Agenda

Trust Board Meeting in Public

Date: Thursday, 3 June 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				
1.4	Chief Executive Update	Chief Executive	3	12:35	Note
1.5	Clinical Presentation – Diagnostic Imaging	Chief Medical Officer	Presenta-tion	12:45	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 06.05.21	Chair	7	13:15	Approve
2.2	Matters arising and Action Log: 06.05.21	Chair	19		Discuss
3.	**High Quality Care**				
3.1	Integrated Quality Performance Report	COO, CNQO, CMO	21	13:20	Note
3.2	Quality Assurance Committee Assurance Report. Meeting date: 25.05.21	Chair of Committee/ Chief Nursing and Quality Officer	49	13:50	Assure
3.3	Clinical Negligence Scheme for Trusts	Chief Nursing and Quality Officer	53	14:00	Note
3.4	Learning from Deaths	Chief Medical Officer	93	14:10	Note
4. Strategy and Resilience					
4.1	Estates Strategy	Director of Estates and Facilities	97	14:20	Discuss
4.2	Health and Safety Annual Report	Director of Estates and Facilities	125	14:30	Approve
5.	**Financial Stability**				
5.1	Finance Report - Month 1	Chief Finance Officer	131	14:40	Note
5.2	Finance Committee Assurance Report. Meeting date: 20.05.21	Chair of Committee/ Chief Finance Officer	143	14:50	Assure
6.	**Innovation**				
6.1	Trust Improvement Plan - Patient First Programme; Operational Update	Chief Operating Officer (Interim)	147	15:00	Note
7.	**Our People**				
7.1	People Committee Assurance Report. Meeting date: 20.05.21	Chair of Committee/ Chief People Officer	167	15:10	Assure
8.	**Any Other Business**				
8.1	Council of Governors Update	Lead Governor	Verbal	15:20	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: 08 July 2021, 12:30 – 15:30				

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – June 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

I am pleased to say the number of COVID-19 inpatients has been in low single figures for several weeks now, with no patients in critical care on most days.

We have eased some of the restrictions on visiting, recognising how important this is to patients and their loved ones. Our restaurant and coffee shop remain open for staff only at this stage, but patients and visitors can purchase food and drink from the League of Friends shop in the main entrance.

We have restarted elective surgery and surgery for cancer patients, outpatients and diagnostic services and are working hard to reduce the backlog.

On 17 May, the country moved to the next stage of lockdown, with more restrictions being lifted. This remains a time to be cautious and it is as important as ever that we maintain social distancing, hand hygiene and mask wearing.

Care Quality Commission

Over the last month we have welcomed the CQC back to the Trust and our staff have enjoyed the opportunity to speak proudly of the care they provide, as well as being open and honest about the challenges that they face.
So far, the CQC has carried out reviews of medical and older persons' care, infection control, children and young people's care and a well-led review.
We are expecting to receive a formal report in June/July, and I will of course ensure you are informed of their findings.

Celebrating research at the Trust

We were very proud to officially unveil the DNA (Deoxyribonucleic Acid) Helix and Research and Innovation artwork on International Clinical Trials Day. The artwork was created as a visual display to increase the awareness of research specialties within the Trust, to celebrate our successes and to encourage greater participation in future projects.

The DNA Helix was chosen as the symbol as it is the molecule that carries the genetic instructions in all living things and is responsible for the development, functioning, growth and reproduction of all known organisms, including humans and viruses.

For the past eight years, Medway NHS Foundation Trust has had the highest number of patients participating in clinical research in the Kent, Surrey and Sussex region and is recognised at national and international level.

By participating in research, the Trust offers our patients novel and up-to-date treatments. For example, during the COVID-19 pandemic, we saved many lives by offering experimental treatment such as Dexamethasone (part of the RECOVERY trial), which was subsequently adopted as standard treatment

Special thanks to Iram Ahmed, Edyta McCallum the Medway Hospital Charity and other colleagues involved in the installation and Tony van de Bospoort and his team at the Hospital Art Studio for creating and installing such a striking piece of art.

We are proud of the Trust's research successes and would like to thank members of the public and our patients for their support, as without them, we would not be able to function.

Developing a sustainable Medway for the future

As one of the biggest employers in the area, and Kent's busiest hospital site, it is really important that we take our environmental impact seriously – like all large organisations we need to improve the efficiency and resilience of the services we offer.

That's why I am really pleased to let you know that we have launched our Green Plan which aims to improve our organisational performance in this area to deliver environmental, social and financial benefits.

You can read the Green Plan in full on our website.

Celebrating our nurses, midwives and ODPs

Every May we take a moment to celebrate our nurses, midwives and operating department practitioners and the fantastic work that they do for our community.

They work around the clock, to provide care of the highest quality and we are incredibly proud of the difference they make to our patients' lives.

Autism reality experience

We were really fortunate to be able to host a special autism reality experience last month. We know that being in hospital can be a particularly challenging time for people with autism and learning disabilities, and this innovative training experience (kindly funded by our Innovation Institute) gave a sense of what living with autism can feel like; Karen McIntyre, our Associate Director of Patient Experience spoke about her experiences of doing the training; you can watch this here.

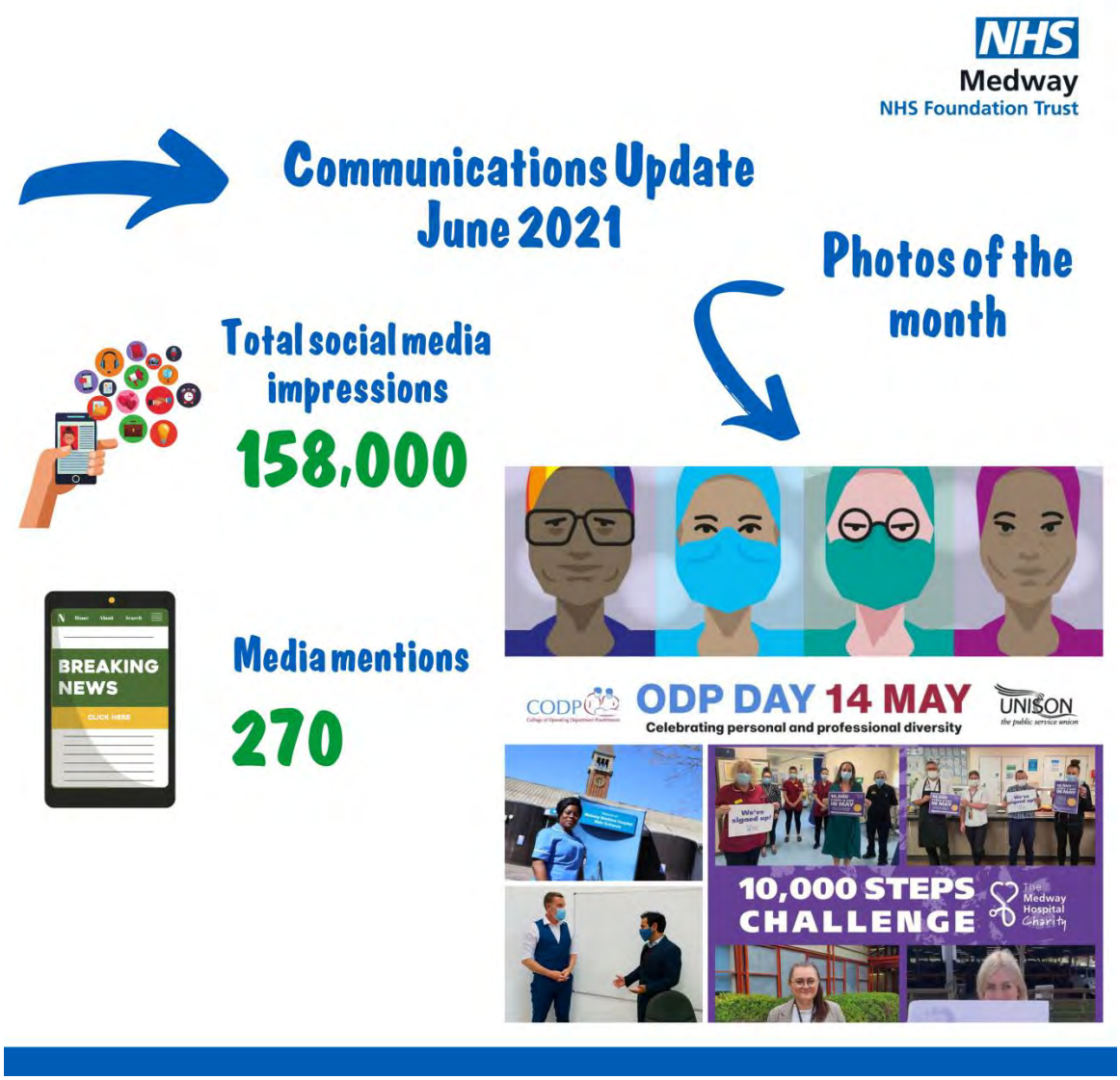
Remembering our organ donation heroes

It was great to see the installation of our Organ Donation 'Hero Wall Plaque' in the Atrium in May – this adds to the spectacular 'Gift of Life Wall' artwork which is already on display in dedication to all those who have selflessly become organ donors.

Thank you to Dr Gill Fargher, Trust Organ and Tissue Donation Committee Chair, who oversaw the installation with the help of Hospital Artwork Studio. Gill's late husband Tristan Lewis, who worked at the hospital, will be the first person to be commemorated. Tristan died in 2015 and consented for his organs and tissues to be donated, including both of his corneas, which allowed two people to regain their sight.

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.



Minutes of the Trust Board PUBLIC Meeting

Thursday, 06 May 2021 at 12:30 - 15:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Alan Davies	Chief Finance Officer
	Annyes Laheurte	Non-Executive Director
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	David Sulch	Chief Medical Officer
	George Findlay	Chief Executive (Interim)
	Gurjit Mahil	Deputy Chief Executive
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Chief People Officer
	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
	Harvey McEnroe	Chief Strategy and Integration Officer
	Jenny Chong	Associate Non-Executive Director
	Paula Tinniswood	Chief Staff Officer (Interim)
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	Carol Atkins	Medical Education Manager
	David Seabrooke	Company Secretary
	Gary Knowles	Simulation Team
	Gemma Dockrell	Clinical Simulation Operational Manager
	Ginny Bowbrick	Deputy Director of Medical Education
	Glyn Allen	Lead Governor
	Janette Cansick	Director of Medical Education
	Manisha Shah	Simulation Lead
	Sheila Adam	NHSEI Improvement Director
Observing:	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
Apologies:	Adrian Ward	Non-Executive Director

	Ewan Carmichael	Non-Executive Director
	Sue Mackenzie	Non-Executive Director

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 and hoped this would not be for much longer. Chair welcomed the Board and particularly its guests as listed above, who were observing the meeting.

a) Chair was delighted to introduce the Trust's new Chief Executive, Dr George Findlay, who joined this week and is attending his first official Board meeting. She also welcomed Katie May Nelson, Local Democracy Reporter for Medway, who is once again observing the meeting. Today the Board also looks forward to hearing from the Medical Education/Simulation team who are going to give a presentation; it is good to see colleagues from that team. Medical education is such an important area within a hospital, the Trust is fortunate to have a very strong team here at Medway.

b) Since the April meeting the number of inpatients with Covid-19 has continued to reduce and the hospital hopes to not see a further increase, although the team is prepared in case there is a summer spike.

c) Chair thanked the community for observing the government rules and guidance during the lockdown which has helped reduce the infection rate. This has also been helped by the successful vaccination programme that the Trust has been proud to rollout. Almost 37,000 people have received their vaccination in the hospital which is a tribute to the Trust's excellent team.

d) Chair stated that it has been heartening to know that more patients have been able to have their elective surgery and diagnostic and outpatient appointments, and also to have been able to allow visitors back on site, albeit with some restrictions still in place.

e) Following the last meeting the Trust was notified that the Care Quality Commission would be carrying out inspections of core services and infection prevention and control measures, and also reviewing leadership under what is known as the 'Well Led' domain. In the past week the CQC have visited twice and you will hear more about this from George in his update. The CQC will return before the end of the month, and hopefully will note further improvements in a number of areas. On behalf of the Board Chair conveyed her thanks to the teams who welcomed the CQC team and spoke with pride about the care they provide and achievements in their services. The Board is aware from the feedback that colleagues spoke with confidence, openness and honesty, and for that we thank them. The Board will hear final findings in due course.

1.2 Quorum

The meeting was confirmed to be quorate with at least one-third of the whole number of the Directors (including at least one Executive Director and one Non-Executive Director) being present.

1.3 Conflicts of Interest

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

1.4 Chief Executive Update

George Findlay, Chief Executive (Interim), 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) George stated that he was incredibly proud to have taken over from James Devine as Interim Chief Executive of the Trust and he thanked him for his achievements to date and to everyone for the very warm welcome that he had received.
b) Although he has only been at the Trust for a few days it is already apparent that we have a skilled and compassionate workforce. There is a real drive for improvement. This is a very important time for the Trust as we enter the second phase of our improvement programme and restart our services following the second wave of the pandemic, but there is no doubt that with such a committed and positive group of staff, and the support we enjoy from our community, we will meet the challenges. There are only four patients who are covid positive today.
c) A good deal of work has already taken place to improve the quality of care for our patients and my aim now will be for us to build on these foundations and make a real difference to patient experience as the Trust continues to drive improvement across the hospital. The challenge is to change the pace of change now.
d) Many of you will know that I have a clinical background and one of my key aims will be to continue the work already started in making the Trust more clinically led, putting our clinical colleagues at the heart of decision-making to enhance patient outcomes. There is a lot of work to do and I am looking forward to getting started. Managerial/leadership excellence is just as important.

1.4.2 COVID-19

a) Gorge Findlay was really pleased to say that we have now resumed our surgical, diagnostic and outpatient services, and in a further important step, relaxed some of the visiting restrictions that had been in place. It is difficult it is to be unable to see a loved one when they are in hospital and he thanked the community for their patience during this really challenging time. As we continue to see more members of the public return to our site, he reminded everyone of the importance of wearing masks, using the hand sanitiser provided and socially distancing when in the hospital.

1.4.3 Supporting our staff

a) As an NHS Trust it is our job to look after the members of our community, and it is a job that we take extremely seriously. But we also have to make sure we look after those who are doing the caring. An important part of this is listening and responding to staff feedback. We have a number of mechanisms to enable to staff to provide their feedback, one of which is the national Staff Survey.
b) While there are teams where morale and engagement are strong, with good leadership and a positive culture, there are also areas where we know this is not the case. We want all colleagues to feel supported and he was determined to tackle issues that are affecting how they feel about coming to work.
c) There are already a number of initiatives in place to improve our culture – for example we are putting a greater emphasis on staff wellbeing, and we have our Change Team, a group of colleagues who have volunteered to be part of creating a more positive future. We know we still have more work to do but in the coming months he will be focused on working with all staff to make the Trust an even better place to work. We have some real challenges and focus to improve on morale within the team and would like to significantly move this forward in the next 12 months.

1.4.4 Care Quality Commission

a) There have been a number of improvements in recent months, thanks to colleagues across the Trust. Actions have been implemented to address issues highlighted by the Care Quality

Commission, including ambulance handover times, and waits within the Emergency Department, and I am pleased to say these continue to improve.

b) On 28 April there was a core service inspection and on 05 May an inspection with a focus on IPC. It is great to hear feedback from inspectors they said they enjoyed being at the hospital – this is a reflection on how well our staff did during inspections. They said what they were proud of what they have achieved and what challenges they face. There were no serious issues raised but small items to address.

1.4.5 10,000 step challenge

a) I have already mentioned the great support we have from our community and that has been reflected in the number of people signing up to take part in our 10,000 step challenge in May. All money raised from this event will be used to enhance staff rooms and clinical areas at the hospital. Thank you to everyone who is getting involved.

1.4.6 Charlie and Me

a) George Findlay said he is always looking for areas of praise alongside areas for improvement and was very proud to say that Hospital Radio Medway has won the Best Speech Package or Special Event award at the National Hospital Radio Awards. This award is designed to showcase the power of speech through the medium of radio.

b) The winning documentary is about a man called Charlie from Sittingbourne who battled Covid-19 last year and was cared for at the hospital. It is narrated entirely by his family and friends who speak very highly of the care he received here at the hospital.

c) He had heard a lot of great things about the support provided to the Trust by Hospital Radio Medway and The Medway League of Friends and looked forward to working with them in the coming months.

d) To close, he said he is looking forward to the coming months and years ahead at the Trust.

1.4.7 Chair thanked George for his update and welcomed him to the Trust

1.5 Clinical Presentation – Medical Education Team – Medical Education Initiative and Development of Virtual Reality Training

1.5.1 Ginny Bowbrick, Deputy Director of Medical Education, gave some background to the team and the Medical Education Initiative and Development of Virtual Reality Training and handed over to the Simulation Team.

1.5.2 Gary Knowles gave his presentation on the Simulation Suite and gave the Board a virtual tour. It was a virtual scenario of a patient in the hospital giving medical students the opportunity to work in the simulation suite virtually. It would then take the students on to a feedback session.

1.5.3 360 films is an immersive way to train by viewing and exploring the environment around them. It is highly accessible so is a step forward. For example, this means that international nurses to have potential to explore the hospital virtually prior to working.

1.5.4 Manisha Shah, Simulation Lead, gave a presentation which included:

a) Healthcare Education
b) NHS Patient Safety
c) Funding
d) Medway Branding

1.5.5 Rama Thirunamachandran stated that this work is part of the future and is really promising to see such positive steps towards this. There has been lots of positive feedback from the University students who have their placements at Medway. He encouraged the team to continue with joined up working, sharing expertise will help.

1.5.6 Manisha confirmed that joined-up working is in the planning with a focus on the medical school. She confirmed that there are discussions on trainees returning to work and she has negotiated local training with experts.

1.5.7 Jenny Chong stated that the team are multi award winning, high engagement, technological advances but with a personal connection to people on the training. It is a state of the art simulation and a huge contribution to the future of the Trust. She thanked the team for their work as they are being modest about their achievements. She invited Harvey McEnroe to raise the profile with system partners and encouraged the Board to take part in the simulation process at some point.

1.5.8 Chair stated that the team deserves the recognition they are getting and thanked them for attending. The Board would be delighted to visit the team now restrictions are easing.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 15 April 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 actions:
TBPU/21/112, 116, 117, 119, 120, 121 and 122

a) The Board asked Harvey McEnroe for the 90 Day Recover Plan to be submitted to the June 2021 meeting.

3 Governance

3.1 Board Assurance Framework

Gurjit Mahil, Deputy Chief Executive, presented to the Board for noting.

a) A summary of the BAF as the 26 April 2021 was presented in the paper including the Trust's principal risks;
   1) 3a – Delivery of financial control total
   2) 3b – Capital Planning
   3) 4a – Sufficient Staffing – Clinical Areas

b) Tony Ullman asked that the Integration Risk; the owner of the risk needs to change, the risk needs updating and for this risk to be taken through QAC.

3.2 Quarterly Risk Register Review - Risks relating to capital programme; risks from increased ED attendances

Gurjit Mahil, Deputy Chief Executive, presented to the Board for noting and assurance regarding the processes in place around risk management.

a) The corporate risk register included 20 risks assigned to Executives with a number of divisional risks scoring 15+ linked to these. In January 2021 these risks were unlinked and presented on the register in their own right, making a total of 52 risks on the corporate risk register. The risk appetite was agreed by the Board and risks scoring 16+ would be presented to Risk Assurance Group for discussion and approval prior to being added to the corporate risk register. The existing 32 unlinked risks were to be reviewed at deep dive meetings.

b) During February and March 2021 deep dive meetings took place with the Divisions to review their high scoring corporate risks. At the March Risk Assurance Group all risks were reviewed. The work taken place has resulted in the reduction of the number of risks on the corporate risk register to 28. Still some work to do but it is an improving position.

c) Page 45 shows the principal risks. They are recognised at the Executive Team and Risk Assurance Group meetings. Controls and mitigations are in place but updates are needed to be given to the corporate teams to ensure risk ratings are reviewed.
d) Chair stated that this is a big step forward and there is more clarity around risks. She asked Gurjit to work ranking the top eight risks
e) Gurjit confirmed she would do so and would circulate a ranked list of risks post the Executive Group meeting. A report would come back to the June Board meeting. *[Post meeting note: email sent to Gurjit to remind her to do this and agenda item was added]*

3.3 Integrated Audit Committee. Assurance report Meeting on 30.04.21

Mark Spragg, Chair of Committee/NED, presented to the Board for assurance. The paper was taken as read.

a) There were no matters to escalate to the Board or other Committees.
b) The Chair thanked Mark for the Committees report and work.

3.4a Kent and Medway Integrated Care System - Restart

Harvey McEnroe, Chief Strategy and Integration Officer, presented for noting.

a) As part of the resubmission for the ICS accreditation process, the Sustainability and Transformation Partnership (STP) was asked to identify its immediate strategic priorities for the system.
b) The nine improvements and development priorities are the key focus of the ICS, and will be the means by which the effectiveness of the system will be assessed, both internally and externally. The delivery of these priorities will be overseen by the STP/ICS Executive Group, supported by relevant sub-committees.
c) Regular progress reports will be provided to the STP/ICS Partnership Board. The paper provided the Board with an overview of the strategic priorities.
d) Work is happening to review priority set with the Executive as discussed early in the meeting. More work to follow to align 2021/22 work to the strategic priorities.
e) Chair stated that the county Chairs have been paired with workstream leads to enhance system relationships and to drive cross-system working. There are briefing sessions for NEDs to understand system plans. This will encourage more collaborative working across Kent & Medway and there are opportunities to do so.

3.4b ED Performance; Root Causes

Angela Gallagher, Chief Operating Officer (Interim), gave a verbal update to the Board for noting.

a) There is additional resource in place for the ED team. Angela is ensuring that they are engaged to go through issues and to assure them that as an Executive team that the issues are understood. Also that their involvement in the improvement work is very much welcomed.
b) The key issues from the ED team were the feeling that the emergency flow was left to ED to manage. Angela has addressed this through subsequent actions and the patient first programme

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. The paper was taken as read with the following key highlights:

a) Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting.
    1) Increase in C-Section rates, this has been noted through the IQPR and submitted to the Quality Assurance Committee. Further work is required to go back to the Committee

and into the assurance report to Board. Chair asked that the focus is on what is causing the increasing numbers.
2) Falls remain below national average but remains a focus
3) Pressure ulcers, there has been one patient which is the first in a year.
4) Mixed sex accommodation is an area of concern but improvements expected.

b) Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting.
1) DM01 is currently at aggregate of 95 on course to improve for April 2021. Currently there are 389 patients waiting over six weeks compared to 1,000 in January. The teams have worked extremely hard to reduce this number and manage the backlog.
2) ED four hour performance; there are gradual improvements, including the overall improvement of the patient experience.
3) The issues relating to ED performance during Covid-19 have been improved such as 12 hour trolley breaches and waiting times.
4) Improvements have been made with the ambulance handover times. The entire team has had input into this work which has been addressed with interventions and there are resilient initiatives to maintain this improvement work.
5) RTT and Elective Pathways; all elective pathways are up and running. There are still some capacity issues whist the team deal with long wait and emergency cancer patients. The 52 week wait backlog is gradually making a decline as expected.
6) The Cancer 62 day pathway breach suffered the most during suspended activity. The Cancer Improvement Plan focuses on this work. Trajectories are in place but they can be improved on. Treatments for cancer patients are being booked in as quickly as possible.

c) David Sulch, Chief Medical Officer, presented to the Board for noting.
1) COVID-19 patients are excluded from the HSMR, but the impact the second wave may have had on care provided to other patients would still affect the HSMR. While the Trust's HSMR has risen for the last three months, there has been no change in the crude mortality rate over that period, which provides some reassurance
2) George Findlay stated that the detail of the 'learning from deaths programme' would give the Board some assurance. The coding would be useful to see as the Trust recovers. Chair asked that the item is added to the June Board agenda.

d) George stated that he would like to encourage a higher reporting culture and would work with Gurjit Mahil on improvements in reporting.

4.2 Quality Assurance Committee Assurance Report. Meeting on 28.04.21

Tony Ullman, Chair of Committee/NED, presented to the Board for assurance. The paper was taken as read.

a) The Committee escalated the following to Trust Board:
1) The paper on patients with acute mental health, in particular within Paediatrics and patients in ED. The Committee noted that more work is taking place to improve the pathway.
2) ED department and flow pressures.
3) Quality assurance visits for NEDs at the hospital was circulated by Jane Murkin, Tony encouraged the team to attend when they are able to do so.

4.3 Infection Prevention and Control

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting the progress to date in the IPC Improvement Plan.

a) Following the IPC visit by the National Team on 26 November 2020 an action plan setting out the key actions to address the following three areas was created aimed at reducing hospital

acquired infections: Leadership and Governance, Prevention of Transmission and Prevention of Infection. The Trust's previous IPC Improvement Plan was 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 plan also incorporated actions relating to gaps identified from the updated Infection Prevention and Control (IPC) Board Assurance Framework (BAF).

b) 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. The paper detailed the criteria.
c) Since the visit significant progress has been made to address the issues identified and related actions with infection prevention and control remaining a high priority.
d) Covid-19 inpatient levels are now at the lowest for 12 months and the Trust continues to monitor other Healthcare Acquired Infections.
e) Recruitment within the IPC team remains a priority to provide the infrastructure required and sustainable changes within the Trust.
f) Mark Spragg asked Jane to consider if the hospital became extremely busy again would it be as safe as it currently is. Jane took this comment to consider.
g) George stated that resilience is a mark of a good system. He would like better visibility of quality risks so the team can mitigate things quickly that may go off track. He would work with Jane to ensure that the challenge is responded to.

4.4 Midwifery Staffing

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board and was asked to review and approve the recommendation in response to Birth rate Plus and to sign off the PID for the new post of Director of Midwifery role which has been previously approved, to strengthen Midwifery leadership.

a) The paper was previously submitted to the Executive Group on 21 April 2021. The Executive Group approved the post of Director of Midwifery and 13 WTE midwifery posts in response the continuity of the carer Birthrate Plus review, acknowledging the funding stream is to be confirmed.
b) In addition, the Executive Group noted the request for the Birthrate Plus essential leadership and specialist roles. The Executive requested a further risk scoring before review and approval.
c) Mark Spragg as NED Lead on Maternity stated that he has met with the Midwifery team in an informal setting to discuss any concerns they had. There were very little raised and the ones they had can be addressed by themselves. One area of concern was staffing, it is a fantastic service but the department does need additional funding. He believed that there is no compromise on this and urged the Executive to find the finances for this.
d) Alan Davies confirmed that this is one of the service developments captured within the financial planning and is high on the list of priority risks. It is likely to get the funds it needs. There is a follow up meeting with the Executive to discuss the financial plans on 07 May 2021. He needs to ensure that it aligns with the corporate risk register. Jane Murkin should review the maternity risk with Gurjit Mahil. **ACTION TBPU/21/123:** Jane Murkin
e) George stated that this is a key area of focus but more work needs to be done to understand the resourcing issues. The Executive will look at where we are with recruitment and how we are going to get there. He would like this work to move forward with a blended view from a nursing point of view.
f) Chair proposed that the Board approved the principles in the paper subject to the Executive resolving the issue with affordability, if it needs to be reprioritised, then resubmit to the Board.
g) The Board APPROVED subject to this caveat.

5 Strategy and Resilience

5.1 The Green Plan

Gary Lupton, Director of Estates and Facilities, presented to the Board for approval. The paper was taken as read and Gary gave some background from the report as to why the plan is in place and how it impacts on the hospital's carbon footprint, waste output and finances.

a) The Green Plan was written to comply with the NHS Standard Contract, which mandates that all healthcare services are required to have a Board approved Green Plan. Plans are seen as evidence of a well-led organisation that is committed to local public health outcomes by NHSEI. At present the Trust does not have an existing Green Plan or the former policy known as a Sustainable Development Management Plan.
b) The Green Plan outlines the Trust's visions, strategy and objectives for delivering sustainable healthcare for 2021 to 2026. The Green Plan is underpinned by a delivery plan that provides actions to be taken relating to each module of the Sustainable Development Assessment Tool (SDAT). In order to assist the delivery of this plan, timescales and responsibilities have been specified for each action. Areas of priority are provided, which has been influenced by stakeholders' feedback to guide future decision making at the Trust.
c) This paper requested approval for the Trust's newly drafted Green Plan to:
    1) Identify clear actions to drive forward sustainable healthcare
    2) Achieve cost savings in areas such as utilities, waste disposal and transport
    3) Improve the health of the local community
    4) Meet legislative and policy requirements
    5) Provide the required evidence that the Trust is effectively managing sustainability and enhancing social value when bidding for work.
d) Gary stated that this will be a live plan for the next five years and asked for the Board to approve.
e) Chair gave her thanks to Gary and the team for their work on this especially Jessica Brown, Sustainability and Business Performance Manager, who leads on this work. There is a lot of colleague advocacy for this work and the boundaries do not have to stop within the hospital. Chair will nominate a NED Champion for the Green Plan work. **ACTION NO: TBPU/21/124: Jo Palmer**
f) Chair asked Gary to consider how the Trust holds itself to account for the improvements as this information is also included in the annual report. She suggested an independent accreditation from the Carbon Trust and support for RE100
g) Gary confirmed that the ICS are keen to see the plan and are agreeing some principles across the system, there will be collaboration with others.
h) The Board **APPROVED** the Green Plan and for work to continue to deliver to the targets.

6 Financial Stability

6.1 Finance Report - Month 12

Alan Davies, Chief Finance Officer, presented to the Board for noting. The paper was taken as read.

a) The Trust reports a full year surplus, which adjusts to breakeven against the NHSEI control total.
b) CIP: Schemes delivered for the year totalled £8.8m, this being £3.2m adverse to the plan of £12.0m. The main schemes that delivered were related to the full year effect of schemes from 19/20, reduced orthopaedic insourcing costs, as well as procurement and pharmacy savings from nationally agreed prices.
c) Capital: The final capital position for 2020/21 is in line with our resource limited at £317k underspent, thanks to Gary Lupton and his team.
d) Cash: High levels of cash reserves have been maintained in month due to £6m of payments in advance from commissioners and much higher than expected un-invoiced costs across revenue and capital.
e) Pay costs: Total pay costs have increased in month by £3.2m to £24.4m. The actual underlying in-month cost position is £21.2m after adjusting for the annual leave carried forward accrual of £2.9m,

in addition to the well-being day of £0.7m, and the release of the pay contingency into the position £0.4m. The position is adverse to budget by £7.0m; of this £1.4m is due to incremental Covid costs, the remainder is predominantly a consequence of the accruals mentioned above as well as the 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. Nursing whole time equivalents have increased significantly since November due to recruitment and training of new staff, the higher establishment has been reflected in the draft budgets for 2021/22. Additional controls are being put into place.

f) Alan presented the draft accounts to the Integrated Audit Committee and they are now going through the audit process. These will be presented to the Board in June.

6.2 Finance Committee Assurance Report. Meeting on 22.04.21

Jo Palmer, Chair of the Committee, presented to the Board for assurance.

a) Chair thanked the Board for convening an extraordinary meeting for the financial planning.
b) At the end of the financial year the team has completed the process of reviewing financial risk. The decision was to highlight, the CIP targets and the risk. Over the last year the focus has been on Covid-19 and not CIP. Going forward there will be a refocus on reinvigorating these and a review at the next Committee.
c) Annyes Laheurte will take over as Chair of the Committee from 20 May 2021. The Trust is grateful for her agreement to take on the role and her commitment. Jo Palmer will stand down but remain an attendee at the meetings.
d) Mark Spragg thanked Jo Palmer for her tenure as Chair of the Committee, the Trust is grateful for her hard work and efforts as Finance Committee Chair over a considerable amount of time.

7 Innovation

7.1 Trust Improvement Plan Update

Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting. The paper provided a progress update on three key and interrelated elements of the Patient First programme.

a) Good progress continues to be made on the programmes; however this is against the context of a particularly challenging period from just before Easter which has seen increased demand on services and deterioration in some areas of performance, flow, notably ambulance handover delays and ED 4 hour performance.
b) Angela suggested that the new Clinical Director and the team attend the August Board meeting with their view on ED and the challenges they meet. The Board agreed.

8 Any Other Business

8.1 Council of Governors Update

Glyn Allen, Lead Governor, gave the Board an update on the Council of Governors for noting.

a) Welcomed George Findlay to the Trust and assured him of the Council's support.
b) Sophie Causey is the new Engagement Officer and Kim Willsea is the new Governor Officer.
c) The Governor election has 20 candidates for 13 vacancies. Elections close on 13 May with results to be declared on 14 May 2021.
d) There was a successful Members' Event on Patient Experience in April. Innovation is the topic for the next event.
e) Meet the Governors event will be held virtually on 18 May 2021.
f) Chair thanked Glyn as Lead Governor and the other governors who standing down on 30 June; there will be a date in the diary to mark the end of their terms.

8.2 Questions from the Public

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

8.3 Any Other Business

There were no matters of any other business.

8.4 Date and time of next meeting

The next meeting will be held on Thursday, 03 June 2021, 12:30 – 15:30.

The meeting closed at 15:00

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 06 May 2021

Signed …….. Date ……
Chair

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
15-Apr-21	TBPU/21/118	Submit the Patient Experience Strategy to the Board, agree with David Seabrooke when.	08-July-21 ~~06-May-21~~	Jane Murkin, Chief Nursing and Quality Officer	**Bring final version to the July Board**	White
06-May-21	TBPU/21/123	Review the Maternity risk rating with Jane Murkin	03-Jun-21	Jane Murkin, Chief Nursing and Quality Officer		
06-May-21	TBPU/21/124	Select a NED Champion for the Green Plan work	03-Jun-21	Jo Palmer, Trust Chair	**Propose to close -** Jo Palmer will be the NED Green Plan Champion	Green

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	3.1
Report Author	Jane Murkin – Chief Nursing and Quality Officer David Sulch – Medical Director Angela Gallagher – Chief Operating Officer		
Lead Director	Jane Murkin – Chief Nursing and Quality Officer Gurjit Mahil – Deputy CEO		
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 March shows that the Trust has had 0 MRSA bacteraemia cases and 4 hospital acquired C-diff cases. January's overall HSMR rate is 106.79; the weekend HSMR rate is at 112.74 and links to risks during the weekends with Bed Occupancy. **Caring** Unfortunately, whilst MSA had shown improvement, April has seen that 104 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 for three areas, remain close or above the national standard of 85% (ED: 81.78%, Maternity: 100%, Outpatients: 89.64%). The inpatients recommended rates have reduced to 79.07%, the feedback received is currently being under review to identify themes. **Effective** Discharges before Noon, whilst close to the Mean are still below at 16.26% and significantly below the Target of 25%, this is being reviewed through the Patient First work. **Responsive** Due in part to the lower discharges before noon rate and the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 63.07%. The number of patients breaching 52 weeks is still high; however the April 2021 figure of 500 is lower than previous months in line with the restart of elective activity within the Trust. ED (Type 1) 4 hour performance as a result of site pressures reported 73.20% in April. Additionally, the Trust saw 160 Ambulance Handover delays of +60mins.		

	The DM01 Diagnostics performance is at 94.74% for April 2021. In March 2021, 97.55% of patients were seen within 2 weeks of their referrals into the cancer pathways and 71.43% of patients were treated within 62 days. **<u>Well Led</u>** We have seen an increase in appraisal rates, reporting 85.09% and the Trust has maintained compliance statutory and mandatory training at 89.03%. 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 November – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing January data, this is reliant on D r Foster and this is 3 to 4 months in arrears. • The bed oc cupancy includes all beds within the Trust including maternity and paediatrics.
Resource Implications	None
Legal Implications/Regulatory Requirements	State whether there are any legal implications
Quality Impact Assessment	Not required.
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.

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

Appendices	Appendix 1 – IQPR – April 2021

NHS
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Integrated Quality and Performance Report

Reporting Period: April 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.

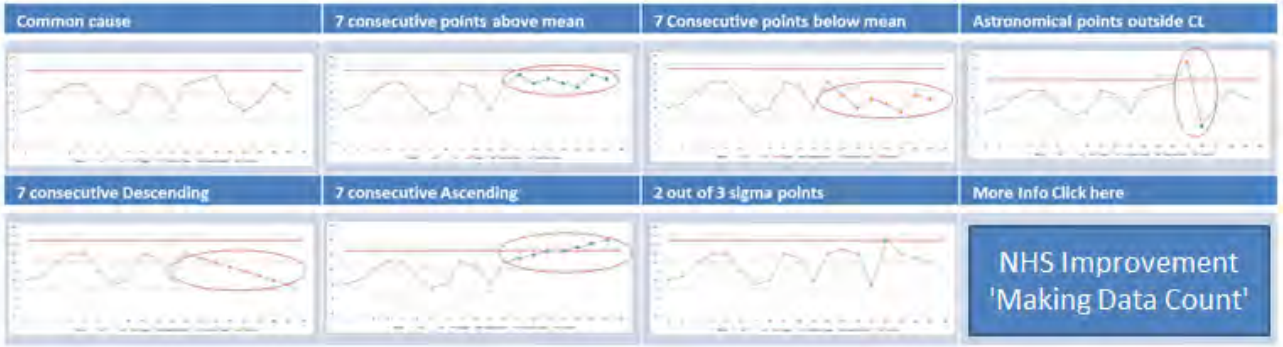
Key Facts about a SPC Chart:

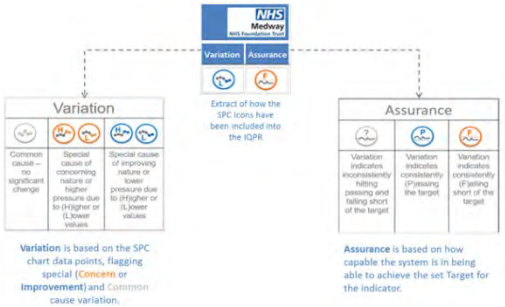
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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:





NHS
Medway
NHS Foundation Trust

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls) & Caring	• Flow & Elective Pathways
Caring	• The Friends and Family recommended rates for Maternity services, Outpatients and ED are above the national standard of 85%. IP FFT rates, whilst not meeting plan, has remained very close to target.	• High number of breaches in Mixed Sex Accommodation continues into March, although early signs of improvement again • 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 • Maternity 12+6 Risk Assessments, whilst still slightly under target, has shown improvement and remains very close to achieving	• 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 and Sis response rate is 100%	• Infection data shows spikes in C-Diff cases throughout February and March • Overall HSMR levels have risen, again, and are still above the national threshold (100)
Responsive	• Cancer 2ww Performance has exceeded the target • 60+ Min Ambulance Handover delays are significantly down from levels seen over Winter, as to are +12 Hour DTA Breaches in ED, with 0 reported	• DM01 Diagnostics performance has dropped • ED 4 hour performance remains under LCL • RTT Incomplete Performance decreased and is again slightly below LCL. +52wk breaches has also seen an increase above UCL
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 spend has stabilised in month but bank spend has increased considerably • 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			
		(L)	(H)	(L)	(H)	(P)	(F)	(?)	●
Caring									
Admitted Care	4	1	0	0	0	0	1	4	0
ED Care	1	0	0	0	1	0	1	1	0
Maternity Care	1	0	0	0	1	1	0	1	0
Outpatients Care	1	1	0	0	0	1	1	0	0
Effective									
Best Practice	2	0	2	0	1	0	2	3	0
Maternity	0	0	3	0	1	0	3	1	0
Safe									
Harm Free Care	2	0	0	0	0	2	0	0	0
Incident Reporting	2	0	0	0	1	1	0	1	1
Infection Control	3	0	0	1	0	3	0	0	1
Mortality	4	0	1	0	0	0	1	4	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	3	1	0	0	0	0	2	2	0
Elective Access	0	1	2	0	0	0	2	1	0
Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Well Led									
Staff Experience	0	0	0	0	2	0	2	0	0
Workforce	3	0	2	1	2	0	0	7	1

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Mar-21	3	0	43	27		
S2	Number of C-diff (HAI)	Mar-21	0	4	0	26		-
S3	MRSA Bacteraemia (Trust Attributable)	Mar-21	0	0	5	1		
S4	E-coli (Trust Acquired)	Mar-21	2	5	30	44		
S5	Falls per 1000 bed days	Apr-21	6.63	4.48	6.63	5.18		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Apr-21	1.04	0.00	1.04	0.03		
S7	Never Events	Apr-21	0	0	0	2		
S8	% of SIs responded to in 60 days	Apr-21	100%	100%	100%	100%		-
S9	HSMR (overall)	Jan-21	100	106.79	100	100.58		
S10	HSMR (weekday)	Jan-21	100	104.76	100	97.69		
S11	HSMR (weekend)	Jan-21	100	112.74	100	108.87		
S12	SHMI	Nov-20	1	1.05	-	-		

Caring		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Apr-21	0	104	0	1257		
C2	New Complaints	Apr-21	41	43	-	575		
C3	% Complaints responded to within target	Apr-21	85%	58.33%	85%	66.47%		
C4	% EDNs completed within 24 hours	Apr-21	100%	70.72%	100%	69.48%		
C5	Inpatients Friends and Family Response rate	Apr-21	22%	18.36%	22%	18.92%		
C6	Inpatients Friends and Family % recommended	Apr-21	85%	79.07%	85%	82.18%		
C7	ED Friends and Family Response rate	Apr-21	22%	15.41%	22%	15.81%		
C8	ED Friends and Family % recommended	Apr-21	85%	81.78%	85%	84.59%		
C9	Maternity Friends and Family Response rate	Apr-21	22%	25.07%	22%	29.75%		
C10	Maternity Friends and Family % recommended	Apr-21	85%	100.00%	85%	99.65%		
C11	Outpatients Friends and Family Response rate	Apr-21	22%	8.79%	22%	11.71%		
C12	Outpatients Friends and Family % recommended	Apr-21	85%	89.64%	85%	89.20%		

Responsive - Non-Elective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Apr-21	85%	80.09%	85%	79.91%		
R2	Average Length of stay (Non-elective)	Apr-21	5	23.11	5	9.31		
R3	Average Length of stay (Elective)	Apr-21	5	2.11	5	2.56		
R4	% of Delayed Transfers of Care	Apr-21	4%	0.73%	4%	0.38%		
R5	% Medically Fit For Discharge	Apr-21	7%	11.73%	7%	10.44%		
R6	ED 4 hour performance (All)	Apr-21	95%	82.97%	95%	84.72%		
R7	ED 4 hour performance (Type 1)	Apr-21	95%	73.20%	95%	75.42%		
R8	ED 12 hour DTA Breaches	Apr-21	0	2	0	420		
R9	Ambulance Attendances	Apr-21	-	1,939	-	40,551		
R10	60 minute handover delays	Apr-21	0	160	0	2332		

Effective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Mar-21	5%	6.93%	5%	7.06%		
E2	30 day readmission rate	Mar-21	10%	13.17%	10%	13.48%		
E3	Discharges before noon	Apr-21	25%	16.26%	25%	14.65%		
E4	Fractured NOF within 36 hours	Mar-21	100%	68.42%	100%	72.76%		
E5	VTE risk assessment % completed	Apr-21	95%	92.32%	95%	94.52%		
E6	Elective C-section rate	Apr-21	13%	13.78%	13%	14.77%		
E7	Total C-Section rate	Apr-21	28%	38.92%	28%	37.18%		
E8	Average Occupancy (maternity)	Apr-21	15%	25.14%	15%	22.39%		
E9	12+6 risk assessments	Jan-21	90%	85.42%	90%	87.25%		
E10	Number of deliveries	Apr-21	-	370	-	4970		-

Responsive - Elective		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Apr-21	99%	94.74%	99%	74.59%		
R12	18 weeks RTT Incomplete Performance	Apr-21	92%	63.07%	92%	64.24%		
R13	18 Weeks over 52 week breaches	Apr-21	0	500	0	2984		
R14	Operations cancelled by hospital - on the day	Apr-21	0	5	0	143		
R15	Cancelled operations not rescheduled <28	Apr-21	0	0	0	26		
R16	Cancer 2ww performance	Mar-21	93%	97.55%	93%	96.75%		
R17	Cancer 2ww performance - breast symptomatic	Mar-21	93%	94.83%	93%	94.42%		
R18	Cancer 31 day first definitive treatment	Mar-21	96%	98.48%	96%	96.57%		
R19	Cancer 62 day treatment - GP referrals	Mar-21	85%	71.43%	85%	74.54%		
R20	104 day cancer waits	Mar-21	0	4	-	21		

Well Led		Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	Dec-20	0	8	0		-	-
W2	CIP savings	Dec-20	£1,521k	£851k	£5,978k			
W3	Appraisal %	Apr-21	85%	85.09%	85%	84.40%		
W4	Sickness Rate	Apr-21	4%	3.82%	4%	4.31%		
W5	Turnover rate	Apr-21	12%	11.92%	12%	12.18%		
W6	StatMan compliance	Apr-21	85%	89.03%	85%	88.72%		
W7	Contractual staff in post	Apr-21	-	4195.04073	-	53219.27	-	-
W8	Agency spend as % pay bill	Apr-21	4%	3.66%	4%	3.65%		
W9	Bank spend as % pay bill	Apr-21	9%	11.03%	9%	11.05%		
W10	Overall safe staffing fill rate							

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	Apr-21	0	104.00	0.00	131.16	268.15		
		MSA %	Apr-21	0%	0.78%	0.00%	0.89%	1.83%		
		% of EDNs Completed Within 24hrs	Apr-21	100%	70.72%	67.30%	73.01%	78.73%		
		Inpatients Friends & Family % Recommended	Apr-21	85%	79.07%	77.31%	84.24%	91.18%		
		Inpatients Friends & Family Response Rate	Apr-21	22%	18.36%	15.35%	20.02%	24.68%		
	ED Care	ED Friends & Family % Recommended	Apr-21	85%	81.78%	72.53%	79.86%	87.19%		
		ED Friends & Family Response Rate	Apr-21	22%	15.41%	12.26%	14.74%	17.21%		
	Maternity Care	Maternity Friends & Family % Recommended	Apr-21	85%	100.00%	97.66%	99.37%	100.00%		
		Maternity Friends & Family Response Rate	Apr-21	22%	25.07%	11.52%	26.38%	41.24%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Apr-21	85%	89.64%	87.54%	90.07%	92.60%		
		Outpatients Friends & Family Response Rate	Apr-21	22%	8.79%	11.18%	13.39%	15.59%		

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	Mar-21	5%	6.93%	4.29%	5.91%	7.53%		
		30 Day Readmission Rate	Mar-21	10%	13.17%	9.47%	11.67%	13.86%		
		Discharges Before Noon	Apr-21	25%	16.26%	12.30%	14.97%	17.65%		
		Fractured NOF Within 36 Hours	Mar-21	100%	68.42%	34.99%	65.64%	96.29%		
		VTE Risk Assessment % Completed	Apr-21	95%	92.32%	77.93%	87.57%	97.21%		
	Maternity	Elective C-Section Rate	Apr-21	13%	13.78%	10.01%	13.59%	17.16%		
		Emergency C-Section Rate	Apr-21	15%	25.14%	15.33%	20.05%	24.78%		
		Total C-Section Rate	Apr-21	28%	38.92%	28.64%	33.66%	38.67%		
		12+6 Risk Assessment	Jan-21	90%	85.42%	78.75%	84.31%	89.86%		

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

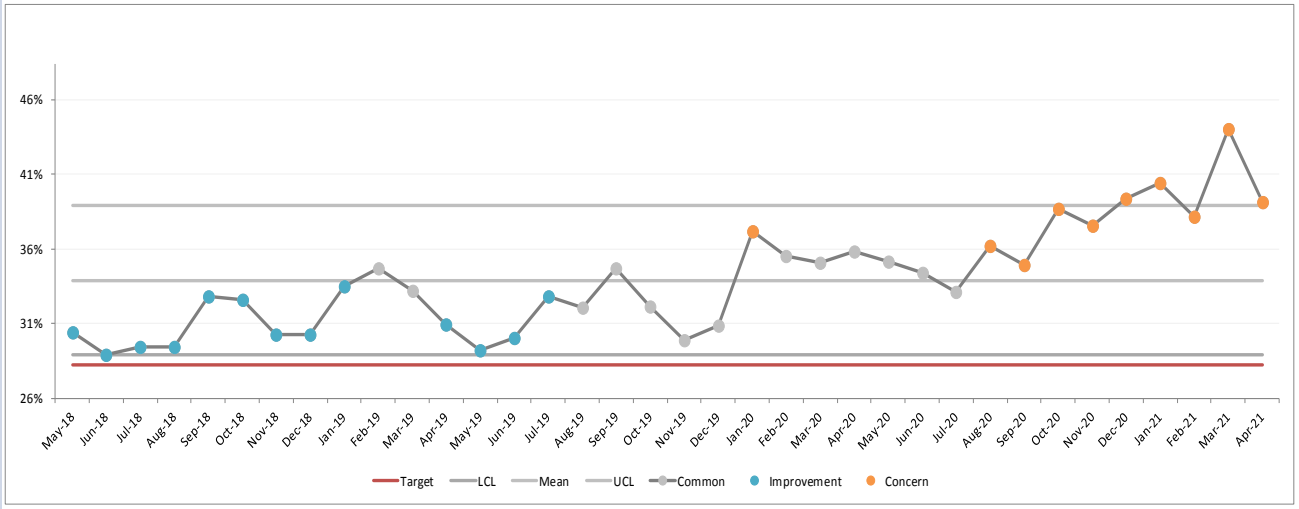
Executive Lead: Jane Murkin – Chief Nursing & Quality Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate

Total C-Section Rate

KPI Target	KPI Actual	LCL	Mean	UCL	V	A
28.00%	38.92%	28.64%	33.66%	38.67%		



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 Nursing & Quality Officer
David Sulch – Chief Medical Officer
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

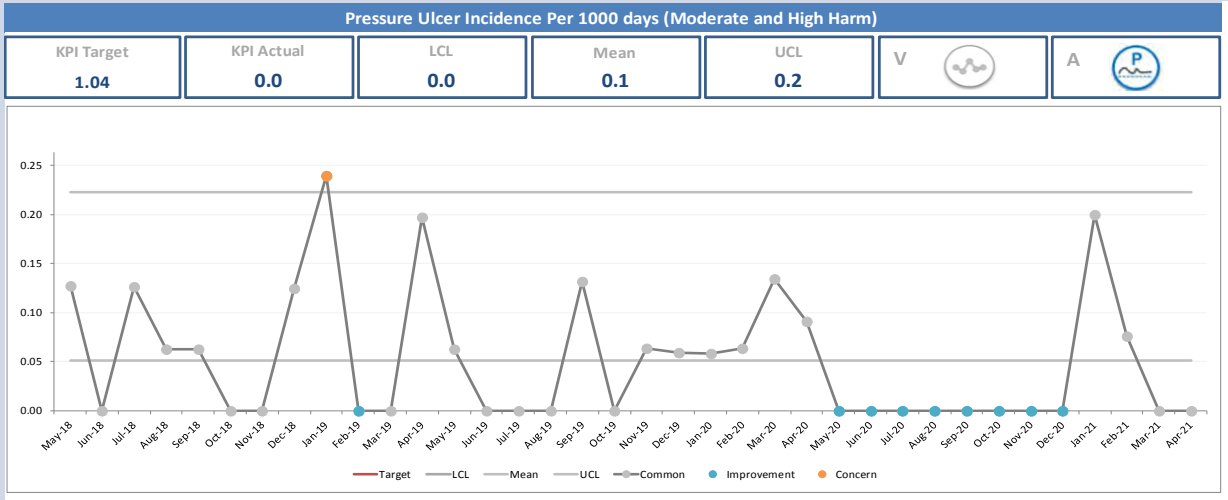
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Apr-21	6.63	4.48	2.94	4.78	6.61		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Apr-21	1.04	0.00	0.00	0.05	0.22		
	Incident Reporting	Never Events	Apr-21	0	0.00	0.00	0.14	0.87		
		No of SIs on STEIS	Apr-21	90	11.00	0.00	13.24	28.02		
		% of SIs Responded To In 60 Days	Apr-21	0%	100.00%	93.79%	98.47%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Mar-21	5	0.00	0.00	0.44	2.19		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Mar-21	43	0.00	0.00	2.46	8.13		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Mar-21	0	4.00	0.00	1.83	6.81		
		E-coli (Trust Acquired) Infections	Mar-21	30	5.00	0.00	4.39	10.54		
	Mortality	Crude Mortality Rate	Mar-21	3%	1.58%	0.43%	1.88%	3.33%		
		HSMR (All)	Jan-21	100	106.79	100.10	104.70	113.97		
		HSMR (Weekday)	Jan-21	100	104.76	97.13	101.89	113.03		
		HSMR (Weekend)	Jan-21	100	112.74	98.84	112.38	127.36		
		SHMI	Nov-20	1	1.05	0.60	0.98	1.37		

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

Executive Lead: Jane Murkin – Chief Nursing & Quality Officer
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?

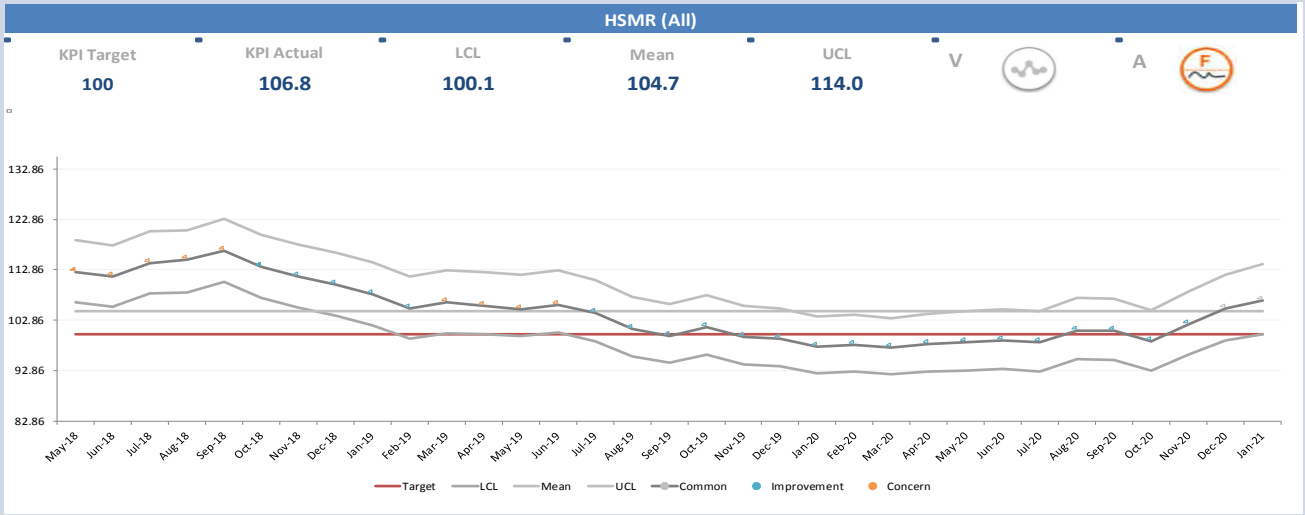
There has been a hospital acquired category 4 and unstageable which are currently being investigated as a SI.

Safe: Mortality
Aim: TBC
Latest Period: January – 2021

Executive Lead: David Sulch – Chief Medical Officer
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 discussed at the Quality Assurance Committee. This review will be extended to Wave 2/3 when the Dr Foster data is available (likely to be by June or July 2021)

What do the measures show?

HSMR showed an encouraging trend until October 2020, 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 fallen from a peak value of 112.3 (the year to July 2019) to a most recent value of 105.5 (the year to November 2020).

Crude mortality at the Trust is very similar to crude mortality for both elective and non-elective patients across all acute non-specialist providers. Overall crude mortality is 3.29% compared to 3.23% nationally

The small rise in HSMR (and all cause mortality) from October 2020 to January 2021 appears on initial analysis to relate to statistical anomalies due to COVID Wave 2/3 (nationally the HSMR has risen by a similar percentage over the same period).

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Apr-21	85%	80.09%	80.38%	87.65%	94.92%		
		Average Elective Length of Stay	Apr-21	5	2.11	1.31	2.39	3.47		
		Average Non-Elective Length of Stay	Apr-21	5	23.11	6.65	8.85	11.05		
		% of Delayed Transfer of Care Point Prevalence in Month	Apr-21	4%	0.73%	0.29%	1.25%	2.21%		
		% Medically Fit For Discharge Point Prevalence in Month	Apr-21	7%	11.73%	13.76%	17.09%	20.41%		
	ED Access	ED 4 Hour Performance All Types	Apr-21	95%	82.97%	75.13%	82.89%	90.66%		
		ED 4 Hour Performance Type 1	Apr-21	95%	73.20%	63.89%	74.34%	84.79%		
		ED 12 hour DTA Breaches	Apr-21	0	2.00	0.00	21.38	76.57		
		60 Mins Ambulance Handover Delays	Apr-21	0	160.00	0.00	120.46	275.40		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

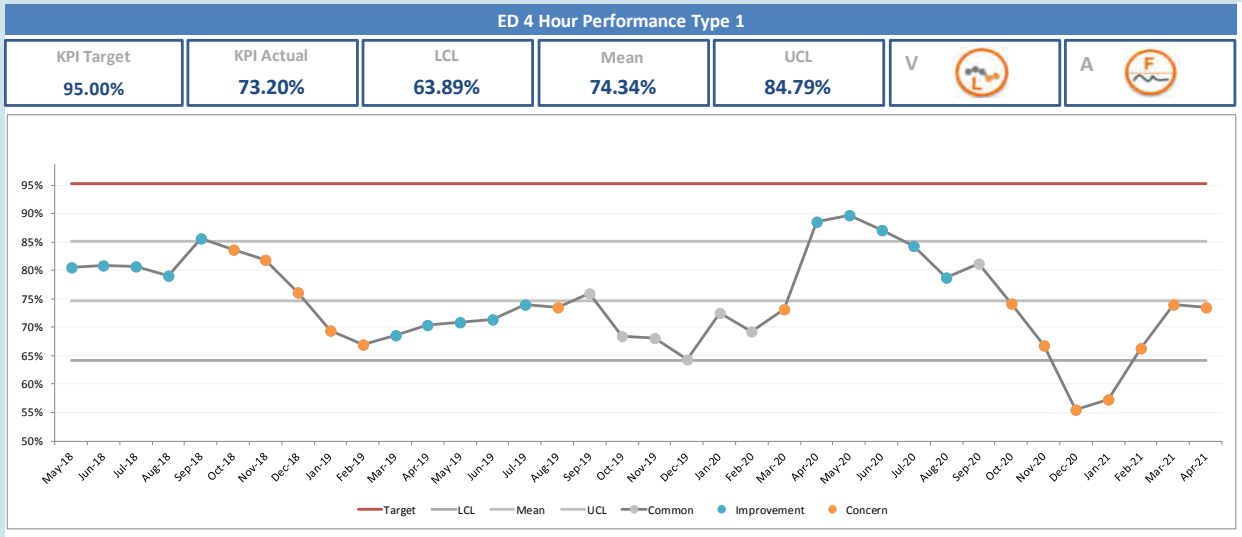
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Diagnostic Access	DM01 Performance	Apr-21	99%	94.74%	76.22%	89.27%	100.00%		
	Elective Access	PTL Size	Apr-21	22477	23013	20192	21341	22489		
		18 Weeks RTT Incomplete Performance	Apr-21	92%	63.07%	69.89%	75.78%	81.67%		
		18 Weeks RTT Over 52 Week Breaches	Apr-21	0	500.00	1.57	85.14	168.70		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Apr-21	0	8.00	0.00	20.59	46.83		
		Cancelled Operations Not Rescheduled < 28 days	Apr-21	0	0.00	0.00	4.32	12.08		
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Mar-21	93%	97.55%	79.25%	89.46%	99.68%		
		Cancer 2ww Performance - Breast Symptomatic	Mar-21	93%	94.83%	51.58%	81.27%	100.00%		
		Cancer 31 Day First Treatment Performance	Mar-21	96%	98.48%	89.60%	96.28%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Mar-21	85%	71.43%	59.15%	77.01%	94.87%		
		104 Day Cancer Waits	Mar-21	0	4.00	0.00	2.28	5.47		
	Complaints Management	Number of Complaints	Apr-21	41	43.00	19.56	58.86	98.17		
		% Complaints Responded to Within 30 Days	Apr-21	85%	58.33%	39.22%	67.69%	96.16%		

Responsive: – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - Interim 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.

Actions:

- Validate Trust Internal Professional Standards in response to emergency referral and flow and implement across all pathways;
- Improve the escalation in ED regarding compliance with IPS.
- Improve the impact of the regular huddles to enable ED NIC and EPIC to manage ED flow.
- Improve and expedite decision-making for specialty referrals .
- 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 for admitted and non-admitted patients
- Total time in department <150mins
- ED IPS compliance

Underlying issues and risks:

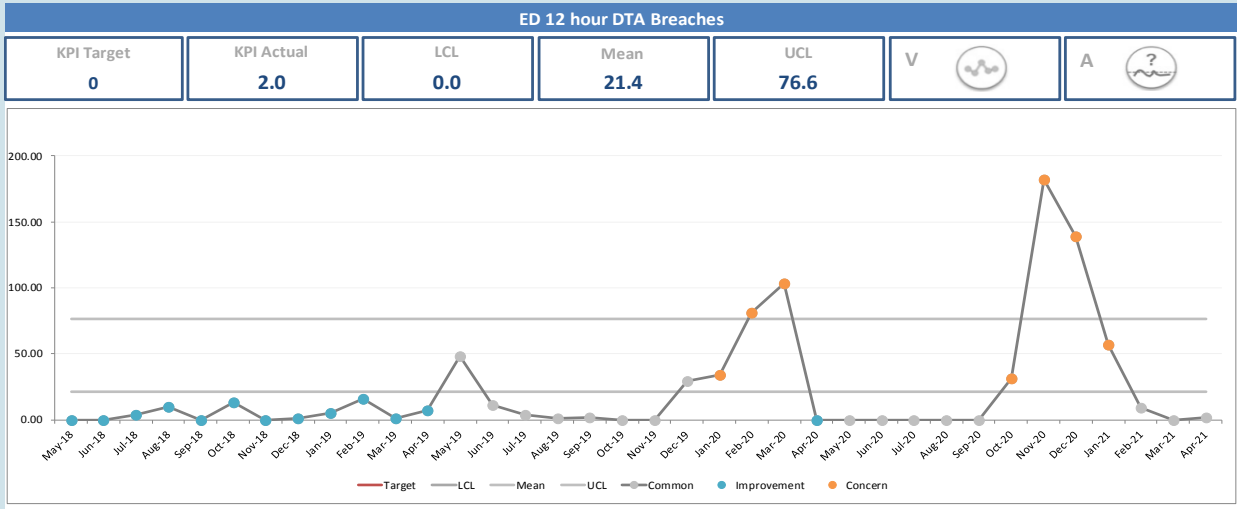
- Need for more clarity re the roles of NIC and EPIC in managing ED processes to delivery 4 hour standard.
- Workforce gaps in acute medicine has meant increased LOS for referred patients.
- Loss of AAU capacity due to covid-driven reconfiguration and revised IPC regulation.
- Delays in POCT and availability of results.
- Poor overnight processes causing excess admitted and non-admitted breaches between 2100 – 0300.
- Gaps in Senior ED leadership

Responsive: – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - Interim 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 chart illustrates the considerable improvement over the past few months as a result of the interventions and action in place mainly through the patient first programme.

Actions:

- Daily senior operations review of patient flow and issues relating to demand and capacity, with agreed interventions as appropriate.
- Regular ED and Site management huddles in place to highlight potential issues and agree interventions.
- Escalation by ED to site team of patients who have decisions regarding their treatment and /or onward .
- Continued engagement with ECIST in relation to ED pathways and use of assessment units.

Outcomes:

- Zero 12hr DTA breaches
- Reduction in total time in department to <150mins
- Appropriate and timely patient reviews and decision making

Underlying issues and risks:

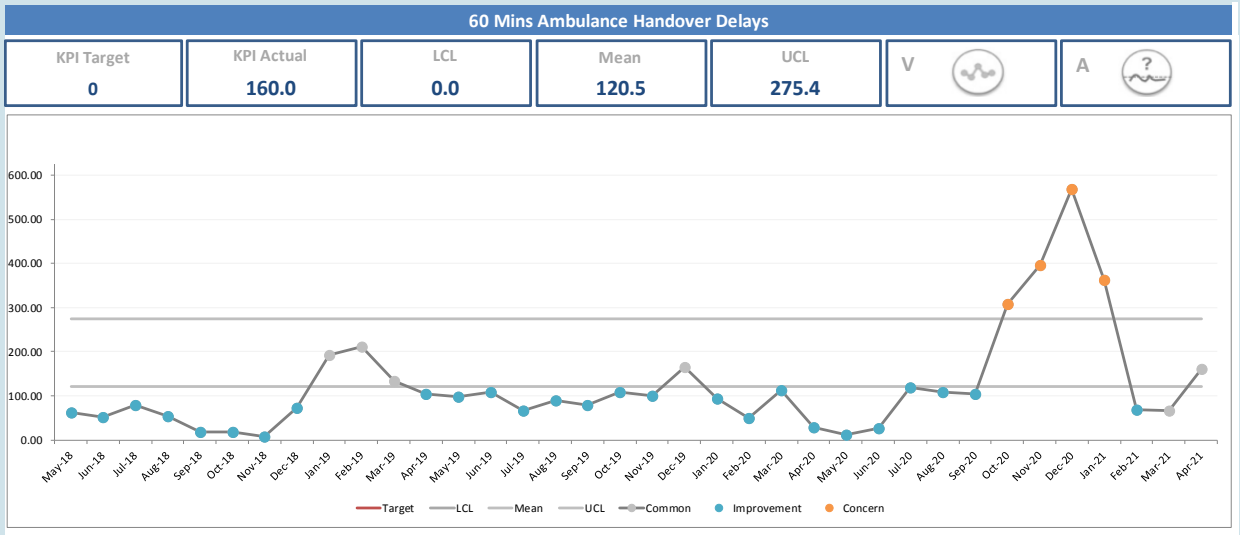
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Slow re-launch of acute assessment due to capacity, IPC considerations and staffing.
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - Interim 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.

Actions:

- Continue to use the Acute Care Transformation programme to deliver the improvements and changes relating to effective front-door processes.
- SOP formalised to establish risk mitigated corridor care for use in extremis (risk of very long handover times)
- Additional oversight of operational team in support of clinical team. This includes a revision of FCP actions to maintain clinical assessment and treatment on ambulance platform (OPEL 4);
- Optimise direct ambulance conveyance to SDEC, SAU and FAU;
- Optimise pre-conveyancing activities to avoid hospital attendance when appropriate.
- Triage in place as part of escalation when delays are foreseen. Additional space created to expand RAU.

Outcomes:

- Minimal 60min hand over delays
- Any deterioration will be identified and acted on early by using triage and immediate assessment as appropriate.
- Care Group led and clinically-led solution for internal ED decompression during surge required to compliment operational oversight;

Underlying issues and risks:

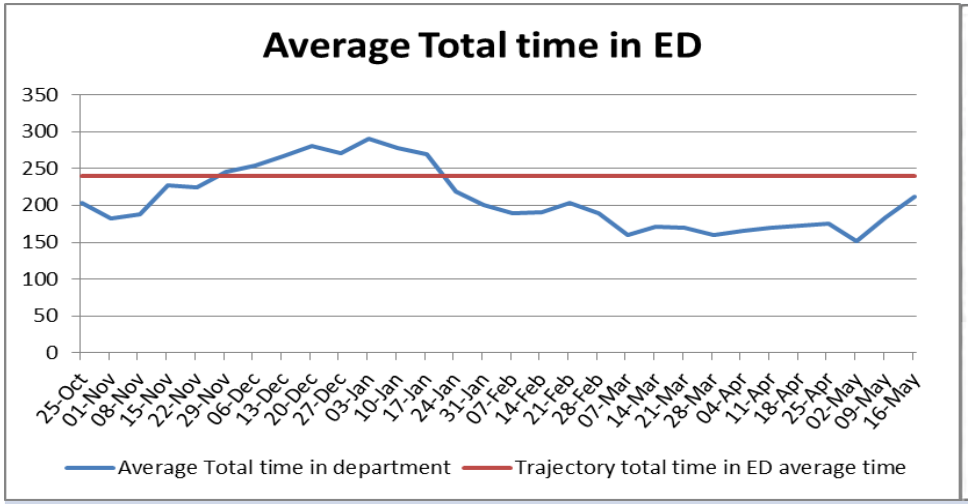
- Workforce and rosters not always in sync with demand.
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Gaps in Senior ED Leadership

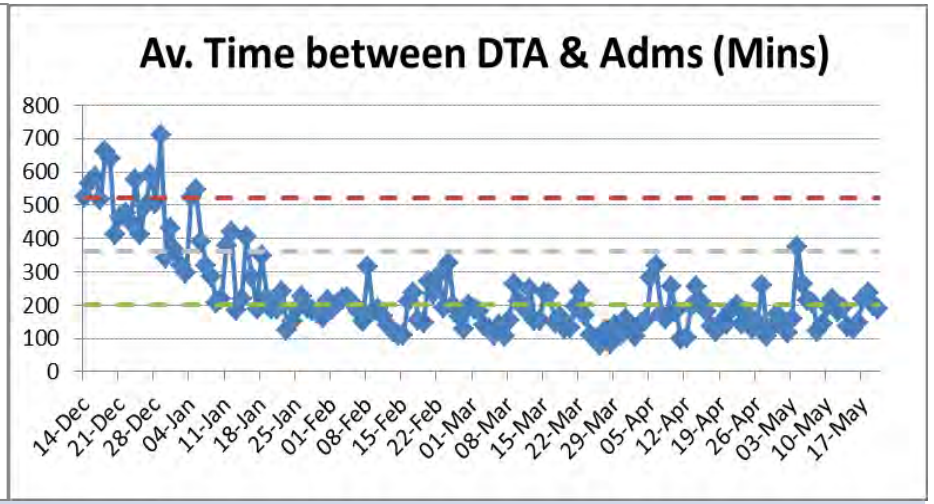
Safe: Operational flow
Aim: TBC
Latest Period: Jan/Feb-21

Executive Lead: All
Operational Lead: All
Sub Groups:

NHS Medway NHS Foundation Trust

Outcome Measure:





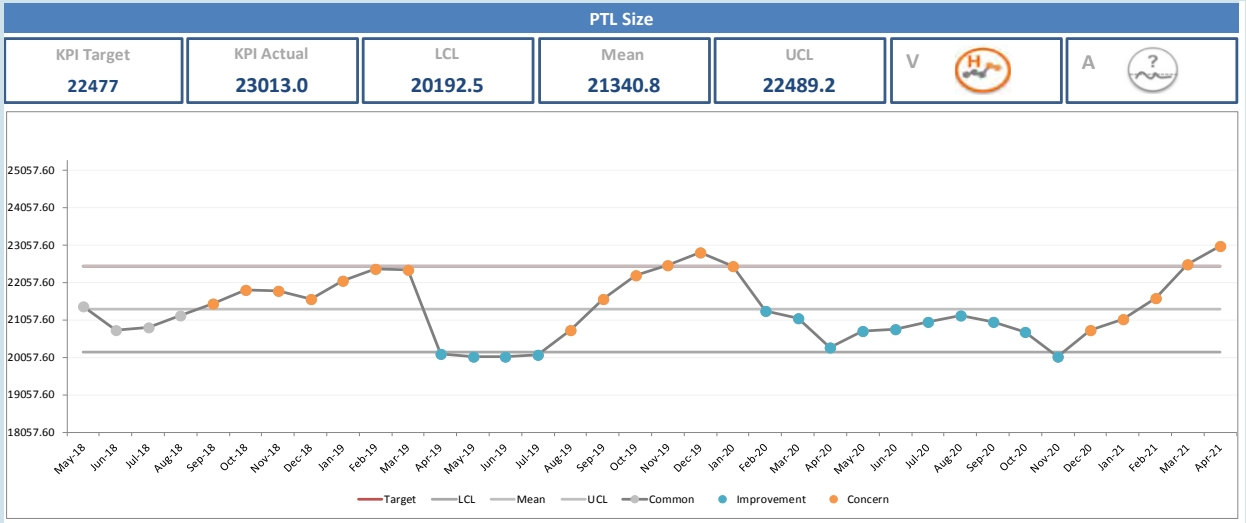
Average total time in department has seen some increases in May but aside from one day the average is below 240minutes with a weekly average of 160mins.
Average time between DTA and admission increased over 3 consecutive days at the beginning of May, directly related to a change in admission conversion rates and an increase in bed occupancy. This change is being monitored daily at a care group and divisional level.

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: PTL Size



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high concerning nature. The increase in the PTL is directly related to the pandemic and a reduction has been consistent since restart.

Actions:

- Demand and capacity modelling completed for Q1
- All elective activity has restarted
- Activity plans agreed with all specialties
- Continuous validation of patients with long waiting times and harm review process established.
- Independent sector capacity used as available .

Outcomes:

- Clarity on patients and treatment in accordance with clinical priority (all patients will have a designated P category)
- All elective patients will be managed via safe green pathway including appropriate isolation and pre-op swabbing.

Underlying issues and risks:

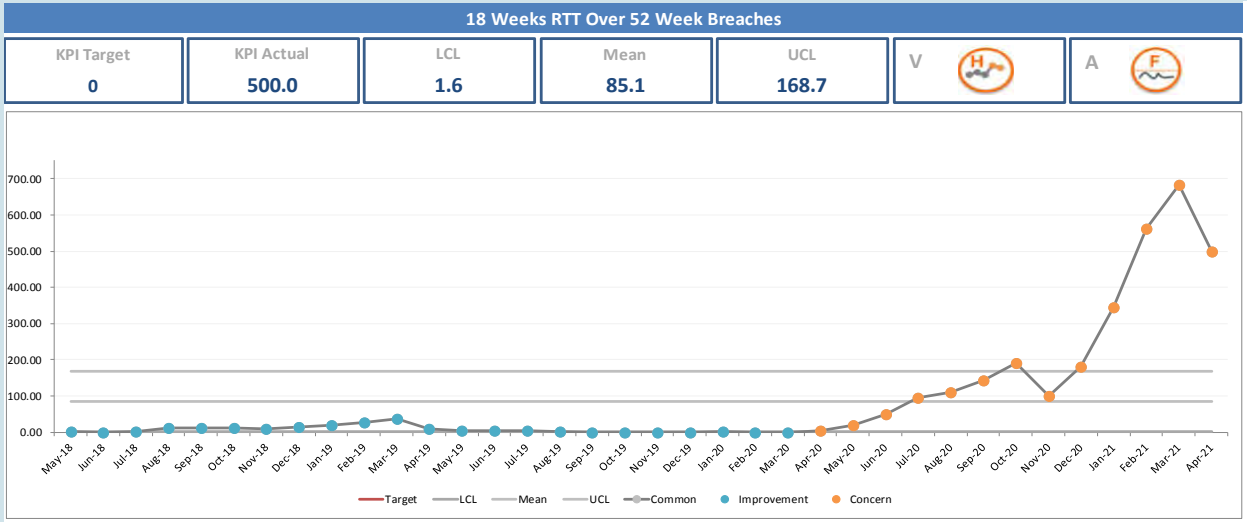
- Estate programme relating to the completion of ED phase 3 and release of Ocelot of elective orthopaedics.
- Uncertainty on NEL activity and associated impact on elective plans
- End of national contracts for IS activity and financial impacts.

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. The increase in 52 week waits is directly related to the pandemic and a reduction has been consistent since restart.

Actions:

- Demand and capacity modelling completed for Q1
- All elective activity has restarted
- Activity plans agreed with all specialties
- Continuous validation of patients with long waiting times and harm review process established.
- Independent sector capacity used as available .

Outcomes:

- Zero capacity related 52-week waiting patients by end October 2021.
- Clarity on patients and treatment in accordance with clinical priority (all patients will have a designated P category)
- All elective patients will be managed via safe green pathway including appropriate isolation and pre-op swabbing.

Underlying issues and risks:

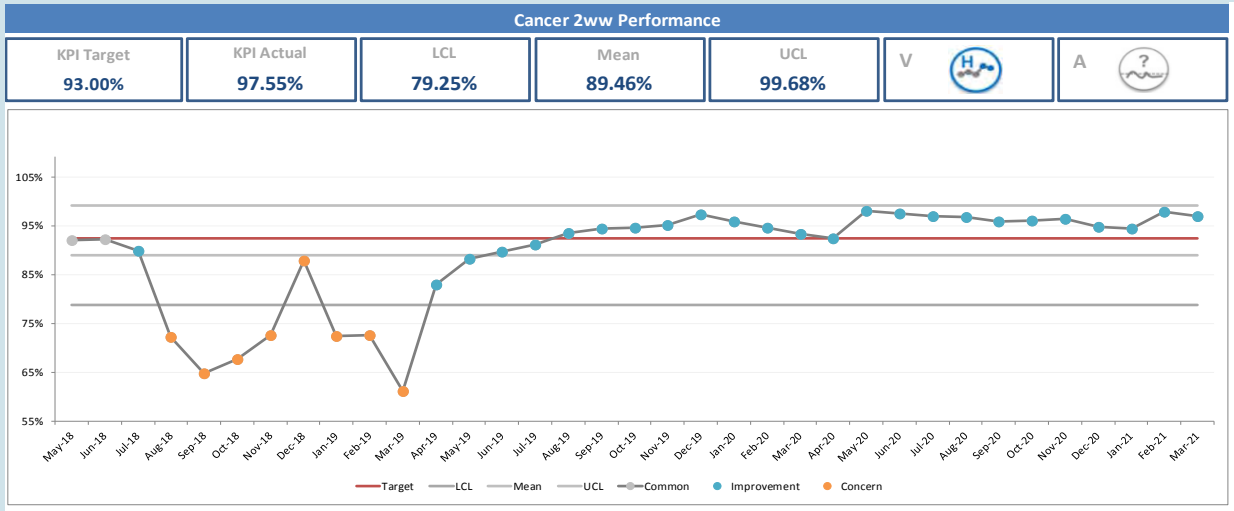
- Estate programme relating to the completion of ED phase 3 and release of Ocelot of elective orthopaedics.
- Uncertainty on NEL activity and associated impact on elective plans
- End of national contracts for IS activity and financial impacts.

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:

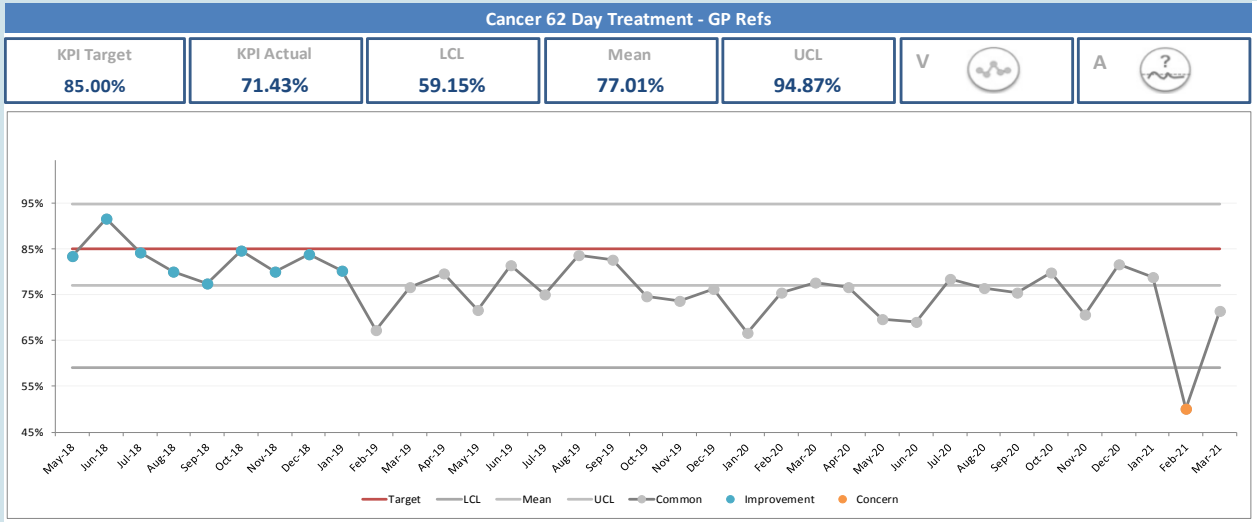
- Internal Stretch target of 7 Days is now being achieved by 2 services Urology & H&N
- 7/9 Services booking at day 14 or under.
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic Capacity could challenged as the trust pushes ahead with restart.

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:

- Revised improvement plan in place which is addressing the underlying issues with diagnostic pathway.
- Revised trajectory for activity and performance developed.
- All roles and responsibilities within the care group under review and relaunched with clarity of function and objectives (e.g MDT co-ordinator & pathway navigators)
- Revised focus of weekly cancer PTL and daily progress reviews for patients waiting their next event.
- Weekly review with COO regarding progress with action plan and delivery of weekly recovery actions.
- Implementation o f straight to test service for LGI suspected cancer patients.

Outcomes:

- Confirmed Cancer patients are being identified on the PTL much earlier in the pathway.
- More patients being investigate d via "faster diagnostic" pathway.
- Increased number of patients being "ready willing and able to progress with treatment plan earlier in their referral pathway.
- More clinical lead engagement with tumour specific challenges to find solutions.

Underlying issues and risks:

- Sufficient diagnostics and outpatient capacity to clear the backlog of patients waiting.
- PTL validation resource
- 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 – Chief People Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

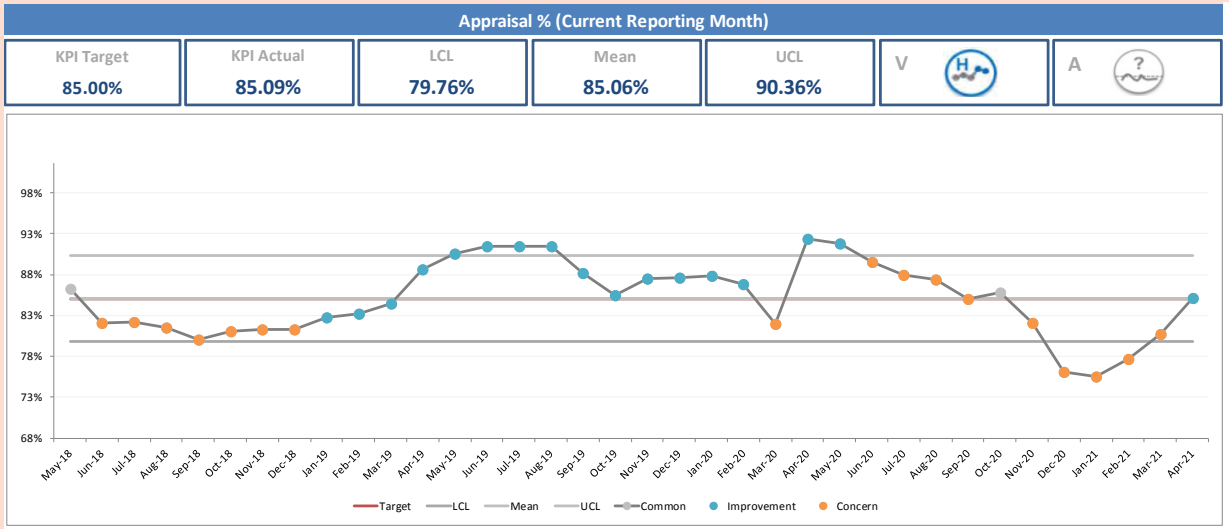
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-21	62%	63.00%	1.62%	26.99%	52.36%		
		Staff Friends & Family - Recommend Care of Treatment	Mar-21	79%	74.00%	3.91%	35.70%	67.49%		
	Workforce	Appraisal % (Current Reporting Month)	Apr-21	85%	85.09%	79.76%	85.06%	90.36%		
		Sickness Rate (Current Reporting Month, FTE%)	Apr-21	4%	3.82%	3.34%	4.44%	5.54%		
		Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Apr-21	12%	11.92%	10.33%	12.05%	13.17%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Apr-21	0	4195.04	3819.40	3918.67	4017.93		
		StatMan Compliance (Current Reporting Month)	Apr-21	85%	89.03%	66.34%	80.39%	94.44%		
		Agency Spend as % Paybill (Current Reporting Month)	Apr-21	4%	3.66%	1.85%	3.63%	5.41%		
		Bank Spend as % Paybill (Current Reporting Month)	Apr-21	9%	11.03%	7.86%	12.89%	17.92%		
		Temp Staffing Fill Rate - Nurse & Midwifery (Current Reporting Month)	Mar-21	75%	60.08%	59.08%	71.35%	83.62%		

Well Led: Workforce - Insights

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: Ayesha Feroz, Unplanned Care, Temi Alao, Planned
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The percentage of staff who have had an appraisal in the last 12-months compared to the total number of staff.

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

Outcomes:

3373 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 3970).

Underlying issues and risks:

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

Domain: Well Led - 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

£'000	
Income	30,893
Pay	(19,474)
Non Pay	(9,993)
Post EBITDA	(1,433)
TOTAL	**(7)**
Technical adj.	7
CONTROL TOTAL	**-**

Indicator Background:

The Trust reports a £7k deficit in month 1; after making the required adjustments for donated asset income and depreciation this is breakeven against a control total of the same..

What the Chart is Telling Us:

The Trust has achieved its control total in month 1.
Capital spend in month was £1.8m.
CIP delivered in month was £0.1m.

Actions:

- Budgets agreed by the Trust – detailed versions to be uploaded into the ledger.
- Business cases to be prepared for service developments reserved/agreed in principle.
- CIP showcase event scheduled for 9 June.

Outcomes:

The Trust has met its control total; it has not recognised any income in respect of the Elective Recovery Fund but believes it has met its month 1 target.

Underlying issues and risks:

CIP plans still require significant development to meet H1 requirements and deliver c3% in H2.

The capital resource allocation for the Trust is significantly below 2020/21 levels. Additional resource is being requested given the scale of works required and the pipeline programme in place.

Meeting of the Board of Directors in Public

Thursday, 03 June 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.2
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 25 May 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. Quality report and CQC inspection Visits The Committee received the quality report which provided an update to with progress of delivery against the following for the month of April: • The Trust CQC action plans • CQC information requests • Safety matters • Implementation of the quality strategy • Effectiveness – NICE / audits The report also included an update on the CQC inspection visits that took place during April and the Well Led inspection this week. Feedback so far from the inspection team has been positive.	**Green**

2. Quality account The Committee received the draft Quality Account of 2020/2021. The draft report provides an overview of progress made against the delivery of key quality indicators based on the details requirements of guidance published by NHSE/I. The report was presented to the Committee for approval as part of the working time table of the Trust Annual report which will be submitted to NHSE/I at the end of June 2021. The Committee approved the draft Quality Account which will now be circulated to the lead governor, external stakeholders such as Kent and Medway CCG and Health Watch for comment and feedback.	**Green**
3. Implementation of the quality strategy The Committee was briefed on the progress against the implementation of the Trust's Quality Strategy and achievements to date. Work has continued to be progressed on quality improvements despite the COVID pandemic. The Committee were informed of the planned quality showcase event which will be an opportunity for staff to come together to share their achievements and learning.	**Green**
4. Infection prevention and control improvement plan The Committee received an update on the infection prevention and control improvement plan and follow up visit from the National IPC team on 23 April 2021. Feedback from the visit was positive with the national team noting the improvements in IPC since their visit in November. Progress against the IPC improvement plan includes a reduction to zero of the COVID-19 outbreak areas and standing down of the daily outbreak meetings, divisional forums reflecting on learning from the pandemic, regular DIPC blogs to staff and both internal and external audit of IPC standards and compliance. To provide additional assurance the Chief Nursing and Quality Officer commissioned a series of unannounced IPC visits with took place in March with a report of the findings presented at the May IPC committee. The Committee were advised of the progress being made on recruitment to the IPC team. The Committee noted the progress made and were pleased by the positive feedback from the national inspection team and CQC.	**Green**
5. Quality and Patient Safety Group highlight report The Committee received the highlight report from the Quality and Patient Safety Group held on 18 May 2021 noting its content.	**Green**
6. Update on discharge management and how it is communicated across the Trust The Committee received an update on the work being undertaken to improve discharge management and the flow. A program of work has been set up under patient first and under the high quality care pillar involving every ward which sets out the roles and responsibilities of ward staff and clinical staff focusing on board rounds to ensure every patient is reviewed and updated on discharge status and escalation on the next event in terms of their stay. Work has taken place reviewing diagnostics to ensure this is not delaying discharge and work continues on EDN's to ensure everything is	**Green**

ready for the patient to be discharged. Mini Maid events take place each week with a rotation of wards which are multi-disciplinary with internal and external system leaders involved in patient discharge for care homes or home with support. The integrated discharge team meets every day to review the list of patients for discharge. The Committee were assured by the progress being made.	
7. 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 in June.	**Green**
8. Medicines management – quarterly report The Committee received the medicines management quarterly report which provided a summary of the actions of the Medicines Management Group for the months of October 2020 to March 2021. The Committee noted the content of the report.	**Green**
9. Quality IQPR The Committee received the Quality IQPR noting the content. The Committee were informed that there has been an increase to falls and that work is currently underway by the Falls Specialist Nursing team carrying out a deep dive into contributory factors. The Committee will be updated at the next meeting.	**Green**
10. BAF – risk one (integration) The Committee reviewed the BAF risk one (integration) noting the risks and mitigations. The Committee will continue to monitor BAF risk one as part of its work plan.	**Amber/Green**
11. Review of the quality assurance committee terms of reference The Committee undertook the annual review of its terms of reference. The Committee approved the suggested changes to the terms of reference and will submit to Trust Board for approval.	**Green**
12. Review and agree work plan for quality assurance committee The Committee undertook the annual review of its work plan. The Committee approved the work plan and will submit to Trust Board for approval.	**Green**
13. Escalation to Board The Committee escalates the following to Trust Board:- • Review of SI's and addressing the backlog The Committee notifies the board of the following:- • Duty of Candour – a review of the compliance of duty of candour for those patients with nosocomial infections is being presented to the June Quality Assurance Committee and to Trust Board in July. • The Committee approved the draft Quality Account which is now being circulated to key stakeholders for comment and feedback.	

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

Title of Report	**Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme – Safety Actions 7, 8, 9 and 10.**	**Agenda Item**	3.3
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 1.3.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 QAC on 16 March 2021. The Assurance report for Safety Action 4, 5 and 6 was presented to Trust Board on 15 April 2021. This report also confirmed compliance with Safety Action 2. This report, providing full oversight and assurance report for Safety Action 7, 8, 9 and 10 was presented to the QAC on 25 May 2021. 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. NHSR has since 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.		

	This report will provide the Board with oversight of Safety Action 7, 8, 9 and 10. The report will also provide an update on progress against Safety Action1. Evidence and BRAG rating to achieve compliance with the CNST standards found in appendix 1.
Committees or Groups at which the paper has been submitted	Divisional Management and Governance Board CNST Task and Finish Group 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 Key Lines of Enquiry
Quality Impact Assessment	Quality Impact Assessment is not required for this report.
Recommendation/ Actions required	The Board is asked to review the evidence provided and to note that the service is on track to demonstrate compliance with CNST Safety Actions 7,8,9 and 10.

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

Appendices	Appendix 1: Gap Analysis Appendix 2: Continuity of Carer Action Plan

1 Executive Overview

1.1 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.

1.2 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.

1.3 The Board will maintain full accountability for the authorisation of final sign-off for CNST by the Chief Executive Officer, following a schedule of alternate month reporting to QAC as referenced below. The Board will have oversight of evidence as set out in the technical guidance.

1.3.1 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

1.3.2 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

1.3.3 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

1.3.4 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

1.4 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.

1.5 A full oversight and assurance report for Safety Actions 4, 5 and 6 was presented to the Quality Assurance Committee (QAC) on 16 March 2021. The Assurance report for Safety Action 4, 5 and 6 was presented to Trust Board on 15 April 2021. This report also confirmed compliance with Safety Action 2.

1.6 This report, providing full oversight and assurance report for Safety Action 7, 8, 9 and 10 was presented to the QAC on 25 May 2021.

1.7 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. NHSR has since 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.

1.8 This report will provide oversight of Safety Action 7, 8, 9 and 10, along with providing the Board with an update on progress against Safety Action 1. Evidence links and BRAG rating to achieve compliance with the CNST standards found in appendix 1.

2 Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard.

2.1 CNST guidance requires the Maternity Service to present details of all perinatal deaths each quarter.

2.2 Quarter 1 to Quarter 3 2020/2021 were reported to the Trust Board in February 2021.

2.3 The report assures the Board that for all deaths in Quarter 3, the PMRT review has been completed, with each case reviewed by a multidisciplinary team. For all cases, the parents were informed of the review and their views were considered as part of the review. The PMRT generated report for quarter 3 is linked in evidence in Appendix 1 and shows that all cases have been reviewed and are closed.

2.4 The details of the quarter 4 2021/2021 deaths are below:

Quarter 4: 2020/21	Stillbirths and late fetal loss	Neonatal Death on delivery suite	Neonatal death on Neonatal unit
January	4	1	2
February	3	1	2
March	0	1	2

2.5 CNST requires that all eligible deaths are reported to MBRRACEUK within seven working days. The report assures the Board that the service is compliant with this requirement. One case was reported outside the seven-day requirement in Quarter 4, however MBRRACE have confirmed that this case will not be counted against compliance. The service have reviewed their process for reporting cases and a second reporter has now been added to cover the lead reporter during periods of sickness or annual leave. A monthly meeting has been established between Maternity and Neonatal teams to monitor and discuss PMRT cases.

2.6 CNST requires that for 95% of all eligible deaths a PMRT review is commenced by 15 July 2021. The report confirms that for 100% of all eligible deaths have been commenced, including the 14 eligible cases for Quarter 4.

2.7 CNST also requires that 50% of cases from December 2019 have a PMRT report completed to at least draft stage by 15 July 2021. The report assures the Board that for Quarter 4, 50% of eligible cases have report completed to draft stage. This figure reflects the period of waiting and the time to collate results, as several cases occurred at the end of the quarter. The remaining cases have a date scheduled to complete multidisciplinary PMRT within the CNST timeframe.

2.8 CNST requires that all parents are informed of the review and that their views and concerns are considered. The report assures the Board that for 100% of cases parents have been involved informed and contributed to the review.

2.9 The PMRT generated Board report for Quarter 4 is linked in evidence in Appendix 1.

2.10 Details of all actions are linked in the PMRT Action plan for Trust Board review. Progress against this action plan is monitored via CNST Task and Finish Group and the Stillbirth Review meeting.

3 Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

3.1 The report seeks to assure the Board that the Maternity Service has a mechanism in place for gathering service user feedback and that they work with the Medway MVP to coproduce services.

3.2 The MVP is established with meetings in place with a core membership including service users, Commissioner and Local Maternity System Representative, the Head of Midwifery and Consultant Obstetrician. The MVP Chair is in regular communication with the Head of Midwifery and provides service user feedback. The MVP Chair is called upon to review new information that will be provided to service users, including communications on social media and the Trust Website. The MVP Chair is a member of the Maternity Transformation Assurance Board and provides quarterly updates on co-production of services and service user feedback.

3.3 The role of the MVP and the gathering of service user feedback also links to the Ockenden Immediate and Essential Actions (IEA), in particularly IEA2 Listening to Women and their families. The Maternity Service assures the Board that they are committed to continue to work with the MVP to gather service user feedback. A monthly meeting with the MVP Chair, HOM and Matrons has been re-established to formally monitor service user feedback received and track progress and actions against them. It will also formally document the input the MVP has in service development and co-production of services.

3.4 The March 2021 CNST guidance provided Trusts with a template pack to support compliance with the guidance, including a revised template for Terms of Reference. The MVP has updated the TOR and it is with the Local Maternity System (LMS) for review and will be included in the final evidence presented to the Board in July.

3.5 The CNST guidance requires the MVP to prioritise the voices of BAME women and their families. The MVP chair is currently in the process of arranging a listening event for the BAME community, which will give them the opportunity to provide feedback directly to heads of service and key stakeholders within the LMS. The MVP chair will also work with the Maternity Service and the Professional Midwifery Advocate to develop online decision-making tools, including one specifically for the BAME community. This work will also support the Trust's compliance with Ockenden IEA2 and IEA7 (Informed Consent)

4 Safety Action 8 : Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of the MIS in year three in December 2019?

4.1 The report seeks to provide assurance to the Trust Board that staff within the Maternity Service had attended 'in-house' multi-professional maternity emergencies training (PROMPT) since December 2019.

4.2 The March 2021 guidelines removed the requirement for each staff group to be 90% compliant with the training requirements of Safety Action 8. The Maternity Service had identified that achieving 90% compliance was a risk, and had BRAG rated this standard as Amber. With the removal of the 90% compliance for all staff groups, this action can now be BRAG rated green for CNST year three compliance. The maternity leadership team, however, would like this Safety Action to remain amber/green for overall assurance, due to the significant work required to achieve 90% for some staff groups including Anaesthetic and Obstetric Consultants, and the risk this poses for achieving compliance with future CNST MIS submissions.

4.3 The Maternity Service continues to strive to achieve 90% compliance for all relevant staff groups for PROMPT training. This is an important target to maintain patient safety and quality and also links to Ockenden IEA 3 "Staff Training and Working Together" which also requires multi-professional to be

delivered. A trajectory is in place for face-to-face training which will see midwives and maternity support workers achieve above 90% compliance by May 2021. Theatre staff, obstetric consultants and junior doctors, along with anaesthetic consultants and junior doctors are not currently on a trajectory to achieve 90% compliance with face-to-face training alone. In response to this, the maternity education team have implemented an online training package which will be offered to all staff who are non-compliant. This will support achieving a compliance rate of a minimum of 90% for all staff groups.

4.4 The report assures the Board, a schedule of multidisciplinary, face-to-face training is in place for 2021/2022. CNST guidance requires the Board to formally minute the commitment of the service and the Trust to continue this training and the ambition of the leadership and education team to achieve 90% compliance for all staff groups.

4.5 The CNST guidance also requires that staff groups have had Covid-19 specific e-learning made available to them. The report assures the Board that both as part of the PROMPT package and as a separate Covid-19 update, Covid-19 specific training has been undertaken and Covid-19 specific simulations have been shared electronically with all staff.

4.6 The CNST guidance also requires that staff involved in the immediate resuscitation of the new born have undertaken New Born Life Support (NBLS) training. The March 2021 guidance removed the 90% compliance requirement but the report assures the Board that all reportable staff groups have achieved greater than 90% compliance for NBLS since December 2019.

Staff Group	NBLS Trained Since December 2019
Neonatal Consultants	100%
Neonatal Junior Doctors	100%
Neonatal Nursing	96%
ANNP	100%
Midwives	98%

4.7 As for Safety Action 6, Safety Action 8 requires staff to be compliant with intrapartum fetal monitoring training. This is a requirement of the Saving Babies Lives Care Bundle version 2. Compliance with this training is essential for patient safety and also links into the requirements of the Ockenden IEA 6 “Monitoring Fetal Wellbeing”. The 90% compliance requirement was removed by CNST in March 2021, however the service continues to work towards this goal.

4.8 Due to clinical pressures, the 90% target for Fetal monitoring training was not achieved across all staff groups. Junior doctors had reached 90% compliance, however the rotation of new junior doctors in April 2021 saw their compliance rate reduced to 71%. The compliance rate for Fetal monitoring training and assessment as of 30 April 2021 are as follows:

Staff Group	Fetal Monitoring Training Compliance	Fetal Monitoring Assessment Compliance
Obstetric Consultants	58%	58%
Junior Doctors	71%	71%
Midwives	96%	95%

4.9 The report assures the Board that training for 2021/2022 commenced on 27 May 2021 and all staff have been allocated a training place. The Maternity Service therefore assures the Board that they are committed to achieving a minimum of 90% compliance across all staff groups and requests that that Board formally notes this.

5 Safety Action 9 : Can you demonstrate that the Trust Safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

5.1 The report seeks to provide assurance to the Board that the Trust frontline Safety Champions (obstetric, midwifery and neonatal) are meeting monthly with Board level Safety champions to escalate locally identified issues.

5.2 A written pathway is in place which clearly describes how frontline, neonatal, obstetric and Board level Safety Champions share safety intelligence between each other, the Board, the Local Maternity System (LMS) and Patient Safety Networks. This pathway is displayed on Patient Safety Boards on each unit. The pathway contains the names of the Safety Champions and a poster is also on display which names each Safety Champion from Ward to Board.

5.3 The Board Level Safety Champion is the Chief Nursing and Quality Officer and the report assures the Board that monthly meetings have been taking place in line with the CNST guidance. The local Safety Champions met with the Board Level Safety Champion in January and February 2020 as required and then a pause in the meetings was acceptable between March and October 2020. In November 2020 the meetings were re-launched with Terms of Reference agreed in line with the requirements of CNST. The meetings have been undertaken month, with the exception of April 2021, since November 2020, giving the front line Safety Champions the opportunity to escalate locally identified issues. The group have reviewed the Avoiding Term Admissions into NICU (ATAIN) action plan, along with national reports on perinatal and maternal mortality. They have also reviewed concerns arising from Covid-19, including staff and service user concerns, the impact of Covid-19 on BAME communities, and considered national reports on mortality in light of Covid-19 for which an action plan is in place.

5.4 In response to Ockenden IEA 2 which requires a dedicated Non-Executive Director (NED) for Maternity to work with the Board Level Safety Champion, a dedicated NED has been assigned to Maternity and the Terms of Reference for the Safety Champion meeting have been revised to reflect this. The Maternity Board Level Dashboard is under review prior to agreed implementation by the Chief Nursing and Quality Officer, in response to the requirements of Ockenden, for reporting monthly at Board by the Board Level Safety Champions.

5.5 The report assures the Board that the Governance Board on Maternity Units contains safety performance indicators which are visible to staff. Staff feedback relating to safety concerns are displayed, including those relating to Covid-19, along with the response and actions taken by the leadership team.

5.6 The Chief Nursing and Quality Officer has been undertaking monthly walk arounds on the Maternity and Neonatal Units in order to gain feedback from staff, and a safety and quality focus group was held in April 2021. Progress is being monitored against any staff concerns. The Chief Nursing and Quality Officer also commissioned a quarterly Safety Champion Newsletter which allows the Safety Champions to feedback to staff on actions against concerns raised along with ongoing Patient Safety and Quality Improvement work.

5.7 The Maternity Service is working towards achieving 35% Continuity of Carer (CoC). CoC is part of a national ambition to improve maternity outcomes and the Maternity Service is committed to achieving this. In light of the pressures facing Trusts as a result of Covid-19 the requirement to achieve 35% compliance with CoC has been removed by NHSR, but an action plan must be in place and approved by the Board Level Safety Champion and reviewed by the Trust Board Quarterly from January 2021. The report assures the QAC that the Action plan has been approved by the Board Level Safety Champion via the Safety Champion Meeting and Maternity Transformation and Assurance Board, and was presented to Trust Board in April 2021. The Maternity Service has identified additional staff and resources needed to achieve 35% and have prepared appropriate workforce papers and a Business

Case to support this. The Board has endorsed the CoC action plan and an updated version of the action plan is in appendix 2.

5.8 The Chief Nursing and Quality Officer has supported the Head of Midwifery to progress a workforce paper to request the additional 13WTE midwives recommended by Birthrate Plus to support the implementation of Continuity of Carer. This workforce paper was presented to the Trust Board on 6 May 2021 and the Board approved the funding for 13WTE midwives. Furthermore, in order to support the Royal College of Midwives (RCM) manifesto and the commitment of the Chief Nursing and Quality Officer to strengthen nursing and midwifery leadership, the Chief Nursing and Quality Officer put forward a PID to the Executive Group and Trust Board for a Director of Midwifery post. This post has also been approved by the Trust Board.

5.9 The Maternity Service have escalated concerns regarding funding for the Transformation Midwife, who is integral to the implementation of the project, to the Board Level Safety Champion and the LMS project manager, who has confirmed funding for 2021/2022 for 0.6 WTE band 8a until 31 March 2022. The Transformation Midwife is now in post and a project implementation plan with a timeline to achieve CoC by March 2022.

5.10 The Board Level Safety Champion, along with the Frontline Safety Champions have reviewed maternal and neonatal morbidity and mortality rates, including women who delayed or did not access healthcare in light of Covid-19. The appropriate reports including the UK Obstetric Surveillance System (UKOSS) and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK) and have implemented an action plan (linked in evidence in Appendix 1) to ensure the findings of these reports are considered within local Maternity and Neonatal Service. The Safety Champion Group also reviewed the letter advising targeted perinatal support for BAME groups and this guidance has been reflected in the Maternity Standard Operating Procedure: Care of pregnant BAME women during COVID-19 Pandemic (SOP0622).

5.11 The Board has supported Maternity and Neonatal staff in their work with Patient Safety Networks, Local Maternity System (LMS), Clinical Networks, Commissioners and other groups on both Covid-19 and non Covid-19 related challenges and Safety Concerns. The Board Level Safety Champion commissioned an independent review of Maternity Safety with the CCG to ensure scrutiny and oversight of Maternity Safety. The Board has supported the Maternity Service in their response to the recommendations made by the Ockenden Report, working with the LMS to approve the assurance tool required by NHS England. Progress against both the Safety Review and Ockenden response have been monitored by the QAC.

5.12 The frontline safety champions have shared the results of the 2018 SCORE survey with the Board Level Safety Champion, along with more recent surveys on staff safety culture undertaken by the Professional Midwifery Advocates(PMAs). The Board Level Safety Champion has supported the frontline champions to undertake further work to understand the recent survey results, particularly around staff perception of blame when something goes wrong. The front line safety champion, supported by the PMAs is undertaking focus groups with staff to gain a better understanding of staff concerns. Furthermore, the SCORE and PMA surveys have been benchmarked against the Trust Improvement Plan and this will be presented to the Board in July.

5.13 The Trust Board has supported the Frontline Safety Champions in the undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers via the Medway Innovation Institute which has provided funding and support for the Thermoregulation Project

5.14 The report assures the Board that there has been appropriate Safety Champion representation at a number engagement events including Patient Safety Network meetings and MatNeoSIP webinars as required. The Maternity Service will review attendance at these meetings with the Board Level Safety Champion and NED and agree a plan for ongoing attendance and representation at these meetings.

6 Safety Action 10 : Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme

6.1 Health Safety Investigation Branch (HSIB) and NHSR Resolution's (NHSR) EN scheme require that all term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [OR]
- Was therapeutically cooled (active cooling only) [OR]
- Had decreased central tone AND was comatose AND had seizures of any kind.

6.2 The report assures theBoard that 100% of qualifying cases have been reported to HSIB for 2020/2021 and NHSR EN scheme for 2019/2020.

6.3 During Covid-19, Trusts were not required to report directly to NHSR EN, but only to HSIB who would then notify NHSR EN. The Trust has been informed that this process will continue on a permanent basis from 1 April 2021 and HSIB will continue to notify NHSR EN. This has been done to decrease the burden of reporting on Trusts and to increase the role of HSIB in sharing learning from maternity investigations.

6.4 The report assures the Board that Duty of Candour has been applied to all qualifying cases from October 2020 and families have been involved of the role of HSIB and NHSR EN scheme. Prior to October 2020 Duty of Candour was performed in line with the statutory requirements.

6.5 CNST guidance requires the Trust Board to have sight of the Trust Legal Services and maternity clinical governance records of all notifications along with evidence of Duty of Candour and confirmation that families have been involved of the role of HSIB and NHSR EN. The legal and governance records are linked in Appendix 1 and a summary table outlining all reported cases are detailed below.

6.6

Date of del	HSIB NO.	Legal Services informed	NHSER NO	EBC No.	DoC- Mandatory for all cases from 1/10/20
9/1/19	1901-305	9/1/19	M18CT035/026	062-052	N/A
17/1/19	1901-332	21/1/19	M18CT035/027	062-053	N/A
7/3/19	1903-486	12/3/19	M18CT035/034	062-055	N/A
11/3/19	1902-492	12/2/19	M18CT035/038	062-056	N/A
26/3/19	1903-547	26/3/19	M18CT035/038	062-057	N/A
11/4/19	1904-599	15/4/19	M19CT035/003	062-058	N/A
22/5/19	1905-738	22/5/19	M19CT035/005	062-059	N/A
23/5/19	1905-768	24/5/19	M19CT035/008	062-060	N/A
28/5/19	1905-765	29/5/19	M19CT035/007	062-061	N/A
8/6/19	1096-814	10/6/19	M19CT035/009	062-062	N/A
31/7/19	1908-1049	31/7/19	Not eligible- stillbirth	062-063	3/8/20
20/8/19	1908-1129	29/8/19	M19CT035/072	062-064	N/A
22/10/19	1910-1350	24/10/20	M19CT035/024.	062-065	26/10/19
11/11/19	1911-1421	13/11/19	M19CT035/025	062-066	N/A
11/11/19	1911-1427	14/11/19	M19CT035/026	062-067	N/A

17/3/20	2003-1837	23/3/20	M19CT035/045	062-1837	23/3/20
19/3/20	2003-1841	24/3/20	M19CT035/044	062-069	N/A
28/6/20	2006-2202	29/6/20	N/A-Change due to Covid-reporting to HSIB only from 1/4/20	062-2202	3/7/20
4/7/20	2007-2220	6/7/20	N/A-Change due to Covid-reporting to HSIB only from 1/4/20	062-071	N/A
15/7/20	2007-2265	15/7/20	N/A-Change due to Covid-reporting to HSIB only from 1/4/20	062-072	N/A
23/12/20	2012-2857	23/12/20	N/A-Change due to Covid-reporting to HSIB only from 1/4/20	062-073	29/12/20
18/1/21	MI-003119	26/1/20	N/A-Change due to Covid-reporting to HSIB only from 1/4/20	EBC project finished	25/1/21

7 Conclusion and Next Steps

7.1 The report provides assurance to the Board that the Maternity Service is on track to achieve and demonstrate compliance with Safety Action 7, 8, 9 and 10.

7.2 The report also assures the Board the Maternity Service remains compliant with Safety Action 1 and that identified actions are being monitored via the PMRT Action plan.

7.3 The Maternity Service will submit a final assurance report, addressing any outstanding data and providing final confirmation of compliance with all ten Safety Actions to the Board in July 2021.

8 Appendix 1: BRAG Analysis (UPDATE for 1, 7, 8, 9. 10)

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 20	BRAG Nov 20	BRAG Dec 20	Further Action Required	Evidence
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Were all perinatal deaths eligible notified to MBRRACE-UK from the 1st October 2020 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death? .				Continue with PMRT to ensure compliance in line with July 2021 Submission.	S:\CNST\Safety Action 1\PMRT Process
		Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20th December 2019 to Wednesday 30 September 2020 been started by 31st December 2020? This must include deaths after home births where care was provided by your Trust staff and the baby died.				Continue with PMRT to ensure compliance in line with July 2021 Submission.	S:\CNST\Safety Action 1\PMRT Reports S:\CNST\Safety Action 1\Preventing Still Birth Presentation
		Has a review using the				Continue with	S:\CNST\Safety

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 20	BRAG Nov 20	BRAG Dec 20	Further Action Required	Evidence
		Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1st October 2020 been started within four months of each death? This must include deaths after home births where care was provided by your Trust staff and the baby died				PMRT to ensure compliance in line with July 2021 Submission.	Action 1\PMRT Reports
		Were at least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool by Thursday 31 December 2020.					S:\CNST\Safety Action 1\PMRT Reports
		Were at least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 1st August 2020 to the 31st December 2020 reviewed using the PMRT, by a multidisciplinary review team.				Continue with PMRT to ensure compliance in line with July 2021 Submission.	S:\CNST\Safety Action 1\PMRT Reports

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 20	BRAG Nov 20	BRAG Dec 20	Further Action Required	Evidence
		Each review must have been completed to the point that at least a PMRT draft report has been generated by the tool.					
		For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.				PMRT letter has been approved at Care Group and Divisional Level and is being implemented from November 2020. Prior to this, the conversation was recorded in the Maternity Records. An audit is being completed to evidence this.	S:\CNST\Safety Action 1\PMRT Letter
		For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.				This currently documented in the hand held records and reflected in the PMRT submission, but will also be included in the letter to families as above.	S:\CNST\Safety Action 1\PMRT Reports
		If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely				Delays in reviewing Quarter 4 cases (January February March	S:\CNST\Safety Action 1\PMRT Reports

Safety action No.	Maternity safety action	Safety action requirements Requirement	BRAG Oct 20	BRAG Nov 20	BRAG Dec 20	Further Action Required	Evidence
		completion?				2020) were identified due to Covid-19. Parents were informed and given a timetable for completion. These cases were reviewed at the Stillbirth Review Meeting in June 2020.	S:\CNST\Safety Action 1\Still Birth Review Meeting Minutes
		Have you submitted quarterly reports to the Trust Board from 1st October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.				This will be presented by the Chief Nursing & Quality Officer to be approved February 2021 Trust Board and quarterly thereafter.	S:\CNST\Safety Action 1\PMRT Reports \\mmhnasv03\Shared\CNST\Safety Action 1\PMRT Action Plan
		Were the quarterly reports discussed with the Trust maternity safety champion from 1st October 2020 onwards?				The report has been shared at Women's and Children's Care Group Board Meeting where there Maternity Safety Champion attends. This will return quarterly to this meeting for review.	S:\CNST\Safety Action 1\Women's and Children's Care Group Board Meeting

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?					March 2021 revised guidance changed template for TOR. Sent to MVP Chair to review and refresh.	Safety Action 7
		Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?					The template of the minutes to be updated to meet technical guidance – New template provided in March 2021 guidance. Sent to MVP chair	
		Do you have evidence of service developments resulting from coproduction with service users?					Presented at MTAB on 22 October 2020 MVP log established to capture service user feedback and service developments/co-production.	
		Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?					Letter from MVP Chair linked in evidence.	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?					Presented at MTAB on 22 October 2020 March 2021 guidance included template for MVP to complete regarding prioritising BAME. Sent to MVP for completion.	
8	Can you evidence that at least 90% of each maternity unit staff group have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS Year 3 in December 2019?	**IN HOUSE MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, * including CoVID-19 training**					COVID 19 element to be introduced by November 2020	CNST\Safety Action 8
		Obstetric consultants					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							escalated to clinical leads as required.	
		All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required.	
		Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required.	
		Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required. .	
		Obstetric anaesthetic consultants					Significant work to be done to achieve	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							compliance in this staff group. Has been escalated to Clinical Director. E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required.	
		All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota					Significant work to be done to achieve compliance in this staff group. Has been escalated to Clinical Director. E-learning now being offered to all non-compliant	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required	
		Maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							CNST Task and Finish Group and escalated to clinical leads as required. .	
		*Can you evidence that 90% of all staff group mentioned above caring for pregnant & postpartum women with suspected or confirmed COVID-19, including a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes?					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required. .	
		*Can you evidence that 90% of all staff groups have attended a specific training concerning women requiring maternal critical care and also the triage of pregnant & postpartum women with mental health concerns?					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required. .	
		*Can you evidence that 90% of all staff groups mentioned above have attended a maternal critical care training, including: the use of maternal critical care observation charts, structured review proformas, deterioration & escalation thresholds, timing of birth and postnatal care? *These training sessions should also cover an understanding of COVID-19 specific therapies in pregnancy, and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings.					E-learning now being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required. .	
		*Can you evidence that 90% of all					E-learning now	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		maternity staff groups mentioned above have been trained in the recognition, triaging and caring for women with mental health & safeguarding concerns in pregnancy? This must include information on local pathways and procedures to ensure face-to-face assessments and fast-track access to specialist perinatal mental health and safeguarding support services. Training should also include recognition of concerning 'red flags', particularly repeated referrals, that referrals that should prompt urgent review					being offered to all non-compliant staff. 90% requirement removed from guidance in March 2021 but service committed to working towards 90% compliance for all staff groups. Compliance will continue to be monitored via CNST Task and Finish Group and escalated to clinical leads as required. .	
		NEONATAL RESUSCITATION TRAINING						CNST\Safety Action 8\NBLS
		Neonatal Consultants or Paediatric consultants covering neonatal units					90% requirement removed from March 2021 guidance, however staff group compliant with 90%.	
		Neonatal Junior doctors (who attend any deliveries)					90% requirement removed from March 2021 guidance, however staff	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
							group compliant with 90%.	
		Neonatal nurses (Band 5 and above)					90% requirement removed from March 2021 guidance, however staff group compliant with 90%.	
		Advanced Neonatal Nurse Practitioner (ANNP)					90% requirement removed from March 2021 guidance, however staff group compliant with 90%.	
		Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres					90% requirement removed from March 2021 guidance, however staff group compliant with 90%.	
		LOCAL HALF/ONE DAY INTRAPARTUM FETAL MONITORING TRAINING (SBLCBv2)						CNST\Safety Action 8\Fetal Monitoring
		Obstetric consultants					Trajectory in place to achieve a minimum of 90% compliance by May 2021.	
		All other obstetric doctors (including staff grade doctors,					Trajectory in place to achieve	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota					a minimum of 90% compliance by May 2021.	
		Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and As above bank/agency midwives).Maternity theatre midwives who also work outside of theatres					Trajectory in place to achieve a minimum of 90% compliance by May 2021.	
9	**Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?**							S:\CNST\Safety Action 9
		Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence from floor to Board? and through the LMS and MatNeoSIP Patient Safety Networks?					Pathway in place and Safety Champion meeting established. Work ongoing to share Safety Champion work with staff and to get ward to board feedback.	S:\CNST\Safety Action 9\Safety Champion - Flow Charts, Posters, Responsibilities
		Do you have evidence that the written pathway is in place and it is visible to staff and meeting the requirements detailed in part a) and b) of the action since Friday 28 February 2020?					Pathway visible by the required deadline. Safety Champion Poster and further information also displayed.	
		Has the above pathway been shared through the LMS and					Pathway visible by the required	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		MatNeoSIP Patient Safety Networks?					deadline. Safety Champion Poster and further information also displayed.	
		Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?					Pathway visible by the required deadline. Safety Champion Poster and further information also displayed.	
		Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?					Monthly sessions taken place. Task and finish group agreed to change BRAG to Blue to ensure each month was compliant before declaration.	S:\CNST\Safety Action 9\Safety Champion MFT Meeting S:\CNST\Safety Action 9\Saftey Champion Newsletter
		Was a monthly feedback sessions for staff undertaken by the safety champions in February 2020?						
		Were monthly feedback sessions for staff undertaken by the safety champions from Thursday 1 October 2020 going forward?						
		Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress						

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		made on identified concerns raised by staff and service users? This must include concerns relating to the COVID-19 pandemic.						
		Is the progress with actioning named concerns from staff walk arounds visible from no later than Monday 30 November 2020?						
		* **Has the Board level safety champion reviewed the continuity of carer action plan in the light of COVID-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.**					On MTAB Agenda 22.10.2020 Discussed at Safety Champion Meeting 5.11.2020	S:\CNST\Safety Action 9\Safety Champion MFT Meeting S:\CNST\Safety Action 9\Continuity of Carer
		*Has this action plan been reviewed by the safety champions by 31/10/2020 and then monthly?					Updated guidance requires quarterly review by the Board from January 2021.	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		Together with their frontline safety champions, has the Board safety champion and MatNeoSIP Patient Safety Networks reviewed local outcomes in relation to:						S:\CNST\Safety Action 9\Safety Champion MFT Meeting
		I) *Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?						S:\CNST\Safety Action 9\Covid-19
		I) *The UKOSS report on Characteristics and II) outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.						S:\CNST\Safety Action 9\Covid-19
		III) *The MBRRACE-UK SARS-COVID19 report						S:\CNST\Safety Action 9\Covid-19
		IV) *The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups						S:\CNST\Safety Action 9\BAME

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		***Together with their frontline safety champions, has the Board safety champion and MatNeoSIP Patient Safety Networks r considered the recommendations and requirements of II, III and IV on I?**						S:\CNST\Safety Action 9\Covid-19
		***Together with their frontline safety champions, has the Board safety champion and MatNeoSIP Patient Safety Networks reviewed local outcomes in relation to:**						S:\CNST\Safety Action 9\Safety Champion MFT Meeting
		1)Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to COVID-19 safety concerns?						S:\CNST\Safety Action 9\Local Maternity System Meetings
		2)The Patient Safety Networks of which each Trust will be a member?						S:\CNST\Safety Action 9\Kent & Medway Safety & Quality Meeting
		3)Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with?						S:\CNST\Safety Action 9\MatNeo
		4) The Patient Safety Network clinical leaders Group where						

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		Trust staff are members.						
		***Do you have evidence that the frontline and Board safety champions have reviewed local outcomes as set out in point d) and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups**?						S:\CNST\Safety Action 9\Safety Champion MFT Meeting
		***Do you have evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to:**						
		*work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on COVID-19 and non COVID-19 related challenges and safety concerns						
		active participation in contributing to the delivery of the collective aims of the Patient Safety						S:\CNST\Safety Action 9\MatNeo

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		Network and undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers						
		utilise SCORE culture survey results to inform local quality improvement plans					Updated Guidance (February 2021) changed wording from local quality improvement plans to "Trust" quality improvement plans. Working with Board Level Safety Champion to utilise the results of the surveys in this way.	S:\CNST\Safety Action 9\SCORE Survey
		engage in relevant improvement/capability building initiatives nationally, regionally or via Patient Safety Networks						S:\CNST\Safety Action 9\Local Maternity System Meetings
		maintain oversight of improvement outcomes, learning and ensure intelligence is actively shared with key system stakeholders.						S:\CNST\Safety Action 9\Kent & Medway Safety & Quality Meeting
		Attendance or representation at a minimum of two engagement					Suitable representation at	S:\CNST\Safety Action

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by Tuesday 14 April 2020.					relevant events. Review attendance going forward.	9\Safety Champion Engagement Events
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?					Final remaining case has now been submitted to NHSR EN.	S:\CNST\Safety Action 10
		Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?						
		For qualifying cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and2. There has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.					To be presented at Trust Board in June 2021 All DOC completed.	
		Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and					To be presented at Trust Board in June 2021.	

Safety Action No.	Maternity Safety Action	Safety Action Requirements	BRAG Oct 2020	BRAG Dec 2020	BRAG Feb 2021	BRAG Mar 2021	Further Action Required	Evidence
		numbers reported to NHS Resolution Early Notification team?						

9 Appendix 2: Continuity of Carer Action Plan

Accountable Lead: Lisa Price, Community Matron **Action Plan Completion Date: 5T**

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	**Completes** 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 **30/04/2021 Funding agreed.**.	30/04/2021	Maternity Transformation Lead-
	Advertise and recruit to post.	Transformation lead in post with appropriate funding.	22/02/2021	HR	Lisa Price	**Complete** Advertisement ready to progress once funding agreed. 10/3/2021 No update from LMS re funding. Unable to progress. **30/4/21 Transformation Midwife in Post**	30/04/2021	e.g. E Doc2.docx mail, minutes, report or plan.

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**
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
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	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
requirements to meet 35% COC and implement agreed Geographical Model.								
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	**Complete** Plan to submit paper to Executive Group in March and to Trust Board in April 2021 **May 2021 Workforce paper submitted to Trust Board and approved 13WTE**	15/5/21	
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	5T	COC equiptment f business plan .ms
Undertake rota mapping exercise to understand	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

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
change required to working patterns.								
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
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

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
	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 progress against COC targets	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 System Manager	Lisa Price	**Complete** All MSDSv2 criteria submitted for CNST Safety Action 2. COC criteria met		CNSTSCORECARD C20 Final.xlsx
	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	5T	
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		

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 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 Consultation paper to staff	Appropriate managed formal consultation process	30/06/2021	HR Business Partner Union Leads HOM	Lisa Price	On Target		

Overdue | On target | At Risk | Complete

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

Title of Report	**Learning From Deaths - Overview**	**Agenda Item**	3.4
Report Author	Dr David Sulch, Chief Medical Officer		
Lead Director	Dr David Sulch, Chief Medical Officer		
Executive Summary	This paper describes the Learning from Deaths process, and the changes that have been made to the process following the introduction of the Medical Examiner process. This process adds granular detail to the higher level data analysis of HSMR and SHMI carried out via Dr Foster. Aspects of the process require strengthening, and the clear links between identified issues and ongoing themes from Serious Incident management are a key focus for work in the short term.		
Committee Approval:	Follow up from previous discussions at the Trust Board and the Quality Assurance Committee		
Executive Group Approval:	N/A		
National Guidelines compliance:	The paper describes the Trust's implementation of the national Learning from Deaths and Medical Examiner processes.		
Resource Implications	None		
Legal Implications/Regulatory Requirements	Failure to effectively address known issues in patient care, are a potential legal and regulatory concern.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE the update		
	Approval ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☒
Appendices	None		

1 Executive Overview

1.1 The Quarterly Mortality Report was presented to the Quality Assurance Committee in April. The current position in terms of the recent rise in HSMR was discussed, and it was explained that this was likely to be related to Waves 2 and 3 of the COVID pandemic and the impact of this on the underlying data. It will be noted that the HSMR for the whole of England – which of course is usually 100 – has risen to 104 during the same time period.

1.2 It was suggested that an overview of the Trust's approach to Learning from Deaths would be helpful for Board members to provide further assurance around the processes in place to scrutinise the care provided to patients who die at MFT.

1.3 This is particularly timely given the changes in the system that occurred since the Medical Examiner model was introduced in the summer of 2020.

2 Responding to Deaths Process

2.1 The Responding to Deaths policy and process was introduced by my predecessor as Medical Director, Dr Diana Hamilton Fairley supported by Dr Richard Leech, Deputy Medical Director.

2.2 In essence the approach taken mirrored the recommendations of the Royal College of Physicians. All patients who die while an inpatient at MFT require a review (Level 1) of the care provided to them. If concerns are identified relating to possible lapses in care, the patient is reviewed using the Structured Judgement Review process (Level 2).

2.3 The doctor carrying out the Level 2 review is from the same speciality as the consultant who was responsible for the patient's care, but would have had no involvement in the care of the patient.

2.4 The Level 2 review ensures that any lapses in care which may have contributed to the patient's death are identified. If this is the case, a Serious Incident is logged and investigated accordingly. The assessing doctor also allocates a grading to assess the quality of care provided (ranging from 1 – Very Poor Care to 5 – Excellent Care).

2.5 A number of criteria are stated which automatically lead to a Level 2 Structured Judgement Review. Some of these criteria are investigated via other nationally mandated processes (such as child or maternal deaths). These criteria are:

- 2.5.1 Infant or child (under 18) deaths
- 2.5.2 Perinatal or maternal deaths
- 2.5.3 Deaths of patients with learning disabilities or severe mental illness
- 2.5.4 Deaths in areas where people are not expected to die (such as lower risk elective surgical patients)
- 2.5.5 All deaths where bereaved families and carers or staff, have raised a significant concern about the quality of care provision
- 2.5.6 All deaths in a service specialty, particular diagnosis or treatment group where an 'alert' has been raised with the Trust through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)
- 2.5.7 Deaths which should be investigated under the Serious Incident framework, including any inpatient detained under Mental Health Act in circumstances where there is reason to believe the death may have been due or in part due to problems in care. This includes suspected self-inflicted death which must be reported as a serious incident and investigated appropriately.

2.6 Prior to the COVID pandemic, it would be typical for 10-15% of all deaths at the Trust to be subject to a Structured Judgement Review. Typically this would convert to a total of between 130 and 200 reviews every year.

2.7 Typical issues identified via the Structured Judgement Review process are as follows:

- 2.7.1 Importance of good communication within and between teams
- 2.7.2 Failure to consider DNACPR status
- 2.7.3 Lack of Treatment Escalation Planning
- 2.7.4 Delay in recognition of deteriorating patient
- 2.7.5 Poor standard of documentation

2.8 These issues mirror many of the themes seen during Serious Incident reviews.

3 Medical Examiner System

3.1 The Trust launched its Medical Examiner system in the summer of 2020. The Trust currently employs four Medical Examiners. All are independent of the Trust, with their main employment based elsewhere. Three work for other acute providers in Kent and Medway, and the fourth is a General Practitioner in London.

3.2 The Medical Examiners scrutinise all deaths occurring at the Trust. They do this via three different approaches:

3.2.1 Review of the case notes

3.2.2 Discussion with a member of the treating clinical team

3.2.3 Discussion with the patient's family

3.3 This scrutiny takes the place of the Level 1 Review as mentioned above. The Medical Examiner will identify any patient fulfilling the criteria detailed above and any other patients where concerns are identified regarding a lapse in care. These patients are listed for a Stage 2 Structured Judgement Review.

3.4 The experience to date indicates that the Medical Examiners identify a lower percentage of patients for a Level 2 Structured Judgement Review than was seen in the previous system. Between 5 and 10% of patients have been identified as requiring a Level 2 review since the Medical Examiner system was introduced. However, the Medical Examiner system has largely been running during Waves 2 and 3 of the COVID pandemic, which inevitably would have an impact on the pattern of mortality across the Trust. It has been reported previously that although the Trust has seen more deaths in the 2020-21 calendar year than in previous years, there have been fewer deaths than in a normal year once the patients who died of COVID have been removed from the figures.

3.5 This is also likely to have had an impact on the level of coronial referrals from the Trust. Prior to the Medical Examiner system, approximately 25% of patients who died at MFT were referred to the coroner. That rate has decreased slightly since the Medical Examiner model was introduced, with 22% of patients being referred to the coroner. National experience pre-COVID suggests that coronial referrals increase by around 33% when a Medical Examiner system is introduced.

3.6 The Structured Judgement Review process was postponed during Waves 2 and 3 of COVID in the light of the intense pressures on the Trust. This has resulted in a backlog of reviews numbering 51 (to the end of March 2021) which are currently being addressed by the Divisions. An updated picture of the current position will be provided to the Board.

3.7 A formal review of the Learning from Deaths process incorporating the Medical Examiner process is scheduled for presentation to the Mortality Committee in May.

4 Royal College of Physicians Review

4.1 The Trust commissioned a review from the RCP Learning from Deaths team in early 2020 to specifically review patients who died of two conditions at MFT – pneumonia and septicaemia. The reviewing team, led by Andrew Gibson, the Clinical Director for Learning from Deaths at the RCP reviewed a total of 40 sets of case notes (20 for each condition).

4.2 Among other areas the reviewers focused on the quality of Structured Judgement Reviews that had already been carried out by the Trust's consultants.

4.3 The 'Quality of Care' criteria were considered by the reviewers. The review looked at two specific areas: firstly, the 40 patients whose care was specifically addressed during the review, and secondly, an overview of the Quality of Care rating across all patients reviewed at MFT compared to data from a

large teaching hospital. Their assessment compared to the assessments from the MFT reviewers are as in the table below (all data given is percentages).

4.4 It can be seen that the assessments of Quality of Care carried out internally at Medway grade the care provided at a higher level both than that assessed by the reviewers for the specific cases studied, but also in overall terms when compared to another Trust. In particular, many fewer patients are graded as having received 'Poor Care' at Medway compared to the normal expectation.

4.5 Two key actions to address this are planned but have not yet been implemented. Firstly a selection of patients whose care is identified as requiring a Structured Judgement Review by the Medical Examiners will have their notes reassessed by a senior member of Trust medical staff after the initial Structured Judgement Review has been carried out. Secondly, a random selection of 10% of patients who are not selected for Structured Judgement Review will have their notes scrutinised to assess the quality of care provided. A selection of these patients will also be rechecked by a senior member of the medical staff. This will also serve as an audit process to monitor the decision making and recommendations of the Medical Examiner team.

4.6 It is also intended to expand the number of Trust medical colleagues who have been formally trained in the Structured Judgement Review process. At present 22 Trust colleagues have been formally trained in this process.

	Excellent	Very Good	Good	Poor	Very Poor
Cases – MFT	12.5	65	15	5	2.5
Cases – RCP	5	43	32	20	0
Overall – MFT	16	64	18	1.5	0.1
Overall - RCP	9	48	28	14	1

5 Conclusion and Next Steps

5.1 The Trust fully supports the Learning from Deaths process as described by the Royal College of Physicians. This provides an additional granular level of assurance and identification of issues to support the data analysis possible using Dr Foster.

5.2 The introduction of the Medical Examiner system provides independent scrutiny for all deaths that occur at the Trust.

5.3 Evidence from previous reviews suggests two significant concerns that need to be addressed in the short to medium term.

5.4 Firstly, the reviews of patient care carried out at Medway may give an overly optimistic view of the quality of the care that has been provided. An audit and review process to scrutinise the accuracy of Structured Judgement Reviews will be introduced.

5.5 Secondly, themes identified in Structured Judgement Reviews prior to the COVID pandemic continue to be echoed in the root causes and action plans derived from the serious incident management process. A further, focused approach to addressing the issues relating to Treatment Escalation Plans / Do Not Attempt Cardiopulmonary Resuscitation decisions, and to escalation of deteriorating patients (and their effective management) is necessary.

5.6 The Learning from Deaths process is currently being reinvigorated after falling into abeyance during the Waves 2/3 of the COVID pandemic. Progress will be reported to the Board alongside this report.

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

Title of Report	**Estates Strategy 2021 - 2041**	**Agenda Item**	4.1
Report Author	Gary Lupton, Director of Estates and Facilities		
Lead Director	Gary Lupton, Director of Estates and Facilities		
Executive Summary	This Estates and Facilities Strategy outlines for discussion the key areas we need to consider in respect to the short and medium term, to meet capacity requirements and how we can mobilise the estate more effectively. We must also plan for the longer term Strategic needs to meet the significant demands on our services due to the growth in housing over the next 20 years, through a combination of on and off site solutions. The service is in year 3 of 5 years of a transformation programme and we have seen some really positive improvements to-date. We need this transformation to be successful to ensure all the required strategic changes can be achieved efficiently in a timely and cost effective way by a well-trained and motivated team. We will continue to invest in our staff and this is evidenced through the 18 month programme of training in our housekeeping services to move them to mid or upper quartile performance. We will continue to develop our services for the benefit of the ICP as a whole and continue to explore collaborative working across partners and share and lead on services where required across the ICP & ICS and work closely with the county councils.		
Committees or Groups at which the paper has been submitted	Shared for discussion at Executive level		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Estates and Facilities services have numerous national standards and statutory obligations to meet and this is built into our governance frameworks.		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to discuss the contents of this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☐
Appendices	Estates and Facilities Strategy 2021 - 2041		

NHS
Medway
NHS Foundation Trust

Estates and Facilities Strategy

2021 – 2041

DRAFT FOR DISCUSSION

Best of care
Best of people

Estates and Facilities Strategy 2021 - 2041

Author:	Gary Lupton, Executive Director of Estates and Facilities
Document Owner	Gary Lupton, Executive Director of Estates and Facilities
Revision No:	Version 1
Document ID Number	
Approved By:	
Implementation Date:	
Date of Next Review:	

Document Control / History	
Revision No	**Reason for change**

Consultation

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1 Introduction

This strategy document articulates the direction of travel over the next 5 to 20 years, acknowledging that further work will be undertaken to develop the detailed delivery plans.

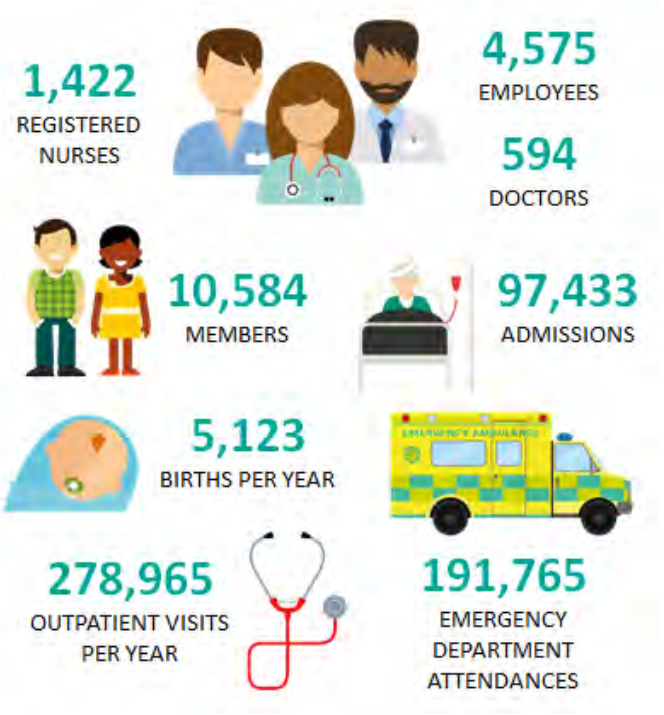
The Estates and Facilities directorate's contribution is important to the Trust's delivery of its ambitious long term goals. The directorate contributes actively towards the delivery of the Trust's emerging Clinical Strategy while remaining vigilant to the recommendations of the Lord Carter NHS Productivity review.

2 History of the site

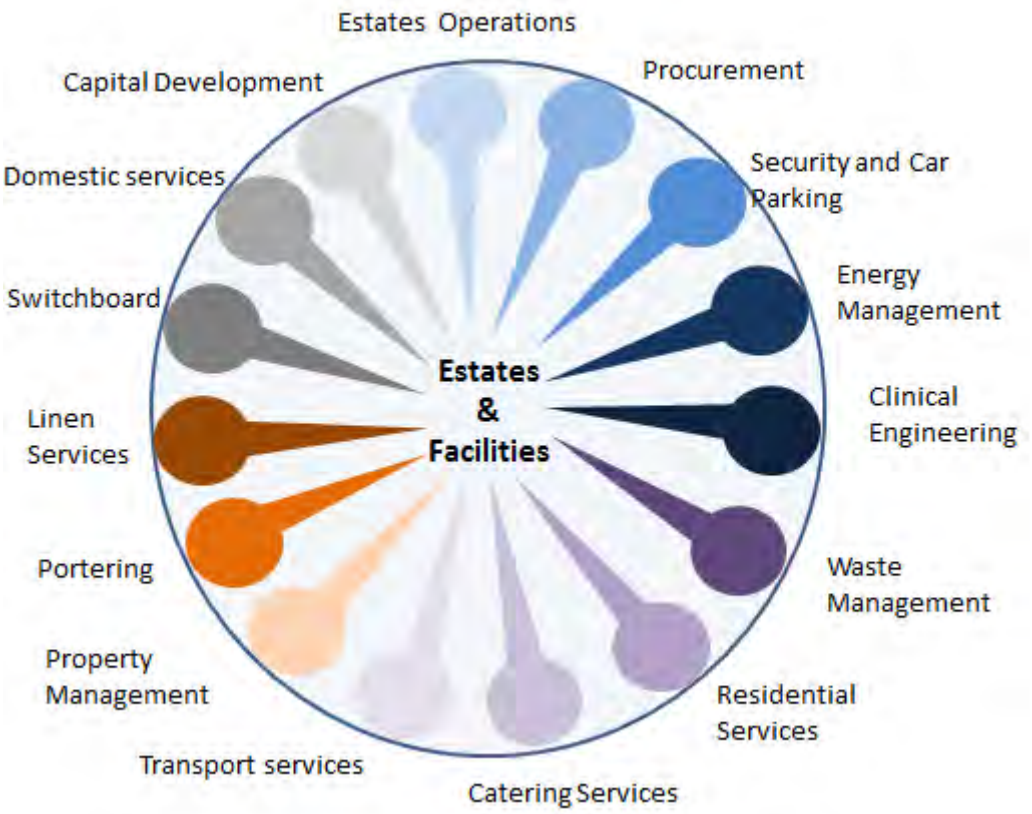
The original Hospital was constructed as a military (Naval) Hospital between 1900 and 1905 when it was opened by King Edward VII. It remained a Naval hospital through two World Wars, until the Admiralty transferred it to the NHS in 1961. Following this, and extensive works and refurbishment, the "Medway Hospital" re-opened in 1965. The site runs alongside the Great Lines which is part of a Conservation Area.

3 Our current position

Medway NHS Foundation Trust is a single-site hospital based in Gillingham, serving a population of more than 424,000 across Medway and Swale, which employs over 4,000 staff. The hospital provides clinical services including more than 190,000 Emergency Department attendances, more than 97,000 admissions, more than 278,000 outpatients' appointments and more than 5,000 babies born last year.

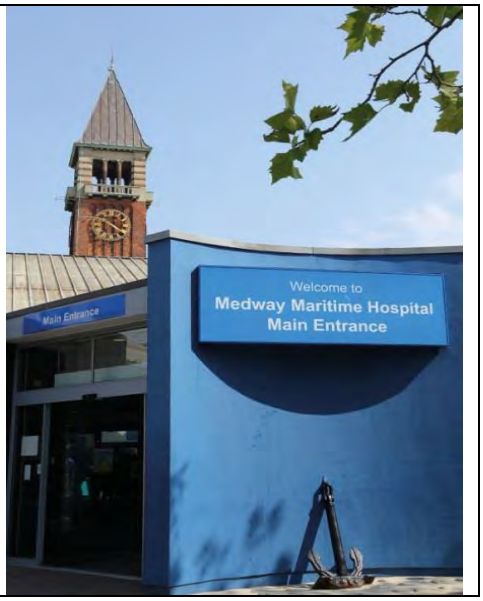


Estates and Facilities consist of the following services:



Hard Facilities Management	Soft Facilities Management
Building 24/7 Electrical 24/7 Mechanical maintenance 24/7 Grounds and Gardens Energy Management Expert contractors to support the ongoing compliance of the buildings and its fabric Project Management of new works	Procurement Clinical engineering/maintenance of medical equipment Health and Safety Manual Handling Fire Management Security 24/7 Space utilisation – landlord responsibility for all space used by the Trust Housekeeping 24/7 Laundry Portering 24/7 Catering Switchboard 24/7 Accommodation Transport Waste Management Car Parking

Land area of 14.4 Hectares (35.5 acres) with a Gross Internal Area (GIA) of 97,827m^2
Trusts are considered good if their total estates and facilities running cost metric is lower than £320/m^2. (402.10/m^2 peer median, MFT £384/m^2).

2020/21 Total Trust Building Backlog = £75.6M	High Risk Backlog = £15.9M (Red)	
	Significant Backlog = £16.7M (Amber)	
	Moderate Backlog = £32.7M (Yellow)	
	Low Backlog = £10.3M (Green)	

It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. Each NHS Trust is duty bound to review the condition of the estate every five years. The Trust undertakes reviews of 20 per cent of the estate every year.

Any area where the condition or compliance falls below 'condition B' investment is required to bring the defect back to 'condition B'. Physical condition B is defined as sound, operationally safe and exhibits only minor deteriorations, whereas statutory compliance B is defined as complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature.

An ageing estate

Some of our buildings date back to the 1905 and 17.3 per cent of the hospital site was constructed before 1948. Although there have been major improvements in terms of the 2000 building and Emergency Department, there are areas that need significant modernisation and do not meet the needs of those using the buildings.

The backlog of work needed to bring our existing building up to standard would cost £75.6million. Most costs relate to the building fabric and the plant and equipment which keep our hospital running.

The Naylor Report (March 2017) builds on the foundations of the Lord Carter Report (2016) in relation to productivity and operational costs. It also recognises that the NHS has not focused sufficiently on estates rationalisation as a vehicle for moving to a more efficient, lower cost estate. Medway NHS Foundation Trust, however, has consciously decided not to dispose of areas of land as the site is landlocked and the development of 29,000 more houses locally will put more demand on acute services based currently on our site. Moving site and or having a second site are all options for consideration as demand outgrows the capacity of the site. Short to medium term changes can

accommodate some of the clinical and environmental challenges but a significant level of investment is required to meet the standards now required for our patients and staff.

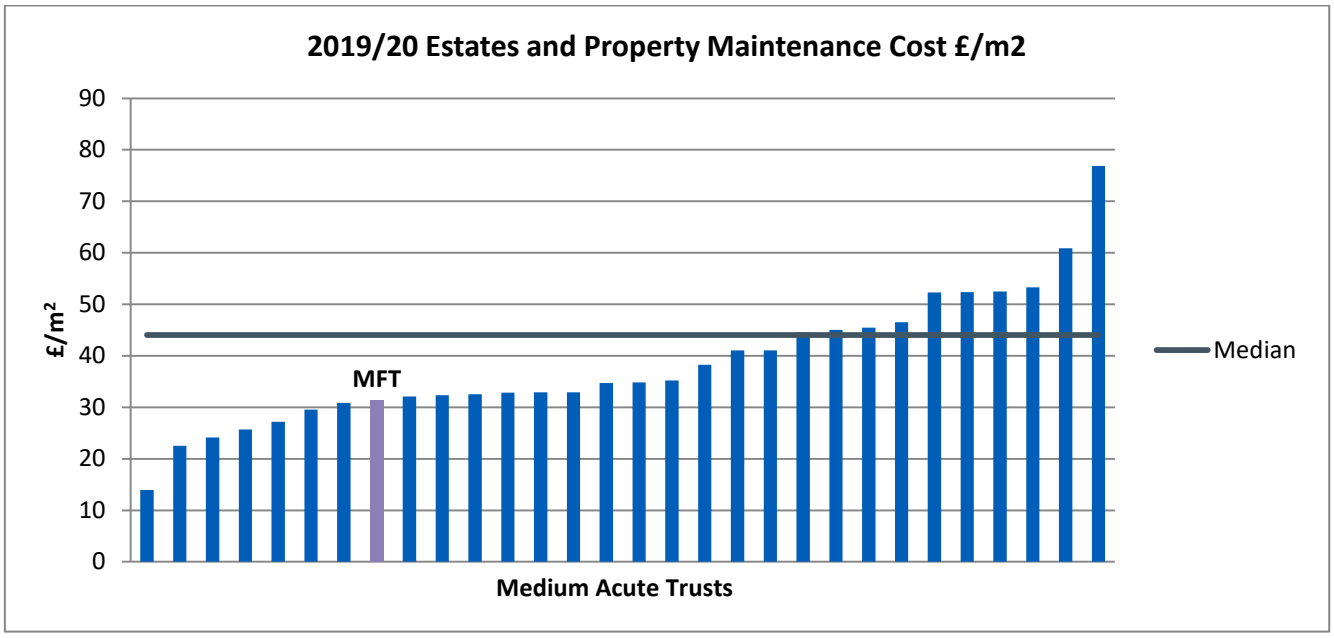
The Naylor Report suggests that “the backlog maintenance of the critical estates has risen faster than the overall average”. NHS Trusts have historically under reported its backlog maintenance, we believe Medway figures to be reasonably robust and will be testing this further during our annual site surveys.

Patient experience

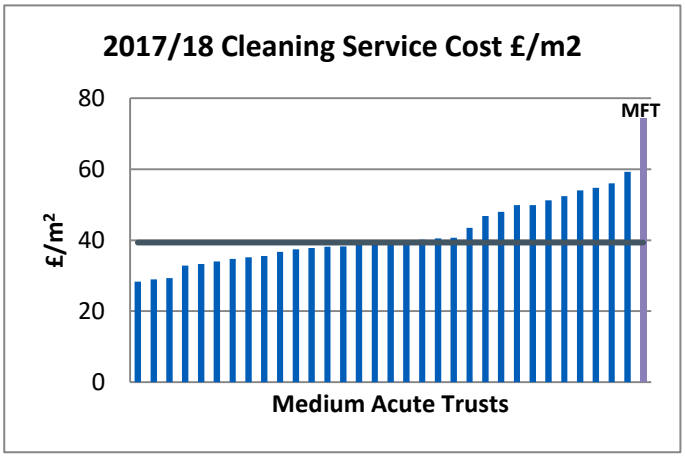
Some of the very outdated Nightingale wards do not offer the levels of privacy and dignity and Infection Control expected from modern healthcare facilities. It is vital that we improve the standard of our estate to meet national guidelines for good patient experience.

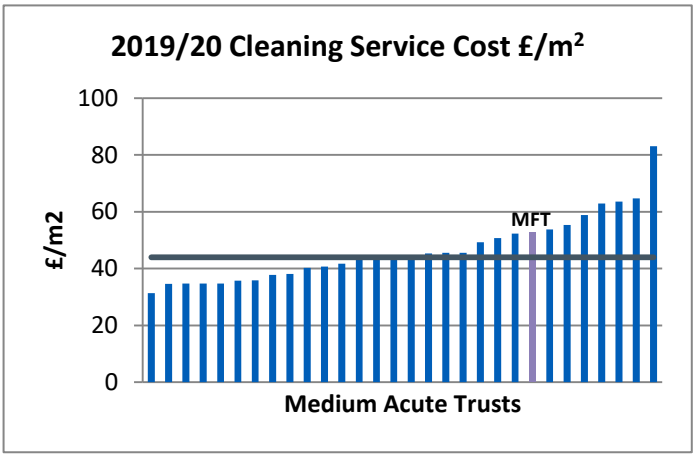
Value for Money

Our services in terms of Hard Facilities, such as maintenance, delivers top second quartile value for money, set out against the backdrop of poor estate.



Our Soft Facilities Management Services however show a clear gap in value for money when it comes to cleaning our hospital, with efficiency levels in 2017/18 showing us as one of the most expensive trusts in the country. Considerable progress has been made over the last three years with a significant level of investment in training to take place over the next two years.





Recent programmes

In light of recent events, the Trust worked with local fire safety regulators to review its current preventative and protective measures. A decision to invest £17.7million in fire was made, with a further £7.2million committed over the period 2021 to 2024. This work continues across the site. Significant areas of investment include, cladding replacement, fire door upgrades, replacement lift programme, compartmentation, fire alarms.

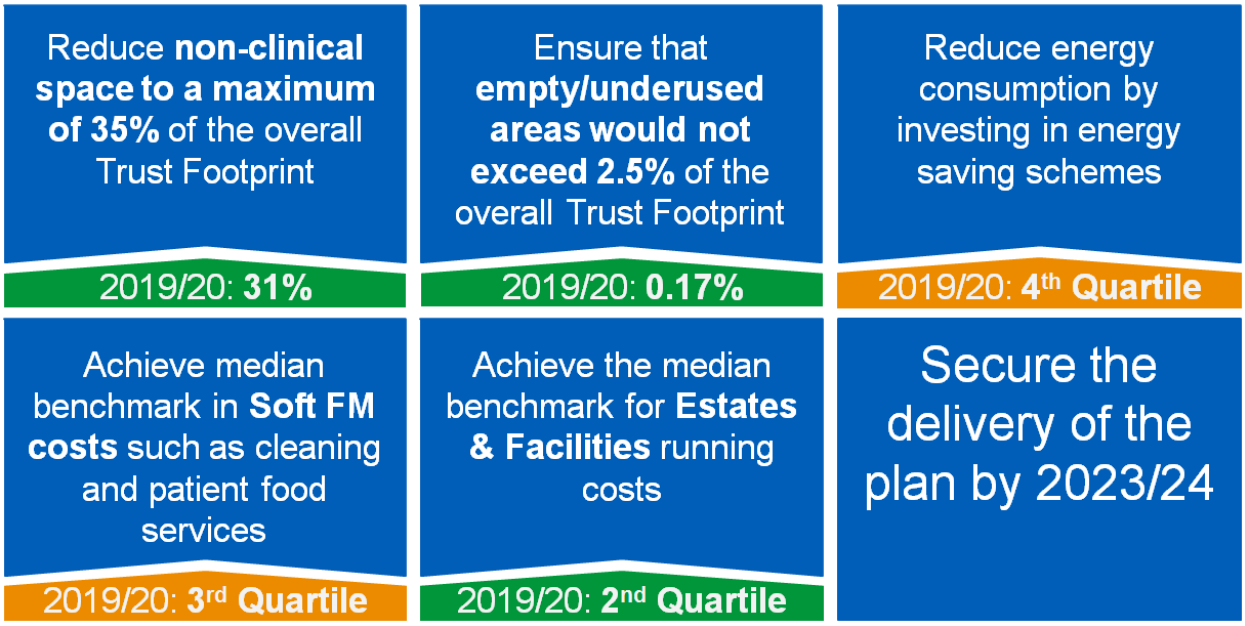
Understanding our strategic drivers

National drivers

The independent report by Lord Carter of Coles (February 2016), recommends reducing operational running costs through the sharing of best practice and reducing the percentage of non-clinical floor area in addition to reducing empty underutilised floor space. The COVID-19 pandemic has introduced new ways of working, with working from home and the introduction of virtual clinics providing opportunities to further utilise our estate more effectively. Opportunities being identified include all public services sharing space. We are taking an active role across Kent and Medway including the ICP (Medway and Swale - Integrated Care Partnership) and ICS (Kent & Medway - Integrated Care System) to deliver an overall reduction in non-clinical occupations of space allowing this to be reused for clinical services.

We must remain conscious of the cost of providing our services and continue to benchmark ourselves against those high performers and learn from their experiences. Lord Carter of Cole has also set out some clear guidelines on how we should manage our estates with a target of 35 per cent (currently achieving 31 per cent) being the maximum of non-clinical space, ensuring as much space as possible is used for clinical activity. This target is likely to reduce to 30 per cent (pre-Covid) over the next couple of years, so new ways of working, such as virtual clinics and home working, will be required to achieve these targets. Locally we should be ambitious about moving to 20 per cent or lower on our acute site and this will enable more dedicated space for providing clinical care. COVID-19 enables us to harness the positive impact of home working.

The Trust is working through the recommendations of the Lord Carter Efficiency Review in addition to pursuing a self-analysis of opportunities for increasing productivity and reducing costs. The review required Trusts to have plans in place by 2017 to:



A further independent report by Sir Robert Naylor (March 2017), highlighted the amount of surplus land owned by NHS Trusts. It recommends incentivising the disposal of this surplus land by offering matched treasury capital to the value of the surplus land capital receipts. We will however consciously protect all our land while the planned 29,000 houses being developed locally can be properly assessed against patients' need to access acute services. We will also explore opportunities to relocate and or expand our services across two or more sites to enable us to meet the demands driven by population growth.

Regional drivers

The strategy will also need to be cognisant of – and aligned with – developing clinical strategies in particular those decisions made as a result of the ICP and ICS local plans.

The Trust's Estates and Facilities department with its associated services will seek to expand and provide its high quality, specialist services to the public and commercial partners through the ICP and ICS work-streams.

We continue to work closely with our local healthcare partners and the local authority so that we can better understand the impact of the around 29,000 new houses to be built by 2037. This will lead to a significant increase in population and demand for our services in the future. With the Trust already experiencing acute capacity pressures, we need to prepare our estate to meet those population growth numbers and in parallel acknowledge how clinical services are evolving to better meet the medical needs of our patients across the ICP. Options will include reviewing which services must be on the acute site and where patients would benefit by through services can be accommodated in locations accessible by the community and supported by a robust travel plan which will be developed in conjunction with Medway Council.

The Medway Integrated Growth Needs Plan identifies a comprehensive growth plan covering the areas shown below:

		Medway
Housing (number of dwellings) 2012 to 2037	OAN	32,025
	Affordable	17,389
Employment (sqm land requirement) 2012-2037	Office	50,152 - 51,967
	Industrial	163,198 - 163,914
	Warehousing	174,235 - 175,907
Retail (sqm floorspace requirement) 2015-2031	Convenience	10,500
	Comparison	34,900

As outlined above, there is clearly a need to align healthcare provision to address the inevitable impacts.

We have established a close working relationship with our health partners to ensure we optimise our NHS estates and look for opportunities to share our services as part of an ICP. Our physical estate needs to recognise the demographics of our area and the patients who live here by ensuring physical access to all is achieved, especially for those with physical and/or mental health challenges and ensuring their privacy and dignity is respected at all times.

Trust drivers

The Trust Vision is “to support excellent healthcare” with high quality patient-focused environments

The hospital ambition is to provide the best facilities and environment to ensure a positive experience of delivering services by creating an environment where our staff will be leaders in delivering best of care. This will ensure our patients get brilliant care.

The Trust clinical strategy will clearly articulate our priority goals and our measures for success as well as our approach to achieving them. To support our operational teams in achieving the ambitious improvements set out in this strategy, we have created a portfolio of improvement programmes. Using project management tools and techniques and service improvement methods, these programmes will support our teams to design, test and measure and spread new ways of working in pursuit of our goals.

The Estates Strategy embraces the Trust's clinical service and quality improvement strategies in addition to the people and information management strategies.

This strategy responds to these challenges and describes how the estate will be developed to meet those requirements. The strategy also reflects the enthusiasm of the workforce and the desire to do its best for the population we serve, providing high quality, affordable and safe services in fit for purpose facilities.

Clinical Strategy

- Be recognised as one of the specialist emergency centres in Kent providing the highest standard of acute and emergency care.
- Provide the highest quality of care by developing all our services based on the latest research and / or the best evidence of care provision that yields the best health outcomes for patients.
- Achieve and surpass the constitutional, statutory and regulatory standards of the NHS for the care of our patients.
- Work with our partners locally and across Kent and Medway to ensure patients receive the right care in the right place from the most appropriate healthcare professional to agree and subsequently meet their needs.
- Continuously improve our efficiency and effectiveness in the interests of our patients.
- To support these objectives the strategy identifies that digital transformation is a key enabler, stating that it is expected that the Trust will have a fully implemented electronic patient record by 2025.

Quality Strategy

Delivered through three delivery domains:

1. Best Quality Design: We will undertake a systematic review of our core services using our 'designing for quality' assessment criteria, ensuring we check and adjust our quality position from board to ward.
2. Best system: We will develop our staff and build their capability to deliver Quality Improvement throughout the organisation as daily "business as usual" and apply the concepts to improving quality in our services.
3. Best Delivery: We will have a continued and even more robust focus on delivery of our National and Local Quality Priorities with effective communication and dissemination across our organisation and a focus on joined up improvement.

People Strategy

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

1. Best of People: The Trust aim to transform ourselves through innovative staff-led improvements that meets the needs of our patients now and in the future. Two key areas of this plan which relate to digital are: Make quality, care and innovation core to staff-led improvements and Workforce productivity though utilisation of technology.
2. Best Culture: The Trust aim to have a culture of openness and transparency, lived-by values, quality-led actions across our entire workforce.

3. Best Future: The Trust will deliver a workforce for the future, supported with the right skills to allow us to reach our full potential.

Digital Strategy

Provide digital solutions which empower our people to provide the best possible patient care experience and transform clinical outcomes. Deliver the vision through five core missions:

1. Clinically Led: We will deliver digital tools which support the Trust to improving outcomes and patient experience, while reducing wasted clinical time by ensuring that clinicians are at the forefront of design and decision making in implementing our digital strategy.
2. Paperless and Accessible: Full Electronic Patient Records will be implemented, and will provide clinical decision support tools supporting prescribing, managing pathways, automating clinic outcomes and prioritising work, with this data driving service improvement. Medical devices and point of care testing will be integrated to enrich the patient record, making a direct impact on the quality of our clinical services. Patients, carers and staff will be able to seamlessly access data, systems and tools from any location with devices fit for the services they are delivering.
3. Integrated and Flexible: Collaborative working across NHS and social care organisations will be a priority, ensuring interoperability of digital tools across organisational boundaries, and providing access to data which supports the delivery of effective care across the local care system. Data will be integrated between Acute, Community, Mental Health, GPs and Social Care, making available a comprehensive patient record.
4. Secure: Data and systems will be robustly secured and protected from cyber-attacks, while not hindering appropriate access.
5. Innovative: We will adopt and utilise technology which improves services, reduces risk or enhances the patient experience.

4 Estate and Facilities vision and strategy

The Trust's strategic pyramid highlights how Estates and Facilities underpin and support the organisation in progressing towards being "Brilliant".

Vision

To support excellent healthcare with high quality patient-focused environments.

Our Estates Strategy provides a framework for future consultations on how we will develop and protect our services. As part of the Estates Strategy, we will set a vision of how we intend to improve our estate over the next three, five and 20 years and will make our case for funding each of those stages.

Strategy

Our key strategic objectives are:

1. Estates Efficiency and Rationalisation
2. Future Development Zones
3. Technology and Data
4. Safety and Quality
5. Our People
6. System Partnership
7. Green Plan.

Estates Efficiency and Rationalisation

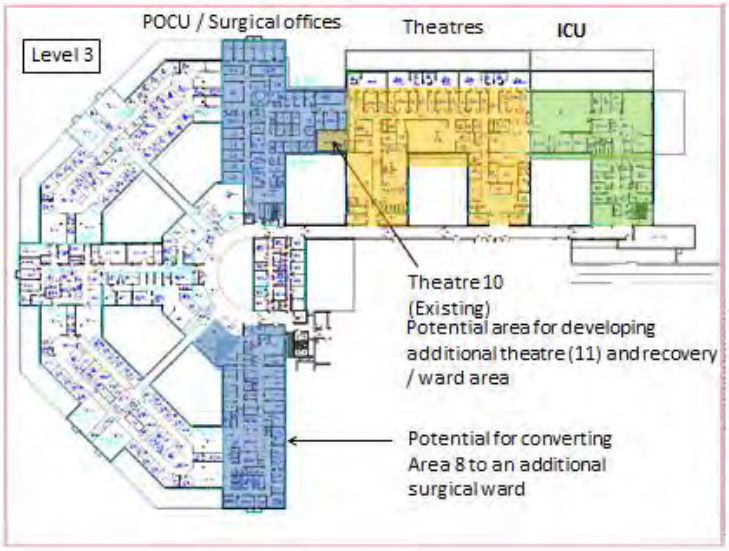
- Achieve the current targets set by Lord Carter and plan beyond this, taking in to consideration the new ways of working which will free up more space for onsite clinical services. Sharing space with healthcare partners.
- Reduce the size of the estates backlog. Look at how to reuse old and inefficient building stock more efficiently.
- Strengthen our cost base and optimise our capacity by expanding and offering our services to NHS partners bringing the overall costs to the NHS down.
- Developing the function internally - Estates and Facilities visible to the Trust Board ensures it can be responsive to the needs of the hospital and offer cost efficient and timely solutions to support the patient journey and experience.
- Portering: We have invested in staff to support the movement of patients round our sites and enable clinical staff to remain on wards supporting care for patients.
- Discharges: We will look to support early discharge where we can through initiatives such as an in-house repatriation service where we can provide the in home aids within 48 hours enabling the patients to discharge at the optimum time.

Future Development Zones

- We want to transform the way our Estate delivers care to our patients – ensuring it is well used to deliver a consistent and excellent environment in a way that we can afford. We want our staff to have excellent, modern and supportive environments

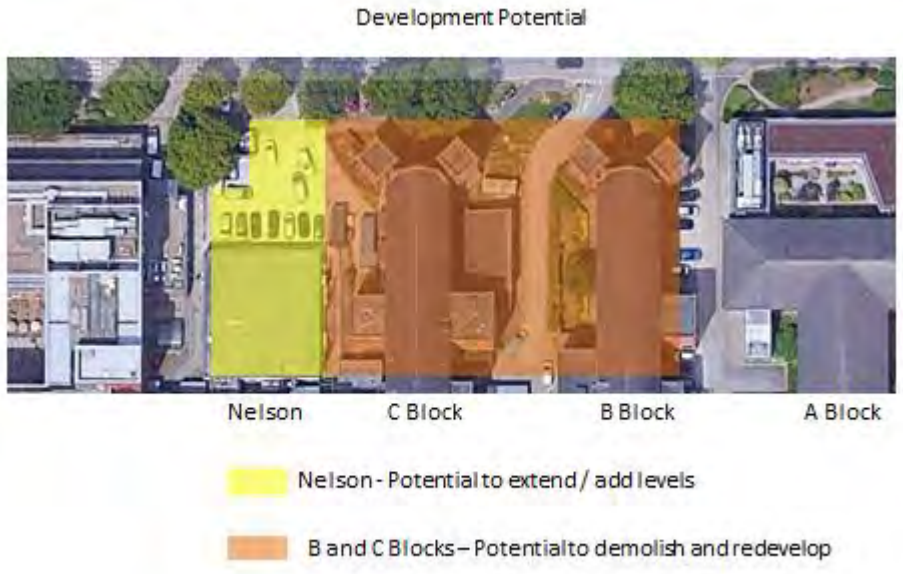
A ICU (L3)
B Theatres (L3)
C POCU / offices (L3)
D McCulloch / Trafalgar
E Area 8
F Nelson Ward
G Disabled Service Centre, Gate lodge, Res6
H Car Park 2
I Post Grad / Nurse Ed
J B&C Block (nightingales)

- We are fortunate to have space on site to develop services and explore different options for organising and delivering care. The areas above highlight where we can increase our capacity to treat more patients.
- The diagram below shows how an additional theatre could be provided with additional recovery beds by reconfiguring Pre-Operative Care Unit and surgical office space.



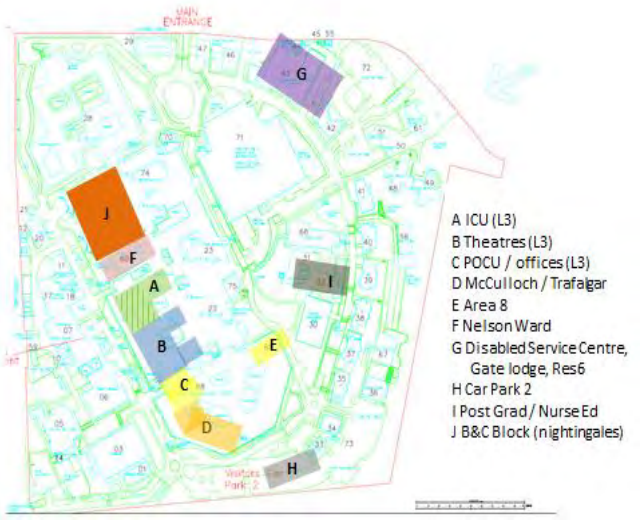
- Additional beds can be provided by relocating Outpatient areas that are currently sited without logical adjacency.

  There is potential to develop the current Nelson ward facility, creating a three story building that could link to the existing ICU. This would provide options for expanding existing ICU with minimal operational impact, and also provide an opportunity to provide additional general wards.



- Other areas for development include the Post Graduate / Nurse Education area and existing accommodation areas which would be aligned to the Trust's ambition to gain university status and ensure optimal recruitment and retention opportunities.

  This diagram illustrates that contrary to initial perception, space is not a limiting factor when considering the medium term strategic plans, as some of the existing services can be relocated away from the main acute site.



- We have ruled out land sale, because it limits our potential growth, and we are surrounded by housing or land designated as protected due to its heritage. Without a clear vision and understanding of the impact on growth within the population it is not considered to be prudent to restrict the hospital's ability to modernise through the existing land it currently owns to meet the short to medium term demands on clinical services.

What do we want to achieve	How will we measure it	How can we achieve it
Decant support functions and re-provide additional clinical space. Review, relocate, dispose and development Estate no longer fit for serving an expanding local population	Identify development zones and consolidate long term corporate strategy.	Develop core groups to include Clinical and Estates Expertise. Engage with external bodies and funding partners. Develop robust governance including clear decision processes.

- Development zones can be achieved as a result of demolitions and more ambitious schemes to vacate and demolish older and obsolete buildings. These development zones provide differing options to the Trust.
  - Retail opportunities and re-engineering drop off and collection areas for those service users that have mobility problems and disabilities.
  - Opportunities for the development of new state of the art clinical accommodation with links to current facilities via existing hospital streets, which will improve the overall patient experience.
  - Further opportunities for partnership working with neighbouring Trust's and other public sector services for shared facilities.
  - Enabling the Trust to respond to decisions based on clinical strategies and developments as determined by the ICS.

- It is important that future development zones identified are freed up to enable services to be developed to meet the population's needs.

Car Parking

Surplus land created by vacated and unaffordable buildings has been converted to use for public car parking, avoiding patients being late for clinic and reducing the adverse impact of traffic tailbacks on our neighbours.

Plans are already developed to provide additional multi-storey parking as shown below.

OVERHEAD GOOGLE EARTH VIEW (EXISTING CAR PARK HATCHED RED)

Step-down units

Following the conclusion of conversations with partner tenants, this allows for the freeing up of some space which can be considered for clinical and non-clinical use, examples might be an onsite healthy living centre or community step-down facilities.

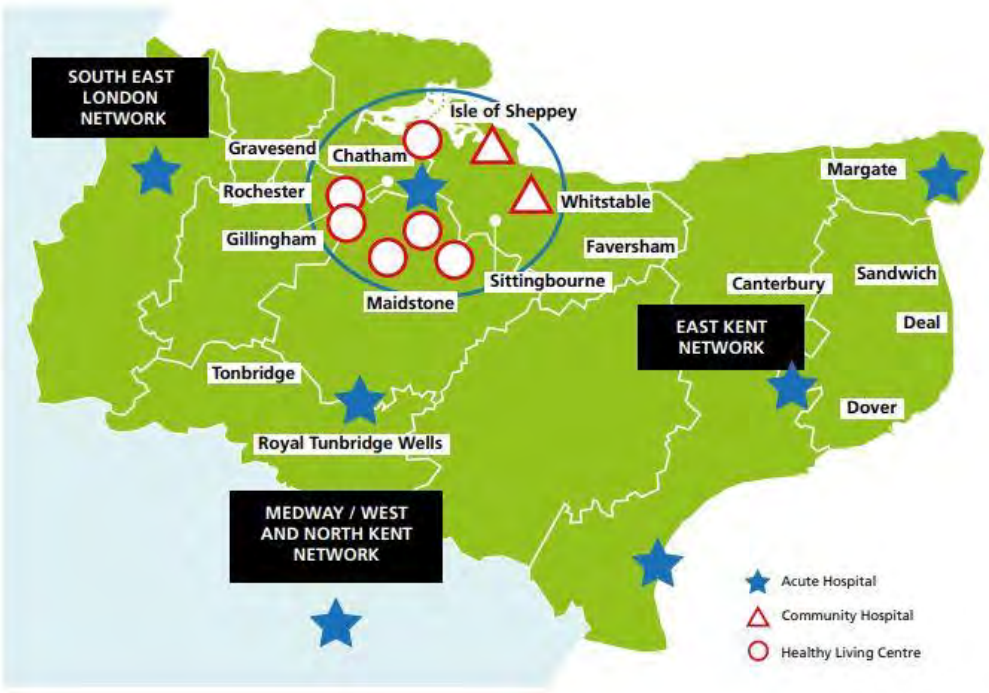
Development of more general clinical areas

We need to review our ICP footprint to enable the expansion of diagnostic services as part of the partial repatriation of services currently outsourced due to lack of sufficient capacity onsite.

We will also need to monitor the ICP clinical models as they emerge to ensure we can adapt swiftly if required.

Elective options appraisal

The Trust currently lacks capacity to accommodate all the requirements of our local commissioners. This includes surgical elective services. We want to optimise the Medway and Swale capacity, in the short to medium term through the use of the existing estate by converting office and non-clinical space so as much of this can be used for clinical services. If however, this does not provide a complete solution on site, we will work with partners to optimise NHS estate across both the ICP and ICS.



Estates technology and data

- Embrace digital transformation and technology to improve processes, safety, staff satisfaction and patient experience.
- Leverage data analytics to identify trends and opportunities for efficiency and improvement.

Safety and Quality

- Provide safe and high quality services and facilities.
- Implement feedback systems for patients, staff and visitors.
- Prioritise backlog work to sustain critical services.
- Soft Facilities Management – Patient Nutrition: Facilities have a key role to play in ensuring our patients, visitors and staff get the appropriate nutritional intake to make and keep them healthy. We will continue to work with our Dietician teams to ensure the correct calorific values are achieved for patients with good hydration both playing a key role in the patient's recovery.

Our People

- Staff development programme with the first phase being House-Keeping services.
- Grow our staff through training and mentoring.
- Through a restructuring of our services and strong leadership, we will provide the opportunities for staff to retrain via apprenticeship schemes to motivate and make them more productive; we anticipate moving to a National Model Hospital mid-point level of performance within two years 2022/23.
- Get the right leadership in place and ensure robust succession plans are in place.
- Support and complement the environment for our staff in respect of their health and wellbeing.
- Developing the Estates and Facilities Business Unit
  - Recruitment plans/Growing capabilities – Model Hospital/Business Analysts
  - Yellow Belt projects
  - Culture – uniforms, branding
  - Case studies from other organisations to follow.

System Partnership

Integrated Care Partnership – the role of Estates and Facilities. As the largest provider of Estates and Facilities services across Medway and Swale we will support our partner health providers in ensuring our patients get the facilities they deserve and need.

- Local Care – we will, in partnership, ensure all our health providers' facilities are optimised where possible through a strategic review and reduction of non-health care facilities
- System Outpatients Transformation
- Healthy Living Centre Strategy

- Partnership working with other organisation.

We want to work closely with our healthcare partners to deliver:

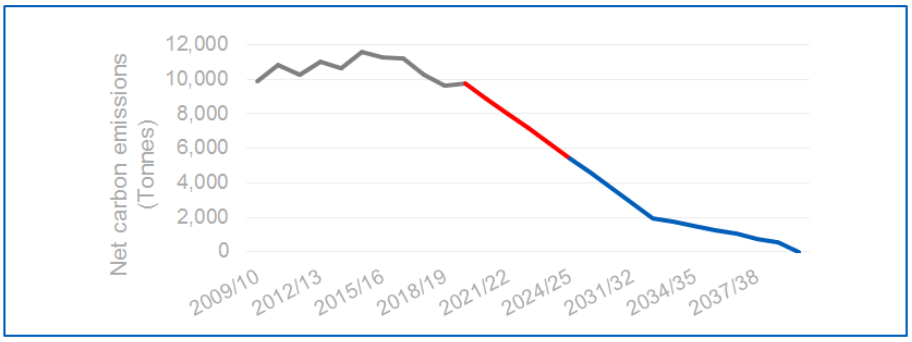
- Services that better meet health and social care needs of our population.
- Better value for money and a reduction in running costs by optimising our existing Estate.
- An Estate that aligns to future commissioning plans.
- Agreements with our health and social care services to share property where possible.
- A clear plan to optimize our under used buildings.

Sustainability

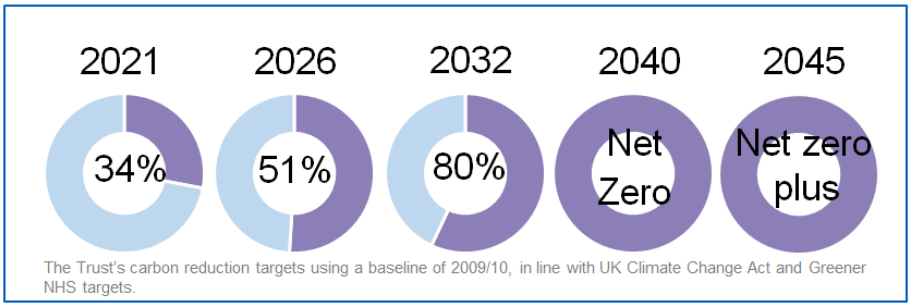
In May 2021 the Board approved the Trust's Green Plan, formerly known as the Sustainable Development Management Plan (SDMP). The Plan provides an organisation-wide strategy that outlines the Trust's plan of action for 2021-2026, in line with our vision and objectives. It aims to improve our organisation performance by generating financial savings and environmental and social benefits.

In January 2020 the campaign 'For a Greener NHS' was launched and a target of reaching net zero emissions by 2040 for the care we provide was set. The Green Plan addresses this target and sets a clear action plan for meeting net zero.

The Trust's Carbon Reduction Performance against the UK Governments National Targets



UK Government Carbon Reduction Targets



The Trust's carbon reduction targets using a baseline of 2009/10, in line with UK Climate Change Act and Greener NHS targets.

Green Plan Targets to achieve by 2026

Increase staff engagement to a score of 7/10 by 2026 (NHS Staff Survey)	Sustainable travel plan reduce business mileage by **15%**	Continue to achieve electricity consumption under **70 kWh/m²**
Improve **air quality** with annual air quality audit measuring well below the **PM2.5** concentration threshold	Increase recycling rates to at least **30%**	Reduce water consumption by **14%** to 1.66m³ per m²

What do we want to achieve?	How will we measure it?	How can we achieve it?
Embed sustainability within organisational values and behaviours	• Assess using SDAT (or replacement tool) • Undertake annual staff surveys • Provide progress report of the Green Plan within annual report • PAM	• Develop environmental policy • Establish a Sustainability Steering Group and Green Champions network • Embed sustainability within Trust values
Reduce consumption, cost and environmental impacts of our utilities	• ERIC • Model Hospital	• Energy saving campaign • Develop and implement a Heat Decarbonisation Plan • Install sub-metering across the site
Deliver cost and carbon savings through resource and waste management	• ERIC • Procurement for Carbon Reduction Tool	• Develop a resource and waste management action plan • Recycling awareness campaign
Reduction in carbon emissions from staff and patient transport	• Measure and calculate our carbon emissions fro travel, annually • Measure and report on site air quality annually	• Develop a Sustainable Travel Plan • Provide and encourage the use of electric vehicles • Provide additional active travel incentives

5 Impact on the Trust, staff and patients

Trust

- Cost efficiency - Model Hospital opportunities around water consumption, Domestic services, and maintenance costs, waste and catering.

Staff

- A more engaged and motivated workforce through feedback systems, staff development and apprenticeship retraining schemes.

- Through technology adoption, improve the staff experience in their work environment and drive up the staff survey results.

Patients and Community

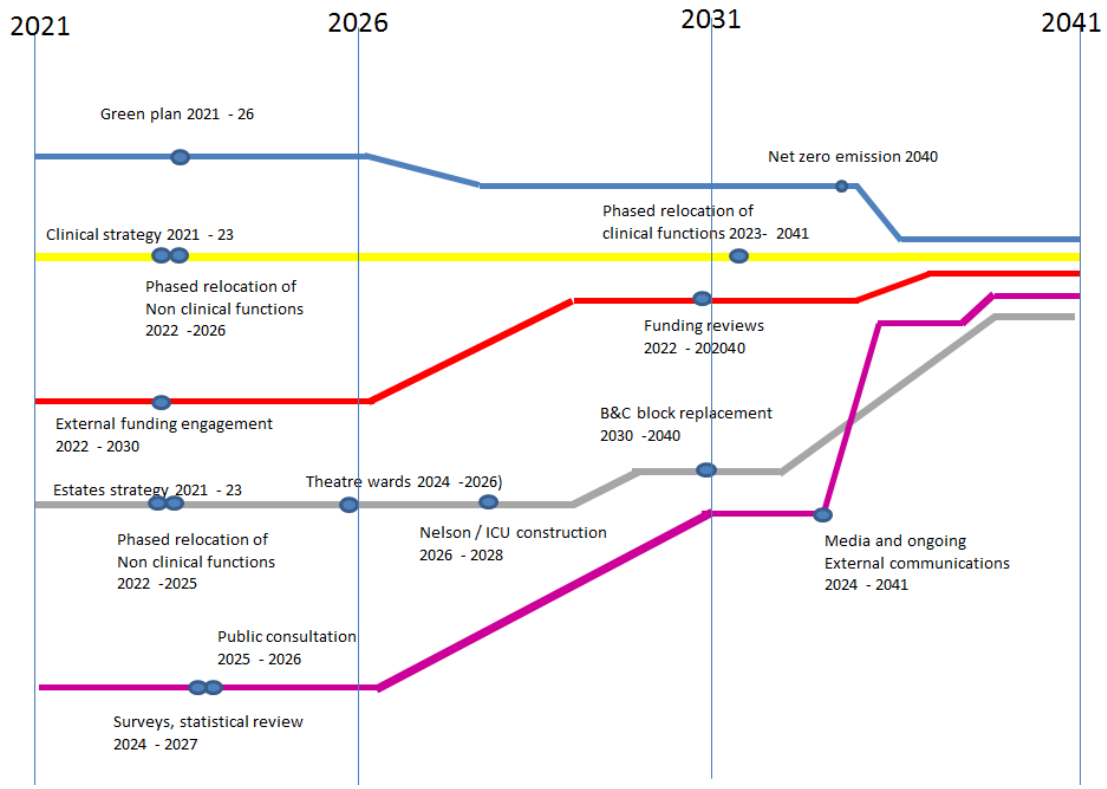
- Green Travel Plan – provide alternative options of accessing the site other than by car. Incentivise staff to use alternative transport and increase health and wellbeing by making it easier to access healthy living services, create a wellbeing culture with appropriate facilities where staff and patients can reflect and find peaceful space.

6 Strategy roadmap

Years 1 – 3 2021 - 2022

- Optimise our services by ensuring as many services are co-located where possible
- Reviewing and refining our understanding of our backlog maintenance schedule
- Ensuring formal compliance data is maintained and monitored through an Estates and Facilities Compliance Board
- Establishment of a performance management reporting system underpinning KPIs which we can use to ensure we provide a timely and effective service
- Conclude the ED development
- Finalise improvement plans and have completed significant levels of fire planning works
- To have completed 50% of the sites lift replacement programme
- To have installed a new lift(s) in the 2000 building
- Review the car parking policies, granting car parking to staff who need it the most and preserving spaces for our patients
- Identify space on the site for the creation of a step down facility
- Support creating the capacity for the repatriation of elective and diagnostic services
- Finalising plans for the development of a 3 storey, 3 ward building and submit capital bid
- Ongoing maintenance and clear backlog:
    - Theatres – to have completed the full refurbishment of our theatres 2021/2022
    - To have supported the development of the Imaging Strategy across the ICP ensuring Medway and Swale has sufficient MRI/CT/X-ray capacity across the Acute site and Healthy living centres – 2021/22
    - To have supported the replacement of the existing 14 year old Cardiac Catheter suite – 2021/22
    - To have reviewed all outpatient and pathology space to ensure these are optimized for clinical services
    - Meet the requirements of the ED pathways including Ambulatory Care Facilities

Years 3 – 5 **2023 - 2025**	• Deliver 75 more units of staff accommodation to meet the growth in Junior Doctor Numbers of 75. 25 per annum starting from 2021. • Complete the detailed planning of the decommissioning of our older wards and finalise plans for the replacement of these via investment in a new building • Be clear on the route to capital to make the required improvement to the Estates • Ongoing maintenance and clear backlog: - Theatres - increase the capacity - To have supported the implementation of additional Endoscopy capacity - Implement all the requirements in respect to Fire Management of the site and keep under constant review
Years 5 – 20 **2026 - 2031**	• Implement the second phase of building new wards to replace outdated and not fit for purpose estate • Ensure the estate across Medway and Swale is optimized for the benefit of all the community in terms of access and value for money



Key targets

2020 to 2025

- Roll out of Green Plan
- Develop Estates phasing options and investment trajectory.

- Engage with external partners such as members of Parliament, NHS Improvement/England, ICS, and local councils to ensure plans are integrated and capable of being funded robustly
- Engage in public consultations re displaced services and expansion of key acute services.
- Develop communications strategy
- Development of new wards and diagnostic capacity started.

2025 to 2030

- Continue developments such as Theatres, Wards
- Continue displacement programme (freeing up of non-clinical space and development of modern working practices)
- Continuation of Green Plan including replacement of CHP
- Staff accommodation expansion completed (oversees Dr's / nurses required to meet growth predictions, alongside a cohesive local recruitment plan)

2030 to 2041

- Demolish B and C blocks (phased) thus eliminating all nightingale wards and replacing with modern compliant wards.
- Achieve net zero carbon emission by 2041 in line with mandatory obligation

7 Delivery

Finance and investment profile

A backlog programme has been developed which requires a minimum investment of £4 million per annum. The programme has been developed to limit the impact on the delivery of clinical services.

8 Governance, measuring and monitoring

Directorate Compliance Framework

The Compliance Framework provides organisations with a self-assessment capability to determine their level of compliance against legislative and regulatory standards.

The Framework also identifies five sub-domains in order that more focused scrutiny can be undertaken when identifying strengths and weaknesses. This allows organisations to identify areas of improvement and measure progress towards improved compliance targets.

We are looking to benchmark ourselves against other acute trusts who are using the same Compliance Framework so that we can contribute positively and share and learn from best practice amongst our peers.

What do we want to achieve?	How will we measure it?	How can we achieve it?
An improved compliance rating with regulatory and legislative requirements, achieving an overall rating of 85% for the aggregated technical domains, ensuring that there are no amber or red rated sub-domains	• Periodic reviews of each technical domain with the staff responsible for delivery and compliance using the Compliance Framework	• Develop, monitor and complete action plans generated by the Compliance Framework • Ensure all Authorising Engineers, Authorised Persons and Competent Persons are trained for their duties and are appointed in writing. • Ensure Annual Reports are compiled and communicated in order that the Board is sighted on matters associated with compliance. • Ensure that robust mechanisms are implemented to reduce risks, e.g. Permit to Work systems.

	Accountability	Process	Monitor & Review	Capability	Outcomes
Asbestos Asset Management Contingency Planning Contractor Management Decontamination Electrical Systems Facilities Infection Control Fire Safety Health, Safety & COSHH Lifts Mechanical Systems Medical Devices Medical Gas Systems Safe & Accessible Buildings Security Management Sustainability Ventilation Waste Management Water Systems	• Board understand professional responsibilities • Approved Policy • Robust risk management and governance arrangements in place	• Operational procedures developed and widely understood • Risk Assessments in place • As fitted drawings available • Permit to work systems in place • Risk assessment and building records are maintained and updated appropriately • Fully documented planned preventative maintenance in place • Systems maintained and validated in accordance with best practice	• Monitor and review systems in place • Independent assurance provided to the Board	• Appointment of key staff e.g. Authorised persons • Sufficient trained and competent staff • Sufficient budget allocation available • Access to upto date legislation and guidance • Risks identified and managed • Periodic appraisals of key personnel by the external Authorising Engineers	• Key Performance Indicators developed and reported to Board • Evidence of root cause analysis and learning from incidents and near misses • Benchmarking against other organisations

Business Continuity Plans and testing

Undertake regular exercises to test the resilience and business continuity plans for Estates and Facilities.

Agree KPIs to respond to serious incidents relating to the Estate.

Estates efficiency and rationalisation

Estates

What do we want to achieve?	How will we measure it?	How can we achieve it?
A more efficient, lower cost estate	• Annual backlog condition appraisal • ERIC • Reduced operating costs	• Demolitions of old/inefficient building stock • Space utilisation surveys
Lord Carter recommendation on empty and underutilised areas and clinical/non clinical space ratio metric	• Lord Carter dashboard	• Demolitions of old/inefficient building stock • Space utilisation surveys • Support increased productivity in clinical areas

Operations

What do we want to achieve?	How will we measure it?	How can we achieve it?
An estate that is maintained to a high standard and is compliant with statutory legislation and NHS guidance	• Compliance Assessment & Analysis System • Audit programmes	• Address improvement opportunities identified through CAAS audits • Develop robust action plans to address any issues and benefits identified in audits
Establish the baseline of customer satisfaction for repairs and defects. Agree an improvement target by 2022	• Customer satisfaction data (Customer & Stakeholder Test, CST)	• Develop and implement actions from CST data • Identify and deliver quality and improvement training as necessary
Improve performance and quality for building and engineering services	• External Benchmarking • Data Validation	• Review Contracts (Merging with Public Sector bodies - partnership working) • Targeted investment in plant and equipment • Review working practices/skill mix • Review preventative maintenance regimes

Facilities

What do we want to achieve?	How will we measure it?	How can we achieve it?
Provide a sustainable and profitable Catering Service with an increased catering retail performance year on year	• Profit and Loss accounts (weekly and monthly) • Sales/Product Analysis • Sales targets	• Increased sales • Reduction in operating costs • Improved procurement of provisions • Development of staff
High quality and effective contract services	• Contractor KPIs • Model Hospital	• Explicit tender specifications including; activity scheduling, innovative use of technology, payment by results and partnership work.
Provision of a 'hotel standard' facilities management service which is safe, clean and high quality	• PLACE • Friends and Family Test feedback • Fundamental Standard Audits • Customer Feedback score cards • PALS/Complaints • Lord Carter Dashboard	• Implementation of a 'Hotel' quality rating system • Focus on quality over cost • Improve monitoring and response to environment related issues • Establish an integrated Facilities Helpdesk

Capital Development

What do we want to achieve?	How will we measure it?	How can we achieve it?
Delivery of the backlog maintenance programme and energy reduction projects	• Annual backlog condition appraisal • ERIC • Reduction in energy costs	• Programme of demolitions of old building stock • Deliver the backlog maintenance programme • Deliver energy reduction projects
Provide buildings, services and surroundings that are high quality, fit for purpose, safe and affordable	• Peer review of designs • Project scorecards/feedback • PLACE • CQC Inspections	• Establish clear standards and ensure these standards are attained • Projects delivered to an agreed budget and timescale • Dedicated team focusing on environment improvement
Support clinical developments in line with the Trust's Clinical Strategy and determined by STP and national policies	• Deliver capital programme on time • Assist with delivery of STP • Post project reviews	• Provide technical advice and support for clinical teams to deliver their clinical strategy • Flexible enough to react to developments and changes to strategy and policy
Provide efficient and cost effective procurement of construction solutions	• Provide best value • Benchmarking • Post project evaluation • Lessons Learned	• Broad range of procurement routes available e.g tender, MTC, frameworks • Use best practise guidance, HBN's etc. • Use innovative solutions to improve programme or reduce cost e.g. modular/off-site manufacture

Our people

We will invest in our staff, enabling them to become multi-skilled and motivated, with continuous career and learning opportunities.

We will monitor progress through the staff survey and via regular formal and informal huddles.

We will as a senior management team listen and learn from colleagues in Estates and Facilities and encourage great ideas to be implemented across all of our services.

We will encourage the continued use of the apprenticeship scheme and build the success of this participation into our succession planning.

Continuous feedback

Customer/staff/patient satisfaction.

We want to have regular feedback from patient's visitors and staff.

We will measure our performance through regular audits of the environment.

We will work with colleagues to ensure we meet the needs of all of the public from access to travel and meeting dietary needs

9 Risks

The risks to delivery of this strategy are the availability of a skilled workforce and sufficient capital investment. These risks will be considered at each annual review when the progress against the strategy is evaluated.

Additional risks include

- Nightingale wards are expensive to maintain and could impact on patient safety and experience, early replacement must be prioritised.
- During January 2021, the hospital experienced severe pressure brought about by the second COVID-19 wave. The strategy document contains realistic and achievable aspirations to significantly match not only growth capacity, but also provide pandemic resilience by increasing theatre, wards, isolation and ICU capacity.
- The Trust will need to urgently meet the local population growth due to increased housing growth.

Document	Ref No
References:	
Trust Associated Documents:	

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

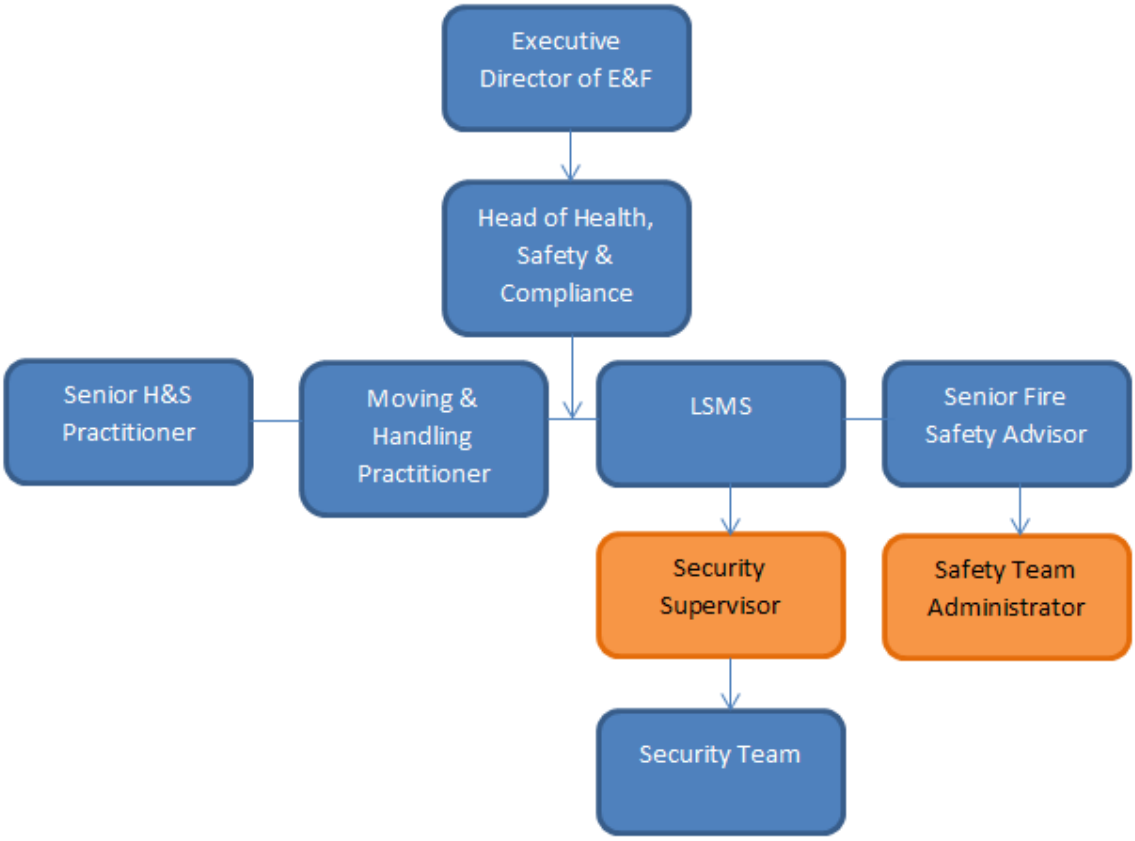
Title of Report	**Annual Health and Safety Report**	**Agenda Item**	4.2
Report Author	Louise Furlong, Senior Health and Safety Practitioner		
Lead Director	Gary Lupton, Director of Estates and Facilities		
Executive Summary	This report, aims to ensure the Chief Executive and the Board, are aware of the Trust activities relating to Health and Safety compliance during the period of 01 April 2020 and 31 March 2021		
Committees or Groups at which the paper has been submitted	Health and Safety Strategic Committee, 18 May 2021		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Health and Safety Strategic Committee plays a key role in monitoring the Trust's compliance with current legislation and the requirements of the Health and Safety Executive (HSE). The Health and Safety at Work Act 1974 (HASAWA), places a duty on employers to ensure so far as is reasonably practicable, the health, safety and welfare at work of all their employees. A breach of the Act could give rise to prosecution, financial implications, civil claims and reputational damage.		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to note and approve the contents of this report.		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

1 Executive Overview

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

2 Structure

2.1 A re-structure to the security team has enabled the introduction of a Security Supervisor Role. The previous fire trainer role has been replaced by a Safety Team Trainer & Administrator.



2.2 The Safety Team is further supported by colleagues within the Trust, undertaking roles such as Keyworkers for Health & Safety (81) or Moving & Handling (82), or Fire Wardens (circa 700)

3 Training

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

1. **Health, Safety and Welfare**; completed at induction with a renewal period of 3 years. Training is available via a national e-learning package.
2. **COSHH Awareness;** completed at induction with a renewal period of 3 years. Training is available via an e-learning package.

3.2 Mandated Moving & Handling training within the Trust currently consists of 3 levels of training:

1. **M&H Level 1 (theory);** completed at induction by all staff, renewal every 2 years, available as e-learning module of face to face
2. **M&H Level 2**, is a practical session for all clinicians and non-clinical roles where manual handling is required, such as portering. Renewal every 2 years, face to face only.
3. **M&H Level 3**, is a practical session for Doctors only with a renewal period of 3 years.

3.3 Mandated Fire Safety training consists of a single level of training, completed at induction and renewed annually. There is a requirement for this to be carried out face to face although an e-learning module was made available during the last year to manage issues with social distancing in classroom settings.

3.4 **Table 1** shows the current compliance figures for Health, Safety & Welfare training as of the statutory and mandatory report released on 05/04/2021, in comparison to the compliance figures in 2019/20.

Table 1

Subject	2018/2019 Compliance	2019/20 Compliance	2020/21 Compliance
Health, Safety & Welfare	92%	94%	89%
COSHH Awareness	NA	N/A	65%
M&H Level 1	93%	96%	89%
M&H Level 2	NA	N/A	77%
M&H Level 3	NA	N/A	64%
Fire Safety	85%	86%	89%

3.5 Additional training is available to volunteers as Health & Safety Keyworkers, Moving & Handling Keyworkers and Fire Wardens. The number of H&S keyworkers has risen by 27% in the last year.

3.6 A training proposal for managers has been put forwards to the Health & Safety Strategic Committee for consideration, which would enable staff to gain an accredited qualification in H&S, enabling them to focus on practical management skills; ensuring work is carried out safely and without risks to health, and ensuring that health & safety management can be integrated into normal business processes.

4 Incident Reporting

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

4.2 **Table 2** shows the number of RIDDOR submissions over the last 4 financial years.

Table 2

Financial Year	No. of RIDDOR Submissions

2017-18	16
2018-19	35
2019-20	16
2020-21	23

4.3 For 2019-20, data submitted for the ERIC return (Estates Returns Information Collection), suggests for Medium Acute Trusts, an average of 7.7 RIDDOR notifications were submitted for the Estates and Facilities Division.

4.4 **Table 3** shows the breakdown of RIDDOR submissions by directorate for the both current and previous financial year.

Table 3

Directorate	**2018/19 RIDDOR Submissions by Division**	**2019/20 RIDDOR Submissions by Division**	**2020/21 RIDDOR Submissions by Division**
Unplanned & Integrated Care	8	1	6
Planned Care	16	9	12
Estates & Facilities	6	4	4
Corporate	2	1	0
Injuries to members of the public	3	1	0
Other Service Provider	0	0	1
TOTAL	**35**	**16**	**23**

4.5 **Table 4** shows the breakdown of RIDDOR submissions by accident type for the last three years.

Table 4

Injury Type	2018/19 Number of Submissions	2019/20 Number of Submissions	2020/21 Number of Submissions
Crush Injury	1	1	0
Fall from Height	1	0	2
Formalin Spill	2	1	0
Incorrect Use of Equipment	3	2	0
Inoculation Injury	2	0	5
Moving & Handling Injury	8	2	3
Slip, Trip & Fall	12	6	4
Struck By Object	3	2	2
Physical Assaults	1	2	5
Work-Related Dermatitis	2	0	1
Contact with a Hazardous Substance	0	0	1

4.6 The Health & Safety Team rely on staff using the internal incident reporting system (DATIX) in order to identify trends.

4.7 Inoculation injuries accounted for 23% of the incidents reportable under RIDDOR.

4.8 Physical assaults accounted for 23% of the incidents reportable under RIDDOR.

5 Enforcement Notices

5.1 Over the last 5 years, the Trust has received a single enforcement notice from the HSE.
The notice was in relation to the category level 3 (CL3) containment facilities within microbiology, which has now been taken out of service since the introduction of the North Kent Pathology Service;

Type of Notice	Date Received	Details
Improvement Notice	December 2017	MHSWR 1999, Reg 5(1), inadequate health and safety management arrangements for the planning, organisation, monitoring and review of work with biological agents.

5.2 Following a visit by the Care Quality Commission in November 2019, the trust was issued with a Warning Notice under Section 29A which, among other things, raised concerns with the securing of areas accessible to patients, especially where COSHH products were stored. A task and finish project was carried out to address the concerns in the notice and longer term controls have been implemented to monitor these areas, including:

1. Introduction of a COSHH Awareness e-learning module for ALL staff. Compliance at year end was 65%.

2. Completion and return of weekly COSHH checklists by all in-patient wards.
3. Completion of monthly COSHH audits by the Health & Safety Team across in-patient wards; compliance has increased to a level where compliance confidence levels are high.
4. Installation of several engineering controls such as sink-mounted soap dispensers, 'push-to-close springs' and door alarms.
5. Introduction of lockable housekeeping trolleys across services.

6 Conclusion and Next Steps

6.1 The management of Health and Safety remains a key priority for the Trust with appropriate resources being provided to manage this within the organisation.

6.2 The Trust must work to improve both the incident reporting culture and the systems within which the data is captured. Further work is required to improve staff training for DATIX, to ensure data is captured correctly.

6.3 The Trust has seen an increase in the number of incidents reported in relation to:

Incident Type	2019/20	2020/21	Increase
Occupational Stress Referrals	77	80	+4%
Red Cards Issued	25	32	+28%

Although there has been a decrease across all other incident types, this is likely due to decreased footfall across the site caused by the impact of Covid-19.

6.4 Work will need to focus on these key areas and also to embed a culture where the focus is on prevention and learning.

Meeting of the Board of Directors in Public
Thursday, 03 June 2021

Title of Report	**Finance Report – Month 1**	**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 breakeven against the NHSE/I control total.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday, 20 May 2021		
Executive Group Approval:	Date of Approval: Wednesday, 19 May 2021		
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 1		

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Finance report

For the period ending 30 April 2021

Contents

Appendices

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	TBC	(7)	TBC	The Trust reports a £7k deficit position for April; reducing to breakeven after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes a contingency of £0.9m to cover the impact of unforeseen events in the future. Total pay costs have decreased in month by £4.9m to £19.5m. The previous month's position included the accruals for carry forward annual leave £2.7m and the wellbeing day £0.7m. The remainder of the decrease is attributed to lower Covid-19 incremental costs (reduction of £0.9m) and clinical excellence awards being included in the final month of 20/21 (which totalled £0.3m).
Donated Asset Depn.	TBC	7	TBC	
Control Total	**-**	**-**	**-**	
* Budgets have not been finalised at the time of writing this report.				
CIP				
In-month		86	-	Currently, the anticipated level of CIP included in the submitted plan to the STP is £1.5m for the first 6 months. This is deemed to be a prudent and achievable level of efficiencies as the services continue to recover and restart elective activity. Delivery for April totals £0.1m, and is from the full year effect of schemes that started in the previous financial year. £0.6m of the target os covered by the FYE of last year's schemes and therefore the additional ask is £0.9m in 6 months (or the remaining 5 months) – c.0.5% on average. PMO and Finance are currently working with Care Groups and Divisions to identify schemes and we will be running 2 CIP Showcase events in June to relaunch the CIP Programme.
YTD	TBC	86		
Capital				
In-month	TBC	1,801	-	The Trust Capital Resource Limit (CRL) has been set at £13,877k for 2021/22 by the STP. This is funded by Trust depreciation of £10,711k, additional internal cash reserves of £2,059k and £1,107k planned PDC for the UTC project. This CRL is less than 50% of Trust capital expenditure in the prior year. The Trust has highlighted a further £8m of schemes to the ICS which we would wish to critically pursue should any additional resources become available.
YTD	TBC	1,801	-	

£'000	PY	Actual	Var.	
Cash				
Month end	49,184	47,126	(2,057)	Cash balances have reduced by £2,057k since 31st March 2021; £9.7m of income received in advance of service provision is included within this balance.

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2. Income and expenditure Analysis

£'000	Apr-21/22 Actuals	Variance to Q3 Average plus Covid Adjustment: Q3 Included Covid	Variance to Q3 Average plus Covid Adjustment: Variance to Q3 Average	Variance to Exit run rate: 20/21 Exit Run Rate	Variance to Exit run rate: Variance Actuals to Exit Run Rate	Variance to Q3 Average plus Covid Adjustment: Q3 Including COVID	Variance to Q3 Average plus Covid Adjustment: Apr-21/22 Additional Funding Requests	Variance to Q3 Average plus Covid Adjustment: Apr-21/22 "Draft" Budget	Variance to Q3 Average plus Covid Adjustment: Variance Actuals to Draft Budget
Corporate									
Income	1,013	1,002	11	1,002	11	1,002	-	1,002	11
Pay	(2,027)	(1,841)	(186)	(1,927)	(100)	(1,841)	(15)	(1,856)	(171)
Non Pay	(689)	(630)	(59)	(642)	(47)	(630)	(52)	(682)	(7)
Sub-total	**(1,703)**	**(1,469)**	**(234)**	**(1,566)**	**136**	**(1,469)**	**(67)**	**(1,536)**	**(167)**
E&F									
Income	265	257	8	257	8	257	-	257	8
Pay	(1,368)	(1,381)	14	(1,158)	(210)	(1,381)	-	(1,381)	14
Non Pay	(1,274)	(980)	(294)	(1,108)	(166)	(980)	(21)	(1,001)	(273)
Sub-total	**(2,376)**	**(2,104)**	**(273)**	**(2,009)**	**368**	**(2,104)**	**(21)**	**(2,125)**	**(252)**
Planned Care									
Income	668	626	42	626	42	626	-	626	42
Pay	(7,986)	(7,863)	(123)	(7,923)	(63)	(7,863)	(139)	(8,002)	16
Non Pay	(2,599)	(2,588)	(11)	(1,996)	(603)	(2,588)	(10)	(2,598)	(1)
Sub-total	**(9,918)**	**(9,826)**	**(92)**	**(9,293)**	**625**	**(9,826)**	**(149)**	**(9,975)**	**57**
UIC									
Income	1,772	1,885	(114)	1,885	(114)	1,885	-	1,885	(114)
Pay	(7,544)	(7,487)	(57)	(7,644)	100	(7,487)	(23)	(7,510)	(34)
Non Pay	(3,764)	(3,613)	(151)	(3,601)	(163)	(3,613)	(233)	(3,846)	82
Sub-total	**(9,537)**	**(9,214)**	**(322)**	**(9,360)**	**177**	**(9,214)**	**(394)**	**(9,471)**	**(66)**
Central									
Income	174	1,382	(1,207)	1,381	(1,207)	1,382	-	1,382	(1,207)
Pay	(549)	(659)	110	(1,055)	506	(659)	193	(466)	(83)
Non Pay	(1,667)	(1,760)	92	(1,478)	(190)	(1,760)	82	(1,678)	11
Post EBITDA	(1,433)	(1,369)	(64)	(1,379)	(54)	(1,369)	-	(1,369)	(64)
Sub-total	**(3,475)**	**(2,406)**	**(1,069)**	**(2,530)**	**945**	**(2,406)**	**275**	**(2,131)**	**(1,344)**
Trust Income									
Income	**27,002**	**25,010**	**1,992**	**25,010**	**1,992**	**25,010**	**219**	**25,229**	**1,773**
Total									
Income	30,893	30,162	731	30,161	732	30,162	219	30,381	513
Pay	(19,474)	(19,231)	(243)	(19,707)	233	(19,231)	16	(19,215)	(258)
Non Pay	(9,993)	(9,571)	(423)	(8,824)	(1,169)	(9,571)	(234)	(9,805)	(188)
Post EBITDA	(1,433)	(1,369)	(64)	(1,379)	(54)	(1,369)	-	(1,369)	(64)
TOTAL	**(7)**	**(8)**	**1**	**251**	**259**	**(8)**	**1**	**(8)**	**1**

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Key messages:

1. Q3 funding envelopes for the divisions are equal to the actual run rate spend of quarter 3 in 2020/21; these have then been adjusted for Covid (no longer held centrally). The draft budget includes those executive agreed cost pressures along with reserving centrally for those service developments also agreed (subject to investment governance approval).
2. The Trust continues to invoice other provider organisations in Kent using the same methodology applied by NHSE/I in calculating their baseline.
3. CCG income for block contract, top-up, growth and covid is the same as the last six months of 2020/21, this includes the additional £2.5m of covid income, less the lost income adjustment of £1.5m.
4. Total expenditure includes the incremental cost of Covid-19, where possible this is held within the divisions and will be funded from a central reserve when the budgets are finalised.
5. April actuals include some costs that were not in the Q3 run rate, such as more substantive staff across the divisions and costs for outsourcing Catheter Lab activity to KIMS.
6. Cost pressures, service developments, investments and unfunded posts not in the quarter 3 average run rate total £0.5m.
7. Of the additional £0.5m, £0.2m is to fund outsourcing cardiac activity to KIMS, £0.1m for EPR and licenses, these costs are included in the actuals. £0.1m for unfunded posts in Planned Care have not all been recruited to.
8. Total expenditure includes the incremental cost of Covid-19, being £0.4m in-month.
9. Due to a delay in the impact of some of the recruitment plans, cost pressures and service developments; as well as the lower Covid costs than estimated, a £0.9m contingency has been created. This is £0.5m higher than the contingency included in the draft plans.
10. Variance to the Q3 run rate includes the impact of the restart and restore activity as well as some additional cost pressures that have

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3. Balance sheet summary

Prior year end	£'000	Month end actual	Var (PY v Actual)
221,951	**Non-current assets**	**222,866**	**915**
6,962	Inventory	6,889	(73)
16,216	Trade and other receivables	16,156	(60)
49,184	Cash	47,126	(2,058)
72,362	**Current assets**	**70,172**	**(2,190)**
(137)	Borrowings	(139)	(2)
(37,101)	Trade and other payables	(33,729)	3,372
(8,839)	Other liabilities	(10,938)	(2,099)
(46,077)	**Current liabilities**	**(67,230)**	**(18,285)**
(2,151)	Borrowings	(2,151)	0
(1,424)	Other liabilities	(1,425)	(1)
(3,575)	**Non-current liabilities**	**(3,576)**	**(1)**
244,661	**Net assets employed**	**244,655**	**(6)**
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,277)	(6)
36,062	Revaluation reserve	36,062	0
244,661	**Total taxpayers' equity**	**244,655**	**(6)**

Key messages:

1. Net assets employed are £244.7m, no change from the prior year,

2. Working balance movement; cash, payables and deferred income (other liabilities) are the only notable variations since 31st March 2021.

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4. Conclusions

The Finance Committee is asked to note the report and financial performance which is £7k deficit in-month reducing to breakeven after removing the adjustment for donated asset depreciation and income. 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 the full year effect of schemes that started in the previous financial year.

The following risks have been identified with the financial position for the financial year ahead:

- Managing cost pressures & service developments within financial evelope
- Delivery of CIP targets
- ERF income £1.3m
- Managing cost of elective recovery within plan

Mitigations to reduce the risk:

- Phasing on cost pressures / services developments
- Additional ERF >£1.3m & Maternity funding
- M1 contingency £0.9m

Alan Davies
Chief Financial Officer
May 2021

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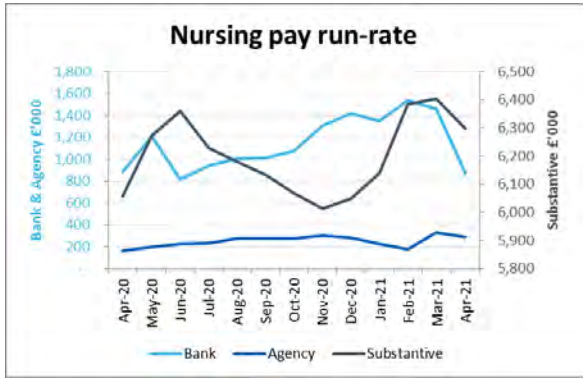
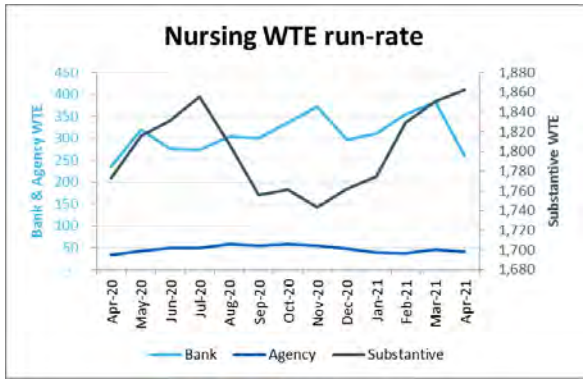
Appendix 1 - Pay (nursing including Covid-19 costs)

£'000	In-month		
	Budget	Actual	Var.
Substantive	TBC	6,298	-
Bank	TBC	871	-
Agency	TBC	360	-
Total	**TBC**	**7,529**	**-**
Less: Covid	-	(148)	-
Net total	**TBC**	**7,381**	**-**



WTE	In-month		
	Budget	Actual	Var.
Substantive	TBC	1,862.8	-
Bank	TBC	260.4	-
Agency	TBC	41.4	-
Total	**TBC**	**2,164.5**	**-**
Less: Covid	-	(41.0)	-
Net total	**TBC**	**2,123.5**	**-**



Nursing staff costs in month have reduced by £0.6m to £7.5m, of this drop £0.4m is due to lower Covid activity and sickness requiring less temporary staff cover, as well as the incentive pay rates for bank staff ceasing.

There is 12WTE additional substantive staff in month as recruitment continues and services aim to restore activity levels and maintain safer staffing levels.

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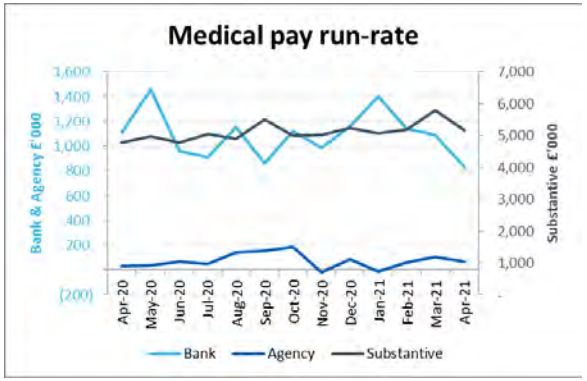
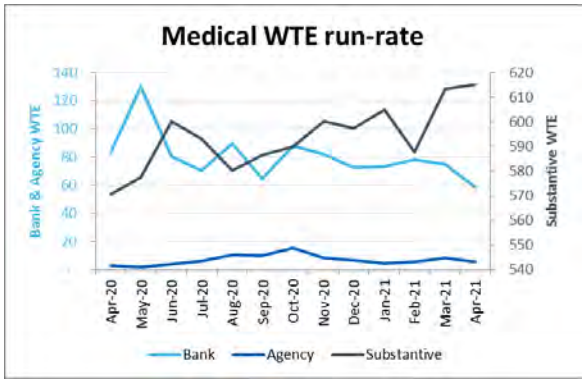
Appendix 1 - Pay (medical including Covid-19 costs)

£'000	In-month		
	Budget	Actual	Var.
Substantive	TBC	5,156	-
Bank	TBC	831	-
Agency	TBC	66	-
Total	**TBC**	**6,053**	**-**
Less: Covid	-	(70)	-
Net total	**TBC**	**5,983**	**-**



WTE	In-month		
	Budget	Actual	Var.
Substantive	TBC	615.1	-
Bank	TBC	58.8	-
Agency	TBC	5.7	-
Total	**TBC**	**679.5**	**-**
Less: Covid	-	(5.4)	-
Net total	**TBC**	**674.1**	**-**



Medical pay has decreased in-month by £0.7m as incremental costs of Covid continue to reduce, a further £0.4m this month. The previous month also included the impact £0.2m of the local Clinical Excellence Awards payment.

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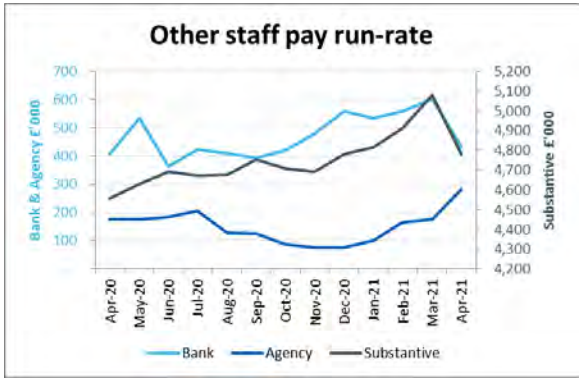
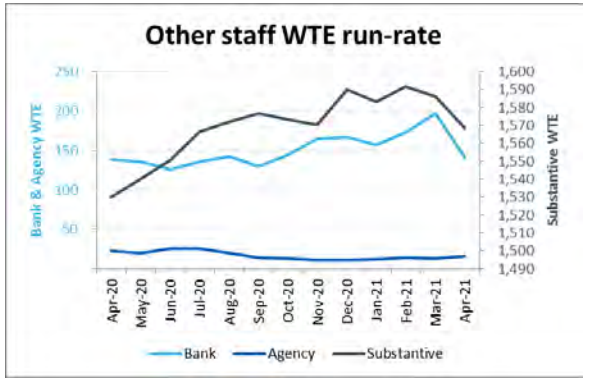
Appendix 1 - Pay (other staff including Covid-19 costs)

£'000	In-month		
	Budget	Actual	Var.
Substantive	TBC	5,176	-
Bank	TBC	434	-
Agency	TBC	281	-
Total	**TBC**	**5,891**	**-**
Less: Covid	-	(275)	-
Net total	**TBC**	**5,617**	**-**



WTE	In-month		
	Budget	Actual	Var.
Substantive	TBC	1,568.5	-
Bank	TBC	141.4	-
Agency	TBC	15.5	-
Total	**TBC**	**1,725.4**	**-**
Less: Covid	-	(41.0)	-
Net total	**TBC**	**1,684.4**	**-**



Overall the other pay category spend has decreased by £3.6m since March as the previous month included the accruals for carried forward annual leave and the wellbeing day. There has been a reduction in Covid spend by £0.3m and smaller movements within the divisions. The final position includes £0.4m of the £0.9m contingency accrual.

Any changes in cost exclude the pay award for 21/22 as this has yet to be agreed

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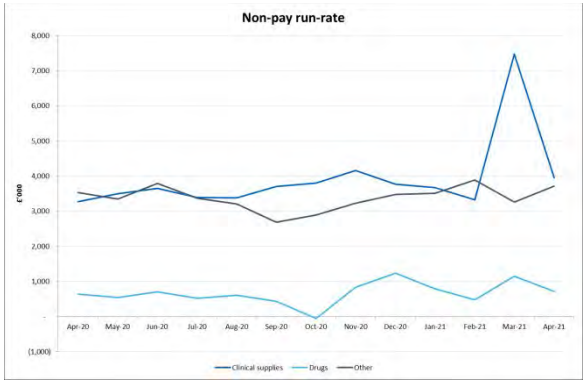
Appendix 2 - Non-pay (including Covid-19 costs)

£'000	In-month		
	Budget	Actual	Var.
Clinical supplies	TBC	3,818	-
Drugs	TBC	714	-
Other	TBC	3,785	-
Sub-total	**TBC**	**8,317**	**-**
High cost drugs	TBC	1,677	-
Total	**TBC**	**9,993**	**-**
Less: Covid	-	65	-
Net total	**TBC**	**10,059**	**-**



The above table summarises total non-pay spend across the Trust including specific Covid-19 costs but excluding depreciation, PDC dividend and net finance costs.

In month, non-pay expenditure has decreased from March by £3.8m to £10.1m although much of this significant decrease is due to the year-end technical accounting adjustments of £4.8m associated with Covid stock received from the DHSC along with income to cover these costs. Increases in cost in month are driven by the restart of elective activity in the Planned Care division as well as the other services that are restoring back to a normal service as they recover from the impact of the pandemic.

Other increased movements in spend across the services includes £0.2m of drugs and £0.4m of high cost drugs as activity increases. The high cost drugs expenditure is offset by £2.0m of income included in the block contract received from the CCG.

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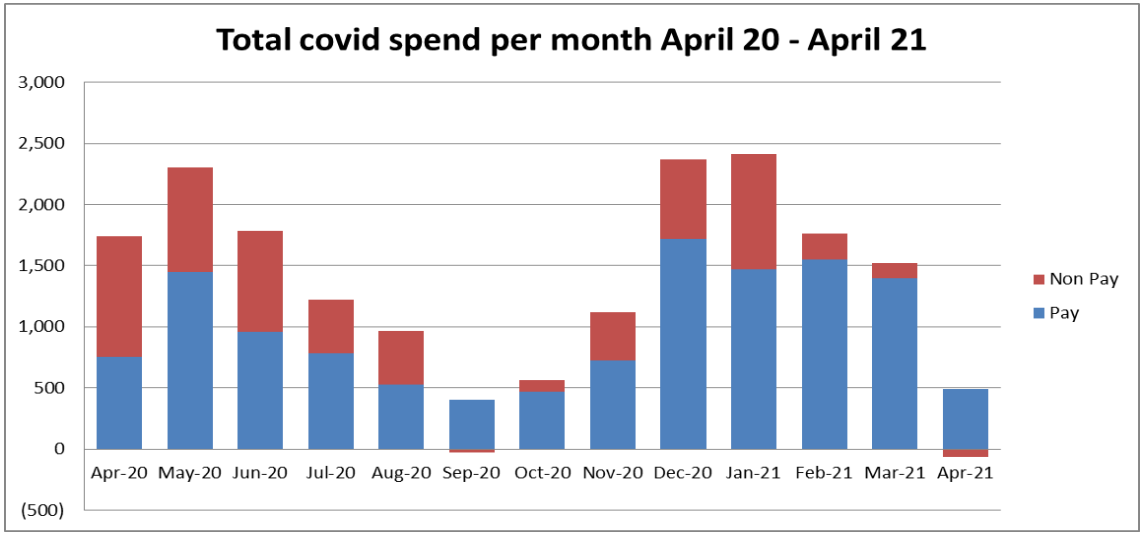
Appendix 3 – Covid-19

COVID-19 £'000	In month		
	Budget	Actual	Var.
Clinical income	-	-	-
High cost drugs	-	-	-
Other income	-	-	-
Total income	**-**	**-**	**-**
Nursing	-	(148)	(148)
Medical	-	(70)	(70)
Other	-	(275)	(275)
Pay	**-**	**(493)**	**(493)**
Clinical supplies	-	78	78
Drugs	-	-	-
High cost drugs	-	-	-
Other	-	(13)	(13)
Total non-pay	**-**	**65**	**65**
Total expenditure	**-**	**(427)**	**(427)**
Surplus/(deficit)	**-**	**(427)**	**(427)**

COVID-19 WTE	In month		
	Budget	Actual	Var.
Nursing	-	41.0	(41.0)
Medical	-	5.4	(5.4)
Other	-	41.0	(41.0)
Total WTE	**-**	**87.4**	**87.4**



The expenditure reported here is the incremental cost to the Trust as a result of the Covid pandemic and are reported to NHSE/I.

For the 2021/22 financial year, where possible the covid costs have been reported within each division and summarised in total for the Finance Committee. There are ongoing specific costs identified that will continue despite the reduction in Covid activity; these include additional staff to promote social distancing in clinics, extra housekeeping / security staff, and temperature checking at the front door of the hospital. In addition to this, it is expected costs associated with cover for staff unable to work due to Covid sickness or self-isolating, those staff suffering from long Covid sickness and a lesser number of additional shifts for high acuity patients will continue.

The pay costs decreased in-month by £0.9m to £0.5m with the significant drop in positive covid cases, this being more than expected. Non-pay expenditure in month is a credit of £0.1m as actual costs incurred were less than accrued.

The forecast Covid spend for April was £1.3m reducing to £0.8m in May and £4.5m in total for April – September.

Meeting of the Board of Directors in Public

Thursday, 03 June 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte, Non-Executive Director		
Date of Meeting:	Thursday, 20 May 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 were noted as reflecting the discussions held at the previous meeting. It was agreed that the risk scores will be kept under review as we progress through the financial year, particularly as budgets have now been agreed for the first six months.	**Amber/Green**
2. Corporate risk register There were no items scoring 16 or higher to be presented at this meeting, although it was noted this would be kept under review. All divisions have been reminded to capture their own financial risks in their registers.	**Green**
3. Annual plan and budget setting 2021/22 The Chief Financial Officer presented the paper, noting that the Trust Board agreed to a balanced plan; this was submitted to the ICS on 6th	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
May. It was confirmed that the proposed service developments were scrutinised by the executive and those agreed will have funding centrally reserved until such time as the appropriate investment governance process has been followed. Concern was noted over new CIP plans as we entered the financial year; a "CIP showcase" meeting led by executives is being held to re-energise and refocus this work. Information packs will be issued pulling on a variety of financial and non-financial sources. It is the objective that by the end of June there would be a programme and implementation will have begun. Discussion was held and actions confirmed over how this needs to be seen as efficiency and productivity, and managed as a multi-year programme of work across the system, rather than a simple in-year target for the organisation. The Chief Financial Officer confirmed that a capital programme has also been agreed by executives following a prioritisation process. Further resource – including freed up capital from the ICS – are expected during the year; consequently, the Trust remains mindful of those projects that are currently "below the line" for funding in 21/22.	
4. Finance report – month 1 It was confirmed that the Trust is developing its long term financial strategy and will build this into reporting accordingly. The Chief Financial Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total of breakeven in month 1. • The Covid expenditure has reduced notably from Q4 of 2020/21 – particularly in pay expenditure related to patient acuity and staff absence – and this has allowed the Trust to create a contingency reserve. • The impact of agreed (but not approved) service developments has not yet been realised and represents a risk of increased expenditure moving forwards. • Capital expenditure of £1.8m was reported, reflecting that the schemes are largely a continuation of those which began in 2020/21. • It was noted that no income from the Elective Recovery Fund has been recognised at this time; the Trust believes it has met its targets and is awaiting confirmation that the system has done so in order for the funds to be released. The meeting heard that there is an opportunity to use the Independent Sector to support treatment of our patients.	**Amber/Green**
5. Pathology LIMS full business case Representatives from the ICS presented a summary of the full business case, setting out the drivers for change and the benefits to be realised. The headline message from a finance perspective was that the lifetime costs of the project had reduced since approval of the OBC, principally	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
due to lower supplier costs following procurement. It was emphasised that the efficiency and cost reductions of the pathology programme (compared to the current baseline expenditure) come from the multiple projects being undertaken. The final case will be available in early June for approval at the Trust Board. The members **APPROVED** recommendation of the case in principle to the Trust Board, subject to the final case being prepared as discussed.	
6. Model Hospital The Chief Financial Officer presented the paper, highlighting the presentations from different care groups to the Committee during 2020/21. It was noted that the Trust has gone from being the median organisation nationally (on a cost per weighted activity unit or "WAU") basis to better than median, i.e. more efficient relative to other organisations. The recommendation to monitor the use of Model Hospital through CIP reporting was **AGREED** with the information to include service line cost per WAU over time versus peers.	**Amber/Green**
7. Business case policy Feedback on the policy was provided, including: - Reference to project monitoring at the Finance Committee during implementation. - Stronger reference to the Trust strategy and ICS. - The "concentration risk" of individual suppliers undertaking a significant volume/value of work. It was **AGREED** that the above amendments would be made and the policy brought back to the next meeting.	**Amber/Green**
Decisions made The Pathology LIMS full business case was **APPROVED** for recommendation in principle to the Trust Board, subject to finalisation of the case. It was **AGREED** that use of Model Hospital would be monitored through the monthly CIP reporting to the Committee. A number of proposed changes to the Trust's Business Case Policy were **AGREED**.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee The Trust Board is due to receive the final Pathology LIMS full business case at its meeting on 08 July 2021.	

Meeting of the Trust Board in Public
Thursday, 03 June 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 detailed slides provide a progress update on three key and interrelated elements of our Patient First programme. Engagement in the programmes continues to be strong. We continue to experience challenges with emergency demand, high levels of bed occupancy and flow. We remain absolutely committed to completing the identified actions leading to improvement in line with our performance and quality trajectories.		
Committees or Groups at which the paper has been submitted	Trust Improvement Board, 19 May 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

This briefing describes at a headline level the progress made, with further detail in the slide pack.

1 Effective Site Management

The Site Team continues to engage closely with departmental situational report (SitRep) meetings with a clearly defined function and commitment to ensure actions are captured and specific updates provided in a timely manner. We have revised the Site standard Operating Procedure (SOP) and Site Meeting rhythm document and are ready to launch the Site e-form.

2 Flow and Discharge

The Flow and Discharge programme continues to support in the delivery of increased discharge volumes with Mini-MADEs (Multi Agency Discharge Events) held each week to support flow and improve further the processes at ward level. Through the programme we are encouraging real-time clinical system entry, realistic estimated discharge date (EDD) setting, medically fit for discharge (MFFD) communications and Criteria to Reside discussions to help improve flow throughout the Trust and expedite the patient journey and overall patient experience.

Bed occupancy within the Trust has made this work even more important, with occupancy averaging at 94% month to date in May compared to 90% in April and 87% in March.

3 Acute Care Transformation (ACT)

We continue to work through the actions within the ACT work stream and have completed the following key actions since the previous update:

- Implementation of 24/7 Ambulance Nurse Command in ED
- ED Senior Nursing Roles & Responsibilities revision and re-draft
- Completion of SDEC / Acute Medicine Peer Review and publication of ECIST recommendations
- Revised ED SitRep implementation

We are refreshing our ED Escalation Tool with the Clinical Teams within ED and plan to complete this by the end of May 2021. This will form part of the wider Trust escalation plan and feed into the Covid-19 and winter planning process.

4 The slide pack presented at Trust Improvement Board (TIB) follows this paper.

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PATIENT FIRST

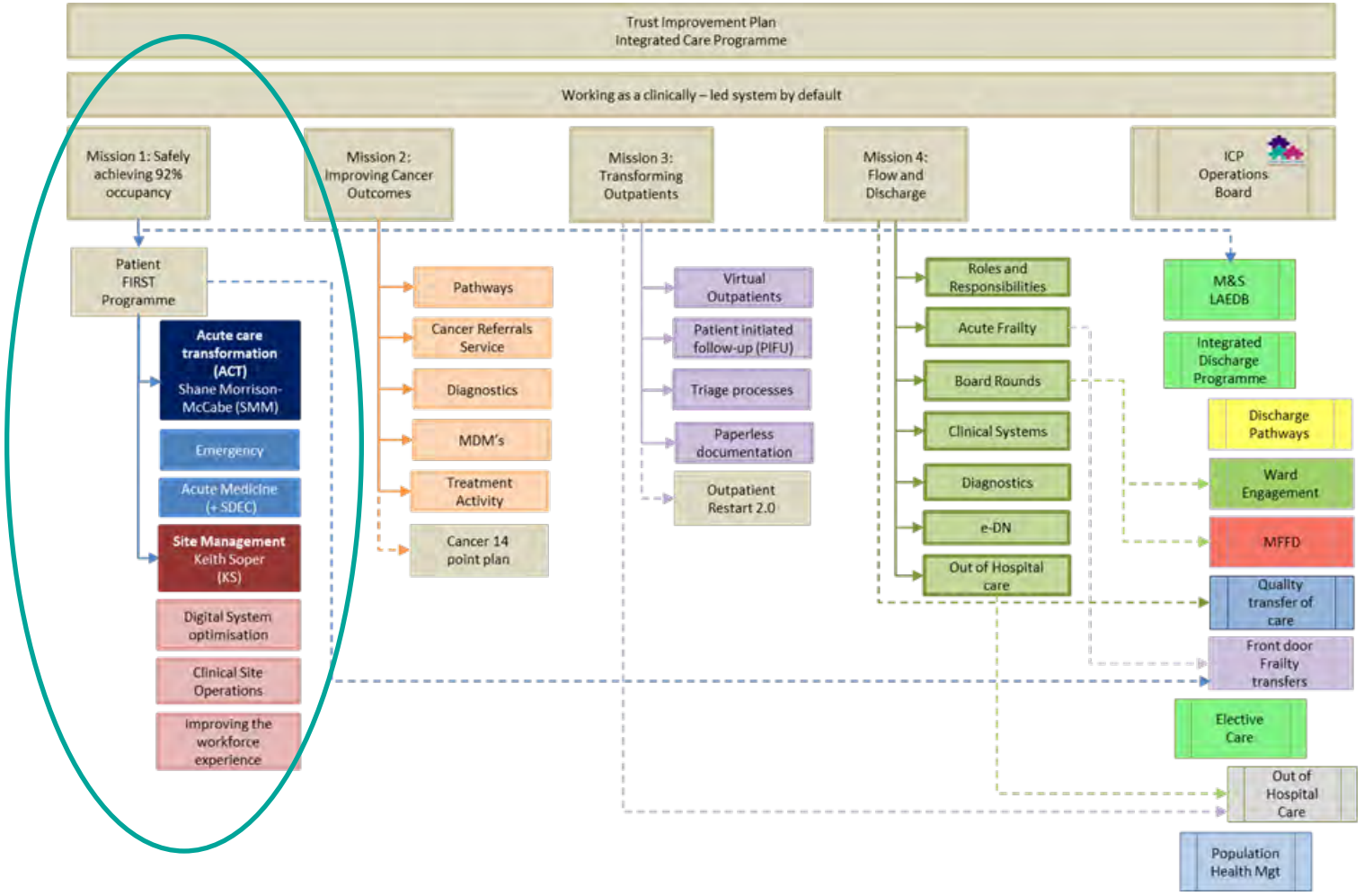
TIB 19/05/2021
Update

Best of care
Best of people

Our Medway

PATIENT FIRST (INTEGRATED CARE)

Phase 2 delivery structure



Please note that the revised Patient FIRST structure includes two key workstreams + workforce

Workstreams:
WS1: Acute Care Transformation (ACT)
- Emergency Medicine
- Acute Medicine

WS2: Site Management

The Flow & Discharge workstream has now been created into a standalone Mission in its own right – Mission 4 of the Integrated Care Pillar.

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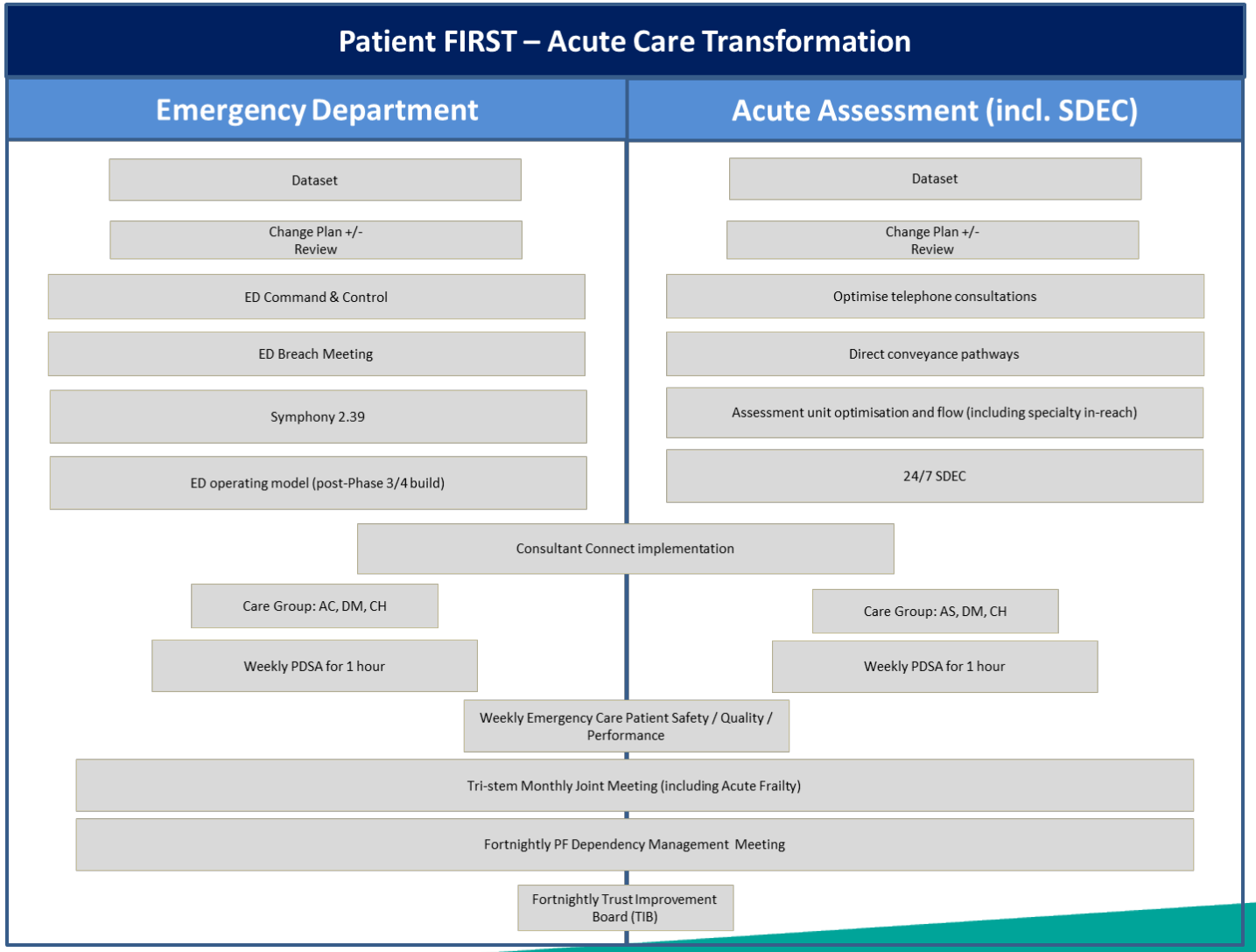
1. ACUTE CARE TRANSFORMATION

Best of care
Best of people

Our
Medway

ACT Workstream (Phase 2) Summary



ACT Workstream Highlight Report

RO: Shane Morrison-McCabe
Clinical Lead: Ashike Choudhury / Ashraf Syed
Improvement Resource: Jodie Taggart / Jacqui Leslie

Status:
Current Gateway: Deliver
Next Gateway: Completion

NHS Medway NHS Foundation Trust

Activities since last update

- Implementation of 24/7 Ambulance Nurse Command in ED
- ED Senior Nursing Roles & Responsibilities revision and re-draft
- Completion of SDEC / Acute Medicine Peer Review and publication of ECIST recommendations
- Revised ED SitRep implementation

Upcoming Milestones / Gateways

1. Complete of ED Escalation Tool and implementation Nursing R&R's to improve Command and Control structures in ED and optimise Site support into the ED SitRep (using PDSA cycles)
2. Design Clinical System pilot for SDEC based on hybrid recording within Symphony and PAS Extramed
3. Implementation of the SDEC Sitrep with CSM support 4 x daily
4. Mobilisation plan to optimise SDEC virtual clinics (based on SDEC Audit)

Highest Risks

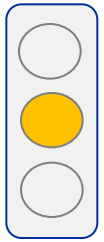
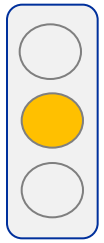
Compliance with and attendance at ED SitRep to support flow and decompression of ED

Highest Issues

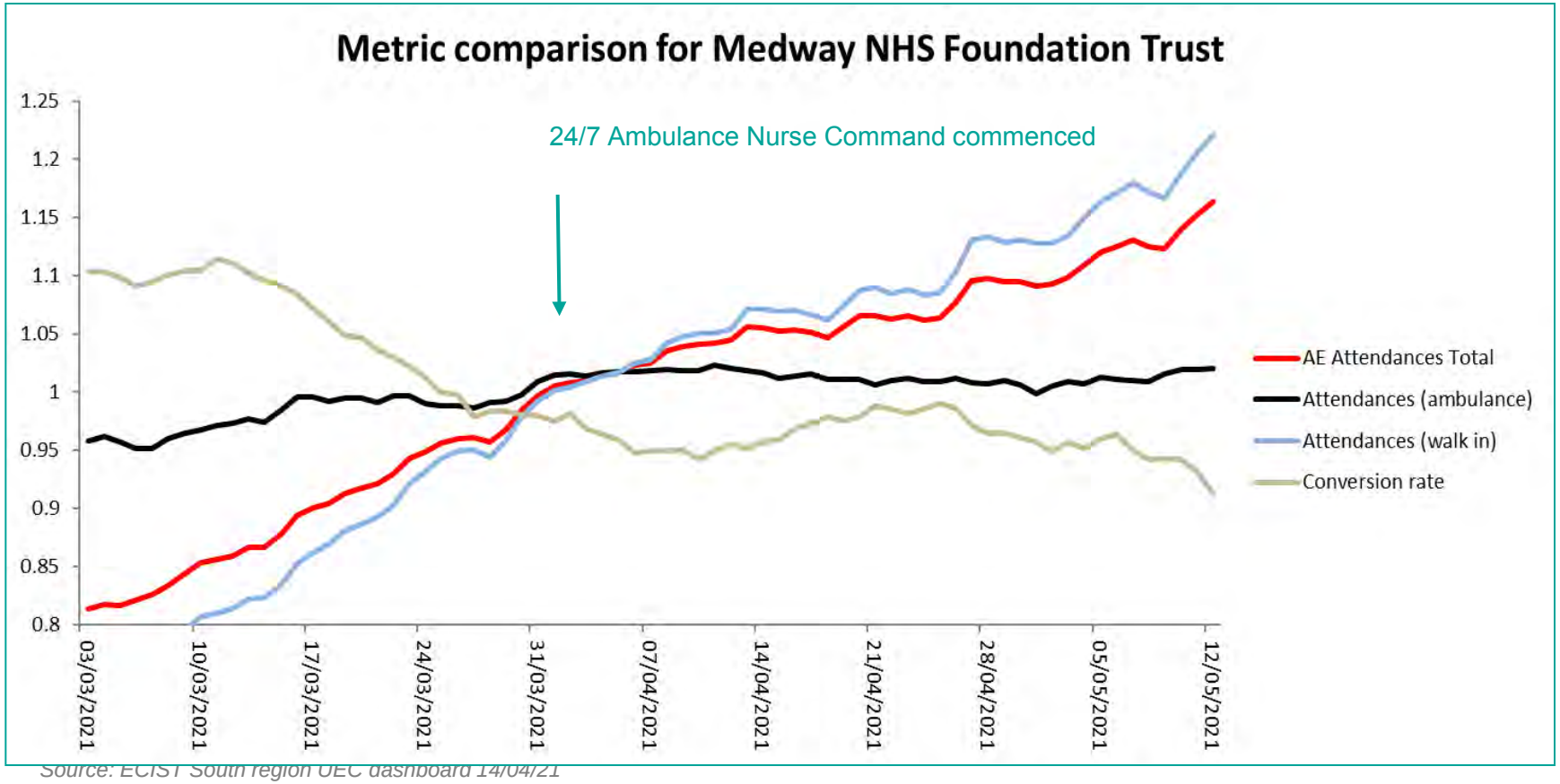
Lister Assessment Unit is not fully optimised for refer and move and impacts on ability to flow out of ED.

A single Clinical System to enable visibility and manage patient safety, capacity and flow across the whole of the Emergency Floor.

Workstream Level Update

Project Name & CQC Domain		RAG	Narrative update	Top risks / issues
ACT Emergency Medicine	CQC Domain / Ref Safe X Effective X Caring X Responsive X Well-Led X		• ED Nursing R&R's completed and having SME assurance undertaken by ECIST Improvement Manager by 14/05/21 • ED Escalation Tool in development with the Clinical Teams within ED with planned completion by end May 2021 • Phase 3 ED build reaching conclusion	• Clinical / Site Engagement to support the ED SitRep success and optimise flow and decompression • Ownership of the ED SitRep process to embed and sustain
ACT Acute Medicine	CQC Domain / Ref Safe X Effective X Caring X Responsive X Well-Led X		• SDEC Peer Review visit completed 30/04/21 and improvement opportunities identified • SDEC Sit Rep structures • Lister reinstatement delayed	• Re-establishment of Lister Assessment Unit in alignment with IPC requirements and agreed model of Specialty in-reach to support flow

Measures: Attendances and conversion rate (April -May

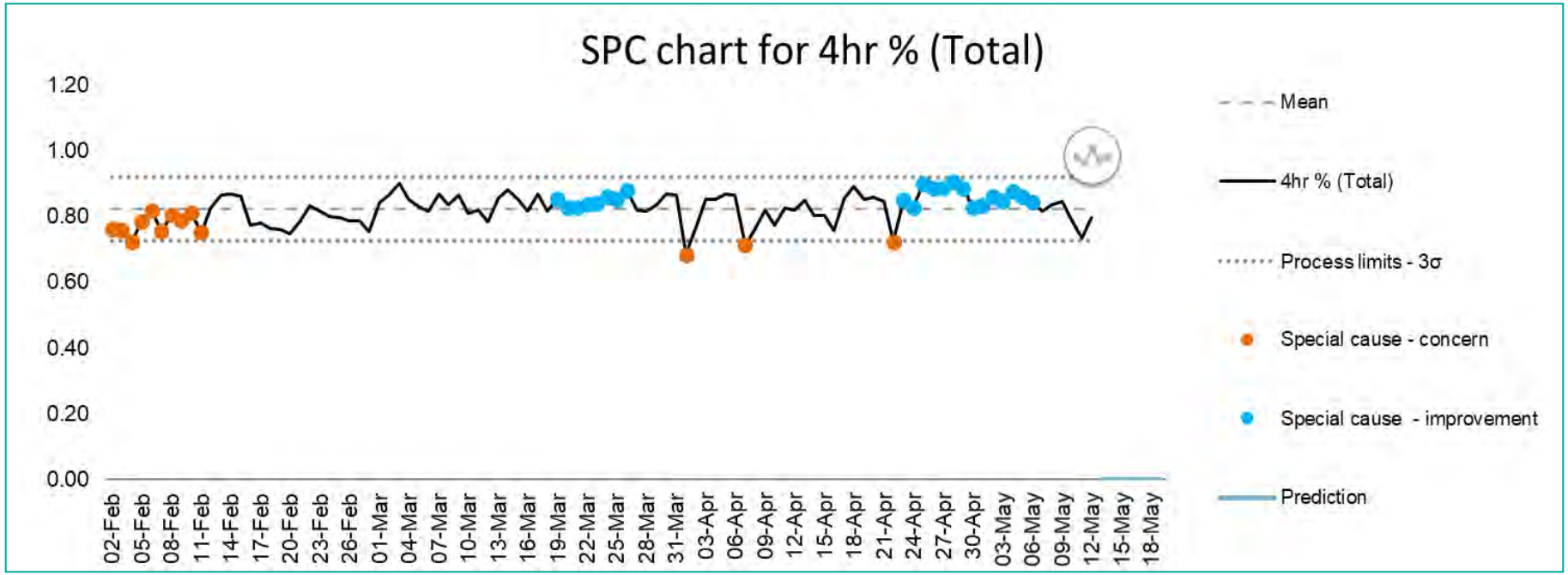


Source: ECIST South region UEC dashboard 14/04/21

Overall attendances have continued to increase since late April, most notably in “walk in” attendances. This explains high patient footfall but this has not converted to admission. This will, however, have led to higher patient volumes through UTC / STREAMing and an increase in overall activity across the emergency floor, including SDEC.

Direct STREAMing to SDEC pilot from UTC will be piloted via a dedicated Consultant-held phone line will take place over the weekend of 15/16 May.

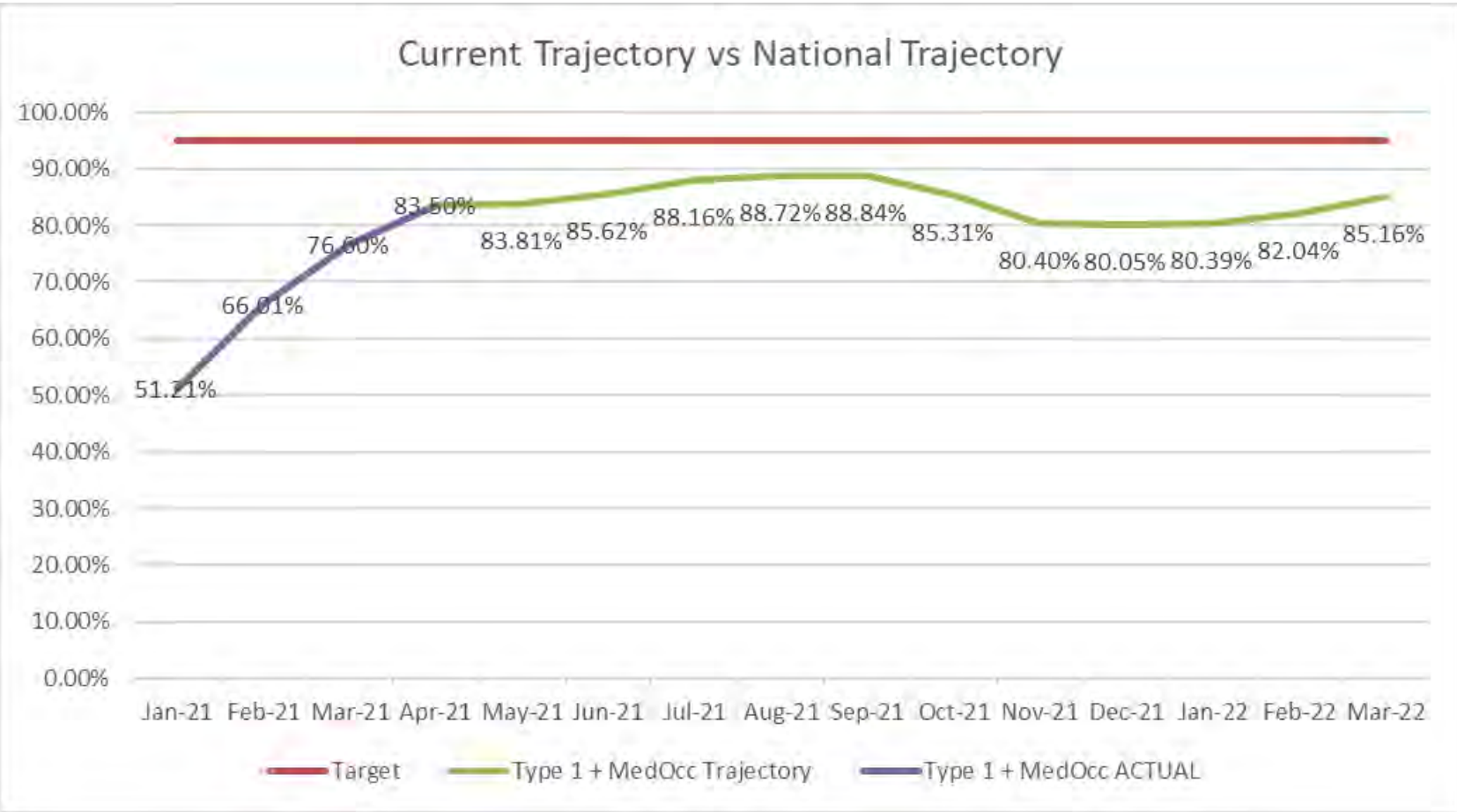
Measures: 4 hour performance



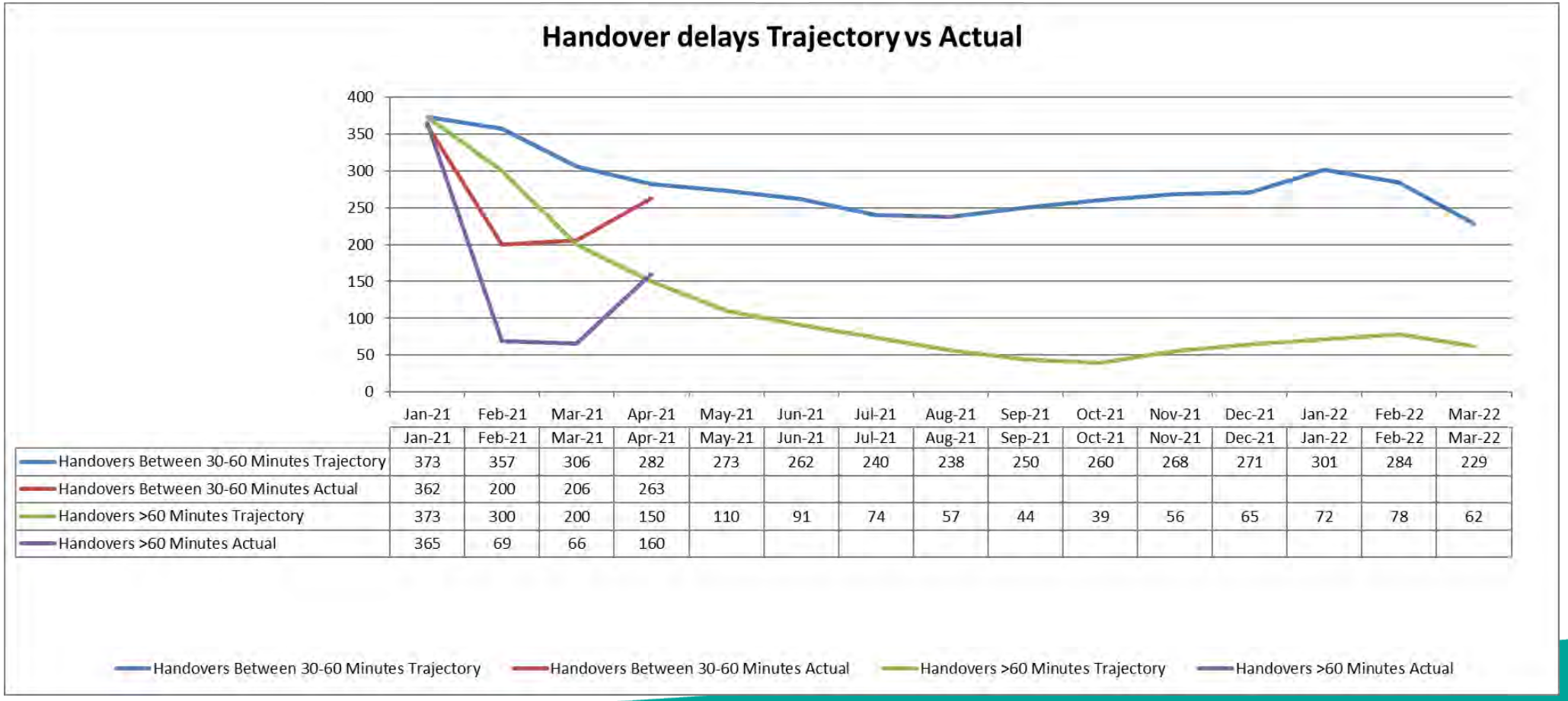
Overall 4 hour performance showed volatility at the start of April but this stabilised at or above 80% in late April and early May. This correlates with Type 1 performance for the same period. Significantly increasing volumes of walk-in attendances has destabilised this in the second week of April but this was recovering by the 12/05/21.

Weekly focussed continuous improvement sessions with the clinical and operational leads in ED and Acute Medicine remain in place. The session actions are being tracked through a series of internal process metrics and improvement activities with targeted support from ECIST.

Measures: 4 hour actual vs trajectory

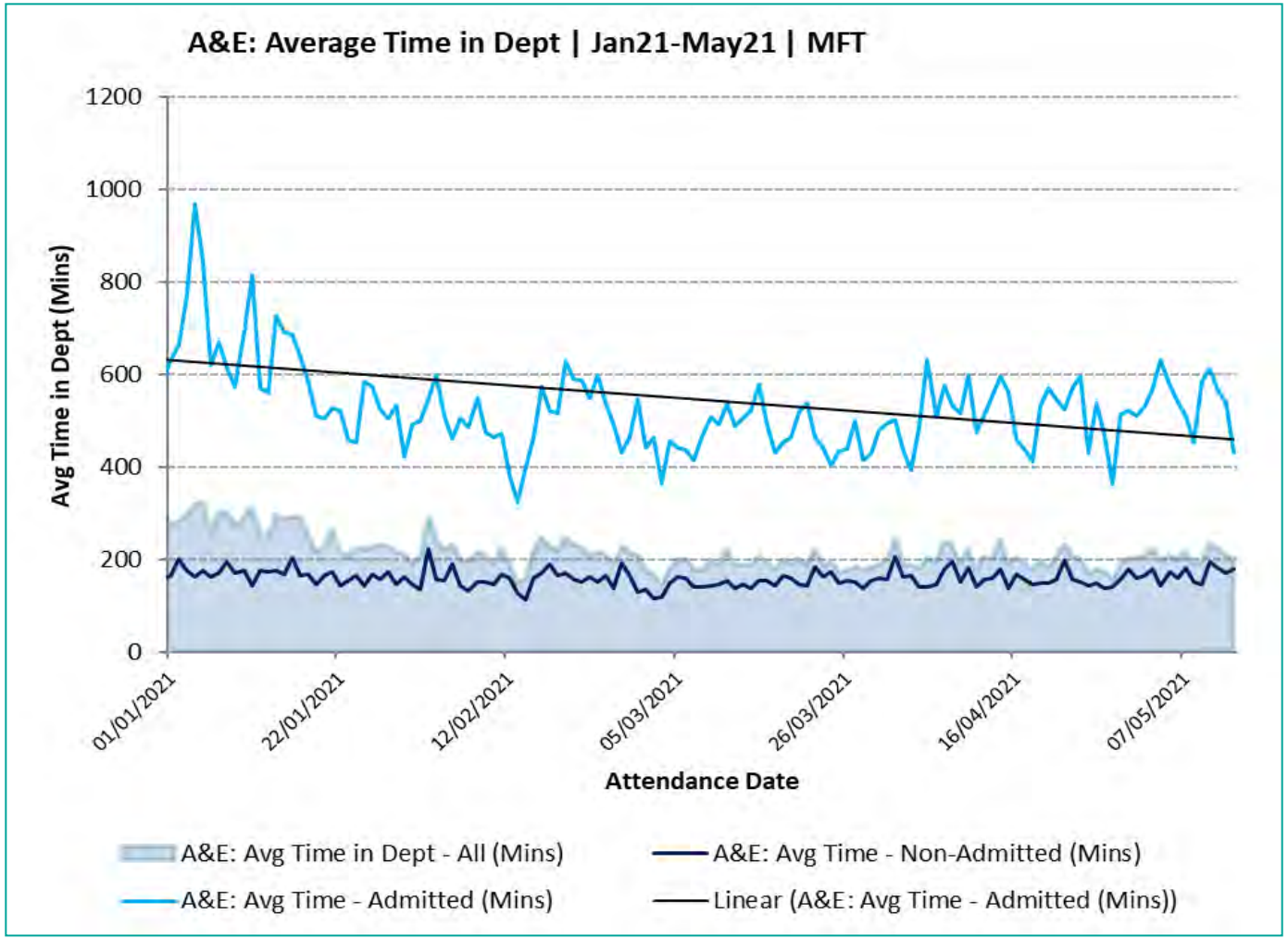


Measures: Ambulance handover actual vs trajectory



	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	Mar-22
Handovers Between 30-60 Minutes Trajectory	373	357	306	282	273	262	240	238	250	260	268	271	301	284	229
Handovers Between 30-60 Minutes Actual	362	200	206	263											
Handovers >60 Minutes Trajectory	373	300	200	150	110	91	74	57	44	39	56	65	72	78	62
Handovers >60 Minutes Actual	365	69	66	160											

Measures: Average total time in ED



Source: MFT Business Intelligence Flow Dashboard 14/0521

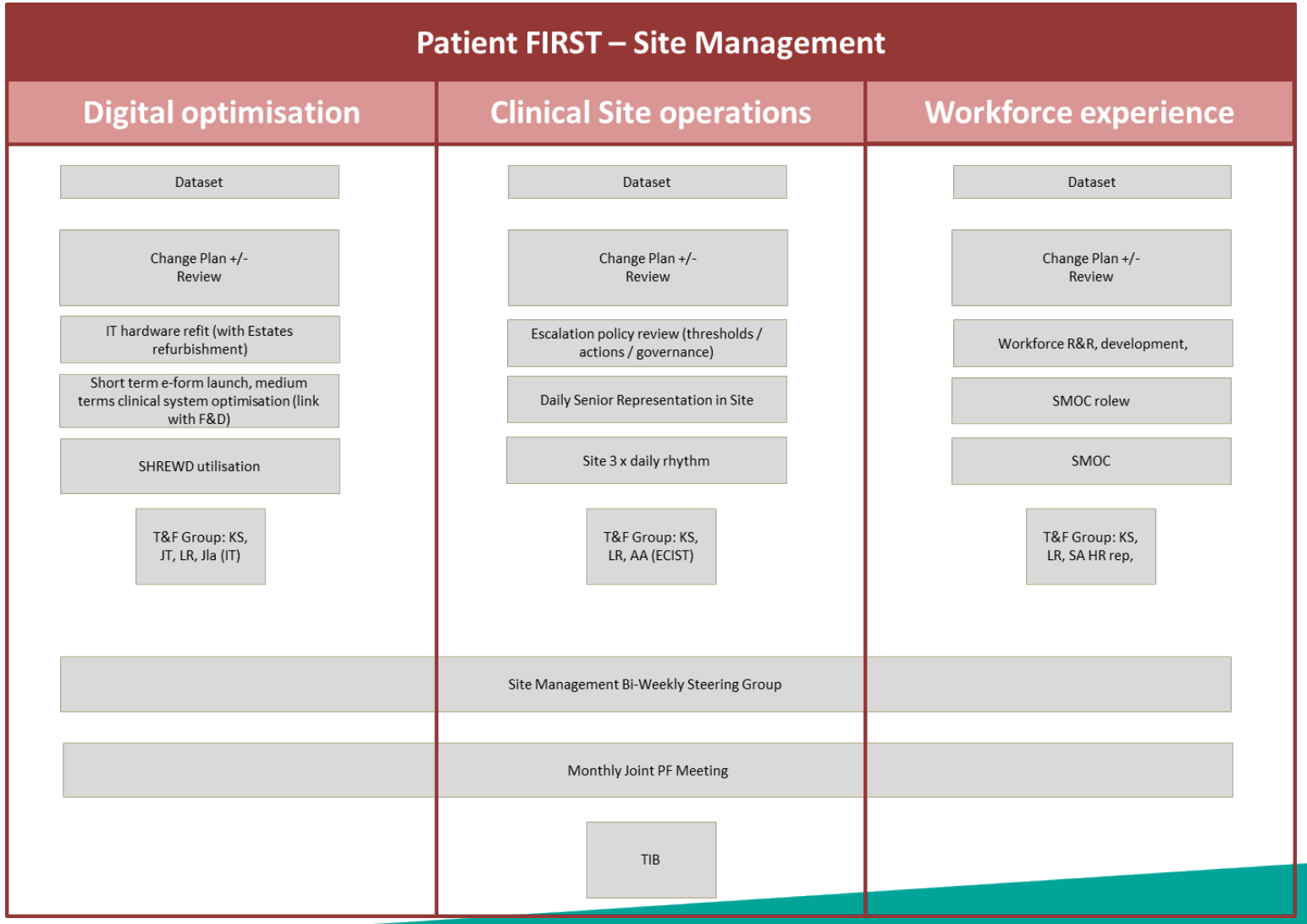
Average total time in ED has decreased over Q4, impacted by improving timeliness of the admitted pathway (noted by the trend-line).

The reconfiguration of the G&A bed base to correlate with the overall reduction in CoVID positive patient admissions has supported this and will be further stabilised and improved through the re-establishment of “refer and move” into Assessment Units.

Additional activities to review and support direct Ambulance conveyance to MedOCC and SDEC, and the implementation of recommendations from the ECIST visit on 30/04/21 will further improve this position.

2. SITE MANAGEMENT

Site Management Workstream Summary



Site Management Workstream Highlight Report

RO's: Keith Soper
Clinical Lead: Ashike Choudhury / Ashraf Syed / Lesley Roberts
Project Manager: Jodie Taggart / Jacqui Leslie

Status:
Current Gateway: Deliver
Next Gateway: Completion

NHS Medway NHS Foundation Trust

Activities since last update

- Site Offices fully refurbished and re-occupied
- Revised Site SOP and Site Meeting rhythm document drafted
- Site e-form ready for launch

Upcoming Milestones / Gateways

1. Complete Site SOP to articulate Site Management working model (function and structure), R&R's, standardise the Site Meetings with Site Team and stakeholders.
2. Launch Site e-form w/c 17/05/21 across four initial pilot wards (dovetailing with Flow & Discharge Clinical Systems dartOCM roll-out
3. Mobilisation of the CoVID/Winter Plan task and finish group to oversee plans refresh

Highest Risks

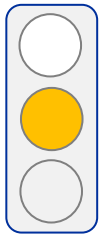
Involvement and engagement within the ED SitRep to support flow and decompression of ED

Highest Issues

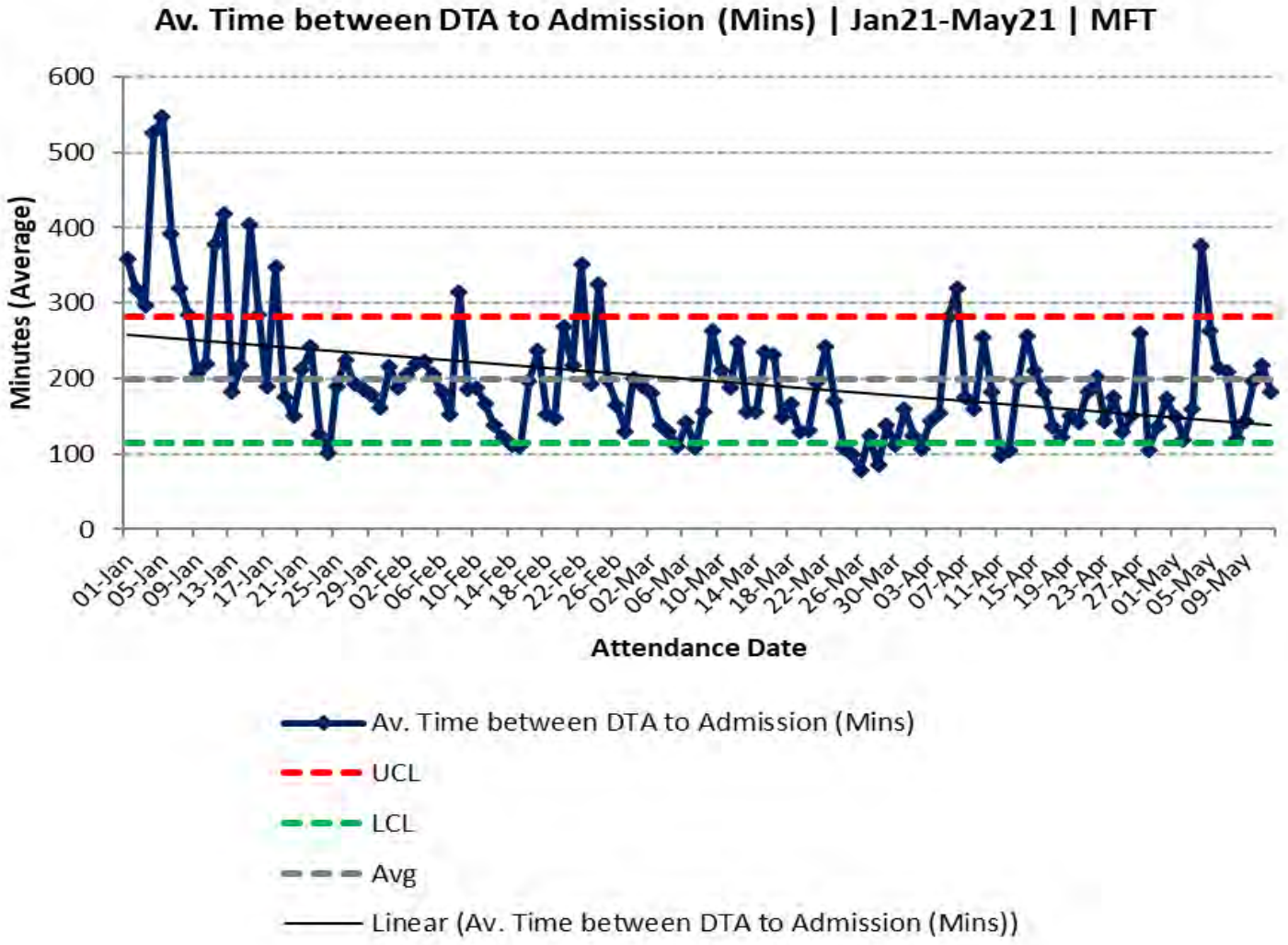
Staffing capacity across the Clinical Site Team to enable greater visibility of CSM's

Lister Assessment Unit is not fully optimised for refer and move and impacts on ability to flow out of ED and DTA > Admission performance / GIRFT.

Workstream Level Update

Project Name & CQC Domain		RAG	Narrative update	Top risks / issues
Site Manage-ment	CQC Domain / Ref Safe X Effective X Caring X Responsive X Well-Led X		• Site office refurbishment completed • Phased launch of the electronic site form from w/c 17/05/21 • Re-draft of Site SOP underway – out to consultation w/c 17/05/21 • Mobilisation of the C-19/Winter TFG	• Leadership capacity to support role-model and support the CSMs to improve visibility and embed new working practice as per Site SOPS • Engagement and relationships between Site and ED

Measures: Decision to Admit / Admission



Decision to admit (DTA) to admission

Average time from DTA to admission has trended down from the 1st January. Since last submission, some peaks (>250mins) have been experienced, thus increasing the average DTA to Admission time. The re-establishment of the "refer and move" pathway and the implementation of the single clerking proforma are expected to impact positively on this metric, pending IPC agreement on Lister AAU.

Source: MFT Business Intelligence Flow Dashboard 14/0521

Insert name Programme Highlight Report

SRO: Leon Hinton
RO: Dave Hurrell
Clinical Lead:
Programme Manager: Alex Hayes

Status:
Current Gateway: Deliver
Next Gateway: Completion

NHS Medway NHS Foundation Trust

Activities since last update

- ED Staff Engagement – the programme has continued with the nursing and medical groups as planned with good representation for both.
- Healthy Workforce Champions – the Head of Organisational Development held an introductory session with interested members of staff supported by a pack of information & resources to support this initiative.

Upcoming Milestones / Gateways

1. Remaining ED staff engagement sessions to be completed by end June.

2. Healthy Workforce Champions Network meeting has been planned for 9th June and interested parties who attended the introductory session and those who have expressed an interest since, have been invited. The aim is to have 100 HW champions in place this coming year and at least one within each department of the Trust including ED.

Highest Risks

- Lack of resources/capacity to successfully deliver on HWB strategy. *Awaiting approval of resourcing options.*
- Staff engagement due to operational pressures.

Highest Issues

Cross-over with Trust Improvement Plan – Our People Programme in terms of Health & Wellbeing agenda and also the Culture and Leadership Programme.

Meeting of the Board of Directors in Public

Thursday, 03 June 2021

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	**7.1**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 20 May 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 continued decrease from January 2021; the monthly sickness rate for April increased slightly March but remained below the 4% mark: Underlying sickness in April: 0.7% due to stress/anxiety (down from 0.8%) 0.4% due to MSK (up from 0.3%) 2) Temporary staff spend, as percentage of the paybill, has reduced significantly to less than 15%; however, this is likely to increase over the summer months in order to provide additional resource to support the additional planned capacity. 3) Appraisals, with health and wellbeing conversations, have risen significantly over the last two months and is now above the minimum 85% with clinical divisions significantly improving. 4) Statutory and Mandatory training remains consistent with slight overall improvements and positive to target overall; however, the compliance within resus remains below target overall but with an improving position – a Trust focus on moving this to compliant is to be made. Fire safety has demonstrated significant improvement and remains compliant. Health and safety training remains compliant but showing a decreasing trend.	**Amber/Green**
2. HR Resourcing Dashboard 1) Pipeline remains strong for band 5 nursing posts in the medium term and longer term with mitigations in place for internal recruitment barriers. The Trust has 25 band 6 nurses in the recruitment pipeline and a further 14 band 7 nurses. 2) The top five specialties with highest/most difficult to recruit to consultant vacancies are now demonstrating progress. Three consultants joined the Trust in April and a further seven Consultants are in the pipeline (ICU, Medicine, ED, Radiology and Elderly Care). ENT	**Amber/Green**

remains a difficult to recruit to speciality.	
3. Highlight Paper – Improvement Board – Our People 1) An update was provided confirming that the Our People programme remained on track with its improvement, this included the draft Talent Management strategy under consultation, launch of the manager's toolkit, continued trajectory for zero clinical support worker vacancies and band 5 ward nurses by end of Q1/start of Q2; and, succession planning based on talent management scores.	**Green**
4. Culture and Leadership Programme (including Staff Survey) 1) An update was provided detailing the long list of culture interventions to support the staff survey outcomes, this is to be further reviewed with priorities identified and implemented across the Trust over a one to three year cycle.	**Amber/Green**
5. Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) and Gender Pay Gap update 1) The Committee APPROVED the publication of the Trust's Gender Pay Gap and supporting statement. 2) The Committee will receive the WDES and WRES reports in July to meet the publication deadline of August 2021; reviews of ethnicity pay disparities was reported to the Committee.	**Amber/Green**
6. Freedom to Speak Up strategy refresh 1) The refreshed strategy will be presented to the Committee in July 2021.	**Red**
7. BAME community support and risk assessment 1) The number of staff with a valid covid risk assessment has decreased to 78.21% and is higher for white staff and lower for BAME staff. 2) 84% of the Trust workforce have had either their first or second covid vaccine; however, this is lower in the BAME staff at 72%. Activities have taken place to increase uptake particularly for BAME staff including videos designed in conjunction with the BAME network.	**Red**
8. EU Exit – Impact on Staffing and Mitigation 1) As at 30 April 2021, this affects up to 191 substantive employees of the Trust, and 88 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. Response rate is extremely low. The Committee requested focus on this work to address the low response rate.	**Red**
9. Interim Wellbeing Guardian Assurance report 1) Reporting through the national assurance dashboard, the Trust has improved its activity assurances from 54% in place (quarter 3 2020/21) to 57% at the end of quarter 4 2020/21. 2) The report remains in development for first publication as at the end of quarter 1 2021/22.	**Amber/Red**

Decisions made: None to report
Further Risks Identified: None to report
Escalations to the Board or other Committee: 1) Low response rate to the EU settled status for the Trust's workforce; 2) Below minimum compliance with StatMan, in particular Paediatric Immediate Life Support training and Paediatric Basic Life Support training; 3) Decreasing completion of covid risk assessment.