Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 15 April 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	Declarations of Interest, Register: - Annyes Laheurte (new addition) - Sue Mackenzie (update)		3		
1.4	Chief Executive Update	Chief Executive	5	12:35	Note
1.5	Clinical Presentation – Frailty (Care of Older Persons) Team. Presented by Dr Sanjay Suman	Chief Medical Officer	Presenta-tion	12:45	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 04.03.21	Chair	9	13:10	Approve
2.2	Matters arising and Action Log: 04.03.21	Chair	17		Discuss
3.	**Governance**				
3.1	Medway and Swale Integrated Care Partnership	Chief Strategy and Integration Officer	19	13:20	Note
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNQO, CMO	23	13:35	Note
4.2	Infection Prevention and Control: a) Assurance Framework b) Improvement Plan	Chief Nursing and Quality Officer	51	13:55	Note/ Approve
4.3	Quality Assurance Committee Assurance Report. Meeting on 16.03.21	Chair of Committee/ Chief Nursing and Quality Officer	101	14:05	Assure
4.4	Clinical Negligence Scheme for Trusts (Maternity) - Safety Actions 4, 5 and 6	Chief Nursing and Quality Officer	105	14:15	Note/ Approve
4.5	Nursing Standards Assurance Framework	Chief Nursing and Quality Officer	145	14:25	Note/ Assure
5.	**Financial Stability**				
5.1	Finance Report - Month 11 a) Q1 / Q2 Interim Plan	Chief Finance Officer	153	14:35	Note
5.2	Finance Committee Assurance Report. Meeting on 25.03.21	Chair of Committee/ Chief Finance Officer	171	14:50	Assure
6.	**Innovation**				
6.1	Trust Improvement Plan – Patient First Update	Chief Operating Officer	177	15:00	Note
7.	**Our People**				
7.1	People Committee Assurance Report. Meeting on 23.03.21	Chief People Officer	207	15:15	Assure
8.	**Any Other Business**				
8.1	Council of Governors Update	Lead Governor	Verbal	15:25	Note
8.2	Questions from the Public	Chair	Verbal		Note
8.3	Any Other Business	Chair	Verbal		Note
8.4	Date and time of next meeting: Thursday, 06 May 2021, 12:30 – 15:30				

MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS
APRIL 2021

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

		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		BMT Global Ltd	Non-Executive Director
		Logistics UK	Non-Executive Director
		Port of London Authority	Non-Executive Director
		Women's Royal Army Corps Association	Trustee
Annyes Laheurte	**Non-Executive Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
		Finance Committee for the British Association for Music Therapy	Trustee and Chair
		Funding For All	Trustee
		Global Parametrics Ltd	Head of Finance (working notice)
Rama Thirunamachandran	**Academic Non-Executive Director**	Canterbury Christchurch University	Vice-Chancellor and Principal Director and Trustee
		Universities UK	Director and Trustee
		Million Plus (Lobby Group for HE)	Chair
Jenny Chong	**Associate Non-Executive Director**	Knightingale Consulting	Managing Partner
		KogoPay	CTO, Head of Innovation
		Imperial College London	Advisor to IVMS (Imperial Venture Mentoring Service) and ITES (Imperial Technology Experts Service)
		The Design Museum	Co-opted Member of the Finance & Operations Committee
		Egypt Exploration Society	Co-opted Member of the Collections Committee
		Business of Data	Global Advisory Board Member
James Devine	**Chief Executive**	London Board for the Healthcare People Management Association	Member
		Medway Health and Well-Being board	Member
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
David Sulch	**Chief Medical Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Chief People Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Alan Davies	**Chief Finance Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jane Murkin	**Chief Nursing and Quality Officer**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Chief Executive's Report – April 2021

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

COVID-19

At the time of writing, we were just beginning to see the first steps in the relaxation of the national lockdown restrictions.

Although this is really fantastic news, our expectation is that things will not change too significantly on our hospital site for the moment. We will still be expecting staff, patients and visitors to wear masks, use dedicated entrances, wash their hands and socially distance. It is so very important that we remain vigilant to avoid seeing unnecessary surges in cases in the community or the hospital.

The vaccination programme within the hospital has gone very well, but I would encourage more colleagues, particularly those from BAME communities to have their vaccine over the coming weeks. I am grateful to the vaccination team for all their efforts in administering over 26,000 jabs to colleagues in the hospital, the wider health and social care workforce, and our community.

I am really pleased to say that we have restarted some of our elective procedures, but we must do this with caution. In addition, we will continue to review the restrictions on visiting, and relax these as soon as it is safe to do so. We are fully committed to bringing all our services back to full capacity as quickly, and as safely as possible. We are extremely grateful for the support of our community and thank them for their continued patience and understanding.

National recognition

I am delighted to say that we have been shortlisted for not one but two HSJ value awards. Both nominations come in the same category – Acute Service Redesign Initiative – and I would like to congratulate the MeFit Prehabilitation Team and Emergency Department Team for this national recognition of the work that they have done to improve care for our patients.

We will not find out who takes the prize home until June 2021 but both teams can be extremely proud of being shortlisted in what are regarded as amongst the most prestigious awards in healthcare.

Culture Conference

Last month we were proud to host our first culture conference – this had previously been rescheduled as a result of the first wave of the pandemic.

The event gave us an opportunity to speak to colleagues about the aims of the programme and to focus on some of the achievements so far. Continuing to develop the culture of our organisation remains a very important aspect of the improvement work that we are doing. We know that if we get our culture right, we will get things right for our patients much more consistently. It has also been great to see improving scores with the Friends and Family Test on the number of our colleagues who would recommend Medway as a place to be treated, and to work.

Wellbeing Day
The last 12 months have been incredibly challenging for everyone at Medway, and I know that many of our colleagues feel exhausted from all that they have been through. Spring is here, and with it brings hope of return to a form of normality but, as the pressure begins to ease, it is more important than ever that they take the time to take stock of all that has happened and think of their wellbeing.

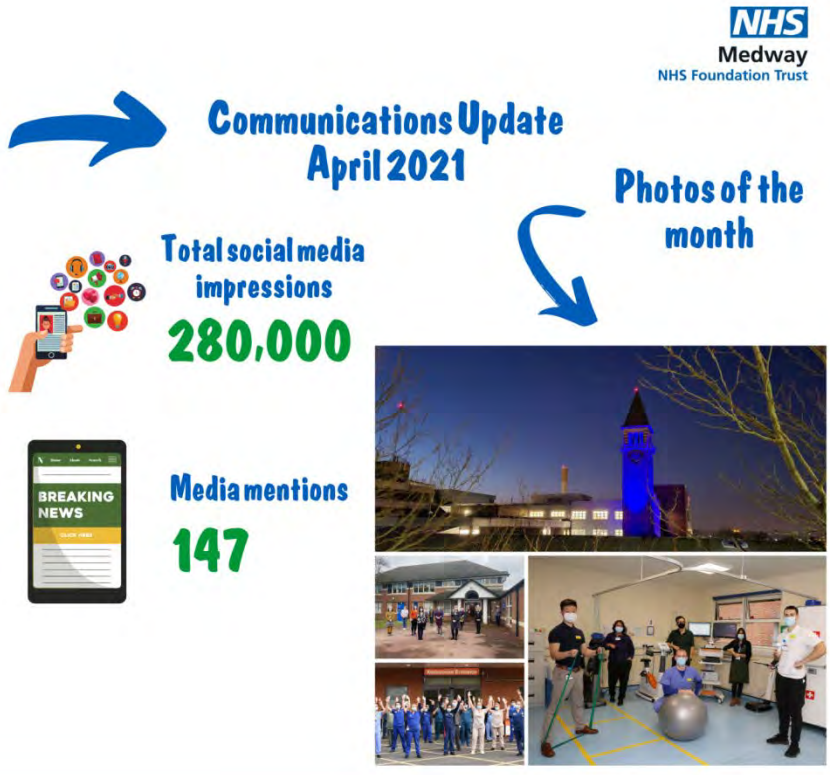
That is why we I am proud to say that we have given our Medway colleagues one day's additional paid leave in 2021/22 to take some time to recuperate and do something to relax or re-energise.

Autism Awareness Week
Last month we were very proud to support Autism Awareness Week - a week that is aimed at improving people's understanding of autism and helping make the world friendlier for those who are affected by it.

This is something we take very seriously at the Trust and last year we launched the 'Different Not Less' campaign to improve care for people with learning disabilities or autism. The campaign was created by Ginny Bowbrick, a consultant vascular surgeon at Medway, who is the mother of two autistic twins. We are hoping to see the campaign launched in other trusts in the coming months.

In addition, we are working to become a JAM Card friendly Trust. JAM stands for 'Just A Minute' and is an important communication aid for those with a hidden disability. A JAM Card allows people with a learning difficulty, autism or a communication barrier to tell others they need 'Just A Minute' discreetly and easily. Those with a communication barrier are often reluctant or unable to tell others about their condition. JAM Card allows this to happen in a simple, effective non-verbal manner.

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



And finally…

I want to conclude my last CEO message by reflecting on the recent announcement of my departure.

You have heard me say many times that Medway is my local hospital, and it will always have a special place in my heart. I have been incredibly proud to be Chief Executive and privileged to work with colleagues who care as passionately as me about caring for our patients.

We have so much to be proud of – an outstanding critical care unit which has ensured excellent care for the sickest patients during the pandemic, a first-class maternity service, enhanced care for some of the most vulnerable people such as elderly patients, those with dementia, and those nearing the end of life, and met ambitious financial targets.

But as ever, there is more to do to ensure we are providing the best of care in all areas, and as we embark on the next phase of our transformation, I feel now is the right time to hand over the reins of leadership.

I would like to formally thank everyone connected with the hospital for their support during my time here, and particularly as Chief Executive. It never ceased to amaze me, the lengths that individuals here go to in order to provide compassionate care to those in our community and to have worked with so many talented and professional people has been a real privilege; the way in which our league of friends and hospital charity have continued to support us has been extraordinary and my thanks to our partners across Kent who have supported us well over the last year.

And finally, to our Trust Board, I offer my thanks and gratitude to you all for putting your faith in me as Chief Executive.

Minutes of the Trust Board PUBLIC Meeting

Thursday, 04 March 2021 at 13:00 - 15:30

Meeting via MS Teams

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

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts and patience as they continue to use MS Teams for these meetings. Chair welcomed the Board and particularly its guests as listed above, who were observing the meeting.

a) Chair informed the Board that today it is reintroducing the Patient Story, so the Board can hear first-hand accounts from patients and their loved ones. The stories are so important in helping the Trust learn from the experience of its patients; whether it be a positive or negative experience, there will always be a balance of these stories brought to the Board. They also help Board members to check that what we read in the Board papers and what the Board hear from Executives matches the experience of patients themselves.
b) Patient experience is at the heart of all that the Trust does. During the pandemic it has been at the forefront of all thinking, especially since difficult decisions have been made, such as limiting visiting. The Trust is very conscious of how disappointing it is for patients to have their surgery delayed in order for the Trust to cope with the pressure caused by Covid-19.
c) Chair was pleased to inform the Board that the number of Covid cases has now reduced, and the Trust has begun to undertake some surgery, and looks forward to restoring services further over the coming weeks. The Trust also looks forward to being able to allow visitors, volunteers and Governors back into the hospital, when it is safe to do so.
d) Today the Board will hear more about the hospital's current challenges and also encouraging and heart-warming news about its vaccination programme. Chair took this opportunity to thank all those involved in the vaccination hub, all of the Trust's colleagues who have cared for patients throughout the pandemic, those who have provided the very important support services to keep the hospital running, and in particular those now working to restart the hospital's surgical and diagnostic services.
e) It is continuous efforts by all, which is helping to ensure patient experience at the hospital is the best it can be and that the community it serves, gets the health care it needs.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Conflicts of Interest

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

1.4 Chief Executive Update

James Devine, Chief Executive, gave an update to the Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. The Board was asked to note the content of this report, which provided a high level summary of the past month within the hospital. He drew particular attention to a number of salient points for the Board:

a) James welcomed everyone to the March Board meeting. He was pleased to report of a glimmer of hope for all, following the news from the Prime Minister setting out the route map to leave Lockdown and returning to some degree of normality through the spring and summer.
b) James thanked the community for bearing with the hospital and for bearing with the Trust through some of its challenges over the last year. He also thanked the patients who have endured delays, for their patience and also gave his sincere apologies for these delays. James hopes that the hospital will be back to some sort of normality into spring and summer with the restart and recovery plan.
c) The Vaccination Programme is part of this plan and to date the Trust has vaccinated over 16,000 people which is a significant number since the programme started in December. James gave thanks to the Vaccination Hub team and Angela Gallagher for leading on this and

providing vaccines to Trust colleagues and further afield to the social care system, the community and other residents across Medway and Swale.

d) The Trust is happy to report that there are fewer patients in hospital requiring Covid-19 care. The Trust is now working as normal within the planned intensive care unit. That being said there are still Covid-19 cases in the hospital. The government guidelines of hands, face, space should continue to be adhered to. Covid-19 will be in the community for some time and as we go into the next winter period.
e) The Trust is committed to getting the hospital back to normal, especially for patients who need elective and cancer care, whilst also balancing the needs of staff who have worked relentlessly over the last year.
f) James informed the Board of the Care Quality Commission Inspection which took place on the 14 December 2020, this particularly focused on the Emergency Department. Colleagues would have now seen the published report which came out in February 2021. James and the Board are disappointed by the ratings that have been applied. Nonetheless the Trust absolutely accepts the observations and findings from the Care Quality Commission on the day that they came. The Trust would never accept or tolerate long ambulance delays. James gave his genuine and sincere apologies to patients who have experienced long delays from the ambulance service and within the hospital. The team have spent time addressing the findings over the last six to eight weeks and have put some very clear and immediate plans in to place to address the issues, particularly in regard to ambulance and time spent in the Emergency Department. It is absolutely right to do this to ensure that change is embedded and to minimise the risk of the hospital being in the same position again.
g) The pleasing thing to come out of the report is that the Caring and Effective domains were rated as good and the inspectors observed compassionate care being provided in the Emergency Department, especially with a significant number of Covid-19 positive patients.
h) James closed by reiterating his thanks to the community for their ongoing support and tolerance of some of the decisions that the Trust has had to make.
i) James extended his thanks to colleagues across the hospital that have worked incredibly hard over what is always a difficult period during winter, but over a time which has been incredibly hard given the covid issues that the hospital has faced.
j) On a final note James thanked the Board for their input, ongoing support, additional hours, resilience and commitment to ensuring that the hospital deal with patients with compassion from a Covid-19 perspective but also support of the restart programme.

1.5 Patient Story

Jane Murkin introduced Stephen Browne and thanked him for taking the time to record and to share his story with the Board today.

a) Stephen was brought to the Urgent Treatment Centre by ambulance in March 2020 with a cough and symptoms of lethargy. This was at the start of the Covid-19 pandemic (wave one). Stephen was cared for in the Emergency Department initially where he was swabbed and placed in an isolation room before being transferred to Lister ward. Stephen is a Covid-19 survivor but from his experience at the hospital there are some key lessons for the Trust. Stephen's pre-recorded interview with the Trust was played for the Board.
b) Stephen spoke openly and honestly about his experience at the hospital. Initially his experience within the Emergency Department was poor but later his experience on the ward where he recovered was exceptionally good. Since his stay in hospital Stephen has had a number of procedures non-covid related and the NHS service has been excellent. The positive experiences at the hospital override the negative ones and he cannot thank the staff enough for assisting with his recovery and getting him home to his family.
c) Jane Murkin has taken away the positive and negative feedback from Stephen and will take on the learning from his experience and feedback to the team.
d) The Board asked that Jane Murkin thank Stephen by letter for sharing his story.

e) The Board found it unsettling to hear some of the negative experiences from Stephen's story, especially some of the cultural issues. This is not the sort of behaviour anyone would expect a family member to have to go through. The hospital has been in tough times recently but this is certainly not acceptable behaviour for the Trust.

f) Chair passed on her thanks to Stephen for sharing his story. This was obviously a difficult experience for him, especially with Covid-19 being so unknown and daunting at the time. Colleagues may feel familiar but patients and their families would be understandably frightened. It is important that the team learn from this story, especially the cultural issues that the team did not get right. The Trust are delighted Stephen is recovering well but the Trust expect his experience to be positive from start to finish. The Board left actions with Jane to work on and this adds weight to the discussions already in hand with the Emergency Department.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 04 February 2021 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting
The action log was reviewed and the Board agreed to CLOSE the following action:
TBPU/21/115

3 Governance

3.1 Board Assurance Framework Review

Gurjit Mahil, Deputy Chief Executive, presented to the Board for noting. Gurjit took the paper as read and summarised the BAF as of the 18 February 2021 and detailed the Trust's principal risks as follows:

a) 5c – Patient Flow – Capacity and Demand (rated at 16)
b) 5f – Covid-19 (rated at 16)
c) 4a (rated at 16)

3.1.1 Tony Ullman stated that Risks 5c and 5f would be reviewed at the Quality Assurance Committee. The Board thanked Gurjit for the report.

3.2 Integrated Audit Committee Assurance Report. Meeting on 25.02.21 – Delegation of Approval of Annual Report and Accounts

Mark Spragg, Chair of Committee, presented to the Board for noting, it was taken as read and he gave the following key highlights:

3.2.1 The decisions made at the Committee meeting were as follows:

a) It was agreed that Grant Thornton would provide a summary paper that can be shared with the Trust Governors which outlines the additional procedures required to give the Value for Money opinion, which is for 2020/21. It is quite a significant rise; therefore the Committee asked Grant Thornton to set out what exactly it is extra they will do. The Committee will then review this and submit it to the Council of Governors to approve.
b) The plan is by 15 June the Trust accounts are to be approved but the Board can extend this to the 29 June if necessary. In previous years the Board has delegated authority to the Integrated Audit Committee.

The Board APPROVED the request to delegate authority to the Committee to approve the Annual Accounts for 2020/21 on its behalf.

3.3 Wellbeing Guardian – Introduction and Nomination

Leon Hinton, Chief People Officer, presented to the Board for noting. The Board was asked to note the requirements of the Wellbeing Guardian and was asked to nominate a Non-Executive Director for this brief. Leon took the paper as read and gave the following background and key highlights:

a) The NHS People Plan 2020/21 sets out national health and wellbeing policy ambitions to enable the Trust to create a culture of wellbeing, where NHS people are cared for. One of the key new roles introduced through the plan is the Wellbeing Guardian who strategically steers and holds the organisation to account for the wellbeing of its employees.
b) The Wellbeing Guardian is supported by an assurance mechanism through nine board principles as documented in the submitted report.
c) It is proposed that a Non-Executive Director is nominated to act in the capacity of the Wellbeing Guardian for the Board, to receive quarterly assurance reports, gaps and risks through the People Committee. It is proposed that the Trust undertakes an annual self-assessment of the implementation of the principles as part of its assurance mechanisms.
d) Chair suggested awaiting the new NED to join the Board to be part of this discussion, as to who takes on this role. Leon agreed and assurance reports will continue to be submitted to the People Committee.

4 High Quality Care

4.1 Integrated Quality Performance Report

The Board was asked to note the report and discuss the content. 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.

4.1.1 Jane Murkin stated that falls and hospital acquired pressure ulcers, remain below the national average. There is an increasing rate of C-Sections, this has been discussed at the Quality Assurance Committee and a detailed review is underway. This will be submitted in a report to the Committee as a deep dive review of contributory factors later in March 2021.
The Chief Executive awarded three Gold Awards today within the hospital, for good quality care.

4.1.2 David Sulch informed the Board that the HSMR is currently below 100, an encouraging position. There has been an audit on mortality rates between Medway and Swale areas. The Frailty Team presented to the Mortality and Morbidity Committee in February 2021 and it did not turn up anything surprising. There is not much difference in rates between them. With weekend mortality also improving the Trust is in a positive position.

4.1.3 Angela Gallagher gave her update on metrics as detailed in the paper, which are going in the right direction for the Trust; this is mainly due to the hard work of colleagues. There is more work to be done on discharge management. The elective pathway has been suspended since early November 2020 but the Trust is emerging from this now. The restart work will focus on reducing the waiting list. 22 February 2021 restart commenced on cancer care and by 22 March the Trust will increase the capacity to include care for other long waiting patients. Angela has mapped the work with colleagues to correlate with the activity plan and the team is confident on this going forward.

4.1.4 Angela stated that there is a clear plan working with the independent sector, being able to move patients into private care for surgeries. There is more access to places such as KIMS Hospital for cancer care. More work is to be done on trajectories which will be detailed at the May Board meeting, ensuring that the Trust has the capacity and finances.

4.1.5 Tony Ullman stated that the hospital breaches would be tracked through the Quality Assurance Committee.

4.1.6 Chair thanked the team for their hard work and for addressing the issues and navigating safely through Wave 2. The Trust is in a much more acceptable position and it is now an encouraging picture.

4.2 Quality Assurance Committee Assurance Report. Meeting on 16 February 2021

Tony Ullman, Chair of Committee, gave the Board an update on the Committee meeting held on Tuesday, 16 February 2021. The paper was taken as read and noted.

4.2.1 There were no formal escalations to Board.

4.2.2. The discussion around the IPC assurance framework will come back to the Quality Assurance Committee in March 2021, along with the initial IPC Improvement Plan. The Trust is making good progress and the Committee is well sighted on this.

4.3 Ockenden Response

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting and took it as read. Jane explained that the submitted report provides an overview the Trust's position in response to the findings and recommendations of the Ockenden review. The paper detailed the following and some key highlights were given:

a) Donna Ockenden's first interim report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts were published on 11 December 2020. The report identified seven Immediate and Essential Actions (IEAs) for Trusts with a number of requirements for each IEA.

b) On 14 December 2020 a letter was sent to all Trust Chief Executives who provide maternity services outlining the twelve Urgent Clinical Priorities (UCPs) from the IEAs. Chief Executives were required to confirm their Trust's position against the urgent clinical priorities by 21 December 2020 and a formal response was provided by the Trust.

c) Further to the response the Trust was requested to undertake a self-assessment against the seven IEAs, linking with the 12 Urgent Clinical Priorities and requirements of the Clinical Negligence Scheme for Trusts (CNST) Safety Actions. The maternity service completed the assurance and workforce tool, as detailed in the report, benchmarked against the findings of the Ockenden review as requested by the Regional Chief Midwifery Officer.

d) The Trust was requested to complete the assurance tool and submit by 15 February 2021, with a requirement for this to be reviewed by the Trust Board and Local Maternity System, and approved by the Trust's Chief Executive and Local Maternity System Senior Responsible Officer. The Ockenden assurance and workforce tool was presented to the Executive Team prior to submission to the Board, following approval of the Chief Executive.

e) The Ockenden assurance and workforce benchmarking tools illustrate the status of the Trust's compliance to the recommendations of the IEA's, as follows:

1) Enhanced Safety
2) Listening to Women and Families
3) Staff Training and Working Together
4) Managing Complex Pregnancy.
5) Risk Assessment throughout Pregnancy
6) Monitoring Fetal Wellbeing
7) Informed Consent

f) Regular updates will be submitted to the Quality Assurance Committee and onward to Board. It was suggested this is a monthly update to QAC but monthly if there is something to escalate to the Board. Jane would action this for the QAC.

5 Financial Stability

5.1 Finance Report – Month 10

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

a) In summary the Trust reports a deficit of £9,000 in month and £94,000 year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 01 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level.
b) Incremental Covid costs have continued at similar levels to December. An additional £2.5m of Covid income has been agreed with the STP to fund the increase above the original plan; total income for October to March is £10.1m. The forecast outturn position remains at breakeven after being updated using the January position.
c) Schemes delivered 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 under achievement against plan as savings identified to happen in the later part of the financial year have not delivered. The forecast position of actual delivery has been updated with the scheme owners identifying £8.9m of the £12m plan; this is £0.1m less than December.
d) The 2020/21 capital plan includes £24.4m STP capital allocation plus additional business cases and Covid-19. The agreement with the STP to underspend by £1.3m has been revisited, commissioners have approved acceleration of the EPR to utilise the funds in Medway. Additional PDC funding of £0.827m has been agreed by NHSI since month 9. However the UTC scheme planned for 2020/21 has not been submitted or approved by NHSI removing that scheme from the plan for this year. The Capital Resource Limit (CRL) has therefore changed from £31.833m to £31.659m, from which £31.350m is expected to be spent.
e) The Trust Capital COVID bid has been approved by NHSI.
f) Capital Expenditure is currently well below the CRL, IT schemes and building works are expected to rapidly accelerate throughout February and March.
g) Planning work for next year is increasingly focused on business planning and budgets and the team are working hard on this. The Deputy Director at NHSEI Improvement Team is giving the Trust advice on how to take the work forward with the financial strategy. An update on this work will be submitted to the Finance Committee and on to the Board.
h) Gary Lupton confirmed that the weekly forecast on the Capital position would be with Alan and James Devine on 05 March and will discuss this with James in the 1:1. He thanked the team for the plans to date and positive effort.
i) James Devine thanked Alan and the Finance team as it is an achievement for hitting the control total for the third year in a row. Thanks also to the operational teams for their efforts. – thanks to finance and operational teams for this
j) Alan would circulate some pay spend head line figures w/c 08 March 2021 relating to covid and overseas recruitment which impacted on the January position. There is to be a further deep dive on pay costs at the Finance Committee to see if there are some underlying factors for the increase.

5.2 Finance Committee Assurance Report: Meeting on 25 February 2021

Jo Palmer, Chair, took the paper as read and informed the Board of the following key issues from the Finance Committee meeting of Thursday, 25 February 2021 for the Board to note. The paper was taken as read and noted. The Committee agreed the following:

a) The BAF Finance score was reduced
b) The Committee agreed a more detailed review on pay costs, as it has been a theme over last 12 months. More information on this would be brought to the April Board in the finance report.
c) The Cardiac catheter business plan was approved after the required changes were made, the approval process did not hold up the work in the suite.

6 Innovation

6.1 Trust Improvement Plan

Angela Gallagher, Chief Operating Officer (Interim), took the paper as read and asked the Board to note the current position and progress made. Angela detailed the progress made on three key and interrelated elements of the Trust's Patient First programme.

a) This work targets regulatory requirements and is supported by the Emergency Care Intensive Support Team (ECIST). There has been good engagement in the programme, with a number of areas in development.
b) For each element the Trust has agreed metrics to track work and the impact of interventions and changes, this is reported via the Trust Improvement Board. It is important for the Trust to understand how it is performing against key indicators, since the programme has both a direct and indirect influence on the Trust's overall performance.
c) Angela talked through the presentation.
d) Chair asked that Alan Davies picks up the financial risk.
e) Chair thanked Angela and the team and stated that consistent performance across the organisation is what is needed.

7 Any Other Business

7.1 Council of Governors Update

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

a) The Members Virtual Event took place recently and there were 22 members of public in attendance. The event went well, but there were some slight technical issues with MS Teams. 18 March 2021 is the next meeting.
b) The Governors shortlisted four candidates for the new NED position. Following interviews, the preferred candidate does have a financial background. The Council have approved the appointment subject to correct checks and due diligence.
c) Nominations for governor elections are underway; there are 17 vacancies to fill from 1 July. There is a prospective candidates' briefing session on 12 March 2021.
d) The Council gave their thanks to the Trust for helping with the broadcast of the funeral of Stella Dick. It was a nice service and Stella would have been pleased with many of her friends being able to attend.

7.2 Questions from the Public

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

7.3 Any Other Business

7.3.1 David Seabrooke is working through a consultation process on the provider licence and the Fit and Proper Persons Test that directors are subject to. David is working with Sinton's Solicitors on this matter.

7.3.2 The Board acknowledged that today was Jack Tabner's last Board meeting as he leaves at the end of March 2021. The Board thanked Jack for all of his work and wished him well for the future.

7.3.3 There were no matters of any other business.

7.4 Date and time of next meeting

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

The meeting closed at 15:30

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

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
14-Jan-21	TBPU/21/112	**Item 4.1 - Integrated Quality Performance Report:** - Provide some clarity to see what areas may deteriorate, where we may see changes. - How can the team quantify the indicators that may go off track with Covid. - Add a specific metric in the IQPR for the Emergency Department (such as ambulance handovers) Will be tracked through QAC	15-Apr-21 ~~04-Mar-21~~ ~~04-Feb-21~~	Jane Murkin, Chief Nursing and Qaulity Officer David Sulch, Chief Medical Officer Anglea Gallagher, Chief Operating Officer (Interim) Leon Hinton, Chief People Officer	**Update at the April Board**	Amber
04-Feb-21	TBPU/21/114	**Item 4.4 - Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Assurance Report:** information on the number of deaths in comaprison to other hospitals.	15-Apr-21 ~~04-Mar-21~~	Jane Murkin, Chief Nursing and Qaulity Officer	**Update at the April Board** - Report to go to March QAC	Amber

Meeting of the Public Trust Board
Thursday, 15 April 2021

Title of Report	**Medway and Swale Integrated Care Partnership (ICP)**	Agenda Item	**3.1**
Lead Director	Harvey McEnroe, Chief Strategy and Integration Officer		
Report Author	Harvey McEnroe, Chief Strategy and Integration Officer Martin Riley, Joint SRO for Medway and Swale ICP		
Executive Summary	This paper provides the Board with a summary of the work underway via the Medway and Swale ICP. The paper outlines the progress of the STP to ICS status and the work across the 'place' on population heath and our recovery from Covid19.		
Committees or Groups at which the paper has been submitted	The Medway and Swale ICP Programme Board		
Resource Implications	n/a		
Legal Implications/ Regulatory Requirements	n/a		
Quality Impact Assessment	None		
Recommendation/ Actions required	The Board is asked to note the paper.		
	Approval ☐	Assurance ☐	Discussion ☒	Noting ☒
Appendices	None		

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

1 Kent and Medway Integrated Care System development

Amber / Green

1.1 As discussed at the last meeting of the Trust Board, Kent and Medway STP was asked to resubmit its application to become an Integrated Care System during February 2021, to enable the system to deal with the immediate pressures created by Wave 2 of the COVID-19 pandemic, and to provide additional assurance to NHSE/I on the steps it would take to address long-term challenges faced by the local health and care system.

1.2 On 22 February 2021 the STP wrote to NHSE/I providing the additional information required. A copy of this letter has been shared with the Trust executive via the CEO.

1.3 As at 15 March 2021 the ICS was formally confirmed and the accreditation was formally approved via the regional team.

2 ICP recovery support programme

Amber /Red

2.1 The Recovery Support Programme approach is being developed by NHSEI to support health and care systems facing performance, quality, safety, finance and/or legal challenges. The approach is still in development, but is currently being tested with systems facing challenges with the management of COVID Wave 2 and wider winter pressures. The Programme offers intensive support to identify the root causes of these challenges, and to put in place effective actions to rectify issues in a timely manner.

2.2 As part of the Recovery Support Programme, Medway and Swale ICP has been asked to develop a 'place-based' integrated improvement roadmap to tackle the key challenges faced by the system (as identified in the ICP PID), with a particular focus on issues with ambulance handovers, and the ED front door. This is being worked up from the Trust and the ICP teams.

2.3 NHSEI and the CCG will work with the system to monitor progress with the development and delivery of the Integrated Improvement Roadmap through regular 'Checkpoint Meetings'. The first of which is planned for April 2021.

2.4 Checkpoint Meetings will be jointly chaired by NHSEI and the CCG, and will include representation from NHSEI, the CCG, and the ICP Board and Leadership Team.

2.5 The aim of these meetings is to gain assurance that the system is making progress with the implementation of ICP Delivery Plan 2021/22, and with the development of Integrated Improvement Roadmap.

3 Developments in our Population Health plan

3.1 Medway and Swale ICP have been selected to lead the NHSEI population health management work as part of the wave 3 national rollout for the ICS. Whilst this is an exciting opportunity, the pace of travel of the national programme is not in line with the local need to use population health management as the foundation for local transformation; and as a system we have agreed to move forward with local plans which will run in parallel with the national programme.

3.2 The first steering group was held on the 10 March 2021, and had strong representation from both statutory and non-statutory organisations. Key discussions were had around the wider determinants of health being the most important driver of health and areas that as a system we need to address; in addition to income and wealth, these determinants include education, housing, transport and leisure.

3.3 The group discussed health behaviours and lifestyles including smoking, alcohol consumption, diet and exercise. For example, while reductions in smoking have been a key factor in rising life expectancy since the 1950s, obesity rates have increased and now pose a significant threat to health outcomes.

3.4 The third key area of discussion was the increasing recognition of the key role that places and communities play in our health. For example, our local environment being an important influence on our health behaviours and the strong evidence of the impact of social relationships and community networks, including on mental health.

3.5 There was a strong consensus that in order to build community resilience we need equal recognition of statutory and non-statutory organisations as partners to set the priorities. It was agreed that as a system we would develop an MOU to give equal recognition to all partners and develop joint social policies in order to drive forward change.

3.6 It was recognised that whilst we need to understand the impact of covid on population health and social care need and planning going forward, we do already have a very rich data source, which would be used to establish our initial priority areas. To secure commitment to the programme, each organisation signed up to deliver tangible actions based on current position.

4 ICP Covid19 recovery update

Amber / Green

4.1 The ICP is currently co-ordinating the provision of three pathways to support patients with COVID monitoring, early escalation, community treatment and management and supported discharge.

4.2 **COVID Oximetry @ Home Service:**

4.2.1 Through collaborative working across the Medway and Swale ICP the COVID Oximetry at Home Service (CO@H) was launched. The purpose of the CO@H service was to remotely monitor patients with confirmed COVID-19 through the use of a pulse oximeter, to monitor their oxygen levels to enable early warning of deterioration and rapid intervention and treatment. The aim was to monitor patients to detect 'silent hypoxia' at an early stage where intervention will reduce mortality and may reduce the risk of 'long COVID'. Two hubs were set up one in Medway and one in Swale working with the Alliances home visiting services so patients who were assessed as needing a home visit were managed by the local teams. Since the launch in December to the end of February, 820 patients have been referred into the hubs for remote monitoring. Patients were monitored for 14 days post referral which equated to 4807 phone calls being held with the patients to collect their pulse oximeter recordings as well as ask patients about their wellness. An escalation process underpinned how the patients were managed based on their oxygen saturation levels and their overall condition. This is service is currently commissioned to end of March 2021.

4.3 **Community COVID-19 Pathway:**

4.3.1 Medway Community Healthcare launched a Community COVID-19 pathway for the active treatment and management of patients in the community with the aim of reducing the need for admission to the acute for treatment and managing the patient in the community through agreed interventions and an individual patient Treatment Escalation Plan. The pathway was established based on the Kent and Medway CCG out of hospital treatment SOP which was developed by a multi-disciplinary team providing a framework to inform clinical decision and provide treatment guidelines. A team from Urgent Response, Community Respiratory, MedOCC and the inpatient units quickly developed a local model, arranged for equipment to be delivered, engaged and trained staff. Eight beds were identified within Harmony House as a step-up facility should a patient's condition suggest closer monitoring in the community but not require acute hospital intervention. Since the service was launched in January, seven patients have been referred into the service, predominantly by SECAmb. Once the patients have completed their community intervention and care and are ready for discharge, the patients are then referred into the CO@H service for a further 7 days of monitoring before being discharged back to the care of their GP. If the patient's condition changes during the 7-

day period of pulse oximetry monitoring, the CO@H engage with the Urgent Response Service for advice and can refer back to the service where indicated.

4.4 **Early Supported Discharge (Covid Virtual Ward):**

4.4.1 The Early Supported Discharge pathway has been locally developed between Medway and Swale community and acute clinical teams to enable patients to be discharged 2-3 days earlier from an acute hospital when they are nearing the end of their COVID-19 inpatient treatment and therapy. The service combines the Medway NHS Foundation Trust (MFT) SMART team, respiratory consultant and community respiratory teams in Medway Community Healthcare and VirginCare, who provide monitoring and continued treatment/therapy of patients once they are discharged. The patient stays with the community teams for approx. 1-2 weeks and when the patient has successfully completed their intervention, the patient is then referred to the CO@H service for a further 7 days of monitoring with links back into the Urgent Response Service should the patient's condition deteriorate. This newly established service was launched in February for patients identified by the respiratory nurses and other consultants in MFT. Clinicians hold a weekly virtual ward to review each patient and agree treatment plans including weaning off oxygen. With the pathway being multi-disciplinary with access to the Respiratory Consultant and hospital team, should a patient's condition deteriorate, there is a quick access for the community team to refer the patient back into the hospital as well as have a follow-up process for patients who are discharged from the community teams for longer term follow-up. To date 37 patients have been discharged into this pathway.

5 Conclusion and Next Steps

5.1 The Board is asked to note the progress of the ICP and its developments

5.2 There will be a further update to the May 2021 Board regarding the restart programme across the ICP and the improvement plans at 'place' level incorporating MFT and the wider system plans.

Meeting of the Board of Directors in Public
Thursday, 15 April 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Jane Murkin – Chief Nursing and Quality Officer David Sulch – Chief Medical Officer Angela Gallagher – Chief Operating Officer (Interim)		
Lead Director	Jane Murkin – Chief Nursing and Quality Officer Gurjit Mahil – Deputy Chief Executive		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for February shows that the Trust has had 0 MRSA bacteraemia cases and 1 hospital acquired C-diff case. Whilst, November's overall HSMR rate is 102.3, the weekend HSMR rate is at 109.0 and links to risks during the weekends with Bed Occupancy and MSA also increasing. **Caring** Unfortunately, whilst MSA had shown improvement in previous months, February has reduced to 72 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 has seen all areas achieving the national standard of 85% (Inpatients: 85.3%, ED: 85.6%, Maternity: 100%, Outpatients: 90.16%). **Effective** Discharges before Noon, whilst close to the Mean are still below at 14.21% and significantly below the Target of 25%, this is being reviewed through the Patient First work. **Responsive** The 18 weeks Referral to treatment (RTT) performance for January is recorded at 64.96%, with 563 +52 week breaches, clinical harm reviews have been completed for these patients. ED (Type 1) 4 hour performance as a result of site pressures reported 66.48% in February. Additionally, the Trust saw a reduction of the 60 minute ambulance handover delays to 69. However, DM01 Diagnostics performance is at 75.78% for January. **Well Led**		

We have seen a slight increase in appraisal rates at 77.64% however the Trust has maintained compliance statutory and mandatory training.

To note:

- The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay.
- The SHMI data is currently showing September 2020 – this is reliant on NHS I/E/D and is 3 to 4 months in arrears.
- The HSMR is currently showing November data, this is reliant on Dr Foster and this is 3 to 4 months in arrears.
- The bed occupancy includes all beds within the Trust including maternity and paediatrics.

From April reporting the following changes will be made to the metrics presented with the appropriate trajectories:

- Safe
  - Inclusion of crude mortality alongside HSMR and SHMI
- Caring
  - No further changes
- Effective
  - Discharges before noon with trajectory
  - EDNs with trajectory
- Responsive
  - Inclusion of Planned activity levels compared to actual activity levels by category type.
  - ED
    - Will include:
    - Total time in ED
    - Highlight on all ED performance and 12 hour breaches.
  - RTT
    - Will include:
    - Total waiting list size
    - 52 weeks trajectory
    - 40 weeks trajectory
    - Cancelled operations will be removed.
  - Cancer
    - Will include:
    - 62 day breaches
    - 104 day breaches
  - DM01
    - Will include:
    - Highlight report on performance
- Well Led
  - No further changes

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: February 2021

What is Statistical Process Control (SPC)?

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

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

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

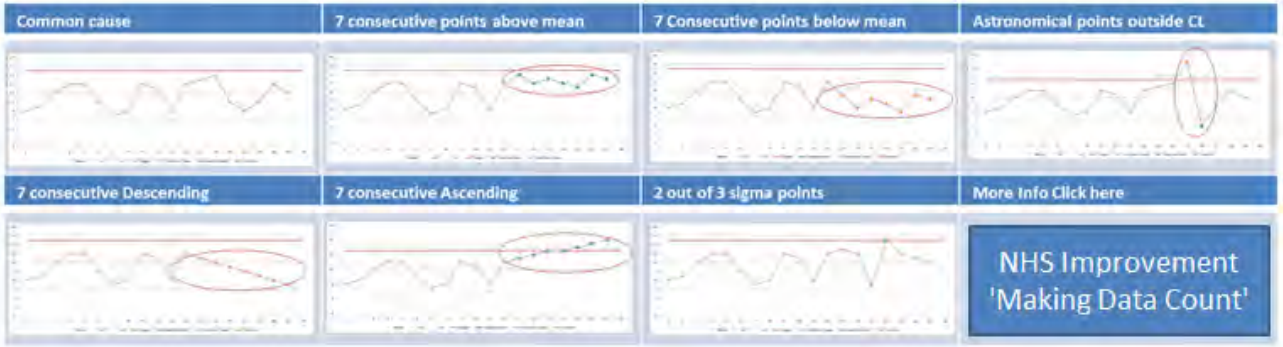
Key Facts about a SPC Chart:

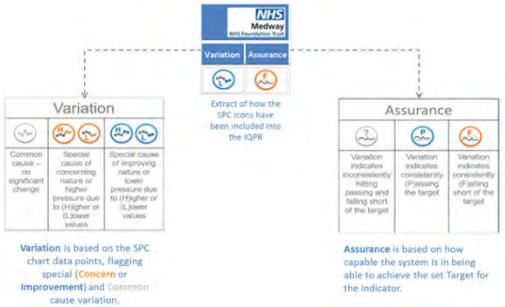
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls) & ED	• Flow
Caring	• The Friends and Family recommended rates for Maternity services and Outpatients remain above the national standard of 85%. In particular, both ED and IP FFT rates have improved in month, and have exceeded target.	• High number of breaches in Mixed Sex Accommodation continues into February, although early signs of improvement • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set
Effective	• VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement • Fractured NOF, whilst under target, has improved in month and is above the Mean	• Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • 0 Never Events in month	• Infection data shows spikes in C-Diff cases throughout January • Overall HSMR levels have risen from 98.8 to 102.36 – and are now above the national threshold (100)
Responsive	• Cancer 2ww Performance has exceeded the target in Jan-21 • 60+ Min Ambulance Handover delays are significantly down from levels seen over Winter, as to are +12 Hour DTA Breaches in ED	• DM01 Diagnostics performance has dropped significantly • ED 4 hour performance remains under LCL • RTT Incomplete Performance decreased in Dec-20 and is again slightly below LCL. +52wk breaches has seen an increase above UCL in Jan-21
Well Led	• Maintained compliance with Trust target for StatMan Compliance • Sickness rates have stabilised in month and are now slightly above target but under Mean	• Agency and Bank spend in Feb-21 has increased significantly • Appraisal % has continued to fall below target and is now below the LCL position

Executive Summary

NHS Medway NHS Foundation Trust

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

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Feb-21	3	1	43	26		
S2	Number of C-diff (HAI)	Feb-21	0	1	0	22		-
S3	MRSA Bacteraemia (Trust Attributable)	Feb-21	0	0	5	1		
S4	E-coli (Trust Acquired)	Feb-21	2	5	30	37		
S5	Falls per 1000 bed days	Feb-21	6.63	5.47	6.63	5.25		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Jan-21	1.04	0.2	1.04	0.03		
S7	Never Events	Feb-21	0	0	0	2		
S8	% of SIs responded to in 60 days	Feb-21	100%	100%	100%	100%		-
S9	HSMR (overall)	Nov-20	100	102.3	100	99.4		
S10	HSMR (weekday)	Nov-20	100	100.0	100	96.3		
S11	HSMR (weekend)	Nov-20	100	109.0	100	108.2		
S12	SHMI	Sep-20	1	1.07	-	-		

Caring			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Feb-21	0	72	0	1102		
C2	New Complaints	Feb-21	41	40	-	490		
C3	% Complaints responded to within target	Feb-21	85%	51.28%	85%	68.1%		
C4	% EDNs completed within 24 hours	Feb-21	100%	64.83%	100%	70.1%		
C5	Inpatients Friends and Family Response rate	Feb-21	22%	18.0%	22%	19.1%		
C6	Inpatients Friends and Family % recommended	Feb-21	85%	85.3%	85%	82.5%		
C7	ED Friends and Family Response rate	Feb-21	22%	16.22%	22%	15.95%		
C8	ED Friends and Family % recommended	Feb-21	85%	85.6%	85%	84.8%		
C9	Maternity Friends and Family Response rate	Feb-21	22%	21.43%	22%	31.32%		
C10	Maternity Friends and Family % recommended	Feb-21	85%	100%	85%	99.63%		
C11	Outpatients Friends and Family Response rate	Feb-21	22%	10.68%	22%	12.2%		
C12	Outpatients Friends and Family % recommended	Feb-21	85%	90.16%	85%	89.1%		

Responsive - Non-Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Feb-21	85%	80.06%	85%	80.18%		
R2	Average Length of stay (Non-elective)	Feb-21	5	9.08	5	8.25		
R3	Average Length of stay (Elective)	Feb-21	5	2.97	5	2.28		
R4	% of Delayed Transfers of Care	Feb-21	4%	0.17%	4%	0.36%		
R5	% Medically Fit For Discharge	Feb-21	7%	9.31%	7%	10.25%		
R6	ED 4 hour performance (All)	Feb-21	95%	79.4%	95%	85.12%		
R7	Ed 4 hour performance (Type 1)	Feb-21	95%	66.48%	95%	76.16%		
R8	ED 12 hour DTA Breaches	Feb-21	0	72	0	1102		
R9	Ambulance Attendances	Feb-21	-	2,986	-	35,180		
R10	60 minute handover delays	Feb-21	0	69	0	2,106		

Effective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Jan-21	5%	8.67%	5%	7.12%		
E2	30 day readmission rate	Jan-21	10%	15.1%	10%	13.52%		
E3	Discharges before noon	Jan-21	25%	14.21%	25%	14.46%		
E4	Fractured NOF within 36 hours	Jan-21	100%	88.00%	100%	72.45%		
E5	VTE risk assessment % completed	Feb-21	95%	92.47%	95%	94.26%		
E6	Elective C-section rate	Feb-21	13%	16.71%	13%	14.62%		
E7	Total C-Section rate	Feb-21	28%	37.96%	28%	36.4%		
E8	Average Occupancy (maternity)	Feb-21	15%	21%	15%	21.8%		
E9	12+6 risk assessments	Nov-20	90%	86.2%	90%	88%		
E10	Number of deliveries	Feb-21	-	353	-	4,218		-

Responsive - Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Jan-21	99%	75.78%	99%	71.38%		
R12	18 weeks RTT Incomplete Performance	Feb-21	92%	64.96%	92%	64.65%		
R13	18 Weeks over 52 week breaches	Feb-21	0	563	0	1801		
R14	Operations cancelled by hospital - on the day	Feb-21	0	1	0	105		
R15	Cancelled operations not rescheduled <28	Feb-21	0	0	0	26		
R16	Cancer 2ww performance	Jan-21	93%	94.85%	93%	96.52%		
R17	Cancer 2ww performance - breast symptomatic	Jan-21	93%	94.11%	93%	94.74%		
R18	Cancer 31 day first definitive treatment	Jan-21	96%	91.04%	96%	97.59%		
R19	Cancer 62 day treatment - GP referrals	Jan-21	85%	78.78%	85%	76.34%		
R20	104 day cancer waits	Jan-21	0	2	-	13		

Well Led			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	Dec-20	0	8	0	85	-	-
W2	CIP savings	Dec-20	£1,521k	£851k	£5,978k	£6,306		
W3	Appraisal %	Feb-21	85%	77.64%	85%	84.67%		
W4	Sickness Rate	Feb-21	4%	4.23%	4%	4.55%		
W5	Turnover rate	Feb-21	12%	11.7%	12%	12.2%		
W6	StatMan compliance	Feb-21	85%	88.83%	85%	88.67%		
W7	Contractual staff in post	Feb-21	-	4162.82	-	-		-
W8	Agency spend as % pay bill	Feb-21	4%	2.11%	4%	2.44%		
W9	Bank spend as % pay bill	Feb-21	9%	15.98%	9%	15.5%		
W10	Overall safe staffing fill rate	Dec-20						

Domain: Caring Dashboard

Executive Lead: Jane Murkin – Chief Nurse
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	Feb-21	0	72.00	0.00	134.23	273.49		
		MSA %	Feb-21	0%	0.56%	0.00%	0.91%	1.85%		
		% of EDNs Completed Within 24hrs	Feb-21	100%	64.83%	67.80%	73.38%	78.95%		
		Inpatients Friends & Family % Recommended	Feb-21	85%	85.26%	77.60%	84.46%	91.31%		
		Inpatients Friends & Family Response Rate	Feb-21	22%	18.01%	15.24%	20.13%	25.01%		
	ED Care	ED Friends & Family % Recommended	Feb-21	85%	85.62%	72.22%	79.63%	87.04%		
		ED Friends & Family Response Rate	Feb-21	22%	16.22%	12.25%	14.71%	17.18%		
	Maternity Care	Maternity Friends & Family % Recommended	Feb-21	85%	100.00%	97.53%	99.34%	100.00%		
		Maternity Friends & Family Response Rate	Feb-21	22%	21.43%	12.11%	26.71%	41.31%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Feb-21	85%	90.16%	87.46%	90.10%	92.73%		
		Outpatients Friends & Family Response Rate	Feb-21	22%	10.68%	11.41%	13.59%	15.77%		

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

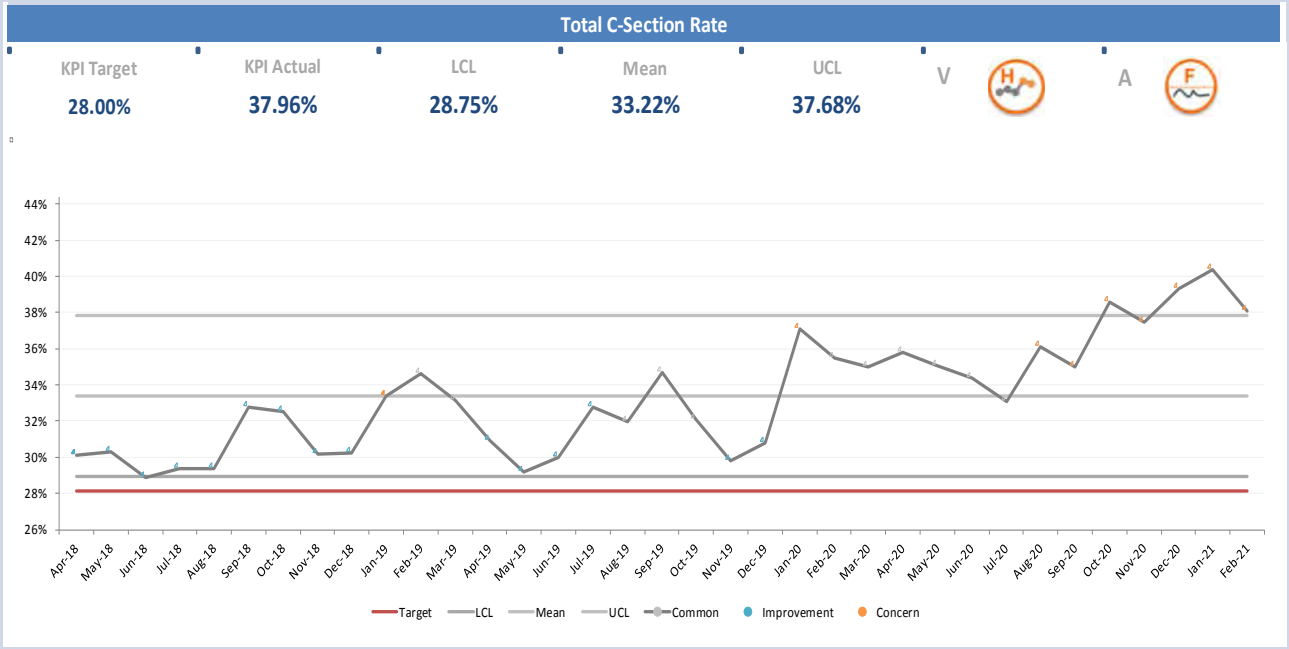
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	Jan-21	5%	8.68%	4.29%	5.85%	7.42%		
		30 Day Readmission Rate	Jan-21	10%	15.10%	9.39%	11.57%	13.75%		
		Discharges Before Noon	Jan-21	25%	14.21%	12.35%	14.93%	17.51%		
		Fractured NOF Within 36 Hours	Jan-21	100%	88.00%	35.28%	65.13%	94.98%		
		VTE Risk Assessment % Completed	Feb-21	95%	92.47%	77.09%	87.09%	97.08%		
	Maternity	Elective C-Section Rate	Feb-21	13%	16.71%	10.01%	13.48%	16.94%		
		Emergency C-Section Rate	Feb-21	15%	21.25%	15.29%	19.72%	24.16%		
		Total C-Section Rate	Feb-21	28%	37.96%	28.75%	33.22%	37.68%		
		12+6 Risk Assessment	Nov-20	90%	86.17%	60.79%	81.47%	100.00%		

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

Executive Lead: Jane Murkin – Chief Nurse
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate



What changes have been implemented and improvements made?

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

What do the measures show?

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

The caesarean section rate is monitored by the Care Group on a monthly basis via the maternity dashboard. It has been recognised that there has been a gradual rise caesarean section rate since September 2020, with December 2020 being the highest. The Matron and Consultant for Intrapartum Care have commenced a case review for September to December 2020 to better understand details of case management and clinical decision making.
It is anticipated that the locally implemented KPI of 28% is no longer realistic or reflective to the national ambition to reduce stillbirths by 50%, resulting in an increased induction of labour rate. In response to Ockenden (2020) the LMS is reinstating work to develop a LMS dashboard to support the Perinatal Surveillance too/model.

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

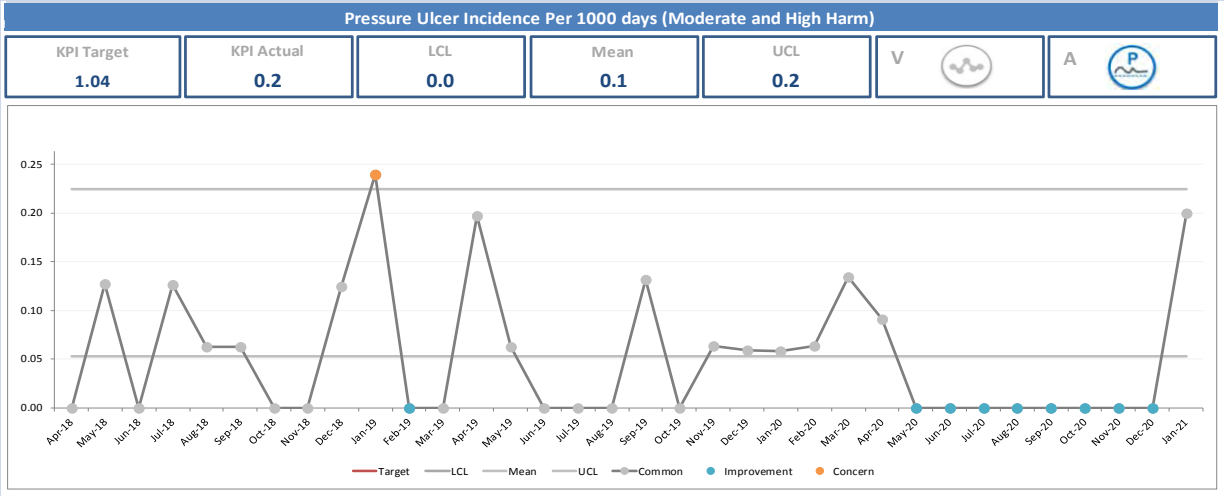
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Feb-21	6.63	5.47	2.91	4.77	6.64		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Jan-21	1.04	0.20	0.00	0.05	0.22		
	Incident Reporting	Never Events	Feb-21	0	0.00	0.00	0.14	0.93		
		No of SIs on STEIS	Feb-21	90	17.00	0.00	13.37	28.55		
		% of SIs Responded To In 60 Days	Feb-21	0%	100.00%	93.43%	98.38%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Jan-21	5	0.00	0.00	0.47	2.32		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Jan-21	43	1.00	0.00	2.64	8.72		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Jan-21	0	1.00	0.00	1.82	6.63		
		E-coli (Trust Acquired) Infections	Jan-21	30	5.00	0.00	4.44	10.49		
	Mortality	Crude Mortality Rate	Jan-21	3%	4.87%	0.59%	1.86%	3.14%		
		HSMR (All)	Nov-20	100	102.36	96.29	104.58	108.86		
		HSMR (Weekday)	Nov-20	100	100.02	88.55	101.70	101.70		
		HSMR (Weekend)	Nov-20	100	109.08	96.51	112.38	122.27		
		SHMI	Sep-20	1	1.07	0.79	1.01	1.23		

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

Executive Lead: Jane Murkin – Chief Nurse
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

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



What changes have been implemented and improvements made?

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

What do the outcome measures show?

The Quality strategy aim to hospital acquired pressure ulcer incidents by 10%.

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

What do the process measures show?

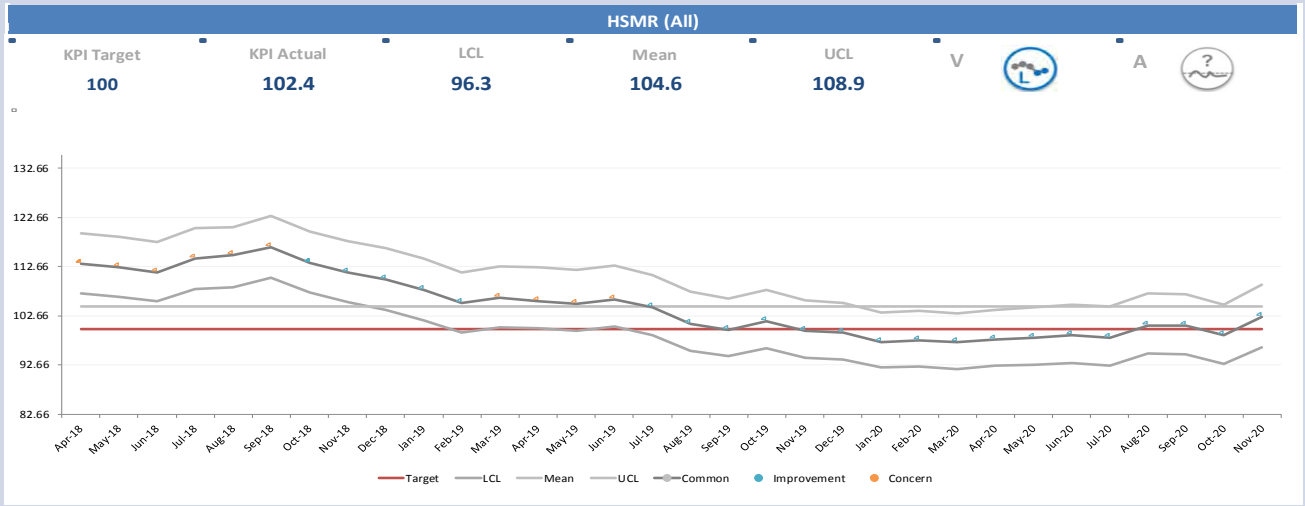
There has been a hospital acquired category 4 and unstageable which are currently being investigated as a SI.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Mortality - HSMR



What changes have been implemented and improvements made?

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

The audit into the higher mortality among Swale patients has not revealed any significant issues apart from a possible finding that Swale patients are unwell for longer before their presentation than Medway patients. However there is no difference in their time to arrive at hospital after calling an ambulance, or their physiological scores on arrival.

Mortality of non-COVID conditions during Wave 1 of COVID has been reviewed at the M+M Committee and will be discussed at the April QAC.

What do the measures show?

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

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

The small rise in HSMR (and all cause mortality) in November is likely related to the impact of COVID Wave 2 prior to the data reset which occurs every 3 months.

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Feb-21	85%	80.06%	81.00%	88.18%	95.35%		
		Average Elective Length of Stay	Feb-21	5	2.28	0.00	2.72	5.44		
		Average Non-Elective Length of Stay	Feb-21	5	9.09	7.35	8.50	9.65		
		% of Delayed Transfer of Care Point Prevalence in Month	Feb-21	4%	0.17%	0.32%	1.29%	2.27%		
		% Medically Fit For Discharge Point Prevalence in Month	Feb-21	7%	9.32%	14.08%	17.41%	20.75%		
	ED Access	ED 4 Hour Performance All Types	Feb-21	95%	79.41%	75.67%	83.13%	90.59%		
		ED 4 Hour Performance Type 1	Feb-21	95%	66.48%	64.21%	74.63%	85.05%		
		ED 12 hour DTA Breaches	Feb-21	0	9.00	0.00	22.54	80.12		
		60 Mins Ambulance Handover Delays	Feb-21	0	69.00	0.00	120.89	277.36		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

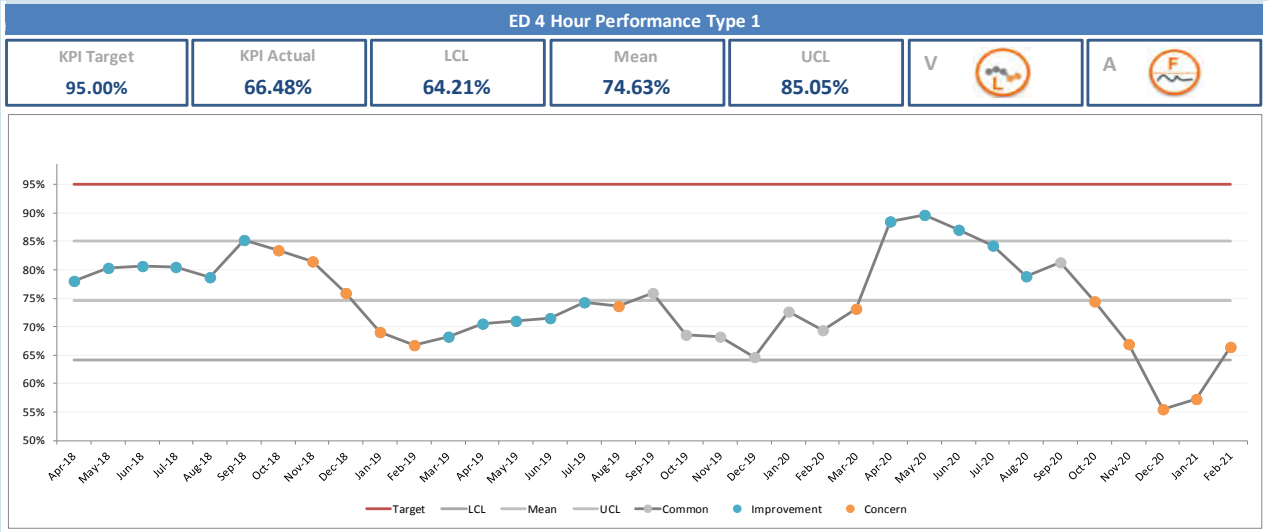
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Elective	Diagnostic Access	DM01 Performance	Jan-21	99%	75.78%	77.15%	89.54%	100.00%		
	Elective Access	18 Weeks RTT Incomplete Performance	Feb-21	92%	61.53%	70.49%	76.56%	82.62%		
		18 Weeks RTT Over 52 Week Breaches	Feb-21	0	563.00	0.00	56.20	120.98		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Feb-21	0	1.00	0.00	20.69	48.69		
		Cancelled Operations Not Rescheduled < 28 days	Feb-21	0	0.00	0.00	4.57	12.79		
Responsive – Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Jan-21	93%	94.86%	78.49%	88.96%	99.44%		
		Cancer 2ww Performance - Breast Symptomatic	Jan-21	93%	94.12%	51.76%	80.90%	100.00%		
		Cancer 31 Day First Treatment Performance	Jan-21	96%	91.04%	89.81%	96.31%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Jan-21	85%	78.79%	62.72%	78.05%	93.38%		
		104 Day Cancer Waits	Jan-21	0	2.00	0.00	2.18	5.40		
	Complaints Management	Number of Complaints	Feb-21	41	40.00	18.41	59.80	101.19		
		% Complaints Responded to Within 30 Days	Feb-21	85%	51.28%	38.75%	68.34%	97.94%		

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:

- Validate Trust Internal Professional Standards in response to emergency referral and flow and implement across all pathways;
- Re-introduce the 'refer and move' flow principle to surgical, frailty and medical assessment areas;
- ED patient safety checklist content aligned to ED Nursing documentation (30D)
- Improve application of swabbing protocol and TAT in laboratory has increased LOS for admitted patients;

Outcomes:

- Compliance in 4hr standard
- Total time in department <150mins
- ED IPS compliance

Underlying issues and risks:

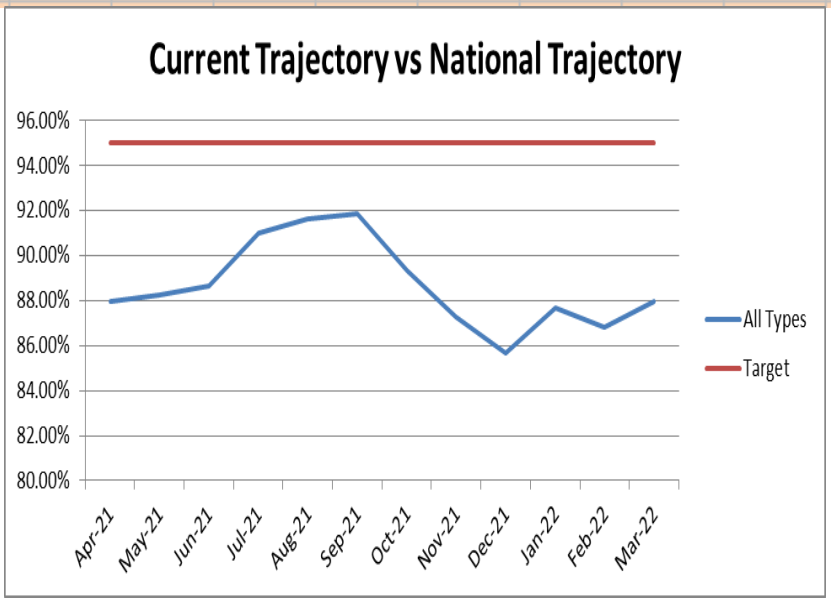
- Workforce gaps in acute medicine has meant increased LOS for referred patients. This wouldn't be a problem if we had Refer and Move capacity available on Lister. AAU capacity reduced by 50% in M9;
- Excess admitted and non-admitted breaches between 2100 – 0300.
- Ongoing issues with roles and responsibilities
- Gaps in Senior ED leadership

Safe | Responsive | Well Led

Emergency Care 4 hour Standard Improvement Trajectory

Performance	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Type 1	73.64%	74.42%	75.77%	79.36%	81.96%	81.94%	76.12%	69.90%	66.79%	72.65%	71.13%	73.26%
MedOcc Streamed Type 3	99.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
WIC/UIC Type 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All Types	87.94%	88.22%	88.65%	90.97%	91.65%	91.86%	89.35%	87.27%	85.66%	87.66%	86.83%	87.94%
Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

Currently, as the first cut the internal trajectory does not meeting the national standard during 2021-22. The improvement actions under the auspices of the Patient First Programme will be further revised to confirm the additional interventions needed to deliver 95% in year. Once these are validated the trajectory will be updated.

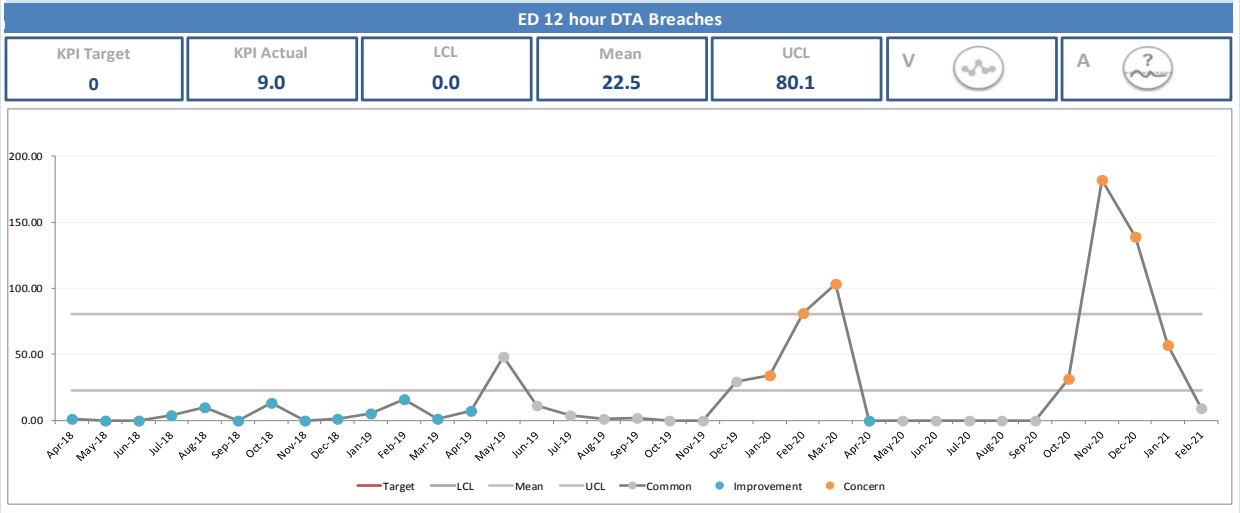


Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- The Patient First Programme is focused on acute care, flow and discharge and site management all of which are underpinning improvements in patient flow through ED and the wards.
- Regular MADE events to maintain focus on flow out of the wards.
- Engagement with ECIST support to align priorities and resourcing

Outcomes:

- Zero 12hr DTA breaches - no breaches sine March 4th.
- Reduction in total time in department to <150mins
- Improvement in patient outcomes

Underlying issues and risks:

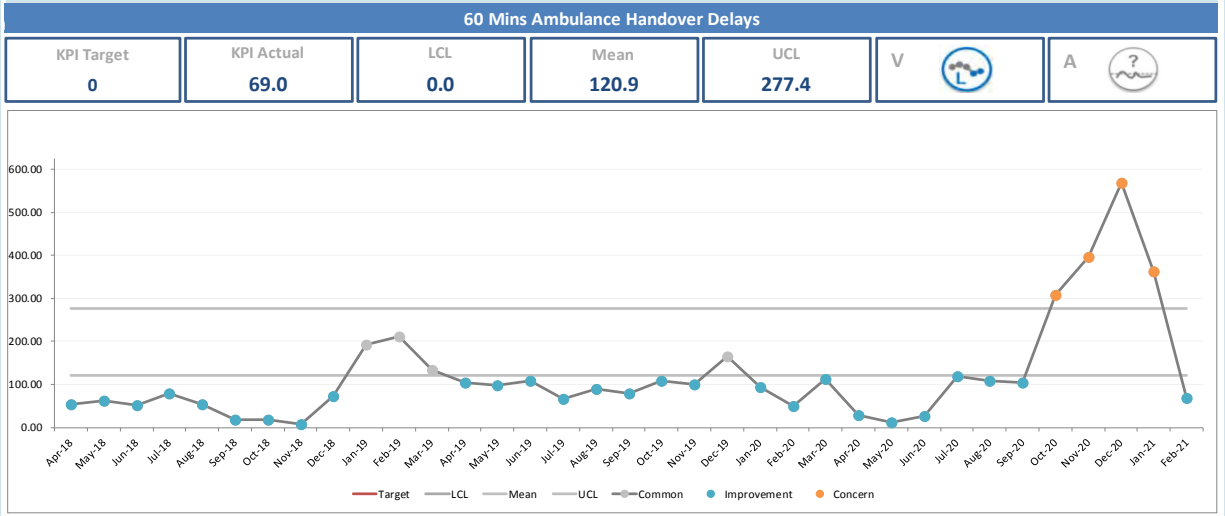
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Lack of refer and move assessment capacity due to COVID 19
- Gaps in Senior ED Leadership
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Validate each 60min handover delays to understand causes.
- SOP formalised to establish risk mitigated corridor care;
- Revised roles and responsibilities in ED to increase clinical responsibility,
- Relaunch SAU and AAU pathways.

Outcomes:

- Zero 60min hand over delays
- Actions to monitor and respond to patient deterioration are improved and refined. This includes access by order of clinical priority;
- We have increased RAU to N=8 cubicles with Covid19 pathway specification ;
- Care Group led and clinically-led solution for internal ED decompression during surge required to compliment operational oversight;

Underlying issues and risks:

- Workforce mismatch demand
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Gaps in Senior ED Leadership

Emergency Care – Ambulance Handover Turnaround Times

Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Arrivals	3400	3274	3237	3644	3373	2970	2874	3144	3269	3417	3006	3188
Handovers <15 Minutes	1974	1878	1907	2119	1934	1061	1286	1416	1919	1993	1689	1772
Handovers Between 15-30 Minutes	1044	1073	988	1185	1101	1559	1338	1460	1179	1123	958	1080
Handovers Between 30-60 Minutes	382	323	342	340	338	350	250	268	171	301	359	336
Handovers >60 Minutes	0	0	0	0	0	0	0	0	0	0	0	0

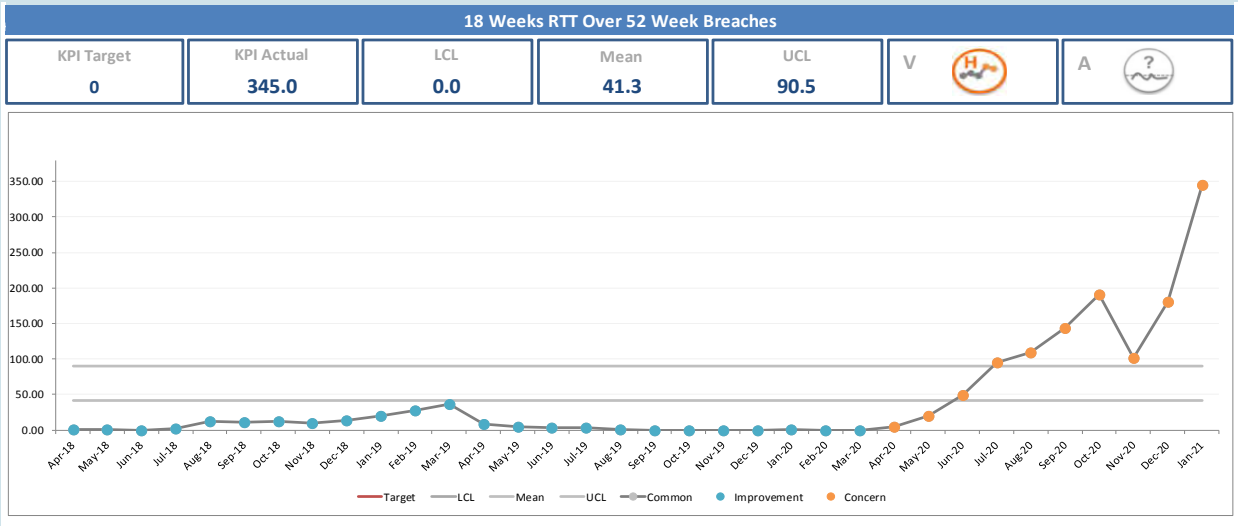
The trajectory for 60min handover delays has been set to zero in accordance with the aspiration to eradicate 60min handover delays. In March we have achieved 20 days with zero +60 minute breaches and are setting furtehr interventions to support the sustainability of this, largely centred on improved flow through ED (aCT) and flow out of beds.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature.

Actions:

- Elective Restart go live from 22nd March
- Demand and capacity models being worked on to include recovery of long waiters by end August 2021
- Full PTL validation
- System –wide planning and ownership of capacity and demand

Outcomes:

- 0 x 52 week by August 2021 with exception of ENT.
- Clarity on patients and treatment in accordance with clinical priority (P1,2,3,4)
- Established green pathways for elective patients.

Underlying issues and risks:

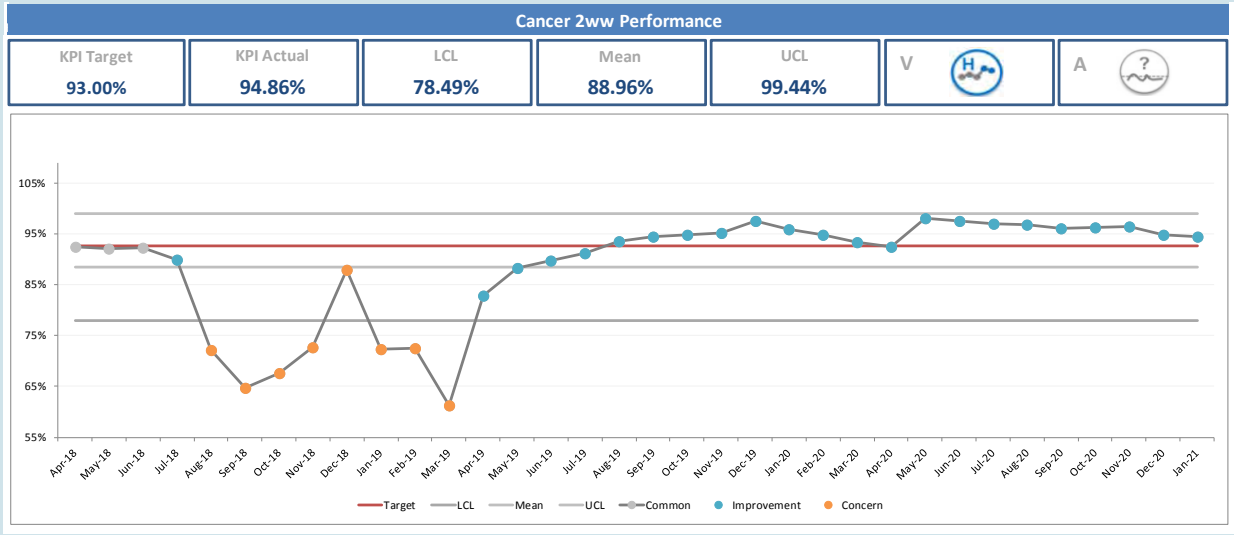
- Workforce issues - Leave accumulation and vacancies
- Uncertainty on NEL and associated impacts
- End of national contracts for Independent work and financial impacts

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

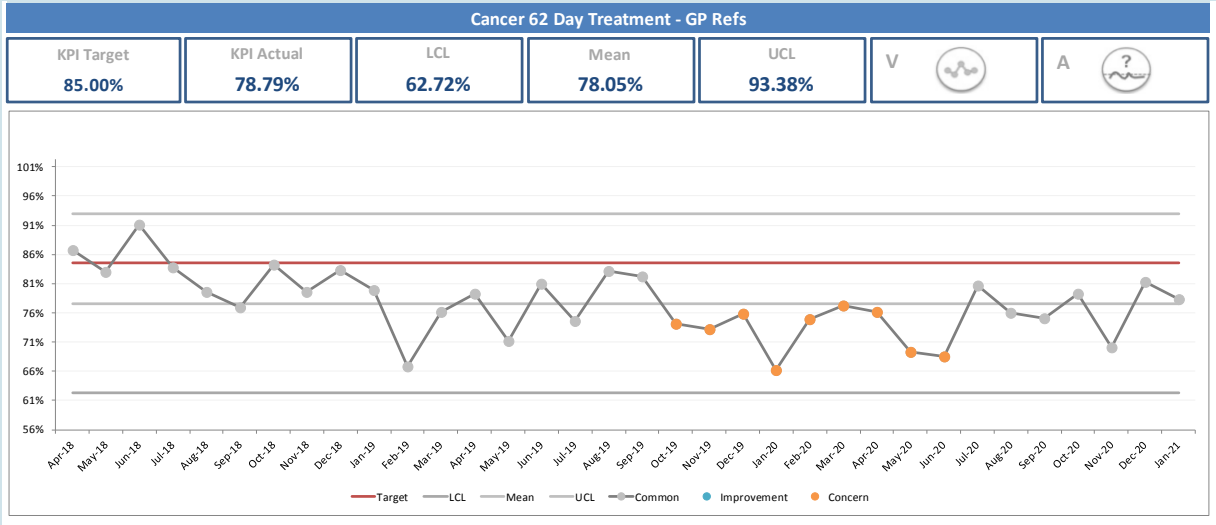
- Internal Stretch target of 7 Days is now being achieved by 2 services Urology & H&N
- 7/9 Services booking at day 14 or under.
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic Capacity could challenged as the trust pushes ahead with restart.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Review and revision of all diagnostic capacity and access for patients with suspected cancer .
- Develop straight to test pathways for Colorectal and UGI cancer referrals..
- Increase the frequency of cancer PTL meetings to ensure that all patients progress on their treatment pathway is reviewed regularly and appointments booked promptly.

Outcomes:

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

Underlying issues and risks:

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

Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Director of HR & OD
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)	Feb-21	85%	77.64%	80.15%	85.18%	90.21%		
		Sickness Rate (Current Reporting Month, FTE%)	Feb-21	4%	4.23%	4.00%	4.28%	4.56%		
		Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Feb-21	12%	11.71%	10.90%	12.07%	13.23%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Feb-21	0	4162.82	3800.93	3303.52	4006.10		●
		StatMan Compliance (Current Reporting Month)	Feb-21	85%	88.83%	65.04%	79.90%	94.75%		
		Agency Spend as % Paybill (Current Reporting Month)	Feb-21	4%	2.11%	2.00%	3.69%	5.38%		
		Bank Spend as % Paybill (Current Reporting Month)	Feb-21	9%	15.98%	8.87%	13.12%	17.38%		
		Temp Staffing Fill Rate - Nurse & Midwifery (Current Reporting Month)	Dec-20	75%	41.15%	60.80%	72.65%	84.49%		

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month NHSE/I Baseline	In-month Actual	In-month Variance	YTD NHSE/I Baseline	YTD Actual	YTD Variance
Income	29,921	31,016	1,095	321,788	331,185	9,396
Pay	(19,248)	(20,225)	(977)	(205,663)	(211,360)	(5,697)
Total non-pay	(9,299)	(9,442)	(144)	(101,235)	(104,838)	(3,603)
Non-operating expense	(1,374)	(1,358)	16	(14,891)	(15,091)	(200)
Reported surplus/(deficit)	**0**	**(9)**	**(9)**	**0**	**(104)**	**(104)**
Donated asset deprecation	0	9	9	0	104	104
Control total	**0**	**0**	**0**	**0**	**0**	**0**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	2,077	887	(1,190)	9,878	8,006	(1,872)	12,000
Capital	(7,123)	(5,152)	1,971	(26,338)	(19,728)	6,610	(32,109)

Indicator Background:

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

What the Chart is Telling Us:

The Trust is reporting breakeven against its control total. CIP is adverse to plan, this is mainly due to the pressures from Covid-19. The forecast CIP for 20/21 remains at £8.9m. Capital spend is forecast to continue to increase and complete the year at £0.3m underspent to plan.

Actions:

- Currently monitoring the forecast outturn together with identified risks and opportunities.
- Draft Business Plans for 2021/22 have been submitted, ensuring establishments, budgets, activity and cost pressures are identified and developed in the divisions.
- CIP development with focus now on schemes for 2021/22.

Outcomes:

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

- Incremental costs associated with Covid-19 of £16.6m year to date. The forecast spend of £18.4m is within the agreed level of funding from the STP and NHSE/I.
- Of the Kent & Medway STP deficit for Oct-Mar, £3.7m is due the Trust's annual leave carry forward accrual.
- 20/21 forecast outturn for the Trust is breakeven excluding annual leave accrual.

Underlying issues and risks:

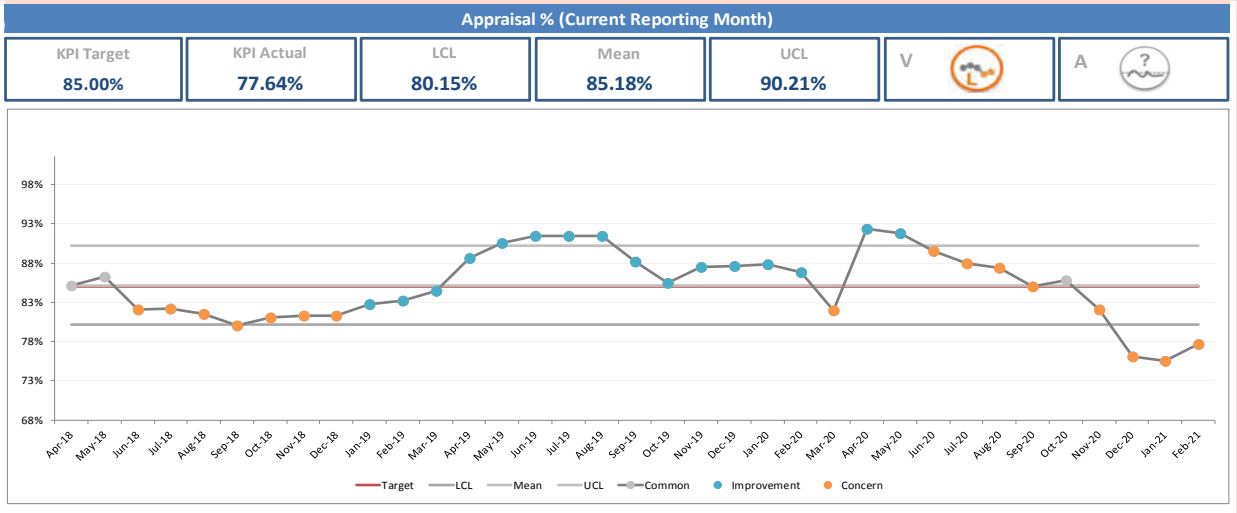
Following a revised plan submission, new arrangements came into force from 1 October with control of top-up, Covid and growth monies now held at STP level.
Pay costs remain adverse to budget and £1.6m adverse to the Oct-Mar plan. This a consequence of the continued high levels of Covid activity and increased bed capacity.
CIP forecasts are £3.1m below the £12.0m plan, this has not changed from January.
Capex is increasing as forecast and is expected to recover further to achieve a small variance of £0.3m to the £32.1m plan.

Well Led: Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed the appraisal process.

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

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

Meeting of the Public Board
Thursday, 15 April 2021

Title of Report	**Trusts Infection Prevention and Control Improvement Plan**	Agenda Item	**4.2**
Lead Director	Jane Murkin, Chief Nursing and Quality Officer, and DIPC		
Report Author	Liam Edwards, Deputy Chief Nurse		
Executive Summary	Effective infection prevention and control is fundamental to the delivery of high quality, safe and effective patient care. At the Executive team meeting on 17 March 2021 the Chief Nursing & Quality Officer provided a high level overview and current status of IPC across the organisation on accepting Executive responsibility for the service on 14 December 2020. The plan was also approved at the Quality Assurance Committee meeting on 16 March 2021. Following the IPC visit by the National Team on 26 November the Chief Nursing & Quality Officer produced an action plan setting out the key actions to address the following three areas aimed at reducing hospital acquired infections: Leadership & Governance, Prevention of Transmission & Prevention of Infection. The Trust's previous IPC Improvement Plan has been reviewed in light of the visit and refreshed to incorporate the actions from the national team visit setting out short, medium and long term goals. The improvement plan also incorporates actions relating to gaps identified from the updated Infection prevention and Control (IPC) Board Assurance Framework (BAF), the BAF is appended to this paper. The IPC Improvement Plan directly references the 10 criteria set out in the code of practice on the prevention and control of infection which links to Regulation 12 of the Health and Social Care act 2008 (regulated activities) Regulations 2014. These criteria are: 1) Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. 2) Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. 3) Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. 4) Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion. 5) Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. 6) Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the		

	process of preventing and controlling infection. 7) Provide or secure adequate isolation facilities. 8) Secure adequate access to laboratory support as appropriate. 9) Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. 10) Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection. Since the National IPC Team visit on 26 November significant progress has been made to address the issues identified and related actions. Progress on the delivery of actions within the improvement plan has been acknowledged by the National IPC Team. References: The Health and Social care Act 2008, Department of Health (2015) Regulation 12: safe care and Treatment, Care Quality Commission (2014) Health and Safety at work act, Department of Health (1974)
Committees or Groups at which the paper has been submitted	Quality Assurance Committee Executive Group Infection Prevention and Control Committee
Resource Implications	Nil identified
Legal Implications/ Regulatory Requirements	The Health and Social care Act 2008, Department of Health (2015) Regulation 12: safe care and Treatment, Care Quality Commission (2014) Health and Safety at work act, Department of Health (1974) Regulatory compliance with CQC framework and CCG commissioning process
Quality Impact Assessment	Quality Impact Assessment detailed as part of the CQC inspection report
Recommendation/ Actions required	The Board is asked to note progress to date in addressing actions relating to findings from the National Team visit in November 2020 and note the Trust's IPC Improvement Plan that has been approved by the Executive Group and Quality Assurance Committee.

Approval	Assurance	Discussion	Noting
☒	☐	☐	☒

Appendices	IPC BAF

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

Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.	

Infection Prevention & Control Trust Improvement plan.						
Aim: To reduce Hospital Acquired Infections						
Short Term Actions (1 – 5 Months**)**						
Identified Issue	**Area of Action**	**Action to be taken**	**Progress Update of action**	**Responsible Officer**	**By when**	**RAG**
Implementation of National Covid Guidelines	IPC Board Assurance Framework (BAF) Health & Social Care Act Compliance Criterion 1	1. IPC BAF to be urgently updated and reviewed by Chief Nursing & Quality Officer & Chief Medical Officer	1. BAF currently in progress of updating and to be checked and authorised by the CNQO and CMO 2. IPC BAF updated and shared externally for input from National Team by CNQO 3. IPC BAF shared with CCG colleagues	CNQO CNQO	15/03/21	B
		2. Collate evidence folders to support full compliance with the BAF	1. IPC BAF and associated action plans will be reported at all the appropriate meetings going forward and evidence collated. Evidence folder is now saved onto the shared nursing drive.	CNQO	30/03/21	A
		2. Updated IPC BAF to be reported at Exec Team, QAC and Trust Board monthly with associated action plan to address gaps in assurance.	1. In progress, BAF presented to QAC on 19/1/2021 and 16/2/2021 2. IPC BAF and current state paper on IPC presented to the Executive Team on 7/10/2020 and update on the 3/2/2021 3. IPC BAF presented to Trust Private Board on 4/3/21 4. Formal communication sent from CNQO to Executive Leads setting	CNQO	30/03/21	G

			out individual executive areas of accountability & responsibility 5. Separate meetings held with responsible executives regarding assurance needed to mitigate gaps. 6.			
	Outbreak Management Health & Social Care Act Compliance Criterion 1, 4, 5,9	1. COVID data provided to CNQO & CMO prior to daily outbreak meetings	1. Covid 19 outbreak data is provided by Business intelligence on a daily basis prior to outbreak meetings. Plans in place to provide the meeting with COVID HAI data to monitor trends and identify issues.	Deputy Director of Business Intelligence/ IPC Team	04/01/21	G
		2. Outbreak management data collection and reporting to be reviewed	1. Internal data collection and reporting to be reviewed and identify issues which will be actioned and resolved	Deputy Director of BI/IPC Team	31/01/21	B
		3. Outbreak management overseen by responsible Exec	1. Outbreak management overseen by CNQO as DIPC to provide executive leadership	DIPC/Executive Lead	31/01/21	B
		4. COVID outbreak policy to be virtually approved by Executive (approval from IPC Tactical team already obtained) and introduced into routine practice. Use of COVID-19 outbreak checklist for ward managers/nurse in charge	1. Outbreak policy: part of the review of COVID related SOPS and policies undertaken by NHSI/E IPC Regional Lead Jackie Dalton on behalf of the Trust. Final document to be presented to the April 2021 IPCC	CMO/CNQO	30/04/21	G

		5. Produce updated communications and focused/cascade training for outbreak management for clinical staff	1. CNQO currently provides executive oversight through the DDoNs and Clinical Directors and all areas needing further decision making are brought to the attention of the CMO /CNQ. 2. DDoNs and operational teams have had and are cascading outbreak management principles. 3. Matrons checklist in place for wards that are effected by an outbreak to monitor compliance with IPC. 4. Gaps in assurance discussed at the daily outbreak meeting with learning shared and mitigations discussed 5. Daily communications cascade provided via central communications team	CNQO	1/12/21	B
		6. CMO and CNQO to provide professional oversight to ensure decisions and bed moves are clinically led	1. The operations team meets daily with IPC during Covid outbreak meetings. The site team have clarity around patient pathways and screening via the urgent care patient flow chart. 2. Changing status of a ward e.g. red-amber is governed by a ward de-escalation checklist.	Director of Operations	11/01/21	B

			3. Once IPC team is established to join in the daily bed meetings to give IPC update and ensure input into operational meetings		19/4/21	G
		7. COVID HAI data collection process is governed by existing SOPs and guidance	7. Business intelligence (BI) to compile report using existing reporting structures. 8. Once recruited into BI to link with IPC Data Analyst to provide more current reports and enable ad hoc analysis of information to review action plans and updates more timely. This will also enable more systematic learning of PIR and	Deputy Chief Executive / Lead IPC nurse	30/04/21	G
	PPE Management Health & Social Care Act Compliance Criterion 1, 4, 6,7,9,10	1. Launch remobilisation guidance and ensure all staff are aware of the current guidelines	1. Remobilisation guidance to be re launched at the IP&C Committee 22nd December as the official advice to follow. With widespread sharing of the documents and contents.	DIPC/DCN	22/12/21	B
			2. NHSE/I Regional IPC Lead Jackie Dalton supporting the Trust by comparing current SOPS and guidelines to the main UK IPC guidelines to ensure all staff have access to clear and up to date guidelines. Final document to come to IPCC committee for ratification in April 2021	DIPC/DCN	22/04/21	G

		2. Include in agency/locum induction training https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control Matron PPE champions Discussion and updates at daily safety huddles/handovers	1. Mobilisation guidance sent out to all Senior Nursing Teams for further distribution across the organisation. 2. Guidance sent to Chief Medical Officer for distribution down through medical workforce.	DCN	22/12/20	B
		3. Guidance to be sent to all senior nurses and Clinical Directors in the Trust to provide a readily available resource for information and guidance.	1. All communications from ward to Board are now to be approved by the DIPC prior to release to ensure correct and appropriate information is being shared. This information is considered to be the COVID bulletin. 2. DIPC will also produce a regular blog of updates so staff can refer back for advice. This will be produced by the band 7 IPC nurse and reviewed by the DIPC 3. In addition regular staff huddles via Matrons / Heads of Nursing / Divisional Directors of Nursing / Clinical colleagues will take place as required. 4. Link practitioner program re-launched with participation in regional IPC Link practitioner program. First meeting in April	DIPC DIPC DDON DDON	01/12/20 14/04/21 31/04/21 31/04/21	G

			2021.			
		4. Communications from Board to Ward to be revisited to ensure frontline clinicians receiving effective and up to date guidance on Covid/PPE communication	1. To be addressed in conjunction with progress point 3 above	DIPC	31/03/21	G
		5. Joint Executive/Senior Leadership Team clinical walk rounds to support staff engagement and create a culture of safe challenge	1. Matron's quality rounds already in place and initiated by CNQO in 2020. 2. CNQO ward visits in place 3. DDON ward visits in place 4. Senior team reviews to commence in March 2021	DDON	31/03/21	G
		6. Monitoring PPE/covid guidance compliance across the organisation using an auditing tool and disseminate immediate results back.	1. IPC Team and CCG liaison IPC Nurse currently conducting Trust wide audit and will present findings to IPCC in April 2021	DIPC	30/04/21	G
		7. Monitor PPE/Covid compliance though Divisional governance meetings	1. Post presentation at IPCC in April 2021 there will be an action plan based on findings. This will establish targeted areas for additional work.	DDON	30/04/21	G
		8. Confirm the responsibility for centrally held mask FIT testing with evidence of	1. Awaiting executive decision of where the responsibility for recording and monitoring this	Executive board	31/03/21	G

		SOP's to show to show all appropriate staff are tested with a process of escalation for those that fail the testing and a process for auditing compliance	would belong			
	Visibility of IPC Team Health & Social Care Act Compliance Criterion 1,6,9	1. Improve and increase daily visibility of IP&C Team on wards and clinical areas to provide assurance of good IP&C Practice.	1. Currently IPC team visibility is provided both by NHS E/I colleagues, CCG colleagues and internal resources. This is due to the recent appointment of the band 7 IPC nurse and interim Associate Director of IPC starting on the 15th March. The AD for IPC will be a staff facing role and provide a strong clinical focus going forwards.	DIPC/DCN	31/03/21	A
			2. Interim IPC Lead due to start 15/03/2021	DCN	15/03/21	G
			3. Data Analyst role commencing 19/4/21	DCN	08/03/21	G
			4. IPC Matron, IPC Nurse and ADoN role re-advertised 5/3/21	DCN	05/03/21	R
			5. The new DIPC has Chaired the IP&C Committee (22nd December) to set out new strategic direction and Vision for IP&C moving forward.	DIPC/DCN	22/12/21	B
			6. Video to be produced by Communication team and currently working on narrative for	DIPC/Comms Team	30/04/21	A

			DIPC			
		2. Utilise existing IPC Link Practitioners to support local resilience.	1. IPC link nurse role reinvigorated and relaunched in April 2021	DCN	30/04/21	G
		3. Dedicate IPC Band 3 to support and challenge hand hygiene and PPE and other standards and transmission based precautions on wards and departments.	1. Divisional Matrons made aware by CNQO of their increased responsibility for monitoring IP&C during this time and are asked to report any variation to IPC Team and request support where additional advice or learning may be required	Divisional Matrons	03/01/21	B
		4. Divisional Matrons to undertake monitoring and provide assurance during the regular ward quality rounds. Include summary's in Board reports	1. Divisional Matrons conducting audits as part of assurance process. To utilise audit tool once verified by CCG liaison currently being trialled in March 2021. For review of tool and results at April IPC committee and then embedding into clinical practice.	Divisional Matrons	30/04/21	G
		5. Identify and share key learning and good practice in relation to IPC	1. Blog to be prepared and consideration of regular seasonal/current messaging throughout the year	DIPC/Comms Team	30/04/21	G
			2. Dissemination of key messages to be included as part of IPC link nurse roll out	DDON	30/04/21	G

			3. Build on lessons learned and reflective practice through CNQO facilitated debrief sessions	CNQO	09/03/21	B
		6. Communication video from new DIPC providing consistent clear advice on IPC	1. New DIPC video completed	DIPC	22/12/20	B
			2. Additional revised DIPC update video to be completed	DIPC	30/04/21	G
		7. Initiate Regular DIPC Blog to ensure all staff have access to clear accurate and up to date advice and support.	1. DIPC blog in development		30/04/21	G
	Clinically led patient moves Health & Social Care Act Compliance Criterion 1,2,5,6,7,9	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.	1. All bed moves coordinated through the bed /site team with oversight provided by the Senior Nurse/DDoN. When capacity issues patient bed moves are escalated to DDoNs whilst attending site/operational meetings to ensure appropriate movement of patients. The site team have clarity around patient pathways and screening via the urgent care patient flow chart. Patients moved from admitting ward for clinical need, operational pressures in light of risk mitigation elsewhere in the Trust or due to a change in COVID pathway status, or to de-escalate a ward. Changing status of a ward e.g. red-amber is governed by a ward de-escalation checklist and	DDoNs /IPC Team / Operations Team	01/12/20	B

			agreed with the COO and DIPC.			
	Environment Cleaning/ Signage Health & Social Care Act Compliance Criterion 1,2,4,5,6,7,9	1. Review all patient toilet facilities to ensure correct signage relating to COVID risk status.	1. All signage has been part of the daily review by IP&C nurses and where changes have been necessary signage has changed	Health and Safety Team	01/12/20	B
		2. Ensure appropriate signage in all clinical areas indicating clearly the level of Covid risk status (Red/Amber/Green)	1. 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	01/12/20	B
		3. Identify responsible lead to review and update as changes/guidance occurs	1. To be reviewed between estates and IPC when IPC team is fully established.	IP&C Team and Director of Estates	30/04/21	G
	Distancing Health & Social Care Act Compliance Criterion 1,2,6,7,	1. All nightingale wards to be converted into red wards to prevent transmission in the initial phase.	1. With the support and advice of the NHSE/I Senior IPC Lead all nightingale wards have been converted to red wards and are kept under review daily 2. When deescalating from red to amber in later phases of the pandemic, mitigations include; daily COVID Testing of all patients, twice daily cleaning of the ward and the rapid (within a hour) movement of any patient that tests positive for COVID 19.	IP&C Team and Operations Team	01/12/20	B
		2. Director of Estates to undertake an urgent review of all Nightingale Wards to	1. Director of Estates currently reviewing nightingale wards looking to identify improvements	Director of Estates/Team	31/03/21	A

		identify opportunities to improve the ward infrastructure in partnership with CNQO & CMO include RAG rating of programme according to priority of work with timelines	which could support IP&C although it should be noted that this is not currently on the capitol estates plan. This will however be covered under the ward refurbishment program funded via Capital incorporating specific IPC issues			
		3. Strategic review to be undertaken of Medway's bed base in relation to the bed availability across the health system and provide a clear bed management plan.	1. To be discussed at executive level	CEO/COO	31/04/21	G
		4. Reduce number of chairs in staff and doctors rooms.	1. 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. Signage currently being place on doors relating to the maximum occupancy. Completed by Health and Safety.	Estates Team / IPC team	31/03/21	A
		5. 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.	1. This action is currently in progress as the IP&C Team work with clinical colleagues 2. Phase 1 review currently underway by Estates Team	Director of Estates/Team & Health & Safety Team	31/03/21	A

		6. 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	1. Office space under review by estates team	Director of Estates	31/03/21	G
		7. IT to review access to Trust systems via virtual networks on staff's personal computers (appropriately protected and with safe storage at work provided)	1. IT has a process in place to review virtual networks and provide additional network access with appropriate safeguards in place for all staff where it is deemed they need to work off site.	Director of IT/Team	10/01/21	B
	IPC Audit compliance Health & Social Care Act Compliance Criterion 1, 5,6,7,9	1. Monitor the COVID screening of all patients on admission day 3 and day 5 to 7.	1. Ward and Care Group Data to be provided daily by BI point. 2. To be reviewed as part of the IPC committee meetings	Deputy Director of BI	28/02/21	A
		2. Identify and embed ward based system to flag screening protocol to provide assurance of swabbing compliance	1. COVID screening audits undertaken by planned and unplanned care. With divisional action planning to address gaps. Plan in place to audit monthly.	DDON	1/03/2021	G
			2. Some areas undertaken but not comprehensively. DDONs continue to roll out COVID screening audit with all areas to be completed and reviewed by end of March 2021.	DDON	31/03/21	A
		3. IP&C Audit plan required that provides the organisation with both assurance and early	1. NHSE / I IPC Improvement Lead to meet with DDONs to develop a proposal for IPC Audit for the Trust. Proposal to be presented	DDON	30/04/21	G

		identification of IPC risks	at April 2021 IPCC			
	Review Emergency Response Strategically/Operationally Health & Social Care Act Compliance Criterion 1,2,6,7,	1. To be reviewed as part of the overall Governance review.	1. External review of IPC BAF being undertaken by NHS E/I via Lorna Squires. To await recommendation of review which should be completed by the end of March 2021	CNQO	31/03/21	G
Workforce						
IPC Leadership & Capacity	Opportunity to Review Key Roles & Responsibilities Health & Social Care Act Compliance Criterion 1,2,6,7,	1. Review of current arrangements and strategic oversight by CEO supported by CNQO & CMO: specifically reviewing the DIPC role and Exec responsibility for IPC	1. Initial review undertaken and CNQO to take on role of DIPC in the short term to provide executive leadership for IP&C.	CEO	14/12/20	B
		2. Additional resources being sourced by CNQO to bolster IPC Team whilst awaiting appointment of Associate Director of IPC.	1. Support in the form of additional IP&C expertise from NHSI/E and the local CCG both sourced and now in place	CNQO	04/01/21	B
		3. Recruitment process to be reviewed and shortened for new Associate Director of IPC.	1. Interim Associate Director of IPC starting 15/3/2021 Substantive role continues with external advertisement and out to agencies. Advertisement closes on the 18th March 2021.	CNQO	15/03/21	A

		4. Review of IPC Team to be undertaken to strengthen IPC Team	1. Team under review to identify the required resources. Interviews for data analyst role planned for 08/03/21 2. Band 7 IPC nurse appointed to 15/02/2021. 3. Associate Director for IPC appointed to in an interim capacity starting on the 15/03/2021 4. Associate Director substantive appointment, band 6 IPC nurse and Matron positions advertised with interviews on the 17th and 25th March 2021	DIPC	18/01/21	A
		5. Chief Nursing & Quality Officer to be appointed as DIPC	1. Chief Nursing & Quality Officer appointed as DIPC	CEO	14/12/20	B
		6. Deputy Chief Nurse requested to provide day to day leadership and oversight of IP&C Team	1. Deputy Chief Nurse now providing day to day management of the team.	DCN	01/12/20	B
		7. Roles and responsibilities of team to be reassessed and provide clarity of function	1. Role and responsibilities of team members have initially been reviewed by Senior NHSI IPC Expert to ensure appropriate cover and advice is available to the wards and clinical areas.	CNQO	01/12/20	B

		8. Confirm in writing to all Senior Managers & Consultants a change in responsibility as Executive Lead for IPC and notification of the new DIPC.	1. Communications team 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.	DIPC/DCN	25/01/21	B
		9. Leadership oversight to be provided by weekly meeting with Improvement Director.	1. Initial meeting held week 16th December. Weekly meetings planned going forward of internal oversight meeting	CNQO/Comms	16/12/20	B
		10. Request mutual Aid from MCH/KCNFT to support the IPC team in the short to medium term	1. CNQO to discuss with counterparts in local organisations for mutual aid. 2. Unfortunately local counterparts unable to provide assistance at present 3. Additional resource provided by CCG one day per week from 15/2/21	CNQO	16/12/20	B
		11. Check if there are any existing staff able to be seconded in to the IPC team to provide daily support.	1. Request from CNQO to DDONs to identify any Registered Nurses who have shown an interests or have been identified from annual appraisals an interest in working in IPC. Advert for matron as a bank secondment modified and verbal presentation given to matrons. Some candidates shown initial interest and asked to put forward a expression of formal	CNQO/DIPC	30/03/21	B

			interest			
		12. HR to request from existing agencies experience IPC staff that may be able to provide support and help during this acute phase.	1. Request extensive search via local and regional agencies for additional qualified IPC Nurses. Interim agency Associate director of IPC starting 15/3/21	CNO/DIPC	15/03/21	G
		13. Use existing contacts in NHSE/I to search existing networks for potential IPC qualified staff that may be able to support	1. Contact made with NHSE/I Annemarie Vicary to use existing networks to search for suitable candidates to support IPC Team. 2. Support now in place with Esther Taborn (NHSE/I) and Martha Ugwu (CCG)	Annemarie Vicary	01/12/20	B
Governance Review						
	Review of Ward to Board governance in relation to IP&C with support from NHSE/I. Health & Social Care Act Compliance Criterion 1, 6,9	1. To be arranged with the support of NHSE/I Senior IPC Lead	1. TOR in discussion and waiting agreement and sign off by CNQO. 2. TOR approved by CNQO & review commenced. 3. Report to provided to CNQO by 12/03/21	CNQO CNQO DIPC	31/01/21 28/02/21 12/03/21	A
Medium Term Actions (6-11 Months**)**						

Work Plans						
	Review support sub-groups for IPC Committee Health & Social Care Act Compliance Criterion 1,2,3,6,7,8,9,10	1. Explore if sub groups are required for IPC and develop the terms of reference for these. 2.Workplan for the year clearly identified against any national , regional and statutory guidance 3. Ensure clear line of reporting and escalation mechanism: • Estates & Facilities • Soft Facilities • Occupational Health • Water Safety Group • Decontamination Group • Antimicrobial Stewardship group		DIPC/AND (IPC) DIPC/AND (IPC) DIPC/AND (IPC)	31/05/21 31/05/21 31/05/21	G
Workforce						
	Review of Team resources Health & Social Care Act Compliance Criterion 1, 2,3,4,5,6,7,8,9,10	1. Review existing team resources and identify if sufficient to comply with workload		ADN(IPC)	31/05/21	G
Assessment against Health & Social Care Act						
	Overview	1. Ongoing learning and				G

	Health & Social Care Act Compliance Criterion 1, 2,3,4,5,6,7,8,9,10	dissemination of Post infection reviews relating the HCAI infections				
Long Term Actions (12 – 18 Months**)**						
Assessment against Health & Social Care Act						
	Overview Health & Social Care Act Compliance Criterion 1, 2,3,4,5,6,7,8,9,10	1. Assessment of current state of practice in relation to the Health & Social Care Act. 2. Review compliance against set requirements 3. Provide an update to the IPC Committee and Trust Board for assurance.	1. To be reviewed once short term actions completed for progress report			
Work plans for 2021/2022						
	Educational strategy	1. DIPC to work with both Educational team and IPC Team to develop an educational work plan to ensure all staff are educated in relation to IPC.	1. New Associate Director of Nursing IPC will review existing training and provide recommendations to the DIPC/CNQO 2. Review of induction training to confirm all key elements of COVID included	ADN(IPC)	25/07/21	G
	Annual report	1. Associate Director of IPC to develop an annual report	1. ADN IPC to review existing arrangements and audit against	ADN IPC	31/07/21	G

		based on the Hygiene Code and Health & Social Care Act to ensure compliance	Hygiene code to produce a draft report for the IPC Committee			
	Annual Plan	1. Development of an annual plan of activities to ensure compliance with the Health & Social Care Act. 2. Provide Regular (two monthly) updates to the Trust Board. 3. Provide monthly reports on completed actions to the IPC Committee	1. Review and audit of current compliance with the H&SC Act. 2. Development of annual work plan. 3. Development of meaningful monthly reports for the IPC Committee	ADN IPC/DIPC	30/07/21	G
	Policy Implementation	1. Review of all polices relating to IPC and update in relation to National Policy. 2. Develop a regular monthly plan to review polices and ensure updates are communicated and placed on intranet.	1. IPC Team to review all policies in conjunction with Matrons to identify gaps in practice relating to national policy. Review currently being undertaken in March 2021 for amalgamated policy document for Covid 19 response	IPC Team/Matrons	30/08/21	G
	Audit Plan	1. Develop yearly audit plan to provide assurance to the IPC Committee and then Trust Board the organisation is complaint with all guidance 2. Implement IPC snapshot local audits to support areas/practices of concern/acquisition of	1. ADN IPC to develop yearly audit plan with regard to national policy and guidance and compliance with the H&SC Act. Using internal peer review to ensure appropriate compliance	ADN IPC	30/08/21	G

		HCAI's/period of increased incidence 3. Provide systematic learning through Post infection review (PIR) to continue to reduce HCAI and presentation of such through the IPCC for dissemination of findings				
Prevent active Estates Work						
	Programme of preventative estates work to support IPC regulations and compliance	1. Programme of preventative IPC Estates work to be reviewed by DIPC in conjunction with Director of Estates. 2. Clear programme of improvements to be provided and agreed to reduce transmission and provide optimal achievable healthcare environment	1. 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. 2. Director of Estates is currently reviewing all opportunities where it may be possible to make improvements to reduce transmission and will discuss these with the DIPC for approval and will be monitored and progress report through IPCC	Director of Estates/ DIPC Director of Estates/ DIPC	30/09/21	G

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(MFT- V1.8)

Infection prevention and control board assurance framework

15 October. Version 1.4

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory; however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in evidence- based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance e as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative e appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff that is treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	Patient triage undertaken in the Emergency Department (ED) with evidence on white board in the site office. Process in development to ensure patients 14 days post Covid who represent at ED are flagged on Patient Administration System (PAS) to ensure appropriate pathway management	Triage questions asked in ED but documentation not consistent in the notes. Positives are on occasion moved to facilitate patient flow	Action with Executive Responsible to provide assurance of actions taken and evidence to support
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	It is stated as policy and site manager oversees compliance	Breeches do occur due to operational pressure	Mitigating processes in place with IPC NHSE/I Improvement lead co-ordinating daily with site manager.
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Discharge screening in place for those eligible. Evidenced by screening audits		Risk assessments are undertaken when operational pressures escalate with IPC input to support decision making on safest action, with DIPC approval

• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice		Under resourced IPC team unable to robustly monitor compliance with IPC or PPE	Band 5 post now substantive, Band 8a and BAND 5 posts advertised 4/2/21 Matrons have developed an Outbreak checklist. Snapshot audits by IPC Champions. Matrons developing an IPC awareness month campaign with different topics weekly. • PPE • Hand Hygiene • Saving Lives • Waste & Sharps Observation and Challenging staff who are non-compliant IPC Team daily ward visits – medium to longer term resolution when IPC team in place
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Lateral flow testing available for all frontline staff including ancillary and agency staff. Mass PCR testing in December 2020. Data available on request. Monitored through Occupational Health		
• training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff	Provided for all staff at induction. Recorded on Mandatory and statutory database. In light of Covid this process is to be reviewed. Reported monthly.	Modules available but currently no monitoring of update.	To be addressed by HR / OD and reported to the IPC Committee on a monthly basis

Induction and mandatory training • all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Infection, Prevention and Control Champions COVID-19 Essential Guidance from the NHS, Government and WHO RCGP - COVID-19 CPD Hub COVID-19 Public Health England - Personal Protective Equipment (PPE) COVID-19 Infection Control Resources		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	As part of COVID Trust bulletin and communications updates. Information reinforced at daily ward huddles and monitored by Matrons. Partial compliance, staff are trained in the Emergency Department (ED) and ITU and respiratory wards. Record keeping re FFP3 Fit Testing in place.	No process for staff who fail fit testing and alternative reusable items. No robust process in place for assessment and monitoring of the same.	Health and Safety developing a process to be shared and communications to support. Inappropriate use of FFP3 masks with some medical staff felt to be due to their personal concerns
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	In place from Dec 14th 2020- see communications bulletin and internal Trust communications seen by all ancillary staff and discussed at ward safety huddles		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	All national guidance will be reviewed and logged to ensure there is a robust audit trial of review and actions taken in light of guidance received.	Central Alerting System Alert of the 24th Dec not brought to the attention of relevant staff. New COVID guidelines not launched in August 2020.	NHSE/I Improvement Lead ensuring that relevant guidelines are disseminated. Long term sustainable solution part of the Trust IPC Ward to Board review commissioned by the Chief Nursing & Quality Officer to identify gaps and make recommendations to strengthen governance for IPC/ Governance review due end Feb 2021.

• risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC Risks placed on IPC Risk register and reviewed at IPC Committee. Assurance evidence required	Cases of patients admitted from other Trusts with no risk assessment in terms of other pathogens. Transfer documentation including IPC concerns to be introduced to the Trust before the end of April 2021. Any gaps in processes and practices to be confirmed	Mitigation Actions to be confirmed
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial SitRep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • Ensure Trust Board has oversight of ongoing outbreaks and action plans.	CEO receives weekly update on all alert organisms and signs off monthly DCS data. Screening data available from Board to Ward from SSRS system. NED for IPC currently attends some outbreak meetings Evidence required	Gaps identified	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Clinical teams with experience of managing Covid cases are treating patients in designated areas		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	There must be some assurance about the cleaning staff who are trained and FFP3 fit tested? Could you get % from Gary and say that it's monitored and recorded and that there is a rolling plan?	Not all staff FFP3 Fit Tested; this affects the Trust when areas change function, e.g. the AGP bay on Sapphire Ward.	Plan to be developed to ensure all staff trained.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Areas are currently cleaned once per day	Areas need to be cleaned twice a day to achieve compliance with national guidance. High touch items not frequently cleaned.	Plans in development for full compliance by beginning of February 2021. 10 staff employed onto bank. Plan in place to prioritise the cleaning of wards with any Outbreaks and Amber pathway wards with twice daily cleaning.
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance			Cleaning of high touch points and toilets between uses to be discussed with DDoNS and plan developed. Further employment of

			cleaning staff requires final sign off by CEO due to the costs. Offices supplied with own cleaning wipes.
• cleaning is carried out with neutral Detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Chlorclean 1,000 ppm is used throughout the Trust		
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	No evidence that it is not. No system to monitor and audit at present Health & Safety team to audit on a regular basis.	Whilst there is no evidence to the contrary, there is currently no system to monitor and audit compliance.	Health and Safety Team to develop a monitoring system and begin auditing compliance
• 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	Frequently touched surfaces are currently cleaned once per day	Frequently touched items need to be cleaned more than twice daily	Cleaning of high touch points discussed with DDoNS and plan developed including deployment of recently employed cleaning staff by March 5th
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be	Additional appropriate cleaning wipes available to all office-based staff.		Campaign initiated by DIPC reminding staff of their responsibility to maintain the

cleaned a minimum of twice daily			ward and office environment's cleanliness.
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	How are they currently cleaned?	Donning and doffing station areas to be cleaned twice a day.	Further mitigation actions to be confirmed
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Gap in current status of evidence	Linen cupboards for dirty linen were previously removed from clinical areas. Cages now used on ward corridors. Collection will be twice daily.	
• single use items are used where possible and according to single use policy	Audit of COVID IPC practice – clinical staff equipment cleaning in place and undertaken		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Is this in place?	Are there any gaps?	
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning standards in place and regular established monitoring with ability to escalate if needed	New Cleaning Standards are imminent and assessment against these will be required	Any mitigation required?
ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Where possible, windows are open to aid dilution of air. Previously sealed windows have been opened.	No overall Trust ventilation Assessment	Gap analysis in process relating to New National Cleaning Standards Ventilation Assessment

			requested and discussed at IPC Committee in January with a further update at March IPC Committee
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	N/A at this time due to volume of COVID Admissions. This will be kept under review in relation to current outbreak. New process designed and agreed for de-escalation of wards from Red to Amber and Amber to green.		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship (AMS) is maintained	AMS committee met in the autumn and on 12th Jan 2021	No reported formal auditing in place. Pathology does not currently supply the committee with sensitive and resistance data to base formulary decisions on. No reports to IPCC.	Comprehensive report provided to IPC Committee outlining the long term plan and current risks with mitigations. Policy developed on Antimicrobial stewardship. Working with laboratory to obtain culture and sensitivity information to support antibiotic prescribing
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory reporting in place	No data analyst or admin in the team so no internal mandatory data reporting or monitoring. Band 5 Data Analyst post to be recruited over the next few weeks.	Band 5 data analyst post advertised 2/02/2021

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	Visiting for at risk groups End of Life in place and Palliative care – All visitors advised to follow national guidance when visiting. Local SOP produced and in place to support		
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	Signage in place, access restricted		
• information and guidance on COVID-19 is available on all trust websites with easy read versions	Information and guidance is kept up-to-date on the Trust website, which meets accessibility standards. It can be made available in other formats on request. Communications department responsible for maintaining up to date information.		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Flag on Extra Med for internal transfers, communication on discharge includes COVID -19 status		
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	Information Boards present at all entrances to hospital. Staff testing temperatures and marshalling visitors at main entrance		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Patients screened as per National guidance day 1, 3, & 5. SAMBA testing available in ED and inpatients as required. Screening audit in place to monitor screening.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid- 19 cases to minimise the risk of cross-infection as per national guidance	Red, Amber and Green pathways exist in ED to keep patients separate as per National Guidance	Building work in A&E prevents true separation of flow in corridors and ancillary spaces.	Currently all patients considered Amber pending triage and SAMBA testing which will be kept under review.
• staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Triage in place in ED	Triage is in place but not documented	Action underway to address documentation of triage
• face coverings are used by all outpatients and visitors	All outpatients are provided with face coverings at entrance to the hospital and all outpatients and visitors are reminded of their use		
• face masks are available for	Face masks are available for patients		

patients with respiratory symptoms	with respiratory symptoms		
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Verbal advice given to patients depending on the patient's condition and ability to tolerate		
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Screens erected in reception area all visitors/ out patients required to wear face covering and have temperature taken prior to entering the building		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative		Gaps in contact tracing when patients have been discharged. In that these patient contacts are not consistently identified and advised. Gaps in contact tracing of inpatients, in that not all patient contacts are robustly identified and followed up.	Plan to be developed with Business Information (BI) to mitigate risk.
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly			
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	All patients entering the building are asked about symptoms and have temperature taken. Refused entry if high temp or symptomatic and referred for testing. Pre-site assessment in place.		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Separate entrances to the hospital for staff and patients/visitors		
• all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	Training Needs Analysis created 04.03.20, verified by IP&C. FFP3 training in place since –17th Feb 2020 and available every day. Testing available for all appropriate staff.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	Additional training and support offered with bespoke training sessions with the Practice Development Team, Head of Infection Prevention & Control. A PPE Steward program was implemented across the Trust; in immediate response to PPE related issues and concerns led by the Chief Nurse and coordinated though the nursing tactical group.		
• a record of staff training is maintained	Training attendance sheets are completed by FFP3 mask FIT testers and forwarded to OD team for entry on		

	ESR (OLM). Fit Mask competence updated when “pass” achieved. Compliance reports and training records available		
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed		SOP in the process of being developed on reusable masks however, no escalation process to use reusable masks. No current monitoring arrangement is place.	Plan in development to rectify the current situation.
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	All adverse events (incidents) such as the re- use of PPE reported via the Trust incident reporting system (Datix).		
• adherence to PHE national guidance on the use of PPE is regularly audited		There is no current audit against the use of PPE	IPC currently using national checklist to audit PPE usage on all wards
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: o hand hygiene facilities including instructional posters o good respiratory hygiene measures o maintaining physical distancing of 2	Visual signs in place throughout the organization explaining hand hygiene and wearing of face masks etc plus; Hand hygiene audits are regularly completed as part of the ward manager / Nurse in Charge (NiC) daily checks completed in the divisions. Staff reminded of the requirements by the communications team; site	Audit results reported through Divisional Governance meetings to ensure good compliance	

metres wherever possible unless wearing PPE as part of direct care o frequent decontamination of equipment and environment in both clinical and non-clinical areas o clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	matrons; IPC team and the executive team. Equipment cleaning undertaken and staff in offices provided with equipment for cleaning Posters re face masking and coverings in place		
• staff regularly undertake hand hygiene and observe standard infection control precautions	All in place and staff communications and guideline documents can be used as the evidence	All centralised audits currently suspended by the IPC team as cannot resource	Plans for mitigation?
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	Any issue with hand air driers?		
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Posters and guidelines displayed		
• staff understand the requirements for uniform laundering where this is not provided for on site	Communicated via communications bulletin		

• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Information provided to all staff via staff bulletin and Covid Bulletin. Occupational Health advice available to all staff on the management of Covid symptoms and testing.		
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	There are currently gaps in Contact tracing and. Gaps in provision for IT and data management do not facilitate rapid surveillance	Data now available but not automated and the process will be managed by the end of February No failsafe mechanism / process to trigger an outbreak.	
• Positive cases identified after admission that fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC team reviewing all HAIs and looking at contacts to identify a common source. In addition, instigation of RCA process for all HAIs which will be reviewed weekly with HAI data .Started screening all HAIs contacts.		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	Outbreak policy to be updated and approved by IPC Committee	Draft COVID specific Outbreak policy in the process of finalising and will be in in place by mid-February 2021. Content currently being reviewed to ensure it is complaint with new national guidance	

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Signage in place for red, amber and green zones. Most areas currently red or amber. Nightingale wards are dedicated to Red zones. Signage and communications refreshed in Dec 2020		
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Ward doors electronically controlled to prevent entry which acts as a physical barrier. Clinical areas clearly identified as to Covid status		
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Ward doors electronically controlled to prevent entry which acts as a physical barrier. Clinical areas clearly identified as to Covid status		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Amber and Red clinical areas designated across the trust.		
• areas used to cohort patients with suspected or confirmed COVID- 19 are compliant with the environmental requirements set out in the current PHE national guidance		Actions required on decluttering, cleaning and linen collection (see previous actions) Sequence of decluttering days to be arrange over February	A declutter of the Ward environments is in the process of being organised including escalating to Estates where appropriate

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Currently approximately 80 side rooms are available (excluding ITU)	There are some concerns and restrictions in older parts of estate.	Need to put in mitigation – patient placement is risk assessed

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • ensure screens taken on admission given priority and reported within 24hrs	Turnaround times now on average less than 24 hours. 24/7 SAMBA PCR testing now in place in A&E	Initially, unable to provide assurance that screening is taking place as per policy. Screening compliance now being monitored (Jan 21).	It is expected by the end of February data will be monitored and reported.
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Staff who undertake screening are competent and have been assessed		
• testing is undertaken by competent and trained individuals			
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance			
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Gap in evidence to be sourced		
• screening for other potential infections takes place	Screening for other infections currently in place.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	HoN / Matron support provided to clinical staff to ensure adherence to IPC Guidance with audits and assurance reports to support		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Changes to guidance are communicated to staff via a bulletin published every 24 hours.		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance		There are currently some issues with linen management (see previous entry)	Insert mitigation as per previous comment on linen
• PPE stock is appropriately stored and accessible to staff who require it	Evidence of PPE stock appropriately stored to be sourced PPE is generally available to staff as required	There is currently pressure on supplies due to inappropriate use of FFP3 masks	What action is being taken on this?

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported on alternative respirators and hoods	The Trust has implemented a risk assessment tool in line with national guidance and other Trusts for staff to complete with their managers. This can then be escalated to occupational health if further information and guidance is required. Data held by Occupational health.		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Staff who fail on all FFP3 options notify their manager and a referral is made to Clinical Simulation manager who arranges half mask, and alternative arrangements if still no option for makes Staff member redeployed		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health		Currently no record of discussions held with staff who need redeployment is made	Actions to be progressed to address

• following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Staff are redeployed within the Divisional structure taking into consideration their skills and training	Currently, there is no centralised record of this redeployment	As above
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	There is a centrally held record of fit testing on the electronic roster system. However, this is not regularly reviewed at the Board	Currently no system in place	
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	This cannot be maintained at all times due to the staffing shortages across the site. Safe staffing is maintained by moving staff to ensure an appropriate safe staffing level and is based on a risk assessment		
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Information on social distancing is provided at regular internal using the Covid bulletin. Office spaces and staff rooms have clearly identified maximum number of occupants displayed	Offices in ward and clinical areas are still in the process of being assessed.	

• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	All staff are mandated to wear face mask while on the Hospital site. Monitored by line managers and Matrons.		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	All staff absences should are reported on the central reporting system e-Roster. Those who are indicated as self or household isolating will then be contacted within 24 hours of entry on the system for swab testing.		
• staff who test positive have adequate information and support to aid their recovery and return to work	Staff who receive a positive result are advised in line with national guidance relating to isolation criteria for themselves and household members and who to contact if their symptoms persist		

Meeting of the Board of Directors in Public

Thursday, 15 April 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.3**
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 16 March 2021		
Lead Director:	Jane Murkin, Chief Nursing and Quality Officer		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Innovation and Quality Improvement The Committee received a presentation from Jack Tabner, Director of Transformation and IT , Lee Bridgeman Head of QI and GIRFT and Professor Ranjit Akolekar, Clinical Lead for Research and Innovation on the work and progress of the Medway Innovation Institute since its launch in July 2020. Key highlights from the presentation: • 122 projects registered • 26 projects currently live • >200 staff trained in introductory QI methods • 13 skill QI trained coaches • >500 attendees at events • £170k funding awarded for projects • Facilitated BIG room events in patnership with the Chief Nursing & Quality Officer, and • BIG conversations – external speaker to open up topics	**Green**

The chair asked for the Innovation Instituite to report in to the quality assurance committee on a quarterly basis to provide an update on projects and how the institute is helping to improve patient outcomes and support delivery of the quality strategy and priorities.	
2. Quality report, Trust CQC ED action plan and duty of candour presentation The Committee were sighted on the final CQC ED action plan and current position on progress with the actions, noting areas of improvement. This action plan supersedes the previous action plan developed following the CQCs inspection in December 2020 and incorporates the Must Do & Should Do actions from the published report. Any other actions from the original plan are being addressed through the Patient First Improvement Programme. The action plan continues to be monitored and overseen by the Quality Panel as the governance mechanism supported by the evidence provided who provide the scrutiny of the evidence to demonstrate progress and completion of actions, including the identification of any gaps. The Committee received the quality report noting progress with the implementation of the quality strategy, achievements to date alongside progress on other quality and patient safety priorities. The Committee noted the progress to date and current datix backlog and reporting of SI's and works underway to strengthen the reporting and investigating of incidents and their management across the Trust. The Committee received a presentation on Duty of Candour.	**Amber/Green**
3. Infection Prevention Control Improvement Plan The Committee received the Trust's final infection prevention and control improvement plan noting this has been developed following a visit from regulators and the national IPC team which was approved by the Executive Group. The improvement plan incorporates the previous plan priorities, actions following the National Team visit and gaps in assurances from the IPC BAF. The plan has been agreed with regulators setting out the short, medium and long term goals over the next 18 months. The Committee thanked the Chief Nursing and Quality Officer for her work and staff involved in developing the plan and noted the progress in completing the short term actions over the last 4 months.	**Amber/Green**
4. Review of the top risks of COVID The Committee received a verbal update on the top risks of COVID, noting work from the Chief Nursing and Quality Officer on the nursing related risks to date. A comprehensive paper will be provided by Chief Nursing and Quality Officer, Chief Operating Officer (Interim), Chief Medical Officer and Chief Strategy and Integration Officer at the April 2021 meeting that will incorporate broader associated risks.	**Green**
5. **Maternity Services Quality Report and presentation on twin still births** The Committee received a report and presentation from Robin Edwards, Consultant Obstetrician and Gynaecologist and Head of Midwifery on the C-section rate as a result of the data from the December IQPR and a subsequent review commissioned by the Chief Nursing and Quality Officer. Highlights from the presentation: • C-section rates have increased over time and will continue to do so	**Green**

• Measurable neonatal outcomes • C-sections are carried out when there is presumed fetal compromise or failure to progress in labour or delivery of babies at high risk of intrapartum complications and unless fully dilated a C-section is the only way to deliver a baby • Medway is not an outlier for C-section rate; MTW and Darent Valley are showing the same trends. Dr Ghada Ramadan, Consultant Neonatologist spoke about mortality and morbidity in neonates and the outcome in neonates over the last 3 years, stating that the survival rate for very preterm babies is high and above the national average survival rate. The Committee will receive a report and presentation from Professor Ranjit Akolekar on the MBRACE report on still births in twin pregnancies at the April meeting.	
6. Clinical Negligence (CNST) The Committee noted the CNST report and progress with demonstrating compliance with the safety actions noting this will also be presented to the Trust Board. All 3 safety actions contained within the report are on track. The Committee were advised by the Chief Nursing and Quality Officer that she is taking a paper focused on strengthening midwifery leadership to the Executive group meeting to implement a Director of Midwifery role alongside the Birth rate plus safe staffing review.	**Green**
7. Quality and Patient Safety Group Highlight Report The Committee were advised that the Associate Director Quality and Patient Safety is undertaking a review of the terms of reference, purpose and frequency of the quality and patient safety group and therefore the March meeting did not take place. The committee will be provided with an update of the review at the next meeting.	**Green**
8. Safeguarding annual report The Committee received the safeguarding annual report noting the content was reflective of the 2019 to 2020 work of the Trust and safeguarding team and noted the work. The report contained the Trust wide review of Safeguarding commissioned by the Chief Nursing and Quality Officer which had been shared with the Committee at a previous meeting. The Committee were sighted on the delay in completion of DoLs with the local authority which means that at times we are detaining patients against their will without a legal framework to do so, which is a national issue and is on the Trust risk register. The Committee raised some concerns on a few areas highlighted within the annual report and were advised by the Chief Nursing and Quality Officer that she had commissioned an independent review of safeguarding to support providing assurances and work had been addressed to improve areas such as pressure ulcer management and prevention across the Trust with improvements noted in several ward areas. The report from the review has 41 recommendations which are being worked through and will support the Trust with becoming an outstanding organisation in relation to Safeguarding; including work progressed thus far to strengthen processes over the last year. The Committee will receive a report on the progress on the recommendations at the May 2021 meeting.	**Amber/Red**
9. Quality IQPR	**Green**

The Committee received the IQPR and asked for hospital acquired COVID to be included on future reports. The Chair asked for the lead executive on incident reporting to be changed to the Chief Medical Officer on future reports and for the title on ED hours slide to be reviewed. The Committee were assured by the Director of Nursing Quality/Professional Standards that the Sepsis task and finish group have put in a process and have a PGD signed off to allow the ART team to administer antibiotics to patients with sepsis in the first hour, as this was sometimes not being completed within the first hour. The Committee asked for ED handover and DTA to be monitored via the IPQR over the next few months.	
10. BAF – Quality The committee were advised that as part of good governance at the end of the financial year and planning ahead for 2021/22 the BAF Quality is having a robust review and the updated document will be presented at the next committee meeting for agreement.	**Green**
11. Escalation to Board The Committee are concerned about the data set of 2019/20 being reported in the safeguarding annual report, versus a more up to date report but note the positive independent review of safeguarding which has been completed. The Committee will receive a progress update on the recommendations at the May meeting and will keep the Board updated on the progress. The Committee were concerned by the C-section rate within the December IQPR and requested a review be undertaken. The Committee received a robust presentation at its March meeting and are assured the Trust is not an outlier for C-sections. The Committee noted the progress to date and current Datix backlog and reporting of SI's and works underway to strengthen the reporting and investigating of incidents and their management across the Trust.	**Green**

Meeting of the Board of Directors in Public
Thursday, 15 April 2021

Title of Report	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Report – Safety Actions 4, 5 and 6**	**Agenda Item**	4.4
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Executive Summary	NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts delivering maternity services and who are members of the CNST. As in year two, members will contribute an additional 10% of the CNST At the 2 December 2020 meeting of the Trust Board the Chief Nursing & Quality Officer presented a paper on CNST which included a gap analysis against each of the ten safety actions and the actions being addressed to recover compliance. The Trust Board requested that the Quality Assurance Committee oversee the review and evidence relating to the Ten Safety actions. The Board will maintain full accountability for the authorisation of final sign-off for CNST by the Chief Executive; following a schedule of alternate month reporting to QAC as referenced in section 1.2.The Board will have oversight of evidence as set out in the technical guidance. The Board received an assurance report on 4 February 2021 relating to Safety actions 1, 2 and 3 to provide assurance regarding progress against Safety Actions 1 and 3. The report identified some additional actions required for Safety Action 2 and provided an update to the Board on progress against Safety Action 2. A full oversight and assurance report for Safety Actions 4, 5 and 6 was presented to the Quality Assurance Committee on 16 March 2021. This report seeks to provide assurance to the Trust Board that the Maternity Service is progressing work and providing evidence to demonstrate compliance with Safety Actions 4, 5 and 6 that form the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). In December 2020 NHSR advised that the deadline for submission for the CNST MIS had been revised to 15 July 2021. This was in response to the continued pressure facing Trusts in response Covid-19. Since the last report to the Trust Board, NHSR has published two revisions to the guidance. The first in February 2021 and the second on 18 March 2021. The March 2021 guidance removed a number of sub-requirements from Safety Actions 3, 4 and 9 and also amended the approach to validating the Maternity Services Data Set data (Safety Action 2) and made changes within Safety		

	Action 8's standards removing the 90% threshold for training.
Committees or Groups at which the paper has been submitted	CNST Task and Finish Group Planned Care Divisional Management and Governance Board Quality Assurance Committee
Resource Implications	No additional resource implications for this report.
Legal Implications/Regulatory Requirements	CNST Premium payments Compliance against CNST Safety Standards will be reviewed as part of CQC Regulatory Framework
Quality Impact Assessment	No Quality Impact Assessment required for this report.
Recommendation/ Actions required	The Board is required to note compliance and review the evidence against Safety Action 4, 5 and 6 that provides assurance that the Maternity Service is on track to demonstrate compliance with CNST safety actions 4, 5 and 6. The Board is requested to note progress and compliance with safety actions 4, 5 and 6 including, note review of the Continuity of Carer Action Plan in Appendix 5. The Board is requested to approve the action plans for Neonatal Medical and Nursing workforce in Appendix 3 and 4.

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

Appendices	Appendix 1: Gap Analysis Appendix 2: Obstetric Medical Workforce Action Plan Appendix 3: Neonatal Medical Workforce Action Plan Appendix 4: Neonatal Nursing Workforce Action Plan Appendix 5: Continuity of Carer Action Plan

1 Executive Overview

1.1 This report provides assurance to the Board that the Maternity Service is progressing reviewing and compiling evidence to demonstrate compliance with the Safety actions as part of the CNST MIS.

1.2 The Board will maintain full accountability and sign-off for CNST and the full and final assurance report will be presented by the Maternity Service to the Board in July 2021 as detailed below.

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

1.2.2 Safety Action 4, 5 and 6 – Full report to QAC by Maternity Services March 2021, Key issues from QAC and Essential Reporting by Maternity Services to Trust Board April 2021.

1.2.3 Safety Action 7, 8, 9 and 10 – Full report to QAC by Maternity Services May 2021, Key issues from QAC and Essential Reporting by Maternity Services to Trust Board June 2021.

1.2.4 Final Assurance report by Maternity Services to the Trust Board – July 2021. This report will provide assurance that any outstanding gaps have been resolved so that the Trust Board may proceed to authorise the Chief Executive to sign the Board declaration form prior to submission to NHSR by 12 noon on 15 July 2021.

1.3 The Board received an assurance report relating to the progress of Safety Action 1, 2 and 3 on 4 February 2021 where the Board was assured that the Maternity Service was progressing compliance against Safety Action 1 and 3 and that appropriate actions were in place to achieve compliance with Safety Action 2.

1.4 On 1 February 2021 NHSR published revised guidance for the CNST MIS in response to continued pressure facing Trusts in response to Covid-19. This guidance was reviewed by the core members of the CNST Task and Finish Group on 4 February 2021 to ensure appropriate progress was being made against achieving compliance with the 10 Safety Actions. The group was assured, and BRAG rated the declaration table as 18 Amber, 65 Green and 44 Blue actions.

1.5 On 18 March 2021 NHSR published further revisions to the guidance, removing a number of sub-requirements from Safety Actions 3, 4 and 9. It also amended the approach to validating the Maternity Services Data Set data (Safety Action 2) and made changes within Safety Action 8's standards removing the 90% threshold for training.

1.6 A full assurance report for Safety Action 4, 5 and 6 was presented to the QAC on 16 March 2021.

1.7 This report provides an update to the Trust Board relating to compliance against Safety Action 2 and draws the Board's attention to the specific elements of Safety Action 4, 5 and 6 that require Trust Board to formally minute, approve and review as per the CNST guidance.

1.8 The detailed evidence for submission is found in the links in Appendix (1).

2 Safety Action 2: Maternity Services are submitting data to the Maternity Services Data Set (MSDS) to the required standard

2.1 On 4 February 2021 the Maternity Service reported that they were taking the appropriate actions to demonstrate compliance with Safety Action 2, however data gaps had been identified. The October Digital Scorecard showed that 5 out of 11 criteria had been achieved.

2.2 The report assures the Board that an improvement was seen in the November 2020 Digital Scorecard with 9 out of 11 criteria being achieved.

2.3 The BI and Digital Team worked to validate and rectify any remaining data errors and the Digital Scorecard for December 2020 showed 11 out of 11 criteria were met. The Board, therefore, can declare that the Maternity Service have submitted data to the MSDS to the required standard.

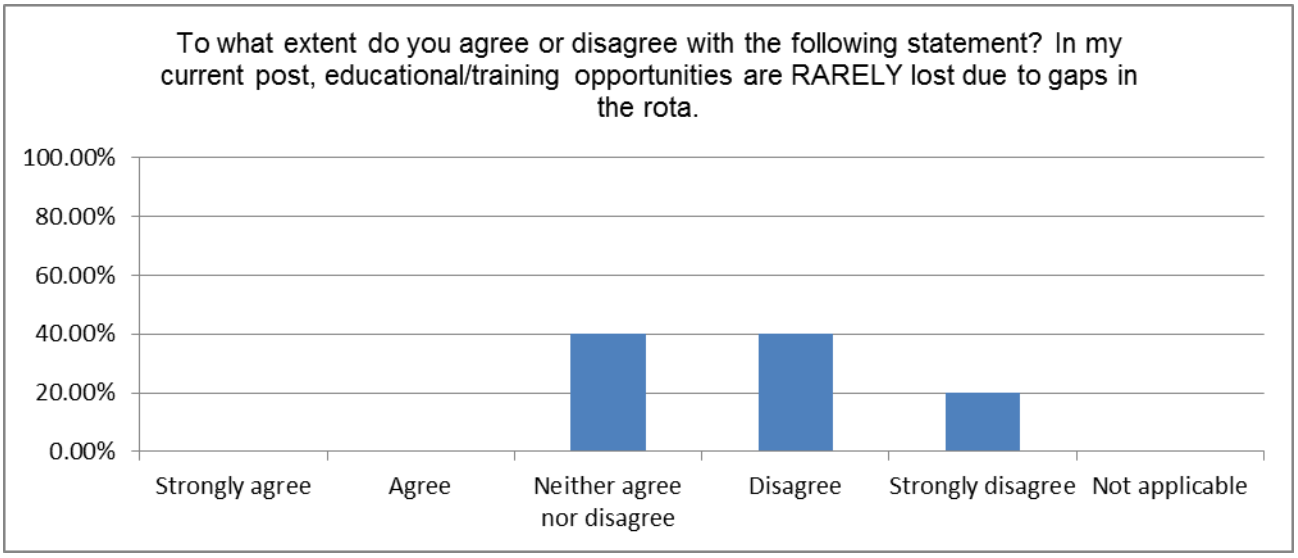
2.4 The updated guidance published on 1 February 2021 also included the requirement for SNOMED-CT coding to be submitted alongside the data for the MSDS. NHS Digital have confirmed that Trusts and providers must have a plan with their information system provider to submit SNOMED-CT to be compliant. The Maternity Service have received assurance and confirmation from the EuroKing provider, Wellbeing, that they have an action plan in place to fully conform with the MSDSv2 Information Standards Notice, DCB1513 and 10/2018, including the submission of SNOMED-CT coding. Deployment to Maternity Services is anticipated for Quarter 2/Quarter 3 2021.

3 Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard

3.1 The report seeks to assure the Board that the Obstetric, Anaesthetic and Neonatal service has an effective system of clinical workforce planning and the appropriate action plans in place to mitigate any rota gaps as per the requirements of CNST.

3.2 **Obstetric Workforce**

3.2.1 The revised CNST guidance (March 2021) for Safety Action 4 has removed the standards related to obstetric workforce. The standard previously required the Trust Board to formally record in their minutes the proportion of obstetric and gynaecological trainees who responded 'Disagreed or/strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' The Maternity Service identified that 3 out of 5 trainees responded 'Disagree or/ strongly disagree' to the question. '



3.2.1 The GMC Survey report was received by the Trust in December 2019 and was reviewed at the Obstetrics and Gynaecology Consultant meeting in January 2020.

The Specialty Lead for Obstetrics and Gynaecology confirms that the rota gaps reported by the trainees were present during the survey period, however advises that from August 2019 there were no further rota gaps. Mitigation to prevent rota gaps has included the recruitment of additional middle grade doctors and ensuring consultant presence at Friday teaching sessions by including this on their rota.

3.2.2 An action plan has been completed to ensure ongoing monitoring of potential rota gaps and to ensure trainees have an opportunity to provide formal and informal feedback. This action plan is included in Appendix 2.

3.2.3 The Maternity Service will continue to monitor its obstetric workforce requirements and will escalate any concerns or actions via the Board Level Safety Champion to the Trust Board.

3.3 Anaesthetic Workforce

3.3.1 The CNST guidance requires the Trust Board to formally record in its minutes the proportion of Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5. 1.7.2.1 and 1.7.2.6 are met. The details of each standard are as follows:

1.7.2.5	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.
1.7.2.6	The duty anaesthetist for obstetrics should participate in labour ward rounds

3.3.2 The February 2021 guidance changed the evidential requirements for 1.7.2.5 and 1.7.2.6 from “rotas and theatre lists demonstrating named consultants” to “rota and theatre lists with named consultant or SAS (Staff Grade Associate Specialist and Speciality Doctors) doctor who is able to work without consultant supervision, with no other clinical commitment”.

3.3.3 The February 2021 guidance removed the requirement to audit theatre lists to demonstrate minimal delays to elective lists and rapidness of emergencies. The Maternity Service had already undertaken audits to support this requirement and will continue to monitor these elements in the interest of patient safety and quality.

3.3.4 The Maternity Services, along with the Obstetric Anaesthetic lead have reviewed the standards and have assessed compliance against these standards. The Trust Board will be assured that appropriate evidence in the form of dedicated rotas, theatre lists, induction material for obstetric anaesthetists are linked in Appendix 1 below. The report therefore, requests the Board formally record compliance with all 3 (100%) of the ACSA standards required by CNST.

3.4 Neonatal Medical Workforce

3.4.1 The CNST guidance requires the Board to formally record in its minutes whether the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

3.4.2 The Neonatal Unit has a 3 Tier rota and has an adequate number of funded posts to comply with BAPM standards. However, due to national shortages of junior staffing and the Deanery being unable to fill all posts, vacancies do exist on the rota. These vacancies, however, are filled with locum cover, and the unit therefore remains complaint with BAPM standards.

3.4.3 In order to address the gaps in the rota, the Neonatal Unit have made successful Business cases for and recruited to Advanced Neonatal Practitioner and Physician Associate roles to further support BAPM compliance.

3.4.4 An action plan has been completed (Appendix 3) and the report requests that the Trust Board approve the action plan. Following Trust Board approval, the action plan will be submitted to the Neonatal ODN as required to be compliant with CNST guidance.

3.4.5 The report requests the Board to formally minute that the Neonatal Unit maintains BAPM compliance through the use of locum doctors and internal cover and that an action plan is in place to strengthen BAPM compliance with substantive staff.

3.4.6 Progress against the action plan will be monitored through Speciality and Care Group Board meetings and CNST Task and Finish Group and returned to the Trust Board for final assurance in July 2021 prior to submission.

3.5 Neonatal Nursing Workforce

3.5.1 The CNST guidance requires the Trust Board to formally record in its minutes whether the Neonatal nursing workforce is compliant with the service specification standards as calculated by the neonatal clinical reference group workforce calculator (Dinning Tool). The Neonatal unit completed the Dinning Tool in June 2020, the findings of which are as follows:

	Jun-20	Recommended	Shortfall
Number of nurses (budget) (WTE)	91.79	99.84	8.05
Number of nurses (actual) (WTE)	87.7	99.84	12.14
Registered/Qualified in Speciality	57.99%	77.64%	19.65%
Registered/Trained	90.62%	94.12%	3.50%

3.5.1 The Chief Nursing and Quality Officer has reviewed the results of the Dinning tool as part of the Safe Staffing review following the national submission.

3.5.2 The vacancy rate and Qualified in Speciality (QIS) rate is closely monitored by the Neonatal Service and reviewed monthly at their Speciality Governance meeting.

3.5.3 An action plan has been completed (Appendix 4) and the report requests Trust Board approval of the action plan. Following Trust Board approval, the action plan will be submitted to the Royal College of Nursing (RCN) as required to be compliant with CNST guidance.

3.5.4 Progress against the action plan will be monitored through Speciality and Care Group Board meetings and returned to the Trust Board for final assurance in July 2021 prior to submission.

4 Safety Action 5 : Can you demonstrate an effective system of midwifery workforce planning to the required standard?

4.1 The report seeks to provide assurance to the Trust Board that the Maternity Service has an effective system of midwifery workforce planning.

4.2 Birthrate plus review of maternity safe staffing has now been formalised into a report by the Head of Midwifery which has been reviewed by the Chief Nursing & Quality Officer and will be presented at the next Executive Team meeting for formal approval.

4.3 Over the past year 2020/2021 the Chief Nursing & Quality Officer, has taken a strategic approach to prioritise and focus on strengthening nursing and midwifery leadership across the Trust. This work has included investing heavily in the development of senior nursing and midwifery leaders, which has been financially supported both by the Trust and NHS E / I. This work has been well received and has included reviewing roles, responsibilities and job descriptions of senior nursing and midwifery leaders including a refreshed job description for the Matron which has bene implemented aligned to the national profile.

4.4 Strengthening midwifery leadership and raising its status *though providing strong, visible and highly effective leadership within midwifery will be crucial to address the challenges facing our maternity service and the profession.*

4.5 The Royal College of Midwives in their manifesto – "Strengthening midwifery leadership" have set out the expectation that every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation (with exceptions for very small units). This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.

4.6 Currently Medway Foundation Trust is the only maternity provider in Kent and Medway's Local Maternity System (LMS) who does not have a Director of Midwifery positon and when benchmarked against peers in all eleven provider sites on the SE Coast.

4.7 The Trust now has an opportunity to create a senior midwifery leadership role as a Director of Midwifery which will send a strong message on the importance and value the Trust places on Maternity Services. This is against the backdrop of an increasing national level of scrutiny on Maternity services following the Ockenden report which shared the emerging findings and recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts, published in December 2020 and the review into maternity services at East Kent Hospital Trust.

4.8 The revised CNST guidance (March 2021) requires an annual midwifery staffing oversight report that covers staffing and safety issues to the Trust Board. . The Head of Midwifery has prepared a workforce review paper which addresses all the elements required by CNST along with the recommendations of the Birthrate Plus tool. This report has been reviewed and endorsed by the Chief Nursing and Quality Officer and presented at the Executive Group meeting on 7April 2021 and then will subsequently be shared with the Trust Board..

4.9 The Birth Rate Plus tool was undertaken in October 2020 to provide systematic, evidence based calculation of the midwifery staffing establishment. The tool used a baseline of two months' case mix from 2018 and adjusted its findings based on change to uplift from 24% to 22%, a review of acuity and birth rate.

4.10 The most significant finding of the Birth Rate Plus tool was the shortfall in specialist and managerial midwives. These roles are vital to running, shaping and improving the Maternity Service.

4.11 The Birth Rate Plus tool also made recommendations on the staffing required to achieve the requirements of Continuity of Carer (CoC) as set out in Better Births (2016). In order to achieve CoC, an increase of 13.14 WTE Registered Midwives and postnatal Maternity Support Workers are required.

4.12 CNST also requires the Trust Board to review progress against the CoC Action plan quarterly from January 2021. The CoC Action Plan is included in Appendix 5 for Trust Board review. The report provides assurance the that CoC is a standing item on the Maternity Transformation and Assurance Board Agenda and has been reviewed by the Board Level Safety Champion monthly since November 2020. Progress against the CoC action plan will be supported by the recommendations of the Midwifery Workforce report referenced in 3.2. The report requests the Board formally note review of the CoC action plan.

4.13 CNST requires the Maternity service to be complaint with 1:1 care in labour over a consecutive 6 month period between 1 July 2020 and 15 July 2021. The 1:1 care in labour is monitored via the maternity dashboard. The Maternity Service reports 100% compliance with 1:1 care in labour for the 6 month period 1 September 2020 to 28 February 2021.

4.14 CNST requires the Maternity service to be compliant with 100% supernumerary status for the delivery suite coordinator. An audit is ongoing to demonstrate compliance with this requirement, with 100% compliance with supernumerary status noted in all months audited. (November-December 2020 and February-March 2021). If the supernumerary status of the Delivery Suite Coordinator falls below 100% with the current workforce, the recommendations of the Maternity Workforce paper would support 100% compliance with this requirement.

5 Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

5.1 The report seeks to provide assurance to the Trust Board that the Maternity service is complaint with all five elements of the Saving Babies' Lives Care Bundle (SBLCBv2).

5.2 The implementation of the five elements of the SBLCBv2 is fundamental to the provision of safe, evidence based, best practice care to women and families. CNST requires specific targets to be met for each Element, and the report provides assurance that the Maternity Service has achieved, or is on track to achieve, the targets and to continue to provide care in line with evidence based best practice

5.3 The CNST guidance requires the Trust Board to be sighted on the completion of SBLCBv2 surveys. The report provides assurance that these surveys have been completed and they are linked in evidence in Appendix 1.

5.4 **Element 1: Smoking in Pregnancy**

5.4.1 Reducing smoking in pregnancy is a national priority and the Maternity Service's Lead Midwife for Smoking in Pregnancy works with staff to support women to stop smoking whilst pregnant. To support this, pre-Covid-19, Carbon Monoxide (CO) measurements were taken at booking and again at 36 weeks.

5.4.2 CNST requires the Maternity Service achieve 80% compliance with Carbon Monoxide (CO) measurements taken at booking and again at 36 weeks. However, due to restrictions on CO monitoring during Covid-19 the CNST requirements have been adjusted and Trusts are required to demonstrate 80% compliance with recording smoking status at time of booking and time of delivery.

5.4.3 This data is closely monitored by the Lead Midwife for Smoking in Pregnancy and the report assures the Board that compliance with recording smoking status, both at the time of booking and time of delivery, is 99% for quarter 1 and 2, and 100% for quarter 3 2020/2021.

5.5 **Element 2: Fetal Growth Restriction**

5.5.1 This element seeks to identify all women who are at risk at Fetal Growth Restriction (FGR), particularly those at highest risk in order to determine the appropriate pathway of care. The Maternity Service provides assurance that women are being identified at booking as part of the risk assessment process.

5.5.2 CNST requires the Maternity service to identify and record risk status for FGR at booking for at least 80% of cases. The Maternity Service has worked closely with the Digital team to update EuroKing to allow this data to be extracted from March 2021. The Maternity Service will advise the Board of compliance against this requirement in July 2021 and if compliance falls below 95% an action plan will be put in place.

5.5.3 A Body Mass Index (BMI) greater than, 35km/g^2 is an identified risk factor for FGR and stillbirth. Women with a BMI greater than 35 account for 10% of births at MFT and have accounted for 16% (13) of stillbirths recorded at MFT between 2015 and 2019. SBLCBv2 identifies the benefit of additional growth scans for these women from 32 weeks gestation. The Maternity service does not currently provide this service as it would require an additional 2000 scans per year (each woman would require a double scan appointment due to complexity of the scan). This increase in scanning cannot be accommodated within the current workforce and would require additional staffing of 1.0 WTE band 7 midwife sonographer.

5.5.4 The Maternity Service has identified that this role is essential to provide safe, best practice care to women and families and have completed a successful Business Case to support a Lead Sonographer role, which will enable the Fetal Medicine Service to offer the required scanning service for women with a BMI over 35km/g^2.

5.5.5 The CNST guidance requires the Trust Board to specifically confirm that women with a Body Mass Index (BMI) greater than 35km/g^2 are offered an ultrasound and assessment of growth from 32 weeks gestation and the Maternity Service will provide confirmation to the Trust Board in July 2021 that this pathway is in place.

5.5.6 The report provides assurance to the Board that all women are offered uterine artery doppler at their 20-22 week scan as standard. Any women who returns a uterine artery doppler velocimetry reading >95th percentile will go on to be seen in the placental disorders clinic as outlined in the guideline GUDNM031 'Management of small for gestational age fetuses'. The CNST guidelines requires the Trust Board to specifically confirm that in pregnancies identified as high-risk at booking a uterine artery doppler flow velocimetry is performed by 24 weeks completed gestation. The report assures the Board that this is the case for all pregnancies, including those identified as high-risk at booking.

5.5.7 The CNST guidance also requires the Trust Board to record the percentage of a babies born <3rd centile >37+6 weeks gestation. A local audit of all cases has been undertaken and the report is being finalised and the findings of this will be presented to the Trust Board in July 2021 prior to submission.

5.6 Element 3: Reduced Fetal Movements

5.6.1 SBLCBv2 Element 3 encourages Trusts to promote awareness amongst women of the importance of detecting and reporting reduced fetal movements (RFM). The report provides assurance that the Maternity Service has the appropriate pathways and protocols in place for women who present with RFM and all colleagues are aware of the importance of promoting awareness amongst pregnant women.

5.6.2 It is a requirement of CNST for at least 80% of women to receive information about RFM by week 28+0 weeks. The Maternity Service has worked closely with the Digital Team to revise the electronic system to allow this data to be captured, and the report assures the Board that this is now in place. Initial reports will be run in March 2021 which will allow the Maternity Service to advise of the percentage of women who received the RFM information. This will be included in the report to the Board in July 2021 prior to submission.

5.6.3 Women who present with RFM should have a computerised Cardiotocography (CTG). Computerised CTG categorises CTG readings, providing an additional safety mechanism, alongside health care professional interpretation. The Trust's recent purchase of 20 new CTG monitors with computerised CTG Capacity will enable the Maternity Service to provide computerized CTGs for all women who present with RFM. Updated Fetal Monitoring guidelines for intrapartum and antenatal care were launched on 1 February 2021 which support staff in the use of the new monitors. CNST guidance requires Trusts to confirm that at

least 80% of women who attend with RFM have a computerised Cardiotocography (CTG). This data cannot be captured via EuroKing and a local audit has been completed which demonstrates 100% compliance.

5.7 Element 4: Fetal Monitoring

5.7.1 It is vital that all colleagues are appropriately trained and are competent to interpret CTGs. The report assures the Board that that Maternity System has a robust, Multidisciplinary training programme and competency assessment in place, overseen by the Fetal Wellbeing Midwife.

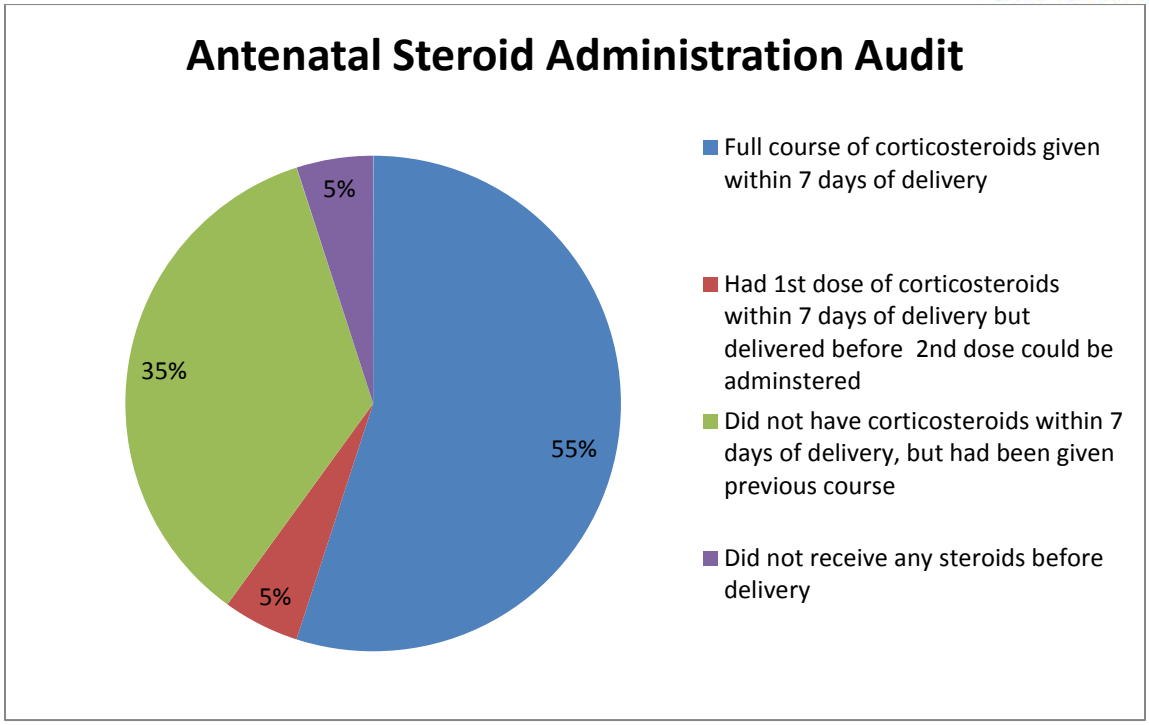
5.7.2 The revised CNST guidance (March 2021) has removed the 90% requirement for obstetric and midwifery staff to attend intrapartum fetal monitoring training and complete the mandatory annual competency assessment. The guidance requests the Trust Board minute the Trust's commitment to facilitate local, in-person, fetal monitoring training when permitted. The Maternity Service has continued to offer Fetal Monitoring training throughout Covid-19 and have already achieved 90% compliance for midwifery staff and 81% for junior doctors. The report assures the Trust Board that the Maternity Service continues to strive for a minimum of 90% across all staff groups and that a firm trajectory is in place to achieve by May 2021. The report requests that this plan be reflected in the Trust Board minutes. The final percentage of staff compliance with intrapartum fetal monitoring training will be returned to the Trust Board in July 2021 prior to submission.

5.8 Element 5: Reducing Preterm Birth

5.8.1 The CNST guidance requires the Trust to confirm that women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. The report provides assurance to the Board that there is an established pathway and guideline in place for the management of women at risk of preterm birth (GUDNM047) is in place and the appropriate preterm clinic and scanning for cervical length is in place.

5.8.2 Antenatal optimisation is important for fetal lung maturity and the Maternity Service has guidelines in place to administer corticosteroids to all appropriate mothers as per national guidance. Current data captured by the MSDS and Badgernet identifies the Trust is 96% compliant with administering at least one dose of antenatal corticosteroids.

5.8.3 The CNST guidance requires the Trust to confirm the Percentage of singleton live births less than 34+0 weeks receiving a full course of antenatal corticosteroids within 7 days of birth. A local audit has been undertaken of 3 months and 20 out of 21 cases were reviewed which demonstrates 55% of singleton live births less than 34+0 weeks received a full course of antenatal corticosteroids within 7 days of birth.



5.8.4 The findings of the audit reflect the unpredictability of preterm birth. CNST guidance requires an action plan to be put in place if the results show less than 85% compliance. The audit findings are being presented at local audit and departmental meetings to raise awareness and an action plan is in place, which includes the introduction of an Antenatal Optimisation bundle sticker and a review of steroid guidelines.

5.8.5 The updated CNST (February 2021) removed “less than 34+0 weeks” from the audit requirements so additional audit is underway to support this and the findings will be shared with the Board in July 2021 prior to submission.

5.8.6 The administration of Magnesium Sulphate to mothers at risk of preterm birth has been proven to provide neuro protection to the neonate. The report provides assurance to the Trust Board that the Trust is currently achieving 95.2%, with missed cases being women who present and deliver before Magnesium Sulphate can be administered. The CNST guidance requires the Trust to confirm the percentage of singleton live births (less than 30+0 weeks) receiving Magnesium Sulphate within 24 hours prior to birth, requiring 85% compliance. Compliance will continue to be monitored quarterly and if it falls below 85% an action plan will be put in place.

5.8.7 Delivery in an appropriate care setting is essential for maternal and neonatal safety. As Medway is a level 3 Neonatal Unit, we do not transfer pregnant women or newborn babies to other units, unless there are issues of capacity or there is a plan in place to deliver the baby at another specific unit for specialised treatment. CNST guidance requires the Trust to confirm the percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

5.8.8 As Medway Hospital has a level 3 Neonatal Unit, we do not transfer pregnant women or newborn babies to other units, unless there are issues of capacity or there is a plan to deliver the baby at another specific unit for specialised treatment.

5.8.9 The exception reports submitted nationally by the ODN include:

- Babies born outside of a Neonatal Intensive Care unit at less than 27 weeks gestation.

- Babies born in Special Care Units at less than 31 weeks gestation and less than 1250gms.

5.8.10 The only babies planned to be born at Medway who would meet the ODN exception criteria would be babies born prematurely outside of hospital. All premature births between 22+0 and 36+6 weeks were reviewed for 2020. This review showed 6 babies between 36+0 and 36+6 weeks gestation born outside of hospital. No themes or trends were identified, and 3 cases were of un-booked pregnancies, born at home with term birth weights. It is reassuring that no babies were unexpectedly born outside hospital before 36 weeks.

5.8.11 The report therefore assures the Board that 100% of women gave birth in an appropriate care setting for gestation in accordance with local ODN guidance.

6 Conclusion and Next Steps

6.1 The report provides assurance and supportive evidence to the Trust Board that demonstrates the Maternity Service is on track to achieve compliance with Safety Action 4, 5 and 6.

6.2 The report provides assurance to the Board that the Trust is compliant with submission of data to the MSDSv2 to the required standard.

6.3 The report requests the Board approves the action plans included in Appendix 3 and 4 and formally notes review of the Continuity of Carer Action Plan in Appendix 4.

6.4 The Maternity Service will provide an assurance report to the QAC in May 2021 to demonstrate progress towards compliance for Safety Action 7, 8, 9 and 10 and evidence to the Board in June 2021.

6.5 A final assurance report will be presented to the Trust Board in July 2021 prior to sign-off of the Trust declaration form by the Chief Executive Officer and submission to NSHR by 15 July 2021.

7 Appendix 1: BRAG Analysis

Red (overdue)

Amber – off track but with actions to deliver

Green – action is on track

Blue - action completed

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	**Trust Board must formally record in their minutes the proportion of obstetrics and gynaecology trainees in their Trust who responded 'Disagreed or /Strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota'. Is the above minuted in the Trust Board minutes and has an agreed strategy been produced by the Trust jointly with an action plan with deadlines to address these lost educational opportunities due to rota gaps?**				Detail recorded in the report. Requires Trust Board to formally minute following April 2021 meeting.	\\mmhnasv03\Shared\CNST\Safety Action 4\Obstetric Workforce
		Has the action plan to address lost educational opportunities been signed off by the Trust				The GMC report was received by the Trust in	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		Board?				December 2019. Whilst lost training opportunities due to rota gaps were identified for the survey period (December 2018-April 2019), Mr Hany Habeeb, Lead Clinician for Obstetrics and Gynaecology has provided assurance that these rota gaps had been rectified by the time the report was received. An action plan to monitor rota gaps is included in Appendix 2 and requires Trust Board approval.	
		Have you submitted a copy of the action plan (with evidence of Board approval) to the RCOG at workforce@rcog.org.uk?				Submission of Action plan required following Board approval. .	
		Anaesthetic medical workforce Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?				Report confirms compliance with ACSA standards and requests Trust Board to formally minute this.	\\mmhnasv03\Shared\CNST\Safety Action 4\Anaesthetic Workforce

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
							\\mmhnasv03\Shared\CNST\Safety Action 4\Audits
		If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?				Standards met. Action plan not required.	
		Neonatal medical workforce Does the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?				Rota gaps have been mitigated by Locum cover and other staff to meet BAPM standards.	\\mmhnasv03\Shared\CNST\Safety Action 4\Neonatal Medical Workforce
		Has six month period between Wednesday 1 January 2020 and Thursday 20 May 2021been audited to demonstrate compliance?				6 months rota has been provided and demonstrates compliance.	\\mmhnasv03\Shared\CNST\Safety Action 4\Neonatal Medical Workforce
		If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?				NHSR clarified action plan required. To be submitted to Trust Board in April 2021	\\mmhnasv03\Shared\CNST\Safety Action 4\Neonatal Medical Workforce
		Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards.				Neonatal nursing workforce does not meet the required standards. Action Plan completed.	\\mmhnasv03\Shared\CNST\Safety Action 4\Neonatal Nursing Workforce
		Has six month period between Wednesday 1 January 2020 and				6 months nursing rota provided and	\\mmhnasv03\Shared\CNST\Saf

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		Thursday 20 May 2021 been audited to demonstrate compliance				workforce calculation (Dinning Tool) completed. .	ety Action 4\Neonatal Nursing Workforce
		If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?				Nursing service does not meet the required standard. Action plan in place. To be submitted to Trust Board for approval in April 2021.	\\mmhnasv03\Shared\CNST\Safety Action 4\Neonatal Nursing Workforce
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?				Birthrate+ completed.	\\mmhnasv03\Shared\CNST\Safety Action 5\Birth Rate Plus
		Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?					
		Has an action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?				Action plan cannot be progressed until Workforce review recommendations are reviewed and agreed by Trust Board.	
		Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?				Action plan cannot be progressed until Workforce review recommendations are reviewed and agreed by Trust	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
						Board.	
		Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status? This must include mitigations to cover shortfalls.				Audit ongoing to monitor compliance with Supernumerary Status.	\\mmhnasv03\Shared\CNST\Safety Action 5\Red Flag and Acuity
		Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with 1:1 care in labour? This must include mitigations to cover shortfalls.				September 2020-January 2021 – 100%	\\mmhnasv03\Shared\CNST\Safety Action 5\Maternity Dashboard
		*Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID?- How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?				Review undertaken and detail included in the Workforce Report.	\\mmhnasv03\Shared\CNST\Safety Action 5\Covid-19 \\mmhnasv03\Shared\CNST\Safety Action 5\Escalation & Staffing Policies
		Has a bi-annual midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board?				Report completed and to be presented to the Trust Board,	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	**Have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?** **Evidence of the completed quarterly care bundle surveys for 2020/ 21 should be submitted to the Trust Board.**				Evidence to be presented to Trust Board in April 2021 and again in July 2021.	\\mmhnasv03\Shared\CNST\Safety Action 6\Overview and Dashboard
		Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network				Evidence to be presented to Trust Board in April 2021 and again in July 2021.	
		The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted				Evidence to be presented to Trust Board in April 2021 and again in July 2021.	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		ELEMENT 1 Reducing smoking in pregnancy					\\mmhnasv03\Shared\CNST\Safety Action 6\Element 1 - Carbon Monoxide Monitoring
		Has standard a) been successfully implemented (80% compliance or more)?					
		If the process metric scores are less than 95% for Element 1 standard a), has an action plan for achieving >95% been completed?				No action plan required	
		Has standard b) been successfully implemented (80% compliance or more)?					
		If the process metric scores are less than 95% for Element 1 standard b), has an action plan for achieving >95% been completed?				CO monitoring stopped nationally due to COVID therefor alternative approached as per CNST guidance-compliant	
		Has standard c) been successfully implemented (80% compliance or more)?				99% compliant	
		If the process metric scores are less than 95% for Element 1 standard c), has an action plan for achieving >95% been completed?				99% compliant	
		ELEMENT 2 Risk assessment,					\\mmhnasv03\S

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		prevention and surveillance of pregnancies at risk of fetal growth restriction					hared\CNST\Safety Action 6\Element 2 - Fetal Growth Restriction
		Has standard a) been successfully implemented (80% compliance or more)?				Working with Digital midwife and BI to ensure correct question on EuroKing to allow for accurate data collection.	
		If the process metric scores are less than 95% for Element 2 standard a), has an action plan for achieving >95% been completed?				On track to achieve compliance.	
		Do you have evidence that the Trust Board has specifically confirmed that all the following 3 standards are in place within their organisation:				Elements on track for compliance. Require Trust Board to specifically confirm in minutes.	
		1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards				Business case approved by Division to enable service to support this requirement. Guidelines to be update to reflect change to service.	
		2) in pregnancies identified as high risk at booking uterine artery Doppler					

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		flow velocimetry is performed by 24 completed weeks gestation					
		3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation				Audit has been completed. Awaiting final report.	
		If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?				No changes due to C19. Appendix G not followed services continued as normal.	
		If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?				No changes due to C19, Appendix G not followed services continued as normal.	
		If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?				No changes due to C19. Appendix G not followed services continued as normal.	
		If the above is not the case, has your Trust Board described the alternative intervention that has				No changes due to C19. Appendix G not	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
		been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice				followed services continued as normal.	
		ELEMENT 3 Raising awareness of reduced fetal movement					\\mmhnasv03\Shared\CNST\Safety Action 6\Element 3 - Reduced Fetal Movements
		Has standard a) been successfully implemented (80% compliance or more)?				Working with digital midwife and BI to ensure correct question is asked in EuroKing to allow for meaningful data collection. To be presented to the Trust Board in July 2021	
		If the process metric scores are less than 95% for Element 3 standard a), has an action plan for achieving >95% been completed?				Working with digital midwife and BI to ensure correct question is asked in EuroKing to allow for meaningful data collection. To be presented to the Trust Board in July 2021	
		has standard b) been successfully implemented (80% compliance or more)?				Audit completed and demonstrates compliance.	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
						Formal audit report to be submitted as evidence.	
		If the process metric scores are less than 95% for Element 3 standard b), has an action plan for achieving >95% been completed?				Expect to be compliant >95% therefore action plan not required.	
		ELEMENT 4 Effective fetal monitoring during labour					\\mmhnasv03\Shared\CNST\Safety Action 6\Element 4 - Fetal Monitoring
		Has standard a) been successfully implemented (80% compliance or more)?				Trajectory in place to achieve a minimum of 90% compliance by April 2021..	
		If the process metric scores are less than 95% for Element 4 standard a), has an action plan for achieving >95% been completed?				Trajectory in place to achieve a minimum of 90% compliance by April 2021. Will be monitored by CNST T&F Group and action plan completed if required.	
		Has standard b) been successfully implemented (80% compliance or more)?				Trajectory in place to achieve a minimum of 90% compliance by April 2021. Will be monitored by CNST T&F Group and action plan completed if	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
						required.	
		If the process metric scores are less than 95% for Element 4 standard b), has an action plan for achieving >95% been completed?				Trajectory in place to achieve a minimum of 90% compliance by April 2021. Will be monitored by CNST T&F Group and action plan completed if required.	
		ELEMENT 5 Reducing preterm births					\\mmhnasv03\Shared\CNST\Safety Action 6\Element 5 - Preventing Preterm Birth
		Has standard a) been successfully implemented (80% compliance or more)?				Current data collection does not meet CNST specificity. Audit being undertaken.	
		If the process metric scores are less than 95% for Element 5 standard a), has an action plan for achieving >95% been completed?				Expect to achieve >95% compliance.	
		Has standard b) been successfully implemented (80% compliance or more)?				Currently 95.2%	
		If the process metric scores are less than 95% for Element 5 standard b), has an action plan for achieving >95% been completed?				Currently 95.2%. Guidance and declaration form have different threshold for action	

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	Further Action Required	Evidence
						plan. Seeking clarification from NSHR.	
		Has standard c) been successfully implemented (80% compliance or more)?				Due to level 3 neonatal unit expect to be compliant with this standard. Awaiting evidence from Neonatal/Maternity Information System.	
		If the process metric scores are less than 95% for Element 5 standard c), has an action plan for achieving >95% been completed?				Due to level 3 neonatal unit expect to be compliant with this standard	
		Do you have evidence that the Trust Board has specifically confirm that all the following standards e) and f) are in place within the organisation?				Included in report to QAC in March 2021 and will be presented at Trust Board in April 2021 to specifically confirm.	

8 Appendix 2: Obstetric & Gynaecology Trainee Action Plan

Accountable Lead: Hany Habeeb, Clinical Lead **Action Plan Completion Date:**

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Ensure that educational opportunities for O&G trainees are not lost due to rota gaps.	Recruit additional middle grades to maximize staffing numbers.	Recruitment of additional doctors to meet	31/12/2019		Hany Habeeb	**Complete** From June 2019 additional middle grades have been recruited to maximize staffing.	30/06/2019	ROTAS
	Ensure consultant presence at Friday teaching.	Consultant Rota and Friday Teaching schedule/attendance list	30/12/2019		Hany Habeeb	On target	6T	
	Reinstate Friday teaching following Covid-19 restrictions	Teaching Schedule and attendance sheets.	30/09/2020		Padma Vankayalapati	Complete	September 2020	Friday Teaching attendance.pdf 2020.09 Friday Teaching Rota Sep

								Teaching rota - Sheet6.pdf 2020-2021 O&G Friday Teaching Sh
	Monitor middle grade and junior staffing – College Tutor and Clinical Lead	Maintain appropriate staffing levels.	31/07/2021		Hany Habeeb	On target	6T	
	Increase utilisation of specialist nurses in theatres to allow trainees to attend their teaching sessions.		31/07/2021		Hany Habeeb	On target	6T	
	Seek regular feedback from trainees to ensure training needs are being met.	Formal and informal feedback to be discussed at Faculty/Consultant meetings.				On target		Feed-back OG trainees Novembe Feed-back O&G trainees June 202 2020.06.09 FINA O&G LFG Minutes. 2020.01.16 Consultant Meetin

9 Appendix 3: NICU Junior Medical Staffing Action Plan

Accountable Lead: Ghada Ramadan, Clinical Lead **Action Plan Completion Date:**

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Resources What or who can help you complete the action	Owner	Current position	Actual Date	Evidence Source
Junior Doctor establishment allows for rota to be covered to BAPM standards (3 tier rota system in place 24/7)	Work with Deanery to ensure maximum allocation of junior doctors.	Deanery positions filled by substantive staff.	On going	Support from HR to find trainees on short term contracts to fill in vacant deanery posts	Pediatric College Tutor and Training program director	2 vacant registrar posts (1 mat leave) 4 vacant SHO posts (1 mat leave) Internal and external locums are filling gaps currently so this is fully mitigated. Consultants are stepping down to support some of the shifts.	On going	HR (SL)
Develop new role in consultant JP's for workforce	New senior leadership structure agreed with roles and responsibilities identified.	JP agreed and signed off by directorate triumvirate.	Completed April 2020.	PA allocation found from within	Ghada Ramadan	Completed.		JP for Dr FB

lead				consultant budget.				
Mitigate Deanery Shortages to ensure BAPM compliance.	Develop new roles in NICU medical workforce (Neonatal Physician Associate role to support the Junior Doctor Rota)	Successful business case and appointment of Physician Associate	Jan 2020	Will be found from unfilled deanery posts. Contract renewed for a further year 20/21.	Ghada Ramadan	Complete	In post from Jan 2020	2020.09.30 Physician Associat 2020.09.30 Physician Associat
Mitigate Deanery Shortages to ensure BAPM compliance.	Develop new roles in NICU (Advanced Neonatal Practitioner Role to support the junior Doctor Rota).	Successful business case and appointment of trainee ANNP in NICU.	August 2020	Training funds found from LMS support.	Ghada Ramadan	Complete	August 2020	JD ANNP 7 March2020.docx ANNP Bussiness Case 29 01 20.do
Ensure retention of current CTF staff in NICU	Convert historical CFT posts into SAS grade posts.	2 posts have been converted to SAS posts through agreement in VCP.	November 2019	None required and pay protection granted for post holders for 2 years.	Ghada Ramadan	Complete	November 2019	VCP Records – 7/11/2019
Expansion on MTI recruits in NICU	Appoint new MTI junior doctor	Doctor taking up post.	2020 (delayed in view of C19 travel restrictions).	HR support	Palaniappan Sashikumar	On target	2019	HR corresponda nce.

			Post filled in with new recruited CTF					

10 Appendix 4: NICU Nursing Qualified in Speciality Action Plan

Accountable Lead: Anna Francis, Matron **Action Plan Completion Date:**

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Achieve 60% QIS by June 2021.	14 staff members due to complete the QIS course between December 2020-June 2021	Staff members on the course gain their qualification in specialty	30/06/2021	Divisional support to maintain funding for University specialist neonatal course	Matron	On target	6T	6T
Recruit Additional QIS staff.	Continue recruitment and retention payments for QIS staff. Education team support induction and supervision for new staff Offer new roles and opportunities for promotion Rolling adverts for QIS staff Band 5, 6 and 7	Monitor staff recruitment and retention rates.	31/03/2021	HR Recruitment Team Divisional support to maintain funding for payments.	Matron	On target	6T	
Support existing staff to complete QIS course.	18/9/2020 7 staff currently on course expected to be qualified by December 2020.	Increased percentage of QIS staff.	31/03/2021	HR Divisional and HON support to secure	Matron HoN	On target	6T	

	Funding agreed for additional 7 staff to complete course – commenced September 2020 **14/1/2021** 7 staff due to complete QIS by end of January 2021. Will be added to the QIS figures once confirmation from University received.			funding to support staff to complete course.				
Enhanced Bank rates for QIS staff	To continue in order to maintain the high quality service safely and to be able to react flexibly to unpredictable changes in acuity and avoid more expensive agency costs	No unit closures for lack of nursing staff	31/03/2021	HR Recruitment Team Divisional support to maintain funding for payments.	Matron HoN	On target	6T	
Workforce Review	Establishment review including Dinning tool which takes into consideration acuity and cot days in individual neonatal units. Increase nursing establishment with additional Band 5 funding as easier to recruit to Band 5 post and develop Band 5 nurses to be able to complete QIS course- 'Grow our own'	Increase in nursing establishment	31/03/2021	HR Recruitment Team Divisional and HON support	Matron HoN	On target		

	Additional Band 5 posts would allow for further overseas recruitment							
GIRFT Review	Review of all staffing, Medical, nursing and AHP to ensure meets benchmark of GIRFT and Neonatal critical care review (NCCR)		31/03/2021	HR Recruitment Team Divisional and HON support Network lead post holders to support	Matron Clinical Lead HoN	On target		
External review of Neonatal Critical Care Services	NCCR underway.		31/03/2021	HR Recruitment Team Divisional and HON support Network lead post holders to support Trust and National GIRFT team to support and advise	Matron Clinical lead HoN	On target	6T	

11 Appendix 5: Continuity of Carer Action Plan

Accountable Lead: 6T **Action Plan Completion Date: 6T**

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Gain funding for and employ a Transformation midwife to lead the CoC Project.	Secure funding from LMS.	Funding agreed and permission to advertise post.	19/02/2021	LMS funding	Dot Smith	**Overdue** **05/2/2021** Funding agreement not reached with LMS and advertisement withdrawn. **10/3/2021** No update from LMS re. funding. **17/3/21** Discussed at Safety Champion Meeting. CNQO to escalate with LMS SRO	6T	Maternity Transformation Lead-
	Advertise and recruit to post.	Transformation lead in post with appropriate funding.	22/02/2021	HR	Lisa Price	**Overdue** Advertisement ready to progress once funding agreed. **10/3/2021** No update from LMS re funding. Unable to progress.		e.g. E Doc2.docx mail, minutes, report or plan.
Undertake Birth Rate plus assessment to identify staffing requirements to meet COC	Undertake Birth rate Plus assessment.	Completed Birth Rate Plus tool with COC recommendations.	30/10/2020		Dot Smith	**Complete**	30/10/20	2020.10.22 Birth Rate Plus Report f

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Training for senior midwifery staff for COC	Senior staff to enroll and attend COC Engagement training.	Evidence of completed training	30/01/21		Lisa Price	**Complete**		Coc cert.pdf COC HEE Trainin Dates and Staff.x
Develop strategy to implement COC	Options appraisal review with senior team.	Agreement of options of appraisal.	30/11/2020	General Manager W&C HOM	Lisa Price	**Complete 13/11/20 –** Hybrid Model and Geographical Model considered- Geographical model agreed.	30/11/2020	Continuity of Car Hybrid model for h 2020.11.23 Continuity of Care
	Write strategy paper and present to key stakeholders	Approval of strategy paper.	31/12/2020		Lisa Price	**Complete**	December 2020	Continuity of Care update report 07.12.
Undertake workforce modelling to identify staffing requirements to meet 35% COC and implement agreed Geographical Model.	Workforce Modelling	Completed workforce mapping that identifies staffing requirements.	31/12/2020	Finance	Lisa Price	**Complete**	December 2020	COCModelling fo business case.do

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Secure funding for additional workforce required to meet COC.	Workforce Review paper.	Completed workforce paper with COC workforce uplift identified.	30/01/2021	Chief Nursing and Quality Officer approval of paper.	Dot Smith	**Complete** Paper reviewed and endorsed by CNQO and plan to submit to Executive Group	18/2/21	
	Divisional, Executive and Trust Board approval.		31/03/2021	Chief Nursing and Quality Officer	Dot Smith	**On Target** Plan to submit paper to Executive Group in March and to Trust Board in April 2021		
Identify additional resources required to implement Geographical model.	Develop business case to identify resources and funding required.	Approved Business case and agreed funding.	30/03/2021	General Manager for W&C, Finance and Procurement	Lisa Price	**On Target:** Business Case written and awaiting review and sign-off	6T	 COC equiptment f business plan .ms
Undertake rota mapping exercise to understand change required to working patterns.	Complete sample rota and share with staff.	Presentation of sample rota with staff.	31/01/2021	LMS Workforce Lead	Lisa Price	**Complete**	January 2021	 MCOC Staff engagement even
Review role of dedicated Home Birth Team to help meet the requirements of COC	Develop Proposal for Homebirth team in line with COC requirements.	Completed proposal for Homebirth Team	31/12/2021		Lisa Price	**Complete**	December 2021	 Proposal for a Dedicated Homebi

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Resources** What or who can help you complete the action	**Owner**	**Current position**	**Actual Date**	**Evidence Source**
Identify key stakeholders to continue Task and Finish Group	Identify Obstetric Lead to support T&F group.	Obstetric Lead attendance at T&F Group	28/02/21	Clinical Lead	Clinical Lead	**Overdue 10/3/21** No decision on Obstetric Lead **13/3/21** Discussed at Safety Champion Meeting. DS advised that new Clinical Lead due to be appointed end of March 2021. Await re-allocation of lead roles to determine obstetric lead for COC		
Undertake staff engagement	Run Staff engagement sessions	Delivery of staff engagement sessions.	29/01/2021	LMS Workforce Lead Intrapartum Matron	Lisa Price	**Complete**	29/01/2021	MCOC Staff engagement events.p 2021.01.21 Safe Champion Meeting
	Engage staff via social medial	Posting of COC information via social media.	29/01/2021	LMS Workforce Lead Intrapartum Matron	Lisa Price	**Complete**	29/01/2021	Continuity Of Ca FB Posts.docx
Work with BI to ensure appropriate data can be pulled to monitor	Work with BI to submit Continuity of Carer Data as required by CNST.	Compliance with CNST Safety Action 2	28/2/2021	Digital Midwife IT Project Manager BI EuroKing	Lisa Price	**Complete** All MSDSv2 criteria submitted for CNST Safety Action 2. COC criteria met		CNSTSCORECARD C20 Final.xlsx

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Resources What or who can help you complete the action	Owner	Current position	Actual Date	Evidence Source
progress against COC targets				System Manager				
	Monthly review of COC data with BI team to track progress.	Improved COC data and figures	31/12/2021	Digital Midwife IT Project Manager BI EuroKing System Manager	Lisa Price	On Target	6T	
Work with facilities and estates to review	Review strategy paper along with workforce mapping with Facilities and Estates to establish requirements support COC workforce.	Meeting held with appropriate staff and resource requirements identified	30/06/2021	Head of Facilities and Estates General Manager W&C	Lisa Price	**On Target** 10/3/21 Risk assessment completed for community premises – awaiting feedback		
	Identify appropriate premises to support COO	Appropriate premises identified and contract negotiations commenced.	30/08/2021	Head of Facilities and Estates General Manager W&C	Lisa Price	On Target		
Undertake formal staff consultation.	Engage HR Engage with Unions Deliver	Appropriate managed formal consultation process	30/06/2021	HR Business Partner Union Leads HOM	Lisa Price	On Target		

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Resources What or who can help you complete the action	Owner	Current position	Actual Date	Evidence Source
	Consultation paper to staff							

Overdue | On target | At Risk | Complete

Meeting of the Trust Board in Public
Thursday, 15 April 2021

Title of Report	**Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework – Progress update on progress**	Agenda Item	**4.5**
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Report Author	Katy White, Director of Nursing Quality and Professional Standards		
Executive Summary	On 01 October 2020 the Chief Nursing and Quality Officer presented the Trust Board with the Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework, as one of the deliverables set out within the strategic priorities for nursing and midwifery 'Reclaiming the nursing landscape', which the Board subsequently approved. The purpose of this Ward to Board assurance framework is to provide a clear framework and process of assurance for the Chief Nursing and Quality Officer, and onward to the Trust Board, regarding the quality of nursing and midwifery care provided at the Trust. Incorporating any matters requiring escalation, including sharing and celebrating best practice, lessons learning and demonstrating impact in improving patient outcomes, processes of care, fundamental standards and patient experience. Despite the significant impact and challenges that the Coronavirus has had on the Trust over the past year, advancing the delivery of this framework has continued to be prioritised with improvements in standards of care, reductions in harm and increased days between hospital acquired pressure ulcers, infections and Falls in many wards across the Trust . This paper provides the Trust Board with an update on progress of the implementation of this framework thus far.		
Committees or Groups at which the paper has been submitted	Trust Board, 01 October 2020		
Resource Implications	There are no resource implications identified within this report		
Legal Implications/ Regulatory Requirements	Failure to implement this Framework could lead to breaches in the Care Quality Commission Fundamental Standards not being known, leading to regulatory action being taken by the CQC and NHSEI		
Quality Impact Assessment	QIAs will be carried out on individual projects as appropriate		
Recommendation/ Actions required	The Board is asked to discuss and note the content of this report, progress to date and consider the level of assurance that this provides in relation to the progression of the Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework.		

	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	There are no appendices to this report			

The key headlines and levels of assurance are set out below:	
Partial assurance	Amber/ Green - Assurance with minor improvements required

1 Executive Overview

1.1 Good health and care outcomes are highly dependent on the professional practice and behaviours of nurses and midwives. The purpose of professionalism in nursing and midwifery is to ensure the consistent delivery of safe, effective and person centred care and achieving the best outcomes and experiences for people.

1.2 On 01 October 2020 the Chief Nursing and Quality Officer presented the Trust Board with the Ward to Board Nursing and Midwifery Quality Assurance and Improvement Framework, as one of the deliverables set out within the strategic priorities for nursing and midwifery document 'Reclaiming the nursing landscape', which the Board subsequently approved.

1.3 The purpose of this assurance framework is to provide a clear framework and process of assurance for the Chief Nursing and Quality Officer and onward to the Trust Board regarding the quality of nursing and midwifery care. Incorporating any matters requiring escalation, including sharing and celebrating best practice, lessons learning and demonstrating impact in improving patient outcomes, processes of care, fundamental standards and patient experience

1.4 Despite the significant impact and challenges that the Coronavirus has had on the Trust over the last year, advancing the delivery of this framework has continued.

1.5 This report provides the Trust Board with an update on progress of the implementation of this framework thus far.

2 Background and context

2.1 Following the planned inspection of five core services and an unannounced inspection of a sixth service by the Care Quality Commission (CQC) during December 2019 and January 2020, it was identified by the CQC that leaders were not always aware of all the risks, issues and challenges within the services. The resulting CQC report, published in April 2020, also reported "concern with nurse leadership throughout the trust, and that nursing standards fell way below those expected in a caring organisation".

2.2 In undertaking a proactive approach to this feedback, and leading on a diagnostic phase of work with senior nurses and midwives in January 2020, the newly appointed interim Chief Nurse identified the strategic priorities for nursing and midwifery at the Trust for 2020 which were set out in the document 'Reclaiming the nursing landscape'. Throughout 2020 the Executive Group and the Quality Assurance Committee have received regular progress reports against that strategic plan, which cuts across five broad domains:

1) Nursing and Midwifery Standards and Practice
2) Nursing and Midwifery Governance
3) Nursing and Midwifery Leadership
4) Nursing and Midwifery Workforce and Education
5) Nursing and Midwifery Strategy

2.3 As part of the resetting of senior nursing leadership expectations and nursing and midwifery governance at the Trust, the interim Chief Nurse commissioned the production of a Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework (hereafter referred to as the Framework), being clear that it must be a patient centred framework focused on outcomes and ensuring the processes and fundamental standards of care would be reliably implemented for every patient.

2.4 Implementation of this framework covers three distinct phases, each of which dovetail and are described in more detail in section 3.

3. Delivery of the Assurance Framework

3.1 As previously mentioned the implementation of this framework covers three distinct phases, each of which dovetail and are set out below:-

Phase 1: Establishing Senior Nursing Leadership Roles and Responsibilities in Providing Quality Assurance

Phase 2: Accountability, delivery and monitoring for improvement

Phase 3: A ward accreditation scheme will be implemented in early 2021/22 as a key priority aligned to the strategic nursing and midwifery priorities. This will build on the award scheme implemented by the Chief Nurse in 2020.

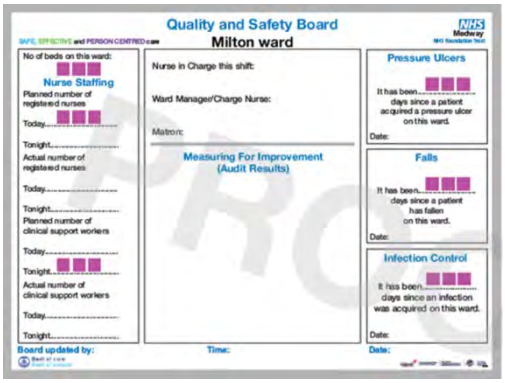
3.2 Phase 1 has been fully implemented and embedded. Initiatives implemented in this phase include:

1) Resetting senior nursing leadership expectations, behaviours and fundamental standards of care.
2) Investing in strengthening nursing and midwifery leadership through leadership development programmes for senior nurses and midwives to support delivery and demonstrating impact.
3) A complete revision and formal launch of the Matron Job description, based on the 2020 national Matron handbook; the job description clearly articulates the role of the Matron as a guardian of quality and has responsibilty for ensuring that the fundamental standards of care are met on each of their wards and departments.
4) This has been complemented by a suite of competencies which each Matron self-assessed themselves against with their Head of Nursing and which was overseen by the Director of Nursing Quality and Professional Standards.
5) Reviewed and strengthened the Heads of Nursing/ Midwifery job description putting an emphasis on the distinct quality elements that Heads of Nursing/ Midwifery are responsible for and the roles they have within this.
6) In partnership with the Chief Operating Officer, reviewed and strengthened the Divisional Director of Nursing job description and recruited two new substantive Divisional Directors of Nursing
7) Reviewed and strengthened the Deputy Chief Nurse Job description and appointed a new substantive Deputy Chief Nurse.

Each Ward Manager, Matron and Head of Nursing/ Midwifery has each received a letter from the Chief Nursing and Quality Officer setting out her clear expectations regarding the quality of nursing and midwifery care that she has, and the unique responsibilities and accountabilities expected of each of their roles.

3.3 Phase 2: Accountability and monitoring for improvement is being implemented with several elements well established and embedded. Initiatives implemented in this phase include:

1) We have reviewed and strengthened nursing and midwifery governance processes by introducing a formal monthly senior nursing and midwifery management group meeting that focuses on Nursing and Midwifery Standards and Practice
2) Nursing and Midwifery Governance
3) Nursing and Midwifery Leadership
4) Nursing and Midwifery Workforce and Education
5) Nursing and Midwifery Professional Practice and Regulatory Oversight
6) We have implemented a series of ward assurance reports from matrons through to the Chief Nursing and Quality Officer. These ward assurance visits and reports are undertaken by Matrons on a weekly basis and on a fortnightly basis are distilled into an assurance report to their Head of Nursing/ Midwifery. The reports are focused on patient care, fundamental standards, outcomes and experience, nursing & midwifery documentation compliance, safe medicines management, equipment safety, infection prevention and control and the built environment.
7) The Heads of Nursing/ Midwifery thereafter produce an assurance report for their care group to their Divisional Director of Nursing, who in turn produces a divisional level report to the Chief Nursing and Quality Officer. These reports improve accountability and encourage shared governance by enabling a focus on the key risks associated with the delivery of care as well as by identifying excellent practice.
8) We have introduced and embedded a daily standards and practice report that is focused on the reliability, compliance and completeness of core patient level risk assessments relating to the fundamental standards of care such as nutrition, falls and skin care.
9) This report serves as an early warning for all senior nurses when patient level assessments are at risk of not being completed within the required timescale, giving the Matrons an opportunity to address any wards that may not be carrying these out to the required standard before it becomes a problem and creates harm to patients. Gathering information in this way helps senior nursing and midwifery leaders, specifically Ward Managers and Matrons to identify areas of risk of patient harm and best practice, supporting accountability of clinical leaders and managers in the delivery of safe, effective and person-centered care.
10) Quality and safety boards have been introduced on all adult in patient wards; the boards for the more specialized areas have been designed and are on order. These boards are aligned to the quality strategy priorities and demonstrate a proactive approach to measure the quality of care using increasing ‘days between’ hospital acquired harms such a pressure ulcers, falls and infections.



11) The boards also demonstrate process compliance, audit performance and staffing levels and provide a visible display of data at the frontline for patients, families and other staff to see.

12) The award scheme implemented by the Chief Nurse provides a forum to celebrate and reward achievements and has been positively received across the Trust.

13) When a ward achieves 50 days between a hospital acquired 'harm' they are awarded a bronze star by their matron, a silver star is awarded at 100 days between, and when a ward achieves 150 days between they are visited by the Chief Nursing and Quality Officer and the Chief Executive and awarded a gold star.

14) The ward managers are encouraged to conduct their ward safety huddles at the boards but due to achieving safe distancing this may have not always been possible. These boards provide a visible platform for shared learning so that wards and units can learn from each other and disseminate and spread excellent practice.

15) Since the quality boards were introduced on 9 September 2020 the following wards have been awarded stars, in addition February data has now been analysed and a number of additional wards will receive there stars:-

Sapphire ward achieved **239** days between a hospital acquired pressure ulcer

Subject/Award	September 2020	October 2020	November 2020	December 2020	January 2021
IPC Gold		Lister Nelson McCulloch Tennyson			
IPC Silver		Harvey Sapphire			
IPC Bronze		Bronte Pembroke			
Falls Gold					
Falls Silver					
Falls Bronze		Pembroke		Lawrence	
PU Gold	Sapphire				Keats Arethusa Nelson

PU Silver	Nil		Kingfisher Lawrence McCulloch		Sapphire Jade
PU Bronze	Byron Keats Kingfisher/SAU Lawrence Lister McCulloch Nelson Victory		Harvey Milton	Tennyson Will Adams	Victory Phoenix Bronte

16) Due to the impact of Covid-19 on both the nursing and business intelligence teams and their attentions having been diverted to more urgent matters, the development of the nursing and midwifery scorecard has been delayed. However this is now being remedied at pace; the first set of metrics have been agreed and the prototype for the scorecard is taking shape.

17) The scorecard covers 15 core aspects of care across the five domains of Safe, Effective, Caring, Responsive and Well Led for which nurses and midwifes are directly in control of. The scorecard will drill down from Trust to ward level quality metrics and will utilise and build upon the days between approaches.

18) It is expected that the final version will be approved at the senior nursing and midwifery management group in April, with implementation due to be rolled out by the 31 May 2021.

19) Aligned to the roll out of the nursing and midwifery scorecard, will be the introduction of the Nursing and Midwifery Accountability Panel chaired by the Chief Nursing and Quality Officer, who along with the Deputy Chief Nurse and both Divisional Directors of Nursing will form the Panel.

20) Each Head of Nursing/ Midwifery will be invited to account on a rolling eight week cycle for a defined set of patient quality and safety metrics for measuring and monitoring the fundamental standards of care, demonstrating and sharing improvements and good practice, but also being held to account where these metrics have not been met across their Care Group. The Ward Managers and Matrons for the Care Group will also attend the Panel when their Head of Nursing/ Midwifery is presenting.

21) These accounting sessions will provide a Trust wide standardised mechanism to support the oversight, monitoring and reporting of nursing standards as well as a forum for the sharing and spreading of best practice and will be triangulated with the assurance reports identified above and with the ward quality assurance visits led by the Central Quality Governance team.

22) Supported by the Institute a series of forums commenced in 2020 to bring ward teams together taking a multidisciplinary approach, to share their improvements in fundamental standards aligned to the quality strategy priorities and share how teams are demonstrating improvements in both processes and outcomes for patients. These forums were positively evaluated and will recommence as part of the framework approach to share, spread and disseminate best practice and support work to create a culture of continuous quality improvement across the Trust.

3.4. Phase 3: Ward Accreditation

As set out within ‘Reclaiming the nursing landscape: Strategic Priorities for nursing and midwifery 2020’, the intention has been to implement a Ward Accreditation Process in 2021.

One of the key priorities of the Chief Nursing and Quality Officer is to support the implementation of shared governance – the harnessing of collective nursing and midwifery leadership to influence and drive change, initially at local level, and going forward to regional and national levels. Ward Accreditation is a key enabler of shared governance.

Ward accreditation is based on the continuous improvement principle of standardisation – recognising, sharing and sticking to best practice in the interests of consistent and reliable delivery of high quality safe, effective and person centred care.
Wards and departments will progress through bronze, silver and gold standards as they achieve their designated targets for consistent practice and performance over a two-year period.

Using a mix of data sources, such as the nursing and midwifery scorecard, assurance reports and triangulation with patient experience and ward visits, the Ward Accreditation Tool will be completed for each ward providing a baseline assessment. That baseline assessment will result in each ward being awarded Bronze, Silver or Gold. It is anticipated that most wards will initially score Bronze.

A steering group has now been established to oversee the implementation of the Ward Accreditation process, with 31 July 2021 as the formal commencement of the Ward Accreditation assessments.

It is envisioned that the completion of Phase 3 of this Nursing and Midwifery Quality Improvement and Accountability Framework will strengthen Board confidence and assurance in nursing and midwifery practice and create a platform for continuous improvement in the delivery of high quality patient care.

Meeting of the Board of Directors in Public
Thursday, 15 April 2021

Title of Report	**Finance Report – Month 11**	**Agenda Item**	5.1
Report Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Finance Officer		
Executive Summary	The Trust reports a deficit of £9k in month and £104k year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 01 October 2020 for the second half of the year, with control of top-up, Covid and growth monies now held at STP level.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 25 March 2021		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report – Month 11		

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Finance report

For the period ending 28 February 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.
Trust surplus/(deficit)			
In-month (NHSE/I)	-	-	-
YTD (NHSE/I*)	-	-	-
In-month (budget)	(4,161)	(9)	4,152
YTD (budget)	(9,821)	(104)	9,717
Forecast	-	-	-

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

The Trust reports a £9k deficit position for February; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. Incremental Covid costs have reduced by £0.6m from January to £1.8m. The forecast outturn position remains at breakeven after being updated using the February position.

Covid spend	**1.8**
Base underspend	**(0.2)**
Covid Income	**(1.8)**
Assets Under Construction Write Off	**0.7**
Partially Completed Spells / Mat Pathway	**(0.5)**
Reported against control total	**0.0**

CIP				
In-month	2,077	887	(1,190)	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 under achievement against plan as some schemes could not be implemented in the later part of the financial year due to pressures on the services caused by the pandemic. The forecast position of actual delivery has been updated with the scheme owners identifying £8.9m of the £12m plan; this has not changed since November.
YTD	9,878	8,006	(1,872)	
Forecast	12,000	8,863	(3,137)	

Capital				
In-month	7,123	5,152	(1,970)	The 2020/21 capital plan includes; £17.1m STP capital allocation increased by £0.5m in month for an IT project. £7.3m PDC relating to previously agreed capital loans for ED and Fire Safety £7.2m PDC for business cases and COVID funding agreed in year Total CRL for the Trust is now £32.1m with a predicted underspend of £0.31m as agreed with NHSI. Capital Expenditure is currently well below the CRL, due to late funding allocations and slow progress across projects throughout the pandemic. IT schemes and building works have accelerated this month, more equipment purchases and contracts are due to be finalised in March. PDC cannot be rolled forward into the new year. If PDC projects remain underspent on 31st March then the Trust will have breached the funding agreement and may be asked to return unspent funding.
YTD	26,338	19,728	(6,609)	
Forecast	32,109	31,800	(309)	

1. Executive summary (continued)

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£'000	Budget	Actual	Var.	
Cash				
Month end	31,014	59,036	28,022	High levels of cash reserves have been maintained in month due to £30m of payments in advance from commissioners- £5m higher than expected. The favourable variance continues partly due to the additional cash payments, and much higher than expected uninvoiced costs across revenue, capital and in relation to PDC dividends which can be seen on the Statement of Financial Position payables balance. Contract payments are not expected from commissioners in March, therefore scheduled cash payments of £30m will reduce the value of this cash reserve. PDC funding drawdowns of £22m will be received but are expected to be largely spent on the corresponding expenditure depending on how promptly suppliers invoice.
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 £185.5m, this being £40.4m adverse to the draft budget. In month performance excluding high cost drugs is £15.7m compared to a M1 to M10 average of £17.0m, lower by £1.3m.
Pay costs are higher than expected				Total pay costs have increased in month by £0.1m to £20.2m. The high level of cost remains as Covid activity and the enhanced pay incentive continue to impact on the position, along with increased temporary staff spend to cover staff sickness and vacancies, as well as supernumerary costs in areas where recruitment has taken place. The position is adverse to budget by £2.7m, of this £1.6m is due to incremental Covid costs, the remainder is predominantly a consequence of non-achievement of CIP plans where budget has been removed from the divisions and the changes in bed capacity not in the original NHSE/I plan.

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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	26,837	27,358	521	256,722	256,098	(624)
High cost drugs	1,613	1,737	124	19,319	20,382	1,064
Other income	1,471	1,921	450	19,245	18,497	(749)
Top-up income	-	-	-	26,502	26,517	15
True-up income	-	-	-	-	9,690	9,690
Total income	**29,921**	**31,016**	**1,095**	**321,788**	**331,184**	**9,395**
Nursing	(7,821)	(8,109)	(287)	(74,660)	(83,586)	(8,926)
Medical	(6,191)	(6,399)	(208)	(64,877)	(68,965)	(4,089)
Other	(5,236)	(5,718)	(482)	(66,126)	(58,809)	7,317
Total pay	**(19,248)**	**(20,225)**	**(977)**	**(205,663)**	**(211,360)**	**(5,698)**
Clinical supplies	(3,393)	(3,190)	203	(39,623)	(39,285)	338
Drugs	(553)	(478)	75	(6,971)	(6,568)	403
High cost drugs	(1,613)	(1,807)	(193)	(19,618)	(20,452)	(834)
Other	(3,739)	(3,496)	243	(35,024)	(38,060)	(3,037)
Total non-pay	**(9,299)**	**(9,442)**	**(144)**	**(101,235)**	**(104,836)**	**(3,601)**
EBITDA	**1,374**	**1,349**	**(25)**	**14,891**	**14,987**	**97**
Depreciation	(829)	(813)	16	(9,152)	(9,096)	56
Net finance income/(cost)	(2)	(2)	(0)	223	(28)	(251)
PDC dividend	(542)	(543)	(1)	(5,962)	(5,968)	(6)
Non-operating exp.	**(1,374)**	**(1,358)**	**16**	**(14,891)**	**(15,091)**	**(200)**
Reported surplus/(deficit)	**-**	**(9)**	**(9)**	**-**	**(104)**	**(104)**
Adj. to control total	-	9	9	-	104	104
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.

4. Total expenditure includes the incremental cost of Covid-19, being £1.8m in-month; £1.6m of this is reported in pay and £0.2m in non-pay (£10.8m and £5.8m YTD respectively). Excluding the impact of Covid, the pay and non-pay variances would improve in month by these amounts. The favourable income variance would reduce by £0.5m as additional income was required to cover higher costs.

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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	19,559	27,358	7,798	228,824	256,098	27,273
High cost drugs	1,810	1,737	(73)	21,177	20,383	(795)
Other income	2,231	1,921	(310)	23,573	18,497	(5,075)
FRF/MRET	769	-	(769)	43,973	36,207	(7,766)
Total income	**24,370**	**31,016**	**6,646**	**317,548**	**331,185**	**13,637**
Nursing	(7,471)	(8,109)	(638)	(81,428)	(83,586)	(2,158)
Medical	(5,586)	(6,399)	(813)	(61,401)	(68,965)	(7,565)
Other	(4,457)	(5,718)	(1,261)	(54,646)	(58,809)	(4,163)
Total pay	**(17,514)**	**(20,225)**	**(2,711)**	**(197,475)**	**(211,360)**	**(13,885)**
Clinical supplies	(3,566)	(3,190)	376	(41,720)	(39,285)	2,435
Drugs	(630)	(478)	152	(7,367)	(6,568)	799
High cost drugs	(1,832)	(1,807)	25	(21,431)	(20,452)	980
Other	(3,449)	(3,967)	(518)	(42,435)	(38,533)	3,902
Total non-pay	**(9,477)**	**(9,442)**	**34**	**(112,953)**	**(104,838)**	**8,115**
EBITDA	**(2,621)**	**1,349**	**3,970**	**7,120**	**14,987**	**7,867**
Depreciation	(958)	(813)	145	(10,540)	(9,096)	1,444
Net finance income/(cost)	(39)	(2)	37	(432)	(27)	405
PDC dividend	(543)	(543)	-	(5,968)	(5,968)	-
Non-operating exp.	**(1,540)**	**(1,358)**	**182**	**(16,940)**	**(15,091)**	**1,850**
Reported surplus/(deficit)	**(4,161)**	**(9)**	**4,152**	**(9,821)**	**(104)**	**9,717**

Key messages:

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

2. If income had been earned on a cost and volume basis (based on consultation tariff), excluding HCD the Trust would have reported clinical income of £15.7m in month; this is £1.3m lower than the monthly average for the first 10 months and 19% underperformance to plan in month.

3. Total expenditure includes the incremental cost of Covid, this being £1.8m in month and £16.8m year to date.

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

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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	1,603	(11)	(4,355)	(4,167)	188	(2,741)	(2,564)	177
Specialist Medicine	147	118	(29)	(1,921)	(1,990)	(69)	(1,774)	(1,872)	(98)
Therapies & Older Persons	5	9	4	(1,425)	(1,414)	11	(1,420)	(1,405)	15
Unplanned & Integrated Care	52	61	9	(1,154)	(1,177)	(23)	(1,102)	(1,116)	(14)
Urgent & Emergency Care	43	39	(5)	(2,275)	(2,312)	(37)	(2,232)	(2,274)	(42)
Sub-total	**1,861**	**1,830**	**(31)**	**(11,130)**	**(11,060)**	**70**	**(9,269)**	**(9,230)**	**39**
Planned care									
Cancer Services	408	413	6	(886)	(837)	49	(479)	(423)	55
Critical Care & Perioperative	43	94	51	(3,069)	(2,624)	444	(3,026)	(2,530)	495
Planned Care Infrastructure	-	-	-	(147)	(164)	(17)	(147)	(164)	(17)
Surgical Services	100	119	19	(2,770)	(2,691)	79	(2,670)	(2,572)	99
Women & Children	111	92	(19)	(3,257)	(3,429)	(173)	(3,146)	(3,337)	(191)
Sub-total	**661**	**718**	**58**	**(10,129)**	**(9,745)**	**383**	**(9,468)**	**(9,027)**	**441**
Corporate									
Communications	2	2	-	(40)	(50)	(10)	(39)	(48)	(10)
Finance	1	1	0	(214)	(220)	(6)	(213)	(219)	(6)
HR & OD	109	152	44	(362)	(429)	(67)	(253)	(276)	(23)
IT	2	2	-	(404)	(351)	53	(402)	(350)	53
Medical Director	849	1,139	291	(473)	(441)	32	376	699	323
Medway Innovation Institute	-	-	-	-	(26)	(26)	-	(26)	(26)
Nursing	-	2	2	(348)	(378)	(30)	(348)	(376)	(28)
Strategy, Governance & Perform	-	-	-	(246)	(246)	0	(246)	(246)	0
Transformation	-	-	-	(84)	(55)	29	(84)	(55)	29
Trust Executive & Board	-	-	-	(273)	(346)	(73)	(273)	(346)	(73)
Sub-total	**962**	**1,298**	**336**	**(2,444)**	**(2,541)**	**(97)**	**(1,482)**	**(1,243)**	**239**
E&F									
E&F	**274**	**195**	**(79)**	**(2,074)**	**(2,233)**	**(160)**	**(1,800)**	**(2,039)**	**(239)**
Central									
Central	**26,163**	**26,975**	**812**	**(2,662)**	**(5,445)**	**(2,783)**	**23,501**	**21,530**	**(1,971)**
TOTAL	**30,883**	**31,016**	**133**	**(30,883)**	**(31,025)**	**(142)**	**-**	**(9)**	**(9)**
Donated Asset Adjustment			**-**		**9**	**9**	**-**	**9**	**9**
Control total	**30,883**	**31,016**	**133**	**(30,883)**	**(31,016)**	**(133)**	**-**	**-**	**-**

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	17,539	18,208	669	(47,360)	(47,328)	32	(29,820)	(29,120)	700	(298)	999
Specialist Medicine	2,512	1,685	(827)	(23,168)	(22,154)	1,014	(20,656)	(20,469)	187	967	(780)
Therapies & Older Persons	43	66	23	(15,903)	(15,555)	348	(15,860)	(15,490)	371	326	44
Unplanned & Integrated Care	932	506	(426)	(12,461)	(11,551)	911	(11,529)	(11,045)	484	111	373
Urgent & Emergency Care	661	443	(218)	(24,747)	(24,725)	22	(24,086)	(24,282)	(196)	100	(296)
Sub-total	**21,688**	**20,908**	**(780)**	**(123,640)**	**(121,313)**	**2,326**	**(101,952)**	**(100,406)**	**1,546**	**1,205**	**341**
Planned care											
Cancer Services	4,156	4,591	435	(9,453)	(9,687)	(235)	(5,296)	(5,096)	200	94	106
Critical Care & Perioperative	1,193	-	(1,193)	(34,283)	(2,046)	32,237	(33,090)	(2,046)	31,044	16,961	14,084
Planned Care Infrastructure	338	1,040	702	(19,296)	(30,248)	(10,953)	(18,958)	(29,208)	(10,250)	2,463	(12,714)
Surgical Services	498	577	79	(15,109)	(32,081)	(16,972)	(14,611)	(31,505)	(16,893)	(16,011)	(882)
Women & Children	963	809	(154)	(34,463)	(35,709)	(1,246)	(33,501)	(34,901)	(1,400)	(1,045)	(355)
Sub-total	**7,147**	**7,016**	**(131)**	**(112,604)**	**(109,772)**	**2,832**	**(105,457)**	**(102,756)**	**2,701**	**2,461**	**240**
Corporate											
Communications	9	19	11	(427)	(458)	(30)	(419)	(439)	(20)	(26)	6
Finance	32	23	(8)	(2,796)	(2,684)	112	(2,764)	(2,660)	103	185	(82)
HR & OD	1,336	1,372	36	(4,140)	(4,097)	43	(2,804)	(2,725)	79	70	8
IT	9	39	30	(3,888)	(3,963)	(75)	(3,879)	(3,924)	(45)	(171)	127
Medical Director	9,029	9,407	379	(5,074)	(4,907)	167	3,954	4,500	546	178	368
Medway Innovation Institute	-	-	-	-	(32)	(32)	-	(32)	(32)	-	(32)
Nursing	-	11	11	(3,630)	(3,889)	(259)	(3,630)	(3,878)	(248)	(92)	(156)
Strategy, Governance & Perform	-	-	-	(2,745)	(2,730)	16	(2,745)	(2,730)	16	31	(15)
Transformation	-	-	-	(669)	(732)	(62)	(669)	(732)	(62)	(244)	181
Trust Executive & Board	-	-	-	(2,987)	(3,083)	(97)	(2,987)	(3,083)	(97)	(10)	(87)
Sub-total	**10,414**	**10,872**	**457**	**(26,357)**	**(26,575)**	**(218)**	**(15,943)**	**(15,703)**	**240**	**(80)**	**319**
E&F											
E&F	**4,008**	**2,626**	**(1,382)**	**(21,907)**	**(22,632)**	**(725)**	**(17,898)**	**(20,006)**	**(2,107)**	**(1,516)**	**(353)**
Central											
Central	**278,531**	**289,760**	**11,229**	**(30,711)**	**(50,523)**	**(19,812)**	**247,819**	**238,765**	**(9,054)**	**(2,132)**	**(6,922)**
TOTAL	**326,600**	**331,181**	**4,581**	**(326,600)**	**(331,285)**	**(4,685)**	**-**	**(104)**	**(104)**	**(60)**	**(44)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**104**	**104**	**-**	**104**	**104**	**60**	**44**
Control total	**326,600**	**331,181**	**4,581**	**(326,600)**	**(331,181)**	**(4,581)**	**-**	**-**	**-**	**-**	**-**

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	2,912	1,603	(1,309)	(4,350)	(4,167)	183	(1,438)	(2,564)	(1,125)
Specialist Medicine	2,384	118	(2,266)	(2,149)	(1,990)	159	235	(1,872)	(2,107)
Therapies & Older Persons	741	9	(732)	(1,500)	(1,414)	86	(759)	(1,405)	(646)
Unplanned & Integrated Care	96	61	(35)	(910)	(1,177)	(267)	(814)	(1,116)	(302)
Urgent & Emergency Care	4,457	39	(4,418)	(2,184)	(2,312)	(129)	2,273	(2,274)	(4,547)
Sub-total	**10,590**	**1,830**	**(8,760)**	**(11,093)**	**(11,060)**	**32**	**(503)**	**(9,230)**	**(8,728)**
Planned care									
Cancer Services	693	413	(279)	(837)	(837)	0	(144)	(423)	(279)
Critical Care & Perioperative	1,004	94	(910)	(2,994)	(2,624)	370	(1,990)	(2,530)	(540)
Planned Care Infrastructure	150	-	(150)	140	(164)	(304)	290	(164)	(454)
Surgical Services	5,084	119	(4,965)	(2,876)	(2,691)	186	2,208	(2,572)	(4,780)
Women & Children	4,781	92	(4,688)	(3,175)	(3,429)	(255)	1,606	(3,337)	(4,943)
Sub-total	**11,711**	**718**	**(10,993)**	**(9,742)**	**(9,745)**	**(3)**	**1,969**	**(9,027)**	**(10,996)**
Corporate									
Communications	2	2	-	(37)	(50)	(13)	(36)	(48)	(13)
Finance	-	1	1	(234)	(220)	14	(234)	(219)	15
HR & OD	148	152	4	(401)	(429)	(28)	(253)	(276)	(24)
IT	-	2	2	(347)	(351)	(5)	(347)	(350)	(3)
Medical Director	827	1,139	312	(462)	(441)	21	366	699	333
Medway Innovation Institute	-	-	-	(26)	(26)	(0)	(26)	(26)	(0)
Nursing	0	2	1	(349)	(378)	(28)	(349)	(376)	(27)
Strategy, Governance & Perform	0	-	(0)	(243)	(246)	(3)	(243)	(246)	(3)
Transformation	-	-	-	(62)	(55)	7	(62)	(55)	7
Trust Executive & Board	-	-	-	(255)	(346)	(90)	(255)	(346)	(90)
Sub-total	**978**	**1,298**	**321**	**(2,416)**	**(2,541)**	**(125)**	**(1,438)**	**(1,243)**	**196**
E&F									
E&F	**437**	**195**	**(242)**	**(2,191)**	**(2,233)**	**(43)**	**(1,754)**	**(2,039)**	**(285)**
Central									
Central	**654**	**26,975**	**26,321**	**(3,089)**	**(5,445)**	**(2,356)**	**(2,436)**	**21,530**	**23,965**
TOTAL	**24,370**	**31,016**	**6,646**	**(28,531)**	**(31,025)**	**(2,494)**	**(4,161)**	**(9)**	**4,152**

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	33,832	18,208	(15,624)	(48,689)	(47,328)	1,361	(14,857)	(29,120)	(14,262)
30,542	(26,313)	4,228	Specialist Medicine	27,854	1,685	(26,169)	(24,135)	(22,154)	1,981	3,719	(20,469)	(24,188)
9,505	(17,894)	(8,389)	Therapies & Older Persons	8,668	66	(8,602)	(16,394)	(15,555)	839	(7,726)	(15,490)	(7,764)
1,237	(10,941)	(9,704)	Unplanned & Integrated Care	1,128	506	(622)	(10,031)	(11,551)	(1,519)	(8,904)	(11,045)	(2,141)
57,144	(26,012)	31,131	Urgent & Emergency Care	52,112	443	(51,669)	(23,826)	(24,725)	(899)	28,286	(24,282)	(52,568)
135,505	**(134,357)**	**1,148**	**Sub-total**	**123,594**	**20,908**	**(102,686)**	**(123,076)**	**(121,313)**	**1,762**	**518**	**(100,406)**	**(100,924)**
			Planned care									
8,884	(10,380)	(1,496)	Cancer Services	8,102	4,591	(3,511)	(9,486)	(9,687)	(201)	(1,384)	(5,096)	(3,712)
12,837	(36,485)	(23,648)	Critical Care & Perioperative	1,650	-	(1,650)	(1,040)	(2,046)	(1,006)	610	(2,046)	(2,656)
1,800	(866)	934	Planned Care Infrastructure	59,451	1,040	(58,411)	(32,461)	(30,248)	2,213	26,990	(29,208)	(56,198)
65,191	(35,407)	29,784	Surgical Services					(32,081)	11,709	577	(11,132)	(33,412)
61,242	(38,098)	23,144	Women & Children	55,853	809	(55,045)	(34,880)	(35,709)	(829)	20,973	(34,901)	(55,874)
149,955	**(121,237)**	**28,718**	**Sub-total**	**136,765**	**7,016**	**(129,749)**	**(111,279)**	**(109,772)**	**1,507**	**25,486**	**(102,756)**	**(128,242)**
			Corporate									
21	(499)	(478)	Communications	19	19	-	(462)	(458)	4	(443)	(439)	4
4	(2,957)	(2,953)	Finance	4	23	19	(2,724)	(2,684)	40	(2,719)	(2,660)	59
1,778	(4,787)	(3,009)	HR & OD	1,630	1,372	(258)	(4,387)	(4,097)	290	(2,757)	(2,725)	31
-	(4,198)	(4,198)	IT	-	39	39	(3,852)	(3,963)	(112)	(3,852)	(3,924)	(72)
9,930	(5,554)	4,376	Medical Director	9,102	9,407	305	(5,092)	(4,907)	185	4,010	4,500	490
-	(32)	(32)	Medway Innovation Institute	-	-	-	(32)	(32)	-	(32)	(32)	-
4	(4,193)	(4,189)	Nursing	4	11	7	(3,844)	(3,889)	(45)	(3,840)	(3,878)	(38)
-	(2,921)	(2,921)	Strategy, Governance & Perform	-	-	-	(2,677)	(2,730)	(52)	(2,677)	(2,730)	(53)
-	(860)	(860)	Transformation	-	-	-	(804)	(732)	73	(804)	(732)	73
-	(3,074)	(3,074)	Trust Executive & Board	-	-	-	(2,818)	(3,083)	(265)	(2,818)	(3,083)	(265)
11,737	**(29,076)**	**(17,339)**	**Sub-total**	**10,760**	**10,872**	**112**	**(26,692)**	**(26,575)**	**117**	**(15,932)**	**(15,703)**	**230**
			E&F									
5,238	**(25,055)**	**(19,817)**	**E&F**	**4,801**	**2,626**	**(2,175)**	**(22,788)**	**(22,632)**	**157**	**(17,987)**	**(20,006)**	**(2,018)**
			Central									
54,112	**(46,821)**	**7,290**	**Central**	**41,628**	**289,760**	**248,132**	**(43,534)**	**(50,994)**	**(7,460)**	**(1,906)**	**238,765**	**240,671**
356,547	**(356,547)**	**-**	**TOTAL**	**317,548**	**331,182**	**13,633**	**(327,369)**	**(331,285)**	**(3,917)**	**(9,821)**	**(104)**	**9,717**

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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 system plan for October to March identified a £36.9m deficit; the MFT plan included a deficit of £3.6m arising solely to the inclusion of an increased annual leave accrual in month 12. This forms part of the STP system plan and is not included in the figures below.

- Positive confirmed Covid cases have reduced but still remained high during February. A prudent estimate has been included for March that costs will not drop dramatically despite a continued reduction on activity.

- For the period of October to March, £10.1m of funding to cover incremental Covid costs has been approved. Of this, £8.3m has been required from October to February; the remaining £1.8m for March is equal to the February spend.

- The forecast position has been updated using the February financial position. The Trust continues to forecast compliance with our control total, this is summarised in the following table.

Summary Forecast October - March £'m	Oct'20 Actual	Nov'20 Actual	Dec'20 Actual	Jan'21 Actual	Feb'21 Actual	Mar'21 Forecast	Oct - Mar Total
Income	29.0	30.3	31.2	31.2	30.5	30.3	**182.5**
Pay	(19.0)	(18.9)	(19.7)	(20.1)	(20.2)	(19.8)	**(117.8)**
Non-pay	(8.6)	(10.0)	(10.1)	(9.7)	(9.0)	(9.1)	**(56.5)**
EBITDA	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	**(8.3)**
Surplus / (Deficit)	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.1)**	**(0.1)**

* Includes the impact of donated asset depreciation

Covid Costs included in the Forecast	(0.6)	(1.1)	(2.5)	(2.3)	(1.7)	(1.8)	(10.0)

Key forecasting assumptions

1) Covid costs estimate for March is £1.8m.
2) Clinical Income as per block contract arrangements.
3) Other income and expenditure continues at run-rate.
4) No additional CIP schemes expected to be implemented.
5) £0.2m additional cost of opening bed capacity on Ocelot and Emerald (excluding Frailty SDEC).
6) Restart of elective activity in March 2021.
7) The forecast assumes a contingency of £1.2m.

Risks to the Forecast	£'m
PDC Dividend	TBC
Depreciation	TBC
Bad Debt Provision Review	TBC
MCH patients referred to MEDDOC	0.3
NHS Property Company Charges	TBC
Annual leave buy back	TBC
Agency Invoices	0.1
North Kent Pathology Service (NKPS)	0.6
Ward reconfiguration / bed capacity	0.2
Total	**TBC**

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	2,199	359	-	3,005	**4,682**	(1,677)	**5,100**	(2,095)
UIC	501	2,119	15	195	2,831	**4,253**	(1,422)	**5,505**	(2,674)
E&F	-	415	386	-	800	**661**	139	**800**	-
Corporate	600	184	91	61	936	**1,113**	(177)	**1,709**	(773)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	-
Total	**2,838**	**4,918**	**851**	**256**	**8,863**	**12,000**	**(3,137)**	**14,405**	**(5,542)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**2,077**	**887**	**(1,190)**	**9,878**	**8,006**	**(1,872)**	**12,000**	**8,863**	**(3,137)**

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 were phased to be realised in the second half of the financial year.

At the end of February the total forecast CIP did not change in-month remaining at £8.9m, this leaves a gap of £3.1m to the original CIP Plan as some savings programmes continue to encounter delays due to the operational pressures experienced across the Trust.

During the year, a revised stretch target of £14.4m was set, this being 20% higher than the required CIP to mitigate the risk of individual scheme failure. The PMO team continue to work with Divisions and the Finance Business Partners to identify and quantify CIP schemes as well as assess schemes for the new financial year along with any that did not deliver being carried forward and implemented. Delivery to date is £8.0m; this is adverse to plan by £1.9m and as forecast in January.

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.

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5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,791	**Non-current assets**	**218,560**	**214,800**	**(3,760)**
6,307	Inventory	7,400	6,260	(1,140)
36,686	Trade and other receivables	22,000	16,993	(5,007)
12,385	Cash	33,853	59,036	28,022
55,378	**Current assets**	**60,414**	**82,290**	**21,876**
(292,111)	Borrowings	(77)	(134)	(57)
(24,478)	Trade and other payables	(19,000)	(35,020)	(16,020)
(4,519)	Other liabilities	(29,868)	(32,076)	(2,208)
(321,108)	**Current liabilities**	**(48,945)**	**(67,230)**	**(18,285)**
(2,278)	Borrowings	(2,278)	(2,151)	127
(1,317)	Other liabilities	(1,317)	(1,317)	0
(3,595)	**Non-current liabilities**	**(3,595)**	**(3,468)**	**127**
(64,534)	**Net assets employed**	**226,434**	**226,391**	**(43)**
140,581	Public dividend capital	431,609	431,610	1
(246,481)	Retained earnings	(246,541)	(246,574)	(44)
41,366	Revaluation reserve	41,336	41,366	-
(64,534)	**Total taxpayers' equity**	**226,434**	**226,391**	**(43)**

Key messages:

1. Current net assets are £226.4m, unchanged from month 10.
   This is a material change from the prior year when the Trust operated with net liabilities due to the level of deficit support borrowings from the Department of Health in prior years.

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

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

2. Receivables are £5m adverse to plan, overall decease of £4.4m in month.
   This is mainly due to the removal of 'Partially Completed Spell' income accruals as a result of commissioning changes in year. Additionally Maternity Pathway deferred income has been removed resulting in a positive I&E impact overall- despite the decrease in receivables.

3. Payables are £16m adverse to plan due to a high level of capital accruals and an accrual for PDC dividends payable (£5.3m).

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

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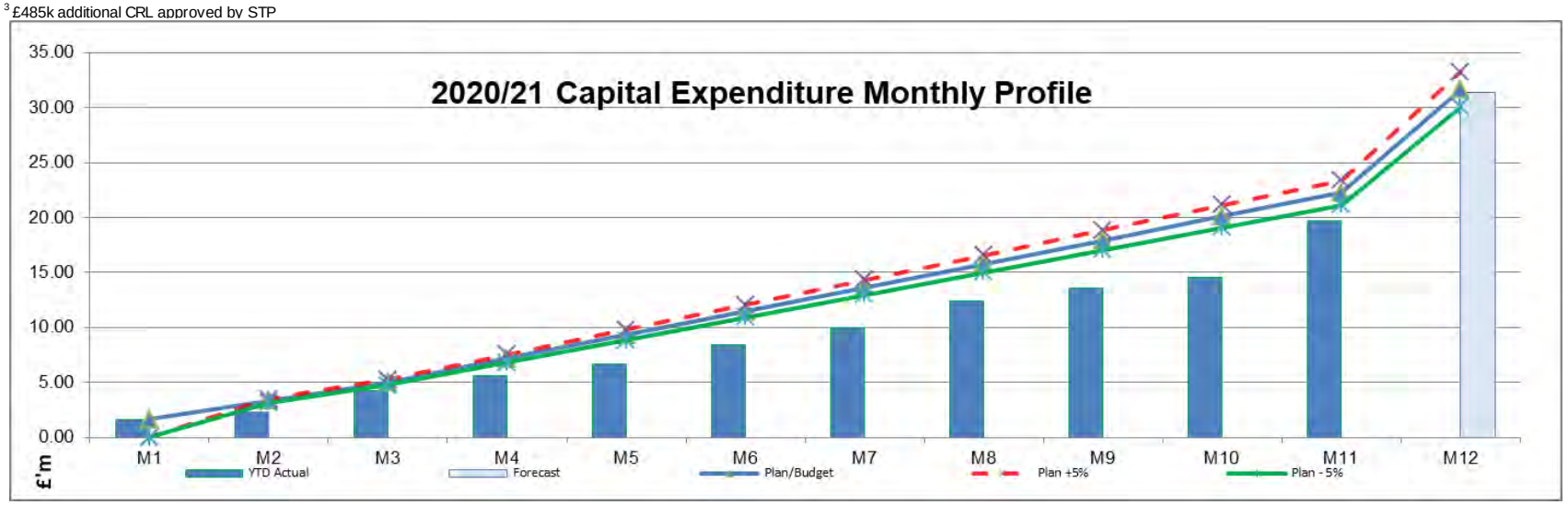
6. Capital

£'000	In-month			Year To Date			Annual			Funding (Forecast)		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	497	1,261	764	5,638	5,552	(85)	6,340	6,340	0	746	0	5,594
Routine Maintenance[1]	471	224	(248)	2,288	1,132	(1,156)	2,929	2,906	(23)	2,551	0	355
Fire Safety	468	549	81	5,276	4,705	(571)	5,744	5,744	0	390	4,252	1,102
IT[2 3]	922	1,000	78	3,208	2,800	(408)	4,580	4,580	0	4,580	0	0
New Build - Inc ED	320	192	(128)	3,520	733	(2,787)	3,835	3,835	0	0	3,000	835
Plant & Equipment	(102)	127	229	1,861	958	(904)	1,547	1,547	0	1,547	0	0
Total Planned Capex	**2,576**	**3,352**	**776**	**21,791**	**15,880**	**(5,911)**	**24,975**	**24,952**	**(23)**	**9,814**	**7,252**	**7,886**
COVID*	1,959	64	(1,895)	1,959	1,959	(0)	1,959	1,959	0	0	1,959	0
IT MOU	95	6	(89)	95	90	(5)	190	190	0	0	190	0
A&E MOU	429	56	(373)	429	85	(343)	857	548	(309)	0	548	0
Diagnostic equipment(breast) MOU	593	0	(593)	593	0	(593)	1,186	1,186	0	0	1,186	0
UTC MOU	0	6	6	0	29	29	0	23	23	23	0	0
Adopt & Adapt MOU	315	183	(132)	315	201	(114)	630	630	0	0	630	0
EPMA MOU	743	1,485	743	743	1,485	743	1,485	1,485	0	0	1,485	0
Diagnostic Equipment Replacement MOU	139	0	(139)	139	0	(139)	277	277	0	0	277	0
Secure Boundary MOU	25	0	(25)	25	0	(25)	50	50	0	0	50	0
HSLI EPR MOU	250	0	(250)	250	0	(250)	500	500	0	0	500	0
Total Additional Capex	**4,547**	**1,800**	**(2,747)**	**4,547**	**3,848**	**(698)**	**7,134**	**6,848**	**(286)**	**23**	**6,825**	**0**
Total Capex	**7,123**	**5,152**	**(1,970)**	**26,338**	**19,728**	**(6,609)**	**32,109**	**31,800**	**(309)**	**9,837**	**14,077**	**7,886**

[1] £12k Salix Grant added to Internal Funds

[2] £1,400k EPR Project added utilising previously agreed underspend

[3] £485k additional CRL approved by STP



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6. Capital (continued)

Capital expenditure consists of:

• Planned YTD expenditure of £15.88m, £5.91m behind plan.
All programmes except routine maintenance are currently behind plan but have accelerated in month.

• NHSI funded COVID capital £1.96m of unplanned YTD expenditure.

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

• PDC funded capital £1.89m, £0.7m behind plan
A number of other 'funding' applications as listed in the table above have been approved by NHSI.
Expenditure across these schemes is mostly on track. If underspent at year end NHSI may ask for remaining balances to be returned.

£1.8m of capital orders have been raised since this position was finalised, there are now £15.4m of capital orders raised in year which have not yet been receipted and therefore not yet in this position. These orders include whole project costs for future years so do not all relate to the 2020/21 programme. If71% of these goods and services are applicable, delivered by 31st March and relate to the funding approved then the Trust will meet its capital expenditure plan.

The Trust CRL has increased 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. Total PDC to be drawn for 2020/21 schemes is £21,963, £20,004 is subject to the 3.5% PDC dividend charge, total expense £0.7m which has been fully accounted for in the year end I&E forecast.

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7. Cash

Cash Flow, 12 months ahead

				Forecast											
£m	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
BANK BALANCE B/FWD	**55.94**	**59.21**	**52.84**	**58.97**	**35.74**	**69.91**	**70.07**	**67.78**	**73.96**	**70.55**	**63.97**	**70.18**	**66.79**	**60.37**	**69.73**
Receipts															
NHS Contract Income	22.55	22.88	22.97	0.21	53.95	27.12	28.94	26.94	26.94	26.94	26.94	26.94	26.94	26.94	26.94
NHS Top Up	8.08	1.30	7.68	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	4.43	1.26	3.50	4.56	4.23	1.46	1.30	4.52	1.69	1.75	4.46	1.69	1.69	4.35	1.64
Total receipts	**35.06**	**25.44**	**34.15**	**4.77**	**58.18**	**28.58**	**30.24**	**31.46**	**28.63**	**28.69**	**31.40**	**28.63**	**28.63**	**31.29**	**28.58**
Payments															
Pay Expenditure (excl. Agency)	(19.10)	(20.35)	(19.79)	(19.77)	(19.68)	(19.05)	(18.91)	(19.54)	(18.90)	(18.87)	(19.45)	(18.80)	(19.36)	(18.74)	(18.71)
Non Pay Expenditure	(10.48)	(10.69)	(8.04)	(21.74)	(13.36)	(8.37)	(12.70)	(14.77)	(12.22)	(12.22)	(14.77)	(12.22)	(14.77)	(12.22)	(10.72)
Capital Expenditure	(2.21)	(0.77)	(0.19)	(4.50)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)	(0.92)
Total payments	**(31.79)**	**(31.81)**	**(28.02)**	**(46.01)**	**(33.96)**	**(28.34)**	**(32.53)**	**(35.23)**	**(32.04)**	**(32.01)**	**(35.14)**	**(31.94)**	**(35.05)**	**(31.88)**	**(30.35)**
Net Receipts/ (Payments)	**59.21**	**52.84**	**58.97**	**17.73**	**59.96**	**70.15**	**67.78**	**64.01**	**70.55**	**67.23**	**60.23**	**66.87**	**60.37**	**59.78**	**67.96**
Funding Flows															
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	9.95	0.00	0.00	9.95	0.00	0.00	9.95	0.00	0.00	9.95	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	23.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	(5.74)	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**18.01**	**9.95**	**(0.08)**	**0.00**	**9.95**	**0.00**	**(3.26)**	**9.95**	**(0.08)**	**0.00**	**9.95**	**0.00**
BANK BALANCE C/FWD	**59.21**	**52.84**	**58.97**	**35.74**	**69.91**	**70.07**	**67.78**	**73.96**	**70.55**	**63.97**	**70.18**	**66.79**	**60.37**	**69.73**	**67.96**

13 Week Forecast

w/e

	Actual					Forecast												
£m	29/01/21	05/02/21	12/02/21	19/02/21	26/02/21	05/03/21	12/03/21	19/03/21	26/03/21	02/04/21	09/04/21	16/04/21	23/04/21	30/04/21	07/05/21	14/05/21	21/05/21	28/05/21
BANK BALANCE B/FWD	**64.08**	**52.86**	**52.65**	**49.29**	**75.64**	**59.00**	**54.24**	**55.76**	**66.58**	**47.64**	**34.97**	**33.45**	**79.62**	**66.52**	**54.40**	**50.71**	**76.38**	**72.67**
Receipts																		
NHS Contract Income	0.12	0.14	0.00	28.54	2.29	0.01	0.00	0.43	0.00	0.00	0.00	50.72	0.00	0.00	0.00	28.38	0.00	0.00
Other	0.15	0.25	0.60	0.15	2.21	0.33	0.56	3.05	0.25	0.25	0.58	0.30	0.25	0.25	0.25	0.58	0.25	0.25
Total receipts	**0.27**	**0.39**	**0.60**	**28.68**	**4.50**	**0.33**	**0.56**	**3.47**	**0.25**	**0.25**	**0.58**	**51.02**	**0.25**	**0.25**	**0.25**	**28.96**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(9.07)	(0.49)	(0.48)	(0.47)	(18.35)	(0.49)	(0.49)	(0.49)	(9.89)	(8.91)	(0.49)	(0.49)	(9.89)	(8.91)	(0.49)	(0.49)	(0.49)	(9.91)
Non Pay Expenditure	(2.18)	(0.11)	(3.48)	(1.75)	(2.72)	(4.61)	(4.11)	(4.61)	(9.31)	0.49	(1.61)	(4.36)	(3.46)	(1.46)	(3.46)	(2.81)	(3.46)	(0.81)
Capital Expenditure	(0.24)	0.00	0.00	(0.12)	(0.07)	0.00	0.00	0.00	0.00	(4.50)	0.00	0.00	0.00	(2.00)	0.00	0.00	0.00	(2.00)
Total payments	**(11.49)**	**(0.59)**	**(3.96)**	**(2.34)**	**(21.14)**	**(5.10)**	**(4.60)**	**(5.10)**	**(19.20)**	**(12.92)**	**(2.10)**	**(4.85)**	**(13.35)**	**(12.37)**	**(3.94)**	**(3.30)**	**(3.95)**	**(12.72)**
Net Receipts/ (Payments)	**(11.22)**	**(0.21)**	**(3.36)**	**26.34**	**(16.64)**	**(4.76)**	**(4.04)**	**(1.62)**	**(18.95)**	**(12.67)**	**(1.52)**	**46.17**	**(13.10)**	**(12.12)**	**(3.69)**	**25.67**	**(3.70)**	**(12.47)**
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	5.56	18.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.01)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(5.74)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**5.56**	**12.44**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.01)**	**0.00**
BANK BALANCE C/FWD	**52.86**	**52.65**	**49.29**	**75.64**	**59.00**	**54.24**	**55.76**	**66.58**	**47.64**	**34.97**	**33.45**	**79.62**	**66.52**	**54.40**	**50.71**	**76.38**	**72.67**	**60.20**

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	31,014	59,036	28,022

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

- £5.2m planned PDC dividend has not yet been collected by DH, now expected to be taken in March.
- £6.6m capital expenditure slippage
- £3.5m unexpected increase in revenue expenditure accruals
- £30.4m of cash received in advance of costs being incurred, £13 m of which was unexpected due to commissioning payment profiles variations.

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9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £9k deficit in-month and £104k 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 and forecast to breakeven in line with the control total.

The year to date CIP programme delivery is £1.9m adverse to plan; this is mainly due to pressures caused by Covid affecting the delivery of planned efficiencies in the second half of the year. The total schemes identified remains at £10.2m of these it is forecast that £8.9m will be delivered, this being £3.1m adverse to the target £12.0m.

Alan Davies
Chief Finance Officer
March 2021

Meeting of the Board of Directors in Public

Thursday, 15 April 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Jo Palmer, Chair of Committee		
Date of Meeting:	Thursday, 25 March 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**
1. BAF strategic risks The BAF scores remain unchanged from prior month for all items. As further information is provided for planning in 2021/22 we will scrutinise these scores.	**Amber/Green**
2. Risk register There were no items scoring 16 or higher to be presented at this meeting.	**Green**
3. Finance report The Chief Finance Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total in month 11 and year to date. The forecast is that we will meet our control total for the full year. • The Covid expenditure has reduced as number of Covid patients	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
has reduced, from £2.4m down to £1.8m. The STP has confirmed additional Covid funding is to be provided to the Trust. • Offsetting adjustments were noted in month in respect of a couple of technical accounting matters relating to the previous year end, being assets under construction (write-off) and partially complete spells (write-back). • CIP continues behind plan on a year to date basis, although the forecast outturn value remains unchanged at £9m. This value is included in our overall forecast in meeting the Trust control total. • Capital expenditure was noted as being behind plan at the month end; however, daily monitoring of this position is occurring and at the time of the meeting the Trust was close to its full year target value. • Cash remains strong, although the block contract sums paid in advance are beginning to unwind (i.e. no payment) in March. • The Trust us exploring year end flexibility with the STP and in particular a focus on resolving the outstanding debt between the organisations.	
4. Capital plan and performance The Director of Estates and Facilities presented the paper noting that as of today the Trust is now close to achieving the plan total of £31m for the year, acknowledging the hard work across the teams in delivering this programme. A number of recent projects were noted as being appreciated by patients and staff, including lighting of the grounds, flooring and progress on the staff gym. It was **AGREED** that an annual review of the projects implemented in 20/21 would be produced which reflects the benefits to staff and patients.	**Amber/Green**
5. Annual plan and budget setting 2021/22 The Chief Finance Officer presented the paper. It was noted that STP allocations for the first half of 2021/22 are expected in the week commencing 29 March; these will be predicated on the same lines as existing arrangements, albeit adjusted for current conditions/allowances. Current expectations are that operating plans/budgets will be due back to NHSEI at the beginning of May 2021. A presentation was tabled which compared the expected NHSEI "baseline" (being the 2020/21 Q3 actual performance), the current financial run-rate and the budget position (inclusive of proposed service developments). It was noted that the baseline and run-rate are currently aligned; however, the budget requests are unaffordable as they currently stand. It was noted that further work is required and the risks and opportunities will be clearer once national guidance is released and allocations are announced.	**Amber/Green**
5. Model Hospital – obstetrics and gynaecology The Clinical Director for Paediatrics presented a report which set out some of the key opportunities indicated by Model Hospital, including skill mix changes of staffing and settings of care.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
6. Finance Committee Terms of Reference Comments were received on the terms of reference and were **APPROVED** based on the agreed revisions. A copy of the updated version to follow this report.	**Green**
Decisions made It was **AGREED** that an annual review of the projects implemented in 20/21 would be produced which reflects the benefits to staff and patients. Subject to minor agreed edits, the Committee terms of reference were **APPROVED**.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee No further matters to note.	

Terms of Reference

Finance Committee

1. Purpose

1.1. To assure the Trust Board on the review and scrutiny of its financial planning and performance and to scrutinise major business cases on the Board's behalf and oversee the delivery of major capital and estates projects.

2. Constitution

2.1. The Finance Committee is established on the authority of the Trust Board.

3. Authority

3.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Finance Committee

3.2. The Finance Committee is also authorised to implement any activities which are in line with its terms of reference.

4. Accountability

4.1. The Committee will report to the Trust Board.

4.2. The Committee will provide a report to the Council of Governors as required.

5. Chairperson

5.1 The Chair of the Committee will be chosen and appointed by the Trust Board from among the Non-Executives Directors (NEDs); in the absence of the Chair at any given meeting, the Chair will ahead of the meeting, select one of the NEDs to act as Chair.

6. Membership

a) Two NEDs one of whom will be the Chair of the Committee
b) Chief Finance Officer
c) Chief Operating Officer
d) Director of Estates and Facilities
e) Chief Executive

In Attendance: directors and other staff will invited to attend the committee as and when the business requires it. The following normally attend:

a) Company Secretary
b) Up to three governors may attend each meeting, Attendees may contribute at the invitation of the Chair.

6.1 There is a requirement for members to attend at least 75% of all meetings in one calendar year.

7. Quorum

7.1. Meetings will be quorate when at least one non-executive and two executive members are present.

8. Frequency

8.1. The meetings will normally be held monthly.

9. Key responsibilities

9.1. Responsibilities: To enable the Trust Board to obtain assurance that:

9.1.1. There is oversight of financial planning in the short and long term.

9.1.2. There is scrutiny of the Trust's financial performance against plans agreed by the Trust Board.

9.1.3. There is review of areas of financial risk through the board assurance process, and that all appropriate and available mitigations are in place.

9.1.4. There is scrutiny of major business cases, service developments and proposed investment decisions in excess of £1m on behalf of the Trust Board.

9.1.5. Post project evaluation and benefits realisation of major investments is in place.

9.2. To provide a written or verbal report to the Trust Board that provides this assurance and highlights any areas that are of concern.

9.3. Finance Committee meetings will include the following standing items:

9.3.1. Review of the monthly Finance Report.

9.3.2. Review of Capital Programme.

9.3.3. Review of cost improvement plans (CIP) and delivery.

9.3.4. Review of business cases for service developments/changes/contracts in excess of £0.5m.

9.4. Committee papers will be published at least five working days before the date of the Committee.

9.5 Committee minutes will be produced within five working days.

Terms of Reference

10. Terms of Reference

10.1 The Committee's terms of reference will be reviewed and approved by the Trust Board annually.

10.2 The Committee will monitor its performance against its terms of reference six monthly.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Compliance against terms of reference	Annual review	Company Secretary	Chair of Finance Committee	

Terms of Reference approved by the: Trust Board on 15 April 2021

Meeting of the Trust Board in Public
Thursday, 15 April 2021

Title of Report	**Patient First Programme- Operational Update**	Agenda Item	**6.1**
Lead Director	Angela Gallagher, Chief Operating Officer (Interim)		
Report Author	Keith Soper, Deputy Chief Operating Officer		
Executive Summary	This paper and the accompanying slides provide a progress update on three key and interrelated elements of our Patient First programme. This work targets regulatory requirements and links to a number of key performance and quality indicators. It also seeks to positively respond to the recommendations from Emergency Care Intensive Support Team (ECIST), who have played a positive role in the programmes and are active members of the committees and supporting workstreams.		
Committees or Groups at which the paper has been submitted	Trust Improvement Board, 24 March 2021		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	NA		
Recommendation/ Actions required	The Board is asked to NOTE the report and progress made		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒

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

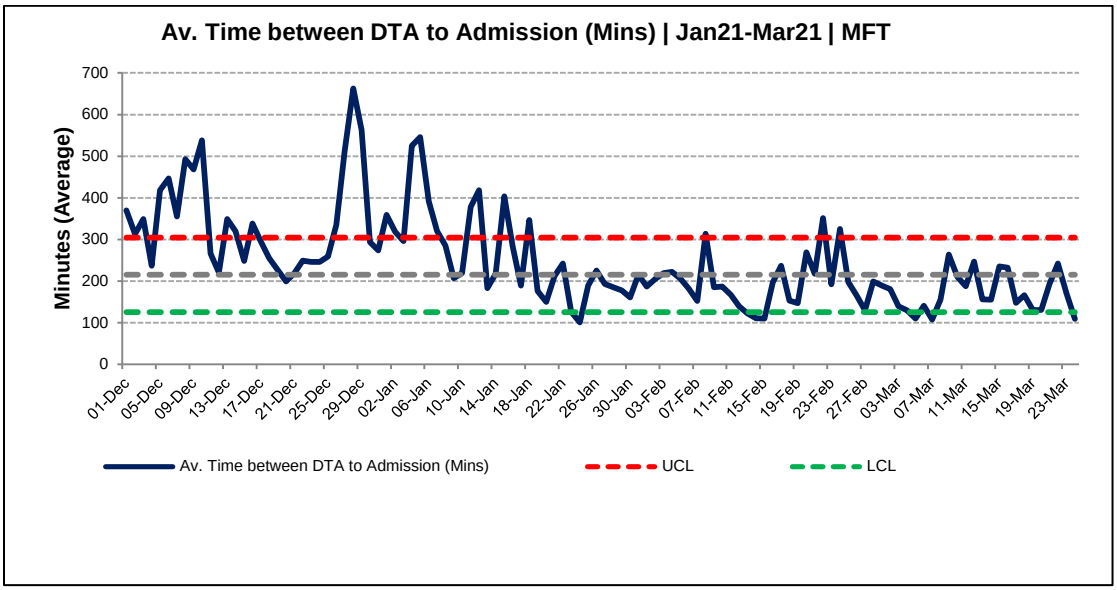
1 Executive Overview

1.1 This briefing describes at a headline level the progress made, future programme priorities and references relevant performance indicators.

2 Effective Site Management

2.1 We are continuing to work on the focus of the site office moving from reporting to supporting, and we have seen good levels of engagement from clinical teams in the site meetings and an improvement in communication. This appears to be yielding results, both in terms of the positive discharge profile (ably supported by the targeted Flow and Discharge work detailed below) and in terms of the safe and timely placement of patients requiring emergency admission. We have continued to see very positive improvements in the time between the decision to admit and entry to a bed (see below) and this has been supported by further ward de-escalations, with six wards de-escalated from red to amber within a five week period. Recent peaks indicate where amber capacity became limited, which was quickly alleviated by the de-escalations. It should also be noted that this position has been achieved in the context of the restart of our elective programme.

The Site Office is currently undergoing refurbishment and installation of new technology to further support our objectives, and will be completed after the Easter break.



2.2 Our priorities for the next month include:

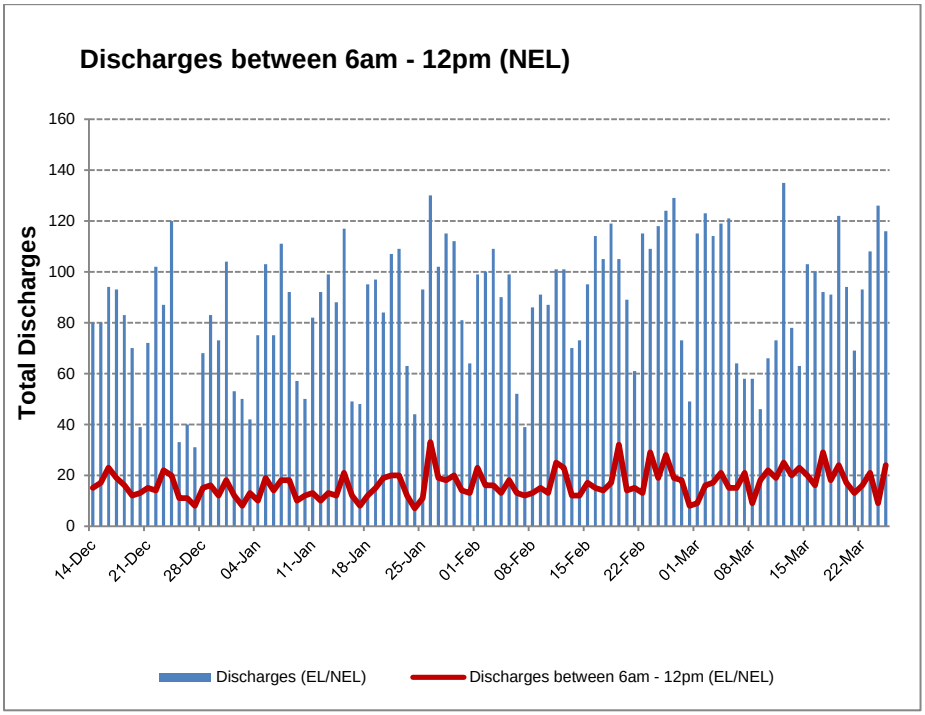
- Trial the new twilight shift in the Site Team
- Launch the new electronic data capture forms and Site Sit Report
- Complete the review of the Trust Escalation documents and action cards, including SHREWD
- Introduce new Standard Operating Procedures within the Site Office and Site Team.

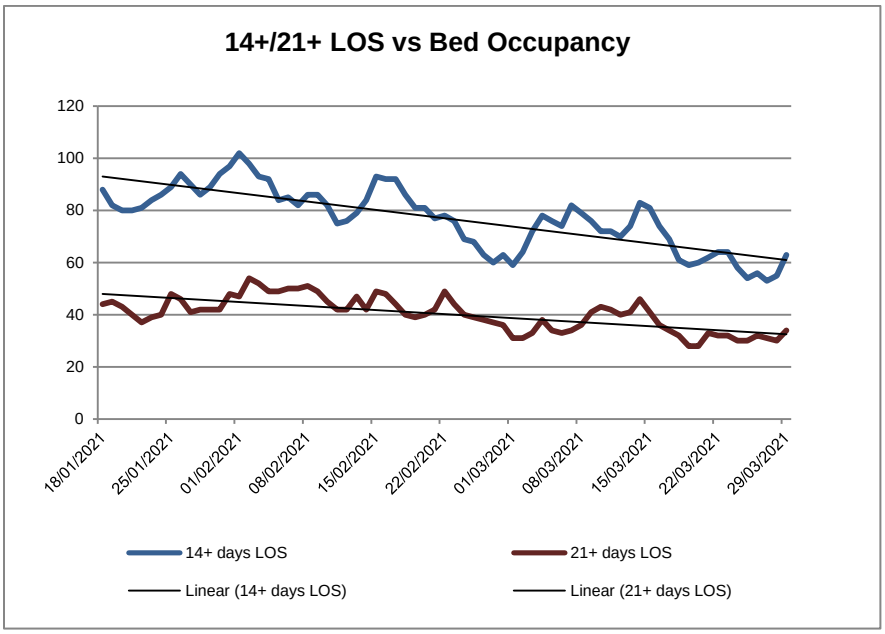
3. Flow and Discharge

3.1 The Flow and Discharge programme is focusing on four key areas with a view to improving process and outputs. This work is being completed with system partners but also has an absolute goal on a day to day basis of supporting bed availability and timely discharge:

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

3.2 We have continued to run at least two mini-MADEs (Multi Agency Discharge Events) each week to support flow and learn about the process at a ward level. These have had positive results, both in improving the discharge profile and supporting ward teams and system partners, as indicated by the improvement in earlier discharges, the number achieved at the weekend and a reducing length of stay. We have achieved an average of an additional 14 discharges per day in the previous thee week period. The learning from our work with teams is informing the wider programme of improvement.





3.6 Our priories for the next month include:

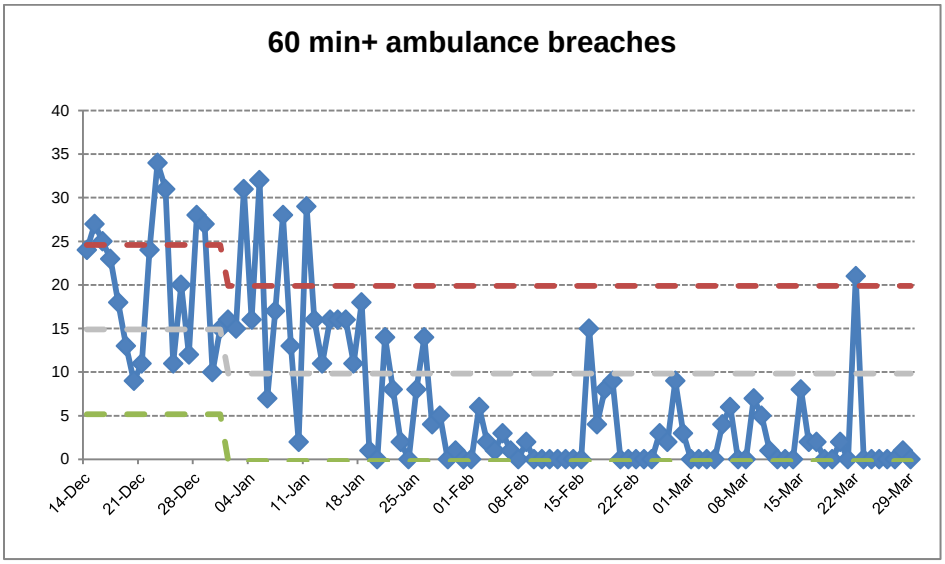
- Improved patient flow through all wards and further improvement on pre-noon discharges

- Compliance with clinical systems and using estimated date of discharge as a measure of performance
- Continuing to support the Trust's bed reconfiguration plan, targeting those wards that demonstrated the need for further support and where a change in use is anticipated
- Working with clinical teams and system partners to ensure the right infrastructure is in place to return to business as usual

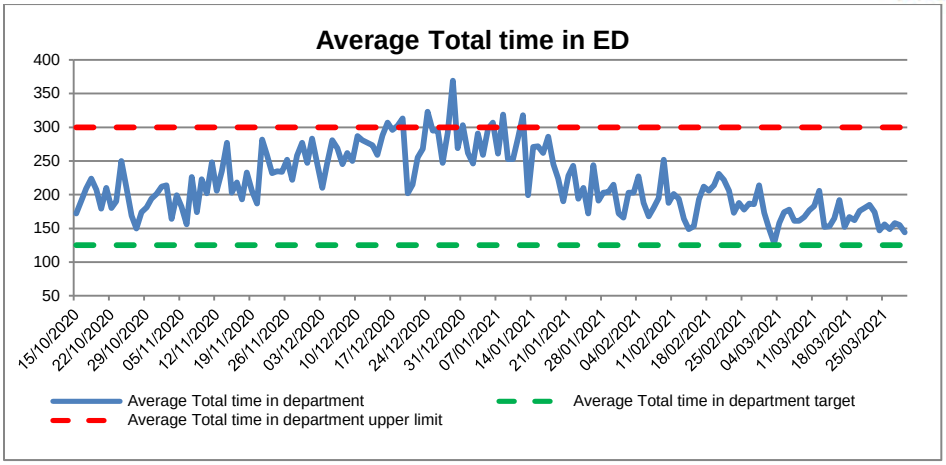
4. Acute Care Transformation

4.1 The work of the Acute Care Transformation (ACT) programme links closely to our Care Quality Commission action plan. At its heart the programme is striving to ensure safe access and initial assessment for all patients and to minimise delays at every step of the emergency journey. Whilst we have agreed a number of programme metrics, the key indicators and measures of success are ambulance handovers, time spent in the Emergency Department (ED) and 4 hour performance.

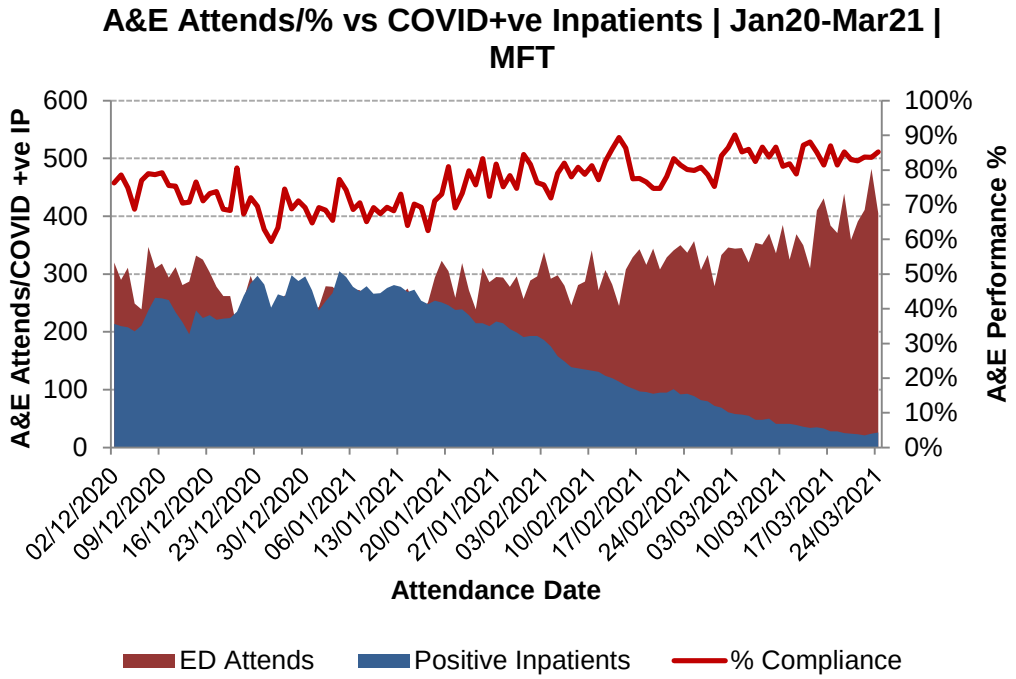
4.2 Ambulance handover delays are a symptom of reduced capacity in ED and a lack of flow. We have minimised long delays and achieved zero 60 minute breaches on 14 out of last 20 days, and no consecutive days of 60 minute ambulance breaches for 14 days. This demonstrates our increasing ability to recover from challenging periods. We have flexed our capacity in ED to ensure the right amount of red and amber space, increased the capacity for Covid-19 swabbing and identified an escalation area, with an agreed implementation process, should pressure in ED dictate the need to open additional cubicle capacity. The output of this work is illustrated by the chart below.



The average time spent in ED has been on a downward trajectory since the New Year, and is tracking close to our target of 125 minutes from a peak of 369 minutes.



Our four hour performance has shown steady and sustained improvement, with one day of sub-80% performance in the last 30 days and an average performance since the last sub-80% of 84.4%, which is close to our internal standard of 85%. It has been 30 days since our last patient waited 12 hours for a DTA.



4.3 Our priories for the next month include:

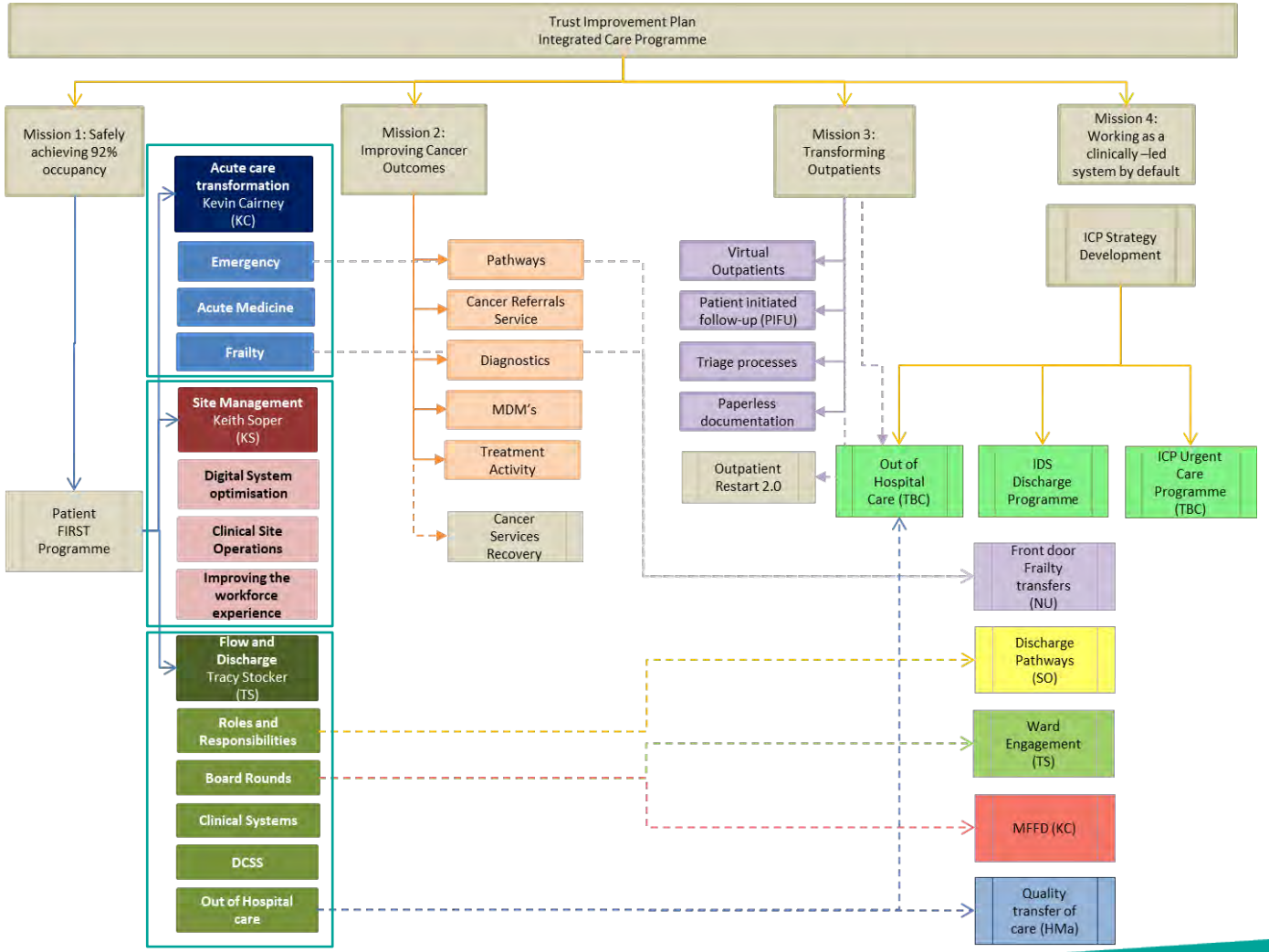
- Consistent achievement of over 85% performance and a plan developed to reach 90% and then 95% in Quarter 2
- Process to review breaches daily with clinical oversight
- Re-establishing the medical assessment unit refer and move model to improve flow
- Facilitating the integration of the new Interim Director of Operations as RO for the ACT programme.

5. Slide Pack presented at Trust Improvement Board to follow this paper.

PATIENT FIRST

TIB 24 March 2021
Update

PATIENT FIRST (INTEGRATED CARE)



1. ACUTE CARE TRANSFORMATION

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

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Aims of the work

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

Short-term tests of change (PDSA cycles)

30, 60, 90 days

- ED patient safety checklist content aligned to ED Nursing documentation (30D)
- Business intelligence suite that informs our clinical leaders and operational teams of pathway performance and flows directly Site (60D);
- Time stamping the Emergency care, assessment and ambulatory pathways in line with IPS (90D with dependency on Clinical System support into SDEC, FAU, SAU and AAU);
- Frontline staff are contributing to lean process mapping and quality improvement cycles;

Long-term priorities and key deliverables

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

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

Outcome measures

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

Process measures

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

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

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

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

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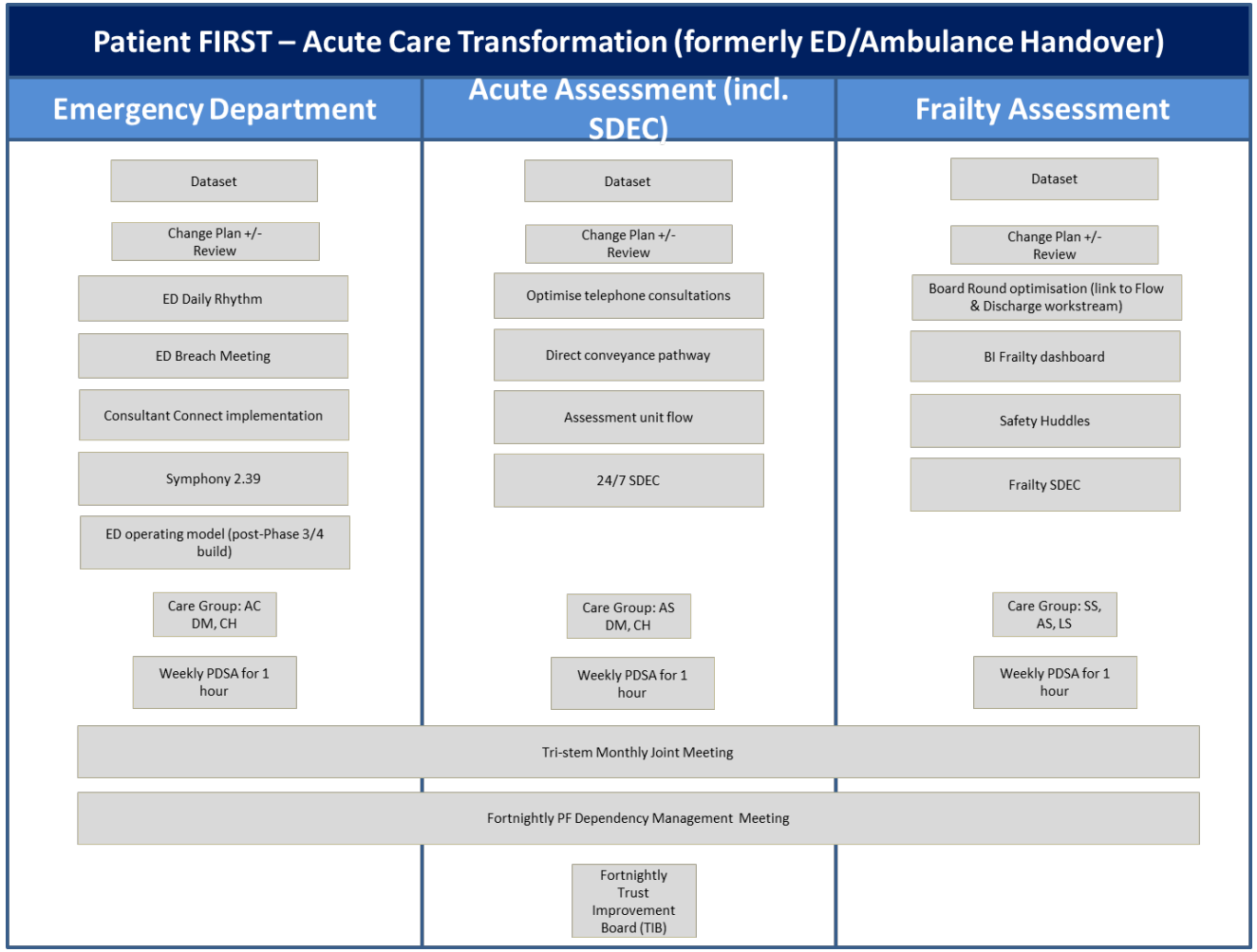
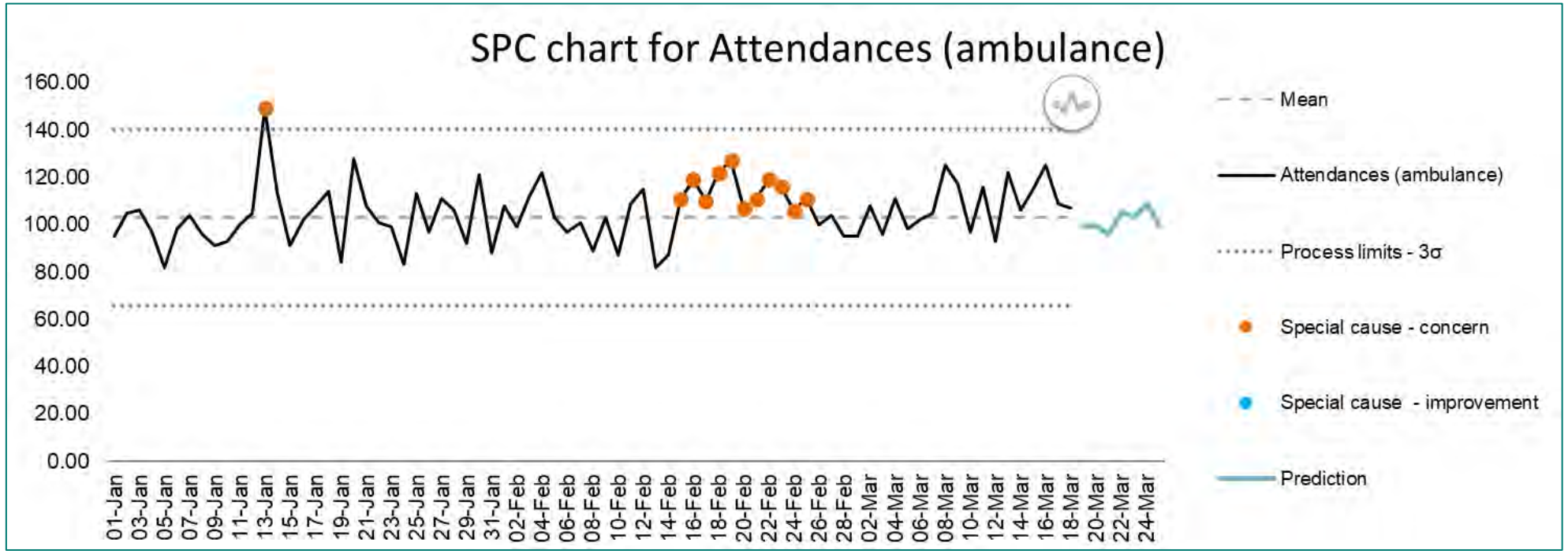
Activities completed in last 2 weeks	Activities planned for next 2 weeks
▪ ED IPS and Emergency Care Standards (UIC) baselined (where metrics are currently reportable) ▪ First phase priorities commenced within the three "stems" of ACT (Emergency, Acute and Frailty). ▪ Reassigned ACT workstream RO responsibilities between Deputy COO (ED / Acute Medicine) and Assistant COO (Frailty) ▪ Re-engagement with the Consultant Connect project via KMCCG ▪ T&F Group mobilisation for Clinical System across the "emergency floor" (ED, SDEC, FSDEC, AAU and FAU)	▪ Finalise monthly trajectories to "green" status on ED and Emergency Care standards for UIC ▪ Progress Emergency Care Standards within Planned Care, integrating the SAU/SSDEC plans into the ACT workstream ▪ Complete ED process maps (detailed) within Frailty to track into Emerald AU ▪ Patient experience measures co-design ▪ Symphony v2.39 upgrade within ED ▪ Progress Clinical Systems implementation project to include SAU
Needs & Dependencies	**Risks, Issues & Blockers**
▪ Activity related to development of the ED workforce model to reflect professional standards and national guidance throughout the emergency pathway (support from Workforce stream) ▪ Emergency Care Dependencies: ▪ Clinical Systems upgrade, including the implementation into SDEC / FAU ▪ Emerald Assessment Unit phased mobilisation ▪ ICP-led Ambulance handover group ▪ Business case	▪ Current IPC restrictions impacting Acute Assessment Unit function ▪ ICP / ICC assurances to support Frailty SDEC Business Case ▪ BI resource to map and mitigate data / information gaps impacting on ability to measure and track improvement ▪ Integrating Emergency Surgical Standards into timescales for the delivery of the Clinical Systems mobilisation project for AU's ▪ Integration with other plans / deliverables and reporting structures focussed on Emergency Care (including ICP, CQC, other plans) ▪ BI identified risks (contractual / financial) attached to the implementation of Symphony across the "emergency floor"

ACT Workstream Summary



Measures: Ambulance attendances (01/01/21 - 18/03/21)

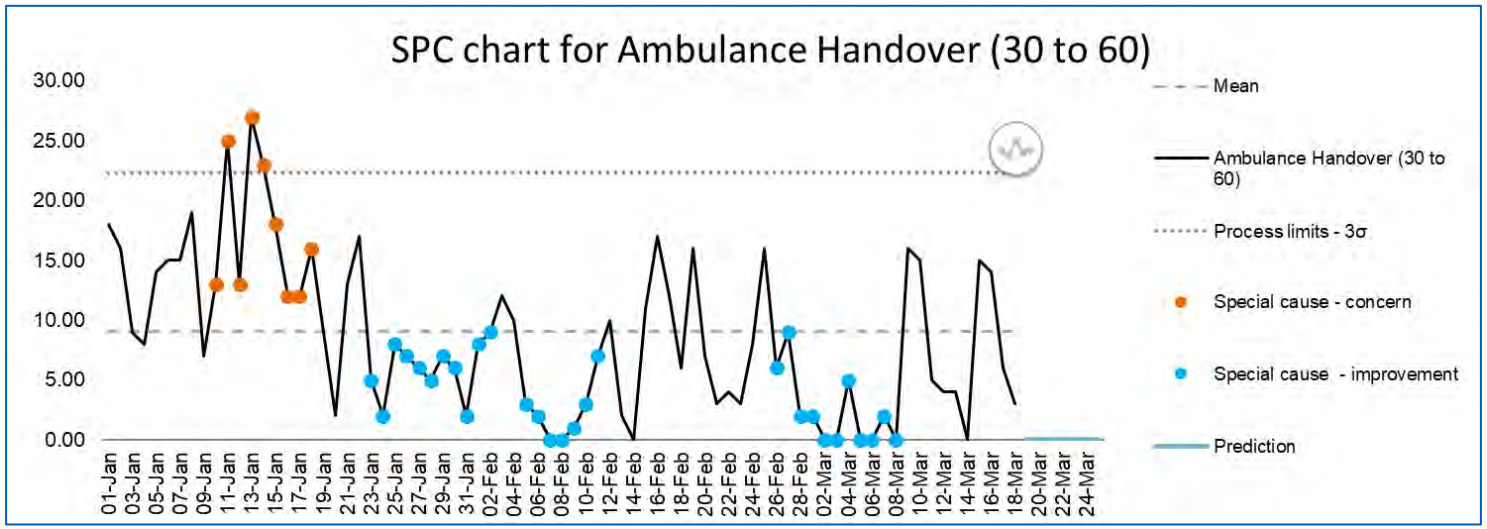


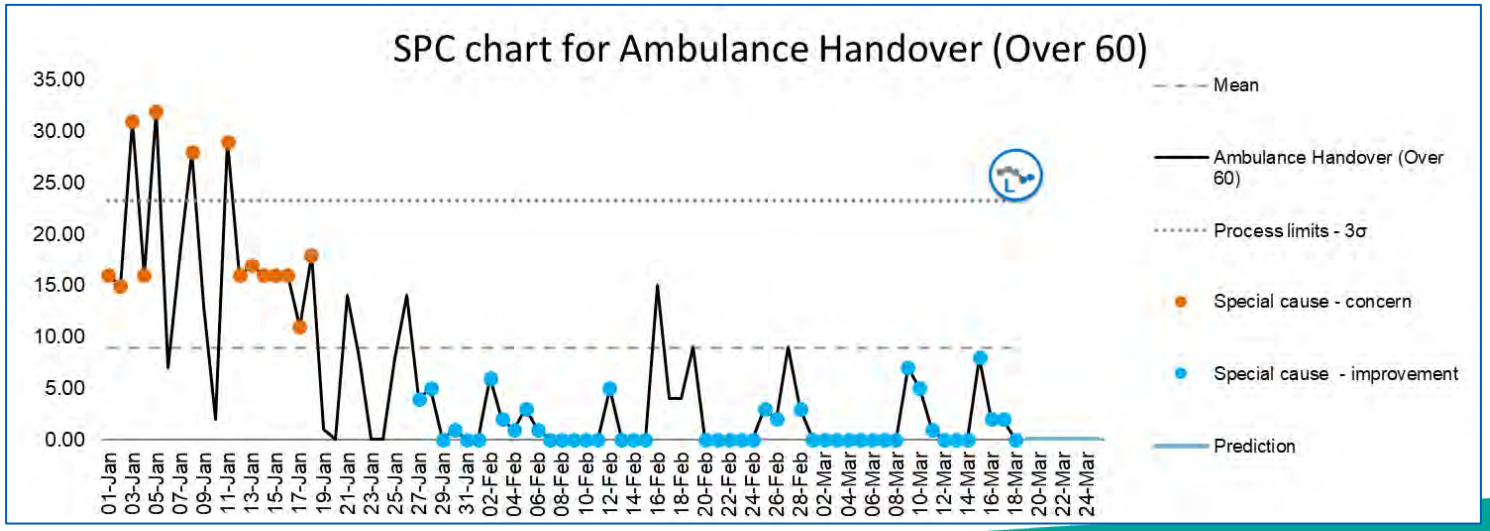
Source: ECIST UEC dashboard 19/03/21

Ambulances attendances remain broadly steady with some notable increase evident in mid-Feb and the second week in March.

This attendance activity correlates with Ambulance handover delays (30 – 60 min and >60 min) shown in the next slide.

Measures: Ambulance handover delays (1)





Source: ECIST UEC dashboard 19/03/21

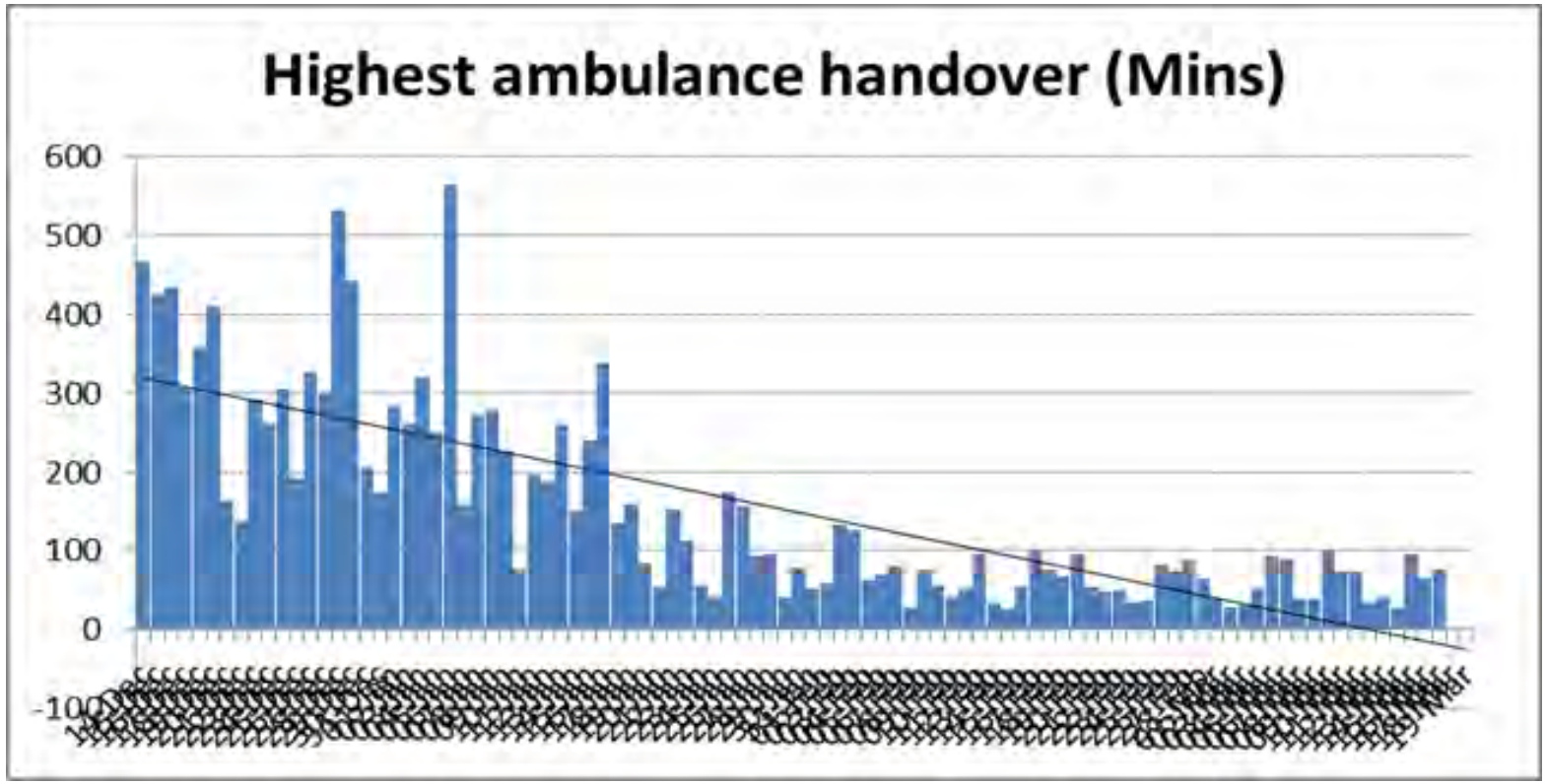
There is an improving picture with Ambulance handover delays since the second half of January.

Notable peaks in the second half of Feb. correlate with greater than average Ambulance attendances in the same period.

Since late Feb. Ambulance handover delays in both 30 – 60 mins and the 60min+ have shown improvement with two exceptions noted in March, correlating with Ambulance attendance increases.

Highest handover delay since the beginning of Feb peaked at 100 minutes on 09/03/21.

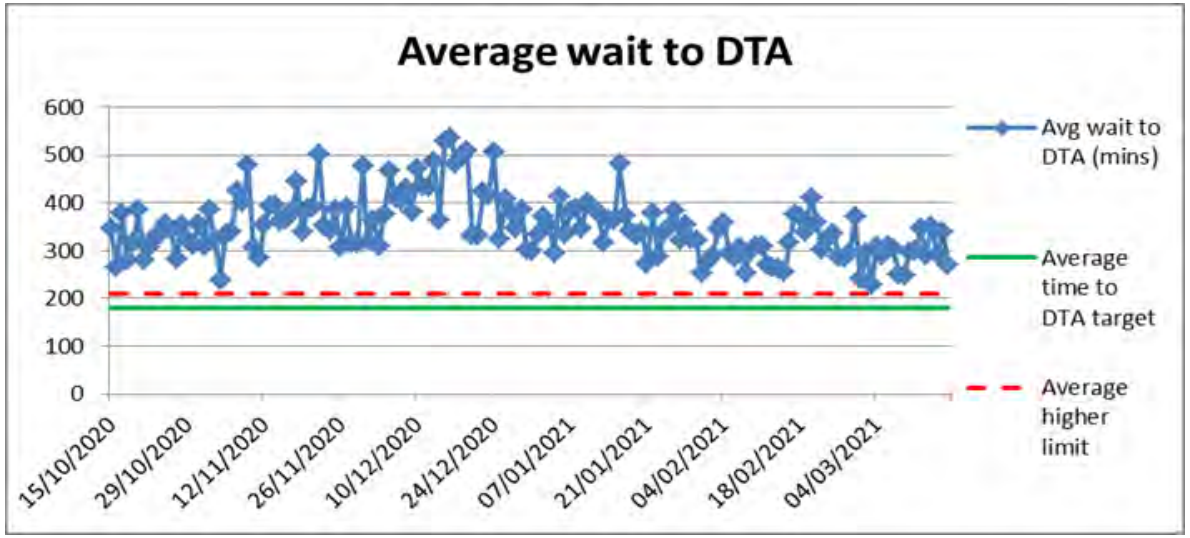
Measures: Ambulance handover delays (2)

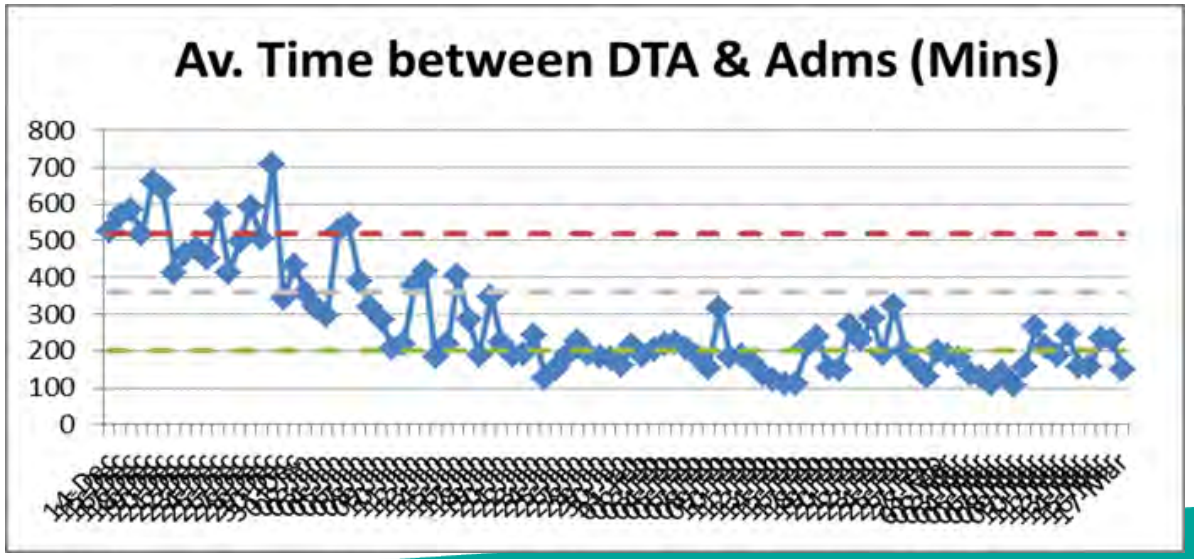


Source: MFT Business Intelligence (GB) 18/03/21

Highest handover delays have reduced significantly since mid-Dec. The longest delay experienced in the past 6 weeks was on 09/03/21 at 100 minutes.

Measures: Decision to Admit / Admission





Source: MFT Business Intelligence (GB) 18/03/21

Arrival to decision to admit (DTA)

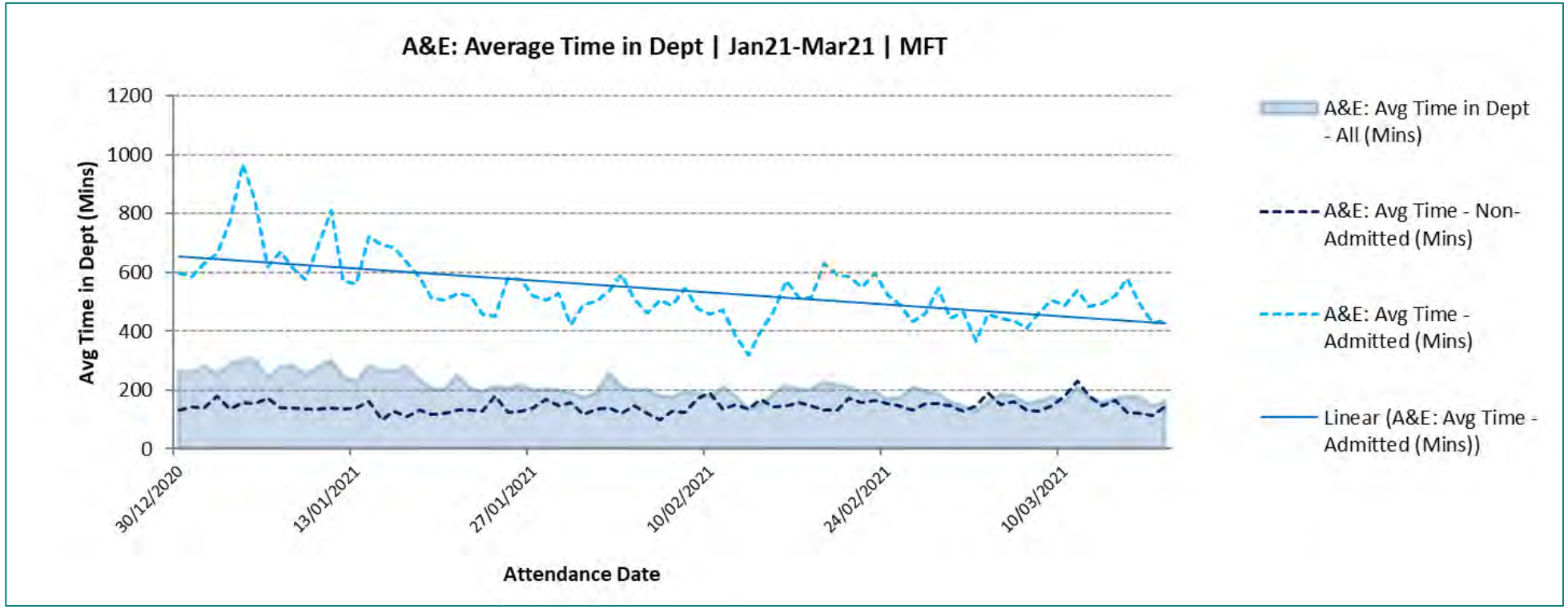
Average time from arrival to DTA remains >250mins indicating most patients are being assigned a DTA over 4hrs.

Initial reviews by Senior clinical staff are underway to explore time taken to swab and refer patients. The outcomes of this and further monitoring will form part of the next round of improvement activities within the ED Acute Care Transformation workstream.

Decision to admit (DTA) to admission

Average time from DTA to admission has trended down from mid-December. Since last submission, some peaks (>200mins) have been experienced.

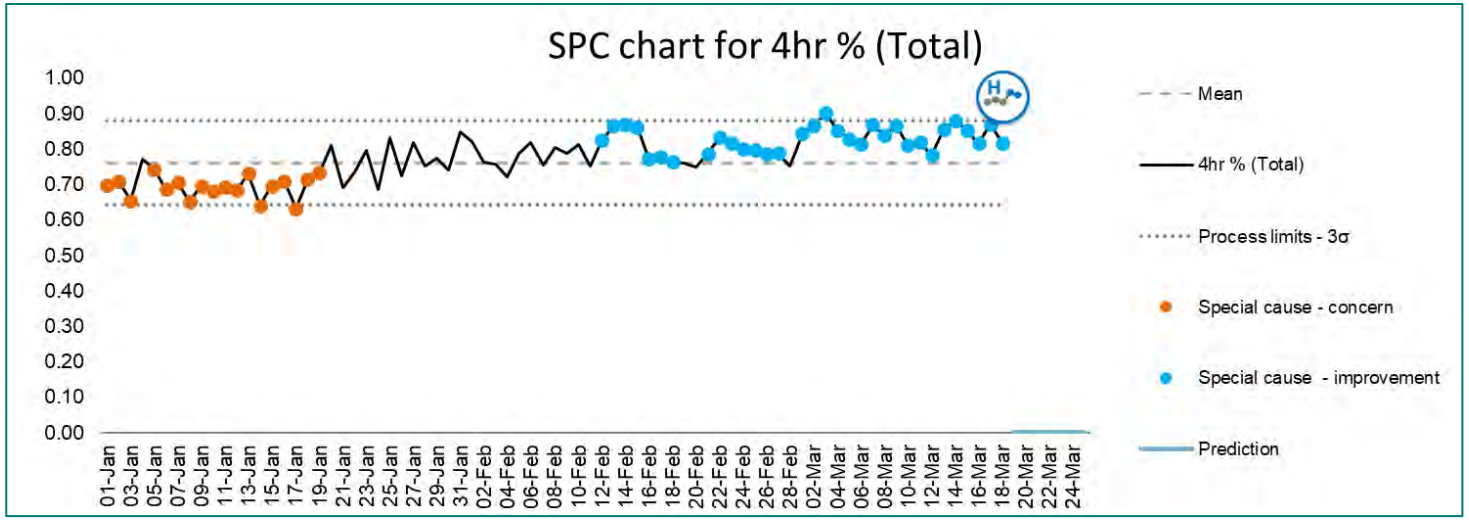
Measures: Average total time in ED

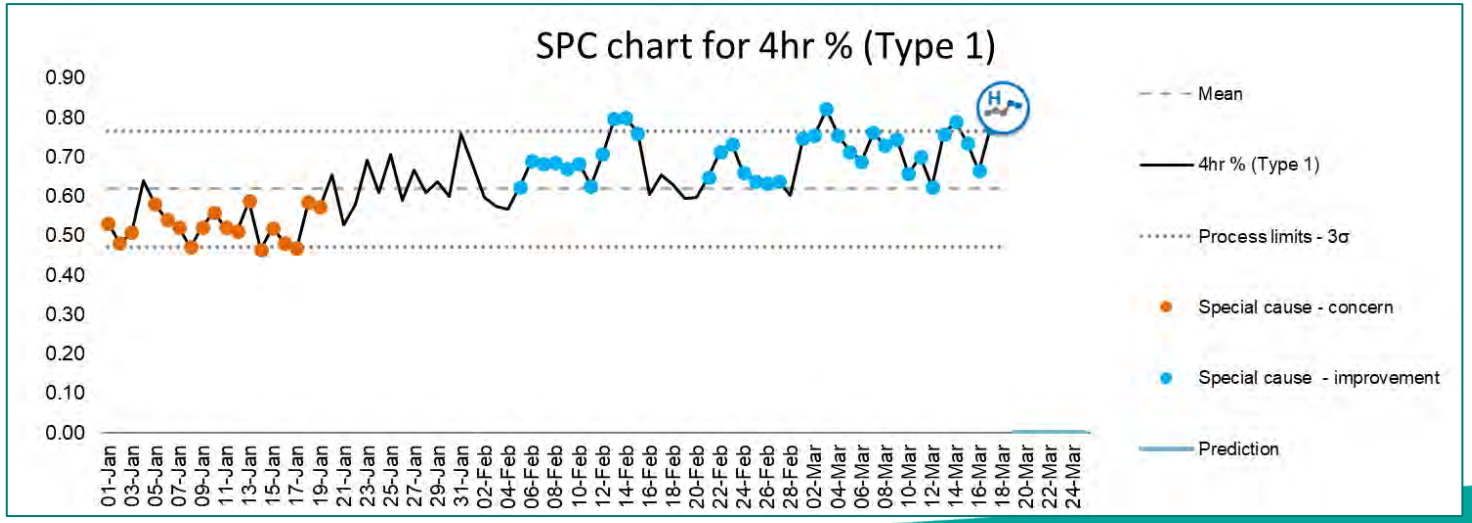


Source: MFT Business Intelligence Flow Dashboard 19/03/21

Average total time in ED has continued to decrease since the beginning of January, impacted by improving timeliness of the admitted pathway (noted by the trend-line). Steady performance on the non-admitted pathway, despite a small rise mid-month in Feb and March, has resulted in a maintained average performance below 240mins.

Measures: 4 hour performance





Source: ECIST UEC dashboard 19/03/21

Overall 4 hour performance has shown consistent improvement since mid-Feb. and remains >80%

The Patient FIRST Acute Care Transformation (ACT) workstream is supporting weekly focussed continuous improvement sessions with the clinical and operational leads in ED, Acute Medicine and Frailty. The session actions are being tracked through a series internal process metrics and improvement activities with targeted support from ECIST.

2. FLOW AND DISCHARGE

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

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Aims of the work

- Develop and deliver transformed multi disciplinary/ agency twice daily Board Rounds in line with SAFER principals. Creating system wide processes that enhance the patient journey, clinical outcomes and overall flow across the Trust and system
- Optimise and implement the use of Clinical Systems to record, interpret and share patient information to enhance the patient journey and system wide operations.
- Develop and monitor internal and professional standards to optimise length of stay, timely discharge, including criteria-led discharge (CLD) and criteria to reside (C2R)
- Inform, influence and support out of hospital care, including CoVID Virtual Ward, early supported discharge (RPM, D2A) pathways and admission prevention pathways
- Enhance networking and relationships with system partners to improve patient care and reduce variation

Short-term tests of change (PDSA cycles)

30, 60, 90 days

- Developing and further integrating pathways with System partners.(30D)
- Collaborating and enabling IT PMO to deliver and drive important IT roll outs as the benefits are recognised (60D)
- Finalisation of pathway and referral process for all early supported discharge and admission avoidance (60D)
- Extramed optimisation and dashboard development: EDD management, consistent use of clinical / pathway flags, inpatient reports – criteria to reside, medically optimised, discharge pathway (incl. CLD, ESD pathways)(90D)
- Engaged with system partners and MFT clinicians to establish best practice discharge planning and board round productivity. All processes mapped and to be piloted with Frailty wards as a test of change. (30D) Evaluate pilot and cascade Trust-Wide.
- Review eDN completion and compliance reducing failures and Pharmacy errors

Long-term priorities and key deliverables

- Clarity of patient pathways from point of admission through to completion of care
- Standardised, improved and clinically-led twice-daily Board Rounds supported with continuous improvement approaches including patient FIRST and SAFER principals. CLD. C2R
- Continue to develop and build on the integration of services and pathways which support effective transfers of care, virtual patient care and prevention of re-admission
- 7 day clinical/operational working across the ICP

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

Outcome measures

- Criteria to reside (no. & %)
- Reduction in Acute LoS (7D, 14D, 21D)
- Increase pre-noon discharges, 7 day discharges and failed discharges
- Overall bed occupancy (reducing outliers)
- Readmission rates %
- Avoidable harm measures
- Compliance monitoring of internal metrics and professional standards
- Reviewing and baselining proposed metrics in line with current NHSEI guidelines including the national hospital discharge policy

Process measures

- EDD completion rates %
- EDD vs Actual Discharge date (“accuracy” %)
- Pre-noon discharge %
- Criteria-led discharges%
- SAFER/BR compliance
- Medically optimised no. & %
- Early Supported Discharge (ESD) discharge pathways utilisation (no. & %)

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

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Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Optimise the flow of patients from assessment > inpatient areas as early in the day as possible to reduce pressure and improve patients' experience of care; • Deliver consistent, standardised twice daily inpatient board rounds to optimise acute care for patients who need it (criteria to reside / SAFER) over 7 days and prioritise "day before" and early discharges preparations; • Develop and monitor internal and professional standards to ensure safe, timely discharge (pre-noon where possible), including CLD and ESD pathways; • Improve data completion and quality rates through establish concise roles and responsibilities , virtual BR support and clinical leadership and engagement; • Support the delivery of high quality clinical care with a reduction of outlying patients and improvement of patient experience	• SAFER Board Round auditing, actions and tests of change including criteria to reside and the optimisation of the principles "home first" and third sector support services (30D) • Pilot virtual board rounds across Frailty bed base with community partners including IDT (30D) • Finalisation of pathway and referral process for CVW (30D) • Extramed optimisation and dashboard development: EDD management, inpatient reports – criteria to reside, discharge pathway (incl. CLD), IPC status (60 - 90D) • Clarity of patient pathways from point of admission through to out of hospital services • Standardised, improved and clinically-led Board Rounds supported with continuous improvement approaches including Multi disciplinary/multi agency discussions as required • Continue to develop and build on the integration of services and pathways which support effective transfers of care, virtual patient care and prevention of re-admission • 7 day clinical/operational working across the ICP • Increase in pre-noon discharges and golden patients through development of a discharge pipeline (60-90D)	• EDD completion rates % • EDD vs Actual discharge (within 48 hrs of EDD) % • Pre-noon discharge % • Criteria-led discharges% • Twice daily BR compliance • Medically optimised no. & % • Early Supported Discharge (ESD) pathways utilisation (no. & %) • Criteria to reside (no. & %) • Reduction in Acute LoS including 7D, 14D, 21D+ occupancy • Overall bed occupancy • Readmission rates % • Avoidable harm measures • Compliance monitoring of internal metrics and professional standards • Outlying patient no. • Reviewing and baselining proposed metrics in line with current NHSEI guidelines including the national hospital discharge policy

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

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Activities completed in last 2 weeks

- BR Audit / mini-MADE events in planned care, thematic analysis completed and used to inform focus areas for improvement activity
- Workstream structure and governance established including engagement with senior clinicians and system partners and set up a ward engagement steering group to drive the programme forward
- Clinical Systems audit / review to ensure interoperability and user friendly approach
- Training needs analysis conducted to assist with formation of training matrix. Established role specific training support to embed best practice and clinical system utilisation
- First phase improvement activities commenced w/c 15/03/21
- ExtraMed T&F group set up with membership including clinical/medical staff ,IT, BI and IDT
- eDN T&F Group set up with membership including clinical/medical ,IT, BI and IDT and led by Pharmacy colleagues

Activities planned for next 2 weeks

- Flow and Discharge workstream continue to develop roles and responsibilities to support the programme. Shadowing IDT colleagues to collaborate on system practices that enhance the patient journey
- Continue to work with IT PMO to dovetail system roll out and training initiatives to enhance progress of this workstream
- Deliver role based training and implement Clinical Systems prompt sheets in pilot areas to improve data completion rates and implement reporting of Criteria to Reside (C2R)
- Baseline workstream metrics and trajectories pending BI resources
- Establishing the roles and responsibilities of Progress Chasers, Virtual bed bureau/ward clerks to support Board Rounds and discharge
- Adopt the use of diagnostic ordering systems (OrderComms) in early implementer areas (TOP care programme)
- Create detailed project plan, supported by clear process maps, SOPS and IPS documentation to support with Go Live of B.E.S.T Ward

Needs & Dependencies

Needs:
- Refreshed Clinical Systems support for inpatient teams

Dependencies
- ICP working group plans for IDS Discharge Programme
- Optimisation of Extramed functionality to support IP dashboard On-site / workforce capacity to support SAFER Board Rounds
- System activity on ESD pathways

Risks, Issues & Blockers

- Divisional Clinical engagement to support workstream beyond early adopter group (TOP Care Programme)
- BI resource to map and mitigate data / information gaps impacting on ability to measure and track improvement
- Clinical capacity to engage in board rounds which SAFER rounds
- Capacity to support real-time clinical systems entry from a systems access, hardware and workforce perspective

Flow and Discharge Workstream Summary

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Patient FIRST – Flow and Discharge

Roles and Responsibilities	Board Rounds	Clinical Systems	Diagnostics	Out of Hospital care
Dataset	Dataset	Dataset	Dataset	Dataset
Change Plan +/- Review	Change Plan +/- Review	Change Plan +/- Review	Change Plan +/- Review	Change Plan +/- Review
Senior Leadership Engagement	SAFER Audits	Electronic Order Comms Implementation	Lean process mapping	Discharge Week
7 Day Discharges	Actions and Responsibilities	ExtraMed Initiative	Electronic Order Comms (DartOCM) Go Live	SMART Referral
Compliance and Consistency	Processes	eDN Drive	Elimination of paper requests	IDT Collaboration
Actions to Plan Discharge	Escalation	Frailty Pilot	Service review, agreed processes and escalation pathway	Discharge Pathways Admission avoidance
T&F Group: TS,CH Various Clinicians	T&F Group: TS,CH, SS,AS,LS,LP,KL	T&F Group: TS,CH, SS,AS,LS,LP,KL	T&F Group: TS,CH, KdR,SS, AT, JB (IT)	T&F Group: Various Representatives from MFT and IDT
Frequency: Bi-Weekly	Frequency: Weekly	Frequency: Weekly	Frequency: Bi-Weekly	Frequency: Weekly

Weekly Steering Group

Fortnightly PF Dependency Management Meeting

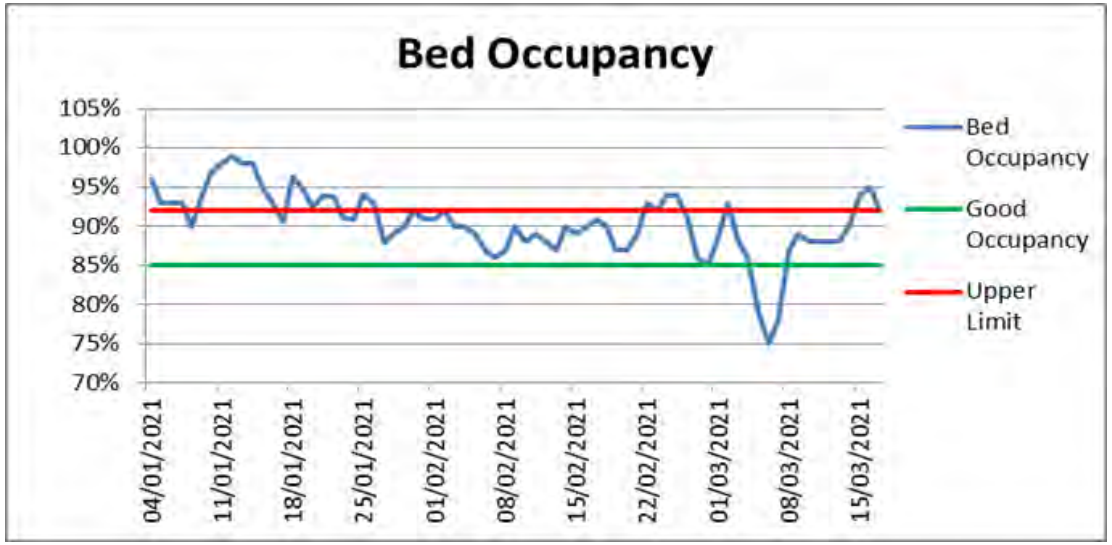
Fortnightly Trust Improvement Board (TIB)

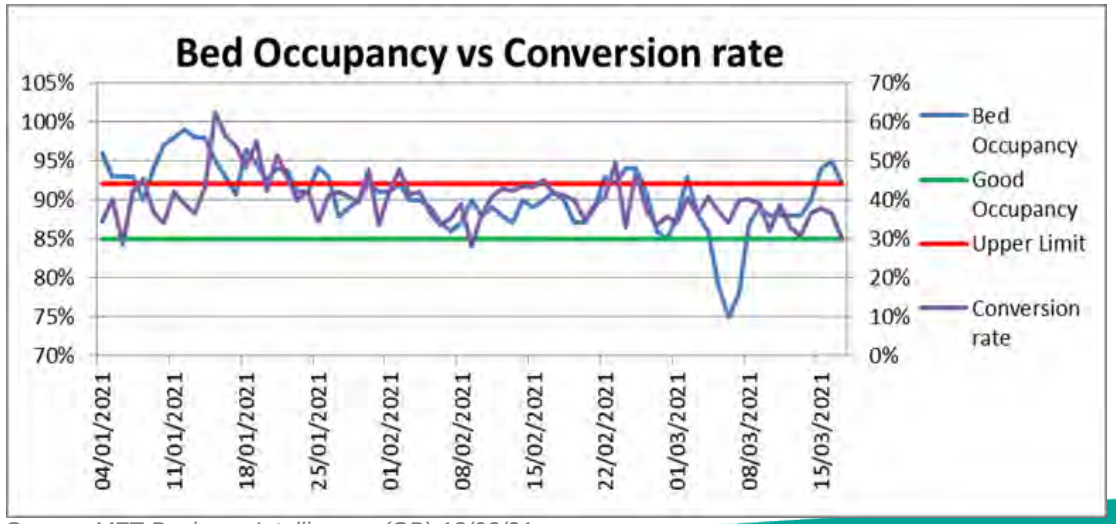
Fortnightly Integrated Discharge System Board (IDS)

Best of care Best of people

Our Medway

Measures – Bed Occupancy



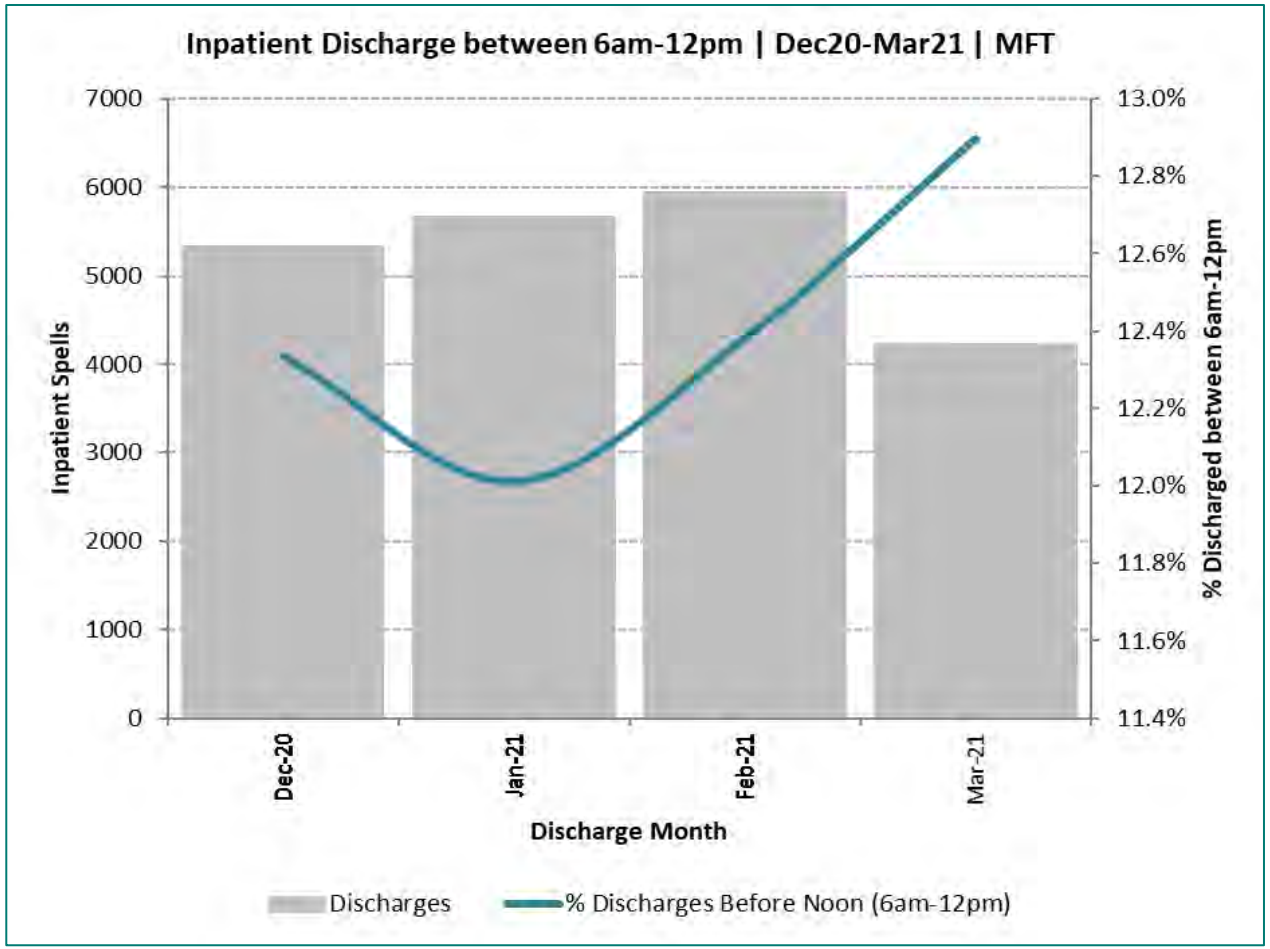


Source: MFT Business Intelligence (GB) 18/03/21

Bed occupancy is currently above the upper level of 92%.

In the w/c 15/03/21, occupancy was linked to the closure of Jade ward and therefore an overall reduction in available beds, in addition to an increase in admissions overall, as evidenced by the conversion rate.

Measures – Pre-noon discharges



Source: MFT Business Intelligence Flow Dashboard 19/03/21

Pre-noon discharges shows an improving position since January (partial data only available for Mar.)

The Patient FIRST Flow and Discharge (F&D) workstream is supporting mini-MADE events with internal and system partners in Medical and Surgical wards three – five times / week. This is in addition to continuous improvement sessions with the Therapies and Older People's Care Programme to support a Centre of Excellence (B.E.S.T Ward) project within the Frailty assessment and inpatient areas. The F&D workstream is also progressing improvement activities across clinical systems recording of care and discharge pathways.

The project and the wider workstream are being tracked through a series internal process metrics and improvement activities with some targeted support from ECIST.

3. SITE MANAGEMENT

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

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Aims of the work

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

Short-term tests of change (PDSA cycles)

30, 60, 90 days

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

Long-term priorities and key deliverables

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

How will we know we are successful – and by when

Outcome measures

- Senior decision-making attendance at Site Meetings

Process measures

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

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

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

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

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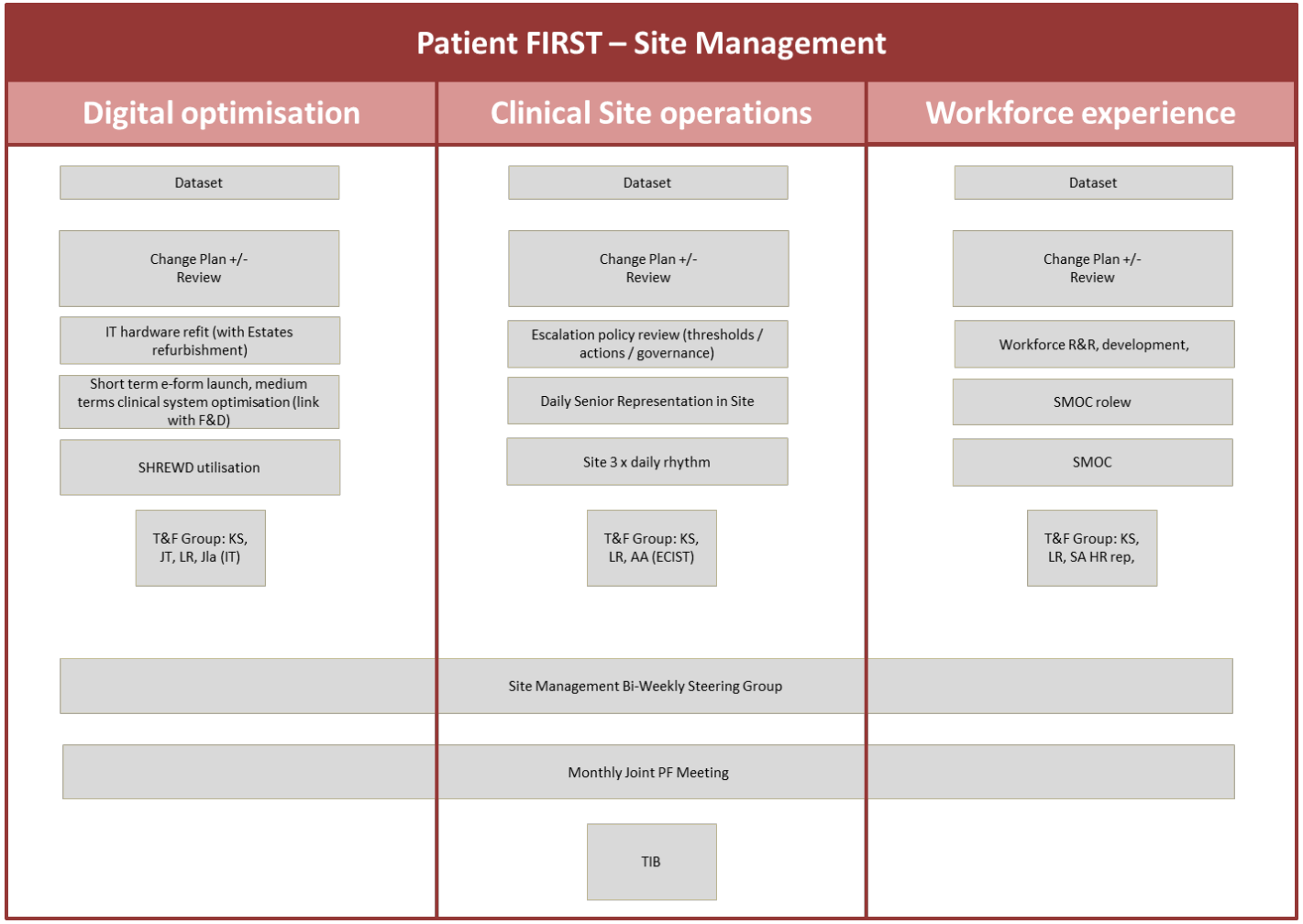
Activities completed in last 2 weeks	Activities planned for next 2 weeks
▪ Electronic Site documentation completed and tested for planned go-live on 06/04/21 ▪ Site Management project structure with RO / Clinical Lead / ECIST established w/c 01/03/21 on a fortnightly rhythm ▪ ECIST baselining of current escalation and Site operational processes and appreciative enquiries completed with key stakeholders ▪ New daily Site sit-rep produced ▪ On call manager survey completed ▪ Attendance at Site meetings from ED nurse in charge	▪ Internal site office reconfiguration due for completion w/e 26/03/21, including COVID bed status board replacement with digital screen ▪ Temporary site move to Dolphin Seminar Room ▪ Finalise Trial twilight site management shift to support on-call managers and manage staffing ▪ Further comms to be issued re: new Site e-form to support 3 x daily Site Meetings ▪ Pilot new Site sit-rep ▪ Complete draft of revised Full Capacity Protocol
Needs & Dependencies	**Risks, Issues & Blockers**
Needs ▪ SAFER Board Round compliance and improvements in data completion rates (Discharge & Flow) ▪ BI Dashboard development support aligned to revised escalation processes Dependencies ▪ Emergency Care Standards finalisation and implementation (ED / Ambulance handover) ▪ Clinical Systems upgrades (SDEC / AAU / SAU / FAU)	▪ Data completion and accuracy rates within Clinical Systems to inform site management functions ▪ SAFER Board Round compliance and management of criteria to reside ▪ BI resource to map and mitigate data / information gaps impacting on ability to measure and track improvement ▪ Timely Comms regarding the temporary relocation of Site Office whilst works are complete ▪ Ongoing challenges around the flow from ED, assessment unit capacity and flow and de-escalation of areas

Site Management Workstream Summary



Meeting of the Board of Directors in Public

Thursday, 15 April 2021

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	**7.3**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Monday, 22 March 2021		
Lead Director:	Leon Hinton, Chief People Officer		
Report Author:	Leon Hinton, Chief People Officer		

Key headlines and assurance level

Key headline	Assurance Level
1.IQPR – People KPIs Key highlights were noted as follows: 1) Total Sickness (Rolling 12 month) which demonstrated a plateaued value and the monthly sickness outcomes showing a marked decrease in sickness to seasonal normal in February: a) Spiked at 7.82% in December b) Decreased to 6.10% in January c) Decreased to 4.23% in February. Underlying sickness in Feb: 1% due to Covid (down from 2.5%) 0.9% due to stress/anxiety (down from 1%) 0.3% due to MSK (down from 0.35%) The Trust's sickness rate is recovering the sickness rates to normal seasonal levels and in conjunction with the ending of shielding on 31 March and we should see an improvement to normal staffing availability by April 2021 subject to the risk assessment process. 2) Temporary staff spend there is a slight decrease to agency and bank but it will be higher than normal through to the end of March 2021. 3) Appraisals there has been a 3% increase compared to last month, the data submitted detailed appraisals by care group and staff group, with medical and dental having the highest compliance. 4) Statutory and Mandatory training remains consistent and positive to target overall; however, the compliance within resus is extremely low due to the difficulty of staff to be able to attend the face to face training sessions. The Trust has commissioned an external company to support delivering the training; this will include supporting staff to be able to attend training sessions in person and completing the virtual elements of the training. Chair asked that an update on how statman training compliance has improved is submitted to the April 2021 Quality Assurance Committee. The information needs to be more granular and the Board needs to understand where and why colleagues are not	**Amber/Red**

complying. 5) Staffing vacancies; Chair asked for a small group to consider where the Trust is positioned with safe staffing compliance as a whole. An overall assurance report will be submitted to the next meeting. The report will identify the top five higher risk areas.	
2. HR Resourcing Dashboard 1) All registered nursing vacancies have increased following the inclusion of additional posts following the Q1 Safe Staffing Review that was previously submitted to the Board. Pipeline remains strong for band 5 nursing posts in the medium term and longer term. 18 international RNs (registered nurse) arrived in the Trust in February 2021 and a further 242 are in the pipeline. Five RNs left the Trust in February; however 14 RNs commenced in post. 2) The top five specialties with highest/most difficult to recruit to consultant vacancies are now demonstrating progress. One consultant joined the Trust in February and a further seven Consultants are in the pipeline (ICU, Medicine, ED, Radiology and Elderly Care). One hire in ENT has reduced the 4.5 vacant FTEs to 3.5 FTEs however this remains a difficult to recruit to speciality. 3) A plan has been put in place to support international recruitment, NHSEI have given the Trust funds to support this recruitment. To date the Trust has received £555,000.	**Amber/Green**
3. Highlight Paper – Improvement Board – Our People: Organisational Development Update 1) An update was provided listing year 1 outcomes from the Improvement Plan with KPI on track for voluntary turnover; equality, diversity and inclusion KPI; apprenticeship target; appraisal performance scores and appraisal value score. However, the programme is behind target for improvement to substantive paybill costs; staff recommending Trust as a place to work, staff morale and staff engagement. 2) Staff Survey; Chair suggested a focused workshop to be held with Executive Team, NEDs and selected HR colleagues in April 2021. The workshop would be to discuss the staff survey findings, address themes and work on the action plan. Meeting scheduled for 20 April 2021.	**Amber/Green**
4. EU Exit – Impact on Staffing and Mitigation 1) As at 28 February 2020, this affects up to 193 substantive employees of the Trust, and 83 bank-only workers. 2) A current issue is that the Trust cannot legally require individuals to state their EU settled status in advance of 01 July 2021; however, individuals can voluntarily provide the information to update their record. Communications will be circulated to colleagues to encourage more voluntary disclosure with a clear offer of assistance for those who would like to apply.	**Amber/Red**
5. Gender Pay Gap 1) The report set out the gender pay gap calculations for 2020, together with a supporting statement. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Committee was asked to approve the publication of the Trust's Gender Pay Gap and supporting statement. The 2020/21 report would be submitted to the May 2021 Committee meeting. 2) The Committee asked how the Trust can support the recruitment of	**Amber/Green**

women into roles and improve the position. The Head of Equality and Inclusion would submit a report including actions and outcomes to the next Committee meeting 2021.	
6. WRES and WDES 1) The report detailed the current WRES and WDES actions relating to recruitment and retention are in progress, with some deliverables delayed attributable to pressures on the Resourcing Teams over covid Wave 2. A Fair Recruitment Working Group has been established as part of the 'Our People' Trust Improvement Programme to progress the delayed actions. Actions are currently on track or achieved. 2) The formal report would come back to the Committee in May 2021.	**Amber/Red**
7. BAME Community Support and Risk Assessments 1) Covid-19/Vaccine risk assessments would continue to be reported to this Committee and potentially to the Quality Assurance Committee. More detailed work to be completed on the areas where the vaccine take up is lower. 2) The vaccination rate is 78% for substantive staff, which goes up to 90% including bank and temporary staff. BAME take up is 65% - 13% adrift between all groups. Recently, there was a slower take up of the Oxford vaccine due to the negative media reporting.	**Amber/Red**
8. Staff Health and Wellbeing Strategy 1) The Committee **AGREED** that Sue Mackenzie was the nominated NED Wellbeing Guardian. 2) The Committee **APPROVED** the Staff Health and Wellbeing Strategy.	**Green**
Decisions made: None to report	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: None to report	