Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 6 May 2021 at 12:30 – 15:30,
Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest, Register: - Dr George Findlay (new addition)		3		
1.4	Chief Executive Update	Chief Executive	5	12:35	Note
1.5	Clinical Presentation – Medical Education Team - Med Ed Initiative and Development of Virtual Reality Training	Chief Medical Officer	Verbal	12:45	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 15.04.21	Chair	7	13:05	Approve
2.2	Matters arising and Action Log: 15.04.21	Chair	19		Discuss
3.	**Governance**				
3.1	Board Assurance Framework	Deputy Chief Executive	21	13:10	Note
3.2	Quarterly Risk Register Review - Risks relating to capital programme; risks from increased ED attendances	Deputy Chief Executive	39	13:20	Note
3.3	Integrated Audit Committee. Assurance report Meeting on 30.04.21	Chair of Committee/Chief Finance Officer	To follow	13:30	Assure
3.4	a) Kent and Medway Integrated Care System - Restart	Chief Strategy and Integration Officer	47	13:40	Note
	b) ED Performance; Root Causes	Chief Operating Officer (Interim)	Verbal	13:50	Note
4.	**High Quality Care**				
4.1	Integrated Quality Performance Report	COO, CNQO, CMO	51	13:55	Note
4.2	Quality Assurance Committee Assurance Report. Meeting on 28.04.21	Chair of Committee/ Chief Nursing and Quality Officer	To follow	14:10	Assure
4.3	Infection Prevention and Control	Chief Nursing and Quality Officer	79	14:20	Note
4.4	Midwifery Staffing	Chief Nursing and Quality Officer	83	14:30	Approve
5. Strategy and Resilience					
5.1	The Green Plan	Director of Estates and Facilities	93	14:40	Approve
6.	**Financial Stability**				
6.1	Finance Report - Month 12	Chief Finance Officer	133	14:50	Note
6.2	Finance Committee Assurance Report. Meeting on 22.04.21	Chair of Committee/ Chief Finance Officer	145	15:00	Assure
7.	**Innovation**				
7.1	Trust Improvement Plan Update	Chief Operating Officer (Interim)	149	15:10	Note
8.	**Any Other Business**				

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Subject		Presenter	Page	Time	Action
8.1	Council of Governors Update	Lead Governor	Verbal	15:20	Note
8.2	Questions from the Public	Chair	Verbal		Note
8.3	Any Other Business	Chair	Verbal		Note
8.4	Date and time of next meeting: 03 June 2021, 12:30 – 15:30				

MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS
MAY 2021

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

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

Chief Executive's Report – May 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.

I am incredibly proud to have taken over from James Devine as Interim Chief Executive of the Trust and I would like to thank everyone for the very warm welcome that I have received.

Although I have only been at the Trust for a few days it is already apparent that we have a skilled and compassionate workforce. This a very important time for the Trust as we enter the second phase of our improvement programme and restart our services following the second wave of the pandemic, but there is no doubt that with such a committed and positive group of staff, and the support we enjoy from our community, we will meet the challenges.

A good deal of work has already taken place to improve the quality of care for our patients and my aim now will be for us to build on these foundations and make a real difference to patient experience as the Trust continues to drive improvement across the hospital.

Many of you will know that I have a clinical background and one of my key aims will be to continue the work already started in making the Trust more clinically led, putting our clinical colleagues at the heart of decision-making to enhance patient outcomes. There is a lot of work to do and I am looking forward to getting started.

COVID-19
I am really pleased to say that we have now resumed our surgical, diagnostic and outpatient services, and in a further important step, relaxed some of the visiting restrictions that had been in place. I know how difficult it is to be unable to see a loved one when they are in hospital and I would like to thank our community for their patience during this really challenging time.

As we continue to see more members of the public return to our site, I would like to remind everyone of the importance of wearing masks, using the hand sanitiser provided and socially distancing when in the hospital.

Supporting our staff
As an NHS Trust it is our job to look after the members of our community, and it is a job that we take extremely seriously. But we also have to make sure we look after those who are doing the caring.
An important part of this is listening and responding to staff feedback. We have a number of mechanisms to enable to staff to provide their feedback, one of which is the national Staff Survey.

While there are teams where morale and engagement are strong, with good leadership and a positive culture, there are also areas where we know this is not the case. We want all colleagues to feel supported and I, alongside the senior leadership team of the Trust, am determined to tackle issues that are affecting how they feel about coming to work.

There are already a number of initiatives in place to improve our culture – for example we are putting a greater emphasis on staff wellbeing, and we have our Change Team, a group of colleagues who have volunteered to be part of creating a more positive future. We know

we still have more work to do but in the coming months I will be focused on working with all staff to make the Trust an even better place to work.

Care Quality Commission
There have been a number of improvements in recent months, thanks to colleagues across the Trust. Actions have been implemented to address issues highlighted by the Care Quality Commission, including ambulance handover times, and waits within the Emergency Department, and I am pleased to say these continue to improve.

At the time of writing we are anticipating a further visit from the Care Quality Commission and look forward to welcoming them to the hospital.

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

Charlie and Me
I am very proud to say that Hospital Radio Medway has won the Best Speech Package or Special Event award at the National Hospital Radio Awards. This award is designed to showcase the power of speech through the medium of radio.

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

I have heard a lot of great things about the support provided to the Trust by Hospital Radio Medway and The Medway League of Friends and I look forward to working with them in the coming months.

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

Minutes of the Trust Board PUBLIC Meeting

Thursday, 15 April 2021 at 12:30 - 15:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Annyes Laheurte	Non-Executive Director
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	David Sulch	Chief Medical Officer
	Ewan Carmichael	Non-Executive Director
	Gurjit Mahil	Deputy Chief Executive
	James Devine	Chief Executive (Excused at 13:20, returned 13:40)
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Chief People Officer
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer (Interim)
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Harvey McEnroe	Chief Strategy and Integration Officer
	Jenny Chong	Associate Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Company Secretary
	George Findlay	Incoming Interim Chief Executive
	Glyn Allen	Lead Governor
	Nye Harries	NHSEI Improvement Director
	Sanjay Suman	Clinical Director, Therapies and Older Persons Programme (Clinical Presentation)
Observing:	Alison Streatfield	Head of Nursing
	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
	Katy White	Director of Nursing Quality and Professional Standards
	Kit Bradshaw	On-Screen Journalist, ITV News Meridian
Apologies:	Paula Tinniswood	Chief Staff Officer (Interim)

	Rama Thirunamachandran	Academic Non-Executive Director
	Sue Mackenzie	Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

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

a) The Trust was saddened to learn of the death of His Royal Highness, the Duke of Edinburgh, and sends condolences to the Royal Family. Many colleagues will have added their messages to the online Book of Condolence.

b) Chair particularly wanted to welcome Annyes Laheurte to her first Board meeting as a new Non-Executive Director. Annyes has more than 25 years' experience in financial reporting together with financial planning and analysis for international organisations. Her skills and experience will be invaluable to the Board and we are delighted to have her.

c) Chair was also pleased that Dr George Findlay has been able to join the Board to observe today's meeting. As Board members will know, George joins us in May 2021 as Interim Chief Executive, colleagues look forward to meeting him properly in the coming weeks.

d) Chair welcomed Dr Sanjay Suman who was giving a presentation on Frailty and the Care of Older Persons, in addition; Katie May Nelson, Local Democracy Reporter with Kent Online, and Kit Bradshaw, ITV News Meridian, both observing.

e) The Board meets today in the knowledge that the hospital only has a small number of inpatients with Covid-19, which is a far cry from the very high numbers seen during the peak in December and January. This is, of course, great news, and it is also heartening to see more patients able to have their elective surgery and diagnostic and outpatient appointments as the hospital restarts its services.

f) The majority of colleagues have now had their Covid-19 vaccinations, including second doses. At the start of this week the Trust has given more than 28,000 jabs – a great achievement. Chair stated she is particularly proud that the Trust has been able to offer the vaccine to colleagues from other health and care organisations and to local residents to support the community vaccination programme. The vaccination team has been fantastic and Chair thanked them all.

g) Finally, as you will be aware, this is James's last Board meeting before stepping down as Chief Executive at the end of this month. James joined the Trust as Executive Director of HR in 2016, soon becoming Deputy Chief Executive, before being appointed as Chief Executive two and half years ago. A former HPMA HR Director of the Year, with experience at Great Ormond Street, St Barts and elsewhere, James started his career at Medway and fulfilled an ambition when he was appointed to lead the Trust. During his time at Medway James has worked tirelessly to lay the foundations of the Trust's improvement programme. He has invigorated the hospital in many areas, ensuring a compassionate and patient-centred approach. He has also focused on improving the culture of the Trust, and his personal approachable style has been appreciated by colleagues. Whether visiting a ward, addressing hundreds of staff at a briefing, or meeting with housekeepers and porters on a night shift, he has an impressive ability to relate to colleagues and to 'walk in their shoes'. From the beginning of May James will be taking on a national leadership role in NHS Confederation, Chair on behalf of the Board wished James all the very

best for the future. She added her personal thanks for his support on her journey from NED, to Chair at the Trust.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Conflicts of Interest

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

1.4 Chief Executive Update

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

1.4.1 **Covid-19:** At the time of writing, the Trust was just beginning to see the first steps in the relaxation of the national lockdown restrictions. Although this is really welcome news, the expectation is that things will not change too significantly on the hospital site for the moment. The Trust will still be expecting staff, patients and visitors to wear masks, use dedicated entrances, wash their hands and socially distance. It is so very important that we remain vigilant to avoid seeing unnecessary surges in cases in the community or the hospital.

The Trust as always supports staff health and wellbeing and hope they can take some time off in the coming weeks and months.

The vaccination programme within the hospital has gone very well, but James wants to encourage more colleagues, particularly those from BAME communities to have their vaccine over the coming weeks. He is grateful to the vaccination team for all their efforts in administering over 28,000 jabs to colleagues in the hospital, the wider health and social care workforce across Medway and Swale, and the community. He added his thanks to Angela Gallagher and Gemma Nauman for managing the hub. In the coming weeks the next group of people to be vaccinated, are those in the 40 – 45 age category.

James was extremely pleased to say that the Trust has restarted some of its elective procedures, but this is being done with caution. The Trust must ensure it gets this right and ensures safety. In addition, the Trust will continue to review the restrictions on visiting, and relax these as soon as it is safe to do so. The team is fully committed to bringing all our services back to full capacity as quickly, and as safely as possible. The Trust is extremely grateful for the support of the community and thanks them for their continued patience and understanding during an anxious time for many.

1.4.2 **National recognition:** James informed the Board that the hospital has been shortlisted for two HSJ value awards. Both nominations come in the same category – Acute Service Redesign Initiative. James congratulated the MeFit Prehabilitation Team and Emergency Department Team for this national recognition of the work that they have done to improve care for our patients.

1.4.3 **Culture Conference:** Last month the Trust was proud to host its first culture conference. The event gave an opportunity to speak to colleagues about the aims of the programme and to focus on some of the achievements so far. Continuing to develop the culture of the organisation remains a very important aspect of the improvement work that the Trust is doing.

1.4.4 **Wellbeing Day:** The last 12 months have been incredibly challenging for everyone at Medway, and many colleagues feel exhausted from all that they have been through. With the hope of returning to some form of normality and as pressure eases, it is more important than ever that colleagues take some time to reflect on all that has happened and think of their wellbeing. The Trust held a wellbeing day in March 2021.

James was delighted to say that the Trust has given colleagues one day's additional paid leave to be taken in 2021/22, to take some time to recuperate and re-energise.

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

The Trust is working to become a JAM Card friendly Trust. JAM stands for 'Just A Minute' and is an important communication aid for those with a hidden disability. A JAM Card allows people with a learning difficulty, autism or a communication barrier to tell others they need 'Just A Minute' discreetly and easily.

1.4.6 James concluded his last Chief Executive Message by reflecting on the recent announcement of his departure at the end of April 2021.

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

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

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

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

James gave his sincere wishes to incoming Chief Executive George Findlay, the best of luck.

1.5 Clinical Presentation – Frailty (Care of Older Persons) Team. Presented by Dr Sanjay Suman
The presentation included:

a) Designing Services for Frailty
b) Care group staffing – lead positions and numbers

c) Scope of services – TOP Care Group
d) Core Business – Managing Frailty
e) Acute Frailty Pathway: Development History at MFT
f) Improvements – Reducing Length of Stay
g) Improvements – Mortality (Dr Foster – Frailty)
h) TOP – String Medical Engagement
i) Covid-19 - How Did We Contribute
j) Covid-19 - Recovering Through the Phases
k) Designing Frailty Pathways Fit for Future
l) Emerald based Acute Frailty Pathway: A Proof of Concept Study
m) Emerald Frailty – SDEC: A Proof of Concept
n) Next Steps
o) Frailty – SDEC: Rapid Access Clinic for Elderly (RACE)
p) Emerald Frailty Pathway: Next Steps
q) TOP - Ambitions and Challenges
r) Designing Services for Frailty – Are We There Yet?

1.5.1 Chair thanked Sanjay for an excellent presentation and for his enthusiasm. It is important that consultants have time to present to the Board and thanked him for his time.

1.5.2 Chair asked Alan Davies to review the Frailty Funding Business Case through the Finance Committee. Alan confirmed that this proposal is already feeding into the annual planning and is due to be submitted to the Committee in April. It is something that will have internal and external funding and a conclusion will be finalised in a few weeks.

1.5.3 Tony Ullman confirmed that at the next Quality Assurance Committee that they are looking at how to give Board members safe access back into the hospital for visits and will visit the Frailty Team/Emerald Ward as part of this.

2 Minutes of the previous meeting and matters arising

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

Item 3.2.1a – "…to approve [ADD] ' and for information'

2.1.1 Ewan Carmichael suggested that a brief update should be added at the end of the minutes, in regard to the actions taken following the negative feedback from the Patient Story. Ewan would have expected that the member of staff that removed the call button from the patient should receive disciplinary action.

2.1.2 Jane Murkin stated that there were experiences of care that were unacceptable. Actions taken are; facilitated discussion, the patient tory has been shared with colleagues, a review of specific complaints and a further investigation into the specific issues within the patient story. Going forward complaints must be investigated in a much timelier manner. The matter has been taken very seriously and the team is using this story as a learning experience going forward.

2.1.3 Chair stated that parts of the story were very positive but there were also some concerning negatives, she asked that Jane comes back in May and presents to the Board and assure them that the lessons learnt have been embedded.
[Post meeting note: Alana Marie Almond added to the Board agenda for May 2021]

2.2 Matters arising and actions from the last meeting
The action log was reviewed and the Board agreed to CLOSE the following action:
TBPU/21/114

3 Governance

3.1 Medway and Swale Integrated Care Partnership

Harvey McEnroe, Chief Integration and Strategy Officer, presented to the Board for noting. The paper provided the Board with a summary of the work underway via the Medway and Swale ICP. It outlined the progress of the STP to ICS status and the work across the 'place' on population heath and the Trust's recovery from Covid-19.

The Trust has received a note from Wilf Williams with support and how we formally move to an ICS structure. The ICS Structure will be submitted to Board in the coming months and it will be presented at the next Board Development session in April.

The ICP Recovery Programme is to be noted. The Trust is being offered a leadership structure to be defined; there will be a discussion next week to see what the support will look like. This will be linked to the Improvement Road Map and the Trust Improvement Plan.

Harvey informed the Board that there will be monthly meetings as a check point. In addition there has been work on the Public Health management into the ICP. The Restart Programme across the ICP will be submitted to the May Board.

The board NOTED the update.

4 High Quality Care

4.1 Integrated Quality Performance Report

The Board was asked to note the report and discuss the content. The IQPR uses Statistical Process Control charts to display the data within the report. The report informed Board Members of the quality and operational performance across key performance indicators. The paper was taken as read with the following key highlights:

a) The Trust had zero MRSA and one hospital acquired C-diff cases in February.
b) The HSMR (mortality) figure is currently 102.3; the weekend HSMR rate is 109.0 and links to risks during the weekends with bed occupancy and mixed sex accommodation.
c) Unfortunately, while mixed sex accommodation had shown improvement in previous months, February has seen 72 breaches recorded. This was mainly in the high dependency unit and at weekend periods where bed occupancy within the organisation was high.
d) The Trust saw the four-hour performance standard for patients being seen, treated and admitted or discharged reaching 66.48 per cent in February.
e) Referral to treatment (RTT) performance for January is recorded at 64.96%, with 563 52-week breaches. Clinical harm reviews have been completed for these patients.
f) Diagnostics performance is at 75.78% for January.
g) Cancer two-week wait performance continued to exceed national standards at 94.86%, while 62-day performance was recorded as 78.79%
h) Chair asked Angela Gallagher to detail a one page summary of where we were and where we are now with Cancer performance. **ACTION NO: TBPU/21/116:** Angela Gallagher

4.2 Infection Prevention and Control: Assurance Framework and Improvement Plan

Jane Murkin, Chief Nursing and Quality Officer presented to the Board for approval. Effective infection prevention and control is fundamental to the delivery of high quality, safe and effective patient care. In March 2021 the Executive Team has been presented with a high level overview and current status of IPC across the organisation on accepting Executive responsibility for the service on 14 December 2020. The plan has been approved by the Quality Assurance Committee meeting on 16 March 2021.

4.2.1 Following the IPC visit by the National Team on 26 November 2020, an action plan was created setting out the key actions to address the following three areas aimed at reducing hospital acquired infections: Leadership and Governance, Prevention of Transmission and Prevention of Infection.

4.2.2 The Trust's previous IPC Improvement Plan has been reviewed in light of the visit and refreshed to incorporate the actions from the national team visit setting out short, medium and long term goals. The improvement plan also incorporates actions relating to gaps identified from the updated Infection prevention and Control (IPC) Board Assurance Framework (BAF).

4.2.3 The IPC Improvement Plan directly references the 10 criteria set out in the code of practice on the prevention and control of infection which links to Regulation 12 of the Health and Social Care act 2008 (regulated activities) Regulations 2014. The paper listed the criteria.

4.2.4 Since the National IPC Team visit on 26 November significant progress has been made to address the issues identified and related actions and the progress of delivery of actions within the improvement plan has been acknowledged by the National IPC Team.

4.2.5 The Board was asked to note progress to date in addressing actions relating to findings from the National Team visit in November 2020 and note the Trust's IPC Improvement Plan that has been approved by the Executive Group and Quality Assurance Committee.

4.2.6 Gary Lupton stated within the Estates Strategy and Improvement Plan the hospital environment is considered, and increasing capacity by captilising on non-clinical spaces. The Executive Team will see more information on this in the coming weeks.

4.2.7 The Board **APPROVED** the report.

4.3 Quality Assurance Committee Assurance Report. Meeting on 16 March 2021

Tony Ullman, Chair of the Committee presented to the Board for assurance. The paper was taken as read and the following highlights were given:

a) The Committee is concerned about the data set of 2019/20 being reported in the safeguarding annual report, versus a more up to date report but note the positive independent review of safeguarding which has been completed. The Committee will receive a progress update on the recommendations at the May meeting and will keep the Board updated on the progress.
b) The Committee is concerned by the C-section rate within the December IQPR and requested a review be undertaken. The Committee received a robust presentation at its March meeting and is assured the Trust is not an outlier for C-sections.
c) The Committee noted the progress to date and current Datix backlog and reporting of Serious Incidents and work is underway to strengthen the reporting and investigating of incidents and their management across the Trust.
d) The Committee will continue to monitor all of the above.
e) James Devine asked the Board to note that Jane Murkin is working on the Midwifery Staffing; it is a work in progress and is being submitted to the Executive Team on 21 April 2021 for onward submission to the Board in May. **ACTION NO: TBPU/21/117:** Jane Murkin
f) The Board **NOTED** the report.

4.4 Clinical Negligence Scheme for Trusts (Maternity) - Safety Actions 4, 5 and

Jane Murkin, Chief Nursing and Quality Officer presented to the Board for noting and approval. NHS Resolution (NHSR) is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts delivering maternity services and who are members of the CNST. As in year two, members will contribute an additional 10% of the CNST scheme.

4.4.1 In December 2020 Jane presented a paper to the Board on CNST which included a gap analysis against each of the ten safety actions and the actions being addressed to recover compliance. The Board requested that the Quality Assurance Committee (QAC) oversee the review and evidence relating to the Ten Safety actions.

4.4.2 The Board will maintain full accountability for the authorisation of final sign-off for CNST by the Chief Executive; following a schedule of alternate month reporting to QAC and the Board will have oversight of evidence.

4.4.3 The Board received an assurance report on 4 February 2021 relating to Safety actions 1, 2 and 3 to provide assurance regarding progress against Safety Actions 1 and 3. The report identified some additional actions required for Safety Action 2 and provided an update to the Board on progress against Safety Action 2. Later a full oversight and assurance report for Safety Actions 4, 5 and 6 was presented to QAC on 16 March 2021.

4.4.4 The report sought to provide assurance to the Board that the Maternity Service has progressed work and providing evidence to demonstrate compliance with Safety Actions 4, 5 and 6 that form the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). In December 2020 NHSR advised that the deadline for submission for the CNST MIS had been revised to 15 July 2021. This was in response to the continued pressure facing Trusts in response Covid-19.

4.4.5 Since the last report to the Board, NHSR has published two revisions to the guidance, one in February 2021 the second on 18 March 2021. The March 2021 guidance removed a number of sub-requirements from Safety Actions 3, 4 and 9 and also amended the approach to validating the Maternity Services Data Set data (Safety Action 2) and made changes within Safety Action 8's standards removing the 90% threshold for training.

4.4.6 The Board was required to note compliance and review the evidence against Safety Action 4, 5 and 6 that provides assurance that the Maternity Service is on track to demonstrate compliance with CNST safety actions 4, 5 and 6.

4.4.7 The Board was requested to note progress and compliance with safety actions 4, 5 and 6 including, note review of the Continuity of Carer Action Plan in Appendix 5.

4.4.8 The Board was requested to approve the action plans for Neonatal Medical and Nursing workforce in Appendix 3 and 4, as follows:
1.7, 3.3.1, 3.4.1, 3.4.5, 4.1.2, 5.3, 5.5.6, 5.5.7 – to be approved at Board in July 2021, 5.6.2 one plan approved now and one to be approved at Board in July 2021, 5.7.1 and 5.72

4.4.9 James Devine stated that there needs to be a greater grip and control within the care group.

4.4.10 The Board **APPROVED** the items listed above and detailed within the report.

4.5 Nursing Standards Assurance Framework

Jane Murkin, Chief Nursing and Quality Officer presented to the Board for noting. In October 2020 the Board was presented with the Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework, as one of the deliverables set out within the strategic priorities for nursing and midwifery 'Reclaiming the nursing landscape', which the Board

subsequently approved. The paper provided the Board with an update on progress of the implementation of this framework.

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

4.5.2 Despite the significant impact and challenges that the Coronavirus has had on the Trust over the past year, advancing the delivery of this framework has continued to be prioritised with improvements in standards of care, reductions in harm and increased days between hospital acquired pressure ulcers, infections and Falls in many wards across the Trust .

4.5.3 The Board was asked to discuss and note the content of this report, progress to date and consider the level of assurance that this provides in relation to the progression of the Nursing and Midwifery Ward to Board Quality Assurance and Improvement Framework.

4.5.4 Jane specifically asked the Board to note Page 148 – 149. She also thanked Katy White for her efforts on this piece of work.

4.5.5 Chair encouraged the NEDs when they are able to visit the hospital safely, to talk to the Ward Managers about performance and their work. It would be useful to stand by their white boards to give full information.

4.5.6 Chair asked that Jane works on the Patient Experience Strategy and to agree with David Seabrooke when this can come back to the Board for review. **ACTION NO:** TBPU/21/118: Jane Murkin

4.5.7 The board **NOTED** the report and progress.

5 Financial Stability

5.1 Finance Report - Month 11 and Q1/Q2 Interim Plan

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

5.1.1 The Trust reports a deficit of £9k in month and £104k year to date, which adjusts to breakeven against the NHSE/I control total. New arrangements came into force from 01 October 2020 for the second half of the year, with control of top-up, Covid-19 and growth monies now held at STP level.

5.1.2 Capital

The 2020/21 capital plan includes;
£17.1m STP capital allocation has increased by £0.5m in month for an IT project.
£7.3m PDC relating to previously agreed capital loans for ED and Fire Safety.
£7.2m PDC for business cases and COVID funding agreed in year.

Total CRL for the Trust is now £32.1m with a predicted underspend of £0.31m as agreed with NHSEI. Capital Expenditure is currently well below the CRL, due to late funding allocations and slow progress across projects throughout the pandemic. IT schemes and building works have accelerated this month, more equipment purchases and contracts are due to be finalised in March 2021.

PDC cannot be rolled forward into the new financial year. If PDC projects remain underspent on 31 March 2021 then the Trust will have breached the funding agreement and may be asked to return unspent funding.

The capital underspend is quite an achievement; Alan gave his thanks to Gary Lupton and his team for their efforts. More information on this will be submitted to the Executive Team meeting and the Finance Committee.

5.1.3 Draft plans - Q1/Q2 Interim Plan
The planning is focused on the first part of the year. There are a significant numbers of cost pressures which are being reviewed and considered. This will later be considered by the Executive team.

Gurjit Mahil would work with Alan Davies to capture the capital allocation on the Corporate Risk Register. **ACTION NO: TBPU/21/119:** Gurjit Mahil

James Devine stated that the capital allocation should also be aligned to the estates and clinical strategy; he gave his thanks to everyone involved in hitting the break-even point for the third successive year.

5.2 Finance Committee Assurance Report: Meeting on 25 March 2021
Jo Palmer, Chair presented to the Board for assurance and the paper was taken as read with the following key highlights:

a) The Trust accounts are in a satisfactory position to be signed off in a timely manner.
b) The Finance Committee Terms of Reference have been updated and were included in the Board papers for review.
c) The Board **NOTED** the report.

6 Innovation

6.1 Trust Improvement Plan – Patient First Update
Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting. The paper provided an update on three key and interrelated elements of the Patient First programme. The work targets regulatory requirements and links to a number of key performance and quality indicators.

6.1.1 The paper also seeks to positively respond to the recommendations from Emergency Care Intensive Support Team (ECIST), who has played a positive role in the programmes and are active members of the committees and supporting workstreams.

6.1.2 Acute care transformation; handovers and pathways, the 60 minute delays were a key part of patient safety concerns. With the support from an external company to focus on the medical model, the Trust is ensuring that there is escalation in place and professional standards in place across the organisation.

6.1.3 Gurjit Mahil would work with Angela Gallagher to capture the increasing acuity of patients since Easter on the Corporate Risk Register. **ACTION NO: TBPU/21/120:** Gurjit Mahil

6.1.4 Chair stated that it is an encouraging sign to see the level of sustainability within the charts.

6.1.5 James Devine asked that the ED Action Plan is included in this data set. He also asked for it to be investigated whether or not the Trust is getting to the root cause of the issues and asked

Harvey McEnroe to lead on this as part of the Transition Plan. **ACTION NO: TBPU/21/121:** Harvey McEnroe to lead.

7 Our People

7.1 People Committee Assurance Report. Meeting on 23.03.21

Leon Hinton, Chief People Officer, presented to the Board for assurance, the paper was taken as read with the following key highlights:

a) Sickness rates have reduced for the month of February 2021 and into March (but March figures are not included on the report).
b) Gender pay gap has improved.
c) Recruitment has improved including the international recruitment rates; this is a positive note for the WRES Delivery Plan.
d) Vaccine rates are largely unchanged.
e) The Health and Wellbeing Strategy approved and Sue Mackenzie, NED, was nominated as the Health and Wellbeing Guardian.
f) There is ongoing work on developing other staff networks; there is lots of focus on BAME networks but more to be done on disability and LGBTQ+ networks. Chair suggested that action plans for the networks must be worked on soonest. **Action No: TBPU/21/122:** Leon Hinton to lead
g) The Board **NOTED** the report.

8 Any Other Business

8.1 Council of Governors Update

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

a) The Governors gave their condolences to the Queen on the loss of Prince Philip.
b) There are 17 Governor Vacancies in 2021, voting opens on Monday 19 April and results will be on 14 May 2021.
c) The Governors held a virtual meeting on 18 March 2021 and the meeting was attended by people from the local community alongside a number of Governors.
d) The next meeting is scheduled in May 2021 and it would be good if the Council could meet in person.
e) The Members' Event on 28 April 2021 would be held virtually.
f) The Governors welcomed Annyes Laheurte as the new NED on the Trust Board.
g) The Governors welcomed Dr George Findlay to the Trust and look forward to him joining the team in May 2021
h) The Governors gave their thanks to Victoria Bean, Governor and Membership Officer, who leaves the Trust on the 16 April after two years at the Trust.
i) Glyn and the Governors wanted to record an enormous thank you to James Devine for his work and wished him well for the future. The Governors are impressed how James has led with a focus on patient care and quality.

8.2 Questions from the Public

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

8.3 Any Other Business

8.3.1 There were no matters of any other business.

8.4 Date and time of next meeting

The next meeting will be held on Thursday, 06 May 2021, 12:30 – 15:30.

The meeting closed at 15:10

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 15 April 2021

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
14-Jan-21	TBPU/21/112	**Item 4.1 - Integrated Quality Performance Report:** - Provide some clarity to see what areas may deteriorate, where we may see changes. - How can the team quantify the indicators that may go off track with Covid. - Add a specific metric in the IQPR for the Emergency Department (such as ambulance handovers) This will be tracked through QAC - How to obtain more timely information.	06-May-21 ~~15-Apr-21~~ ~~04-Mar-21~~ ~~04-Feb-21~~	Gurjit Mahil, Deputy Chief Executive ~~Jane Murkin, Chief Nursing and Quality Officer up to April 21~~	**Propose to close**	Green
15-Apr-21	TBPU/21/116	**Item 4.1 Integrated Quality Performance Report:** One page summary of where we were and where we are now with Cancer performance.	06-May-21	Angela Gallagher, Chief Operating Officer (Interim)	**Propose to close** - on the agenda	Green
15-Apr-21	TBPU/21/117	**Item 4.3 Quality Assurance Committee Assurance Report:** Submit the Midwifery Staffing report to 21.04.21 Executive team for onward submission to Board.	06-May-21	Jane Murkin, Chief Nursing and Quality Officer	**Propose to close** - on the agenda	Green
15-Apr-21	TBPU/21/118	Submit the Patient Experience Strategy to the Board, agree with David Seabrooke when.	06-May-21	Jane Murkin, Chief Nursing and Quality Officer	**Update to the Board in May 2021**	
15-Apr-21	TBPU/21/119	**Item 5.1 Finance Report - Month 11:** Capture the capital allocation on the Corporate Risk Register.	06-May-21	Gurjit Mahil, Deputy Chief Executive		
15-Apr-21	TBPU/21/120	**Item 6.1 Trust Improvement Plan – Patient First Update:** Capture the increasing acuity of patients since Easter on the Corporate Risk Register.	06-May-21	Gurjit Mahil, Deputy Chief Executive		
15-Apr-21	TBPU/21/121	**Item 6.1 Trust Improvement Plan – Patient First Update:** Investigated whether or not the Trust is getting to the root cause of the issues. Harvey to lead on this as part of the Transition Plan.	06-May-21	Harvey McEnroe, Chief Integration and Strategy Officer		
15-Apr-21	TBPU/21/122	**7.1 People Committee Assurance Report:** Work on the action plans for the staff networks.	06-May-21	Leon Hinton, Chief People Officer	**Propose to close** - delegated to the People Committee	Green

Meeting of the Public Board
Thursday, 06 May 2021

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework</td><td>Agenda Item</td><td>3.1</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 the 26 April 2021 is presented in this paper.

The Trust's principal risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Feb 2021</th><th>March 2021</th><th>April 2021</th></tr>
<tr><td>3a – Delivery of financial control total</td><td>9</td><td>16</td><td>8</td><td>8</td><td>16</td></tr>
<tr><td>3b – Capital Planning</td><td>12</td><td>16</td><td>12</td><td>12</td><td>16</td></tr>
<tr><td>4a – Sufficient Staffing – Clinical Areas</td><td>6</td><td>16</td><td>12</td><td>15</td><td>15</td></tr>
</table>
</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>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☒</td></tr>
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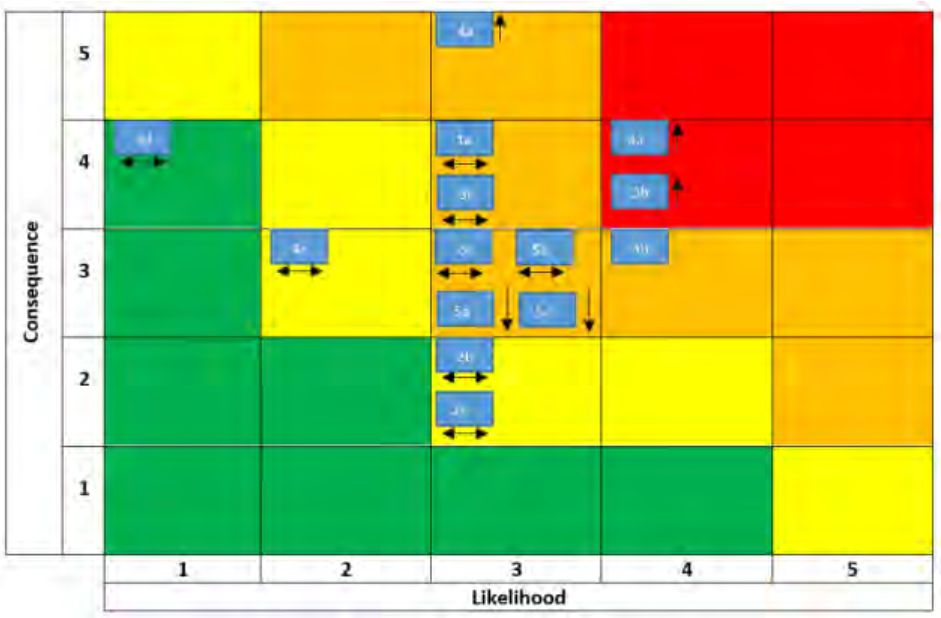
1 Board Assurance Framework

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. Fundamental Quality Standards	↓
	5b. Infection, Prevention and Control (IPC)	↔
	5c. Patient flow	↓



In the current reporting period the Trust has seen the increase of three risks, delivery of the financial control total, capital planning and sufficient staffing.

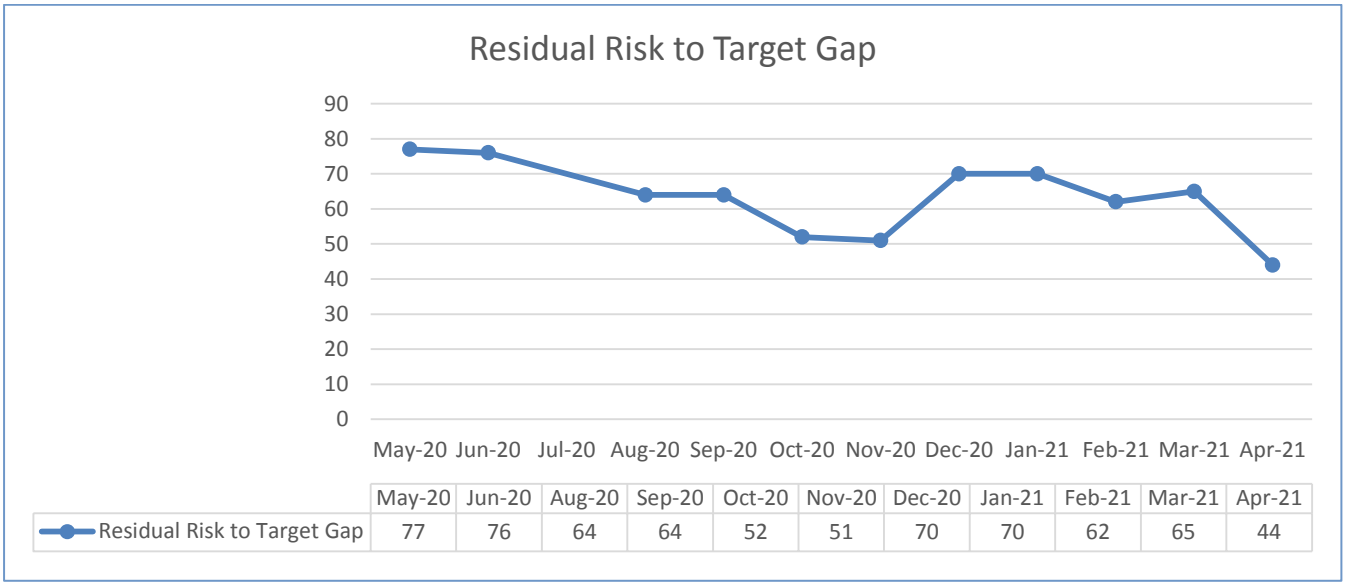
There are two principles risks that are rated as high, 3a – delivery of financial control total and 3b – capital planning. Financial risks are being managed through the current planning rounds within the Trust and the wider system with the clinical and corporate areas.

The Quality section has been reviewed and 3 risks have been closed and moved to the corporate risk register (Quality Governance, Covid 19 and loss of services).

		Target Score	Initial Score	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Integrated Healthcare	1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12	12	12	12
Innovation	2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9	9	9	9
	2b. Capacity and Capability	9	9	12	12	12	12	12	6	6	6	6	6	6	6
	2c. Funding for investment	9	9	9	9	9	9	9	6	6	6	6	6	6	6
Finance	3a. Delivery of financial control total	9	16	6	9	9	9	9	9	16	16	16	8	8	16
	3b. Capital Investment	12	16	20	20	20	20	20	20	12	12	12	12	12	16
	3c. Failure to achieve long term financial sustainability	4	16	16	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
Workforce	4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	12	12	12	12	15	15
	4b. Staff engagement	6	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
Quality	5a. Fundamentals of Nursing Care	4	16	16	16	16	12	12	12	12	12	12	12	12	9
	5b. Infection, Prevention and Control (IPC)	6	16	16	16	16	9	9	9	9	9	9	9	9	9
	5c. Patient flow – Capacity and demand	6	12	12	12	12	12	12	9	9	16	16	16	16	9
	5d. Quality Governance - CLOSED		12	12	12	12	9	9	9	9	9	9	9	9	Closed
	5d - RELABELLED. Loss or temporary moves of key clinical services off the MFT site. - CLOSED	4	16				6	6	6	6	6	6	6	6	Closed
	5f. Covid 19 - CLOSED		20								16	16	16	16	Closed
	Total Risk Score	105	242	174	173	173	165	165	153	152	175	175	167	170	147
	Residual Risk to Target Gap		137	77	76	76	64	64	52	51	70	70	62	65	44

Table 1.1 – Summary of BAF

1.1



	May-20	Jun-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Residual Risk to Target Gap	77	76	64	64	52	51	70	70	62	65	44

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 3a and 3b have been increased due to the new financial year and these risks are being mitigated through the planning process within the Trust.

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

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

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

COMPOSITE RISK: 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		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Staff networks are further developed, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 21]	**3 x 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 10.6%. 2. Monthly Sickness rate 4.23% 3. Substantive workforce 81.9%					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					

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

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

				programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom To Speak Up Guardian route to Chief Executive; b. Respect: countering bullying in the workplace policy; c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Respect policy in place; 3. JSC and JLNC in place.						
			Well-being interventions in place: a. Employee assistance programme and counselling; b. Advice and health education programmes; c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support. d. National #How are you (HAY) wellbeing framework implemented	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. #HAY implemented and monitored						
			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place Qualitative and quantitative values-based appraisal						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board		Refresh of Freedom to Speak Up strategy [Apr 21]	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented). 1. StatMan compliance >89% 2. Appraisal rate >79%						
			Right attitude and values: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance; c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; d. Respect – countering bullying in the workplace policy.	1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place. 4.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and	1. Trust vacancy rate at 10.6%; 2. Substantive workforce 81.9% 3. Monthly PRM including discussion on workforce, vacancies,						

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

COMPOSITE RISK: 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 STP 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 very high risk of the Trust not meetings its control total.	4 x 4 = 16 **Very High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. STP has allocated funds to manage the system performance, including potential "Elective Recovery Funds".	STP plan submission for H1 2021/22 BY 20 April for draft submission to NHSEI by 06 May; final submission to NHSEI due 03 June.	4 x 4 = 16 **Very High** (Previous risk rating: Mar 2021 4 x 2 = 8 **High**)	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate**)	
			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. d. Working with NHSEI intensive support team.	Financial improvement director in place.						
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. Capital resource is allocated at a system level across the STP and hence both national and local priorities (including top-slicing for STP projects) could impact availability.	4 x 4 = 16 **Very 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 STP 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 Capital Group, Finance Committee and Board.		1. Trust clinical and divisional strategies to be developed. 2. National shortage of capital funding recognised. Will need some key choices to be made by the Board. 3. Clarity and support from STP is required for capital prioritisation / funding.	4 x 4 = 16 **Very High** (Previous risk rating: Mar 2021 4 x 3 = 12 **High**)	4 x 3 = 12 **High**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3c **Failure to achieve long term financial sustainability**	If the Trust does not achieve financial sustainability could lead to reputational damage, difficulty in recruitment into key roles, further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Establishment of System Delivery Board with System Recovery as key cornerstone of the programme monitoring delivery and engaging with partners. 2. NHSEI financial improvement/recovery group established including NHSE/I intensive support team collaboration.	Development of longer 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.	STPs currently responsible for managing system positions, with principle that all organisations achieve breakeven.	Development of system wide financial narrative and joint plans with commissioners and other key stakeholders.	4 x 3 = 12 **Moderate** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 1 = 4 **Moderate** (Previous target risk rating: Mar 2020 4 x 3 = 12 **High)**	
3d **Going concern**	If the Trust is unable to improve on the proportionality of the continued and sustained deficits and/or service provision there is a risk that it could lead to further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Interaction with STP to fund to breakeven. 2. Management of cash reserves.		Considered by the Integrated Audit Committee and by the 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 **Low**	4 x 1 = 4 **Low**	

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. 3. Poor staff morale and engagement. 4. Damage to patient experience and patient outcomes.	**12 High 3(L) x4(C)**	1. Trust wide and ED specific CQC action plans being implemented 2. Enhanced leadership within Patient Experience and Quality & Patient Safety 3. CNST (Maternity Incentive Scheme) action plan being implemented 4. Quality Strategy Priorities Year 2 agreed and being implemented 5. High Quality Care Programme Year 2 improvement priorities agreed, measures being developed and work progressed 6. Refreshed ward assurance and accreditation visits being developed 7. Quality Boards in place on all wards 8. Gold 'stars' awards being implemented to recognised and celebrate achievements in achieving high standards and improving patient outcomes. Daily trust wide safe staffing reviews undertaken by HON with escalation to DDON and CN&QO as appropriate. 9. Daily senior nurse staffing meeting with escalation to CN&QO as appropriate. 10. Annual provider review on safe nurse staffing. 11. Recruitment pipeline progressing as per plan.	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.	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. 4. Due to additional bed capacity requirements there remains additional ward capacity open without substantive staffing and funding.	Chief Nursing and Quality Officer is commissioning a review of Quality Governance with the aim of improved quality governance. Associate Director of Quality & Patient Safety to design and propose a single source for assuring the QAC and Trust Board on the future of monitoring of CQC compliance. Chief Nursing and Quality Officer and the Associate Director of Quality and Patient Safety to review the Q&PSG and QAC TOR and work plans to ensure alignment. Executive to undertake a Trust wide risk assessment of nurse staffing versus capacity risks	**9 Moderate 3(L)x3(C)**	**2 x 2 = 4 Very Low**	Partial

			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Nursing Ward to board quality assurance framework approved c. Quality and safety boards on wards demonstrating 'days between'.	Scorecard developed. 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	Internal and External Audits	PRMs for 21/22 to c. TBC. Refreshed Nursing and Midwifery Scorecard under development.	PRMs for 21/22 to c. TBC. N&M Scorecard to be implemented by end of Q1			Partial
			5. Audit and review processes: Clinical Audit programme in place	Quarterly report on clinical audit plan compliance to Q&PSG	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			Partial
			9. Central and local oversight of quality metrics: a. Complaints management b. Incident management, including Serious Incident (SI) processes and monitoring c. Compliance with Duty of Candour policy and training	Care Group and Divisional Governance Boards Complaints review completed, actions to improve agreed Safeguarding review completed actions to improve agreed	Monthly Quality reports to the Executive Group, QAC and Quality and Patient Safety Group		Lack of organisational shared learning from SI, claims and complaints	Complaints review completed, actions to improve agreed by Execs and are now being implemented by divisions.			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 developed, setting out short, medium and long term goals 2. IPC Improvement plan approved by Executive Team and QAC and reported at Trust Board 3. IPC Intensive Support programme supporting the Trust 4. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 5. Refreshed IP&C Team structure and leadership 6. Interim AD for IP&C in place whilst recruiting to post substantively 7. Identified improvement priority work through HQCP to reduce C- Diff Infections 8. IP&C Governance Review completed and report in draft form. 9. IPC Unannounced inspections commissioned by CNQO with findings being drafted with themes and learning to be shared 10. COVID-19 BAF updated, reviewed externally and maintained with evidence to support collated 11. CNQO wrote to Executives regarding their executive areas of responsibility to support delivery of Trust Improvement Plan 12. Interim Matron sourced due to start ASAP -6months contract and recruited into substantive Matron 13. Additional IPC team posts recruited 14. MFT participating in Kent & Medway IPC Network- peer support and sharing learning 15. CNQO IPC monthly blogs to communicated key messages 16. Communication plan for IPC in development to support effective IPC communications and the Every Action Matters initiative from NHSEI	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 -	IPAS (NHS I/E) meeting Oversight from system DIPC	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.	**3 x 3 = 9 Moderate**	**2 x 2 = 4 Very Low**	Partial

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

Meeting of the Public Board
Thursday, 06 May 2021

<table>
<tr><td>Title of Report</td><td>Corporate Risk Register</td><td>Agenda Item</td><td>3.2</td></tr>
<tr><td>Report Author</td><td colspan="3">Julie Wilson, Head of Risk
Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="3">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="3">The corporate risk register included 20 risks assigned to Executives with a number of divisional risks scoring 15+ linked to these. In January 2021 these risks were unlinked and presented on the register in their own right, making a total of 52 risks on the corporate risk register. The risk appetite was agreed by the Board and risks scoring 16+ would be presented to Risk Assurance Group for discussion and approval prior to being added to the corporate risk register. The existing 32 unlinked risks were to be reviewed at deep dive meetings.

During February and March 2021 deep dive meetings took place with the Division's to review their high scoring corporate risks. At March's Risk Assurance Group all risks were reviewed. The work taken place has resulted in the following reducing the number of risks on the corporate risk register to 28:

<table>
<tr><th>Number of Risks</th><th>Action</th><th>Reason</th></tr>
<tr><td>9</td><td>Closed</td><td>• Risk no longer applicable
• Historical risk closed - new risk to be written
• Risk does not fit current situation
• Risk actioned but not updated on RiskAssure</td></tr>
<tr><td>6</td><td>Closed</td><td>• Duplicated risks on RiskAssure</td></tr>
<tr><td>3</td><td>Moved to issues log</td><td>• Risk identified as an issue rather than a risk</td></tr>
<tr><td>9</td><td>Moved to divisional register</td><td>• Existing risk scoring below 16
• Risk score reduced following review</td></tr>
</table>

Currently there are 16 high risks on the corporate risk register graded 16 or above, as seen in page 7 of this report. These are being managed through the Risk Assurance Group, with the appropriate executive owner of the risk.</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="3">Risk Assurance Group</td></tr>
<tr><td>Resource Implications</td><td colspan="3">N/A</td></tr>
</table>

Legal Implications/Regulatory Requirements	N/A			
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to note the report for assurance regarding the processes in place around risk management.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒

1 Corporate Risk Register - Dashboard

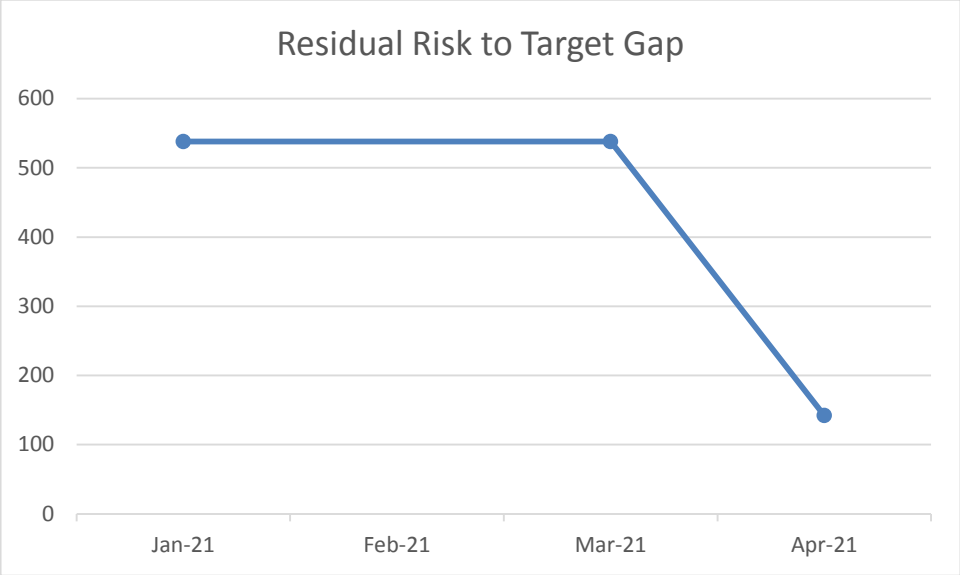
2. Corporate Risk Register – Residual to Target

Risk Domain	Risk	Risk Owner	Target Score	Initial Score	Jan-21	Feb-21	Mar-21	Apr-21
Adverse Publicity/Reputation	ED Corridor Care- Trust reputation	Chief Nursing and Quality Officer	4	16	16	16	16	CD
Agreed Targets	Imaging: Inadequate MRI capacity	Chief Operating Officer	4	16	20	20	20	20
	Failure to deliver quality care in a timely manner - patient care may be compromised.	Chief Operating Officer	4	16	20	20	20	C
	Phase 3 ED Estate- Capacity - impact on performance and safety metrics	Chief Operating Officer	12	20	20	20	20	20
Compliance/Audit/Governance	Lack of compliance with fundamentals of nursing care (CQC compliance)	Chief Nursing and Quality Officer	4	16	16	16	16	16
	Failure to adhere to NHS Provider Licence Conditions & NHSI operational undertakings	Chief Executive	4	4	16	16	16	12
	CQC Compliance	Chief Nursing and Quality Officer	4	16	12	12	12	12
Finance	Not achieving CIP target for 20/21	Chief Finance Officer	6	15	20	20	20	C
	: Access to capital monies for Covid works is now more stringent.	Chief Finance Officer	6	16	16	16	16	C
	Financial performance against capital control total	Director of Estates and Facilities	4	16	16	16	16	C
	Covid-19 – Restart of Activity / Ward Configuration	Chief Finance Officer	6	25	16	16	16	C
	Capital Financial Monitoring & Asset Capitalisation	Chief Finance Officer	4	16	16	16	16	C
	Not achieving CIP target for 2020/21	Chief Operating Officer	6	15	16	16	16	C
Fire Safety/General Security	Trust wide Fire Safety Risks	Director of Estates and Facilities	4	15	15	15	15	15
	ED- Staff Security	Director of Estates and Facilities	4	16	12	12	12	D
Human Resources	ED Senior Nurse perception of leadership and safety	Chief Nursing and Quality Officer	4	20	20	20	20	I
Information Governance/ IT	Existing Telephony Solution Obsolete - No Manufacturer Support	Director of Estates and Facilities	4	16	16	16	16	16
Patient Safety	Lack of Winter Pressures preparedness	Chief Operating Officer	5	20	20	20	20	I
	Management and control of secure areas and COSHH products in patient areas	Director of Estates and Facilities	4	20	20	20	20	CD
	Increased waiting times in Endoscopy	Chief Operating Officer	8	20	20	20	20	20
	ED- Mental Health Escalation Plans	Chief Operating Officer	10	20	20	20	20	CD
	COVID19	Chief Operating Officer	4	16	20	20	20	8
	ED- Mental Health Treatment Delays	Chief Nursing and Quality Officer	10	20	20	20	20	CD
	ED Corridor Care- Patient Safety	Chief Nursing and Quality Officer	9	20	20	20	20	20
	Patients with cancer as well as other patients requiring urgent respiratory outpatient appointments will experience a delay in diagnosis and treatment and those patients may require an admission due to cancellation of clinic activity in view of second wave of Covid	Chief Operating Officer	4	16	16	16	16	16
	Mental Health Pathways - our ability to provide parity of esteem for mental health patients in the emergency setting with regards to the Hospital Emergency Care Standard (4hrs)	Chief Operating Officer	4	16	16	16	16	16
	ED- Application of parity of esteem for mental health patients	Chief Nursing and Quality Officer	4	16	16	16	16	CD
	Patients with vulnerabilities such as mental health and learning disabilities are not recognised as potential or actual safeguarding concerns and not escalated in a timely manner. Especially those who frequently attend and / or do not wait to be seen	Chief Nursing and Quality Officer	4	16	16	16	16	16
	Lift availability	Director of Estates and Facilities	4	16	12	12	12	D
	Weekend Mortality	Chief Medical Officer	4	15	12	12	12	D

	Infection Control Prevention Compliance	Chief Medical Officer	4	16	9	9	9	9
	Safe Medical Staffing	Chief Medical Officer	4	12	8	8	8	D
	Un-investigated open Datix	Chief Nursing and Quality Officer	4	16	6	6	6	6
	eDNs	Chief Medical Officer	4	12	6	6	6	2
Quality / Audit	Management and control of secure areas and COSHH products in patient areas	Director of Estates and Facilities	4	16	16	16	16	12
	Operational Performance & delivery of constitutional standards	Chief Operating Officer	4	16	12	12	12	12
	Breaching Deprivation of Liberty safeguards (DOLS) legislation	Chief Nursing and Quality Officer	4	16	12	12	12	12
	Learning from incidents, complaints, inquests and claims and application of Duty of Candour	Chief Nursing and Quality Officer	4	12	9	9	9	9
Service/Business Interruption	IMAGING: Risk of inability to deliver constitutional standards in imaging service due to ageing and insufficient equipment to meet current and rising demand.	Chief Operating Officer	5	20	25	25	25	25
	CR Reader (machine failure)	Chief Operating Officer	3	15	20	20	20	20
	Post April 2019 the current cardiac catheter suite is unsupported. It will not be serviced and any breakdown will not be covered by a maintenance plan.	Director of Estates and Facilities	5	25	20	20	20	20
	Imaging: Loss of ability to provide fluoroscopy service.	Chief Operating Officer	4	20	20	20	20	20
	Lack of diagnostic equipment at community Rheumatology centre following transfer of service from DVH.	Chief Operating Officer	8	16	16	16	16	C
	NKPS – Covid	Chief Operating Officer	6	16	16	16	16	16
	Leaking Library Roof	Chief Medical Officer	6	16	16	16	16	D
	Diagnostic equipment across multiple specialities is coming to end of life and is unsupported by manufacturer maintenance contract within the next 6 months.	Chief Operating Officer	8	16	16	16	16	16
	Pandemic Flu	Chief Operating Officer	4	16	16	16	16	16
	Innovation and digital technology	Director of Transformation	9	16	12	12	12	12
	Estates	Director of Estates and Facilities	6	16	6	6	6	D
	Equipment Failure	Director of Estates and Facilities	6	12	6	6	6	D
Staffing/Competence	ED Corridor Care- Workforce	Chief Nursing and Quality Officer	8	16	16	16	16	CD
	Inability to deliver safe and effective care as a direct result of the high nurse vacancy rates.	Chief Operating Officer	4	12	16	16	16	C
		Total Risk Score	**272**	**853**	**810**	**810**	**810**	**414**
		Residual Risk to Target Gap			**538**	**538**	**538**	**142**

C	Risk Closed
I	Risk moved to issues log
D	Risk moved to divisional register
CD	Closed - duplicated risk

2 Corporate Risk Register – Residual to Target



Residual Risk to Target Gap - Deep dive meetings and the Risk Assurance Group took place during Q4. The reduction in the residual gap is mainly due to a high number of risks being closed, duplicated risks removed and risks moving to different registers as approved in the January Board meeting.

3 Principal Risks

Risk	Risk Owner	Target Score	Jan-21	Feb-21	Mar-21	Apr-21
Imaging: Inadequate MRI capacity	Chief Operating Officer	4	20	20	20	20
Phase 3 ED Estate- Capacity - impact on performance and safety metrics	Chief Operating Officer	12	20	20	20	20
Lack of compliance with fundamentals of nursing care (CQC compliance)	Chief Nursing and Quality Officer	4	16	16	16	16
Existing Telephony Solution Obsolete - No Manufacturer Support	Director of Estates and Facilities	4	16	16	16	16
Increased waiting times in Endoscopy	Chief Operating Officer	8	20	20	20	20
ED Corridor Care- Patient Safety	Chief Nursing and Quality Officer	9	20	20	20	20
Patients with cancer as well as other patients requiring urgent respiratory outpatient appointments will experience a delay in diagnosis and treatment and those patients may require an admission due to cancellation of clinic activity in view of second wave of Covid	Chief Operating Officer	4	16	16	16	16
Mental Health Pathways - our ability to provide parity of esteem for mental health patients in the emergency setting with regards to the Hospital Emergency Care Standard (4hrs)	Chief Operating Officer	4	16	16	16	16
Patients with vulnerabilities such as mental health and learning disabilities are not recognised as potential or actual safeguarding concerns and not escalated in a timely manner. Especially those who frequently attend and / or do not wait to be seen	Chief Nursing and Quality Officer	4	16	16	16	16
IMAGING: Risk of inability to deliver constitutional standards in imaging service due to ageing and insufficient equipment to meet current and rising demand.	Chief Operating Officer	5	25	25	25	25
CR Reader (machine failure)	Chief Operating Officer	3	20	20	20	20
Post April 2019 the current cardiac catheter suite is unsupported. It will not be serviced and any breakdown will not be covered by a maintenance plan.	Director of Estates and Facilities	5	20	20	20	20
Imaging: Loss of ability to provide fluoroscopy service.	Chief Operating Officer	4	20	20	20	20
NKPS – Covid	Chief Operating Officer	6	16	16	16	16
Diagnostic equipment across multiple specialities is coming to end of life and is unsupported by manufacturer maintenance contract within the next 6 months.	Chief Operating Officer	8	16	16	16	16
Pandemic Flu	Chief Operating Officer	4	16	16	16	16

These are currently being reviewed via the Risk Assurance Group to ensure controls and mitigations are in place and the appropriate executive forums.

Meeting of the Trust Board Meeting
Thursday, 06 May 2021

Title of Report	**Kent and Medway Integrated Care System update – ICS priorities**	Agenda Item	**3.4a**
Lead Director	Harvey McEnroe, Chief Strategy and Integration Officer		
Report Author	Harvey McEnroe, Chief Strategy and Integration Officer		
Executive Summary	As part of its resubmission for the ICS accreditation process, the Sustainability and Transformation Partnership (STP) was asked to identify its immediate strategic priorities for the system. These 9 improvement and development priorities are the key focus of the ICS, and will be the means by which the effectiveness of the system will be assessed, both internally and externally. The delivery of these priorities will be overseen by the STP/ICS Executive Group, supported by relevant sub-committees. Regular progress report will be provided to the STP/ICS Partnership Board. This paper provides the Board with an overview of these strategic priorities.		
Committees or Groups at which the paper has been submitted	Trust Executive Group		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE the update.		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒

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

Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

1 Executive Overview

1.1 As part of its resubmission for the ICS accreditation process, the STP was asked to identify its immediate strategic priorities for the system. These 9 improvement and development priorities are the key focus of the ICS, and will be the means by which the effectiveness of the system will be assessed, both internally and externally. The delivery of these priorities will be overseen by the STP/ICS Executive Group, supported by relevant sub-committees. Regular progress report will be provided to the STP/ICS Partnership Board. This paper provides the Board with an overview of these strategic priorities.

1.2 The Board is asked to note the report.

2 ICS Priorities 2021/22

Amber / Green

2.1 The table below sets out the 9 priorities, and their system sponsors and executive and non-executive leads:

Priority	System Sponsor	Non-Exec Lead	Executive Lead
Continuing to respond effectively to the COVID pandemic as a cohesive system.	Wilf Williams	David Astley (SECAmb)	Caroline Selkirk
Delivering against the Kent & Medway Improvement & Recovery Plan.	Wilf Williams	Joanne Palmer (MFT)	Lisa Keslake

Priority	System Sponsor	Non-Exec Lead	Executive Lead
Working as a system to increase diagnostic and elective capacity	Miles Scott	Peter Coles (DGT)	Caroline Selkirk
Implementing the 'ICS end-state'	Wilf Williams	John Goulston (KCHFT)	Lisa Keslake
Implementing population health management.	James Williams	Joanne Palmer (MFT)	Rachel Jones
Working with NHSE/I to deliver system change priorities (East Kent and Stroke)	Susan Acott & Louise Ashley	Niall Dixon (EKHUFT)	Rachel Jones
Exploring options for provider collaboration.	Paul Bentley	David Highton (MTW)	TBC

Developing a strategy for the creation of county-wide leadership, expertise and capacity for quality and service improvement.	Wilf Williams	Dr Navin Kumta	Paula Wilkins
Refreshing the system digital strategy, creating system capability for digital.	Susan Acott	David Highton	Morfydd Williams

3 Conclusion and Next Steps

3.1 The Trust and the ICP will work to support the priorities and feed into the wider ICS plans.

3.2 A further report will be shared with Board next month as this work progresses

Meeting of the Board of Directors in Public
Thursday, 06 May 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.1
Report Author	Jane Murkin, Chief Nursing and Quality Officer David Sulch, Medical Director Angela Gallagher, Chief Operating Officer		
Lead Director	Jane Murkin, Chief Nursing and Quality Officer Gurjit Mahil, Deputy CEO		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for March shows that the Trust has had 0 MRSA bacteraemia cases and 0 hospital acquired C-diff cases. December's overall HSMR rate is 105.17; the weekend HSMR rate is at 111.37 and links to risks during the weekends with Bed Occupancy. **Caring** Unfortunately, whilst MSA had shown improvement, March has seen that 51 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates remain close or above the national standard of 85% (Inpatients: 81.96%, ED: 85.95%, Maternity: 100%, Outpatients: 89.75%). Whilst Inpatients remains relatively static, improvements have been seen in ED, Maternity and Outpatients. **Effective** Discharges before Noon, whilst close to the Mean are still below at 14.26% and significantly below the Target of 25%, this is being reviewed through the Patient First work. **Responsive** Due in part to the lower rate of discharges before noon and the pause in elective work, the 18 weeks Referral to treatment (RTT) performance for March is recorded at 61.20%. ED (Type 1) 4 hour performance as a result of site pressures reported 84.65% in March. Additionally, the Trust saw 66 Ambulance Handover delays of +60mins. However, DM01 Diagnostics performance is at 73.79% for February.		

	Well Led We have seen an increase in appraisal rates, reporting 80.76% and the Trust has maintained compliance statutory and mandatory training. To note: • The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay. • The SHMI data is currently showing August – this is reliant on NHS Digital and is 3 to 4 months in arrears. • The HSMR is currently showing October 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 – March 2021

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: March 2021

What is Statistical Process Control (SPC)?

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

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

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

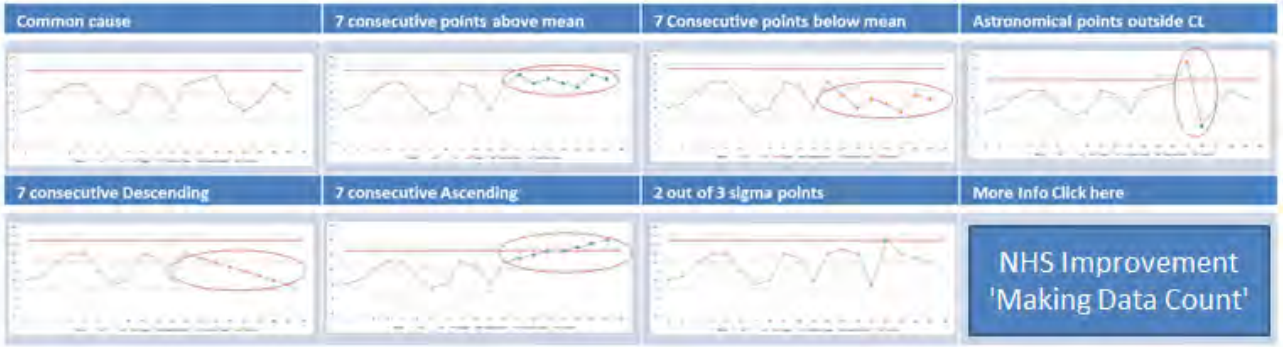
Key Facts about a SPC Chart:

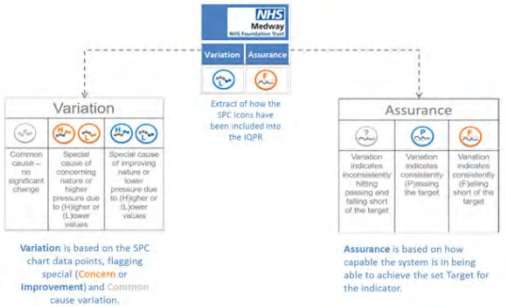
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





NHS
Medway
NHS Foundation Trust

Topic	Overview	Deep Dive
Executive Summary	4	5
Caring	7	8
Effective	10	11
Safe	12	12
Responsive	13	15
Well Led	22	23

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls) & Caring	• Flow & Elective Pathways
Caring	• The Friends and Family recommended rates for Maternity services, Outpatients and ED are above the national standard of 85%. IP FFT rates, whilst not meeting plan, has remained very close to target.	• High number of breaches in Mixed Sex Accommodation continues into March, although early signs of improvement again • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set
Effective	• VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement • Maternity 12+6 Risk Assessments, whilst still slightly under target, has shown improvement and remains very close to achieving	• Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • 0 Never Events in month and Sis response rate is 100%	• Infection data shows spikes in C-Diff cases throughout February and March • Overall HSMR levels have risen, again, and are still above the national threshold (100)
Responsive	• Cancer 2ww Performance has exceeded the target • 60+ Min Ambulance Handover delays are significantly down from levels seen over Winter, as to are +12 Hour DTA Breaches in ED, with 0 reported	• DM01 Diagnostics performance has dropped • ED 4 hour performance remains under LCL • RTT Incomplete Performance decreased and is again slightly below LCL. +52wk breaches has also seen an increase above UCL
Well Led	• Maintained compliance with Trust target for StatMan Compliance • Sickness rates have stabilised in month and are now slightly above target but under Mean	• Agency spend has stabilised in month but bank spend has increased considerably • Appraisal % has continued to fall below target and is now below the LCL position

Executive Summary

NHS Medway NHS Foundation Trust

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

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Mar-21	3	0	43	27		
S2	Number of C-diff (HAI)	Mar-21	0	4	0	26		-
S3	MRSA Bacteraemia (Trust Attributable)	Mar-21	0	0	5	1		
S4	E-coli (Trust Acquired)	Mar-21	2	5	30	44		
S5	Falls per 1000 bed days	Mar-21	6.63	5.13	6.63	5.24		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Mar-21	1.04	0.00	1.04	0.03		
S7	Never Events	Mar-21	0	0	0	2		
S8	% of SIs responded to in 60 days	Mar-21	100%	100%	100%	100%		-
S9	HSMR (overall)	Dec-20	100	105.17	100	100.18		
S10	HSMR (weekday)	Dec-20	100	103.09	100	97.16		
S11	HSMR (weekend)	Dec-20	100	111.37	100	108.78		
S12	SHMI	Sep-20	1	1.07	-	-		

Caring			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Mar-21	0	51	0	1153		
C2	New Complaints	Mar-21	41	42	-	532		
C3	% Complaints responded to within target	Mar-21	85%	54.29%	85%	67.06%		
C4	% EDNs completed within 24 hours	Mar-21	100%	67.06%	100%	69.63%		
C5	Inpatients Friends and Family Response rate	Mar-21	22%	17.80%	22%	18.97%		
C6	Inpatients Friends and Family % recommended	Mar-21	85%	81.96%	85%	82.47%		
C7	ED Friends and Family Response rate	Mar-21	22%	14.83%	22%	15.84%		
C8	ED Friends and Family % recommended	Mar-21	85%	85.95%	85%	84.86%		
C9	Maternity Friends and Family Response rate	Mar-21	22%	15.98%	22%	30.14%		
C10	Maternity Friends and Family % recommended	Mar-21	85%	100.00%	85%	99.63%		
C11	Outpatients Friends and Family Response rate	Mar-21	22%	10.74%	22%	12.05%		
C12	Outpatients Friends and Family % recommended	Mar-21	85%	89.75%	85%	89.17%		

Responsive - Non-Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Mar-21	85%	76.75%	85%	79.90%		
R2	Average Length of stay (Non-elective)	Mar-21	5	8.50	5	8.28		
R3	Average Length of stay (Elective)	Mar-21	5	3.19	5	3.00		
R4	% of Delayed Transfers of Care	Mar-21	4%	0.25%	4%	0.35%		
R5	% Medically Fit For Discharge	Mar-21	7%	10.79%	7%	10.29%		
R6	ED 4 hour performance (All)	Mar-21	95%	84.65%	95%	83.72%		
R7	Ed 4 hour performance (Type 1)	Mar-21	95%	73.65%	95%	73.66%		
R8	ED 12 hour DTA Breaches	Mar-21	0	0	0	418		
R9	Ambulance Attendances	Mar-21	-	3,432	-	38,612		
R10	60 minute handover delays	Mar-21	0	66	0	2172		

Effective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Feb-21	5%	6.80%	5%	7.09%		
E2	30 day readmission rate	Feb-21	10%	13.60%	10%	13.53%		
E3	Discharges before noon	Mar-21	25%	14.26%	25%	14.44%		
E4	Fractured NOF within 36 hours	Feb-21	100%	69.60%	100%	72.19%		
E5	VTE risk assessment % completed	Mar-21	95%	94.12%	95%	94.54%		
E6	Elective C-section rate	Mar-21	13%	17.15%	13%	14.83%		
E7	Total C-Section rate	Mar-21	28%	43.54%	28%	37.01%		
E8	Average Occupancy (maternity)	Mar-21	15%	26.39%	15%	22.16%		
E9	12+6 risk assessments	Dec-20	90%	86.96%	90%	87.47%		
E10	Number of deliveries	Mar-21	-	379	-	4598		-

Responsive - Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Feb-21	99%	73.79%	99%	71.53%		
R12	18 weeks RTT Incomplete Performance	Mar-21	92%	61.20%	92%	64.35%		
R13	18 Weeks over 52 week breaches	Mar-21	0	683	0	2484		
R14	Operations cancelled by hospital - on the day	Mar-21	0	5	0	110		
R15	Cancelled operations not rescheduled <28	Mar-21	0	0	0	26		
R16	Cancer 2ww performance	Feb-21	93%	98.45%	93%	96.64%		
R17	Cancer 2ww performance - breast symptomatic	Feb-21	93%	80.00%	93%	94.33%		
R18	Cancer 31 day first definitive treatment	Feb-21	96%	93.33%	96%	96.45%		
R19	Cancer 62 day treatment - GP referrals	Feb-21	85%	50.00%	85%	74.96%		
R20	104 day cancer waits	Feb-21	0	4	-	17		

Well Led			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	0	8	0		0	-	-
W2	CIP savings	£1,521k	£851k	£5,978k		£1,521k		
W3	Appraisal %	85%	80.76%	85%	84.35%	85%		
W4	Sickness Rate	4%	3.65%	4%	4.33%	4%		
W5	Turnover rate	12%	11.72%	12%	12.20%	12%		
W6	StatMan compliance	85%	88.80%	85%	88.69%	85%		
W7	Contractual staff in post	-	4172.69	-	49024.23	-	-	-
W8	Agency spend as % pay bill	4%	1.63%	4%	2.38%	4%		
W9	Bank spend as % pay bill	9%	6.64%	9%	13.47%	9%		
W10	Overall safe staffing fill rate							

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	Mar-21	0	51.00	0.00	131.92	268.79		
		MSA %	Mar-21	0%	0.30%	0.00%	0.90%	1.83%		
		% of EDNs Completed Within 24hrs	Mar-21	100%	67.06%	67.64%	73.16%	78.69%		
		Inpatients Friends & Family % Recommended	Mar-21	85%	81.96%	77.47%	84.39%	91.30%		
		Inpatients Friends & Family Response Rate	Mar-21	22%	17.80%	15.30%	20.06%	24.82%		
	ED Care	ED Friends & Family % Recommended	Mar-21	85%	85.95%	72.58%	79.80%	87.03%		
		ED Friends & Family Response Rate	Mar-21	22%	14.83%	12.22%	14.72%	17.22%		
	Maternity Care	Maternity Friends & Family % Recommended	Mar-21	85%	100.00%	97.60%	99.36%	100.00%		
		Maternity Friends & Family Response Rate	Mar-21	22%	15.96%	11.82%	26.41%	41.01%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Mar-21	85%	89.75%	87.49%	90.09%	92.68%		
		Outpatients Friends & Family Response Rate	Mar-21	22%	10.74%	11.39%	13.51%	15.63%		

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

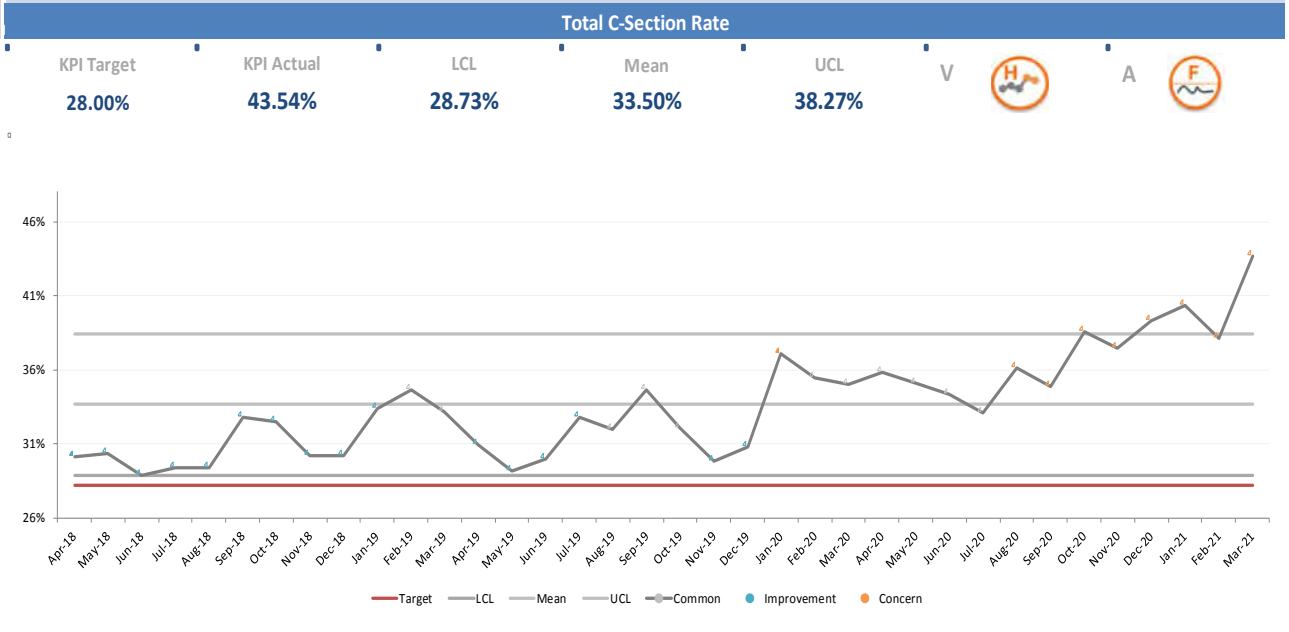
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	Feb-21	5%	6.80%	4.22%	5.88%	7.53%		
		30 Day Readmission Rate	Feb-21	10%	13.60%	9.38%	11.63%	13.86%		
		Discharges Before Noon	Mar-21	25%	14.26%	12.35%	14.91%	17.48%		
		Fractured NOF Within 36 Hours	Feb-21	100%	69.60%	34.85%	65.26%	95.67%		
		VTE Risk Assessment % Completed	Mar-21	95%	94.12%	77.66%	87.38%	97.10%		
	Maternity	Elective C-Section Rate	Mar-21	13%	17.15%	10.19%	13.58%	16.97%		
		Emergency C-Section Rate	Mar-21	15%	26.39%	15.20%	19.91%	24.61%		
		Total C-Section Rate	Mar-21	28%	43.54%	28.73%	33.50%	38.27%		
		12+6 Risk Assessment	Dec-20	90%	86.96%	78.67%	84.27%	89.87%		

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate



What changes have been implemented and improvements made?

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

What do the measures show?

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

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

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

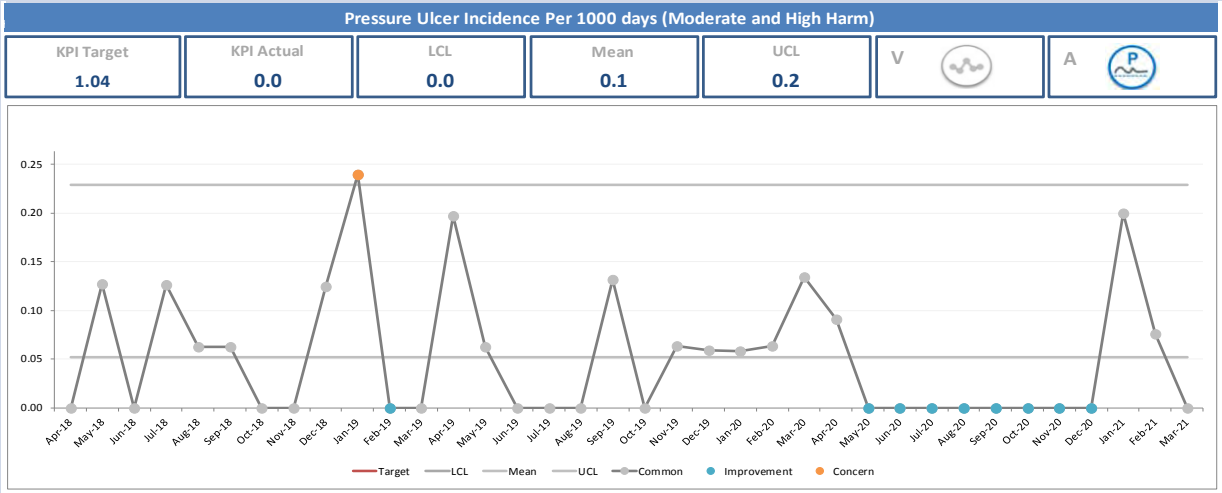
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Mar-21	6.63	5.13	2.95	4.78	6.62		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Mar-21	1.04	0.00	0.00	0.05	0.23		
	Incident Reporting	Never Events	Mar-21	0	0.00	0.00	0.14	0.90		
		No of SIs on STEIS	Mar-21	90	11.00	0.00	13.31	28.51		
		% of SIs Responded To In 60 Days	Mar-21	0%	100.00%	93.61%	98.43%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Mar-21	5	0.00	0.00	0.44	2.19		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Mar-21	43	0.00	0.00	2.46	8.13		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Mar-21	0	4.00	0.00	1.83	6.81		
		E-coli (Trust Acquired) Infections	Mar-21	30	5.00	0.00	4.39	10.54		
	Mortality	Crude Mortality Rate	Feb-21	3%	2.62%	0.47%	1.89%	3.30%		
		HSMR (All)	Dec-20	100	105.17	98.81	104.69	112.01		
		HSMR (Weekday)	Dec-20	100	103.09	95.84	101.83	110.96		
		HSMR (Weekend)	Dec-20	100	111.37	98.04	112.45	125.38		
		SHMI	Sep-20	1	1.07	0.79	1.01	1.23		

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

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

NHS Medway NHS Foundation Trust

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



What changes have been implemented and improvements made?

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

What do the outcome measures show?

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

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

What do the process measures show?

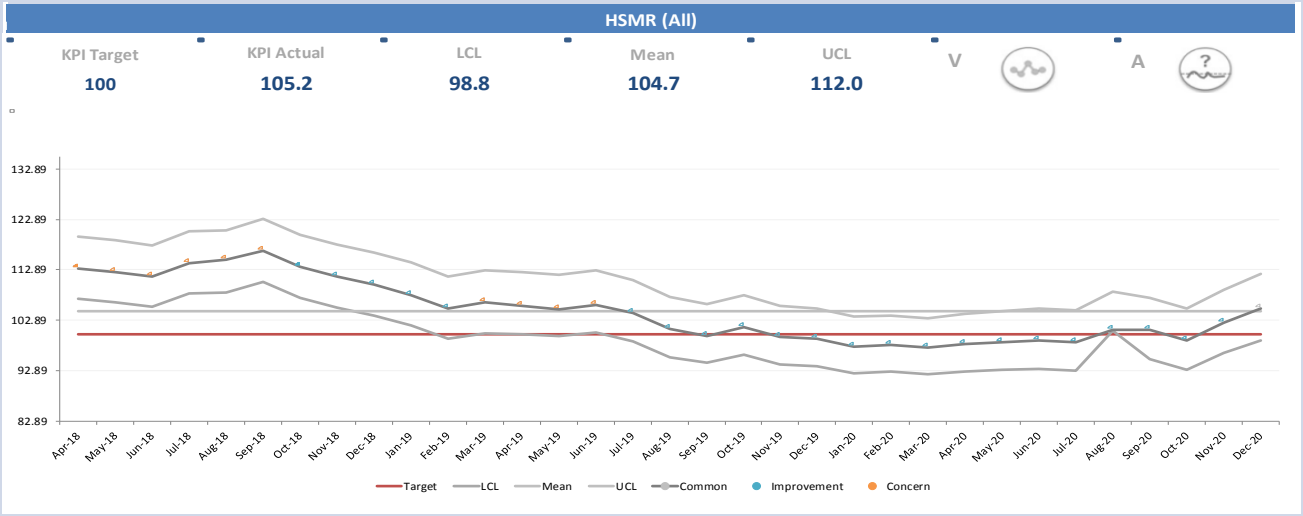
There has been a hospital acquired category 4 and unstageable which are currently being investigated as a SI.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Mortality - HSMR



What changes have been implemented and improvements made?

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

The difference between the mortality for Medway and Swale patients observed particularly at the weekend, but also to a lesser extent during the week is being investigated via a prospective audit from the Frailty and Acute Medicine teams. This audit will report initial findings to the September meeting of the Mortality and Morbidity Committee.

What do the measures show?

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

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

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Mar-21	85%	76.75%	80.64%	87.86%	95.08%		
		Average Elective Length of Stay	Mar-21	5	3.19	0.02	2.73	5.44		
		Average Non-Elective Length of Stay	Mar-21	5	8.50	7.34	8.50	9.66		
		% of Delayed Transfer of Care Point Prevalence in Month	Mar-21	4%	0.25%	0.31%	1.26%	2.21%		
		% Medically Fit For Discharge Point Prevalence in Month	Mar-21	7%	10.79%	13.87%	17.22%	20.57%		
	ED Access	ED 4 Hour Performance All Types	Mar-21	95%	84.65%	75.24%	82.54%	89.83%		
		ED 4 Hour Performance Type 1	Mar-21	95%	73.65%	63.30%	73.55%	83.81%		
		ED 12 hour DTA Breaches	Mar-21	0	0.00	0.00	21.92	78.54		
		60 Mins Ambulance Handover Delays	Mar-21	0	66.00	0.00	119.36	271.59		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

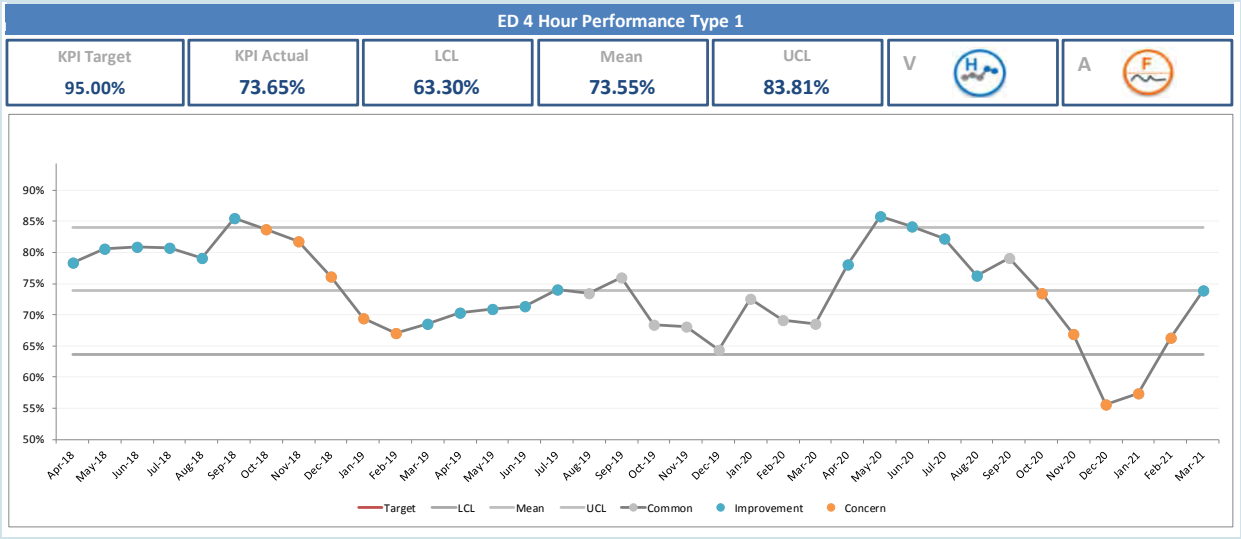
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Responsive - Elective	Diagnostic Access	DM01 Performance	Feb-21	99%	73.79%	76.91%	89.09%	100.00%		
	Elective Access	18 Weeks RTT Incomplete Performance	Feb-21	92%	61.53%	70.49%	76.56%	82.62%		
		18 Weeks RTT Over 52 Week Breaches	Feb-21	0	563.00	0.00	56.20	120.98		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Mar-21	0	5.00	0.00	20.25	47.76		
		Cancelled Operations Not Rescheduled < 28 days	Mar-21	0	0.00	0.00	4.44	12.42		
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	Feb-21	93%	98.45%	78.79%	89.23%	99.68%		
		Cancer 2ww Performance - Breast Symptomatic	Feb-21	93%	80.00%	51.48%	80.88%	100.00%		
		Cancer 31 Day First Treatment Performance	Feb-21	96%	93.33%	89.74%	96.22%	100.00%		
		Cancer 62 Day Treatment - GP Refs	Feb-21	85%	50.00%	60.12%	77.25%	94.38%		
		104 Day Cancer Waits	Feb-21	0	4.00	0.00	2.23	5.51		
	Complaints Management	Number of Complaints	Mar-21	41	42.00	18.95	59.31	99.66		
		% Complaints Responded to Within 30 Days	Mar-21	85%	54.29%	38.98%	67.95%	96.93%		

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

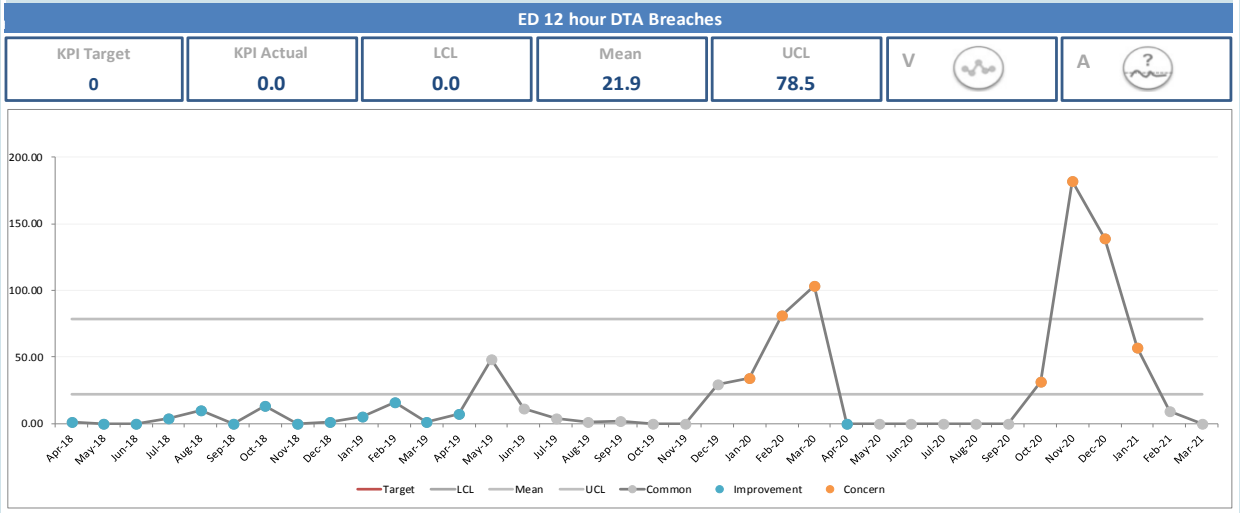
- Workforce gaps in acute medicine has meant increased LOS for referred patients. This wouldn't be a problem if we had Refer and Move capacity available on Lister. AAU capacity reduced by 50% in M9;
- Excess admitted and non-admitted breaches between 2100 – 0300.
- Ongoing issues with roles and responsibilities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

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- To reduce risks to patient safety, ED has increased the use of physical beds in the department for extended LOS patients;
- A MADE event was held in late December to reduce inpatient occupancy to reduce the risk of prolonged stay in ED;
- Engagement with ECIST support to align priorities and resourcing
- NHSI have reviewed our operational validation policy. Our nursing and governance team continue to improve the 12hr breach clinical review process;

Outcomes:

- Zero 12hr DTA breaches
- Reduction in total time in department to <150mins
- Improvement in patient outcomes

Underlying issues and risks:

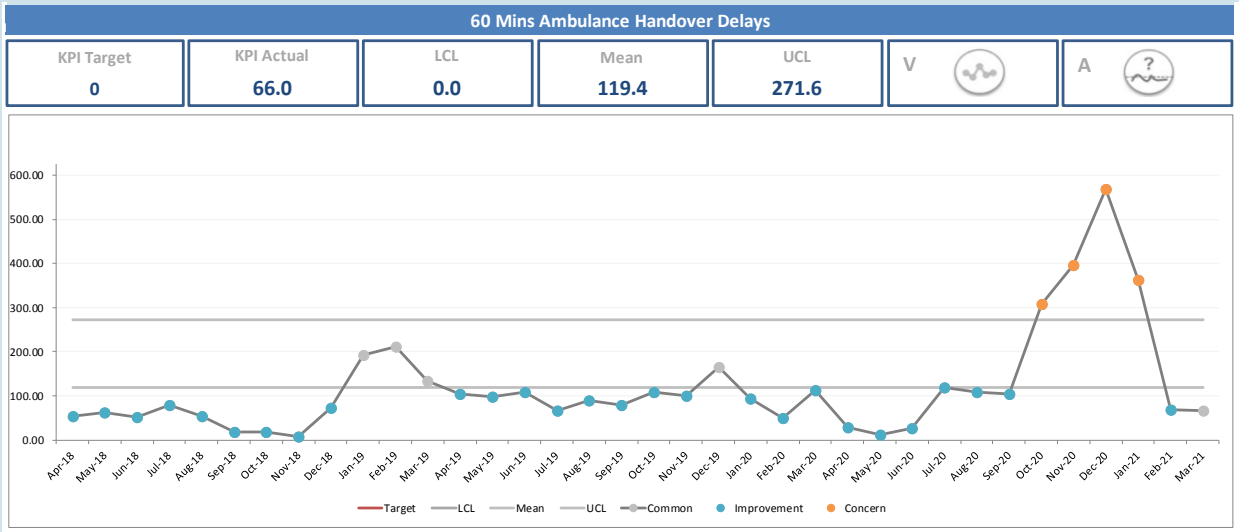
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Lack of refer and move assessment capacity due to COVID 19
- Gaps in Senior ED Leadership
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Validate each 60min handover delays
- SOP formalised to establish risk mitigated corridor care;
- Harm reviews on all patients
- 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;

Outcomes:

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

Underlying issues and risks:

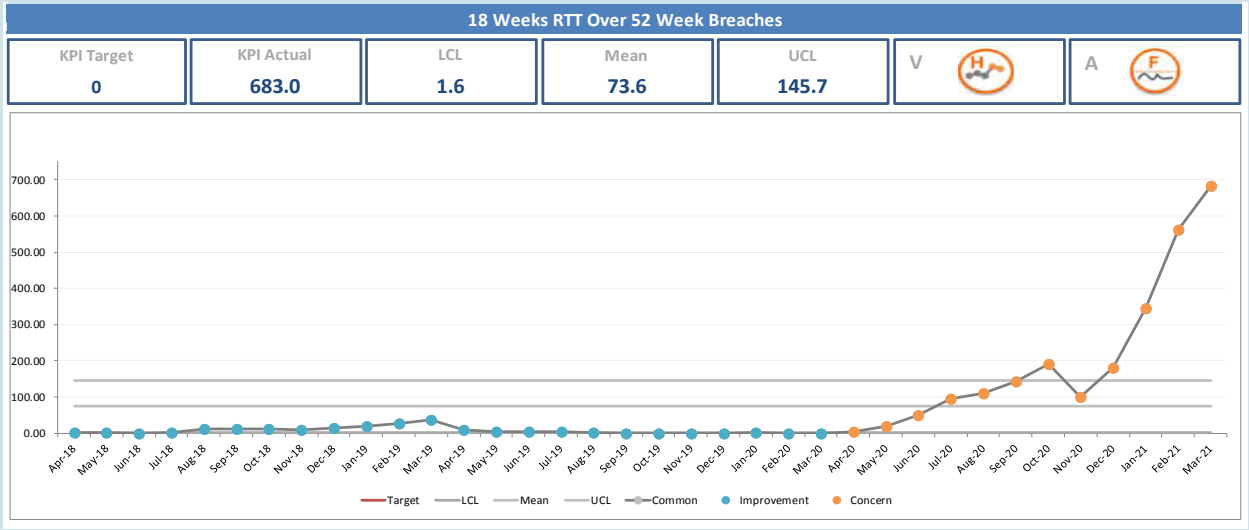
- Workforce mismatch demand
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Gaps in Senior ED Leadership

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Restart 2 being developed with go live from 22nd March
- Demand and capacity models being worked on to include recovery
- Harm reviews on all patients over 52 weeks
- Full PTL validation

Outcomes:

- 0 x 52 week by August 2021
- Clarity on patients and treatment in accordance with clinical priority
- Established green pathways

Underlying issues and risks:

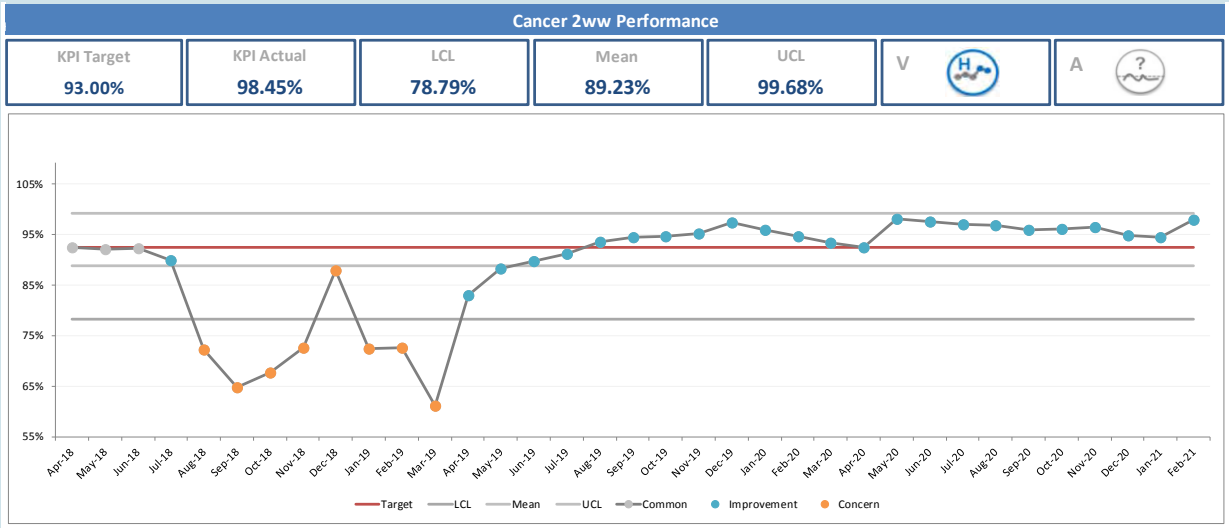
- Workforce issues - Leave accumulation and vacancy
- Uncertainty on NEL and associated impacts
- End of national contracts and financial impacts

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

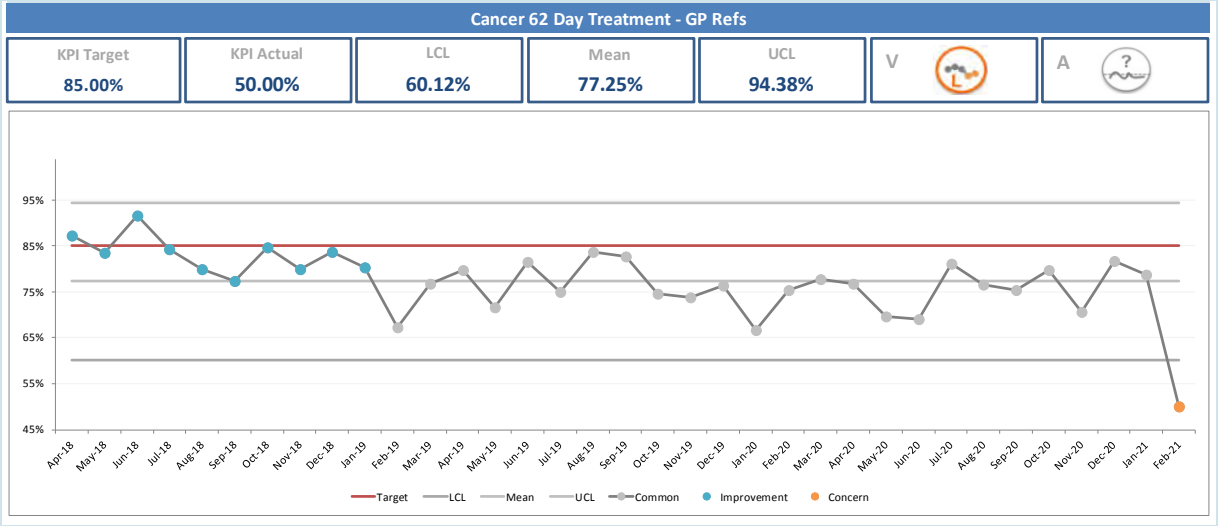
- Internal Stretch target of 7 Days is now being achieved by 2 services Urology & H&N
- 7/9 Services booking at day 14 or under.
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic Capacity could challenged as the trust pushes ahead with restart.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Weekly PTL chaired by Cancer GM and supported by tumour site service managers, now attended by MDT coordinator, Navigator and tracker to ensure detailed feedback provided.
- Weekly PTL now highlights potential Cancers earlier to promote referral to tertiary centre before day 38 also added 38 Day IPT target on MDT list allowing the service to work more towards delivery of this target.
- Full time support for LGI MDTC has begun to support PTL.
- Cancer Pathway Manager working with challenged tumour sites to ensure patients tracked and progressed along pathway in timely fashion.

Outcomes:

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

Underlying issues and risks:

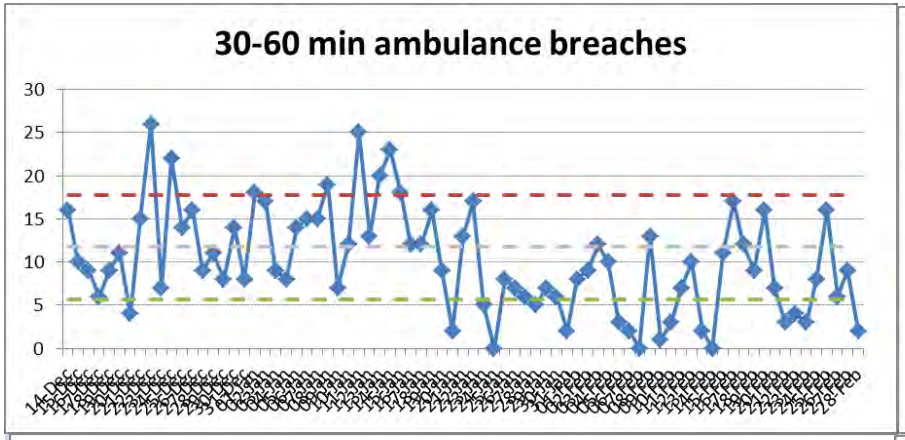
- Inappropriate prioritisation – Increase in 2ww referrals
- Services currently competing for limited HDU capacity.
- Patient engagement is causing some issues as patients are worried and at times reluctant to attend for diagnostics or treatment.
- Post 2nd wave peak influx of referrals could overwhelm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

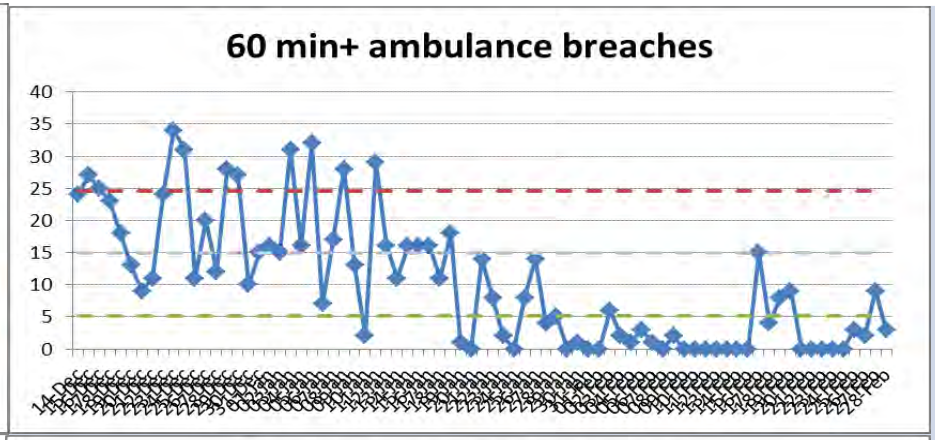
Safe: Operational flow
Aim: TBC
Latest Period: Jan/Feb-21

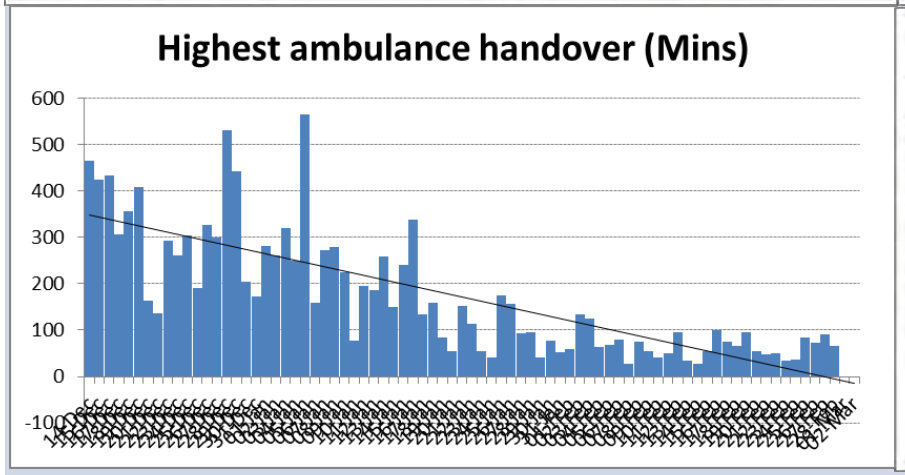
Executive Lead: All
Operational Lead: All
Sub Groups: Quality Assurance Committee

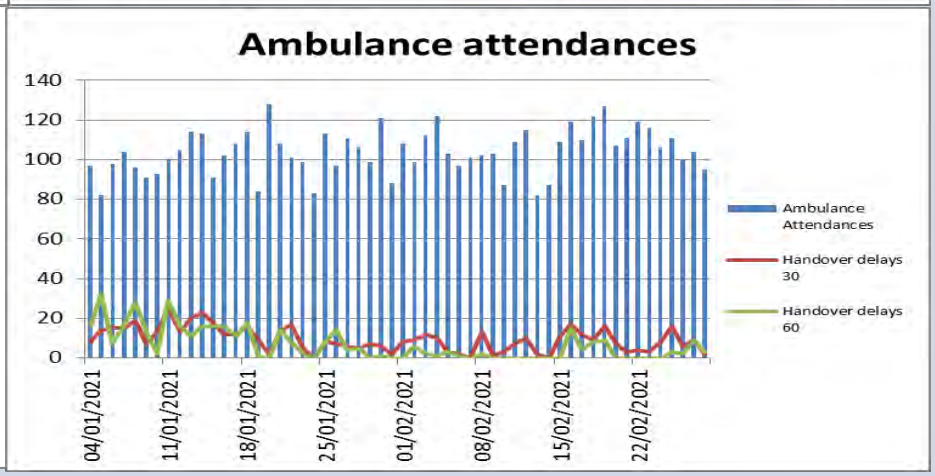
NHS Medway NHS Foundation Trust

Outcome Measure:









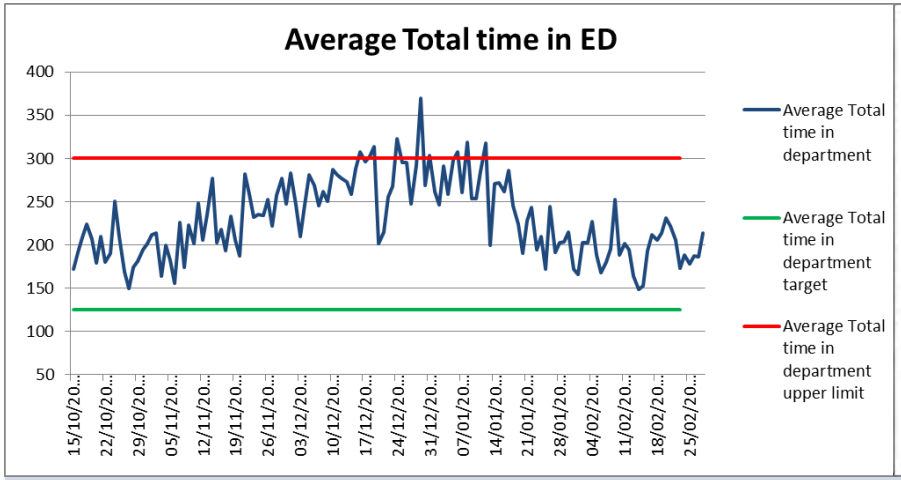
Ambulance handover delays have decreased overall however we continue to see sporadic days of 60min handover delays.

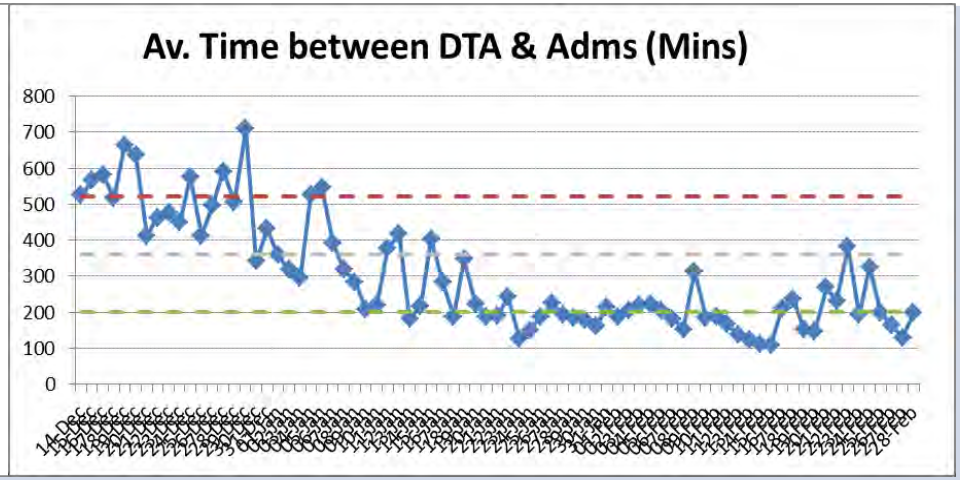
Safe: Operational flow
Aim: TBC
Latest Period: Jan/Feb-21

Executive Lead: All
Operational Lead: All
Sub Groups:

NHS Medway NHS Foundation Trust

Outcome Measure:





Average total time in department continues to reduce and the trust had an average total time wait of 150mins twice in February – the first time since October 2020. Despite an increase in bed occupancy and reduction of beds there has not been a significant sustained increase in total time.

Average time between DTA and admission increased over 3 consecutive days last week, directly related to a change in admission conversion rates and an increase in bed occupancy. This change is being monitored daily at a care group and divisional level.

Domain: Well Led – Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-21	62%	63.00%	1.62%	26.99%	52.36%		
		Staff Friends & Family - Recommend Care of Treatment	Mar-21	79%	74.00%	3.91%	35.70%	67.49%		
	Workforce	Appraisal % (Current Reporting Month)	Mar-21	85%	80.76%	79.94%	85.06%	90.18%		
		Sickness Rate (Current Reporting Month, FTE%)	Mar-21	4%	3.65%	3.34%	4.46%	5.58%		
		Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Mar-21	12%	11.72%	10.92%	12.06%	13.19%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Mar-21	0	4172.69	3810.59	3910.99	4011.39	•	•
		StatMan Compliance (Current Reporting Month)	Mar-21	85%	88.80%	65.71%	80.15%	94.58%		
		Agency Spend as % Paybill (Current Reporting Month)	Mar-21	4%	1.63%	1.96%	3.63%	5.31%		
		Bank Spend as % Paybill (Current Reporting Month)	Mar-21	9%	6.64%	8.10%	12.94%	17.79%		
		Temp Staffing Fill Rate - Nurse & Midwifery (Current Reporting Month)	Mar-21	75%	60.08%	59.08%	71.35%	83.62%		

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month NHSE/I Baseline	In-month Actual	In-month Variance	YTD NHSE/I Baseline	YTD Actual	YTD Variance
Income	29,798	41,072	11,274	351,587	371,527	19,940
Pay	(19,173)	(24,445)	(5,272)	(224,835)	(235,805)	(10,969)
Total non-pay	(9,252)	(13,993)	(4,742)	(110,487)	(118,831)	(8,344)
Non-operating expense	(1,374)	(1,319)	54	(16,264)	(15,680)	585
Reported surplus/(deficit)	**(0)**	**1,315**	**1,315**	**(0)**	**1,211**	**1,211**
Donated Asset / DHSC Stock Adj.	0	(1,300)	(1,300)	0	(1,196)	(1,196)
Control total	**(0)**	**15**	**15**	**(0)**	**15**	**15**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	2,122	807	(1,315)	12,000	8,813	(3,187)	12,000
Capital	(7,853)	(12,783)	(4,930)	(32,828)	(32,511)	317	(32,828)

Indicator Background:

The Trust reports a £15k surplus position for the year; after making the required adjustments for donated asset income and depreciation, as well as Covid stock issued by DHSC during the year.

What the Chart is Telling Us:

The Trust has achieved its control total and reported a small surplus of £15k for the year. CIP is £8.8m and adverse to plan due to the pressures from Covid-19 hindering scheme delivery. The final capital spend recovered and finalised at £0.3m underspent to the £32.8m plan.

Actions:

- Draft Business Plans for 2021/22 have been submitted, ensuring establishments, budgets, activity and cost pressures are identified.
- The Executive Team will review all cost pressures and service developments to agree those that can proceed.
- CIP development with focus now on schemes for 2021/22.

Outcomes:

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

- Incremental costs associated with Covid-19 of £18.3m for the year. This is within the £18.4m level of funding from the STP and NHSE/I.
- The Trust's annual leave carry forward accrual in £2.9m and covered by additional income of the same level.
- The cost the Well-being day offered to all staff has been accrued £0.8m.

Underlying issues and risks:

Pay costs remain adverse to budget due to cost pressures and unfunded posts. These have been included in the draft budget plans for 2021/22. Overall pay costs remain high compared to budget and above the 21/22 half year income allocation. Further scrutiny of these plans continues across all services.

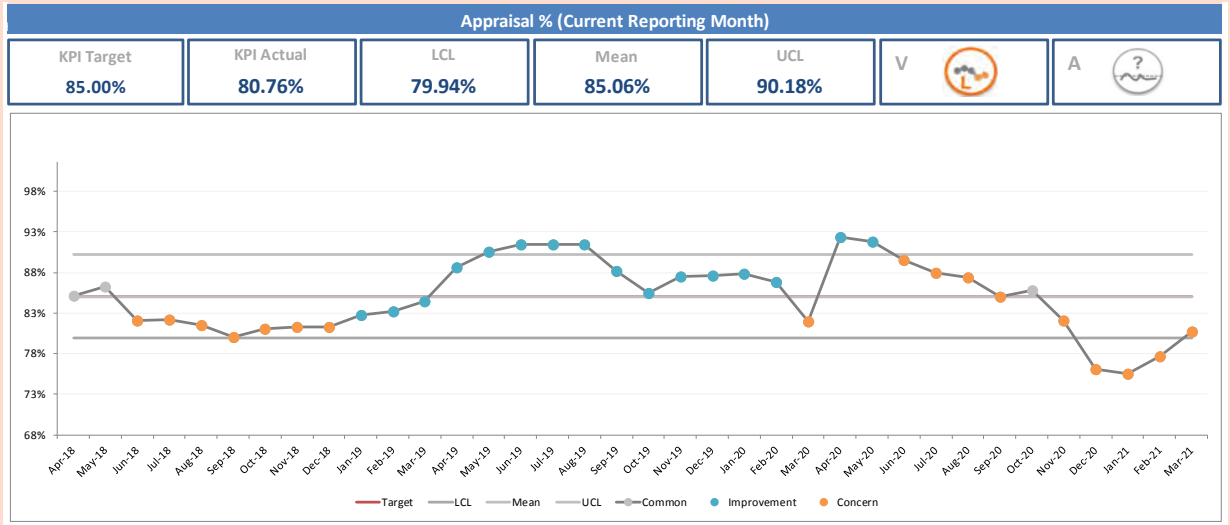
Reduced levels of Covid activity have reduced costs significantly as expected. Further planning of covid costs during phase 4 & 5 is currently happening with input fro the divisions.

Well Led: Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

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

Meeting of the Public Board
Thursday, 06 May 2021

Title of Report	**Infection Prevention and Control (IPC) progress update against the IPC Improvement plan**	Agenda Item	**4.3**
Lead Director	Jane Murkin, Chief Nursing and Quality Officer – Director of Infection Prevention and Control		
Report Author	Liam Edwards, Deputy Chief Nurse		
Executive Summary	Effective infection prevention and control is fundamental to the delivery of high quality, safe and effective patient care. Following the IPC visit by the National Team on 26 November 2020 the Chief Nursing and Quality Officer produced an action plan setting out the key actions to address the following three areas aimed at reducing hospital acquired infections: Leadership and Governance, Prevention of Transmission and Prevention of Infection. The Trust's previous IPC Improvement Plan has been reviewed in light of the visit and refreshed to incorporate the actions from the national team visit setting out short, medium and long term goals. The improvement plan also incorporates actions relating to gaps identified from the updated Infection Prevention and Control (IPC) Board Assurance Framework (BAF). The IPC Improvement Plan directly references the 10 criteria set out in the code of practice on the prevention and control of infection which links to Regulation 12 of the Health and Social Care act 2008 (regulated activities) Regulations 2014. These criteria are: 1) Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. 2) Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. 3) Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. 4) Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion. 5) Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. 6) Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. 7) Provide or secure adequate isolation facilities.		

	8) Secure adequate access to laboratory support as appropriate. 9) Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections. 10) Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection. Since the National IPC Team visit on 26 November 2020 significant progress has been made to address the issues identified and related actions with infection prevention and control (IPC) remaining a high priority. COVID-19 inpatient levels are now at the lowest for 12 months and the Trust continues to monitor other Healthcare Acquired Infections (HCAI). Recruitment within the IPC team remains a priority to provide the infrastructure required and sustainable changes within Medway NHS Foundation Trust.
Due Diligence	Information contained within this report has also been reported through the Infection Prevention and Control Committee (IPCC), Executive Team, QAC and Council of Governors
Executive Group Approval:	
National Guidelines compliance:	
Resource Implications	None
Legal Implications/ Regulatory Requirements	There are legal implications relating to the Health and Social Care Act 2008
QIA	NA
Recommendation/ Actions required	The Board is asked to NOTE progress to date in the IPC Improvement plan

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

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

Infection Prevention and Control update

COVID-19 inpatient levels have declined steadily for the preceding month with the lowest reported figures in 12 months.

The Trust has recruited substantively into the Matron and Data Analyst roles, and an interim appointment into the Assistant Director of IPC role for six months. In addition a second matron position has been included for three months in light of the substantive appointment not commencing until June 2021. Recruitment is ongoing for the Assistant Director of IPC role.

High level progress on the IPC improvement plan includes:

- A reduction in the number of outbreaks and effective outbreak management in place with a daily outbreak meetings and external attendance.
- Facilitated two divisional forums focused on reflecting on lessons and learning from the COVID- 19 pandemic to improve IPC practice.
- Amalgamation of Covid policies into one central document to be approved by DIPC prior to dissemination.
- Minimum monthly IPC DIPC message to all staff with key messages and updates relating to IPC.
- Audit of IPC practices within the Trust completed by Head of Infection Prevention and Control.
- NHS Kent and Medway CCG. Report currently being finalised for presentation
- FFP3 mask fitting now held centrally on ESR and Healthroster where appropriate.
- Review of hand hygiene tool to indicate profession, enabling targeted improvement work to be undertaken
- Review of current Red pathway areas, now limited to McCullouch ward for AGP and two bays if required on Sapphire ward for non-AGP COVID-19 patients only.
- Roll out of maximum occupancy in room signage across the Trust.
- Embedding of COVID-19 swab timelines following divisional audits of compliance.

Healthcare Acquired Infections other than COVID-19 continue to be monitored with focused efforts focused on reducing Clostridium Difficile with briefings advising on best practice guidance.
A series of Planned Unannounced IPC inspections were performed on the 30 and 31 March 2021 in 10 areas and will be reported to the Infection Prevention and Control Committee in May 2021.

NHSEI senior IPC support was concluded in March with Esther Taborn returning to her national IPC role although additional support for one day a week from CCG.
The Chief Nursing and Quality Officers Award scheme continues to highlight examples of best practice and days between infections, pressure ulcers and Falls.

Recently week the Chief Nursing and Quality Officer awarded two Gold Stars to two wards for more 150 days since their last healthcare acquired infection.

A national IPC visit occurred on the 23 April 2021 with improvements and positive progress noted by the national IPC Team, an official report will be forthcoming although there were no immediate concerns identified.

Meeting of the Board of Directors in Public
Date: Thursday, 06 May 2021

Title of Report	**Midwifery Establishment Review**	Agenda Item	**4.4**
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Report Author	Dot Smith, Head of Midwifery		
Executive Summary	This paper was presented to the executive committee on 21 April 2021 by the Chief Nursing and Quality Officer. The Executive group approved the post of Director of Midwifery and 13 WTE midwifery posts in response the continuity of carer Birthrate Plus review, acknowledging the funding stream is to be confirmed. In addition the Executive group noted the request for the Birthrate Plus essential leadership and specialist roles and have requested further risk scoring before review and approval at the next executive group meeting. Safe staffing is cited as the main factor which affects quality, patient safety and outcomes for mothers and babies in maternity services, referenced by national policy documents and recommendations from published reports and reviews from the Department of Health (2016), Kirkup (2016), Betterbirths (2016) and the Ockenden Report (2020). The recent and ongoing scrutiny on maternity services identifies patient safety as the essential golden thread which runs through the maternity service and an expectation that service leaders respond to the recommendations of Birthrate plus. The priority is to deliver the highest standards of care for women and their families ensuring the right number of appropriately trained staff are available to deliver safe, effective and person centred care for women and their babies and therefore reduce risks of harm, poor outcomes an impact on morbidity and mortality rates. This paper requests support for additional funding to increase the midwifery establishment, and provides a PID for the Director of Midwifery Role previously presented to the Executive Board by the Chief Nursing and Quality Officer. This is underpinned by the RCM manifesto and the Chief Nursing and Quality Officer's ambition to strengthen the nursing and midwifery leadership at the Trust and will ensure compliance with: • Ockenden NHS England Maternity report (2020) • RCM approved Birth rate Plus workforce tool (2020) • RCM strengthening leadership manifesto (2019) • NHS England recommendations Better Births (2016) • NICE Workforce standards (2015) • Nursing and midwifery council (NMC) safe staffing levels • Care Quality Commission (CQC) regulations. • NHSR CNST Maternity Incentive Scheme Year 3 This paper provides evidence in support of the additional funding which is required to support: • Birthrate Plus® - Continuity of carer recommendations of 13 WTE (Better Births,		

	2016) - £572,177 • Birthrate Plus® - Strengthen the midwifery leadership and specialist roles to support complex pathways and transformation by 8 WTE (Ockenden 2020) - £441,270 • Director of Midwifery 1WTE (RCM Manifesto 2019) - £96033 • The total additional fund requested is therefore £1,109,480
Committees or Groups at which the paper has been submitted	PID for the Director of Midwifery Role, previously presented to the Executive Board by the Chief Nursing and Quality Officer
Resource Implications	Financial impact referenced within the paper
Legal Implications/ Regulatory Requirements	Potential medicolegal and quality implications due to unsafe levels of staffing
Quality Impact Assessment	N/A
Recommendation/ Actions required	The Board is asked to review and approve the recommendation in response to Birth rate Plus and to sign off the PID for the new post of Director of Midwifery role which has been previously approved, to strengthen Midwifery leadership.

Approval	Assurance	Discussion	Noting
☒	☐	☐	☒

1. Executive Summary / Background

Safe staffing is cited as the main factor which affects quality, patient safety and outcomes for mothers and babies in maternity services and is referenced by national policy documents and recommendations from published reports and reviews from the DH (2016),Kirkup (2016), Betterbirths (2016) and Ockenden (2020).

The recent and ongoing scrutiny on maternity services identifies patient safety as the essential golden thread which runs through the maternity service and an expectation that service leaders respond to the recommendations of Birthrate plus.

The priority is to deliver the highest standards of care for women and their families ensuring the right number of appropriately trained staff are available to deliver safe, effective and person centred care for women and their babies and therefore reduce risks of harm, poor outcomes an impact on morbidity and mortality rates.

Over the past year 2020/21 the Chief Nursing and Quality Officer, has taken a strategic approach to prioritise and focus on strengthening nursing and midwifery leadership at the Trust. This work has included investing heavily in the development of senior nursing and midwifery leaders, which has been financially supported both by the Trust and NHSE/I. This work has been well received and has included reviewing roles, responsibilities and job descriptions of senior nursing and midwifery

leaders including a refreshed job description for the Matron which has been implemented aligned to the national profile.

2. Strategic Context

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families.
Central to this has been the overarching national policy published in 2016 Better births, which highlighted the following vision:

- "For maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances. And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

Critical to delivering this is the safe, sustainable and productive staffing of maternity services and this paper requests support for additional funding to increase the midwifery establishment following the review of safe staffing by Birth rate plus.

It also includes the PID for the new Director of Midwifery role previously presented to the Executive Team in March 2021 by the Chief Nursing and Quality Officer and approved in principle. This is underpinned by the RCM manifesto and the Chief Nursing and Quality Officer's ambition to continue to strengthen nursing and midwifery leadership.

This is to ensure compliance with:

- Ockenden NHS England Maternity report (2020)
- RCM approved Birth rate Plus workforce tool (2020)
- RCM strengthening leadership manifesto (2019)
- NHS England recommendations Better Births (2016)
- NICE Workforce standards (2015)
- Nursing and midwifery council (NMC) safe staffing levels
- Care Quality Commission (CQC) regulations.
- NHSR CNST Maternity Incentive Scheme Year 3

This paper provides evidence to support the additional funding requested including any risks associated with not investing which has been broken down into 3 essential areas underpinning the national midwifery agenda:

- Continuity of Carer - Birthrate Plus®: This is a national policy document which provides maternity units recommendations for safe staffing to support delivery of safe and effective midwifery care. Key to the success of implementing the "Continuity of carer" model as recommended by the policy document, Birth rate plus is the appropriate number of midwives to respond to the increased ratio of 1:35 of midwife to women per continuity team. This is a recommended ratio compared to the current traditional model of 1:96 in community teams. The Birth rate plus workforce review undertaken for Medway recommends an additional 13.0 WTE at a cost of £572,177 to ensure compliance with the above measures.

- Essential Midwifery leadership specialist roles - Birthrate Plus®: The 2020 Medway NHS Foundation Trust Birth rate plus review recommends strengthening the midwifery leadership and investing in specialist roles to support complex pathways and transformation. The recommendation is for 8.0 WTE at a cost of £441,270.

- Strengthening Midwifery leadership – RCM Manifesto: Director of Midwifery 1.0 WTE at a cost of £96.033. Currently Medway Foundation Trust is the only maternity provider in Kent

and Medway's Local Maternity System (LMS) which does not have a Director of Midwifery positon when benchmarked against peers in all eleven provider sites on the SE Coast. (Appendix 1: PID document)

The above 3 funding streams will ensure that Medway has safe and sustainable staffing levels in line with local and national recommendations.
The Executive group approved the post of Director of Midwifery and 13 WTE midwifery posts in response the continuity of carer Birthrate Plus review on 21st April 2021, acknowledging that and the funding stream is yet to be confirmed. In addition the Executive Board have noted the request for the Birthrate Plus essential leadership and specialist roles and have requested further risk scoring to be undertaken before further approval by the Executive Team.

3. What is the risk of not investing?

The cost to the NHS of getting maternity care wrong can be severe, not only in terms of the damage that can be done to lives of women and their babies, or loss of life, but also it can have a significant financially impact on the Trust. Clinical negligence claims relating to obstetrics represented only 10 per cent of the volume of claims received in 2018/19 but accounted for half of their total value.
The risk of not investing into the maternity workforce establishment will result in:

- Noncompliance to Better Births, continuity of carer
- Noncompliance to CNST MIS safety actions 5 and 9 (Loss of £650,000 incentive moneys)
- Noncompliance to Ockenden IEA's
- CQC deteriorating from Good/Outstanding to Requires Improvement in the safe and Well led domain.
- Loss of reputation.

In context, the risk of not investing in the:-
Continuity of Carer - Birth rate Plus: - Unable to deliver the 35 % and subsequent 51% continuity of carer model for the women of Medway and Swale. This puts CNST compliance at risk therefore losing £650,000 CNST incentive and loss of reputation due to deteriorated CQC position in the Safe and Well Led domains.
Essential Midwifery leadership specialist roles, Birthrate Plus: Medway will be non-compliant for Ockenden IEA and CNST safety action 5, 6, 8 and 9 again risking the CNST incentive money with further risk to CQC ratings and external scrutiny by NHSE I.
Strengthening Midwifery leadership – RCM Manifesto: The Trust now has an opportunity to create a senior midwifery leadership role as a Director of Midwifery which will send a strong message on the importance and value the Trust places on maternity services. This is against the backdrop of an increasing national level of scrutiny on Maternity services following the Ockenden report, which shared the emerging findings and recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trusts, published in December 2020 and the review into maternity services at East Kent Hospital Trust.

Role and Brief role description	Risk to not investing
Consultant Midwife – Responsible for significantly moving forward professional standards in relation to practice development and education. To provide transformational leadership to ensure focused woman centred care and a maternity service which is fit for the future.	No senior leadership to support the HEE ambition to increase the student intake in support of sustainable next generation midwifery. Lack of support for delivering the strategic priorities e.g. Ockenden IEA's and CNST aligned to staff development and training.
Matron – The Fetal Medicine matron is responsible for leading and developing Fetal	No Matron to provide assurance on the development of the fetal and maternal

and Maternal Medicine (Ockenden – complex pathways). Adhering to the Nursing and Midwifery priorities this role will ensure standards of IPC and patient safety are maintained in the outpatient setting.	medicine centre to a high standard in response to Ockenden and developing complex maternal pathways. Unable to proceed to a level 2 fetal medicine commissioning which will be a missed opportunity to raise the profile for Medway Foundation Trust as a centre of excellence with the associated income.
Digital Midwife – Intrinsic to the delivery of the digital agenda aligned to transformation as per Better Births 2016 and CNST MIS	No focused clinical involvement to support the building of maternity systems to meet the requirement for MSDS and data viability for saving babies lives and continuity of carer. Noncompliance to CNST MIS
Bereavement Midwife –Provides focused support across the bereavement pathway and responds to Ockenden regarding women not being listened to following pregnancy loss.	Not to expand the bereavement team increases limitations on the team's efficacy to safely manage the growing complex needs for families experiencing pregnancy loss. Increased risk of SI's HATARI and complaints. Loss of reputation due to perceived lack of compassion by the public.
Diabetes Midwife – To enhance the current service and meet the increasing caseload in response to Ockenden complex pathways. High standards of diabetic care significantly reduced the risk of maternal and neonatal morbidity and mortality.	Not to expand the diabetes team to meet the needs of this growing complex pathway will increase the risk to maternal and neonatal resulting in increased length of stay NICU admissions and morbidity and mortality. Noncompliance to Ockenden IEA
Governance Midwife - To provide a full cycle of learning through incidents, complaints audit and training to underpin the development of robust systems to ensure sustainable patient safety.	Unable to provide assurance of an embedded programme of audit and learning from SI's and Complaints. No ability to check compliance with clinical guidelines, imbedding of safety actions which are sustainable. Risk to Ockenden IEA's compliance and CQC rating
Screening Midwife - To provide fail safe and support for increasing antenatal new born screening programme.	Unable to ensure sustainable failsafe to support compliance with national KPI's. Unable to future proof current staffing with succession planning for a business critical post. Increased number of SIAF's and poor quality assurance
Fetal Wellbeing Midwife – Business critical in response to Ockenden Immediate and Essential Action 6 (IEA) and CNST Safety Action 6 and 8. This role was funded by the LMS however this ceased 31/03/2021.	Limited ability to deliver annual MDT CTG training therefore failed compliance to Ockenden IEA's, CNST and deterioration to CQC rating.
CNST Compliance Manager – To enable sustainable CNST governance and reporting	Inability to maintain timely audit, archiving and reporting on the 10 safety actions

integral to our CNST MIS evidence submission.	therefor loss of CNST incentive money and inability to provide assurance to CQC on safety in maternity at Medway Foundation trust.

Further Risk scoring will be undertaken by the Head of Midwifery, as requested by the Executive Group and will be presented by the Chief Nursing and Quality Officer at the next meeting of the executive group prior to approval of funding.

4. Why is the investment required now?

A review of the midwifery establishment was not included in the Safe Nurse Staffing Establishment Review presented to the Executive Group and approved by the Trust Board in July 2020. This is because the nursing model for safe staffing is not comparable. The midwifery establishment covers both hospital and community settings and supporting caseloads in the provision of ongoing midwifery risk assessment and care throughout the midwifery continuum.

The Ockenden paper (December 2020) outlines that appropriate staffing levels and skill mix positively influences midwifery outcomes, whereas poor midwifery staffing levels are attributable to increases in maternal and neonatal morbidity and mortality resulting in increased length of stay and incurring financial costs and litigation.

The release of the Ockenden paper has enabled a focussed piece of work to identify our current gaps at Medway Foundation Trust. Our biggest area of risk is not meeting the staffing requirements set out nationally and locally. Reports into Mid Staffordshire, Morecombe Bay, and Shrewsbury and Telford all cite staffing as a leading factor and common theme influencing how safe a service is. These reports identify staffing which were inadequate in number and without the appropriate skills and competency to provide safe care. To show that we are responsive to these findings it is important our staffing levels are regularly reviewed and reported at Board level.

Birthrate Plus is the recognised staffing tool used to focus on the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour. This standard is set as the bench mark for safe care by CQC, CNST and Kirkup report (2016) and most recently Ockenden (2020). Previous Birthrate plus reviews have focused on the traditional midwifery model however in October 2020 the methodology included the provision of continuity of carer as set out in Better Births (2016) and CNST Safety Action 5. Birthrate plus also reviews the essential leadership and specialist roles establishment which is set as 9% of the establishment and this standard is again factored into the CNST technical guidance for safety action 5 and the RCM manifesto for better midwifery care (2019). A review undertaken in 2021 showed Medway to be an outlier due to lack of a Director of Midwifery in the current structure. In response to this regional review a PID has been written (Appendix 1: PID document) to articulate the need for additional funding.

5. Continuity of Carer - Birthrate Plus:

In the traditional model the ratio of midwife to mother is 1:96 however the recommended caseload for continuity of carer as described in “Better Births 2016” is 1:35. The staffing requirements for continuity of carer identify a shortfall of 13 WTE clinical midwives (6.4% establishment increase) as set out below:

BR + Continuity Carer			
Midwife	Band 6	11.70	£538,635
Midwifery Support Worker	Band 3	1.30	£33,541
TOTAL		13.00	£572,177
% establishment increase		*6.4%*	

One key finding of the Better Births 2016 review and subsequent recommendation was the need for most women to receive continuity of carer (CoC), to ensure safe care based on a relationship of mutual trust and respect in line with the woman's choices and decisions. Better Births recommends that "every woman should have a midwife, who is part of a small team of up to 8 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally".

The Better Birth report (2016) recommended that 51% of women should be offered continuity of carer by 2021 however timescales have been pushed back due to the impact of COVID19. It is likely that 100% of women will be required to be offered a CoC pathway by 2022 (NHS England 2020). The anticipated clinical benefits to mother and baby include:

- 19% less likely to lose their baby before 24 weeks
- 16% less likely to lose their baby
- 24% less likely to experience pre term birth
- 15% less likely to have regional analgesia

It is important that as a Trust, we demonstrate the highest standards and adhere to evidence based practice; creating a culture of both clinical excellence and compassionate care for women and staff. To ensure we are able to provide Continuity of Carer and deliver on all elements of the transformation plan, the traditional model of care that we currently offer needs to undergo wide scale change in order to reduce the caseloads for midwives to provide intrapartum care. This requires significant financial support and midwifery staffing uplift.

6. Essential leadership and specialist roles - Birthrate Plus

The cost to the NHS of getting maternity care wrong can be severe, not only in terms of the damage that can be done to lives of women and their babies, or loss of life, but also have a significant financially impact on the Trust. Clinical negligence claims relating to obstetrics represented only 10 per cent of the volume of claims received in 2018/19 but accounted for half of their total value.

The 2020 local Birth rate plus review recommends strengthening the midwifery leadership and investing in specialist roles to support complex pathways and transformation. The recommendation is for 8.0 WTE at a cost of £441,270 (4.0% establishment increase) as set out below:

BR + Midwifery leadership and Speciality Roles			
Consultant Midwife	Band 8b	1.00	£69,571
Matron	Band 8a	1.00	£67,326
Digital Midwife	Band 7	1.00	£53,501
Bereavement	Band 6	0.60	£25,863
Diabetes	Band 7	0.40	£21,401
Governance	Band 7	1.00	£53,501
Screening	Band 6	1.00	£43,106
Fetal Wellbeing Midwife	Band 7	1.00	£53,501
CNST Compliance Manager	Band 7	1.00	£53,501
TOTAL		8.00	£441,270
% establishment increase		*4.0%*	

7. Strengthening Midwifery leadership – RCM Manifesto

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

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

The PID is attached for the Director of Midwifery Role previously presented to the Executive Team in March 2021 by the Chief Nursing and Quality Officer and approved in principle. This is underpinned by the RCM manifesto and the Chief Nursing and Quality Officer's ambition to continue to strengthen nursing and midwifery leadership.

The Director of Midwifery requires additional funding of £96.033 as set out below:

Birthrate Plus (BR+)

Director of Midwifery	Band 8d	1.00	£96,033
% establishment increase		*0.5%*	

8. Recommendations

The recommendations set out below were presented to the Executive group by the Chief Nursing and Quality Officer on 21 April 2021.

The Executive group approved the post of Director of Midwifery and 13 WTE midwifery posts in response the continuity of carer Birthrate Plus review, acknowledging the funding stream is yet to be confirmed.

The Executive group requested further risk scoring be undertaken to the additional midwifery leadership specialist roles and for this to be presented to the Executive group at a future meeting.

In light of the ongoing and increasing scrutiny for maternity service it is essential that Medway Foundation trust is in a position to deliver the highest standards of care for women and their families ensuring the right number of appropriately trained staff are available to deliver safe, effective and person centred care for women and their babies. The Trust also needs to demonstrate compliance on the national maternity safety agenda and policy context ensuring that the Ockenden IEA's are progressed.

To enable this recommended next step actions are:

- The executive team are asked to review and support this paper with agreement to provide the financial investment to support safe staffing and the recommendations from Birth rate plus, which will support the delivery of high quality, safe and effective care to mothers and babies, with sustainable staffing.

- These critical roles should be considered in the following order.

I. Director of Midwifery 1WTE (RCM Manifesto 2019) - £96033
II. Birthrate Plus - Continuity of carer recommendations of 13 WTE (Better Births, 2016).- £572,177
III. Birthrate Plus - Strengthen the midwifery leadership and specialist roles to support complex pathways and transformation 8 WTE (Ockenden 2020) -£441,270

- The total additional investment requested is £1,109,480 therefore the opportunity to apply a phased approach should be considered.

- For the Board to review and sign off the Director of Midwifery PID following the in principle agreement at the last Executive Team meeting when the Chief Nursing and Quality Officer proposed the appointment to this pivotal role, as set out in a paper for approval .

Meeting of the Board of Directors in Public
Thursday, 06 May 2021

Title of Report	**MFT Green Plan**	**Agenda Item**	5.1
Report Author	Jessica Brown, Sustainability and Business Performance Manager		
Lead Director	Gary Lupton, Director of Estates and Facilities		
Executive Summary	The Green Plan has been written to comply with the NHS Standard Contract, which mandates that all healthcare services are required to have a Board approved Green Plan. Plans are seen as evidence of a well-led organisation that is committed to local public health outcomes by NHSI and NHS England. At present the Trust does not have an existing Green Plan or the former policy known as a Sustainable Development Management Plan. The Green Plan outlines our visions, strategy and objectives for delivering sustainable healthcare for 2021-2026. Our Green Plan is underpinned by a delivery plan that provides actions to be taken relating to each module of the Sustainable Development Assessment Tool (SDAT). In order to assist the delivery of this plan, timescales and responsibilities have been specified for each action. Areas of priority have also been provided, which has been influenced by stakeholders' feedback to guide future decision making at the Trust. This paper requests approval for MFT's newly drafted Green Plan to: • Identify clear actions to drive forward sustainable healthcare • Achieve cost savings in areas such as utilities, waste disposal and transport • Improve the health of our local community • Meet our legislative and policy requirements • Provide the required evidence that we are effectively managing sustainability and enhancing social value when bidding for work.		
Committees or Groups at which the paper has been submitted	Executive Group, 21 April 2021		
Resource Implications	Funding will be sourced through grant applications		
Legal Implications/Regulatory Requirements	The Green Plan has been written to comply with the NHS Standard Contract, which mandates that all healthcare services are required to have a Board approved Green Plan		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to APPROVE the Green Plan		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1 – Green Plan		

1 Why do we need a Green Plan?

1.1 The NHS Standard contract mandates that all healthcare services are required to have a Board approved Green Plan

1.2 Public Health England also view these plans as evidence of an organisations commitment to local public health outcomes.

1.3 NHS Improvement and NHS England expect all NHS providers to have a Board approved Green Plan as this is considered a measure of a well-led organisation.

1.4 The Green Plan has been written to deliver the sustainable development related NHS Long Term Plan (LTP) commitments.

1.5 At present the Trust does not have a Board approved Green Plan.

1.6 Delivering sustainable healthcare will achieve the goals of reducing our environmental impact (and associated carbon footprint), reducing costs and enhancing our social value.

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

1.8 The Green Plan has been assigned a maximum validity of 5 years and will be subject to regular reviews during the interim period, or in light of major national policy or organisational changes.

2 What's in the Green Plan?

2.1 The strategy has been fully aligned with national guidance, best practice, Medway specific policies and follows the structure set out in a guide recently published by NHSI in conjunction with the national Sustainable Development Unit.

2.2 The content is based on the latest organisational assessment, undertaken against the national Sustainable Development Assessment Tool (SDAT), a qualitative assessment of sustainable development for healthcare providers. The results from this assessment were used in conjunction with stakeholder feedback to ensure that the plan meets the needs of the organisation. Objectives have been set against each of the ten areas within the SDAT;

- Corporate Approach
- Green Space and Biodiversity
- Asset Management and Utilities
- Sustainable Care Models
- Travel and Logistics
- Our People
- Climate Change Adaptation
- Sustainable Use of Resources
- Capital Projects
- Carbon and Greenhouse Gases (GHGs)

2.3 The Trust's performance has been measured against national sustainability targets in order to determine key targets for 2026.

Metric	2020*	2026**
Carbon emissions***	9,756 tCO2	4,845 tCO2
Business mileage	98.9 tCO2	84.01 tCO2
Percentage of waste recycled	15%	30%
Water Consumption	1.79 m3/m2	1.66 m3/m2
Electricity Consumption	55 kWh/m2	51 kWh/m2
Staff Engagement	6.6/10	7/10
Sustainable Development Assessment Score	30%	50%

Table 1 - Trust Performance vs Target

* Appendix 5.1 Trust Performance

** Appendix 5.2 Trust Targets

*** Scope 1 & 2 emissions against 2009/10 baseline.

3 How will the Green Plan be delivered?

3.1 Delivery of the strategy will be through a combination of an ongoing programme of work that is being undertaken by the Sustainability Manager and collation and reporting of other relevant work programmes that the organisation is undertaking.

3.2 The Sustainability Manager will be responsible for monitoring, tracking and reporting performance against the Green Plan through internal and external channels as required.

3.3 The Director of Estates and Facilities will be responsible for providing the resources required to deliver the plan and has senior ownership of the Sustainability portfolio.

4 Recommendation

4.1 The Board of Directors are requested to approve the attached Green Plan, continue to provide active support, champion the associated work programmes and receive an update on progress against the Green Plan at least annually.

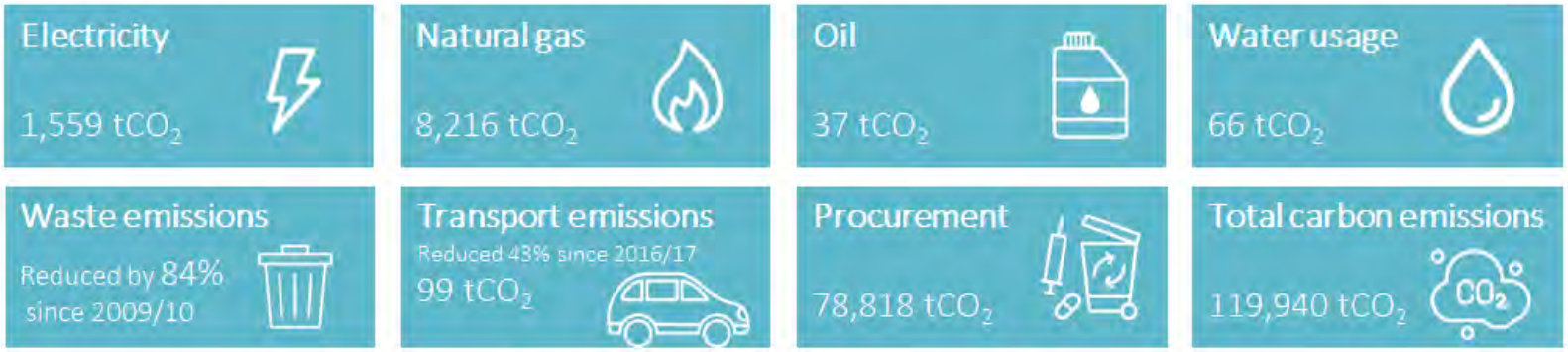
4.2 The Green Plan recommends introducing a Sustainability Steering Group (SSG) and Green Champions network to the Trust. These responsible bodies will drive sustainable changes and behaviours at MFT and will ensure progress is being made.

5 Appendix

5.1 Trust Performance - Page 8

Our current performance

In 2019/20 we emitted **119,940 tonnes of CO_2e**, equivalent to the carbon impact equivalent to the carbon impact of over **14,000 homes' energy use for one year**.



Electricity

60% less carbon emissions since 2009/10

Our annual electricity usage is enough to power over **1,700** homes

Waste

84% less carbon emissions from waste since 2009/10

0% waste to landfill

15% recycled

Procurement

30% CO_2 emissions from construction

32% medical instruments

11% business services

Procurement is the largest contributor for carbon emissions at the Trust.

5.2 Trust Targets – Page 14

Targets to be achieved by 2026

Increase staff engagement to a score of 7/10 by 2026 (NHS Staff Survey)

Sustainable travel plan reduce business mileage by 15%

Increase our overall SDAT score to >**50%**

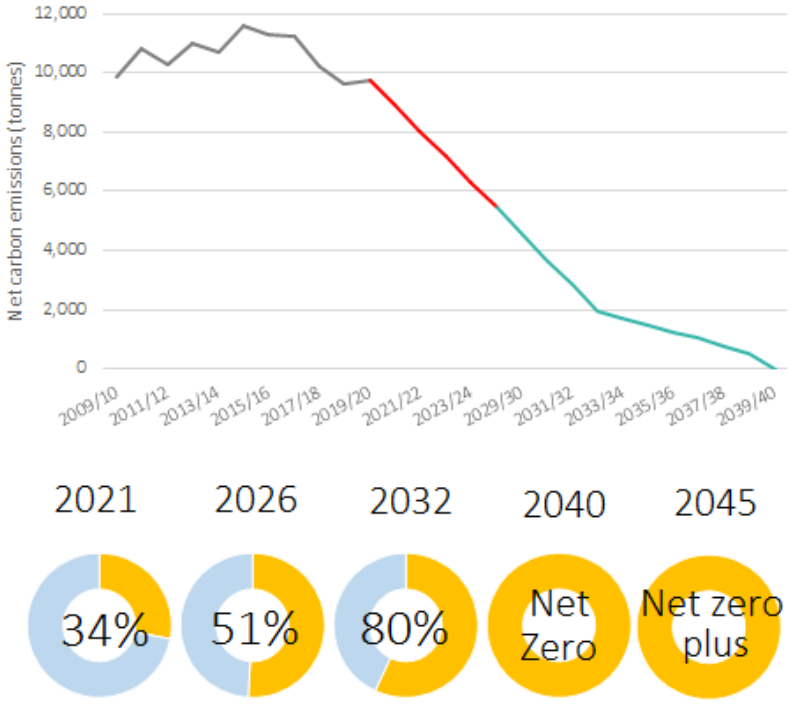
CQC score of 'Outstanding' across our services*

Improve **air quality** with annual air quality audit measuring well below the **PM2.5** concentration threshold

Increase recycling rates to at least **30%**

Continue to achieve electricity consumption under **70 kWh/m²** (11)

Reduce water consumption by **14%** to 1.66m³ per m²



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

*as outlined in our Quality Strategy (2019-2022)

11. Health Technical Memorandum 07-02: EnCO2de 2015 – making energy work in healthcare

NHS
Medway
NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

Green Plan

2021 to 2026






Best of care
Best of people

Contents

About us

Medway NHS Foundation Trust attained Foundation status in 2008. The single-site hospital, Medway Maritime Hospital in Gillingham, serves a population of more than 424,000 across Medway and Swale. It is Kent's largest and busiest hospital, dealing with around 400,000 patients annually.

We have a 24-strong Council of Governors and more than 10,000 public members. The Trust employs around 4,400 staff, making us one of Medway's largest employers.

The hospital is made up of two clinical divisions – Unplanned and Integrated Care and Planned Care – supported by corporate functions. We offer a wide range of specialist and general hospital services. The hospital site is home to the Macmillan Cancer Care unit and the West Kent Centre for Urology and a state-of-the-art obstetrics theatre suite.

Medway NHS Foundation Trust was in special measures from 2013 to 2017, and with tremendous effort and dedication to improving, it was rated overall as 'Requires Improvement' by the Care Quality Commission (CQC) in March 2017 and again in 2020.

Alongside our current strategies for the future, this Green Plan, formerly Sustainable Development Management Plan (SDMP), aims to improve our organisational performance by generating financial savings and environmental and social benefits.

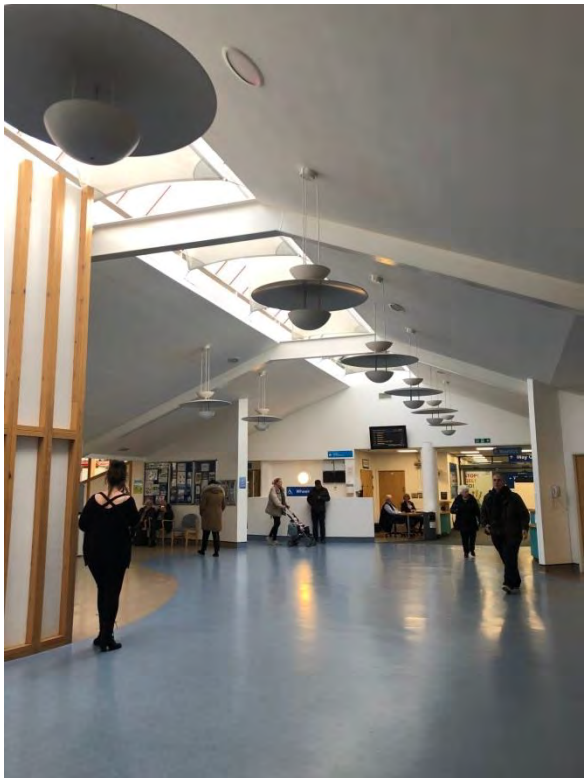
For additional information, please visit https://www.medway.nhs.uk/

Foreword

I and the wider leadership team are in full support of this Green Plan. We appreciate that implementing the plan will be a challenge, but the Trust is committed to delivering sustainable healthcare. The Trust has already made changes towards a sustainable future and will continue to embed sustainability into everyday practices.

As a large organisation, our environmental impact needs to be addressed to improve the efficiency and resilience of the services we offer. We encourage everyone involved with Medway NHS Foundation Trust to get involved in embedding sustainability across our organisation and wider community.

Gary Lupton
Executive Director of Estates and Facilities



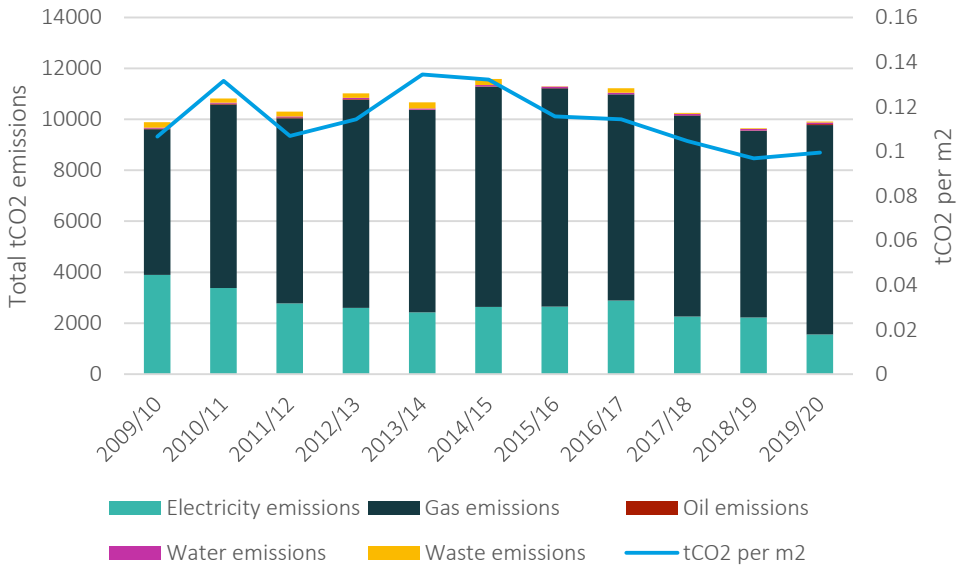
Executive summary

This Green Plan provides an organisation-wide strategy that outlines the Trust's plan of action for 2021-2026, in line with our vision and objectives.

Sustainability at Medway NHS Foundation Trust is driven by financial, environmental, social and legislative factors, including the Greener NHS Programme's net zero carbon by 2040 target set in 2020.

Medway NHS Foundation Trust has made progress in reducing emissions from Scope 1 and 2 emissions. Since 2014/15, our carbon emissions have reduced year on year (see figure below). In 2019/20, the Trust's total carbon footprint from scope 1, 2 and 3 emissions (including travel and procurement) was 119,940 tCO_2.

This plan outlines how we will continue to reduce our emissions and improve our monitoring and reporting of emissions from travel and procurement.



The action plan provides actions to be taken relating to each module of the Sustainable Development Assessment Tool (SDAT).

In order to assist the delivery of this plan, timescales and responsibilities have been specified for each action. Areas of priority have also been provided, which has been influenced by stakeholders' feedback to guide future decision making at the Trust.

The Green Plan introduces a Sustainability Steering Group (SSG) and Green Champions network to the Trust. These responsible bodies will drive sustainable changes and behaviours at MFT and will ensure progress is being made.

The main risks associated with this plan have been outlined, and the Trust will undertake measures to identify and manage all risks related to sustainable development and climate change.

In order to retain and increase engagement with sustainability at the Trust, a Sustainability Communications Plan has been developed alongside this Green Plan; outlining key audiences, communication networks and activities specific to Medway NHS Foundation Trust.

Introduction

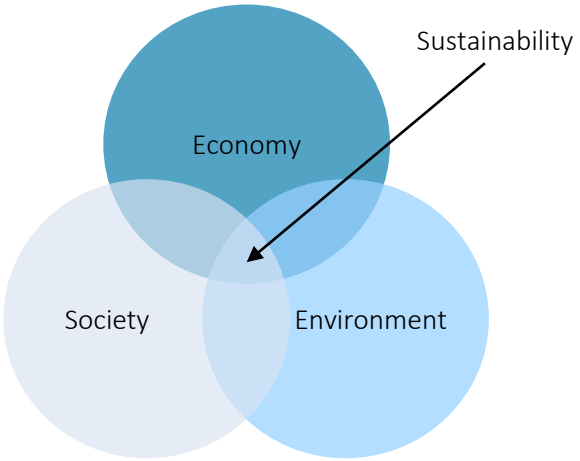
As the largest and busiest NHS Trust in Kent, Medway NHS Foundation Trust (MFT) consumes a significant quantity of resources and consequently has a large carbon footprint; contributing to climate change and its associated impacts on a local and global scale.

Medway NHS Foundation Trust aspires to make substantial improvements to the sustainability of its operations. We recognise the impact we have on the environment and our responsibility to integrate sustainability within our core business.

This Green Plan provides an organisation-wide strategy that outlines the Trust's plan of action for 2021-2026, in line with our vision and objectives.

This plan aims to deliver more sustainable healthcare; improving the quality of care while enhancing our resilience, sustainability and wellbeing in preparation for future pressures and challenges.

Sustainable development involves the Trust adopting a holistic view of all its activities, considering the three spheres of sustainability; environmental, economic and social implications. To achieve sustainability, we must balance these three elements to ensure we meet the needs of the present without compromising the ability of future generations to meet their needs.



Sustainability Venn Diagram

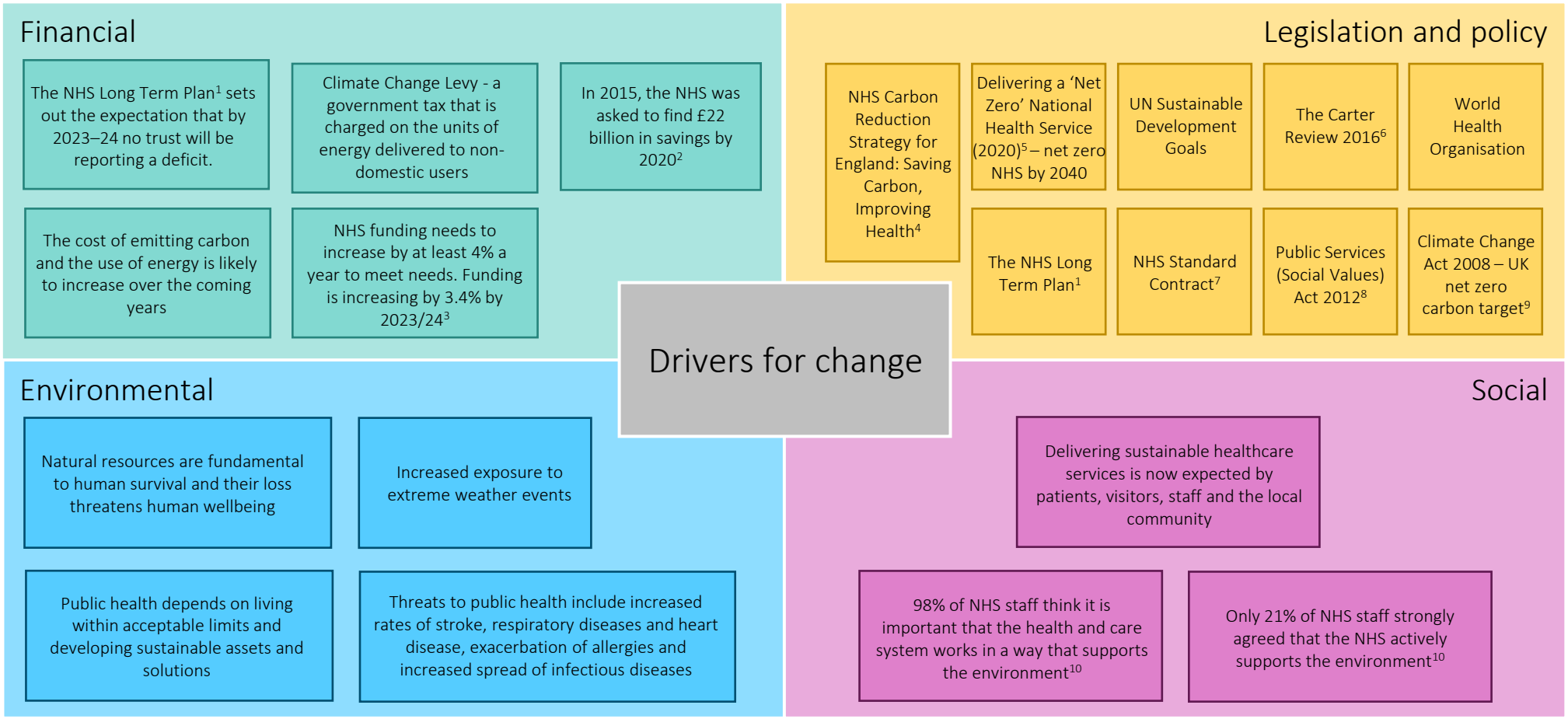
Seeking financial savings through improved efficiency measures will help the Trust create financial sustainability as well as improve health both now, and in the future.

Delivering sustainable healthcare will improve services to the community and reduce the Trusts environmental impact. It will require collective action from staff, patients and visitors.

Incorporating sustainability into the Trust's approach will help us make more informed, sustainable decisions to benefit the future as well as the present.

Drivers for change

A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage. The diagram below outlines the different factors driving sustainability within the NHS.



1. The NHS Long Term Plan ; 2. Department of Health's settlement at the Spending Review 2015; 3.PM speech on the NHS: 18 June 2018; 4. NHS Carbon Reduction Strategy for England: Saving Carbon, Improving Health 5. Delivering a 'Net Zero' National Health Service Report 2020; 6. Productivity in NHS hospitals, 2015; 7. NHS Standard Contract; 8. Public Services (Social Value) Act 2012; 9. UK becomes first major economy to pass net zero emissions law; 10. NHS Sustainable Development Unit Survey

Our vision

This Green Plan aims to address the Sustainable Development Unit's (SDU) vision for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments.

The Trust strives to deliver brilliant care outcomes through brilliant people and be a leading partner within an integrated system of health and social care, providing a patient experience without boundaries.

As an organisation we have demonstrated that we can be better, and now- **our vision is to be the best**!

BOLD	We are inspiring and ambitious
EVERY PERSON COUNTS	We are respectful and supportive
SHARING AND OPEN	We are open and speak up
TOGETHER	We are inclusive and responsible

Best of care
Best of people

The Trust's overall objective is to continually improve our service through our strategic objectives:

1. High quality care

We will make the delivery of consistent, high quality care a priority for all staff.

2. Integrated health 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.

3. Innovation

We will lead the way in the use of innovative and digitally enabled technology solutions to support the delivery of brilliant care.

4. Financial stability

We will deliver financial stability and create value in all we do.

5. Our people

We will enable our people to be brilliant and achieve brilliant outcomes.

Incorporating sustainability into Trust operations will help us achieve our strategic objectives though efficiently using our resources to deliver long term financial, environmental and social sustainability.

10. Sustainable Development Unit

Our current performance

In 2019/20 we emitted **119,940 tonnes of CO_2e**, equivalent to the carbon impact equivalent to the carbon impact of over **14,000 homes' energy use for one year**.

Electricity
1,559 tCO_2

Natural gas
8,216 tCO_2

Oil
37 tCO_2

Water usage
66 tCO_2

Waste emissions
Reduced by 84% since 2009/10

Transport emissions
Reduced 43% since 2016/17
99 tCO_2

Procurement
78,818 tCO_2

Total carbon emissions
119,940 tCO_2

Electricity

60% less carbon emissions since 2009/10

Our annual electricity usage is enough to power over **1,700** homes

Waste

84% less carbon emissions from waste since 2009/10

0% waste to landfill

15% recycled

Procurement

30% CO_2 emissions from construction

32% medical instruments

11% business services

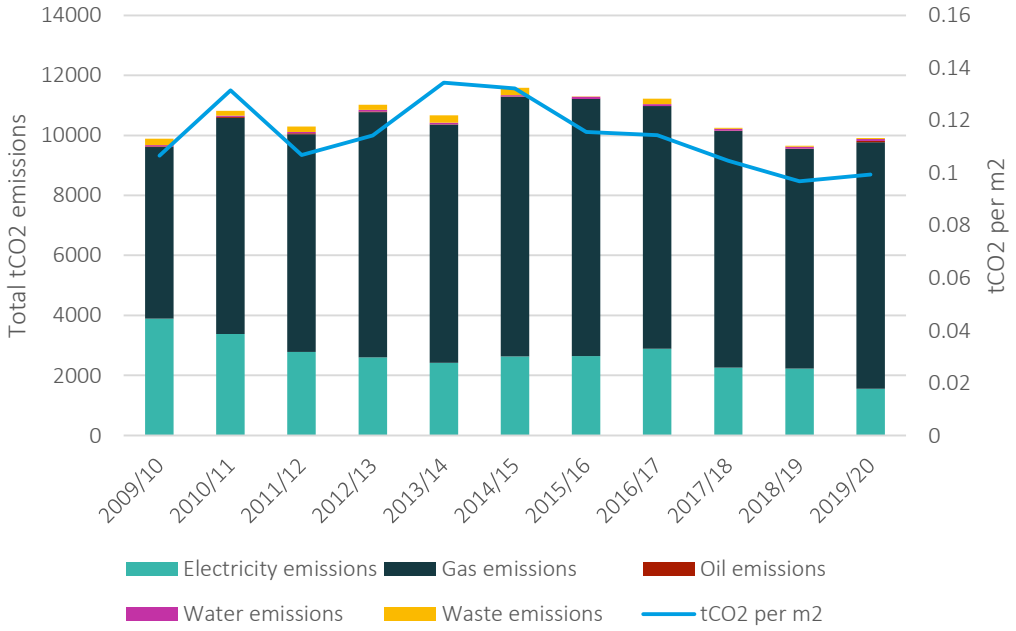
Procurement is the largest contributor for carbon emissions at the Trust.

Our current performance

Carbon emissions are categorised into 3 scopes; scope 1 emissions (direct from owned resources), scope 2 emissions (indirect, through the generation of purchased energy), scope 3 emissions (indirect, within the value chain).

In 2019/20, the Trust's total carbon footprint from scope 1, 2 and 3 emissions (including procurement and travel) was 119,940 tCO_2.

The Trust has made some progress towards reducing its carbon emissions from each of these scopes. However, business-as-usual is no longer an option. We acknowledge that more needs to be done if we are to deliver net zero carbon by 2040 and sustainable healthcare.



Scope 1 and 2 CO_2e emissions from 2009 to 2020

£11.5 million new Emergency Department building

Refurbished CHP increasing its efficiency by 15%

Zero waste to landfill

LED lighting upgrades across our estate

MFT's recent achievements

Since 2014/15, total CO_2e	Since 2009/10, CO_2e /WTE Employee	Since 2009/10 CO_2e /m^2
14% ↓	26% ↓	4% ↓

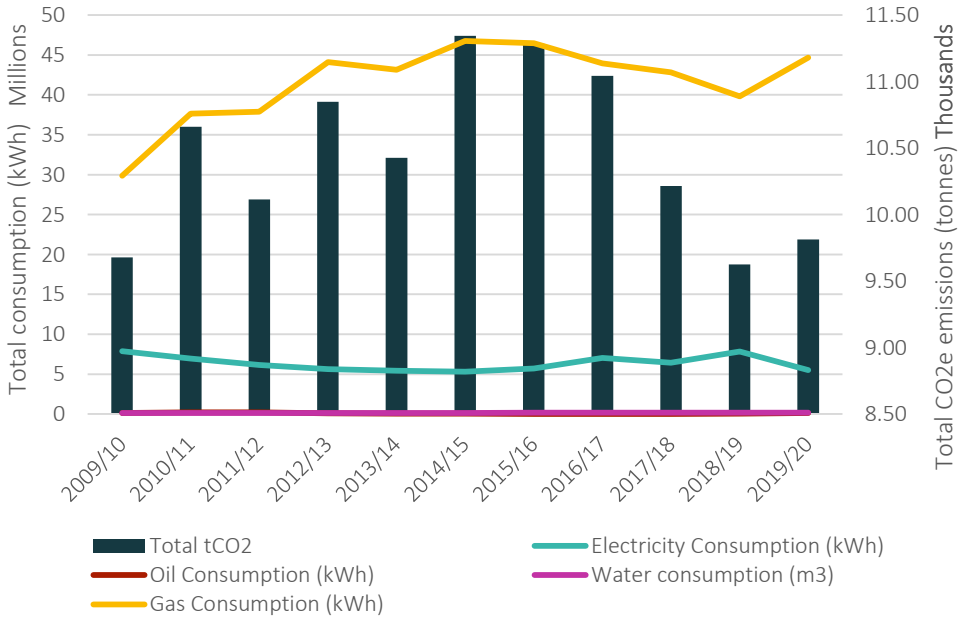
Analysis of Scope 1 and 2 CO_2e emissions from 2009 to 2020

Our current performance

Utilities

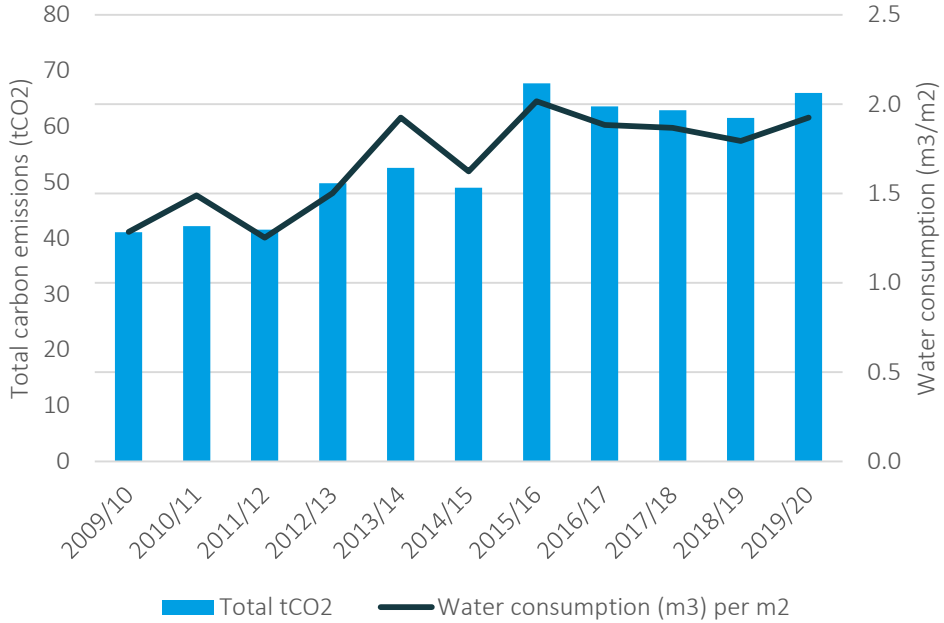
Emissions from utilities include electricity, gas, oil and water. As seen in the figure below, oil consumption is insignificant compared to that of gas and electricity. Since our baseline year of 2009/10, emissions from utilities have returned to a similar level of carbon emissions, largely due to the decarbonisation of the National Grid.

Despite significant reductions since our peak in 2014/15, the Trust will continue to drive the conservation of energy and water to use our resources sustainably.



The breakdown of carbon emissions from utilities from 2009/10 to 2019/20; indicating gas, electricity and oil consumption.

Water consumption per m^2 has shown a general increase over the period of 2009/10 to 2019/20. Owing to on-site laundry services, Medway NHS Foundation Trust's water consumption is comparatively higher than many Acute NHS Trusts. Going forward, the Trust will encourage water saving behaviours, for example through engagement activities and water-saving campaigns.

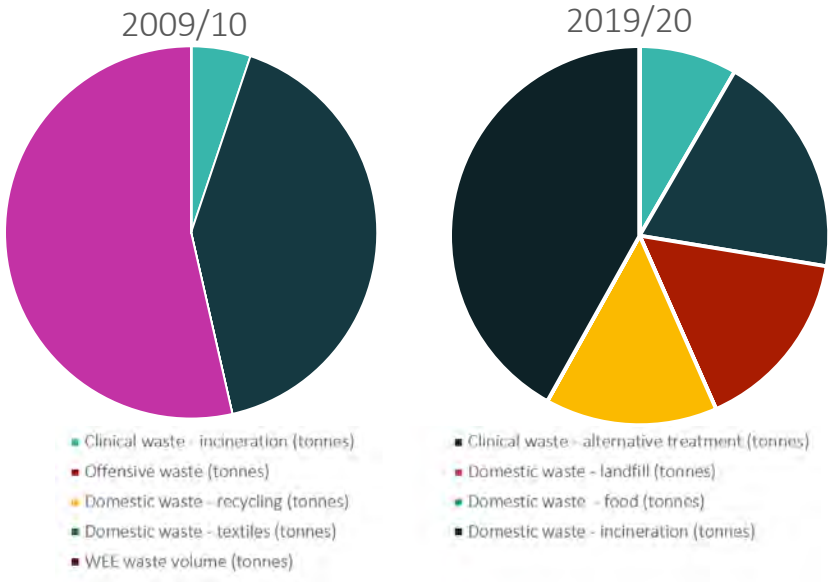


Water consumption and subsequent carbon emissions from 2009/10 to 2019/20.

Our current performance

Waste

Medway has worked hard, alongside South East NHS Total Waste Management Consortium to achieve zero waste to landfill. The Trust continues to ensure waste is disposed of in the most appropriate and sustainable manner and has reduce the number of domestic waste collections. This has reduced carbon emissions and costs from transporting waste.



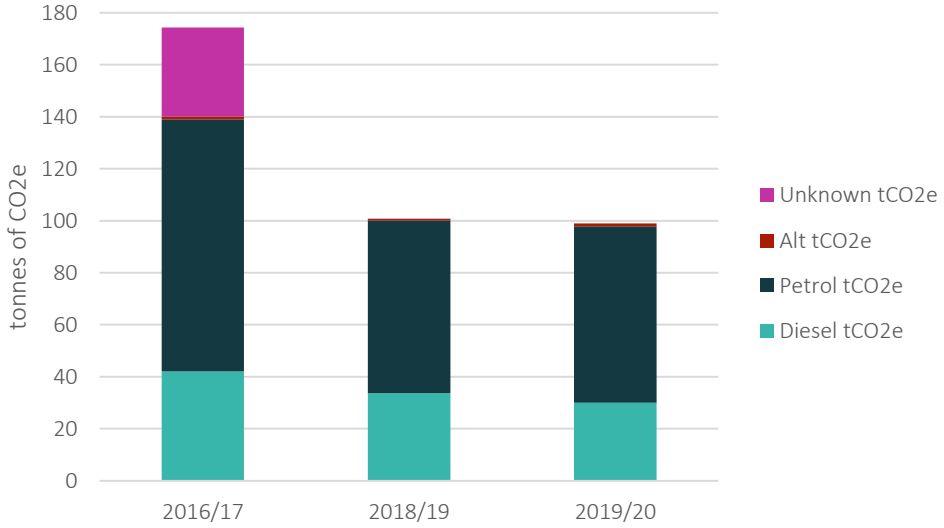
The breakdown of waste streams in the baseline year (2009/10) and in 2019/20.

The above charts indicate the breakdown of waste streams used in the baseline year (2009/10) and 2019/20. Carbon emissions from waste have significantly reduced from 211 tCO_2e in 2009/10 to 33 tCO_2e in 2019/20. Moving forwards, Medway will continue to reduce our impact of waste on the environment through increased recycling rates and re-use schemes.

Travel

Medway NHS Foundation Trust's staff business travel data is available from 2016/17. Since 2016/17, the Trust's carbon emissions from business travel have reduced by 43%, from 174.3 tCO_2e to 98.9 tCO_2e in 2019/20.

The breakdown of business travel emissions is shown below.



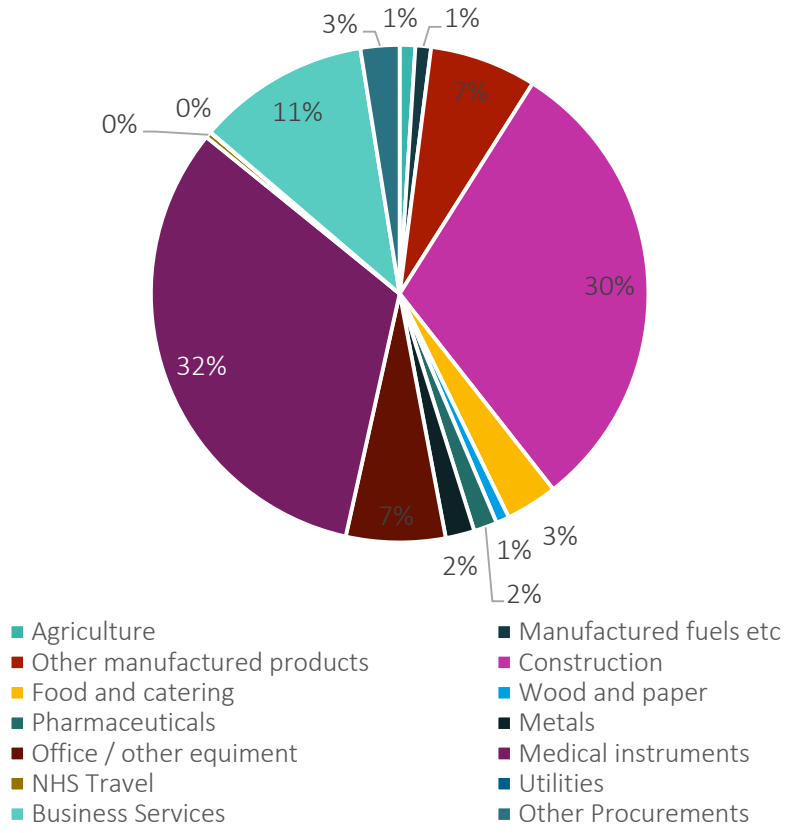
The breakdown of carbon emissions from staff business travel in 2016/17, 2018/19 and 2019/20

The Trust will continue to encourage more sustainable travel by installing electric vehicle charging points and providing sustainable travel incentives such as bus concessions, season ticket loans, and cycle to work, walk to work and car share schemes.

Our current performance

Procurement

Using the Procuring for Carbon Reduction (P4CR) tool, the Trust has calculated an estimate of carbon emissions from its procurement activities.



The estimated breakdown of carbon emissions (tCO_2) from procurement in 2019/20

The Trust's total carbon emissions from procurement in 2019/20 are estimated at 78,818 tCO2e. The largest contributors of emissions from procurement include medical instruments and equipment (32%), construction and construction materials (30%) and business services (11%).

As the most significant source of carbon emissions for the Trust, Medway NHS Foundation Trust will focus on driving carbon reduction interventions of the key contributors indicated above as well as considering greenhouse emissions associated with the goods and services we supply and purchase.

Key success measures to be implemented by 2026

The Trust has outlined these 5 key overarching actions required to achieve our targets set out in this plan. These developments will enable long term progress for sustainability at the Trust.

The Trust will review and update these 5 key actions in 2026 in order to set measurable objectives to progress towards our carbon reduction target of net zero by 2040.

Develop and implement net zero programmes

Employee **engagement**: Sustainability Champions within each directorate

Implement an **Energy Performance Programme** to deliver guaranteed energy, carbon and cost savings

Develop and implement a **Sustainable Procurement Plan**

Develop and implement a **Green Travel Plan**

Targets to be achieved by 2026

Increase staff engagement to a score of **7/10 by 2026**
(NHS Staff Survey)

Sustainable travel plan **reduce business mileage by 15%**

Increase our overall SDAT score to >**50%**

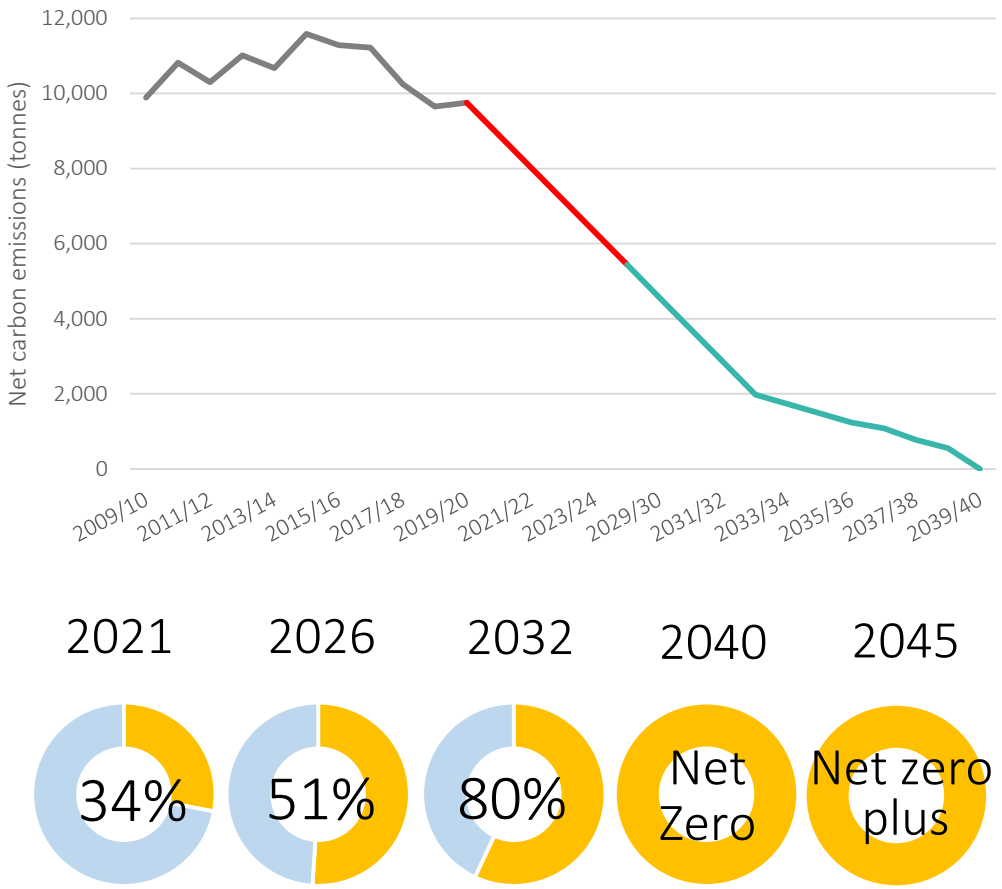
CQC score of **'Outstanding'** across our services*

Improve **air quality** with annual air quality audit measuring well below the **PM2.5** concentration threshold

Increase recycling rates to at least **30%**

Continue to achieve electricity consumption under **70 kWh/m²** (11)

Reduce water consumption by **14%** to 1.66m³ per m²



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

*as outlined in our Quality Strategy (2019-2022)

11. Health Technical Memorandum 07-02: EnCO2de 2015 – making energy work in healthcare

Our sustainable action plan

Areas of focus

This section outlines the Trust's plan of action against each of the key areas of the Sustainable Development Assessment Tool (SDAT)[2] from the Sustainable Development Unit (SDU). Progress towards the delivery of this strategy has been presented throughout this section indicating the aim, current progress, actions and monitoring for each key area. Through providing measurable, ambitious, achievable targets, this plan sets a clear path that we need to follow in order to reach our targets.

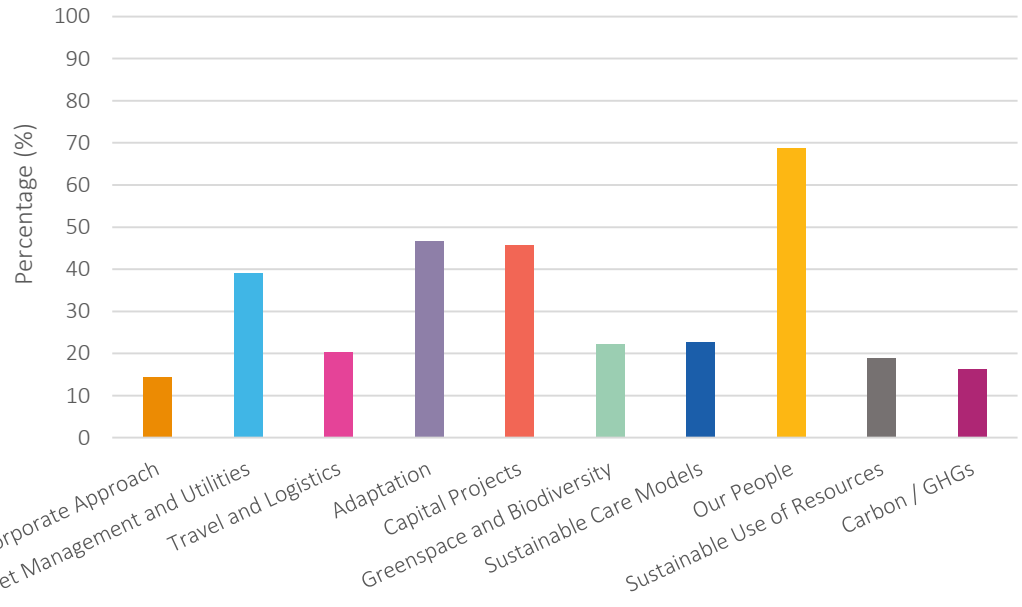
- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Greenspace and Biodiversity
- Sustainable Care Models
- Our People
- Sustainable Use of Resources
- Carbon and Greenhouse Gases

Sustainable Development Goals (SDGs)

As part of the NHS, we need to identify how we can help meet the United Nations Sustainable Development Goals (2015-2030).

Throughout the action plan, we have aligned the 10 SDAT modules with the 17 SDGs (2015-2030).

In our latest SDAT assessment, the Trust achieved an overall score of 30%. Our progress within each SDAT module is shown below.



Our sustainable action plan

Understanding what matters to us

Sustainability Survey 2020

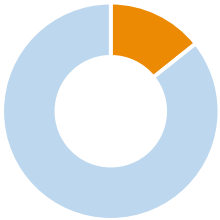
In order to understand our community's understanding and priorities for this strategy we undertook a sustainability survey. 187 people participated in the survey, including staff, patients and the public.

The results indicate that 64% of staff believe highlighting more sustainable options on site would encourage more sustainable behaviours. Alongside this, the other top responses for support staff were: help to understand how this can fit into my role (23%) and provide training (23%).

The results from our sustainability survey indicate that they key priorities for staff cover waste, resources, procurement and air pollution. The survey highlighted the top 3 barriers for staff to live more sustainable lifestyles strongly include a lack of understanding and support surrounding sustainability.

6.34 was the average score given on how important sustainability is in the decisions made by the Trust. Additional feedback from survey respondents has been input into a word cloud to the right. The word cloud indicates that some of the main concerns and priorities of respondents surround waste management, procurement and travel.

Corporate approach



It is essential that senior representatives, staff and stakeholders are committed to delivering our Green Plan by aligning our policies, procedures and processes to reflect our sustainability vision.

Aim: Embed sustainability within organisational values and behaviours and be accountable for the progression of this strategy, with support from the Trust Board.

Sustainability is currently considered in procurement (environmental and social impact) as well as suppliers' impact. Sustainability is included within tenders and the Terms and Conditions of our contracts with suppliers.

Priorities for the Trust

1. Develop environmental policy
2. Embed sustainability within Trust values
3. Establish a Sustainability Steering Group and Green Champions network

Measuring progress

- Assess sustainability using SDAT in line with targets
- Undertake annual staff awareness surveys
- Include a thorough progress report of the Green Plan in the annual report

Action	Timescale
Expand colleague engagement with sustainability and environmental issues through a green champions network	Annually
Undertake a materiality assessment to understand stakeholder priorities and deliverability of actions	2021/22
Recognise and reward staff for sustainable behaviours and actions	Annually
Review sustainability and net zero progress and benchmark our performance against other acute NHS Trusts	Annually
Undertake an annual sustainability awareness survey for staff and patients	2022/23
Revise our business case templates and assessment tools to ensure that sustainability is embedded into business decisions	2021/22
Work collaboratively and share best practice in annual meetings with Kent County Council, Medway Council and Kent and Medway STP in order to achieve targets	Annually
Support the government's commitment that £1 in every £3 be spent on small businesses by 2020	Annually

Asset management and utilities

Medway Maritime Hospital consumes significant energy and resources every year, which represents a large revenue cost to the Trust. The Trust will continue to adopt initiatives focused on improving our efficiency to reduce utility use and costs, as well as facilitate future decarbonisation of the Trust Estate.

Aim: Undertake energy reduction schemes to reduce the consumption, cost and environmental impact of our utilities.

The Trust has undertaken a range of energy efficiency measures around the Trust site; including heat-loss survey, LED lighting upgrades, a sub-metering pilot and CHP refurbishment.

Priorities for the Trust

1. Energy saving campaign
2. Develop and implement a Heat Decarbonisation Plan
3. Install sub-metering across the site

Action	Timescale
Purchase a 100% renewable energy tariff	2021
Develop a Heat Decarbonisation Plan	2021/22
Create a plan for implementation of LED lighting across 100% of your estate	2022/23
Identify potential locations where sub-metering would encourage energy reduction and install where appropriate	2021/22
Run an energy and resource saving campaign, developing guidance for temperature control	Annually
Undertake an Energy Performance Contract (EPC) to increase the efficiency of our estate	2026
Integrate whole life costing into the procurement of goods and services	Ongoing
Develop and implement energy and water efficiency strategies	2022/23

Measuring progress

- Report ERIC annually
- Calculate annually the percentage of energy from renewable sources
- Calculate the energy, carbon and cost savings from LED lighting projects

Asset management and utilities

Case studies

1. LED Lighting Project

7,398 lights have been replaced in 2020

Annual savings projected:

576 tonnes of carbon

2,255,150 kWh of electricity

2. Heat-loss survey

Including windows, building, pipework and plant insulation continues to improve energy efficiency and reduce energy consumption at the Trust.

3. Switch to green energy in 2021/22

→ 1,408 tCO_2e saved per year → 14% reduction in our carbon footprint

4. Refurbished CHP

During 2018/19, the Medway CHP was refurbished. The by-product heat is used to heat water and make our hospital more comfortable.

15% increase in efficiency, saving

716,000 kWh of electricity per year

5. Metering pilot programme

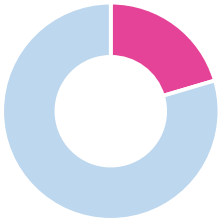
10.5% overall reduction in electricity, indicating potential annual savings of:

£73,000

640,000 kWh

225,000 $kgCO_2e$

Travel and logistics



Travel accounts for 18% of the NHS' carbon footprint. There is significant scope to reduce these emissions, improve the flow of people to and from the Trust site, and create health benefits to our employees and wider Trust community.

Aim: Deliver a robust travel plan to enable staff, patients and visitors to use more sustainable methods of travel and reduce the Trust's impact on carbon emissions and air quality, as well as deliver financial and health benefits.

- From 2016/17 to 2019/20, CO_2 emissions from business travel reduced by 43%
- The Trust are currently in the process of developing a Sustainable Travel Plan
- Cycle to Work Scheme offered to staff
- Parking permit only for staff outside a 1 mile exclusion zone and free bus travel is available for those within the exclusion zone – this has resulted in a reduction of 260 staff driving to work
- Commissioning a Traffic Management Survey to highlight opportunities for sustainability and improve transport for patients, visitors and staff

Priorities for the Trust

1. Provide and encourage the use of electric vehicles
2. Develop a Green Travel Plan
3. Provide additional active travel incentives

Measuring progress

- Annual travel survey for staff and public
- Measure and calculate our carbon emissions and expenses from travel, annually
- Measure and report on site air quality, annually
- Annual review of public transport available for Trust site
- Record the number of low emission vehicles used by the Trust, annually

Action	Timescale
Promote virtual meeting technologies to reduce the requirement for staff travel	Ongoing
Convert fleet and pool vehicles to electric vehicles	2026
All vehicles purchased/leased are low and ultra-low emission	2021/22
Explore the possibility of a shuttle bus service to connect Trust site with Gillingham train station and implement if feasible	2022/23
Collect data on staff and patient transport modes and mileage through a travel survey	2022/23/ Annually
Review Trust business travel policy to ensure sustainable transport where possible	2021/22
Collaborate with Medway Council to develop and implement a sustainable travel plan	2022/23
Install 2 electric vehicle charging points across the site	Annually

Adaptation

The future of our healthcare delivery will depend in part on the adaptive capacity of Trust infrastructure required to respond to predicted physical and health-related impacts of climate change, without hindering the continuity and quality of our services.

Aim: Take practical actions to manage risks from climate change impacts, particularly extreme weather events, in order to protect Trust services, the community and strengthen our resilience.

In October 2019, we carried out **emergency planning exercises** at Medway Maritime hospital in order to teach staff how prepare and manage a range of potential emergency situations.

Priorities for the Trust

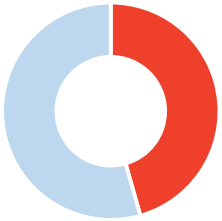
1. Develop Climate Change Adaptation Plan
2. Undertake Impact Assessment
3. Risk management and awareness

Measuring progress

- BREEAM scores of new and existing buildings
- Annual risk register
- Emergency preparedness drills, annually

Action	Timescale
Develop and implement a climate change adaptation plan including but not limited to heatwaves, cold weather and flood management	2023/24
Embed sustainability into the risk register	2021/22
Raise awareness of current and emerging climate impacts and risks through posters and articles; and take action to build our resilience	Annually
Undertake an impact assessment of adaptation decisions on patients and local communities	Annually
Maximise the quality and resilience of our greenspace to help mitigate the effects of climate change	Ongoing
Explore options for mitigation and adaptation technologies around the Trust site	Ongoing

Capital projects



Developing the Trust estate must consider the future needs and pressures faced by the organisation. By continually upgrading and embedding sustainability into existing and developing estate, the Trust will be able to simultaneously build resilience and improve operational efficiency.

Aim: Improve the environmental and social impact of Trust estates by encompassing sustainable concepts in the development and construction of buildings.

On 7th November 2019: MFT opened its **new £11.5 million Emergency Department** building. Sustainability is currently included within tenders and the Terms and Conditions of our contract with suppliers.

Priorities for the Trust

1. Building fabric upgrades
2. Introduce lessons learnt discussions after projects
3. Develop sustainable design objectives for all new builds and refurbishments

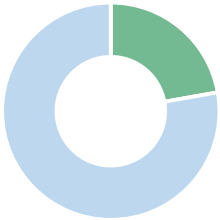
Measuring progress

- BREEAM score for all Trust buildings
- Monthly reporting of gas and electricity
- Annual reporting of ERIC
- Monitor heating, lighting, cooling and ventilation systems weekly

Action	Timescale
Comply with the zero carbon standard for buildings to be published in April 2021	April 2021 onwards
Provide procurement guidance to suppliers on the expected level of Environmental Management Systems for new capital projects	2021/22
Achieve a minimum of BREEAM Excellent for new builds and very good for refurbishments.	Ongoing
Apply the BSRIA Soft Landings[3]. Framework to capital projects	Ongoing
Consider all aspects of sustainability by accounting for the whole life costs of capital projects	Ongoing
Develop Sustainable Design Guidance to integrate sustainability within the design, specification and requirements of new builds and refurbishments	2022/23

12. BSRIA Soft Landings

Greenspace and biodiversity



Having access to greenspace is vital in for health promotion, illness prevention and illness recovery. MFT must protect and enhance the greenspace we have around the Trust site and encourage our community to reap its benefits.

Aim: Provide high quality greenspaces across our estate that encourages wildlife and biodiversity, benefits health and wellbeing and improves air quality on site.

The Butterfly Garden: dementia-friendly, therapeutic garden to provide a safe, peaceful space for individuals (including patients and staff) to reduce stress and anxiety whilst promoting wellness, strength and rehabilitation through the use of gardening and wellness activities.

Priorities for the Trust

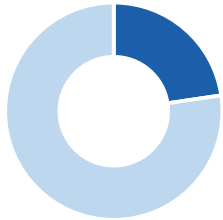
1. Develop walking maps
2. Integrate greenspace within estate development
3. Undertake air quality audit

Action	Timescale
Undertake an air quality audit to establish a baseline	2021/22
Promote, establish and safeguard greenspace including grasslands, trees and green roofs within our estate	Ongoing
Undertake a feasibility study for urban greenspace within our estate, through the use of green roofs and wildflowers	Ongoing
Prioritise the redevelopment of brownfield sites when commencing new capital projects	Ongoing
Encourage the use of greenspace to staff and patients through walking maps and outdoor education and therapy sessions	2021/22
Plant 2 new trees every month	Monthly
Compost biodegradable and food waste	2022/23

Measuring progress

- Improved air quality, monitored via an annual audit
- Record the awareness and use of Trust greenspace through the annual survey

Sustainable Care Models



All our services aim to deliver the best quality of care within the resources available. Transforming healthcare using a whole systems approach to develop and deliver sustainable care models will enable the Trust to best prepare our services for future challenges and technological advancements.

Aim: Embed sustainability into our processes, systems and services with transparent measurement to track progress, ensuring the services are safe, effective and person-centred.

Priorities for the Trust

1. Virtual Clinics
2. Electronic Patient Records
3. Care Closer to Home

Measuring progress

- Annual patient feedback and scores
- Annual staff sickness rates
- Record patients' length of stay and number of patients being treated at home (SMART initiative)
- Annual review of our Quality Strategy

Action	Timescale
Work closely with our Clinical Commissioning Group colleagues and across the STP to identify and deliver joint sustainable initiatives	Ongoing
Maintain relationships with experts who support the delivery of quality improvement and cultural change through regular communications and monthly meetings	Ongoing
Develop and implement a sustainable anaesthesia programme	2022/23
Provide training to staff on how we can embed sustainable practice into our care models	Annually
Establish a sustainable workforce through a focussed and targeted recruitment plan	Ongoing
Involve and engage with patients in the redesign of services through open discussion sessions	Ongoing

Sustainable Care Models

Case studies

SMART initiative: Streamlining all patients to avoid admissions and reduce length of inpatient stay with 35 new patients a week to be treated at home rather than a hospital bed.

MASCOE: a whole system improvement collaborative with the Clinical Commissioning Group (CCG) and Medway Council to deliver new models of care.

Continuous Improvement Training: aims to deliver training to 1,000 of our staff over the next 24 months, empowering them to make improvements within the Trust.

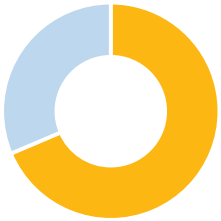
Daily Improvement Huddles: adopting a 'ground up' approach to empower staff to bring continuous improvement into daily business as usual.

Improvement Specialists: train and qualify a number of staff in advanced improvement techniques in order to support and coach our internally trained improvement practitioners.

Local Quality Improvement Projects: measurable and structured local improvement projects.

The Same Day Emergency Care (SDEC) centre: opened July 2019 to rapidly assess, diagnose and treat patients without admitting them to a ward.

Our people



Numerous actions stated in the Green Plan rely on engagement from a variety of audiences from around the Trust. Engaging staff is key in driving change across the organisation and encouraging the adoption of sustainable practices to deliver this strategy.

Aim: Encourage sustainable behaviours at work, home and across our supply chain by empowering individuals to make sustainable choices every day.

Priorities for the Trust

1. Sustainable behavioural campaign
2. Host sustainability forums and discussion panels to gather feedback and ideas
3. Include sustainability in staff job descriptions, inductions and training

Measuring progress

- Staff satisfaction and engagement annual survey
- Response rate of staff surveys
- Participation rates in sustainability engagement opportunities/events
- Ongoing feedback from Green Champions

Action	Timescale
Develop and implement a sustainability communications strategy	2020/21 / Ongoing
Promote and run at least 6 meetings per year to provide opportunities for colleague discussions and feedback on sustainability initiatives	Annually
Staff awards to encourage and recognise sustainable staff behaviours	Annually
Introduce sustainability into corporate staff induction and job descriptions	2021/22
Provide flexible policies and roles to provide staff with flexible careers and a better work/life balance	2021/22
Conduct an annual staff survey to gain an understanding of staff satisfaction	Annually
Continue to hire apprenticeships, undertake research, offer coaching and mentoring across all levels	Ongoing
Promote health and wellbeing through staff and patient comfort, access to greenspace and sharing best-practice	Ongoing

Our people

Case studies

The Trust undertakes a range of engagement activities for staff, patients, visitors and the wider community. Currently, the Trust has around 188 apprenticeships and 400 volunteers who provide invaluable support together with the League of Friends, Hospital Radio and the Voluntary Services Department.

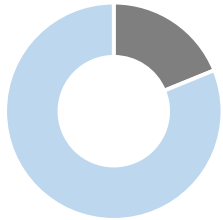
The Trust connects with its staff through a number of channels including a Facebook group and the @MFT staff app, enabling staff to access Trust news, policies and book onto shifts through their mobile devices. This has proven successful, with more than 25 per cent of staff registered and more than 1,500 downloads.

Staff engagement and recognition is also achieved the Best of People Awards, which celebrate and showcase staff success and contribution.

In order to communicate with the public and our stakeholders, Medway NHS Foundation Trust holds engagement sessions and presentations across Medway and Swale, enabling residents to share ideas and feedback with the Trust. Alongside this, News@Medway provides a platform for raising awareness of Trust developments on a quarterly basis.

The Trust understands the importance of research and innovation and works in collaboration with academia, particularly local universities such as the University of Kent, University of Greenwich, and Canterbury Christ Church University.

Sustainable use of resources



Evaluating and improving the efficiency of our resources (including finance, staff, estates and facilities, technology and procurement) can improve the quality of care we provide to our patients, deliver greater value for money, and minimise our impact on the environment.

Aim: Tackle resource and waste management to deliver significant cost and carbon savings.

Priorities for the Trust

1. Single-use plastic reduction campaign
2. Repair and reuse schemes
3. Recycling awareness campaign

Measuring progress

- Use the Procurement for Carbon Reduction Tool (P4CR) to calculate an estimate for procurement emissions
- Monitoring and reporting waste streams and volumes, annually
- Track food miles
- Record the number of suppliers including sustainability as a key priority

Action	Timescale
Develop and implement digitisation initiatives to reduce paper use	2021/22
Identify areas of common wastage and eradicate through a behavioural change programme	2022/23
Identify and progress opportunities for repair and reuse, such as furniture re-use schemes and donations	Ongoing
Work with our suppliers to reduce waste in the supply chain, especially packaging	Ongoing
Develop and implement a plastic reduction campaign	Annually
Continue to drive sustainability in catering through open discussion groups and the green champions network	Ongoing
Introduce a weekly separate food waste collection	2021/22
Switch to 100% recycled content paper for all office-based functions	2021/22

Sustainable use of resources

Case studies

Within catering, a push for sustainability has resulted in:

538 items of plastic packaging being removed from the department; this equates to a saving **of £13,345 and 12 tonnes CO_2e**

Introduced **recycling** bins in the restaurant

Replacing single-use plastic cups and lids with **reusable coffee cups** has generated savings of **1.5 tonnes of waste and 33 kg of CO_2e**

Around the Trust site, we provide **water filling stations** to reduce plastic waste

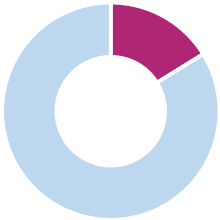
Amazon lockers are available for patients, staff and visitors to reduce deliveries and the resulting carbon emissions

Materials management: using a medical consumables stock replenishment system supported by an electronic bar coding/PDA system. This is linked directly to the local NHS Supply Chain warehouse facility; minimising logistical costs by rationalising orders, deliveries and consolidated invoicing

All of our paper is now from a **recycled source**; producing less waste, energy and subsequent carbon emissions than manufacturing non-recycled paper

To reduce water consumption and costs, the Trust **monitors water leakage** and there are active water use reduction measures installed in public areas such as controlled cistern flow, self-closing and touchless basin taps

Carbon and greenhouse gases



In April 2019, Medway Council declared a climate change emergency. Working collaboratively, we are committed to addressing our emissions in order to work towards our carbon emissions targets, legislation and sector requirements.

Aim: To achieve net zero carbon by 2040, eliminate poor air quality and deliver clean growth.

Through a range of measures, MFT has steadily reduced its emissions through improvements to the efficiency of our energy and resources.

Priorities for the Trust

1. Collaboration with existing partners and local organisations to reduce emissions
2. Anti-idling campaign
3. Car park management and improvement plan

Measuring progress

- Calculate and report our carbon footprint annually
- Publish progress towards our carbon reduction targets through internal and external communications networks
- Calculate and report our carbon footprint from anaesthetic gases

Action	Timescale
Develop and implement a heat decarbonisation plan	2021/22
Report carbon emissions in Trust's Annual Report	Annually
Promote and run and Annual Carbon Awareness Day	Annually
Review and improve current space utilisation	2022/23
Identify carbon hotspots using the Procuring for Carbon Reduction (P4CR)[13] tool, and create a procurement strategy to reduce emissions	Ongoing
Collaborate with the council to deliver Kent and Medway Energy and Low Emissions Strategy (ELES) and Kent Environment Strategy	Ongoing
Encourage drivers to switch off their engines when stationary through educational signs and security measures	2021/22

13. Procuring for Carbon Reduction (P4CR) research, tools and guidance

Communications and engagement

By creating an accessible, engaging and structured approach to sustainability communications, Medway NHS Foundation Trust will be able to progress towards our targets and promote sustainable development.

In the 2019/20 NHS Staff Survey staff engagement at the Trust was rated 6.6 out of 10, compared to the benchmarking group for acute Trusts at 7.4.

The Trust aims to develop and implement a Trust-wide Sustainability Communications Strategy which reflects our commitment to sustainability and informs the public, staff and partners.

Through this strategy, we aim to increase the staff survey response rate and overall staff engagement with sustainability.

Internal Communications

- Develop an annual calendar of sustainability promotion campaigns such as swap shop events, Clean Air Day and NHS Sustainability Day
- Sustainability discussions, for staff, patients and visitors seeking information and/or providing feedback
- Publish updates and success stories in News@Medway magazine, on social media and through the @MFT Staff app
- Develop green champions network
- Educational signs and posters developed and uploaded to Trust intranet
- Run interdepartmental competitions to reduce carbon emissions
- Staff awards to encourage and recognise sustainable staff behaviours

External Communications

- Educational signs and posters distributed around Trust sites and on the Trust website
- Work closely with local agencies, for example, universities, museums and other NHS Trusts to contribute to the delivery of area-wide carbon reduction strategies
- Introduce sustainability into the agenda at Governor meetings
- Run public Q&A sessions regarding sustainability
- Communicating the progress of the Green Plan via social media (Facebook and Twitter), the website and Hospital Radio
- Invite stakeholders to quarterly sustainability discussion groups

Green Champions

- Promote sustainability around the Trust and consider how they could improve energy and resource efficiency in their area
- Represent sustainability and gather feedback and ideas from staff and patients
- Attend and promote sustainability initiatives

Monitoring

- Feedback from staff perception annual survey
- Annual audit of internal communications
- Participation rates in sustainability engagement opportunities
- Social media activity analysis: followers, shares, likes, hashtag use

Governance

Effective leadership is built on a clear vision, strategy and the ability to communicate the organisational direction to other staff, patients and public. Allocating responsibility across the organisation will provide a solid foundation to execute this plan.

Board of Directors

Ensure senior level leadership and responsibility of this plan, ensuring it aligns with Trust values and policies, as well as the needs of relevant stakeholders. The Board oversees the progress and direction of this strategy through clear communication with the Sustainability Steering Group.

Sustainability Steering Group

The Sustainability Steering Group (SSG) comprises representatives from across the Trust, including:

- Sustainability and Business Performance Manager
- Health and Safety Manager
- Procurement and Finance
- Head of Estates and Facilities
- Head of Culture and Workforce Engagement
- Head of Resourcing
- Director of HR and OD
- Head of Workforce Intelligence
- Non-Executive Director
- Public member

This group will represent sustainability at the Trust; integrating sustainability into Trust practices, as well as monitoring and reporting on Green Plan progress quarterly.

Green champions

Involves representatives from all directorates of the Trust who will drive and communicate sustainability initiatives among staff and patients. The group will convene bi-monthly to share ideas and feedback. Quarterly, the group will report back to the SSG.

Reporting

Medway NHS Foundation Trust will report progress on the Green Plan, in line with reporting requirements, to review our performance against Trust and legislative targets.

Annually

Sustainability within the annual report

Highlight our progress, inform of upcoming plans and inform stakeholders of our commitment to sustainability.

Completion of SDAT

Measure the Trust's progress of sustainability compared to the previous year.

Estates Return Information Collection (ERIC)

The Department of Health require NHS Trusts to submit annually.

Quarterly

Progress reports

The SSG will submit updates and feedback to the Board and Governors, including monthly reports from the Trust's Green Champions.

Monthly

Data collection

Collation of utilities, waste data and other required data recorded for KPIs.

Green Champions

Will convene monthly to report any new ideas or feedback from staff and patients.

Risk

We have identified the potential risks relating to the delivery of this strategy and by creating a full risk register, can state the likelihood and impact of these risks and take actions to minimise them. Potential risks have been categorised below.

Funding and finance

This strategy relies on financial support. If funding isn't allocated, the Trust may be unable to invest in sustainability improvements.

Carbon reduction targets

Not achieving our carbon targets can result in financial penalties and negatively impact our reputation.

Legislation

Non-compliance with legislation will result in financial penalties and likely damage our reputation.

Climate change

Climate change threatens our estate, staff, patients, supply chain and services through extreme weather events, i.e. heatwaves and flooding.

Reputation and staff satisfaction

Failing to deliver this strategy may result in a loss of reputation, engagement and morale.

Disruption

Sustainability projects need to be carefully executed to minimise the effect on hospital services, patient wellbeing, buildings, greenspace and habitats.

Finance

Medway NHS Foundation Trust aims to reduce its financial deficit, break-even and achieve financial sustainability for health and social care across Medway and Swale.

Delivering longer term financial sustainability will enable MFT to become more resilient to rising utility, carbon and transport costs, as well as funding uncertainty.

Medway will identify external funding options, such as the recent Public Sector Decarbonisation Scheme, to finance carbon reduction initiatives. The Trust will continue to improve its overall economy, efficiency and effectiveness of its current use of resources. We will reinvest the savings generated from the actions outlined in this plan and seek to obtain grants and work with the local council to implement sustainability measures across the Trust.

Identifying costs associated with sustainability is challenging. This plan outlines sustainability initiatives with a range of costs and savings which can be allocated depending on the funding available to the Trust.

Nonetheless, effective management of procurement and utilities can help reduce costs and environmental impact, through changes in staff behaviours, without upfront cost.

References

1. The NHS Long Term Plan
2. Department of Health's settlement at the Spending Review 2015;
3. PM speech on the NHS: 18 June 2018;
4. NHS Carbon Reduction Strategy for England: Saving Carbon, Improving Health
5. Productivity in NHS hospitals, 2015;
6. NHS Standard Contract;
7. Public Services (Social Value) Act 2012;
8. UK becomes first major economy to pass net zero emissions law;
9. NHS Sustainable Development Unit Survey
10. Sustainable Development Unit
11. Health Technical Memorandum 07-02: EnCO2de 2015 – making energy work in healthcare
12. BSRIA Soft Landings
13. Procuring for Carbon Reduction (P4CR) research, tools and guidance

Glossary

CHP – Combined Heat and Power

CO_2 – Carbon Dioxide

CO_2e – Carbon Dioxide Equivalent

ERIC – Estates Returns Information Collection

LED – Lighting-emitting Diode

NHS – National Health Service

NIHR - National Institute for Health Research

SDAT – Sustainable Development Assessment Tool

SDMP – Sustainable Development Management Plan

SDMPSG – Sustainable Development Management Plan Steering Group

SDU – Sustainable Development Unit

Meeting of the Board of Directors in Public
Thursday, 06 May 2021

Title of Report	**Finance Report – Month 12**	**Agenda Item**	6.1
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 full year surplus, which adjusts to 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, 25 March 2021		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report – Month 12		

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Finance report

For the period ending 31 March 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month (budget)	9,821	1,315	(8,506)	The Trust reports a £1.3m surplus position for March; after adjusting for donated asset depreciation and income, DHSC income for stock and the impairment following revaluation of assets, the Trust reports a £15k surplus and in line with the NHSE/I control total. The stock adjustment is income received for stock that has not been issued and therefore included on the balance sheet. The donated asset income is for covid equipment that is included in capital not revenue. It is a reporting requirement to exclude these items from the final position along with the impairment and donated asset depreciation prior to finalising a reported position against the control total. Incremental Covid costs have reduced by £0.3m from February to £1.5m.
YTD (budget)	-	1,211	1,211	
Less (YTD Adjustments):				
DHSC Stock Adjust		(691)	(691)	
Impairment		108	108	
Donat Asset Income		(730)	(730)	
Donat Asset Depn		117	117	
Reported Position	**-**	**15**	**15**	
* Months 1-6 are per the NHSE/I baseline which reported breakeven budget and actual. Months 7-12 are per the October plan.				
CIP				
In-month	2,122	807	(1,315)	Schemes delivered for the year totalled £8.8m, this being £3.2m adverse to the plan of £12.0m. The main schemes that delivered were related to the full year effect of schemes from 19/20, reduced orthopaedic insourcing costs, as well as procurement and pharmacy savings from nationally agreed prices. The under performance against plan is due to those schemes that could not be implemented due to Covid pressures on the services;, the impact of this was reduced as there were underspends across clinical divisions as elective activity was stopped and emergency care reduced during waves 1 and 2 of the pandemic.
YTD	12,000	8,813	(3,187)	
Capital				
In-month	7,853	12,783	4,931	The final capital position for 20/21 is in line with our resource limited at £317k underspent. £309k of this underspend was agreed with STP/NHSI for a PDC-funded scheme in children's ED; this funding was not drawn down. The position against CRL allocations is; STP CRL £17,066k - £8k underspent CIF PDC £7,886k breakeven Other PDC £7,134k - £309k underspent re Children's A&E Donations £742k – breakeven, £730k relates to COVID equipment donations from DHSC
YTD	32,828	32,511	(317)	

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1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	15,630	49,184	33,554	High levels of cash reserves have been maintained in month due to £6m of payments in advance from commissioners and much higher than expected uninvoiced costs across revenue and capital.
Activity is below draft budgeted levels as a result of Covid				Clinical income based on the consultation tariff would have reported a year to date position of £205m, this being £42.3m adverse to the draft budget. In month performance excluding high cost drugs is £19.6m compared to a M1 to M11 average of £16.9m, higher by £2.7m due to the restart of elective services at the end of February 2021.
Pay costs are higher than expected				Total pay costs have increased in month by £3.2m to £24.4m. The actual underlying in-month cost position is £21.2m after adjusting for the annual leave carried forward accrual of £2.9m, in addition to the well-being day of £0.7m, and the release of the pay contingency into the position £0.4m. The position is adverse to budget by £7.0m; of this £1.4m is due to incremental Covid costs, the remainder is predominantly a consequence of the accruals mentioned above as well as the non-achievement of CIP plans where budget has been removed from the divisions and the changes in bed capacity not in the original NHSE/I plan. Nursing whole time equivalents have increased significantly since November due to recruitment and training of new staff, the higher establishment has been reflected in the draft budgets for 2021/22.

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

£'000	In-month			Year-to-date*		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	26,837	27,592	878	283,437	283,690	254
High cost drugs	1,613	2,262	648	20,932	22,644	1,712
Other income	1,471	11,218	9,748	20,716	29,715	8,999
Top-up income	-	-	-	26,502	26,517	15
True-up income	-	-	-	-	9,690	9,690
Total income	**29,921**	**41,072**	**11,274**	**351,587**	**372,256**	**20,670**
Nursing	(7,791)	(8,135)	(344)	(82,451)	(91,720)	(9,270)
Medical	(6,164)	(6,692)	(528)	(71,041)	(75,658)	(4,617)
Other	(5,218)	(9,617)	(4,400)	(71,344)	(68,427)	2,917
Total pay	**(19,173)**	**(24,445)**	**(5,272)**	**(224,835)**	**(235,805)**	**(10,969)**
Clinical supplies	(3,389)	(7,348)	(3,959)	(43,011)	(46,632)	(3,621)
Drugs	(552)	(1,150)	(598)	(7,523)	(7,718)	(195)
High cost drugs	(1,613)	(2,156)	(543)	(21,231)	(22,608)	(1,377)
Other	(3,698)	(3,339)	358	(38,721)	(41,871)	(3,150)
Total non-pay	**(9,252)**	**(13,993)**	**(4,742)**	**(110,487)**	**(118,830)**	**(8,343)**
EBITDA	**1,374**	**2,634**	**1,260**	**16,264**	**17,622**	**1,357**
Depreciation	(829)	(1,096)	(267)	(9,981)	(10,192)	(211)
Net finance income/(cost)	(2)	(2)	(0)	221	(30)	(251)
PDC dividend	(542)	(221)	322	(6,504)	(6,188)	316
Non-operating exp.	**(1,374)**	**(1,319)**	**54**	**(16,264)**	**(16,410)**	**(146)**
Reported surplus/(deficit)	**-**	**1,315**	**1,315**	**-**	**1,211**	**1,211**
Adj. to control total	-	(1,315)	(1,315)	-	(1,211)	(1,211)
Control total	**-**	**-**	**-**	**-**	**-**	**-**

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

Key messages:

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

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

3. The top-up and months 1-6 true-up income are reported under "FRF/MRET" income in the table on the following page.

4. Total expenditure includes the incremental cost of Covid-19, being £1.5m in-month; £1.4m of this is reported in pay and £0.1m in non-pay (£12.2m and £5.9m YTD respectively). Excluding the impact of Covid, the pay and non-pay variances would improve in month by these amounts.

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

£'000	In-month								
	Income			Expenditure			Contribution		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
UIC									
Diagnostics & Clinical Support	1,614	1,874	260	(4,355)	(4,368)	(13)	(2,741)	(2,494)	247
Specialist Medicine	147	157	10	(1,921)	(2,186)	(265)	(1,774)	(2,029)	(255)
Therapies & Older Persons	5	(2)	(7)	(1,425)	(1,322)	103	(1,420)	(1,324)	96
Unplanned & Integrated Care	52	53	1	(1,154)	(1,275)	(121)	(1,102)	(1,221)	(120)
Urgent & Emergency Care	43	55	12	(2,275)	(2,376)	(101)	(2,232)	(2,321)	(89)
Sub-total	**1,861**	**2,137**	**276**	**(11,130)**	**(11,526)**	**(396)**	**(9,269)**	**(9,389)**	**(120)**
Planned care									
Cancer Services	408	816	409	(886)	(1,182)	(296)	(479)	(366)	113
Critical Care & Perioperative	43	29	(14)	(3,069)	(2,897)	172	(3,026)	(2,869)	157
Planned Care Infrastructure	-	-	-	(147)	(151)	(4)	(147)	(151)	(4)
Surgical Services	100	284	184	(2,770)	(3,064)	(294)	(2,670)	(2,780)	(110)
Women & Children	111	161	50	(3,257)	(3,357)	(100)	(3,146)	(3,196)	(50)
Sub-total	**661**	**1,289**	**629**	**(10,129)**	**(10,650)**	**(522)**	**(9,468)**	**(9,361)**	**107**
Corporate									
Communications	2	2	-	(40)	(33)	8	(39)	(31)	8
Finance	1	1	0	(214)	(218)	(4)	(213)	(217)	(4)
HR & OD	109	57	(51)	(362)	(185)	177	(253)	(127)	126
IT	2	6	5	(404)	(584)	(180)	(402)	(578)	(175)
Medical Director	849	945	96	(473)	(482)	(9)	376	463	88
Medway Innovation Institute	-	-	-	-	(123)	(123)	-	(123)	(123)
Nursing	-	78	78	(348)	(292)	56	(348)	(214)	134
Strategy, Governance & Perform	-	-	-	(330)	(293)	37	(330)	(293)	37
Transformation	-	-	-	(273)	(88)	185	(273)	(88)	185
Trust Executive & Board	-	-	-	-	(324)	(324)	-	(324)	(324)
Sub-total	**962**	**1,090**	**127**	**(2,444)**	**(2,621)**	**(177)**	**(1,482)**	**(1,532)**	**(49)**
E&F									
E&F	**274**	**422**	**148**	**(2,074)**	**(2,246)**	**(172)**	**(1,800)**	**(1,824)**	**(24)**
Central									
Central	**26,163**	**26,975**	**812**	**(2,662)**	**(5,445)**	**(2,783)**	**23,501**	**21,530**	**(1,971)**
TOTAL	**29,798**	**41,072**	**11,274**	**(29,798)**	**(39,757)**	**(9,959)**	**-**	**1,315**	**1,315**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**(1,315)**	**(1,315)**	**-**	**(1,315)**	**(1,315)**
Control total	**29,798**	**41,072**	**11,274**	**(29,798)**	**(41,072)**	**(11,274)**	**-**	**-**	**-**

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

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

£'000	Year to date									YTD contribution variance	
	Income			Expenditure			Contribution				
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.	M1-6	M7-12
UIC											
Diagnostics & Clinical Support	19,154	20,082	929	(51,715)	(51,696)	19	(32,561)	(31,613)	947	(298)	1,246
Specialist Medicine	2,659	1,842	(817)	(25,089)	(24,340)	749	(22,430)	(22,498)	(68)	967	(1,035)
Therapies & Older Persons	48	64	16	(17,328)	(16,877)	451	(17,281)	(16,814)	467	326	141
Unplanned & Integrated Care	984	559	(425)	(13,597)	(12,825)	772	(12,613)	(12,266)	347	111	236
Urgent & Emergency Care	704	498	(206)	(27,023)	(27,101)	(79)	(26,318)	(26,603)	(285)	100	(384)
Sub-total	**23,549**	**23,045**	**(504)**	**(134,752)**	**(132,839)**	**1,912**	**(111,203)**	**(109,795)**	**1,408**	**1,205**	**203**
Planned care											
Cancer Services	4,564	5,407	843	(10,339)	(10,869)	(530)	(5,775)	(5,462)	313	94	219
Critical Care & Perioperative	1,236	-	(1,236)	(37,351)	(2,196)	35,155	(36,116)	(2,196)	33,919	16,961	16,959
Planned Care Infrastructure	338	1,324	986	(19,443)	(33,312)	(13,869)	(19,105)	(31,989)	(12,883)	2,463	(15,347)
Surgical Services	598	605	8	(17,879)	(34,978)	(17,099)	(17,282)	(34,373)	(17,091)	(16,011)	(1,080)
Women & Children	1,073	970	(104)	(37,720)	(39,066)	(1,346)	(36,647)	(38,096)	(1,450)	(1,045)	(404)
Sub-total	**7,808**	**8,306**	**497**	**(122,733)**	**(120,422)**	**2,311**	**(114,924)**	**(112,116)**	**2,808**	**2,461**	**347**
Corporate											
Communications	11	21	11	(468)	(491)	(23)	(457)	(470)	(12)	(26)	14
Finance	33	16	(17)	(3,010)	(2,748)	262	(2,977)	(2,732)	245	185	60
HR & OD	1,445	1,429	(15)	(4,502)	(4,282)	220	(3,057)	(2,853)	205	70	134
IT	11	45	35	(4,292)	(4,547)	(255)	(4,282)	(4,502)	(220)	(171)	(49)
Medical Director	9,877	10,352	475	(5,547)	(5,389)	159	4,330	4,964	634	178	456
Medway Innovation Institute	-	-	-	-	(155)	(155)	-	(155)	(155)	-	(155)
Nursing	-	88	88	(3,978)	(4,181)	(203)	(3,978)	(4,092)	(114)	(92)	(22)
Strategy, Governance & Perform	-	-	-	(2,487)	(3,023)	(535)	(2,487)	(3,023)	(535)	31	(566)
Transformation	-	-	-	(1,885)	(820)	1,065	(1,885)	(820)	1,065	(244)	1,309
Trust Executive & Board	-	-	-	(1,624)	(3,407)	(1,784)	(1,624)	(3,407)	(1,784)	(10)	(1,774)
Sub-total	**11,377**	**11,953**	**577**	**(27,793)**	**(29,042)**	**(1,249)**	**(16,416)**	**(17,089)**	**(673)**	**(80)**	**(593)**
E&F											
E&F	**4,282**	**3,056**	**(1,226)**	**(23,980)**	**(25,031)**	**(1,051)**	**(19,698)**	**(21,975)**	**(2,277)**	**(1,516)**	**(761)**
Central											
Central	**304,571**	**325,897**	**21,326**	**(42,329)**	**(63,710)**	**(21,381)**	**262,242**	**262,186**	**(56)**	**(2,132)**	**2,075**
TOTAL	**351,587**	**372,256**	**20,669**	**(351,587)**	**(371,045)**	**(19,458)**	**-**	**1,211**	**1,211**	**(60)**	**1,271**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**(1,211)**	**(1,211)**	**-**	**(1,211)**	**(1,211)**	**60**	**(1,271)**
Control total	**351,587**	**372,256**	**20,669**	**(351,587)**	**(372,256)**	**(20,669)**	**-**	**-**	**-**	**-**	**-**

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

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3. CIP (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Gap	Mitigated target	Gap
Planned care	446	2,199	359	-	3,005	**4,682**	(1,677)	**5,100**	(2,095)
UIC	501	2,041	15	195	2,753	**4,253**	(1,500)	**5,505**	((2,752)
E&F	-	415	386	-	800	**661**	139	**800**	-
Corporate	628	184	91	61	964	**1,113**	(149)	**1,709**	(745)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	-
Total	**2,866**	**4,840**	**851**	**256**	**8,813**	**12,000**	**(3,187)**	**14,405**	**(5,592)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**2,122**	**807**	**(1,315)**	**12,000**	**8,813**	**(3,187)**	**12,000**	**8,813**	**(3,187)**

Process

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

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

At the end of the financial year, the total CIP delivered was £8.8m; this is 2.5% or total operating expenses and as previously forecast leaving a gap of £3.2m to the original CIP plan. Some of the clinical services encountered difficulties to deliver efficiencies due to the operational pressures experienced across the Trust arising from Covid.

During the year, a revised stretch target of £14.4m was set, this being 20% higher than the required CIP to mitigate the risk of individual scheme failure. The PMO team along with Divisions and the Finance Business Partners are focusing on developing a CIP plan for 2021/22 as well as assessing schemes that did not deliver being carried forward and implemented.

The main efficiencies have been achieved from the full year effect of 19/20 schemes.

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4. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,791	**Non-current assets**	**220,786**	**221,180**	**394**
6,307	Inventory	7,400	6,963	(437)
36,686	Trade and other receivables	25,600	17,517	(8,083)
12,385	Cash	15,630	49,184	33,554
55,378	**Current assets**	**48,630**	**73,664**	**25,034**
(292,111)	Borrowings	(77)	(137)	(60)
(24,478)	Trade and other payables	(22,600)	(37,637)	(15,037)
(4,519)	Other liabilities	(4,163)	(8,831)	(4,668)
(321,108)	**Current liabilities**	**(48,945)**	**(67,230)**	**(18,285)**
(2,278)	Borrowings	(2,278)	(2,151)	127
(1,317)	Other liabilities	(1,317)	(1,425)	(108)
(3,595)	**Non-current liabilities**	**(3,595)**	**(3,468)**	**127**
(64,534)	**Net assets employed**	**238,981**	**244,663**	**5,682**
140,581	Public dividend capital	447,851	453,871	6,020
(246,481)	Retained earnings	(250,236)	(245,270)	4,966
41,366	Revaluation reserve	41,336	36,062	(5,304)
(64,534)	**Total taxpayers' equity**	**238,981**	**244,663**	**5,682**

Key messages:

1. Net assets employed are £244.7m (prior year: net liabilities of £64.5m). This represents a net asset increase of £309.2m between years.
   £291.5m relates to the conversion of loans to PDC
   £17.7m relate to a net fixed asset increase (additions, less revaluations).

2. Receivables are £8m favourable to plan.
   This is due to changes in contracting arrangements in year where most clinical income was paid directly to the Trust on a block basis in a monthly basis.

3. Payables are £15m adverse to plan mainly due to a high level of capital payables and accruals.

4. Other Liabilities are £4.6m adverse to plan due to an unexpected additional cash advances from commissioners to ensure the Trust has sufficient cash in April.

5. The Public Dividend Capital increase of £6.0m is the total additional funding allocated to the Trust since the last refresh of the plan in December.

6. Revaluation reserve movement of £5.3m decrease relates to the net reduction in the value of the Trust estate as advised by professional valuers in their desktop review as at 31st March 2021.

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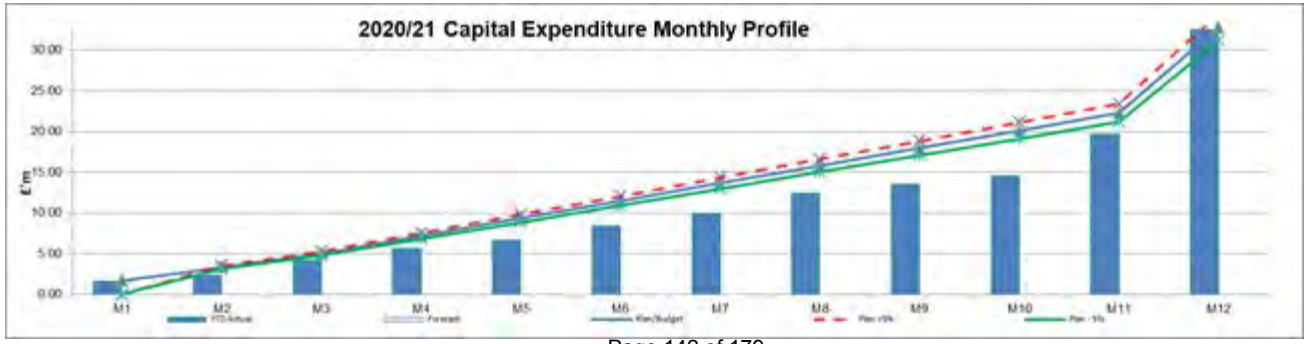
5. Capital

£'000	In-month			Year To Date M1-M12			Funded by;			CRL allocation from		
	Plan	Actual	Var.	Plan	Actual	Var.	Internal	PDC	CIF PDC	STP	EXTRA	TOTAL
Backlog Maintenance	497	925	428	6,340	6,477	137	48	0	6,429	48	6,429	6,477
Routine Maintenance1	459	1,392	933	2,917	2,512	(405)	1,450	0	1,062	1,450	1,062	2,512
Fire Safety	468	(58)	(526)	5,744	4,647	(1,097)	0	4,252	395	4,252	395	4,647
IT2 3	922	933	11	4,580	3,717	(863)	3,717	0	0	3,717	0	3,717
New Build - Inc ED	320	2,267	1,947	3,835	3,000	(835)	0	3,000	0	3,000	0	3,000
Plant & Equipment	(102)	3,633	3,735	1,536	4,590	3,055	4,591	0	0	4,591	0	4,591
Total Planned Capex	**2,564**	**9,092**	**6,528**	**24,952**	**24,944**	**(8)**	**9,806**	**7,252**	**7,886**	**17,058**	**7,886**	**24,944**
COVID*	1,959	33	(1,926)	1,959	1,959	0	0	1,959	0	0	1,959	1,959
IT MOU	95	93	(2)	190	190	0	0	190	0	0	190	190
A&E MOU	429	595	166	857	548	(309)	0	548	0	0	548	548
Diagnostic equipment(breast) MOU	593	1,181	588	1,186	1,186	0	0	1,186	0	0	1,186	1,186
UTC MOU	0	31	31	0	0	0	0	0	0	0	0	0
Adopt & Adapt MOU	315	255	(60)	630	630	0	0	630	0	0	630	630
EPMA MOU	743	0	(743)	1,485	1,485	0	0	1,485	0	0	1,485	1,485
Diagnostic Equipment Replacement MOU	139	273	135	277	277	0	0	277	0	0	277	277
Secure Boundary MOU	25	0	(25)	50	50	0	0	50	0	0	50	50
HSLI EPR MOU	250	500	250	500	500	0	0	500	0	0	500	500
Total Additional Capex	**4,547**	**2,961**	**(1,586)**	**7,134**	**6,824**	**(310)**	**0**	**6,825**	**0**	**0**	**6,825**	**6,825**
Total Capex	**7,111**	**12,053**	**4,943**	**32,086**	**31,769**	**(317)**	**9,806**	**14,077**	**7,886**	**17,058**	**14,711**	**31,769**
Grant/Donation Funded Capex	**742**	**730**	**(12)**	**742**	**742**	**0**	**742**	**0**	**0**	**0**	**742**	**742**
Total Capex	**7,853**	**12,783**	**4,931**	**32,828**	**32,511**	**(317)**	**10,548**	**14,077**	**7,886**	**17,058**	**15,453**	**32,511**



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5. Capital (Continued)

Capital expenditure consists of:

• Planned YTD expenditure of £24.944m, £8k underspent

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

• PDC funded capital £7.13m, £309k underspent
A number of other 'funding' applications as listed in the table above have been approved by NHSI.
The £309k underspent is as agreed with NHSI regarding finds allocated to the Trust for Children's ED which could not be utilised to the timescale and availability of contractors.

The Trust declared its inability to use these funds at the start of Q4 so which recorded as an underspend PDC funds were not actually drawn by the Trust for this project.

The Trust CRL has increased in line with the PDC issued and annual dividends of 3.5% (i.e. £35k pa for every £1m granted) will be payable; PDC issued for COVID related assets do not attract this charge. Total PDC to be drawn for 2020/21 schemes is £21,962k; £20,004k is subject to the 3.5% PDC dividend charge. The total expense of £0.7m has been fully accounted for in the year end I&E actuals.

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6. Conclusions

The Finance Committee is asked to note the report and financial performance which is £1,315k surplus in-month and £1,211k surplus year to date, reducing to breakeven after removing the adjustment for donated asset depreciation and income, as well income for Covid stock adjustment and the impairment. This financial performance is as per the plan submitted to the Kent & Medway STP and forecast to breakeven in line with the control total.

The year to date CIP programme delivery is £3.2m adverse to plan; this is mainly due to pressures caused by Covid affecting the delivery of planned efficiencies in the second half of the year.

Alan Davies
Chief Financial Officer
April 2021

Meeting of the Board of Directors in Public

Thursday, 06 May 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**6.2**
Committee Chair:	Jo Palmer, Chair of Committee		
Date of Meeting:	Thursday, 22 April 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 having been updated as follows: 3a Delivery of financial control total – this had increased from a score of 8 (4x2) to 16 (4x4) as a result of plans for the first half of 2021/22 still being finalised. 3b Capital investment – this had increased from 12 (4x3) to 25 (5x5) due to pipeline plans being significantly higher than the resource allocation for 2021/22. This score was discussed further and it was confirmed that it would be reviewed and on finalisation of the capital plan be reassessed, inclusive of mitigations, prior to the Board meeting on 06 May 2021.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level**
2. Corporate risk register There were no items scoring 16 or higher to be presented at this meeting, although it was noted this would be kept under review once the 2021/22 financial plan is finalised.	**Green**
3. Finance report The Chief Financial Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total for the year. • A number of technical adjustments have been made at the year end, including: o recognising income and expenditure in respect of centrally procured inventory/consumables o revaluation of property, plant and equipment • CIP delivered was £8.8m which, whilst below the draft budget at the start of the year, is a good achievement. The concern now remains the rate of identification of new CIP for 2021/22. • Capital spend was £32m for the year, meeting the plan and resource allocation. • Cash of £49m at the year end was higher than anticipated. • Pay appears very high in March but were noted as a consequence of a series of year end technical adjustments, such as the annual leave accrual (higher due to more untaken leave arising during the pandemic). After these non-recurrent adjustments the pay costs were still noted as being higher than previous months largely as a result of increased substantive recruitment. Concern was noted over the CIP identification, increasing pay costs and other cost pressures/service developments; discussions have been held at the Trust executive group with actions identified to address these matters. It was **AGREED** that a paper would be brought back to next month's committee specifically addressing CIP, pay costs and cost pressures/service developments. Challenge of inventory levels were also made and it was confirmed that year end counts had taken place, noting in addition that volumes at 31 March include the national push stock.	**Amber/Green**
4. Annual capital performance review The Chair acknowledged the efforts of the teams in delivering such a significant capital programme of work in 2020/21. It was formally noted that executive responsibility for the capital programme is moving from the Executive Director of Estates and Facilities to the Chief Financial Officer. The Executive Director of Estates and Facilities presented the paper, noting some of the highlights, including:	**Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
• The lift refurbishment programme continues in support of the fire safety works. • The delivery suite refurbishment has made a notable difference to the patient environment. • Maternity soundproofing has improved the patient experience. • The residence 10 conversion is underway and will provide accommodation for our growing workforce. • The cardiac catheter suite approved at the committee has begun – equipment has been procured and estates works are planned. • The Electronic Patient Records project was brought forward to begin implementation in 2020/21. • The staff gym is a couple of weeks from completion, although due to national availability we are still procuring the equipment. It was noted that approximately 35% of the Trust site is used for non-clinical activity (slightly above the average) and whilst we are seeking to reduce this figure the Trust is looking to improve the staff wellbeing areas. The importance of careful planning and readiness – particularly should monies be released nationally – was highlighted.	
5. Annual plan and budget setting 2021/22 The Chief Financial Officer presented the paper, setting out the internal business planning process/timelines and the relevant matters from the national planning guidance. The financial framework for the first half of 2021/22 was confirmed and funding is based on achieving breakeven using actual costs from Q3 2020/21 as a baseline. Additional monies were confirmed as being available nationally via the Elective Recovery Fund for achieving elective activity targets. The Chief Financial Officer noted that the Trust and the system are currently indicating significant pressures for 2021/22; the System finance leads are meeting to address the risks, including CIP assumptions, Covid expenditure and the elective restart. The system as a whole must achieve a breakeven. A presentation was made setting out the current budget proposals for the Trust, moving from the actual cost base in Q3 2020/21 to the exit run-rate and then the requested budgets. It was noted that further work and scrutiny is required to be able to achieve breakeven on the allocated funding. A contingency reserve has been created within the position but the committee wished to emphasise that this should not be utilised to mitigate known cost pressures but held for emerging/unknown risks. It was noted that a plan submission to the ICS is anticipated next week and the Board will therefore need to convene an additional meeting to give approval.	**Amber/Green**
6. 2021/22 CIP planning The Chief Financial Officer set out the current status of the 2021/22 CIP programme together with the next steps/actions to refocus and	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
reinvigorate initiatives. The committee was supportive of the approach to be undertaken at pace.	
7. Finance Committee work plan The plan was **APPROVED** for commencement with an opportunity to refresh in May should the incoming chair of the committee wish to make any further amendments.	**Green**
Decisions made It was **AGREED** that a paper would be brought back to next month's committee specifically addressing CIP, pay costs and cost pressures/service developments. The committee work plan for 2021/22 was **APPROVED**, although will be subject to any further matters identified by the incoming chair of the committee.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee A Board meeting will need to be convened in the week commencing 26 April - following confirmation of timings from the CFO - in order to approve the 2021/22 financial plan for the first six months of the year.	

Meeting of the Trust Board in Public
Thursday, 06 May 2021

Title of Report	**Patient First Programme - Operational Update**	Agenda Item	**7.1**
Lead Director	Angela Gallagher, Chief Operating Officer (Interim)		
Report Author	Keith Soper, Deputy Chief Operating Officer		
Executive Summary	This paper and the accompanying detailed slides provide a progress update on three key and interrelated elements of our Patient First programme. Good progress continues to be made on the programmes; however this is against the context of a particularly challenging period from just before Easter which has seen increased demand on our services and deterioration in some areas of performance, notably ambulance handover delays and ED 4 hour performance.		
Committees or Groups at which the paper has been submitted	Trust Improvement Board, 21 April 2021		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	NA		
Recommendation/ Actions required	The Board is asked to NOTE the report and progress made		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒

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

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

1 Effective Site Management

The Site Office refurbishment has now been completed following a short period where the team worked from the Dolphin Seminar Room. We are continuing to work on the focus of the site office moving from reporting to supporting, and we have seen good levels of engagement from clinical teams in the site meetings and an improvement in communication both ways. We are introducing new electronic reporting systems as the team get accustomed to their new surroundings and technology. The site team has continued to support changes to our inpatient bed status as numbers of Coivid-19 positive patients stabilise to single figures, and is working on a refreshed escalation trigger document based on the latest modelling of predicted increases in cases from June 2021.

2 Flow and Discharge

The Flow and Discharge programme continues to support in the delivery of increased discharge volumes, particularly at the weekends, and has focused on wards where de-escalation or a change of purpose has been planned. Min-MADEs (Multi Agency Discharge Events) continue to be held at least twice each week to support flow and improve further the process at ward level.

We have launched the BEST practices elements pertinent to Flow and Discharge. The BEST project forms part of a wider piece of work to ensure high quality patient care and helps to:

- prevent duplication of work
- reduce disruption to clinical teams due to communication traffic·
- minimise delays experienced by patients in receiving diagnostic services and discharge
- assist discharge teams to prepare for patients leaving the hospital more effectively
- enable site team to plan and prepare – improving overall flow throughout the hospital
- modernise the way we work
- allow services to prioritise their duties more efficiently

The project will incorporate the phased launch of DartOCM (electronic order comms system) for inpatient areas. DartOCM enables instant, digitalised diagnostic request to be sent to our imaging, pathology and phlebotomy departments.

3 Acute Care Transformation

The work of the Acute Care Transformation (ACT) programme links to our Care Quality Commission action plan and is designed to ensure safe access and initial assessment for all patients and to minimise delays through the emergency journey. Whilst we have agreed a number of programme metrics, key indicators and measures of success are ambulance handovers, time spent in the Emergency Department (ED) and 4 hour performance. We, along with other acute system partners, have struggled with emergency demand since just before Easter and this has resulted in an overall deterioration in these areas contrary to the previous improving trend, although at the time of writing we have begun to see improvements.

We have re-commenced, in stages, our refer and move assessment model operating out of Lister Ward. This is designed to safely expedite clinically appropriate patients from ED for required diagnostics and other observations to be completed.

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

NHS
Medway
NHS Foundation Trust

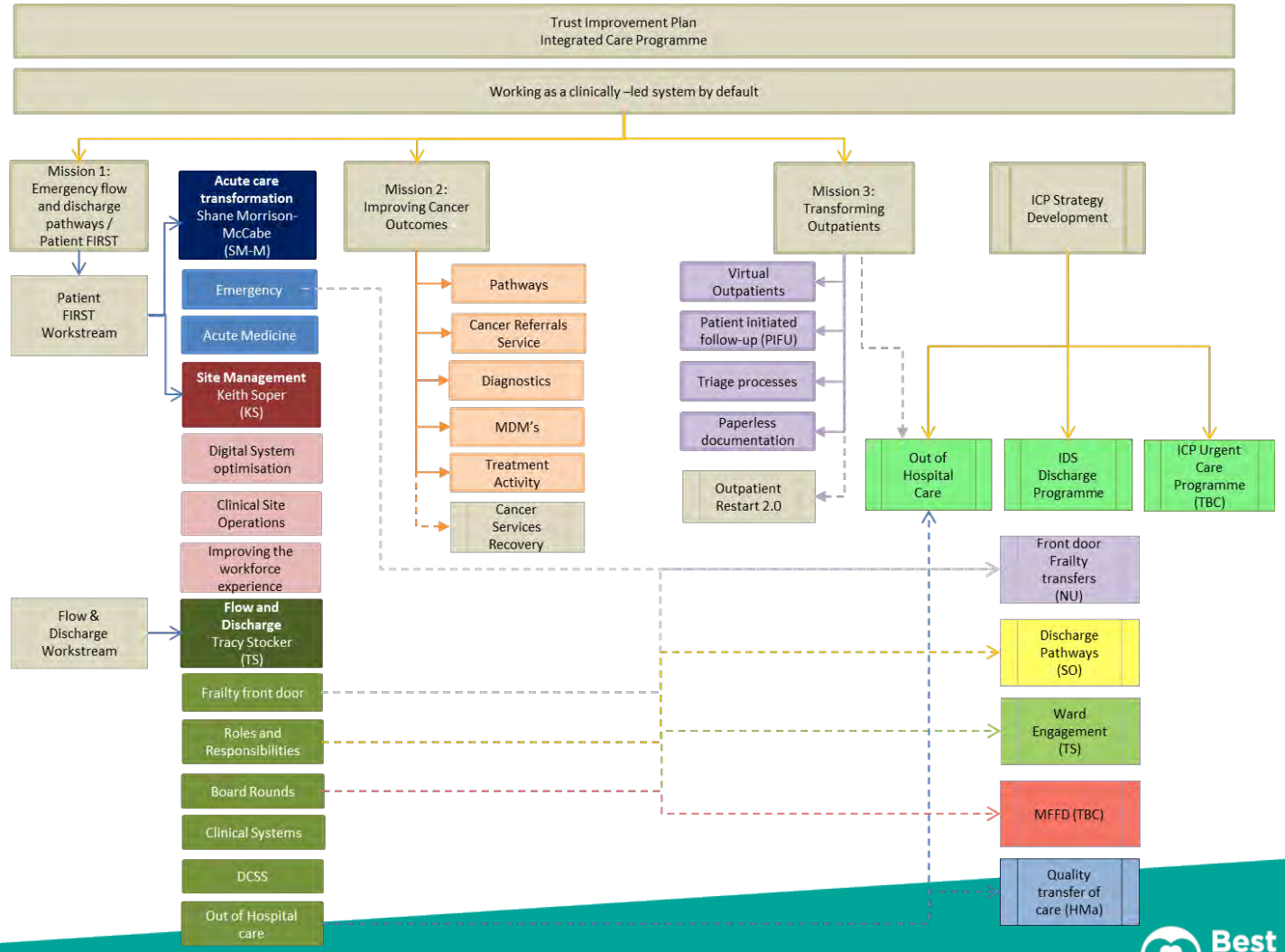
PATIENT FIRST

Trust Improvement Board 21 April 2021
Update

Best of care
Best of people

Our Medway

PATIENT FIRST (INTEGRATED CARE)
Phase 2 proposed delivery structure



Best of care Best of people

Our Medway

1. ACUTE CARE TRANSFORMATION

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Shane Morrison-McCabe, Dr Ashike Choudhury, Dr Ashraf Syed, Dr Sanjay Suman,
Improvement resource: Jacqui Leslie, Jodie Taggart, Hannah Scott + ECIST

NHS Medway NHS Foundation Trust

Aims of the work

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

Short-term tests of change (PDSA cycles)

30, 60, 90 days

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

Long-term priorities and key deliverables

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

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

Outcome measures

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

Process measures

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

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Shane Morrison-McCabe, Dr Ashike Choudhury, Dr Ashraf Syed, Dr Sanjay Suman,
Improvement resource: Jacqui Leslie, Jodie Taggart, Hannah Scott + ECIST

NHS Medway NHS Foundation Trust

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

Work stream: Emergency Flow (Acute Care Transformation)
Clinical and Operational leads: Shane Morrison-McCabe, Dr Ashike Choudhury, Dr Ashraf Syed
Improvement resource: Jacqui Leslie, Jodie Taggart, Hannah Scott +ECIST

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Activities completed in last 4 weeks

- New RO in post for ACT ED and Acute Medicine “stems” of the ACT workstream
- ACT Frailty workstream realigned to Flow & Discharge workstream
- Revised Patient Safety, Quality and ED Performance meeting established by incoming workstream RO
- ED Demand and Capacity against staffing review completed for all clinical teams (actions to progress Nursing staffing)
- C-19 Swabbing review completed for patients on Assessment / Admission pathways
- Re-establishment of the Consultant Connect in Emergency Care project via KMCCG
- Timetabled ECIST peer review / support visits from w/c 19/04/21
- Site management presence in ED SitRep meeting embedded

Activities planned for next 2 weeks

- Finalise trajectories to “green” status on ED and Emergency Care standards
- Director level meeting to re-establish delivery of clinical system resolution for the entire “emergency floor” (ED, SDEC, FSDEC, AAU, FAU and SAU)
- Integration of the SAU/SSDEC plans into the ACT workstream
- Re-establishment of IPC compliant Acute Med Assessment pathway on Lisrt to support ED “refer and move”
- Engagement with Mental Health partners regarding the use of the Clinical Decision Unit
- Trial adjustment to Nursing staffing to meet demand and capacity profiling
- ECIST workshop to revise and refine ED Escalation protocols (22/04/21) and complete SDEC Peer Review (30/04/21)
- Finalisation of ED Roles & Responsibilities (Nursing and other) for daily Command & Control functions
- Patient experience measures co-design
- Implementation of single clerking proforma
- ED Breach analysis process review by Divisional Director

Needs & Dependencies

- Activity related to development of the ED workforce model to reflect professional standards and national guidance throughout the emergency pathway (support from Workforce stream)
- Clinical engagement to support Consultant Connect project

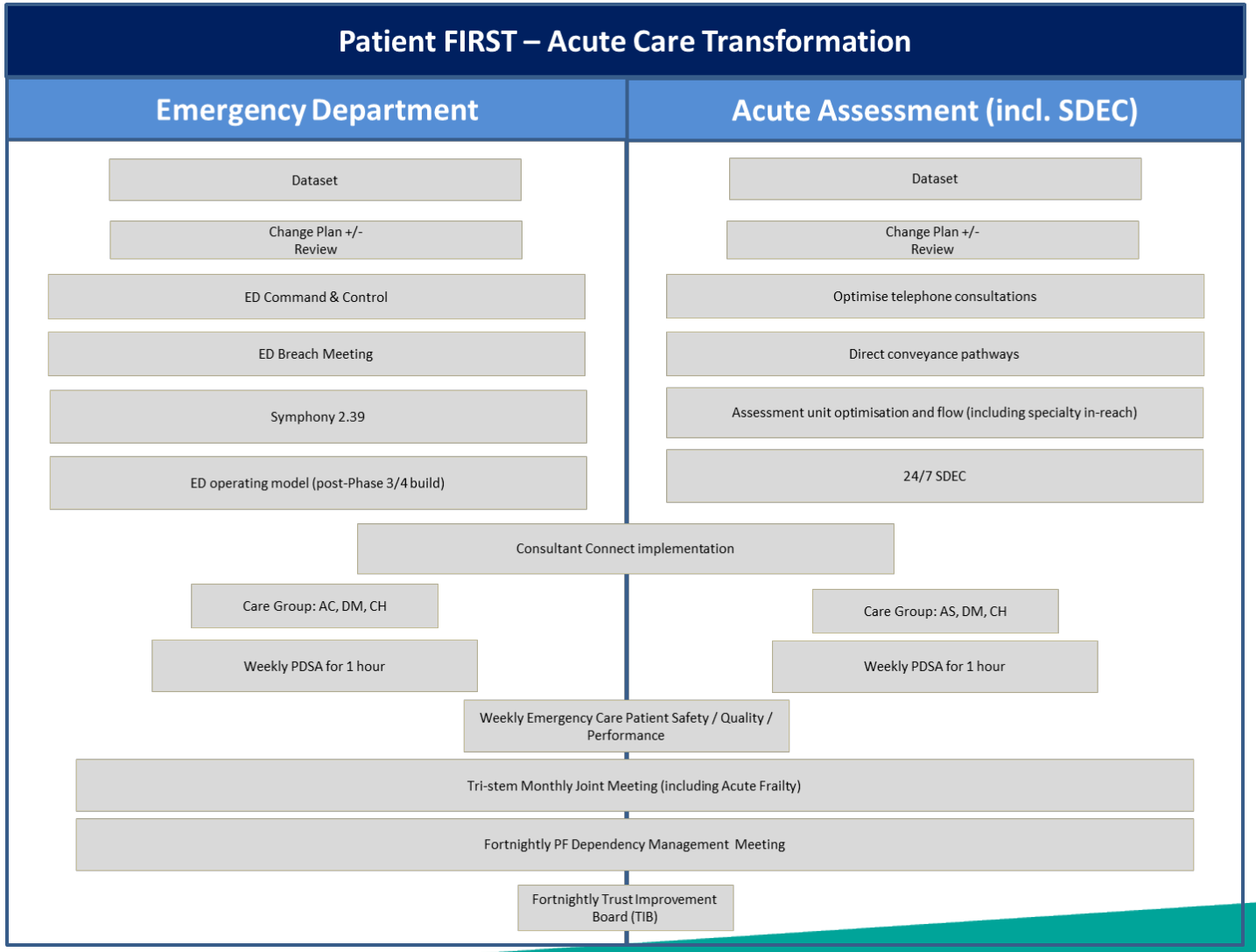
Dependencies:

- Clinical Systems upgrade (now delayed to May 2021), including the implementation into SDEC / FAU
- Clinical Review of Standards publication to enable revision to metrics and clinical systems requirements

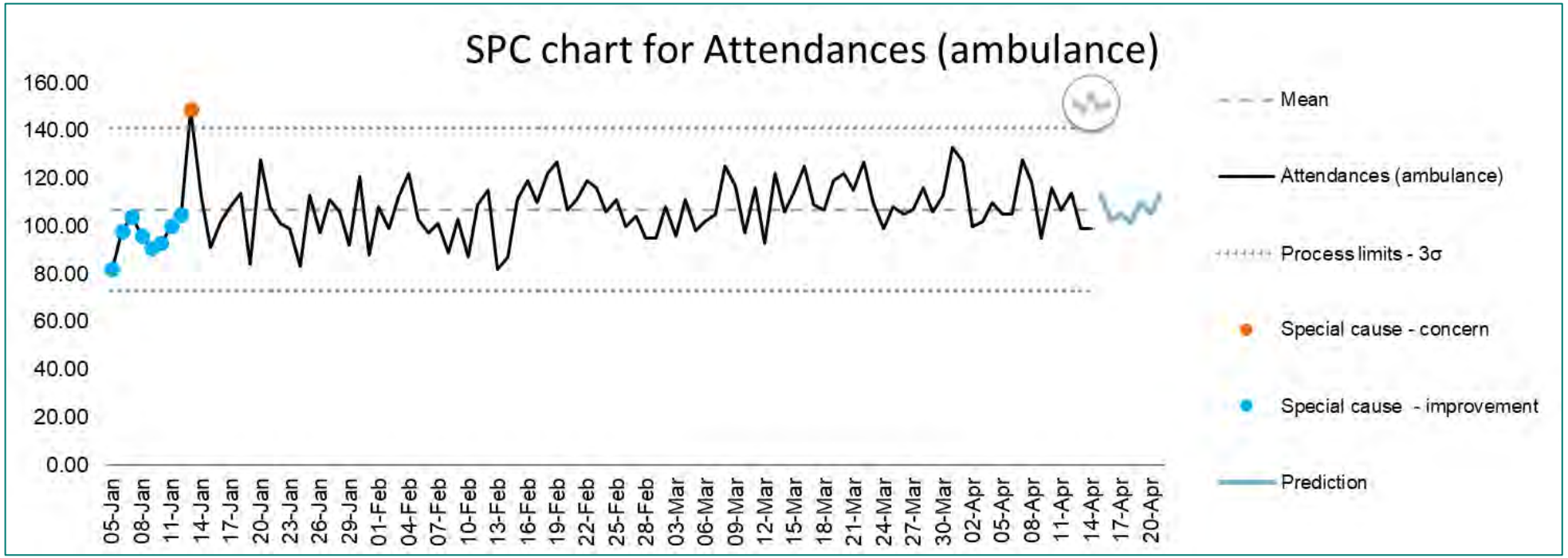
Risks, Issues & Blockers

- Integration with other plans / deliverables and reporting structures focussed on Emergency Care (including ICP, CQC, other plans)
- BI identified risks (contractual / financial) attached to the implementation of a single clinical system across the “Emergency floor”
- Diagnostic capacity issues impacting emergency care standards
- Clinical capacity to support the mobilisation of Consultant Connect for Emergency Care

ACT Workstream (Phase 2) Summary



Measures: Ambulance attendances (01/01/21 – 14/04/21)

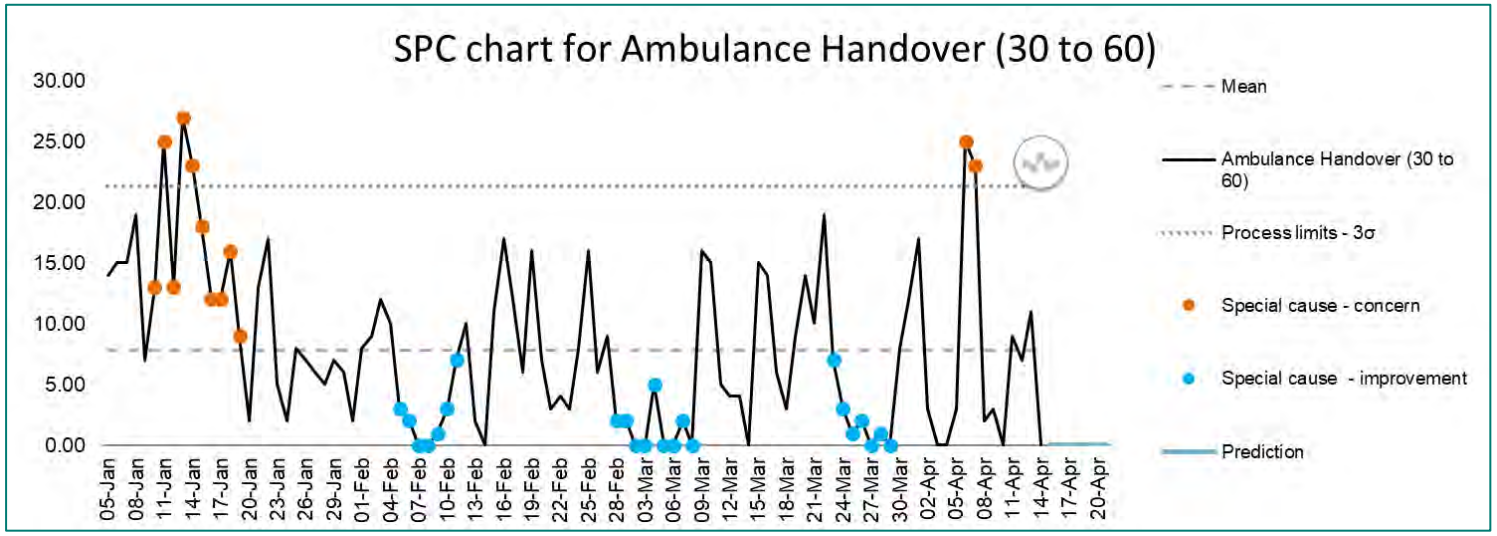


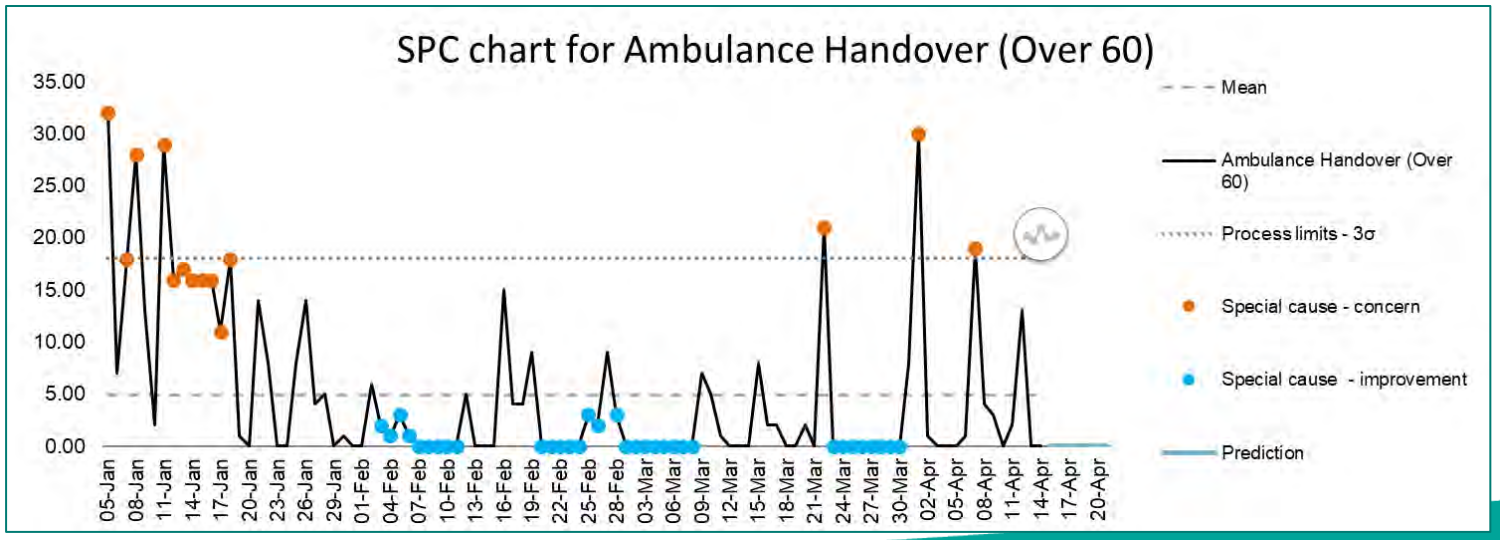
Source: ECIST UEC dashboard 14/04/21

Ambulances attendances have experienced greater variability late March and early April..

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

Measures: Ambulance handover delays (1)





Source: ECIST UEC dashboard 14/04/21

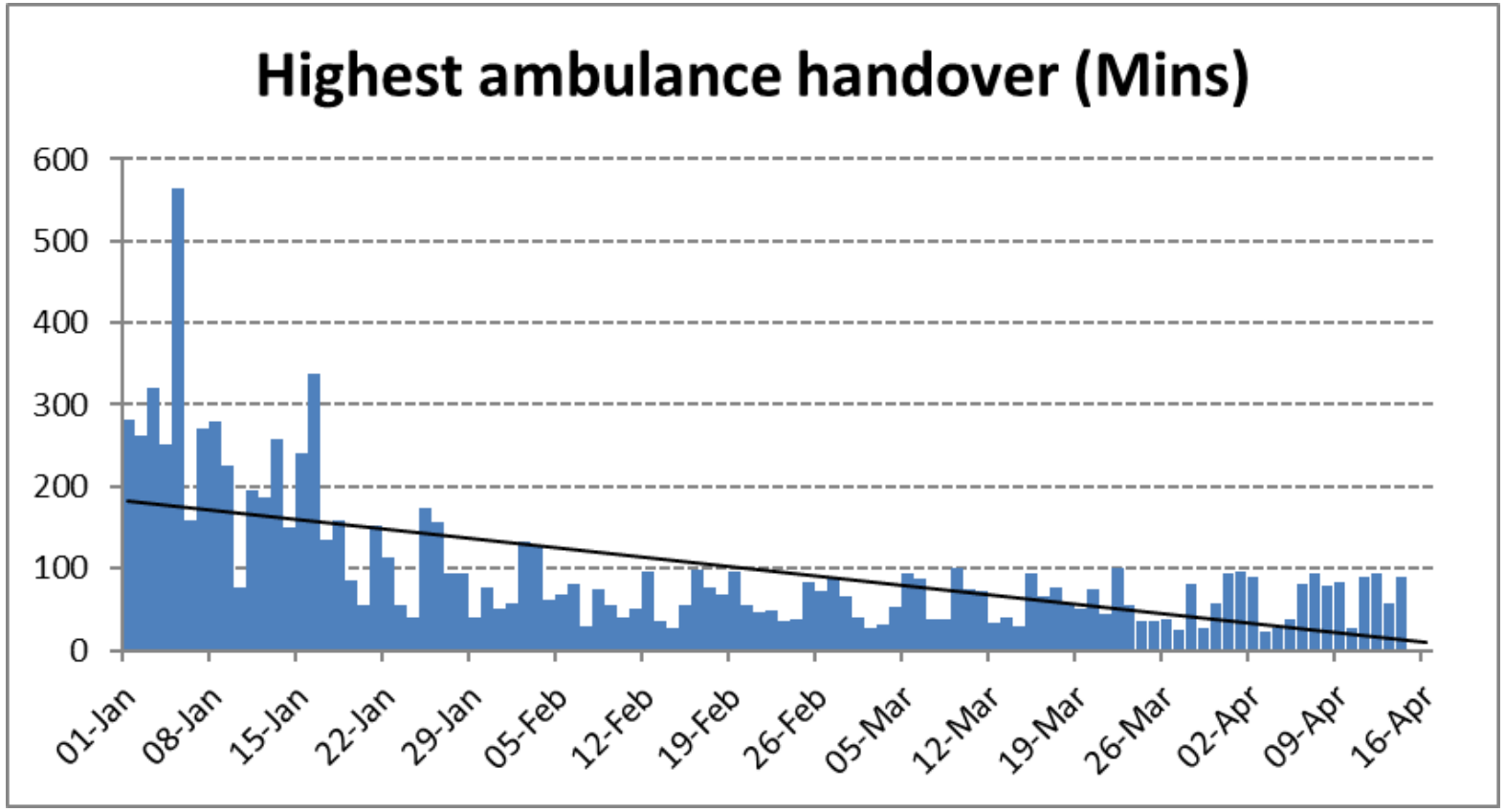
There is a broadly improving picture with Ambulance handover delays since the second half of January.

Notable peaks at the end on the 1st and 7th April correspond to elevated Ambulance Attendances >125 on each day (mean = 107)

Since late Feb. Ambulance handover delays in both 30 – 60 mins and the 60min+ have shown improvement with three notable exceptions in late March and early April.

Highest handover delay since the beginning of Feb peaked at 100 minutes on 22/03/21.

Measures: Ambulance handover delays (2)



Source: MFT Business Intelligence (GB) 15/04/21

Highest handover delays have reduced significantly since 1st Jan. The longest delay experienced in the past 6 weeks was on 22/03/21 at 100 minutes.

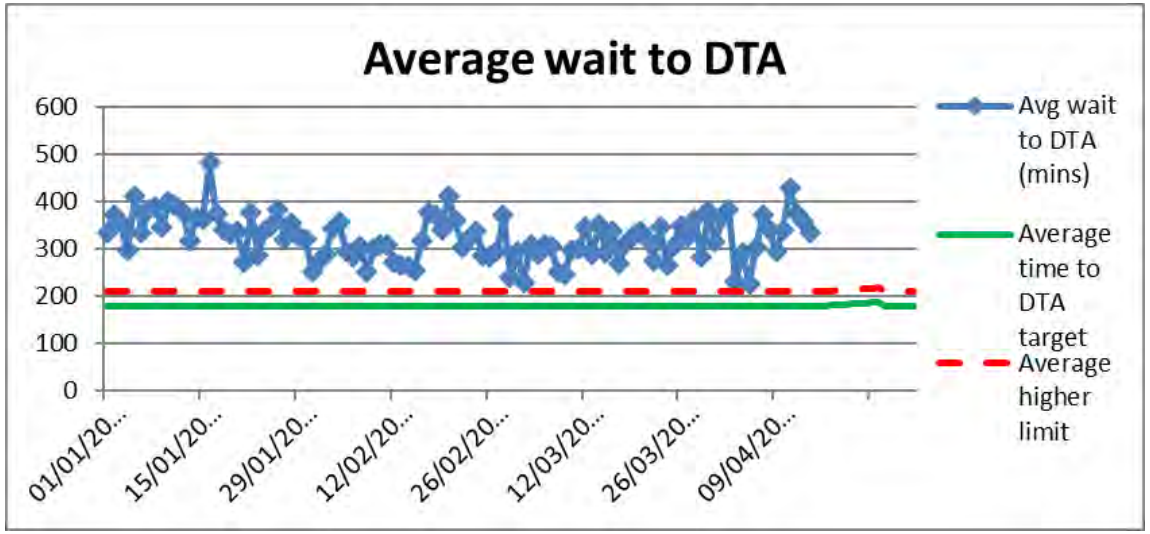
Measures: Decision to Admit / Admission

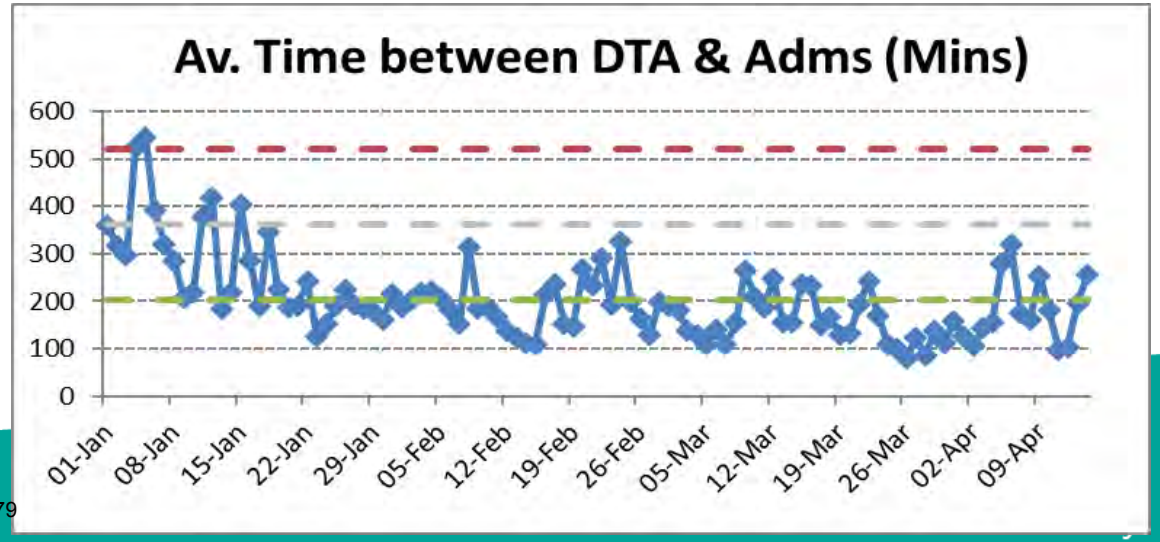
Arrival to decision to admit (DTA)
Average time from arrival to DTA remains >250mins indicating most patients are being assigned a DTA over 4hrs.

Initial reviews completed by Senior clinical staff are have not identified any issues with time taken to swab. Breach analysis supported by the weekly ED Patient Safety, Quality and performance meetings will form next round of improvement activities within the ED Acute Care Transformation workstream.

Decision to admit (DTA) to admission
Average time from DTA to admission has trended down from the 1st January. Since last submission, some peaks (>250mins) have been experienced, thus increasing the average DTA to Admission time.

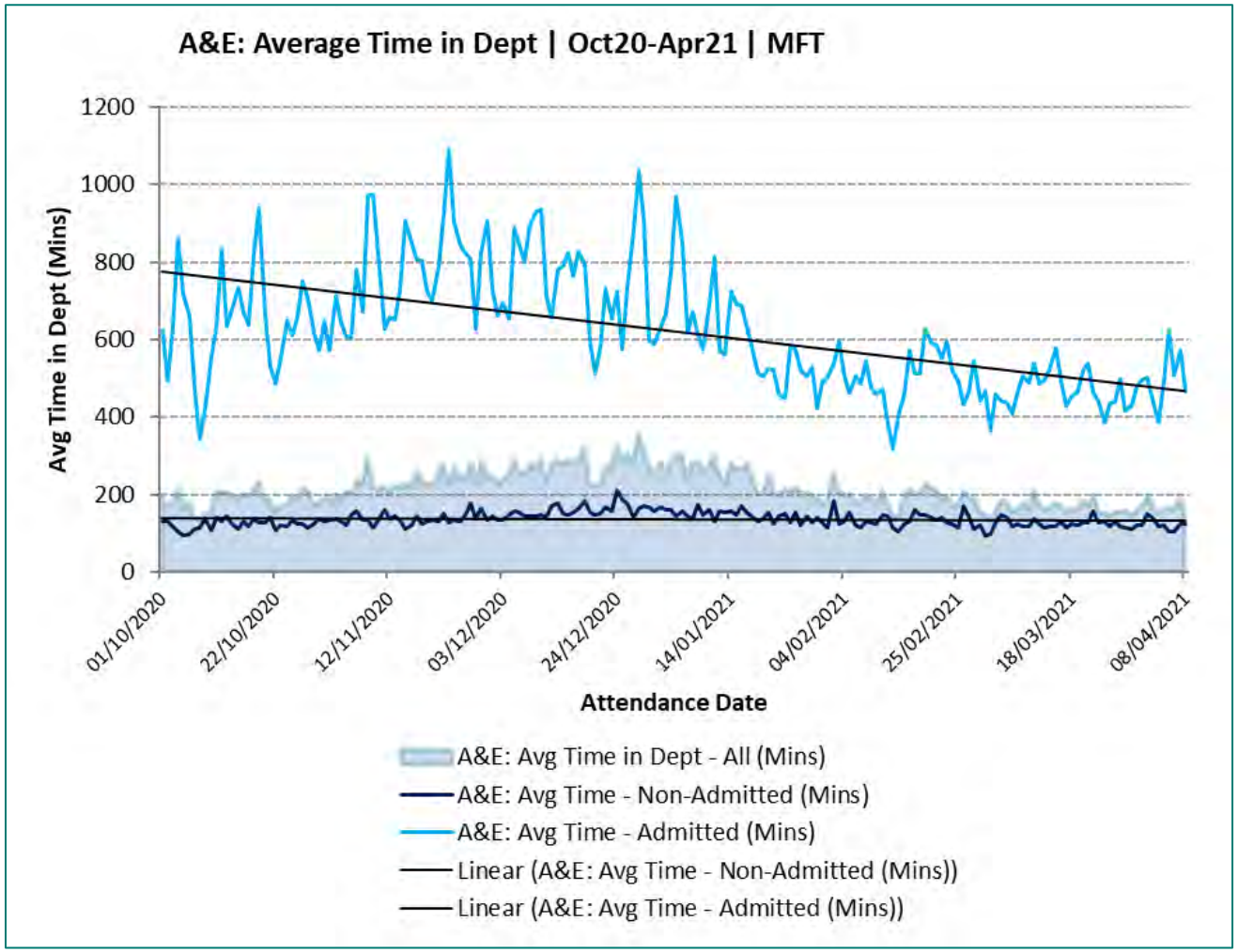
The re-establishment of the Acute Medical Assessment pathway and the implementation of the single clerking proforma are expected to impact positively on this metric





Source: MFT Business Intelligence (GB) 15/04/21

Measures: Average total time in ED

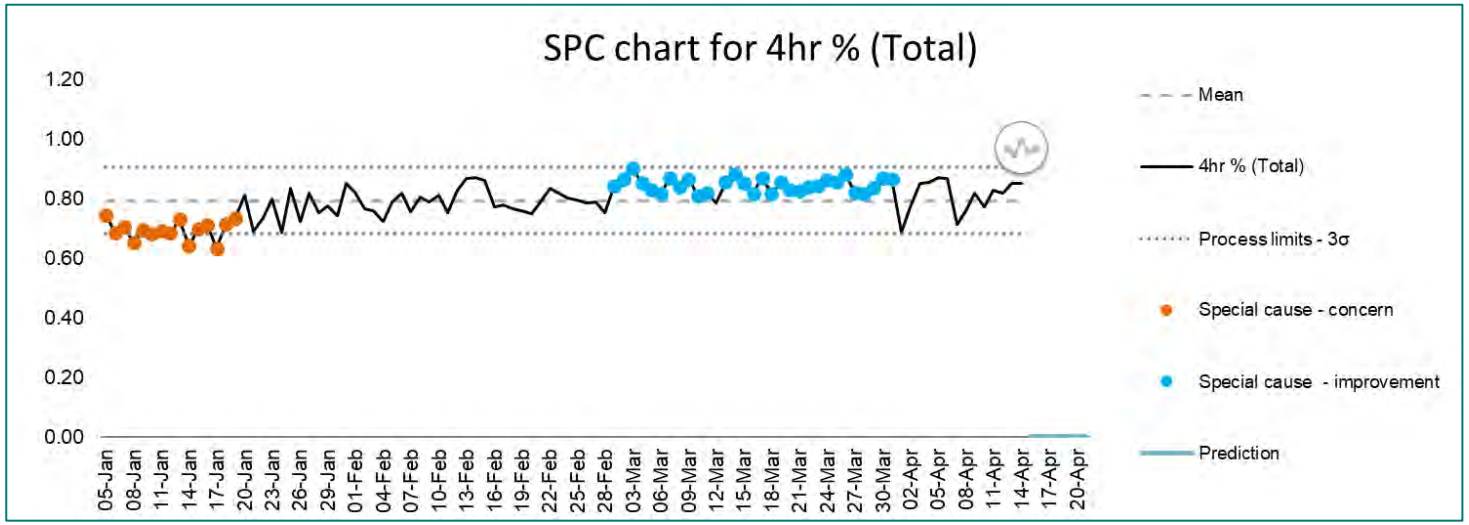


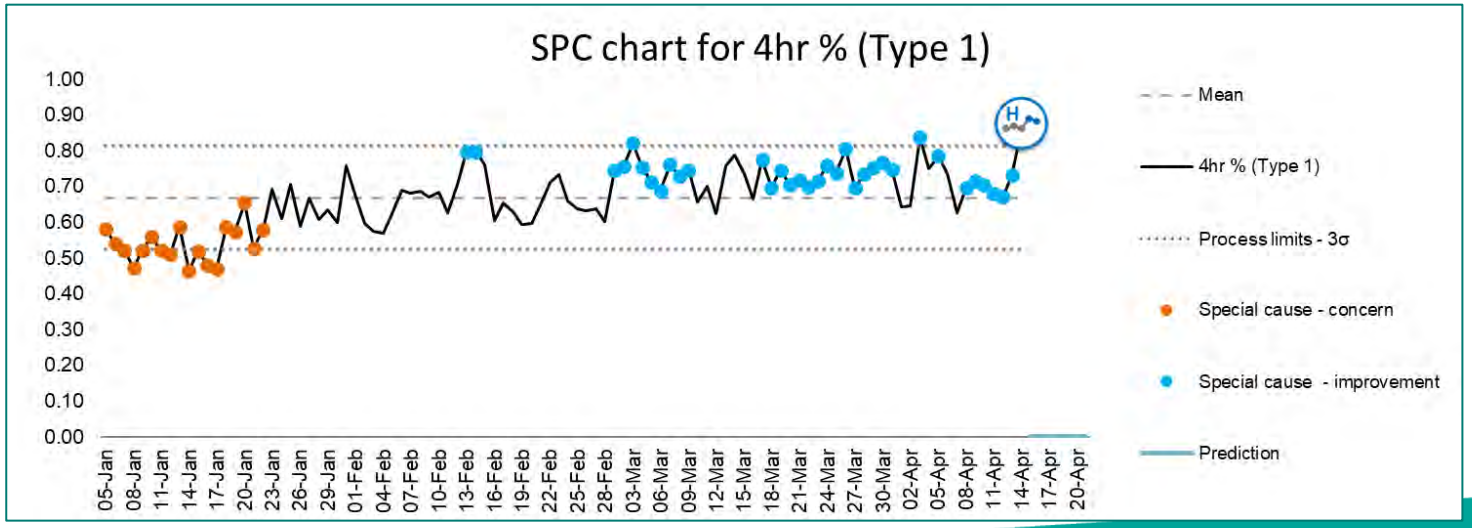
Average total time in ED has decreased over Q3 and Q4, impacted by improving timeliness of the admitted pathway (noted by the trend-line).

The reconfiguration of the G&A bed base to correlate with the overall reduction in CoVID positive patient admission has supported this and the and will be further stabilised and improved through the re-establishment of Lister Acute Medical Assessment functionality

Source: MFT Business Intelligence Flow Dashboard 18/04/21

Measures: 4 hour performance





Source: ECIST UEC dashboard 14/04/21

Overall 4-hour performance has shown some volatility since the start of April but had achieved >80% consistently in March. This correlates with Type 1 performance for the same period.

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

2. FLOW AND DISCHARGE

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

NHS Medway NHS Foundation Trust

Aims of the work

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

Short-term tests of change (PDSA cycles)

30, 60, 90 days

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

Long-term priorities and key deliverables

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

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

Outcome measures

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

Process measures

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

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

NHS Medway NHS Foundation Trust

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

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

NHS Medway NHS Foundation Trust

Activities completed in last 4 weeks

- Alignment of flow initiatives (SAFER Board Rounds, LOS reviews, EDD compliance) and inclusion of Acute Frailty in Phase 2 scope
- IDT collaboration to explore improvement opportunities
- Shadowing IDT colleagues to build relationships and improve understanding of discharge pathways. Encouraged the return of IDT colleagues at Board Rounding
- Engaged with clinical teams to establish best practice through gap analysis and process mapping
- Engaged with IT teams to audit wards to ensure they have the devices and support required for real-time system entry
- Prepared diagnostic teams for electronic OrderComms installation
- Created SMART service matrix for current services
- Full scoping of F&D programme completed and submitted to IC Programme SRO
- Initial draft Phase 2 metrics set developed with BI

Activities planned for next 2 weeks

- Deliver role based training and implement Clinical Systems prompt sheets in pilot areas (to improve data completion rates)
- Complete workshop with Clinical teams for Criteria to Reside (C2R)
- Baseline workstream metrics and trajectories pending BI resources
- Finalise roles and responsibilities of Progress Chasers, Virtual bed bureau/ward clerks to support Board Rounds and discharge
- Adopt the use of diagnostic ordering systems (OrderComms) in early implementer areas (Emerald, Pembroke and Will Adams wards).
- Create SOPS and IPS documentation to support with Go Live of B.E.S.T Ward planned for May 2021
- Training needs analysis to be conducted and Trust's Training Team to engage with wards and offer bespoke, relevant training.
- Cross – Programme working with IT PMO to roll out DartOCM project
- Cross - Programme working with EPR Programme Director to support efficient deliverables for both programmes

Needs & Dependencies

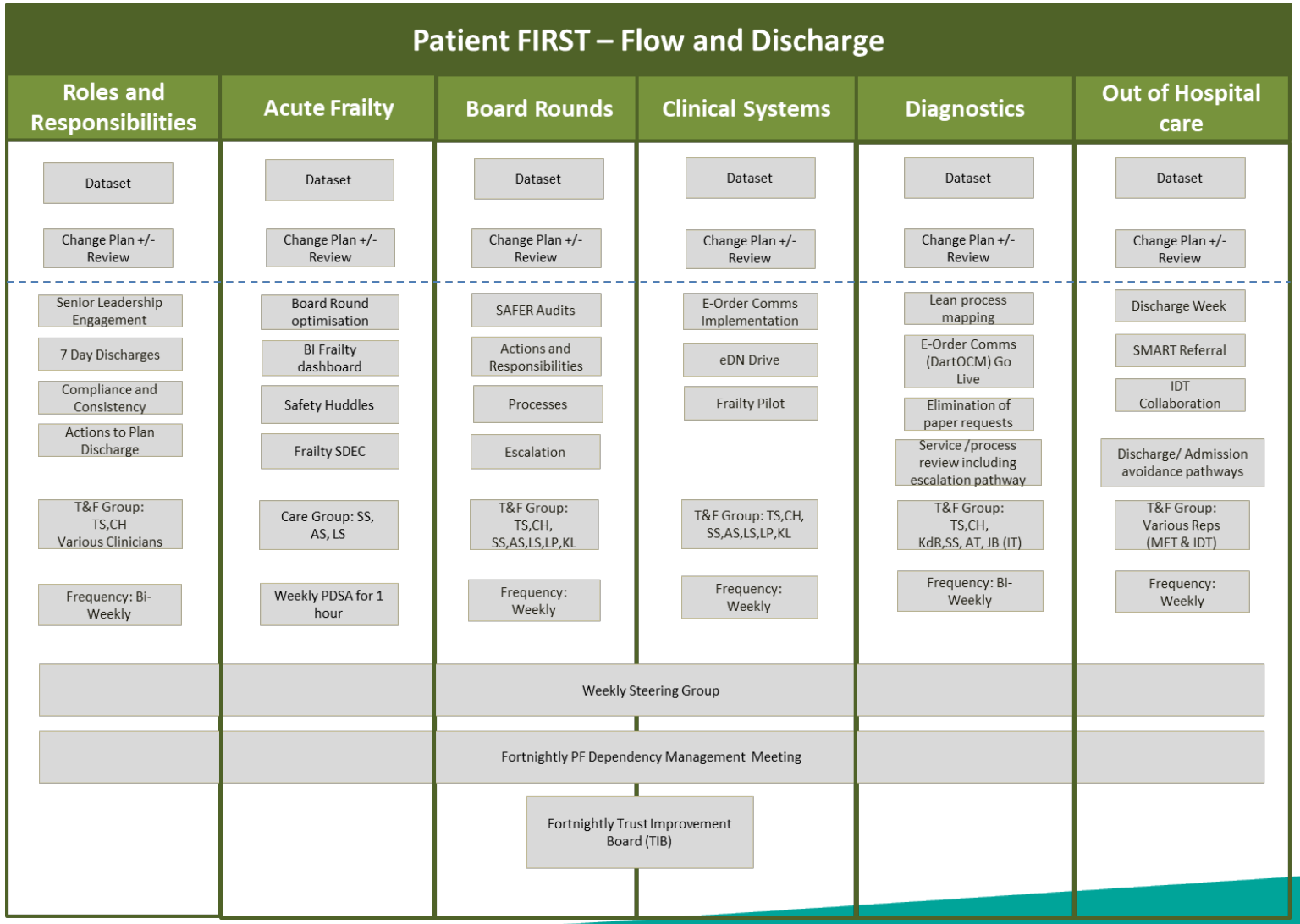
Needs:
- Refreshed Clinical Systems support for inpatient teams

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

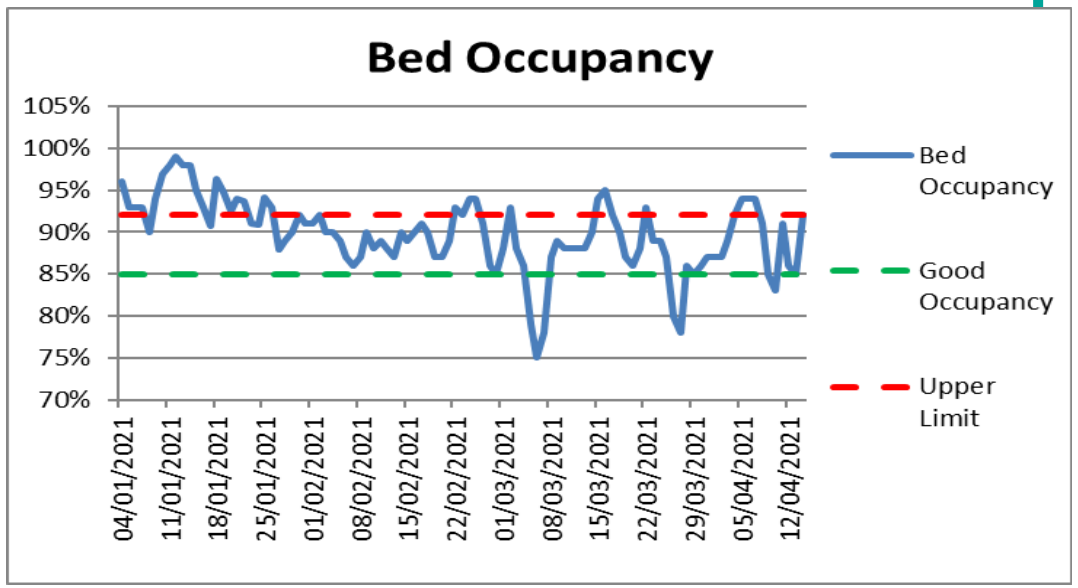
Risks, Issues & Blockers

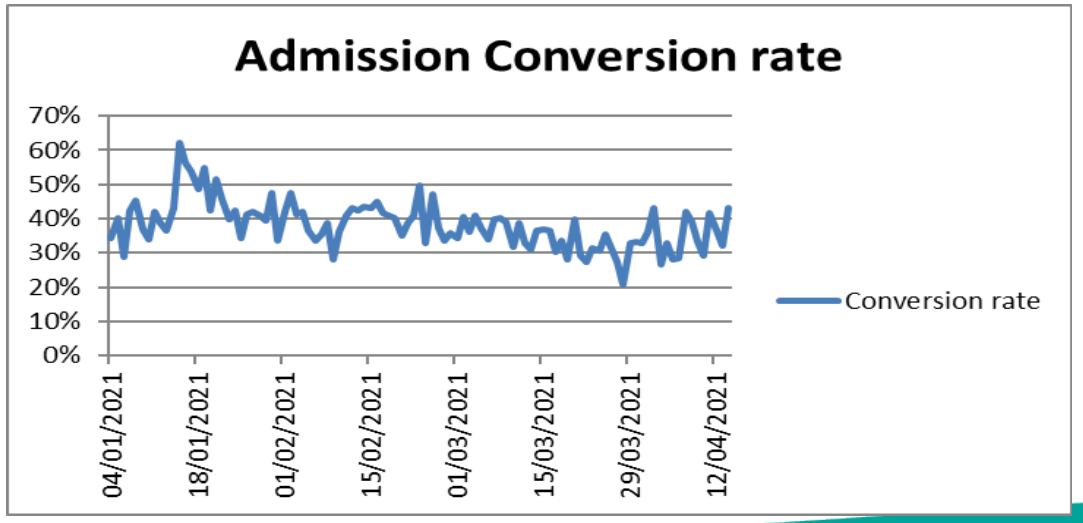
- ICP / ICC assurances to support Frailty SDEC Business Case
- Divisional Clinical engagement to support workstream beyond early adopter group (TOP Care Programme)
- Clinical capacity to engage in board rounds which SAFER rounds particularly in planned care
- Capacity to support real-time clinical systems entry from a systems access, hardware and workforce perspective

Flow and Discharge Workstream (Phase 2) Summary



Measures – Bed Occupancy



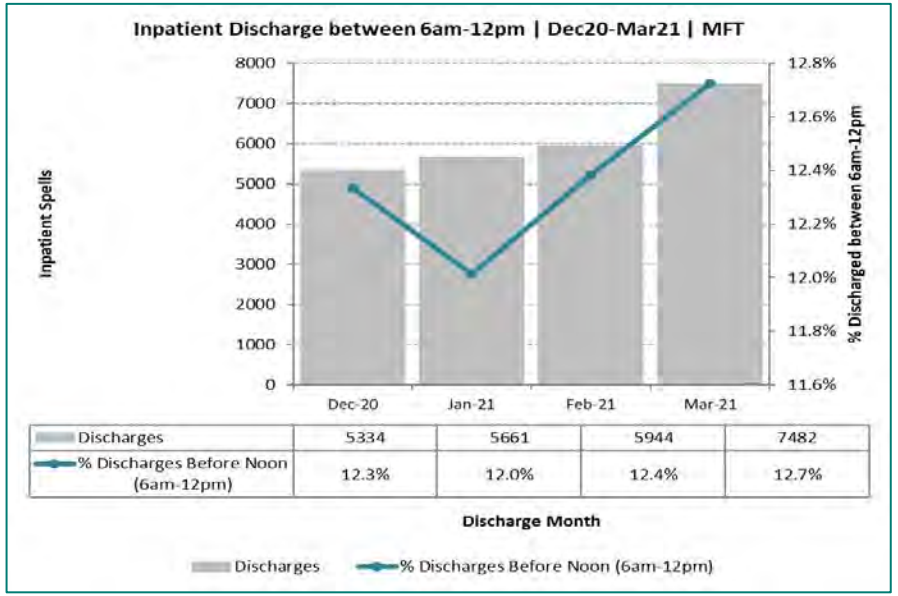


Bed occupancy is currently above the upper level of 92% but continues to fluctuate.

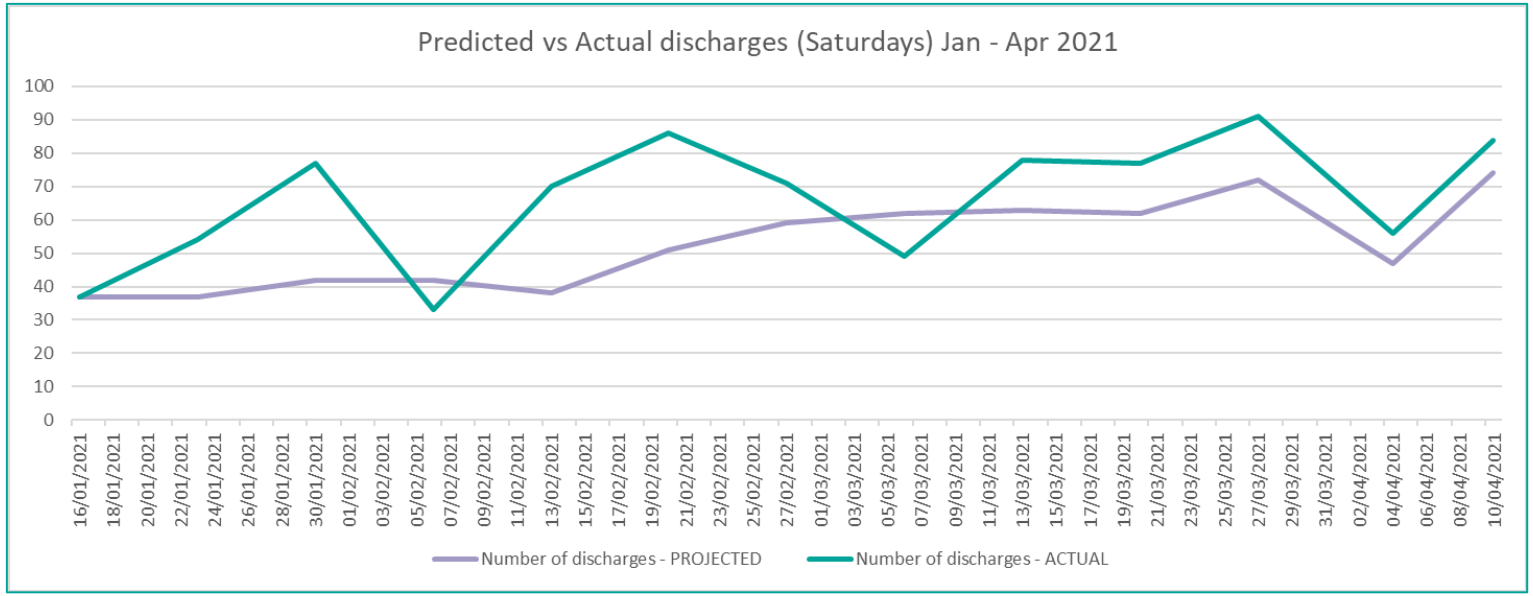
The overall increase in bed occupancy corresponds to an increase in admissions overall, as evidenced by the conversion rate, coupled with the phased closure of Jade Ward.

Source: MFT Business Intelligence (GB) 15/04/21

Measures – Pre-noon / Weekend discharges



Source: MFT Business Intelligence Flow Dashboard 18/04/21



Source: MFT Business Intelligence A&D report (GB) 15/04/21

Pre-noon and Saturday discharges show an improving position since January 2021. The Flow and Discharge (F&D) workstream has supported mini-MADE events with internal and system partners in Medical and Surgical wards three – five times / week since mid January. This is in addition to weekly continuous improvement sessions with the Therapies and Older People's Care Programme to support a Centre of Excellence (B.E.S.T Ward) project scheduled to commence in early May.

The F&D workstream is also progressing improvement activities across clinical systems recording of care and discharge pathways in three wards from 26/04/21 to improve data completion and real-time Site information.

3. SITE MANAGEMENT

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

NHS Medway NHS Foundation Trust

Aims of the work

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

Short-term tests of change (PDSA cycles)

30, 60, 90 days

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

Long-term priorities and key deliverables

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

How will we know we are successful – and by when

Outcome measures

- Senior decision-making attendance at Site Meetings

Process measures

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

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

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

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

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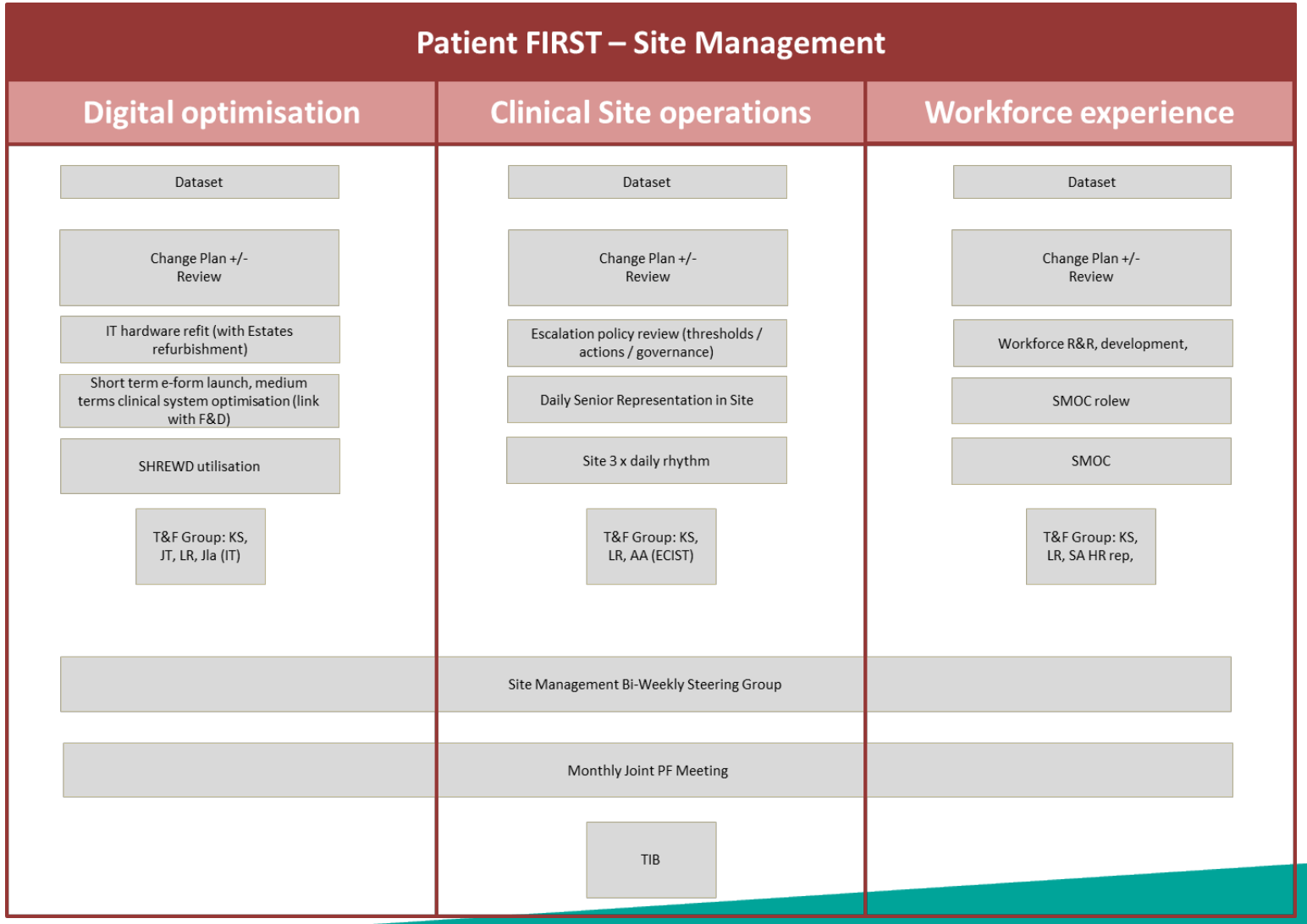
Activities completed in last 4 weeks	Activities planned for next 2 weeks
▪ Electronic Site documentation completed and tested for planned go-live in April 2021. Training guide available on intranet for ease of access for all staff ▪ New daily Site sit-rep trialled ▪ On call manager survey completed ▪ Attendance at Site meetings from ED nurse in charge ▪ Site office refurbishment complete – New screens , IT hardware and furnishings.	▪ Finalise Trial twilight site management shift to support on-call managers and manage staffing ▪ Further comms to be issued re: new Site e-form to support 3 x daily Site Meetings ▪ Complete redesign of site SOP ▪ Comms to be issued with new photos of refurbished site office
Needs & Dependencies	**Risks, Issues & Blockers**
Needs ▪ SAFER Board Round compliance and improvements in data completion rates (Flow & Discharge) ▪ BI Dashboard development support aligned to revised escalation processes Dependencies ▪ Emergency Care Standards finalisation and implementation (ED / Ambulance handover) ▪ Clinical Systems upgrades (SDEC / AAU / SAU / FAU)	▪ Data completion and accuracy rates within Clinical Systems to inform site management functions ▪ SAFER Board Round compliance and management of criteria to reside (see Flow & Discharge workstream for mitigation) ▪ BI resource to map and mitigate data / information gaps impacting on ability to measure and track improvement ▪ Ongoing challenges around the flow from ED, assessment unit capacity and flow and de-escalation of areas

Site Management Workstream Summary



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4. WORKFORCE AND ORGANISATIONAL DEVELOPMENT

Best of care
Best of people

Our Medway

Workstream: Workforce and Organisational Development

Clinical and operational leads: David Hurrell, Allison Burrell with input from Simon Smith, Doug McClaren, Clive Evans, Clare Hughes, Ashike Choudhury, Ayesha Feroz

Improvement resource: Alex Hayes

NHS Medway NHS Foundation Trust

Aims of the work

- Ensure patient-centred care is at the heart of decision making.
- Strengthen improvement methodology and management skills to support sustainable change.
- Ensure workforce model reflects professional standards and national guidance throughout the emergency pathway.
- Ensure all colleagues feel valued, empowered and supported to provide safe, high quality care.

Short-term tests of change (PDSA cycles)

30 days

- Agree staff engagement approach for all Patient First workstreams via an agreed engagement plan.
- Create Health & Wellbeing Plan specifically for ED.
- Review opportunities for professionally qualified staff to work a higher proportion of time at the top of their licence.
- Trouble-shoot Band 7 Senior Nurse retention.

60 days

- Facilitate staff engagement sessions.
- Review practice development support to aid retention.
- Review and start implementation of changes so that emergency pathway staffing meets national effectiveness standards.
- Begin developing current quality improvement capability.
- Support clinical leaders to evaluate past improvement campaigns and lessons learnt.
- Instigate monthly staff open forums.

60 days+ Long-term priorities and key deliverables

- Benchmarking of workforce development in other Trusts
- Update and refresh workforce strategy for ED.

How will we know we are successful – and by when

(measures and timeframes)

NHS Staff Survey

- % confirming frequent opportunities to show initiative in their role.
- % confirming able to make. suggestions to improve the work of their team / department.
- % confirming able to make improvements happen in their area.
- % confirming trust definitely takes positive action on health & wellbeing.

*[*2020 results to inform quarterly KPI]

Repeat of B7 Nurse questionnaire

- Do you see the Emergency Department as being Clinically led?

Outputs

- Staff in post in line with national effectiveness standards [Jul 2021]
- Number of engagement sessions – monthly.

Workstream: Workforce & Organisational Development

Clinical and operational leads: David Hurrell, Allison Burrell with input from Simon Smith, Doug McClaren, Clive Evans, Clare Hughes, Ashike Choudhury, Ayesha Feroz

Improvement resource: Alex Hayes

NHS Medway

Priorities	Deliverables (30, 60 or 90 Days)	Measures
• Review staffing model in ED (in relation to variation in demand and for the opening of new capacity). • Engagement/Comms Plan for ED. • Create Health & Wellbeing Plan specifically for ED. • Review the "Managing Your Mind" initiative as a resource for ED. • Develop 'healthy workplace allies' within existing workforce. • Support Clinical Leaders in reviewing past improvement campaigns and review QI capability within the department. • Update and refresh workforce strategy for ED.	• 30 Days – Mid-January to end February 2021 *(completed).* • 60 Days – February to end March 2021 *(ongoing)* • 60 Days – February to end March 2021*(in progress in conjunction with global initiative)* • 60 Days – February to end March 2021 *(taster sessions current with dates for course in place)* • 60 Days – February to end March 2021*(progress of JDs achieved)* • 60 Days – February to end March 2021 *(delayed due to mediation initiative)* • 90 Days – January to end March 2021 *(ongoing)*	• HWB: My immediate manager takes a positive interest in my health and well-being • Morale: I am involved in deciding on changes introduced that affect my work area/team/department • Quality of care: I feel that my role makes a difference to patients/service users • Safety culture: when errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again • Staff engagement: I am able to make suggestions to improve the work of my team/department

Workstream: Workforce & Organisational Development

Clinical and operational leads: David Hurrell, Allison Burrell with input from Simon Smith, Doug McClaren, Clive Evans, Clare Hughes, Ashike Choudhury, Ayesha Feroz

Improvement resource: Alex Hayes

NHS Medway NHS Foundation Trust

Activities completed in last 2 weeks

- Mediation work with ED colleagues is underway.
- Job descriptions for HWB workforce allies/champions have been produced.
- Managing Your Mind Programme tester sessions for staff have taken place.
- Planned Care have confirmed funding available to support the location costs for the Managing Your Mind Programme.
- Band 7 Development Programmed initiated by the Director of Nursing.

Activities planned for next 2 weeks

- Progress global comms with the Communication team to promote the HWB workforce allies/champions' roles.
- As part of the Culture & Leadership change team phase 2, seek increased representation from within ED.
- Confirm funding with Unplanned Care to support the HWB allies/champions within ED as previously discussed with KC.

Needs and dependencies

- HR & OD resource supported by Transformation Programme Manager.
- Interdependencies with other Patient First workstreams and Trust Improvement Plan programmes to ensure a transparent approach to deliverables and to avoid duplication.

Risks, issues and blockers

- Reaching agreement from a leadership perspective in terms of 'who, what, when' to be able to take the workstream aims forward.
- Difficulty in achieving staff engagement due to operational pressures.
- Cross over with Trust Improvement Plan programmes of work.