Agenda

NHS Medway NHS Foundation Trust

Public Trust Board Meeting

Wednesday, 15 May 2024 at 12:30 – 15:30 Trust Board Room, Gundulph Offices

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 06 March 2024	Chair	3	12:35	Approve
2.2	Action Log – none for May 2024		-		Discuss
2.3	Chief Executive Update	Chief Executive	11	12:40	Note
2.4	Council of Governors Report (April 2024)	Lead Governor	14	12:50	Note
2.5	Constitution – Review	Company Secretary	Verbal	12:55	Note
3.	**Board Story Presentation**				
3.1	None for May 2024	Associate Director of Patient Experience	-	-	Note
4.	**Board Assurance Reports**				
4.1	Quality Assurance Committee Update (March 2024, (meeting via correspondence), April and May 2024)	Chief Medical Officer, Chief Nursing Officer (Interim), Committee Chair	16	13:00	Assurance
4.2	People Committee Update (March 2024)	Chief People Officer, Committee Chair	22	13:15	Assurance
4.3	Finance, Planning and Performance Committee Update (March and April 2024)	Chief Finance Officer, Committee Chair	26	13:25	Assurance
5.	**Public Board Papers**				
5.1	Perinatal Culture Leadership Report	Interim Chief Nursing Officer	35	13:40	Note
5.2	Perinatal Quality Surveillance		42		Note
5.3	Claims, Incidents, Complaints Triangulation Report		90		Note
5.4	Emergency Preparedness, Resilience and Response – Policy	Chief Operating Officer	97	14:00	Approve
~ WELLBEING BREAK - 10 minutes ~					

Agenda

5.5	Finance Report (Month 12)	Chief Finance Officer	115	14:20	Note
5.6	Annual Business Plan	Chief Delivery Officer	129	14:35	Approve
5.7	Green Plan - Review	Chief Operating Officer	142	14:45	Note
6.	**Performance, Risk and Assurance**				
6.1	Integrated Quality Performance Report – March 2024 (Refreshed)	All Executives	148	14:55	Note
6.2	Risk Register – Refresh Update	Company Secretary	Verbal	15:10	Note
6.3	Board Assurance Framework – Refresh		186		Note
7.	**Closing Matters**				
7.1	Questions from the Public – **None**	Chair	Verbal	15:20	Note
7.2	Risks Identified				
7.3	Reflection				
7.4	Any Other Business				
7.5	Date and time of next meeting: Wednesday, 17 July 2024				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 06 March 2024 at 12:30 – 15:30

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

and on MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	Mark Spragg	Acting Chair
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Jayne Black	Chief Executive
	Leon Hinton	Chief People Officer
	Nick Sinclair	Chief Operations Officer
	Sarah Vaux	Chief Nursing Officer (Interim)
Attendees:	Adrian Ward	Non-Executive Director
	Akshay Dhir	Public - Chime Care
	Alana Almond	Deputy Company Secretary (Minutes)
	Chris Burton	Academic Non-Executive Director
	David Brake	Lead Governor
	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
	Jignesh Patel	Governor
	Louise Black	Macmillan Nurse
	Matt Capper	Director of Strategy and Partnerships/Company Secretary
	Michael Taylor	Public - Head of Strategic Relationships for Healthcare Business Solutions UK
	Nicola Cooper	Director of Operations (Cancer and Core Clinical Services)
Apologies:	Mojgan Sani	Non-Executive Director
	Paulette Lewis	Non-Executive Director
	Sue Mackenzie	Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all to the meeting, particularly Chris Burton, our Academic NED from Canterbury Christ Church University. Apologies were noted as above.

1.2 Quorum

The meeting was confirmed to be quorate; at least one-third of the whole number of the voting Directors are present including at least one Executive Director and one Non-Executive Director.

1.3 Declarations of Interest

There were no declarations of interest against any agenda item.

2 Minutes of the last meeting, Action Log, Chief Executive and Council of Governors Updates

2.1 Minutes of 17 January 2024

The Minutes of the meeting held on 17 January 2024 were **APPROVED** as a true and accurate record.

2.2 Action Log

There were no actions for Board on the log. Action Log is held under separate cover

2.3 Trust Board Workplan

Matt Capper, Director of Strategy and Partnerships/Company Secretary, presented the report for approval.

The Board **APPROVED** the work plan.

2.3 Chief Executive Update

Jayne Black presented the report to the Board.

a) Tackling Operational Pressures – thanking staff for their continued efforts. Four-hour emergency performance remained broadly in line with national average. Teletracking has improved the flow through the hospital.
b) A year of Sheppey Frailty Unit.
c) Patient Knows Best (PKB) – Patients are able to access their own hospital appointments with launch on the online portal.
d) Royal College of Anaesthetists Accreditation – the accreditation has been received demonstrating a commitment to patient safety and high-quality care.
e) Care Quality Commission Maternity Survey – published in February 2024, the positive responsive rate was better than the national average in a number of areas.
f) Governor Elections – taking place during March.
g) League of Friends Donations - £81k donated last year with further substantial donations still to be made which are really appreciated by the Trust and Patients.

The Board **NOTED** the report

2.4 Council of Governors Update

David Brake presented the report for the February Council of Governors meeting. There were no matters to be escalated to the Board.

The Board **NOTED** the update.

3 Board Story Presentation

3.1 **Macmillan Nurses – Cancer Services**

Nicola Cooper introduced the presentation for the Macmillan Cancer services at the Trust. Louise Black, Macmillan Nurse, attended the meeting to discuss the work they do on site and across the system and the close relationship that we have with the MacMillan Foundation.

Check and Challenge

1) Chair; thanked the entire team for their work and asked Nicola to highlight the funding the Trust receives. Nicola; of the 18 posts we applied for the Cancer Alliance gave us funding for 16. This is just as crucial as the other funding given to us by MacMillan.
2) This is just as crucial as the funding given to us by MacMillan Care, which is currently funding 10 posts amounting to approximately £576,146 per year for the 24-month pump prime posts. MacMillan has also agreed funding for additional 24 month pump prime posts, x3 Band 7 CNSs and x2 Band 4 CSW at an estimated value to the Trust of £300,000.
3) Gavin; how do you organise as a team? Louise; each team has work and job plans liaising with Consultants.
4) Jayne; gave the team congratulations, listening to the team at recent events and being so passionate about their work was brilliant.
5) Chair; take thanks back to the team, for the excellent work.

The Board **NOTED** the presentation

4 Board Assurance Committee Updates

4.1 **Quality Assurance Committee**

Alison Davis and Sarah Vaux presented the report for the meeting held on 08 February 2024. The Committee approved the closure of Risk 1e.

Check and Challenge

1) Jayne; queried the level of assurance around violence and aggression. Sarah; will cover this in her update later in the meeting.

The Board was **ASSURED** and **NOTED** the report

4.2 **People Committee**

Leon Hinton presented the report for the meeting held on 06 March 2024. The Committee approved the Trust's Bullying, Harassment and Discrimination and Conflict Resolution Policy subject to a separate easy reference guide.

The Board were **ASSURED** and **NOTED** the report

4.3 **Finance, Planning and Performance Committee (FPPC)**

Alan Davies and Gary Lupton presented the reports for the meetings held on 25 January 2024 and 29 February 2024 (by way of separate paper). The Committee approved the closure of Risk 4a, and the Overseas Visitors Handbook on the 25 January. The Committee approved the Terms of Reference, the Interventional Radiology Business Case, and the Trust Investment Group Terms of Reference at the meeting held 29 February 2024. Capital Programme Overspend will be a report circulated in the next week and may need a potential extraordinary meeting of the Committee or approval via correspondence.

The Board were **ASSURED** and **NOTED** the reports

5 Public Board Papers

5.1 **Violence and Aggression Update**

Sarah Vaux gave the Board a verbal update.

a) There has been more agreement around the governance on this issue, plus adjusting the management of it. This area now reports to Audit and Risk Committee. KMPT and MTW have agreed to do some work on check and challenge and cross learning. ICB has recognised its role in this and will support all organisations.
b) Security; there is confidence around reporting of incidents. Feedback from the teams is positive. Most of the incidents are in ED and CDU. There has not been a permanent security presence in ED within the memory of our current staff and team. However, this is something that is being explored again at the moment with the ED leadership team, given the increase in incidents of violence and aggression.
c) There has been good use of the red and yellow cards.
d) Safeguarding team is working closer with the team. There is now a monthly meeting in with the police.
e) The team is now asked to complete Breakaway Training, this is provided by a company called Ethical Care www.eccruk.com. This is a one day course and soon there will be over 1,000 staff trained in this methodology. Still work to do with partners and the system, policies and enhanced care.

Check and Challenge

Gavin; asked about training and who does this. Sarah; answered post meeting with details above.
Jayne; must ensure that there is support for staff through the Wellbeing team. Sarah; yes, Trust is doing as much as it can and will monitor this.
Gary; is locating a Security guard in the ED needed? Sarah; answered post meeting with details above.

The Board **NOTED** the update

5.2 **Perinatal Quality Surveillance Report**

Alison Herron presented the report providing an update on the Quarter 3 data.

Check and Challenge

a) Jayne; with turnover, there is a breakthrough objective to keep this under 1%. Alison H; yes and the team have sustained being under the 1% for four months
b) Jayne; update on the breakthrough objective of induction of labour? Alison H; in the last month it has reduced retaining less than 12 women on the list at any time. There has been good progress but team has not been able to maintain this over the last few weeks.
c) Chair; how is the feedback from friends and family. Alison H; not quite hitting 100% response rate but getting good feedback with responses received.
d) Chair; how are the team addressing negative staff behaviours on the team. Alison H; there is an action plan in place, senior sister unannounced drop-ins, team working and linking to well-being.
e) Chair; there will be PSIRF training upcoming. Alison; yes, this is being rolled out.

The Board were **ASSURED** and **APPROVED** the report

~ Wellbeing Break for 10 Minutes ~

5.3 **Finance Report – Month 10 (replaced the original Month 9 report circulated)**

Alan Davies presented the report.

a) The Trust reports a £37m deficit year to date, this being £23.6m adverse to the plan.
b) The monthly deficit target for the Trust to as per the original £15.1m deficit plan is a c.£0.8m deficit per month for the remainder of the year.
c) Industrial action costs for the 6 days of January are £1.4m and £4.4m YTD. Additional funding is included for industrial action (£1.7m).
d) Winter pressures costs are £0.2m in month and £0.4m YTD, this is offset by additional income of £0.4m.
e) Bank staff costs have increased by £0.7m to £3.5m in month; this is mainly due to industrial action £0.3m, supernumerary costs £0.1m, and patient acuity £0.1m. There has been a £0.2m reduction to agency staff costs as services choose to book bank whenever possible.
f) Efficiency delivery to date total £9.8m; the total efficiency delivery reporting £12.4m YTD this being £9.1m adverse to plan.
g) The capital position is underspent due to delays in progress across the main major projects including CDC, endoscopy, diagnostic and medical equipment replacement.
h) Cash is £16.8m adverse to plan due to the unplanned deficit position.

The Board **NOTED** the report.

5.4 **Annual Accounts Review**

Alan Davies presented the report in line with the paper submitted, advising the draft annual accounts are to be submitted by noon on 24 April 2024. The audited annual accounts and text of the annual report is due to be submitted by noon on 28 June 2024. There are no changes in accounting standards or annual report contents to note.

Progress on this will be given to the Audit and Risk Committee next week.

The Board **NOTED** the report

5.5 **Annual Business Plan Checkpoint**

Nick Sinclair gave the Board a verbal update. There is good process so far and on track, there is a first draft of demand and capacity modelling and gap analysis. There is budget build from scratch for each division. Complete work force plan review. No national guidance released at present. The ICB are asking for plans to be submitted, so the Trust are submitting with the caveat that they are subject to change.

Check and Challenge

1) Annyes; if the Trust still needs to do the budgets, is it not quite late now it is March? Nick; the process will become more efficient going forward with new processes now in place. Next year the budget element will be ahead. Alan; budget planning actually started in December 2023. First draft of the budgets will come to the next FPPC in March 2024.
2) Annyes; is there more engagement with the teams in regard to bottom up budget planning. Nick; yes. Nicola; it has been really useful to be part of the inter-divisional planning meetings and to be able to see across.

The Board **NOTED** the update.

5.6 **Strategy Review and Summary**

Matt Capper presented the report highlighting the current and on-going status of the Strategy and Partnership portfolio.

Check and Challenge

1) Jayne; July and September looks like a heavy few months for strategy. Matt; may have to revisit how to stage manage presenting the strategies.
2) Alison; thanks to the Strategy team for their excellent work. Can the team capture the implementation plans on the road map? Matt; yes will discuss with the team and work on slightly different metric on this.
3) Jenny; can the Board see the top five/six highlights from each strategy, to see how they flow and interlink through all of the strategies.
4) Jenny; Partnerships with the system, is there a regional strategy? Matt; some detail on the partnerships is in the report but not a specific strategy around partnerships. Will take to the region to see how it all maps together.

The Board **NOTED** the report

5.7 **Replacement of Interventional Radiology Machine**

Nicola Cooper presented the report highlighting the reasons behind the request for investment in the purchase of a new Interventional Radiology (IR) Machine, costing £1,958k. The business case was approved at FPPC on 29 February 2024.

Check and Challenge

1) Chair; good cover sheet and executive summary and report. Excellent example of a business case.
2) Chair; the end of life was 2020, end of service was in 2022, could have been decommissioned last week. Why are we in this position now and why not brought to us earlier? Nick; completely agree, he does not know history on this but the Trust should have inventory on medical equipment. Jayne; the equipment has been safe to date, because the Trust put mitigations in place.
3) Alan; the governance process is; Medical Devices Steering Group, this feeds into the Investment Group, but not sure why this has not come through earlier.
4) Gary; was there an opportunity to review the selection process? A solution to this could be an EME Response Team. It could be a way to mitigate some of these concerns. Will pick this up with Jayne outside of the meeting.
5) Annyes; how many other medical equipment items that are end of life, can this information come to Audit and Risk Committee? Jayne; yes, this information can be shared and should be on risk register.
6) Chair; there is a part of the report which states that it could generate further income within the report. Would like to see this aspect and opportunities developed in every business case, it is useful to have this.
7) Alan; will try to purchase the equipment in this financial year to take up any slack in capital spend.

The Board **APPROVED** the business case.

6 Integrated Quality Performance Report (IQPR) and Board Assurance Framework (BAF)

6.1 **IQPR – January 2024**

a) Gavin; about a month away of a relaunch of the new style of the IQPR. Chair; The Board needs to see high level reporting. What is useful, quality reporting, and what happens at other levels of the Trust. Jayne; the committees are in place to review the detail and giving assurance. Must take the time to get it right.
b) Chair; could it be reported in an assurance report from the SDR meetings that the executive attend with the divisions? Jayne; will review with the Executive team the best way forward.
c) Gary; when reviewing the report he is having to decipher where there have been major changes, it would give assurance to have major movements highlighted.

d) Alison; ongoing improvement with risk assessments. Fracture neck of femur is a driver metric through Patient First. Ongoing work and improvements with EDN. SHMI is within the expected range. Need to improve data from a quality perspective.
e) Sarah; friends and family testing, using all positive and negative feedback for learning. Response rate – there is less capture in Outpatients. Mixed sex accommodation, there has been manual capture for this. Changing pressure ulcer guidance in the next couple of months.
f) Nick; ongoing position with RTT and endoscopy capacity. Explored all options and short term option is to get increased mutual aid with Dartford, MTW and the ICB to reduce the backlog. Also discussions if MTW will support with cancer endoscopy. Jayne; discussing with ICB if there is scope for additional capacity on this site.
g) Leon; classroom based stat man training are the areas that need more focus. Diversity of workforce is new introduction and there has been a seismic increase shift on this. Turnover decrease and the Trust is becoming more stable. Sickness has increased in January for short term sickness, divisions are looking at this as breakthrough objectives. Alan; looking at the growth in the workforce, this has been flagged by the region. Gary; can we track the average and bring back through FPPC. Alan; yes.

6.2 **Risk Register**

Matt Capper, presented the risk register which will be a quarterly report.

Check and Challenge

1) There will be a refresh of the risk register going forward and trajectories will be added. Will take into consideration the possible confusion between rating the risk as opposed to the review of the risk. Jayne; it needs a system wide approach for a solution, it is a national issue.
2) Chair; how and when does a risk appear on the Trust's Capital Register? Matt; will take away and clarify.

The Board **NOTED** the register.

6.3 **Board Assurance Framework (BAF)**

Matt Capper, presented the BAF, it will also be refreshed alongside the risk register.

The Board **NOTED** the document.

7. Closing Matters

7.1 **Questions from the Public**

Akshay Dhir – Chime Care

1) In the report from the last Board meeting, you report that there were challenges with discharging medically fit patients occupying beds, out of interest how many is this a day? How many were due to inadequate access to social care? On average, how what was the duration of the delay for these patients?
2) What options are you considering to solve this problem of delayed discharges?
3) Has the Trust investigated no cost managed discharge options?

Nick; The latest figure is 103 patients with no criteria to reside. The average delay is 1-3 days. Trust is working with Health and Care Partnership to provide best discharge model.

7.2 **Risks Identified**

No new risks identified.

7.3 **Reflection**

Jayne stated the team need to do some work around assurances and will address the medical equipment registers and ensuring it goes through correct governance.

7.4 **Any Other Business**
There were no matters of any other business.

7.5 **Date of next meeting**
Wednesday, 15 May 2024

The meeting closed at 14:50

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 06 March 2024

Signed by Chair of the Board …….. Date ……

Chief Executive's report: May 2024

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.

Improving emergency performance

I would like recognise the extraordinary team effort to meet the national target in March of seeing, treating, discharging or admitting more than 76 per cent of patients within four hours of arriving at our Emergency Department (ED).

We achieved 77.4 per cent, which is seven per cent higher than in January, and saw us ranked 17th in the country for emergency performance. This progress is the culmination of a tremendous amount of hard work in recent months, right across the hospital and with our partners, which is something that we continue to build on.

This isn't about targets of course – it's about people who come to us in need of the high quality, compassionate care that we strive to provide to every patient, every time. I recognise that we have much more to do to this, particularly for those who wait a long time to be admitted to a ward.

Flow through the hospital remains a challenge due in part to the number of patients who are well enough to leave our wards but awaiting out of hospital care, which equates to about a fifth of all our beds. Numbers are coming down a little, thanks to the work we're doing with our partners, but we need to do more here too, which remains an ongoing focus of our Patient First improvement programme.

Care Hub pilot underway

Part of this work includes a new 'Care Hub' pilot with our ambulance and community partners based in our Care Coordination Centre. Clinicians from our ED are working with clinical colleagues from our community and ambulance to decide on the most appropriate care pathway while the ambulance crew are on scene with the patient.

Since the launch of the pilot in March, we have seen approximately 10 fewer ambulances arriving at our ED every day, which is helping patients get the care they need in the most appropriate place, and reducing demand on our ED. We hope to see further positive results for the rest of the pilot and are seeking funding to continue this important partnership work.

Ruby Ward opens

Also key to helping us treat patients sooner is opening new areas for our patients to be treated. I am delighted that in April we opened Ruby Ward, a fantastic new 32-bed ward for cardio respiratory patients, thanks to funding awarded by NHS England last year.

This is a significant development for the hospital which is already benefiting our patients and staff greatly. It also marks the first step in our aim of creating a cardio respiratory village, which will encompass a new cardiac catheterisation laboratory for patients in need emergency treatment for a heart attack.

Surgery improvements

We have seen significant improvements in how we use our operating theatres and in March were ranked tenth in the country for theatre utilisation. As with our ED improvements, this is thanks to determined team work over many months which means that we can treat more patients sooner.

There is more to do to reduce long waits for patients in need of planned procedures but I am pleased to report that the number of patients waiting more than 65 weeks for treatment is coming down, as is the waiting list for Trauma and Orthopaedics.

Maternity achieves safety actions for fifth year

Our maternity service has achieved all 10 safety actions for year five of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.

The scheme aims is to improve the quality and safety of maternity services and provides financial incentives for trusts that can demonstrate they have implemented 10 key safety actions. These include training, governance, staffing, and measures to prevent hypoxic ischemic encephalopathy, a major cause of brain injury in new-borns.

Not all trusts meet these safety actions and I am especially proud that our service is clearly demonstrating their commitment to continuous improvement and safe care for our families.

Our Clinical Strategy

As well as focusing on what we do to improve our services for patients now, it's right that we plan ahead and set out how we intend to advance and innovate to provide the best possible healthcare services for our future patients. This is our Clinical Strategy and a summary of it is now available on our website.

We will be showcasing some of the advances we are already making through innovation and technology to transform services at a special event on Friday 10 May. Booking information is available on our website.

National recognition for support programme for newly registered healthcare professionals

We recently received the National Preceptorship Interim Quality Mark for the support we provide to newly registered healthcare professionals.

Preceptorship provides a period of guidance, support and structured learning to help newly registered healthcare professionals, such as nurses, midwives and Allied Health Professionals to develop their knowledge and skills in their first year to ensure they can work as confident and competent practitioners as they transition from student to professional.

The Quality Mark is the national gold standard that is now used by trusts across the country to benchmark themselves against. This will help us attract early career nurses, midwives and AHPs to the hospital as it indicates that its preceptorship programme will provide them with a firm foundation for their career development.

Staff recognised with highest civic honour

I am delighted that the Trust was officially granted the Freedom of Medway at a ceremony in Rochester last month in recognition of our hardworking staff and volunteers.

The honorary freedom of the borough is the highest civic distinction that can be given to individuals or collective bodies in recognition of outstanding service or civic association, ensuring that their memory is maintained within the community.

It is great honour for us to receive this prestigious accolade and on behalf of the Trust Board, our staff and volunteers, I would like to sincerely thank Medway Council for recognising our staff with this prestigious accolade.

Marking 25 years of maternity at Medway Maritime Hospital

Sunday 07 July 2024 marks the 25th anniversary of maternity services and the neonatal unit transferring from All Saints Hospital in Chatham to Medway Maritime Hospital. To mark this moment, we are appealing to the public, and current and former staff, to get in touch and share their photos and stories. This is an opportunity for us to celebrate the significant advances in care over the last quarter of a century. Further information is available on our website.

The Meeting of the Public Trust Board
Wednesday, 15th May 2024

Meeting	Council of Governors Update		
Title of Report	**Assurance and Escalation Report**	Agenda Item	**2.4**
Lead Director	Matt Capper – Director of Strategy and Partnership and Company Secretary		
Report prepared by	Emma Tench – Assistant Company Secretary		
Report Approved by	Mark Spragg – Acting Chair		
Executive Summary	This report is tendered by the Council of Governors. The report enables escalations from the Council of Governors to be directed to the Trust Board for review and comment. Key items: 1) Update on Governor Elections		
Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	None		

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

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

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Council of Governors	Next meeting 22.05.24	**Mark Spragg – Trust Chair**

Number of attendees	Number of apologies	Quorate	
		Yes	No

Declarations of Interest Made

No declarations of interest received against any agenda item

Assurance received at the Group meeting

N/A

Key actions

1) Governor Elections - Elections are now open for new Governor positions, to be completed in May 2024. New Governors will be invited to a thorough induction.

Highlights from sub-groups reporting into this group

N/A

Items to come back to the Group

N/A

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

N/A

Items/risks/issues for escalation

None

Implications for the corporate risk register or Board Assurance Framework

None

Examples of outstanding practice or innovation

N/A

Meeting of the Board of Directors in Public
Wednesday, 15 May 2024

Title of Report	Quality Assurance Report – 11 April 2024	**Agenda Item**	4.1a
Author	Sarah Vaux, Chief Nursing Officer (Interim)		
Committee Chair	Paulette Lewis, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Papers from the meeting on the 07 March were approved by the Committee.	
2. The committee reviewed The Quality and Safety Risk Register. Areas to note included discussion regarding violence and aggression and the level of reporting, as well as mitigations in place. The committee noted that the new Violence, Aggression and Security meeting has been established and is following up on reporting.	
3. Assurance and Escalation report received from the Quality, Patient and Safety Sub Committee held on 27 March. The Sub Committee reviewed the assurance and escalation report from its reporting assurance groups and noted the key items raised and the actions described to manage them: • Hydration risk added to the risk register. • Ensuring implementation of learning from claims is disseminated to Divisions. • Winter pressures and waits impacting on patient experience and safe effective care. • Level 3 safeguarding training remains a focus. • Patients safety group focus on mortality. • Digital midwife received national award from Ruth May.	
4. Mothers and Babies Reducing Risk through Audits and Confidential Enquires	

	The Committee received the presentation. The Trust's still-birth rate is similar to the national standards this is despite Medway being the referral center for all complex pregnancies in Kent and Medway ICB. Analysis of cases in the review period showed that: • 70% of still births are due to placental cause – Small baby (<10th centile) • 60% occur in obese mothers • 40% are smokers • No relationship to ethnicity for stillbirths locally. • The team is self-critical, reflective and responsive. The presentation provided assurance there are safe pathways of reporting and robust process for investigations of deaths in maternity.
	5. The first draft of the Quality Account was noted, the final version is due for approval at Trust Board in June.
	6. Integrated Quality and Performance Report (IQPR) The Committee reviewed the Quality and Patient elements of the IQPR. It reported on the quality and patient experience performance across all key performance indicators. Committee noted the reduction in Mixed Sex Accommodation.
	7. The Committee Reviewed the Patient and Quality Board Assurance Framework and noted: • Review of Breakthrough objectives underway. • Work to update the BAF continues. • Data around unavoidable 2222 calls has improved. • Basic Life Support and Advance Life Support training attendance by staff is being reviewed.
	Further Risks Identified: Risk identified regarding compliance with mandatory training and on-going challenge with attaining all target levels, specifically noted Safeguarding Children L3 trajectory for improvement. **Reflection:** The importance of submitting papers on time was emphasised. Authors were encouraged to keep papers concise. The Committee Chair took confidence in and assurance from the discussions held.
	Escalations to the Board or other Committee: 1) No matters to raise.

Proposal and/or key recommendation:	Not applicable			
Purpose of the report	Assurance	✓	Approval	
	Noting		Discussion	

Committee/Group at which the paper has been submitted:	Quality Assurance Committee 11 April 2024

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: ✓	Effective:	Caring: ✓	Responsive:	Well-Led:

Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Quality Assurance Committee.
Resource implications:	Individual resource considerations are provided at the Quality Assurance Committee
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the Quality Assurance Committee
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Quality Assurance Committee
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Quality Assurance Committee
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information or any enquires relating to this paper please contact:	Sarah Vaux, sarah.vaux3@nhs.net Alison Davis, Alison.davis20@nhs.net

Meeting of the Trust Board
Wednesday, 15 May 2024

Meeting	Quality Assurance Committee – held 02 May 2024		
Title of Report	**Assurance and Escalation Report**	Agenda Item	4.1
Lead Director	Alison Davis, Chief Medical Officer Sarah Vaux, Interim Chief Nursing Officer Chair of Committee, Paulette Lewis, NED		
Report Prepared by	Sarah Vaux		
Report Approved by			
Executive Summary	Reports were reviewed for this meeting and discussed by members. Information received reflected progress being made in a number of areas, but with the need to continue to drive improvement and maintain close oversight evident.		
Committees or Groups at which the paper has been submitted	n/a		
Resource Implications	n/a		
Legal Implications/ Regulatory Requirements	n/a		
Quality Impact Assessment	none		
Recommendation/ Actions required			
	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	n/a		

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

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

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Quality Assurance Committee	02.05.24	Paulette Lewis

Number of attendees	Number of apologies	Quorate	
		Yes	No
13	3	X	

Declarations of Interest Made

Nil

Assurance received at the Group meeting

Key actions

As per action log

Highlights from sub-groups reporting into this group

1. The Committee received the Quality and Safety risk register
Members discussed the content including the Trust's risk management system, how risks are reviewed and updated, and the highest rated risks. There was a discussion regarding radiology risk and a report was requested to be presented at the next meeting.

2. Assurance and Escalation Reports
Quality Patient and Safety Sub-Committee (QPSSC) held 22 April 2024
The Committee received the report from the meeting and noted the content. Areas for escalation were discussed including:

- Compliance with mandatory training and the monitoring happening within divisions.
- EPR flags as an area of improvement.
- HCAI breached thresholds for 2023/24, low level of avoidable instances noted and work across the network.
- Antimicrobial consumption, including potential impact of new sepsis guidance which was rolling out currently.
- Learning from deaths further embedding of Mortality and Morbidity meetings.

3. Infection Prevention and Control (IPC) Annual Programme
The report set out the proposed activities which will ensure the programme of work continues to focus on two main areas; raising awareness of IPC through education and training and reducing the incidence of Health Care Associated Infection (HCAI). Discussion regarding contract tracing on EPR and air ventilation systems in waiting areas and mitigations put in place by the IPC team, a further update will come back to the August meeting.

4. Maternity reports
4.a Perinatal Quality Surveillance Report
The report included an update on activity, incidents and cases, training risk, feedback from staff and patients, compliance and improvement. The issue included within the report regarding uptake of antenatal steroids was discussed, including how communication is being adapted to ensure families have full information.

4.b Claims, Incidents, Complaints Triangulation Report
The report highlighted a review of the claim's scorecard for the past ten years alongside current incidents and complaints.

4.c Perinatal Cultural Leadership Report

Assurance

The report included the target of the perinatal culture and leadership programme, to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024 and included diagnosis of local culture (SCORE survey).

5. Draft Quality Accounts
Members agreed to provide further feedback outside of the meeting. The paper will come back to the Quality Assurance Committee and the Audit and Risk Committee (ARC) for approval.

6. Quality Strategy Implementation Update Report
The report included a comprehensive implementation plan of metrics laid out in the approved Quality Strategy, detailing historical data where appropriate, current data, and a target.

7. Integrated Quality Performance Report (IQPR)
Discussion regarding some of the key quality highlight areas including:

- Friends and Family March data in report - refresh of True North and Breakthrough objectives
- Mixed sex accommodation – latest data shows continued reduction, however, the main driver for this is escalation areas and the sustained pressure on beds due to poor flow out to the community was noted.
- Reduction in violence and aggression incidents reported.
- Hospital Standardised Mortality Ratio (HSMR) and (SHMI) improvement on last month.
- Incidents causing moderate harm or above was below average for March.
- Zero avoidable 222 calls in March.

8. BAF
The Committee noted the strategic risks aligned to the Quality True North Domain.

Items to come back to the Group

n/a

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
n/a		

Reports not received as per the annual workplan and action required

n/a

Items/risks/issues for escalation

Risks Identified:

a) Learning from Deaths, ensure processes Mortality and Morbidity meetings are embedded in all areas.
b) Need to ensure that we achieve compliance on mandatory training.
c) Further reports will come back to the Committee regarding risk and also IPC.

Reflection
The committee noted positive feedback received from a Governor regarding the NHS App. The Governor feels in control of their data, and able to manage appointments easily.

Implications for the corporate risk register or Board Assurance Framework

Examples of outstanding practice or innovation

Meeting of the Board of Directors in Public
Wednesday, 15 May 2024

Title of Report	Assurance report – People Committee 28 March 2024			**Agenda Item**	4.2
Author	Leon Hinton, Chief People Officer				
Committee Chair	Sue Mackenzie, Chair of Committee/NED				
Executive Summary	Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.				
Proposal and/or key recommendation:	Not applicable				
Purpose of the report (tick box to indicate)	Assurance	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	People Committee, 28 March 2024				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Leon Hinton, leon.hinton@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			

	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
3	2	x	

Declarations of Interest Made

None

Items referred to another Group, Subcommittee and or Committee for decision or action

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

Issues and or Risks to note: (1) staff appraisals continue to deteriorate; (2) resuscitation and moving/handling StatMan remain significantly below target; (3) DBS assurance works to continue and to provide assurance to the People Committee.
Reflection: (1) Agenda time allocations to be reviewed and wellbeing break included.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for February 2024. The Committee were **ASSURED** by the report: • True North (Staff Engagement) – [6.65, 0.02 improvement, 0.28 below target] third successive increase; however, ranked score has worsened with the Trust remaining in the further quartile for staff engagement nationally; • Breakthrough (turnover) – [0.6%, 0.4% improvement, on target] on target for three-months; • Staff appraisal – [87.6%, -1% deterioration, 2.4% off target] fifth successive month below target, clinical divisions remain largely on target, corporates remain off target; • Vacancy rate – [2.4%, -0.8% improvement, on target] continues to improve with improvements to nursing, AHP and CSW vacancies and strong pipeline; • Voluntary turnover – [9.6%, -0.5% improvement, 1.6% off target] continues to improve along with stability and reduced vacancies. No significant outliers to improving position by staff group. • Staff fill rates – improving position for achieving required staffing versus planned staffing and increased care hours per patient day (CHPPD) however below target of CHPPD target of 9.5;	Assurance

• Sickness absence – [4.6%, 0.8% improvement, 0.6% off target] an expected seasonable reduction across the Trust; • StatMan – [87.9%, +0.5% improvement, on target] slight improvement over target; however, capacity and DNA issues continue particularly for classroom-based learning, fire, safeguarding/MCA and resus – recovery plan requested from subject matter experts. Employment standards –compliance work continues with the Head of Safeguarding.	
2. People Strategy 2024-2027 The Committee received the new People Strategy setting the direction for the People Domain for the next three years. The Strategy outlined its alignment to national drivers including the NHS Long Term Workforce Plan 2023 and the Kent and Medway ICB People Strategy; and to the Trust's Clinical Strategy and Quality Strategy. The Strategy has been built on the engagement of staff from the Trust's Equality, Diversity and Inclusion events; national staff survey and Patient First approach. The main aspirations of the policy are 'We will ensure that our people are treated with compassion and respect', 'We will support our people to develop and reach their full potential', 'We will improve employee experience to attract and retain people', 'We will create a sustainable and resilient workforce'. Objectives and key results are detailed within the Strategy with governance and reporting included. The Committee **APPROVED** the People Strategy 2024-2027.	Not Applicable
3. Leadership and Management Competencies The Committee received an update report detailing the proposals and progress for the management competencies for existing and new leaders. The Committee **APPROVED** the mandating of the leadership and management competencies and the current high-level content for further development, stakeholder involvement, communication/launch plan and phasing proposal.	Not Applicable
4. Recruitment, Retention and Education Report The Committee received a report detailing the progress and achievements made so far with nursing, midwifery and AHP recruitment. The Committee **NOTED** the report.	Assurance
5. Health and Wellbeing Guardian Assurance Report Q3 2023/24 The Committee received a report providing an updating of the wellbeing dashboard metrics and a migration based on the new guidance; this reported against the newly updated 12 key responsibilities. The Committee were **ASSURED** by the report.	Assurance
6. Board Assurance Framework (BAF) and Risk Register The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items 3d, 3e and 3f. Not changes were made to the scoring. The Committee were **ASSURED** and **NOTED** the report.	Assurance
7. HR and OD Performance The Committee were **ASSURED** of HR and OD performance against workplan, including an improvement to recruitment time to hire and the review of DBS levels by role.	Partial Assurance

8. Gender Pay Gap Supporting Statement The Committee **APPROVED** the 2023 Gender Pay Gap supporting statement for publication.	Partial Assurance
9. National Staff Survey 2023 The Committee received a report outlining the results of the 2023 Staff Survey. The response rate was 38%, with a fall of 2% from previous year's survey. Overall, the Trust has made improvements across 6 of the 7 People Promise elements and has achieved improved scores for both staff morale and staff engagement. In relation to our Patient First breakthrough objective, progress had reversed towards reaching the upper quartile for staff engagement by 2025 our comparative rank deteriorated by 13 points from 94th in 2022 to 107th in 2023; however, the score improved from 6.63 to 6.65; this indicates an improved staff engaged score for the Trust, but other Trusts have improved faster than MFT. The Committee received an update in relation to the next steps for building on the progress to date. The Committee **NOTED** the report.	Partial Assurance
10. Industrial Action The Committee **NOTED** an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff. The Committee **NOTED** the report.	Assurance

Meeting of the Board of Directors in Public
Wednesday, 15 May 2024

Title of Report	Finance Planning and Performance –28 March 2024	**Agenda Item**	4.3.a
Author	Paul Kimber, Deputy Chief Financial Officer		
Committee Chair	Gary Lupton, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Committee work plan The plan for the next 12 months was presented; whilst there were a large number of items it was noted that conversations will be risk focussed rather than each item requiring presentation. The Chair confirmed that he would like to see an additional plan item in respect of procurement strategy. The Committee **APPROVED** the work plan.	Assurance
2. Workforce planning and controls The report was presented by the Chief People Officer, noting that current vacancy rates are low (at 2.4%) and the workforce controls in place. The Chief Financial Officer also provided context in respect of the staffing growth and roster controls/issues. He further discussed the learning being taken into the 2024/25 budgeting, such as centralisation of maternity pay costs. Effectiveness of the Vacancy Control Panel was discussed. The Committee challenged how the Trust was assured over the "right" sizing and grading of the establishments. The Committee **NOTED** the report.	Assurance
3. Finance Report M11 (inclusive of IQPR) The Committee received the paper for Month 11/February 2024. This reported a year to date deficit of £21.2m, being £21.0m adverse to plan. The in-month performance was noted as being	Partial assurance

skewed due to national funding awards together with recognition of Elective Recovery Fund over performance. The underlying deficit remained unchanged, as did the drivers of that deficit as reported previously through the year. The revised forecast is for a small surplus in month 12, requiring careful cost management and non-recurrent mitigations to delivery; whilst the risk to forecast was acknowledged there was cautious optimism about delivery. The capital programme is seeking to utilise emerging slippage in this financial year, although there is a risk of underspending by c£1m. The aged receivables were discussed – this may require further escalation in due course. The Committee **NOTED** the report.	
4. Financial recovery An oral update was given, noting that system work is expected to restart following final operating plan submissions. The Committee was informed of new intensive support from NHSE beginning in April.	No assurance required
5. Revenue cash flow application The Committee Chair noted that he and the Trust Chair were consulted on and approved the application prior to submission and the Committee therefore **APPROVED** ratification of the application. Feedback had been received from NHSE and this had been responded to.	No assurance required
6. Business planning and budget setting The key highlights from the paper were noted, particularly in respect of activity and performance plans. The Committee heard that the national guidance has now been released (on 27 March 2024). Discussion was had around funding of services at the Trust and across the system, including the improvement in the Trust's underlying position within the draft plan. The Committee **NOTED** the update.	Assurance
7. Activity report The report presented was noted as continuing to evolve. Outpatient utilisation was confirmed as being 98-100% and thus very good. The new to follow up ratios were within national averages but we are targeting being in upper quartile. The Committee **NOTED** update.	Assurance

8. Efficiencies Programme Update 2023/24 The paper, which included a progress report on 2024/25 planning, was taken as read by the Committee. The Committee **NOTED** the report.	Assurance
9. Performance Report The Committee were provided with an update on the operational performance of the Trust. Specifically: • RTT performance continues to target 92%, but is currently deteriorating; industrial action has played a part in that. We have seen a reduction in patients waiting 78+ weeks. We are exploring all options to reduce the patient waits, especially in respect of endoscopy and ENT. • ED performance is on track for 75-76% this month. There has been a reduction in the long-wait patients and spend on "day 2 and 3" doctors has reduced. The Committee **NOTED** the report.	Assurance
10. Community Diagnostic Centre The Committee Chair noted that he and the Trust Chair were consulted on and approved the proposal to de-scope the CDC on grounds of affordability. It was also agreed to broker the capital monies. The Committee **APPROVED** ratification of the proposals.	Assurance
11. Board Assurance Framework (BAF) The reports for Sustainability and Systems and Partnership were reviewed. The Committee were **ASSURED** and **NOTED** the reports. The Committee **APPROVED** closure of risk 5c on drugs overspend based on this consistently scoring below the target score.	Assurance
12. Corporate Risk Register The Sustainability and Systems and Partnership Risk Registers were reviewed by the Committee. The Committee were **ASSURED** and **NOTED** the reports.	Assurance
Decisions made: 1) The Committee approved the work plan for the coming year. 2) The Committee ratified the approval of the cash support funding application.	

	3) The Committee ratified the approval of the capital brokerage and de-scoping of the CDC programme. 4) Closure of risk 5c on the BAF was approved. **Further Risks Identified:** • No additional risks identified. **Reflection:** The importance of submitting papers on time was emphasised. Authors were encouraged to keep papers concise. The Committee Chair took confidence in and assurance from the discussions held. **Escalations to the Board or other Committee:** 1) No matters to raise.
Proposal and/or key recommendation:	Not applicable

Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Performance and Planning Committee – 28 March 2024			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: ✓	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Board Assurance Framework item.				
Resource implications:	Individual resource considerations are provided at the Finance, Planning and Performance Committee				
Sustainability and /or Public and	Individual considerations are provided at the Finance, Planning and Performance Committee				

patient engagement considerations:	
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Finance, Planning and Performance Committee
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Finance, Planning and Performance Committee
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information or any enquires relating to this paper please contact:	Alan Davies, alan.davies@nhs.net

Meeting of the Board of Directors in Public
Wednesday, 15 May 2024

Title of Report	Finance Planning and Performance – 25 April 2024	**Agenda Item**	4.3b
Author	Paul Kimber, Deputy Chief Financial Officer		
Committee Chair	Gary Lupton, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Terms of reference The terms of reference were re-presented. The Director of Planning and Operational Performance will be added as an attendee. The Committee **APPROVED** the terms of reference.	No assurance required
2. KPMG financial recovery implementation plan The action plan developed from the KPMG report was acknowledged and the implementation progress discussed, in particular the business planning processes. The governance route for monitoring this programme of work was recognised as being under development. The Committee **NOTED** the report.	Assurance
3. Finance Report M12 (inclusive of IQPR) The Committee received the paper for Month 12/March 2024, being the year end performance. The year end non-recurrent benefits were noted, however there remained an underlying deficit. The Chief Financial Officer noted that a late decision has been taken since issuing of the report that increases the deficit from £19.7m to £23.8m. This was done in discussion and with agreement of the ICB and NHSE and was undertaken in light of emerging risks; this movement has been agreed as an "allowable miss" against the control total and forecast.	Partial assurance

Over performance against elective targets was noted, supporting an increase in the total clinical income as a result. The Trust's cash position remains a concern and the Trust awaits further feedback from NHSE on the revenue support loan application. The capital programme was noted as spending its full allocation of c£30.3m, despite the slippage in the CDC projects. The Trust continues to pursue its outstanding receivables and this will be with renewed focus having now submitted the year end draft annual accounts. Concern was noted that the nursing costs continued to rise despite the various mitigating actions being taken; it was noted that the expectation was that this should plateau and reduce over coming months. Further assurance was requested in respect of A&E activity from the report. The Committee **NOTED** the report.	
4. Financial Sustainability Strategy The Strategy was presented, paying particular attention to those areas that were determined to be the biggest contributing factors to the Trust's deficit performance, being: culture; productivity; funding, and; demand and capacity. The Committee **APPROVED** the report.	Significant Assurance
5. Performance Report The Committee were provided with an update on the operational performance of the Trust. Specifically: • Despite the report showing two patients breaching 78-weeks wait, these are through patient choice and hence the Trust has met this target. ENT has shown improvement. Endoscopy has shown a slight increase and relates to a pause in referring patients to Dartford as a result of the MOU end date being reached on 31 March; these have now restarted. • ED performance reported was 77.6% and improves to 77.8% on validation, showing the best performance improvement in the south of England. • LOS is in line with national average for surgical services, whilst we are implementing improvement actions for general medicine. The Committee **NOTED** the report.	Assurance
6. Urgent operational efficiencies process	Partial assurance

The paper – produced in conjunction with support from the NHSE Improvement Director - was presented, outlining the proposed alternative approach to deliver reduce the expenditure run-rate. There was a particular focus on the workforce growth and speficially high usage of temporary staffing (at premium rates). This has been agreed by Trust Executives and shared with divisions, with the latter now being tasked with The Committee **NOTED** the report.	
7. Efficiencies Programme The paper noted the delivery of budget out, run-rate reduction and cost avoidance schemes during 2023/24. The target for 2024/25 was noted at £21.6m, with all but £3.6m allocated to divisions. £12.1m of schemes have currently been identified, with £3.1m approved through the efficiencies panel. The Committee **NOTED** the report.	Partial assurance
8. Business planning and budget setting The key highlights from the paper were noted, particularly in respect of activity and phasing of financial plans. The Committee **NOTED** the update.	Assurance
9. Activity report The paper was taken as read.	Assurance
10. Investment Delivery Group – terms of reference The terms of reference were taken as read. The Committee **APPROVED** the terms of reference.	Significant Assurance
11. Board Assurance Framework (BAF) The reports for Sustainability and Systems and Partnership were reviewed, including the proposed changes to Sustainability risks. The Committee were **ASSURED** and **NOTED** the reports.	Partial assurance
12. Corporate Risk Register The reports for Sustainability and Systems and Partnership were reviewed, including the proposed changes to Sustainability risks. The Committee were **ASSURED** and **NOTED** the reports.	Partial assurance

Proposal and/or key recommendation:	Not applicable

	Assurance	✓	Approval	

Purpose of the report (tick box to indicate)	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Performance and Planning Committee – 25 April 2024			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: ✓	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Board Assurance Framework item.				
Resource implications:	Individual resource considerations are provided at the Finance, Planning and Performance Committee				
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the Finance, Planning and Performance Committee				
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Finance, Planning and Performance Committee				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Finance, Planning and Performance Committee				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to	Alan Davies, alan.davies@nhs.net				

Meeting of the Public Trust Board
15 May 2024

Title of Report	**Perinatal Culture and Leadership Quarterly Report – Quarter 4**	**Agenda Item**	5.1
Author	Ali Herron, Director of Midwifery		
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer		
Executive Summary	a) Goal of the perinatal culture and leadership programme is to improve the safety and quality of care delivered to women, birthing people and babies by enabling those with specific responsibility for safety in maternity and neonatal units to understand the relationship between leadership, safety improvement and safety culture in order in enable change. b) Commitment of the three-year delivery plan to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024. c) Included diagnosis of local culture (SCORE survey) and provided practical support to nurture culture and leadership d) Intended to support provision of a deeper understanding at trust board level of the support required for safe and personalised maternity and neonatal services including exploring: • psychological safety • accountability and negotiation • continuous learning • reliability • transparency • quality improvement methodology and measurement		
Proposal and/or key recommendation:	Approval for onward reporting to Trust Board as per the requirements of CNST Year 6 and the Perinatal Surveillance Model.		

Purpose of the report (Please mark with 'X' the box to indicate)				
	Assurance	X	Approval	
	Noting	X	Discussion	

Committee/Group submitted:	a) Maternity and Neonatal Safety Champion Assurance Board – 12.04.24 b) QPSSC - 25.04.24 c) QAC – 02.05.24

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)

Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X

Identified Risks, issues and mitigations:	N/A

Resource implications:	N/A		
Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Has the quality and equality assessment been undertaken? Yes		
Legal and Regulatory implications:	Compliance with CNST Year 6		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance	X	There are no gaps in assurance
	Not Applicable		No assurance required.

Perinatal Culture and leadership Programme (PCLP) & SCORE survey

April 2024

Ali Herron, Director of Midwifery

Executive Summary

- Goal of the perinatal culture and leadership programme is to improve the safety and quality of care delivered to women, birthing people and babies by enabling those with specific responsibility for safety in maternity and neonatal units to understand the relationship between leadership, safety improvement and safety culture in order in enable change.
- Commitment of the Three year delivery plan to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024.
- Included diagnosis of local culture (SCORE survey) and provided practical support to nurture culture and leadership
- Intended to support provision of a deeper understanding at trust board level of the support required personalised maternity and neonatal services including exploring:
    - psychological safety
    - accountability and negotiation
    - continuous learning
    - reliability
    - transparency
    - quality improvement methodology and measurement

Phase 1- Quad leadership development

Medway NHS Foundation Trust

Content

- 3 face to face modules and 4 action learning sets.
- 360 degree feedback.

Learning

- Individual reflection
- Support and challenge from peers
- A chance to find creative ways to bring about change
- A chance to test beliefs and assumptions and learn what works
- A safe environment to explore new ways of thinking and doing
- Personal, as well as professional, learning and development
- Insight into how others achieve different solutions
- A chance to progress new opportunities and develop new ideas.

Phase 2- Culture Survey

Content

- 4 month process
- Identified local champions to support culture survey
- Mapping
- Go live with survey
- 6 week 'live' period
- Results

Learning

- Provided insight from clinical and non-clinical colleagues regarding what it feels like to work in maternity and neonatology
- Provided data to have useful conversations
- Encouraged participation of staff
- Developed transition to appreciative conversations that would otherwise be difficult to engage in.

Phase 3- Cultural Conversations

Content

- 4-5 month process
- Quad development sessions
- Team conversations
- Improvement Planning

Learning

- How our leadership behaviours are perceived by colleagues
- Take action to improve the weaker areas.
- Designed a leadership strategy
- Focus on a small number of objectives that are achievable

Our Quad team purpose statement

Our team inspires our staff to deliver outstanding care to our families through promotion of a safe culture/ collaboration and innovation.

Our Quad collective vision

For our families to have a positive experience by being provided with safer, clinically effective care.

Perinatal Culture and Leadership April 2024

Medway NHS Foundation Trust

Key Messages:

- Now in final phase of QUAD programme
- QUAD met with NHSE Coach in February 2024
- Action plan and Board presentation was shared and approved.
- Positive feedback received.
- Minor changes made to the action plan in response to feedback.
- BAF updated to incorporate all actions, 4 actions completed, 15 on track.
- Clinical Psychologist commenced on Neonatal Unit in March 2024.
- MCU/Triage QI Project commenced and process mapping completed. Working with Trust Transformation team to finalise “fishbone” mapping. Working with staff and service user stakeholders.
- PMA team are currently benchmarking service against new Labour Ward Coordinator Competency Framework.
- Local culture survey undertaken February 2024:
    - 73% “agree or strongly agree” their team treats each other with respect.
    - 70% “agree or strongly agree” they feel able to escalate concerns at work
    - 71% “agree or strongly agree” their team really values diversity

Issues, Gaps and Concerns:

- Executive support required to ensure community connectivity PID is successful
- Executive support required to ensure PID for Birthrate Plus recommendations including Equality and Diversity Midwife is approved.
- Ensure CNST monies are directly reinvested in Maternity and Neonatal to continue to develop and support perinatal safety.

Actions and Improvements:

- Breaks audit commenced March 2024. To audit March, April May 2024 and report
- PMAs to complete service level benchmarking against Labour Ward Coordinator Framework and develop action plan.
- Director of Midwifery escalating connectivity and birth-rate plus PIDs to Executives.

Meeting of the Public Trust Board
15 May 2024

Title of Report	**Perinatal Quality Surveillance Report, Q4 2023/24**			**Agenda Item**	5.2
Author	Alison Herron, Director of Midwifery				
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Office				
Executive Summary	Quarterly Summary of: a) 355 Maternity Incidents reported via datix b) 24 NICU incidents c) 4 MSNI referrals d) 79 MDT incident reviews at CRIG e) 1 AAR case f) 11 MBRRACE reportable cases in Q4 g) >98% compliance for Fetal Monitoring Training for all staff groups. h) Overall mandatory training compliance increased to 86.76% i) Improvements required in obstetric emergency training and some mandatory training topics. j) 11 risks in maternity and 2 in neonatology – Midwifery workforce (20) and Maternity Information System (15) k) Staff and Service user feedback, including launch of CQC Picker Survey 2024 and Co-production charter. l) CNST Year 6 published 2 April 2024.				
Proposal and/or key recommendation:	Approval for onwards reporting to Trust Board as per workplan/CNST requirements.				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval		
	Noting	X	Discussion		
Committee/Group submitted:	Maternity and Neonatal Safety Champion Assurance Board – 12.04.24 QPSSC – 25.04.24 QAC – 02.05.24				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: x
Identified Risks, issues and mitigations:	N/A				
Resource implications:	N/A				

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	Compliance with CNST Year 6		
Appendices:	N/A		
Freedom of Information (FOI) status:	Tick either: This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: Alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Perinatal Surveillance – Quarterly Report: Jan – Mar 2024

Ali Herron
Director of Midwifery

Incidents, investigations and PMRT

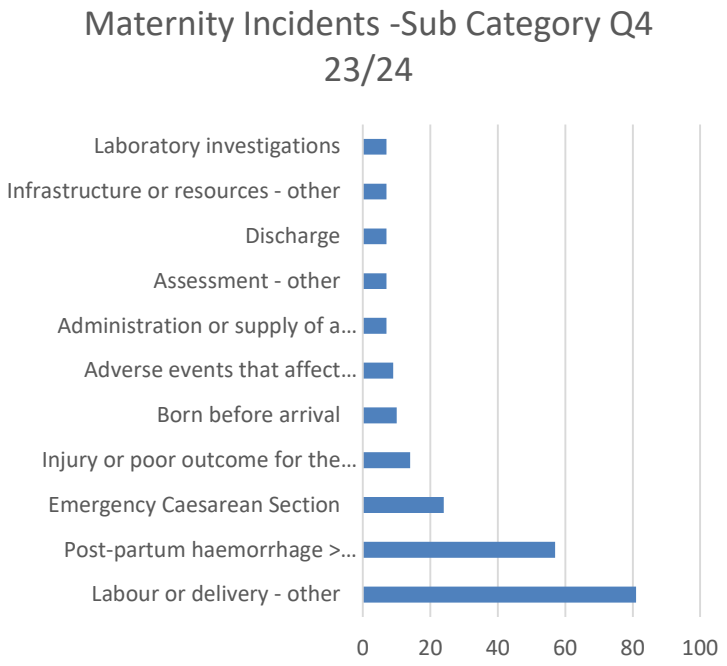
True North: Quality

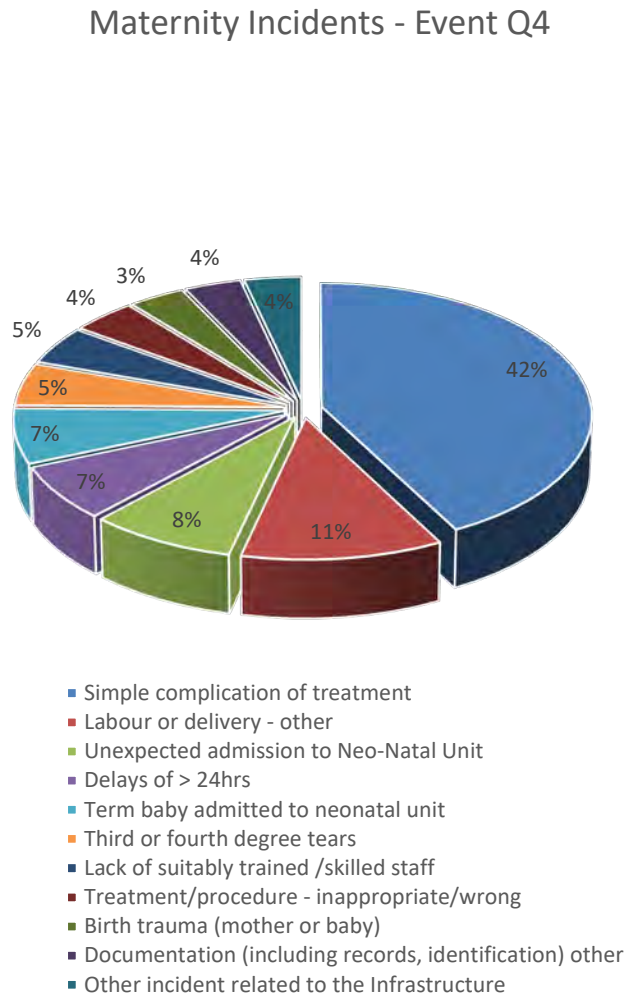
Perinatal Surveillance Tool: Quarterly Report
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight. **Goal:** To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

- Reduction in incidents reported in Q4, with 335 reported. 458 incidents reported in Q3
- 99% of incidents reported are no or low harm.
- 4 incidents reported as Moderate Harm or above
  - Maternal death in Community – MSNI Referral (no actions for Trust)
  - IUD of 32+1 baby on Pearl Ward – AAR
  - Management of BBA with PPH risk by SECAMB – Investigation by SECAMB
  - EMCS for unbooked pregnancy, baby therapeutically cooled – MSNI referral (rejected as no care concerns).





Top Three themes in maternity incidents for (sub-category) for Q4:

- Labour or Delivery (81)
- PPH > 1L (57)
- Emergency C-section (24)

Top Three Maternity Incidents by event for Q4 :

- Simple complication of treatment (82)
- Labour & Delivery – other (22)
- Unexpected admission to Neonatal Unit (16)

True North: Quality

Perinatal Surveillance Tool: Quarterly Report

Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight. **Goal:** To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Issues, Concerns & Gaps:

- Staff training for PSIRF not yet rolled out.
- Workforce continues to remain a challenge despite recruitment and retention activities. Remains highest risk on risk register ID 1134 Score= 20)
- MDT CRIG attendance inconsistent
- Escalation of cases to consultant in line with RCOG guidelines. 1 instance identified where consultant not called for 4th degree tear.
- Increase in BBAs noted in quarter with 8 noted in February 2024.

Actions & Improvements:

- Learning from datix and incident investigations, including MSNI cases incorporated into mandatory training in 2024.
- Engage with Labour Ward Lead and Clinical Director to support obstetric attendance at CRIG.
- PSIRF went live in February 2024 and PSIRF approach has been incorporated into weekly CRIG meeting. Risk midwives supporting staff through PSIRF model whilst training awaited.
- Reviewing all term admissions (ATAIN cases) with dedicated MDT meeting from May 2024 as numbers for review not manageable in weekly CRIG meeting. New Lead Neonatal Consultant for ATAIN in post and to support standalone MDT meeting.
- All ATAIN cases reviewed and quarterly audit report presented to MNSCAB and MDT action plan in place.
- Fetal Wellbeing midwives reviewing antenatal counselling with regards to antenatal steroids following identified trend in patients declining steroids.
- All PPHs >1500ml are reviewed at CRIG and actions and learning identified where required.
    - Re-audit of Carbetocin in PPH management is in progress.
- BBA audit underway by community midwives.
- NEWTT-2 Implemented across the unit – audit with compliance ongoing.
- Escalation Raised at consultants meeting, communicated to all MICS, criteria for escalation printed and displayed on delivery suite.

True North: Quality

Perinatal Surveillance Tool: Quarterly Report
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight. **Goal:** To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages:

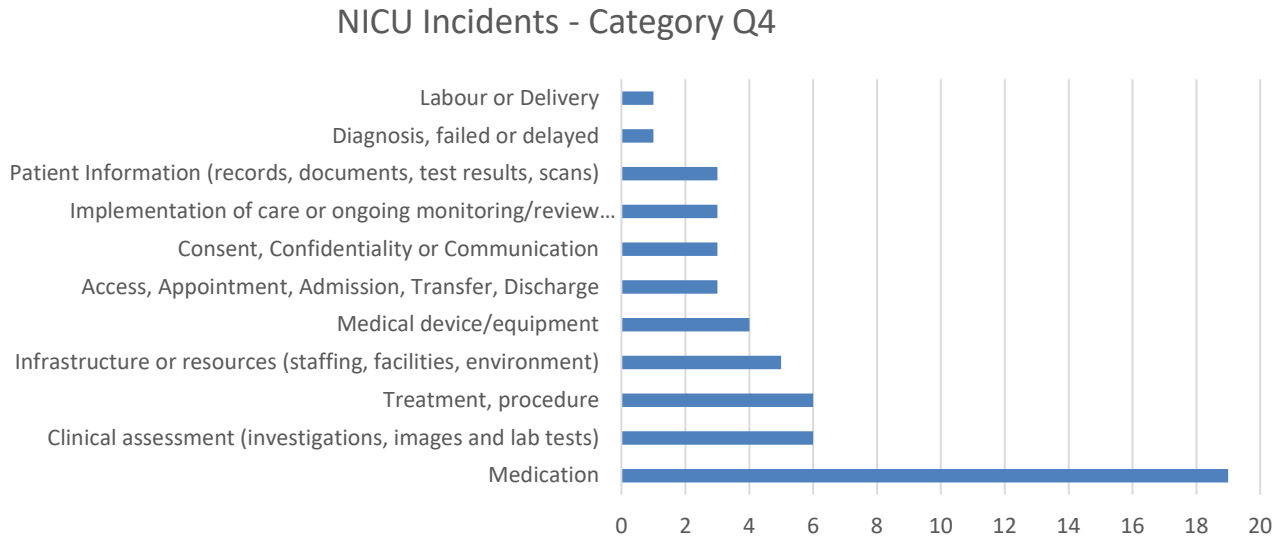
- 34 incidents reported in Q4 (44 in Q3)
- 100% of incidents reported are no or low harm.
- Medication incidents include errors/delays in administering milk to babies.
- 0 SIs or HLIs in Q4

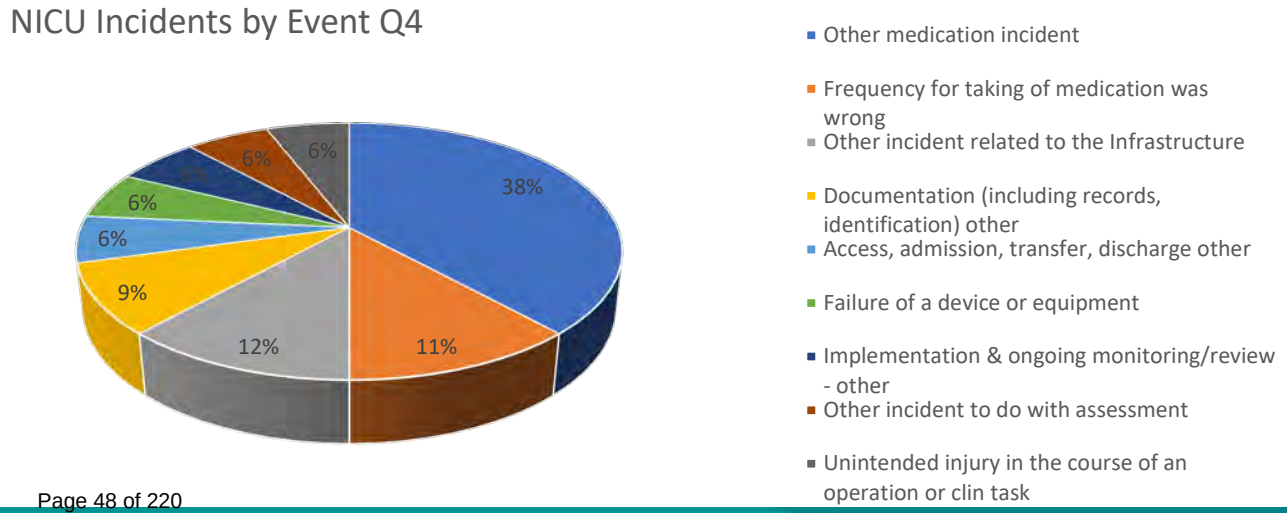
Top 3 NICU Incidents by Category

- Medication (19)
- Clinical assessment (investigations, images and lab tests (6)
- Treatment, procedure (6)

Actions and Improvements

- Thematic Review of UVC extravasation/migration in the past
- Awareness of Prep for Prem forms amongst NICU staff
- Request for quotation for Neopuff blender for NICU
- New Fridge ordered for drugs
- Re-establishment of Human Factors Group
- New storage system for vaccines





True North: Quality

Perinatal Surveillance Tool Data Dec 2023 – PSIRF Investigations & Maternity & Newborn Safety Investigations (MNSI)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

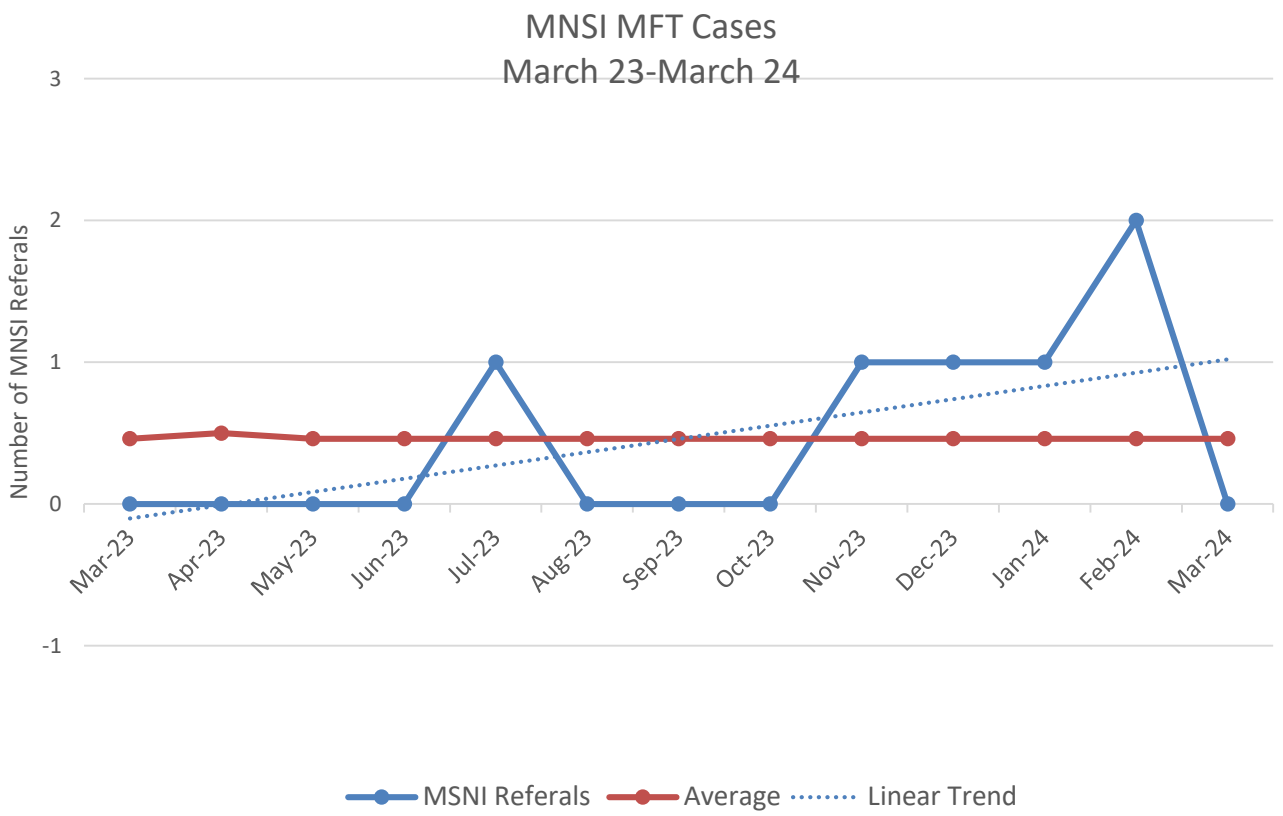
NHS Medway NHS Foundation Trust

Key Messages:

- 4 MSNI Referrals in Q4
  - Maternal Death in community
  - 3 therapeutically cooled babies
- 1 MSNI investigation closed in Q4 – incident affecting multiple trusts, no actions for MFT
- 1 After Action Review undertaken for IUD on Pearl Ward at 32+ 1

Issues, Concerns & Gaps:.

- Delays with accessing the different systems across the trust. Unable to send MNSI documentation with details of admissions across different departments.
- Concerns regarding timely escalation of cord gas/blood values identified in MSNI case.
- The need to identify subtle trends in maternal observations to detect deterioration noted in AAR case.
- Delay in diagnosis of IUD due to missing cords for bedside scanner in AAR case.



True North: Quality

Perinatal Surveillance Tool Data Dec 2023 – PSIRF Investigations & Maternity & Newborn Safety Investigations (MNSI)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Actions & Improvements:

- Risk team, Delivery Suite coordinators and obstetric triage staff to have access to Trust clinical systems outside maternity in order to be able to access patient records in emergency situations and for incident review.
- Immediate actions and learning from Q4 referrals:
    - Learning regarding CTG management – Fetal Wellbeing Midwives working with individual staff.
    - BMI guideline updated.
    - Process for escalation of abnormal cord blood results reviewed and visual prompts/guides for all staff now in place on delivery suite and obstetric theatres. NICU auditing compliance with escalation to support ongoing learning.
    - Urgent education and comms rolled out to support staff to recognise trends in observations in a deteriorating patient rather than just abnormal observations in response to AAR case. PMRT review also to take place.
    - Bedside scanners added to daily equipment checklist including responsibility for charging. 2 Rapid chargers purchased.
- Completed actions Q4:
    - Fetal monitoring guideline updated and training updated to reflect learning from MSNI case. Ongoing regular MDT meetings where fetal monitoring are reviewed for shared learning.

True North: Quality

Perinatal Surveillance Tool Data Q4– PSIRF

Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

Key Messages :

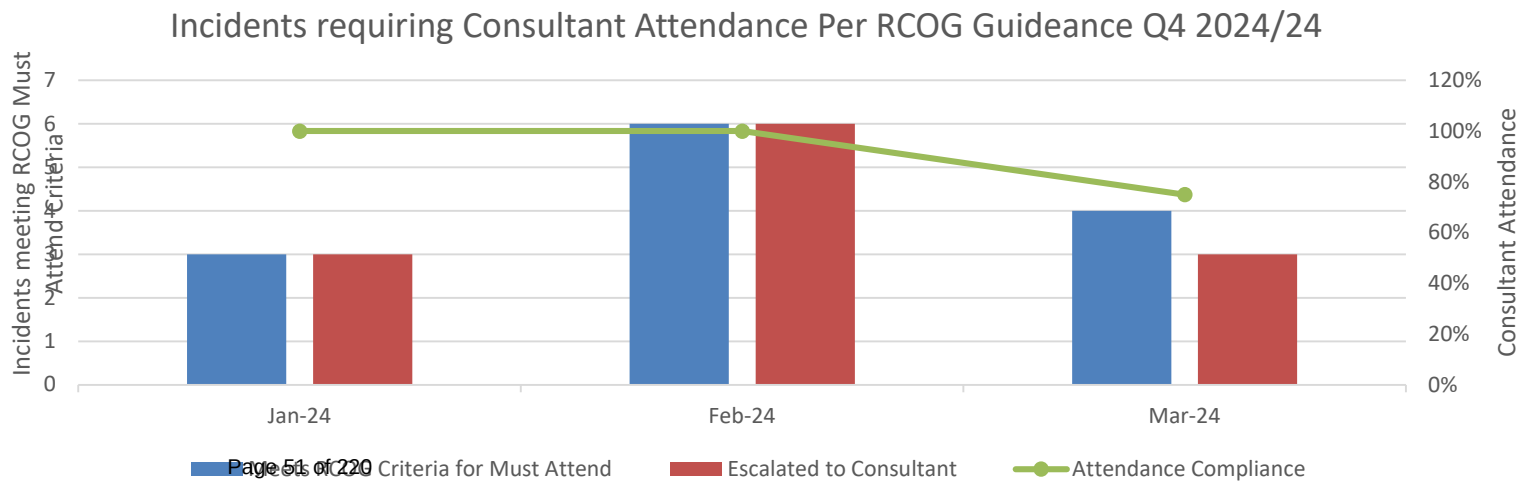
- 74 cases reviewed at MDT CRIG meeting in Q4
  - 39 ATAIN Reviews
  - 33 CRIG Reviews
  - 2 Rapid Reviews
  - 1 case proceeded to AAR
- Trend of late pre-term refusal of antenatal steroids in response due to new RCOG guidance for late preterm administration of steroids.
- Trend of management of deteriorating patients/MMEWS observations.
- 2 Neonatal deaths 1 August 2023 and 1 November 2023 referred to coroner for review.
  - Unbooked unknown twin pregnancy – <24 weeks. Syntocinon given following delivery of twin 1. SWARM held and learning regarding management of unbooked pregnancies
  - MNSI case – Management of cord prolapse at home. Actions and learning for SECAMB

Issues, concerns, gaps:

- PSIRF Training for key staff still outstanding.
- Delay in implementing new National MEWS charts with revised parameters. Will require staff training and roll out.
- 1 case of 4th Degree tear not escalated to Consultant.

Actions and improvements

- Staff supported to attend PSIRF training from April 2024.
- Risk bulletin news letter launched and circulated focus on cord gases, steroids, documentation.
- Immediate action following 4th degree tear not being escalated: recirculated RCOG criteria and guideline for escalation to consultant to all MICs and doctors. List of Must attend criteria now on display.
- Case reviewed by Urogynae specialist and need for urogynae review prior to patient discharge also shared with all staff.

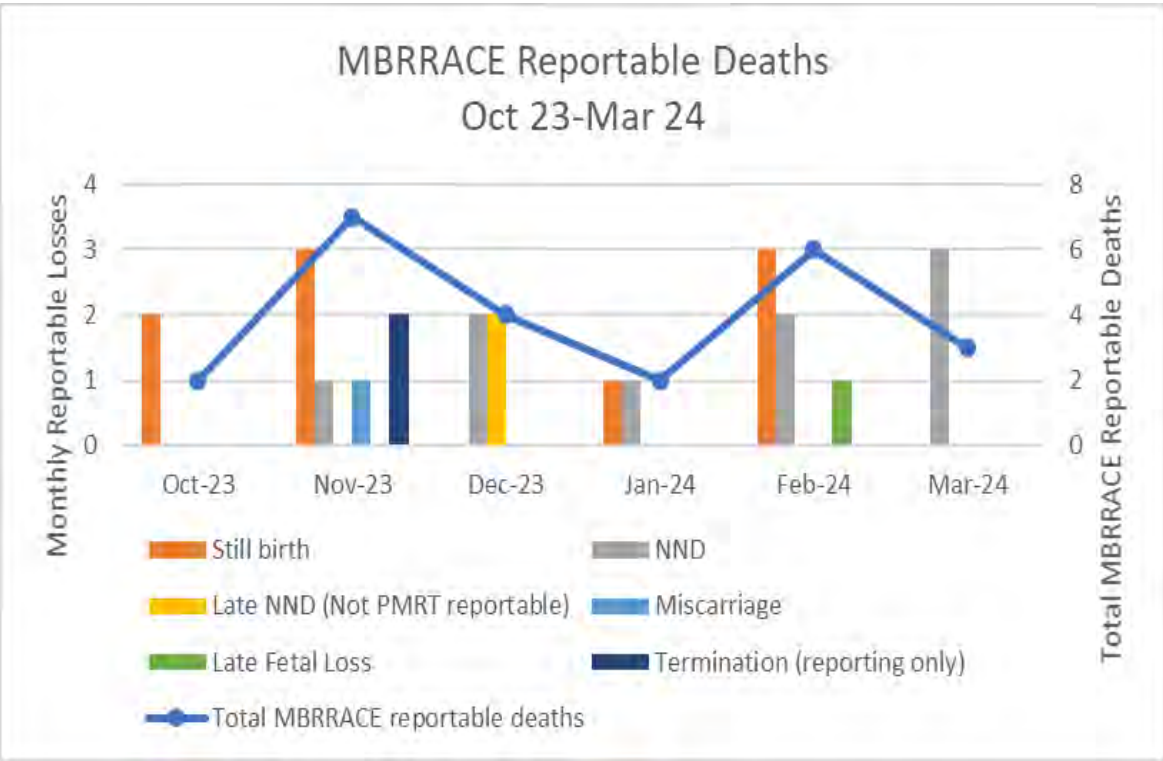


Perinatal Surveillance Tool Q3 2023/24 – Perinatal Mortality Review Tool
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight
Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Key Messages :

- 11 MBRRACE reportable cases in Q4.
- All cases reported within CNST/MBRRACE timeframes
- 8 PMRT reviews completed in Q4. Key concern raised regarding communication.



Issues, Concerns, Gaps:

- Communication during antenatal, intrapartum and postnatal period flagged as a concern across a number of PMRT cases in quarter.
- Delay in pathology results following a loss.
- Delay in publication of NICU reports – 4 outside 6 month requirement.
- Increase noted in late fetal losses.

Actions & Improvements:

- Remind Neonatal Staff to discuss PMRT and provide parents with written information prior to leaving the Neonatal Unit. This is being audited for the next 3 months – still ongoing
- There is continual improvement in the collaborative working between the Maternity and Neonatal Team regarding the PMRT reporting.- ongoing
- Maintenance of PMRT spreadsheet for yearly themes including both Maternity and Neonatal reviews – commenced
- Meeting to be held with Neonatal Consultants so Neonatal Reports are completed and reports published in a timely fashion – to be undertaken in March
- Monthly meetings organised for Maternity PMRT for 2024 with change of day
- Widened invitation list for meetings – Obstetric Trainees, midwives
- Monthly meetings organised between Chair/Vice chair of Maternity PMRT meetings to discuss themes and ensure timely publication of reports.
- Decision to present yearly themes and Action Plans for PMRT meetings at the June PMRT meeting
- HOM To arrange a round table review of all late second trimester losses in the last 6 months to ensure appropriate management, identify any themes/ trends and resulting actions

MBRRACE Reportable Loses Q3

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
3	1	Stillbirth	36+4/40	Unexplained	PMRT, HLI	Review call the midwife process
3	2	Stillbirth	39+1/40	Unexplained	PMRT	Care grading AA, no concerns
3	3	Stillbirth	36+4/40	Unexplained	PMRT	Care grading AA, no concerns
3	4	Stillbirth	30+0/40	Placental Dysfunction	PMRT	Care graded AB, Due to genetic sample not taken at time of delivery. GOSH Sample Requested to be sent for genetic testing. Comms - Top 5
3	5	Stillbirth	40+4/40	Unexplained - probable placental	PMRT	Care Graded BA, parents felt results patwhay was not communicated well post-delivery. Review guidelines for fetal monitoring when cervial balloon insitu.
3	6	Termination	27/40	Fetal Abmormality	Notifcation only	N/A
3	7	Termination	22/40	Oligohydraminos	Notification only	N/A
3	8	Miscarriage	22+4/40	Triplet 1 following laser treatment	PMRT	Laser treatment at London Trust. Transfer of care to MFT following loss of triplet. AA, no actions for Trust.
3	9	Neonatatal death	23/40	Prematurity	PMRT	Care graded B,A, A due to communication concerns raised regarding antenatal management
3	10	Neonatal death	36+4	Unexplained - probable placental dysfunction,	PMRT	No immediate care concerns raised. B, A, Miscommunication regarding testing for suspected UTI
3	11	Neonatal death	23/40	Pneumothorax, pneumoperitoneum and bilateral interventricular haemorrhages, RDS, extreme prematurity	PMRT	Born at neighbouring Trust. No immediate care concerns. A,B,A Action plan for neonatal team At MFT - improving respiratory management for neonate within first 24 hours. Guideline review and staff education.
3	12	Late Neonatal Death	40/40	HIE	Referral to MSNI from neighbouring Trust	Care grading D, A, A Born at neightbouring Trust following placental abruption. Learining for other Trust regarding management of induction, monitoring of mother and fetal heart in labour.
3	13	Late Neonatal Death	40+4/40	HIE, Cord Prolapse	Referral to MSNI	Learning identified for SECAMB colleagues . Case referred to coroner. A, A, A Well managed cord prolapse once admitted to Trust.

MBRRACE Reportable Loses Q4

Medway NHS Foundation Trust

Q	Case	Category	Gestation	Initial Findings	Level of investigation	Immediate learning/Actions
4	1	Stillbirth	25+1	Eary onset growth restriction	PMRT	A,A Identified early and managed on appropriate pathway.
4	2	Neonatal death	20+0		N/A	MBRRACE reportable - not for PMRT
4	3	Late fetal loss	22+2	Turners	PMRT	PMRT May 2024
4	4	Stillbirth	26+5	Unexplained	PMRT	PMRT May 2024
4	5	Stillbirth	32+3	Unexplained	PMRT	PMRT 5/4
4	6	Stillbirth	38+5	Unexplained	PMRT	PMRT 5/4
4	7	Neonatal death	31	Severe Growth Restriction	PMRT	Awaiting PMRT
4	8	Neonatal death	26+2	Prematurity	PRMT/Coroner	Awaiting PMRT - Coroner referral due to unexpected deterioration in NICU. 1 of twins.
4	9	Neonatal death	23+3	Extreme Prematurity - Twin	PMRT	Awaiting PMRT
4	10	Neonatal death	23+3	Extreme Prematurity - twin	PRMT	Awaiting PRMT
4	11	Neonatal death	21+5	Extreme Prematurity	MBRRACE Reportable only	MBRRACE reportable - not for PMRT Provided comfort care only, parents unhappy with outcome

Gradings of Care on PMRT Tool

A - The review group concluded that there were no issues with care identified up the point that the baby was born

B - The review group identified care issues which they considered would have made no difference to the outcome for the baby

C - The review group identified care issues which they considered may have made a difference to the outcome for the baby

D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Workforce – training and clinical safe staffing

Perinatal Surveillance Tool Q4 2023/24 – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.

Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust

Key Messages:

- Fetal monitoring training 100% for obstetric doctors and 97.7% for midwives
- 2 PROMPT training days running per month to support >90% compliance (previously 1 day per month).
- Midwives, MSWs and Theatre staff >90% for PROMPT training.
- Anaesthetic and obstetric doctors <85%
- Midwifery essential skills 90% compliance.
- Increase in compliance with ABLS, NBLS training and Safeguarding adults, however the latter remains below Trust target.
- Overall compliance for Maternity and Neonatal Staff for mandatory training has increased to 86.76% in Quarter 4.
- CNST Year 6 reporting period for training compliance >90% is December 2023 to 30 November 2024.

Issues, concerns, gaps:

- Doctors strikes have prevented consultants from attending PROMPT training currently below 85% for all medical groups.
- A number of mandatory training topics remain below Trust target.
- Have not met training trajectory for Safeguarding Adults. 66.95 for all maternity and neonatal staff, 73% for Midwifery staff.

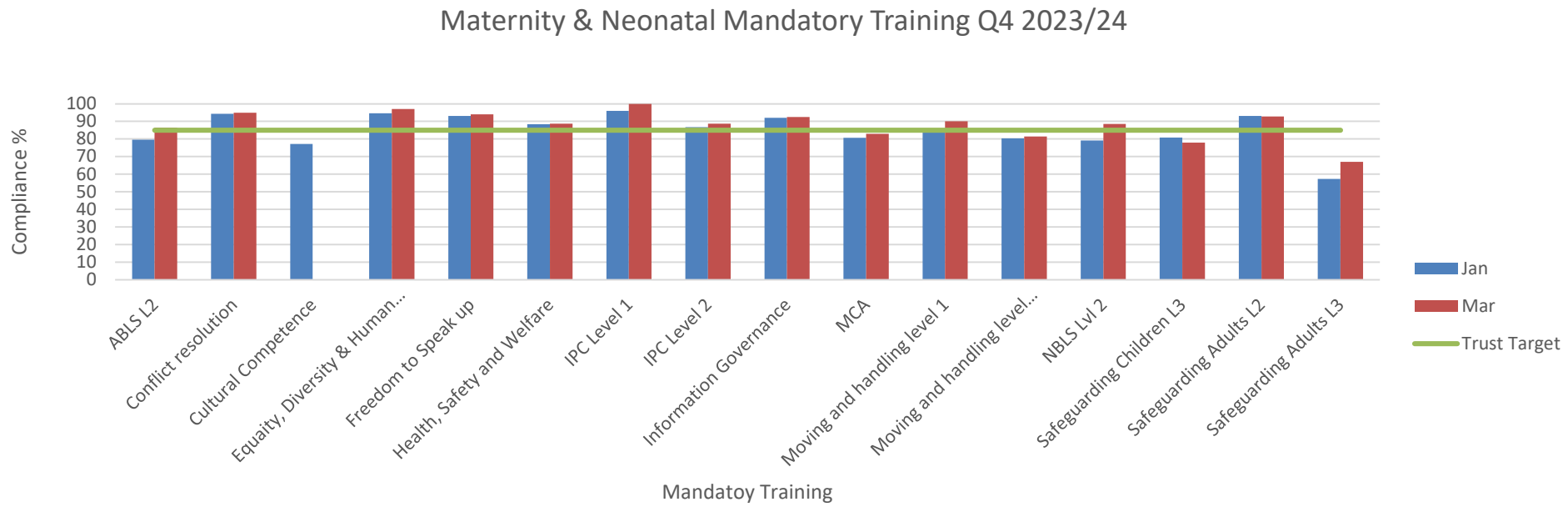
Actions and improvements

- Insitu SIM programme relaunched in January 2024 with MDT attendance supported.
- SBAR to be included in PROMPT and essential skills.
- All new starters receive PROMPT training within 3 months.
- Education team to flag with Service Manager and General Manager non-attendance by medical team to ensure rebooking. Midwifery non-attendance escalated to senior sister.
- Mandatory training compliance to form part of appraisal process
- Senior sisters to identify individual staff needs and to roster attendance to support compliance.
- Those with significant lapse in training compliance to have 1:1 review with matrons/clinical supervisor.
- Band 6 research midwife to complete keyworker course in February 2024 to be able to undertake workplace assessments for moving and handling training

Perinatal Surveillance Tool Q3 2023/24 – Training

Ambition: To ensure the maternity and neonatal workforce have the skills and knowledge to provide safe and evidence based care.
Goal: To ensure all staff are trained to the required compliance.

Medway NHS Foundation Trust



Fetal Monitoring Training and Assessment	Compliance December 2024	Compliance March 2024
Midwives	100%	**97.7%**
Obstetric Consultants	89%	**100%**
Doctors in training	80%	**100%**

PROMPT training Q4	Active Staff	Complaint	%
Midwives	178	161	**90%**
MA & MSW	51	47	**92%**
Theatre Nurses and ODNs	30	28	**93%**
Obs Consultants	22	16	**72%**
Obs SpR/SHO	34	29	**85%**
Aneaesthetic Consultant	7	5	**75%**
Aneas. SpR/SHO	23	19	**82%**
Total	**345**	**305**	**75%**

Essential Skills March 2024	Active Staff	Compliant	%
Midwives	178	161	90

Perinatal Surveillance Tool Q4 2023/24 – Midwifery Workforce

Ambition: To ensure safe staffing workforce model is in place.
Goal: To have a workforce that is staff to the required level.

NHS Medway

Key Messages :

- Midwifery staffing remains a challenge with true vacancy rate remaining high across the quarter.
- Long term sick leave also increased across the quarter, with slight reduction in Maternity leave.
- Positive midwifery workforce retention rates.
- NHSE Funding for Recruitment and Retention Midwife extended for 2024/25 (1WTE Band 7)
- Benchmarking against Labour Ward Coordinator Framework Underway by PMAs
- Bi-annual workforce report required for Trust Board to be presented to MNSCAB in May 2024 and onwards to Trust Board for July 2024 meeting.

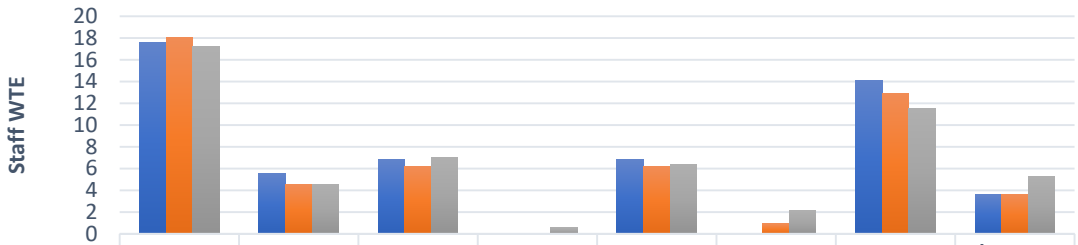
Issues, concerns, gaps:

- Vacancy rate in midwifery staff continues to be a challenge.
- Shortfall in newly qualified midwives due to the impact of the displacement of CCCU students.
- Long-term sickness increased in quarter.

Actions and improvements

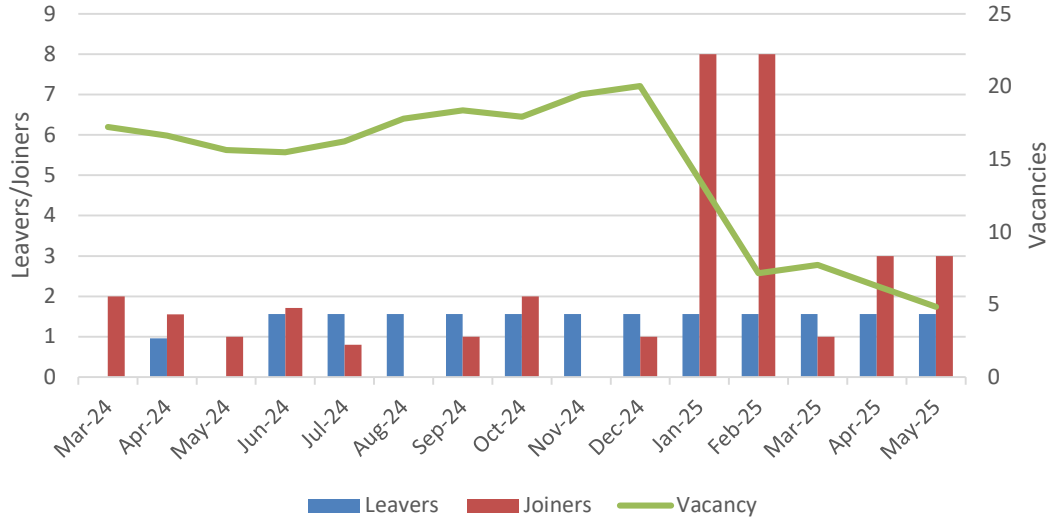
- Appropriate oversight and escalation of workforce concerns with Action plan in place.
- Working locally, regionally and internationally to support recruitment.
- Working to support wellbeing of staff to maintain good retention rates.
- Surrey University taken on CCCU students with anticipated graduation date of March 2025.
- Long-term sickness has been managed inline with Trust policy.

Midwifery Staffing Q4 2023/24



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Jan-24	17.57	5.53	6.82	0	6.82	0	14.12	3.64
Feb-24	18.09	4.57	6.26	0	6.26	0.96	12.96	3.65
Mar-24	17.21	4.57	7.06	0.64	6.42	2.12	11.52	5.24

Midwifery Workforce Trajectory Mar 24-May 25



Perinatal Surveillance Tool Q4 2023/24 – NICU Nursing Workforce

Ambition: To ensure safe staffing workforce model is in place.
Goal: To have a workforce that is staff to the required level.

Medway NHS Foundation Trust

Key Messages :

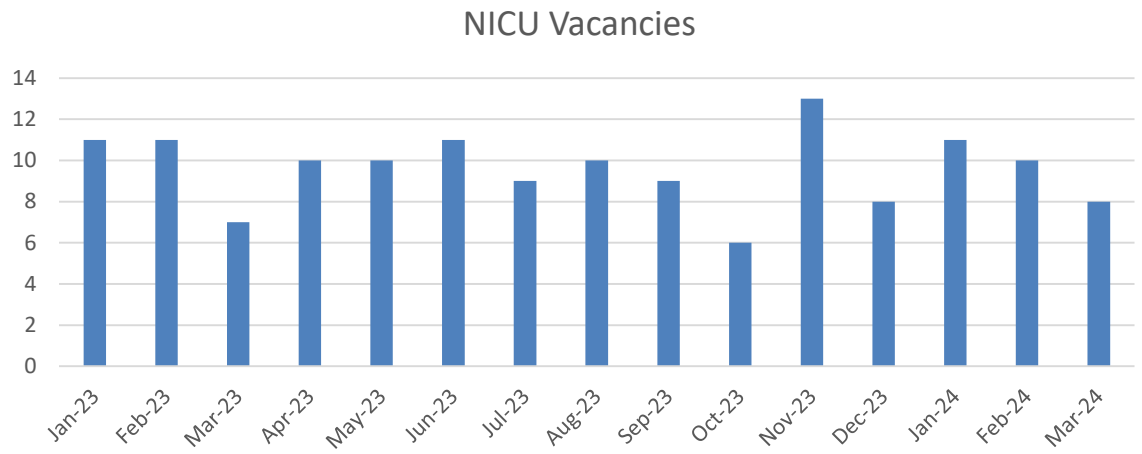
- NICU Nursing vacancy rate reduced to 8.03WTE across all bands.
- Recruited 4 Band 5s.
- QIS trained staff at 62%, with recruitment and retention payments continuing for all QIS staff.
- Escalated bank rate offered to mitigate gaps in clinical nursing workforce.

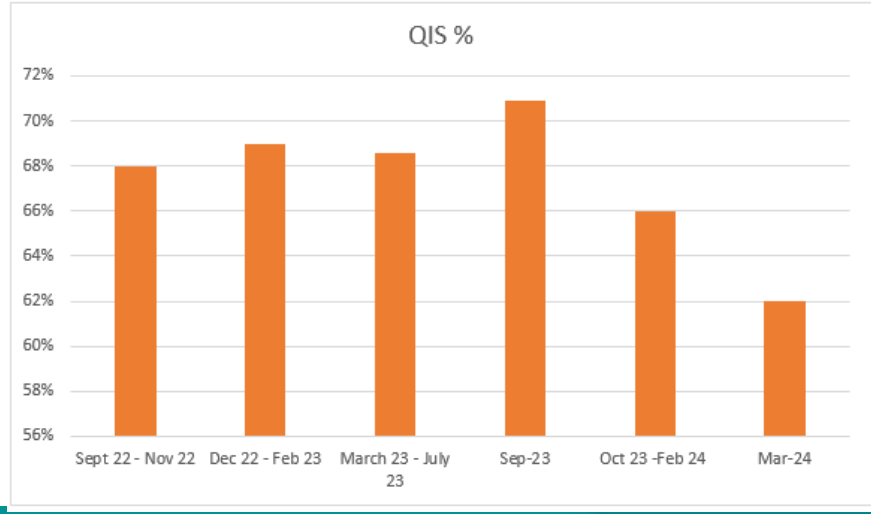
Issues, concerns, gaps:

- NICU workforce <70% QIS.
- Offering opportunities to make Medway NICU attractive to staff.

Actions and improvements

- .6 staff currently on QIS course, with a further 6 to commence in September.
- Staff education plan being developed for year ahead to ensure all learning needs are captured and facilitated.
- Learning contract to be introduced for staff to aid retention.
- Work with staff to promote wellbeing and career development opportuntiies.





Feedback – including MNVP Service users and MFT maternity and neonatal staff

Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
Goal: To embed service user feedback into service development and improvement.

NHS Medway NHS Foundation Trust

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
  - Review of complaint responses
  - Maternity Triage/MCU QI Project
  - Patient Booking Letters
  - Personalised Care/Birth choices and care outside of guidance.
- MNVP lead on MNSCAB bi-monthly for service user feedback update.
- FFT Response rate for March 2024 38.7% with 85.8% recommend rate.
- CQC Picker Survey for 2024 underway. Comms launched to engage service users.
- Patient stories now embedded into MNSCAB.
- MNVP leads review all patient information leaflets for Trusts across LMNS using DISCERN tool to ensure consistent and timely review.
- Co-production of letters to support new risk-assessment pathway in response to Ockenden.
- Applied for NHSE Funding to support the implementation of Martha's Rule.

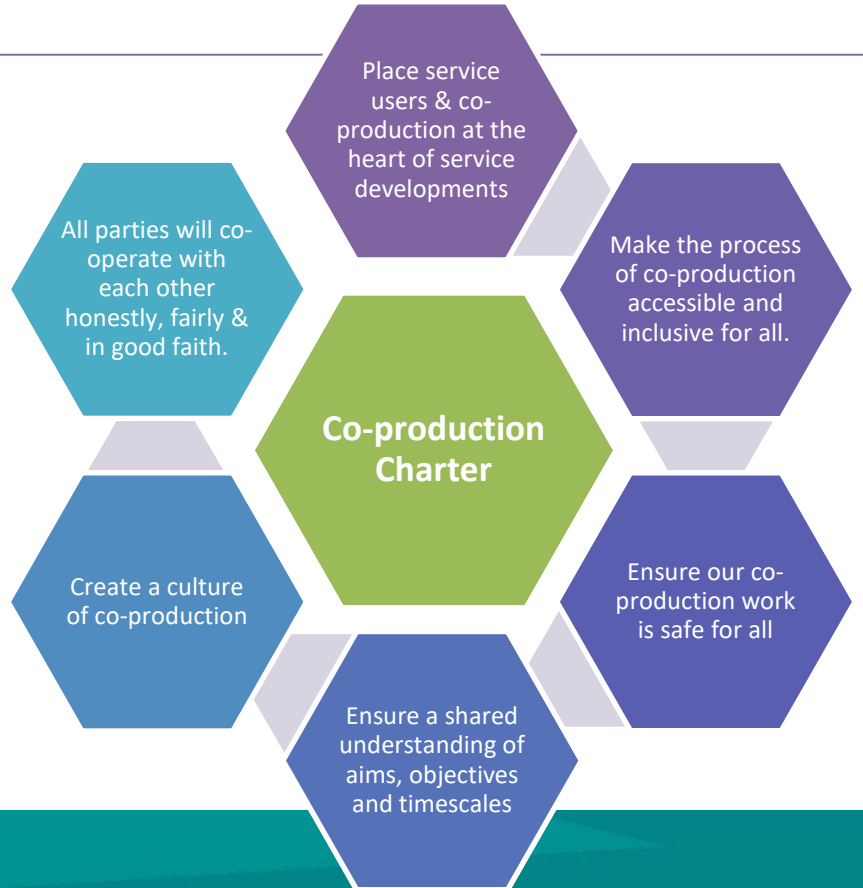
Issues, concerns, gaps:

- Ongoing challenges to engage with service users, particularly those from minority groups. Patient Experience and EDI midwife to support ongoing development of service user engagement.

Actions and improvements

.Patient Experience Midwife and Equality, Diversity and Inclusion Midwife included in business case for 2024 following birth rate plus recommendations.

- Plans for 15 Steps Challenge and "Who's Shoes' challenge in 2024.
- Co-production charter developed across the LMNS.
- 10 free data SIMS purchased to support families in need achieve data equity.



Perinatal Surveillance Tool Data Q4 2023/24– Service User Feedback

Ambition: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Goal: To embed service user feedback into service development and improvement.

Medway NHS Foundation Trust

"A lots changed since I had my first baby 5 years ago, much better care. I was really well looked after and my partner felt really part of it all which wasn't the same in my last pregnancy"

"I had a great experience at Medway 2 weeks ago. …I had to be induced and it took a few days to get my day to go in which was a little annoying but I was called and spoken to and everything explained really well. The midwives I had looking after me were so lovely and I couldn't have had a better experience."

Service User Feedback via MNVP

"I had a lady who declined all scans during pregnancy and had chosen to just have community midwife appointments. She was hoping to have a homebirth but wanted to know whether she could do if she had declined care. The community midwife put her in touch with a consultant midwife who called and my client did not like this… I also spoke with the Maternity voices team and she answered some of my clients questions and offered to put her in touch with someone else. I have to say that my client had huge reservations about her care and what she should expect, however after speaking to the consultant midwife and discussing care outside of guidance she felt really reassured, and really listened too."

What can I say- the whole of my pregnancy and birth with Medway has been incredible. I've had 3 children and 2 diff trusts, and this was the absolute best even though my birth ended up being on induction suite in a side room instead of delivery, but my body moved far faster than any of us were expecting! The most important thing was that the midwife caring for me dealt with the unexpected emergency amazingly and the neonatal team also came running as soon as I gave birth and were on hand to help my baby born 35+3. I've had previous birth trauma and every midwife caring for me in labour read my Mental health note and treated me with respect even when things were out of their control- I felt listened to and validated. I am on transitional care now with our baby and again the care has been amazing. I have nothing but good things to say about my care.

Perinatal Surveillance Tool Data Q4 2023/24– Staff Feedback
Ambition: To create a culture where staff feel empowered and supported to raise concerns and contribute to service improvement.
Goal: To ensure staff feedback forms and integral part of service improvement

NHS Medway NHS Foundation Trust

Key Messages:

- SCORE culture survey undertaken in November 2023
- Action plan developed by staff and monitored via BAF and shared with Board Level Safety Champions.
- Local culture survey undertaken February 2024:
  - 73% “agree or strongly agree” their team treats each other with respect.
  - 70% “agree or strongly agree” they feel able to escalate concerns at work
  - 71% “agree or strongly agree” their team really values diversity
- Teams Talks well established and action log produced to ensure all actions and staff comments are responded to.
- Opportunities for Staff to be involved in QI projects across service.

Issues, concerns, gaps:

- High caesarean section rate.
- Poor attendance at audit, particularly from midwifery staff.
- Admin shortages to support key clinical roles
- Staff concerns regarding vacancy and progress with recruitment work.

Actions and improvements

- MCU/Triage QI Project commenced. All staff interested in joining invited to attend. PMA representation to be included.
- Business planning for admin shortages.
- Audit to commence for caesarean section, opportunities for staff to become involved.
- Monthly poster established to communicate current recruitment and retention position to all staff.
- Audit plan for 2024/25 being finalised with plan to ensure midwifery-led audits are scheduled alongside obstetric/gynae audits and early publication of dates to allow midwives to attend.
- Break audit commenced in March 2024. To audit 3 months and then develop plan to improve compliance with breaks.
- Board Level Safety Champion Engagement sessions to continue in line with CNST Year 6 requirements.

Maternity & Neonatal Risks

NHS Medway NHS Foundation Trust

Patient FIRST

Executive Summary – Risks

Currently 11 risks in maternity and 2 in Neonatology

Two risk with scores 15 to 20 (Maternity)

Highest risk related to midwifery workforce challenges – reduced to 16 outside of Divisional Governance Process. Not approved by Division.

All mitigations and scores have been reviewed within required timeframes

Maternity and Neonatal Risks

Risk ID	Maternity Risk	Jan-24	Feb-24	Mar-24
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.		20	20	20
1864	Maternity Information System coming to end of contract		15	15	15
1025	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	N/A		15	15
1131	Delays in IOL		12	12	12
1776	Delivery suite birthing beds in state of disrepair, inability to source parts may result in patient harm		12	12	12
1460	Potential failure to appropriately risk assess women in the community due to lack of experienced Midwives allocated to work within the community setting.		9	9	9
1128	Community Midwifery Premises		9	9	6
1300	Unable to access patient records at community antenatal clinics		9	9	9
1737	Inconsistent and inaccurate data being shared outside the organisation		6	6	6
1302	Movement of staff to support acuity on Delivery Suite creates red flags in other areas		6	6	6
1741	Risk of harm to maternity staff whilst lone working		4	6	6

Risk ID	NICU Risk	Jan-24	Feb-24	Mar-24
	Lack of available space in NICU for equipment storage		8	8	8
	Inability to provide Nasogastric tube feeding for NICU graduates in the community setting		9	9	9

Maternity Risks

Maternity Risks

Risk ID	Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.	Insufficient midwifery workforce to meet demand. • Inability to provide 1:1 care in labour. • Avoidable delays in the IOL pathway. • Poor patient experience. • Potential for adverse clinical outcome. • Poor staff morale and burnout. • Inability to implement continuity of carer in line with national directive.	Current vacancy at 17.57 wte vacancy and 14.12 wte maternity leave. Covering some shifts with RN's rather than RM's. 6.82 wte Midwives are in pipeline; 1.6 wte midwives leaving in next 3 months to work closer to home. Not expected to see significant reduction until April 2025.	Staff retention and international recruitment options Risk score has been discussed with the CNO since last report and rescored under the safe domain.	12 (4x3)	20 (5x4)	20 (5x4) ⟺	04 (2x2)
1025	Euroking maternity system not fit for purpose, impacting patient safety, data quality, stat analysis, CNST and clinical information	A number of issues have been identified with Euroking maternity system, inclusive of: - Back-copying of answers and - Duplication of records caused by failed data migration (Sep 2020) These issues have resulted in no assurance of reporting output and may result in issues relating to patient safety, data quality, statistical analysis, CNST and clinical information. The impact may be financial implication by way of the ICO or harm to patients as a result of incorrect patient information being available.	- Manual data adjustments made to ensure MSDS is uploaded and local data reported. - Local data reconciliation being done to expose gaps occurring together with close working relationships between BI and Maternity. - Manual review and individual case file analysis underway - Gone into capital planning for 24/25. Sited on risk through digital data and technology group.	System supplier aware of insufficient mappings provided but are not acting on need. - Lack of funding to procure new system. - No reconciliation between System, System Reporting solution & automated Data Output. - EuroKing supplier will not provide mapping for fields, - National risk identified by Another EuroKing Trust - Unable to fully ascertain the extent of the issue - Some legal records are overwritten or completed when none was there. The amendments and additions can be seen in the auditing software but may be misleading to the front end user. Risk score remains the same. Supplier working with Trust.	09 (3x3)	15 (3x5)	15 (3x5) ⟺	03 (3x1)

Maternity Risks

	Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
1864	Maternity Information System coming to end of contract	Euroking contract end date is 03 December 2025.	• Discussions with LMNS and Trust IT Directors re sourcing alternative system. • Scoping to be reviewed	Business case in development. Risk score increased following discussion at QAC	10 (5x2)	10 (5x2)	15 (5x3) ↑	04 (2x2)
1131	Delays in Induction of Labour	The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff vacancies.	The A3 has been revised. Pilot project to commence 10 July whereby there will be an Induction of Labour pathway Consultant and Midwife Lead to manage IOL pathway in conjunction with Lead Obstetrician. Daily tracking audit.	There has been improvement in the IOL pathway with sustained improvement. Risk score reduced to reflect this Risk score has not changed, Feb challenging in terms of acuity and increase in delays.	12 (3x4)	12 (4x3)	12 (4x3) ⟺	04 (2x2)
1776	Delivery suite birthing beds in state of disrepair, inability to source parts may result in patient harm	5 birthing beds on the delivery suite are > 10 years old and in a state of disrepair. Potential of being unable to repair or obtain parts if required. Potential harm to patient if beds dysfunctioned.	• An equipment bid has been submitted to the Trust medical devices group. • Delivery beds are currently being serviced to highlight any existing issues. • Monitoring of any adverse outcomes or patient harm in relation to bed mechanics dysfunctioning	- Lack of funding to purchase replacement Notification received being purchased by capital funding slippage; will remove once delivered	12 (3x4)	12 (3x4)	12 (3x4) ⟺	04 (2x2)
1460	Potential failure to appropriately risk assess women in the community due to lack of experienced Midwives allocated to work within the community setting.	Due to current staffing concerns within the community setting, B5 and junior/inexperienced midwives are being allocated to work within the community teams. Due to the nature of community work it is difficult to provide close supervision/support to these midwives. Delay in assessment/escalation of clinical situation by junior midwife. Failure to appropriately risk assess women in the community due to lack of experience. Dissatisfaction of the midwife in her role in	• Close contact with community team senior sister. • Provision of 'New Starter Pack'. • Supernumerary period of 1-2 weeks. Band 5 Midwives continue to work in the community setting with enhanced support due to high vacancies.	There is a lack of B6 Midwives to allocate to community working, due to high vacancy and maternity rate. Due to current vacancy rate we are not able to allocate B6 midwives to community setting only therefore risk will remain the same score until vacancy rate improves.	09 (3x3)	09 (3x3)	09 (3x3) ⟺	06 (2x3)

Maternity Risks

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
1300	Unable to access patient records at community antenatal clinics	Digital connectivity support inadequate to provide safe clinical risk assessment and record keeping. No/limited access to critical clinical information.	• LMNS discussing Midwives being able to access hard wiring internet at all centres.	• Broadband permission or alternative connectivity confirmed for all centres in Phase 1. • GovRoam tested and working in one centre yesterday. • New Guest WiFi setup created for 2 centres • Awaiting further feedback from users on GovRoam and new Guest WiFi setups	12 (4x3)	09 (3x3)	09 (3x3) ⟺	04 (2x2)
1741	Risk of harm to maternity staff whilst lone working	A proportion of maternity staff spends some or all of their working hours working alone. This creates risk when working in community hubs and when visiting families. They could be subject to violence and aggression and if taken unwell there is no-one else to alert or observe.	Lone worker devices Provide staff with conflict resolution training Provide staff with mobile phones Arrangements for maintaining contact at home births	Not every community midwife has a lone worker device Increased due to lack of lone worker devised allocated.	04 (2x2)	04 (2x2)	06 (2x3) ↑	04 (2x2)
1302	Inconsistent and inaccurate data being shared outside the organisation	Poor quality, completeness and availability of maternity data resulting in reduced efficiency and potential reputational damage	• Preventative measures include regular manual review of data, audit and data cleaning • Digital midwife ongoing working with BI to align front and back end system reporting • Weekly checking of data	Data anomalies continue to be an issue Improved data in IQPR. Risk remains in recognition of dashboard anomalies.	06 (2x3)	06 (2x3)	06 (2x3) ⟺	04 (2x2)

Maternity Risks

Medway NHS Foundation Trust

Risk ID	Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
1302	Movement of staff to support acuity on Delivery Suite creates red flags in other areas	Due to staffing shortfalls and high acuity Senior Sisters, community midwives and specialist midwives are being either redeployed or moved from their own roles to cover the deficit. This impacts negatively effective clinical leadership and clinical oversight of the maternity unit. Community midwives are working over the working time directive and staff morale is low.	The movement of staff across the unit has reduced following the implementation of the new on-call roster. However with the high vacancy and maternity factor score remains the same.	Staff retention and recruitment options Staff movement remains and supported with area orientation packs. No harm or incidents noted.	09 (3x3)	06 (3x2)	06 (3x2) ⟺	04 (2x2)
1741	Community Midwifery Premises	There is a lack of community office space for community midwifery teams which is causing disruption to the maternity provision. There is further risk of loss of premises and financial implications due to a lack of contracts for most of the community midwifery venues	• Working with contracts team to get SLA's in place • Still no hub for All Saints. Saxon Way clinics also being misplaced at end of August 2023. Conversations continue to take please with ICB and Space Utilisation group at MFT.	• Appropriate community space to be found and contracts for venues to be written. • Options being explored with Paul Mullane / CHP for All Saints Hub.	09 (3x3)	06 (2x3)	06 (2x3) ⟺	04 (2x2)

NICU Risk

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Lack of available space in NICU for equipment storage	Equipment which is being used regularly in NICU is being stored in: 1. Corridors - equipment is covered and stored in corridors which pose an IPC and health and safety risk. 2. Bedroom 3 - equipment is currently stored in bedroom 3, meaning that a parent is unable to stay on site. Not meeting GIRFT recommendations. 3. NICU seminar room and impacting on team meetings and social distancing.	1. Store equipment in isolation room. 2. Cease using the NNU seminar room for meetings or staff breaks while clean equipment is in. 3. Equipment in corridors being covered. 4. Reduced NICU capacity is managed through network referrals and cot closure.	• Equipment stored in seminar has been section off, with the use of screens. Funding now approved for renovations of the seminar room to start – • 29/09/2023 Awaiting start date for the works to start • 26/10/2023 Weekly planning meetings arranged- to commence 27/10/2023. provisional start date for works is January 2024 • 17/11/23 Weekly planning meetings continue - Asbestos survey completed, Architect visit arranged. Storage cupboard clearance commenced. Provisional start date remains Jan 2024 • 15/12/2023 – Concerns flagged with electrical supply. May delay start of works. Weekly update meetings continue • 15/01/2024 – Works out to tender, Store rooms in seminar room cleared. Seminar room meetings cancelled in preparation for work. • 12/02/2024 - Preparation works continue, weekly meeting with estates continue - Awaiting construction start date • Notified 07/03/2024 that due to additional funding requirements for this project - The project has been moved the next financial year. Risk to remain on the risk register until the works have been completed.	9 (3x3)	8 (4X2)	8 (4x2) ⟷	04 (2x2)

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Inability to provide nasogastric tube feeding for NICU graduates in the community setting	Currently we do not have the infrastructure and resources to enable short term NGT feeding at home as recommended by GIRFT. Inability to meet GIRFT standards. Increased LOS in hospital. Impact on patient flow in NICU.	This care is provided to babies as inpatients. Parents are supported to provide this care to their baby while they remain in hospital. Additional nurses added to NOAH work force to prepare for expansion in community role	Guidelines are currently being written, plans for 'virtual wards' are underway NGT feeding at home / Virtual ward will commence on 29/01/2024	9 (3x3)	9 (3x3)	9 (3x3) ⟷	3 (3x1)

New risks – awaiting approval

- Upgrade of NICU gantry system – ITU
- Lack of pharmacy support for Principal Clinical Pharmacist for NICU – rejected by governance, as risk sits within pharmacy and is already on their risk register

NHS
Medway
NHS Foundation Trust

Safeguarding Performance Report

Data through to March 2024

Patient
FIRST

SIOR - Safeguarding

Successful Deliverables

- Progress has been made in completing necessary actions from LCSPR
- Improvements in communication with the maternity safeguarding team

Next Steps

- Continued oversight of safeguarding training in maternity
- Escalation to senior sisters if communication is not received from hospital staff of admission of a person with safeguarding history, to follow up with individual staff members

Identified Challenges

- Supervision for non-CP case holder compliance is low at present
- Ongoing difficulties with staff following the DNA pathway
- Reduction in number of Pre Birth Plans completed prior by 36 weeks

Next Steps

- Supervision improvements for non-CP case holders has commenced and will be in two phases. The first phase is targeting Community Maternity Teams , the second will target the Maternity Unit Staff
- All missed contact checklists are being reviewed by the maternity safeguarding team, and are being returned to the member of staff for amendments if needed and the senior sisters are being copied in for ongoing oversight of timely completion
- Email reminder sent to all of Team Connect and Senior Sister for further oversight of completion of Pre Birth planning meeting

Opportunities

- Implementation of antenatal toxicology testing

Next Steps

- PID for antenatal toxicology screening to be completed and submitted no later than March 2024

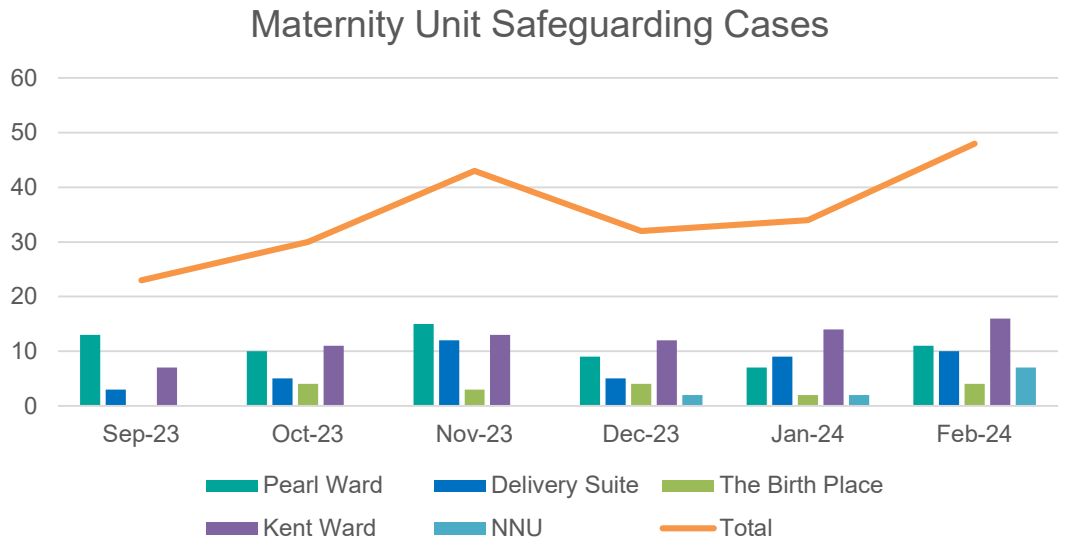
Risks

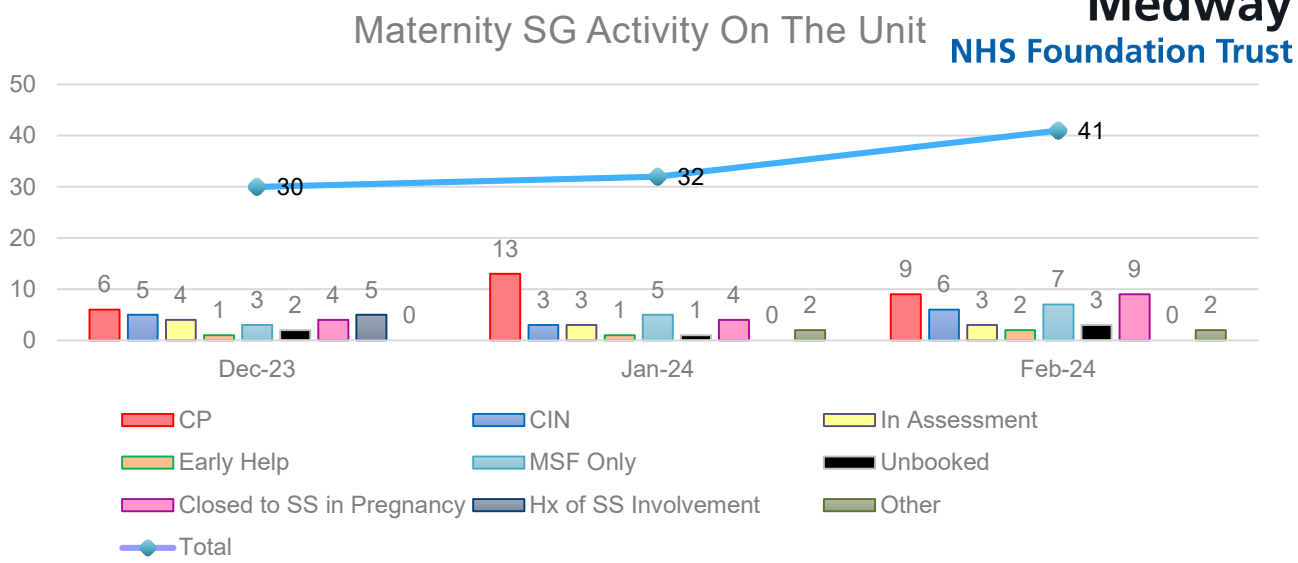
- Maternity staff are currently non-compliant for Adult Level 3 Safeguarding training
- Although CP-IS checking has been implemented in maternity a recent review of processes has highlighted that admissions to the unit are not being checked

Next Steps

- Information has been sent to all staff to complete the Adults Level 3 Safeguarding training as a priority , full day face to face training now added to ESR
- Monthly compliance update sent to all Senior Sisters/ Matrons/ Head of Maternity for continued oversight and review
- All new bookings are being checked on CP-IS by community MTA's, Ward Clerks are being re allocated smart cards and training to be provided, how to guide and information to be sent to Midwives In Charge and hospital senior sisters to check Unbooked pregnancies when attending the unit whilst Ward Clerks await training

Safeguarding Related Incidents/ Activity – Maternity Unit





Key Messages:

- Maternity Safeguarding had oversight of 41 services users on the maternity wards in February. Further support was given to 7 Babies on the neonatal unit.
- There has been 3 service users that have presented for care Unbooked, 1 was an inter-utero transfer.
- There has been a total of 9 Child Protection cases all requiring pre discharge planning meetings, in addition one family under a CIN plan also required a pre discharge meeting.

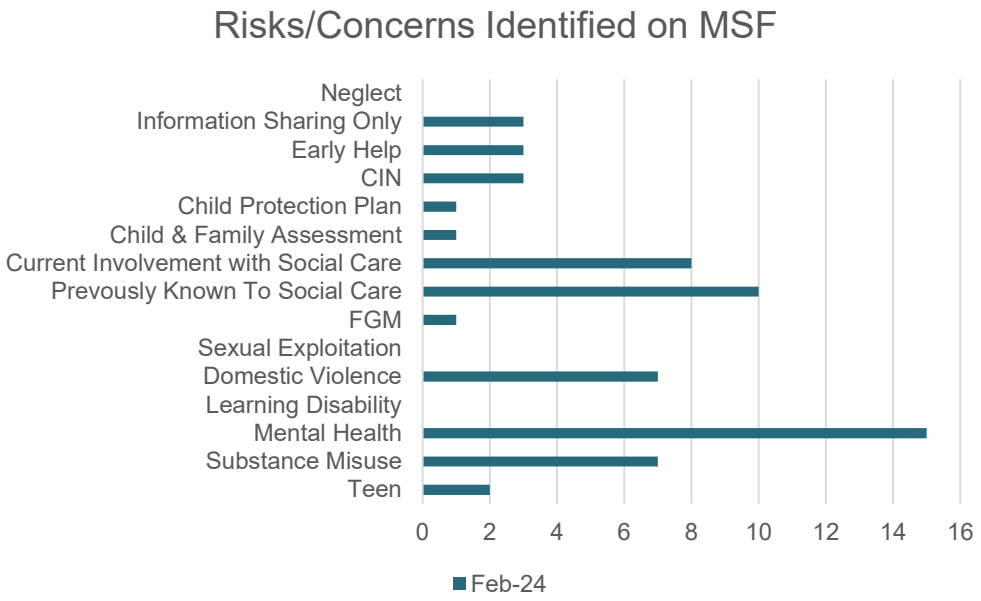
Issues, Concerns & Gaps:

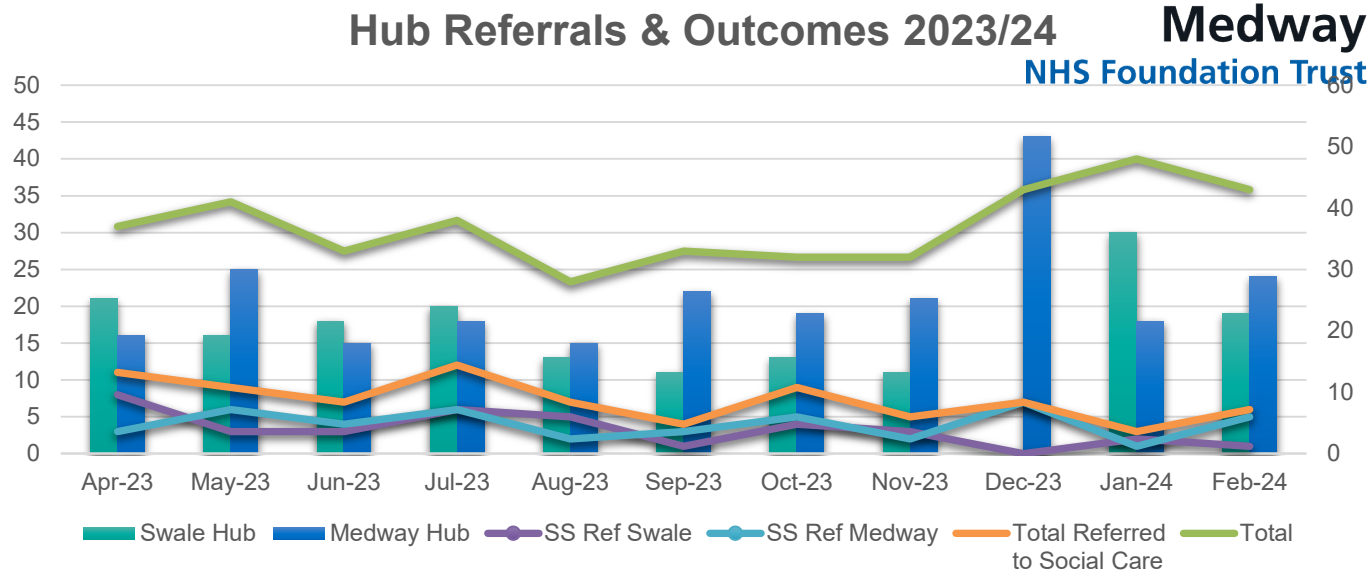
- There has been delays in pre discharge planning meetings being held due to social workers not following hospital processes- This is causing delays in discharge and bed blocking

Actions & Improvements:

- Meeting held with MFT Maternity Safeguarding and Kent social care , draft pre discharge process and Pre Discharge Meeting form completed. Meeting on 05/04/2024 to present to Senior management for Kent Children's service to finalise before submitted through MFT governance processes.
- Once Kent Pre discharge process amended and approved , same process to be completed for Medway. Discussed at PMQA meeting.
- Unbooked Pregnancy guideline has been reviewed and submitted for final approval, improvement noted in ward staff booking staff without prompting from Maternity Safeguarding.

Safeguarding Related Incidents/ Activity – Community





Key Messages:

- 31 Maternity Support Forms were raised in February 2024, Highest reason for MSF was Mental health, current involvement with social care, and previous involvement with social care.
- Hub processes are currently being reviewed between Named Midwife for Safeguarding and Medway/ Kent Children's Services

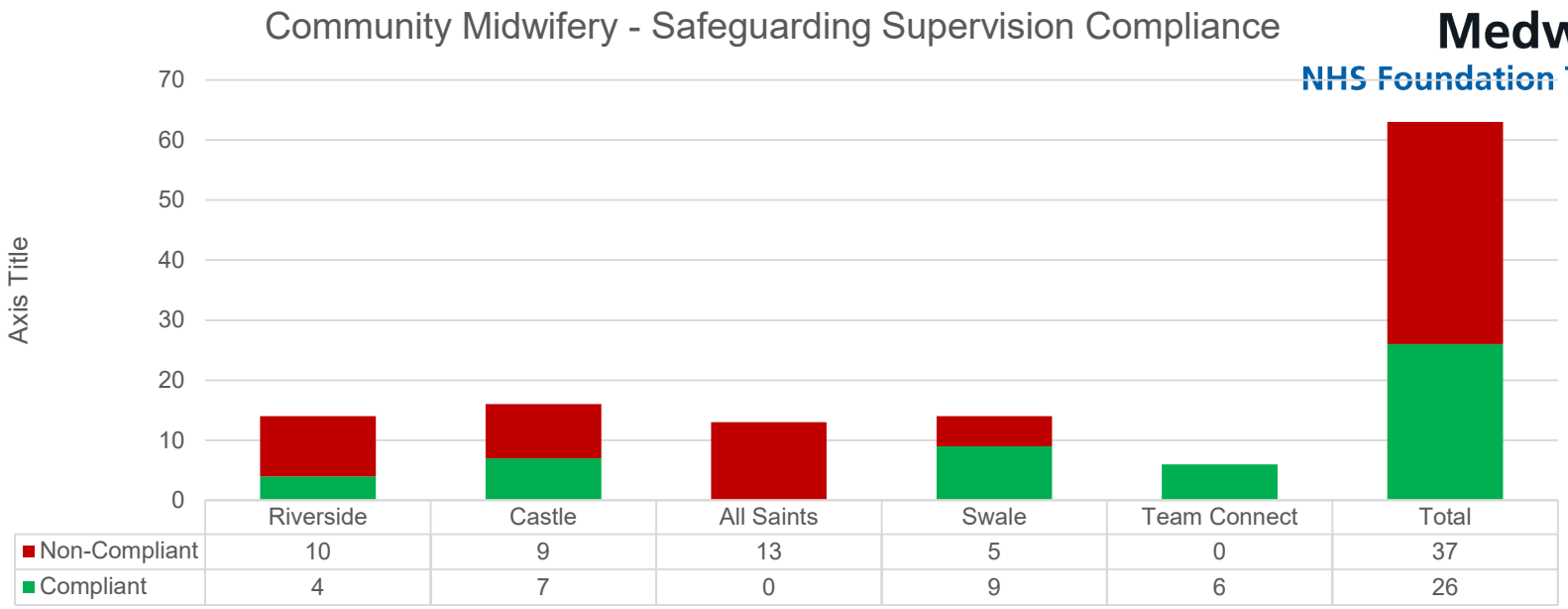
Issues, Concerns & Gaps:

- There is a gap in reporting activity and incidences in the community and further data is required to evidence the oversight provided to cases and to identify any areas of improvement
- Professionals are struggling to fill in the correct information on Maternity Support Forms, there is a worry that the value of the form will be lost if not used appropriately

Actions & Improvements:

- MSF's are screened and reviewed upon receipt by the maternity safeguarding team, to continue this process and ensure that MSFs are sent back to the midwife if completed incorrectly or inappropriately
- Meeting arranged between Named Midwife for Safeguarding and Sarah Featherstone from Medway Childrens Services to create plan of action to improve hub processes, review Terms of Reference, and consider a 'criteria' for hub. To be completed February 2024 – Delay in meeting , re-arranged for 25th March 2024
- Spreadsheet has now been created for Community Safeguarding oversight, similar to that of the Unit reporting that has recently been implemented. Commenced February 2024.

Safeguarding Supervision



Key Messages:

- Ongoing compliance with 100% Supervision completed for all CP case holders (Team Connect) .
- Supervision improvements for non-CP caseholders has commenced and will be in two phases. The first phase is targeting Community Maternity Teams , the second will target the maternity unit staff~
- Improvements seen in attendance to Safeguarding Drop In sessions, and invitations to attend team meetings with allocated time for group supervision to be completed
- Senior sisters are allocating individual midwives to drop in sessions to account for this in their day-to-day workloads and encourage attendance

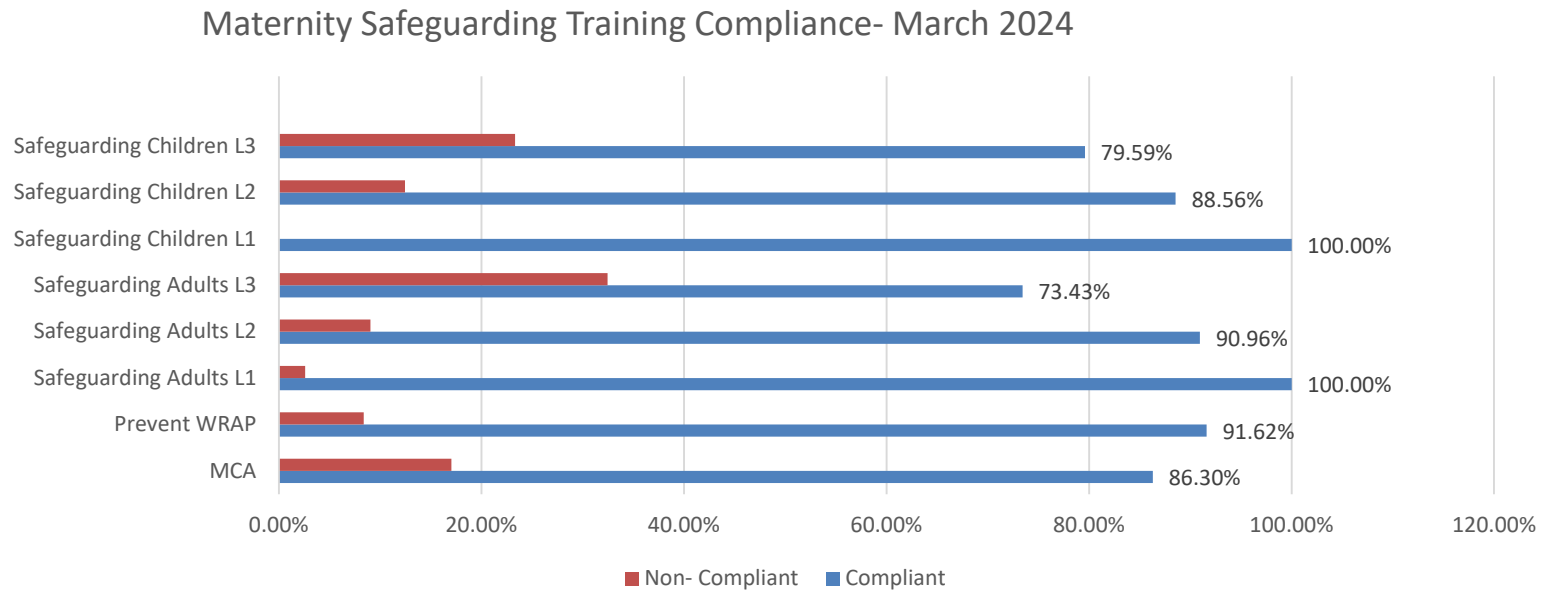
Issues, Concerns & Gaps:

- Wider maternity staffing are not engaging with supervision due to them feeling its not relevant, lack of understanding, difficulties in access due to pressures in work areas

Actions & Improvements:

- Supervision tracker has been commenced and held by Named Midwife for Safeguarding to have better oversight of attendance to supervision
- Meeting completed with Community senior sister to reiterate importance of Supervision , community senior sisters are starting to allocate staff to attend the drop in sessions throughout the year to improve compliance
- Meeting to be arranged with the hospital senior sisters to request the same process as community , expectation is twice yearly supervision for all staff
- New dates for drop in supervision sessions have been sent to all maternity areas for the next 6 months, additional links and information added to the Maternity Safeguarding PADLET
- Deputy Named Midwife for Safeguarding has been included in the safeguarding team group supervision

Safeguarding Training



Key Messages:

- Compliance for Adult Level 3 Safeguarding Training is increasing in maternity, however it is currently below the expected trajectory
- Improvements seen in compliance across all training, however additional focus remains on Adult and Children's Level 3
- Maternity are now above the minimum compliance of MCA training

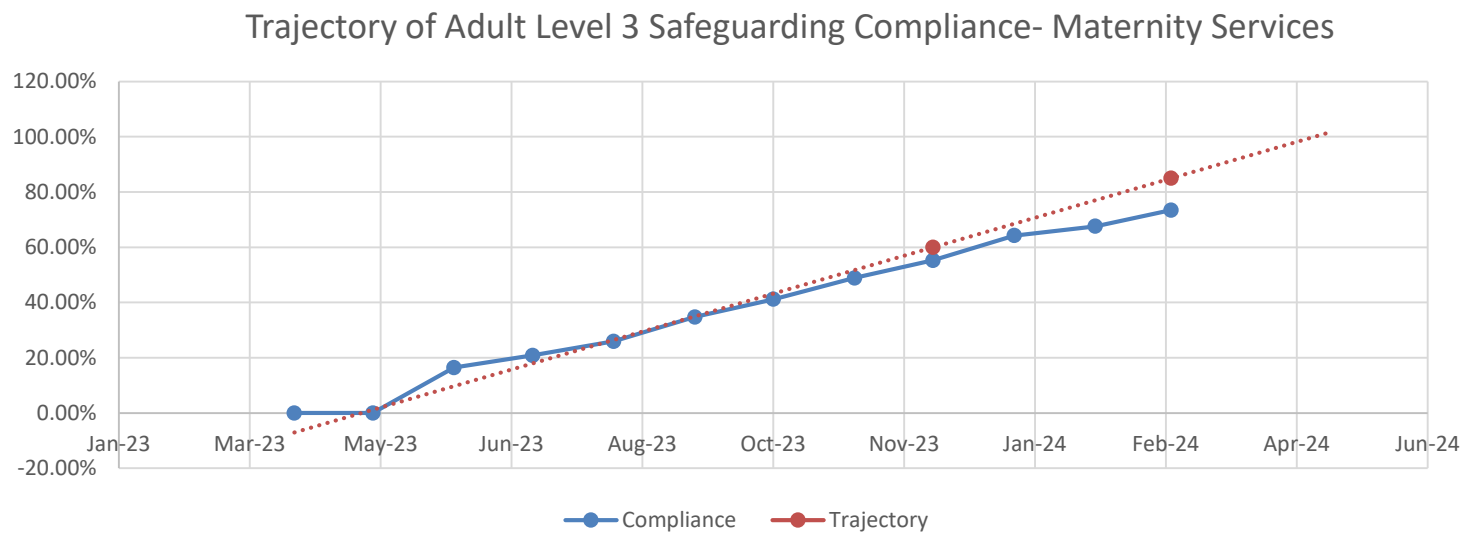
Issues, Concerns & Gaps:

- Adults Level 3 Training compliance is steadily improving however is not meeting the expected trajectories set
- Due to the focus being on improving the Adults Level 3 and MCA compliance, we have seen a reduction in compliance in Childrens Level 3 Compliance
- Staff report difficulties in attending multiple training sessions due to high work demand and low staffing levels

Actions & Improvements:

- With the continue full day training which includes Adults Level 3 Safeguarding, Prevent WRAP, MCA compliance should continue to improve. The new trajectory based on the number of Maternity staff at each session is for 85% and above compliance for Adults Level 3 by May 2024.
- Email updates are being sent to senior sisters and matrons re: training compliance so that they can follow up directly with individual staff and plan time away from clinical work to attend training – this to commence monthly as there has been a decrease in compliance and momentum seen in recent months.
- Children's Level 3 Safeguarding Training has historically been booked by the Named Midwife for Safeguarding for all staff, this responsibility has now been returned to the individual midwives with oversight of the senior sisters

Safeguarding Training



Key Messages:

- Compliance for Adult Level 3 Safeguarding Training is increasing in maternity, however is below the expected trajectory currently
- Trajectory for compliance in maternity is for 60% compliance by December and 85% or above by March 2024- This has been reviewed with the aim to reach 85% or above by May 2024

Issues, Concerns & Gaps:

- High demand of staff requiring training but limited sessions to book onto due to Safeguarding Team capacity and staff not attending booked sessions
- Mapping issues have been identified and there is a concern that the data available is not representative of those who have completed training

Actions & Improvements:

- Ward managers/Senior sisters are being notified of staff that have booked but not attended training to manage on a 1:1 basis
- Monthly email updates sent to all Maternity Senior Sisters , Matrons , Head of Midwifery with current compliance, trajectory and list of staff who are and are not compliant
- Mapping issues has been escalated to Bridget Fordham and Laura Green who are currently in the process of reviewing this

NHS
Medway
NHS Foundation Trust

NICU Safeguarding Update

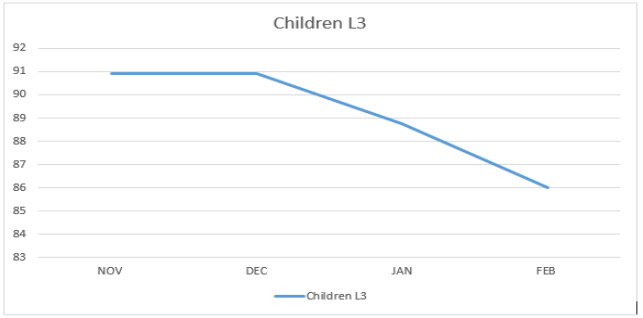
Data through to March 2024

Patient FIRST

SIOR - Patients

Successful Deliverables

- 9 inpatients with safeguarding concerns (FEB)
- Safe guarding Level 3 staff statman compliance 86%
- Embedded NIC handover



Next Steps

SG L3 compliance:
Nov 90.91%
Dec 90.91%
Jan 88.76%
Feb 86%

Identified Challenges

- **Available courses – Now only classroom learning**
- Improved communication between NICUs within the Network is required to ensure seamless transfers of care
- To improve communication between Out of Area Hospitals/Outreach Teams

Next Steps

- Work with BadgerNet Leads to move all NICU Safeguarding documentation to BadgerNet so it will be paperless, and will then be more visual to all NICU staff for information sharing
- Online handover sheet to be created, safety netting handover process

Opportunities

- New staff supported to complete mandatory training during their supernumery induction period
- Weekly meetings are face to face, ensuring positive information sharing
- Add safeguarding documentation to BadgerNet

Next Steps

- Continue to work closely with the multi professional team.
- Continue to support team to complete training
- Organise with BadgerNet leads to implement new area for documentation

Risks

- Reduced compliance since online course was removed
- Gaps in sharing of information regarding maternal mental health and safeguarding between units.
- Missed information, as currently hybrid style of paper and BadgerNet - Working with BadgerNet to get this added to the system, online handover sheet required
- Information being missed at NIC shift handover

Next Steps

- Encourage staff to book into classroom training sessions and plan learning before competency expires
- Transfer all safeguarding documentation on BadgerNet EPR
- Online handover sheet created – now embedded in practice

Maternity (and perinatal) Incentive Scheme – Year 6

Executive Summary

- Maternity (and perinatal) Incentive Scheme Year 6 published on 2 April 2024.
- 10 Safety Actions remain broadly unchanged.
- Reporting period for Safety Actions 2-7 and 9, 2 April 2024-30 November 2024
- Reporting period for Safety Actions 1, 8 and 10 continue from year 5, therefore reporting period is December 2023 to November 2024.
- Submission to NHSR due 3 March 2025.
- Focus on Board Oversight and assurance remains key across all Safety Actions.
- NHSR have provided an audit tool to support with compliance.
- Compliance Manager working with colleagues across LMNS to review guidance and agree assurance process.
- Local review with senior team and Safety Action leads due to take place in April and timeline for reporting and actions to be agreed.

Maternity (and Perinatal) Incentive Scheme – Year 6

Ambition: To deliver safe and effective Maternity and Perinatal Care.
Goal: To achieve compliance with all 10 Safety Actions for the Maternity and Perinatal Incentive Scheme – Year 6

Medway NHS Foundation Trust

Key Messages:

- Year 6 Maternity and Perinatal Incentive Scheme (CNST) published 2 April 2024.
- Reporting period runs from December 2023 for Safety Actions 1, 8 and 10, and from April 2024 for the remaining Safety Actions. The Reporting period closes on 30 November 2024 with submission to NHSR due on 3 March 2025.
- Trust Board Oversight remains key to the requirements across all Safety Actions.
- All evidence for CNST Year 5 remains on shared drive which is able to be accessed by the Executive Team. It is also stored on the NHS Futures platform. This will continue to for CNST Year 6.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

- ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
- ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.
- ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

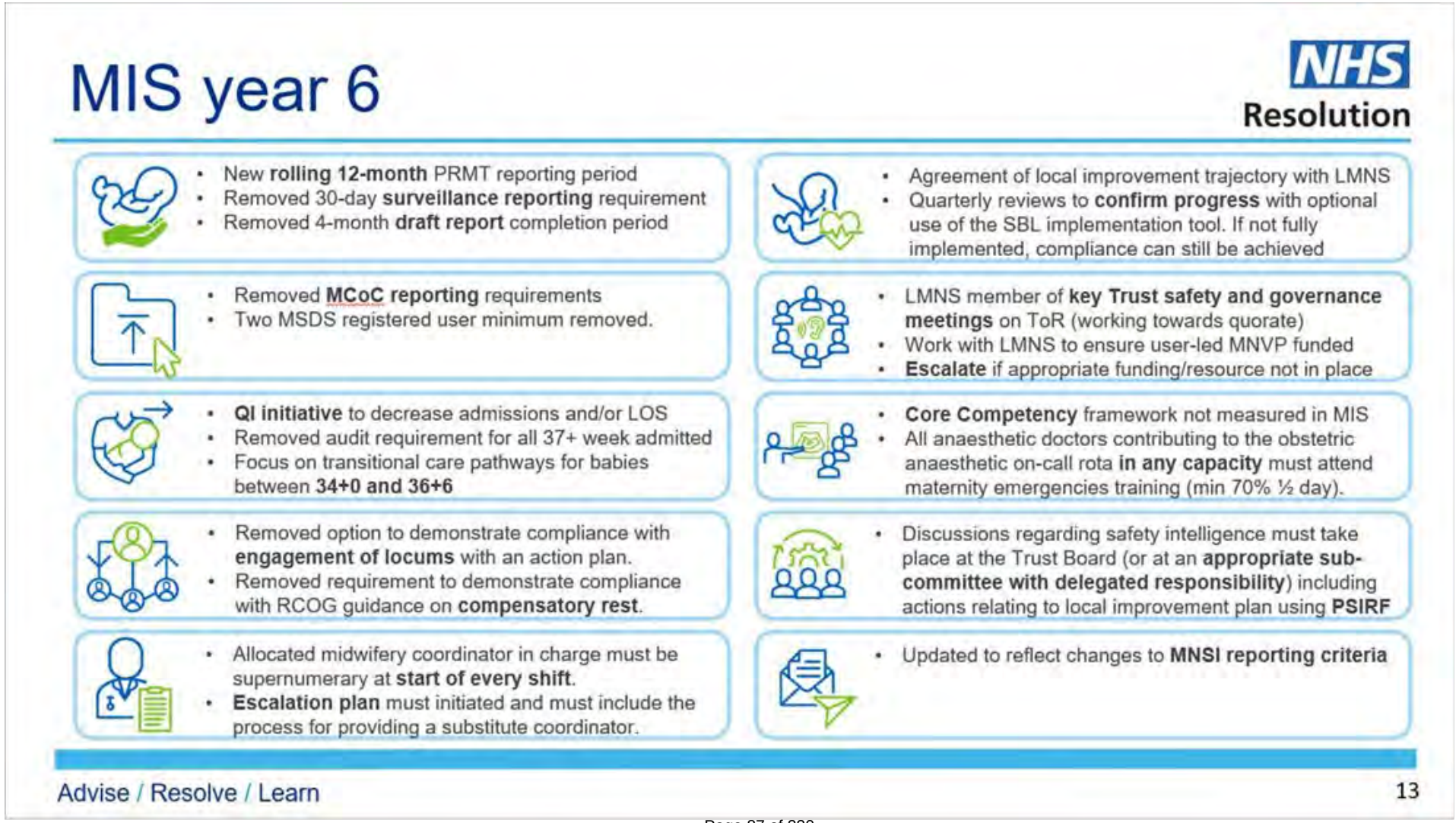
Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Maternity (and Perinatal) Incentive Scheme – Year 6

Ambition: To deliver safe and effective Maternity and Perinatal Care.
Goal: To achieve compliance with all 10 Safety Actions for the Maternity and Perinatal Incentive Scheme – Year 6

NHS Medway NHS Foundation Trust



Next Steps:

- Work with LMNS to review Year 6 guidance and ensure consistent approach to evidence across Trusts within LMNS.
- Engage in LMNS peer assurance process.
- Ensure reporting schedule meets requirements of Year 6 guidance.
- Meet with Safety Action Leads to agree actions, reporting and dates for evidence submission.
- Continue with monthly reporting to MNSCAB, Care Group Board and onwards to QPSCC, QAC, Trust Board and LMNS meetings as required.

Perinatal Surveillance Next Steps

- Continue to monitor all action plans via Maternity BAF. Full BAF report to be presented to MNSCAB in March 2024 meeting
- Continue to share key perinatal surveillance information with Trust Board and the K&M LMNS for oversight and to maintain compliance with national requirements including CNST and 3 Year Delivery Plan.

Meeting of the Public Trust Board
15 May 2024

Title of Report	**Maternity Claims, Incidents and Complaints Triangulation Report**		**Agenda Item**	5.3
Author	Ali Herron, Director of Midwifery			
Lead Executive Director	Sarah Vaux, Interim Chief Nurse			
Executive Summary	Review of claims scorecard for past 10 years alongside current incidents and complaints, key highlights: a) 55 Claims from 2013-23 b) 15 SIS/PSIRF investigations from Dec 22 to March 2024 c) Outcomes of claims and incidents reviewed. d) Increased numbers of HIEs noted in Q4 incidents however no thematic or root cause correlations. Continue to monitor.			
Proposal and/or key recommendation:	Approve for onwards reporting to Trust Board to meet requirements of CNST year 6			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Committee/Group submitted:	Maternity and Neonatal Safety Champion Assurance Board – 12.04.24 QPSSC – 25.04.24 QAC – 02.05.24			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X

Identified Risks, issues and mitigations:	N/A
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	Yes

Legal and Regulatory implications:	Compliance with CNST Year 6		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Maternity Claims Scorecard: Thematic Review 2023

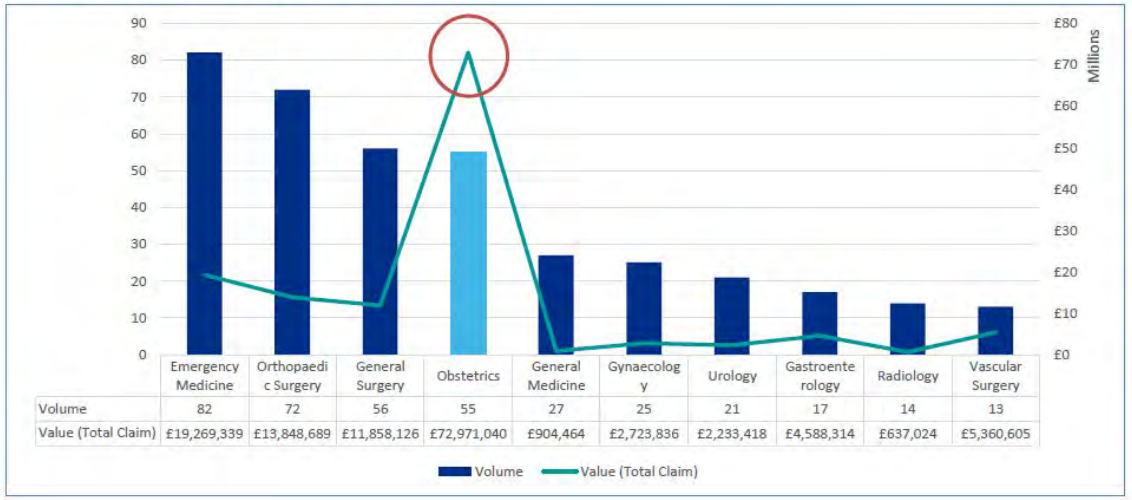
Ali Herron

Director of Midwifery

Overview

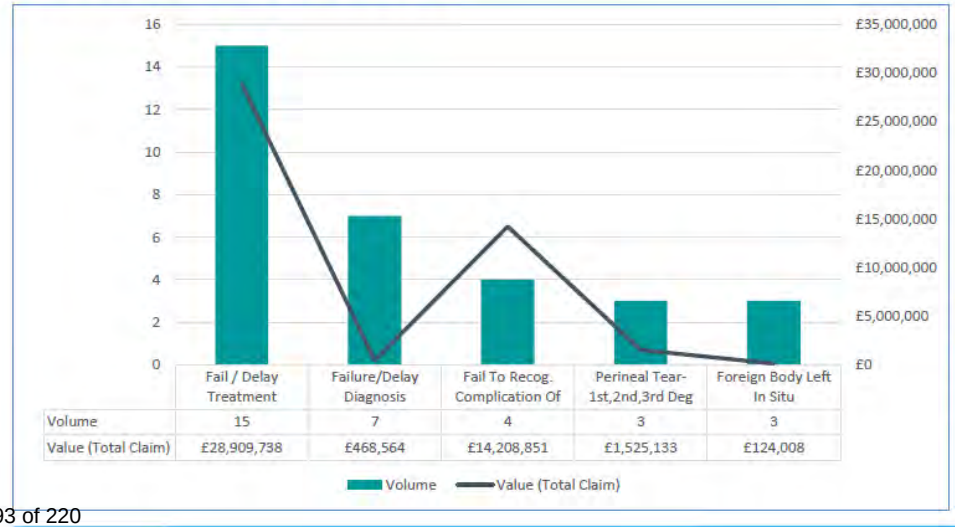
- NHSR Claims scorecard published annually in September with data for the previous 10 years.
- MFT have had 55 Obstetric claims in the 10 year period from 2013/14 to 2022/23.
- Of these claims, 11 are currently open with 1 incident ongoing. 43 have been closed, 20 of which have been settled with damages.
- CNST Year 5 and 6 requires Trust Boards to have a quarterly oversight of obstetric claims data triangulated with data from incidents and complaints.
- This report reviews the NHSR Claims scorecard along with incidents and complaints from 2023 to provide thematic analysis and identify areas for improvement and areas where improvements have been made following past incidents and claims.
- Nationally, obstetrics account for 13% of all claims (volume) and 64% of the value of all claims paid.
- At MFT, Obstetrics account for 12% of claims volume and 41% of claims value.
- The highest volume and value of obstetric claims for MFT relate to failed or delayed treatment including retained placenta/membranes and cases of shoulder dystocia.

MFT – Top 10 specialisms by volume & value 2013/14 to 2022/23



	Emergency Medicine	Orthopaedic Surgery	General Surgery	Obstetrics	General Medicine	Gynaecology	Urology	Gastroenterology	Radiology	Vascular Surgery
Volume	82	72	56	55	27	25	21	17	14	13
Value (Total Claim)	£19,269,339	£13,848,689	£11,858,126	£72,971,040	£904,464	£2,723,836	£2,233,418	£4,588,314	£637,024	£5,360,605

MFT – Top 5 Obstetrics cause codes 2013/14 to 2022/23



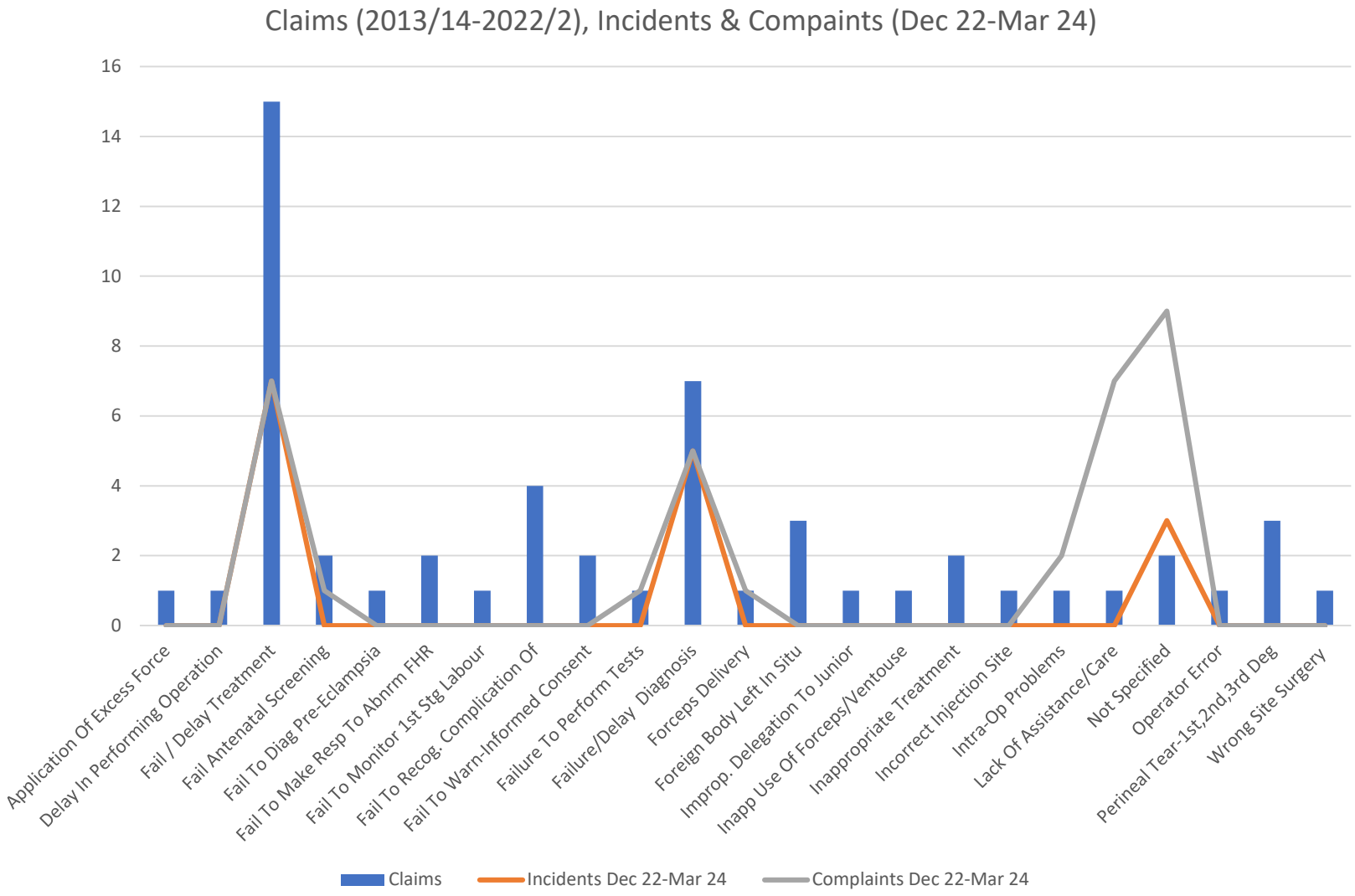
	Fail / Delay Treatment	Failure/Delay Diagnosis	Fail To Recog. Complication Of	Perineal Tear-1st,2nd,3rd Deg	Foreign Body Left In Situ
Volume	15	7	4	3	3
Value (Total Claim)	£28,909,738	£468,564	£14,208,851	£1,525,133	£124,008

Repeated claims

Fail/Delay treatment:
- Retained Placenta and /or membranes
- Shoulder Dystocia.

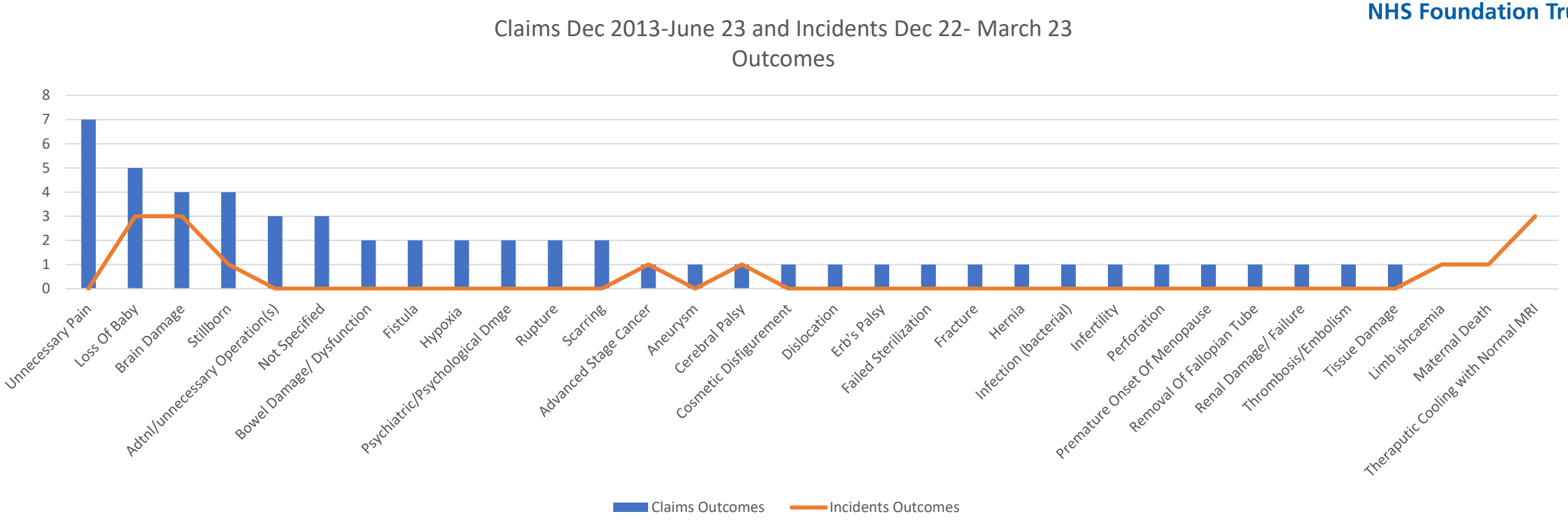
Failure/Delay Diagnosis:
- Stillbirth
- Ectopic.

Incidents & Complaints



- 15 Serious incidents/After Action Reviews (1) and MNSI referrals between December 2022 and March 2024..
- 7 cases related to failure/delay in treatment and 5 related to failure/delay in diagnosis (failure to recognise deterioration).
- 1 case was escalated due to family concerns and listed as not-specified.
- Incidents for Dec 22 to December 23 are in line with highest causes for claims in past 10 years.
- 9 out of 15 incidents related to babies requiring additional care after birth including admission to Neonatal Unit and therapeutic cooling.
- 3 incidents coded as not specified as do not meet any of the claims criteria.
- No new complaints received since last report.

Claims Injuries/Outcomes



- Review of claimed injury/outcome from claims scorecard along with outcomes from the 15 MSNI/SIs from December 2022-March 2024 reveal a correlation in outcomes.
- Due to MNSI referral process, babies who require therapeutic cooling but have a good prognosis on MRI account for 3 of the incidents in the period.

Findings

- Reviewing the repeated claims of shoulder dystocia and retained placenta/membranes identified on the scorecard it is reassuring that there have been no complaints or incidents relating to either of these in the period Dec 22- March 24.
- There is a robust process in place to review all stillbirths, unexpected neonatal admissions, including those admitted due to HIE requiring cooling, and neonatal deaths (MNSI, PMRT)
- Increased trend of HIEs, with 3 noted in Q4, however all cases reviewed and no common causations or themes. All referred to MSNI with one case rejected as un-booked pregnancy and no care concerns identified once mother attended hospital. Continue to monitor for themes and trends.

Next steps

- Annual report from Fetal Wellbeing Midwives to review all HIEs to identify any learning or themes across all cases.
- Incidents and Action logs now collate data on all incidents, including PMRT, MSNI and PSIRF investigations. These have been coded against PSIRF themes and local themes to support the early identification of themes and trends across all incidents.
- Key actions to be grouped thematically and incorporated into BAF.
- Continue with quarterly reporting to MNSCAB, QPSCC, QAC and Trust Board in line with CNST Year 6 requirements.

Meeting of the Trust Board
Wednesday, 08 May 2024

Title of Report	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy**		**Agenda Item**	5.4
Author	Brian Williams - Head of Emergency Preparedness, Resilience and Response			
Lead Executive Director	Nick Sinclair – Chief Operating Officer			
Executive Summary	This Policy ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). This enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.			
Proposal and/or key recommendation:	Review and approval.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	X
	Noting		Discussion	
Committee/Group submitted:	EPRR Group – 22.02.24 Senior Ops - 22/02/24 Approved			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
					x
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe:	Effective:	Caring:	Responsive:	Well-Led:
				x	

Identified Risks, issues and mitigations:	Adherence to The NHS England EPRR Framework (2022) NHS England Business continuity management framework in alignment with ISO 22301 Civil Contingencies Act 2004
Resource implications:	N/A – Existing policy.
Sustainability and /or Public and patient engagement considerations:	This policy is in alignment with the Trust Sustainability plan in support of managing Adverse and severe weather.

Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	The NHS England EPRR Framework (2022) NHS England business continuity management framework (2013) in alignment with ISO 22301 Civil Contingencies Act 2004 NHS Act 2006 Health and Care Act 2022, NHS standard contract NHS Core Standards for EPRR (annual assurance)		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Brian Williams Job Title: Head of EPRR Email: brian.williams4@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	X	No assurance required.

Medway NHS Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

Policy Reference Number:	COPS-EPR-POL-1
Version Number:	10
Approving Committee/Group	Trust Board
Department / Category	Emergency Preparedness, Resilience and Response
Accountable Executive Lead	Accountable Emergency Officer
Name of Author	Head of Emergency Preparedness, Resilience and Response
Brief Outline of This Policy and Standard Operating Procedure	This Policy ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). This enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery.
Date Approved	30 June 2023
Approved By	Trust Board & Senior Ops Group
Date Ratified	30 June 2023
Ratified By	Trust Board
Published Date	30 June 2026

Medway Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

(made live for use)	
Review Date	4 July 2026
Target Audience	All staff

Key Principles of This Policy	
1.	To prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario
2.	To have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios
3.	To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience
4.	To ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities.

This policy has been reviewed and is compliant with the most up to date Code of Practice and NICE Guidelines	
Title of Code of Practice	**NICE Reference Number (s)**
N/A	N/A

Document Control/History List			
Version No	**Date**	**Author**	**Reason and Summary of Change**
1.0	June 2014	Head of Emergency Preparedness, Resilience and Response	Detail the arrangements of the Trust in relation to the Local Health Resilience Partnership (LHRP) and Kent Resilience Forum (KRF).
2.0	March 2016	Head of Emergency Preparedness, Resilience and Response	Reference to include National Risk Register 2014
3.0	October 2016	Head of Emergency Preparedness, Resilience and Response	Change of Organisational leads.

4.0	September 2017	Head of Emergency Preparedness, Resilience and Response	Streamlined into Corporate Trust Policy for Board approval. Responsibilities of the Board and EPRR Group added. References to supporting documents added.
5.0	November 2017		Change of author, owner, Accountable Executive and update of Trust Logo
6.0	June 2018		Role and Responsibility of Non-Executive Director with EPRR Portfolio Trust Annual Report requirement
7.0	September 2019		Revision of terminology in line with the NHS England EPRR Standards and update of roles in place. Critical Plan referenced superseding the Significant Incident Plan, Structure
8.0	July 2020		Combination of EPRR and Business Continuity Policy into one document
9.0	October 2022		Update to the structure of EPRR responsibilities Section 4.1 update Board responsibilities to; *Ensuring they review annually and are satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its duties*
9.1	September 2022		Complete sections review and update of content throughout. Updated EPRR staffing and governance structure and full content alignment to the updated EPRR Framework (2022). Includes reference to new NHS Minimum Occupation Standards and Trust Business Continuity Management System Framework (2022).
9.2	April 2023		Change to organisation structure diagram. Review of content throughout. No additional changes made.
10	June 2023	Head of Emergency Preparedness, Resilience and Response	Transfer over to current Trust template

Medway Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

POLICY ON A PAGE

1. Why do we need this Policy
Medway Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.

2. What do I need to know	3. Quality Standards
Medway Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.	Civil Contingencies Act 2004, NHS Act 2006 Health and Care Act 2022, NHS standard contract NHS Core Standards for EPRR (annual assurance) The NHS England EPRR Framework (2022) NHS England business continuity management framework (2013) in alignment with ISO 22301.
4. Understanding the Process	**5. Contact**
To prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario To have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience To ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities.	Head of Emergency Preparedness, Resilience & Response 01634 825275 brian.williams4@nhs.net

Table of Contents

POLICY SECTION

1. Introduction

Medway Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.

2. Policy Purpose

This Policy ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). In alignment with the legislations, policies and frameworks described in section 3.0, this enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery.

3. Policy Statement

EPRR supports the Trust Business and Strategy objectives by ensuring the continuous improvement and rolling programme of EPRR, to achieve organisational resilience and annual compliance with the 64 NHS EPRR core standards for Acute Trusts. The EPRR function is promulgated throughout the Trust by the EPRR team, who promote and the Trust's EPRR group to collaboratively develop and deliver a programme of Training and Exercising to ensure staff are familiar with EPRR best practice, internal response plans and resilience arrangements and know who to approach for tactical advice to support an effective response to an emergency or disruptive event, when required.

4. Related Policies

- Mass Casualty Incident Plan
- Chemical, Biological, Radiological and Nuclear Explosion (CBRNe) Plan
- MFT Incident Response Plan

5. Glossary of Terms

Under section 1(1) of the CCA 2004 an 'emergency' is defined as:
"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom; (b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; or (c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

Emergency preparedness: The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

Resilience: Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

Response: Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery.

Incidents: For the NHS, incidents are defined as:
Business Continuity Incident – an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Critical Incident – any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Major Incident – The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder. In the NHS, this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

6. References

- The NHS England EPRR Framework (2022) NHS England business continuity management framework (2013) in alignment with ISO 22301
- Civil Contingencies Act 2004
- NHS Act 2006
- Health and Care Act 2022, NHS standard contract
- NHS Core Standards for EPRR (annual assurance)

7. Roles and Responsibilities

Trust Board

Whilst it is recognised that EPRR is a collective board level responsibility, a number of Non-Executive Directors bring skills and experience in crisis and incident management. Where this is the case, additional support to the AEO from a suitably experienced NED is recommended. This will be a decision for local Chairs and Chief Executive Officers (CEOs), in addition to:

- Approving the Trust's Corporate Policy for EPRR and Business Continuity.
- Reviewing and approving the annual reports to the Board, on Trust compliance with the NHS England EPRR Core standards and overview of EPRR annual activity.
- Understanding the statutory EPRR framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.
- Supporting the delegated responsibility of Strategic Command and Control during an incident, that requires such structures to be implemented.
- Ensuring that the organisation has sufficient and appropriate resource, to effectively discharge its EPRR duties

Chief Executive

NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. Chief executives will be able to delegate this responsibility to a named director.

- Responsible for designating the responsibility of EPRR as a core part of the organisation's governance and operational delivery programmes
- Is aware of the factors within the organisation which could negatively impact on public protection within their health community as a result of a major incident
- Is aware of the Trust's legal duty to respond to and recover from a major incident, in parallel with continuing patient services
- Responsible for nominating an Accountable Emergency Officer

Accountable Emergency Officer

The Chief Operating Officer is the designated Executive for EPRR and often the delegated Accountable Emergency Officer who can delegate responsibilities below, to a deputy:

- Ensure the Trust has appropriate resources committed and funds available to the EPRR Function
- Plans and policies are in place to fulfil the requirements of the statutory framework
- Commitment from Senior Leadership towards their staff engagement with the programme of EPRR work
- Ensure the organisation is properly prepared and resourced to respond to a major incident
- Attend the Local Health Resilience Partnership Executive Group (no less than 75% of meetings)
- Provide EPRR reports to the Board no less frequently than annually and as a minimum, include an overview on;
    - Training and exercising undertaken by the organisation
    - High level EPRR risks and mitigations
    - Summary of any business continuity, critical incidents and major incidents

- Summary of lessons identified from Incidents and exercises
- The organisation's compliance position in relation to the latest NHS England EPRR Assurance process

Emergency Preparedness Resilience and Response Manager

- Ensure the Trust EPRR and Business Continuity Policy is effectively delivered in liaison and engagement with all relevant staff across the Trust
- Ensure all relevant response and resilience plans aligned to the EPRR Core standards and local risks, are developed in accordance to national and local guidance; are tested and accessible to staff
- Develop an annual EPRR Work Plan which is fully aligned with the NHS EPRR Core standards, the Trusts' Business strategy and is agreed by the Trust Board. The work plan will address: Training and exercise requirements for all staff, 'lessons learnt' process from incidents and exercises, Identification of risks to inform plan mitigations, Business Continuity Management in accordance with the Trust's Business Continuity Management System Framework (2022) and Identify outcomes of assurance and audit processes. The work plan must consider the LHRP and LRF work plans as appropriate.
- Mentor and provide leadership to staff in the EPRR team and support their personal development in delivering elements of the EPRR work plan.
- Represent the Trust at local resilience sub and partnership groups related to EPRR and the LRF, to input into the development of response plans, training and exercising
- Support the Accountable Emergency Officer in providing regular assurance to the Trust Board regarding the delivery of the EPRR work programme, aligned to the NHS EPRR Core Standards.
- Ensure the EPRR function, including all Training and Exercising, is delivered to a high standard, aligned with local risk registers and Minimum Occupational Standards for EPRR (england.nhs.uk) objectively to achieve organisational resilience.
- Provide regular training sessions for On Call staff to ensure resilience out of hours including access to personal log books, a contacts directory for internal and external stakeholders in an emergency and a list of trained Loggists to be called upon.

Divisional Directors, General Managers, Service leads and Heads of Department (Clinical and non-clinical)

- Commit to attending the EPRR group meetings to understand the engagement required from staff across each of the divisions and departments, with the EPRR team to achieve the annual work plan and programme of continuous improvement via Lessons Identified.
- Regularly input into the EPRR group to highlight risks and issues to continuity of service and organisational resilience and work collaboratively to mitigate these.
- Ensure that Business Impact assessments and business continuity plans are in place, have appropriate ownership in departments, are up to date and accessible
- Release staff to undertake Training and Exercises to develop and test EPRR Plans and for personal development, in compliance with the Trust EPRR Training needs analysis.
- Directors, General Managers and Heads of Department who are aligned to the Trust On Call rotas will comply with the agreed EPRR training programme for On Call staff, ensuring an up to date EPRR portfolio is kept and training attendance is recorded.
- Ensure that when 'On Call', they are accessible and are fit to carry out their duties at all times and have access to the required equipment, information and policies on ResilienceDirect and the staff intranet, including the Trust On Call protocol for SMoC and DoC staff.

On Call EPRR Duties – Senior Managers and Directors

In response to an emergency incident, which requires activation of an emergency plan, the Incident Coordination Centre and/or the command and control structure out of hours, the Senior Manager on Call and Director on call have a duty to assume the relative command positions. The SMoC will assume the role of the Tactical Commander and the DoC will assume the Strategic Commander. This policy permits those staff who have undertaken the Trust EPRR Incident Command Training module, the authority to act outside of their normal scope of duties in direct response to an evolving incident, in order to preserve life, ensure the safety and security of patients, staff and visitors, in keeping with the Trust's vision and values.

Communications Teams

The Communications Team are responsible for regularly attending the EPRR Group, developing Incident Communication plans, being aware of the internal and external Incident alerting process and warning and informing civil protection duties under the CCA 2004.

Trust Communications staff will sit within Strategic and Tactical Command during an incident and ensure effective and timely communications to staff, patients, visitors and external stakeholders as appropriate.

ICT

The Head of IT will ensure that there is an effective Disaster Recovery Plan (Covering loss of physical assets and recovery with a recovery time objective), reviewed annually and is made available to staff in the Trust for awareness.

Ensure the Trust can demonstrate its resilience to Cyber Security threats with a Cyber resilience and response plan which is compliant with the Data protection and security toolkit and Kent LHRP Cyber Security standards, annually.

Estates and Facilities

All teams within this department will ensure the organisation has appropriate resilience plans, processes and resources in place to ensure continuity of utilities and accommodation provision for all areas of the Trust to operate safely.

8. Process for Monitoring Compliance and Effectiveness

All relevant response and resilience plans aligned to the EPRR Core standards and local risks are developed in accordance to national and local guidance; are tested and accessible to staff.

Provide EPRR reports to the Board no less frequently than annually and as a minimum, include an overview on;

- Training and exercising undertaken by the organisation
- High level EPRR risks and mitigations
- Summary of any business continuity, critical incidents and major incidents

- Summary of lessons identified from Incidents and exercises
- The organisation's compliance position in relation to the latest NHS England EPRR Assurance process

The lessons identified from debriefing activities are vital to improving the way we respond to incidents. Inquests and inquiries focus heavily on previous lessons and responder organisations must be able to prove they have identified and shared learning to try to prevent future similar issues.

9. Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
EPRR Risk Register	EPRR Group – each meeting	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
EPRR and Business Continuity Policy review	Annually	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
Trust compliance with EPRR Core standards and overview of EPRR activity during the year	EPRR Group - Annually	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
EPRR work plan	EPRR Group – twice yearly	EPRR Manager	AEO, RCAG, Risk and Audit	

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
			Committee, Trust Board	
Lessons Identified (from exercises and/or incidents)	EPRR Group – each meeting	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	

10. Equality Impact Assessment Statement and Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”. This is most easily achieved through an Equality Impact Assessment.

When developing or revising policies, programmes, projects, strategic decisions, the person responsible for that work and associated decisions must record and publish their assessment of impact against the protected characteristics, and the public sector equality duty, as described in the Equality Act 2010. They must also put in place systems to monitor and review those impacts.

Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment.

The following Equality Impact Assessment Screening Tool is designed to help identify the key issues for each protected characteristic and element of the Public Sector Equality Duty. This is not the impact assessment, simply a tool to help identify potential impacts.

11. Completed Equality Impact Assessment Statement and Tool

Is there any evidence that some groups are affected differently? (use the screening below)					
Protected Characteristic	Could there be an adverse impact? Yes/No/ Unknown	Relevance None/Low/ Medium/High	Proportionality (likelihood of risk/impact)		Notes
			None/Low/ Med/High	+ve / -ve	
Age	NO	None	None		
Disability	NO	None	None		
Gender / Sex	NO	None	None		
Gender Identity	NO	None	None		
Race	NO	None	None		
Religion/Belief	NO	None	None		
Sexual Orientation	NO	None	None		
Pregnancy & Maternity	NO	None	None		
Marriage / Civil Partnership	NO	None	None		

Questions		
1	Does the proposal …	
a	• promote equality of opportunity?	N/A
b	• eliminate unlawful discrimination?	N/A
c	• good community relations?	N/A
d	• amount to illegal discrimination?	N/A
e	• create an inequality?	N/A
2	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? Is the impact of the case likely to be negative and if so can the impact be mitigated? Can we reduce the impact by taking different action: what alternatives are there to achieving the aim?	N/A

Meeting of the Trust Board in Public
Wednesday, 15 May 2024

Title of Report	Finance Report – Month 12 - 2023/24			**Agenda Item**	5.5
Author	Alan Davies, Chief Finance Officer Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director Income & Contracts Isla Fraser, Financial Controller				
Lead Executive Director	Alan Davies – Chief Finance Officer				
Executive Summary	a) The Trust reports a £19.9m deficit YTD, this being £19.7m adverse to the revised plan. b) The reported position of £19.9m deficit reduces to £19.7m after adjusting for donated assets, this being an in-month improvement of £0.3m c) The Trust delivered the month 7 forecast position of £19.7m as agreed by the Executive Team with the ICB. d) Efficiency delivery to date includes £11.9m of budget out schemes, and a further £1.9m of run-rate reductions, and £2.7m of cost avoidance schemes, reporting the total efficiency delivery of £16.5m YTD. In addition to this there is a further £2.8m for capture and coding work to increase income. e) The final capital position breakeven as schemes were prioritised to utilise all funding available. f) Cash is £8.5m adverse to plan due to the unplanned deficit position.				
Proposal and/or key recommendation:	The committee is asked to note this report.				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval		
	Noting	✓	Discussion		
Committee/Group submitted:	Meeting: Finance, Planning and Performance Committee Date: 25 April 2024				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	Non-delivery of breakeven and/or control total				
Resource implications:	N/A				

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	Achieving breakeven is a statutory duty		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alan Davies Job Title: Chief Finance Officer Email: alan.davies13@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	X	No assurance required.

Finance report

For the period ending 31 March 2024

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	289	1,622	1,333	The Trust is reporting a £1.6m surplus for March, this includes £1.3m of the £15m deficit support funding. The final reported position for the year is a £19.9m deficit, this reduces to £19.7m after adjusting for donated assets, this being an in-month improvement of £0.3m. The in-month surplus is supported by non-recurrent mitigations being released into the position, as well as ERF income over performance £0.6m. The following table summarises the main factors in achieving an in-month surplus.
Donated Asset Depreciation	22	(93)	(116)	
In-month total	**311**	**1,529**	**1,217**	
YTD total (adjusted)	**120**	**(19,656)**	**(19,777)**	

	£m
Average monthly run-rate	(4.0)
ERF over performance	0.6
Other income increases	1.6
Accruals	1.4
Revenue to capital transfers	0.7
Rostering controls	0.1
Depreciation & dividend increases	(0.5)
Stock adjustments	0.4
Total surplus	**0.3**

The final adverse expenditure variances to budget continue to be due to overspending on medical staff (£19.5m), nursing staff (£9.3m) as well as the unfound efficiencies to date (£10.5m); this is partially offset by the remaining Central reserves. £10.5m of the medical staff adverse variance relates to non-operational issues including industrial action (£5.0m), unidentified stretch efficiency target (£6.2m) and pay award under funding (£1.4m).

Efficiencies Programme				
In-month	2,744	2,199	(545)	The delivered efficiency programme totals £2.3m for March, this includes cost avoidance schemes for patient flow length of stay £0.3m and MRI recharge £0.3m, as well as run-rate reduction schemes of £0.4m. The remaining £1.2m is delivered from budget reduction schemes, mainly Medicines Management £0.2m, Theatres optimisation £0.3m, Service Redesign £0.3m, and procurement £0.1m. The final position reported adverse to plan, predominantly due to the stretch target not being identified/delivered, the £19.3m includes £2.8m capture and counting income scheme
YTD	27,000	19,316	(7,684)	

1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	29,537	21,042	(8,495)	The Trust cash balance is lower than plan due to the unplanned deficit position, albeit that has been suppressed with the receipt of revenue support. Based on current plans cash reserves will be sufficient to operate until Month 2 of 2024/25. A PDC revenue support application has been submitted to NHSE to access additional cash. Due to pressures to produce the annual accounts, the usual updated cash detail in the report is not available at the time of writing.
Capital				
YTD	30,312	30,310	(2)	The Trust has met its revised plan and delivered over £30m of capital schemes in year, of which £2m relate to leased assets. CDC brokerage of c£4.9m was eventually required and was utilised in-year against medical devices, IT equipment, other project overspends and revenue-to-capital transfers.
Of which are IFRS16 Leases	2,027	2,027	-	The Trust is validating the carry forward capital project commitments into 2024/25 and is prioritising known schemes to finalise the programme for the year.

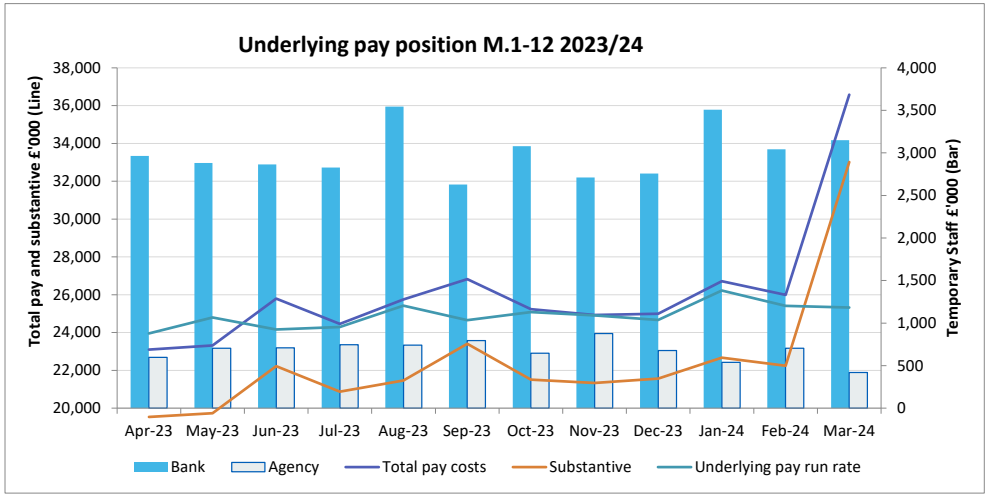
2. Income and expenditure

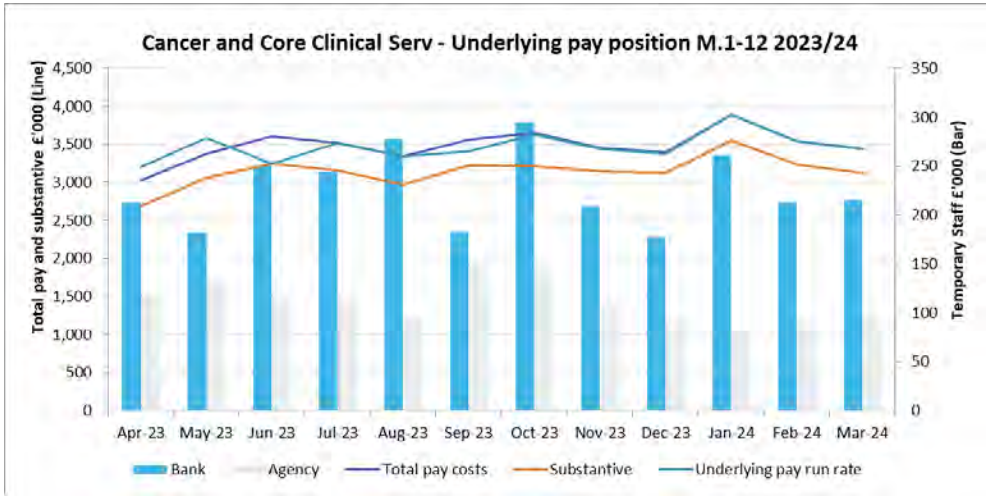
£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	31,531	34,407	2,877	378,378	395,402	17,025
High cost drugs	2,030	3,137	1,107	24,362	27,624	3,262
Other income	2,251	14,487	12,235	27,088	47,095	20,007
Donated Asset Adjustment	-	240	240	-	324	324
Total income	**35,812**	**52,271**	**16,459**	**429,828**	**470,446**	**40,618**
Nursing	(9,334)	(10,562)	(1,228)	(112,131)	(121,398)	(9,268)
Medical	(6,727)	(8,041)	(1,314)	(80,926)	(100,452)	(19,526)
Other	(5,962)	(17,977)	(12,015)	(72,591)	(91,841)	(19,250)
Total pay	**(22,022)**	**(36,579)**	**(14,557)**	**(265,648)**	**(313,692)**	**(48,044)**
Clinical supplies	(3,755)	(4,305)	(550)	(47,070)	(56,610)	(9,540)
Drugs	(855)	(1,047)	(191)	(10,513)	(13,203)	(2,690)
High cost drugs	(2,041)	(2,074)	(33)	(24,496)	(26,558)	(2,063)
Other	(4,726)	(4,100)	626	(56,770)	(54,219)	2,550
Total non-pay	**(11,377)**	**(11,526)**	**(149)**	**(138,848)**	**(150,591)**	**(11,743)**
EBITDA	**2,412**	**4,166**	**1,753**	**25,333**	**6,164**	**(19,169)**
Depreciation	(1,508)	(1,728)	(220)	(18,095)	(18,460)	(365)
Donated asset adjustment	(22)	119	141	(265)	(44)	221
Net finance income/(cost)	96	103	7	1,150	1,338	188
PDC dividend	(689)	(1,037)	(348)	(8,268)	(8,908)	(640)
Gain/Loss on Disposal	0	0	0	0	19	19
Non-operating exp.	**(2,123)**	**(2,543)**	**(420)**	**(25,478)**	**(26,054)**	**(576)**
Reported surplus/(deficit)	**289**	**1,622**	**1,333**	**(145)**	**(19,890)**	**(19,746)**
Adj. to control total	**22**	**(93)**	**(116)**	**265**	**234**	**(31)**
Control total	**311**	**1,529**	**1,217**	**120**	**(19,656)**	**(19,777)**

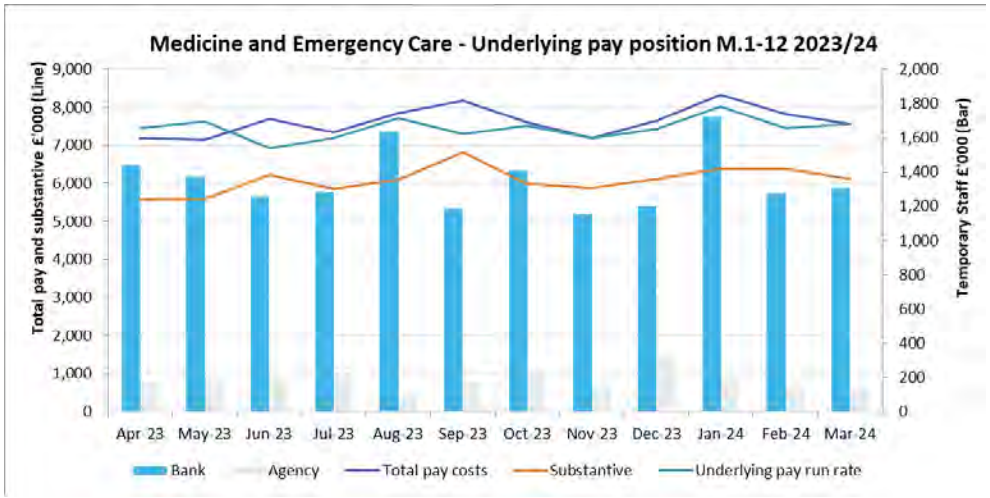
1. Actual clinical income reported position includes £15.0m deficit support funding, this reduces the overall plan to breakeven. The position includes the full value of CDC income, as well as a £5.3m overperformance of ERF activity and a further £4.0m of industrial action funding YTD. The cost to the independent sector and additional sessions to deliver ERF activity for the year is £6.5m.
2. Other income includes £10.9m in-month for the 6.3% pension contributions funded by NHSE; this is offset with costs in the other pay category. The main remaining favourable variances include medical education (£4.1m), nurse training and international recruitment (£1.6m), high cost devices (£1.2m), Amherst bed contract (£1.3m) offset with cost, maternity (£1.6m), and catering income (£0.3m).
3. Pay adverse variance £48.0m for the year includes £10.9m additional 6.3% pension costs offset with income, £8.2m efficiency stretch target, £6.3m unidentified efficiencies in Medicine & Emergency Care, £5.0m industrial action costs, £3.0m vacancy factor, £3.2m negative reserve and £1.7m enhanced care 1:1 nursing. The remaining variance is due to unfunded cost pressures mainly for escalation capacity, pressures in the Emergency Department and a reliance on temporary staff often at premium rates to cover to cover vacancies, and gaps in the rotas and staff absences.
4. To date, a benefit of £4.7m of the ERF non-pay reserve is offsetting some of the adverse variances from overspending and non-delivery of efficiencies.
5. Clinical supplies adverse variance includes £7.2m efficiency stretch target, £1.3m Amherst beds contract (offset with income), £0.2m medical equipment maintenance, £1.0m NKPS activity pressures, and £0.6m theatre supplies.
6. YTD drugs adverse variance includes £1.2m of insulin pump expenditure being offset by income. The remaining variance is driven by unfound efficiencies and activity.
7. Other non-pay in month position includes £1.0m central reserves offsetting some of the unfound efficiencies.

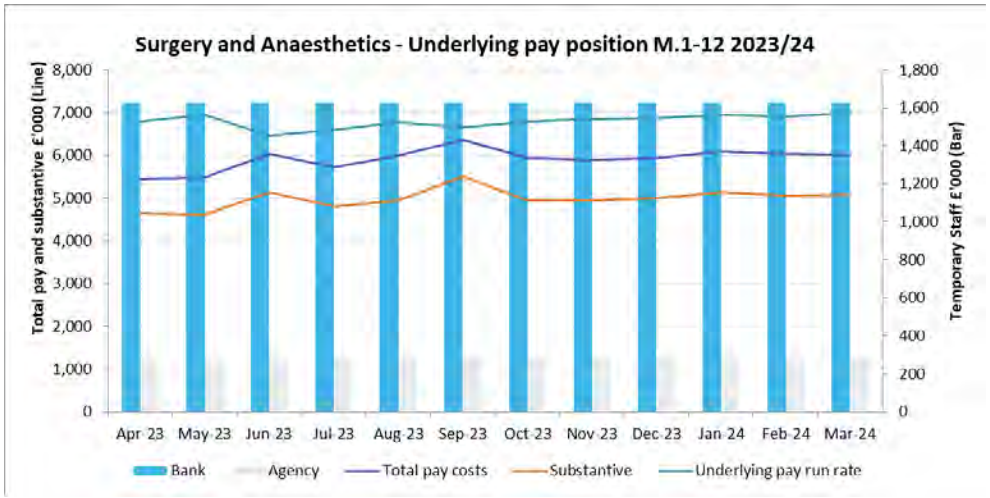
3. Pay

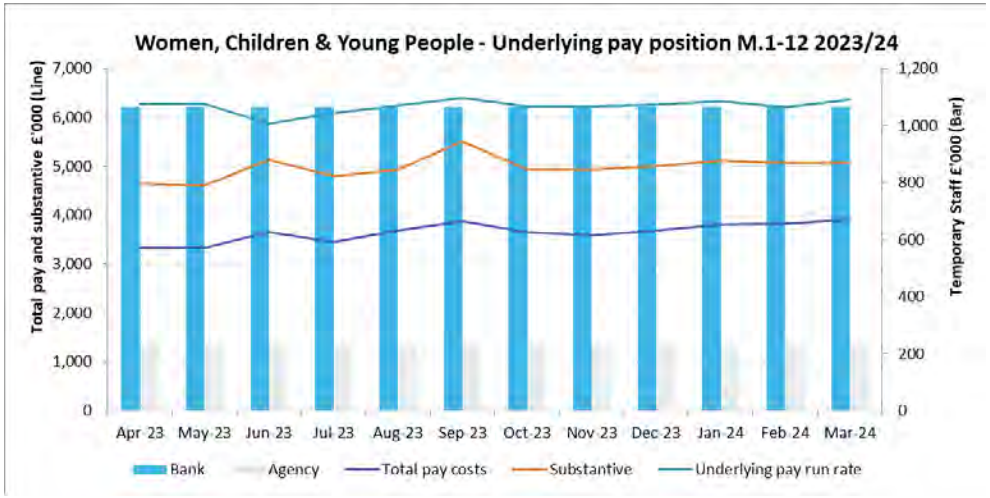
The final pay overspending for the year is £48.0m, this reduces to £37.1m after adjusting for the £10.9m of 6.3% pension increase for which funding is received. Pay remains the leading cause of the Trust's adverse financial performance, the medical and nursing pay budgets accounts for £29.0m of the overspend with a further £8.1m within the remaining other staff category. The charts below present the underlying pay expenditure position by division after removing non-recurrent items and phasing the back dated pay awards over the months to which the costs relate. The charts represent the run-rate and therefore do not include any impact from the unfound efficiency targets. The overall underlying pay position has improved in March by £0.3m mainly due to a decrease in additional sessions and temporary staff. Reliance on bank staff usage due to activity pressures continues, mainly in in Acute, Emergency Department and Frailty, as well as supernumerary and maternity cover.

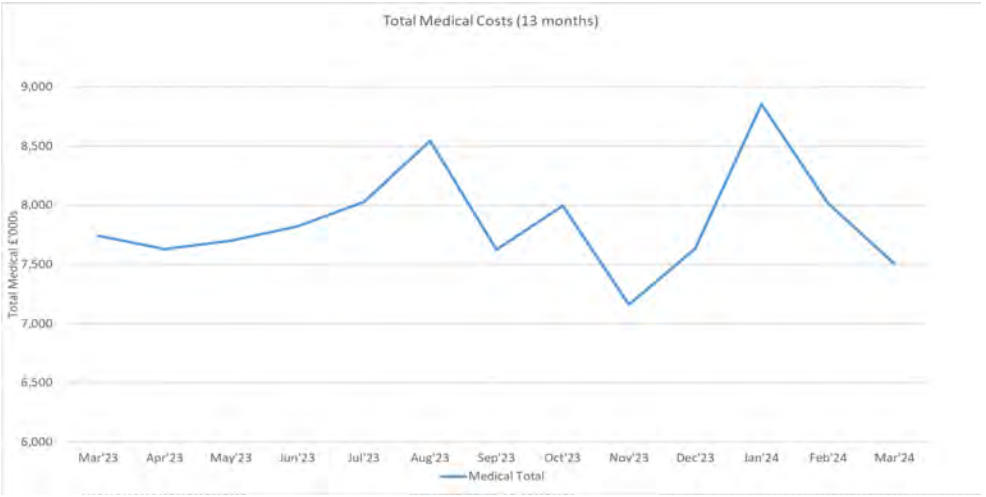


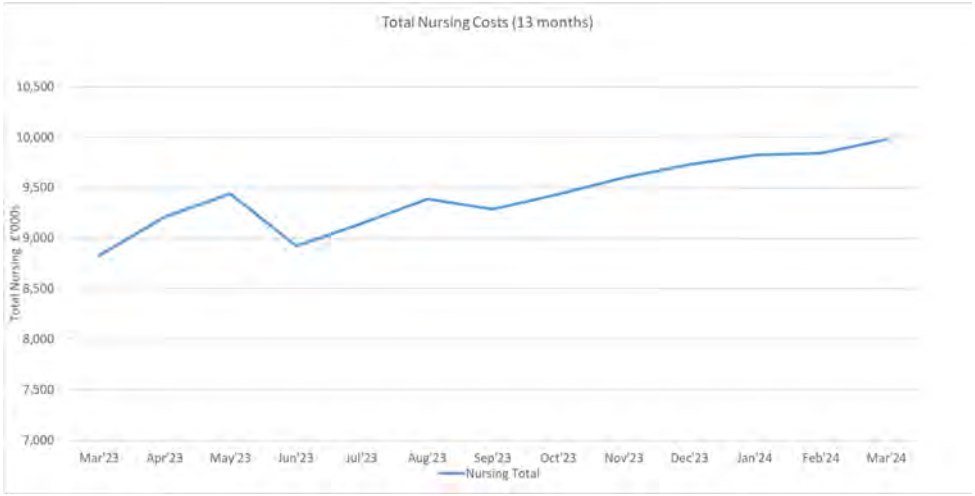












After phasing the backdated pay award over the financial year, the trend chart above shows medical staffing costs are reacting to the number of industrial action days in the month; there is a decrease in February which follows an increase in January from December, there was no action in March. Nursing costs include the impact of escalation capacity remaining open; the other drivers of nursing staff costs include supernumerary costs, maternity leave cover, premium costs of temporary staff as well as enhanced care and activity pressures. The impact of the 6.3% pension increase as well as any adjustments through reserves is excluded from the charts.

4. Clinical Income

Clinical Income by Commissioner	In Month Movement			YTD Month 12		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
NHS Kent and Medway ICB						
Fixed Income	21,048	21,220	172	252,378	259,613	7,235
ERF - Variable Income	2,719	3,121	401	66,379	71,227	4,848
Non-ERF Variable Income	5,382	5,458	76	31,037	32,153	1,116
Other…	-	-	-	-	30	30
Sub-Total	**29,149**	**29,798**	**649**	**349,793**	**363,023**	**13,229**
NHS England						
Fixed Income	1,953	1,864	(88)	24,592	23,801	(790)
ERF - Variable Income	444	682	239	5,178	5,580	402
Non-ERF Variable Income	1,503	2,973	1,470	17,025	19,483	2,457
Other…	-	179	179	-	1,123	1,123
Sub-Total	**3,900**	**5,699**	**1,799**	**46,795**	**49,987**	**3,192**
Other Contracted ICBs						
Fixed Income	113	113	-	1,307	1,307	-
ERF - Variable Income	41	54	13	656	722	66
Non-ERF Variable Income	27	27	-	206	206	-
Other…	-	88	88	-	811	811
Sub-Total	**181**	**193**	**13**	**2,169**	**2,234**	**66**
Non-Contracted K&M ICB	-	1,372	1,372	-	2,495	2,495
Non-Contracted ICB (LVA)	193	206	13	2,318	2,450	132
Other…	138	187	49	1,665	2,026	361
Grand Total	**33,560**	**37,544**	**3,983**	**402,740**	**423,026**	**20,286**

The table outlines clinical income for the Trust split by NHS contracted and non-contracted services as at month 12. The variance to plan YTD equates to £20m favourable. A summary of the key drivers is provided opposite.

- All ERF variable income is over-performing YTD by £5.3m. Agreement of the final ERF targets with all commissioners is now complete. This accounts for the various changes introduced during the year to compensate for the impact of the industrial action and tariff changes published. Full YTD and retrospective adjustments have been applied in this report. A summary of the YTD actual ERF achievement is included in section 4a and includes the achievement for the year.
- Income from NHS Kent and Medway ICB is over-performing by £13.2m YTD which relates to in-year allocations for Sheppey Frailty Unit (£0.5m), Capital Charges support (£2.46m), funding for the reinstated Diabetic Foot service (£0.4m) and national funding support for costs associated with the various Industrial Action YTD (£4m). There is also over-performance YTD for High Cost Tariff excluded Devices (Insulin Pumps) which matches overspends in expenditure. The position also includes £15m of support funding YTD in both actuals and plan.
- High Cost Drugs are above plan (over-performance £3.3m) YTD which is mostly recoverable from NHSE as these costs are on a pass-through basis for Specialised Commissioning and offsets expenditure. HCDs are fixed with the ICB and is overspent YTD by £1.2m causing a cost pressure for the Trust, however the block HCDs within the NHSE contract is underspent by circa £0.4m and so marginally offsets the ICB cost pressure.
- Non-contracted income from Kent & Medway ICB has a positive variance YTD for funding that was not planned at the beginning of the year; this includes Winter Schemes (£1m), Smoking Cessation Pilot (£0.2m), Further Faster scheme (£0.1m), Amhurst £0.3m and accruals for other contract related adjustments yet to be confirmed (£1.4m).
- Contracts with the ICB and NHSE have been signed for 23/24.

4a. Elective Recovery Fund (ERF)

The Trust ERF over-achievement YTD is currently showing a positive over-performance of £5.3m which is line with what was forecast. The full value of the over performance has been recognised in the position at M12. Elective performance was maintained during February and resulted in further improvement in ERF performance against the adjusted stretch target agreed with the ICB. The year-end over-achievement improved by circa £2m due to the continued work on identification and implementation of counting and capture opportunities which improved ERF performance by over £3m in total, which included backdated changes to April 2023.

	YTD ACTUAL PERIOD												
Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FY Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adjusted Plan	**5,491**	**6,085**	**5,836**	**5,967**	**6,000**	**6,058**	**6,094**	**6,318**	**5,494**	**5,548**	**5,680**	**5,946**	**70,515**
YTD Reported Actual	5,133	6,246	6,501	6,356	6,514	6,325	6,580	7,289	5,737	6,697	6,847	6,475	**6,475**
Actual / Forecast	**5,133**	**6,246**	**6,501**	**6,356**	**6,514**	**6,325**	**6,580**	**7,289**	**5,737**	**6,697**	**6,847**	**6,475**	**6,475**
Re-Forecast Adjustments													
Additional Counting and Capture									0	0	0	0	**0**
NHSE and LVA ERF Zero Clawback	-46	-70	-63	-75	-89	-66	-87	-80	-58	-84	-71	-94	**-883**
Adjusted Forecast Actual	**5,087**	**6,175**	**6,438**	**6,281**	**6,426**	**6,259**	**6,493**	**7,209**	**5,679**	**6,613**	**6,776**	**6,380**	**75,816**
Variance to Revised Plan	**-404**	**90**	**602**	**314**	**425**	**201**	**399**	**892**	**185**	**1,065**	**1,097**	**435**	**5,301**
% Achievement of Plan	*92.6%*	*101.5%*	*110.3%*	*105.3%*	*107.1%*	*103.3%*	*106.5%*	*114.1%*	*103.4%*	*119.2%*	*119.3%*	*107.3%*	***107.5%***
2019/20 Baseline	4,842	5,252	5,888	5,338	5,179	5,220	5,212	5,726	4,622	5,358	5,858	5,636	**64,131**
Variance to Baseline	**245**	**923**	**550**	**943**	**1,247**	**1,039**	**1,280**	**1,483**	**1,057**	**1,255**	**918**	**745**	**11,685**
% Variance to Baseline	*105.1%*	*117.6%*	*109.3%*	*117.7%*	*124.1%*	*119.9%*	*124.6%*	*125.9%*	*122.9%*	*123.4%*	*115.7%*	*113.2%*	***118.2%***
Impact of Industrial Action	-640	0	-202	-937	-380	-227	-351	0	-314	-426	-524	0	**-4,000**

- Industrial action impact accounts for the previous action between April 2023 and February 2024.
- Based on the Counting and Capture review completed to date, it is estimated that this has supported delivery of the ERF over-performance which includes activity reported and backdated to April 2023, most of which is already reflected in the YTD performance. The Programme Board has now been established and will oversee and monitor the changes and report on progress with new opportunities being scoped and quantified to support further financial improvement in 2024/25.
- The ERF position includes an adjustment for NHSE and Low Value Activity (LVA) due to the expected removal of clawback in H2 for under-achievement and that the NHSE Health & Justice contract and LVA will not be subject to variable payments for ERF.

5. Efficiency programme

Status £'000	Blue	Green	Amber	Red	Sub-total	Cross Cutting	Sub-total Identified	Over / (un-) identified	Plan Target	Cost reductions	Total Efficiencies
Planned care	88	1,358	0	0	1,446	3,471	4,917	(886)	5,803	276	5,193
UIC	0	125	0	0	125	4,030	4,155	(1,416)	5,571	5,960	10,115
E&F	251	1,420	0	0	1,671	0	1,671	396	1,275	0	1,671
Corporate	6	142	0	0	147	394	542	(809)	1,351	0	542
Central	0	555	0	0	555	3,000	3,555	3,555	0	0	3,555
Sub-total	**346**	**3,599**	**0**	**0**	**3,945**	**10,895**	**14,840**	**840**	**14,000**	**6,236**	**21,076**
Unidentified	0	0	0	0	0	0	0	(13,000)	13,000	0	0
Total	**346**	**3,599**	**0**	**0**	**3,945**	**10,895**	**14,840**	**(12,160)**	**27,000**	**6,236**	**21,076**
Month 11 position	*346*	*3,599*	*0*	*0*	*3,945*	*10,895*	*14,840*	*(12,160)*	*27,000*	*6,236*	*21,076*
Movement in-month	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	**0**	***0***	***0***

Cross cutting schemes BRAG status

Status £'000	Blue	Green	Amber	Red	Sub-total
Total	231	11,918	154	-	**12,304**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	2,744	2,199	(545)	27,000	19,316	(7,684)	27,000	19,316	(7,684)

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 Project Management Office (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 Delivery Officer monitors and works with budget-holders to achieve targets.

The delivered efficiency programme position for the year to date is £16.5m; this includes £9.2m from the cross-cutting schemes, mainly for procurement £1.0m, clinical productivity in theatres £2.0m, patient flow length of stay reduction £0.5m, medical job planning £0.6m, medicines management £1.0m, reduced staff sickness £0.4m and elective work efficiencies £3.0m.

The final delivery position for the year included £11.9m "budget out" schemes, in addition to this there is a further £1.9m of run-rate reductions, and £2.7m of cost avoidance initiatives, there has been recognised a further £2.8m capture and counting activity; all of these categories are included in the £19.3m actual YTD in the table above.

The efficiency programme continues to be prioritised by the Executive Team along with support from the project management office (PMO). There are regular check & challenge meetings where all schemes are addressed or discussed in more detail with divisions, with specific feedback and actions requested as well as finalising of PIDs to be presented at the panel.

6. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
273,519	**Non-current assets**	**281,889**	**8,370**
6,375	Inventory	6,554	179
29,119	Trade and other receivables	29,959	840
34,742	Cash	21,042	(13,700)
70,206	**Current assets**	**57,555**	**(12,651)**
(953)	Borrowings	(374)	579
(50,315)	Trade and other payables	(53,835)	(3,520)
(1,320)	Other liabilities	(1,166)	154
(52,557)	**Current liabilities**	**(55,375)**	**(2,818)**
(1,952)	Borrowings	(3,054)	(1,102)
(1,031)	Other liabilities	(1,307)	(276)
(2,983)	**Non-current liabilities**	**(4,361)**	**(1,378)**
288,185	**Net assets employed**	**279,708**	**(8,477)**
475,198	Public dividend capital	489,836	14,638
(251,419)	Retained earnings	(271,309)	(19,890)
64,406	Revaluation reserve	61,181	(3,225)
288,185	**Total taxpayers' equity**	**279,708**	**(8,477)**

1. Non-current assets are £8.4m higher than the prior year end, being the net impact of investment expenditure of £28.2m, with a further £2m in right of use assets (essentially leased assets), £8.8m of impairments, £5.4m of upwards revaluations and £17.5m depreciation. £1.6m of assets (gross cost value; NBV was nil) were disposed of during the year.

2. The Trust has net current assets of £2.2m. This has reduced since February due mainly to the capital expenditure incurred in the month.

3. Cash has decreased by £13.7m since the start of the financial year due to the adverse Trust deficit. This has however increased since month 11 due to receipt of revenue support of £15m in month. The loss of cash reserves is temporarily offset by additional PDC funds for capital projects where expenditure has not yet occurred. Once utilised, cash reserves will be too low to manage with a continuing deficit and revenue support cash will be required from NHSE. The latest cash flow and bank statements have been submitted as part of this application and the Trust is awaiting the final agreement.

4. Public Dividend Capital has increased by £14.6m; this relates to capital project funding for the CDC, Endoscopy, and Ruby. These funds are issued to the Trust at the PDC dividend borrowing rate of 3.5%.

7. Capital

£'000	Annual				
	Revised Trust Plan	Outturn	PDC brokerage	Revised Outturn	NHSE Reported Variance
Backlog Maintenance	2,480	2,461	0	2,461	(19)
Routine Maintenance	0	0	0	0	0
Fire	1,251	1,233	0	1,233	(18)
Medical and Surgical Equipment Programme	4,871	3,450	0	3,450	(1,421)
IT	480	1,126	0	1,126	646
Service Developments	384	314	0	314	(70)
Total System Capital	**9,466**	**8,584**	**0**	**8,584**	**(882)**
IT - EPR	2,705	3,884	(1,179)	2,705	0
IT - PACS/RIS/IREFER	108	120	0	120	12
Endoscopy	2,725	531	(31)	500	(2,225)
CDC	7,572	3,269	4,303	7,572	0
Total Planned Additional Capital	**13,110**	**7,804**	**3,093**	**10,897**	**(2,213)**
Total Planned Capital	**22,576**	**16,388**	**3,093**	**19,481**	**(3,095)**
TLH - CT SCANNER	1,050	463	587	1,050	0
Cardio Village	3,854	3,979	(125)	3,854	0
Cyber	83	83	0	83	0
RAAC	30	25	5	30	0
Breast Screening	451	487	(36)	451	0
LED Lighting	173	173	0	173	0
Donated Equipment - LOF	228	228	0	228	0
Total Additional Capex	**5,869**	**5,438**	**431**	**5,869**	**0**
Unplanned Expenditure*	49	1,414	0	1,414	1,365
Approved Slippage schemes	2,878	5,199	(3,524)	1,675	(1,203)
Total Capex	**31,372**	**28,439**	**0**	**28,439**	**(2,933)**
Slippage Target	(3,087)	(156)	0	(156)	2,931
Total Capex inc slippage target	**28,285**	**28,283**	**0**	**28,283**	**(2)**
IFRS16 leases	2,027	2,027	0	2,027	0
Total Capex inc slippage target	**30,312**	**30,310**	**0**	**30,310**	**(2)**

The Trust reports capital expenditure of £30.3m against a plan of the same value (£28.3m excluding lease capitalisation).

The Committee has previously been notified of areas of underspend as they have arisen, including the Trust Executives undertaking a process in November where monies were repurposed to other schemes (including the theatres robot, theatre lights, windows servers, private ambulance for the mortuary, etc.).

The endoscopy PDC monies were withdrawn by NHSE and hence the underspend against that programme relates entirely to the internal capital, which funded many of those items noted above.

A paper was later circulated, discussed and agreed in respect of the CDC cost pressure and slippage between years; it was agreed that monies would be brokered between 2023/24 and 2024/25, i.e. the funding would be used for internal projects in 2023/24 and the same value would be ring-fenced from internal capital in 2024/25 to pay for CDC works. The final outturn position on the CDC is that £4.3m of brokerage is required together with £0.6m of funding for the targeted lung health CT scanner which could not be purchased in-year, i.e. £4.9m in total.

These monies were utilised at the end of the year to fund a number of medical devices, IT equipment and cover overspends (including revenue to capital transfers) on other projects.

8. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is £1.6m surplus in-month and £19.7m deficit YTD; this position is adverse to the deficit plan position as agreed with the ICB and NHS, however the revised forecast position agreed with the ICB and approved by the Executive Team has been delivered.

The Trust is in the final stages of agreeing the financial plan for 2024/25 and this will be submitted to the ICB and NHSE adhering to the national timetable.

Alan Davies
Chief Financial Officer
April 2024

Meeting of the Public Trust Board
Wednesday, 15 May 2024

Title of Report	Annual Business Plan		**Agenda Item**	5.6
Author	Paul Kimber, Deputy Chief Financial Officer Gemma Brignall, Director of Planning and Operational Performance			
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer			
Executive Summary	There has been good progress on all aspects of business planning and the Trust has reached proposed activity, workforce and financial plans that are triangulated. Trust Executives have undertaken a rigorous check and challenge process with clinical divisions, including scrutiny of overspends and cost pressures. The financial plan remains a deficit of £29m. Further scrutiny of the overspends and cost pressures is due to be undertaken by Trust Executives before the final submission in June 2024.			
Proposal and/or key recommendation:	The Board is asked to discuss this report and approve the business plan subject to feedback from the system.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	X
	Noting		Discussion	X
Committee/Group submitted:	Business plans have been discussed at various check and challenge meetings with the divisional teams. The overall position has been discussed and agreed with Trust Executives.			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	The key risks to the plans for 2024/25 include: a) Delivery of another challenging efficiencies programme b) Delivery of increasing levels of activity c) Managing inflationary cost pressures d) Limited capital allocation			
Resource implications:	This paper sets out the proposed resource allocations for 24/25.			
Sustainability and /or Public and patient engagement	None specifically at this time.			

considerations:			
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	The Trust has a statutory duty to breakeven.		
Appendices:	None		
Freedom of Information (FOI) status:	This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.		
For further information please contact:	Gavin MacDonald, Chief Delivery Officer		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	X	No assurance required.

1 Purpose of this Report

1.1 This paper sets out the activity and financial plans as submitted to the Integrated Care Board (ICB), in the expectation that this will be the final version.

1.2 We herein provide the key assumptions, risks and points of note in developing the plans.

2 General progress

2.1 All operational divisions have now built their bottom up/ line by line budgets. Trust Executives have completed check and challenge sessions with divisions on that basis, having a particular focus on reducing overspends in the run rate and eradicating arising cost pressures.

2.2 Plans have been triangulated against activity, budget and workforce; work continues to complete a full Health Care Records Group (HRG) analysis on the income for 24/25

2.3 Corporate business plans are almost complete with completion is expected by 26th April.

2.4 We are expected to now make the final submission in June (date to be confirmed).

3 Activity

3.1 Following divisional business planning the below shows the demand and capacity broken down by specialty and at point of delivery, (POD) level. Adjusted demand is based on referrals plus growth into the organisation, existing waiting list and Referral to Treatment, (RTT) recovery down to 18 weeks, noting that as a Trust we have submitted a performance trajectory to eradicate patients over 65 weeks and for those specialties where they are already below 65 weeks to eradicate 52wk+ waits. Adjusted capacity has been calculated with the starting point being core capacity and then additional capacity has been identified through additional sessions, maximising lists (added a case per list), Getting It Right First Time, (GIRFT) improvements to reduce pateint who do not attend (DNA's) and cancellations, reducing follow up capacity and converting to outpatient news, theatre utilisation improvements and full year effect of our new theatre 5.

Division	POD	Adjusted Demand	Adjusted Capacity	GAP
Surgery and Anaesthetics	Electives DC/ IP	18504	15730	-2774
	OP New	64969	53591	-11378
	OP Procedures	30494	29606	-888
	OP FUP	65336	68117	2781
Medicine and Emergency Care	Electives DC/ IP	12219	8959	-3260
	OP New	24814	20037	-4777
	OP Procedures	7473	7255	-218
	OP FUP	46566	53307	6741
Womens and Children	Electives DC/ IP	3216	2833	-383
	OP New	28571	26719	-1852
	OP Procedures	14020	13611	-408
	OP FUP	63727	55694	-8034

3.2 Non Elective, (NEL) spells at 104% of 23/24 this includes growth of 4% made up of 2% Office of National Statistics growth and a 2% increase due to service developments as a result of opening Ruby Ward. The reduction in NEL spells for 23/24 was in part driven by a reduction in beds with the demand remaining in the Emergency Department, (ED) for >12hrs this is factored in to planning and the trajectory to reduce 12 hours waiting times.

3.3 Please also refer to the income growth assumptions in the section(s) that follow.

3.4 Following publication of the national planning guidance there were only two elements that had previously not been considered. This was an increase in the ED 4 hour performance target from 77% to 78% by March 2025 and the inclusion of 812 in outpatient procedures for Elective Recovery Fund (ERF) purposes. Following regional feedback there were some minor adjustments to diagnostic phasing but the overall activity remains the same as the previous submissions.

3.5 Further work is underway looking at the capacity model for emergency care and non-elective spells because whilst the capacity is less than the demand to ensure the job plans are aligned sufficiently we are looking at an hourly model to ensure that the capacity is available at the right time of day this in turn will feed into the internal professional standards.

4 Financial overview

4.1 The summary financial plan submitted to the ICB is as follows, reporting a deficit of £29m.

£'000	Year Ending
Operating income from patient care activities	424,714
Other operating income	25,344
Employee expenses	(300,681)
Operating expenses excluding employee expenses	(169,273)
OPERATING SURPLUS/(DEFICIT)	**(19,896)**
Finance income	696
Finance expense	(50)
PDC dividends payable/refundable	(9,972)
NET FINANCE COSTS	**(9,326)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(29,222)**
Remove capital donations/grants/peppercorn lease I&E impact	264
Adjusted financial performance surplus/(deficit)	**(28,958)**

4.2 The approach to financial planning has necessitated a two-track approach.

4.2.1 In order to meet the draft planning deadline, Trust Executives took a "top down" approach by using the forecast outturn for 23/24 and making adjustments for known items as we move into 24/25, e.g. tariff adjustments/commissioner contract offers, inflation, approved service developments, known cost pressures, etc.

4.2.2 In parallel, divisions have been developing their "bottom up" budgets based on the demand and capacity work to generate an activity plan, triangulating this with workforce and consequential financial resource needs.

4.3 The top down approach gave rise to the £29m deficit plan previously reported, including the need to deliver a £21.6m efficiencies target (c5%). The bottom up approach has also produced a budget proposal of £29m, albeit with some different assumptions, cost pressures and revenue streams in arriving at that sum. This also assumes deliver of a £21.6m efficiencies target.

4.4 Trust Executives have held a number of check and challenge sessions with divisions to understand their proposals.

4.5 Inherent within the bottom up budgets is an implied efficiency of c£6.5m, arising from establishments being costed at substantive rates rather than premium bank/agency, etc. That is to say, although £6.5m of implied efficiencies have been identified bottom up, these have been offset by other cost pressures / developments, which requires further review by the Executive team with Divisions. Through that review there should be an oppoortunity to realise benefits that can be attributed to the efficiencies programme.

5 Reducing Waste Programme

5.1 The final position of The Efficiency Programme FY 23/24 was £19.87m. This total comprised of budget out efficiencies, run-rate reduction, cost avoidance along with counting and capture benefits realised.

5.2 Focus has now moved to The Reducing Waste Programme FY 24/25 – which currently has £12.93 million of schemes costed. £3.1 million have been through panel. Weekly steering groups are taking place to progress schemes from identified into delivery phase.

5.3 Key areas of opportunity have been recognised and work is ongoing to scope programmes to mitigate the gap between current forecast and the total target.

6 Financial bridge

6.1 The bridge from 23/24 budget to 24/25 plan is as follows.

£'000	23/24 Annual Budget	Non-recurrent	23/24 Start Budget	Agreed Service Developments 23-24	New Cost pressures (above 23-24 run rate)	23/24 CIP Budget Unidentified	24/25 CIP	24/25 Pay increments	Pay Enhancements 23/24	ERF	23/24 Overspends	Safer Staffing	Service Developments 24/25	Income Adjustments	Internal movements	Inflation reserves	2024-25 Plan
Income	(414,791.8)	29,655.4	(385,136.3)	0.0	219.2	0.0	0.0	0.0	0.0	(29,067.5)	0.0	0.0	0.0	(36,332.4)	0.0	0.0	(450,317.0)
Pay	265,510.6	3,819.8	269,330.4	9,081.2	964.0	5,536.6	(10,978.4)	2,693.4	1,364.2	0.0	14,131.1	2,555.4	12,231.8	0.0	10.3	2,429.4	309,349.3
Non Pay	138,948.3	(13,293.0)	125,655.3	480.0	3,197.9	5,233.6	(10,577.7)	0.0	0.0	1,400.0	12,623.0	0.0	284.7	0.0	0.0	2,812.7	141,109.4
Post EBITDA	25,477.6	0.0	25,477.6	0.0	2,100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1,503.9	29,081.5
Surplus/(deficit)	**15,144.7**	**20,182.2**	**35,327.0**	**9,561.2**	**6,481.1**	**10,770.2**	**(21,556.2)**	**2,693.4**	**1,364.2**	**(27,667.5)**	**26,754.1**	**2,555.4**	**12,516.4**	**(36,332.4)**	**10.3**	**6,746.0**	**29,223.2**

6.2 The key movements within each category are:

Non-recurrent

- Removal of central reserves, including for ERF, Clinical Diagnostic Centre, (CDC) and credit reserves
- Removal of efficiencies stretch target held centrally
- Remove centrally held Trust income that should be devolved to divisions

Agreed service developments

- Full year effect of Harvey Ward/Theatre 5
- Full year effect of CDC
- Approved business case for breast services
- Discharge team, Non Criteria to Reside (NCTR) therapies and rapid testing team services

New cost pressures

- North Kent Pathology Service increases, including hisotirc disputes
- Depreciation, public dividends capital, dividends and reduced interest income (the latter two also being a consequence of lower cash balances)
- Various other smaller posts and pressures approved, including medical examiner, insourcing, theatres robot, etc.

CIP (Reducing Waste Programme or Efficiencies)

- The first column removes the credits from undelivered efficiencies in 23/24
- The second column introduces the 24/25 target, including £3.6m held centrally

Pay increments, enhancements and safer staffing

- These reflect the anticipated pay increases based on actual staff in post where they meet their increment date in year
- It also reflects the pay enhancements that require funding for the posts

ERF

- Reflecting the total ERF income (contract baseline plus over performance assumed)

23/24 overspends

- These relate to costs incurred during 2023/24 that are anticipated to continue on a recurrent basis
- Enhanced care and maternity reserves are created centrally for divisions to draw on and avoid having to manage these in isolation
- Use of additional sessions, bank/agency and insourcing in order to dleiver ERF activity
- Activity triangulation pressures
- Low value medical devices, including non-invasive ventilation machine costs
- ED, assessment unit and escalation capacity costs
- Various other lower value expenditure, such as catering at Sheppy Frailty Unit, clinical supplies, drugs, etc.

Service developments

- Ruby ward costs, as per business case
- Endoscopy mobile unit rental costs
- Rotational doctors budgets

Income

- This represents the net movements arising from tariff inflators and deflators, growth, convergence, capital charges funding, etc. The national tariff adjustments arising within this are:
  - 2.1% growth funding (£6.5m)
  - 1.7% inflationary uplift (£5.2m)
  - -1.1% efficiency deflator (-£3.4m)
  - 0.6% incrasing capacity support (£1.8m)
  - -1.1% system convergence adjustment (-£3.4m)

6.3 Whilst the ongoing and new cost pressures together with proposed triangulation/service development costs have been challenged by the Trust Executive during the divisional meetings, these will be scrutinised further to identify opportunities for efficiency and/or improvement to the bottom line deficit.

7 Key assumptions

The following represent the key financial assumptions in the plan:

7.1 Clinical income is aligned to commissioner offers, with the exception of the following:

7.1.1 ERF over performance of £12.6m included in the Trust position. This is a Trust risk as funding would flow down from the national team via the ICB on delivery.

The inclusion of this sum is based upon 2023/24 outturn delivery, the full year effect of Harvey Ward/ Theatre 5, assumptions around a mobile endoscopy unit (with an offsetting cost) and further capture and counting benefits.

7.1.2 Ruby ward revenue funding of £3.8m, as per the approved NHS England (NHSE) business case in 2023/24. We assume that these funds have not been notified to the ICB by NHSE at this time.

7.1.3 The Trust has included £2.4m in respect of insulin pumps; these are a pass through cost and hence has no Trust or ICB risk. Similarly, the Trust has included £4.3m of Specliaised Commissioning income and expenditure on pass through that is not in the contract position.

7.1.4 Further to the consultation on the vascular service, the Trust has requested and included funding of £1.2m of stranded costs.

7.1.5 We have made an application to NHSE Specialised Commissioning for £0.75m funding of our aseptic pharmacy unit. Without this unit the Trust would be required to procure the end products directly at a greater cost but on pass through from NHSE. We are aware that other providers are funded in a similar manner.

7.1.6 £0.6m of funding was awarded recurrently for discharge and therapies in “023/4 that has not been included in the commissioner contract offer; the Trust has included this sum in its plan.

7.2 Inflation reserves are only included up to the level funded through the tariff uplift; using the tariff inflationary factors against actual spend gives rise to an expenditure ris of c£1.9m - see risks section below for further information.

7.3 No contingency is held.

7.4 As far as possible, posts are budgeted for at substantive rates. Within central reserves we have created an equal and opposite adjustment at Trust level to create an agency budget (through adjustment to overall substantive budgets) to create an overall agency spend of 3.2% (in line with 24/25 target).

8 Phasing

8.1 The monthly phased 2024/25 plan is as follows:

£'000	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending
Operating income from patient care activities	35,392	35,392	35,392	35,392	35,392	35,392	35,392	35,392	35,392	35,392	35,392	35,402	424,714
Other operating income	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	2,112	25,344
Employee expenses	(26,024)	(25,789)	(25,405)	(25,096)	(24,843)	(24,768)	(24,786)	(24,768)	(24,882)	(24,826)	(24,673)	(24,822)	(300,681)
Operating expenses excluding employee expenses	(14,274)	(14,440)	(14,218)	(14,154)	(14,064)	(13,986)	(14,153)	(14,026)	(14,241)	(14,204)	(13,423)	(14,088)	(169,273)
OPERATING SURPLUS/(DEFICIT)	**(2,794)**	**(2,725)**	**(2,119)**	**(1,745)**	**(1,403)**	**(1,250)**	**(1,435)**	**(1,290)**	**(1,619)**	**(1,526)**	**(592)**	**(1,396)**	**(19,896)**
Finance income	58	58	58	58	58	58	58	58	58	58	58	58	696
Finance expense	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(50)
PDC dividends payable/refundable	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(831)	(9,972)
NET FINANCE COSTS	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(777)**	**(9,326)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(3,571)**	**(3,502)**	**(2,896)**	**(2,523)**	**(2,180)**	**(2,028)**	**(2,213)**	**(2,067)**	**(2,396)**	**(2,303)**	**(1,369)**	**(2,174)**	**(29,222)**
Remove capital donations/grants/peppercorn lease I&E impact	22	22	22	22	22	22	22	22	22	22	22	22	264
Adjusted financial performance surplus/(deficit)	**(3,549)**	**(3,480)**	**(2,874)**	**(2,501)**	**(2,158)**	**(2,006)**	**(2,191)**	**(2,045)**	**(2,374)**	**(2,281)**	**(1,347)**	**(2,152)**	**(28,958)**

8.2 The following pattern of phasing has been applied:

8.2.1 Clinical income: currently phased in equal twelfths but will follow the phasing of the activity, using calendar days and working days.

8.2.2 Other income: phased in equal twelfths.

8.2.3 Clinical pay: phased based in calendar days, weekend days and bank holidays.

8.2.4 Non-clinical pay: phased in equal twelfths.

8.2.5 Gas and electricity: phased based upon 2023/24 usage trends respectively.

8.2.6 Clinical supplies: phased based on number of calendar days. Other non-pay: phased in equal twelfths.

8.2.7 Efficiencies: based on actual schemes identified where known; given the unidentified value of schemes, the overall efficiencies programme has been phased to deliver 2% in April 2024, increasing by 2% delivery per month until August when it reaches 10%, which is then maintained for the remainder of the year.

8.2.8 Capital: phasing to be reviewed and will be subject to final programme.

9 Unfunded services

9.1 In addition to those areas noted above in respect of income risk, the Trust runs a number of services for which it is not being paid a tariff/services are not formally commissioned. The service and its estimated income are as follows:

Description	£'000	Comments
Amherst FY funding support	3,200	Part-funded; this represents the FYE (and "request" for service to be taken over by MCH?)
Discharge Schemes Allocation	1,480	FYE of the Discharge schemes
HCD 23/24 Over-Performance	1,200	Cost pressure of ICB HCD block value
SMART service	1,327	
Unfunded Pay Award 23/24 Rolled Fwd	2,937	Medical pay award under-funding through tariff in 23/24
Paediatrics Diabetes BPT	700	Agreed in 19/20 as meeting criteria but never incorporated into allocation due to Covid contracting arrangements
Rapid Testing Team	769	Agreed through double lock but funding must be found by Trust
Continued funding to extend the 2nd mobile MRI (assuming all revenue costs) - 6 months	650	
Extend the capacity of the community respiratory service (inc LTC - cardiology)	75	
Overseas 50% debt share	350	Year end invoicing
COVID-19 Testing (50% reduction from 23/24)	289	Covid funding reduced from last year
Prehab	TBC	
Fetal Medicine L2 Commissioning	216	Meeting criteria but not commissioned by Spec Comm - application made and costs being incurred.
Team NOAH	400	Meeting criteria but not commissioned by Spec Comm - application made and costs being incurred.
Single Point of Access	TBC	
Sleep studies	TBC	
PAS	200	Meeting criteria but not commissioned by Spec Comm - application made and costs being incurred.
Sacral Nerve Stimulation	30	Meeting criteria but not commissioned by Spec Comm - application made and costs being incurred.
NPTS pilot	394	Cost pressure of the pilot during 23/24
MacMillan/ Cancer Alliance posts - end of funding	TBC	
Sub-total	**14,217**	

9.2 None of these income items are included in the plan.

10 Risks

10.1 The key risks to delivery of the 2024/25 plan are included in the risk register. Those scoring above the Trust's risk appetite are as follows:

10.1.1 ERF does not deliver to plan.

10.1.2 Income assumed by the Trust from the ICB remains misaligned to the allocation offered by the ICB. Approximately £12.6m of this relates to ERF (as set out above) and is a Trust/system risk and has no impact on the ICB. Similarly, we have assumed £2.4m of pass through income aligned to expenditure. The key areas of difference relate to assumptions over funding of Ruby ward (£3.8m – should be allocated from national monies), stranded vascular costs (£1.2m funded in 23/24), endoscopy mobile unit (£0.7m – reducing risk if unit is not in site as matched to cost) and therapies funding awarded recurrently excluded from commissioner baseline (£0.6m).

10.1.3 Unfunded escalation capacity is required to be opened to meet demand.

10.1.4 The £21.55m /5% efficiencies target is not delivered.

10.1.5 Growth in deployment of staff (i.e. worked FTEs) continues unabated.

10.1.6 Through review of the leases for Community Diagnostic Centres, it has been identified that both IT and medical diagnostic equipment to the value of £9.4million

is currently uninsured. Not only may this result in a negative financial outcome for the Trust should the equipment be damaged, the Trust are also uninsured for potential litigation in the event of staff or patients suffering harm from any of the equipment.

10.1.7 The Trust does not hold any contingency reserve to mitigate unforeseen events in line with the ICB approach.

10.1.8 The Trust has a capital allocation of £12.8m against which c£7m is committed; this means there is limited funding (unless external funding can be secured) to deliver transformational and urgent capital programmes of work.

10.2 A further emerging risk relates to the medical pay award. This is funded through the tariff uplift, however, the inflation % applied to the Trust's cost base gives rise to a funding gap of c£1.9m. This will be discussed further with the ICB/NHSE.

11 Capital

2024/25 allocation

11.1 The Trust's current capital allocation from the ICS is c£12.8m. No PDC funding, other than £1.9m for EPR, is yet confirmed for 2024/25, although based on recent years we would expect to apply for and receive such monies where valid schemes exist.

Carry forward commitments

11.2 The Trust must ringfence £4.9m of capital for completion of the CDC works arising from the 2023/24 brokerage.

11.3 Including those brokered monies, the known commitments and pre-approved schemes at this time are as follows:

Project Name	£'000	Comment(s)
Community Diagnostics Hubs (CDC) Sheppey	4,303	Brokered from 23/24
TLHC Sheppey CT Scanner	587	Brokered from 23/24
Breast Screening BC - New rooms x 2	840	PDC funding received 23/24
Breast Screening BC - Pristina 3d Full spec x1	432	PDC funding received 23/24
IR machine enabling works	1,046	Machine purchased 23/24
MRI software Upgrade	198	
General x ray room Sheppey Hospital enabling	200	Machine purchased 23/24
Capital Projects Team (IT)	150	Standing item for projects team costs
Cyber Security	100	
Edge Network Provision	100	
Capital Projects Team (ESTATES)	400	Standing item for projects team costs
Compartmentation& Dampers (Fire safety)	250	
Emergency lights - non self-test (Fire Safety)	150	
Fire alarm upgrade (Fire Safety)	750	
Fire door replacement (Fire Safety)	350	
Legionella works: TMV replacement with TMT	100	

Project Name	£'000	Comment(s)
Lift Refurbishment Programme - Lifts 8-10	200	
Pathology Chillers	14	
Theatre operating lights	290	
2022A028 Defibrillator replacement (y2 & 3)	101	
NICU Equipment storage /redesign	180	
Total	**10,741**	

11.4 This gives an overall commitment/pre-approval of c84% of our capital allocation, leaving c£2m for other priorities and any emerging issues.

11.5 The Trust has a further £57.6m of schemes proposed for 2024/25, ranging in priority as below (5 being the highest priority):

Priority score	£'000	Scheme examples
4-5	11,650	Cardio village; blood transfer tube upgrade; Metavision upgrade; Keates cooling;Therapies gym refurb
3-4	17,594	Access control; ward flooring; various medical equpment; various estates
2-3	5,716	Theatres recovery area; various medical equpment; various estates; Microsoft licensing;
1-2	9,806	Various estates backlog; AI
No score	11,111	Pemrboke ward refurbishment; imaging and other medical equipment; gantry replacement in NICU

11.6 Clearly the above is unaffordable against our allocation, even if filtered on those highest priority scoring items. The Trust Executive will therefore undertake an exercise to agree scheme prioritisation and a programme for the year.

12 Conclusions and Next Steps

12.1 Following good engagement and ownership, divisions have produced bottom up budget proposals and these have been subject to a check and challenge process by Trust Executives.

12.2 Activity plans have been built through demand and capacity modelling.

12.3 The Trust presents a deficit plan for 2024/25 of £29m, being unchanged from the draft plan submission. This is not without its challenges to deliver, including another stretching efficiences target on top of an inherent efficiency.

12.4 The Trust plan is subject to triangulation by the ICB before submission to NHSE no later than 2 May, although a further date in June is being confirmed.

12.5 Trust Executives will undertake a further review of the ongoing and new cost pressures that bridge from the 2023/24 outturn to the 2024/25 financial position; the intention will be to mitigate and reduce these as far as possible (potentially converting these into efficiency opportunities).

12.6 Scrutiny of the capital projects will need to take place, with Trust Executives agreeing the final priorisation and a programme for the year.

12.7 Business planning leads are already discussing the ways in which the process can be further improved for 2025/26, including a debrief of this year's process and an earlier start in general.

Meeting of the Trust Board
Wednesday, 15 May 2024

Title of Report	Green Plan (Update)			**Agenda Item**	5.7
Author	Louise Stewart, Sustainability and Business Performance Manager				
Lead Executive Director	Nick Sinclair, Chief Operating Officer				
Executive Summary	In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero. This commitment was made in response to the significant and escalating threat to health posed by climate change. The "Delivering a Net Zero Health Service" report outlines the NHS trajectories and actions necessary to achieve net zero carbon emissions. The NHS has established a clear ambition along with two evidence-based targets; • Net zero by 2040 for the NHS Carbon Footprint • Net zero by 2045 for the NHS Carbon Footprint Plus The Trust's formal Green Plan issued during 2020-21 provides an organisation-wide strategy that outlines the Trust's plan of action necessary to achieve the targets within the Greener NHS Net Zero Programme.				
Proposal and/or key recommendation:	The Trust Board is asked to note the contents of this report.				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval		
	Noting	X	Discussion		
Committee/Group submitted:	NA				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe:	Effective:	Caring:	Responsive:	Well-Led:
Identified Risks, issues and mitigations:					
Resource implications:	NA				
Sustainability and /or Public and patient engagement considerations:	This paper relates directly to the delivery of the Green Plan.				

Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	The National Greener NHS Programme requires each NHS Trust to publish a Green Plan. NHS net zero targets are embedded into legislation as statutory guidance.		
Appendices:			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Neil Adams Job Title: Associate Director of Estates and Facilities Email: neil.adams5@nhs.net Name: Louise Stewart Job Title: Sustainability and Business Performance Manager Email: louise.stewart36@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance	✓	There are no gaps in assurance
	Not Applicable		No assurance required.

Introduction

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero. This commitment was made in response to the significant and escalating threat to health posed by climate change. The "Delivering a Net Zero Health Service" report outlines the NHS trajectories and actions necessary to achieve net zero carbon emissions.

The Trust's formal Green Plan issued during 2020-21 provides an organisation-wide strategy that outlines the Trust's plan of action necessary to achieve the targets within the Greener NHS Net Zero Programme. This report presents some of the key successes of the Green Plan achieved in the previous year.

Overview

Carbon Emissions

The NHS commitment to become the world's first carbon net-zero health system comes amid growing evidence of the health impacts of climate change and air pollution. Climate change poses a threat to both public health and the NHS's ability to deliver essential services, both in the immediate future and longer term. As one of the largest single emitters of carbon dioxide in the UK, the NHS accounts for 40% of England's public sector emissions.

Carbon emissions are categorised into three scopes;

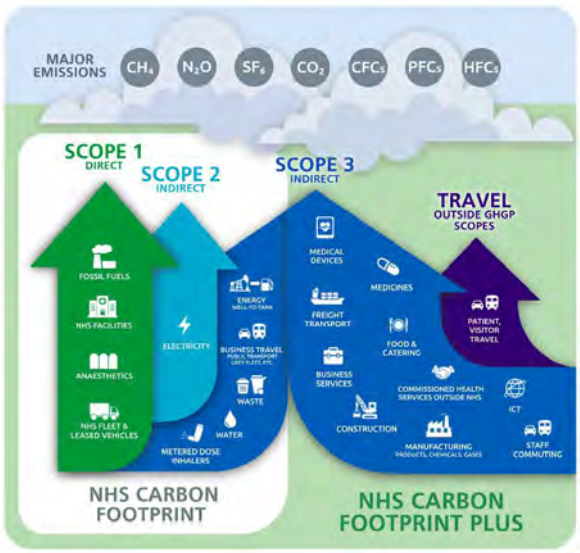
- Scope 1: Direct emissions from owned resources.
- Scope 2: Indirect emissions related to purchased energy.
- Scope 3: Indirect emissions within the supply chain.

The targets for decarbonisation, outlined in the 'Delivering a Net Zero Health Service' report, are now legally mandated through the Health and Care Act 2022, making it statutory guidance to meet these requirements.

The NHS has established a clear ambition along with two evidence-based targets;

- Net zero by 2040 for the NHS Carbon Footprint
- Net zero by 2045 for the NHS Carbon Footprint Plus

In addition to this target, the NHS is committed to reaching an interim target of an 80% reduction by 2028 to 2032 for the NHS Carbon Footprint and an 80% reduction by 2036 to 2039 for the NHS Carbon Footprint Plus. Both reductions are measured against a 1990 baseline. The following diagram illustrates the constituent elements of each group.



A carbon footprint is a calculated measure of the greenhouse gases generated by our activities. While the calculation aims for a high degree of accuracy, it also involves some uncertainties around scope coverage, emission factors and methodology.

In partnership with the NHS Kent and Medway Integrated Care Board, consultant Greener Edge were commissioned to calculate our carbon footprint adopting a new methodology. These findings still require internal refinement. This newly adopted approach ensures consistency across local Trusts and will help develop a baseline from which progress can be tracked. We are actively developing internal processes for such reporting, and the team will now be responsible for quarterly calculations, of which, will be reported to the ICB.

The Trust has made remarkable achievements within the last year on its sustainability journey, a summary of some of the key highlights are presented below.

Key Areas

1 Governance

Throughout this year, significant strides have been made in advancing our sustainability objectives through the establishment of a robust governance and assurance framework to facilitate the delivery of our Green Plan.

Chief Financial Officer Alan Davies, who will oversee the resourcing and delivery of this Green Plan, has been appointed as the Trust's Net Zero Lead. As the Senior Responsible Officer (SRO) for our Green Plan, Neil McElduff, the Director of Estates and Facilities, is accountable for leading the Green Plan and reports into the NHS Kent and Medway Integrated Care Board Environmental Sustainability Steering Group.

The Green Sustainability Operational Group, convenes bi-monthly with the participation of 10 senior staff members, including Directors and Associate Directors of the Trust. Together, they are tasked with the implementation of the various workstreams and actions outlined in the Green Plan.

The Green Sustainability Strategic Group, comprising of the Trust's Executive Directors, and chaired by Jayne Black, the Chief Executive, assumes the responsibility of overseeing the activities of the Operational Group. This entails ensuring alignment with the Trust's strategic objectives. The group meets quarterly and will receive performance updates on the workstreams and action plan of the Operational Group.

The Green Champion Network, is still in its early stages but already boasts 25 registered Champions actively involved in championing sustainability initiatives. The Green Champions will identify initiatives at a grass roots level within the Trust and will lead on implementation of the projects that we are running.

2 Funding

Over the past year, the Sustainability Team has successfully secured funding for various decarbonisation projects. In June 2023, the Trust secured £83,000 through the Low Carbon Skills Fund (LCSF) run by the Department for Energy Security and Net Zero and delivered by Salix, to develop our Heat Decarbonisation Plan (HDP). This plan provides a net zero framework, outlining several stages to guide our transition from fossil fuel reliant heating systems to low carbon alternatives.

The initial stage of the HDP, projected to result in 3500 tonnes of annual carbon savings, is currently underway, thanks to the £25.9million secured through the Public Sector Decarbonisation Scheme (PSDS), which is run by the Department for Energy Security and Net Zero and delivered by Salix. The proposed initiatives for this stage of the HDP include:

- De-steaming part of the hospital with heat pump systems
- Installing roof-mounted solar PV arrays across multiple buildings
- Replacing single glazed windows with double glazed units

The programme of works are a complex undertaking and will be carried out over two financial years, 2024/2025 and 2025/2026.

An optimisation study to identify areas of sub-optimal performance and enhance efficiency in the heating system is also underway. This initiative has been made possible by securing £23,000 through the Heat Network Efficiency Scheme (HNES). This study is exploring subsequent stages of the HDP and presents an opportunity for the Trust to not only mitigate energy expenditure but also minimise our carbon footprint.

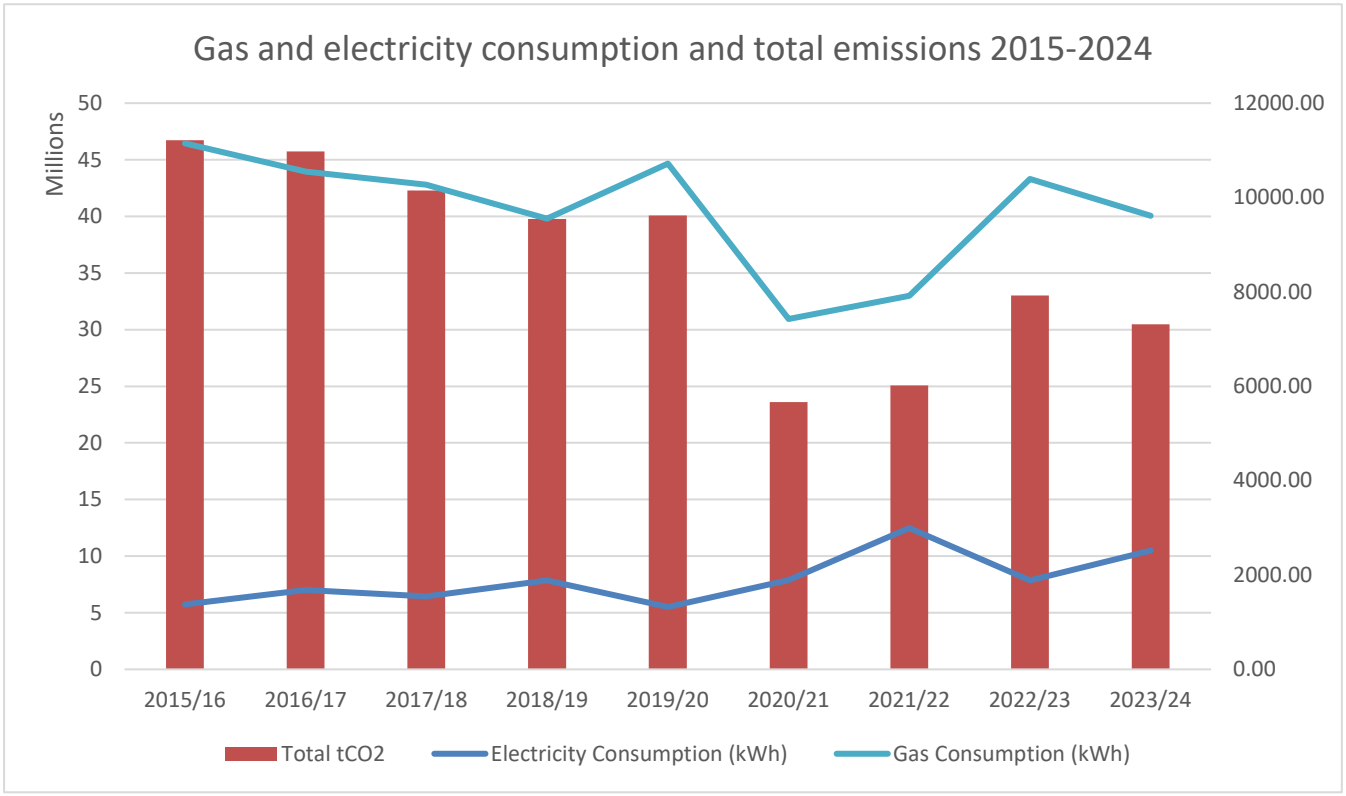
Finally, the Trust also secured £173,000 in January 2024 through the National Energy Efficiency Fund (NEEF). This funding supports the ongoing implementation of LED lighting throughout the Trust. LED lighting offers significant benefits over traditional lighting options, such as reduced energy consumption and carbon emissions.

3 Energy

During the most recent year, 2023/24, the Trust spent a total of around £8.2million on Electricity and Gas. This increase in spending can be attributed to rising energy costs. Supply pressures on gas and generated electricity have directly resulted in significant increases in the unit costs charged by suppliers.

Energy Usage and Costs 21-22 to 23-24						
	Consumption			Costs		
	21-22	22-23	23-24	21-22	22-23	23-24
	KWH	KWH	KWH	£	£	£
Gas	36,491,997	46,214,831	40,064,445	874,698	3,300,348	4,016,482
Electricity	12,558,811	8,565,071	10,473,540	1,924,119	2,344,706	4,174,831
Total	**49,050,809**	**54,779,902**	**50,537,985**	**2,798,817**	**5,645,054**	**8,191,313**

The Combined Heat and Power plant (CHP) is approximately 15 years old. While it does provide cost savings, gas yields a degree of unit price efficiency over electricity, as part of the HDP and our move towards decarbonisation, replacing the CHP is necessary in the long term. Since it has only been operating intermittently, a review of the use of the CHP is needed in the short term. The energy consumption patterns shown below, reflect the operational patterns of the CHP and also the switch to carbon neutral electricity in 2020/21.



Conclusion and Recommendations

Throughout this year, we have made significant strides in advancing our sustainability objectives. The establishment of a robust governance and assurance framework will facilitate the delivery of our Green Plan. This leadership will play a pivotal role in supporting the Trust's sustainability agenda and driving our performance in sustainability initiatives.

Various decarbonisation projects are now completed or underway, made possible by successful funding bids. These projects are moving the Trust along its decarbonisation journey. Of particular note, the PSDS programme of works are a huge undertaking at the Trust and is expected to deliver significant carbon savings. These works are the first stage of the HDP and future works and subsequent stages of the HDP will need to be implemented to fully decarbonise the site.

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

March - 2024

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

Key Messages

- Whilst Workforce sub-domain continues to show the highest volume in metrics improving for Statistical Variance, proportionately FFT and Complaints are showing the highest % of statistical improvement metrics (50% of all metrics)

- The Access sub-domain continues to have the highest number of variances that are statistically showing concern, with Pressure Ulcer and Financial Position domains also showing a high number of concerns

- Mortality, Emergency Care and Incident Management domains indicate a mix of metrics that are both statistically concerning and improving.

- Whilst the FFT sub-domain is showing the highest % of statistical improvement metrics, it also shows the highest proportion of metrics that don't meet the threshold target

- Both Systems & Partnerships sub-domains (Access & Emergency Care), together with Workforce are demonstrating a mix of metrics that both pass and fall short of the thresholds

- Overall, 54 metrics are now showing improved statistical variance (+3 from last month) against 45 which are showing concern (-5 from last month) in month

True North	Sub Domain	Variation			Assurance		
			L	H L	P	F	?
Patients	Complaints	3	3	0	0	1	1
	FFT	3	5	2	0	8	2
	PALS	3	1	0	0	0	0
	Patient Experience	1	0	0	0	0	1
	PHSO	3	2	0	0	0	0
People	Workforce	23	22	5	13	16	15
Quality	Falls	7	0	0	0	0	3
	Health & Safety	1	1	0	0	0	0
	Incident Management	9	6	5	1	3	1
	IPC	5	0	4	1	0	2
	Legal & Information Governance	1	1	1	0	0	0
	Maternity	7	0	2	0	0	0
	Medicines	2	0	0	1	0	0
	Mortality	8	2	3	1	3	4
	Pressure Ulcer	4	0	4	0	0	2
	Risk & Policy	4	1	1	0	0	0
	VTE	0	1	0	0	0	1
Sustainability	Financial Position	5	3	6	0	0	9
Systems & Partnerships	Access	13	3	10	2	5	12
	Emergency Care	6	3	2	1	4	3

Patients

Sarah Vaux
Chief Nursing Officer

Operational Lead:
Vacant - ***Director of Quality & Patient Safety***
Nicola Lewis - ***Associate Director of Patient Experience***

Committees:
Quality Assurance Committee (QAC)

Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

FFT

Total FFT Recommend %

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	95.0%	H	F	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%

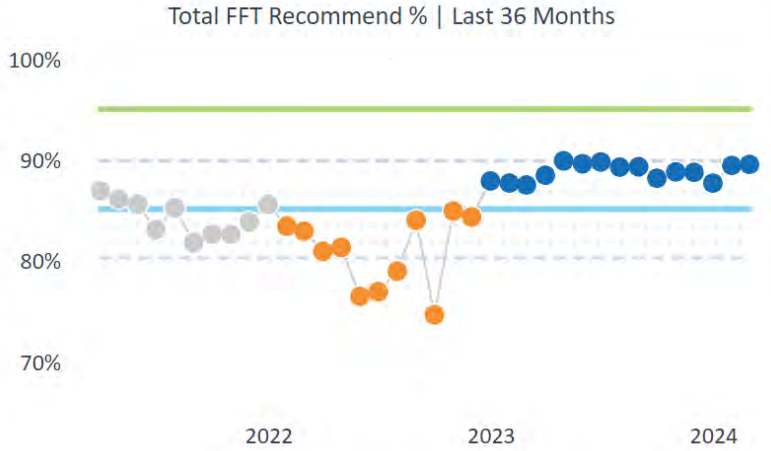
True North Domain: **Patients**

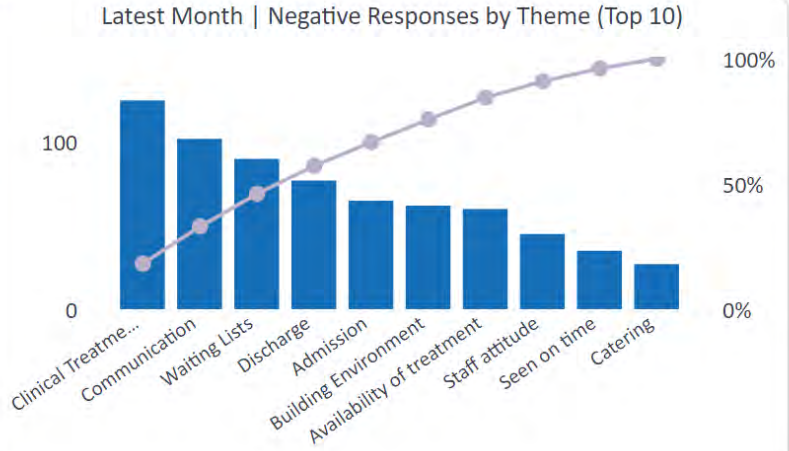
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

	L	H	L	H
3	2	0	0	5





Key Messages

- FFT recommend rate has remained static since the last reporting period
- The 3 top themes in relation to feedback remain unchanged, however there has been a reduction in the number of these concerns overall.
- Inpatient response rate has improved by 4% since the last reporting period, and only 1% off target overall.

Issues, Concerns & Gaps

- Concerns continue to be shared from patients that have experienced care within the ED that relate to quality and communication. However the overall experience of care rate in ED has improved marginally in comparison to the last reporting period.

Actions & Improvements

- Bespoke action plans have been created for OPD and ED areas and some improvements have been noted as a result
- The quality focus week has been scheduled for late April to address issues that relate to care concerns within the ED. The senior teams will be facilitating this. Full plans are to follow as they are developed.
- A full review and refresh of the Breakthrough objective is underway at senior level.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Patients	FFT			Total FFT Recommend %	95.0%	H	F	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%
				Total FFT Response Rate %	45.0%	H	F	9.4%	11.2%	11.5%	11.6%	11.9%	10.6%	12.7%	13.6%	11.8%	12.1%	14.4%	13.9%
				Inpatients FFT Recommend %	95.0%	H	F	85.5%	90.8%	92.5%	93.2%	93.5%	91.3%	90.7%	92.2%	93.3%	92.3%	94.2%	93.1%
				Inpatients FFT Response Rate %	45.0%	H	F	16.3%	26.2%	31.7%	33.3%	32.9%	29.3%	36.3%	44.4%	37.5%	35.4%	40.2%	44.6%
				Emergency Care FFT Recommend %	95.0%		F	83.1%	80.7%	75.3%	75.2%	73.1%	74.8%	75.2%	67.9%	69.2%	64.7%	68.9%	71.6%
				Emergency Care FFT Response Rate %	45.0%	L	F	7.7%	8.4%	7.1%	7.2%	8.3%	6.1%	9.7%	8.6%	7.4%	8.1%	9.8%	7.5%
				Outpatient FFT Recommend %	95.0%	H	F	91.4%	92.8%	92.2%	91.9%	91.6%	92.0%	91.1%	92.4%	91.9%	91.5%	91.9%	91.5%
				Outpatient FFT Response Rate %	45.0%		F	8.0%	8.4%	8.4%	8.4%	8.2%	7.9%	8.3%	8.6%	7.4%	8.4%	9.8%	9.2%
				Maternity FFT Recommend %	95.0%	L	?	95.6%	89.5%	83.8%	82.3%	87.8%	92.5%	92.5%	90.5%	82.7%	88.5%	85.8%	88.8%
				Maternity FFT Response Rate %	45.0%		?	32.3%	44.2%	35.0%	16.9%	31.3%	31.4%	33.4%	26.1%	14.4%	30.7%	38.7%	30.5%
	Patient Experience			Mixed Sex Accommodation Breaches	0		?	205	189	130	147	83	109				486	278	90
	Complaints			Complaints	-	L		32	24	23	28	42	35	28	32	19	19	25	29
				Complaints Closed	-			15	38	90	58	45	52	36	38	30	22	20	27

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Patients	Complaints			Complaints Open - Month End	-	L		234	220	153	123	122	105	97	92	81	78	83	85
				Complaints Re-Opened	-			0	0	9	4	2	7	1	2	2	2	1	6
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	97.0%	100.0%	96.2%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%		F	84.1%	87.5%	54.8%	40.9%	57.5%	60.0%	38.9%	41.2%	42.4%	62.5%	60.0%	82.1%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			253	404	380	333	425	388	416	528	428	496	463	417
				PALS Closed	-			235	382	322	340	411	371	385	554	485	714	463	433
				PALS Open - Month End	-	L		227	249	309	302	316	333	363	340	283	66	66	50
				PALS Converted to Complaints	-			2	2	0	7	6	4	0	0	0	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			1	1	2	3	0	0	0	0	1	0	0	1
				PHSO Cases Closed - Partially Upheld	-			0	0	0	0	1	0	1	0	0	0	0	0
				PHSO Cases Closed - Upheld	-			0	0	0	0	0	0	0	0	0	0	1	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-	H		0	0	0	0	0	1	0	0	0	1	1	4

SIOR - Patients

Successful Deliverables

- Mixed sex breaches have reduced significantly in March . This is attributed to appropriate allocation of patients in escalation areas and the implementation of the new MSA breach process.
- Open complaints remains low compared to April 2023.
- System solution created for PALs management bringing open PALs down to 50.

Next Steps

- To circulate the draft MSA policy and SOP for comments prior to publication.

Identified Challenges

- Challenges with flow throughout the hospital have seen continued use of the admission and discharge lounge as a facility to care for patients overnight, and therefore breaches are reported more frequently.
- The BI team are unable to report MSA breaches reported by the ward on teletracking. The reporting of this data is reliant on the Associate Director of Patient Experience
- Complaints breaching 20 working day turnaround time remains challenged

Next Steps

- Ward moves to accommodate the newly refurbished Ruby ward have been approved. This will relinquish capacity and help with flow issues in the longer term. This will be monitored daily.
- The BI team are meeting with the teletracking team to resolve the accessibility issues.
- Review national guidance on turnaround times for complaints

Opportunities

- To improve the quality of care provided for patients who identify as trans male or trans female when admitted to inpatient areas. This work has commenced with the EDI lead and is to be reflected in the MSA policy. Work to embed this changes will be managed through the MSA Project group.
- Reduced open PALS and complaints numbers giving opportunity to focus on improvement actions – including a reduction in complaints related to staff attitude as per the quality priority for 2024/25

Next Steps

N/A

Risks

- There is a risk that due to lack of process and issues with flow that MSA breaches will increase. Mitigations against this risk number 1647 are in the final stages.

Next Steps

- To circulate the MSA policy for final comments prior to publishing, once complete, the risk score will reduce and the risk will close.

Quality

Sarah Vaux
Chief Nursing Officer

Alison Davis
Chief Medical Officer

Operational Leads:
Vacant - ***Director of Quality & Patient Safety***
James Alegbeleye - ***Medical Director for Quality & Safety***

Committees:
Quality Assurance Committee (QAC)

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	95.0%		P	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.3%	99.0%	99.6%	98.9%	98.8%	99.2%

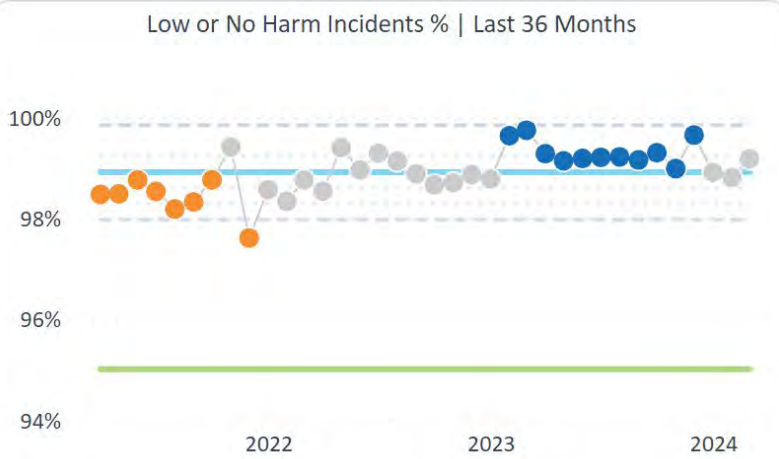
True North Domain: Quality

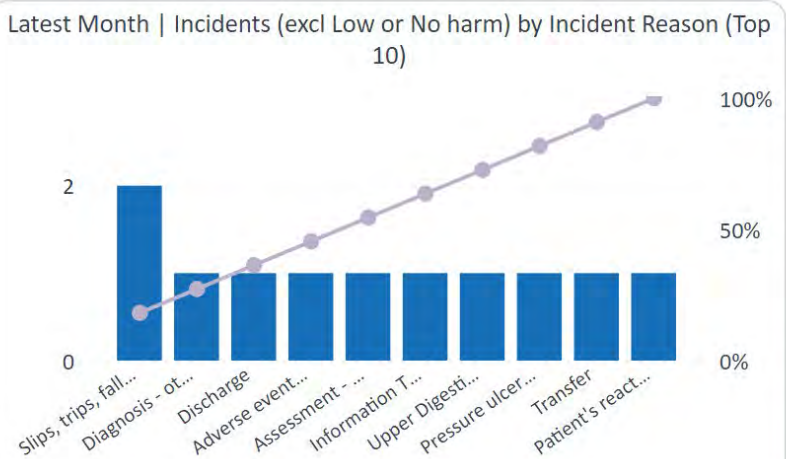
KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary:

	L	H	L	H
9	0	5	2	4





Key Messages

- Over 99% of reported incidents result in no or low harm
- Falls causing moderate harm or above remains the most frequent incident reported.
- Incidents causing moderate harm or above below average for March (11 vs 13)
- 0 avoidable 2222 calls in March
- No significant change in low or no harm incidents reported this month
- Slips, trips and falls remains the top reported area for this month. Falls team will validate the level of harm and will recommend level of investigation via the specialist incident decision matrix.

Issues, Concerns & Gaps

- Limited progress in the numbers of falls causing moderate harm and above over 12 month period.
- 20% of all moderate harm and above incidents attributable to patients falling
- Falls per 1000 OBDs is high and above national averages
- High number of open overdue incidents

Actions & Improvements

- Reduction in unwitnessed falls is one of 5 quality priorities for 2024/25
- True north refresh of Harm has identified falls as the key area of focus for 2024/25
- Establishing Violence and aggression steering group
- Encouraging incident reporting of V&A incidents so that we can identify themes and target improvement work
- Continued training on how to complete extra LFPSE questions for areas on request at present until training package developed.

Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	1.30%			1.99%	1.41%	1.27%	1.28%	1.31%	1.44%	1.53%	1.18%	2.13%	2.00%	1.66%	1.53%

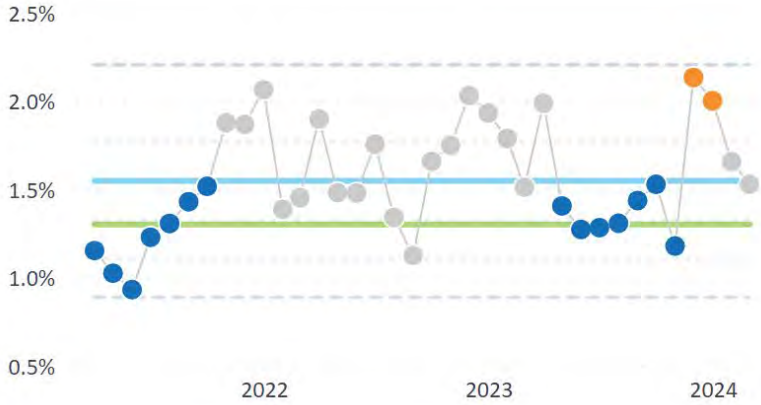
True North Domain: Quality

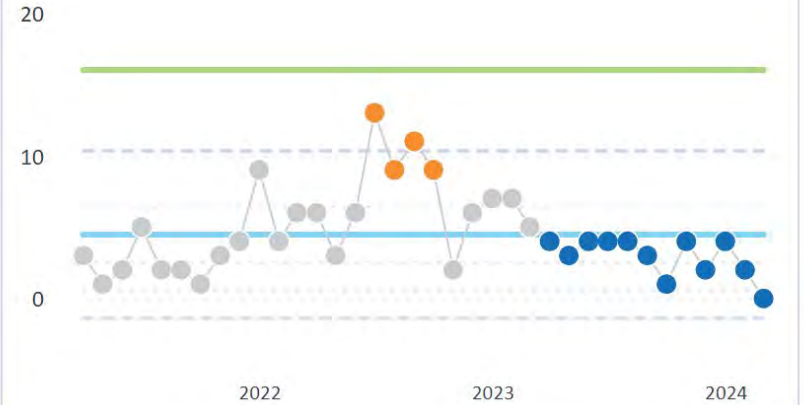
KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary:

8	0	3	1	1





Key Messages

- HSMR for Dec 22- Nov 23 107.98 and 'higher than expected'.
- SHMI for Nov 22- Oct 23 is 1.15 and 'higher than expected' which is a slight improvement on last months data.
- Top 5 themes for Q4 from SJR: problems with documentation, communication between clinical teams, communication with NoK, issues with bed capacity and delays in treatment.
- Cases were forwarded to the relevant team to reflect on their learning at speciality M&M and ward huddles. Three cases were highlighted to IRG for further investigation.
- Evidence of impacts of long stays in ED on quality of patient care was highlighted across the speciality M&M reports received for Q4.

Issues, Concerns & Gaps

- COPD and Bronchiectasis remains an outlier for the Trust in the month's data.
- Specialty M&M compliance with reporting remains poor. This is an area of focused improvement in the A3 True North Mortality Refresh. Divisional leads are encouraged to take ownership of the meetings and to ensure they attend and submit reports.
- The Datix system used currently for SJRs is not fit for purpose. The current process is arduous and requires significant time to create an SJR for review. Datix cloud is currently being explored to provide a system support that allows reviewers to complete an SJR on a record which is automatically created. The system focuses on highlighting learning from SJR reviews and provides better monitoring of actions.

Actions & Improvements

- A new SJR process is being developed combining the RCP approach of single SJR reviewers with a stage 2 panel that will review cases of poor/very poor care and excellent care. The panel will focus on themes and monitor actions from SJR reviews.
- A3 True North Mortality refresh group in place with a focus on learning from deaths and developing reporting structures, including a review group which will require speciality lead attendance to present M&M reports which will feed into MMSG.
- Nov 23 HSMR was 85.0 and 'as expected'. This has resulted in a statistically significant improvement in overall HSMR.
- Coding and Learning from Deaths manager continue to present at Speciality M&Ms, depth of coding and charlson comorbidity scoring maintains a sustained improvement.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.3%	99.0%	99.6%	98.9%	98.8%	99.2%
				Total Incidents Reported	-	H		1,102	1,154	1,463	1,505	1,650	1,766	1,984	2,155	1,686	1,366	1,337	1,329
				Incidents with Harm (Moderate and above)	0		F	8	10	12	12	13	15	14	22	6	15	16	11
				Incidents Open - Month End	-	H		1,297	1,128	1,261	1,245	1,316	1,662	2,126	2,383	2,945	2,737	2,701	2,737
				Incidents Overdue - Month End	-	H		275	242	186	169	200	362	446	672	1,108	1,619	1,738	1,699
				Serious Incidents	-			2	8	4	3	4	7	7	16	2	4	2	1
				Serious Incidents Closed	-			10	9	11	8	14	12	11	6	9	9	2	9
				Serious Incidents Open - Month End	-	L		62	61	54	49	40	35	30	40	33	28	28	20
				Serious Incidents Responded to Within 60 Days %	95.0%		F	30.0%	14.3%	57.1%	40.0%	0.0%	40.0%	25.0%	33.3%	66.7%	56.3%	16.7%	50.0%
				Serious Incidents Closed by ICB 1st Time %	-	H		40.0%	44.4%	36.4%	62.5%	35.7%	75.0%	81.8%	100.0%	100.0%	88.9%	50.0%	55.6%
				Never Events	0	L	?	0	0	0	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%
				Duty of Candour Compliance Stage 2 %	-			0.0%		77.8%	50.0%	72.7%	66.7%	83.3%	100.0%	100.0%	71.4%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Incident Management			RIDDOR Incidents	-			3	2	4	4	5	4	2	0	0	4	4	2
				RIDDOR Compliance %	-			66.7%	100.0%	75.0%	100.0%	40.0%	75.0%	0.0%	-	-	75.0%	50.0%	100.0%
				Health & Safety Incidents	-	H		25	17	19	107	118	118	96	108	80	119	151	114
				Sharps Injuries	-			8	11	8	15	14	10	6	12	10	7	17	8
				Violence & Aggression Incidents	-	H		74	83	155	141	109	136	127	138	176	193	252	174
				Assaults - Patient on Staff	-	H		41	44	71	58	63	75	55	64	60	64	99	78
				EDNs Completed Within 24hrs %	90.0%	H	F	69.8%	73.7%	74.3%	72.9%	71.5%	74.2%	77.9%	77.7%	74.4%	75.5%	78.5%	78.1%
	Falls			Low or No Harm Falls %	95.0%		?	96.4%	100.0%	100.0%	97.1%	96.2%	97.8%	97.4%	95.9%	98.9%	100.0%	97.9%	100.0%
				Falls - Total	-			84	61	71	69	78	92	78	74	88	77	94	80
				Falls - Low Harm	-			15	14	20	24	25	26	23	11	30	24	22	22
				Falls - Moderate Harm	-			0	0	0	1	2	0	2	1	0	0	0	0
				Falls - Severe Harm	0		?	3	0	0	1	1	2	0	1	1	0	2	0
				Falls Resulting in Death	0		?	0	0	0	0	0	0	0	1	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Falls			Falls per 1,000 Bed days	-			5.67	3.98	4.81	4.47	5.08	5.96	4.99	4.98	5.88	5.07	6.68	5.22
	Pressure Ulcer			Pressure Ulcers - Total	-	H		33	30	37	43	41	41	44	46	40	33	37	42
				Pressure Ulcers - Grade 1	-	H		8	2	6	16	15	14	19	16	20	10	12	18
				Pressure Ulcers - Grade 2	-			5	10	3	9	5	5	3	6	3	5	8	5
				Pressure Ulcers - Grade 3	0	H	?	0	0	1	0	0	0	0	1	0	0	2	3
				Pressure Ulcers - Grade 4	0		?	0	1	0	1	0	0	3	1	2	0	0	0
				Pressure Ulcers - Unstageable	-			9	9	14	7	9	6	7	7	8	8	8	5
				Pressure Ulcers - Deep Tissue Injury	-			11	8	13	10	12	16	12	15	7	10	7	11
				Pressure Ulcers per 1,000 Bed Days	-	H		2.23	1.96	2.51	2.79	2.67	2.66	2.82	3.10	2.67	2.17	2.63	2.74
	Medicines			Medicine Errors - Total	-			71	72	82	98	101	74	87	97	70	63	89	82
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	98.6%	100.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%
	IPC			IPC Incidents	-	H		11	7	24	30	54	41	56	39	53	35	45	50
				C-Diff Cases - Hospital Acquired Total	-			7	6	8	3	1	5	3	3	5	3	4	7

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	33			7	13	21	24	25	30	33	36	41	44	48	55
				C-Diff Cases - Hospital Acquired (HOHA)	-			5	4	5	2	0	3	3	3	3	1	3	6
				E.coli Cases - Hospital Acquired	-			6	4	4	5	9	4	9	5	8	2	6	4
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			6	10	14	19	28	32	41	46	54	56	62	66
				MRSA Cases - Hospital Acquired	0		?	1	1	0	0	0	0	1	1	0	0	0	0
				MSSA Cases - Hospital Acquired	-			2	3	7	2	1	2	4	3	1	4	3	2
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			2	5	12	14	15	17	21	24	25	29	32	34
	Mortality			Crude Mortality Rate %	1.30%		?	1.99%	1.41%	1.27%	1.28%	1.31%	1.44%	1.53%	1.18%	2.13%	2.00%	1.66%	1.53%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	2	1	1	2	0	1	1	2	2	1	0	0
				Avoidable 2222 Calls – Peri-Arrests	3		?	2	2	3	2	4	2	0	2	0	3	2	0
				Avoidable 2222 Calls	16	L	P	4	3	4	4	4	3	1	4	2	4	2	0
				HSMR (All)	100	H	F	116.25	114.14	113.42	111.25	111.05	111.89	111.91	107.97				
				Expected Death Rate %	-	H		3.7%	3.8%	3.8%	3.7%	3.7%	3.8%	3.8%	3.8%				
				SHMI	1	H	F	1.14	1.15	1.14	1.12	1.13	1.16	1.15					

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%		?	67.6%	72.2%	56.0%	48.4%	76.7%	31.3%	52.1%	71.9%	50.0%	71.4%	73.7%	
				Number of Deaths Reviewed via SJR	-	H		8	11	14	15	9	8	12	13	8	13	12	11
				SJRs Completed %	25.0%		F	5.0%	8.5%	11.0%	11.2%	7.0%	6.3%	7.8%	9.8%	4.3%	6.6%	7.2%	6.8%
				Total Number of Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	1	0	0
				Number of LD Deaths Reviewed via SJR	-			1	1	0	1	0	1	1	1	0	1	1	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	?	84.6%	88.4%	91.8%	98.2%	98.8%	99.5%	98.2%	98.7%	97.2%	98.3%	98.3%	98.0%
	Maternity			Caesarean Section %	-			49.3%	45.2%	50.8%	48.2%	44.9%	47.3%	46.7%	51.6%	48.8%	49.6%	52.0%	44.1%
				Elective C-Section %	-	H		17.2%	16.7%	20.8%	16.4%	16.9%	22.0%	21.0%	21.5%	17.6%	19.8%	19.6%	19.2%
				Emergency C-Section %	-			32.1%	28.6%	29.9%	31.8%	28.0%	25.3%	25.6%	30.0%	31.2%	29.8%	32.3%	24.9%
				PPH greater than 1000mls	-			40	35	44	35	56	30	39	49	54	35	44	41
				Total Number of Still Births Greater Than 24 weeks Gestation	-			3	0	2	1	1	2	2	3	0	1	3	0
				Neonatal Deaths	-			2	2	1	2	4	4	0	1	4	1	2	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Maternity			Maternity Serious Incidents	-			0	1	0	2	0	0	0	0	1	2	2	1
				Maternity HSIB Referrals	-			0	0	0	1	0	0	0	0	1	2	2	1
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	1	0	0	0	1	1	1	1	0
	Risk & Policy			Risks Approved	-			18	13	18	12	16	17	11	10	20	11	16	17
				Risks Approved - Low	-			0	0	0	0	0	0	0	0	0	1	1	1
				Risks Approved - Moderate	-			0	0	1	0	2	0	1	0	1	1	3	2
				Risks Approved - High	-			10	8	11	8	11	11	6	7	11	6	11	5
				Risks Approved - Extreme	-			8	5	6	4	3	6	4	3	8	3	1	9
				Risks Approved - Closed	-			6	33	24	3	6	14	12	17	3	9	9	14
	Health & Safety			Resuscitation Training Compliance %	-			79.4%	79.3%	80.9%	81.1%	78.6%	79.5%	81.3%	81.6%	81.2%	82.2%	82.4%	
				Mental Capacity Act Training Compliance %	-			81.9%	81.9%	83.1%	82.3%	81.3%	80.6%	80.3%	80.6%	81.5%	81.4%	81.7%	
	Legal & Information Governance			Inquests Received	-			0	5	3	14	18	16	6	8	21	15	14	7
				Inquest Hearings	-			2	4	3	3	5	6	6	13	3	6	9	8

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Quality	Legal & Information Governance			Regulation 28 Reports	-			0	0	0	0	0	0	0	0	0	0	0	0

SIOR - Quality

Successful Deliverables

- The number of incidents relating to falls have reduced during March.
- No falls with a severe harm during March
- There has been a slight increase in grade 1 pressure damage overall.
- The VTE risk assessment remains on target with 98% compliance
- Continued closure of SIs in line with trajectory.
- 0 avoidable 2222 calls in march

Next Steps

N/A

Identified Challenges

- Staffing in the falls team has been identified as an issue due to long term sickness and a member of staff retiring.
- The transfusion and thrombosis group commenced in November, the next meeting is scheduled mid-March. Risks and actions will be handed over to the group
- Falls and TVN equipment process has been a consistent challenge. Stock continues to be destroyed or discarded in appropriately.
- New wound care guidance has been published nationally which is required to be implemented by April 2024.
- High number of overdue open incidents - >1200 incidents are 12 hour breaches in ED that need closing by clinical teams.
- 11 incidents causing moderate harm or above (uninvestigated)

Next Steps

- Mitigations to consider increasing the capacity in the falls team have been included in the business planning cycle.

Opportunities

- New pressure ulcer guidance was published in January 2024. a full roll out plan was drafted and actions have commenced with the clinical teams.
- PSIRF giving opportunities to learn from incident and implement improvements much faster

Next Steps

N/A

Risks

- 1557 – VTE risk assessments are being accurately captured however the scope for inclusion of elective patients needs to be agreed at HTTG . A proposal to increase the frequency of the HTTG group has been discussed but not agreed.
- Mattresses and falls equipment failures are not being escalated to the specialist teams which results in their disposal. There is no process within the clinical engineering team to monitor and track equipment appropriately.

Next Steps

- To propose to increase the VTE nurse post from 0.6 WTE to 1.0 WTE though the business planning cycle, to decrease the risks raised on the register.
- TVN / Falls - A Task and finish group continues to remedy the equipment issues with estates and facilities

SIOR - Maternity

Successful Deliverables

- All MBRRACE cases reported within required timeframes.
- Launch of MCU/Triage QI Project
- SBLv3 Quarter 3 audits and evidence collation complete for submission to LMNS March 2024. Achieved 90% compliance across all elements.
- Fetal Monitoring Training and Assessment 100% for Consultants and Doctors in Training, 99.7%% for midwifery staff.
- PROMPT >90% for Midwifery and support staff.
- First AAR completed.
- New choosing Place of Birth Guideline now live to help staff support service users to make informed, personalised care choices. Staff engagement sessions held with all community teams.
- Teams talks staff raised concerns regarding Audit attendance; High Caesarean Section rate; Admin Shortages to support key clinical work; Vacancy and progress with recruitment.
- 0 Complaints received in month.
- Ongoing co-production work with MNVP including review of patient information and guidelines.
- Positive Service User feedback received from MNVP.

Next Steps

- Finalise Q3 SBL evidence in review period and prepare Q4 for submission.
- Continue to delivery obstetric emergency (PROMPT) and Fetal Monitoring training to ensure >90% compliance is maintained.
- Audit of NEWTT-2 Implementation.
- Publish audit plan for 2024/25 with dedicated Midwifery-led audit slots. Ensure dates are booked in advance and staff are supported to attend via their rota where possible.
- Business planning underway to consider additional admin staff to support specialist and essential clinical roles.
- Monthly workforce poster to keep staff informed of recruitment and retention work now in use.

Identified Challenges

- Coroner's case completed in March 2024 – no regulations or warnings issues against Trust.
- 0 Incidents Moderate or above in March 2024
- 0 referrals to MSNI and 0 PSIRF investigations undertaken
- 3 MBBRACE reportable deaths in March 2024 – 3 Neonatal deaths – 23+3 (twins), 21+5.
- 1 Maternity PMRT meetings March 2024 (1st Case, B,A, Parents felt results pathway was not communicated well post-delivery)
- 2 Neonatal PMRT (1st Case, A,B,A – Born at neighbouring Trust. Actions for MFT to improve respiratory management for neonate within first 24 hours / 2nd Case B,A Miscommunication regarding testing for UTI)
- Mandatory training below Trust Target for core subjects including Moving and Handling and Safeguarding, off trajectory to achieve 85% compliance for Safeguarding Adults Level 3 by March 2024 (currently 71% for midwives)
- Obstetric and Anaesthetic medical staff <85% compliance with PROMPT training. Consultant attendance impacted by junior doctors strikes.

Next Steps

- Share learning and findings from Coroner's inquest with staff.
- Escalating concerns regarding delays in post-loss bloods. Patient information sheet to be developed to outline post-loss bloods timescales.
- Targeted approach at monthly pick"N"Mix sessions to support staff to increase compliance in core subjects.
- Escalation to matrons for continued/prolonged non-compliance with mandatory training requirements for individual staff.
- Trajectory in place for Safeguarding adults following incorrect mapping noted in December 2022. Off-track to achieve trajectory of >85% by March 2024. Named midwife for Safeguarding reviewing compliance. Need to ensure all medical staff are booked onto training.
- Education team continue to liaise with Service Manager and General Manager to ensure all medical staff are allocated PROMPT training place on rota.

Opportunities

- Launch of PSIRF provides opportunities to work more closely with families when investigating incidents.
- CNST Year 6 published 2 April 2024.
- Audit of caesarean section pathway to help understand increased caesarean section rate, in particular ELCS for maternal request with no other medical reason.
- Carbetocin Trial for PPH to be extended to all theatre deliveries to help determine best management for PPH.
- Audit of 3rd and 4th degree tears underway to help understand and reduce incidences of perineal trauma.
- Working with Trust Leads to consider transfer of dual qualified International nurses to midwifery to support vacancy.
- CQC Picker Maternity Survey underway. Comms shared on social media/Trust website/across department to seek service user feedback.

Next Steps

- Key staff to attend PSIRF training to support the investigation process.
- Review Perinatal Quality Surveillance tool and CNST Year 6 reporting requirements with LMNS in light of move to PSIRF.
- LMNS CNST Review day arranged 23 April 2024.
- Await findings of audits to consider next steps in management of PPH and Perineal Trauma.

Risks

- Maternity Staffing remains the highest scoring risk on the Women's risk register (Risk ID Midwifery staffing ID 1134 Score= 20). Score reviewed by CNO remains 20 and moved to Safety Domain. Vacancy remains >17 with an additional 11.52 maternity leave.
- Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info Risk ID 1025 Score =15)
- Maternity Information system coming to end of contract (Risk ID 1864 Score =15). Business case being drafted.
- Delays in Induction of Labour (Risk ID 1131 Score =12)
- Delivery Suite Birthing Beds >10 years old and require replacement (Risk ID 1776 Score =12). Beds now ordered and risk will be removed when arrived.

Next Steps

- Continue with recruitment and retention work, alongside business case for Birthrate Plus recommendations.
- Work with Trust Leads to consider transfer of dual qualified international nurses to Midwifery.
- September 2024 anticipate 3 graduates and 9 in January 2025. Full cohort expected Spring 2025 (approx. 30). Planning underway to ensure robust preceptorship programme in place to support large numbers of newly qualified staff.
- Euroking to be standing agenda item at IGG meetings as agreed with DPO from October 2023 onwards until issue resolved.
- Euroking procurement risk now with CDO, waiting for capital budget to be confirmed in 24/25 to procure new system.
- Changes to the IOL pathway, including daily consultant review, mitigating risk, however increase in delays in February 2024. Risk remains at 12 and was not able to be reduced in March 2024.

Systems & Partnerships

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Operational Leads:
Benn Best - ***Divisional Director - Surgery and Anaesthetics***
Holly Reid - ***Divisional Director - Medicine and Emergency Care***
Nicola Cooper - ***Divisional Director - Cancer and Core Clinical Services***
Vacant - ***Divisional Director - Women, Children and Young People***

Committees:
Finance & Performance Committee

Patient FIRST

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	92.0%	L	F	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%

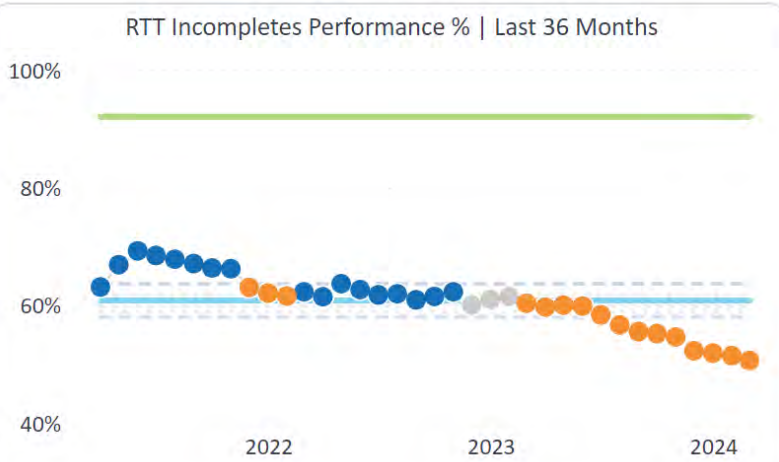
True North Domain: **Systems & Partnerships**

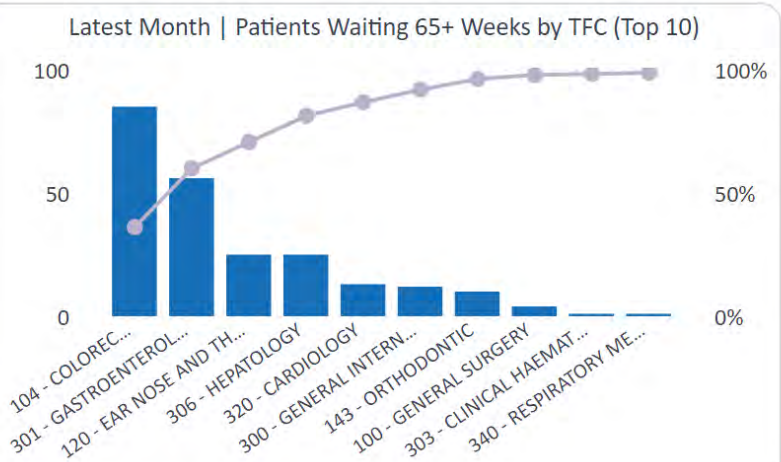
KPI Threshold: 92.0%

Sub Domain KPIs: 26

Variation Summary:

	L	H	L	H
13	4	6	2	1





Key Messages

Trust declared 2 x 78 week breaches at end of March 2024 (both patient choice). Now working to reduce >65 week waits
Lack of Endoscopy capacity linked poor performance in Gastro and colorectal

Issues, Concerns & Gaps

Lack of Endoscopy capacity linked poor performance in Gastro and colorectal

Actions & Improvements

GM PTL meetings recommence 18.04.2024 providing assurance around validation and PTL management within the care groups

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	76.0%			77.5%	76.9%	75.5%	73.7%	75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%

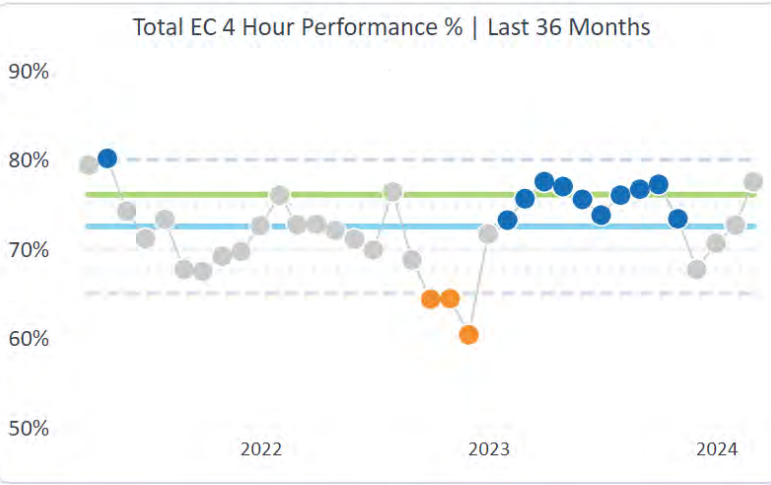
True North Domain: Systems & Partnerships

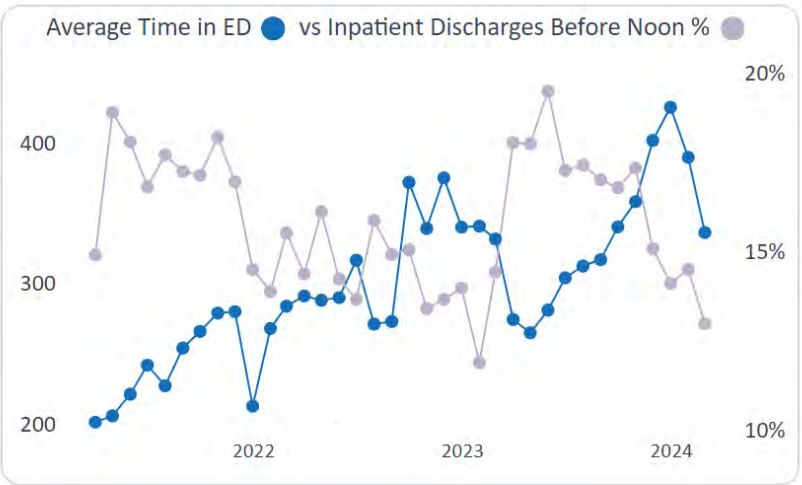
KPI Threshold: 76.0%

Sub Domain KPIs: 11

Variation Summary:

6	0	2	3	0





Key Messages

Total 4 Hour performance has improved again in March achieving 77.6% and most improved performance within the south east region. Area 3 remains challenged with assessment rooms being blocked, although this did improve during March as there was an increase inpatients identified for SDEC / SAU. Type 3 performance continues to be challenging. SPOA has launched and has contributed to on average 6-8 conveyance avoidances daily.

Issues, Concerns & Gaps

Flow out of the acute floor continues to be challenged with corridor care, although corridor care has reduced significantly and numbers remain low. The utilisation of CDA hit its highest numbers in March with 380+ patients accessing. LOS remained a concerns, although DTA within ED has also reduced.

The Trust have not yet achieved 40% of discharges by midday with a high number of medically fit patients occupying beds across the Trust.

Actions & Improvements

Relaunch of Acute Medical model to ensure optimal use of SDEC to unblock Area 3 has been well utilised with the largest number of patients accessing SDEC via ED recorded in March. Maintain utilisation of CDU & plan workforce to provide 24 hours a day with RMN. Collaborative working with KMPT to tackle LOS for mental health patients.

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Systems & Partnerships	Access			RTT Incompletes Performance %	92.0%	L	F	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%
				RTT 65+ Week Waiters	0	H	F	119	90	91	101	176	220	246	217	237	257	286	235
				RTT 40+ Week Waiters	-	H		3,083	3,236	3,139	3,465	4,235	4,370	4,395	4,523	5,311	5,569	5,927	6,329
				RTT Waiting List Size	-	H		36,659	37,018	37,847	38,661	39,676	40,403	41,150	41,562	42,487	43,133	43,716	44,704
				RTT 52 Week Breaches	0	H	F	581	820	877	1,019	1,143	1,209	1,291	1,441	1,439	1,659	1,886	2,160
				OP Average Time to First Appointment (days)	60	H	F	79.19	89.81	88.44	91.89	88.42	96.12	98.39	98.62	94.83	98.98	103.94	102.92
				Outpatient DNA Rate %	10.0%	L	P	7.3%	7.5%	7.7%	7.6%	7.4%	8.9%	7.5%	7.0%	7.5%	6.3%	6.2%	6.1%
				OP First to Follow Up Ratio	-	L		2.19	2.19	2.07	1.99	2.05	1.99	2.03	1.89	1.96	1.96	1.85	1.81
				Operations Cancelled by Hospital on Day	0		?	8	13	13	11	5	14	9	20	12	15	7	10
				Cancelled Operations Not Rescheduled < 28 Days %	-			37.5%	53.8%	7.7%	45.5%	80.0%	21.4%	22.2%	70.0%	75.0%	53.3%	42.9%	30.0%
				Urgent Operations Cancelled for 2nd Time	0		?	2	2	1	2	0	2	1	3	2	0	2	1
				Day Case Rate %	-			85.8%	85.6%	83.9%	85.6%	86.1%	85.5%	87.0%	85.9%	86.2%	87.9%	86.8%	83.9%
				Average Elective Length of Stay (days)	3	H	?	2.78	2.48	2.49	2.46	2.60	2.74	3.32	3	2.79	2.54	2.49	3.10

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10		P	4.93	4.57	4.63	4.51	4.50	4.89	4.83	4.79	4.81	4.66	4.63	4.29
				104 Day Cancer Waits	-			7	12	7	13	12	10	17	17	7	13	12	
				Cancer 2ww Performance %	93.0%	L	?	94.5%	94.9%	92.2%	94.3%	88.5%	93.4%	90.2%	85.8%	92.7%	84.9%	73.0%	
				Cancer 2ww Performance - Breast Symptomatic %	93.0%	L	?	93.6%	100.0%	83.3%	100.0%	41.7%	83.1%	80.0%	63.5%	69.4%	58.4%	38.4%	
				Cancer 31 Day First Treatment Performance %	96.0%		?	100.0%	98.8%	98.7%	99.3%	98.2%	98.8%	98.1%	93.6%	99.2%	97.0%	98.7%	
				Cancer 31 Day Subsequent Treatments - Drugs %	98.0%		?	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	97.5%	100.0%	100.0%	91.2%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	94.0%		?	94.4%	91.3%	100.0%	100.0%	85.0%	95.0%	93.9%	93.8%	100.0%	81.3%	86.4%	
				Cancer 62 Day Treatment - GP Refs %	85.0%		?	79.2%	67.1%	71.4%	72.5%	74.8%	78.9%	65.6%	68.1%	79.0%	72.5%	68.1%	
				Cancer 62 Day Treatment - Cons Upgrades %	50.0%	H	?	77.8%	72.7%	34.4%	75.9%	76.7%	83.3%	81.3%	81.6%	78.4%	80.3%	72.2%	
				Cancer 62 Day Treatment - Screening Refs %	90.0%		?	88.9%	40.0%	70.0%	77.8%	87.5%	65.9%	72.4%	85.2%	74.1%	73.3%	47.6%	
				Cancer 28 Day Faster Diagnosis %	75.5%		?	77.6%	69.3%	72.4%	73.3%	74.0%	70.0%	66.6%	65.2%	69.8%	63.1%	73.0%	
				Cancer 28 Day Faster Diagnosis Screening %	-			78.6%	82.1%	55.8%	68.6%	66.1%	61.9%	68.5%	74.1%	76.7%	47.7%	79.3%	
				DM01 Performance %	99.0%	L	F	67.7%	65.5%	67.1%	65.1%	59.8%	61.6%	61.3%	62.1%	56.6%	59.5%	66.7%	66.9%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	76.0%		?	77.5%	76.9%	75.5%	73.7%	75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%		?	84.0%	82.1%	81.1%	79.1%	81.8%	82.3%	82.6%	78.7%	73.8%	75.7%	77.9%	82.8%
				IP Discharged Before Noon % (Inc transfers to ADL)	40.0%		F	18.0%	18.0%	19.5%	17.2%	17.4%	17.0%	16.8%	17.3%	15.0%	14.1%	14.5%	12.9%
				Type 1 EC 4 Hour Performance %	75.0%		F	62.8%	64.8%	65.9%	63.0%	64.2%	65.8%	65.2%	62.0%	52.9%	59.1%	63.5%	69.3%
				Total EC 12 Hour Breaches	0	H	F	131	106	190	344	387	572	742	766	785	953	798	798
				Average Time in EC Department (mins)	200	H	F	273.57	264.10	280.22	303.22	311.69	316.19	339.50	357.44	401.08	424.67	389.02	335.46
				Number of ED Arrivals by Ambulance	-			2,929	3,048	2,777	3,007	2,978	3,009	3,107	3,137	3,167	3,281	2,956	3,173
				Ambulance Handover Delays (> 30 mins)	-	L		57	32	40	59	42	46	73	85	177	161	90	103
				Ambulance Handover Delays (> 60 mins)	0	L	?	2	2	3	1	2	3	1	3	10	9	5	6
				Medically Fit for Discharge Patients %	9.0%			-	-	-	-	-	-	-	-	-	-	-	-
				30 Day Readmission Rate	13.0%	L	P	10.0%	9.1%	9.9%	9.6%	9.1%	9.3%	10.1%	9.7%	10.1%	9.3%	10.3%	9.1%

SIOR - Access

Successful Deliverables

RTT
- Continued reduction in outpatient DNA rates – currently 6.1% (Lowest for 13 months)
- ASI list reduced to 5
- OP New:follow ratio reduced to 1.95

CANCER
- 31 day exceeds national target with 98.3% performance against a target of 96%

Next Steps

Continuation of mutual aid provision with DVH to support backlog reduction in Cancer/DM01 and RTT

Identified Challenges

Lack of Endoscopy capacity impacting cancer, DM01 and RTT performance. 28 day performance 66.4% against a target of 75%
Industrial Action has had an impact on annual capacity
Mutual Aid with DVH was paused for 3 weeks due to JAG notification around outsourcing to non-accredited Trusts – now resolved and patients been sent over to book.

Next Steps

Continued work with regional and national colleagues around sustainable solution for Endoscopy. Mutual Aid with DVH continues and is working well.

Opportunities

RTT
- Relaunch of PIFU programme
- AI in outpatients

Next Steps

PIFU - engaging with clinical and operational teams through care group and clinical governance meeting
AI proof of value approved at TIG

Risks

Lack of Endoscopy capacity impacting cancer, DM01 and RTT performance

Next Steps

Continued work with regional and national colleagues around sustainable solution for Endoscopy. Mutual Aid with DVH continues and is working well.

SIOR - Emergency Care

Successful Deliverables

- Although our non-admitted performance is below the 85% threshold, we achieved 77.6% in March and most improved in the south east regions, securing £2m in capital.
- CDA performance is also improved on the previous month with our highest number of patients accessing in a single month, 380+.
- 111 pathway continues to deliver with no patients accessing breaching the four hour non admitted target.
- SPOA has launched and early signs show it is contributing to 6-8 conveyance avoidance.

Next Steps

- Continued push for improvement of CDA utilisation
- Continue to work towards implementation of HARIS initiatives covering High Intensity Users and reduction of Ambulance Conveyance
- Life validation of breaches, although significantly improved to 80+%, need to maintain this daily.
- Continue to provide senior support within ED to improve on our 4 hour performance in March.

Identified Challenges

- Increased acuity and number of referrals remain high, although reduced there is room to improve
- Type 3 performance remains challenged.
- Sustained non admitted performance above national targets and work towards 95%
- Mental Health CDA utilisation – Identify appropriate location for MH patients to allow CDA to fully function 24/7

Next Steps

- Review of referrals to be undertaken to provide assurance around need to refer and admit patients.
- Utilisation of Mental Health pathways – Allowing CDA to function.
- Increase utilisation of streaming to Meddoc and alternative care pathways, although improved, ensure that SDEC is functioning and referrals going at earliest opportunity rather than late referrals.

Opportunities

- Partnership working with KMPT to fully utilise mental health pathways.
- SDEC emergency care pathway.
- Single point of access pathway to reduce unnecessary conveyances to ED, ongoing but work towards maintain number of admission avoidances.
- Speciality in-reach
- Operational management on the shop floor to directly monitor 4 hour performance – Senior rota developed

Next Steps

- Improved utilisation of Mental health pathways in collaboration with KMPT.
- Review of SDEC clinics – to be matched in line with avoidable DTA's and ensure full utilisation, early opportunities.
- Provide senior support to shop floor and complete reviews of performance when senior support not present, early data suggests it has a positive impact.

Risks

- Capacity across ED, with patients lodging across floor and corridor, although reduced maintains a concern.
- Finance restrictions to implement improvements.
- High acuity and increased attendances via ED.
- Industrial Action.

Next Steps

- System partnership working to address and understand support when acute Trust is at critical capacity.
- KMPT to review and address prolonged wait times for mental health patients i.e. awaiting admission.
- Review pilot of SDEC emergency care and launch SPOA – reviews to be conducted shortly.
- Improvements within department to allow fully function of all areas – Area 2 etc.

People

Leon Hinton
Chief People Officer

Operational Lead:
Dominika Kimber - ***Deputy Director of HR & Organisational Development***

Committees:
People Committee

NHS Medway NHS Foundation Trust

Patient FIRST

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65

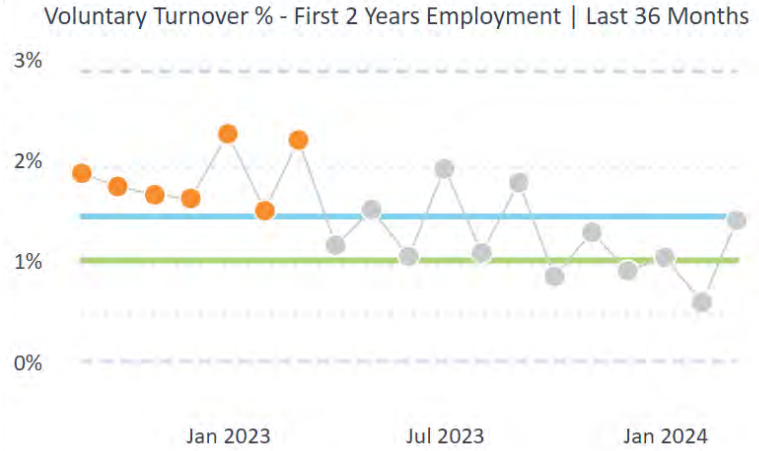
True North Domain: People

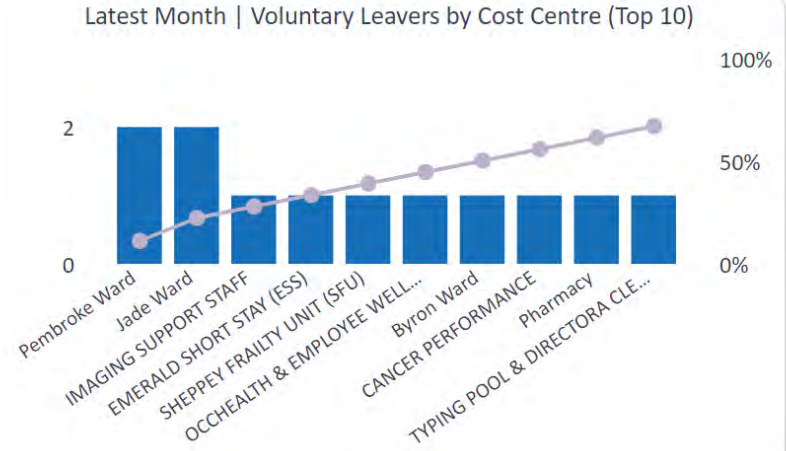
KPI Threshold: 6.93

Sub Domain KPIs: 50

Variation Summary:

	L	H	L	H
20	5	0	2	23





Key Messages

The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey.

The breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% with March 2024 reporting off-target from the monthly target. The new stay conversation processes and intention to leave process are now both live; however, with A3 in progress to improve take-up. A significant number of countermeasures have been enacted to address the turnover (improving trend over 12-months).

Issues, Concerns & Gaps

- Quality of the leaver process in ensuring exit interviews are carried out and learning applied;
- Limited data in real-time, to ensure we have a system in place to identify future leavers (intention to leave) – low compliance with new process;
- Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice;
- Limited data regarding flexible working take up.

Actions & Improvements

- Revised communication plan, developed with divisions to ensure managers and staff understand the new intention leave processes;
- New datasets for the stay and intention to leave processes to be presented to breakthrough huddle when take up is sufficient to report.
- Delivery of improvement plan developed and governed by anti-bullying and harassment group;
- Breakthrough huddle pack to be improved to ensure divisions have quality stratified data with the new datasets.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
People	Workforce			National Staff Engagement Score	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.2%	1.5%	1.0%	1.9%	1.1%	1.8%	0.8%	1.3%	0.9%	1.0%	0.6%	1.4%
				Staff Appraisal Rate %	90.0%	L	F	92.3%	92.2%	92.3%	91.5%	91.7%	90.0%	89.7%	89.6%	89.0%	88.8%	88.4%	88.0%
				Staff in Post (FTE)	-	H		4,683.45	4,701.74	4,735.50	4,767.53	4,845.66	4,841.64	4,923.12	4,956.28	4,984.52	5,005.97	5,051.81	5,078.78
				Staff Leavers (FTE)	-			55.76	50.59	45.45	59.55	129.36	82.43	66.89	57.12	46.37	39.76	37.66	51.02
				Staff Starters (FTE)	-			66.93	80.02	59.85	74.79	164.09	102.71	133.28	78.48	45.43	86.30	68.08	45.99
				Vacancy Rate %	9.0%	L	?	7.5%	7.3%	6.3%	5.7%	5.1%	4.5%	4.0%	4.2%	3.7%	3.3%	2.5%	2.0%
				Voluntary Turnover %	8.0%	L	F	12.6%	12.5%	12.5%	12.1%	11.4%	11.3%	10.9%	10.8%	10.7%	10.2%	9.7%	9.4%
				Staff Fill Rate - Total %	85.0%	H	?	87.7%	89.9%	91.1%	91.8%	90.5%	88.1%	89.5%	92.8%	90.0%	91.1%	91.6%	92.3%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		86.0%	87.1%	88.4%	88.1%	86.3%	84.8%	87.7%	89.3%	88.2%	88.8%	90.0%	89.9%
				Care Hours per Patient Day (CHPPD)	9.50	H	F	9.14	9.21	9.27	9.14	9.15	9.03	9.05	9.18	9.05	9.09	9.20	9.02
				Sickness Absence Rate - Total %	4.0%		?	4.0%	4.0%	3.9%	4.3%	4.7%	4.9%	4.9%	4.4%	5.1%	5.5%	4.8%	4.3%
				Sickness Absence Rate - Short Term %	2.0%		?	2.1%	2.0%	1.8%	1.9%	2.4%	2.7%	2.4%	2.2%	2.9%	3.2%	2.5%	2.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
People	Workforce			Sickness Absence Rate - Long Term %	2.0%			1.9%	1.9%	2.1%	2.4%	2.3%	2.2%	2.5%	2.3%	2.2%	2.2%	2.4%	2.2%
				StatMan Training Compliance %	85.0%			85.5%	86.2%	87.4%	86.5%	83.7%	84.9%	86.0%	86.7%	87.4%	87.4%	87.9%	87.7%
				Professional Registration Compliance %	100.0%								100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				DBS Compliance %	100.0%		F						-	-	99.1%	99.2%	99.1%	99.1%	99.0%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	92.3%	92.6%	93.5%	92.4%	92.0%	92.4%	92.7%	93.5%	94.0%	93.5%	94.1%	94.5%
				StatMan: EDI Compliance %	85.0%		P	94.6%	94.0%	95.2%	94.3%	94.3%	94.2%	94.3%	95.0%	95.5%	95.4%	95.4%	95.4%
				StatMan: Fire Safety Compliance %	85.0%		F	81.3%	81.5%	85.8%	83.6%	83.7%	83.2%	83.1%	82.5%	82.1%	81.7%	82.9%	81.2%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H		88.7%	89.4%	91.3%	85.5%	87.7%	89.5%	90.5%	91.7%	92.7%	93.0%	93.6%	94.0%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H		83.5%	83.6%	84.9%	87.2%	74.0%	76.6%	79.4%	82.4%	83.7%	86.8%	87.2%	88.0%
				StatMan: Health Safety and Welfare Compliance %	85.0%		P	90.1%	89.1%	87.1%	83.4%	90.2%	88.3%	86.7%	86.7%	89.8%	89.3%	89.6%	89.2%
				StatMan: Infection Prevention L1 Compliance %	85.0%	H	P	95.4%	95.8%	96.1%	93.9%	93.6%	93.9%	94.8%	95.8%	95.6%	96.3%	96.9%	97.5%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	88.3%	88.9%	90.3%	88.3%	87.1%	87.7%	89.1%	89.0%	89.6%	88.8%	88.7%	88.5%
				StatMan: Information Governance Compliance %	85.0%	H	P	88.7%	89.0%	91.6%	90.0%	89.7%	89.9%	90.8%	90.7%	90.9%	90.4%	91.0%	90.8%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
People	Workforce			StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	87.0%	87.6%	90.9%	90.6%	47.3%	66.6%	77.9%	83.2%	85.8%	87.4%	89.0%	90.1%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	78.7%	80.0%	81.3%	82.8%	83.9%	81.0%	80.6%	80.7%	81.2%	79.2%	78.9%	78.9%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	L	F	53.3%	53.5%	51.5%	51.1%	50.6%	48.0%	44.1%	44.9%	45.1%	45.0%	44.5%	43.7%
				StatMan: Patient Safety L1 Compliance %	85.0%		P	90.5%	91.0%	93.0%	92.2%	92.9%	93.5%	94.3%	94.5%	95.1%	95.3%	95.4%	88.6%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	87.5%	93.3%	86.7%	80.0%	-	-	-	-	-	-	-	-
				Diversity of workforce %	-	H		-	-	-	-	-	38.8%	39.4%	39.9%	40.2%	40.5%	40.6%	41.0%
				Diversity of Board %	-			-	-	-	-	-	100.0%	100.0%	100.0%	100.0%	100.0%	200.0%	22.2%
				StatMan: Basic Prevent Compliance %	85.0%	H	P	94.9%	95.0%	94.3%	92.1%	92.3%	92.4%	93.7%	94.9%	96.1%	94.6%	96.0%	97.0%
				StatMan: Prevent WRAP Compliance %	85.0%	L	P	91.1%	90.8%	91.7%	91.2%	90.3%	88.1%	87.3%	87.3%	87.6%	86.9%	87.2%	87.8%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	91.8%	92.0%	93.7%	94.2%	93.6%	94.1%	94.0%	95.0%	96.0%	95.8%	96.4%	97.3%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%		P	91.5%	91.0%	91.9%	91.3%	91.6%	93.0%	93.1%	93.2%	94.0%	92.0%	91.8%	91.1%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	3.1%	12.5%	21.5%	24.7%	36.6%	43.6%	48.2%	54.5%	57.2%	59.6%	63.6%	66.9%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%	H	P	94.9%	94.8%	94.4%	92.0%	92.7%	93.4%	94.2%	94.6%	95.5%	96.0%	96.4%	97.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
People	Workforce			StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	90.5%	90.5%	90.7%	89.9%	88.3%	88.0%	85.7%	84.6%	84.4%	82.8%	83.2%	82.9%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	?	84.7%	83.0%	83.6%	83.2%	82.2%	80.8%	80.9%	82.0%	80.0%	79.9%	77.6%	76.7%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	81.7%	80.5%	79.6%	77.6%	71.8%	77.0%	77.7%	76.6%	74.5%	74.5%	71.8%	75.2%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	79.6%	79.2%	80.5%	80.8%	79.4%	81.4%	82.7%	82.4%	81.4%	82.0%	80.9%	82.1%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	74.9%	74.0%	76.0%	78.9%	78.6%	75.8%	74.3%	74.4%	75.1%	76.3%	80.2%	80.2%
				StatMan: Anaphylaxis Compliance %	85.0%	H	?	87.9%	88.2%	89.7%	89.5%	83.2%	84.4%	87.7%	90.2%	90.1%	91.1%	91.8%	91.7%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%		F	60.7%	66.7%	78.6%	83.3%	73.2%	72.7%	80.4%	81.8%	81.5%	76.4%	65.5%	74.1%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	69.7%	71.7%	71.1%	72.3%	72.6%	69.5%	68.0%	66.3%	70.7%	71.7%	71.2%	77.8%
				StatMan: New Born Life Support Compliance %	85.0%	H	F	80.4%	79.5%	79.0%	74.7%	72.8%	73.4%	77.3%	77.5%	71.7%	73.4%	78.5%	82.9%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	68.1%	68.8%	72.1%	74.6%	74.0%	75.4%	77.7%	77.7%	78.2%	79.3%	77.6%	79.1%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	77.9%	76.5%	80.0%	75.9%	78.7%	72.2%	68.9%	64.1%	70.7%	76.1%	87.7%	83.4%

SIOR - People

Successful Deliverables

- Continued improvement trajectory for nursing and clinical support worker posts;
- Overall improvement in non-medical and medical recruitment KPIs (3 of 7 and 4 of 7 KPIs met respectively);
- People Strategy 2024-2027 presented to People Committee and other stakeholders;
- Continued target met for agency spend. Bank rates harmonisation agreed and enacted for April;
- Exceed annual target of 50 apprentices (60) and new T-level placements in place;
- OH stress handbook finalised.
- 85% EDI high-impact actions met, with remaining two in sign-off stage.

Next Steps

- Comments from People Committee re People Strategy to be finalised with stakeholder input;
- EDI high-impact actions to be finalised;
- Positive action policy draft for completion in April along with Disability Health Passport.

Identified Challenges

- Medical pay gap (EDI high-impact action) requires considerable time to improve.
- Capacity issues in relation to organisational development due to staffing issues.
- Capacity issues in relation to occupational health to meet KPIs, business case has been resubmitted.

Next Steps

- Focus on women's progression into medical leadership to address medical pay gap.

Opportunities

- Assurance required on the effectiveness of international recruitment induction and on-boarding.
- Promotion of flexible working policy in all advertising and recruitment packs.
- Consultant recruitment campaign in development.

Next Steps

- Go-live for consultant recruitment campaign, particularly in relation to shortage occupations of anaesthetics and otolaryngology.

Risks

- Continued capacity of occupational health facilities have a direct effect on the ability of the organisation to reduce time to hire metrics and address sickness rates within the Trust.

Next Steps

- Resubmission of the occupational health business case.

Sustainability

Alan Davies
Chief Financial Officer

Operational Lead:
Paul Kimber - *Deputy Chief Financial Officer*

Committees:
Finance & Performance Committee
Audit & Risk Committee

NHS Medway NHS Foundation Trust

Patient FIRST

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Financial Position

Breakeven Revenue Budget (£)

Type	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	£0.00m			-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	-1.33m

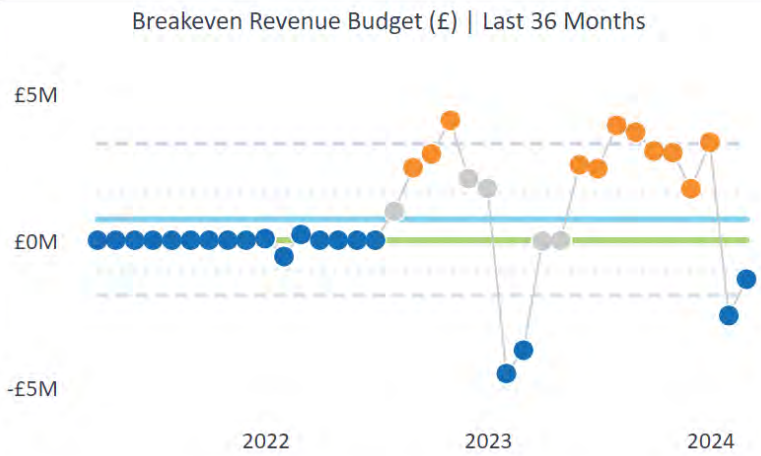
True North Domain: **Sustainability**

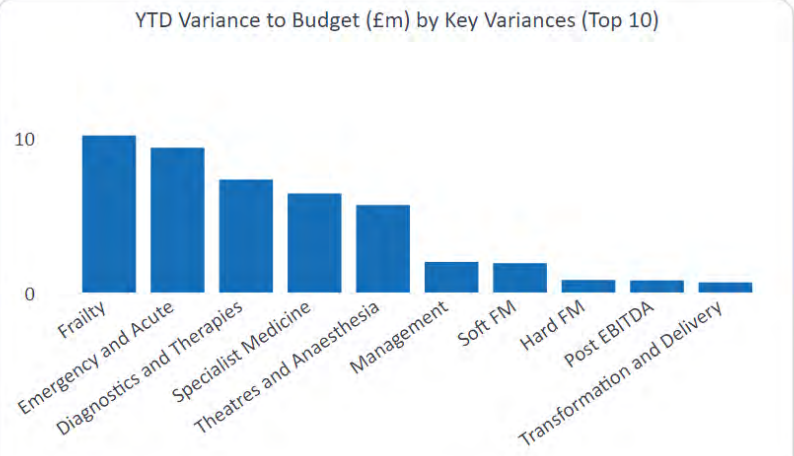
KPI Threshold: £0.00m

Sub Domain KPIs: 14

Variation Summary:

5	1	5	2	1





Key Messages

The Trust reports a surplus of £1.6m in month 12, this includes £1.3m of the £15m deficit support funding. After removing the allowable technical accounting for impairments and donated assets, the adjusted year to date deficit is £19.6m.

The adverse financial performance continues to be addressed through the efficiency programmes and business planning.

Issues, Concerns & Gaps

The Trust delivered the agreed forecast outturn position of £19.6m deficit for the year, this is mainly supported by non-recurrent mitigations being released into the position, ERF income over performance and additional income for patient transport, high cost drugs and overseas visitors.

The overspending continues to be primarily driven by the unbudgeted cost of escalation capacity, overspendings on medical and nursing staff, drugs and clinical supplies and a shortfall against efficiencies target.

Actions & Improvements

Robust business planning for 2024/25, including development of the efficiencies/waste reduction programme.

Development and implementation of an action plan to address the recommendations from the KPMG financial improvement report.

Drive to meet compliance of budget holder training.

Progress financial management team expansion proposal.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m	L	?	-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	-1.33m
				Total Financial Overspend (£)	£0.00m	H	?	1.02m	1.31m	3.30m	4.56m	5.33m	4.83m	5.43m	5.17m	5.79m	6.32m	6.02m	14.83m
				Agency Spend %	3.7%		?	2.6%	3.0%	2.7%	3.0%	2.9%	3.0%	2.6%	3.5%	2.7%	2.0%	2.7%	1.1%
				Bank Spend %	10.0%		?	12.8%	12.4%	11.1%	11.6%	13.8%	9.8%	12.2%	10.9%	11.0%	13.1%	11.7%	8.6%
				(Surplus) / Deficit (£)	£0.00m		?	2.46m	2.47m	4.82m	3.42m	4.90m	4.66m	3.84m	3.78m	2.55m	4.13m	-15.51m	-1.61m
				Agency Spend (£)	-			0.60m	0.70m	0.71m	0.75m	0.74m	0.80m	0.65m	0.88m	0.68m	0.54m	0.71m	0.42m
				Income (£)	-	L		-34.16m	-34.78m	-35.20m	-36.16m	-35.35m	-36.35m	-35.74m	-36.63m	-39.02m	-38.07m	-56.72m	-52.27m
				Income (£) vs Budget	£0.00m	L	?	-0.24m	-0.89m	-0.02m	-1.83m	-1.02m	-0.58m	-1.18m	-2.07m	-4.45m	-3.49m	-8.38m	-16.46m
				Total Pay Spend (£)	-	H		23.10m	23.32m	25.79m	24.45m	25.75m	26.83m	25.24m	24.93m	25.00m	26.71m	25.99m	36.63m
				Total Pay Spend (£) vs Budget	£0.00m	H	?	0.88m	1.12m	2.51m	2.64m	4.04m	3.22m	3.25m	3.70m	3.17m	4.85m	4.10m	14.63m
				Total Non-Pay Spend (£)	-	H		11.58m	11.70m	12.29m	12.91m	12.52m	11.77m	12.22m	13.18m	14.42m	13.35m	13.09m	11.47m
				Total Non-Pay Spend (£) vs Budget	£0.00m		?	-0.47m	-0.35m	0.26m	1.53m	1.04m	0.74m	0.97m	1.17m	3.01m	1.95m	1.72m	0.08m
				Actual Worked FTE	-	H		5,127.10	5,174.36	5,229.67	5,215.43	5,344.21	5,240.17	5,444.71	5,403.07	5,461.76	5,527.16	5,542.70	5,570.28
				Actual Worked FTE vs Budget	0	H	?	43.79	82.68	156.70	138.77	211.60	150.93	284.50	204.96	264.97	332.87	347.90	361.66

SIOR - Sustainability

Successful Deliverables

Overperformance against the ERF plans.
Further progress with the capture and counting work.
Delivery of the revised forecast position for 2023/24.

Next Steps

Focus on the efficiency programme for 2024/25 and submission of the financial plan to adhere to the NHSE and ICB timetable.

Identified Challenges

The key challenges currently faced by the Trust continue to be:

1. Finalising the Trust business plan for 24/25.
2. Management of medical and nursing pay costs, both of which are significantly overspent year to date.
3. Identification, development, implementation and delivery of the efficiencies programme..

Next Steps

Full delivery of KPMG report action plan.

Continued use of escalation capacity and activity pressures in acute and emergency care.

Opportunities

Focused support being received from NHSE Intensive Support Director.
Business planning for 24/25 identifying gaps between service provision and anticipated income.
Enhanced financial controls as agreed by the Executive team, as well as further opportunities recommended in the KMPG report.
A number of areas have been identified where the financial run-rate can be improved, particularly around workforce, including: Supernumerary periods; Enhanced care Roster headroom; Rostering

Next Steps

Development of financial improvement opportunities with NHSE ISD.
Medical efficiency Corporate Project A3's to be completed and agreed.
Action plan to be agreed in response to recommendations from the KPMG financial improvement report.
Delivery of enhanced controls agreed by executives, in particular pay related and rostering controls.

Risks

Ongoing risks continue, including:

- Identification and delivery of the efficiency programme for 2024/25.
- Run-rate remains high
- Possibility of further Medical staff industrial action impact of delivering care to the patients.
- Reducing cash balance if deficit continues.

Next Steps

Ongoing monitoring and reporting of risks through to Execs and FPPC

Meeting of the Trust Board
Wednesday, 15 May 2024

Title of Report	Board Assurance Framework		**Agenda Item**	6.3
Author	Integrated Governance Practitioner			
Lead Executive Director	Chief Financial Officer - Sustainability Chief Medical Officer - Quality Chief Nursing Officer (Interim) - Patient Chief Operating Officer - Systems and Partnerships Chief People Officer - People			
Executive Summary	The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through the Executive Board. The Board Assurance Framework (BAF) consists of 16 strategic risks aligned to each of the Trust's True North Domains.			
Proposal and/or key recommendation:	The Trust Board is asked to note the report for assurance and discussion.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	X
Committee/Group submitted:	Risk and Compliance Assurance Sub-Committee – 23.04.24			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) ✓	Priority 2: (People) ✓	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems) ✓
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	As outlined in the relevant sections of the Board Assurance Framework.			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	Not applicable			

Legal and Regulatory implications:	There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk.		
Appendices:	Board Assurance Framework (PDF)		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Integrated Governance Team medwayft.integratedgovernance@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1a	**Objective:**	Providing outstanding, compassionate care for our patients and their families, every time.
Executive Owner	Chief Nursing Officer		
Operational Owner	Nicola Lewis, Associate Director of Patient Experience	**Principal Risk Name & Description**	Low uptake as a result of patient feedback fatigue due to patients not being able to see the improvement being made from completing a survey makes.
Primary Risk Grouping	Patient		
CQC Domain	Responsive	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	3	4	**12**	—
Current Risk Score	3	4	**12**	—
Target Risk Score	2	4	**8**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	13.0%	14.4%	12.4%	12.6%	14.6%	13.9%	13.5%	
Inpatients FFT Response Rate	45.0%	35.4%	45.1%	42.2%	34.9%	40.3%	44.7%	40.4%	
Emergency Care FFT Response Rate	45.0%	9.5%	8.3%	7.2%	8.0%	9.7%	7.5%	8.4%	
Outpatient FFT Response Rate	45.0%	8.8%	9.5%	8.0%	9.0%	10.1%	9.2%	9.1%	
Maternity FFT Response Rate	45.0%	33.3%	26.3%	14.4%	30.7%	38.7%	30.4%	29.0%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

This is the local target for the FFT response rate as part of the patient first breakthrough objective and the patient experience strategy. The risk score was raised in June as the response rate scores for ED and OPD reamin low and maternity response rate dropped in comparison to the months previously. There is little likelyhood that covid will have an impact on FFT response rate in the near future

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Quality Improvement Projects have been commenced based on patient feedback Engaging with patients to understand why they do not complete the FFT survey Change of SMS text provider Widened scope of text distribution Increasing use of electronic devices Paper surveys have been discontinued Posters and QR codes disseminated	Increased uptake in FFT responses in all areas Improvement in recommend rate and overall experience of care Improved response for completed surveys versus opened and incomplete surveys via text Improvement in recommend rate and overall experience of care CQC surveys / data Patient Experience Group

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	On Track/Not Yet Due	Malou Bengtsson-Wheeler	16/04/24 S&A areas completed. Other divisions will be completed by the end of April
Closure of feedback loop from patient feedback from FFT to patients/carers/staff and visitors	1a Regular updates regarding improvements made based on patient feedback on Trust website, social media and patient information. 1b Comms and patient exp team to create SOP for quarterly updates on the website.	31/03/2024	Complete	Nicola Lewis, Associate Director of Patient Experience	15/01/2024 Information is being passed onto patients via social media however, the Patient information group to commence January 2024. Comms will update when the new website is launched in late March 2024. the due date to change in line with the launch of the new website. Update 16/04/24 - new website has been launched
Low response feedback rate in ED in OPD areas	2 Targeted focus with improvement initiatives in OPD in ED such as, an FFT champion each shift, FFT infomration placement for patients to understand why it is important to complete the feedback survey	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	OPD Staff are engaging clinical teams in each clinic to provide a reminder to each patient to provide feedback if they get a text in OPD. action reviewed and split into 2 new actions for tracking and assurance. This action to be closed. Actino closed January 2024
Some wards still utilising paper surveys	3 Business case to be written to Lease patient experience IPADS. This work is being carried out with the estates and facilities team to include digital meal ordering. Tablets to be fixed and returned to the wards for FFT use.	31/07/2023	On Track/Not Yet Due	Nicola Lewis, Associate Director of Patient Experience	Proposal is awaiting input from the director of IT and Estates and facilities team. The aim for this to be ready is w/c 02/10/2023. 16/10/23 update was received from DoIT which have been reflected in the BC. Further discussion is required with EH prior to submission. 09/11/23 an audit to account for all tablets in clinical areas was completed in October. scoping to be completed by the transformation team / CNO / COO to agree next steps. 15.01.24 update - PMO are supporting this action with the aim to close by the end of February. update 07/03/24 - action to be extended and proposal for closure is early MAy 2024. update 16/04/24 -
Low response FFT rate in ED	A3 has commenced in AEM, led by the HoN and Matrons	30/04/2024	On Track/Not Yet Due	Kathy Ward (HoN) and Kate Holmes (DDoN)	A3 countermeasures devleoped with the team. ADPE supporting. This action due date has been extended as the project will be long term
Low FFT response rate in OPD areas	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas. • ADPE to attend the OPD patient experience meeting to promote the use of FFT. • New divisional structure commenced in late 2023, areas in OPD to be updated on Gather and refresh of the system to commence in the next reporting period		Complete	Chris O'Connell (Matron) Laura Potter (DDoN / AHP Acting)	actions are complete. A marginal rise in FFT reposne has been noted. 16/04/24 propose the action to be closed
Poor response rate and uptake from text messages sent to patients	4 To review the reasonable adjustments requried for patients who may not be able to afford data / Wifi to connect to the survey. To provide adjustments for patients who may have dyslexia. To request assistance from the comms team to engage with patients who receive a text following an appointment or admission but do not provide their feedback to identify themes and trends.	15/12/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	this action has been reviewed with the action to understand national themes and trends for low reposne rates and reasons for not engaging. To be considered for closure please

Trust Risk Register Aligned to Board Assurance Framework	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:
	Ref:	Current Risk Score:

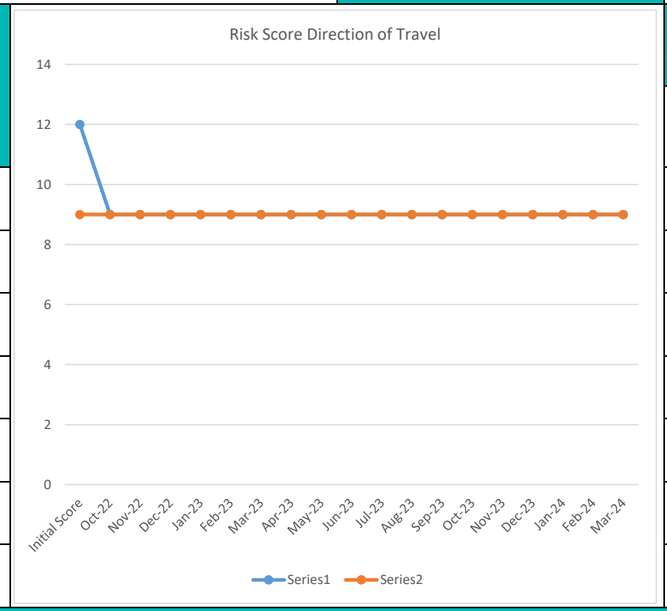
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	16th April 2024
Date of Next Review:	07th May 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1b	**Objective:**	Providing outstanding, compassionate care for our patients and their families, every time.
Executive Owner	Chief Nursing Officer		
Operational Owner	Nicola Lewis, Associate Director of Patient Experience	**Principal Risk Name & Description**	Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which could lead to data variation which cannot be used for benchmarking across the Trust
Primary Risk Grouping	Patient		
CQC Domain	Responsive	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	3	**12**	N
Risk Score at Last Review	3	3	**9**	—
Current Risk Score	3	3	**9**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	High			
Adequacy of Controls	Adequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	13.0%	14.4%	12.4%	12.6%	14.6%	13.9%	13.5%	
Inpatients FFT Response Rate	45.0%	35.4%	45.1%	42.2%	34.9%	40.3%	44.7%	40.4%	
Emergency Care FFT Response Rate	45.0%	9.5%	8.3%	7.2%	8.0%	9.7%	7.5%	8.4%	
Outpatient FFT Response Rate	45.0%	8.8%	9.5%	8.0%	9.0%	10.1%	9.2%	9.1%	
Maternity FFT Response Rate	45.0%	33.3%	26.3%	14.4%	30.7%	38.7%	30.4%	29.0%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

Key Existing Controls
(What are we currently doing about the risk?)

Original surveys approved by Senior teams based on NHSE guidance
All survey requests to be approved via the Executive Team
All survey changes actioned by Gather Team

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

Gather system and FFT feedback to benchmark the responses in each

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. An increase in requests for new or changes to the FFT surveys have been received from different clincal areas	1. Full review of all FFT surveys to take place and cross reference the relevance against all clinical areas	31/07/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	All surveys have been reviewed and updated. This action is complete and awaiting approval with Execs. . 15/01/24 all reviews for surveys are complete and published on Gather. Action to be closed

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

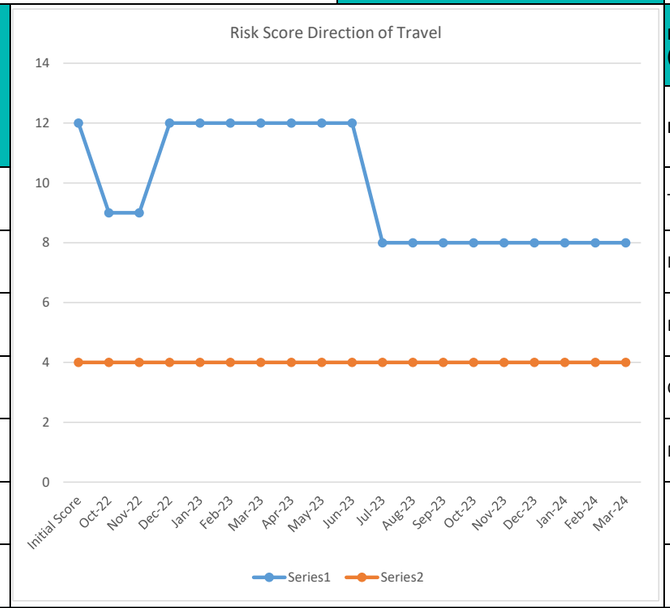
Risk submitted to QAC for proposal of closure October 2023. Target score reached

Date of Last Review:	16th April 2024
Date of Next Review:	7th May 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1c	**Objective:**	Providing outstanding, compassionate care for our patients and their families, every time.
Executive Owner	Chief Nursing Officer		
Operational Owner	Nicola Lewis, Associate Director of Patient Experience	**Principal Risk Name & Description**	Potential lack of delivery across other True North Domains could lead to patients not recommending our services as a place to receive care
Primary Risk Grouping	Patient		
CQC Domain	Responsive	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, —, ▼, N)	Likelihood	Consequence	Risk Score	Direction of Risk Score
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	2	4	**8**	—
Current Risk Score	2	4	**8**	—
Target Risk Score	1	4	**4**	—
Trust Risk Appetite	Appetite: Low Range: 5-8 Score (trigger level): 8			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	Tar	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Average	Comments:
Total FFT Recommended Rate	95.0%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	88.7%	
Inpatients FFT Recommended Rate	95.0%	90.7%	92.2%	93.3%	92.3%	94.2%	93.1%	92.6%	
Emergency Care FFT Recommended Rate	95.0%	75.2%	67.9%	69.2%	64.7%	68.9%	71.6%	69.6%	
Outpatient FFT Recommended Rate	95.0%	91.1%	92.4%	91.9%	91.5%	91.9%	91.5%	91.7%	
Maternity FFT Recommended Rate	95.0%	92.5%	90.5%	82.7%	88.5%	85.8%	88.8%	88.1%	

Context Summary
(Patient First problem statement, current situation)

FFT is a quick and simple way for our patients and other people who use our services to give us feedback, which would enable us to identify what is working well and where there are areas for improvement in any aspect of the patient experience. This is a national requirement set by NHS England whereby patients can express their opinion at all touch points of their journey.
Currently at Medway NHS Foundation Trust, only 9.9% of our patients and people who use our services provide us with FFT feedback which is behind target of 50% and only 87.9% of respondents would recommend us to their friends or family which is behind target of 95%.
The recent annual Care Quality Commission (CQC) Adult Inpatient Survey 2022 provided us with a baseline of how our patients feel about the quality of care and services we provide. This information doesn't enable us to be proactive in identifying examples of good practice, immediate issues requiring improvement or themes that are emerging.
Our patients, their families and carers have told us through many engagement routes, including the Care Quality Commission (CQC) Adult Inpatient Survey 2022, what is important to them. We are currently not capturing enough timely information around:
The different stages of the patients' journey, for example, from admission to discharge, every time they interact with our services, after leaving ED if not admitted.
Text messages are sent to patients after they have left our services and during inpatient admission.

Rationale for Current Score

National target and evidence of exemplary care. Risk score has reduced as the recommend rate has increased consistently within inpatient areas.
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Developing specifc improvements based on feedback themes and trends from patients	All actions are monitored via driver huddles, catch ball and SDR Patient Experience Group

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
Errors in data with the FFT questionnaire on GATHER	To review all areas line by line to ensure accuracy when patients are completing the survey on gather	30/04/2024	On Track/Not Yet Due	Malou Bengtsson-Wheeler	S&A division complete.

Low recommend and response rate in ED	To consider standing up a quality event which engages all the clinical quality teams to support patient care in ED - a break the cycle week. This is awaiting a final approval with the senior teams	01/05/2024	On Track/Not Yet Due	Nikki Lewis / Wayne Blowers / Steph Gorman	a week to support the quality of care will commence in late April. Plans to support this are underway.
Operational flow and processes in maternity have caused a reduction in recommend rate over the last 2 months.	Maternity teams to implement a deep dive / A3 into the issues surrounding induction of Labour	31/07/2024	On Track/Not Yet Due	Alison Herron, Director of Midwifery / Kate Harris, Head of Midwifery	This project will be running for 1 year
Noise at Night	A full evalutation of the noise at night project to be completed	31/08/2023	Overdue	Divisional Directors of Nursing	15/01/2024 awaiting the evaluation report from DDoNs. 16/04/24 - no further update
Staff attitude has been a theme from patient feedback, PALS and Complaints in maternity areas	A3 deep dive into issues surrounding staff attitude, with intentional rounding from senior staff out of hours	31/08/2023	Complete	Kate Harris, Head of Midwifery	Maternity A3 and action are complete 15/09/2023. action to be closed
Staff attitude has been a theme from patient feedback in inpatient areas	A3 deep dive discussions have commenced with further detail around actions and improvements will be collated with the CNO and team	30/11/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	the A3 for staff attitude to be shared at the PE Group / QPSSc and QAC
Staff attitude and concerns at night have been raised from patient on inpatient areas	A rota for senior staff support and visibility has been developed with the CNO. The approach to be approved at the next CNO meeting	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	to be closed
Low recommend rate in OPD and ED	Clinicans in OPD to offer a reminder to patients complete the survey following their consultation. Actions are being collated in care group huddles to improve the FFT recommend rate, these are escalated	30/11/2023	Complete	Outpatients / ED Team	to separate this into 2 separate actions.to close this action.
Low recommend Rate in ED	to meet with the ED teams and join their huddles. Restart A3	01/01/2024	Complete	Kathy Ward (HoN) Kate Holmes (DDoN)	Complete. Action to be closed
Low recommend rate in OPD	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas.	15/02/2024	Complete	Chris O'Connell (Matron) Laura Potter (DDoN/AHP interim)	complete - to be closed

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

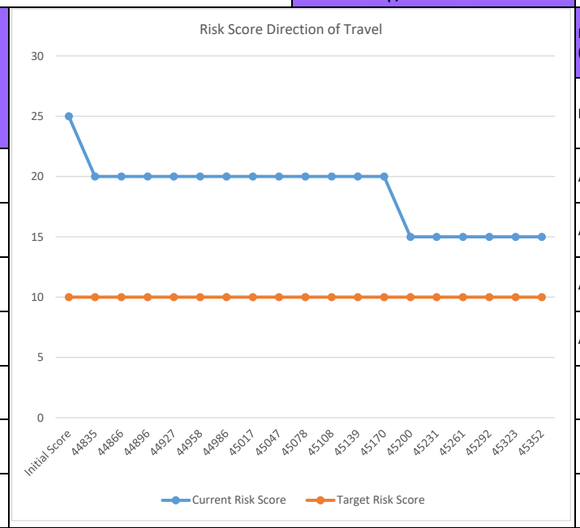
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation

Date of Last Review:	16th April 2024
Date of Next Review:	7th May 2024

QUALITY BOARD ASSURANCE FRAMEWORK

Risk ID:	2a	**Objective:**	Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have
Executive Owner	Chief Medical Officer		
Operational Owner	James Alegbeleye, Medical Director for Quality and Safety	**Principal Risk Name & Description**	Lack of timely escalation and treatment of deteriorating patients
Primary Risk Grouping	Quality		
CQC Domain	Safe	**Relevant Group/Committee**	Quality Assurance Committee

Risk Rating & Analysis (▲, ▬, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	N
Risk Score at Last Review	3	5	**15**	▬
Current Risk Score	3	5	**15**	▬
Target Risk Score	2	5	**10**	▬
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Avoidable 2222 Calls - Total	16	1	4	2	4	2	0	2	
Avoidable 2222 Calls - Cardiac Arrest	1	1	2	2	1	0	0	1	
Avoidable 2222 Calls - Peri-Arrest	3	0	2	0	3	2	0	1	
ALS/BLS Training Compliance	85.0%	81.0%	80.0%	81.2%	81.0%	81.0%		80.8%	

Context Summary
(Patient First problem statement, current situation)

We have patients in the hospital who die unnecessarily and the data tells us that this is more likely at the weekend than during the week. From analysis we have identified that possible delay or failure to monitor or escalate is one of the biggest causes of “death” harm incidents behind implementation of care or ongoing monitoring.

Rationale for Current Score

Risk reviewed with CMO on 06/12/2023 - Avoidable 2222 data demonstrates special cause variation statistically significant reduction in trustwide avoidable 2222’s. Score remains at 3x5 as frequency of avoidable 2222 has reduced but not yet to such a point that likelihood can be reduced to 2 (Unlikely) from current likelihood of 3 (Possible).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Delays in whole patient pathway from initial deterioration to patient receiving correct treatment in correct part of hospital. Investigating critical care reasons for delay in taking patient. Ongoing work with Care Group leads focusing on 'culture change'. CITO (digital critical care information) now available for all medical staff. Cardiac and peri – arrest proforma in process of being implemented onto EPR. ART team feeing back the trends with avoidable ART calls. Resolved Issues - Investigating delays in review by Surgeons not answering bleep (Pilot for Surgical Teams to attend Hospital @ Night huddle with ART to support response times out of hours, SOP updated to reflect this change to process and engagement will be fully effective from 1 March 2023with new rota in place to support) - resolved. A3 started regarding ALS and EPALS compliance, and arrangements for providing this training. Resus Service now attending doctors (in training) inductions to manually gather Resus certificates data for ESR. - Resolved	These are reviewed in weekly 'huddle' and remain under review until marked as complete. Training and funding for ALS/EPALS – funding confirmed and has been requested by Divisions as part of Business planning. Status paper drafted which will provide clear countermeasures to deal with known gaps.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1a. Doctors not ALS/BLS Trained	1a. Improve ALS/BLS training compliance	22/05/2023	Overdue	Chief Medical Officer	**15.04.2024 - Divisional directors will work with Resus team to identify staffs who are non-cmpliant** 11.03.24: Als 81% BLS - 73% YTD average only at 80%, target not yet achieved. Work ongoing with action plan. Service Managers working with respective areas on compliance.

2a. EPR system needs optimisation	2a. Cardiac and pre-arrest proforma on to EPR	24/04/2024	On Track/Not Yet Due	Tamara Stephens, Sherwin Sinocruz	**11.03.24: going through testing** Ongoing SIM testing referral tool for escalation. Re-design complete and awaiting electronic completion.
2b. EPR system needs optimisation	2b. Electronic SBAR referral tool for escalation	24/04/2024	On Track/Not Yet Due	Emma Coutts	**11.03.24 : Going through testing 20/03/2024** This has been moved through to testing which will take place 08/02/2024 and will then be taken back to the EPR Board for approval.
2c. EPR system needs optimisation	2c. ABG/Point of Care Testing integration with EPR	22/04/2024	On Track/Not Yet Due	Tamara Stevens, Kerry O'Reilly, Dilip Pillai	**Order Comms live is 16.04.2024** 11.03.24: deferred to 20/04/2024 Awaiting Order Comms Switch on 04/2024
2d. EPR system needs optimisation	2d. Medicus ART clinical entry integration with EPR	31/03/2025	On Track/Not Yet Due	Dilip Pillai, Kerry O'Reilly, Emma Coutts, James Alegbeleye, Zohreen Amir	**There will be an integration cost involved of £6000 which has been reduced by £3000 if the trust can complete this integration along with the update that MEDICUS will be completing for us . To be confirmed if this can be sought from the critical care budget in line with the ICU IT Medicus costing. Update due 21/02/2024. MAy go through Stategic Filter? corporate project**
2e. EPR system needs optimisation	2e. **ReSPECT/DNACPR/TEP development + electronic integration with community ICS and Trust	01/09/2024	On Track/Not Yet Due	James Alegbeleye, Zohreen Amir, Dilip Pillai	**15.04.2024 - Update: Going through Governance approval before piloting** 11.03.24 going through consultation final version available soon Larger project, pending JaA work + recruiting next Darzi fellow. Discussions/review ongoing around content, electronic integration and whether there can be a single form across the community and Trust. Not yet complete, ongoing discussions. Pilot form to be tested. Update 13/03/2024
2f. EPR system needs optimisation	2f. Rewrite of TEP form	30/06/2023	Complete	James Alegbeleye	See action ref 2e. **This has been marked as complete despite ongoing work as it is now included in action 2e.**
3a. Failure to escalate/escalate/gap in clinical plan: Gap in knowledge of SOP/Standard	3a. Targeted NEWS/Alert training to be mandatory for all staff	15/11/2023	Complete	Emma Coutts	Complete
3b. Failure to escalate/escalate/gap in clinical plan: NEWS not captured as per standards	3b. A3 on timeline for NEWS	01/09/2024	On Track/Not Yet Due	Jamie Moore, Kate Holmes, Emma Coutts	**11.03.24 Bring back by end of march 2024** Three streams - i) Ensure Observations are undertaken as needed; ii) ward scores visible on whiteboards; iii) Streamline and automate processes for uploading results to EPR and acting upon these. Updates om all three by 06/03/2024
3c. Failure to escalate/escalate/gap in clinical plan: Lack of data, ownership, review delays	3c. Metavision critical care virtual ward for ITU outliers reintroduced - SOP to be written on referrals	08/11/2023	Complete	Rachel Krol	It has become clear that Metavision is not suitable for this and RaK is pursuing other options. Marked as complete as moved to BAU in critical care
3d. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3d. Tazocin PGD	08/11/2023	Complete	Emma Coutts, Rachel Krol, Godwin Simon	Upon review, this action is not required.
3e. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3e. Metraminol in ED, SOP to be implemented	08/11/2023	Complete	Emma Coutts, Godwin Simon	Marked as complete as moved to BAU
3f. Failure to escalate/escalate/gap in clinical plan: Board rounds and handover pilot	3f. Escalation on board rounds	08/11/2023	Complete	Jamie Moore, Kate Holmes, Dilip Pillai, Tracy Stocker	This is now BAU. Ongoing, trial on Harvey and Pembroke for ward handovers is now underway, using WOW's to share information amongst team.
3g. Patients leaving ICU/HDU do not always have an appropriate level; of consultant and other senior review, knowledge of patient, and escalation of care when transferred to a ward. Also concerns re admission handover and access to parent teams whilst on ICU	3g. Review of ICU pathway including admission, parent clinical team review whilst patient on ICU/HDU and medical and nursing handover arrangements when patient leaves ICU/HDU	13/03/2024	On Track/Not Yet Due	Chris Parokkaran, Rachel Krol, Howard Cottam	**15.04.2024 - Ongoing A3** 11.03.24 - Ongoing discussions A3 Had initial meeting. Ongoing discussions

4a. Failure of appropriate delivery of care, monitoring and escalation by specialist team whilst awaiting transfer, lack of ownership of patient care	4a. SRO led session to establish full root cause and key tests of change and engagement with wider stake holder group	31/03/2025	On Track/Not Yet Due	Howard Cottam	**11.03.24 Ongoing** A3 completed. HoC workign with other DMD's re how to mitigate
5a. End of Life Decision being made at night rather than earlier in the day. End of Life decisions are often not prioritised and therefore, are not always completed by the end of the day.	5a. Discussed and agreed at QPSC that action is required but multi-disciplinary meeting needed and learning	24/04/2024	On Track/Not Yet Due	Emma Coutts	**15.04.2024 - Expected data analysis** 11.03.24 data collected ongoing Clincal fellow & Emma Weekly data to be provided. Audit presentation to be reviewed at quality huddle on 21/02/2024.
6a. Epilepsy following cardiac arrest - reduced awareness of time critical drugs	6a. Clarify status of non-avoidance of 2222 call - Review case of epileptic patient and clarify whether this was a non-avoidable 2222 call.	08/11/2023	Complete	Godwin Simon, Tamara Stephens, Emma Coutts, Rachel Krol	Missed dosage working group to look at report and identify ongoing actions to resolve issue. Drugs issues to be raised on risk register for both Divisions - JD to circulate list of time critical drugs to doctors for comment. Pharmacy students currently working on this list as a project supervised by Chief Pharmacist. **Action complete.**

Trust Risk Register Aligned to Board Assurance Framework	Risk 1433: Delayed recording of Observations on EPR	Current Risk Score: 20
	Risk 1539: Blood Gas results not recorded electronically on EPR	Current Risk Score: 12

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

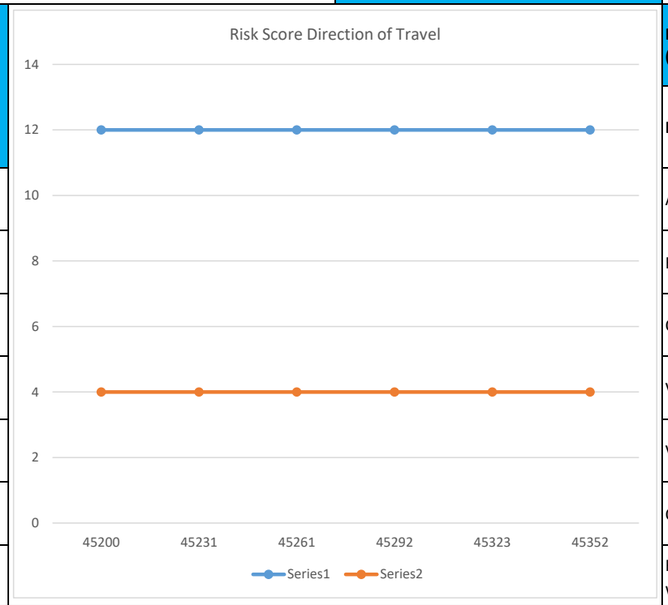
Investigations taken forward - new rota in place
Current status - Hospital at Night - working well

Date of Last Review:	11 April 2024
Date of Next Review:	11 May 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3d	**Objective:**	To be the employer of choice and have the most highly engaged staff within the NHS
Executive Owner	Chief People Officer		
Operational Owner	Dominika Kimber, Deputy Chief People Officer	**Principal Risk Name & Description**	There is a risk the Trust is unable to retain sufficient levels of staff to ensure safe staffing levels, which results in higher turnover and in turn higher than expected levels of recruitment.
Primary Risk Grouping	People		
CQC Domain	Well-Led	**Relevant Group/Committee**	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**N**
Current Risk Score	3	4	**12**	**N**
Target Risk Score	2	2	**4**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Agency Spend	3.7%	2.6%	3.5%	2.7%	2.0%	2.7%	1.2%	2.4%	
HR KPI - Time to Hire (days)	42.0	66.7	61.2	60.4	88.0	60.0		67.3	
Care Hours Per Patient Day (CHPPD)	9.5	9.1	9.2	9	9.1	9.2		9.12	
Voluntary Turnover First 2 Years of Employment (in month)	1.0%	0.7%	1.0%	0.8%	0.6%	0.5%	0.7%	0.7%	
Voluntary Turnover (Annual)	8.0%	10.8%	10.8%	10.6%	10.1%	9.6%	9.4%	10.2%	
Contractual Vacancy Rate	9.0%	4.0%	4.1%	3.6%	3.2%	2.4%	2.0%	3.2%	
HR KPI - OH pre-employment checks reviewed within 2 working days.	90.0%			17.8%	76.2%	9.0%		34.3%	

Context Summary
(Patient First problem statement, current situation)

The Trust's refreshed People Breakthrough Objective revealed much higher than expected level of voluntary turnover in the first two years of employment. The overall voluntary turnover rate also exceeds the set target, which indicates difficulties with our ability to retain staff. Countermeasures developed through the People BO include proactive measures such as Stay Conversations, re-launched as part of the Intention to Leave process. High turnover leads to increased recruitment activity, which results in extended time to hire, poor candidate experience and Trust losing applicants during the recruitment process. High number of new employees requiring OH clearance also impacts on the team's effectiveness and the overall time to hire. Recruitment efforts continue to deliver safe staffing levels and enable the Trust to maintain vacancy rates below the set targets.

Rationale for Current Score

The Trust's metrics indicate that there are no risks to its ability to staff clinical or corporate areas substantively. Ongoing dispute with the Government, union ballots and risks of industrial action by all staff groups can have a negative effect on the staffing levels however this would be temporary and safe staffing levels would be ensured. There is however an indication that the candidate experience during the recruitment process, results in the process being inefficient due to the number of candidates withdrawing before their appointment (this KPI needs to be developed).

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. NHS Long Term Workforce Plan and MFT People Strategy aligned to the Plan. 2. Retention programmes across Trust. 3. Attraction: Resourcing plans based on local, national and international recruitment. 4. Temporary staffing delivery: a. NHSE agency ceiling reporting in place; b. Monthly breach report to NHSE; c. Reporting to Board of substantive to temporary staffing paybill. 5. Workforce redesign: a. SDR review of hard to recruit posts and introduction of new roles; b. Reporting to People Committee apprenticeship levy and apprenticeships. 6. Operational: a. Operational KPIs for HR processes and teams reported monthly. 7. Care group nursing recruitment plan: Number of substantive nurses currently at highest point since 2015 and international nursing offers in place. 8. Bi-weekly CNO led meetings focussing on recruitment, retention, education and develepment of nursing and midwifery and CSW staff 9. People Breakthrough Objective focussed on staff turnover in the first 24 months of employment	1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs. 2. 'Our People' true north and breakthrough is monitored through the Trust Management Board SDR. 3. Monitoring of KSS benchmarking during elevated national turnover. 5. Monthly SDR including discussion on workforce, vacancies, recruitment plan and temporary staffing. 6. Regular reports to People Committee a. Resourcing Report b. Temporary staffing utilisation c. Safe staffing report 7. 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)) 8. Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. 9. 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.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Safe staffing levels for the periods of industrial action.	1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is an ongoing action for the periods of strike action.
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	2. We are exploring robotic automation of the elements of the recruitment process	31/05/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Exploring procurement routes
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	3. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment.	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Progressing well
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	4. Review of the end to end medical recruitment process.	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is aligned with Action 3 - A3 on medical recruitment
3. We need to understand how we might improve our retention by preventing resignations.	5b.Stay Conversations to be offered as an action as part of Staff Survey action planning (where staff indicated intention to leave the organisation)	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
	5a. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average.	30/03/2024	On Track/Not Yet Due	Lisa Webb, Associate Director OD	Communications campaign to take place
4. We need to improve our understanding of the reasons why staff leave clinical areas difficut to recruit to.	6b.Intention to Resign process is going to be linked with the VCP process for vacant roles.	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
	6a. Continue to promote Intention to Leave process and Exit Interviews through team huddles and HR BPs.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
5. Consider implementation of recruitment and retention premia for difficult to recruit and retain roles, including medics	7. New approach to be explored with the system and new policy written.	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Development of an ESR report to identify difficult to recruit areas.
				Dominika Kimber, Deputy Chief	
				Dominika Kimber, Deputy Chief	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

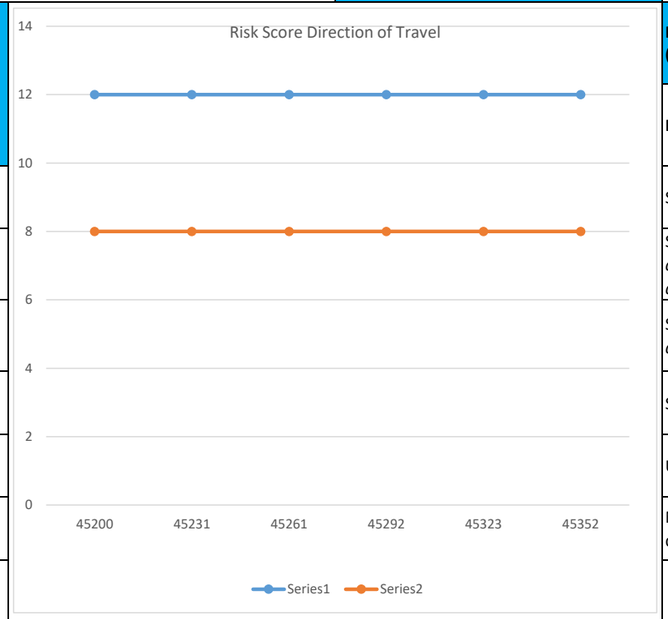
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget) External labour market - addressed through annual skills demand profile through operational planning returns to ICB (education commissioning shortages) and continued international recruitment to address domestic skills shortage through ethical recruitment. Our ability to retain staff through competitive rewards packages is limited due to the Trust's financial position and a natonally agreed rates of pay, therefore we plan to develop and promote Trust's Employee Value Proposition through the refreshed Employer Brand.

Date of Last Review:	
Date of Next Review:	

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3e	**Objective:**	To be the employer of choice and have the most highly engaged staff within the NHS
Executive Owner	Chief People Officer		
Operational Owner	Dominika Kimber, Deputy Chief People Officer	**Principal Risk Name & Description**	There is a risk that staff will not feel confident to raise concerns and that their concerns will be dealt with by the organisation. This may lead to worsening engagement levels and quality of patient care.
Primary Risk Grouping	People		
CQC Domain	Well-Led	**Relevant Group/Committee**	People Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	**N**
Risk Score at Last Review	3	4	**12**	**N**
Current Risk Score	3	4	**12**	**N**
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Staff Survey Engagement Score	6.93	6.63	6.63	6.63	6.63	6.63	6.65	6.63	
Staff Survey Question: *If I spoke up about something that concerned me, I am confident my organisation would address my concern* (Q25F)	48.7%	42.0%	42.0%	42.0%	42.0%	42.0%	41.5%	41.9%	2021,22 and 23 survey results are between 39% and 41%. National average is 47-48%
Staff Survey Question: *My organisation respects individual differences.* (Q21)	70.0%	65.7%	65.7%	65.7%	65.7%	65.7%	67.9%	66.1%	2021 survey - 61.7%; 22 Survey - 65.7%, 23 Survey - 67%. National average 70%
Staff Appraisal Rate	90.0%	89.4%	89.0%	88.6%	88.0%	87.6%	88.0%	88.4%	
Uptake of Management Essentials Training	120ANN	9	21	14	14	9	9	76	
New metric on incidents reported once we have sufficient data from the Anti-Bullying and Harassment Group									

Context Summary
(Patient First problem statement, current situation)

Our staff engagement across the Trust has improved slightly for the last three years; however, remains in the lowest quartile which impacts on our ambition to have a better work culture, improved productivity, improving patient experience and outcomes. Analysis of Staff survey questions which have the highest correlation with staff engagement levels releaved two questions where the gap to the national average result is the highest (e.g. If I spoke up about something that concerned me, I am confident my organisation would address my concern and My organisation respects individual differences.). This indicates that, in order to improve staff engagement, we should address lack of confidence in the speak up process and perceived lack of respect of individual differences by the organisation.
The Trust has been in the lowest quartile for staff survey results (score 6.63, rank 94/126) for staff engagement for the last five years but has improvement in the last financial year to the threshold between quartile 3 and 4 having improved by 18 trust rank score.
National Staff Survey 2023 return rate shows decline in staff engagement with the Survey, from 40% in 2022 to 37% in 2023.
There appears to be an increase in staff raising concerns using formal channels, these relate to violence and aggression in ED and more general reports of bullying and harassment.
Current management essentials training does not link management / leadership behaviours with staff engagement levels.

Rationale for Current Score

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. 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' 2. Staff Health and Wellbeing strategy in place with nominated NED Wellbeing Guardian 3. 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 which is embedded in induction. 4. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme. 5. Communication routes well established in Trust 6. Freedom to speak up guardians are in place. 7. VBR in place Qualitative and quantitative values-based appraisal to continue to embed values into the Trust culture. 8. Culture Intervention: Principles of 'Just Learning Culture' are embedded in all HR processes and into training (e.g. management essentials, Trust Induction) delivered to staff. 9. New Starter Survey ICB led project is under way and the results are being analised. 10. Refreshed Strategic Leadeship Initiative (Leadership and Behaviours)	1. HR&OD performance meeting monitoring the People Strategy and operational HR KPIs. 2. JSC and JLNC in place. 3. 'Our People' programme reviewed through the Trust Improvement Board (including NHS People Plan) 4. Annual report to the Board on staff survey results 5. Regular reports to People Commitee: a. Freedom to Speak Up Guardian report b. Leadership Development programme c. Wellbeing Guardian quarterly assurance report d. Staff survey results annual report 6. New Starter Survey (ICB) will be analised and actions reported to the People Committee. 7. Spirit of Medway meetings have restarted and feedback is collated for repoirting to the People Commitee.

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. We need to ensure that Leadership and Management behaviours make a clear link with staff engagement levels. This is part of the People Startegic Initiative.	1. Staff Compact to be reviewed and updated to include new / additional leadership behaviours.	30/04/2024	On Track/Not Yet Due	Lisa Webb	Action to be progressed when new Head of Staff Exp is in place in April
2. Management essentials to be reviewed to identify gaps which deliver skills required to improve staff engagement levels. This is part of the People Strategic Initiative.	2. In conjunction with colleagues in East Kent, review our management essentials offer and identify modules for development / collaborative work.	30/04/2024	On Track/Not Yet Due	Lisa Webb	Action to be progressed when new Head of Staff Exp is in place in April
3. Currently we have little data which could be used to improve staff retention e.g. reasons behind our high turnover of staff in the first two years of employment.	3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool.	30/03/2024	On Track/Not Yet Due	Lisa Webb	Communications plan to follow
4.We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	4. ICB New Starter Survey 2023 results need to be analised and actions assigned to the respective teams.	01/05/2024	On Track/Not Yet Due	Lisa Webb	In depth analysis of the data is underway. A dedicated T&F Group will be established to discuss actions.
4. We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	5. MFT own New Starter Survey, replicating ICB survey is going to be launched.	01/05/2024	On Track/Not Yet Due	Lisa Webb	Welcome Aboard event rolled out & survey to become part of this event
5.We need to see an increase in appraisal completion and ensure that the level is sustained.	5. Identify areas where completion falls below 90% and raise in care group/team meetings.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Action to be progressed by HR BPs.
6. We need to improve perception of appraisals and their addedd value, to improve engagement levels.	6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group.	31/03/2024	Off Track	Lisa Webb	QA underway waiting for first iteration of data. Risk relating to the use of Survey Monkey for this process has
7. Review Trust's Freedom to Speak Up Policy and process for comissioning investigations.	7. FTSU process has been reviewed. Policy needs to be updated and published.	31/01/2024	Complete	Katrina Ashton	
8. We need to provide staff with alternative ways of raising concerns with the organisation.	8. Launch and promote Dignity at Work Advisors.	31/01/2024	Complete	Dominika Kimber, Deputy Chief People Officer	
9. Improve staff confidence that the organisation listens to their concerns and implements improvements.	9. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accesible.	30/04/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Meeting with Hayley to take place in March. This will link wth the new People Promise Manager role. New delivery date of 30/04 agreed with

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

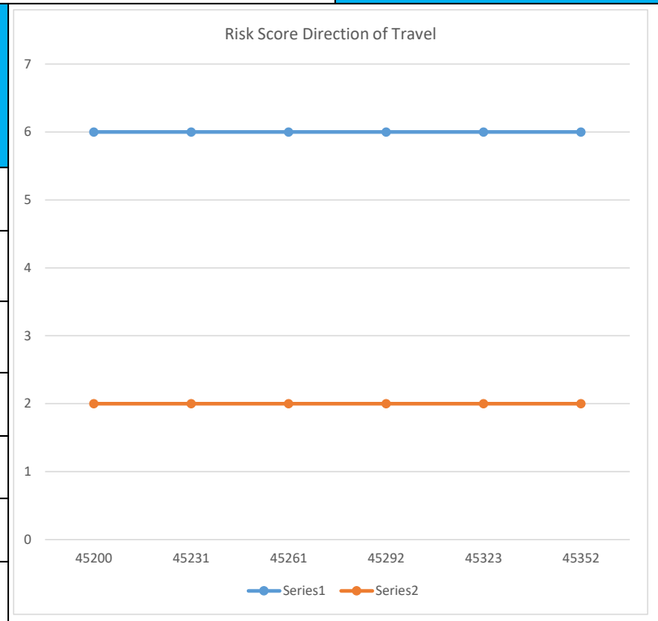
Factors which are external to the Trust and not in our control are likely to have a negative impact on staff engagement and morale (worstening financial situation, cost of living crisis, recession).

Date of Last Review:	
Date of Next Review:	

PEOPLE BOARD ASSURANCE FRAMEWORK

Risk ID:	3f	**Objective:**	To be the employer of choice and have the most highly engaged staff within the NHS
Executive Owner	Chief People Officer		
Operational Owner	Alister McClure, Head of Equality and Inclusion	**Principal Risk Name & Description**	Should the Trust fail to deliver its strategic objectives relating to EDI, there is a risk that our people will not be able to thrive at work and that the Trust will not meet its statutory obligations to its employees. This may lead to poor employee experience and negative impact on staff wellbeing, both at work and in general. IMPACT: Failure to meet the requirements of the Equality Act 2010; increase in staff turnover; increase recruitment and retention challenges; and therefore impact negatively on quality of patient care and experience.
Primary Risk Grouping	People		
CQC Domain	Well-Led	**Relevant Group/Committee**	People Committee

Risk Rating & Analysis (▲, ═, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	2	**6**	**N**
Risk Score at Last Review	3	2	**6**	**N**
Current Risk Score	3	2	**6**	**N**
Target Risk Score	1	2	**2**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
WRES 5 and 6	29% 20%	34.6% 31.9%	N/A	N/A	N/A	35.86% 25.4%	35.86% 25.4%		WRES 5 - % of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. WRES 6 - % of BAME staff experiencing
WRES 8	15.0%	18.3%	N/A	N/A	N/A	18.1%	18.1%		% of BAME staff responding to say they had personally experienced discrimination at work from managers, team leaders, or other colleagues
WDES 4a I and 4a ii	33% 15%	35.75% 17.09%	N/A	N/A	N/A	34.5% 19.5%	34.5% 19.5%		% of staff with a lon term illness experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months; and % of staff
WDES 4b	48.0%	55.0%	N/A	N/A	N/A	47.9%	47.9%		% of staff with a long term illness saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
WDES indicator 8 (Reasonable Adjustment)	75.0%	74.7%	N/A	N/A	N/A	70%	70%		% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
% BAME Staff at Band 8a and above (AFC)			N/A	N/A					This will need to be new monthly data request to Workforce Intelligence, and will need to be a comparison between Band 8a and All bands. Workforce request has been submitted.
AfC staff Gender Pay Gap	0.0%	1.9%	N/A	N/A	N/A	N/A			

Context Summary
(Patient First problem statement, current situation)

The measures of equality, diversity and inclusion, as expressed through the Workforce Race and Disability Equality Standards (WRES, WDES) and gender pay gap demonstrate areas of disproportionality lower than expected protected characteristics as a ratio of the Trust population. This in turn may have a direct impact on staff engagement from underrepresented groups, lower diversity of thought, lower motivation, which in turn can also affect staff performance, professional conduct, quality of patient care and retention.

Rationale for Current Score

WRES and WDES are currently only assessed annually; periodic calculations could be made only for the quantifiable measures such as pay gaps.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
1. Strategy: People Strategy in place to address the underlying cultural issues within the Trust, to ensure EDI elements are embedded and aligned to NHS Long Term Workforce Plan and People Promise 2. Action Plans are in place for the WRES, WDES and in development for the Gender Pay Gap 3. Key policies include Anti-bullying, Harassment and Conflict Resolution, and Reasonable Adjustment and Modified Duties. 4. Right skills: 30 Advisors and 60 investigators trained in Dignity at Work (bullying and harassment) complaints; EDI Mandatory Training and EDI element of Management Essentials 5. Culture Intervention: Culture and wellbeing programmes (including NHSEI Culture, Engagement and Leadership programme), wellbeing champions, staff equality networks 6. Non-Executive Wellbeing Champion; Executive Champions for some staff networks 7. Staff networks in place: LGBTQ, BAME, Disability and Wellbeing (DAWN), Womens'. Development of the Faiths and Beliefs (FaBs) Network 8. Revision and further communication of the Anti-Discrimination Statement	1. 2019-22 People Strategy in place with monitored delivery plans. (HR&OD performance meeting) 2. 'Our People' programme fortnightly review meeting which includes the NHS People Plan 3. Overall statutory and mandatory training compliance report to Board (bi-monthly) and internally weekly. 4. Regular reports to the People Committee and the Equality and Inclusion Steering Group, including: a. Freedom to Speak Up Guardian report b. Leadership Development programme c. Wellbeing Guardian quarterly assurance report d. Staff survey results e. IQPR data f. EDI Metrics (Pay Gap, WRES, WDES, and Action Plans) g. Staff survey results h. Statutory mandatory training update

Gaps in Controls (What additional controls and assurances should we seek?)	Mitigating Actions to Address Gaps (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff.	1. Review of the People Startegic Initiative (Leadership and Behaviours) and implementation of the agreed actions.	Ongoing	On Track/Not Yet Due	Dominika Kimber	
2. Executive team and Trust Board have committed to EDI Objectives as part of their personal objectives (HIA1); although now signed off, work is required over 2024/25 to support delivery of those objectives	2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024	31/07/2024	On Track/Not Yet Due	Alister McClure	HIAs now developed
3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactve measures can be taken.	3a. Anti-bullying and harassment group to be reviewed and re-established.	31/01/2024	Complete	Dominika Kimber	Reviewed and meeting monthly
	3c. All Network Leads were offered regular informal meetings with Senior HR team to offer an opportunity to discuss issues in confidence and to agree what actions should be taken	30/04/2024	On Track/Not Yet Due	Dominika Kimber	
	3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan)	31/01/2024	Complete	Dominika Kimber	Published and communicated
4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI.	31/01/2024	Complete	Alister McClure	Programme launched in February

Trust Risk Register Aligned to Board Assurance Framework		
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

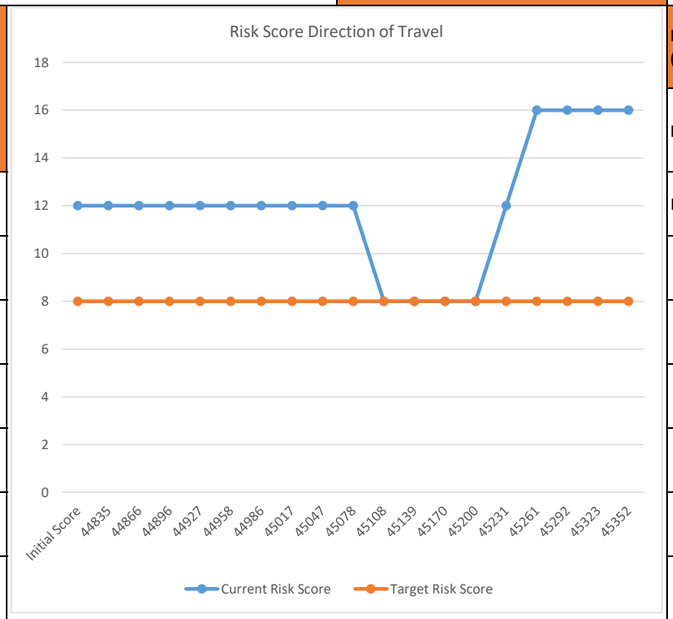
Poor adherance to the Trust values may lead to the worstening employee and patient experience with negative impacts on quality of care and patient safety and the Trust's reputation amongst the patients, their families, current and prospective employees.

Date of Last Review:	15 April 2024
Date of Next Review:	10 May 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4b
Executive Owner	Chief Operating Officer
Operational Owner	Nicola Cooper, Divisional Director of Operations
Primary Risk Grouping	Systems & Partnerships
CQC Domain	Safe
Objective:	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Principal Risk Name & Description	Not meeting the RTT standards brings a risk to the quality of care we are providing our patients as well as their overall experience.
Relevant Group/Committee	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, ▬, ▼, N)	Likelihood	Consequence	Risk Score	Direction of Risk Score
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	4	4	**16**	▲
Current Risk Score	4	4	**16**	▬
Target Risk Score	2	4	**8**	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	Tar	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Average	Comments:
RTT Incomplete Performance	92.0%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	52.6%	

Context Summary
(Patient First problem statement, current situation)

% of patients that have been treated within 18weeks from referral to treatment

Rationale for Current Score

Risk reviewed and still remains appropriate. RTT postion continues to decline. The total number of patients over 65 weeks has increased largely due to endoscopy. Mutual aid for Endoscopy continues with Dartford and outsourcing to PPG, both organisations now taking RTT patients. Industrial action has also had a negative impact waiting times due to clinic cancellations

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The trust had 28 x 78 week breaches majority of which relate to ENDO and all related to endoscopy capacity. 9 x ENT 4 have no TCI and due to national equipment issue 2 are patient choice others are not a concern. 1 patient choice in general surgery. Trust are now reporting 2 x 78 week breaches by end of March (both of which are patient choice) A request has come from exec to complete an affordability chart on elective WLI which will be done in the next few weeks.	Weekly RTT meeting including robust review of RTT process Reports direct to COO Monthly reporting to TMB Focus on clinical urgent and then long waits Patient P control in operation Use of ERF monies to support increased activity Breach validation plus clinical harm

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. There is a risk associated with the junior doctor strike which has increased the PTL.	1 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown			

2. Increase risks due to onging industrial action	2 - Cancellations continue in line with IA in order to provide safe care on wards	Unknown			
3 Lack of Endoscopy capacity in K&M	3-Ongoing work with ICB/NHSE to provide additional capacity	Unknown			
4 Lack of RTT training programme for operational managers	4-Training programme design underway for non-clinical and clinical staff	31/03/2024		Nicola Cooper	

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Trust has agreed to hit no 65 week breaches for next year.
Lack of ward and outpatient space currenlty. New Ward has been assigned which is due in August.
Increase in winter presentations may negatively impact RTT performance.
No sustainable long term solution for Endiscopy currently - continuing with mutual aid to support Cancer/RTT/DM01 performance

Date of Last Review:	20 April 2024
Date of Next Review:	20 May 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4c	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Holly Reid, Divisional Director of Operations	**Principal Risk Name & Description**	Lack of operational performance for example not meeting constitutional measures (new quality indicators)
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Average time in EC Dept (mins)	7	339.5	357.5	401.2	424.7	389.0	335.4	374.5	
Ambulance HO delays > 60mins	0	1	3	10	9	5	6	6	
ED 12 Hour Breaches	0	742	766	785	953	798	798	807	
IP Discharge Before Noon	40%	16.8%	17.3%	15.2%	14.1%	14.6%	12.9%	15.2%	
Total ED 4 Hour Performance	95%	75.4%	71.0%	65.6%	68.3%	70.4%	77.6%	71.4%	

Context Summary
(Patient First problem statement, current situation)

The Trust is currently not achieving national KPIs, the Breakthrough objective for flow and discharge is to achieve 95% performance for ED. Our ambition is to improve flow across the Trust and reduce patient waiting times. This will support our ED performance targets, avoid delays and contribute to smooth flow through the organisations.

Rationale for Current Score

The score reflects the continued challenge and deterioration with our MFFD position and the estate/evironment restrictions that impact on the ability to achieve escalation capacity. However these controls are strengthened by the current Flow and Discharge Programme under the Patient First Programme, and ongoing work to explore alternatives to ED, admission and delayed discharge.

Key Existing Controls
(What are we currently doing about the risk?)

Continuing to embed the Acute Medical Model
Reviewing the Full capacity protocol, opel triggers and actions
Embeding fit to sit/pulling next patients to wards
Focused work through the HARIS group
Reviewing existing protocols and processes to achieve improvements
Improving relationships with SECAmb and working in partnership has mitigated high numbers of ambulance handover delays increace in Virtual beds to 155 by end of Q4 currently av. 75 virtual beds for early supported discharge and admission avoidance
Single Point of Access pilot
Rota of Senior Operational staff on the shop floor

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

Ongoing review of current systems and processes
Breakthrough huddles weekly
SDR score card reflecting performance
Safer staffing huddles to support safe flow
Care group SDRs currently being implemented
Dedicated daily support on the floor to prevent 4 hour breaches
Live validation and review of 4 hour breaches

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. Need to consider benefit realisation for the Acute Medical Model and unintended consequences Standard work for Board Round Processes	1. Care Group to review and implement and bring to Divisional management Board.	31/03/2022	Complete	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
2. Full utilisation of community capacity at all times to support flow	2. Exec escalation for ICB support.	01/04/2024	On Track/Not Yet Due	Linda Stevens, General Manager / Kathy Ward, Head of Nursing / Chris Parokkaran, Clinical Director	
3. Review In-reach support from Spec Med to ED	3. Review current in-reach with clinical leads	19/03/2024	Overdue	Chris Parokkaran/Tanya McKie	SOP drafted for expectations of in-reach. Next draft to include CSN
4	4				

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

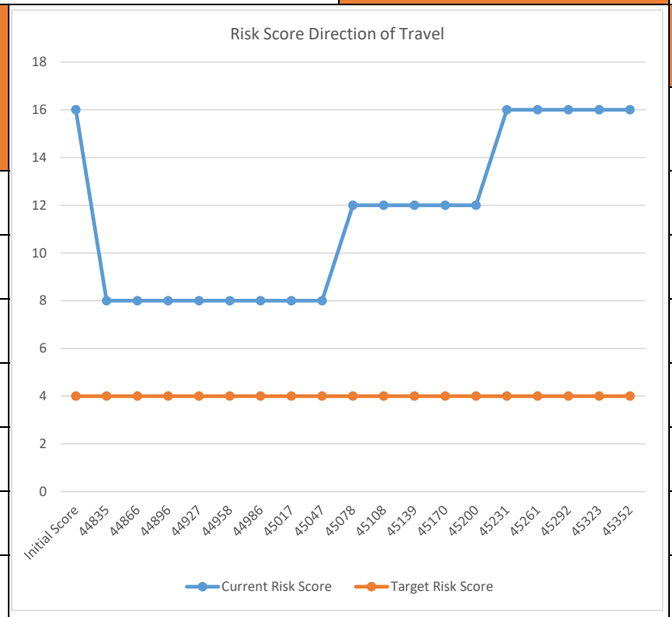
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	15 April 2024
Date of Next Review:	14 May 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4d	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Holly Reid, Divisional Director of Operations	**Principal Risk Name & Description**	Shared quality of care and performance across the heath and Care Partnership may impact on the Trusts quality and safety through increased ambulance handovers, patient acuity, mortality and admissions.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Total ED 12 Hour Breaches	0	742	766	785	953	798	798	807	
Total 4 hour performance	78%	75.4%	71.0%	65.6%	68.3%	78.4%	77.6%	72.7%	
>14 day LOS		337	349	403	424	380	375	378	Currently based on sum of 'Those discharged between 14 and 20 days' and 'Discharged 21 Days or Over'
#NCTR								#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
Average wait to 1st OPA (days)	60	96.34	94.4	94.43	99.37	104.18	102.83	98.6	

Context Summary
(Patient First problem statement, current situation)

There is a risk that conflicting priorities, fianancial pressures and/or ineffective governance results results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care. Examples of this could included but are not limited to: changes in ambulance attendances resulting in increased demand and poorer patient experience, increase in Medically Fit for Discharge (MFFD) patients 'blocking' access to Acute hospital beds, and increases in levels of risk held within the Acute setting.

Rationale for Current Score

Conflicting priorities, infancy of ICB and systems and processes supporting are not yet well established. Despite this, good working relationships exist with focus on key metrics for all providers, and established forums to capture and resolve unintended consequnces of any sytem-based decisions. Deterioration in performance of system partners (community, Medocc) contributing to increased risk in last quarter, additionally the sustained high number of NCTR patients in MFT beds.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
• LAEDB - Oversight dashboard • Kent and Medway Integrated Care Board • Kent and Medway Intregrated Care Partnership Joint Committee • Joint development of plans at ICS level • Kent CEOs Meeting • Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans • Trust-wide Flow and Discharge Corporate Project	• Dashboard capturing actions and unintended consequences on system partners • Evidence attendance at ICS and ICP meetings • Updated ICP and ICS risk register, reflecting input from system organisations • Risk Report monthly • Finance Committee report to Board • Internal review and monitoring of access to care metrics with exec oversight

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. LAEDB Refresh, pulling together renewed dahsboard to capture actions and impact across all agreed system KPIs	1. Review of LAEDB ToR, agenda and required reports	31/08/2023	Complete	Chief Operating Officer	Extended due to AL in July.

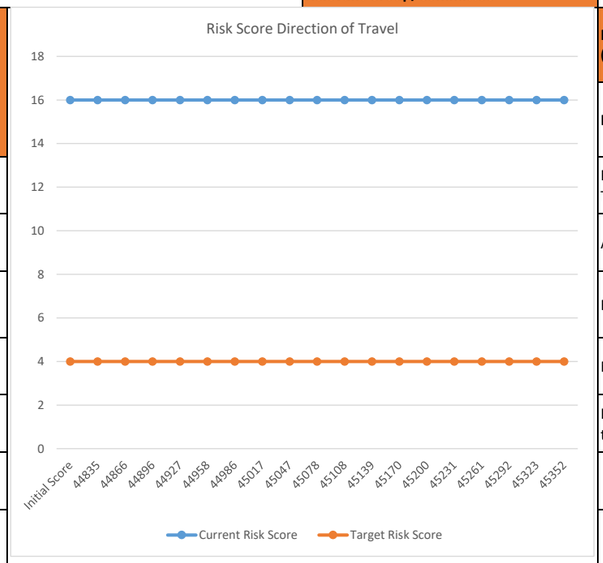
2. Trajectory for Medocc Performance		2. To work with MEDOCC to agree trajectory for sustained improvements	31/08/2023	Overdue	Chief Operating Officer	Some incremental improvement seen but not yet sustained
3		3				
4		4				
Trust Risk Register Aligned to Board Assurance Framework			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)						
Date of Last Review:	15 April 2024					
Date of Next Review:	14 May 2024					

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4e
Executive Owner	Chief Operating Officer
Operational Owner	Tracy Stocker, Director of Operations for Flow & Integration
Primary Risk Grouping	Systems & Partnerships
CQC Domain	Safe

Objective:	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Principal Risk Name & Description	There is a risk of financial impact if we are unable to increase flow and close escalation areas.
Relevant Group/Committee	Trust Management Board / Finance, Planning & Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	16	N
Risk Score at Last Review	4	4	16	—
Current Risk Score	4	4	16	—
Target Risk Score	1	4	4	
Trust Risk Appetite	Appetite: Very Low Range: 1-4 Score (trigger level): 4			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Pre Noon Discharge - G&A Adult > 1 Day LoS (Including Transfer to ADL)	40%	16.8%	17.3%	15.2%	14.1%	14.6%	12.9%	15.2%	
Avg. Length of Stay - G&A Adult > 1 Day LoS	7	11.8	11.7	11.1	11.7	11.7	12.1	11.7	
Bed Occupancy - G&A Adult > 1 Day LoS	92%							#DIV/0!	Due to the TT deployment BI are not able to supply figures from October.
NCTR at Midnight (count) - Month Average	80	78	119	100	106	112	96	101.8	
IP Discharges - - G&A Adult > 1 Day LoS (Including Transfer to ADL)		1823	1873	1834	1789	1812	1920	1842	

Context Summary
(Patient First problem statement, current situation)

The Trust has a high number of escalation beds open due to high demand for beds and reduced care capacity which is impacting discharge numbers and flow. The functioning of these escalation area's puts added pressure on the financial position of the Trust, as well as placing pressure on the wellbeing of our clinical teams as staffing levels are spread over a wider demographic throughout the Trust. By focusing on reducing the length of stay of our inpatients will increaces the potential for the reduction of escalation beds and will have a posative impact on both financial and operational efficiencies.

Rationale for Current Score

The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity our increase in patients without a criteria to reside (100 - 150) and the low discharge profile reduces flow and increases demand for bed capacity. The improvement activity taking place requires a cultural and transformational change as well as informed training to support best practice which will take some time to fully embed.
The availability of residential and home care capacity has been significantly impacted by many factors including cost of living, reduced funding and the impact of the covid pandemic. The impact of this has left MFT with very high numbers of patients across our bed base without a criteria to reside. These patients are at risk of functional deterioration and further complications from hospital acquired infections and disability, tissue damage and low mood. The combined impact of reduced care capacity and increased LoS in an acute bed is not only costly, more importantly it impacts the well being of our patients and staff. There are many things causing increased length of stay for patients without a criteria to reside that are not within our gift to improve, however efficiencies can be made in reducing LoS for patients not requiring care after discharge (PW 0), including standardised processes and discharge planning. in addition to this there is a risk relating to data quality regarding discharge date and time, this is currently being investigated to ascertain the extent of the issue and develop process to mitigate this.
There are increased delays to dscharging PW1 and PW3 patients dur to a change in comissioned services for Medway PW2, lack of availability for complex nursing PW3 placements. TS is working with partners to resolve these issues and new PW2 pathways being developed which will enable time monitoring. Ongoing system demand is continuing to impact flow and ED capacity. There are still delays in discharging ps via PW1 -3. MFT requires assurance from system partners on availability for on-ward ToC and pathway work to improve discharge opportunities.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
The Trust has alined the reducing LoS work into a corporate project within Patient First Flow and Discharge, this is focusing on systems and processes that will improve discharge planning and expedite the patients journey home. A training programme is being developed to ensure consistency and standardisation in Board Rounds to support actions for early discharge planning and avoid unneccesary delays to discharge. A National MADE requirement has enabeled us to review board round functions, attendance and processes; there is also a large amount of data from this event which will help us identify oportunities for improved flow and reduced delays. The wards should apply a full MDT conribution to the care and consequent discharge of our patients following SAFER princiles and the Red to Green concept. Integrated Duscharge Team (IDT) are SME's regarding discharge pathways and processes, they work with LA and and community partners and support ward teams across the Trust with discharge planning and management of PW 1-3 and complex patients. TeleTracking, Virtual Wards and the opening of Amhurst Court beds will support reducing bed occupancy and improve transfer of care timeescalse. these mitigations will require time to bed in (Amhurst Court to Open)	Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. This is monitored via; Flow and Discharge Corporate project, These workstreams review current position on a regular basis as well as seek further opportnities whilst following Patient First methodology, improving pre-noon discharge breakthrough objective hudles, HCP Discharge Group, Efficiencies Group and LAEDB. Data dashboards including the Flow dashboard (MFT) and the Discharge dashboard (HCP) to capture current performance and help create realistic trajectories for improvement moving forward.

Gaps in Controls	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. An operational plan that supports the closure of escalations area's. Full collaboration with system partners in discharging patients that have no criteria to reside in an acute bed. Cultural change within clinical teams across the Trust. Training programme that emphasises golden standard discharge processes.	1. Both Divisions providing senior oversight of BR's to support discharge planning against EDD.	31/03/2023	Complete	Divisional Management Teams	New action to be agreed as part of the Corporate programme to improve flow and reduce LoS 16/02/24 Action complete, BR improvement within the new F&D corporate project. Asurance via 4th action below
2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MDT, Snr review	2. Each care group attends a LLoS meeting BiWeekly chared by6 DoOF&I	31/10/2023	Complete	Care Group Management Teams	update 20/11/23 these meeting are in diaries and LoS for all IP >14 days for CTR and NCTR
3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS	3. HaCP discharge group reviewing pathways via an action plan following the Vital Hub audit	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. TS has discussed this with the COO and is writing a PID for a solution to this. 16/02/24 HACP decideing on plan to review, MFT waiting for HaCP exec decision. All discharge related work through the HCP has been stopped pending HCP / ICB decisions on the Transfer of Care functions. this is due in Q2 of 24/25.
4 Board Round improvement as part of the reducing LoS CP.	4. Re-embed SAFER, red2green and operationalise electronic BR's as part of the Flow and Discharge Corporate Project6	31/08/2024	On Track/Not Yet Due	Tracy Stocker, Director of Operations for Flow & Integration	Work with the care groups has started. Work with Sapphire and with Planned care ward commenced in early november 16/02/2024 Five wards have been supported with BR and escalation improvement. Further wards to be planned.

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

The Trust regularly has 100+ patients bedded within the Trust that have no criteria to reside. Exploratory work needs to be constructed to understand what can be done to expedite the journey home for these patients. Initial focus should be on pathway 0 patients that require little intervention and are within the Trusts own ability to discharge.
The KPMG Audit on Discharge Data published in April along with the Vital Hub audit on LoS and discharge processes have a number of recommendations being reviewed at HaCP level alongside the Patient First Flow and Discharge project to make improvements. This will form basis for all future training materials as processes will be confirmed, creating a standardised approach to discharge throughout the Trust and allow Clinicians to embed the golden standard of discharge that our patients expect.

LoS efficiency work to support effective Board Rounds (sept '23), Virtual wards and the mobilisation of 41 beds at Amhurst Court in October will support the trust in reducing LoS across the acute wards. There is an element of concern with our partner organisations ability to meet the demand for PW 1-3 moving into winter and MFT are working with the wider HaCP to manage these pathways more efficiently and to mitigate additional risk of increased LoS and reduced flow across our beds.

All discharge work relating to the HCP has been paused pending ToC development and review. MFT have started a programme of work through the Flow and Discharge corporate project to improve discharge planning and EDD setting which will lead to improvements in LoS and bed occupancy. it is acknowledged that this needs to be a back to basics approach that is delivered to be fully embedded.

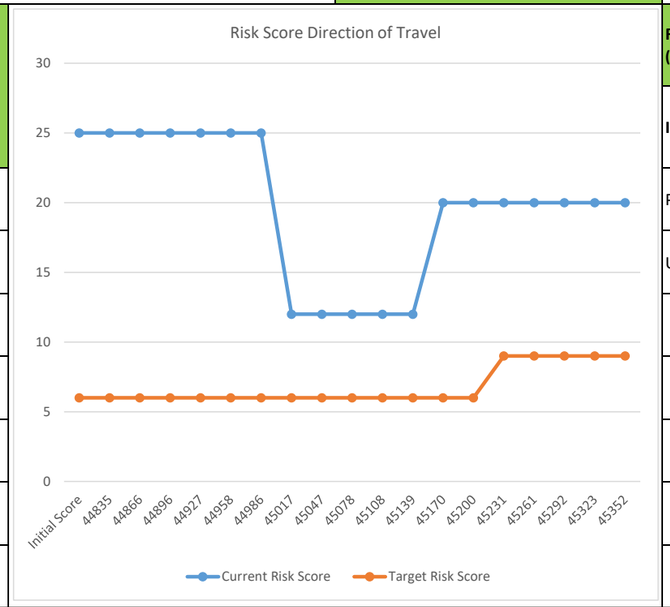
The Board Rounding project requires some PMO / Transformation resource to move forwards, this is a mission critical corporate project and this additional resource is recognised a fundamental success to re-educate and embed SAFER BR process. The HCP is still reviewing ToC services and no improvement work will be commenced regarding discharge, ToC Hub, reducing complex pathways until this review and remodel has been completed. MFT have commenced the Faculty Frontier AI project which will work on EDD accuracy and support discharge planning. run concurrently with the BR project we should be in a position to reduce this risk. there are no timescales set for this yet.

Date of Last Review:	11 April 2024
Date of Next Review:	11 May 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5a	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Operating Officer		
Operational Owner	Holly Reid, Divisional Director of Operations	**Principal Risk Name & Description**	The cost of our escalation capacity raises a risk against our current overspend. If the Length of Stay efficiency cannot mitigate this there will be a financial impact.
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	
Risk Score at Last Review	5	4	**20**	—
Current Risk Score	5	4	**20**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**YTD**	**Comments:**
Patient Flow and Discharge efficiency variance to plan (£m)	0	0.0	-0.5	-0.8	-0.6	-0.6	-0.6	-4.7	
Unbudgeted cost of escalation capacity (£m)	0	0.1	0.1	0.2	0.3	0.1	0.1	1.5	

Context Summary
(Patient First problem statement, current situation)

During 2022/23 the Trust reported unbudgeted costs of c£6m arising from escalation capacity, which directly impacted on its ability to deliver a breakeven control total.
A number of escalation areas have been budgeted for 2023/24, although closure of some of this capacity is included in the 'Patient Flow and Discharge' efficiency project. Non-closure of this capacity - or requiring more capacity than has been budgeted - could lead to cost pressures against the control total.
The Trust was successful in submitting a bid to NHSE for capital (and revenue) funding to create additional capacity (Ruby ward) the construction works are due to complete in March 2024.
The Trust was also awarded monies to open step down beds from October at the Amherst site.
Teletracking (digital bed management) has been implemented to support patient flow/capacity.

Rationale for Current Score

The YTD variance is greater than 0.5%-1% of the Trust's annual budget and hence scores as 4.
The likelihood is 5 given the year has now finished.

Key Existing Controls
(What are we currently doing about the risk?)

"Patient Flow and Discharge" is a cross-cutting scheme within the efficiency programme.
There is a SOP for opening escalation capacity.
Site meetings held several times per day. Site director is in post.
The Executive Team has agreed a de-escalation plan.
Transfer of c40 patients to Amherst as part of community step down bed provision underway - need to ensure these are fully utilised.
Implementation of Teletracking (digital bed management).
Business case development for a ring-fenced elective hub.

Assurances on Control:
(What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

Patient Flow and Discharge working group / corporate project team.
Efficiencies Delivery Group oversight.
Site meetings attended by clinical and operational staff, site office and execs.
Medically fit/no criteria to reside patients are monitored daily.
Medway and Swale Commissioning / Discharge Group meetings.
Implementation of Teletracking at other NHS organisations.

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. Clarity between the drivers of escalation closure, split between activity volumes, admission rates and length of stay/patient flow improvements.	1. Capacity and capital planning meetings to proceed, including a plan for the development of an estates strategy upon approval of the clinical strategy.	30/09/2023	Overdue	Nick Sinclair, Chief Operating Officer	
2	2. Plan and design the construction works associated with the UEC awarded funding for the Cardio-Respiratory village.	31/08/2023	Overdue	Nick Sinclair, Chief Operating Officer	
3	3. Development, approval and implementation of the winter plan.		Overdue	Nick Sinclair, Chief Operating Officer	

Trust Risk Register Aligned to Board Assurance Framework	Risk 1690: Escalation Capacity	Current Risk Score: (3x4 = 12)
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

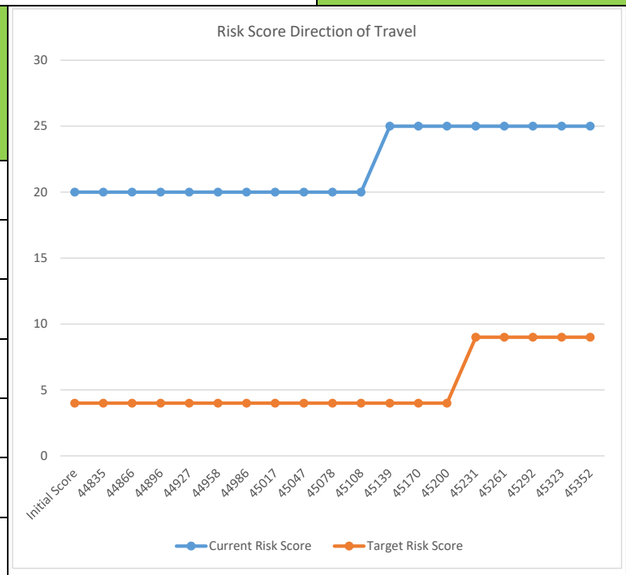
Awaiting outcome of elective hub proposals.

Date of Last Review:	11 April 2024
Date of Next Review:	TBC

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5b	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Delivery Officer		
Operational Owner	Steve Reipond, Director of PMO	**Principal Risk Name & Description**	Not delivering the Efficiencies Programme will impact Trust overspend and increase cost pressures Trust wide.
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	4	20	
Risk Score at Last Review	5	5	25	—
Current Risk Score	5	5	25	—
Target Risk Score	3	3	9	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**YTD**	**Comments:**
Identified vs planned schemes variance (£m)	-	- 10.0	- 11.8	- 11.8	- 12.2	- 12.0	- 9.6	- 9.6	
Actual vs planned performance variance (£m)	-	- 1.0	- 1.9	- 1.2	- 0.1	- 0.8	- 15.1	- 9.7	
Forecast variance (£m)	-	-	- 8.1	- 8.1	- 10.2	- 12.0	15.1	15.1	

Context Summary
(Patient First problem statement, current situation)

An efficiency target of £27m for 2023/24 has been set in order to meet a revenue control total deficit of £15m.
This target is 6.6% of planned income and is the highest across Kent & Medway this financial year, although other organisations across the South region and wider NHS have larger proportional targets.
The requirement arises due to a number of factors, including but not limited to: cost inflation rising faster than tariff growth; activity growth against historic rollover budgets, coupled with reducing productivity; historic position of underlying financial deficit; use of non-recurrent mitigations in prior years.
Failure to deliver against efficiency plans could impact on the Trust's financial performance and its Strategic Oversight Framework rating.

Rationale for Current Score

The YTD variance is greater than 1% of the Trust's annual budget and hence scores as "catastrophic" / 5.
The likelihood is 5 given the year has now finished.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
• Approval panel for schemes > £50k gross value/impact. • Scrutiny and challenges at the Efficiencies Delivery Group. • PMO Director and Chief Delivery Officer in place. • Long term structure for a PMO is being recruited to - approved by NHSE on the assumption that this will be self-funding/no additional cost pressure. • Supported by / participants of the system productivity and efficiency group. • Business planning including benchmarking data • Dragons den/check and challenge sessions	• Reporting to Efficiency Delivery Group and the Finance, Performance and Planning Committee (identified vs budget, delivered vs budget [in-month and YTD]). • External audit value for money procedures/opinion. • Internal audit procedures on a cyclical basis. • SOF reporting / meetings with NHSE, including leveraging knowledge and best practice from Intensive Support Team. • Model Health Systems, NHS Benchmarking, GIRFT, national cost collection/reference cost benchmarking

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Financial culture and awareness.					
2. Capacity and use of benchmarking.	2. Implementation of substantive PMO structure.	31/03/2024	Complete	Gavin MacDonald, Chief Delivery Officer	PMO will be at full strenght by the end of April 2024, With programme managers, project managers and support all in substantive post

	3. Permanent recruitment into PMO	31/03/2024	Complete	Gavin MacDonald, Chief Delivery Officer	Complete - please see above

Trust Risk Register Aligned to Board Assurance Framework	1673: Potential for Divisional CIP Target for 2023/24 not being achieved	Current Risk Score: (3x4 = 12)
	1689: If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk	Current Risk Score: (5x5 = 25)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

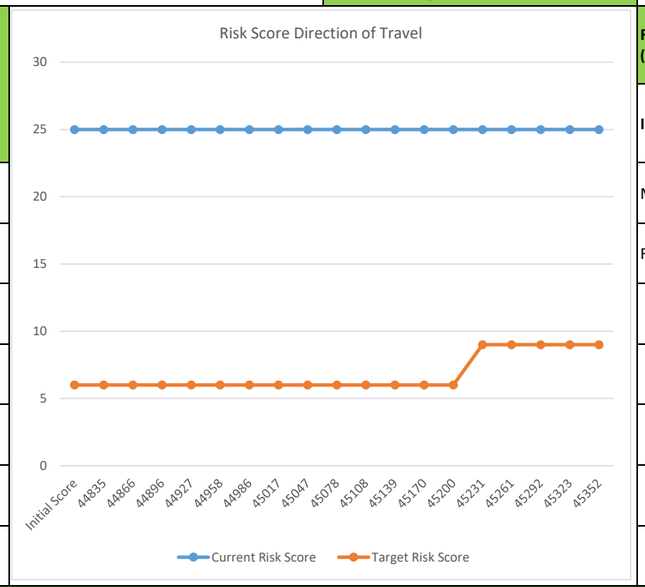
New governance process presented to EDG and to be implemented for 2024/25
Implementation of additiona steering groups to support the delivery of the mission critical corporate projects
PMO closly involved with the business planning process to ensure capture of all CIP's for 2024/2025

Date of Last Review:	11 April 2024
Date of Next Review:	TBC

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5d	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Jeremy Davis, Deputy Chief Medical Officer	**Principal Risk Name & Description**	Mitigating against medical staffing (agency/locum/additional sessions) is a risk to overspend
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	
Risk Score at Last Review	5	5	**25**	—
Current Risk Score	5	5	**25**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**YTD**	**Comments:**
Medical staff variance to budget in-month £m	-	- 2.0	- 1.2	-1.556	-2.7	-1.9	-4.9	- 23.1	The YTD adverse variance to plan includes costs associated with the industrial action, vacancies, ED pressures, weekend anaesthetics cover and cover for ENT and HDU, together with rotational doctor/GIM costs and unidentified efficiencies.
Forecast variance to budget £m	-	- 18.6	- 18.6	- 18.6	- 17.8	- 18.6	- 23.1	- 23.1	

Context Summary
(Patient First problem statement, current situation)

The medical staffing overspend in 2022/23 was £6.7m (c£4.2m before pay award and pension adjustments at the year end).
This category of expenditure was included as part of the breakthrough objective huddles in that year and continues into 23/24.
The Trust has an unmitigated cost pressure arising from the pay award of £2.7m for the year.

Rationale for Current Score

The YTD variance is greater than 1% of the Trust's annual budget and hence scores as "catastrophic" / 5.
The likelihood is 5 given the year has now finished.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Month end variance analysis. Strengthened escalation process for additional sessions, including executive VCP. Part of the "control of overspending" breakthrough objective. Medical staff Deep Dive report to December FPPC Medical staff stood up as Corporate Project under CMO leadership	Budget holder meetings. Sustainability Breakthrough Objective huddle. Finance, Planning and Performance Committee reporting. Medical workforce efficiency scheme and project group.

Gaps in Controls
(What additional controls and assurances should we seek?)

Mitigating Actions to Address Gaps
(What more should we do to address the gaps?)

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**

1. Implementation of actions arising from finance huddle.	1. Complete job planning.	i) 31/08/2023 for "straight forward" rosters ii) 31/10/2023 for "less simple" rosters	Overdue	Alison Davis, Chief Medical Officer	Divisons have been asked to complete job planning for all relevant doctors by end of March 2024. A job planning A3 workstream is progressing
2. Progression and implementation of medical efficiency cross-cutting scheme actions.	2. Recruitment plan development, particularly for hard to recruit to posts.	30/09/2023	Overdue	Leon Hinton, Chief People Officer	A workstream as been set up using 'Patient First' with Janette Cansick and Howard Cottam as the joint SRO for this
3. Job planning is currently incomplete.	3. Identify and procure an appropriate rostering platform to ensure all specialties have rostered medical staffing. Internal audit review of adequacy of rostering processes and controls.	31/03/2024	On Track/Not Yet Due	Jeremy Davis, Deputy Chief Medical Officer	An A3 has been partially completed. A PID will be pesented to the Excutive before the end of March 2024 to recruit a professional lead for this project.
	4. Medical efficiencies is being stood up as Corporate Project. The governance and arrangements are to be put in place.	28/02/2024	Overdue	Alison Davis, Chief Medical Officer	The workstreams are in place

Trust Risk Register Aligned to Board Assurance Framework		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

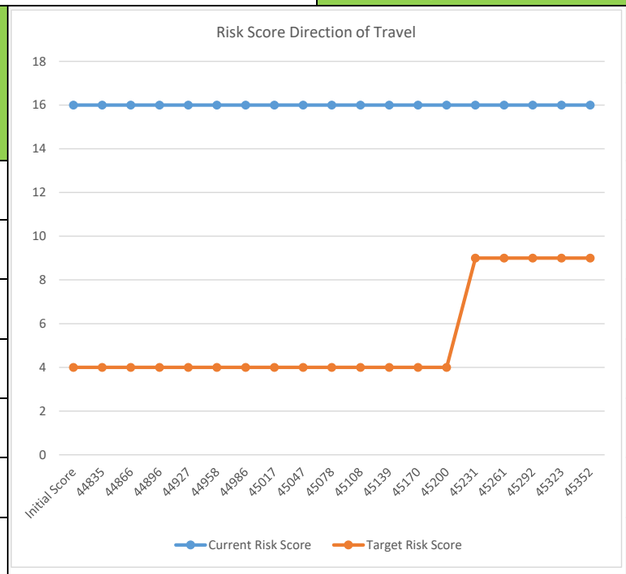
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	11 April 2024
Date of Next Review:	TBC

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5e	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Paul Kimber, Deputy Chief Financial Officer	**Principal Risk Name & Description**	Financial governance to be strengthened.
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	4	4	**16**	N
Risk Score at Last Review	4	4	**16**	—
Current Risk Score	4	4	**16**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**YTD**	**Comments:**
Number of lapsed budget holder training (no.)	0	81	76	79	74	75	75		
Number of lapsed budget holder training (%)	0%	42%	39%	39%	36%	36%	36%		

Context Summary
(Patient First problem statement, current situation)

The financial awareness and relative importance across the Trust is considered to be low, e.g. engagement/ownership of financial performance, time given to this at performance reviews, etc.
This manifests in poor budget management and financial performance.
Failure to address this as an issue could impact the Trust's exit from SOF4.

Rationale for Current Score

Consequence: staffing and competence - moderate error(s) due to levels of competency (individual or team). Finance including claims: before utilisation of reserves the Trust is adverse by >1% of budget in clinical divisions. Statutory duty: low performance rating.
Likelihood: expected to occur at least weekly.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Budget holder meetings Budget holder training (statman) Finance Training Policy Mandatory objective in appraisal form Efficiencies as a corporate project Control of overspending implementation as a breakthrough objective Communication via senior managers meetings and Trust Management Board Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. Better Business Case trained staff.	Previously performance review meetings - now Strategic Deployment Reviews. Care group and divisional board meetings. Budget holder meetings Efficiency Delivery Group Finance, Planning and Performance Committee Trust Board Oversight meetings Internal audit

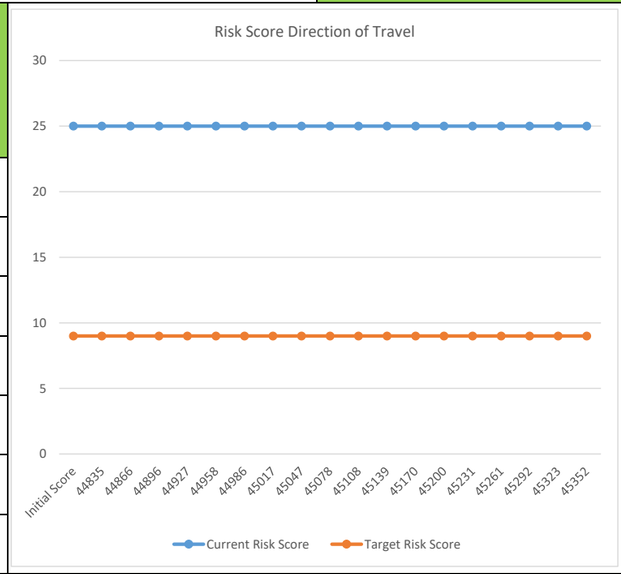
Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. The controls themselves should be sufficient if implemented wholly and fully. Non-adherence to the controls (and SFIs) to be considered.	1. 'Finance Business Partners to emphasise the requirement for budget holder training to relevant staff.	Ongoing	On Track/Not Yet Due	Finance Business Partners	There has been better attendance at recent training events.

2		2. Confirmation required for inclusion of budget holder training as part of statman	31/10/2023	Overdue	Leon Hinton, Chief People Officer	A full review of the statman programme is being undertaken to confirm.
Trust Risk Register Aligned to Board Assurance Framework	1722: Individuals could be open to a charge of Fraud or Bribery		Current Risk Score: (4x2 = 8)			
	1724: Contract Management		Current Risk Score: (4x3 = 12)			
			Current Risk Score:			
			Current Risk Score:			
			Current Risk Score:			
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)						
A wider leadership training programme is being explored at the Trust, which would require individuals to complete specified elements of financial training. The recently completed KPMG report has highlighted some areas for improvement in financial governance, including budget setting, forecasting and financial engagement of budget holders - actions have been agreed and will be reported though FPPC going forward.						
Date of Last Review:	11 April 2024					
Date of Next Review:	15 May 2024					

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

Risk ID:	5g	**Objective:**	Living within our means providing high quality services through optimising the use of our resources.
Executive Owner	Chief Financial Officer		
Operational Owner	Paul Kimber, Deputy Chief Financial Officer	**Principal Risk Name & Description**	Delivery of the control total and FRP
Primary Risk Grouping	Sustainability		
CQC Domain	Well-Led	**Relevant Group/Committee**	Finance, Planning and Performance Committee

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	N
Risk Score at Last Review	5	5	**25**	—
Current Risk Score	5	5	**25**	—
Target Risk Score	3	3	**9**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Inadequate			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**YTD**	**Comments:**
Variance to control total	-	- 3.0	- 3.0	- 1.7	- 3.3	2.6	1.3	- 19.7	

Context Summary
(Patient First problem statement, current situation)

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 contracting arrangements the ICB must meet its control total; this equates to a £15m deficit for the Trust as submitted in the May plan. Given the YTD performance, inherent risks within the plan and current position on unidentified efficiencies and mitigations, there is significant uncertainty and a risk of the Trust not meetings its control total.
The Trust currently remains in SOF4.

Rationale for Current Score

The YTD variance is greater than 1% of the Trust's annual budget and hence scores as "catastrophic" / 5.
The likelihood is 5 given the year has now finished.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)

1. Rebasing of divisional plans through robust business planning/budget setting. 2. Seek additional monies from third parties to support initiatives and/or the underlying financial position, including the Charity, ICS and national funding sources. 3. Work with NHSE intensive support team. 4. Application of NHSE “Grip and Control” actions to limit spending, at least on a temporary basis. 5. PMO: a. Work with divisional teams to identify, develop, implement and track operational delivery and financial consequences of efficiency schemes. b. Delivery of efficiency showcase events. 6. Financial Training Policy and SOP, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon. 7. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings. c. Patient First Programme work streams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication. e. HARIS, CDC and virtual wards projects 8. Breakthrough Objective on "control of overspending". 9. Enhanced VCP process and approval group. 10. NHSE 2023/24 controls spreadsheet and enhanced internal controls. 11. Application of safe staffing recommendations in budgets. 12. Drivers of deficit and Financial Recovery Plan	Monthly reporting and insight of actual v budget performance for review at care group boards, divisional boards, divisional SDRs, Finance, Planning and Performance Committee and the Trust Board. Internal accountability framework at programme level, i.e. budget holder meetings. Delivery of and attendance at training programmes for staff. Appraisals / objective setting Efficiency Delivery Group. NHSE intensive support team Internal audit Breakthrough huddle Oversight meetings with NHSE and ICB

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Communication to and understanding of Trust staff to the financial issues and their resolution.	1. Undertake further FRP reset work.	30/09/2023	Overdue	Paul Kimber, Deputy Chief Financial Officer	LTFM document delayed due to ongoing ICS process.
2. Accountability/responsibility of budget holders.	2. Budget holder training	Ongoing	On Track/Not Yet Due	Finance Business Partners	See BAF entry 5e
	3. Implementation of enhanced financial controls, including action plan derived from KPMG report	Ongoing	On Track/Not Yet Due	Alan Davies, Chief Financial Officer	Action plan and implementation/delivery

Trust Risk Register Aligned to Board Assurance Framework	1237: Increase bank spend due to enhanced care requirements will lead to overspend against budget	Current Risk Score: (5x2 = 10)
	1064: Debt Recovery - Non NHS Trade Debt	Current Risk Score: (2x2 = 4)
	1065: Debt Recover - NHS Trade Debt	Current Risk Score: (2x2 = 4)
	1688: Capital Allocation	Current Risk Score: (4x3 = 12)
	1692: Inflation	Current Risk Score: (3x3 = 9)
	1691: Potential for the Trust to have an unfunded cost pressure should the proposed harmonised bank rate be applied	Current Risk Score: (4x4 = 12)
	1687: Potential for Trust not to deliver against activity plan for 2023/24 which could jeopardise delivery of deficit control total	Current Risk Score: (5x5 = 25)
	1696: Data Quality may result in risk to patient safety and financial income loss	Current Risk Score: (4x3 = 12)
	1861: Cash holdings depleting may result in Trust running out of cash	Current Risk Score: (3x4 = 12)

Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

KPMG have provided the Trust with their report on financial improvmement, including further counter measures and mitigations.

Date of Last Review:	11 April 2024
Date of Next Review:	15 May 2024