Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 6 August 2020 at 10:00 – 13:30

Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Acting Chair	Verbal	10:00	Note
1.2	Quorum				
1.3	Conflicts of Interest		-		
1.4	Chief Executive's Update	Chief Executive	3	10:05	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 2 July 2020	Acting Chair	7	10:20	Approve
2.2	Matters arising and actions from: 2 July 2020	Acting Chair	23		Discuss
3.	**Governance**				
3.1	Board Assurance Framework and Corporate Risk Register Summary (Presented by David Seabrooke)	Deputy Chief Executive	25	10:35	Note
4.	**High Quality Care**				
4.1	Covid-19 Update (Presented by Angela Gallagher)	Strategic Commander/ Medical Director	39	11:05	Assurance
4.2	Integrated Quality Performance Report	Deputy Chief Executive	49	11.25	Assurance
4.3	Quality Assurance Committee Assurance Report - Control of Substances Hazardous to Health (CoSSH)	Chair of Committee	79	11:45	Assurance
4.4	Referral To Treatment – Current Position	Chief Operating Officer	83	11:50	Discuss
5.	**Innovation**				
5.1	Trust Improvement Plan	Chief Executive	89	11.55	Approve
Screen Break 12:25					
6.	**Financial Stability**				
6.1	Finance Report - Month 3	Director of Finance	103	13:00	Assurance
6.2	Finance Committee Assurance Report	Chair of Committee	117	13:20	Assurance
7.	**Our People**				
7.1	People Committee Assurance Report	Chair of Committee	121	13:40	Assurance
8.	**Any Other Business**				
8.1	BAF Reflection	Chair	Verbal	14:10	Discuss
8.2	Any other business	Chair	Verbal	14:20	Note

NHS
Medway
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Chief Executive's Report – August 2020

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

The Board is asked to note the content of this report.

In and around Medway

After a number of months battling the COVID-19 pandemic, it certainly feels like a corner has been turned and our focus over the last month has not only been on returning our services to normal but looking to our more long-term future.
Following the national directive from NHS England in March, we had to take the very difficult step to postpone and cancel some services at the Trust in order to be able to manage the surge in emergency requirements, additional critical care services and other services related to the COVID-19 pandemic.

During this time, we continued to treat patients who required urgent care and patients receiving cancer treatment.

We were able to offer many outpatient appointments via telephone or video call. Unfortunately, we had to postpone planned surgeries and were unable to accept many routine referrals for diagnostic tests.

We quickly responded to the NHS England letter issued by Simon Stevens and Amanda Pritchard on 29 April requiring all Trusts to begin to safely reintroduce these services and facilities. We immediately started on our plans and actions to restart and restore our routine elective surgeries, outpatients and diagnostic services safely, while continuing to manage the COVID-19 challenge.

Following an intense period of work involving teams and specialities from across the Trust, we were able to restart our elective surgery services, and increase the number of outpatient appointments on site. Diagnostic services are also now available.
We have plans in place to reduce the number of patients waiting for their surgeries, including reconfiguring areas of the hospital to increase theatre capacity, and working in partnership with our colleagues in health and care across our Integrated Care Partnership.

We are fully committed to bringing all our services back to full capacity as quickly, and as safely as possible. We are extremely grateful for the support of our community and thank them for their continued patience and understanding.

I would like to extend my thanks to all our staff who have worked so hard to restart services for our community; it has been a fantastic effort, typifying the teamwork I have come to expect from the staff at Medway.

One of our key aims throughout the pandemic has been to ensure our staff remain updated with the latest information, not only to ensure that they can do their role safely but also to provide some assurance during a very challenging time. I am really pleased to say that a

recent survey has shown that more than 90 per cent of staff felt that the communications throughout the pandemic was either ‘excellent’, ‘very good’ or ‘good’.

We have also invited staff to share their stories about working through the pandemic, publishing them in a series of ‘Medway Moments’.

Planning for winter
Planning for winter and a potential second wave of coronavirus is essential, and Executive colleagues are now working on this, together with health and care partners in our Integrated Care Partnership.

The flu vaccination programme, which will launch shortly, is a key element of preparing for winter and protecting our patients and staff, and our focus will be on a campaign that encourages staff to have the vaccination. This will be supported by other communications reminding staff and patients of the importance of hand washing, wearing masks and social distancing.

Trust Improvement Plan
As I mentioned, we must now also look to the future, and I am really pleased that today we will be presenting our Trust Improvement Plan to the Board.

This plan is clinically led and has been developed following extensive consultation with our staff, community and stakeholders. Thanks to this engagement we have obtained valuable information on staff and stakeholder perceptions about the improvement plan as well as the findings in the CQC report.

We also want the plan to have a fresh and exciting visual identity, designed to instil collective ownership and a celebration of success and today you will see some of the outputs of this branding work from our Communications Team.

As we continue the process of involving staff in the delivery of the plan, we will develop a clear narrative to support each of the projects, clearly articulating the aims and objectives, with the emphasis on plain English and story-telling.

The full version of the plan will be made available electronically, on the intranet and website, and in printed form. More importantly for our target audiences, a shorter, more visual version will be produced to encourage engagement with the key themes.

This plan sets out the kind of organisation we want Medway to be and I know I speak for all staff when I say that we are committed to delivering this plan for our community.

Chief Executive’s Scholarship for Brilliance
It’s that time of the year when I open applications for my £10,000 Chief Executive’s Scholarship for Brilliance. The purpose of the Scholarship, funded by our hospital charity, is to celebrate excellence within the Trust’s workforce by supporting an exceptional candidate’s, or multiple candidates’, learning and development; it aims to support sustainable innovation within the Trust and accelerate quality improvement in patient experience.

In addition to a scholarship of up to £10,000, this year’s winners will receive the added bonus of Quality Improvement coaching from the Medway Innovation Institute. This trained coach will be matched to the winners’ needs and will be available to support and facilitate the development and implementation of your project.

Communicating with colleagues and the community

During this period engaging colleagues and local residents in the work of the Trust has been more challenging. We usually attach great importance to face-to-face opportunities to provide updates on our progress and to receive feedback, however, we have implemented virtual engagement events with our staff and with our governors and members, using technology to have conversations and listen to views. Our Community Engagement Officer is also reaching out to community and voluntary groups to maintain those important links.

Meanwhile, there has been plenty for us to communicate about – the graphic below gives a flavour.

Minutes of the Trust Board PUBLIC Meeting

Thursday, 02 July 2020 at 12:30 - 15:30 - MS Teams, Online Conferencing

Members	Name	Job Title
Voting:	Jo Palmer	Acting Chair
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	Adrian Ward	Non-Executive Director
	David Sulch	Medical Director
	Ewan Carmichael	Non-Executive Director
	James Devine	Chief Executive
	Jane Murkin	Interim Chief Nurse
	Leon Hinton	Director of HR and OD
	Richard Eley	Interim Director of Finance
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Gurjit Mahil	Deputy Chief Executive
	Harvey McEnroe	Strategic Commander
	Jack Tabner	Director of Transformation/IT
	Jenny Chong	Associate Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Interim Company Secretary
	Glyn Allen	Lead Governor
	Ian Renwick	Intensive Improvement Director NHSEI
	Iram Ahmed	Senior Clinical Research Practitioner
	Natasha Pritchard	Lead Freedom to Speak Up Guardian
Observing:	Gemma Craig	Deputy Chief Nurse, MTW NHS Trust
	Judith Douglas	Project Lead for Forensic Services, Nottinghamshire Healthcare NHS Foundation Trust
	Kris Fowler	Account Manager Fluid Systems at Baxter Healthcare Ltd
	Michael Beckett	Interim Director of IT
	Nye Harries	Deputy Director of Intensive Support NHSEI

	Robert Nicholls	Deputy Director of Nursing
Apologies:	Rama Thirunamachandran	Academic Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked everyone for their efforts to make the meeting on MS Teams. Whilst the threat of Covid-19 remains, the Board must do all that it can to adhere to government guidance on social distancing. Apologies for absence were noted as recorded above.

1.1.1 Chair stated there will be an update today about the current position regarding Covid-19, and took the opportunity to say how proud she was of the way the pandemic has been managed at Medway. Staff have provided the most amazing care, and leadership has been exemplary. The presentation on the crucial clinical trials that patients have been involved with in recent months, is another reason to be positive.

1.1.2 As an organisation the Trust has moved into the next phase of our response to the pandemic, and that means working towards the return of surgical and diagnostic services; you will hear an update on how this is progressing today.

1.1.3 Trust staff have been exceptional throughout this whole pandemic but over the last few weeks we have seen a shift in their roles that is in some ways as challenging as when we were in the peak of the pandemic. Staff are not only caring for our patients with Covid but also looking to the future and a return to routine services for our community. This is a challenge that they are rising to and the Chair placed on record her thanks for the incredible job they are doing. She went on to say that the communities are every bit as grateful as she is.

1.1.4 Chair brought the Board's attention to the Trust Improvement Plan on the agenda. This plan is currently being developed to not only address feedback from the CQC report but to shape the future of healthcare services for local communities and the Board will hear more about this today. The plan is clinically lead and shaped by the staff feedback. The initial engagement sessions show that there is real interest from staff.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Conflicts of Interest

There were no conflicts of interest in relation to items on the agenda.

1.4 Patient Story: Dexymethazone Trials for COVID

Iram Ahmed, Senior Clinical Research Practitioner for the Trust gave a presentation to the Board on the Dexymethazone Trials for Covid-19. Following the meeting the presentation was circulated to the Board for information.

Chair gave thanks to Iram from the Board for a wonderful and informative presentation and for the team's achievements. The Board are supportive of the work and invited Iram Ahmed to present later in the year on other Research projects outside of Covid-19.

Action No: TBPU/20/85: Iram Ahmed to come back to the Board in October 2020 to report on Research Projects outside of the Covid-19 study.

Chair stated that Dexymethazone will benefit countries across the world, it is cheap and readily available and will support with the fight against Covid-19. James Devine gave his thanks and congratulations to Iram and the team.

1.5 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.

1.5.1 James stated that now there are fewer patients in the hospital with Covid, he would like to thank Trust staff who continue to work hard to deliver high-quality care for our patients whilst managing the continuing challenges of Covid-19 and progressing plans to resume routine clinical activity. He expressed his sincerest thanks for their hard work and dedication throughout this period; they continue to embody the very best of Medway. This is a moment to reflect, especially with the NHS 72nd birthday on 05 July 2020.

1.5.2 James expressed his gratitude to the community for their support and donations during this time and for abiding to the lockdown rules which in turn takes the pressure off the hospital. Sunday, 05 July 2020 there will be one last clap to celebrate the NHS birthday and to commemorate those that have lost their lives to Covid.

1.5.3 James informed the Board that the Innovation Institute has been launched today and gave his praise to Jack Tabner and the team on this. It is an impressive piece of work to expedite and embed change and a good investment to engage people with innovation.

1.5.4 All stroke services across Kent and Medway face some level of challenge recruiting and retaining specialist stroke staff. The Trust successfully retained sufficient numbers of specialist staff to deliver safe care for stroke patients up to the end of June. However, at this point, the number of stroke specialist nurses responsible for initial assessment of stroke patients and for providing vital clot-busting drugs, reduced from an original establishment of six to one. Specialist stroke nurses are responsible for the initial assessment of stroke patients, alongside specialist doctors, and for administering vital clot-busting drugs.

The loss of these specialist nurses have made it impossible to maintain the necessary quality of stroke service at Medway Maritime Hospital, 24 hours a day, seven days a week. Despite the Trust's best efforts, it has not been able to recruit new appropriately trained and qualified specialist nursing staff to fill the soon to be vacant posts.

As a result, Medway NHS Foundation Trust and the Kent and Medway Clinical Commissioning Group (CCG) made the difficult decision to carry out an emergency temporary transfer of acute (urgent) stroke services out of Medway Hospital from 1 July 2020. James informed the Board that it will be kept informed on the progress with this.

1.5.5 In line with government recommendations, all visitors to the hospital are asked to wear a face covering at all times. Staff are also following government guidance by wearing surgical masks when on site. James gave his thanks to the Executive team for their support with the introduction of face masks in the hospital and ensuring that all visitors to the hospital adhere to wearing one.

1.5.6 Thanks to the Charity who have funded the purchase of the iPads which have been used to help patients in the hospital with Covid stay in touch with their family who have been unable to visit, especially in the end of life care unit.

1.5.7 The Trust continues its support with the enhanced measures around work risk assessments for staff in the BAME community. As a Trust we promote a culture of equality and inclusion and aim to provide a working environment free from discrimination, harassment or victimization. The Trust has plans and policies in place to ensure it operates in line with equality and human rights legislation, and to meet the needs of its black, Asian and minority ethnic staff, as well as staff who fall under the nine protected characteristics.

There are many mechanisms in place to enable staff to speak up if they encounter any form of discrimination, and strongly encourage an environment where staff feel able to discuss matters of race and cultural identity free from fear of prejudice or discrimination.

James has written to all staff to offer his support during this very difficult period and as a Trust we were proud to join other trusts across Kent in pausing for two minutes to support our BAME colleagues to show its support for 'Black Lives Matter'.

1.5.8 June marked the annual celebration of the contribution millions of people make across the UK through volunteering. The Trust are particularly proud of its volunteers at Medway including the League of Friends, and although many of them have had to change their working patterns and avoid visiting the hospital since the Covid outbreak, the Trust does not forget all the years of service they have given to the Trust to help us deliver brilliant care to our patients. The Trust looks forward to many of them returning back to the hospital in the near future. Volunteers, who have been unable to come in, have been able to support in different ways for which the Trust is truly grateful.

1.5.9 James confirmed with pride that the Trust's endoscopy unit has again successfully achieved JAG (Joint Advisory Group) accreditation following reassessment of the unit. This is formal recognition that our endoscopy service has demonstrated the competence to deliver against the measures in the endoscopy Global Rating Scale standards and demonstrates our commitment to providing high-quality, safe and appropriate endoscopy services. Congratulations to all involved.

1.5.10 The Board have consistently been astonished by the Trusts response to Covid and the hard work of the staff. The Board reiterated its concern that staff are now getting sufficient rest/annual leave, to ensure they are ready for the challenges ahead as we return to the new normal and if there is a second wave.

Harvey McEnroe, Angela Gallagher, David Sulch and Jane Murkin are leading on this and are ensuring staff are getting adequate leave and time to recuperate. Thanks to Ewan Carmichael for his input and support from his military background.

James Devine added that he is actively encouraging the Executive team to take some leave as soon as possible.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 4 June 2020 was reviewed by the Board. The minutes of the last meeting were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting
The action log was reviewed and the Board agreed to CLOSE the following actions:
TBPU/20/74, 75, 76, 78, 79, 80, 81, 82 and 84

3 Governance

3.1 Board Assurance Framework

Gurjit Mahil, Deputy Chief Executive, asked the Board to note the discussions that have taken place and discuss any further changes required on the BAF. The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the achievement of the Trust's strategic objectives. The report was taken as read

3.1.1 No further changes to Integrated Healthcare, Innovation or Workforce.

3.1.2 Finance BAF; the following changes have been made:
3a – Current risk rating decreased to 9 from 12 and target risk rating changed to 9.
3b – Renamed to Capital Investment.
3c – Current risk rating decreased to 12 from 16.

3.1.3 Quality BAF; the following changes have been made:
The Quality risks have been reviewed and updated to ensure controls are clear and appropriate.
5a - Has been updated with the relevant CQC action plans and improvement plan actions progress.
5b - has been updated to include progress on actions.
5c - has been updated to include the impact of Covid restart plan.
5d - No further changes.
Potential new risk to be added regarding loss of or temporary moves of clinical services, this will be agreed at the next QAC meeting.

3.1.4 Gurjit confirmed that all BAF scoring and risks are reviewed at the appropriate Committees.

3.1.5 Innovation is expected to report to the Finance Committee, Gurjit is waiting confirmation on this.

3.2 Integrated Audit Committee Assurance Report

Mark Spragg, Chair of the Integrated Audit Committee, gave the Board an updated on the Committee meetings held on Monday 22 June 2020 and Wednesday 24 June 2020.

3.2.1 Mark advised the Board that the Annual report and Accounts were APPROVED on behalf of the Board and the Annual Report and Accounts have been submitted.

3.2.2 This was the first audit completed by the external auditors Grant Thornton. Mark Spragg will meet with them later this year for a debrief session. They were very complimentary of the finance team including Paul Kimber and Isla Fraser.

3.2.3 The internal auditors (KPMG LLP) work had slowed due to the Covid crisis and some of their audits will be moved into the current year. They have confirmed that there is time for them to do so.

3.2.4 The Head of Internal Audit Opinion was what the Trust wanted, with a 'significant' rating. There are minor improvements that are currently being worked on.

3.2.5 The Committee agreed that the temporary increases to three Executives in terms of payment limits should revert. The Board agreed this change.

3.2.6 Mark gave his thanks and on behalf of the Committee for the hard work of the team.

4 High Quality Care

4.1 Covid-19 Update
- Sustainability and Transformation Plan Update
- ICS Recovery and Restore

James Devine, Chief Executive, confirmed to the Board that the Covid-19 confirmed cases have gone back to more manageable numbers. James advised that going forward the paper would inform the Board on the focus for the future.

4.1.1 Harvey McEnroe, Strategic Commander, asked the Board to note the update and be assured. The paper outlined the Trust's current response plans to Covid-19, focusing on the restore and recover programme as well as the wider work with system partners across the ICP and the ICS/STP. This will be the last paper in this format and going forward it will be more strategic and looking to the future. The Trust is now a Level 3 incident level (down from a Level 4).

4.1.2 The paper covered the following key updates:

1) MFT and the ICP restore and recover governance structure
2) Our current position on:
   a) Ward configuration
   b) Elective Care
   c) Urgent and Emergency Care
   d) Cancer and Diagnostics
   e) Covid-19 Wave 2
3) An update national guidance regarding face masks
4) MFTs response to BAME assessments
5) Waiting list and management plans

4.1.3 The Board acknowledged the incredible effort made by the Occupational Health team on the Covid swabbing and anti-body testing. The Board asked Leon Hinton to send his thanks to Gemma Nauman who has led the team.

4.1.4 Tony Ullman asked if the Trust is getting the information from the Community regarding Covid cases. David Sulch confirmed that the hospital would expect a rise in admissions in three to four days if there was a rise in the community. Currently there is no rise to be concerned with.

4.1.5 Sue Mackenzie asked about ambulance activity levels and is there an NHS wide 'lessons learnt' document. Harvey McEnroe confirmed that SECAM activity has returned to standard operating levels in the last two weeks. He also confirmed that there will be a Kent and Medway review over the entire response to Covid, there is a legal obligation to do so. He will discuss with Chair and James Devine how to share this information with the Board. He will also seek NED involvement with this. It is expected to be the largest wash-up/debrief in NHS history.

4.1.6 Chair raised her concerns over the waiting list and what may be in the diagnostic work load. **Action No: TBPU/20/86:** Harvey McEnroe to write a briefing note on waiting lists and work load, the clear priorities and assurance to the Board that the Trust is getting this right.

4.1.7 Chair asked if there was anything the Trust could do to encourage locals to being to come back to their GP and hospital to help with the reduction in referrals, need to assure the public they can come back now and alleviate any anxiety. Glynis Alexander confirmed that the Trust is supporting the national message locally.

4.1.8 Chair asked whether the consultants were happy to be working across a number of sites, David Sulch confirmed that they are content working in different locations.

4.1.9 Chair asked how the BAME workforce are feeling and are they getting the support they need, is the Trust doing enough. Harvey McEnroe confirmed that the Trust is following guidance and lines of communication are fully open. Leon Hinton confirmed that the Trust has used this opportunity to ensure that the BAME Community are meeting regularly. The BAME Network Lead is now a member of a wider community group. James Devine confirmed that all of the Network Leads for BAME Groups have come together across Kent. There will now be a consistent approach to issues and the outputs from these groups will be available over the next few weeks. The outputs of the BAME Risk Assessments will be provided to the Board once available.

Action No: TBPU/20/87: BAME Community Support and Risk Assessments, submit this issue to the People Committee and Leon Hinton to submit a report to Board in August 2020 as part of the Workforce Report.

4.2 Integrated Quality Performance Report

Gurjit Mahil, Deputy Chief Executive, asked the Board to note the report and its new format. The refreshed version of the IQPR uses Statistical Process Control charts to display the data. The report informed the Board of the quality and operational performance across key performance indicators for May 2020. Gurjit asked for the Executives to comment.

4.2.1 <u>Safe</u>

Jane Murkin confirmed the Trust has had 9 c-difficile cases reported in May. Investigations are currently ongoing. Falls remains below the national average rate. The updated February HSMR figure now sits at 99.2 (95.4 – weekday and 109.8 – weekend), this is an improvement from the January position. The SHMI sits at 1.11

4.2.2 <u>Caring</u>

Jane Murkin confirmed that Mixed Sex Accommodation continues to demonstrate an improvement; however in May, two breaches were recorded, which is still higher than the national compliance levels.

4.2.3 Jane Murkin confirmed that she had briefed the Executive Team earlier in the week on the CQC letter received on 25 June 2020. The letter stated that the results from the Inpatient Survey are below the National expectation. Due to this an independent investigation has been launched and a comprehensive report with analysis will be submitted to the Executive and later to the Board.

James Devine confirmed that more work is needed to go through the results and come back with an action plan and analysis. He gave his apologies on this and confirmed there will be more detailed summary submitted as soon as possible.

Action No: TBPU/20/88: Jane Murkin to submit an action plan and analysis report regarding the outcome of the investigation on the Inpatient Survey and letter from CQC (25 June 2020). Submit to the Executive Team and then to Board.

4.2.4 Effective

David Sulch confirmed that the VTE performance for April sits at 94.3% against the 95% national target. Fractured NOF procedures within 36 hours performance shows a slight improvement moving from 68.4% to 72.7%. A number of different actions are in place to improve the experience for patients and the performance. He stated that one of the issues is dealing with surges and not being able to meet the demand on the service. This is being investigated and more detail will be submitted to the Quality Assurance Committee in July 2020. The decrease in fractured neck of femur will also be investigated and brought back to Board at a later date.

4.2.5 Mortality

The weekend mortality remains a concern but there is slight improvement. There has been a discussion on a prospective audit to look at Swale patients when they are admitted to hospital.

4.2.6 Infection Control

This was discussed at the Quality Assurance Committee, the IPC Plan was presented. Tony Ullman asked when the Trust could reduce the risk level for IPC. David Sulch believed that we should keep the risk level until the Trust is fully assured. Tony suggested further discussion at the Committee as to when the Trust can reduce risk levels.
Action No: TBPU/20/89: Jane Murkin to submit a paper on IPC and COSHH to the QAC, showing progress and plans.

4.2.4 Responsive

Angela Gallagher informed the Board that the Trust saw a significant improvement to the 4 hour performance standard reaching 93% for May 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for April is recorded at 72.6%, with four 52 week breaches, May is recording at 65.53% with twenty 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for May as 56.5%. Cancer 2 week wait performance for April continues to be achieving national standards at 93%. 62 day performance is recorded as 77.5%. Angela confirmed that the Trust should be back to normal waiting times by September 2020. There is a regional action plan for this issue. Clinically urgent and cancer is the focus now, the 52 week breaches come under this. Harm reviews are being looked into.
Action No: TBPU/20/90: Angela Gallagher to submit a paper on the clearance of the waiting lists and the 52 week breaches/cancer to the QAC and then to Board.

4.3 Quality Assurance Committee Assurance Report

Tony Ullman, Chair of the Quality Assurance Committee, gave the Board an updated on the Committee meetings held on Tuesday, 16 June 2020. The paper was taken as read.

4.3 Safe Staffing Review

Jane Murkin, Interim Chief Nurse, discussed the paper, which was taken as read and the Board was asked to:
- Discuss the content of this review.
- Endorse the decision of the Executive Group to support uplifting of the recommended Registered Nurse and Clinical Support Worker posts to support safe nurse staffing levels.

- Delegate to the Executive Group to determine how this investment will be afforded, alongside the post COVID reconfiguration plan.

4.3.1 James Devine confirmed that there have been robust discussions on this with the Executive team. The focus has been less on cost and more on quality of care. Leon Hinton confirmed that it is a significant increase in international nurse staffing. Original projections for nursing would have been reaching small number of vacancies but since Covid it has increased due to the turnover. Every month that goes by adds an extra 1.5 months on top to the time to recruit.

4.3.2 Chair raised concern that if it is going to take that long to recruit, is there an immediate safety concern? Jane Murkin confirmed that it is not, staffing is of a safe level currently and is an ongoing review. She said that it is a phased approach and will continue to promote Medway as an excellent place to work and retaining current workforce.

4.3.3 Richard Eley confirmed that there will be more work on reducing costs but the figures are reasonable as to our current position. Chair asked for this to be brought to the Finance Committee and it is on the risk log.

Action No: TBPU/20/91: Alana Almond to add Safe Staffing Costings risk to the Finance Committee Action Log, for a more in depth review into reducing costs.

4.3.4 James Devine confirmed that the People Committee would do an in-depth review of Safe Staffing. The risks should be continually reviewed based on quality. Leon added that it is the substantive role recruitment that needs more work.

Action No: TBPU/20/92: The People Committee to do an investigation into the nursing shortages, an analysis around returners, turnover, role redesign, etc.

4.3.5 The Board **APPROVED** the paper in principle and **DELEGATED** to the People Committee to review all of the above from today, to ensure that the Chief Nurse Interim can recruit the levels needed to deliver quality care. The Board asked that the report be brought back if there is any material change.

5 Innovation

5.1 Trust Improvement Plan

Ian Renwick, Intensive Improvement Director, provided an update to the Board on the further development and mobilisation of the Trust's Improvement Plan, including on the process of engagement and consultation currently underway.

5.1.1 James Devine confirmed that he and Ian Co-Chair the Trust Improvement Board. Every two weeks the SRO report on the progress made, future plans, risk analysis and points of escalation. To date it seems to be working well and the team is getting into a good rhythm for closing the must dos and should dos. The team should be able to close with confidence so that the same issues will not come back to future inspections.

5.1.2 Ian stated that the team is taking a relatively traditional approach to the work but with an innovative way of reporting. The highlight report draws attention to the main issues within the pillars of the plan. There have been three meetings to date and already the group is exposing the risks. These risks are reported through the BAF to the Board. The submitted paper is an update with a number of minor risks and the mitigations that are in place. The risk of the overall plan is low.

5.1.3 The process of engagement with staff has started; this is what makes it different to previous plans. The sessions have been held in person and on Zoom and given very direct feedback and a positive outcome. There has been an overwhelming response to the plan. These sessions will run until July and the final version of the plan will come back to the Board in August for formal sign off.

5.1.4 Glynis Alexander confirmed that there is a date in the diary for the Council of Governors and a Members Event later in the year, which will allow for public engagement.

5.1.5 Jenny Chong has attended some of the sessions and confirmed that the feedback has been very candid. There is a much higher level of engagement and the Trust needs to show how it is going to be different and relatable. Jenny will share with James and Glynis some feedback she has from the session on 01 July 2020 and will then send on to the Chair.

5.2 Digital Strategy

Jack Tabner, Director of Transformation/IT updated the Board on the Digital Strategy. To support digital transformation at the Trust the organisation has commenced the development of a strategy, to set out the digital vision and roadmap over the next five years.

5.2.1 The strategy will eventually aim to deliver a clear vision and roadmap, which supports the Trust's objective of making improvements to the way it cares for patients. Digital services are required to support the needs of staff and patients, ensuring that IT enables staff in providing the best possible patient care. This whilst also meeting the requirements of local and national strategies and drivers, along with consideration of how current and future technology could be used to the benefit future care and patient experience.

5.2.2 The paper submitted was the initial draft of this strategy which will aid the digital strategy agenda item at the Trust Board, which looks to discuss and input into the direction, focus and delivery of the strategy.

5.2.3 This item was accompanied by a presentation highlighting the key areas from the strategy document to support the discussion at the meeting. The presentation was circulated post-meeting on 03 July 2020.

5.2.4 Following this presentation to the Board and the subsequent discussion, the team will embark on a period of staff and stakeholder engagement with a target final publication in the autumn. The intention is to present this to the Board in September 2020 in a variety of formats; eg: technical appendices and a patient/public accessible document.

5.2.5 Michael Beckett talked through the presentation to the Board.

5.2.6 Jenny Chong made some points for Jack and Michael to consider, including data collection, training, storage, sage and challenge. They would liaise outside of this meeting.

5.2.7 Chair asked for the team to consider how the Trust can support eh public to use technology to take the pressure off the hospital. She advised to look back at the initial principles on this matter. The Board thanked Jack, Michael and the team for their efforts.

6 Integrated Health Care

6.1 Communications and Engagement Report

Glynis Alexander asked the Board to note the update and the paper was taken as read.

7. Financial Stability

7.1 Finance Report – Month 2

Richard Eley, Director of Finance (Interim), asked the Board to note the report which sets out the summary financial position to the end of May 2020. The paper was taken as read.

7.1.1 Richard confirmed that the concerns are that Covid expenditure is up by £2m, there has been a significant rise in staffing costs.

7.1.2 Covid Capital; £160,000 has been given, a further request for funds has been submitted and the Trust is waiting on a response.

7.2 Finance Committee Assurance Report

Jo Palmer, Chair, took the paper as read and informed the Board of the following key issues to note:

7.2.1 BAF Strategic Risks; The Committee noted the availability of capital investment.

7.2.2 Risk Register; the Committee noted that whilst there has been a reduction in the gap, there still remains a risk. Mark Hackett is investigating this and more assurance will be given to the Committee.

7.2.3 Staff Costs; there is a disparity between staff costs and activity. The Committee has asked Richard Eley to do an analysis of this and why the Trust is an outlier. He will work with Leon Hinton and Gurjit Mahil. The Committee will do more work on this.

7.2.4 The Committee approved for the Trust to participate in the Kent Pathology Project.

8. Our People

8.1 Workforce Report

Leon Hinton asked the Board to note the content of the report. This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The paper was taken as read.

8.1.1 The Trust's recruitment campaigns, including national, local and international have delivered 668 candidates to date; 170 of these candidates have commenced in post since January 2019.

Trust turnover has decreased to 12.33% (-0.18%) from 12.15%, sickness absence has decreased to 4.31% (+0.05%), compared to the month of April and is above the Trust's tolerance level of 4%. Appraisal compliance has decreased to 91.74% (-0.64% from 92.38%) and is above Trust target of 85%. Statutory and Mandatory training is at 87.59% (-0.71% from 88.3%) and is meeting the Trust target of 85%. More focus on StatMan training is needed going forward.

The percentage of pay bill spent on substantive staff in May at 82% has decreased (-3%) compared to the month of April. The percentage of agency usage at 2% has remained unchanged compared to the month of April. The percentage of pay bill spent on bank staff at 16% has increased (+3%) compared to April.

Chair stated that Leon should be proud of the work he and his team have done over the last few years managing the workforce.

James Devine confirmed that going forward the Workforce Report will be more focused on key issues and risks, Leon and James are discussing this.

8.2a Workforce Race Equality Standard

Leon Hinton, Director of HR and OD, asked the Board to approve the publication of the Trust's Workforce Race Equality Standard Data Report. The paper has been approved at Executive level and was taken as read.

1) The report provided the annual Workforce Race Equality Standard summary (WRES) for 2020. This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater racial equality, as required by the Equality Act 2010. Under the NHS Standard Contract (schedule 6a) the Executive Group and Board are required to consider and approve the WRES report prior to publication by 31 July 2020, but extended this year to 31 August 2020.

2) The performance is stable or improved compared to previous years. An action plan to address concerns and improve performance must be prepared and published by 31 October 2020.

Action No: TBPU/20/93: Leon Hinton to take this to the People Committee to deep dive into Workforce Race Equality Standard and report plans to promote positive discrimination if required.

The Board **APPROVED** the report to be submitted.

8.2b Workforce Disability Equality Report

Leon Hinton, Director of HR and OD, asked the Board to approve the report for submission to the NHS England WRES Portal and the Trust's website.

1) The report provided the second annual Workforce Disability Equality Standard summary (WDES). This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater disability equality, as required by the Equality Act 2010. Under the NHS Standard Contract the Executive Group and Board are required to consider and approve the WDES report prior to publication by 31 July each year, but extended to 31 August in 2020.

2) The performance on the quantifiable indicators shows disabled people to be disadvantaged compared to non-disabled people in recruitment and senior representation. The staff perception indicators (drawn from the staff survey) consistently indicate that disabled employees are less satisfied than their non-disabled colleagues, but the direction of travel is both an improvement in the perceptions of disabled staff, and a narrowing of differentials between disabled and non-disabled staff.

The NED lead on this issue is still to be decided and Harvey McEnroe has proposed himself as Executive lead. The Disability Network Group will be reestablished as it has not met for some time. This was highlighted in the CQC Report and will be considered at the People Committee. There is still much work to be done.

Action No: TBPU/20/94: Leon Hinton to take to the People Committee the CQC highlighted issue that the staff networks are not meeting.
The Board **APPROVED** the report to be submitted.

8.3 Freedom to Speak Up Update

8.3.1 Natasha Pritchard, Lead Freedom to Speak up Guardian, gave the Board an update to note. Natasha confirmed that people are communicating more and there is positive progress being made. The paper included the progress of the Lead Guardian who commenced in post on the 31 July 2019 and is employed for 0.4 FTE. The following figures are detailed:

a) Previously in Q1, 2019/20, the Trust had 22 new concerns raised and in Q2 24 concerns were raised.
b) In Q3 there were 17 concerns raised and in Q4 22 concerns were raised.
c) Presently 12 cases remain open; these are being looked into by Executives and overseen by the Chief Executive.

8.3.2 Natasha said although there is progress there is more work to be done. The HR team is doing more with the workforce including more listening events. Leon confirmed that NHSEI Culture Team is also doing work with staff.

8.3.3 The Lead Guardian meets with the Chief Executive weekly and the Chair monthly with ad-hoc meetings in between as required. Meetings with other Executives are arranged as required. Adrian Ward is FTSU Non-Executive Director lead.

8.3.4 The Trust has had one report of an individual experiencing detriment as a result of raising concerns. Unfortunately this person did not wish to pursue this.

8.3.5 During Covid crisis there has been a rise in cases brought to Natasha's attention. For this reason there are discussions as to whether or not the offer of FTSU should be enhanced and the opportunity to speak to James Devine or other Executives should be made available. This should help the Trust to not lose momentum.

8.3.6 The Trust has offered Natasha to increase her working hours as a FTSU Guardian which will help. The plan is to increase the time to four days a week. James Devine confirmed that Natasha is excellent and an asset to the Trust in this field.

8.3.7 There is a correlation between FTSU, data, Staff Survey and Exit Data. The Committee also needs to consider anonymity with reporting. This information will flow through the People Committee and then back to the Board.
Action No: TBPU/20/95: Alana Almond to add Freedom to Speak Up to the People Committee work plan, in order to consider the above.

8.3.8 Should the Trust consider having more Champions, it currently has seven. Natasha confirmed that you can have as many as the Trust sees fit. There is more that can be done later in the year and will promote the recruitment of more Champions.

8.3.9 The Chair thanked Natasha for her hard work and confirmed that the People Committee would focus more on this area and triangulate reports, with the Board's full support. Chair also thanked her for the extra commitment she will be giving to her role.

9 For Approval/Review

9.1 Updating the Trust Constitution

David Seabrooke, Interim Company Secretary, asked the Board to note that the Council of Governors will consider the proposals as detailed in the report later in July 2020.

9.1.1 A further review of the Constitution has been undertaken, following the completion of the 2017 review. The details will go to the July meeting of the Council of Governors for discussion.

9.1.2 A number of suggested amendments have been identified and the significant cases are described in the paper and as below:

a) At present, the Constitution prohibits directors and governors joining other trusts. The Trust may want to consider relaxing current prohibitions on individuals having roles on other Boards, or being governors on other foundation trusts (e.g. paragraph 16 of the governors' disqualification criteria; paragraph 30 for the Board).

b) The Constitution should be clearer in respect of the appointment of a Vice Chairman. The Chairman should appoint the Vice-chairman and senior independent director, subject to consultation with the Council of Governors. (E.g. Annex 5 paragraph 2.5; Annex 6, paragraphs 2.4. and 2.5)

c) An inconsistency in the process for the removal of a governor has been identified. This, should it ever be necessary, needs to be a function of the Council of Governors.

d) Steps should be taken to avoid this happening, to investigate any disputed facts or circumstances, and to hear from the governor concerned before a decision is made by the Council. (Annex 8, paragraph 6)

9.1.3 This is just for noting today and it will be brought back at a later date for the Board's approval .

10 Any Other Business

10.1 Council of Governors Update

Glyn Allen, Lead Governor, gave the Board a verbal update on the Council of Governors.

10.1.1 The Governors are continuing to meet remotely using MS Teams and the 26 July meeting to discuss the Improvement Plan will be the same. The Deloitte Review will also be discussed on this date. On 27 October there will be a session on Infection Control.

10.1.2 The Governor elections are now open, deadline of the 28 July and results will be on 15 September 2020.

10.1.3 Governor Questions:

a) Masks, how is this working and are there any issues?

James Devine stated that we are not quite there yet, the Trust is sending out constant communication on this. It is the Trusts job to remind people it is an instruction not an option. Angela confirmed that it is not consistent yet but in addition to the communications there are staff including Executives in person reminding people at the entrances. There are plenty of masks in stock and there is improvement day to day.

b) League of Friends Shop, when will it be able to serve the general public?

Gary Lupton confirmed that this issue will be discussed at the upcoming Strategic Group meeting. The point is that the hospital wanted to avoid people to lingering in public areas at this stage.

James Devine confirmed that close contact has been kept with the League of Friends through the pandemic. The Trust does not want to increase the risk of unnecessary infection. It is a frustrating situation and it does impact on revenue but the safety of patients and visitors is paramount.

Chair stated as bars and restaurants open this weekend, some people will want to know why they have one set of rules and the hospital rules are different. This is something for Glynis to consider, perhaps some signage to go up in reception as to why the hospital is not like the high street.
Action No: TBPU/20/96: Glynis Alexander to consider signage on site and communications as to why the hospital is functioning differently, in regard to PPE and rules around Covid-19.

10.2 BAF Reflection

10.2.1 The Board AGREED that the BAF covers everything discussed today and concerns raised. The ratings do not need changing currently.
Action No: TBPU/20/97: Gurjit Mahil to add to the BAF: Safe Staffing Risk, Detailed actions on Quality, Swale Patients and Weekend Mortality, Waiting list; 52 week, cancer breaches and diagnostics to have their own actions .

10.2.2 Ewan Carmichael extended his thanks to David Sulch who dealt with the recent episode of the Consultant testing positive with Covid so efficiently. The prompt grip of the situation reduced the risk to staff and patients. David confirmed that conversations about this have been robust and severe.

10.2.3 Questions from the Public
Kris Fowler from Baxter Fluid is working with Graeme Sander sat the Trust looking at IV Therapy and offered to present to the Board at a later date.

Action No: TBPU/20/98: Harvey McEnroe and Angela Gallagher to consider proposals from Baxter Fluid on IV Therapy, in the light of current requirements alongside other providers.

10.2.4 There were no matters of any other business.

11. Date and time of next meeting
The next meeting will be held on Thursday, 6 August 2020, 10:00 – 13:30, location and type of meeting to be confirmed.

The meeting closed at 16:50

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 2 July 2020

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
05-Sep-19	TB/2019/030	Patient Story; Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	03-Sept-20 ~~12-May-20~~ ~~5-Mar-20~~	David Sulch, Medical Director	Update to be submitted in September 2020	White
05-Mar-20	TBPU/20/60	IQPR; Write a report on the Trusts position on EDNs to go to the Executive Group, then to the QAC and later submit to Board.	06-Aug-20 ~~02-Jul-20~~ ~~12-May-20~~	David Sulch, Medical Director	This action can be closed once the report has been submitted to the Executive Group/QAC	White
04-Jun-20	TBPU/20/77	Merge the Mortality and Morbidity work into the QAC terms of reference. Work with Tony Ullman.	06-Aug-20 ~~02-Jul-20~~	David Sulch, Medical Director	Keep open so Tony, Ewan and David can discuss - update at August 2020	Amber
04-Jun-20	TBPU/20/83	Health and Safety Report Update to be submitted	03-Sep-20	Gary Lupton, Director of Estates and Facilities	Not due until September 2020	White
02-Jul-20	TBPU/20/85	MFT Research Project Report	01-Oct-20	Iram Ahmed, Senior Clinical Research Practitioner	Not due until October 2020	White
02-Jul-20	TBPU/20/86	Covid-19 RRR; Submit a briefing note on waiting lists and work load, the clear priorities and assurance to the Board that the Trust is getting this right.	10-Jul-20	Harvey McEnroe, Strategic Commander	Update on position at August meeting	
02-Jul-20	TBPU/20/87	Covid-19; BAME Staff Support and Risk Assessments, submit this issue to the People Committee and Leon Hinton to submit a report to Board in August 2020.	06-Aug-20	Leon Hinton, Director of HR and OD	Propose to close - this action has been transferred to the People Committee	Green
02-Jul-20	TBPU/20/88	Submit an action plan and analysis report regarding the outcome of the investigation on the Inpatient Survey and letter from CQC (25 June 2020). Submit to the Executive Team, then to Board.	06-Aug-20	Jane Murkin, Chief Nurse (Interim)	Update on position at August meeting	
02-Jul-20	TBPU/20/89	Submit a paper on IPC and COSHH to the QAC, showing progress and plans. Update at the next Board meeting	21-Jul-20	Jane Murkin, Chief Nurse (Interim)	Propose to close - update on the agenda with the QAC Assurance Report	Green
02-Jul-20	TBPU/20/90	Submit a paper on the clearance of the waiting lists and the 52 week breaches/cancer to the QAC and then to Board.	06-Aug-20	Angela Gallagher, Chief Operating Officer	Propose to close - on the agenda	Green
02-Jul-20	TBPU/20/91	Add Safe Staffing Costings risk to the Finance Committee Action Log, for a more in depth review to reduce costs.	03-Jul-20	Alana Marie Almond, Assistant Company Secretary	Propose to close - submitted to the Finance Committee	Green
02-Jul-20	TBPU/20/92	People Committee to investigate nursing shortages; an analysis around returners, turnover, role redesign, etc.	06-Aug-20	Leon Hinton, Director of HR and OD	Propose to close - this action has been transferred to the People Committee	Green
02-Jul-20	TBPU/20/93	People Committee to deep dive into Workforce Race Equality Standard and report plans to promote positive action if required.	06-Aug-20	Leon Hinton, Director of HR and OD	Propose to close - this action has been transferred to the People Committee	Green
02-Jul-20	TBPU/20/94	People Committee to consider the CQC highlighted issue, that the staff networks are not meeting.	06-Aug-20	Leon Hinton, Director of HR and OD	Propose to close - this action has been transferred to the People Committee	Green
02-Jul-20	TBPU/20/95	People Committee to add Freedom To Speak Up to its work plan in order to consider the correlation between data, FTSU, Staff Survey and Exit Data	03-Jul-20	Alana Marie Almond, Assistant Company Secretary	Propose to close - this action has been transferred to the People Committee	Green

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
02-Jul-20	TBPU/20/96	Consider signage on site and communications as to why the hospital is functioning differently, in regard to PPE and rules around Covid-19.	10-Jul-20	Glynis Alexander, Director of Communications and Engagement	Propose to close - Signage and information is in place throughout the Trust and is regularly updated as the situation changes.	Green
02-Jul-20	TBPU/20/97	Add to the BAF: Safe Staffing Risk, Detailed actions on Quality, Swale Patients and Weekend Mortality, Waiting list; 52 week, cancer breaches and diagnostics to have their own actions .	10-Jul-20	Gurjit Mahil, Deputy Chief Executive	Propose to close - this action has been transferred to the QAC.	Green

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 06 August 2020

Title of Report	**Board Assurance Framework Update**	**Agenda Item**	3.1
Report Author	Gurjit Mahil, Deputy Chief Executive Officer		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	The Board Assurance Framework (BAF) is the means by which the Board holds itself to account and defends its patients and staff as well as the trust. It helps to clarify what risks will compromise the Trust's strategic objectives.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Resource Implications	None		
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 – Board Assurance Framework		

1 Integrated Healthcare

Executive Lead – Chief Operating Officer

Risk	Initial Score	Current Score	Previous Month Score	Target Score
1a – Failure of system integration	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 3 = 12 (Moderate)	3 x 2 = 6 (Low)

No further changes.

2 Innovation

Executive Lead – Executive Director of Transformation and Digital

Risk	Initial Score	Current Score	Previous Month Score	Target Score
2a – Future IT strategy	4 x 4 = 16 (High)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 2 = 6 (Low)
2b – Capacity and Capability	3 x 3 = 9 (Moderate)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)
2c – Funding for investment	3 x 3 = 9 (Moderate)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)

No further changes.

3 Finance

Executive Lead – Director of Finance

Risk	Initial Score	Current Score	Previous Month Score	Target Score
3a – Delivery of financial control total	4 x 4 = 16 (High)	**3 x 3 = 9 (Moderate)**	3 x 3 = 9 (Moderate)	3 x 3 = 9 (Moderate)
3b – Capital Investment	4 x 4 = 16 (High)	**5 x 4 = 20 (High)**	5 x 4 = 20 (High)	4 x 3 = 12 (Moderate)
3c – Failure to achieve long term financial sustainability	4 x 4 = 16 (High)	**4 x 3 = 12 (Moderate)**	4 x 3 = 12 (High)	4 x 1 = 4 (Moderate)
3d – Going concern	4 x 3 = 16 (high)	**4 x 1 = 4 (Very Low)**	4 x 1 = 4 (Very Low)	4 x 1 = 4 (Very Low)

Independent assurance levels updated.

Actions identified for 3b and 3c.

4 Workforce

Executive Lead – Executive Director of Human Resources and Organisational Development

Risk	Initial Score	Current Score	Previous Month Score	Target Score
4a – Sufficient staffing of clinical areas	4 x 4 = 16 (High)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
4b – Staff engagement	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
4c – Best staff to deliver the best care	3 x 4 = 12 (Moderate)	**3 x 2 = 6 (Low)**	3 x 2 = 6 (Low)	3 x 2 = 6 (Low)

All risks have updated assurances and actions.

5 Quality

Executive Lead – Chief Nurse

Risk	Initial Score	Current Score	Previous Month Score	Target Score
5a – CQC Progress	4 x 4 = 16 (High)	**4 x 4 = 16 (High)**	4 x 4 = 16 (High)	2 x 2 (Very Low)
5b – Failure to meet requirements of Health and Social Care Act	4 x 4 = 16 (High)	**4 x 4 = 16 (High)**	4 x 4 = 16 (High)	3 x 2 = 6 (Low)
5c – Patient flow – Capacity and demand	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	3 x 2 = 6 (Low)
5d – Quality Governance	3 x 4 = 12 (Moderate)	**3 x 4 = 12 (Moderate)**	3 x 4 = 12 (Moderate)	2 x 2 = 4 (Very Low)

The Quality risks have been reviewed and updated to ensure controls are clear and appropriate.

5a and 5b – Further controls, assurances and actions identified.

5b - has been updated to include progress on actions.

5c - has been updated to include the impact of Covid restart plan.

5d – Oversight functions updated (Partial assurance)

Potential new risk (5e) to be added regarding loss of or temporary moves of clinical services – to be agreed at the next QAC meeting (28 July 2020).

Action plans being created for high risks.

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**	**3 x 2 = 6 Low**	Partial
			3. The ICP's agreed ambition is as follows and will have detailed population health outcome measures developed as part of the multi-agency development work which will read across to the ICS and ICP Joint Strategic Needs .	1. Monthly Medway and Swale System Delivery Board. a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive. b. Membership is made up of executive from provider and commissioning organisation						

COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Director of Transformation										
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 and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace of the STP.	4 x 4 = 16 **High**	1. Establish Digital Delivery Group in the Trust which will also consider the wider interfaces to the STP and the emerging ICS and ICP. 2. Maintain priority and focus on the investment on digital technology within the Trust which supports the Trust wider transformation agenda.	Senior IT and Transformation Team Weekly CIO call with all provider Trusts.	Digital Delivery Group in place. Reporting to the Executive Team Reporting to the Executive Team every fortnight.	NHS X / E/I, and NHS Digital reviews.	Development of longer term Digital and innovations Strategy Agree Digital Governance	**3 x 3 = 9 Moderate**	**3 x 2 = 6 Low**	Partial
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**	3. Prioritisation of digital programmes to support key transformation deliverables. 4. Review and restructure IT Services department undertaking a capability and skills assessment 5. Seek private sector partners to support the delivery of foundation services	IT services have undertaken a skills review with a proposed new structure, further work with HR required deploying.	Trust Improvement Board – Innovation Pillar	NHS X / E/I, and NHS Digital reviews.	Development of longer term Digital and innovations Strategy System approach to IT services	**4 x 3 = 12 Moderate**	**3 x 3 = 9 Moderate**	Partial
2c There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research. 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**	6. Trust investment in the R and D 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. 7. Partnering arrangements being secured for managed services in a number of areas to enable cost of innovation to be spread over the life, as well as ensuring there is sufficient expertise for optimum implementation and adoption. 8. Continue to work with the STP (ICS) and NHS England, NHS X, and NHS Digital to apply for digital innovation funds when released. 9. Work with the ICP, CCG and other external partners to secure funding to support collaborative working. 10. Agree the capital programme for the delivery of digital innovation and foundation IT services. 11. Ensure that best value is being delivered through current contracts. 12. New IT solutions in place during Covid lockdown. a. MS Teams b. Virtual outpatients	Senior IT and Transformation Team	Trust Improvement Board – Innovation Pillar	NHS X / E/I, and NHS Digital reviews.	On-going discussions with I/E regarding funding.	**3 x 3 = 9 Moderate**	**3 x 3 = 9 Moderate**	Partial

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Director of Finance										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a **Delivery of Financial Control Total**	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. If the STP does not meet its control total then the Trust will lose up to 50% of its FRF allocation, resulting in a variance to reported plan of up to £23.7m in 2020/21.	4 x 4 = 16 **Very High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. NHSE/I is providing funding to enable providers to achieve breakeven from 1 April 2020 to 31 July 2020. The eight CCGs in Kent have merged with effect from 1 April 2020, enabling them the scale and reach to support management of the system as a whole.		3 x 3 = 9 **High** (Previous risk rating: Mar 2020 3 x 4 = 12 **High)**	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate)**	
			2. Programme Management Office and scrutiny by Financial Improvement Director to track operational delivery and financial consequences of those actions.	Financial improvement director in place.						
3b **Capital Investment**	If there is insufficient cash to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan.	4 x 4 = 16 **Very High**	1. Governed entirely by the availability of cash, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the STP and regulators unless affordable within the existing capital programme or through a revenue stream. (**Note**: Risk not fully mitigated from the Trust's perspective until it starts to generate a cash surplus).	Standard business case process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Capital Group, Finance Committee and Board.		1. Trust strategy for innovation together with Care Group /directorate strategies to be developed. 2. National shortage of capital funding recognised. Will potentially need some key choices to be made by the Board during 2020/21 3. Clarity and	5 x 4 = 20 **Extreme** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 3 = 12 **High**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Director of Finance										
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**
							support from STP is required for capital prioritisation / funding from 20/21.			
3c **Failure to achieve long term financial sustainability**	If the Trust does not achieve financial sustainability could lead to reputational damage, difficulty in recruitment into key roles, further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Establishment of System Delivery Board with System Recovery as key cornerstone of the programme monitoring delivery and engaging with partners. 2. Multi-year control total agreement with NHSE/I that does not require return to financial breakeven without national support.	Development of longer term financial model based on impact of 2019/20 delivery on 5 year programme, including sensitivity analysis. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans).	Reporting of identified risks and pressures alongside CIP and financial performance to Finance Committee regularly.	Current national policy is to provide Financial Recovery Fund support to achieve breakeven for those organisations with an agreed deficit. NHSE/I have in principal set an agreed deficit control total up to and including 2023/24 with FR funding to support a breakeven position.	Development of system wide financial narrative and joint plans with commissioners and other key stakeholders.	4 x 3 = 12 **High** (Previous risk rating: Mar 2020 4 x 4 = 16 **Extreme)**	4 x 1 = 4 **Moderate** (Previous target risk rating: Mar 2020 4 x 3 = 12 **High)**	
3d **Going concern**	If the Trust is unable to improve on the proportionality of the continued and sustained deficits there is a risk that it could lead to further licence conditions and potential regulatory action.	4 x 4 = 16 **Very High**	1. Interaction with regulators for Public Dividend Capital (and loans) to support deficit and capital requirements has mitigated this risk. 2. National policy in 20/21 to write-off all interim debt financing through issuance of Public Dividend Capital. 3. Management of cash reserves. (**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).		Considered by the Integrated Audit Committee and by the Board as part of the annual report and accounts approval.	Change would be required in national context. STP and national regulatory bodies have not indicated intentions to divest services. A statement from NHSE/I on 27 May 2020 in light of Covid contracting arrangements it stated:		4 x 1 = 4 **Low**	4 x 1 = 4 **Low**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Director of Finance										
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**
						"Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs."				

COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Director of Human Resources and Organisational Development										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16** **High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting)	2019-22 People Strategy in place with monitored delivery plans. (People Committee)		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Staff networks are further developed, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 21]	**3 x 4 = 12** **Moderate**	**3 x 2 = 6** **Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 13%. 2. Sickness rate 4.2% 3. Substantive workforce 85%					
			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 4% 4. Bank workforce 11%					
			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 117 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.	People Committee		Local survey action plans to be developed and discussed through PRM processes. March 2020-August 2020 Delivery of Freedom to Speak Up strategy [Mar 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.	1. You are the difference (YATD) commenced in Q2 18/19, Phase 2 implemented February 2019 2. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme.						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session (December 2018 onwards); c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: c. Trust scores across key domains; d. Comparative results from previous years and other organisations; e. Heat maps for targeted interventions. f. Local survey action plans to address key concerns.	Survey 2018 staff engagement score, 6.4 – lower than average 7						
			Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom to speak up guardian route to Chief Executive; b. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; c. Respect: countering bullying in the workplace policy; d. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place; 4. 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.	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live.						

			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 since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018.						
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.	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.	People Committee		Delivery of Freedom to Speak Up strategy [Mar 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 StatMan (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 >92% 2. Appraisal rate >88%						
			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 since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018; 3. Promoting professional pyramid in place, training for peer messengers continuing; 4. Respect policy in place.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and temporary staffing usage at PRMs; c. Reporting to Board of substantive to temporary staffing paybill.	1. Trust vacancy rate at 13%; 2. Substantive workforce 85%; 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing;						
			Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.						

COMPOSITE RISK: Quality
EXECUTIVE LEAD: Chief Nurse
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently achieve delivery of high quality care. Failure to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Ineffective leadership, oversight and timely remedial action of the quality standards. 2. Lack of effective governance systems and processes. 3. Too much focus on flow versus quality standards. **Impact:** 1. Regulatory action by CQC &/ or NHSI 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. **4.** Inability to reduce avoidable harms to patients	**4 x 4 = 16 High**	1. CQC action plan developed and being implemented 2. Programme of ward assurance visits commenced , 2 wards per week	Quality Panel Governance in place; fortnightly meetings.	Regular progress reports to Executive Group, Quality Assurance Committee and Trust Board CQC Evidence panel in place. High Quality care Programme Board established. Ward Assurance Visits in place.	Internal Audit and External Quality Audit. IPAS Meetings (NHS I/E) CCG Quality Meetings CQC Engagement Meetings	Evidence sent thus far being quality assured	Complete QA process	**4 x 4 = 16 High** **June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Annual quality goals and priorities agreed and being implemented through the quality strategy Leadership for Safety & Quality Ward Managers programme implemented	Programme of continuous quality improvement: a. Improvement huddles b. Improvement Specialists c. Local improvement Projects	Quality Report and Accounts AGM to take place in September 2020.		CQI training paused since November 2019	Need to review CQI training			Partial
			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Quality strategy c. Ward to board assurance framework approved by Executive Group 15/07/2020	New Scorecard developed. Quality strategy priorities reported to QAC Fortnightly Matron assurance reports Monthly Heads of Nursing Assurance Report	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board. High Quality care Programme Board		PRMs for 20-21 commenced 27 May 2020 Ward to board assurance framework approved by Executive Group 15/07/2020	First PRM 27 May 2020. Ward to board assurance framework to be in place 30 June 2020 - Completed			Partial
			4. Audit and review processes a. Clinical Audit programme and monitoring b. Daily MSA breach reporting and validation c. PLACE, COSHH and environmental audits	Revised Quality and Patient Safety Group Divisional Governance Boards	Integrated Audit Committee QAC		PLACE audit outcomes not yet seen by QAC	To determine when this will be presented			Partial
			5. Central and local oversight of quality a. Complaints management b. Incident management, including Serious Incident (SI) processes and monitoring c. Compliance with Duty of Candour policy and training	Centralisation of the Divisional Quality Governance Teams	Regular reports to the Executive Group.		Compliance with 48 hour SI reporting to StEIS averaging 50%	Divisions have a plan in place to rectify.			Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	The result may be sub optimal outcomes and patient harm with potential regulatory action.	4x4 = 16 High	1. IPC Improvement plans	IPC policies, procedures and protocols being reviewed Annual IPC work plan Mandatory IPC training Directorate and programme scorecards with key IPC indicators	Infection Control and Anti-Microbial Stewardship Group meeting (ICAS) Quality Assurance Committee Evidence review panel in place High Quality Care Programme commenced of which IPC is within Mission 1. Safe Care	IPAS (I/E) meeting	Many IPC policies out of date and being reviewed IPC Committee met June 2020. 9 patients acquired C. Diff in May, 1 June No AMS audits for last three months due to audit lead long term sickness No decontamination group in place	Support secured from CCG to update all policies PIR's completed. Medical Director to consider contingency plan	**4 x 4 = 16** **High** **June 2020**	**2 x 2 = 4** **Very Low**	Partial
5c There is a risk that 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. Integrated healthcare pillar of the Trust Improvement Plan including a Trust Delivery Board. 2. Future Hospital Reconfiguration Plan in development 3. Covid – Strategic Planning processes in place to monitor all hospital activity. a. Elective modelling underway to ensure backlogs are being reviewed. Private provider options being explored. b. Cancer pathways in place with Private providers. c. Outpatients with social distancing and virtual outpatients managed through strategic command. d. Restart programme is being managed through the System approach of restart alongside system partners. e. Outpatients and Elective day cases and IP will recommence on the 29th of June 2020 – with a stop/go assessment week commencing the 15th of June 2020. f. Elective and outpatient work will recommence based on the ability of the North Kent Pathology Services to make sure there are no delays in swab results.	Recovery plans including agreed trajectories for all constitutional standards Weekly Best Flow Programme Board	Reviews and updates discussed at Executive Group, TAG and Board National planning tools being used.	External reviews by NHS I/E	Weekly Best Flow Programme Board has not met during COVID-19	Restart and Recovery programme ongoing.	**3 x 4 = 12** **Moderate** **June 2020**	**2 x 2 = 4** **Very Low**	Partial

Assurance

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
5d If quality governance is not sufficiently understood or embedded there is a risk that the Trust may not deliver our quality priorities.	Risks to quality and safety of care may not be identified or controlled resulting in poor patient experience, sub optimal outcomes and patient harm with potential regulatory action.	**3 x 4 = 12 Moderate**	1. Quality ambitions a. Quality goals and priorities agreed for 2019/20 b. Quality Account	Quality governance groups established for delivery and monitoring quality Patient Safety Patient experience Clinical Effectiveness and Research Medicines Management Mortality Safeguarding	Executive Group and Quality Assurance Committee Risk Assurance Group in place	IPAS (I/E) meeting	None	None	**3 x 4 = 12 Moderate** **June 2020**	**2 x 2 = 4 Very Low**	Partial
			2. Key leadership roles in place a. Corporate business critical posts in place providing governance, quality and safety leadership b. Directorate and programme clinical governance, quality and patient safety leads in place c. Quality Governance teams in place centrally and within directorates	Divisional Governance Boards in place	Executive Group	Internal and external audit reviews	New processes have not yet had a chance to embed	Maintain oversight of Divisional Governance effectiveness and provide support and training as required.			Partial
			3. Quality Governance monitoring a. CQC Assure b. Risk registers c. Quality Impact Assessments	Divisional and corporate risk meetings in place	Risk Assurance committee in place reporting to executive team.	CQC	CQC Compliance Framework not in place	CQC compliance framework being developed			Partial

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 06 August 2020

Title of Report	**Board update on Trust Response to Covid-19**	**Agenda Item**	4.1
Report Author	Harvey McEnroe – Strategic Commander and Winter Director		
Lead Director	Harvey McEnroe		
Executive Summary	This paper outlines the Trust's current response plans to the Covid19 pandemic and the subsequent work of the restore and recovery programme. The restore and recovery programme has progressed in line with regional and national expectations focused on the four core areas of recovery: - Urgent and Emergency Care - Elective Care - Community and Primary Care - Discharges The paper is supported by an attachment deck which outlines in more detail.		
Link to strategic Objectives 2019/20 ***(Please mark X against the strategic goal(s) applicable to this paper - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Date of approval:		
Executive Group Approval:	Date of Approval:		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state):		
Resource Implications	Not at present		
Legal Implications/Regulatory Requirements	State whether there are any legal implications		
QIA	N/A		
Recommendation/	The Board is asked to note and discuss the paper.		

Actions required	Approval ☐	Assurance ☐	Discussion ☒	Noting ☒
Appendices	Yes – R & R Overview (PowerPoint)			

1 Executive Overview

1.1 The Trust remains in a level 4 major incident; nationally the incident has been stood down to a level 3.

1.2 The Trust has taken steps to establish a robust oversight structure which oversees the recovery and restoration,

1.3 The Trust has taken a leadership role for our system in regards to medium/long term plan for future resilience and wave2 planning and winter preparedness.

1.4 MFT has now entered the restore and recovery phase of our Covid19 response plan. This programme will see us through the next six months as we return our servicers back to normal for our patients and our community.

1.5 The restore and recovery programme is governed by a twice weekly system board with all partners across the Medway and Swale region. This group oversees the work across each workstream.

1.6 The core workstream in restore and recovery are:

- 1.6.1 Urgent and Emergency Care
- 1.6.2 Elective Care
- 1.6.3 Community and Primary Care
- 1.6.4 Discharges

1.7 The resilience planning linked to winter and wave2 has commenced and is being led by the ICP, with MFT supporting via the ICP programme board.

2 Recovery and Restore Plan – Trust Oversight

2.1 The following outlines the strategic update linked to the core workstreams (as at 23/07)

2.2 **Urgent and Emergency Care**

- 2.2.1 All urgent and emergency care pathways and now open across the Trust
- 2.2.2 Demand for the emergency care pathway via ambulatory pathways (all types) is at 88% of pre Covid19 levels
- 2.2.3 Ambulance activity is back to pre Covid19 levels
- 2.2.4 The Trust is working with SECAmb on alternative care pathways
- 2.2.5 Admission levels are at 85% of pre Covid19 levels
- 2.2.6 Risk remains re 111 access and direct booking and the ambulance activity set (we remain the busiest site in K&M)

2.3 **Elective Care, Cancer and Diagnostics**

- 2.3.1 Diagnostics pathways are fully open across all services
- 2.3.2 Capacity in Diagnostics is at 80% pre Covid19 levels, due to physical distancing
- 2.3.3 All Cancer pathways are fully open, as per during Covid19
- 2.3.4 Elective care is in ramp up phase, with the limiting factor being testing pre elective spell.

2.3.5 All elective care pathways with the exception of Orthopaedic inpatients are now open.

2.3.6 All outpatient clinics have started and are running at 85% of pre Covid19 capacity. Virtual service remain operational at 80% for FU and 20% for New

2.3.7 Risk remains around the size of backlog and long waiting patients on the PTL

2.3.8 The Trust is working with the regional Cancer Alliance on the Endoscopy

2.4 **Discharge Pathways**

2.4.1 Medically ready for discharge numbers has maintained below 25 patients on the list since May 2020

2.4.2 All integrated discharge pathways are reopen and we have access to 24 hour restart and new Package of Care pathways across Medway and Swale and Kent County Council services

2.4.3 Discharges pre noon have increased to 27% on frailty wards

2.4.4 Risk remains around community occupancy and access to care homes – this is being addressed via the ICP programme board

2.4.5 During the Covid pandemic a discharge team were brought together to provide a balanced team to provide Strategic, System, Operational and Regional leadership across health and social care. An SRO for Hospital Discharge was appointed in North Kent to drive and coordinate the implementation of the NHS Hospital Discharge guidance.

2.4.6 The establishment of a team enabled them to work together to deliver the common goal and ensure patients were safely and quickly discharged when they became medically fit for discharge.

2.4.7 The team took ownership for their respective areas/organisations which has led to breaking down boundaries and resulted in working in a collaborative and coordinated way, as system partners, to unblock issues, and fast track actions and support a safe discharge of patients from the acute hospital.

2.4.8 A process was quickly put in place to ensure the Covid status was known and communicated for every patient discharged to alternative care providers – e.g. care providers visiting patients at home, care homes and community wards, to ensure safety for the patient being discharged, as well as the wider Medway and Swale community.

2.4.9 Clear discharge pathways being defined and agreed by the Integrated Discharge Team and IDT leadership team to manage pathways 0-3.

2.4.10 Introduction of SPoA with care packages was another key factor of the joint pathways with health and social care and/or clear community pathways.

2.4.11 Medway Council and MCH quickly combined resources in community for all D2A / community care provision.

2.4.12 The process is robust and has continued to be managed seven days a week since March 2020

2.4.13 The team are currently working to embed the new model of working and discharge processes to ensure continuity and a sustainable model continues.

3 Recovery and Restore Plan – Integrated Care Partnership (ICP)

3.1 The Medway and Swale Local and Primary Care teams are focused on the Six high performing systems, with their constituent organisations working seamlessly to provide world class, place based health & care for their populations, focusing on the vulnerable.

3.1.1 Deliver the early cancer diagnosis and SMR specs of the Network DES

3.1.2 Continue focus on Population Health Management (PHM) via the Aspirant ICS PHM Development Programme

3.1.3 For Phase 3, plan and ensure there is a Network approach to meeting Health Inequalities challenges

3.1.4 Once available, support implementation of recommendations of the Access Review

3.1.5 Support Systems with their PCN Development Support approaches for 2020/21, ensuring continued investment against 2019/20 'top 3 priorities'

3.1.6 Take an integrated approach across health and care, particularly partners in primary care, to the delivery of services e.g. homelessness and hard to reach communities

3.2 The six workstreams are large and multi-factoral using an extensive multi-disciplinary teams approach to support patients and primary care in its development as Primary Care Networks.

3.3 The programmes build upon the excellent work and services put into place prior to Covid including; social prescribing, ILRs, working with Care Homes, community providers, using local intelligence and data analysis, digital workstreams and platforms to dynamically make the necessary developments and changes.

4 Wave2 Covid19 planning and Winter 2020

4.1 The Trust has commenced its Wave2 and Winter Planning.

4.1.1 The plan focuses on three component parts:

- Winter resilience and surge planning
- Covid19 wave2 planning and critical care surge planning
- EU exit planning and system resilience

4.2 The Trust and the ICP have formally stood up the system Winter Planning group chaired by the Strategic Commander with representatives across all organisations in the ICP.

4.3 The Winter Planning group and the Covid19 Wave2 planning group will meet twice monthly as a steering group and weekly as an operational group.

5 Conclusion and Next Steps

5.1 The Trust continues to respond well to Covid19 and the wider system response is supporting the Trust in its restore and recovery programme.

5.2 The Trust and the ICP are working closely with regional and system partners to ensure that our ongoing work on recovery and restore continues to meet the national expectations and timescales.

5.3 Next steps for the restore and recovery plan and the wider Covid19 response plan are:

5.3.1 Formalise and seek approval for the Covid19 Wave2 plan and bed configuration

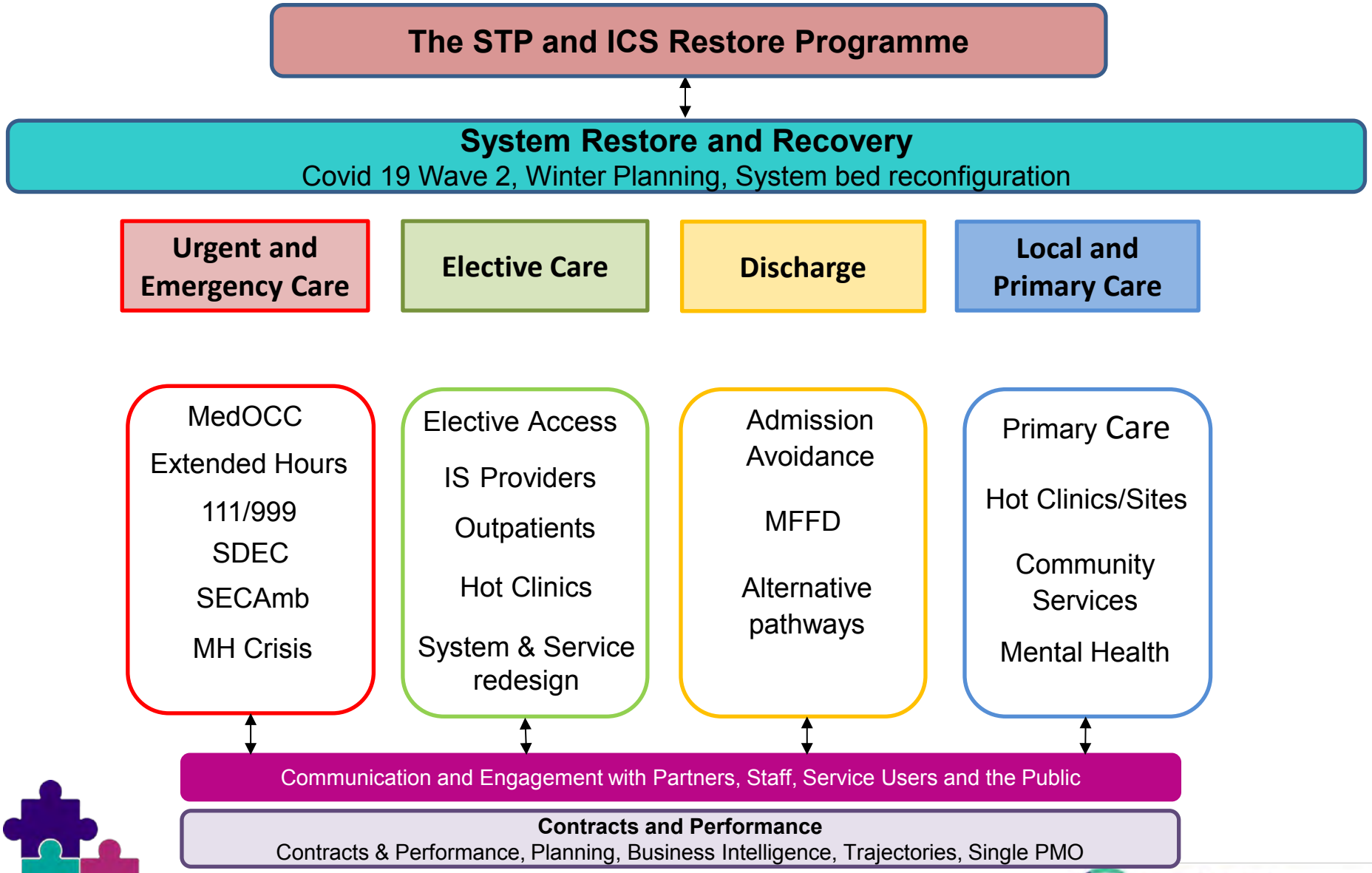
5.3.2 Formalise and seek approval for the Winter Plan and system resilience plan for the Trust and the ICP

Medway and Swale Integrated Care Partnership – C19 Update for MFT

Restore and Recovery Plans Overview

Medway and Swale
Integrated Care Partnership

Restart and recovery priorities for operational services across the ICP



Medway and Swale Integrated Care Partnership

Transforming health and social care in Kent and Medway

Urgent and Emergency Care

- The main drivers for the urgent and emergency care workstream is to work together as system partners to provide patients with a service which is responsive to meeting the emergency care standards in an environment which meets new infection control measures.

- The key workstreams to ensure the patient pathways ensure patients are seen by the right team, for their presenting needs are as follows:

  - **Direct Access Booking from 111** into the emergency department, same day emergency care and the urgent treatment centre. Patients will need to phone 111 and they will be directly booked into the appropriate service to meet their presenting needs based on pathways which have been developed by the local clinical and system partner teams. Working collecting to introduce direct access booking into Medway NHS Foundation Trust by September 2020.

  - **Direct communication between Paramedics and ED consultants** exploring the use of a digital solution for paramedics to dial into gain Consultant advice as to whether the patient needs to be directed to ED or an alternative urgent care environment.

  - **Maintaining improved flow of beds** Medway NHS Foundation Trust are undertaking significant redesign of their emergency department layout to provide improved flow of patients and adhere to the new IPC regulations.

- The urgent and emergency care programme is on track for the delivery of the changes with positive inputs and collaborative working between mental health, social care, SECAmb, MCH, MFT and the CCG.

Elective Care

- The focus for the elective care workstream has been to restore elective services for patients at both the acute hospital and Independent Sector Hospitals so patients can confidently attend clinic appointments, attend their diagnostic procedures and be admitted for elective surgery.
- Collectively the teams have worked together undertaking risk assessments, redesigning pathways, changing working patterns and set patient wayfinders to services throughout the hospital. Under the guidance of clinical, quality and infection control measures patients can now attend outpatients, diagnostics and attend for surgery within the acute hospital.
- Due to the impacts of social distancing, spacing. extra cleaning, quality controls and protecting our vulnerable patients it has been necessary to identify additional capacity for diagnostics, outpatients and daycase surgery. This has been provided at our local Independent Sector Hospitals – Will Adams Treatment Centre, Spire Alexander Hospital and KIMS.
- Our clinical teams have worked closely with the Independent Sector Hospitals to ensure clinical pathways and infection control measures are in place to ensure a consistent approach and to give patients confidence to attend for surgery and procedures by the MFT consultant teams at the Independent Sector Hospitals:
  - **Outpatient appointments** during the covid pandemic MFT introduced a virtual outpatient appointment process to enable patients, where appropriate to continue to have their outpatient appointments with the clinical teams. Since the end of June, following completion of all necessary changes within the outpatient department areas, patients have attended face to face appointments. Marshalls have been identified and are positioned at the front entrance of the hospital and in clinical areas to welcome and signpost patients to use the outpatient attendance pathways, minimising crossover of patients and staff walking around the hospital. Additionally extra capacity has been made at Spire Alexander to hold outpatient appointments for some specialties where required
  - **Endoscopy** – working in conjunction with the Will Adams Treatment Centre, endoscopy capacity has been made available throughout the covid pandemic for urgent and cancer endoscopy pathways so our high risk patients could continue to have their procedures during that time. This has since been expanded to see all endoscopy patients and endoscopy procedures are carried out at Will Adams Treatment Centre 6 days a week..
  - **Diagnostics -** Medway NHS Foundation Trust have restarted all their diagnostic and imaging services for elective patients.
  - **Inpatient and Daycase surgery** – Following advice and adhering to strict guidelines to ensure safety for our patients and staff, Medway NHS Foundation Trust restored their inpatient and day surgery theatres at end of June. Additional capacity has been agreed with our local Independent Sector Hospitals where surgery and procedures have been undertaken throughout the covid pandemic for urgent and cancer cases however this has since been expanded to offer daycase surgery by MFT consultants for routine planned surgery, five days a week. We continue to work with our Independent Sector colleagues to identify capacity to manage our surgical waiting list as approximately 30% of hospital elective bed capacity has been lost due to spacing and extra precautions required to safely undertake elective and non-elective surgery.

Discharge Process

- During the covid pandemic a discharge team were brought together to provide a balanced team to provide Strategic, System, Operational and Regional leadership across health and social care. AN SRO for Hospital Discharge was appointed in North Kent to drive and coordinate the implementation of the NHS Hospital Discharge guidance.
- The establishment of a team enabled them to work together to deliver the common goal and ensure patients were safely and quickly discharged when they became medically fit for discharge.
- The team took ownership for their respective areas/organisations which has led to breaking down boundaries and resulted in working in a collaborative and coordinated way, as system partners, to unblock issues, and fast track actions and support a safe discharge of patients from the acute hospital.
- A process was quickly put in place to ensure the covid status was known and communicated for every patient discharged to alternative care providers – e.g. care providers visiting patients at home, care homes and community wards, to ensure safety for the patient being discharged, as well as the wider Medway and Swale community.
- Clear discharge pathways being defined and agreed by the Integrated Discharge Team and IDT leadership team to manage pathways 0-3.
- Introduction of SPoA with care packages was another key factor of the joint pathways with health and social care and/or clear community pathways.
- Medway Council and MCH quickly combined resources in community for all D2A / community care provision.
- The process is robust and has continued to be managed seven days a week since March 2020
- The team are currently working to embed the new model of working and discharge processes to ensure continuity and a sustainable model continues.

Local and Primary Care

The Medway and Swale Local and Primary Care teams are focused on the Six high performing systems, with their constituent organisations working seamlessly to provide world class, place based health & care for their populations, focusing on the vulnerable.

1. Deliver the early cancer diagnosis and SMR specs of the Network DES
2. Continue focus on Population Health Management (PHM) via the Aspirant ICS PHM Development Programme
3. For Phase 3, plan and ensure there is a Network approach to meeting Health Inequalities challenges
4. Once available, support implementation of recommendations of the Access Review
5. Support Systems with their PCN Development Support approaches for 20/21, ensuring continued investment against 19/20 'top 3 priorities'
6. Take an integrated approach across health & care, particularly partners in primary care, to the delivery of services e.g. homelessness & hard to reach communities

The six workstreams are large and multi-factoral using an extensive multi-disciplinary teams approach to support patients and primary care in its development as Primary Care Networks.

The programmes build upon the excellent work and services put into place prior to covid including; social prescribing, ILRs, working with Care Homes, community providers, using local intelligence and data analysis, digital workstreams and platforms to dynamically make the necessary developments and changes.

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 06 August 2020

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	4.2
Report Author	Jane Murkin – Chief Nurse		
Lead Director	Gurjit Mahil, Deputy Chief Executive Officer		
Executive Summary	This is the refreshed version of the IQPR in using Statistical Process Control charts to display the data. This report informs Board Members of the quality and operational performance across key performance indicators for June 2020. **Safe** Our Infection Prevention and Control performance for June shows that the Trust has had 0 MRSA bacteraemia cases and 2 C-diff cases. The updated March HSMR figure now sits at 98.6 (94.5 – weekday and 110.3 – weekend). The SHMI sits at 1.11 **Caring** MSA continues to demonstrate an improvement; however in June 6 breaches were recorded which is still higher than the national compliance levels. Electronic Discharge Notification (EDN) performance remains below trajectory at 77.7%, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system. **Effective** VTE performance for June sits at 93.6% against the 95% national target. Fractured NOF procedures within 36 hours performance remains at 72.7%. A number of different actions are in place to improve the experience for patients and the performance. **Responsive** The Trust saw the 4 hour performance standard reaching 87.1% for June 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for June is recorded at 80.5%, with 20 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for June as 91.8%. Cancer 2 week wait performance for May continues to be achieving national standards at 98.5%, 62 day performance is recorded as 70.6%. **Well Led** We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 3 of 2020/2021.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒

	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Resource Implications	None	
Legal Implications/Regulatory Requirements	NHS providers need to be compliant with the Health and Social Act 2008 as regulated and monitored by the Care Quality Commission (CQC). As such, this report supports the Trust in its' obligations in demonstrating compliance and the mitigations against associated risks where there is non-compliance.	
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 – June 2020

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: June 2020

NHS
Medway
NHS Foundation Trust

Guide to Statistical Process Control (SPC)

NHS Medway NHS Foundation Trust

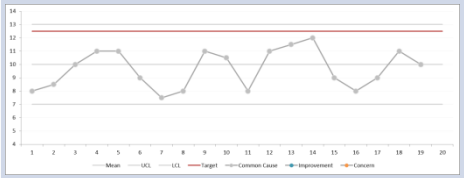
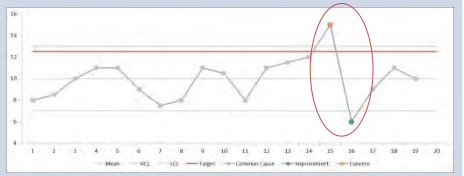
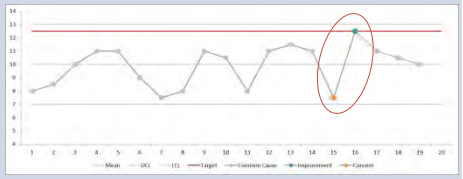
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

The main aim 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.

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.

NHS Improvement have published two documents '**Making Data Count**' which will provide further information on SPC. Please click on the More Info box in the bottom right hand corner to access the documents.

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

Common cause	7 consecutive points above mean	7 Consecutive points below mean	Astronomical points outside CL
			
7 consecutive descending	**7 consecutive ascending**	**2 out of 3 sigma points**	**More Info Click here**
			NHS Improvement 'Making data count'

Guide to Statistical Process Control (SPC) Icons

Extract of how the SPC Icons have been included into the IQPR

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

Safe

Our Infection Prevention and Control performance For June shows that the Trust has had 0 MRSA bacteraemia cases and 2 C-diff cases.

The updated March HSMR figure now sits at 98.6 (94.5 – weekday and 110.3 – weekend). The SHMI sits at 1.11

Caring

MSA continues to demonstrate an improvement; however in June 6 breaches were recorded which is still higher than the national compliance levels.

Electronic Discharge Notification (EDN) performance remains below trajectory at 77.7%, deep dive analysis and task and finish groups have been completed with clear actions to improve the EDN compliance to ensure appropriate information is available to patients and the wider healthcare system.

Effective

VTE performance for June sits at 93.6% against the 95% national target. Fractured NOF procedures within 36 hours performance remains at 72.7%. A number of different actions are in place to improve the experience for patients and the performance.

Responsive

The Trust saw the 4 hour performance standard reaching 87.1% for June 2020. Due to the pause in elective work the 18 weeks Referral to treatment (RTT) performance for June is recorded at 80.5%, with 20 52 week breaches, clinical harm reviews have been completed for these patients. Diagnostics has been recorded for June as 91.8%. Cancer 2 week wait performance for May continues to be achieving national standards at 98.5%, 62 day performance is recorded as 70.6%.

Well Led

We have maintained compliance with Trust target for appraisal and statutory and mandatory training. The Trust has also reported breakeven against the control total for month 3 of 2020/2021.

Executive Dashboard

Current Month Overview of KPI Variation and Assurance Icons

NHS Medway NHS Foundation Trust

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

Domain: Caring Dashboard

Executive Lead: Jane Murkin – Interim Chief Nurse
Operational Lead: N/A
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

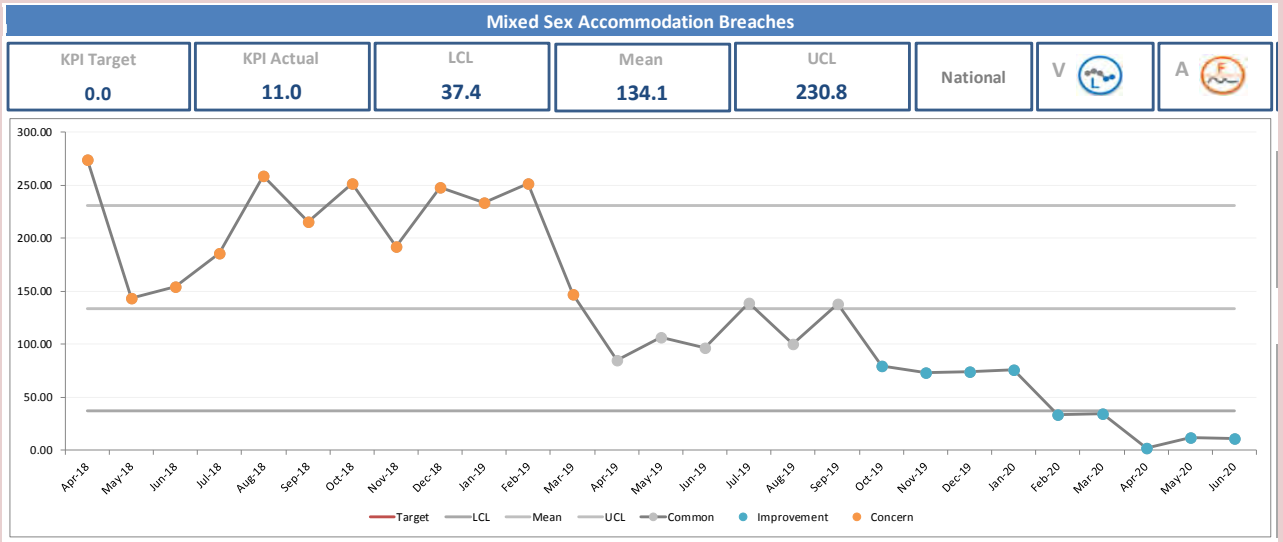
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	N	Jun-20	0	11	37	134	231		
		MSA %	N	Jun-20	0%	0.1%	0.3%	0.9%	1.5%		
		% of EDNs Completed Within 24hrs	N	Jun-20	100%	77.7%	70.1%	75.0%	79.9%		
		Inpatients Friends & Family % Recommended	N	Jun-20	85%	88.1%	80.3%	86.3%	92.3%		
		Inpatients Friends & Family Response Rate	N	Jun-20	22%	21.4%	16.0%	20.7%	25.4%		
	ED Care	ED Friends & Family % Recommended	N	Jun-20	85%	84.3%	71.4%	78.4%	85.3%		
		ED Friends & Family Response Rate	N	Jun-20	22%	16.9%	11.8%	14.5%	17.1%		
	Maternity Care	Maternity Friends & Family % Recommended	N	Jun-20	85%	99.4%	97.0%	99.2%	100.0%		
		Maternity Friends & Family Response Rate	N	Jun-20	22%	36.2%	11.2%	25.1%	39.1%		
	Outpatient Care	Outpatients Friends & Family % Recommended	N	Jun-20	85%	89.2%	88.2%	90.4%	92.7%		
		Outpatients Friends & Family Response Rate	N	Jun-20	22%	13.7%	12.0%	14.1%	16.3%		

Domain: Caring Insights

Executive Lead: Jane Murkin – Interim Chief Nurse
Operational Lead: Simone Hay – Divisional Director of Nursing
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: Mixed Sex Accommodation Breaches



Indicator Background:

The number of patient breaches by day of mixed-sex accommodation (MSA)

What the Chart is Telling Us:

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

Actions:

- Continued focus on eliminating mixed sex accommodation
- Critical care review of stepdowns escalated early to site.
- Site encouraged to allocate stepdown patients to avoid breach and to move ahead of DTA
- Proactive management of patient movements to avoid breach in critical care

Outcomes:

6 breaches June 2020. 5 breaches occurred within critical care units where patients were unable to be stepped out to ward based care. 1 breach occurred in McCulloch specialist respiratory ward.

Underlying issues and risks:

Challenge will be to sustain good performance

On occasion team fail to critique data and errors within report – refocus with HoN's and Matrons their role in accurate data collection and validation

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

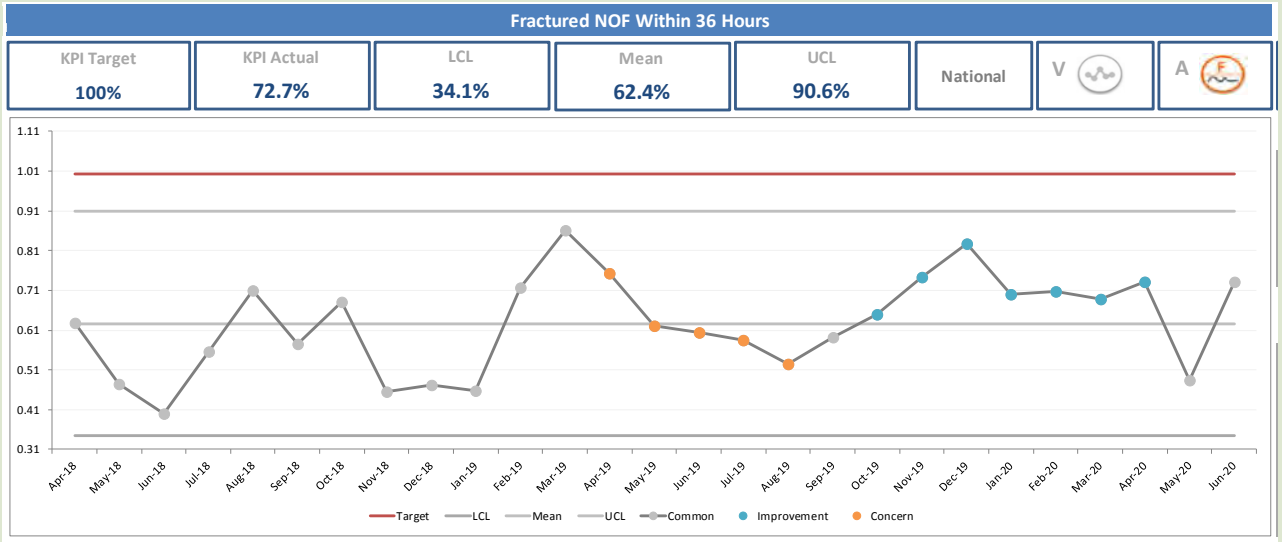
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Effective	Best Practice	7 Day Readmission Rate	N	May-20	10%	8.9%	4.1%	5.5%	7.0%		
		30 Day Readmission Rate	N	May-20	10%	16.2%	9.1%	11.1%	13.0%		
		Discharges Before Noon	N	Jun-20	25%	12.1%	12.5%	15.0%	17.5%		
		Fractured NOF Within 36 Hours	N	Jun-20	100%	72.7%	34.1%	62.4%	90.6%		
		VTE Risk Assessment % Completed	N	Jun-20	95%	93.6%	72.7%	85.0%	97.3%		
	Maternity	Elective C-Section Rate	L	Jun-20	13%	14.0%	9.7%	13.1%	16.5%		
		Average occupancy	L	Jun-20	15%	20.2%	15.2%	18.9%	22.7%		
		Total C-Section Rate	L	Jun-20	28%	34.2%	27.7%	32.1%	36.4%		
		Number of Deliveries (Count of Mothers)	L	Jun-20		421	347	409	470		
		12+6 Risk Assessment	N	Mar-20	90%	81.6%	77.3%	83.1%	88.9%		
	Stroke	Stroke SSNAP Rating *	N	Mar-20	B	D					
		% of Pts Seen by Stroke Cons in 24 Hours *	N	Mar-20	95%	40.0%	32.0%	37.4%	42.9%		
		Stroke Pts Scanned Within 1 hour *	N	Mar-20	90%	40%	38%	43%	49%		

Domain: Effective Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Dr Graeme Sanders & Mr Neil Kukreja
Sub Groups : Orthopaedics, Anaesthesia, Orthogeriatrics

NHS Medway NHS Foundation Trust

Indicator: Fractured NOF Within 36 Hours



Indicator Background:

The proportion of patients admitted with fractured neck of femur (NOF) and had surgery within 36 hours of admission.

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

Extra half day trauma list has been started in July 2020. Mon-Fri only. Allows space for sub-specialty trauma operating with minimal disruption to #NOF surgery.

Outcomes:

Improved compliance expected to be visible in next month's data set.

Underlying issues and risks:

Weekend orthogeriatric cover.
Turn-around time in Trauma Theatre has slowed because of Covid-19 infection control processes.

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

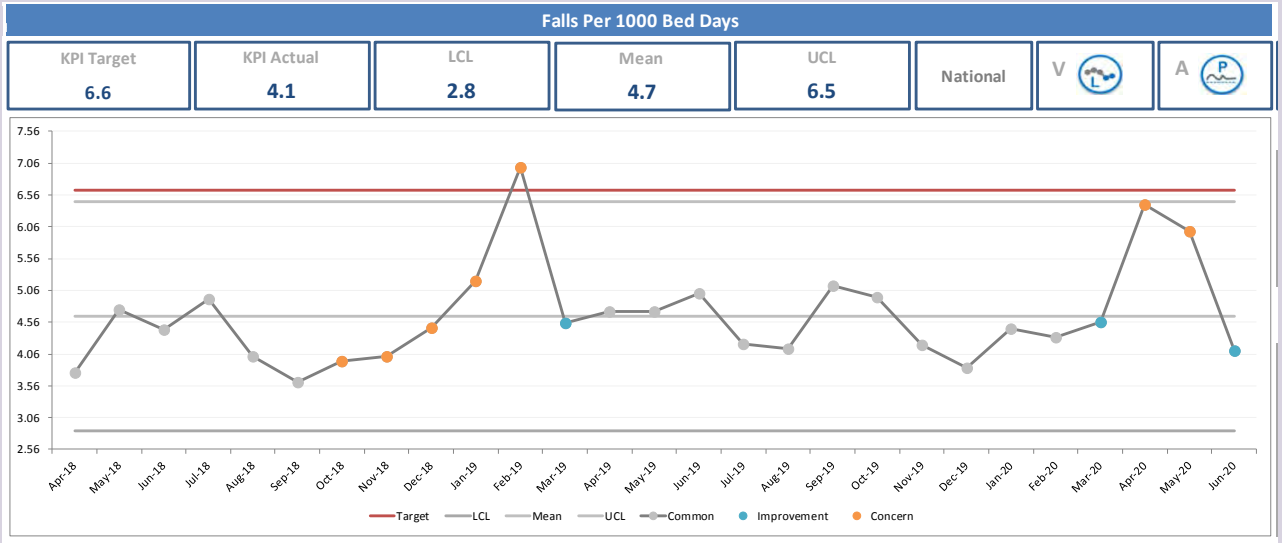
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	N	Jun-20	6.63	4.12	2.85	4.65	6.46		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	N	Jun-20	1.04	0.00	0.00	0.06	0.26		
	Incident Reporting	Never Events	N	Jun-20	0.0	1.0	0.00	0.1	0.9		
		No of SIs on STEIS	N	Jun-20	90	17	0	10	21		
		% of SIs Responded To In 60 Days	N	Jun-20		100%	91%	98%	100%		●
	Infection Control	MRSA Bacteraemia (Trust Attributable)	N	Jun-20	0	0.00	0.00	0.59	2.95		●
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	N	Jun-20	0	2.0	0.00	2.9	10.7		●
		C-Diff Acquisitions HAI (HOHA + COHA)	N	Jun-20		0.0	0.00	1.5	5.8		●
		E-coli blood stream hospital associated infections	N	Jun-20	0	3.0	0.00	4.6	0.0		●
	Mortality	Crude Mortality Rate	N	May-20	2.5%	2.07%	0.54%	1.68%	2.82%		
		HSMR (All)	N	Mar-20	100%	98.6%	102.9%	106.5%	100.0%		
		HSMR (Weekday)	N	Mar-20	100%	94.5%	99.6%	103.8%	100.0%		
		HSMR (Weekend)	N	Mar-20	100%	110.3%	109.6%	114.0%	100.0%		
		SHMI	N	Mar-20	1.0	1.11	1.06	1.09	1.11		

Domain: Safe Insights

Executive Lead: Jane Murkin – Interim Chief Nurse
Operational Lead: Kerry O'Neill
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: Falls Per 1000 Bed Days



Indicator Background:

The number of patient falls per 1000 bed days.

What the Chart is Telling Us:

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

Actions:

Collaborating with orthotics Department to assemble post fall " grab boxes" for each ward to improve and guide post fall assessment.
All sling hoists have laminated warning sign to avoid use if clinical signs of hip fracture or spinal injury,(improve use of flat lift kit).
Delirium assessment currently at testing phase before upload to ExtraMed, (To improve consistent assessment)

Outcomes:

5 patients (10%) were COVID positive
13 patients (26%) had a confirmed diagnosis of Dementia
3 patients (6%) had increased alcohol consumption
15 patients (30%) had confirmed Delirium
1 Moderate Harm fall (wrist fracture) Keats ward/ 2 Severe harm falls (Hip fracture) in the Emergency Department

Underlying issues and risks:

Lessons learned from incidents in Emergency Department (ED)

- require further dedicated falls prevention equipment to ensure implemented as soon as risk identified.
- No low level trauma trolleys

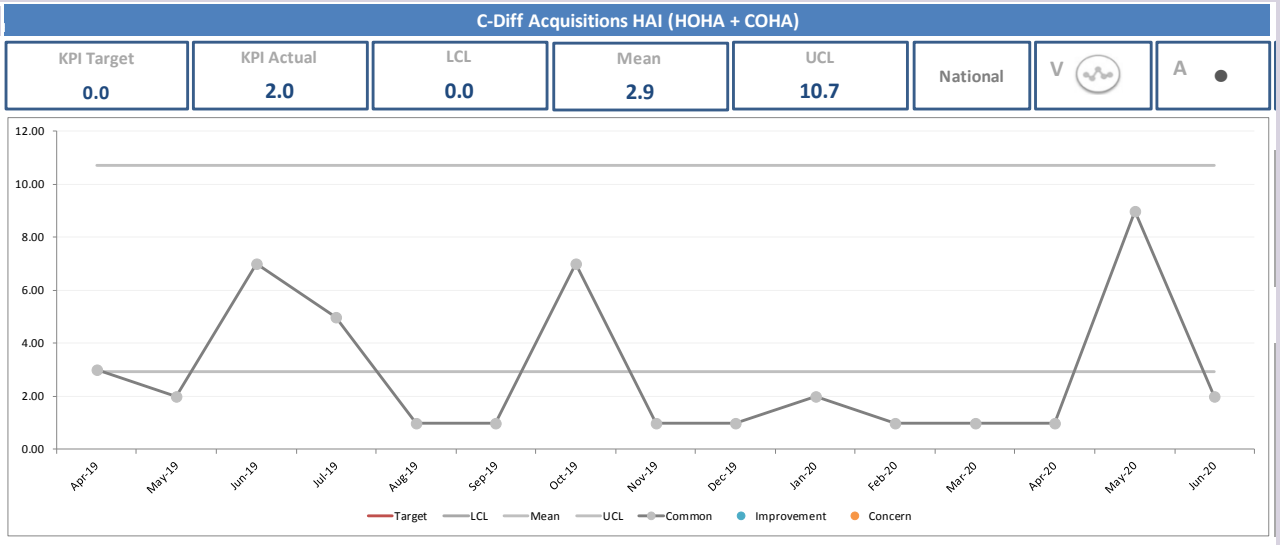
Lack of consistent approach to delirium assessment and care bundle

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: C-Diff Acquisitions HAI (HOHA + COHA)



Indicator Background:

The number of Clostridium difficile Infection (CDI) cases.
June 2020 there were two cases of community onset hospital associated. Both cases have been investigated.

What the Chart is Telling Us:

Compared to June 2019 at which time there had been 12 cases cumulative, in June 2020 there is no change with a YTD of 12 cases.

Actions:

Antimicrobial Stewardship (AMS) Group meets monthly. Work plan is in place for this group to target stewardship activities towards CDI reductions. AMS policy has been drafted for ratification. Compliance reports for AMS ESR online training module have been developed to monitor uptake by prescribers.

Outcomes:

CDI controls are in place and holding therefore no rising increase in numbers of cases.

CDI preventative measures require implementation to further reduce HAI cases as no reduction achieved YTD compared to 2019/20.

Underlying issues and risks:

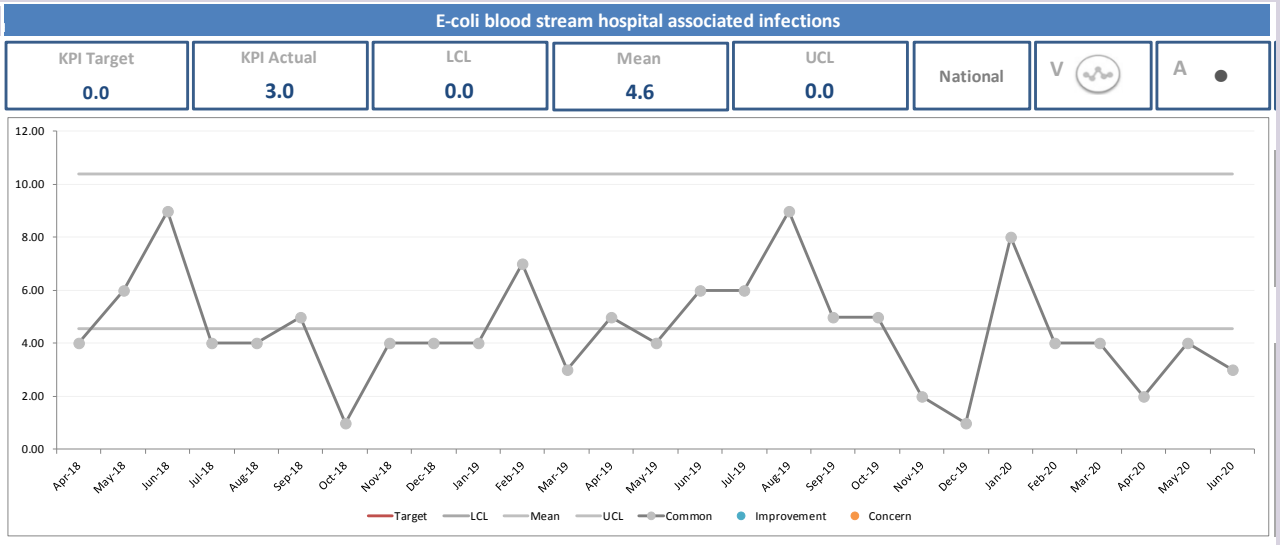
Inappropriate sampling
Limited application of Start Smart then Focus AMR reduction initiatives
Delays in sampling when patient presents with diarrhoea
Loose stool management protocol not always robustly applied on wards
Delays in isolation of patients due to no side room beds

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: E-coli blood stream hospital associated infections



Indicator Background:

Escherichia coli (E. coli) blood stream infections (BSI) is part of the gram negative mandatory surveillance. YTD there has been 9 cases of HAI E.coli BSI.

What the Chart is Telling Us:

Provider Trusts are expected to work towards health economy reductions of around 15% year on year. 2019/20 month 3 there were 15 cases cumulative. This year 9 cases YTD in June, reduction of 6 cases.

Actions:

Trust wide work continues around hydration which positively impacts this target
Raised awareness through training delivered to nurses, doctors and pharmacists
Application of HOUDINI initiative continues to be monitored during surveillance activity

Outcomes:

Data analysis of surveillance findings has been completed and shows no correlation between urine catheter insitu and E.coli BSI incidence.
Two top sources of infection are Upper Urinary Tract (pyelonephritis/ abscess) and Hepatobiliary.
Keats ward has seen the largest number of E.coli BSI positive samples

Underlying issues and risks:

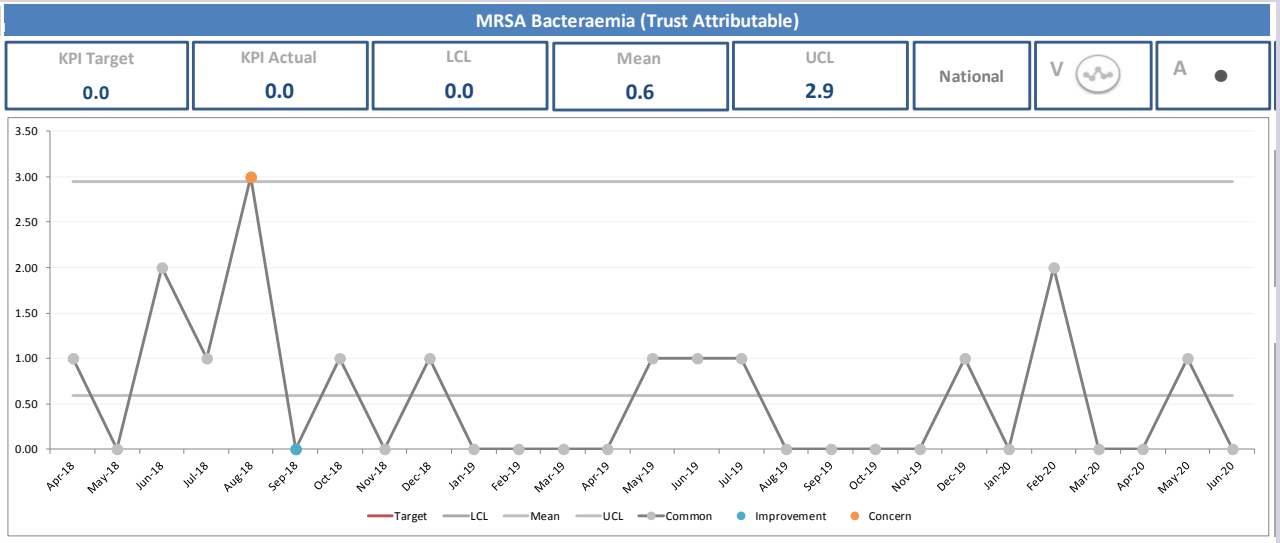
NHSI site 15.6% of E.coli BSI's nationally have a source of hepatobiliary. Single incision laparoscopic cholecystectomy, and robust management and prevention of gall stone disease is advocated in reducing E.coli BSI incidence.

Domain: Safe Insights

Executive Lead: David Sulch – Medical Director
Operational Lead: Kris Khambhaita
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

Indicator: MRSA Bacteraemia (Trust Attributable)



Indicator Background:

Meticillin-resistant Staphylococcus aureus (MRSA) there is zero tolerance to cases. Each case is considered a serious incident and a post infection review is completed.

What the Chart is Telling Us:

At month 3 of 2020/21 4 cases YTD already for MRSA BSI. Performance is outside trajectory, and not met zero tolerance. 2019/20 annual figure was 6 cases.

Actions:

Training has been delivered to doctors, nurses and pharmacists to raise awareness

All positive MRSA skin infections are followed up to ensure treatment is instigated and where these are hospital acquisitions notification of incident is completed to allow follow up investigation within division.

Outcomes:

Group in place to review line related infections and ensure policy, practice and products are aligned to current best practice. A small work group with a plan of action is being developed around this and the first meeting has been held to review current arrangements in place; identify gaps.

Underlying issues and risks:

MRSA acquisition rate – patient getting MRSA after admission to hospital remains higher than acceptable

Lack of monthly audit on MRSA colonisations and admission screening

Data that can be warehoused by MFT from NKPS is an ongoing issue

Domain: Responsive – Non Elective Dashboard

Executive Lead: Harvey McEnroe – Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

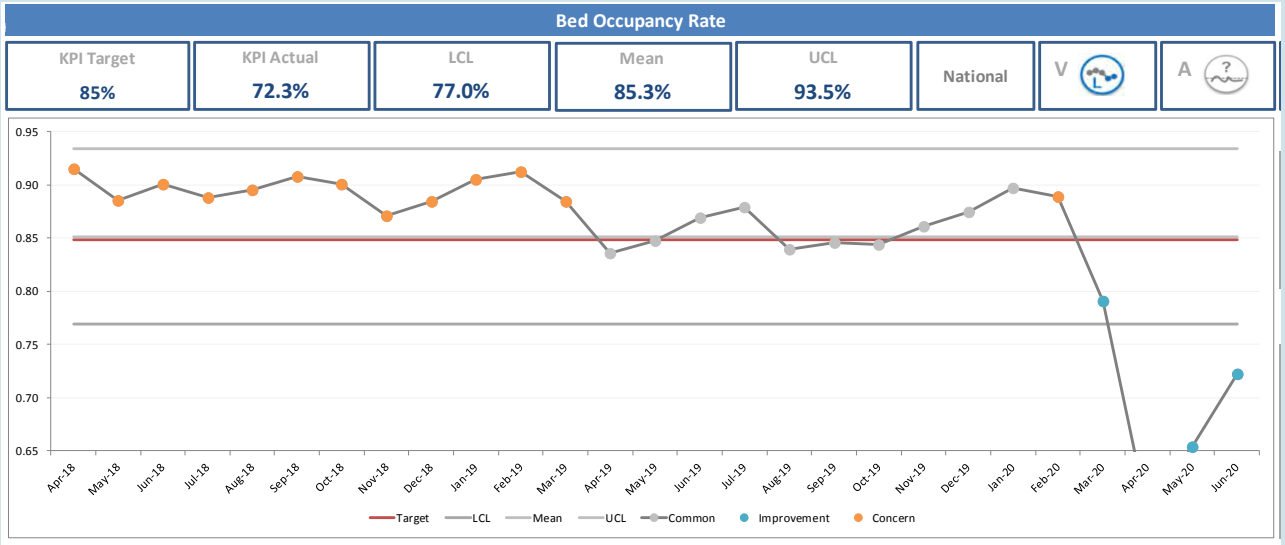
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Non Elective	Bed Management	Bed Occupancy Rate	N	Jun-20	85%	72.3%	77.0%	85.3%	93.5%		
		Average Elective Length of Stay	N	Jun-20	5	2.86	1.46	2.32	3.18		
		Average Non-Elective Length of Stay	N	Jun-20	5	7.27	7.31	8.52	9.72		
		% of Delayed Transfer of Care Point Prevalence in Month	N	May-20	3.5%	0.60%	0.44%	1.58%	2.72%		
		% Medically Fit For Discharge Point Prevalence in Month	L	Jun-20	7%	11.42%	15.50%	19.11%	22.71%		
	ED Access	ED 4 Hour Performance All Types	N	Jun-20	95%	91.6%	76.7%	83.5%	90.3%		
		ED 4 Hour Performance Type 1	N	Jun-20	95%	87.11%	67.04%	75.83%	84.62%		
		ED 12 hour DTA Breaches	L	Jun-20	0	0	0.00	13.74	52.72		
		60 Mins Ambulance Handover Delays	N	Jun-20	0	27	0	81	176		

Domain: Responsive – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Bed Occupancy Rate



Indicator Background:

The proportion of beds occupied at midnight.

What the Chart is Telling Us:

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

Actions:

- Partial application of site rhythm to maintain control of admissions & discharges from G&A bed-base;
- MFFD clearance within ICP structure emains effective;
- New bed tracking software being planned and executed by Head of Site alongside BI;
- Ambulance conversion to DTA <25%;
- Occupancy metric needs revision to G&A only and LoS metric needs revision to GIRFT standard (PC and UIC);

Outcomes:

- Site rhythm dependent on Duty Manager role;
- 21+ days stranded approximately 5% (record low) but consists of acute respiratory cohort;
- MFFD caseload oscillating with acute demand but clearance to 0 on most-days;
- G&A occupancy circa 92% with UIC occupancy >96%;
- Discharge lounge utilisation in-month steadily reducing to 9 patients per day;
- Discharge <1200hrs metric not met;

Underlying issues and risks:

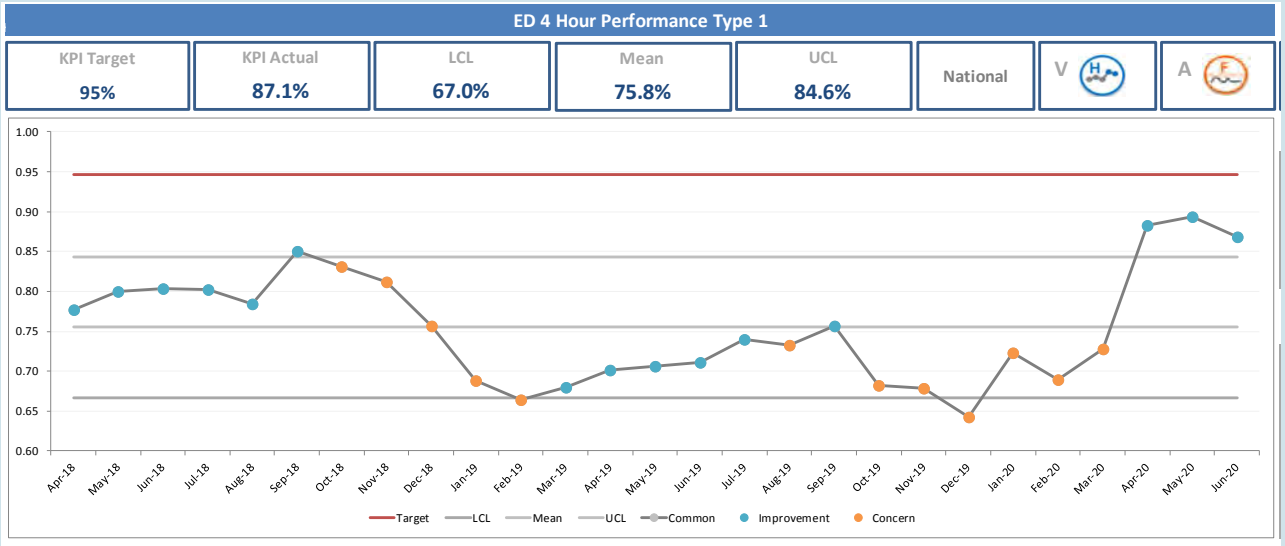
- Duty Manager competency remains variable with impact on core site operations;
- Limited site operations knowledge of internal flow & quality linked issues;
- Elective RESTART programme gathering pace. Consideration to removing protected beds from G&A report;
- NEL LOS is improving but remains approximately 1.5 days above national mean;

Domain: Responsive – Non Elective Insights

Executive Lead: Harvey McEnroe – 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:

- Maintain effective non-admitted type 1 performance;
- Operational control of admitted pathway for type 1 patients;
- Monitoring and escalation of mental health patients with increased LoS. New AMPHS algorithm being governed through ICP UEC recovery team;
- Closed beds monitored by Head of Site Management;

Outcomes:

- Non-admitted performance in region of 94% against target of 95%;
- Admitted performance deteriorating in-month with poor flow into SAU/AAU. Both Divisions <70% compliant;
- Bed occupancy in UIC >97% with 28 beds closed due to non-estates;
- Mental health performance is <70% and LoS in excess of 24hrs noted on numerous occasions (SI reports);

Underlying issues and risks:

- Loss of CDU pathway (Ph3 estates likely to reduce non-admitted performance by 4%;
- Site rhythm is off-protocol with reduced grip on ward flow & intelligence;
- Discharge <1200hrs in UIC not met;
- KMPT not meeting internal operational standards with AMPHS service sub-optimal;
- Non-estates bed closures through G&A bedbase;
- ED & DCSS workforce fatigue being monitored;

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

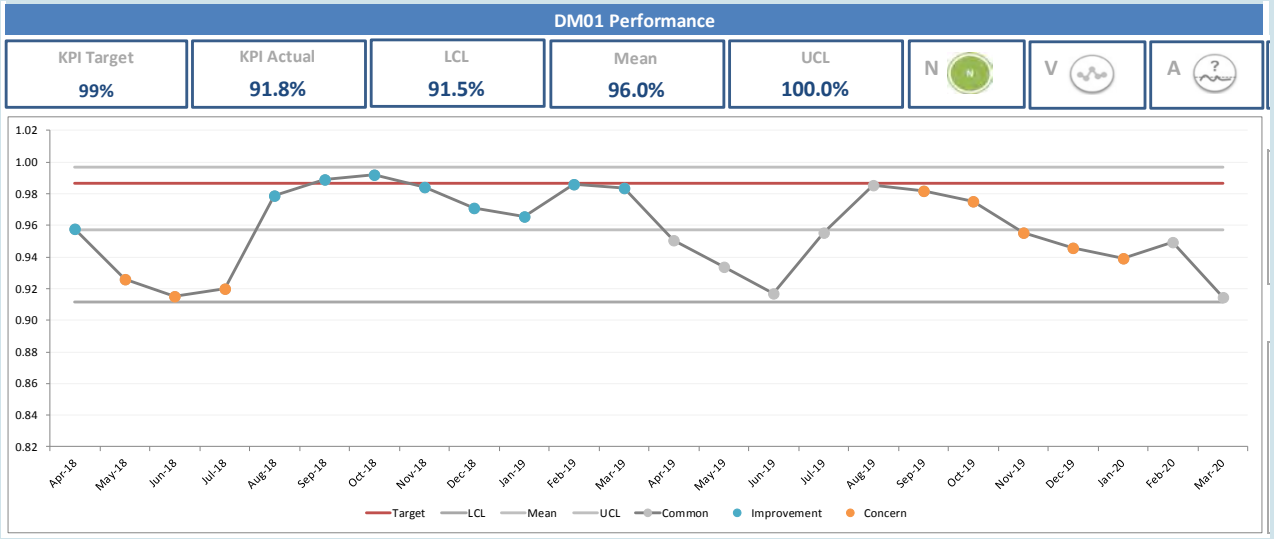
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Elective	Direct Access	DM01 Performance	N	May-20	99%	43.3%	82.9%	92.3%	100.0%		
	Elective Access	18 Weeks RTT Incomplete Performance	N	May-20	92%	65.5%	77.5%	81.0%	84.5%		
		18 Weeks RTT Over 52 Week Breaches	N	May-20	0	20.00	0.00	7.31	18.48		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	N	Jun-20	0	5.00	0.00	23.33	53.21		
		Cancelled Operations Not Rescheduled < 28 days	N	Jun-20	0	0.00	0.00	5.33	13.62		

Domain: Responsive – Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: DMO1 Performance



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is Inconsistently achieving target.

Actions:

- *DM01 Meetings have restarted*
- *Plans have been developed to support routine procedures*
- *Recovery trajectories for all diagnostic modalities are being developed*
- *Endoscopy recovery plan developed to increase capacity (both Trust and IS)*

Outcomes:

- *Focus and support for diagnostic services*
- *Return to elective activity*
- *Reduction in diagnostic backlogs*
- *Patients treated in clinical priority and referral date order*

Underlying issues and risks:

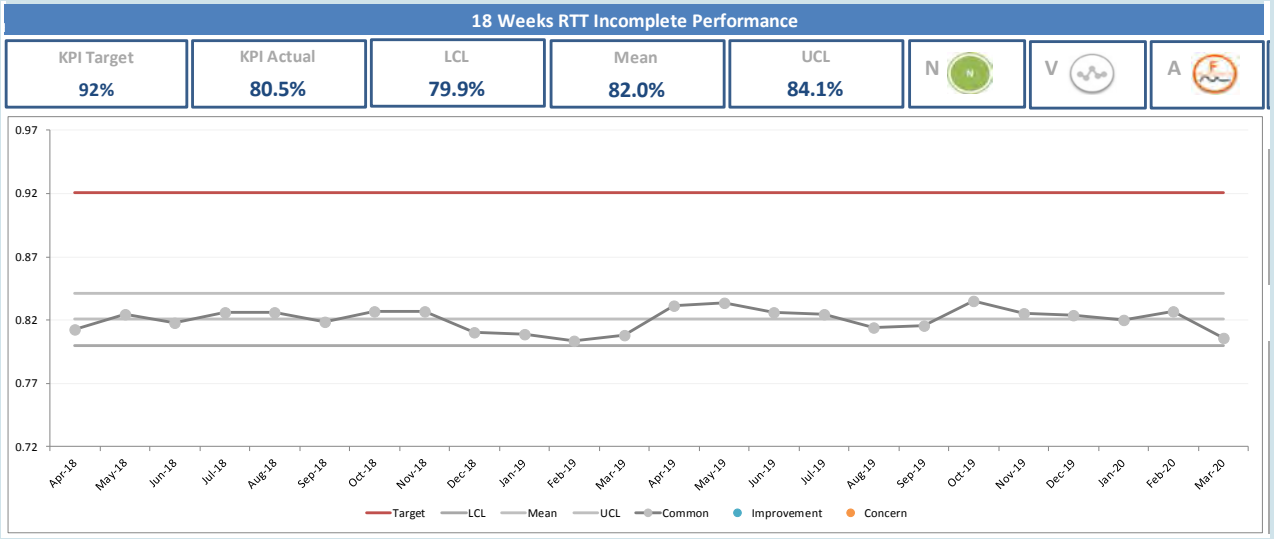
- COVID 19 and a potential 2nd wave
- Decrease in capacity in endoscopy again due to infection control
- Only urgent procedures undertaken in imaging with a plan to return to electives ASAP
- Patients choice declining appointments

Domain: Responsive – Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Incomplete Performance



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing common cause variation indicating no significant change. Assurance indicates that the KPI is consistently failing to achieve target.

Actions:

- *Outpatient elective activity has restarted*
- *Processes in place for admitted patients to attend safely*
- *Speciality level RTT recovery trajectories being developed*
- *Review and revision of Access Policy*

Outcomes:

- *Increase in clinic capacity*
- *Patients remain safe when visiting*
- *Patients treated in clinical order*
- *Planned reduction in patients waiting over 52 weeks*
- *Improved Covid-19 guidance for staff managing patients on RTT pathways*

Underlying issues and risks:

- *COVID-19 impact on elective work:*
  - *Reduced theatre capacity*
  - *Reduced outpatient capacity*
  - *Patients cancellations for both theatre & outpatients*
- *Increase in referrals from GP's and CAS*

Domain: Responsive – Cancer and Complaints Dashboard

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

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

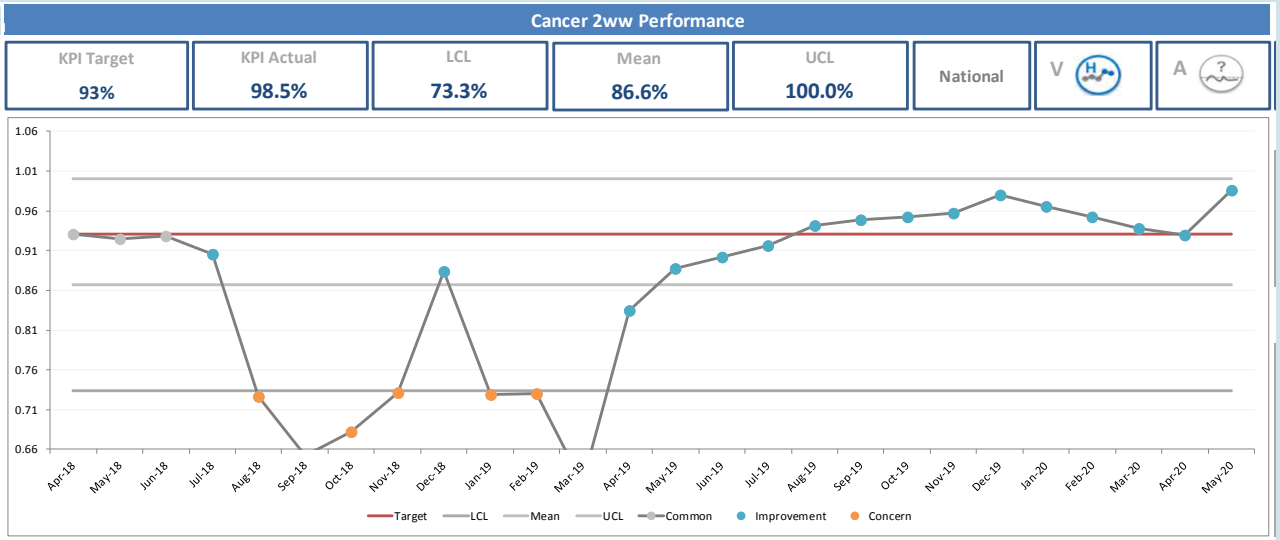
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive - Cancer & Complaints	Cancer Access	Cancer 2ww Performance	N	May-20	93%	98%	73%	87%	100%		
		Cancer 2ww Performance - Breast Symptomatic	N	May-20	93%	96%	46%	77%	100%		
		Cancer 31 Day First Treatment Performance	N	May-20	96%	93%	90%	96%	100%		
		Cancer 62 Day Treatment - GP Refs	N	May-20	85%	71%	65%	79%	92%		
		104 Day Cancer Waits	N	May-20	0	1	0.11	5.12	10.12		
	Complaints Management	Number of Complaints	N	Jun-20	41	30	28	61	94		
		% Complaints Responded to Within 30 Days	L	Jun-20	85%	64%	38%	66%	95%		

Domain: Responsive – Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- The Trust has maintained compliance against this KPI since August (9 consecutive months)
- Any service booking beyond day 7 will be escalated to the Service Manager.
- Real time 2WW performance shared with CRO.
- Now working to target of 7 days in each service

Outcomes:

- Working to reduce the polling range available in each Service to 7 days.
- Regular engagement with services to ensure that issues are escalated and resolved before they impact performance.
- 7 day target is allowing for more time in the diagnostic/treatment planning phase of the patients pathway.

Underlying issues and risks:

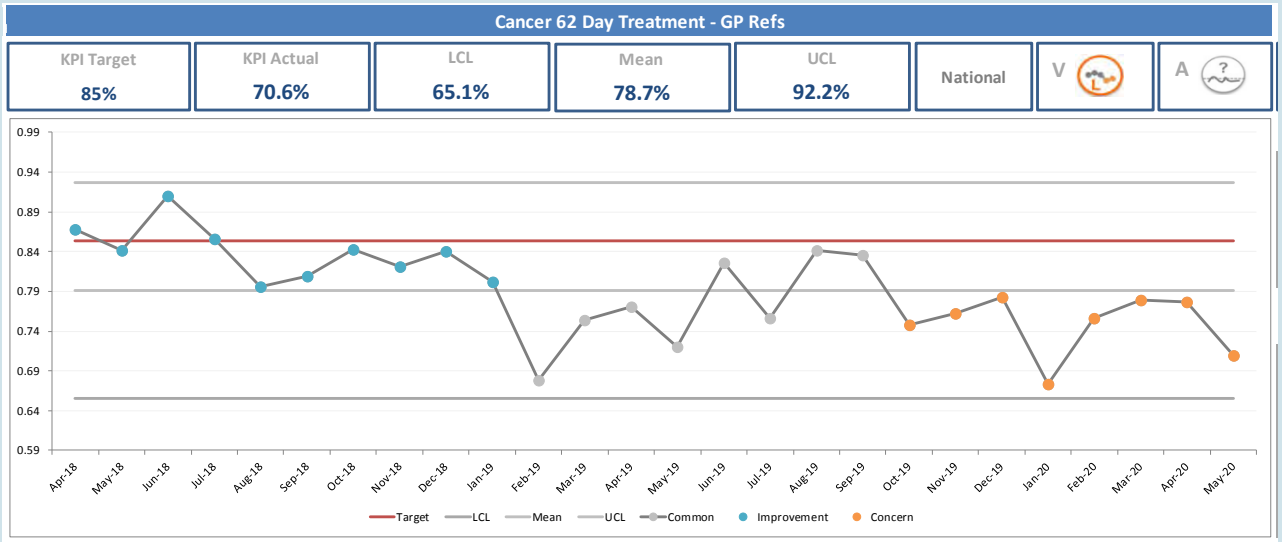
- Ongoing challenges with the Prison services around ensuring patients are able to attend their OPA's in line with the 7/14 day targets.
- qFIT to be used for LGI low risk patients and assessment of how this impacts performance will need to be closely monitored following implementation.

Domain: Responsive – Cancer and Complaints Insights

Executive Lead: Harvey McEnroe – 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 had first definitive treatment within 62 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:

- MDTC handbook is being created with tumour specific guidance, once completed to be reviewed with each tumour site lead.
- Each Service manager will meet with Cancer GM to review EVERY patient on PTL beyond day 104.
- Clear escalation points to be introduced for all KPI's to support trusts Zero tolerance on breaches

Outcomes:

- MDTC's will be expected to read understand and then sign off saying that they understand the processes as defined with handbook. This will increase MDTC accountability.
- Targeted effort to proactively manage all patients beyond 104 days.
- 40% reduction in the number of patients beyond day 104 in 3 weeks.

Underlying issues and risks:

- Trust has removed all 62d patients from alternative pathway and are now back on the PTL, clearing of this backlog will impact performance until September.
- Swab results either being inconclusive or not ready have delayed some patients diagnostics and or treatments.

Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Director of HR & OD
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

NHS Medway Foundation Trust Integrated Quality & Performance Report

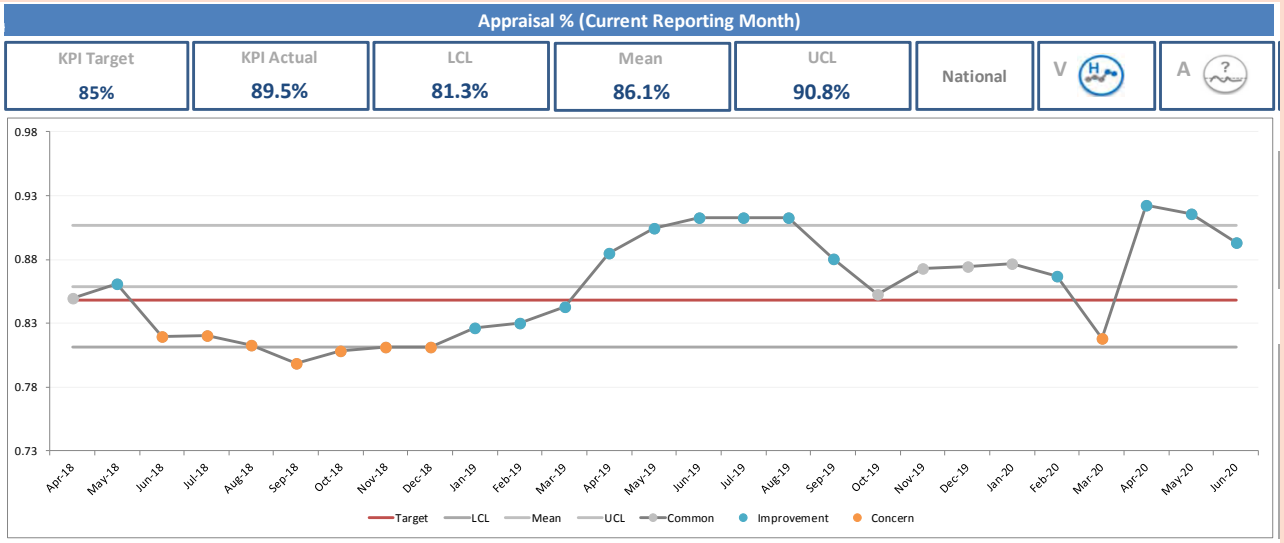
CQC Domain	CQC Sub Domain	Key Performance Indicator	National	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	L	Sep-19	62%	51.4%	45.5%	49.2%	52.9%		
		Staff Friends & Family - Recommend Care of Treatment	N	Sep-19	79%	67.6%	65.0%	66.9%	68.9%		
	Workforce	Appraisal % (Current Reporting Month)	N	Jun-20	85%	89.5%	81.3%	86.1%	90.8%		
		Sickness Rate (Current Reporting Month, FTE%)	N	May-20	4%	4.4%	4.0%	4.2%	4.4%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	L	Jun-20	12%	11.8%	10.8%	12.0%	13.3%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	L	Jun-20		4,113	3,737	3,851	3,966		
		StatMan Compliance (Current Reporting Month)	N	Jun-20	85%	88.6%	58.1%	77.2%	96.4%		
		Agency Spend as % Paybill (Current Reporting Month)	L	May-20	4%	2.2%	2.1%	4.1%	6.1%		
		Bank Spend as % Paybill (Current Reporting Month)	L	May-20	9%	16.1%	8.5%	12.8%	17.2%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	L	May-20	75%	68.0%	64.9%	73.6%	82.4%		

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed the appraisal process.

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

- 3695 members of staff have an in-date appraisal with objectives and personal development plan outlined.

Underlying issues and risks:

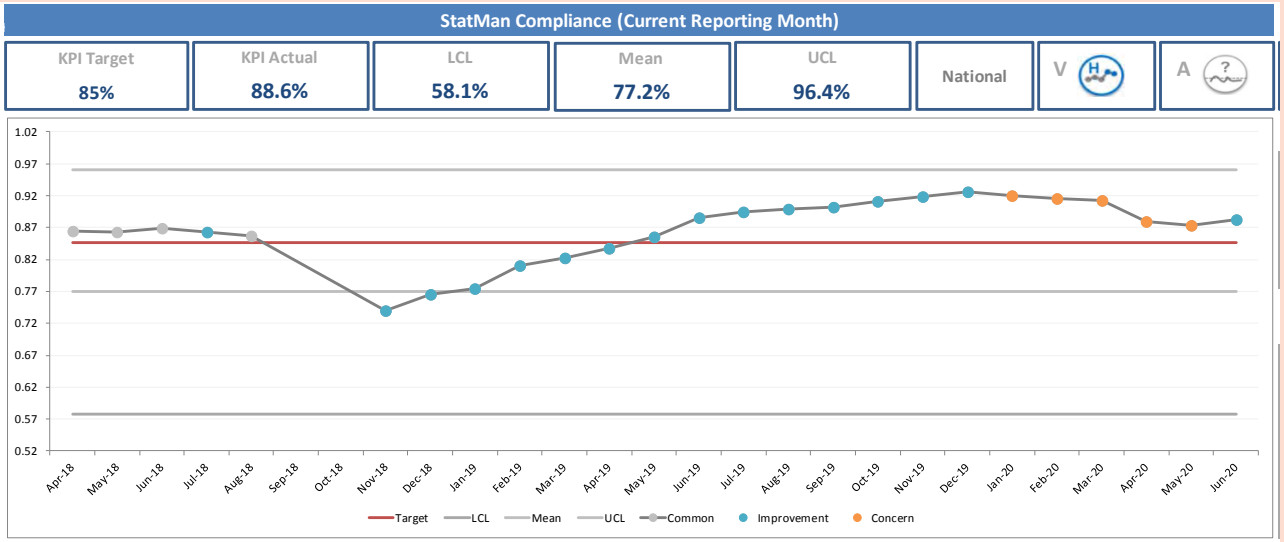
- Current COVID-19 is interrupting clinical area's capacity to carry out appraisals in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Failure to appraise staff timely reduces the opportunity to identify skills requirement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

Domain: Well Led – Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: StatMan Compliance (Current Reporting Month)



Indicator Background:

The proportion of staff that has completed their appropriate training to comply with their statutory and mandatory requirements.

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);
- Significant number of classroom-based learning events moved to webinar or video to support remote working and flexible access to StatMan content due to Covid. Reviewing the impact of quality and learning post-covid – and delivery of course content in future.
- Pay progression policy linked to StatMan completion in place (nationally suspended due to Covid)

Outcomes:

- Competencies, on average, being met (>85%) includes conflict resolution; equality and diversity; health and safety; infection, prevention and control (L1, 2); moving and handling (L1); information governance; prevent (basic, WRAP); safeguarding children (L1,2); safeguarding adults (L1,2)
- Competencies, on average, not being met (<85%) includes fire; safeguarding children (L3), resuscitation (L2,3 adult, L2,3 paediatrics, L2 newborn); moving and handling (L2); MCA/DoLS.

Underlying issues and risks:

- Current COVID-19 is interrupting clinical staff's capacity to carry out StatMan in a timely fashion.
- Continued COVID-19 disruption is likely to continue to negatively affect StatMan completion for clinical areas.
- Uneven StatMan renewal cycles can impact on the training capacity thereby limiting the availability for timely compliance.
- Failure for staff to be compliant with StatMan can negatively affect staff and patient safety, patient quality and experience and clinical skills.
- Low StatMan compliance can be linked to higher number of incidents and negatively impacts a safety culture.

Domain: Well Led - Financial Position

Executive Lead: Richard Eley
Operational Lead: Paul Kimber – Deputy Director of Finance
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	28,654	29,637	983	85,962	89,573	3,611
Pay	(18,216)	(18,660)	(444)	(54,647)	(56,707)	(2,060)
Total non-pay	(9,101)	(9,506)	(405)	(27,304)	(28,767)	(1,464)
Non-operating expense	(1,337)	(1,482)	(145)	(4,011)	(4,131)	(120)
Reported surplus/(deficit)	**(0)**	**(11)**	**(11)**	**(0)**	**(33)**	**(33)**
Donated asset deprecation	0	11	11	0	33	33
Control total	**0**	**0**	**0**	**0**	**0**	**0**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance
Cost Improvement Programme	210	732	522	630	1,152	522
Capital	(1,671)	(1,894)	(223)	(5,013)	(4,226)	787

Indicator Background:

The Trust reports a £11k deficit position for June; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total.

What the Chart is Telling Us:

The Trust is reporting breakeven against a control total for the month and year to date.
CIP is achieving ahead of plan due to timing differences on schemes.
Capital Programme is underspent.

Actions:

- Financial modelling based on operational actions to "restore, recover, return".
- Continued work with divisions to assess the financial impact of revised ward configuration
- CIP development and implementation of efficiencies within divisions.

Outcomes:

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

- Incremental costs associated with Covid-19 in month are £1.8m (£5.8m year to date).
- In month "true-up" income accrued to achieve breakeven is £1.6m (£5.3m year to date).

Underlying issues and risks:

Clinical income on a cost and volume basis is £20.9m adverse to plan YTD (£7.1m adverse in-month) this being the impact of reduced activity as a result of Covid.
The gap in the £12m CIP programme is £1.6m and of the £10.4m of CIPs identified, £1.9m are BRAG rated as amber or red.
Covid capital funds will be allocated to the STP; allocation of funds is not yet agreed.

Meeting of the Board of Directors in Public

Thursday, 06 August 2020

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.2**
Committee Chair:	Tony Ullman, Non-Executive Director		
Date of Meeting:	Thursday, 28 July 2020		
Lead Director:	Jane Murkin, Chief Nurse		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Radiology Reporting The committee was provided with an update on the issue pertaining to a backlog of radiology reporting linked to 3 patient groups' in-patient, outpatient and emergency department, the issue related to the examination of the scans linked to a failure of upload at the time that resulted in a delay in reporting. There were 648 reports that had not been reviewed, of that number 64 were identified as having an abnormal report, the governance team assisted with the process of review and requirement of harm review process and an action plan was competed to ensure all steps to rectify the issue and prevent re-occurrence. All patient notes were called and reviewed and all patients were found to have been followed up in clinic, treated at time of attendance and there was no delay in start of treatment.	
2. Restart and Recovery The committee received a presentation from Harvey McEnroe on restart and recovery with the Trust remaining at level four major incident, nationally the incident has been stood down to level three. The Trust has taken steps to establish robust oversight of structure which oversees the recovery and restoration. The Trust has now entered the restore and recovery phase of our COVID-19 response plan. This programme will see us through the next six months as we return our services back to	

normal for our patients and our community. • The restore and recovery programme is governed by a twice weekly system board, with all partners across the Medway and Swale region. This group oversees the work across each workstream. • The core workstream in restore and recovery are: – Urgent and Emergency Care – Elective Care – Community and Primary Care – Discharges • The resilience planning linked to winter and wave two has commenced and is being led by the Integrated Care Provider (ICP), with MFT supporting via the ICP Programme Board.	
3. CoSHH and IPC Jane provided a report and update on progress and actions taken in relation to CoSHH and IPC with support from Gary Lupton, Director of Estates and Facilities and David Sulch Medical Director in their Executive Lead roles. Gary advised the committee of the compliance issues that have been highlighted from a recent audit undertaken by the Health and Safety team two weeks ago with 17 failures across areas such as unattended cleaning trollies, sluice room doors open, washing up liquid out on kitchen sides and cupboard not locked. The committee discussed the importance and challenge in relation to changing human behaviours and how the Trust can support and assist staff in the wards and clinical areas. Gary stated that the majority of the recent compliance issues relate to housekeeping his team are looking to move to CoSHH-free products and the committee suggested looking at what other Trusts are doing to address these issues. Jane added that following receipt of the section 29a warning in December a short life working group had been set up to review products and asked as to why this had not moved forward and what barriers and challenges had there been to progress this work. David added that the challenge with IPC is the level of assurance that we have on how things are progressing however current data on MRSA, MSSA and C.diff is encouraging. The report to the committee included the following principal points. The Chief Nurse has recently submitted further evidence to the CQC Inspection team in July which included: • **Governance -** Quality Panel agendas, minutes and two examples of completed templates that are submitted to the panel by operational leads. Copy of letter sent to Executive and Operational Leads from the Chief Nurse and CEO. • **Audit template -** Flow chart reviewed and approved at the Quality panel • **IPC & COSHH -** action plans, evidence of audits, draft IPC education strategy • **Nursing standards -** Nursing and Midwifery Assurance Framework and daily standards and practice report Other actions noted: • A programme of Quality Assurance Visits has been developed and implemented based on the CQC Key Lines of Enquiry (KLOE). Led by the Central Team and using a peer review process and includes assessing IPC and CoSHH standards. • The Chief Nurse has implemented a programme of joint ward visits with the Director of Estates and Facilities at which compliance with PC and COSHH is assessed, any issues immediately dealt with and results fed back to the ward and any additional environmental actions agreed with the Estates Team. • CoSHH is reported as an agenda item directly through to the Executive Team on a regular basis • IPC training for Matrons and HoNs • Updating IPC policies; updated IPC Improvement Plan was presented at the IPC Committee on 23 June.	**Red**

• Trust-wide leadership roles for Matrons to support delivery of fundamental standards and quality priorities, one of which is for IPC. The following issues were identified and actions agreed at the Evidence Panel at the beginning of July: • MD01 – IPC - Issues around providing IPC training have continued. The team is focusing on delivering this element of the IPC Improvement Plan. The Chief Nurse commissioned training for Matrons and Heads of Nursing, the DIPC has also trained ED staff and ward Pharmacists and training will continue with junior doctors induction scheduled for the first week of July 2020. • MD03 – CoSHH - Daily checks were being undertaken on wards in the UPIC Division, but the practice is still not embedded. Quality rounds were completed at the weekend with only nine out of 14 wards being complaint. The DDoN has met with housekeepers and nurses about COSHH and they all understand the importance of this and their responsibilities. These will supplement the matron's quality reports and audits provided to the Chief Nurse via the DDoN report. Daily and weekly ward level CoSHH spot checks are now undertaken. The committee will escalate CoSHH to the Trust Board.	
4. CQC action plan mapped against quality strategy Jane presented a paper on the CQC action plan and how it is mapped against the quality strategy following discussion at the last Board meeting. The paper outlined specific areas where the quality strategy is focusing on reducing harms and improving outcomes for patients which align with the 'must do and should do' actions and the benefits of delivery of one will positively impact on the delivery of the other. The CQC action plan and quality strategy are reported on in separate ways. Jane recommended that going forward the quality strategy will be reporting on the delivery of metrics that align to the CQC action plan Must Do and Should Do actions. Similarly with the CQC action plan the related Quality strategy priorities will be referenced and how it links to the CQC action plan. Ian Renwick commented that there is a strong correlation on both CQC must do and should do and references to the quality and nursing strategy. The committee discussed the quality assurance visits that the central quality team are undertaking and asked how these compare with the Gemba visits undertaken by the Executive team and NEDs. Jane will work with Glynis Alexander, Director of Communications and Engagement, on a paper for the next meeting to set out the two approaches and opportunities to reintroduce the NED visits to these with a quality assurance approach.	**Amber/Green**
5. Quality Report The committee received the quality report which continues to report progress against the implementation quality strategy, SI reporting and quality matters. Jane advised the committee that a new evidence panel meeting has been set up to review evidence submitted against the must do and should do CQC action plan, this group ensures the evidence provided is robust, any gaps in assurance and confirms if the action can be closed. The committee will continue to receive the quality report on a monthly basis.	**Green**
6. BAF – Quality and integrated healthcare The committee received the updated BAF on Quality which had been updated following the last committee meeting. The committee discussed and reviewed each of the risks and were advised that the risks are reviewed at the risk assurance group (fortnightly). The Committee	**Amber/Green**

will continue to monitor the Quality BAF at future meetings. The committee received the Integrated Healthcare BAF, this risk relates to the Medway and Swale system not enabling a true partnership working which designs a long term population based integrated health and social care system with patients at its centre. Governance arrangements for the Medway and Swale system have been agreed, weekly calls between all partners and NHS E/I regarding MFFD patient pathways and a monthly Medway and Swale Delivery Board takes place.	
3. IQPR The committee received the refreshed IQPR and discussed each of the sections and associated metrics. Jane explained that work continues with the business intelligence team on a couple of areas to ensure the metrics and data being reported are related to the Quality strategy priorities, representative and meaningful. The committee were assured on the progress made in a number of areas with particular note to the reduction in number of falls with harm and reduction of harm from pressure ulcers that Jane referenced. Jane advised the committee that she had facilitated a Pressure Ulcer event that was of a multidisciplinary nature on the 17 July where nurses, doctors, allied health care professionals, dieticians came together to share the successes and achievements to date in improving nursing fundamental standards and reducing hospital acquired pressure ulcers, sharing best practice and outlined one ward that has achieved 170 days since their last pressure ulcer and another ward with 160 days. Jane shared the plans to continue to build on this work and spread to other areas across the Trust. The HSMR has dropped from 135 three years ago to 80 with improvements made to Sepsis 6 bundle and the David advised the royal college review had noted good practice in ED with the administration of medication to patients in ED. The committee will continue to receive the IQPR each month.	**Green**
7. Exception report from Quality and Patient Safety Group The committee received an exception report from the Quality and Patient Safety Group from its meeting on the 22 June 2020 which Jane Murkin, Chief Nurse presented at. The key points discussed at the group were 1) A request to support making massive blood loss training a mandatory course for all clinical staff. 2) Medical Devices – no system in place for managing Field Safety Notices. Jane advised the committee that she had met with David Sulch; Medical Director to discuss the process for all alerts and actions to provide assurance the Trust is responding the notices. The Medical Devices Group is working with the Patient Safety Team on the process. 3) The Resuscitation Group has not had a quorate membership, Jane reassured the committee that she has picked this matter up with Philip Kemp; Associate Director Quality and Patient Safety, it is important that this meeting is attended and issues discussed such as the deteriorating patient. The group received key issues reports from its sub-groups. The Quality Assurance Committee will receive monthly exception reports from the quality and patient safety group.	**Green**
Further Risks Identified There were no further risks identified.	
Escalations to the Board or other Committee The quality assurance committee escalates the following issues to the Trust Board: 1) COSHH as a significant risk 2) Cancer waiting times, to note assurance that two week waits are on track and have been through the period of COVID. 3) Stroke, to note the positive assurances received following the recent move of the stroke service	

Meeting of the Trust Board in Public
Thursday, 06 August 2020

Title of Report	**Referral To Treatment – Current Position**	Agenda Item	**4.4**
Lead Director	Angela Gallagher, Chief Operating Officer		
Report Author	Angela Gallagher James Clary, Head of Performance Gemma Brignall, Deputy Director of BI		
Executive Summary	This paper provides the Trust Board with: • A summary of the Trusts Referral To Treatment (RTT) performance prior to the onset of the Covid-19 pandemic • An update on the current RTT position for the Trust overall and major specialities • An update on the restart of elective activity (Outpatients and Inpatients) • Work to date in developing a trajectory for improved performance including non-admitted, admitted and patients waiting over 52 weeks and then moving to 40 weeks.		
Committees or Groups at which the paper has been submitted	Regular updates provided to the Executive Team and the Quality Assurance Committee.		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	*State whether there are any legal implications*		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Trust Board is asked to discuss the content of this report.		

Approval	Assurance	Discussion	Noting
☐	☒	☒	☐

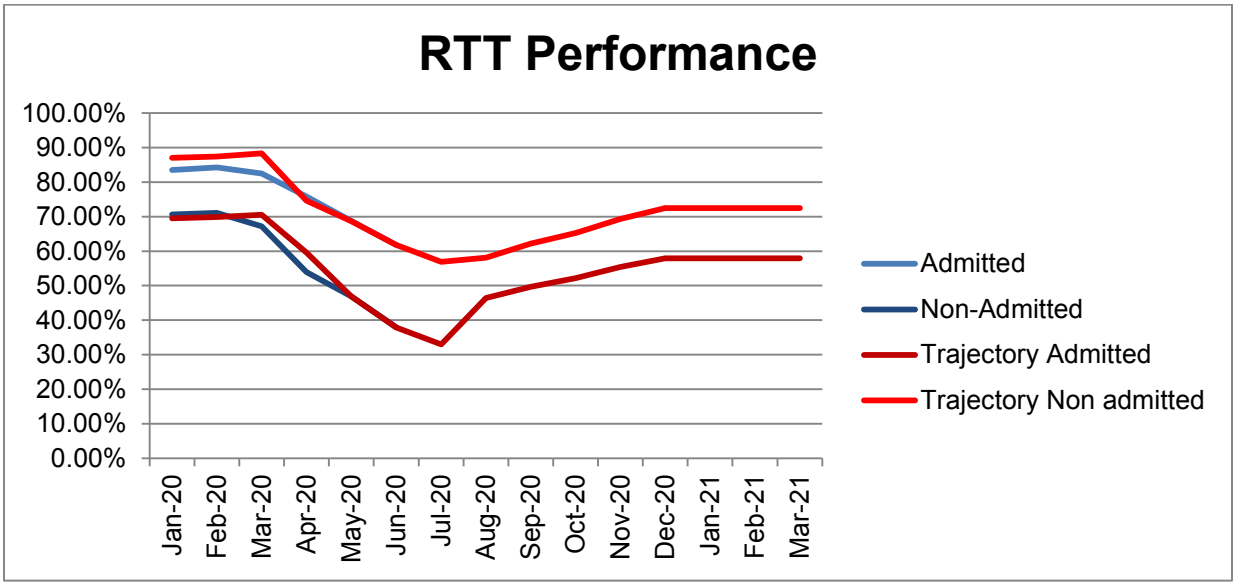
1 Executive Overview

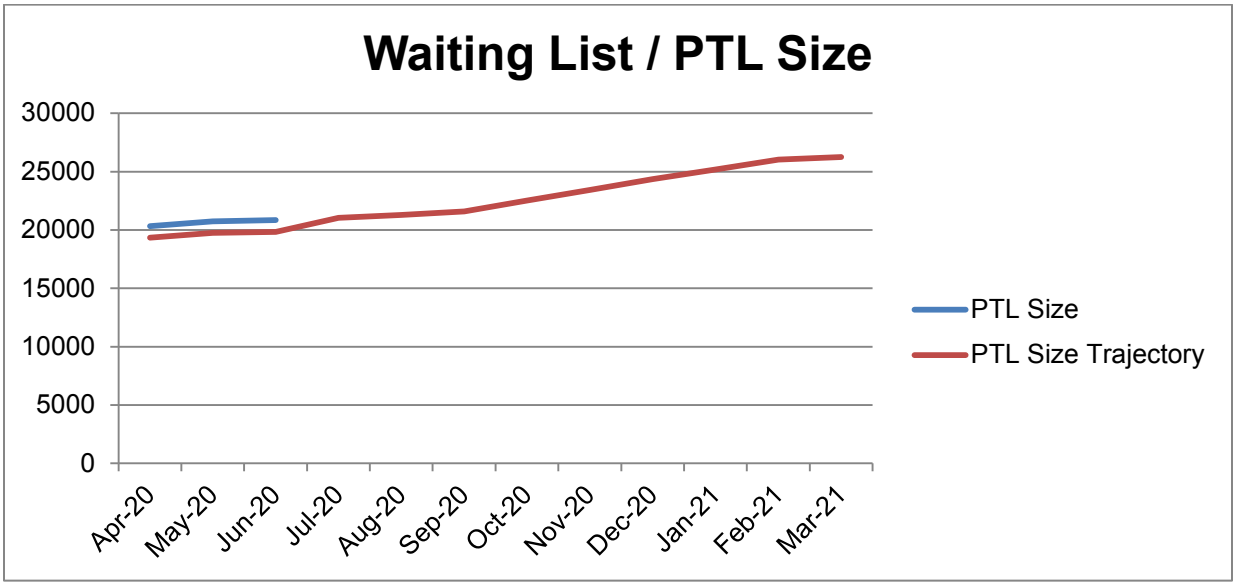
In January 2020, prior to the onset of the Covid-19 Pandemic, the Trusts Referral to Treatment (RTT) Incomplete performance was 81.94% (a negative variance of 3.80% against the Trusts planned target of 85.74% and 10.06% against the national standard of 92%).
The Trusts total waiting list size (Patient Tracking List or PTL) was 22,476 and the Trust reported one patient waiting in excess of 52 weeks.

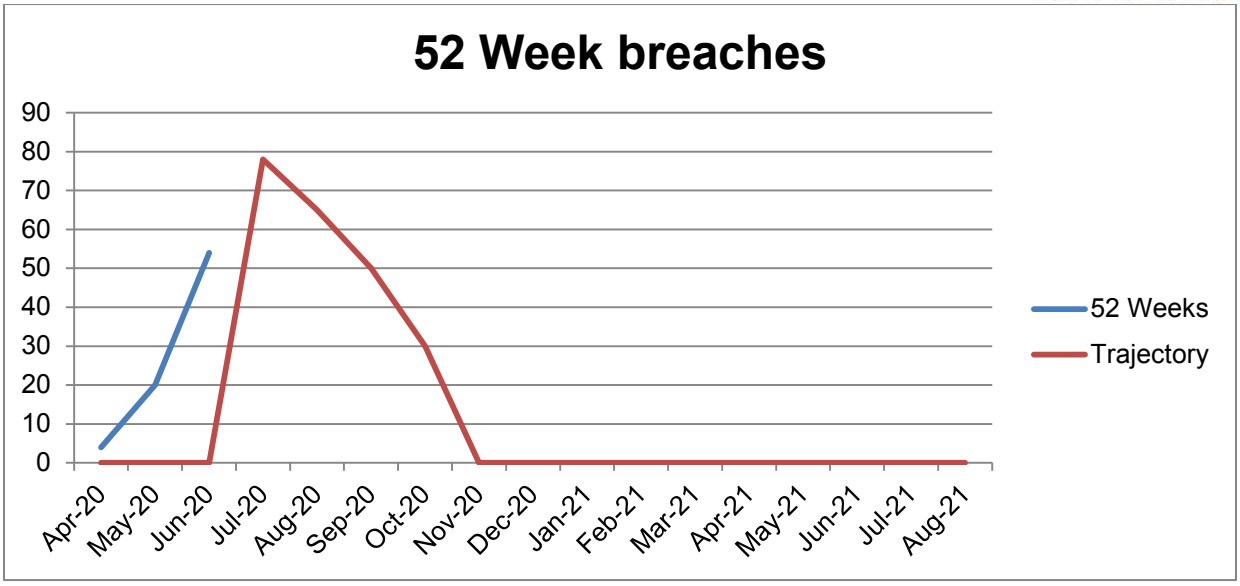
Impact of Covid19 Pandemic on the Trusts RTT performance
Since March 2020, when the Trust stopped the majority of its elective activity, there has been a progressive fall in performance and an increase in patients waiting in excess of 52 weeks.

In June 2020, the Trusts RTT Incomplete performance was 58.22%. The Trusts total PTL size was 20,795 (a decrease of 1,681) and the Trust reported 55 patients waiting in excess of 52 weeks. The decrease in the PTL numbers are due to the drop in new referrals received and referrals are now starting to rise.

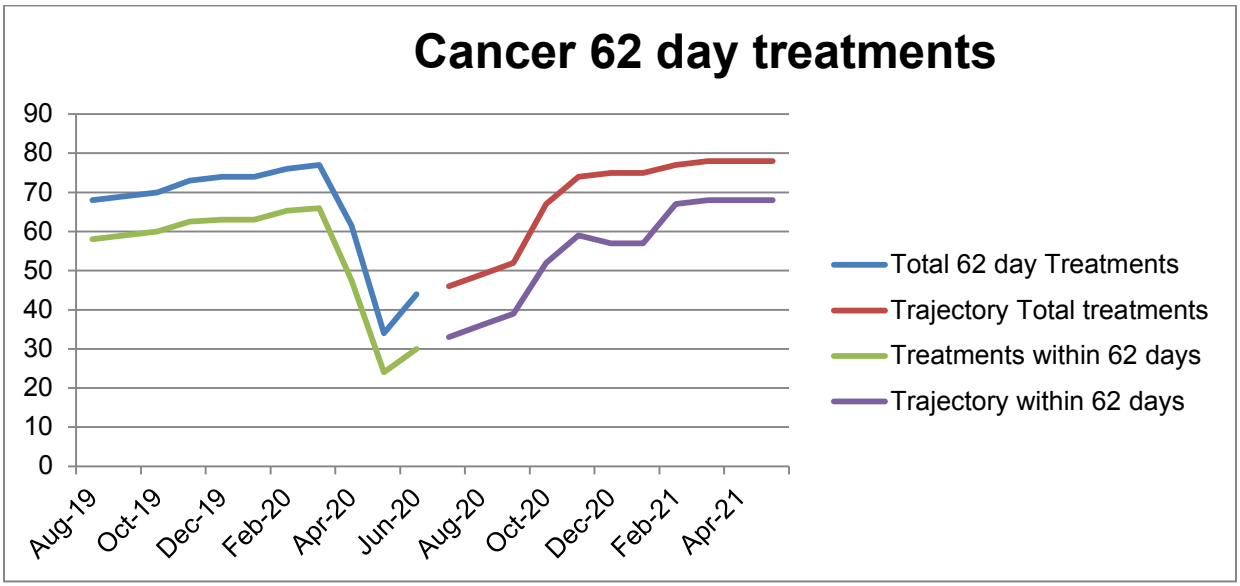
Based on assumptions regarding demand and the time to clear the existing backlog it is expected that the recovery of the RTT performance will stretch beyond March 2021 unless additional revenue or changes to the provision of elective activity are put in place.

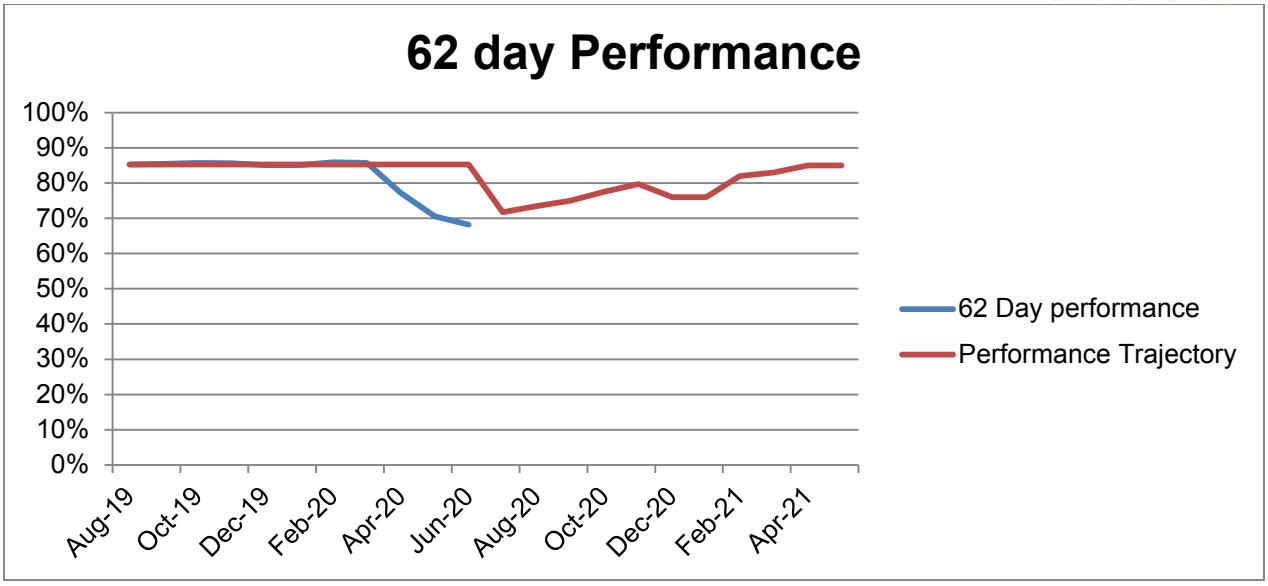






The majority of 52 week risks are across 2 main specialties, predominately ENT and Vascular services that undertook little or no routine activity during Covid but did manage the cancer referrals and cancer surgery procedures. With the restart programme both services have agreed a recovery plan for all aspects of service and tackling long waiting patients as a priority.





The 62 day performance dropped earlier this year and has remained low throughout the Covid period. The key risk area is GI which is directly linked with the reduced endoscopy capacity. Arrangements for additional endoscopy sessions are in place through a combination of additional private sector capacity, temporary use of one day surgery theatre and weekend working in the Trust's existing rooms. There is a plan to clear the outstanding backlog by the end of December 2020.

The Cancer team undertake harm reviews for all patients who breach 62 days at the point of treatment and this involves a full review of the chronology of the patient pathway.

2 Restart of Elective activity

Following guidance from NHS England, in May the Trust started a programme of work to reopen elective activity for both outpatients and inpatient. This required a Trust wide response involving clinicians, management, estates, administration and communication teams to ensure that the risk to patients and staff from Covid-19 would be minimised.

Patient and staff flows through the hospital were mapped and improved and capacity was developed to allow for the swabbing of patients and staff in line with government guidelines.

Some elective activity had already started (outpatients using both virtual appointments and face to face), diagnostics and theatres using the Trust and Independent Sector.

The Trust formally reopened to elective outpatients from 29 June 2020 and has just finalised a new a operating theatre template to allow for the booking of inpatient and day case procedures from 03 August 2020. This new planned activity also includes the use of the Independent Sector for outpatients, diagnostics and theatres.

The activity is ramping up on an incremental basis with two limitations on progress yet to be fully resolved which are; the configuration of wards to include an ultraclean Orthopaedic ward and to have a seamless covid swabbing service in place.

From a patient perspective the intensive pre-operative requirements of isolation and swab-testing mean that a number of patients have difficultly agreeing a date for surgery and it is much more difficult to substitute patients for the same reason.

3 Management of patients waiting over 52 weeks

With the interruption in elective activity, the trust has seen a steady increase in the number of patients waiting in excess of 52 weeks before a clock stop. With limited elective capacity (outpatient, diagnostics and treatment) the specialities have, until recently, had limited resources to manage this group of patients.

In line with Trust Governance guidelines, all patients waiting over 52 weeks have a received a clinical harm review. Patients who have elected to delay diagnosis and treatment through concerns about Covid-19 are being managed by the specialities as are those patients who cannot follow self-isolating guidance before treatment.

With the phased return to elective work, the services are now identifying the capacity to see long waiting patients, both those above 52 weeks and those patients above 40 weeks.

These plans are being supported by the divisional management teams and the Head of Access to ensure that there is a clear plan for every patient and that the

With the support of the Business Intelligence team, activity modelling is now underway to support the development of trajectories. As more elective activity information is added to the models, these will inform the services and Trust senior management of any additional capacity that may be needed as the elective care continues to increase. It is expected that the activity models will also function as 'activity trackers' to support services in the weekly planning cycles and PTL meetings.

4 Management & Oversight

- Development (at speciality level) of trajectories to eliminate all capacity related 52-week breaches and achieve a maximum 40 week waiting time by the end of November 2020, progressing to a 26 week maximum wait by end March 2021.

- Weekly RTT/ Patient Target List Meetings with specialty level monitoring for clinically urgent and long waiting patients against agreed trajectories.

5 Outstanding risks / Issues

- Demand increases at higher rate than capacity creating longer waiting lists.
- Provision and maintenance of ultra-clean elective wards.
- A second wave of Covid interrupts the elective plan.
- Impact of unreliable covid testing
- Impact of pre-operative requirements for patients and how this will influence their decision to proceed.

6 Conclusion

The elective recovery plan is underway across all specialties and the recovery trajectories are due to be signed off as the Restart Programme migrates to delivery and oversight by the 31 July 2020.

Meeting of the Board of Directors in Public
Thursday, 06 August 2020

Title of Report	**Trust Improvement Plan**	**Agenda Item**	5.1
Report Author	Ian Renwick, Improvement Director		
Lead Director	James Devine, Chief Executive		
Executive Summary	This report presents the Trust Improvement Plan for approval. It describes the background to the Plan, and the process of engagement and consultation undertaken to include the views of staff and partners in the final version.		
Link to strategic Objectives 2020/21	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence:	-		
Committee Approval:	Regular updates have been presented to Executive Group and Planning and Delivery Board throughout the development of the Improvement Plan. Updates to Trust Board May/June/July 2020 Engagement and Consultation Session with Clinical Council 24 June 2020 Presentation to Council of Governors 22 July 2020 Engagement Session with Members 28 July 2020		
Executive Group Approval:	As above		
National Guidelines compliance:	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback.		
Resource Implications	The introduction of a standardised approach to Quality Improvement, and the development of a Trust-wide Organisational Development programme will have financial implications, although external funding may be available to support these costs.		
Legal Implications/Regulatory Requirements	The development of a single Improvement Plan is a requirement of NHSI/E as part of the Trust's overall response to recent regulatory and other feedback The Improvement Plan and associated governance structures have been developed to ensure high level clinical involvement and engagement in its finalisation and delivery.		
Quality Impact	QIA is not necessary for the Plan itself, but will be an integral part of its		

Assessment	implementation			
Recommendation/ Actions required	The Trust Board is recommended to approve the Trust Improvement Plan, noting the process of engagement and consultation with staff and partners.			
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1 – Structure of the Improvement Plan Appendix 2 – Detailed Improvement Plan Workstreams: • High Quality Care • Our People • Integrated Care • Innovation • Financial Stability Appendix 3 – Trust Improvement Plan (to follow) Appendix 4 - High Level Governance Structure			

1 Executive Overview

1.1 Building on the updates provided in previous months, this paper presents the final Trust Improvement Plan for approval by the Trust Board. In particular, the Board's attention is drawn to the extensive process of consultation and engagement with staff, Governors and Members, and with external partners, to develop the Plan from its original draft state to the final version (Section 3).

2 Improvement Plan

2.1 The Trust's Improvement Plan has been developed across five pillars aligned to the Trust's existing strategic corporate priorities (Appendix 1):

Improvement Plan Domain	Senior Responsible Officer
High Quality Care	David Sulch & Jane Murkin
Our People	Leon Hinton
Integrated Care	Harvey McEnroe
Innovation	Jack Tabner
Financial Stability	Richard Eley

2.2 The Chief Executive has overall responsibility for the delivery of the Improvement Plan.

2.3 The Trust's priorities across each of the five pillars are shown at Appendix 2 to this report. These have been developed to provide a balanced response to the challenges facing the Trust in the light of Regulatory and other feedback, and to meet the challenge of delivering safe, consistent, high quality services in a post-COVID setting. The final Plan also includes some of the Trust's own improvement priorities, balanced against the ambitions of an increasingly system-focused approach to the delivery of health and care services.

2.4 The improvement priorities have been mapped against the CQC Action Plan to ensure that all of those actions and the response to the findings of the Well Led review are reflected in the Plan.

2.5 The implementation, delivery and sustainability of the single Improvement Plan will need to be supported by a number of enabling programmes. These are a requirement placed on the Trust by NHSI/E as a component of the on-going Intensive Support package being provided to the Trust.

- **Standardised Approach to Quality Improvement**

  Discussions are underway with ACT Academy (part of NHSI) exploring the options for them to partner with the Trust on the introduction of the NHS QSIR approach to QI. This is a Programme designed and delivered for the NHS by the NHS, and i s consistent with improvement methodology already used by key partners locally, some of whom may be involved in the initial stages of training at MFT.

- **Organisational Development Programme**

  As part of the work supporting the People Strategy, the Trust intends to run the NHSI Culture and Leadership Programme. In addition, a proposal for a Board Development Programme has been received from NHS Providers and is under consideration to ensure that its brief addresses the findings and recommendations emerging from CQC Well Led inspection; the Deloitte Review of Board Effectiveness and the recent Medway Talks staff feedback process as far as is practicable. The Director of HR and OD is reviewing these to see what additional specialist OD support the Trust might need, in advance of a bid for Intensive Support funding being submitted.

2.6 A summarised version of the Improvement Plan has also been produced which is intended to support ongoing engagement an involvement in the improvement process across the Trust (Appendix 3).

3 Mobilisation and Engagement

3.1 Within the context of the governance structure provided at Appendix 4, the Trust's Improvement Board had its first meeting in June 2020, and is meeting fortnightly. The five Programme Boards are all now active, and provide updates on their Programme Brief to the Improvement Board via a structure moving towards risk-based 'highlight' reporting aligned to the CQC domains.

3.2 In parallel with this mobilisation of the workstreams within the Plan, the Trust has been carrying out an extensive process of engagement and consultation with staff on both the content and the delivery of the Plan:

- An independent company (Public Engagement Agency - PEA) was commissioned to conduct a programme of staff engagement following the publication of the CQC inspection report in April 2020. To date, this process has comprised the following three elements:
  - a series of conversations with groups of staff via 'Zoom' in early May;
  - twelve semi-structured interviews with staff to explore the issues identified through the 'Zoom' sessions in more detail (June 2020);
  - a staff survey was disseminated to staff over the period 03 to 17 June 2020 and received 316 responses;

- On 08 June 2020 the draft priorities were shared with Senior Managers across the Trust seeking their feedback on:
  - Whether the priorities within the plan are the right areas of focus;
  - How realistic the delivery of the priorities is;
  - Whether anything was missing from the draft at that stage.

  This was followed up with a combined 'launch' and feedback session (both in person and virtually) on 25 June 2020;

- In June, the draft Improvement Plan was similarly shared with colleagues more broadly across the Trust, with a corresponding feedback session held on 01 July 2020;
- A session of Clinical Council specifically to discuss the Improvement Plan was held on 24 June 2020;
- Council of Governors received a presentation on the draft Improvement Plan at its meeting on 22 July 2020;
- On 28 July 2020 a virtual engagement event was held for Members to seek their feedback on the Improvement Plan priorities;
- Following prior distribution of the draft Plan, key external partners were invited to the first meeting of a quarterly forum to provide external assurance and challenge on 29 July 2020, which was used as an opportunity to gather feedback on the draft priorities.

3.3 Feedback from each of these processes has been used to develop the Improvement Plan into its final state as presented here today.

4 Feedback from within the Trust

4.1 During previous discussions on the Improvement Plan, the Board has issued appropriate challenge with regard to what will be different about this compared with previous Plans. The extent of the engagement and consultation associated with the development of this Plan, particularly within the Trust, is a fundamental demonstration of this difference. The Trust has engaged in a genuine process of taking the draft improvement priorities out to the organisation and then listening to feedback from staff at all levels, both clinicians and non-clinical staff.

4.2 It is clear that staff have engaged in the consultation process, and have felt able to provide very honest feedback, whether that is positive or negative. Throughout the staff engagement sessions (both those specific to the Plan and via the more general feedback process facilitated by PEA) there has been a high level of support for the priorities within the Improvement Plan as being the right focus at this point in time, as demonstrated in the following feedback which was collected in real time during the staff engagement and feedback sessions:

Question……	Response
Do the themes reflect the right priorities for the service where you work?	97% said yes
Do you think they are likely to improve patient care?	98% said yes

4.3 However, there has also been a consistent theme within the feedback (typically articulated through a feeling of having 'been here before' and 'why should this Plan be any different to those we have seen before?') which demonstrates an underlying level of cynicism in the ability of the Trust to deliver against the priority areas for improvement.

4.4 This stresses the importance of the OD programme to support the delivery of the Plan. It also demonstrates the opportunity which the QSIR programme brings through the involvement of staff in the change process which will make the improvement journey real and tangible to them rather than the more distant and nebulous approach they feel has been adopted in the past.

4.5 Another key difference in the approach to this Plan has been the level of engagement with front line clinical teams, to ensure that it is clinically driven and as 'bottom up' as possible, as opposed to the 'top down' approach to imposing previous such plans on the organisation. This is reflected in the broad range of powerful feedback the Trust now has from the process of listening to the organisation, which confirms the findings of CQC and Deloitte in their assessments of the organisation.

4.6 We have taken on board feedback from colleagues where possible, including:

Feedback/Comment	How we have responded
More detail is needed so everyone can understand what is intended.	The Plan has now been developed further with more detail than in the original draft.
The Plan needs to be written in language everyone can relate to.	The Plan has been edited, and in places rewritten, to use plain English and avoiding 'management speak'. A summary version will also be produced for a more general audience.
The pillars and programmes suggest a 'silo' approach.	The pillars are set out separately but in practice there is joint working in many areas and the governance of the Plan ensures they do not operate in isolation.
Staff need to be kept informed to show what differences are being made and what it means to patients and staff.	Communications will be regular and linked to specific improvements, described through the eyes of staff and patients to demonstrate their impact.
Executives need to 'get out there' and have conversations with staff, not just giving presentations.	Informal sessions with the Executive Team have been arranged and Directors have committed to engaging with staff 'on the shop floor'.
There is a reality at Medway that corporate activity supresses clinical development (usually for financial reasons) rather than promoting it.	The Improvement Plan is, and its implementation will be, clinically-led – this is critical to its success. The Innovation Institute is one initiative designed to encourage and support clinical innovation.

4.7 This process of listening to the organisation (as well as to the feedback of partners), with the openly articulated objective of developing an Improvement Plan which is clinically led and outcome focussed, will serve to broaden the feeling of ownership of it, and of engagement in the improvement journey itself, across a far greater span of the Trust than has previously been achieved. Dialogue with staff will continue into the delivery phase, and informal conversation sessions on Microsoft Teams have already begun.

5 Feedback from External Partners

5.1 On 13 July 2020 the draft Improvement Plan was shared with the following local partners and stakeholders for comment and feedback:

- Local MPs – Rehman Chishti, Kelly Tolhurst, Tracey Crouch, Gordon Henderson and Helen Whately
- Neil Davies, Chief Executive, Medway Council
- Cllr Alan Jarrett, Leader, Medway Council
- Cllr David Wildey, Chair, Medway HASC

- Cllr Teresa Murray, Opposition Health Spokesman, Medway Council
- Cllr David Brake, Chair of the Health and Wellbeing Board, Medway Council
- Cllr Angela Harrison, Health Lead, Swale Borough Council
- Cath Foad, Chair, Healthwatch Medway
- Maggie Cane, Manager, Healthwatch Medway
- Medway and Swale GPs (via CCG comms)

At the time of writing, their formal feedback remains outstanding, so an update will be provided at the Board meeting.

5.2 The draft Improvement Plan has also been shared with Kent and Medway CCG, Medway Community Health and Kent and Medway NHS and Social Care Partnership Trust for comment. In addition, the Joint Strategic Response Team (JSRT) - which includes local health and system partners - received the draft Improvement Plan at its meeting in July 2020.

5.3 As is identified above, the Trust's formal engagement and feedback session with external partners (via the '90 Day Forum' in the governance structure at Appendix 4) takes place on 29th July 2020. A verbal update on this will also be provided at the Board meeting.

6 Conclusions and Recommendations

6.1 The Trust Improvement Plan is presented in its final format following an extensive process of engagement and consultation, both within the Trust and externally. Honest and often very direct feedback from staff has been critically important throughout this process, not so much in terms of the content of the Plan itself - although some colleagues have provided helpful comments - but particularly to help us understand where there is an underlying mood of scepticism across the organisation.

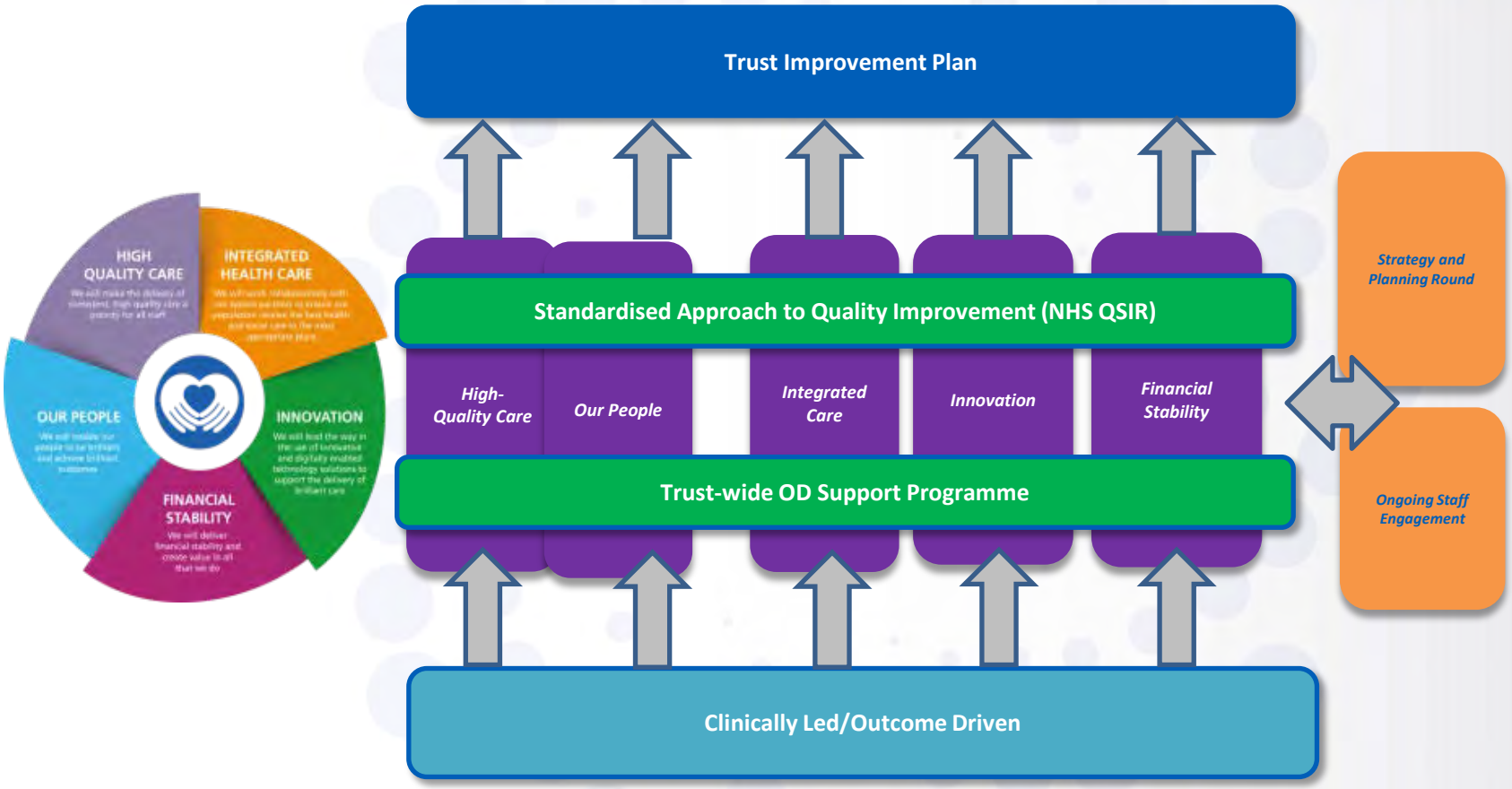
6.2 However, it is also true that the process of engagement and consultation has in itself served a very positive purpose in addressing that mood music head on and demonstrating that the Leadership team is taking an inclusive and collaborative approach. In addition, based on feedback on the content of the Improvement Plan as presented for approval today, the Board can be assured that there is overwhelming support for the improvement priorities the final version contains.

6.2 Board members are asked to:

- Note the process of engagement and consultation which has supported the development of the Improvement Plan;
- Approve the service change and transformation priorities contained within the Trust Improvement Plan (as set out at Appendix 2 of this report);
- Note the summarised version of the Improvement Plan to be used as part of on-going engagement across the organisation (Appendix 3 – to follow), and
- Approve the governance structure for oversight of the delivery of the Improvement Plan (Appendix 4).

Structure of the Improvement Plan aligned to Strategic Objectives

NHS Medway NHS Foundation Trust



Best of care
Best of people

Appendix 2 (i)

HIGH-QUALITY CARE

Mission 1: SAFE – Deliver Safe Care and Reduce Harm	Mission 2: EFFECTIVE – Reduce Variation and Create a Safety Learning Culture	Mission 3: PERSON-CENTRED – Transform the Patient Experience	Mission 4: Create the Conditions for Quality

DELIVER NOW [0-9 months]

Safeguarding:
- Review systems and processes
- Training to Level 5 (WL29)

Safe Ward Staffing (SD05)

Safe Staffing (OP, Theatres, Specialist Nurses and Corporate)

Serious Incident Review Framework:
- Develop a Serious Incidents Framework
- Thematic learning from Incidents and Complaints (WL34, WL35, WL36)

Infection Prevention and Control Action Plan

Develop a Patient Experience Strategy including the use of Patient-Centred language (WL13/WL18)

Enhance Patient Experience:
- Review of Complaints

Reclaiming the Nursing Landscape:
- Improve Nursing & Midwifery governance (Ward to Board Assurance Framework)
- Nursing & Midwifery Leadership Development
- Develop a Nursing & Midwifery Strategy (including developing the workforce)
- Nursing Quality Standards

(WL07, WL24)

Design and implement a 'Business as Usual' Quality Assurance Peer Review Process

Fundamentals of Nursing Care:
Standardised* approach to:
- Pressure damage
- Nutrition and hydration
- Falls
- Delirium and Dementia

Quality Governance and Safety Learning Culture:
Standardised* approach to:
- Reducing SHMI and HSMR Variation
- Improve learning from Mortality Reviews (WL28)

Improve Medical Leadership:
- Revised Professional Standards
- Develop Medical Leadership Programme

WORK TO IMPROVE [12-18 months]

***Standardised Approach:**
QI approach – PDSA/tests of change having established our baseline and encompassing a review:
- People/Structures/Reporting lines
- Training and education
- Governance and reporting
- Audit and Assurance
- Thematic learning
- Documentation and IT Systems

PLAN TO TRANSFORM [18-months+]

SUSTAIN AND EMBED IMPROVEMENTS

CONTINUE OUR QI JOURNEY USING DATA TO INFORM IMPROVEMENT IN PROCESSES AND PATIENT OUTCOMES

Appendix 2 (ii)

OUR PEOPLE

	Mission 1: *Best of People*	***Mission 2:*** *Best Culture*	***Mission 3:*** *Best Future*	***Mission 4:*** *Strategic Design of the Trust to be Well-led*
DELIVER NOW [0-9 months]	Local, National and International Recruitment Workforce Grip and Control (VCP)	Values, Behaviours and Tools – induction (YatD)	Talent Management and Succession Planning Apprenticeship alignment to Skills Demand	Ensuring corporate strategies have read across through Board and Executive reports (WL10)
	Performance Management processes to support High-Performing Teams			Executive presence in committees (WL22)
		Staff Family and Friends Pulse Survey expansion Just Culture – Expansion beyond policy		
WORK TO IMPROVE [12-18 months]	Staff Retention and Stability Workforce Planning incorporating New Roles Equality and Inclusion Plans to narrow differentials WRES, WDES, GPG	Dovetail culture, OD with QSIR FTSU Strategy delivery (WL17, WL33)	Staff Survey 2020 (WL33)	
			NHSEI Culture and Leadership Programme and Organisational Development delivery (WL14, WL16, WL32)	
PLAN TO TRANSFORM [18-months+]	Remote and New Ways of Working: • Virtual Office • AI and Robotics			
				Executive Leadership Capability (WL01) Stability (WL02) Risk Visibility (WL03, WL20, WL21) Board Development (WL04) CoSec structure (WL05) NED Role (WL06) Strategy deployment (WL09) Executive Culture (WL14) Executive Visibility (WL15) Regulatory Requirements (WL19, WL31) Results-based Gemba (WL23) Corporate Risk Register (WL25) Risk Escalation (WL26) SI Management Process (WL27) Reporting Assurance (WL30) Executive Innovation (WL37) Board Effectiveness Assessment completed annually (WL06)

Appendix 2 (iii)

INTEGRATED CARE	***Mission 1:*** *Safely Deliver 92% Occupancy*	***Mission 2:*** *Improve Cancer Outcomes*	***Mission 3:*** *Transform Outpatients Pathways*	***Mission 4:*** *Work as a "System by Default" in a Clinically-led Way*
DELIVER NOW [0-9 months] 	Demand and Capacity Internal Discharge Delivery Flow and Site Ops	Demand and Capacity PTLs WHO Checklist Cancer Booking Process 62 day Breach avoidance	Demand and Capacity OP areas Estate	ICP/ System Engagement
WORK TO IMPROVE [12-18 months] 	12 hr, 7 Day SDEC Admission Avoidance MFFD , Stranded and SS	Access to Diagnostics Tumour-Site Specific Groups 28-Day Standard		Parity of Esteem
PLAN TO TRANSFORM [18-months+] 	UEC, 111, Comm. Pharmacy Integrated Discharge Hot/Cold Elective Care	Work w/ Cancer Alliance	Virtual outpatients (Attend Anywhere)	

Appendix 2 (iv)

INNOVATION

	Mission 1: Single EPR	Mission 2: User Experience	Mission 3: System by Design	Mission 4: Invisible IT	Mission 5: Supporting Evidenced Based Decision Making
DELIVER NOW [0-9 months]	Order Comms; EDRMS; Stabilise Extramed	CCIO & Clinical Advisory Group; Perfect Ward; Digital Dictation; Virtual Outpatients	ICP Digital Plan; Kent Data Sharing; Access Anywhere	Core IT Infrastructure; Telephony	IQPR (WL11)/ GIRFT; Business Intelligence Enablers; Data Accuracy - 'R.I.R.O.'
	Digital Strategy				
WORK TO IMPROVE [12-18 months]	PAS Upgrade; RPA; Vital Signs	Single Sign-On; Remote User Working	Patient Portal	Data Centre	
PLAN TO TRANSFORM [18-months+]	EPR	Natural Language Processing	Population Health		AI/ML

Appendix 2 (v)

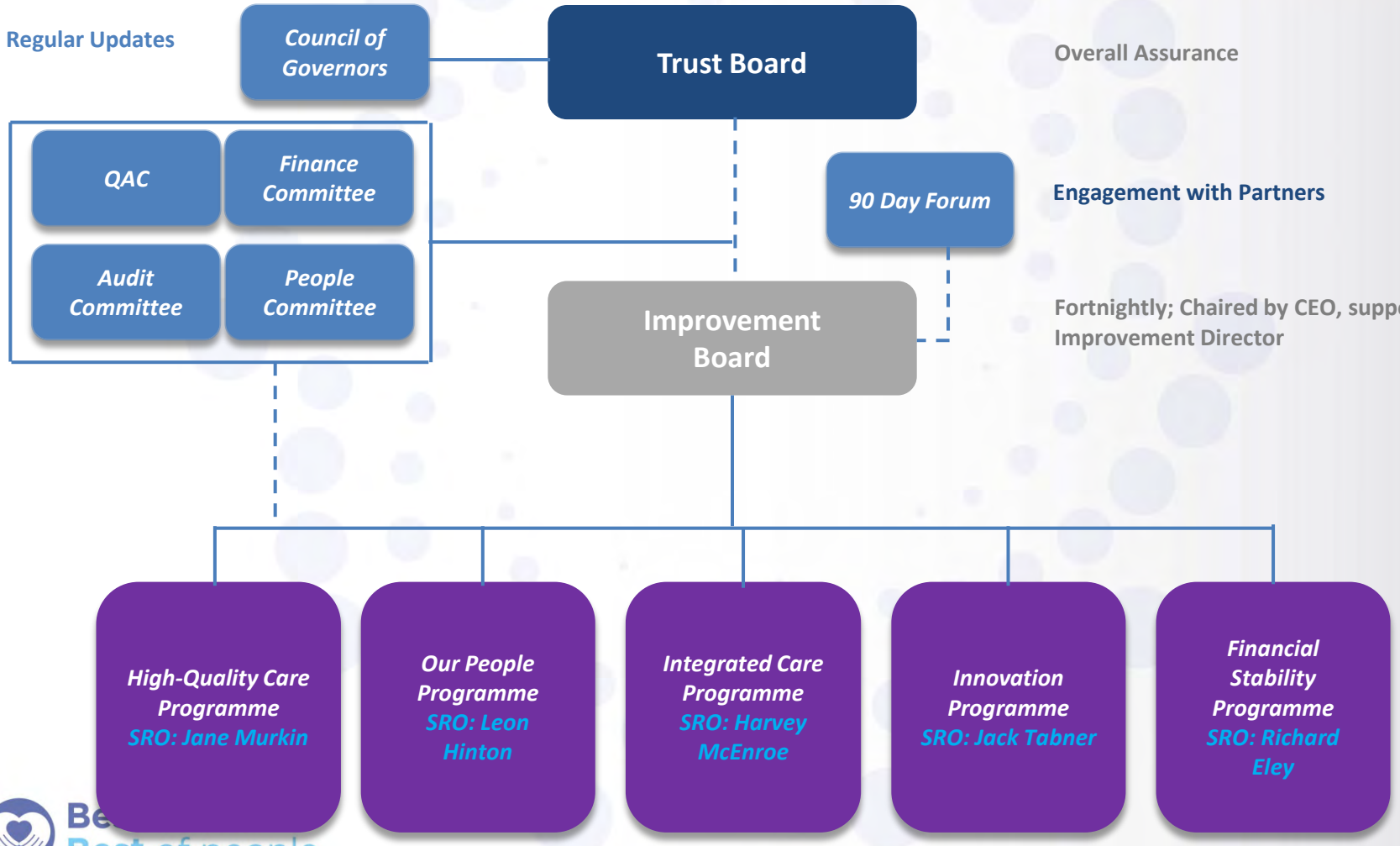
FINANCIAL STABILITY

	Mission 1: *Achieve Financial Targets – 'Getting to Zero'*	***Mission 2:*** *Improve Value for Tax Payers' Money*	***Mission 3:*** *Plan our Investments Efficiently*	***Mission 4:*** *System Working*
DELIVER NOW [0-9 months]	Reimbursement of COVID Costs Management of Staff Costs Deliver I&E and Capital Targets	Deliver CIP Benchmarking of Services Commercial Plan Product Standardisation	Business Cases for Quality and Operational improvements Plan to recover Backlog Equipment and Maintenance	Review Portfolio of Services
WORK TO IMPROVE [12-18 months]	Deliver I&E and Capital Targets Long-Term Financial Plan to deliver future sustainability	Model Hospital, GIRFT Virtual outpatients Deliver CIP	Plan to implement an EPR	ICS Financial Plan Shared Provision Shared Control Totals
PLAN TO TRANSFORM [18-months+]	Deliver I&E and Capital Targets	Review Back Office Functions Deliver CIP		

Appendix 4

Improvement Plan Governance Structure

NHS Medway NHS Foundation Trust



Best of people

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 06 August 2020

Title of Report	**Finance report**	**Agenda Item**	6.1
Report Author	Richard Eley, Director of Finance Paul Kimber, Deputy Director of Finance		
Lead Director	Richard Eley, Director of Finance		
Executive Summary	The Trust reports a deficit of £11k in month and £33k year to date, which adjusts to breakeven against the NHSE/I control total.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 23 July 2020		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance report and its appendices therein		

Finance report

For the period ending 30 June 2020

Contents

Appendices

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month (NHSE/I)	-	-	-	The Trust reports an £11k deficit position for June; after adjusting for donated asset depreciation the Trust reports breakeven in line with the NHSE/I control total. Summary:
YTD (NHSE/I)	-	-	-	
In-month (budget)	7,904	(11)	(7,915)	
YTD (budget)	(2,679)	(33)	2,646	
Forecast	-	-	-	

	£'m
Covid spend	**1.8**
Base underspend	**(0.3)**
True-up income accrued	**(1.6)**
Other adjustments	**0.1**
Reported against control total	**-**

CIP				
In-month	210	210	-	Schemes delivered to date relate to the full year effect of 19/20 schemes as well as procurement savings from nationally agreed prices and reduced external consultancy spend. The CIP forecast is currently as per budget although there is a £2.6m gap between this and plans at this time. Over achievement against plan is due to timing differences of schemes delivered.
YTD	630	1,152	522	
Forecast	12,000	12,000	-	
Capital				
In-month	(1,671)	(1,894)	(223)	Capital expenditure is currently behind plan YTD, although that gap has reduced in month. Contractor workforce restrictions in relation to the pandemic have impacted on building projects. As those staff return to work, these projects are expected to catch up and deliver on plan by year end.
YTD	(5,013)	(4,226)	787	
Forecast	(20,048)	(20,048)	-	
Cash				
Month end	24,022	43,517	19,495	Cash balances held at 30 June were £19.5m in excess of the plan. This is due to temporary COVID related changes to contract payment profiles. Additional contracts have been received one month in advance and monthly top up funding received in replacement of quarterly FRF and MRET payments.

Activity is significantly 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 £40.4m, this being £20.9m adverse to the draft budget or 34% of the income target. (£7.1m adverse in-month or 33% of the income target). This reflects the impact that Covid has had on the performance of "routine" activity.
Pay costs are higher than expected	Pay costs have reduced by £0.7m in month but remain overspent as the impact of incremental Covid costs continue.

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

£'000	In-month			Year-to-date		
	Baseline	Actual	Var.	Baseline	Actual	Var.
Clinical income	20,380	20,697	318	61,139	61,458	320
High cost drugs	1,876	1,426	(449)	5,627	4,878	(748)
Other income	1,982	1,503	(479)	5,946	4,686	(1,260)
Top-up income	4,417	4,417	-	13,251	13,253	2
True-up income	-	1,593	1,593	-	5,297	5,297
Total income	**28,654**	**29,637**	**983**	**85,962**	**89,573**	**3,611**
Nursing	(5,927)	(7,507)	(1,580)	(17,781)	(23,010)	(5,228)
Medical	(5,640)	(5,839)	(199)	(16,920)	(18,236)	(1,316)
Other	(6,649)	(5,314)	1,335	(19,946)	(15,462)	4,484
Total pay	**(18,216)**	**(18,660)**	**(444)**	**(54,647)**	**(56,707)**	**(2,060)**
Clinical supplies	(3,774)	(3,668)	106	(11,323)	(10,508)	815
Drugs	(701)	(706)	(5)	(2,103)	(1,889)	214
High cost drugs	(1,925)	(1,437)	489	(5,776)	(4,882)	894
Other	(2,701)	(3,695)	(995)	(8,102)	(11,488)	(3,386)
Total non-pay	**(9,101)**	**(9,506)**	**(405)**	**(27,304)**	**(28,767)**	**(1,464)**
EBITDA	**1,337**	**1,471**	**134**	**4,011**	**4,098**	**87**
Depreciation	(834)	(912)	(77)	(2,503)	(2,487)	16
Net finance income/(cost)	39	(29)	(69)	117	(19)	(136)
PDC dividend	(542)	(541)	1	(1,626)	(1,626)	0
Non-operating exp.	**(1,337)**	**(1,482)**	**(145)**	**(4,011)**	**(4,131)**	**(120)**
Reported surplus/(deficit)	**-**	**(11)**	**(11)**	**-**	**(33)**	**(32)**
Adj. to control total	-	11	11	-	33	32
Control total	**-**	**-**	**-**	**-**	**-**	**-**

Key messages:

1. NHSE/I baseline budgets are calculated centrally and are based on average financial performance for defined periods during 2019/20, uplifted for inflation or known pressures where applicable.
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 true-up income are reported under "FRF/MRET" income in the table on the following page.
4. Total expenditure includes the incremental cost of Covid-19, being £1.8m in-month; £0.8m of this is reported in non-pay and £1.0m in pay (£2.7m and £3.2m YTD respectively). Feedback from other providers within the STP suggests that pay expenditure is in the upper quartile whereas non pay is not extraordinary.
5. Further details of incremental Covid-19 costs are included in Appendix 11.

2. Income and expenditure (reporting against draft budget)

£'000	In-month			Year-to-date		
	Budget	Actual	Var.	Budget	Actual	Var.
Clinical income	21,194	20,697	(497)	61,300	61,458	158
High cost drugs	2,025	1,426	(599)	5,854	4,878	(975)
Other income	2,090	1,503	(587)	6,272	4,686	(1,586)
FRF/MRET	12,607	6,010	(6,597)	14,145	18,550	4,405
Total income	**37,916**	**29,637**	**(8,279)**	**87,571**	**89,573**	**2,002**
Nursing	(7,229)	(7,507)	(278)	(21,905)	(23,010)	(1,105)
Medical	(5,557)	(5,839)	(282)	(16,736)	(18,236)	(1,500)
Other	(5,045)	(5,314)	(269)	(15,769)	(15,462)	307
Total pay	**(17,831)**	**(18,660)**	**(829)**	**(54,410)**	**(56,707)**	**(2,297)**
Clinical supplies	(3,101)	(3,668)	(567)	(9,038)	(10,508)	(1,470)
Drugs	(2,675)	(706)	1,969	(7,736)	(1,889)	5,847
High cost drugs	(1,991)	(1,437)	554	(5,757)	(4,882)	875
Other	(2,873)	(3,695)	(822)	(8,686)	(11,488)	(2,802)
Total non-pay	**(10,640)**	**(9,506)**	**1,134**	**(31,218)**	**(28,767)**	**2,450**
EBITDA	**9,445**	**1,471**	**(7,974)**	**1,944**	**4,098**	**2,155**
Depreciation	(958)	(912)	46	(2,874)	(2,487)	387
Net finance income/(cost)	(41)	(29)	12	(123)	(19)	104
PDC dividend	(542)	(541)	1	(1,626)	(1,626)	-
Non-operating exp.	**(1,541)**	**(1,482)**	**59**	**(4,623)**	**(4,131)**	**491**
Reported surplus/(deficit)	**7,904**	**(11)**	**(7,915)**	**(2,679)**	**(33)**	**2,646**

Key messages:

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

2. Total income YTD is higher than the draft budget primarily as a result of the NHSE/I requirement to breakeven each month from April to July.

3. If income had been earned on a cost and volume basis (based on consultation tariff) the Trust would have reported clinical income of £40.4m, or £20.9m adverse to plan YTD (£7.1m adverse in-month). This reflects the impact that Covid has had on the performance of "routine" activity.

4. Non-pay expenditure includes incremental costs of c£0.8m in respect of Covid (£2.7m YTD).

5. The incremental cost of Covid-19 on pay costs was £1.0m in June (£3.2m YTD.

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

£'000	Year to date								
	Income			Expenditure			Contribution		
	B.line	Actual	Var.	B.line	Actual	Var.	B.line	Actual	Var.
UIC									
Diagnostics & Clinical Support	4,734	4,076	(658)	(12,792)	(12,181)	612	(8,058)	(8,105)	(46)
Specialist Medicine	889	446	(443)	(6,782)	(5,687)	1,095	(5,893)	(5,242)	652
Therapies & Older Persons	9	16	6	(4,389)	(4,328)	61	(4,379)	(4,312)	67
Unplanned & Integrated Care	336	98	(238)	(3,444)	(3,163)	281	(3,108)	(3,065)	43
Urgent & Emergency Care	223	84	(139)	(6,686)	(6,298)	388	(6,463)	(6,214)	249
Sub-total	**6,191**	**4,720**	**(1,471)**	**(34,093)**	**(31,657)**	**2,436**	**(27,902)**	**(26,937)**	**964**
Planned care									
Cancer Services	1,059	1,196	137	(2,511)	(2,615)	(104)	(1,452)	(1,419)	33
Critical Care & Perioperative	489	-	(489)	(9,470)	(504)	8,966	(8,981)	(504)	8,477
Planned Care Infrastructure	169	214	45	(9,280)	(7,901)	1,379	(9,111)	(7,687)	1,424
Surgical Services	-	140	140	(630)	(8,528)	(7,898)	(630)	(8,388)	(7,758)
Women & Children	204	161	(44)	(9,090)	(9,378)	(288)	(8,886)	(9,217)	(332)
Sub-total	**1,921**	**1,711**	**(210)**	**(30,981)**	**(28,926)**	**2,055**	**(29,059)**	**(27,215)**	**1,845**
Corporate									
Communications	-	-	-	(113)	(123)	(10)	(113)	(123)	(10)
Exec & Board	-	-	-	(812)	(787)	25	(812)	(787)	25
Finance	13	-	(13)	(862)	(684)	178	(849)	(684)	166
Governance & Legal	-	-	-	(277)	(272)	4	(277)	(272)	4
Health Informatics	-	24	24	(934)	(1,071)	(137)	(934)	(1,047)	(113)
HR & OD	397	333	(64)	(1,165)	(1,031)	134	(768)	(698)	70
Medical Director	2,392	2,419	27	(1,355)	(1,298)	57	1,037	1,121	84
Nursing	-	5	5	(946)	(981)	(35)	(946)	(976)	(30)
PMO	-	-	-	(125)	(285)	(161)	(125)	(285)	(161)
Strategy and Partnerships	-	-	-	-	(470)	(470)	-	(470)	(470)
Sub-total	**2,802**	**2,780**	**(21)**	**(6,587)**	**(7,001)**	**(414)**	**(3,786)**	**(4,221)**	**(435)**
E&F									
E&F	**1,320**	**657**	**(663)**	**(5,769)**	**(5,903)**	**(134)**	**(4,449)**	**(5,246)**	**(797)**
Central									
Central	**73,728**	**79,705**	**5,977**	**(8,532)**	**(16,120)**	**(7,588)**	**65,196**	**63,585**	**(1,611)**
TOTAL	**85,962**	**89,573**	**3,611**	**(85,962)**	**(89,606)**	**(3,644)**	**-**	**(33)**	**(33)**
Donated Asset Adjustment	**-**	**-**	**-**	**-**	**33**	**33**	**-**	**33**	**33**
Control total	**85,962**	**89,573**	**3,611**	**(85,962)**	**(89,573)**	**(3,611)**	**-**	**-**	**-**

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

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

Annual plan				Year to date								
				Income			Expenditure			Contribution		
Income	Exp.	Contr.	£'000	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Actual	Var.
			UIC									
37,001	(53,301)	(16,300)	Diagnostics & Clinical Support	9,084	4,076	(5,008)	(13,247)	(12,181)	1,067	(4,163)	(8,105)	(3,942)
30,542	(26,586)	3,956	Specialist Medicine	7,485	446	(7,040)	(6,632)	(5,687)	945	854	(5,242)	(6,095)
9,505	(17,245)	(7,740)	Therapies & Older Persons	2,329	16	(2,313)	(4,311)	(4,328)	(17)	(1,983)	(4,312)	(2,330)
1,237	(11,025)	(9,789)	Unplanned & Integrated Care	303	98	(205)	(2,756)	(3,163)	(407)	(2,453)	(3,065)	(612)
57,144	(25,956)	31,187	Urgent & Emergency Care	14,001	84	(13,917)	(6,464)	(6,298)	166	7,537	(6,214)	(13,751)
135,428	**(134,113)**	**1,315**	**Sub-total**	**33,203**	**4,720**	**(28,483)**	**(33,411)**	**(31,657)**	**1,753**	**(208)**	**(26,937)**	**(26,729)**
			Planned care									
8,884	(10,357)	(1,473)	Cancer Services	2,177	1,196	(980)	(2,559)	(2,615)	(56)	(382)	(1,419)	(1,037)
1,800	1,392	3,192	Critical Care & Perioperative	450	-	(450)	(484)	(504)	(19)	(34)	(504)	(469)
65,145	(36,274)	28,871	Planned Care Infrastructure	15,962	214	(15,748)	(9,025)	(7,901)	1,124	6,936	(7,687)	(14,623)
12,791	(37,718)	(24,927)	Surgical Services	3,136	140	(2,996)	(9,380)	(8,528)	852	(6,244)	(8,388)	(2,143)
61,181	(38,046)	23,135	Women & Children	14,994	161	(14,834)	(9,485)	(9,378)	107	5,509	(9,217)	(14,727)
149,801	**(121,003)**	**28,798**	**Sub-total**	**36,719**	**1,711**	**(35,008)**	**(30,934)**	**(28,926)**	**2,008**	**5,785**	**(27,215)**	**(32,999)**
			Corporate									
-	(439)	(439)	Communications	-	-	-	(119)	(123)	(3)	(119)	(123)	(3)
-	(2,693)	(2,693)	Exec & Board	-	-	-	(673)	(787)	(114)	(673)	(787)	(114)
-	(2,805)	(2,805)	Finance	-	-	-	(701)	(684)	17	(701)	(684)	17
-	(1,044)	(1,044)	Governance & Legal	-	-	-	(261)	(272)	(11)	(261)	(272)	(11)
-	(3,989)	(3,989)	Health Informatics	-	24	24	(997)	(1,071)	(73)	(997)	(1,047)	(50)
1,452	(4,454)	(3,002)	HR & OD	363	333	(30)	(1,113)	(1,031)	82	(750)	(698)	52
9,930	(5,719)	4,210	Medical Director	2,482	2,419	(64)	(1,478)	(1,298)	180	1,004	1,121	117
82	(3,897)	(3,815)	Nursing	23	5	(18)	(976)	(981)	(4)	(954)	(976)	(22)
-	(832)	(832)	PMO	-	-	-	(288)	(285)	3	(288)	(285)	3
-	(1,892)	(1,892)	Strategy and Partnerships	-	-	-	(473)	(470)	3	(473)	(470)	3
11,463	**(27,763)**	**(16,300)**	**Sub-total**	**2,868**	**2,780**	**(88)**	**(7,081)**	**(7,001)**	**80**	**(4,212)**	**(4,221)**	**(8)**
			E&F									
5,359	**(24,552)**	**(19,192)**	**E&F**	**1,332**	**657**	**(675)**	**(6,169)**	**(5,903)**	**265**	**(4,836)**	**(5,246)**	**(410)**
			Central									
54,457	**(49,077)**	**5,380**	**Central**	**13,449**	**79,705**	**66,258**	**(12,656)**	**(16,120)**	**(3,464)**	**793**	**63,585**	**62,794**
356,508	**(356,508)**	**-**	**TOTAL**	**87,571**	**89,573**	**1,998**	**(90,250)**	**(89,606)**	**648**	**(2,679)**	**(33)**	**2,646**

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

3. Forecast

Further discussions have taken place within the ICS, however no detailed forecast has been prepared at this time, principally because:

- The planning guidance has not been received upon which to budget for the period August 2020 to March 2021;
- The period to 31 July 2020 will be funded by way of true-up income to allow the Trust to achieve a control total of breakeven;
- The Trust continues to face uncertainty in respect of when and how the Trust returns to “normal business”. Progress has been achieved in modelling the services although until this is completed the impact on the financial plans has not been possible.

The Trust remains committed to delivering a full year control total of breakeven and will work with its commissioners, partners and regulators through developments over the coming days, weeks and months.

4. CIP (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Mitigated target	Gap	Budget	Gap
Planned care	368	2,225	-	420	3,013	**5,100**	(2,087)	**4,682**	(1,669)
UIC	518	3,002	509	933	4,962	**5,505**	(543)	**4,253**	709
E&F	-	801	-	-	801	**800**	1	**661**	140
Corporate	363	-	-	-	363	**1,709**	(1,346)	**1,113**	(750)
Procurement	1,291	-	-	-	1,291	**1,291**	-	**1,291**	0
Total	**2,540**	**6,028**	**509**	**1,353**	**10,430**	**14,405**	**(3,975)**	**12,000**	**(1,570)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**210**	**732**	**522**	**630**	**1,152**	**522**	**12,000**	**12,000**	**-**

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 w orks 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 t he Director of Improvement monitor and work with budget-holders to achieve targets.

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

The CIP programme is updated on a daily basis, at the end of June £8.6m of savings have been BRAG rated as blue or green, this is an increase of £1.3m from the end of May. A further £1.9m of schemes is assessed as amber or red; the remaining £1.6m gap to achieve the NHSE/I plan are schemes in progress or yet to be identified.

CIP schemes are being developed through CIP panels and the QIA assessment process; however due to the change in activities and responding to Covid, some efficiency programmes have encountered delays and the plan is regularly updated.

The PMO team continue to work with Divisions and the Finance Business Partners to identify and quantify CIP schemes whilst working towards a stretch target of £14.4 million (this being 20% higher than the required CIP to mitigate the risk of individual scheme failure). Delivery to date is £1.2m and favourable to plan by £0.5m; this over achievement has mainly been achieved through the full year effect of 19/20 schemes for agency rate reductions, legal tendering and ILM income £0.1m as well as procurement measures exceeding the original plan £0.4m. This is expected to be a timing difference only.

Further detail of CIP schemes by Division is presented in Appendix 6.

5. Balance sheet summary

Prior year end	£'000	Month end plan	Month end actual	Var.
204,790	**Non-current assets**	**216,604**	**206,525**	**(10,079)**
6,306	Inventory	7,400	5,899	(1,501)
36,687	Trade and other receivables	31,391	27,566	(3,825)
12,385	Cash	24,022	43,517	19,495
55,378	**Current assets**	**62,813**	**76,982**	**14,170**
(24,478)	Trade and other payables	(38,371)	(22,969)	15,402
(292,111)	Borrowings	(1,657)	(292,042)	(290,385)
(4,519)	Other liabilities	(22,624)	(29,468)	(6,844)
(321,108)	**Current liabilities**	**(62,652)**	**(347,945)**	**(281,827)**
(2,278)	Borrowings	(23,273)	(2,278)	20,995
(1,317)	Other liabilities	(900)	(1,317)	(417)
(3,595)	**Non-current liabilities**	**(24,173)**	**(3,595)**	**20,578**
(64,534)	**Net assets employed**	**192,592**	**(64,567)**	**(257,159)**
140,581	Public dividend capital	410,790	140,580	(270,209)
41,366	Revaluation reserve	47,336	41,366	(5,970)
(246,481)	Retained earnings	(273,438)	(246,502)	19,020
(64,534)	**Total taxpayers' equity**	**192,592**	**(64,567)**	**(257,159)**

Key messages:

1. Cash and other liabilities are impacted by the revised commissioning arrangements; block income and top-up income (replacing FRF and MRET) for both April and May was paid to the Trust in April and continues to be paid monthly in advance.
   The plan only expected advance payments from North Kent and quarterly payments of FRF. This has resulted in a significantly higher cash balance and levels of deferred income.
   The advance payments are not expected to unwind until March so these balances are expected to remain high for the remainder of the year.

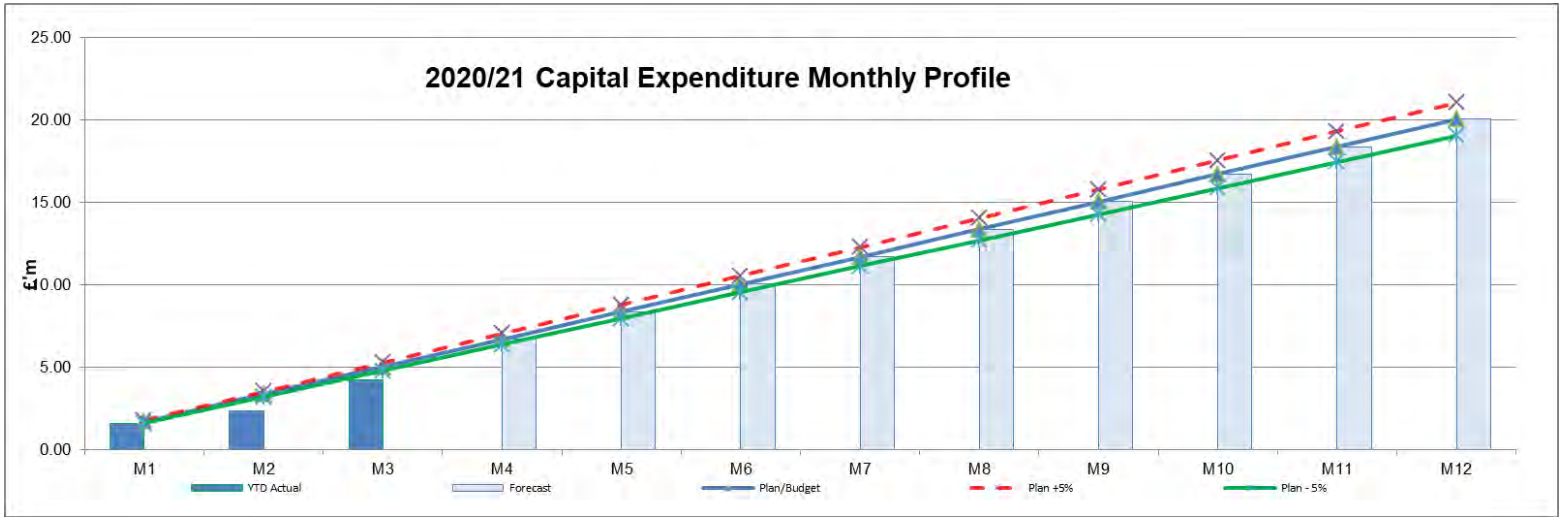
2. Where invoices are matched and approved, the Trust continues to pay suppliers on immediate terms and will do so whilst cash balances remain high.

3. Following the guidance released at year end, the interim loans have been reclassified as due within one year; new PDC will be issued and the debt written off. The effective date of the transaction will be 30 September 2020 (assumed to be 1 April 2020 in draft plan). The value of loans originally thought to be eligible for this transaction was notably lower in our budget assumptions than we have now been informed.

6. Capital

£'000	In-month			Year To Date			Annual			Funding	
	Budget	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC
Backlog Maintenance	290	1,136	(846)	870	1,601	(731)	3,473	3,473	-	3,473	-
Routine Maintenance	27	537	(510)	81	636	(555)	326	326	-	326	-
Fire Safety	416	(69)	485	1,248	606	642	4,991	4,991	-	-	4,991
IT	228	8	220	684	96	588	2,730	2,730	-	2,730	-
ED	320	25	295	960	(144)	1,104	3,835	3,835	-	835	3,000
Plant & Equipment	390	257	133	1,170	1,432	(262)	4,693	4,693	-	3,589	1,104
COVID	-	-	-	-	-	-	-	-	-	-	-
Total	**1,671**	**1,894**	**(223)**	**5,013**	**4,226**	**787**	**20,048**	**20,048**	**-**	**10,953**	**9,095**

* ED credit relates to VAT refund



Capital expenditure to date is below plan. This is mainly due to delays in main projects being impacted by contractors working restrictions in relation to the pandemic and delayed STP plan allocations. The Trust is expecting to recover this variance by the end of the financial year.

As noted in a previous budget update to the Finance Committee, new financing requirements are typically expected to be funded through the issue of Public Dividend Capital rather than from loans or cash reserves.

7. Cash

13 Week Forecast w/e

£m	Actual 05/06/20	12/06/20	19/06/20	26/06/20	03/07/20	Forecast 10/07/20	17/07/20	24/07/20	31/07/20	07/08/20	14/08/20	21/08/20	28/08/20	04/09/20	11/09/20	18/09/20	25/09/20	02/10/20
BANK BALANCE B/FWD	47.48	46.18	42.18	63.87	52.94	43.82	42.90	69.04	57.89	47.02	44.22	69.44	65.12	53.18	42.52	40.04	59.68	46.22
Receipts																		
NHS Contract Income	0.26	0.19	25.34	1.35	0.79	0.12	31.16	0.00	0.00	0.00	29.17	0.00	0.00	0.00	0.00	27.57	0.00	0.00
Other	0.16	0.41	0.11	0.11	0.68	1.97	0.30	2.12	0.25	0.25	0.61	0.25	0.25	0.25	0.56	0.30	0.25	0.25
Total receipts	0.42	0.60	25.45	1.46	1.47	2.10	31.46	2.12	0.25	0.25	29.78	0.25	0.25	0.25	0.56	27.87	0.25	0.25
Payments																		
Pay Expenditure (excl. Agency)	(0.38)	(0.35)	(0.34)	(9.55)	(8.29)	(0.32)	(0.35)	(9.56)	(8.22)	(0.35)	(0.35)	(0.42)	(9.49)	(8.21)	(0.35)	(0.34)	(9.56)	(8.21)
Non Pay Expenditure	(1.34)	(4.25)	(3.43)	(2.83)	(0.41)	(2.72)	(4.97)	(3.71)	0.60	(2.70)	(4.20)	(4.15)	(2.70)	(1.16)	(2.70)	(4.20)	(4.15)	(1.16)
Capital Expenditure	0.00	0.00	0.00	0.00	(1.89)	0.00	0.00	0.00	(3.51)	0.00	0.00	0.00	0.00	(1.54)	0.00	0.00	0.00	(1.54)
Total payments	(1.72)	(4.60)	(3.76)	(12.38)	(10.59)	(3.05)	(5.32)	(13.27)	(11.13)	(3.05)	(4.55)	(4.57)	(12.19)	(10.91)	(3.05)	(4.55)	(13.71)	(10.91)
Net Receipts/ (Payments)	(1.30)	(4.00)	21.69	(10.92)	(9.12)	(0.95)	26.14	(11.15)	(10.88)	(2.80)	25.22	(4.32)	(11.94)	(10.66)	(2.49)	23.32	(13.46)	(10.66)
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	291.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(291.42)	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.25)	0.00	0.00
Total Funding	0.00	0.00	0.00	0.00	0.00	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.67)	0.00	0.00
BANK BALANCE C/FWD	46.18	42.18	63.87	52.94	43.82	42.90	69.04	57.89	47.02	44.22	69.44	65.12	53.18	42.52	40.04	59.68	46.22	35.57

Cash Flow, 12 months ahead

£m	Actual Apr-20	May-20	Jun-20	Forecast Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
BANK BALANCE B/FWD	12.37	37.58	47.48	43.46	47.02	45.38	38.53	42.18	38.51	31.91	31.65	30.22	1.84	36.01	36.17
Receipts															
NHS Contract Income	45.11	22.70	24.52	23.13	22.52	22.52	22.52	22.52	22.52	22.52	22.52	0.70	53.95	27.12	28.94
NHS Top Up	8.84	6.28	2.39	8.45	6.42	4.82	4.42	4.42	4.42	4.42	4.42	4.42	0.00	0.00	0.00
Other	4.66	1.56	1.53	5.30	1.64	1.69	4.38	1.64	1.64	4.33	1.64	1.74	4.23	1.46	1.30
Total receipts	58.61	30.54	28.44	36.88	30.58	29.03	31.32	28.58	28.58	31.27	28.58	6.86	58.18	28.58	30.24
Payments															
Pay Expenditure (excl. Agency)	(18.79)	(18.57)	(18.58)	(18.78)	(18.47)	(18.46)	(18.78)	(18.42)	(18.73)	(18.39)	(18.37)	(18.35)	(19.68)	(19.05)	(18.91)
Non Pay Expenditure	(13.03)	(8.73)	(11.99)	(11.06)	(12.21)	(12.21)	(14.91)	(12.21)	(14.91)	(12.21)	(10.71)	(12.71)	(13.36)	(8.37)	(12.70)
Capital Expenditure	(1.58)	(0.75)	(1.89)	(3.51)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(1.54)	(0.92)	(0.92)	(0.92)
Total payments	(33.40)	(28.05)	(32.46)	(33.35)	(32.22)	(32.21)	(35.23)	(32.17)	(35.18)	(32.14)	(30.62)	(32.60)	(33.96)	(28.34)	(32.53)
Net Receipts/ (Payments)	37.58	40.07	43.46	46.99	45.38	42.20	34.62	38.59	31.91	31.04	29.61	4.48	26.06	36.25	33.88
Funding Flows															
DOH - FRF/Revenue Support	0.00	5.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.95	0.00	0.00
PSF	0.00	2.31	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.03	0.00	291.00	7.56	0.00	0.00	0.61	0.61	0.62	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	(0.08)	0.00	0.00	0.00	(291.42)	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	(3.25)	0.00	0.00	0.00	0.00	0.00	(3.26)	0.00	0.00	0.00
Total Funding	0.00	7.41	0.00	0.03	0.00	(3.67)	7.56	(0.08)	0.00	0.61	0.61	(2.64)	9.95	(0.08)	0.00
BANK BALANCE C/FWD	37.58	47.48	43.46	47.02	45.38	38.53	42.18	38.51	31.91	31.65	30.22	1.84	36.01	36.17	33.88

Prior year end	£'000	Month end plan	Month end actual	Var.
12,385	Cash	24,022	43,517	19,495

Cash balances held are in excess of the plan due to £4m of additional commissioning advances and £12.6m of block top up payments in advance of FRF/MRET payments expected. Opening cash was also higher than originally planned; this plan was due to be refreshed to reflect outturn numbers in April which would have closed the gap by £7.3m.

Whilst cash balances remain high the trust continues to pay all suppliers on invoice approval instead of contractual payment terms. Unfortunately there are many delays in invoice approval as detailed in the payables preventing benefit maximisation of the cash position and payment discounts that often come with early payment.

8. Risks

Title	Description	£'000	Mitigation(s)	Lead(s)
Loss of stroke service	The Trust has agreed to transfer its stroke activity to other providers given the local issues. Current indications are that this could leave a contribution gap of up to £1.8m (FYE).	£1,325	Work with the STP is underway to validate the budgeted and actual income, expenditure and activity of the service.	Richard Eley
CIP (planning)	There remains a gap between RAG rated CIP programmes and the draft budget requirement of £12m.	£1,570	CIP meetings continue to be held by the Director of Improvement. Oversight moved from Transformation to Finance. Return of CIP governance following pause during Covid pandemic.	Richard Eley, Mark Hackett
Staff costs	Staff costs continued to rise despite the significant reduction in activity during April, May and June. Unchecked, this could drive a need for additional CIP and/or additional true-up income from NHSE/I and/or the Trust missing its control total.	-	Deep dive paper submitted to the July Finance Committee meeting.	Divisional Directors
Safer staffing	The Trust has approved the safer staffing proposals, which considered the acuity, bed occupancy and activity during the pre-Covid period. Further review will be required on finalisation of the ward reconfigurations.	£900	As Model Hospital suggests an expensive nursing cost per WAU compared to peers and nationally, nursing colleagues are asked to explore staffing levels in areas not covered through the safer staffing exercise.	Richard Eley, Jane Murkin
Ward reconfiguration	As part of the restart planning wards will need to change at pace. The changing nature, specialty and bed bases could impact cost and efficiency.	TBC	Restart modelling is underway.	Richard Eley, Angela Gallagher, Mark Hackett
Microsoft licensing	The Trust was part of a government licensing arrangement for MS products. Licensing arrangements have subsequently changed and were originally intended to be addressed as part of ITaaS.	£300	STP is seeking a collaborative and united approach for all providers.	Michael Beckett
Covid capital	Monies in respect of Covid capital claims are still unapproved from NHSE/I. This is a national position.	c.£1,500	If not funded by NHSE/I this will need to be drawn from the Trust's capital allocation.	Richard Eley, Gary Lupton

9. Conclusions

The Finance Committee is asked to note the report and financial performance which is £11k deficit in-month and £33k deficit year to date, reducing to breakeven after removing the adjustment for donated asset depreciation. This financial performance is as per the NHSE/I control total. The position has been achieved through £1.6m of true-up funding being accrued after incurring £1.8m of incremental expenditure related to Covid.

Richard Eley
Director of Finance
July 2020

Meeting of the Board of Directors in Public

Thursday, 06 August 2020

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**6.2**
Committee Chair:	Jo Palmer		
Date of Meeting:	Thursday 23 July 2020		
Lead Director:	Richard Eley, Director of Finance		
Report Author:	Paul Kimber, Deputy Director of Finance		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks The BAF was discussed and the current risk scores, mitigations and controls were accepted.	**Amber/Green**
2. Risk register The risk register was noted. The Director of Finance confirmed that further progress had been made in closing the gap to plan.	**Amber/Green**
3. Finance report The Director of Finance took the committee through the report, noting key	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
highlights as being: • The Trust is meeting its control total as set by NHSE/I; within this year to date performance the Trust has incurred c£5.8m of incremental Covid expenditure and accrued £5.2m of true-up income. • The Trust is close to the south region median in terms of proportion of Covid expenditure being incurred; this is a little higher than median for pay and lower than median for non-pay. • Identified CIP has improved to £11m, leaving a gap of £1m to budget for the year. • Capital expenditure is behind plan but has an agreed programme which is expected to catch up. There has been a national release of additional capital monies for backlog maintenance and the Trust has been allocated a further £4m, of which 30% is being held for STP wide schemes. • Cash is notably higher than planned due to receipts in advance under current contracting arrangements. • Activity is approximately one third below planned levels; if the Trust were not on national contracting for Covid the cost and volume income would be £20.9m adverse to plan. • There has been a small improvement in the total debt outstanding; the STP finance teams are seeking to resolve all open issues on this over the course of the next 6-8 weeks. • The transfer of the stroke service has been flagged as a new financial risk in year – further work is being undertaken with the STP to provide assurance over the impact. • Reimbursement of Covid capital remains a risk; a meeting with NHSE/I has been held and the Trust's capital programme has made an allowance in the expectation that the applications may not be fully funded. The Committee noted that the CIP budget of £12m effectively allows the Trust to maintain its underlying financial position rather than reduce that deficit. Our response to Covid has meant that progress to fully identify a programme for 2020/21 has been impeded but that progress was now being made. Feedback was provided that some care groups who are currently underspending against their budgets are seeking to use those monies in the remainder of the financial year. It was confirmed that this is not appropriate under the current arrangements as nationally we are being managed on a month-by-month basis. The Trust's referral to treatment ("RTT") times have grown during Covid; work will be undertaken to determine the extent to which it can recover this position given operational arrangements and funding available post-Covid.	

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
4. Pay review The highlights from the paper were articulated by the Director of Finance. This noted that the growth in pay spend has been driven by deployment of additional staff rather than an increase in the rates of staff pay. In a number of cases this staffing growth has been directly as a result of Trust approved investments. The recommendations in the report were **APPROVED** subject to a final review meeting between the Director of Finance and the Interim Chief Operating Officer. These recommendations will be added to the Finance Committee action log and into other committees (such as the People Committee) as applicable.	**Amber/Red**
5. Pharmacy inventory review The Committee was joined by the Chief Pharmacist who narrated the key matters from the report. This informed members of the additional controls employed in managing pharmacy inventory and the movements that have been experienced, e.g. through Brexit preparation and Covid.	**Green**
6. Budget setting update / "Restart" The Director of Finance took the committee through the paper. This highlighted that we are awaiting formal written guidance on the contracting mechanisms that will be put in place for the remainder of the financial year, although a national webinar has set out the broad expectations.	**Green**
7. Model Hospital The report was presented by the Director of Transformation which noted that the Model Hospital opportunity for the Trust is c£14.0m-£28.3m. The committee **APPROVED** the proposed schedule for clinical and service teams to present back their plans to realise opportunities.	**Green**
Decisions made The committee **APPROVED** the recommendations made in the pay review paper, subject to final review by the Director of Finance and the Interim Chief Operating Officer. The committee **APPROVED** the proposed schedule for clinical and service teams to present back their plans to realise the Model Hospital opportunities.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee There are no matters to escalate.	

Meeting of the Board of Directors in Public

Thursday, 06 August 2020

Assurance Report from Committee

Title of Committee:	**People Committee**	**Agenda Item**	**7.1**
Committee Chair:	Sue Mackenzie		
Date of Meeting:	21 July 2020		
Lead Director:	Leon Hinton, Executive Director of Human Resources and Organisational Development		
Report Author:	Leon Hinton, Executive Director of Human Resources and Organisational Development		

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Terms of Reference (ToR) and Committee Work Plan The committee has agreed its terms of reference and the work programme continues to develop. All NEDs can attend the meeting.	**White**
2. IQPR – People Key highlights were noted as follows: • Sickness had increased by +0.2%, which is the same increase as COVID-related sickness reason increase – all sickness cases were actively being managed; • Voluntary turnover was above the target; Appraisal rates show common cause variation and is exceeding target; • StatMan: Good rates of compliance; some areas affected by disruption to face-to-face training provision	**Amber/Red**
3. Resourcing and Temporary Staffing Noted key highlights as follows: • The percentage of pay bill spent on substantive staff in June returned to pre-Covid at 86% along with associated decrease to bank usage at 11%; • Net increases noted for numbers of registered nursing, clinical support workers, consultants, physiotherapists, radiographers, pharmacists – in line with recruitment plan; • No net decreases noted for other clinical staff;	**Green**

• Trust's total agency spend, at 2.33% of pay bill year to date, which remains in the NHS England and Improvement's (NHSEI) 'green' target of under 5.5%; • OSCE (objective, structured clinical examination) centres had reopened nationally which will enable the Trust to move forward with NMC registrations for overseas nurses. The Committee **AGREED** for the report to move to a dashboard report with a focus on the top five specialties.	
4. Trust Improvement Plan – Our People Programme It was noted that the programme's outcomes and KPIs continued to be developed. A brief description of the scope for a Trust-wide organisational development programme was described by the Director of HR& OD and the Improvement Director and that a draft bid was written but was not yet signed off by all parties.	**Amber/Green**
5. BAF – People The BAF was discussed and the current risks, mitigations and controls were accepted; actions required to be updated in line with the People Improvement Programme.	**Green**
6. CQC Well Led The interim Company Secretary provided a brief overview of the proposed five Board Development sessions to support Well Led. The Chief Executive provided a brief overview of the Executive development session in liaison with the NHSEI Improvement Director to support Well Led. The Committee was updated with the sources of CQC feedback, through staff engagement sessions and the draft Improvement Plan feedback mechanisms.	**Amber/Green**
7. Employee Relations Report The Committee noted the activity of Employee Relations over the last 12-months, including: • Total ER activity in May was down by 8% compared to April, largely due to a reduction in short-term sickness cases. Furthermore the Committee was informed that: • Covid sickness cases are not managed through sickness policy following a national directive – and do not count for the purpose of triggers nor pay. • 11% of the entire workforce is currently working with a form of ER casework; • All long -term sickness cases are being managed by line managers with seven cases of 6-12 months absence. It was **AGREED** that the employee relations information will be triangulated with claims data for future reports by specialty.	**Green**
8. Staff Survey 2019 Analysis The committee noted an overall improved picture from the 2018 survey	**Amber/Green**

and the range of improvement actions underway across the hospital.	
9. Staff Networks on WRES The Committee noted the progress of the building of the BAME staff network over the last three years, with particular progress made since April into a functioning staff network, lessons learned in order to translate into the other staff networks (disability, LGBT and armed forces). Actions arising, in particular in relation to the Workforce Race Equality Scheme (WRES) will be escalated through to the People Committee along with approval of the relevant equality scheme action plan.	**Amber/Green**
10. Staff Health and Wellbeing (#How are you?) The Committee, noted key highlights as being: • Decompression room in place; • Wellbeing meetings in place; • Trauma, Risk, Injury Management (TRiM) in commissioning phase with CCG as a sector response; • Care of sick absent staff, policy approved and enacted; • Risk assessments being carried out for all staff in addition to 'at risk' and BAME staff; • Staff swabbing service continues (MFT 1,182 undertaken, 178 positive; Community 1,024 undertaken, 148 positive); Covid antibody testing underway (66% complete).	**Amber/Green**
Decisions made: none to report	
Further Risks Identified: none to report	
Escalations to the Board or other Committee: none	