Agenda

Trust Board Meeting in Public

Date: Wednesday, 12 January 2022 at 12:30 – 16:00

Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Chief Executive's Update	Chief Executive	3	12:35	Note
1.5	Presentation: Population Health Management	Rachel Jones, Kent & Medway CCG	Presenta-tion	12:45	Note
1.6	Clinical Presentation: Cancer Services	Jeremy Davies	Presenta-tion	13:15	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of previous meeting: 04.11.21	Chair	7	13:45	Approve
2.2	Matters arising and Action Log: 04.11.21	Chair	15		Discuss
3.	**High Quality Care**				
3.1	Integrated Quality Performance Report	COO, CNQO, CMO	17	13:50	Note
3.2	Quality Assurance Committee Assurance Report - Meeting: 21.12.21	Chair of Committee/ Chief Nursing and Quality Officer (Interim)	49	14:10	Assure
3.3	Update on role of Patient Safety Specialist	Chief Medical Officer	Presenta-tion	14:15	Note
3.4	Safeguarding Adults and Children Annual Report	Chief Nursing and Quality Officer (Interim)	53	14:25	Note
4.	**Strategy and Resilience**				
4.1	Board Assurance Framework	Deputy Chief Executive	93	14:45	Note
4.2	Mortuary Security Self-assessment	Chief Operating Officer	111	15:00	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 8	Chief Finance Officer	115	15:10	Note
5.2	Finance Committee Assurance Report. Meeting: 16.12.21	Chair of Committee/ Chief Finance Officer	127	15:20	Assure
6.	**Any Other Business**				
6.1	Council of Governors Update	Lead Governor	Verbal	15:40	Note
6.2	Questions from the Public	Chair	Verbal		Note
6.3	Any Other Business	Chair	Verbal		Note
6.4	Date and time of next meeting: 10 February 2022, 12:30 – 15:30				

NHS
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Chief Executive's Report – January 2022

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

COVID-19

The significant rise in the number of Covid-19 cases in the community has led to an increase in the number of patients that we are treating in the hospital with Covid; I would like to thank our staff who have worked so hard over the Christmas and New Year period to care for these patients safely.

Vaccination remains our best defence against the highly transmissible Omicron variant, and I would urge members of our community who are eligible to have their Covid booster vaccination, to do so.

Due to the rise in Covid patients in the hospital we have introduced further visiting restrictions on some of our wards. We have taken this step to ensure the safety of our patients, staff, and the wider community. We know how important it is for our patients to see their loved ones, so this decision has not been taken lightly, but we hope that the public will understand the necessity of this change. It remains critical that visitors to our site adhere to the infection control procedures in place for the protection of our patients and staff.

Getting our patients home for Christmas

We know that home is often the best place for our patients to be, especially at Christmas time, so I would like to thank colleagues across the hospital who worked hard with system partners before Christmas to streamline discharge processes and expedite discharge for our patients who were medically fit. We were able to discharge 315 patients who were able to enjoy Christmas with their friends and family. This also provided an opportunity for us to free-up some beds ahead of the increase in COVID-19 patients over the Christmas and New Year period.

Christmas at Medway

I'd also like to take the opportunity to say a very special thank you to all colleagues who left their friends and families over Christmas to care for our patients. Not only did they provide excellent care during a challenging time, they also did all that they could to make Christmas as special for our patients as possible.

This year, with support from the Medway Hospital Charity and our good friends at Staxson Electrical services, we provided some festive mugs filled with treats for our adult inpatients. I hope that these brought some cheer to everyone who received one.

Patient First

We are very excited to be launching our Patient First initiative in early 2022; this is our new programme to build on the successes of the past, but bringing greater clarity, structure, and support so that we can make more significant improvements quicker.

Patient First will focus on fewer priorities –helping us to concentrate on projects that will make the biggest difference to our performance and therefore to the experience of our patients.

Medway Annual Staff Awards

In December, we were proud to recognise the achievements of teams and individuals who have gone the extra mile for colleagues and patients, at our annual staff awards. I would like to extend my congratulations to the winners and all nominees.

Vision and Values Award	Winner - Lowella Suba Nurse Co-ordinator for Frailty Flow Pathways, Elderly Care
Teamwork Award	Winner – Pharmacy Team

Highly commended - Iram Ahmed, Acting General Manager for Diagnostics and Clinical Support Services

Learning and Innovation Award	Winner – Simulation Team
Equality and Inclusion Award	Winner – Alexandra (Dianne) Sobers, Medical Records Manager
Employee of the Year Award	Winner – Amber Servante, Clinical Support Worker on Trafalgar Ward
Team of the Year Award	Winner – Dolphin Ward
Support and Compassion Award	Winner – Claire Harrison, Patient Advice and Liaison Service (PALS) Officer (awarded posthumously)

Highly commended – Pat Craddock, Ward Hostess

Goals and Performance Award	Winner – McCulloch Ward
Volunteer of the Year Award	Winner – Therapy dogs Yazzy, Poppy and Fred - awarded to their owners Volunteer Janice McCauley, bank Clinical Support Worker Charlotte Dawson and the Trust's Voluntary Services Manager Zoe Goodman

Once again, the Trust also teamed up with the Medway Messenger for the Hospital Hero Award. Patients and members of the public were asked to send in their nominations to thank staff for their dedication, hard work and compassion, with the winner chosen by the paper.

Samira McDonald, a bank staff member on Lister Ward, and Yvonne Morrison, Lead Specialist Bereavement Midwife, each received a special mention, but the overall winner was Alison Youdale, Advanced Neonatal Nurse Practitioner on the Oliver Fisher Special Care Baby Unit.

Instead of the winners attending an awards ceremony they were individually filmed receiving a trophy and a certificate as part of a special ceremony-style video for patients, staff and the public to watch.

You can watch the video at www.tinyurl.com/2p93u9zx

Communicating with colleagues and the community

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

Minutes of the Trust Board PUBLIC Meeting

Thursday, 04 November 2021 at 13:00 - 16:00

Meeting at The St Georges Centre, Chatham

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director (Via Teams)
	Alan Davies	Chief Finance Officer
	Annyes Laheurte	Non-Executive Director
	David Sulch	Chief Medical Officer
	Evonne Hunt	Chief Nursing and Quality Officer (Interim)
	Ewan Carmichael	Non-Executive Director
	George Findlay	Chief Executive
	Leon Hinton	Chief People Officer
	Gurjit Mahil	Deputy Chief Executive
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Jayne Black	Chief Operating Officer
	Jenny Chong	Associate Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director (Via Teams)
Attendees:	Adrian Parsons	Governor (Via Teams)
	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Brake	Lead Governor
	David Seabrooke	Company Secretary
	Janette Cansick	Director of Medical Education (Item 3.3)
	Katie May Nelson	Local Democracy Reporter (Left after Item 1.4)
	Sheila Adam	NHSE/I Improvement Director
	Zoe Van-Dyke	Governor
Apologies:	Mark Spragg	Deputy Chair/Senior Independent Director/NED

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

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

a) *Firstly, thank you for joining us for this Trust Board meeting; we have held several very successful virtual Board meetings during this pandemic but it is always nice to get back together in one room today. It is fitting to be at the St Georges Centre as we approach Remembrance Day, the Trust will be marking the occasion to commemorate service personnel and veterans.*

b) *It has been a challenging time for colleagues, as we move towards winter. Attendances are up and we are continuing to manage COVID patients within the hospital. I would like to thank them all for their hard work and continued commitment to patients. Never has it been more important to support and celebrate our colleagues than it is right now, so I am really pleased to be able to tell you about two developments that have happened in recent weeks.*

c) *Looking after the health and wellbeing of our colleagues is an important focus for the Trust and I am really pleased to say that the Medway Fitness Hub – the first of its kind in Kent and Medway – is now open. We were very proud to welcome Olympic rower Sara Parfett to cut the ribbon on the day! We have had more than 500 colleagues sign up to use the facility and feedback has been great. We knew our staff were very keen to have a gym, so it is wonderful that, with the help of our supporters, we have been able to provide this dedicated area for them.*

d) *Recognition from our patients and their loved ones means a great deal to our staff, so I am very happy to say that we are once again teaming up with the Medway Messenger for the Hospital Hero award. This award recognises those who have gone above and beyond for our patients.*

e) *Last month we were delighted to welcome Dr Katherine Henderson, President of the Royal College of Emergency Medicine to formally open our new ED Majors department. This was the final phase of the comprehensive re-build of the department. Since 2013 more than £25million has been invested in constructing the emergency care department environment that our community deserves. The new space was designed in conjunction with the ED team to the latest standards for an Emergency Department. It provides 19 patient cubicles that provide greater privacy and dignity for patients, while a more spacious environment and open layout of the area can be effectively monitored by clinical staff whilst also provided a safe space during the Covid pandemic.*

f) *Finally, I would just like to make a plea to our community to continue to support the Trust as we approach winter. That means only using our Emergency Department if you require emergency treatment, having your flu and COVID vaccination/booster, if you are eligible, and adhering to all infection control processes such as mask wearing, social distancing and handwashing, when on our site. Our colleagues really do appreciate your ongoing support.*

g) *David Sulch the Chief Medical Officer is retiring this month, this is his final meeting, it has been a pleasure to have him as part of the team he will be sadly missed and his calm and analytical approach is much appreciated, we hope that we still see him from time to time.*

1.2 Quorum

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

1.3 Conflicts of Interest

There were no conflicts of interest raised.

1.4 Chief Executive Update

George Findlay, Chief Executive gave an update to the Board providing an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. He echoed a number of points made by the Chair in relation to the handling of the Covid pandemic. The Board was asked to note the report and George gave the following key highlights:

1.4.1 COVID-19; The virus remains a very real threat to the health of our community, although I am pleased to say that, despite the high number of cases, we have seen a relatively low number of admissions. I would strongly advise members of our community who are eligible to have their Covid booster vaccination and their flu vaccination, to do so. There is evidence to suggest that we will experience large numbers of flu cases over the winter and the threat to health for someone who contracts both flu and Covid at the same time is considerable. I am pleased to say that we are well into the vaccination roll-out campaign in the hospital with large numbers of staff having both their Covid booster and flu vaccination. It remains critical that visitors to our site adhere to the infection control procedures in place for the protection of our patients and staff.

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

1.4.3 Marking Baby Loss Awareness Week; on a sadder not Last month, I had the pleasure of welcoming Kate Fenwick, the Deputy Lord-Lieutenant of Kent, to the Trust to visit Abigail's Place along with representatives from the Abigail's Footsteps charity. Abigail's Place is our maternity bereavement suite, a space where mothers who have sadly lost children in childbirth can spend time with their baby and – with the support of our bereavement midwives – begin the process of coming to terms with their loss. It does help families to come to terms with their loss. Baby loss is still a subject that is not widely talked about. With Baby Loss Awareness Week taking place, I was grateful for the opportunity to meet with the Deputy Lord-Lieutenant to discuss the issue, alongside our Lead Bereavement Midwife Yvonne Morrison and Faye and David from Abigail's Footsteps. To mark the week, we lit up the hospital's clock tower as a reminder of those who have left us far too soon.

1.4.4 Award winning HR Team; Big congratulations to our HR Team who won the overall award at the Health Tech Awards. This award was shared with NHS Shared Business Services for our innovative work around staff retention. Together we have developed a new workforce analytics solution, which uses data science techniques to improve our staff retention rates. With this information we can learn and intervene when colleagues leave. Congratulations to the Medway Innovation Institute who were also shortlisted for an award.

1.4.5 A welcome return for our therapy dogs; I was delighted to see the return of our Trust therapy dogs, Yazzy and Fred, last month, after procedures were finalised to ensure the safety of the dogs, their owners, and the patients they see, amid the ongoing COVID-19 pandemic. I know that therapy animals can make a real difference to our staff and patients, helping to reduce stress and anxiety, and they have been a very welcome sight in the hospital. Thanks to Yazzy, Fred and their owners – volunteer Janice McCauley and Trust Voluntary Services Manager Zoe

Goodman – for the time and effort they all put in to making our patients' stay a happier one and for our staff.

1.4.6 Congratulations to Cliff Evans for the award he won for his work in Critical Care. It is a huge achievement and it is testament to the work he has done over a number of years.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 07 October 2021 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting. Action No: TBPU/21/118: An extension to the deadline was agreed by the Executive Team, QAC and Board to January 2022 Board meeting.

High Quality Care

3.1 Integrated Quality Performance Report

The Board received the report; the paper was taken as read with the following key highlights:

3.1.1 Jayne Black presented to the Board.
ED attendances have increased steadily.
Ambulance attendances increase month on month, with seven additional ambulances per day.
Steady increase in long length of stay, which resulted in bed occupancy being above 92%
Covid numbers are relatively stable.
Number of discharges have reduced and maintained early discharge before 12:00.
Ambulance handover time delays; there have been eight 12 hr breaches. This remains a focus and challenge. Currently it is a 25 minute handover and teams are trying to reduce this to 15 minutes.

Team is trying to improve the position by:
- Escalation triggers
- Prioritised actions around discharge
- Medical model – how to ensure patients get senior decisions in the right time
- How to manage flow through the hospital – electronic discharge process, early planning
- Working with MEDDOC – ensuring patients are in the right place
- What provision we have going into the winter months – winter planning

RTT there is good progress against performance in 52 weeks in our trajectory. There is an increase in GP referral and waiting lists.
Cancer good achievements in this area, on track around trajectory.

3.1.2 Evonne Hunt presented to the Board.
There are some challenges around mixed sex accommodation; ensuring patients are in the right place, for the right care. There will be focus of this in the coming months to understand why and to mitigate.
Increase in FFTE, the Trust is meeting but an improvement is necessary.
Good performance with falls and pressure ulcers.
There are workshops for teams to understand serious incidents, also how to address the backlog.
The Board asked that IPC Performance is included in the IQPR going forward.

3.1.3 David Sulch presented to the Board.
Mortality slide is slightly out of date on Page 27. The Trust now has data from Dr Foster up to June 2021. There has been an improvement in the HSMR.

3.2 Quality Assurance Committee Assurance Report: 18.10.21

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

1) Continuing operational pressures on the Trust, added to the Quality BAF – Risk 5c.

2) Concerns about in-patient experience as reflected in the results of the in-patient survey. Chair asked that this is followed up through the QAC.

3.3 Annual Report on Medical Education

Janette Cansick, Director of Medical Education presented and the Board was requested to:

1) Be aware of the risks identified within Medical Education:
a) Delayed configuration of the Medical Education Centre leading to risk for KMMS and University status
b) Threat to trainee placements due to longstanding unresolved Medicine service quality issues within Unplanned Care Division
2) Receive an update on use of COVID recovery funds
3) Receive an update on HEKSS Quality Visits and GMC survey response
4) Receive an update on progress for KMMS students

3.3.1 Janette informed the Board of:

1) Introduction and the structure of Medical Education
2) Trainee Establishment
3) Finance
4) Education Facilities
5) COVID19 recovery funds from HEKSS
6) Update on HEKSS Quality Visit action plans
7) GMC 2021 survey
8) KMMS

3.3.2 The Director of Medical Education is accountable to the Trust Chief Medical Officer and Health Education Kent Surrey Sussex (HEKSS) Postgraduate Dean. The three main priorities are:

1) Support of trainees in Covid-19 recovery
2) Response to HEKSS Quality and the GMC survey principally for Medicine (both acute and general internal)
3) Progression in our readiness for the first KMMS medical students to arrive at MFT in September 2022

3.3.3 Chair informed the Board of their experience and visit to the University last month and it gave a taster of what the Trust is to expect. The Board gave their thanks to Janette.

3.4 Safe Staffing Review

Evonne Hunt, Chief Nursing and Quality Officer, presented the report..

3.4.1 The Trust Board had received a six monthly update on nurse staffing in January 2021 which outlined progress with recruitment to the additional posts and work undertaken to ensure safe nurse staffing across adult inpatient wards.

3.4.2 The paper gave the Board a high level overview of the annual provider review of nurse staffing levels as reviewed for 24 consecutive days from the 08 July 2021. Although it is not routinely recommended to change staffing based on one review, some areas have highlighted that staffing requirements have changed within the timeline from the last review and should be considered.

3.4.3 The annual safe staffing review commenced on the 08 July 2021. There has been a delay in completing this review this year, in part due to external training and validation that was brokered by the Chief Nursing and Quality Officer through Hilary Chapman and the national safe staffing team.

3.4.4 As stated, this review has focused solely upon adult general areas. Additional reviews into Emergency Care, Paediatrics, Theatres, Critical Care, Specialist Nursing / Clinical Nurse Specialists, Outpatients and corporate nursing will be required in the coming months to provide a composite picture of the nursing resource available within the Trust.

3.4.5 It was noted that no episodes of staffing not meeting safe staffing requirements have been reported from divisions following mitigation, although the increase in need for 1:1 nursing of patients has increased. It would not explicitly be collected as part of the SNCT review.

3.4.6 Evonne will be revising the approach to safe staffing, what are the opportunities and report back to the Board. George stated that the report assures that the Trust does have a safe level of staffing notwithstanding the hospital pressures through the winter. The revised report is expected to be submitted to the Board early in 2022.

3.5 Patient Experience Strategy

No further update. Paper was taken as read.

3.6 Maternity CNST Compliance

Evonne Hunt, Chief Nursing and Quality Officer, presented to the Board for noting.

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

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

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

3.6.7 The Board NOTED the update.

4 Strategy and Resilience

4.1 Sustainable Procurement

Gary Lupton, Director of Estates and Facilities, presented for the Board to note that the Greener NHS National Programme published its new strategy, 'Delivering a Net Zero NHS' in October 2020.

4.1.1 The report set out trajectories and actions for the NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence such as those embedded within the supply chain, (also known as the NHS Carbon Footprint Plus).

4.1.2 Gary mentioned a number of items from the report which aim to assist to reduce the footprint, such as; encouraging staff to work from home, increasing recycling on site, reducing supplier deliveries to site by holding more stock, using local produce etc.

4.1.3 The Board are to expect a Sustainability Action Plan in the near future to take this all forward.

4.1.4 The Board thanked Gary and the team for their work to date and enthusiasm, all colleagues need to be engaged to make this work. The team are working on recruiting Green Plan Champions.

4.2 Integrated Care System Update

Paula Tinniswood, Chief of Staff presented for the Board to note the following:

4.2.1 Cedi Frederick has been appointed as the new Chair of the Kent & Medway ICS Board.

4.2.2 In November 2020 NHS England and NHS Improvement published Integrating care: Next steps to building strong and effective integrated care systems across England. It described the core purpose of an ICS being to:

1) Improve outcomes in population health and healthcare
2) Tackle inequalities in outcomes, experience and access
3) Enhance productivity and value for money
4) Help the NHS support broader social and economic development.

4.2.3 The foundations of integrated care are to support collaboration, local decision making and flexibility. Co-development with system leaders, people who use services and many other stakeholders, supports the development of guidance, through to implementation.

4.2.4 Paula attends the Population Health Management meetings.

4.3 Board Assurance Framework

Gurjit Mahil presented to the Board for noting, a summary of the BAF as of 20 October 2021. The Trust's principle risks are:

3a – Delivery of financial control total
3b – Capital Planning
5c – Patient Flow

4.3.1 Chair asked for the team to carry out deep dives into the moderate risks on the BAF to further improve controls and mitigations and therefore the rating.

5 Financial Stability

5.1 Finance Report - Month 6

Alan Davies, Chief Finance Officer gave an update to the Board. The following highlights were noted:

5.1.1 The Trust reports a breakeven against the NHSE/I control total.

5.1.2 Efficiencies programme - The in-month position is reporting a £0.1m increase compared to August as the £0.5m surplus ERF income above the cost of delivering activity thresholds has been included and reported across the 6 months to date.

5.1.3 Capital the Trust is behind but certain to deliver on target. The Trust programme is currently £1,763k behind plan - this is mainly due to slippage across the Backlog Maintenance and Fire Safety Programme due to a delay in scoping and Covid related access restrictions earlier in the year.

5.2 Finance Committee Assurance Report: 28.10.21

Annyes Laheurte, Chair of Committee presented to the Board for assurance, the paper was taken as read. The Committee reviewed the following:

5.2.1 It was AGREED that there would be a particular focus on risk "3c Failure to Achieve Long Term Financial Sustainability" at the next meeting.

5.2.2 Corporate risk register - There was one item scoring 16 or higher with regards to the capital resource limit for the year.

5.2.3 Finance Report – Month 6 - The Committee **AGREED** that a list of immediate actions and controls that could be deployed to support delivery of the financial control total as required would be brought back to the next meeting. There are risks around this relating to hospital pressure, PAY award and winter planning. The Committee noted the draft deficit position and the risk at this time in being able to plan for breakeven.

5.2.4 The ongoing work to present a breakeven plan for H2 should be noted.

5.2.5 The Committee recommended APPROVAL of the Patient First Business Case to the Trust Board, noting the two key issues to resolve were on affordability and performance management.

6 Any Other Business

6.1 Council of Governors Update

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

6.1.1 18 November there is a members meeting on teams with Dr Sanjay Suman presenting on how patients are cared for in the hospital and what the future might hold. Invitations have gone out to members and all are welcomed.

6.1.2 An event to discuss the quality priorities is due to go into the diary in January 2022.

6.1.3 There was an Engagement session held in the Pentagon Shopping Centre in Chatham. Many of the public were engaged with to discuss their experiences at the hospital; it was a success so another session will be held in December. There will also be an engagement event at the Sunlight Centre in Gillingham.

6.1.4 The Governors plan with the support of the Trust to work with as many of the community as possible.

6.1.5 Chair thanked David and apologised for the technical difficulties at the last Council meeting.

6.2 Questions from the Public

There were no questions from the public.

6.3 Any Other Business

There were no matters of any other business.

6.4 Date and time of next meeting

The next public meeting will be held on Wednesday, 12 January 2022.

The meeting closed at 14:30

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

Signed …….. Date ……

Chair

Board of Directors in Public
Action Log

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

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
15-Apr-21	TBPU/21/118	Submit the Patient Experience Strategy to the Board	12-Jan-22 ~~04-Nov-21~~ ~~08-July-21~~ ~~06-May-21~~	Evonne Hunt, Chief Nursing and Quality Officer (Interim)	An extension to the deadline was agreed by the Executive Team, QAC and Board to February 2022 Board meeting.	Red

Meeting of the Board of Directors in Public
Wednesday, 12 January 2022

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	3.1
Report Author	Evonne Hunt – Chief Nursing and Quality Officer (Interim) Graeme Sanders – Medical Director (Interim) Jayne Black – Chief Operating Officer		
Lead Director	Evonne Hunt – Chief Nursing and Quality Officer (Interim) Graeme Sanders – Medical Director (Interim) Jayne Black – Chief Operating Officer		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators for the November 2021 reporting period. **Safe** Our Infection Prevention and Control performance for October shows that the Trust has had 0 MRSA bacteraemia cases and 0 hospital acquired C-diff cases. **Caring** MSA has shown improvement, November has seen that 57 breaches were recorded, in October the Trust recorded 196 breaches. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates for three areas, remain close or above the national standard of 85% (Inpatients: 74.9%, Maternity: 100%, Outpatients: 88.7%, ED: 70.3%). **Effective** Discharges before Noon, whilst close to the Mean are still below at 17.1% and significantly below the Target of 25%, this is being reviewed through the rapid improvement work. **Responsive** The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In November the RTT standard was 66.2% and the Trust recorded 145 52 week breaches which is lower than previous months. ED (Type 1) 4 hour performance as a result of site pressures reported 60.2% in November. Additionally, the Trust saw 299 Ambulance Handover delays of +60mins. The DM01 Diagnostics performance is at 82.5% for November 2021. In October 2021, 93.9% of patients were seen within 2 weeks of their referrals into the cancer pathways and 82.1% of patients were treated within 62 days. **Well Led** We have seen a stable position in appraisal rates, reporting 83.6% and the Trust has maintained compliance statutory and mandatory training at 89.8%.		

	To note: • The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay. • The SHMI data is currently showing March – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing March data, this is reliant on Dr Foster and this is 3 to 4 months in arrears. • The bed occupancy includes all beds within the Trust including maternity and paediatrics.			
Resource Implications	None			
Legal Implications/Regulatory Requirements	State whether there are any legal implications			
Quality Impact Assessment	Not required.			
Recommendation/ Actions required	The Board is asked to note the discussions that have taken place and discuss any further changes required.			
	Approval ☒	**Assurance** ☒	**Discussion** ☒	**Noting** ☒
Appendices	Appendix 1 – IQPR – November 2021			

NHS
Medway
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Integrated Quality and Performance Report

Reporting Period: November 2021

What is Statistical Process Control (SPC)?

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

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

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

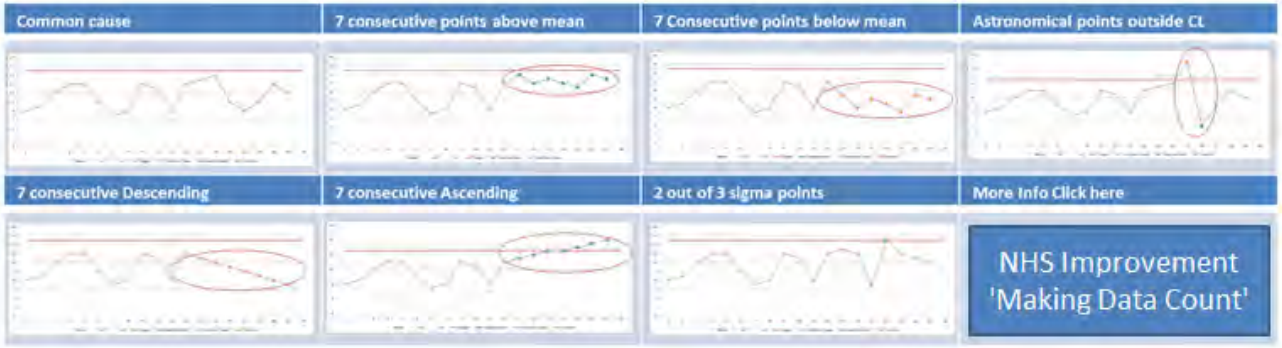
Key Facts about a SPC Chart:

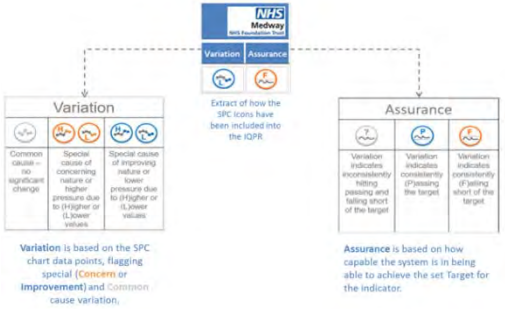
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls)	• Flow, Emergency & Elective Pathways
Caring	• EDNs completed within 24hrs is showing signs of improving • Whilst slightly over plan, the number of Complaints received is statically lower than normal	• High number of breaches in Mixed Sex Accommodation continues • % Complaints responded to within target has declined • FFT scores are showing sign of decline
Effective	• Discharges before Noon showing high statistical variation, and signs of improvement • VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement	• High statistical variance in Readmission rates evidenced • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • 0 Never Events in month • Trust Attributable MRSA cases have reported 0	• Overall HSMR levels above the national threshold (100) • E-Coli cases are above plan for month and YTD
Responsive	• Cancer 2ww & 31day Performance has exceeded the target • Average Length of Stay for Elective patients has reduced • DToC levels have reduced	• 60min Ambulance Handover delays have increased and ED 4-hr compliance has decreased • RTT Incomplete Performance decreased plus the PTL size is showing signs of increasing • Cancer 62day metric showing under-performance
Well Led	• Maintained compliance with Trust target for StatMan Compliance. • Agency staff spend has reduced	• Turnover Rate shows an increase in statistical variance • Bank spend has increased considerably • CIP schemes currently shows an under plan position

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

Best of care Best of people

Executive Summary

CQC Domain	CQC Sub Domain	TRUST Variation					TRUST Assurance			
Caring	Admitted Care	4	1	0	0	0	0	1	4	0
	ED Care	0	2	0	0	0	0	1	1	0
	Maternity Care	2	0	0	0	0	1	0	1	0
	Outpatients Care	0	2	0	0	0	1	1	0	0
Effective	Best Practice	4	0	0	0	1	0	2	3	0
	Maternity	4	0	0	0	0	0	2	2	0
Responsive	Bed Management	3	0	2	0	0	2	2	1	0
	Cancer Access	3	0	0	0	2	0	0	5	0
	Complaints Management	1	1	0	0	0	0	0	2	0
	Diagnostic Access	1	0	0	0	0	0	0	1	0
	ED Access	1	2	1	0	0	0	2	2	0
	Elective Access	0	1	2	0	0	0	2	1	0
	Theatres & Critical Care	2	0	0	0	0	0	0	2	0
Safe	Harm Free Care	2	0	0	0	0	1	0	1	0
	Incident Reporting	3	0	0	0	0	1	0	1	1
	Infection Control	3	0	0	1	0	0	0	3	1
	Mortality	1	0	1	3	0	0	1	2	2
Well Led	Staff Experience	0	0	0	0	2	0	2	0	0
	Workforce	3	0	1	2	2	1	0	6	1

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	0	43	52		
S2	C-Diff: Hospital Onset Hospital Acquired (HOHA)	0	0	0	38		
S3	MRSA Bacteraemia (Trust Attributable)	0	0	5	0		
S4	E-coli (Trust Acquired) Infections	2	6	30	68		
S5	Falls Per 1000 Bed Days	6.63	4.52	6.63	4.82		
S6	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.04	0	1.04	0.03		
S7	Never Events	0	0	0	3		
S8	% of SIs Responded To In 60 Days	100.0%	100.0 %	100.0%	96.5%		
S9	HSMR (All)	100	97.51	100	1.01		
S10	HSMR (Weekday)	100	95.78	100	0.98		
S11	HSMR (Weekend)	100	107.47	100	1.09		
S12	SHMI	1	1.03	-	17		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	57	0	2,269		
C2	Number of Complaints	41	59	-	895		
C3	% Complaints Responded to Within 30 Days	85.0%	40.6%	85.0%	58.9%		
C4	% of EDNs Completed Within 24hrs	100.0%	72.6%	100.0%	68.8%		
C5	Inpatients Friends & Family Response Rate	22.0%	17.8%	22.0%	18.8%		
C6	Inpatients Friends & Family % Recommended	85.0%	74.9%	85.0%	80.4%		
C7	ED Friends & Family Response Rate	22.0%	13.1%	22.0%	14.7%		
C8	ED Friends & Family % Recommended	85.0%	70.3%	85.0%	81.4%		
C9	Maternity Friends & Family Response Rate	22.0%	25.5%	22.0%	27.6%		
C10	Maternity Friends & Family % Recommended	85.0%	100.0 %	85.0%	98.2%		
C11	Outpatients Friends & Family Response Rate	22.0%	7.9%	22.0%	10.2%		
C12	Outpatients Friends & Family % Recommended	85.0%	88.7%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R1	Bed Occupancy Rate	85.0%	90.0%	85.0%	82.5%		
R2	Average Non-Elective Length of Stay	5	9.82	5	8.30		
R3	Average Elective Length of Stay	5	2.50	5	2.28		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	2.4%	4.0%	0.8%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	14.7%	7.0%	11.6%		
R6	ED 4 Hour Performance All Types	95.0%	71.4%	95.0%	81.0%		
R7	ED 4 Hour Performance Type 1	95.0%	60.2%	95.0%	71.8%		
R8	ED 12 hour DTA Breaches	0	77	0	524		
R9	Number of ED arrivals by Ambulance	-	3,285	-	64,234		
R10	60 Mins Ambulance Handover Delays	0	299	0	4,183		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	5.5%	5.0%	6.8%		
E2	30 Day Readmission Rate	10.0%	11.1%	10.0%	13.0%		
E3	Discharges Before Noon	25.0%	17.1%	25.0%	16.1%		
E4	Fractured NOF Within 36 Hours	100.0%	57.7%	100.0%	70.6%		
E5	VTE Risk Assessment % Completed	95.0%	91.0%	95.0%	95.3%		
E6	Elective C-Section Rate	13.0%	13.5%	13.0%	14.7%		
E7	Total C-Section Rate	28.0%	39.2%	28.0%	37.1%		
E8	Emergency C-Section Rate	15.0%	25.7%	15.0%	22.4%		
E9	12+6 Risk Assessment	90.0%	83.0%	90.0%	85.8%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	82.5%	99.0%	79.8%		
R12	18 Weeks RTT Incomplete Performance	92.0%	66.3%	92.0%	65.4%		
R13	18 Weeks RTT Over 52 Week Breaches	0	225	0	4,596		
R14	Operations Cancelled By Hospital on Day	0	14	0	249		
R15	Cancelled Operations Not Rescheduled < 28 days	0	1	0	46		
R16	Cancer 2ww Performance	93.0%	93.9%	93.0%	96.0%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	86.1%	93.0%	92.4%		
R18	Cancer 31 Day First Treatment Performance	96.0%	96.1%	96.0%	97.0%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	82.1%	85.0%	72.7%		
R20	104 Day Cancer Waits	0	2	-	50		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	83.0%	-	84.0%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	5.0%	4.0%	4.9%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	13.0%	12.0%	12.4%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	89.8%	85.0%	89.1%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,321	-	82,855 .63		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	0.0%	4.0%	2.8%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	12.4%	9.0%	12.7%		

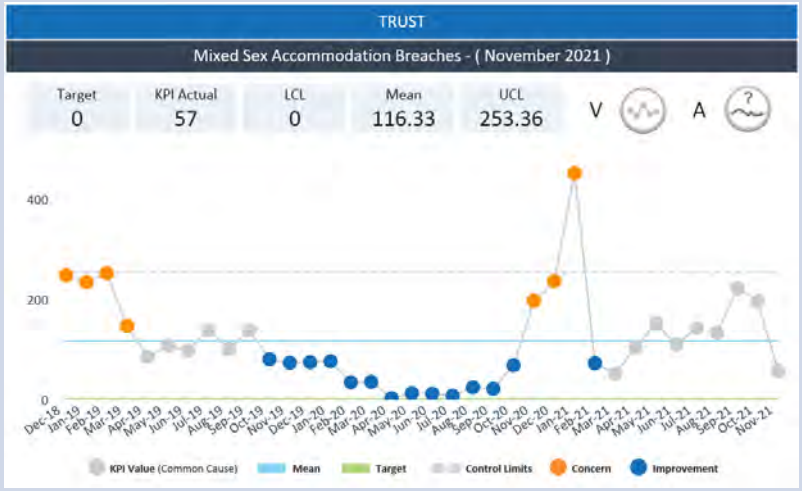
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Nov-21	100.0%	72.6%	65.0%	71.2%	77.3%		
		Inpatients Friends & Family % Recommended	Nov-21	85.0%	74.9%	74.7%	82.5%	90.4%		
		Inpatients Friends & Family Response Rate	Nov-21	22.0%	17.8%	14.3%	19.3%	24.2%		
		Mixed Sex Accommodation Breaches	Nov-21	0	57	0	116.33	253.36		
		MSA %	Nov-21	0.0%	0.4%	0.0%	0.8%	1.8%		
	ED Care	ED Friends & Family % Recommended	Nov-21	85.0%	70.3%	71.0%	79.3%	87.6%		
		ED Friends & Family Response Rate	Nov-21	22.0%	13.1%	11.9%	14.4%	16.8%		
	Maternity Care	Maternity Friends & Family % Recommended	Nov-21	85.0%	100.0%	94.6%	98.9%	103.1%		
		Maternity Friends & Family Response Rate	Nov-21	22.0%	25.5%	9.6%	25.6%	41.6%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Nov-21	85.0%	88.7%	87.3%	89.8%	92.4%		
		Outpatients Friends & Family Response Rate	Nov-21	22.0%	7.9%	10.0%	12.1%	14.3%		

Safe: Mixed Sex Accommodation (MSA)
Aim: Reduction in mixed sex accommodation
Latest Period: November - 2021

Executive Lead: Evonne Hunt
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Mixed Sex Accommodation Breaches



Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	Septem	Octobe	November
Bronte								25	20						4	7		14		
Critical Care Unit										2										
Dolphin Ward									1			2			4	4	2			1
Intensive Care Unit		3	1	3	6	1	15	12	10	12	6		18	20	11	3	6	1	5	2
McCulloch Ward		1	1		2		8	1		1		6	7	7		19		3	15	
Harvey Ward			5				7													
Jade Ward																			4	4
Keats Ward									14		2				3			14		
Lawrence Ward														2			2	7		
Lister Assessment Unit									50	19	16			12	16	43		34	22	
Nelson Ward									4	14	11	5	24	8		6		5	10	
Ocelot										6								29	32	1
Pembroke Ward										1						7	15			
Phoenix Ward									2		19	7								
Pre Op Care Unit											2	11								
Sapphire Ward			5						3	39				2	9	3	57	25	24	
SDEC									108	312					2	2				
Sunderland Day Case Centre								82		6								5	19	
Surgical Assessment Unit								57		12					12		7	20		
Theatre Intensive Care Unit									7	8	1									
Trafalgar Ward SHDU	2	8	5	4	10	19	22	16	7	13	11	19	55	45	47	46	33	86	65	46
Tennyson Ward							16													
Wakeley															1		5			
Victory																	6			
Will Adams								4	5	6	4			7		3		8		4
																			136	58

Today	Yesterday	Last 7 Days	Last 14 Days	Current Month

Ward Name	Total MSA Days	Unjustified Breaches - Unanswered	Unjustified Breaches - Answered	Justified Breaches
DOLPHIN WARD	245	0	1	244
INTENSIVE CARE UNIT	2	0	2	0
JADE WARD	4	0	4	0
MCCULLOCH WARD	557	0	0	557
OCELOT WARD	1	0	1	0
TRAFALGAR WARD HDU	69	0	44	25
WILL ADAMS	4	0	4	0
Total	882	0	56	826

What do the outcome measures show?

The number of patient breaches by day of mixed-sex accommodation (MSA)
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
Improved oversight from the critical care team in reporting 4 hour step down MSA breaches has increased the accuracy of reporting and the overall total in O
Average bed occupancy in Medway has been very high
Assessment areas and same day care regularly used for overnight care and admitted patients
Maintaining green and amber pathways for safety and the elective restart program within the SARS2 pandemic has care impacts on bed utility

What changes have been implemented and improvements made?

Continuous monitoring of patient safety and ensuring that where possible the patients are informed and bed moves prioritised and facilitated in a timely way to correct the breach
Rapid improvement exercise has articulated a plan for the use of assessment areas which aims to maintain function and protect the beds from admitted patients where possible as critical care step down and bedding of assessment areas is a significant cause of MSA breaches
Unjustified breaches are on the whole directly due to not being able to step patients out of critical care areas

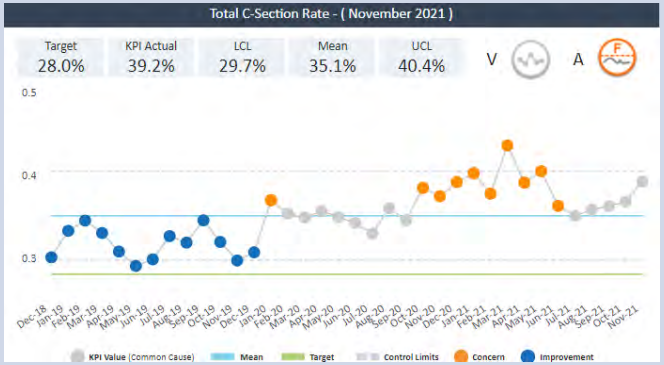
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Oct-21	10.0%	11.1%	9.8%	12.1%	14.3%		
		7 Day Readmission Rate	Oct-21	5.0%	5.5%	4.6%	6.2%	7.8%		
		Discharges Before Noon	Nov-21	25.0%	17.1%	12.9%	15.6%	18.3%		
		Fractured NOF Within 36 Hours	Oct-21	100.0%	57.7%	40.9%	68.2%	95.5%		
		VTE Risk Assessment % Completed	Nov-21	95.0%	91.0%	87.2%	93.4%	99.6%		
	Maternity	12+6 Risk Assessment	Aug-21	90.0%	83.0%	79.1%	84.6%	90.1%		
		Elective C-Section Rate	Nov-21	13.0%	13.5%	10.0%	14.1%	18.1%		
		Emergency C-Section Rate	Nov-21	15.0%	25.7%	15.8%	21.0%	26.2%		
		Total C-Section Rate	Nov-21	28.0%	39.2%	29.7%	35.1%	40.4%		

Effective: Maternity
Aim: TBC – Currently Under Development
Latest Period: November - 2021

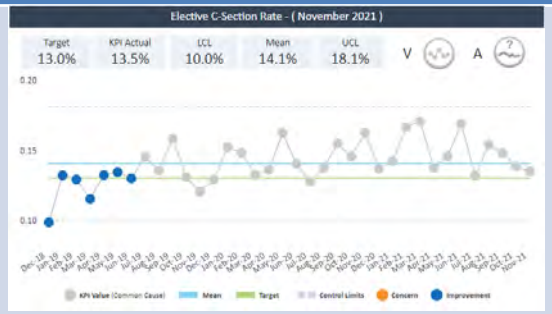
Executive Lead: Dot Smith
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

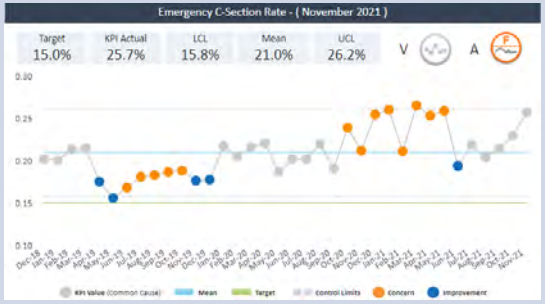
NHS Medway NHS Foundation Trust

Outcome Measure: Total Elective & Emergency C-Section Rate



Outcome Measure: Elective and Emergency C-Section Rate





What changes have been implemented and improvements made?

Total CS rate: The total rate of CS was relatively stable at Medway for the last several years at around 28-30% until 2019. The CS rate in 2019 was 31%, which increased to 36% in 2020 and further to 44% in 2021.
Elective CS rate: The rate of elective CS has remained relatively stable over the years between 13-15% from 2019-2021.
Emergency CS rate: The rate of emergency CS has increased from 18% in 2019, 21% in 2020 to 23% in 2021

The increased rates were due to increase in rates of emergency and not elective CS. This was accompanied by a corresponding drop in rates of assisted vaginal delivery.

In the emergency CS group, the indication for which the highest increase was noted was CS for failure to progress (FTP)

Majority of CS (56%) were carried out of hours. Majority of CS (58%) were carried out by middle grade staff who made the decision for the CS.

We are addressing workforce shortages in Consultant body at present and a PID document and business case to address these was written and approved

The increased consultant workforce will allow us to:
Have a 13 hour presence of delivery suite which will allow continuous presence with continuity of care with one Consultant for every 24 hour shift
Twice daily ward rounds by Consultant obstetrician along with Huddles with midwifery, neonatal and anaesthetic staff
Dedicated cover for obstetrics and separate cover for Gynaecology emergencies so the Consultant on-call for delivery suite is available at all times for emergencies
Introduce daily audits of all emergency CS to be done by Consultant obstetrician along supported by midwifery and middle grade staff
Consider new initiates such as testing for amniotic fluid lactate in mothers who have prolonged labour to decide when to augment and when not; this will help reduce CS due to FTP

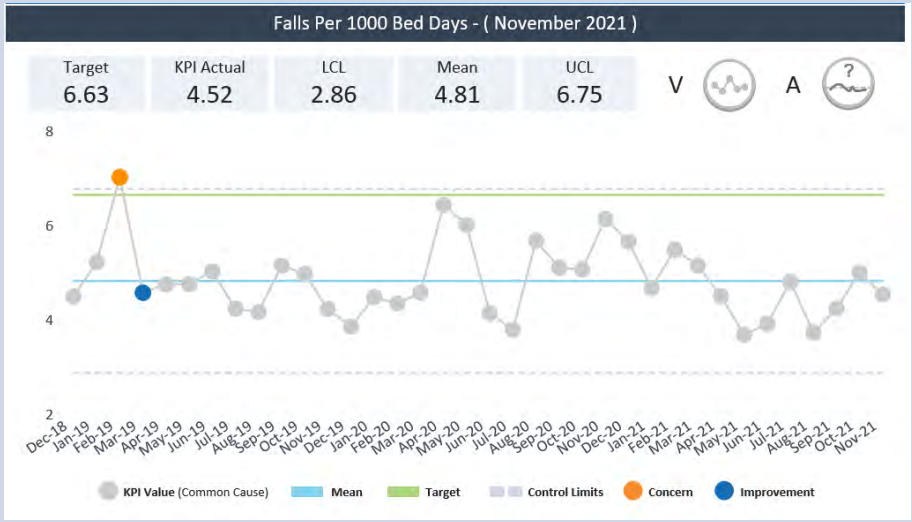
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Nov-21	6.63	4.52	2.86	4.81	6.75		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Nov-21	1.04	0	0	0.04	0.18		
	Incident Reporting	% of SIs Responded To In 60 Days	Nov-21		100.0%	90.7%	97.8%	104.9%		
		Never Events	Nov-21	0	0	0	0.14	0.90		
		No of SIs on STEIS	Nov-21	90	8	0	13.36	28.26		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Oct-21	4 [43]	0	0	2.71	9.01		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Oct-21		0	0	1.81	6.33		
		E-coli (Trust Acquired) Infections	Oct-21	0	6	0	4.14	9.93		
		MRSA Bacteraemia (Trust Attributable)	Oct-21	0 [5]	0	0	0.20	0.90		
	Mortality	Crude Mortality Rate	Nov-21	2.5%	1.9%	0.4%	1.9%	3.4%		
		HSMR (All)	Jun-21	100	97.51	97.78	101.77	105.76		
		HSMR (Weekday)	Jun-21	100	95.78		98.42			
		HSMR (Weekend)	Jun-21	100	107.47		111.26			
		SHMI	Jul-21	1	1.03	1.06	1.08	1.11		

Safe: Falls management and reduction
Aim: 12% reduction in number of falls with harm
Latest Period: November 2021

Executive Lead: Chief Nursing and Quality Officer
Operational Lead: Prevention of Falls Clinical Nurse Lead
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days



What do the outcome measures show?

- The total number of falls in November is 78 compared to 85 last month and 84 in the same month last year.
- Of the 85 falls reported, 57 were no harm, 20 low harm and 1 moderate harm that required sutures.
- 76% of falls occurred in unplanned care (size of division and specialties),
- 26% of falls occurred in Planned care
- The majority of the types of falls were fall from a bed or level ground and both were mainly unwitnessed.

What changes have been implemented and improvements made?

Falls Awareness week was held in September 2021in conjunction with #endPJparalysis (avoiding long periods of bedrest resulting in muscle wasting). All wards made individualised pledges to reduce falls and deconditioning with 13 wards submitting data to demonstrate achievement. All wards submitting data demonstrated achievement in their pledges with 2 wards achieving 100% in 2 of their pledges and 3 wards achieving 100% in one of their pledges.

The Falls Team are currently formulating falls e-learning modules as the training modules developed by the Fallsafe Project are no longer available.
Milton ward made significant improvement in reliability this month and achieving target. Harvey Ward continued to reach target alongside Byron ward who achieved 100%.
Sapphire ward have consistently reduced reliability over the past 3 months. Those staff identified as requiring training as part of a quality Improvement project were offered bespoke training sessions.
Although the CRASH Bundle audit is performed Trust wide, the graph below demonstrates the results of the Quality Strategy Pilot wards for falls only. Lister was the lowest scoring Ward with 53%. The introduction of Electronic Patient Records (EPR) may have affected some aspects of the audit and the location of recordings and documents.

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

Executive Lead:
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

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

What do the outcome measures show?

- Tissue Viability (TV) audits the ASSKING bundle which comprises of seven key elements of care: **A**=assess the risk, **S**=skin inspection, **S**=looking at the Surfaces the patients use, **K**=keep moving to prevent PU, **I**=incontinence assessment as moisture can increase the risk, **N**=nutrition assessment, **G**=giving of information). Target = 95%
- The Quality Strategy aim to reduce hospital acquired pressure ulcer (PU) incidents by 10% meaning no more than 181 hospital acquired incidents by the end of March 2022.To date there have been 120 Hospital Acquired (HA) PU Incidents.
- The total number of acquired PU in November is 18 compared to 15 in October 2021 and 22 in November 2020.
- The process measure is achieving 95% reliability with the ASSKINg care bundle audit. The Trust continues to show progress towards achievement with increasing days between PU in pilot wards and improvement with ASSKINg reliability care bundle.
- 6 areas of non- compliance for November were Kent 57%,Byron 89%, Phoenix 91%, Lister 71%,Sapphire 74%, Keats 94%.
- This is a reduction in achievement

What changes have been implemented and improvements made?

There have been a total of 18 Hospital acquired pressure ulcers in November 2021. This is an increase on 15 the previous month. There were 22 incidences in November 2020
Of the 18 HAPU:

6 Were category 1
3 Were category 2
0 Were category 3
0 Were category 4 and
9 Were Unstagable
5 Were Deep Tissue Injury (these are not included in formal reporting)

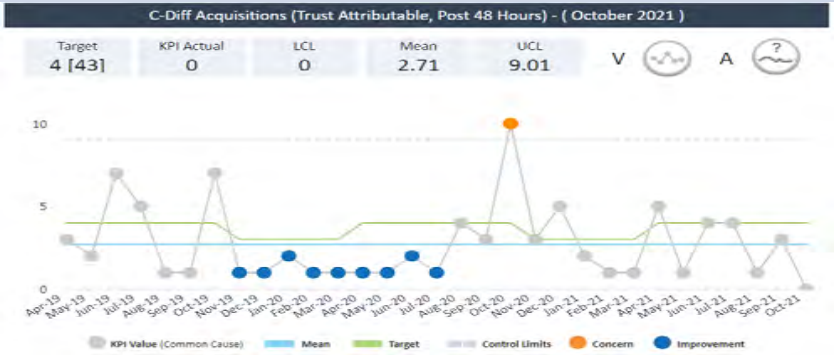
Continue to perform monthly trust wide audits for ASSKING bundle and report on the 11 quality wards. Byron ward, Pembroke ward, Phoenix ward, Keats ward, Tennyson ward, Milton ward, Emerald ward, Harvey Ward, Will Adam's ward, Sapphire Ward and Jade ward
Pressure Ulcer surveys continue to be disseminated to the quality improvement wards to ascertain in clinical practice what barriers there are to preventing pressure ulcers.
There has been poor engagement from some wards to enable staff to attend bespoke training sessions informed by the results of staff knowledge surveys. One aim of the surveys is to ensure consistent knowledge of fundamentals of pressure ulcer prevention and management. Further sessions have been arranged for November.
In November the Tissue viability team celebrated National stop the pressure day by visiting the wards providing education and raising awareness of pressure ulcers.

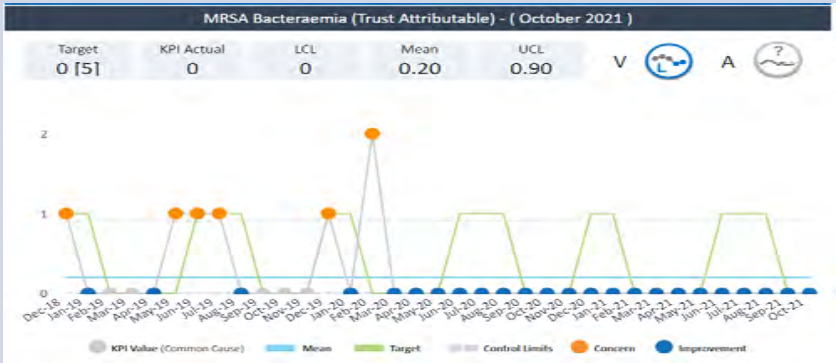
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: October 2021

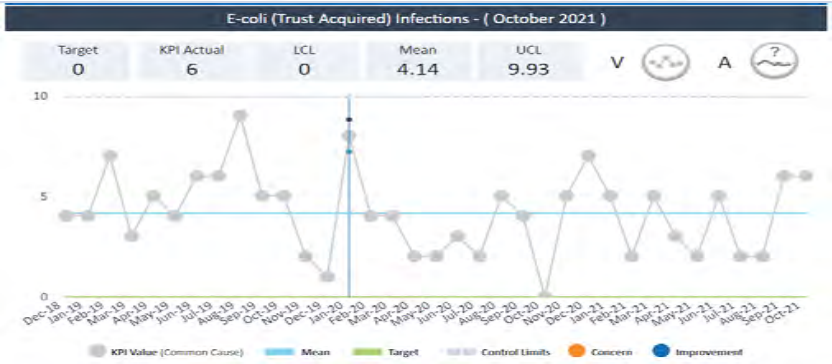
Executive Lead: Evonne Hunt
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Infection Prevention Control measures







What do the outcome measures show?

MFT continues to present a lower level of all key hospital acquired infections, including MRSA bacteremia, C difficile and gram negative blood stream infections 2021-2022 compared to 20/21
MFT MRSA Bacteraemia 0 (since May 2020)
C.Difficile hospital acquired rates since 1st April 2021 is 18 against a target of 35.
To date **88** days since HA C.difficile.
Other HAI since 1st April 2021 – October 2021:-
E.coli : 26 against a threshold of 112
Klebsiella acquired: 15 against a threshold of 38
IPC processes in place continue to demonstrate low HAI

What do the process measures show?

IPC processes in place continue to demonstrate low HAI

What changes have been implemented and improvements made?

- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- IPC Team now fully complemented.
- DIPC Trust-wide IPC Blogs.
- Monthly hand hygiene audits commenced via Perfect Ward
- Monthly IPC audits (including BBE and Saving Lives ,PV, Urinary catheter via Perfect Ward
- IPC Audit Schedule 2021/2022
- Review of COVID-19 Pathways and Screening Protocols
- Sharing & learning best practice IPC standards via IPC Partnership working with the Kent & Medway Network and Supportive meetings with CCG

Infection Rate April 2021 - March 2022

Month	C-Diff		MRSA		E-Coli	
	Total Hospital Cases	Total Hospital Cases	Total Hospital Cases	Ward Breakdown	Total Hospital Cases	Total Hospital Cases
Apr 2021	5	0	3	1	0	1
May 2021	1	0	2	2	3	1
June 2021	4	0	5	5	2	1
July 2021	4	0	2	1	1	2
Aug 2021	1	0	2	1	3	0
Sept 2021	3	0	6	3	2	3
Oct 2021	0	0	6	1	4	0
Nov 2021	0	0	3	2	2	0
Dec 2021	1					
Total	**19**		29	16	17	8

Patient Centred: Dementia and Delerium Management

Aim: TBC – Currently Under Development

Latest Period: November - 2021

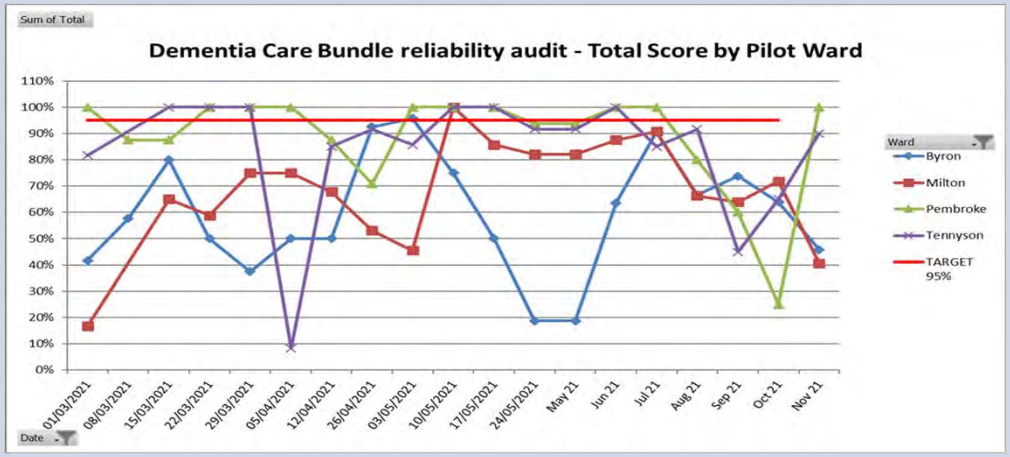
Executive Lead:

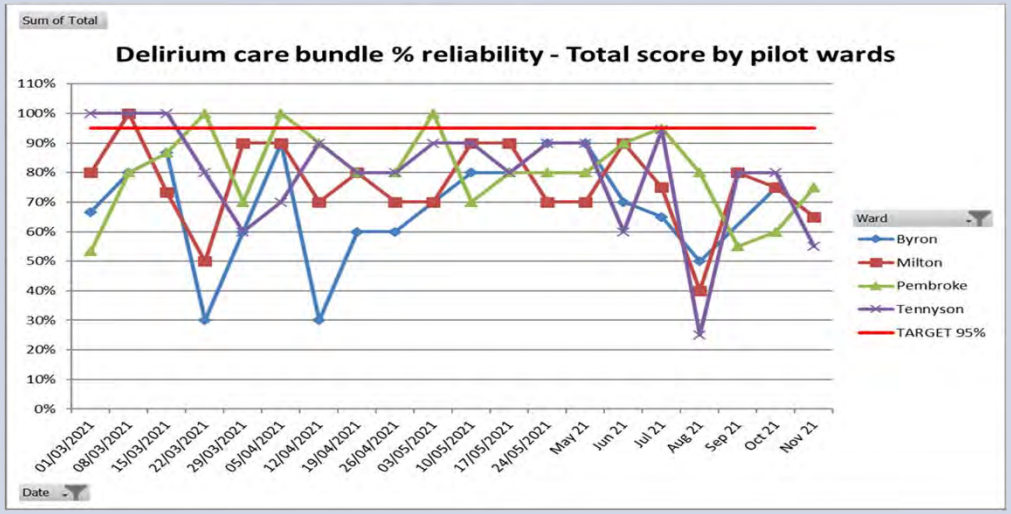
Operational Lead: Not applicable

Sub Groups: Quality Assurance Committee

Medway NHS Foundation Trust

Dementia Measures:





What do the outcome measures show?

The Dementia Care Bundle should be implemented for at all patients admitted with dementia / suspected dementia with a target of 95% reliability. This consists of a This-is-Me document (an essential component of dementia care, which is often over looked), a Butterfly symbol above the bed, on the medical notes and on Extramed. The audit for this care bundle will continue while extramed is still in use, as there is no flag for dementia on EPR.

What do the process measures show?

The dementia care bundle audit is a point prevalence survey of all patients with dementia in-patient on the participating wards on the day of the audit. Large variations can be seen according to the number of people that are admitted.
The results for both the dementia and delirium audits are disheartening. With Covid visiting restrictions relaxed and dementia buddy support to complete the This-is-Me documents the implementation of the document should be considerably higher.

What changes have been implemented and improvements made?

Competency booklets (Care Bundle Knowledge Packs) were distributed to Nursing and Care staff. The aim was to assess levels of understanding and knowledge about dementia and delirium and to meet gaps through training.
The Dementia Buddy co-ordinators can assist with completing This-is-Me documents.
dementia, requires ratification at senior level before it can be introduced – currently awaiting the results of Patient Experience discussion / approval about the scheme.
An on-line This-is-Me being created, to be access externally via the Trust website.
Delirium screening (4AT) and care plan is now on EPR

Domain: Responsive – Non Elective Dashboard

Executive Lead: Jayne Black– Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Bed Management	% Medically Fit For Discharge Point Prevalence in Month	Nov-21	7.0%	14.7%	12.5%	15.6%	18.6%		
		% of Delayed Transfer of Care Point Prevalence in Month	Nov-21	3.5%	2.4%	0.3%	1.3%	2.3%		
		Average Elective Length of Stay	Nov-21	5	2.50	1.47	2.34	3.21		
		Average Non-Elective Length of Stay	Nov-21	5	9.82	7.22	8.53	9.85		
		Bed Occupancy Rate	Nov-21	85.0%	90.0%	78.5%	86.6%	94.6%		
		Delayed Transfer of Care Point Prevalence in Month	Nov-21		412	43.52	202.97	362.42		
		Escalation Beds Open Point Prevalence in Month	Nov-21	0	0	0	0	0		
		Medically Fit For Discharge Point Prevalence in Month	Nov-21		2,540	1,793.89	2,346.64	2,899.39		
	Complaints Management	% Complaints Responded to Within 30 Days	Nov-21	85.0%	40.6%	40.0%	64.6%	89.2%		
		Number of Complaints	Nov-21	41	59	14.50	54.56	94.61		
	ED Access	30 Mins Ambulance Handover Delays	Nov-21	0	958	182.70	593.03	1,003.35		
		60 Mins Ambulance Handover Delays	Nov-21	0	299	0	165.69	364.89		
		ED 12 hour DTA Breaches	Nov-21	0	77	0	24.08	83.82		
		ED 4 Hour Performance All Types	Nov-21	95.0%	71.4%	72.3%	80.8%	89.2%		
		ED 4 Hour Performance Type 1	Nov-21	95.0%	60.2%	60.5%	71.4%	82.3%		
		ED Conversion Rate	Oct-20	20.0%	0.0%	0.0%	0.0%	0.0%		
		Median Time to Ambulance Assessment (15mins)	Nov-21	15	33	7.91	14.14	20.37		
		Median Time to ED Clinician (60mins)	Nov-21	60	62	24.62	37.85	51.07		
		Number of ED arrivals by Ambulance	Nov-21		3,285	2,583.31	3,297.03	4,010.74		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Nov-21	0	1	0	4.44	11.06		
		Operations Cancelled By Hospital on Day	Nov-21	0	14	0	19.69	44.62		
		Urgent Operations Cancelled for the 2nd Time	Nov-21	0	0	0	0.03	0.18		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

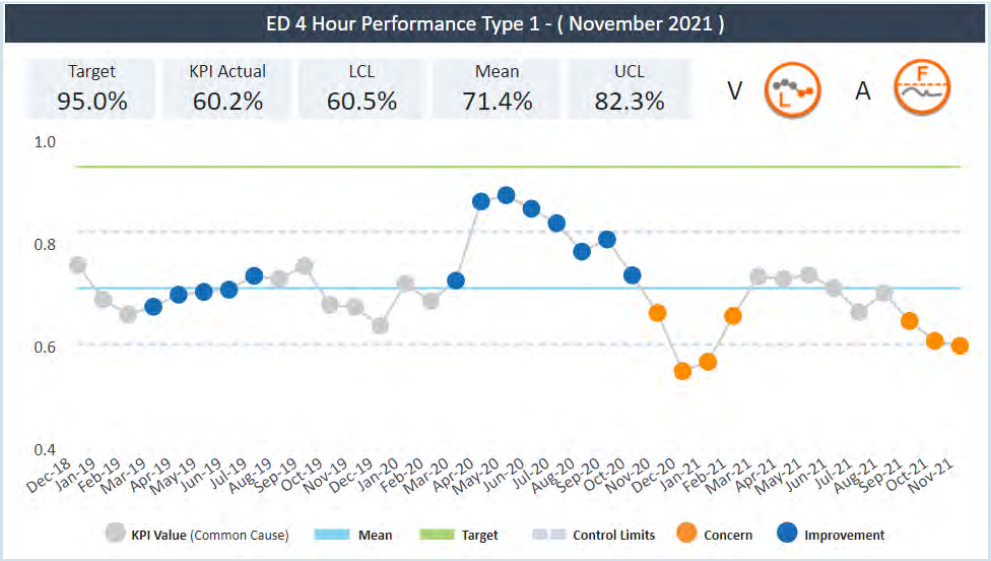
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Oct-21	0	2	0	2.23	5.67		
		Cancer 2ww Performance	Oct-21	93.0%	93.9%	85.4%	92.5%	99.6%		
		Cancer 2ww Performance - Breast Symptomatic	Oct-21	93.0%	86.1%	55.3%	82.6%	109.8%		
		Cancer 31 Day First Treatment Performance	Oct-21	96.0%	96.1%	89.9%	96.2%	102.4%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Oct-21	98.0%	96.2%	89.7%	97.1%	104.6%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Oct-21	94.0%	93.3%	64.6%	90.4%	116.1%		
		Cancer 62 Day Treatment - Cons Upgrades	Oct-21		59.3%	50.3%	76.3%	102.4%		
		Cancer 62 Day Treatment - GP Refs	Oct-21	85.0%	82.1%	54.5%	74.1%	93.8%		
		Cancer 62 Day Treatment - Screening Refs	Oct-21	90.0%	85.1%	17.8%	69.9%	122.1%		
	Diagnostic Access	DM01 Performance	Nov-21	99.0%	82.5%	74.1%	87.8%	101.4%		
	Elective Access	18 Weeks RTT Incomplete Performance	Nov-21	92.0%	66.2%	66.0%	72.5%	79.0%		
		18 Weeks RTT Over 52 Week Breaches	Nov-21	0	145	23.37	138.46	253.54		
		Daycase Rate	Nov-21	85.0%	60.1%	60.7%	67.9%	75.1%		
		DNA Rate	Nov-21	10.0%	8.8%	6.6%	7.6%	8.7%		
		First to Follow Up Ratio	Nov-21		2.89	1.98	2.42	2.86		
		PTL Size	Nov-21	22,477	27,444	20,889.42	22,237.57	23,585.72		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Nov-21	0	1	0	4.44	11.06		
		Operations Cancelled By Hospital on Day	Nov-21	0	14	0	19.69	44.62		
		Urgent Operations Cancelled for the 2nd Time	Nov-21	0	0	0	0.03	0.18		

Responsive: – Non Elective Insights

Executive Lead: Jayne Black– Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - Interim Director of Operations, UIC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low declining position. As the overall attendances increase the performance has continued to decline and is now below the lower control limits

Actions:

- Validate Trust Internal Professional Standards in response to emergency referral and flow and implement across all pathways;
- Improve the escalation in ED regarding compliance with IPS.
- Improve the impact of the regular huddles to enable ED NIC and EPIC to manage ED flow.
- Improve and expedite decision-making for specialty referrals
- Re-introduce the 'refer and move' flow principle to surgical, frailty and medical assessment areas;
- ED patient safety checklist content aligned to ED Nursing documentation (30D)
- Trialling a new staff rota to effectively manage patients in the Department

Outcomes:

- Compliance in 4hr standard for admitted and non-admitted patients
- Total time in department <150mins
- ED IPS compliance
- Reduction in Ambulance handover delays

Underlying issues and risks:

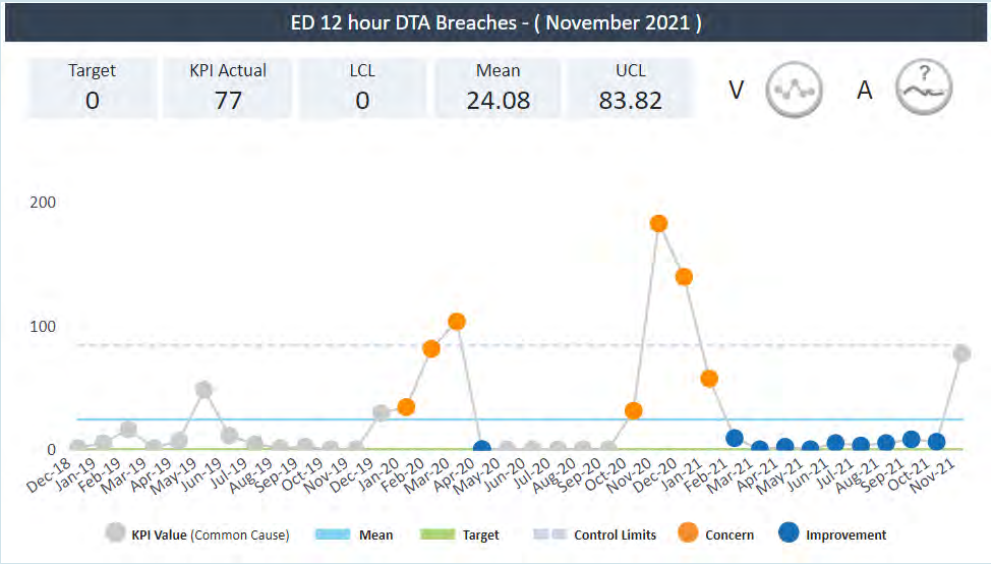
- Need for more clarity re the roles of NIC and
- EPIC in managing ED processes to delivery 4 hour standard.
- Poor overnight processes causing excess admitted and non-admitted breaches between 2100 – 0300.
- Gaps in Senior ED leadership

Responsive: – Non Elective Insights

Executive Lead: Jayne Black– Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - Interim Director of Operations, UIC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

The chart shows an increase in the number of 12 hour DTA breaches in November.

Actions:

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

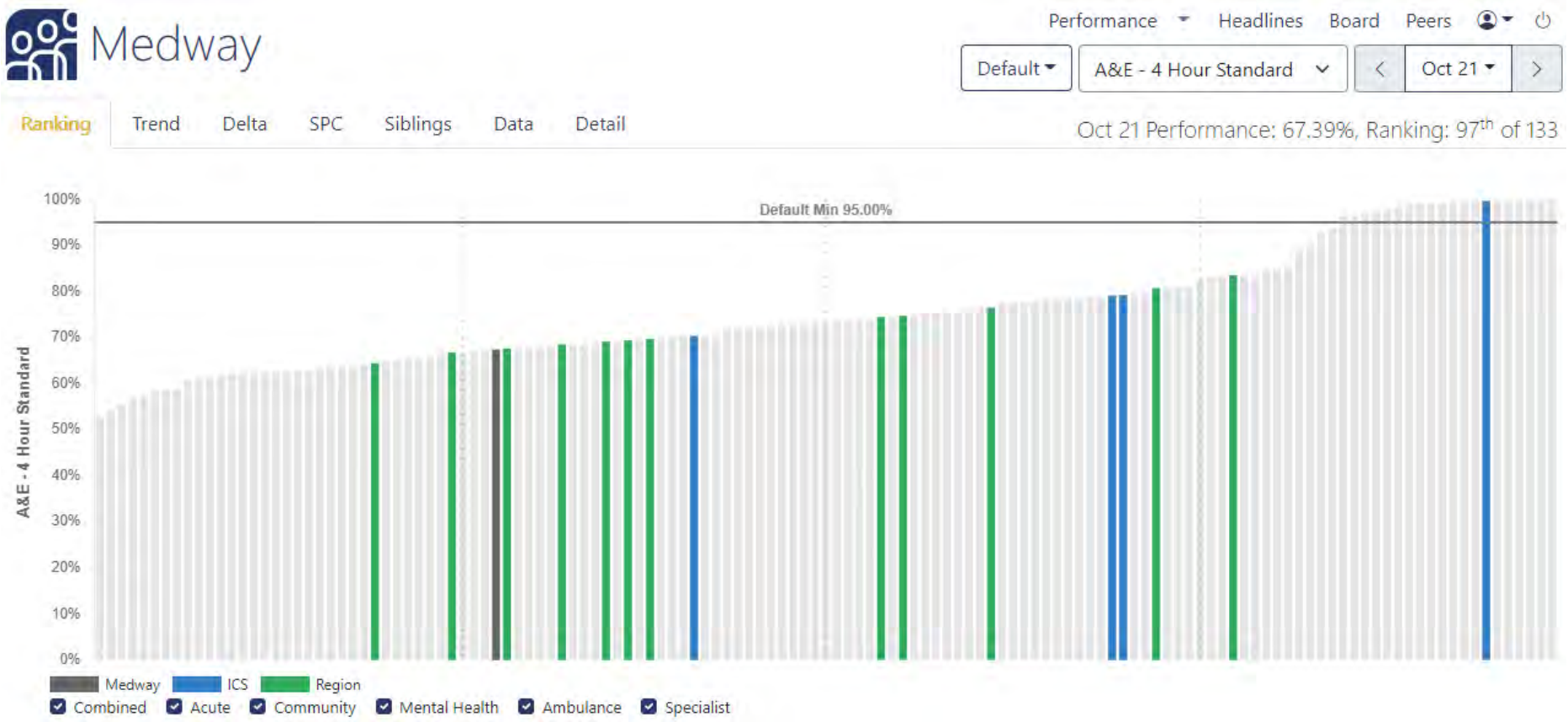
Outcomes:

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

Underlying issues and risks:

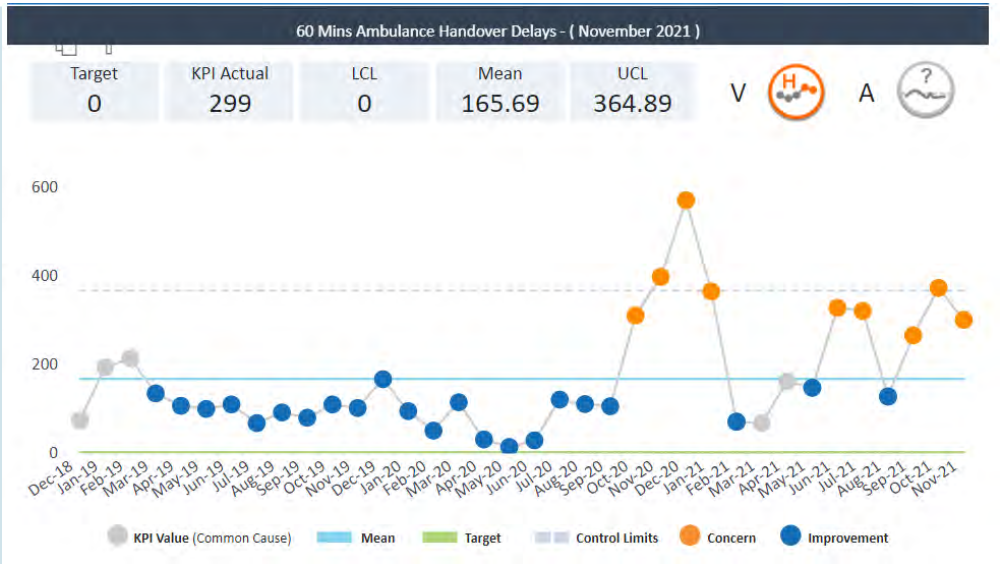
- As COVID numbers increase the complexities of placing patients can cause delays so timely POCT will be key to manage
- Current general and acute adult bed occupancy continues to be over 96% consistently with most mornings beginning the day at 98%

EC 4 Hour Benchmarking



Responsive: – Non Elective Insights	**Executive Lead:** Jayne Black–Chief Operating Officer **Operational Lead:** Shane Morrison-Mccabe - Interim Director of Operations, UIC **Sub Groups :** N/A

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

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

What the Chart is Telling Us:

The chart shows us that delayed handovers did decrease in November.

Actions:

- Continue to use the Acute Care Transformation programme to deliver the improvements and changes relating to effective front-door processes.
- SOP formalised to establish risk mitigated corridor care for use in extremis (risk of very long handover times)
- Additional oversight of operational team in support of clinical team.
- Optimise direct ambulance conveyance to SDEC, SAU and FAU;
- Additional space created to expand RAU.
- Escalation of difficulties at earlier stages (2 over 15mins) to promote early interventions

Outcomes:

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

Underlying issues and risks:

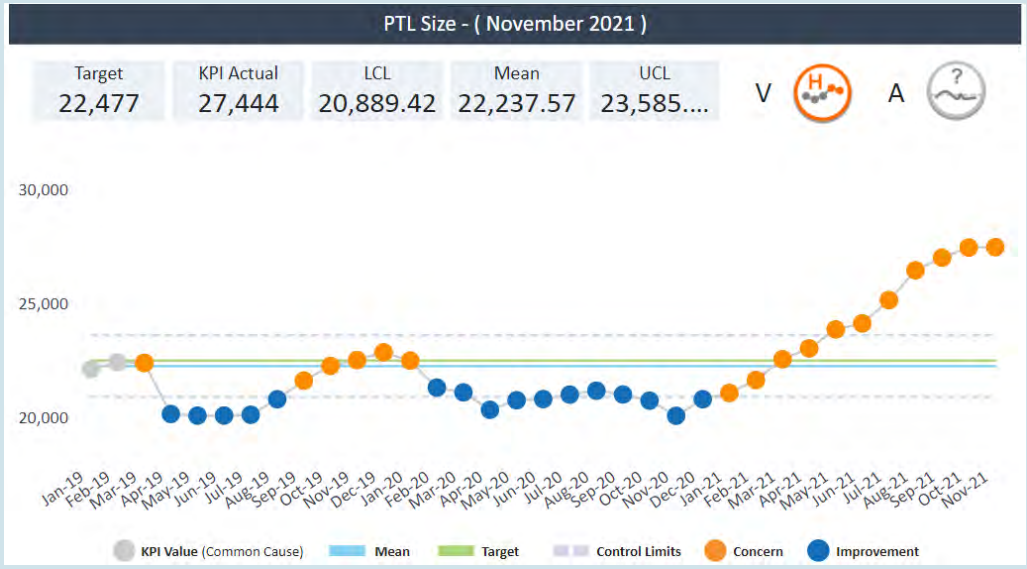
- Workforce and rosters not always in sync with demand.
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Increasing conveyances and limited flow out of ED
- Limited external options for ambulances

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high concerning nature. The increase in PTL size is directly related to the pandemic which impacted elective capacity and continues to exceed nationally expected levels

Actions:

- Review with ICP partners re referral assumptions and adjust trajectory accordingly completed and focus is being shifted to look at alternative pathways
- Extended EBI to be released to stem the flow of referrals in key areas
- Maximise current capacity, including using agreed transformation approaches to keep pace where possible with elective activity.
- Review on the increase of follow up to follow up ratio and whether this is linked to the national drive to virtual appointments

Outcomes:

- Delivery of H2 planning performance targets (phase four guidance) and reduction in outpatient backlogs
- Delivery of 52 week trajectories and reduction in admitted surgical backlogs on target to deliver
- Delivery of DM01 trajectory and management of inpatient and 2ww waiting lists

Underlying issues and risks:

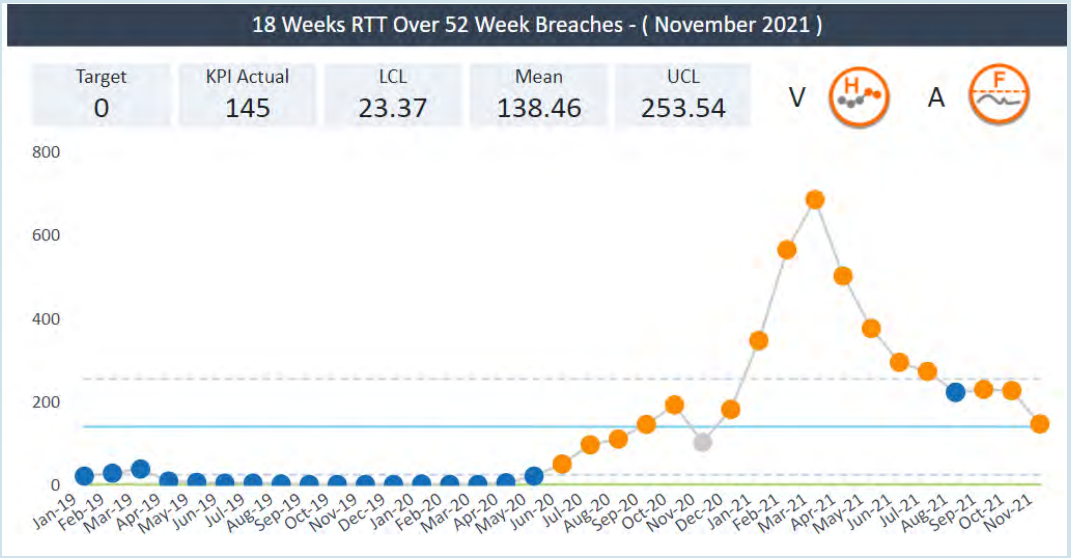
- Suspension of elective activity resulting in reduced clock stops
- Increased sickness absence driven by pressure of work and /or Covid related isolation or illness.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway over 52 weeks.

What the Chart is Telling Us:

Despite the chart showing variation of a high concerning nature the chart actually shows an improving position.

Actions:

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

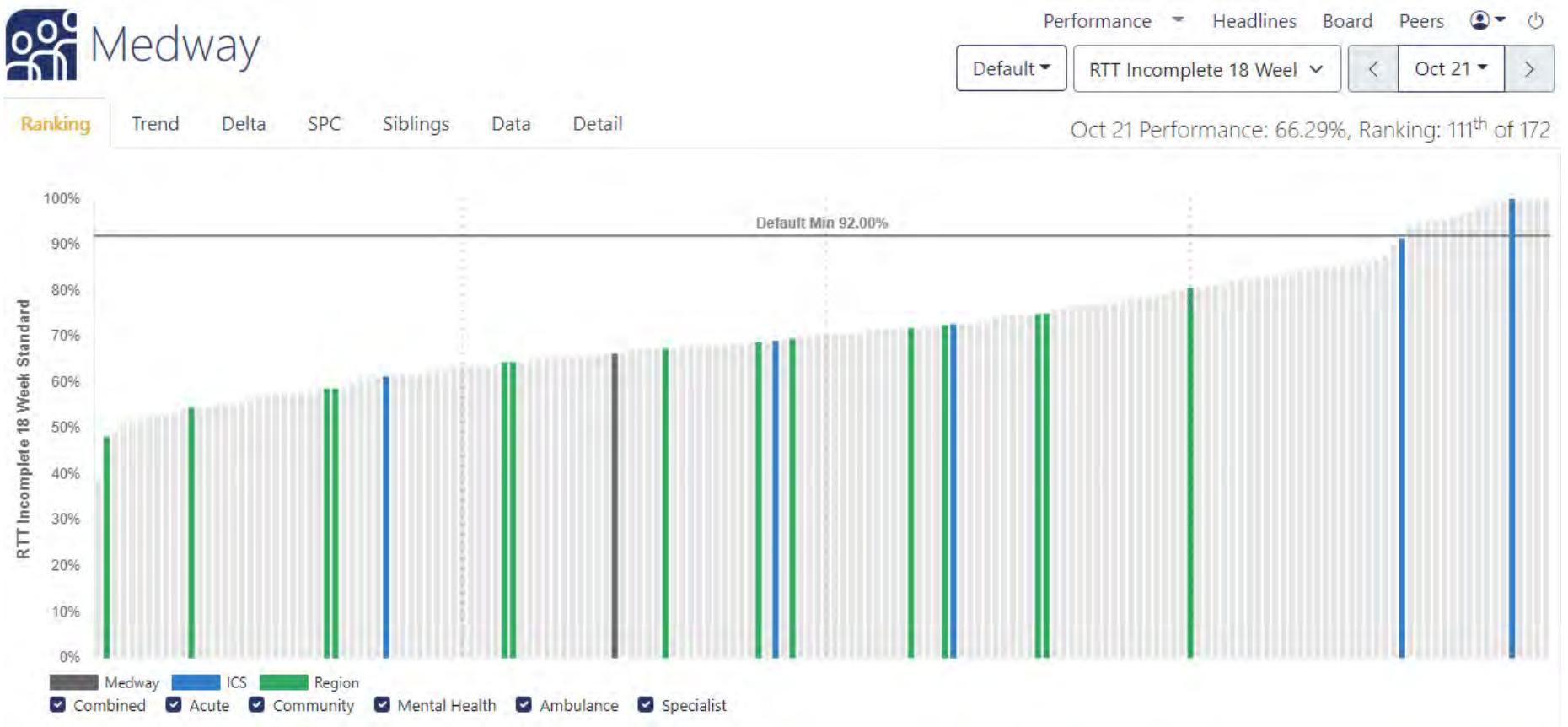
Outcomes:

- Zero capacity related 52-week waiting patients by end of March 2022
- Clarity on patients and treatment in accordance with clinical priority (all patients will have a designated P category)
- All elective patients will be managed via safe green pathway including appropriate isolation and pre-op swabbing.
- Elective capacity will be preserved for as long as possible within the winter and covid planning model.

Underlying issues and risks:

- Ocelot was closed during October due to increasing issues with bed occupancy and NEL demand which has resulted in some Orthopaedic patients dropping into the backlog which was not predicted.
- Growing PTL and impact going into Q4 with an increase in number of patients in the 12-15wk categories

RTT Benchmarking

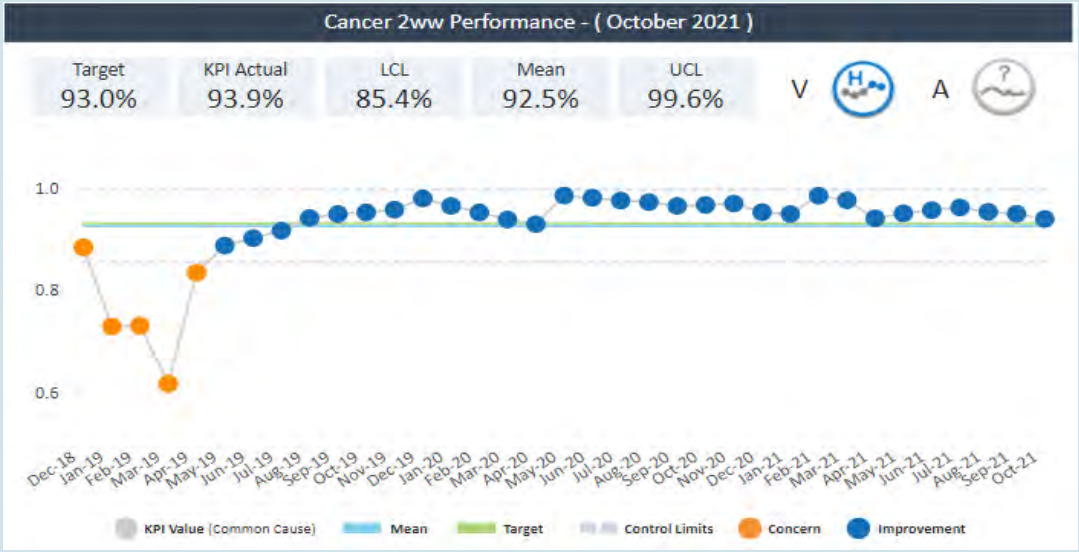


Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

- Trust has remained compliant with this KPI since August 2019
- Weekly referral numbers and day of OPA shared with each service.
- Regular meetings with Service Managers ensure that there is adequate capacity to facilitate demand.
- Internal Stretch target of 7 Days is now being achieved by a number of specialties on a regular basis
- Work continues with primary care to ensure referrals are sent on appropriate pathways.

Underlying issues and risks:

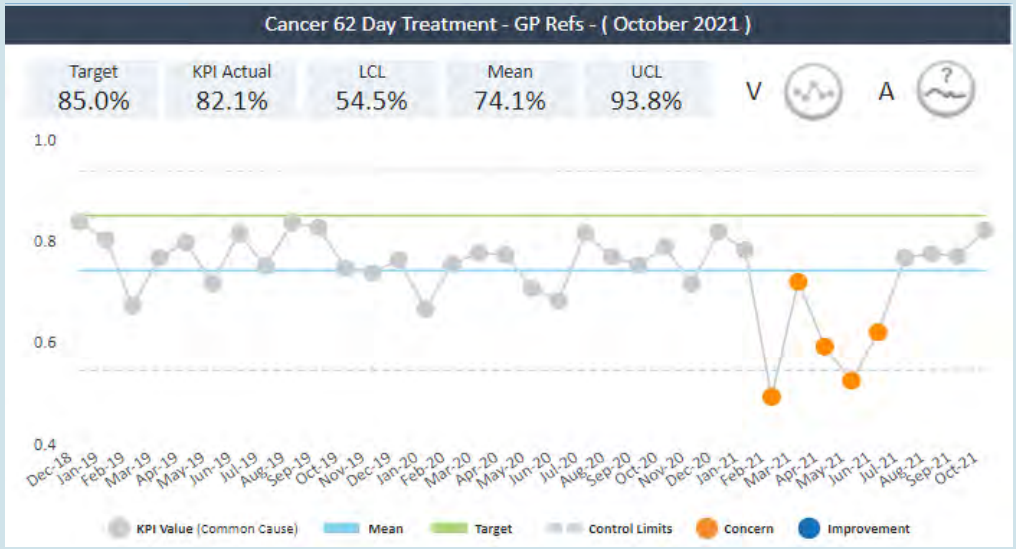
- Capacity issues in the breast unit for the high demand of cancer referrals.
- Outpatient clinic capacity challenged as referral numbers in general are increasing.
- A further wave of Covid impacting on service provision.

Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

The proportion of patients urgently referred by GPs/GDPs for suspected cancer and receive their first treatment within 62 days of referral.

What the Chart is Telling Us:

The chart shows that there has been no special cause variation. However when place alongside the improvement trajectory on next slide the performance continues to improve ahead of trajectory, and November data is showing an improvement to 87%

Actions:

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

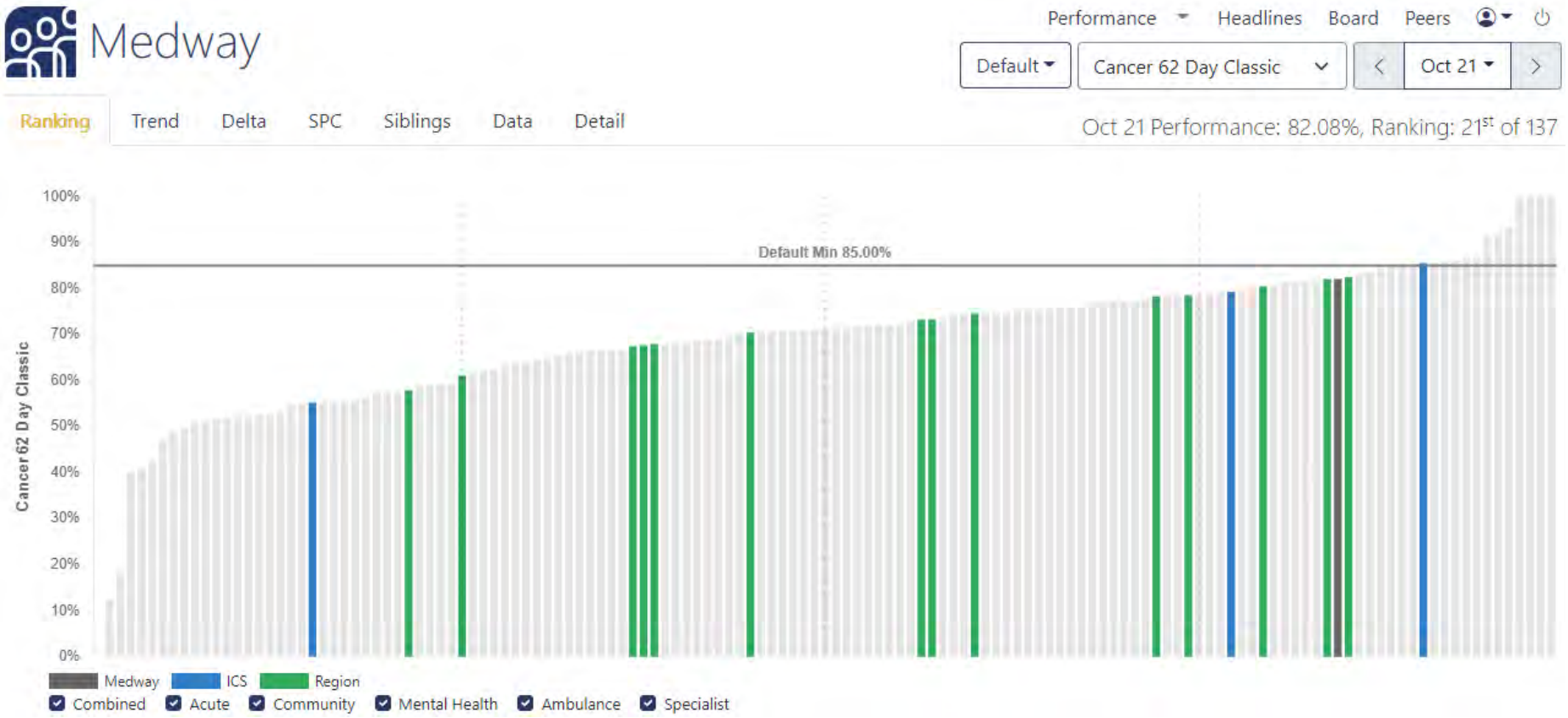
Outcomes:

- Confirmed Cancer patients are being identified on the PTL much earlier in the pathway.
- More patients being investigate d via “faster diagnostic” pathway.

Underlying issues and risks:

- Capacity issues in endoscopy for the high demand of cancer referrals.
- Patients remains reluctant to attend for diagnostics or treatment.

Cancer 62day Benchmarking



Domain: Well Led – Dashboard

Executive Lead: Alan Davies – Chief Financial Officer & Leon Hinton – Chief People Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

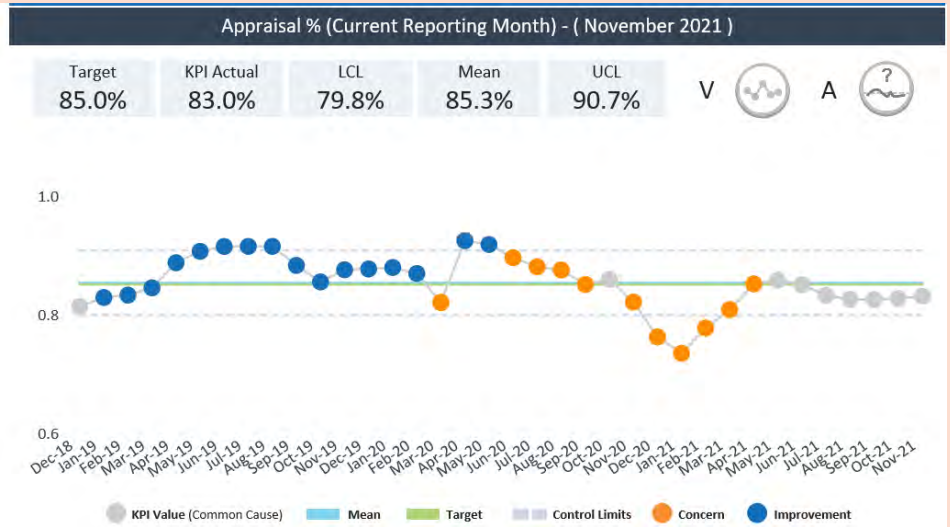
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Financial Position	Capital Spend Vs Plan	Mar-20	0.0%	0.0%	0.0%	16.9%	38.1%		
		Cash Actual (in £m)	Mar-20	1.40	0	0	7.05	17.18		
		Cost Improvement Plans (CIPS) - Var to Plan YTD (in £'000)	Mar-20	0	0	0	150,750	381,992.67		
		Liquidity Ratio	Mar-20	2	0	0.06	0.18	0.29		
		Overall Underlying Financial Surplus / Deficit (in £m)	Mar-20	0	0	0	-12.09	0.82		
		Variance from Plan	Mar-20	0.0%	0.0%	0.0%	-1.2%	11.7%		
	Staff Experience	Staff Friends & Family - Recommend Care of Treatment	Mar-21	79.0%	74.0%	3.5%	32.4%	61.4%		
		Staff Friends & Family - Recommend Place to Work	Mar-21	62.0%	63.0%	1.4%	25.5%	49.6%		
	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Nov-21	4.0%	0.0%	1.4%	3.0%	4.7%		
		Agency Spend as % Paybill (Financial Year YTD)	Nov-21	4.0%	1.7%	2.5%	3.4%	4.3%		
		Appraisal % (Current Reporting Month)	Nov-21	85.0%	83.0%	79.8%	85.3%	90.7%		
		Bank Spend as % Paybill (Current Reporting Month)	Nov-21	9.0%	12.4%	8.4%	13.0%	17.5%		
		Bank Spend as % Paybill (Financial Year YTD)	Nov-21	9.0%	6.1%	11.1%	12.6%	14.1%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Nov-21		4,321	3,937.71	4,014.78	4,091.85		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Nov-21	2.5%	2.3%	1.8%	2.3%	2.9%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Nov-21	1.5%	2.7%	1.7%	2.0%	2.3%		
		Sickness Rate (Current Reporting Month, FTE%)	Nov-21	4.0%	5.0%	3.3%	4.6%	5.8%		
		StatMan Compliance (Current Reporting Month)	Nov-21	85.0%	89.8%	86.2%	88.4%	90.5%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Nov-21	75.0%	0.0%	50.0%	66.4%	82.9%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Nov-21	12.0%	13.0%	11.5%	12.3%	13.1%		

Well Led: Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

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

What the Chart is Telling Us:

The SPC data variation indicates common cause – no significant change. Assurance indicates inconsistently hitting, passing and falling short of the target.

Actions:

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

Outcomes:

2920 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 3519).

This data has been refined to now only report on those who would be within appraisal periods (so excludes any colleagues who are within their first 12m of employment at MFT)

Underlying issues and risks:

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

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	30,938	32,302	1,363	253,317	255,233	1,916
Pay	(19,924)	(20,555)	(631)	(158,012)	(161,398)	(3,386)
Total non-pay	(9,615)	(10,296)	(680)	(83,846)	(82,343)	1,503
Non-operating expense	(1,407)	(1,459)	(52)	(11,523)	(11,555)	(32)
Reported surplus/(deficit)	**(8)**	**(8)**	**0**	**(64)**	**(64)**	**0**
Donated Asset / DHSC Stock Adj.	9	8	(1)	65	64	(1)
Control total	**1**	**0**	**(1)**	**1**	**0**	**(1)**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Efficiency Programme	613	255	(358)	2,717	2,542	(175)	5,171
Capital	877	644	(233)	10,591	8,099	(2,492)	19,274

Indicator Background:

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

What the Chart is Telling Us:

The Trust has reported breakeven for the year to date. The efficiency programme is £175k adverse to budget, main schemes include ERF income, procurement, closing theatre 5, pharmacy and FYE of 20/21 schemes. Capital spend is £2.5m behind the budgeted plan, although mainly due to timing issues and expected to recover.

Actions:

- Financial Recovery Plan Director appointed and taking forward programme of work.
- Implement "grip and control" processes to both ensure that costs are being managed robustly as well as to further develop the information base from which the financial plan must be derived.
- Further work with operational services to develop achievable efficiency plans.

Outcomes:

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

- Pay expenditure has increased by £0.6m to £20.6m due to increased escalation capacity, PAHU, enhanced rates for bank staff and temporary cover for staff sickness
- Incremental costs associated with Covid-19 of £3.2m year to date, £0.3m in month.
- H2 ERF Income has been agreed at £4.4m.
- There is no contingency reserve included.

Underlying issues and risks:

The financial position is monitored against the plan submitted to NHSE/I for Oct-Mar (H2). The risks identified with the financial position for the 2nd half of the financial year ahead include managing cost pressures & service developments, delivery of efficiencies targets, managing the incremental cost of elective recovery and Covid costs within the financial envelope for H2, escalation capacity and PAHU, as well as winter pressures. The efficiency programme continues to be closely monitored, as well as the use of benchmarking tools to drive proposed efficiencies.

Meeting of the Board of Directors in Public

Wednesday, 12 January 2022

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.2
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 21 December 2021		
Lead Director:	Evonne Hunt, Chief Nursing and Quality Officer (Interim)		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Quality report (including incident backlog update) The Committee received the quality report, which provided an update on progress for the month of November, and delivery on the Trust's CQC Action plans for ED and IPC, CQC information requests, quality assurance visits, patient safety issues, implementation of the quality strategy and clinical effectiveness. The Committee were advised that 4 CQC showcase events have taken place (surgery, critical care, outpatients and maternity). The other planned CQC showcase forums and some quality assurance visits have been cancelled due to operational pressures and rise in COVID numbers, these will be rescheduled in the New Year. The Committee were informed of the desktop approach undertaken by the divisional governance and corporate governance teams and clinical and non-clinical staff to get the back log of incidents removed. The Committee congratulated the teams for clearing the backlog, and were provided with assurance that processes are in place to stop further back logs building up.	**Amber\Green**

2. Infection Prevention and Control Update The Committee were informed that Stephanie Gorman, Head of Nursing has been appointed to the role of Head of Infection Prevention and Control. The Committee received an update of the work taking place to maintain patient and staff safety, enhancing the 2 meter distancing within wards and departments, and changes to patient visiting times; along with key messages to reinforce infection control practices.	**Amber/Green**
3. Safeguarding quarterly report The Committee received the safeguarding quarterly report, which provided a comprehensive update on the work of the Adult and Children's safeguarding teams.	**Amber/Green**
4. Mental Health services at MFT The Committee received the Mental Health Services at MFT paper which provided an update on the current position relating to patients with mental health needs receiving care at the Trust, including Paediatric inpatients, and adults with mental health issues attending ED and inpatients on wards. The paper described the actions and work being undertaken to mitigate risk and improve the environments and experience for these patients, and proposed the adoption of the CQC Mental Health service standards.	**Amber/Red**
5. Safe Discharges The Committee received a comprehensive update on the ongoing work on safe discharges which forms part of the larger flow and discharge programme. The Committee will receive a paper covering the wider discharge programme at the January meeting.	**Amber/Green**
6. CNST safety actions 2, 3, & 4 The Committee received the CNST safety actions 2, 3 and 4 which provided an update of the compliance status of the safety actions. The Committee approved the action plan.	**Amber/Green**
7. End of Life Care quarterly report The Committee received the End of Life Care quarterly report which provided an update on the work of the End of Life Care team for the reporting period. The Committee were informed that the 2 CQC actions for End of Life Care have been closed. These actions related to access to end of life care training and capacity to deliver the training. The Committee discussed the need to make end of life care part of mandatory training. The team have undertaken quality improvement training on wards to raise awareness of the Dandelion Care Bundle and have 27 end of life care champions across the Trust. The Committee discussed provision of a 7 day service, which had been paused during COVID, and the need for staff on wards to have better knowledge and understanding of supporting death and dying so that specialist nurses are not always required to see every dying patient. The Committee were informed of a joint workshop planned for the new year with the End of Life Care team and the Palliative Care team from Medway Community Healthcare which will look at how both organisations work together to provide end of life care to our patients.	**Green**
8. Analysis on in-patient survey	**Red/Amber**

The Committee discussed the analysis from the in-patient survey and acknowledged the work that is needed to improve the Trust's position across a number of areas. The Committee were informed about benchmarking with other Trusts and how the results from the survey will form the basis of the patient experience strategy. The Committee will receive the draft patient experience strategy at the January meeting.	
9. CQC Well Led Core Service CQC action plan The Committee were advised that following a review of the CQC action plan it has become evident that a number of deadlines have breached and not all the actions have been closed down. The new process that have been put in place to address this was explained to the Committee who welcomed the streamlined approach. The Committee will receive an update on the CQC action plan at the next meeting	**Amber/Green**
10. Quality IQPR The content of the quality IQPR was noted and the committee acknowledged the discussion that had taken place at the Trust Board last week on these metrics.	**Green**
11. Risk report The Committee received the first risk report to the meeting which incorporated the BAF quality risks and quality and nursing risks on the Corporate Risk Register. The Committee were advised of the review of the BAF risks 5a, 5b and 5c which resulted in a proposed reduction to the risk ratings. The Committee approved the recommendations to reduce the risk ratings to go to Trust Board for approval.	**Green**
12. Quality and Patient Safety Group – key issues report The committee noted the key issues report from the quality and patient safety group.	**Green**
Escalation to Board The Committee escalates the following to Trust Board:- • Mental health quality of care for patients in our care • In-patient survey results • Discussion on the BAF quality and reduction to risk ratings. • The business case proposal for a 7 day service for End of Life Care • CQC Well Led Core Services Action Plan – change in approach and actions proposed to clear delays.	

Meeting of the Trust Public Board
Wednesday, 12 January 2022

Title of Report	**2019-2020 Annual Safeguarding Report and Maternity Safeguarding Report**	Agenda Item	3.4
Lead Director	Evonne Hunt, Chief Nursing and Quality Officer (interim)		
Report Author	Bridget Fordham, Head of Safeguarding Cheryl Herbert, Named Midwife		
Executive Summary	This report provides an update on safeguarding progress and achievements during 2020/21 and demonstrates assurance of meeting our statutory duties. 2020-21 has been challenging for everyone during the pandemic, however we have continued to see growth in our activity across all areas of safeguarding and progress towards the recommendations from the Safeguarding Governance Review.		
Due Diligence	To give the Board assurance, please complete the following:		
Quality Assurance Committee Approval:	Date of Approval: 19 October 2021		
Resource Implications	Nil		
Legal Implications/ Regulatory Requirements	The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. The Mental Capacity Act 2005 sets out a legal framework which is supported by The Code of Practice. The Children Acts 1989 and 2004 section 47 requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm. These can only be discharged with the full cooperation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004. Working together to Safeguard Children 2018 is a new statutory guidance to ensure partnership working of agencies to Safeguard and promote the welfare of children.		
Quality Impact Assessment	None		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒
Appendices	Safeguarding Report 2020/21 Maternity Safeguarding Report 2020/21		

NHS
Medway
NHS Foundation Trust

Annual Safeguarding Report 2020-2021

Bridget Fordham - Head of Safeguarding

03 SEPTEMBER 2021

Best of care
Best of people

Contents

1 EXECUTIVE SUMMARY

1.1 Medway Foundation NHS Trust is committed to ensuring safeguarding is considered core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for collaborative working between partner agencies and professionals.

1.2 Medway Foundation NHS Trust is committed to working in partnership with carer's, agencies and staff to ensure that children and adults at risk in our care are identified early and protective measures implemented to protect them.

1.3 The purpose of this report is to provide an overview of safeguarding activity during 2020/21 and provide an update on safeguarding progress and achievements during 2020/21 and demonstrates assurance of the execution of our statutory duties.

1.4 The Children Acts 1989 and 2004 set out specific duties:

1.5 Section 17 puts a duty on the local authority to provide services to children in need in their area, regardless of where they are found;

1.6 Section 47 requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm, these can only be discharged with the full cooperation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004.

1.7 Under section 10 of the same Act, the local authority is under a duty to make arrangements to promote cooperation between itself and organisations and agencies to improve the wellbeing of local children. This co-operation should exist and be effective at all levels of an organisation, from strategic level through to operational delivery.

1.8 Section 11 of the Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The Trust is required to undertake section 11 audits to evidence compliance with this statutory duty.

1.9 Working together to Safeguard Children 2018 is statutory guidance to ensure partnership working of agencies to Safeguard and promote the welfare of children.

The purpose of the guidance is stated as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent
- with the provision of safe and effective care

- taking action to enable all children to have the best outcomes

1.10 The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

1.11 The Mental Capacity Act 2005 sets out a legal framework which is supported by the Code of Practice to protect the rights of those unable to make decisions for themselves.

2 SAFEGUARDING CHILDREN

2.1 Training

The training compliance remains very good across all 3 levels of safeguarding children (SGC) training, especially in the face of the pandemic. Unfortunately, all face to face safeguarding training was cancelled from 16th March 2020 due social distancing measures introduced by the government in March 2020.

All training moved to eLearning and the courses used have been approved by NHS E. Staff have also been given the option to complete online training or through the Microsoft Teams platform via the Medway Safeguarding Partnership website. All training is compatible with the intercollegiate document for children and young people (2019) which stipulates the knowledge, skills and values the various levels of training should contain. The training strategy has been reviewed and updated to reflect the current arrangements.

Quarter	Level 1 SGC	Level 2 SGC	Level 3 SGC
Quarter 1	97%	92%	82%
Quarter 2	97%	91%	82%
Quarter 3	97%	92%	85%
Quarter 4	97%	92%	85%

2.2 Safeguarding Children Activity

The safeguarding team continues to work closely with our partner agencies in the completion of section 47 and section 17 enquiries for our social work colleagues. This entails the safeguarding team to share relevant key information that MFT holds regarding children and their family. Section 47 and section 17 enquiries are for children who are subject to open investigations and assessments. This has been an increase to the workload of the safeguarding team without extra resource to meet this demand from the requirements of Statutory Guidance “Working Together to Safeguard Children” (2018) and the recent development of the Multi Agency Safeguarding Hub (MASH) team.

2.3 When a MASH enquiry is received, the safeguarding administrators check the emergency department and both in and out patient systems for any information MFT may have on each family member. They populate the form with this information and send it to a safeguarding practitioner for analysis. Please see

table below showing the extent of resources utilised in order to meet this statutory duty.

Quarter	Mash requests per family received	Number of individual checks are made
Quarter 1	562	2000
Quarter 2	481	1698
Quarter 3	426	1464
Quarter 4	440	1554
Totals	1909	6716

2.4 The safeguarding team also attends strategy meetings, professional meetings and discharge planning meetings to ensure the children known to us or in our care are safeguarded appropriately.

2.5 On a daily basis, all children who access services within both our children's wards and children's Emergency Department are routinely checked through multiple systems to recognise those children who are identified as vulnerable children. This information is liaised daily (Monday – Friday) to relevant external health and educational agencies. Direct liaison with external agencies is a standard practice within all areas where a concern for a child or young person has been identified.

2.6 Please see table below for a monthly list of children's attendances that demonstrates the impact of Lockdown restrictions, with reduced Children's emergency department (ED) attendances for April, May and June whilst we were in the first lockdown. Then in July, August, September and October as lockdown restrictions were lifted you can see children's ED attendances increased. However, the attendances then reduced back down from November as Covid -19 cases started to rise again and lockdown measures were reintroduced. These low attendance figures were concerning.

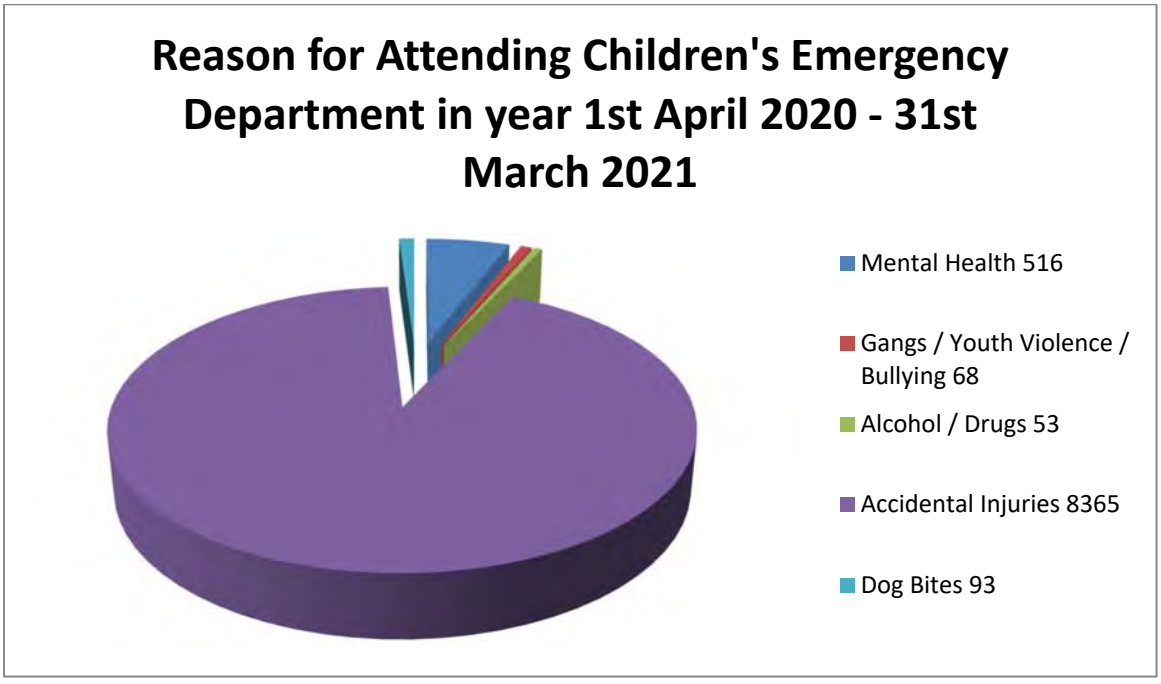
2.7 The current social distancing measures mean that children living in difficult circumstances have reduced access to the safety net of regular contact with education, health and social care professionals. This may have an impact on the number of vulnerable children experiencing neglect or maltreatment; in the same way increases in domestic violence are being reported in media (Isba et al 2020 and NSPCC 2020).

Month	Attendances at Children's Emergency Department
Q1 April 2020	1019 1st national lockdown beginning
Q1 May 2020	1534
Q1 June 2020	1743
Q2 July 2020	1974
Q2 August 2020	2052 1st lockdown restrictions lifted
Q2 September 2020	2505
Q3 October 2020	2055 Kent and Medway placed in Tier 1 restrictions (the lowest tier)

Q3 November 2020	1714 2nd national lockdown beginning
Q3 December 2020	1306 National lockdown ends but Kent and Medway are placed in Tier 3 restrictions and then later in the month Tier 4 restrictions.
Q4 January 2021	1204 3rd national lockdown beginning
Q4 February 2021	1262
Q4 March 2021	2260 3rd national lockdown restrictions begin to ease
Total number of children	20628

2.8 All children have been checked using the Child Protection Information Sharing national system (CP-IS). This has identified 513 children who are either on a child protection plan or are a looked after child (LAC) both within Kent and Medway and out of area.

2.9 The paediatric liaison nurse continues to share information with our primary care partners. As part of Facing the Future: Standards for children in Emergency Care Settings (RCPCH 2018); there is a requirement for Robust systems to inform the primary care team about each child's attendance at an emergency care setting. This should include the GP, community midwife, health visitor or school nurse. Therefore, Children's ED attendances are now screened by the safeguarding children's liaison nurse, utilising a rag rating system as detailed in the standard operating procedure 'Safeguarding communication agreement with partner agencies', which is available on Q pulse. All priority attendances are shared with health visiting/ school nurse service in full via secure email on the next working day. General attendances are also shared on the next working day, however only a summary is shared with partner agencies.



2.10 Secondary to accidental injuries, children and young people's mental health remains the biggest area of concern. Please see table below for a quarterly breakdown of mental health attendances.

Quarter for year 2020 - 2021	Number of children presenting at ED with mental health concerns
Quarter 1	114
Quarter 2	138
Quarter 3	141
Quarter 4	123
Total number of children	516

2.11 The lockdown restrictions have been in place for most of the year 2020 – 2021. NSPCC (2021) suggest the pandemic has affected everyone's mental wellbeing, particularly vulnerable groups such as children. Children and young people may feel worried or anxious about different things. Beyond the virus, there has been the interruption of the normal school routine, suddenly spending most of their time indoors and no longer regularly seeing family and friends. Children may also experience someone close to them, such as a family member, carer, friend or teacher who became seriously ill or were dying. This can cause feelings of sadness, loss and grief.

2.12 The number of children in recorded gang activity is broken down into knife, stab or gunshot wounds as per national reporting requirements. Kent and Medway safeguarding children procedures (online) are followed and all gang activity is reported to the police. Please see table below for a breakdown of all children presenting with youth violence.

Quarter for year 2020 - 2021	Number of children presenting at ED with youth violence
Quarter 1	9
Quarter 2	23
Quarter 3	23
Quarter 4	13
Total number of children	68

2.13 <u>Multi Agency Working</u>

The Named Nurse for safeguarding children completed the biannual section 11 self-assessment audit tool. The self-assessment tool aims to assess the effectiveness of the arrangements for safeguarding children. The tool assesses the Trust against the key features as set down in the Statutory Guidance on Making Arrangements to Safeguard & Promote the Welfare of Children under Section 11 Children Act 2004. The table below demonstrates the areas we have been unable to provide the Medway Safeguarding Children's Partnership (MSCP) full assurance for as the MSCP believe that an agreement was reached previously to ensure that staff working directly with children would have a 3 yearly DBS check.

Name of	Action	Outcome	Timescale	Progress

person responsible				
Chief People Officer	The organisation has in place arrangements to monitor and review their recruitment and selection policies in line with national guidance including DBS.	DBS checks are carried out on all new staff before a letter of final acceptance is sent. There is no legal requirement for employers to undertake periodic checks. The Trust complies with national guidance, but does not currently comply with the local Safeguarding Partnerships expectations that DBS checks should be completed on staff every 3 years	ASAP	This has been pushed back to the partnership to identify and benchmark against other providers.
Chief People Officer	Safer recruitment e-learning to be added to all recruiting manager ESR profiles	For all recruiting managers to undertake safer recruitment training	September 2020	14/10/20 OPD have provided a link to MSCP safer recruitment e-learning training. 16/04/21 Safer recruitment training has now been signed off by the board as essential training. This action has also been picked up as part of the safeguarding governance review and is overseen by the Chief People Officer.

2.14 The Children's safeguarding team continues to work very closely with our multi-agency partners including Health, social care, police and education as per Working Together Statutory Guidance (2018). In order to provide current data regarding the health and wellbeing of the children and young people of Swale and Medway, we continue to provide key performance indicator data to support local service development to the Kent and Medway clinical commissioning group.

2.15 When a child dies or is seriously harmed representatives from the local safeguarding children's partnership will consider the referral against the criteria for a rapid review or whether multi-agency or single agency learning processes are more appropriate. The purpose of the rapid review is to gather facts about the case, discuss whether there is any immediate action needed to ensure the children's safety, share learning appropriately, consider the potential for identifying improvements to safeguard, promote the welfare of children and decide on next steps. This year has seen 9 requests for a rapid review from both

Kent Safeguarding Children Multiagency partnership (KSCMP) and Medway safeguarding children partnership (MSCP). Of these 9, 5 were known to the Trust.

2.16 More detailed information will be sought if the rapid review concludes the case has potential to identify national or local learning. In England, child safeguarding practice reviews (previously known as serious case reviews) should be considered for serious child safeguarding cases where abuse or neglect of a child is known or suspected and a child has died or been seriously harmed. This may include cases where a child has caused serious harm to someone else.

There are 2 types of reviews:

Local reviews – where safeguarding partners consider that a case raise issues of importance in relation to their area.

National reviews – where the Child Safeguarding Practice Review Panel considers that a case raises issues which are complex or of national importance.

The Panel may also commission reviews on any incident(s) or theme they think relevant. A Child practice review is conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children. This is as per Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2018).

2.17 All learning from rapid reviews and child practice reviews are shared with the relevant department, either through attending paediatric governance meetings, children's ED governance meetings, safeguarding operational group and the safeguarding assurance group. In addition global communications emails are sent out to all staff highlighting learning. Learning is also reinforced during supervision and via ad hoc telephone advice giving if appropriate.

2.18 There are some outstanding actions from child practice reviews and sexual health audit for MSCP which we are continuing to work towards. Please see table below.

Case	Action	Evidence
SCR "F" – published 28.01.2020 And as a result of the sexual health audit	MFT to develop a MDT paediatric/ gynaecological approach for assessment and response to sexual activity and harmful sexual behaviours	This was agreed in the paediatric governance meeting, however this has not been formalised and has been further delayed by the pandemic. There is evidence of collaborative working between paediatrics and gynecology but no formal pathway to provide robust external assurance
Sexual Health Audit	Routine enquiry regarding sexual behaviours needs to be encompassed within the paediatric assessment	20/04/21 The Named Nurse has met with the Matron on Children's ward areas. She will look

	pro-forma	at how to incorporate the safeguarding assessment that ED use on her triage pro-forma and ward admission form.
SCR Baby H – published 18.03.2021	All midwives will receive regular robust safeguarding supervision from a suitably trained and recognised supervisor.	The lead midwife has attended safeguarding supervision training and is attending team meetings for quarterly supervision to offer supervision for all community teams. Team connect will undertake safeguarding supervision Training in October 2021
Learning Lessons "Smith family"	To ensure midwifery DNA checklist is in line with MFT Was Not Brought guidance / DNA policy	A 'was not brought' audit has been undertaken. The lead midwife for safeguarding has amended the midwifery DNA checklist policy to be in line with Was Not Brought guidance

2.19 This year has seen an increase in children who are suspected of suffering from fabricated or induced illness (FII). The increase has prompted the safeguarding team to start reporting on FII cases from quarter 3. FII is a rare form of child abuse. It happens when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child. In quarter 3 and 4 there were 5 FII cases. The safeguarding team has taken the lead with 4 of the cases and has amalgamated lengthy chronologies from multi agency partners to get a better understanding of all the health appointments the children have attended, along with investigations.
In all cases the safeguarding team worked closely with the consultant paediatricians and 2 of the children have received a formal diagnosis of FII. For one child, the plan is for social services to go to court and request a mother and child placement. For the other child the plan is to go to initial child protection conference and public law outline. An expert paediatrician and psychologist in FII will be commissioned by social services to assess the family. Where the other 2 cases did not receive a formal diagnosis of FII, the children were already known to social services for other reasons. The cases remain ongoing and the safeguarding team acts as a point of contact regarding health information from other agencies, so the information from the parent can be verified with the relevant health Trust. Parents are now aware this is happening. The other FII

case was being managed by a community Trust and the safeguarding team provided a chronology of contact.

2.20 In quarter 1 we had a case where Stage 3 of the professional disagreement policy was utilised with support from the CCG regarding a child with a learning disability and mental health concerns who had been an inpatient on the ward for 27 days and the child would have been resident on the children's ward for 41 days by the time the placement was ready. The escalation was successful as a plan was drawn up and the child was discharged home with support in place until the placement was ready.
From quarter 4 the safeguarding team has started collecting data on the children who are medically fit for discharge, but are waiting for a suitable placement to be found. The named nurse has requested this information is reported quarterly to the MSCP's performance management quality assurance (PMQA) sub group going forward from quarter 1 2021.

In quarter 4, there were 3 cases where children were fit for discharge but were staying on the ward as they were waiting for a suitable placement to be found. The first child was admitted to Dolphin ward and discharged to a placement 71 days later. The child was waiting for a tier 4 mental health placement and was sectioned under section 3 of the Mental Health Act. This child was refusing to eat and as part of the mental health plan from the consultant psychiatrist from North East London Foundation Trust (NELFT) who provides the Child and Adolescent Mental Health Service (CAMHS) in Kent and Medway, Trust staff had to occasionally use restraint to ensure a naso gastric tube was passed so the child would eat.
Both Trust and NELFT legal services were involved to ensure staff were acting appropriately and legally. This case highlighted the importance for paediatric nursing staff to have restraint training and identified the restraint policy needed to be updated to incorporate guidance from the Royal College of Nursing and NICE guidance on restraint. The training has now been rolled out and staff have now been trained in restraint.
The second child was admitted to Dolphin ward and was discharged to a tier 4 mental health placement after being on the ward for 77 days. In both cases there have been daily telephone calls between Trust staff and NELFT who provide the CAMHS in Kent and Medway. This child unfortunately attempted to take her own life whilst in our care. The staff were following the care plan as detailed by NELFT. However, after the incident, the paediatric staff reviewed the care plan and made necessary adjustments to keep the child safe from harm. This child is under s3 of the Mental Health Act. The third child was voluntarily admitted to the ward following an overdose. The child was discharged to a tier 4 mental health bed after being on the ward for 16 days.

2.21 In addition to the ward attenders there was a 10 year old child who presented in Children's emergency department (CHED) and was discharged home the next day having spent 21 hours in CHED. The child was brought in by carers from a residential placement for children who have suffered trauma and was known to an out of area social services looked after children team. The child was displaying

aggressive behaviours towards other children and staff at the placement. Staff were concerned for her mental health and brought her to CHED. The child was reviewed by CAMHS who advised there was no role for them as the concerns were behavioural and not mental health. The placement then refused to take the child home as the child's care plan stated the Trust is a place of safety for the child. A plan was made to admit the child to Dolphin ward if a placement could not be found. However, the managers of placement agreed to take the child home. Unfortunately the child returned to CHED the following day as she was being destructive to herself and property. She was restrained by care home staff. Another placement was found in her home authority and she left CHED after nearly 24 hours for this attendance. As a result of this case, the Head of Safeguarding is completed a multi-agency review of the case to see what lessons can be learnt.

2.22 Child Deaths

There have been 35 child deaths across Medway and Swale in the past year. 20 were for extreme prematurity, 1 was a 17 year old child who died from a hypoxic brain injury, 6 deaths occurred at the child's home, 3 occurred in NICU, 3 occurred at the Evelina, 1 was a public place from a traumatic head injury from a fallen tree and 1 was a cardiac arrest in children's emergency department. Each of these deaths is reported to the child death overview panel. A child death review must be carried out for all children regardless of the cause of death; however a review will not be initiated for a still birth (after 24 weeks gestation) or any late foetal loss (gestation < 24 weeks). This procedure fulfils the responsibilities set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The arrangements also comply with the requirements set out in Working Together to Safeguard Children 2018.

2.23 Youth Service and Emerge

The Emerge youth team are mostly volunteers but are all specifically trained to support young people up to the age of 25. Emerge youth volunteers provide short term support for young people who attend ED because they have self-harmed or are struggling with suicidal ideation. The volunteers do not take the place of any NHS service, but offer time and emotional support while young people are in hospital and beyond. It is up to each young person whether or not they'd like one of the volunteers and they can chat about anything, from what's brought them to hospital to what they like to watch on TV. Emerge objective is to make the young person's time in hospital easier and more productive. The Emerge volunteers have been providing support for the young people of Medway via a telephone service due to Covid -19 restrictions. They have supported 25 young people who have attended children's Emergency Department. The plan is for the Emerge volunteers to be placed in ED for face to face support during quarter 1 2021. The plan is that all volunteers will have completed their level 3 safeguarding children training.

2.24 The Medway Youth Service are employed by Medway Council and work within the Trust on an honorary contract. They provide support for vulnerable young people between the ages of 8 and 19 (up to 25 with additional needs) who

present at the Trust exhibiting issues including: youth violence, mental health and challenging behaviours. Young people in Medway face challenges such as gang culture, county lines, child sexual exploitation, domestic abuse and violence, and substance misuse. This is an excellent opportunity to make an impact through timely intervention. Youth workers started at the hospital in April 2021 and they are based at the hospital, working with young people that access the emergency department, linking in with the wards and MedOCC.

3 SAFEGUARDING ADULTS

3.1 Safeguarding Adults Training

Safeguarding training is profiled in line with the national intercollegiate document for safeguarding adults.

The intercollegiate document published in 2018 specified levels according to roles and responsibilities. The new addition of level 3 for some staff was initiated in January 2021 following approval of a revised safeguarding training strategy.

Due to the pandemic all face to face training has been cancelled since March 2020, eLearning packages have been made available to staff to assist in achieving the correct level of competence required. This new training has already achieved a 25% compliance with the eLearning 3 hour package.

Despite the challenges faced through the pandemic, the Trust has met and exceeded its Key Performance Indicators of 85% in all aspects of safeguarding training with slight exception to safeguarding children level 3.

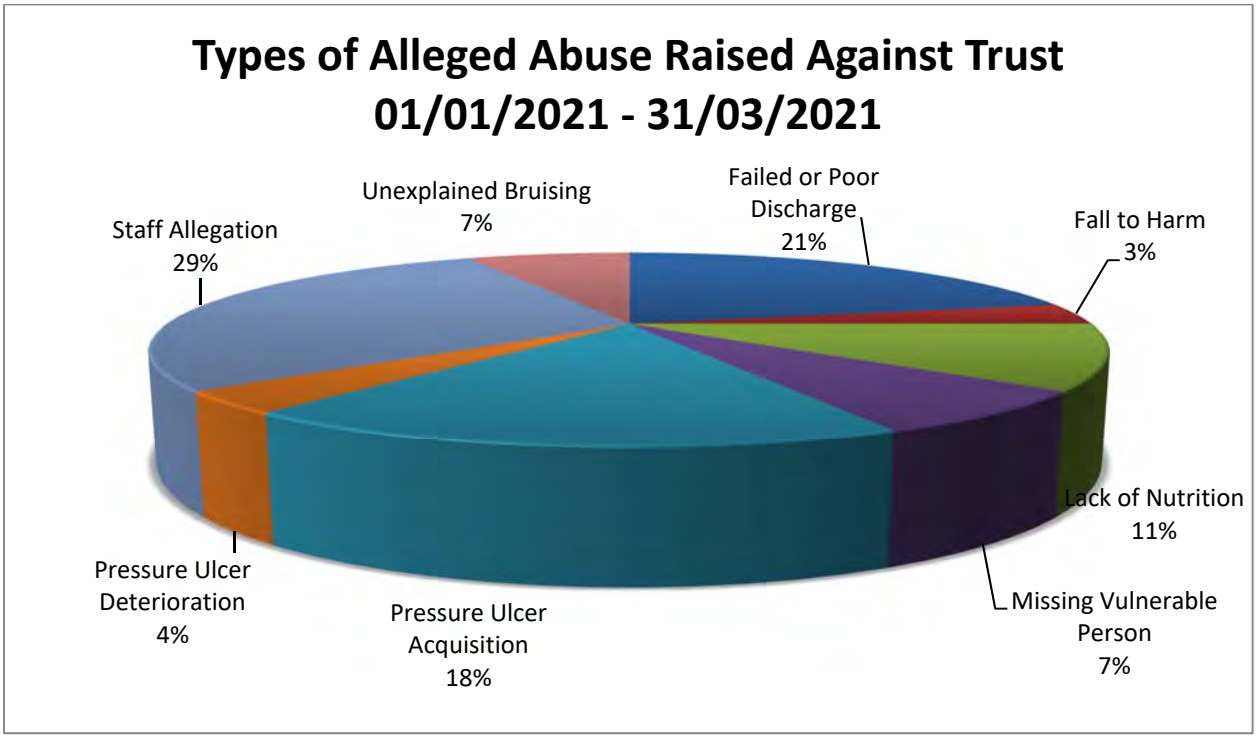
	Corporate	**Facilities and Estates**	**Planned**	**UPIC**	**Trust Wide**
MCA / DoLS	89%	N/A	89%	88%	**88%**
Prevent Level 1	96%	97%	98%	98%	**97%**
WRAP	89%	N/A	94%	93%	**93%**
Safeguarding Adults Level 1	96%	95%	98%	97%	**96%**
Safeguarding Adults Level 2	92%	N/A	94%	94%	**94%**
Level 3 SGA					
SG Adults L3 eLearning					**25.71%**

This is an exceptional achievement given the challenges and constraints faced by staff in an unprecedented year.

3.2 Safeguarding Activity

3.3 The table below shows the safeguarding concerns received by they Trust during 2020-2021. The numbers may show some discrepancies with other data, this is due to more than one concern on a safeguarding alert form.

Types of Alleged Abuse Raised Against Trust - by Date of Incident	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
Failed or Poor Discharge	2	2	3	1	4	3	1	4	2	4	0	2	**28**
Delay in Treatment or Missed Diagnosis	0	0	0	0	1	0	1	0	0	0	0	0	**2**
Fall to Harm	1	0	1	1	0	0	0	0	0	0	1	0	**4**
Inappropriate Restraint	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Lack of Nutrition	0	0	0	0	0	0	1	0	0	1	1	1	**4**
Medication Issue	1	2	1	0	1	0	0	0	0	0	0	0	**5**
Missed Fracture	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Missing Vulnerable Person	1	0	0	0	1	2	1	0	1	1	0	1	**8**
Pressure Ulcer Acquisition	1	0	1	0	2	2	1	1	3	2	2	1	**16**
Pressure Ulcer Deterioration	2	1	0	0	0	1	0	0	0	1	0	0	**5**
Staff Allegation	0	2	1	1	1	1	0	2	0	2	5	1	**16**
Unexplained Bruising	0	0	0	1	0	0	0	1	0	1	0	1	**4**
Total	**8**	**7**	**7**	**4**	**10**	**9**	**5**	**8**	**6**	**12**	**9**	**7**	**92**



3.4 23 of these concerns have been substantiated to date. These include 4 failed discharges, 2 falls to harm, 4 medication issues including giving unnecessary sedation to restrain a patient, 1 missing person coming to harm, 7 pressure ulcer acquisition, 3 pressure ulcer deterioration and 2 safeguarding allegations against staff.

3.5 3 cases were partially substantiated 1 nutrition concern and 2 pressure ulcer concerns.

3.6 11 of these were closed by the local authority as no case to answer – this would mean that they did not meet the safeguarding threshold or that no harm or risk

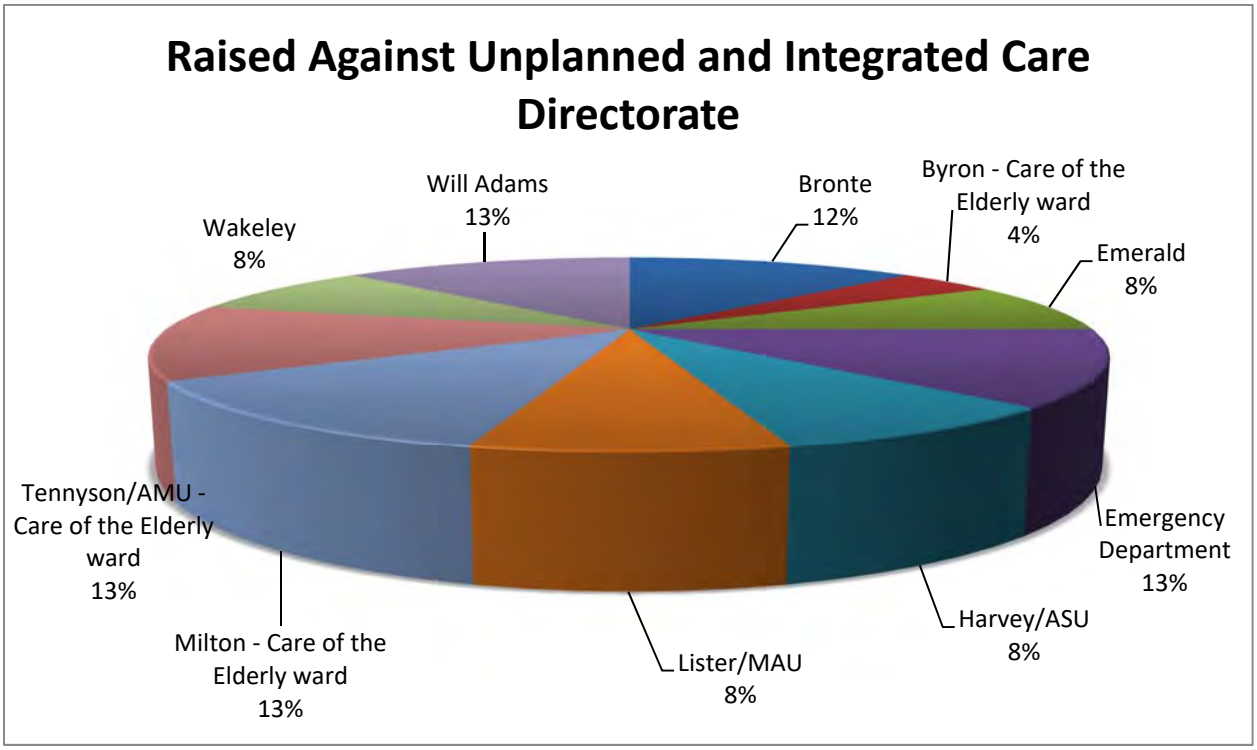
was present. This included 5 Failed discharge concerns, 1 fall to harm, 1 medication issue, 1 pressure ulcer deterioration, 2 allegations against staff and 1 unexplained bruising.

3.7 6 safeguarding concerns were investigated and were deemed inconclusive. These included 1 failed discharge, 1 nutrition concern, 2 pressure ulcer acquisitions, 1 staff allegation and 1 unexplained bruising. Inconclusive meaning that it was not possible to say for sure if more could have been done to safeguard the patient or if the harm they came to was attributable to the Trust.

3.8 14 cases have so far been investigated and have been given the outcome of unsubstantiated. This includes 5 failed discharges, 1 fall to harm, 4 pressure ulcer acquisition and 2 pressure ulcer deterioration and 2 staff allegations.

3.9 A number are still in the enquiry phase, this does not mean that the investigation has not taken place or that safeguards are in place but that at the time of this report being written the outcomes are not yet known.

3.10 17% of safeguarding concern raised about care and treatment provided at the Trust were in the planned care division. 83% were in unplanned and integrated care division.



3.11 Due to the impact of the pandemic on clinical areas, wards did change function and specialities moved during the year, this has made it very challenging for safeguarding to ensure accuracy of the location of safeguarding concerns.

3.12 Our data shows that the 3 greatest reasons for safeguarding concerns during 2020-21 to be discharge concerns, pressure ulcer acquisition and safeguarding allegations against staff. Many of the discharge safeguarding concerns did not meet the safeguarding threshold under the 3 stage criteria of The Care Act but were redirected to the Transfer of Care Concern (TOCC) group. Pressure ulcer

acquisition increased during the pandemic nationally due to the pressures of care delivery, staffing levels, prone positioning, and oxygen masks. Safeguarding allegations against staff has had a raised profile following the introduction of a monthly review of safeguarding allegations against staff meeting initiated by the Chief Nursing and Quality Officer. Managers have improved at recognising the safeguarding concerns in the allegations and are better at reporting this.

3.13 Safeguarding Allegations Against Staff

The Kent and Medway Safeguarding Adults Board released guidance as required by The Car Act 2014 "Managing Concerns around People in Positions of Trust" (PiPoT). This states that a person can be considered to be in a 'position of trust' where they are likely to have contact with adults with care and support needs as part of their employment or voluntary work and where the role carries an expectation of Trust and the person is in a position to exercise authority, power or control over an adult with care and support needs.

The Local Safeguarding Children's Partnerships work with the legislation of the Children Act 1989 /2017 and Working Together Guidance and where this could be an allegation that a professional has:

- behaved in a way that has harmed, or may have harmed a child
- possibly committed a criminal offence against children, or related to a child
- behaved in a way that suggests they could pose a risk of harm to children

for example if you think they may be abusive physically, emotionally, sexually or by being neglectful.

3.14 The Head of Safeguarding advises and supports managers on the considerations to make when managing an allegation, however the process is not robust enough and the Chief Nursing and Quality Officer initiated regular review meetings.

3.15 Recording and maintaining review of these cases is a timely process, especially those with police involvement. The Chief People Officer is assisting in obtaining support for data collection and recording purposes.

3.16 Safeguarding Adult Reviews (SAR's)

The Kent and Medway Safeguarding Adults Board (KMSAB) took the decision at the beginning of the first lockdown to suspend some of the activity due to the impact of the pandemic.

The activity resumed from September 2020 and at present we are participating in 5 SAR's. IMR's and / or chronologies have been submitted and these are all in the independent author stage.

2 SAR's have been published on the KMSAB website that the safeguarding team contributed to. These have been given pseudonyms.

1. Harold Garrett – Published on the 12th March 2021.

The learning for the Trust in this case is in regard to the discharge of the patient in 2018 during a period of black escalation for beds. The patient was complex and had impaired mental capacity. He demonstrated mental health behaviours

resulting from a brain injury and alcohol misuse; he was receiving 1:1 supervision on the ward. The place of discharge was not suitable for his needs and the placement broke down. A 7 minute briefing is being prepared to share the learning.

There was significant multi-agency learning to come from this and there was clear evidence agencies did not work well together to ensure his ongoing safety.

2. Gordon Fields – Published on 11th June 2021.

Gordon died in 2019 a few days after admission. His condition on admission was very poor and he was in a state of neglect. The review found that he did not live alone and was in receipt of "care". The learning from the review demonstrated that staff did not explore the wider issues as to how he became to be in a state of neglect. There were children in the house, known to children's social services. Again agencies did not exercise curiosity and did not explore beyond the contact they were there for.

This is in direct conflict with the "Think Family" principles that safeguarding promote. We are currently working with the Medway Institute for Quality Improvements to undertake a "Big Conversation" on Think Family.

3.17 Domestic Homicide Reviews (DHR's)

The Community Safety Partnership (CSP) are currently awaiting Home Office approval of a DHR that the Trust contributed to. This was in relation to a married couple where the wife had dementia and was killed by her husband who then tried to kill himself. The learning from this and a similar DHR was shared with the elderly care teams and at the medical Dr's lunchtime meeting.

Both victims had been patients at the Trust shortly before the homicide took place and the learning shared was about how we support carer's and the use of referral to the integrated discharge teams to undertake carers assessments in those that consent or disclose that they are struggling.

An audit has just been undertaken to review if carers are supported and referred for a Carer's Assessment.

We are currently participating in a further 4 domestic homicide reviews, having submitted agency contact summaries.

3.18 Domestic Violence & Abuse

The Hospital Independent Domestic Violence Advisor (HIDVA) is firmly embedded within Medway Foundation Trust.

As of the end of March 2021 COVID was still limiting the HIDVA working within the hospital, visits to the wards were not always possible because of the restrictions, however the multi-agency and collaborative work with Hospital staff is positive there has been no drop in referrals.

The HIDVA has supported a number of staff members who have made disclosures of domestic abuse, this may be sign posting or ensuring that the relevant support is in place for them in the workplace.

The HIDVA was employed by Choices Domestic Abuse Charity and is commissioned through Medway Domestic Abuse Services (MDAS) and is working within the safeguarding team on an honorary contract. Choices Charity has now merged with Oasis Charity and going forwards will be referred to as Oasis.

3.19 Additional Work

The safeguarding team have continued to represent the Trust at the relevant multi agency meetings and subgroups of the KMSAB.

When the Trust became a vaccine hub for COVID 19 the safeguarding practitioners supported the first week of vaccinations due to previous experience in this area.

The Head of Safeguarding independently chaired and authored a thematic review SAR for the KMSAB on Self Neglect which has been a growing concern throughout the pandemic and lockdowns, this was published on the 7th May 2021.

Self-Neglect has quickly risen to the greatest safeguarding concern in safeguarding referrals to social services. The pandemic and lockdown periods have been found to be instrumental in patients trying to manage conditions at home without seeking help quickly enough.

Those who had informal care provisions prior to the lockdown lost this vital contact. The safeguarding team have been checking Datix on a daily basis to highlight cases of possible “self-neglect” and encourage the working together of agencies to ensure safer discharge.

3.20 Mental Capacity and Deprivation of Liberty Safeguards

The table below shows the total number of Deprivation of Liberty Safeguard applications were made by year. The growth of this activity evidences the increased understanding and statutory compliance with the Mental Capacity Act. This also evidences the increasing number of complex patients for whom decision making is impacted.

	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Planned Care	**69**	**169**	**156**	**197**	**144**
Unplanned and Integrated Care Division	**277**	**386**	**478**	**661**	**927**
Total DoLS applications	**346**	**555**	**634**	**858**	**1071**
Patients that died whilst subject to a DoLS	**60**	**95**	**115**	**147**	**177**

3.21 The number of standard authorisations granted by the local authorities however is significantly lower that previous years, this in part is due to the pandemic and assessors not coming on site. The local authorities are also only prioritising cases where the patient is actively experiencing restraints and restrictions due to objection to care, treatment and remaining in hospital.

Standard Authorisations made by the local authority					
	2016-2017	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**

Planned Care Division	**8**	**5**	**2**	**3**	**1**
Unplanned and Integrated Care Division	**31**	**13**	**24**	**11**	**1**
	39	**18**	**26**	**14**	**2**

3.22 The table below demonstrates the number of patients subject to a deprivation of liberty, who breached the urgent authorisation after 14 days and remained under restrictions in the Trust without the local authority providing suitable assessment and standard authorisations. This risk remains on the corporate risk register.

	2016-2017	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Planned Care Division	**42**	**86**	**76**	**83**	**48**
Unplanned and Integrated Care Division	**176**	**168**	**215**	**289**	**238**
Total	**218**	**254**	**291**	**372**	**286**

3.23 The risk is mitigated somewhat by utilising the wider scope of the Mental Capacity Act and treating the patient in their best interest. The DoLS applications are reviewed by the safeguarding practitioners and the daily review of Datix alerts raised are reviewed for evidence of patients requiring interventions and demonstrating resistance to care and treatment or to remaining in hospital. These cases are then escalated to the local authority again.

3.24 Schedules 7 to 11 of the Coronavirus Bill made temporary changes to the Mental Health Act, Mental Capacity Act and Care Act to support staff during the pandemic. This did not impact greatly on MCA during this time as this was unchanged, however if a deprivation of liberty was deemed necessary to ensure that life sustaining treatment could be administered it was not necessary to apply for a DoLS. That said, the safeguarding team supported the Trust staff throughout the pandemic in ensuring that the statutory duties were upheld.

3.25 <u>Liberty Protection Safeguards</u>

A review of the Mental Capacity Act 2005 (MCA) by the Law Commission in 2014 recommended the replacement of the Deprivation of Liberty Safeguards (DoLS) scheme. The review highlighted that the current system was unable to cope, it found it to be a complex overly bureaucratic scheme which is overly burdensome for people, carers, families and services.

In October 2020 the Liberty Protection Safeguards (LPS) were due to be implemented, however the pandemic and Brexit led to delays in this. The new date for implementation of LPS is 1st April 2022.

3.26 Key objectives of this reform Bill are:

- To ensure that people have their human rights respected, ensuring the right people are getting the right protections at the right time as per Article 5 European Court of Human Rights - Right to liberty and Security.
- People have better experiences of the system, with improved quality of care.
- Greater flexibility to support those with the greatest needs.
- The streamlined process will deliver a more efficient system and better value for money.

3.27 LPS is to include 16- and 17-year old's. This brings it in line with the Mental Capacity Act which starts from 16 years of age, this will impact paediatric inpatient areas.

3.28 The accountability will sit with the New "Responsible Body" i.e. Hospital Trusts (including NHS Foundation Trusts). New responsible bodies will be responsible for organising assessments, pre authorisation reviews, authorising any deprivation of liberty and monitoring.

3.29 New role of Approved Mental Capacity Professional (AMCP) instead of the role of the current DoLS Best Interests Assessor (BIA) – likely to be first tier nurses, occupational therapists and social workers, awaiting regulations, with the AMCP to be involved only in certain cases, rather than the BIA in every DoLS case.

3.30 AMCP completes pre-authorisation review where an objection has been raised, in independent hospital cases or other relevant (complex) cases as set out in the Code of Practice – will meet with person, complete consultation and look at information relied upon for assessments.

3.31 Qualified staff to undertake most of LPS assessments, to be completed as part of routine care or Care Act Assessment. There appears to be no funding to support NHS Trusts in this implementation.

3.32 In some cases the LPS will be transferrable if the original assessment covers the medical care and treatment necessary for the person.

3.33 This is currently on the risk register and risk will increase as implementation time decreases. There will need to be significant investment into this to ensure success. Risks of failing to be ready for the implementation date is of concern as training, policies and capacity to undertake assessments is required.

3.34 In preparation, like most acute Trusts we are focusing on preparing staff to have legal literacy around the mental capacity assessments. MCA eLearning has been improved and has 11 modules to complete in total.

4 LEARNING DISABILITIES

4.1 Covid-19 & people with Learning Disability (LD) & Autism

4.2 Throughout the past year we have continued to provide support to patient's relatives and carers, albeit not always at the bedside which is desirable. In order

to maintain the support and guidance we have learned to adapt our working practices to give greater support and advice over the telephone.

In particular we became essential for families of our patients who required reassurance and updates on their loved ones. We liaised with clinical teams and nursing staff to ensure that families and carers received timely updates as much as was possible.

4.3 The Learning Disability nurses have supported over 30 people with LD & Autism whom have required treatment for Covid-19 of which 5 people with LD & Autism had this documented as the cause of their death.

4.4 During the past year we have seen a higher level of deaths amongst the learning disability population, this is in keeping with national findings following the outbreak of COVID-19.

2017-2018	2018-2019	2019-2020	2020-2021
4	7	7	20

4.5 Following concern in the increased number of LD patient deaths a review was undertaken in September 2020 by the learning disability liaison nurse to identify any learning or themes and trends needing to be addressed.

4.6 From the retrospective case note review there was no evidence of delays in care and treatment that contributed to the deterioration in each of the patients care journey. Indeed the reviews demonstrated that the patients were given appropriate ICU admission and treatment escalation as necessary. Sadly in many cases the existing comorbidities the patients lived with were exacerbated by the COVID 19 infection.

4.7 The review did highlight that each of the patients should have been subject to the Mental Capacity Act and evidence of best interest and consideration for deprivation of liberty should have been available. The lack of this evidence demonstrates that the legal framework to protect patients and their decision making was not adhered to.

4.8 This learning was shared with clinical teams and the LD nurses are reminding staff of this as the patient arrives.

4.9 Recent data indicates that people with LD are more likely to contract COVID-19, have a more severe case of COVID-19, and are three times more likely than people without LD to die from COVID-19.

4.10 Inequalities in health, wellbeing, social isolation, employment and poverty that existed before COVID-19, along with separation from family and friends and changes to routines, may have been exacerbated during the COVID-19 pandemic.

4.11 <u>Learning Disabilities Mortality Review (LeDeR) Programme</u>

4.12 The LD nurses have continued to embed the awareness of the Learning Disabilities Mortality Review (LeDeR) Programme within the Trust by attending the Mortality & Morbidity meetings, attending team meetings and teaching. The

LD nurses have been able to share the LeDeR review findings and learnings across the Divisional Care Groups.

4.13 Each person with LD & Autism whom has died in Medway Hospital has been referred to LeDeR once the cause of death is confirmed.

4.14 Some national LeDeR reviews have shown that sometimes health professionals do not resuscitate someone because they have a learning disability. Professor Stephen Powis, the National Medical Director, wrote an urgent letter to NHS Trusts in 2019 stating a learning disability should never be a reason for not trying to resuscitate someone.

4.15 During the external undertaking of LeDeR reviews, the LeDeR reviewers have received positive feedback from family members about the LD nurses at Medway Hospital & the support they provided during difficult times. This feedback was fed back to the local LeDeR steering group for Kent & Medway.

4.16 National Learning Disability week 2020

Learning Disability Week 2020 took place online from 15 to 21 June 2020. The "theme of the week" was the importance of friendships during lockdown. Due to the pandemic and the lockdown imposed, many people were feeling isolated, as they has been unable to see their friends and families. A stand in the main entrance was provided to promote and provide leaflets. Activities were limited due to the restrictions.

4.17 NHSE & NHSI Learning Disability Improvement Standards

The Learning Disability Improvement Standards Review is a national data collection, commissioned by NHS England and NHS Improvement (NHSE & NHSI) and run by the NHS Benchmarking Network (NHSBN). The data collection has been designed to fully understand the extent of Trust compliance with the recently published NHSE & NHSI Learning Disability Improvement Standards and identify improvement opportunities.

4.18 The improvement standards reflect the strategic objectives and priorities described in national policies, programmes and the LeDeR programme. Compliance with these standards requires Trusts to assure themselves that they have the necessary structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, their families and carers, expect and deserve. It also demonstrates a commitment to sustainable quality improvement in developing services and pathways for people with LD.

4.19 The standards review aims to collect data from a number of perspectives to understand the overall quality of care across LD services.

4.20 The data collection comprises of the following 3 elements.

- An organisational level data collection
- A staff survey, completed from the perspective of individual staff members, this is used to survey the workforce, training and skills.

- A patient survey, this is used to survey the quality of care received by people with LD, and overall patient experience. This is managed through postal questionnaires

4.21 We have participated in the Improvement programme for 3 consecutive years. The recent staff survey has proven challenging to engage Trust staff, likely due to the pandemic and winter pressures. The report from year 2 data collection was only published in March this year.

4.22 There are a number of areas that require senior executive and Board level decisions regarding the reporting and oversight of data into patients with LD. A report has been written to look at gaps and progress. This will be presented to the Safeguarding Assurance Group.

4.23 Learning Disability Awareness Training

During the pandemic LD awareness training has continued via Microsoft teams, this has proved challenging to engage the audience, it can be difficult to judge the audience's level of understanding.

Where possible the LD nurses have facilitated face to face training or in some cases part face to face and part virtual when there has been sufficient space allow for social distancing.

The Oliver McGowan Mandatory Training in LD and Autism is due to be rolled out across the UK; however the start date has been delayed due to the pandemic. This training will ensure staff working in health and social care receive learning disability and autism training, at the right level for their role. They will have a better understanding of people's needs, resulting in better services and improved health and wellbeing outcomes.

4.24 Health Education England and Skills for Care are coordinating the development of training in both health and social care. The training is being co-produced and delivered by autistic people, people with a LD and family carers.

4.25 The training is named after Oliver McGowan, whose death highlighted the need for health and social care staff to have better training.

4.26 Autism

During Autism Awareness week in March 2021, the Learning Disability nurses held an awareness stand in the restaurant with Miss Bowbrick- Vascular consultant surgeon.

4.27 The LD nurses have provided support and advice regarding patients with Autism, whether they have a LD or not. We were pleased to support Miss Bowbrick with the launch of the Different Not Less campaign.

4.28 The Not Less initiative pledges to promote equality in care, not make assumptions about our patients with autism or LD and to listen to them and their families. The campaign asked staff to challenge other healthcare professionals if you do not think they are treating patients with autism or LD equally and to listen to them or their families or try to understand.

4.29 Changing Places

4.30 The Changing Places Consortium launched its campaign in 2006 on behalf of the over 1/4 of a million people who cannot use standard accessible toilets. This includes people with profound and multiple learning disabilities, motor neurone disease, multiple sclerosis, cerebral palsy, as well as older people.

4.31 The Department of Health and Social Care made funding available for NHS Acute (Hospital) Trusts in England to install Changing Places toilets. This capital funding can only be used for the creation of Changing Places facilities. This includes items such as installation, building and equipment costs.

4.32 Changing Places toilets have adult changing bench and hoist facilities as well as extra space for carers. This provides a safe toileting environment for physically disabled people who are non-ambulant, as well as for those with learning disabilities who may need carer support. The equipment provided also ensures that manual moving and handling techniques are minimised for any carers involved.

4.33 There are currently 84 hospitals in England that are registered as having a Changing Places toilet. With 854 hospitals in England, that means less than one in ten hospitals have one. Recognition of the value of planning ahead and ensuring they are putting in place an infrastructure that includes everyone.

4.34 The Learning Disability Liaison Nurse is working with the Medway Innovation Institute to ensure this campaign is implemented in Medway Foundation Trust. A Changing Places committee was formed in January 2021. This committee includes members from Estates, Finance, Head of Equality and Inclusion, Associate Non- Executive Director and a Quality Improvement coach. The application of funding has been completed by the Changing Places committee and a location has been identified. The installation of the facility will continue over the next year.

4.35 Jam Card

4.36 Jam stands for Just A Minute and is a communication aid. This initiative is being led by one of our Learning Disability champions who works in the Emergency Department.

4.37 A patient comes to book in and you ask their date of birth. They do not answer straight away and so you think maybe they didn't hear you and so you ask again. This at times can become frustrating for patients because they can experience this on many occasions and can feel that they are not being listened to.

4.38 The JAM card is to aid this communication, by a patient having either a physical card or the app on their phone they can show the person behind the desk discreetly that they need a minute.

4.39 Not all disabilities are visible; many are hidden so the use of the JAM card will be beneficial for this patient group with a long term plan to become a Jam Card Friendly NHS Trust.

5 SAFEGUARDING GOVERNANCE REVIEW

5.1 The Chief Nursing & Quality Officer commissioned a Trust wide review of Safeguarding as a proactive approach following the published findings from the CQC Inspection to respond to the Must Do action contained within the Trust CQC Action plan.

5.2 The “Must do” Action - Ensure that systems and processes are established and operated effectively to prevent abuse of service users.

5.3 This review was undertaken in the autumn of 2020 and the draft report received in January 2021.

5.4 The review team heard and saw good evidence in relation to the Trust’s statutory responsibilities and Board members had a good understanding of these statutory responsibilities.

5.5 A draft action plan has been drawn up to address the recommendations from the review and significant progress has been made against some of these.

6 CONCLUSION AND NEXT STEPS

6.1 As the Lockdown restrictions are slowly eased, we are likely to see an increase in attendances at both the children’s ED and on the children’s wards particularly in mental health presentations.

6.2 Safeguarding training has been online and local contextual safeguarding is missing from these packages. Therefore, the plan is to resume face to face safeguarding training to make it relevant to the local area as soon as we are able.

6.3 From quarter one 2021-22 the named nurse will report to the quarterly performance management quality assurance sub group of the Medway safeguarding Children’s partnership on all children who are medically fit for discharge, but are on the ward awaiting a specialist placement.

6.4 Quarter will see the ‘was not brought’ guidance audit completed to establish whether the ‘was not brought guidance’ is embedded into practice. The paediatric liaison nurse is leading on the audit for the safeguarding documentation that is used within children’s ED and on the children’s ward.

6.5 The new safeguarding children’s assessment pro-forma which includes an area for staff to document the voice of the child is now being used for some attendances (there are different pro-formas for different attendances; mental health, head injury, unwell child etc.). This will be audited as part of the safeguarding children team yearly audit cycle.

6.6 The Governance review action plan will be focused on to ensure continual improvement and assurances are in place across the Trust.

6.7 Liberty Protection Safeguards are to be prepared for and launched in April 2022, a business case will be submitted for a Mental Capacity Lead and administrator to support this roll out.

7 REFERENCES

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NHS
Medway
NHS Foundation Trust

Specialist Midwife Report

Maternity Safeguarding Annual Report

MARCH 2021

Cheryl Herbert

Named Midwife for Safeguarding

Best of care
Best of people

Contents

1 Executive summary

1.1 Maternity safeguarding for the year 2020/21 has been challenging, predominantly due to the Covid-19 pandemic. Continuous review of the service has ensured that risks can be identified and mitigation put in place.

1.2 Team Connect have continued to provide continuity in the antenatal and postnatal period to vulnerable families, including those with complex social histories. The Team are aiming to become the first team to commence Continuity of Carer, which will aim to provide continuity throughout the whole puerperium.

1.3 Maternity Safeguarding activity has remained high. However, Key Performance Indicators have been maintained.

1.4 The global increase in domestic abuse (DA) has been reflected within Medway and Swale.

1.5 Attendance at safeguarding meetings has been maintained throughout the year, moving to a virtual platform to facilitate this.

1.6 The substance misuse pathway and guideline has been developed, with the Windmill Clinic being re-instated as a virtual multi-professional monthly meeting.

1.7 Multi-professional/Multi-partnership working has continued. This has ensured that vulnerable families are identified and the support required is provided in a timely manner.

1.8 Maternity Safeguarding are continuing to support the Medway Safeguarding Children's Partnership (MSCP) fulfil their strategic plan for 2020-22, with emphasis on their five priorities.

1.9 Provision of Maternity Safeguarding training has continued, moving from face to face to virtual, ensuring Government guidelines for social distancing are maintained.

2 MATERNITY SAFEGUARDING SERVICE

2.1 The Named Midwife for Safeguarding (NMS) is one whole time equivalent (WTE) Band 7 post. The current NMS has been in post in July 2020.

2.2 The NMS is responsible for co-ordinating, managing and taking responsibility for the day-to-day safeguarding of all unborn and newborns, within the care of Medway NHS Foundation Trust (MFT). The role comprises of, co-ordination of all Maternity safeguarding activity, education of staff, supporting staff across the service to support families with complex social needs, provision of safeguarding supervision, co-ordination of out of area/National alerts, guideline review and development, service planning, acting as a point of contact and liaison with partnership agencies and local safeguarding children's partnerships and strategic elements.

2.3 The NMS also acts in the capacity of Team Leader for Team Connect. This area of the role includes staff management, day to day overseeing of the team workload, liaison with other community teams regarding workload and working clinically as required supporting the service.

2.4 Team Connect are a community midwifery team that provide care to women and pregnant people accessing Maternity services and who are experiencing additional vulnerabilities and identified safeguarding concerns. The Team consists of four (3.8 WTE) Midwives and a (0.64 WTE) Midwifery Support Worker (MSW). Each Midwife is aligned with one of the four community teams and is responsible for holding the Team Connect caseload for each of these geographical areas. Team Connect provide specialist holistic care to families with complex social histories. They provide continuity of care within the antenatal and postnatal period and work closely with other healthcare professionals, Children's Services and agencies that are supporting the family. The MSW works alongside Team Connect, undertaking appropriate clinical work and providing home parent preparation visits for families that require support.

The NMS and Team Connect offices are based within the Safeguarding Team residence. This ensures that Maternity Safeguarding is not seen as a standalone service and facilitates liaison with all members of the wider Trust safeguarding team.

2.5 The NMS represents Maternity for the Trust at many partnership meetings, including the Health Reference Group (HRG), Performance Management and Quality Assurance (PMQA), Lessons Learned, co-ordination of Multi-Agency Risk Assessment Conference (MARAC) research and liaison with the Child Death Overview Panel (CDOP).

2.6 The NMS attends regular Regional and National NMS Network Meetings. This provides an opportunity to benchmark MFT against other Trusts. Furthermore, these forums provide an opportunity to share good practice, service development and review National drivers for the service.

2.7 At Trust level, the NMS provides representation at the Safeguarding Operation Group (SOG), Safeguarding Assurance Group (SAG), Maternity Transformation Assurance Board (MTAB), Women and Children's Governance, Midwifery Manager's meeting, Community Team Leader's meeting and the weekly Neonatal Multi-disciplinary (MDT) meeting.

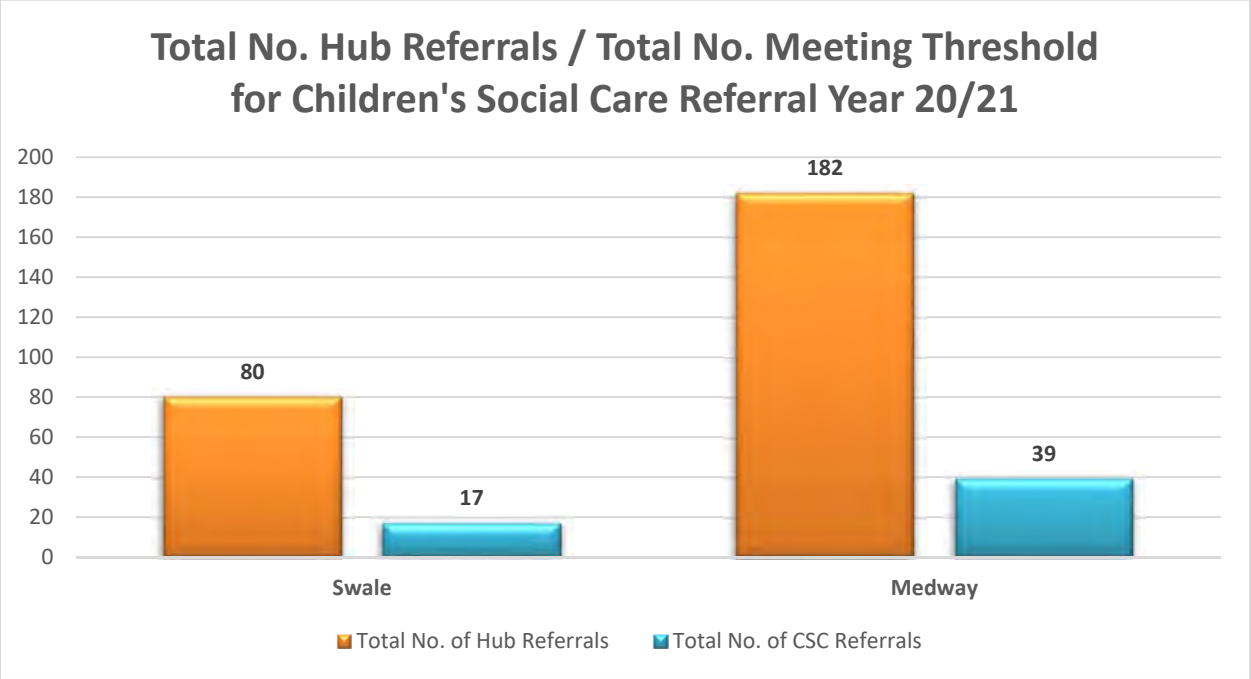
2.8 Maternity Safeguarding specific meetings, which are chaired by the NMS, are the Midwifery Safeguarding Hub and the newly re-formed Windmill Clinic.

2.9 Midwifery Safeguarding Hub

The Midwifery safeguarding hub is held monthly in Medway and bi-monthly in Swale. The safeguarding hub members consist of professionals from Children's Social Care (CSC), Health Visiting (HV), Early Help (EH), DA services and members of Team Connect.

The partnership agencies discuss cases of concern, referred by members of the wider community teams, in a multi-disciplinary setting. These cases are discussed, information shared by each agency and then appropriate decisions are made on how to provide support and guidance to families of concern. This includes assessing whether the threshold has been met for a full referral to CSC for a Child and Family assessment.

Across both Medway and Swale, 262 referrals to the Midwifery Safeguarding Hub were made for 2020/21, resulting in 56 referrals to CSC. This constitutes an average of 21% of all hub referrals meeting the threshold for a child and family assessment.



2.10 The Windmill Clinic

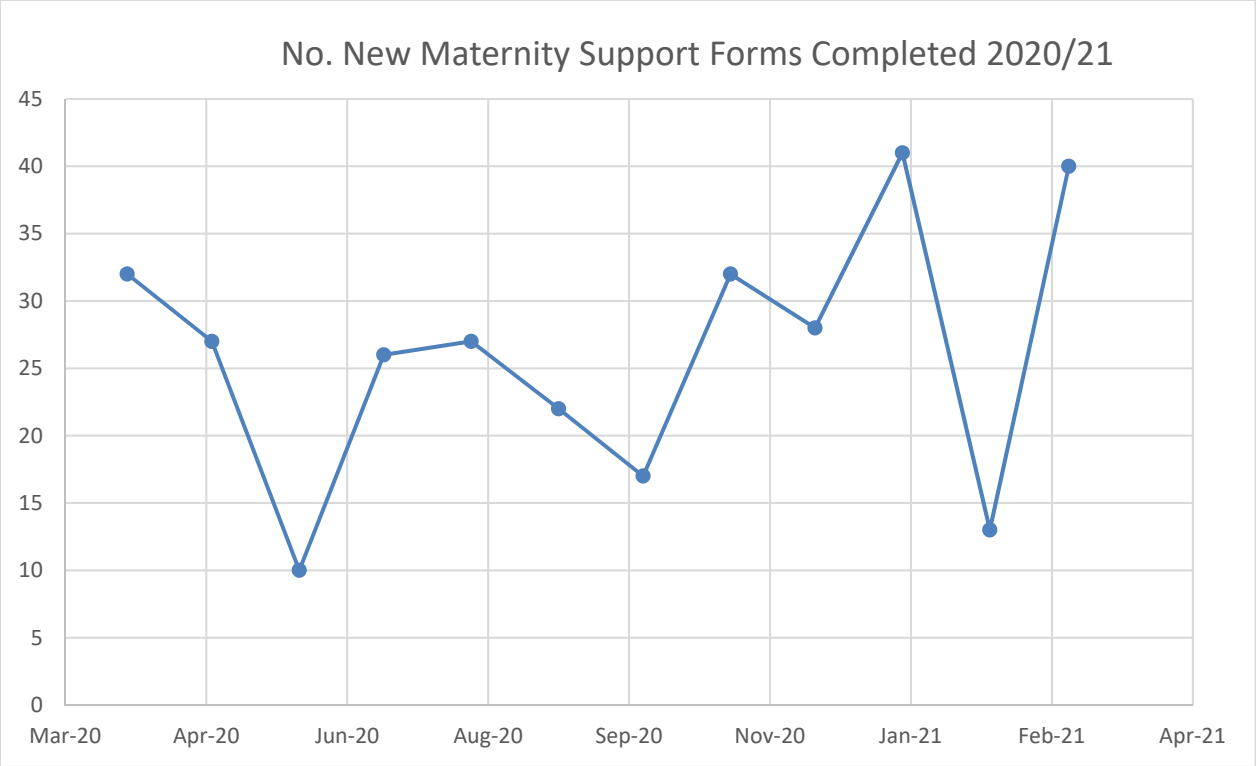
The Windmill clinic is a virtual multi-disciplinary professionals meeting, that is held monthly. The clinic is designed to ensure that multi-professional support and planning is provided for women and pregnant people, who are known to misuse substances. The members of the meeting include the NMS, Consultant Obstetrician, Specialist Mental Health Midwives, Neonatal Consultant, Neonatal Outreach Team, Team Connect Midwives and a representative from local Drug and Alcohol Services (Turning Point for Medway and Forward Trust for Swale). The meeting allows for information sharing between professionals, updates on care, prescribing pathways and safeguarding concerns.

The first virtual clinic was held in March 2021, with management for 7 women being discussed.

2.11 Maternity Safeguarding Activity

Throughout 2020/21, 315 families have required a Maternity Support Forms (MSF) to be completed. The MSF is a tool used to share information regarding identified vulnerabilities and safeguarding concerns. This document is updated throughout pregnancy and is attached the digital maternity record on Euroking. The MSF is shared with Health Visiting and General Practitioners (GP), both when initially completed and following each update.

2.12 The below graph illustrates the number of MSF's raised across the year.

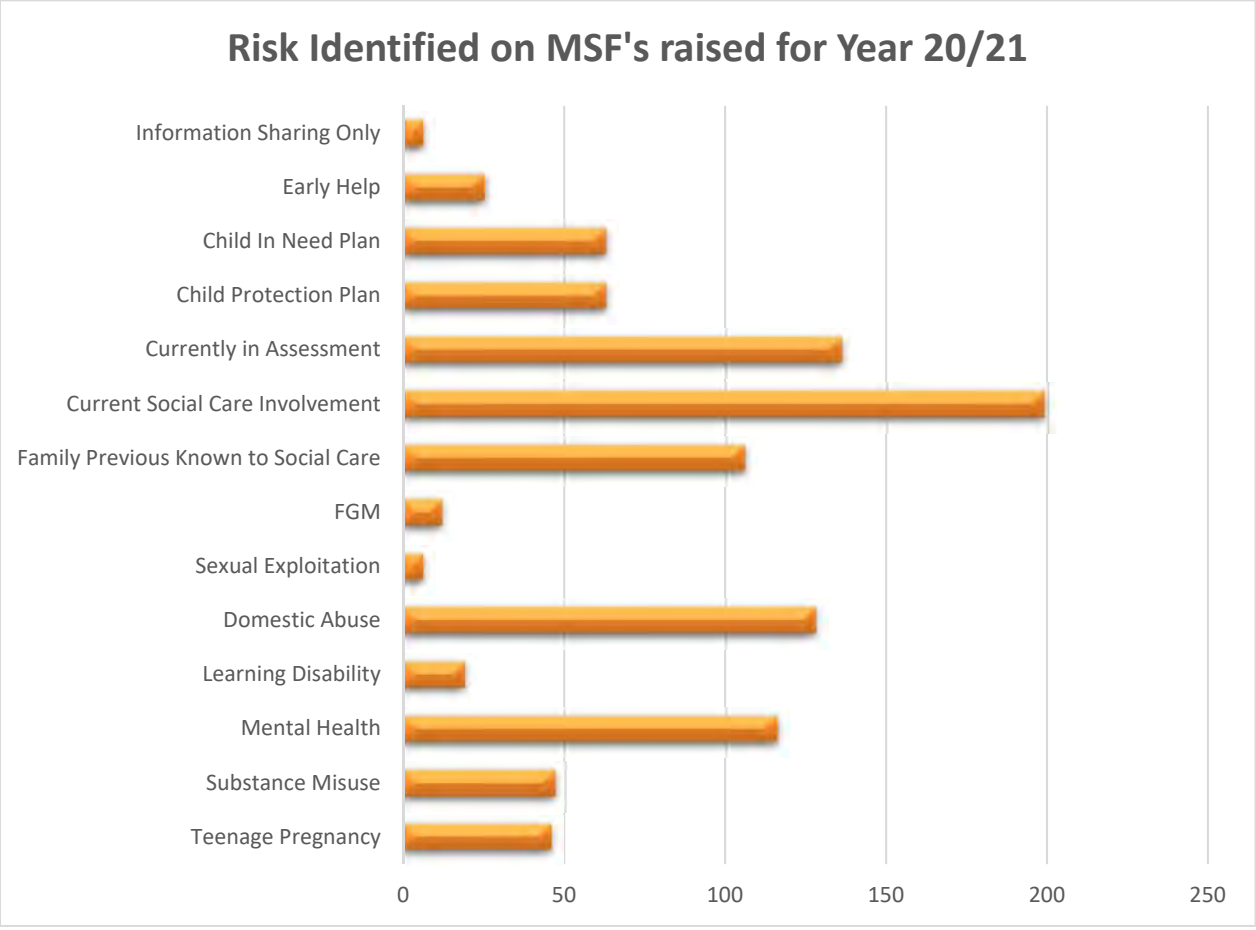


The decreased numbers at points throughout the year demonstrate times of National lockdown and/or increased restrictions due to the Covid-19 pandemic. This illustrates the influence that Covid-19 has had on identification of vulnerable families. Maternity rely on partnership working to help identify families that require further support, or highlighting of safeguarding concerns. Throughout the pandemic, many services have withdrawn face-to-face contact. This has resulted in many children, going "unseen". National lockdown and the restrictions around the pandemic has meant that many risks are intensifying for children. These risks have been highlighted within the NSPCC Learning (2020) 'Isolated and Struggling – Social isolation and the risk of child maltreatment, in lockdown and beyond'.

Team Connect have continued to provide a full midwifery service to families that are part of the caseload, including home visits. The service was maintained to ensure that our known vulnerable families continued to receive appropriate support and children within the home were being seen.

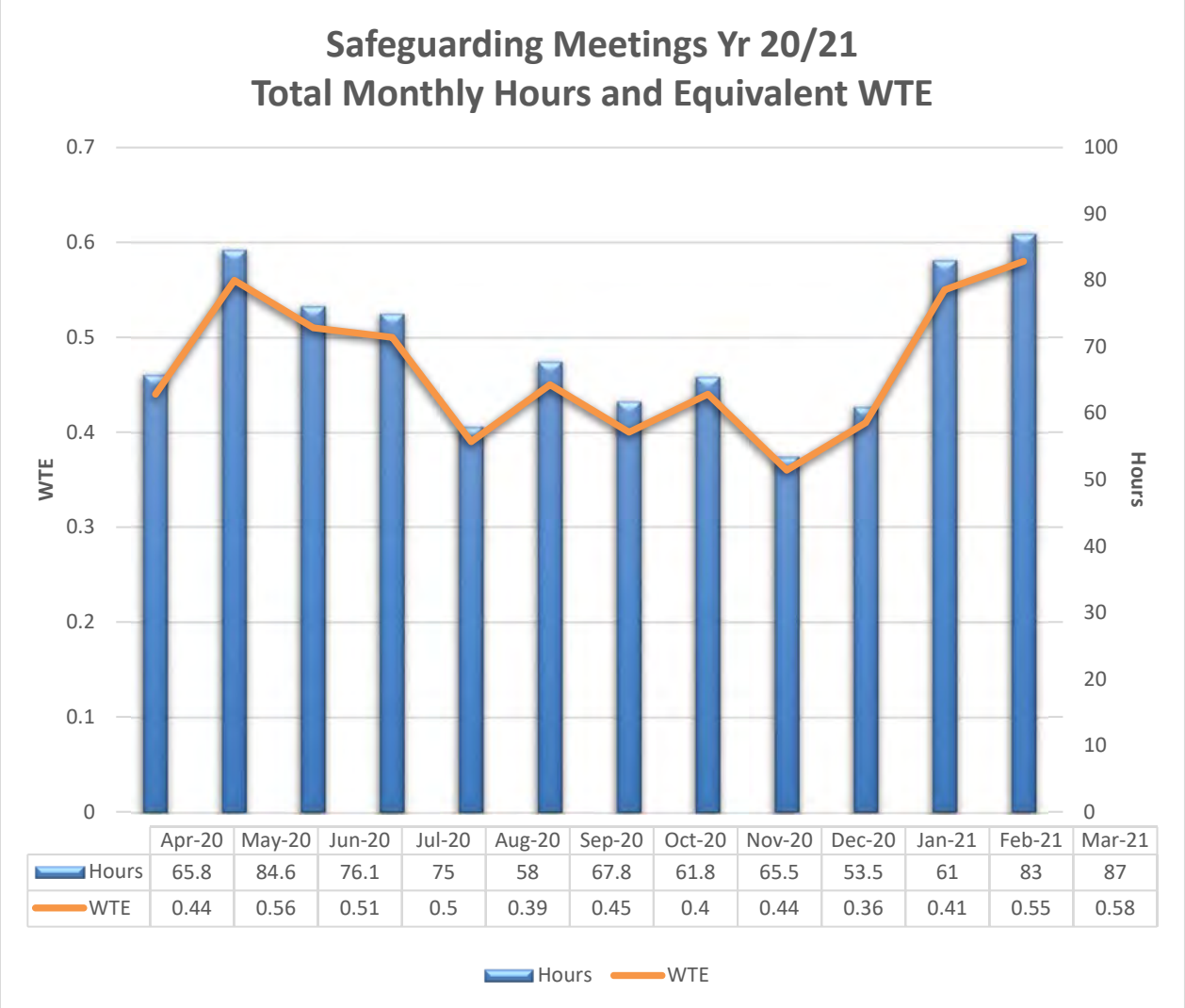
2.13 The below graph illustrates the concerns that were identified that triggered an MSF being raised.

Please note that the majority of MSF's are raised for multiple concerns and therefore the total number of MSF's raised may appear lower than the number of risks identified.



2.14 Covid-19 has seen a global increase in DA. The National Domestic Abuse Helpline reported more than 40,000 telephone calls during the first 3 months of lockdown, with an 80% increase in calls in June alone. Medway historically has a high rate of DA and the statistics illustrate that DA concerns were included in 41% of all MSF's raised, in comparison to 31% the previous year 2019/20. However, the data is not broken down in to new reports of DA and escalation within pre-existing abusive relationships. Therefore, it is difficult to interpret the data, other than reports of DA have increased during the year 2020/21. The total MSF's raised with DA listed as a risk factor, averaged 10.7 families a month.

2.15 For families that have CSC involvement, Midwifery attendance at meetings is required. The majority of these meetings are attended by Team Connect or the NMS and constitute a large amount of Midwifery hours. The below table displays the total number of Midwifery hours spent per month for the year 2020/21 and the WTE that this equates to. Averaged across the year 0.47 WTE Midwifery hours per month are used on meeting attendances.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Hours	65.8	84.6	76.1	75	58	67.8	61.8	65.5	53.5	61	83	87
WTE	0.44	0.56	0.51	0.5	0.39	0.45	0.4	0.44	0.36	0.41	0.55	0.58

2.16 Throughout the Covid-19 pandemic, due to restrictions around social distancing, all meetings have been held virtually via Microsoft Teams. This has improved attendance at meetings and led to smarter ways of working. Prior to the pandemic, staff were required to travel to meetings, which meant that increased Midwifery hours were used. Furthermore, this meant that fewer meetings could be attended due to being held at similar times, in different areas. Virtual meetings have meant that staff can attend meetings that run directly following others. Therefore, Midwifery representation at meetings has been vastly improved throughout the year. Going forward, many meetings may continue virtually, although Initial and Review Child Protection conferences are likely to resume face to face. This is due to the sensitive nature of the meetings and ensuring that they are family focused.

3 Service Performance Indicators

3.1 Medway Safeguarding Children's Partnership (MSCP) have agreed five new priorities for 2020-22 with their strategic plan. These priorities are:

- 3.1.1 Effective Partnerships
- 3.1.2 Contextual Safeguarding and trauma informed practice
- 3.1.3 Domestic Abuse
- 3.1.4 Neglect
- 3.1.5 Effective Early Help

3.2 Key performance indicator's (KPI) specific to Maternity Safeguarding at MFT are:

- 3.2.1 Reduction in length of stay within MFT during the postnatal period
- 3.2.2 Pre-birth planning for 100% of babies subject to a Child Protection plan
- 3.2.3 100% safeguarding supervision for all CP cases

3.3 Provision of Education/Training including:

- 3.3.1 Level 3 Safeguarding Children
- 3.3.2 Female Genital Mutilation
- 3.3.3 Domestic abuse
- 3.3.4 Child Exploitation
- 3.3.5 Contextual Safeguarding
- 3.3.6 Adverse Childhood Experience (ACE)

4 PERFORMANCE

MSCP Priorities for 2020/-22

4.1 All five of the MSCP priorities relate directly to Maternity. Therefore, the NMS is directly involved with Task and Finish groups for DA and Implementation of the Graded Care Profile, which provides professionals with a tool to identify Neglect. Furthermore, the NMS was included in the Early Help Priorities Consultation for development of their strategic priorities for 2021-24.

4.2 Effective partnership working is promoted within Maternity as evidenced by the Midwifery Safeguarding Hub and Windmill Clinic. Furthermore, day-to-day liaison with partner agencies is ongoing to support families accessing care at MFT.

4.3 Contextual safeguarding and trauma informed practice identification has been included within safeguarding training, to ensure that staff are aware and can identify these issues and act appropriately.

Key Performance Indicators:

4.4 A 2018 audit illustrated that there was a delay in discharge for families with children subject to a CP plan. The majority were due to delays in court actions, inappropriate advice given by Out of Hours Children's Services and lack of pre-birth planning. Following this audit and implementation of Team Connect, the length of stay for these families has been reduced, with minimal delay for discharge. Following the original audit, this KPI has not been officially re-audited. Therefore, the plan for 2021/22 is to complete an audit to provide assurance that this KPI is being maintained.

4.5 For the year 2020/21, 96% of families with children subject to a CP plan had pre-birth plans completed prior to birth. Of the 4% that were not completed (three families) , two babies were unexpectedly born prematurely and the Social Worker was unavailable for the other child and therefore the meeting did not take place as planned.

4.6 Throughout 2020/21, safeguarding supervision for 100% of CP cases was achieved.

Supervision is provided in many ways, such as direct discussions at meetings, supporting the decision making at the midwifery safeguarding hub, email exchanges and telephone conversations. Supervision is also enhanced by the NMS supporting Team Connect in their safeguarding activity, by attending safeguarding meeting on their behalf and meeting the families and professionals supporting them.

4.7 Each member of Team Connect provides the NMS with a monthly caseload review of the women currently receiving Team Connect input. This caseload is reviewed in regular one to one supervision given to each member of the team; further information is obtained by reading and reviewing the safeguarding paperwork. Safeguarding supervision and requested actions are documented, to ensure evidence of this has taken place.

Provision of Education and Training

4.8 Prior to the Covid-19 pandemic, all training was face to face. To enable continuation of training and maintaining compliance, all training and education has been completed virtually. Monthly sessions for Level 3 Safeguarding Children has been provided, with good uptake from staff. Provision of the majority of subjects are provided within this training. However, monthly updates are provided by the NMS for the Essential Skills mandatory training. This enables targeted updating on the required subjects, but also allows discussion for 'hot topics' that may have been noted within recent practice, or changes within the service.

5 SERVICE DEVELOPMENT

5.1 Following commencement of Team Connect, safeguarding supervision with the wider community midwives has been reduced to ad hoc conversation and emails as required. Without intent, the community midwives have become de-skilled in safeguarding due their reduced exposure and therefore, formal group safeguarding supervision will be offered quarterly to all teams. The NMS will provide this as a session following a team meeting, to ensure that a large number of staff can be reached. This supervision will be recorded in line with MFT Supervision Policy.

5.2 Following the recommendations from Better Births (2016) for continuity of carer, Team Connect have been identified as the Pilot team for MFT. Recruitment for a further 2 WTE Midwives to join the team has commenced, with the aim to start in the year 2021/22. Team Connect have fantastic continuity within their caseload, although this is only currently capturing antenatal and postnatal care. The Continuity of Carer team will aim to also provide intrapartum care. This will further improve outcomes for our vulnerable families.

5.3 The Substance Misuse Guideline has been developed by the NMS, in partnership with other members of the MDT team. As previously discussed, the Windmill Clinic has resumed, which is enabling a 'wrap-around' service for our women and pregnant people that are misusing substances.

5.4 The NMS is in liaison with the Designated Nurse for Safeguarding Children for the Clinical Commissioning Group (CCG) to support the implantation of the ICON approach across Kent and Medway. The intention of the approach is to prevent abusive head trauma (AHT). There have been a number of cases of that have been serious case reviews, or safeguarding practice reviews across Kent and Medway, where babies have died, or been seriously injured. One of the recommendations that was for a promotional campaign aimed at raising awareness of risks of AHT. The CCG have agreed funding for all Kent and Medway Trusts. This will enable MFT access to use all resources and promotional content. The launch is scheduled for summer 2021.

5.5 MFT has a large number of out of area bookings for Maternity care. Historically, the safeguarding information provided by these women has been taken at face value, with only new concerns being escalated. Evidence from Serious Case Reviews, such as the review into the death of 'George', illustrate that it is common for families to move around to evade involvement with Social Care. Therefore, the lack of safeguarding procedures around out of area families has been identified as a safeguarding risk.

5.6 Mitigation for this risk commenced in Quarter 3. The NMS provides a monthly spreadsheet of all out of area women that have booked during that month, to the NMS for the respective Trust that they fall under. This information sharing does not provide a 100% guarantee that there are no current safeguarding concerns, as each Trust will only hold information for families that have previously accessed care. However, it does provide a safety net. Information is also provided to other Trusts from women that live in our area, but have chosen to book with another Trust.

5.7 Further liaison with other Trusts for development of a formal pathway of information sharing has been commenced. This has included discussion at both Regional and National NMS Networks.

6 POSSIBILITIES & CHALLENGES

6.1 The main challenge within the NMS role, has been regarding the additional management responsibilities of Team Connect. Historically, the NMS role has been specifically a standalone specialist role. With development of Team Connect with Midwives attached to each community team, to becoming a team within its own right, it has created additional work. This at times has affected the role of the NMS, as they have been required to cover clinical shifts, due to staff sickness and acuity. Within the pandemic, the strain on staffing has been across the board and is unprecedented; therefore, the wider community teams were unable to support Team Connect as they have previously.

6.2 To support the NMS with management of Team Connect, recruitment for a Deputy Team Leader has commenced. This should enable the day-to-day management of the team to be maintained, with the NMS acting as a point of contact, whilst not taking focus from the heavy workload that the NMS role generates.

6.3 Maternity Safeguarding and the roles and responsibilities, generates a huge amount of administration. The NMS has, at times, found that time is spent collating information and inputting data. This has meant that this has taken priority over developing the service, providing visibility on the ward and supporting staff and Team Connect. Admin support has been requested for 2 days a month, which would release time for the NMS to focus on the service.

6.4 Overall 2020/21 has seen some positive changes and development of excellent safeguarding practice during an unprecedented time. The NMS will continue to support and develop these excellent practices in 2021/22.

Meeting of the Public Board
Wednesday, 12 January 2022

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework</td><td>Agenda Item</td><td>4.1</td></tr>
<tr><td>Report Author</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="5">A summary of the BAF as of 31 December 2021 is presented in this paper.

The Trust's principal risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Oct 21</th><th>Nov 21</th><th>Dec 21</th></tr>
<tr><td>3a – Delivery of financial control total</td><td>9</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>5c – Patient Flow</td><td>6</td><td>16</td><td>16</td><td>16</td><td>20</td></tr>
</table>
</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="5">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="5">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="5"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="5">N/A</td></tr>
<tr><td rowspan="2">Recommendation/ Actions required</td><td colspan="5">The Board is asked to note the report for assurance regarding the processes in place around risk management.</td></tr>
<tr><td>Approval
☐</td><td>Assurance
☐</td><td>Discussion
☐</td><td colspan="2">Noting
☒</td></tr>
</table>

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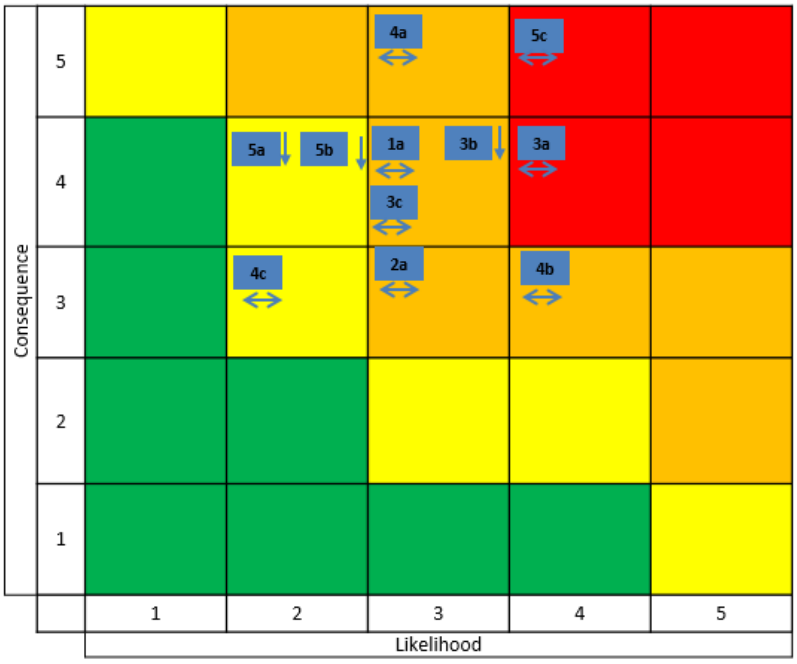
1 Board Assurance Framework

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



In the current reporting period the Trust has seen the decrease of 3 risks, 3b – Capital investment, 5a – CQC progress and 5b – Health and Social Care Act requirements, and the closure of 3 risks, 2b – Capacity and capability, 2c – Funding for investment and 3d – Going concern.

There are a two principal risks that are rated as high, 3a – delivery of financial control total - Financial risks are being managed through the current planning rounds within the Trust and the wider system with the clinical and corporate areas, and 5c – Patient flow, which is being managed through the clinical and operational teams.

	Target Score	Initial Score	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12	12	12	12
2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9	9	9	9
2b. Capacity and Capability	9	9	6	6	6	6	6	6	6	6	6	6	6	
2c. Funding for investment	9	9	6	6	6	6	6	6	6	6	6	6	6	
3a. Delivery of financial control total	9	16	16	8	8	16	16	16	16	16	16	16	16	16
3b. Capital Investment	12	16	12	12	12	16	16	16	16	16	16	16	16	12
3c. Failure to achieve long term financial sustainability	4	16	12	12	12	12	12	12	12	12	12	12	12	12
3d. Going concern	4	12	4	4	4	4	4	4	4	4	4	4		
4a. Sufficient staffing of clinical areas	6	16	12	12	15	15	15	15	15	15	15	15	15	15
4b. Staff engagement	6	12	12	12	12	12	12	12	12	12	12	12	12	12
4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	6	6	6	6	6
5a. CQC Progress	4	16	12	12	12	9	9	9	9	9	9	9	9	8
5b. Failure to meet requirements of Health and Social Care Act	6	16	9	9	9	9	9	9	9	9	9	9	9	8
5c. Patient flow – Capacity and demand	6	12	16	16	16	9	9	12	12	16	16	20	20	20
Total Risk Score	105	242	175	167	139	141	141	144	144	148	148	152	148	130
Residual Risk to Target Gap			70	62	65	36	36	39	39	43	43	47	43	25

Table 1.1 – Summary of BAF

	May -20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov -20	Dec-20	Jan-21	Feb-21	Mar -21	Apr-21	May -21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov -21	Dec-21
Residual Risk to Target Gap	77	76	76	64	64	52	51	70	70	62	65	36	36	39	39	43	43	47	43	25

1.1

Figure 1.2: Residual risk to target gap

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

1.3 The reduction in the residual gap between November 2021 and December 2021 was due to the closure of three risks.

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

COMPOSITE RISK: Innovation										
EXECUTIVE LEAD: Chief of Staff										
LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
2a There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP/ICS and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace with new technologies, other organisations locally and the ICP and ICS/STP.	4 x 4 = 16 **High**	1. Author a Digital Strategy that is well socialised across the region and well engaged with by teams internally. 2. Develop a roadmap to a single Electronic Patient Record. 3. Focus initially on key projects and investments to stabilise IT services (telephony, networks, end user devices, licenses, systems upgrades, service desk). This will provide a strong technology and information foundation to build upon: EPR, innovation, whole system analytics, specialist services. 4. Seek Regulator support for IT investments and longer-term Digital Strategy	Director of Transformation and Digital, CIO and Senior Digital Team Weekly CIO call with all Kent & Medway provider Trusts	Reporting to the Executive Team Reporting to the Innovation Board, Trust Improvement Board Reporting to Finance Committee as part of Committee work plan	ICP Digital Strategy group (re-forming from October 2020) ICS CIO NHS E/I South East Digital team NHS Digital (TSSM, Cyber) NHS X	Formally publish Digital Strategy and EPR business case, ratified by Board Participate well in ICP Digital Strategy Group Form Digital First Team Appoint CCIO Re-launch Digital/IT team Continue to work closely with Regulators	**3 x 3 = 9 Moderate**	**3 x 2 = 6 Low**	P

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a Delivery of Financial Control Total	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. Under 2021/22 contracting arrangements the ICS must meet its control total. Given the uncertainty of Covid, efficiency delivery risks and the system operating on a block income, there is significant uncertainty and a risk of the Trust not meetings its control total. This risk is exacerbated by significant activity / demand above planned levels, particularly emergency and non-elective demand, in particular through the winter months.	4 x 4 = 16 **High**	1. Rebasing of divisional plans through robust business planning/budget setting. 2. Seek additional monies from third parties to support initiatives and/or the underlying financial position, including the Charity, ICS and national funding sources. 3. Work with NHSEI intensive support team. 4. Application of NHSEI "Grip and Control" actions to limit spending, at least on a temporary basis.	Internal accountability framework at programme level, i.e. budget holder meetings.	Monthly reporting and insight of actual v budget performance for review at care group boards, divisional boards, divisional IQPRMs, Finance Committee and the Trust Board.	Monthly Integrated Assurance Meetings with regulators.	Further assurance of monies available / awarded to the Trust in respect of Targeted Investment Fund and UEC national funding. Pursuit of Statistical Process Charts in understanding financial performance.	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 2 = 8 **Low**)	3 x 3 = 9 **Moderate** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Low)**	
			5. Programme Management Office: a. Work with divisional teams to identify, develop, implement and track operational delivery and financial consequences of efficiency schemes. b. Delivery of efficiency showcase events.	Chief Financial Officer and Chief of Staff.	Efficiency Delivery Group.		Progression of cross-cutting schemes to implementation. Rapid assessment of red schemes with no value. Progression of red and amber schemes through PID panel. Attend efficiency support session for divisions with NHSEI.			
			6. Financial Training Policy and SOP approved, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon.	Delivery of and attendance at training programmes for staff. Appraisals / objective setting.	Financial Stability Programme Board.		Financial training packages to be continually reviewed. Training dates diarised for next 18 months and first sessions delivered; finance induction leaflet issued. Global and targeted communication issued.			
			7. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings.	Chief Operating Officer	Weekly Senior Operations Meeting that reports via IQPR	Monthly IQPR meetings with NHSE/I	Agreement from Trust Executive Group as to which elements of the winter plan must be implemented			

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
			c. Patient First Programme workstreams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication.				irrespective of funding.			
3b Capital Investment	If there is insufficient resource to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan, patient safety and/or staff wellbeing. Capital resource is allocated at a system level across the ICS and hence both national and local priorities (including top-slicing for ICS projects) could impact availability.	4 x 4 = 16 **High**	1. Governed entirely by the availability of capital resource, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the ICS and regulators unless affordable within the existing capital programme or through a revenue stream. 2. Project lead completion of prioritisation scoring matrix; Trust review to moderate and agree scores with highest priority projects being proposed as the in-year plan. Trust executive to review and agree the plan, including those items "below the line" in any given year. 3. Bid against/for additional capital sums released during the course of the year, whether that be from the ICS allocation or national funds for particular themes.	Trust business case governance process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Trust Capital Group, Business Case Review Group, Finance Committee and Board.	Sharing and scrutiny via the ICS capital planning group.	1. Trust clinical and divisional strategies to be developed by 31 March 2022. 2. Clarity and support from ICS where further funding is made available (ongoing/as applicable). 3. Capital plans / pipeline from divisional teams for 22/23 to be notified by early December 2021. PIDs (and where required, business cases) to be written for approval in advance so schemes are "ready to go" as funds are known/awarded.	4 x 3 = 12 **Moderate** (Previous risk rating: Oct 2021 4 x 4 = 16 **High**)	4 x 3 = 12 **Moderate**	
3c Failure to develop, approve and deliver against a Financial Recovery Plan ("FRP")	If the Trust does not understand and agree with its partners the route(s) and impediments to financial sustainability, and then deliver against this, it will not exit the Recovery Support	4 x 4 = 16 **High**	1. Financial sustainability has been agreed as one of the Trusts top corporate priorities following an executive director exercise. 2. NHSE/I financial improvement/recovery group established including NHSE/I intensive support team collaboration. 3. Work on the financial modelling has begun with sound collaboration and engagement across the ICP.	Development of long term financial model. Clinical service strategies in place and aligned to the Trust, ICP and ICS strategies.	Reporting of identified risks and pressures alongside efficiency and financial performance to Finance Committee regularly. Monitored at Financial Stability Programme Board.	NHSE/I-led steering committee of ICS partners. ICS currently responsible for managing system positions, with principle that all organisations	Agreement of activity growth/trajectories and associated financial modelling assumptions. Development of local and system interventions.	4 x 3 = 12 **Moderate** (Previous risk rating: Mar 2020 4 x 4 = 16 **High)**	4 x 1 = 4 **Very low** (Previous target risk rating: Mar 2020 4 x 3 = 12 **Moderate)**	

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
	Programme, leading to reputational damage, further licence conditions and potential regulatory action.				ICP working group and ICP steering groups.	achieve breakeven.				

COMPOSITE RISK: Workforce										
EXECUTIVE LEAD: Chief People Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Four – We will enable our people to give their best and achieve their best										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
4a There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	This may lead to an impact on patient experience, quality, staff morale and safety	**4 x 4 = 16** **High**	1. Strategy: People Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) Wellbeing Guardian quarterly assurance report	Monthly Oversight Meeting with regulators.	Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] Patient First to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Date TBC] Delivery of equality action plans, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 22]	**3 x 5 = 15** **Moderate**	**3 x 2 = 6** **Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 10%. 2. Monthly Sickness rate 5% 3. Substantive workforce 85% Safe staffing report (twice yearly)					
			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 2% 4. Bank workforce 13%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 150 apprentices of 101 target	People Committee					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						

				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'. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) NED Wellbeing Guardian assurance report Freedom to Speak Up strategy quarterly assurance report Wellbeing Guardian quarterly assurance report	Monthly Oversight Meeting with regulators.	Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] Delivery of the Staff Health and Wellbeing strategy [Mar 22 milestone] Delivery of ILM level 3 leadership programme [Dec 21] Refresh of Dignity at Work policy and approach [Dec 21]	**3 x 4 = 12 (Moderate)**	**3 x 2 = 6 (Low)**	
			Culture Intervention: The Trust has embedded the delivery of 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme.	1. You are the difference (YATD) embedded in induction 2. NHSEI Culture, Engagement and Leadership Programme Board						
			Staff Communications: a. Weekly Chief Executive communications email; b. Monthly Chief Executive all staff session; c. Senior Team briefing pack monthly.	Communications routes well-established in Trust.						
			Staff Survey results: Annual report to Board demonstrating: a. Trust scores across key domains; b. Comparative results from previous years and other organisations; c. Heat maps for targeted interventions. d. Local survey action plans to address key concerns.	Survey 2020 staff engagement score, 6.6 – lower than average 7 (6.4 2018, 6.8 2019)						
			Leadership development programmes: a. Implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fifth year; 3. Henley Business School MA leadership						

				programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom To Speak Up Guardian route to Chief Executive; b. Respect: countering bullying in the workplace policy; c. Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Respect policy in place; 3. JSC and JLNC in place.						
			Well-being interventions in place: a. Employee assistance programme and counselling; b. Advice and health education programmes; c. Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support. d. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live. 3. Staff Health and Wellbeing strategy and delivery plan						
			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place Qualitative and quantitative values-based appraisal						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) Freedom to Speak Up strategy quarterly assurance report Wellbeing Guardian quarterly assurance report	Monthly Oversight Meeting with regulators.	Delivery of ILM level 3 leadership programme [Dec 21] Civility and Respect launch [Nov 21] Appraisal rate below requirement (85%) [Dec 21]	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance linked to incremental pay progression (policy implemented). 1. StatMan compliance >89% 2. Appraisal rate >82%						
			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. Civility and respect toolkit, actions and behaviours; d. Respect – countering bullying in the workplace policy. Triangulation between FTSU, Employee Relations, Legal and Equality and Inclusion.	1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Civility and respect toolkit (live Nov 2021) 3. 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 10%; 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 fifth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.						

COMPOSITE RISK: Quality 2021/22											
EXECUTIVE LEAD: Chief Nursing and Quality Officer (5a and 5b) and Chief Operating Officer (5c)											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently demonstrate compliance with the Care Quality Commission Fundamental standards, and as such, to meet the statutory requirements of the Health and Social Care Act	**Cause and Impact:** 1. Lack of effective governance systems and processes to routinely monitor compliance with the fundamental standards. 2. Lack of evidence to demonstrate compliance with NQB and NICE guidance (2015) Workforce Standards 3. Potential for regulatory action by CQC &/ or NHSI. 4. Loss of confidence in the Trust by the wider healthcare system e.g. CCG, patients and carers. 5. Poor staff morale and engagement. 6. Damage to patient experience and patient outcomes.	**12 Moderate 3(L) x4(C)**	**1.** Agreed Quality Strategy Priorities Year 2 **2.** Quality Report and Accounts **3.** Agreed High Quality Care Programme Year 2 improvement priorities: monthly monitoring **4.** Ward Quality & Safety Boards **5.** Ward Gold 'stars' awards to recognise and celebrate patient high standard achievements. **6.** CQC showcase events **7.** CQC Engagement Meetings **8.** Daily Trust wide safe staffing reviews: CNO & DDON escalation **9.** Annual Safe Staffing reviews **10.** Recruitment pipeline as per plan. **11.** ED MD/ SD action plan following December 2020 unannounced CQC inspection now completed **12.** NHSEI Independent Quality Governance review completed. Recommendations accepted by the Executive **13.** Programme of Ward Quality Assurance Visits **14.** Refreshed CQC MD SD action plan **15.** CNST Maternity Incentive Scheme **16.** Quality metrics monitored & reported via IQPR and divisional scorecards, Quarterly triangulation report on Claims, Complaints and Incidents to QAC **17.** Audit review processes: Clinical Audit programme, Perfect Ward, NICE, NCEPOD & GIRFT providing enhanced assurance and oversight. **18.** Quality Governance team, systems & processes **19.** CCG CQR meeting **20.** Quarterly report on clinical audit plan compliance to Q&PSG **21.** Chief Medical Officer Grand Rounds **22.** SI & IR Group meeting CQC action plan Must and Should Do with accountable executive and operational owners	Quality Panel Governance in place with fortnightly meetings. CQC Evidence panel in place with fortnightly meetings. Quality and Patient Safety Group meeting monthly. CNST Task and Finish Group meeting fortnightly. Care Group and Divisional Governance Boards meeting monthly	Monthly progress reports on divisional Quality Governance to Q&PSG, Executive Group, Quality Assurance Committee and Trust Board. High Quality Care Programme Board provides monthly progress reports to the Trust Improvement Board. Rolling programme of preparedness CQC care group showcase forums in place. Quality Report and Accounts. All actions on the ED MD/ SD action plan, following the unannounced CQC inspection of ED in December 2020, have now been completed and approved by the Quality Panel and incorporated into BAU. A refreshed CQC MD SD action plan was presented to the Executive Group on 6 October2021 for approval CNST Maternity Incentive Scheme approved by the Trust Board and submitted to NHS Resolution in July.	Internal Audit and External Quality Audit. QGR meetings with GCCG CQC Engagement Meetings Single Item Multi-Agency meetings	1. Divisional ownership and accountability for quality governance needs to be strengthened. 2. No single source of oversight & accountability for compliance with CQC Fundamental standards at divisional or Trust level. 3. Terms of Reference for QPSG to be approved at May QAC to ensure TOR are in alignment with QAC TOR. TOR under further review following the NHSI governance review 4. AD Patient Experience post vacant posing a risk to the delivery of improving the Patient Experience Strategy and patient experience overall oversight	**1.** Organisational plan for moving Trust from good to outstanding in development led by Chief Strategy & Transformation Officer, CNO & AD QPS **2.** Ward accreditation and CQC preparedness approach under review with the aim of combining the approach: self-assessment, assurance visit and showcase events **3.** Monthly Matron & HON assurance monitoring meeting to discuss early warning quality assurance findings **4.** Independent Quality Governance review structure implementation underway **5.** Approach of Divisional governance report summary to be presented at QAC in development **6.** Development of early warning quality assurance scorecard underway **7.** Review of safe staffing review	**8 Low 2(L)x4(C)**	**4 Very Low 1(L)x4(C)**	Partial

								approach underway **8.** Recruitment to Head of Patient Experience underway **9.** Effectiveness & Outcome Group ToR under review **10.** Learning framework to articulate the Trust wide methodology for shared learning being developed			

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	**Cause and Impact:** 1. Lack of effective IP&C governance systems and processes to routinely monitor and maintain compliance with the hygiene code 2. Potential for regulatory action by CQC &/ or NHSI. 3. Loss of confidence in the Trust by the wider healthcare system. 4. Poor staff morale and engagement. Damage to patient experience and patient outcomes.	**12 Moderate 3(L) x4(C)**	1. IPC Improvement plan 2. NHSEI & CCG IPC Intensive Support programme supporting the Trust 3. CNO is the DIPC 4. IPC Doctor is also Associate DIPC 5. Head of IPC is Deputy DIPC 6. IP&C Team structure and leadership 7. Improvement priority work through HQCP to reduce C- Diff Infections 8. IP&C Governance Review completed 9. Covid BAF reviewed and updated 10. MFT participation in Kent & Medway IPC Network 11. CNO IPC monthly blogs to communicated key messages 12. Mandatory IPC training compliance at over 95% for the majority of the last several months 13. Infection Prevention and Control Committee 14. Antimicrobial Stewardship Committee 15. Quality Assurance Committee 16. High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction 17. Decontamination included as part of IPC Committee 18. IPC Cell initiated as per COVID Plan	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual approach to be adopted, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan developed setting out short, medium and long term goals for delivery Mandatory IPC training compliance at over 95% for the majority of the last several months. Divisional and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Assurance Committee Quality Panel High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction Decontamination Group in place – IPC Cell initiated as per COVID Plan	IPAS (NHS I/E) meeting Oversight from system DIPC NHSE/I report CQC IP&C Inspection report	IPC policies currently undergoing review. PIRs not being completed in a timely way, therefore limited lessons learned and shared.	**1.** IPC policies, procedures and protocols being reviewed **2.** CNO IPC monthly blog to be recommenced: Every Action Matters NHSEI initiative **3.** Development of early warning quality assurance scorecard underway: will include IPC KPIs **4.** Monthly Matron & HON assurance monitoring meeting to discuss early warning quality assurance findings **5.** IPC Governance Review: implementation and improvement plan and update report to be presented at Exec, IPCC and QAC **6.** Outbreak policy being updated	**8 Low 2(L) x 4(C)**	**4 Very Low 1(L)x4(C)**	Partial

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
5C There is a risk that the Trust is unable to meet the constitutional standards for emergency and elective access	**Cause and Impact:** 1. Insufficient capacity to manage the totality of the emergency and elective demand over a 12 month period causing a deficit of bed on occasions leading to AMB hand over delays, long waits in ED and cancellation of elective activity 2. The demand for emergency care exceeds the expected levels for attendances and admissions	**16** **High** **4(L)x4(C)**	1. Restart programme includes a refresh of demand and capacity across all specialties 2. Pathways reviewed to ensure patients receive care in most appropriate settings. 3. Emergency pathways further developed to include range of assessment options through frailty, acute assessment (medical and surgical) and Same Day Emergency Care (SDEC). 4. A priority admission unit (PAHU) has been set up to facilitate transfers out of ED once patients have a DTA. 5. Bed reconfiguration programme undertaken to profile the planned and unplanned beds based on expected demand, co-location of specific areas & full ring-fencing of elective capacity. 6. Renewed focus on length of stay to ensure patients get the most effective care as short a stay in hospital as is appropriate for their care (Patient First). 7. Covid and Winter Plan identified further interventions to expand capacity and maximise use of beds. 8. Elective, outpatients & cancer care modelling completed to ensure patients with a prolonged wait for treatment are appropriately prioritised and managed. 9. Recovery programme managed through System approach to ensure all out-of hospital capacity and opportunities are highlighted and used appropriately. 10. Elective standards delivered as per the agreed trajectories (some ahead of trajectory). 11. NEL trajectories for the 4 hour standard, time spent in ED and ambulance handovers. 12. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A 13. ECIST 14. Patient First Programme:- focus is on 3 aspects of flow management: Acute Care Transfer, Flow and Discharge, Site Operations 15. SAFER principals taught ward by ward basis	Recovery plans including agreed trajectories for all constitutional standards Patient Discharge & Flow Programme with focused clinically led work-streams. Regular Mini-MADE events on targeted wards to highlight an manage delayed discharges for medically optimised patients. Daily and Weekly operational performance reviews for elective, cancer and emergency activity Daily check points for activity & flow Trajectories for all constitutional standards in place. Involvement of Matrons and Clinical Leads in Flow management More clarity and targeted actions with system-partners on out of hospital capacity and responsiveness Outputs and rapid changes from the Rapid Improvement Event held w/c 16	Reviews and updates discussed at Executive Group, TIB and Board. Daily and weekly senior operational oversight. National planning tools being used. System calls in place to ensure escalations. IQPR PIRM Progress against ED action plan will be overseen by Quality Panel	External reviews by NHS I/E Single Item Multi-Agency meetings Monthly checkpoint with SE Region Monthly ICS Performance Reviews	1. Inability to fully mobilise the bed configuration and refurbishment plan 2. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22 3. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22.	**1.** Restart programme focused on Elective, Cancer and Diagnostics **2.** Pathway interrogation to seek opportunities in accelerating frequent causes for delays (e.g., specialist beds prosthetic rehabilitation). Working with system partners to find care alternatives **3.** SAFER, BR process and IDT work to improve discharge opportunities in back end wards and enable Assessment units to function **4.** Revision and embedding of safer discharge principals **5.** Regular Mini-MADE events on targeted wards to highlight and manage delayed discharges for medically	**20** **High** **5(L)x4(C)**	**8** **Low** **2(L)x4(C)**	Partial

			16. Recovery plans including agreed trajectories for all constitutional standards 17. Patient Discharge & Flow Programme with focused clinically led work-streams 18. Daily and weekly senior operational oversight 19. System calls 20. IQPR 21. PIRM 22. Monthly checkpoint with SE Region 23. Monthly ICS Performance Reviews 24. Weekly length of stay meetings with Matrons to focus on patients with LOS 14+, Intention to reflect this to patient 7days+ once numbers reduce	July 2021 being reviewed as to whether to adopt, adapt or discard any of the 'tests of change'.				optimised patients **6.** More engagement with Estates and Facilities re priorities for capacity configuration **7.** Full mobilisation of Frailty SDEC **8.** Inability to fully mobilise the bed configuration and refurbishment plan **9.** Roles and responsibilities review of IDT to ensure that MFT and MCH colleagues can work collaboratively to ensure that patient discharges are expedited **10.** Work with system partners to explore alternative options for intermediate resolution whilst care packages are extremely restricted (eg step down beds)			

Meeting of the Board of Directors in Public
Wednesday, 12 January 2022

Title of Report	**Access To and Oversight of Mortuary Arrangements**	**Agenda Item**	4.2
Report Author	Keith Soper, Deputy Chief Operating Officer		
Lead Director	Jayne Black, Chief Operating Officer		
Executive Summary	Following the recent high profile incident all NHS Trusts received a communication from NHS England and NHS Improvement regarding access to and oversight of mortuary and body store arrangements. The letter requested that all Trusts with either a mortuary or body store urgently review their practices and ensure a number of actions are implemented. This paper summarises the progress against the areas outlined in the communication and the Trust is compliant with all requirements.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Executive Committee		
National Guidelines compliance:	Yes		
Resource Implications	Yes - c£10k		
Legal Implications/Regulatory Requirements	Yes		
Quality Impact Assessment	Not required		
Recommendation/ Actions required	The Board is asked to note.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

Executive Summary

Following the recent high profile incident all NHS Trusts received a communication from NHS England and NHS Improvement regarding access to and oversight of mortuary and body store arrangements. The letter requested that all Trusts with either a mortuary or body store urgently review their practices and ensure the following actions are implemented:

1. **Ensure all access points to the mortuary or body store are controlled by swipe card security access. Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.**

2. **There must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task.**

3. **A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area.**

4. **Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract.**

Trusts were asked to assure themselves they have reviewed the evidence in response to the above actions and confirm they are satisfied with the appropriate response. The deadline for completion was Tuesday 16th November 2021. The response was completed via an e-form with Yes or No answers. Our response was Yes to all four points.

Assessment at the time of Return to NHSE/I

1. **Ensure all access points to the mortuary or body store are controlled by swipe card security access. Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.**

   There are three access points into the main mortuary:

   - Access point 1 - Main Door (to hospital street) Access. This is swipe access and is covered by a camera in Hospital Street as well as a camera on the key pad.
   - Access point 2 - Viewing room. There is a digilock on the external door to the viewing room which is only known to the Mortuary staff, however as a further control the door to the viewing room from inside the mortuary is locked from the inside with a deadbolt lock.
   - Access point 3 - Porch area. This has a key lock as well as swipe card access and is covered by external CCTV.

   Further internal controls include swipe card access to the post-mortem room.

   The secondary body store has one access point this is locked and alarmed. The key holder is the mortuary team and the site is alarmed with the reset code held by the mortuary team. The third storage area is a rented mobile unit with access via key lock, again which is held by mortuary and alarmed.

   Response on return - **Yes**

2. **There must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task.**

   There is CCTV coverage external to and within the main mortuary. There are three CCTV cameras that cover all areas of the fridge room with no blind spots. There is no CCTV in the post mortem room.

   The most recent CCTV audit was carried out 3 weeks ago and audits of access are scheduled every 6 months. The mortuary team randomly audit 5 instances of swipe card access and review on CCTV for appropriateness.

   A member of the mortuary team views the internal CCTV cameras every morning.

   Response on return - **Yes**

3. **A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area.**

   Assessments for different elements of the facilities exist within our governance systems. These include departmental risk assessments, care group risk register entries, and divisional risk register entries.

   Response on return - **Yes**

4. **Ensure there is consistent application of appropriate levels of DBS checks for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract.**

   We are compliant with NHS Employment Checks Standards for all appointments and use ESR position-based controls to ensure compliance with relevant checks. The Trust uses e–DBS services for the purposes of processing - this includes volunteers and ensuring contractor DBS checks are in place. We do not currently have a periodic rechecking policy as part of our DBS policy, which is in line with the NHS Employment Checks Standards and other Trusts. DBS compliance has been discussed at the Quality Assurance Committee in October 2021 and is due to be discussed at the People Committee in November 2021. Both of these are Board sub-committees.

   Response on return - **Yes**

<u>Further Work</u>

Whilst our review did not identify any significant gaps, we are conducting a full assessment against the Human Tissue Authority guidelines for mortuaries be completed with an associated action plan. This will come to the Quality Assurance Committee in early 2022. Alongside this, we are progressing the following actions:

Action	Update	Timescale
Assessing the potential to replace the door code access from the bereavement room into the mortuary with swipe card access	This is being actioned and will be changed	End January 2022
Reviewing swipe access rights at an individual level, whilst recognising that a number of colleagues will need to be	We are revoking all mortuary swipe access and providing it only to porters, fire response (including Site Team), security and mortuary colleagues. We can re-	End December 2021

gain access legitimately and in the event of an emergency	instate access on assessment of each request as it arises. We are also introducing an automated access report with increased frequency	
Documenting internal and external CCTV audits and the production of an associated Standard Operating Procedure	There is an existing SOP in place but a change will be made to reflect the increased frequency of security audits and to include the checking of image quality. We are also further increasing CCTV coverage by a further 13 cameras within the access corridor and in the three walk-in body stores	End January 2022
Discussion at ICS level regarding a consistent approach to periodic DBS checks for those staff that have not auto-enrolled in the DBS service, including consideration of contractors	This will be taken forward with ICS colleagues	April 2022
Reviewing the ongoing use of our mobile storage facility with a view to considering the relative benefits of increasing capacity within the main or secondary store	This is being reviewed as part of our overall Estates plan and will be a consideration for the capital programme if the assessment determines this is practical and preferable	April 2022

Meeting of the Board of Directors in Public
Wednesday, 12 January 2022

Title of Report	**Finance Report**	**Agenda Item**	5.1
Report Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Finance Officer		
Executive Summary	The Trust reports a breakeven against the NHSE/I control total.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 16 December 2021		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report		

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Finance report

For the period ending 30 November 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(8)	(8)	0	The Trust reports a £8k deficit position for November; reducing to breakeven in month and year to date after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes Elective Recovery Funding (ERF) income of £4.6m in H1 and £1.4m for year to date in H2, this covers the incremental costs of delivering ERF activity. There is no contingency accrued into the position. This month's pay expenditure has increased by £0.6m to £20.6m, this is due increased escalation capacity, PAHU, enhanced rates for bank staff and temporary cover for staff sickness.
Donated Asset Depreciation	9	8	(1)	
Control Total	**-**	**-**	**-**	
Efficiencies Programme				
In-month	613	255	(358)	The in-month position is reporting a £0.1m decrease from October as the previous month included the pharmacy procurement rebate. The total schemes identified for the year is £4.1m leaving a gap £1.0m to the overall plan of £5.1m for the full year; this includes some of the 9 crosscutting efficiency schemes. Of the £4.1m schemes, following a review by the Finance Business Partners it is forecast that £3.6m of efficiencies will be delivered. There was an overdelivery against budget in H1 mainly driven by ERF income efficiency; current forecast is a £0.3m deficit to budget per month.
YTD	2,717	2,542	(175)	
Capital				
In-month	877	644	(233)	The Trust Capital Resource Limit (CRL) and plan was set at £13,877k for 2021/22 by the ICS. Since the plan was set an additional £5,397k capital funding has been secured: £2,796 PDC, £3,128k additional ICS allocation and £80k donations, offset by a £607k PDC for UTC being deferred into 2021/22. £1,800k of the additional CRS allocation is from East Kent Hospitals NHS FT Emergency Department project slippage, which the system will be required to fund in 2021/22. The Trust Capital programme is currently 41% complete / £2,492k (24%) behind plan. This mainly relates to delays in the CSSD Conversion project due to asbestos complications (£710k), partial deferral of the UTC Project (£552k) due to a delay in the confirmation of DHSC funding and permanent deferral of Bronte Ward refurbishment due to access issues(£497k) other projects have replaced this but will be completed over a later timescale. The Trust forecasts full achievement of the revised plan although this is achieved with some flexibility over £1,960k now set aside as a contingency for the final quarter. There are bids way in excess of the contingency pot, which will be prioritised accordingly by the Trust Capital Group.
YTD	10,591	8,099	(2,492)	
Annual (reported forecast)	19,274	19,274	0	

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1. Executive summary (continued)

Cash				
Month end	49,184	38,369	(10,815)	Cash balances have decreased in month by £2.6m, mainly due to Health Education England failing to pay their quarterly education funding invoice of £3.8m. Their outsourced financial services provider is currently holding the payment for fraud checks. The cash balance is £10.8m adverse to the cash balance held on 31st March 2021, which the plan is set at. This is due to the late issue of PDC in the prior year for capital schemes. Since year-end capital expenditure associated with these schemes has been paid in cash resulting in a decreased cash balance, as debts are settled and current year PDC issues cash is expected to rise again. Cash balances are expected to be maintained at a similar level (£40m to £50m) throughout the year, however this is dependent on the approval of cash reserves being utilised for additional capital investment.

Activity is below draft budgeted levels as a result of Covid	Clinical income based on the 21/22 consultation tariff would have reported a year to date position of £171.8m, this being £7.1m lower than income in the same period of 19/20. In month performance excluding high cost drugs is £21.9m, which is £1.8m lower compared to M7, reported figure.

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

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	27,326	28,093	767	224,928	224,015	(914)
High cost drugs	1,817	1,803	(14)	14,683	14,719	37
Other income	1,795	2,296	501	13,706	16,292	2,586
PSF/MRET/FRP	0	0	0	0	0	0
Donated Asset Adjustment	0	109	109	0	207	207
Total income	**30,938**	**32,302**	**1,363**	**253,317**	**255,233**	**1,916**
Nursing	(8,026)	(8,287)	(261)	(64,900)	(64,688)	212
Medical	(6,262)	(6,570)	(308)	(50,592)	(51,665)	(1,073)
Other	(5,636)	(5,698)	(61)	(42,520)	(45,045)	(2,525)
Total pay	**(19,924)**	**(20,555)**	**(631)**	**(158,012)**	**(161,398)**	**(3,386)**
Clinical supplies	(3,829)	(4,449)	(620)	(31,260)	(33,895)	(2,635)
Drugs	(545)	(905)	(360)	(4,679)	(6,607)	(1,928)
High cost drugs	(1,817)	(1,799)	18	(14,725)	(14,715)	10
Other	(3,424)	(3,142)	282	(33,182)	(27,126)	6,055
Total non-pay	(9,615)	(10,296)	(680)	(83,846)	(82,343)	1,503
EBITDA	**1,399**	**1,451**	**52**	**11,459**	**11,492**	**32**
Depreciation	(854)	(904)	(50)	(7,120)	(7,120)	1
Donated asset adjustment	(9)	(8)	1	(64)	(64)	0
Net finance income/(cost)	2	(3)	(5)	13	(22)	(35)
PDC dividend	(545)	(544)	2	(4,352)	(4,349)	3
Non-operating exp.	**(1,407)**	**(1,459)**	**(52)**	**(11,523)**	**(11,554)**	**(31)**
Reported surplus/(deficit)	**(8)**	**(8)**	**0**	**(64)**	**(63)**	**1**
Adj. to control total	9	8	(1)	64	64	(0)
Control total	**1**	**0**	**(1)**	**0**	**1**	**1**

1. Funding arrangements for the full year 2021/22 have been agreed with the Kent & Medway CCG.
2. The adverse YTD clinical income variance arises from £1.3m ERF income under performance in H1, offset by £0.2m Targeted Investment Funding (TIF) for H2. Also included is income for medical devices that are excluded from the block income payment. These are offset by costs included in expenditure.
3. Other income favourable position includes over performance on P2P contracts, £0.5m of out of envelope income to cover vaccination and quarantine costs, medical education contribution to overheads £0.3m and drugs recharges offsetting costs in the divisions.
4. YTD ERF income of £6.0m is included; this is further detailed as £4.6m for H1 and £1.4m for H2, as confirmed by NHSE/I.
5. In month pay budgets includes the impact of ERF costs in the Planned Care division £0.5m, additional escalation capacity and PAHU costs in the Unplanned Care division £0.3m, these are offset by some areas of underspending across the divisions and reserves not issued to cover cost pressures awating a PID or business case.
6. Medical staffing adverse variance is due to junior doctor shifts associated with patient flow and activity increases in acute & emergency care linked to patient activity and acuity £0.5m.
7. Nursing pay includes in month enhanced bank rates £0.1m, and £0.2m YTD. In addition to this, more substantive staff have been recruited resulting in supernumerary costs as the new staff are trained. Overall though temporary nursing costs continue to rise due to increased escalation capacity, sickness cover and 1:1 specialling.
8. Non-pay category includes the contingency and reserves budgets not issued to divisions.
9. Total expenditure includes £0.3m of incremental Covid costs (£3.2m YTD).

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3. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Unidentified	YTD Plan	YTD Delivery	Variance
Planned care	70	1,311	72	230	1,682	**2,132**	(450)	994	994	**0**
UIC	179	1,303	0	165	1,647	**2,190**	(543)	1,237	1,286	**49**
E&F	21	407	0	0	428	**382**	46	217	179	**(39)**
Corporate	73	316	5	0	394	**467**	(73)	78	84	**6**
Total	**343**	**3,336**	**77**	**395**	**4,151**	**5,171**	**(1,020)**	**2,526**	**2,542**	**16**
Previous Month	343	3,019	74	603	4,039	**5,171**	(1,133)	1,995	1,984	**(11)**
Monthly Movement	**0**	**317**	**3**	**(207)**	**113**	**0**	**113**	**531**	**558**	**27**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**613**	**255**	**(358)**	**2,717**	**2,542**	**(175)**	**5,171**	**3,616**	**(1,555)**

Process

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

The total efficiencies target for the financial year is £5.1m including the full year effect schemes from 20/21, which total £0.3m. Included in the year to date budget position are £2.5m of planned efficiencies and £0.2m schemes not identified, the actual performance of delivery across the services is £2.5m.

The main schemes that have delivered include improved ERF contribution margin £0.5m, cross cutting programme for procurement £0.7m, closure of theatre 5 in the Planned Care division £0.1m, Pharmacy procurement optimisation £0.2m, Facilities & Estates patient meals £0.1m, and full year effect of 20/21 schemes £0.3m.

The efficiency programme continues to be prioritised across all of the services; more schemes are in the pipeline and the crosscutting efficiency schemes continue to be developed. The PMO team and Finance Business Partners are continuing to support the services to identify potential areas of efficiency.

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4. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
221,951	**Non-current assets**	**222,868**	**917**
6,962	Inventory	7,102	140
16,216	Trade and other receivables	19,065	2,849
49,184	Cash	38,369	(10,815)
72,362	**Current assets**	**64,536**	**(7,826)**
(137)	Borrowings	(137)	0
(37,101))	Trade and other payables	(27,151)	9,950
(8,839)	Other liabilities	(12,075)	(3,236)
(46,077)	**Current liabilities**	**(39,363)**	**6,714**
(2,151)	Borrowings	(2,016)	135
(1,424)	Other liabilities	(1,425)	(1)
(3,575)	**Non-current liabilities**	**(3,441)**	**134**
244,661	**Net assets employed**	**244,600**	**(61)**
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,332)	(61)
36,062	Revaluation reserve	36,062	0
244,661	**Total taxpayers' equity**	**244,600**	**(61)**

Key messages:

1. Receivables have increased by £2.8m from the prior year. The current month balance includes an overdue quarterly HEE invoice of £3.8m. Excluding these balances receivables have decreased by approx. £1m since 31st March due to the settlement of some CCG and MCH debts.

2. Payables have decreased by £9.9m from the prior year due to the receipt and payment of material capital invoices; this balance includes £1.1m accrual for PDC dividend.

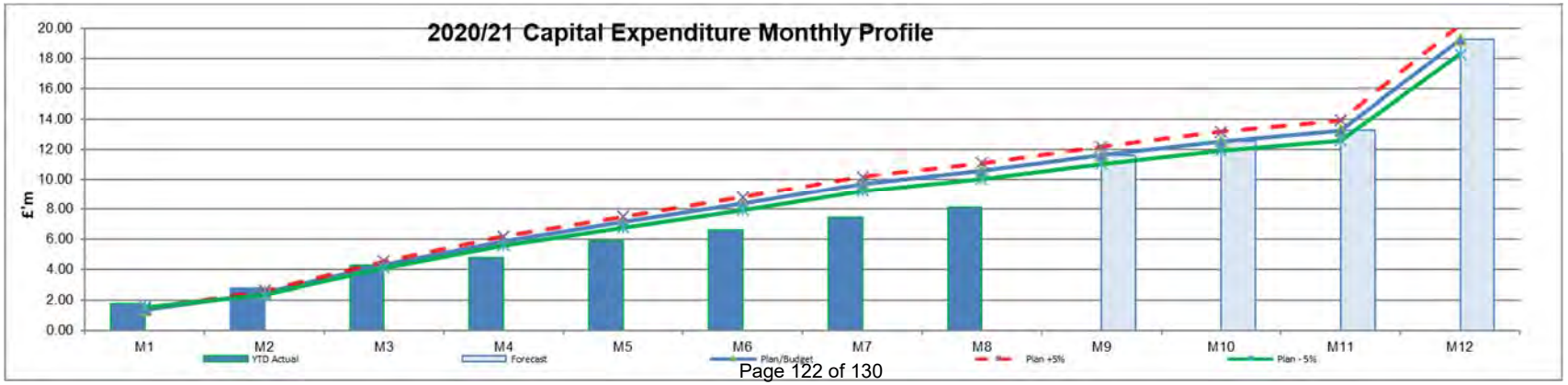
3. Other liabilities have increased by £3.2m from the prior year due to an increase in payments in advance from NHS Commissioners

4. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

6. Capital

2021/22 Capital Expenditure Update

£'000	In-month			Year To Date M1-M8			Annual					Funding (PLAN)			CRL allocation from		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	Var on NHSI plan	Var on revised Trust plan	Internal	PDC	OTHER	ICS	OTHER	TOTAL
Backlog Maintenance	(251)	387	639	2,885	2,885	0	3,014	3,205	3,612	598	407	3,205	0	0	3,205	0	3,205
Fire Urgency Works	222	187	(36)	1,882	795	(1,087)	2,331	2,331	2,533	202	202	2,331	0	0	2,331	0	2,331
Emergency Department	0	(2)	(2)	1,211	1,022	(189)	1,211	1,257	0	(1,211)	(1,257)	1,257	0	0	1,257	0	1,257
Information Technology	288	249	(38)	2,862	2,699	(163)	4,023	4,023	2,880	(1,143)	(1,143)	4,023	0	0	4,023	0	4,023
Medical and Surgical Equipment Programme	134	0	(134)	188	76	(112)	142	321	321	179	0	321	0	0	321	0	321
Service Developments	207	(18)	(225)	899	676	(223)	1,919	1,523	2,147	228	624	1,523	0	0	1,523	0	1,523
Routine Maintenance	0	(0)	(0)	110	71	(39)	130	110	116	(14)	6	110	0	0	110	0	110
Specific Business cases pending UTC	277	2	(275)	554	2	(552)	1,107	500	500	(607)	0	0	500	0	0	500	500
Total Planned Capex	**877**	**806**	**(71)**	**10,591**	**8,226**	**(2,365)**	**13,877**	**13,270**	**12,109**	**(1,768)**	**(1,161)**	**12,770**	**500**	**0**	**12,770**	**500**	**13,270**
Unfunded	0	(162)	(162)	0	(126)	(126)	0	0	(126)	(126)	(126)	0	0	0	0	0	0
Capital Donation -schemes	0	0	0	0	0	0	0	80	80	80	0	0	0	80	0	80	80
ICS Emergency Department	0	0	0	0	0	0	0	1,500	1,257	1,257	(243)	1,500	0	0	1,500	0	1,500
ICS KLS	0	0	0	0	0	0	0	300	320	320	20	300	0	0	300	0	300
Diagnostics CR/DR	0	0	0	0	0	0	0	440	440	440	0	20	420	0	20	420	440
TIFF Safer Sleep	0	0	0	0	0	0	0	500	500	500	0	500	0	0	500	0	500
UTF Cyber	0	0	0	0	0	0	0	250	250	250	0	0	250	0	0	250	250
UTF EPR	0	0	0	0	0	0	0	1,600	1,600	1,600	0	0	1,600	0	0	1,600	1,600
UTF Diagnostics	0	0	0	0	0	0	0	26	26	26	0	0	26	0	0	26	26
ICS Dolphin Ward	0	0	0	0	0	0	0	508	508	508	0	508	0	0	508	0	508
ICS TMT to TVT	0	0	0	0	0	0	0	300	300	300	0	300	0	0	300	0	300
ICS Site Generators	0	0	0	0	0	0	0	500	500	500	0	500	0	0	500	0	500
Total Additional Capex	**0**	**(162)**	**(162)**	**0**	**(126)**	**(126)**	**0**	**6,004**	**5,655**	**5,655**	**(349)**	**3,628**	**2,296**	**80**	**3,628**	**2,376**	**6,004**
Back up schemes TBC								**0**	**1,960**	**1,960**	**1,960**						
Total Capex	**877**	**644**	**(233)**	**10,591**	**8,099**	**(2,492)**	**13,877**	**19,274**	**19,724**	**5,847**	**450**	**16,398**	**2,796**	**80**	**16,398**	**2,876**	**19,274**



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The Capital programme is currently 41% complete £2,492k behind projected expenditure plan.

- **Backlog Maintenance is currently on plan overall although there are schemes within the programme ahead and behind.**

- **Fire Urgency Works £1,087k behind plan, forecast for year is 31k overspent.**
  Main schemes generating this slippage are;
  - Compartmentation, £196k slippage, behind due to scoping delays, expected to complete by YE on plan.
  - Fire Alarm, £100k slippage, access to certain areas within the Trust have resulted in works delays across both of these projects, as areas are now available work is back underway and still on course to complete this financial year on plan.
  - X Ray doors, £140k slippage, delayed development and approval of the PID has resulted in a delayed start. The project is now underway and will complete in 2021/22. The final works quote is £50k lower than expected; as long as no complications arise this will be permanent slippage.
  - CSSD, £710k slippage, asbestos issues have caused a delay in scoping, these are now resolved and the work is to start imminently the project will catch up and complete in 2021/22 on plan.

- **Emergency Department, £190k underspent**, **forecast for year is £1,257k underspent; however, this line should be reviewed in conjunction with the ICS Emergency Department project in the additional CAPEX section.**
  Additional ICS funding of £1,500k has been allocated to the Trust to complete these works releasing the original funding of £1,257k into the contingency fund.

- **IT schemes £163k behind plan forecast for year is £1,593k underspent due to additional funding and various schemes within the additional CAPEX section.**
  The additional funding therefore releases this underspend into the contingency fund.

- **Service Developments, £223k behind plan, although forecast is £624k overspent.**
  Ward refurbishments in the original plan have been deferred to 2021/22 and replaced by other projects to be completed over a different timescale. Additional emergency projects such as bathroom refurbishments (£70k), quick win beds (£571k), Blue zone refurbishments (£115k) have also been approved causing the forecast overspend, this overspend will be now be funded from other programme slippage as a result of the additional monies secured.

- **Routine Maintenance £39k behind plan, forecast for year is £6k overspent**

- **Unfunded, £126k credit, forecast £126k credit.**
  Unfunded summarises transactions relating to prior year projects and expenditure that hasn't been aligned to CY approved schemes. It is possible that some of this expenditure does relate to the IT programme, which would result in forecast double count. The balance is not material but will be fully validated before month 9.

- **Additional Funding**
  Currently the Trust has agreed additional funding of £6m as detailed in the capital table on the previous page. The UTC PDC funded scheme partially deferred to 21/22 reduces funding by £0.6m, net additional funding is therefore £5.4m. All additional funds are forecast to be fully utilised.

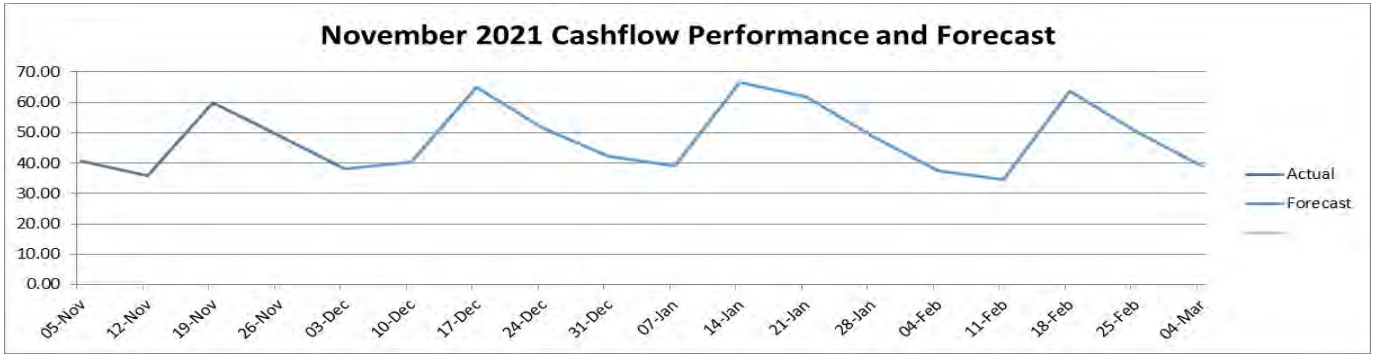
- **Overall capital forecast is still on plan but with a contingency fund of £1,510k yet to be allocated.**

This contingency fund will be utilised to tackle any priority issues that may arise in the final quarter of the year, with up to £2.5m of IT schemes, which could be brought across from revenue or from the 22/23 plan up until March to ensure all funding is fully spent.

6. Cash

13 Week Forecast w/e

	Actual					Forecast												
£m	05/11/21	12/11/21	19/11/21	26/11/21	03/12/21	10/12/21	17/12/21	24/12/21	31/12/21	07/01/22	14/01/22	21/01/22	28/01/22	04/02/22	11/02/22	18/02/22	25/02/22	04/03/22
BANK BALANCE B/FWD	**40.89**	**40.70**	**35.88**	**59.83**	**49.08**	**38.18**	**40.30**	**64.91**	**51.40**	**42.14**	**39.03**	**66.59**	**61.77**	**48.84**	**37.30**	**34.52**	**63.61**	**50.61**
Receipts																		
NHS Contract Income	0.07	0.06	29.60	0.16	0.10	4.00	29.75	0.00	0.00	0.00	30.24	0.00	0.00	0.00	0.00	29.80	0.00	0.00
Other	0.19	0.64	0.23	0.22	0.32	2.88	0.35	0.25	0.25	0.25	0.68	0.25	0.25	0.25	0.58	2.65	0.25	0.25
Total receipts	**0.26**	**0.70**	**29.83**	**0.38**	**0.42**	**6.88**	**30.10**	**0.25**	**0.25**	**0.25**	**30.91**	**0.25**	**0.25**	**0.25**	**0.58**	**32.45**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(0.37)	(0.38)	(0.38)	(10.36)	(8.81)	(0.43)	(0.36)	(10.26)	(8.76)	(0.36)	(0.36)	(0.44)	(10.18)	(8.79)	(0.36)	(0.36)	(10.26)	(8.79)
Non Pay Expenditure	(0.08)	(4.80)	(4.52)	(0.76)	(1.97)	(3.79)	(4.63)	(3.00)	(0.25)	(2.50)	(2.50)	(4.13)	(2.50)	(2.50)	(2.50)	(2.50)	(2.50)	(2.50)
Capital Expenditure	0.00	(0.35)	(0.90)	(0.01)	(0.55)	(0.54)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)
Total payments	**(0.45)**	**(5.53)**	**(5.80)**	**(11.13)**	**(11.32)**	**(4.75)**	**(5.49)**	**(13.76)**	**(9.51)**	**(3.36)**	**(3.36)**	**(5.07)**	**(13.18)**	**(11.79)**	**(3.36)**	**(3.36)**	**(13.26)**	**(11.79)**
Net Receipts/ (Payments)	**(0.19)**	**(4.83)**	**24.03**	**(10.75)**	**(10.90)**	**2.12**	**24.60**	**(13.51)**	**(9.26)**	**(3.11)**	**27.55**	**(4.82)**	**(12.93)**	**(11.54)**	**(2.79)**	**29.09**	**(13.01)**	**(11.54)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.08)	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
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	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**(0.08)**	**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**
BANK BALANCE C/FWD	**40.70**	**35.88**	**59.83**	**49.08**	**38.18**	**40.30**	**64.91**	**51.40**	**42.14**	**39.03**	**66.59**	**61.77**	**48.84**	**37.30**	**34.52**	**63.61**	**50.61**	**39.07**



Prior year end	£'000	Month end actual	Var.
49,184	Cash	38,369	(10,815)

Cash balances have moved from the prior year due to
- £3.5m additional cash payments made in advance of contracts
- £9.9m reduction in trade payables, most of which will have been paid out in cash.
- £3.8m HEE quarterly payment delayed

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7. Risks and opportunities

Title	Risk description	RAG	£'000	Mitigation(s)	Lead(s)
Efficiencies	The Trust has not yet identified its target of 3% efficiencies (as communicated at the beginning of the year) for H2. The quantified gap is as shown, however a further £395k is currently red rated and £77k is amber rated.		1,000+	Oversight from Efficiency Delivery Group to develop current schemes and identify more schemes. Red rated schemes with no value currently quantified.	Alan Davies
Winter	The Trust has compiled a winter plan with a number of interventions. The amount of funding agreed is currently £0.9m. Schemes are currently moving through PID / business case governance processes before being agreed.		5,679	Executive discretion over which schemes to implement. Potential external funding following bid to/via the system.	Trust Executive
PAHU	The opening of PAHU is unfunded.		1,470	Manage from within current Targeted Investment Funding agreed.	Trust Executive
H1 Overspends	The Trust overspent against a number of budget lines (not already captured in the draft baseline) and these may continue in the run-rate.		TBC	Re-deployment of resources.	Alan Davies
Covid	Whilst the Covid activity levels have remained relatively low during the summer, there is a risk that these increase		Unknown	Final confirmation from commissioner of meeting the incremental costs of this elective work.	Alan Davies

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8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £8k deficit in-month reducing to breakeven year to date after removing the adjustment for donated asset depreciation and income. This financial performance is as per the plan submitted to the Kent & Medway STP and forecast to breakeven for the second half of the year in line with the control total. The year to date efficiency programme is on plan at £2.5m, the majority of delivery is from pharmacy procurement, closure of theatre 5 and the full year effect of schemes that started in the previous financial year. ERF income of £6.0m has been included; £4.6m of this has been paid by the CCG relating to H1, the remaining £1.4m is an agreed amount to cover the incremental cost of delivering ERF activity.

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

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

Mitigations to reduce the risk:

- Continued development and implementation of the 9 crosscutting efficiency schemes.
- Use of benchmarking data including the Model Hospital to drive efficiencies.
- National funding for (some) winter schemes.

Alan Davies
Chief Financial Officer
November 2021

Meeting of the Board of Directors in Public

Wednesday, 12 January 2022

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte, Chair of Committee		
Date of Meeting:	Thursday, 16 December 2021		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Matthew Chapman, Head of Financial Management		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. BAF strategic risks The BAF scores were note, and it was It was **AGREED** to regrade the BAF risk 3c "Failure to develop, approve and deliver against a financial recovery plan" to 4 x 4 (=16) and amend RAG rating to red.	**Red**
2. Corporate risk register As agreed at the previous committee, the risk for the delivery of the efficiency programme target has been included and rated at 4 x 4 = 16 and RAG rated as red. It was **AGREED** to update the risks & opportunities of the Finance function's efficiency target and identifying deliverable schemes to reduce the gap.	**Amber/Red**
3. Finance report – month 8	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
The Chief Finance Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total of breakeven in month 8 and for the year to date. • ERF+ Income of £1.4m had been accrued into the position, this being 2 months of the agreed £4.4m for H2. • The in-month position includes cost pressures from bank staff enhanced rates, increased staff sickness cover, additional capacity in PAHU and escalation wards, as well as pressures within urgent and emergency care. There is no contingency carried forward to future months. • The efficiencies delivered are £358k lower than budgeted for November and £175k year to date. Focus continues on moving schemes forward through the governance process and embedding them within the divisions. • It was noted there continues to be some capital slippage in the year to date position that is primarily due to phasing of schemes being delivered. The overall capital programme is now £19.7m and the forecast is to achieve plan. • Cash sums remain in a strong position. • A detailed forecast will be included for the month 9 report, this will further detail on changes to H1 overspends in H2 as well as winter pressures and associated funding. • An update was provided regarding the benefits of transferring patients that are deemed able placed in a community inpatient bed rather than continuing their care in an acute hospital setting. There is an operational weekly meeting ICS partners to take this forward as soon as possible, with the Trust taking a lead in the provider role from a staffing perspective.	
4. Efficiency programme update The Chief Finance Officer updated the committee on the latest position with the efficiency programme. It was noted there continues to be a £1m gap in the £5.1m programme, and of the £4.1m it is forecast currently that £3.6m will be deliverable. Progress continues to turn those schemes RAG rated as red to green. The Head of PMO provided a summarised update of work to date with the business partners and operational services, an also updated on efficiencies identified through the use consultancy firms Meridian and Four Eyes that the Trust is following up in detail. It was **AGREED** to provide an update on resolution of solving the gap currently with Corporate services efficiency programme.	**Amber/Red**
5. Financial Recovery Plan ("FRP") The Chief Finance Officer updated on the appointment of Paul Kimber on secondment to the role of FRP Director. Further support would be provided to the Finance Team from Richard Brailey from the CCG as well	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
as the Finance Senior Team sharing some of the responsibilities from the Deputy CFO role. The FRP Director took the Committee through his main areas of work and the areas for immediate focus as well as in detail the grip & control checklist, this being the main criteria and monitoring tool to assess the financial recovery plan. This included: • Drivers of deficit analysis • Progressing efficiency schemes from RAG Red to Green • Providing granular detail of work plans as part of FRP. • Assessing high value opportunities and following these up with services directors. • Planning ahead for 3 years and linking this work with the ICS. • Monitoring progress of grip and control actions. • Deep dive financial review analysis with divisions where performance has not achieved plan in terms of budget as well as efficiency delivery. The immediate grip and control actions were approved by the Executive Team and also at the Finance Committee meeting, along with the financial escalation process for those services reporting an adverse performance.	
6. IFRS 16 Update A brief update on the work to date was given to the Committee. It was **AGREED** provide a further IFRS 16 (Capital Lease Accounting) update on any impact to the Trust.	**Green**
7. GIRFT Presentation It was **AGREED** the GIRFT presentation would go ahead at the next Finance Committee in January.	**Green**
8. Annual Work Plan The FRP Director distributed the updated annual work plan prior to the meeting and briefed the committee on any changes included. Any subsequent comments and feedback were welcomed with a view to updating the plan accordingly.	**Green**
Decisions made It was **AGREED** to regrade the BAF risk 3c “Failure to develop, approve and deliver against a financial recovery plan” to 4 x 4 (=16) and amend RAG rating to red. It was **AGREED** to update the risks & opportunities of the Finance function’s efficiency target and identifying deliverable schemes. It was **AGREED** to provide an update on resolution of solving the gap currently with Corporate services efficiency programme. It was **AGREED** provide a further IFRS 16 (Capital Lease Accounting) update on any impact to the Trust. It was **AGREED** the GIRFT presentation would go ahead at the next Finance Committee in January.	

Key headlines and assurance level	
Key headline	**Assurance Level**
It was **AGREED** the results of the effectiveness of the finance committee survey would be sent to the Chair of the Committee	
Further Risks Identified No further risks were identified.	
Escalations to the Board or other Committee No escalations were identified.	