Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: Thursday, 09 September 2021 at 13:00 – 16:15

St George's Centre

Pembroke Road, Chatham Maritime, Chatham, ME4 4UH

Subject		Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chair	Verbal	13:00	Note
1.2	Quorum				
1.3	Declarations of Interest				
1.4	Chief Executive Update	Chief Executive	3	13:05	Note
1.5	Patient Story	Chief Nursing and Quality Officer	7	13:20	Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting: 08.07.21	Chair	13	13:50	Approve
2.2	Matters arising and Action Log: 08.07.21	Chair	23		Discuss
3.	**High Quality Care**				
3.1	Integrated Quality Performance Report	COO, CNQO, CMO	25	13.55	Note
3.2	Fire Prevention Update	Director of Estates and Facilities	51	14:15	Note
3.3	Annual Report on Medical Appraisal / Revalidation (Kirti Mukherjee)	Chief Medical Officer	57	14:25	Assure/ Approve
3.4	Quality Assurance Committee Assurance Reports. Meeting dates: 20 July, 17 August	Chair of Committee/ Chief Nursing and Quality Officer	75 79	14:35	Assure
3.5	Safe Staffing Review Update	Chief Nursing and Quality Officer	83	14:50	Note
4. Strategy and Resilience					
4.1	Integrated Care System Update	Chief of Staff	87	15:00	Note
4.2	Board Assurance Framework	Company Secretary	91	15:10	Note
4.3	Winter/Covid Planning 2021/22	Chief Operating Officer	111	15:20	Note
4.4	Medway Innovation Institute – 1st Annual Report	Chief of Staff/ Associate Non-Executive Director	113	15:25	Note
5.	**Financial Stability**				
5.1	Finance Report - Month 4	Chief Finance Officer	161	15:35	Note
5.2	Finance Committee Assurance Reports. Meetings: 29 July, 26 August 2021	Chair of Committee/ Chief Finance Officer	179 183	15:45	Assure
6.	**Our People**				
6.1	People Committee Assurance Report. Meeting date: 20 July	Chair of Committee/ Chief People Officer	187	15:55	Assure
7.	**Any Other Business**				
7.1	Council of Governors Update	Lead Governor	Verbal	16:05	Note

Agenda

Subject		Presenter	Page	Time	Action
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: 04 November 2021, 12:30 – 15:30				

Chief Executive's Report – September 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

Over the last month we have experienced a steady increase in the number of COVID-19 patients in the hospital. Although this has not reached the levels of the previous waves, it has still represented significant challenges for colleagues across the Trust.

This increase in cases provides a timely reminder of the impact that the virus can have, and we continue to exercise strict infection control practices on site, with the need for hand hygiene, mask wearing and social distancing continually reinforced.

Care Quality Commission report

At the end of July the Care Quality Commission published a report following visits to the hospital, and I was pleased to see improvements noted within the inspection team's feedback.

The CQC had visited in April and May to carry out inspections of Medical and Older People's services, and Children and Young People's services. They also reviewed the leadership of the Trust.

Our staff have worked incredibly hard throughout the pandemic to deliver safe and compassionate care to our community, and we were pleased that the CQC recognised some of the improvements the Trust had made since its last inspection.

The Trust's overall rating remains unchanged as 'requires improvement' but the CQC has acknowledged improvements leading to positive changes in some domains, including:

- Services for children and young people are now rated as 'good' in the safe domain.
- Medical care is now rated as 'requires improvement' from 'inadequate'.
- The Trust's well-led rating is now rated as 'requires improvement' from 'inadequate'.

We know we still have more to do to consistently deliver the safe, high quality care that our patients expect, and we are working closely with clinicians to implement our improvement plan and achieve this aim.

Recovery Support Programme

We have for some time been receiving support from colleagues at NHS England/ Improvement to help us improve care in areas where we have been particularly challenged.

Nationally an NHS System Oversight Framework has now been created, combining the previously separate oversight and improvement arrangements for Trusts, and we will in future be taking advantage of support through this new Recovery Support Programme.

We welcome the support that we can access through this programme to provide extra capacity or expertise where we identify that additional support will help us work on our challenges and achieve improvements over the next few months.

Our leadership team is, of course, committed to supporting all of our staff to improve the experience of our patients, including recovering from the additional pressures resulting from COVID-19. This is an opportunity for us all to work together to build better and more sustainable services for our community with specialised support during this period.

Rapid Improvement Week

In July we held a Rapid Improvement Week focusing on the patient, and specific objectives, driven by clear and measurable goals. It provided an opportunity for colleagues to come together to test ideas, internal professional standards and the latest best practice.
Some of the aspirations for the event included reducing length of stay, a reduction in hospital acquired harm, an improvement in staff and patient experience and launching revised processes to enable the best of care.
Throughout the week members of the Executive Team visited the frontline on 'Gemba' walks, to provide them with an opportunity to see first-hand some of the changes and initiatives being trialled.
The week was a success, with numerous tests of change now being adopted into business as usual as well as other tests that will, with some adaptations, be piloted over the coming weeks.
Thank you to all colleagues involved for their enthusiasm and commitment; it was a busy and challenging week, but one that led to some great changes throughout the Trust, all of which will lead to improvements in the care we provide for our patients.

Ruby Ward

A public consultation has been launched on proposals to relocate Ruby Ward, the inpatient mental health ward, from Medway to a new purpose-built unit in Maidstone. The seven-week consultation, led by Kent and Medway Clinical Commissioning Group, will run until midnight on Tuesday 21 September.
Ruby Ward is currently run by Kent and Medway NHS and Social Care Partnership Trust (KMPT), caring for older women with functional mental illness, for example severe depression, schizophrenia or bi-polar disorder.
KMPT is proposing a new unit designed specifically to meet the needs of older adults with complex mental illness, with single en suite rooms and dedicated space for a range of therapies such as counselling, group therapy and creative activities. The move would ensure the Trust could meet a national Government target of eradicating all dormitory style wards for mental health patients by 2024.
Full details including a questionnaire are available at www.kentandmedwayccg.nhs.uk/get-involved/ruby-ward. The consultation will also include virtual public meetings and face to face drop in exhibitions.
Freeing up the area occupied by KMPT within the hospital will provide more space for patient care and support our estates strategy.

Annual Members' Meeting

The Annual Members' Meeting of Medway NHS Foundation Trust will take place at 6pm on Thursday 16 September 2021. You will hear from me and from our Chair, as well as other presentations on improvements at the Trust. Due to the current Covid position, this will be a virtual meeting on Microsoft Teams only.

To book your place, please visit https://medwayamm2021.eventbrite.co.uk
For any further information, please email met-tr.members-medway@nhs.net

Communicating with colleagues and the community

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

NHS
Medway
NHS Foundation Trust

Communications Update
September 2021

Total social media impressions

62,000

Media mentions

101

NHS
Medway
NHS Foundation Trust

ELIZABETH'S STORY

Best of care
Best of people

Our
Medway

Elizabeth's Story

Elizabeth, aged 90, was brought into hospital by ambulance following a fall and injuring her hip, and remained in hospital until she sadly passed away five days later.

Initially the family felt that Elizabeth was well cared for by the Emergency Department and the Trauma and Orthopaedic Teams. They felt included and involved in decision making and were realistic that surgery was a risk in view of Elizabeth's age and existing health conditions.

Elizabeth was cared for post-operatively on Pembroke ward where her condition deteriorated and sadly passed away.

Sarah and her family have overwhelming respect for the NHS, however they did not feel included in decisions about her care or listened to when Elizabeth's condition deteriorated.

Sarah describes how she wanted to talk to somebody about her experience, she was reluctant to make a formal complaint, but felt that those that she spoke to were not responsive and guided her towards the formal complaints route. Sarah felt she had no other option but to make a formal complaint.

The complaint was responded to, however Sarah was unsatisfied with the response as the response was not empathetic and did not fully address her concerns. Sarah felt that she had no alternative other than to refer the case to the Parliamentary and Health Service Ombudsman (PHSO).

There are some key messages from this story in relation to the importance of including relatives on the journey of care and how we deal with immediate patient concerns.

Elizabeth's Story

COPY AND PASTE LINK BELOW TO WATCH VIDEO

https://360.articulate.com/review/content/533cb4ae-801f-4413-8818-1416b16bd7d2/review

Actions taken to share the learning from Elizabeth's experience.

The PHSO identified missed opportunities for better communication with the family, particularly when a patient's condition deteriorates.

Actions and learning by the Trauma and Orthopaedic Team:

During the junior doctor teaching session on 23 December 2020 the following was taught and fully discussed:

- importance of involving relatives in discussions prior to signing DNACPR forms.
- importance of a family member being involved in decisions about care when a patient deteriorates
- awareness of the risks of Morphine / analogue medication for elderly patients, particularly those with a history of chronic renal failure
- effectiveness of infusing Naloxone as a reversal agent rather than a single short acting dose
- Elizabeth's care, along with the actions and learning, was fully discussed at the Trust mortality and morbidity meeting.

Actions taken by the nursing team on Pembroke ward

- This family's feedback has been used to reflect on how we could have improved their experience. Reflecting on feedback and attending empathy training, which helps to put yourself in others' shoes, has helped us to communicate more effectively with families and manage worries that both patients and relatives may face. Communicating with empathy is a priority for nursing teams.
- A clinical sister for each ward in planned care is registered to attend the empathy training and share their learning.
- The learning from this complaint has been shared at the divisional governance meeting.

Trust-wide learning

- It is recognised that actions from learning in relation to this complaint were not progressed in a timely manner and is indicative of the complaints challenges that the Trust faced with managing the complaints process and embedding learning.
- In recognition that the Trust did not meet the complaints standard and the complaint response was not always person centred the Chief Nursing and Quality Officer commissioned a review of complaints management.
- The revised complaints process began in April 2021 and includes early discussion with each complainant to agree the scope of investigation, this interaction gives the complainant the opportunity to describe their experience, be listened to, acknowledge the concerns raised and in partnership set the scope of the investigation.
- The central complaints team supports the divisions to ensure that the response letter answers the scope of investigation and is empathetic and details learning before it is sent to the complainant, promoting a person centred approach when responding to complaints.
- In addition, the introduction of a new approach offering early mitigation and resolution by the PALS team has been embedded which endorses receptiveness to feedback and a compassionate approach promoted to address concerns raised.
- There is a notable reduction in the number formal complaints being received following contact with the PALS team, demonstrating the effectiveness of the revised ethos and approach
- Empathy training sessions have been commissioned, facilitated and offered to staff across the Trust, promoting a person-centred approach to patient feedback, complaints and learning. This relates very much to Sarah's comment of asking yourself if you have truly listened and understood the patient perception while delivering care.

- The ethos of early resolution is promoted within the Trust so that the complainant feels listened to and has assurance that the concerns which they raise will be addressed, responded to and learning identified.

- The co-design and development of the Trust's new patient experience strategy is being produced in partnership with service users, staff and stakeholders and will be key to endorsing our vision of how we receive and respond to patient feedback, truly listen to what our patients are telling us, and act on the information to improve patient experience.

- Working in partnership with our cultural change programme there is a need to refocus our approach to patients and their families to ensure their experience should be considered as much of a priority as safe and effective care. This requires focused leadership which role models an approach to patients truly demonstrating 'Putting the Patient First' as an ethos of the Trust.

- The Chief Nursing and Quality Officer has commissioned the development of a framework to support the Trust's approach to sharing and using patient stories and ensuring actions and learning are embedded and shared. This work is under development by the Patient Experience Team.

Minutes of the Trust Board PUBLIC Meeting

Thursday, 08 July 2021 at 13:00 - 15:30

Meeting via MS Teams

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	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)
	Harvey McEnroe	Chief Strategy and Integration Officer
	Jenny Chong	Associate Non-Executive Director
	Paula Tinniswood	Chief of Staff (Interim)
	Rama Thirunamachandran	Academic Non-Executive Director
Attendees:	Alana Marie Almond	Assistant Company Secretary (Minutes)
	David Seabrooke	Company Secretary
	Glyn Allen	Lead Governor (Associate)
	Michael Addley	Deputy Director of Communications (Deputising for Glynis Alexander)
	Michael Beckett	Director of IT (Item 6.2)
	Sheila Adam	NHSEI Improvement Director
Observing:	Katie May Nelson	Local Democracy Reporter, Medway (Kent Online)
Apologies:	Adrian Ward	Non-Executive Director
	Gary Lupton	Director of Estates and Facilities
	Glynis Alexander	Director of Communications and Engagement

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 soon. Chair continued with the following highlights:

a) Despite the increase in Covid-19 cases, this has not translated into increased Covid admissions at the Trust. Earlier this week the Trust celebrated a very special moment of zero Covid inpatients for the first time since the pandemic began. Trust staff continue to work hard to reduce the backlog of patients awaiting treatment and are making steady progress with this. Thank you to all our staff for their hard work over many months.

b) It is important to remember that the pandemic is far from over, so Chair encouraged the community to please continue following all government guidelines and have the Covid-19 vaccination if not done so already.

c) Earlier this week the Trust celebrated the 73rd anniversary of the birth of the NHS; it is a particularly poignant year for as the NHS reflects on the contribution of staff during the pandemic and throughout the 73 years of the NHS. The Trust also reflected on those that it has lost. The Charitable Trust are working on a way to commemorate those lost in a permanent way.

d) The Trust is proud to serve its community and be at the very heart of it and the hospital has had fantastic support throughout the pandemic. That support has never been more evident than this week. Chair said a big 'thank you' to Chatham Town Football Club, construction firm Bauvil and other local businesses who organised a very special event to thank staff for their hard work throughout the pandemic. The family fun day, which took place on Sunday, raised money to help improve facilities and staff areas at Medway Maritime Hospital. Which is much needed in a high-pressure time for all at the hospital.

e) Chair also thanked the Trust's friends at the Rapid Relief Team who provided hospital colleagues with a free lunch and refreshments this week.

f) Finally, Chair thanked Chief Strategy and Integration Officer, Harvey McEnroe, who was attending his final Board meeting. Harvey has secured the position of Director of Vaccine Integration at the national programme, working on the long-term plans for vaccine deployment across primary, secondary and community care. Harvey made an invaluable contribution to the Trust; particularly during the pandemic as Strategic Commander, and Chair wished him every success for the future and he goes with the best wishes of all Board members.

1.2 Quorum

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

1.3 Conflicts of Interest

There were no conflicts of interest raised.

1.4 Chief Executive Update

George Findlay, Chief Executive gave an update to the Board providing an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. The Board was asked to note the report and George gave the following key highlights:

a) **Covid-19:** George was pleased to say that throughout the month the Trust has continued to see only a low level of admissions for patients with Covid-19, despite the increase in community transmission. While the Trust must still be alert to the impact that the virus can have in addition to ensuring staff and patients continue to exercise strict infection control practices on site; the Trust is also focused on the recovery of its services. George urged members of the public to continue to be safe and have their vaccine.

b) The Trust has now fully restarted elective operations and surgery for cancer patients, outpatients and diagnostic services, but a crucial aspect of work over the next few months will be reducing the current backlog of cases. The Board understands it is extremely upsetting for our patients to have to wait a significant period for treatment, and staff are committed, and working very hard, to reduce these waiting times as quickly as possible. George gave his thanks to the team for their efforts.

c) **Improving how we make calls:** Last month the Trust launched a new telephony system. It is a long overdue update, with the previous system being more than 25 years old. 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. George gave apologies to anyone who may have waited slightly longer than usual to get through to the Trust during this time.

d) Ofsted inspection of Apprenticeship Centre: Last month the Trust had an Ofsted inspection of its 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 provided. The inspectors said there is a strong curriculum and were clear about the rationale for why the Trust provides apprenticeships. It was evident learners are developing skills consistent with Trust strategic objectives, and that the Trust is prepared in relation to the safeguarding of learners, and have an excellent wellbeing offering. There were areas for improvement, to be worked on. A 'Reasonable' rating was awarded for all three domains; this is good progress at this stage.

e) **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 the Staff LGBTQI+ Network hosted a number of events for colleagues to come and listen and talk and to understand more. It is important for the Trust to continue to work on inclusion and diversity.

f) **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. George said 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.

g) **News@Medway:** the latest edition of News@Medway is now available on the website. The Trust's 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. Please take some time to have a read of this.

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 03 June 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 action:
TBPU/21/123

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) There has been an increase in C-sections. There has been a deep dive at QAC. A report will be submitted to the August QAC and will report back to Board in September as to why there has been an increase. **Action No: TBPU/21/124:** Jane Murkin
   2) CDiff; there is a link with CDiff and Covid. A refreshed post-infection review process has been implemented. Jane is assessing the process and learning from Cdiff cases to be able to report back to QAC and the IPC Committees. There is focus on hospital acquired infection in the Trust Improvement Plan.
   3) Chair asked about mixed sex accommodation for transgender patients and how is the Trust protecting their dignity. Jane would report back. **Action No: TBPU/21/125:** Jane Murkin

b) Angela Gallagher, Chief Operating Officer (Interim), presented to the Board for noting.
   1) Emergency care - ambulance wait time, 4 hour standard and total time patients spend in ED: the Trust saw an improvement in metrics from the work of the patient first group. There has been an increase in attendance since March, therefore there has been a deterioration in 4hr standard and ambulance wait times. The Trust is focusing work on acute care. Discharge and flow is being managed and improved throughout the site. Improvement work overall with continue on ED and flow in hospital.
   2) RTT elective: there has been an improvement against all metrics. The Trust is meeting activity targets and reducing number of patient wait time. RTT performance is improving month on month. The growth in waiting list is in line with other trusts in the area and MFT is delivering against the plan.
   3) Cancer: the 2 week wait has been maintained through the pandemic. The focus is on patients who have waited over 62 days for treatment. The cancer recovery plan is in place and the Trust currently is matching trajectory set. Treatments are increasing month on month. The Trust is back to pre-pandemic rate on referrals and is reducing the wait time for first appointments. For the 62 day pathway, the team have process mapped the tumour site pathways again to maximise all opportunities to ensure the pathways are as effective as possible. The management oversight has improved as well and vacancies are being filled. There is much more work to do but is being tracked positively. Very few patients are waiting 6 weeks for their diagnostics.

c) David Sulch, Chief Medical Officer, presented to the Board for noting.
   1) HSMR has climbed for four months up to February. There has been no update for June due to data supply. July data will give information up to April, which will be sent in the next week. Chair asked David to ensure that the Trust is doing everything it can to improve on this. George said it would be useful to see output from Structured Judgement Review and the depth and effectiveness of clinical coding. **Action No: TBPU/21/126:** David Sulch to take an update on HSMR data to QAC in August.

3.2 Quality Assurance Committee Assurance Report. Meeting on 22.06.21

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

a) Actions taken to mitigate risks associated with paediatric patients in the Paediatric Inpatient Ward waiting for Tier 4 beds.
b) CQC Inspection on Infection Control. **Action No: TBPU/21/127:** Jane Murkin to submit a report to September Board.

3.3 Clinical Negligence Scheme for Trusts – Final Sign-Off
Jane Murkin, Chief Nursing and Quality Officer, presented to the Board for noting. The Board was 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.

3.3.1 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.

3.3.2 At the 2 December 2020 meeting of the Trust Board the Chief Nursing and 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.

3.3.3 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. The Board will have oversight of evidence as set out in the technical guidance.

3.3.4 Chair and Mark Spragg thanked Jane Murkin and her team for the work and final submission.

3.3.5 Chair asked Jane to look at mandatory training rates, as the Board would expect at least 95% compliance; colleagues must be encouraged to complete training.
Action No: TBPU/21/128: Jane Murkin

3.3.6 The Board APPROVED the final sign-off of the Clinical Negligence Scheme for Trusts.

3.4 Board Assurance Framework and Corporate Risk Register Review
Gurjit Mahil, Deputy Chief Executive, presented to the Board to assure. In the current reporting period the Trust has seen the increase of one risk, patient flow (5c).

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

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

3.4.3 Figure 1.2 in the paper, showed 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. 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.

3.4.4 Patient Flow risk has been increased due to the current pressures and this risk is being mitigated through the appropriate work streams.

The corporate risk register includes 27 risks assigned to Executives.

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

3.4.6 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.

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

3.4.8 Building on from the work at the deep dive meetings and the monthly RAG meetings, 6 risks have reduced in score.

3.4.9 Action deadline dates are being worked on and monitored through the Board committees.

3.4.10 Chair thanked Gurjit Mahil for all her hard work, the Trust is in a much better risk management position than it has been.

4 Strategy and Resilience

4.1 Integrated Care Partnership and System Update

Harvey McEnroe, Chief Integration and Strategy Officer, presented the Board for noting. The report provided Board members with an overview of key system activity across the ICP and the ICS since the last meeting. At the request of the QAC the paper also takes a deep dive into the work of the ICP and the ICS into Mental Health across the Place and the ICP.

4.1.1 The first draft of the operating model has been submitted to NHSEI. In terms of form and function of the ICP this is in discussion; function first on how the Trust develops and then how it fits into ICS structures.

4.1.2 The Partnership Board is focused at ICS level and there is focus on the importance of working collaboratively. There will be a number of workshops coming up when meetings are face to face.

4.1.3 Mental health work will be monitored through QAC. Harvey, David Sulch and Jane Murkin are working on this.

4.1.4 Chair would talk to fellow Chairs on adding the University to the Partnership Board.

4.1.5 New oversight model to be added to Board work plan by David Seabrooke.

4.2 Emergency Planning Resilience and Response – Update Report

Harvey McEnroe, Chief Integration and Strategy Officer, presented the Board for noting. The report provided an update on the work currently underway with the EPRR team. 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.

a) Work is in progress to move the Trust forward on EPRR following the learning from Covid-19. The Board noted the work and gave thanks to Keith Soper and Steve Arrowsmith who are continuing on work with emergency response to covid and planning for future waves.
b) Business continuity; there is focus on a few areas specifically on-site media centre and fall back incident control area.
c) Training and exercises; face-to-face training has recommenced in the emergency planning process; the compliance for senior manager is at 100%.
d) Incident response training sessions are planned in the next two months, the two missed last year during the pandemic will be completed.
e) There has been progress on recruitment of new officers to be appointed to the EPRR team.

5 Financial Stability

5.1 Finance Report - Month 2

Alan Davies, Chief Finance Officer, presented to the Board for noting. The Trust reports a breakeven against the NHSE/I control total. Month 3 is looking to report a breakeven position but there is an increase in emergency services with increased activity.

a) Trust surplus - 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.
b) Efficiencies programme - 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.
c) The PMO and Finance teams are currently working with Care Groups and Divisions to identify schemes and following up on the first efficiencies show case events that happened in June. There is to be a follow-up event in July 2021 and firming plans by the end of August 2021. Alan will continue to report progress through the Executive and Committee. It is a promising start for the first part of the Trust's financial year.
d) George thanked Alan and the team; the Trust needs to continue to focus on efficiencies and managing budgets.

5.2 Finance Committee Assurance Report. Meeting on 24.06.21

Annyes Laheurte, Chair of the Committee, presented to the Board for assurance. The paper was taken as read. The summary of decisions made at the Committee was:

a) The proposed arrangements to provide stronger governance and oversight of the efficiency programme was AGREED.
b) It was AGREED that the detailed action plan in response to the NHSEI intensive support unit recommendations would be presented at the next meeting.
c) 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'.
d) There was nothing to escalate to the Board or any other Committee. The Board noted the decisions made and the positive progress being made.

5.3 Integrated Audit Committee Assurance Report. Meeting on 07.06.21

Mark Spragg, Chair of the Committee, presented to the Board for assurance. The paper was taken as read. The summary of decisions made at the Committee was:

a) 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.
b) The Committee APPROVED the letter of representation subject to completion of the audit and an update to 'Point 5' confirming those accounting estimates applied.
c) Value for money piece of work is still to be completed by the auditors later in year. The auditors signed off the report and final laying of the report before parliament will happen after this piece of work is done. Chair asked David Seabrooke to keep the Board informed on this.
d) Head of Internal Audit Opinion was: "Significant assurance with minor improvements".
e) Chair gave her thanks to the Committee for approving the accounts and the additional activity to finalise the audit opinion. There was lots of extra effort from Gurjit Mahil, her team and the Finance team. This is much appreciated by the Board.

6 Innovation

6.1 Trust Improvement Plan - Update

Angela Gallagher, Chief Operating Officer (Interim), presented to the Board to note the progress made. The paper provided a progress update on the four keys Missions and interrelated elements of the Patient First programme within the Integrated Care Improvement Pillar (of the Trust Improvement Plan).

6.1.1 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.

6.1.2 George stated that the discharge work is extremely important as it unlocks pathways. MADE events are helpful and they help to make discharges but the existence of the MADE events suggest things are not working correctly. George recognized that there are successes and discharge rates are improving, the right work is being done but the pace needs to increase. He thanked Angela for her efforts.

6.1.3 George stated that there are capacity issues in primary secondary and community care. There is work for the Trust to do, it is important that silo working stops and relationships between primary and secondary care are developed and techniques that get interactions improved. If the community are given a better offer then they would be less likely to be referred to A&E, this will help greatly.

6.1.4 Angela confirmed that the Trust is part of the Outpatient Transformation Group led by the CCG; this is where the infrastructure is being developed.

6.2 Digital Update

Paula Tinniswood, Chief of Staff and Michael Beckett, Director of IT, presented to the Board for noting.

a) Digital solutions within the NHS, including the Trust, have not developed at the required pace over the last 10-15 years. This has meant that basic IT has not always been helpful to clinicians, systems cannot communicate with each other and utilisation of evolving technology has been slow. Digital transformation within the NHS has the potential to release front-line staff back to care, improve patient experience and advance clinical outcomes.

b) The Trust developed a digital strategy in 2020 to ensure that digital services support the needs of its 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.

c) The paper focused on providing an update to key projects currently being delivered or completed. It also focused on updates to be made to the digital strategy to support new technology for the Trust and in line with national strategies. The Project Delivery was detailed in the report and Michael highlighted some of the content.

d) Chair asked for a map of governance to be submitted to Board. Where does the governance of technology and innovation go through the organization? Does it need more visibility, what forums should it go to and what frequency should it report to the Board. Paula confirmed that she is working on enhancing the foundations to give the confidence that patients are being treated the right way and will continue to update the Board. **Action No: TBPU/21/129:** Paula Tinniswood.

8 Any Other Business

8.1 Council of Governors Update

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

a) Twelve new Governors are now in place from 1 July complimenting the existing Governors and the first Council meeting will be on 22 July 2021.
b) The last Members' Meeting discussing innovation and improvement was held on 27 June 2021.
c) 'Meet the Governors' event will be held on 21 July 2021 and will hopefully be the last time it is held virtually.

d) The Annual Members Meeting is planned for 16 September 2021.
e) On behalf of the Governors Glyn wanted the Board to note their thanks to Harvey McEnroe for all of his hard work and best wishes for the future.
f) This would be Glyn's last Board meeting as Lead Governor, there will be a new Lead Governor appointed in September 2021.
g) Chair stated from 22 July the Governors would be reinstating the previous format of how the Council meetings are run. The NEDs will position their work with their committees, followed by the Governors who attend the committees and the Executives would be available to update on specific activities within the Trust and to answer any questions.
h) Chair gave her thanks to Glyn for all of his efforts leading the Governors, for his participation as a Governor prior to being Lead Governor and for his work with the Finance Committee. Glyn has been a huge support to the Trust and Chair is delighted Glyn is remaining involved as a member of public on the Sustainability Group.

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, 09 September 2021, 12:30 – 15:30.

The meeting closed at 15:15

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Thursday, 08 July 2021

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

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

Actions are RAG Rated as follows:

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
15-Apr-21	TBPU/21/118	Submit the Patient Experience Strategy to the Board	04-Nov-21 ~~08-July-21~~ ~~06-May-21~~	Jane Murkin, Chief Nursing and Quality Officer	An extension to the deadline was agreed by the Executive Team and QAC - the refreshed timelines will be draft in Sept then come to Board in November - the work plan will be updated by CoSec	Amber
08-Jul-21	TBPU/21/124	Report to be submitted on why there has been an increase with C-Sections. To go to the QAC then to Board.	09-Sep-21	Jane Murkin, Chief Nursing and Quality Officer		
08-Jul-21	TBPU/21/125	What protection is in place for mixed sex accommodation for transgender patients?	09-Sep-21	Jane Murkin, Chief Nursing and Quality Officer	**September Update:** Transgender patients and patients who are undergoing gender reassignment should be cared for in line with their wishes and the same sex accommodation policy applies equally to transgender patients as it does with other patients.	
08-Jul-21	TBPU/21/126	Report to QAC on climbing HSMR, to include output from Structured Judgement Review and the depth and effectiveness of clinical coding.	09-Sep-21	David Sulch, Chief Medical Officer	**September Update:** Full overview of the mortality issues will come to the Board Development Session on 7 October 2021.	Green
08-Jul-21	TBPU/21/127	Report to the Board on the CQC Inspection on Infection Control.	09-Sep-21	Jane Murkin, Chief Nursing and Quality Officer	**September Update:** Jane will provide a verbal update to the Board	Green
08-Jul-21	TBPU/21/128	Look at the mandatory training rates (Maternity/CNST), as the Board would expect at least 95% compliance, colleagues must be encouraged to complete training.	09-Sep-21	Jane Murkin, Chief Nursing and Quality Officer		
08-Jul-21	TBPU/21/129	Map of Governance for Technology and Innovation to be submitted to the Board.	09-Sep-21	Paula Tinniswood, Chief of Staff	**September Update:** local diagram completed - will feed into governance review	Green

Meeting of the Board of Directors in Public
Thursday, 09 September 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 (Interim)		
Lead Director	Jane Murkin – Chief Nursing and Quality Officer Gurjit Mahil – Deputy Chief Executive		
Executive Summary	This report informs Board Members of the quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for June shows that the Trust has had 0 MRSA bacteraemia cases and 4 hospital acquired C-diff cases. March's overall HSMR rate is 108.10, the weekend HSMR rate is at 115.16 and links to risks during the weekends with Bed Occupancy. **Caring** Unfortunately, whilst MSA had shown improvement, July has seen that 143 breaches were recorded. This has mainly been in the high dependency unit and at weekend periods where bed occupancy within the organisation was high. The Friends and Family recommended rates for three areas, remain close or above the national standard of 85% (Inpatients: 81.64%, Maternity: 98.7%, Outpatients: 87.71%). The ED recommended rates have reduced to 73.59%, the feedback received is currently being under review to identify themes. **Effective** Discharges before Noon, whilst close to the Mean are still below at 14.49% and significantly below the Target of 25%, this is being reviewed through the rapid improvement work. **Responsive** The Trust continues to deliver the elective programme working with system partners for key clinical pathways. In July the RTT standard was 68.43% and the Trust recorded 271 52 week breaches which is lower than previous months. ED (Type 1) 4 hour performance as a result of site pressures reported 66.73% in July. Additionally, the Trust saw 319 Ambulance Handover delays of +60mins. The DM01 Diagnostics performance is at 93.57% for July 2021. In June 2021, 95.83% of patients were seen within 2 weeks of their referrals into the cancer pathways and 62.82% of patients were treated within 62 days.		

	Well Led We have seen a stable position in appraisal rates, reporting 83.15% and the Trust has maintained compliance statutory and mandatory training at 89.89%. 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 NHS 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 – July 2021

Integrated Quality and Performance Report

Reporting Period: July 2021

What is Statistical Process Control (SPC)?

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

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

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

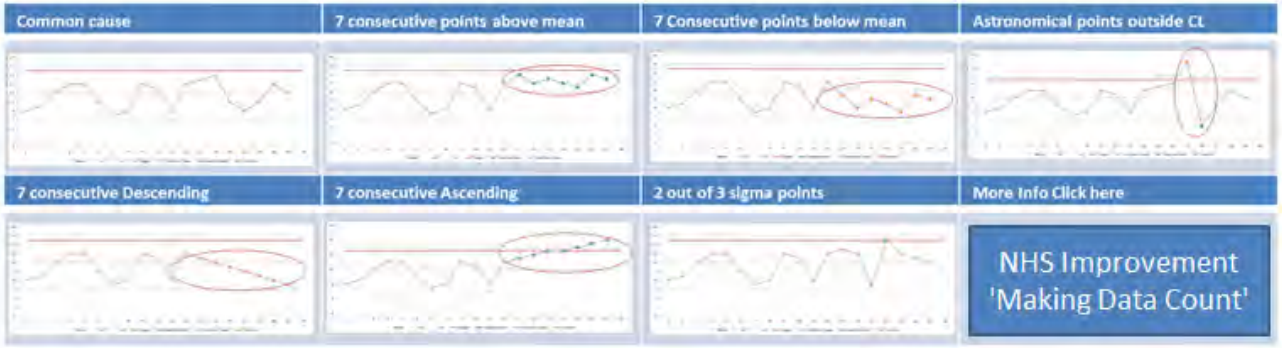
Key Facts about a SPC Chart:

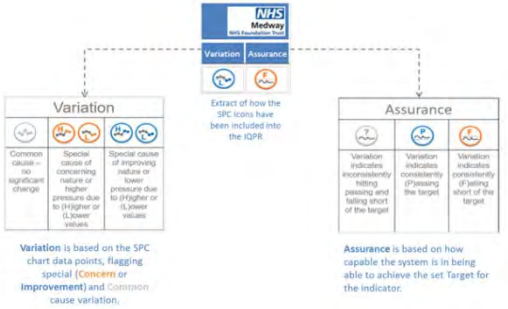
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

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

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

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





Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Vital Signs improvement (VTE, PU, Falls)	• Flow, Emergency & Elective Pathways
Caring	• The Friends and Family recommended rates for Maternity services and Outpatients are above the national standard of 85%.	• High number of breaches in Mixed Sex Accommodation continues • EDNs completed within 24hrs is below LCL's, has continuously decreased and not met the target set • % Complaints responded to within target has declined
Effective	• VTE Risk Assessment % Completed, whilst still under target, has continued to show improvement • Maternity 12+6 Risk Assessments, whilst still slightly under target, has shown improvement and remains very close to achieving	• High statistical variance in Readmission rates evidenced • Discharges before Noon are significantly below the target of 25% and have continuously not met this. • Total C-Section Rate is continuing to increase and is above UCL and Target
Safe	• Falls per 1,000 Bed Days, together with PU Incidence, continuously passes (achieves under) the target set • 0 Never Events in month • Trust Attributable MRSA cases have reported 0 for Jun-21	• Overall HSMR levels above the national threshold (100) • % of SIs response rate has dipped to below 100% (Target) for the second consecutive month • Trust attributable Cdiff cases above plan in Jun-21
Responsive	• Cancer 2ww & 31day Performance has exceeded the target • Whilst still above target, RTT over 52 week breaches continues to decrease for a 3rd consecutive month • DToC levels have reduced	• 60min Ambulance Handover delays have increased and ED 4-hr compliance has decreased • RTT Incomplete Performance decreased plus the PTL size is showing signs of increasing • Cancer 62day metric showing under-performance
Well Led	• Maintained compliance with Trust target for StatMan Compliance. • Appraisal %, Sickness rates & Turnover - whilst all slightly above plan, are showing improvement against YTD position	• Agency spend has stabilised in month but bank spend has increased considerably • CIP schemes currently shows an under plan position

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

Best of care Best of people

Trust Domains		Variation (L)	Variation (H)	Variation (L)	Variation (H)	Assurance (P)	Assurance (F)	Assurance (?)	
Caring									
Admitted Care	4	1	0	0	0	0	1	4	0
ED Care	2	0	0	0	0	0	1	1	0
Maternity Care	2	0	0	0	0	1	0	1	0
Outpatients Care	1	1	0	0	0	1	1	0	0
Effective									
Best Practice	3	0	2	0	0	0	2	3	0
Maternity	3	0	1	0	0	0	3	1	0
Safe									
Harm Free Care	2	0	0	0	0	2	0	0	0
Incident Reporting	1	1	0	1	0	1	0	1	1
Infection Control	3	0	0	1	0	2	0	1	1
Mortality	1	0	2	2	0	0	3	2	0
Responsive									
Bed Management	2	0	0	3	0	2	2	1	0
Cancer Access	2	1	1	0	1	0	0	5	0
Complaints Management	0	1	0	1	0	0	0	2	0
Diagnostic Access	1	0	0	0	0	0	0	1	0
ED Access	2	1	1	0	0	0	2	2	0
Elective Access	0	1	2	0	0	0	2	1	0
Theatres & Critical Care	2	0	0	0	0	0	0	2	0
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)	Jun-21	3	4	43	44		
S2	Number of C-diff (HAI)	Jun-21	0	3	0	31		-
S3	MRSA Bacteraemia (Trust Attributable)	Jun-21	0	0	5	0		
S4	E-coli (Trust Acquired)	Jun-21	2	5	30	52		
S5	Falls per 1000 bed days	Jul-21	6.63	4.79	6.63	4.95		
S6	Pressure Ulcer incidence per 1000 days (M/H)	Jul-21	1.04	0.00	1.04	0.03		
S7	Never Events	Jul-21	0	0	0	2		
S8	% of SIs responded to in 60 days	Jul-21	100%	53%	100%	97%		-
S9	HSMR (overall)	Mar-21	100	108.10	100	100.70		
S10	HSMR (weekday)	Mar-21	100	105.56	100	97.82		
S11	HSMR (weekend)	Mar-21	100	115.16	100	108.90		
S12	SHMI	Feb-21	1	1.05	-	-		

Caring			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
C1	Mixed Sex Accommodation Breaches	Jul-21	0	143	0	1661		
C2	New Complaints	Jul-21	41	45	-	695		
C3	% Complaints responded to within target	Jul-21	85%	48.15%	85%	63.13%		
C4	% EDNs completed within 24 hours	Jul-21	100%	65.85%	100%	68.82%		
C5	Inpatients Friends and Family Response rate	Jul-21	22%	20.45%	22%	19.14%		
C6	Inpatients Friends and Family % recommended	Jul-21	85%	81.64%	85%	81.66%		
C7	ED Friends and Family Response rate	Jul-21	22%	13.04%	22%	15.28%		
C8	ED Friends and Family % recommended	Jul-21	85%	73.59%	85%	83.22%		
C9	Maternity Friends and Family Response rate	Jul-21	22%	28.47%	22%	30.00%		
C10	Maternity Friends and Family % recommended	Jul-21	85%	98.70%	85%	97.91%		
C11	Outpatients Friends and Family Response rate	Jul-21	22%	8.50%	22%	10.88%		
C12	Outpatients Friends and Family % recommended	Jul-21	85%	87.71%	85%	89.07%		

Responsive - Non-Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R1	Bed Occupancy	Jul-21	85%	86.97%	85%	81.08%		
R2	Average Length of stay (Non-elective)	Jul-21	5	8.67	5	9.09		
R3	Average Length of stay (Elective)	Jul-21	5	2.28	5	2.51		
R4	% of Delayed Transfers of Care	Jul-21	4%	0.95%	4%	0.49%		
R5	% Medically Fit For Discharge	Jul-21	7%	12.68%	7%	10.77%		
R6	ED 4 hour performance (All)	Jul-21	95%	76.88%	95%	83.43%		
R7	ED 4 hour performance (Type 1)	Jul-21	95%	66.73%	95%	74.30%		
R8	ED 12 hour DTA Breaches	Jul-21	0	3	0	428		
R9	Ambulance Attendances	Jul-21	-	3,363	-	50,909	-	-
R10	60 minute handover delays	Jul-21	0	319	0	3123		

Effective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
E1	7 day readmission rate	Jun-21	5%	6.17%	5%	6.95%		
E2	30 day readmission rate	Jun-21	10%	12.23%	10%	13.35%		
E3	Discharges before noon	Jul-21	25%	14.49%	25%	14.54%		
E4	Fractured NOF within 36 hours	May-21	100%	84.60%	100%	73.29%		
E5	VTE risk assessment % completed	Jul-21	95%	86.25%	95%	95.02%		
E6	Elective C-section rate	Jul-21	13%	13.21%	13%	14.78%		
E7	Total C-Section rate	Jul-21	28%	34.91%	28%	37.18%		
E8	Average Occupancy (maternity)	Jul-21	15%	21.70%	15%	22.39%	-	-
E9	12+6 risk assessments	Apr-21	90%	82.61%	90%	86.34%		
E10	Number of deliveries	Jul-21	-	424	-	6190	-	-

Responsive - Elective			Current Month		YTD			
ID	KPI	Period	Plan	Actual	Plan	Actual	Variation	Assurance
R11	DM01 performance	Jul-21	99%	93.57%	99%	78.18%		
R12	18 weeks RTT Incomplete Performance	Jul-21	92%	68.43%	92%	65.07%		
R13	18 Weeks over 52 week breaches	Jul-21	0	271	0	3922		
R14	Operations cancelled by hospital - on the day	Jul-21	0	28	0	192		
R15	Cancelled operations not rescheduled <28	Jul-21	0	5	0	34		
R16	Cancer 2ww performance	Jun-21	93%	95.61%	93%	96.28%		
R17	Cancer 2ww performance - breast symptomatic	Jun-21	93%	95.83%	93%	93.93%		
R18	Cancer 31 day first definitive treatment	Jun-21	96%	99.29%	96%	96.96%		
R19	Cancer 62 day treatment - GP referrals	Jun-21	85%	62.82%	85%	70.75%		
R20	104 day cancer waits	Jun-21	0	6	-	38		

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 %	Jul-21	85%	83.15%	85%	84.44%		
W4	Sickness Rate	Jul-21	4%	5.15%	4%	4.60%		
W5	Turnover rate	Jul-21	12%	12.34%	12%	12.20%		
W6	StatMan compliance	Jul-21	85%	89.89%	85%	88.95%		
W7	Contractual staff in post	Jul-21	-	4211.05	-	65828.95	-	-
W8	Agency spend as % pay bill	Jul-21	4%	4.21%	4%	3.54%		
W9	Bank spend as % pay bill	Jul-21	9%	13.27%	9%	12.01%		
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	Jul-21	0	143.00	0.00	131.43	266.40		
		MSA %	Jul-21	0%	0.93%	0.00%	0.89%	1.82%		
		% of EDNs Completed Within 24hrs	Jul-21	100%	65.85%	67.24%	72.61%	77.97%		
		Inpatients Friends & Family % Recommended	Jul-21	85%	41.67%	73.60%	82.92%	92.24%		
		Inpatients Friends & Family Response Rate	Jul-21	22%	20.45%	15.41%	19.99%	24.56%		
	ED Care	ED Friends & Family % Recommended	Jul-21	85%	73.59%	72.17%	79.71%	87.26%		
		ED Friends & Family Response Rate	Jul-21	22%	13.04%	12.21%	14.65%	17.09%		
	Maternity Care	Maternity Friends & Family % Recommended	Jul-21	85%	98.70%	94.28%	98.82%	100.00%		
		Maternity Friends & Family Response Rate	Jul-21	22%	28.47%	12.02%	26.73%	41.45%		
	Outpatient Care	Outpatients Friends & Family % Recommended	Jul-21	85%	87.71%	87.39%	89.96%	92.53%		
		Outpatients Friends & Family Response Rate	Jul-21	22%	8.50%	10.92%	13.02%	15.13%		

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

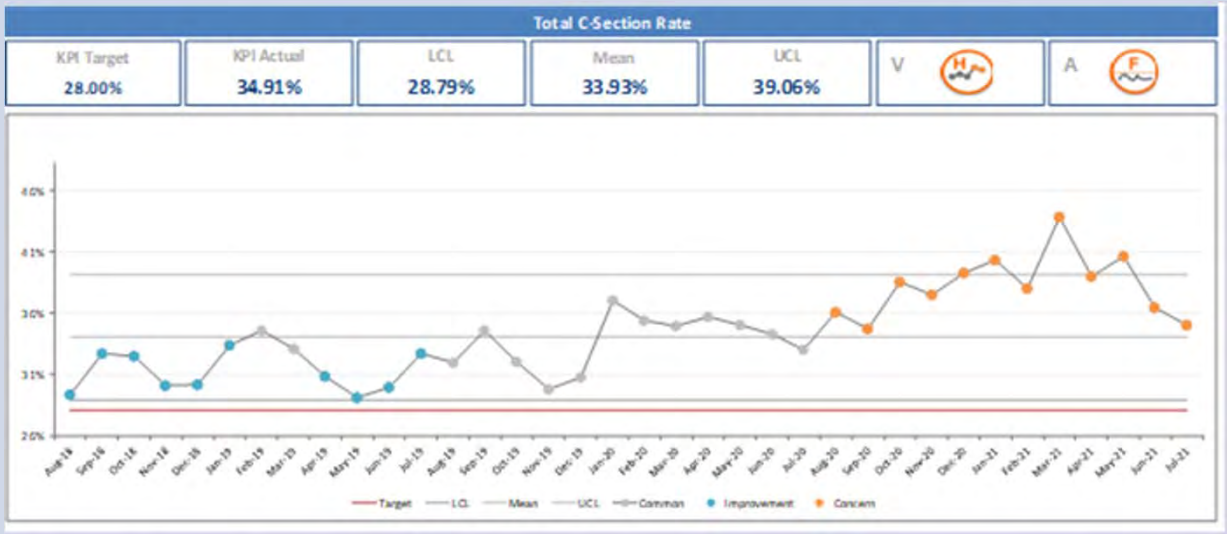
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Effective	Best Practice	7 Day Readmission Rate	Jun-21	5%	6.17%	4.40%	5.96%	7.52%		
		30 Day Readmission Rate	Jun-21	10%	12.23%	9.64%	11.77%	13.89%		
		Discharges Before Noon	Jul-21	25%	14.49%	12.38%	14.83%	17.28%		
		Fractured NOF Within 36 Hours	May-21	100%	84.60%	36.06%	66.21%	96.37%		
		VTE Risk Assessment % Completed	Jul-21	95%	86.25%	79.26%	88.70%	98.14%		
	Maternity	Elective C-Section Rate	Jul-21	13%	13.21%	9.91%	13.69%	17.46%		
		Emergency C-Section Rate	Jul-21	15%	21.70%	15.21%	20.23%	25.25%		
		Total C-Section Rate	Jul-21	28%	34.91%	28.79%	33.93%	39.06%		
		12+6 Risk Assessment	Apr-21	90%	82.61%	78.93%	84.23%	89.53%		

Effective: Total C-Section Rate
Aim: TBC
Latest Period: July – 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 considered 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

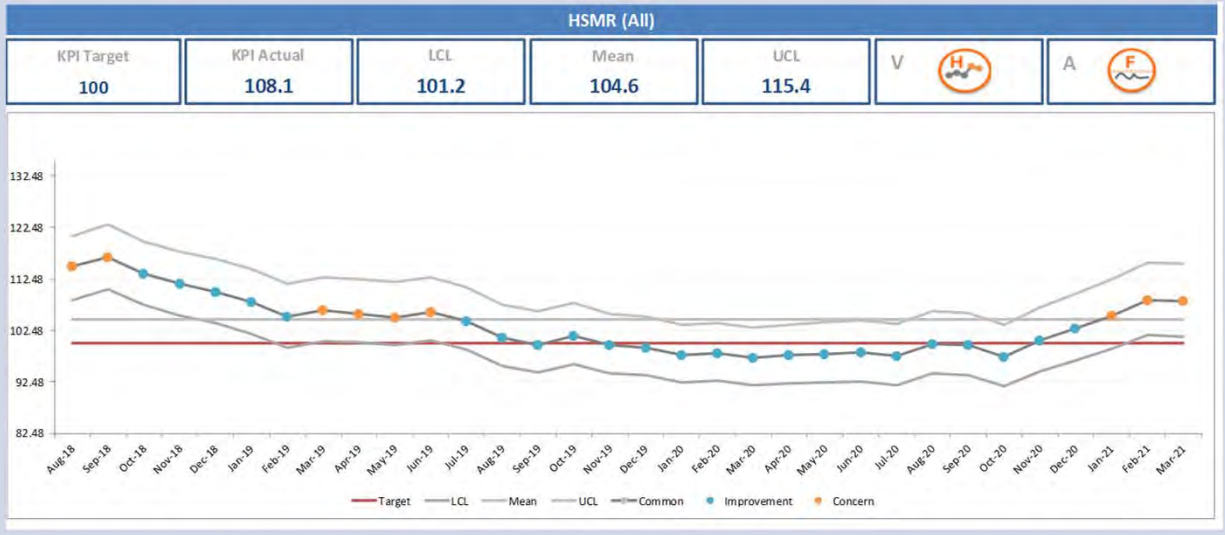
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Safe	Harm Free	Falls Per 1000 Bed Days	Jul-21	6.63	4.79	2.90	4.73	6.55		
		Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	Jul-21	1.04	0.00	0.00	0.05	0.22		
	Incident Reporting	Never Events	Jul-21	0	0.00	0.00	0.13	0.81		
		No of SIs on STEIS	Jul-21	90	5.00	0.00	12.78	26.83		
		% of SIs Responded To In 60 Days	Jul-21	0%	53.33%	89.83%	97.33%	100.00%		
	Infection Control	MRSA Bacteraemia (Trust Attributable)	Jun-21	5	0.00	0.00	0.38	1.85		
		C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Jun-21	43	4.00	0.00	2.81	9.26		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Jun-21	0	3.00	0.00	1.81	6.32		
		E-coli (Trust Acquired) Infections	Jun-21	0	5.00	0.00	4.26	10.21		
	Mortality	Crude Mortality Rate	Jun-21	3%	0.94%	0.43%	1.81%	3.20%		
		HSMR (All)	Mar-21	100	108.10	101.19	104.58	115.42		
		HSMR (Weekday)	Mar-21	100	105.56	97.70	101.76	114.10		
		HSMR (Weekend)	Mar-21	100	115.16	101.08	112.26	129.97		
		SHMI	Feb-21	1	1.05	1.06	1.08	1.11		

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

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

NHS Medway NHS Foundation Trust

Outcome Measure: Mortality – HSMR All



What changes have been implemented and improvements made?

Further analysis of the large datasets is indicated – in particular to review the impact of nosocomial COVID on key indicators. However, the major effect of COVID has made the underlying data difficult to interpret and compare between Trusts, particularly given the wide variation in pressure seen during Wave 2 of COVID. Granular data is needed from case note review to inform the Trust's assurance process. This will be examined for a range of conditions, alongside the current review of the SJR backlog. The information will be presented to the Trust Board for scrutiny in October.

What do the measures show?

HSMR has shown a trend of a worsening position since November 2020. The rolling 12 month graph masks an underlying month-on-month picture which demonstrates a significant spike in HSMR in November and December 2020 with a gradual return to baseline subsequently. The HSMR for March 2021 is 94.4.

The HSMR position has clearly been affected by the second wave of the COVID pandemic. Total deaths and spells in the HSMR cohort reduced nationally during Wave 2, and both HSMR and crude mortality rose. The change in both of these variables at Medway was greater than seen nationally, but the pressure from Wave 2 was also greater than that seen nationally.

Medway is not an outlier for all cause mortality: in fact, deaths from all causes apart from COVID fell by 22% compared to a 14% fall nationally. However, the crude mortality for COVID during Wave 2 is one of the highest in the country.

Domain: Responsive – Non Elective Dashboard	**Executive Lead:** Angela Gallagher – Interim Chief Operating Officer **Operational Lead:** N/A **Sub Groups :** N/A

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Responsive – Non Elective	Bed Management	Bed Occupancy Rate	Jul-21	85%	86.97%	80.32%	87.53%	94.73%		
		Average Elective Length of Stay	Jul-21	5	2.28	1.30	2.39	3.49		
		Average Non-Elective Length of Stay	Jul-21	5	8.67	5.69	8.80	11.92		
		% of Delayed Transfer of Care Point Prevalence in Month	Jul-21	4%	0.95%	0.29%	1.22%	2.15%		
		% Medically Fit For Discharge Point Prevalence in Month	Jul-21	7%	12.68%	13.53%	16.71%	19.88%		
	ED Access	ED 4 Hour Performance All Types	Jul-21	95%	76.88%	75.06%	82.64%	90.23%		
		ED 4 Hour Performance Type 1	Jul-21	95%	66.73%	63.88%	74.07%	84.25%		
		ED 12 hour DTA Breaches	Jul-21	0	3.00	0.00	19.98	71.54		
		60 Mins Ambulance Handover Delays	Jul-21	0	319.00	0.00	131.20	287.94		

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

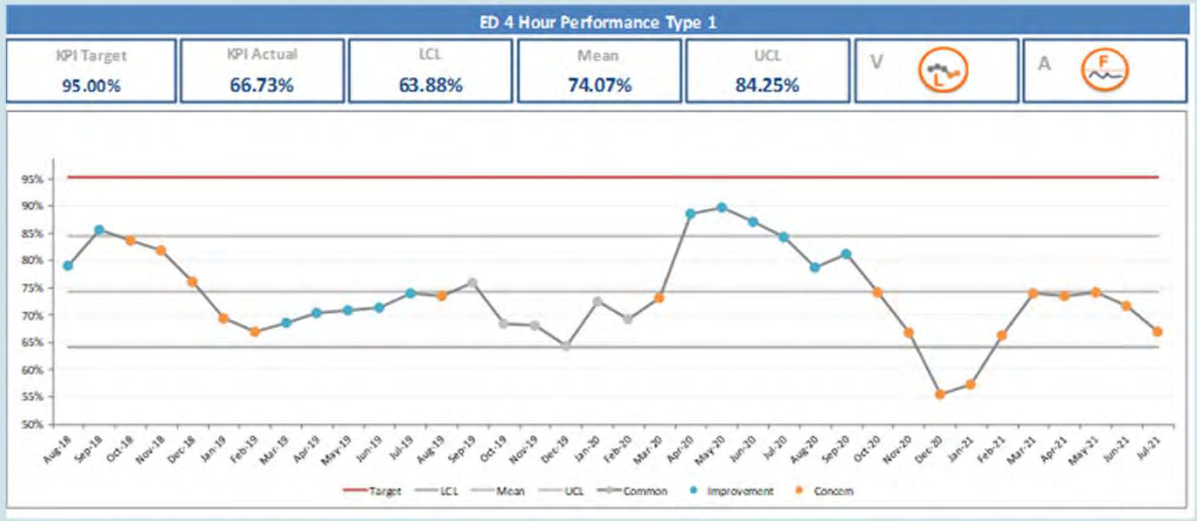
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variatio	Assurance
Responsive – Elective	Diagnostic Access	DM01 Performance	Jul-21	99%	93.57%	77.42%	89.65%	100.00%		
	Elective Access	PTL Size	Jul-21	22477	25125	20363	21567	22771		
		18 Weeks RTT Incomplete Performance	Jul-21	92%	68.43%	69.30%	75.21%	81.11%		
		18 Weeks RTT Over 52 Week Breaches	Jul-21	0	271.00	9.44	102.20	194.96		
	Theatre & Critical Care	Operations Cancelled By Hospital on Day	Jul-21	0	28.00	0.00	20.28	45.85		
		Cancelled Operations Not Rescheduled < 28 days	Jul-21	0	5.00	0.00	4.20	11.70		

Responsive: – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Shane Morrison-McCabe - Divisional 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:

- Improved compliance with Internal Professional Standards through the ACT and since Rapid Improvement Week.
- Staff development programme and mediation process
- Consistent application and deployment of ACT actions
- Improved and expedited decision-making for specialty referrals.
- Improved consistency of escalation of long stay Mental Health patients in CDU to facilitate mobilisation of CDU model
- Focus on earlier discharges to reduce admitted pathway breaches
- To re-introduce the 'refer and move' flow principle to surgical, frailty and medical assessment areas;
- Improved pathway to refer patients to SDEC
- Implementation of the Priority Admission Unit (APHU).

Outcomes:

- Fewer patients having a prolonged wait / stay in ED.
- Increased compliance with the 4 hour standard
- Fewer patients affected by ambulance handover delays.

Underlying issues and risks:

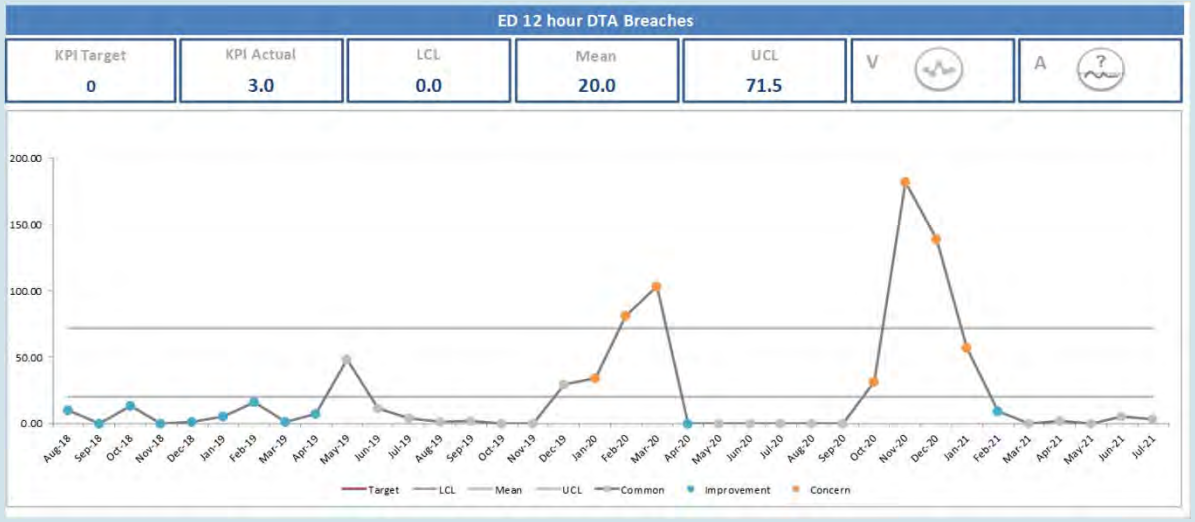
- Loss of AAU function due to reduced discharges, increased LOS high and bed occupancy level (95%+)
- Capacity in POCT to meet peaks of demand.
- Evening demand leading to a backlog of speciality decisions (DTAs) and delays in accessing inpatient beds when they are available in the absence of an Acute Assessment unit

Responsive: – Non Elective Insights

Executive Lead: Angela Gallagher – Interim Chief Operating Officer
Operational Lead: Shane Morrison-Mccabe - 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:

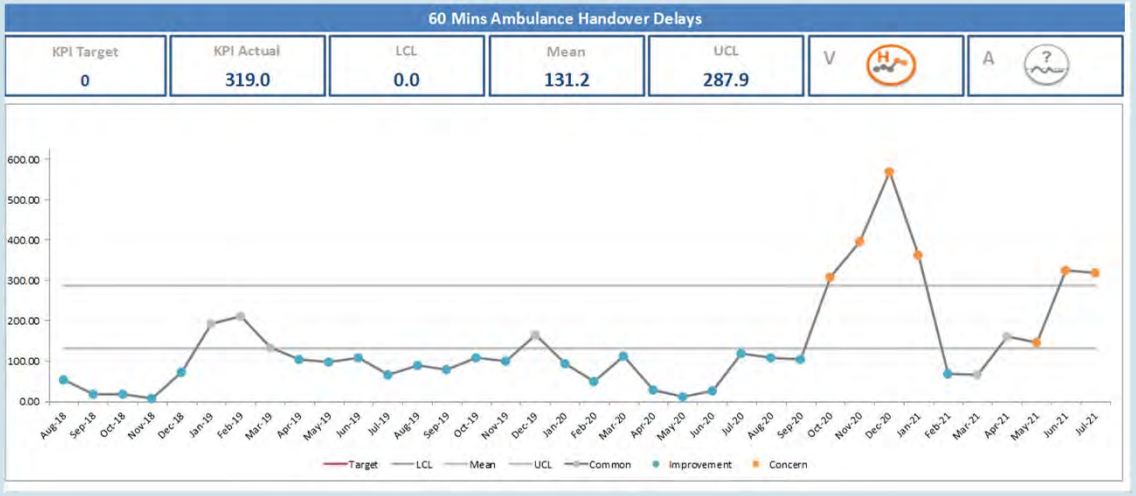
- Covid19 IPC regulation has slowed bed-flow and increased the decision making complexity.
- Slow re-launch of acute assessment due to capacity, IPC considerations and staffing.
- Consultant gaps in acute medicine with the new medical model

Responsive: – Non Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

The number of ambulance handover delays that exceed 60 minutes.

What the Chart is Telling Us:

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

Actions:

- Continue to drive the improvements agreed in the Acute Care Transformation workstream in relation to demand, capacity, use of assessment areas & distribution of workforce.
- Adoption of the revised escalation and FCP actions and triggers aligned to the Ambulance handover SOP
- Continued engagement with the ICP and ICS through the Local A&E Deliver Board on schemes to reduce conveyance rates to ED through alternate pathways as appropriate.
- Triage in place as part of escalation when delays are foreseen.
- Continuous review of capapcity when there is a change in the RED / AMBER Demand.
- Continuous collaboration with colleagues across the specialties to promote effective and timely discharges from in-patient beds.
- Deliver the patient cohorting protocol appropriately.

Outcomes:

- Better management of flow to avoid AMB handover delays & subsequent delays to patients starting treatment.

Underlying issues and risks:

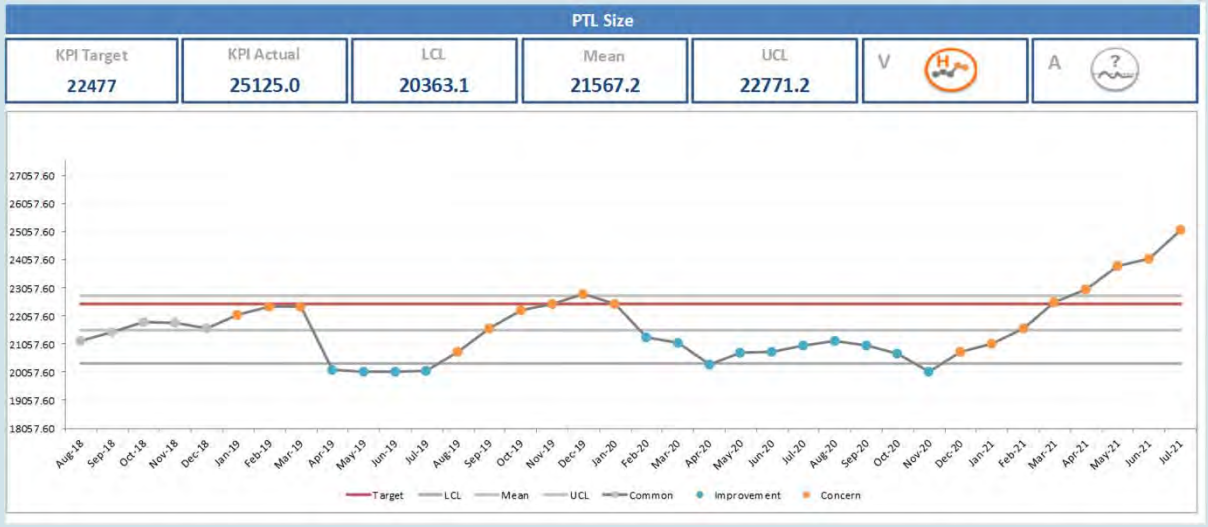
- Restrictions on meeting Red and Amber pathways through current IPC requirements.
- Capacity in POCT to meet peaks of demand.
- Insufficient discharges from in-patient beds before noon and too many discharges later in the day to accommodate ED demand through peak attendance.
- Capacity allocation in the evening is not sufficient or is out of sync with the non-elective demand (1800 onwards)

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: Incomplete Waiting List (PTL) Size



Indicator Background:

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

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. The increase in PTL size is directly related to

- the pandemic which impacted elective capacity and has changed the referral profile from Primary Care
- Assumptions identified by NHSI to be used in planning have exceeded what has actually happened.

Actions:

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

Outcomes:

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

Underlying issues and risks:

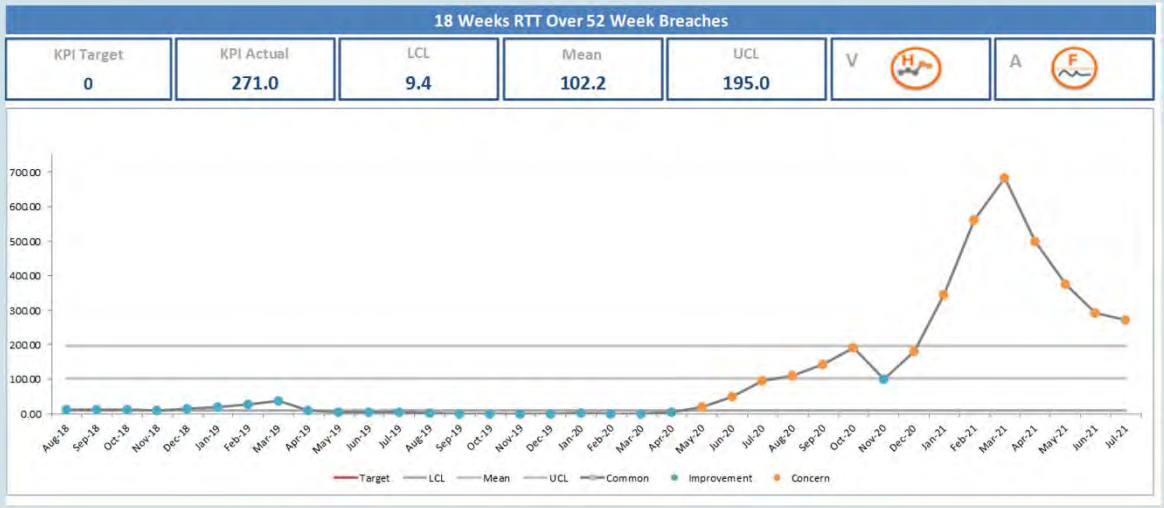
- Potential of third COVID wave resulting in increased NEL demand beyond modelled levels impacting on ability to continue same levels of elective work.
- Increased sickness absence driven by pressure of work and /or Covid related isolation or illness.

Responsive: Elective Insights

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

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

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

Outcomes:

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

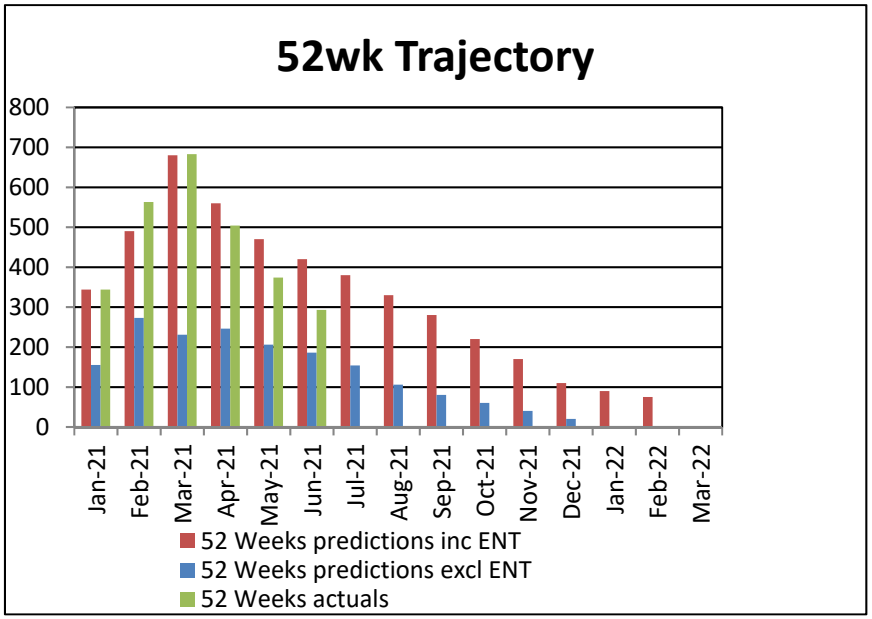
Underlying issues and risks:

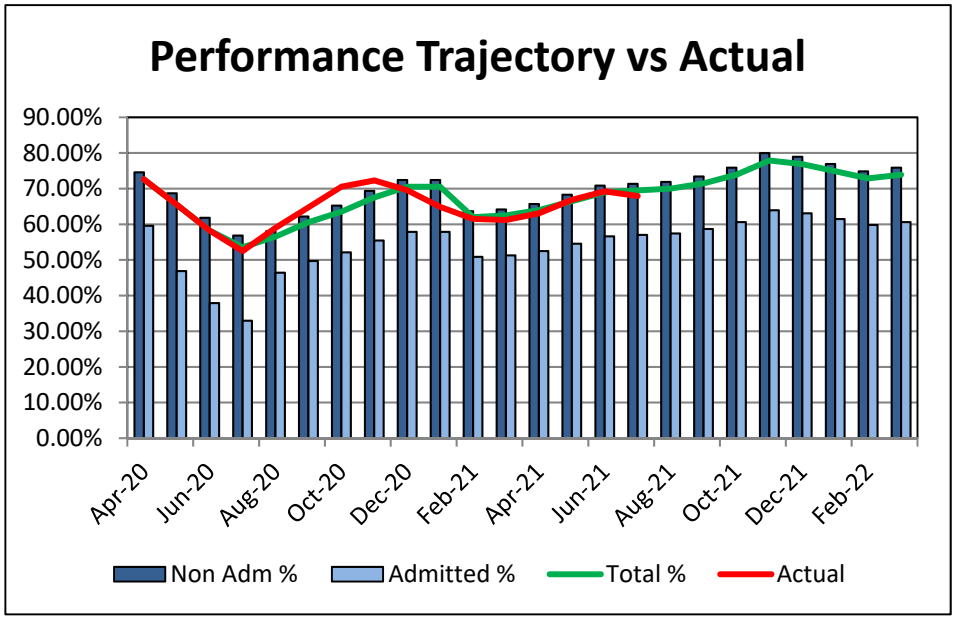
- Estate programme relating to the completion of ED phase 3 and release of Ocelot for elective orthopaedics.
- Uncertainty on covid and other NEL activity and associated impact on elective plans.

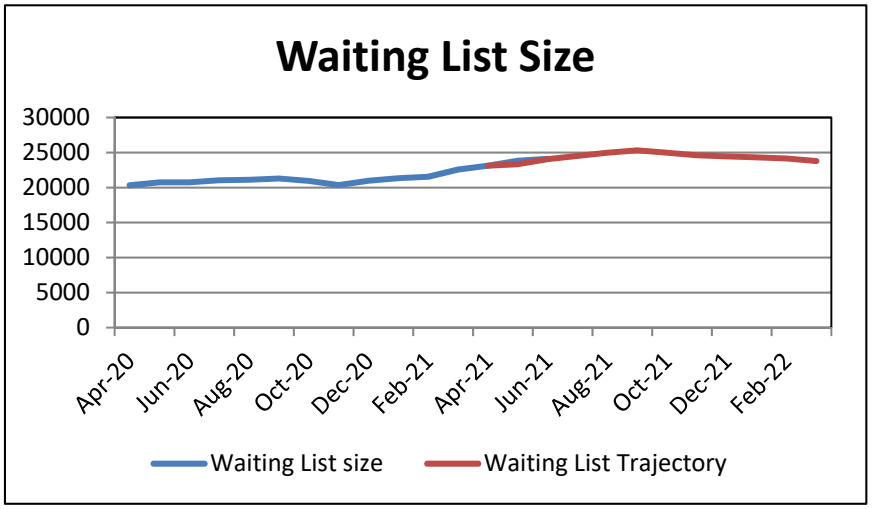
Best of care Best of people

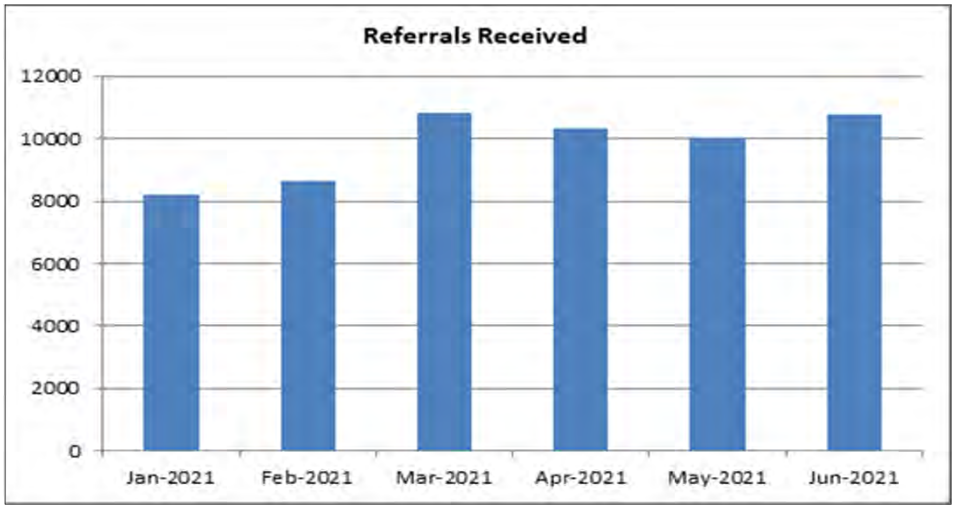
Responsive: Elective Insights

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







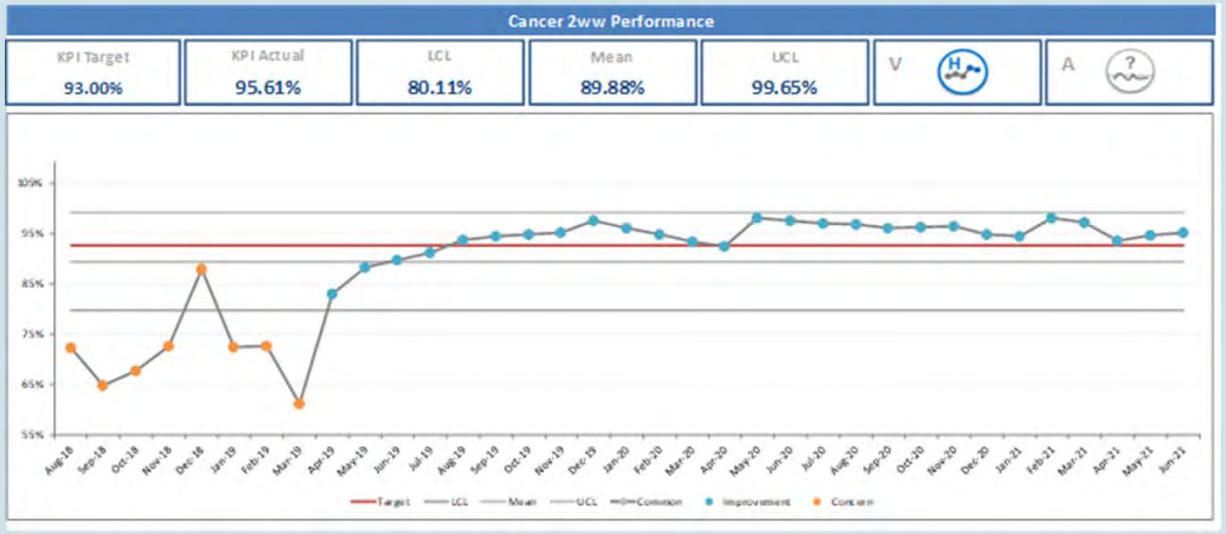


Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

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

What the Chart is Telling Us:

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

Actions:

- Working to an internal stretch target of 7 Days to first appointment.
- Providing regular real time updates on demand (referrals received) to Cancer Board and Tumour Site leads.
- Undertake daily and weekly Patient Target List review meetings at specialty level.
- Advance escalations made to all services considered at risk of breaching 14 Day target
- Weekly referral numbers and day of OPA shared with each service.

Outcomes:

- Trust has remained compliant with this KPI since August 2019 (22 Consecutive Months)
- Daily escalations facilitated early remedial actions allowing service to remain compliant.
- Effective communications and collaboration between Cancer Manager and service managers .
- Regular meetings with Service Managers ensure that there is adequate capacity to facilitate demand.

Underlying issues and risks:

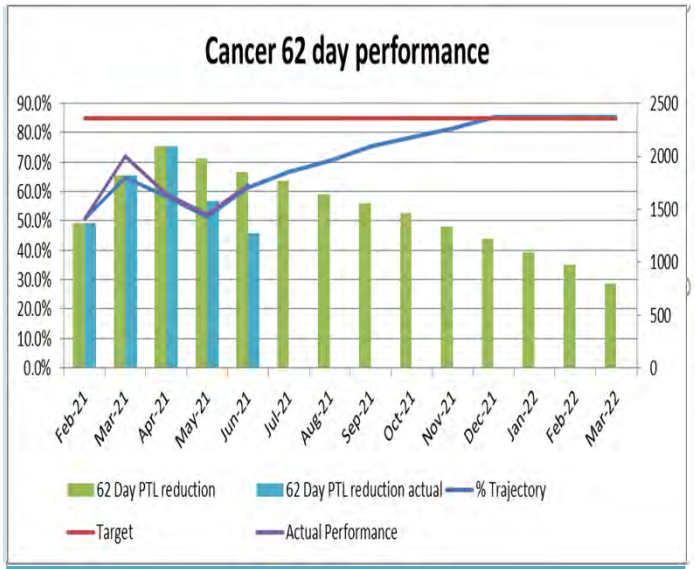
- Internal Stretch target of 7 Days is now being achieved by a number of specialties on a regular basis
- Work continues with primary care to ensure referrals are sent on appropriate pathways.
- Outpatient clinic capacity challenged as referral numbers in general are increasing.
- A further wave of Covid impacting on service provision.

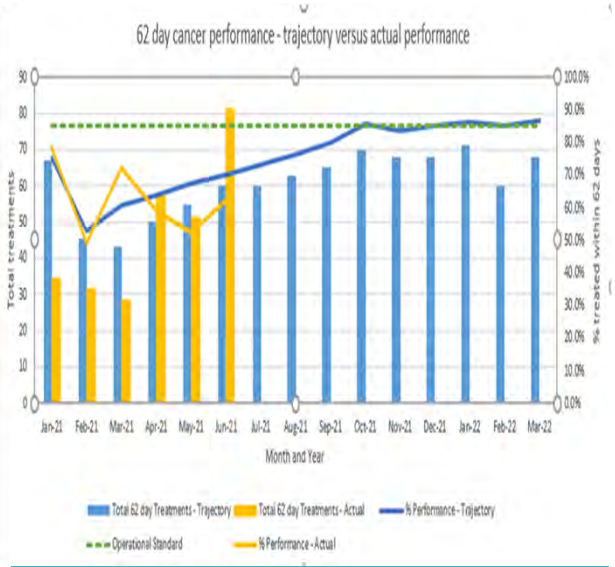
Responsive: Cancer Insights

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

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days First Definitive Treatment.





Actions:

- Revised improvement plan in place which is addressing the underlying issues with diagnostic pathway.
- Change in senior leadership of the Cancer Care Group.
- Revised trajectory for activity and performance developed and submitted to ICS.
- 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 specification for tumour-site clinical leads.
- Revised focus of weekly cancer PTL and daily progress reviews for patients waiting their next event.
- All patients who are waiting +62 days have a clear plan in place and reviewed daily until treatment date or alternate pathway agreed.
- 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.

Indicator Background:

The proportion of patients urgently referred by GPs/GDPs for suspected cancer and receive their first definitive treatment within 62 days from referral. The standard is 85% and MFT is currently delivering at 72% (June data)

What the Chart is Telling Us:

The 62 day FTD % is volatile following the resumption of the full range of activity in March. The recovery action plan is focused on

- Reducing the overall PTL to optimal size.
- Increasing the number of monthly treatments
- Reducing the number of patients waiting over 62 days.
- Incrementally increasing the FDT %

Underlying issues and risks:

- Sufficient diagnostics and outpatient capacity to clear the backlog of patients waiting.
- Further pandemic related reduction or suspension of activity.
- Workforce gaps in some specialties.

Best of care Best of people

Domain: Well Led – Dashboard	**Executive Lead:** Leon Hinton – Chief People Officer **Operational Lead:** N/A **Sub Groups :** N/A	NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	Variation	Assurance
Well Led	Staff Experience	Staff Friends & Family - Recommend Place to Work	Mar-21	62%	63.00%	1.62%	26.99%	52.36%		
		Staff Friends & Family - Recommend Care of Treatment	Mar-21	79%	74.00%	3.91%	35.70%	67.49%		
	Workforce	Appraisal % (Current Reporting Month)	Jul-21	85%	83.15%	79.92%	85.03%	90.14%		
		Sickness Rate (Current Reporting Month, FTE%)	Jul-21	4%	5.15%	3.36%	4.47%	5.58%		
		Voluntary Turnover Rate - (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Jul-21	12%	12.34%	10.99%	12.07%	13.15%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Jul-21	0	4211.05	3847.29	3940.01	4032.73		
		StatMan Compliance (Current Reporting Month)	Jul-21	85%	89.89%	68.06%	81.10%	94.14%		
		Agency Spend as % Paybill (Current Reporting Month)	Jul-21	4%	4.21%	1.84%	3.62%	5.40%		
		Bank Spend as % Paybill (Current Reporting Month)	Jul-21	9%	13.27%	7.80%	12.85%	17.90%		
		Temp Staffing Fill Rate - Nurse & Midwifery (Current Reporting Month)	Jul-21	75%	59.18%	0.00%	84.23%	100.00%		

Domain: Well Led - Financial Position

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

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month			YTD		
	Baseline budget	Actual	Variance	Baseline budget	Actual	Variance
Income	31,960	31,412	(548)	92,286	93,405	1,120
Pay	(19,154)	(19,240)	(85)	(57,614)	(58,345)	(730)
Total non-pay	(11,370)	(10,714)	656	(30,360)	(30,752)	(392)
Non-operating expense	(1,445)	(1,466)	(21)	(4,335)	(4,331)	4
Reported surplus/(deficit)	**(9)**	**(7)**	**2**	**(24)**	**(23)**	**1**
Donated Asset / DHSC Stock Adj.	8	7	(0)	24	22	(1)
Control total	**(1)**	**0**	**1**	**(0)**	**(1)**	**(0)**

Other financial stability work streams £k	In-month			YTD			Annual
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Cost Improvement Programme	119	95	(25)	357	236	(121)	5,171
Capital	1,866	1,484	(382)	4,394	4,265	(129)	13,877

Indicator Background:

The Trust reports a £7k deficit position for June; 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 £121k adverse to plan, this is expected to recover as services focus on implementing schemes. Capital spend is £129k behind the budgeted plan year to date, although overall the programme is on track to achieve the £13.9m plan.

Actions:

- Efficiency programme development for 2021/22.
- Monitor performance of activity against 2019/20 thresholds to achieve ERF, along with associated costs increases.
- Monitor impact of higher Covid activity on staff sickness and cost.
- Develop and agree income & expenditure plans for Oct-Mar'22.

Outcomes:

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

- Incremental costs associated with Covid-19 of £1.3m year to date. Funding is included within the affordability envelope.
- ERF Income has been accrued into the position to achieve breakeven of £1.1m. The forecast is £4.8m 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:

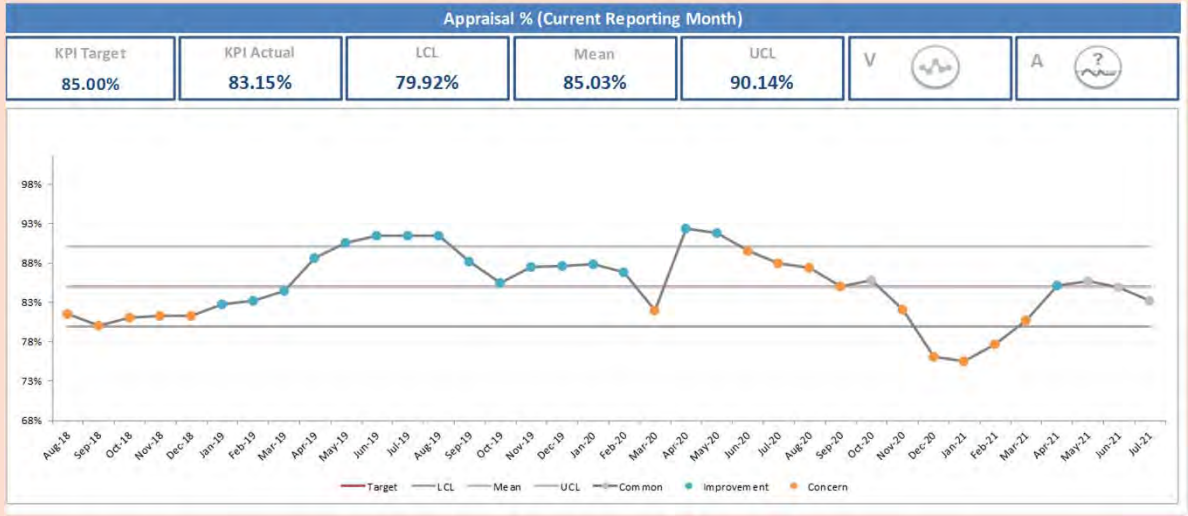
Funding arrangements have been agreed for the period Apr-Sep. A plan was resubmitted to NHSE/I based on a calculated budget required to deliver the activity plan for the first half of the financial year. This replaced the previous plan that used 20/21 quarter 3 results.
The incremental cost of delivery ERF activity thresholds is increasing, this is predominantly to the independent sector for insourcing and outsourcing totalling £1.1m. This has been matched by 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.

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:

3327members of staff have an in-date appraisal with objectives and personal development plan outlined (from a total of 4001).

Underlying issues and risks:

- Failure to appraise staff timely reduces the opportunity to identify skills requirement for development, succession planning and talent management. Low appraisal rate are linked to high turnover of staff, low staff engagement and low team-working.

Meeting of the Board of Directors in Public
Thursday, 09 September 2021

Title of Report	**Fire Prevention Update**	**Agenda Item**	3.2
Report Author	Paul Norman-Brown, Head of Health, Safety and Compliance Gary Lupton, Director of Estates and Facilities		
Lead Director	Gary Lupton, Director of Estates and Facilities		
Executive Summary	This summary confirms the progress on fire safety, and an update on the findings of an independent audit by the Trust's Authorising Engineer (Fire) and a recent inspection by Kent Fire and Rescue Services, along with the draft fire capital programme.		
Committees or Groups at which the paper has been submitted	Fire Assurance Group		
Resource Implications	N/A		
Legal Implications/Regulatory Requirements	The Regulatory Reform (Fire Safety) Order 2005 places a clear duty of care on the Trust as a responsible person. A breach of the Order could give rise to prosecution, financial implications, civil claims and reputational damage.		
Quality Impact Assessment	A quality impact assessment has not been undertaken.		
Recommendation/ Actions required	The Board is asked to note and approve the contents of this report.		
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	1 Authorising Engineers recommendations		

1 Executive Overview

1.1 The Board is asked to note that the Trust's Authorising Engineer (Fire) has recently audited the fire safety management arrangements at Medway, and Kent Fire and Rescue Services (KFRS) have inspected parts of the site as part of a routine inspection programme; no significant deficiencies in fire safety management have been found. The overall feedback is very positive.

1.2 The Trust is beginning to resume its normal fire safety training activities following the implementation of Covid restrictions; a new Safety Trainer facilitates this training.

1.3 Capital investment in fire safety continues, but further progress is contingent on having areas released for invasive works such the replacement of the fire alarm system and fire compartmentation works.

2 Fire Training

2.1 The Trust has recruited a new safety trainer and has re-commenced delivering face-to-face fire safety training following the implementation of COVID controls. The sessions have been risk assessed and are socially distanced which, although affecting capacity, are enabling fire wardens to receive training in an interactive fashion, including the use of a fire extinguisher simulator. The Trust has trained 705 wardens over the last couple of years and many of them are now due for refresher training.

2.2 Fire awareness training is available in a classroom setting, initially to groups by request, but bookable sessions will be available on ESR soon. The on-line training module will augment these sessions for the next twelve months whilst we complete the transition back to normal. Currently, Fire Safety Awareness training stands at 90%.

3 Exercises

3.1 Desktop Exercise: due to pressures on the Trust, the programme of desktop exercises had been delayed. The first exercise took place on Wednesday 11th August and included senior representation from across the Trust, it was found to be very beneficial to those who attended, and more groups of staff will go through the same exercise over the next couple of months. The exercise tested the current arrangements in the Emergency Department and the nearby diagnostic area.

3.2 Joint Exercise with Kent Fire and Rescue Service: the Head of Emergency Planning is working with Kent Fire and Rescue Service to agree a date for a joint exercise; however, he has been advised that this is not likely to be before October. We are awaiting an update.

4 Assurance

4.1 Authorising Engineers' Annual Fire Safety Audit (Appendix 1): BB7, the appointed Authorising Engineer (Fire), conducted an audit on the fire safety arrangements at Medway between the 9th and 16th of March 2021. The audit is an annual activity and is good practice under NHS's Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety.

4.2 BB7's auditor concluded that: *'Overall, the Trust fire safety management & leadership at this Hospital is undertaken to a very good standard and reflects the significant effort to organise and manage and constantly improve. The nomination of the Executive Director of Estates and Facilities as the board level responsible person is, given the significant challenges posed in managing and upgrading crucial systems an effective one.'* A list of BB7's recommendations from the audit is in Appendix 1.

4.3 Fire Brigade Inspection Kent Fire and Rescue Service carried out a routine inspection of the Neurosciences & Medical Infusion Suite, Macmillan Cancer Care Unit & Dolphin Ward on 12th July. The purpose of the inspection was to ensure there are no significant concerns with fire safety at the hospital.

4.4 Based on the visit, the brigade's inspecting officer, Paul Wood, was 'satisfied' that the premises were broadly compliant with the requirements of The Regulatory Reform (Fire Safety) Order. A satisfactory inspection is the only assurance the brigade can provide. During the visit, the inspecting officer identified issues with an escape route in an area occupied by another trust, has written to them identifying remedial actions, and will undertake a separate inspection of their areas. This does not affect MFT, but we are working with our tenant to assist them in complying with the brigade's requirements.

5 Investment

5.1 Passenger Lifts: The £3m, 3 year lift replacement programme is over halfway through, with lifts 1, 2, 3, 4 & 7 replaced, lift 9 underway and lift 5 scheduled to start on 1st September.

5.2 The replacement of lifts 5 and 6 poses some operational challenges, the plan is to protect the operational lift whilst its twin is replaced. This includes restricting use, by way of a lift attendant to patient and essential equipment moves only, and to ensure a full service on lift 6 before lift 5 is decommissioned. A complete set of spare parts will be salvaged from the decommissioned lift and kept on site to enable a swift replacement should a component fail on the remaining lift. Jackson's, the lift engineering company, will be on site six days a week to reduce the replacement programme for lift 5 from 12 to 10 weeks, and the installation team will be available to move across to the remaining lift quickly, should it fail. The potential for failure whilst very low, has a clear plan highlighted above to react if required.

5.3 Fire Alarm Installation: The prioritisation is based on the intrinsic risk of the areas and the reliability of the alarm system covering them. In practical terms, we aim to minimise the number of mixed systems in any one part of the building, as this reduces the complexity of the system, as well as being contrary to best

practice. 104 new panels have been fitted ready for transferring old systems on to this new system, to-date 26 of these panels are now live.

5.4 The Red Zone is the area we wish to complete first. If another area is to be refurbished for another reason, the alarms will be replaced, as it is the best time to do it.

5.5 Please note that the Green Zone is the most reliable and coherent part of the system, so it will be the last area to be replaced, unless evidence from the monitoring and maintenance programmes determines otherwise.

5.6 The prioritisation process has been discussed with our AE and KFRS, whom we keep regularly updated on the progress of the works.

5.7 Relocation of Stores: The relocation of the Stores from Level 1, Green Zone to the former central sterile services department building is progressing, with the refurbishment of the new stores scheduled for completion in January. Once the Stores have moved, the risk associated with fire loading will be mitigated, further increasing the levels of fire safety within the main building.

5.8 Ventilation in Green Zone: The replacement of the cladding necessitated having fixed windows on proportions of some of the elevations. The Estates Department are now working on a scheme to extend the mechanical ventilation to compensate for the loss of natural ventilation. Once the work is complete, the cladding project can receive final sign-off from building control.

6 Conclusion and Next Steps

6.1 The recent audits provide independent assurance that the Trust has appropriate Fire Safety Management arrangements in place.

6.2 The capital investment in fire safety continues, although progress needs to be made to ensure the fire alarm replacement can progress in a timely fashion – this will only be possible when decant space is available. The same applies to compartmentation works.

6.3 Work has started on establishing the expenditure profile of the works and how they fit with clinical priorities. Once the costs are established and priorities agreed, a more detailed plan can be prepared which will help determine capital investment requirements for the coming years.

Appendix 1 – BB7 Audit Action Plan

2. Audit – Action Plan

Item	Report Section	Recommendation	Priority
1.	3.2	In order to indicate high level 'buy in' It is recommended that the new roles are signed off at the most senior level.	Medium
2.	3.4	It is proposed that the fire risk assessment process be split into two parts: • Management of fire safety – Carried out annually by the Ward Manager. • Infrastructure assessments – Carried out by the Fire Safety Advisor, in line with risk based criteria.	Medium
3.	3.4	The control of beds in ward corridors and lobbied areas is an area for possible improvement. Although it is understood that additional pressures caused by the Covid 19 crisis it is important that hospital streets remain clear as principal means of escape routes.	Medium
4.	3.7	In order to facilitate the replacement of the fire alarm a vacant ward should be provided to allow for decant of the patients during the works. The ongoing risk associated with the continued use of an obsolete alarm will be increased with the possible delay caused by poor access to wards.	Medium
5.	3.9	It is recommended that a risk based approach to compartment surveys is adopted, as detailed in the BB7 report *Proposed Compartmentation Survey Strategy* dated 3rd February 2021.	Medium
6.	3.9.1	It is recommended that the management of fire door testing and maintenance be changed to a data based system to facilitate wider scrutiny and information security.	Low
7.		New works often include the provision of new fire doors, although they are subject to building codes and standards provision should be made to facilitate input by the fire safety adviser to ensure they reach the Trust's standards.	Low
8.	3.9.2	It is recommended that a hospital wide approach to the provision of dampers is pursued in order to focus resources.	Low

NHS Medway NHS Foundation Trust

Title of Report	**Medical Appraisal and Revalidation Annual Report**	Agenda Item	**3.3**
Lead Director	David Sulch, Chief Medical Officer and Responsible Officer		
Report Author	Kirti Mukherjee, Deputy Medical Director and Deputy Responsible Officer		
Executive Summary	In view of Covid-19 pandemic, appraisals and revalidation process for the doctors was put on hold completely by NHS England from Mid-March 2020. From June 2020, the appraisal and revalidation process was restarted as per choice of the individual organisations and MFT restarted the process in a phased manner taking into account the individual doctor's personal ability and circumstances to complete the appraisal. We are able to positively respond to all assurance statements, as we are compliant with all regulatory requirements. NHS England has stopped the requirement of sending the Annual Organisational Audit (AoA) report for this reporting year. As a result, no AoA has been submitted to NHSE for 2020-21 reporting year. We are still required to submit a compliance report to NHSE which is attached as Appendix 1– section 7. Medway NHS Foundation Trust has **409** doctors connected as on 31 March 2021. • **373 (91.2%)** doctors completed an appraisal for the reporting year. • **34 (8.31%)** doctors had an approved missed or incomplete appraisal out of which – 1. **22 (5.37%)** doctors were working for less than six months and were new to UK and were not required to complete an appraisal before March 2021. 2. **4 (0.9%)** doctors were on maternity leave. 3. **6 (1.4%)** appraisals were closed due to sickness of the individual doctors. 4. **1** doctor retired on 31st March and did not complete an appraisal. 5. **1** doctor's appraisal was delayed due to relocation. • **2 (0.48%)** doctors had unapproved or missed appraisals. • For the year ending 31 March 2021, **33** Doctors received a positive recommendation for revalidation, **3** doctors received a recommendation for deferral. • Current Responsible Officer, Dr David Sulch, will be retiring on 01 December 2021 and a new RO will need to be appointed. In addition, the Deputy Medical Director/Deputy RO will also be leaving at the beginning of November, meaning that there is a need to transfer knowledge and experience within medical revalidation.		
Committees or Groups at which the paper has been submitted	Presented to and approved by Executive Group on 07 July 2021 and by Peoples Committee on 20 July 2021.		
Resource Implications	No new additional resources required		

Legal Implications/ Regulatory Requirements	The purposes of this report are: • To provide assurance to the Board as part of the Responsible Officer's Regulations. • To seek approval of the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the regulations.			
Quality Impact Assessment	None			
Recommendation/ Actions required	The Board is given assurance and asked to approve the report.			
	Approval ☒	Assurance ☒	Discussion ☐	Noting ☐

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

1 Executive Overview

This is the Trust Responsible Officer's (RO) annual report for 2020-21 reporting year. This report is a required item of assurance, and we are also required to submit a compliance statement, signed off by or on behalf of the Board.

We are able to positively respond to all assurance statements, as we are compliant with all regulatory requirements.

2 Background

The GMC's aims for medical revalidation are that it:

- is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession.
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors.

To achieve these aims, the GMC requires that all doctors identify the Designated Body that monitors and assures their practice. MFT is a Designated Body for 409 doctors and this report is about them. This report does not cover the doctors in training grade as their designated body is Health Education England.

3 List of Attached Documents

Appendix 1 – Designated Body - Appraisal and Revalidation Report (NHS England Format) for year 2020-21.

This Framework is used across all designated bodies to enable a consistent approach for Boards to Quality Assure their appraisal and revalidation systems. Each section in the appendix relates to specific items set out in the Responsible Officer regulations 2010.

4 Conclusion and Next Steps

Overall, MFT achieved **91.2%** appraisal completion for the doctors in spite of 2nd wave of Covid-19 pandemic from October 2020.

Appraisals and Revalidation process was on hold from March 2020 but the appraisal and revalidation process was restarted in a phased manner June 2020. We also restarted recommendations for revalidation from July 2020. A total of 33 doctors were revalidated by GMC during the reporting year.

General review of last year's actions

- Completed Actions:
  - 16 New appraisers trained
  - Running sessions for doctors "new to UK" facilitated by GMC Liaison Officer
  - Running regular session for new doctors to further their understanding about the appraisal process**.**
  - "Help guides" developed on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document
- Actions partially completed:
  - To strengthen information flow about starters and leavers list of doctors.
  - Audit of appraisal output summary and give one to one formative feedback was given to 15% appraisers (instead of 40% as per last year's action) on their appraiser performance as we suspended the feedback from October 2020 in view of 2nd wave of Covid-19 pandemic.
- Current Issues:
  - In spite of tightening the process of information flow from Medical staffing, we get late information occasionally, later than usual turnaround time of one month but the process has been much more strengthened from previous years.
  - To receive reports consistently from a centralised data base to check any SI/Complaints received for any individual doctor.
- New Actions:
  - To provide training for new appraisers.
  - Electronic Patient feedback process for individual doctors.
  - Audit of appraisal output summary and give one to one formative feedback to at least 25% appraisers on their appraiser performance.

Overall conclusion:

- We have continued to strengthen our appraisal and revalidation process.
- There is overall good engagement from our doctors.

Appendix 1

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**
  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**
  The Board Report template now includes the qualitative questions previously contained in the AOA. They were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

  a) help the designated body in its pursuit of quality improvement,

  b) provide the necessary assurance to the higher-level responsible officer, and

  c) act as evidence for CQC inspections.

- **Statement of Compliance:**
  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report
Section 1 – General:

The board / executive management team of Medway NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has not been submitted as NHS England has cancelled the requirement for a 2020-2021 AOA report.

Date of AOA submission: No submission

Action from last year: To submit the AOA as per NHS England directive.

Comments: Action Not completed as AoA for 2020-21 was not required to be submitted to NHS England due to Covid Pandemic.

Medway NHS Foundation Trust has **409** doctors connected as on 31st March 2021.

1. **373(91.2%)** of the Doctors have completed an appraisal for the reporting year.
2. **34(8.31%)** of the Doctors had an approved missed or incomplete appraisal for the reporting year.

2.1. **22(5.37%)** Doctors started working in the trust during September 2020 – March 2021 and were new to UK practice and were not required to complete an appraisal before 31st March 2021.
2.2. **4(0.9%)** Doctors were on maternity leave during this reporting year.
2.3. **6(1.4%)** Doctors Appraisals were closed due to prolonged sickness
2.4. **1** Doctor retired on 31st March 2021 and did not complete an appraisal.
2.5. 1 Doctor's appraisal was delayed due to their Relocation.

3. **2 (0.48%**) Doctors have unapproved or missed appraisals

Action for next year: None required as NHS England has stopped AoA submission for the year 2021-22.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None

Comments: Dr David Sulch meets all the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely he is a medical practitioner and has been continuously registered as medical practitioner for the previous 5 years.

Action for next year: Current RO, Dr David Sulch will be retiring on 1st December 2021 and a new Responsible Officer will need to be appointed.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Funding will be available to complete a new appraiser training session in November 2020 to replace those who have retired or who wish to step down as an appraiser

Comments: **Action Completed**

Designated body (MFT) provides sufficient funds and resources to carry out RO responsibilities. The Responsible Officer is supported by Deputy Responsible

(Deputy Medical Director), a senior medical appraiser and an administrative team. The Trust has an electronic appraisal system in place (L2P).

Every year, we recruit new appraisers to make up the loss in number of current appraisers either thorough retirement, leaving the trust or standing down as an appraiser. An appraisal training session via MIAD Health care, to train new appraisers was held in November 2020 and thirteen new appraisers were trained.

Three more doctors completed Appraiser training subsequent to November 2020, so we had 16 new appraisers starting in the reporting year.

No appraiser refresher course was commissioned in the reporting year due to Covid pandemic and the hospital being extremely busy.

Action for next year: Funding will be available to complete a new appraiser training session in November 2021 to replace those who have retired or who wish to step down as an appraiser. Appraiser refresher will be arranged for 2021-22 year.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: The Revalidation team will receive monthly reports for staff in post, weekly medical induction training report, weekly starters' lists, and also working with temporary staffing to contact doctors leaving the training programme in August 2020, so that Revalidation team can maintain accurate records.

Comments: Action Completed

The Human Resources Department/Medical Staffing provides the Medical Director's office with a weekly list of all new non-training grade doctors, together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC connection list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible.

Despite the Standard Operating Procedure (SOP) in place for information flow for starter and leavers list, few Doctors still continue to slip through the net, particularly those Doctors that left training grade but continued at MFT on the bank and the doctors that go from a bank posting to a substantive posting or in a training grade post.

When the monthly staff in post list is received, this is cross-checked with the Appraisal system to ensure that no Doctors have been missed.

Action for next year: To tighten the process of maintaining accurate records in collaboration with the medical workforce team and also with the Medical Education team to identify Doctors leaving the training programme in August 2021.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None required

Comments: The Appraisal and Revalidation of Medical Staff policy is in date.

Action for next year: None required.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary by using an appraisal output quality tool. This will be done on 40% of the current appraisers within the trust for 2020-21 year and one to one feedback will be provided on their performance as a Medical Appraiser. The aim will be to give individual feedback to all appraisers over a period of next 2-3 years.

Comments: Partially Completed

Internal Quality Review of the appraisal output summary was completed for 15% of appraisers who were given individual feedback along with the scores and tips to improve the quality of appraisal output if indicated by the scores.

This process was put on hold since November 2020 during the second wave of the Covid pandemic as the clinicians became increasingly busy.

Also, the previous senior appraiser stepped down from the role and we have appointed a new senior appraiser who will now be taking up the internal review along with the Deputy Medical Director.

We are not planning HLRO Quality Review in 2021-22 as there is a discussion nationally regarding the medical appraisal form format.

Action for next year:

We will complete internal quality review of appraisal output summary for 25% appraisers in the year 2021-22.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To develop "help guides" on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document.

Comments: Completed

The appraisal platform L2P has the relevant information to help completion of appraisal under the resources section.

Non-training grade Trust doctors and doctors working on MFT employment bank undertake an Annual appraisal. All doctors with a prescribed connection to MFT as Designated body are connected on GMC Connect and added to MFT appraisal system L2P.

New doctors are invited to the appraisal training and are sent all the necessary information for them to carry out an appraisal. Regular appraisee training sessions have been provided by Deputy Responsible Officer and 1:1 sessions if needed, to all doctors new to UK and any doctor who is new to the appraisal system. Revalidation team also offer all the support needed for completion of appraisals, including facilitating collection of patient and colleague feedback. The Revalidation administrator receives a monthly report of starters and leavers lists of doctors including any doctors who leave training and take up a non-training role.

For Agency doctors who are connected to their Agency RO - only agencies, where the trust has assurance of appraisal and revalidation processes, are used to source agency locum doctors.

All Doctors are encouraged to attend their own directorate governance meetings with attendance to be recorded within their CPD diaries. All short term placement doctors receive a Study Leave entitlement. All doctors are also encouraged to attend grand rounds, local tutorials/teaching sessions as appropriate.

MFT currently offer in house sessions “Welcome to UK practice” delivered by GMC’s *Regional Liaison Adviser (South East)* for those doctors who are new to UK practice and who did not attend this session during the GMC registration programme.

Action for next year: To continue to monitor and support short term or locum doctors for their appraisal needs.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor’s whole practice, which takes account of all relevant information relating to the doctor’s fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: To continue reviewing the SIs and complaints to ensure relevant complaints / SI are included in appraisals. To continue to send HES data reports, taken from Dr Foster, to relevant Doctors.

Comments: Action Partially completed

The Revalidation team sends out HES data reports taken from Dr Foster to all Doctors, where available, for inclusion in their appraisal supporting documentation. At times, we have not received the list of all SIs and complaints in a timely fashion so that we can check the compliance as to their inclusion in the individual appraisal.

All Doctors are required to complete an appraisal every year containing supporting evidence on their full scope of work. If a doctor works outside MFT in any capacity as a medical doctor, the doctor is required to complete an Annual Declaration form duly signed and confirmed by RO/hospital Director from the Private Hospital or other organisations where they practice.

Action for next year: To ensure that the revalidation team gets the list of SIs/Complaints in a timely fashion.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

To continue to monitor timely completion of appraisals after introducing Standard Operating Procedure (SOP) to increase the number of doctors fully completing their appraisal in scheduled month.

Comments: Partially completed.

Although SOP for monitoring the timely completion of appraisals was introduced, due to second wave of Covid pandemic, a number of doctors could not complete their appraisals in their allocated month for reasons such as their own illness or increased workload due to absent colleagues. We had agreed that postponement of appraisals was appropriate and we would not be referring any doctor for non-engagement till the hospital could return to normal working. None the less, all doctors were still encouraged to complete their appraisals as soon as they could and the appraisal completion rate was over 91% which under the circumstances was a significant achievement.

Action for next year:. SOP for late appraisals will be initiated again and actioned once hospital returns to normal working conditions.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None identified.

Comments:

Medical Appraisal policy is current and up to date.

Action for next year: None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To provide New Appraiser Training in November 2020, with an aim to recruit up to 15 new appraisers.

Comments: Action Completed.

13 new appraisers were recruited and given training to act as medical appraisers in November 2020. 3 colleagues completed external appraiser training, making a total of 16 new appraisers for the reporting year The Trust had 118 trained appraisers on 31st March 2021.

In 2020 – 2021, a total of 10 appraisers from MFT ceased to be appraisers due to retirement, leaving the trust or stepping down from the role. There is a prediction that similar number of appraisers will be lost in 2021 – 2022. In order to mitigate this, new Appraisers will continue to be recruited.

Action for next year: To provide New Appraiser Training in November 2021, with an aim to recruit up to 12 new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Deputy Responsible Officer and Senior Appraiser will undertake an individual internal quality review of the appraisal output summary and give one to one feedback. This will be done on 40% of appraisers within the trust for the 2020-21 year.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: Partially Completed

Internal Quality Review of the appraisal output summary was completed for 15% of appraisers who were given individual feedback along with the scores and tips to improve the quality of appraisal output if indicated by the scores. This process was put on hold since November 2020 during the second wave of the Covid pandemic as the clinicians became increasingly busy.

Also, the previous senior appraiser stepped down from the role and we have appointed a new senior appraiser who will now be taking up the internal review along with the Deputy Medical Director.

Regular appraisal feedback reports are provided to the individual appraisers, based on the feedback questionnaire completed by each appraisee once the appraisal process is complete. A help guide sheet has been developed with suggestions as to what kind of supporting evidence appraisers can submit within their own appraisal, for their role as a Medical appraiser under their full scope of practice.

Action for next year: We will complete internal quality review of appraisal output summary for 25% appraisers in the year 2021-22.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To continue presenting yearly report to Board for compliance.

Comments: Action Completed

All appraisals are checked by the Deputy Responsible Officer/ senior appraiser and a final sign off of appraisals is undertaken once all the required supporting information is checked to be present. If not ready for 'sign off' the appraisals are sent back to the doctor to upload required or missing information.

The yearly appraisal and Revalidation Report is first presented to Executive Group and then the Peoples Committee of the Board and once ratified, the report is presented to the Trust Board.

Action for next year: To continue presenting yearly report to Board for compliance.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To continue with the correct processes in place to support Revalidation Recommendations.

Comments: Due to the Covid-19 pandemic, the GMC had postponed all revalidations which were due between March 2020 to March 2021 for further one year from their due date and subsequently by another 4 months from Aug 2020 to August 2021. Revalidation recommendations could still be made if all supporting evidence is available including previous satisfactory appraisals in the last 5 years and accordingly, we sent positive revalidation recommendations for 33 Doctors and 3 doctors for their revalidation to be deferred. There was no non-engagement recommendation for any doctor.

Action for next year: To continue with the correct processes in place to support Revalidation Recommendations.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue with the correct processes in place to support Revalidation Recommendations.

Comments: Action completed

All Doctors are contacted by the Revalidation team four months prior to a submission date to discuss any outstanding areas and the type of recommendation which can be sent. Once a recommendation has been sent to the GMC, confirmation is communicated to the doctor on the day the recommendation is sent. If a non-engagement or deferral recommendation is sent to the GMC, the Doctor is made aware of this and notified as to the reasons of these recommendations. Before any non-engagement recommendation is sent to the GMC, a Standard Operating Procedure is followed.

Action for next year: To continue with the correct processes in place to support Revalidation Recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: The Revalidation team will continue to monitor information on complaints/SIs for inclusion in medical appraisal.

Comments:

The revalidation team continues to monitor information on complaints/SIs for inclusion in medical appraisal.

Key aspects of clinical governance for the RO are the collection and use of clinical information and systems to assist clinicians in their annual appraisal and more rarely to trigger the raising of concerns about a doctor's practice from our clinical risk management systems.

The Revalidation team continues to work with the Governance teams in the organisation to provide information on complaints, involvement in incidents and similar items for the medical appraisal process.

All Consultants, Specialty Doctors and doctors (not in a formal training programme) are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a regular basis by the Revalidation team to ensure that progress in meeting these deadlines is being maintained.

Action for next year: To continue to monitor the present system.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: We will strengthen the process of identifying early conduct and performance issues and monitor regularly in biweekly meeting with HR.

Comments: Action completed

There is a biweekly meeting of decision making group chaired by Medical Director and HR where any conduct or capability issues are triangulated from information received from HR processes, complaints/SIs/Never Events and regular weekly meetings of Medical Director with Deputy and Divisional Medical Directors.

Upon connecting a Doctor to MFT, RO to RO references (MPIT) are requested which contain any relevant information to share. The team receives regular requests from Private Practices to complete Practicing Privileges references and share relevant information to the RO of the organisation where a doctor works.

All doctors are required to include reports of any SIs/Datix/Complaints in which they were involved during the appraisal year, with appropriate reflections and learning.

All doctors are required to undergo formal Multisource feedback both from Colleagues and Patients once in the 5 yearly revalidation cycle. All doctors are encouraged to share and reflect any compliments received (including thank you cards and feedback received from patient experience team) during every appraisal discussion.

Training grade Doctors have Postgraduate Dean at Health Education Kent, Surrey and Sussex (HEKSS) as their Responsible Officer. While they are working in MFT, the Doctors have regular work placed based assessments by their named Educational and Clinical supervisors and their performance discussed and documented in the quarterly Local Faculty Group and Local Academic Board meetings. Any identified concerns are flagged up to HEKSS via Director of Medical Education of MFT. They undergo Annual Review of Competency Progression (ARCP) in their respective School at HEKSS.

Action for next year: To continue biweekly decision making group meetings to discuss and action any conduct/capability issues of doctors.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None Identified

Comments: The Medical Director / Responsible Officer chairs the Decision Making Group, which meets bi-weekly to review all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the GMC as required in each case. The Deputy Responsible Officer and a member from HR attend this meeting.

Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified, these are then managed under the appropriate Trust policy.

Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with the Trust policy.

The Trust has 18 trained Case Investigators and 8 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed.

All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance.

As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate.

Action for next year: None identified.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Nil

Comments: A senior team including the Chief Medical Officer (RO), Deputy Medical Director, Head of Employee Relations and Head of MD services meets on a biweekly basis to review concerns about doctors and decide on appropriate actions. Investigations where required, are undertaken under MHPS guidelines, using appropriately trained Case Manager and Case Investigators.

Doctors in training have their RO at the Health Education Kent, Surrey and Sussex (HEKSS) and any concerns are flagged up to RO at HEKSS via Director of Medical Education.

The following table outlines the number and outcome of cases reviewed by the Decision Making Group in the reporting year.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

	2021 – 2022 – issues managed within the Decision Making Group *(n.b. - Figures in brackets relate to the comparative figures for 2019 – 2020)*	White 23% (27%)	BAME 77% (73%)	Male 64% (70%)	Female 36% (30%)	**TOTAL**
Conduct/ Capability	Outcome					
5	Reviewed and no case to answer	0 (2)	5 (2)	4 (3)	1 (1)	**5 (4)**
3	Reviewed and advice given regarding future conduct	3 (3)	0 (1)	2 (2)	1 (2)	**3 (4)**
1	Reviewed and advice given regarding improving performance (capability)	0 (0)	1 (0)	1 (0)	0 (0)	**1 (0)**
3	Reviewed and managed by other HR policy (grievance, Dignity at work, sickness)	1 (0)	2 (0)	3 (0)	(0)	**3 (0)**
1	Formal MHPS investigation	0 (0)	1 (2)	1 (2)	0 (0)	**1 (2)**
	% Figures in brackets are the Proportion within protected characteristic	4 (5) (31%)	9 (5) (69%)	11 (7) (85%)	2 (3) (15%)	**13(10)**

Action for next year: To continue with the present format.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None identified.

Comments: Upon connecting a Doctor to the designated body, an RO to RO reference request is sent to the previous designated body. Dependent on the information shared, more details may be requested which can result in an RO to RO conversation to elaborate further.

All doctors who work in other places are required yearly to produce a signed form from RO/Hospital Director of the other organisation (s) about their practice and any concerns regarding their practice. This form is uploaded to their medical appraisal every year.

For doctors connected elsewhere but working in MFT fall under two categories:

Training grade doctors who are regularly monitored by their educational supervisors and any concerns raised are dealt with through the Local faculty groups chaired by the specialty College Tutors and the Local Academic Board chaired by the Director of Medical Education and escalated to RO of HEKSS and the RO at MFT is updated immediately for any necessary actions.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Other groups of doctors who may work in MFT could be bank doctors or contracted through agencies and have their own RO. The Revalidation team would contact their designated body if any concern arises.

Action for next year: To continue with the current process set in place.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Nil

Comments: All processes for responding to concerns are managed according to our Trust Policy (Disciplinary and Capability Procedures for Medical and Dental Staff) which is consistent with MHPS. We have trained Case Investigators and Case Managers to ensure appropriate processes. Issues around potential bias and discrimination are considered by our Senior Team before any formal process is commenced.

Action for next year: Nil

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None identified.

Comments: All doctors employed by MFT are subject to NHS mandatory recruitment pre-employment checks. To ensure compliance with pre-employment checks, a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.

Action for next year: To continue to monitor compliance.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall, MFT achieved 91.2% appraisal completion for the doctors in spite of Covid-19 outbreak which saw suspension of the appraisal process between March 2020 – June 2021. A total of 33 doctors were revalidated by GMC during the reporting year.

Appraisals and Revalidation process was on hold from March 2020 but the appraisal and revalidation process was restarted in June 2020.

General review of last year's actions

Completed Actions:

- 16 New appraisers trained
- Running sessions for doctors "new to UK" facilitated by GMC Liaison Officer

- Running regular session for new doctors to further their understanding about the appraisal process.
- "Help guides" developed on CPD activities, appraisal completion and relevant supportive information to upload into appraisal document

Actions partially completed

- To strengthen information flow in regards to SI/Complaints to ensure that Doctors include in their appraisals.
- Audit of appraisal output summary and give one to one formative feedback was given to 15% appraisers (instead of 40% as per last year's action) on their appraiser performance as we suspended the feedback from October 2020 in view of 2nd wave of Covid-19 pandemic

Current Issues:

- In spite of tightening the process of information flow from Medical staffing, we get late information occasionally, later than usual turnaround time of one month but the process has been much more strengthened from previous years.
- To receive reports consistently from a centralised data base to check any SI/Complaints received for any individual doctor.

New Actions:

- To provide training for new appraisers.
- Introduce Electronic Patient feedback process for individual doctors.
- Audit of appraisal output summary and give one to one formative feedback to at least 25% appraisers on their appraiser performance

Overall conclusion:

- In spite of appraisals and revalidations put on hold during the reporting year, we made a good progress in achieving over 91% completion of appraisals.
- There is overall good engagement from our doctors

Section 7 – Statement of Compliance:

The Board / executive management team of ***Medway NHS Foundation Trust*** has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Medway NHS Foundation Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Meeting of the Board of Directors in Public

Thursday, 09 September 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.3a
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday, 20 July 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 The Committee received the quality report, which provided an update on progress on the CQC Must Do Should do actions and feedback from recent inspections. The report provided an update on the backlog of incidents and a recovery plan to address this with re-set trajectories. The Committee will receive a progress update at the next meeting.	**Green**

2. Infection Prevention and Control The Committee received the infection control improvement plan – bi-monthly update and noted the progress to date on the actions. The committee was informed of the discussions taking place to enable the Trust to move away from the review of the regulatory framework. The Committee received the IPC CQC inspection report action plan, which will be monitored by the evidence panel and quality panel. The committee requested an update at the next meeting.	**Green**
3. Learning from Paediatric claims The Committee received the learning from paediatric claims paper noting its content and learning, and the consideration of maintaining a learning log. Further discussions on this will take place with the Associate Medical Director for Patient Safety.	**Green**
4. Mortality and Morbidity quarterly report The committee received the mortality and morbidity quarterly report noting the delay in publication of the Dr Foster data and the back log of internal structured judgement reviews. The Committee were informed these issues have been discussed at the Mortality and Morbidity Group, which has set an action for the back log of structured judgement reviews to be completed by the end of August. The Committee requested an update at the next meeting on progress.	**Amber/Green**
5. Review of sample set of patient notes – duty of candour for hospital acquired COVID The Committee discussed the paper of the review of duty of candour for patients who died of hospital acquired COVID. The Committee agreed that a consistent approach across Kent and Medway is required when considering writing or meeting with families of those who have died. The Committee were informed of a system meeting taking place to discuss this and will receive an update at the next meeting.	**Amber/Green**
6. Update of themes from improved learning initiatives The Committee received an update on learning initiatives and were informed about the pilot of weekly grand rounds and quality rounds where learning from incidents is shared. Going forward these will be quality rounds and will include patient stories and learning.	**Green**
7. Patient experience quarterly report The Committee received the patient experience quarterly report and noted the progress on the development of the patient experience strategy. The Committee noted the in-patient survey results and discussed how the Trust can use the results to shape improvements; and considered a proposal of holding an executive workshop to focus on patient experience in order to assure ourselves that we consistently embed good care and patient experience across the Trust.	**Amber/Green**
8. Quality IQPR The Committee received the Quality IQPR and noted the performance against metrics. The Committee raised its concern over the increase to the C-section rate and will receive an update at the next meeting.	**Amber/Green**

9. Governance Review update and terms of reference The Committee received the terms of reference for the proposed Trust governance review and were informed that an Advisory Group has been set up to oversee the work. The Committee will receive a draft report at the September meeting with a final report to the October Board.	**Green**
10. Quality and Patient Safety Group – key issues report The Committee received the quality and patient safety group key issues report and noted its content.	**Green**
• **Escalation to Board** The Committee escalates the following to Trust Board:- • Capacity and system pressures and difficulty with discharges • Duty of candour during COVID • Patient experience - asking the Board for a dedicated session to consider the implementation of what the in-patient survey is telling us, engaging the Board in the development of the patient experience strategy.	

Meeting of the Board of Directors in Public

Thursday, 09 September 2021

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	3.4
Committee Chair:	Tony Ullman, Chair of Committee/NED		
Date of Meeting:	Tuesday 17 August 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 The Committee received the quality report which provided an update on progress for the month of July and delivery on the Trusts CQC Action plans for ED and IPC, CQC information requests, quality assurance visits, patient safety issues, implementation of the quality strategy show case forum and clinical effectiveness. The Committee were informed about the Quality Strategy Showcase Forum which took place last week which was an opportunity to share progress across the Trust, successes and achievements to date and next phase of implementation which included reductions in hospital acquired Pressure Ulcers, Falls and Infections and improvements in nutritional care and management of patients with dementia and delirium. The Committee also heard about the Clinical Audit & Quality Improvement Poster competition which took place as part of the Medway Innovation Institute week of celebrations.	**Red/Amber**

The Committee acknowledged the work and progress made to date but was not assured on the progress with the reduction in the backlog of datix and the impact on quality and safety. The Committee have requested the new clinical director for ED to attend the September or October Committee meeting to share their plans to address backlogs and improvements in ED.	
2. Progress on sustainable discharge process The Committee were updated on progress on sustainable discharge process following the last update in May. The Committee noted the content of the report and progress to date. The Committee acknowledged and discussed the discharge challenges in recent months due to lack of capacity in the system and partners and how this effects flow, length of stay and patient experience. The Committee noted the risks to the system regarding the lack of discharge funding that has been escalated regionally and to the treasury. The Committee will continue to monitor at the next meeting.	**Amber/Green**
3. Medicines management quarterly report The Committee received the medicines management quarterly report noting its content and were assured by the proactive response taken to recent controlled drug incidents. The Committee noted the medication safety group has been set up to manage medication incidents and acknowledged the work underway to address issues related to missed or late administration of antibiotics. The Committee will receive a further update in 3 months.	**Green**
4. Innovation and QI quarterly report The Committee received a quarterly update from the Medway Innovation Institute and QI on the work and projects supported since the launch in July 2020. The Committee noted the good balance of ideas being put forward by staff that have flourished into projects and improvements across the Trust. The Committee discussed the potential of duty of candour being a QI project and conversations will take place outside of the Committee meeting to progress this.	**Green**
5. Quality IQPR The Committee received the Quality IQPR and noted performance against metrics. The Committee noted the compliance rate of the friend and family test and were informed of the work currently being undertaken by the Associate Director of Patient Experience and Matron with divisions to improve patient experience. The Committee will be updated on progress via the Patient Experience report.	**Amber/Green**
6. BAF – quality The Committee received the BAF – quality noting the changes highlighted within the document and agreed to the increase in risk rating for 5c being appropriate given the challenges at the Trust. The Committee requested the risks relating to the backlog of incidents be incorporated into risk 5a.	**Green**

The Committee will receive a refreshed BAF – quality at the next meeting.	
7. Quality and Patient Safety Group – key issues report The Committee received the key issues report from the Quality and Patient Safety meeting held on the 12 August 21 noting its content.	**Green**
8. Review of the Quality Assurance Committee Work Plan The Committee undertook a review of its work plan with the Chair requesting comments to be sent through to the Committee secretariat with an updated work plan to be approved at the next meeting.	**Green**
9. Effectiveness survey The Committee completed an online survey on the effectiveness of the Committee. The results will be shared at the next meeting.	**Green**
• **Escalation to Board** The Committee escalates the following to Trust Board:- • Lack of assurance on the back log of Datix • On-going concern with pressures on discharge and what the Trust can to do to aid discharge and lack of system resources to support discharge	

Meeting of the Trust Board
Thursday, 09 September 2021

Title of Report	**Safe Staffing and Workforce Review Update**	Agenda Item	**3.5**
Lead Director	Jane Murkin, Chief Nursing and Quality Officer		
Report Author	Liam Edwards, Deputy Chief Nurse		
Executive Summary	As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, provider Trust Boards are required to receive an annual review and approve any changes to nursing establishments. This is also aligned to the recently published Royal College of Nursing (RCN) Nursing Workforce Standards (2021) which outline the responsibility and accountability of organisations for setting, reviewing and taking decisions and action on staffing levels and skill mix. The annual review of nursing staffing levels presented by the Chief Nursing & Quality Officer to the Board in July 2020, at which funding was approved to increase nurse establishments by 65 FTE and recruitment has continued over the past year to support achievement of last year's provider review recommended levels for safe nurse staffing. The Trust Board received a six monthly update on nurse staffing in January 2021 which outlined progress with recruitment to the additional posts and work undertaken to ensure safe nurse staffing across in patient wards. This paper provides the Trust Board with a high level progress update on the annual provider review of nurse staffing levels and associated timelines for the completion of the annual review with a formal report to the Trust Board. This paper also highlights additional areas related to safe nurse and midwifery staffing at Medway NHS Foundation Trust. The nationally recommended Safer Nursing Care Tool (SNCT) is the nationally recommended NICE tool which provides a standardised and systematic measure of nurse staffing levels at ward level, calculating adult inpatient ward staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guide Chief Nurses in their safe staffing decisions. The SNCT is in use across the inpatient wards of the Trust and allows nurses to take decisions on nurse staffing levels in line with patient acuity and dependency. The review of in patient adult wards includes 21 wards. The annual safe staffing review commenced on the 08 July 2021 and has been delayed this year due to external training and validation that was brokered by the Chief Nursing and Quality Officer through Hilary Chapman and the national safe staffing team. International recruitment continues with a significant decrease in staff nurse vacancies. Areas to highlight with vacancy rates above 5% are maternity and		

	paediatrics which are recognised nationally as an area of challenge with regards to recruitment. A pilot of international recruitment of Midwives is currently being scoped by NHSEI and the Trust has been successful in submitting an expression of interest for this.
Committees or Groups at which the paper has been submitted	Nil
Resource Implications	Due to challenges with obtaining support with data entry to the SNCT this has resulted in a two week delay to timelines. It is hoped this can be reduced within the rest of the plan. Resource implications highlighted were included in the RMN business case with agreement to test and pilot the approach for a small team of CSW for a year and evaluate prior to being substantiated.
Legal Implications/ Regulatory Requirements	Failure to comply with validated safe staffing levels and workforce standards in line with Royal College of Nursing (RCN) guidance, the National Institute of Clinical Excellence (NICE) guidelines, NHSI recommendations and Care Quality Commission Regulations, could lead to the Trust not meeting its terms of authorisation, resulting in breaches of regulation.
Quality Impact Assessment	Quality Impact Assessments (QIA) will be completed following analysis of the SNCT for areas that have significant deviation (more than 10%) from the recommended staffing model for that area.
Recommendation/ Actions required	The Trust Board is asked to note the content of the report and progress to date with the annual provider safe nurse staffing review.

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

The key headlines and levels of assurance are set out below:	
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required

1 Introduction

The purpose of this paper is to provide the Trust Board with a high-level progress update on the annual provider review of nurse staffing levels and associated timelines for the completion of the annual review with a formal report to the Trust Board

This paper also highlights additional areas related to safe nurse and midwifery staffing at Medway NHS Foundation Trust.

As part of the National Quality Board (2016) requirements around the monitoring of sustainable safe staffing levels on inpatient wards, provider Trust Boards are required to receive an annual review and approve any changes to nursing establishments.

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

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

The review encompasses the adult in patient wards which totals 21 areas.

The annual safe staffing review commenced on the 08 July 2021 and has been delayed this year due to external training and validation.

The Chief Nursing and Quality Officer brokered this external training through Hilary Chapman and the National Safe Staffing Workforce Team to provide an additional level of assurance that staff had been trained in the use of the tool and methodology.

Due to the training the review timelines were extended by two months with the training which commenced in June 2021 by the National Safe Staffing team from NHS E/I.

The training has provided additional assurances and validation of the Safer Nursing Care Audit (SNCA) which had not previously been undertaken in the Trust.

Due to operational pressures there were some challenges with all areas completing the training; however the majority of areas completed the training with the adoption of the more robust training with areas covering adjacent wards to assist with scoring as a mitigation.

All adult inpatient areas are included in the review with notable exceptions being Critical Care, Maternity Paediatrics and specialist areas such as Theatres and Outpatients.

Birthrate plus has been reported to the Trust Board and the recruitment plans in place to address Maternity safe staffing. Additional areas not covered in this annual provider review will be reviewed in quarter 4.

Following the unannounced inspection of the Emergency Department in December 2020 and concerns raised relating to nurse safe staffing, the Chief Nursing and Quality Officer requested support from the national team to undertake a review of the ED nurse staffing. The analysis was undertaken using attendance data with feedback to date which has been provided verbally with a formal report to follow.

The recently developed national tool by NHSEI for Emergency Care (ED) is due to be published in the next month and once this has happened the national team will use the tool to run the Trust data and information through to reassess the safe nurse staffing and benchmark against other similar sized providers.

The safe staffing review data collection commenced on the 08 July 2021 and was completed on the 8th August 2021. Currently the data is being manually inputted into the SNCT which will perform an average data of dependency and acuity of the wards. Unfortunately due to challenges in obtaining assistance in data entry this has led to a two week delay to this process, although it is anticipated this will be reduced with further efficiencies within the latter timescales. Following data entry there will be a period of validation by senior nursing staff led by the Deputy Chief Nurse who has had training by the National team prior to a

final review by the Chief Nursing and Quality Officer. Once completed the report will be presented to the executive group on the 06 October 2021 prior to being presented to the Trust Board.

It should be noted that escalation areas were included within the annual review and as such are not all staffed with established and permanent staff who are substantively employed within this area. This will lead to an overall increase in FTE overall as these would not have previously been included in last year's provider review. Additionally due to the current Covid-19 situation some deviation between previous results would be expected due to the changes in function and role of certain clinical wards and departments areas e.g. McCulloch ward with an increased ventilatory patient caseload will increase both acuity and dependency of this area. For areas which have changed focus there has been a divisional review of staffing which is further mitigated by daily staffing meetings which mitigate both changes in area and the additional staffing requirements of escalation areas.

2 Recruitment

- The trust has made significant progress in recruiting band 5 nurses into the most of the vacancies in both planned and unplanned care divisions. The majority of the current vacancies are at band 5 nurse level within specialist areas such as critical care, theatre and the chemotherapy suite. A specific campaign for the specialist areas is being trialled and as a short term mitigation, lines of agency have been secured. The table below shows the current vacancies but does not include those in the pipeline who have already been allocated and are just going through the OSCE training.
- Central recruitment for CSW, band 5 and 6 continues on a rolling timetable. Our new to care CSW (Care support Worker) initiative continues successfully in line with the HCSW2020 campaign from NHSEI. The new to care CSW programme increases our ability to recruit CSW positions as it requires no previous experience of healthcare and attracts an additional funding premium from NHS I /E for support. This is utilised by supported by the newly recruited band 4 CSW associate educator role along with the new accelerated care certificate programme.
- A leadership programme to assist with band 5 ward developments to more senior roles and support the gap in band 6 vacancies is being commissioned and will be launched in December 2021 (earliest date available from provider).
- Nursing Vacancies as of 01 August 2021 excluding additional open capacity which is not established.
    - Band 5 = 37.28 WTE
    - Band 6 = 65..58 WTE (of which Emerald Same Day Emergency Care 10.57 WTE, HDU 7.91 WTE, ICU 9.2 WTE)
- An automatic offer of employment is offered to all adult nurses that complete their programme whilst at Medway NHS Foundation Trust

3 Increase in patient population requiring Mental Health support whilst an inpatient

- Supporting the needs of patients with Mental Health needs and challenging behaviour and responding to the increased numbers of children admitted to the paediatric ward, providing a safe environment with the relevant expertise and staffing levels has been an area of need and risk.
- Specifically addressing the requirement of children with additional mental health concerns waiting for specialist placement also continues to be an area of challenge and staffing with increased need upon RMN staff within the Paediatric area.
- Challenges remain with regards to fill rate although mitigations have been applied such as movement of staff, to reduce risk. The recently approved Business case for a lead RMN to lead a team of professionals has been advertised and closes on the 28 August 2021.

Meeting of the Trust Board in Public
Thursday, 09 September 2021

Title of Report	**Integrated Care System Update**	Agenda Item	**4.1**
Lead Director	Paula Tinniswood – Chief of Staff		
Report Author	Paula Tinniswood – Chief of Staff		
Executive Summary	In November 2020 NHS England and NHS Improvement published Integrating care: Next steps to building strong and effective integrated care systems across England. It described the core purpose of an ICS being to: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development. The foundations of integrated care are to support collaboration, local decision making and flexibility. Co-development with system leaders, people who use services and many other stakeholders, supports the development of guidance, through to implementation.		
Committees or Groups at which the paper has been submitted	Executive Group		
Resource Implications	N/A		
Legal Implications/ Regulatory Requirements	N/A		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	None		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices			

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

Introduction

In advance of the full development of the Kent & Medway ICS, Medway NHS Foundation Trust is currently participating in committees and groups, collaborating in Population Health, Sustainability, Digital, Estates, EPRR and Workforce discussions across the region. Each committee will formally feed into the ICS Board, as a constituent member of the ICS Partnership. Providers of NHS services will play a central role in establishing the priorities for change and improvement across our healthcare system, delivering the solutions to achieving better outcomes.

NHS England and NHS Improvement will be delegating commissioning of primary care and appropriate specialised services.

All clinical commissioning group (CCG) functions and duties will transfer to the ICS when established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Medway NHS Foundation Trust: will play a critical role in the transformation of services and outcomes across and beyond systems. We will continue to work alongside primary care, social care, and public health, to tailor our services to local needs and ensure integration in local care pathways. We will also be more involved in collectively agreeing with partners how services and outcomes can be improved for our community, how resources should be used to achieve this and how we can best contribute to population health improvement as both service providers and as local 'anchor institutions'. The ICS will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure all are fully engaged.

Provider collaboratives, are partnership arrangements involving two or more trusts, working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 demonstrated both the need for and potential of this type of provider collaboration. Providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022, Medway NHS Foundation Trust, along with all acute and/or mental health services are expected to be part of one or more provider collaboratives. The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers.

Staff are at the centre of the collective ambition for greater integration and better care. The ICS have a central role to play in delivering the vision for our 'one workforce'. From April 2022, the ICP will have the responsibility for delivering the ten people functions as listed below. These are built on delivering aspects of the NHS People Plan and also align with the Trust's Our People strategy.

1. Supporting the health and wellbeing of all staff;
2. Growing the workforce for the future and enabling adequate workforce supply;
3. Supporting inclusion and belonging for all, and creating a great experience for staff;
4. Valuing and supporting leadership at all levels, and lifelong learning;
5. Leading workforce transformation and new ways of working;
6. Educating, training and developing people, and managing talent;
7. Driving and supporting broader social and economic development;
8. Transforming people services and supporting the people profession;
9. Leading coordinated workforce planning using analysis and intelligence;
10. Supporting system design and development.

Specifically, the actions required through 2021/22 by system leaders are required to deliver:

i. Agree the formal governance and accountability arrangements for people and workforce
ii. functions in the ICS, including appointed SROs.

iii. Agree how and where specific people responsibilities are delivered within the ICS.

iv. Review and refresh the ICS People Board.

v. Assess the ICS's readiness, capacity and capability to deliver the people function.

Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight.

The ICS NHS Board

The appointment of the ICS Chair is progressing, with Stakeholder discussions with candidates, carried out on Thursday 26th August 2021.

As a new type of organisation, the governance arrangements for ICS NHS bodies is different to those of existing commissioner and provider organisations in the NHS. They will reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies. The board will be the senior decision-making structure for the ICS NHS body.

The Board: will consist of Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees).

Executive roles: chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.

Partner members: a minimum of three additional board members, including at least:

– one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area.

– one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body.

– one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

Governance arrangements: to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.

Contracts and agreements: to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system

Supporting providers: to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together.

Local authority and VCSE partners: to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.

System implementation of the People Plan: by aligning partners across each ICS to develop and support the 'one workforce', including through closer collaboration across the health and care sector, and with local government, the voluntary and community sector and volunteers

System-wide action on data and digital: ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care.

Join-up data and digital capabilities: to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.

Work alongside councils to invest in local community organisations and infrastructure: through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.

Drive joint work: on estates, procurement, supply chain and commercial strategies to maximise value for money across the system

Plan, respond and lead recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.

Meeting of the Public Board
Thursday, 09 September 2021

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework</td><td>Agenda Item</td><td>4.2</td></tr>
<tr><td>Report Author</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Lead Director</td><td colspan="5">Gurjit Mahil, Deputy Chief Executive</td></tr>
<tr><td>Executive Summary</td><td colspan="5">A summary of the BAF as of 24 August 2021 is presented in this paper.

The Trust's principal risks are:

<table>
<tr><th>Risk</th><th>Target Score</th><th>Initial Score</th><th>June 2021</th><th>July 2021</th><th>August 2021</th></tr>
<tr><td>3a – Delivery of financial control total</td><td>9</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>3b – Capital Planning</td><td>12</td><td>16</td><td>16</td><td>16</td><td>16</td></tr>
<tr><td>5c – Patient Flow</td><td>6</td><td>12</td><td>12</td><td>12</td><td>16</td></tr>
</table></td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="5">Board Sub Committees</td></tr>
<tr><td>Resource Implications</td><td colspan="5">N/A</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="5"></td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="5">N/A</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="5">The Board is asked to note the report for assurance regarding the processes in place around risk management.

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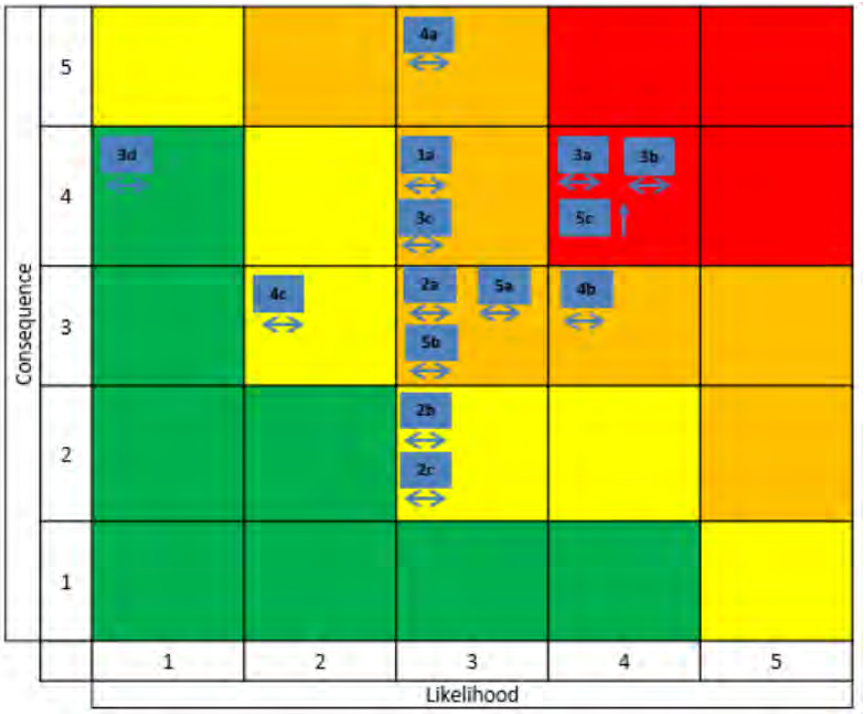
1 Board Assurance Framework

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

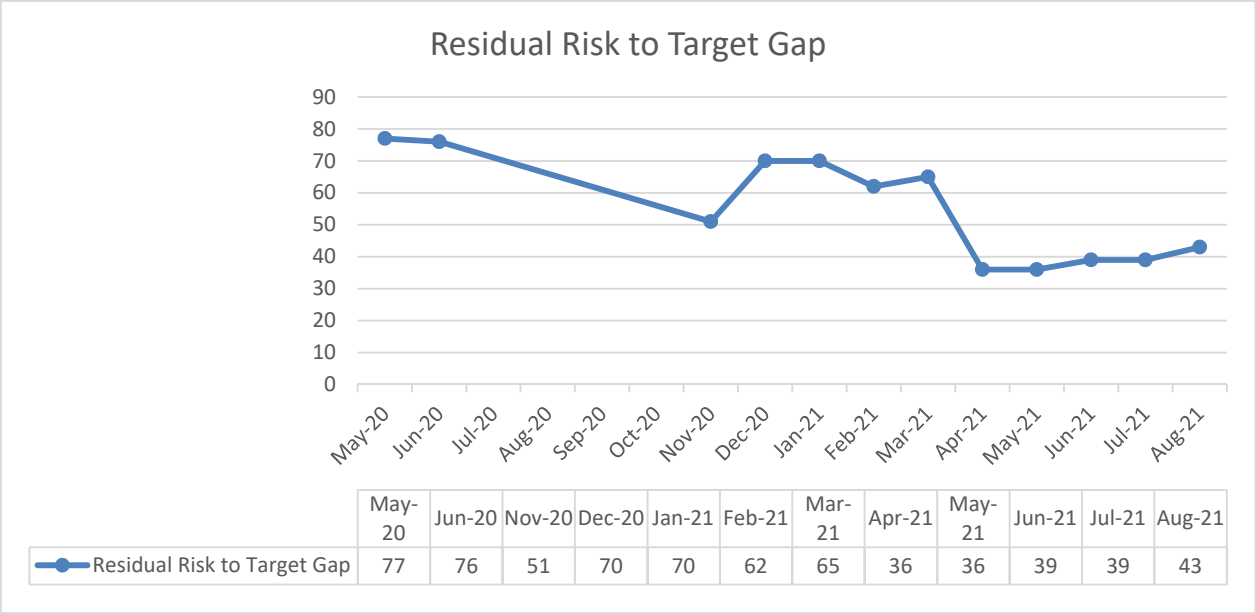
There are three principles risks that are rated as high, 3a – delivery of financial control total, 3b – capital planning and 5c – Patient Flow.

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

Patient Flow is being managed through with the clinical and operational teams and continued work with the rapid improvement event with the transformation team, which has seen changes in the delivery of key pathways to improve patient care.

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

Table 1.1 – Summary of BAF



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

Figure 1.2: Residual risk to target gap

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.

COMPOSITE RISK: Innovation

EXECUTIVE LEAD: Chief of Staff

LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care

				Assurance						
Risk Number / Description	**Cause and Impact**	**Initial Risk Rating**	**Mitigations / Controls**	**Level 1 (Operational Management)**	**Level 2 (Oversight Functions – Committees)**	**Level 3 (Independent)**	**Actions to be Taken**	**Current Risk Rating**	**Target Risk Rating**	**Overall Assurance F, P, N**
2a There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP/ICS and the organisation's role therein.	Trust may slow down investment in digital innovation to keep to the pace with new technologies, other organisations locally and the ICP and ICS/STP.	4 x 4 = 16 **High**	1. Author a Digital Strategy that is well socialised across the region and well engaged with by teams internally. 2. Develop a roadmap to a single Electronic Patient Record. 3. Focus initially on key projects and investments to stabilise IT services (telephony, networks, end user devices, licenses, systems upgrades, service desk). This will provide a strong technology and information foundation to build upon: EPR, innovation, whole system analytics, specialist services. 4. Seek Regulator support for IT investments and longer-term Digital Strategy	Director of Transformation and Digital, CIO and Senior Digital Team Weekly CIO call with all Kent & Medway provider Trusts ICP Digital Strategy Group	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	Appoint CCIO – appointment of 4 digital clinical leads completed – Nursing digital leads to be in place by October 2021. Re-launch Digital Hub – September 2021 Work closely with regulators – ongoing.	**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. Appointment of 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	Re-launch Digital Hub – September 2021 Work closely with regulators – ongoing.	**2 x 3 = 6 Low**	**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	ICS and HSLI funding discussions ongoing - £3.5m received in 20/21, Finalising £1m bid for 21/22 Adopting Innovation bid ongoing	**2 x 3 = 6** **Low**	**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 ICS must meet its control total. Given the uncertainty of Covid, CIP delivery risks and the system operating on a block income, there is significant uncertainty and a risk of the Trust not meetings its control total. This risk is exacerbated by significant activity / demand above planned levels, particularly emergency and non-elective demand.	4 x 4 = 16 **High**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: a. substantive fill rates are increasing with a decrease in bank and agency usage b. improving run rate during the year c. live monitoring of cost improvement programme d. rebasing of directorate plans	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".	Preparation for H2 planning. Formal written guidance expected September 2021. Internal guidance drafted and due to be issued w/c 23 August 2021.	4 x 4 = 16 **High** (Previous risk rating: Mar 2021 4 x 2 = 8 **Low**)	3 x 3 = 9 **Moderate** (Previous target risk rating: Mar 2020 3 x 2 = 6 **Low**)	
			2. Programme Management Office: a. Track operational delivery and financial consequences of those actions. b. Review of team hierarchy to ensure capacity to deliver c. Further consideration to be given to reintroduction of a Financial Improvement Director / Financial Recovery Plan lead. d. Working with NHSEI intensive support team. e. Delivery of efficiency showcase events.	Chief Financial Officer and Chief of Staff.	Efficiency Delivery Group.		Efficiency Delivery Group to be established with TOR by 1 September 2021.			
			3. Financial Training Policy and SOP drafted, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon.	Delivery of and attendance at training programmes for staff. Appraisals / objective setting.	Financial Stability Programme Board.		Financial training packages to be reviewed and refreshed, including development of an induction leaflet, by 30 September 2021.			
			4. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings. c. Patient First Programme workstreams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication.	Chief Operating Officer	Weekly Senior Operations Meeting that reports via IQPR	Monthly IQPR meetings with NHSE/I				
3b Capital Investment	If there is insufficient resource to invest in new	4 x 4 = 16 **High**	1. Governed entirely by the availability of capital resource, obtaining Public Dividend Capital (or loans) for significant investment	Trust business case governance process and templates	Project reviews by Finance Committee		1. Trust clinical and divisional strategies to be	4 x 4 = 16 **High**	4 x 3 = 12 **Moderate**	

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

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**
	lead to further licence conditions and potential regulatory action.					provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.				

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)	1. Trust vacancy rate at 11%; 2. Substantive workforce 84% 3. Monthly PRM including discussion on workforce, vacancies,						

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

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 requirements of the Health and Social Care Act	**Cause:** 1. Lack of effective governance systems and processes to routinely monitor compliance with the fundamental standards. 2. Lack of evidence to demonstrate compliance with NQB and NICE guidance (2015) Workforce Standards **Impact:** 1. Potential for regulatory action by CQC &/ or NHSI. 2. Loss of confidence in the Trust by the wider healthcare system. 3. Poor staff morale and engagement. 4. Damage to patient experience and patient outcomes.	**12 High 3(L) x4(C)**	1. Trust wide and ED specific CQC action plans being implemented 2. Enhanced leadership within Patient Experience and Quality & Patient Safety 3. CNST (Maternity Incentive Scheme) action plan being implemented 4. Quality Strategy Priorities Year 2 agreed and being implemented 5. High Quality Care Programme Year 2 improvement priorities agreed, measures being developed and work progressed 6. Refreshed ward assurance and accreditation visits being developed 7. Quality Boards in place on all wards 8. Gold 'stars' awards being implemented to recognised and celebrate achievements in achieving high standards and improving patient outcomes. Daily trust wide safe staffing reviews undertaken by HON with escalation to DDON and CN&QO as appropriate. 9. Daily senior nurse staffing meeting with escalation to CN&QO as appropriate. 10. Annual provider review on safe nurse staffing. 11. Recruitment pipeline progressing as per plan.	Quality Panel Governance in place with fortnightly meetings. CQC Evidence panel in place with fortnightly meetings. Quality and Patient Safety Group meeting monthly. CNST Task and Finish Group meeting fortnightly. Care Group and Divisional Governance Boards meeting monthly	Monthly progress reports on divisional Quality Governance to Q&PSG, Executive Group, Quality Assurance Committee and Trust Board. High Quality Care Programme Board provides monthly progress reports to the Trust Improvement Board. Rolling programme of preparedness CQC care group showcase forums in place. Quality Report and Accounts.	Internal Audit and External Quality Audit. QGR meetings with GCCG CQC Engagement Meetings Single Item Multi-Agency meetings The report on the CQC core service and well led reviews has been published and development of action plan to address MD / SD actions and future organisational approach and plan / proposal for taking teams to outstanding and good being progressed under leadership of CNQO & AD QPS	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. The independent Quality Governance review led by NHSI is currently underway and an Advisory Group has been established. 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. June 2021: 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. June 2021: 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.	IPRMs for 21/22 now confirmed and being implemented N&M Scorecard to be implemented by end of Q1. The Scorecard has been developed with a delay in implementation as pending IT connection of PowerBI, matter has been escalated to the relevant Executives. – to be resolved by ealry September 2021.			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. June 2021: 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. Bi monthly Quality meeting implemented and in place with divisional leadership teams to support delivery of quality priorities and address any areas of concern or risk			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 requirements of the Health and Social Care Act (Hygiene Code) will result in a risk to patient safety.	**Cause:** Lack of effective IP&C governance systems and processes to routinely monitor and maintain compliance with the hygiene code **Impact:** Potential for regulatory action by CQC &/ or NHSI. Loss of confidence in the Trust by the wider healthcare system. Poor staff morale and engagement. Damage to patient experience and patient outcomes.	**12 High 3(L) x4(C)**	1. IPC Improvement plan developed, setting out short, medium and long term goals 2. IPC Improvement plan approved by Executive Team and QAC and reported at Trust Board 3. IPC Intensive Support programme supporting the Trust 4. IPC now under the Executive leadership of the CN&QO who is also now designated as DIPC 5. Refreshed IP&C Team structure and leadership 6. Interim AD for IP&C in place whilst recruiting to post substantively. 7. Identified improvement priority work through HQCP to reduce C- Diff Infections 8. IP&C Governance Review completed and Report in draft form. 9. IPC Unannounced inspections commissioned by CNQO with findings being drafted with themes and learning to be shared 10. COVID-19 BAF updated, reviewed externally and maintained with evidence to support collated 11. CNQO wrote to Executives regarding their executive areas of responsibility to support delivery of Trust Improvement Plan 12. Interim Matron sourced due to start ASAP -6 months contract and recruited into substantive Matron - substantive matron now in post 13. Additional IPC team posts recruited to Assoc. Director for IP&C commenced 9 August 2021 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. IPC CQC action plan developed in response to CQC inspection findings.	IPC policies, procedures and protocols being reviewed. Scottish Infection Control manual approach to be adopted, reducing number of out-of-date policies from 46 to 18. IPC Improvement Plan developed setting out short, medium and long term goals for delivery Mandatory IPC training compliance at over 95% for the majority of the last several months. Divisional and programme scorecards with key IPC indicators	Infection Prevention and Control Committee Antimicrobial Stewardship Committee Quality Assurance Committee Quality Panel High Quality Care Programme - IPC is within Mission 1. Safe Care focussing on C Diff reduction Decontamination Group in place – IPC Cell initiated as per COVID Plan	IPAS (NHS I/E) meeting Oversight from system DIPC NHSE/I report CQC IP&C Inspection report	IPC policies currently undergoing review. PIRs not being completed in a timely way, therefore limited lessons learned and shared.	IPC Governance Review: final report to Exec Meeting, QAC and IPC Committee. Executives have agreed to all recommendations which have been added to the IP&C Improvement Plan. CQC IP&C Inspection Report received, action plan approved by the Executive and oversight and being monitored through existing governance arrangements of the Quality and Evidence Panels	**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 beds 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. c. All the elective standards are delivering as per the agreed trajectories (some ahead of trajectory). d. The NEL trajectories for the 4 hour standard, time spent in ED and ambulance handovers have regressed in recent months. e. The demand for emergency care has exceeded the expected levels for attendances and admissions. 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.	Recovery plans including agreed trajectories for all constitutional standards Patient Discharge & Flow Programme with focused clinically led work-streams. Daily and Weekly operational performance reviews for elective, cancer and emergency activity Daily check points for activity & flow Trajectories for all constitutional standards in place. Involvement of Matrons and Clinical Leads in Flow management More clarity and targeted actions with system-partners on out of hospital capacity and responsiveness Outputs and rapid changes from the Rapid Improvement Event held w/c 16 July 2021 being reviewed as to whether to adopt, adapt or discard any of the 'tests of change'	Reviews and updates discussed at Executive Group, TIB and Board. Daily and weekly senior operational oversight. National planning tools being used. System calls in place to ensure escalations. IQPR PIRM Progress against ED action plan will be overseen by Quality Panel	External reviews by NHS I/E Single Item Multi-Agency meetings Monthly checkpoint with SE Region Monthly ICS Performance Reviews	Inability to fully mobilise the bed configuration and refurbishment plan. Inability to deliver the improvements in LOS & discharge management in a sufficiently timely way make sufficient progress before winter 21-22.	Wave 3 planning & mobilisation of escalation capacity. – Plan agreed More engagement with Estates and Facilities re priorities for capacity configuration. Funding decisions for "progress chasers", - September 2021.	**4x 4 = 16 High (previously 4x3 moderate)**	**2 x 2 = 4 Very Low**	Partial

			8. The Trust has been ~~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								

Meeting of the Trust Board
Thursday, 09 September 2021

Title of Report	**Winter Plan 2021/22**	Agenda Item	**4.3**
Lead Director	Angela Gallagher, Chief Operating Officer (Interim)		
Report Author	Keith Soper, Deputy Chief Operating Officer		
Executive Summary	Our Winter Plan sets out the organisational and system response to anticipated additional pressure as a result of seasonal demand. Developed to work alongside our Covid-19 Surge Plan, the Winter Plan describes the capacity gap and triggers that will prompt actions and the mobilisation of escalation capacity to ensure operational and quality standards are met. It is acknowledged that, in doing so, additional risk is introduced and therefore the plan contains a proportionate set of actions that seek to mitigate, as far as is possible, any increase in risk. Like most hospitals, we will have a predicted bed gap at the peak of winter and with additional escalation capacity this is 73. Our business as usual bed deficit is in the range of 12 to 24 beds and therefore the difference is likely to be an adverse variance of circa 55 beds which we will mitigate through improving timely discharge, working closely with partners in the community and reviewing how we use parts of the hospital to maximise bed space.		
Committees or Groups at which the paper has been submitted	Executive Group via the Winter Planning and Covid-19 Group		
Resource Implications	There are additional financial implications relating to increases in capacity outside of what is within the 2021/22 financial plan		
Legal Implications/ Regulatory Requirements	The Winter Plan is designed to ensure compliance with our regulatory requirements and safeguard performance against key indicators across our elective and non-elective work		
Quality Impact Assessment	A risk and impact assessment is incorporated as part of the Winter Plan		
Recommendation/ Actions required	The Board is asked to note progress.		
	Approval ☐	Assurance ☐	Discussion ☐	Noting ☒
Appendices			

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:

Assurance	Amber/ Green - Assurance with minor improvements required

1 Executive Overview

Every year our health and social care system faces significant demands, with 2021/22 bringing the additional challenge of a global Covid-19 pandemic. Each wave of Covid-19 has manifested differently, and whilst the current and most recent wave has had less of an impact than earlier waves, it has provided the first experience of managing both Covid-19 and 'normal' hospital demand. As a result, we have remained in escalation capacity throughout the summer. We have, however, maintained our elective programme and managed the pressures associated with the current Covid-19 surge in line with our agreed plan.

Seasonal variations in illness have historically resulted in increased emergency admissions and length of stay in hospital during the winter months with pressures tending to peak between November and March. This winter is expected to see a return to traditional winter demand (e.g. seasonal flu, norovirus, snow etc.) alongside attendances and admissions for Covid-19. There will also likely be an increase in incidental findings of Covid-19, including amongst our workforce and within partner organisations, as the impact of the lifting of restrictions continues to be felt. This combination of pressures will significantly impact on service delivery, emphasising the need for rigorous and robust resilience planning.

Our draft Winter Plan sets out the scale of the challenge. It seeks to preserve, for as long as possible, business and usual. However it is inevitable that additional escalation capacity will be required. At the peak of pressures it is anticipated that the bed gap is as high as 73. The plan details the identified capacity and the implications of introducing it on our performance, partners, workforce and, most importantly, our patients. Like most hospitals, we will have a predicted bed gap at the peak of winter and with additional escalation capacity this is 73. Our business as usual bed deficit is in the range of 12 to 24 beds and therefore the difference is likely to be an adverse variance of circa 55 beds which we will mitigate in the final plan through improving timely discharge, working closely with partners in the community and reviewing how we use parts of the hospital to maximise bed space.

2 Conclusion and Next Steps

The plan has been informed by clinically-led escalation triggers and responses at a care group and specialty level. These triggers are being consolidated into a new set of site level triggers, which will be tested throughout September and finalised prior to the plan being completed.

In addition, work is underway to quantify the impact of a series of 'bridging the gap' actions from our improvements to flow, whilst also including the impact of less palatable changes to increase capacity within the hospital.

A final version of the plan including the outputs from the above work will be presented to Board in October 2021.

2021 Annual Report

MEDWAY INNOVATION INSTITUTE

NHS Medway NHS Foundation Trust

MEDWAY INNOVATION INSTITUTE

"Engage and empower your staff to be improvement partners within your organisation.

Be focused on continuous learning and curiosity. Learning is so important in everything that we do.

Use external help. Look at what colleagues are doing great – share what you're doing great.

Cath Campbell, Head of Hospital Inspection
South East – CQC

Contents Page

Professor Ranjit Akolekar

Co-Founder, Medway Innovation Institute
Consultant, Fetal Medicine, Medway NHS FT

"

I came to work at Medway because I saw the opportunity to develop a service from the ground-up and to improve the lives of some of the most vulnerable people in society.

For many years, I have engaged with research at Medway and made the case that a research-active organisation delivers better, safer care.

In all my time here, the Institute is by far the most ambitious and coherent attempt we have made to coordinate our efforts in research, QI, service evaluation and clinical audit.

Dr Edyta McCallum

Co-Founder, Medway Innovation Institute
Head of Research & Innovation, Medway NHS FT

"

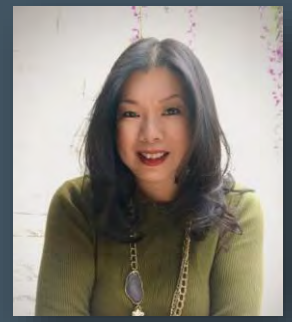
Before coming to Medway Hospital, I worked at a number of large Trusts but none of them compare to the drive, enthusiasm and creative culture that I found at Medway. I was given an autonomy and provided with support that enabled me to develop a successful Research & Innovation Department, offering novel and up to date clinical treatments to our patients.

The next step on the journey was to enable the staff to develop and implement their own innovative ideas, leading to an improvement in services and better care. The answer was the inception of the Medway Innovation Institute. I was delighted to be involved in the creation of the Institute. Working with my colleagues in other departments such as clinical effectiveness and audit, medical teams & HR, we created an environment that empowers the staff to invent, innovate and improve. The Institute's ethos and culture is reflected through its people and the Institute plays crucial part in reinforcing the positive, listening and engaging ethos that the Trust prides itself on.

We have achieved a lot already and there is more to come in the next year!

Jenny Chong

Steering Committee Chair, Medway Innovation Institute
Associate Non-Executive Director, Medway NHS FT



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The Institute started as an idea - a reaction to the frustration that our grassroots staff could not get their innovative solutions off the ground or prototyped for impact analysis, in a safe space where they can explore and learn. Our staff are the experts on what our patients need; many of our staff are long-standing members of our community, they and their families are our patients; many of our staff have worked in the Trust for many years. They possess unique insights and solutions that can improve care and outcomes for our local community, so why would we not harness this valuable resource?

I want to thank Jack Tabner, one of our co-founders and former Executive Director of Transformation and IT, who developed and executed the vision of the Institute during his time in the Trust. He recognized that an Institute was essential to epitomize and galvanize the *collective willingness*. A willingness to default to a "hell yes!' when someone says "I've got an idea!". A willingness to bring a bunch of brilliant people together and tackle problems that everyone says are too difficult. And a willingness to accept that innovating - done properly - takes a method and takes a set of skills that can be acquired and constantly honed.

Jack , Ranjit and Edyta created the foundations for success through their persistence to transform their spark of an idea to reality; their stoic resilience to plough on despite a global pandemic; and their perseverance to embed innovation in the Trust.

A year later, I can say with pride that our staff have embraced an innovation mindset – they have developed confidence in their capabilities underpinned by QI methodologies and feel empowered to push improvement ideas. Whenever I speak to our staff who have implemented their projects via the Institute, I see the pride in their eyes, I hear the enthusiastic energy in their voice and I sense the immense achievement they feel in delivering positive impact for our patients and Trust.

The Institute is proud to have supported our staff to be their best, nurtured a future generation of Innovators and delivered value.
When we believe. We can.

Our Story

The Medway Innovation Institute

WHO WE ARE

Here at Medway, we are determined to innovate, transform and improve our Trust for the health of our patients.

The Medway Innovation Institute brings together all the experience, resource and support you need to capture your learning and provide the momentum needed for real change.

We are here to open doors for you. We'll cut out the red tape and make sure that your ideas turn into action.

OUR STRAPLINE

Accelerating quality improvement

Our Story

The Context

CASE FOR CHANGE

In October 2019, we undertook a programme of research and stakeholder engagement, including 50+ hours of one-to-one interviews, shadowing ward-rounds, informal data gathering, social events and traditional surveys.

Our staff at all levels recognised a 'pride deficit' and a limited response to our transformation programme, particularly amongst clinical staff.

The insight gathered identified the key barriers to engagement like siloed working and management that was top-down and directive. Clear recommendations were provided on how these could be overcome.

In their April 2020 report, the CQC identified "sporadic innovation" and insufficient time from leaders and staff in considering innovation.

Central to our strategy was the development of a virtual 'Institute' for all innovation and quality projects along with a defined methodology and accompanying support framework.

Quality improvement is essential for improved patient care. But too much progress falls to the wayside because of red tape or lack of resource. The Medway Innovation Institute changes that.

Our Story

COVID-19

One silver-lining of the pandemic is that it has untapped the potential of NHS innovators, unfettered by red tape.

COVID-19 prompted a cultural phenomenon across the NHS. Medway was not immune to the wave of innovative impetus that allowed us to adapt to the situation.

Our Covid response demonstrated that grassroots-driven solutions, accelerated adoption of innovation and empowered decision making at all levels improved staff engagement and motivation.

"It was improvement methodology by stealth, we were PDSA-ing and rapid cycle testing."

"We had permission to fail."

"It was local ownership of change, not top-down directives."

"It was genuine teamwork and we had valued contributions from everyone."

"We appreciated the corporate support for clinical leadership, decision-making and innovation."

Clinical Council, 13 May 2020

Our Story

Genesis of the Institute

ESTABLISHING THE INSTITUTE

We researched the frameworks and took inspiration from the following proven and successful models to create the Medway Innovation Institute:

CW Innovation (led by Chelsea and Westminster Hospital FT and their CW+ charity); The Solent Academy; The Health Foundation; and the Kent Surrey Sussex AHSN.

THE BRAND

We created a high quality, branded identity for all improvement work across the Trust and drove a stakeholder engagement programme to ensure that staff experienced this virtual hub as having been created for them, and based on staff insight.

The logo is based around an abstract representation of an open door, to signify the Institute's primary purpose of accelerating quality improvement.

Our Journey – From Idea to Impact

AUTUMN 2019

Idea for an Institute was sparked

OCTOBER 2019

Market research with staff focus groups

MAY 2020

Steering Committee established, Clinical leadership appointed

2 JULY 2020

Medway Innovation Institute Launched!!!

Our Team

The Steering Committee manage the general course of the Institute's operations.

CORE LEADERSHIP TEAM

Jenny Chong	SteerCo Chair ; Associate Non-Executive Director
Prof. Ranjit Akolekar	Co-Founder ; Clinical Lead for Improvement and Innovation – Clinical Research
Dr. Edyta McCallum	Co-Founder ; Head of Research and Innovation
Paula Tinniswood	Chief of Staff ; Director of Transformation and Strategy
Lee Bridgeman	Head of QI & GIRFT
Steve Houlihan	Head of Medical Director's Office
Denise Thompson	Head of Clinical Effectiveness
Lauren Pryor	QI Project Manager

STEERING COMMITTEE MEMBERSHIP

Jenny Chong
Paula Tinniswood
Jack Tabner (Honorary Fellow)
Ranjit Akolekar
Edyta McCallum
Steve Houlihan
Temi Alao
Paul Kimber
Lee Bridgeman
Lauren Pryor
Will Chambers
Denise Thompson
Affra Al Shamsi
Hayley Pegden
Abu Ahmed
Synthia Enyioma

ALUMNI MEMBERSHIP

Jack Tabner (Honorary Fellow)

Our Values

Our values underpin our vision, our beliefs, what we strive for, what we never compromise on.

If something we say or do conflicts with one of these values, we know it is not right for the Institute.

PRIORITISING PATIENT CARE

Everything we do is to improve health, making sure our patients at Medway are kept safe and receive the highest standard of care.

MAINTAINING EXCELLENCE

Our standards are unapologetically high because nothing matters more than the outcomes we want to achieve for our patients.

HAVING A POSITIVE IMPACT

Change can be an incremental nudge or a bold and creative transformation. Either way, it must be guided by a consistent, coherent methodology and result in measurable results that solve real problems for the Trust.

THINKING STRATEGICALLY

Our Trust priorities guide us to get where we need to be. We align and map to those aims and ensure that every project the Institute supports gets us closer to delivering on the Trust priorities and goals.

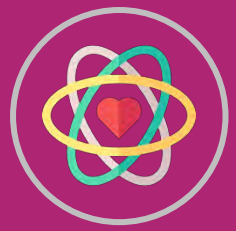
INCLUSIVE COLLABORATION

We believe in the Medway workforce and their capacity to innovate. By bringing the best diverse minds together, we can achieve more, faster.

MISSION

Embed QI, Research and Innovation in the Medway DNA to deliver the best patient care.

ETHOS



- Empower our grassroots to drive positive change.
- Provide an inclusive, safe and collaborative space for prototyping, exploration and learning.
- Provide staff with a QI toolkit and support framework to accelerate innovation.

THEMES

- Rebuild Better – Recovery from Covid and build a resilient workforce.
- Population Health – Preventative healthcare and health equality for our community.
- Joy at Work – Build a strong culture; equip our staff with tools and processes to be their best.

How It Works

- **A single front door**
- A single change method: Aims, measures, changes
- Training
- The role of the ‘Coach’

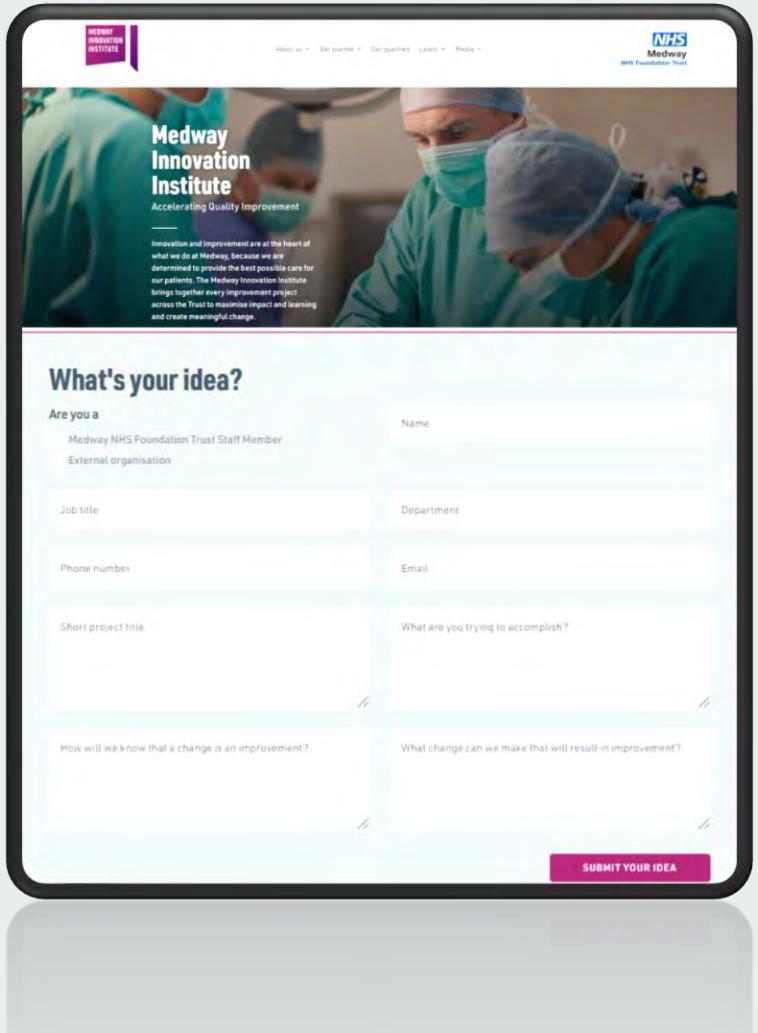
SINGLE FRONT DOOR:

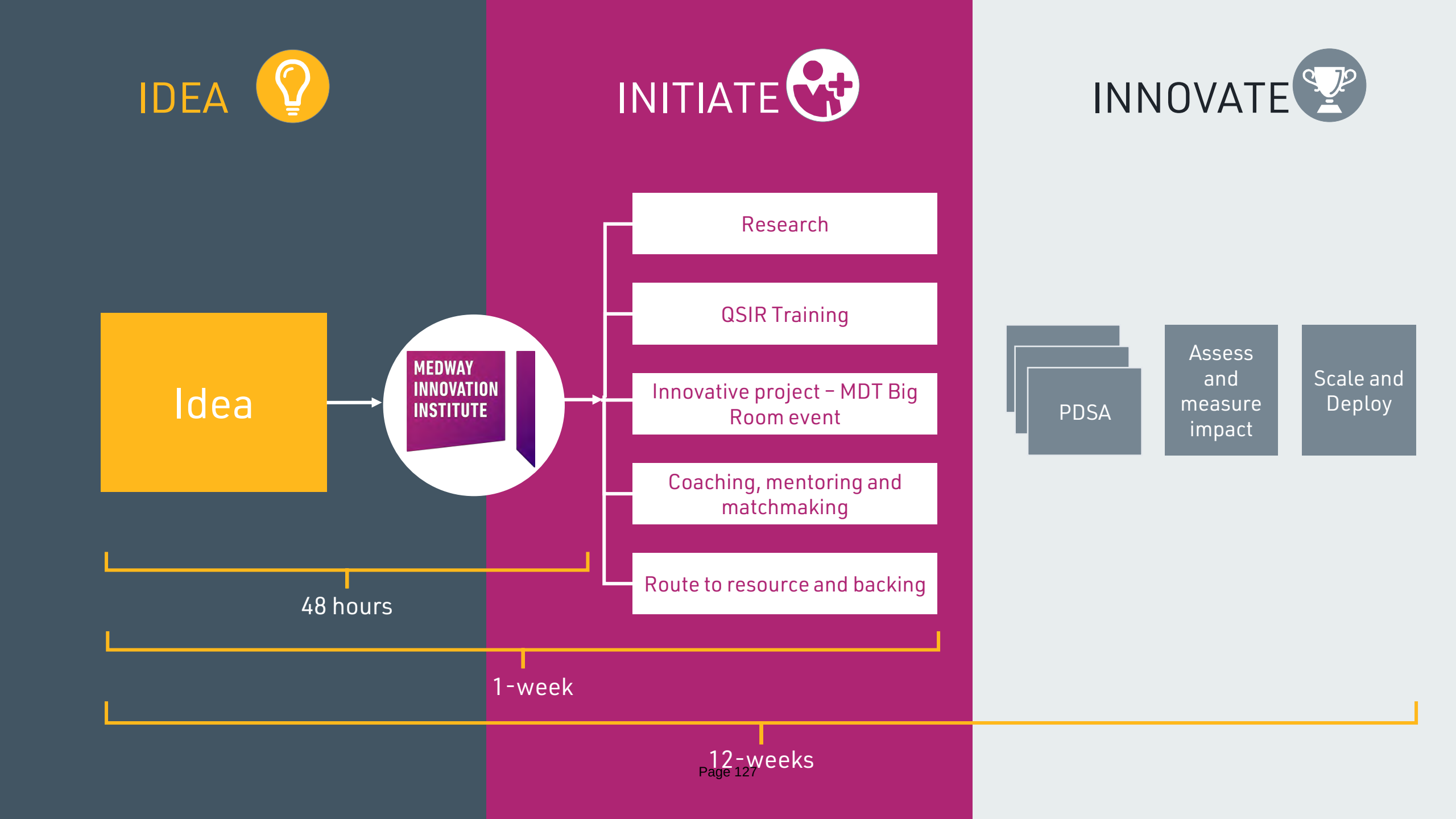
MEDWAY INNOVATION INSTITUTE WEBSITE

The Medway Innovation Institute is for everyone and we welcome all types of innovation and quality improvement projects. From initial ideas to prototypes; minimal viable products; to innovations that are ready to scale, the Institute signposts and triages all submissions appropriately.

The single front door for the Institute is the website: https://medwayinnovationinstitute.com/

The website is also the portal for training resources; tools and templates; case studies; interviews and videos; and our blogs.




IDEA
INITIATE
INNOVATE
Idea
MEDWAY INNOVATION INSTITUTE
Research
QSIR Training
Innovative project – MDT Big Room event
Coaching, mentoring and matchmaking
Route to resource and backing
PDSA
Assess and measure impact
Scale and Deploy
48 hours
1-week
12-weeks

GET QUALIFIED

The Institute's curriculum has been designed around the organisation's need to build QI capability at all levels.

We currently offer the following programmes: Quality Improvement Fundamentals, QSIR Virtual, QI Coach and MediLead.

We are growing and evolving this curriculum, as well as ensuring it can all be delivered virtually.

GET FUNDING

We have a ring-fenced investment fund for projects seeking up to £10,000 via a lean application and panel process.

There is 25% re-investment rate applied to efficiencies delivered through projects.

Project seed funding is also available from Medway Hospital Charity (up to £2,000) and through the CEO Scholarship for Brilliance.

GET GOING

All projects are supported with an assigned and trained QI Coach.

The Institute supplies the essential tools and templates for projects to succeed.

For larger projects, multi-disciplinary project teams are each assigned an Executive sponsor.

Weekly touchpoints ensure progress is made, and after 12-weeks we 'pivot' or 'persevere'.

How It Works

- A single front door
- **A single change method: Aims, measures, changes**
- Training
- The role of the 'Coach'

SINGLE CHANGE METHOD

For change and improvement to embed, a common change methodology for all Medway Innovation Institute projects is needed.

We developed a model for Improvement.

AIMS

MEASURES

CHANGES (PDSA)

All projects are scoped and designed with a common change approach.

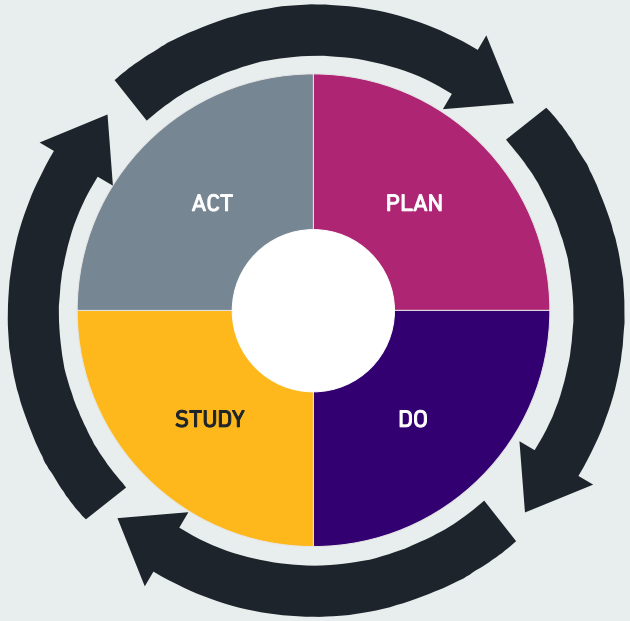
Simple and intuitive, this method ensures we start with the impact in mind for patient outcomes and quality of care.

MODEL FOR IMPROVEMENT

AIMS: What are we trying to accomplish?

MEASURES: How will we know that a change is an improvement?

CHANGES: What change can we make that will result in improvement?



How It Works

- A single front door
- A single change method: Aims, measures, changes
- **Training**
- The role of the 'Coach'

TRAINING

We want to create a critical mass of innovators within the organization.

They need the skills, capabilities, common language and toolkit to translate this into benefit for patients.

The Institute provides training. We make Quality Improvement Fundamentals and Quality, Service Improvement and Redesign (QSIR) courses available to as many staff as possible at Medway, so the Trust has one unified approach to change. This training curriculum will evolve and grow over time.

* More details on the training curriculum in the "Building the Foundations of Innovation" section.

How It Works

- A single front door
- A single change method: Aims, measures, changes
- Training
- **The role of the 'Coach'**

THE ROLE OF THE COACH

Innovative ideas in health and social care can originate from many sources, including commercial companies, academics, healthcare professionals, and patients. However, their uptake may be impeded by a lack of a clear pathway or effective support to take them forward.

The Institute changes that and opens the right doors – largely through the role of the coach.

An innovation 'Coach' will support each idea from idea to impact. Coaches are cross-divisional members of staff across clinical and non-clinical disciplines, who have a good working knowledge of the Trust and are skilled in the practicalities of making change happen at Medway. They are facilitative in style and well-versed in QI tools and approaches.

GOVERNANCE

Medway Innovation Institute Steering Committee (Chair: Jenny Chong)

Trust Improvement Board (Chair: George Findlay)

Innovation Programme Board (Chair: Paula Tinniswood)

MEASURES

- Completed, live and pipeline projects
- Time from 'Idea to impact'
- Training numbers vs. QSIR roll-out plan
- # of funding submissions
- # of clinical trial patient recruits
- # of publications and collaborative studies
- Marketing metrics
- Morale and engagement metrics

FUNDING

Secured investment pot for projects seeking up to £10,000 via lean application and panel process.

25% re-investment rate applied to efficiencies delivered through projects.

Project seed funding from Medway Hospital Charity (up to £2,000).

Matchmaking and awareness raising of external funding streams.

Year 1

The first 12-months were critical for engaging with staff and for gaining product credibility.

YEAR 1 IN NUMBERS

Summer

- ✓ Launch (July 2nd)
- ✓ Roadshow
- ✓ Develop training programmes
- ✓ Support early projects
- ✓ Generate content and maintain a captive audience

Autumn / Winter

- ✓ 100-day impact - 5 flagship projects delivered
- ✓ Big Room events and Big Interviews
- ✓ 'Big bang' QSIR Virtual programme
- ✓ Build the team

Spring

- ✓ Re-launch in-person training
- ✓ Publish case studies
- ✓ Summer conference
- ✓ End of Year Awards
- ✓ Refresh our Strategy

148 Projects registered

32 Projects currently live

£170K Funding awarded

240 Staff trained in QI

26 QI coaches trained

4.5 / 5 Average feedback training score

1314 Twitter followers

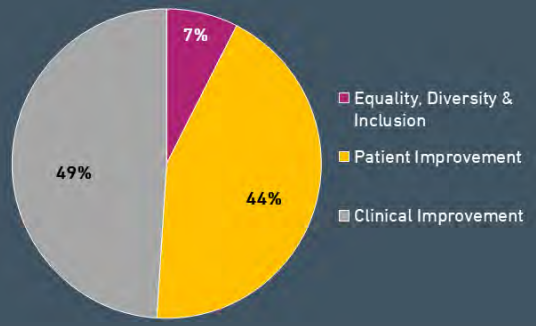
31,000 + Monthly impressions

500+ Event attendees

REVELATIONS

Over the past year, we discovered some interesting findings....

- It was not always about the funding. Many ideas did not come seeking funding, our staff just wanted support and guidance on implementing their project.
- All clinical and non-clinical staff were hungry for QI training.
- We had many hidden stars amongst our staff. They never knew what they were capable of, they just needed the confidence and support to shine.
- Equality, diversity and inclusion is of growing importance to our staff. It made up 7% of our projects.



LESSONS

..... and we also took away lessons to improve. The Medway Innovation Institute started as a PDSA project and we practice what we preach.

- We are working with the BAME Network to ensure our language and wording is inclusive.
- 5% of our submission are from BAME staff, we need to improve our outreach to engage them.
- We were pleasantly surprised by the huge influx of ideas and requests for QI training, we need to build a scalable robust operational process to cope with the demand.
- Many of our projects are now reaching deployment stage, we need to follow up and continue to track impact and measurable improvement.

Year 2

The Institute's agile approach has enabled us to pivot and adapt during the pandemic and deliver impactful projects. This nimbleness will continue as we recover from Covid.

LOOKING FORWARD TO YEAR 2

Year 1 saw our staff respond to our "Call to Action" with enthusiasm and many projects and ideas submitted. We approach Year 2 with an ambitious plan to embed QI, research and innovation in our DNA, whilst also scaling up our collaborations and partnerships across the system.

We will continue to host our successful model of Big Room events which bring together healthcare professionals and patients to discuss and solve patient-centered issues; Big Conversations to open our minds to topical discussions; and Big Interviews to showcase the success and lived experiences of our staff.

Summer

- ❑ Embed QI and the Institute at Ward level
- ❑ Initiate Year 2 projects
- ❑ Build and scale the team

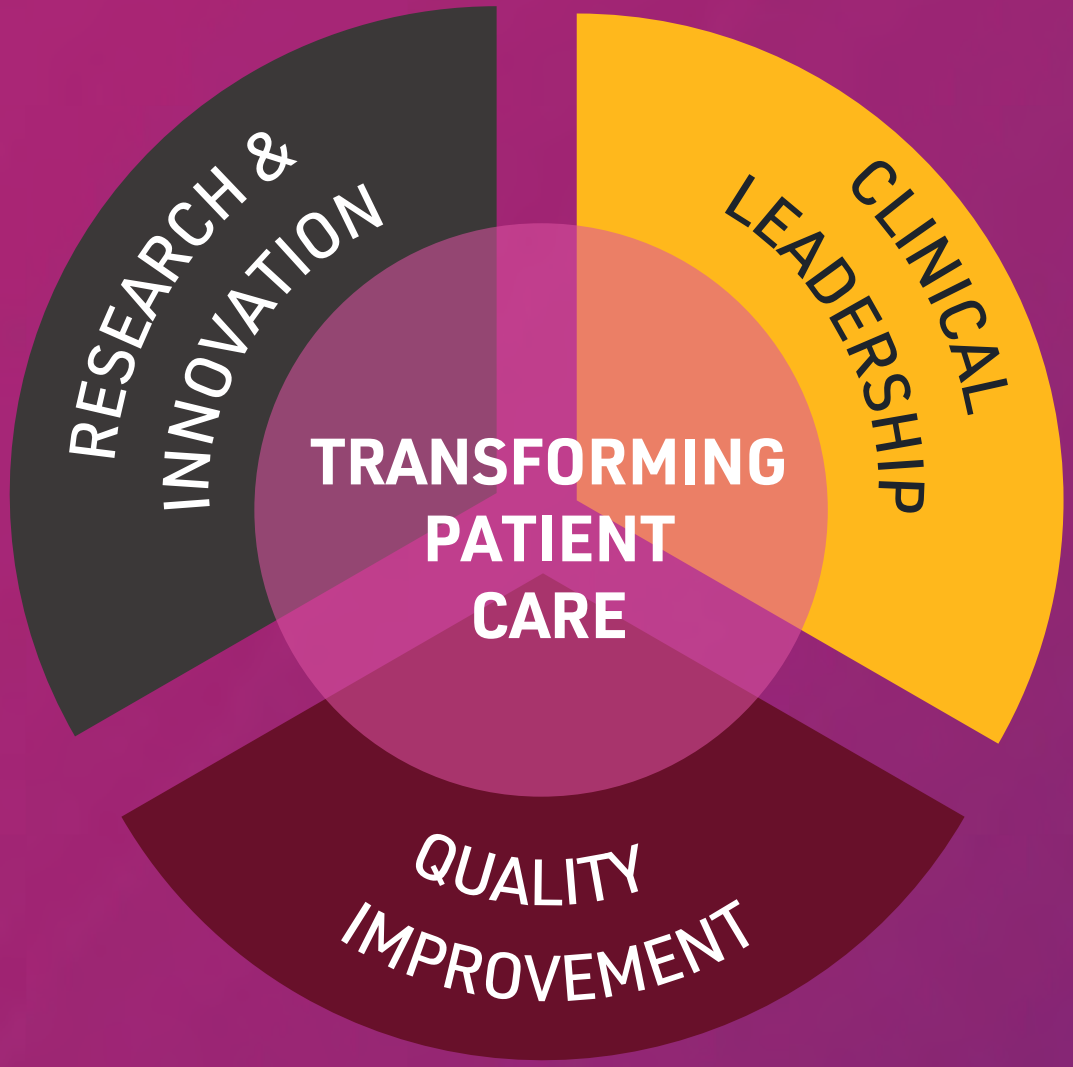
Autumn / Winter

- ❑ Align with new Trust strategy and priorities
- ❑ Develop engagement strategy with system partners (CQC, ICS, GIRFT)
- ❑ Build scalable operational processes for the Institute
- ❑ Develop strategy to support medical publications

Spring

- ❑ Evolve training curriculum
- ❑ Publish the MII Journal
- ❑ Launch the Gallery of Innovation
- ❑ Summer conference
- ❑ Celebration Awards event

Building the Foundations of Innovation



Building the Foundations of Innovation

- **QI Methodology**
- Dosing Strategy
- Curriculum

QUALITY IMPROVEMENT METHODOLOGY

Quality improvement (QI) goes beyond traditional management, target setting and policy making. QI methodology is best applied when tackling complex adaptive problems – where the problem isn't completely understood and where the answer isn't known.

QI utilizes the subject matter expertise of people closest to the issue – staff and service users – to identify potential solutions and test them. To truly achieve the improvement in quality, outcomes and cost that the healthcare system needs, we need to make this goal part of everyone's daily work. QI helps by:

1. Bringing a systematic approach to tackling complex problems
2. Focusing on outcomes
3. Flattening hierarchies and mainstreaming collaboration
4. Giving everyone a voice and bringing staff and service users together to improve and redesign the way that care is provided

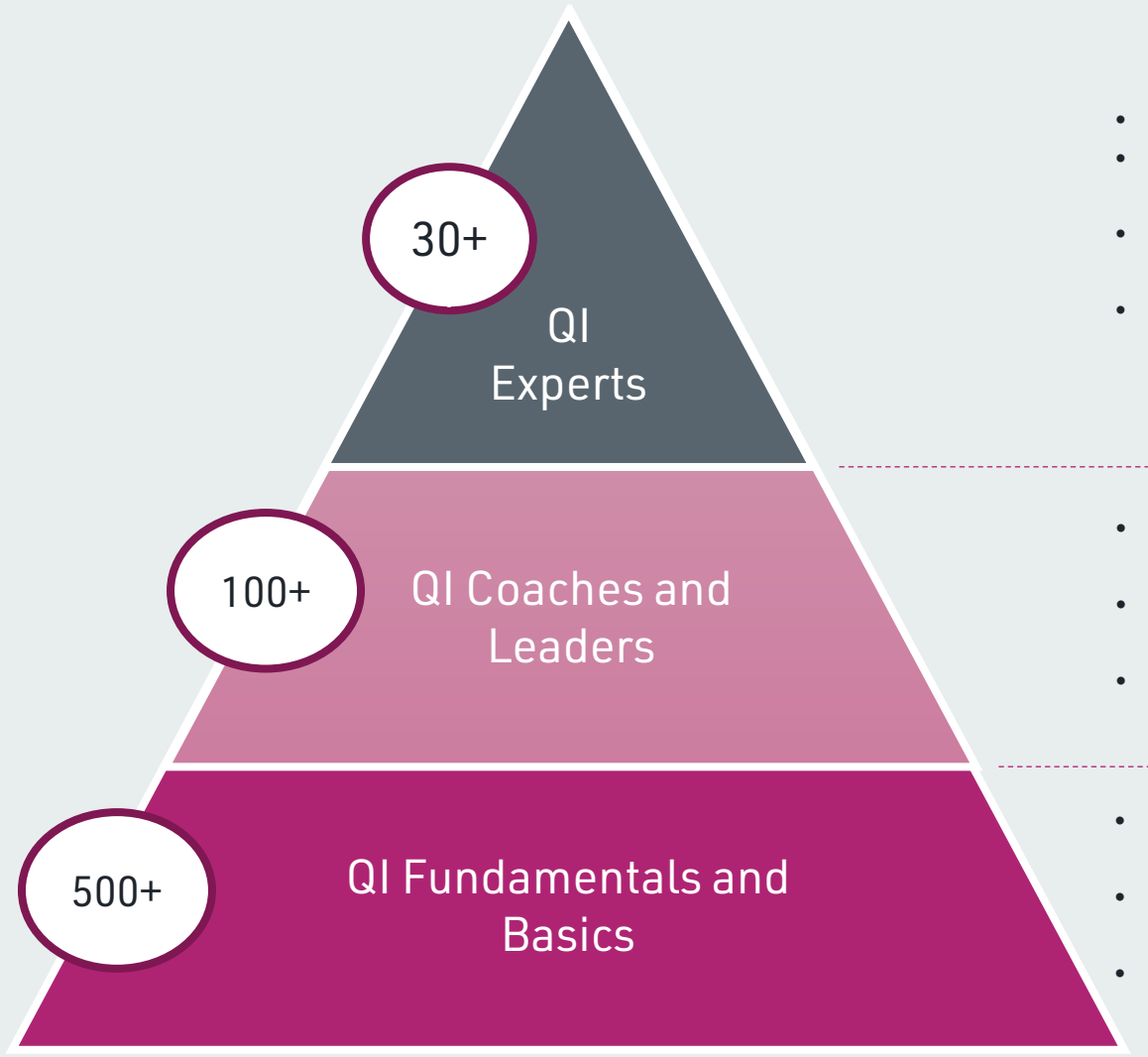
When done well, QI can release great creativity and innovation in tackling complex issues which services have struggled to solve for many years. The types of problems that we should be using quality improvement to tackle, are those that require not only changes in behaviours or preferences, but also hearts and minds.

Building the Foundations of Innovation

- QI Methodology
- **Dosing Strategy**
- Curriculum

We designed and developed our QI 'dosing strategy' and launched the Institute's core curriculum of training programmes.

DOSING STRATEGY



- Trust Leaders
- Supporting local ambitions and strategic direction
- Developing and embedding QI culture
- Match capability to organisation priorities and local strategic objectives

- Oversee and mentoring QI projects
- Vocal supporters of QI methodology
- Developing and improving improvement tools

- Awareness of basic tools and approaches in QI
- Internal and external training accessible
- Embedding QI culture at grass roots level

Building the Foundations of Innovation

- QI Methodology
- Dosing Strategy
- **Curriculum**

We have also sponsored a Belbin pilot and King's Fund Divisional Governance Leads Training.

OUR CURRICULUM

QI Fundamentals & Basics

- The nuts and bolts of QI for staff not likely to be directly leading a QI project but who need to know the fundamentals of QI to support projects or be aware of the QI approach being taken in the organization.
- Training options available include a 2-hour interactive workshop and self-directed online learning.

QI Experts

- High level QI training for Trust leaders who will promote and embed QI methodology at a strategic level.
- This includes QSIR accredited training and QI Level 5 & 6 apprenticeship training as well as specific QI training for board members.

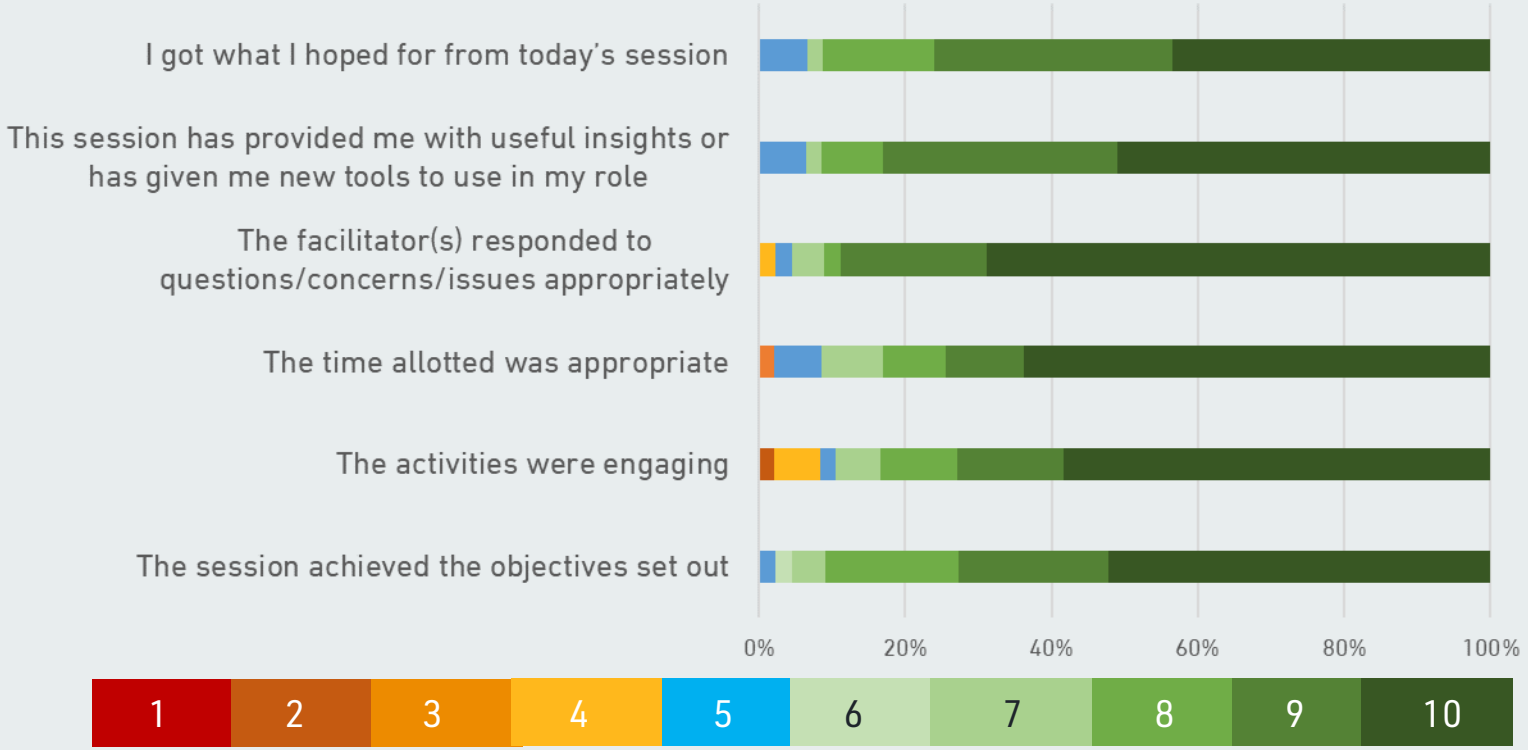
QI Coaches & Leaders

- Coaching is an essential tool in the leader's toolbox and complements QI tools and techniques.
- QI coaches can support QI practitioners with help, advice and guidance.
- This training is delivered over a 6-week programme of 1-hour sessions.
- This may progress to external accredited QI training.

Building the Foundations of Innovation

We collect feedback from our QI training sessions to ensure we can iteratively learn from and improve the experience.

QI TRAINING FEEDBACK SCORE



QI Fundamentals Feedback

"I will try to implement PDSA cycles in my future projects to improve the area in which I am involved"

"I felt it empowering that we can make change"

"Fun filled, informative and educative session"

"I have gained confidence and tools surrounding QI"

QI Coaching Feedback

"Let's PDSA our own coaching experience"

"We will be supporting our clients but also continuing to learn as coaches"

"We now have to match your level of enthusiasm when we meet with our clients"

"Inspiring!"

MEDILEAD

A bespoke course designed specifically for Junior Doctors which provides workshops, training events and lectures in leadership and quality improvement.

Enables and empowers doctors to lead change for safe high quality care; nurtures our medical leaders of the future.

https://medwayinnovationinstitute.com/medilead/

MediLead 2020

Launched in August 2020, hosted and administered by Medway Innovation Institute.

Covered topics like "Anatomy and physiology of a hospital", "The dark art of running a hospital" and QIP discussions.

A MediLead evaluation was featured in the BMJ.


Development and implementation of a structured leadership programme for junior doctors

Recent MediLead evaluation featured in BMJ - full report available on the website

Funding and Finance

The Medway Innovation Institute funding programme provides financial backing to projects and pilots that will improve patient care and staff experience for the Trust.

There are a number of funding options available depending on the type of project.

Funding Options

The Medway Innovation Institute funding programme provides financial backing to projects and pilots that will improve patient care and staff experience for the Trust.

There are a number of funding options available depending on the type of project

Project Type		Funding	Approval Process
Small Change Projects	Projects that benefit patient care and/or staff experience.	Up to £2000	Application form, internal evaluation by the Institute
Innovative Pilots	Demonstrate that your idea is evidence-based and offers potential benefit to the Trust. Rapid seed funding available via a streamlined bidding process to allow you to pilot a 'minimum viable product' or prototype on a small-scale to demonstrate the measurable impact of your work.	£2,000 to £10,000	Application form, 5-minute pitch presentation and Q&A to the Institute's Funding Panel
Exceptional Circumstances	If you believe your project will require more than £10,000, email the Institute directly to discuss options.		A Project Initiation Document (PID) Business Case is required
Research Funding	The Institute has access to additional funding and grants for research via the Research & Innovation (R&I) department.		Research & Innovation (R&I) department approval process
Chief Executive's Scholarship for Brilliance	The Medway Hospital Charity invites applications for its scholarship, which will be awarded the Trust's Chief Executive. The Scholarship celebrates excellence and sustainable innovation within the workforce by supporting an exceptional candidate's (or multiple candidates') learning and development. Applications are welcome from any member of staff employed by the Trust and the successful recipient will be expected to use their training to influence and embed new practices within the Trust. It is an opportunity for outstanding candidates to bid for their own bespoke training programme. Applications are reviewed annually and winners are announced at the Trust's Annual Members' Meeting	Up to £10,000	Application form

Institute Expenditure

The Medway Innovation Institute funding programme provides financial backing to projects and pilots that will improve patient care and staff experience for the Trust.

JULY 2020 to MARCH 2021

Project / Item	Funding / Cost
Incident Control Centre Setup	£10,088.00
Maternity - Induction of Labour	£4,184.76
Site Office Improvements	£10,000.00
Menopause Awareness	£10,000.00
Improve Well	£7,200.00
CHARM-CoV study	£15,000.00
The Shift to Digital and E-Mode	£7,000.00
Belbin Pilot	£4,554.00
Enhanced Care Unit	£35,568.67
Divisional Governance Leads Training - King's Fund	£10,440.00
Lancet Publication	£2,900.00
Staff Sleep Support	£8,388.00
Greatix	£1,188.00
Talk Health Training	£864.00
Mind Genius	£1,536.00
Autism Reality Experience	£2,040.00
MBTI Courses	£798.60
Merchandise	£1,068.06
Digital Templates	£734.40
TOTAL	**£133,552.49**

APRIL 2021 to AUGUST 2021

	Budget		Spend	
	Annual	**YTD**	**YTD**	**Variance**
Medway Innovation Institute Total Budget	£233,105.00	£77,701.67	£8,578.74	£69,122.93
Running Costs (including Staffing and Institute Costs)	£48,105	£16,035.00	£7,828.79	£8,206.21
Total for Projects in 21/22 (Approved & Paid)	£160,000	£53,333.33	£749.95	£52,583.38
Projects Approved in 21/22 (not yet paid)		£21,519		

Putting Innovation to Work

Case Studies

Every one of the 148 innovation projects submitted to the Institute is worthy of its own spotlight.

We have selected a few highlights, projects that have completed or are in a mature stage to deliver positive impact across patient care, staff wellbeing and operational efficiency.

Project Spotlight 01

Deep Infiltrating Endometriosis

Professor Hasib Ahmed

Winner of The Chief Executive's Scholarship for Brilliance

This scholarship was for funding to visit centres of excellence for deep infiltrating endometriosis. The aim was for Medway FT to become a fully accredited endometriosis centre by January 2022.

Endometriosis is a very significant burden on Women's health. The prevalence is increasing and it causes a great deal of misery for women in the reproductive age group. In the severest forms, as well as debilitating pelvic pain and difficulties with their relationships, there is also a significant impact on fertility. A lot of young ladies with severe endometriosis are desperate to start a family. These unfortunate young women almost always end up requiring assisted conception which causes a great deal of anxiety.

I am organising team visits to some notable centres of excellence in Europe and potentially the USA. The project requires a team approach and the whole team deserve the accolade. I am confident that this initiative will prove of real value for the women of Medway.

Project Spotlight

02

AUTISM AWARENESS

Ginny Bowbrick, Consultant Vascular Surgeon

Winner of "Innovator of the Year" Award &
"Project of the Year – Patient Experience" Award

4

45 staff members attended the Autism Virtual Reality Experience.

"Such an impact on beginning to understand the experience and feelings of patients with autism."

3

BIG CONVERSATIONS
MEDWAY INNOVATION INSTITUTE

The Institute hosted a showcase event, bringing together those with personal interest and autism experience with subject matter experts, discussing the importance of embracing differences in our workforce and patients.

This led to conversations about how to develop a more empathetic workforce.

2

The Institute supported two autism friendly campaigns: "Different Not less" and "JAM" (Just a minute).

1

Started as a 1-2-1 conversation between colleagues.

Project Spotlight 03

VIRTUAL BED BUREAU

Belinda McCann, Senior Clinical Systems Administrator

Winner of the "Special Recognition" Award for supporting and implementing new ways of working during the Covid -19 Response

The Reason

The COVID-19 pandemic created a significant reduction of ward clerks across the Trust during October/November 2020.

This meant the critical role that the ward clerks play in ensuring core clinical systems being updated in real time were lacking, increasing the risk for patient safety and incorrect patient flow data

The Idea

A pilot scheme, to contact admin staff who were working from home in order to run a Virtual Bed Bureau (VBB).

The Change

I was able to create an SOP (standard operating procedure) and provide "How To Guides" on being a Ward Clerk.

With the VBB running 24/7, it was clear that the Bed Management System had fewer "pending" patients and more discharges were completed in real time then they had for months.

Although the initial idea was that the Wards would call the VBB, in fact the reverse happened. The VBB team monitored our Bed Management System and proactively contacted the Wards.

The Outcome

Both PAS and ExtraMed were displaying identical patient information and all electronic discharge notices (eDNs) were initiated to ensure clinicians could complete them without delay.

The VBB has proved we can pull a service together at a rapid pace and ensure essential patient data is captured.

With the right people with passion and dedication – anything is possible.

Project Spotlight 04

BEBEVUE

Harriet Hickey, Midwife

Nominee of the "Project of the Year - Patient Experience" Award

BebeVue is a unique service that allows expecting parents to purchase their full-motion ultrasound video online. Once a new mum's regularly scheduled ultrasound is completed the video will be available online. Mums can share their baby's first pictures and video with family and friends instantly at their fingertips.

Bebevue videos are high quality and less fragile than paper prints and give more options to find the perfect baby snapshots. Bebevue images are captured at a regularly scheduled ultrasound appointment so doesn't expose the baby to any more ultrasound energy than clinically necessary.

View it. Keep it. Share it.

Project Spotlight

05

MENOPAUSE AWARENESS

Sharon Griffin, Consultant Gynaecologist

Winner of the "Project of the Year - Staff Wellbeing" Award

Sharon Griffin, a Consultant Gynaecologist at our Trust and one of only circa 100 British Menopause Society specialists' nationwide has been promoting menopause awareness, the impact menopause can have at work and education for managers on how they can support members of staff experiencing symptoms.

AIMS

1) Improve awareness of Menopause symptoms and treatments amongst patients and staff.
2) Become an employer that is aware and forward-thinking, looking after our staff who may be menopausal or perimenopausal with progressive policies, protocols and occupational health adjustments.
3) Socialise the scale of the challenge amongst clinicians in Primary and Secondary Care across Medway and Swale.

MEASURES

- Awareness amongst staff using surveys
- Uptake of treatment plans made available
- Qualitative and quantitative feedback on the quality of the information and education materials developed
- Potentially collect throughput data and outcomes from the Menopause clinics we could establish with the right support from our local PCNs.

OUTCOMES

- Survey undertaken
- Two tailored webinars have been recorded and produced for both staff and managers.
- The CBT (cognitive behavioural therapy) programme is underway with positive feedback.
- The Trust's Menopause policy has been reviewed and approved.

Shining the Spotlight on Innovation

Bringing people together.

Discuss and ideate on things that matter.

To them, to the patient and to the community.

PROFILE, CELEBRATE, SHARE

Celebrate the innovation and the innovator

Share the good practice and scale

Communicate and market excellence

Build capability

KICK-START AND INCUBATE

Stimulate ideas

Convene contributors

Horizon-scan and gather information

DRIVE TO DELIVER

Secure dedicated resource

Day-to-day driving and tracking

Working within existing governance framework

Spotlight Channels

We use various events and channels to ensure maximum reach and engagement with our staff and system partners.

EVENTS

Big Rooms
Big Conversations
Big Interviews
Grand Rounds
Research & Innovation Conference
End of Year Awards Ceremony
CEO Scholarship for Brilliance
Roadshows
Medway Members Events
Council of Governor Events
Patient Events
Clinical Council

COMMUNICATIONS

Case Study Write-Ups
Blog Posts
Monthly Roundup Newsletter
CEO Message
Trust Weekly Message

SOCIAL MEDIA

Twitter
Facebook
LinkedIn
Podcasts and Interviews

BIG ROOMS

We believe that improvement is a team sport. Undeterred by Covid-19, we have hosted and facilitated 'Big Room" events, which are multi-disciplinary sessions combining QI training with focused problem-solving on a specific theme.

July
Reducing Harm from Pressure Ulcers

September
Reducing Harm from Pressure Ulcers (follow-up)

Improving Nutrition and Hydration Care

October
Falls Prevention

BIG CONVERSATIONS

Innovation thrives when we feel we can discuss and debate the things that matter fervently. Our "Big Conversations" series invites globally renowned industry experts to spend a lunch break with us, sharing their insights on a given topic with our staff.

- What is healthcare innovation?
- The future of health & digital innovation
- Innovation & health of the economy post-Covid
- Embracing differences: Learning Disabilities & Autism
- We need to talk about the menopause
- Bringing Medway out of the closet: Being LGBTQ+ in the NHS
- Mental Health & Staff Wellbeing post-Covid

BIG INTERVIEWS

Our staff have so much to be proud of. Through our "Big Interviews", we help amplify their voices, showcase their achievements and share their learnings.

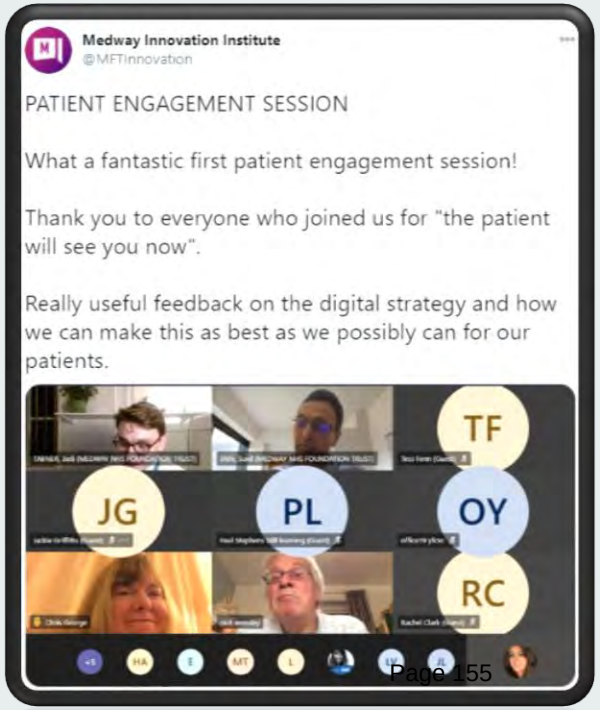
- Virtual Bed Bureau during Covid-19: The highs, the lows and the challenges (Belinda McCann)
- QI and how Innovation supports patients (Dr Sarah Elliott)
- Using QI to run the Medway Innovation Institute and being a Service Manager (Sophie Buck)
- QI Journey, patient experience and culture (John McLaughlin)
- Building the Incident Control Room during Covid (Steve Arrowsmith)
- The importance of change culture and QI projects (Kerry O'Neill)

Event Spotlight 01

PATIENT ENGAGEMENT SESSION:
THE PATIENT WILL SEE YOU NOW

We are committed to co-design with our patients and this event was just the first of many. This was the first in our series of public and patient events, led by Jack Tabner, Executive Director of IT and Transformation and Mr Sunil Jain, Consultant Orthopaedic Surgeon. This fantastic event saw 30 patients provide feedback and influence the direction of the Trust's Digital Strategy.

Spurred on by the feedback from this event, we hosted another event in December, focused on the challenges and opportunities digital technologies pose for health care and the inclusivity of all patients.



Event Spotlight 02

BIG ROOM EVENT: PRESSURE ULCERS

The first multi-disciplinary Big Room Event was led by Jane Murkin, our Chief Nurse. The event focused on the work implemented as part of the quality strategy in October 2019, specifically relating to 'Reducing Harm from Pressure Ulcers' and improving the key processes known to impact on patient outcomes. It also recognized the need for further improvement work to reduce the numbers of hospital acquired pressure ulcers in the Trust.

The event was a huge success and gave colleagues the opportunity to share and celebrate achievements to date and learn from the work of the pilot wards that had made significant improvements over the past months in reducing harm from pressure ulcers. Lessons learnt from a specific patient story were shared and this really helped set the tone of the day and gave context as to why focusing on pressure ulcers is so significant.

The same group conducted a follow up session two months later, focusing on the work that had been done since the first event and planning for the next steps.

"I though the event was great as I also got to see everyone else's information and what they are doing in reducing pressure ulcers and can implement this to my ward. I also felt proud of my ward presenting the information that I had and it was great to see the positive reaction by my colleagues. Going forward I am continuing to implement the changes that both myself and the tissue viability Nurse's have changed and can't wait for the next event."

- Ryan Kendall, Byron Ward Manager

"I appreciated being able to focus and share the good work. The multidisciplinary approach was a lightbulb moment for people to think 'this involves me too'."

- Hayley Jones, Tissue Viability Clinical Lead

"The pressure ulcers Big Room event was inspiring to hear how ward teams have taken on the challenge to reinvigorated pressure ulcer care. Although a vitally important fundamental for nursing care, the event also promoted a prominent reminder that all disciplines have a role in skin care and reduction of pressure ulcer harm."

- Jane Murkin, Chief Nurse

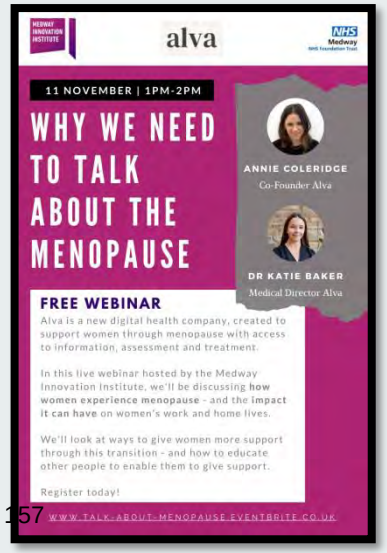
Event Spotlight 03

BIG CONVERSATION:
WHY WE NEED TO TALK ABOUT THE MENOPAUSE

We have a shocking lack of research and information around menopause. The stigma and taboo have resulted in women suffering, and continuing to suffer, in silence. This "Big Conversation" turned out to be our highest attended and most watched event. Feedback was great and the conversations demonstrate how important this subject is to our workforce.

This session showed our women in Medway that they are not alone. Medway is here to support them through it and also raise awareness amongst male and younger colleagues.

This session featured Alva, a clinically-led organization on a mission to support women through menopause with evidence-based information, real stories and treatment. Following this session, a survey was conducted which highlighted the lack of awareness around peri-menopausal symptoms and the Trust's menopause policy. Consequently, the Trust's menopause policy is being refreshed and follow up sessions on menopause have been conducted for both staff and managers. Menopause cafes and CBT training sessions have also been scheduled.



Event Spotlight 04

CELEBRATE OUR SUCCESS:
EDUCATION, RESEARCH, INNOVATION & AUDIT CELEBRATION WEEK

To celebrate the first birthday of the Institute, we organized a week-long summer conference with Research and Innovation, Clinical Audit and Quality Improvement, Nursing Education and Medical Education. We had a marketplace to showcase projects, talk about QI, conduct poster competitions, demonstrate medical solutions and build up the community to share knowledge and learn from each other. A Big Conversation on Mental Health and Staff Wellbeing also took place with speakers from across the system sharing their insights.

We are nothing without the ideas and hard work of our staff. We had our inaugural Medway Innovation Institute awards ceremony to celebrate and recognize all their good work despite a tumultuous year.

Innovation Partners

Innovation is a team sport and the Institute will open Medway's door to external contributors and advisors who play a critical role in the scaling and spreading of exceptional research and innovation

Medway INNOVATION HUB

A primary care innovation accelerator. They host quarterly 'matchmaking' events for suppliers, focusing on transforming primary care.

https://twitter.com/healthovation

DigitalHealth. London ACCELERATOR

Digital Health London's Accelerator programme aims to speed up the adoption of technology in London's NHS. They work with cohorts of digital solutions to provide mentoring and support market entry.

https://digitalhealth.london/programmes/accelerator

Kent Surrey Sussex Academic Health Science Network

One of the 15 AHSNs across England to improve health and generate economic growth by spreading innovation at pace and scale.

https://kssahsn.net

University of Kent

Canterbury Christ Church University

Our local Universities, who support us with collaborative research studies.

https://www.kent.ac.uk
https://www.canterbury.ac.uk

MEDWAY INNOVATION INSTITUTE

THANK YOU

www.medwayinnovationinstitute.com @MFTinnovation medwayft.innovationinstitute@nhs.net

Medway Maritime Hospital, Windmill Road, Gillingham, Kent ME7 5NY

Meeting of the Board of Directors in Public
Thursday, 09 September 2021

Title of Report	**Finance Report – Month 4**	**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, 26 August 2021		
Executive Group Approval:	Date of Approval: N/A		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	The Trust has met its regulatory control total.		
Quality Impact Assessment	N/A		
Recommendation/ Actions required	The Board is asked to note this report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Finance Report – Month 4		

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Finance report

For the period ending 31 July 2021

Contents

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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(8)	(7)	1	The Trust reports a £7k deficit position for July; reducing to breakeven after making the technical adjustment for donated asset depreciation to report against control total. The reported position includes accrued Elective Recovery Funding (ERF) income of £3.9m - this being the figure notified from NHSE/I - and a contingency of £1.0m, this being an increase of £0.4m since the previous month. Total pay costs have increased in month by £0.4m as the use of temporary staff is needed for increased activity in the clinical services.
Donated Asset Depreciation	8	7	(1)	
Control Total	**-**	**-**	**-**	
Efficiencies Programme				
In-month	278	93	(185)	Work has continued with services to identify schemes, however no additional schemes have been agreed in the month of July. Work continues with the services to identify efficiency schemes alongside the cross-cutting themes; this will be helped by the second showcase event which was held on 18th August (see separate report)
YTD	645	329	(316)	
Capital				
In-month	1,583	507	(1,076)	The Trust Capital Resource Limit (CRL) was set at £13,877k for 2021/22 by the STP, in July an additional £440k CRL has been authorised for diagnostics, £420k to be funded from additional PDC and £20k from the Trusts own cash reserves. The programme is currently £1,205k behind plan, this is mainly due to slippage on schemes. The capital plan is drawn up based upon high level/in principle approval of estimates of both time and money. As the scoping is finalised and more detailed plans are in place inevitably the profile changes due to contractor commitments and lead times. Schemes totalling £1,311k have been approved in excess of the budget available which will be funded from slippage as it arises. Overall the programme is expected to be in line with the plan at year end. The Trust has highlighted a further £10m of high priority schemes to the ICS which we would wish to critically pursue should any additional resources become available.
YTD	5,977	4,772	(1,205)	
Annual	14,317	14,317	0	

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1. Executive summary

£'000	PY	Actual	Var.	
Cash				
Month end	49,184	42,845	(6,339)	Cash balances have reduced by £3.9m in month mainly due to the continued clearance of prior year capital creditors Cash balances are expected to be maintained at a similar level (£40m to £50m) throughout the year.
Activity is below draft budgeted levels as a result of Covid				Clinical income based on the 21/22 consultation tariff would have reported a year to date position of £88.4m, this being £1.6m lower than income in the same period of 19/20. In month performance excluding high cost drugs is £24.3m which is £1.9m higher compared to M3 reported figure.

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

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	28,469	27,984	(485)	110,229	110,078	(151)
High cost drugs	1,814	1,832	19	7,254	7,240	(15)
Other income	1,678	1,878	200	6,764	7,783	1,019
PSF/MRET/FRP	0	0	0	0	0	0
Donated Asset Adjustment	0	0	0	0	0	0
Total income	**31,961**	**31,695**	**(267)**	**124,247**	**125,100**	**853**
Nursing	(7,883)	(8,057)	(174)	(31,970)	(31,217)	753
Medical	(6,421)	(6,519)	(99)	(24,987)	(24,762)	226
Other	(4,822)	(5,210)	(388)	(19,782)	(22,152)	(2,370)
Total pay	**(19,125)**	**(19,787)**	**(661)**	**(76,740)**	**(78,131)**	**(1,392)**
Clinical supplies	(3,934)	(4,522)	(588)	(15,735)	(16,900)	(1,165)
Drugs	(598)	(887)	(289)	(2,393)	(3,305)	(913)
High cost drugs	(1,821)	(1,857)	(37)	(7,283)	(7,286)	(3)
Other	(5,046)	(3,192)	1,854	(16,349)	(13,719)	2,630
Total non-pay	**(11,399)**	**(10,458)**	**941**	**(41,759)**	**(41,210)**	**549**
EBITDA	**1,437**	**1,450**	**13**	**5,748**	**5,759**	**11**
Depreciation	(895)	(903)	(8)	(3,581)	(3,575)	6
Donated asset adjustment	(8)	(7)	0	(31)	(30)	2
Net finance income/(cost)	2	(3)	(5)	7	(10)	(17)
PDC dividend	(544)	(544)	0	(2,175)	(2,174)	1
Non-operating exp.	**(1,445)**	**(1,457)**	**(12)**	**(5,780)**	**(5,788)**	**(8)**
Reported surplus/(deficit)	**(8)**	**(7)**	**1**	**(32)**	**(30)**	**2**
Adj. to control total	8	7	(1)	32	30	(2)
Control total	**(0)**	**0**	**0**	**(0)**	**(0)**	**(0)**

1. Funding arrangements for 6 month period have been agreed with the Kent & Medway CCG. The Trust plans to breakeven for Apr-Sep.

2. Other Pay includes £0.5m contingency, unfound efficiency targets and a vacancy factor of £0.9m. In addition £1.2m from budget changes on the ledger that were not in the NHSE/I plan, this is offset by underspending against reserves in other non-pay.

3. Overall pay budgets are overspending by £1.4m, of this £0.5m is the pay contingency, the budget is included in other non-pay. In addition, £0.3m is for unfound efficiences, £0.4m specialling costs and £0.2m provision for outstanding agency staff invoices.and unfound efficiencies. Clinical pay is underspending from vacancies within medical and nursing posts, where possible these are covered by temporary staff. Pay budgets were set using costed establishments, there is no premium included for higher temporary staff costs.

4. Income favourable to plan from overseas and RTA income £0.4m, additional £0.4m for vaccination and quarantine costs included in the position; £0.2m medical education contribution to overheads, also catering and car parking income.

5. Independent sector costs to achieve ERF are £1.6m YTD, this is offset by the ERF reserve. In additional to these costs, increases in drugs and clinical supplies are also covered by the ERF reserve. Following confirmation from NHSE/I £3.1m of ERF income has been recognised with a forecast position for the 6 months of £4.9m.

6. Total expenditure includes the £0.4m of incremental Covid costs, £1.7m YTD.

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3. Efficiency Programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Sub-total	Budget	Unidentified
Planned care	70	0	0	203	273	**2,132**	(1,859)
UIC	179	0	89	200	468	**2,190**	(1,722)
E&F	21	350	0	30	401	**434**	(33)
Corporate	73	56	0	0	129	**415**	(286)
Total	**343**	**406**	**89**	**433**	**1,271**	**5,171**	**(3,900)**
Previous Month Total	343	406	89	433	1,271	**5,171**	(3,900)

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**278**	**93**	**(185)**	**645**	**329**	**(316)**	**5,171**	**5,171**	**0**

Process

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

The total efficiencies included in the draft budget for the first 6 months are £0.9m; this increases to £4.8m for the 12 month period as the need for efficiencies increases in the second half of the financial year. In addition to this there is the full year effect impact of 20/21 schemes totalling £0.3m.

During the month of July, no additional schemes have been signed off as deliverable, mainly due to services being focused on operational issues. A second showcase event was held on 18th August and specific programmes with nominated leads are being developed across the Trust (see separate report). The PMO team and Finance Business Partners are continuing to support the services to identify potential areas of efficiency using Model Hospital data and benchmarking tools.

The main efficiencies have been achieved from the full year effect of 20/21 schemes as well as Facilities and Estates division schemes linked to patient meals costs, and Corporate division schemes reducing printing costs and I.T. contracts.

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4. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
221,951	**Non-current assets**	**222,214**	**263**
6,962	Inventory	7,112	150
16,216	Trade and other receivables	21,298	5,082
49,184	Cash	42,845	(6,339)
72,362	**Current assets**	**71,255**	**(1,107)**
(137)	Borrowings	(69)	68
(37,101))	Trade and other payables	(30,766)	6,335
(8,839)	Other liabilities	(14,426)	(5,587)
(46,077)	**Current liabilities**	**(45,261)**	**816**
(2,151)	Borrowings	(2,151)	0
(1,424)	Other liabilities	(1,425)	(1)
(3,575)	**Non-current liabilities**	**(3,576)**	**(1)**
244,661	**Net assets employed**	**244,632**	**(29)**
453,870	Public dividend capital	453,870	0
(245,271)	Retained earnings	(245,300)	(29)
36,062	Revaluation reserve	36,062	0
244,661	**Total taxpayers' equity**	**244,632**	**(29)**

Key messages:

1. Receivables have increased by £5.0m from the prior year mainly due to:
   - Increase in prepayments of £2.8m, which is expected; many contracts are paid a quarter/year in advance.
   - Increase in income accruals due to ERF.
2. Payables have decreased by £6.3m from the prior year due to the receipt and payment of material capital invoices
3. Other liabilities have increased by £5.6m from the prior year due to an increase in payments in advance from NHS Commissioners
4. Total Trust borrowings are £2.2m and relate to long term capital loans issued by DHSC in a prior year.

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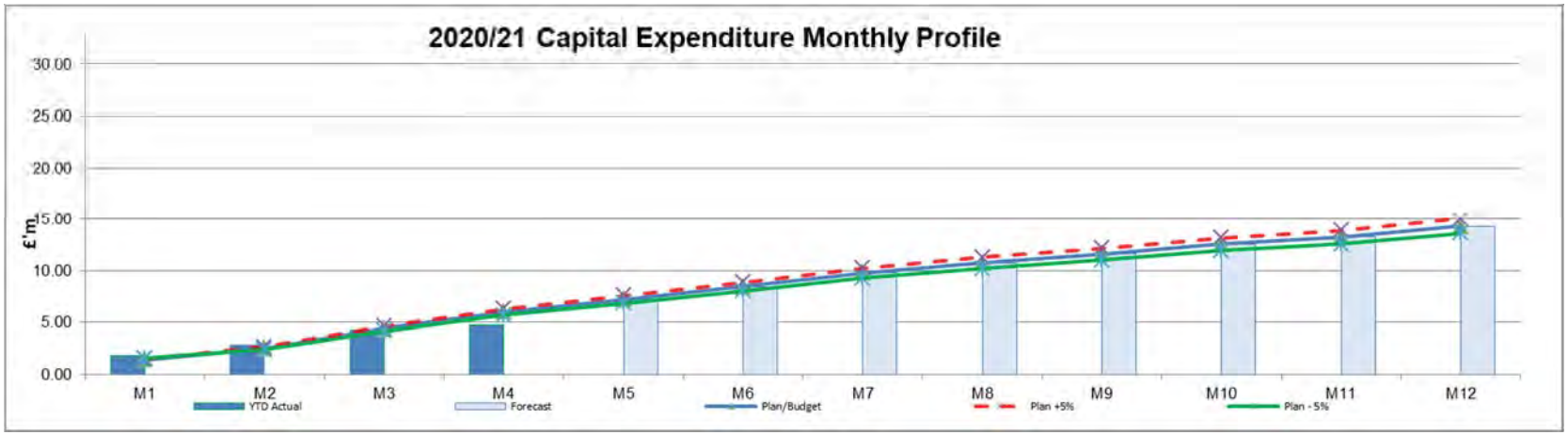
6. Capital

£'000	In-month			Year To Date M1-M4			Annual			Funding (PLAN)		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Forecast	Var.	Internal	PDC	CIF PDC
Backlog Maintenance	740	138	(602)	1,932	1,244	(688)	3,014	3,014	0	3,014	0	0
Fire Urgency Works	162	45	(117)	524	125	(399)	2,331	2,331	0	2,331	0	0
Emergency Department	0	172	172	1,211	1,381	170	1,211	1,211	0	1,211	0	0
Information Technology	308	(18)	(327)	1,670	1,577	(93)	4,023	4,023	0	4,023	0	0
Medical and Surgical Equipment Programme	8	(0)	(8)	31	(0)	(31)	142	142	0	142	0	0
Service Developments	325	72	(253)	500	436	(64)	1,919	1,919	0	1,919	0	0
Routine Maintenance	40	8	(32)	110	87	(23)	130	130	0	130	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	**1,583**	**417**	**(1,166)**	**5,977**	**4,850**	**(1,128)**	**13,877**	**13,877**	**0**	**12,770**	**1,107**	**0**
Unfunded	0	90	90	0	(78)	(78)	0	0	0	0	0	0
Diagnostics	0	0	0	0	0	0	440	440	0	20	420	0
Total Additional Capex	**0**	**90**	**90**	**0**	**(78)**	**(78)**	**440**	**440**	**0**	**20**	**420**	**0**
Total Capex	**1,583**	**507**	**(1,076)**	**5,977**	**4,772**	**(1,205)**	**14,317**	**14,317**	**0**	**12,790**	**1,527**	**0**
Grant/Donation Funded Capex	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Capex	**1,583**	**507**	**(1,076)**	**5,977**	**4,772**	**(1,205)**	**14,317**	**14,317**	**0**	**12,790**	**1,527**	**0**



The Capital programme is currently 34% complete, £1,205k behind projected expenditure plan.

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- **Backlog Maintenance, £688k behind plan, forecast for year is on plan.**
  Main schemes generating this slippage are;

		Plan	Actual	Var.	Comments
N/A	PY credits	0	0	-259	£185k VAT credits; £74k accrual slippage
N/A	Slippage Target	-127	0	127	
21/22-079	Res 10 Upgrade	600	487	-113	expected to catch up
21/22-008	Lifts upgrade	333	231	-102	expected to catch up
21/22-007	Social Club	372	251	-121	expected to catch up
21/22-005	Mortuary Roof	350	170	-180	expected to catch up
21/22-052	Paed medical gas upgrade	20	0	-20	expected to catch up
21/22-066	Ocelot ventilation	50	0	-50	expected to catch up
	Various	334	364	30	
				-688	

- **Fire Urgency Works £399k behind plan, forecast for year is on plan.**
  Main schemes generating this slippage are;

		Plan	Actual	Var.	Comments
N/A	Py credits	0	0	-52	£185k VAT credits; £74k accrual slippage
21/22-039	Fire alarm upgrade	265	157	-108	expected to catch up
21/22-042	fire doors	25	0	-25	expected to catch up
21/22-021	south wing xray door	50	0	-50	expected to catch up
21/22-041	fire compartmentation	167	11	-156	expected to catch up
	Various	17	9	-8	
				-399	

- **Emergency Department, £170k overspent**, with annual budget fully utilised. VAT credits are expected to offset this overspend

- **IT schemes 93k behind plan, forecast for year is on plan.**
  Main schemes generating this slippage are;

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		Plan	Actual	Var.	Comments
N/A	Py credits	0	0	-148	£185k VAT credits; £74k accrual slippage
N/A	Slippage target	-127		127	
21/22-047	EPR (Sunrise)	1102	872	-230	expected to catch up
21/22-053	Core Server Hardware/ Data Centre	287	624	337	ahead of plan, still within annual budget
21/22-046	EPR servers	165	0	-165	expected to catch up
	Various	243	229	-14	
				-93	

- **Service Developments £64k behind plan, forecast for year is on plan**
  Main schemes generating this slippage are;

		Plan	Actual	Var.	Comments
N/A	Py debits	0	0	149	VAT accrual - vat adjusts = £229k but across the projects
21/22-025	Fluroscopy	300	177	-123	expected to catch up
21/22-069	Fluoroscopy with over couch	92	0	-92	expected to catch up
21/22-024	Cath lab	100	110	10	expected to catch up
21/22-045	Public View Visualisation Tool	8	0	-8	expected to catch up
				-64	

- **Unfunded, £78k underspent**
  Unfunded summaries transactions relating to prior year projects, currently the value of credits from supplier, VAT and accrual slippage returns a balance of £78k credit.

- **Diagnostics**
  £440k of additional CRL has been allocated to this area in July, a programme plan is yet to be shared so all of this budget has currently been phased into month 12.

- **Overall capital forecast is still on plan but with a risk of £1,311k,** £514k is expected to be achieved due to a delay in one of the planned ward refurbishments and some charity funding to part fund an equipment purchase.

  £1m slippage targets have also been assigned to IT & Estates, plans to achieve are currently being drawn up. If plans are identified the financial risk will be fully mitigated. Until then the unmitigated risk is currently £797k

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Approval Category	Project Ref	Project Name	Pressure £'000
Original Plan	N/A	IT slippage - to date unidentified	503
Original Plan	N/A	F&E slippage target - to date unidentified	503
PY	N/A	Coffee Shop	84
TCG Approval - June	21/22-077-001	Equip - Lifestart	19
TCG Approval - June	21/22-077-002	Equip - Orthfix	57
TCG Approval - June	21/22-136	Children's ED	41
TCG Approval - July	21/22-136	Children's ED	5
TCG Approval - July	TBC	Keates Ward	60
TCG Approval - July	21/22-077	30 x VP infusion pumps - Panda/Dolphin	39
			1,311

Mitigations

Approval Category	Project Ref	Mitigations	£'000
Original Plan	21/22-027	Bronte Ward deferred to 22/23	500
TCG Approval - June	21/22-077-001	Equip - Lifestart - Charity Funding	14
			514

Shortfall	**797**

- Finance will be working with programme leads on a detailed capital forecast to be reported from month 6 onwards.

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

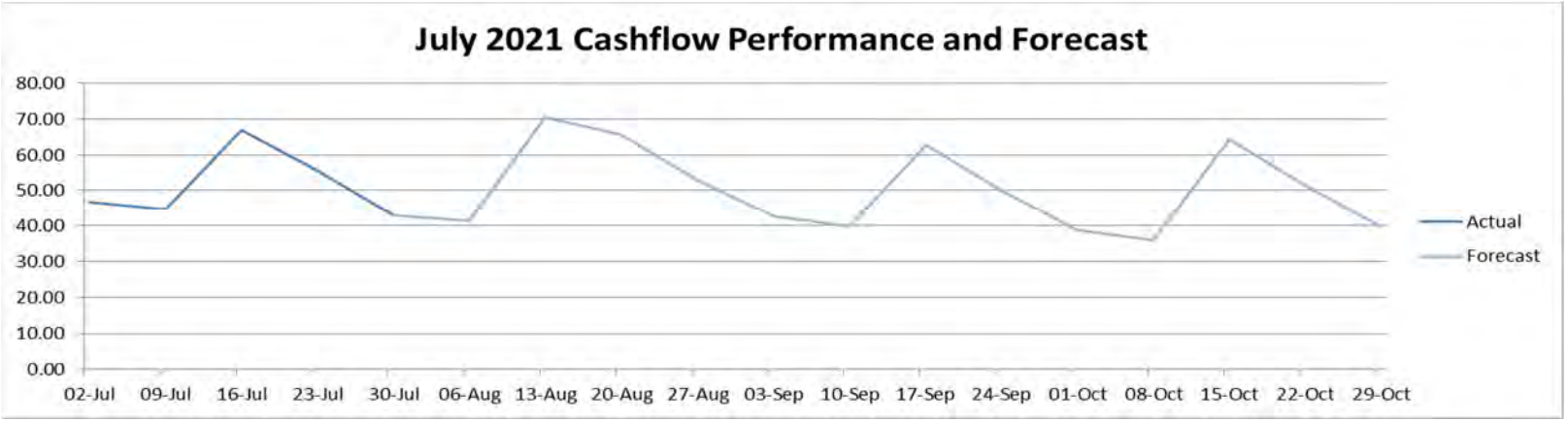
TCG Approved subject to funding being made available

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

6. Cash

13 Week Forecast w/e

£m	Actual 02/07/21	09/07/21	16/07/21	23/07/21	30/07/21	Forecast 06/08/21	13/08/21	20/08/21	27/08/21	03/09/21	10/09/21	17/09/21	24/09/21	01/10/21	08/10/21	15/10/21	22/10/21	29/10/21
BANK BALANCE B/FWD	**57.76**	**46.74**	**44.82**	**66.97**	**55.59**	**42.78**	**41.45**	**70.56**	**65.71**	**53.05**	**42.64**	**39.86**	**62.80**	**50.11**	**38.80**	**36.02**	**64.20**	**51.43**
Receipts																		
NHS Contract Income	0.21	0.06	28.56	0.31	0.12	0.17	30.52	0.00	0.00	0.00	0.00	30.52	0.00	0.00	0.00	30.52	0.00	0.00
Other	0.63	0.25	0.42	0.15	0.26	0.17	2.98	0.25	0.25	0.25	0.58	0.35	0.25	0.25	0.58	2.65	0.25	0.25
Total receipts	**0.84**	**0.30**	**28.98**	**0.46**	**0.38**	**0.35**	**33.50**	**0.25**	**0.25**	**0.25**	**0.58**	**30.87**	**0.25**	**0.25**	**0.58**	**33.17**	**0.25**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(8.48)	(0.37)	(0.35)	(9.88)	(8.59)	(0.41)	(0.39)	(0.48)	(9.90)	(8.56)	(0.36)	(0.36)	(9.94)	(8.56)	(0.36)	(0.36)	(9.94)	(8.56)
Non Pay Expenditure	(3.08)	(1.37)	(6.42)	(1.73)	(3.54)	(0.90)	(3.50)	(4.13)	(2.50)	(1.60)	(2.50)	(4.13)	(2.50)	(2.50)	(2.50)	(4.13)	(2.50)	(3.00)
Capital Expenditure	(0.31)	(0.48)	(0.06)	(0.23)	(1.05)	(0.37)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)
Total payments	**(11.87)**	**(2.22)**	**(6.83)**	**(11.84)**	**(13.19)**	**(1.68)**	**(4.39)**	**(5.11)**	**(12.90)**	**(10.66)**	**(3.36)**	**(4.99)**	**(12.94)**	**(11.56)**	**(3.36)**	**(4.99)**	**(12.94)**	**(12.06)**
Net Receipts/ (Payments)	**(11.03)**	**(1.92)**	**22.15**	**(11.38)**	**(12.81)**	**(1.33)**	**29.11**	**(4.86)**	**(12.65)**	**(10.41)**	**(2.79)**	**25.88**	**(12.69)**	**(11.31)**	**(2.79)**	**28.18**	**(12.69)**	**(11.81)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(2.94)	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(2.94)**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**
BANK BALANCE C/FWD	**46.74**	**44.82**	**66.97**	**55.59**	**42.78**	**41.45**	**70.56**	**65.71**	**53.05**	**42.64**	**39.86**	**62.80**	**50.11**	**38.80**	**36.02**	**64.20**	**51.43**	**39.62**



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

Prior year end	£'000	Month end actual	Var.
49,184	Cash	42,845	(6,339)

Cash balances have moved from the prior year due to

- £5.8m additional cash due to increase in income paid in advance
- £2.8m additional cash payments made in advance of contracts
- £10.4m reduction in capital payables, most of which will have been paid out in cash.

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7. Forecast, risk and mitigations

£'000	Actuals				Forecast			Budget	H1
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	H1 21/22	H1 21	Variance
Clinical income	27,174	27,519	27,400	27,984	28,045	28,045	166,168	167,168	(1,000)
Donated Asset Adjustment	222	1	(222)	0	0	0	0	0	0
High cost drugs	1,677	1,776	1,954	1,832	1,560	1,560	10,359	10,881	(522)
Other income	1,821	1,804	2,280	1,878	1,920	1,920	11,623	10,120	1,503
PSF/MRET/FRP	0	0	0	0	0	0	0	0	0
Income Total	**30,893**	**31,100**	**31,412**	**31,695**	**31,525**	**31,525**	**188,150**	**188,170**	**(20)**
Medical	(6,053)	(6,250)	(5,940)	(6,519)	(6,350)	(6,311)	(37,423)	(37,512)	89
Nursing	(7,529)	(7,832)	(7,799)	(8,057)	(7,856)	(7,839)	(46,912)	(47,581)	668
Other	(5,892)	(5,549)	(5,501)	(5,210)	(5,301)	(5,298)	(32,751)	(29,858)	(2,893)
Pay Total	**(19,474)**	**(19,630)**	**(19,240)**	**(19,787)**	**(19,506)**	**(19,448)**	**(117,086)**	**(114,950)**	**(2,136)**
Clinical supplies	(3,785)	(4,144)	(4,416)	(4,522)	(4,067)	(4,070)	(25,004)	(23,603)	(1,401)
Drugs	(714)	(793)	(912)	(887)	(894)	(894)	(5,093)	(3,589)	(1,504)
High cost drugs	(1,677)	(1,784)	(1,967)	(1,857)	(1,821)	(1,821)	(10,928)	(10,924)	(4)
Other	(3,785)	(3,324)	(3,419)	(3,193)	(3,785)	(3,874)	(21,379)	(26,482)	5,103
Non Pay Total	**(9,960)**	**(10,044)**	**(10,714)**	**(10,459)**	**(10,567)**	**(10,660)**	**(62,404)**	**(64,597)**	**2,194**
Depreciation	(880)	(880)	(912)	(903)	(903)	(903)	(5,381)	(5,371)	(10)
Donated Asset Adjustment	(7)	(7)	(7)	(7)	(8)	(8)	(45)	(47)	2
Net finance income/(cost)	(4)	(1)	(2)	(3)	(3)	(3)	(16)	10	(26)
PDC dividend	(542)	(545)	(544)	(544)	(545)	(545)	(3,264)	(3,262)	(2)
Post EBITDA Total	**(1,433)**	**(1,433)**	**(1,466)**	**(1,457)**	**(1,459)**	**(1,459)**	**(8,706)**	**(8,670)**	**(36)**
Surplus/(deficit)	**25**	**(7)**	**(7)**	**(7)**	**(7)**	**(42)**	**(46)**	**(48)**	**2**
Remove Donated Asset Depn.	7	7	7	7	8	8	45	47	(2)
Control Total	**33**	**0**	**0**	**0**	**0**	**(34)**	**(1)**	**(1)**	**0**

The key matters to note from this forecast are:

- Based on run-rate.
- Adjustments for non-recurrent items / known issues.
- Control total forecast to be met.
- ERF income assumed of £4.9m, of this £3.1m has been confirmed with NHSE/I for April and May.
- Contingency included of £1.4m (increase of £0.4m from month 4)
- No new CIP delivered
- No significant service developments before H2.
- Clinical supplies & drugs adverse variance due to restart activity and insourcing / outsourcing costs.
- Favourable variance on the "other" category includes £4.6m ERF reserve that was included in the re-submitted plan. This was instructed by the CCG to increase ERF income from £1.3m to £5.9m.

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The table below sets out the forecast variance to budget for all divisions.

£'000	Forecast Variance to Budget					
	Unplanned & Integrated Care	Planned Care	Corporate	Facilities & Estates	Central & Trust Income	Total
Clinical income	1,020	954	0	0	(2,974)	**(1,000)**
Donated Asset Adjustment	0	0	0	0	0	**0**
High cost drugs	(1,499)	136	0	0	841	**(522)**
Other income	(216)	653	248	217	601	**1,503**
PSF/MRET/FRP	0	0	0	0	0	**0**
Income Total	**(696)**	**1,743**	**248**	**217**	**(1,532)**	**(20)**
Medical	(145)	(1,074)	(216)	0	1,525	**89**
Nursing	(1,127)	1,215	169	0	410	**668**
Other	149	(731)	150	230	(2,690)	**(2,893)**
Pay Total	**(1,123)**	**(590)**	**103**	**230**	**(755)**	**(2,136)**
Clinical supplies	273	(1,178)	(284)	(512)	300	**(1,401)**
Drugs	(1,076)	(728)	7	0	293	**(1,504)**
High cost drugs	1,499	(136)	0	0	(1,367)	**(4)**
Other	(5)	(319)	250	(633)	5,811	**5,103**
Non Pay Total	**691**	**(2,361)**	**(27)**	**(1,145)**	**5,036**	**2,194**
Depreciation	0	0	0	0	(10)	**(10)**
Donated Asset Adjustment	0	0	0	0	2	**2**
Net finance income/(cost)	0	0	0	0	(26)	**(26)**
PDC dividend	0	0	0	0	(2)	**(2)**
Post EBITDA Total	**0**	**0**	**0**	**0**	**(36)**	**(36)**
Surplus/(deficit)	**(1,128)**	**(1,208)**	**323**	**(698)**	**2,712**	**2**
Remove Donated Asset Depn.	0	0	0	0	(2)	**(2)**
Control Total	**(1,128)**	**(1,208)**	**323**	**(698)**	**2,710**	**0**

Forecast variance to budget:

Unplanned Care income mainly includes £0.3m ERF income as well as homecare provider drugs, the budget for ERF is held within Trust income. The pass through costs that are recharged to the CCG for drugs and medical devices are included in the non-pay forecast as well as adverse variances for increased medical staffing pressures and the escalation ward.

Planned Care includes £0.8m ERF income, this is budgeted for in Trust Income category. The favourable variance in the division is offset by insourcing costs as well as premium costs for temporary medical staff, clinical supplies and drugs expenditure increases due to higher activity levels associated with the restart programme.

Corporate services favourable variance is mainly due to the contribution to overheads from Medical Education and vacancies across the various functions.

Facilities & Estates adverse variance is driven by higher energy costs due to the CHP equipment not functioning as well as high minor works costs and medical equipment.

The contingency budget included in “other” includes 4.6m additional ERF income. This is used to fund budget transfers from reserves; the remaining £5.0m favourable variance offsetting adverse variances across divisions and cost pressures in reserves. The adverse income variance includes £1.0m ERF income under-recovery and £0.5m high cost drugs.

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7. Forecast, risk and mitigations (continued)

Title	Risk description	RAG	£'000	Mitigation(s)	Lead(s)
ERF income - receipt	Early indications were that ERF income may not accrue due to gateway planning targets being undefined/unmet at a system level. The full £3.1m has remained as a risk in case of retraction as the actual payment has not yet been received.		3,100 (month 1+2)	NHSE/I are due to imminently make payment of ERF for April and May with indications of values for June expected. The CCG has agreed to underwrite any additional costs incurred to deliver against the elective targets.	Cleo Chella
ERF income - threshold	It has been confirmed that with effect from 1 July the threshold for ERF would be increased from 85% to 95%.		1,000 (predicted H1 impact)	The Trust is not penalised if it does not meet the threshold target. The CCG has agreed to underwrite any additional costs incurred to deliver against the elective targets.	Cleo Chella
Efficiency	Cross-cutting schemes from the showcase are being scoped. Divisional schemes are still being developed.		4,800 (full year)	Further efficiency showcase event on 23 July is rescheduled to 18 August. Project teams being established to take forward the cross-cutting schemes.	Alan Davies
Covid	Covid patient numbers have been low, although they are now starting to rise and restrictions are being lifted. The H1 funding has exceeded incremental cost; H2 funding will be adjusted (anticipated downwards) to reflect activity.		n/a	Use of contingency reserve. H2 funding negotiation/settlement.	Alan Davies
ED activity / patient flow	Increased activity from the Emergency Department (ED) while waiting for inpatient beds to be available. This can restrict patient flow through the hospital.		n/a	Opening of Priority Admission Unit (PAHU)	Alan Davies

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8. Conclusions

The Finance Committee is asked to note the report and financial performance which is £7k deficit in-month reducing to breakeven after removing the adjustment for donated asset depreciation and income. This financial performance is as per the plan submitted to the Kent & Medway STP and forecast to breakeven for the first six months in line with the control total. The year to date efficiency programme is adverse to plan and the majority of delivery is from the full year effect of schemes that started in the previous financial year. ERF income of £3.1m has been included; this is the figure notified by NHSE/I and based on the Trust delivering the activity thresholds in April and May.

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 the incremental cost of elective recovery and covid costs within plan as well as the receipt of ERF income at the higher figure.

Mitigations to reduce the risk:

- Efficiency programme showcases and increased focus on delivering efficiencies using Model Hospital data.
- ERF income of £4.9m, this being an increase from the previous month of £1.1m following confirmation from NHSE/I of £3.1m.
- M4 contingency £1.0m, forecast for H1 £1.4m.

Alan Davies
Chief Financial Officer
August 2021

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Meeting of the Board of Directors in Public

Thursday, 29 July 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**5.2a**
Committee Chair:	Annyes Laheurte, Chair of Committee, NED		
Date of Meeting:	Thursday, 29 July 2021		
Lead Director:	Alan Davies, Chief Finance Officer		
Report Author:	Matthew Chapman, Head of Financial Management		

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

Key headlines and assurance level	
Key headline	**Assurance Level**
1. BAF strategic risks The BAF scores were noted as being unchanged; it was discussed and agreed the narratives would be regularly updated along with finalising timescales with dates for each action to monitor progress.	**Amber/Green**
3. Finance report – month 3 The 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 3 and for the year to date. • Pay costs had continued to decrease in month reflecting the reduction in need for temporary to cover Covid staff sickness and self-isolation as cases reduce. Some of this reduction has been	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
offset by emergency care operational pressures, in particular within the inpatient services. • In addition to the above, £0.6m of contingency reserve is held within the position. • ERF income has been accrued at £1.1m this reflecting the incremental cost of delivering the ERF activity thresholds and lower than the actual income calculated as receivable. The cautious approach continued as the Trust has received confirmation the incremental cost of delivering ERF would be underwritten by the ICS however the higher full amount due has not yet been confirmed. • Capital expenditure was slightly adverse to plan but is due to timing differences and expected to recover. Currently £750k of capital is over committed with the capital group looking to risk assess the schemes, with a view to possible slippage, re-phasing and scaling down. The following actions were **AGREED**: • A further analysis of debts over 90 days as the total remains high. • More detail of specific cost pressures identified within the forecast (for example 1:1 nurse specialling, costs to care for patients with mental health needs, outsourcing and insourcing). • Further detail of the efficiency programme. This is a follow up to the CIP showcase event that generated a number of cross-cutting themes that are now being scoped, developed and will be implemented accordingly.	
4. Pay run-rate review The Chief Finance Officer introduced the paper, highlighting the executive summary. It was noted that as a subset from the review, Safer Staffing and an overall nursing staff review should be reported back to the meeting in the future. It was **AGREED** that over the next 2 months, further analysis should be presented to the committee where information is available, including: • Link cost changes to activity. • Analysis of staff by grade and whether this has changed significantly. • Review control procedures regarding recruitment of medical staff as the Trust is over budgeted establishment. • Benchmarking and review of non-clinical staffing structures • NHSE/I to provide analysis of pay costs from other providers within the ICS. This would help with continuing previous work reviewing pay metrics and benchmarking to other providers • Review efficiency initiatives to reduce pay costs.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
5. NHSE/I intensive support action plan The plan was **APPROVED** by the committee, including timescales. . A discussion then ensued regarding keeping the plan on the Finance Committee agenda and also inter-weaving the actions into business as usual. It was requested that further updates at future meetings would be presented as to how the plan is being implemented.	**Amber/Green**
6. Financial recovery plan – briefing The Chief Finance Officer updated the committee and informed that a PID has been produced along with the ICS scoping the work required in the recovery plan and established a group within the ICS to oversee the delivery of the plan. It was noted that the financial recovery plan is intrinsic with the trust strategy & ICS strategy plans. Actions will be identified to mitigate underlying deficit. It has been agreed with the ICS for additional support to help with the recovery plan; it is likely this will be in place over the next couple of weeks.	**Green**
7. Financial training policy – SOP The policy was discussed by the group and noted this links in with financial improvement plan. The following points were raised: • Budget holders will need specific efficiency training as well as budget training. • Training to be a rolling program, and refresher training every two years for all budget managers. The Committee **APPROVED** the policy and asked for the above amendments to be made.	**Amber/Green**
Decisions made **AGREED** The Trust Capital Group (TCG) to review the risk of all schemes and report back to the September meeting. **AGREED** more detail of debts, cost pressures and efficiency programme to be presented at future meetings. **AGREED** further analysis work of pay costs to continue following the presentation of the pay review report. To be presented at future meetings. NHSE/I intensive support action plan was **APPROVED** Financial training policy – SOP was **APPROVED**	
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, 09 September 2021

Assurance Report from Committees

Title of Committee:	**Finance Committee**		**5.2**
Committee Chair:	Annyes Laheurte, Chair of Committee		
Date of Meeting:	Thursday, 26 August 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. Timescales had been added to the actions to manage the risk. It was **AGREED** that "3a Delivery of Financial Control Total" would be discussed outside of the meeting to determine how this – and all entries on the BAF - can be reported in a way to provide more assurance over the mitigations and progress.	**Amber/Green**
2. Corporate risk register	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
There was one item scoring 16 or higher with regards to the capital resource limit for the year. There had been no change from the previous month.	
3. Finance report – month 4 The 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 4 and for the year to date. • Pay costs continued to be adverse to budget, notably as a result of unmet efficiency and nurse specialling cost increases. • The forecast had been revisited and the control total still expected to be met. • Efficiency delivery remained low – c50% of the target year to date. • Capital expenditure was behind plan but is attributed to plan phasing at this time. The biggest challenge remained an over commitment against the programme and managing this down to the allocated resource limit. It was noted that the prioritisation of schemes will be revisited by executives for the second half of the year. • Cash remains buoyant, although slightly reduced due to payment of the year end capital accruals. • The Chief Financial Officer confirmed that the income position is supported by funding that is over and above activity levels and that this regime is expected to continue until the end of the year. • The incremental Covid expenditure is currently c£0.3m per month, down from the high of the fourth quarter of 2020/21. It was confirmed that the costs of the national pay award are not included in the pay expenditure; these are to be paid (including arrears) in September 2021 with the funding to follow. The need to increase the Trust bank rates will be considered, particularly in light of other regional providers. Reassurance was given that the fire safety works under the capital programme are progressing and that any variance arises purely due to a phasing issue of the plan.	**Amber/Green**
4. NHSE/I run-rate analysis of Kent & Medway ICS The Chief Financial Officer took the meeting through the pack that had been prepared by NHSE/I. This included: • A lower % pay increase compared to the rest of the system • A higher % delivery of efficiency schemes compared to the rest of the system, albeit concerns for 21/22 The conclusion was that there are positive indicators, including control of bank and agency usage. It was however noted that during 2021/22 the	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
Trust has had to incur additional costs at little/no margin to deliver against the Elective Recovery Fund thresholds, i.e. a loss of productivity.	
5. Aged debtors and Better Payment Practice Code ("BPPC") The Deputy Chief Financial Officer communicated the key highlights from the aged debtors paper, noting: • That outstanding debt is less than half the monthly income and had improved compared to recent years. • That the pandemic has meant that current debt does not represent an issue. • £8m of the £13.5m outstanding debt was with NHS organisations, of which we are expecting settlement of £4m of this shortly. • Of the non-NHS debt outstanding, a significant portion was in respect of overseas visitors. Discussion was held about the difficulty of identification, payment and ultimate recovery of these debts. It was **AGREED** that the immediate focus should be on recovery of the NHS debt and the local community provider; future finance papers are to include a focus on the recovery of debt from other NHS organisations and the local community provider. The Deputy Chief Financial Officer presented the BPPC paper, noting that this issue was on the national radar across the NHS, and that the Trust had been asked to submit an improvement plan. The action plan was **APPROVED** subject to tightening of the timetable and more regular/granular reporting to the Trust Executive and divisional leads.	**Amber/Green**
6. Efficiency programme The Chief Financial Officer introduced the paper, noting that the second showcase event was well attended and productive. The cross-cutting themes were progressing and had an executive SRO assigned; granular work plans are due to be developed for each of the 9 themes by 10 September. The current year performance and identification was acknowledged as being poor, although the cross-cutting themes and their action plans offer some significant opportunities to bridge the gap in the second half of the financial year. The terms of reference for the newly established 'Efficiencies Delivery Group' ("EDG") was shared. An Improvement Director is expected to be appointed shortly to support the Trust with its Financial Recover Plan.	**Amber/Red**
7. National cost collection / reference cost update The progress update paper was noted by the meeting.	**Green**
8. Picture Archiving Communication System ("PACS") and Radiology Information System ("RIS") outline business case for the Kent & Medway ICS	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level**
Sue Lang from East Kent Hospitals University NHS Foundation Trust joined the meeting to present the case. This set out the need for replacement of the PACS/RIS and the procurement route being taken. The Full Business Case is anticipated in December 2021. The outline business case was **APPROVED** to proceed to full business case.	
9. Post project assessment: Same Day Emergency Care ("SDEC") The Chief Operating Officer presented the paper, noting that this had generally been positive but had been impacted to some extent by the pandemic.	**Amber/Green**
10. Finance Committee self-assessment A Slido poll was conducted on-line to assess the effectiveness of the Committee. The Company Secretary noted that he would discuss the results with the Committee Chair outside of the meeting.	**Amber/Green**
11. H2 budget setting The Trust's internal guidance on H2 budget setting was shared and confirmed that this had been both agreed with Trust Executives and distributed across the organisation.	**Amber/Green**
Decisions made It was **AGREED** that "3a Delivery of Financial Control Total" would be discussed outside of the meeting to determine how this can be reported in a way to provide more assurance over the mitigations and progress. It was **AGREED** that the immediate focus should be on recovery of the NHS debt and the local community provider; future finance papers are to include a focus on the recovery of debt from other NHS organisations and the local community provider. The BPPC action plan was **APPROVED** subject to tightening of the timetable and more regular/granular reporting. The Picture Archiving Communication System ("PACS") and Radiology Information System ("RIS") outline business case for the Kent & Medway ICS was **APPROVED** and is due to be presented at the September Trust Board.	
Further Risks Identified None other than as set out.	
Escalations to the Board or other Committee The Picture Archiving Communication System ("PACS") and Radiology Information System ("RIS") outline business case for the Kent & Medway ICS was approved and is due to be presented at the September Trust Board.	

Meeting of the Board of Directors in Public

Thursday, 09 September 2021

Assurance Report from Committees

Title of Committee:	**People Committee**	**Agenda Item**	**6.1**
Committee Chair:	Sue Mackenzie, Chair of Committee/NED		
Date of Meeting:	Thursday, 20 July 2021		
Lead Director:	Leon Hinton, Chief People Officer		
Report Author:	Leon Hinton, Chief People Officer		

Key headlines and assurance level	
Key headline	**Assurance Level**
1.IQPR – People KPIs Key highlights were noted as follows: 1) Total Sickness (monthly) which demonstrated two successive increases to 5.04%, higher than seasonal average. Usage of occupational health services has increased for anxiety and stress. Underlying sickness in June: 1% due to stress/anxiety (up from 0.7%) 0.9% due to MSK (up from 0.4%) 2) Temporary staff spend, as percentage of the paybill, has reduced significantly to less than 15%; however, this is likely to increase over the summer months in order to provide additional resource to support the additional planned capacity. 4) Statutory and Mandatory training remains consistent with slight overall improvements and positive to target overall; improvements to resuscitation training compliance were noted.	**Amber/Green**
2. HR Resourcing Dashboard 1) International recruitment for nursing remained on trajectory along with clinical support worker recruitment. 2) The top five specialties with highest/most difficult to recruit to consultant vacancies reported a slightly improving position for neonatology and ICU. ENT remains a difficult to recruit to speciality.	**Amber/Green**
3. Talent management strategy 1) An update was provided of the draft talent management strategy. The existing nine-box grid approach for talent management is being overhauled nationally and will require integration into the Trust's strategy.	**White**
4. Wellbeing guardian report for Q1 2021/22 1) The committee received the assurance report. The framework dashboard, alongside Key Performance Indicators from NHS Staff Survey and Freedom to Speak Up metrics, aims to provide oversight of	**Amber/Green**

progress of the Staff Health and Wellbeing Strategy. The dashboard overall score at quarter 3 2020/21 was 54%; at quarter 4 2020/21 was 57%, as at the end of quarter 1 2021/22 the score was 60% (+3%).	
5. Institute of Leadership Management Assurance Report 1) The Committee received the quarterly report and noted the agreed action plan following the positive Ofsted new provider inspection.	**Green**
6. Freedom to Speak Up strategy refresh 1) The refreshed strategy to be presented to the Committee in July '21.	**Red**
7. Medical Appraisal and Revalidation Report 1) The Committee APPROVED the report for it to be submitted to the Board in September 2021. 2) The Committee noted that 34 (8.3%) of doctors had an approved missed or incomplete appraisal with the breakdown of reasons. 3) It was noted that for the year ending 31 March 2021, 33 Doctors received a positive recommendation for revalidation, three doctors received recommendation for deferral with a demographic breakdown similar to the profile of the Trust.	**Amber/Green**
8. Just Culture – Update 1) The Committee were informed of the development session for managers for Just Culture, Investigations and Hearings at the end of July. The associated policies, including the review of the disciplinary policy, were updated with the disciplinary policy now published on the Trust's publication scheme. 2) Policy updates were ongoing. The Trust's suspension checklist has been updated with better connections to safeguarding and health and wellbeing.	**Amber/Green**
9. Workforce Race Equality Scheme (WRES) and Disability WDES formal reports 1) The Committee received the two equality scheme reports and progress from 2020/21 with some minor improvements to the diversity profile in the organisation, but a change to near parity for disciplinary profile (a deterioration of the metric). Of particular concern is that the staff perception data, measured by the Annual Staff Survey 2020, has largely deteriorated in terms of both race and disability, illustrating the need for a focus on cultural/behavioural change across the whole Trust. 2) The WRES and WDES data must be published by 31 August 2021, and the action plans, developed with the networks published by 30 September 2021.	**Amber/Red**
10. Gender Pay Gap Report 1) The Committee approved the publication of the 2020/21 gender pay gap (GPG) demonstrating a mean gender pay gap is 34.06% and the median gender pay gap of 25.54%. This is a wider gap than reported for 2020. Since September 2019, quarterly monitoring has taken place, showing that an initial improvement in the gender pay gap occurred in the April to June quarter 2020, deteriorating marginally in the following two quarters, but still on target in December 2020 for an improvement on the 2020 pay gap report. Improving the gender profile of medical and dental roles, therefore, is likely to have the greatest impact on improving the	**Amber/Red**

pay gap, but analysis has also identified the need to improve the progression of women through to higher pay bands.	
Decisions made: None to report	
Further Risks Identified: None to report	
Escalations to the Board or other Committee: 1) Medical Appraisal report reviewed and agreed for submission to Board,	