Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 04 November 2021 at 13:00 – 16:00

St George's Centre, Chatham ME4 4UH

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	13:00	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Chief Executive's Update	Chief Executive	3	13:05	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of previous meeting: 07.10.21	Chair	5	13:15	Approve
2.2	Matters arising and Action Log: 07.10.21	Chair	13		Discuss
3.	**High Quality Care**				
3.1	Integrated Quality Performance Report	COO, CNQO, CMO	15	13.25	Note
3.2	Quality Assurance Committee Assurance Report - Meeting date: 18.10.21	Chair of Committee/ Chief Nursing and Quality Officer (Interim)	41	13:40	Assure
3.3	Annual Report on Medical Education	Chief Medical Officer	45	13:45	Note
3.4	Safe Staffing Review	Chief Nursing and Quality Officer (Interim)	57	14:00	Approve
3.5	Patient Experience Strategy	Chief Nursing and Quality Officer (Interim)	Verbal	14:15	Note
3.6	Maternity CNST Compliance	Chief Nursing and Quality Officer (Interim)	75	14:20	Note
4.	**Strategy and Resilience**				
4.1	Sustainable Procurement	Director of Estates and Facilities	83	14:30	Note
4.2	Integrated Care System Update	Chief of Staff	87	14:45	Note
4.3	Board Assurance Framework	Deputy Chief Executive	91	14:50	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 6 (H1)	Chief Finance Officer	111	15:00	Note
5.2	Finance Committee Assurance Report. Meeting: 28.10.21	Chair of Committee/ Chief Finance Officer	127	15:10	Assure
6.	**Any Other Business**				
6.1	Council of Governors Update	Lead Governor	Verbal	15:15	Note
6.2	Questions from the Public	Chair	Verbal		Note
6.3	Any Other Business	Chair	Verbal		Note
6.4	Date and time of next meeting: 13 January 2022, 12:30 – 15:30				

Chief Executive's Report – November 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

The virus remains a very real threat to the health of our community, although I am pleased to say that, despite the high number of cases, we continue to see a relatively low number of admissions.

I would strongly advise members of our community who are eligible to have their Covid booster vaccination and their flu vaccination, to do so. There is evidence to suggest that we will experience large numbers of flu cases over the winter and the threat to health for someone who contracts both flu and Covid at the same time is considerable. I am pleased to say that we are well into the vaccination roll-out campaign in the hospital with large numbers of staff having both their Covid booster and flu vaccination.

It remains critical that visitors to our site adhere to the infection control procedures in place for the protection of our patients and staff.

Celebrating Black History Month

I am incredibly proud of our diverse workforce and it was wonderful to come together across several events to celebrate the wide range of ethnicities and cultures at the Trust. A big thank you to the Black, Asian and Minority Ethnic Network for their hard work in hosting the celebrations and to everyone involved in the events.

Marking Baby Loss Awareness Week

Last month, I had the pleasure of welcoming Kate Fenwick, the Deputy Lord-Lieutenant of Kent, to the Trust to visit Abigail's Place along with representatives from the Abigail's Footsteps charity. Abigail's Place is our maternity bereavement suite, a space where mothers who have sadly lost children in childbirth can spend time with their baby and – with the support of our bereavement midwives – begin the process of coming to terms with their loss.

Baby loss is still a subject that is not widely talked about. With Baby Loss Awareness Week taking place, I was grateful for the opportunity to meet with the Deputy Lord-Lieutenant to discuss the issue, alongside our Lead Bereavement Midwife Yvonne Morrison and Faye and David from Abigail's Footsteps. To mark the week, we lit up the hospital's clock tower as a reminder of those who have left us far too soon.

Award winning HR Team

Big congratulations to our HR Team who won the overall award at the Health Tech Awards. This award was shared with NHS Shared Business Services for our innovative work around staff retention. Together we have developed a new workforce analytics solution, which uses data science techniques to improve retention by predicting – with 95% accuracy – which

individual employees are at increased risk of leaving. Congratulations to the Medway Innovation Institute who were also shortlisted for an award.

A welcome return for our therapy dogs

I was delighted to see the return of our Trust therapy dogs, Yazzy and Fred, last month, after procedures were finalised to ensure the safety of the dogs, their owners, and the patients they see, amid the ongoing COVID-19 pandemic.

I know that therapy animals can make a real difference to our staff and patients, helping to reduce stress and anxiety, and they have been a very welcome sight in the hospital.

Thanks to Yazzy, Fred and their owners – volunteer Janice McCauley and Trust Voluntary Services Manager Zoe Goodman – for the time and effort they all put in to making our patients' stay a happier one.

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, 07 October 2021 at 14:00 - 16:00

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Annyes Laheurte	Non-Executive Director
	David Sulch	Chief Medical Officer
	Ewan Carmichael	Non-Executive Director
	George Findlay	Chief Executive
	Leon Hinton	Chief People Officer
	Mark Spragg	Deputy Chair/Senior Independent Director/NED
	Gurjit Mahil	Deputy Chief Executive
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer (Interim)
	Gary Lupton	Director of Estates and Facilities
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	Beth Williams	Acting Chief Nursing and Quality Officer
	David Brake	Lead Governor
	David Seabrooke	Company Secretary
	Michael Addley	Deputising for Glynis Alexander Director of Communications and Engagement
	Paul Kimber	Deputising for Alan Davies, Chief Finance Officer
	Sheila Adam	NHSE/I Improvement Director
Apologies:	Sue Mackenzie	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Glynis Alexander	Director of Communications and Engagement

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and apologies were given as listed above. Chair continued with the following highlights:

a) Chair thanked everyone for joining the virtual Trust Board meeting

b) Chair thanked colleagues who are working incredibly hard to care for increasing numbers of patients while also planning to ensure that the Trust are prepared for winter, it is going to be a challenging period. It is more important than ever that the hospital have the full support of the community. People can help by ensuring they have had their winter vaccinations and continuing to follow COVID precautions on site – this includes social distancing, wearing masks, and wash hands regularly and not entering the hospital if you have COVID symptoms.

c) In September 2016, the Trust celebrated the installation of our commemorative organ donation artwork "The Gift of Life" at the Hospital. Following nearly three further years of collaborative work between the Organ and Tissue Donation Committee at the Trust and NHS Blood and Transplant (the special health authority that manages organ and tissue donation nationally) the Trust were delighted to celebrate the unveiling of new wall panels to personally honour organ and tissue donors in Organ Donation Week this year. Donating organs or tissue after death can save or transform the lives of others and the Trust is so grateful for the donations that have taken place over the years – it is only right that the Trust memorialises those that have given so much for others. Chair extended thanks to families of organ donors. Please do stop and take a moment to look at the wall panels when you are next at the hospital.

d) Looking after the health and wellbeing of colleagues is an important focus for the Trust and Chair was delighted to announce the official opening the Medway Fitness Hub in October, a dedicated gym for all colleagues. The Trust are grateful that the facility has been made possible with funding from Medway NHS Foundation Trust, The Medway Hospital Charity and NHS Charities Together, with additional contributions from UNISON and the Medway Labour and Co-operative Group.

e) Chair noted the departure of Jane Murkin and acknowledged the work she did at the Trust. Jane has now left to start a new national role with NHSEI. Chair acknowledged her work on Reclaiming the Nursing Landscape, IPC and on building the Patient Experience Strategy.

f) Chair thanked Angela Gallagher for her hard work and everything she has done for the Trust, as she prepares to leave the Trust at the end of October. Angela worked tirelessly through the pandemic her pace and commitment to the hospital was incredible and had a positive impact. Angela leaves with the Board's gratitude, respect and best wishes.

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

There were no conflicts of interest raised.

1.4 Chief Executive Update

George Findlay, Chief Executive gave an update to the Board providing 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. He echoed a number of points made by the Chair in relation to the

handling of the Covid pandemic. The Board was asked to note the report and George gave the following key highlights:

a) ***COVID-19:*** *Over the last month we have seen a stabilisation in the number of COVID-19 patients within the hospital; this number is significantly lower than we have experienced in the other waves, but there is no doubt that the virus still poses a significant threat to the health of our community and also the hospital. The Trust is focused on its winter/Covid plan. As you will be aware, the Government has advised that a booster vaccination should be administered to the most vulnerable; this includes those aged over 50, care home residents and frontline health and social care workers. From the end of September, we began to offer the COVID booster vaccination and the flu vaccination to colleagues. I would encourage all members of our community who are eligible to receive a COVID booster vaccination or flu vaccination to come forward and have theirs when invited. As has always been the case, we continue to practise robust infection control procedures on site.*

b) ***Preparing for winter:*** *This winter, with the ongoing threat of COVID-19 and the resurgence of other respiratory conditions, is likely to be one of significant challenge for the NHS. That is why colleagues have been working hard with system partners to develop a robust winter contingency plan. This plan builds on lessons that learnt from previous waves and will ensure we are prepared for a potential surge of patients in the winter months. I am confident we have a good plan in place and the important thing now will be to ensure all teams and our system partners are able to deliver. We will of course, need to closely monitor demand in line with Covid modelling as we move into autumn. The plan will be submitted as an ICS System plan on 05 November 2021.*

c) ***Patient First:*** *We remain focused on making improvements to the care received by our patients. We have been delivering improvements through the five pillars that make up the Our Medway Improvement Plan for some time, but now we are looking ahead to the next phase of the programme. Over the coming months we will be moving into a new approach to quality improvement called Patient First, which brings together our values, vision, objectives and priorities to focus all our energy on delivering the best of care for patients, and making sure nothing is standing in the way. Patient First is not just an improvement plan, it is a full methodology based on evidence and is data-driven – colleagues will be fully trained in this methodology and encouraged to drive improvements in their working areas. Patient First has a good track record of working in other trusts and we have every confidence that it will be a success here at Medway. Work is now underway to decide on our strategic themes, objectives and priority initiatives. Most importantly of all, we will ensure that our patients are at the very centre of all our decisions.*

d) ***Annual Members' Meeting:*** *Last month we held our virtual Annual Members' Meeting with around 75 Governors and members of the public in attendance. I was extremely proud to speak at the meeting, my first since joining Medway. I took the opportunity to reflect on a very busy, but significant year for Medway, highlighting the important role colleagues have played at the front and centre of the response to the COVID-19 pandemic. At the end of the evening, I was also very pleased to announce the winner of this year's Chief Executive's Scholarship for Brilliance – Advanced Critical Care Practitioner, Joe Wood, who will be using the £10,000*

scholarship to develop an ultrasound assessment programme in perioperative and critical care to provide quick, efficient, and accurate diagnosis by the bedside.

e) ***New outdoor space for staff:*** *wellbeing of staff is so important to the Trust. In September we were delighted to open our new staff courtyard. The area has had an impressive makeover and provides another space for colleagues to relax and recoup during their breaks. Thank you to the Medway Hospital Charity, NHS Charities Together and the Medway Sunlight Rotary Club for funding this project, and to the Estates and Charity Teams for making it happen. I know it will be greatly appreciated by all of us.* George encouraged members of the Board to visit.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 09 September 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 following actions were closed: *TBPU/21/128*

High Quality Care

3.1 Integrated Quality Performance Report

The Board received the report for July. The paper was taken as read with the following key highlights:

a) Angela Gallagher presented to the Board.
Emergency Care Performance – this is the key priority for the Trust. In August it was 73%, below trajectory due to a drop off in admission and attendance and improvement in hand over delays. The hospital is busy and medically fit for discharge area numbers decreased. Angela is working with colleagues across the system on the discharge and flow programme. It is a work in progress but there are improvements.
Elective and cancer delivering against trajectory with good improvements throughout
DM01 there was deterioration last month but there is a recovery plan against echo cardiograms.

b) Beth Williams presented to the Board.
There is an improvement in maternity and outpatients which report above the national standards.
Complaints are improving on their position but numbers are still high with a strong focus on improving this.
FFTE compliance is under target but improving.
Continued focus on falls and pressure ulcers with number of ward areas receiving star awards.
C-Diff cases above the plan in July however still hitting trajectory.

c) David Sulch presented to the Board.
Confirmed that the Trust has reviewed in detail the mortality rates.
SHMI is the lowest it has been for some time, which is encouraging.
C-section rate suggests a minor decrease over last two to three months. QAC completed an intensive review with issues are being investigated further.

d) The Board questioned Appraisal Rates and StatMan Training, both with deteriorating numbers. This issue has been discussed at the People Committee. George stated that it is crucial that appraisal numbers are improved for staff wellbeing. There is a lot of focus needed to hit the 95% compliance target. It will become more challenging in the winter months so the teams need to be ahead of this. The Executive team are focusing on this and hope to give upward performance over the next few months.

e) Chair thanked Ranjit and Dot for the positive work on analysing C-section rates, there was a good discussion at QAC which had addressed the issues raised. It is a positive step to clarify around root cause and how the Trust can intervene and make a difference. Chair asked that thanks are passed on to the maternity team. Mark Spragg added, as part of the Maternity Transformation Group, more work has been asked for on the report. There is a suggestion that the stats/analysis might not be correct. Another report will come back to the group.

3.2 Quality Assurance Committee Assurance Report: 21.09.21

Tony Ullman, Chair of Committee presented to the Board for assurance, the paper was taken as read. The Committee escalated the following to the Board that will be monitored:

a) Incident reporting backlog and noting the proposals brought to the Committee and monitoring of progress against the plan. It is a challenging trajectory to get the backlog down before February 2022 another report is coming to Committee in few weeks.
b) The good progress against the IPC improvement plan with the Trust exiting the Infection Prevention and Control Safety Support programme. Good report from the national team, it was encouraging to see their findings on improvements.

The Committee request the Board note the following:

a) The C-section audit results and discussions at the Committee to increase consultant presence on the labour ward into the evening, the business case proposal and support given on this recommendation from the Committee. If Board members would like to see this it can be supplied.

4 Financial Stability

4.1 Finance Report - Month 5

Paul Kimber, Deputy Chief Finance Officer gave an update to the Board. The Trust continue to hit the control total. There were the following highlights noted:

a) The Trust reports a £7k deficit position for August; reducing to breakeven after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes accrued Elective Recovery Funding (ERF) income of £4.3m - this being the April and May figure notified from NHSE/I plus an estimate for June of £1.2m – the contingency of £1.0m has not changed since month 4.

b) Total pay costs have increased further from July by £0.5m, the majority of this is driven by emergency care increased demand as well as services recovering from the pandemic and delivering activity similar to that of 2019/20 levels. This is a concern and it sits within the Urgent and Integrated Care Division. The teams have had meetings and will have follow up in coming weeks to follow up on the actions and mitigations and ask if there was any safety concerns.

c) Capital remains behind plan at this point and there is a large pipeline approved.

d) Cash remains strong and no changes expected in the foreseeable future. Trust performance is 75% paying invoices in line with required payment standard, there is an action plan in place to improve on performance.

4.2 Finance Committee Assurance Report: 23.09.21

Annyes Laheurte, Chair of Committee presented to the Board for assurance, the paper was taken as read. There was no escalations and no further risk to note to the Board. This will be reviewed after six months.

4.2.1 The decision with CDU, would be more appropriate to be part of the overall project. This is due back to the Committee in March 2022.

4.3 Integrated Audit Committee Assurance Report: 23.09.21

Mark Spragg, Chair of Committee presented to the Board for assurance, the paper was taken as read. There was no escalations to the Board. There was the following highlights noted:

a) The BAF for Finance was reviewed at the meeting and a deep dive on this was carried out.

b) The Counter Fraud Plan was approved for the current year.

c) A low return on gifts and hospitality was noted and the Committee discussed how to improve the reporting.

d) There was a review of the effectiveness of the Committee, attendees were generally happy with the effectiveness but the Committee strive to improve on this.

5 System Resilience

5.1 EPRR Annual Sign-off

Angela Gallagher presented to the Board for noting. The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

a) NHS England have published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards that NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer (at Medway NHS Foundation Trust this is the Chief Operating Officer) in each organisation is responsible for making sure these standards are met.

b) As part of the national EPRR assurance process for 2021/22, the Trust has assessed compliance against the core standards. The outcome of the self-assessment shows that against 46 of the applicable core standards, the Trust is fully compliant with all 46 standards. There is a full set of evidence to provide if necessary.

c) The plan set out the actions against all core standards, where full compliance is yet to be achieved. The Board was informed that the overall rating is: Full Assurance

d) Chair thanked Angela and Steve Arrowsmith for an encouraging report.

6 Our People

6.1 People Committee Assurance Report: 23.09.21

Sue Mackenzie handed over to Mark Spragg and Leon Hinton as Sue was unable to attend the last meeting. The report was presented to the Board for assurance, the paper was taken as read. The Committee escalated the following to the Board that will be monitored:

a) Deteriorating appraisal rates, particularly across corporate areas with a challenge to improve corporates rates to over 90%. [Post-committee note: rates deteriorated further to 82.1%]
b) Sickness rates – Gary is taking forward the work on back injuries to see if manual handling training could assist to reduce the incidents
c) Appraisal rates need improving
d) Approved the Freedom to Speak Up Strategy Refresh. There is a change in the governance and the way it is reported to Board, more information to follow.

e) Approved the small amendments to the Committee TOR
f) Staff survey is launching; the more information the Trust has, the better intelligence there is to support staff, the response rate needs to be improved and there is work on this happening.

7 Any Other Business

7.1 Council of Governors Update

Cllr David Brake, Lead Governor presented to the Board, with the following highlights:

a) The next COG meeting is on 21 October 2021, one focus for the Council is to reintroduce themed meetings. Kimberley Willsea is developing a programme.

b) Annual Members Meeting was in September, there was good online engagement. It was a complex event and congratulations and thanks were sent from David and the Council to everyone involved.

c) Meeting the Governors in September was a good event and supported by the Governors. It was held in the Pentagon Centre in Chatham. Thanks was given to Kimberley Willsea and Sophie Cawsey for organizing. There was good engagement with members of public and forms available for comment. 30 people signed up to be members of the Trust in two hours, which is a positive sign. David stated he is extremely proud to be part of the Trust.

d) On behalf of the Council David wished Angela Gallagher well and thanked her for her service and her positive contribution to the Trust and wish her well for the future.

e) Congratulations to the Organ and Tissue Donation Committee for the Organ Hero Wall and well done to all involved. David was here for the first event held at the Trust when they planted the tree outside the Boardroom many years ago. Chair confirmed that it was a moving ceremony to see the families commemorated and thanked David for being there at the start and for this.

7.2 Questions from the Public

There were no questions from the public.

7.3 Any Other Business

There were no matters of any other business.

7.4 Date and time of next meeting

The next public meeting will be held on Thursday, 04 November 2021.

The meeting closed at 15:05

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 07 October 2021

Signed …….. Date ……

Chair

Board of Directors in Public
Action Log

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

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
15-Apr-21	TBPU/21/118	Submit the Patient Experience Strategy to the Board	04-Nov-21 ~~08-July-21~~ ~~06-May-21~~	Liam Edwards, Chief Nursing and Quality Officer (Interim)	An extension to the deadline was agreed by the Executive Team and QAC - the refreshed timelines will be draft in Sept then come to Board in **November** - the work plan will be updated by CoSec	Amber

Meeting of the Board of Directors in Public
Thursday, 04 November 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	3.1
Report Author	Evonne Hunt, Chief Nursing and Quality Officer (Interim) David Sulch, Chief Medical Officer Jayne Black, Chief Operating Officer		
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer (Interim) Gurjit Mahil, Deputy Chief Executive		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for August shows that the Trust has had 0 MRSA bacteraemia cases and 1 hospital acquired C-diff cases. March's overall HSMR rate is 108.10, the weekend HSMR rate is at 115.16 and links to risks during the weekends with Bed Occupancy. **Caring** Unfortunately, whilst MSA had shown improvement, September has seen that 314 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% (Inpatients: 73.8%, Maternity: 100%, Outpatients: 88.4%, ED: 73.8%). **Effective** Discharges before Noon, whilst close to the Mean are still below at 16.6% and significantly below the Target of 25%, this is being reviewed through the rapid improvement work. **Responsive** The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In September the RTT standard was 67.0% and the Trust recorded 228 52 week breaches which is lower than previous months. ED (Type 1) 4 hour performance as a result of site pressures reported 65% in August. Additionally, the Trust saw 264 Ambulance Handover delays of +60mins. The DM01 Diagnostics performance is at 84.4% for September 2021. In August 2021, 95.3% of patients were seen within 2 weeks of their referrals into the cancer pathways and 75.7% of patients were treated within 62 days.		

	Well Led We have seen a stable position in appraisal rates, reporting 82.5% and the Trust has maintained compliance statutory and mandatory training at 89.4%. 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 March – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing March data, this is reliant on Dr Foster and this is 3 to 4 months in arrears. • The bed occupancy includes all beds within the Trust including maternity and paediatrics.
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 – September 2021

Integrated Quality and Performance Report

Reporting Period: September 2021

What is Statistical Process Control (SPC)?

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

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

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

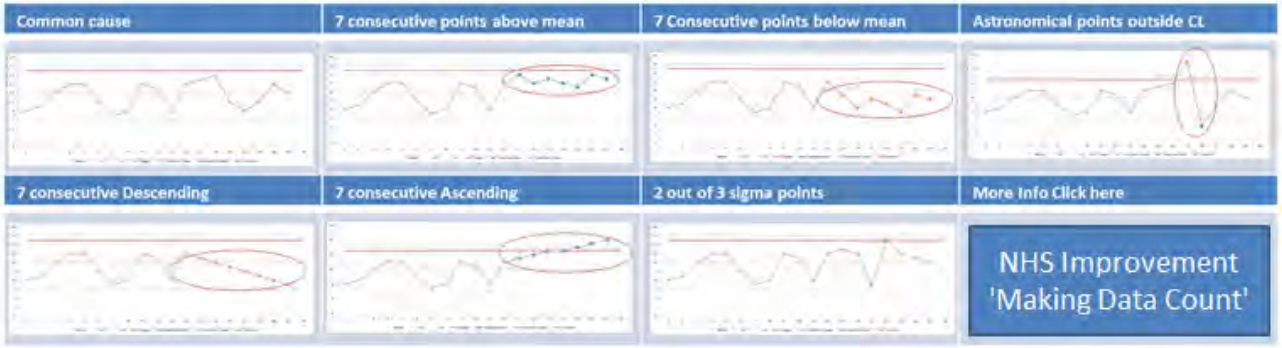
Key Facts about a SPC Chart:

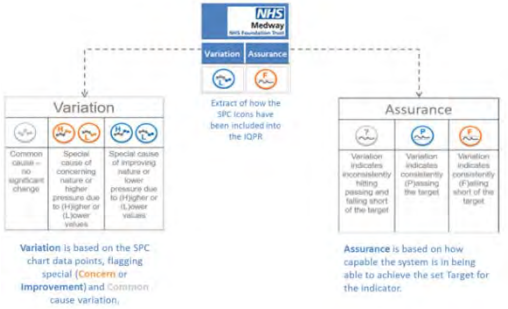
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls)	• Flow, Emergency & Elective Pathways
Caring	• The Friends and Family recommended rates for Maternity services and Outpatients are above the national standard of 85%.	• High number of breaches in Mixed Sex Accommodation continues • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set • % Complaints responded to within target has declined
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	• High statistical variance in Readmission rates evidenced • 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 • Trust Attributable MRSA cases have reported 0 for Jun-21	• Overall HSMR levels above the national threshold (100) • % of SIs response rate has dipped to below 100% (Target) for the second consecutive month • Trust attributable Cdiff cases above plan in Jun-21
Responsive	• Cancer 2ww & 31day Performance has exceeded the target • Whilst still above target, RTT over 52 week breaches continues to decrease for a 3rd consecutive month • DToC levels have reduced	• 60min Ambulance Handover delays have increased and ED 4-hr compliance has decreased • RTT Incomplete Performance decreased plus the PTL size is showing signs of increasing • Cancer 62day metric showing under-performance
Well Led	• Maintained compliance with Trust target for StatMan Compliance. • Appraisal %, Sickness rates & Turnover - whilst all slightly above plan, are showing improvement against YTD position	• Agency spend has stabilised in month but bank spend has increased considerably • CIP schemes currently shows an under plan position

Summary | Caring | Effective | Safe | Responsive | Well Led

Best of care Best of people

Executive Summary

CQC Domain	CQC Sub Domain	TRUST Variation					TRUST Assurance			
			L	H	L	H	P	F	?	N/A
Caring	Admitted Care	3	2	0	0	0	0	1	4	0
	ED Care	1	1	0	0	0	0	1	1	0
	Maternity Care	1	0	0	0	1	1	0	1	0
	Outpatients Care	0	2	0	0	0	1	1	0	0
Effective	Best Practice	1	0	1	0	3	0	2	3	0
	Maternity	3	0	1	0	0	0	3	1	0
Responsive	Bed Management	4	0	0	1	0	2	2	1	0
	Cancer Access	3	0	1	0	1	0	0	5	0
	Complaints Management	0	1	0	1	0	0	0	2	0
	Diagnostic Access	1	0	0	0	0	0	0	1	0
	ED Access	0	2	1	1	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
Safe	Harm Free Care	2	0	0	0	0	2	0	0	0
	Incident Reporting	1	0	0	1	1	1	0	1	1
	Infection Control	3	0	0	1	0	0	0	3	1
	Mortality	2	0	2	1	0	0	3	2	0
Well Led	Staff Experience	0	0	0	0	2	0	2	0	0
	Workforce	4	0	1	3	0	1	0	6	1

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	1	43	49		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	1	0	36		N/A
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5	0		
S4	E-coli (Trust Acquired) Infections	2	2	30	56		
S5	Falls Per 1000 Bed Days	6.63	4.23	6.63	4.83		
S6	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.04	0	1.04	0.03		
S7	Never Events	0	0	0	3		
S8	% of SIs Responded To In 60 Days	100.0%	100.0 %	100.0%	96.4%		N/A
S9	HSMR (All)	100	108.10	100	1.01		
S10	HSMR (Weekday)	100	105.56	100	0.98		
S11	HSMR (Weekend)	100	115.16	100	1.09		
S12	SHMI	1	1.04	-	13.89		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	314	0	2,108		
C2	Number of Complaints	41	44	-	793		
C3	% Complaints Responded to Within 30 Days	85.0%	41.4%	85.0%	60.3%		
C4	% of EDNs Completed Within 24hrs	100.0%	70.2%	100.0%	68.6%		
C5	Inpatients Friends & Family Response Rate	22.0%	17.6%	22.0%	18.9%		
C6	Inpatients Friends & Family % Recommended	85.0%	73.8%	85.0%	80.9%		
C7	ED Friends & Family Response Rate	22.0%	12.3%	22.0%	15.0%		
C8	ED Friends & Family % Recommended	85.0%	73.8%	85.0%	82.6%		
C9	Maternity Friends & Family Response Rate	22.0%	52.9%	22.0%	32.7%		
C10	Maternity Friends & Family % Recommended	85.0%	100.0 %	85.0%	98.1%		
C11	Outpatients Friends & Family Response Rate	22.0%	7.4%	22.0%	10.5%		
C12	Outpatients Friends & Family % Recommended	85.0%	88.4%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	88.5%	85.0%	81.8%		
R2	Average Non-Elective Length of Stay	5	8.60	5	9.07		
R3	Average Elective Length of Stay	5	2.28	5	2.47		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	1.5%	4.0%	0.6%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	13.7%	7.0%	11.1%		
R6	ED 4 Hour Performance All Types	95.0%	73.9%	95.0%	82.4%		
R7	ED 4 Hour Performance Type 1	95.0%	65.0%	95.0%	73.4%		
R8	ED 12 hour DTA Breaches	0	8	0	441		
R9	Number of ED arrivals by Ambulance	-	3,389	-	57,471		N/A
R10	60 Mins Ambulance Handover Delays	0	264	0	3,513		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	6.5%	5.0%	6.9%		
E2	30 Day Readmission Rate	10.0%	12.5%	10.0%	13.2%		
E3	Discharges Before Noon	25.0%	16.6%	25.0%	16.0%		
E4	Fractured NOF Within 36 Hours	100.0%	73.1%	100.0%	74.1%		
E5	VTE Risk Assessment % Completed	95.0%	92.5%	95.0%	95.4%		
E6	Elective C-Section Rate	13.0%	14.8%	13.0%	14.8%		
E7	Total C-Section Rate	28.0%	36.2%	28.0%	37.1%		
E8	Emergency C-Section Rate	15.0%	21.4%	15.0%	22.2%		
E9	12+6 Risk Assessment	90.0%	82.6%	90.0%	85.9%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	84.4%	99.0%	79.2%		
R12	18 Weeks RTT Incomplete Performance	92.0%	67.0%	92.0%	65.4%		
R13	18 Weeks RTT Over 52 Week Breaches	0	228	0	4,371		
R14	Operations Cancelled By Hospital on Day	0	14	0	225		
R15	Cancelled Operations Not Rescheduled < 28 days	0	4	0	42		
R16	Cancer 2ww Performance	93.0%	95.3%	93.0%	96.2%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	88.8%	93.0%	92.8%		
R18	Cancer 31 Day First Treatment Performance	96.0%	96.9%	96.0%	97.0%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	75.7%	85.0%	71.6%		
R20	104 Day Cancer Waits	0	5	-	46		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	82.5%	-	84.1%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	4.8%	4.0%	4.9%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	13.0%	12.0%	12.3%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	89.4%	85.0%	89.0%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,257.51	-	74,243.50		N/A
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	3.6%	4.0%	3.3%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	11.0%	9.0%	12.8%		

Domain: Caring Dashboard	**Executive Lead:** Evonne Hunt– Chief Nursing & Quality Officer (Interim) **Operational Lead:** N/A **Sub Groups :** Quality Assurance Committee

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Sep-21	100.0%	70.2%	66.8%	72.4%	77.9%		
		Inpatients Friends & Family % Recommended	Sep-21	85.0%	73.8%	76.6%	83.5%	90.5%		
		Inpatients Friends & Family Response Rate	Sep-21	22.0%	17.6%	15.3%	19.9%	24.4%		
		Mixed Sex Accommodation Breaches	Sep-21	0	314	-4.98	135.81	276.59		
		MSA %	Sep-21	0.0%	0.0%	-0.1%	0.9%	1.8%		
	ED Care	ED Friends & Family % Recommended	Sep-21	85.0%	73.8%	71.5%	79.6%	87.7%		
		ED Friends & Family Response Rate	Sep-21	22.0%	12.3%	12.1%	14.6%	17.0%		
	Maternity Care	Maternity Friends & Family % Recommended	Sep-21	85.0%	100.0%	94.5%	98.9%	103.3%		
		Maternity Friends & Family Response Rate	Sep-21	22.0%	52.9%	12.4%	28.0%	43.6%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Sep-21	85.0%	88.4%	87.3%	89.9%	92.4%		
		Outpatients Friends & Family Response Rate	Sep-21	22.0%	7.4%	10.7%	12.8%	14.9%		

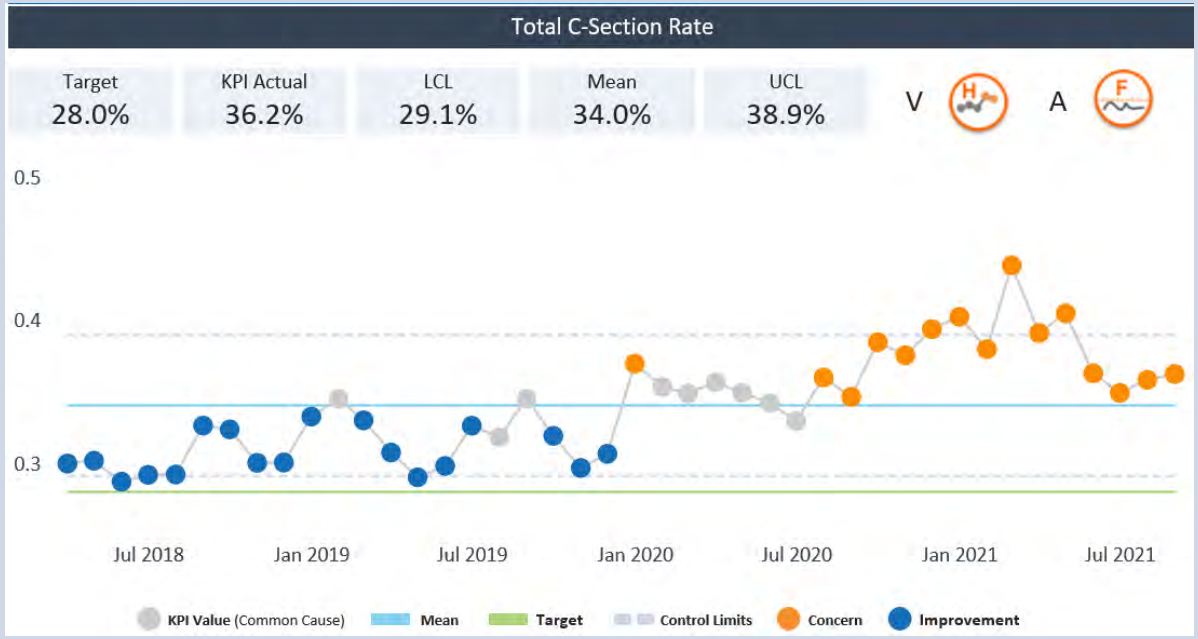
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Aug-21	10.0%	12.5%	9.7%	11.8%	13.9%		
		7 Day Readmission Rate	Aug-21	5.0%	6.5%	4.4%	6.0%	7.5%		
		Discharges Before Noon	Sep-21	25.0%	16.6%	12.8%	15.6%	18.4%		
		Fractured NOF Within 36 Hours	Jul-21	100.0%	73.1%	37.3%	66.9%	96.4%		
		VTE Risk Assessment % Completed	Sep-21	95.0%	92.5%	80.6%	89.1%	97.7%		
	Maternity	12+6 Risk Assessment	Jun-21	90.0%	82.6%	79.1%	84.2%	89.2%		
		Elective C-Section Rate	Sep-21	13.0%	14.8%	9.9%	13.8%	17.6%		
		Emergency C-Section Rate	Sep-21	15.0%	21.4%	15.4%	20.3%	25.2%		
		Total C-Section Rate	Sep-21	28.0%	36.2%	29.1%	34.0%	38.9%		

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

Executive Lead: Evonne Hunt– Chief Nursing & Quality Officer (Interim)
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate



What changes have been implemented and improvements made?

Job planning is due to commence and this will enable time for the intrapartum lead to conduct a daily C Section audit on the previous 24 hour emergency C Sections' to improve learning.

Approval has been given up to upskill and upgrade SAS doctors to associate specialists to support the consultant rota in line with Ockenden and the requirement for increased on site presence. This will strengthen clinical leadership, decision making and the development of junior registrar competencies.

It is anticipated that these two actions will prevent avoidable C Sections

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
Presentation to QAC was made on 21/9/21 to provide assurance and share the improvement plan.
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.

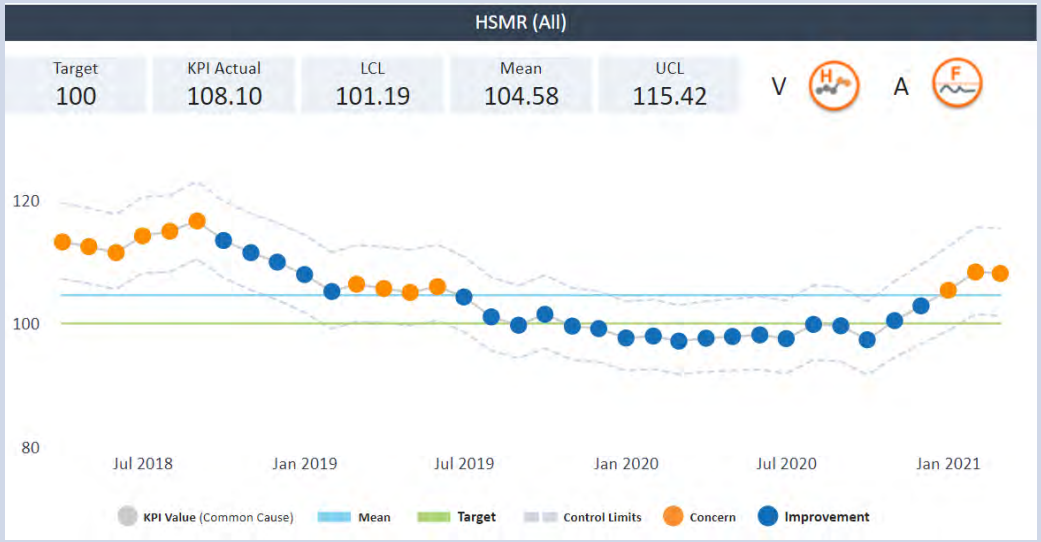
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Sep-21	6.63	4.23	2.85	4.69	6.53		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Sep-21	1.04	0	-0.11	0.05	0.21		
	Incident Reporting	% of SIs Responded To In 60 Days	Sep-21		100.0%	86.6%	96.8%	106.9%		N/A
		Never Events	Sep-21	0	0	-0.64	0.14	0.92		
		No of SIs on STEIS	Sep-21	90	11	-1.28	12.74	26.75		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Aug-21	4 [43]	1	-3.48	2.79	9.06		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Aug-21		1	-2.70	1.86	6.42		N/A
		E-coli (Trust Acquired) Infections	Aug-21	0	2	-1.71	4.15	10		
		MRSA Bacteraemia (Trust Attributable)	Aug-21	1 [5]	0	-1.03	0.37	1.76		
	Mortality	Crude Mortality Rate	Aug-21	2.5%	1.3%	0.4%	1.8%	3.1%		
		HSMR (All)	Mar-21	100	108.10	101.19	104.58	115.42		
		HSMR (Weekday)	Mar-21	100	105.56	97.70	101.76	114.10		
		HSMR (Weekend)	Mar-21	100	115.16	101.08	112.26	129.97		
		SHMI	Apr-21	1	1.04	1.05	1.08	1.11		

Safe: Mortality
Aim: TBC
Latest Period: March – 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 All



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: Jayne Black – 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	V	A
Responsive	Bed Management	% Medically Fit For Discharge Point Prevalence in Month	Sep-21	7.0%	13.7%	13.5%	16.6%	19.6%		
		% of Delayed Transfer of Care Point Prevalence in Month	Sep-21	3.5%	1.5%	0.3%	1.2%	2.2%		
		Average Elective Length of Stay	Sep-21	5	2.28	1.33	2.39	3.44		
		Average Non-Elective Length of Stay	Sep-21	5	8.60	5.77	8.81	11.84		
		Bed Occupancy Rate	Sep-21	85.0%	88.5%	80.5%	87.5%	94.6%		
		Delayed Transfer of Care Point Prevalence in Month	Sep-21		253	43.22	190.69	338.16		N/A
		Escalation Beds Open Point Prevalence in Month	Sep-21	0	0	-23.04	21.86	66.75		
		Medically Fit For Discharge Point Prevalence in Month	Sep-21		2,242	1,959.20	2,495.29	3,031.37		N/A
	ED Access	30 Mins Ambulance Handover Delays	Sep-21	0	414	191.15	544.29	897.42		
		60 Mins Ambulance Handover Delays	Sep-21	0	264	-36.33	134.24	304.80		
		ED 12 hour DTA Breaches	Sep-21	0	8	-30.04	19.33	68.71		
		ED 4 Hour Performance All Types	Sep-21	95.0%	73.9%	74.7%	82.3%	90.0%		
		ED 4 Hour Performance Type 1	Sep-21	95.0%	65.0%	63.5%	73.8%	84.0%		
		ED Conversion Rate	Oct-20	20.0%	0.0%	-0.8%	1.6%	3.9%		
		Median Time to Ambulance Assessment (15mins)	Sep-21	15	25	5.45	10.57	15.70		
		Median Time to ED Clinician (60mins)	Sep-21	60	54	23.92	37.42	50.91		
		Number of ED arrivals by Ambulance	Sep-21		3,389	2,604.21	3,258.57	3,912.93		N/A

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

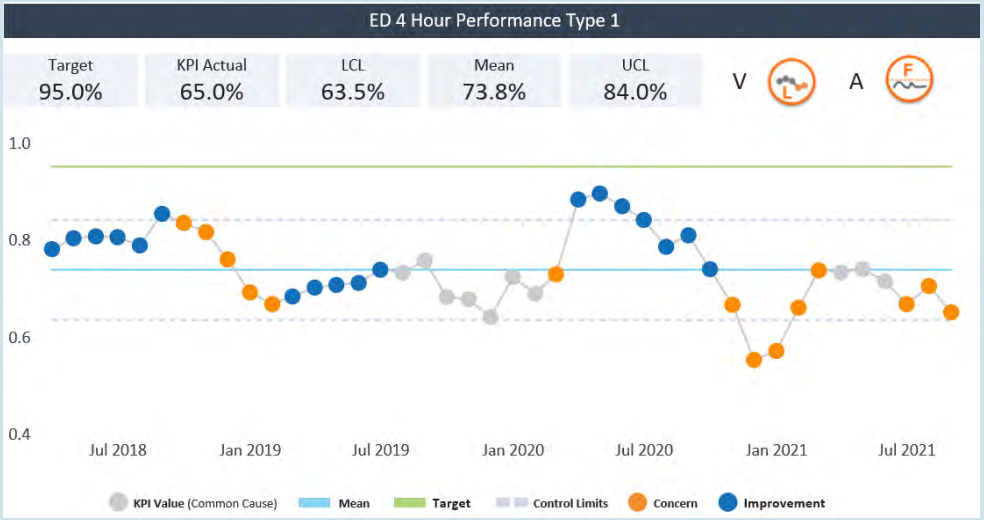
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Elective Access	18 Weeks RTT Incomplete Performance	Sep-21	92.0%	67.0%	69.1%	74.8%	80.5%		
		18 Weeks RTT Over 52 Week Breaches	Sep-21	0	228	16.09	108.02	199.96		
		Daycase Rate	Sep-21	85.0%	63.6%	61.8%	68.2%	74.5%		
		DNA Rate	Sep-21	10.0%	8.9%	6.9%	7.8%	8.7%		
		First to Follow Up Ratio	Sep-21		3.01	1.94	2.32	2.71		N/A
		PTL Size	Sep-21	22,477	26,984	20,545.94	21,811.90	23,077.87		
Responsive	Diagnostic Access	DM01 Performance	Sep-21	99.0%	84.4%	77.3%	89.5%	101.7%		
Responsive	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Sep-21	0	4	0	4.19	11.39		
		Operations Cancelled By Hospital on Day	Sep-21	0	14	0	20.10	45.33		
		Urgent Operations Cancelled for the 2nd Time	Sep-21	0	0	0	0.10	0.42		

Responsive: – Non Elective Insights

Executive Lead: Jayne Black – 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:

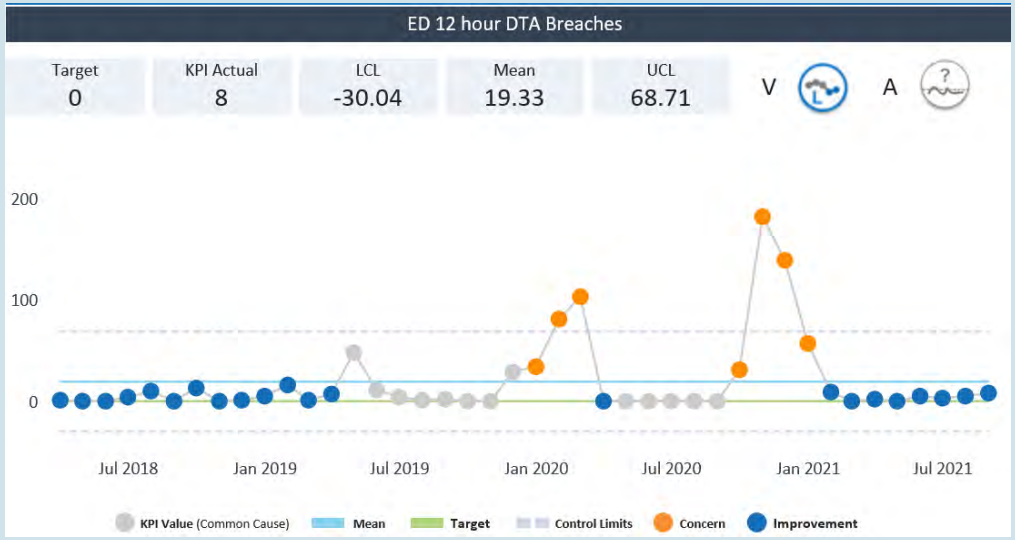
- Need for more clarity re the roles of NIC and EPIC in managing ED processes to delivery 4 hour standard.
- Workforce gaps in acute medicine has meant increased LOS for referred patients.
- Loss of AAU capacity due to covid-driven reconfiguration and revised IPC regulation.
- Delays in POCT and availability 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: Jayne Black – 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 revews and decision making

Underlying issues and risks:

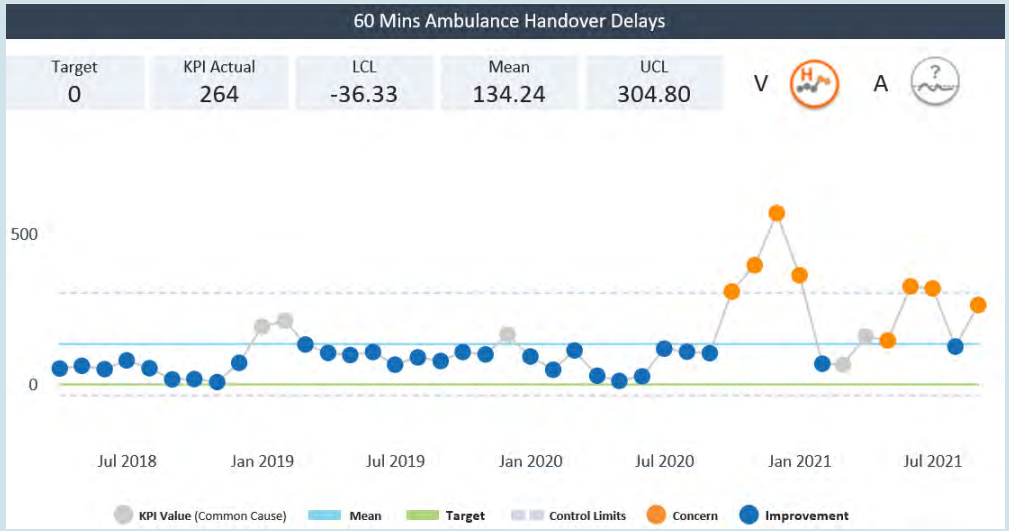
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Slow re-launch of acute assessment due to capacity, IPC considerations and staffing.
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

Executive Lead: Jayne Black – 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:

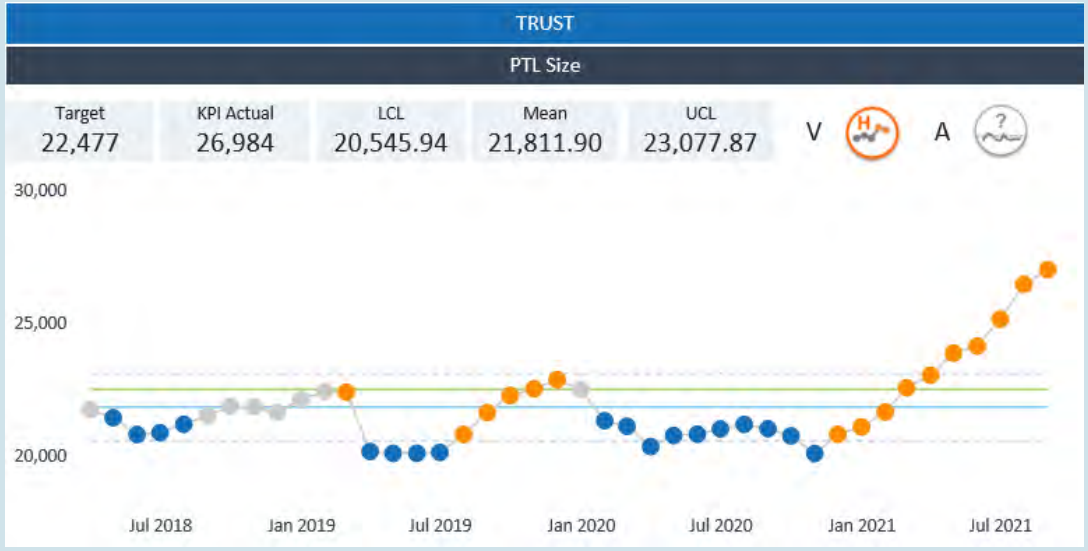
- Workforce and rosters not always in sync with demand.
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Gaps in Senior ED Leadership

Responsive: Elective Insights

Executive Lead: Jayne Black – 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 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 PTL size is directly related to
- the pandemic which impacted elective capacity and has changed the referral profile from Primary Care
- Assumptions identified by NHSI to be used in planning have exceeded what has actually happened.

Actions:

- Review with ICP partners re referral assumptions and adjust trajectory accordingly.
- Agree system-wide interventions re controls for referral increases.
- Start to map impact of increased referrals on PTLs for Q4 and 2022-23
- Maximise current capacity, including using agreed transformation approaches to keep pace where possible with elective activity.

Outcomes:

- Delivery of H1 planning performance targets (phase four guidance) and reduction in outpatient backlogs
- Delivery of 52 week trajectories and reduction in admitted surgical backlogs
- Delivery of DM01 trajectory and management of inpatient and 2ww waiting lists

Underlying issues and risks:

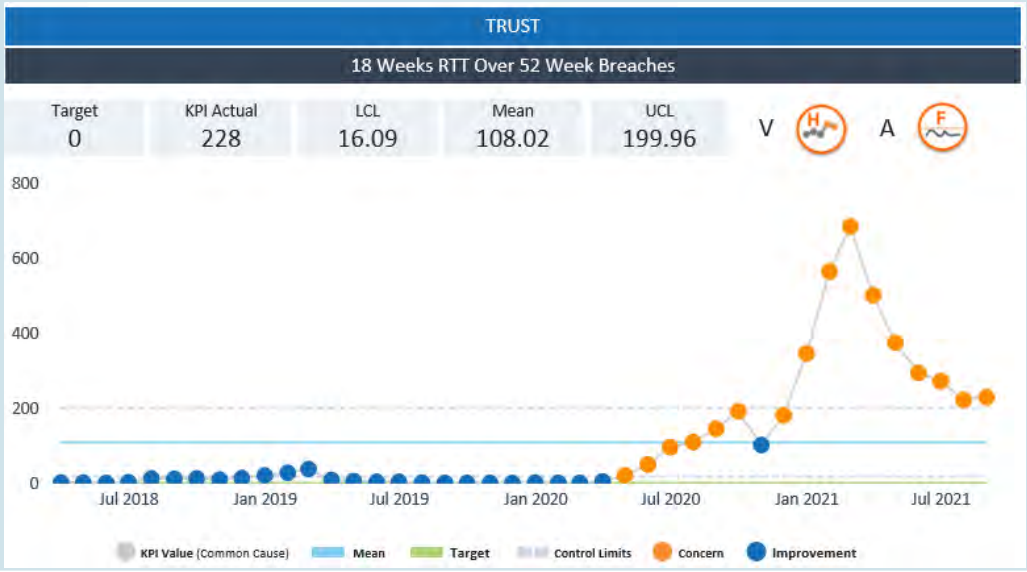
- Potential of third COVID wave resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Increased sickness absence driven by pressure of work and /or Covid related isolation or illness.

Responsive: Elective Insights

Executive Lead: Jayne Black – 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.
- Activity plans in place for all specialties reflecting the standards and targets for all elective activity and performance trajectories.
- All patients on the waiting list have an identified priority category (P) which is reviewed and updated regularly.
- Continuous validation of patients with long waiting times and harm review process established.
- Independent sector capacity used extensively where available to manage waiting times and increase volumes of activity. This includes both insourcing and outsourcing of activity in a number of specialties.

Outcomes:

- Zero capacity related 52-week waiting patients by end of March 2022 at the latest.
- 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.
- Elective capacity will be preserved for as long as possible within the winter and covid planning model.

Underlying issues and risks:

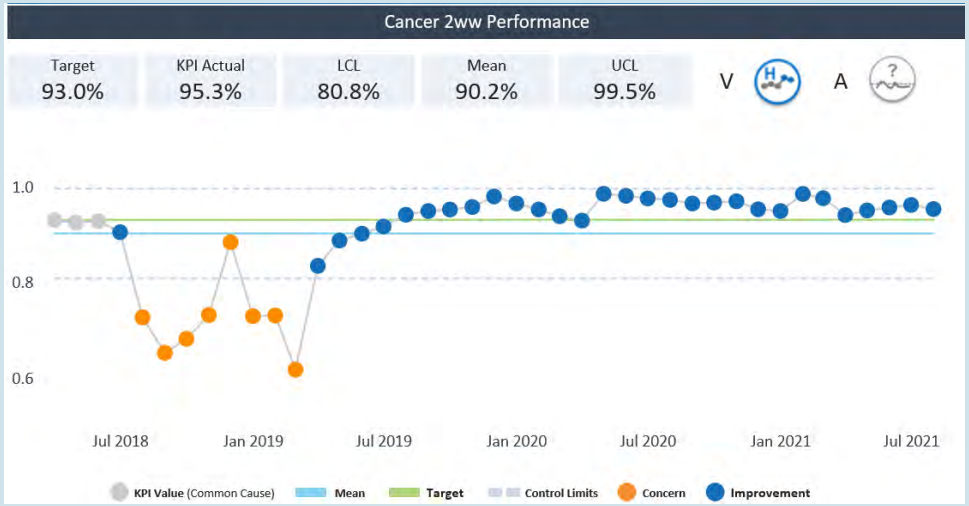
- Estate programme relating to the completion of ED phase 3 and release of Ocelot for elective orthopaedics.
- Uncertainty on covid and other NEL activity and associated impact on elective plans.

Responsive: Cancer Insights

Executive Lead: Jayne Black - 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 who should be 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 consistently achieving target.

Actions:

- Working to an internal stretch target of 7 Days to first appointment.
- Providing regular real time updates on demand (referrals received) to Cancer Board and Tumour Site leads.
- Undertake daily and weekly Patient Target List review meetings at specialty level.
- Advance escalations made to all services considered at risk of breaching 14 Day target through 2 new reports ASIs and polling times
- A weekly meeting has been arranged for strengthened oversight by Head of Cancer Compliance
- A daily touchpoint with Head of Cancer Compliance and Cancer Pathway Manager has been introduced for timely escalations of issues

Outcomes:

- Trust has remained compliant with this KPI since August 2019
- Daily escalations facilitated early remedial actions allowing service to remain compliant.
- Effective communications and collaboration between Cancer Manager and service managers .
- Weekly referral numbers and day of OPA shared with each service.
- Regular meetings with Service Managers ensure that there is adequate capacity to facilitate demand.
- Internal Stretch target of 7 Days is now being achieved by a number of specialties on a regular basis
- Work continues with primary care to ensure referrals are sent on appropriate pathways.

Underlying issues and risks:

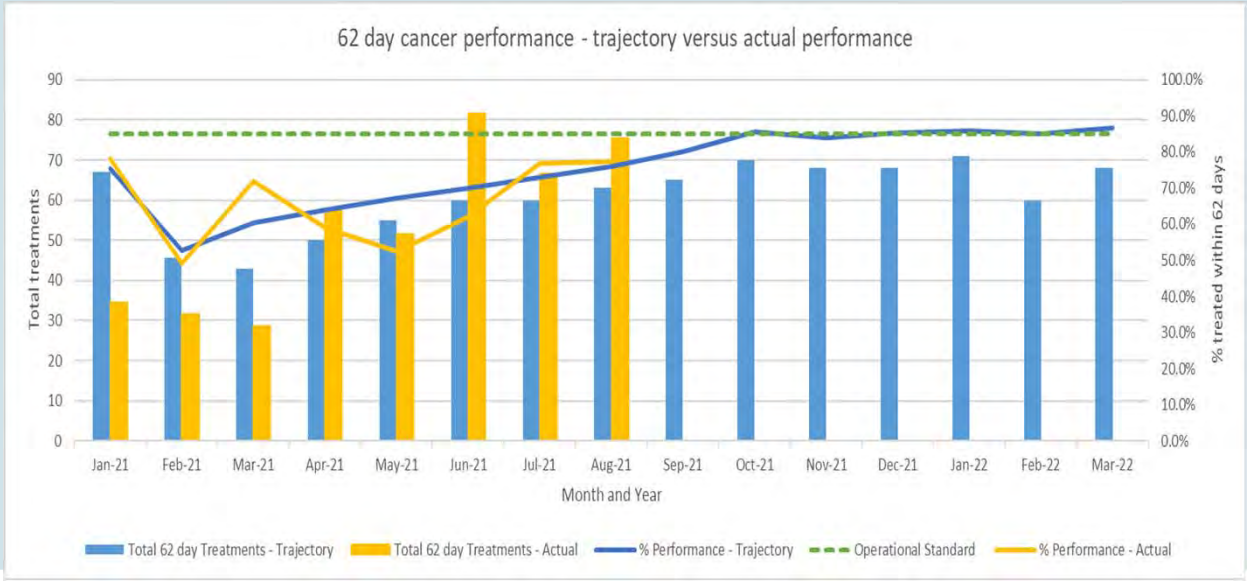
- Capacity issues in the breast unit for the high demand of cancer referrals.
- A vacancy within the CRO has meant early prompt communication between cancer referrals office and services has been challenged. Mitigations have been put in place.
- Outpatient clinic capacity challenged as referral numbers in general are increasing.
- A further wave of Covid impacting on service provision.

Responsive: Cancer Insights

Executive Lead: Jayne Black– 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 receive their first treatment within 62 days of referral.

What the Chart is Telling Us:

The Trust is delivering against the agreed trajectory for treatments and performance.

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 UGI/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.
- Patients waiting over 14 days has significantly decreased from 1892 from 26/04 to 596 on 18/10.
- Patients waiting over 104 days has significantly decreased from 32 from 26/04 to 9 on 18/10.

Underlying issues and risks:

- Capacity issues in endoscopy for the high demand of cancer referrals.
- Sufficient outpatient capacity to clear the backlog of patients waiting.
- Decide a date to end paper requests for imaging and transfer to DartOCM.
- Oncology delays 3-4 weeks needs to be reviewed
- Patients remains 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	V	A
Well Led	Workforce	Agency Spend as % Paybill (Financial Year YTD)	Sep-21	4.0%	4.5%	3.9%	4.4%	4.8%		
		Appraisal % (Current Reporting Month)	Sep-21	85.0%	82.5%	39.2%	78.0%	116.8%		
		Bank Spend as % Paybill (Current Reporting Month)	Sep-21	9.0%	11.0%	-5.1%	16.7%	38.6%		
		Bank Spend as % Paybill (Financial Year YTD)	Sep-21	9.0%	14.9%	13.0%	15.2%	17.4%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Sep-21		4,257.51	2,569.77	3,919.17	5,268.58		N/A
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Sep-21	2.5%	2.6%	0.4%	2.2%	4.1%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Sep-21	1.5%	2.3%	0.8%	1.9%	3.1%		
		Sickness Rate (Current Reporting Month, FTE%)	Sep-21	4.0%	4.8%	1.3%	4.2%	7.0%		
		StatMan Compliance (Current Reporting Month)	Sep-21	85.0%	89.4%	55.2%	84.0%	112.7%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Sep-21	75.0%	57.7%	51.8%	68.6%	85.3%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Sep-21	12.0%	13.0%	7.0%	11.7%	16.5%		
	Staff Experience	Staff Friends & Family - Recommend Care of Treatment	Mar-21	79.0%	74.0%	3.9%	35.7%	67.5%		
		Staff Friends & Family - Recommend Place to Work	Mar-21	62.0%	63.0%	1.6%	27.0%	52.4%		
	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Sep-21	4.0%	3.6%	1.3%	4.9%	8.5%		

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
- HR Business Partners continue to work with their respective Divisions to produce improvement plans before the end of October 2021.

Outcomes:

3210 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 3960).

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.
- Recent increase in sickness levels across the Trust has had a negative impact on compliance
- 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

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	31,961	34,045	2,083	188,170	191,025	2,856
Pay	(19,105)	(22,487)	(3,382)	(114,950)	(120,873)	(5,923)
Total non-pay	(11,419)	(10,105)	1,314	(64,597)	(61,492)	3,105
Non-operating expense	(1,445)	(1,460)	(15)	(8,670)	(8,705)	(35)
Reported surplus/(deficit)	**(8)**	**(8)**	**0**	**(48)**	**(45)**	**3**
Donated Asset / DHSC Stock Adj.	8	8	0	48	45	(3)
Control total	**(0)**	**0**	**0**	**0**	**0**	**0**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	278	201	(77)	1,192	1,135	(57)	5,171
Capital	1,233	683	(550)	8,374	6,611	(1,763)	14,317

Indicator Background:

The Trust reports a £8k deficit position for September; after adjusting for donated asset depreciation the Trust reports breakeven in line with the plan.

What the Chart is Telling Us:

The Trust has reported breakeven for the year to date. The efficiency programme is £57k adverse to plan, the actual efficiency includes £0.5m of Elective Recovery Fund income. Capital spend is £1.8m behind the budgeted plan, although overall the programme is on track to achieve the £14.3m plan.

Actions:

- Develop and agree income & expenditure plans for Oct-Mar'22. Exec Team to approve cost pressures / service developments.
- Develop 9 cross cutting efficiency themes. This will support H2 planning and reduce funding gap.
- Monitor impact of one to one nursing care across divisions, as well as impact of activity changes.

Outcomes:

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

- Incremental costs associated with Covid-19 of £2.6m year to date. Funding is included within the affordability envelope.
- ERF Income has been received £4.6m, this is £0.5m higher than the cost of delivering ERF activity.
- Costs include the national pay award backdated to April-21 £2.8m.

Underlying issues and risks:

Funding arrangements are still being finalised for the period Oct-Mar. Negotiation continues with the CCG regarding funding of ERF activity in the future as well as COVID, emergency care activity and growth.
Premium costs to employ temporary staff continue, these are required to meet planned activity levels and fill vacancies; the higher costs are not budgeted for.
Divisions continue to work with Finance and PMO to develop efficiency plans. The efficiency programme for the full year is £5.1m in total, £0.3m of this relates to FYE schemes from 2020/21.

Meeting of the Board of Directors in Public

Thursday, 04 November 2021

Assurance Report from Committee

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.2
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 19 October 2021		
Lead Director:	Liam Edwards, Chief Nursing and Quality Officer (interim)		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Quality report The Committee received the quality report, which provided: a) Update on progress for the month of September, and delivery on the Trust's CQC Action plans for ED and IPC, CQC information requests, quality assurance visits, patient safety issues, implementation of the quality strategy and clinical effectiveness. b) Update on the progress being made on the backlog of Datix, incidents and complaints. The Committee were advised on the review of systems and processes to ensure that once the backlog is cleared it does not build up again. c) Information on a restructure in the allocation of PA's for time for consultants engaged in patient safety, which will assist in patient safety work.	**Amber\Green**

d) Discussion over the incomplete local audits and were advised that this relates to junior doctors starting an audit but not completing it by the end of their rotation at the Trust. The committee agreed that the junior doctors need to link into the clinical effectiveness team for audits to be agreed that link to the organisational priorities so they can be completed by any junior doctors coming into the trust.	
2. Mortality and Morbidity summary The Committee discussed the mortality and morbidity summary and were informed about the structured judgement review group that meets weekly with a multi-disciplinary approach to review deaths that require further review. The Committee were informed the patients with learning disabilities deaths and paediatrics deaths go through a separate review process with learning disability death reported via the LeDer reviews. The Trusts learning disability nurse is involved in all the reviews and the Trust carried out a deep dive recently because there was an increase in deaths during the peak of COVID. The deep dive was reported at the safeguarding assurance group and the QAC.	**Green**
3. Safeguarding annual report and maternity safeguarding report The Committee received and discussed the annual safeguarding report and maternity safeguarding report, which provided an update on the work of the safeguarding team and maternity safeguarding along with the impact of COVID on safeguarding referrals. The reports provided an update on partnership working and the challenges of access to partner organisation information and the importance to 'think family' to flag other members of households who may be at risk. The Committee were informed about the Youth service working with the Trust to assist with children with mental health needs in paediatrics and the charity 'Emerge' working in ED to assist adults with mental health needs. The Committee discussed the number of allegations against staff and were informed about the changes in the process in managing allegations to ensure the process is robust and the need for safer recruitment and the correct level DBS checks for staff interacting with patients. The Committee requested the People Committee lead on the safer recruitment work.	**Green**
4. Implementation of the National Patient Safety Strategy The Committee received the implementation of the national patient safety strategy, which provided an update on the key initiatives with national guidance that the trust is working on to implement PSIRF, the role of the patient safety specialist and requirement for an executive and non-executive lead responsible for patient safety. The Executive team will discuss and agree the executive lead; and whether a designated non executive patient safety lead is required will be considered through the wider review of NED champion roles. The Committee were informed about the national patient safety syllabus and training requirements for staff, and the patient safety lead and other initiatives associated with the national patient safety strategy.	**Green**

The Committee discussed the update to the current reporting system and associated costs, which will need to be discussed as capital investment. The Committee noted the level of risk associated with the current backlog. The Committee will receive further updates on the work to implement the national patient safety strategy.	
5. Triangulation of data for organisational learning and improvement The Committee received the triangulation of data for organisational learning and improvement which provided an update on the paper received 6 months ago. The report reviewed SI's, harms and deaths alongside complaints, inquests and claims for the 6 month period. The Committee will receive a further update in 6 months time which will include high level investigations.	**Green**
6. Organ and tissue donation summary The Committee received a comprehensive summary and presentation from the Organ Donation Committee by Dr Gillian Fargher and Dr Paul Hayden. The Committee were informed of the number of organ donors from the Trust and the specific criteria in dying to be an organ donor; organ donation is only possible if a patient dies on ICU and in certain circumstance. The Committee were told about the change in law on 20 May 2020 with the introduction of Max and Kiera's Law, which means that every adult is deemed as being an organ donor unless they opt out. However, family members continue to be asked about organ donation so it is important to ensure your family and loved ones know your wishes.	**Green**
7. NHSE/I governance review The Committee discussed the governance review undertaken by NHSEI, which has been reviewed at Trust Board. The Committee discussed the recommendations from the review relating to the quality and patient safety group and its sub-groups and the impact upon reporting into the Committee and the work and focus of the Committee. The Committee acknowledged the work already underway on a number of the recommendations.	**Green**
8. CNST The Committee received the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 Overview paper and approved the proposed reporting schedule into the Committee and Trust Board.	**Green**
9. Patient experience report The Committee were advised that the draft patient experience strategy will be available for the next meeting and the draft is going to Trust Board. The patient experience report provided an update on the work to improve the volunteer service, the high impact actions for the in-patient survey, the re-launch of the patient experience group, the implementation of a complaints panel.	**Amber/Green**

The Committee discussed the variation across the trust on the use of the 'what matters to me' boards, and were advised that the patient experience Matron is visiting wards to educate staff on the use of the boards. The Committee requested analysis from the next in-patient survey for the November meeting.	
10. Quality IQPR The Committee received the Quality IQPR and noted performance against metrics. The Committee acknowledged there continues to be ongoing challenges with discharges and pressure within the local system to support patients who need domiciliary packages of care and noted the work with system partners to resolve this.	**Amber/Red**
11. BAF – Quality The Committee received the updated BAF – quality and noted the inclusion of the backlog of datix to risk 5a. The Committee were asked to agree the revised risk for 5c which has increased from 16 (high) to 20 (extreme). Due to the continuing operational pressures the Trust is experiencing the Committee approved the increase to the risk rating. The Committee asked for actions, interventions and mitigations to be included in risk 5c and for this to be shared with the Trust Board.	**Green**
12. Quality and Patient Safety Group – key issues report The Committee received the key issues report from the Quality and Patient Safety meeting held on the 14 October, noting its content.	**Green**
Escalation to Board The Committee escalates the following to Trust Board: 1) Continuing operational pressures on the Trust, added to the Quality BAF – Risk 5c. 2) Concerns about in-patient experience as reflected in the results of the in-patient survey.	

Meeting of the Board of Directors in Public
Thursday, 04 November 2021

Title of Report	**Medical Education Report**	**Agenda Item**	3.3
Report Author	Janette Cansick, Director of Medical Education Ginny Bowbrick, Deputy Director of Medical Education Shirley Chan, Deputy Director of Medical Education Carol Atkins, Head of Medical Education Services		
Lead Director	David Sulch, Chief Medical Officer		
Executive Summary	To inform/advise the Board of: 1. Introduction & the structure of Medical Education 2. Trainee Establishment 3. Finance 4. Education Facilities 5. COVID19 recovery funds from HEKSS 6. Update on HEKSS Quality Visit action plans 7. GMC 2021 survey 8. KMMS The Director of Medical Education is accountable to the Trust Chief Medical Officer and Health Education Kent Surrey Sussex (HEKSS) Postgraduate Dean. Our three main priorities are: 1. Support of trainees in Covid-19 recovery 2. Response to HEKSS Quality and the GMC survey principally for Medicine (both acute and general internal) 3. Progression in our readiness for the first KMMS medical students to arrive at MFT in September 2022		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Executive Group Approval:	20 October 2021		
National Guidelines compliance:	GMC Promoting Excellence: Standards for Medical Education & Training GMC Generic Professional Capabilities Framework GMC Excellence by Design: Standards for Postgraduate Curricular Gold Guide		
Resource Implications	New HEKSS contracts with enhanced oversight of our budgets from them		
Legal Implications/Regulatory Requirements	Health Education Kent, Surrey and Sussex, Learning Development Agreement (Contract)		
Quality Impact Assessment	Quality and delivery of Education and Training to Medical workforce and through Simulation the wider clinical workforce.		

Recommendation/ Actions required	The Board is requested to: 1) Be aware of the risks identified within Medical Education: a. Delayed configuration of the Medical Education Centre leading to risk for KMMS and University status b. Threat to trainee placements due to longstanding unresolved Medicine service quality issues within Unplanned Care Division 2) Receive an update on use of COVID recovery funds 3) Receive an update on HEKSS Quality Visits and GMC survey response 4) Receive an update on progress for KMMS students			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒

1. Introduction & structure of Medical Education at MFT

Health Education England (HEE) is committed to the provision of quality education and training for the development of healthcare professionals. Budget is allocated to every Local Education and Training Board (LETB) to fund specific education and training and to meet strategic education and training objectives. The Learning and Development Agreement (LDA) is a three year contract managed on behalf of HEE by HEKSS.

HEE commissions a broad range of education and training services from a variety of Local Education Providers (LEPs), such as MFT with the expectation of provision of high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust. HEE expects the Trust to support national workforce priorities and those identified locally through HEKSS, and to make investment plans and decisions based on long-term workforce planning using local and national data sources including that currently produced by the Centre for Workforce Intelligence.

The Trusts have a duty to demonstrate that the quality of the education and training that they provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to the needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The expected outcome of quality placements and training is excellent patient care provided by competent and capable staff.

MFT Chief Medical Officer is the main point of contact for the organisation with HEKSS on all matters involving workforce or education contained within the LDA. The Director of Medical Education (DME) is responsible for managing the KSS Contract on behalf of their LEP, within the national guidelines set out by the GMC and the medical Royal Colleges, and the regional systems set out in KSS Graduate Education and Assessment Regulations.

HEKSS expects the quality of training to be maintained and improved in terms of: administrative support for PGME; clinical medical education; programmed activities and local course delivery; provision of library services and resources supporting IT access; provision of simulation facilities; and faculty development.

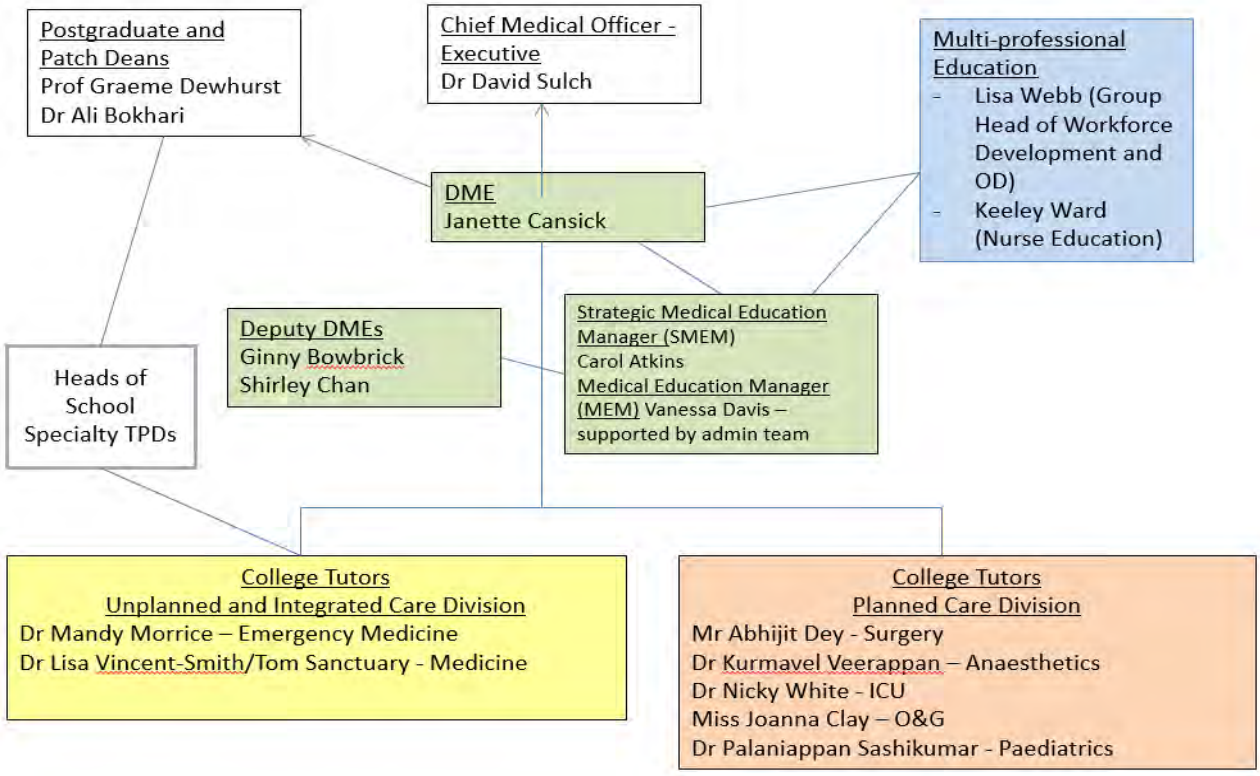
During the pandemic the majority of the Medical Education Operations team worked off site in keeping with Trust policy. Teaching and induction continued but virtually. We have now returned to the Centre and are offering a hybrid approach to teaching and induction. We are working differently not only in format and method of delivery but also by embracing new technologies particularly in relation to technology enhanced learning. In some aspects we are ahead of our neighbouring Trusts and leading the way particularly in the use of Virtual Reality (VR). The workforce has been expanded as was planned in our accepted Business case to ensure we are able to manage the Education Centre and the forthcoming changes particularly relating to KMMS students. The team has been affected by COVID on a personal level unfortunately but we were able to maintain “business as usual” to the best of our ability for our trainees by working flexibly and covering posts for colleagues who were unwell on either short or long term basis.

Workforce (see Figure 1 & 2)

- DME dually accountable in the Trust to Dr. David Sulch, Chief Medical Officer (CMO), and at HEE to Prof. Graeme Dewhurst, Postgraduate Dean. Dr. Janette Cansick, DME, meets with the CMO at the weekly CMO Operational Meeting.
- Two Deputy DMEs (Miss Ginny Bowbrick and Miss Shirley Chan)
- Strategic Medical Education Manager (SMEM, Carol Atkins) is responsible to the DME. The SMEM has an operations Medical Education Manager (MEM, Vanessa Davis) and administration team (including the Undergraduate & Simulation team).

- LFG leads (College Tutors) in all clinical areas, Foundation Training Program Directors, Director of Undergraduate Medical Education (DUME) and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME.
- There are currently 160 Educational Supervisors, with HEKSS approval and on the GMC trainer list.
- In addition the quality of Pharmacy education and training is overseen by the DME.
- The Library & Knowledge Services reports to the DME & SMEM.

Figure 1: Structure of Senior Medical Education with links and reporting lines



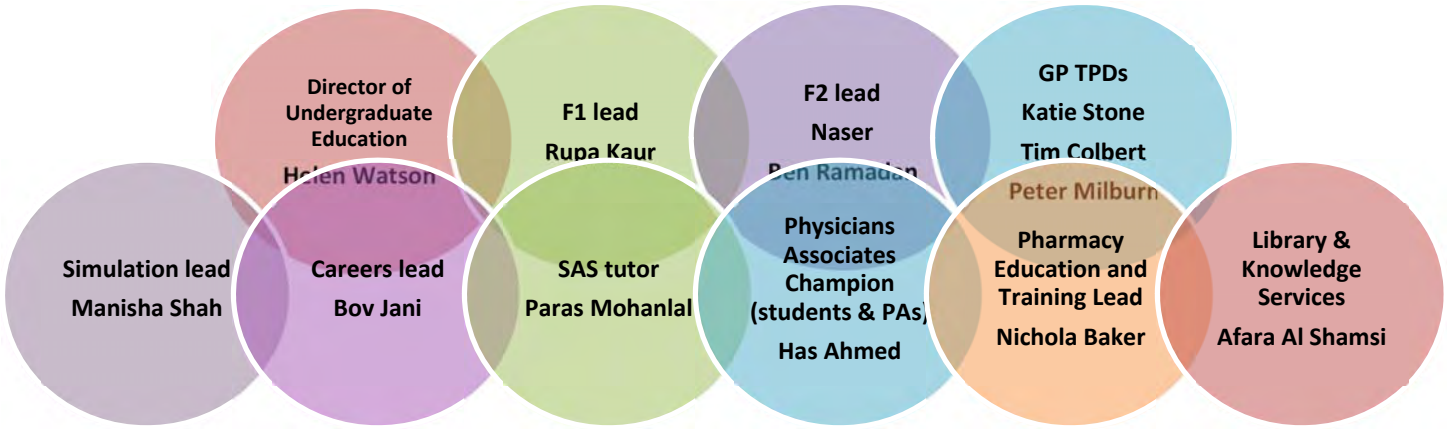
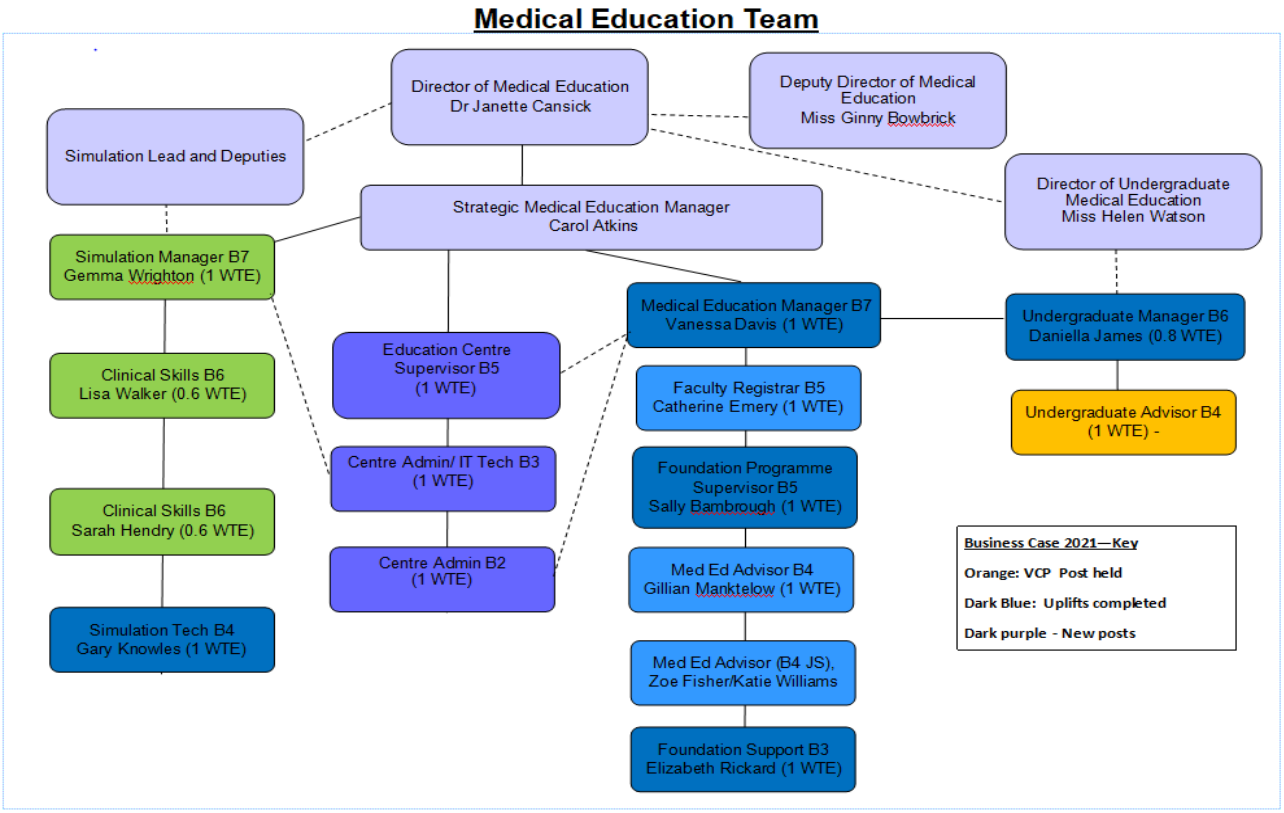


Figure 2: Structure of Operations Medical Education with links and reporting lines



Educational Quality Governance

- Trainee Voice
  - Trainee in Action groups in key areas of need (medicine, pharmacy)
  - Trainee representatives at LFG and LAB
  - Meetings with DME and CMO
  - Junior Doctors' forum (contract issues)

- Local Faculty Groups (LFG, chaired by College Tutors) meet three times a year

- Local Academic Board (LAB) meets three times a year
  - Reports from all areas of medical education, with joint learning
  - Simulation, pharmacy and library reports
  - All LFG leads summarise improvements and any concerns arising
  - Trainee Representatives provide feedback, including patient safety concerns
  - GMC survey results and HEKSS visits are discussed.
  - All quality metrics are discussed.

2. Update on Trainee Establishment

1. Chief Registrar in Medicine – two appointments (October 2018 and 2019) were made, each of one year tenure; the posts have been very successful in supporting quality improvements in Medicine and our last Chief Registrar had significant involvement in the development of the Hospital at Night and Medical Award Ceremony for Excellence in Training. Unfortunately no appointment was made for 2020/2021 or 2021/2022. In 2020/2021 this occurred because the funding from Unplanned Care could not be agreed and this year we were able to advertise but were too late due to delays with funding agreement and VCP.

2. Internal Medicine Training (IMT) - In response to the recommendations set out in the Shape of Training Report, the Joint Royal Colleges of Physicians Training Board (JRCPTB) developed a new curriculum for Internal Medicine (IM) to replace the current Core Medical Training (CMT) programme; this commenced in August 2019. As part of this new curriculum the IMTs have to undertake 80 supervised clinics over their three year training. This has proved difficult particularly with the move to virtual/telephone clinics and was discussed with the Patch Dean at the last LAB. This issue remains unresolved despite discussions at LAB. We are investing £15K of COVID recovery funds into the service to enable trainee catch-up and establish improved access.

3. Rota gaps and recruitment - HEKSS are responsible for the recruitment and allocation to the Trust training posts and programmes. This year we have two vacancies at F1 level with one at F2 and two at GP ST1 levels. This is a significant improvement on previous years. This is the first year of the IMT3 training with six of the doctors staying at MFT in Medicine. They have already completed Years 1&2 at MFT. Trust posts were converted to training posts to enable this, with the added benefit of continuity of service for our patients.

4. Foundation Priority Programme - Foundation Priority Programmes (FPP) have been developed and initiated in August 2020 to support specific areas of the UK that have historically found it difficult to attract and retain trainees through the foundation and specialty recruitment processes. Every FPP enrols in a Postgraduate Certificate (PGCert) and remains at the Trust for both Foundation years. At MFT in 2020 we welcomed four FPPs; two undertaking PGCerts in Medical Education and two in Leadership. Due to the success of the program last year, this year we have welcomed nine FPPs: five in Leadership, three in Medical Education and one in Simulation. We are particularly pleased at our links with KMMS through this programme as all of the Medical Education FPPs are enrolled at the medical school as Education Fellows and the Dean has promoted this to our neighbouring Trusts for their FPPs.

5. New curricula roll out - all specialties have transitioned to their new curricula in August 2021. This is to comply with changes to postgraduate education laid out by the GMC in “Excellence by design” (2017). The aims of the curricula are to meet the Generic Professional Capabilities and Capabilities in Practice which have a wider scope than before and not only focus on professional knowledge but also behaviours assessing the capabilities of the trainees over a wider number of environments such as multidisciplinary meetings, outpatient clinics and ward rounds. At CCT (Certificate of Completion of Training) the trainee should be able to function as a day one consultant. This change in direction of training is to support the changes needed in healthcare as our population ages and specialist skills not covered by the curricula will instead be achieved by credentialing which is currently being piloted. This has for many specialties meant different assessment tools now being employed and we have been rolling out education to our Educational Supervisors (ES) through our ES Refresher workshops for the last three years in preparation as the curricula change was meant to be implemented in 2020 but delayed for the pandemic.

6. 24 Month General Practice Training – this reduction in GP training from three to two years is a major national change, driven by the Department of Health, to be implemented by August 2022. This is going to affect the Trust financially, in workforce availability and, possibly, in continuity of care by the loss of a number of full-time training posts. Integrated Training Posts (ITPs) will take the place of some of the full-

time posts in Paediatrics, Frailty, O&G, ENT & ED; these trainees will only be in the departments for two days a week and in GP community for the rest of their training placement. However, there is a drive to establish more ITP posts in our Trust, to counteract the loss of the full-time posts.

7. New posts - Cancer care is one of the Five Year Forward View's key priorities - focusing on prevention, earlier diagnosis, better treatment and living with cancer. Having access to more skilled staff in the right areas will be key to delivering on that strategy and therefore part of this initiative is to increase workforce through an increase in training posts. We have benefitted at MFT with new posts in radiology and haematology at higher specialty trainee level.

3. Finance

Medical Education in MFT oversees the funding and quality of the training programmes and posts in a wide variety of specialties in the Trust and community. The DME carries direct responsibility for the financial management of the postgraduate and undergraduate tariffs, which cover funding for all direct costs involved in delivering medical education and training by the Trust. The new NHS Education Contract came into force April 2021 and will be a key tool for improving the quality of education and training, driving change, and providing oversight of funding. New finance schedules and reporting of education & training funds are included within the contract T&Cs, with requirements to submit 'Annual Accountability Reports' for both undergraduate and postgraduate tariffs.

Budget oversight at MFT for Medical Education tariffs has been agreed from April 2021, and work has begun on financial plans to sustain the Education Centre redesign and refurbishment. There is a new Centre team in position, to oversee the booking system and to ensure the room spaces are utilised to the full. This investment in both facilities and staff will provide the Trust and all its staff with a sustainable education & training resource for the future.

4. Quality Visits - Medicine

Medicine and ED first received Quality visits in 2015, and HEKSS scrutiny of Medicine has been ongoing since then. There have been significant ongoing issues which have remained unresolved for over 5 years, including lack of bleep filtering at night, significant rota gaps and lack of feedback following Datix.

Following the 2019 GMC survey, there was a Risk Based Review by HEKSS to Gastroenterology, Geriatrics and Core Medical training. There are still nine actions open and outstanding.

Lack of progress in the implementation of Hospital at Night, including lack of bleep filtering, is a significant concern and under scrutiny. The CMO is continuing to work on this and has written an action plan including the formation of a Task and Finish group. A lead role has been advertised to ensure that this is successfully established in Medicine with a view to subsequently rolling out in Surgery.

Other areas of concern include unsupervised clinics and opportunities to attend clinic (particularly for IMTs), reports of lack of support from the on-call consultant, staffing levels, workload on call and departmental training sessions. The DME and Deputy DME (GB) are supporting the Medicine College Tutors in working with Service leads and managers to effect changes. We believe that there needs to be a change in how Medical Education and training is prioritised by Unplanned Care as a whole to facilitate resolution of many of the issues.

We anticipate a further HEKSS Visit to Medicine, especially following the many red and pink flags in General Internal and Acute Medicine in the GMC training survey (see 5). Given the long-standing concerns, we believe

that trainee placements are jeopardised i.e. we may face actual or threat of trainee withdrawal from Trust. This carries patient safety and financial risk to Unplanned Care as well serious reputational risk to the Trust.

5. GMC National Trainee Survey (NTS) 2021

In the shorter adapted NTS of 2020, the national results uncovered the substantial upheaval to training brought about by the pandemic. Three quarters of trainees and trainers reported that training had been disrupted and over four-fifths said that opportunities to gain required curriculum competencies had been reduced. The GMC survey reverted to its standard format for 2021 with a full version of NTS. Therefore the last full survey for comparison is 2019. This year there was a national response rate of only 76% by trainees; previously 100% response was mandated.

MFT Results 2021:
Overall satisfaction of our trainees saw a distinct drop in comparison to 2019 (77.09 to 73.31) – this may in part be due to the substantial redeployment of trainees from September 2020 to February 2021 at the Trust which impacted significantly on this cohort.

We were pleased to see several Green flags in T&O and ENT specialties across the categories to include overall satisfaction, Clinical Supervision out of hours, supportive environment and feedback.

It was disappointing to see an increase in the number of red and pink flags across the survey in 2021, compared to 2019, notably in General Internal Medicine, Acute Medicine and Paediatrics.

Furthermore, there were red flags in all specialties for Team Working. The questions about team working are not related to the team working within the department in which the trainees are placed, but across all specialties, grades and related to all other non-medical colleagues within the Trust.

The results of the GMC survey were presented and discussed at Clinical Council on 11 August and 08 September 2021. The CQC report was also presented and there were many parallels to be drawn. Issues of culture and communication within the Trust as a whole, not only between doctors but all Allied Health Professionals and Managers, has been highlighted by these two reports.

We have reported back to HEKSS Quality our initial responses and actions, including overview of actions to be taken in Medicine (detailed in the table). As already stated, we are unfortunately anticipating a further visit from the School of Medicine to the Trust because of the number of red flags in Medicine.

Acute Medicine / GIM response:

Please detail your initial actions and investigations	What measures have you put in place or planned to address concerns?
There are numerous issues across the Medicine Directorate impacting trainees. Some of these have previously been identified and are ongoing issues for improvement (eg lack of bleep filtering, Hospital at Night, rota gaps). Medicine trainees (IMT and Reg) met with Associate Medical Director for Patient Safety and Quality with Director of Medical Education 15.09.21; significant concerns were raised.	The following streams of work are being actioned: 1. Transformation day with HR, education and service to review ward staffing levels and shift times. 2. Engagement of medicine consultant body - DME and CTs to attend first consultant meeting 28.09.21 to state concerns. Ongoing education and training slot agreed for CTs to discuss issues and share good practice. 3. Trainee feedback for consultants in acute medicine and on take - new model to be implemented and collated by Medical Education 4. Hospital at Night task and finish group set up - to be attended by deputy DME. 5. Trainee in action group commenced 15.09.21 to be attended by IMTs, Registrars with Assoc. MD for patient safety and quality with DME. To be continued as monthly meeting with CEO and CMO to be invited to next meeting. 6. Overview of Datix system to improve feedback to trainees.

6. COVID Recovery Funds from HEKSS

It has been acknowledged that the pandemic has severely disrupted training for all trainees and at all levels either by change in activity or redeployment and particularly for craft specialities such as all the surgical specialties, Gynaecology, Anaesthetics, Cardiology and Gastroenterology. There is therefore a threat to future workforce planning if the shortfall in training is not addressed as a priority as time spent in training has been or will be extended for large numbers of trainees. Therefore, in every aspect of COVID Recovery planning and activity, Trusts need to ensure that training is prioritised. HEE requested funding for recovery of training post-COVID from the Secretary of State for Health and were successful in their bid. This money has been divided between all the regions and then further divided between Trusts and Schools.

Each Trust has been awarded a sum of money determined by their size via our Education Contract. MFT have received £60,000 and we have outlined to HEKSS our plans as to how this money will be spent to benefit our trainees. The money needs to be allocated/spent by the end of March 2022 and HEKSS have the final approval as to what it is spent on.

We have allocated £20,000 to each of three projects, each covering an area in which we see trainees as most requiring additional support, and also enabling investment to benefit trainees in the long-term.

1. Simulation - Presented with a simulation patient, the trainee will be able to listen to the chest, read blood results, examine chest x-ray, and take a set of observations all virtually, using newly purchased Oculus headsets. Each education module will involve an interactive element which leads the user to the natural progression post decision. For example, the simulated patient presents with shortness of breath, low saturations, and high respiratory rate. Once they have diagnosed, for example, a tension pneumothorax, the trainee will indicate what the next stage of treatment is and this will proceed to a new scene of either improvement or deterioration of patient.

The clinical skills 360 allows the trainee to observe, make clinical decisions and chose the appropriate pathway for the skill involved. It will ask questions in regards to indications/contraindications of the intervention and applying settings, choice of anatomical landmarks etc. This online platform can be accessed from anywhere, at any time and has exciting possibilities for training of the future multidisciplinary workforce.

2. Medicine - We allocated £5k to deliver a local Medicine Training Day for higher trainees on 6th September 2021. This extra training day included Hybrid Simulation, Human Factors, Part Task training and didactic lectures.

We have also allocated £15k for designated training outpatient clinics to support loss of training opportunities for IMTs and higher trainees during the pandemic. IMTs and higher trainees, who are identified as trainees who will benefit, will be allocated enhanced training clinics where a consultant is present in the room to support and train.

3. Surgery - A new laparoscopic simulator will allow trainees to perform laparoscopic surgery on a variety of simulated models outside of theatre. It allows them to develop surgical skills safely and at their own pace, whilst allowing them to shorten their learning curve for when they are in theatres. It does not require a patient to be present in theatres and will help address the reduction in experience and shortfall of training cases that occurred during the COVID pandemic.

7. Education Centre - Facilities

The Trust Board agreed in 2019 that the Postgraduate Centre needed an upgrade to its current facilities, in order to meet the requirements for all staff (including HEE contract and GKT medical school contract), to prepare for a large increase in undergraduate medical students through KMMS (September 2022), and be appropriate to support University status application.

Agreement has now been reached on the funding (capital and revenue) of various aspects of the development, and work will commence in this financial year.

8. KMMS

Kent and Medway Medical School took their first intake of 100 students in September 2020 and MFT is due to take KMMS medical students from 2022. The tariff for these students will commence in September 2022 with no priming.

As a Trust we have actively supported KMMS, for example through MFT Medical Education multidisciplinary team marking the Multiple Mini Interviews (MMI) student selection process. Three MFT consultants hold Senior Lecturer Posts at KMMS - Dr Richard Patey (3PA), Dr Shanti Paramothayan (1PA) and Miss Helen Watson (1PA).

The focus in Trust is to be ready for the students in September 2022, ensuring both educational faculty and facilities as well as accommodation. This is facilitated by a monthly KMMS meeting which includes representation from Finance, Estates, R&I, the Postgraduate Centre and Education leads.

To launch our countdown to our first students, KMMS Founding Dean Professor Chris Holland joined us for a Grand Round in September when we began a year countdown before the first students arrive in September 2022. There will be ongoing events and communications, with support from the Trust Communications team. Success is vital to maintain and further establish the Trust's reputation as a training establishment; this achievement will further support the Trust re-application for University status.

Meeting of the Trust Board in Public
Thursday, 04 November 2021

Title of Report	Safe Staffing Nurse Establishment Review 2021	**Agenda Item**	3.4
Report Author	Liam Edwards, Deputy Chief Nurse		
Lead Director	Evonne Hunt, Chief Nurse and Quality Officer (Interim)		
Executive Summary	As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, provider Trust Boards are required to receive an annual review and approve any changes to nursing establishments. This review is also aligned to the recently published Royal College of Nursing (RCN) Nursing Workforce Standards (2021) which outline the responsibility and accountability of organisations for setting, reviewing and taking decisions and action on staffing levels and skill mix. The previous annual review of nursing staffing levels was presented by the Chief Nursing and Quality to the Trust Board in July 2020, at which funding was approved to increase nurse establishments by 65 FTE. Recruitment has continued over the past year to support achievement of last year's provider review recommended levels for safe nurse staffing. The Trust Board received a six monthly update on nurse staffing in January 2021 which outlined progress with recruitment to the additional posts and work undertaken to ensure safe nurse staffing across adult inpatient wards. This paper provides the Trust Board with a high level overview of the annual provider review of nurse staffing levels as reviewed for 24 consecutive days from the 08 July 2021. Although it is not routinely recommended to change staffing based on one review some areas have highlighted that staffing requirements have changed within the timeline from the last review and should be considered. The nationally recommended Safer Nursing Care Tool (SNCT) is the nationally recommended NICE tool which provides a standardised and systematic measure of nurse staffing levels at ward level, calculating adult inpatient ward staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guide Chief Nurses in their safe staffing decisions. The SNCT is in use across the inpatient wards of the Trust and allows senior nurses to take decisions on nurse staffing levels in line with patient acuity and dependency. The review of inpatient adult wards includes 21 wards. The annual safe staffing review commenced on the 08 July 2021. There has been a delay in completing this review this year, in part due to external training and validation that was brokered by the Chief Nursing and Quality Officer through Hilary Chapman and the national safe staffing team. As stated, this review has focused solely upon adult general areas. Additional reviews into Emergency Care, Paediatrics, Theatres, Critical Care, Specialist Nursing / Clinical Nurse Specialists, Outpatients and corporate nursing will be required in the coming months to provide a composite picture of the nursing resource available within Medway NHS Foundation Trust. It should be stated that some national comparison tools are not available however and local variation may occur e.g. Outpatients and Clinical Nurse Specialists.		

	It should be noted that the previous review, which is used for comparison in 2019/20, would not have incorporated the increased ward provision on Jade ward as escalation ward as this is a temporary arrangement and also the impact of Covid 19 upon patient dependency and acuity, most notably on McCulloch ward. Both of these circumstances will change the requirement of staffing from the Trust. In addition to this review it has been recommended by the SNCT national team that no significant changes to staffing establishments be taken until after a second review in February 2022. Finally it should be noted that no episodes of staffing not meeting safe staffing requirements have been reported from divisions following mitigation although the increase in need for 1:1 nursing of patients has increased and would not explicitly be collected as part of the SNCT review
Executive Group Approval:	Date of Approval:
National Guidelines compliance:	This paper conforms to National Guidelines : National Quality Board (2016) Workforce Safeguards Guidance (NHS Improvement (NHSI) 2018) Royal College of Nursing (RCN) Nursing Workforce Standards (2021)
Resource Implications	There are no financial implications in relation to this paper as recommendations are to review findings post the subsequent review in February 2022.
Legal Implications/Regulatory Requirements	Failure to comply with validated safe staffing levels, in line with Royal College of Nursing (RCN) guidance, the National Institute of Clinical Excellence (NICE) guidelines, NHSI recommendations and Care Quality Commission Regulations, could lead to the Trust not meeting its terms of authorisation, resulting in breaches of regulations.
Quality Impact Assessment	Not applicable for this report.
Recommendation/ Actions required	The Board is recommended to: - Discuss the content of this review. - acknowledge that safe staffing has been achieved across the areas included in the review. - review this paper when the additional review is completed in February 2022.

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

1. Introduction

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

1.1.2 As such, this report focusses on a peri-COVID configuration of the adult in-patient ward nursing establishments as per the national requirement which includes the additional escalation ward, Jade, although it is acknowledged this is a temporary ward.

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

1.1.4 There is also a requirement as stated in the NMC Nursing Workforce Standards (2021) which outlines the responsibility and accountability of organisations for setting, reviewing and taking decisions and action on staffing levels and skill mix as part of the three strand recommendations also including clinical leadership and safety and health, safety and wellbeing

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

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

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

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

1.1.9 This report outlines the peri-COVID ward configuration nursing establishments across all adult inpatient areas with the exception of Sunderland ward where data collection was not collated due to a loss of data.

1.1.10 Following review this report also makes recommendations on provision of safe nurse staffing levels but should be used with caution as Covid level have fluctuated and therefore patient placement may be different and variable in the coming months. A significant investment is not recommended at this stage but may be revisited following the subsequent six month review.

1.1.11 Based on an assessment of the areas of highest risk relating to the analysis of safe staffing requirements (section 5) and acknowledging that plans are being reviewed in light of the hospital bed base including the temporary winter ward.

1.1.12 This review focuses solely upon adult general areas. Additional reviews into Emergency Care, Paediatrics, Theatres, Critical Care, Specialist Nursing / Clinical Nurse Specialists, Outpatients and corporate nursing will be required in the coming months to provide a composite picture of the nursing resource available within Medway NHS Foundation Trust. It should be stated that some national comparison tools are not available however and local variation may occur e.g. Outpatients and Clinical Nurse Specialists.

1.1.13 It has been recommended by the SNCT national team that no significant changes to staffing establishments be taken until after a second review in February 2022.

1.1.14 It should be noted that no episodes of staffing not meeting safe staffing requirements have been reported from divisions following mitigation. Mitigation can include the moving of staff between areas, proactive roster management and planning and the re-prioritisation of work on a daily basis depending upon the clinical need of the organisation and patient base on a daily basis.

1.1.15 The increase in need for 1:1 nursing of patients has increased and would not explicitly be collected as part of the SNCT review but would need daily evaluation as per escalation with booking of additional staff as required..

1.1.16 Finally it should be stated that this review looks at planned staffing figures and recommends the safe staffing figures based upon the information collected. This does not include additional demand when escalation areas are opened, periods of high sickness or other unplanned events occur.

2. Background

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

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

2.3. There are staffing review meetings each weekday which are chaired by a Divisional Director of Nursing or Head of Nursing to enable effective live re-deployment of staff.

3. Historical Establishment Review Process and Outcomes

3.1. In undertaking the 2021/22 nursing establishment review, the Chief Nursing and Quality Officer is confident that this has been undertaken in line with all of the requirements set out within the guidance mentioned in section one due to the additional training and understanding as provided by the National Safe Staffing Team.

4. Methodology

4.1. SNCT data was collected and recorded once per twenty four hours over a 32 day period from 8th July 2021 to 09 August 2021 by either the nurse in charge of the shift who has been trained by the national team and assessed by the corporate team or a designated responsible senior nurse who has assisted with the collection.

4.2. Validation of the data was undertaken by Matrons and or Heads of Nursing using the following principles:

1) The ward manager was to be in a supervisory role whenever possible as per national recommendations. Although this is established at 100% there is often the need for the ward manager to be incorporated into the numbers due to shortfalls in staffing. The supervisory role facilitates the oversight of quality standards, management of complaints, incidents, staff management, supervision and appraisal and is recognised to be pivotal in supporting effective ward leadership. It is acknowledged that sometimes the ward manager was included within shift numbers due to the staffing of certain areas and inability to fill gaps in rosters due to bank coverage.

2) The nurse in charge was to be outside of the clinical numbers whenever possible. This is a national recommendation to provide oversight of the whole clinical picture on shift.

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

4) The RN: CSW ratio had to be set at 65:35 ratio in most areas but is capable of flexing.

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

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

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

4.5. Specialling i.e. the provision of 1 to 1 care is not effectively captured by the SNCT tool as carries the same multiplier as a patient that requires full care. Full care would not require a nurse or care worker f

5. Analysis in National context

5.1. Nationally, the Trust is the first quartile for total amount of staff (FTE) employed when compared to a peer organisation. Peer and National Median values are 2,609.6 FTE opposed to Medway NHS Foundation Trust with 1,801.8 as validated by ESR (appendix 1.)

5.2. Staff costs per average are not available on Model Hospital at time of this report for 2021. The most recent staff cost timeframe available is 2019/20 which shows the Trust to be in the third quartile nationally for average staff cost with a trust value of £39,881 against a national mean of £39,664 (appendix 2.)

6. Unplanned and Integrated care Divisional Analysis

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

Table 1 : breakdown of wards in unplanned and integrated care and findings

Ward	2020/21 FTE current	SNCT 2021 / 2022 FTE current findings	Difference	Divisional suggestion to for potential change post professional judgement	Notes: All areas do not include the ward manager being supernumerary or shift coordinators also not being included in the numbers
Byron Ward	42.58	38.4	-4.18	0	See notes describing ward changes below
Emerald ward	50.57	24.2	-26.37	0	See notes describing ward changes below
Harvey Ward	46.75	37.3	-9.45	0	See notes describing ward changes below
Jade ward	**Not established in budget**	19.9	**Not established in budget**	+26.1	See notes describing ward changes below
Keats Ward	43.26	33.4	-9.86	0	See notes describing ward changes below
Lister ward	59.03	37.4	-21.63		See notes describing ward changes below
McCulloch ward	35.91	39	+3.09	0	Note commentary in ward description for respiratory specialist unit case
Milton Ward	47.84	40.3	--7.54	0	See notes describing ward changes below

Ward	2020/21 FTE current	SNCT 2021 / 2022 FTE current findings	Difference	Divisional suggestion to for potential change post professional judgement	Notes: All areas do not include the ward manager being supernumerary or shift coordinators also not being included in the numbers
Nelson ward	34.8	**33**	**-1.8**		Note change in location of cardiology to Bronte ward
Sapphire acute frailty unit / Sapphire ward	51.59	35.9	-15.69	0	Note Sapphire was on Arethusa ward in 2020
Tennyson ward	48.85	49.2	+0.35	0	See notes describing ward changes below
Wakeley ward	41.48	33	-8.55	0	See notes describing ward changes below
Will Adams ward	42.85	34.3	-8.55	0	See notes describing ward changes below
Total	545.51	455.3	-90.21	+26.1	

Table 2: costings and FTE changes for unplanned and integrated care wards

	2020/21 current FTE	Proposed divisionally agreed 2021/22 Safer Staffing FTE	Professional Judgement applied Difference
Total	545.51	455.3 (note Emerald, Lister and Sapphire wards have significantly impacted upon the review by only including inpatient areas)	No change to current establishment proposed

Ward analysis and professional judgement review

The Senior Nursing Team agree that no changes be made to establishments until the February 2022 audit with the exception of temporary booking of staff to McCulloch Ward to safely manage the level 1.5 – level 2 patients including those on respiratory support such a Non-invasive ventilation (NIV)

Byron Ward

Byron is a specialist elderly care ward consisting of 26 beds. SNCT data suggests a decrease of 4.18 WTE although this does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In addition the ward layout is such that a reduction in staffing would reduce visibility and therefore professional judgement suggests this is not supported

Emerald ward

Emerald ward is a 15 bedded acute frailty short stay unit with 9 additional assessment beds. This audit only included the inpatient area. In addition this is a new ward and therefore there is no baseline from last year to avail comparison. SNCT data suggests an establishment of 24.2 WTE which is inadequate for an acute admissions frailty unity and ward. Emerald Ward requires 39.63 WTE and Emerald EAU requires 10.57 WTE (additional awarded from business case) to turn 9 beds twice daily. Total of 50.57 WTE required

Harvey Ward

Harvey is a specialist elderly care ward consisting of 25 beds. These patients are highly dependent due to frailty. SNCT data suggests a decrease of 9.45 WTE although this does not reflect the dependency of this

patient group the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In addition the ward layout is such that a reduction in staffing would reduce visibility and therefore professional judgement suggests this is not supported

Milton ward
Milton is a specialist elderly care ward consisting of 26 beds. These patients are highly dependent due to frailty. These patients can require enhanced care levels to support safe care. The SNCT data shows there has been an increase in both patient acuity and dependency on the ward. SNCT data suggests a decrease of 7.54 WTE although this does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In addition the ward layout is such that a reduction in staffing would reduce visibility and therefore professional judgement suggests this is not supported

Tennyson ward
Tennyson is a specialist elderly care ward consisting of 27 beds. Analysis of the SNCT data suggests a decrease of 11.97 WTE but does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In light of the challenges of a frailty unit including visibility of patients to prevent hospital acquired harm, professional judgement suggests this is not supported

Jade ward
Jade ward is a 16 bedded Nightingale ward used as a winter escalation area for Covid 19 patients. This ward has no established staff recruited into post as this is a temporary provision of additional capacity.

Keats ward
Keats ward is a specialist gastroenterology ward consisting of 26 beds. The speciality ward supports patients who are withdrawing from the effects of alcohol and drugs misuse. These patients can exhibit challenging clinical and emotional requirements requiring enhanced levels of nursing support. The SNCT data analysis shows an increase in both patient acuity and dependency on the ward. SNCT data suggests a decrease of 9.86 WTE although this does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In addition the ward layout is such that a reduction in staffing would reduce visibility and therefore professional judgement suggests this is not supported until second review in February 2022 with additional data. Finally the specialist nature of the ward requires a higher establishment including the need for specialling of patients due to the effects of alcohol withdrawal and the ageing estate.

Will Adams
Will Adams ward is a 26 bedded ward for general medical and endocrine patients. Analysis of the SNCT data suggests a decrease of 8.96 WTE but does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. Additionally this ward also has a higher proportion of patients with Alcohol and or drug dependency, with this specialist nature of the ward it requires a higher establishment including the need for specialling of patients due to the specific needs of these patients.

Wakely ward
Wakely ward is a 25 bedded general medical ward for inpatients with a higher than normal older persons population. SNCT data suggests a decrease of 7.84 WTE but does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In light of the challenges of this ward being used for Covid19 in escalation, professional judgement suggests this is not supported

McCulloch ward
McCulloch ward is a 23 bedded Respiratory ward which has been used specifically for patients requiring enhanced therapeutic interventions such as Non Invasive Ventilation. This enhanced care requirement requires additional nurses and is considered between level 1.5 and level 2 depending upon the additional patient requirements.
SNCT data suggests a decrease of 1.48 WTE although this does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In the SNCT data does not reflect the acuity of the patients or the ward layout and the need to keep bays closed due to Covid19 and

other respiratory illnesses. Therefore professional judgement suggests a reduction in staffing would not be supported. In order to safely provide level 1.5 – level 2 respiratory care for covid-19 positive and negative patients, additional staffing is supported to provide safe care. A business case for the development of a Respiratory Specialist Unit demonstrates the need for 51.2 WTE

Nelson ward (Cardiology now Bronte Ward)
At the time of the SNCT audit Nelson ward was a 24 bedded Cardiology ward with adjacent Coronary care unit. For the purposes of the SNCT data the CCU was not included. Staffing for this area is not considered to be a reliable baseline in light of the temporary nature of the location of this ward. The ward has now been relocated to Bronte ward following the refurbishment of CCU in the adjoining area. The SNCT tool would not be applicable to use in this area due to the changes described. It is proposed that no changes are made to current establishment.

Sapphire Acute Medical Admission Ward
Sapphire Ward is a 26 bedded Acute Medical Admission Ward. SNCT data suggests a decrease of 1.94 WTE although this does not reflect the Ward Manager of 1 WTE and additionally the supernumerary status of the nurse in charge at 5.2 WTE. In light of the acuity and rapid turnover of acute medical admission, the nursing ratios are required to be higher in order to maintain patient safety and flow. It should be noted that based on the proposed changes to the acute medical model within the hospital, professional judgement suggests that no changes in staffing establishment should be made

Lister Acute Assessment Unit
Sapphire Ward is a 27 bedded Acute Assessment Unit. In light of the acuity and rapid turnover of acute assessment patients, including a direct GP referral assessment area, the nursing ratios are required to be higher in order to maintain patient safety and flow. It should be noted that based on the proposed changes to the acute medical model within the hospital, professional judgement suggest that no changes in staffing establishment

Emergency Care:

6.2. As part of the national support brokered by the Chief Nurse and Quality Officer through the National Safer Staffing Team there was the opportunity to use the newly devised Emergency Department staffing tool (table 3.) This tool uses attendance data only and was based on 2019 data to avoid bias due to the Covid19 pandemic which saw decreased numbers of attendance but much higher acuity.

6.3. It should be noted that in addition to the review there would need to be analysis of local factors such as location, additional services such as MEDOC etc and therefore the below table should not be viewed in isolation.

6.4. Although there is acknowledged that additional information and scrutiny of the data supplied must be used before suggesting any changes to staffing workforce or shift patterns it should be noted that this also shows a deficit of approximately 7.68FTE

6.5. Table 8 analysis of ED attendance data by NHS E / I safer nursing care team

National ED averages applied to 2019 annual attendances with recommended 25% uplift for headroom and 86% RN skill mix

Table 3

A	B	C	D
1	**Attendances**	**Local Average**	**ED Average**
2	Annual attendance?	133912	69165
3	Daily cv-19 patients?	0	29%
4	Level 0 patients (daily average)?	233	63.5%
5	Level 1a patients (daily average)?	35	9.7%
6	Level 1b patients (daily average)?	52	14.1%
7	Level 1c patients (daily average)?	31	8.5%
8	Level 2 patients (daily average)?	10	2.7%
9	Level 3 patients (daily average)?	6	1.6%
10	Daily attendance	367	100.0%
11	**Adjustments**	**Local Average**	**ED Average**
12	Preferred headroom?	25.0%	27.0%
13	Ready for action (RfA) time	10.5%	10.5%
14	Preferred registered nurse (RN)	86.2%	86.2%
23	**Recommended Staffing**	**FTEs (Including Headroom)**	**Care Hours per Contact**
24	Total	154.1	1.69
25	RN	132.9	1.45
26	SW	21.3	0.23
27	**Local Staffing**	**FTEs (ED Average)**	**Care Hours per Contact**
28	Funded (budgeted)?	146.42	1.60
29	Actual (in post)?		0.00
30	Temporary (bank, agency, overtime)?		0.00

7 Planned Care Divisional Analysis

7.1.1 Following divisional review of the SNCT data and validation the Divisional Director of Nursing for the Division has recommended no changes to current establishment or skill mix. This will be revisited as part of the terms of reference for the second SNCT audit in February 2022.

Table 4: breakdown of wards within Planned care and findings

Ward	2020/21 FTE current	SNCT 2021 / 2022 FTE current findings	Difference	Divisional suggestion to for potential change post professional judgement	Notes: All areas do not include the ward manager being supernumerary or shift coordinators also not being included in the numbers
Arethusa Ward (Kingfisher)	43.77	42.66	-1.11	0	See notes describing ward changes below
Ocelot (Victory)	22.01	12.24	-9.77	0	See notes describing ward changes below
Lawrence ward	34.75	24.35	-10.4	0	See notes describing ward changes below
Pembroke Ward	50.98	56.74	+5.76	0	See notes describing ward changes below
Phoenix Ward	80.4	45.23	+3.17	0	See notes describing ward changes below
Victory ward (McCulloch)	32.5	33.44	-0.94	0	See notes describing ward changes below
Kingfisher (Ocelot)	34.24	34.92	-0.68	0	See notes describing ward changes below
Sunderland Day case unit	34.29	NA	0	0	See notes describing ward changes below
Total	252.54	**249.58**	-13.97	**0**	

7.1.2 Table 5: costings and FTE changes for planned care wards

	2020/21 Safer Staffing FTE	Proposed divisionally agreed 2022/23 Safer Staffing FTE	Professional Judgement applied Difference
Total	252.54	249.58	0

Ward analysis and professional judgement review

The Planned Care (PC) Senior Nursing Team agree that no changes be made to establishments until the February 2022 audit with the exception of an additional 1 FTE RN on phoenix ward for night duty which currently is being filled with a daily temporary staffing request as an overspend to safely manage acuity and the enhanced Covid function of this ward area.

The PC team would highlight that ward managers are included in the numbers from 2020 and in the budget represented in 2021 Band 6 nurses in charge of shift are also included in the safe care numbers for our wards. It is suggested that in line with Trust and national recommendations that following the second review in February 2022 that the supernumerary status of both ward managers and nurse in charge of shifts be revisited and removed from inclusion from the numbers.

Arethusa Ward (2020 Kingfisher)

Arethusa ward is a short stay ward consisting of 14 beds. The surgical admission unit is co-located and has 2 assessment rooms, 5 chairs and 5 trolleys.
The SAU is as assessment unit although the appropriate tool was requested it was not provided therefore the assessment unit was treated as a ward.

The current establishment matches 2020 recommendations

Bronte / Ocelot (was Victory ward)

Ocelot ward continues to function as a 12 bedded elective orthopaedic ward. The function is the same as during the review just in different location. Minimal safe staffing requirements for 2 RNs and 2 CSW would invalidate any reduction in staffing identified from this review.
In 2020 Victory ward was an 18 bedded ring-fenced orthopaedic ward bed number reduced in line with demand and establishment reduced to match clinical requirements and bed size of this unit with FTE moved within the care group in line with increased clinical demands and ward relocations

Pembroke ward

Pembroke ward is a 27 bedded orthopaedic trauma ward. The majority of patients are frail elderly with complex care needs.

It should be noted that this cohort of patients often have additional needs relating to dementia and or delirium and therefore require additional staffing to provide a safe environment and reduction of hospital associated harm such as falls. In light of this and utilising professional judgement it is suggested that the review of staffing is revisited following the second review in February 2022 with additional data and scrutiny.
No changes to ward function the current establishment matches 2020 recommendations

Phoenix ward

Phoenix ward is combined general surgery and vascular ward of 30 beds. With the increased Covid 19 bed demand this area is also used to provide surgical services to patients who additionally have a diagnosis of Covid 19.

Currently establishment has 4 RN at night to manage increased acuity an additional RN has been requested 7 days a week to support. The division supports an additional FTE RN for all day shifts and an additional 2 FTE RN at night

No changes to ward function but additional 35.81 WTE not supported through Professional Judgement due to variable position of the ward due to acuity during month of collection.

Victory ward (was McCulloch ward)
Victory ward is an 18 bedded general surgical ward. Utilising professional judgment it is suggested that the review of staffing is revisited following the planned review in February 2022.
In 2020 Victory (McCulloch) was a 30 bedded surgical ward and changed location to Victory ward with 18 surgical beds and the FTE was reduced in line with clinical need and reduced bed base

Kingfisher ward (was Ocelot ward)
Kingfisher is a 22 bedded female surgical ward which also provides emergency assessment care for patients with gynaecology issues after hours and at weekends. The functioning of the GAU is not currently within the establishment of this ward and would be considered as part the planned review in February 2022.

In 2020 Ocelot ward had 12 gynaecology beds the relocation of this area to Kingfisher increased the bed base to 22 and the nursing establishment adjusted to fit increased beds and clinical need

Lawrence ward
Lawrence ward is a speciality haematology / oncology ward which facilitates complex chemotherapy, palliative and end of life care for cancer patients. This 2021 review has not provided reliable information of patients receiving complex infusion and chemotherapy and the acuity not accurately recorded.
The reduction of CSW is also not supported at this time as high number of inter-hospital transfers for therapies (radiotherapy or specialist appointments in the cancer network) requiring escorts In light of this and utilising professional judgement it is suggested that the review of staffing is revisited in February 2022 with additional data and scrutiny.

The recommendation of 2020 was not matched as the ward had progressed with training and embedding nursing associate position (Band 4) and divisional decision making in 2020 did not support the increased establishment recommendation

Sunderland ward (Sunderland day care unit)
The function of Sunderland during the pandemic shifted to green pathway elective in patient and day case surgery which continues into 2021/22.
The current establishment matches 2020 recommendations and is considered appropriate by the division at this time

7. Nurse sensitive indicators Analysis

7.1 To enable a comprehensive picture to be evaluated, nurse sensitive indicators for Tissue Damage and falls has been compared below on 2019/20 and 2020/2021 data. It should be noted that there has been a considerable change in focus and function and therefore direct correlation is challenging in light of this.

7.2 Tables 6 and 7: falls comparison 2019 /20 and 2020/21

7.3 Tables 6 and 7: Tissue Damage 2019/20 and 2020/221

Both show a decrease in hospital acquired harm as measured. It should be noted some gaps in reliability would need to be applied in line with the changes in the ward provision and staffing of such during the challenging staffing episodes of the covid19 pandemic.

Table 6: Unplanned and integrated care falls and pressure damage yearly comparison

Unplanned and integrated care				
Ward	**Datix reporting 2020/2021 (brackets = 2019/20)**	**Complaints reporting 2020/2021 (brackets = 2019/20)**	**Pressure Damage / Tissue Viability reporting 2020/2021 (brackets = 2019/20)**	**Falls reporting 2020/2021 (brackets = 2019/20)**
Byron Ward	5 (13)	7 (5)	12 (23)	53 (46)
Emerald ward	NA	2 (NA)	0 (NA)	7 (6)
Harvey Ward	35 (29)	12 (15)	9 (18)	53 (75)
Jade ward	4	4 (NA)	0 (NA)	13 (2)
Keats Ward	6 (17)	7 (23)	10 (12)	80 (78)
McCulloch ward	10 (7)	5 (21)	12 (8)	21 (43)
Milton Ward	NA	11 (10)	15 (14)	46 (56)
Nelson ward	2 (1)	6 (2)	2 (3)	29 (42)
Sapphire acute frailty unit	7 (3)	9 (6)	7 (0)	86 (58)
Tennyson ward	9 (7)	3 (8)	5 (6)	46 (45)
Wakeley ward	8 (3)	7 (11)	19 (16)	40 (49)
Will Adams ward	2 (0)	24 (20)	7 (5)	46 (40)
Total	88 (80)	97(121)	98 (105)	520 (540)

Table 7: Planned care falls and pressure damage yearly comparison

Planned care				
Ward	**Datix reporting 2020/2021 (brackets = 2019/20)**	**Complaints reporting 2020/2021 (brackets = 2019/20)**	**Pressure Damage / Tissue Viability reporting 2020/2021 (brackets = 2019/20)**	**Falls reporting 2020/2021 (brackets = 2019/20)**
Arethusa Ward	4 (3)	7 (14)	3 (13)	35 (53)
Bronte Ward	4 (NA)	4 (9)	6 (8)	28 (23)
Pembroke Ward	1 (9)	15 (14)	16(22)	12 (22)
Phoenix Ward	10 (3)	25 (12)	19 (20)	34 (43)
Victory ward	5 (4)	18 (6)	10 (4)	28 (10)
Total	24 (19)	69 (55)	54 (67)	137 (151)

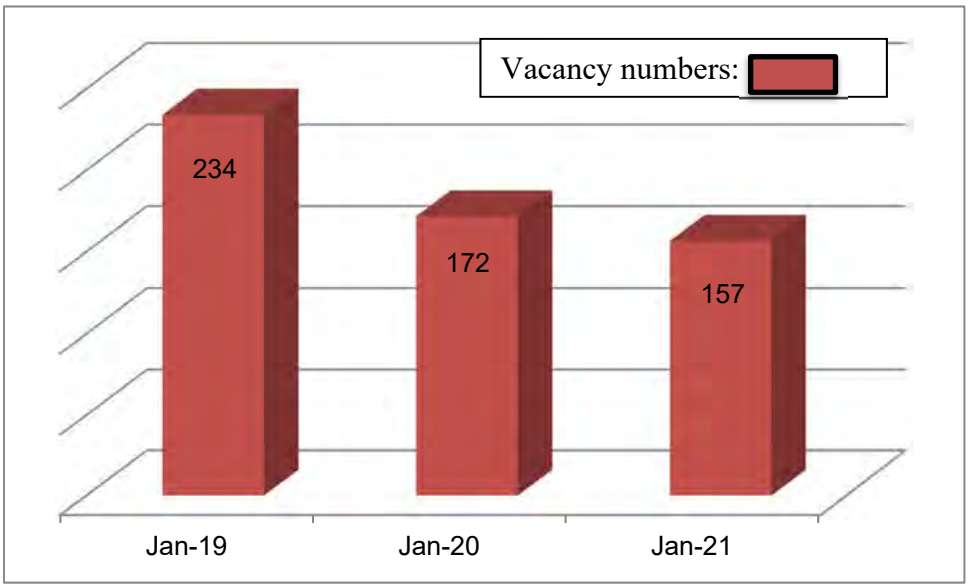
8. Nurse Vacancy and turnover rate 2019/20 and 2020/2021

7.1 In line with best practice and to ensure unintended consequences are captured nurse vacancies for the years 2019/20 and 2020/2021 have also been captured to enable a comprehensive picture of a stable workforce with a reducing vacancy rate based on established areas.

7.2 Table 8: vacancy rates for all grades of nursing 2019/20 and 2020/221 show a year on year decrease of vacancy rates against a standard turnover rate of 0.8% for nursing staff. This does not currently include staff awaiting deployment into the hospital from our international pipeline of over 100 nurses. The data shows an improving picture of staffing vacancy although this does not include staffing of additional bed capacity areas such as Jade ward. The provision of additional services, if established would increase the vacancy gap in addition to the provision of redeployed staff and the increased sickness rate due to seasonal variation and the Covid19 pandemic.

7.3 It should be noted that additional establishment increases from the 2019/2020 review increased the overall staffing establishment by 65 WTE which would have conversely increased the vacancy figures at this time. This would not explicitly be apparent when looking at whole vacancy figures alone.

Table 8



7.3 Table 9: Turnover rates for all grades of nursing 2019/20 and 2020/221 shows an average rate of 0.8% when compared at set points over the years.

Month	Monthly Turnover %
Apr-19	1.0%
Apr-20	0.6%
Apr-21	0.8%

8. Conclusion

8.1. Running the Safer Nursing care audit during a Covid 19 pandemic has changed the function and demands both for acuity and dependency of wards

8.2. Changes in function of wards and movement as part of the Covid 19 response and also service re-design i.e. elective orthopaedic surgery on Bronte ward, Cardiology on Nelson ward etc has additionally caused a challenge in interpreting the data from the SNCA

8.3. Jade ward as a temporary increase in bed capacity has not been a focus of the SNCT in line with its temporary nature.

8.4. The tool has been used to inform a safer nursing staffing profile although this has data challenges due to the variable nature of wards functions and the new variables associated with Covid19.

8.5. Divisional ratification and validation of the findings has revealed minimal additional staffing requirement has been asked for reflective of the additional winter pressure ward which has been open since 2020

8.6. Table 10 : difference in FTE staffing suggestions

	2020/21 current FTE	**2021/2022 divisionally supported FTE Safer Staffing**	Professional Judgement applied Difference
Total	**798.05**	704.05	+30

9. Recommendations

9.1. The Trust Board is recommended to:

1) Discuss the content of this review.

2) Note the changes in ward function and location across multiple areas leading to challenges with data quality and comparison

3) Support the temporary increase in staffing costs associated with McCulloch ward establishment prior to a business case for a specialist respiratory unit

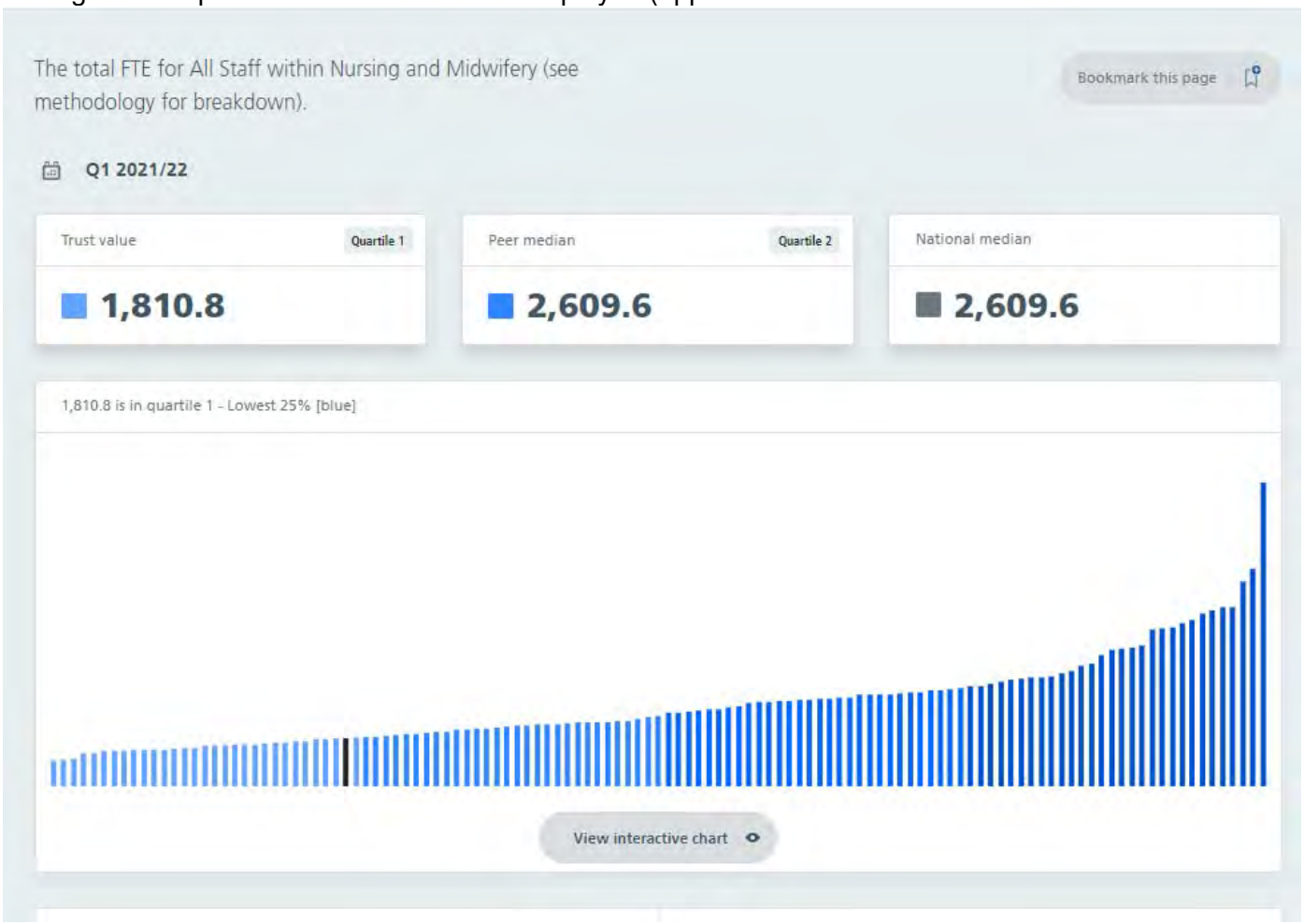
4) Acknowledge and support the additional review in February 2022 which will inform any changes to suggested ward establishment in line with the national safe nursing care team recommendation.

5) Continue to support the recommendation of ward managers remaining supernumerary to enable oversight of quality and safety within the ward environment

6) Acknowledge the limitations of this paper in line with not having the entire nursing workforce within Medway NHS Foundation Trust represented within this review.

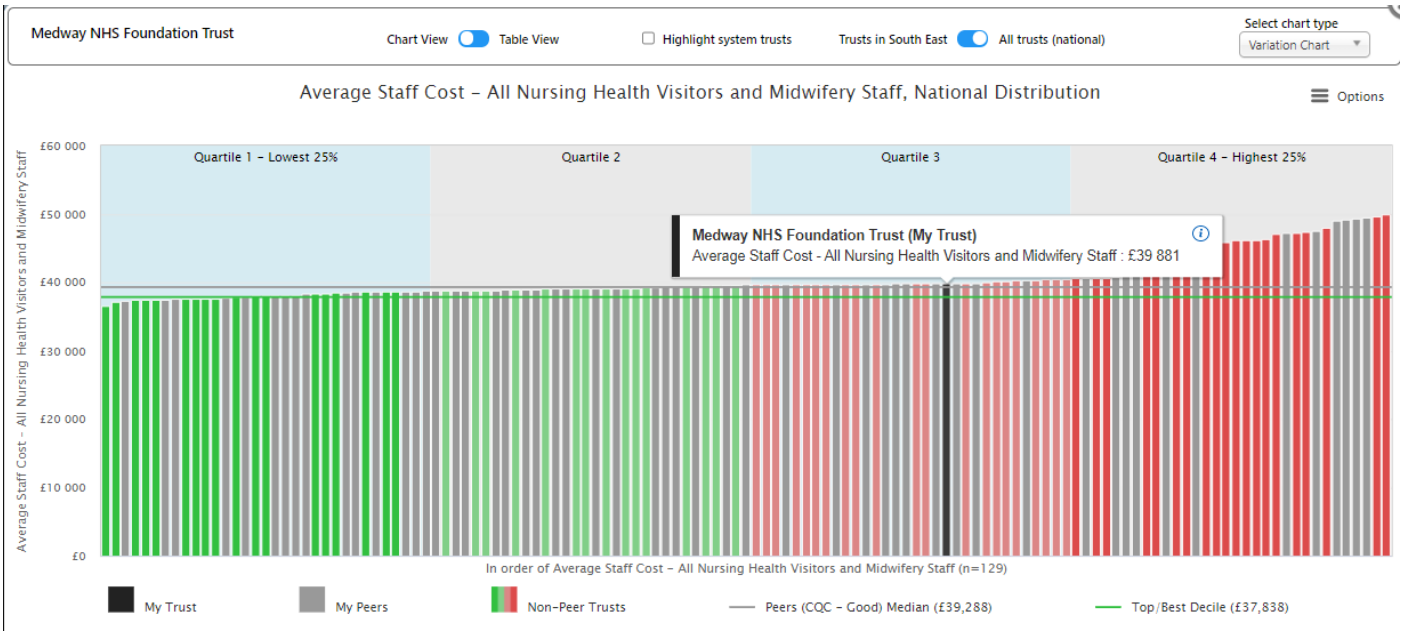
Appendix 1:

Using Model hospital shows Medway NHS Foundation Trust (Medway NHS FT) is in the lowest quartile among national peers for total FTE of staff employed (app



Appendix 2:

9.2. Table 2: average nursing staff costs on model hospital as a comparator nationally



Meeting of the Board of Directors in Public
Thursday, 04 November 2021

Title of Report	**Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4 Overview**	**Agenda Item**	3.6
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer (Interim)		
Executive Summary	NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts delivering maternity services and who are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme, creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Throughout Year 3, the maternity service maintained a regular reporting schedule to the Quality Assurance Committee and the Trust Board. The Trust Board maintained full accountability for the authorisation of final sign-off for CNST by the Chief Executive Officer, and maintained oversight of evidence as was set out in the technical guidance. The CNST year 3 self-declaration form was submitted to NHS Resolution on 19 July 2021 and declared compliance with all 10 Safety Actions. Year 4 of the CNST MIS launched on 8 August 2021. The Maternity Service presented this report to the Quality Assurance Committee (QAC) on 19 October 2021, and seeks to assure the Trust Board that the maternity service has a robust processes in place to monitor and achieve compliance with all 10 Safety Actions. The Report also proposes a regular schedule of reporting to the QAC, along with the Trust Board in Private and Public. As in year 3, the Board will maintain full accountability of sign-off of the declaration form and all evidence will be presented to the Trust Board as per the technical guidance.		
Committees or Groups at which the paper has been submitted	Quality Assurance Committee, 19 October 2021 Planned Care Divisional Governance, 20 October 2021		
Legal Implications/Regulatory Requirements	Compliance with CNST Year 4, Ockenden (2020), CQC		
Recommendation/	The Board is asked to note the report		

1 Executive Overview

1.1 NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts delivering maternity services and who are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme, creating the CNST maternity incentive fund.

1.2 As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.3 Throughout Year 3, the maternity service maintained a regular reporting schedule to the Quality Assurance Committee and the Trust Board. The Trust Board maintained full accountability for the authorisation of final sign-off for CNST by the Chief Executive Officer and maintained oversight of evidence as was set out in the technical guidance. The CNST year 3 self-declaration form was submitted to NHS Resolution on 19 July 2021 and declared compliance with all 10 Safety Actions.

1.4 Year 4 of the CNST MIS launched on 8 August 2021. The Maternity Service presented this report to the Quality Assurance Committee (QAC) on 19 October 2021, and seeks to assure the Trust Board that the maternity service has a robust processes in place to monitor and achieve compliance with all 10 Safety Actions.

1.5 The Report also proposes a regular schedule of reporting to the QAC, along with the Trust Board in Private and Public. As in year 3, the Board will maintain full accountability of sign-off of the declaration form and all evidence will be presented to the Trust Board as per the technical guidance.

1.6 The proposed reporting schedule is as follows:

Month	QAC	Private Board	Public Board
Oct-21	Overview		
Nov-21		Perinatal Surveillance Tool & Safety Action 1	Overview/Workforce
Dec-21	Safety Action 2,3 & 4		
Jan-22		Perinatal Surveillance Tool & Safety Action 1	Safety Action 2, 3 & 4
Feb-22	Safety Action 5, 6, 7		
Mar-22		Perinatal Surveillance Tool & Safety Action 1	Safety Action 5, 6 & 7
Apr-22	Safety Action 8, 9, 10		
May-22	Final Oversight Report	Perinatal Surveillance Tool & Safety Action 1	Safety Action 8, 9, 10
Jun-22			Final Oversight report

1.7 This schedule of reporting was approved by the QAC on 19 October 2021 and the report requests the Board approve the proposed reporting schedule to both QAC and the Trust Board.

2 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

2.1 As in year 3, Safety Action 1 requires all eligible perinatal deaths to be reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and a multidisciplinary review be completed using the Perinatal Mortality Review Tool (PMRT) within a specific timeframe. The Trust declared compliance with this Safety Action in year 3, and advises the

QAC that all processes are in place to continue to meet all the requirements, including informing parents and incorporating their views and questions into the review.

2.2 The Bereavement Midwife and Head of Midwifery, along with their colleagues across the region raised concerns that the year 4 guidance reduced the reporting time to MBRRACE from 7 working days to 2 working days. This was escalated to NHS Resolution by the Regional Chief Midwifery Officer. NHS Resolution has now revised the technical guidance and all eligible cases must now be reported within 7 working days. The Bereavement Midwife continues to work closely with obstetric and neonatal colleagues to ensure that all cases are reviewed and the report published within the required timeframe.

2.3 CNST requires that the details of all PMRT reviews, along with associated actions be shared with the Board Quarterly. The report proposes that this be reported to the Trust Board in Private, along with the Perinatal Surveillance Tool Board Level Dashboard as per the recommendations in the Ockenden Report (December 2020) and the requirements of Safety Action 9.

3 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

3.1 The maternity service declared compliance with all requirements of Safety Action 2 in year 3. In year 4 the maternity services are required to submit data to the national Maternity Services Dashboard for data submissions relating to activity in January 2022 (published in April 2022). The Board must be assured that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national dashboard. This data includes Body Mass Index (BMI) being recorded, complex social factors and continuity of carer and Personalised Care and Support Plans.

3.2 The Maternity Service is working with the Business Intelligence (BI) team to ensure the appropriate data is being input and retrieved from the Maternity Information System (EuroKing) to meet the requirements as outlined in the technical guidance. Further assurance is required from the EuroKing provider that all required data is being captured and meets the technical guidance, and an additional work stream for Safety Action 2 is being established to ensure progress is being made to achieve compliance.

4 Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

4.1 As in year 3, Safety Action 3 requires the maternity and neonatal service to provide assurance to the Board regarding the Avoiding Term Admissions into Neonatal units (ATAIN) programme. The report provides assurance to the QAC that the Transitional Care (TC) Unit is well established and, along with the Maternity Additional Care (MAC) unit, supports the ATAIN programme.

4.2 ATAIN remains a regular item on the Maternity and Neonatal Safety Champion agenda and any identified actions will be shared with the Board Level Safety Champions as per the technical guidance. The ATAIN reviews are supported by the multidisciplinary Born in Poor Condition Group which meets monthly and provides a quarterly report identifying themes, trends and actions.

4.3 The technical guidance also requires the findings of ATAIN reviews to be shared with the LMNS and ICS quality surveillance meeting. The service is waiting further guidance from the LMNS on the reporting schedule for these reports.

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

5.1 Safety Action 4 requires the Board to be assured around the workforce planning for obstetric, anaesthetic and neonatal medical and neonatal nursing.

5.2 With regards to obstetric workforce, the expectation is that the service and the Board will commit to implementing the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) "Roles and Responsibilities of the consultant providing acute care in obstetrics and gynaecology". The Board is required to sign off this commitment by no later than January 2022. The report assures the Board that the service has developed a SOP based on the RCOG guidance and changes to the on-call rota and consultant expectations will be job planned as required. This is supported by changes to the on-call rota, including the addition of five associate specialist roles. The formal commitment to this guideline will be reported to the Trust Board in January 2022 as per the reporting schedule. An audit proforma has been devised alongside the SOP and this will be monitored and reported within the Care Group monthly, prior to being reported to Trust Board in the final assurance report in June 2022.

5.3 The anaesthetic workforce requirements is the immediate availability of a duty anaesthetist for the obstetric unit 24 hours a day 7 days per week. The obstetric anaesthetic rota and on-call rota support this requirement and this will be monitored via the CNST Safety Compliance Group.

5.4 CNST requires Neonatal junior medical staffing to meet the British Association of Perinatal Medicine (BAPM) standards. In year 3, the service did not meet this standard and an action plan with appropriate mitigation to maintain staffing and safety was completed and signed off by the Trust Board, allowing the Trust to declare compliance. In year 4 the position has improved, however it is anticipated that the service will not meet the standard due to the ongoing national shortage of junior neonatal doctors. The Patient Safety Lead for Neonates is reviewing compliance following new doctors starting in the Trust and an action plan will be presented to Trust Board in January 2022 for sign off.

5.5 In year 3, the neonatal nursing workforce did not meet the required qualified in speciality (QIS) specifications and an action plan was presented and approved by Trust Board allowing the Trust to declare compliance. This action plan has been completed and the neonatal nursing workforce has achieved the required QIS specification (currently 71%) with five additional staff enrolled on the course. It is anticipated that compliance with this requirement will be maintained, and this will be monitored via the CNST Safety Compliance Group. The Matron for NICU will undertake a workforce review in line with the technical guidance in January 2022 and if any shortfall in QIS is identified an action plan will prepared and presented to Trust Board.

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

6.1 In year 3, the Head of Midwifery prepared a workforce paper with proposed additional roles to meet the recommendations of the Birth Rate Plus assessment undertaken in October 2020. This workforce paper has now been approved in full and a phased approach to recruitment is now underway.

6.2 In year 4, CNST requires a further workforce review using a systematic, evidence-based process to calculate midwifery staffing and establishment (Birth Rate Plus). This must be completed within the year 4 reporting period. The Head of Midwifery has submitted a PID to fund a full Birth Rate Plus assessment based on current activity and acuity, and this will inform future workforce papers.

6.3 CNST and NICE guidance requires 6 monthly midwifery workforce oversight reports to be presented to the Trust Board and the report proposes a workforce oversight paper be presented to Trust Board in November 2021 followed by May 2022.

6.4 The service continues to monitor midwifery red flags, including induction of labour delays and the supernumerary status of the Delivery Suite Coordinator. CNST requires 100% compliance with supernumerary status of the Delivery Suite Coordinator and in year 3 the service was at 98%. An action plan was completed and signed off by Trust Board allowing the Trust to declare compliance.

6.5 In year 4 the service has not been able to maintain 100% supernumerary status due to staffing shortages and high acuity. The additional workforce approved from the 2020 Birth Rate Plus review will support improved compliance with this requirement, and a revised action plan will be presented to the Board to provide further assurance.

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

7.1 As in year 3, Safety Action 6 requires Trusts to declare compliance with all five elements of the Saving Babies' Lives care bundle version two (SBLCBv2). The five elements are:

7.1.1 Element 1: Carbon Monoxide Monitoring

7.1.2 Element 2: Fetal Growth Restriction (FGR)

7.1.3 Element 3: Reduced Fetal Movements (RFM)

7.1.4 Element 4: Fetal Monitoring

7.1.5 Element 5: Preventing Pre-term births

7.2 The service declared compliance with Safety Action 6 in year 3, with all evidence and audit reports presented to Trust Board as required. An audit and reporting schedule has been agreed with the staff responsible for each element and all audits will be added to the department audit schedule for shared learning.

7.3 The service anticipates continued compliance with all 5 elements, however some challenges may present regarding compliance the reintroduction of Carbon Monoxide monitoring (paused in year 3 due to Covid-19 restrictions) and compliance with Fetal monitoring training, the latter requires 90% compliance across all staff groups. The Smoking in Pregnancy Midwife is closely monitoring compliance with Carbon Monoxide monitoring and working with community teams to ensure compliance. A training plan is in place to ensure all staff receive the required Fetal Monitoring training within the CNST timeframe, however Covid-19 restrictions on training rooms and the potential for disruption to training sessions due to staffing shortages or acuity remain a risk to achieving full training compliance. The Fetal Wellbeing midwife and medical CTG lead are working closely with their colleagues to ensure staff enragement and compliance with training will be monitored monthly via the CNST Safety Compliance Group and Care Group Governance.

8 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?

8.1 As in year 3, the Maternity service maintains a strong working relationship with the MVP. Covid-19 restrictions have limited the face-to-face contact and meetings held by the MVP, however work is ongoing with the Head of Midwifery, MVP chair and LMNS to ensure the service is fully compliant with the requirements of CNST year 4.

9 Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

9.1 The service provides assurance to the Board that a the local training plan is being reviewed to ensure all six core modules of the core competency framework is including in the training programme for the next 3 years. Benchmarking has been undertaken and a working group will be established to complete the training plan.

9.2 As in year 3, training compliance remains a risk for the service. Face-to-face training has resumed in line with current Covid-19 restrictions and a training plan is in place to ensure all staff are trained within the year 4 reporting period. NHSR confirmed in October 2021 that e-learning would be acceptable if required, and the report assures the Board that whilst face to face training is being prioritised by the education team, an appropriate contingency plan of e-learning is in place should this be required.

10 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

10.1 Safety Action 9 requires the Board Level Safety Champions to meet regularly with the Maternity and Neonatal Safety Champions to discuss safety and quality issue. It also requires the Board level champions to seek feedback from frontline staff and support Quality Improvement work across maternity and neonatal services. Safety Champion meetings and Walk-rounds have continued from year 3 and an appropriate work plan in place.

10.2 Following the Ockenden recommendations (December 2020), CNST requires the sharing of perinatal surveillance information with the Trust Board and the LMNS. The dashboard as outlined in "Implementing a Perinatal Surveillance Model" (December 2020) has been shared with the LMNS and Board Level Safety Champions since May 2021 and has been presented to the Executive Group in October 2021 with a request that this be presented at the next Trust Board in Private in November 2021.

10.3 Safety Action 9 also requires that the Trust claims scorecard is reviewed alongside incident and complaints data by Board Level and local safety champions to ensure targeted learning. The findings of this review are required to be presented a Trust level quality meeting at least twice in the reporting period.

10.4 The Trust Continuity of Carer (CoC) action plan also requires Board level oversight as part of Safety Action 9, with sign-off by the Board Level Safety Champion. The report assures QAC the service has a robust plan to implement CoC to 35% ahead of the March 2023 deadline. Progress against this is monitored via the Maternity Transformation Assurance Board and will be presented to the Trust Board as per the reporting schedule in section one.

11 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

11.1 The report assures the Board that the maternity service has appropriate processes in place to ensure all eligible cases are reported to HSIB and NHS Resolution EN scheme as required. Duty of candour is completed for all cases as required and compliance is monitored through the CNST Safety Compliance group.

Conclusion and Next Steps

11.2 The report assures the Board that the Maternity Service has appropriate processes in place to monitor and achieve compliance with all 10 Safety Actions in year 4. Close monitoring of all Safety Actions will take place via the CNST Safety Compliance Group, which reports to Women's and Children's Governance.

11.3 The report requests that the Board approve the reporting schedule to QAC and Trust Board in Public and Private to support scrutiny and oversight by both QAC and the Trust Board as required by the technical guidance.

Meeting of the Board of Directors in Public
Thursday, 04 November 2021

Title of Report	**Sustainable Procurement**	**Agenda Item**	4.1
Report Author	Jessica Brown, Sustainability and Business Performance Manager Dan Small, Associate Director of Procurement		
Lead Director	Gary Lupton, Director of Estates and Facilities		
Executive Summary	The Greener NHS National Programme published its new strategy, 'Delivering a Net Zero NHS' in October 2020. The report sets out trajectories and actions for the NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence such as those embedded within the supply chain, (also known as the NHS Carbon Footprint Plus).		
Committees or Groups at which the paper has been submitted	Finance Committee		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	N/A		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Trust Board is asked to note the contents of this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices (available on request)	8.1 Green Plan 8.2 Delivering a 'Net Zero' National Health Service report		

1 Executive Overview

1.1 The NHS Carbon Footprint Plus considers an expanded scope of emissions, including products procured from its 80,000 suppliers. While Trusts do not control these emissions directly, the NHS and MFT can use its considerable purchasing power to influence change.

1.2 In April 2021 MFT's Green Plan was agreed at Trust Board, evidencing the Trust's commitment to reducing its emissions in line with national targets. This further meets the Trust's requirements set out in the NHS Standard Contract.

1.3 The supply chain accounts for 62% of the NHS Carbon Footprint Plus and as part of the 'Delivering a Net Zero NHS' report, it outlines that we can reduce emissions in three ways:

- more efficient use of supplies
- low-carbon substitutions and product innovation
- ensuring our suppliers are decarbonising their own processes

1.4 NHSEI are reviewing the way in which we measure carbon within the supply chain and health-specific guidance. In the interim they have identified key deliverables as part of the 'Delivering a Net Zero NHS report'. MFTs progress to date, short term goals and long term goals are presented below for review.

2 Supply chain carbon emissions

2.1 The NHS is committed to tackling climate change by reducing its carbon emissions and reducing the environmental impact of our services.

2.2 The supply chain accounts for 62% of the Total NHS carbon footprint plus (Figure 1.)

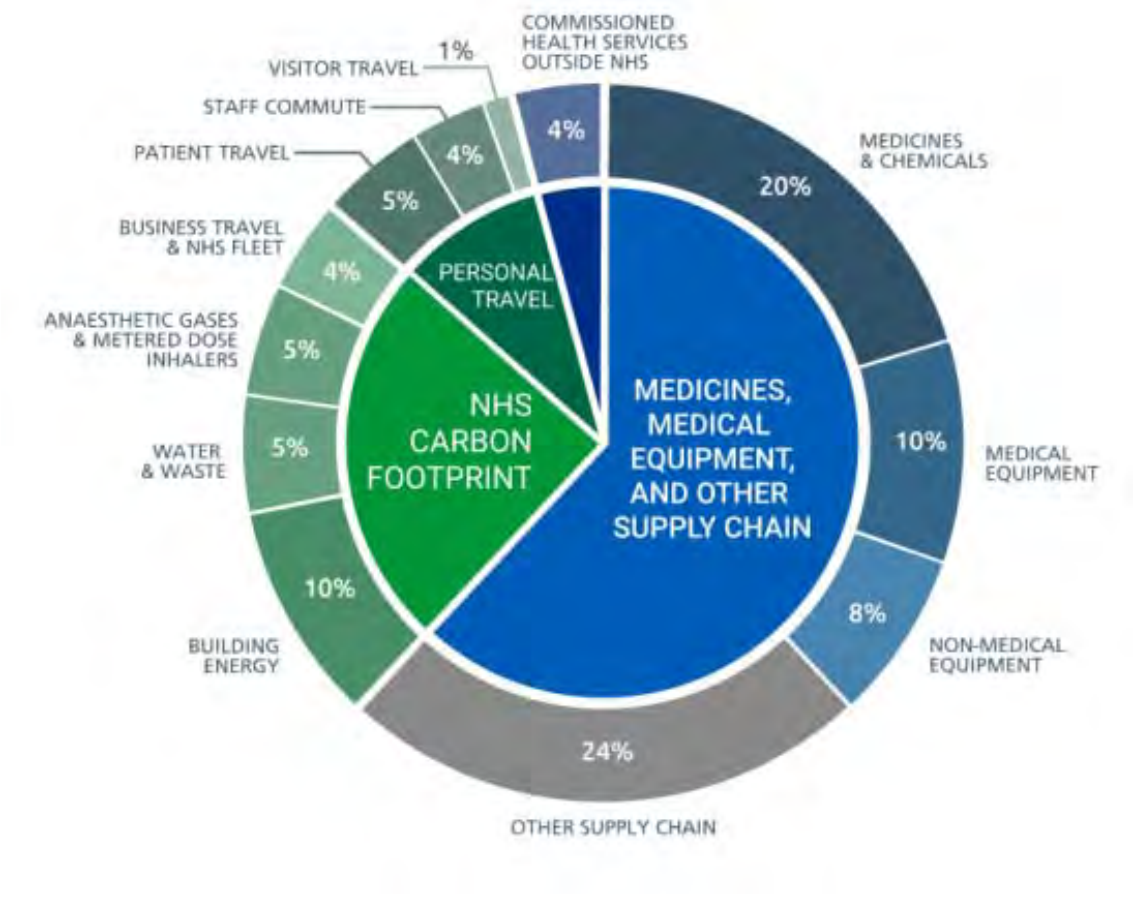


Figure 1. Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

2.3 The Procuring for Carbon Reduction Tool (P4CR) estimates MFT's total carbon emissions from procurement in 2019/20 as 78,818 tCO2e.

2.4 MFT's largest contributors of emissions from procurement include medical instruments and equipment (32%), construction and construction materials (30%) and business services (11%).

2.5 It is challenging when estimating the financial value of carbon within the supply chain. For this reason financial and carbon savings will be calculated on a project-by-project basis and include life cycle costs.

3 Sustainability Committee

3.1 The Strategic and Operational Sustainability Committee's terms of Reference are currently subject to approval. Once approved, invitations will be sent to departmental leads including the strategic and operational leads. Leads will be responsible for delivery of the Green Plan's action plan and their allocated sustainability projects.

3.2 Procurement leads will be responsible for the delivery of sustainability projects within their service area.

4 More efficient use of supplies examples

4.1 NHSEI have set a target that 40% of walking aids will be refurbished in the next 5 years. MFT procure walking aids through an equipment loans scheme from Medequip and NRS Healthcare. This service promotes a circular economy approach through the return of equipment for refurbishment and reuse, helping the Trust to reduce our carbon emissions and meet the 40% national target. Further work to reduce emissions will include the inclusion of orthopaedic crutches.

4.2 In 2019/20 MFT removed 538 items of plastic packaging from the catering department. This equates to a saving of £13,345 and 12 Tonnes CO2e a year. Pilot audits will be replicated across the Trust to determine sustainable alternatives.

4.3 The Greener NHS Programme has set a target of 10% reduction in clinical-single use plastics. MFT are in discussions with suppliers including Johnson and Johnson to trial collection of their products for recycling and reuse.

4.4 Reducing reliance on office paper by 50% across MFT through increased digitisation can achieve savings of £19,000 per year, with a switch to 100% recycled content paper for all office-based functions achieving a £5,000 per annum saving.

4.5 The Trust currently spends £327,000 on waste management and recycling. In 2020/21 MFT recycled 12% of its total waste against national targets of 30%. An increase in domestic recycling to meet the national target would achieve financial savings of £13,000 per year and carbon emission savings of 106 tCO2e per annum. Further savings will be achieved through training and correct segregation of clinical waste as well as supplier engagement.

4.6 National measures introduced to reduce the transmission of COVID-19 have meant more people are working from home and accessing services online. Whilst some of the national measures have changed, the Trust is still running virtual clinics and encouraging staff to work from home where suitable. The reduction in travel and consumption of consumables will be measured as part of the action plan.

5 Substitute for low-carbon alternatives

5.1 Initial engagement with Bates and the London Procurement Partnership (LPP) is investigating innovative approaches to deliver improved patient outcomes whilst reducing climate change impact.

5.2 Bates (framework providers of furniture and office supplies) completed a Green Audit which has identified 70% of our purchases have an ‘environmental plus’ rating. Further engagement will increase this rating.

5.3 Bates have also reduced their deliveries to the site to twice a week and are now utilising electric delivery vehicles. Once Procurement relocate, stock arrangements will reduce with a view to reducing deliveries even further by holding more stock in the new Stores area.

5.4 LPP are working with their membership and suppliers on numerous sustainability efficiency and MFT have requested to be part of all work streams as they are mobilised.

5.5 NHS Supply Chain are the biggest supplier to NHS Trusts. MFT will be an active member of initiatives that are set up nationally. Again, when Procurement moves to its new building we will be able to review the number of deliveries that we take from NHSSC with a view to reducing deliveries and holding more stock in stores.

5.6 Supplier engagement will continue to identify additional opportunities for sustainable choices. In some cases, sustainable alternatives may include increased costs and these will be reviewed as part of the Sustainability Committee.

6 Suppliers decarbonising their own processes

6.1 In September 2020 a Procurement Policy Note (PPN) was released stating that all NHS Procurement will include a 10% weighting for social value in all their tenders. It is suggested the social weighting should take into account supplier's impact on local employment, the community, well-being and decarbonisation. Trusts are being encouraged to consider what their local social value needs are and include these within the weighting. NHS commissioners and central government adopted this from 01 April 2021 and MFT will be reviewing our tender documents and scoring mechanisms when the "health specific" guidance is released in the autumn. The sustainability committee will recommend this change and a proposal will be made in due course.

6.2 Initial supplier engagement indicates long-term commitments to sustainability. Through further engagement, we will identify sustainable opportunities to reduce packaging, drive a circular economy approach, and reduce carbon emissions within the supply chain.

7 Conclusion and Next Steps

7.1 The supply chain is the largest contributor to carbon emissions within the NHS Carbon Footprint Plus.

7.2 NHSEI have identified key deliverables within the supply chain and are developing health-specific guidance and tools to drive carbon emission reductions

7.3 The Green Plan and associated action plan includes supply chain deliverables.

7.4 The action plan will be delivered through the Strategic and Operational Sustainability Committee to help meet the NHS Carbon Footprint Plus target of 2045

7.5 Supply chain projects will be delivered through the Sustainability Operational Committee and will include life cycle costs. Cost and carbon emissions will be evaluated as part of the life cycle costing.

8 Recommendation

8.1 The Strategic Sustainability Committee will formulate an action plan and seek to obtain the support of the Finance Committee in undertaking steps, which do not adversely affect the financial position of the Trust, but do ensure sustainability is embedded within our strategic and operational decision-making. Business cases will be developed to support investments that reduce costs over time.

9 Appendix

9.1 Medway NHS FT Green Plan – available upon request

9.2 Delivering a 'Net Zero' National Health Service – available upon request

Meeting of the Trust Board in Public
Thursday, 04 November 2021

Title of Report	**Integrated Care**	Agenda Item	4.2
Lead Director	Paula Tinniswood – Chief of Staff		
Report Author	Paula Tinniswood – Chief of Staff		
Executive Summary	In November 2020 NHS England and NHS Improvement published Integrating care: Next steps to building strong and effective integrated care systems across England. It described the core purpose of an ICS being to: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development. The foundations of integrated care are to support collaboration, local decision making and flexibility. Co-development with system leaders, people who use services and many other stakeholders, supports the development of guidance, through to implementation		
Committees or Groups at which the paper has been submitted	Executive Group		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	None		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices			

The ICS NHS Board

Cedi Frederick will be the new Chair-designate of Kent and Medway Integrated Care Board from April 2022 but will commence working immediately in order to progress the appointment of ICB executive roles, with the ICB CEO stakeholder Interviews held on Monday 25th October 2021. Executive roles: Chief Executive (who will be the accountable officer for the funding allocated to the ICS NHS body), Director of Finance, Director of Nursing and Medical Director.

Mr Frederick's appointment has been confirmed by the Secretary of State, alongside appointments for all the other systems in the South East and many more across the country.

Cedi Frederick has held a number of NHS appointments as part of a 30-year career as a non-executive director in various organisations. His current NHS appointment is Chair of North Middlesex NHS Trust which he left at the end of October. He has also been a non-executive director at Hertfordshire Partnership NHS Foundation Trust and Barnet Enfield and Haringey NHS Trust.

Population Health Management (PHM)

Our health and care needs are changing: we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease and the health inequality gap still needs reducing.

A new approach - called Population Health Management – will help us understand and predict our future health and care needs, reducing health inequalities and making better use of resources, tailoring care better for individuals and sustaining health and social care services.

The NHS Long-Term Plan committed that in 2021/22, we will have systems that support population health management in every Integrated Care System across England

Medway Foundation Trust is participating in Population Health and Prevention meetings helps us understand and predict our future health and care needs, reducing health inequalities and making better use of our resources, tailoring care better for individuals and sustaining health and social care services.

Intelligence - Outcomes & Population Segmentation

Whole System Intelligence requires a core suite of analytics tools, based on an integrated dataset that will highlight those cohorts where health and wellbeing can be improved through; early interventions, addressing health inequality and targeted approaches to improve outcomes.

Kent & Medway CCG has adopted the 'Bridges to Health Segmentation Model' which will be one of the fundamental enablers of their PHM Intelligence Strategy and this model is currently in the technical phase of deployment.

Bridges to Health segments the entire population into six core groups and two episodic groups:

1. Healthy
2. Maternal & Infant Health (Episodic)
3. Acutely Ill (Episodic)
4. LTCs
5. Disability
6. Incurable Cancer
7. Organ Failure
8. Frailty

Once implemented, this will underpin the data set that will support the development of PHM in Kent & Medway. Each of these segments needs to be clinically reviewed and configured to include conditions and definitions that are relevant to the Kent & Medway ICS before it is used. Bridges to Health (B2H) has been

adopted as the Segmentation Model of Choice by NHSE/I to be used on the National Data platform. As part of that implementation NHSE/I have configured the B2H model using its own analysts and clinical input.

In order to make this process as efficient and effective as possible the PHM Technical Task & Finish Group recommends that Kent & Medway adopts the NHSE/I configuration as the starting point for this exercise.

By adopting this approach, it will allow Kent & Medway to compare their local intelligence against the national data and make cross ICS and regional comparisons relevant. It will also reduce the clinical time required to review the model and advise on amendments and in addition allow clinicians to validate the data model against the target cohorts defined.

Configuring the Model for Kent & Medway

The PHM Programme now requires local Clinical Leads to review and work with the Clinical & Data Leads from the Programme in order to:

1. Assure themselves that the proposed configuration is appropriate to the local population
2. Make recommendations for amendments where appropriate
3. Assure themselves that they will be able to identify and define their target cohorts from the resulting model.

PHM involves intelligence-led planning and delivery of services, aligning services with population needs in order to improve outcomes. Once the right infrastructure is in place, the first step in the intelligence process is to understand population need. This is then followed by use of tools and techniques to align the need with effective interventions and incentives. These are the 4 core capabilities for Population Health Management.

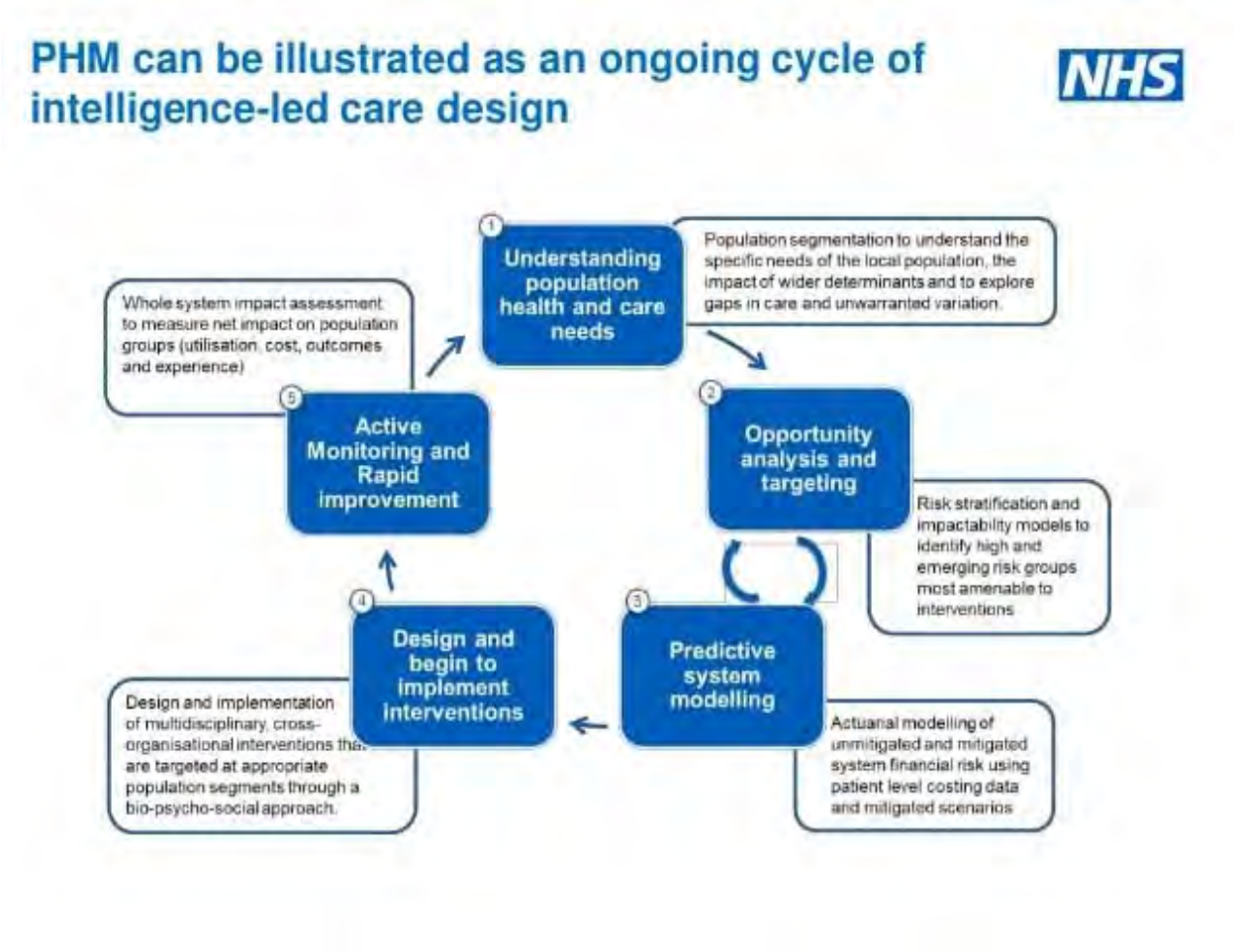
Action Learning Sets (ALS) have been structured as part of PHM to bring representatives from across the system together to learn from each other as a group, to work on real challenges and issues, using the knowledge, skills and experiences of the group and working collectively to develop solutions.

- Learning best practice
- Acquiring problem solving skills
- Having to articulate a challenge clearly and succinctly so that all understand
- Being challenged by the group
- Forming effective plans for immediate implementation
- Getting results in a constructive way
- Sustain momentum and encourage spread to other PCNs

Participation in an ALS is aimed at bringing health and social care professionals together to build skills and capabilities to enable them to deliver improved health outcomes for people.

Kent & Medway ICS Improvement - (Patient First)

An event was held in September, hosted by the Accountable Officer for Kent & Medway CCG, to assess the Quality Improvement culture across the system. The event was designed to help understand the existing quality improvement landscape across all Kent and Medway providers and to ensure that all stakeholders can be involved in the development of an ICS QI strategy. Of the four Acute Providers, three are adopting the Patient First methodology, which supports the development of a management system which prioritises, aligns, delivers and continuously improves.



Meeting of the Public Board
Thursday, 04 November 2021

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework</td><td>Agenda Item</td><td>4.3</td></tr>
<tr><td>Report Author</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="5">A summary of the BAF as of 20 October 2021 is presented in this paper.

The Trust's principle risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Aug 21</th><th>Sep 21</th><th>Oct 21</th></tr>
<tr><td>3a – Delivery of financial control total</td><td>9</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>3b – Capital Planning</td><td>12</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>5c – Patient Flow</td><td>6</td><td>16</td><td>16</td><td>16</td><td>20</td></tr>
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</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="5">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="5">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="5"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="5">N/A</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="5">The Board is asked to note the report for assurance regarding the processes in place around risk management.

<table>
<tr><th>Approval</th><th>Assurance</th><th>Discussion</th><th>Noting</th></tr>
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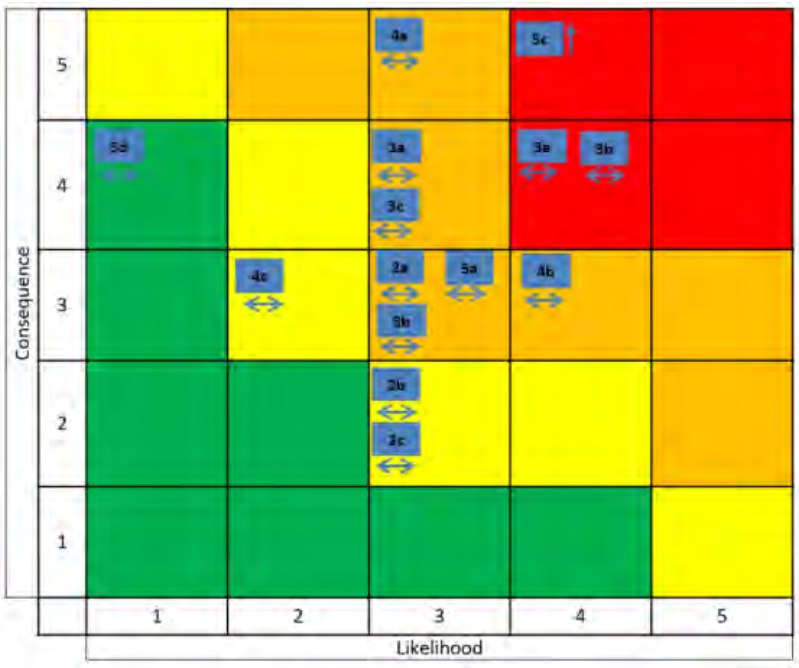
1 Board Assurance Framework

Integrated Healthcare	1a. Failure of system integration	↔
Innovation	2a. Future IT Strategy	↔
	2b. Capacity and Capability	↔
	2c. Funding for investment	↔
Finance	3a. Delivery of financial control total	↔
	3b. Capital investment	↔
	3c. Long term financial sustainability	↔
	3d. Going Concern	↔
Workforce	4a. Sufficient staffing – clinical areas	↔
	4b. Staff engagement	↔
	4c. Best staff to deliver best care	↔
Quality	5a. CQC progress	↔
	5b. Health and Social Care Act requirements	↔
	5c. Patient flow	↑



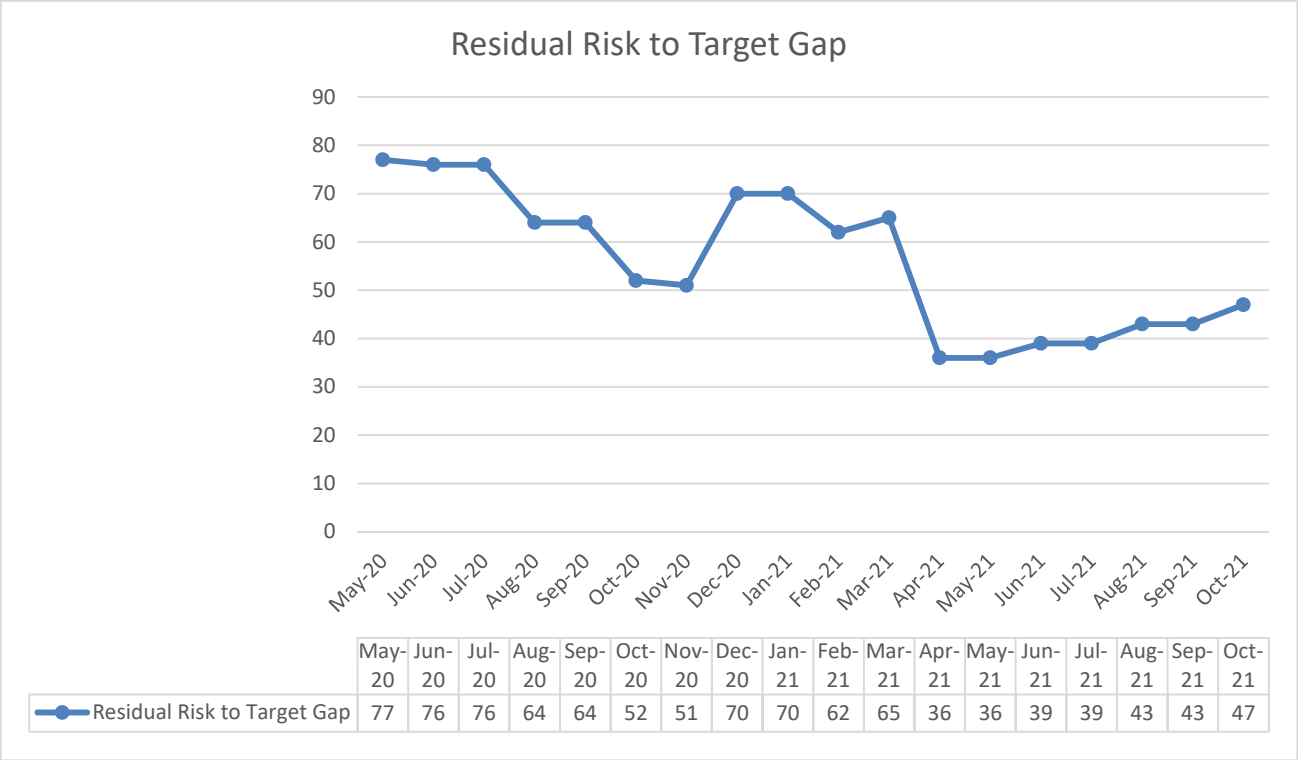
In the current reporting period the Trust has seen the increase of one risk, patient flow (5c) from 16 to 20.

There are a further two principles risks that are rated as high, 3a – delivery of financial control total and 3b – capital planning. Financial risks are being managed through the current planning rounds within the Trust and the wider system with the clinical and corporate areas.

	Target Score	Initial Score	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**
2a. Future IT strategy	6	16	9	9	9	9	9	9	9	**9**	**9**	**9**	**9**	**9**	**9**	**9**
2b. Capacity and Capability	9	9	12	6	6	6	6	6	6	**6**	**6**	**6**	**6**	**6**	**6**	**6**
2c. Funding for investment	9	9	9	6	6	6	6	6	6	**6**	**6**	**6**	**6**	**6**	**6**	**6**
3a. Delivery of financial control total	9	16	9	9	16	16	16	8	8	**16**	**16**	**16**	**16**	**16**	**16**	**16**
3b. Capital Investment	12	16	20	20	12	12	12	12	12	**16**	**16**	**16**	**16**	**16**	**16**	**16**
3c. Failure to achieve long term financial sustainability	4	16	12	12	12	12	12	12	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**
3d. Going concern	4	12	4	4	4	4	4	4	4	**4**	**4**	**4**	**4**	**4**	**4**	**4**
4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	15	**15**	**15**	**15**	**15**	**15**	**15**	**15**
4b. Staff engagement	6	12	12	12	12	12	12	12	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**
4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	**6**	**6**	**6**	**6**	**6**	**6**	**6**
5a. CQC Progress	4	16	12	12	12	12	12	12	12	**9**	**9**	**9**	**9**	**9**	**9**	**9**
5b. Failure to meet requirements of Health and Social Care Act	6	16	9	9	9	9	9	9	9	**9**	**9**	**9**	**9**	**9**	**9**	**9**
5c. Patient flow – Capacity and demand	6	12	12	9	9	16	16	16	16	**9**	**9**	**12**	**12**	**16**	**16**	**20**
Total Risk Score	105	242	165	153	152	175	175	167	139	**141**	**141**	**144**	**144**	**148**	**148**	**152**
Residual Risk to Target Gap			**64**	**52**	**51**	**70**	**70**	**62**	**65**	**36**	**36**	**39**	**39**	**43**	**43**	**47**

Table 1.1 – Summary of BAF

1.1



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Residual Risk to Target Gap	77	76	76	64	64	52	51	70	70	62	65	36	36	39	39	43	43	47

Figure 1.2: Residual risk to target gap

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

1.3 The reduction in the residual gap between March 2021 and April 2021 was due to the closure of three quality risks which have moved to the corporate risk register.

1.4 5c has been increased due to the current pressures and this risk is being mitigated through the appropriate work streams.

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

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

COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Chief People Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16 High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan)	Monthly Oversight Meeting.	Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Delivery of equality action plans, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 22]	**3 x 5 = 15 Moderate**	**3 x 2 = 6 Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 11%. 2. Monthly Sickness rate 4.8% 3. Substantive workforce 84%					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					

			5. Temporary staffing delivery: a. NHSI agency ceiling reporting to Board; b. Weekly breach report to NHSI; c. Reporting to Board of substantive to temporary staffing paybill.		People Committee reporting 1. £6m favourable to ceiling; 2. Averaging 30 breaches per week compared to c1000 in 2016 3. Agency workforce 3% 4. Bank workforce 13%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 150 apprentices of 101 target	People Committee					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						
4b Staff engagement Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) NED Wellbeing Guardian assurance report	Oversight Meeting	Refresh of Freedom to Speak Up strategy [Aug 21] Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] Delivery of the Staff Health and Wellbeing strategy [Mar 22 milestone] Delivery of ILM level 3 leadership programme [Dec 21] Refresh of Dignity at Work policy and approach [Dec 21]	**3 x 4 = 12 (Moderate)**	**3 x 2 = 6 (Low)**	
			Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.	1. You are the difference (YATD) embedded in induction 2. NHSEI Culture, Engagement and Leadership Programme Board						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session; c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: a. Trust scores across key domains; b. Comparative results from previous years and other organisations; c. Heat maps for targeted interventions. d. Local survey action plans to address key concerns.	Survey 2020 staff engagement score, 6.6 – lower than average 7 (6.4 2018, 6.8 2019)						
			Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fifth year; 3. Henley Business School MA leadership programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom To Speak Up Guardian route to	1. Freedom to speak up guardians in place;						

			Chief Executive; b. Respect: countering bullying in the workplace policy; c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	2. Respect policy in place; 3. JSC and JLNC in place.						
			Well-being interventions in place: a. Employee assistance programme and counselling; b. Advice and health education programmes; c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support. d. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. #HAY implemented and monitored						
			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place Qualitative and quantitative values-based appraisal						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate**)	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan)	Oversight Meeting	Refresh of Freedom to Speak Up strategy [Sep 21] Delivery of ILM level 3 leadership programme [Dec 21]	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented). 1. StatMan compliance >90% 2. Appraisal rate >86%						
			Right attitude and values: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance; c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; d. Respect – countering bullying in the workplace policy.	1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place. 4.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.	1. Trust vacancy rate at 11%; 2. Substantive workforce 84% 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing;						

			Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fifth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.						

COMPOSITE RISK: Quality 2021/22											
EXECUTIVE LEAD: Chief Nursing and Quality Officer											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently demonstrate compliance with the Care Quality Commission Fundamental standards, and as such, to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Lack of effective governance systems and processes to routinely monitor compliance with the fundamental standards. 2. Lack of evidence to demonstrate compliance with NQB and NICE guidance (2015) Workforce Standards **Impact:** 1. Potential for regulatory action by CQC &/ or NHSI. 2. Loss of confidence in the Trust by the wider healthcare system e.g. CCG, patients and carers. 3. Poor staff morale and engagement. 4. Damage to patient experience and patient outcomes.	**12 High 3(L) x4(C)**	**1.** Enhanced leadership within Patient Experience and Quality & Patient Safety 2. Quality Strategy Priorities Year 2 agreed and being implemented 3. High Quality Care Programme Year 2 improvement priorities agreed, measures developed and work progressed 4. Refreshed ward assurance and accreditation visits being developed 5. Quality Boards in place on all wards 6. Gold 'stars' awards being implemented to recognised and celebrate achievements in achieving high standards and improving patient outcomes. 7. Daily trust wide safe staffing reviews undertaken by HON with escalation to DDON and CN&QO as appropriate. 8. Annual provider review on safe nurse staffing. 9. Recruitment pipeline progressing as per plan. 10. Programme of Ward Quality Assurance Visits in place	Quality Panel Governance in place with fortnightly meetings. CQC Evidence panel in place with fortnightly meetings. Quality and Patient Safety Group meeting monthly. CNST Task and Finish Group meeting fortnightly. Care Group and Divisional Governance Boards meeting monthly	Monthly progress reports on divisional Quality Governance to Q&PSG, Executive Group, Quality Assurance Committee and Trust Board. High Quality Care Programme Board provides monthly progress reports to the Trust Improvement Board. Rolling programme of preparedness CQC care group showcase forums in place. Quality Report and Accounts. All actions on the ED MD/ SD action plan, following the unannounced CQC inspection of ED in December 2020, have now been completed and approved by the Quality Panel and incorporated into BAU. A refreshed CQC MD SD action plan was presented to the Executive Group on 6 October2021 for approval CNST Maternity Incentive Scheme approved by the Trust Board and submitted to NHS Resolution in July.	Internal Audit and External Quality Audit. QGR meetings with GCCG CQC Engagement Meetings Single Item Multi-Agency meetings	1. Divisional ownership and accountability for quality governance needs an improved structure and strengthened processes. 2. No single source of oversight & accountability for compliance with CQC Fundamental standards at divisional or Trust level. 3. Terms of Reference for QPSG to be approved at May QAC to ensure TOR are in alignment with QAC TOR. TOR under further review following the NHSI governance review 4. AD Patient Experience post vacant and being actively recruited to	The independent Quality Governance review led by NHSI has been completed. Recommendations accepted by the Executive and being worked through The future organisational approach and plan / proposal for CQC compliance for taking teams to good and outstanding is being progressed under leadership of Chief of Staff, CNQO & AD QPS Annual Provider review of ward safe staffing completed with report and recommendations going to October Executive Group and November Trust Board	**9 Moderate 3(L)x3(C)**	**2 x 2 = 4 Very Low**	Partial

			11. Quality metrics reported via: a. IQPR and divisional scorecards b. Nursing Ward to board quality assurance framework approved c. Quality and safety boards on wards demonstrating 'days between'. d. Quarterly triangulation report on Claims, Complaints and Incidents to QAC	Scorecard in development. Fortnightly Matron assurance reports. Monthly Heads of Nursing assurance report. Monthly DDON assurance reports to the Chief Nursing and Quality Officer	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board. High Quality care Programme Board Monthly divisional quality forum Quality Report and Accounts	Internal and External Audits	Refreshed Nursing and Midwifery Scorecard in developed.	IPRMs for 21/22 now confirmed and being implemented N&M Scorecard to be implemented and now being rolled out.			Partial
			12. Audit and review processes: a. Clinical Audit programme in place b. Implementation of Perfect Ward c. Revised structure for audits, NICE, NCEPOD and GIRFT which provides enhanced assurance and oversight being developed. d. New Trust Clinical Audit Lead in post to support improving oversight and accountability across the organisation which includes a review of the TOR for the clinical audit leads meeting	Quarterly report on clinical audit plan compliance to Q&PSG Audit and innovation showcases highlighting learning from audit. Nursing audits now being managed through Perfect Ward Programme	Audit Leads Group Q&PSG QAC Integrated Audit Committee		Lack of confidence that the Clinical Audit Leads Group is fulfilling its TOR in terms of sharing audit outcomes.	Review of the effectiveness of the outputs and sharing from the Audit Leads Group. June 2021: Pending the outcome of the governance review referred to above. Review has been completed. Recommendations accepted by the Executive and being worked through			Partial
			13. Central and local oversight of quality metrics: a. Complaints management b. Compliance with Duty of Candour policy and training c. Incident management, including Serious Incident (SI) processes and monitoring	Care Group and Divisional Governance Boards Chief Medical Officer Grand Rounds Central Patient Safety Team newsletter Incident Review Group SI Panel Daily review of incidents by divisions to identify any new SIs for reporting Weekly divisional CLIP meetings Executive Quality meeting implemented and in place with divisional leadership teams to support	Monthly Quality reports to the Executive Group, QAC and Quality and Patient Safety Group Complaints review completed, actions to improve agreed Safeguarding review completed actions to improve agreed Quarterly triangulation report on Claims, Complaints and Incidents to QAC		Trajectory to reduce divisional incident backlogs agreed but not yet being met. There remains a backlog of open complaints that have breached the required deadlines within UPIC division. Divisional Leadership Team to develop a trajectory to improve the response to complaints	Learning framework to articulate the Trust wide methodology for shared learning being developed. Trajectory to reduce divisional incident backlogs agreed but not yet being met – daily review of incident reporting to ensure timely identification of SI and prevent further backlog. Support being provided from CMO and AMD Patient Safety to review backlogs.			Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	**Cause:** Lack of effective IP&C governance systems and processes to routinely monitor and maintain compliance with the hygiene code **Impact:** Potential for regulatory action by CQC &/ or NHSI. Loss of confidence in the Trust by the wider healthcare system. Poor staff morale and engagement. Damage to patient experience and patient outcomes.	**12 High 3(L) x4(C)**	1. IPC Improvement plan approved by Executive Team and QAC and reported at Trust Board 2. IPC Intensive Support programme supporting the Trust 3. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 4. Refreshed IP&C Team structure and leadership 5. Identified improvement priority work through HQCP to reduce C- Diff Infections 6. IP&C Governance Review completed and Report in draft form. 7. IPC Unannounced inspections commissioned by CNQO with findings being drafted with themes and learning to be shared 8. COVID-19 BAF updated, reviewed externally and maintained with evidence to support collated 9. CNQO wrote to Executives regarding their executive areas of responsibility to support delivery of Trust Improvement Plan 10. Assoc. Director for IP&C commenced 9 August 2021 11. MFT participating in Kent & Medway IPC Network- peer support and sharing learning 12. CNQO IPC monthly blogs to communicated key messages 13. Communication plan for IPC in development to support effective IPC communications and the Every Action Matters initiative from NHSEI. 14. IPC CQC action plan developed in response to CQC inspection findings.	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual approach to be adopted, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan developed setting out short, medium and long term goals for delivery Mandatory IPC training compliance at over 95% for the majority of the last several months. Divisional and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Assurance Committee Quality Panel High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction Decontamination Group in place – IPC Cell initiated as per COVID Plan	IPAS (NHS I/E) meeting Oversight from system DIPC NHSE/I report CQC IP&C Inspection report	IPC policies currently undergoing review. PIRs not being completed in a timely way, therefore limited lessons learned and shared.	IPC Governance Review: final report to Exec Meeting, QAC and IPC Committee. Executives have agreed to all recommendations which have been added to the IP&C Improvement Plan. CQC IP&C Inspection Report received, action plan approved by the Executive and oversight and being monitored through existing governance arrangements of the Quality and Evidence Panels IPC scorecard developed	**3 x 3 = 9 Moderate**	**2 x 2 = 4 Very Low**	Partial

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
5C There is a risk that the Trust is unable to meet the constitutional standards for emergency and elective access	Insufficient capacity to manage the totality of the emergency and elective demand over a 12 month period causing a deficit of bed on occasions leading to AMB hand over delays, long waits in ED and cancellation of elective activity.	**4 x 4 = 16 High**	1. The restart programme has included a refresh of the demand and capacity across all specialties. 2. Pathways have been reviewed to ensure patients receive their care in the most appropriate settings including non-face to face, independent setting and at MFT. 3. Emergency pathways have been further developed to include the range of assessment options through frailty, acute assessment (medical and surgical) and Same Day Emergency Care (SDEC). 4. A priority admission unit (PAHU) has been set up to facilitate transfers out of ED once patients have a DTA 5. A bed reconfiguration programme has been undertaken to profile the planned and unplanned beds based on expected demand, co-location of specific areas & full ring-fencing of elective capacity. 6. The Trust has a renewed focus on length of stay to ensure that patients get the most effective care during as short a stay in hospital as is appropriate for their care (Patient First). 7. The Covid and Winter Plan has identified further interventions to expand capacity and maximise use of beds. 8. In summary: a. Elective, Outpatients & cancer care modelling completed to ensure patients with a prolonged wait for treatment are appropriately prioritised and managed and that the new physical distancing and pre-hospital preparations are clear. b. The recovery programme is being managed through the System approach to ensure that all out-of hospital capacity ad opportunities are highlighted and used appropriately. c. All the elective standards are delivering as per the agreed trajectories (some ahead of trajectory).	Recovery plans including agreed trajectories for all constitutional standards Patient Discharge & Flow Programme with focused clinically led work-streams. Regular Mini-MADE events on targeted wards to highlight an manage delayed discharges for medically optimised patients. Daily and Weekly operational performance reviews for elective, cancer and emergency activity Daily check points for activity & flow Trajectories for all constitutional standards in place. Involvement of Matrons and Clinical Leads in Flow management More clarity and targeted actions with system-partners on out of hospital capacity and responsiveness Outputs and rapid changes from the Rapid Improvement	Reviews and updates discussed at Executive Group, TIB and Board. Daily and weekly senior operational oversight. National planning tools being used. System calls in place to ensure escalations. IQPR PIRM Progress against ED action plan will be overseen by Quality Panel	External reviews by NHS I/E Single Item Multi-Agency meetings Monthly checkpoint with SE Region Monthly ICS Performance Reviews	Inability to fully mobilise the bed configuration and refurbishment plan. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22.	Wave 3 planning & mobilisation of escalation capacity. More engagement with Estates and Facilities re priorities for capacity configuration. Funding decisions for “progress chasers”, Full mobilisation of Frailty SDEC.	**Risk score reviewed - propose to increase form 4x 4 = 16 (High) to 5x4 = 20 (Extreme)**	**2 x 2 = 4 Very Low**	Partial

			d. The NEL trajectories for the 4 hour standard, time spent in ED and ambulance handovers have regressed in recent months. e. The demand for emergency care has exceeded the expected levels for attendances and admissions. 9. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A. Actions arising from the December 2020 CQC inspection are reflected in the Patient First Improvement Plan as well as the dedicated ED action plan. 10. The Trust has been supported by ECIST to make the necessary improvements in ED processes and patient flow. 11. Patient First Programme:- focus is on 3 aspects of flow management:- • Acute Care Transfer • Flow and Discharge • Site Operations 12. Restart programme focused on Elective, Cancer and Diagnostics	Event held w/c 16 July 2021 being reviewed as to whether to adopt, adapt or discard any of the 'tests of change'.							

COMPOSITE RISK: Integrated Healthcare										
EXECUTIVE LEAD: Chief of Staff										
LINKS TO STRATEGIC OBJECTIVE: Objective One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
1a There is a risk that the Medway and Swale system cannot enable true partnership working which designs a long term population based, integrated health and social care system with the patients at its centre. Thus leading to a failure to deliver systems integration, stability and better patient services via the enablement of clinically led patients centred system redesign.	The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) and at a locality level within Medway and Swale that is based on a joint strategic needs assessment. We will therefore not leverage the ability to redesign the system for better quality of care to be provided to those we serve in the short and long term.	**3 x 4 = 12 Moderate**	1. Systems wide strategic vision written in partnership with all organisations. Agreed Intergraded Care Partnership (ICP) model in place with systems partners actively working to mobilise key collaborative elements. 2. The Trust now has senior representation at ICP and the ICS (the Chief Executive Officer and Chair) level across core governance structures and decision making groups. 3. The Trust has aligned their clinical and quality strategy with the wider ICP quality strategy which ensures pathways and patient experience are central to the work of the Trust and the ICP.	Governance arrangements for the Medway and Swale system agreed. Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways and mini MADE's taking place. Attendance from the Trust at the ICP executive and the ICP partnership board.	Regular updates against milestones submitted to Executive and Board of Directors meetings.	Progress against system recovery and integration plans monitored independently via NHS England and Improvement.		**4 x 3 = 12 Moderate**	**3 x 2 = 6 Low**	Partial

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a Delivery of Financial Control Total	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. Under 2021/22 contracting arrangements the ICS must meet its control total. Given the uncertainty of Covid, CIP delivery risks and the system operating on a block income, there is significant uncertainty and a risk of the Trust not meetings its control total. This risk is exacerbated by significant activity / demand above planned levels, particularly emergency and non-elective demand.	4 x 4 = 16 **High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans e.	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Assurance Meetings with regulators. STP has allocated funds to manage the system performance, including potential "Elective Recovery Funds".	Preparation for H2 planning. Formal written guidance expected 16 September 2021. Internal guidance issued.	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 2 = 8 **Low**)	3 x 3 = 9 **Moderate** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Low)**	
			2. Programme Management Office: a. Track operational delivery and financial consequences of those actions. b. Review of team hierarchy to ensure capacity to deliver c. Further consideration to be given to reintroduction of a Financial Improvement Director / Financial Recovery Plan lead. d. Working with NHSEI intensive support team. e. Delivery of efficiency showcase events.	Chief Financial Officer and Chief of Staff.	Efficiency Delivery Group.		Efficiency Delivery Group TOR approved and first meeting diarised for 27 September 2021.			
			3. Financial Training Policy and SOP approved, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon.	Delivery of and attendance at training programmes for staff. Appraisals / objective setting.	Financial Stability Programme Board.		Financial training packages to be reviewed. Training dates diarised for next 18 months and finance induction leaflet drafted. Global communication to be issued.			
			4. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings. c. Patient First Programme workstreams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication.	Chief Operating Officer	Weekly Senior Operations Meeting that reports via IQPR	Monthly IQPR meetings with NHSE/I				

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3b Capital Investment	If there is insufficient resource to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan, patient safety and/or staff wellbeing. Capital resource is allocated at a system level across the ICS and hence both national and local priorities (including top-slicing for ICS projects) could impact availability.	4 x 4 = 16 **High**	1. Governed entirely by the availability of capital resource, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the ICS and regulators unless affordable within the existing capital programme or through a revenue stream. 2. Project lead completion of prioritisation scoring matrix; Trust review to moderate and agree scores with highest priority projects being proposed as the in-year plan.	Trust business case governance process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Trust Capital Group, Business Case Review Group, Finance Committee and Board.		1. Trust clinical and divisional strategies to be developed by 31 March 2022. 2. National shortage of capital funding recognised. Prioritisation of schemes undertaken and signed off by Trust Executives and continually reviewed at the monthly Trust Capital Group meetings. Exercise being refreshed for H2 21/22 and 22/23+ planning. 3. Clarity and support from ICS where further funding is made available (ongoing/as applicable).	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 3 = 12 **Moderate**)	4 x 3 = 12 **Moderate**	
3c Failure to achieve long term financial sustainability	If the Trust does not achieve financial sustainability, it could lead to reputational damage, difficulty in recruitment into key roles, further licence conditions and potential regulatory action.	4 x 4 = 16 **High**	1. Financial sustainability has been agreed as one of the Trusts top strategic priorities following an executive director exercise. 2. NHSEI financial improvement/recovery group established including NHSE/I intensive support team collaboration.	Development of long term financial model, including sensitivity analysis. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans).	Reporting of identified risks and pressures alongside CIP and financial performance to Finance Committee regularly.	ICS currently responsible for managing system positions, with principle that all organisations achieve breakeven.	Development of a Financial Recovery Plan at ICP level by end of December 2021.	4 x 3 = 12 **Moderate** (Previous risk rating: Mar 2020 4 x 4 = 16 **High)**	4 x 1 = 4 **Very low** (Previous target risk rating: Mar 2020 4 x 3 = 12 **Moderate)**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3d Going concern	If the Trust is unable to improve on the proportionality of the continued and sustained deficits and/or service provision there is a risk that it could lead to further licence conditions and potential regulatory action.	4 x 4 = 16 **High**	1. Interaction with ICS to fund to breakeven. 2. Management of cash reserves.		Considered by the Integrated Audit Committee and the Trust Board as part of the annual report and accounts approval.	Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.		4 x 1 = 4 **Very low**	4 x 1 = 4 **Very low**	

Meeting of the Board of Directors in Public
Thursday, 04 November 2021

Title of Report	**Finance Report**	**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, 28 October 2021		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance report		

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Finance report

For the period ending 30 September 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(8)	(7)	1	The Trust reports a £7k deficit position for September; reducing to breakeven after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes Elective Recovery Funding (ERF) income of £4.6m – this is the figure agreed with the ICS for quarter 1 performance. The contingency has reduced from £1.0m to £0.5m, the majority of the £0.5m utilised was to cover an increase in the provision for bad debt. The pay award and the related pay arrears to April-21 was paid in September and resulted in an additional cost of £2.8m, which was also funded through additional income. Excluding the impact of the pay award, pay expenditure reduced by £0.4m from that of August due to reductions in both bank and agency costs across nursing and medical staff.
Donated Asset Depreciation	8	7	(1)	
Control Total	**-**	**-**	**-**	
Efficiencies Programme				
In-month	278	201	(77)	The in-month position is reporting a £0.1m increase compared to August as the £0.5m surplus ERF income above the cost of delivering activity thresholds has been included and reported across the 6 months to date. All divisions together with support from the corporate functions continue with developing the 9 cross cutting efficiency schemes presented at the efficiency showcase meeting, these will be reported in future as they are implemented.
YTD	1,192	1,135	(57)	
Capital				
In-month	1,233	683	(550)	The Trust Capital Resource Limit (CRL) was set at £13,877k for 2021/22 by the STP; in July an additional £440k CRL has been authorised for diagnostics (£420k to be funded from additional PDC and £20k from the Trusts own cash reserve). Additional CRL bids of £1,000k for IT and £508k for Dolphin have provisionally been agreed by the ICS, when final approval is given the CRL will increase to £15,825k. The ICS have submitted a capital Targeted Investment Fund bid to NHSE/I, with a number of schemes put forward Medway. At this stage the outcome of the bid is unknown. The Trust programme is currently £1,763k behind plan - this is mainly due to slippage across the Backlog Maintenance and Fire Safety Programme due to a delay in scoping and covid related access restrictions earlier in the year. Schemes totalling £3,012k have been approved in excess of the current CRL available, all but £486k is mitigated with forecast slippage and additional funding allocations. £486k (3%) is therefore the level of risk in the programme currently, as further slippage and funding is likely the reported forecast remains as on plan at this stage, a potential breach of CRL duties will only be reported when certain the risk cannot be mitigated.
YTD	8,374	6,611	(1,763)	
Annual (reported forecast)	14,317	14,317	0	

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1. Executive summary (continued)

Cash				
Month end	49,184	37,015	(12,169)	Cash balances have decreased in September due to pay award arrears, an unwinding of contractual payments in advance and bi-annual payment of PDC dividends. However, cash receipts in relation to pay award funding and clearance of agreed debts are pending which will bring levels back up in line with the plan in future months. Cash balances are expected to be maintained at a similar level (£40m to £50m) throughout the year.

Activity is below draft budgeted levels as a result of Covid	Clinical income based on the 21/22 consultation tariff would have reported a year to date position of £129.7m, this being £4.5m lower than income in the same period of 19/20. In month performance excluding high cost drugs is £20.9m which is £0.5m higher compared to M5 reported figure.

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

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	28,469	29,881	1,412	167,168	167,960	792
High cost drugs	1,814	1,965	152	10,881	10,978	97
Other income	1,678	2,198	520	10,120	12,088	1,967
PSF/MRET/FRP	0	0	0	0	0	0
Donated Asset Adjustment	0	0	0	0	0	0
Total income	**31,961**	**34,045**	**2,083**	**188,170**	**191,025**	**2,856**
Nursing	(9,132)	(9,274)	(143)	(48,922)	(48,477)	445
Medical	(6,780)	(7,188)	(408)	(38,062)	(38,487)	(425)
Other	(3,194)	(6,025)	(2,831)	(27,966)	(33,909)	(5,943)
Total pay	**(19,105)**	**(22,487)**	**(3,382)**	**(114,950)**	**(120,873)**	**(5,923)**
Clinical supplies	(3,934)	(4,145)	(211)	(23,603)	(25,282)	(1,679)
Drugs	(598)	(726)	(128)	(3,589)	(4,809)	(1,220)
High cost drugs	(1,821)	(1,860)	(39)	(10,924)	(10,983)	(59)
Other	(5,066)	(3,375)	1,692	(26,482)	(20,418)	6,064
Total non-pay	**(11,419)**	**(10,105)**	**1,314**	**(64,597)**	**(61,492)**	**3,105**
EBITDA	**1,437**	**1,452**	**15**	**8,622**	**8,660**	**38**
Depreciation	(895)	(905)	(9)	(5,371)	(5,383)	(12)
Donated asset adjustment	(8)	(7)	0	(47)	(44)	3
Net finance income/(cost)	2	(4)	(5)	10	(16)	(26)
PDC dividend	(544)	(545)	(1)	(3,262)	(3,262)	0
Non-operating exp.	**(1,445)**	**(1,460)**	**(15)**	**(8,670)**	**(8,705)**	**(35)**
Reported surplus/(deficit)	**(8)**	**(8)**	**0**	**(48)**	**(45)**	**3**
Adj. to control total	8	7	(0)	47	44	(3)
Control total	**(0)**	**(0)**	**(0)**	**(1)**	**(1)**	**0**

1. Funding arrangements for 6 month period have been agreed with the Kent & Medway CCG.
2. Overall pay budgets are overspending by £5.9m, of this £0.3m is the pay contingency, £0.6m is attributable to unfound efficiencies, £0.6m to additional specialling costs, £0.3m estimated agency invoices not yet receipted, and £3.1m relating to budget changes since the NHSE/I plan resubmission that were included in non-pay reserves; in the table this is offset by underspending against reserves in other non-pay.
3. Nursing pay is underspending year to date mainly from vacancies. This position is unlikely to continue as further recruitment across the services is ongoing, along with 1:1 nursing and temporary cover for staff absences. Pay budgets do not include a premium for high temporary staff costs.
4. Pay costs in month have increased by £2.3m. This includes £2.8m impact of the 3% pay award to all staff except the Executive Team and doctors in training roles. Previous cost pressures relating to non-elective activity and pressures within the Emergency Department (E.D.) have reduced in-month by £0.3m.
5. Clinical income favourable position includes income for insulin pumps and medical devices that are excluded from the block income payment.
6. Other Income favourable position includes over performance on P2P contracts and vaccination and quarantine costs £0.6m, medical education contribution to overheads £0.3m and drugs recharges offsetting costs in the divisions.
7. YTD ERF income recognised is £4.6m; this is the full value of ERF confirmed by NHSE for April to June; we do not anticipate additional sums for July to September.
8. Total expenditure includes the £0.4m of incremental Covid costs (£2.6m YTD).

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3. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Unidentified
Planned care	70	52	867	576	1,565	**2,132**	(567)
UIC	179	841	462	90	1,572	**2,190**	(618)
E&F	21	407	20	145	593	**434**	159
Corporate	73	138	69	77	357	**415**	(58)
Total	**343**	**1,438**	**1,417**	**888**	**4,086**	**5,171**	**(1,085)**
Previous Month Total	343	406	89	433	1,271	**5,171**	(3,900)

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**278**	**201**	**(77)**	**1,192**	**1,135**	**(57)**	**5,171**	**4,086**	**(1,085)**

Process

1. Efficiency schemes are the responsibility of the budget holders.
2. The Improvement team supports the budget holders to deliver both quality and cost improvements.
3. The PMO oversees these programmes, supporting with PID writing/management and works to fill the programme.
4. The Finance department counts the extent to which the financial improvements have been made.
5. The Chief Finance Officer monitors and works with budget-holders to achieve targets.

The total efficiencies included in the draft budget for the first 6 months are £0.9m; this increases to £4.8m for the 12 month period as the need for efficiencies increases in the second half of the financial year. In addition to this there is the full year effect impact of 20/21 schemes totalling £0.3m.
For September, ERF efficiency of £0.5m has been recorded as delivered, this represents the lower than budgeted cost to deliver the ERF activity. There are more schemes in the pipeline that are currently going through the governance processes and being finalised. These are specific measurable schemes relating to pharmacy procurement £0.6m in the Unplanned Care division, closure of Theatre 5 and outpatient department vacancies £0.7m in the Planned Care division, as well as procurement reductions relating to price control and numbers of items purchased. The services also continue to develop the 9 cross-cutting efficiency schemes presented at the last show case event to support the development of an efficiency plan for the period of October to March as well as the following financial year. The PMO team and Finance Business Partners are continuing to support the services to identify potential areas of efficiency using Model Hospital data and benchmarking tools.
In addition to the new schemes included from the clinical divisions, efficiencies have also been achieved from the full year effect of 20/21 schemes as well as Facilities and Estates division schemes linked to patient meals costs, Corporate division schemes reducing printing costs and I.T. contracts, as well procurement measures over price increases and inflation.

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4. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
221,951	**Non-current assets**	**222,231**	**280**
6,962	Inventory	7,132	170
16,216	Trade and other receivables	19,122	2,906
49,184	Cash	37,015	(12,169)
72,362	**Current assets**	**63,269**	**(9,093)**
(137)	Borrowings	(73)	64
(37,101))	Trade and other payables	(27,116)	9,985
(8,839)	Other liabilities	(10,118)	(1,279)
(46,077)	**Current liabilities**	**(37,307)**	**8,770**
(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**	**244,617**	**(44)**
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,315)	(44)
36,062	Revaluation reserve	36,062	0
244,661	**Total taxpayers' equity**	**244,617**	**(44)**

Key messages:

1. Receivables have increased by £2.9m from the prior year mainly due to an accrual for pay award funding to come from the CCG.
2. Payables have decreased by £9.1m from the prior year due to the receipt and payment of material capital invoices; additionally, PDC dividends are paid twice a year (in months 6 and 12) and hence the accrual for PDC dividends has been elininated.
3. Other liabilities have increased by £1.4m from the prior year due to an increase in payments in advance from NHS Commissioners
4. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

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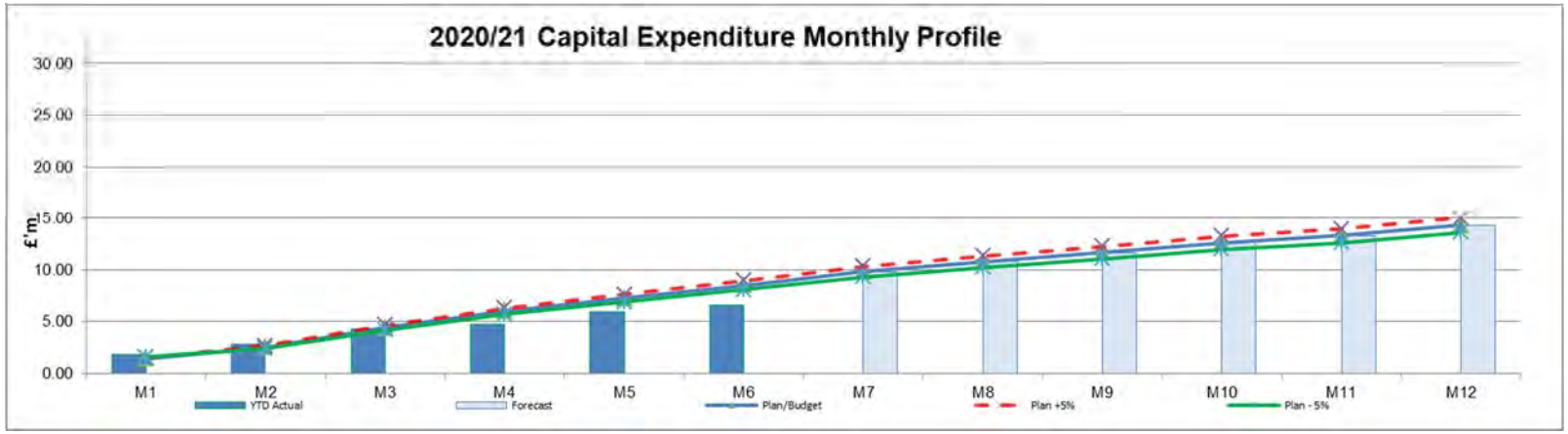
6. Capital

£'000	In-month			Year To Date M1-M4			Annual			Funding (PLAN)	
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC
Backlog Maintenance	351	191	(159)	3,012	1,665	(1,347)	3,014	3,014	0	3,014	0
Fire Urgency Works	412	249	(163)	1,248	481	(767)	2,331	2,331	0	2,331	0
Emergency Department	0	73	73	1,211	1,457	246	1,211	1,211	0	1,211	0
Information Technology	308	1,096	787	2,287	2,211	(76)	4,023	4,023	0	4,023	0
Medical and Surgical Equipment Programme	8	0	(7)	46	76	30	142	142	0	142	0
Service Developments	154	(3)	(157)	460	656	196	1,919	1,903	(16)	1,919	0
Routine Maintenance	0	2	2	110	50	(60)	130	130	0	130	0
Specific Business cases pending UTC	0	0	0	0	(0)	(0)	1,107	1,107	0	0	1,107
Total Planned Capex	**1,233**	**1,608**	**375**	**8,374**	**6,595**	**(1,779)**	**13,877**	**13,861**	**(16)**	**12,770**	**1,107**
Unfunded	0	(924)	(924)	0	16	16	0	16	16	0	0
Diagnostics	0	0	0	0	0	0	440	440	0	440	0
Total Additional Capex	**0**	**(924)**	**(924)**	**0**	**16**	**16**	**440**	**456**	**16**	**440**	**0**
Total Capex	**1,233**	**683**	**(550)**	**8,374**	**6,611**	**(1,763)**	**14,317**	**14,317**	**(0)**	**13,210**	**1,107**
Grant/Donation Funded Capex	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Capex	**1,233**	**683**	**(550)**	**8,374**	**6,611**	**(1,763)**	**14,317**	**14,317**	**(0)**	**13,210**	**1,107**



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The Capital programme is currently 46% complete, £1,880k behind projected expenditure plan.

- **Backlog Maintenance, £1,347k behind plan, forecast for year is on plan.**
  Main schemes generating this slippage are;
  - Mortuary roof - £227k slippage, after some contractor delays the project has accelerated and is expected to complete in October.
  - Lifts - £210k slippage, whole project value is £1,000k. Delays have occurred due to access issues and as a result £200k of the project is now expected to be incurred in 21/22, creating slippage for the current financial year but a pressure on the next.
  - Social Club - £232k slippage, this project is almost complete but an asbestos complication has arisen delaying the final IT cabling works.
  - Accommodation upgrades - £435k slippage, scoping and design delays resulted in a late start, work is now underway and expected to expected to catch up in the next few months.
  - Laundry Equipment - £144k slippage relating to the supplier being unable to fulfil the equipment order, this has recently been delivered at a lower than accrued cost in the last financial year, overall the year end forecast is £80k slippage.
  - Ocelot Ventilation - £150k slippage, this work is now almost complete but some additional scoping and design is now required to finalise.

- **Fire Urgency Works £767k behind plan, forecast for year is on plan.**
  Main schemes generating this slippage are;
  - Compartmentation, £131k slippage, a catch up from the £200k slippage reporting in month 5.
  - Fire Alarm, £140k slippage

  Access to certain areas within the Trust have resulted in works delays across both of these projects, as areas are now available work is back underway and still on course to complete this financial year.
  - X Ray doors, £148k slippage, delayed development and approval of the PID has resulted in a delayed start. The project is now underway and will complete in 2021/22. The final works quote is £50k lower than expected, as long as no complications arise.
  - CSSD, £400k slippage, asbestos issues have caused a delay in scoping, these are now resolved and the work is to start imminently the project will catch up and complete in 2021/22.

- **Emergency Department, £246k overspent**, **forecast for year in on plan** with annual budget fully utilised. VAT credits are expected to offset this overspend when Vat consultants complete their review at year end. There is also additional funding that may be available from the ICS being considered but this would be repayable in the next financial year.

- **IT schemes £76k behind plan forecast for year is on plan.**
  Potential duplicate billing investigated from month 5 was confirmed and removed in month 6 and a recoding of invoices placed against incorrect projects has moved expenditure from ‘unfunded’ to IT and service developments.

- **Service Developments £196k ahead of plan, forecast for year is £16k underspent to offset the unfunded.**
  A negative budget is held within service developments to offset projects approved since the original plan was set. At year end underspends in other programmes will be transferred to offset.

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- **Routine Maintenance £60k behind plan, forecast for year is on plan**
  Slippage relates to the boundary wall project which is complete but there are some issues with the conservation officer requiring the Trust to withhold approval of works until resolved.

- **Unfunded, £16k overspent**
  Unfunded summarises transactions relating to prior year projects. Overall this balance is not material but overspends within need to be investigated further.

- **Additional Funding**
  Currently the Trust has applied for;

    - £440k diagnostics CRL, £420k PDC, which will attract 3.5% dividend repayments and £20k internal resources
      An MOU has now been issued to the Trust for the £420k with funds to be withdrawn as soon as required.

    - £1,000k IT Digital aspirants funding which will be used to fund existing projects, this would also be PDC attracting 3.5% dividends but as yet no provisional agreement or MOU has been issued by NHSE/I.

    - £508k ICS CRL to fund critical Dolphin ward refurbishments approved since the plan was approved, previously identified as a potential financial risk,

- **Overall capital forecast is still on plan but with a revised risk of £3,132k,** slippage of £1,138k has been identified in project manager forecasts to date plus likely additional funding bids of £1,508k means all but £486k of this risk has been mitigated.
  Additional programme slippage and funding is likely so the reported forecast remains as on plan at this stage.

Risks

Approval Category	Project Ref	Project Name	Pressure £'000
Original Plan	N/A	IT slippage - to date unidentified	503
Original Plan	N/A	F&E slippage target - to date unidentified	503
PY	N/A	SDEC	84
TCG Approval - June	21/22-077-001	Equip - Lifestart	19
TCG Approval - June	21/22-077-002	Equip - Orthfix	57
TCG Approval - June	21/22-136	Children's ED	41
TCG Approval - June	21/22-137	Dolphin	300
TCG Approval - July	21/22-136	Children's ED	5
TCG Approval - July	21/22-138	Keates Ward	60
TCG Approval - July	21/22-077	30 x VP infusion pumps - Panda/Dolphin	39
TCG Approval - August	21/22-139	Main Entrance Reception Demolition	26
TCG Approval - Sept	21/22-137	Dolphin Ward	188
TCG Approval - Sept	21/22-006	Res 10	350
TCG Approval - Sept	21/22-140	Rapid Test Centre	15
TCG Approval - June, Sept	21/22-016	Laundry Wall	15
Urgent approval sept	21/22-141	Quick Win Beds	571
Urgent approval sept	21/22-142	ERIC (Education Research Innovation Centre)	260
Urgent approval sept	21/22-143	KLS (Knowledge and Library Services) Security	60
Original Plan - Overspend	21/22-042	Fire door replacements	36
			3,132

Approval Category	Project Ref	Mitigations	£'000
Original Plan	21/22-027	Bronte Ward deferred to 22/23	500
Original Plan	21/22-033	Lister Ward deferred to 22/23	500
TCG Approval - June	21/22-077-001	Equip - Lifestart - Charity Funding	14
Original Plan	21/22-036	Maternity Soundproofing deferred to 22/23	30
Original Plan	21/22-047	Release from EPR budget when IT PDC bid approved	1,000
TCG Approval - June & September	21/22-137	ICS Additional CRL bid (Dolphin)	508
VARIOUS	VARIOUS	PY net credit (VAT, under & over accruals, credits)	44
Original Plan	21/22-021	SouthWing x-raydoors - quote lower than expected	50
			2,646

Shortfall	486

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- **Additional Priority schemes,**

£765k of additional priority capital schemes have been approved by TCG YTD pending funding being made available. If further funding is not available in 2021/22 then these schemes will take precedence in the 2022/23 capital programme.

TCG Approved subject to funding being made available

Approval Category	Project Ref	Project Name	Estimated Cost £'000
TCG Approval - June	21/22-011	Generators	360
TCG Approval - June	21/22-014	TMV to TVT	300
TCG Approval - June	21/22-007	Social Club	68
TCG Approval - July	21/22-077	3x Monitor Recovery - Delivery Suite	37
			765

£22k of additional priority schemes where presented to TCG and approved in principle subject to final scoping work being re-presented to TCG. These schemes will be added to risk when final values are confirmed.

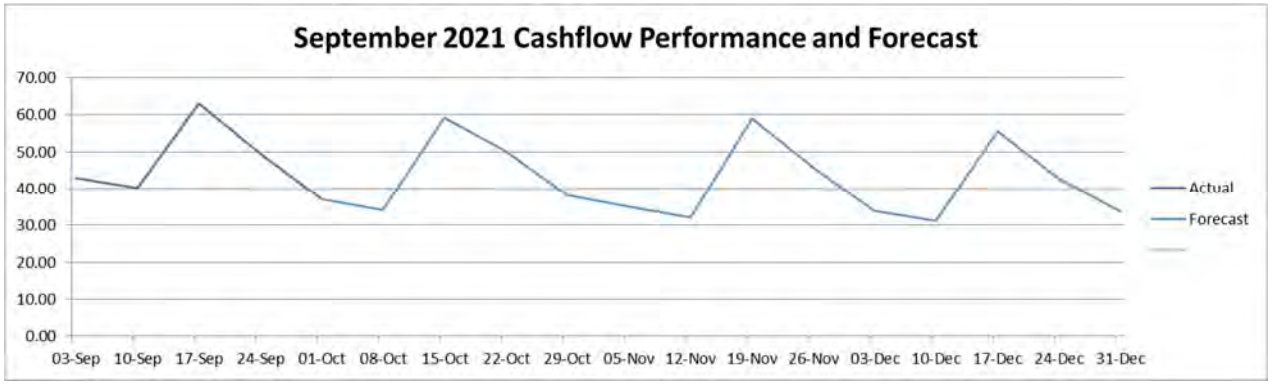
Risks - awaiting further approval

Approval Category	Project Ref	Project Name	Pressure £'000
TCG Approval - August (in principle only r TBC		Maternity Neonates Infant Abduction	22
			22

6. Cash

13 Week Forecast w/e

£m	Actual 03/09/21	10/09/21	17/09/21	24/09/21	01/10/21	Forecast 08/10/21	15/10/21	22/10/21	29/10/21	05/11/21	12/11/21	19/11/21	26/11/21	03/12/21	10/12/21	17/12/21	24/12/21	31/12/21
BANK BALANCE B/FWD	**53.57**	**42.97**	**40.18**	**63.14**	**49.48**	**37.00**	**34.22**	**59.16**	**50.16**	**38.12**	**35.01**	**32.23**	**58.96**	**45.96**	**33.92**	**31.14**	**55.65**	**42.65**
Receipts																		
NHS Contract Income	0.32	0.65	28.56	0.22	0.04	0.00	29.59	4.00	0.00	0.00	0.00	29.15	0.00	0.00	0.00	29.15	0.00	0.00
Other	0.13	0.49	2.58	0.15	0.50	0.58	0.35	0.25	0.25	0.25	0.58	2.65	0.25	0.25	0.58	0.35	0.25	0.25
Total receipts	**0.45**	**1.14**	**31.14**	**0.37**	**0.55**	**0.58**	**29.94**	**4.25**	**0.25**	**0.25**	**0.58**	**31.80**	**0.25**	**0.25**	**0.58**	**29.50**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(8.57)	(0.42)	(0.38)	(11.20)	(10.08)	(0.36)	(0.36)	(10.26)	(8.79)	(0.36)	(0.36)	(0.36)	(10.26)	(8.79)	(0.36)	(0.36)	(10.26)	(8.76)
Non Pay Expenditure	(1.15)	(3.03)	(4.83)	(2.49)	(2.79)	(2.09)	(4.13)	(2.50)	(3.00)	(2.50)	(2.50)	(4.13)	(2.50)	(3.00)	(2.50)	(4.13)	(2.50)	0.00
Capital Expenditure	(1.33)	(0.47)	(0.05)	(0.34)	(0.16)	(0.91)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)
Total payments	**(11.05)**	**(3.93)**	**(5.25)**	**(14.03)**	**(13.03)**	**(3.36)**	**(4.99)**	**(13.26)**	**(12.29)**	**(3.36)**	**(3.36)**	**(4.99)**	**(13.26)**	**(12.29)**	**(3.36)**	**(4.99)**	**(13.26)**	**(9.26)**
Net Receipts/ (Payments)	**(10.60)**	**(2.79)**	**25.89**	**(13.65)**	**(12.48)**	**(2.79)**	**24.95**	**(9.01)**	**(12.04)**	**(3.11)**	**(2.79)**	**26.81**	**(13.01)**	**(12.04)**	**(2.79)**	**24.51**	**(13.01)**	**(9.01)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	(2.94)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**(2.94)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**42.97**	**40.18**	**63.14**	**49.48**	**37.00**	**34.22**	**59.16**	**50.16**	**38.12**	**35.01**	**32.23**	**58.96**	**45.96**	**33.92**	**31.14**	**55.65**	**42.65**	**33.64**



A full year forecast cannot be shared at this point due to lack of agreement on contracting arrangements from Month 7 (October). Based upon current arrangements cash would be maintained around current levels, £40m to £50m with fluctuations dependant on working balances.

Prior year end	£'000	Month end actual	Var.
49,184	Cash	37,015	(12,169)

Cash balances have moved from the prior year due to
- £1.5m additional cash payments made in advance of contracts
- £12m reduction in capital payables, most of which will have been paid out in cash.

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7. Risks and opportunities

Title	Risk description	RAG	£'000	Mitigation(s)	Lead(s)
ERF income - threshold	It has been confirmed that with effect from 1 July the threshold for ERF would be increased from 85% to 95%.		700 (predicted H1 impact)	The Trust is not penalised if it does not meet the threshold target. The CCG has agreed to underwrite any additional costs incurred to deliver against the elective targets.	Cleo Chella
Efficiency	Cross-cutting schemes from the showcase are being scoped. Divisional schemes are still being developed.		4,036	Project teams being established to take forward the 9 cross-cutting schemes.	Alan Davies
Covid	Covid patient numbers have been lower than expected, although this remains a risk through the winter months. The H1 funding has exceeded incremental cost; H2 funding will be adjusted (anticipated downwards) to reflect activity.		n/a	Use of contingency reserve. H2 funding negotiation/settlement.	Alan Davies
ED activity / patient flow	Increased activity from the Emergency Department (ED) while waiting for inpatient beds to be available. This can restrict patient flow through the hospital.		n/a	Opening of Priority Admission Unit (PAHU)	Alan Davies
Winter pressures / activity	The Trust is anticipating significant negative bed balances during winter unless additional capacity can be found and funded. The need for additional staffing in particular could create unbudgeted cost pressures.		TBC	Submission made to NHSE/I via the ICS seeking funding. Executive prioritisation of pressures and funding.	Trust Executive

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8. 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 for the first six months in line with the control total. The year to date efficiency programme has caught up to plan as previous schemes not reported have been included this month; the majority of delivery is from pharmacy procurement, closure of theatre 5 and the full year effect of schemes that started in the previous financial year. ERF income of £4.6m has been included; this is the figure agreed with the ICS and based on the Trust delivering the activity thresholds in quarter 1.

The risks identified with the financial position for the 2nd half of the financial year ahead include:

- Managing cost pressures & service developments within financial envelope for H2.
- Delivery of efficiencies targets.
- Managing the incremental cost of elective recovery and covid costs within the financial envelope for H2.

Mitigations to reduce the risk:

- Development and implementation of the 9 cross-cutting efficiency schemes.
- Use of benchmarking data including the Model Hospital to drive efficiencies.
- M6 contingency £1.0m, forecast for H1 £1.3m.
- National funding for (some) winter schemes.

Alan Davies
Chief Financial Officer
October 2021

Meeting of the Board of Directors in Public

Thursday, 04 November 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte, Chair of Committee/NED		
Date of Meeting:	Thursday, 28 October 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 being unchanged. Some minor changes around the actions taken and latest position thereon. It was **AGREED** that there would be a particular focus on risk "3c Failure to Achieve Long Term Financial Sustainability" at next month's meeting.	**Amber/Green**
2. Corporate risk register There was one item scoring 16 or higher with regards to the capital resource limit for the year. There had been no change from the previous month.	**Amber/Green**
3. Finance report – month 6 The Chief Financial Officer took the Committee through the report, with the key highlights being:	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
• The Trust has met its control total of breakeven in month 6 and for the year to date. • The increase in the pay costs reflect the backdated pay award being paid in-month; excluding this the actual pay had reduced a little compared to previous month. • The efficiencies delivered have increased notably in month as a result of recognising the contribution from the Elective Recovery Fund for the year to date. • It was noted that although there was some capital slippage in the year to date position this was primarily due to phasing and early supplier engagement. The forecast is an over commitment at this time, although there are some additional funding streams that are being pursued to mitigate that position. Further schemes and funding thereon are being pursued to support winter. • Cash sums were noted as having reduced compared to prior months and is largely due to payment of capital creditors and the half year payment of the 'Public Dividend Capital' dividend. • It was also flagged that the level of activity undertaken was below the 2019/20 levels on a monetary basis if payment by results were still applicable. • Some progress had been made on the outstanding debtors, with further follow up work/meetings between CFO's scheduled to address and resolve during November. • The Better Payment Practice Code performance was noted as being improved, largely as a result of applying clock stop for disputes, in line with policy. Further actions to improve this performance are also underway. Further discussion was held to gain assurance over the recovery of debtors external to government, along with delivery of the capital programme. Concern continued to be raised in respect of the gap and deliverability of the efficiency programme, particularly in light of the pending winter pressures. It was noted that support from NHSE/I was forthcoming and we are seeking further funding from national sources for winter costs. Additional analysis is also underway for a number of pipeline schemes that would add to the currently reported forecast, including diagnostic work from a third party that has identified significant further opportunities. The Committee **AGREED** that a list of immediate actions and controls that could be deployed to support delivery of the financial control total as required would be brought back to the next meeting.	
4. Efficiency programme update The Chief Finance Officer noted the work that had taken place to refocus and reenergise the efficiency programme and referenced the discussion held as part of the main finance paper above. Both the Chief Finance Officer and the Chief Operating Officer will be routinely and regularly meeting with the divisions to take forward this work.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level**
It was noted that the Efficiency Delivery Group is still in its infancy and so difficult to measure the impact it has had just yet. It was **AGREED** that the group will bring an assurance report to the Finance Committee at future meetings.	
5. H2 budget setting 2021/22 The Chief Finance Officer presented the paper, noting that the draft position is a £1.8m deficit; work continues in order that the Trust plan is breakeven. It was noted that a number of cost pressures are included in the draft position and these are being scrutinised and agreed by the Trust executive team. Some pressures are excluded at this stage and therefore present a risk; for example, some of the proposed responses to winter preparedness are not included at this time but may be mitigated as a funding application has been made via the ICS to NHSE/I. Some of the risks and pressures on the H2 budget were noted, including full funding of the pay award, agreement with the system on block funding and an assumption that incremental expenditure to deliver additional elective work will be funded by the system if the threshold is not met. The CFO's from the ICS are due to meet to review the system position. Plans are due for submission to NHSE/I by 16 November and hence the Chief Finance Officer will make arrangements for Trust approval in advance of that date. The Committee noted the draft deficit position and the risk at this time in being able to plan for breakeven.	**Amber/Red**
6. Financial Recovery Plan ("FRP") The Deputy Chief Operating Officer presented the update setting out the progress in developing the FRP, some of the obstacles to be overcome and next steps for delivery. It was noted that approval of a FRP is one of the criteria to exit the Recovery Support Programme from NHSE/I's oversight framework.	**Amber/Green**
7. Electronic Patient Records ("EPR") implementation The EPR programme director took the Committee through the presentation to update on progress of the implementation. It was noted that the first three phases of the programme were on track. User acceptance testing has been undertaken with significant involvement – all identified issues arising from this have been resolved. The e-learning for the system has been launched, alongside classroom and ward based training. There is also a digital hub in the staff dining room which acts as a drop-in point for staff. Training is available/being provided 24/7. "Sandpits" have been established – these are areas where staff can go to practice using the system over and above training, along with a number of short videos showing how staff can expect to use the system in practice, e.g. on a ward round. Interfaces between the EPR and other Trust systems have been thoroughly tested and no problems are currently envisaged.	**Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
The communication around the programme has also been carefully managed and broadly positive. The financial costs of implementation were confirmed as on track.	
8. Overseas visitors policy The updated policy was presented, noting that they key changes were in a couple of paragraphs which reflect the impact of the exit from the European Union. The policy was **APPROVED**.	**Green**
9. National cost collection submission The Committee heard that the submission was made in line with national guidance and timetable.	**Green**
10. Patient First business case The business case was presented, setting out the benefits and measures of success. The Committee heard that the financial cost of the case can in part be met through the reallocation and reprioritisation of existing budgets, however this still left a residual gap that required funding from other sources. This may partially be met through funding from NHSE/I (subject to their approval of the business case). The importance of this programme was agreed and thus work is to be taken forward to understand how this can be made affordable. The Committee recommended **APPROVAL** of the business case to the Trust Board, noting the two key issues to resolve were on affordability and performance management.	**Amber/Green**
Decisions made It was **AGREED** that there would be a particular focus on risk "3c Failure to Achieve Long Term Financial Sustainability" at the November meeting. It was **AGREED** that a list of immediate actions and controls that could be deployed to support delivery of the financial control total in 2021/22 would be presented at the November meeting. It was **AGREED** that the Efficiency Delivery Group will bring an assurance report to the Finance Committee at future meetings. The Overseas Visitors policy was **APPROVED**. The Committee recommended **APPROVAL** of the Patient First business case to the Trust Board, noting the two key issues to resolve were on affordability and performance management.	
Further Risks Identified The Committee noted the risk to being able to present a breakeven H2 budget.	
Escalations to the Board or other Committee The ongoing work to present a breakeven plan for H2 should be noted. The Committee recommended **APPROVAL** of the Patient First Business Case to the Trust Board, noting the two key issues to resolve were on affordability and performance management.	