Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 12 March 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 15 January 2025	Chair	3	12:35	Approve
2.2	Action Log		11		Note
3.	**Opening Matters**				
3.1	Chief Executive Update a) CQC ED Report	Chief Executive	12 14	12:40	Note
3.2	Council of Governors Report	Lead Governor	Verbal	12:45	Assurance
	Board Story Presentation				
3.3	Experience of the late Lisa Scott and Breast Cancer Screening	Associate Director of Patient Experience	28	12:50	Note
4.	**Performance, Risk and Assurance**				
4.1	Risk and Issue Register and Board Assurance Framework	Company Secretary	36	13:10	Assurance
4.2	Integrated Quality Performance Report **APPENDIX 1**	Chief Delivery Officer	69	13:20	Assurance
5.	**Papers**				
5.1	Finance Report (Month 10) **APPENDIX 2**	Chief Financial Officer (Interim)	72	13:30	Note
5.2	Improving Financial Governance Tracker	Chief Delivery Officer	74	14:00	Note
	~ WELLBEING BREAK – 10 minutes ~				
5.3	Learning from Deaths – Quarterly Update **APPENDIX 3**	Chief Medical Director	90	14:20	Note
5.4	Maternity Services Reports: a) Perinatal Quality Surveillance and Leadership Culture	Director of Midwifery	94	14:30	Assurance

	b) Maternity; Claims, Incidents and Complaints Triangulation **APPENDIX 4A and 4B**		97		
5.5	Response to the David Fuller Case	Chief Medical Officer	100	14:40	Assurance
5.6	Safe Staffing	Chief Nursing Officer (Interim)	109	14:55	Assurance
6. Board Assurance Reports					
6.1	Quality Assurance Committee (Mar)	CNO/CMO/Committee Chair	118	15:05	Assurance
6.2	People Committee (Jan)	Chief People Officer, Committee Chair	122	15:10	Assurance
6.3	Finance, Planning and Performance Committee (Jan/Feb)	Chief Finance Officer, Committee Chair	126 129	15:15	Assurance
6.4	Strategy Road Map - Update	Director of Strategy and Partnerships	134	15:15	Approve
7. Closing Matters					
7.1	Questions from the Council of Governors and Public	Chair	Verbal	15:25	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, 14 May 2025				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the Trust Board Meeting in Public

Wednesday, 15 January 2025 13:00 – 15:00

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

Gundulph Boardroom and via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust Chair
	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
	Nick Sinclair	Chief Operating Officer
	Sarah Vaux	Chief Nursing Officer (Interim)
	Simon Wombwell	Chief Financial Officer (Interim)
Attendees:	Alana Marie Almond	Deputy Company Secretary (Minutes)
	Alannah Jefferies	Radiographer (Item 3.3)
	Ali Herron	Director of Midwifery (Item 6.4)
	Anan Shetty	Governor
	David Brake	Lead Governor
	Glynis Alexander	Director of Communications and Engagement.
	Hari Aggarwal	Governor
	Ian Frankcom	Chugai Pharma UK Ltd, Health Solutions Partner
	Jane Perry	Academic Non-Executive Director
	Jignesh Patel	Governor
	Joy Onuoha	Governor
	Karen Fegan	Governor
	Lorna Gibson	Director of NHSE
	Matt Capper	Director of Strategy and Partnership/Company Secretary

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	Natasha Turner	Governor
	Nikki Lewis	Associate Director of Patient Experience (Item 3.3)
	Paul Stephens	Member of the Public
	Tess Fenn	Governor
Apologies:	Mojgan Sani	Non-Executive Director
	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.

Chair noted to the Board; a special mention for Simon Wombwell who started as the Trust's interim Chief Financial Officer on and Lorna Gibson who has joined the Trust as Director of Efficiency, Productivity and Development.

Chair welcomed colleagues presenting the Patient Story on the subject of breastfeeding, and thank you to Radiographer and patient Alannah Jefferies who has been willing to share her experience with the Board.

Chair thanked colleagues across the hospital who cared for patients over the Christmas and New Year period.

The Emergency Department has been under significant pressure, partly due to the high number of patients attending with respiratory illnesses, especially flu.

The final thought, which is really important, is the sad news in regard to the stabbing that happened last Saturday in Royal Oldham Hospital of the nurse. Violence and aggression in the NHS is a major issue and it is a challenge for the Trust. To remind everyone that in the Trust's Cultural Transformation Programme, there are two priorities; violence and aggression and ensuring that colleagues feel there is equity across the entire organisation. Listening events have commenced and the Trust are looking for 800 staff to join.

1.2 Quorum

The meeting was confirmed as quorate.

1.3 Declarations of Interest

Chair informed the Board that he will continue to be an Advisor to Medinet UK Clinical Services for another year. There are no contracts within Kent and Medway.

There were no further declarations of interest.

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

2.1 The minutes of the meeting held on 13 November 2024 were **APPROVED** as a true and accurate record.

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 for noting, highlighting the following key points:

1) Addressing Winter Pressures
2) New Diagnostic centre opening in Sheppey
3) Extending the benefits of robotic assisted surgery
4) Day surgery improvements
5) Medway clinicians take on national leadership roles
6) Staff recognised for doctor training in national awards
7) Changes to patient and visitor parking
8) Review praises Veteran Aware progress
9) Manager saves co-worker's life from meningitis

The Board **NOTED** the update.

3.2 Council of Governors Report

David Brake had no update from the last meeting.

[Post meeting note: Alana Almond agreed with Adrian Billington to designate an IT Support Desk contact (Richard Lowrey) who would be available for direct contact for the Governors and Non-Executive Directors to address any IT issues]

The Board **NOTED** the update

Board Story Presentation

3.3 Breast Feeding Story

Nikki Lewis introduced Alannah Jefferies to the board to present the staff story.

Check and Challenge

a) Jayne and Jenny – related to the story as mothers and thanked Alannah for raising the issue and informing Board. Jayne thanked the team for picking this up and making the improvements for all.
b) Sarah – this work will also benefit patients. The message is that 'Medway is a breastfeeding friendly hospital'.
c) Chair – gave thanks for the work and improvements for staff and patients to breastfeed safely. The Board thanked Alannah for her presentation.

4. Performance, Risk and Assurance

4.1 Trust Risk and Issues Register

Matt Capper presented the report accurate as of 03 January 2025, data in the report has changed since submission. 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.

Check and Challenge

a) Gary – Page 36 – the risk description needs some clarity, the risk title, description and rating needs some work. Matt – agreed, there will be risk training to support staff better in the logging.

b) Jenny – in regard to the cyber risk; this was previously was certified but is not currently, how did the Trust relapse and how do we get recertified? Matt – will take this away for discussion, updating and actions to be added.
c) Jenny – in regard to Metavision in critical care, this has not worked since January 2020, is this now an issue not a risk? What is stopping the Trust updating to Metavision 6 and why does it not have a backup? Nick – these risks will be taken to his team on Thursday (16.01.25), if there is a failure of the first backup, there is an independent backup. Gavin – there is a business case in development. Jenny – with this in mind, February 2025 is not a realistic closure date. Nick – agreed, will change.
d) Chair – some of the issues do not have actions? Matt – actions will be added.
e) Chair – Issue No. 2109; Mortuary – the mitigation is to have hired 80 spaces of a cold room unit; did it arrive and will this be sufficient throughout winter? Are there GEMBA visits to the Mortuary? Is there a response to the Fuller Report? Alison – yes Jayne and Alison have attended GEMBA to the Mortuary. The Cold Room did arrive and additional permanent capacity is being considered. Alison confirmed a response to the Fuller Report would be developed.
ACTION NO: TB/2024/009 – response to the Fuller report to go to Quality Assurance Committee then to Board.
f) Chair – Pathology results; what level of issue is it in terms of patient safety, as it is listed as a significant issue? Alison – will need to discuss this outside of the meeting and there may be a residual risk to be added to the Risk Register. Matt – agreed will review with Alison.

The Board were **ASSURED** by the report

4.2 Board Assurance Framework (BAF)
Matt Capper presented the report for assurance and noting.

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

4.3 Integrated Quality Performance Report (IQPR)
Gavin MacDonald presented the report for assurance and noting.

Check and Challenge

a) Jenny – in regard to operations cancelled by hospital on the day, is this quite typical as the numbers have not gone down? Gavin – these are non-clinical cancellations. Nick – will look into this and how the Trust compares to other organisations.
b) Annyes – asked Alison to detail latest actions on Summary Hospital-level Mortality Indicator (SHMI) rate as it is not improving? Alison – gave the Board assurance on a number of actions progressing in addition to the areas of focus being patients admitted across the emergency pathway, as the Trust is an outlier. Understanding respiratory deaths and patient care, has been delayed due to the flu numbers. The Learning from Deaths process, the new Structured Judgement Review (SJR) is now in place.
c) Annyes – when will work be completed for respiratory? Alison – by end of March 2025.
d) Chair – raised the fact that there is a large number of abbreviations in the report and detailed these.
e) Annyes – Page 30 - 62 weeks cancer waiting time – is there an action point around this? Nick – will investigate this further.

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

5 Board Assurance Reports

5.1 Quality Assurance Committee (QAC)

Alison Davis and Sarah Vaux presented the report for assurance.

Check and Challenge

a) Chair – at the QAC meeting there was an important discussion around 12 hour harm review. BAF 14 – impact of OPAL4, this talks about the impact of pressures in terms of emergency care and business continuity, that is a risk in terms of lack of patient flow. There is a second risk relating to this, which is; potential risk of harm to patients, which should be on corporate risk register. Matt - agreed.

The Board were **ASSURED** by the report

5.2 People Committee

Leon Hinton and Jenny Chong presented the report for assurance.

Check and Challenge

a) Chair – in regard to the healthcare worker vaccination campaign; what is the current uptake on flu vaccination? Leon – the Trust did not hit the target of 65%; Flu was 36%, Covid was 11%. The team are looking at ways to improve the uptake. Chair – the Trust needs to do everything it can before next October to improve these numbers. Sarah – need to do this with the System and work a combined programme. Chair asked for the level of risk to be reviewed. Matt – agreed.
b) Chair – when can the Board see Staff Survey results. Leon – will confirm either March or April 2025 for Board following submission to People Committee. Noted on the Board future planning.

The Board were **ASSURED** by the report

5.3 Finance, Planning and Performance Committee

Simon Wombwell and Gary Lupton presented the report for assurance.

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

~ The Board took a 10 Minute Wellbeing Break ~

6 Board Papers

6.1 Finance Report (Month 8)

Simon Wombwell presented the report, with the following items to note:

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.

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Check and Challenge

a) Jayne – this is not the position the Trust wants to be in, the Executives have been reviewing grip and control and reducing expenditure. The Trust has opened escalation areas and is progressing work with the System to reduce the deficit. There is work on business planning and lessons learnt on why the forecast is out.
b) Chair – it is a very serious position that the Trust is in. Discussion will continue on the current position at FPPC on 30 January 2025. Accounts will be closed at March Board.

The Board **NOTED** the report.

6.2 RSP, Financial Recovery and Integrated Improvement Plans Update

Gavin MacDonald presented the report for noting. The 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.

Following the oversight meeting in December 2024 with NHS England and the ICB 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. by circa £6m and is the third month of deterioration with four criteria turning red as a result. The Trust is working towards an exit date of March 2026.

Check and Challenge

a) Chair – when will the Board review the refreshed Plan? Jayne – date for submission to Board will follow the Oversight meeting.
ACTION NO: TB/2024/010 - confirm when the Board should expect to see the refreshed plan.

The Board **NOTED** the update.

6.3 Strategy: Freedom to Speak Up

Leon Hinton presented the strategy to the Board. 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 the Trust will deliver its vision for all staff members to feel safe and confident to speak up.

Check and Challenge

a) Jayne – really pleased as this is a fundamental step forward and goes in line with the Trust's Cultural Transformation Programme and for colleagues feeling like they can speak up. It is really important to ensure psychological safety for all.
b) Chair – suggested Leon speak to two other organisations who are using an external FTSU service for peer review/comparison.
c) Chair – in regard to the 20 Dignity Advisors; do they feel valued and does the Trust see value from them? Leon – will take this away.
d) Chair – add this to the Council of Governors meeting. [*Post meeting note: Added to the Council meeting on 20 February 2025.*]

The Board **APPROVED** the Strategy.

6.4 Maternity Services Report

6.4a Maternity Workforce Oversight Report

Alison Herron presented the report for assurance. The paper was taken as read.

Check and Challenge

a) Chair – Jayne – thanked Alison and the entire team for their work, as the Trust continues to see the improvements. Asked Alison to take back the thanks to the team, well done.
b) Chair – added that the report and work is excellent and something to be proud of.

The Board were **ASSURED** by the report

6.4b Maternity CNST Compliance Assurance Report – Updates and Actions

Alison Herron presented the report for assurance. The paper was taken as read.

Check and Challenge

a) Alison – asked if all necessary training is complete. Ali – yes, all staff are fully trained and compliant.
b) Chair – asked for confirmation that the Trust is compliant with the 10 safety standards? Ali – yes and the Trust are to expect a rebate in 2025 as long as the submission is received well.

The Board were **ASSURED** by the report and **APPROVED** for the Trust to submit its declaration of being compliant.

7 Closing Matters

7.1 Questions from the Council of Governors and Public

The following questions were received in advance of the Board meeting from Paul Riley, Public Governor:

1) what are current waiting times to see Cardiology team via an urgent referral from GP?
2) what plans are in place to improve current waiting lists in Cardiology?
3) how accurate are the waiting times data via the NHS app when a patient has to choose a hospital for treatment?
4) how does the Trust ensure that data accuracy and quality is maintained to allow patients to make an informed decision on their care?

ACTION NO: TB/2024/011 – Question submitted by: Paul Riley, Governor. Added to the Board Action Log and delegated to Nick Sinclair and Sarah Vaux for a response.

The following questions were raised and answered at the Board meeting, from Paul Stephens, Member of the General Public. In regard to the Morgue facilities Mr. Stephens had a personal experience at the Trust when his mother passed away and his sister where unable to view following her death.

5) Is there access for family to visit the additional capacity temporary units? Alison – yes, she would double check on the opening times. Out of normal working hours it may be difficult for family to gain access but with some planning it may be possible. Alison apologised sincerely for his loss, the negative experience Mr. Stephens family had and for any upset it caused.

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6) Is there sufficient restrictions on who can access and security on the temporary facilities such as CCTV? Alison – gave significant assurance that the Trust take the security of the Mortuary incredibly seriously. There are appropriate levels of security access which are monitored. In addition to monthly reports submitted to the Human Tissue Authority Committee (HTAC), chaired by Alison. As the designated individual she is assured that the Trust has appropriate measures in place. There is CCTV in location. If there was anything else the Trust needs to do to ensure that its standards go above and beyond, this is addressed at the HTAC. An update on the Trust's response to the Fuller Report will come back to the Board in the coming months. Chair – added his condolences and apologised for the negative experience.
7) Asked what the Trust are doing in regard to the protection of data, data accuracy and data coding of that data. Gavin – there has been more work in the last year around data quality, improvements in capture and coding. The Trust are in process of a 'go live' with new software product within the Coding team, which will enhance this. In addition to this the Trust have commissioned an external review on all of this to ensure that the Trust is doing absolutely everything it can to make sure that its data quality is the best it can be.

7.2 Escalations to the Council of Governors

Freedom to Speak Up Strategy
Financial position; Finance Report
Refreshed Integrated Improvement Plan
CNST Submission

7.3 Any Other Business

There were no matters of any other business.

7.4 Reflection

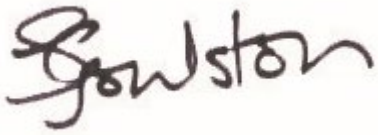
There were no reflections to note.

7.5 Date of next meeting

Wednesday, 12 March 2025

The meeting closed at 14:40

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Wednesday, 15 January 2025



Signed by the Chair …… Date: Wednesday, 12 March 2025

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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
15.01.25	**TB/2024/009**	**ACTION FOR QUALITY ASSURANCE COMMITTEE - Trust Risk and Issues Register:** Response to the Fuller report to go to Quality Assurance Committee then to Board.	12.03.25	Alison Davis, Chief Medical Officer	**PROPOSE TO CLOSE** - 16.01.25 - delegated to QAC Committee Chair and Executive Leads - on QAC agenda for March 2025	Green
15.01.25	**TB/2024/010**	**Recovery Support Programme:** Integrated Improvement Plans Update: Confirm when the Board should expect to see the refreshed plan.	12.03.25	Gavin MacDonald, Chief Delivery Officer	**PROPOSE TO CLOSE** - Finance Action Tracker has been produced and is being monitored. Business Plan for 2025/26 on the agenda for May 2025 following submission through Executive Team and FPPC	Green
15.01.25	**TB/2024/011**	**Questions from Paul Riley, Governor:** 1. what are current waiting times to see Cardiology team via an urgent referral from GP? 2. what plans are in place to improve current waiting lists in Cardiology? 3. how accurate are the waiting times data via the NHS app when a patient has to choose a hospital for treatment? 4. how does the Trust ensure that data accuracy and quality is maintained to allow patients to make an informed decision on their care?	24.01.25	Nick Sinclair, Chief Operating Officer Sarah Vaux, Chief Nursing Officer	**PROPOSE TO CLOSE** - answers provided directly to Paul Riley and report submitted to February Council of Governors to update. Governor Engagement Officer (Kim Willsea) is the main point of contact for coordinating Governor enquiries.	Green

Chief Executive's report: March 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.

Emergency care update

After a few months of more challenged emergency performance, where our four-hour performance dipped below the 78 per cent target (74 per cent in December and 76 per cent in January), the trend has continued to improve in recent weeks, thanks to continued hard work by all staff involved. This is despite the significant and ongoing pressure on our services since the start of winter, with large numbers of high acuity patients attending the Emergency Department (ED).

We are working hard to address the often-long waits for patients to be admitted to a ward by improving our processes, such as completing electronic discharge notifications (EDNs) sooner, turning beds around more quickly, and better use of the discharge lounge. Also key here is our ongoing work with systems partners to ensure that the stubbornly high number of patients who no longer need to be in our hospital can continue their care in a more suitable setting sooner.

Improving access to diagnostics

I am pleased to report that we have seen a significant improvement in diagnostic waiting times in recent months. In January 82 per cent of patients had their test or scan within six weeks of referral, exceeding the 73 per cent target for the third consecutive month, and up from 56 per cent in December 2023. Key to this has been expanding our endoscopy capacity with a new mobile unit that opened on-site last autumn.

These improvements are further supported by the opening of the first phase of the Community Diagnostic Centre (CDC) at Sheppey Community Hospital, which saw a new CT scanner open before Christmas. We are also due to open a new CT scanner at Rochester's CDC soon. The second phase of the multi-million-pound investment in Sheppey's CDC will see patients accessing a new MRI scanner later in the spring, further extending the options for patients to access vital diagnostics closer to home.

National recognition for our Patient First improvement approach

I was delighted to welcome Dr Amar Shah, NHS England's National Clinical Director for Improvement, to Medway recently to demonstrate how we are using the Patient First improvement methodology to drive improvements in patient care.

Having spent time with colleagues in our Emergency Department, Specialist Medicine Division and Care Coordination Centre, I was especially pleased to receive these comments from him afterwards: "I think you should be hugely proud of the progress that you've made in embedding an improvement system with such structure, rigour and results, in such a short space of time. There is much for the rest of the country to learn from your work, and I'm sure there will be many others, like me, coming to visit and hear about your fantastic approach to improving care and outcomes for your local population."

Driving improvements in patient feedback

One Patient First 'Patients' priority has been to better listen to, and act on, patient feedback by increasing the number of people who respond to the Friends and Family Test (FFT) and have a positive experience of our care.

In January, 95 per cent of our inpatients who responded to the FFT had a positive experience of care, up from 65 per cent at the start of our Patient First improvement journey in July 2022. In the same month, 98 per cent of our maternity patients had a positive experience of care, up from 82 per cent in December 2023.

We closely monitor critical feedback, which has recently focussed on concerns about treatment, communication and waiting times, and agree actions to address these in our weekly Patient First improvement huddles. I am pleased to report that we have seen a significant improvement in positive feedback about staff which is fed back to teams.

Extending visiting hours

We have extended visiting hours to 8am to 8pm across most adult wards (previously 1pm to 8pm), to make it easier for families and visitors to spend time with loved ones and be more involved in their care. Flexible arrangements will continue in areas such as intensive care, maternity, children's wards, neonatal intensive care, and for patients receiving end of life care.

Additional vaccination support

We have been working with system partners to improve the uptake of winter vaccinations among staff and eligible patients and visitors, with a dedicated vaccination hub running on site since late January, alongside our ongoing staff vaccination clinics provided by Occupational Health colleagues. High levels of winter illness, including flu, have been a significant factor in driving high demand for our services since the start of the year. Vaccination rates are increasing as a result of this welcome extra capacity.

Leadership arrangements

I will be leaving Medway later this year to take up the role of Chief Executive of my local trust, East Sussex Healthcare NHS Trust. It has been a difficult decision to leave as I am very proud to lead this organisation and of the Patient First improvements that we are making. More detail about the next steps to find my replacement will follow soon. When the time comes, I will be handing over to very capable colleagues who are leading improvements from the frontline to the Board. In the meantime, I remain as determined as ever to lead this organisation to improve the experience of our patients.

Meeting of the Board in Public
Wednesday, 12 March 2025

Title of Report	Care Quality Commission (CQC) Report following inspection of the Emergency Department in February 2024	**Agenda Item**	3.1a
Author	Sarah Vaux, Chief Nursing Officer (Interim)		
Lead Executive Director	Sarah Vaux, Chief Nursing Officer (Interim)		
Executive Summary	On Wednesday 05 March 2025 the Care Quality Commission published its report following an inspection of our Emergency Department on 21 February 2024. Given that the publication is more than a year after the inspection, the CQC apologised for the length of time taken to publish the report, which was due to problems with systems and processes following changes at the CQC. Inspectors rated the services 'Good' for being Well-led, 'Requires Improvement' for being Effective, Responsive and Caring, and 'Inadequate' for safety. The service was rated 'Requires Improvement' overall. Following a previous inspection in 2022, it had been rated 'Good'. They commended the engagement and commented on the improvements that have begun. We will continue to engage with the CQC, the Integrated Care Board, and NHS England as we pursue further improvements. The report is published on the CQC's website.		
Proposal and/or key recommendation:	The board is asked to note the report.		

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

Governance Process: Committee/Group and Date of Submission/approval:	Not Applicable				
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) 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:	-				
Resource implications:	-				

Sustainability and /or Public and patient engagement considerations:	The Trust delivered a full communications plan to support the publication of the report, engaging with staff and key external stakeholders. We will continue to share the findings of the report, and the improvements achieved, through our communications channels.		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	-		
Appendices:	-		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Sarah Vaux Job Title: Chief Nursing Officer Email: sarah.vaux3@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

1. Summary and Background

The Care Quality Commission published a report on Wednesday 05 March 2025, following an unannounced inspection of the Emergency Department at Medway Maritime Hospital on 21 February 2024.

The CQC has apologised for the length of time taken to publish the report, which was due to problems with systems and processes following changes at the CQC.

Inspectors rated the services 'Good' for being Well-led, 'Requires Improvement' for being Effective, Responsive and Caring, and 'Inadequate' for safety. The service was rated 'Requires Improvement' overall. Following a previous inspection in 2022, it had been rated 'Good'.

Overall rating: Requires Improvement.

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Good

The report highlighted a number of areas for improvement. In its press release, the CQC noted that the Trust had engaged well with the CQC since the visit more than a year ago, and had taken steps to start addressing the issues highlighted.

2. Findings

No concerns were raised with the Trust by inspectors on the day of the visit. However, on 24 April 2024 a Section 29A Warning Notice of the Health and Social Care Act 2008 was issued, instructing significant improvements to be made in Urgent and Emergency Care by 28 June 2024.

Breaches were identified regarding Regulations 10,12,15,17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The Trust produced an action plan to address the concerns raised, and has engaged with the CQC, Integrated Care Board and NHS England over the past year to ensure improvements in these areas.

Within the inspection report, which was published on 05 March 2025, a number of areas were identified for improvement. These included:

- Does not ensure the **privacy, dignity and respect of patients in the ED**. Inspectors heard from people that some staff spoke to patients in a disrespectful manner
- Does not ensure patients who attend the emergency department and need admitting do not experience **long waits in the department** before admission to an inpatient bed
- Does not ensure all staff have **clear processes** to guide them to provide safe care and treatment to patients who are accommodated on non-designated care areas
- Does not ensure there are **sufficient numbers of suitably qualified nursing staff** to provide safe care and treatment to the number of patients within the department
- Does not ensure all **incidents** are reported and acted on
- Does not ensure **medicines** are managed well and patients receive their medicines on time.

While the report details examples where patients were let down, it also recognises that many patients '*had a good experience of the department with staff being compassionate and receiving care and treatment in a timely manner*.

Inspectors also praised a '*supportive culture at local level'* and recognised that *'staff were committed to providing care in challenging circumstances. Staff and leaders were proud that partnership working had reduced ambulance off-load times.'*

3. Oversight

- Initially fortnightly engagement meetings were requested by the Trust and held with the CQC. These are now monthly
- Weekly meeting of the Trust's leadership team
- Weekly task and finish group
- Fortnightly meetings with the Kent and Medway Integrated Care Board and NHS England
- Regular meetings of the Trust's Quality Assurance Committee
- Reporting to the Trust's Board.

4. Progress and Actions taken

An ED improvement plan had been developed by Trust Executives in November 2023, recognising the challenges the ED and whole organisation was facing at the time. This was later revised to take account of the concerns identified in the Warning Notice. The ED Improvement Action plan comprised 49 actions categorised under the following areas:

- Patient Care, Privacy, Dignity, and Respect
- Staff and Support
- Escalation process/Policies, Procedures and Protocols
- Patient Flow
- Medication Administration
- Risk Management.

To date 43 (88 per cent) actions are closed, with two on track and four complete and awaiting evidence approval.

	Total number of improvement actions	49
	Action not started/action overdue	0
	Action on track	2
	Action complete; awaiting evidence sign off from approval committee	4
	Action closed; evidence approved	43

5. Achievements to date

In the 13 months since the inspection the Trust has made significant number of improvements. These include:

- Focused teaching and support from falls team, tissue viability service, infection control team and patient experience lead provided to staff.
- Improvement huddles in ED, led by ED staff with improvement ideas and actions being owned by the department and its staff, have been embedded.
- Improved dietitian risk assessments and referrals are being made to the service.
- Patients have greater access to food and drink within the department.
- Patients have their hygiene needs addressed promptly and professionally and with dignity and respect – matrons' checks to provide assurance.
- ED information leaflet produced for patients to receive clearer information about help and support, what options are available to them and what they can do if they are unhappy with the care provided.
- Stock of pillows and blankets within the Emergency Department, which are available at all times.
- Safe Staffing reviews undertaken in April and October 2024 – recruitment of substantive nursing staff underway and additional matron posts developed.
- New acute medical model (right number of staff at the right time) embedded across the department.
- Coaching sessions and leadership development programme for Band 7 Lead Nurse Managers.
- Escalation process for raising any staffing concerns outside of formalised meetings embedded within the department.
- Effective and efficient orientation and induction for any staff allocated to support the ED.
- The Trust's Full Capacity Protocol revised and re-launched.
- Shortest ambulance handover times in England maintained.
- Designated cupboard in Area 3 and Resuscitation to be used for the storage of ward level medications.

The Care Group is continuing to work on ensuring that the actions are embedded and addressing any additional areas of improvement required.

It is important to note that overcrowding within an ED department, with patients waiting long periods for admission to beds, is symptomatic of system inability to move patients who are fit for discharge onto more suitable settings in a timely manner, with suitable support for their needs.

The Trust routinely has more than 120 patients waiting for an onward care destination, representing at least 20 per cent of its bed base.

6 Performance

Our ED continues to be very challenged, and it has been a difficult winter with high levels of flu, and patients with COVID-19 and other respiratory illnesses.

The improvements detailed in this report have helped us to better manage demand than in the past, and although performance is far from where we would want it to be, there are areas, such as ambulance handovers, where we are consistenly one of the best in the country.

Emergency Department four-hour performance:

February 2024	72 per cent (national target 76 per cent)
March 2024	77 per cent
April 2024	81 per cent (national target 78 per cent)
May 2024	78 per cent
June 2024	79 per cent
July 2024	79 per cent
August 2024	80 per cent
September 2024	78 per cent
October 2024	79 per cent
November 2024	77 per cent
December 2024	74 per cent
January 2025	76 per cent

Monthly emergency performance data is published on the NHS England website.

Emergency Department attendances:

Patient attendances at the Emergency Department continue to increase year on year:

- February 2023: 14,595 [521 emergency attendances per day]
- February 2024: 15,747 [562 emergency attendances per day]
- January 2025: 16,585 [592 emergency attendances per day]

Ambulance handovers

Ambulance handovers are consistently below the national average. Monthly data for average ambulance handovers is published on the NHS England website.

- January 2024: 14 minutes
- January 2025: 14 minutes

Patient feedback

The Friends and Family Test (FFT) provides patients with an opportunity to leave anonymous, honest feedback about the care and treatment either they or their friend or relative, or the person they care for, have received. Feedback is used to identify what is working well, what can be improved and how.

The feedback we are now receiving is much improved on 2023 and 2024. For January it was 74.6 per cent, a 10 per cent improvement since January 2024.

One of the reasons for the uannounced inspection in February 2024 was that they had been contacted by patients and staff with concerns about the care in ED caused by overcrowding. They have told us that they are not now having the same volume of issues raised.

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CQC report following ED inspection, February 2024

Patient FIRST

Section 29A Warning Notice issued 24 April 2024

1. Does not ensure the **privacy, dignity and respect of patients in the ED**. They heard from people that some staff spoke to patients in a disrespectful manner
2. Does not ensure patients who attend the emergency department and need admitting do not experience **long waits in the department** before admission to an inpatient bed
3. Does not ensure all staff have **clear processes** to guide them to provide safe care and treatment to patients who are accommodated on non-designated care areas
4. Does not ensure there are **sufficient numbers of suitably qualified nursing staff** to provided safe care and treatment to the number of patients within the department
5. Does not ensure all **incidents** are reported and acted on
6. Does not ensure **medicines** are managed well and patients receive their medicines on time

ED Improvement Action Plan

Medway NHS Foundation Trust

Key Messages:

- Development of the ED Improvement Action plan comprising of 49 actions
- Actions are categorised under the following areas:
  - Patient Care, Privacy, Dignity, and Respect
  - Staff and Support
  - Escalation process/Policies, procedures and Protocols
  - Patient Flow
  - Medication Administration
  - Risk Management
- 88% of actions closed or achieving and gathering evidence
- Additional actions have been developed following inspection report

	Total number of improvement actions	49
	Action not started/action overdue	0
	Action on track	2
	Action complete; awaiting evidence sign off from approval committee	4
	Action closed; evidence approved	43

Challenges:

- Maintaining Privacy and Dignity in crowded department
- Patients spending too long waiting for a bed
- Tracheostomy training for ED nursing staff
- Ensuring the right amount of seating is available in the department
- Audit results demonstrating improvements in sepsis and medicines management
- Digital solutions delayed by EPR change freeze

Oversight:

- Weekly executives meeting
- Weekly task and finish group
- Fortnightly ICB oversight meeting
- Monthly CQC engagement meeting
- Quality Assurance Committee

What we have achieved

- Focused teaching and support from falls team, tissue viability service, infection control team and patient experience lead provided to staff.
- Improvement Huddles in ED led by ED staff with improvement ideas and actions being owned by the department and its staff has been embedded
- Improved Dietitian risk assessments and referrals are being made to the service
- Patients have greater access to food and drink within the department
- Patients have their hygiene needs addressed promptly and professionally and with dignity and respect
- ED Information leaflet for patients to receive clearer information about help and support, what options are available to them and what they can do if they are unhappy with the care provide
- Stock of pillows and blankets within the emergency department which is available at all times
- Safe Staffing reviews undertaken in April and October
- New acute medical model (right number of staff at the right time) embedded across the department
- Coaching sessions and leadership development programme for Band 7 Lead Nurse Managers
- Escalation process for raising any staffing concerns outside of formalised meetings embedded within the department
- Effective and efficient orientation and induction for any staff allocated to support the ED
- Full Capacity Protocol revised
- Shortest ambulance handover times in England
- Designated cupboard in Area 3 and Resuscitation to be used for the storage of ward level medications.

Findings in the report

- Inspectors rated the services Good for being Well-led, Requires Improvement for being Effective, Responsive and Caring, and Inadequate for safety
- The service was rated Requires Improvement overall. It was previously rated Good
- The regulator's report finds that much of the care inspectors witnessed and heard about fell below the standard that patients should expect.

Overall rating: Requires Improvement.

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Good

Positive comments

- The report also recognises that many patients '*had a good experience of the department with staff being compassionate and receiving care and treatment in a timely manner*.'
- Inspectors praised a '*supportive culture at local level'*
- They recognised that *'staff were committed to providing care in challenging circumstances. Staff and leaders were proud that partnership working had reduced ambulance off-load times.'*

How progress is being monitored

- Initially fortnightly engagement meetings were held with the CQC at the request of the Trust Chief Executive. These are now monthly
- Weekly meeting of the Trust's leadership team
- Weekly task and finish group
- Fortnightly meetings with the Kent and Medway Integrated Care Board and NHS England
- Regular meetings of the Trust's Quality Assurance Committee
- Reporting to the Trust's Board.

Next steps

- It is important that we continue to focus on improving the experience for our patients – much has changed since the inspection and we are continuing to make progress
- We will continue to engage with the CQC, ICB and NHS England to demonstrate how we are improving care for patients
- We look forward to further visits from the CQC, when we will be keen to show them how much has changed.

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Story to Board

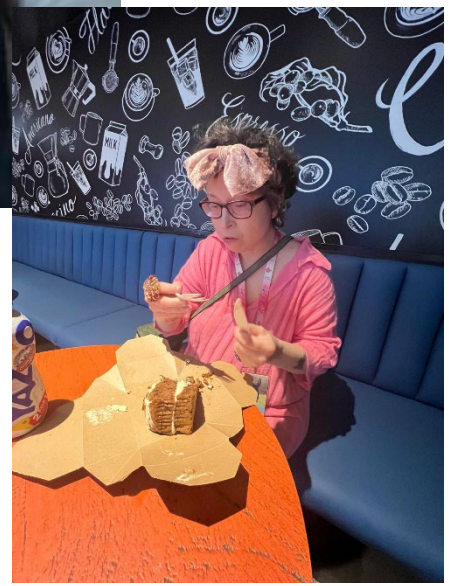
The experiences of the late Lisa Scott
Shared by Lorna Young

Nikki Lewis, Associate Director of Patient Experience

Patient FIRST

Lisa’s journey

- Lisa was a young 42-year-old who had a love for life, had a huge heart and a bigger smile
- Lisa loved her craft, music and dancing and was probably the biggest fan of the boy group ‘One Direction’. I think that most of the Medway Hospital staff are now quite well versed in their songs – including Dr Chu who lovingly added the songs to his playlist for Lisa on the days when he would see her.
- Lisa loved crafts and was always making little things for her friends, family and the staff at the hospital.
- …and she loved cake!!



Lisa's journey

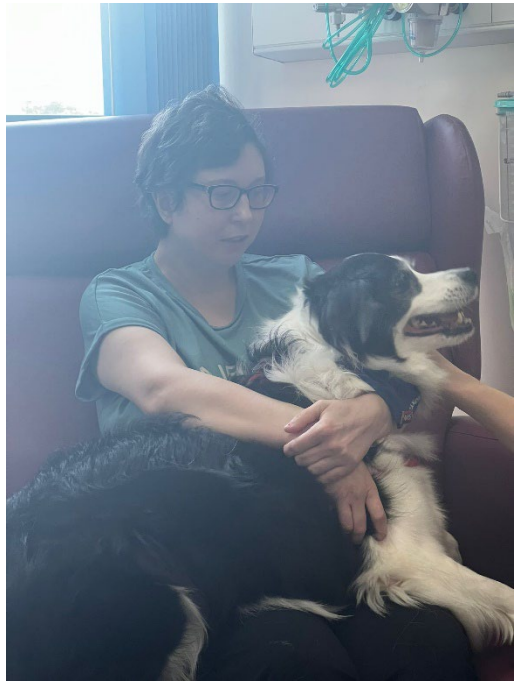
- Sadly Lisa was diagnosed with breast cancer in mid 2023

- With having a learning disability, Lisa feared coming into hospital. She had little understanding of the journey ahead of her but equally each trip, scan, blood test was a huge hurdle for her to deal with.

- Learning Disability (LD) Nurses first met Lisa at her Breast Clinic appointment following a GP referral. It was quickly established that Lisa had a love of the dogs – including Mabel, Fred and Jarvis – who supported her to theatre and appointments on many occasions.

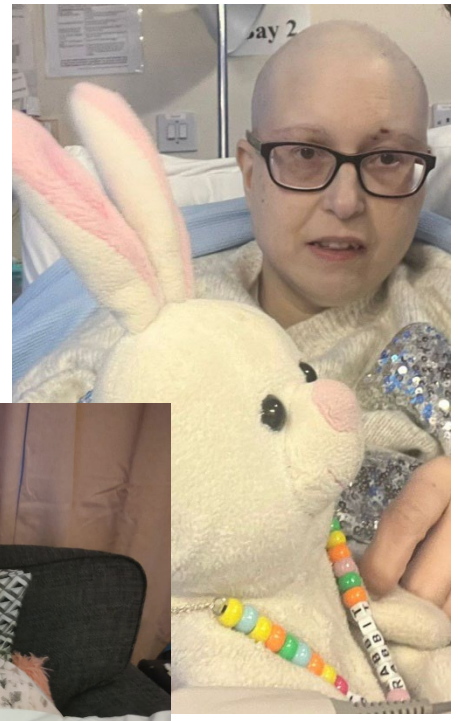
- The therapy dogs all played a huge part in getting her through her hospital journey as well as the LD team and the Trust volunteers.

- She loved the dogs and the dogs adored Lisa.



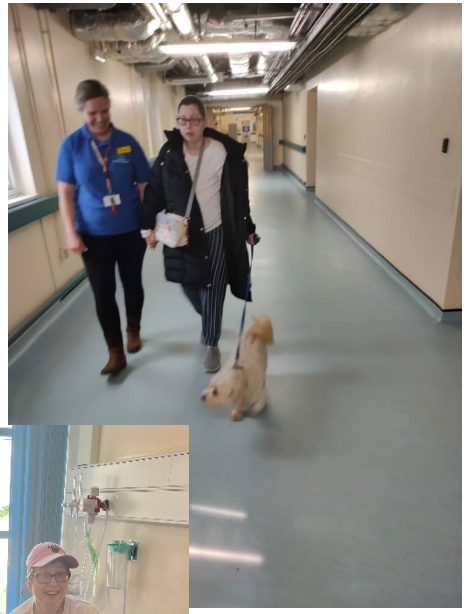
Lisa’s journey

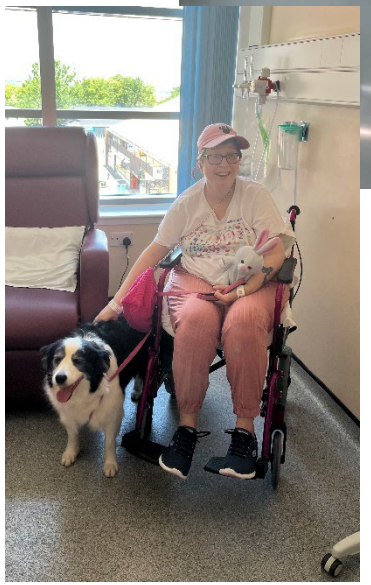
- Lisa was so brave throughout her entire journey, navigating aggressive breast cancer and the treatments she required along the way.
- Sadly, Lisa developed sepsis at the end of her life that required an admission to hospital.
- Lisa passed away peacefully on her birthday with the people she loved most by her side.



Lisa’s journey

- Lisa left a legacy to the Therapy dogs and Galton day unit for the wonderful care she received.
- Equally in her memory we are campaigning to reduce inequalities for people with learning disability to have earlier access to cancer screening.
- Ideally we would like to work with the Trust to make that happen.





Lisa’s legacy

NHS Medway NHS Foundation Trust

- Lisa’s story has highlighted a wider concern of how accessible screening is to people with learning disabilities and in particular who are under the screening age threshold.
- This has encouraged discussion around how we can develop a comprehensive and accessible cancer screening program specifically tailored for individuals with learning disabilities. This population often faces barriers to healthcare, including physical, sensory, and cognitive challenges that can hinder access to cancer screening services. This initiative will create an inclusive, easy-to-navigate process to ensure that people with learning disabilities receive timely cancer screenings and follow-up care.
- There is an abundance of resources available to support patients with learning disabilities but the need is to bring them together as part of a patients’ ‘all about me’ plan and a more enhanced pathway of care.

Lisa’s legacy – project objectives

- To increase cancer screening rates among individuals with learning disabilities.
- Create accessible screening material (written, visual and audio) tailored to different learning needs.
- Collaborate with healthcare providers and advocacy groups to ensure inclusivity and sensitivity in cancer screening processes.
- Reduce the healthcare disparities faced by individuals with learning disabilities.
- Establish ongoing support and follow-up system for patients.
- Evaluation that assesses the projects impact, identifies successes and suggest areas for improvement.
- This project is essential to ensure that people with learning disabilities are not excluded from life-saving cancer screening opportunities. By developing accessible screening programs and support systems, we will help reduce health disparities, improve outcomes, and ensure better quality of life for this underserved population.

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Trust Risk Register and Issues Log Summary Report

Report submitted 03 March 2025

Patient FIRST

Risk Summary

NHS Medway NHS Foundation Trust

The detail within this report is accurate as of 03 March 2025.

The Trust Risk Register has 68 approved risks in total of which, 6 are scoring 15 and above.

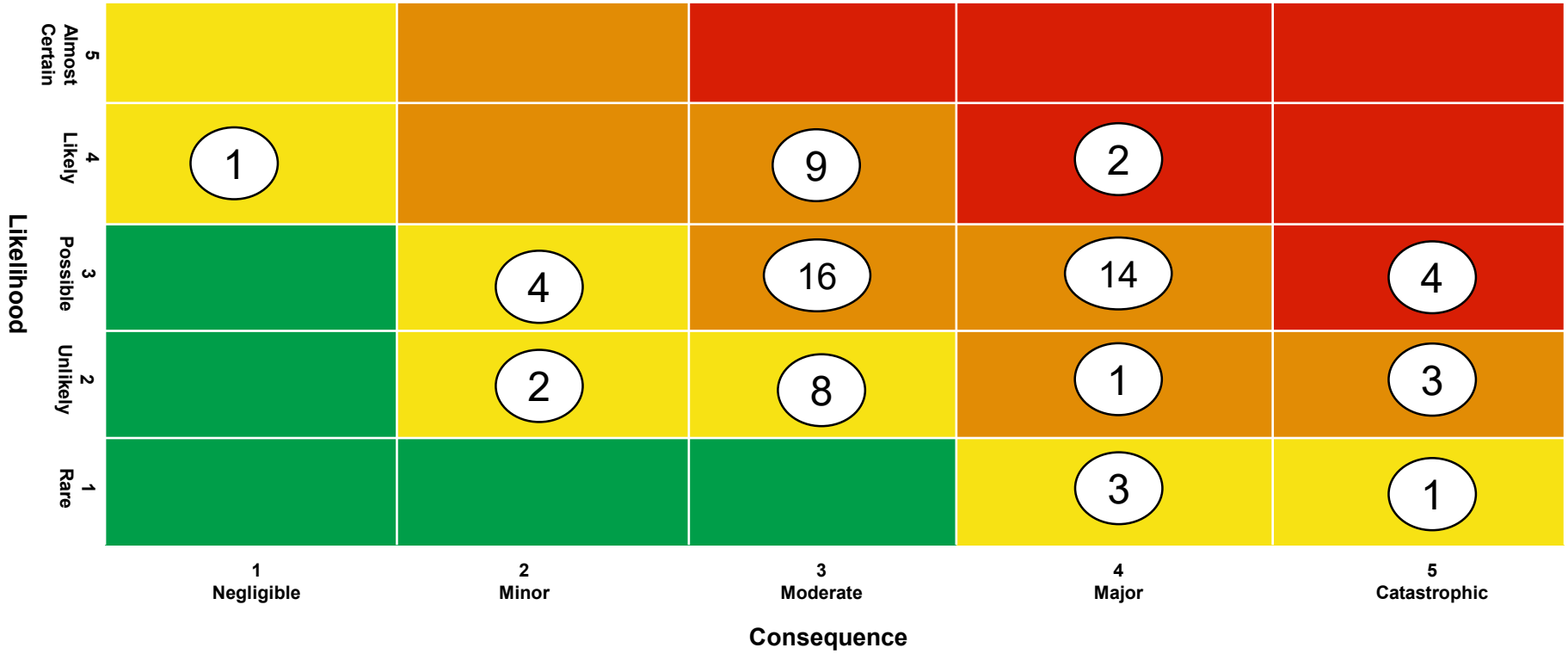
7 new risks were raised in February of which,
1 is awaiting review,
1 has been approved and,
5 are awaiting approval.

During the month of February,
5 risks were closed down,
8 risks have had the score reduced and
1 risk has had the score increased.
87% of approved risks have had no movement in the last month.
76% of the approved risks were reviewed within their timeframe (last month 86%),

A summary of ‘extreme’ risks is provided in slides 5 to 10, with those overdue for review highlighted accordingly.

Risk Register – Heat Map

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



Risks Scoring 15 and above:

Risk ID: 2158
Risk Title: Backlog Maintenance impacting on the infrastructure and clinical safety
Risk Owner: Paul Norman-Brown, Associate Director of Estates

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

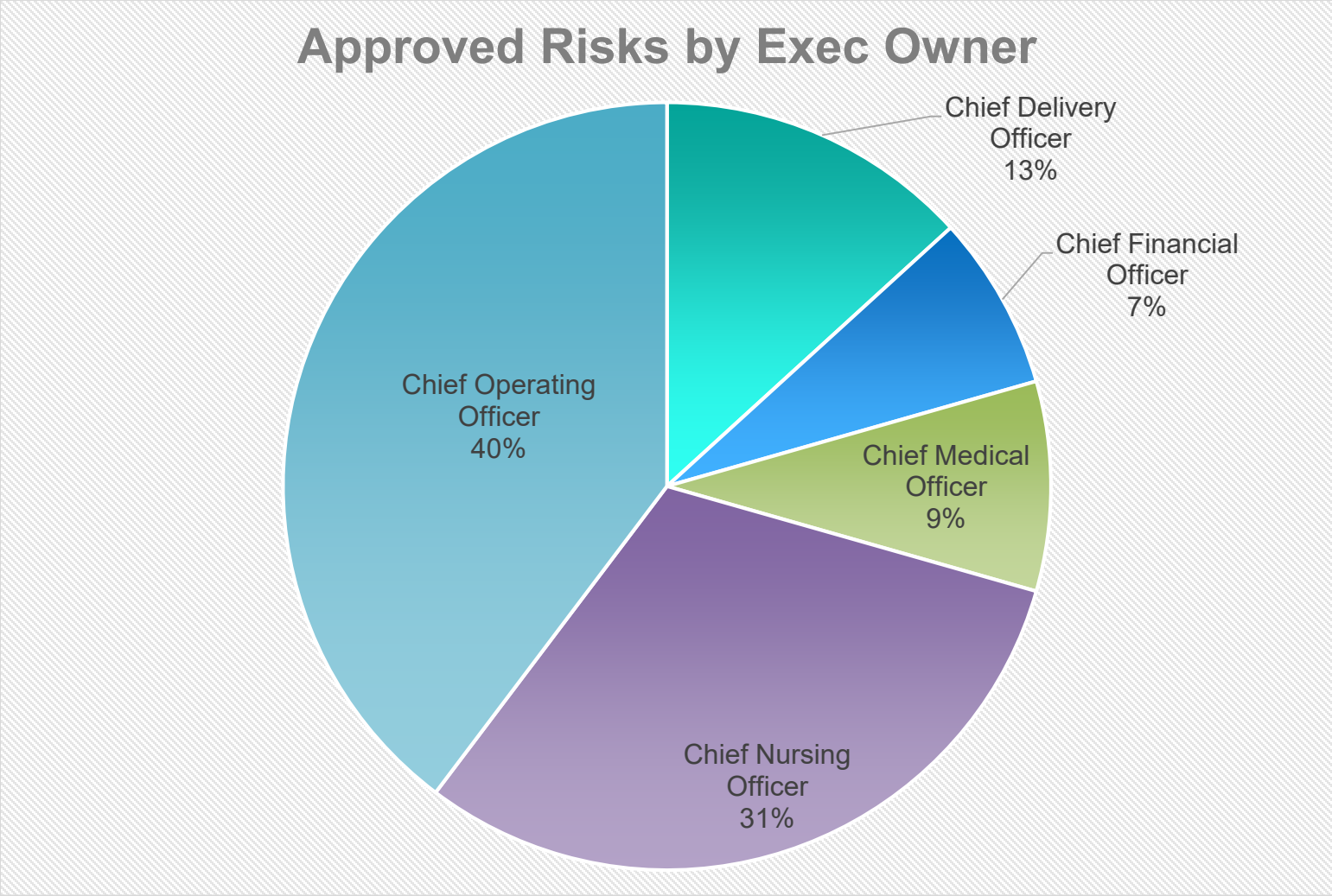
Risk ID: 2166
Risk Title: Non Compliance with HTM 05-01 Managing Healthcare Fire Safety
Risk Owner: Neil Adams, Deputy Director of Estates & Facilities

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, Head of IT

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

Risk ID: 2304
Risk Title: Ligature Risk in Paediatric Areas
Risk Owner: Amanda Russell, Head of Nursing

Risks by Executive



Extreme Risks by Executive

6 Risks scoring 15+

CDO	2 (33%)
CNO	1 (17%)
COO	3 (50%)

Chief Delivery Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Update Position	Current Score	Target Score	Target Date		Owner	Director
1965	14/02/2024	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.	1. NHSE Cyber Funding: The Trust has submitted bids to NHS England for investment into Cyber Assurance Dashboard renewal and the implementation of a Ransomware response software and MFA for domain admins and privileged accounts. 2. Cyber Security Strategy	1. 13 Feb 2025: The Trust has been awarded funding from NHSE. Orders have been raised for implementation prior to end of March 2025 2. The Director of IT is engaged with a 3rd party provider and the ICS to produce a first draft of a cyber security strategy for the Trust.	5 x 3 (15)	5 x 1 (5)		–	Craig Allen	Adrian Billington

Chief Delivery Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Update Position	Current Score	Target Score	Target Date		Owner	Director
2068	13/05/2024	31/05/2024	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 interopability 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. • Drug charts still being used in most areas. If unable to access the drug charts, a Blood Transfusion Integrated Care Pathway is available as an alternative which can be downloaded from the Intranet QPulse. • Covered in Blood Training • Key staff in ED are checking on duplications of patient allocations. • Patient ID checks being undertaken before medication.	1. Solution for ED EPR Bed Allocation. 2. Review Lack of Dose Range Limits when Prescribing on EPMA. 3. Verify ED Bed Allocation. 4. Dose range limits to be implemented post-system upgrade (date to be confirmed). 5. POCT 1539, 1488 integration into EPR	1. Complete 05/07/2024 2. Complete 03/09/2024 3. Overdue: Historical discussions with ED confirmed this risk should not be open - review with ED required. Detail is yet to be confirmed 07/10. 4. No progress due to EPMA Pharmacist not in post. 5. Interface with PAS complete. EPR result display agreement to be made in Feb 2025 to support integration.	4 x 4 (16)	4 x 1 (4)	Oct 2025	–	Dilip Pillai	Adrian Billington

Chief Operating Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Update Position	Current Score	Target Score	Target Date		Owner	Director
1979	01/03/2024	29/05/2024	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.	1. IT Support: advice and urgent meeting required form IT following initial meeting with GM, as to next steps.	1. Business Plan with finance to present to TIG in March.	5 x 3 (15)	5 x 1 (5)	June 2025	–	Sharon Kaur	Stewart Nisbet

Chief Operating Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Update Position:	Current Score	Target Score	Targe t Date		Owner	Director
2158	31/07/2024	27/08/2024	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.	1. Identify backlog items. 2. Model of priorities to be developed. 3. Group to be set up to agree organisational priorities for backlog monies. 4. Establish Capital Pipeline for 2024/25.	Feb 2025: Paper going to FPPC on 27/02/2025, with a strategy for backlog maintenance. Discussed at COO Op group, paper for Cap Ex going to capital group on 20/2/2025. Capital plan for 2025-26 being discussed with CFO 20/02/2025.	4 x 4 (16)	4 x 1 (4)	July 2030	–	Paul Norman -Brown	Neil McElduff

Chief Operating Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Position Update	Current Score	Target Score	Target Date		Owner	Director
2166	05/08/2024	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 • 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 • All cladding replaced on-site post-grenfell. • Walkarounds undertaken by fire safety team to check controls • Capital allocation for 2023/24: • Capital Project: Install Fire Compartmentation & Fire dampers • Capital Project: 21/22-042 Replace Fire Doors • Capital Project: 21/22-039 Replace Fire Alarm • Capital Project: Emergency Lighting Replacement • ED misting system was requested after building works had commence however the build remains HBN compliant • Smoking group now established. • Pembroke works complete.	1. Compartmentation works to Pembroke ward as a capital project, due to commence mid October 2024. This will address only the compartmentation issues with the ward but should reduce the risk rating as this represents the highest risk to the Trust. 2. Capital program now approved to continue fire works in the Trust, and in particular to address Panel 5, Red Zone. This will improve the reliability of the fire alarm and remove a weak panel which has many faults. 3. Smoking Group.	Feb 2025: Risk score requires review after works completed to Pembroke Ward and additional transfer to advance panels.	5 x 3 (15)	5 x 1 (5)		–	Neil Adams	Neil McElduff

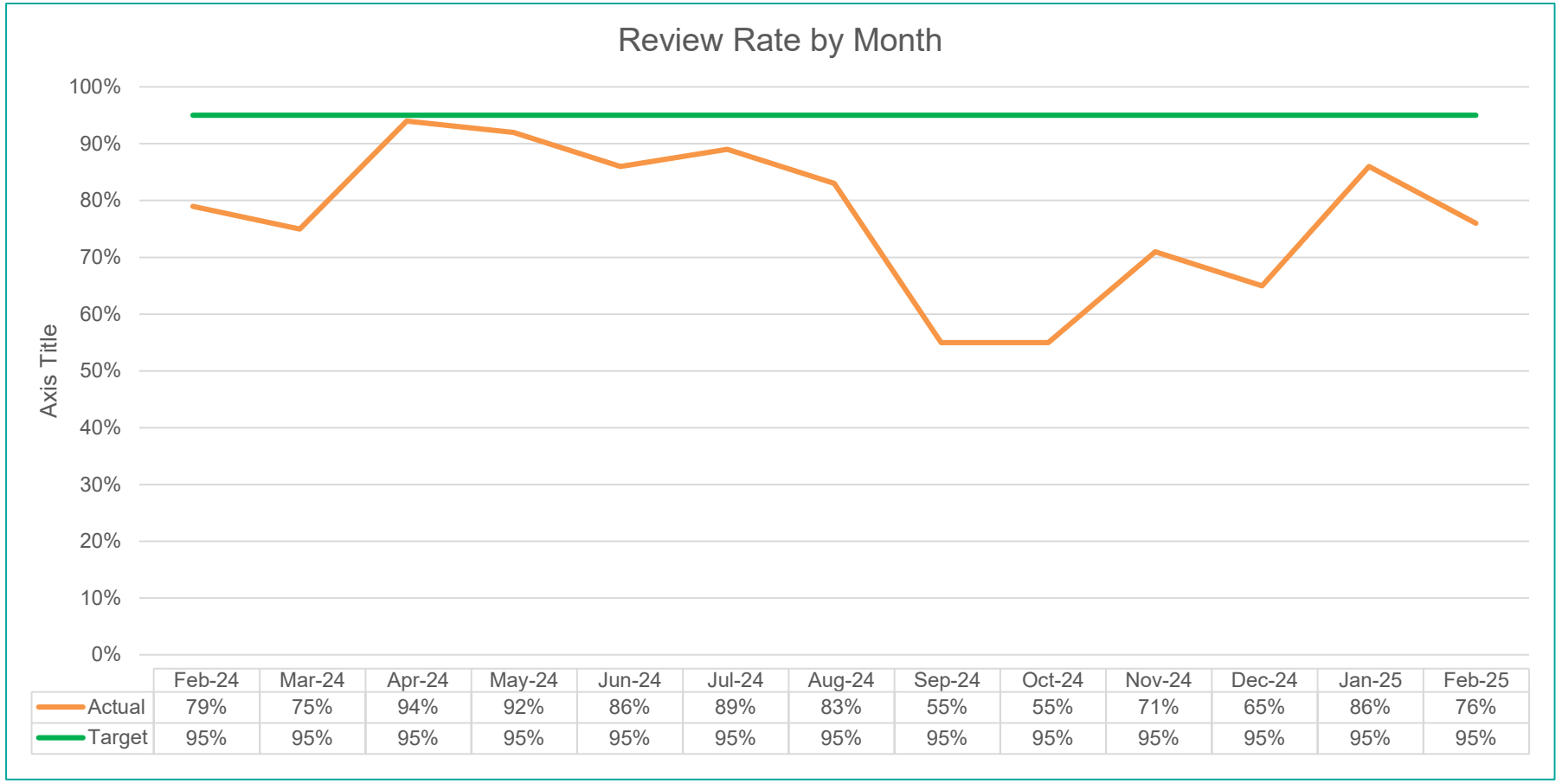
Chief Nursing Officer: Extreme Risk Profile

NHS Medway NHS Foundation Trust

Risk ID	Date Added	Date Approved	Risk Title	Risk Description	Controls	Actions	Position Update	Current Score	Target Score	Target Date		Owner	Director
2304	22/01/2025	26/02/2025	Ligature Risk in Paediatric Areas	As a result of the Trust not having a clear and implemented Ligature assessment policy, and subsequent ligature assessments not being completed, there is no documented oversight of the identified ligature anchor points. It is clear there are several ligature anchor points and unclear safety processes in place in the Paediatric areas. There have been several NPSA alerts and Estates and Facilities Alerts over a period of years which do not appear to have been actioned, for example (but not limited to) EFA/2010/007: Window blinds with looped cords or chains. All types. Looped cords and chains on window blinds can present a strangulation hazard. HAZ(SC)06/18: Showerheads: risk of use as a point of ligature We have frequent admissions of CAMHS patients with suicidal ideation who regularly attempt to tie things around their necks. This has included shower hoses, electrical cables and blind cords. This is a risk to both young people with mental health or dysregulated behaviour who may intentionally use ligature anchor points, or by CYP who may accidentally become caught in a ligature. The intentional or non intentional ligature presents a risk of death or serious harm to a child or young person.	• Patient requiring a ligature free / light room, are supervised by a RMN, • Current space is removed of any obvious ligature risk however some are unable to be removed as they are permanent estates fixtures. • Staff are aware to be vigilant and escalate any support needed through the correct escalation routes.	1. To write and implement a clear ligature assessment policy for the trust that is also suitable for the CYP services. 2. Estates Review: To have ligature anchor points reviewed and assessed by the estates team To give assurance that national NPSA alerts and estates and facilities alerts have been actioned and are adhered to. If alert recommendations not met then estates / trust representatives to provide an action plan.	Feb 2025: Gemba arranged with Chief Nurse to visit the ward and review the environment.	5 x 3 (15)	1 x 2 (2)	Aug 2025	–	Amanda Russell	Karen Kessack

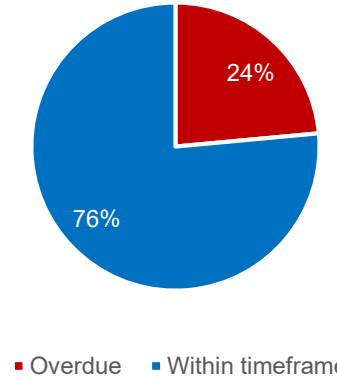
Approved Risks

Of the 68 approved risks;
10 have breached their review date, with 1 of these being scored Extreme.

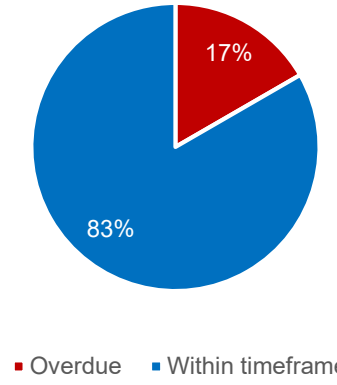


	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Actual	79%	75%	94%	92%	86%	89%	83%	55%	55%	71%	65%	86%	76%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Risks by Review Status



'Extreme' Risks by Review Status



Risks Closed

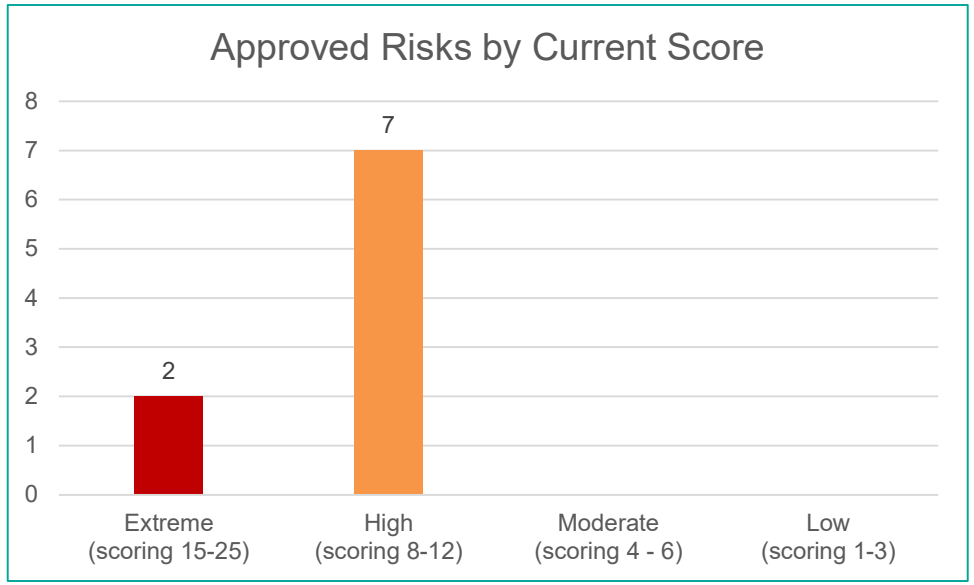
There were 5 risks closed during the month of February.

ID	Date Added	Risk Title	Risk Description	Rationale for Closure	Initial Risk Score	Target Score	Closed Date	Risk Owner
1397	08/07/2022	Lack of recruitment to PSP posts may result in non-compliance with the NHSE Framework 'Involving Patients in Patient Safety'	If the Trust does not recruit into the patient safety partner posts, then this may result in the Trust being non-compliant with elements of the "Framework for Involving Patients in Patient Safety" leading to a reputational impact on the organisation.	Risk agreed to be closed at Patient Safety Group as PSPs have been recruited.	2 x 4 (8)	2 x 2 (4)	13/02/2025	Jessica Campbell, Head of Patient Safety Improvement
1717	07/07/2023	Communications Cascade Failure	The Trust has previously carried out communications tests, although these do not fall in line with the recommendations of communications exercising every 6 months. A recent exercise included those areas as determined by the communications cascade, site team, EPRR team & switchboard. Through conversations with staff, there is a clear feeling of concern regarding the issue with telephone communications at Medway. Wards often find it difficult to contact other areas by telephone as there is a general feeling that during an incident, the current cascade system failed at several points with a 91.5% failure of messages being passed on via the cascade tree.	The current communications cascade is now a tertiary product having being replaced entirely with Everbridge. Discussed and approved to be closed at Central Operations Divisional Governance Meeting	4 x 3 (12)	2 x 2 (4)	12/02/2025	Leanne Gambell, Response Officer
1871	24/11/2023	Blood Sampling and Labelling could result in transfusion never event.	Because of poor sample labelling there is a risk that there will be a transfusion never event. Current sample rejection rate is 6.5% (national rate 4.4%, regional rate 4.3%)	Risk mitigated. Agreed at Divisional Board.	5 x 3 (15)	4 x 1 (4)	28/02/2025	Kathleen Sharp, Transfusion Practitioner
2052	26/04/2024	If the trust does not deliver its 24/25 efficiency programme then the financial performance vs. control total could be at risk.	The efficiencies target for 2024/25 is £21.6m / 5% of income. The Trust has not identified the full value of efficiencies at the start of the financial year. If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk. (NB - there is a statutory duty to breakeven.)	The Trust has submitted a forecast deficit that is adverse to control total. Propose to close this action for 24/25.	5 x 4 (20)	3 x 3 (9)	28/02/2025	Paul Kimber, Deputy Chief Financial Officer
2126	26/06/2024	Potential for Divisional CIP target for 2024/25 not being achieved	Potential for Divisional CIP target for 2024/25 not being achieved	Agreed for closure at Divisional Board as programme of efficiencies are being delivered and target has been met.	4 x 3 (12)	4 x 1 (4)	26/02/2025	Stewart Nisbet, Divisional Director of Operations

Risk Deep Dive – Information Technology

The Information Technology Risk Register has 9 approved risks in total, of which, 2 are scored 15 and above.

- There are no risks awaiting review or approval.
- 0 risks have been closed down in month.
- 33% of risks have been reviewed within their required timeframes.



Risk Deep Dive – Information Technology

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
1965	14/02/2024	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.	5 x 3 (15)	• 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.	5 x 3 (15)	5 x 1 (5)		Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. The Trust has submitted bids to NHS England for investment into Cyber Assurance Dashboard renewal and the implementation of a Ransomware response software and MFA for domain admins and privileged accounts. *The Trust has been awarded funding from NHSE. Orders have been raised for implementation prior to end of March 2025.*

2. Cyber Security Strategy: The Director of IT is engaged with a 3rd party provider and the ICS to produce a first draft of a cyber security strategy for the Trust.

Risk Deep Dive – Information Technology

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
2068	13/05/2024	31/05/2024	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 interopability impacting user experience of the system impacting patient care and staff and workflow efficiencies.	4 x 4 (16)	• 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. • Drug charts still being used in most areas. If unable to access the drug charts, a Blood Transfusion Integrated Care Pathway is available as an alternative which can be downloaded from the Intranet QPulse. • Covered in Blood Training • Key staff in ED are checking on duplications of patient allocations. • Patient ID checks being undertaken before medication.	4 x 4 (16)	4 x 1 (4)	31/10/2025	Dilip Pillai, Speciality Doctor

Actions Planned to Reduce Risk:

1. Solution for ED EPR Bed Allocation: The EPR team are working with ED and suppliers to identify a solution for the bed allocations. A suggestion has been made for an alert to be notified to the user when they try to add a patient to a location that has already been populated. This issue has been escalated as high importance to the supplier with a request for resolution.
2. Review Lack of Dose Range Limits when Prescribing on EPMA: Further review of adding dose range limits for more medications in the administration instruction section on EPMA. Education posters in common prescriber locations such as the doctor's office.
3. Verify ED Bed Allocation: Historical discussions with ED confirmed this risk should not be open - review with ED required. Detail is yet to be confirmed 07/10.
4. POCT 1539, 1488 integration into EPR: EPR Programme planning - integration interface costings are required in order to complete the work to be done. This action is part of the EPR programme road map, time line to be confirmed once funding confirmed.
5. Dose range limits to be implemented post-system upgrade (date to be confirmed).

Risk Deep Dive – Information Technology

Medway NHS Foundation Trust

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
1858	17/11/2023	11/07/2024	End of support Windows 10 25/10/25	The End of Support (EOS) date for Windows 10 of October 2025, established by Microsoft, poses a risk to the operational efficiency and security of the Trust's IT resources, clinical and information systems. Failure to upgrade the operating systems of PC/Laptop hardware across the organization before the deadline may lead to increased vulnerability to security threats, lack of support from Microsoft, and potential disruptions in operational service delivery. Inline with previous operating system progressions, the IT department anticipates a mandate of at least 90% of devices running on supported operating systems based on NHS England and DSPT mandates	4 x 3 (12)	The Trust is currently exceeding the mandated 90% of PC/Laptop devices utilising supported operating systems. With 99% of Trust devices operating on supported variations of Windows 10.	4 x 3 (12)	4 x 1 (4)	01/10/2025	Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. Confirmation of investment in Hardware and Resources. Allocating sufficient budget and resources to upgrade PC/Laptop hardware.
2. Production of and agreement to a phased upgrade plan.
3. Implement a communication plan to inform staff about the importance of the upgrade, provide training on new features, and address concerns to ensure a smooth transition.
4. Engagement with Vendors: Collaborate with software vendors to ensure compatibility with the new operating system, minimizing potential disruptions.

Risk Deep Dive – Information Technology

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
1860	17/11/2023	11/07/2024	End of Support Microsoft Office 2016 & 2019 10/25	The End of Support(EOS) for Microsoft Office 2019 applications, scheduled for October 2025 by Microsoft, poses a risk to the Trust's operational and financial landscape. Since 2020, the Trust has utilised a per device perpetual license model on a per device model. However unless Microsoft announces a successor per device product, it is likely the Trust will need to move to a per-user O365 subscription model. Review and assessment of commercial models, planning and investment will be required to migrate all staff to a changed licensing model, currently likely to be O365 E5 licenses and/or Microsoft Apps for Enterprise subscriptions. This represents a considerable increase in annualised licensing costs when compared with existing licensing arrangements. Microsoft Office applications (as oppose to web based versions) are required by all staff who utilise applications such as Altera/Allscript PAS to produce correspondents (e.g. patient letters) through a process called mailmerge.	3 x 3 (9)	The Trust is currently compliant with Microsoft licensing with a combination of NHS England allocated N3R licenses allowing access to the central tenant of NHSmail, Teams and web based office 365 applications. The Trust also utilises 3500 device based Office 2016/2019 licenses to provide application based copies of MS Office applications and support the use of mailmerge and other correspondent producing applications.	3 x 3 (9)	3 x 1 (3)	01/09/2025	Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. Financial Planning: A detailed plan and budget associated with the change in licensing models needs to be produced and agreed, that accounts for the additional costs associated with transitioning to a per-user O365 subscription model.
2. Phased Transition Plan: Trust IT to produce and implement a phased migration plan to minimize operational disruption.
3. Staff Training and Communication: Develop comprehensive training programs and communication strategies to educate staff about the changes, benefits, and efficient utilization of O365 applications.

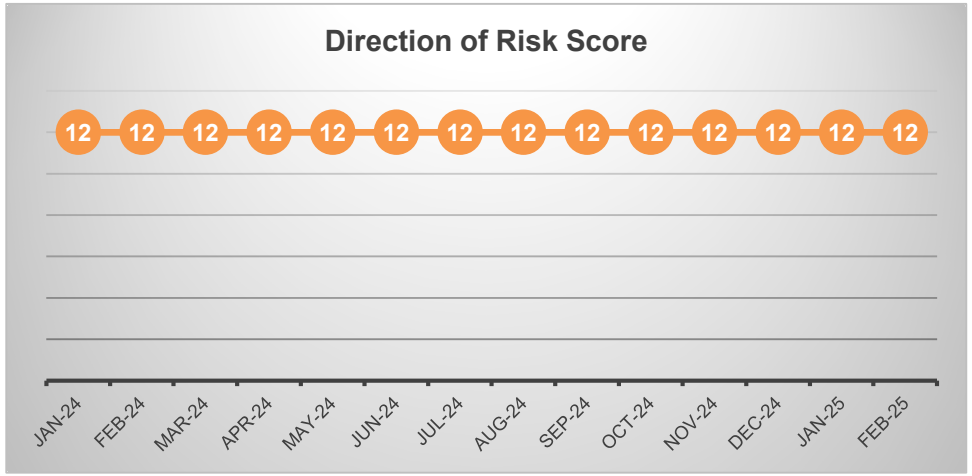
Risk Deep Dive – Information Technology

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
1919	16/01/2024	11/07/2024	Firewalls End of Support/Lifecycle Jan-25	The 2 x Fortigate 3000D on-premise firewalls deployed within the Trust network are approaching the end of their supported lifecycle, with the official support set to expire in January 2025. These firewalls are critical components of the Trust's network infrastructure. If the firewalls are used beyond their serviceable lifecycle, the devices may become susceptible to emerging threats and vulnerabilities. This could expose our network to potential cyber attacks and compromise sensitive information. Also, In the absence of vendor support, addressing issues and troubleshooting problems may become more challenging, leading to prolonged downtime and potential disruptions to the Trusts network, likely to have a significant impact on the Trusts operational capabilities. A project and associated budget to review and replace the Trust's firewall provision has not yet been established/confirmed.	4 x 3 (12)	The firewalls are currently within Vendor support and a managed service agreement until January 2025.	4 x 3 (12)	5 x 1 (5)		Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. Monthly update report through DDaT.
2. The Trust should evaluate and plan for the replacement/upgrade of the Fortigate 3000D firewalls with newer, supported models to ensure continued security and compliance.

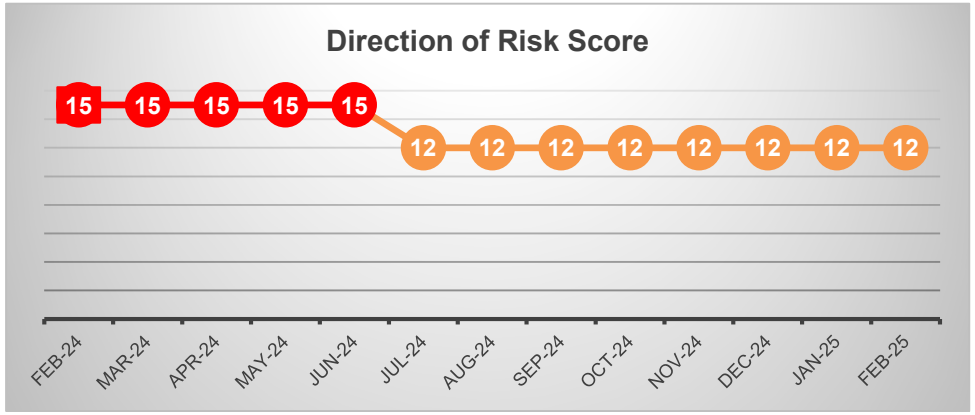


Risk Deep Dive – Information Technology

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
1962	14/02/2024	11/07/2024	Core Network Switch Management (Increased risk of Cyber Attack)	The current configuration of the Trusts core network switches allows for diverse routing through the Trust's primary and secondary Data Centres (DCs) and the Trusts Health and Social Care Network (HSCN) primary and backup, diversely routed Points of Presence (PoPs). However these core switch stacks currently manage both the Local Area Network (LAN) and the Trust's Data Centre/Server environments this presents an increased level of risk should the Trust be victim to a Cyber Attack. The consolidation of LAN and Data Centre functions onto the same core switches increases the potential impact of failures, security breaches, and performance bottlenecks. In the event of a critical failure, the entire network infrastructure could experience downtime, resulting in disruptions to hospital operations and potentially compromising patient care and data integrity. Following a review by a third party specialist, it has been recommended that the Trust review diversifying its core network infrastructure to provide a Fabric methodology with Spine and Leaf switching infrastructure for the Data Centre requirements and utilise the existing Core switch infrastructure for the LAN.	5 x 3 (15)	The Trust has core network switching and ToR server switching that enables operational networking to Trust resources.	4 x 3 (12)	5 x 1 (5)	28/03/2025	Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. Procure replacement Core switches: Plan established to implement new core switches and the data centre spine leaf design with support from CAE 3rd party support. *Initial preparatory upgrade works (version updates and patches) have now been completed.*



Risk Deep Dive – Information Technology

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
2067	13/05/2024	31/05/2024	Deployment and Interfacing of EPR/EPMA System Impacting Patient Safety	As a result of limited integration between EPR and Trust systems there is no direct update of patient information. This may lead to transcribing errors, incorrect updates in the wrong patient file, prolonged time documenting, with potential risk of harm to patients due to miss communications.	4 x 3 (12)	Patient records within Medicus are copied and pasted into Sunrise EPR at present to mitigate the risk. ICU will directly refer to ART to let them know when the patient has been stepped down. The ward will also notify ART of patients stepped down from critical care . ART ensure patient ID checks when updating the system and copy and pasting into EPR to reinforce with team any near misses are reported and documented. Patient records printed and transferred with patients from ED. Rollout plan agreed for Paediatrics.	4 x 3 (12)	4 x 1 (4)	31/03/2025	Stacey Spence, EPR Project Manager

Actions Planned to Reduce Risk:

1. Enhancements of EPR Upgrade: Review of system enhancements as part of the system upgrade to assess what is to be taken by the Trust.
2. Medicus interopability with EPR is under review - this may have a financial requirement and is to be reviewed to support next steps. As of December 24, there has been no progress on exploring this further so this action has been dated for March 25' to review what the Trust wishes to do.
3. Assessment of Maternity and EPR: Maternity services are not in scope of using the EPR Sunrise solution due to using a maternity focused system - to be reviewed if this is suitable to be part of this risk for EPR Sunrise. Maternity business case is in progress - link with EPR will be a future review. Maternity services are using OCS today and there is a future project for EPMA to go into Maternity services.
4. Delivery of Electronic Pathways in Outpatients.

Risk Deep Dive – Information Technology

NHS Medway NHS Foundation Trust

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
2077	17/05/2024	20/05/2024	Increase of nosocomial transmission of infections in hospital inpatient areas	The infection screening assessment tool on EPR that should be completed for every admission to an inpatient area is not a mandatory required field on EPR. This may mean that understanding a patients risk of infection is not recognised on admission and the patient may not be appropriately isolated increasing the risk of transmission to other patients and the potential for an outbreak. This may lead to harm to other patients, closed beds in an area, increased external scrutiny and reputational damage	4 x 3 (12)	Robust repatriation process in place for screening infections for patients returning from another hospital either in UK or abroad Infections flagged on EPR by IPC team once results available IPC team visit area once notified of infections to discuss plan or care, treatment and isolation Policies for all organisms incorporate isolation need Infection status flagged on teletracking by IPC team once infection known 7day service by IPC team to ensure consistant process	3 x 3 (9)	4 x 1 (4)		Rodney Harford-Rothwell, Head of IPC

Actions Planned to Reduce Risk:

1. Mandatory field on EPR.
2. Compliance with Infection screening tool on admission: IPC team to audit 5 patients per ward per week to determine percentage of screening tools completed as well as patients admitted with a known infection

Risk Deep Dive – Information Technology

ID	Date Added	Date Approved	Risk Title	Risk Description	Initial Risk Rating	Controls	Current Risk Rating	Target Rating	Target Date	Risk Owner
2225	25/10/2024	14/11/2024	Expiry of 8x8 IP Telephony Contract	The Trust entered into a 5 (3 +1 +1) year contract with 8x8 starting 29th June 2020, this will expire June 29th 2025. The Trust has been advised by 8x8 that we will not be able to continue the contract further on existing pricing and contract terms. The Trust should allow for suitable commercial competition and possible migration works (if another provider is selected) to be completed ahead of the contract end date.	4 x 3 (12)	The Trust entered into a 5 (3 +1 +1) year contract with 8x8 starting 29th June 2020, this will expire June 29th 2025. A decision is required to either further renew existing arrangements or test the market for a potential replacement.	4 x 3 (12)	4 x 1 (4)	28/02/2025	Craig Allen, Head of IT

Actions Planned to Reduce Risk:

1. Draft business case and framework spec to be presented at DDAT

Issues Summary

The detail within this report is accurate as of 03 March 2025.

The Trust has 173 approved Issues in total of which, 4 are rated Significant.

During the month of February:
12 new Issues were raised and,
12 Issues were closed down.

There are 19 Issues awaiting review, and 18 awaiting approval.

76% of the approved Issues were reviewed within their timeframe (last month 91%).

A summary of ‘Significant’ Issues is provided in slides 24 to 26, with those overdue for review highlighted accordingly.

Issues Log – Significant Priority

NHS Medway NHS Foundation Trust

Issue ID	Date Added	Date Approved	Issue Title	Issue Description	Update Position	Actions	Priority Rating	Target Date	Owner	Exec Owner
2060	30/04/2024	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	**Feb 2025:** Issue reviewed, refreshed and updated with CFO. Note that there will be links to operational performance. **Jan 2025:** Position unchanged.	1. Develop an estates strategy - in parallel propose the risk mitigation approach in light of insufficient internal capital funds. 2. Identify alternative sources of capital funding to mitigate capex. 3. Annual capital programme agreement (in principle) by Trust Executives and Trust Board. 4. Investment Governance Policy and templates, including prioritisation matrix. 5. Update Technical Issues Group and Investment Delivery Group terms of reference. 6. To develop a business case development tracker (to establish a list of all projects in action, held pending funding identification and potential projects not taken forward at this point). 7. Medical devices replacement programme (forward look 5 years and link to 5 year capital programme list). 8. Risk Assessment and mitigation plans for assets/estate pending replacement.	5 Significant		Paul Kimber, Deputy Chief Financial Officer	COO

Issues Log – Significant Priority

NHS Medway NHS Foundation Trust

Issue ID	Date Added	Date Approved	Issue Title	Issue Description	Update Position	Actions	Priority Rating	Target Date	Owner	Exec Owner
2083	20/05/2024	01/07/2024	The Trust is not actively 'culling or destroying' Medical Records which is a breach of the Records Management Code of Practice	Due to the lack of resources available, the Trust is not currently culling or destroying patient records in line with the Public Records Act and retention schedules as set out in the Records Management Code of Practice. The impact is that organisations may be asked for evidence to demonstrate that they operate a satisfactory records management regime. There is a range of sanctions if satisfactory arrangements are not in place i.e. regulatory intervention leading to conditions being imposed upon the organisation, or monetary penalty issued by the ICO.	**Feb 2025:** A site visit undertaken and the Chief People Officer has contacted the individuals that have documents stored at Regal for them to review what they have. The view is that most of the documents stored can be destroyed but to be confirmed. There is now a Health Records Handbook in place that reflects the requirements of the NHS Records Management Code of Practice. **Jan 2025:** Business case is being fine tuned with a view of going to the next appropriate TIG Business as usual destruction still happening.	1. Draft business case required. 2. Review of documents located in Regal - HR review of records, with outcome aim of removal to site and cull and destruction. Complaints review of records, with outcome aim of removal to site and cull and destruction. 3. Tighter process to be implemented around files being destroyed.	5 Significant		Jo Lambert, IT - Head of Clinical Systems	CDO

Issues Log – Significant Priority

Issue ID	Date Added	Date Approved	Issue Title	Issue Description	Update Position	Actions	Priority Rating	Target Date	Owner	Exec Owner
2241	15/11/2024	15/11/2024	Breached CDiff threshold for 2024/25	The Trust has breached its Cdiff infections/acquisitions against the current trajectory for 2024/25.	**Feb 2025:** Transferred to the Issues Log (rated Significant) as the Trust has breached the threshold.	1. Completion of assessment tool being a mandatory field on EPR. 2. Implement simulation training sessions.	5 Significant	31/03/2025	Jo Lambert, IT - Head of Clinical Systems	CDO
2258	04/12/2024	14/01/2025	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.	**Jan 2025:** Reviewed by Board 15/01. CMO agreed to take away and review to determine how big an issues this is in relation to patient safety - currently scored as priority rating 5 - significant.	1. Update from EPR team to determine if the result format can be amended to ensure results are viewed in chronological order.	5 Significant		Penny Archer, Clinical Operations Manager Diagnostics & Therapies Care Group	CMO

Issues Closed – February 2025

NHS Medway NHS Foundation Trust

ID	Date Added	Issue Title	Issue Description	Priority Rating	Rationale for Closure	Closed Date	Risk Owner
1052	11/04/2019	Imaging: Inadequate MRI Capacity	Due to the increased demand for MRI IP and OP work, and a period of absence of the mobile MRI unit, the waiting list in MRI has continued to rise to an untenable level. Demand for the MRI scanner currently equates to approximately 2.75 scanner per week, however the department only has 2 static scanners and adhoc mobile capacity as and when purchased. Failure to increase static MRI capacity, through a permanent solution i.e. build, will result in waiting lists continuing to rise and patients waiting longer than the expected performance standard of: 24 hours for IP, 10 days for Cancer, 14 days for Urgent and 42 days for routine.	1 Insignificant	New scanner is improving throughput and we are compliant against DMO1 standard.	28/02/2025	Lorraine Becconsall, Head of Imaging
1370	30/06/2022	Insufficient Consultant Anaesthetist to provide consultant delivered care to meet demand.	There is currently insufficient Consultant Anaesthetists to provide consistent cover to manage the lists for major surgery, emergency surgery and trauma safely. Currently, there is approximately 6 WTE vacant position. This means that we do not meet the GPAS and HRSP guidance for Consultant delivered care, the recommendations for pre-assessment and optimisation, and finally the supervision of Junior Doctors. Patient safety, flow of patients, lack of training, poor reputation, poor training and therefore poor future recruitment of Consultants. Quality of care, teamwork and human factors impact when there are last minute changes to teams.	3 Moderate	Recruited 2 new anaesthetists and both have started in October. Therefore the Issue of cancellations on the day due to lack of anaesthetists has minimised.	12/02/2025	Sharon Kaur, General Manager
1650	25/04/2023	Lack of prescriptions for Oxygen administered	Oxygen not being prescribed as required in many instances. This may have an impact on patient safety, but also has legislative and regulatory consequences. Oxygen is classified as a prescription only medicine and should be prescribed by an appropriately qualified health care Professional, specifying the oxygen concentration, flow rate and type of device (eg mask / nasal specs)	1 Insignificant	EPMA Hard stop implemented - mandatory requirement to prescribe oxygen if necessary.	11/02/2025	Steve Cook, Chief Pharmacist
1749	15/08/2023	Long waiting times for Nurse Led Rapid access chest pain clinic affecting Patient Experience	The rapid access chest pain clinic has seen demand for the service with an increase in patients being referred to the nursing team. The aim of this service is to see patients within 2 weeks of the referral as per current guidelines. However, gaps in workforce due to recruitment and current clinic capacity means that patients are currently being seen at or around 13 weeks.	1 Insignificant	Patients are now seen within 2 weeks of the referral as per current guidelines.	13/02/2025	Linda Stevens, General Manager

Issues Closed – February 2025

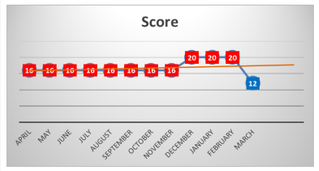
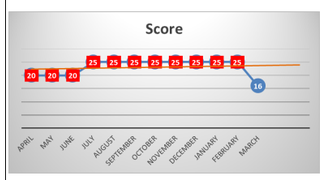
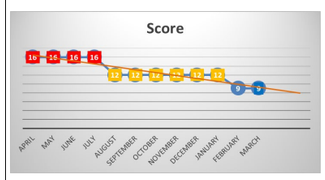
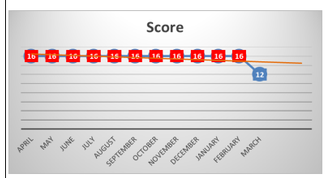
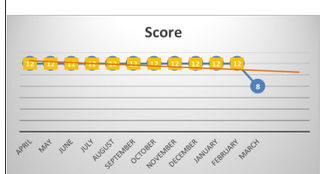
ID	Date Added	Issue Title	Issue Description	Priority Rating	Rationale for Closure	Closed Date	Risk Owner
1856	16/11/2023	Faulty TURBT & TURP sets	TURBT and TURP sets required for urology procedures in theatres are more than 10 years old and many have been condemned due to being faulty and unrepairable. Some instruments are bent and damaged and can overheat, which can cause harm to patient and staff. The number of sets available for these procedure are now minimum and therefore lists have to be planned with certain number of patients to save being cancelled on the door. The impact is cancellation of cancer patients and breaching constitutional targets.	4 High	Equipment delivered.	26/02/2025	Sharon Kaur, General Manager
2017	03/04/2024	UKAS 15189 accreditation for NKPS services	Because of the suspension of microbiology UKAS 15189 accreditation and the non accreditation of the biochemistry and haematology/blood transfusion services based at the MFT site there is a risk that required standards may not be met resulting in a loss of confidence in the delivery of quality service.	1 Insignificant	Assurance from NKPS team on regular accreditation for MFT site.	11/02/2025	James Shaw, General Manager
2044	18/04/2024	Insufficient Transcutaneous Bilirubinometer (TCB) Monitors in Community Midwifery	The care group require an additional 6 TCB monitors to effectively risk assess babies for jaundice in the community setting. There are currently 10 monitors (2 per team) but any servicing or repairs require monitors to be returned to Germany which takes several months for return and therefore significantly impacts ability of teams to assess and monitor babies for jaundice in the community.	1 Insignificant	Equipment delivered.	12/02/2025	Kate Harris, Associate Director of Midwifery & Ambulatory Gynae
2053	29/04/2024	Late & Unreturned Radiation Dose Badges	As a result of regular monitoring of dosimetry compliance and liaising with our finance department, there were a higher than usual amount of late/unreturned dose badges from September-December 2023. This has resulted in high financial implications to the Trust and could lead to investigation by HSE.	1 Insignificant	Several months data & trending to show badges are being issued and returned correctly. This will now become an Agenda item at the RPG.	11/02/2025	Sarah Lee, Imaging Radiation Protection Co-ordinator

Issues Closed – February 2025

ID	Date Added	Issue Title	Issue Description	Priority Rating	Rationale for Closure	Closed Date	Risk Owner
2113	19/06/2024	Disruption to PoCT HbA1C testing service for diabetes clinics leading to delays in patient treatment	As a result of insufficient HbA1C testing devices and old/failing devices patients may not be able to have an HbA1C test performed at clinic and will have to return for a second clinic appointment following an HbA1c being taken by phlebotomy and tested at the laboratory. This wil lead to a delay in patient treatment and poor patient experience.	1 Insignificant	Capital bid approved. Analysers are being purchased.	11/02/2025	Lucy Coutts, Point of Care Testing Manager
2124	25/06/2024	Insufficient number of permanent Clinical Coders to cover activity levels - financial income at risk, data quality impacted	Due to an insufficient number of permanent Clinical Coders to cover activity levels, the backlog in coding has been growing steadily where we are soon to be at risk of not meeting financial/data deadlines if we continue on this trajectory without change/intervention. Just 1% of activity uncoded at deadline would equate to approx. £130K loss, and significant negative impacts on Trust data metrics such as HSMR and SHMI	3 Moderate	All 3 coders now in post so there are now sufficient numbers of coders to cover current activity levels. The backlog position has been steadied.	17/02/2025	Chris Carter, Clinical Coding and Data Quality Advisor
2254	29/11/2024	Car Park Gantry	A Gantry to indicate vacant parking spaces has been installed on the perimeter road for approximately 15 years During this period, planned safety inspections have not been implemented. The initial protection barrier has recently failed which would suggest the main gantry is now at risk of failure with potential to cause harm.	4 High	Testing has been carried out and confirmed no corrosion. This is no longer an issue.	20/02/2025	Paul Norman-Brown, Associate Director of Estates
2307	23/01/2025	Under-reporting of security incidents	The under-reporting of security incidents is commonplace and prevents the Trust from learning from incidents, alongside being unable to accurately identify themes/trends. In order to address the issue, all incidents in which security are requested for require reporting on DATIX by the service who has requested assistance.	1 Low	This is already a Patient First strategy and the issue is being deal with by that.	20/02/2025	Neil Adams, Deputy Director of Estates and Facilities

Action Required

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	Review rate currently at 76%
02	Review of process for new risks to ensure they are approved in a timely way with 95% approved within 60 day of being raised.	IGT	31 July 23	Process complete. 95% target not yet achieved – currently at 56%
03	To draft a revised risk approvals and BAF process	Company Secretary	TBC	Drafted
04	95% of risks to be reviewed within the required timeframes.	IGT	31 Mar 25	Currently at 76%

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	**Feb 25 -** (Target score to be revised) 1. Completed 1b. Revised process being input into 2025/26 business planning. 2. Completed 3. Completed 4. SOP review continues 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 revised '33' lines. Specific sessions held within Executive Committee. 8. Being tracked through the new SPP Group. 9. Reviews completed and resultant actions being worked through and input into new action tracker and revised FRP. 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.	4	5	20	▬		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 Meldrum	**Feb 25 -** (Target score to be revised) 1a. Completed 1b. Completed 1c. Options for areas investment included in the Capital underspend review being undertaken through Executive Committee (and reported to FPPC). Outputs from survey are being included into 25/26 business planning. 2. Reviewed monthly and part of the capital spend prioritisation work. Capital slippage and its utilisation reviewed by Executives (as described in 1.c) Local mitigations being put in place to maintain estate with the available resources.		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	**Feb 25 -** 1. Trust Management Board review completed and approach supported. 2. Business planning is underway for 25/26 and demand and capacity work drafted. 3. As BAF 1 4. Draft completed with the exception of revised procurement levels. Draft to be submitted to FPPC in Feb 5. Progressing - listening events promoted and underway. 6. Linked to action 2. Finance session held with senior leaders on 29 Jan 25 to promote current position and need for focus.		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	**Feb 25 -** 1. All actions - including those from KPMG - have been pulled into a single tracker to aid delivery monitoring. Core financial policies being reviewed and updated for amendments to legislation and regulation. Output to go to FPPC. 2. NOF4 exit criteria and evidence paused until 25/26 financial period. The FRP is being heavily revised. 3. System focus on investigation and intervention regime. 4. The FRP is being heavily revised and will be presented to FRRP, Exec and Board before being submitted to ICB and NHSE.		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.
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	**Feb 25 -** 1. **Completed**. 2a. We are exploring robotic automation of the elements of the recruitment process. Part of ICB People Strategy (recommendations due Q1 25). 2b. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment. External expertise brought in to support Medical job planning (began Jan 25) 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. **Completed** 6. Component of the revised FRP. (the '200'). 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.

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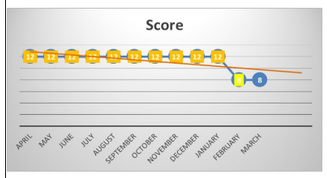
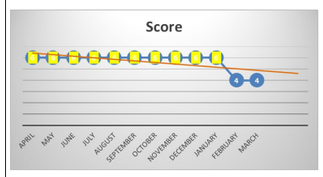
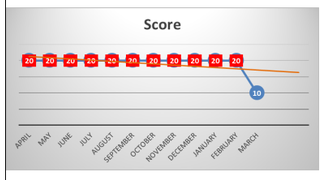
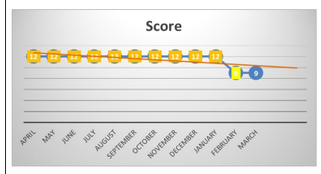
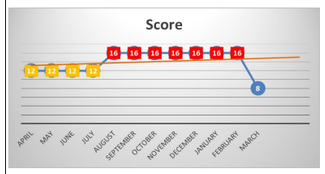
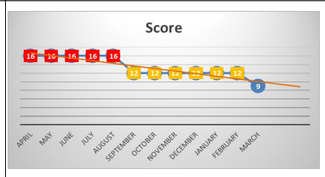
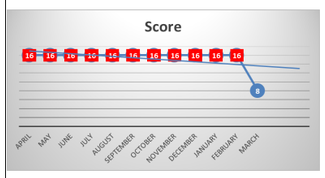
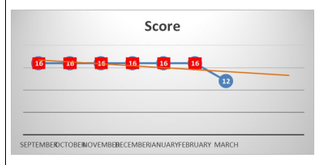
BAF6	**People**	People		There is a risk that staff will not feel confident to raise concerns and that their concerns will be dealt with by the organisation. This may lead to worsening engagement levels and quality of patient care.	4	3	12	1. Strategy: People Strategy in place 2.Culture Intervention: The cultural transformation 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 independent 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 implementation plan to support people strategic initiative. updated monthly and A3 reviewed bi-monthly to track progress.	4	2	8	↓		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 engagement. 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	**Feb 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 solution is being consulted on. 4. Results are being analysed and an outcome report being produced which will be presented to the People Committee in Feb 25. 5a.New Starter Survey and quarterly Pulse surveys restarted in Q1 25. 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 People Committee. The FTSU strategy development is underway. 8. **Completed** 9. Dedicated intranet page in operation. 10. Listening events underway and being promoted.		
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 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 Alegbeleye	**Feb 25 -** 1. Review work has been completed and identified specific areas of focus (e.g. Respiratory disease) to target. Recovery actions designed. Recovery programme being rolled out. 2. Moving to BAU. Reporting schedule being honed. 3. **Completed** 4. Data quality continues to be comparable with national metrics. Metrics still show an adverse position SHMI. 5. Medical models being delivered and are kept under review. This was brought to the Trust Board in Jan. 6. Mortality Breakthrough Objective established, root causes and countermeasures identified (as above). Contributing 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	3	9	–		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	**Feb 25 -** 1. The programme continues to be rolled out and assurance on delivery is being reported through the QAC. 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 six have 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 imbedding 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	**Feb 25 -** (Target score to reviewed) 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. External supported programme underway. Session held on 29 Jan 25. **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 and governance framework, agenda and required reports. 2. review in-reach with clinical leads	3	3	9	Mar-25	COO	Exec	**Feb 24 -** 1. Review underway. Particular focus on the frailty elements to compliment the Corporate Project (Flow and Discharge) A3 due to be completed wb 3 Feb 25. 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. Acute model is being deployed. 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, increase the number of 12 hour delays in our ED and increase demand for bed capacity. This in turn impacts on the quality of care provided and increases the opportunity for harm to occur. In addition this may increase overall Trust mortality as delays in ED over 5 hours correlate with increased risk of mortality. This risk also 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 6. Linked to BAF9 improvement of SHMI	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	Darren Palmer	**Feb 24 -** (Target score to be reviewed) 1. Plan compiled and in operation but under review owing to seasonal demand. 2. Meetings in place and approach being deployed and effectiveness reviewed. 3. 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. The governance for this work is through the UEC programme board. Internally an A3 on LoS is starting wb 3 Feb 25. 4. Work has commenced with 5 wards. COO presented to Senior leaders on 29 Jan 25 with areas of focus highlighted.		Risk 2154: Harm 25/07/24.
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	**Feb 25 -** 1. Ongoing. Assurance reports produced and submitted to FPPC. 2. Capital programme discussions nearing completion and capital investment requests reviewed by Executive Committee and FPPC. 3. **Completed**. Included on the annual Board development plan. 5. Programme continuing to be delivered. 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, 12 March 2025

Title of Report	Integrated Quality and Performance Report for Month 10: 2024/25	**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 10: 2024/25 (January 2025) and provides the Board with an update of performance against the Trust's Strategic Priorities. Overall summary: • The Patients domain is now showing the highest % volume in metrics improving for Statistical Variance (53.8%), with the People domain achieving 53.6% metric improvement • The Sustainability domain is showing the highest number of metrics statistically showing concern (4), with 33.3% of all metrics flagging • The Patients Domain is showing the least amount of metrics showing concern (1), with ~4% against all metrics flagging. • The majority of the metrics (58%) in the Quality domain continue to show no significant statistical variation and as such are showing common variation. • Overall, 66 metrics are now showing improved statistical variance (-5 from last month) against 38 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 • The Patients domain is now showing the highest % volume in metrics improving for Statistical Variance (53.8%), with the People domain achieving 53.6% metric improvement • The Sustainability domain is showing the highest number of metrics statistically showing concern (4), with 33.3% of all metrics flagging • The Patients Domain is showing the least amount of metrics showing concern (1), with ~4% against all metrics flagging. • The majority of the metrics (58%) in the Quality domain continue to show no significant statistical variation and as such are showing common variation. • Overall, 66 metrics are now showing improved statistical variance (-5 from last month) against 38 which are showing concern (+3 from last month). Quality • Fractured Neck of Femur (FNoF): A total of 41 patients with hip fractures were admitted in January 2025. Of these, 12 patients underwent surgery after 36 hours, resulting in 70.7% compliance for prompt surgery. In December 2024, only 4 patients breached the 36 hours target with an 83.3% compliance. Over the last year there has been an overall upward trend in compliance for prompt surgery. In the 12 months up to December		

	2024, our compliance was higher at 63%, compared to 12 months up to December 2023 when our compliance was only 54.3%. The prompt surgery KPI on NHFD for Medway is 63%, which is above the national average of 58%. • The number of falls in the last reporting period has increased • There has been an increase in hospital acquired pressure ulcers, this is in line with the increase in capacity, acuity and reduction in flow across the Trust • Positively there have been more than seven wards which have remained harm free for more than 30 days and five areas over six months Systems and Partnerships • Predicted position for patients waiting for more than 65 weeks at the end of February is approximately 191. Due to unforeseen clinician leave/sickness in Cardiology and Rheumatology, a number of job-planned and additional clinics had to be stood down in December, January and February which has led to an increase in the number of patients waiting more than 65 weeks. • Fortnightly Tier 2 meetings in place with NHS England and ICB to monitor elective performance and provide any necessary support. • Total ED performance for four-hour waits is 75.8%, with Type 1 performance 61.2%, Type 3 performance 91.4% • Admitted performance 3.6%, Non-admitted performance 81.9% • While ambulance handover delays increased, the Trust remained top in the country People • New breakthrough objective for People domain now live which is to reduce, by half, the number of reported incivilities – expect baselining by March; • Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. Spend improvement across maternity. • New staff survey dashboard, developed with business intelligence, is now live. • 188 mental health first aiders in place; 10 listening ear events conducted. • Sickness rate, whilst static, shows a dramatic increase in the reduction of long-term sickness cases – however, a corresponding increase in short-term sickness cases. Targeting of reducing management referral times remain key priority through occupational health investment. Sustainability • We are working to contain our deficit position to £22.9m by year end. • Whilst this position represents £20.5m adverse to our Plan (£2.4m deficit), this has to be seen in the context of activity pressures, unfunded services and debt write-offs required in-year. • We are currently working through 2025/26 planning proposals, with a view to balance outturn spending levels with an expected increase in activity to improve Referral to Treatment and other performance targets. • Medium term financial planning is being addressed by work to complete a Financial Recovery Plan (FRP).
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:	-			
Resource implications:	-			
Sustainability and /or Public and patient engagement considerations:	-			
Integrated Impact assessment:	Not applicable			
Legal and Regulatory implications:	-			
Appendices:	-			
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 Trust Board
Wednesday, 12 March 2025

Title of Report	Finance Report for January 2025 (Month 10)			**Agenda Item**	5.1
Author	Dan Thompson, Finance Business Partner Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director Income and Contracts Isla Fraser, Financial Controller Paul Kimber, Deputy Chief Financial Officer				
Lead Executive Director	Simon Wombwell, Chief Finance Officer (Interim)				
Executive Summary	Key points in relation to the Month 10/January financial results: a) In-month deficit of £4.9m worsens the Trust's reported YTD position to £18.5m deficit; this is adverse to Plan by £16.4m. b) In-month performance was £0.3m / 0.9% worse than forecast. c) The year-end forecast outturn position remains unchanged at £22.9m deficit as presented to Finance, Planning and Performance Committee in December. Risk to delivery is heightened due to income below expectations in December and January. d) Efficiency plans are £0.2m adverse to the YTD plan of £17.3m, this includes a £1.3m adjustment for Elective Recovery Fund (ERF) over performance e) The capital plan is underspending, principally in relation to Community Diagnostic Centre leases being signed. Substitute schemes are being progressed. f) Cash at the end of January was £7.0m – the cash forecast is under constant review given the forecast run-rate. Cash support application started in February. g) Report provides further detail on debtors and creditors, but this area requires further attention.				
Proposal and/or key recommendation:	The Committee is asked to note this report.				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	✓	Approval		
	Noting	✓	Discussion		✓
Committee/Group submitted: Date of Submission:	Finance, Planning and Performance Committee, 27 February 2025				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	Non-delivery of the breakeven control total. Income and cash support, with pro-active working capital / cash management and forecasting.				

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. Failing to meet agreed financial targets means we are subject to regulatory conditions.		
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 Finance 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	X	There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

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Patient FIRST

Meeting of the Trust Board
Wednesday, 12 March 2025

Title of Report	Improving Financial Governance Tracker			**Agenda Item**	5.2
Author	Executive Team				
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer				
Executive Summary	This report relates to an amalgamation of various recommendations and actions taken from various Assurance Reports (including Margaret Pratt, KPMG and Grant Thornton) with a Status Update from the Executive Team to inform next steps and progress.				
Proposal and/or key recommendation:	The Committee 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 will be monitored through the weekly Executive Group meeting and monthly Finance, Planning and Performance Committee.				
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:	Not applicable				
Resource implications:	Not applicable				
Sustainability and /or Public and patient engagement considerations:	Not applicable				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	Not applicable				
Appendices:	Not applicable				

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.

Master Financial Governance Action Tracker V0.4

Theme: Trust Board and Board Governance

Rec. No.	*Source Report*	*Recommendation*	*Improvement Action*	*Responsible Person/s*	*Expected Completion Date*	*Status update*	*Status*
1	MPratt Report	Review financial reporting and forecasting to Board	Ensure concerns are escalated and debated at the Board, with firm recommendations for SMART actions Develop a “golden thread” anchoring actions to sustainable finances	CEO, Lead Executives, Non-Executive Chairs	28.03.25	Financial Report including detailed presentation on YTD and forecast presented to FPPC in December, with invite extended to whole Board. Finance Report updated with I&E forecast, risks and opportunities explained. Review of Board Report format to be part of 2025/26 objectives. Sustainable finances will be linked to Financial Recovery Plan and ongoing discussions for Exit Criteria.	In progress
2	MPratt Report	Ensure the Board considers the most up-to-date financial position in public	Revise agenda planning; Ensure communications reflect actions to address issues; Circulate reports	Director of Strategy, partnerships and	28.02.25	The Board has and will continue to receive a monthly report on the trusts	In progress

			to Board members when the Board does not meet	Company Secretary		financial position as well as a forecast on financial performance until the end of the financial year. Finance discussions held in the FPPC and other committees are reported to the board monthly as per the annual work plans and ToR.	
3	MPratt Report	Review Board Assurance Framework (BAF) and corporate risks	Review BAF and corporate risks; Develop revised assessments and action plans	Director of Strategy, partnerships and Company Secretary	28.02.25	The review of the BAF has been completed and a revised version was presented to the Board in September 2024. The corporate risk and issues process were reviewed and amended in November 2024. Both the BAF and the risk and issues registers are submitted to Board and all committees on a monthly basis. The BAF is shared with the ICB on a quarterly basis.	Complete (evidence-evidence submitted to internal audit review)
4	MPratt Report	Improve the recording of check and challenge discussions	Ensure check and challenge exchanges at each Board and Committee meeting are captured with SMART actions and reporting timelines in action logs	Director of Productivity, Efficiency and Development.	28.02.25	The committee/board assurance template has been amended to prompt SMART	Complete (evidence-new template circulated

						actions. – December 24.	to committees in Feb 25)
5	MPratt Report	Strengthen Unitary Board financial awareness, roles and responsibilities	Consider commissioning a Board and Team development program	Board Chair, CEO	28.02.25	A Board development programme has been in operation for the 2024/25 reporting period and is being refreshed for the 2025/26 year. This action is reflected in the board annual work plan and the trusts standing orders. Interim CFO presentation to Board development day Dec 2024	Complete (evidence-submitted to internal audit review)
6	MPratt Report	Improve budget-setting process	Implement revised processes to ensure the Board is fully sighted on budget-setting assumptions; Ensure mitigations to control risks are explicit and formally agreed	Board Chair, CEO, CFO	27.03.25	Process paper submitted to Board in November 24, update papers presented to Exec committee, FPPC and Board on a monthly basis.	Started Dec 2024

Theme: Capacity and Capability

Rec. No.	***Source Report***	***Recommendation***	***Improvement Action***	***Responsible Person/s***	***Expected Completion Date***	***Status update***	***Status***
7	MPratt Report	Executive Team to reassess approach to change	Executive Team to reassess its appetite for change and risk to give greater emphasis, pace, and urgency to the actions needed to achieve financial sustainability	CEO	31.03.25	Executive Weekly meetings and away day in March 2025	Commenced

8	MPratt Report	Implement performance management arrangements	Consider and implement performance management arrangements demonstrating increased effectiveness in delivering financial control and sustainability	CEO	28.01.25	Performance management (SDR's, BO)of Sustainability breakthrough objective (BO) at Board, division and care group level already in place. CFO revising BO.	In place and being revised
9	MPratt Report	Interim CFO to reinvigorate the finance department	Act with pace and urgency to reinvigorate the finance department by setting clear expectations of professional standards; Hold team and colleagues to account for delivering agreed actions	CFO	Immediately, ongoing	Independent review of process, reporting and structures underway using NHSE Improvement Director. 2025/26 objectives in draft, awaiting completion of Review. Development Plan being put in place, starting in March, using SE Finance Academy.	Completed
10	MPratt Report	Ensure sufficient financial business partner support	Ensure sufficient financial business partner support to divisions to promote improved financial control and business planning to deliver Trust financial sustainability	CFO	28.02.25	2*FBPs employed. Expect to make substantive appointments once budget setting is complete.	Completed
11	KPMG	Budget setting process starts too late and there are limited protocols to prepare budgets	Seek budget sign-offs prior to submission: budgets should be submitted to the finance committee only after the budget holders agree on the draft budgets	CFO	31.03.25	Process started in December 2024.	In progress for 2025/26 planning

12	KPMG	Different divisions use varied and inconsistent approaches when preparing budgets	Training for FBPs: we will consider the need for training sessions for FBPs, budget holders and divisional leads to support effective and efficient usage of existing system capabilities	CFO	31.03.25	Independent review to identify areas for improvement. Objectives will create standardisation. Part of revised Trust management competencies	Progressing
13	KPMG	Management reports are backwards looking and sub-optimal in length	Training for FBPs: we shall consider the structure of the financial management team and seek (further) investment in training and development; the purpose will be to shift management reports from being a 'scorekeeper' to predictive/prescriptive reports	CFO	31.12.24	Objectives to include standardisation of reporting, including emphasis on a forward look and greater focus on information to support data presentation.	Progressing
14	KPMG	Medical recruitment: time to hire and candidate withdrawals (pay)	Discussions with KCHFT to outsource recruitment transactional services to improve reporting and time to hire (using robotics) to be progressed	Chief People Officer	31.03.25	February position. ICB have commissioned review of full system shared business opportunity for RPA transactional recruitment. Report due March 2025. Also workstream within Medical Productivity corporate project 24/25	Progressing
15	KPMG	Rota reviews (pay)	Following assessment of current rostering practices for ED Nursing, Anaesthetics doctors and Radiology against the 'nine' rules of good rostering this work should	Chief Operating Officer	31.03.25	Rota post in place and review commenced late 2024	Progressing

			now be expanded to include other areas with evidence of rostering challenges and/or in-year budget overspends				

Theme: Financial Controls

Rec. No.	*Source Report*	*Recommendation*	*Improvement Action*	*Responsible Person/s*	*Expected Completion Date*		*Status*
16	MPratt Report/Grant Thornton	Task the interim CFO with improving understanding of financial recovery plan details	Review and update the financial recovery action plan; Propose updated monthly run-rate projections as key delivery metrics	CFO	31.03.25	FRP in draft. This will include a description of strategy and actions required to achieve sustainability. The process is expected to be iterative, involving ICB and NHSE, as well as the MFT Board. A description of the approach presented to December FPPC.	Progressing
17	MPratt Report	Revise “Patients First” break-through objectives	Consider revising “Patients First” break-through objectives to encourage a focus on monthly run-rate against budget	CDO. CFO	28.02.25	Proposed Breakthrough Objective is required reduction in headcount i.e. the main driver for delivering to budget.	Progressing

18	MPratt Report	Revisit performance and action plans	Revisit performance and action plans to ensure that all outstanding action plans are owned and delivered; Revisit performance and action plans and benchmark them against best practices	CEO	28.02.25	This is and will be an output of future SDRs.	Completed
19	KPMG	Bottom up budgets prepared by the divisions do not align with the top-down funding available, due to lack of consensus on demand, activity and workforce levels	Timing of information availability: Any refresh or changes to the data and information landscape should result in alignment of workforce and activity data being available along with finance information, as well as to be available on-demand.	CDO	01.12.25	Triangulation of data source into one reporting package is a key delivery. The Finance (Income) & Activity Dashboard 1st draft is now complete and with Finance team for testing. Delay in progressing Workforce data solution however is now moving forward and progressing data source issues via automated data flows from ESR. Next stages include daily refreshed dashboards to include (1) Activity & Income, (2) Costing, (3) ESR Workforce, (4) Quality metrics	Progressing

20	KPMG	Misalignment in finance, activity and workforce data being available prevents timely decisions	Digital landscape assessment: the Trust will consider an assessment of our digital infrastructure to explore opportunities for integration across multiple systems to minimise manual links and be able to generate bespoke reports	CDO	01.12.25	As above (action 20), same action update.	Progressing
21	KPMG	MFT is potentially losing income due to incorrectly coded activities informing the block contract	Continue optimising coding opportunities: we are already exploring where capture and counting of activity can be improved	CDO	31.12.24	Workstream and programme of work underway in 24/25 al Programme of work being agreed for 25/26	In place
22	KPMG	High cost drugs claims are not adjusted regularly, leading to overspends	Ensure demand and capacity modelling reflects accurate activity coding: we will ensure that the activity estimates resulting from the demand and capacity modelling exercise are mapped correctly to the appropriate codes, to inform the appropriate block contract with the ICB	CDO	31.12.24	In place for business planning for 25/26	complete
23	KPMG	Standing financial instructions (SFIs) are not up to date	Update the SFIs to reflect new capital governance structure	CFO	31.03.25	SFIs are under review, including adjustments to align with the Procurement Act 2023.	Progressing
24	KPMG	Contract spend reductions (pay and non-pay)	The Trust will implement new booking system on 1stFeb to provide more visibility, governance and controls for taxis	CFO	24.02.25	Process for spend on Taxis is under further review.	Progressing

25	KPMG	Medical recruitment: time to hire and candidate withdrawals (pay)	Commence measuring candidate experience against agreed KPI to inform decision making/ required actions. Example themes and KPI include 'Effective Recruitment Process' e.g. accurate role information provided to candidates; 'Supportive on-boarding process' e.g. personal details uploaded onto HR systems in timely manner to support salary payment ; Expectations and employer brand perception' e.g. reasons for joining	CPO	31.12.24	February update: part 1: ensuring resident doctors pay correct, dashboard in place, no further opportunity (completed). Part 2 Employee value proposition – work commissioned through Circus, EVP survey completed with initial findings – next steps to be identified	Partial complete, progressing part 2

Theme: Financial Recovery

Rec. No.	***Source Report***	***Recommendation***	***Improvement Action***	***Responsible Person/s***	***Expected Completion Date***		***Status***
26	Grant Thornton	Activity data used in service line reporting should be reviewed carefully for completeness	As gaps in budgeted activity are identified, the Trust should promptly make any relevant adjustments to activity data used by the costing team so that comparative exercises to monitor and understand cost are reliable and robust	CFO	31.12.24	This will be picked up in Finance objectives for 2025/26 and become BAU.	Progressing
27	NHS CFA	The Procurement, Finance and Pharmacy Teams will take part in a working group and report to the ARC to establish how all	The Procurement, Finance and Pharmacy Teams will take part in a working group and report to the ARC to establish how all departments can contribute to	CFO/ Chief Pharmacist	31.12.24	We have established the Atamis contract database and will develop contract	In progress.

		departments can contribute to ensure effective due diligence and contract management at the Trust	ensure effective due diligence and contract management at the Trust			management capability in line with the new Procurement Act. We will also need to create clarity between the role of Procurement and contract management i.e. to identify which department is best placed to be the contract owner/manager – this should not automatically default to Procurement, who will not be close to supplier performance on a day-to-day basis.	
28	KPMG	CIP stretch targets are deemed unrealistic in some cases, and not managed in line with leading practice.	Explore transformational CIP schemes: given the Trust benchmarks well in Model Health Systems cost per WAU and reference index cost, we will explore transformational opportunities (e.g. rationalisation and transformation of back office functions, digital transformation opportunities, opportunities from increased collaboration and service transfers within the region and/or mergers). This	Director of productivity and efficiency & development	31.01.25	CIP changes were undertaken in 2024. A review of 24/25 delivery has taken place in terms of lessons learned. For 25/26 The Exec team have discussed 4 options around CIP allocation, and a methodology agreed, taking in to account NHSE identified	Ongoing

			will also include full engagement with the ICB/ICS.			opportunities shared by the ICB (based on Model Health System data). In addition, the Trust is exploring internal data to support delivery of productivity and efficiency improvements. To also note that the Trust is working closely with the Acute Provider Collaborative on key service pathways (Outpatients, ENT, Endoscopy) on transformation opportunities.	
36	KPMG	Medical recruitment: time to hire and candidate withdrawals (pay)	Explore opportunities with ICB for collaborative medical workforce planning and working i.e. medical staff work across Trusts to avoid duplication/ mitigate hard to fill posts	CMO	31.03.25		
39	KPMG	Middle grade WTE growth (pay): FY20 to FY24 YTD M6	Reduced agency & bank spend across the clinical directorates through: •Detailed review each middle grade rota to confirm the number required for the rota and to test balance between funded training numbers and	CMO	28.02.25		Completed

			non-training (for service) roles. Non-training posts not required for rota compliance and safe service provision should be removed. •Improved rostering practices, particularly for those specialties with significant WTE growth •Job planning (aligned to demand & workforce capacity modelling) •Recruitment strategy actions for hard to recruit to posts, particularly in light of system partners competing for the same staff and offering incentives to fill vacancies covered by bank				
41	KPMG	Reducing emergency medical length of stay, total bed opportunity per year: 81-134 beds	Continued focus on long stay patients, maximising virtual wards and focus on flow and discharge related delays to reduce LoS Expedited discharge: discharge patients earlier in the day Reduce multiple ED attendances	COO	31.03.25	Phase 1 of Flow and discharge corporate project to reduce LOS completed. Phase 2 acute and frailty models implemented December 2024. Nexus review completed dec 2024 & Better Use of Beds programme.	Ongoing
42	KPMG	Contract spend reductions (pay and non-pay)	Consideration required on use of internal bank staff who may	CNO	31.03.25	Service spec has been drafted and is	Progressing

			be instead booked at cheaper rates (as seen at other Trusts) Use of technological tools to avoid face to face bookings where appropriate and to track interpreters actual timesheets Implementation of a central booking team who may govern interpreters scheduling, authorise bookings and govern cancelled sessions Enhanced controls on invoice reconciliations and raising of purchase orders to ensure Trust not being overcharged / paying late payment charges			with procurement on the service moving forward	
43	KPMG	We recommend that a formal Procurement Strategy or Policy is created which includes: - References to fraud, bribery, corruption or the relevant legislations in the context of the procurement process, e.g. contract splitting. - The processes in place for single tender waivers (or reference to these processes in a separate document) - The consequences of staff	Creation of a procurement strategy	CFO	24.02.25	We will take this forward as part of Finance and Procurement objectives in 2025/26 and create greater awareness of the rules. Much of this is already covered in the SFIs and existing policies – rather than specifically creating a strategy – which is unlikely to widely read – we will	Progressing

		failure to comply with procurement processes - A section referencing associated policies including: Anti-Fraud, Bribery and Corruption; SFIs; Conflicts of Interest; Disciplinary and Code of Conducts.				provide training and enforce existing rules more tightly.	

Meeting of the Trust Board in Public
Wednesday, 12 March 2025

Title of Report	**Learning from Death Q3 2024-25 Update**	**Agenda Item**	5.3
Author	Sofia Power, Learning from Death Manager Wayne Blowers, Director for Quality and Patient Safety James Alegbeleye, Medical Director for Quality and Safety		
Lead Executive Director	Alison Davis, Chief Medical Officer		
Executive Summary	This is report outlines an overview of the Trusts mortality rates, together with outputs from the Learning from Deaths work that are continual on-going processes throughout the Trust, covering Quarter 3 (October 24- Dec 24) of the financial year of 2024/25. The Trust recorded 386 adult deaths over Q3. 10.3% of deaths were reviewed via the Structured Judgement Review (SJR) process. The new single SJR process is fully underway with single reviewers completing the stage 1 review and any cases requiring a second review are reviewed via a multidisciplinary team at the Stage 2 panel. Challenges include availability of SJR reviewers with sickness and annual leave. Three reviewers have stepped down from the role due to not having capacity to complete reviews. One of these has been replaced but it remains as 16 trained SJR reviewers with 2 licences unfulfilled from the Nursing cohort. Any SJRs that have learning identified are forwarded to the speciality to discuss at their Mortality and Morbidity (M&M) meetings; both positive and negative. From the data analysed from the SJR reviews, we can see that: • The majority of the patients we review are aged 70 and over and expected deaths (79.4%). • The majority of patients are female and of white ethnicity. • The majority of patients reviewed have a length of stay of between 1-6 days. Any deaths that are judged as the following criteria will be escalated to Patient Safety Incident Review Group (IRG) for investigation: 1) Definitely preventable 2) Strong evidence of preventability 3) Possibly preventable (greater than 50:50). No deaths in Q3 were graded as any of the above. However, 8 cases were escalated to the stage 2 panel for further review and six of these required investigation at the Incident Review Group (IRG). None of the deaths escalated to IRG had a harm level of death but there were some further investigations in		

the form of After Action Reviews (AAR) and A3 thinking. The details of these cases are included as an appendix to this report.

The top five themes identified from SJRs for Q3 were:

1) Problems with documentation this often relates to copy and paste of epR, specifically around working diagnoses not being updated and multiple medical eateries copied a number of times throughout the notes.
2) Problems with communication between clinical teams- this often related to patients who are seen by a number of specialities or who are on wards but being reviewed by a different specialty, with lack of ownership being identified
3) Problems with bleep systems and communication systems- this related to bleeps not being answered and a lack of awareness around the bleep escalation policy
4) Long stays in the Emergency Department (ED) .This related to frail elderly patients who have prolonged stays in ED
5) Sepsis 6 pathway not followed- a number of reviews has highlighted an issue with the sepsis 6 pathway not being followed and this often related to blood and urine cultures.

Four patients with Learning Disabilities were reviewed and in all four cases, good or excellent care was identified through all the phases of admission. There were excellent examples of MDT working and great communication with familied with sensitive, timely updates. These were shared with the specialties involved who were grateful to receive positive feedback.

Eleven out of nineteen speciality M&Ms took place in December with a lot team reporting staffing issues or administrative issues over the December period. Administration support remain the main reason minutes are delayed or not received. Although M&Ms are taking place, the feedback to the Mortality Team remains an issue with some teams having multiple reminders to send minutes through to the Mortality Team. The teams highlighted in red is where no feedback has been provided, despite several reminders being sent.

Of the 29 actions from the NICHE recommendations, only three main action areas remain. These relate to the start of the Mortality and Morbidity Review Group (MMRG) which will provide specialities an opportunity to share learning, theme and trends from mortality reviews with other specialties and triangulate this with themes and trends seen through the SJR process. The other outstanding actions relate to ongoing team relationship building and the process for a family feedback loop once concerns with care are raised to the Bereavement Team and the Medical Examiner Office. The Lead Bereavement Officer vacancy is currently going through the recruitment process. Once this position has been filled, the processes will be reviewed.

Mortality
HSMR+ for the period of Sept 23- Aug 24 Is 98.3 and ‘within expected’

SHMI for the period of Aug 23- Jul 24 is 1.20 and ‘higher than expected’. The reason for the high value is the increase in crude rate and the divergence between the expected and observed death rates. In-hospital deaths are at the

	highest point they have been whilst the out of hospital deaths has decreased. Recommendations are to review elderly patients with long lengths of stays who may have Advanced Care Packages (ACP) in place to understand challenges with discharging patients to be treated in the community. Chronic Obstructive Pulmonary Disease and Bronchiectasis and Other Connective Tissue Disease remain persistent outlying diagnoses groups. The recommendation is to review three elderly and highly frail patients who were included in the other connective tissue disease group, to review the documentation and coding and to see if they had ACPs in place, in line with the SHMI analysis. Recommendations are also to continue to focus on the validations of deaths work with a focus on respiratory.
Proposal and/or key recommendation:	Report for noting

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

Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Mortality and Morbidity Surveillance Group (MMSG) Date: 13.01.25 Meeting: Quality Assurance Committee Date: 06.02.25

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

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

Identified Risks, issues and mitigations:	-
Resource implications:	-
Sustainability and /or Public and patient engagement considerations:	-
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	-
Appendices:	Appendix 3 in 'Appendices'

Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Sofia Power Job Title: Learning from Death Manager Email: sofia.power@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 Trust Board in Public
Wednesday, 12 March 2025

Title of Report	**Perinatal Quality Surveillance Q3 2024/25 and Cultural Leadership quarterly update report**	**Agenda Item**	5.4a
Author	Alison Herron, Director of Midwifery		
Lead Executive Director	Sarah Vaux, Chief Nursing Officer (Interim)		
Executive Summary	a) Clinical Negligence Scheme for Trusts (CNST) Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9). Plus updates aligned with the minimum dataset of the PQSM are submitted monthly via Integrated Quality Performance Review (IQPR) to Quality Patient Safety Committee (QPSSC) and Quality Assurance Committee (QAC) plus every Trust Board. b) This report provides quarterly oversight for Q3 2024/25 and includes the following: c) Increase of 15% for maternity reported incidents (Datix) from last year – top categories of Medication, Clinical assessment, Infrastructure/resources, Medical Device/equipment, Treatment, procedure. d) 3 incidents reported as Moderate Harm or above: Maternal Collapse & Major Obstetric Haemorrhage at home following late referral from neighbouring Trust for Placenta praevia/accreta. Baby suffered Higher Ischaemic Encephalopathy (HIE) III and sadly demised. (Maternity Neonatal Safety Investigation (MNSI) referral)/ Post-Partum Haemorrhage (PPH) >1000mls (Termination of Pregnancy (TOP) using misoprostol. 1.8L Estimated blood loss (EBL) – patient moved to theatre for Examination Under Anaesthetic (EUA) which was converted to hysterotomy. Total EBL 3L – postnatal care provided in Maternity Enhanced Care Unit (MCU))/PPH>1000mls (PPH 1.5Ls at Elective Caesarean Section (ELCS) with placenta praevia. Further blood loss on postnatal ward and MECU. Return to theatre and required Intensive Care Unit (ICU) admission). e) Q3 Patient Safety Investigation Review Framework (PSIRF) - Database commenced March 2024 - 4 After Action Reviews (AAR) declared in 2024/5 MNSI referrals/Proportionately small numbers of incidents requiring higher level investigation both locally and via MNSI and Perinatal Mortality Review Tool (PMRT). Psychological harm is not captured on Datix and there is no clear guidance (national or local to assess level of psychological harm). f) 7 Mothers and Babies Reducing Risk through Audit and Confidential enquiries (MBRRACE) reportable cases in Q3 with all cases reported within CNST/MBRRACE timeframes. Communication and documentation being the most common themes of Perinatal Mortality Review Tool (PMRT) actions. g) Friends and Family (FFT) feedback consistently above 95% and above 70% response rate h) Re-launch of Safety Champions, with updated poster, feedback form, Standard Operating Procedure (SOP) and communication to staff. i) Safety Champion Engagement Session and Teams Talks held in quarter. Staff discussion points and concerns included: Community Broadband/Desk availability for Specialist staff/Damage to		

	Equipment/Improved team morale and retention noted across service/Community Teams note positive reduction of on-call requirements following introduction of hospital on-call/uniform j) SCORE survey (Psychological safety scale of Safety, Communication, Operational, Reliability and Engagement) postponed due to ongoing cultural improvement work/surveys across the Trust. To utilise learning from Trust survey and consider further maternity/neonatal survey if required. Staff attending Culture and Inclusion Training. k) Leadership team working to ensure staff receive updates on key national initiatives including CNST by sharing newsletter via Maternity Matters. "You Said, We Listened Posters" displayed across the unit. l) Public Health England to visit MFT on 7th March 25 to celebrate our success with the maternal vaccination programme. m) Full year 'Did Not Attend (DNA)' audit completed and presented with action plan. Training video around completion of DNA checklist created and ready for launch. n) Increase in safeguarding adults and children level 3 and Maternity Care Assistant (MCA) training for midwifery and doctor staff groups with exception of children level 3 for maternity staffing due to additional staff being added to mapping for this instead of level 2.
Proposal and/or key recommendation:	The Board is asked to note and be assured of the findings of the report

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

Governance Process: Committee/Group and Date of Submission/approval:	• Maternity and Neonatal Safety Champion Assurance Group (MNSCAG) - 7 February 2025. • QAC – noted as an Appendix to the MNSCAG Assurance and escalation report – 06 March 2025

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 to CNST Year 6/7		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery/Deputy Chief Nurse Email: alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board in Public
Wednesday, 12 March 2025

Title of Report	**Claims, Incidents and Complaints Triangulation Quarterly Report - Q3 2024/25**	**Agenda Item**	5.4b
Author	Alison Herron, Director of Midwifery		
Lead Executive Director	Sarah Vaux, Chief Nursing Officer		
Executive Summary	a) The 2014 to 2024 Claims scorecard has been published in October 2024 – with total of 52 maternity claims, 36 closed, 12 open, 4 incidents b) A significant claim was settled in 2023, with total claim value >£26 million (periodic payments). This incident took place in 2017 and related to CTG interpretation. Significant learning and improvement has been made, including implementation of Fetal Wellbeing Team and regional physiological fetal monitoring training. c) Total claims paid in past 10 years £28.5 million (£46.5 million potential value) with 2 further high-value claims currently open: 2019, ENM – Breach of Duty, admission, causation unknown, hypoxia, £14.7 million – Medium probability and 2020, Letter of response – Admission, Fistula, £2.2 million – High probability d) 11 Claims received in 2022 - 7 Closed – Nil Damages, 1 letter of admission, 2 Settled damages paid, 1 authority to negotiate/offer made. e) 12 claims have been received in 2023/2024 - Highest predicted value £0.5 million, 1 certain, 3 High probability, 8 Medium probability, 3 repudiated, 1 damages agreed out of court, 1 authority to negotiate/offer made f) Trend of paid claims remains low, with exception of the above mentioned significant claim, with approximately £2 million across all other paid claims for the 10 year period. g) Based on 2017-2022 data, MFT is the second lowest for claim value within the South East Region, and the lowest within comparable Trusts with Level 3 NICU within the South East Region. NHSR have noted that premiums for all Trusts have increased in 2024/25. h) Report also presents claims, alongside incidents reviewed at CRIG and complaint themes by Theme/Sub-Theme, Severity, Probability of Claim, Level of Harm, Level of Investigation i) The highest theme relates to fetal monitoring (9) claims, with delay in diagnosis, escalation, failure to recognise deteriorating patients, failure/delay to diagnose or treat accounting for 15 claims. This is aligned to the review of incidents for 2024 where this was also collectively a clear theme. j) Due to move to PSIRF, the numbers of higher-level investigation has significantly reduced in Maternity, with the majority of further investigations undertaken by MNSI and PMRT. We may need to consider the impact this will have on our ability to identify and defend potential claims in the future. k) 18 (5%) incidents were rated moderate harm or above in 2024 on review at CRIG. Given that 41% of current claims were datixed at moderate or above, there is a potential for some of these incidents to convert to claims in coming years. l) Asian families continue to be over represented in claims (14% compared to 6% of birth rate), with Black families underrepresented in claims – 0 claims received, >7% of birth rate and 16.8% of incidents reviewed at CRIG.		

	m) Maternity CNST rebates have successfully been reinvested in maternity and neonatal services to drive safety and quality improvements for women, birthing people and families. The importance of continuing to use maternity CNST rebates to improve outcomes for our families cannot be underestimated.			
Proposal and/or key recommendation:	The Board is asked to note and be assured of the findings of the report			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	X
Governance Process: Committee/Group and Date of Submission/approval:	• Maternity and Neonatal Safety Champion Assurance Board - 07 February 2025. • QAC – noted as an Appendix to the MNSCAG Assurance and escalation report – 06 March 2025			
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:	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 to CNST Year 6/7			
Appendices:	N/A			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act			
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery/Deputy Chief Nurse Email: Alison.herron2@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.

NHS Medway NHS Foundation Trust

Meeting of the Trust Board in Public
Wednesday, 12 March 2025

Title of Report	Human Tissue Authority Committee (HTAC) Response to the Phase 1 Independent Inquiry onto the Issues Raised by the David Fuller case chaired by Sir Jonathan Michael	**Agenda Item**	5.5
Author	Lesley Timlin, Mortuary Manager Penny Archer, Clinical Operations Manager Diagnostics and Therapies		
Lead Executive Director	Alison Davis, Chief Medical Officer and Designated Individual		

Executive Summary

Background

Phase 1 of the Independent Inquiry into the issues raised by the David Fuller case, chaired by Sir Jonathan Michael was published in November 2023. This phase of the Inquiry was established to investigate what happened in the Maidstone and Tunbridge Wells NHS Trust (MTW) to allow Fuller to commit such awful crimes and to understand how his offending remained undetected for so long.

Phase 2 (interim) of the inquiry was published in October 2024 which considers the broader national picture and the wider lessons for the NHS and those organisations outside the NHS. The inquiry sped up its work on the funeral sector because of recent reports of cases of neglect in the sector. The published interim report therefore deals specifically with the funeral sector. For wider lessons for the NHS we await the full Phase 2 report.
The final report, looking at the broader national picture and the wider lessons for the NHS and for other settings, is now planned for publication in 2025

Phase 1 of the report made 17 recommendations with the aim of preventing anything similar happening again at MTW.

	Recommendation
1	Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs
2	Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.
3	Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements
4	Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's

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	management structure and must be adequately managed and supported.
5	The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.
6	Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.
7	Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors
8	Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility
9	Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.
10	Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.
11	Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.
12	Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.
13	We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.
14	Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.
15	Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.
16	The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.
17	Maidstone and Tunbridge Wells (MTW) NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

Proposal and/or key recommendation:	The Board is asked to NOTE that the Fuller Inquiry made a total of 17 recommendations for MTW; the mortuary at the Trust underwent a full security

<table>
<tr><td></td><td colspan="5">review and upgrade in response to the initial finding of the Fuller Inquiry in December 2021 and at a recent unannounced Human Tissue Authority (HTA) inspection on 19 September 2024 security of the department was found to be fully compliant with no shortfalls identified.</td></tr>
<tr><td rowspan="2">Purpose of the report (Please mark with ‘X’ the box to indicate)</td><td>Assurance</td><td>X</td><td>Approval</td><td colspan="2"></td></tr>
<tr><td>Noting</td><td></td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td><u>Governance Process</u>: Committee/Group and Date of Submission/approval:</td><td colspan="5">Meeting: HTAC
Date: 21 February 2025
Medway NHS Foundation Trust HTA Committee</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Please mark with ‘X’ the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)</td><td>Priority 2: (People)</td><td>Priority 3: (Patients)</td><td>Priority 4: (Quality)
X</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Please mark with ‘X’ the CQC domain the report aims to support:</td></tr>
<tr><td>Safe:
X</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led:</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5">Phase 1 of the Independent Inquiry into the issues raised by the David Fuller case, chaired by Sir Jonathan Michael was published in November 2023. This phase of the Inquiry was established to investigate what happened in the Maidstone and Tunbridge Wells NHS Trust (MTW) to allow Fuller to commit such awful crimes and to understand how his offending remained undetected for so long.

The Report makes 17 recommendations with the aim of preventing anything similar happening again at MTW.

1. Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust’s external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs

A risk (issue 1344) was raised in response to the initial findings of the Fuller Inquiry and Mortuary security was significantly enhanced in December 2021 following joint review of access and security systems by the Mortuary Manager, Head of Health and Safety and Compliance, Security, and Estates.

• Paxton swipe access is located:
o Main hospital corridor, entry and exit
o Exit to covered access
o Body prep/trolley area
o Transit corridor to PM room
o Male changing areas</td></tr>
</table>

- Female changing area
- Corridor to PM room (alternative fire route-this fire exit is not automatically opened in the event of a fire alarm, it can ONLY be activated from inside the PM room)

a) Main hospital entry and rear exit (covered access/undertaker entry) controlled by both intercom and camera which is directly linked to the manned mortuary office

b) 14 CCTV cameras located in the Mortuary footprint covering all corridors, including to and from the PM room, body preparation area, covered access (undertaker) lobby

c) 14 key locked rooms, including office spaces, changing areas and the outside door

d) Numerical code locks are located on 6 doors including the relatives waiting area and viewing room

e) Access to the viewing room is by arranged appointment only and only available when Mortuary staff are able to facilitate

f) All CCTV camera footage is reviewed on a daily basis – footage is retained as per Trust policy, (CORP-EFA-HANB-6) up to 56 days

g) Swipe access reports sent and reviewed weekly in conjunction with CCTV and cross referenced

h) Unreplicable key for Mortuary outside door

i) All windows are closed at night and all internal and external doors are key locked

j) A visitor log is in place which must be completed by all visitors including contractors. Includes details of the attendee, information such as first aid and fire, and an overview of departmental security. The completed form is kept for one year and an electronic copy retained on the shared-drive

HTAC meets on a monthly basis and Mortuary Access – Security Update is a standing item.

Review of data for both access and CCTV assures the security arrangements in place and, there has been no unauthorised entry into the mortuary.

2. *Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.*

Since the publication of the Fuller Inquiry the mortuary premises have undergone two Human Tissue Authority inspections, with the last taking place on 19 September 2024. There were no shortfalls relating to security
Please see appendices for report

Mortuary SOPs and associated risk assessments direct that deceased are not left outside of refrigerated storage overnight or during maintenance.

When maintenance work is scheduled on fridges, deceased are relocated to overflow facilities. Planned preventative maintenance is undertaken during reduced pressures to accommodate this.
All documentation, including SOPs and risk assessments, and audit findings are discussed at the monthly HTA Committee meetings to ensure oversight.

3. *Maidstone and Tunbridge Wells NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements*

Mortuary staff are DBS checked on appointment in line with the Trust policy.

The Trust facilities provider is in-house and therefore covered by the revised DBS Policy. Where external contractors are used, named individuals who will be attending the mortuary are requested, along with evidence of DBS checks. Irrespective of this, works are not carried out in the mortuary without the attendance of mortuary staff being present

4. *Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.*

Mortuary Manager holds the Royal Society of Public Health Diploma in Anatomical Pathology Technology, has Fellow membership of the AAPT, and over 15 years of experience as an APT.

The mortuary sits in the Cancer and Core Clinical Services Division. The Mortuary Manager reports directly to the General Manager for Diagnostic & Therapies and is supported and accountable through this management structure.

5. *The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across two sites, that requires the appropriate level of management attention.*

N/A

6. *Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.*

Please see response to recommendation 1

7. *Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors*

The Mortuary monitors and reports on any unauthorised access, reviews CCTV footage daily and undertakes access audits weekly, plus a biannual audit of mortuary security. Although deviation/ non-conformance would be raised as an

internal report, this would also be monitored though the assurance reports discussed at the monthly HTA Committee meetings

Reviews of CCTV are undertaken each working day by mortuary staff who are Persons Designate under the HTA licence. Access event reports and access lists are provided weekly. Deviations, or omissions in data while raised internally are also discussed at the monthly HTA Committee meetings

To date there has been no unauthorised access and a report is presented by the Trust's Security Team at the monthly HTA Committee meetings.

8. *Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility*

Mortuary works closely with Estates/Security Teams to ensure that the Mortuary premises are secure and patient's safety is maintained.

Mortuary security access (including access to restricted area Abigail's Place, where deceased babies may be located) is an item on the risk register (reference:1344) and therefore an agenda item for the HTA Committee meetings. Reports from this meeting are escalated through Trust governance structures the Clinical Effectiveness and Outcomes Group (CEOG) for oversight

9. *Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.*

CCTV installed throughout the department (previously just in fridge room).

Guidance was reviewed however a decision was made not to install CCTV inside the PM room. CCTV placement, in combination with enhanced swipe access and monitoring t is in place and any illegitimate access to deceased people in the PM room is prevented and therefore negates the need for CCTV inside the PM room.

Please see full reports in the appendices (upon request).
The unannounced HTA inspection 19th September 2025 found no shortfalls relating to CCTV and security.

10. *Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern*.

CCTV is reviewed each working day by mortuary staff who are Persons Designate under the HTA licence. Staff are trained and competency assessed for this process against the SOP.

There are weekly reviews of swipe access, including checking both access lists and access events. Deviations, or omissions in data while raised internally are also discussed at the monthly HTA Committee meetings. This is for mortuary, overflow body store and Abigail's Place

Swipe access records are cross referenced against CCTV activity to ensure the legitimacy of random-access events. This forms a part of the security audit and is reported at HTA Committee meetings within the mortuary report.

11. *Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary*.

This is contractual requirement with Section 60 of the Kent County Council Coroner's Contract stating "*the mortuary will notify the coroner's contract manager of any planned HTA inspections at the earliest opportunity and inform the coroner's contract manager of unannounced HTA inspections. The mortuary will provide a copy of the inspection report"*

12. *Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased*.

N/A

13. *We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.*

Human Tissue Act Committee chaired by the DI is held monthly and provides an assurance and escalation report to the Clinical Effectiveness and Outcomes Group which in turn reports to the Quality Assurance Committee.

Mortuary access (including Abigail's Place) is a standing agenda item at HTAC and the meeting is attended by estates and security leads. Further agenda items such as assurance and escalation reports and reviews of the risk register provide comprehensive oversight of activity in the licenced areas, and associated assurance.

14. *Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.*

The DI is also the CMO (board member) who provides the board with oversight of licensed activity in the mortuary. Mortuary updates and assurance provided to Trust Board and the DI undertakes a twice yearly review of mortuary premises to enable board assurance.

15. *Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.*

The Trust recognises the HTA standards as a statuary responsibility – see unannounced inspection findings and CAPA plan in appendices.

	16. The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased. Work was undertaken by the Estates team to improve security and access, please see response to recommendation 1. 17. *Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.* In addition to the steps outlined in response 1, care after death is taught as part of EOLC training which the Trust provides to staff.		
Resource implications:	Resources have been allocated for security upgrade in the Mortuary. Additional funds have been allocated to Estates and Facilities for an Access Control Manager (in post) and software upgrade for enhanced data management.		
Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	Recent unannounced HTA inspection on 19 September 2024 reaffirmed that there are no legal or regulatory improvements in relation to the Fuller recommendations required. No shortfalls in security were identified. Inspection shortfalls were identified under Premises, Facilities and Equipment **(PFE)** and are being addressed with PIDs for staffing and refurbishment (x3) • PFE1a (*The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue*) -cleaning, damage to porous walls and limescale build up • PFE3a (*Equipment is appropriate for use, maintained, validated and where appropriate monitored)* -end of life for PM tables, replacement of whiteboards • PFE2c (*There are appropriate facilities for the storage of bodies and human tissue*) – failure of freezer affecting long term storage of bodies		
Appendices:	Appendix 1 – Response to ICB May 2024 Appendix 2 – Response to ICB July 2024 Appendix 3 – HTA Inspection report 29/11/2024 Appendix 4 - Corrective Action/Preventative Action plan in response to HTA inspection		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Lesley Timlin Job Title: Mortuary Manager Email: lesley.timlin@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		Assurance minor improvements needed.
	Significant Assurance	X	There are no gaps in assurance

Meeting of the Trust Board in Public
Wednesday, 12 March 2025

Title of Report	Safe Staffing Nursing Establishment Review		**Agenda Item**	5.6
Author	Steph Gorman, Acting Deputy Chief Nursing Officer			
Lead Executive Director	Sarah Vaux, Chief Nursing Officer (Interim)			
Executive Summary	The Safer Staffing Nursing Establishment Review paper is to provide the Executive Team and Trust Board with a high-level overview of the bi-annual review of nursing staffing levels on the Trusts inpatient adult and paediatric wards/areas. For the first time this year this report includes data from the Maternity Birthrate+ report which has been to board for the purpose of CNST. The team were able to use SNCT to conduct an Emergency Department review not previously completed. Also, Theatres, outpatients, critical care and specialist nursing teams completed an establishment review. With the changes to the SNCT tool this year this review has been able to provide better data on the need for enhanced care as the amended tool measures 2 new descriptors which relate to 1:1 care and 2:1 care. This will help form judgements on the needs for enhanced care as part of business planning for corporate nursing looking to centralise the service. Through analysis of the data from the various reports this has allowed for a clear recommendation and the next steps include future management of staffing reviews and incorporating them into divisional business planning.			
Proposal and/or key recommendation:	Recommendation is for Divisional and corporate teams to take account of safer staffing recommendations within their business planning 25/26			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Recruitment, Retention, Education and development Group Date: 27 February 2025 Trust Management Board Date: 05 February 2025 Trust Executive meeting Date: 28 January 2025 Finance, Planning and Performance Committee Date: 27 February 2025 Quality Assurance Committee Date: 06 February 2025			

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)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective:	Caring:	Responsive:	Well-Led: X
Identified Risks, issues and mitigations:	N/A				
Resource implications:	Following the uplift in establishments in April 2024 to meet the previous recommendations all further uplifts will form part of Divisional Business Planning				
Sustainability and /or Public and patient engagement considerations:	N/A				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	N/A				
Appendices:	Appendices can be supplied upon request from the Chief Nursing Officer (Interim) or Acting Deputy Chief Nursing Officer				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Name: Steph Gorman Job Title: Acting Deputy Chief Nursing Officer Email: stephanie.gorman@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.	

Safer Staffing Nursing Establishment Review

Steph Gorman – Acting Deputy Chief Nursing Officer
Caroline Mpita – Head of Clinical Workforce
Ryan Kendall – Nursing Workforce Lead

Executive Summary

- The National Quality Board (NQB 2016) requires an annual safer staffing report and the monitoring of sustainable safe staffing levels on inpatient wards to be presented to provider Trust Boards. This is also aligned to the Royal College of Nursing (RCN) Nursing Workforce Standards (2021). Boards and Executive teams have responsibility and accountability for setting, reviewing and taking decisions and action on staffing levels and skill mix.
- To meet it's responsibilities the Trust has agreed a safer staffing policy, setting out a full review of staffing establishments twice a year with data collection using the national tool undertaken with the Divisions.
- This paper complies with a good governance process and will be presented at Committees and Board to provide the Executive team and Trust Board assurance that staffing levels are safe and to highlight any areas that need further investment or development.
- Nationally agreed tools (such as the Safer Nursing Care Tool and Birthrate Plus) to support measuring of patient acuity for inpatient areas and the Emergency Department (ED) are used for safe staffing reviews. For areas where specific tools are not available guidance was used such as from the Intensive Care Society (ICS) for critical care staffing. Where there is no recommended tool, advice has been sought from the national workforce team, who have agreed the approach.
- There was an additional challenge this financial year with multiple ward moves and some areas changing bed-base between May and October.
- This report asks the committee to note the findings which divisions will build into business planning.
- The overall finding is that staffing levels across the Trust meet the requirements of safe staffing and specific findings are included at slides 4 and 5.

Introduction

- All Trust Boards have a duty to ensure that safe staffing levels are in place and that patients are cared for by appropriately qualified and experienced staff in a safe environment. They should oversee workforce issues and identify any risks to safe and high-quality care whilst ensuring that their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing (NHSEI, 2018).
- In addition, the Nursing & Midwifery Council (NMC) set out nursing and midwifery responsibilities in relation to safe staffing levels. Demonstrating safe staffing is also one of the standards that all healthcare providers must meet to comply with Care Quality Commission (CQC) regulations to ensure the delivery of safe and effective health and care. Evidence demonstrates that appropriate staffing levels and skill mix positively influence patient outcomes whereas increases in patient harm resulting in an increased length of stay and incurred financial costs to the provider are attributable to poor nurse staffing levels.
- This financial year the staffing review was carried out in May 2024 and October 2024. The review took place across general inpatient wards, maternity services, ED, theatres, Same Day Emergency Care (SDEC), critical care, outpatients.
- We also included a review for specialist nurses. The key finding there suggests there are opportunities to develop our clinical workforce in line with the NHS Long Term Workforce Plan (2023) through service transformations deploying the Advanced Clinical Practitioner (ACP) role. This is also in support of a priority in the Trust clinical strategy.
- Our approach has been externally validated and supported by safe staffing experts from NHS England.

Findings of the review

- Recording of enhanced care has become more accurate during the past financial year and we are capturing enhanced care demand - above that already built into establishments separately - with a separate budget and oversight in place. Corporate nursing will consider further development of the enhanced care team within business planning for 25/26.
- The review highlighted that we are underutilising the ‘red flag’ function on e-roster. This is a tool to support daily management of staffing in the organisation to communicate that a ward is becoming in danger of being understaffed and therefore requires escalation input from nursing managers to appropriately re-adjust the numbers and allocation of nursing staff.
- The review highlighted theatres as an area where the division is proposing service development. There is a plan to move to a 6 day elective service, therefore requiring a change to the staffing model. This is outside the scope of a safe staffing review.
- Opportunities were highlighted to develop ACP roles to support transformation of the workforce across the Trust to support priorities in the clinical strategy.

Findings for potential change to be taken forward into business planning

- During recent ward moves Keats (26 beds) moved to Sapphire (31 beds) which required an increase in staffing by 4.3 RN's and 4.3 Clinical Support Worker (CSW's). However, there are other areas where staffing needs have reduced within Medicine and Emergency Care (MEC), so divisions will be supported to manage staffing via transformation.
- Following the last safer staffing review, Surgery and Anaesthetics did not fully recruit to their increase. They developed a staffing pool to reduce reliance on temporary staffing. The pool is now recruiting and the next review will evaluate the effectiveness of this change on safer staffing levels.
- The theatres staffing review was completed by division colleagues with workforce input, and was undertaken as a service development rather than as a specific safer staffing exercise. Service developments taken forward as part of business planning are not within the scope of safer staffing. The 25/26 safer staffing review will be led by workforce with input from division colleagues to ensure robust methodology.
- Paediatric staffing was included for the wards, departments and ED. Higher acuity was found to be related to high levels of mental health presentations and safeguarding. The recruitment of a paediatric mental health liaison nurse in 25/26 is predicted to have a positive impact on this so further review is required before recommending change in establishment for those areas. Care groups continue to work collaboratively and support efficient pathway and bed utilisation.
- There remains a high level of CSW vacancies across the Trust despite continuous recruitment. The next review will consider whether any of these posts can be safely removed.

Staffing Issues and Risks

The Risk Register has 14 approved issues relating to nursing and midwifery staffing in total:

- 11 issues score 3 and are a medium priority.
- The remaining issues score 2 or less and are low priority.

There were no risks identified prior to this report however 4 risks were identified during this process which have been added to the risk register awaiting RRED approval

All issues and risks are reviewed regularly at the Recruitment, Retention, Education and Development Meeting (RRED)

Next Steps and Recommendations

- Divisions to be encouraged to utilise the reviews as part of business planning 25/26.
- Divisions and workforce teams to promote and embed the use of SafeCare - Live and the ‘red flag’ tool as part of daily staffing reviews to increase consistency of use and integrate as part of the rhythm of the Care Coordination Centre.
- Divisional leadership teams to continue to work closely with the corporate nursing workforce and education team to further reduce nurse and CSW vacancies and an overreliance on temporary staff. This joint working will use the monthly e-roster meetings to ensure compliance with rostering KPI’s, make sure we have safe, effective rosters and that the templates match against establishment and budget agreements.
- Data captured at ward level during the safe staffing review will be used to inform enhanced care needs analyses and to develop a business case for ensuring enhanced care team ‘right sizing’.

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday, 12 March 2025

Title of Report	Quality Assurance Committee - Thursday, 06 March 2025		**Agenda Item**	6.1
Author	Alana Marie Almond, Deputy Company Secretary			
Committee Chair	Paulette Lewis, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee (QAC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to assure the Board.			
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 - Thursday, 06 March 2025			

Patient First Domain/True North priorities (tick box to indicate):	Tick 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:	Tick CQC domain the report aims to support:				
	Safe: X	Effective: X	Caring: X	Responsive: X	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

Best of care Best of people Patient FIRST

	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
5	0	X	

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
a) Incivility issue need more assurance – triangulate with People Committee	People Committee	06.03.25

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

Issues and or Risks to note:

a) Risk, issues, actions and narrative must be considered in more depth on the Risk Register.
b) MSA recording in TeleTracking is an area which we are working with other providers to escalate to the provider.
c) Incivility issue needs more assurance as it keeps coming up and need to triangulate with People Committee.
d) Variation in data around PPH being taken forward in the Maternity and Neonatal Safety Champion Assurance Board.

Implications for the corporate risk register or Board Assurance Framework

There was a discussion regarding the assurance and oversight provided by the risk and issues log and the need for NEDs to have clarity on which areas of concern remain unmitigated. It was recognised that there remains work to do to ensure that there is accurate description of risk and issues and clarity on mitigations and actions which support good oversight of the areas of concern for the organisation. **ACTION NO: QAC/2025/013** – CoSec to work on the report and support development of work to ensure accuracy and timely review of risk actions to demonstrate movement and narrative.

Key Headlines	Assurance Level
2.3 and 2.4 - Committee Work Plan and Terms of Reference Both documents were **APPROVED** subject to few minor amendments as listed in the minutes. Document to be amended by Matt Capper and circulated virtually.	Assurance
2.5 - Effectiveness Survey – Results The results from the survey were presented and the Committee **NOTED** the findings. The Committee asked for the learning to be drawn from analysis of the findings to determine what development options there are for the committee. Matt Capper to action.	Assurance

3.0 - Risk, Issues and Board Assurance Framework (BAF) Discussion regarding on-going development to ensure that risks and issues provide up to date assurance and clarity on areas of focus. The Committee asked that the Risk Register is submitted when it is accurate so members are scrutinising up to date risks, issues and actions. The Committee asked that there is more work on the risk actions to demonstrate movement and more in-depth narrative.	Partial Assurance
4.0 - Patient Story The Story on the late Lisa Scott was **APPROVED** to be presented to the Board on the 12 March 2025. The Committee asked for a Staff Story to be submitted soon.	Significant Assurance
5.0 - Policies, Standards Operating Procedures and Strategies **5.1 - Patient Experience Implementation Plan** The Committee did **NOT APPROVE** the plan and asked for this to come back next meeting with minor amendments including; consideration of patient's language needs, deliverables, outcomes. **5.2 - Research and Innovation Strategy** This item was removed from the agenda and rescheduled for the April 2025 meeting.	Partial Assurance
6.1 - Quality and Patient Safety Sub-Committee The Committee raised the following as items for assurance: a) TeleTracking and MSA reporting issues which are being escalated to the provider. b) Bleep issue, update on progress next meeting with implementation of mitigations and solution. c) Nutrition related incidents are a theme in Datix, a task and finish group is established reporting into fundamental of care to understand and address issues. d) Incidents of incivility were noted in divisional reporting. e) PPH Data Accuracy is being taken forward under the Maternity and Neonatal Safety Champions Assurance Board. f) PSIRF in Maternity and roll out across the organisation was discussed. A number of actions were logged to give the Committee more assurance at future Committee meetings. The Committee were **PARTIALLY ASSURED** by the report.	Partial Assurance
7.1 - Learning from Deaths Assurance and Escalation Report, Niche Action Log The report outlined an overview of the Trust's mortality rates, together with outputs from the Learning from Deaths work up to February 2025. The Board is receiving the quarterly report on 12 March 2025. The Committee asked for further assurance around how learning has been implemented and embedded going forward. The Committee were **ASSURED** and **NOTED** the report	Assurance
7.2 - Maternity **7.2a - MNSCAG Assurance Report** **7.2b - Maternity CQC Picker Paper** **7.2c - Maternity Three Year Delivery Plan Update Report** The Committee were **ASSURED** and **NOTED** all three reports	Assurance
7.3 - Safe Staffing The report provided a high-level overview of the bi-annual review of nursing staffing levels on the Trusts inpatient adult and paediatric wards/areas. Divisional and corporate teams were asked to take account of safe staffing recommendations within their business planning for 2025/26. The Committee asked for assurance that the report is triangulated with the Finance and Clinical teams in addition to the Finance	Significant Assurance

Planning and Performance Committee. This was confirmed and the Committee **NOTED** the report.	
7.4 - Fuller Report The Fuller Inquiry made a total of 17 recommendations for Maidstone and Tunbridge Wells Trust. The Trust Mortuary at Medway underwent a full security review and upgrade in response to the initial finding of the Fuller Inquiry in December 2021 and at a recent unannounced Human Tissue Authority (HTA) inspection on the 19 September 2024 security of the department was found to be fully compliant with no shortfalls identified. The full report is on the Board agenda for March 2025. The Committee were **ASSURED** by the report.	Significant Assurance
7.5 - Quality Accounts Priorities and Timetable The Committee **APPROVED** the priorities and timetable.	Significant Assurance
7.6 - Medical Devices and Equipment Update Report The Committee was **NOT ASSURED** by the report and asked for more assurance around risk, governance and triangulation with the Finance Planning and Performance Committee. The Committee actioned Neil Adams and Matt Capper to liaise in regard to governance and triangulation of risk and inclusion in future reporting.	No Assurance
8.1 - Integrated Quality Performance Report (IQPR) The Committee noted the information on fractured neck of femur and non-ambulatory fragility fracture work on Page 203. The orthopaedic and geriatric teams are making good progress with the work. The Committee **NOTED** the report.	Significant Assurance
9.1 – Reflection a) There was good discussion and appropriate challenge. b) Conscious of time – the meeting overran, the Committee agreed to a 15-minute extension. c) Matt Capper, Alison Davis and Sarah Vaux to review agenda layout (consider the format of the FPPC agenda) to allow deep dive discussions to be earlier and pace of the meeting to be better at the start. d) Ensure papers are read in advance so discussion can be focused on the subject matter and not content/data accuracy in reports. e) Quality of papers needs to be a focus.	Not Applicable

Meeting of the Board of Directors in Public
Wednesday, 12 March 2025

Title of Report	Assurance report – People Committee 30 January 2025			**Agenda Item**	6.2
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	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	People Committee, 30 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) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Leon Hinton, leon.hinton@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None	

Items/risks/issues for escalation

Issues and or Risks to note: None
Reflection: (1) new Freedom to Speak Up report is good with a request for more data on trends; (2) require curiosity to look at MSK deep-dive across demographics and protected characteristics; (3) require reporting on strategy to demonstrate impact; (4) reaching all areas of the organisation through the Cultural Transformation programme requires staff to feel safe and speak up and there is no 'one size fits all' answer for culture.

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 December 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 (reducing incivilities) – reporting in development; • Staff appraisal – [87.9%, -0.4% deterioration, 2.1% off target] progress remains slow, backlog for uploading and reporting of appraisals; • Vacancy rate – [6.2%, 0.3% improvement, on target]; • Voluntary turnover – [8.2%, -0.3% improvement, 0.2% 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 – [5.2%, -0.0% no change, 1.2% off target] five successive months of long-term sickness improvement; however, five successive months of short-term	Assurance

sickness deterioration – addressing through occupational health investment and triangulation; • StatMan – [87.9%, +0.4% improvement, on target] with no improvement to moving and handling and improvements to most resuscitation 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. A deep-dive was included to look at the impact of moving and handling training compliance versus the relative sickness level for musculoskeletal; a detailed paper in relation to moving and handling training was provided.	
2. StatMand Assurance Report The Committee received the new assurance report for StatMand providing oversight into the progress made over all StatMand compliance requirements. A detailed report highlighted the work to improve resuscitation training across the Trust ensuring sufficient capacity. The Committee were **ASSURED** by the report.	Partial Assurance
3. People Strategy 2024-2027 implementation plan and status update The Committee received a new version of the People Strategy implementation plan presented as a dashboard. 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. The Committee requested amendments to the presentation of the dashboard and an addition of a summary and did **NOT APPROVE** the dashboard.	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. BAF 7 remains in development with the results of the 2024 staff survey following the commissioning of the Cultural Transformation programme. The Committee were **NOTED** the report.	Assurance
5. Policies for approval The Committee **APPROVED** the following policies following comment: • Consultant recruitment standard operating procedure.	Not Applicable
6. Freedom to Speak Up Report The Committee received the first Freedom to Speak Up report from the Guardian Service for December 2024. Year to date, the service had received 35 cases in total, 32 of which have been closed. Primary themes include bullying and harassment and behaviours. The majority of responses and action were responded to the same day or within a few days. Committee were **ASSURED** by the report.	Assurance

7. **Staff Health and Wellbeing Assurance Report (quarter 3, 2024/25)** The Committee received the report detailing three debrief sessions; 35 listening ear session;177 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. **National Staff Survey 2024** The Committee received an update in relation the national staff survey 2024. The response rate had improved by 8.3% from 2023 to 45.8%, greater than the 45% target for substantive staff. A 1% improvement to response rate was noted for bank staff. A coordinated effort to improvement the response rate via greater fieldwork, communications and prize drawer had the desired effect to hear from more staff. Results for the 2024 survey are not yet released and work continued at building a new dashboard for staff and managers to develop action plans. The Committee **NOTED** the update.	Not Applicable
10. **People Promise update** The Committee **NOTED** an update in to the People Promise Exemplar programme with all of the twelve focus areas on track with no new risks or barriers to delivery.	Full Assurance

Meeting of the Board of Directors in Public
Wednesday, 12 March 2025

Title of Report	Finance, Planning and Performance Committee Thursday, 30 January 2025		**Agenda Item**	6.3a
Author	Alana Marie Almond, Deputy Company Secretary			
Committee Chair	Gary Lupton, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee (FPPC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to assure the Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee, 30 January 2025			
Patient First Domain/True North priorities (tick box to indicate):	Tick 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:	Tick CQC domain the report aims to support:			
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X
Integrated Impact assessment:	Where applicable, individual considerations are provided at the FPPC Committee.			
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the FPPC 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:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@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
6	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:
No Issues or Risk from the committee to note.

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
3.1 - Financial Report Month 9, including Reducing Waste Programme The Committee **NOTED** the report. The committee requested the following from review of the report: a) Aged Debt Report to be reviewed for debt position and to include the analysis in the next Finance Report b) Model of Activity and Demand requirements for waiting time improvements to be reported to the next committee. The committee require assurance that the Operational Planning targets are being addressed and the business planning principles align with national guidance, together with a recognition of the risks to delivery. c) Recovery Support Programme Exit Criteria tracer and progress to be reviewed by the committee. d) Forward report for efficiency and productivity, taken from strategies.	Partial Assurance
3.2 - Business Planning 2025/26 The Committee were **PARTIALLY ASSURED** and **NOTED** the report. The committee requested further clarity and detail; evidence of progress, alignment of national targets activity targets and financial/workforce budgets, CIP schemes, risks and mitigation plans.	Partial Assurance
3.3 - Funding Report (RSP) The Committee **NOTED** the report, requesting spending against the NHSE allocated funding, ensuring spending matches the purpose for which is allocated.	Partial Assurance

4.1 and 4.2 - Risk and Issue Register and Board Assurance Framework The Committee **NOTED** and were **ASSURED** by the reports	Assurance with minor improvements needed.
5.1 - Maternity IT Solution The Committee **APPROVED** Option 4 in the business case. The Committee did not approve any additional revenue, this BC is self-funded through the CNST rebate	There are no gaps in assurance
7.1 - Integrated Quality Performance Report (IQPR) The Committee **NOTED** the report	No Assurance Required
8.2 - Financial Governance Review and Development of Action Plan All actions to be recorded on the master Financial Action Tracker for review and implementation to be submitted to February Board	Partial Assurance

Meeting of the Board of Directors in Public
Wednesday, 12 March 2025

Title of Report	Finance, Planning and Performance Committee Thursday, 27 February 2025		**Agenda Item**	6.3b
Author	Alana Marie Almond, Deputy Company Secretary			
Committee Chair	Gary Lupton, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee (FPPC), ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	This report is to assure the Board			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee, 27 February 2025			

Patient First Domain/True North priorities (tick box to indicate):	Tick 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:	Tick CQC domain the report aims to support:				
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led: X

Integrated Impact assessment:	Where applicable, individual considerations are provided at the FPPC Committee.	
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the FPPC 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:	Simon Wombwell, Chief Finance Officer (Interim) simon.wombwell@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	
7	1	Yes	No
		X	

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
1) Item 3.1 - The Committee asked for further detail on debtors and creditors, and for this to also form an agenda item at the Audit and Risk Committee.	Audit and Risk Committee	13.03.25

Reports not received as per the annual workplan and action required

None

Items/risks/issues for escalation

Issues and or Risks to note:
No Issues or Risk from the committee to note.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key Headlines	Assurance Level
2.3 - Finance, Planning and Performance Committee (FPPC) Annual Work Plan 2025/26 The Committee **APPROVED** the work plan, subject to minor amends	Significant Assurance
2.4 - FPPC Terms of Reference (TOR) The Committee **APPROVED** the TOR, subject to minor amendments	Significant Assurance
2.5 – Trust Investment Group TOR The proposal is for the group to be called 'Technical Issues and Delivery Group' (TIGB), the TOR was removed from the agenda as not all papers were present. The TOR will be resubmitted to March 2025 meeting.	No Assurance
2.6 - NHSE Correspondence; Kent and Medway ICB – Elective Long Waiting Position The FPPC were tabled a letter from Anne Eden in regard to placing the Trust in Tier 2 for elective care. The following was highlighted: 1) Assurance sought in regards to the 65 weeks to 0 waiting by the end of March 2025 2) Latest submission completed on Monday 24 February 2025	Assurance

3) 31 Patients breaching 65 week – this is a significant improvement 4) Patients waiting for EEG at Kings College Hospital can now access community providers in Kent, aiding the clearing of backlogs. 5) Trajectory has been submitted to the ICB for assurance. The Committee **NOTED** the letter and information tabled.	
3.1 - Financial Report Month 10, including Aged Debt Analysis and Reducing Waste Programme 1) In-month deficit of £4.9m worsens the Trust's reported YTD position to £18.5m deficit; this is adverse to Plan by £16.4m. 2) In-month performance was £0.3m / 0.9% worse than forecast. 3) The year-end forecast outturn position remains unchanged at £22.9m deficit as presented to FPPC in December. Risk to delivery is heightened due to income below expectations in December and January. 4) Efficiency plans are £0.2m adverse to the YTD plan of £17.3m, this includes a £1.3m adjustment for ERF over performance 5) The capital plan is underspending, principally in relation to CDC leases being signed. Substitute schemes are being progressed. 6) Cash at the end of January was £7.0m – the cash forecast is under constant review given the forecast run-rate. Cash support application started in February. Application for £6m, awaiting approval. Other options available via ICB. 7) The Committee asked for further detail on debtors and creditors, and for this to also form an agenda item at the Audit and Risk Committee. 8) The Reducing Waste Programme has been implemented with an efficiency target of £21.5m for 2024/25. The Committee asked for an update on digital benefits. An audit will commence w/c 03 March 2025, the FPPC would like a report on the audit findings. The Committee **NOTED** the reports.	Partial Assurance
4.1 - Strategies to Reduce Estates Maintenance Backlog The report summarised the amount of backlog maintenance identified for the Trust and the level of capital funding necessary to reduce it over a five-year period. The FPPC was asked to note the level of backlog and where it is greatest; and the costs to address the backlog. The target for capital investment is £56.17m over five years (£11.23m per annum). The FPPC was advised that the Estates Strategy will be submitted for review in three sections. The Committee were **ASSURED** and **NOTED** the update.	Assurance
4.2 - Cardiology and Patient Tracking List Management The report was submitted for noting to include the following highlights: 1) Current waiting time for cardiology appointments is around 65 weeks. 2) Discrepancy reviewing waiting times for specialties at the Trust against "My Planned Care" with waiting time of 31 weeks. 3) Business Information (BI) and IT are reviewing how the data is submitted.	Partial Assurance

4) The Medicine and Emergency Care division are working closely with the Specialist Medicine Care Group. 5) New Cardiologist recruited to increase capacity within outpatients. 6) Working through the Getting It Right First Time (GIRFT) workbooks to ensure effectivity. 7) Daily activity validation; weekly oversight. 8) Support from NHSE to redesign RTT training package for all relevant staff. The Committee were **PARTIALLY ASSURED** and **NOTED** the report	
4.3 - Safe Staffing Nursing Establishment Review This was a high-level overview of the bi-annual review of nursing staffing levels on the Trusts inpatient adult and paediatric wards/areas. Divisional and corporate teams have been asked to take account of safe staffing recommendations within their business planning for 2025/26. It is a bigger scope than seen previously, however there is a need to continue review. The Committee **NOTED** the report	Assurance
4.4 - Business Planning Progress Update 2025/26 Trust planning began in September 2024 and is following the strict timeline set nationally, for the first full plan submission on 28 March. The plan to be approved by the FPPC on 27 March with delegated authority from the Board. 1) The 18-week trajectory is 55.4% this represents a 6.6% improvement on current position but falls short of the national ambition to 60%. 2) Eradicating 52-weeks so the trajectory represents this and time to first appointment is set at 67%. 3) 4-Hour Emergency Care wait times - commitment to achieving 92% in the near future. 4) ED safe-staffing from bank to substantive, reducing bank by 15% and agency by 30%. 5) Reduce overall headcount by c.400 FTE using the NHS efficiency opportunity pack. 6) Draft planning gap of £69m with reconciliation of the £22.9m FOT deficit to £69.1m deficit planning gap. 7) Divisions and corporate areas have all been given a 5% reducing waste target. 8) The capital programme is expected to be £13M with the majority allocated against existing commitments The Committee had **LIMITED ASSURED** by the report	Limited Assurance
4.5 - Strategy, Planning and Performance Group - Assurance and Escalation Report Gavin MacDonald is reviewing the scope of the group with Katie Goodwin, NHSE. The Terms of Reference are being developed. The Committee were **ASSURED** by the report	No Assurance Required
4.6 - Improving Financial Governance Tracker The Report related to an amalgamation of various recommendations and actions taken from various Assurance Reports (including Margaret Pratt, KPMG and Grant Thornton) with a Status Update from the Executive Team to inform next steps and progress.	Partial Assurance

The FPPC were not seeing the 'golden threads' and have asked for the Executive Team to take this away and review to give further assurance. The Committee requested **FURTHER ASSURANCE**	
5.1 - Risk and Issues Register – Board Assurance Framework The FPPC Risk Register has 14 approved risks in total with 1 risk scoring 15 and above. The Committee were **ASSURED** by the reports	Assurance
5.2 - Activity and Performance Pack Combined view of all Prescription Ordering Direct (PODs) shows over-performance against Plan in January 2025 and Year to Date. 1) ED activity continues to increase. Likewise, Non-Elective activity is starting to stabilise. 2) Elective Inpatient and Day Case activity is continuing to show an over-performance for January 2025 3) Non-Elective average Length of Stay (LoS) is showing recent areas of concern, with longer periods reported. 4) Bed Occupancy for No Criteria to Reside (NCTR) patients indicates a fluctuating position. 5) Cancer 28-day Faster diagnosis did drop between April to June. 6) 65wks did no hit zero at the end of December 2024/January 7) Significant activity stood down in Cardiology due to emergency leave 8) Cardiology locum due to start April, was planned for February however original candidate withdrew 9) Consultant long-term sickness in Rheumatology which had reduced capacity 10) No Service Manager and General Manager for Rheumatology and Neurology 11) One Cardiology HMP patient currently waiting 79 weeks who have previously cancelled appointment six times 12) One year wait for EEG 13) Review of Spec Comm contract 14) ENT patients seen at DVH are sent to MFT 15) MTW handed back all patients who they had reviewed for mutual aid 16) Meeting with NHSE regarding super clinics on 20 January The Committee were **ASSURED** by the reports	Assurance
6.1 - Business Case Update: Elective Hub The Committee **NOTED** the update	Partial Assurance
7.1 - Integrated Quality Performance Report (IQPR) The report was not reviewed during this meeting.	Not Applicable

Meeting of the Trust Board in Public
Wednesday, 12 March 2025

Title of Report	Strategy Road Map Review		**Agenda Item**	6.4
Authors	Lauren Pryor, Senior Project Manager Maya Guthrie, Project Manager			
Lead Executive Director	Matt Capper, Director of Strategy and Partnerships			
Executive Summary	The strategy review outlines the current and on-going status of the Strategy and Partnerships portfolio.			
Proposal and/or key recommendation:	a) Provide Assurance on updates. b) Approve the following proposal on slide 9: "Governance To ensure a timely governance process to avoid delays, it has been proposed that where appropriate, refreshed Strategies will be submitted virtually to Trust Board for approval with material changes to the content highlighted for ease of reading."			
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:	This is the first piece of governance.			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Re: "Governance" proposal above – to date, multiple refreshed strategies have been delayed multiple times due to other papers needing review more urgently. The mitigation to submit virtually will overcome this, ensuring refreshes follow their intended governance of annual refreshes to time.			
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:	Name: Maya Guthrie Job Title: Project Manager Email: maya.guthrie@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.

NHS
Medway
NHS Foundation Trust

Strategy Review

Strategy and Partnerships

March 2025

Patient FIRST

Approved Strategies

NHS Medway NHS Foundation Trust

	Quarter 2			Quarter 3			Quarter 4			Quarter 1		
	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Patient First	Development of Strategy		Trust Board	✓								
Infection, Prevention and Control	Development of Strategy		Trust Board	✓								
Clinical Strategy	Development of Strategy						Trust Board	✓				
Digital, Data and Technology				Development of Strategy				Trust Board	✓			
Quality Strategy				Development of Strategy				Trust Board	✓			
Research and Innovation					Development of Strategy					Trust Board	✓	
People							Development of Strategy				Trust Board	✓
Financial Sustainability							Development of Strategy				Trust Board	✓

Approved Strategies cont.

NHS Medway NHS Foundation Trust

	Quarter 2			Quarter 3			Quarter 4			Quarter 1		
	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Information Governance	Development of Strategy					Trust Board	✓					
Freedom to Speak Up	Development of Strategy						Trust Board	✓				

Strategies in Progress

NHS Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '25	Feb '25	March '25	April '25	May '25	June '25	Jul '25	Aug '25	Sep '25	Oct '25	Nov '25	Dec '25
Infection Prevention and Control Refresh	Development	Board										
Patient Experience Refresh	Development	Board										
Research and Innovation Refresh	Development		Board									
Patient First Refresh	Development			Board								
DDaT Refresh	Development					Board						
Estates and Facilities	Development											
Nursing, Midwifery and Allied Health Professionals	Development											
Quality Refresh	Development											
Cyber	Development											
Virtual Hospital	Development											
Health and Safety	Development											
Financial Sustainability Refresh	On Hold											
Frailty	Development											

Approved Implementation Plans

Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '24	Feb '24	March '24	April '24	May '24	June '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24
DDaT			Development		DDaT Group	✓						
People				Development		People	✓					
Research and Innovation				Development			QAC	✓				
Financial Sustainability						Development	FPPC	✓				
Quality				Development			QPSSC	✓				

Implementation Plans in Progress

NHS Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan 25	Feb 25	March 25	April 25	May 25	June 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Information Governance	Development	QAC										
Freedom to Speak Up	Development		People									
Patient Experience	Development		QAC									

Governance

To ensure a timely governance process to avoid delays, it has been proposed that where appropriate, refreshed Strategies will be submitted virtually to Trust Board for approval with material changes to the content highlighted for ease of reading.

Coming Up

The following areas will be supported to publish strategies: Virtual Hospital, Frailty, and Health and Safety. Initial meetings have been had, and estimated publication dates will be shared soon.

Accessibility

The Strategy and Partnerships team continue to ensure all Strategy documents comply with accessibility guidance, at a high standard.

Strategy Template

The fully accessible strategy template - available on Q-Pulse – continues to be utilised, as does the approved Implementation Plan template ensuring standardisation across all Trust strategy documents.

Strategy Summaries

The Strategy and Partnerships team work closely with the Communications and Engagement team to produce summaries of our key strategies for publication on the Trust intranet and website. Summaries are available for Clinical, Quality, People and DDaT.

In Progress

- **Clinical Strategy:** The Strategy and Partnerships team is soon to begin a refresh of the Trust Clinical Strategy. The focus will be to interview Divisional and Specialty colleagues to collaborate on a piece showcasing successes achieved over the last year. We aim to have this ready for publication in October 2025.

- **Patient First Strategy Refresh:** The Strategy team are working closely with the Transformation Team to support the refresh as well as attending key meetings with Transformation on the next key steps. We are now awaiting agreement on changes to the existing True North domains.

- **Trust Green Plan:** We plan to support the review and refresh activities of the Trust Green Plan to align with national publications.

- **DCP Nelson Ward:** The strategy team has been instrumental in providing support to the Estates and Facilities team to research for, write and submit to NHSE, a ‘Viability Assessment’ relating to funding for a four storey in-patient building following the demolition of the current Nelson ward.