Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 15 January 2025 at 12:30 – 15:30 - Trust Board Room, Gundulph Offices and via MS Teams

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 13 November 2024	Chair	3	12:35	Approve
2.2	Action Log		12		Note
3.	**Opening Matters**				
3.1	Chief Executive Update	Chief Executive	13	12:40	Note
3.2	Council of Governors Report	Lead Governor	Verbal	12:45	Assurance
	Board Story Presentation				
3.3	Breast Feeding Story	Associate Director of Patient Experience	16	12:50	Note
4.	**Performance, Risk and Assurance**				
4.1	Risk and Issue Register and Board Assurance Framework	Company Secretary	21	13:10	Assurance
4.2	Integrated Quality Performance Report **APPENDIX 1**	Chief Delivery Officer	51	13:20	Assurance
5.	**Board Assurance Reports**				
5.1	Quality Assurance Committee (Jan)	CNO/CMO/Committee Chair	55	14:00	Assurance
5.2	People Committee (Sept)	Chief People Officer, Committee Chair	58	14:10	Assurance
5.3	Finance, Planning and Performance Committee (Nov/Dec)	Chief Finance Officer, Committee Chair	62	14:20	Assurance
	~ WELLBEING BREAK – 5 minutes ~				
6.	**Papers**				
6.1	Finance Report (Month 8) **APPENDIX 2**	Chief Financial Officer (Interim)	71	14:35	Note

6.2	RSP, Financial Recovery and Integrated Improvement Plans Update	Chief Financial Officer (Interim), Chief Delivery Officer	73	14:50	Note
6.3	Strategy: Freedom to Speak Up	Director of Strategy	78	15:00	Approve
6.4	Maternity Services Reports: a) Maternity Workforce Oversight Report b) Maternity CNST Compliance Assurance Report – Updates and Actions **APPENDIX 3**	Director of Midwifery	90	15:05	Assurance
7. Closing Matters					
7.1	Questions from the Council of Governors and Public	Chair	Verbal	15:20	Note
7.2	Escalations to the Council of Governors				
7.3	Any Other Business				
7.4	Reflections				
7.5	Date and time of next meeting: Wednesday, 12 March 2025				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the Trust Board Meeting in Public

Wednesday, 13 November 2024 13:00 – 15:00

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

And via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust 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
	Jenny Chong	Non-Executive Director/Senior Independent Director
	Leon Hinton	Chief People Officer
	Sarah Vaux	Chief Nursing Officer (Interim)
Attendees:	Alana Marie Almond	Deputy Company Secretary (Minutes)
	Ali Herron	Director of Midwifery (Item 6.3)
	Anan Shetty	Governor (left after Item 6.1)
	Angela Harrison	Governor
	Ashike Choudhury	Director of Medical Education (Item 6.7)
	Candice Penfold	Governor (left after Item 6.1)
	Chris Palmer	Governor
	Darren Palmer	Site Director of Operations
	David Brake	Lead Governor
	Glynis Alexander	Director of Communications and Engagement.
	Hari Aggarwal	Governor
	Joy Onuoha	Governor
	Lorna Gibson	Director of NHSE (joined at Item 6.2)
	Martina Rowe	Governor
	Matt Capper	Director of Strategy and Partnership/Company Secretary

	Matthew Tainano	Governor
	Natasha Turner	Governor
	Nikki Lewis	Associate Director of Patient Experience
	Paul Stephens	Member of the Public
	Robin Harmer	Governor
	Victoria Lowe	Business Development Manager, Darwin Group (Estates)
	Yushreen Vadamootoo	Governor
Apologies:	Jane Perry	Academic Non-Executive Director
	Mojgan Sani	Non-Executive Director
	Nick Sinclair	Chief Operating Officer (Deputised by Darren Palmer)
	Paulette Lewis	Non-Executive Director

1. PRELIMINARY MATTERS

1.1 **Chair's Introduction and Apologies**

The Chair welcomed all present. Apologies for absence were noted as above.

a) The Chair informed the Board of a successful visit from Cedi Frederick, Chair of the ICB.
b) The Staff Survey runs until 29 November 2023 and asked that all colleagues are encouraged to complete the survey.
c) Secretary of State has asked for engagement exercise on the ten-year plan which gives us until March 2025. The Board will consider making an online submission on the Trusts behalf.

1.2 **Quorum**

The meeting was confirmed as quorate.

1.3 **Declarations of Interest**

No additional declarations of interest to declare for this meeting.

2. Minutes of the Last Meeting, Action Log and Governance

2.1 The minutes of the meeting held on 10 September 2024 were **APPROVED** as a true and accurate record.

Candice Penfold requested that abbreviations in reports are written in full.

2.2 **Action Log**

The action log was reviewed, updated and is held under separate cover.

3 Opening Matters

3.1 Chief Executive Update

Jayne Black presented the update, highlighting the following key points:

a) Annual Members' Meeting
b) Improving Performance

c) Cancer Care
d) Improving Patient Feedback
e) Staff Recognised in National Awards
f) A Year of Patients Know Best
g) Ticketless Parking Coming Soon
h) "Life-saving" Medway nurse rescues man on street with CPR

The Board **NOTED** the update

3.2 Council of Governors Report

There has been no Council meeting since August 2024. The next meeting will be held on 20 November 2024, at Canterbury Christ Church Medway Campus. David Brake gave the following updates:

1) The Trusts Annual General Meeting had an excellent attendance. He gave thanks to Governor John Wright for presenting on David's behalf in his absence.
2) The Governors have taken part in the PLACE Assessment on site over the last few days. Overall the hospital seemed to be in good working order with some areas needing attention. Feedback will follow in the near future.

The Board **NOTED** the update

Board Story Presentation

3.3 Breast Feeding Story

This item was deferred to January 2025 due to sickness.

4. Performance, Risk and Assurance

4.1 Trust Risk Register and Board Assurance Framework

Matt Capper presented to give the members of the Board assurance as to the current position of the Trusts risks management system. The Trust Risk Register has 226 approved risks in total with 26 risks scoring 15 and above (designated extreme risks). There have been 37 new risks, of which:

- 18 risks are awaiting review, and
- 19 risk is awaiting approval.
- 7 risks have been closed.
- 18 risks have had the score reduced.
- 5 risks have had the score increased in the previous quarter.

A full review of the trusts Risk Management Framework is now underway and revisions will be considered by the Audit and Risk Committee before submission to the Board. This work is expected to be completed in time for the new financial year.

The Board Assurance Framework (BAF) is used to record and report the organisation's strategic objectives, risks, controls, and assurances to the Board. The review and refresh of the Trusts BAF has now been completed. The report detailed changes and new risk identified.

<u>Check and Challenge</u>

1) Chair – asked for update on risks that have not moved or closed for an extended time. Matt – agreed and updated that the team are dealing with this.
2) Jayne – the BAF tracking charts are really useful.

The Board were **ASSURED** by the report

4.2 Emergency Preparedness, Resilience and Response (EPRR) – Annual Assurance Rating

Darren Palmer presented to the Board for noting and current assurance. The EPRR group met in August 2024 and the report provided an overall update on progress against the EPRR Core Standards annual assurance improvements, the work plan for 2024 and current risks and threats.

The Trust obtained 'Full Compliance' for 2023 having not done so for many years. The Trust Business Continuity Network is managed by the Head of EPRR in the absence of a Band 7.

Check and Challenge

1) Alison – the support from the EPRR team has been very good. Table Top exercises are important. Darren – suggested it would be good to have more involvement from Strategic Commanders. Alison – agreed.
2) Gary – need to ensure that Table top exercises are operational alongside strategic. Darren – agreed.
3) Jenny – there have been staffing issues previously, how stable is the workforce now? Darren – the EPRR team are now stable with the recent recruitments.
4) Chair – thanked Darren and the team.

The Board **NOTED** the report and were **ASSURED** by the current position

4.3 Integrated Quality Performance Report (IQPR)

Gavin MacDonald presented the report in relation to Month 5 for 2024 and provided the Board with an update of performance against the Trusts Strategic Priorities:

a) The People domain continues to show the highest volume in metrics improving for Statistical Variance, (30), however the Patients domain shows the highest % of statistical improvement metrics (~61% of all metrics).
b) The Systems and Partnerships domain is showing the highest number of variances that are statistically showing concern, with 38% of all metrics flagging.
c) Both Quality and Sustainability domains show that the majority of their metrics are not showing any significant statistical change and as such are showing common variation.
d) Overall, 69 metrics are now showing improved statistical variance (no change from last month) against 33 which are showing concern (-1 from last month).
e) Key areas of improvement are identified with actions and mitigations being taken by operational teams which were detailed in the report.

Check and Challenge

1) Jayne – percentage of completion with staff appraisals were achieved last year, are actions in place to ensure the Trust can match last year? Leon – there has been a backlog in data and reporting. **ACTION NO: TB/2024/005** – Pick this up at SDR meetings
2) Jayne – statutory mandatory training – Resus and Paediatrics remain an area of concern, this has been a concern for a number of time. Leon – the courses are restricted by their scheduling and availability of staff – this is a focus; more courses are to be made available

throughout the year. The governance around StatMan reporting is going to People Committee (PC). **ACTION NO: TB/2024/006** – get some traction on this through PC

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

5 Board Assurance Reports

5.1 Quality Assurance Committee (QAC)

Alison Davis, Paulette Lewis and Sarah Vaux presented the report, there were the following escalations to the Board:

a) Anti-Microbial Stewardship Report - highest increase in consumption of broad-spectrum antibiotics within the Kent and Medway and South East region. The Committee has requested progress reports to be added to future agendas.
b) Imaging Backlog - support from Corporate Medicine to escalate internally. Process for harm review agreed. Work to address capacity issues in this service are in progress. This was discussed with the Executive team.

The Board were **ASSURED** by the report

5.2 People Committee

Leon Hinton and Jenny Chong presented the report, there were no escalations to Board, however the following was highlighted to note:

a) The Risk Register needs to be reviewed for correct ownership.
b) How does the Trust measure that it is positively changing its culture?
c) The team must ensure high-quality in all of the data sources and reporting.
d) StatMan Training has been discussed numerous times at committee meetings.
e) There are efforts to improve on the Staff Survey response rate.
f) Flu and Covid vaccination rates are reducing.

<u>Check and Challenge</u>

1) John – in regard to the cultural piece around vaccinations and vaccination fatigue; what is the Trust doing about it? Leon – detailed the work around engagement and encouraging colleagues to be vaccinated.

The Board were **ASSURED** by the report

5.3 Finance, Planning and Performance Committee

Alan Davis and Gary Lupton presented the report, there were no escalations to Board, however the following was highlighted to note:

a) Pembroke Ward Fire Safety Works - Electrical Safety Issues
b) There is more work to do with aligning risks with the improvement plan
c) The committee supported the evidence around the RSP work

The Board were **ASSURED** by the report

6 Board Papers

6.1 Finance Report (Month 6)

Alan Davis presented the report for the Board to note, which contained the following highlights:

a) The Trust reported a surplus of £10.9m in month 6 and a deficit of £3.2m year to date (YTD); this is adverse to plan by £1.9m. In-month the Trust received £14.2m of deficit support funding and the control total has been adjusted accordingly; it has also received £0.5m of industrial action funding.
b) The efficiency programme has under delivered by £0.6m against the YTD plan of £8.7m.
c) The capital position is underspent as at month 6 due to the timing of schemes being delivered (principally CDC leases being signed). The CDC issues have now been resolved in principle but are expected to impact completion in 2024/25. The projects are under review to agree timescale/financial slippage into 2025/26.
d) Cash at the end of September was £5.2m. The deficit support funding referenced above (£25.4m for the full year) is cash-backed and as such we shall cease further draw down of Public Dividend Capital as cash support.

Check and Challenge

1) Chair - The Trust has been placed in Financial Segment 4 due to the financial recovery, a letter from the ICB will be submitted to the Finance, Planning and Performance Committee in November 2024, for more information.
2) Chair - will there be sufficient cash to cover the month end and capital. Alan – yes this has been factored in the cash flow forecast, and will make this clear in the report.

The Board **NOTED** the report.

~ The Board took a five-minute Wellbeing Break ~

6.2 Emergency Department Recovery

Sarah Vaux gave a verbal update to the Board for noting. Sarah gave a brief update on where the Trust is with its Emergency Department (ED) improvement plan which has been running since November 2023. The plan has adapted following some initial feedback from the CQC following their inspection in February 2024.

The Trust has continued to implement the plan throughout the year and is now at 90% completion. There are a few residual areas that the Trust continues to work on in addition to continuing to check compliance against the areas that have been implemented.

The Board **NOTED** the update.

6.3 Maternity Services Reports:

6.3a Claims, Complaints and Incidents - Triangulation

Ali Herron presented the report which gave assurance to the Board that the Trust will be reporting to meet requirements of CNST Year 6. The report reviewed the claims scorecard for 2013 to 2023 alongside incidents and complaints for 2023/24. This included a review by ethnicity of service users. The report also reviewed all claims to identify if they were known to the Trust.

The Board were **ASSURED** by the report.

6.3b Maternity CNST Compliance – Update

Ali Herron presented the report which gave assurance to the Board. The team anticipated declaring compliance with all 10 Safety Actions within the required reporting period. CNST

Year 6 Published 02 April 2024 with reporting period ending 30 November and submission due 03 March 2025.

The Board were **ASSURED** by the report.

6.3c Perinatal Culture and Leadership Programme (PCLP) and SCORE Survey Report

Ali Herron presented the report which gave assurance to the Board that the Trust will be reporting to meet requirements of CNST Year 6. The report gave information on the national network of Patient Safety Collaboratives (PSCs) that have been commissioned to offer support to sustainably support the leadership capacity, capability and improvement relating to safety culture within maternity and neonatal units and as part of local systems, building on the progress made during Phases 1-3 of the PCLP.

The Trust reports; 13 actions completed, three on track, two overdue and one-off track.

The Board were **ASSURED** by the report.

6.3d Perinatal Quality Surveillance

Ali Herron presented to the Board to give assurance in regard to the report which provided a quarterly oversight for Q2 in the 2024/25 period.

Check and Challenge

1) Chair – highlighted the sudden maternal death during labour. Ali – advised the Board that the team are continuing to support the family and awaiting the preliminary post mortem results.
2) Chair – Thanked Ali and the team for sustaining the improvements and well done to all.

The Board were **ASSURED** by the report. Chair thanked Ali and the team for their hard work and efforts for all Maternity reports and services.

6.4 Kent and Medway NHS Strategy 2024/25 – 2029/30

Gavin MacDonald presented the report which detailed NHS provider, primary care and NHS Kent and Medway organisations who have come together to produce the NHS Strategy 2024/25 to 2029/30, and asked the Board to:

a) Note the co-production approach to the development and delivery of the NHS Strategy.
b) Approve the NHS Strategy endorsing the direction of travel as described in the A3s.

Check and Challenge

1) John – the timing of delivery plan is important, and also ensuring that the Trust aligns with the provider collaborative. **ACTION NO: TB/2024/007** – add this item to the Board forward plan and agree date with Company Secretary

The Board **NOTED** the co-production approach and **APPROVED** the NHS Strategy.

6.5 Strategy Review and Summary

Matt Capper presented the Strategy Roadmap for the Board to note.

Check and Challenge

1) John – consider the frequency of reporting and asked that this item is submitted to the Council of Governors in November 2024. Matt – agreed and will review.

The Board **NOTED** the roadmap.

6.6 In Patient Survey Results – Update

Nikki Lewis presented the report to the Board for noting, the report outlined divisional actions based on the recent findings from the adult in-patient and cancer patient CQC surveys. The highlights from the survey results were delivered to a previous Board meeting and an action plan is now in place. This was discussed in detail at the Quality Assurance Committee.

Check and Challenge

1) Sarah – would be useful to understand the demography of the sample. Nikki – will feedback on this and is involved in national task force group.

The Board **NOTED** the report.

6.7 Medical Education Annual Report

Alison Davis and Ashike Choudhury presented the report to the Board for noting, the report outlined;

a) The current NHSE KSS Quality Visits and GMC Survey responses
b) The possible future expansion of post-graduate doctors in training establishment
c) Student numbers
d) The Board awareness around risks and mitigations identified within the Medical Education department.
e) Priorities have been continued to be around driving quality improvement programmes. One area of focus currently are Paediatrics and General Surgery; once a year the trainees are given an online survey run by the GMC.

Check and Challenge

1) Jenny – congratulated Ashike on his new role. The discussion has changed around bringing human factors into how we look at clinical practice. Would be good for the Board to visit the Simulation area and test it out. Ashike – agreed
2) Jayne – feedback from trainees; how does the Trust adapt the cultural transformation into Medial Education?
3) Gary – how can the Trust improve overall experience for students and retention of students. Ashike – there needs to be better support overall, including accommodation, training, work experience. The department is very much in a transitional period following the strikes.
4) Chair – how many undergraduates take up work at the Trust – can we do this going forward? Ashike – agreed to add this to future reports.
5) Jayne – areas of focus for the Executive team is on Paediatrics and General Surgery. **ACTION NO: TB/2024/008** – to be added to the Board forward plan, agree with Company Secretary

The Board **NOTED** the report.

7 Closing Matters

7.1 Questions from the Council of Governors and Public

There were no questions received in advance of the meeting. The following questions were raised at the meeting:

1) Martina Rowe – does the 12 hour wait figures include children? Gavin – it is adults waiting for beds.
2) Martina Rowe – how many patients have failed discharges, is this monitored? Darren – yes failed discharges are monitored, this helps the Trust with learning and to understand what the impact the failed discharge had on the hospital the next day. Failed discharges are reviewed as case by case. Data is kept and examined when necessary, the recorded data details quantity and reasons for fail. Chair offered that Darren and Martina discuss further outside of Board, if it would be of benefit and an agenda item would be added to the February Council meeting.
3) Angela Gallagher – following the presentation from Medical Education on overall experience for students at the Trust, it is worth knowing the information from students and the impact it has on them, for the Trust to improve.
4) Chris Palmer – has experienced failed discharge due to the lack of assessment of the patient's home, would welcome a report to the Council.
5) Chris Palmer – asked how the Trust is reducing the waiting lists? Jayne – lot of work has been done on waiting lists, which includes the cardiac department, where the team is working hard to reduce the wait time to under 65 weeks. Consultants review the waiting lists and triage them by level of priority. Darren – the Trust has also increased capacity to include weekend working which will drive the waiting list down.

7.2 Escalations to the Council of Governors

The following escalations were proposed for the Council of Governors:

1) Failed Discharges – add to the February 2025 Council of Governors meeting
2) Kent and Medway NHS Strategy 2024/25 – 2029/30 – November 2024 agenda
3) Strategy Review and Summary – November 2024 agenda
4) In Patient Survey Results - Update – November 2024 agenda

7.3 Any Other Business

There were no matters of any other business.

7.4 Reflection

Nothing to note for reflection at this meeting.

7.5 Date of next meeting

Wednesday, 15 January 2025
The meeting closed at 15:40

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 13 November 2024

Signed by the Chair …….. Date ……

Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
24.07.24	**TB/2024/004**	Timing and refresh of system and partnership work with collaborative partners to be bought back to the Board for review.	15.01.25 ~~13.11.24~~ ~~10.09.24~~	Director of Strategy and Partnership/Company Secretary	**31.12.24** - ICB/MFT awaiting national listening exercise to be completed and reported on. Once this is done then the system strategy will be refreshed to reflect it. Due date request to Feb. 13.11.24 - Deferred to January 2025 - System Partnership Away Day scheduled for 15.11.24.	Amber
13.11.24	**TB/2024/005**	**IQPR** - The decline in appraisal rates, in comparison to last year, will be addressed at SDR meetings	Ongoing	Chief Delivery Officer/ Chief Executive	**PROPOSE TO CLOSE - 02.01.25 - CDO -** Performance will be monitored. Executive oversight for corporate areas has been put in through the weekly Executive Management Committee to address the falling appraisal level. **31.12.24** - CPO - Weekly Executive meeting now incorporates corporate SDR elements including appraisal, StatMand and finances (in place). Backlog of recording appraisals being addressed through resource being reallocated.	Green
13.11.24	**TB/2024/006**	**IQPR** - StatMand training improvement required for resus (adult and children) with reporting governance being a focus for the People Committee.	Ongoing	Chief People Officer/ Chair of People Committee	**31.12.24** - linked to Action 005, StatMand is now on the weekly corporate SDR at Exec Group. Reporting actions and progress to People Committee.	Green
13.11.24	**TB/2024/007**	**Kent and Medway NHS Strategy 2024/25 – 2029/30:** add this item to the Board forward plan and agree date to submit to Board	15.01.25	Chief Delivery Officer/ Director of Strategy and Partnership/Company Secretary	**PROPOSE TO CLOSE** - added to Board Work Plan	Green
13.11.24	**TB/2024/008**	**Medical Education:** area of focus on Paediatrics and General Surgery - add to the Board forward plan and agree date to submit to Board	15.01.25	Chief Executive/ Company Secretary	**PROPOSE TO CLOSE** - added to Board Work Plan	Green

Chief Executive's Report: January 2025

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.

Addressing winter pressures

We have opened escalation beds in recent weeks, increasing our acute medical capacity, so that patients in ED who need admitting to the hospital can be assessed in our expanded Acute Medical Unit. This is helping to improve the flow of patients through the hospital and to reduce the length of stay in ED.

One of the reasons for the high number of patients coming to our ED is the rise in respiratory infections recently, including flu, RSV and COVID-19. In Kent and Medway there has been a significant increase, which is also leading to more staff sickness. We continue to provide regular opportunities for staff who have not yet had their winter vaccinations, to help protect them and our patients.

Our emergency performance dipped to 73 per cent in December 2024, below the consistently above-target performance seen since April 2024. Where dips in performance are seen, we are able to recover more quickly, thanks to the significant and sustained improvement work that's been taking place over many months, both within the hospital and together with our community partners, underpinned by Patient First.

New diagnostic centre opens in Sheppey

I am delighted that our new Community Diagnostic Centre (CDC) has opened at Sheppey Community Hospital in Minster providing patients on the Isle of Sheppey, Sittingbourne and surrounding areas to a range of vital tests and scans closer to home.

The first phase of this multi-million-pound centre has launched with Computerised Tomography (CT) scanning, with the second phase to include Magnetic Resonance Imaging (MRI) scanning later this year.

In Medway and Swale, patients have access to two CDCs, with the first located at Rochester Healthy Living Centre. Since it opened in 2023, it has delivered more than 6,000 diagnostic tests including ultrasound scans, and respiratory and cardiology services.

These centres are not only better for patients, offering more local and often quicker access to tests and scans, they also help to free up diagnostic capacity at our main site for emergency patients and our inpatients.

Extending the benefits of robotic assisted surgery

Since adopting the latest robotic-assisted surgery device, called Hugo, early last year, surgical teams have extended the benefits of this minimally-invasive surgery to many more patients including, for the first time, patients needing a hysterectomy. This has replaced open surgery, traditionally used for hysterectomies, with small incisions which results in less pain, fewer

complications, better outcomes and enables patients to go home sooner. Hugo is our second surgical robot having first introduced robotic surgery in 2017.

Day surgery improvements

Surgical teams have also recently introduced a same day pathway for hip and knee replacement operations. This is a significant improvement for patients as it helps improve patient experience, drive down waiting lists and free up beds to improve productivity across the hospital.

None of this would be possible without the excellent teamwork of everyone involved, from theatres staff to recovery, ward and physiotherapy teams, and the SMART team which runs our virtual ward service, caring patients as they continue their recovery at home.

Medway clinicians take on national leadership roles

I am delighted that two Medway clinicians have recently been appointed to national roles in NHS England's Getting It Right First Time (GIRFT) improvement programme, helping to shape national best practice and improve patient care.

Jeremy Davis, Deputy Chief Medical Officer and ear, nose and throat (ENT) surgeon, has been appointed as a national GIRFT clinical lead for ENT, which he will carry out alongside his role at Medway.

Cliff Evans, Emergency Care Nurse Consultant, was recently been asked to join GIRFT's Urgent and Emergency Care Programme as an Expert Nursing Advisor, alongside his current role.

Staff recognised for doctor training in national awards

Once again, colleagues have been recognised for their innovations in clinical practice in key national awards. Our Simulation Team and Medical Education Department have been selected as finalists at the upcoming Health Service Journal (HSJ) Partnership Awards for their innovative 'Simway Hospital' clinical training event.

The annual session for new foundation year one (F1) doctors enables them to take on their new roles, apply and improve clinical skills using state-of-the-art simulation equipment, and integrate with their hospital colleagues, helping them step from simulation to working with patients as more confident and competent clinicians.

Changes to patient and visitor parking

We have recently upgraded our aging parking system by introducing Automatic Number Plate Recognition (ANPR) for patients and visitors using Car Park 1 (multi-storey ground floor, opposite the main entrance) and Car Park 2 (opposite Green Zone entrance).

The new ticketless system makes it easier for patients and visitors to pay to park, with payment now possible at the car park exit barrier, or at one of the new pay machines located within and outside the hospital. Parking charges have increased slightly, for example, by ten pence for up to two hours. Free parking for Blue Badge holders continues, as do discounted rates for some patients and visitors.

Review praises Veteran Aware progress

Our commitment to being a 'Veteran Aware' organisation has been recognised in a recent review by the Veterans Covenant Healthcare Alliance, which runs the NHS Veteran Aware scheme supporting healthcare providers to meet the needs of the Armed Forces community.

The review recognised the *'significant work undertaken by those responsible for this agenda in your organisation'* since the Trust was accredited in 2023, praising our '*commitment to the military community'* having demonstrated '*significant evidence of continuous improvement and raising awareness of the healthcare needs of the Armed Forces Community."*

Manager saves co-worker's life from meningitis

Finally, I'm often struck by the care and kindness shown by colleagues here at Medway, none more so than James Heather, from our Transport and Waste Department, who saved colleague Eddie Butler's life after he fell seriously ill with meningitis while at home alone.

Eddie had asked James for a lift to work as one of his car windows had been smashed. James became concerned when there was no answer at Eddie's home. After multiple attempts to contact him, James alerted Eddie's partner, Elaine, who found him in bed unresponsive.

Eddie was brought by ambulance to our Emergency Department where tests revealed he had meningitis. Thanks to James raising the alarm and Elaine finding him, together with the excellent work of our clinical colleagues, Eddie has gone on to make a full recovery.

I am delighted to say that Eddie is now back at work. I am immensely proud of James and everyone involved in Eddie's care. What a credit to our Trust.

NHS
Medway
NHS Foundation Trust

Story to Board

Breastfeeding

Alannah Jefferies, Radiographer and Patient at MFT

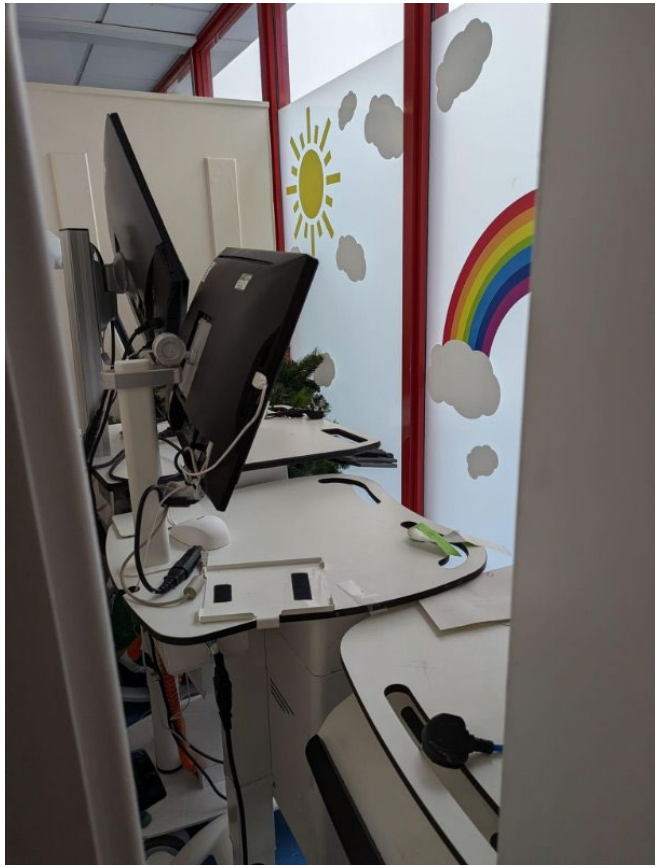
Nikki Lewis, Associate Director of Patient Experience

Patient FIRST

My Story

- I have been working at Medway NHS Foundation Trust as a radiographer for four and a half years.
- The radiography team provides 24-hour service at Medway. They are specialist practitioners who provide diagnostics such as X-rays, CT scans amongst others
- We work in all areas of the hospital: accident and emergency department, operating theatres, outpatient and inpatient areas.
- I became pregnant and went on maternity leave in June 2023, I was well supported during this time.
- Planning my return to work made me emotional but I was excited to return as I love my job. I planned to continue to breastfeed upon my return.
- When I returned, there was no room available in the Trust. I was offered a staff room and office to use to express milk which was not appropriate or fit for purpose. People walked in and out of the office which meant I had no privacy.
- The allocated room that used to be used for breastfeeding was full of equipment

Room in SDEC



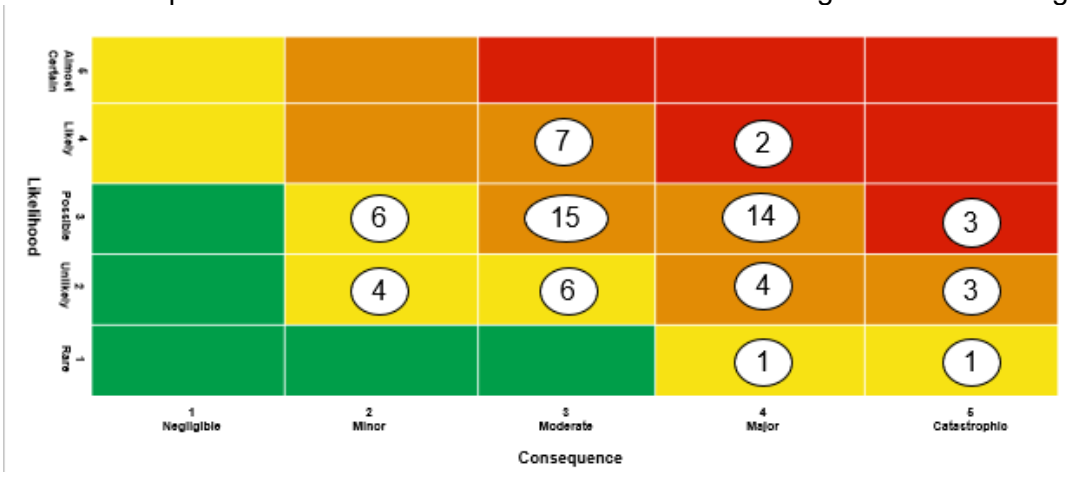
Improvements

- I felt I needed to raise this issue, it was not just me who would be affected, others may have had a similar experience
- I raised an issue with the Chief Executive via email, to highlight there was no safe or clean space to feed or express milk
- We set up a monthly task and finish group with the Deputy Chief Nurse and Associate Director of Patient Experience to outline the concerns with key stakeholders, knowing we needed to make significant improvements
- We identified areas that can be made into a safe clean space for parents who need to express or feed their baby at work
- Identified the need to extend these areas for parents who attend appointments at the hospital that may need to stop and feed / express in a safe clean place
- We are working with the heads of nursing to ensure we have a procedure to support birthing parents who are breastfeeding in a clinical area outside of maternity

Pods

- One idea we have had is to install ‘mum pods’ into two different spaces
- Potentially a booking system can be set up for staff
- Patients can use it when its vacant
- Accessible for pushchairs / wheelchairs
- Safe, clean, calm space for breast feeding / expressing
- Looking to get support from charity to fund the pods
- The group have discussed other opportunities to convert spaces if the pods cannot be fully funded
- The group will contribute to the updated standard operating procedure for staff and patients who need to breastfeed.

Meeting of the Trust Board
Wednesday, 15 January 2025

Title of Report	Risk and Issue Register and Board Assurance Framework	**Agenda Item**	4.1
Author	Matthew Capper, Director of Strategy and Partnership/Company Secretary Claire Cowell, Integrated Governance Lead		
Lead Executive Director	Matthew Capper, Director of Strategy and Partnership/Company Secretary		
Executive Summary	The risk and issue register and board assurance framework (BAF) are intended to give the members of the Trust Board assurance as to the current position of the Trusts risks management system. The detail within the Risk and Issue Register is accurate as of 03 January 2025. **Risk and Issue Register Summary:** The Trust Risk Register has 66 approved risks in total, 5 risks are scoring 15 and above. 4 new risks were raised in December. 6 risks are awaiting review, and 4 are awaiting approval. During the month of December: 0 risks have been closed down 5 risks have had the score reduced 1 risk has had the score increased 65% of the approved risks were reviewed within their timeframe (last month 71%) 91% of approved risks have had no movement in the last month A summary of 'extreme' risks is provided within the pack, with those overdue for review highlighted accordingly. Alongside a summary of Issues and the BAF. The heat map below summarises the total number of risks assigned to each rating.  **Board Assurance Framework summary:** The BAF is used to record and report the organisation's strategic objectives, risks, controls, and assurances to the board. The review and refresh of the Trust's BAF has now been completed.		

Proposal and/or key recommendation:	The Board is asked to note the report and to be given assurance.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Risk and Compliance Sub-Committee Meeting: Executive Management Committee Date: 07 January 2025 The BAF and Risk and Issues are reviewed at relevant committees and Executive Lead check is in place.			

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:	Responsive: X	Well-Led: X

Identified Risks, issues and mitigations:	Contained within the report
Resource implications:	None directly
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	N/A
Legal and Regulatory implications:	Maintenance and oversight of risk is a regulatory and statutory duty overseen by the Care Quality Commission (CQC), Ofsted and Health and Safety Executive to implement effective risk management systems. It is also a criteria within the NHS Foundation Trust Code of Governance, and the Compliance Framework.
Appendices:	Included
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information please contact:	Name: Matthew Capper Job Title: Director of Strategy and Partnership/Company Secretary Email: m.capper@nhs.net

Please mark with 'X' - Reports require an	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance

assurance rating to guide the discussion:	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Medway NHS Foundation Trust

Risk and Issue Summary Report

Claire Cowell, Integrated Governance Lead

Reporting Period: December 2024

Executive Summary (Risk)

The detail within this report is accurate as of 3 January 2025.

The Trust Risk Register has 66 approved risks in total, 5 risks are scoring 15 and above.

4 new risks were raised in December.

6 risks are awaiting review, and 4 are awaiting approval.

During the month of December:
0 risks have been closed down
5 risks have had the score reduced
1 risk has had the score increased

65% of the approved risks were reviewed within their timeframe (last month 71%)
91% of approved risks have had no movement in the last month

A summary of ‘extreme’ risks is provided in slides 6 to 10, with those overdue for review highlighted accordingly.
A summary of Issues is provided in slides 19 to 23.

Aged Risks

NHS Medway NHS Foundation Trust

3 Risks older than 5 years:

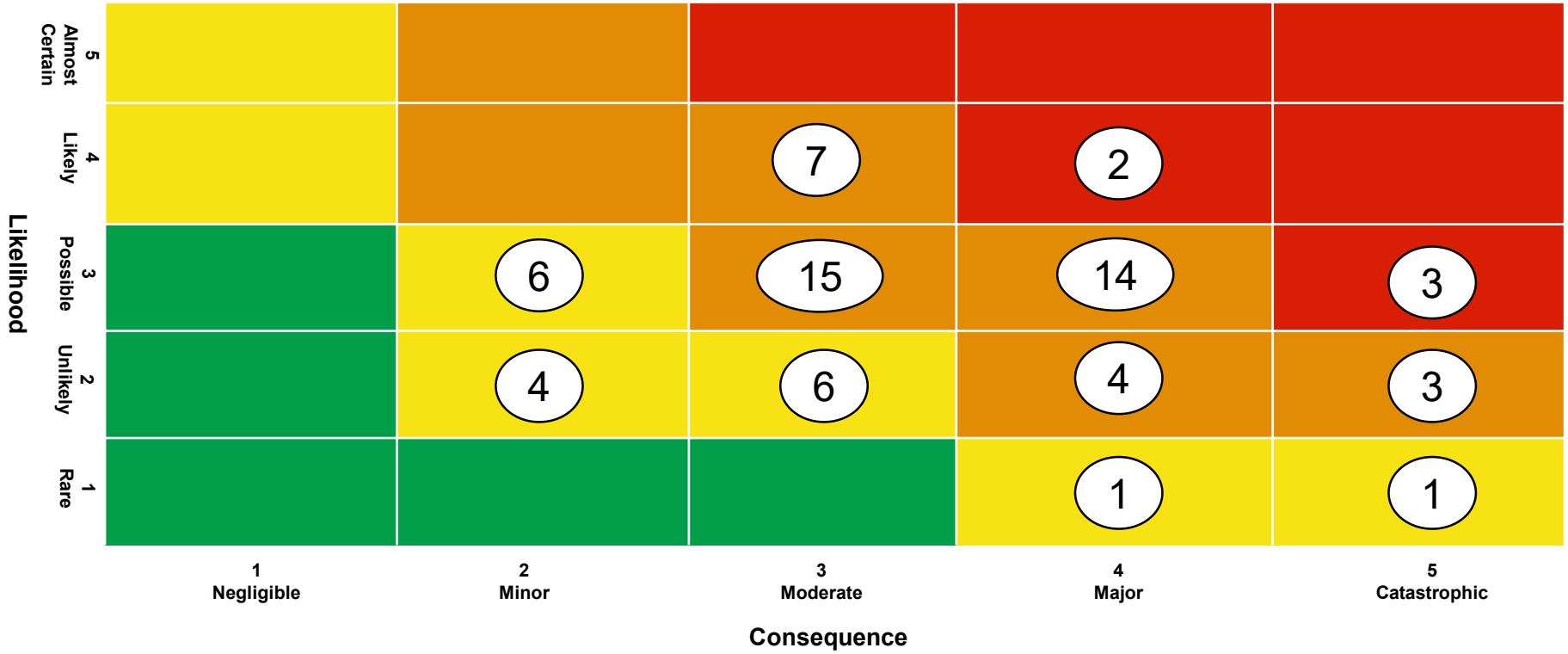
Risk ID	Date Raised	Risk Title	Risk Owner
1044	27/08/2019	Pandemic may impact delivery of service	Leanne Gambell, EPRR Officer
1187	03/09/2019	PHARMACY - there is a risk patients will not be able to receive their medication due to stock shortages	Steve Cook, Chief Pharmacist
1376	28/11/2019	Falls from height – Car Park	Neil Adams, Associate Director of Estates & Facilities

2 Risks between 3 and 5 years:

Risk ID	Date Raised	Risk Title	Risk Owner
1256	18/06/2020	Lack of compliance with fundamentals of nursing care	Steph Gorman, Deputy Chief Nursing Officer
1131	13/07/2021	Inability to meet induction of labour demand	Kate Harris, Associate Director of Midwifery

Risk Register – Heat Map

The heat map summaries the total number of risks assigned to each score



Risks Scoring 15 and above:

Risk ID: 2068
Risk Title: Limitations of EPR/EPMA System Functionality potentially impacting Patient Safety
Risk Owner: Dilip Pillai

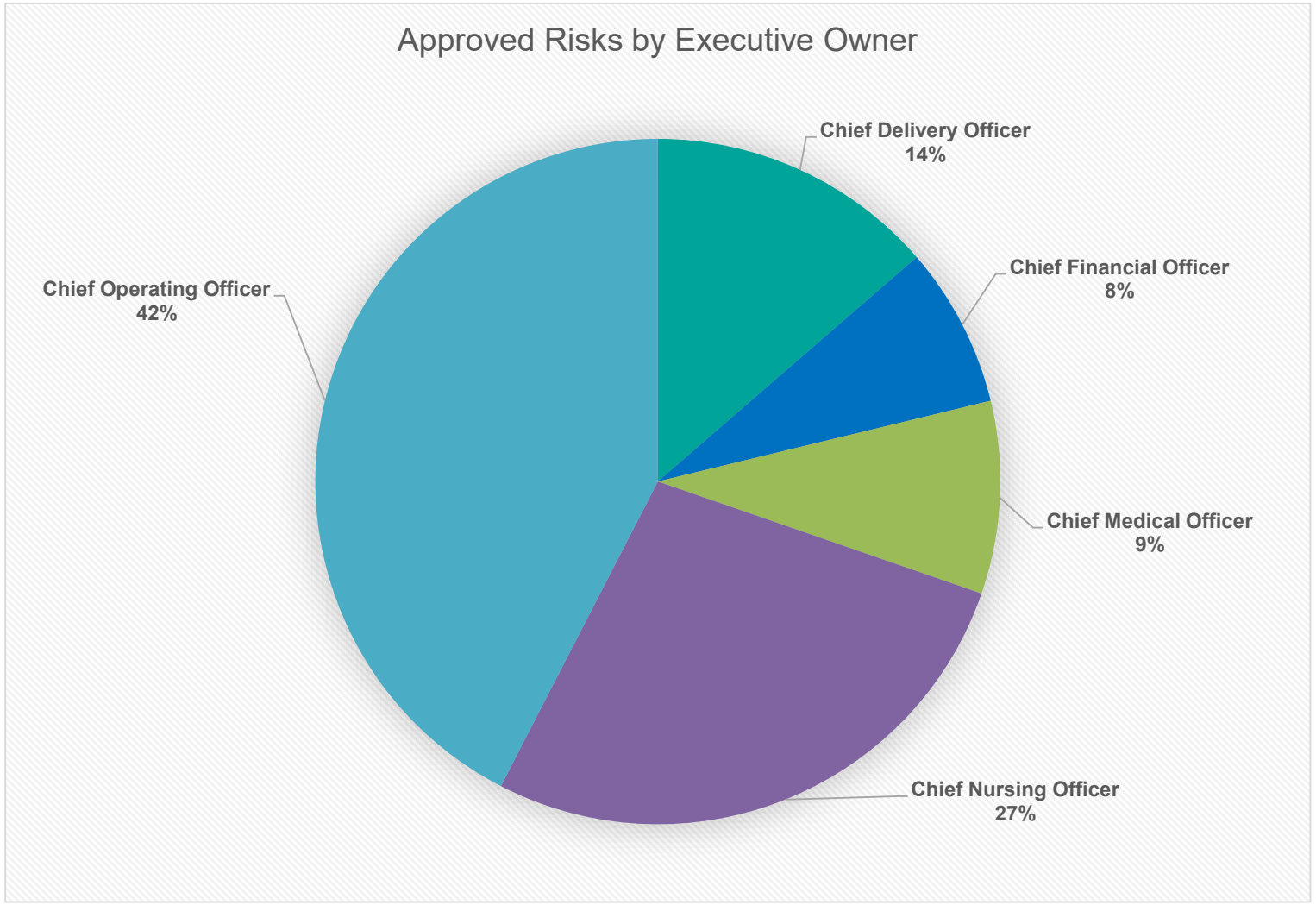
Risk ID: 2158
Risk Title: Backlog Maintenance impacting on the infrastructure and clinical safety
Risk Owner: Paul Norman-Brown

Risk ID: 1965
Risk Title: There is a risk of the organisation being the target of a Cyber Attack, impacting information systems and/or IT infrastructure
Risk Owner: Craig Allen

Risk ID: 1979
Risk Title: Risk of patient harm caused by Metavision failure due to unsupported IT systems.
Risk Owner: Sharon Kaur

Risk ID: 2166
Risk Title: Non Compliance with HTM 05-01 Managing Healthcare Fire Safety
Risk Owner: Neil Adams

Risks by Executive



Extreme Risks by Executive

5 Risks scoring 15+

CDO 2 (40%)

COO 3 (60%)

Chief Delivery Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Approval Date	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score		Owner	Director
2068	31/05/2024	31/03/2025	Limitations of EPR/EPMA System Functionality potentially impacting Patient Safety	Impact to patient safety and quality of care, due to the limitations of the EPR systems caused by the lack of system interoperability impacting user experience of the system impacting patient care and staff and workflow efficiencies.	• ED Flow Coordinators, ward managers and administrators working on the wards have been trained on how to discharge the patient from ED to the inpatient ward. • Doctors and Pharmacy Staff have been trained to identify and correct issue/re-prescribe. • Pharmacy staff carrying out daily checks to correct any medication issues. • If unable to access the drug charts, a Blood Transfusion Integrated Care Pathway is available as an alternative. • Covered in Blood Training – Key staff in ED are checking on duplications of patient allocations. • Patient ID checks being undertaken before transferring/given medication. • Paper results trail of POCT Blood Gas results not being recorded electronically on EPR. • EPMA Incorrect scheduling of as required frequency - report available • Prescribers are trained to know that the EPMA/EPR clinical decision support tool will only alert for interactions between medications and allergies/intolerances. • Working with the vendor to update the system to support dose range limits on EPMA.	• System functionality to enable interoperability with 3rd party supplier • POCT testing is not a North Kent Pathology service and was not in scope for order comms at the time of purchasing the EPR. • POCT Blood Gas results not recorded electronically on EPR. • POCT Incorrect capillary blood glucose ranges on EPR • EPMA Incorrect scheduling of 'as required' frequency. • EPMA Lack of dose range limits when prescribing. • EPMA Order reconciliation manager does not transfer between ED to inpatient. • ED require discharge tracking board view on Sunrise EPR to manage their patient lists for drug histories. • Incorrect blood glucose and ketone results being recorded on EPR. • Prescription of blood components and products NOT on EPMA.	1. Solution for EPR Bed Allocation 2. Review lack of dose range limits when prescribing on EPMA 3. Verify ED Bed Allocation 4. Dose Range Limits 5. POCT Integration into EPR	4 x 4 (16)	4 x 1 (4)	—	Dilip Pillai	Adrian Billington

Chief Delivery Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Approval Date	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score		Owner	Director
1965	03/09/2024		There is a risk of the organisation being the target of a Cyber Attack, impacting information systems and/or IT infrastructure	Like all organisations with a significant IT estate and footprint, there is a risk of being the target of a cyber attack, impacting information systems and/or IT infrastructure. Such attacks may include ransomware, malware infiltration, denial of service (DoS), phishing, or other malicious activities aimed at disrupting hospital operations, compromising patient data, or causing financial losses. The hospital's reliance on digital systems for patient care, medical records management, and administrative functions makes it a significant target for cybercriminals seeking to exploit vulnerabilities and gain unauthorized access to sensitive information. As a public sector organisation, the Trust is also a possible target for international espionage.	• The Trust has a monthly Cyber Security Group that reports into the IGG. • The Trust provides cyber security summaries as part of their monthly board reports. • The Trust utilises firewalls, MDE, Avast AV, Lansweeper Dashboarding and Armis vulnerability detection to support cyber security.	• The Trust does not have dedicated resources or services for cyber security. Associated work is divided between the IT management team and Server Infrastructure staff. • The Trust invests less in personnel and IT infrastructure/Systems to support cyber security than peer organisations. • The Trust has previously been certified to Cyber Essentials standards but is not currently. • The Trust does not have a SIEM or similar solution to provide a single pane of glass view of cyber security vulnerabilities. • The Trust does not have a Cyber Security Strategy, it has been suggested that this may be ICS led, but the Trust has not been engaged with as yet regarding this.	1. NHSE Cyber Funding 2. Cyber Security Strategy	5 x 3 (15)	5 x 1 (5)	—	Craig Allen	Adrian Billington

Chief Operating Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Approval Date	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score		Owner	Director
2158	27/08/2024	31/07/2030	Backlog Maintenance impacting on the infrastructure and clinical safety	The Trust has a backlog maintenance figure of £120m pounds (£107m under ERIC reporting criteria). The current level of funding from capital funds is approximately 20% of the amount required to address the backlog over five years. As backlog maintenance will increase over time, there is a risk that the infrastructure will become too dilapidated and unsafe to provide clinical services.	• A condition survey using the NHS's approved 'A risk-based methodology for establishing and managing backlog' completed in January 2024 by NIFES Consulting • A condition based asset register completed in March 2024 by NIFES Consulting. • An established Estates maintenance team with detailed site knowledge who proactively and reactively manage maintenance failures.	• Failure of the site which will impact clinical service delivery, patient and staff safety, financial sustainability, reputational damage. • Failure of the Trust POD system for transporting blood samples to • Drain blockages caused by clinical wipes and tree root ingress into drains. • General condition and security of the laundry building. • Potential loss of heating and hot water to Rowan and Willow House. • Theatre lights non-repairable beyond end of 2023. • D Block Heating Pumps. • Condition of Boundary Wall. • Drainage/Manholes - internal and external. • Flooring across the Trust has not been updated in many areas. • Closed protocol nurse call system becoming obsolete. • Potential failure of obsolete distribution boards. • Roof Leaks • Environmental issues affecting Nelson Ward. • Fibre connection to Education Centre and Eliot Ward. • No established governance process to agree spending priorities and report on progress. • No consistent methodology for determining spending priorities based on clinical, financial, safety and operational impacts of failure. • Insufficient staff to complete all essential planned maintenance tasks.	1. Create model for maintenance priorities 2. Establish prioritisation group 3. Establish capital pipeline for 2024/25	4 x 4 (16)	4 x 1 (4)	—	Paul Norman-Brown	Neil McElduff

Note: This risk has been outstanding for review since 22 November 2024.

Chief Operating Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Approval Date	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score		Owner	Director
1979	01/05/2024	28/02/2025	Risk of patient harm caused by Metavision failure due to unsupported IT systems	Metavision is a full electronic patient record which includes prescriptions and is used in critical care. The existing Metavision version faces challenges with reported bugs and compatibility issues with the current IT systems in the Trust and therefore requires urgent upgrade to Metavision 6. Without this upgrade there is a risk of patient harm caused by system failure and lack of patient records available to make informed care decisions. The backup Electronic Data Archive (EDA) system serves as a contingency, ensuring uninterrupted access to critical patient data in the event of system or network downtime. The EDA has not worked since 17/01/24. The live Metavision system stopped working in critical care on 7/2/24. Due to having no back up PC there was no access to patient medical records or drug charts available from 1350 to 1630. The impact of having no EPR in CC led to 8 drug errors as clinicians prescribed by memory.	• Revert to BCP and use paper records if live system fails in case of failure of back up system, Print summary of care from MetaVision to be placed at patient bedside • Written paper drug charts – to be updated when changes are made on MetaVision and reviewed/compared with MV on the ward rounds • Ward clerks will print MV patient prescription after the daily ward round. • Critical Care audit nurses checking prescriptions routinely through week to ensure no 7 day cycle drop off. • ICU consultants and nursing teams all aware of issue and support with the above. • In discussion with IT to support current infrastructure and reviewing of 7 day cycle report. • Nurses will print MV patient prescription at the end of each shift	• Upgrade to Metavision urgently required • 2nd EDA backup required in case of failure of 1st • aged system - requires upgrade for Metavision • Review of 7 day cycle report from IT (IMDSoft do not provide this service as IT advised they will be able to support with this reporting) • Single point of failure if critical care audit lead absent		5 x 3 (15)	5 x 1 (5)	▼	Sharon Kaur	Stewart Nisbet

Note: There have been no actions assigned to address the gaps in controls.

Chief Operating Officer: Extreme Risk Profile

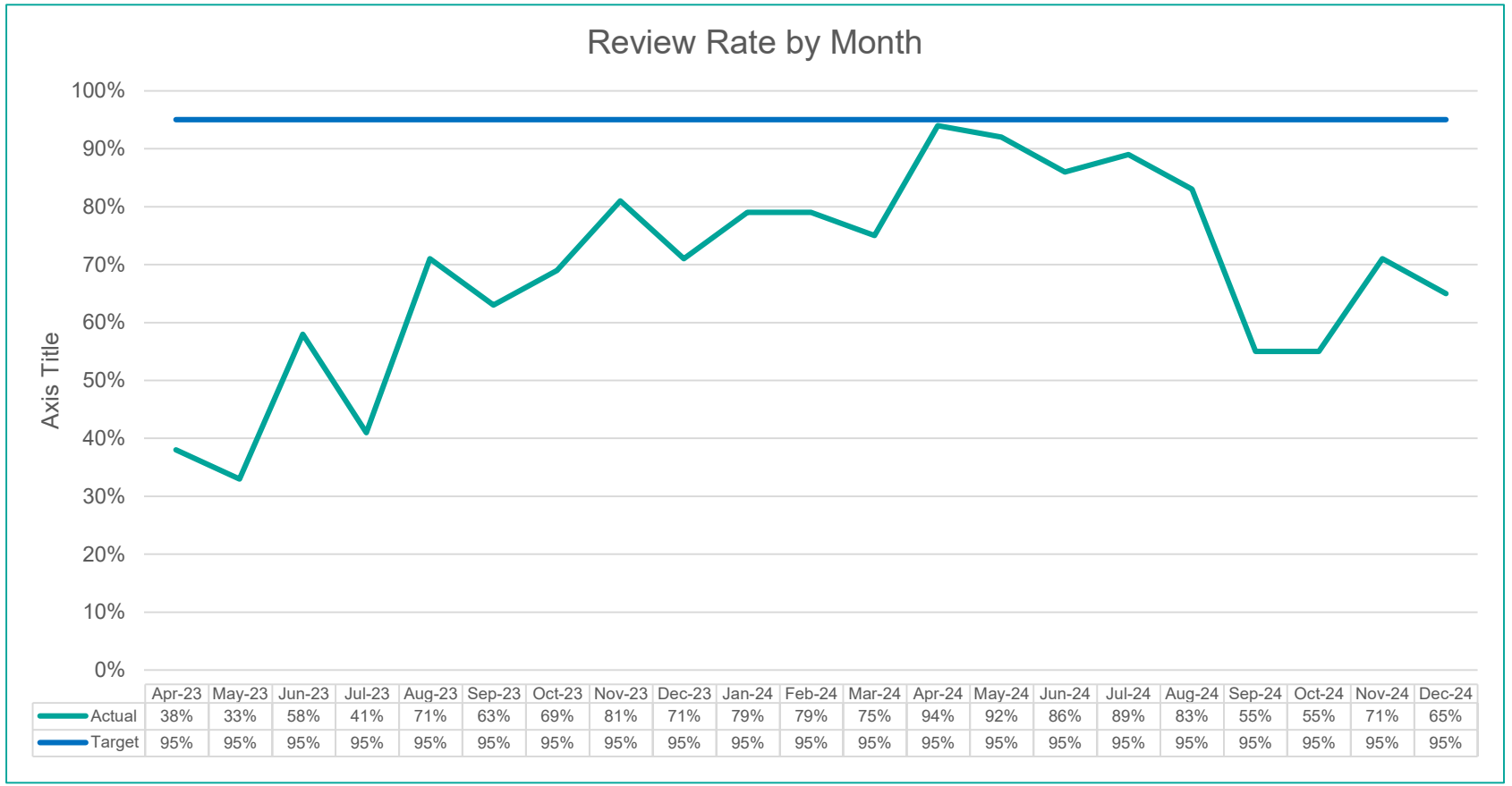
NHS Medway NHS Foundation Trust

Risk ID	Approval Date	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score		Owner	Director
2166	27/08/2024		Non Compliance with HTM 05-01 Managing Healthcare Fire Safety	Non compliance with recommendations and guidance for the management of fire safety in healthcare buildings. A fire on site could lead to: • Loss of life • Injury or harm to people, including patients, staff and visitors etc. • Loss or damage to buildings, infrastructure and equipment • Reputational damage • Impact on patient services/care • Financial impact Fire Safety is multi-faceted and as such, the risk score is impacted by • Detection • Compartmentation • Suppression • Emergency Lighting • Training • Management • Housekeeping (Site safety)	• Mandated annual fire safety training for all Trust employees • Optional annual fire warden training available to all Trust employees • In-house fire response service provided to attend all detector and call-point activations on a 24/7 basis • Departmental fire risk assessments • Annual inspection of all fire doors on site • Repair or replacement of fire doors as required • Fire safety team involved in planning stages of all capital projects • Weekly fire alarm tests • 5-day week presence from fire alarm engineers • New fire alarm being systematically installed • Fire damper inspections undertaken in March 2023 • All cladding replaced on-site post-Grenfell. • Walkarounds undertaken by fire safety team to check controls • Capital Project: Install Fire Compartmentation & Fire dampers • Capital Project: Replace Fire Doors • Capital Project: Replace Fire Alarm • Capital Project: Emergency Lighting Replacement	• Management: No methodology of dealing with smokers. No consequence to rule-breakers. • ED Misting system cannot be commissioned whilst occupied and therefore will not function. • No smoking cessation group established. • Pembroke ward compartmentation inadequate. • Nelson Ward Fire Alarm has faults which prevents some sounders from sounding. • Panel 4 faults mean that large parts of Red Zone require manual notification to Switchboard on activation. • Non-compliance with emergency lighting system.	1. Fire risk mitigation 2. Fire mitigation – alarm 3. Smoking group	5 x 3 (15)	5 x 1 (5)	—	Neil Adams	Neil McElduff

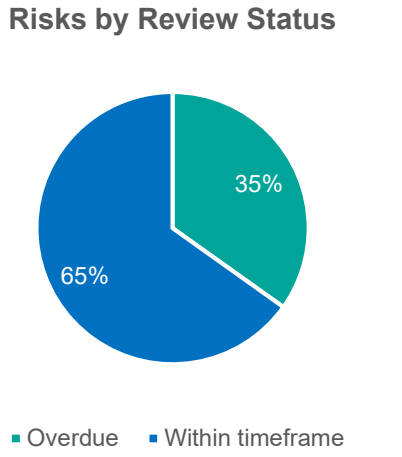
Note: This risk has been outstanding for review since 24 December 2024.

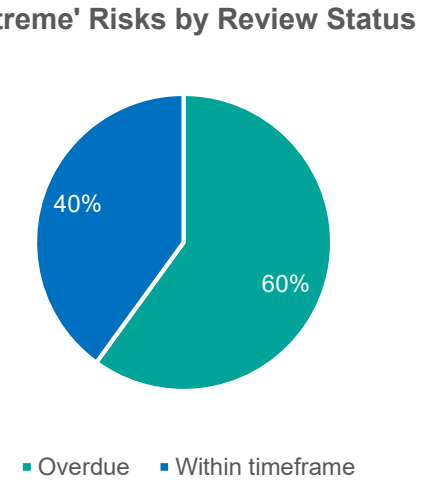
Approved Risks

Of the 66 approved risks;
23 have breached their review date, with 3 of these being scored Extreme.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Actual	38%	33%	58%	41%	71%	63%	69%	81%	71%	79%	79%	75%	94%	92%	86%	89%	83%	55%	55%	71%	65%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%





Risk Register – Awaiting Review

Medway NHS Foundation Trust

The are currently 6 risks awaiting review *(risks cannot be approved until they have been fully reviewed and populated)*

Risk ID	Date Risk Raised	Risk Title	Risk Description	Risk Owner	Initial Risk Score
2195	**16/09/2024**	Delays in receiving Infection Control significant results from Microbiology NKPS Laboratory	Delays in obtaining MRSA results from NKPS laboratory may lead to potential outbreak occurring.	Rod Harford-Rothwell, Head of IPC	3 x 3 (9)
2241	**15/11/2024**	Possibility of breaching our CDI threshold for 2024/25	Due to the current rise in C-diff infections/acquisitions against our current trajectory for 2024/25 there is a possibility that we may exceed the permitted amount for this fiscal year	Rod Harford-Rothwell, Head of IPC	3 x 4 (12)
2243	**15/11/2024**	Possibility of further MRSA Bacteraemia against a zero threshold	Possibility of further MRSA bacteraemia being acquired across the organisation due to the rise in MRSA colonisations and possible line infections against a zero NHSE trajectory	Rod Harford-Rothwell, Head of IPC	3 x 4 (12)
2261	**10/12/2024**	Space for 6 Bariatric bed frames and mattresses	The cost of bariatric hire over the past 12 months has been £147,668. The tissue viability team has worked on a Trust wide proposal to reduce spend, improve patient care and enhance patient safety. Part of this project is the purchase of 6 bariatric bed frames and mattresses costing £59,100. When not in use these will need to be stored onsite. A space utilisation request was sent to the estates team on 30/09/2024 with no response.	Neil Adams, Associate Director of Estates and Facilities	3 x 5 (15)
2273	**27/12/2024**	Part time Consultant Resignation may lead to failure to provide Antenatal Diabetic Service	Part time diabetes consultant who works 20hours a week to cover the entire antenatal diabetes service, tendered his retirement resignation for beginning of February 2025, Failure to provide the service indicates pregnant diabetic women will not have in house support from the current diabetic team and would be reliant on community services. The service cross over into the obstetrics team, Specialist medicine is not funded for this service and are overspent with the consultant running this service within the diabetes budget.	Amy Duchon, Service Manager	3 x 4 (12)
2274	**30/12/2024**	Providing optimal care to 16- and 17-year olds in Medway NHS Foundation Trust	Key Risks for MFT: MFT faces the risk of providing inconsistent and potentially suboptimal care for 16- and 17-year-olds due to the lack of a clear and consistent pathway for their inpatient admissions. This lack of a defined pathway may result in: Increased risk of adverse events: Risk of errors in care, delayed diagnosis, and missed opportunities for timely intervention and potential for delayed or inappropriate treatment. Medication errors due to care by teams (both Doctors and Nurses) lacking specialised knowledge in caring for young people with adult pathophysiology. No Electronic Prescribing in Paediatrics. Discrepancies in care protocols, such as different Early Warning Systems (PEWS/NEWS) and no access to specialist retrieval services (STRS), increase patient safety risks. Transferring to tertiary paediatric centres cut of is age 16.Therefore require transfer to Adult centres, which is problematic from a Paediatric perspective. Uncertainty and potential for inappropriate placements can cause significant anxiety, stress, feelings of isolation, and negative mental health outcomes. Young people in work and college being placed with babies and young children can present a risk from both sides Operational and Financial Implications: Delays in treatment, extended hospital stays, and potential for litigation due to suboptimal care. Reputational Damage: Inconsistent practices and potential patient safety concerns can damage the Trust's reputation and impact on CQC rating, potentially not meeting Regulation 9 (Person Centred Care) and Regulation 13 (Safeguarding Service Users from improper treatment). Despite drafting a policy and instigating a Task and Finish Group there are considerable blocks to moving this forward and the risks currently remain.	Dr Sachin Patil, Consultant Paediatrician	4 x 4 (16)

Risk Register – Awaiting Approval

The are currently 5 risks awaiting approval *(risks cannot be approved until they have been fully reviewed and populated)*

Risk ID	Date Risk Raised	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score	Owner
2093	03/06/2024		Non Compliance with HTM02-01 Medical Gas Pipeline Systems	If the Trust fails to comply with the regulatory requirements of HTM02-01, in the management, maintenance and provision of pipeline Medical Gas Systems this may result in harm from failure of plant supporting the delivery of Medical Gas to the patient.	• Competent independent advice - AE appointed • Competent staff - AP appointed (Mechanical Supervisor) • Competent staff - Additional AP trained (Estates Engineer Mechanical awaiting assessment by AE) • Governance - Medical Gas Group chaired by Chief Pharmacist • Maintenance - PPM and reactive maintenance contract in place • Oversight of new projects - AE consulted on new projects and alterations • Competent staff - Annual training on manifold cylinder swaps	• Estates Engineer to be AP appointed. • Relevant document not available for all external MGPS contractors to provide evidence of compliance. • SOPs and EOPs should be prepared and included in the operational procedure document. • PPM tasks are not set out in a Maintenance Specification. • PPM contractors do not provide the necessary service report documentation related to the systems on site. • No record of annual AGSS LEV tests. • No facility to record cylinder bank contents (Aether Medical Service • No review of manuals • All permits are not completed in full and signed off by the relevant parties • There is a lack of documentation to support the works undertaken on all MGPS equipment. • Only AP (MGPS) to issue permits. • Archived permit books are not filed in separate location.	45 point action plan assigned to this risk to address the gaps in controls	4 x 4 (16)	4 x 1 (4)	Paul Norman -Brown

Risk Register – Awaiting Approval

NHS Medway NHS Foundation Trust

Risk ID	Date Risk Raised	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score	Owner
2143	10/07/2024		Inappropriate admission of 16-18 years old to the Paediatric Ward	An increasing number of young adults (16-18 years old) are being admitted to the Children's ward. These patients are not known to the Paediatric service. Some are mental health patients requiring forward referrals, some have medical or surgical issues which require adult services. This is leading to concerns regarding patient and staff safety on the ward as well as inappropriate placements of these patients. Patients requiring review by the adult services is often delayed due to lack of approved policy. The latter leads to more complications for the patients affected.	• Identifying the children that are at risk of having a delay in treatment referring as soon as possible. Consultant to consultant conversations. MDT Working in early planning. • For staff offering wellbeing and OH support that are affected by this cohort of patients.	• Lack of timely reviews from specialty teams or teams agreeing to see young people on paediatric ward. • 16-18year old policy has not been signed off by senior team so this cohort of patients still get admitted to the ward. Risk cannot be decreased		3 x 3 (9)	3 x 2 (6)	Amanda Russell, Head of Nursing

Risk Register – Awaiting Approval

NHS Medway NHS Foundation Trust

Risk ID	Date Risk Raised	Proposed Date for Closure	Risk Title	Risk Description	Controls	Gaps in Controls	Actions	Current Score	Target Score	Owner
2270	23/12/2024	31/03/2025	Ambulance Provider for Kent Surrey and Sussex Neonatal Transport Service (KSS NTS) gave notice on contract	SECAMB (the current ambulance provider for KSS NTS), gave notice to NHS specialised commissioning that they wish to end their contract effective 1st April 2025. NHSSC were given 12months notice to find a replacement provider. It was recognised 2 years ago that the neonatal ambulances needed replacement however, review of the service delayed this procurement and since then ambulance breakdowns are becoming more common. Not having contracted ambulance provider or replacement neonatal ambulances may compromise the transport service causing possible delay to necessary in-patient transfers impacting direct patient care and reduced patient safety to the 13 neonatal units across South East Operational Delivery Network (SE ODN). This includes: Sick/ preterm babies born at SCBUs or LNUs who require uplift to NICU care. Sick babies requiring uplift to specialised care e.g. surgical, neurological or cardiac centres Babies requiring specialist reviews preventing/ delaying discharge. Delayed repatriation of well babies to their local units for ongoing care in order to maintain flow across the network and reduce resource or cot capacity related issues. Reduced neonatal capacity may result in increased need to close maternity services/ transfer out expectant mothers prior to delivery.	Neonatal ODN and commissioners are working together to seek new contract	Service is currently covered by SECAMB, SECAMB have served notice, there contract is coming to an end (March 2025). The age and maintenance of the ambulances' is also a concern. We have assurance from the ODN that a new contract and service is being sought.		3 x 4 (12)	2 x 1 (2)	Sarah Clarke, Neonatal Matron

Risk Deep Dive - Estates and Facilities

The Estates and Facilities Risk Register has 9 approved risks in total, of which, 2 are scored Extreme, 6 High and 1 Moderate.

1 risk is awaiting Exec approval
Risk ID: 2093
Risk Title: Non Compliance with HTM02-01 Medical Gas Pipeline Systems
Date Raised: 3 June 2024
Owner: Paul Norman-Brown, Associate Director for Estates

1 risk is awaiting review
Risk ID: 2261
Risk Title: Space for 6 Bariatric bed frames and mattresses
Date Raised: 10 December 2024
Owner: Neil Adams, Associate Director for Estates & Facilities

0 risks have been closed down in month.

33% of risks have been reviewed within their required timeframes

Oldest risk:
Risk ID: 1376
Risk Title: Falls from Height (Car Park)
Dated Raised: 28/11/2019
Current Score: 5 x 2 (10) – there has been no movement to the risk score for 12 months

Risks Closed

There have been no risks closed during the month of December 2024.

Risks Rejected November 2024

There were 2 risks rejected in December:

Risk Already Resolved	**0**
Incorrect Form Completed	**2**
Duplication	**0**
No Reason Given	**0**

All risk originators were contacted to advise of the reasons for rejection, and where applicable asked for incidents to be raised instead.

Issues Log – Significant Priority

NHS Medway NHS Foundation Trust

Issue ID	Approval Date	Proposed Date for Closure	Issue Title	Issue Description	Progress Notes	Actions	Priority Level	Owner	Director	Exec
2060	25/04/2024		Capital allocation vs requirements	The Trust receives a capital allocation/limit from the ICS, which in turn receives its limit from NHSE. Typically we would expect this to be approximately the same value as our depreciation expense, however our actual allocation is only approximately two thirds of this value at a little under £13m. (Any third party funding/PDC that can be secured allows us to spend over and above that sum.) Given the estates survey in early 2024, together with the 5-year capital programme request list and 2024/25 capital commitments, this sum is significantly below our needs. This could put patient and staff safety at risk. Actions needed: - 5-year capital programme list - Annual capital programme agreement (in principle) by Trust Executives - Investment governance policy and templates, including prioritisation matrix - Medical devices replacement programme - Applications to access additional funding	Dec 2024: No change in position. Nov 2024: Risk reviewed and transferred to Issues Log. Oct 2024: 2024/25 forecast being updated given further CDC slippage. Reallocation against other projects of internal funding will be required in due course	1. Estates Strategy 2. Capital Funding	5 Significant	Paul Kimber		CFO

Issues Log – Significant Priority

NHS Medway NHS Foundation Trust

Issue ID	Approval Date	Proposed Date for Closure	Issue Title	Issue Description	Progress Notes	Actions	Priority Level	Owner	Director	Exec
2109	14/06/2024		Insufficient levels of capacity within the Mortuary	The issue itself presents as two parts. A) Insufficient capacity due to population growth and increased work levels. Every year the trust rents out 2x 40 space cold rooms at a cost of £90,800 to help mitigate the increased patient load. (This however does not include any freezer spaces.) - Funeral homes are chased for collection dates however are not legally required to collect in any given time. B) Insufficient long term sub zero storage capacity. For patients that are eligible for being frozen have their cases chased weekly with the KCC for updates regarding the funeral arrangements. On the off chance that the HTA perform a spot inspection, the evidence of the cases being chased will show them that Medway is proactive in helping to provide the best care for these specific patients. There is the option for off site deep freeze with coronial deceased transport team at cost.	02 Dec 2024: Priority rating increased due to HTA shortfall. A) Winter capacity mitigated for 2024/2025 by hire of 2x 40 space cold rooms (arriving to site 7/12/24) This does not reflect the significant manual handling effort or time to relocate deceased to these units (on site but not part of the main facility), and provides only a short term mitigation for the duration of the hire period. B)Issues with DF capacity results in major shortfall against HTA standards at unannounced inspection September 2024. Recommended action to address both of these issues is increasing mortuary capacity via an expansion into the courtyard. PID required	1. Ensuring winter resilience 2. PID for increased capacity	5 Significant	Lesley Timlin	Sam Chapman	COO

Issues Log – Significant Priority

Issue ID	Approval Date	Proposed Date for Closure	Issue Title	Issue Description	Progress Notes	Actions	Priority Level	Owner	Director	Exec
2258	04/12/2024		Pathology results in incorrect chronological order on EPR	When viewing pathology results utilising the cumulative result screen some results do not appear in chronological order-the timeline on the cumulative result column is the timestamp of result authorisation not collection time therefore if results are not released due to pending additional testing and subsequently authorised after further tests have been ordered and authorised the result appears on this screen out of sequence.	05 Dec 2024: Discussed at EPR Programme Board. Investigation underway from Altera (supplier) and Trust-awaiting update. Potential comms to be prepared. NKPS informed.		5 Significant	Penny Archer	Sam Chapman	CMO

Awaiting Approval

Issues Log – Significant Priority

Issue ID	Approval Date	Proposed Date for Closure	Issue Title	Issue Description	Progress Notes	Actions	Priority Level	Owner	Director	Exec
2263	12/12/2024	30/06/2025	Reduction in Acute Oncology Service and the Provision of Medical Oncology Cover at Medway Hospital for Cancer Patients	The AOS ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting. The team also provide further advice and on-going management guidance for patients that are subsequently admitted to hospital during this acute phase. Due to the resignation of 3 out of 5 AOS Clinical Nurse Specialists (CNS), the service will not have sufficient CNS capacity and resources to provide the current level of service for a minimum period of 6 months. Furthermore, one of the Medical Oncology Consultants and the Oncology SpR have resigned which will leave one Consultant to cover the AO service and inpatients on Lawrence Ward, until the vacant post is substantively recruited to. The AO service currently runs Monday – Friday 08.00hrs – 18.00hrs and Sat/Sun 09.00hrs – 17.00hrs.			5 Significant	Louise Farrow	Tahir Bhat	CMO

Awaiting Approval

Issues Deep Dive - Estates and Facilities

The Estates and Facilities Issue Log has 7 approved Issues in total of which,

2 rated Low,

2 rated Moderate and,

3 rated High

2 Issues are awaiting review and 0 awaiting approval.

0 Issues have been closed down in month.
57% of Issue's have been reviewed within their required timeframes

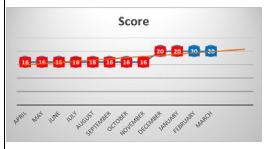
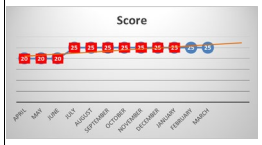
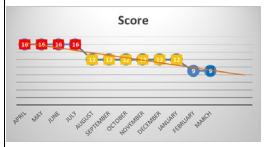
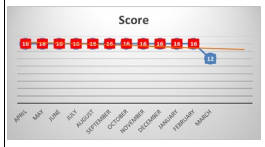
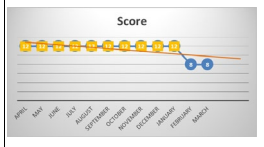
Oldest Issue:
ID: 1073
Risk Title: Unsupported IT System (FRAN)
Dated Raised: 18 June 2021
Priority Rating: 2 - Low

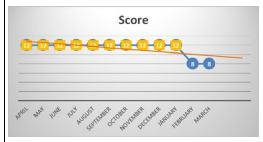
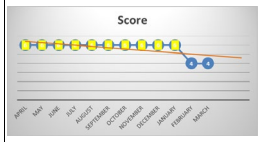
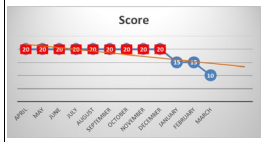
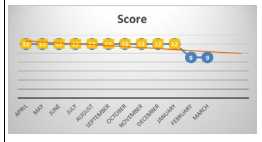
Action Required

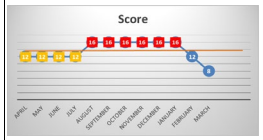
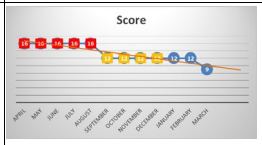
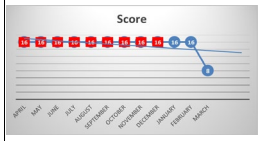
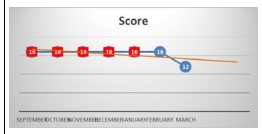
NHS Medway NHS Foundation Trust

Ref	Action	Owner	Date	Status
01	95% of approved risks to have been reviewed within timeframe	Risk Owners with oversight by IGT	31 July 23	Overdue. Review rate currently at 65%
02	Review of process for new risks to ensure they are approved in a timely way with 95% approved within 1 month of being raised	IGT	31 July 23	Process complete. 95% target not yet achieved
03	100% of approved risks are fully completed	Risk Owners with oversight by IGT	31 July 23	Complete
04	Quarterly reporting against Risk Management KPIs	IGT	31 July 23	Complete
05	Consolidate all EPR and EPMA Risks into 2 singular risks as agreed with Chief Medical Officer and Chief Nursing Officer. These 2 new risks should focus on functionality of the system and staff not following processes/using workarounds	Kerry O'Reilly with support from IGT	31 July 23	Complete
06	Assign every risk to the 'group or committee' responsible for onward monitoring	IGT	31 July 23	Complete
07	Work with divisions to 'cascade' information relating to the difference between incidents and risk	IGT	31 Oct 23	Complete
08	To draft a revised risk approvals and BAF process	Company Secretary	TBC	Drafted
09	To create a separate issues log and transfer issues across from the risk register to this	IGT	31 Oct 24	Complete

MFT Board Assurance Framework **Jan-25**

ID	Patient First Domain	Lead Committee	Date Added	Full Description of Risk -	Initial Consequence	Initial Likelihood	Initial Risk Rating	Mitigation / controls	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Forecast	Actions Planned to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date	Exec Owner	Senior Manager Lead	Update position	Date closed	Corporate Risk Register / Issues log mapping
BAF1	**Sustainability**	FPPC	Mar-24	There is a risk that the trust does not effectively manage its budgets/experiences unbudgeted cost pressures resulting in a risk to the delivery of the in year control total.	4	4	16	1. Robust budget setting 2. Weekly executive-led check and challenge sessions re efficiencies/mitigations 3. Access operational group 4. Budget statements/budget holder meetings 5. Full staffing of PMO 6. NHSE Improvement Director support and NHS Intensive Support team 7. Application of "Grip and Control" checklists, and "Core/Level 2-3-4" NHSE controls 8. Self-assessment and implementation of HFMA sustainability checklist 9. VCP and enhanced non-pay controls	4	5	20			1. Medical staffing project underway to deliver a roster solution. 1b. Reconciliation of budgets to rosters (Oct). 2. Budgets to be signed off by divisions (sept). 3. Approval of month end variance and forecasting SoP (Sept) 4. Escalation process/SOP (Oct) 6. Task and Finish Group implementation. 7. '21' lines programme. 8. Implement revised clinical non-pay measures. 9. Grip and control checklists review NEW (Jan 2025) 10. Revised FOT communication, mitigation plan and ownership.	4	3	12	Mar-25	CFO	Paul Kimber	**Jan 25 -** 1. Recruitment of a roster specialist underway 1b. Rolling forward into 2025/26 business planning. 2. Completed 3. Completed 4. SOP review with a view to amend. Informal escalation process implemented between divisions and finance team. 6/7. Operating weekly with a focus on forecast and the '21' lines. 8. Being tracked through the new SPP Group. 9. Reviews completed and resultant actions being worked through. 10. Exec leads appointed - mitigations being worked through.		Risk 2052: If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk. Risk 2055: ERF / Elective Activity Plans. Risk 2058: Unchecked staff growth. Risk 2126: Potential for S&A Divisional CIP target for 2024/25 not being achieved. Risk 2156: WCYP Division unable to identify efficiency schemes to meet CIP target. Risk 2172: Trust wide blood glucose and ketone contract expires 26th August, unable to extend will have a financial & operational impact.
BAF2	**Sustainability**	FPPC	Mar-24	**ISSUE** - The backlog maintenance report for the Trust indicates critical works that far exceed the in-year and even a multi-year allocation from system operational capital. The risk is that large parts of the estate will not be fit for use and therefore impact on the quality of care provided and impact the trusts ability to meet its other statutory and recovery objectives.	5	4	20	1. Completion of Trust prioritisation matrix, including risk register entries 2. Programme review and approval by Trust Executive each financial year 3. Proposal paper drafted setting out options to address findings of the 6-Facet survey 4. Submission of capital plans and requests via the system to secure minimum fair share of operating capital allocation 5. Application for additional capital funds where available, e.g. PDC, charity, grants, etc.	5	5	25			1a. Risk based prioritisation matrix produced and being used for the capital spend discussions. 1b. Explore strategic capital finance options with ICS and NHSE.(ongoing). 1c. Report findings of the 6-facet survey to ICS/NHSE Revised business planning links including establishment of dedicated group. 2. Spend scrutiny for Rev to Cap transfers.	3	4	12	Dec-24	COO	Neil Maidstuff	**Jan 25 -** 1a. Completed 1b. Completed 1c. Paper presented to October FPPC meeting setting out risk based approach to address the backlog; links to patient safe to be evidenced. To be repoted back to FPPC and built into 25/26 business planning. 2. Reviewed monthly and part of the capital spend prioritisation work. Capital slippage and its utilisation reviewed by Executives.		Risk 2135: Multiple areas of non-compliance with H&S legislation within E&F may lead to harm and/or enforcement action. Risk 2158: Backlog Maintenance impacting on the infrastructure and clinical safety.
BAF3	**Sustainability**	FPPC	Jun-23	A number of independent reports into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Without addressing the culture the Trust may struggle to deliver its financial plans. Failure to address this as an issue could impact the Trust's exit from NOF4.	4	4	16	1. Budget holder meetings 2. Budget holder training (stat man) 3. Finance Training Policy 4. Mandatory objective in appraisal form 5. Sustainability work stream within Patient First 6. Communication via senior managers meetings and Trust Management Board 7. Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. 8. Better Business Case trained staff. 9. Audit tracker	4	3	12			1. Add budget holder training to Stat and Man training list (90% target) 2. business planning ownership by divisions. 3. escalation process implemented (as BAF 1). 4. Core financial policy refresh and relaunch (from Oct). 5. Link through to the trust cultural transformation programme. 6. Divisional care group service involvement in future financial strategy and recovery and sustainability.	3	3	9	Mar-25	CFO	Exec	**Jan 25 -** 1. Trust Management Board review completed and approach supported. 2. Business planning is underway for 25/26 and demand and capacity work completed. 3. As BAF 1 4. Draft being compiled, awaiting for revised procurement guidance (due to come into legislation in Feb 2025). 5. Progressing - listening events promoted. 6. Linked to action 2.		Risk 2052: If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk. Risk 2055: ERF / Elective Activity Plans. Risk 2126: Potential for S&A Divisional CIP target for 2024/25 not being achieved. Risk 2156: WCYP Division unable to identify efficiency schemes to meet CIP target.
BAF4	**Sustainability**	FPPC	Mar-24	Delivery of the Trust's financial strategy Without clear enablers, system and NHSE support and full alignment to the clinical strategy, this could be at risk. The Trust currently remains in SOF4	4	4	16	1. Patient First True North and governance 2. Trust Board approved Finance Strategy 3. Working alongside NHSE Intensive Support director 4. Trust IIP 5. ICS financial recovery work being undertaken (of which the Trust is engaged)	4	4	16			1. Implementation of KPMG financial improvement recommendations which includes a review of core financial policies. 2. Board approved financial strategy and IIP. Implementation of IIP and agree with ICB. 3. ICS producing a financial recovery plan which the trust will contribute to. 4. Trust FRP drafted.	3	3	9	Mar-25	CFO	Paul Kimber	**Jan 25 -** 1&2. Strategy, Planning and Performance Group has met and begun scrutinising NOF4 exit criteria and evidence. CFO and CEO escalation in respect of unfunded services. 3. System focus on investigation and intervention regime. FRP temporarily paused. 4. Draft presented to October FPPC. Updated timline and FRP format to Dec FPPC and further discussions to extend final deadline inlight of delays to RSP exit.FRP drafting continues through new CFO.		
BAF5	**People**	People	Jul-24	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.	4	3	12	1. NHS Long Term Workforce Plan and MFT People Strategy aligned to the Plan. 2. Dedicated recruitment, retention and education meeting monthly; lead by the Dep CNO. 3. Attraction: Reviewed end to end recruitment process to ensure streamlined and more attractive to candidates. 4. Time to recruit KPIs. (significant reduction in medical and AFC recruitment achieved) 5. HR and OD performance group reports to People to Committee (on KPIs) 6. 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 pay bill. 7. Workforce redesign: a. SDR review of hard to recruit posts and introduction of new roles; b. Reporting to People Committee apprenticeship levy and apprenticeships. 8. Operational: a. Operational KPIs for HR processes and teams reported monthly. 9. Job planning, productivity, recruitment/retention of medics addressed through medical productivity programme.	4	3	12			1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions. 2a. Explore robotic automation for elements of the recruitment process. 2b. Support the Trust's Medical Productivity Programme. 2c. Review of the end to end medical recruitment process. 3a.Stay Conversations to be offered as an action as part of Staff Survey action planning (where staff indicated intention to leave the organisation). 3b. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average. 3c. Embed Intention to resign process within the divisions. 4a.Intention to Resign process is going to be linked with the VCP process for vacant roles. 4b. Continue to promote Intention to Resign process and Exit Interviews through team huddles and HR BPs. 5. Update policies and protocols. 6. Address staffing issues (FTEs and job roles) through the investment case.	4	2	8	Mar-25	CPO	Dominika Kimber	**Jan 25 - Off trajectory** 1. **Completed**. 2a. We are exploring robotic automation of the elements of the recruitment process. Part of ICB People Strategy (recommnedations due Q1 25). 2b. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment. 2c. **Completed** 3a. **Completed** 3b. **Completed** 3c. Continuing to embed the intention to resign process within the divisions. - This has been identified as a component of the trusts overpayment to staff leavers issue. IT support will be sought to redesign the process. 4a. **Completed** 4b. **Completed (link to 3c)** 5. Policy approved at People Committee in Nov 24. **Completed** 6. Component of the FRP/IIP. (the '400'). Further work required to design the mitigating actions.		Risk 1332: Inability to recruit substantive microbiologists could mean delays in identifying infections and clinical reviews of patients.

ID	Patient First Domain	Lead Committee	Date Added	Full Description of Risk -	Initial Consequence	Initial Likelihood	Initial Risk Rating	Mitigation / controls	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Forecast	Actions Planned to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date	Exec Owner	Senior Manager Lead	Update position	Date closed	Corporate Risk Register / Issues log mapping
BAF6	**People**	People		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.	4	3	12	1. Strategy: People Strategy in place 2.Culture Intervention: The cultural transofrmation programme. 3. Dedicated intranet page launched (autumn 24) displaying regular updates (monthly) on actions taken following staff feedback and concerns. ("You said we did, we all have a voice") 4. New external independant Freedom to Speak-Up service (launched Oct 2024). 5. VBR in place Qualitative and quantitative values-based appraisal to continue to embed values into the Trust culture. 6. 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. 7. Freedom to speak up strategy (approval in January 25) 8. Regular meetings with FTSU service and senior HR Team. Management information reports. 9. Dedicated leadership behaviour /competency focus within the implementatio plan to support people startegic initiative. updated monthly and A3 reviewed bi-monthly to track progress.	4	3	12	-		1. Link trust programme to the NHSE Behaviours Framework which is being developed. 2. In Review our management essentials offer and identify modules for development / collaborative work. 3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool. 4. Undertake surveys and engagment. 5a. MFT own New Starter Survey, replicating ICB survey is going to be launched. 5b. Identify areas where appraisal completion falls below 90% and raise in care group/team meetings. 6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group. 7. FTSU process has been reviewed. Policy needs to be updated and published. 8. Launch and promote Dignity at Work Advisors. 9. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accessible. 10. Cultural transformation listening events and action plans taken forward as part of the people strategic initiative (corporate project).	4	2	8	Mar-25	CPO	Dominika Kimber	**Jan 25 -** 1. The release of the National Behaviours framework has been delayed. Collation of feedback from networks completed. 2. Scoping ILM centre collaboration options. 3. The programme soluti9on is being consulted on. 4. Results are being analysed and an outcome report being produced which will be presented to the People Committee in the new year. 5a.New Starter Survey and quartely Pulse surveys restareted in Q1. 5b.New dashboard displaying key outcomes from staff surveys - Q1 25. 6. **Completed.** 7. FTSU policy updated and is scheduled for the 30 Jan 25. The FTSU strategy development was discussed at the Nov 24 people Committee. 8. **Completed** 9. Dedicated intranet page launched (autumn 24) displaying regular updates (monthly) on actions taken following staff feedback and concerns. ("You said we did, we all have a voice"). 10. Programme underway.		
BAF7	**People**	People	Sep-23	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.	2	3	6	1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff. 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 3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactive measures can be taken. 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.	2	3	6	-		1a. Review of the People Strategic Initiative (Leadership and Behaviours) and implementation of the agreed actions. 1b. Development of Behaviours Framework (aligned with Trust Values, incorporating all existing tools referencing behaviours e.g. Compact, Our Leadership Way, Nolan Principles) 1c. Development of examples of negative staff behaviours to be included in the Behaviours Framework 2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024 3a. Anti-bullying and harassment group to be reviewed and re-established. 3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan) 3c. New duty to protect staff from sexual harassment and actions relating to the Sexual Safety Charter will be embedded into Trust's policies and processes 4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI. 5. Cultural transformation programme.	2	2	4	Mar-25	CPO	Alister McClure	**Dec 24 -** 1.NHSE plan to develop a similar Framework - we are continuing to liaise with them. Consultation with staff networks initially, using examples of negative/uncivil behaviours recorded to Datix. 2. **Completed** 3a. **Completed** 3b/c. Policies ratified at Nov People Committee 4. Dignity at Work Advisors programme continues, with regular updates on policy changes and peer support. 5 – Equality Impact Assessment of Employee Relations and Organisational Development functions being designed. Cultural transformation Programme diagnostic phase has begun with baseline performance data. **Jan 25 - BAF 7 under review by People Committee**		
BAF9	**Quality**	QAC	Aug-24	SHMI and HSMR mortality indices show that Medway Foundation Trust are outside the expected range. There is a risk that patients maybe dying unnecessarily whilst at an inpatient at Medway Foundation Trust or within 30 days of discharge. (To be reviewed once Patient First Breakthrough objective is confirmed)	5	4	20	1. Avoidable #2222 breakthrough objective. 2. Depth of coding level. 3. Mortality Breakthrough Objective. 4. Admission pathway and medical model. 5. Learning from deaths process, End of life care pathway and data validation of deaths processes. 6. Revised breakthrough objective.	5	4	20	-		1. Review of the emergency admission pathways / medical model with a focus on patients admitted with respiratory disease. 2. Further embedding of learning from deaths methodology including the SJR process to utilise skills of the MDT. 3. Improving identification of end of life and communication with patients and families regarding end of life care. 4. Continue to focus on data quality improvements. 5. Include in the review of medical models. 6. Refresh the Breakthrough Objective.	5	2	10	Mar-25	CMO	James Akgbeleye	**Jan 25 - Off trajectory** 1. Review work has been completed and identified specific areas of focus (e.g. Respiratory disease) to target. Recovery actions designed. 2. App tool being rolled out. Board level training undertaken in Dec 24 3. Completed 4. Data quality continues to be comparable with national metrics. 5. Medical models being delivered and are kept under review.This will be brought back to Exec Committee Jan. 6. Mortality Breakthrough Objective established, root causes and countermeasures identified (as above). Contrubuting risks being mapped to the strategic objective - Jan 25		
BAF11	**Patient**	QAC	Sep-24	There is a risk that patients and their families may not receive outstanding, compassionate care every time	4	3	12	1. Weekly FFT huddles to discuss top themes and trends from feedback 2. Divisional and Exec SDR to review the top contributors 3. Monitoring complaints against the trajectory for the quality priority and staff attitude	3	4	12	-		1. Fundamentals of care programme of work 2. The re-established ward accreditation programme 3. Internal assurance visit schedules 4. Bespoke education, training and intense support in clinical areas	3	3	9	Mar-25	CNO	Nikki Lewis	**Jan 25 -** 1. The programme continues to be rolled out and progress is being reported through the QPSSC. 2. The ward accreditation programme continues. Support will continue to be provided to those wards that have not reached the Bronze rating. One ward has now achieved the 'Gold standard' and one has achieved 'Silver'. 3. Schedule being worked through, the outputs of which are fed into QPSSC and QAC. 4. Requirements are being reviewed.		Risk 1256: Lack of compliance with fundamentals of nursing care. Risk 2006: Patients awaiting G4S transport in CT.

ID	Patient First Domain	Lead Committee	Date Added	Full Description of Risk -	Initial Consequence	Initial Likelihood	Initial Risk Rating	Mitigation / controls	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Forecast	Actions Planned to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date	Exec Owner	Senior Manager Lead	Update position	Date closed	Corporate Risk Register / Issues log mapping
BAF12	System & Partnership	FPPC, QAC	Jun-23	High levels of 'no criteria to reside' patients and a lack of operational performance; for example not meeting constitutional (e.g. RTT) measures has wide-ranging implications, affecting patient care, trust, finances, and overall NHS performance It's essential for trusts to address these issues promptly to maintain high-quality healthcare services.	4	3	12	1. Focused work through the HARIS group 2. Weekly RTT meeting including robust review of RTT process 3. Reports direct to COO 4. 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	4	4	16	–		1. Revising and embeding acute medical and frailty Model 2. Reviewing the Full capacity protocol, opel triggers and actions. 3. Develop SPOA (Pilot) and virtual wards. 4. Waiting list maintenance and review process in place. 4. Rota of Senior Operational staff on the shop floor. 5. Safe Haven 24 hour mental health provision.	4	2	8	Mar-25	COO	Divisional Directors	**Jan 25 -** 1. Medical / Clinical Model has been reviewed at two dedicated events and the outputs of these have been reported to the Trust Board and TMB (for frailty). New model went live in Dec 24and its effectiveness is being monitored. 2. Protocol in operation and being monitored. 3. SPOA programme now operating, activity levels are being reviewed. Virtual wards are developing at pace. 4. Waiting list monitoring continues (including assessing harm) progress being made to reduce in line with national aspirations. 4. Rostering and job planning activities underway and a dedicated programme has been designed. **5. Completed**		
BAF13	Systems & Partnership	EMC, FPPC	Jun-23	There is a risk that conflicting priorities, financial pressures and/or ineffective governance across the ICS results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care.	4	4	16	1. LAEDB - Oversight dashboard 2. Kent and Medway Integrated Care Board 3. Kent and Medway Integrated Care Partnership Joint Committee 4. Joint development of plans at ICS level 5. Kent CEOs Meeting 6. Trust-wide Flow and Discharge Corporate Project 7. Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans	3	4	12	–		1. Review of LAEDB ToR, agenda and required reports. 2. review in-reach with clinical leads	3	3	9	Mar-25	COO	Exec	**Dec 24 -** 1. Review underway. 2. Medical / Clinical Model has been reviewed at two dedicated events and the outputs of these have been reported to the Trust Board and TMB (for frailty) in Nov. 3. Undertake benefit realisation for the Acute Medical Model. **Complete**		
BAF14	Systems & Partnership	EMC, FPPC, QAC	Jun-23	The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity. There is a risk that the increase in patients without a criteria to reside and the low discharge profile will reduce flow through the hospital and increase demand for bed capacity. This in turn impacts on the quality of care provided, increases length of stay and adds pressure to the financial sustainability of the trust.	4	4	16	1. Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. 2. Flow and Discharge Corporate project. 3. HCP Discharge Group, Efficiencies Group and LAEDB. 4. TeleTracking. 5. Virtual Ward initiatives	4	4	16	–		1. Create an operational plan that supports the closure of escalation beds. 2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MD. 3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS. 4. Board Round improvement as part of the reducing LoS CP.	4	2	8	Mar-25	COO	Tracey Stocker	**Dec 24 -** 1. Plan compiled and in operation. 2. Meetings in place and approach being deployed. 3. Action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. 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. Work has commenced with 5 wards.		
BAF15	Corporate	EMC	Sep-24	As the dependency on digital solutions increases to undertake trust business there is a risk that without continual investments and maintenance (including cyber security) that the trust will not be able to deliver on its core responsibilities and duties. The Trust operates its own internal data centres and servers for the majority of its IT systems and hosts and/or manages service arrangements with some suppliers. These are potential targets for cyber-attacks and/or cyber crime.	4	4	16	1. Digital and data (DDaT) strategy and implementation plan. 2. IT investment summary (business planning item) 3. Board level leadership and oversight (Chief Delivery Officer). 4. Annual maintenance programme. 5. Server upgrade programme. 6. Cyber security review findings and resultant action plan. 7. Links to national IT initiatives and programmes (e.g. CSOC).	4	4	16	–		1. Delivering the DDaT implementation plan. 2. Drafting an investment summary to be included in the trust business planning process. 3. Awareness raising and education on cyber security and associated IT risks. 4. Reviewing and producing a cyber strategy for Medway in collaboration with ICB. 5. Continuation of the server upgrades programme. 6. Implement the trusts ransom ware backup solution 7. Continuation of the trusts network refresh. 8. Continuation of the trusts digitisation of 'paper case notes' project.	4	3	12	Mar-25	CDO	Adrian Billington	**Jan 25 -** 1. DDat implementation underway and monitored monthly. Assurance reports produced and submitted to FPPC. 2. Capital programme discussions nearing completion and capital investment requests considered. ICB monies have been received to support server infrastructure upgrades. 3. Cyber security training delivered in Dec 24 (board development day). 5. will be completed in January 25. 6. **Completed** 7. In line with national timeline the trust is linking all its windows devices to CSOC. 8. The inpatient element is now complete and the project has moved on to the outpatient records. This is tracked through the SDR programme. 9. The trust has reviewed its cyber security arrangements and is producing a cyber strategy for Medway in collaboration with ICB.		Risk 1858: End of support Windows 10 25/10/25. Risk 1860: End of Support Microsoft Office 2016 & 2019 10/25. Risk 1919: Firewalls End of Support/Lifecycle Jan-25. Risk 1962: Core Network Switch Management (Increased risk of Cyber Attack). Risk 1965: There is a risk of the organisation being the target of a Cyber Attack, impacting information systems and/or IT infrastructure. Risk 2067: Deployment and Interfacing of EPR/EPMA System Impacting Patient Safety.

Meeting of the Trust Board
Wednesday, 15 January 2025

Title of Report	Integrated Quality and Performance Report for Month 8: 2024	**Agenda Item**	4.2
Author	Simon Bailey, Director of Business intelligence		
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer		
Executive Summary	This report relates to the Month 8: 2024 and provides the Board with an update of performance against the Trust's Strategic Priorities. Overall summary: • The People domain continues to show the highest volume in metrics improving for Statistical Variance (30), and shows the highest % of statistical improvement metrics (~55% of all metrics) • The Sustainability domain is showing the highest number of metrics statistically showing concern, with 33% of all metrics flagging • The Systems and Partnerships Domain is showing an equal distribution of metrics across all variations (both Improvement and Concern show 32%) • The majority of the metrics (59%) in the Quality domain continue to show no significant statistical variation and as such are showing common variation. • Overall, 77 metrics are now showing improved statistical variance (+7 from last month) against 36 which are showing concern (+3 from last month). Key areas of improvement are identified with actions and mitigations being taken by operational teams which are contained in the report. **Domain summary:** **Patients** • 100% complaints acknowledged within timeframe; No Patient Advice and Liaison Services (PALS) converted to complaints • Themes from complaints in November: delays in diagnosis, delays in treatment, discharge decision making • Increase in concerns being received relating to delays receiving imaging results – known backlog in radiology reporting being rectified. • Noted increase in requests for financial recompense • Themes from PALS in November: appointment concerns, communication with patients and families, dissatisfaction with care and treatment. • Two Parliamentary and Health Service Ombudsman (PHSO) cases closed: one partly upheld. • 21% of complaints breached target response time (n=6); 5 within Specialist Medicine Care Group • Two complaints re-opened – complex cases involving increased length of stay and complex discharge.		

- Mixed sex breaches improvement sustained. The top contributors remain stepping patients down from Intensive Care Unit (ICU) and High Dependency Unit (HDU) onto the ward.

Quality

- Fractured Neck of Femur: A total of 39 patients with hip fractures were admitted, of which 11 underwent surgery beyond the 36-hour target, resulting in a compliance rate of 72.1%. Despite this, we have maintained an average compliance rate above 70% over the past three months (August: 76%, September: 74%).
- Fractured Neck of Femur: Root Cause Analyses (RCA) continue to be conducted for each breach, positively influencing the prioritisation of Neck of Femur patients by the orthopaedic and anaesthetic teams on the trauma list. The anticoagulation pathway is currently being updated in collaboration with haematologists, anaesthetists, orthogeriatricians, and orthopaedic specialists.
- Falls - There has been an overall reduction in falls in comparison to the previous reporting period; There has been an increase in compliance with the CRASH bundle
- Tissue Viability Nurse - A reduction in overall Hospital Acquired Pressure Ulcer noted in November; Roll out of the new national assessment tool called 'Purpose T assessment' continues in line with the Quality Improvement Project; A replacement programme of all pressure relieving equipment and mattresses has been approved which will commence in April 2025.

System and Partnerships

- Work ongoing to clear >65 week waits – 120 Cardiology patients remain a risk
- Cardiology capacity remains a risk, mutual aid has been sourced from Maidstone and Tonbridge Wells NHS Trust and Dartford and Gravesham NHS Trust to support with clearance of >65 week waits.
- Awaiting dates for Cardio super clinics to be provided by NHS-England (NHSE) and Specialised-Commissioning agreement confirmation with Integrated Care Board (ICB)
- November Emergency Department position just under 78% target at 77.3%
- Long waiting time in Emergency Department (ED) for beds once Decision To Admit (DTA) given remains an issue. Total DTA was high at 771 compared to 693 previous month
- Cancer faster diagnostic standard just under target at 76.1%
- Diagnostic (DM01) performance which is a 6% improvement on October and the highest achievement since pre-pandemic.

People

- The Trust has a new breakthrough objective to reduce incivilities in the Trust which is going through catch-ball with the divisions.
- The Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. No further agency within estates and facilities.
- Appraisals remain off target and deterioration. Executive Strategic Deployment Review (SDR) for corporate areas has been put into address the falling appraisal level;

	• Cultural transformation programme is now live within the Trust; senior leadership cultural competency assessments underway; • Staff survey has concluded, current completion rate is 45.9% for substantive (+8.4% from previous) and 18.3% for bank staff (+1%) – pending the outcome of the survey. • Improvement to temporary staffing processes including stronger compliance controls in place (monitoring hours) and communicating cancelled shifts; • Continued focus on sickness with additional 63 cases taken to formal stages in last month; • Extended training dates now available for menopause training; • The Trust holds the most industry T-level placements for any one employer for science and Health. Successfully hosted T-level event on 5 December to promote and attract new hosts. **Sustainability** • The Trust is reporting a month 8 deficit of £5.1m and Year To Date (YTD) deficit of £9.3m. When adjusted for technical items this represents an adverse performance against control total of £5.4m and £8.95m respectively. • Those key pressures previously reported continue with no/little non-recurrent measures now available to offset; these include: Emergency Department safe staffing levels; medical staffing in Medicine and Emergency Care (MEC) and Surgery & Anaesthetics (S&A); enhanced care; Ruby ward and High Cost Drugs funding. In addition, the Year To Date pay award expense and under-accrual versus income has given rise to a cost pressure in month of £2.5m. On a full year basis this is anticipated as c£3.4m cost pressure. • After "normalising" the position, the underlying deficit showed a small deterioration in month. • Following the month 8 results the forecast outturn is under review – given the YTD performance there is some risk to the full year control total. • Further mitigations against potential forecast overspend to be developed. • Task and finish group meetings agreed to continue on a weekly basis.
Proposal and/or key recommendation:	The Board is asked to review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive Director to undertake.

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

Governance Process: **Committee/Group and Date of Submission/approval:**	This has been requested in response to Trust Chair / NED feedback from regulatory preparations

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:	Effective:	Caring:	Responsive:	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:	N/A				
Appendices:	N/A				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Gavin MacDonald, Chief Delivery Officer gavin.macdonald3@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.

Meeting of the Board of Directors in Public
Wednesday, 15 January 2025

Title of Report	Quality Assurance Committee – 09 January 2025			**Agenda Item**	5.1
Author	Emma Tench, Assistant Company Secretary				
Committee Chair	Paulette Lewis, Chair of Committee/NED				
Executive Summary	Assurance report to the Trust Board from the Quality Assurance 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	X	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	Quality Assurance Committee, 09 January 2025				
Patient First Domain/True North priorities (tick box to indicate):	Tick 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:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: X
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the QAC Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the QAC 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:	Alison Davis, Chief Medical Officer: alison.davis20@nhs.net Sarah Vaux, Chief Nursing Officer: sarah.vaux3@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
4	1	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:

- Bleep System – mitigations in place with a programme of work to deploy a new system, the committee required assurance no patient has come to harm due to issues.
- 12 Hour Harm Review – Risk of Harm to be logged as a Risk on the Register.

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
Committee Work Plan • Approved with minor amendments	Assurance
Risk and Issues Register • Refresh of out of overdue issues to be completed, for update at the next QAC. • 12 Hour wait for patients in ED to be added to Risk and Issues Log. • Review process for updates to ensure narrative behind risk/issues is clear • Aged Risks – under review, these will not show as 'aged' moving forward as will be reviewed and updated yearly.	Assurance
Quality Strategy Refresh • Updates to include: ○ How are successes measured ○ Broader narrative on Prisoner Health and programme of work being delivered by Tracy Stocker (Director of Operations for Flow and Integration) ○ Referencing to Maternity plan within the Strategy (expand on narrative) ○ Suggestion for 2 headline metrics – overall Staff Engagement score and Patient Experience score. The Strategy refresh was **NOT APPROVED** by the Committee	Partial Assurance

Quality and Patient Safety Sub-Committee Assurance and Escalation Report • Members raised the following check and challenge: ○ VTE Nurse in position and making a positive impact with process changes ○ Mitigations in place for issues with the hospital bleep system (see issue and risks to note above) ○ Suggestion for a visual dashboard highlighting divisional position re quality and clinical effectiveness standards.	Assurance
Maternity and Neonatal Safety Champion • Members raised the following check and challenge: ○ An understanding of the demographic for the Safeguarding DNA report ○ Impact of induction of labor. ○ Response to negative feedback regarding amenity rooms being offered. ○ New midwives are being supported by an expanded education team.	Assurance
12 Hour Harm Review • Members raised the following check and challenge: ○ How will Datix be reviewed for incidents relating to 12 hour delays.	Assurance
Royal College of Physicians Rheumatology Review • The committee members were **ASSURED** by the report, requesting and update in 3 months.	Assurance
Learning from Death - Monthly Update and Niche Action Log • The committee members requested the actions and updates from divisions to be reflected in the report.	Assurance
Successes to report: The new clinical model commenced on 18 December 2024, functioning to improve quality.	

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 15 January 2025

Title of Report	Assurance report – People Committee: 28 November 2024		**Agenda Item**	5.2
Author	Leon Hinton, Chief People Officer			
Committee Chair	Jenny Chong, 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	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	People Committee, 28 November 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) X	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: X
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 Chief People Officer 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.		

Best of care Best of people Patient FIRST

	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
4	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: None
Reflection: (1) appraisal rates need focus to return to being back on track; (2) moving and handling training needs focus to improve compliance; (3) focus on short-term sickness and measures to address the high rate; (4) reporting of employee relations processes to be improved for pre-disciplinary panels; (5) we must ensure data is accurate for monitoring protected characteristics; (6) BAF item 7 to be reviewed; (7) timings of meetings and agenda planning to assist.

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 October 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) – [1.1%, 0.1% improvement, off target], moving to new breakthrough objective addressing incivilities; • Staff appraisal – [87.5%, -1.5% deterioration, 2.5% off target] progress remains poor, reviewing how Strategy Deployment Reviews for corporate areas can address underperformance; • Vacancy rate – [6.6%, 0.7% improvement, on target]; • Voluntary turnover – [8.7%, +0.1% deterioration, 0.7% off target] holding position, signification improvements forecast with recruitment pipeline for nursing and midwifery in particular; • Staff fill rates – a review is currently being undertaken in relation to CHPPD calculation methodology and reporting; • Sickness absence – [5.3%, -0.0% no change, 1.3% off target] review of short-term trigger metric methodology to support earlier indication and intervention;	Assurance

• StatMan – [87.2%, -1.8% deterioration, on target] with improvement across most competencies with the exception of resuscitation decreasing over a number of courses. A new task and finish group is being initiated for compliance to national competency requirements, frequency and gaps (e.g. resus); applying an A3 methodology to StatMand capacity;	
2. Mandated Equality Reports Action Plan The Committee **APPROVED** the report including the combined action plan across the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap. The action plan had been considered by the Equality and Inclusion Steering Group and shared with the Staff Networks.	Not Applicable
3. People Strategy 2024-2027 implementation plan and status update The Committee **NOTED** the update on the People Strategy implementation plan, the detailed actions underway and informed that there were no immediate barriers to implementation. No new risks nor issues were raised. In the future, the Committee is to receive a status update report evidencing impact on agreed KPIs. Of the 63 activities, 42 (72%) were green rated, 11 amber (19%) and five red (9%). The Committee reviewed the four pillars of i) Becoming an employer of choice; ii) growing our talent; iii) keeping our people thriving at work; iv) delivering new ways of working.	Not Applicable
4. Board Assurance Framework (BAF) and Risk Register The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items five, six and seven. No changes were made to the scoring; however, the committee as for a review of BAF 7 to ensure alignment to the Cultural Transformation Programme. The Committee were **ASSURED** and **NOTED** the report.	Assurance
5. Policies for approval The Committee **APPROVED** the following policies following comment: • Appraisal and pay progression policy; • Right to work policy; • StatMand training handbook; • Temporary workforce policy (pending amendments for local onboarding); • Leaving the organisation policy; • Sexual safety policy statement; • Disciplinary policy.	Not Applicable
6. Freedom to Speak Up strategy The Committee received the updated Freedom to Speak Up strategy to set the strategic direction for the next three years. The Committee asked for further development before being submitted to the Trust Board to address	Assurance

7. **Staff Health and Wellbeing Assurance Report (quarter 2, 2024/25)** The Committee received the report detailing three debrief sessions; 37 listening ear session; 3.8% staff accessing the Trust's employee assistance programme; 176 mental health first aiders trained and in place. The Trust was presented with the Platinum award in the Healthy Workplace Programme delivered by Medway Council. The Committee **APPROVED** the report.	Assurance
8. **HR and OD Performance** The Committee were **ASSURED** of HR and OD performance against workplan.	Partial Assurance
9. **Anti-Bullying and Harassment Group Assurance report** The Committee received the assurance reports covering the periods since the last committee. Listening events had been commissioned for medical and emergency care and these will be linked to the commissioned cultural transformation programme. The Committee were informed how the new People breakthrough objective for reducing incivilities in the workplace would be linked to the objectives of this group. The Committee were **ASSURED** by the report.	Assurance
10. **People Promise update** The Committee **NOTED** an update in to the People Promise Exemplar programme with ten of the twelve focus areas on track with no new risks or barriers to delivery.	Assurance
11. **NHS England Self-Assessment for Placement Providers 2024** The Committee received the outcome of the self-assessment for the annual return requiring Trusts to carry out their own quality evaluation against a set of standards: Domain 1. Learning environment and culture Domain 2. Educational governance and commitment to quality Domain 3. Developing and supporting learners Domain 4. Developing and supporting supervisors Domain 5. Delivering programmes and curricula Domain 6. Developing a sustainable workforce Year-on-year improvements to compliance with the framework were reported with detailed areas of development to demonstrate how services are planned to improve further. The Committee **APPROVED** the return to the NHS England.	Assurance
12. **Modern Day Slavery Report** For the financial year 2023/24, no reports were received from Trust staff, the public, or law enforcement agencies to indicate that modern slavery or human trafficking practices have been identified in line with our statement. The Committee reviewed and **APPROVED** the report refreshing the Trust's Modern-Day Slavery and Human Trafficking Statement for the financial year 2024/25.	Significant Assurance

Meeting of the Trust Board in Public
Wednesday, 15 January 2025

Title of Report	Finance Planning and Performance Committee Assurance Report – 28 November 2024	**Agenda Item**	5.3a
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. Annual work plan Further consideration is due to be given by the Trust Executive to those areas for deep dive during the year and thus the work plan will be brought back to the December meeting. An agenda item was also requested on the Recovery Support Programme. The Committee **NOTED** the report.	Partial assurance
2. Corporate Risk Register A number of risks were noted as being "issues" and as such are awaiting the creation of the issues log (in particular the capital requirement/backlog maintenance). Discussion was held noting that actions to address the risks must be populated for every risk. The Committee **NOTED** the report.	Partial assurance
3. Board Assurance Framework (BAF) The reports for Sustainability and Systems and Partnership were presented. The Sustainability BAF noted that the delivery of the in-year control total was an escalating risk and would be re-assessed next month if performance continued to be off plan, i.e. for a third consecutive	Partial assurance

month. Closer triangulation of these risks with the Integrated Improvement Plan was requested.	
4. Strategy, Planning and Performance Group assurance and escalation The Chief Delivery Officer gave a verbal update at the meeting, noting that a written report would be issued for future meetings. The Integrated Improvement Plan evidence was noted as being signed off with a recommended overall rating of "Amber"; progress was seen by the Group against all workstreams. (NB – the evidence/progress was an agenda item at this Committee meeting – see section 11 below). The Committee **NOTED** the update.	Assurance
5. Replacement Maternity Information System The business case was removed from the meeting – feedback to be addressed was referenced.	Not applicable
6. Finance Report M7 The Committee received the paper for Month 7/October 2024, noting that the Trust was adverse to plan by £1.8m in month and £3.5m Year To Date. Despite this, there was an underlying improvement compared to month 6. The risk adjusted forecast outturn was presented and reflected the discussion held at the most recent Oversight meeting. This indicated a residual adverse gap to control total of £2.5m, albeit with risk to delivery of that performance. The actions arising from the task and finish group were reviewed and executive leads are clear on their actions. Divisional meetings were noted as being held to consider further mitigations, including where services are running above their budgeted establishments. The wider system is part of the "Investigation and Intervention" level 4 regime – see below – and a number of additional controls and peer-to-peer reviews are underway. Cash was noted as being in a stronger position than earlier in the year as a result of the support funding. Capital remained behind but there was confidence that the schemes will deliver in this financial year; the one exception was the Community Diagnostic Centre where alternative plans to spend the slippage of c£2.5m were under development. Discussion was held in respect of the mitigations and timing thereon in delivery of the forecast. The Committee **NOTED** the report.	Partial assurance
7. Financial Recovery Plan report	Partial assurance

The report was presented setting out the approval governance routes and dates for the Trust and ICB up to the RSP meeting on 6 March 2025. Early sight of the document itself was requested to be presented through the Trust Executives. The Committee **NOTED** the report.	
8. Reducing waste programme The latest position on both the waste reduction efficiencies, operational efficiencies and run-rate improvement opportunities was presented and discussed by the Committee. The Committee **NOTED** the report.	Assurance
9. Activity report The Director of Planning and Performance presented the report, outlining key activity variances from plan, the drivers and the constitutional standards performance. The Committee **NOTED** the report.	Assurance
10. Business Planning 2025/26 The Director of Planning and Performance noted that at this time the work was approximately one week behind plan. Focussed work on establishments was being undertaken and could create further delay. The Committee **NOTED** the report.	Partial assurance
11. Recovery Support Programme - Integrated Improvement Plan The Chief Delivery Officer articulated the highlights of the report, including the overall "Amber" rating. The Committee **NOTED** the report.	Partial assurance
12. Flex and Freeze Clinical Coding Rates The Chief Deliver Officer gave the key messages from the paper and provided assurance that income was not being lost at the clinical coding freeze point, despite lower than expected coding at flex (i.e. the earlier point in the process). NHSE have agreed to provide some support to review and assess our practice and performance. The Committee **NOTED** the report.	Assurance
13. Month end variance and forecasting SOP	Significant assurance

	The document had been updated for the comments and feedback received at the September meeting. Consideration was requested as to an independent review, eg internal audit, NHS England financial governance review, etc. The Committee **APPROVED** the report.	
	14. ICB Level 4 Letter/Report The Committee **NOTED** the report with no further questions arising.	Not applicable
	15. Integrated Quality Performance Report (IQPR) The Committee **NOTED** the report.	Partial assurance
	16. ED Nursing (safer staffing) As the proposal had been presented at a previous meeting the Committee focused on changes (eg arising from the recent pay award) and any further questions. The Committee **APPROVED** the proposal and asked the Board to consider funding implications..	Assurance

Proposal and/or key recommendation:	The ED nursing proposal was approved to proceed to Trust Board.

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 November 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 Corporate Risk Register and Board Assurance Framework items.

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 this paper please contact:	Gary Lupton, gary.lupton1@nhs.net

Meeting of the Trust Board in Public
Wednesday, 15 January 2025

Title of Report	Finance Planning and Performance Committee Assurance Report – 19 December 2024	**Agenda Item**	5.3b
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. Annual work plan This has been reviewed by the Trust Executives and adjustments made in respect of timings, clarity of reports and the post implementation reviews for approved business cases. The deep dives will be programmed during the year to ensure balance. The Committee asked for some minor changes to lead executives and timing of the business planning reporting. An additional item on procurement strategy was also requested. The Committee **NOTED** the report.	Assurance
2. Finance Report M8 The Committee met privately to discuss the YTD financial performance and latest forecast outturn.	Partial assurance
3. Financial Recovery Plan report The Interim CFO presented an update paper. He stated that whilst the work to date is very helpful, it is not yet sufficient for the purposes required. The paper set out the further work required. The Committee **NOTED** the report.	Assurance
4. Business Planning 2025/26	Assurance

The Director of Planning and Performance gave a verbal update on progress. Assurance was given that work on the demand and capacity is being used early in this process. Updated timelines will be shared and agreed with Trust Executives. The Committee **NOTED** the update.	
5. Recovery Support Programme - Integrated Improvement Plan The Chief Delivery Officer articulated the highlights of the report, including the overall "Red" rating. The Chief Executive Officer noted that the Oversight meeting was held in the previous work and the Trust highlighted that we were not yet ready to transition out of Oversight level 4 as we could not now demonstrate six months of delivery against the criteria. We expect a new date for transition/exit is likely Mach 2026, although this is yet to be formally agreed. The exit criteria are also expected to be refined. The Committee **NOTED** the report.	Partial assurance
6. Corporate Risk Register The Director of Strategy and Partnership/Company Secretary presented the key highlights from the report. The Committee **NOTED** the report.	Partial assurance
7. Board Assurance Framework (BAF) The Director of Strategy and Partnership/Company Secretary presented the key highlights from the report. The Committee **NOTED** the report.	Partial assurance
8. Reducing waste programme The Chief Operating Officer presented the key highlights from the report, noting that work has already started on the 25/26 programme. The Committee **NOTED** the report.	Assurance
9. Activity report The Director of Planning and Performance presented the report, outlining key activity variances from plan, the drivers and the constitutional standards performance. In particular, the level of "uncashed clinics" from November was discussed - further investigation was requested on this issue. The COO noted that we are reporting a number of expected 65-week breaches by the end of December; many of these sit within	Partial assurance

	Cardiology. The COO explained the driver of these (including patient choice) and the work being undertaken to ensure these patients are seen as quickly as possible, which includes use of other capacity within the system. The Committee **NOTED** the report.	
	10. Strategy, Planning and Performance Group assurance and escalation The Chief Delivery Officer gave a verbal update from the meeting held earlier in the week. The Committee **NOTED** the update.	Assurance

Proposal and/or key recommendation:	For assurance			
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 – 19 December 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 Corporate Risk Register and Board Assurance Framework items.				
Resource implications:	Individual resource considerations are provided at the Finance, Planning and Performance Committee				
Sustainability and /or Public and patient engagement	Individual considerations are provided at the Finance, Planning and Performance Committee				

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:	Gary Lupton, gary.lupton1@nhs.net

Meeting of the Trust Board
Wednesday, 15 January 2025

Title of Report	Finance Report – Month 8			**Agenda Item**	6.1
Author	Dan Thompson, Finance Business Partner Cleo Chella, Associate Director Income and Contracts Isla Fraser, Financial Controller Paul Kimber, Deputy Chief Finance Officer				
Lead Executive Director	Simon Wombwell, Chief Financial Officer (Interim)				
Executive Summary	1) The Trust reports a deficit of £5.6m in month 8 and a deficit of £10.6m year to date (YTD); this is adverse to plan by £9m. In-month the Trust has received £1.8m of deficit support funding. 2) The efficiency programme has under delivered by £1.1m against the YTD plan of £13.7m. 3) The capital position is underspent as at month 8 due to the timing of schemes being delivered (principally in relation to CDC leases being signed). 4) Cash at the end of November was £15.7m.				
Proposal and/or key recommendation:	The Trust Board is asked to note this report.				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval		
	Noting	X	Discussion		
Committee/Group submitted: **Date of Submission:**	Meeting: Finance, Planning and Performance Committee Date: 28 November 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) X	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: X
Identified Risks, issues and mitigations:	Non-delivery of the breakeven control total. Careful cash management.				
Resource implications:	The report sets out the financial resources/performance/position of the Trust				
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: Simon Wombwell Job Title: Chief Financial Officer (Interim) Email: simon.wombwell@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.

Meeting of the Trust Board
Wednesday, 15 January 2025

Title of Report	Months 1 – 8: Progress against the Transition Criteria for the Recovery Support Programme (RSP) and supporting evidence	**Agenda Item**	6.2
Author	Gemma Brignall, Director of Planning and Performance		
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer		

Executive Summary

This paper provides a report against the six transition criteria (formally known as exit criteria) which includes the Integrated Improvement Plan (IIP) submitted to Board in July 2024. Following the oversight meeting in December there has been a discussion on readiness to transition.

The M8 position for the trust has been self assessed as red. This is driven by the trust being off plan by circa £6m and is the third month of deterioration with four criteria turning red as a result.

Criteria	Description	Comments	Actions from M8 Review to mitigate	M7 RAG	M8 RAG
1	Agreed Financial Recovery Plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system	This was self-assessed as Green compared to Red by the ICB and NHSE. The difference lies in there being an Integrated Improvement Plan for the Trust for in-year improvement, but not yet a 3 year Financial Recovery Plan (which is noted is in development and due to go to Board in December).	A paper is being submitted to FPPC in December which provides a new format for FRP as such this RAG is moved to red as the proposed 1st draft completion will potentially be delayed		
2	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes	Progress noted but further evidence of improvement (green really needs 6 months to demonstrate sustainability)	Trust remains off plan at M8 whilst plans are ongoing and mitigations are being proposed there is a risk to FOT remaining of circa £6m as such this RAG remains Red		
3	The Trust fulfils its statutory duties with regard to financial management	This was self-assessed as Amber compared to Green by the ICB and NHSE because the Trust delivered to the 24/25 plan in Q2. This was later revised to Amber to reflect trust RAG	Same as above. Trust remains off plan at M8 whilst plans are ongoing and mitigations are being proposed there is a risk to FOT remaining of circa £6m as such this RAG remains Red		
4	Expertise and capacity to deliver on FRP	Self-assessed Green compared with ICB and NHSE as Amber. The difference being due to clear evidence of delivery.	This will remain Amber until 6 months delivery noted. This may be a challenge on the basis that the roles were not recruited until Q3 and as such demonstration of delivery for 6 months may not be achieved		
5	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures	Self-assessed as Red compared with Amber by the ICB and NHSE. The difference lies in the ICB and NHSE recognizing the steps in place to improve financial oversight through the Reducing Waste programme (and PMO improvements) and Vacancy Control Panel, but a gap remains around evidence of sustained recommendations from the KPMG analysis, and evidence against grip and control. This was later re rated to red in line with trust assessment	Report from Margaret due in January to complete this action and turn green		
6	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.	Self-assessed as Amber compared with Red by the ICB and NHSE. The difference is that this aligns with Criteria 1 so there is a clear alignment with the 3 year FRP and evidence of the identification of risk and joint working on mitigations.	This has been turned Red on the basis that criteria 1 has shifted to red and following discussions at oversight regarding risk alignment		

Following the oversight meeting in December 2024 with NHS England and the Integrated Care Board there has been a discussion and agreement that the organisation is not ready to transition. This is driven by the deteriorating position and the requirement to evidence six months of improvement.

Proposal and/or key recommendation:	A clear description of what the board/committee is being asked to agree/discuss/note.

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	X
	Noting		Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Strategy, Planning and Performance group Date: 18 November 2024 Meeting: Finance, Planning and Performance committee Date: 28 November 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) 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:	Effective:	Caring:	Responsive:	Well-Led: X
Identified Risks, issues and mitigations:	Risk of non-delivery of trust financial plan for 2024/25 – Trust off plan by£6m at M8			
Resource implications:	Outline the resources required to implement this recommendation. If a financial contribution is required, please confirm the Trust Finance staff member that this has been agreed with.			
Sustainability and /or Public and patient engagement considerations:	Outline how the proposal aligns with the Trust Green Plan and Sustainability Strategy or whether any communications or medical issues have been considered (and describe these). What engagements with patients and the public has been undertaken or planned in connection with the paper.			
Integrated Impact assessment:	Not applicable			
Legal and Regulatory implications:	Briefly identify the known and/or potential legal or regulatory considerations of the recommendations.			
Appendices:	Enclosed			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act			
For further information please contact:	Name: Gavin MacDonald Job Title: Chief Delivery Officer Email: gavin.macdonald3@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	X	There are gaps in assurance	
	Assurance		Assurance minor improvements needed.	
	Significant Assurance		There are no gaps in assurance	

	Not Applicable		No assurance required.

1 Executive Summary

The Trust has a current transition date from the national Recovery Support Programme in December 2024. This report provides a report against the six transition criteria (formally known as exit criteria) which includes the Integrated Improvement Plan (IIP) submitted to Board in July 2024. Following the oversight meeting in December there has been a discussion on readiness to transition.

The M8 position for the trust has been self assessed as red. This is driven by the trust being off plan by circa £6m and is the third month of deterioration with 4 criteria turning red as a result.

Criteria	Description	Comments	Actions from M8 Review to mitigate	M7 RAG	M8 RAG
1	Agreed Financial Recovery Plan in place supported by a clear evidence base, approved off by the board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system	This was self-assessed as Green compared to Red by the ICB and NHSE. The difference lies in there being an Integrated Improvement Plan for the Trust for in-year improvement, but not yet a 3 year Financial Recovery Plan (which is noted is in development and due to go to Board in December).	A paper is being submitted to FPPC in December which provides a new format for FRP as such this RAG is moved to red as the proposed 1st draft completion will potentially be delayed		
2	Evidence of improved delivery against agreed financial plans, trajectories, and envelopes	Progress noted but further evidence of improvement (green really needs 6 months to demonstrate sustainability)	Trust remains off plan at M8 whilst plans are ongoing and mitigations are being proposed there is a risk to FOT remaining of circa £6m as such this RAG remains Red		
3	The Trust fulfils its statutory duties with regard to financial management	This was self-assessed as Amber compared to Green by the ICB and NHSE because the Trust delivered to the 24/25 plan in Q2. This was later revised to Amber to reflect trust RAG	Same as above. Trust remains off plan at M8 whilst plans are ongoing and mitigations are being proposed there is a risk to FOT remaining of circa £6m as such this RAG remains Red		
4	Expertise and capacity to deliver on FRP	Self-assessed Green compared with ICB and NHSE as Amber. The difference being due to clear evidence of delivery.	This will remain Amber until 6 months delivery noted. This may be a challenge on the basis that the roles were not recruited until Q3 and as such demonstration of delivery for 6 months may not be achieved		
5	Robust oversight, financial controls and processes are in place and overseen through appropriate financial governance procedures	Self-assessed as Red compared with Amber by the ICB and NHSE. The difference lies in the ICB and NHSE recognizing the steps in place to improve financial oversight through the Reducing Waste programme (and PMO improvements) and Vacancy Control Panel, but a gap remains around evidence of sustained recommendations from the KPMG analysis, and evidence against grip and control. This was later re rated to red in line with trust assessment	Report from Margaret due in January to complete this action and turn green		
6	The trust and system have a shared understanding of risks to the financial plan and have agreed mitigations in place.	Self-assessed as Amber compared with Red by the ICB and NHSE. The difference is that this aligns with Criteria 1 so there is a clear alignment with the 3 year FRP and evidence of the identification of risk and joint working on mitigations.	This has been turned Red on the basis that criteria 1 has shifted to red and following discussions at oversight regarding risk alignment		

2 Purpose of this Report

This report is to provide assurance in preparation for transition out of NOF 4 at the end of Q3, the committee is asked to note progress for months 1 to 8 and sign off evidence against each of the 6 transitions criteria.

The report provides a progress update against key metrics and trajectories with evidence being collated to demonstrate progress against the RSP transition criteria. Quality and performance metrics are also included to further demonstrate no unintended consequences by triangulating finance, performance, workforce and quality metrics.

Key components of this report are:

1. Progress against plan with RAG rating of risk of being able to evidence the requirement to exit NOF 4 of RSP
2. Progress against each criterion with links to supporting evidence
3. Highlight reporting of progress against the Integrated Improvement Plan

The FPPC oversees the internal governance for monitoring the delivery of the evidence, including an IIP dashboard. The Evidence Review Group (ERG) meets monthly to review the evidence against the transition criteria and the core workstreams included in the IIP, before it is sent to FPPC for approval.

It has been noted re the differences against RAG status across the multiple documents this is due the end position for which they are monitoring with the Finance BAF risks linked to a breakeven position and RSP to the Trust plan deficit. The two reports have been aligned and are noted.

5. Progress and identified gaps

Following the oversight meeting in December there has been a discussion and agreement that the organisation is not ready to transition. This is driven by the deteriorating position and the requirement to evidence 6 months of improvement. To transition in December this has become unattainable with only 1 month remaining of evidence available.

Following this meeting the executive will be meeting with NHSE and ICB to discuss the criteria with a view to updating and giving clear goals in order to evidence achievement. There will be a working group set up to discuss the next steps for transition requirements and FRP development.

Next steps:

1. Meeting in January with ICB and NHSE to discuss criteria
2. Q3 self assessment to be completed 9th January
3. FRP working group to be established early January
4. NHSE report following audit of financial governance
5. Full establishment of RSP funded FBP's to support the delivery of FRP
6. Update on 400 final review – January FPPC
7. RSP monies against spend update report

6. Risks to delivery

	Risk	Mitigation	Impact
1	Financial position not delivering against improvement trajectories	Increase in CIP targeting to reduce gaps. Review of establishments to understand budget errors	ERF income and CIPs. More focus being placed on these areas. Bring the trust back on target
2	Winter pressures driving increased cost	System support being sought to reduce the average number of NCTR patients in the bed (currently average 120 per day)	Reduce bank spend on escalation areas overnight

7. Integrated Improvement plan Highlight report

IIP Highlight report

NHS Medway NHS Foundation Trust

Overview – Integrated Improvement Plan – October 2024 (Month 7)			RAG
Integrated Improvement Plan			
Core Workstreams		**Progress**	**RAG**
1	Workstream 1	• Month 8 reports a position adverse to control total by £5.6m, as reported to Trust Board and FPPC. Mitigating actions are being developed and implemented. • Capital is underspent against plan, primarily due to CDC slippage. Monies will require brokering into 25/26.	
2	Workstream 2	• Technical planning group across the system established to deliver the financial modelling. • Trust and Integrated Care System have populated modules 1+2 of the system financial model	
3	Workstream 3	• Completed several areas and job planning has commenced for 25/26	
4	Workstream 4	Adverse to operational plan for total FTE worked by 50 FTE.	
5	Workstream 5,6 and 8	• Efficiencies programme substantially identified for 24/25	
6	Workstream 7	• Good Improvements with some work to align to the ICB	

Risks/Issues		RAG
1	The Trust's run-rate does not demonstrably shift to exit the financial year at no more than an underlying deficit of £1.0-1.5m per month	
2	Budgeting arrangements for specific areas do not match operational requirements (headroom)	
3	Team and Individual JP not booked yet in divisions which requires notice 6 weeks to enable clinics schedule to allow to attend those meetings	

Integrated Improvement plan	
Date	12/12/2024
Exec Lead	Gavin MacDonald
SRO	Gemma Brignall
Reporting Month	November 2024

Overall Project RAG	X		

RAG justification

Whilst two workstreams are RAG rated green, overall we remain at Amber whilst we implement mitigations to ensure delivery.

Notable Celebrations

Meeting of the Trust Board
Wednesday, 15 January 2025

Title of Report	Freedom to Speak Up Strategy		**Agenda Item**	6.3
Author	Dominika Kimber, Deputy Director of HR and OD Lauren Pryor, Senior Project Manager - Strategy and Partnerships			
Lead Executive Director	Jayne Black, Chief Executive Leon Hinton, Chief People Officer			
Executive Summary	The Freedom to Speak Up Strategy provides a structured approach and plan to create an environment and culture where speaking up and listening is business as usual. The Strategy sets the direction for the next three years building on the foundations on which we will deliver our vision for all staff members to feel safe and confident to speak up.			
Proposal and/or key recommendation:	Submitted for approval.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	X
	Noting		Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Quality Assurance Committee – 07.11.24 – Feedback provided People Committee – 28.11.24 – Feedback provided			

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:	N/A
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	Engagement and evidence for this Strategy has been formed through the use of the annual NHS Staff Survey. The Strategy has also been shared with the Guardian Service for review and with our Whistleblowing Non-Exec Director for comment. All comments and feedback will be incorporated prior to Trust Board in January.
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	N/A

Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Lauren Pryor Job Title: Senior Project Manager Email: lauren.pryor@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.

Freedom to Speak Up Strategy
2024 to 2027

Author:	Deputy Director of Human Resources and Organisational Development Senior Project Manager, Strategy and Partnerships
Operational Exec Lead:	Chief People Officer
Revision Number:	V1.9
Document ID Number:	*TBC*
Approved By:	Trust Board
Implementation Date:	January 2025
Date of Next Review:	January 2026

Freedom to Speak Up Strategy

Document Control / History

Revision Number	Reason for change
V1.9	Refresh of Strategy 2021-2024

Consultation

People Committee
Quality Assurance Committee
The Guardian Service
Trust Board

TO BE READ IN CONJUNCTION WITH ANY POLICIES LISTED IN TRUST ASSOCIATED DOCUMENTS

Table of Contents

Freedom to Speak Up Strategy

1. Foreword

It is my pleasure to introduce our revised Freedom to Speak Up Strategy, a concept towards which I personally feel extremely passionate.

We have all heard about the tragic consequences that can occur when people do not feel empowered to raise concerns. It is absolutely vital that we have in place clear and robust processes that staff can follow if they see or hear anything that they think could lead to harm to our patients or colleagues. This revised strategy demonstrates our commitment to continue to strive for a culture where staff are not afraid to speak up and know exactly how to do so if they need to.

We have already adopted new initiatives to strengthen and support a healthy speaking up culture, but we want to go further. We have many plans to take forward and these are outlined in this strategy which shows our direction in this area until 2027.

These plans are closely aligned to our Patient First programme of improvement, particularly the domain which focuses on People. My thanks go to all who support us to make the Trust a better place to give and receive care.

Jayne Black, Chief Executive.

2. Introduction

The aim of this strategy is to create an environment and culture where speaking up and listening is business as usual and raising concerns results in improvements for our organisation, our staff and our patients in line with the Trust's Patient First Strategy. Fostering psychological safety is crucial for our workforce and we will ensure that staff feel safe to speak up, are supported to do so, and confidentiality is safeguarded.

The Trust is committed to embedding the appropriate structures and procedures that support speaking up and ensuring that staff members demonstrate the values and behaviours required to deliver this in practice. By placing less emphasis on blame when things go wrong and more emphasis on transparency and learning from mistakes, we can ensure it is safe for staff to raise concerns and ensure that we keep our patients at the heart of what we do. The principles of just and learning culture also enable us to reflect on root causes of the issues reported by staff and taking steps to improve our process, structures and environment for our staff and patients.

Building an open culture is key for the Trust, one in which leadership encourages learning and improvement leads to safer care and improved patient experience. This strategy provides the foundations on which we will build to deliver our vision for all staff members to feel safe and confident speaking up.

3. National and Local Context

Here at Medway NHS Foundation Trust, we have more than 5,700 employees and more than 800 bank staff, working across both clinical and non-clinical roles to deliver healthcare to the people and residents of Medway and Swale.

There are a number of ways for our staff to raise concerns at the Trust through the Freedom to Speak Up (FTSU) Service which plays a key role in helping staff, trainees and volunteers to raise concerns and helps ensure patient safety is maintained at all times. The service acts independently and with autonomy to support colleagues to speak up when they feel that they are unable to in other ways.

Having a voice that counts is a key part of the NHS People Promise and the Trust People Strategy, ensuring that all workers including permanent employees, bank and agency staff, students and volunteers feel safe to raise concerns and confident that the Trust will take the time to really listen and understand the hopes and fears that lie behind the words.

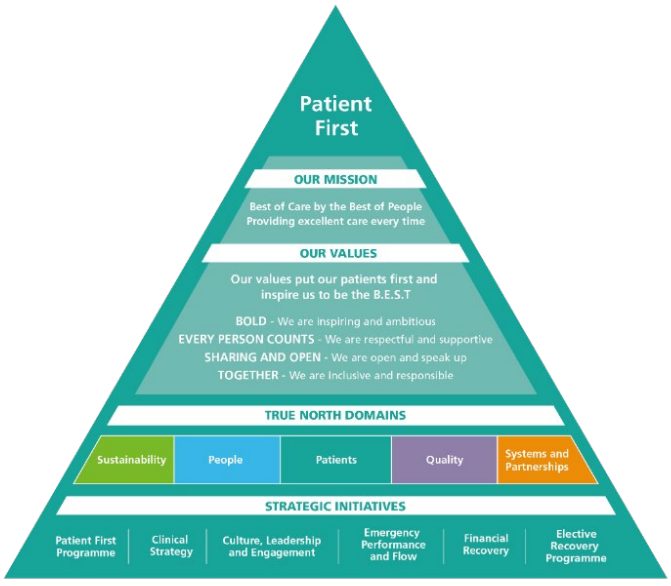
The Freedom to Speak Up review (2015) set out 20 principles to guide the development of a healthy speaking up culture through the NHS, which has led to major changes in NHS policy. In 2017 the National Guardian Office (NGO) published the recommendation for all Trusts to develop a local network of ambassadors / champions to provide assurance that all workers have appropriate support and opportunities to speak up alongside access to the Freedom to Speak up Guardian.

Freedom to Speak Up Strategy

The Trust has adopted the following initiatives, led by the Chief People Officer as the Operational Executive Lead and reported to the Chief Executive as Executive Lead of the Freedom to Speak Up Programme.

- Appointed 20 Dignity at Work Advisors, who are available to staff to provide confidential support and signposting to staff who experienced any form of abuse at work, including bullying, harassment, discrimination.
- Introduced the Guardian Service, an independent and confidential provider will be available at the Trust, extending the opportunity for colleagues to raise concerns about care or behaviour, 24 hours, 7 days a week, 365 days a year.
- Revised Trust's internal process for the commissioning of investigations, with Executive Directors' oversight and reporting to the Board.
- Implemented an action plan to address learning from the recent high-level NHS cases, including Michelle Cox (a senior nurse who won an employment tribunal against NHS England and Improvement regarding racism and whistleblowing).
- Reviewed our approach to the development of management skills and competencies, through the launch of the Leadership Framework, which identifies mandated courses for all levels of leavers.
- People Strategic Initiative is focussed on Leadership and Behaviours, as drivers of organisational culture, which we linked with staff confidence in speaking up and leadership competencies to listen up.
- Introduced Absolute Diversity to the Trust, leading on transforming our culture and focusing on equality, diversity and inclusion and violence and aggression.

The guiding principles of our overarching Patient First Programme highlights that the Freedom to Speak up Strategy is a key part in supporting our Trust's True North vision.



4. Vision and Values

Our values put our patients first, inspire all staff to be the B.E.S.T, and are an important statement of the healthcare provider we want to be. The values were developed by our staff and describe the way we work together and they underpin everything we do. We want staff to work in a positive environment, where colleagues can support each other and are able to be involved in decision making and have a voice. To achieve this, we need a positive culture where staff feel safe and happy in the workplace.

We expect our staff to work to these values in the delivery of high-quality patient care:

- Bold – We are inspiring and ambitious
- Every Person Counts – We are respectful and supportive
- Sharing and Open – We are open and speak up
- Together – We are inclusive and responsible

Our vision for the Trust is to develop an open culture and make Freedom to Speak Up business as usual. This in turn, supports our Clinical Strategy in making Medway an employer of choice, supporting the wellbeing of every member of staff and ensuring the best possible care, experience and clinical outcomes for our patients. The role of the Freedom to Speak Up Guardian is to ensure all methods of speaking up are promoted and training is provided ensuring we learn and improve from patient and staff safety concerns.

5. Culture

One of the most important factors in providing an open and transparent culture, an organisation that learns, and has patients at the heart of everything we do – is for speaking up to be everyone's business and to be normalised and embedded into our day to day working lives. We are committed to the development of positive organisational culture, which we drive through our People Strategic Initiative.

This transformational change programme will be supported by the following objectives:

1. Creating a culture where everyone feels safe to speak up and confident that concerns are appropriately addressed with the strictest confidentiality, where appropriate.
2. Enabling our leaders to be responsive to concerns raised with them.
3. Transparency and sharing any learning from concerns raised, to ensure that speaking up makes a difference.

Transforming our culture is something the Trust is passionate about to ensure each and every one of us feels safe, supported, and able to thrive. Independent experts Absolute Diversity are working with us to understand what needs to change and identify the way forward by looking at how we can improve our equality, diversity and inclusion and violence and aggression against staff.

6. Our Strategy

To deliver our strategic objectives, we will:

Embed the new Guardian Service to ensure it is accessible for all members of staff and that it operates effectively within the Trust's structures.

- Support the roll out of the Guardian Service through a structured communications plan to the organisation ensuring speaking up routes are clear and accessible.
- Embed the new Lead Guardian into the Trust's structures to ensure effective relationships and reporting mechanisms are established.

We will measure this:

- Number of concerns raised by staff to the new FTSU Guardian;
- Through the annual staff survey questions:
  - "I would feel secure raising concerns about unsafe clinical practice";
  - "I feel safe to speak up about anything that concerns me in this organisation".
- The same questions as above using the breakdown of protected characteristics, including ethnicity.
- Any associated people pulse survey questions

Engage with managers to demonstrate how a speaking up culture can improve their services and the quality of patient outcomes and experience:

- We will engage with managers to demonstrate how a speaking up culture can improve their services, the quality of patient outcomes and improve staff engagement, as measured by the national Staff Survey engagement rate. Leaders will be able to access this information through a dedicated dashboard.
- We will equip leaders with skills and competencies to enable them to build psychological safety within their teams and to understand impact of their management style on the team's culture.

We will evidence and measure this through:

- Board papers and FTSU bulletins (quarterly);
- All leaders complete e-learning NGO 'Listen up' training.

Ensure our people understand their obligations as advocated by Freedom to Speak Up and how it can improve outcomes:

- We will ensure that the revised Values and Behaviours Framework outlines our expectations and changes the perception of speaking up, which should be perceived as positive and desired behaviour.
- We will continue to embed Patient First methodology to the teams, which introduces mechanisms for staff feedback to be embedded in day-to-day conversations.
- Our revised Rewards and Recognition Framework will outline Trust's approach to rewarding positive staff behaviours.

Ensure managers understand their roles and responsibilities when handling concerns, are skilled to do so, and are supported effectively:

- We will ensure managers understand their roles and responsibilities when handling concerns, are skilled to do so, and are supported effectively by providing mandatory training on leadership skills. These skills will include coaching, courageous conversations, people management and NGO 'Listen Up' training.
- We will ensure managers understand principles of psychological safety and are able to link their competencies with staff engagement levels. Safety to speak up and raise concerns is identified as one of the key drivers of staff engagement, as measured through the national Staff Survey engagement rate.

We will measure this through the annual staff survey questions:

  - Overall staff engagement rate;
  - "My immediate manager cares about my concerns";

Demonstrate to the organisation where concerns raised have led to positive and embedded changes:

- We will do this through our communications plan to ensure outcomes are communicated and how the teams have taken responsibility for ensuring new processes become embedded and the effect this has had on the culture of the team. This information will be made accessible to all members of staff on the Trust's 'You said, we did' intranet page.
- We will ensure that the Board reports for Freedom to Speak Up reflect the themes of cases, what lessons have been learnt and how this has been adapted for Trust-wide learning.

We will measure this

  - Formal Lead Guardian's report to the People Committee thematic analysis and lessons learnt report.

7. Metrics and Key Performance Indicators

The Trust provides quarterly reporting to Trust committees and the NGO which monitors themes of cases, lessons learnt and how we have adapted for Trust-wide learning.

The Trust proposes to use the following measures to provide assurance incorporated into quarterly reporting:

- Number of speak up cases
- Types of issues (details on the nature of the concerns raised, such as patient safety, worker safety, bullying, harassment and other inappropriate behaviours)

- Outcomes and actions
- Detriment reports (instances where individuals who spoke up experienced any form of detriment as a result)
- Training and support (data on the training and support provided to FTSU Guardians and the effectiveness of the measures)
- Guardian user feedback
- Exit interviews

With the launch of the new Guardian Service and the strategic focus on improving perception of speaking up as a desired and rewarded behaviour, coupled with a new approach to communicating learning and improvements made by the Trust based on the feedback received from staff, we are likely to see an increased volume of cases recorded this year.

8. Key Roles and Responsibilities

Chief Executive

Responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that arrangements meet the needs of the Trust. The Chief Executive role models high standards of conduct and is responsible for ensuring the annual report contains relevant information and engaging with both the regional FTSU Guardian network and the NGO.

Chief People Officer

Provides assurance and role models high standards of conduct around FTSU ensuring the Trust is aware of the latest guidance from the NGO. The Chief People Officer is responsible for overseeing and providing assurance of the FTSU vision, strategy and process through the People Committee, ensuring cases are highlighted to the relevant committee as recommended by the Freedom to Speak Up Guardian.

The Guardian Service (Including the Lead Freedom to Speak Up Guardian)

The FTSU Service is managed by an external provider 'The Guardian Service' which is available 24-hours a day, seven days a week where the Guardian listens and supports staff to decide on a course of action. The Guardian also risk assesses issues raised by staff and ensures that concerns are escalated appropriately. Staff are able to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment and work grievances in a non-judgmental environment. The Guardian Service will regularly report into the Trust's Board and the NGO providing assurance on delivery of the service and the Strategy. Our dedicated FTSU Guardian can be contacted at contact@theguardianservice.co.uk.

Non-Executive Director (NED) with responsibility for Freedom to Speak Up/Whistleblowing

The NED is predominantly a support for the FTSU guardian; a fresh pair of eyes to ensure that investigations are conducted with rigor and to help escalate issues. The NED has an in-depth knowledge of the FTSU process and is readily able to articulate why a healthy speaking up culture is vital and understands the support needed for speaking up and the red flags that may trigger a concern. The NED is there to challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy and effective speaking up culture.

9. Conclusion

When things go wrong, it is important that as an organisation we learn lessons and make improvements to prevent potential harm and establish effective patient safety culture.

The Trust aims to create a positive culture where staff know how to speak up and to whom and ensure that whichever part of the organisation you work from, regardless of role, minority ethnic background or disability you feel able to share those concerns.

As an organisation we recognise the areas and processes that need to improve in order for our vision to become a reality. Our Freedom to Speak Up Strategy has been refreshed to ensure we continue to deliver on this vision for all staff members to feel safe and confident to speak up and highlights the initiatives and measurements we have adopted in order to do so.

10. References

Trust Associated Documents
Patient First Strategy
Clinical Strategy
People Strategy
People Strategic Initiative
Quality Strategy
National Guardian Office
National Speak Up Policy
Freedom to Speak Up Policy
NHS People Promise

END OF DOCUMENT

Meeting of Trust Board in Public
Wednesday, 15 January 2025

Title of Report	Maternity Bi-Annual Workforce Report	**Agenda Item**	6.4
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Sarah Vaux, Chief Nursing Office (Interim)		
Executive Summary	• CNST Year 6 continues the requirement for a bi-annual maternity/midwifery workforce paper to be presented to the Board. • The aim of this report is to provide assurance to the Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels • This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags • The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in January and July 2024. • Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. • A table top birth-rate plus review was completed and reported to MNSCAG December 2024. No additional staffing required, on the basis of this assessment, due to low variance of -0.28wte. Report forwarded to Deputy Chief Nursing Officer for inclusion in the Trust-wide safer staffing report. • Monthly monitoring of workforce embedded into practice • New starter/preceptorship package is now in place • HEE funded Staff Nurse 18-month conversion course in place • Current vacancy of 19.88wte (November 2024) Band 5/6 Midwives • The maternity service currently has a 22% uplift to cover sick leave, annual leave and mandatory training. • In view of the additional training requirements within maternity including Labour Ward Coordinator training and additional requirements in the core competency framework v2, CNST and 3 Year delivery plan an uplift of 25% should be considered for future workforce reviews and planning. A project initiation document will be prepared in 2025 to request Trust support for this. • Incentivise return to work for midwives choosing to retire with flexible working and exemption from clinical on call rota. • Focused work being undertaken to support staff with sickness absence for anxiety and stress. • Midwifery retirement 5year trajectory - 46.45wte currently aged between 51- and 70 who may plan to retire. • Improvement in understanding reasons for staff absence, with “Unknown” reduced from third highest reason to lowest reason due to work of senior sisters and matrons in recording absence data. • The issue previously known as risk ID1133 in relation to midwifery staffing has been altered from a risk (score 15) to an issue (scoring 4) without care group consultation/Divisional understanding of the proposed changes to the risk register. This has been escalated through the Division to Executives.		

	• The Delivery Suite acuity tool data shows that unit was adequately staffed 61%, which is an improvement on April 2023 to March 2024 which showed 53%. • The unit recorded negative acuity 39% of the time (down from 47% of the time). With 5% of the time being 2 or more MW's short (down from 9%)
Proposal and/or key recommendation:	For assurance

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

Committee/Group submitted: Date of Submission:	• Maternity and Neonatal Safety Champion Assurance Group – 13.12.24 • QAC – 09.01.25 (noted as Appendix within MNSCAG Assurance and Escalation report)

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:	Maternity Bi-Annual Workforce Report
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:	Assurance	X	Assurance minor improvements needed.

Meeting of Trust Board in Public
Wednesday, 15 January 2025

Title of Report	CNST Compliance Report - October 2024	**Agenda Item**	6.4
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery Ellen Salmon, Maternity CNST and Compliance Manager		
Lead Executive Director	Sarah Vaux, Chief Nursing Officer (Interim)		
Executive Summary	• CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025 • Maternity Service declaring full compliance with all 10 Safety Actions, including previously off track Safety Action 8. • All local and external reporting deadlines and targets met. • All training targets met with >90% for all staff groups. • 1 Action plan in place for Neonatal Nursing staff, presented and approved by Trust Board in September 2024, allowing us to declare compliance. • All evidence available on shared drive and itemised list in appendix 1 to this report. • K&M LMNS requested escalation to each Trust Board for MNVP service provision: "*At this time the ICB are unable to provide adequate MNVP Lead time to enable MNVP attendance as a quorate member at the required Trust assurance and Governance meetings as set out in year 6 CNST guidance. It had been agreed at LMNS board in July 2024 that a 0.5 band 7 MNVP system level governance lead would be recruited to fulfil this obligation. The role has been advertised, interviewed for and a suitable candidate has been identified. However, due to the recent financial restrictions placed on the ICB the role is awaiting executive sign off by Paul Bentley, ICB CEO. All risks with not providing this much necessary resource to the MNVP have been clearly communicated throughout the LMNS and ICB and we continue to champion the need for this role.*" • LMNS CNST peer review assurance visit completed 3 December 2024. • CNST compliance report presented to MNSCAG 13 December 2024 • QAC – 9 January 2025 – noted as Appendix within MNSCAG Assurance and Escalation report • Following approval at Trust Board 15 January 2025, DOM will ask Trust and ICB CEO to sign the declaration form that MFT are wishing to declare compliance to the CNST 10 safety standards. • CEO signed declaration form to be submitted to NHSR by 28 February 2025.		
Proposal and/or key recommendation:	For Trust Board to approve MFT maternity services declaring compliance to NHSR for all 10 safety standards		

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

Committee/Group submitted: **Date of Submission:**	• Maternity and Neonatal Safety Champion Assurance Group – 13.12.24 • QAC – 09.01.25 (noted as Appendix within MNSCAG Assurance and Escalation report)				
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:	Maternity CNST Compliance Report CNST Year 6 Evidence List				
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.		