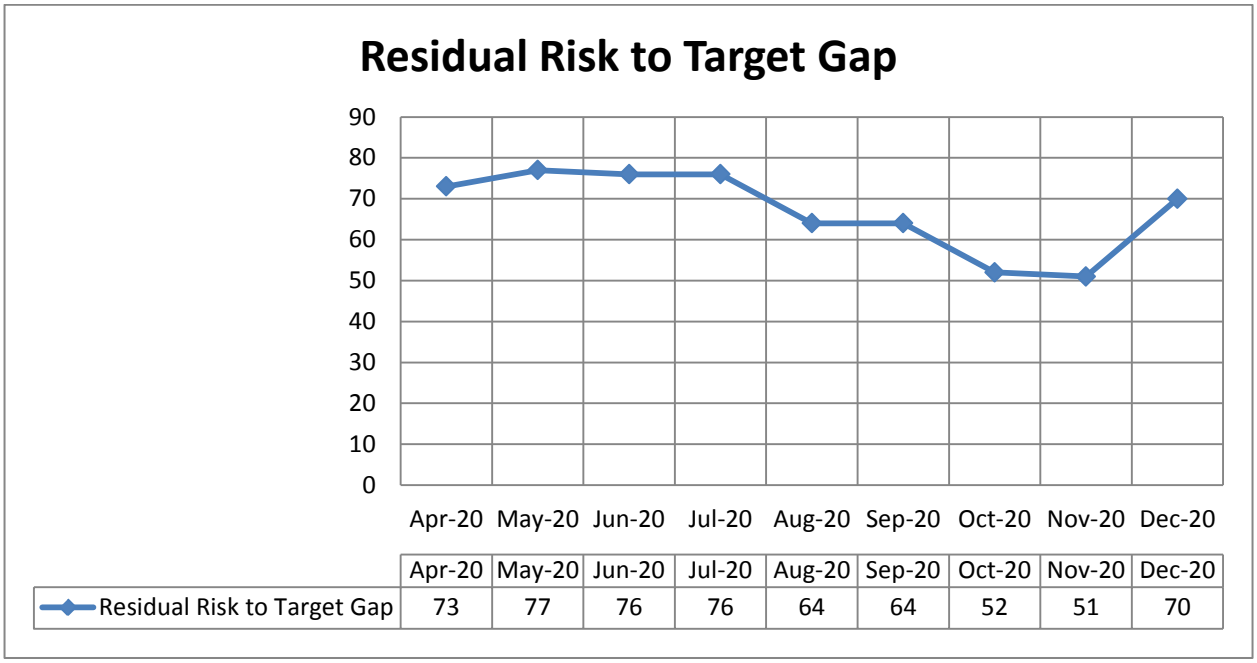
The Trust's principle risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Nov-20</th><th>Dec-20</th></tr>
<tr><td>3a - Delivery of financial control total</td><td>9</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>5c. Patient flow – Capacity and demand</td><td>6</td><td>12</td><td>9</td><td>16</td></tr>
<tr><td>5f - Covid 19</td><td>4</td><td>20</td><td>16</td><td>16</td></tr>
</table>
</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="4">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="4">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="4"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="2">Recommendation/ Actions required</td><td colspan="4">The Board is asked to NOTE the report for assurance regarding the processes in place around risk management.</td></tr>
<tr><td>Approval
☐</td><td>Assurance
☐</td><td>Discussion
☐</td><td>Noting
☒</td></tr>
<tr><td>Appendices</td><td colspan="4"></td></tr>
</table>

1 Board Assurance Framework (BAF)

		Target Score	Initial Score	Apr -20	May -20	Jun-20	Jul-20	Aug -20	Sep-20	Oct -20	Nov -20	Dec-20
Integrated Healthcare	1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12
Innovation	2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9
	2b. Capacity and Capability	9	9	12	12	12	12	12	12	6	6	6
	2c. Funding for investment	9	9	9	9	9	9	9	9	6	6	6
Finance	3a. Delivery of financial control total	9	16	6	6	9	9	9	9	9	16	16
	3b. Capital Investment	12	16	20	20	20	20	20	20	20	12	12
	3c. Failure to achieve long term financial sustainability	4	16	16	16	12	12	12	12	12	12	12
	3d. Going concern	4	12	4	4	4	4	4	4	4	4	4
Workforce	4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	12	12	12
	4b. Staff engagement	6	12	12	12	12	12	12	12	12	12	12
	4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	6	6
Quality	5a. CQC Progress	4	16	16	16	16	16	12	12	12	12	12
	5b. Failure to meet requirements of Health and Social Care Act	6	16	12	16	16	16	9	9	9	9	9
	5c. Patient flow – Capacity and demand	6	12	12	12	12	12	12	12	9	9	16
	5d. Quality Governance	4	12	12	12	12	12	9	9	9	9	9
	5e. Loss or temporary moves of key clinical services off the MFT site.	4	16					6	6	6	6	6
	5f. Covid 19	4	20									20
	Total Risk Score	105	242	170	174	173	173	165	165	153	152	172
	Residual Risk to Target Gap		137	73	77	76	76	64	64	52	51	70

Table 1.1 – Summary of BAF



1.1

Figure 1.2: Residual risk to target gap

1.2 Figure 2.2 (below), shows the residual risk to target score gap. The target score is based on the trigger levels for each of the risk domains and the residual risk is based on the gap between the residual risk score and the target score.

1.3 The increase in the residual gap between November and December was due to the addition of 1 risk and the increase in the rating of another over that period of time.

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)

2 Innovation

Executive Lead – Director of Transformation/IT

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 2 = 6 (Low)	3 x 2 = 6 (Low)	3 x 3 = 9 (Moderate)
2c – Funding for investment	3 x 3 = 9 (Moderate)	3 x 2 = 6 (Low)	3 x 2 = 6 (Low)	3 x 3 = 9 (Moderate)

3 Finance

Executive Lead – Chief Finance Officer

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

4 Workforce

Executive Lead – Chief People Officer

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)

5 Quality

Executive Lead – Chief Nursing and Quality Officer

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

- Proposed increase to 5c
- New risk added – 5f.

COMPOSITE RISK: Lack of System Integration										
EXECUTIVE LEAD: Chief Operating Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance Full, Partial, None**
1a There is a risk that the Medway and Swale system cannot enable true partnership working which designs a long term population based, integrated health and social care system with the patients at its centre. Thus leading to a failure to deliver systems integration, stability and better patient services via the enablement of clinically led patients centred system redesign.	The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) and at a locality level within Medway and Swale that is based on a joint strategic needs assessment. We will therefore not leverage the ability to redesign the system for better quality of care to be provided to those we serve in the short and long term.	**4 x 4 = 16 High**	1. Systems wide strategic vision written in partnership with all organisations. Agreed Intergraded Care Partnership (ICP) model in place with systems partners actively working to mobilise key collaborative elements. 2. Current work through Covid structures is placing a key focus on the system partnerships to ensure timely decision making, for example the reduction in MFFD patients.	Governance arrangements for the Medway and Swale system agreed. Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways.	Regular updates against milestones submitted to Executive and Board of Directors meetings.	Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement Integrated Performance Assurance		**4 x 3 = 12 Moderate March 2020**	**3 x 2 = 6 Low**	Partial
			3. The ICPs agreed ambition is as follows and will have detailed population health outcome measures developed as part of the multi-agency development work which will read across to the ICS and ICP Joint Strategic Needs .	1. Monthly Medway and Swale System Delivery Board. a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive. b. Membership is made up of executive from provider and commissioning organisation						

COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Director of Transformation/IT										
LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
2a There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP/ICS and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace with new technologies, other organisations locally and the ICP and ICS/STP.	4 x 4 = 16 **High**	1. Author a Digital Strategy that is well socialised across the region and well engaged with by teams internally. 2. Develop a roadmap to a single Electronic Patient Record. 3. Focus initially on key projects and investments to stabilise IT services (telephony, networks, end user devices, licenses, systems upgrades, service desk). This will provide a strong technology and information foundation to build upon: EPR, innovation, whole system analytics, specialist services. 4. Seek Regulator support for IT investments and longer-term Digital Strategy	Director of Transformation and Digital, CIO and Senior Digital Team Weekly CIO call with all Kent & Medway provider Trusts	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Reporting to Finance Committee as part of Committee work plan	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X	Formally publish Digital Strategy and EPR business case, ratified by Board Participate well in ICP Digital Strategy Group Form Digital First Team Appoint CCIO Re-launch Digital/IT team Continue to work closely with Regulators	**3 x 3 = 9 Moderate**	**3 x 2 = 6 Low**	P
2b There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology.	Transformational change will be held back which may impact also quality improvements and meeting financial targets.	3 x 3 = 9 **Moderate**	5. Deploy an Electronic Patient Record – to reduce the paper burden on the organisation and consolidate the number of IT systems 6. Appoint a Director of IT 7. Work in collaboration with neighbouring providers (MTW, EKHUFT) where necessary and to support infrastructure convergence 8. Complete IT team recruitment drive to substantiate bank/agency staff 9. Work more proactively with suppliers 10. Train and upskill Digital teams – closely align Digital with Transformation 11. Pursue PoCs and pilots via the Medway Innovation Institute to evidence benefits of key technologies on a small scale	Director of Transformation and Digital, CIO and Senior Digital Team	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Medway Innovation Institute Steering Committee	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X	Progress Electronic Patient Record FBC Confirm plans for IT leadership structure Form Digital First Team Appoint CCIO Re-launch Digital/IT team Continue to work closely with Regulators	**2 x 3 = 6 Low** **(October – was 3x3=9)**	**3 x 3 = 9 Moderate**	F

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
2c There is a risk that the Trust will be unable to secure sufficient funding for investment in new technologies and clinical research. Specifically, there is a risk that the Trust will be unable to secure sufficient capital to invest in the desired new technologies.	The Trust may become less attractive for new medical and clinical staff The Trust may not deliver the transformation required at pace	3 x 3 = 9 **Moderate**	12. Develop longer-term [3-5 year] capital and investments plan, aligned to Digital Strategy and EPR deployment plan. 13. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released e.g. HSLI, EPMA, Cyber. Horizon scan for any new funding avenues e.g. GDE becoming Digital Aspirants. 14. Investment in the R&I department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials. 15. Continue to develop Medway Innovation Institute for Proof of Concepts and to attract external funding and investment. 16. Close working with innovation hubs and accelerators for potential funding routes e.g. Academic Health Science Networks	Director of Transformation and Digital, CIO and Senior Digital Team	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Capital and Investments Group Reporting to Finance Committee as part of Committee work plan R&I Annual Report to Trust Board Medway Innovation Institute Steering Committee	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X NIHR Clinical Research Network Joint Research Office (Kent, Surrey Sussex) KSS AHSN	Progress EPR FBC ICS and HSLI funding discussions ongoing EPMA bid ongoing Adopting Innovation bid ongoing	**2 x 3 = 6** **Low** **(October – was 3x3=9)**	**3 x 3 = 9** **Moderate**	F

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a Delivery of Financial Control Total	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. (If the STP does not meet its control total then the Trust will lose up to 50% of its FRF allocation, resulting in a variance to reported plan of up to £23.7m in 2020/21.) Under 20/21 contracting arrangements the STP must meet its control total. Given the uncertainty of Covid, our cost response during wave one, CIP delivery risks and the removal of true-up income from months 7-12 of 2020/21, there is a very high risk of the Trust not meetings its control total.	4 x 4 = 16 **Very High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. NHSE/I is providing funding to enable providers to achieve breakeven from 1 April 2020 to 30 September 2020. The eight CCGs in Kent have merged with effect from 1 April 2020, enabling them the scale and reach to support management of the system as a whole. STP has allocated funds to manage the system performance.	STP plan submission for months 7-12 2020/21 has been made – effectively requires the Trust to meet its budget.	4 x 4 = 16 **Very High** (Previous risk rating: Oct 2020 3 x 3 = 9 **High)**	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate)**	
			2. Programme Management Office and scrutiny by Financial Improvement Director to track operational delivery and financial consequences of those actions.	Financial improvement director in place.						
3b Capital Investment	If there is insufficient cash to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan.	4 x 4 = 16 **Very High**	1. Governed entirely by the availability of cash, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the STP and regulators unless affordable within the existing capital programme or through a revenue stream. (**Note**: Risk not fully mitigated from the Trusts	Standard business case process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Capital Group, Finance Committee and Board.		1. Trust strategy for innovation together with Care Group /directorate strategies to be developed. 2. National shortage of capital	4 x 3 = 12 **High** (Previous risk rating: Oct 2020 5 x 4 = 20 **Extreme)**	4 x 3 = 12 **High**	

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

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
			(**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).			divest services. A statement from NHSE/I on 27 May 2020 in light of Covid contracting arrangements it stated: "Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs."				

COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Director of Human Resources and Organisational Development										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16** **High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Staff networks are further developed, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 21]	**3 x 4 = 12** **Moderate**	**3 x 2 = 6** **Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 11.4%. 2. Sickness rate 4.4% 3. Substantive workforce 83.6%					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					

			5. Temporary staffing delivery: a. NHSI agency ceiling reporting to Board; b. Weekly breach report to NHSI; c. Reporting to Board of substantive to temporary staffing paybill.		People Committee reporting 1. £6m favourable to ceiling; 2. Averaging 30 breaches per week compared to c1000 in 2016 3. Agency workforce 3% 4. Bank workforce 13%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 131 apprentices of 101 target	People Committee					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						

				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4b Staff engagement Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Refresh of Freedom to Speak Up strategy [Apr 21] Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] Working across the STP to implement TRiM (Trauma and Injury Management) processes in the Trust as part of #HAY [Dec 21]	**3 x 4 = 12 (Moderate)**	**3 x 2 = 6 (Low)**	
			Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.	1. You are the difference (YATD) embedded in induction 2. NHSEI Culture, Engagement and Leadership Programme Board						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session; c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: a. Trust scores across key domains; b. Comparative results from previous years and other organisations; c. Heat maps for targeted interventions. d. Local survey action plans to address key concerns.	Survey 2018 staff engagement score, 6.4 – lower than average 7						
			Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership						

				programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom To Speak Up Guardian route to Chief Executive; b. Respect: countering bullying in the workplace policy; c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Respect policy in place; 3. JSC and JLNC in place.						
			Well-being interventions in place: a. Employee assistance programme and counselling; b. Advice and health education programmes; c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support. d. National #How are you (HAY) wellbeing framework implemented	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. #HAY implemented and monitored						
			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place Qualitative and quantitative values-based appraisal						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Refresh of Freedom to Speak Up strategy [Apr 21]	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented). 1. StatMan compliance >89% 2. Appraisal rate >85%						
			Right attitude and values: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance; c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; d. Respect – countering bullying in the workplace policy.	1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place. 4.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and	1. Trust vacancy rate at 11.4%; 2. Substantive workforce 83.6%; 3. Monthly PRM including discussion on workforce, vacancies,						

			temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.	recruitment plan and temporary staffing;						
			Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.						

COMPOSITE RISK: Quality											
EXECUTIVE LEAD: Chief Nursing and Quality Officer											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently achieve delivery of high quality care. Failure to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Ineffective leadership, oversight and timely remedial action of the quality standards. 2. Lack of effective governance systems and processes. 3. Too much focus on flow versus quality standards. **Impact:** 1. Regulatory action by CQC &/ or NHSI 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. **4.** Inability to reduce avoidable harms to patients	**4 x 4 = 16 High**	1. CQC action plan developed and being implemented 2. Programme of ward assurance visits commenced , 2 wards per week 3. Associate Director of Patient Experience recruited, to commence October 2020 4. Review of Dickens ward undertaken – report being written. 5. Substantive Associate Director of Quality and Patient Safety recruited, to commence in January 2021. 6.Terms of Reference for Maternity Services Review agreed and draft KLOE 7. Terms of Reference in final revision and date for commencing in negotiation with CCG. 8. Substantive Deputy Chief Nurse recruited – to commence in February 2021. 9. Phase one – document review of Maternity Service Review conducted on 29 October 2020. Phase two – staff interview dates being confirmed. 10. Action plan developed and actions progressed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A	Quality Panel Governance in place fortnightly meetings. CQC Evidence panel in place with fortnightly meetings.	Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board CQC Evidence panel in place. High Quality care Programme Board established. Ward Assurance Visits in place. Programme of Matron competence assessment being implemented Report on the first twelve ward assurance visits completed and report produced for September and November Executive Group meetings and QAC	Internal Audit and External Quality Audit. CCG Quality Meetings CQC Engagement Meetings Safeguarding Review completed and draft report received. Complaints Review completed and draft report received Single Item Multi-Agency meetings	Evidence sent thus far being quality assured As a result of increasing operational pressures due to wave 2 of COVID-19, there is a risk that some of the CQC MDSD actions with regard to patient flow may not meet the date set for completion.	Complete QA process for all future evidence submitted Winter Plan and Watchtower plan being prepared. Joint senior medical and nursing tactical meetings have been established with the COO in attendance.	**4 x 3 =12 Moderate**	**2 x 2 = 4 Very Low**	Partial
			Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented cohort 3 being recruited to. Cohort three now midway through their programme. Once this has been completed all ward managers will have been through this programme Matrons Development Programme in place February – September 2020. Programme currently being evaluated. Heads of Nursing Development Programme in place May – November 2020. Aspiring ward leaders programme commissioned commenced 1 October 2020 Aspiring Clinical Leads programme to commence in January 2021 for AHPs Leadership development programme for specialist nurses being commissioned and to commence March 2021 Trust wide Matron Leadership Roles implemented for nursing fundamentals and quality priorities	Programme of continuous quality improvement: a. Improvement huddles b. Improvement Specialists c. Local improvement Projects	Quality Report and Accounts AGM to take place in September 2020. AMM held on MS Teams			Reflection and Recognition event for Matrons and Heads of Nursing planned for 27 November 2020. Rescheduled to 5 March 2021 due to Covid-19 and lockdown			Full

			QI Development session held with Matrons 4 September 2020									
			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Quality strategy c. Ward to board assurance framework approved by Executive Group 15/07/2020 d. Quality boards on wards piloted. Now being rolled out across all areas. Launch 1 September 2020 e. Quality and Safety Boards now on all adult in-patient wards f. 'Big room' event held on 17 July in partnership with the Innovation Institute celebrating improvements in pressure ulcer reduction. g. Second multidisciplinary 'big room' event held on 18 September with a follow up on pressure ulcers and a focus on nutrition. Increasing numbers of 'days between' pressure ulcer acquisition on a number of wards	New Scorecard developed. Quality strategy priorities reported to QAC Fortnightly Matron assurance reports Monthly Heads of Nursing Assurance Report Monthly DDON assurance reports to the Chief Nursing and Quality Officer Sapphire Ward awarded a gold star by the Chief Nursing & Quality Officer and the Chief Executive for 239 days between the last pressure ulcer acquired on the ward. Eight other wards achieved bronze stars (achieving 50 days with no pressure ulcer) these will be presented by the matrons.	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board. High Quality care Programme Board		PRMs for 20-21 commenced 27 May 2020 Ward to board assurance framework approved by Executive Group 15/07/2020	First PRM 27 May 2020. Ward to board assurance framework to be in place 30 June 2020 – Completed Second 'big room' event planned for 18 September with a focus on nutrition			Partial
			4. Audit and review processes d. Clinical Audit programme and monitoring e. Daily MSA breach reporting and validation f. PLACE, COSHH and environmental audits g. Timetable of audits to support CQC action plan in place and being implemented	Revised Quality and Patient Safety Group Divisional Governance Boards The newly implemented mechanical interventions are having the most positive impact on COSHH compliance which should show a significant improvement in the November COSHH audit. 50% of staff compliant with COSHH training however there is an issue with accessing & capturing, Chief	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial

				People Officer to re-circulate instructions to Staff.							
			5. Central and local oversight of quality h. Complaints management i. Incident management, including Serious Incident (SI) processes and monitoring j. Compliance with Duty of Candour policy and training Refreshed SI Framework being developed, development workshop planned for 12 October 2020 Complaints review process approved and in progress. Safeguarding review currently underway	Centralisation of the Divisional Quality Governance Teams Divisional Governance Boards Phase one – document review of Maternity Service Review conducted on 29 October 2020. Phase two – staff interview dates being confirmed. Complaints review completed, draft report with the Chief Nursing and Quality Officer for review. Draft report to Execs on 6 January 2021 Safeguarding review completed final report with the Chief Nursing and Quality Officer for review. Final report to Execs on 6 January 2021	Regular reports to the Executive Group. Quality and Patient Safety Group		Compliance with 48 hour SI reporting to StEIS deteriorating. Further process mapping of the issue underway. Maternity services review scoped and TOR agreed, commenced 29 October 2020	Divisions have a plan in place to rectify.			Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	The result may be sub optimal outcomes and patient harm with potential regulatory action. Patients may be harmed	4x4 = 16 High	1. IPC Improvement plans 2. Infection Control Action Plan developed in response to NHSE/I visit in November and being implemented 3. IPC Intensive Support programme supporting the Trust 4. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 5. Senior IPC nursing advisory function and support received from NHSI	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual adopted by MFT, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan rewritten and forms basis for ongoing work. Mandatory IPC training compliance at over 95% for the majority of the last several months. First draft of practical ward based training plan completed. Directorate and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Panel: Evidence review panel in place and considered IPC evidence on 13/08/20 High Quality Care Programme commenced of which IPC is within Mission 1. Safe Care Quality Assurance Committee Decontamination Group in place – to report into the IPC Committee	IPAS (I/E) meeting Oversight from system DIPC	The total number of all key hospital acquired infections (MRSA bacteraemia, C difficile, gram negative blood stream infections) is lower for Apr-Jul 2020 than for the corresponding period in 2019. MFT had no outbreaks of hospital acquired COVID-19 in wave 1 however there have been two outbreaks in wave 2. Updated position paper going to QAC on 19 January 2021 18 IPC policies currently undergoing review. Resumption of antimicrobial audits in June 2020. Review of IPC team structure under way – Associate Director role appointed to – commencing March 2021. Trust Improvement plan to be comprehensively reviewed and updated to provide current level of assurance. Covid BAF update to be undertaken and	Support secured from CCG to update all policies PIR's completed. Medical Director to consider contingency plan	**3 x 3 = 9 Moderate August 2020**	**2 x 2 = 4 Very Low**	Partial

							presented to February 2021 QAC				

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5c There is a risk that the Trust processes as well as the clinical and managerial leadership regarding patient flow are not sufficiently developed to manage the emergency demand effectively through the available capacity. This subsequently impacts on the elective capacity reducing the level of planned operations and procedures that can take place. poor patient flow and weak capacity and demand planning will fail to achieve the required performance standards (constitutional standards: 4 hour access, RTT, DM01 and Cancer)	Sustained failure to achieve constitutional standards may result in substantial delays to the treatment of patients, poor patient experience, potential patient harm and a possible breach of license.	**3 x 4 = 12 Moderate**	1. The restart programme has included a refresh of the demand and capacity across all specialties. 2. Pathways have been reviewed to ensure patients receive their care in the most appropriate settings including non-face to face, independent setting and at MFT. 3. Emergency pathways have been further developed to include the range of assessment options through frailty, acute assessment and Same Day Emergency Care (SDEC). 4. A bed reconfiguration programme has been undertaken to profile the planned and unplanned beds based on expected demand & full ring-fencing of elective capacity. 5. The Trust has a renewed focus on length of stay to ensure that patients get the most effective care during as short a stay in hospital as is appropriate for their care. 6. In summary: a. Elective, Outpatients & cancer care modelling underway to ensure patients with a prolonged wait for treatment are appropriately managed and that the new physical distancing and pre-hospital preparations are clear. b. The recovery programme is being managed through the System approach to ensure that all out-of hospital capacity ad opportunities are highlighted and used appropriately. 7. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board Weekly ED performance review Daily check points for activity & flow Trajectories for all constitutional standards in place.	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used. System calls in place to ensure escalations. Progress against action plan will be overseen by Quality Panel c. 13 January 2021	External reviews by NHS I/E Single Item Multi-Agency meetings Response on current progress to CQC on 4 January 2021	Weekly Best Flow Programme Board has not met during COVID-19	Wave 3 planning Further response to CQC on 2 February 2021	**Propose increase in score to 4x4 = 16** **3x 3 = 9** **Moderate** (3 x 4 = 12 Moderate **(September 2020)**	**2 x 2 = 4 Very Low**	Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5d If quality governance is not sufficiently understood or embedded there is a risk that the Trust may not deliver our quality priorities.	Risks to quality and safety of care may not be identified or controlled resulting in poor patient experience, sub optimal outcomes and patient harm with potential regulatory action.	**3 x 4 = 12 Moderate**	1. Quality ambitions a. Quality goals and priorities agreed for 2019/20 b. Quality Account	Quality governance groups established for delivery and monitoring quality Patient Safety Patient experience Clinical Effectiveness and Research Medicines Management Mortality Safeguarding	Executive Group and Quality Assurance Committee Risk Assurance Group in place	90 Day forum	None	Ensure full embedding of the RAG processes.	**3 x 3 = 9 Moderate August 2020** **3 x 4 = 12 Moderate June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Key leadership roles in place a. Corporate business critical posts in place providing governance, quality and safety leadership b. Directorate and programme clinical governance, quality and patient safety leads in place c. Quality Governance teams in place centrally and within directorates	Divisional Governance Boards in place	Executive Group	Internal and external audit reviews	New processes have not yet had a chance to embed	Maintain oversight of Divisional Governance effectiveness and provide support and training as required.			Partial
			3. Quality Governance monitoring a. CQC Assure b. Risk registers c. Quality Impact Assessments	Divisional and corporate risk meetings in place	Risk Assurance committee in place reporting to executive team.	CQC	CQC Compliance Framework not in place	CQC compliance framework being developed			Partial
5e **Loss or temporary moves of key clinical services off the MFT site.**	The risk to clinical services and interdependencies with other clinical risks. Risks to quality and safety of patients and teams effected.	**5 x 4 = 20 High**	1. Key strategic decisions being made around clinical services are discussed at Clinical Council, Executive, Board and System levels. 2. This is to ensure that there is no disruption to the services and to ensure safety. 3. Clear links with neighbouring Trusts to ensure patient safety and Programme Board meetings are in place for key services.	Executive Group	Quality Assurance Committee and Trust Board	90 Day Forum		Maintain oversight on patients that are transferred.	**2x 3 = 6 Low July 2020** **(5 x 4 = 20 High June 2020)**	**2 x 2 = 4 Very Low**	Full
5f **Covid 19**	With the high prevalence levels of Covid 19 there is a risk that this will have an impact on the day to day running of the organisation due to suboptimal staffing	**4 x 5 = 20 High**	Daily trust wide safe staffing reviews undertaken by DDON/ HON with escalation to CN&QO Senior IPC nursing advisory function and support received from NHSI Daily reports on PPE availability	Three times per day senior operational meetings Daily nursing tactical meeting at 8am Monday – Friday Executive Group	Quality Assurance Committee and Trust Board				**4 x 4 = 16 High**	**2 x 2 = 4 Very Low**	Partial

Meeting of the Public Board
Thursday, 14 January 2021

Title of Report	Corporate Risk Register	**Agenda Item**	4.4
Report Author	Gurjit Mahil, Deputy Chief Executive Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		

Executive Summary

A summary of the Corporate risk register as of 10 December 2020 is presented in this paper.

The current Corporate Risk Register format is that of themed significant risks, with links to Trust wide risks scoring 15 or above.

The Trust's principle risks are:

Risk	Target Score	Initial Score	Nov-20	Actions Taken
Covid 19	4	16	**20**	The risk relates to the reduced ability to manage the day to day activity within the Trust. Actions are in place through the strategic command processes to manage wave 2 and planning for wave 3.
Delivery of CIP	6	15	**16**	Focus on the red schemes to ensure all the appropriate checks have been taken place in order to ensure delivery.
Mental Health Pathways	4	16	**16**	The Trust has clear actions in place for this patient group. Performance and processes are given oversight in the Local Accident and Emergency Delivery Board (LAEDB) with system partners.
NKPS	4	16	**16**	Processes and escalations have been updated and the Trust is currently reviewing the performance before any further changes are applied to the score.
Management and Control of Secure Areas and COSHH	2	16	**16**	Sensors and dispensers have been placed in appropriate areas. COSHH audits continue to take place. Once results are maintained then the score will be reduced.

Committees or Groups at which the paper has been submitted	Risk Assurance Group.
Resource Implications	N/A

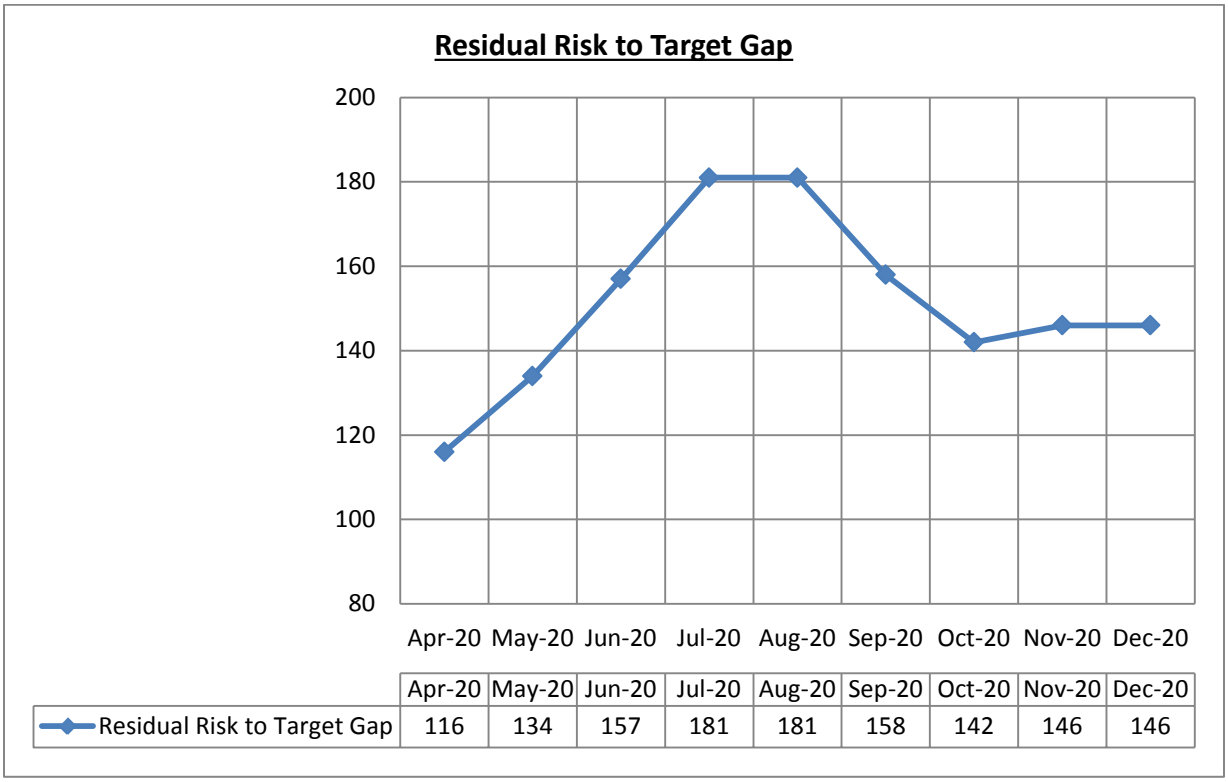
Legal Implications/Regulatory Requirements	The Executive is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation.			
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to NOTE the report for assurance regarding the processes in place around risk management.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒

1 Corporate Risk Register

1.1 There are a total of 20 overall risks on the risk register with 89 linked divisional risks scoring 16 and above (table 2.1).

Risk Domain	Risk	Risk Owner	Target Score	Initial Score	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Patient Safety	Safe Medical Staffing	Chief Medical Officer	4	12	8	8	8	8	8	8	8	8	8
	Fire Safety Risks	Director of Estates and Facilities	4	15	15	15	15	15	15	15	15	15	15
	Lift Availability	Director of Estates and Facilities	4	16	12	12	12	12	12	12	12	12	12
	Un-investigated Open Datix	Chief Nursing and Quality Officer	4	16	-	12	12	12	12	6	6	6	6
	Weekend Mortality	Chief Medical Officer	4	15	15	15	15	15	15	15	12	12	12
	IPC Compliance	Chief Medical Officer	4	16	16	16	16	16	16	9	9	9	9
	Mental Health Pathways	Chief Operating Officer	4	16	16	16	16	16	16	16	16	16	16
	Covid 19	Chief Operating Officer	4	16	16	16	16	16	16	16	16	20	20
	eDNs	Chief Medical Officer	4	12	12	15	15	15	15	15	6	6	6
Quality / Audit	Learning from Incidents, Complaints and Claims	Chief Nursing and Quality Officer	4	12	8	8	8	9	9	9	9	9	9
	Breaching Deprivation of Liberty Safeguards Legislation	Chief Nursing and Quality Officer	4	16	9	12	12	12	12	12	12	12	12
	Management and Control of Secure Areas and COSHH	Director of Estates and Facilities	4	16	9	9	9	16	16	16	16	16	16
	Operational Performance and Delivery of Standards	Chief Operating Officer	4	16	12	12	16	16	16	16	12	12	12
Service / Business Interruption	Estates	Director of Estates and Facilities	4	16	9	9	9	9	9	6	6	6	6
	Equipment Failure	Director of Estates and Facilities	4	12	9	9	9	9	9	6	6	6	6
	Innovation and Digital Technology	Director of Transformation and IT	9	16	12	12	12	12	12	12	12	12	12
	NKPS	Chief Operating Officer	4	16	-	-	16	16	16	16	16	16	16
Finance	CIP	Chief Finance Officer	6	15	9	9	12	12	12	16	16	16	16
Fire / Safety / Security	ED Staff Security	Director of Estates and Facilities	4	16	16	16	16	16	16	12	12	12	12
Corporate Compliance / Audit / Governance	CQC compliance	Chief Nursing and Quality Officer	4	16	-	-	-	16	16	12	12	12	12
	Total Risk Score		**87**	301	203	221	244	268	268	245	229	233	233
	Residual Risk to Target Gap			**214**	**116**	**134**	**157**	**181**	**183**	**158**	**142**	**146**	**146**

Table 2.1 – Summary of Corporate Risk Register



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Residual Risk to Target Gap	116	134	157	181	181	158	142	146	146

1.2

Figure 2.2: Residual risk to target gap

1.3 Figure 2.2 (below), shows the residual risk to target score gap. The target score is based on the trigger levels for each of the risk domains and the residual risk is based on the gap between the residual risk score and the target score.

1.4 The increase in the residual gap between April and June was due to the addition of 3 risks over that period of time.

1.5 Table 2.3 (below), shows the current actions being taken and the monitoring processes in place for each of the corporate risks.

Risk Domain	Risk	Risk Owner	Target Score	Dec-20	Actions Taken
Patient Safety	**Safe Medical Staffing**	Chief Medical Officer	4	8	Known risk with the Deanery in terms of number of junior doctors allocated to the Trust and the clinical services. Early engagement processes in place to identify gaps in services
	Fire Safety Risks	Director of Estates and Facilities	4	15	Fire Safety Programme in place. Large amount of estates work has been completed and action plan to be monitored through the Fire Capital Programme Board.
	Lift Availability	Director of Estates and Facilities	4	12	Clear actions in place to replace key lifts and installation of new lifts. Managed through the Fire Safety Programme.
	Un-investigated Open Datix	Chief Nursing and Quality Officer	4	6	Sustained reduction in number of backlog incidents with support from the central team.
	Weekend Mortality	Chief Medical Officer	4	12	Weekend consultant model has been reviewed, additional on-site consultants in place to cover weekend sessions in key pathways. This risk is reviewed in Quality Assurance Committee.
	IPC Compliance	Chief Medical Officer	4	9	IPC Action plan in place and outcomes being monitored with support from the regional team.
	Mental Health Pathways	Chief Operating Officer	4	16	The Trust has clear actions in place for this patient group. Performance and processes are given oversight in the Local Accident and Emergency Delivery Board (LAEDB) with system partners.
	Covid 19	Chief Operating Officer	4	20	The risk relates to the reduced ability to manage the day to day activity within the Trust. Actions are in place through the strategic command processes to manage wave 2 and planning for wave 3.
	eDNs	Chief Medical Officer	4	6	Clinical teams are currently using an amended template to complete eDNs. Performance is being reviewed – current December figures show a compliance of 71% completed within 24 hours of discharge and 73% being completed within 48 hours of discharge. Managed through the PRM process.
Quality / Audit	**Learning from Incidents, Complaints and Claims**	Chief Nursing and Quality Officer	4	9	Complaints process completed, results and actions to be determined. Systems being reviewed in order to ensure triangulation of all information.
	Breaching Deprivation of Liberty Safeguards Legislation	Chief Nursing and Quality Officer	4	12	Working with system partners to ensure appropriate pathways are in place, further work is required by the Local Authority in order to improve the process time of the referrals.
	Management and Control of Secure Areas and COSHH	Director of Estates and Facilities	4	16	Sensors and dispensers have been placed in appropriate areas. COSHH audits continue to take place. Once results are maintained then the score will be reduced.
	Operational Performance and Delivery of Standards	Chief Operating Officer	4	12	Restore and recover plans are being reviewed in light of wave 2 and a potential wave 3.
Service / Business Interruption	**Estates**	Director of Estates and Facilities	4	6	Backlog is being managed through the capital programme and investments have been made.
	Equipment Failure	Director of Estates and Facilities	4	6	Failure rates are within normal range, some areas of investment required; this is being managed through the Capital Group and the Business Case Review Group.

	Innovation and Digital Technology	Director of Transformation and IT	9	12	Work has been completed in the development of the Digital Strategy which indicates milestones for key IT projects. EPR business case approved.
	NKPS	Chief Operating Officer	4	16	Processes and escalations have been updated and the Trust is currently reviewing the performance before any further changes are applied to the score
Finance	**CIP**	Chief Finance Officer	6	16	Focus on the red schemes to ensure all the appropriate checks have been taken place in order to ensure delivery.
Fire / Safety / Security	**ED Staff Security**	Director of Estates and Facilities	4	12	Analysis has shown a decrease in incidents. Training and monitoring in place.
Corporate Compliance / Audit / Governance	**CQC compliance**	Chief Nursing and Quality Officer	4	12	Framework for monitoring actions in place.

Table 2.3 – Corporate risk register review

2 Next Steps

2.1 Going forward all linked risks on the corporate risk register will be unlinked in order to ensure all risks scored 16+ are visible.

2.2 Risks going forward will be dynamically moved between risk registers dependent on grading:

2.2.1 Very low and Low (1-4, 5-8) risks to be managed locally on care group risk registers.

2.2.2 Moderate (9-15) risks to be managed at divisional level.

2.2.3 High risks (16+) to be managed at corporate level.

2.3 All closed risks will be reviewed every six months.

2.4 All risks with no movement will be reviewed every 4 months.

2.5 The target scores for each domain and therefore each risk will be updated after the approval of the Corporate Risk Management Strategy Policy and Risk Appetite. If approved this will bring the total target risk score to 110, total risk score of 233 and a residual gap of 123.

2.6 The above changes will be governed through the Risk Assurance Group via the Corporate Risk Management Policy and Strategy.

2.7 Risk reports will be aligned on Risk Assure to manage the above.

Meeting of the Board of Directors in Public
Thursday, 14 January 2021

Title of Report	**Finance Report – Month 8**	**Agenda Item**	5.1
Report Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Finance Officer		
Executive Summary	The Trust reports a deficit of £8k in month and £77k year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 1 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Tuesday, 22 December 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.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report – Month 8		

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Finance report

For the period ending 30 November 2020

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month (NHSE/I)	-	-	-	The Trust reports a £8k deficit position for November; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. In-month due to higher clinical supplies costs, £0.3m of the contingency has be released into the position.
YTD (NHSE/I*)	-	-	-	
In-month (budget)	(4,102)	(8)	4,094	
YTD (budget)	(10,324)	(77)	10,2473	
Forecast	-	-	-	

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

£'m	
Covid spend	**1.1**
Base overspend	**0.3**
Covid Income	**(1.1)**
Non-recurrent adjustments	**(0.3)**
Reported against control total	**0.0**

CIP				
In-month	1,119	908	(211)	Schemes delivered so far in the year mainly relate to the full year effect of schemes from 19/20, efficient use of theatres, reduced orthopaedic insourcing, as well procurement and pharmacy savings from nationally agreed prices. Year to date performance reports an over achievement against plan due to timing differences of schemes delivered. The forecast position of actual delivery has been updated with the scheme owners identifying £9.0m of the £12m plan; this is a decrease of £1.3m from prior month as non-CIP underspends previously included in the forecast have now been removed, leaving only schemes implemented as a result of change or control over cost as efficiencies.
YTD	4,457	5,455	998	
Forecast	12,000	9,001	(2,999)	
Capital				
In-month	1,671	2,481	760	The 2020/21 capital plan is includes £24.4m STP capital allocation plus additional business cases and COVID. The Trust has agreed with the STP to underspend against plan by £1.3m so monies can be reallocated to priority schemes in other Trusts which have not received CIF funding. There is a risk of £3.1m with the additional funds: **Low financial risk/moderate operational risk:** UTC business case (£1.1m) cannot be granted final approval until the Trust submits an NHSI compliant business case. The work will not commence until funding has been granted; **High financial risk/no operational risk:** Due to a shortfall in national funds. the Trusts' bid for Covid capital funding (£1,967k) is a significant risk. NHSE/I are nationally reviewing all bids and it is highly likely that at least 50% will not be granted causing a pressure on the current programme.
YTD	15,798	12,452	(3,482)	
Forecast	29,705	28,405	(1,300)	

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1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	38,055	45,515	7,460	The favourable variance this month relates to working balances - more cash received from debtors and less cash spent on creditors than expected. The PDC dividend that was expected to be paid in month 6 has been taken in November and at a lower than expected rate.
Activity is below draft budgeted levels as a result of Covid				Clinical income based on the consultation tariff would have reported a year to date position of £138.9m, this being £26.7m adverse to the draft budget. In month performance excluding high cost drugs is £18.6m compared to a M1 to M7 average of £17.2m, higher by £1.4m.
Pay costs are higher than expected				Total pay costs have remained consistent in month with a small reduction of £0.1m, to £18.9m. There has been an increase in staff sickness and those self-isolating, although the availability of temporary staff reduced resulting in unfilled shifts and no substantial increase in costs. The position is adverse to budget by £1.0m, of this £0.7m is due to incremental Covid costs, the remainder is predominantly a consequence of non-achievement of CIP plans where budget has been removed from the divisions.

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

£'000	In-month			Year-to-date*		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	26,973	31,104	4,131	175,939	173,241	(2,698)
High cost drugs	1,613	1,847	234	14,479	15,109	629
Other income	1,471	1,752	282	14,833	13,228	(1,605)
Top-up income	0	(4,419)	(4,419)	26,502	26,522	20
True-up income	0	0	0	0	9,690	9,690
Total income	**30,057**	**30,284**	**227**	**231,754**	**237,790**	**6,037**
Nursing	(7,855)	(7,632)	223	(51,129)	(59,975)	(8,846)
Medical	(6,221)	(5,994)	227	(46,243)	(49,279)	(3,035)
Other	(5,256)	(5,321)	(65)	(50,379)	(42,075)	8,304
Total pay	**(19,332)**	**(18,947)**	**385**	**(147,750)**	**(151,328)**	**(3,578)**
Clinical supplies	(3,399)	(4,352)	(953)	(29,431)	(28,916)	515
Drugs	(553)	(615)	(61)	(5,312)	(4,057)	1,255
High cost drugs	(1,613)	(1,886)	(272)	(14,778)	(15,152)	(373)
Other	(3,786)	(3,129)	657	(23,713)	(27,429)	(3,716)
Total non-pay	**(9,351)**	**(9,981)**	**(630)**	**(73,234)**	**(75,553)**	**(2,319)**
EBITDA	**1,374**	**1,356**	**(18)**	**10,769**	**10,909**	**140**
Depreciation	(829)	(827)	2	(6,664)	(6,622)	42
Net finance income/(cost)	(2)	9	11	230	(24)	(254)
PDC dividend	(542)	(546)	(4)	(4,336)	(4,340)	(4)
Non-operating exp.	**(1,374)**	**(1,364)**	**9**	**(10,769)**	**(10,986)**	**(216)**
Reported surplus/(deficit)	**-**	**(8)**	**(8)**	**-**	**(77)**	**(77)**
Adj. to control total	-	8	8	-	77	77
Control total	**-**	**-**	**-**	**-**	**-**	**-**

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

Key messages:

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

2. The Trust continues to invoice other provider organisations in Kent using the same methodology applied by NHSE/I in calculating their baseline.

3. The top-up and months 1-6 true-up income are reported under "FRF/MRET" income in the table on the following page. The October Top-Up income has been transferred to the clinical income category this month and will continue to be reported here for the remainder of the year.

4. Total expenditure includes the incremental cost of Covid-19, being £1.1m in-month; £0.7m of this is reported in pay and £0.4m in non-pay (£6.1m and £4.0m YTD respectively). The total spend has not be highlighted as extraordinary compared to other providers within the STP by NHSE/I.

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2. Income and expenditure (reporting against draft budget)

£'000	In-month			Year-to-date		
	Budget	Actual	Var.	Budget	Actual	Var.
Clinical income	20,732	31,104	10,372	167,676	173,241	5,565
High cost drugs	1,919	1,847	(72)	15,518	15,109	(409)
Other income	2,159	1,752	(407)	16,940	13,228	(3,711)
FRF/MRET	769	(4,419)	(5,188)	29,828	36,212	6,384
Total income	**25,579**	**30,284**	**4,705**	**229,962**	**237,791**	**7,829**
Nursing	(7,479)	(7,632)	(153)	(59,013)	(59,975)	(961)
Medical	(5,584)	(5,994)	(410)	(44,641)	(49,278)	(4,637)
Other	(4,906)	(5,321)	(415)	(40,830)	(42,075)	(1,244)
Total pay	**(17,969)**	**(18,947)**	**(978)**	**(144,485)**	**(151,328)**	**(6,843)**
Clinical supplies	(3,780)	(4,352)	(572)	(30,571)	(28,916)	1,655
Drugs	(667)	(615)	53	(5,398)	(4,057)	1,341
High cost drugs	(1,942)	(1,886)	56	(15,704)	(15,152)	553
Other	(3,783)	(3,129)	654	(31,807)	(27,430)	4,377
Total non-pay	**(10,172)**	**(9,981)**	**191**	**(83,481)**	**(75,555)**	**7,926**
EBITDA	**(2,562)**	**1,356**	**3,918**	**1,996**	**10,908**	**8,912**
Depreciation	(958)	(827)	131	(7,666)	(6,622)	1,044
Net finance income/(cost)	(39)	9	48	(315)	(24)	291
PDC dividend	(543)	(546)	(4)	(4,340)	(4,340)	-
Non-operating exp.	**(1,540)**	**(1,364)**	**176**	**(12,320)**	**(10,985)**	**1,335**
Reported surplus/(deficit)	**(4,102)**	**(8)**	**4,094**	**(10,324)**	**(77)**	**10,247**

Key messages:

1. The Trust continues to maintain internal budgets for probity. Divisions, care groups, specialties and cost centres are being monitored against their agreed expenditure budget but not against income during the period of nationally executed contracting.

2. If income had been earned on a cost and volume basis (based on consultation tariff), excluding HCD the Trust would have reported clinical income of £18.6m in month; this is £1.4m higher than the monthly average for the first 7 months and 9% underperformance to plan in month.

3. Total expenditure includes the incremental cost of Covid, this being £1.1m in month and £10.1m year to date.

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

£'000	In-month								
	Income			Expenditure			Contribution		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
UIC									
Diagnostics & Clinical Support	1,614	2,136	522	(4,355)	(4,517)	(162)	(2,741)	(2,381)	360
Specialist Medicine	147	(171)	(318)	(1,921)	(2,110)	(189)	(1,774)	(2,280)	(507)
Therapies & Older Persons	5	4	(0)	(1,425)	(1,371)	54	(1,420)	(1,366)	54
Unplanned & Integrated Care	52	20	(32)	(1,154)	(1,035)	118	(1,102)	(1,016)	86
Urgent & Emergency Care	43	30	(13)	(2,275)	(2,259)	16	(2,232)	(2,229)	3
Sub-total	**1,861**	**2,019**	**158**	**(11,130)**	**(11,291)**	**(161)**	**(9,269)**	**(9,272)**	**(3)**
Planned care									
Cancer Services	408	386	(22)	(886)	(872)	15	(479)	(486)	(7)
Critical Care & Perioperative	43	57	14	(3,069)	(3,151)	(82)	(3,026)	(3,094)	(69)
Planned Care Infrastructure	-	-	-	(147)	(220)	(73)	(147)	(220)	(73)
Surgical Services	100	81	(19)	(2,770)	(2,981)	(211)	(2,670)	(2,900)	(229)
Women & Children	111	(5)	(116)	(3,257)	(3,328)	(72)	(3,146)	(3,334)	(188)
Sub-total	**661**	**518**	**(143)**	**(10,129)**	**(10,551)**	**(423)**	**(9,468)**	**(10,033)**	**(566)**
Corporate									
Communications	2	2	-	(40)	(33)	7	(39)	(31)	7
Finance	1	1	0	(214)	(266)	(52)	(213)	(265)	(52)
HR & OD	109	130	22	(362)	(377)	(15)	(253)	(246)	7
IT	2	2	-	(411)	(360)	51	(410)	(358)	51
Medical Director	849	906	57	(478)	(488)	(10)	370	418	47
Medway Innovation Institute	-	-	-	-	(3)	(3)	-	(3)	(3)
Nursing	-	3	3	(342)	(371)	(29)	(342)	(369)	(26)
Strategy, Governance & Perform	-	-	-	(239)	(266)	(27)	(239)	(266)	(27)
Transformation	-	-	-	(84)	(46)	38	(84)	(46)	38
Trust Executive & Board	-	-	-	(273)	(291)	(18)	(273)	(291)	(18)
Sub-total	**962**	**1,044**	**81**	**(2,444)**	**(2,501)**	**(56)**	**(1,482)**	**(1,457)**	**25**
E&F									
E&F	**274**	**252**	**(22)**	**(2,074)**	**(2,177)**	**(103)**	**(1,800)**	**(1,925)**	**(124)**
Central									
Central	**26,299**	**26,451**	**152**	**(4,280)**	**(3,772)**	**508**	**22,019**	**22,679**	**660**
TOTAL	**30,057**	**30,284**	**227**	**(30,057)**	**(30,292)**	**(235)**	**-**	**(8)**	**(8)**
Donated Asset Adjustment			**-**		**8**	**8**	**-**	**8**	**8**
Control total	**30,057**	**30,284**	**227**	**(30,057)**	**(30,284)**	**(227)**	**-**	**-**	**-**

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

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

£'000	Year to date									YTD contribution variance	
	Income			Expenditure			Contribution				
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.	M1-6	M7-12
UIC											
Diagnostics & Clinical Support	12,697	13,579	882	(34,295)	(34,271)	23	(21,598)	(20,693)	905	(298)	1,204
Specialist Medicine	2,071	1,157	(914)	(17,406)	(16,134)	1,272	(15,334)	(14,976)	358	967	(609)
Therapies & Older Persons	29	49	20	(11,628)	(11,249)	379	(11,599)	(11,200)	399	326	73
Unplanned & Integrated Care	776	370	(406)	(9,054)	(8,492)	562	(8,278)	(8,121)	156	111	45
Urgent & Emergency Care	532	337	(195)	(17,922)	(17,677)	245	(17,390)	(17,340)	50	100	(50)
Sub-total	**16,104**	**15,492**	**(613)**	**(90,303)**	**(87,823)**	**2,481**	**(74,199)**	**(72,331)**	**1,868**	**1,205**	**663**
Planned care											
Cancer Services	2,933	3,190	256	(6,794)	(7,036)	(242)	(3,861)	(3,847)	14	94	(80)
Critical Care & Perioperative	1,064	-	(1,064)	(25,077)	(1,530)	23,547	(24,013)	(1,530)	22,483	16,961	5,522
Planned Care Infrastructure	338	697	359	(18,854)	(22,243)	(3,388)	(18,517)	(21,546)	(3,029)	2,463	(5,492)
Surgical Services	199	358	159	(6,800)	(23,939)	(17,140)	(6,600)	(23,582)	(16,981)	(16,011)	(970)
Women & Children	630	570	(61)	(24,693)	(25,874)	(1,181)	(24,063)	(25,304)	(1,241)	(1,045)	(196)
Sub-total	**5,165**	**4,814**	**(351)**	**(82,218)**	**(80,623)**	**1,595**	**(77,054)**	**(75,809)**	**1,245**	**2,461**	**(1,217)**
Corporate											
Communications	4	14	11	(307)	(339)	(33)	(303)	(325)	(22)	(26)	4
Finance	28	19	(8)	(2,152)	(2,017)	136	(2,125)	(1,997)	127	185	(58)
HR & OD	1,011	970	(40)	(3,054)	(2,941)	113	(2,043)	(1,971)	73	70	2
IT	4	34	30	(2,690)	(2,849)	(158)	(2,687)	(2,815)	(128)	(171)	43
Medical Director	6,482	6,696	214	(3,666)	(3,665)	1	2,816	3,031	215	178	38
Medway Innovation Institute	-	-	-	-	(5)	(5)	-	(5)	(5)	-	(5)
Nursing	-	4	4	(2,576)	(2,699)	(124)	(2,576)	(2,695)	(119)	(92)	(27)
Strategy, Governance & Perform	-	-	-	(1,347)	(1,997)	(651)	(1,347)	(1,997)	(651)	31	(682)
Transformation	-	-	-	(417)	(582)	(165)	(417)	(582)	(165)	(244)	79
Trust Executive & Board	-	-	-	(2,169)	(2,214)	(45)	(2,169)	(2,214)	(45)	(10)	(35)
Sub-total	**7,528**	**7,738**	**210**	**(18,379)**	**(19,309)**	**(930)**	**(10,851)**	**(11,571)**	**(720)**	**(80)**	**(641)**
E&F											
E&F	**3,187**	**1,976**	**(1,211)**	**(15,685)**	**(15,832)**	**(147)**	**(12,498)**	**(13,856)**	**(1,358)**	**(1,516)**	**158**
Central											
Central	**199,770**	**207,771**	**8,001**	**(25,168)**	**(34,281)**	**(9,113)**	**174,602**	**173,490**	**(1,111)**	**(2,132)**	**1,020**
TOTAL	**231,754**	**237,790**	**6,037**	**(231,754)**	**(237,868)**	**(6,114)**	**-**	**(77)**	**(77)**	**(60)**	**((17))**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**77**	**77**	**-**	**77**	**77**	**60**	**17**
Control total	**231,754**	**237,790**	**6,037**	**(231,754)**	**(237,791)**	**(6,037)**	**-**	**-**	**-**	**-**	**-**

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

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2. Income and expenditure delegated budgets (draft budgets: in-month)

£'000	In-month								
	Income			Expenditure			Contribution		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
UIC									
Diagnostics & Clinical Support	3,066	2,136	(930)	(4,415)	(4,517)	(101)	(1,349)	(2,381)	(1,032)
Specialist Medicine	2,524	(171)	(2,695)	(2,163)	(2,110)	53	361	(2,280)	(2,642)
Therapies & Older Persons	785	4	(781)	(1,466)	(1,371)	95	(680)	(1,366)	(686)
Unplanned & Integrated Care	102	20	(83)	(1,151)	(1,035)	116	(1,049)	(1,016)	33
Urgent & Emergency Care	4,722	30	(4,691)	(1,980)	(2,259)	(279)	2,742	(2,229)	(4,970)
Sub-total	**11,199**	**2,019**	**(9,180)**	**(11,175)**	**(11,291)**	**(116)**	**24**	**(9,272)**	**(9,296)**
Planned care									
Cancer Services	734	386	(349)	(863)	(872)	(8)	(129)	(486)	(357)
Critical Care & Perioperative	1,061	57	(1,004)	(3,029)	(3,151)	(122)	(1,968)	(3,094)	(1,126)
Planned Care Infrastructure	150	-	(150)	(35)	(220)	(185)	115	(220)	(335)
Surgical Services	5,387	81	(5,306)	(2,910)	(2,981)	(71)	2,477	(2,900)	(5,377)
Women & Children	5,061	(5)	(5,066)	(3,194)	(3,328)	(134)	1,866	(3,334)	(5,200)
Sub-total	**12,392**	**518**	**(11,875)**	**(10,031)**	**(10,551)**	**(520)**	**2,362**	**(10,033)**	**(12,395)**
Corporate									
Communications	14	2	(12)	(57)	(33)	24	(43)	(31)	12
Finance	-	1	1	(234)	(266)	(33)	(234)	(265)	(31)
HR & OD	148	130	(18)	(398)	(377)	22	(250)	(246)	4
IT	-	2	2	(352)	(360)	(8)	(352)	(358)	(6)
Medical Director	827	906	78	(484)	(488)	(4)	343	418	75
Medway Innovation Institute	-	-	-	(3)	(3)	(0)	(3)	(3)	(0)
Nursing	0	3	2	(327)	(371)	(44)	(326)	(369)	(42)
Strategy, Governance & Perform	0	-	(0)	(243)	(266)	(23)	(243)	(266)	(23)
Transformation	-	-	-	(62)	(46)	16	(62)	(46)	16
Trust Executive & Board	-	-	-	(254)	(291)	(36)	(254)	(291)	(36)
Sub-total	**990**	**1,044**	**54**	**(2,414)**	**(2,501)**	**(86)**	**(1,424)**	**(1,457)**	**(33)**
E&F									
E&F	**371**	**252**	**(119)**	**(2,086)**	**(2,177)**	**(91)**	**(1,714)**	**(1,925)**	**(210)**
Central									
Central	**627**	**26,451**	**25,825**	**(3,976)**	**(3,772)**	**203**	**(3,349)**	**22,679**	**26,028**
TOTAL	**25,579**	**30,284**	**4,705**	**(29,681)**	**(30,292)**	**(611)**	**(4,102)**	**(8)**	**4,094**

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

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

Annual plan				Year to date								
				Income			Expenditure			Contribution		
Income	Exp.	Contr.	£'000	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
			UIC									
37,078	(53,197)	(16,118)	Diagnostics & Clinical Support	24,771	13,579	(11,192)	(35,485)	(34,271)	1,214	(10,714)	(20,693)	(9,978)
30,542	(26,313)	4,228	Specialist Medicine	20,408	1,157	(19,250)	(17,659)	(16,134)	1,526	2,748	(14,976)	(17,725)
9,505	(17,484)	(7,979)	Therapies & Older Persons	6,352	49	(6,303)	(11,621)	(11,249)	372	(5,269)	(11,200)	(5,931)
1,237	(11,366)	(10,129)	Unplanned & Integrated Care	826	370	(456)	(7,583)	(8,492)	(909)	(6,756)	(8,121)	(1,365)
57,144	(25,997)	31,147	Urgent & Emergency Care	38,184	337	(37,847)	(17,263)	(17,677)	(415)	20,921	(17,340)	(38,262)
135,505	**(134,357)**	**1,148**	**Sub-total**	**90,541**	**15,492**	**(75,049)**	**(89,611)**	**(87,823)**	**1,788**	**929**	**(72,331)**	**(73,260)**
			Planned care									
8,884	(10,380)	(1,496)	Cancer Services	5,937	3,190	(2,747)	(6,920)	(7,036)	(116)	(983)	(3,847)	(2,863)
12,837	(36,485)	(23,648)	Critical Care & Perioperative	1,200	-	(1,200)	(1,377)	(1,530)	(154)	(177)	(1,530)	(1,354)
1,800	(866)	934	Planned Care Infrastructure	43,562	697	(42,865)	(23,765)	(22,243)	1,522	19,797	(21,546)	(41,343)
65,191	(35,407)	29,784	Surgical Services	8,577	358	(8,219)	(24,354)	(23,939)	414	(15,777)	(23,582)	(7,805)
61,242	(38,098)	23,144	Women & Children	40,921	570	(40,352)	(25,314)	(25,874)	(560)	15,607	(25,304)	(40,912)
149,955	**(121,237)**	**28,718**	**Sub-total**	**100,197**	**4,814**	**(95,383)**	**(81,729)**	**(80,623)**	**1,106**	**18,468**	**(75,809)**	**(94,276)**
			Corporate									
21	(499)	(478)	Communications	14	14	-	(350)	(339)	11	(336)	(325)	11
4	(2,957)	(2,953)	Finance	4	19	15	(2,022)	(2,017)	6	(2,018)	(1,997)	21
1,778	(4,787)	(3,009)	HR & OD	1,186	970	(215)	(3,187)	(2,941)	245	(2,001)	(1,971)	30
-	(4,198)	(4,198)	IT	-	34	34	(2,805)	(2,849)	(43)	(2,805)	(2,815)	(10)
9,930	(5,825)	4,105	Medical Director	6,620	6,696	76	(3,887)	(3,665)	222	2,732	3,031	298
-	(5)	(5)	Medway Innovation Institute	-	-	-	(5)	(5)	(0)	(5)	(5)	(0)
4	(3,922)	(3,918)	Nursing	3	4	1	(2,616)	(2,699)	(84)	(2,613)	(2,695)	(82)
0	(2,921)	(2,921)	Strategy, Governance & Perform	0	-	(0)	(1,947)	(1,997)	(50)	(1,947)	(1,997)	(50)
-	(844)	(844)	Transformation	-	-	-	(620)	(582)	38	(620)	(582)	38
-	(3,062)	(3,062)	Trust Executive & Board	-	-	-	(2,044)	(2,214)	(170)	(2,044)	(2,214)	(170)
11,737	**(29,021)**	**(17,283)**	**Sub-total**	**7,827**	**7,738**	**(89)**	**(19,484)**	**(19,309)**	**175**	**(11,657)**	**(11,571)**	**86**
			E&F									
5,238	**(25,055)**	**(19,817)**	**E&F**	**3,491**	**1,976**	**(1,514)**	**(16,234)**	**(15,832)**	**402**	**(12,744)**	**(13,856)**	**(1,112)**
			Central									
54,112	**(46,877)**	**7,235**	**Central**	**27,908**	**207,771**	**179,864**	**(33,228)**	**(34,281)**	**(1,053)**	**(5,320)**	**173,490**	**178,811**
356,547	**(356,547)**	**-**	**TOTAL**	**229,962**	**237,791**	**7,829**	**(240,286)**	**(237,868)**	**2,418**	**(10,324)**	**(77)**	**10,247**

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

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3. Forecast

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

- The plan for October to March submitted to the STP identified a £36.9m deficit.
- These plans were finalised and agreed funding at an STP level to cover the deficit.
- Positive confirmed Covid cases continue to rise across the Trust; this has required services to react to the increasing pressure. The Executive Team has undertaken a number of ward reconfigurations as well as a pause on all elective surgery; these changes create an amount of uncertainty in the forecast plan.
- For the period of October to March, £7.6m of funding to cover incremental Covid costs has been approved. Of this, £1.7m has been required from October to November, this being £0.7m within the agreed allocation to date.
- The forecast position has been updated using the November financial position. The Trust continues to forecast compliance with our control total, this is summarised in the following table.

Summary Forecast Oct-Mar £'m	Oct'20	Nov'20	Forecast Dec-Mar	Total Forecast Oct-Mar
Income	29.0	30.3	120.3	179.6
Pay	(19.0)	(18.9)	(76.6)	(114.6)
Non-pay	(8.6)	(10.0)	(38.3)	(56.9)
EBITDA	(1.4)	(1.4)	(5.5)	(8.2)
Surplus/Deficit	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**

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.

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4. CIP (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Gap	Mitigated target	Gap
Planned care	446	2,191	359	9	3,005	**4,682**	(1,677)	**5,100**	(2,095)
UIC	500	2,153	15	255	2,924	**4,253**	(1,329)	**5,505**	(2,581)
E&F	-	591	211	-	801	**661**	140	**800**	1
Corporate	507	184	91	66	980	**1,113**	(133)	**1,709**	(729)
Procurement	1,291	-	-	-	1,291	**1,291**	0	**1,291**	0
Total	**2,877**	**5,119**	**676**	**330**	**9,001**	**12,000**	**(2,999)**	**14,405**	**(5,404)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**1,119**	**908**	**(211)**	**4,457**	**5,455**	**998**	**12,000**	**9,001**	**(2,999)**

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 works 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 the Director of Improvement monitor and work with budget-holders to achieve targets.

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

At the end of November, the total forecast CIP delivery totalled £9.0m, this leaves a gap of £3.0m to the original CIP Plan as some savings programmes continue to encounter delays due to the operational pressures experienced across the Trust.

General underspends against budgets are not categorised as CIP schemes and have been removed from the total. Only those schemes as a result of cost control or improved efficiency are included.

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 £5.5m and is favourable to plan by £1.0m, this being a timing difference as schemes have been implemented earlier than originally expected. The main efficiencies have been achieved from the full year effect of 19/20 schemes for agency rate reductions, as well as lean use of theatres and procurement and pharmacy national pricing measures exceeding the original plan £0.5m.

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5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,791	**Non-current assets**	**211,724**	**211,023**	**(701)**
6,307	Inventory	7,400	6,223	(1,177)
36,686	Trade and other receivables	22,500	23,088	588
12,385	Cash	38,055	56,001	17,946
55,378	**Current assets**	**67,955**	**85,312**	**17,357**
(292,111)	Borrowings	(77)	(4)	73
(24,478)	Trade and other payables	(19,000)	(26,846)	(7,846)
(4,519)	Other liabilities	(30,573)	(39,472)	(8,899)
(321,108)	**Current liabilities**	**(49,650)**	**(66,323)**	**(16,673)**
(2,278)	Borrowings	(2,278)	(2,278)	-
(1,317)	Other liabilities	(1,317)	(1,317)	-
(3,595)	**Non-current liabilities**	**(3,595)**	**(3,595)**	**-**
(64,534)	**Net assets employed**	**226,434**	**226,418**	**(26)**
140,581	Public dividend capital	431,609	431,610	1
(246,481)	Retained earnings	(246,541)	(246,558)	(17)
41,366	Revaluation reserve	41,336	41,366	-
(64,534)	**Total taxpayers' equity**	**226,434**	**226,418**	**(16)**

Key messages:

1. Current net assets are £226.4m which is material change from the prior year when the Trust operated with net liabilities due to the level of deficit support borrowings withdrawn over a number of years.
   As highlighted in previous reports this is due to a national initiative which converted borrowings to PDC (funding).
   Whilst this is a positive move in the financial position of the Trust it does have an I&E impact as interest on borrowings was significantly less than the 3.5% dividend now payable on 'relevant net assets'.

2. Payables are £7.8m adverse to plan due to increases in expenditure accruals which includes PDC dividends payable.

3. Other Liabilities are £8.9m adverse to plan due to additional cash advances from Commissioners.

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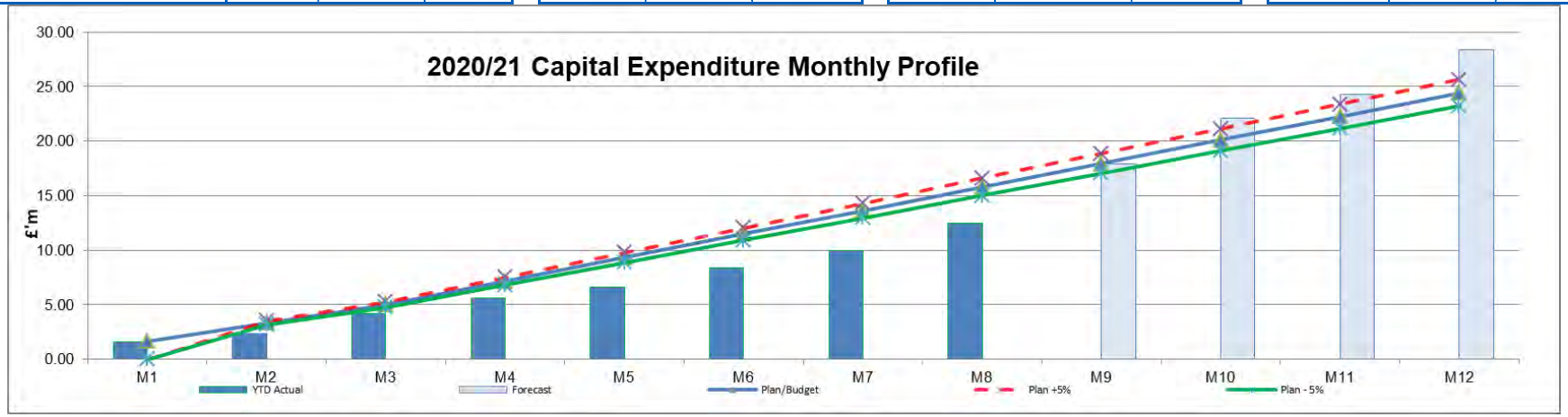
6. Capital

£'000	In-month			Year To Date			Annual			Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	230	448	(218)	3,465	3,170	295	5,671	5,671	0	690	0	4,981
Routine Maintenance	87	122	(35)	696	680	16	1,046	1,046	0	691	0	355
Fire Safety	476	1,251	(775)	3,808	3,759	49	5,720	5,720	0	366	4,252	1,102
IT	228	296	(68)	1,824	798	1,026	2,730	2,730	0	2,730	0	0
New Build - Inc ED	320	(0)	320	3,365	30	3,335	5,283	5,283	0	835	3,000	1,448
Plant & Equipment	330	278	52	2,640	1,923	717	3,964	2,664	(1,300)	3,964	0	0
Total Planned Capex	**1,671**	**2,394**	**(723)**	**15,798**	**10,359**	**5,439**	**24,414**	**23,114**	**(1,300)**	**9,276**	**7,252**	**7,886**
COVID*	0	37	(37)	0	1,957	(1,957)	1,967	1,967	0	0	1,967	0
IT MOU	0	4	0	0	82	0	190	190	0	0	190	0
A&E MOU	0	0	0	0	0	0	857	857	0	0	857	0
Diagnostic equipment MOU	0	0	0	0	0	0	1,173	1,173	0	0	1,173	0
UTC MOU	0	46	0	0	54	0	1,104	1,104	0	0	1,104	0
Total Additional Capex	**0**	**87**	**(37)**	**0**	**2,093**	**(1,957)**	**5,291**	**5,291**	**0**	**0**	**5,291**	**0**
Total Capex	**1,671**	**2,481**	**(760)**	**15,798**	**12,452**	**3,482**	**29,705**	**28,405**	**(1,300)**	**9,276**	**12,543**	**7,886**



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6. Capital (continued)

Capital expenditure consists of:

• Planned YTD expenditure of £10.36m, with actual expenditure £5.44m behind plan. £1.3m is planned underspend relating to an STP agreement for priority projects across the region. Excluding this the plan is £4.14m (26%) behind plan
All programmes are currently behind plan, although IT and ED account for the material underspends. Work on the ED project has been affected by COVID working restrictions and resource shortages but is now picking up .IT schemes are planned to accelerate in the next quarter. A recent scheme by scheme undertaken by programme leads forecasts all projects accelerating in the coming months and delivering on plan by 31st March.

• £1.96m of unplanned YTD expenditure in relation to COVID schemes, of which only £0.16m has approved funding to date. Bids totalling £1.81m have been submitted to NHSI to fund the remaining projects, which are already committed and have incurred expenditure. The Trust has been advised of a national shortfall in funding which puts this funding at risk. If this funding is not approved these schemes are currently unfunded and will need to be resourced from within the original £24.4m capital resource limit (CRL).

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

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7. Cash

Cash Flow, 12 months ahead

	Actual								Forecast										
£m	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
BANK BALANCE B/FWD	**12.37**	**37.57**	**47.46**	**43.44**	**50.09**	**50.33**	**55.09**	**45.45**	**55.94**	**52.02**	**46.71**	**41.79**	**22.02**	**56.19**	**56.35**	**54.06**	**60.24**	**56.83**	**50.25**
Receipts																			
NHS Contract Income	45.11	22.70	24.52	22.99	22.28	22.09	22.28	22.74	22.36	22.35	22.35	0.20	53.95	27.12	28.94	26.94	26.94	26.94	26.94
NHS Top Up	8.84	6.28	2.39	10.15	6.01	5.62	0.92	17.17	3.58	5.72	5.72	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	4.66	1.56	1.53	3.65	2.39	1.95	4.37	1.51	4.39	1.64	1.64	4.58	4.23	1.46	1.30	4.52	1.69	1.75	4.46
Total receipts	**58.61**	**30.54**	**28.44**	**36.79**	**30.68**	**29.66**	**27.57**	**41.42**	**30.33**	**29.71**	**29.71**	**4.78**	**58.18**	**28.58**	**30.24**	**31.46**	**28.63**	**28.69**	**31.40**
Payments																			
Pay Expenditure (excl. Agency)	(18.79)	(18.57)	(18.58)	(18.76)	(18.16)	(13.64)	(23.53)	(18.40)	(19.05)	(19.13)	(18.74)	(18.83)	(19.68)	(19.05)	(18.91)	(19.54)	(18.90)	(18.87)	(19.45)
Non Pay Expenditure	(11.35)	(8.41)	(12.44)	(9.72)	(11.28)	(9.29)	(11.26)	(10.52)	(13.37)	(14.16)	(14.16)	(18.14)	(13.36)	(8.37)	(12.70)	(14.77)	(12.22)	(12.22)	(14.77)
Capital Expenditure	(3.27)	(1.08)	(1.44)	(1.69)	(0.45)	(1.55)	(2.42)	(1.17)	(1.83)	(1.73)	(1.73)	(1.50)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)
Total payments	**(33.41)**	**(28.06)**	**(32.46)**	**(30.17)**	**(29.89)**	**(24.48)**	**(37.21)**	**(30.09)**	**(34.25)**	**(35.02)**	**(34.63)**	**(38.47)**	**(33.96)**	**(28.34)**	**(32.53)**	**(35.23)**	**(32.04)**	**(32.01)**	**(35.14)**
Net Receipts/ (Payments)	**37.57**	**40.05**	**43.44**	**50.06**	**50.88**	**55.51**	**45.45**	**56.78**	**52.02**	**46.71**	**41.79**	**8.10**	**46.24**	**56.43**	**54.06**	**50.29**	**56.83**	**53.51**	**46.51**
Funding Flows																			
DOH - FRF/Revenue Support	0.00	5.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.95	0.00	0.00	9.95	0.00	0.00	9.95
PSF	0.00	2.31	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.03	0.00	291.00	0.00	0.00	0.00	0.00	0.00	18.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	(0.08)	0.00	0.00	(0.55)	(291.42)	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	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	(0.76)	0.00	0.00	0.00	(4.38)	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00
Total Funding	**0.00**	**7.41**	**0.00**	**0.03**	**(0.55)**	**(0.42)**	**0.00**	**(0.84)**	**0.00**	**0.00**	**0.00**	**13.92**	**9.95**	**(0.08)**	**0.00**	**9.95**	**0.00**	**(3.26)**	**9.95**
BANK BALANCE C/FWD	**37.57**	**47.46**	**43.44**	**50.09**	**50.33**	**55.09**	**45.45**	**55.94**	**52.02**	**46.71**	**41.79**	**22.02**	**56.19**	**56.35**	**54.06**	**60.24**	**56.83**	**50.25**	**56.46**

13 Week Forecast w/e

	Actual					Forecast												
£m	06/11/20	13/11/20	20/11/20	27/11/20	04/12/20	11/12/20	18/12/20	25/12/20	01/01/21	08/01/21	15/01/21	22/01/21	29/01/21	05/02/21	12/02/21	19/02/21	26/02/21	05/03/21
BANK BALANCE B/FWD	**45.47**	**43.74**	**81.61**	**78.39**	**64.57**	**54.40**	**51.86**	**76.56**	**62.94**	**52.05**	**48.82**	**72.38**	**59.22**	**46.73**	**43.00**	**39.57**	**64.13**	**41.81**
Receipts																		
NHS Contract Income	0.26	39.85	0.00	0.00	0.07	0.00	26.16	0.00	0.00	0.00	28.30	0.00	0.00	0.00	0.00	28.30	0.00	0.00
Other	0.17	0.47	0.40	0.12	0.21	0.56	3.15	0.20	0.15	0.59	0.28	0.28	0.28	0.28	0.59	0.28	0.28	0.25
Total receipts	**0.43**	**40.32**	**0.40**	**0.12**	**0.28**	**0.56**	**29.30**	**0.20**	**0.15**	**0.59**	**28.57**	**0.28**	**0.28**	**0.28**	**0.59**	**28.57**	**0.28**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(0.36)	(0.37)	(0.46)	(9.51)	(8.35)	(0.40)	(0.40)	(9.67)	(7.93)	(0.70)	(0.40)	(9.67)	(8.36)	(0.40)	(0.40)	(0.40)	(17.54)	(0.40)
Non Pay Expenditure	(0.95)	(1.77)	(3.00)	(3.74)	(2.01)	(2.70)	(4.20)	(4.15)	(1.38)	(3.11)	(4.61)	(3.76)	(2.68)	(3.61)	(3.61)	(3.61)	(3.33)	(3.61)
Capital Expenditure	(0.08)	(0.30)	(0.09)	(0.70)	(0.09)	0.00	0.00	0.00	(1.73)	0.00	0.00	0.00	(1.73)	0.00	0.00	0.00	(1.73)	0.00
Total payments	**(1.39)**	**(2.44)**	**(3.54)**	**(13.94)**	**(10.45)**	**(3.10)**	**(4.60)**	**(13.82)**	**(11.04)**	**(3.81)**	**(5.01)**	**(13.43)**	**(12.77)**	**(4.01)**	**(4.01)**	**(4.01)**	**(22.60)**	**(4.01)**
Net Receipts/ (Payments)	**(0.97)**	**37.87**	**(3.14)**	**(13.82)**	**(10.17)**	**(2.54)**	**24.70**	**(13.62)**	**(10.89)**	**(3.23)**	**23.56**	**(13.16)**	**(12.49)**	**(3.74)**	**(3.43)**	**24.56**	**(22.32)**	**(3.76)**
Funding Flows																		
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	(0.08)	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	0.00
Dividend payable	(0.76)	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	**(0.76)**	**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**	**0.00**
BANK BALANCE C/FWD	**43.74**	**81.61**	**78.39**	**64.57**	**54.40**	**51.86**	**76.56**	**62.94**	**52.05**	**48.82**	**72.38**	**59.22**	**46.73**	**43.00**	**39.57**	**64.13**	**41.81**	**38.05**

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	36,023	56,000	19,977

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

- 1st instalment of PDC was taken at £0.7m, much lower than expected due to RNA calculation omitting restatement of loan conversion. £3.8m planned PDC dividend remains unpaid is not not expected to be taken until after Q4.
- £3.8m capital expenditure slippage
- £5m duplicate payment made by NHSE for October top up
- £32m of cash received in advance of costs being incurred, £10m unexpected advance

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8. Risks

Title	Description	£'000	Mitigation(s)	Lead(s)
Loss of stroke service	The Trust has agreed to transfer its stroke activity to other providers given the local issues. Current indications are that this could leave a contribution gap of up to £1.8m (FYE).	£1,325	Work with the STP is underway to validate the budgeted and actual income, expenditure and activity of the service.	Alan Davies
CIP (delivery)	The risk been updated to reflect the forecast position. There remains a gap between RAG rated CIP programmes and the draft budget requirement of £12m.	£2,999	CIP meetings continue to be held by the Director of Improvement. Return of CIP governance following pause during Covid pandemic. Increased focus to achieve total efficiency target.	Alan Davies
Staff costs	Staff costs remain high; unchecked, this could drive a need for additional CIP and/or the Trust missing its control total.	-	Deep dive paper submitted to the July Finance Committee meeting. Continued monitoring through Finance Business Partners and the Finance Committee. Financial Stability project. Grip and control checklist of actions.	Divisional Directors
Ward reconfiguration	As part of the restart planning wards will need to change at pace. The changing nature, specialty and bed bases could impact cost and efficiency.	TBC	Re-mapping of budgets and rosters is underway. Proposed increases to budgets will require a business case.	Alan Davies, Angela Gallagher
North Kent Pathology Service (NKPS)	Recharge of NKPS based upon historic information.	c.£600	Work through with Dartford & Gravesham NHS Trust to ascertain drivers of increase costs and any possible additional from the CCG or other providers.	Alan Davies
Covid capital	Monies in respect of Covid capital claims are still unapproved from NHSE/I. This is a national position.	c.£1,800	If not funded by NHSE/I this will need to be drawn from the Trust's capital allocation.	Alan Davies, Gary Lupton

The Trust has not fully utilised its Covid funding in months 7 and 8 and therefore has some mitigation against rising Covid expenditure in future months. The Trust also holds a small contingency and has built into its plans some uncommitted cost pressures that could be used to support mitigation of risks should they arise.

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9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £8k deficit in-month and £77k deficit year to date, reducing to breakeven after removing the adjustment for donated asset depreciation. This financial performance is as per the plan submitted to the Kent & Medway STP.

The year to date CIP programme delivery is £1.0m favourable; this is mainly due to the timing of schemes being delivered ahead of the plan. The total schemes identified are £10.2m of these it is that £9.0m will be delivered, this being £3.0m adverse to the target £12.0m. Across the Trust, due to pressures caused by Covid, there are some delays in delivering the planned efficiencies.

Alan Davies
Chief Financial Officer
December 2020

Meeting of the Board of Directors in Public

Thursday, 14 January 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Jo Palmer, Chair		
Date of Meeting:	Tuesday, 22 December 2020		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Paul Kimber, Deputy Chief Finance Officer		

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

Key headline	**Assurance Level (use appropriate colour code as above)**
1. BAF strategic risks The BAF scores reflected the changes proposed at the October meeting and remain appropriate.	**Amber/Green**
2. Risk register The risk register was noted and scores remain unchanged at 16. Further scrutiny will be applied following the end of Q3.	**Amber/Red**
3. Finance report The Chief Financial Officer took the Committee through the report, with the key highlights as being: • The Trust has met its control total in month 8 and year to date.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
• The Covid expenditure has increased in month to £1.1m and is offset by Covid income. It was noted that the STP allocated Covid income for months 7 and 8 has exceeded expenditure and hence is carried forward for use against potential future Covid costs. • It was noted that the Trust has also built in a small contingency into the plan for months 7-12. • The Committee noted that the CIP forecast is below the level budgeted at the start of the year; the plans for months 7-12 however were noted as aligning to the current forecasts. • The Chief Financial Officer noted that the forecast outturn position of the Trust is as per our control total; a detailed assessment will be undertaken following the month 9 results.	
4. Capital plan The Committee noted the report together with the analysis of cost overruns on Emerald ward project.	**Amber/Green**
5. Model Hospital The General Manager for general surgery presented a report which set out how the Model Hospital data was being used as a means to signpost areas to improve efficiency, such as outpatients and day cases.	**Amber/Green**
6. Cardiac catheter suite business case update This paper was a follow up to the outline business case presented in October and queries raised by the Committee at that time. It was **AGREED** that this case should proceed to implementation but with the caveat that the Divisional Director return to January's meeting with a business case that has been updated for issues discussed.	**Amber/Green**
7. Electronic patient records ("EPR") business case update The Committee received an update on this case, which had been approved in principle at November's meeting. The case was **APPROVED** to proceed to implementation.	**Green**
8. Annual plan and budget setting The paper setting out the approach was noted and **AGREED**.	**Green**
9. Reference cost submission The report – setting out the cost collection submission made and anticipated impacts - was noted and accepted.	**Green**
10. Terms of reference and annual work plan The draft terms of reference were noted but not approved - it was **AGREED** that these would be revisited following the approval of the updated Standing Financial Instructions at the Integrated Audit	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Committee.	
Decisions made The Committee **AGREED** that the cardiac catheter suite business case should proceed to implementation but that a refreshed business case covering matters discussed should be represented in January 2021. The electronic patient records business case was **APPROVED** to proceed to implementation. The process for budget setting and the annual plan was **AGREED**. It was **AGREED** to postpone the review of the Committee's terms of reference until after the Trust's Standing Financial Instructions had undergone their annual review at the Integrated Audit Committee.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee No further matters to note.	

Meeting of the Board of Directors in Public
Thursday, 14 January 2021

Title of Report	**Trust Improvement Plan Update**	**Agenda Item**	6.1
Report Author	Gurjit Mahil, Deputy Chief Executive Linda Longley, Head of Trust PMO		
Lead Director	James Devine - Chief Executive		
Executive Summary	This paper provides the Trust Board with an update on the progress against the Trust Improvement Plan's five pillars.		

The 0-9 month deliverables are summarised in the below table:

Pillar	Number of Deliverables	Green	Amber	Red
High Quality Care	10	8	2	-
Our People	7	4	3	-
Integrated Care	10	3	6	1
Innovation	48	17	28	3
Financial Stability	10	3	6	1
Total	**85**	**35**	**45**	**5**
		41%	**53%**	**6%**

Since the last report we have seen an increase in green rated schemes (rising from 26 to 35 deliverables). A small but positive step in the right direction given our current Covid situation.

The 5 red rated deliverables are as follows:
Innovation Pillar - decommissioning of Galaxy, SPI and Omnicell, all of which

	remain delayed due to Covid (as reported last time) Financial Stability Pillar - CIP delivery (as reported last time) Integrated Care Pillar – flow & site operations As previously reported, managing the increase in the acuity of the Covid demand in the Trust continues to present a risk that deliverables within the next stage of the improvement plan may be postponed to a further date. This risk is actively being managed through the fortnightly Trust Improvement Board.
Resource Implications	None
Legal Implications/Regulatory Requirements	NA
Quality Impact Assessment	Not required.
Recommendation/ Actions required	The Board is asked to NOTE the current position for assurance.

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

Appendices	Appendix 1 – Trust Improvement Plan Progress Update

NHS
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NHS Foundation Trust

TRUST IMPROVEMENT PLAN

Progress Update - 16 December 2020

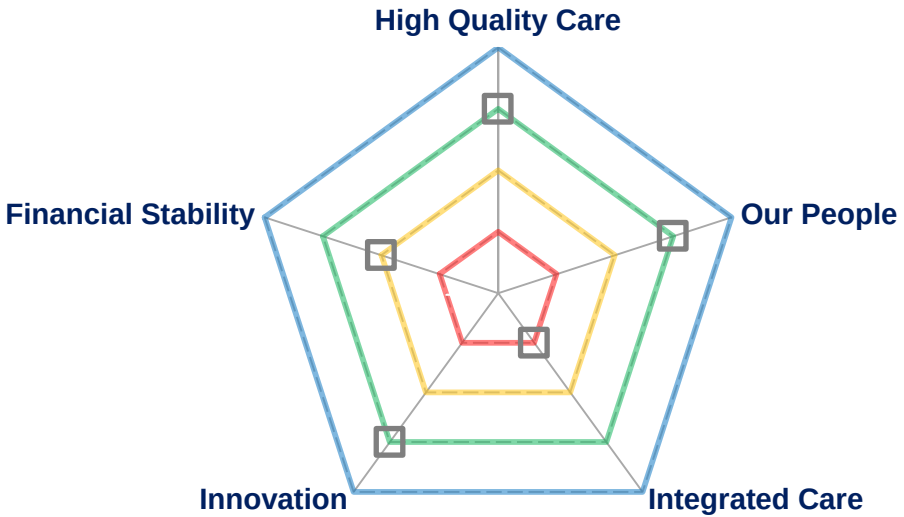
James Devine – Chief Executive

Best of care
Best of people

Our Medway

Trust Improvement Plan Summary

Pillar 1	High Quality Care
Pillar 2	Our People
Pillar 3	Integrated Care
Pillar 4	Innovation
Pillar 5	Financial Stability



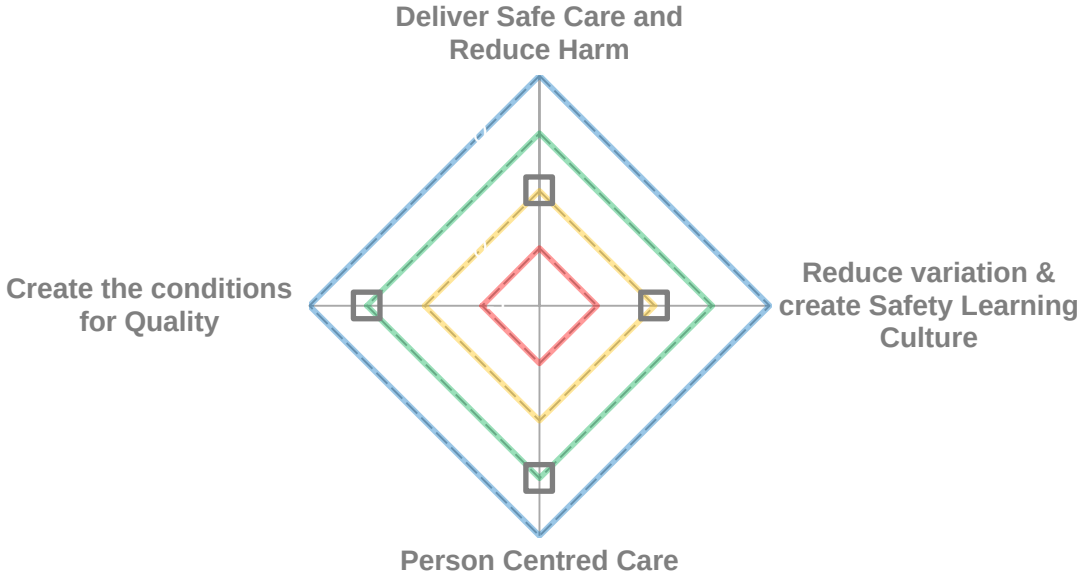
NHS Medway NHS Foundation Trust

HIGH QUALITY CARE

Jane Murkin - Chief Nursing and Quality Officer

High Quality Care

Mission 1	**Deliver safe care and reduce harm**
Mission 2	**Reduce variation and create a safety learning culture**
Mission 3	**Transform the patient experience**
Mission 4	**Create the conditions for quality**



0-9 Month Deliverables

NHS Medway NHS Foundation Trust

Objective	Status
Commission and undertake a Trust wide review of safeguarding	
Undertake an organisational diagnostic assessment against the national framework	
Develop and implement a serious incident framework	
Design and develop a patient experience strategy	
Undertake a Trust wide review of complaints	
Design, test and implement a Quality Assurance programme of visits	
Design, develop, consult and launch a Nursing and Midwifery Strategy	
Implement Quality & Safety boards on all wards	
Undertake a medical engagement scale and develop a plan to address	
Test What Matters to Me Boards	

NHS
Medway
NHS Foundation Trust

OUR PEOPLE

Leon Hinton – Chief People Officer

Our People

Mission 1	**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.***
Mission 2	**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.***
Mission 3	**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.***
Mission 4	**Strategic Design of the Trust to be Well Led**

0-9 Month Deliverables

Objective	Status
Staff retention and stability (Post hire interviews, stability index +7%)	
Staff recruitment (International recovered position by Jan 21, NHS People Plan recruitment process overhaul in line with Workforce Race Equality Scheme action plan; consultant vacancy rate <5%)	
Equality and inclusion (Continued and maturing staff networks working with NHS People Plan; Workforce Race and Disability Equality Scheme co-developed action plans; recruitment pathway inclusion focussed review; Cultural awareness training)	
Culture and leadership, Staff Engagement (57 culture change team members in place, executive interviews and workshops, Schwartz round links and culture conference planned)	
Staff Recommend as a place to work (National pause)	
Freedom to speak up strategy (Regular development meetings with NHSEI, suffering detriment definition, promoting non-anonymous claims through risk assessment approach pilot)	
Talent management, Apprenticeships and apprenticeship learners (New MBA and MA learners in Q3 20/21, L5 ILM learners in place delivered through Trust's ILM centre, new digital apprenticeships commenced (3) Q3 20/21 and mammography apprenticeship)	

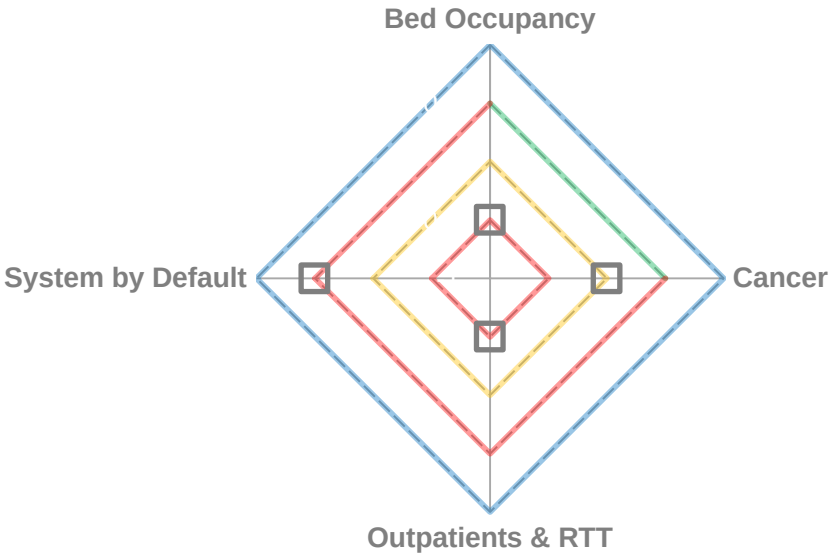
NHS Medway NHS Foundation Trust

INTEGRATED CARE

Angela Gallagher – Chief Operating Officer (Interim)

Integrated Care

Mission ‘0’	Deliver safe care and reduce harm
Mission 1	Safely Deliver 92 per cent Occupancy
Mission 2	Improve Cancer Outcomes
Mission 3	Transform Outpatient Pathways
Mission 4	Work as a ‘System by Default’ in a Clinically-led Way



0-9 Month Deliverables

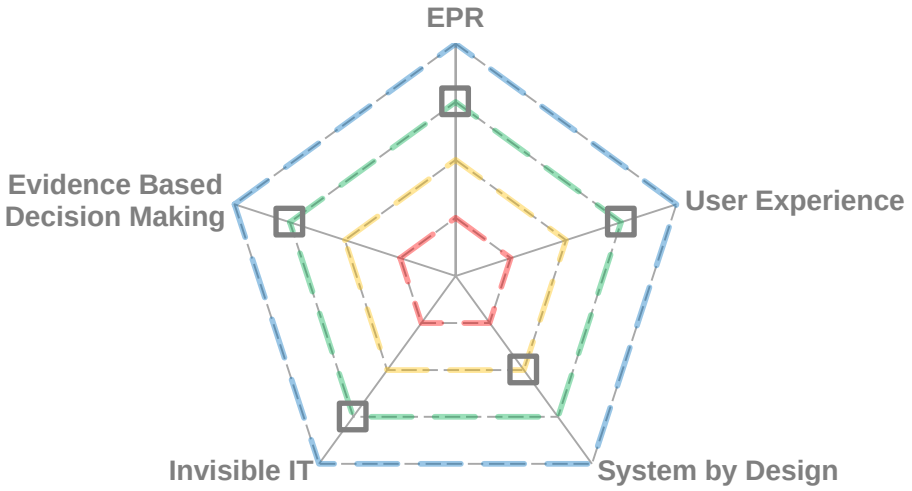
Objective	Status
Outpatient recovery including estates	
Diagnostic recovery	
Elective recovery	
Inpatient ward realignment	
Winter planning	
Demand and capacity	
Internal discharge delivery	
Flow and site operations	
Cancer recovery	
ICP system engagement	

INNOVATION

Jack Tabner – Director of Transformation/IT

Innovation

Mission 1	Electronic Patient Record (EPR)
Mission 2	User Experience
Mission 3	System by Design
Mission 4	Invisible IT
Mission 5	Data and evidence-based decision-making
Mission 6	Medway Innovation Institute



0-9 Month Deliverables

Objective	Status	Objective	Status
Ordercomms		Attend anywhere	
Extramed		Symphony Upgrade	
EDRMS		SPI	Delayed by 6 months due to Covid
Maternity		Remote Patient Monitoring (Current Health)	
Metavision		Auditbase	
Bloodtrack		Hybridmail	
Decommission Galaxy	Delayed for 6 months due to Covid	Omnicell	On hold due to Covid.
CCIO and Clinical Advisory Group		Mortuary	
Digital dictation		Kent data sharing	
Perfect ward		ICP digital plan	

Objective	Status	Objective	Status
Kent data sharing (KMCR) Phase 1		Tracker scope	
KMCR Phase 2 ,3,4		8x8 / Telephony	
WASP		BI portal	
KMMIC RIS		Data infrastructure	
Pharmacy community - TCAM		Data assurance	
Core IT storage		Orthodontics	
End User Devices		Remote desktop	
Server Licensing		EPR business case	
Software Licensing		MFT Digital Strategy	
Networks		Home and remote working - including MS Teams	

NHS Medway NHS Foundation Trust

Objective	Status
Stabilise IT team	
Single Sign On	
Diabetes 3	
PAS Refresh	
PAS Upgrade	
SLAM	
Euroking Decommissioning	
Horizon Project	

NHS
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NHS Foundation Trust

FINANCIAL STABILITY

Alan Davies - Chief Finance Officer

FINANCIAL STABILITY

Financial Stability

NHS Medway NHS Foundation Trust

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

Best of care Best of people

Our Medway

0-9 Month Deliverables

Objective	Status
Reimbursement of covid costs	
Management of staff costs	
Deliver I&E targets	
Deliver capital targets	
Deliver CIP	
Benchmarking of services	
Product standardisation	
Plan to recover backlog maintenance	
Commercial plan	
Review of portfolio of services	

SUMMARY

NHS Medway NHS Foundation Trust

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