Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 08 July 2021 at 13:00 – 15:30

Meeting via MS Teams

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	13:00	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Chief Executive Update	Chief Executive	3	13:05	Note
2.	**Minutes**				
2.1	Minutes of the previous meeting: 03.06.21	Chair	5	13:10	Approve
2.2	Matters arising and Action Log: 03.06.21	Chair	15		Discuss
3.	**High Quality Care**				
3.1	Integrated Quality Performance Report	COO, CNQO, CMO	17	13:20	Note
3.2	Quality Assurance Committee Assurance Report. Meeting date: 22.06.21	Chair of Committee/ Chief Nursing and Quality Officer	45	13:30	Assure
3.3	Clinical Negligence Scheme for Trusts – Final Sign-Off	Chief Nursing and Quality Officer	49	13:40	Decision
3.4	Board Assurance Framework and Corporate Risk Register Review	Deputy Chief Executive	63	13:50	Assure
4.	**Strategy and Resilience**				
4.1	Integrated Care Partnership and System Update	Chief Integration and Strategy Officer	89	14:00	Note
4.2	Emergency Planning Resilience and Response - Update Report	Chief Integration and Strategy Officer	97	14:10	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 2	Chief Finance Officer	101	14:20	Note
5.2	Finance Committee Assurance Report. Meeting date: 24.06.21	Chair of Committee/ Chief Finance Officer	111	14:35	Assure
5.3	Integrated Audit Committee Assurance Report – meeting date 24.06.21	Chair of Committee/ Chief Finance Officer	115	14:40	Assure
6.	**Innovation**				
6.1	Trust Improvement Plan - Update	Chief Operating Officer (Interim)	119	14:50	Note
6.2	Digital Update	Chief of Staff/ Associate Non-Executive Director	125	15:00	Note
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	15:15	Note
7.2	Questions from the Public	Chair	Verbal		Note
7.3	Any Other Business	Chair	Verbal		Note
7.4	Date and time of next meeting: 09 September 2021				

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Chief Executive's Report – July 2021

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

COVID-19

I am pleased to say that throughout the month we have continued to see only a low level of admissions for patients with COVID-19. While we must still be alert to the impact that the virus can have – ensuring we continue to exercise strict infection control practices on site – we are also very much focussed on the recovery of our services.

We have now fully restarted elective operations and surgery for cancer patients, outpatients and diagnostic services, but a crucial aspect of our work over the next few months will be reducing the current backlog of cases.

We know that it can be very upsetting for our patients to have to wait a significant period of time for treatment, and our staff are committed, and working very hard, to reduce these waiting times as quickly as possible.

Improving how we make calls

Last month we were delighted to launch a brand-new telephony system at the Trust. This was a long overdue update, with the previous system being more than 25 years old. I'm pleased to say that colleagues are already enjoying the benefits of using the more modern app-based system.

As is anticipated with such large-scale projects, there were some teething issues in the first few days, which colleagues worked quickly to resolve. I would like to offer our apologies to anyone who may have waited slightly longer than usual to get through to the Trust during this time.

Ofsted inspection of our Apprenticeship Centre

Last month we had an Ofsted inspection of our apprenticeship centre, which has been an accredited centre for ILM5 (Institute of Leadership and Management) for the past 18 months. The Ofsted team made some positive comments about the way the centre is operating and support being provided.

The inspectors said we had a strong curriculum and were clear about the rationale for why we are providing apprenticeships. They said it was evident learners are developing skills consistent with our strategic objectives, and that we are prepared in relation to the safeguarding of learners, and have an excellent wellbeing offering. As we would expect, there were areas for improvement, which we will work on.

We were given a 'Reasonable' rating for all three domains. We can consider this as good progress at this stage – many organisations receive an 'Inadequate' rating at their first inspection.

LGBTQI+ Pride Month

June was LGBTQI+ Pride Month, celebrating lesbian, gay, bisexual, transgender and intersex civil rights. To promote an understanding of LGBTQI+ experiences and perspectives across the Trust, colleagues from our Staff LGBTQI+ Network hosted a number of events for colleagues.

Clinical Audit and Quality Improvement Awards

A big 'congratulations' to the winners and nominees in the 2021 Clinical Audit and Quality Improvement Awards.

The awards, which have been running for more than 20 years, saw clinical staff from all disciplines invited to submit projects that made a positive impact on patient care and experience through improvements in safety, clinical effectiveness, efficiency and/or responsiveness.

It was a great privilege to attend the awards and see some of the great work that has been taking place in the Trust. Well done to colleagues who took home the top three prizes:

Winner – Richard Dickson-Lowe
Observing the perioperative effects of prehabilitation in colorectal cancer patients Quality Improvement Study

2nd Place - Alison Mannering
Assessing the success of implementing an alternative nutritional screen tool in the inpatient oncology ward

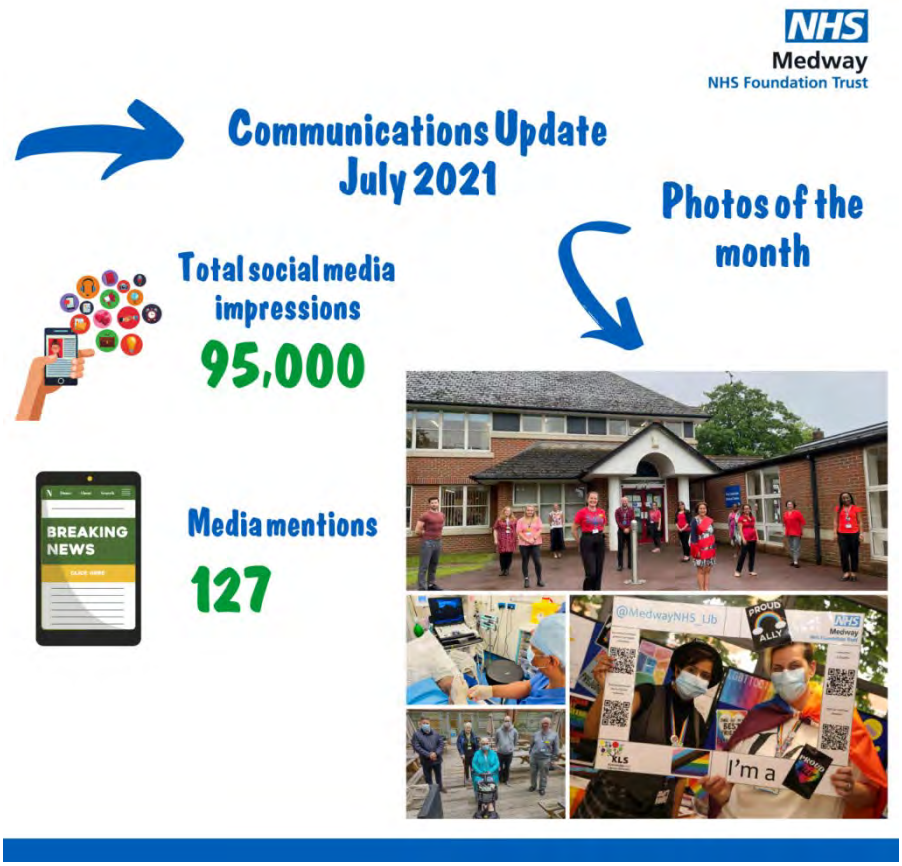
3rd Place - Mudassir Wani
Primary Ureteroscopy vs emergency stenting, quality and cost evaluation

News@Medway
I'm pleased to say that the latest edition of News@Medway is now available on our website.

Our colleague and cover star, Andrew Bell, shares his story of recovering from Prostate Cancer in this edition. Prostate Cancer is the most common cancer in men in the UK, affecting about one in eight men.

You can also find out much more about latest news and developments at the Trust. It's a great read, so please do take a look.

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.



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Minutes of the Trust Board PUBLIC Meeting

Thursday, 03 June 2021 at 12:30 - 15:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Finance Officer
	Annyes Laheurte	Non-Executive Director
	Mark Spragg	Deputy Chair, SID, Non-Executive Director
	David Sulch	Chief Medical Officer
	Ewan Carmichael	Non-Executive Director
	George Findlay	Chief Executive
	Gurjit Mahil	Deputy Chief Executive
	Jane Murkin	Chief Nursing and Quality Officer
	Leon Hinton	Chief People Officer
	Sue Mackenzie	Non-Executive Director
	Tony Ullman	Non-Executive Director
Non-Voting:	Angela Gallagher	Chief Operating Officer (Interim)
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement
	Harvey McEnroe	Chief Strategy and Integration Officer
	Jenny Chong	Associate Non-Executive Director
	Paula Tinniswood	Chief Staff Officer (Interim)
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Company Secretary
	Glyn Allen	Lead Governor
Observing:	Annemarie Vicary	NHSEI (Deputising for Nye Harries/Sheila Adam)
	Fabian Sebastian	Clinical Lead (Diagnostics)
	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
	Lorraine Becconsall	Imaging Manager (Diagnostics)
	Prav Bilagi	CD for DCSS (Diagnostics)
	Temi Alao	MFT HR Business Partner
Apologies:	Nye Harries	NHSEI Improvement Deputy Director

	Rama Thirunamachandran	Academic Non-Executive Director
	Sheila Adam	NHSEI Improvement Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and thanked the Board and its guests for joining the virtual Trust Board meeting; with the improving COVID-19 picture, Chair hoped to hold meetings in person again very soon, potentially from July 2021. Chair continued with the following highlights:

a) It is starting to feel like the hospital is getting back to pre-Covid normal, although colleagues are working incredibly hard to make sure that all necessary Covid precautions are in place for the safety of staff, patients and visitors.
b) It is extremely pleasing to have seen that the hospital is able to relax visiting restrictions further this week. The hospital is able to offer extended visiting hours in most of its wards and it is important for the wellbeing of our patients to be able to see friends and family.
c) Chair was delighted to state that the hospital is well underway with its 'business as usual' work, which means that elective procedures have restarted within the hospital. The pandemic has meant that many patients have had their appointments, diagnostic procedures and surgery delayed, and it is really important that the hospital makes rapid progress in clearing the backlog. The situation has been far from ideal for patients, and it has resulted in some frustration and concern. The Trust thanks them for their patience and understanding.
d) It must remain a concern that this terrible pandemic is far from over and it remains as important as ever that everyone remains cautious and maintain social distancing, hand hygiene and mask wearing. Not just in the hospital but in the community to keep the transmission of this disease low.
e) Chair encouraged that the Covid-19 vaccine is taken as soon as people are eligible. The hospital vaccine hub will be open for a few more weeks to support the community with the vaccination programme. Together, as a community, Chair has every faith that we can work together to protect services throughout whatever time remains of this pandemic, through the summer and winter period.
f) Thanks were given to colleagues at the CQC; they have been welcomed into the Trust for the last five to six weeks and the Trust look forward to their findings.
g) Chair acknowledged and thanked Glyn Allen who has agreed to extend his term during the period of election for the new lead Governor. The new Governors will be joining the Trust on 01 July 2021.
h) Thanks were given to colleagues at the ICS who attended the Board Development Session on 02 June 2021 to discuss current position and the Governments 'White Paper', the implications of this and the aims and objectives across Kent and Medway.
i) Thanks were given to the Research and Innovation team for their efforts, which has resulted in a permanent art installation with the hospital. The Trust welcomes new research trials in the important fight against Covid-19.
j) Chair thanked the Estates team for their work building the Staff Gym and welcomes colleagues to use the new facility when it opens to support good health and wellbeing.
k) Finally Chair thanked the community for its ongoing support for the hospital and NHS over the last 15 months.

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 (Interim), 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. The Board was asked to note the report and George gave the following key highlights:

a) **Covid-19;** CE was pleased to say the number of COVID-19 inpatients has been in low single figures for several weeks now, there was 14 days with no new admissions and no patients in critical care on most days for few weeks. There have been restrictions on visiting, recognising how important this is to patients and their loved ones. There are a few restrictions on site such as the restaurant and coffee shop remains open for staff only at this stage but patients and visitors can purchase food and drink from the League of Friends shop in the main entrance.

The Trust has restarted elective surgery and surgery for cancer patients, outpatients and diagnostic services and is working hard to reduce the backlog of patients, the Trust is aware that patients are waiting longer than it wants.

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

b) **Care Quality Commission;** over the last month the Trust welcomed the CQC back to the site and staff enjoyed the opportunity to speak proudly of the care they provide, as well as being open and honest about the challenges that they face. To date the CQC has reviewed; medical and older persons' care, infection control, children and young people's care and last week culminated in a well-led review. The formal report is expected in June/July, and the Board will be informed of the findings at the appropriate time.

c) **Celebrating research at the Trust;** the Trust was proud to officially unveil the DNA (Deoxyribonucleic Acid) Helix and Research and Innovation artwork on International Clinical Trials Day in the Atrium. The artwork was created as a visual display to increase the awareness of research specialties within the Trust, to celebrate our successes and to encourage greater participation in future projects. For the past eight years, Medway NHS Foundation Trust has had the highest number of patients participating in clinical research in the Kent, Surrey and Sussex region and is recognised at national and international level. It benefits patient and staff so it is something the trust will continue to work on. By participating in research, the Trust offers our patients novel and up-to-date treatments. For example, during the COVID-19 pandemic, we saved many lives by offering experimental treatment such as Dexamethasone, which was subsequently adopted as standard treatment.

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

d) **Developing a sustainable Medway for the future;** as one of the biggest employers in the area, and Kent's busiest hospital site, it is really important that the Trust's environmental impact is taken seriously. The Trust needs to improve the efficiency and resilience of the services it offers. The Trust has launched its Green Plan which aims to improve organisational performance in this area to deliver environmental, social and financial benefits. The Green Plan is on the hospital website.

e) **Celebrating our nurses, midwives and ODPs;** every May the NHS celebrates its nurses, midwives and operating department practitioners and the fantastic work that they do for the communities. They work around the clock, to provide care of the highest quality and the Trust is incredibly proud of the difference they make to patients' lives.

f) **Autism reality experience;** the Trust was fortunate to host a special autism reality experience in May. Being in hospital can be a particularly challenging time for people with autism and learning disabilities, and this innovative training experience, funded by the Trust's Innovation Institute, gave a sense of what living with autism can feel like. It gave a number of colleagues to experience what it is like; George, Gurjit Mahil and Leon Hinton experienced this and Karen McIntyre, Associate Director of Patient Experience, spoke about her experiences of doing the training, this can be found in the papers.

g) **Remembering our organ donation heroes;** it is great to see the installation of the Organ Donation 'Hero Wall Plaque' in the Atrium in May. This adds to the spectacular 'Gift of Life Wall' artwork which is already on display in dedication to all those who have selflessly become organ donors. George gave his sincere thanks to Dr Gill Fargher, Trust Organ and Tissue Donation Committee Chair, who oversaw the installation with the help of Hospital Artwork Studio. Gill's late husband Tristan Lewis, who worked at the hospital, will be the first person to be commemorated. Tristan died in 2015 and consented for his organs and tissues to be donated, including both of his corneas, which allowed two people to regain their sight. Gill is extremely passionate about organ and tissue donation and is a real help in moving this agenda forward.

1.5 Clinical Presentation – Clinical Presentation – Diagnostic Imaging

1.5.1 Fabian Sebastian (Clinical Lead), Lorraine Becconsall (Imaging Manager) and Prav Bilagi (CD for DCSS), gave a presentation to the Board which included:

a) Scope of the Service
b) Year on Year Increases
c) Success Stories
d) Covid-19
e) Challenges in Delivering Your Services
f) Capacity
g) Why Is Capacity Full
h) What Have Our Peers Done
i) Why Are We Struggling
j) System Wide Initiatives
k) Plans and Ambitions
l) Summary

1.5.2 Gary Lupton stated that this work links directly to the Estates Strategy being discussed today. The Trust is aware of the population growth in the near future and it is being taken into consideration.

1.5.3 Capital investment may become available nationally, so it is important that the Trust prepares now to be able to take the business case forward and ensures that governance is correct. The Estates team will work closely with the team to ensure everything is discussed. Gary is also working with external partners on where the Trust can obtain off site support.

1.5.4 George stated that the Board recognises the challenges but thanked the team for providing a good quality service to increasing numbers of patients. The Executive team would work with them to establish a medium term plan. A more collaborative approach is needed going forward.

1.5.5 Jenny Chong offered her support to the team with advice and information on the recruitment of future radiologists being concerned about AI. Chair thanked the team for their time and presentation.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 06 May 2021 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting
The action log was reviewed and the Board agreed to CLOSE the following actions:
TBPU/21/124

3 High Quality Care

3.1 Integrated Quality Performance Report

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

a) Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting.
   1) IPC – Jane and George awarded gold stars to three wards who had more than 150 days without infection.
   2) There have been some cases of C.Diff but there is a link with Covid due to the increased use of antibiotics. Jane has refreshed the PIR to identify any gaps. There are lessons and learning and how to improve, this will continue to be monitored.
   3) Continued improvement in falls and pressure ulcer prevention
   4) MSA; there been some improvement but some increases in breaches however this aligns to safely managing patient flow across the hospital and the team does maintain patient dignity.
   5) C-section; this is increasing and this is being reviewed through the QAC.

b) Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting.
   1) Constitutional Standards; there have been two 12 hour breaches, 160 x 60 minutes ambulance breaches which is up from 66 in March. This represented an increase in demand through ED in April. ED wait time has reduced but it is a key part of the patient first work and will be monitored. Recovery actions continue to look at patient flow and discharge management.
   2) RTT; alongside monitoring and meeting activity targets, the Trust is monitoring patients with long waits. There is a reduction from March and into May. There has been an increase in waiting since covid began. There is work happening to match referrals to activity plans.
   3) Cancer – 62 day wait; this is a concern for the Trust. Additional metrics will be input to the cancer PTL on the IQPR so this can be tracked against trajectories in the report.
   4) DM01; this is a continuing improvement, down to just over 300 waiting six weeks.
   5) ED flow; many breaches/delays occur at night. Angela has met with ED team to look at how the team can modify staffing (nursing and medic cover) at night. The Lead Clinician gave a good insight into the issues comparing day and night, this work will be part of the Improvement Plan.
   6) There has been an increase in ambulance handover times. The Trust are continuing to work on reducing these; the team has increased the resource in the ambulance triage area, so there is 24hr nurse care. It is an area for improvement and is a key part of the patient first work. There are regular meetings with SECAmb to ensure all variables are considered.

7) George confirmed that Phase 3 of the ED work will be handed back shortly with new spaces added, this will help with the flow. The physical building does assist but staffing still needs to be looked at.
8) George stated that in DM01, the diagnostic imaging is a big part of this. The Trust is however delivering within the six week constitutional standard.

c) David Sulch, Chief Medical Officer, presented to the Board for noting.
1) HSMR; the national hsmr has increased up to the end of February 2021 it is 105.5. Covid patients are not included in the national data. The Trust is waiting for data to refresh. There is a review on the care given to patients. The Trust HSMR is 103.5.

3.2 Quality Assurance Committee Assurance Report. Meeting on 25.05.21

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

a) The Committee escalates the following to Trust Board:
1) Review of Datix [*amended from SI's*] and addressing the backlog. David Sulch has been briefing the committee on nosocomial infections and will bring back a report on duty of candour in June 2021.

b) The Committee notifies the board of the following:
1) Duty of Candour; a review of the compliance of duty of candour for those patients with nosocomial infections is being presented to the June Quality Assurance Committee and to Trust Board in July.
2) The Committee approved the draft Quality Account which is now being circulated to key stakeholders for comment and feedback.

3.3 Clinical Negligence Scheme for Trusts

Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting. The Board was asked to review the evidence provided and to note that the service is on track to demonstrate compliance with CNST Safety Actions 7, 8, 9 and 10.

3.3.1 Thanked the maternity services for their work over the last few months to map and gap against the actions and compliance. Jenny Chong seconded this and thanked for the work for the BAME Community mothers and for embracing innovation.

3.3.2 George stated that in regard to Safety Action 8; the commitment to this action has not changed and it is a national position to remove it. All staff must complete face to face training. The Trust is not changing its standards although the national standards have changed.

3.3.3 There will be one more update to the Board on CNST prior to final submission. Chair asked that thanks are given to the team for this important work. It is an outstanding service.

3.4 Learning from Deaths

David Sulch, Chief Medical Officer, presented to the Board to note the Learning from Deaths process, and the changes that have been made to the process following the introduction of the Medical Examiner process.

3.4.1 The process adds granular detail to the higher level data analysis of HSMR and SHMI carried out via Dr Foster. Aspects of the process require strengthening, and the clear links between identified issues and ongoing themes from Serious Incident management are a key focus for work in the short term.

3.4.2 Reviews will be completed by the end of June 2021.

3.4.3 There are a couple of areas that require more focused approach that are still seeing issues from reviews:

1) Awake from resuscitation
2) Treatment escalation planning

3.4.4 George stated that reducing the backlog is crucial. The team must ensure it has links from structured judgement reviews to SI's and ensure that learning from deaths is embedded. He asked with the audit process; how does the Trust explain the gap and how to move forward.

4 Strategy and Resilience

4.1 Estates Strategy

Gary Lupton, Director of Estates and Facilities, presented to the Board for discussion and noting. Gary thanked Jenny for her help and support with this. The paper was taken as read.

4.1.1 The Strategy outlined the key areas for consideration in respect to the short and medium term, to meet capacity requirements and how the Trust can mobilise the estate more effectively. The Trust must plan for the longer term Strategic needs to meet the significant demands on its services due to the growth in housing (29,000 houses at 2.4 people per household) over the next 20 years, through a combination of on and off site solutions.

4.1.2 The service is in year three of five of a transformation programme and the Trust has seen some really positive improvements to-date. The transformation needs to be successful to ensure all the required strategic changes can be achieved efficiently in a timely and cost effective way by a well-trained and motivated team.

4.1.3 The Trust will continue to invest in its staff and this is evidenced through the 18 month programme of training in housekeeping services to move staff to mid or upper quartile performance.

4.1.4 The Trust continues to develop its services for the benefit of the ICP as a whole and exploring collaborative working across partners. It will share and lead on services where required across the ICP and ICS and work closely with the county councils.

4.1.5 Jenny Chong thanked Gary for his work. Things to consider are families moving from London to Kent and also staff wanting and able to work from home freeing up space. Good to see that there are actions from the staff survey results. Energy consumption will need more work but this is considered in the Green Plan and under the lead of Chair as Green Plan Champion she is assured this is in hand.

4.1.6 Glynis Alexander offered her support in early engagement with community support with this strategy.

4.1.7 Mark Spragg asked if the strategy considers charging points for cars and if there is finance available for that. Gary confirmed that this is being worked on by Jessica Brown, the commitment from manufacturers is high and the access to the site will need to be reviewed (public transport etc). A travel plan is in hand and the impact on hospital neighbours but a lot more work is needed.

4.1.8 George thanked Gary and his team; this is a comprehensive piece of work and a real challenge to manage. This work needs to be converted to an annual plan and the risks managed. Harvey McEnroe will be anchoring this work into the strategy steering groups and will drive at service level to assist with the annual plan. There is good collaboration across the ICP and on how to share facilities.

4.1.9 Gary stated that the next step would be for the strategy to be submitted through the Executive Group and a short/long term plan would be submitted to Board at a later date.

4.1.10 Chair asked that consideration is given to future patient groups, everything a modern organisation should consider. Gary confirmed that health building notes are followed which considers these areas and he will be conscious of this.

4.2 Health and Safety Annual Report

Gary Lupton, Director of Estates and Facilities, presented to the Board for noting and approval. The report made the Board aware of Trust activities relating to Health and Safety compliance during the period of 01 April 2020 and 31 March 2021. The report was taken as read.

4.2.1 The Board APPROVED with the following caveat that compliance rates on statman training are to be reviewed and subject to completion of any outstanding Health and Safety training

5 Financial Stability

5.1 Finance Report - Month 1

Alan Davies, Chief Finance Officer, presented to the Board for noting.

a) The Trust reports a breakeven against the NHSE/I control total.
b) Covid related spend has reduced. CCG income for block contract, top-up, growth and covid is the same as the last six months of 2020/21 this includes the additional £2.5m of covid income, less the lost income adjustment of £1.5m.
c) CIP: Currently, the anticipated level of CIP included in the submitted plan to the STP is £1.5m for the first 6 months. This is deemed to be a prudent and achievable level of efficiencies as the services continue to recover and restart elective activity. Delivery for April totals £0.1m, and is from the full year effect of schemes that started in the previous financial year. PMO and Finance are currently working with Care Groups and Divisions to identify schemes and we will be running 2 CIP Showcase events in June to relaunch the CIP Programme. The work now is to close the gap in CIP over the coming weeks. Will report back on this to the FC and to Board in July 2021.
d) Capital: This CRL is less than 50% of Trust capital expenditure in the prior year. The Trust has highlighted a further £8m of schemes to the ICS which we would wish to critically pursue should any additional resources become available.

5.2 Finance Committee Assurance Report. Meeting on 22.04.21

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

a) The Pathology LIMS full business case was APPROVED for recommendation in principle to the Trust Board, subject to finalisation of the case in June 2021. The Trust Board is due to receive the final Pathology LIMS full business case at its meeting on 08 July 2021.
b) It was AGREED that use of Model Hospital would be monitored through the monthly CIP reporting to the Committee.
c) A number of proposed changes to the Trust's Business Case Policy were AGREED with a few minor changes required.
d) Looked at corporate and strategic risk and there was nothing further to report to Board.

6 Innovation

6.1 Trust Improvement Plan – Patient First Programme; Operational Update

Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting.

6.1.1 A progress update was given on three key and interrelated elements of the Patient First programme. Engagement in the programmes continues to be strong.

6.1.2 The hospital continues to experience challenges with emergency demand, high levels of bed occupancy and flow. The teams remain committed to completing the identified actions leading to improvement in line with the performance and quality trajectories. Key highlights were given as follows:

a) The Trust has revised the Sitrep format, regular meetings between site team and ED team are happening.
b) Revised SOP currently being consulted on.
c) No new information on flow and discharge but it is a key workstream and has its own item at Trust Improvement Board.
d) Continuing to do mini MADE events supported by community colleagues.
e) Acute care transformation has focused on ambulance handover, SDEC and acute assessment; this will continue to be built on.
f) ED to increase communication to raise concerns earlier.
g) Discharge and flow remains a key workstream. Ensuring the Trust has high element of preplanning in place for discharge management with regular reviews. The target of 25 patients a day leaving before midday is a difficult target but is an aspiration.
h) George stated that there are improvements needed but in a small number of areas contributing to the headline. Consideration is needed on work start times and more standard work on wards. George would work on this with Angela, David Sulch and Jane Murkin.

7 People Committee Assurance Report. Meeting on 20.05.21

Sue Mackenzie, Chair of the Committee, presented to the Board for assurance. The paper was taken as read.

7.1 Escalations to the Board as follows:

a) Low response rate to the EU settled status for the Trust's workforce. Second letter has been sent to colleagues and reports to the line managers of individuals.
b) Below minimum compliance with StatMan, in particular Paediatric Immediate Life Support training (33 colleagues need to do this) and Paediatric Basic Life Support training. Reviewing the individuals who need to have done this and correct reporting. Communications to the individuals who have not completed. A process will be in place going forward to sustain this.
c) Decreasing completion of covid risk assessment – there is a focus to complete these assessments. Reports are going to individual line managers on this as it is not optional it is a requirement.

8 Any Other Business

8.1 Council of Governors Update

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

8.1.1 Glyn gave his congratulations to the 12 Governors and four existing Governors reelected in May, their experience will be of benefit to the Trust. Their inductions will be in July 2021.

8.1.2 There was another successful Governor Engagement Event in May and one to expect on 21 July 2021. There will be a virtual Members Event on Innovation happening 24 June 2021.

8.1.3 Glyn ends his term as Lead Governor in June 2021 but he has agreed to remain Associate Governor for the next few months until a new Lead Governor is elected.

8.1.4 Chair thanked Glyn and the Council for their continued support and efforts.

8.2 Questions from the Public

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

8.3 Any Other Business

There were no matters of any other business.

8.4 Date and time of next meeting

The next meeting will be held on Thursday, 08 July 2021, 12:30 – 15:30.

The meeting closed at 15:05

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 03 June 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	08-July-21 ~~06-May-21~~	Jane Murkin, Chief Nursing and Quality Officer	**Not submitted**	Red
06-May-21	TBPU/21/123	Review the Maternity risk rating with Gurjit Mahil	08-Jul-21 ~~03-Jun-21~~	Jane Murkin, Chief Nursing and Quality Officer	**Will go to the RAG - Jane to update the July Board**	

Meeting of the Board of Directors in Public
Thursday, 08 July 2021

Title of Report	**Integrated Quality and Performance Report (IQPR)**	**Agenda Item**	3.1
Report Author	Jane Murkin – Chief Nursing and Quality Officer David Sulch – Medical Director Angela Gallagher – Chief Operating Officer		
Lead Director	Jane Murkin – Chief Nursing and Quality Officer Gurjit Mahil – Deputy CEO		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for April shows that the Trust has had 3 hospital acquired C-diff cases and 2 Trust attributable C-diff cases. February's overall HSMR rate is 108.89; the weekend HSMR rate is at 118.25 and links to risks during the weekends with Bed Occupancy. **Caring** Whilst MSA had shown improvement, May has seen that 152 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates for three areas, remain close or above the national standard of 85% (ED: 83.38%, Maternity: 99.65%, Outpatients: 88.56%). The inpatients recommended rates have reduced to 77.76%, the feedback received is currently being under review to identify themes. **Effective** Discharges before Noon, whilst close to the Mean are still below at 17.32% and significantly below the Target of 25%, this is being reviewed through the Patient First work. **Responsive** The 18 weeks Referral to treatment (RTT) performance for May is recorded at 66.87%. The number of patients breaching 52 weeks is still high; however the May 2021 figure of 374 is lower than previous months in line with the restart of elective activity within the Trust. ED (Type 1) 4 hour performance as a result of site pressures reported 73.93% in April. Additionally, the Trust saw 146 Ambulance Handover delays of +60mins. The DM01 Diagnostics performance is at 94.74% for April 2021.		

	In April 2021, 94.02% of patients were seen within 2 weeks of their referrals into the cancer pathways and 58.18% of patients were treated within 62 days. **<u>Well Led</u>** We have seen an increase in appraisal rates, reporting 85.71% and the Trust has maintained compliance statutory and mandatory training at 89.83%. To note: • The maternity 12+6 indicator is calculated by NHS I/E/D and is currently showing a delay. • The SHMI data is currently showing November – this is reliant on MHS I/E/D and is 3 to 4 months in arrears. • The HSMR is currently showing January data, this is reliant on 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 – May 2021

NHS
Medway
NHS Foundation Trust

Integrated Quality and Performance Report

Reporting Period: May 2021

Best of care
Best of people

What is Statistical Process Control (SPC)?

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

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

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

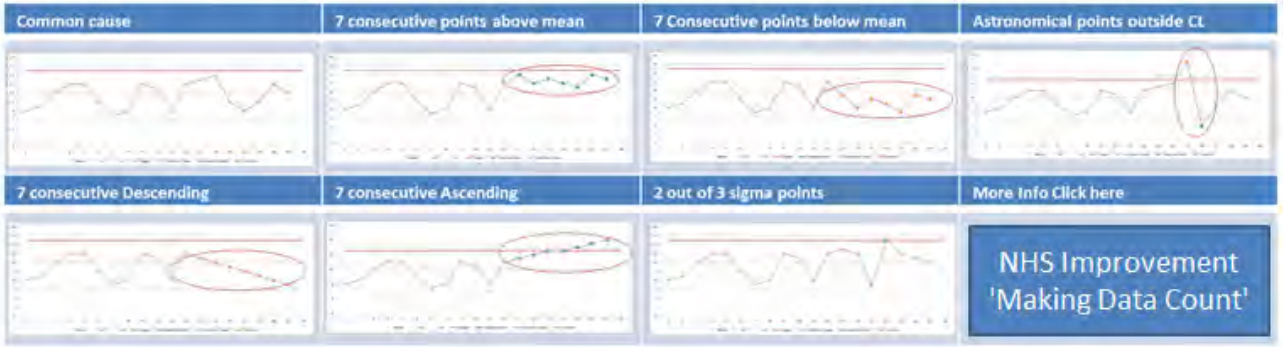
Key Facts about a SPC Chart:

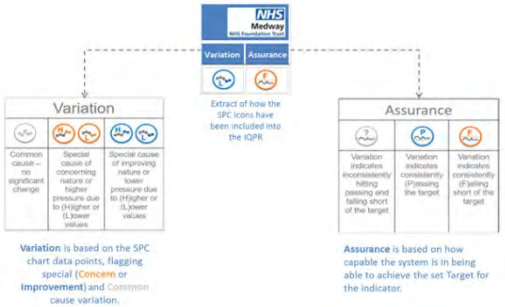
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





NHS
Medway
NHS Foundation Trust

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

Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls) & Well Led	• Flow, Emergency & Elective Pathways
Caring	• The Friends and Family recommended rates for Maternity services and Outpatients are above the national standard of 85%. ED FFT rates, whilst not meeting plan, has remained very close to target.	• High number of breaches in Mixed Sex Accommodation continues • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set • IP FFT rate has declined
Effective	• VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement • Maternity 12+6 Risk Assessments, whilst still slightly under target, has shown improvement and remains very close to achieving	• High statistical variance in Readmission rates evidenced • Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • 0 Never Events in month and Sis response rate is 100%	• Infection data shows spikes in C-Diff (HAI) and E-Coli cases in April-21 • Overall HSMR levels have risen, again, and are still above the national threshold (100)
Responsive	• Cancer 2ww Performance has exceeded the target • DM01 performance, whilst under target, has improved in April • DToC levels have reduced	• 60min Ambulance Handover delays have increased • RTT Incomplete Performance decreased, +52wk breaches high, plus the PTL size is showing signs of increasing • Cancer 62day metric showing volatility
Well Led	• Maintained compliance with Trust target for StatMan Compliance. Appraisal % are now slightly over plan • Sickness rates have stabilised in month and are now slightly above target but under Mean. Turnover rate also appears in-line with Plan and YTD position	• Agency spend has stabilised in month but bank spend has increased considerably • CIP schemes currently shows an under plan position

Executive Summary

NHS Medway NHS Foundation Trust

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

Variation

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

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

Assurance

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

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

Executive Summary

NHS Medway NHS Foundation Trust

Safe			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
S1	Number of C-diff (Trust Attributable)	Apr-21	3	2	43	29		
S2	Number of C-diff (HAI)	Apr-21	0	3	0	29		-
S3	MRSA Bacteraemia (Trust Attributable)	Apr-21	0	0	5	1		
S4	E-coli (Trust Acquired)	Apr-21	2	3	30	47		
S5	Falls per 1000 bed days	May-21	6.63	3.67	6.63	5.06		
S6	Pressure Ulcer incidence per 1000 days (M/H)	May-21	1.04	0.07	1.04	0.03		
S7	Never Events	May-21	0	0	0	2		
S8	% of SIs responded to in 60 days	May-21	100%	100%	100%	100%		-
S9	HSMR (overall)	Feb-21	100	108.89	100	100.55		
S10	HSMR (weekday)	Feb-21	100	105.67	100	97.70		
S11	HSMR (weekend)	Feb-21	100	118.25	100	108.70		
S12	SHMI	Dec-20	1	1.07	-	-		

Caring			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	May-21	0	152	0	1409		
C2	New Complaints	May-21	41	43	-	618		
C3	% Complaints responded to within target	May-21	85%	48.48%	85%	65.39%		
C4	% EDNs completed within 24 hours	May-21	100%	71.40%	100%	69.65%		
C5	Inpatients Friends and Family Response rate	May-21	22%	19.67%	22%	18.98%		
C6	Inpatients Friends and Family % recommended	May-21	85%	77.76%	85%	81.79%		
C7	ED Friends and Family Response rate	May-21	22%	14.14%	22%	15.66%		
C8	ED Friends and Family % recommended	May-21	85%	83.38%	85%	84.50%		
C9	Maternity Friends and Family Response rate	May-21	22%	100.00%	22%	31.33%		
C10	Maternity Friends and Family % recommended	May-21	85%	99.65%	85%	99.65%		
C11	Outpatients Friends and Family Response rate	May-21	22%	8.91%	22%	11.45%		
C12	Outpatients Friends and Family % recommended	May-21	85%	88.56%	85%	89.16%		

Responsive - Non-Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	May-21	85%	83.89%	85%	80.20%		
R2	Average Length of stay (Non-elective)	May-21	5	8.13	5	9.22		
R3	Average Length of stay (Elective)	May-21	5	2.77	5	2.58		
R4	% of Delayed Transfers of Care	May-21	4%	0.79%	4%	0.44%		
R5	% Medically Fit For Discharge	May-21	7%	11.22%	7%	10.50%		
R6	ED 4 hour performance (All)	May-21	95%	82.17%	95%	83.51%		
R7	ED 4 hour performance (Type 1)	May-21	95%	73.93%	95%	73.65%		
R8	ED 12 hour DTA Breaches	May-21	0	0	0	420		
R9	Ambulance Attendances	May-21	-	3,549	-	44,100	-	-
R10	60 minute handover delays	May-21	0	146	0	2478		

Effective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Apr-21	5%	6.97%	5%	7.04%		
E2	30 day readmission rate	Apr-21	10%	13.66%	10%	13.49%		
E3	Discharges before noon	May-21	25%	17.32%	25%	14.80%		
E4	Fractured NOF within 36 hours	Apr-21	100%	68.40%	100%	72.76%		
E5	VTE risk assessment % completed	May-21	95%	93.41%	95%	94.58%		
E6	Elective C-section rate	May-21	13%	14.61%	13%	14.75%		
E7	Total C-Section rate	May-21	28%	40.55%	28%	37.43%		
E8	Average Occupancy (maternity)	May-21	15%	25.94%	15%	22.65%	-	-
E9	12+6 risk assessments	Feb-21	90%	83.87%	90%	86.94%		
E10	Number of deliveries	May-21	-	397	-	5367	-	-

Responsive - Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Apr-21	99%	94.74%	99%	74.59%		
R12	18 weeks RTT Incomplete Performance	Apr-21	92%	66.87%	92%	64.24%		
R13	18 Weeks over 52 week breaches	Apr-21	0	374	0	2984		
R14	Operations cancelled by hospital - on the day	May-21	0	8	0	151		
R15	Cancelled operations not rescheduled <28	May-21	0	1	0	27		
R16	Cancer 2ww performance	Apr-21	93%	94.02%	93%	96.48%		
R17	Cancer 2ww performance - breast symptomatic	Apr-21	93%	92.16%	93%	94.11%		
R18	Cancer 31 day first definitive treatment	Apr-21	96%	97.62%	96%	96.65%		
R19	Cancer 62 day treatment - GP referrals	Apr-21	85%	58.18%	85%	73.17%		
R20	104 day cancer waits	Apr-21	0	7	-	28		

Well Led			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit)	Dec-20	0	8	0		-	-
W2	CIP savings	Dec-20	£1,521k	£851k	£5,978k		-	-
W3	Appraisal %	May-21	85%	85.71%	85%	84.50%		
W4	Sickness Rate	May-21	4%	4.15%	4%	4.26%		
W5	Turnover rate	May-21	12%	12.01%	12%	12.17%		
W6	StatMan compliance	May-21	85%	89.83%	85%	88.80%		
W7	Contractual staff in post	May-21	-	4195.23	-	57414.50	-	-
W8	Agency spend as % pay bill	May-21	4%	3.35%	4%	3.50%		
W9	Bank spend as % pay bill	May-21	9%	12.78%	9%	11.92%		
W10	Overall safe staffing fill rate	Dec-20					-	-

Domain: Caring Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Caring	Admitted Care	Mixed Sex Accommodation Breaches	May-21	0	152.00	0.00	131.71	268.45		
		MSA %	May-21	0%	0.00%	0.00%	0.87%	1.84%		
		% of EDNs Completed Within 24hrs	May-21	100%	71.40%	67.34%	72.97%	78.61%		
		Inpatients Friends & Family % Recommended	May-21	85%	77.76%	77.23%	84.07%	90.91%		
		Inpatients Friends & Family Response Rate	May-21	22%	19.67%	15.37%	20.01%	24.64%		
	ED Care	ED Friends & Family % Recommended	May-21	85%	83.38%	72.70%	79.95%	87.20%		
		ED Friends & Family Response Rate	May-21	22%	14.14%	12.22%	14.72%	17.22%		
	Maternity Care	Maternity Friends & Family % Recommended	May-21	85%	99.65%	97.69%	99.38%	100.00%		
		Maternity Friends & Family Response Rate	May-21	22%	100.00%	8.47%	28.31%	48.16%		
	Outpatient Care	Outpatients Friends & Family % Recommended	May-21	85%	88.56%	87.50%	90.03%	92.57%		
		Outpatients Friends & Family Response Rate	May-21	22%	8.91%	11.11%	13.27%	15.42%		

Domain: Effective Dashboard

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

NHS Medway NHS Foundation Trust

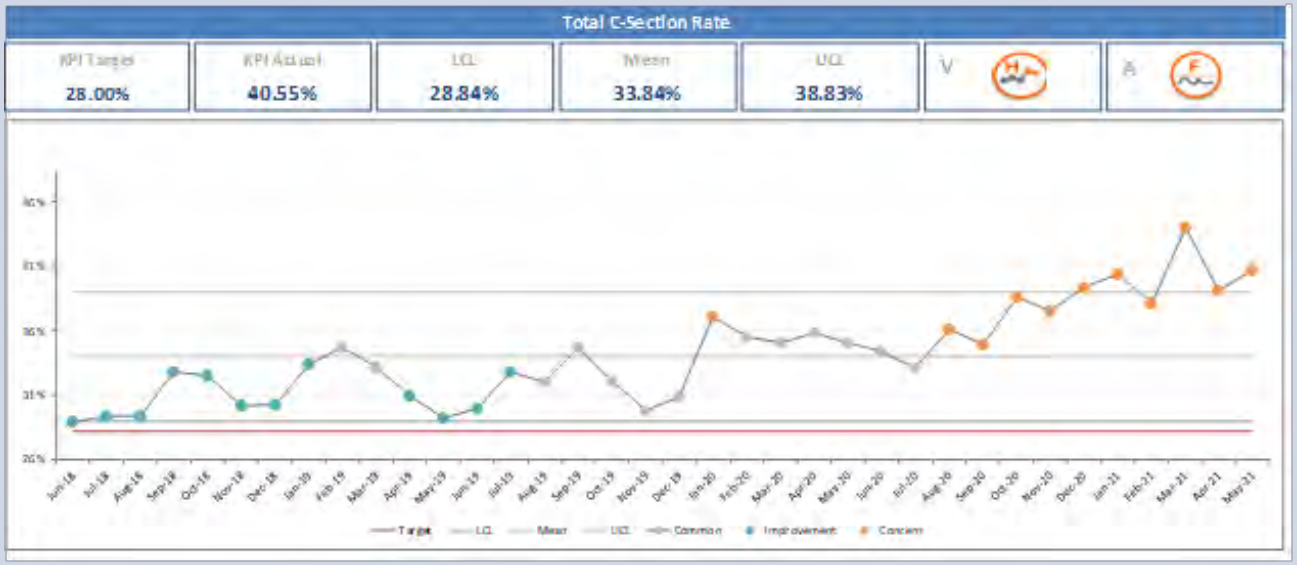
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Effective	Best Practice	7 Day Readmission Rate	Apr-21	5%	6.97%	4.35%	5.93%	7.52%		
		30 Day Readmission Rate	Apr-21	10%	13.66%	9.54%	11.72%	13.90%		
		Discharges Before Noon	May-21	25%	17.32%	12.35%	15.01%	17.67%		
		Fractured NOF Within 36 Hours	Apr-21	100%	68.40%	35.92%	65.72%	95.52%		
		VTE Risk Assessment % Completed	May-21	95%	93.41%	78.47%	87.78%	97.08%		
	Maternity	Elective C-Section Rate	May-21	13%	14.61%	10.08%	13.62%	17.15%		
		Emergency C-Section Rate	May-21	15%	25.94%	15.55%	20.21%	24.86%		
		Total C-Section Rate	May-21	28%	40.55%	28.84%	33.84%	38.83%		
		12+6 Risk Assessment	Feb-21	90%	83.87%	78.78%	84.29%	89.81%		

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Total C-Section Rate



What changes have been implemented and improvements made?

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

What do the measures show?

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

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

Domain: Safe Dashboard

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

NHS Medway NHS Foundation Trust

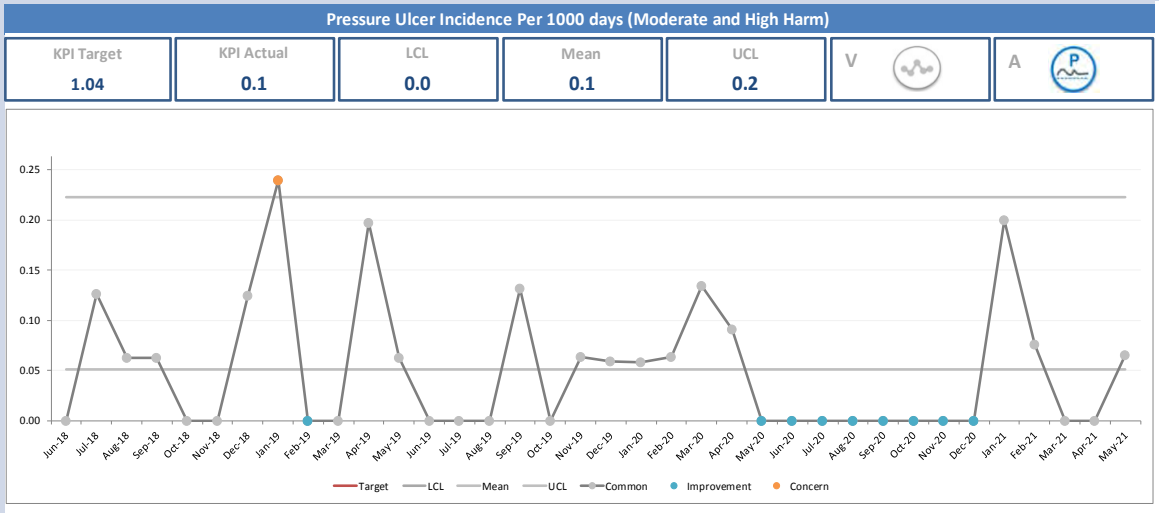
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	May-21	6.63	3.67	2.90	4.75	6.59		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	May-21	1.04	0.07	0.00	0.05	0.22		
	Incident Reporting	Never Events	May-21	0	0.00	0.00	0.13	0.85		
		No of SIs on STEIS	May-21	90	10.00	0.00	13.16	27.61		
		% of SIs Responded To In 60 Days	May-21	0%	100.00%	33.96%	98.51%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Apr-21	5	0.00	0.00	0.43	2.13		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Apr-21	43	2.00	0.00	2.44	8.09		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Apr-21	0	3.00	0.00	1.88	6.76		
		E-coli (Trust Acquired) Infections	Apr-21	30	3.00	0.00	4.35	10.48		
	Mortality	Crude Mortality Rate	Apr-21	3%	1.15%	0.41%	1.86%	3.30%		
		HSMR (All)	Feb-21	100	108.89	101.99	104.61	116.23		
		HSMR (Weekday)	Feb-21	100	105.67	97.81	101.80	114.07		
		HSMR (Weekend)	Feb-21	100	118.25	103.83	112.27	133.44		
		SHMI	Dec-20	1	1.07	0.61	0.99	1.36		

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

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

NHS Medway NHS Foundation Trust

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



What changes have been implemented and improvements made?

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

What do the outcome measures show?

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

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

What do the process measures show?

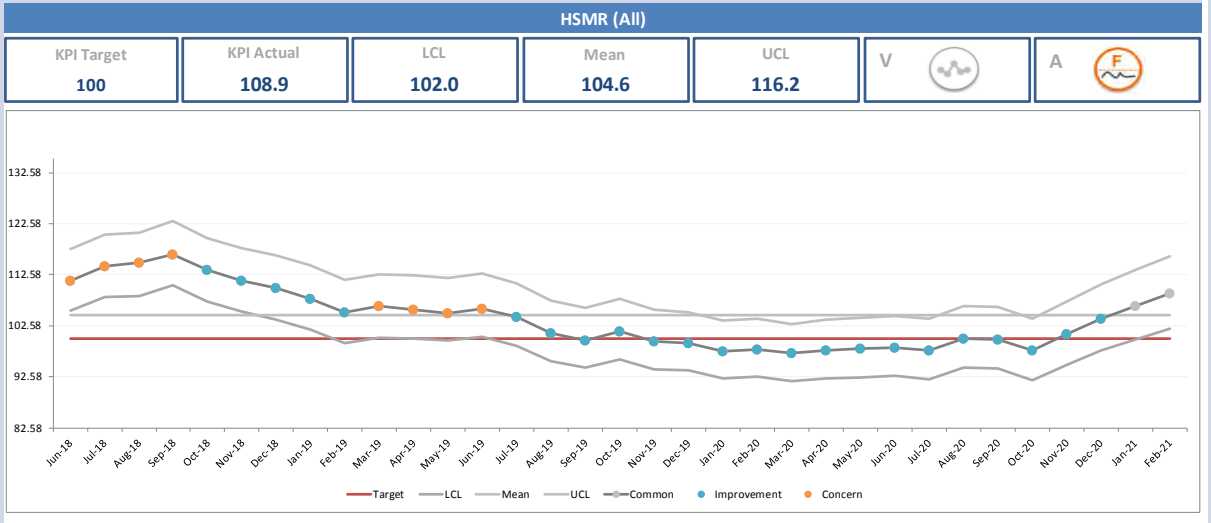
There has been a hospital acquired category 4 and unstageable which are currently being investigated as a SI.

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Mortality - HSMR



What changes have been implemented and improvements made?

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

The audit into the higher mortality among Swale patients has not revealed any significant issues apart from a possible finding that Swale patients are unwell for longer before their presentation than Medway patients. However there is no difference in their time to arrive at hospital after calling an ambulance, or their physiological scores on arrival.

Mortality of non-COVID conditions during Wave 1 of COVID has been discussed at the Quality Assurance Committee. This review will be extended to Wave 2/3 when the Dr Foster data is available (likely to be by June or July 2021)

What do the measures show?

HSMR showed an encouraging trend until October 2020, with the steady reduction in the level being mirrored by a fall in observed deaths within the Trust. The difference between weekday and weekend mortality continues to be addressed via alterations to the medical take process for the weekends: the current position shows a reduction in weekend mortality.

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

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

Domain: Responsive – Non Elective Dashboard

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

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	May-21	85%	83.89%	80.21%	87.55%	94.90%		
		Average Elective Length of Stay	May-21	5	2.77	1.31	2.40	3.50		
		Average Non-Elective Length of Stay	May-21	5	8.13	5.61	8.83	12.05		
		% of Delayed Transfer of Care Point Prevalence in Month	May-21	4%	0.79%	0.31%	1.25%	2.18%		
		% Medically Fit For Discharge Point Prevalence in Month	May-21	7%	11.22%	13.65%	16.93%	20.21%		
	ED Access	ED 4 Hour Performance All Types	May-21	95%	82.17%	75.14%	82.38%	89.62%		
		ED 4 Hour Performance Type 1	May-21	95%	73.93%	63.77%	73.55%	83.34%		
		ED 12 hour DTA Breaches	May-21	0	0.00	0.00	20.82	74.66		
		60 Mins Ambulance Handover Delays	May-21	0	146.00	0.00	121.13	272.90		

Domain: Responsive – Elective Dashboard

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

NHS Medway NHS Foundation Trust

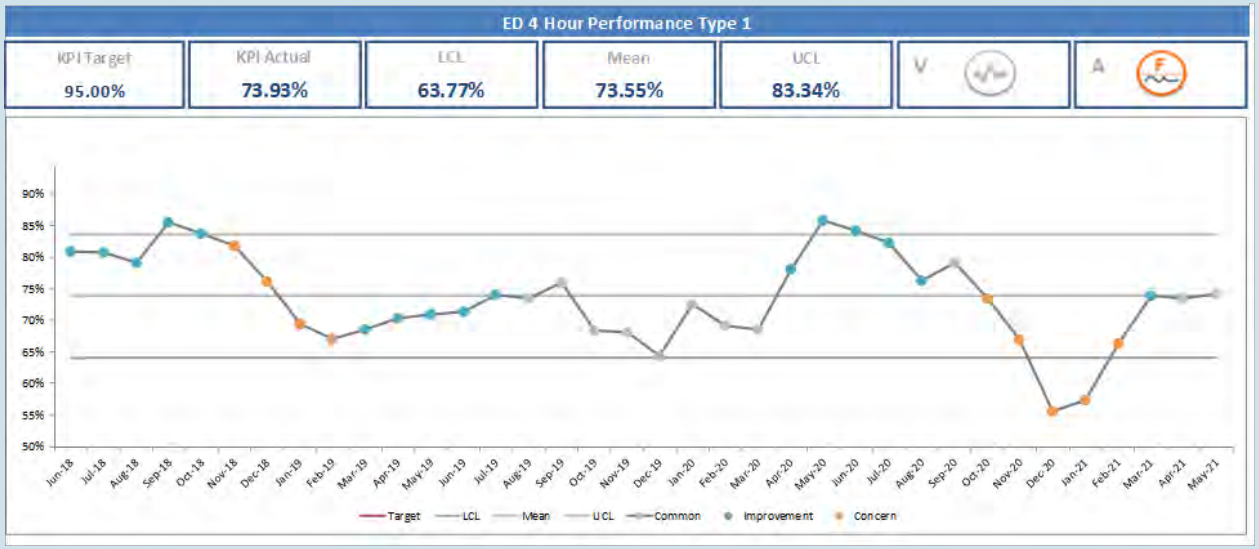
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Responsive - Elective	Diagnostic Access	DM01 Performance	May-21	99%	94.39%	76.68%	89.41%	100.00%		
	Elective Access	PTL Size	May-21	22477	23843	20230	21407	22584		
		18 Weeks RTT Incomplete Performance	May-21	92%	66.87%	69.54%	75.54%	81.54%		
		18 Weeks RTT Over 52 Week Breaches	May-21	0	374.00	2.37	92.74	183.10		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	May-21	0	8.00	0.00	20.26	45.78		
		Cancelled Operations Not Rescheduled < 28 days	May-21	0	1.00	0.00	4.24	11.86		

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high improving nature.

Actions:

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

Outcomes:

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

Underlying issues and risks:

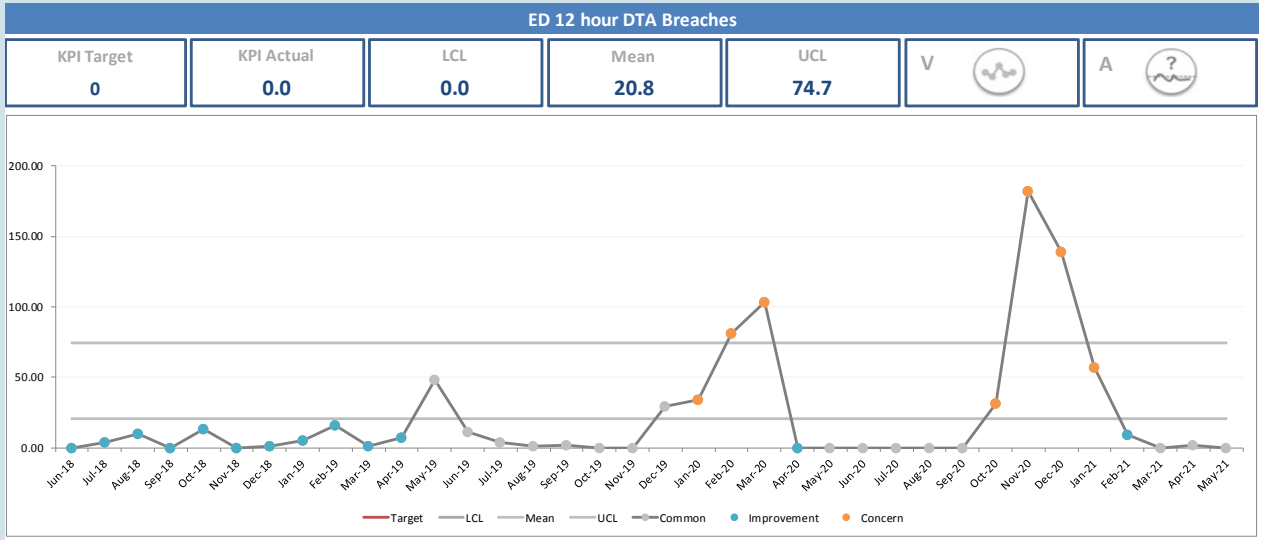
- Need for more clarity re the roles of NIC and EPIC in managing ED processes to delivery 4 hour standard.
- Workforce gaps in acute medicine has meant increased LOS for referred patients.
- Loss of AAU capacity due to covid-driven reconfiguration and revised IPC regulation.
- Delays in POCT and availability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

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

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

What the Chart is Telling Us:

The chart illustrates the considerable improvement over the past few months as a result of the interventions and action in place mainly through the patient first programme.

Actions:

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

Outcomes:

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

Underlying issues and risks:

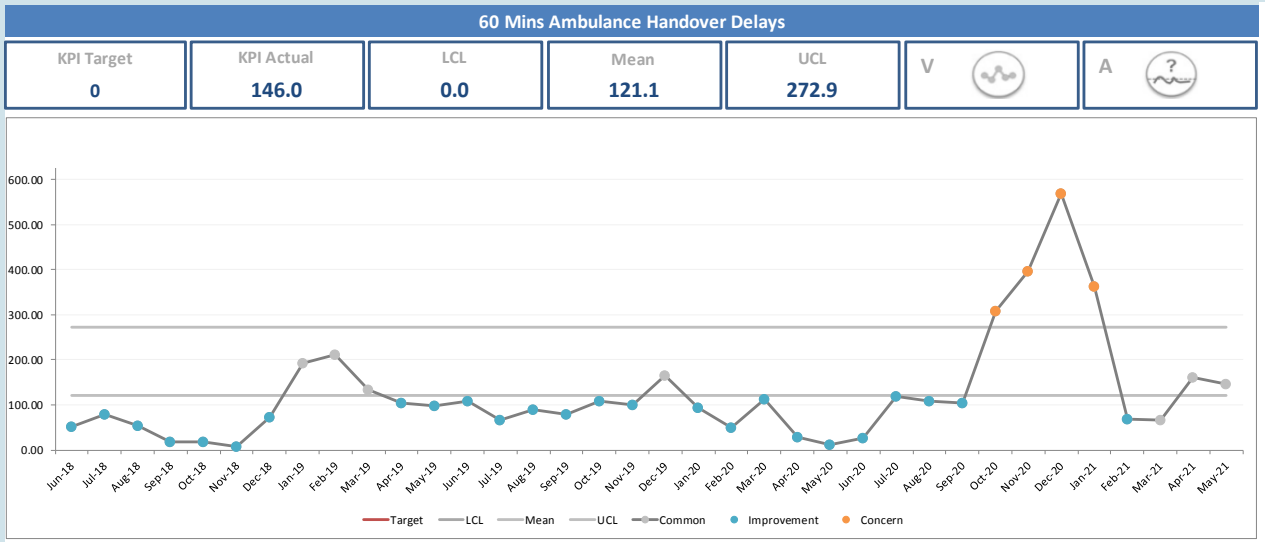
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Slow re-launch of acute assessment due to capacity, IPC considerations and staffing.
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a high improving nature.

Actions:

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

Outcomes:

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

Underlying issues and risks:

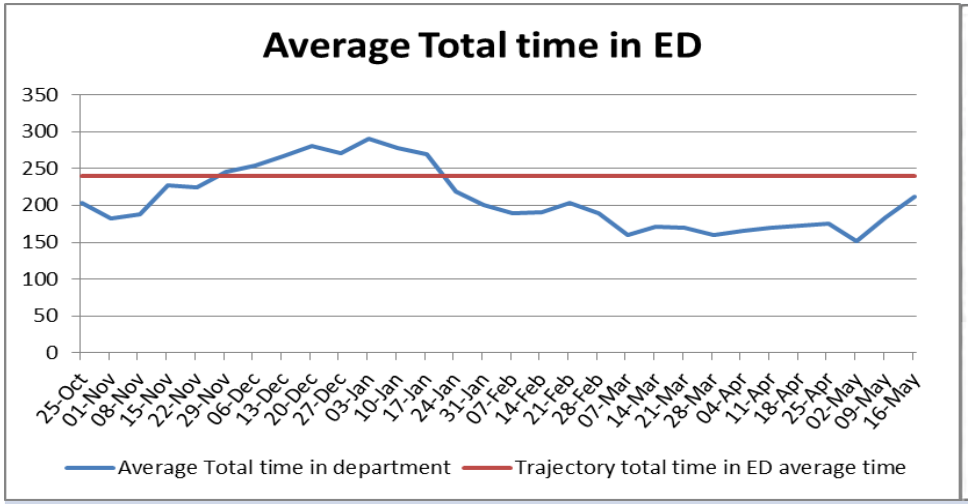
- Workforce and rosters not always in sync with demand.
- Ongoing issues with roles and responsibilities
- Ambulance handover is subject to CQC notice due to excessive delays and decompensation of ED pathways
- Consultant gaps in acute medicine with the new medical model
- Gaps in Senior ED Leadership

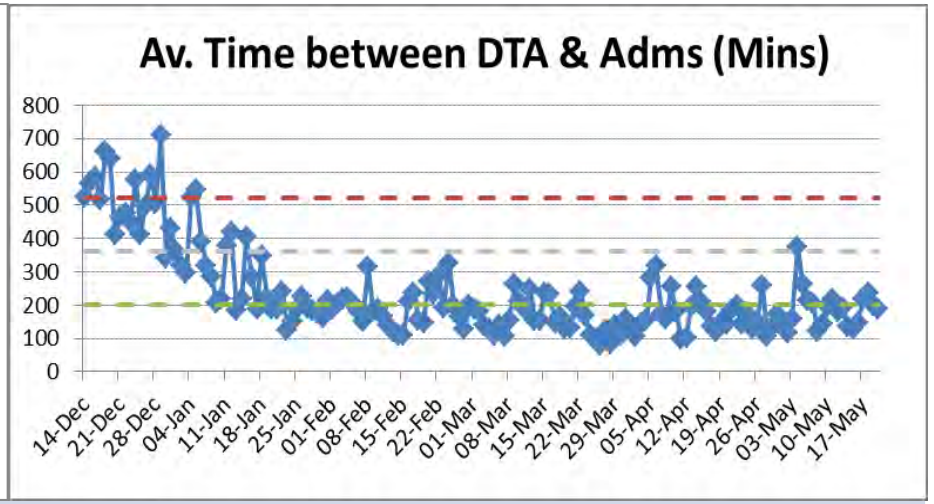
Safe: Operational flow
Aim: TBC
Latest Period: Jan/Feb-21

Executive Lead: All
Operational Lead: All
Sub Groups:

NHS Medway NHS Foundation Trust

Outcome Measure:





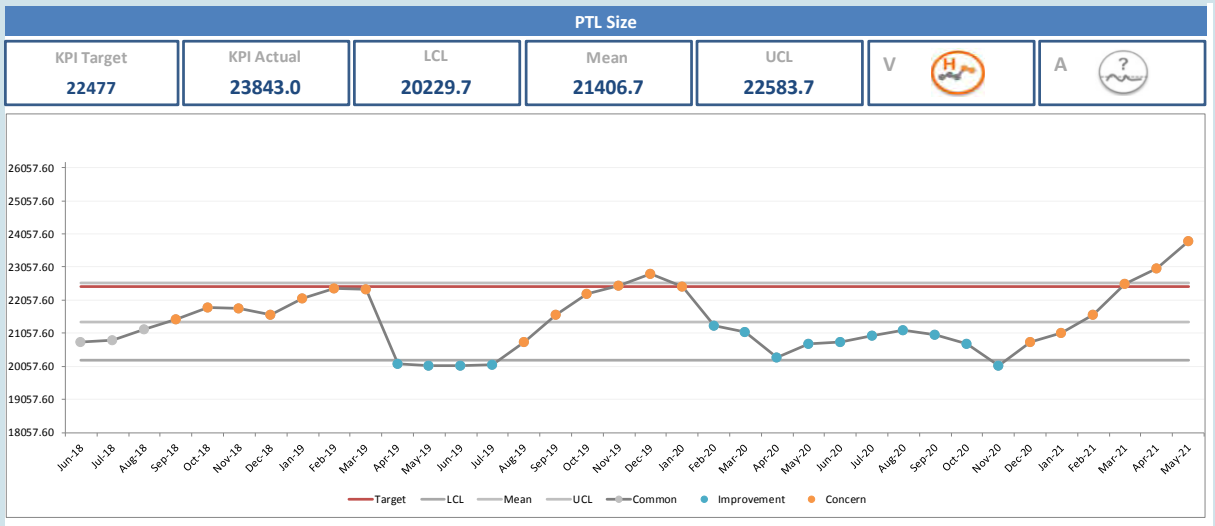
Average total time in department has increased throughout May with a weekly average of 200mins which although below the 4hr standard is higher than the preceding 2 months.
Average time between DTA and admission increased at the beginning of May but the cause was identified and coincided with a bank holiday and increased admissions resulting in a high bed occupancy (>92%) the implementation of refer and move has alleviated some of this pressure and the time has continued to decrease however there is further work to be done as identified at the clinical summit to tackle a high APD.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

The overall number of patients on a Referral to Treatment (RTT) pathway.

What the Chart is Telling Us:

. The SPC data point is showing special cause variation of a low concerning nature.

Actions:

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

Outcomes:

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

Underlying issues and risks:

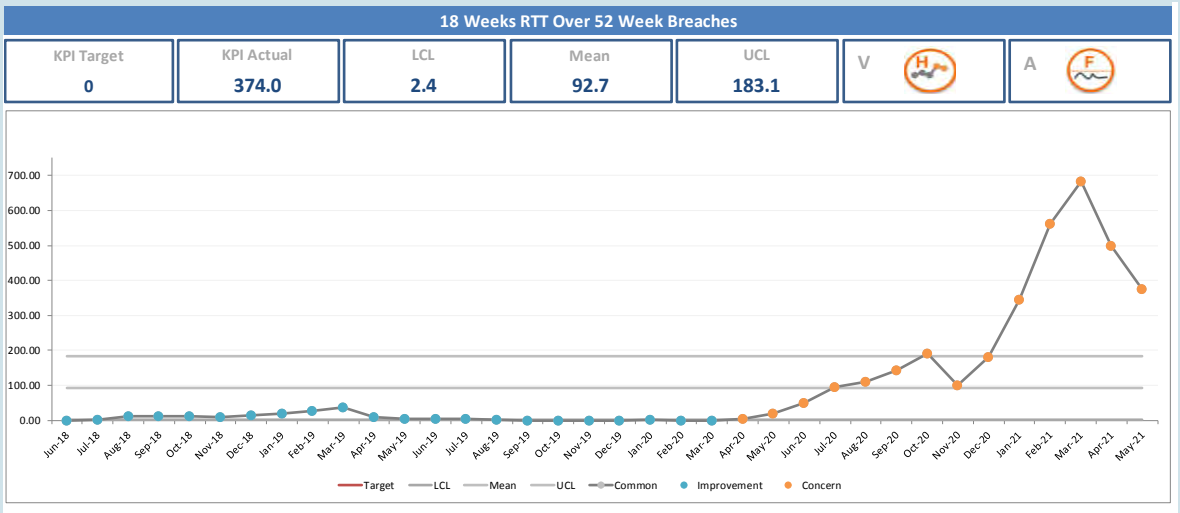
- Estate programme relating to the completion of ED phase 3 and release of Ocelot of elective orthopaedics.
- Uncertainty on NEL activity and associated impact on elective plans
- End of national contracts for IS activity and financial impacts.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. The increase in 52 week waits is directly related to the pandemic and a reduction has been consistent since restart.

Actions:

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

Outcomes:

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

Underlying issues and risks:

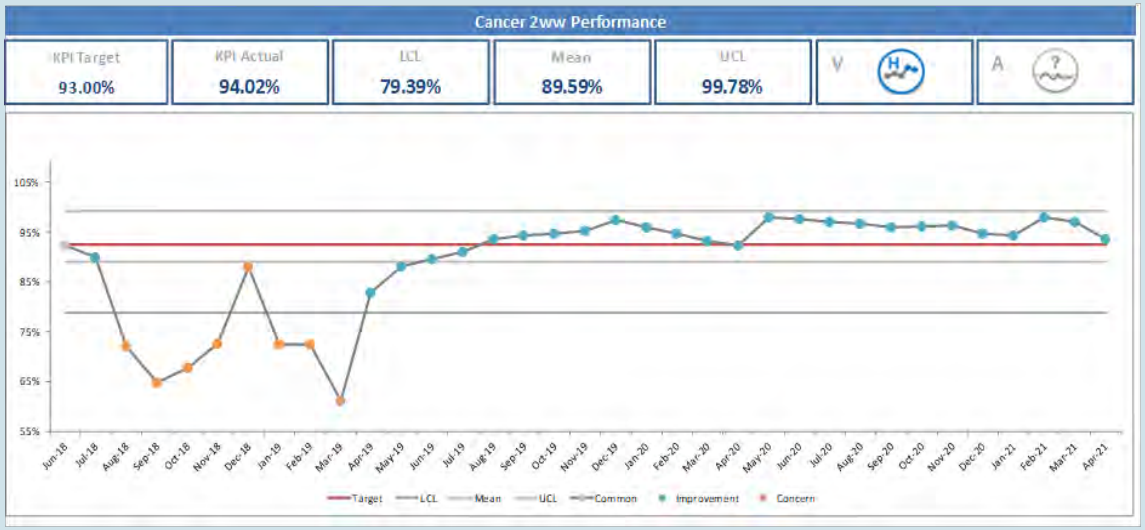
- Estate programme relating to the completion of ED phase 3 and release of Ocelot of elective orthopaedics.
- Uncertainty on NEL activity and associated impact on elective plans
- End of national contracts for IS activity and financial impacts.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

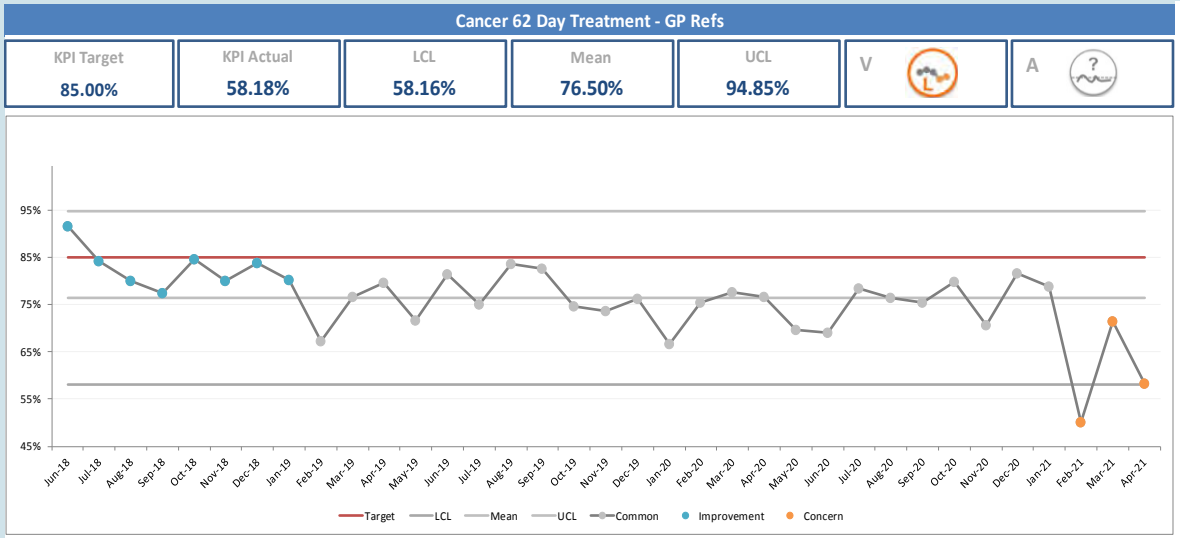
- Internal Stretch target of 7 Days is now being achieved by 2 services Urology & H&N
- 7/9 Services booking at day 14 or under.
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic Capacity could challenged as the trust pushes ahead with restart.

Responsive: Cancer and Complaints Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

Underlying issues and risks:

- Sufficient diagnostics and outpatient capacity to clear the backlog of patients waiting.
- PTL validation resource
- Services currently competing for limited HDU capacity.
- Patient engagement is causing some issues as patients are worried and at times reluctant to attend for diagnostics or treatment.
- Post 2nd wave peak influx of referrals could overwhelm current capacity

Domain: Well Led – Dashboard

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

NHS Medway NHS Foundation Trust

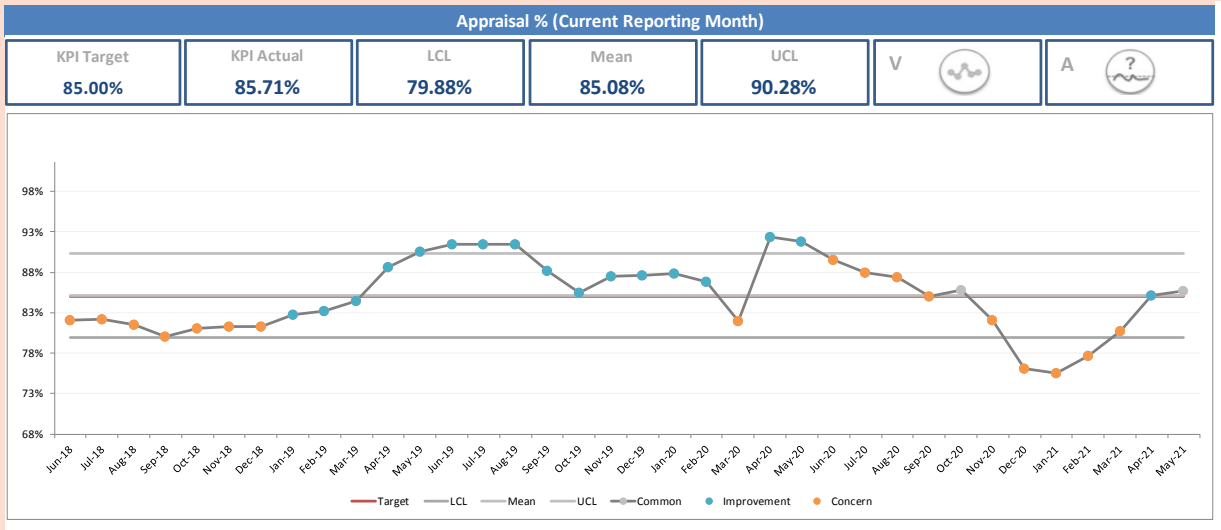
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-21	62%	63.00%	1.62%	26.99%	52.36%		
		Staff Friends & Family - Recommend Care of Treatment	Mar-21	79%	74.00%	3.91%	35.70%	67.49%		
	Workforce	Appraisal % (Current Reporting Month)	May-21	85%	85.71%	79.88%	85.08%	90.28%		
		Sickness Rate (Current Reporting Month, FTE%)	May-21	4%	4.15%	3.34%	4.43%	5.53%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	May-21	12%	12.01%	10.96%	12.05%	13.15%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	May-21	0	4195.23	3829.35	3925.95	4022.54		
		StatMan Compliance (Current Reporting Month)	May-21	85%	89.83%	66.91%	80.64%	94.36%		
		Agency Spend as % Paybill (Current Reporting Month)	May-21	4%	3.35%	1.87%	3.62%	5.38%		
		Bank Spend as % Paybill (Current Reporting Month)	May-21	9%	12.78%	7.87%	12.88%	17.91%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	May-21	75%	62.34%	58.67%	70.97%	83.28%		

Well Led: Workforce - Insights

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

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

3461 members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4007).

Underlying issues and risks:

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

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month NHSE/I Baseline	In-month Actual	In-month Variance	YTD NHSE/I Baseline	YTD Actual	YTD Variance
Income	30,163	31,100	937	60,325	61,993	1,668
Pay	(19,230)	(19,630)	(400)	(38,460)	(39,105)	(645)
Total non-pay	(9,573)	(10,044)	(471)	(19,147)	(20,038)	(891)
Non-operating expense	(1,368)	(1,433)	(65)	(2,735)	(2,866)	(131)
Reported surplus/(deficit)	**(8)**	**(7)**	**1**	**(17)**	**(15)**	**1**
Donated Asset / DHSC Stock Adj.	8	7	(1)	17	15	(1)
Control total	**0**	**0**	**(0)**	**0**	**0**	**0**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	119	76	(43)	238	151	(87)	5,171
Capital	1,091	979	(112)	2,491	2,781	290	13,877

Indicator Background:

The Trust reports a £7k deficit position for May; after adjusting for donated asset depreciation the Trust reports breakeven in line with the plan control total.

What the Chart is Telling Us:

The Trust has reported breakeven for the year to date. The efficiency programme is £87k adverse to plan , this is expected to recover as schemes develop and are implemented.
Capital spend is £290k ahead of budget, Overall the programme is on plan with some schemes ahead and some behind.

Actions:

- Forecast outturn to breakeven for Apr-Sep.
- Monitor performance of activity against 2019/20 thresholds to achieve additional elective recovery funding (ERF).
- Monitor additional costs associated with the restart activity plan.
- Efficiency programme development for 2021/22.

Outcomes:

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

- Incremental costs associated with Covid-19 of £1.0m year to date. Funding is included within the affordability envelope.
- ERF Income has been accrued into the position to achieve breakeven of £0.4m. The forecast is £5.9m income for the half year reporting period.
- 21/22 forecast outturn for the Trust over the first 6 months is breakeven.

Underlying issues and risks:

Funding arrangements have been agreed for the period Apr-Sep. A plan was submitted to NHSE/I based on quarter 3 of 20/21, including income agreed with the CCG.
The pay costs are increasing as the services restart activity following low numbers of Covid positive patients in the hospital. This has required recruitment, additional capacity as well as insourcing and outsourcing costs. These will be funded from ERF income.
The efficiency programme for the 6 months is £5.1m in total, £0.3m of this relates to FYE schemes from 2020/21.

Meeting of the Board of Directors in Public

Thursday, 08 July 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.2
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 22 June 2021		
Lead Director:	Jane Murkin, Chief Nursing and Quality Officer		
Report Author:	Joanne Adams, Business Support Manager		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Quality report and CQC inspection Visits The Committee received the quality report which provided an update on progress on the CQC must do and should do action plan and the ED CQC actions. The Committee were informed that the IPC CQC inspection report had been received for factual accuracy and responded to. The Committee discussed its concerns on a number of issues within the Unplanned and Integrated Care division and were informed of the plans in place to address the concerns and support the division; and will receive an update on progress at the next meeting. The Committee discussed the need for a system-wide approach to duty of candour for patients who died of hospital acquired COVID, and were assured by the Chief Medical Officer that a system wide approach has been agreed. The Committee will receive an update from the Chief Medical Officer at the next	**Green**

meeting. The Committee continues to focus on paediatric life support training , and noted the improvement to compliance; however, the committee also noted the improvement to training needs to be reflected in practice.	
2. Review of patients presenting to ED The Committee received a verbal update from the Chief Medical Officer on the initial findings of his review of patients presenting to ED and if this has been delayed due to COVID. The Committee were advised this does not appear to be an issue and will be provided with a report at the next meeting.	**Green**
3. COVID Risks The Committee received the COVID risks paper which was an action from Board, and noted its content. The paper will be shared with the Board.	**Green**
4. Quality and Patient Safety Group highlight report The Committee received the highlight report from the Quality and Patient Safety Group held on June 2021 noting its content. The quality and patient safety group identified poor attendance at its meetings advising the Committee of the actions taken to address this and will keep the Committee informed. The Committee was advised that a review of quality governance is to be undertaken, by NHSE/I working with the Trust. The Committee will be updated on scope in July, with a final report for the Committee and the Trust Board planned for September.	**Green**
5. End of Life Care – quarterly report The Committee received the End of Life Care quarterly report for quarter 4 noting the content of the report. The Committee discussed the need for 7 day service provision and links to bereavement services for families. The Committee were informed of the changes and improvement to the bereavement services since the introduction of the medical examiner posts at the Trust. The Committee were informed of the challenges the end of life care team experienced during the pandemic coping with the number of deaths.	**Green**
6. Safeguarding Report – progress on implementation of the Trust Wide review of safeguarding The Committee received the safeguarding report on progress on the implementation of the trust wide safeguarding review, and were advised that progress against the 41 recommendations is monitored at the Trust's Safeguarding Assurance Board and at the Quality Review Group with the CCG. The Committee were informed of bespoke safeguarding training for Non-Executive Directors and the role of Non-Executive Safeguarding Champion.	**Green**
7. Quality IQPR The Committee received the Quality IQPR which reported on performance data and metrics for the month of May and noted the content of the report.	**Green**
8. BAF – quality risks The Committee received the review BAF – quality risks noting the changes to the risks. The Committee continue to review the BAF – quality risks as part of its work plan.	**Green**

9. August Committee meeting The Committee discussed the proposal to cancel the August meeting in line with the cancellation of Trust Board. The Committee will review its work plan to inform the decision.	**Green**
10. Escalation to Board The Committee escalates the following to Trust Board:- • Actions taken to mitigate risks associated with paediatric patients in ED waiting for Tier 4 beds	

Meeting of the Board of Directors in Public
Thursday, 08 July 2021

Title of Report	**Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme – Final Assurance Report**	**Agenda Item**	3.3
Report Author	Dot Smith, Head of Midwifery		
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Executive Summary	NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts delivering maternity services and who are members of the CNST. As in year two, members will contribute an additional 10% of the CNST. At the 2 December 2020 meeting of the Trust Board the Chief Nursing & Quality Officer presented a paper on CNST which included a gap analysis which she had commissioned the Head of Midwifery to complete against each of the ten safety actions, with the associated actions being addressed to recover compliance. The Trust Board requested that the Quality Assurance Committee oversee the review and evidence relating to the Ten Safety actions. The Board will maintain full accountability for the authorisation of final sign-off for CNST by the Chief Executive Officer, following a schedule of alternate month reporting to QAC. The Board will have oversight of evidence as set out in the technical guidance. Between January 2021 and July 2021 the Chief Nursing and Quality Officer has maintained a programme of reporting to support the Head of Midwifery to provide assurance and evidence against progress against each of the 10 Safety Actions to the Quality Assurance Committee and the Trust Board. In December 2020 NHSR advised that the deadline for submission for the CNST MIS had been revised to 15 July 2021. This was in response to the continued pressure facing Trusts in response Covid-19. NHSR has since published two revisions to the guidance the first in February 2021 and the second on 18 March 2021. The March 2021 guidance removed a number of sub-requirements from Safety Actions 3, 4 and 9 and also amended the approach to validating the Maternity Services Data Set data (Safety Action 2) and made changes within Safety Action 8's standards removing the 90% threshold for training. This report will provide the Board with final oversight, assurance and evidence that the maternity service is compliant with all 10 Safety Actions.		
Committees or Groups at which the paper has been submitted	Planned Care Divisional Governance Board CNST Task and Finish Group		

Resource Implications	No additional resource implications.			
Legal Implications/Regulatory Requirements	CNST Premium payments Compliance against CNST Safety Standards will be reviewed as part of CQC Key Lines of Enquiry			
Quality Impact Assessment	Quality Impact Assessment is not required for this report			
Recommendation/ Actions required	The Board is asked to approve the Supernumerary Action Plan in appendix 2. The Board is asked to note compliance against all 10 Safety Actions and authorise the Chief Executive Officer to sign the declaration form to be submitted to NHSR by 12 noon on 15 July 2021.			
	Approval ☒	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1: Compliance Summary and Evidence Appendix 2: Supernumerary Action Plan			

1 Executive Overview

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

1.2 At the 2 December 2020 meeting of the Trust Board the Chief Nursing and Quality Officer presented a paper on CNST. This included a gap analysis which the Chief Nursing and Quality Officer had commissioned the Head of Midwifery to complete against each of the ten safety actions, with the associated actions being addressed to recover compliance. The Trust Board requested that the Quality Assurance Committee oversee the review and evidence relating to the Ten Safety actions.

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

1.4 Between January 2021 and July 2021 the Chief Nursing and Quality Officer has maintained a programme of reporting to support the Head of Midwifery to provide assurance and evidence against progress against each of the 10 Safety Actions to the Quality Assurance Committee and the Trust Board.

1.5 In December 2020 NHSR advised that the deadline for submission for the CNST MIS had been revised to 15 July 2021. This was in response to the continued pressure facing Trusts in response Covid-19. NHSR has since published two revisions to the guidance, the first in February 2021 and the second on 18 March 2021. The March 2021 guidance removed a number of sub-requirements from Safety Actions 3, 4 and 9 and also amended the approach to validating the Maternity Services Data Set data (Safety Action 2) and made changes within Safety Action 8's standards removing the 90% threshold for training.

1.6 This report will provide final oversight, assurance and evidence to the Board that the Maternity Service is compliant with all 10 Safety Actions for CNST MIS year three and requests that the Board authorise the Chief Executive Officer to sign the declaration form to be submitted to NHSR by 12 noon on 15 July 2021.

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

2.1 The report provides assurance to the Board that the Trust has been using PMRT to the required standard and are fully compliant with Safety Action 1.

2.2 All eligible deaths from 11 January 2021 have been reported within 7 working days and the surveillance information, where required, has been completed within 4 months of the death.

2.3 The report assures the Board that 100% of eligible cases from 20 December 2019 to 15 March 2021 have had a review using PMRT commenced.

2.4 The report assures that Board that from December 2019 to 15 March 2021 90% of cases had been completed with scheduled reviews for the remaining cases due to take place within the 4 month timeframe. The report assures the Board that the service is fully compliant with this requirement.

2.5 The report assures the Board that for 100% of cases, parents have been informed of review, both verbally and in writing, and their concerns and views have been taken into consideration.

2.6 PMRT quarterly reports have been received by the Board since October 2020, with reports and PMRT action plan being shared with the Board in December 2020, February 2021 and June 2021. The PMRT generated Board reports, along with the PMRT action plan are linked n evidence in appendix 1.

3 Safety Action 2: Maternity Services are submitting data to the Maternity Services Data Set (MSDS) to the required standard

3.1 The report assures the Board that the Maternity Services are submitting data to the Maternity Services Data Set (MSDS) to the required standard and are fully compliant with Safety Action 2.

3.2 The Board received assurance on 15 April 2021 that the Maternity Service had complied with all 13 criteria required for Safety Action 2, and the Digital Scorecards were shared with the Board as evidence.

3.3 The Maternity Information System provider Wellbeing have issued a compliance statement which was shared with the Board on 15 April 2021 and the report assures the Board that progress is being made against this plan by Wellbeing to ensure the Trust is fully compliant with MSDSv2 Information Standards Notice, DCB1513 and 10/2018, including the submission of SNOMED-CT coding. This plan has been shared with and agreed by the LMS and is due to be implemented in Quarter 2/Quarter 3 2021/2022.

4 Safety Action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

4.1 The report assures the Board that the Trust can demonstrate transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme (ATAIN) and are fully compliant with all requirements of Safety Action 3.

4.2 March 2021 guidance removed the requirement for the Transitional Care Guidelines to have been jointly approved by maternity and neonatal teams, however, the report assures the Board that this standard has been met and furthermore Neonatal input into care planning has been audited demonstrating 100% compliance.

4.3 Local audits against the Transitional Care guidelines were removed from the CNST guidance in March 2021, however these audits continue and will be monitored locally to ensure compliance with the policy and identify any areas for improvement.

4.4 A review of all term admissions into the neonatal unit and Transitional Care was undertaken as per the CNST guidance, and included a review of closures or reduced capacity, changes to parental access, staff redeployment and changes to postnatal visits leading to an increase in weight loss and poor feeding. No poor outcomes were identified and the Neonatal Service reinstated parental access as soon as possible and worked closely with parents to reduce the challenges of access and bonding with their baby during the Covid-19 period. The Maternity Service reintroduced face to face postnatal visits as soon as possible and did not suspend these during the second wave.

4.5 Covid-19 concerns and challenges for both maternity and neonatal services have been discussed monthly with the Board Level Safety Champion (the Chief Nursing and Quality Officer), including the introduction of virtual clinics to support Covid-19 positive women and the psychological impact of Covid-19 on Neonatal Parents.

4.6 Progress against the ATAIN action plan is monitored via the CNST Task and Finish Group and Safety Champion meeting as required by the CNST guidance.

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

5.1 The report assures the Board that there is an effective system of clinical workforce planning in place and the Trust is fully compliant with Safety Action 4.

5.2 The Board received a full assurance report for Safety Action 4 on 15 April 2021 and reviewed and approved the Action Plans for Neonatal Medical and Nursing staffing. Progress against the action plans continued to be monitored within the Care Group and the action plans are linked in evidence. The Neonatal Nursing staffing action plan has been submitted to the Royal College of Nursing and the ODN as required by the CNST Guidance.

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

6.1 The report assures the Board that there is an effective system of midwifery workforce planning in place, including annual workforce report to the Trust Board, and that the Trust is fully compliant with all requirements of Safety Action 5.

6.2 The Board was assured on 15 April 2021 that the Birthrate plus review of Maternity Staffing had been undertaken, supported by the Chief Nursing and Quality Officer who submitted a workforce paper produced by the Head of Midwifery and submitted to the Board in May 2021 requesting the required 13WTE midwives, specialist roles to support safe staffing levels. The Chief Nursing and Quality Officer also put forward a proposal and PID for a Director of Midwifery (DOM) post as part of her commitment to strengthen nursing and midwifery leadership within the Trust in alignment with the recommendations of the Royal College of Midwives Manifesto The Board approved the 13TWE midwives and DOM in principle.

6.3 The Maternity Service maintains 100% compliance with 1:1 care in labour, which is reported and monitored monthly on the Maternity Dashboard.

6.4 Compliance with Supernumerary status remains >98%. The recommendations of Birthrate plus and Trust Board support to fund the additional 13WTE midwives will address this shortfall. The Head of Midwifery has added an additional escalation for the Delivery Suite Coordinator should they be unable to maintain supernumerary status, including alerting the Midwifery Manager on-call and raising a datix if they are not supernumerary for more than one hour. The escalation to close policy has been updated to reflect this change. An action plan, including timescales to achieve 100% compliance is in place and is included in Appendix 2. The report asks the Board to approve the action plan.

6.5 Maternity Red flags are monitored and audited regularly by the service. Red flags include delays to induction to labour and delayed medical review. The majority of red flags recorded related to delayed induction of labour. An action plan is in place to improve data collection, escalation and communication around red flags and these will continue to be audited quarterly.

6.6 The Maternity service assures the Board that the impact of Covid-19 on staffing levels was managed effectively with the use of bank and agency staff. A small number of nurses were redeployed from the postnatal ward and these positions were covered. Clinical specialist and management staff were utilised to support the ward based clinical staff and to ensure the service maintained safe care for women and their families. The maternity service was responsive to the challenges posed by the pandemic and implemented inpatient swabbing, red high risk and amber medium risk pathways, and virtual antenatal appointments as appropriate in line with national guidance. In wave two of the pandemic, the Maternity Services implemented a virtual Covid-19 clinic to support women in the community who are Covid-19 positive to encourage safety with ongoing contact and remote support.

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

7.1 The report assures the Board that the Trust is compliant with all five elements of Saving Babies' Lives Care Bundle version two (SBLCBv2) and all requirements of Safety Action 6.

7.2 **Element 1: Carbon Monoxide (CO) Monitoring**

7.2.1 Due to the restrictions imposed by Covid-19 the service suspended CO monitoring. As per CNST guidance, the service has monitored compliance with recording of Smoking at time of Booking and Smoking at time of Delivery. Compliance with recording this information averages at 99% and therefore is compliant with CNST requirements.

7.2.2 The service assures the Board that the service has recommenced CO monitoring from 21 June 2021 and the compliance against this will be monitored in line with CNST and SBLCBv2 guidance.

7.3 **Element 2: Fetal Growth Restriction.**

7.3.1 CNST requires the Trust to record the risk factor for Fetal Growth Restriction (FGR) in a minimum of 80% of cases, with an action plan required for Trusts who achieve <95%. The Maternity Information System (EuroKing) could not provide the required data to measure this requirement, therefore a local audit of all women who gave birth in January 2021 was conducted. 382 women were included in the audit and 367 factors for FGR were recorded on EuroKing. The report therefore assures the Board that 97% of women had the risk factors for FGR identified and recorded at booking.

7.3.2 The report assures the Board that the pathway for providing additional scans for women with a BMI >35 kg/m^2 is now in place as reflected by the revision to the Small for Gestational Age Guideline.

7.3.3 The Board was assured on 15 April 2021 that the appropriate pathway was in place for all women to receive uterine artery Doppler flow velocimetry.

7.3.4 A quarterly audit of babies born <3rd centile born prior to 37+6 weeks was undertaken and showed 85% of babies known to have estimated fetal weight <3rd centile were delivered, as recommended, before 37+6 weeks. The report assures the Board that the recommendations from this audit will be implemented and this audit will be continued on a quarterly basis.

7.4 **Element 3: Reduced Fetal Movements**

7.4.1 CNST requires that a minimum of 80% of women should have information regarding reduced fetal movements (RFM) shared with them by 28+0 weeks, with an action plan required for Trusts who achieve <95%. The Maternity Service conducted an audit of 50 cases and found that all 50 women (100%) had information about RFM discussed with them by their community midwife by 28 weeks. The report assures the Board that the service is 100% compliant with this requirement.

7.4.2 The Board was assured in April 2021 that 100% of women who presented with RFM received a computerised CTG.

7.5 Element 4: Fetal Monitoring

7.5.1 The Board was assured, and noted, on 3 June 2021 of the Maternity Service's commitment to achieve 90% compliance with fetal monitoring training. CNST guidance removed the 90% compliance requirement in March 2021 due to the pressures and restrictions facing Trusts due to Covid-19. Face to face training has continued throughout the Covid-19 period and compliance has been closely monitored. A full schedule of training is in place for 2021/2022 and all staff have been allocated a place to ensure a minimum of 90% compliance for all staff groups going forward as part of the trajectory.

7.5.2 At the time of reporting compliance with the training and assessment are as follows:

Staff Group	Fetal Monitoring Training Compliance	Fetal Monitoring Assessment Compliance
Obstetric Consultants	58%	58%
Junior Doctors	82%	82%
Midwives	96%	96%

7.5.1 Obstetric consultants have achieved 58% compliance due to five consultants yet to receive training. This is due to two new starters, long-term sickness and clinical pressures to support the obstetric rota in response to staff sickness. All consultants are booked to attend sessions and will be compliant by August 2021.

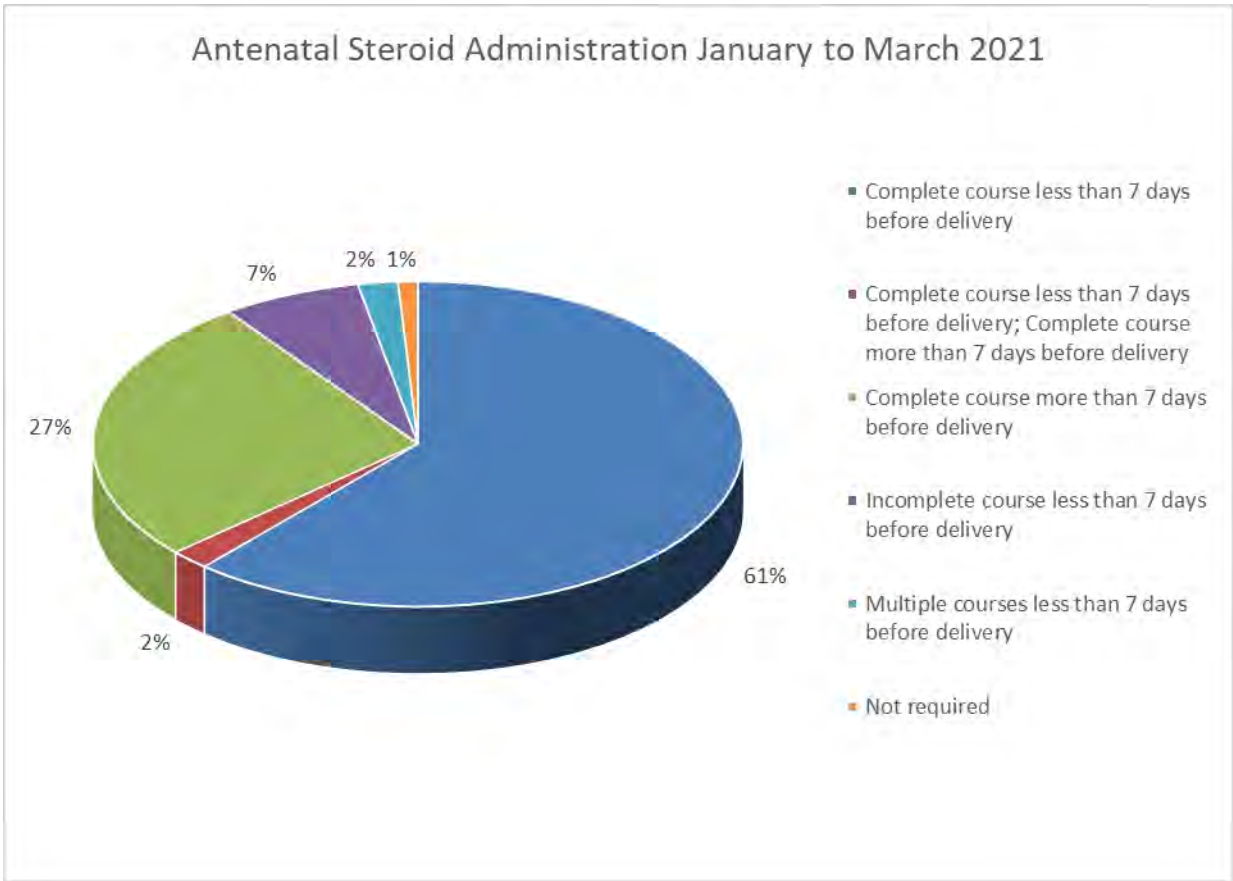
7.6 Element 5: Preventing pre-term birth.

7.6.1 The Board was advised on 15 April 2021 that the Maternity Service had undertaken an audit which demonstrated 55% compliance with the administration of a full course of antenatal corticosteroids within 7 days of birth for babies born at <34+0 weeks gestation. The audit has been shared at Fetal Medicine Governance and an action plan to achieve 85% compliance as per CNST guidance has been agreed by the Clinical Director for Women's Services. A larger retrospective audit will be undertaken to gain further understanding of the themes and trends relating to antenatal corticosteroid administration. All guidelines relating to the administration of antenatal corticosteroids will be reviewed and updated as required. The findings of the retrospective audit will inform a standalone policy for antenatal corticosteroids. The audit report and action plan have been registered with the audit department and are linked in appendix 1.

7.6.2 The Board was assured on 15 April 2021 that the service was maintaining 96% compliance with the administration of Magnesium Sulphate for babies born at less than 30 weeks gestation within 24 hours of birth. The report assures the Board that the Service has continued to maintain compliance with the 85% requirement, with current compliance since December 2019 at 93%.

7.6.3 The Board was assured on 15 April 2021 that 100% of women delivered in an appropriate setting for gestation and that women at risk of preterm birth have access to a specialist preterm birth clinic.

7.6.4 CNST guidance requires the Board to specifically confirm that an audit has taken place to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. The Maternity Service undertook an audit of 3 months of cases of all gestations from January to March 2021. 101 cases were identified from EuroKing and the audit showed that 27% had a complete course more than 7 days before delivery.



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

8.1 The report assures the Board that the Maternity has appropriate mechanism in place to gather service user feedback and that they work with service users through the MVP to coproduce local maternity services.

8.2 The report assures the Board that the Trust is fully compliant with Safety Action 7. The MVP Chair is called upon to review new information that will be provided to service users, including communications on social media and the Trust Website. The MVP Chair is a member of the Maternity Transformation Assurance Board and provides quarterly updates on co-production of services and service user feedback. Following the 15 Step Challenge which is planned for September 2021, all findings will be shared with staff, via Fridays News, as we progress further service development.

8.3 The Board was assured on 10 June 2021 that the Maternity Service had appropriate mechanisms in place to gather and act upon service user feedback via the MVP. The Board was also assured that the MVP was prioritising the voices of women from BAME backgrounds and those with high levels of deprivation.

8.4 The revised Terms of Reference for the MVP has been agreed by the LMS and is linked in Evidence in appendix 1, along with minutes, confirmation that the chair of the MVP is remunerated for her work and evidence of service user feedback and co-production.

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

9.1 The report assures the Board that staff have attended 'in-house' multi-professional training in obstetric emergencies since December 20219 and that the service is fully compliant with all requirements of Safety Action 8.

9.2 On 3 June 2021 the Board was advised that CNST had removed the 90% compliance requirement for Obstetric emergency (PROMPT) training. The Board was assured that the Maternity Service was committed to facilitating face to face multidisciplinary PROMPT training and to achieving 90% compliance. Face to face training was offered throughout the Covid-19 pandemic in-line with social distancing restrictions and supplemented with an online package to support compliance. Current compliance, including face to face and e-learning is as follows:

Staff Group	PROMPT Compliance
Midwives	95.86%
MSW	92%
Obstetric Consultants	100.00%
Obstetric Junior Doctors	97.3%
Anaesthetic Consultants	57.15%
Anaesthetic Junior Doctors	88.89%
Theatre Staff	91.67%

9.3 Three anaesthetic consultants require training, along with two junior anaesthetic doctors as illustrated in the table above. There are six training sessions until December 2021 with dedicated space for anaesthetics. The maternity PROMPT lead is working with the lead obstetric anaesthetic consultant to ensure these places are utilised to achieve compliance by December 2021.

9.4 A training schedule for face to face multidisciplinary training is in place for 2021/22 for all staff, prioritising staff who are currently out of date or who completed e-learning.

9.5 The Board was assured regarding compliance with New born life support training on 03 June 2021 as follows:

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

ANNP	100%
Midwives	98%

9.6 Safety Action 8 also includes Fetal Monitoring training as detailed above in 7.5 the service is committed to continuing to provide face to face multidisciplinary training and assessment to maintain compliance with both CNST, SBLCBv2 and Ockenden requirements.

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

10.1 The report assures the Board that the Trust Ward Level Safety Champions meet monthly with the Chief Nursing and Quality Officer and Non-Executive Director in their roles as designated Board level Champions, to escalate locally identified issues and are fully compliant with all requirements of Safety Action 9.

10.2 The Board was assured on 3 June 2021 regarding the work undertaken by the Ward and Board Level Safety Champions to review and address safety concerns in Maternity and Neonatal services, including the review of Mortality and Morbidity, Covid-19, support for the BAME community during Covid-19, progress against the Avoiding Term Admissions to Neonatal Units (ATAIN) action plan and the Continuity of Carer Action plan.

10.3 The Chief Nursing & Quality Officer in her Executive Board Level Safety Champion role has undertaken regular walk-arounds to speak with staff and discuss any safety concerns or issues and gain staff feedback, along with facilitating a dedicated quality and patient safety focus group with the NED Safety Champion . The Board Level Safety Champions have supported Quality Improvement Work undertaken by the frontline Safety Champions as part of their MatNeoSIP programme including the Safety Culture Survey, flu vaccination clinic, virtual Covid-19 clinic and Each Baby Counts activity. .

10.4 The 2018 SCORE survey results have been reviewed and shared with the Chief Nursing and Quality Officer in her role as Board Level Safety Champion, and is aligned to the four missions of the Trust Improvement Plan. The Maternity Safety Champions will continue to work with the Board Level Champions to promote the Missions of the Trust Improvement Plan, in particular best culture, best of people and the desire to be well-led.

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

11.1 The report assures the Board that 100% of qualifying cases have been reported to HSIB NHSR EN scheme as required and that the Trust is 100% compliant with Safety Action 10.

11.2 The Board was assured on 10 June 2021 regarding compliance and provided evidence of all cases reported, legal records and 100% compliance with Duty of Candour requirements.

12 Conclusion and Next Steps

12.1 The Maternity Service and Chief Nursing & Quality Officer have provided regular reports to the Quality Assurance Committee and Trust Board, ensuring the Board had full oversight of all aspects of the 10 Safety Actions. Evidence was presented to the Trust Board in each report, in line with the technical guidance and links to the full evidence archive can be found in appendix 1.

12.2 The report requests the Board approve the Supernumerary Audit Action Plan in Appendix 2.

12.3 The report assures the Board the Trust is fully compliant with all 10 Safety Actions and requirements of CNST MIS year 3. The Maternity Service and Chief Nursing & Quality Officer have provided regular reports to the Quality Assurance Committee and Trust Board, sharing progress and evidence of compliance.

12.4 The report assures the Board that the lead for Children's Services Commissioning, James Harman, has attended the CNST Task and Finish Group, in his Local Maternity and Neonatal System (LMNS) Maternity lead role, and has had an opportunity to review the evidence provided to support the Safety Actions. The final declaration form was shared and discussed formally with the LMNS panel in their Clinical Commissioning role on 29 June 2021 to meet the requirements of the NHSR technical guidance prior to submission.

12.5 The report assures the Board that there are no reports covering this year (2020/21) or the previous financial year (2019/20) that related to the provision of maternity services that may subsequently provide conflicting information to that presented to the Board.

12.6 The report assures the Board that the Maternity Service will continue to monitor compliance against CNST guidance, including progress on delivery of action plans. The Maternity Service notes the key points of triangulation between CNST, Ockenden and CQC requirements, and will continue to work to ensure compliance with all three are met. This will ensure the Maternity Service maintains a strong and compliant position in anticipation of the launch of CNST Year 4.

12.7 The report recommends continued quarterly reporting to the Trust Board to ensure ongoing compliance with the CNST Maternity Incentive Scheme in anticipation of year 4 CNST compliance. This must include the cases reviewed using the Perinatal Mortality Review Tool. It is recommended that the schedule used in 2020/21 is continued through into 2022 to the Quality Assurance Committee and the Board.

12.8 The report requests that the Board recommend and authorise the Chief Executive Officer to sign the declaration from to allow submission to NHSR by 12 noon on 15 July 2021.

13 Appendix 1: Compliance Summary Sheet

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in	Evidence
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0	Safety Action 1
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	3	0	0	Safety Action 2
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0	Safety Action 3
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	4	0	0	Safety Action 4
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0	Safety Action 5
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes	33	0	0	Safety Action 6
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0	Safety Action 7
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes	14	0	0	Safety Action 8

9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes	19	0	0	Safety Action 9
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes	4	0	0	Safety Action 10

14 Appendix 2: Supernumerary Audit Action Plan

Accountable Lead: Dot Smith, Head of Midwifery **Action Plan Completion Date: 5T**

Objectives List of actions	**Tasks** What you need to do to achieve the action	**Success Criteria** How will you identify success	**Target Date**	**Owner**	**Progress**	**Current position**	**Actual Date**	**Evidence Source**
Monthly Audit of Supernumerary Status to demonstrate compliance.	Monthly Audit. Bi-Annual Report	Monthly Audit and Bi-Annual Report	30/12/2021	Intrapartum Matron	Supernumerary audit underway. Report to be completed July 2021	On target	5T	5T
Timely escalation of barriers to supernumerary status	Update Escalation to Close Policy to include the requirement to raise a datix and inform Manager on Call if Supernumerary status not maintained for >1 hour.	Updated policy Datix and escalation as required	30/06/2021	Intrapartum Matron	Escalation to close policy updated.	Complete	30/05/2021	02. 2021.02 Escalation to Clos
Implement recommendations of Birthrate Plus	Funding for 13WTE midwives to meet Continuity of Carer and support staffing levels on unit.	Funding agreed.	30/07/2021	Head of Midwifery	**June 2021:** Report to Executive Group in April 2021 and Board in May 2021. Agreed in Principle.	On target	5T	06. 2021.06.03 Tru Board Papers.pd 04. May 2021 Maternity Staffin 03. 2021.04.21 Maternity Staffing R
	Recruitment to additional 13WTE roles.	Staff recruited to posts	30/12/21	Head of Midwifery				

Overdue | On target | Near | Complete

Meeting of the Public Board
Thursday, 08 July 2021

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework</td><td>Agenda Item</td><td>3.4</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 is presented in this paper. The Trust's principal risks are:
<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>Feb 2021</th><th>March 2021</th><th>April 2021</th></tr>
<tr><td>3a – Delivery of financial control total</td><td>9</td><td>16</td><td>8</td><td>8</td><td>16</td></tr>
<tr><td>3b – Capital Planning</td><td>12</td><td>16</td><td>12</td><td>12</td><td>16</td></tr>
<tr><td>4a – Sufficient Staffing – Clinical Areas</td><td>6</td><td>16</td><td>12</td><td>15</td><td>15</td></tr>
</table></td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="5">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="5">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="5"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="5">N/A</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="5">The Board is asked to note the report for assurance regarding the processes in place around risk management.
<table>
<tr><th>Approval</th><th>Assurance</th><th>Discussion</th><th>Noting</th></tr>
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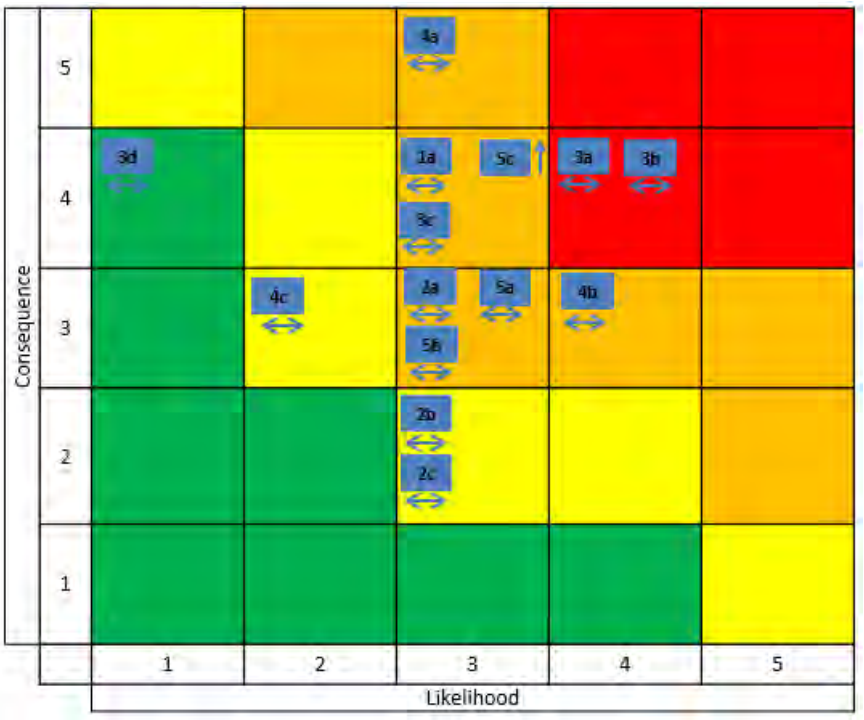
1 Board Assurance Framework

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



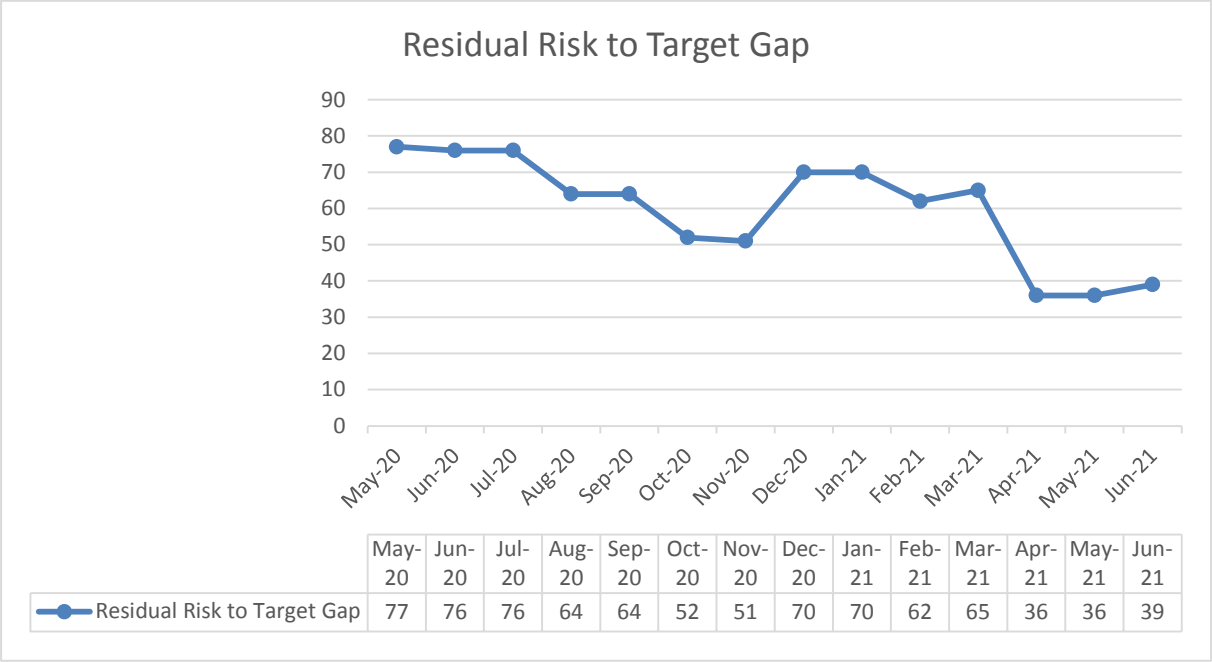
In the current reporting period the Trust has seen the increase of one risk, patient flow (5c).

There are two principal risks that are rated as high:
3a – delivery of financial control total
3b – capital planning.

Financial risks are being managed through the current planning rounds within the Trust and the wider system with the clinical and corporate areas.

		Target Score	Initial Score	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
Integrated Healthcare	1a. Failure of System Integration	6	16	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Innovation	2a. Future IT strategy	6	16	9	9	9	9	9	9	9	9	9	9	9	9	9	9
	2b. Capacity and Capability	9	9	12	12	12	12	12	6	6	6	6	6	6	6	6	6
	2c. Funding for investment	9	9	9	9	9	9	9	6	6	6	6	6	6	6	6	6
Finance	3a. Delivery of financial control total	9	16	6	9	9	9	9	9	16	16	16	8	8	16	16	16
	3b. Capital Investment	12	16	20	20	20	20	20	20	12	12	12	12	12	16	16	16
	3c. Failure to achieve long term financial sustainability	4	16	16	12	12	12	12	12	12	12	12	12	12	12	12	12
	3d. Going concern	4	12	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Workforce	4a. Sufficient staffing of clinical areas	6	16	12	12	12	12	12	12	12	12	12	12	15	15	15	15
	4b. Staff engagement	6	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	4c. Best staff to deliver the best care	6	12	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Quality	5a. CQC Progress	4	16	16	16	16	12	12	12	12	12	12	12	12	9	9	9
	5b. Failure to meet requirements of Health and Social Care Act	6	16	16	16	16	9	9	9	9	9	9	9	9	9	9	9
	5c. Patient flow – Capacity and demand	6	12	12	12	12	12	12	9	9	16	16	16	16	9	9	12
	Total Risk Score	105	242	174	173	173	165	165	153	152	175	175	167	139	141	141	144
	Residual Risk to Target Gap		137	77	76	76	64	64	52	51	70	70	62	65	36	36	39

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
Residual Risk to Target Gap	77	76	76	64	64	52	51	70	70	62	65	36	36	39

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 March 2021 and April 2021 was due to the closure of three quality risks which have moved to the corporate risk register.

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

COMPOSITE RISK: Integrated Healthcare										
EXECUTIVE LEAD: Chief Strategy Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective One - Integrated Health and Social Care: We will work collaboratively with our system partners to ensure our population receive the best health and social care in the most appropriate place										
				Assurance						
Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance
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 (the Chief Strategy Officer) 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. 4. The CISO now serves as Deputy SRO for the ICP and has co-authored the ICP road map and future strategies for the ICP.	Governance arrangements for the Medway and Swale system agreed. Weekly calls between all Partners and NHS I/E regarding MFFD patient pathways. Attendance from the Trust at the ICP executive and the ICP partnership board. The ICP now has a joint appointed deputy SRO for the ICP from the acute trust who now sits on the ICP exec.	Regular updates against milestones submitted to Executive and Board of Directors meetings.	Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement Integrated Performance Assurance		**4 x 3 = 12 Moderate**	**3 x 2 = 6 Low**	Partial
				Monthly Medway and Swale System Delivery Board. a. Chair alternates between the Clinical Commissioning Group Accountable Officer and Medway Foundation Trust (MFT) Chief Executive. b. Membership is made up of executive from provider and commissioning organisation						

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

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

COMPOSITE RISK: Finance										
EXECUTIVE LEAD: Chief Finance Officer										
LINKS TO STRATEGIC OBJECTIVE: Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do										
				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance**
3a Delivery of Financial Control Total	If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact. Under 2021/22 contracting arrangements the STP must meet its control total. Given the uncertainty of Covid, CIP delivery risks and the system operating on a block income, there is significant uncertainty and a very high risk of the Trust not meetings its control total.	4 x 4 = 16 **High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	Internal accountability framework at programme level.	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board.	Monthly Integrated Assurance Meetings with regulators. STP has allocated funds to manage the system performance, including potential "Elective Recovery Funds".	STP plan resubmission for H1 2021/22 on 15 June with provider submissions on 22 June.	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 2 = 8 **High**)	3 x 3 = 9 **High** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Moderate**)	
			2. Programme Management Office: a. Track operational delivery and financial consequences of those actions. b. Review of team hierarchy to ensure capacity to deliver c. Further consideration to be given to reintroduction of a Financial Improvement Director. d. Working with NHSEI intensive support team.	Chief Financial Officer and Chief of Staff.						
3b Capital Investment	If there is insufficient resource to invest in new technologies, equipment and the Trust estate there is a risk to the transformation plan. Capital resource is allocated at a system level across the STP and hence both national and local priorities (including top-slicing for STP projects) could impact availability.	4 x 4 = 16 **High**	1. Governed entirely by the availability of capital resource, obtaining Public Dividend Capital (or loans) for significant investment will require business cases to be signed off by the STP and regulators unless affordable within the existing capital programme or through a revenue stream. 2. Project lead completion of prioritisation scoring matrix; Trust review to moderate and agree scores with highest priority projects being proposed as the in-year plan.	Trust business case governance process and templates	Project reviews by Finance Committee Scrutiny of the overall capital programme by the Capital Group, Business Case Review Group, Finance Committee and Board.		1. Trust clinical and divisional strategies to be developed. 2. National shortage of capital funding recognised. Prioritisation of schemes undertaken and signed off by Trust Executives. 3. Clarity and support from ICS where further funding is made available.	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 3 = 12 **High**)	4 x 3 = 12 **High**	

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

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)		Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to motivate, retain and develop staff. [Oct 22] QSIR (Quality improvement methodology) to be introduced to ensure staff have the opportunity, permission and skills to make value-adding change through continuous improvement [Oct 21] Delivery of equality action plans, in addition to BAME staff networks, for disability and LGBTQ networks to narrow differentials to disciplinaries, access to CPD and shortlist to hire [Mar 22]	**3 x 5 = 15 Moderate**	**3 x 2 = 6 Low**	
			2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: a. Current contractual vacancy levels (workforce report) b. Sickness, turnover, starters leavers (Integrated Quality and Performance Report (IQPR)) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. Retention programmes across Trust.		KPI Board oversight 1. Trust vacancy rate at 11%. 2. Monthly Sickness rate 4.8% 3. Substantive workforce 84%					
			3. Monitoring controls: a. Monthly reporting of vacancies and temporary staffing usage at PRMs; b. Daily temporary staffing reports to services and departments against establishment; c. Daily pressure report during winter periods for transparency of gaps.	Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. Temporary staffing and daily pressure/gap report in operation.						
			4. Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015. C.200 international nursing offers in place.	People Committee resourcing report – All staff groups recruitment					

			5. Temporary staffing delivery: a. NHSI agency ceiling reporting to Board; b. Weekly breach report to NHSI; c. Reporting to Board of substantive to temporary staffing paybill.		People Committee reporting 1. £6m favourable to ceiling; 2. Averaging 30 breaches per week compared to c1000 in 2016 3. Agency workforce 3% 4. Bank workforce 13%					
			6. Workforce redesign: a. PRM review of hard to recruit posts and introduction of new roles; b. Reporting to Board apprenticeship levy and apprenticeships.	OD Performance report 150 apprentices of 101 target	People Committee					
			7. Operational: a. Operational KPIs for HR processes and teams reported monthly.	HR & OD performance meeting 85% of operational HR KPIs met						

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

				programme launched in Q4 2018/19.						
			Policies, processes and staff committees in place: a. Freedom To Speak Up Guardian route to 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. #HAY implemented and monitored						
			Values embedded into the Trust and culture: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance.	1. VBR in place Qualitative and quantitative values-based appraisal						
4c Best staff to deliver the best of care Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 x 4 = 12 (Moderate)**	Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 'Our People' programme fortnightly review meeting which includes the NHS People Plan	2019-22 People Strategy in place with monitored delivery plans. (People Committee) 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan)		Refresh of Freedom to Speak Up strategy [Aug 21] Delivery of ILM level 3 leadership programme [Dec 21]	**3 x 2 = 6 (Low)**	**3 x 2 = 6 (Low)**	
			Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions. Competency compliance to be linked to incremental pay progression from April 2019 (policy implemented). 1. StatMan compliance >90% 2. Appraisal rate >86%						
			Right attitude and values: a. Values-based recruitment (VBR) in place for medical and non-medical positions; b. Values-based appraisal in conjunction with performance; c. Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; d. Respect – countering bullying in the workplace policy.	1. VBR in place Qualitative and quantitative values-based appraisal in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place. 4.						
			Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: a. Current contractual vacancy levels (workforce report) b. Monthly reporting of vacancies and	1. Trust vacancy rate at 11%; 2. Substantive workforce 84% 3. Monthly PRM including discussion on workforce, vacancies,						

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

COMPOSITE RISK: Quality 2021/22											
EXECUTIVE LEAD: Chief Nursing and Quality Officer											
LINKS TO STRATEGIC OBJECTIVE: Objective Five - High Quality Care: We will consistently provide high quality care											
				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in Assurance/ Controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5a Failure to consistently demonstrate compliance with the Care Quality Commission Fundamental standards, and as such, to meet the statutory requirements of the Health and Social Care Act	**Cause:** 1. Lack of effective governance systems and processes to routinely monitor compliance with the fundamental standards. 2. Lack of evidence to demonstrate compliance with NQB and NICE guidance (2015) Workforce Standards **Impact:** 1. Potential for regulatory action by CQC &/ or NHSI. 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. 4. Damage to patient experience and patient outcomes.	**12 Moderate 3(L) x4(C)**	1. Trust wide and ED specific CQC action plans being implemented 2. Enhanced leadership within Patient Experience and Quality & Patient Safety 3. CNST (Maternity Incentive Scheme) action plan being implemented 4. Quality Strategy Priorities Year 2 agreed and being implemented 5. High Quality Care Programme Year 2 improvement priorities agreed, measures being developed and work progressed 6. Refreshed ward assurance and accreditation visits being developed 7. Quality Boards in place on all wards 8. Gold 'stars' awards being implemented to recognised and celebrate achievements in achieving high standards and improving patient outcomes. Daily trust wide safe staffing reviews undertaken by HON with escalation to DDON and CN&QO as appropriate. 9. Daily senior nurse staffing meeting with escalation to CN&QO as appropriate. 10. Annual provider review on safe nurse staffing. 11. Recruitment pipeline progressing as per plan.	Quality Panel Governance in place with fortnightly meetings. CQC Evidence panel in place with fortnightly meetings. Quality and Patient Safety Group meeting monthly. CNST Task and Finish Group meeting fortnightly. Care Group and Divisional Governance Boards meeting monthly	Monthly progress reports on divisional Quality Governance to Q&PSG, Executive Group, Quality Assurance Committee and Trust Board. High Quality Care Programme Board provides monthly progress reports to the Trust Improvement Board. Rolling programme of preparedness CQC care group showcase forums in place. Quality Report and Accounts.	Internal Audit and External Quality Audit. QGR meetings with GCCG CQC Engagement Meetings Single Item Multi-Agency meetings CQC core service and well led reviews	1. Divisional ownership and accountability for quality governance needs an improved structure and strengthened processes. 2. No single source of oversight & accountability for compliance with CQC Fundamental standards at divisional or Trust level. 3. Terms of Reference for QPSG to be approved at May QAC to ensure TOR are in alignment with QAC TOR. .	Chief Nursing and Quality Officer is commissioning a review of Quality Governance with the aim of improved quality governance. An independent Quality Governance review will be undertaken and a draft TOR have been produced and shared. Associate Director of Quality & Patient Safety to design and propose a single source for assuring the QAC and Trust Board on the future of monitoring of CQC compliance. This work has been deferred pending the outcome of the governance review referred to above. Chief Nursing and Quality Officer and the Associate Director of Quality and Patient Safety to review the Q&PSG and QAC TOR and work plans to ensure alignment. This work has been deferred pending the outcome of the governance review referred to above.	**9 Moderate 3(L)x3(C)**	**2 x 2 = 4 Very Low**	Partial

			3. Quality metrics reported via: a. IQPR and directorate scorecards b. Nursing Ward to board quality assurance framework approved c. Quality and safety boards on wards demonstrating 'days between'.	Scorecard in development. Fortnightly Matron assurance reports. Monthly Heads of Nursing assurance report. Monthly DDON assurance reports to the Chief Nursing and Quality Officer	Monthly Performance Review Meetings. Updates to Executive Group, QAC and Trust Board. High Quality care Programme Board Monthly divisional quality forum	Internal and External Audits	Refreshed Nursing and Midwifery Scorecard in development by BI.	PRMs for 21/22 now confirmed N&M Scorecard to be implemented by end of Q1.			Partial
			4. Audit and review processes: Clinical Audit programme in place	Quarterly report on clinical audit plan compliance to Q&PSG	Audit Leads Group Q&PSG QAC Integrated Audit Committee		Lack of confidence that the Clinical Audit Leads Group is fulfilling its TOR in terms of sharing audit outcomes.	Review of the effectiveness of the outputs and sharing from the Audit Leads Group. Pending the outcome of the governance review referred to above.			Partial
			9. Central and local oversight of quality metrics: a. Complaints management b. Incident management, including Serious Incident (SI) processes and monitoring c. Compliance with Duty of Candour policy and training	Care Group and Divisional Governance Boards Complaints review completed, actions to improve agreed Safeguarding review completed actions to improve agreed	Monthly Quality reports to the Executive Group, QAC and Quality and Patient Safety Group		Lack of organisational shared learning from SI, claims and complaints	Complaints review completed, actions to improve agreed by Execs and are now being implemented by divisions.			Partial

				Assurance							
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Gaps in assurance / controls**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
5b Failure to meet the statutory requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	**Cause:** Lack of effective IP&C governance systems and processes to routinely monitor and maintain compliance with the hygiene code **Impact:** Potential for regulatory action by CQC &/ or NHSI. Loss of confidence in the Trust by the wider healthcare system. Poor staff morale and engagement. Damage to patient experience and patient outcomes.	**12 Moderate 3(L) x4(C)**	1. IPC Improvement plan developed, setting out short, medium and long term goals 2. IPC Improvement plan approved by Executive Team and QAC and reported at Trust Board 3. IPC Intensive Support programme supporting the Trust 4. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 5. Refreshed IP&C Team structure and leadership 6. Interim AD for IP&C in place whilst recruiting to post substantively. 7. Identified improvement priority work through HQCP to reduce C- Diff Infections 8. IP&C Governance Review completed and Report in draft form. 9. IPC Unannounced inspections commissioned by CNQO with findings being drafted with themes and learning to be shared 10. COVID-19 BAF updated, reviewed externally and maintained with evidence to support collated 11. CNQO wrote to Executives regarding their executive areas of responsibility to support delivery of Trust Improvement Plan 12. Interim Matron sourced due to start ASAP -6months contract and recruited into substantive Matron - substantive matron commences 21 June 2021 13. Additional IPC team posts recruited to 14. MFT participating in Kent & Medway IPC Network- peer support and sharing learning 15. CNQO IPC monthly blogs to communicated key messages 16. Communication plan for IPC in development to support effective IPC communications and the Every Action Matters initiative from NHSEI. 17. Draft IPC CQC action plan developed in response to draft CQC inspection findings.	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual approach to be adopted, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan developed setting out short, medium and long term goals for delivery Mandatory IPC training compliance at over 95% for the majority of the last several months. Divisional and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Assurance Committee Quality Panel High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction Decontamination Group in place -	IPAS (NHS I/E) meeting Oversight from system DIPC NHSE/I report CQC IP&C Inspection report	IPC policies currently undergoing review. PIRs not being completed in a timely way, therefore limited lessons learned and shared.	IPC Governance Review: final report to Exec Meeting, QAC and IPC Committee.	**3 x 3 = 9 Moderate**	**2 x 2 = 4 Very Low**	Partial

Risk Number / Description	Cause and Impact	Initial Risk Rating	Mitigations / Controls	Level 1 (Operational Management)	Level 2 (Oversight Functions – Committees)	Level 3 (Independent)	Gaps in assurance / controls	Actions to be Taken	Current Risk Rating	Target Risk Rating	Overall Assurance F, P, N
5C There is a risk that the Trust is unable to meet the constitutional standards for emergency and elective access	Insufficient capacity to manage the totality of the emergency and elective demand over a 12 month period causing a deficit of bed on occasions leading to AMB hand over delays, long waits in ED and cancellation of elective activity.	**4 x 4 = 16 High**	1. The restart programme has included a refresh of the demand and capacity across all specialties. 2. Pathways have been reviewed to ensure patients receive their care in the most appropriate settings including non-face to face, independent setting and at MFT. 3. Emergency pathways have been further developed to include the range of assessment options through frailty, acute assessment (medical and surgical) and Same Day Emergency Care (SDEC). 4. A bed reconfiguration programme has been undertaken to profile the planned and unplanned beds based on expected demand, co-location of specific areas & full ring-fencing of elective capacity. 5. The Trust has a renewed focus on length of stay to ensure that patients get the most effective care during as short a stay in hospital as is appropriate for their care (Patient First). 6. In summary: a. Elective, Outpatients & cancer care modelling completed to ensure patients with a prolonged wait for treatment are appropriately prioritised and managed and that the new physical distancing and pre-hospital preparations are clear. b. The recovery programme is being managed through the System approach to ensure that all out-of hospital capacity ad opportunities are highlighted and used appropriately. 7. Action plan developed in response to CQC Unannounced inspection of the Emergency Department on 14 December 2020 and subsequent issuing of a Section 29A. Actions arising from the December 2020 CQC inspection are reflected in the Patient First Improvement Plan as well as the dedicated ED action plan. 8. The Trust is supported by ECIST to make the necessary improvements in ED processes and patient flow. 9. Patient First Programme:- focus is on 3 aspects of flow management:- • Acute Care Transfer • Flow and Discharge • Site Operations 10. Restart programme focused on Elective, Cancer and Diagnostics	Recovery plans including agreed trajectories for all constitutional standards Patient Flow Programme 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 on out of hospital capacity and responsiveness	Reviews and updates discussed at Executive Group, TIB and Board National planning tools being used. System calls in place to ensure escalations. IQPR PIRM Progress against ED action plan will be overseen by Quality Panel	External reviews by NHS I/E Single Item Multi-Agency meetings Monthly checkpoint with SE Region Monthly ICS Performance Reviews	Inability to fully mobilise the bed configuration and refurbishment plan. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22	Wave 3 planning More engagement with Estates and Facilities re priorities for capacity configuration. Funding decisions for "progress chasers", Frailty SDEC.	**4x 3 = 12 Moderate**	**2 x 2 = 4 Very Low**	Partial

Meeting of the Public Board
Thursday, 08 July 2021

Title of Report	Corporate Risk Register	**Agenda Item**	3.4
Report Author	Julie Wilson – Risk Manager Gurjit Mahil, Deputy Chief Executive		
Lead Director	Gurjit Mahil, Deputy Chief Executive		

Executive Summary

The corporate risk register includes 27 risks assigned to Executives.

Risks scoring 16+ are presented to the Risk Assurance Group (RAG) for discussion, challenge and approval prior to being added to the corporate risk register.

Twelve risks were presented to the RAG in May; 3 of these were approved and added to the corporate register. At the June RAG 3 risks were discussed, two were approved and added to the corporate register.

The 'safe staffing' risk transferred to the corporate register in May – this risk originally sat under the covid-19 register.

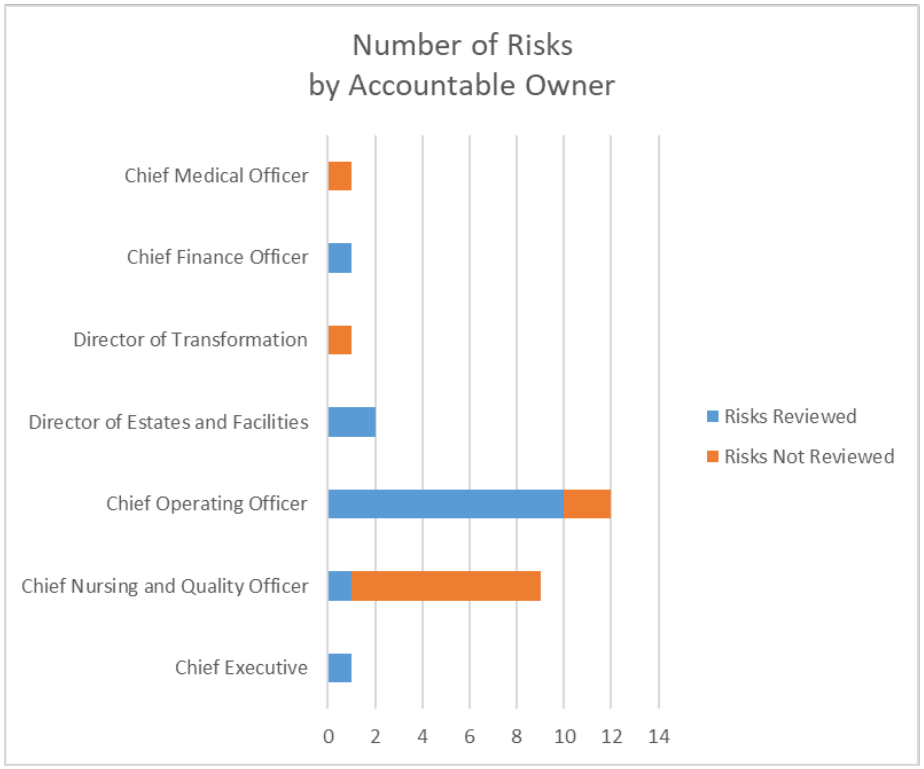
Building on from the work at the deep dive meetings and the monthly RAG meetings, 6 risks have reduced in score. The following table shows additional actions taken place during May & June meetings.

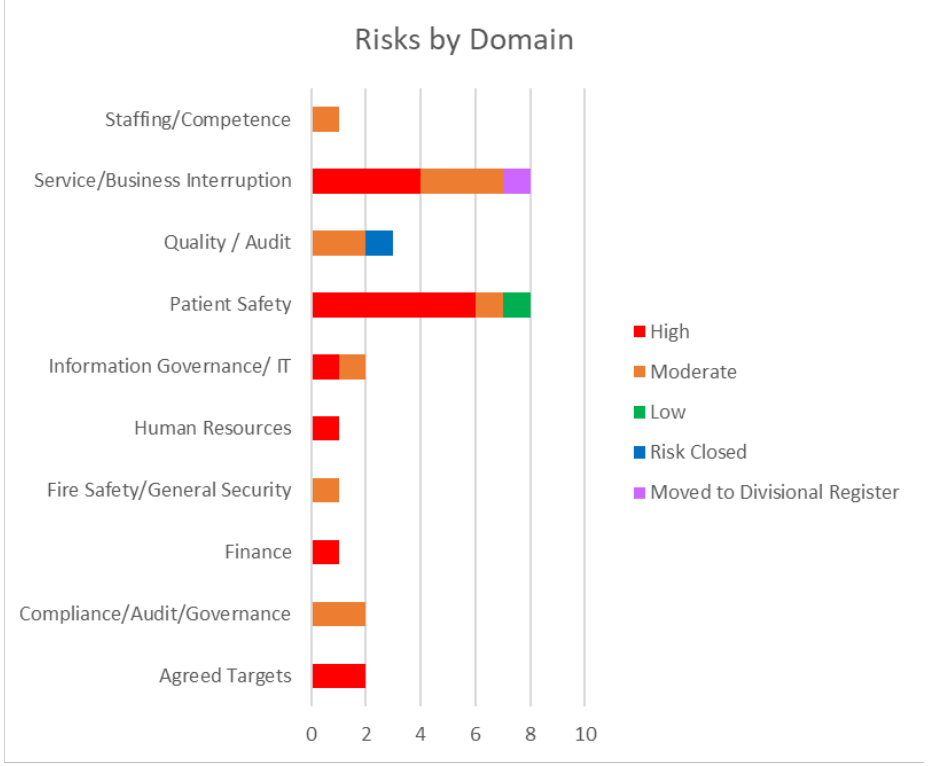
Number of Risks / Description	Action	Reason
1 - Operational Performance & delivery of constitutional standards	Closed	All activity has fully restarted and subject to a further wave this risk can be closed.
1 - CQC Compliance	Closed	Risk was duplicated risk on RiskAssure system
1 - Patients with cancer as well as other patients requiring urgent respiratory outpatient appointments will experience a delay in diagnosis and treatment and those patients may require an admission due to cancellation of clinic activity in view of second wave of Covid	Moved to issues log	Identified as an issue rather than a risk
1 - Post April 2019 the current cardiac catheter suite is unsupported. It will not be serviced and any breakdown will not be covered by a maintenance plan.	Moved to divisional register	Risk reviewed and current score reduced below 16

Currently there are 15 high risks on the corporate risk register graded 16 or above, as seen in page 7 of this report. These are being managed through the Risk Assurance Group, with the appropriate executive owner of the risk. Mitigations to summarised risks are detailed in the main risk register.

Committees or Groups at which the paper has been submitted	Risk Assurance Group			
Resource Implications	N/A			
Legal Implications/Regulatory Requirements				
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to note the report for assurance regarding the processes in place around risk management.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒

1 Corporate Risk Register – Dashboard





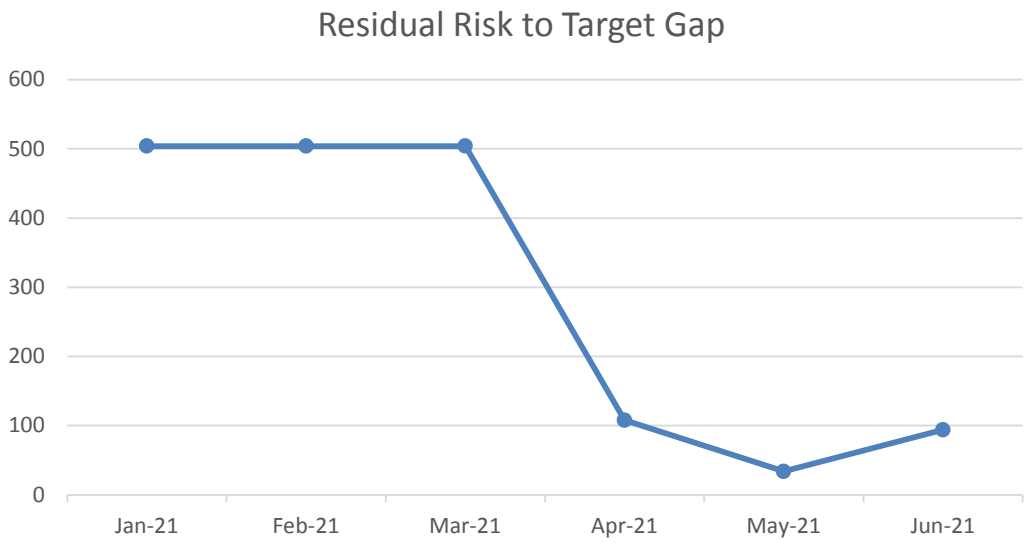
2. Corporate Risk Register – Residual to Target

Risk Domain	Risk	Risk Owner	Target Score	Initital Score	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Adverse Publicity/Reputation	ED Corridor Care- Trust reputation	Chief Operating Officer	4	16	16	16	16	CD	CD	CD
Agreed Targets	Imaging: Inadequate MRI capacity	Chief Operating Officer	4	16	20	20	20	20	16	16
	Failure to deliver quality care in a timely manner - patient care may be compromised.	Chief Operating Officer	4	16	20	20	20	C	C	C
	Phase 3 ED Estate- Capacity - impact on performance and safety metrics	Chief Operating Officer	12	20	20	20	20	20	20	20
Compliance/Audit/Governance	CQC Compliance (merged with lack of compliance with fundamentals of nursing care)	Chief Nursing and Quality Officer	4	16	16	16	16	16	12	12
	Failure to adhere to NHS Provider Licence Conditions & NHSI operational undertakings	Chief Executive	4	4	16	16	16	12	12	12
	CQC Compliance	Chief Nursing and Quality Officer	4	16	12	12	12	12	CD	CD
Finance	Not achieving CIP target for 20/21	Chief Finance Officer	6	15	20	20	20	C	C	C
	: Access to capital monies for Covid works is now more stringent.	Chief Finance Officer	6	16	16	16	16	C	C	C
	Financial performance against capital control total	Director of Estates and Facilities	4	16	16	16	16	C	C	C
	Covid-19 – Restart of Activity / Ward Configuration	Chief Finance Officer	6	25	16	16	16	C	C	C
	Capital Financial Monitoring & Asset Capitalisation	Chief Finance Officer	4	16	16	16	16	C	C	C
	Not achieving CIP target for 2020/21	Chief Operating Officer	6	15	16	16	16	C	C	C
	2021/22 capital resource allocation	Chief Finance Officer	9	-	-	-	-	-	-	16
Fire Safety/General Security	Trust wide Fire Safety Risks	Director of Estates and Facilities	4	15	15	15	15	15	15	15
	ED- Staff Security	Director of Estates and Facilities	4	16	12	12	12	D	D	D
Human Resources	ED Senior Nurse perception of leadership and safety	Chief Nursing and Quality Officer	4	20	20	20	20	I	I	I
	UEC Staff Morale	Chief Operating Officer	9	16	-	-	-	-	-	16
Information Governance/ IT	Existing Telephony Solution Obsolete - No Manufacturer Support	Director of Estates and Facilities	4	16	16	16	16	16	9	9
	Clinical records stored insecurely and are not in line with NHS record keeping retention standards	Chief Operating Officer	4	-	-	-	-	-	-	16
Patient Safety	Lack of Winter Pressures preparedness	Chief Operating Officer	5	20	20	20	20	I	I	I
	Management and control of secure areas and COSHH products in patient areas	Director of Estates and Facilities	4	20	20	20	20	CD	CD	CD
	Increased waiting times in Endoscopy	Chief Operating Officer	8	20	20	20	20	20	20	20
	ED- Mental Health Escalation Plans	Chief Operating Officer	10	20	20	20	20	CD	CD	CD
	COVID19	Chief Operating Officer	4	16	20	20	20	8	I	I
	ED- Mental Health Treatment Delays	Chief Operating Officer	10	20	20	20	20	CD	CD	CD
	There is a risk to patient safety in ED as a result of an immediate ambulance handover threat (previously named ED Corridor Care- Patient Safety)	Chief Operating Officer	9	20	20	20	20	20	20	20
	Patients with cancer as well as other patients requiring urgent respiratory outpatient appointments will experience a delay in diagnosis and treatment and those patients may require an admission due to cancellation of clinic activity in view of second wave of Covid	Chief Operating Officer	4	16	16	16	16	16	I	I
	Mental Health Pathways - our ability to provide parity of esteem for mental health patients in the emergency setting with regards to the Hospital Emergency Care Standard (4hrs)	Chief Operating Officer	4	16	16	16	16	16	16	16
	ED- Application of parity of esteem for mental health patients	Chief Operating Officer	4	16	16	16	16	CD	CD	CD

	Patients with vulnerabilities such as mental health and learning disabilities are not recognised as potential or actual safeguarding concerns and not escalated in a timely manner. Especially those who frequently attend and / or do not wait to be seen	Chief Nursing and Quality Officer	4	16	16	16	16	16	16	16
	Lift availability	Director of Estates and Facilities	4	16	12	12	12	D	D	D
	Weekend Mortality	Chief Medical Officer	4	15	12	12	12	D	D	D
	Infection Control Prevention Compliance	Chief Medical Officer	4	16	9	9	9	9	9	9
	Safe Medical Staffing	Chief Medical Officer	4	12	8	8	8	D	D	D
	Uninvestigated open Datix	Chief Medical Officer	4	16	6	6	6	6	6	6
	eDNs	Chief Medical Officer	4	12	6	6	6	2	D	D
	Vascular Consultant Staffing Levels	Chief Medical Officer	4	-	-	-	-	-	-	16
	General care for mental health patients in paediatric wards	Chief Operating Officer	4	20	-	-	-	-	-	20
Quality / Audit	Management and control of secure areas and COSHH products in patient areas	Director of Estates and Facilities	4	16	16	16	16	12	D	D
	Operational Performance & delivery of constitutional standards	Chief Operating Officer	4	16	12	12	12	12	12	C
	Breaching Deprivation of Liberty safeguards (DOLS) legislation	Chief Nursing and Quality Officer	4	16	12	12	12	12	12	12
	Learning from incidents, complaints, inquests and claims and application of Duty of Candour	Chief Medical Officer	4	12	9	9	9	9	9	9
Service/Business Interruption	IMAGING: Risk of inability to deliver constitutional standards in imaging service due to ageing and insufficient equipment to meet current and rising demand.	Chief Operating Officer	5	20	25	25	25	25	20	20
	CR Reader (machine failure)	Chief Operating Officer	3	15	20	20	20	20	20	20
	Post April 2019 the current cardiac catheter suite is unsupported. It will not be serviced and any breakdown will not be covered by a maintenance plan.	Director of Estates and Facilities	5	25	20	20	20	20	12	D
	Imaging: Loss of ability to provide fluoroscopy service.	Chief Operating Officer	4	20	20	20	20	20	20	20
	Lack of diagnostic equipment at community Rheumatology centre following transfer of service from DVH.	Chief Operating Officer	8	16	16	16	16	C	C	C
	NKPS – Covid	Chief Operating Officer	6	16	16	16	16	16	12	12
	Leaking Library Roof	Director of Estates and Facilities	6	16	16	16	16	D	D	D
	Diagnostic equipment across multiple specialities is coming to end of life and is unsupported by manufacturer maintenance contract within the next 6 months.	Chief Operating Officer	8	16	16	16	16	16	16	16
	Pandemic Flu	Chief Operating Officer	4	16	16	16	16	16	12	12
	Innovation and digital technology	Director of Transformation	9	16	12	12	12	12	12	12
	Estates	Director of Estates and Facilities	6	16	6	6	6	D	D	D
	Equipment Failure	Director of Estates and Facilities	6	12	6	6	6	D	D	D
Staffing/Competence	ED Corridor Care- Workforce	Chief Operating Officer	8	16	16	16	16	CD	CD	CD
	Inability to deliver safe and effective care as a direct result of the high nurse vacancy rates.	Chief Operating Officer	4	12	16	16	16	C	C	C
	Safe Staffing	Chief Nursing and Quality Officer	4	20	-	-	-	-	12	12
		Total Risk Score	**306**	**909**	**810**	**810**	**810**	**414**	**340**	**400**
		Residual Risk to Target Gap			**504**	**504**	**504**	**108**	**34**	**94**

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

2 Corporate Risk Register – Residual to Target



Residual Risk to Target Gap - The reduction in the residual gap is mainly due to a high number of risks being closed, duplicated risks removed and risks moving to different registers as approved in the January Board meeting. The increase from May to June is due to the 5 new risks added to the corporate register following review and agreement of the risks presented to RAG.

3 Principal Risks

Risk	Risk Owner	Target Score	Initital Score	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Imaging: Inadequate MRI capacity	Chief Operating Officer	4	16	20	20	20	20	16	16
Phase 3 ED Estate- Capacity - impact on performance and safety metrics	Chief Operating Officer	12	20	20	20	20	20	20	20
2021/22 capital resource allocation	Chief Finance Officer	9	-	-	-	-	-	-	16
UEC Staff Morale	Chief Operating Officer	9	16	-	-	-	-	-	16
Clinical records stored insecurely and are not in line with NHS record keeping retention standards	Chief Operating Officer	4	-	-	-	-	-	-	16
Increased waiting times in Endoscopy	Chief Operating Officer	8	20	20	20	20	20	20	20
There is a risk to patient safety in ED as a result of an immediate ambulance handover threat (previously named ED Corridor Care- Patient Safety)	Chief Operating Officer	9	20	20	20	20	20	20	20
Mental Health Pathways - our ability to provide parity of esteem for mental health patients in the emergency setting with regards to the Hospital Emergency Care Standard (4hrs)	Chief Operating Officer	4	16	16	16	16	16	16	16
Patients with vulnerabilities such as mental health and learning disabilities are not recognised as potential or actual safeguarding concerns and not escalated in a timely manner. Especially those who frequently attend and / or do not wait to be seen	Chief Nursing and Quality Officer	4	16	16	16	16	16	16	16
Vascular Consultant Staffing Levels	Chief Medical Officer	4	-	-	-	-	-	-	16
General care for mental health patients in paediatric wards	Chief Operating Officer	4	20	-	-	-	-	-	20
IMAGING: Risk of inability to deliver constitutional standards in imaging service due to ageing and insufficient equipment to meet current and rising demand.	Chief Operating Officer	5	20	25	25	25	25	20	20
CR Reader (machine failure)	Chief Operating Officer	3	15	20	20	20	20	20	20
Imaging: Loss of ability to provide fluoroscopy service.	Chief Operating Officer	4	20	20	20	20	20	20	20
Diagnostic equipment across multiple specialities is coming to end of life and is unsupported by manufacturer maintenance contract within the next 6 months.	Chief Operating Officer	8	16	16	16	16	16	16	16

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

The new risks added to the corporate risk register have been discussed and mitigations described:

Risk	Update
21/22 Capital resource allocation	• Planning process for 21/22 currently being reviewed to ensure appropriate risk based capital resource allocation. • Risk to be reduced upon completion of the framework.
UEC Staff morale	• A number of organisational development interventions currently in place to support staff within the department.
Clinical records	• Trust has approved resource allocation for a specific team to ensure records that no longer need to be retained are being reviewed appropriately. • Assessments have taken place with Information Governance. • Road map for clinical records storage currently being developed and overseen by an executive. • Risk to be reduced in line with road map milestones.
Vascular consultant staffing levels	• Staffing levels set to improve as a member of staff is returning from secondment. • Appropriate cover for service in place and risk will be reduced.
General care for patient requiring CAMHS admissions in the paediatric ward areas	• System and Partner discussions have taken place at Executive level with regards to increasing demand of paediatric patients requiring tier 4 admissions externally to the Trust. • These patients are nursed on the paediatric wards with RMN support. • Trust wide Quality, Safety and safeguarding escalation flow chart in place to support reporting to the Executive. • Risk assessments have taken place in order to ensure appropriate measures have taken place. • Environmental risk assessments have taken place. • KMPT Health and Safety expertise has also been used to ensure appropriate steps are being taken. • Immediate works has taken place to remove a number of ligature items in line with clinical advice. • Work will be commenced to ensure appropriate safe environment for these patients. • Estates team and Clinical Teams to sign off long term solutions for the environment.

Meeting of the Trust Board in Public
Thursday, 08 July 2021

Title of Report	**Integrated Care Partnership and System Update**	Agenda Item	**4.1**
Lead Director	Harvey McEnroe – Chief Strategy and Integration Officer (CSIO) and Deputy Senior Responsible Officer (SRO) for the Medway and Swale Integrated Care Partnership (ICP)		
Report Author	Harvey McEnroe – CSIO and Deputy SRO for the Medway and Swale ICP		
Executive Summary	This report provided Board members with an overview of key system activity across the ICP and the ICS since our last meeting. At the request of the Quality Assurance Committee this paper also takes a deep dive into the work of the ICP and the ICS into Mental Health across the Place and the ICP.		
Committees or Groups at which the paper has been submitted	Executive Group		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	None		
Quality Impact Assessment	None		
Recommendation/ Actions required	The Board is asked to NOTE the update		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices	None		

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

Not Applicable	White - no assurance is required
Where a heading has been rated 'Red' or 'Amber-Red', actions taken/ to be taken for improvement with timeline (where applicable), should be included in the report.	

1 Integrated Care System Development

Amber / Green

1.1 With the requirement to establish an ICS statutory body for Kent and Medway by April 2022, the ICS is now working to establish its operating model from April 2022. This includes defining how the ICS will be led and governed, the scope of its functions, and the responsibilities to be delegated to ICPs in the future. This will be supported by a transition plan setting out how the ICS will shift from its current position to the new operating model by the end of March 2022.

1.2 The first draft of the operating model must be submitted to NHSE/I by the end of June, but will continue to be refined over the summer and autumn as more guidance is published.

1.3 The ICS expects that the end of June submission will set out:

- 1.3.1 Design principles for the ICS body and operating model;
- 1.3.2 Working assumptions on ICS leadership, based in current guidance;
- 1.3.3 Draft functions, responsibilities and governance model for the ICS body;
- 1.3.4 Draft oversight model for ICS for 2021/22;
- 1.3.5 Draft HR principles for the transition to the ICS statutory body; and
- 1.3.6 Draft communications and engagement principles.

1.4 As part of the development of the operating model for the statutory body, the ICS has been engaging with stakeholders to understand the

1.5 Key issues relating to the establishment of the ICS. The key issues identified by this work are:

- 1.5.1 The need for a cultural shift away from traditional relationships and ways of working to stronger partnership and breaking down barriers for greater collaboration.
- 1.5.2 There are differing views on the level of accountability that ICPs may take on in the future.
- 1.5.3 Primary care commissioning should remain at ICS level.
- 1.5.4 There is a willingness from both Kent County Council and Medway Council to be full partners in the ICS and at place level.
- 1.5.5 More work is required to map which functions will remain at system level and which could be assigned to place or collaborative level.
- 1.5.6 There is currently an imbalance favouring larger NHS provider organisations, with other partners not feeling they are seen as equal partners around the table.
- 1.5.7 The new Partnership Board will require a wider range of stakeholders at the table. 2.4.8 There is a need for a clearer focus on the wider determinants of health.
- 1.5.8 2.4.9 The Kent and Medway CPAB appeared to have lost its relevance. There is consensus that a clinical and professional forum, with experts in their field, is required at system and place level, but each need to have a clear purpose, remit and structure.
- 1.5.9 Effective citizen engagement is fundamental to the ICS, this needs to be resourced. This engagement must have a clear focus at place and neighbourhood level.

1.5.10 Non-Executive Directors; lay and independent members; patient and public representatives; and the wider group of non-medical clinical and professional staff are a valuable resource that could be better engaged with the work of the ICS and ICPs.

1.5.11 Primary care needs to be able to offer a unified voice at both system and place levels, and needs support to develop this.

1.5.12 Providers collaborative are an important component of future system infrastructure, but a clear framework is needed to support their development.

2 ICP oversight structures

White

2.1 As previously discussed at the Board, given the challenges faced by the Medway and Swale health and care system, the ICP has been included in the shadow Recovery Support Programme (RSP) by NHSE/I.

2.2 As part of the oversight of this process the ICP is required to meet with the CCG and NHSE/I on a quarterly basis to review progress with the Delivery Plan and the development of the Integrated Improvement Roadmap. The CSIO for MFT is leading the work on setting the roadmap for the ICP on recovery and will work across MFT and partners to ensure that this roadmap outlines the improvements needed at Place level to support improvements in:

2.2.1 Emergency Access

2.2.2 Cancer and elective care

2.2.3 Discharge pathways

2.2.4 Out of hospital capacity

2.2.5 Primary care pathways for alternative services to ED.

2.3 The next Checkpoint/Oversight meeting is scheduled for 15th July 2021. Work is underway to develop an information pack for the meeting. This will be shared with Board members once complete.

3 Revised ICP governance to align to ICS oversight

White

3.1 The ICP Board considered a review governance structure for the ICP.

3.2 The structure was ratified by the ICP Board in June, subject to the reinstatement of the Clinical and Professional Advisory Board; and agreement being reached on the most appropriate Boards for the Comms and Engagement, Digital and Estates Groups to report to

3.3 A revised draft of the structure was shared with the ICP Leadership Team, including the Trust CEO and the CSIO and the Clinical and Professional Advisory Board in May, and further refinements were made to the structure in light of feedback from these groups.

3.4 Key changes from the draft previously ratified by the Board are:

3.4.1 The reinstatement of the Clinical and Professional Advisory Board to:

- Provide assurance to the ICP Operational Board that all ICP transformation programmes improve the quality, safety, consistency, access and equity of services; reducing variation to ensure improved experience and outcomes for the local people.

- Support and advise the ICP Operational Board in making decisions, providing constructive challenge on issues affecting the delivery of clinically appropriate services to local people.
- Ensure that all clinicians and professionals working in Medway and Swale are considered as equals.
- Ensure the effective engagement of clinicians, allied health professionals and other health and social care staff from across the ICP.
- Act as a source of advice for service and pathway transformation across the ICP.

3.4.2 The transfer of responsibility for the Estate and Digital Groups from the Elective Care Board to the Primary and Local Care Board.

3.4.3 The split of the Comms and Engagement Group into 2 groups, a Communications Group, which will report to the PCN and ICP Development Board; and an Engagement Group, which will report to the PHM Steering Group.

3.4.4 The revised governance structure will be sent out separately from this paper.

3.4.5 It is proposed that the ICP governance structure be reviewed in 6 months to ensure that it remains fit for purpose.

3.4.6 Chairs of ICP Boards have been asked to begin to establish their respective groups, using the agreed programme management structure and approach. The focus of their work is the achievement of the Delivery Plan 2021/22.

3.4.7 MFT officers (the CSIO, the COO and the CNQO) chair Boards across the ICP

4 OD support for the ICP

Amber / Green

4.1 As part of the RSP, the ICP has been able to access funding from the CCG to begin a programme of organisational development.

4.2 The CCG has commissioned Ascend to work with the ICP on two key areas:

4.2.1 Supporting the ICP to develop its culture and leadership approach, to ensure that it can achieve its vision and deliver real service integration and transformation; and

4.2.2 Working with the Diabetes Task and Finish Group to support the development of an integrated care pathway, establishing an OD model for service transformation that can be used by other ICP working groups.

4.2.3 A small steering group has been established to support this work, which will report to the PCN/ICP Development Board.

4.2.4 Discussions are underway with NHS Elect to undertake a deep dive into the work the system has undertaken relating to the integrated discharge service, in order to understand the lessons that can be learned from this programme to inform the future development of the ICP. The output of this work will be used to inform the work being undertaken by Ascend described above

5 System Recovery update

Amber / Green

5.1 Trajectories for the recovery of elective activity, cancer standards and urgent and emergency care standards have been developed by MFT, and shared with the ICP and ICS. A meeting was held with

MFT Leads, NHSE Performance Lead and Director of ICP Transformation to review the trajectories to ensure these are achievable and meet expectations on recovery. The elective and cancer trajectories with underpinning plans will be monitored and reported through the Elective Care Board and the urgent and emergency care trajectories will be monitored through the UEC Steering Group and A&E Delivery Board noting interventions to support admission avoidance, UEC performance and sustainable flow supporting both the elective and emergency pathways.

5.2 Currently the UEC Steering Group is supporting the development of the System Winter Escalation and Surge Plan, with an expectation that the draft plan will be ready for approval by LAEDB and the ICP Operational Board in September 2021.

5.3 The Medway and Swale ICP COVID Vaccinations Steering Group has continued to meet to support the delivery programme of COVID vaccinations for housebound patients for both 1st and 2nd vaccinations. Following the drive to administer 1st vaccinations in February 2021, the group was set up to plan for the 2nd vaccination in a controlled, planned approach over a longer period of time ensuring patients had their vaccinations within the 12-week period. Between mid-April and mid-May, 923 housebound patients received their COVID vaccination, with a further 202 patients scheduled to receive their 2nd vaccination between mid-May and the end of June in accordance with delivering vaccinations to patients at weeks 10-12 from the patients first dose. The service will also provide vaccinations to newly identified housebound patients.

6 System Mental Health update

Amber / Green

6.1 The MHLDA Improvement Board (MHLDAIB) has been in place since October 2020 with an established membership which is enabling and supporting system working on improvement issues. There are 5 agreed improvement workstreams reporting to the Board: Community Mental Health Framework; Urgent and Emergency Care; Dementia; Learning Disabilities and Autism and Out of Area Placements – each is establishing a governance structure and improvement plan.

6.2 Mental Health Investment Standard (MHIS) - A merge of the eight Kent and Medway Clinical Commissioning Groups financial information has highlighted differences across the previous CCGs areas. Principal achievements to date include:

- Completion of MHIS audit relating to 2019/20 year.
- Agreed adjustments to 18/19, 19/20 and 20/21 targets.
- Finalised year end, achieving MHIS in 20/21, subject to audit.
- Plan for 2021/22 submission is in development to assure financial investment is allocated to meet expectations set out in updated NHS planning guidance and system recovery plan post pandemic
- Funding for suicide prevention in 2021/22 allocation is to be clarified within the investment plan

6.2.1 System Assurance: NHSE/I was updated in March 2021 on progress with K&M mental health system framework. In April 2021 Kent and Medway was rated as green on assurance and infrastructure and amber on data quality. The 4th domain for Patient, public and community engagement whilst not rated does not reflect all the significant work currently underway, including the Prevention Concordat for public mental wellbeing or the Community Mental Health Framework.

6.2.2 Performance Dashboard – This is iterative with a data quality improvement plan agreed. Future versions will include ICP level data on key targets to assure local performance improvement.

6.2.3 Physical health checks for SMI – To reach the target of 60% of prevalence in Medway and Swale 1302 PH checks need to be completed – a recovery plan is in place to achieve target. In Medway the service commenced in July 20 and consists of 3 mental health nurses working within GP practices. All nurses are recruited and in place. In Swale the service is provided by Porchlight where there have been issues with recruitment of permanent staff. Additional issues remain with securing GP engagement (due vaccination programme) and the interface with EMIS.

6.2.4 An assurance meeting has been set up for 29th June, as a part two of the improvement board meeting which will focus on areas where further performance improvement is required.

6.3 Community Mental Health model:

6.3.1 The CMHF programme aims to deliver transformation in mental health for people with a serious mental illness. The six overarching areas the programme will deliver on are: young adults (18-25 years), older adults (65+ years), eating disorders, complex emotional difficulties, community rehabilitation and transformation of CMHTs. At ICP level, task and finish groups can be identified to deliver upon these work streams and to design a model for the locality dependent on local variants.

6.3.2 Medway and Swale was selected as the first ICP area for local implementation. Up to £2.4 million is allocated to support the first year roll out countywide with an allocation to be agreed to support local delivery in Medway and Swale ICP.

6.3.3 The first Medway and Swale delivery group was held with key stakeholders in May 2021 attended by PMO, CMHT representatives, GP representatives and the third sector. The key task and finish groups identified and agreed for Medway and Swale were as follows: mapping services, pathways, data and digital and workforce. Each task and finish group will incorporate health inequalities, trauma informed principles and risks, issues and lessons learnt through the pandemic in its delivery.

6.3.4 It is the aim of the Medway and Swale group is to have a draft model by the end of September 2021, allowing time for co-production of the model and full engagement with local stakeholders.

6.3.5 Through the PMO work is being undertaken across Kent and Medway to engage stakeholder partners and create clear aims and objectives for the programme. A MOU will be created and all stakeholders will be encouraged to sign up to this.

6.3.6 The programme aims to identify key deliverables and outcome measures. The Medway and Swale ICP will have its own deliverables (identified within the data and digital task and finish group), as well as being held accountable to overarching deliverables across the programme.

6.4 Urgent and Emergency Care (UEC)

6.4.1 The Mental Health Urgent and Emergency Care Programme will ensure people who experience a mental health emergency in Medway and Kent can access support and care from outside of hospitals, including NHS 111 in the same way a person can with a physical health emergency.

6.4.2 This work includes the following LTP priorities:

- To provide crisis resolution and home treatment teams (CRHTTs) that operate in line with recognised best practice
- To develop a common point of entry to mental health crisis care; integrate mental health CAS/ 24/7 SPOA so anyone experiencing mental health crisis will be able to call NHS 111and have 24/7 access to a range of clinical and non-clinical crisis care

- To deliver 7 non-clinical approaches for people in crisis (Mental Health App/text service/helpline capacity/safe havens/network for people with ASC/post discharge service/Participation workers)
- 3 acute hospitals to have a liaison mental health service meeting the CORE 24 service standard
- Out of Area Placements will be eliminated for acute mental health care for adults.

6.4.3 Crisis Alternatives: The NHSEI funding for Community Crisis Alternative Services is only guaranteed for 1 year (until 31/03/2022. Initially available until 31/03/2024). There is an ongoing discussion with MHIS Planning Group around source of future funding need to be considered 2022 onwards.

6.4.4 SPOA:

- A significant amount of work has been undertaken including open access crisis programme - bringing together NHS 111, mental health clinical assessment and developing a 24/7 triage service
- Demand and capacity modelling to be completed July 2021 to identify resources required to support the mental health Clinical Assessment Service (MH CAS) within 111 and single point of access.
- Soft launch of integrated MH CAS / common point of entry January 2022 and go live date for integrated MH CAS / common point of entry June 2022. Communication approach / plan to be developed around the new pathway prior to the soft launch and 7 community crisis alternatives to be fully operational by 31/03/2022

6.4.5 The Urgent and Emergency Care oversight group governance arrangements have been reviewed and crisis related working groups, such as section 136, etc. will feed into the UEC oversight group.

6.5 Learning disabilities and Autism

6.5.1 KCC has commissioned work to review the governance and operational management of the commissioned and co-commissioned services with a view to formulate a single LDA management team and delivery functions. This work going forwards will include the engagement with Medway Council to assure an integrated approach.

6.5.2 Kent and Medway all age autism and learning disability strategy (ATLAS) is in development – the 3-year plan (to 2024) is with NHSE for sign off, (3-year plan to 2024). This has three identified phases:

- Phase 1: Scoping – Gaps have been identified and more work is required around older people and older carers
- Phase 2: Creating a high-level strategy outlining the long-term plans
- Phase 3: System and local authority – The need for support from ICS system and both local authorities.

6.6 Children and Young People

6.6.1 The Long-Term Plan requires that by 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it.

6.6.2 C&YP Crisis Summit - High referral and leading to high numbers of patients presenting in acute paediatrics services. Kent & Medway ICS CAHMS summit has taken place to look at local solutions - action plan produced which includes activity to support crisis prevention, crisis response, acute resilience, Tier 4 response and capacity, discharge and complex pathway.

6.6.3 C&YP Inpatient provision - Increasing capacity in the medium term through a bid for 3 additional General CAMHS beds plus up to three 72-hour crisis beds.

6.6.4 Coverage of 24/7 crisis provision for C&YP which combines crisis assessment, brief response and intensive home treatment functions - Business case for Intensive Home Treatment Team to be developed by 15th June 2021

6.6.5 Eating Disorders - A task and finish focus group was established in response to the national crisis of eating disorder beds. This group will feed into the Kent and Medway Joint Health and Wellbeing Board alongside the MHLDA Improvement Board.

7 Conclusion and Next Steps

7.1 The board is asked to note this report and the governance changes therein.

7.2 A further report on the ICS Framework and oversight model will be shared with the Trust Board next month to support discussion re our response to the ICS plan.

Meeting of the Trust Board Meeting Public
Thursday, 08 July 2021

Title of Report	**Emergency Planning Resilience and Response – Update**	Agenda Item	**4.2**
Lead Director	Harvey McEnroe, Chief Strategy and Integration Officer		
Report Author	Keith Soper, Deputy Chief Operating Officer and Steve Arrowsmith, Head of Emergency Preparedness Resilience and Response		
Executive Summary	This report provides the Trust Private Board with an update on the work currently underway with the EPRR team		
Committees or Groups at which the paper has been submitted	Trust Executive		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	Civil Contingencies Act		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	**The Board is asked to note the mid-year update report. This precedes the Annual NHSE/I Assurance report that will be presented in October 2021.**		
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒
Appendices	n/a		

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

1 Update from the previous report

1.1 Part of the requirement of the NHS EPRR Framework as an NHS Trust is to be able to give annual assurance to the preparedness and resilience of the Trust against the NHSE/I EPRR Standards. Due to Covid-19, the 2020 assurance process was carried out with a light touch and focussed more on the Covid-19 response and its wave 1 debriefing. It was suggested that this would be a similar situation in 2021 with wave 2 only just occurring in February 2021 and many hospitals still in a state of recovery; however intelligence has suggested that full assurance reviews will take place this year (however this has yet to be confirmed by NHSE/I). As such, the work programme that was dedicated to debriefing has paused until after the expected august assurance visit to allow the team to be able to focus maximum efforts on working the Trust into a position as close to fully compliant as possible over the next few months.

1.2 A midpoint debrief report was sent as part of the regional system debrief and this can be provided upon request.

1.3 The team have also been working with the Chief Operating Officer of University Hospitals Sussex on a Command and Control Structure that will be the basis of the Trust's future Covid response.

1.4 Winter Surge Planning has begun with EPRR, Business Intelligence and corporate management finishing off a plan to engage service leads to ensure care groups have plans and processes in place and staff are capable to enact these plans during winter. EPRR also sits on the Demand and Capacity group lead by the Chief Operating Officer.

2. Business Continuity and Incident Response

2.1 Following the Internal Audit review in May, focus has turned to business continuity and wrapping governance around business continuity as part of the Business Continuity Management System (BCMS). This has included closer working with the IT Systems team to ensure that the Trust's IT systems have updated plans that dovetail with service business continuity plans, these will then inform a testing programme.

2.2 Work is under way to identify two key areas of a Major Incident response;

- Onsite Media Management Centre; and
- Fall back location for the Incident Control Room

3. Training and Exercising

3.1 Training has restarted with Commander training continuing for all new Senior Managers on Call and Directors on Call.

3.2 A training needs analysis has been submitted to the EPRR Group for approval, which will see the training programme widen its scope in both types of training and participation in line with regional best practice. Most notably focussing on the Joint Emergency Services Interoperability Programme (JESIP).

3.3 At the beginning of June, the Trust committed to providing trainee and trainers as part of the Kent-wide Chemical, Biological, Radiological and Nuclear (CBRN) preparedness programme hosted at Detling Showground. For the first time ever all Trusts in the county provided trainers and trainees and more sessions are booked for October 2021.

3.4 To enable the Trust to gain the greatest value a fire safety based command and control exercise is planned to take place every month from July for 4 months to enable a greater volume of staff the

opportunity to exercise. This exercise is run in conjunction with the Fire Safety team. A post exercise report will be produced at the end of the fourth exercise.

3.5 Work is also in development to ensure the JESIP programme is rolled out within the Trust starting with the Site Team and ED senior management to ensure that principles and processes are consistent in how teams engage with partners and on call personnel.

3.6 An IT exercise focussing on Cyber security is still to be confirmed with the IT team, having been delayed from last September due to the Covid and then the implementation of the 8 x 8 telephony system. This has also meant that the 6 monthly communications test has been paused. Both of these exercises are a requirement of the EPRR Standards and should be supported in being prioritised at the earliest opportunity.

4. Service Provision and Resourcing

4.1 We have successfully appointed into our vacant Band 5 EPRR Officer position, with an expectation that the individual will be in post in August. We have also undertaken an exercise to review our EPRR resource relative to neighbouring and similar sized NHS Trusts. As a result, we have produced a business case for additional staffing on an initial non-recurrent basis. This will both provide immediate short-term capacity and expertise into the team but also enable us to take forward our work within North Kent on the potential collaboration working with EPRR partners in the medium to longer term.

Meeting of the Board of Directors in Public
Thursday, 08 July 2021

Title of Report	**Finance Report**	**Agenda Item**	5.1
Report Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Isla Fraser, Financial Controller Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director of Income and Contracting		
Lead Director	Alan Davies, Chief Finance Officer		
Executive Summary	The Trust reports a breakeven against the NHSE/I control total.		
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: Finance Committee Date of approval: Thursday 24 June 2021		
Executive Group Approval:	Date of Approval: Wednesday 16 June 2021		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to NOTE this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report		

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Finance report

For the period ending 31 May 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(8)	(8)	-	The Trust reports a £8k deficit position for May; reducing to breakeven after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes an accrued Elective Recovery Funding (ERF) of £0.4m and a contingency of £0.8m, this being a reduction of £0.1m since the previous month. Total pay costs have increased in month by £0.1m as services continue to increase activity levels and use temporary staff to support this where vacancies exist and additional capacity is needed.
Donated Asset Depreciation	8	8	-	
Control Total	**-**	**-**	**-**	
Efficiencies Programme				
In-month	119	76	(43)	For the first quarter, divisions are required to find 0.28% of their roll over budget as savings; this equates to £186k in total and prorated £62k per month. This is deemed to be a prudent and achievable level of efficiencies as the services continue to recover and restart elective activity. In addition, £57k per month of schemes relating to 20/21 FYE efficiencies are included, these being the majority of the efficiencies realised for the first two months as shown in the table. The PMO and Finance teams are currently working with Care Groups and Divisions to identify schemes and following up on the first efficiencies showcase events that happened in June.
YTD	238	151	(87)	
Capital				
In-month	1,091	979	(112)	The Trust Capital Resource Limit (CRL) has been set at £13,877k for 2021/22 by the STP. This is funded by Trust depreciation of £10,711k, additional internal cash reserves of £2,059k and £1,107k planned PDC for the UTC project. This CRL is less than 50% of Trust capital expenditure in the prior year. The Trust has highlighted a further £8m of schemes to the ICS which we would wish to critically pursue should any additional resources become available. Overall the programme is on plan with some schemes ahead and some behind. The plan was mainly phased in equal 12th's which may be a contributing factor.
YTD	2,491	2,781	290	

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£'000	PY	Actual	Var.	
Cash				
Month end	49,184	43,965	(5,217)	Cash balances have reduced by £5,217k since 31st March 2021; £8.9m of income received in advance of service provision is included within this balance.

Pay costs are higher than expected	Total pay costs have increased in month by £0.1m to £19.5m. The position is adverse to budget by £0.4m; of this £0.3m is due to incremental Covid costs although offset by underspending on Covid non-pay expenditure. The remainder is due to efficiencies targets included within the budgets that have not had an actual scheme identified against them yet.

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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	26,645	27,519	874	53,290	54,693	1,403
High cost drugs	1,814	1,776	(37)	3,627	3,453	(174)
Other income	1,704	1,805	101	3,408	3,847	439
Top-up income	-	-	-	-	-	-
True-up income	-	-	-	-	-	-
Total income	**30,163**	**31,100**	**937**	**60,325**	**61,993**	**1,668**
Nursing	(8,137)	(7,832)	305	(16,147)	(15,361)	786
Medical	(6,154)	(6,250)	(96)	(12,403)	(12,303)	100
Other	(4,939)	(5,549)	(610)	(9,909)	(11,441)	(1,531)
Total pay	**(19,230)**	**(19,630)**	**(400)**	**(38,460)**	**(39,105)**	**(645)**
Clinical supplies	(3,934)	(4,144)	(210)	(7,868)	(7,962)	(94)
Drugs	(598)	(793)	(195)	(1,196)	(1,507)	(311)
High cost drugs	(1,821)	(1,784)	37	(3,641)	(3,461)	180
Other	(3,221)	(3,324)	(103)	(6,442)	(7,108)	(667)
Total non-pay	**(9,573)**	**(10,044)**	**(471)**	**(19,147)**	**(20,038)**	**(891)**
EBITDA	**1,359**	**1,425**	**66**	**2,719**	**2,850**	**132**
Depreciation	(827)	(887)	(60)	(1,655)	(1,774)	(120)
Net finance income/(cost)	2	(1)	(2)	3	(5)	(8)
PDC dividend	(542)	(545)	(3)	(1,084)	(1,087)	(3)
Non-operating exp.	**(1,368)**	**(1,433)**	**(65)**	**(2,735)**	**(2,866)**	**(131)**
Reported surplus/(deficit)	**(8)**	**(7)**	**1**	**(17)**	**(15)**	**1**
Adj. to control total	8	7	(1)	17	15	(1)
Control total	**-**	**-**	**-**	**-**	**-**	**-**

Key messages:

1. Funding arrangements for the first half year of the financial year have been agreed with the Kent & Medway CCG to be the same level as the last six months of the previous financial year. The table includes NHSE/I plan as opposed to baseline budgets. The Trust plans to breakeven for Apr-Sep.

2. Budgets were set using costed establishments as well as agreed service developments and cost pressures that had been through the relevant governance process and prioritised by the Executive Team.

3. Efficiency programme has been set to 0.28% for Q1 increasing to 1% for Q2, this totals £0.9m.

4. Income favourable to plan due to £0.4m ERF and £0.5m additional Covid, these are budgeted but not included in 20/21 plan figures.

5. Adverse Pay variance due to high use or temporary nursing staff to cover vacancies within the establishments.

6. Non-pay adverse variances due to higher activity and increased costs for the elective recovery plan.

7. Total expenditure includes the incremental cost of Covid-19, being £0.6m in-month and £1.0m YTD.

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3. Efficiency Programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Unidentified
Planned care	70	-	-	182	252	**2,132**	(1,881)
UIC	179	-	-	289	469	**2,190**	(1,721)
E&F	21	295	36	30	434	**434**	-
Corporate	73	56	-	-	77	**415**	(338)
Procurement	-	-	-	-	-	**-**	-
Total	**343**	**351**	**36**	**501**	**1,231**	**5,171**	**(3,940)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**119**	**76**	**(43)**	**238**	**151**	**(87)**	**5,171**	**5,171**	**-**

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 and the Director of Improvement monitor and work with budget-holders to achieve targets.

The total efficiencies included in the draft budget for the first 6 months is £0.9m, in total for the year this increases to £4.8m as the need for efficiencies increases in the second half of the financial year, in addition to this there is the full year effect impact of 20/21 schemes totalling £0.3m

The first efficiency showcase has completed where services were invited to present potential areas of efficiency using The Model Hospital data and benchmarking tools. Under current block contracting arrangements and the pause of payment by results, efficiencies generating income gains are unlikely to be agreed without specific arrangements with the Kent & Medway CCG.

The PMO team along with Divisions and the Finance Business Partners are focused on developing efficiencies for 2021/22 as well as assessing schemes that did not deliver historically being carried forward and implemented.

The main efficiencies have been achieved from the full year effect of 20/21 schemes.

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4. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
221,951	**Non-current assets**	**222,054**	**103**
6,962	Inventory	6,954	(8)
16,216	Trade and other receivables	17,414	1,198
49,184	Cash	43,966	(5,218)
72,362	**Current assets**	**68,334**	**(4,028)**
(137)	Borrowings	(64)	73
(37,101))	Trade and other payables	(31,928)	5,173
(8,839)	Other liabilities	(10,172)	(1,333)
(46,077)	**Current liabilities**	**(42,164)**	**3,913**
(2,151)	Borrowings	(2,151)	0
(1,424)	Other liabilities	(1,425)	(1)
(3,575)	**Non-current liabilities**	**(3,468)**	**127**
244,661	**Net assets employed**	**244,647**	**(14)**
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,285)	(14)
36,062	Revaluation reserve	36,062	0
244,661	**Total taxpayers' equity**	**244,647**	**(14)**

Key messages:

1. Net assets employed are £244.7m (prior year: net assets of £244.7m).
2. Receivables have increased by £1.2m from the prior year mainly due to an increase in prepayments which is expected. At the start of each financial year many contracts are paid a quarter/year in advance.
3. Payables have decreased by £5.2m from the prior year due to the receipt and payment of material capital invoices
4. Other Liabilities have increased by £1.3m from the prior year due to an increase in payments in advance from NHS Commissioners
5. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

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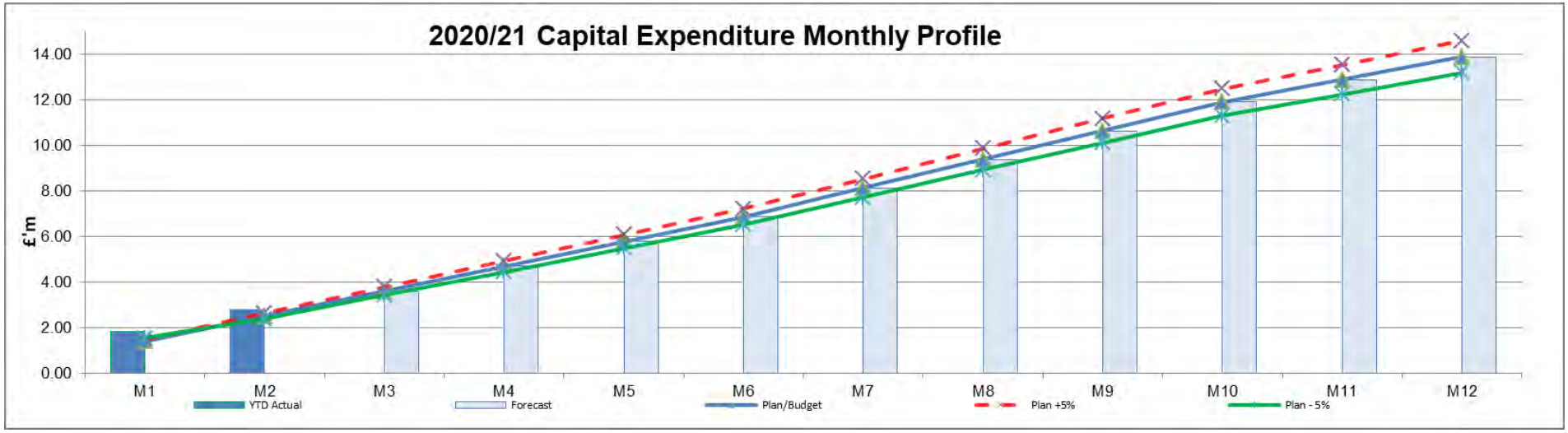
5. Capital

£'000	In-month			Year To Date M1-M2			Annual			Funding (PLAN)		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	261	229	(32)	521	494	(28)	3,110	3,110	0	3,110	0	0
Fire Urgency Works	194	41	(154)	389	323	(65)	2,328	2,328	0	2,328	0	0
Emergency Department	108	640	532	526	894	368	1,211	1,211	0	1,211	0	0
Information Technology	345	25	(320)	690	1,260	570	4,297	4,297	0	4,297	0	0
Medical and Surgical Equipment Programme	8	0	(8)	15	0	(15)	0	0	0	0	0	0
Service Developments	166	(2)	(167)	332	(2)	(333)	1,716	1,716	0	1,716	0	0
Routine Maintenance	9	10	0	18	20	1	108	108	0	108	0	0
Specific Business cases pending UTC	0	(0)	(0)	0	(0)	(0)	1,107	1,107	0	0	1,107	0
Total Planned Capex	**1,091**	**943**	**(149)**	**2,491**	**2,989**	**499**	**13,877**	**13,877**	**0**	**12,770**	**1,107**	**0**
Unfunded	0	37	37	0	(209)	(209)	0	0	0	0	0	0
Total Additional Capex	**0**	**37**	**37**	**0**	**(209)**	**(209)**	**0**	**0**	**0**	**0**	**0**	**0**
Total Capex	**1,091**	**979**	**(112)**	**2,491**	**2,781**	**290**	**13,877**	**13,877**	**0**	**12,770**	**1,107**	**0**
Grant/Donation Funded Capex	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Capex	**1,091**	**979**	**(112)**	**2,491**	**2,781**	**290**	**13,877**	**13,877**	**0**	**12,770**	**1,107**	**0**



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6. Cash

CASH FLOW NOT YET AVAILABLE AS NO CONFIRMATION FROM CCG ON CASH PROFILE

Prior year end	£'000	Month end actual	Var.
49,184	Cash	43,966	(5,218)

Cash balances have decreased from the prior year due to
- £5.2m decrease in payables
- £1.3m increase in deferred income
- £1.2m increase in receivables

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7. Conclusions

The Board is asked to note the report and financial performance which is £8k deficit in-month reducing to breakeven after removing the adjustment for donated asset depreciation and income. This financial performance is as per the plan submitted to the Kent & Medway STP and forecast to breakeven for the first six months in line with the control total. The year to date efficiency programme delivery is the full year effect of schemes that started in the previous financial year.

The Trust continues to forecast a breakeven position as planned for the first half of the financial year.

The risks identified with the financial position for the financial year ahead include:

- Managing cost pressures & service developments within financial envelope
- Delivery of efficiencies targets
- Managing cost of elective recovery within plan

Mitigations to reduce the risk:

- Phasing on cost pressures / services developments
- Additional ERF >£1.3m & Maternity funding. Figures presented by the CCG are significantly higher than this for the first 6 months c.£5.9m
- M2 contingency £0.8m

Alan Davies
Chief Finance Officer
June 2021

Meeting of the Board of Directors in Public

Thursday, 08 July 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2**
Committee Chair:	Annyes Laheurte, Chair of Committee and Non-Executive Director		
Date of Meeting:	Thursday 24 June 2021		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Paul Kimber, Deputy Chief Finance Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. BAF strategic risks The BAF scores were noted as being unchanged; in particular, the uncertainty of the financial regime in the second half of the year and the limited capital resource allocation meant the scores for "3a Delivery of Financial Control Total" and "3b Capital Investment" remained at 16. It was agreed that the following reviews with potential amendment would be made of the BAF before the next meeting: • To consider the role of the Financial Improvement Director and whether this post being unfilled has a bearing on the assurance and mitigation. • To consider the activity/capacity risk and its impact on financial performance given.	**Amber/Green**
2. Corporate risk register	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
There were no items scoring 16 or higher to be presented at this meeting, although it was noted this would be kept under review. All divisions have been reminded to capture their own financial risks in their registers, particularly in light of limited efficiency plans and the capital resource.	
3. Finance report – month 2 The Deputy Chief Financial Officer took the Committee through the report, with the key highlights being: • The Trust has met its control total of breakeven in month 2 and for the year to date. • Pay and non-pay costs had increased but were broadly reflective of the additional "restart" activity being undertaken; this included both insourcing and outsourcing of activity. • The aforementioned activity has meant delivering income/activity levels above the baseline set by NHSE/I and hence would be generating additional income. Estimates were that this is as much as £2.7m in the first two months, however only £0.4m had been recognised to date; this sum is in line with the original plan (and was agreed with the commissioner/system). The full sum was not realised at this time as there remained a risk of non-payment into the system. • In addition to the above, £0.1m of contingency reserve generated in month 1 was also released into the financial position to mitigate the increased cost of activity. • Capital expenditure was £2.8m for the year to date but this is expected to slow in later months in order to remain within the capital resource allocation. The projects are largely those that have were ongoing from the prior year. • Cash remains high and the liquidity position of the Trust is strong. The Committee discussed whether it was appropriate to ask care groups/divisions to attend to explain their financial performance where this was adverse. It was agreed that those conversations should be held at the performance review meetings and assurance given to the Committee. It was noted that the finance report currently stands alone and that there would be benefit in considering how this can be presented in the context of activity and operational performance.	**Amber/Green**
4. Efficiency showcase The Chief of Staff introduced the paper, noting that the showcase event was well attended and productive. The event generated a number of cross-cutting themes that will now be scoped, developed and implemented accordingly. The importance of having multi-disciplinary teams working on these schemes, co-ordinated by a PMO lead and facilitated by other support staff, was noted. Stronger governance arrangements were also proposed, being an executive-led efficiencies programme board. It was **AGREED** that this approach should be adopted.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
A follow up showcase event was being planned and will be communicated in due course.	
5. NHSE/I intensive support action plan The initial observations and recommendations from the NHSE/I intensive support unit were presented to the Committee. This covered matters including the lost rigour of robust financial management during the pandemic, the relationships between finance and divisional/care group leaders, the role of the PMO, the support/ownership of efficiency planning, the links to the Trust improvement plan and how this will also need to dovetail into the Trust's financial recovery plan. A detailed action plan is being prepared to implement the recommendations and it was **AGREED** that this should be brought back to the next Committee meeting for approval. The plan will also cross-reference how the actions address the risks in the BAF.	**Amber/Green**
6. Reference cost pre-submission report The report set out the plan and timetable for submitting the data for the national cost collection. At this time the project was performing in line with the plan. The Committee noted the report.	**Green**
7. Business case policy The changes raised at the previous meeting were noted as having been made. Two further points were raised: • Reference should be made to the requirement for any management consultancy above £50,000 to be approved by NHSEI. • Greater clarity of the staff types covered when referencing "clinical leads". The Committee **APPROVED** the policy and asked for the above amendments to be made.	**Amber/Green**
Decisions made The proposed arrangements to provide stronger governance and oversight of the efficiency programme were **AGREED**. It was **AGREED** that the detailed action plan in response to the NHSEI intensive support unit recommendations would be presented at the next meeting. The business case policy was **APPROVED** subject to additional narrative on NHSE/I approval of management =consultancy above £50,000 and clarification of 'clinical leads'.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee No matters to note from this meeting.	

Meeting of the Board of Directors in Public

Thursday, 08 July 2021

Assurance Report from Committees

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**5.3**
Committee Chair:	Mark Spragg, Chair of Committee and Non-Executive Director		
Date of Meeting:	Monday 7 June 2021		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Paul Kimber, Deputy Chief Finance Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Annual report and accounts The committee discussed the deadlines for the annual report and accounts, noting the external audit value for money opinion will now be deferred (see below). The opinion on the accounts is still anticipated by 15 June 2021, albeit noting that an extension to 29 June 2021 is available. As a result of the deferral of the value for money opinion, it will not be possible to lay the accounts before parliament before its recess. There were only minor amendments made to the document compared to the draft presented at the April meeting. The annual report and accounts were **APPROVED** by the committee subject to completion of the work of the external auditors. This includes an assessment that the going concern basis of preparation adopted is appropriate.	**Green**

2. External audit Grant Thornton noted that the quality of the draft report and accounts prepared by the Trust was high and that is reflected in the minimal changes requested. The areas of outstanding audit work were noted. Included within that work was the new value for money procedures; it was emphasised that the audit is not complete until all work is finished. A letter had been circulated to the committee by Grant Thornton confirming that following an extension granted by the National Audit Office, the value for money opinion would be delayed until no later than 20 September 2021. It was confirmed that there was not a substantial amount of work to complete. Grant Thornton noted that there were no areas of concern in respect of judgement or estimate, along with other areas of risk identified (including the impact of Covid, accruals and capital expenditure), of which the committee needed to be aware. The external auditors confirmed they were still targeting 15 June 2021 accounts submission deadline. The draft audit opinion, subject to completion of procedures, is qualified only as a result of the qualification of inventory in the 2019/20 annual accounts. The committee **APPROVED** the letter of representations subject to an update to point 5 confirming those accounting estimates applied.	**Amber/Green**
3. Internal audit KPMG presented their summary report; the following reports and their rating were also presented with ensuing discussion: • Data quality assurance - significant assurance with minor improvements • Core financial system: accounts payable - significant assurance with minor improvements • Core financial system: SFI waivers – partial assurance with improvements required • Data security and protection toolkit – partial assurance with improvements required • Asset security – advisory only The 'Head Of Internal Audit Opinion' was presented with the conclusion being "significant assurance with minor improvements", being the same as the prior year. This is an improvement on the draft opinion presented in April due to: 1. The split in core financial systems rating above. 2. An improvement in the data quality rating on finalization of that report. The counter fraud annual report was presented to and noted by the committee. This summarised the work undertaken during the course of the year including proactive and reactive reviews. A counter fraud authority compliance review has been undertaken, noting that despite the new standards only being implemented/released in February 2021 they have been required to be used to assess the full year. The individual components score a mixture of green and amber, with an overall rating of green. It was noted that this will be signed off by the Chief Financial Officer and chair of IAC.	**Amber/Green**

3. Single tender waivers The Chief Financial Officer presented the report, noting the discussion that was held as part of the internal audit review on core financial systems.	**Amber/Red**
4. Trust self-assessment against University Hospital of Leicester findings The Chief Financial Officer presented the self-assessment against the criteria set out in the University Hospital of Leicester report, which identified financial reporting failures at that organisation. The rating was “low risk” and supported by the committee.	**Green**
6. Losses and special payments The Chief Financial Officer presented the report, including technical inventory write downs at the year end. One write-off in particular was discussed further; this was an IT Project which was commissioned by the CCG and subsequently abandoned by them due to lack of take-up across the system. It was agreed that the Chief Financial Officer would provide a report into this matter at the next meeting.	**Amber/Red**
7. Current enforcement undertakings The Deputy Chief Executive noted that there was a meeting with NHSE/I the following morning and hence will bring back a paper to the next meeting.	**White**
Decisions made The annual report and accounts were **APPROVED** by the committee subject to completion of the work of the external auditors. This includes an assessment that the going concern basis of preparation adopted is appropriate. The committee **APPROVED** the letter of representation subject to completion of the audit and an update to point 5 confirming those accounting estimates applied.	
Further Risks Identified None, other than as noted.	
Escalations to the Board or other Committee The approval of the annual report and accounts subject to outstanding audit work.	

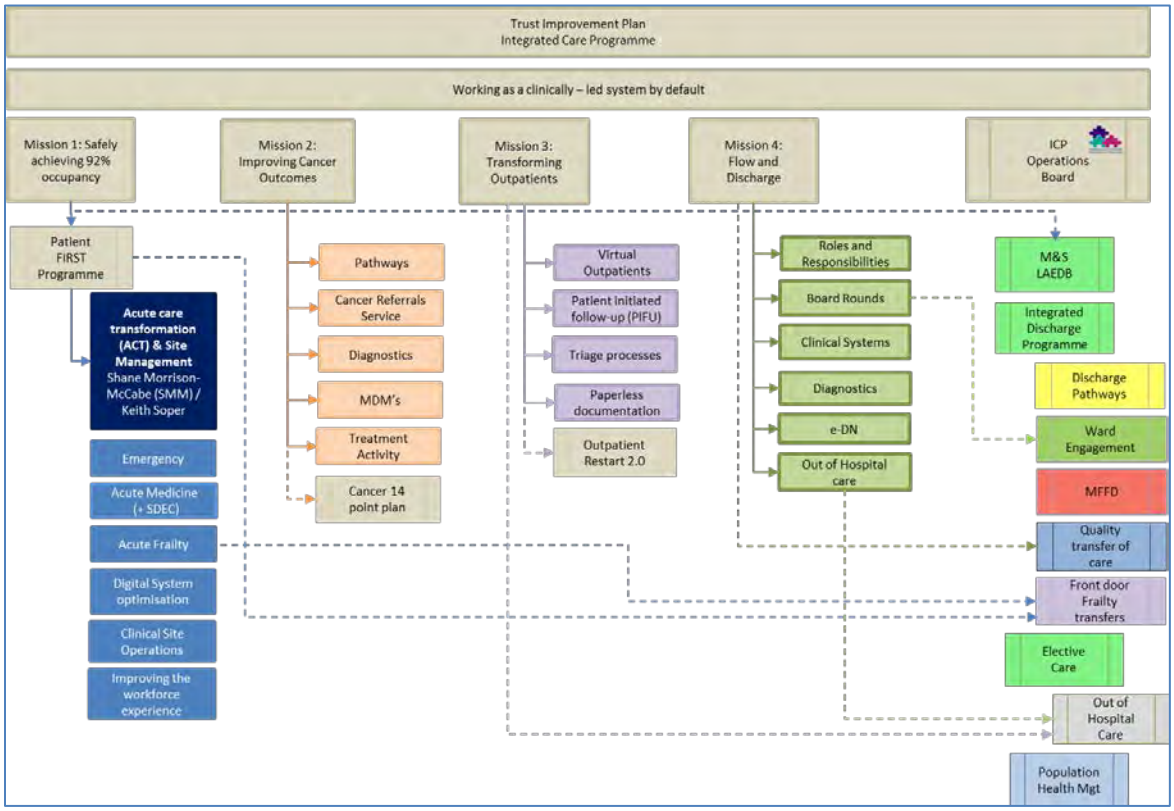
Meeting of the Board of Directors in Public
Thursday, 08 July 2021

Title of Report	**Trust Board – Report on the Integrated Care Pillar of the Trust Improvement Plan**	**Agenda Item**	6.1
Report Author	Angela Gallagher – Chief Operating Officer (Interim) Jacqui Leslie – Programme Manager (Integrated Care Pillar including Patient FIRST)		
Lead Director	Angela Gallagher – Chief Operating Officer (Interim)		
Executive Summary	This paper provides a progress update on the four keys Missions and interrelated elements of our Patient First programme within the Integrated Care Improvement Pillar (of the Trust Improvement Plan). Clinical and operational engagement in the programmes continues to be strong. The Trust continues to experience challenges with emergency demand, high levels of bed occupancy and flow but the Pillar and its constituent Missions remain focused in completing the identified actions leading to improvement in line with our performance and quality trajectories.		
Due Diligence			
Committee Approval:	Name of Committee: Integrated Care Programme Board Date of approval: 16 June 2021		
Executive Group Approval:			
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	N/A		
Quality Impact Assessment	State whether a Quality Impact Analysis has been undertaken or is proposed		
Recommendation/ Actions required	The Board is asked to NOTE the report and progress made		
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☐
Appendices	None		

1 Executive Overview

1.1 The Integrated Care Programme (Phase 2) including Patient FIRST is progressing with key focus remaining on the Emergency Care pathways and Elective / Cancer recovery and transformation plans. Mission 1 re-scoping has been completed and the Phase 2 Patient FIRST programme focuses on the expanded Acute Care Transformation (ACT) incorporating Site Management. The Phase 2 scope continues to be supported and tracked by metrics sets determined in collaboration with ECIST. The legacy flow and discharge workstream has been proposed as a Mission in its own right - Mission 4 -

Flow and Discharge. The Integrated Care Programme Board agreed this realigned programme on 12/05/21 and Trust Improvement Board ratified this on 04/06/21.



1.2 The current Missions within the Integrated Care Programme are detailed above and reflect the updated structures agreed at the May Trust Improvement Board.

1.3 The Trust-wide Internal Professional Standards (IPS) review and refresh has commenced, led by the Divisional Medical Directors across Unplanned and Planned Care. This work is out to wider engagement with the expected ratification of the IPS to occur through Clinical Council in July.

2 Mission 1: Acute Care Transformation (including Patient FIRST)

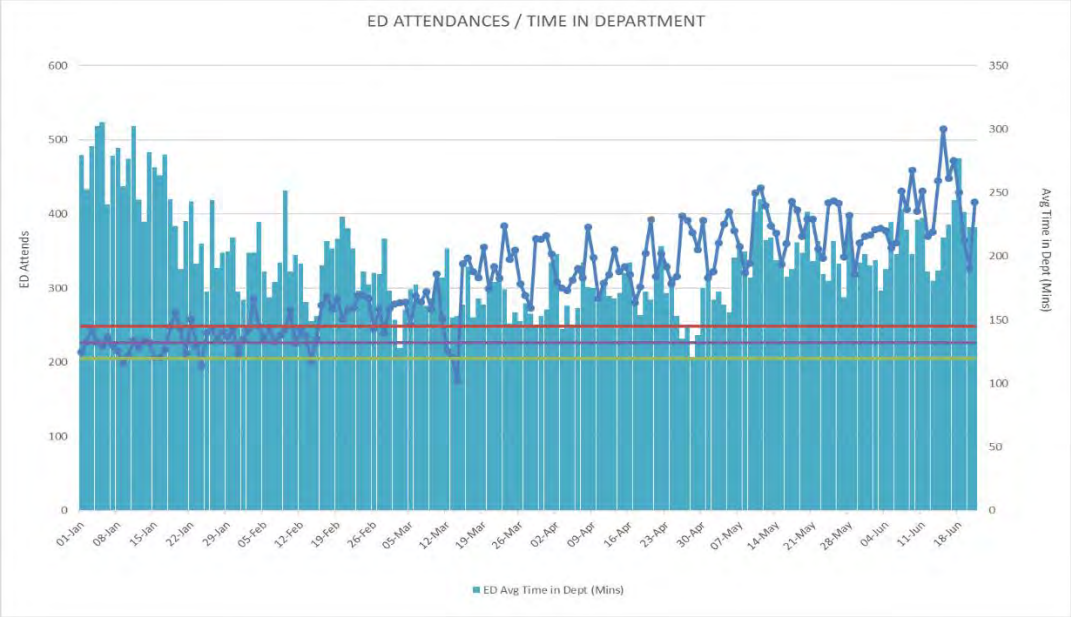
2.1 The Trust continues to work through the actions within the ACT workstream and have completed the following key actions since the previous update:

- Phased re-establishment of the Lister Acute Assessment Unit functionality supporting a "refer and move" model for the Emergency Department
- Implementation of the Departmental Emergency Care Standards and ED Escalation Tool (to dovetail with the Trust's revision of the Escalation Plan - Full Capacity Protocol and link with the revised Covid-19 / Winter Planning process)
- Continuation of the ED Senior Nursing Leadership development programme for Band 7 Nursing staff

2.2 The Phase 3 Emergency Department Estates project has been completed and handed back to the division to transition the facility into use in late June / early July. This will also support the return of Children and Young People's ED Services back into the Department.

2.3 The Trust continues to experience challenges with an increasing demand, particularly in walk-in attendances, which is influencing overall time in the department and shows a recent increase in this time.

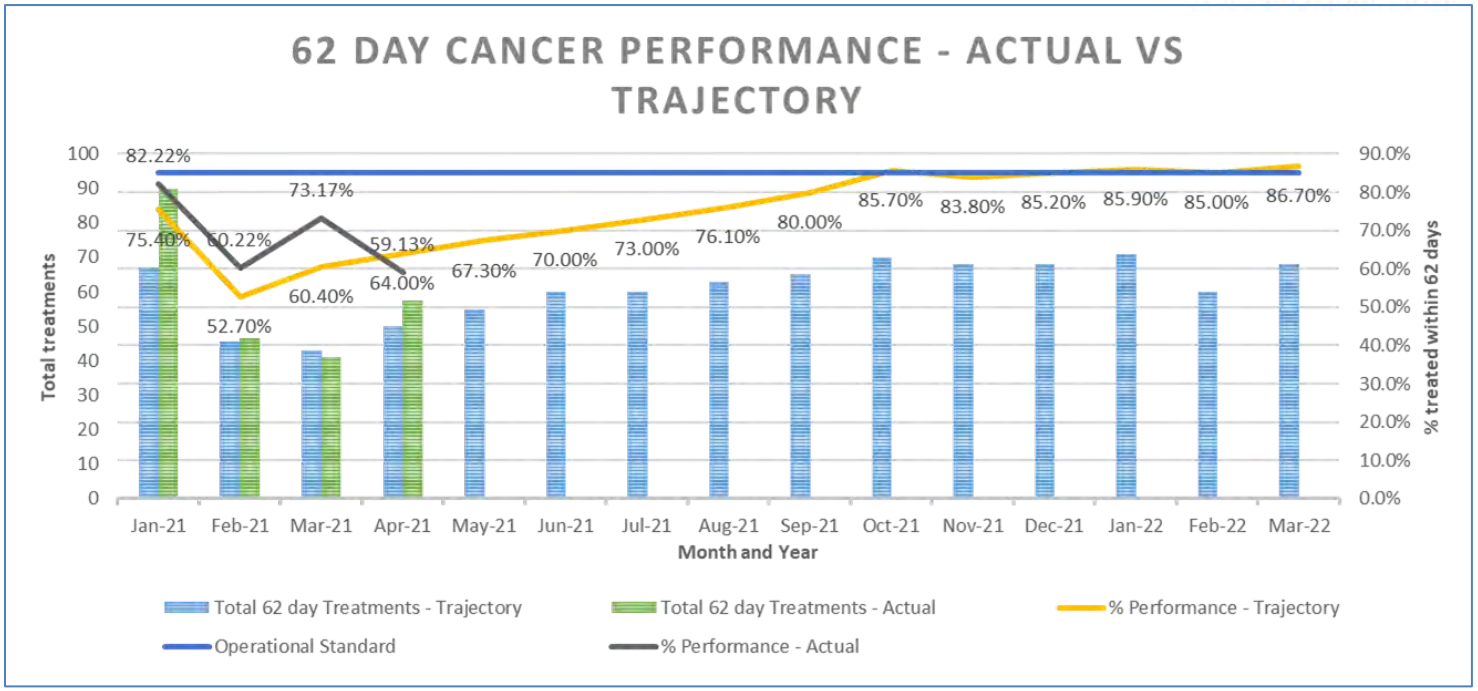
2.4 With the support of NHSE/I, all teams / services who support the emergency pathways are preparing for a Rapid Improvement Event (Week) in the w/c 12/07/21 to improve emergency flow and test the revised Trust's Internal Professional Standards (scheduled for completion by mid-July).



3 Mission 2: Improving Cancer Pathways

3.1 Improving Cancer Pathways has progressed key focus areas to support the trajectory towards compliance with the 62 Day Cancer Waiting Time standard and the 28 Day Faster Diagnosis Standard (FDS). Diagnostic capacity remains a key challenge and is a focus area for improvement activity within the pathways. Key actions completed since last report:

- Tumour site mapping and opportunity identification across all key tumour site specific pathways.
- Opportunity for wider transformation of Cancer pathways in conjunction with Mission 3: *Transforming Outpatients* and Mission 4: *Flow and Discharge*, has been identified and will be aligned to the Trust's 14 Point Cancer Recovery Plan. The optimisation of the DartOCM system for electronic requesting is being progressed with a planned go-live of 4th July 2021 (in conjunction with the Innovation Pillar of the TIP). This project will improve the timeliness and visibility of Cancer diagnostic referrals to Imaging. This project will have a second phase in Q3 to mobilise Pathology requesting with the same expected benefits. Independent Sector capacity has been retained to augment the Trust's capacity the key areas of Endoscopy, Imaging and Cardiology.
- Exploratory work in Galton Day Unit to investigate potential improvement projects linked to the optimisation of chemotherapy chairs and pharmacy, infusion suite interfaces



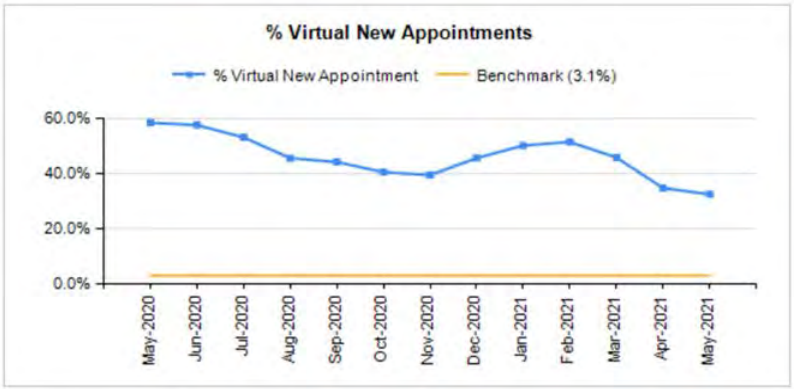
4 Mission 3: Transforming Outpatients

4.1 The Mission has five key focus areas for Outpatient Transformation and will be revising metrics to monitor and deliver targets against agreed trajectories. Patient Initiated Follow-Up (PIFU), Electronic Referrals (ERS), Triage, Patient status on PAS and QFM room booking system.

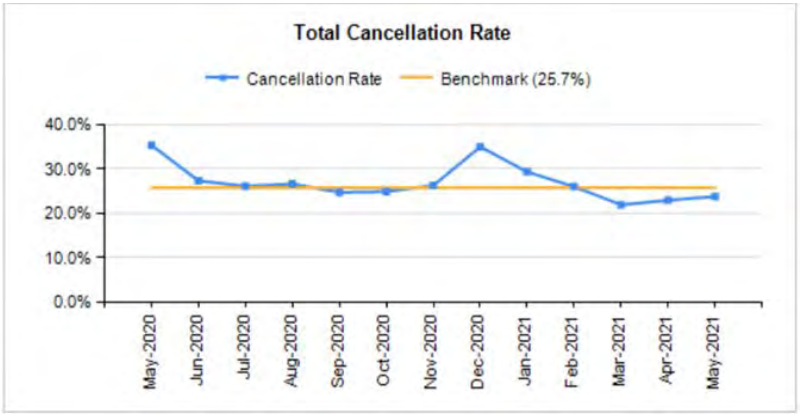
Key actions completed since last Board:

- In discussion with Clinical Leads, agreement has been reached to implement PIFU with Orthopaedics first, as they already use the watchful wait function, this will allow them to have better management of patients and ensure expected timelines are agreed. We would hope to see a decrease in required routine follow-ups for 2022/23.
- The QFM room booking system has been implemented within June and will help Outpatient Services to monitor room utilisation and minimise wastage of capacity across the trust. This should help bring down costs for additional clinics outside of normal working hours, currently we have seen large increases in weekend clinics to help support recovery programme.

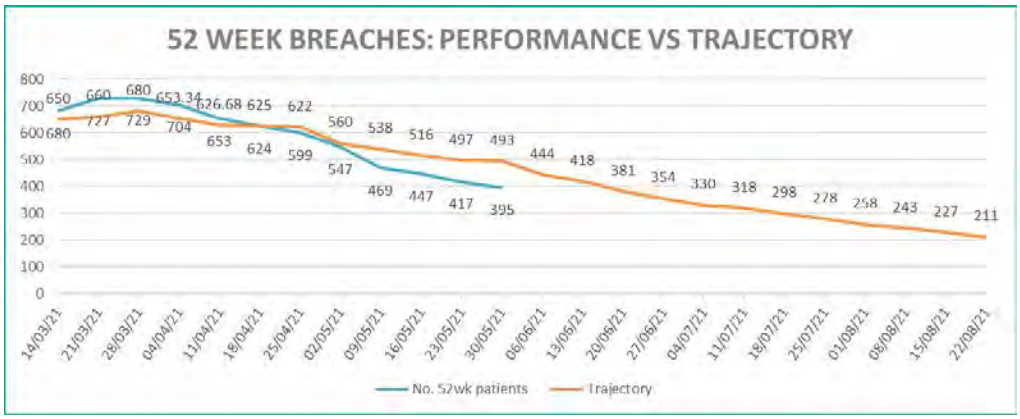
4.2 Virtual outpatient implementation was essential due to pandemic. The Trust has continued to excel in the use of virtual clinics. We are aiming to maintain between 35-40% of total trust activity as virtual.



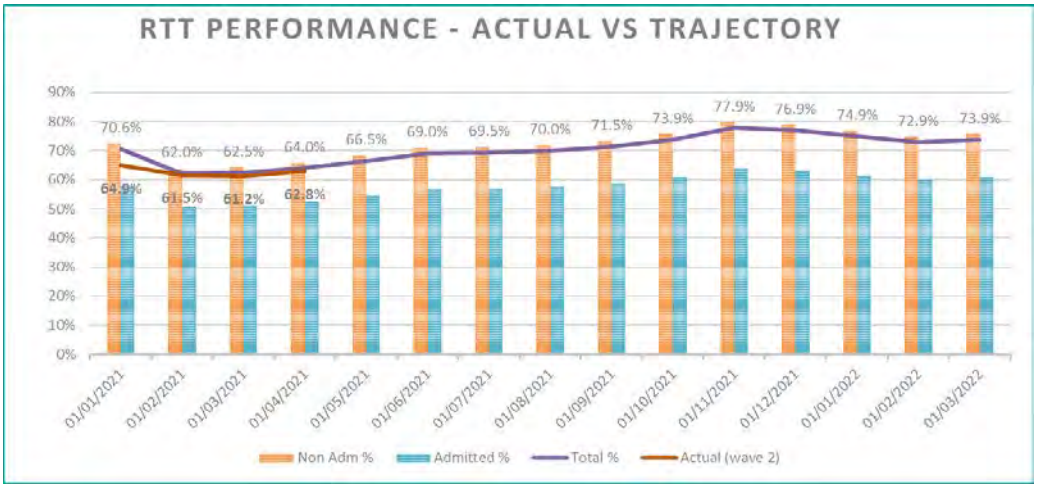
4.3 Drop in DNA's to below benchmark of 7.3% and cancellations for virtual activity to below benchmark to 26.7%



4.4 Sustained reduction (ahead of trajectory) for patients waiting >52 weeks care for routine elective care.



4.5 Overall on trajectory for achievement of the Phase 4 recovery for elective care



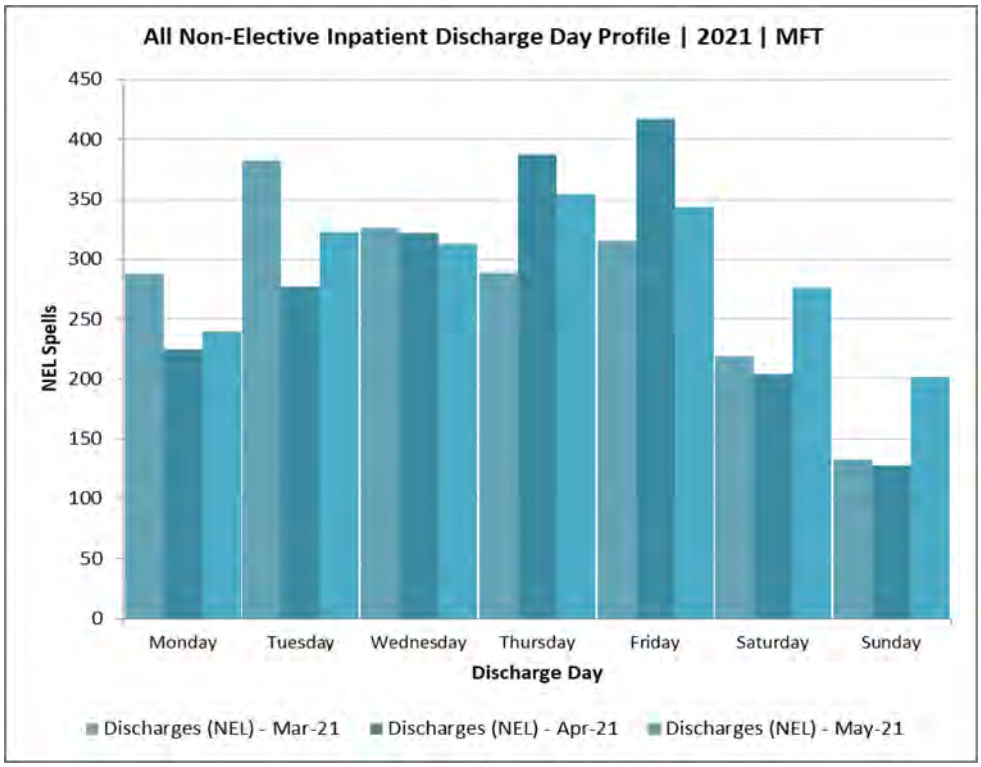
5 Mission 4: Flow and Discharge

5.1 The newly-created Flow and Discharge Mission is moving swiftly into further targeted delivery of BEST Ward projects. The Mission has six key workstreams focusing on some rapid improvements (Dart OCM

requesting) and some long-standing issues (eDN completion and EDD setting). Key activities since last Board:

- System-wide MADE event mobilisation in w/c 21/06/21 to optimise pre-noon discharges and support patients with longer lengths of stay (LLoS) to be safely discharged into an appropriate setting with the required support
- Plan and scope a project to improve e-DN completion rates amongst clinical teams
- Progression of key planning to support 7 day working and improving rates of safe, criteria-led discharges at weekends
- Continue ward-based mini-MADE activity to assist with the Lister AAU re-establishment and profile the uptake of the Discharge Lounge to support emergency flow

5.2 The promotion of weekend discharges continues to indicate capacity to support improved flow along the emergency pathway. This supported activity peaked with > 270 patients able to return home on a Saturday and >200 patients on a Sunday in the month of May, approximately 25% more than in the previous two months.



5.3 Focus on the timing of discharges remains a key improvement activity within the Mission with a target to progress up to a third of patients discharged prior to noon. Presently 12% - 15% of patients are discharged in the morning, which has resulted in the Mission focusing on e-DN completion rates to support timely discharge.

6 Conclusion and Next Steps

6.1 The Integrated Care Mission is working with NHSE/I Executive partners and clinical and operation leads to take forward some key Improvement cycles using the Plan-Do-Study-Act (PDSA) methodology in the second week of July. This work will use the principles of Patient FIRST to concentrate small numbers of improvements to rapid progress flow on the emergency pathway. This will provide the clinical teams with insights into the key actions they need to sustain to improve emergency flow, the admitted patient pathway and reduce delays in Ambulance Handover.

Meeting of the Trust Board
Thursday, 08 July 2021

Title of Report	**Digital Update**	Agenda Item	**6.2**
Lead Director	Paula Tinniswood – Chief of Staff Michael Beckett – Interim Director of IT		
Report Author	Michael Beckett – Interim Director of IT Suzanne O'Neil – EPR Programme Director		
Executive Summary	Digital solutions within the NHS, including Medway NHS Foundation Trust (MFT), have not developed at the required pace over the last 10-15 years. This means basic IT has not always being helpful to clinicians, systems cannot communicate with each other and utilisation of evolving technology has been slow. There is, however, an acceptance that digital transformation within the NHS has the potential to release front-line staff back to care, improve patient experience and advance clinical outcomes. The Trust developed a digital strategy in 2020 to ensure that digital services support the needs of our end-users to provide the best possible patient care. It must correspondingly ensure the Trust meets the requirements of local and national strategies, along with consideration of how current and future technology could be used to benefit the organisation. This paper focuses on providing an update to key projects currently being delivered or completed. It also focuses on updates to be made to the digital strategy to support new technology for the Trust and in line with national strategies.		
Committees or Groups at which the paper has been submitted	Innovation Board and Team		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	None		
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix A – Digital Update		

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board

The key headlines and levels of assurance are set out below:

No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

MFT Digital Update

The Digital Strategy

Below is a brief overview to the Trust digital strategy vision, objectives and an overview to the delivery workstreams. This has been based on national and local drivers and focused on the Trusts desire to improving our clinical services.

Our vision:

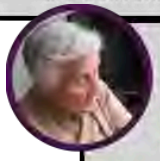
"Our vision is to provide digital solutions which empower our people to provide the best possible patient care experience and transform clinical outcomes."

Mission 1: Clinically Led

We will deliver digital tools which support the Trust to improving outcomes and patient experience, while reducing wasted clinical time by ensuring that clinicians are at the forefront of design and decision making in implementing our digital strategy. A Chief Clinical Information Officer will be appointed to support the development of digital solutions and drive digital clinical engagement, both within the Trust and regionally.

Mission 2: Paperless and Accessible

Full Electronic Patient Records will be implemented, and will provide clinical decision support tools supporting prescribing, managing pathways, automating clinic outcomes and prioritising work, with this data driving service improvement. Medical devices and point of care testing will be integrated to enrich the patient record, making a direct impact on the quality of our clinical services. Login times will be rapid, with the experience being the same working from the hospital or remotely. Patients, carers and staff will be able to seamlessly access data, systems and tools from any location with devices fit for the services they are delivering.



Mission 3: Integrated and Flexible

Collaborative working across NHS and social care organisations will be a priority, ensuring interoperability of digital tools across organisational boundaries, and providing access to data which supports the delivery of effective care across the local care system. Data will be integrated between Acute, Community, Mental Health, GPs and Social Care, making available a comprehensive patient record and building on this to ensure the data will support wider analytics, artificial intelligence and decision support. Additionally, our tools will be designed in a way which makes them easy to develop and change, to support service transformation, within and outside our Trust.

Mission 4: Secure

Data and systems will be robustly secured and protected from cyber attacks, while not hindering appropriate access.

Mission 5: Innovative

We will adopt and utilise technology which improves services, reduces risk or enhances the patient experience.

With the objectives of the Digital Strategy covering a broad area, we have broken down the plan to deliver the programme of work into four workstreams. The aim is to ensure focus on delivering key projects with clear benefits whilst ensuring these meet the aims of the Digital Strategy.

Workstream 1: Electronic Patient Record

Focused on the development of the Trust's Electronic Patient Record (EPR) and how this data can support staff in providing better patient care whilst improving the flow of patients throughout the organisation. Achieve through not just the availability of data but through decision support tools driven by analytics and AI solutions.

Workstream 2: User Experience

Our staff increasingly expect the ease with which they use technology and data at home to be replicated within the NHS. We therefore need to look at how new technology can be adopted to the benefit of our users. The Trust should adopt an attitude of embracing technology where possible, where it would aid our users.

Workstream 3: System Collaboration

As we work with our partners to provide system wide care there is a need to ensure that we use technology to support integrated services across the region. This will include sharing data with other providers, supporting integrated services and embracing patient digital interaction to with the aim of providing improved services to our patients.

Workstream 4: Invisible IT

With the NHS becoming ever reliant on digital solutions we need to ensure that our backend digital infrastructure supports our vision, not hinders it. We need the flexibility to be able to grow quickly and ensure resiliency, while meeting our requirements to protect the Trusts for cyber threats.

Clinicians

2021	2022	2023	2024	2025
IT improves with the introduction of new and increased user devices, single sign-on and IT system stability. The introduction of an electronic system for ordering tests makes it easier to process and reduces errors.	The introduction of Regional Care Record results in clinicians being able to access increased patient records. Introduction of electronic prescribing and integrated ED system improving access to clinical data and supports patient flow.	Reliance on paper starts to reduce with the increase in data being collected electronically in real-time, via the EPR. Decision support tools aid staff in prescribing and providing guidance.	All core clinical system functionality now either resides within the EPR or is integrated to the solution via context aware links. AI integration with the EPR to support diagnosis, alerts and pathway management.	Technology such as Natural Language Processing will be used within outpatients clinics to provide support in completing clinic outcomes. Genomics will be used to personalise treatment, while algorithmic interpretation will be completed by AI tools to aid diagnosis.
Clinicians Single Logon Electronic Ordering New End User Devices Electronic Patient Record (EPR) – Clinical Docs P1 Active Patient Monitoring Regional Care Record (View Only)	EPR – ePrescribing EPR - ED Regional Care Record - Results ICP Data Exchange Radiology AI Population Health EPR – Clinical Docs – P2	EPR Decision Support Tools Patient Portal - Phase 2 Automated Patient Flow Sytem Remote Patient Monitoring EPR – Surgery Point of Care Integration EPR – Clinical Docs – P3	LIMS Replacement AI Integration Medical Device Integration EPR – Pathway Mgt EPR County-wide integration	Genomics Testing Integrated Patient Direct Access EPR Natural Language Processing Algorithmic Interpretation Transfer of Data Nationally AI Developments
Time saved by clinicians due to easier access to IT systems, resulting in more time focused on patients. Patient experience and safety begins to improve due to real-time data availability. Remote consultations for outpatient appointments provides flexibility to patients.	Increased access to data will improve outcomes and reduce risk. Patients will also be able to access their own records via Regional Care Record, while accessing services and change appoints online.	Patients now have the ability to be monitored at home, with proactive support provided when required, reducing patients returning to the hospital via ED. Increased online services available to access data and interact with clinicians.	With the use of AI some online services are automated meaning real-time responses to the patient, while prioritising clinical work where required/desired	Smaller consumer devices contain localized AI to support healthcare. This data will be incorporated into clinical decision making and support the personalization of the patients care.

Patients

Strategy Update

The Trust will be looking to update the digital strategy over the coming 8 weeks to take into account the following:

Updated Local Strategies The Trust's strategy is under review. Combined with a Digital ICS strategy being developed there is a requirement to ensure that the MFT digital strategy aligns.

New Technologies The development of emerging technologies such as AI are essential and also ensure we comply with our strategy. This is unlikely to impact years 1 and 2 of the strategy, but will provide a clear roadmap for the introduction of technology in future years.

NHS Data Strategy NHSX this month have issued a national data strategy. It's objective is to set out a clear vision and a powerful action plan to create a truly 21st century health and care system which is even more efficient, responsive, personalised and ultimately safer. This publication of this strategy will have an impact on the Trusts digital and BI strategies.

Project Delivery

Over the last 12 months the Trust has invested in a range of different projects to support the delivery of the digital strategy. We have selected some of these key projects to provide an update to the achievements and also highlight some of the current schemes underway. We have also provided further detail on the development of the Trusts electronic patient.

Maternity System Upgrade – In progress
The aim of the Maternity Project was to provide a standardised, electronic maternity record that would move the Trust forward in the strategy to become paper-light, create efficiency savings, improve access to records and information sharing between Acute Services, GP's and Community Services.

Utilising the Trust's digital midwives the organisation has completed an upgrade to the existing Euroking system and developed with the supplier latest version with tailor made workflows that the department designed and configured to use at Medway, the first the supplier has completed in the country. The introduction of an electronic personal health record (PHR) instead of paper notes mean that these could be accessed by the woman from anywhere at any time and meant that no appointments would need to be rearranged due to lack of notes being available.

The Go-live in September 2020 went extremely smoothly with only a few minor issues arising over the go-live week. Key benefits already noted are the ability to access or share the woman's record with outside Trusts at any time; no paper notes required, electronic booking referrals such as GP notification and smoking cessation ensure women are seen in a timelier manner, ability to run in-depth reports for both hospital and community settings to meet national reporting such as MSDSv2 and CNST.

However, the Trust has experienced some challenges with the implementation of a paper light system. Our main outstanding issue is community midwives accessing electronic notes remotely due to a lack of internet connectivity. Which we are currently working with are care partners to provide internet access at remote clinic sites to resolve this issue.

DartOCM for Imaging and Pathology Ordering and Resulting – In progress
The objective was to ensure that the diagnostic ordering was changed to an electronic process, reducing transcription errors, ensuring an audited process and speeding up the transactions.

The initial roll out was to General Practice in 2018 however the project within the acute hospital was delayed. However, this year a pilot has been completed in the Paediatrics Specialty and following this has aligned to the Flow and Discharge Best Ward initiative with rollouts in Emerald, Pembroke and Will Adams.

The Trust is currently aiming for a full rollout of order communications by the end of July 2021. At which time the benefits are forecast to be:

- Reduction in paper forms, lost and duplicate referrals
- Increase in better referral information leading to improved data collection
- Improvement in reporting for Order Communications
- Standardisation of ways of working

PAS Upgrade Project - Completed

In 2013 the Medway Foundation NHS Trust implemented a new Patient Administration System (PAS). One element of the contract was to refresh the hardware.

Whilst this work is going on the Trust also agreed with Allscripts to upgrade the PAS software from 2016.1 to 18.4 which is the latest version of PAS that Allscripts supply and support.

The Trust also agreed to complete a number of upgrades to the system which include the following

- Upgrade from the current PAS 2016.1 to the latest version of 18.4
- Upgrade the Microsoft Operation Systems to a later, supported version as the current PAS environment sits on Server 2008, which is no longer supported by Microsoft.

The objective of this project is to ensure the PAS upgrade to 18.4 and hardware refresh upgrade are applied effectively, with minimal impact to the users, appropriate contingencies and effective due diligence to ensure its success.

The Hardware refresh was completed in January 2021. The PAS 18.4 Upgrade was completed in March 2021. These are both prerequisites for the EPR project.

8x8 Telephony - Completed

The Trust operated a Siemens ISDX Telephony solution from the 1980s which passed out of the supplier's advised lifecycle in 2017. In the event of a complete systems failure, where the current break/fix support provider is unable to return the system to a working state, the Trust would be without telephony services whilst an alternative was sourced and deployed.

A Cloud based solution was procured from 8x8, which provides an off-premises fully managed hosted solution. This enables financial benefits to be realized due to resources (both technical and human) not having to be supplied or supported by the Trust. The system also provides flexibility to users who may need to work both on and off site and be contactable during their core hours. Other benefits include a flexible contract allowing the Trust to increase or decrease the number of lines required, together with the scope to move to a single solution for telephony, video conferencing and unified communication.

The solution went live on 2nd June 2021. The Trust resolved a number of configuration requests at this stage. However, at this point the Trust experienced higher than anticipated call volumes to the organisation's switchboard, resulting in longer waiting times for staff, patients and other care professionals using the switchboard service. Over a 3 week period the Trust provided additional staff to address call volumes and provided a further update to the call centre staff, reducing wait-times and prioritising calls. The longest wait time for a GP has been 1 minute 28 seconds.

We are now in discussions with NHSX to develop the solution further, working with the Kent and Swale ICP to provide an integrated phone solution across providers to make it easier for clinicians across the system to communicate.

Single Sign-On – In Progress
Since January 2021 the Trust has been implementing the Imprivata OneSign 'single-sign on' solution into Area 8 and SAU as part of a technical pilot. Following the success of this pilot, the solution has now been implemented into areas 5, 6 and 7, with inpatients starting in June 21. With 50% of clinical computers now running the solution. Imprivata OneSign offers a digital end-to-end authentication and access management solution, enabling fast and secure access onto Trust PC's and computer on wheels and clinical IT systems using Trust ID cards and PIN number, reducing the requirement to remember every clinical IT system username and password.

Simon Lascelles, Consultant Surgeon stated "*The SSO has worked well. It was easy to set up and use. It has been especially helpful for clinics and also during my 'work admin' sessions when I read and respond to reports relating to the two week wait rapid access colorectal clinic. I have to access information / input information from dartOCM, EDN and OLM. The great benefit now is I can move with speed and cut out the continuous retyping of logins, which has made work smoother and efficient rather than clunky and disruptive."*
We expect all clinical areas to be completed by the end of July.

Cloud Desktop - Completed
During COVID Wave 2 the Trust worked with Microsoft on providing a virtual MFT desktop in the Microsoft Azure Cloud. This allowed our staff to access all IT services that they could access in the hospital from home when there was a need to isolate.

Since its implementation we how have over 70 users of the application and are looking at ways how the service can allow clinicians at specialist centres access to patient information in order to support patient care.

BebeVue - Completed
BebeVue is a unique service that allows expecting parents to purchase their full-motion ultrasound video online. Once a new mother's regularly scheduled ultrasound is completed the video will be available online. Parents can share their baby's first pictures and video with family and friends instantly. The Trust worked with the supplier and the Innovation Institute to develop the service.

ImproveWell – In Progress
Currently in a pilot stage the solution is deployed to the surgical team, selected wards (SAU, Victory, Sunderland) Maternity, Paediatrics, ED and the Student Nurses. It increases staff engagement, morale and collaboration via a mobile app for staff to tell us how they are feeling and provides an easy method to send us their ideas on how we can make improvements across all aspects of our Trust. We have received improvement ideas across workforce, pathways, communication, Quality of Care for Patients, Infrastructure and Flow

Radiology Information System - Completed
The Trust implemented a new Radiology Information System (RIS) in March 2021. The Soliton solution was selected as part of the Kent and Medway Radiology Collaborative and provided improved functionality and user interface compared to the previous system. The go-live was successful and benefits have already been realised.

Network Refresh – In Progress
The Trust is currently undertaking a complete network refresh, increasing bandwidth and network capacity, while meeting our cyber security requirements. This work is being completed in stages, with our core switches being replaced by mid-July, followed by the edge switches by November and wi-fi full completed by February.

Electronic Patient Record (EPR) Allscripts – In Progress

The Trust has taken the decision to implement a EPR solution to achieve the following benefits:

Reduce requirement for Health Records to be pulled or scanned. Saving time of tracking notes and reducing Health Records management costs.

Consolidation of IT systems, reducing user logons and application support costs.

Savings made on drug errors through the automation, protocol management, decision support, and availability of data.

Reduce reliance on paper processes, reducing errors, making data more readily available, reducing duplication and improving data quality.

Supports interoperability standards, aiding integrated services across the ICP and supporting business intelligence development.

Decision support tools providing advice and alerts to clinicians, supporting improved patient safety and increasing efficiencies.

Availability of data, ensuring patients are seen/treated with full record available. Enhancing patient experience, and improving outcomes.

Reduce time to complete EDN from current 20 minute average. This will be done by automating some processes, and reducing duplicate data entry.

Reduce the admin burden of clinicians through system automation and providing the data to staff wherever they need it. Ensuring the can spend more time with the patient.

Following the Trusts approval to proceed with the implementation of an EPR solution in December 2020. The project formally started in April with the development Phase 1 of the project to deploy clinical documents and a context aware view.

Since April we have completed the following tasks:

- Successful 2 day detailed planning session with Medway and Allscripts completed by 28th May
- Current State mapping completed
- Gap Analysis to Blueprint (Allscripts & Medway) completed
- Current State v's Gap Analysis Comparison established and submitted
- Clinical Workshops to review findings undertaken
- Localisation Change Assessment completed
- Clinical Leads appointed
- Programme Board established
- Dev, Test and Train Environment Installed
- Initial review of draft Training Strategy undertaken
- Lessons Learnt review completed from 3 Trusts EPR programmes
- Phase 2 – ePMA kick off meeting has taken place.
- Staffing recruited

Risks Log

A summary of the (mitigated) Red Risks for the project are highlighted below.

No.	Risk Description	RAG	Mitigation	Risk Post Mitigation
R3	Data Quality of the PAS system may impact the benefits of the new EPR	**Red**	Ongoing discussions/plans with Operational Colleagues to address BAU solutions.	**Amber**
R5	Trust wide Capital Budget has not yet been finalised which could have an impact on EPR, subject to final capital review.	**Amber**	Capital Budget confirmed.	**Green**
R6.	Reluctance to adopt Blueprint, may result in additional scope creep and impact to go live.	**Red**	Digital First Chair and 4 Clinical Leads signed off Phase 1 scope on Friday 25th June, supporting the large % of blueprint adoption with a small number requiring localisation changes.	**Green**
R4.	Production Environment Availability (last month on Issue log) if shipment delayed from supplier	**Amber**	Additional team member appointed to support build with daily 15min huddles held	**Green**
R9.	Duration of time to undertake Data Loads following Data Quality Tasks.	**Red**	Continue to review and address findings. Overall review and recommendation to be shared at next Programme Board	**Amber**

Issue Log

A summary of the (controlled) Red issues for the project are highlighted below.

No.	Issue Description	Impact x probability	Resolution	Controlled Issue
I7.	Office Space is an issue as recruitment of the EPR team continues, currently rotating available desks, with WFH, however this new team need to be more onsite during key phases so WFH is not always an option, in particular now that Allscripts team are more on site.	High x High	Additional office space required.	Currently managing by desk rota/wfh, but the team increase by 8 additional staff within the next few weeks.

The major key priority for the next period is to agree on scope of go-live deliverables and to underpin the pre-project strategy to utilise UK Blueprint to its fullest extent and minimise customisation and localisation. We are on schedule to complete these tasks and present them at the Programme Board on the 15th July. At which point confirmation of the phase 1 go-live date will be approved (October-November date expected).

Future Developments

The strategy and the projects above focus on the immediate opportunity, over the next 5 years, for developing how digital supports the Trust to achieve it vision, mission and objectives. It is however widely recognised that there exists great opportunity to transform how we safeguard and enhance the health and wellbeing of patients, and work with the wider health and care system to address health inequalities which exist and which are determined by wide ranging factors.

Below we provide a high level overview of some examples of key digital-related themes which the Trust will look to explore, with partners across the ICS, alongside the development of the wider Trust strategy, and which could be transformational for the health and wellbeing of the citizens we serve in the future.

Developing Connected Community Services across the STP

The Trust will continue to work with health and care partners across the STP to collaboratively develop how we use digital to underpin cross boundary service transformation. The Trust's Medway Innovation Institute will seek to ensure our digital strategy is constantly looking beyond the immediate priorities and considering the technologies that can allow us to leapfrog many of the challenges our staff and patients face through the adoption of new and exciting technologies.

Digitally Activating Local People

There exists great opportunity to work with system partners to digitally activate local people to take greater ownership of their health. For example, what began as a limited number of health monitoring devices has transformed into a whole new sector in wearable technologies. These devices range from smartphones which encourage healthy lifestyles to fitness tracking devices which can perform ECGs and blood pressure monitoring, to new technologies embedded in to robotic limbs. Local people are more commonly taking ownership of their health and wellbeing, supported by consumer devices and applications.

Developing Efficiency and Effectiveness Through Artificial Intelligence

The Trust will look to implement AI algorithms which are able to mine medical records, design treatment plans or create drugs faster than through any current process, and with safety concerns being addressed this will have a significant impact on the future of healthcare services. One example of this has been achieved by Google's DeepMind, who recently created an AI for breast cancer analysis. The algorithm outperformed all human radiologists on pre-selected data sets to identify breast cancer, on average by 11.5%. However, to achieve this data is absolutely key. To support the Machine Learning and analytics big data within healthcare becomes essential. Hence the need over the next 5 years to collect this data which can support advancements such as this in the future.

Leveraging Advantages of Genome Sequencing

It is possible to establish valuable information about drug sensitivity, multifactorial or monogenic medical conditions and even family history. Moreover, there are already various fields leveraging the advantages of genome sequencing, such as nutrigenomics, the cross-field of nutrition, dietetics and genomics. At the present time, Genomics testing is expensive, but this will decrease over time, and the NHS and Trust should look to utilise this technology.