Agenda

Public Trust Board Meeting

Wednesday, 12 July 2023 at 12:30 – 15:30 in the Trust Boardroom 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, Action Log and Updates**				
2.1	Minutes of the 10 May 2023	Chair	3	12:35	Approve
2.2	Action Log		7		Discuss
2.3	Chief Executive Update	Chief Executive Officer	9	12:45	Note
2.4	Council of Governors Update	Lead Governor	Verbal	12:50	Note
3.	**Integrated Quality Performance Report and Board Assurance Framework**				
3.1	Integrated Quality Performance Report	All Executives	11	13:00	Assure
3.2	Board Assurance Framework		65	13:15	Assure
	WELLBEING BREAK			13:25	
4.	**QUALITY**				
4.1	Quality Assurance Committee Update (May/June)	Chief Nursing Officer, Chief Medical Officer, NED	69 75	13:35	Assure
4.2	Maternity Reports: a) Caesarean Section Audit	Consultant Obstetrician and Gynaecologist	83	13:45	Note
4.3	Maternity Reports: a) Maternity Workforce Report b) CQC Outcome and Action Plan	Head of Midwifery and Nursing	107 123	13:50	Note
4.4	Data Security Tool Kit - KPMG Audit 2023	Chief Medical Officer	129	14:00	Assure/ Approve
5.	**PEOPLE**				
5.1	People Committee Update (May)	Chief People Officer, NED	157	14:05	Assure

Agenda

6.	PATIENTS				
6.1	Clinical/Staff Story: Mortuary Service Update	Associate Director of Patient Experience	163	14:15	Note/ Discuss
	WELLBEING BREAK			14:30	
7.	**SUSTAINABILITY**				
7.1	Finance, Planning and Performance Committee Update (May/June)	Chief Finance Officer, NED	167 173	14:40	Assure
7.2	Finance Report (Month 2)	Chief Finance Officer	179	14:50	Note
7.3	Trust Annual Report and Accounts 2022/23	Chief Finance Officer	193	15:00	Approve
8.	**SYSTEMS AND PARTNERSHIP**				
8.1	Audit and Risk Committee Update (June)	Chief Financial Officer, NED	323	15:10	Assure
8.2	Kent and Medway Pathology Network Collaboration Agreement	Chief Operating Officer	327	15:20	Approve
9.	**CLOSING MATTERS / COMMITTEE BUSINESS**				
9.1	Questions from the Public	Chair	Verbal	15:25	Discuss
9.2	Reflection				Discuss
9.3	Any Other Business				Note
9.4	Date and time of next meeting: 13 September 2023 – Formal Board				

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 10 May 2023 12:30-15:30

MS Teams / Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

PRESENT		
	Name:	**Job Title:**
Members:	Jo Palmer	Trust Chair
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Evonne Hunt	Chief Nursing Officer
	Gavin McDonald	Chief Delivery Officer (Interim)
	Jayne Black	Chief Executive Officer
	Jenny Chong	Associate Non-Executive Director
	Leon Hinton	Chief People Officer
	Mark Spragg	Non-Executive Director
	Nick Sinclair	Chief Operating Officer
	Rama Thirunamachandran	Academic Non-Executive Director
	Sue Mackenzie	Non-Executive Director
Attendees:	Alana Almond	Deputy Company Secretary (Observing)
	David Brake	Lead Governor
	Emma Tench	Assistant Company Secretary (Minutes)
	Gignesh Patel	Staff Governor
	Jennifer Oliphant	Governor
	Matt Capper	Director of Strategy and Partnership, Company Secretary
	Vanessa Page	Staff Governor
Apologies:	Adrian Ward	Non-Executive Director
	Paulette Lewis	Non-Executive Director

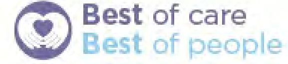
Opening Matters

1 Chair's Introduction, Update and Apologies

The Chair welcomed all present. Alana Almond attended as an observer and additional attendees joined the meeting for their agenda item only, as recorded above.

Apologies for absence were noted as recorded above.

1.1 The Chair updated the Board highlighting the following updates to the Board on this date:



a) Performance of the Trust in relation to waiting times in its Emergency Department, Surgery, and Diagnostics. The Trust continues to work hard to improve the experience of patients.
b) The Patient First strategy continues to drive and deliver improvements, with notable achievements seen.
c) The Trust continues to celebrate successes. On 27 April 2023, trophies were presented at the Annual Staff Award Ceremony, thanking colleagues for their fantastic work last year. The Trust continues to celebrate its successes, continuing to aim ever higher to deliver the best care for patients, working towards a shared goal.
d) There have been many challenges for teams across the Trust, from industrial action to adapting to living with Covid (although numbers are currently very low), however the workforce continues to rise to these challenges.
e) Welcome to Alana Marie Almond, Deputy Company Secretary; Gavin Macdonald, Chief Delivery Officer (Interim) and Nick Sinclair, Chief Operating Officer.

2 Quorum
The meeting was confirmed to be quorate.

3 Declarations of Interest
There were no conflicts of interest in relation to items on the agenda.

4 Minutes of the Last Meeting
The minutes of the meeting held on 29 March 2023 were **APPROVED** as a true and accurate record.

The Action Log was reviewed and updated.

5 Chief Executive Update
Jayne Black presented the paper provided for the Board to note.

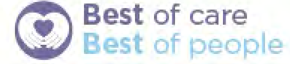
Council of Governors Update

6 Lead Governor Update
David Brake gave a verbal update to the Board for noting and highlighted the following:
a) The Governors attended a public event to support Maternal Mental Health Awareness Week, also attended by the Mental Health Midwife and the Thrive Specialist Mental Health Midwife.
b) Governors joined the Engagement, Charity and Research teams at The English Festival, with new members signing up.
c) Governors are to attend the Drill Hall University with 'Blue' one of the Trust's Therapy Dogs, in addition to the; Kent Dementia Showcase, Medway Armed Forces Day and Summer Fun Day.
d) Staff Governors Mohamed Mohamed and Nithesh Mathai have stood down as Governors, due to leaving the Trust employment. The Board and the Council thank both Staff Governors for their service. Two new staff Governors will be taking up the vacant roles; Mohamed Saleh and Karen Fegan. Both were nominees in the 2022 elections.
e) The Board NOTED the update and thanked the Council for their ongoing support.

Assurance Items

7 Committee Updates

7.1 Quality and Assurance Committee (QAC)



Evonne Hunt, Chief Nursing Officer, presented the QAC assurance report, for Board assurance and noting.

a) The Board was advised the items for Board Escalation on the report are for visibility only.

7.2 Finance, Planning and Performance Committee (FPPC)
Annyes Laheurte, NED/Chair of FPPC, presented the Committee's Assurance Report to the Board for assurance and noting.

7.3 Audit and Risk Committee (ARC)
Mark Spragg, NED/Chair of ARC, gave a verbal update on the last Audit and Risk Committee meeting to the Board for assurance and noting. Highlighting the following:

a) Internal Report has been completed, RAG rated green/amber.
b) Audit Action Tracker; is now managed by the Company Secretariat. Updates sent to KPMG on a monthly basis for formal closure. Management response will be required.
c) Annual Accounts noted the Trust is a going concern, this was approved by ARC.
d) Tender of External Auditors; this is due in June 2023, there are no further discussions at this stage. The current market for external auditors is weak in terms of competition.
ACTION NO - TB/013/2023: Update on External Auditors tender from Alan Davies to come to next Board meeting.

7.4 People Committee (PC)
Leon Hinton, Chief People Officer, presented the Committee's Assurance Report to the Board for assurance and noting.

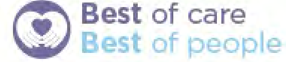
The Board was **ASSURED** by the Committee reports and **NOTED** the updates.

8 Integrated Quality Performance Report (IQPR)
The Executive team presented the IQPR to the Board for noting.

a) The Board was updated on Systems and Partnerships. The 'step change' has been important to the organisation in reducing escalation beds, with PAHU shutting ahead of time. The Admission and Discharge Lounge is now open.
b) The Board was updated on Quality, highlighting Mortality rates increasing. The Board was advised through the QAC that the reviews and deep dives give assurance that there are no issues within clinical care and no harm is being caused by the care being provided. Currently data is being reviewed to ensure quality and consistency in recording and delivery. No failings in care have been identified and this result has been triangulated with the Medical Examiners Office findings. Mortality rates are monitored monthly by QAC and by the Mortality Group.
c) The Board **NOTED** the updates.

9 Annual Business Plan (updated)
Alan Davies, Chief Finance Officer, presented the report updating on progress with the Trust's planning process for 2023/24 and the current position against planning requirements. The Board was asked to note the report.

a) The Board commented on an incredibly stretching plan, that if delivered, will provide the largest saving in any fiscal year. The Board gave its full support and believed that targets are achievable with Patient First initiatives providing the foundation. The Trust is currently in a good position with performance, which will not distract from delivering the plan.
b) The Board **NOTED** the report.



10 Green Plan

Alan Davies, Chief Financial Officer presented the report, outlining the 'Greener NHS National Programme' for the Board to note.

a) The Board suggested the establishment of the Strategic Sustainability Committee, which following the correct governance process, will deliver updates to the Board.
b) The Board discussed recruiting Green Plan Champions to drive the initiative forward. The Patient First methodology would be applied to the programme, ensuring communication is cascaded throughout the Trust and the Champions would drive delivery.
c) The Board **NOTED** the report.

11 Finance Report

Alan Davies, Chief Financial Officer presented the report and updated on the Trust's Month 12 financial position for the Board to note.
a) The Trust reports a £4.9m surplus for Month 12, this being £3.9m favourable to the final plan submitted to NHSE for the month.
b) The Board **NOTED** the update.

Escalation or Decision Items

12 Medway Foundation Trust (MFT) Constitution

Matt Capper, Director of Strategy and Company Secretary presented the Constitution, and asked the Board to approve the document for publication.

a) The Board was advised that the change summary document detailed changes to the document. The Council of Governors approved the Constitution at an extraordinary meeting in April 2023.
b) The Board **APPROVED** the MFT Constitution

Closing Matters

13 Questions from the Public

There were no questions received from the public.

14 Any Other Business

Jo Palmer, Chair, advised the Board of the recognition regarding the investigation by the NMC. The Trust will work with partners and colleagues to support impacted colleagues.

15 Board Review of Meeting
a) APPROVAL of the Trust Constitution.

16 Date and time of next meeting

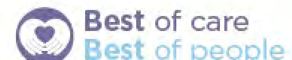
16.1 The next PUBLIC Trust Board meeting will be held on Wednesday, 12 July 2023

16.2 The meeting closed at 14:05

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 10 May 2023

Signed ………………………………………….. Date …………………………………
Chair

DRAFT



Board of Directors in Public
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
01.02.23	TB/005/2023	Steering group reviewing whole Trust data to feed through to QAC and cascade to Board	13.09.23 ~~29.03.23~~	Evonne Hunt, Chief Nursing Officer	19.06.23 - **IN PROGRESS** - verbal update at Board on current position. This will be managed through QAC and reported into Board. 10.05.23 - Governance structures being updated. Meeting held with Directors to discuss. 29.03.23 - Co.Sec to schedule meeting with CNO, focus on sustainability of data.	White
29.03.23	TB/007/2023	Review how data is recorded and presented to Committees via A3.	12.07.23 ~~10.05.23~~	Jayne Black, Chief Executive	19.06.23 - **ONGOING** - CE will update at Board meetings as part of IQPR update. 10.05.23 - using IQPR methodology to drive through committees for an update in July. Patient First session on 02.05.23 to review how A3 can be used in committees.	Amber
29.03.23	TB/010/2023	NEDs to be invited to a Digital Framework session to explore data connectivity, IT and Trust objectives	28.06.23 ~~10.05.23~~	Gavin Macdonald, Chief Delivery Officer (Interim)	**PROPOSE TO CLOSE** - Board was presented to at Board Development session on 28.06.23 (Digital Strategy). 10.05.23 To discuss at Board development day Date to be confirmed for digital framework	Green
29.03.23	TB/011/2023	Audit for c-section rates at Medway to come to the next Board meeting	12.07.23	Ali Herron, Director of Midwifery	**PROPOSE TO CLOSE** - Paper submitted to July Board. 05.04.23 - CS Audit to go to MNSCAB on 5.5.23 then to QPSSC and QAC, then to Board in July.	Green
29.03.23	TB/012/2023	Comparators with fetal medicine unit and c-section to be included in next Perinatal Quality Surveillance report	12.07.23	Ali Herron, Director of Midwifery	**PROPOSE TO CLOSE** - Paper submitted to July Board. 05.04.23 - to be incorporated into the next quarterly PQSM or within CS audit in July 23	Green
10.05.23	TB/013/2023	Update on External Auditors tender at the next Board meeting	12.07.23	Alan Davies, Chief Finance Officer	PROPOSE TO CLOSE - Given the national external audit market conditions, CFO recommending an extention of the existing contract for the second of its 'plus one' years. CFO reviewing conditions with system partners and will launch a procurement exercise as applicable.	Green

Chief Executive's Report – July 2023

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.

Junior doctors' industrial action

Junior doctors across the country took part in further industrial action in June.

To ensure patient safety, we made the difficult decision to cancel some non-urgent outpatient and elective procedures. We are pleased to say that we cancelled fewer appointments than for the previous industrial action, but we do appreciate that any cancellation is one too many. We would like to apologise to any patients that were impacted.

Further industrial action is currently planned for July, and we will continue to work hard to ensure we have robust plans in place to ensure safe care and minimise the impact to patients.

Patient First project wins major award

I was thrilled to see that our Patient First led project to improve the care of deteriorating patients and reduce avoidable cardiac arrest calls (2222 or crash calls) was named a regional winner at the prestigious NHS Parliamentary Awards last month.

This multidisciplinary team project has seen colleagues record an impressive and sustained reduction in avoidable cardiac arrest calls across acute and emergency care from an average of five calls per month to just one.

The Trust has also been named as a finalist in three separate categories for the Health Service Journal (HSJ) Patient Safety Awards. Our 2222 project has been shortlisted in two categories (Quality Improvement Initiative of the Year and Deteriorating Patients and Rapid Response Initiative of the Year), while our positive work in launching an Acute Medical Model and significantly reducing ambulance handover times has also been recognised and is nominated for Urgent and Emergency Care Safety Initiative of the Year.

The winners will be announced at a ceremony in Manchester on 18 September and I would like to congratulate and wish good luck to everyone involved!

Mask wearing – changes to practice

In line with national guidance, and the Trust's living with Covid plans, we have reduced the need for disposable face masks to be worn in some areas of the hospital. Disposable face masks need now only to be worn by staff, patients and visitors in Lawrence Ward and Galton Day Unit.

Staff, patients, and visitors are welcome to wear a mask or face covering in other areas of the hospital if it is their personal preference to do so.

Thanking our volunteers

I was really pleased to be able to present long service awards, with Jo Palmer, our Trust Chair, at the Volunteers' Cream Tea event last month.

It was lovely to see so many of our volunteers in person, to be able to talk to them and find out why they like volunteering at Medway. The annual event, which marked the end of Volunteers' Week, allows us to thank our fantastic volunteers for everything they do to help the Trust provide care to our community.

Celebrating our NHS

This month we celebrated an important moment in history – the 75th birthday of the NHS. Since its creation in 1948, the NHS has become a symbol of hope, compassion, and resilience. The NHS is one of the few totally publicly funded healthcare services in the world and it has treated and saved the lives of millions of people. Each one of those patients was treated on a basis of their need rather than their ability to pay.

I'm sure you will agree that really is something to celebrate, and that's exactly what we have been doing, with a full programme of events, which has included a free staff lunch and an exhibition about our history.

Communicating with colleagues and the community

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

Integrated Quality & Performance Report

May - 2023

Executive Summary

Jayne Black
Chief Executive

True North	Sub Domain	Variation: Common cause	Variation: Improvement (L)	Variation: Improvement (H)	Variation: Concern (L)	Variation: Concern (H)	Assurance: Pass (P)	Assurance: Fail (F)	Assurance: Hit and miss (?)
Patients	Complaints	4	0		2		0	1	1
	FFT	3	5		2		0	9	1
	PALS	3	0		1		0	0	0
	Patient Experience	1	0		1		0	0	2
	PHSO	3	0		1		0	0	0
People	Workforce	4	8		2		1	3	6
Quality	Falls	7	0		0		0	0	3
	Health & Safety	1	1		0		0	0	0
	Incident Management	9	7		4		1	3	1
	IPC	5	4		1		1	0	3
	Maternity	8	1		0		0	0	0
	Medicines	2	0		0		1	0	0
	Mortality	7	1		3		1	2	3
	Pressure Ulcer	4	1		3		0	0	2
	Risk & Policy	4	1		1		0	0	0
	VTE	1	0		0		0	0	1
Sustainability	Financial Position	8	2		3		0	0	8
Systems & Partnerships	Access	16	2		7		3	4	11
	Emergency Care	4	4		3		1	3	5

Patients

Evonne Hunt
Chief Nursing Officer

Operational Lead:
Dan Rennie-Hale - ***Director of Quality & Patient Safety***
Nicola Lewis - ***Associate Director of Patient Experience***

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

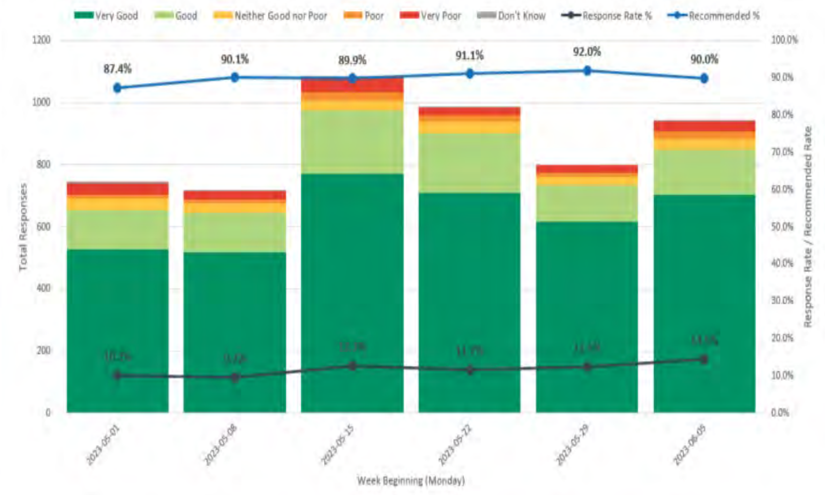
Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	95.0%			81.4%	79.2%	78.9%	84.0%	74.6%	84.9%	84.3%	87.9%	87.7%	87.5%	88.4%	89.9%

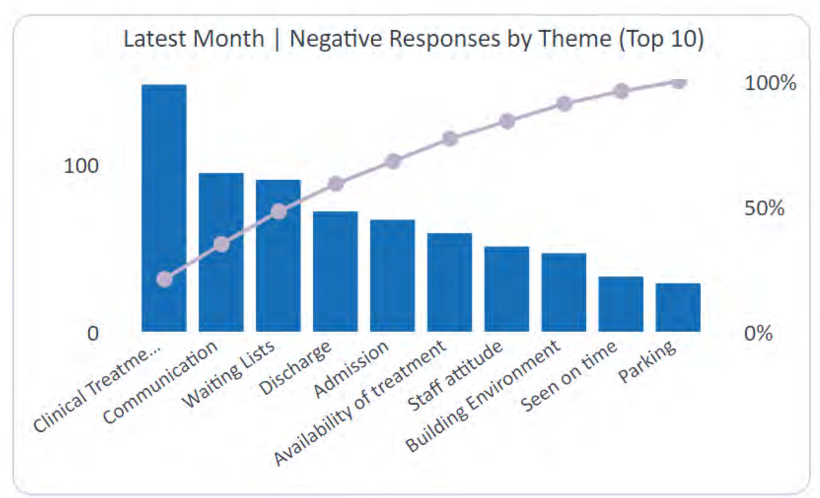
True North Domain: **Patients**

KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary: 3, 2, 0, 0, 5





Key Messages

- The total response rate for FFT Trust wide has marginally improved month on month.
- The inpatient recommend and response rate has improved overall in the last reporting period.
- A two hourly checklist has been developed and implemented in the Paediatric assessment unit to ensure patients and their families are kept informed while they wait
- One electronic display board has been installed in ED to keep patients informed of waiting times and pertinent messages
- The recommend rate for Maternity has decreased in the last period, this is related to operational challenges within the department

Issues, Concerns & Gaps

- The issue with the availability with electronic devices and tablets remains a challenge.
- Specialist nurses and areas are not added to GATHER to collate FFT
- Themes and trends from feedback have identified the need for patients to be informed of waiting time and managing expectations in ED and assessment areas

Actions & Improvements

- A charitable funds request has been considered to purchase 190 tablets for clinical areas. This will equate to three tablets per ward in which to complete the FFT survey and electronic meal ordering.
- To ascertain a complete list of specialist nurses and include them on GATHER to capture feedback from their area
- For ED to install further information boards in waiting and assessment areas

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Patients	FFT			Total FFT Recommend %	95.0%			81.4%	79.2%	78.9%	84.0%	74.6%	84.9%	84.3%	87.9%	87.7%	87.5%	88.4%	89.9%
				Total FFT Response Rate %	45.0%			11.2%	10.5%	10.4%	9.5%	11.2%	8.1%	10.6%	9.8%	9.8%	9.9%	9.4%	11.3%
				Inpatients FFT Recommend %	95.0%			83.5%	65.8%	75.6%	75.6%	70.3%	90.7%	86.0%	87.6%	89.1%	85.5%	85.7%	90.7%
				Inpatients FFT Response Rate %	45.0%			21.2%	17.2%	19.3%	15.8%	18.8%	10.3%	14.7%	14.2%	15.4%	16.7%	15.0%	24.0%
				Emergency Care FFT Recommend %	95.0%			65.1%	66.5%	52.6%	70.9%	61.3%	66.8%	67.3%	75.7%	73.5%	73.7%	82.9%	81.1%
				Emergency Care FFT Response Rate %	45.0%			14.0%	13.8%	15.0%	12.3%	12.7%	8.4%	9.0%	7.9%	7.3%	7.1%	7.4%	8.2%
				Outpatient FFT Recommend %	95.0%			88.4%	88.0%	88.9%	88.5%	89.7%	90.0%	90.3%	91.4%	91.1%	91.7%	91.4%	92.8%
				Outpatient FFT Response Rate %	45.0%			8.1%	8.3%	8.1%	8.0%	8.5%	7.5%	10.5%	9.2%	9.3%	8.8%	8.3%	8.9%
				Maternity FFT Recommend %	95.0%			100.0%	100.0%	100.0%	100.0%	95.0%	88.2%	55.6%	97.3%	92.5%	95.1%	95.6%	89.5%
				Maternity FFT Response Rate %	45.0%			28.1%	28.4%	27.1%	28.7%	10.8%	4.3%	2.4%	31.2%	21.1%	53.6%	31.5%	43.5%
	Patient Experience			Mixed Sex Accommodation (MSA) Compliance %	0.0%			0.4%	0.5%	0.8%	0.8%	1.2%	2.0%	2.0%	2.1%	5.1%	4.3%	1.2%	1.1%
				Mixed Sex Accommodation Breaches	0			69	93	140	139	211	346	348	389	835	795	205	189
	Complaints			Complaints	-			38	28	49	39	50	37	37	32	52	44	30	23

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Patients	Complaints			Complaints Closed	-			59	59	26	34	25	20	21	44	42	31	16	46
				Complaints Open - Month End	-	H		137	106	129	134	159	176	192	180	191	205	219	197
				Complaints Re-Opened	-			2	1	0	1	0	8	0	2	3	6	0	0
				Complaints Acknowledged Within 3 Working Days %	95.0%		?	100.0%	96.4%	95.9%	100.0%	92.0%	94.6%	94.6%	90.6%	96.2%	95.5%	96.7%	100.0%
				Complaints Breached %	5.0%	H	F	61.3%	42.0%	53.1%	67.5%	69.2%	80.0%	75.0%	73.0%	77.3%	82.5%	82.9%	88.6%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			418	441	467	406	469	507	367	432	377	346	251	403
				PALS Closed	-			376	379	433	1,811	451	478	345	357	258	256	188	278
				PALS Open - Month End	-	H		1,327	1,389	1,423	18	36	65	87	163	282	372	435	560
				PALS Converted to Complaints	-			0	3	6	3	2	1	6	4	8	4	2	2
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	H		2	1	1	1	1	1	0	1	2	3	1	1
				PHSO Cases Closed - Partially Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Not Upheld	-			0	0	0	0	0	1	0	0	0	0	0	0

SIOR - Patients

Successful Deliverables

- There has been a consistent reduction in Mixed Sex Breaches across the organisation in the last 2 months. this has been as a result of the deep dive / A3 work that commenced and a wider engagement in weekly meetings to validate the data process.
- 46 complaints closed in month (highest since July 2022) with no indication that there has been an increase in re-opened cases or cases referred to PHSO.
- 197 total complaints open – first reduction in month on month increase since January 2023
- 100% of complaints acknowledged within 3 working days

Next Steps

N/A

Identified Challenges

- There is an emerging theme of administration errors on the SSRS reporting system in relation to MSA breaches.
- Large backlog to address requiring significant time and resource over a continued period
- High and increasing breached position due to historical complaints
- HR delays in recruiting into short term complaints posts

Next Steps

- The BI team and Matrons meet for 30 minutes each week to validate the MSA data
- Revision and completion of the MSA policy which is due for completion, following the A3 deep dive work in June 2023.

Opportunities

- To understand the timeline for the implementation of teletracking and how MSA breaches will be monitored and reported.
- Additional resource for complaints secured to address backlog

Next Steps

- To commence work with the EDI lead to reflect the care needs of patients who are transgender and non-binary when considering MSA.

Risks

- There is a lack of robustness in the management approach to MSA. This is reflected on the risk register as a score of 12.
- HR delays putting recruited individuals at risk of seeking alternative employment
- Complaint responses sitting with the complaints team for drafting currently <25 (down from 87); failure to receive comments from clinicians will cause the recovery plan to stall.

Next Steps

N/A

Quality

Evonne Hunt
Chief Nursing Officer

Alison Davis
Chief Medical Officer

Operational Leads:
Dan Rennie-Hale - *Director of Quality & Patient Safety*
Vacant - *Medical Director for Quality & Safety*

Committees:
Quality Assurance Committee (QAC)

Quality

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

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	95.0%		P	99.0%	99.3%	99.1%	98.9%	98.6%	98.7%	98.8%	98.7%	99.6%	99.6%	99.2%	98.9%

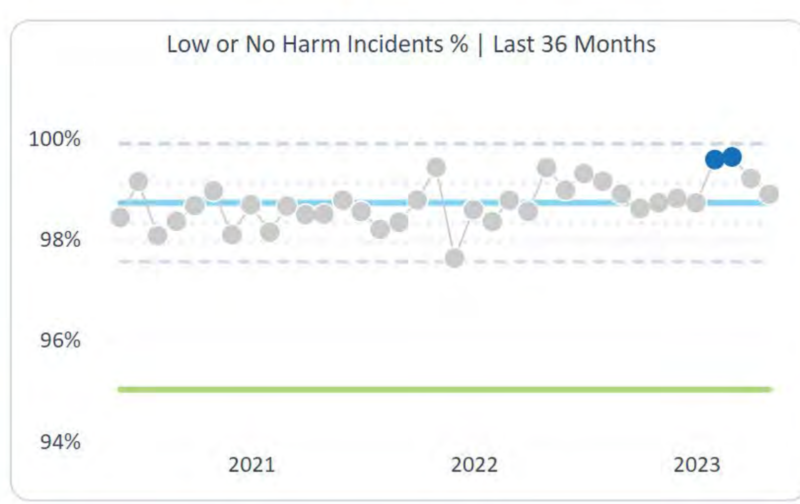
True North Domain: Quality

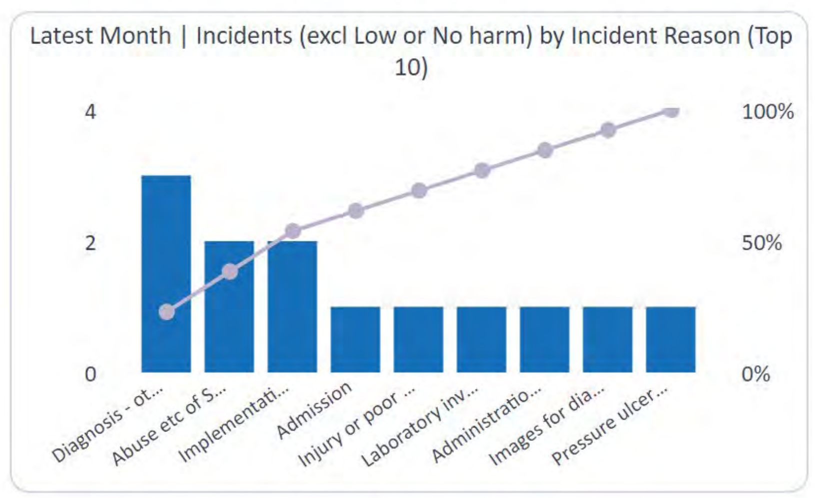
KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary:

	L	H	L	H
9	0	4	3	4





Key Messages

- Patient harms remain variable but above target. Moderate and above harms remain consistent at less than 2% of total reporting.
- Incident reporting has decreased slightly due to a reduction in 12 hour breaches being reported to the datix system.
- Slips, trips and falls has reduced this month, and diagnostic incidents have increased. The cause of this is under review.
- Work to move the Trust towards Patient Safety Incident Response Framework (PSIRF) has commenced.
- Dashboards are under creation for individual care groups. BI have produced an oversight dashboard for care groups and there will be datix dashboards for specialty information.

Issues, Concerns & Gaps

- Learn From Patient Safety Events have now been activated on the datix test system. This will need testing and the form to be redesigned. The impact of this on reporting is as yet unknown but work to make reporting as simple as possible for staff will continue.
- The PSIRF project will require multiple work-streams including involving patients in patient safety, revisions of the incident management policy and collaboration with the ICB. This will detract some staff from patient safety consequences.

Actions & Improvements

- New datix form continues to embed with additional reporting functions being added including; migration of the security officer form and a safeguarding tab to capture safeguarding investigations. The possibility of capturing SJR discussions on this is also under consideration to support the learning from death lead and improve triangulation.
- Data quality issues are being resolved to improve data quality and assurance provided.
- Daily cleanse continues to highlight incidents for early escalation and declaration if meeting SI threshold.

Quality

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

Mortality

Crude Mortality Rate %

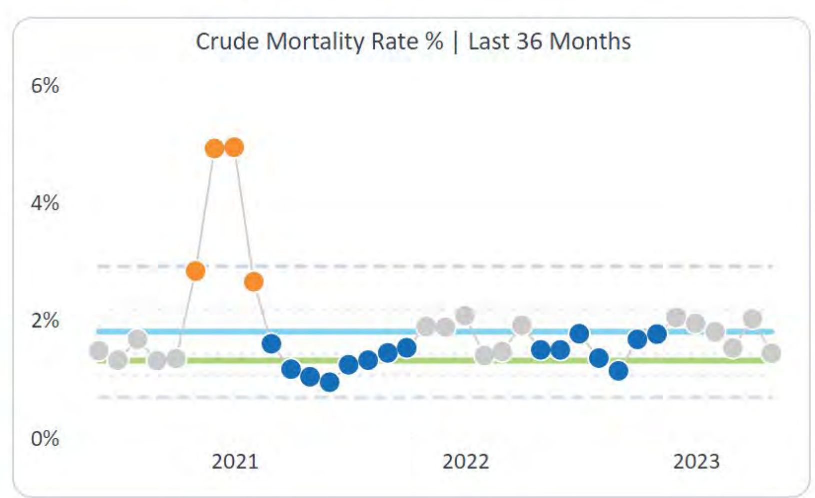
Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	1.3%			1.5%	1.8%	1.3%	1.1%	1.7%	1.7%	2.0%	1.9%	1.8%	1.5%	2.0%	1.4%

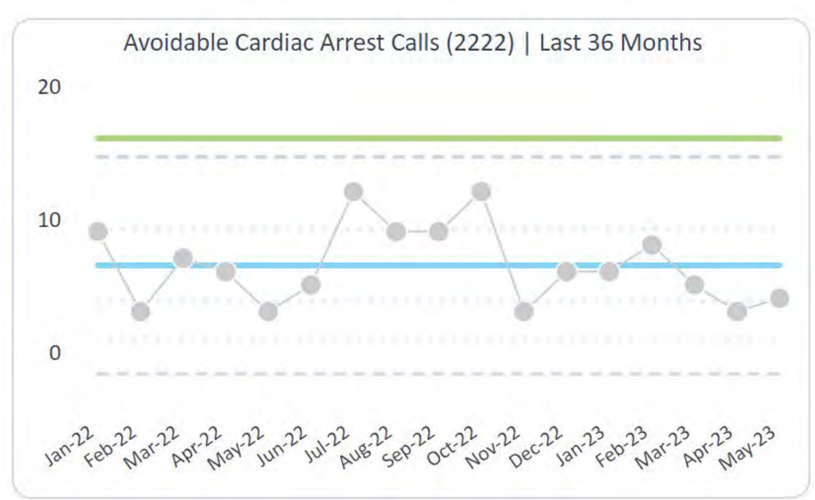
True North Domain: Quality

KPI Threshold: 1.3%

Sub Domain KPIs: 11

Variation Summary: 7 | 1 | 2 | 1 | 0





Key Messages

- SHMI for the period of Jan 22 to Dec 22 is 113.60 and ‘higher than expected’
- HSMR for Feb 22- Jan 23 is 114.5 lower than previous month and ‘higher than expected’ (rolling 12 months)
- HSMR for Jan-23 is 98.30 and “within expected”, based on 2408 superspells and 109 deaths (crude rate 4.53%).
- Expected deaths is rising at the same rate as the observed deaths for January 2023 which is a good sign.
- % of non-elective HSMR palliative spells and deaths increased by +0.05%and +1.1% respectively.

Issues, Concerns & Gaps

Evidence is starting to come through in the data that there are improvements to a number of key metrics related to palliative care, primary diagnosis coding, and comorbidity coding.
There are currently no new Diagnostic group of concern, except the previous seven diagnosis groups reported with “higher-than-expected” deaths where deep dives have either been completed or are underway. No failing in care have been identified.
The 1st Finished Consultant Episode (FCE) process maps have been completed and an SOP for standard work is underway to allow the 1st FCE to be accurately recorded.

Actions & Improvements

Task and Finish Group is held weekly to address 11 key areas of focus for immediate actions to improve the mortality data including clinical documentation and coding of deaths, resources for reviews of all death data within specialties, improved care of our deteriorating patients.
Coder/ consultant reviews have commenced as a pilot to enhance FCE coding.
Mortality Deep Dive SOP has been agreed and being implemented.
We are developing Early warning Mortality Dashboard and Mortality Dashboard by Bi Team following a visit to our neighbouring Trust.
Embedding of the changes needed to ensure clinical recording to enable accurate clinical coding is being implemented by developing a regular educational programme.

Quality

KPI Scorecard

Patient FIRST

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	Incident Management			Low or No Harm Incidents %	95.0%			99.0%	99.3%	99.1%	98.9%	98.6%	98.7%	98.8%	98.7%	99.6%	99.6%	99.2%	98.9%
				Total Incidents Reported	-			955	1,117	1,029	1,157	1,489	1,311	1,405	1,464	1,358	1,538	1,102	1,154
				Incidents with Harm (Moderate and above)	0			10	8	9	13	21	17	17	19	6	6	9	13
				Incidents Open - Month End	-			527	794	758	900	1,096	831	1,019	1,300	824	690	718	818
				Incidents Overdue - Month End	-			376	628	571	583	886	732	984	1,452	1,284	1,305	1,014	632
				Serious Incidents	-			3	0	7	7	9	15	9	8	11	10	2	8
				Serious Incidents Closed	-			6	6	6	3	5	5	11	9	2	9	10	9
				Serious Incidents Open - Month End	-			54	45	43	47	50	60	57	56	65	65	57	56
				Serious Incidents Responded to Within 60 Days %	95.0%			0.0%		28.6%	42.9%	55.6%	20.0%	22.2%	25.0%	9.1%	20.0%	100.0%	100.0%
				Serious Incidents Closed by ICB 1st Time %	-			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	20.0%	11.1%
				Never Events	0			0	0	1	1	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			0.0%	66.7%	50.0%	55.6%	94.7%	92.3%	90.9%	73.3%	87.5%	75.0%	50.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-			60.0%	66.7%	83.3%	75.0%	100.0%	20.0%	37.5%	75.0%	0.0%	12.5%	0.0%	-

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	Incident Management			RIDDOR Incidents	-			0	0	0	0	1	0	2	5	3	1	3	5
				RIDDOR Compliance %	-			-	-	-	-	0.0%	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				Health & Safety Incidents	-			12	43	28	5	4	10	43	38	32	20	22	17
				Sharps Injuries	-			7	3	7	9	8	3	6	10	7	8	8	11
				Violence & Aggression Incidents	-			33	50	40	56	57	45	45	56	54	60	74	83
				Assaults - Patient on Staff	-			9	22	16	15	36	11	24	23	27	36	41	44
				EDNs Completed Within 24hrs %	90.0%			70.7%	71.3%	70.1%	67.2%	53.7%	59.5%	67.0%	68.7%	69.5%	70.5%	70.8%	62.9%
	Falls			Low or No Harm Falls %	95.0%			98.7%	98.7%	100.0%	94.7%	98.0%	91.6%	96.9%	98.2%	95.5%	98.9%	96.4%	100.0%
				Falls - Total	-			75	79	82	76	100	95	96	111	89	90	84	61
				Falls - Low Harm	-			28	14	25	26	26	18	23	23	24	19	15	14
				Falls - Moderate Harm	-			0	1	0	2	1	5	2	1	4	0	0	0
				Falls - Severe Harm	0			1	0	0	2	1	2	1	1	0	1	3	0
				Falls Resulting in Death	0			0	0	0	0	0	1	0	0	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	Falls			Falls per 1,000 Bed days	-			5.24	5.38	5.55	5.28	6.58	6.44	6.24	6.97	6.34	5.89	6.34	4.43
	Pressure Ulcer			Pressure Ulcers - Total	-	H		15	15	18	23	25	45	28	36	51	38	33	30
				Pressure Ulcers - Grade 1	-			0	0	0	0	0	0	0	7	12	15	8	2
				Pressure Ulcers - Grade 2	-			5	4	6	6	5	14	6	5	11	6	5	10
				Pressure Ulcers - Grade 3	0	L	?	0	0	1	0	0	0	0	0	0	0	0	0
				Pressure Ulcers - Grade 4	0		?	0	0	0	0	2	1	0	0	0	0	0	1
				Pressure Ulcers - Unstageable	-	H		4	7	4	10	12	15	11	12	19	10	9	9
				Pressure Ulcers - Deep Tissue Injury	-			6	4	7	7	6	15	11	12	9	7	11	8
				Pressure Ulcers per 1,000 Bed Days	-	H		1.05	1.02	1.22	1.60	1.65	3.05	1.82	2.26	3.64	2.49	2.49	2.18
	Medicines			Medicine Errors - Total	-			64	66	68	77	98	83	64	73	66	87	71	72
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%
	IPC			IPC Incidents	-	L		27	31	23	42	26	15	21	22	9	19	11	7
				C-Diff Cases - Hospital Acquired Total	-			4	4	3	5	3	6	6	3	1	4	7	6

Quality

KPI Scorecard

Patient FIRST

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	35			11	15	18	23	26	32	38	41	42	46	7	13
				C-Diff Cases - Hospital Acquired (HOHA)	-			4	3	3	5	3	5	2	2	1	2	5	4
				E.coli Cases - Hospital Acquired	-			5	4	4	6	2	2	3	5	3	3	6	4
				E.coli Cases - Hospital Acquired YTD (Cumulative)	77			18	22	26	32	34	36	39	44	47	50	6	10
				MRSA Cases - Hospital Acquired	0			0	0	0	0	0	0	0	0	0	0	1	1
				MSSA Cases - Hospital Acquired	-			1	1	2	3	1	3	6	0	2	0	2	3
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			7	8	10	13	14	17	23	23	25	25	2	5
				Covid-19 Diagnosed - Total	0			104	387	136	105	228	58	136	96	153	193	108	25
	Mortality			Crude Mortality Rate %	1.3%			1.5%	1.8%	1.3%	1.1%	1.7%	1.7%	2.0%	1.9%	1.8%	1.5%	2.0%	1.4%
				Avoidable Cardiac Arrest Calls (2222)	16			5	12	9	9	12	3	6	6	8	5	3	4
				HSMR (All)	100			106.06	110.35	112.17	113.35	114.23	115.39	115.93	114.53				
				Expected Death Rate %	-			3.7%	3.7%	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%				
				SHMI	1			1.09	1.10	1.12	1.11	1.13	1.13	1.14					
				Fractured NOF Within 36 Hours	92.0%			69.2%	52.2%	71.9%	55.0%	79.3%	73.0%	73.7%	83.3%	56.1%	48.6%	67.6%	

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	Mortality			Number of Deaths Reviewed via SJR	-			12	12	11	9	20	13	9	18	13	9	8	11
				SJRs Completed %	25.0%		F	10.0%	8.3%	10.0%	9.9%	14.7%	8.9%	5.1%	11.5%	9.7%	6.7%	5.7%	12.4%
				Total Number of Deaths Due to Failings in Care	-			0	1	2	0	1	0	0	1	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	1	1	1	1	0	0	1	3	0	1	1
				Total Number of LD Deaths Due to Failings in Care	-	L		0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%		?	89.1%	94.4%	92.7%	87.9%	72.3%	94.1%	82.6%	73.7%	73.2%	80.6%	84.5%	88.5%
	Maternity			Caesarean Section %	-			47.2%	44.8%	45.6%	45.8%	50.4%	53.3%	50.1%	44.6%	52.5%	40.5%	49.3%	45.2%
				Elective C-Section %	-			17.4%	16.0%	18.5%	18.2%	17.2%	19.3%	19.1%	17.6%	22.7%	15.9%	17.2%	16.7%
				Emergency C-Section %	-			29.8%	28.8%	27.1%	27.6%	33.2%	34.0%	31.1%	27.0%	29.8%	24.7%	32.1%	28.6%
				PPH greater than 1000mls	-			51	39	40	35	46	47	36	52	35	34	40	35
				Total Number of Still Births Greater Than 24 weeks Gestation	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				Neonatal Deaths	-			2	2	1	3	1	0	1	1	0	0	2	2
				Maternity Serious Incidents	-			1	0	1	1	1	1	0	2	2	1	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Quality	Maternity			Maternity HSIB Referrals	-			0	0	0	0	0	0	0	1	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	2	0	0	0	0	2	0	1	0	0	0
	Risk & Policy			Risks Approved	-			11	2	5	7	3	9	5	11	21	52	15	7
				Risks Approved - Low	-			0	0	0	0	0	0	0	1	0	0	1	0
				Risks Approved - Moderate	-			2	0	0	3	0	0	0	2	3	6	1	0
				Risks Approved - High	-			7	2	2	1	3	7	3	7	13	39	10	3
				Risks Approved - Extreme	-	H		1	0	2	3	0	1	2	1	3	5	3	4
				Risks Approved - Closed	-	H		5	1	11	33	23	6	25	13	10	8	49	36
	Health & Safety			Resuscitation Training Compliance %	-	H		74.9%	76.2%	75.9%	76.3%	76.1%	78.3%	78.6%	79.4%	79.1%	78.7%	79.4%	79.3%
				Mental Capacity Act Training Compliance %	-			82.7%	82.2%	81.8%	81.4%	80.5%	79.8%	79.9%	80.1%	81.0%	81.9%	81.9%	81.9%

SIOR - Quality

Successful Deliverables

- Open overdue incidents down 43%; 100% of moderate harm and above incidents received formal DOC; Total number of serious incidents on a 3 month downward trend
- There has been a marginal increase in completion of VTE assessments over the last three months. The hard stop and flag for VTE risk assessment is in place. The group are focussing on the next three top contributors for VTE non-compliance. 16-18 year old paediatric patients are now fully compliant with the VTE assessment process
- There has been a reduction in falls and HAPU's resulting in harm in the last reporting period
- New testing changes for COVID implemented on 01 May in line with national guidance
- Numbers of COVID started reduced to single figures in May and cases now managed in side rooms.
- 0 outbreaks for COVID declared in May 2023 which is the third month
- Simulation style training pilot commenced in May for wards on prolonged or frequent periods of increased incidence for C.difficiles
- Mortality/HSMR: The % with a comorbidity score higher than 20 has increased slightly, meaning that the clinical documentation of high risk patients has improved
- FNoF: In May-23, 36 patients were admitted with Fracture NOF, 26 patients had surgery Within 36 hrs, with compliance at 72%.

Next Steps

Pilot ward for simulation training really enjoyed the sessions and found them useful. Ward has since been able to step down from a prolonged period of increased incidence

To consider reducing mask wearing further now that COVID numbers are in single figures

FNoF: Aim to achieve the 36 hrs surgical target more efficiently – provision for more theatre space

Identified Challenges

- High proportion of SIs not being closed by ICB on first panel adding additional 1 month to patients receiving final report
- High number of historical and out of date risks on the risk register that require closing/updating
- There is inconsistent recording of VTE data for elective patients. VTE assessments are being recorded on safer sleep software. There is no consistent process in place for reporting VTE positive imaging.
- There are identified challenges with the deployment, maintenance and distribution of mattresses and falls equipment
- Second case of MRSA bacteraemia in May 2023
- 6 cases of C.difficile in May taking total to 13. Poor decolonisation practice and a prolonged length of stay for a complex, unwell surgical patient led to bacteraemia

Next Steps

- The group have engaged the clinical and medical directors to be included in the A3 process
- Mandating the process that any patient who does not have a completed VTE assessment on EPR cannot be accepted into theatre.
- To review and amend simulation style training for other infections such as MRSA
- To look at EPMA to group together decolonisation treatment to support prescribing
- To redo the decolonisation treatment chart and then add to EPR

Opportunities

- For falls, VTE, TVN teams to be included as part of mandatory training
- Developing a simulation style training to support wards on PII for more than 4 weeks to reduce number of Hospital acquired infections
- So far Post Infection Reviews (PIR) show minimal lapses care and are unavoidable

Next Steps

- The teams are working with the Deputy Chief nurse to include training for VTE, Falls and TVN as part of the clinical induction working group.
- Look to amend the PIR process and only convene panel if significant lapses in care or if avoidable
- IPC team and microbiologist to commence C.difficile ward rounds to ensure correct treatment and management to reduce reoccurrence of infection
- FNoF: To aim for second orthogeriatric consultant appointment to achieve the NHFD criteria for NOFs, peri-prosthetic fractures and to run the service more efficiently

Risks

- The VTE risk assessment is only being recorded in pre-admission and / or on safer sleep for patients having elective surgery. This assessment does not get duplicated on the EPR system and not recorded in the patient record contemporaneously.
- Mattresses and falls equipment failures are not being escalated to the specialist teams which results in their disposal. There is no process within the clinical engineering team to monitor and track equipment appropriately. This has been added to the risk register.
- Photos of pressure damage that is used to refer to the TVN team have been stored on electronic devices / not deleted. This is in breach of information governance guidance.
- Possibility of breaching the 2023/24 thresholds for MRSA and C.difficile
- All patients who have had C.difficile have had a recent course of Co-Amoxiclav which is a high risk antimicrobial
- FNoF: The best practice tariff was not fully completed in May 2023 due to lack of theatre space and unwell patient

Next Steps

- Mandating the process that any patient who does not have a completed VTE assessment on EPR cannot be accepted into theatre.
- An A3 is required to understand the root causes of the equipment tracking and disposal process.
- An SOP was developed for TVN photography in 2021. All staff to follow the SOP and to delete photos / patient identifiable information on electronic devices when referring to the TVN, the team have sent out comms to all staff as a reminder. The TVN team are working with CNIO to upgrade the SOP to a policy.
- Antimicrobial ward rounds happen two times a week and are beginning to reduce the consumption of the watch group of antimicrobials

SIOR - Maternity

Successful Deliverables

A3's completed for Post Partum Haemorrhage (PPH) and Induction Of Labour (IOL) A3 reviewed and updated in June 2023
Drug trial of Carbetocin and prophylactic Tranexamic acid in progress to reduce risk of PPH
Caesarean section audit complete and presented by CD at QAC in May and will be presented at Trust Board in July
HIE grade 2 and 3 now being reported within IQPR
Correct figures for HSIB reported cases, stillbirth and neonatal death for May 23

Next Steps

MDT Project group in place for implementation of IOL A3 countermeasures and actions

Identified Challenges

Lack of designated IOL space
Inaccuracies continue in IQPR data - HIE Grade 2&3 in Feb 23 - there were 2 cases not 1 and SI's there was 1 in May 23 Limb ischaemia due to femoral artery clot post CS and 1 in March 23 Forceps delivery, cooled baby, MRI normal, parents didn't consent to HSIB but Trust/ICB agreed investigation as SI
2 NNDs both demised in the NICU Unit - 25+5 unexplained and referred to the Coroner- Post mortem results awaited
34+5 expected loss due to poor prognosis due to fetal brain development post fetal maternal haemorrhage in early pregnancy. Parents fully counselled but continued with pregnancy.

Next Steps

Identification of specific Midwifery and Obstetric Leads for IOL pathway
Continue to work with BIU on getting accurate data reported within IQPR

Opportunities

- Reduce PPH rates at Caesarean section
- Introduce STAN for fetal monitoring
- Development of formalised process for management of pre-induction clinic
- Development of formalised audit process for IOL delays

Next Steps

Process mapping to identify area of improvement in clinical pathways for IOL and flow and demand
Identification of specific Midwifery and Obstetric Leads for IOL pathway

Risks

Rates of significant PPH above national benchmark for emergency caesarean section and instrumental delivery
Delays in IOL contributing to numbers of caesarean section and increased risk of harm and poor quality of patient experience

Next Steps

Audit of carbetocin drug trial
Progress the countermeasures and actions from the revised IOL A3

Systems & Partnerships

Nick Sinclair
Chief Operating Officer

Operational Leads:
Benn Best - ***Divisional Director - Planned Care***
Holly Reid - ***Divisional Director - Unplanned and Integrated Care***

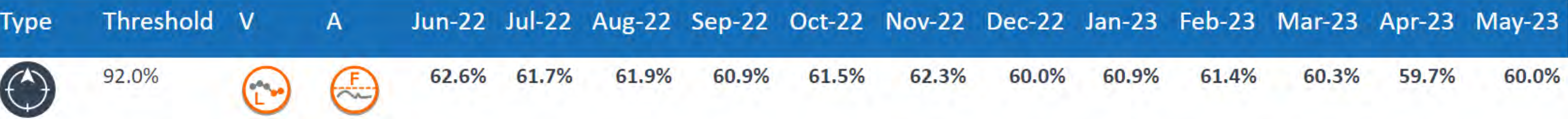
Committees:
Finance & Performance Committee

Systems & Partnerships

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

Access

RTT Incompletes Performance %



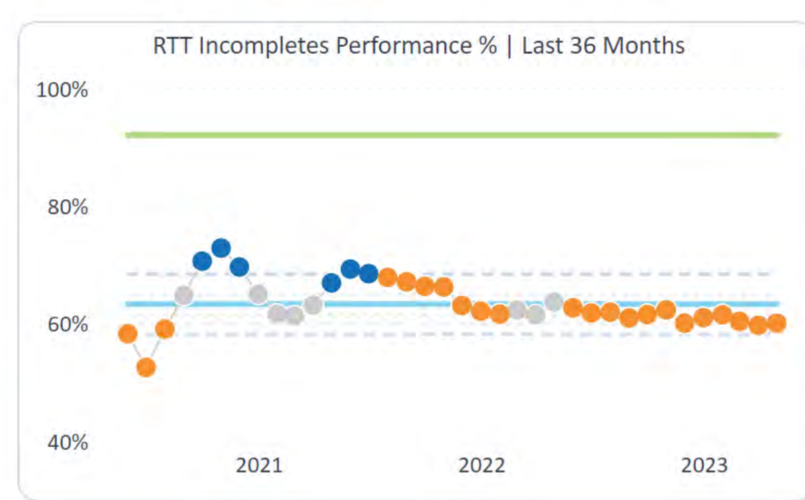
Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	92.0%			62.6%	61.7%	61.9%	60.9%	61.5%	62.3%	60.0%	60.9%	61.4%	60.3%	59.7%	60.0%

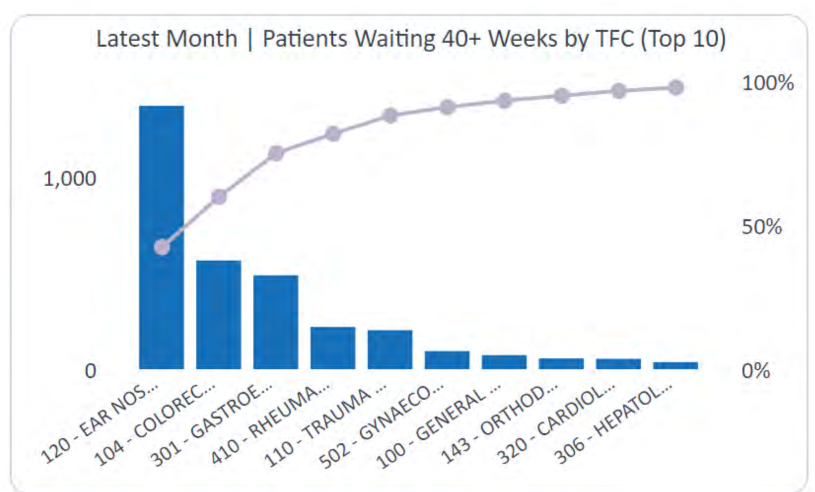
True North Domain: **Systems & Partnerships**

KPI Threshold: 92.0%

Sub Domain KPIs: 25

Variation Summary: 16 | 2 | 5 | 1 | 1





Key Messages

- RTT continues to be a priority for the Trust. Treating all patients within 40 weeks is one of the Trusts key breakthrough objectives in the Patient First programme
- In May 2023 the number of patients waiting longer than 52 weeks has increased (April 591 to May 820)

Issues, Concerns & Gaps

- ENT remains the primary concern for 52 and 78 week risk. Plans being developed to manage backlog and to move to a sustainable position
- Diagnostic capacity in Endoscopy, Echocardiography and Myoview is delaying diagnosis and treatment times

Actions & Improvements

- Recovery plans developed for specialties that are behind trajectory (ENT, Colorectal, Gastroenterology, Rheumatology) to reduce first outpatient waiting times and to treat long waiting patients
- All patients on the admitted waiting list have an identified priority category (P) which is reviewed and updated regularly.
- Validation of patients with long waiting times and harm review process established.
- Independent Sector capacity (insourcing and outsourcing) used where funded to support

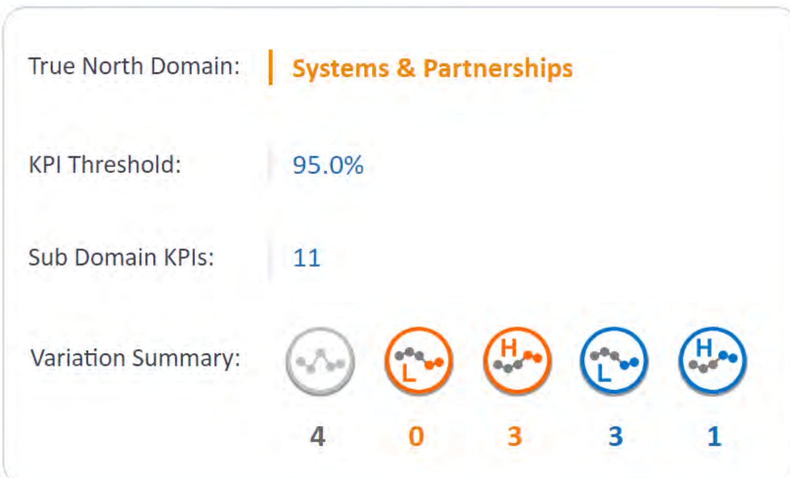
Systems & Partnerships

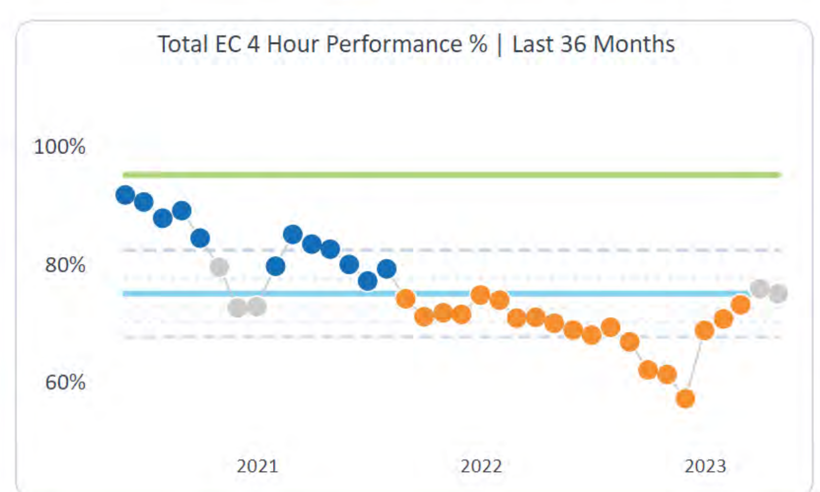
Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

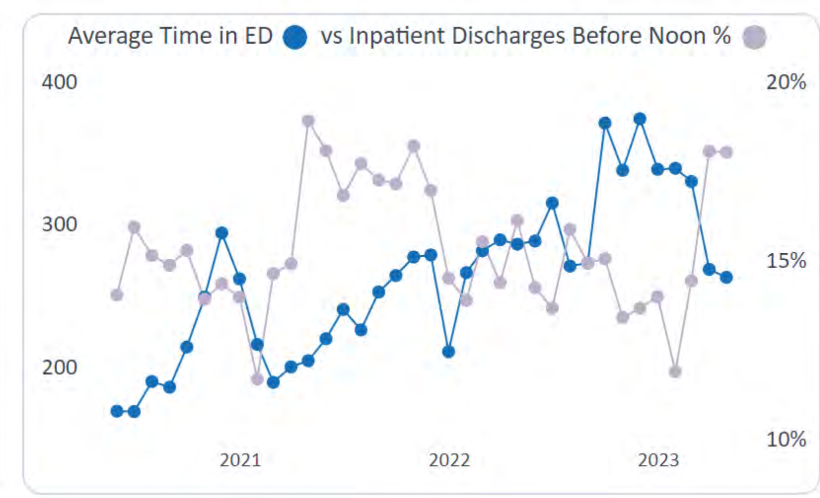
Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	95.0%		F	68.7%	67.8%	69.2%	66.7%	61.9%	61.1%	57.0%	68.6%	70.6%	73.0%	75.7%	74.8%

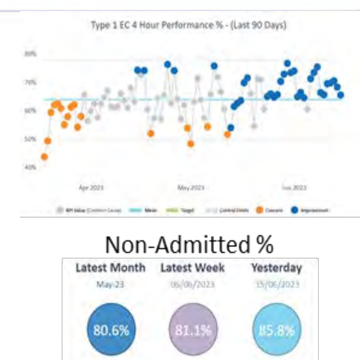






Key Messages

Total 4 hour performance deteriorated from Sept 2022 to mid Dec 2022. It stabilised throughout January and has achieved consistent incremental improvement since 07/01/23. April saw the highest average total 4 hour performance at 75.5%, in more than 12 months. May saw a small dip to 74.5% but both Type 1 and Non-admitted performance have seen consistent and sustained improvements.



Issues, Concerns & Gaps

- Flow out of the acute floor continues to be a key contributor, with the Trust not yet achieving 40% of discharges by midday, caring for large numbers of medically fit for discharge patients, and caring for a number of mental health patients waiting placement
- We continue to see sustained pressure at our UTCs and Medocc, with Type 3 performance being much more volatile than previously experienced.
- ED attendances have been increasing when compared with identical weeks in 2021 and 2022.

Actions & Improvements

We strive to achieve continuous, incremental improvement in our patients journey through acute care, and have taken the following actions:

1. Improvement in ability to utilise refer and move models across acute and frailty, enabling rapid improvements LOS > 12hr in ED, and numbers of 12HR DTA breaches.
2. Refreshed CDU pathway now live, providing improved patient flow , ensuring patients are seen in the right place, by the right individual, at the right time. Capital works within the ED pathway due to be complete in month, enabling much improved care for patients with Mental Health issues.

Key Performance Indicator	Target	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Total EC 12 Hour DTAs	0			23	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	106

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Systems & Partnerships	Access			RTT Incompletes Performance %	92.0%			62.6%	61.7%	61.9%	60.9%	61.5%	62.3%	60.0%	60.9%	61.4%	60.3%	59.7%	60.0%
				RTT 40+ Week Waiters	-			2,188	2,336	2,175	2,135	1,935	1,930	2,258	2,370	2,569	2,726	3,083	3,236
				RTT Waiting List Size	-			32,075	32,675	33,076	33,936	34,347	34,433	34,615	35,403	35,991	36,835	36,659	37,035
				RTT 52 Week Breaches	0			202	271	383	422	504	567	603	590	560	471	581	820
				OP Average Time to First Appointment (days)	60			79.06	79.94	91.13	86.38	88.42	93.22	85.39	87.19	89.57	88.29	78.58	84.58
				Outpatient DNA Rate %	10.0%			8.0%	8.2%	7.7%	7.7%	7.8%	7.5%	8.6%	7.4%	7.1%	7.4%	7.2%	7.5%
				OP First to Follow Up Ratio	-			2.11	1.89	1.93	1.96	1.83	1.82	1.85	1.95	1.80	1.82	1.93	1.99
				Operations Cancelled by Hospital on Day	0			7	17	6	16	15	20	21	19	9	31	10	14
				Cancelled Operations Not Rescheduled < 28 Days %	-			28.6%	23.5%	66.7%	87.5%	53.3%	35.0%	42.9%	36.8%	33.3%	51.6%	30.0%	42.9%
				Urgent Operations Cancelled for 2nd Time	0			5	7	2	4	11	5	9	5	1	10	2	6
				Day Case Rate %	-			84.1%	84.6%	85.0%	84.7%	85.1%	84.8%	84.8%	85.7%	84.9%	84.4%	85.0%	84.9%
				Average Elective Length of Stay (days)	3			0.35	0.32	0.39	0.30	0.33	0.38	0.32	0.29	0.29	0.33	0.35	0.32
				Average Non-Elective Length of Stay (days)	10			4.26	4.29	4.75	4.48	4.71	4.64	4.59	4.76	4.56	4.57	4.96	4.66

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Systems & Partnerships	Access			104 Day Cancer Waits	-			2	4	5	7	4	5	3	5	4	5		
				Cancer 2ww Performance %	93.0%			95.6%	95.0%	93.2%	95.4%	93.3%	89.6%	92.8%	84.6%	70.7%	80.9%	94.5%	
				Cancer 2ww Performance - Breast Symptomatic %	93.0%			85.7%	93.1%	88.1%	85.7%	80.0%	74.3%	68.1%	44.4%	6.9%	16.7%	93.6%	
				Cancer 31 Day First Treatment Performance %	96.0%			96.9%	97.2%	96.7%	98.2%	96.4%	98.1%	98.2%	100.0%	98.2%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Drugs %	98.0%			100.0%	100.0%	100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	94.0%			100.0%	100.0%	95.7%	90.9%	100.0%	89.5%	96.6%	88.9%	91.3%	100.0%	93.8%	
				Cancer 62 Day Treatment - GP Refs %	85.0%			84.9%	82.1%	82.5%	85.6%	85.0%	80.6%	84.8%	71.9%	85.6%	79.0%	80.1%	
				Cancer 62 Day Treatment - Cons Upgrades %	50.0%			53.3%	44.7%	61.3%	76.2%	76.7%	80.0%	76.2%	66.7%	75.0%	87.5%	77.8%	
				Cancer 62 Day Treatment - Screening Refs %	90.0%			87.0%	88.9%	90.0%	88.0%	75.0%	90.9%	66.7%	75.9%	72.7%	100.0%	88.9%	
				Cancer 28 Faster Diagnosis %	75.5%			76.9%	81.8%	77.4%	74.5%	71.5%	71.8%	62.4%	61.2%	75.3%	75.7%	340.1%	
				Cancer 28 Faster Diagnosis Screening %	-			73.4%	40.5%	45.3%	24.2%	40.0%	60.5%	56.3%	73.9%	86.2%	54.5%	81.8%	
				DM01 Performance %	99.0%			72.7%	66.7%	68.7%	73.2%	79.1%	79.3%	74.7%	71.1%	72.4%	72.2%	67.7%	65.5%
	Emergency Care			Total EC 4 Hour Performance %	95.0%			68.7%	67.8%	69.2%	66.7%	61.9%	61.1%	57.0%	68.6%	70.6%	73.0%	75.7%	74.8%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Systems & Partnerships	Emergency Care			IP Discharged Before Noon % (Inc transfers to ADL)	40.0%	H	F	14.2%	13.6%	15.8%	14.9%	15.0%	13.4%	13.6%	13.9%	11.8%	14.4%	18.0%	18.0%
				Type 1 EC 4 Hour Performance %	75.0%		F	58.7%	57.2%	57.4%	54.2%	45.6%	48.5%	46.6%	52.2%	58.6%	58.7%	63.3%	64.8%
				Total EC 12 Hour Breaches	0		?	23	139	148	166	420	263	560	422	428	540	131	106
				Average Time in EC Department (mins)	200	H	?	287.54	314.16	269.99	272.14	370.06	337.02	373.05	337.72	338.42	329.16	267.68	262.13
				Number of ED Arrivals by Ambulance	-			2,980	2,975	2,963	2,922	2,940	2,350	2,984	2,896	2,704	2,915	2,929	3,048
				Ambulance Handover Delays (> 30 mins)	-	L		424	653	446	512	679	150	277	103	111	77	57	32
				Ambulance Handover Delays (> 60 mins)	0	L	?	136	260	151	242	304	10	37	8	5	3	2	2
				Bed Occupancy - General & Acute %	92.0%	H	P	90.3%	91.0%	91.2%	91.4%	92.4%	91.7%	91.8%	92.3%	94.3%	93.3%	90.3%	90.0%
				Medically Fit for Discharge Patients %	9.0%	H	?	11.6%	10.3%	10.2%	10.0%	9.3%	9.9%	10.0%	10.1%	8.6%	9.4%	9.6%	9.4%
				30 Day Readmission Rate	13.0%	L	?	10.4%	10.3%	10.1%	10.0%	8.5%	8.4%	9.3%	9.6%	9.7%	9.4%	10.1%	9.1%

SIOR - Access

Successful Deliverables

RTT
- Additional outpatient activity ongoing for Gastroenterology
- Patient Initiated Follow-up (PIFU) relaunched with ENT

DM01
- Performance in Imaging maintained
- Potential for additional Endoscopy

Cancer
- For May Cancer achieved national targets for 2ww and 31 days. Following submission to the Kent & Medway Cancer Alliance the Trust was successful with funding for 15 out of the 19 bids submitted

Next Steps

RTT
- Continue rollout of PIFU in other specialities to reduce Outpatient follow-ups and increase new appointment capacity

Cancer
- Internal processes being followed to appoint to successful bid positions and PIDs being written for posts that will need funding once KMCA funding ends in 12 months

Identified Challenges

RTT
- ENT capacity will continue to be a challenge for 52 week plus and 78 week plus patients
- Colorectal and Gastroenterology 52 week waits are increasing due to limited Endoscopy capacity

DM01
- Endoscopy capacity and activity with PPG (outsourced provider) has reduced recently. Improvement plans in place

Cancer
- Endoscopy capacity is leading to an increase in the backlog (patients over 62 days) and 28 days. FDS due to delays in scoping
- Currently lung capacity is also providing a challenge with our ability to hit 28 day FDS targets

Next Steps

RTT
- Additional Outpatient capacity for ENT is being identified to reduce waiting times
- Plan for the validation of long waiting ENT patients is being finalised

DM01
- Regular meetings taking place to identify and resolve PPG endoscopy issues

Cancer
- Paper being written around the creation of additional capacity for Endoscopy.
- Meetings in place to start A3 into lung capacity issues

Opportunities

RTT
- Potential for ENT activity to be sent to the Independent Sector. This is being scoped with the ICB's support

DM01
- MTW offering weekend capacity for Endoscopy.

Cancer
- Options for increased Endoscopy capacity – to include mobile units and support from other regional Trusts

Next Steps

RTT
- Follow-up with ICB for potential ENT capacity

DM01
- Contract for additional Colonoscopy capacity at MTW being finalised
- Potential for endoscopy capacity at DVH is being discussed.

Cancer
- Finalisation of paper ready for Exec approval

Risks

RTT
- The Trust is still unable to monitor ENT pathways at DVH due to data issues with the BI team (at DVH). Activity reports are being developed. Senior operational meetings are taking place to resolve the situation.

Cancer
- Ability to achieve national cancer targets around 28 day and 62 days due to capacity issues within Endoscopy

Next Steps

RTT
- DVH ENT contract discussions need to take place at a senior level to progress access to RTT data

Cancer
- Secure additional capacity

SIOR - Emergency Care

Successful Deliverables

Non-Admitted 4 Hour
- Sustained improvements in 4 hour non-admitted performance, regularly achieving upwards of 70% upwards of 80% more regularly. Recent and sustained improvements in overall 4 hour performance, with monthly performance now at highest in over 12 months.

Admitted 4 Hour
- Improved performance with May highest in over 12 months (9.1%), and significant improvements in 12 hour breaches (1,284 March to 856 April and 775 May)

Next Steps

Non-Admitted 4 Hour
- Achieve further incremental improvement through increased utilisation of CDU pathways for ambulant patients requiring observations
- Completion of capital works to improve experience and flow for patients requiring mental health input

Admitted 4 Hour
- Further progress on development of flow and discharge corporate project, focusing on inpatient stay and discharge, improving utilisation of discharge lounge and discharge before Noon further.

Identified Challenges

Non-Admitted 4 Hour
- Physical capacity

Admitted 4 Hour
- Flow from acute floor to admitted wards
- MFFD Numbers
- Misalignment of demand (attendances/admissions) and capacity (flow/discharge)

Next Steps

Non-Admitted 4 Hour
- Full utilisation of CDU capacity, focus on utilisation of SAU, and further progress on in-reach and hot clinic work streams, including RACE clinics

Admitted 4 Hour
- Further increase in utilisation of refer and move model
- MFFD Numbers – improved processes for communication on community capacity and time of discharge to placement

Opportunities

Non-Admitted 4 Hour
- Mental health pathways, enabling new model for CDU to be utilised, trajectory to be worked up and monitored

Admitted 4 Hour
- Work-streams focussing on improving flow and discharge, HARIS/LAEDB looking at hot clinics / in-reach, next steps to re-establish capacity
- De-escalation allowing Refer and Move work-stream, for rapid flow from ED for patients to referred specialties

Next Steps

Non-Admitted 4 Hour
- Monitor and improve utilisation of CDU

Admitted 4 Hour
- Full de-escalation of frailty assessment capacity
- Scale up of RACE clinics within frailty, to improve admission avoidance and reduced LOS
- Further progress on HARIS work-streams – in-reach and hot clinics – scoping exercise complete, now undertaking Trust-wide pathway planning

Risks

Overall
- System capacity
- Operational capacity to enact change and improvements, competing priorities
- Availability of funding for capital changes, and invest to save models
- Increasing acuity and volume of attendances
- Ongoing industrial action

Next Steps

Overall
- Progression on schemes aimed at improved access to alternatives to ED including Mental Health Pathways (via Safe Haven and Capital works) Hot Clinics and In-reach services, etc.
- Analysis of FrailTED and MenTED outputs and development of action plans for MFT
- Closer working with Type 3 providers (MedOcc and UTCs) to improve pathways, streaming and performance. Review of booked appointment systems for Type 3 attendances

People

Leon Hinton
Chief People Officer

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

Committees:
People Committee

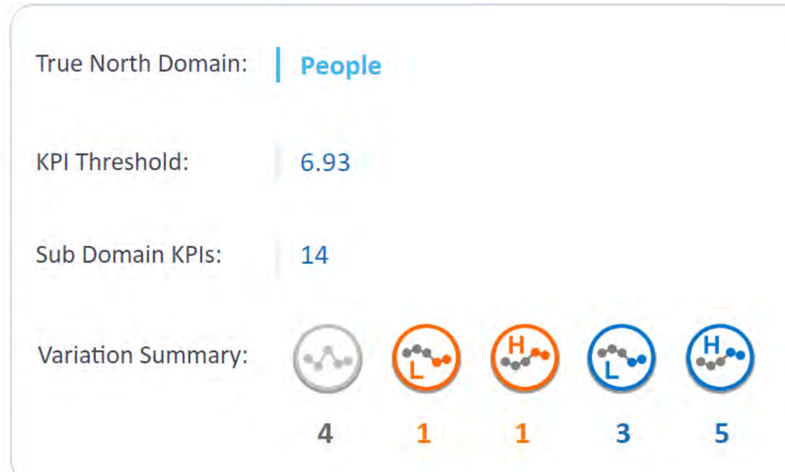
People

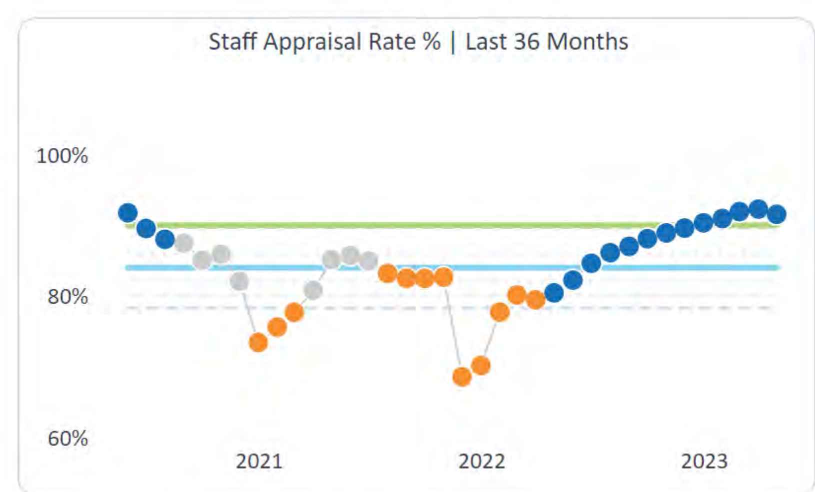
Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

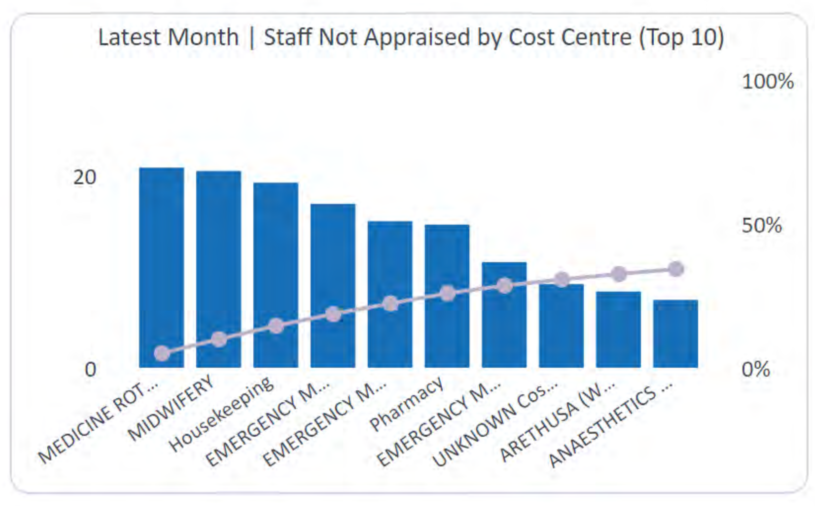
Workforce

National Staff Engagement Score

Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	6.93			6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63







Key Messages

The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey. Both clinical divisions are reporting over 90% compliance.

Continuation of appraisal KPI breakthrough objective being met (>90%); however, a dip to 91.5% (5 months being met, 6 required to meet business rules).

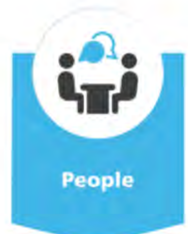
New draft breakthrough objective has been identified through True North refresh.

Issues, Concerns & Gaps

- Quality of wellbeing conversation and appraisal is currently anecdotal and requires regular and objective audit to ensure a quality conversation is in place and also checked via go and see visits;
- Resilience of recording methodology under review between the CMO's office and Human Resources;
- Resources to ensure appraisal quality audit is carried out.

Actions & Improvements

- Local staff survey action plans due to be reported to July's People Committee.
- Enhanced appraisal rollout (wellbeing objectives) completed Q3 2022/23;
- Reporting improvements rolled out, completed Q3 2022/23;
- Driver meeting feedback ongoing for new issues;
- Audit methodology (assessing quality of appraisals) to be in place by Q2 2023/24.



People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
People	Workforce			National Staff Engagement Score	6.93			6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63		
				Staff Appraisal Rate %	90.0%			82.2%	84.6%	86.1%	87.0%	88.1%	88.9%	89.6%	90.3%	90.9%	91.9%	92.3%	91.5%
				Staff in Post (FTE)	-			4,561.10	4,662.66	4,699.91	4,619.58	4,664.29	4,666.83	4,734.35	4,771.29	4,742.16	4,854.84	4,874.58	4,808.18
				Staff Leavers (FTE)	-			50.68	89.85	164.34	88.08	78.57	51.76	57.66	63.97	54.81	65.40	55.76	39.39
				Staff Starters (FTE)	-			63.95	39.24	190.18	82.31	113.06	80.43	46.69	94.05	71	87.72	66.93	62.82
				Vacancy Rate %	9.0%			8.9%	6.9%	6.2%	7.8%	6.9%	6.9%	5.6%	5.0%	5.4%	3.2%	3.7%	5.2%
				Voluntary Turnover %	8.0%			12.5%	12.8%	12.6%	12.9%	12.6%	12.2%	12.1%	12.6%	12.5%	12.1%	12.2%	11.9%
				Staff Fill Rate - Total %	85.0%			83.0%	79.9%	79.7%	81.3%	79.0%	80.6%	78.6%	78.2%	80.0%	82.2%	87.7%	89.9%
				Staff Fill Rate % (Total) - Registered Nurse	-			81.6%	78.5%	77.7%	79.7%	79.4%	79.6%	78.2%	76.5%	78.3%	80.3%	86.0%	87.1%
				Care Hours per Patient Day (CHPPD)	9.50			8.50	8.12	8.25	7.98	7.56	7.76	8.03	8.10	8.53	8.52	9.15	9.19
				Sickness Absence Rate - Total %	4.0%			4.6%	6.0%	4.6%	4.5%	5.1%	4.7%	5.7%	4.9%	4.7%	4.7%	4.0%	
				Sickness Absence Rate - Short Term %	2.0%			2.6%	3.7%	2.3%	2.5%	3.0%	2.5%	3.5%	2.5%	2.5%	2.6%	2.2%	
				Sickness Absence Rate - Long Term %	2.0%			2.0%	2.2%	2.2%	2.0%	2.0%	2.2%	2.3%	2.4%	2.2%	2.1%	1.8%	

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
People	Workforce			StatMan Training Compliance %	85.0%		P	**85.0%**	**85.3%**	**85.9%**	**86.3%**	**86.3%**	**87.0%**	**87.2%**	**87.1%**	**86.8%**	**87.1%**	**87.5%**	**87.6%**

SIOR - People

Successful Deliverables

- Agency spend remains, positively, below NHSE target (2.6% vs 3.7%);
- Medicine junior block rota for Tier 1 & 2 consultation and business case approved for changes effective August 2023;
- Clinical Support Worker Open day, attended by over 100 individuals on the day. 61 interviews completed, with 33 offers being made;
- WRES and WDES quantifiable data published to new shorter deadline, with improvement to the Shortlist to Appointment measure for the WRES (1.17, compared to 1.52 last year, where 1.0 is equity).

Next Steps

- Nursery - Annual parent survey to go out to obtain satisfaction rates for this year.

Identified Challenges

- Impact of industrial action through June (Junior Doctors) to resourcing allocations;
- Ensuring that demographic data gathered at recruitment is consistently transferred to new starter data;
- Number of agency Consultants engaged from April 2023 due to the number of substantive vacancies. Fortnightly meetings with HRBPs, Resourcing and Temporary Resourcing reviewing each post line by line.

Next Steps

- Business case is currently being drafted to restructure and adequately resource the Resourcing Team

Opportunities

- Reviewing bank rates and opportunity to align with ICS bank rates – and subsequent effect on our ability to retain bank workers;
- Emergency Department junior rotas moving to the centralised Medical Rota Coordination Service;
- Diversifying the international pipeline for nurses;
- Apprenticeships - facilitating a successful candidate to complete their level 3 early years qualification within nursery.

Next Steps

- New Terms of Reference for Disability and LGBTQI+ Networks (currently in draft) to help focus staff networks priorities;
- Gender Pay Gap Action Plan to start with A3s for AfC and M&D.

Risks

- Non-adherence to the regional rate card (Nursing and Medical) by neighbouring Trust impacts our bank/agency fill rate;
- Ensuring adult to child ratio in nursery is maintained due to unforeseen absence.

Next Steps

- DBS recheck policy for nursery, review process in place (due 2024);
- Review the nursery business continuity and staffing contingency plans including bank shifts needed to take on role when required.

Sustainability

Alan Davies
Chief Financial Officer

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

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

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

Financial Position

Breakeven Revenue Budget (£)

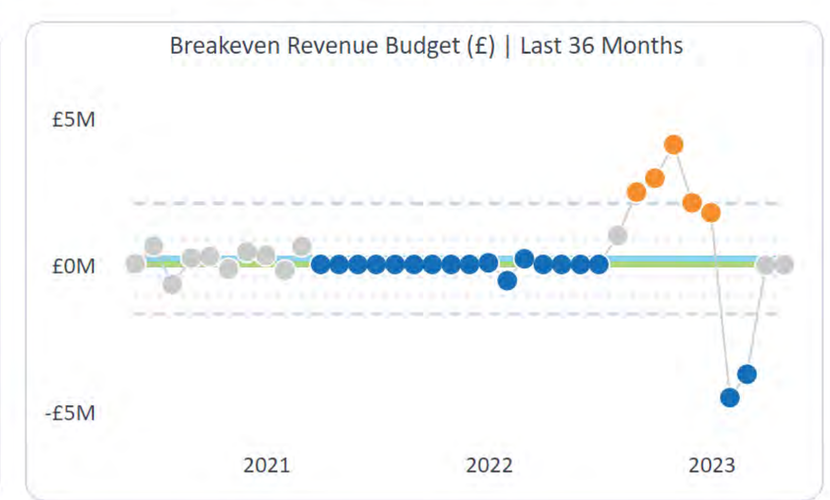
Type	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
	£0			0.00m	0.00m	0.98m	2.46m	2.94m	4.08m	2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m

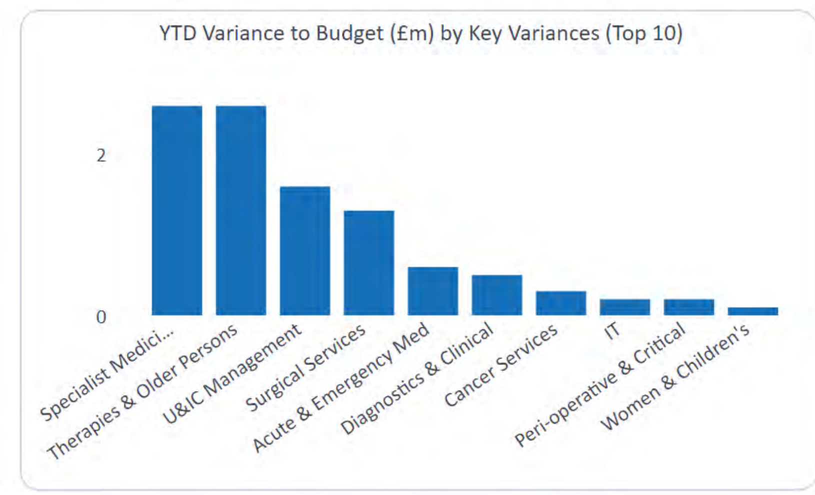
True North Domain: **Sustainability**

KPI Threshold: £0

Sub Domain KPIs: 13

Variation Summary: 8, 0, 3, 1, 1





Key Messages

The Trust reports a deficit of £2.5m in month 2 of 2023/24 and year to date deficit of £5.0m; this is against a plan of the same value.

The Trust is currently in SOF4 and must demonstrate delivery against its financial targets.

Issues, Concerns & Gaps

Due to the industrial action and slow mobilisation of teams, the risk of not delivering elective activity plans continues. The full value of ESRF income has been included in the position, however the Trust is awaiting clarity of how this risk will be managed across the ICB at the end of Q1.

The Trust has a stretching efficiencies target for the year, set at £27m / 6.6% of income. The value of efficiencies identified to date is £13.8m with a number of opportunities still in the pipeline. Proposals to implement a PMO to support this work have been agreed and progressing.

The pay award and income pressures could result in adverse performance in month 3.

Actions & Improvements

As well as Medical pay costs, management of nursing staff overspending is being added to the 'control of overspending' breakthrough objective. A new breakthrough objective for 'efficiencies' is being established.

Further development, approval and implementation of efficiency schemes continues.

Fully scoped and costed plans to deliver additional activity have been drafted and are being implemented.

Sustainability

KPI Scorecard

Patient FIRST

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0			0.00m	0.00m	0.98m	2.46m	2.94m	4.08m	2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m
				Agency Spend %	3.7%			2.6%	3.7%	3.5%	3.0%	3.1%	3.1%	2.8%	2.5%	3.5%	1.9%	2.6%	3.0%
				Bank Spend %	10.0%			16.6%	13.8%	13.4%	10.2%	11.9%	12.2%	11.2%	12.7%	11.6%	7.8%	12.8%	12.4%
				(Surplus) / Deficit (£)	£0			0.43m	0.21m	1.19m	1.65m	3.04m	4.18m	2.20m	1.76m	-4.63m	-4.83m	2.46m	2.47m
				Agency Spend (£)	-			0.52m	0.75m	0.77m	0.76m	0.71m	0.70m	0.63m	0.56m	0.78m	0.80m	0.60m	0.70m
				Income (£)	-			-31.95m	-32.48m	-32.62m	-35.65m	-32.64m	-33.03m	-34.20m	-34.37m	-39.66m	-60.80m	-34.16m	-34.78m
				Income (£) vs Budget	£0			0.86m	-0.29m	-0.42m	-3.26m	-0.41m	-0.69m	-1.93m	-1.65m	-7.35m	-27.50m	-0.24m	-0.89m
				Total Pay Spend (£)	-			19.85m	20.09m	21.91m	25.22m	22.74m	22.74m	22.26m	22.69m	22.54m	42.56m	23.10m	23.32m
				Total Pay Spend (£) vs Budget	£0			-0.64m	-0.33m	1.49m	2.42m	2.28m	2.22m	1.78m	1.85m	2.02m	22.13m	0.88m	1.12m
				Total Non-Pay Spend (£)	-			10.77m	10.35m	10.03m	10.23m	11.19m	12.65m	12.32m	11.14m	10.99m	11.03m	11.58m	11.70m
				Total Non-Pay Spend (£) vs Budget	£0			-0.08m	0.28m	-0.08m	3.32m	1.20m	2.61m	2.30m	1.13m	1.17m	1.13m	-0.47m	-0.35m
				Actual Worked FTE	-			4,989.22	4,934.96	4,935.05	4,911.91	4,952.63	5,017.52	5,001.50	4,999.98	5,102.29	5,227.19	5,127.10	5,174.36
				Actual Worked FTE vs Budget	0			-28.30	-87.63	-91.70	-111.65	-70.95	-5.15	-31.02	-38.51	68.30	192.45	43.79	82.68

SIOR - Sustainability

Successful Deliverables

The plan deficit of £2.5m was delivered for May, and year to date deficit position of £4.9m. The level of expenditure has increased in month 2 by £0.6m, mainly due to additional sessions and independent sector costs to support the delivery of Elective Services Recovery Fund activity. Income also increased by £0.6m for community diagnostic centre funding.

The efficiency programme is currently on plan, delivering £0.6m which principally arose from the full year effect of 2022/23 schemes.

Next Steps

Budget holder sign-offs have been delayed due to month end pressures and industrial action, these continue to be prioritised and are expected to be complete by the end of June.

Focus on the identification and delivery of the efficiency programme for 2023/24.

Identified Challenges

The three key challenges currently faced by the Trust are:

1. Delivery of the activity plans
2. Management of medical and nursing pay costs, both of which are significantly overspent at month 2.
3. Identification, development, implementation and delivery of the efficiencies programme.

Next Steps

1. Delivery of the additional activity scoped by the Theatres and Outpatients efficiencies programme and as funded from ESRF reserves.
2. Development of the A3 for nursing pay costs, identifying root causes, drivers and counter measures for inclusion in the ‘control of overspending’ breakthrough objective.
3. Further development, approval and implementation of efficiency schemes in the pipeline.

Opportunities

The Trust has a long list of efficiency opportunities which are being developed to contribute towards the £27m target. Each has an appointed executive lead and SRO.

The Trust has made a submission to NHSE – with the support of the ICB – for UEC capital and revenue funding to increase the on site bed capacity. Whilst only one of the three schemes has been approved, our estates team are working through the design to determine how to maximise value from the funding.

The HCP is finalising plans to commission step down beds in the community.

Next Steps

Development and approval of efficiency pipeline plans to bring into the programme.

Design works for UEC capital.

Conclusions on funding and costs of the community step down beds.

Risks

Inflation continues to increase which could give rise to a cost pressure in the future. The Trust is working with the ICB to calculate the cost of the pay award and the level of funding proposed to cover this. Further ongoing risks continue including:

- Identification and delivery of the efficiency programme for 2023/24.
- Delivery of the Elective Services Recovery Fund activity as included in the activity and financial plans.
- Ongoing control of recruitment, agency spend, additional sessions, independent sector costs and non-pay.

Next Steps

Ongoing monitoring and reporting of risks through to Execs and FPPC.

Useful Information

Patient First

Patient First

OUR MISSION

Best of Care by the Best of People
Providing excellent care every time

OUR VALUES

Our values put our patients first and inspire us to be the B.E.S.T

BOLD - We are inspiring and ambitious
EVERY PERSON COUNTS - We are respectful and supportive
SHARING AND OPEN - We are open and speak up
TOGETHER - We are inclusive and responsible

TRUE NORTH DOMAINS

Sustainability | People | Patients | Quality | Systems and Partnerships

STRATEGIC INITIATIVES

Patient First Programme | Clinical Strategy | Culture, Leadership and Engagement | Emergency Performance and Flow | Financial Recovery | Elective Recovery Programme

Sustainability	People	Patients	Quality	Systems and Partnerships
Living within our means providing high quality services through optimising the use of our resources	*To be the employer of choice and have the most highly engaged staff within the NHS*	*Providing outstanding, compassionate care for our patients and their families, every time*	*Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have*	*Delivering timely, appropriate access to acute care as part of a wider integrated care system*

Patient First - Guidance

Patient First - Metric Types

	Metric	Description
	True North Metric	• The measures that form the whole focus of improvement with regards to Patient First
	Driver Metric	• The measure you will choose to actively work on to 'drive' improvement. • This is typically selected as areas that have the highest impact on True North domain.
	Watch Metric	• Watch metrics will be monitored monthly • We will watch for adverse trends (i.e. more than 4 months) in performance, at which time we may decide to actively work to improve it
	Breakthrough Objective	• A metric that is targeted for significant improvement (30+%). • It is selected on the evidence base of what will impact True North domain the most.

RAG Status & Thresholds

For every Key Performance Indicator, each monthly position is given a Red/Green status based on performance vs the relevant agreed threshold. If a threshold has not been set or is not required, then no Red/Green status will be applied to the monthly values and the threshold will show as -

Patient First - Business Rules

No.	Rule Description	Expected Actions
1	Driver is **green** for latest reporting period	Share success and move on
2	Driver is **green** for 6 reporting periods	• Switch to watch metric • Increase threshold
3	Driver is for **red** latest reporting period	Share top contributing reason and the amount this contributor impacts the metric
4	Driver is for **red** for 2 reporting periods	Produce countermeasure summary performance report
5	Watch is **green** for latest reporting period	Continue too maintain performance
6	Watch is a **concern** for latest reporting period	Share top contributing reason (e.g special / significant event)
7	Watch is **red** for 4 reporting periods	• Switch to driver metric (replace existing driver metric and amend to a watch metric) • Review Thresholds
8	Specific Watch is **above or below 1 standard deviation** in latest reporting month	Share top contributing reason (e.g special / significant event)

Patient First - Guidance

NHSI 'Plot the Dots' Guidance

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: Orange indicates concerning **special cause variation** requiring action; **Blue** indicates where improvement appears to lie, and grey indicates no significant change (**common cause variation**).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

KPI Glossary

Future Developments

Metric Name	True North Domain	Sub Domain
End of Life (Place of Death Achieved) Care (Number)	Patients	Patient Experience
Nutrition & Hydration (MUST) % Completion	Patients	Patient Experience
Patient Call Bells Answered within 2 Minutes %	Patients	Patient Experience
Privacy & Dignity (Survey Question) % Audit Score	Patients	Patient Experience
Privacy & Dignity % Audit Score	Patients	Patient Experience
Hand Hygiene % Audit Score	Quality	IPC
Bare Below the Elbows % Audit Score	Quality	IPC
IPC Commode % Audit Score	Quality	IPC
IPC Peripheral Intravenous Cannula % Audit Score	Quality	IPC
IPC Urinary Catheter % Audit Score	Quality	IPC
Moving & Handing Incidents	Quality	Health & Safety
Number of SJR declared as SI’s	Quality	Mortality
Number of Inquests Received	Quality	Legal & Information Governance
Number of Inquest Hearings	Quality	Legal & Information Governance
Reg 28	Quality	Legal & Information Governance
Schedule 5	Quality	Legal & Information Governance
FOI New	Quality	Legal & Information Governance
FOI Open	Quality	Legal & Information Governance
Guidance Issued (Number)	Quality	NICE Guidance
% Assessed	Quality	NICE Guidance
% Overdue for Assessment	Quality	NICE Guidance
% Applicable	Quality	NICE Guidance
% Fully Compliant	Quality	NICE Guidance
% Partially Compliant	Quality	NICE Guidance
% Not Compliant	Quality	NICE Guidance
% Not Implemented	Quality	NICE Guidance

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Patients	Complaints		Complaints	The total number of complaints received
Patients	Complaints		Complaints Closed	The total number of complaints closed
Patients	Complaints		Complaints Open - Month End	The total number of open complaints at month end
Patients	Complaints		Complaints Re-Opened	The total number of complaints re-opened
Patients	Complaints		Complaints Acknowledged Within 3 Working Days %	The percentage of complaints acknowledged within 3 working days of the opened date
Patients	Complaints		Complaints Breached %	% of Complaints which have breached
Patients	FFT		Total FFT Recommend %	Total Combined Friends and Family Test Score
Patients	FFT		Total FFT Response Rate %	The proportion of patients who responded to the Friends and Family Test (FFT)
Patients	FFT		Inpatients FFT Recommend %	IP Friends and Family Test Score
Patients	FFT		Inpatients FFT Response Rate %	The proportion of Inpatients who responded to the Friends and Family Test (FFT)
Patients	FFT		Emergency Care FFT Recommend %	EC Friends and Family Test Score
Patients	FFT		Emergency Care FFT Response Rate %	The proportion of Emergency Care patients who responded to the Friends and Family Test (FFT)
Patients	FFT		Outpatient FFT Recommend %	OP Friends and Family Test Score
Patients	FFT		Outpatient FFT Response Rate %	The proportion of Outpatients who responded to the Friends and Family Test (FFT)

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Patients	FFT		Maternity FFT Recommend %	Maternity Friends and Family Test Score
Patients	FFT		Maternity FFT Response Rate %	The proportion of Maternity Patients who responded to the Friends and Family Test (FFT)
Patients	PALS		Patient Advice and Liaison Service (PALS) Concerns	The total number of PALS concerns received
Patients	PALS		PALS Closed	The total number of PALS concerns closed
Patients	PALS		PALS Open - Month End	The total number of PALS concerns open at month end
Patients	PALS		PALS Converted to Complaints	The total number of PALS concerns converted to complaints
Patients	Patient Experience		Mixed Sex Accommodation (MSA) Compliance %	Mixed Sex Accommodation (MSA) Compliance %
Patients	Patient Experience		Mixed Sex Accommodation Breaches	The total number of Mixed Sex Accommodation (MSA) breaches
Patients	PHSO		Parliamentary and Health Service Ombudsman (PHSO) Cases	The total number of PHSO Cases
Patients	PHSO		PHSO Cases Closed - Partially Upheld	The total number of PHSO Cases Closed - Partially Upheld
Patients	PHSO		PHSO Cases Closed - Upheld	The total number of PHSO Cases Closed - Upheld
Patients	PHSO		PHSO Cases Closed - Not Upheld	The total number of PHSO Cases Closed - Not Upheld
People	Workforce		National Staff Engagement Score	National Staff Engagement Score
People	Workforce		Staff Appraisal Rate %	The proportion of staff that has completed the appraisal process

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
People	Workforce		Staff in Post (FTE)	Staff in Post (FTE)
People	Workforce		Staff Leavers (FTE)	Staff Leavers (FTE), in month position
People	Workforce		Staff Starters (FTE)	Staff Starters (FTE), in month position
People	Workforce		Vacancy Rate %	Vacancy Rate %
People	Workforce		Voluntary Turnover %	Workforce Voluntary Turnover %, shown as a 12-Month Rolling Average
People	Workforce		Staff Fill Rate - Total %	Staff Fill Rate % (Day & Night) for Registered Nurses and Care Staff combined
People	Workforce		Staff Fill Rate % (Total) - Registered Nurse	Staff Fill Rate % (Day & Night) for Registered Nurses
People	Workforce		Care Hours per Patient Day (CHPPD)	Number of Care Hours per Patient Day to monitor staffing levels in relation to patient numbers on an inpatient ward.
People	Workforce		Sickness Absence Rate - Total %	Short & Long Term Sickness Absence Rate %
People	Workforce		Sickness Absence Rate - Short Term %	Sickness absence rate - Short Term (%)
People	Workforce		Sickness Absence Rate - Long Term %	Sickness absence rate - Long Term (%)
People	Workforce		StatMan Training Compliance %	Statutory & Mandatory Training Compliance %
Quality	Falls		Low or No Harm Falls %	The percentage of Falls recorded on Datix with No or Low Harm
Quality	Falls		Falls - Total	The total number of Falls recorded on Datix

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Falls		Falls - Low Harm	The total number of Falls recorded on Datix with Low Harm
Quality	Falls		Falls - Moderate Harm	The total number of Falls recorded on Datix with Moderate Harm
Quality	Falls		Falls - Severe Harm	The total number of Falls recorded on Datix with Severe Harm
Quality	Falls		Falls Resulting in Death	The total number of Falls recorded on Datix that resulted in death
Quality	Falls		Falls per 1,000 Bed days	The number of falls per 1,000 bed days
Quality	Health & Safety		Resuscitation Training Compliance %	Resuscitation Training Compliance %
Quality	Health & Safety		Mental Capacity Act Training Compliance %	Mental Capacity Act Training Compliance %
Quality	Incident Management		Low or No Harm Incidents %	The Percentage of Incidents recorded on Datix with either Low or No Harm recorded
Quality	Incident Management		Total Incidents Reported	Total Incidents recorded on Datix
Quality	Incident Management		Incidents with Harm (Moderate and above)	Incidents with Harm (Moderate, Severe, Death)
Quality	Incident Management		Incidents Open - Month End	The total number of Open incidents as recorded on Datix at Month End (Snapshot)
Quality	Incident Management		Incidents Overdue - Month End	The total number of Overdue Open incidents as recorded on Datix at Month End (Snapshot)
Quality	Incident Management		Serious Incidents	The total number of Serious Incidents as recorded on Datix
Quality	Incident Management		Serious Incidents Closed	The total number of Serious Incidents Closed on Datix

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Incident Management		Serious Incidents Open - Month End	The total number of Serious Incidents Open at Month End on Datix
Quality	Incident Management		Serious Incidents Responded to Within 60 Days %	The percentage of Serious Incidents responded to within 60 days
Quality	Incident Management		Serious Incidents Closed by ICB 1st Time %	The percentage of Serious Incidents closed by ICB 1st Time
Quality	Incident Management		Never Events	The total number of Never Events as recorded on Datix
Quality	Incident Management		Duty of Candour Compliance Stage 1 %	Duty of candour compliance Stage 1
Quality	Incident Management		Duty of Candour Compliance Stage 2 %	Duty of candour compliance Stage 2
Quality	Incident Management		RIDDOR Incidents	The total number of RIDDOR Incidents reported on Datix
Quality	Incident Management		RIDDOR Compliance %	RIDDOR Compliance %
Quality	Incident Management		Health & Safety Incidents	The total number of Health & Safety Incidents reported on Datix
Quality	Incident Management		Sharps Injuries	The total number of Sharps Injuries reported on Datix
Quality	Incident Management		Violence & Aggression Incidents	The total number of Violence & Aggression Incidents reported on Datix
Quality	Incident Management		Assaults - Patient on Staff	The total number of Assaults (patient on staff) reported on Datix
Quality	Incident Management		EDNs Completed Within 24hrs %	% of EDNs Completed Within 24hrs
Quality	IPC		IPC Incidents	Total Incidents recorded on Datix relating Infection Control

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	IPC		C-Diff Cases - Hospital Acquired Total	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated & Community Onset Hospital Associated)
Quality	IPC		C-Diff Cases - Hospital Acquired YTD (Cumulative)	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated & Community Onset Hospital Associated) YTD cumulative position
Quality	IPC		C-Diff Cases - Hospital Acquired (HOHA)	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated)
Quality	IPC		E.coli Cases - Hospital Acquired	The number of E.coli cases - Hospital Acquired (Blood Culture Only)
Quality	IPC		E.coli Cases - Hospital Acquired YTD (Cumulative)	The number of E.coli cases - Hospital Acquired (Blood Culture Only) YTD cumulative position
Quality	IPC		MRSA Cases - Hospital Acquired	The number of MRSA cases - Hospital Acquired (Blood Culture Only)
Quality	IPC		MSSA Cases - Hospital Acquired	The number of MSSA cases - Hospital Acquired
Quality	IPC		MSSA Cases - Hospital Acquired YTD (Cumulative)	The number of MSSA cases - Hospital Acquired YTD Cumulative
Quality	IPC		Covid-19 Diagnosed - Total	The number of Covid-19 Inpatients
Quality	Maternity		Caesarean Section %	The percentage of total deliveries where a Caesarean Section was performed
Quality	Maternity		Elective C-Section %	The percentage of total deliveries where an Elective Caesarean Section was performed
Quality	Maternity		Emergency C-Section %	The percentage of total deliveries where an Emergency Caesarean Section was performed
Quality	Maternity		PPH greater than 1000mls	The number of deliveries where PPH was greater than 1000ml
Quality	Maternity		Total Number of Still Births Greater Than 24 weeks Gestation	The total number of still births greater than the 24 weeks gestation period

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Maternity		Neonatal Deaths	The total number of neonatal deaths less than 28 days prior to birth
Quality	Maternity		Maternity Serious Incidents	The total number of maternity related serious incidents recorded on Datix
Quality	Maternity		Maternity HSIB Referrals	The total number of HSIB (Health Safety Investigation Branch) referrals recorded on Datix
Quality	Maternity		Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3
Quality	Medicines		Medicine Errors - Total	The total number of medicine errors recorded on Datix
Quality	Medicines		Low or No Harm Medicine Errors %	The percentage of medicine errors recorded on Datix with either Low or No Harm recorded
Quality	Mortality		Crude Mortality Rate %	Crude Mortality Rate
Quality	Mortality		Avoidable Cardiac Arrest Calls (2222)	Avoidable Cardiac Arrest Calls (2222)
Quality	Mortality		HSMR (All)	HSMR (All)
Quality	Mortality		Expected Death Rate %	Expected Death Rate as calculated within Dr Foster
Quality	Mortality		SHMI	Summary Hospital-level Mortality Indicator (SHMI)
Quality	Mortality		Fractured NOF Within 36 Hours	Fractured NOF Within 36 Hours
Quality	Mortality		Number of Deaths Reviewed via SJR	Total SJR's completed in month irrelevant of when the death occurred
Quality	Mortality		SJRs Completed %	Total SJR's completed in month as a percentage of total deaths in month

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Mortality		Total Number of Deaths Due to Failings in Care	Total SJR's completed with an outcome suggesting failings in care
Quality	Mortality		Number of LD Deaths Reviewed via SJR	Total SJR's completed in month irrelevant of when the LD death occurred
Quality	Mortality		Total Number of LD Deaths Due to Failings in Care	Total SJR's completed with an outcome suggesting failings in care - LD deaths only
Quality	Pressure Ulcer		Pressure Ulcers - Total	The total number of Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 1	The total number of Grade 1 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 2	The total number of Grade 2 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 3	The total number of Grade 3 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 4	The total number of Grade 4 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Unstageable	The total number of Unstageable Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Deep Tissue Injury	The total number of Deep Tissue Injury (DTI) Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers per 1,000 Bed Days	The total number of Pressure Ulcers per 1,000 bed days
Quality	Risk & Policy		Risks Approved	Total number of new approved risks added to the register according to the "Risk Approved Date"
Quality	Risk & Policy		Risks Approved - Low	Total number of new risks added to the register where the risk review score is between 1 and 3 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Moderate	Total number of new risks added to the register where the risk review score is between 4 and 6 (uses current score but if no current score then uses the initial score)

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Risk & Policy		Risks Approved - High	Total number of new risks added to the register where the risk review score is between 8 and 12 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Extreme	Total number of new risks added to the register where the risk review score is between 15 and 25 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Closed	Total number of risks closed in the month according to the "Closed date"
Quality	VTE		VTE Risk Assessment Completed %	The proportion of patients risk-assessed for Venous Thromboembolism (VTE)
Sustainability	Financial Position		Breakeven Revenue Budget (£)	Breakeven Revenue Budget Position
Sustainability	Financial Position		Agency Spend %	Percentage of total spend with regards to Agency staff
Sustainability	Financial Position		Bank Spend %	Percentage of total spend with regards to Bank staff
Sustainability	Financial Position		(Surplus) / Deficit (£)	(Surplus) / Deficit
Sustainability	Financial Position		Agency Spend (£)	Agency Spend £ (Finance Ledger)
Sustainability	Financial Position		Income (£)	Income £ (Finance Ledger)
Sustainability	Financial Position		Income (£) vs Budget	Income £ (Finance Ledger) vs Budget
Sustainability	Financial Position		Total Pay Spend (£)	Total Pay spend
Sustainability	Financial Position		Total Pay Spend (£) vs Budget	Total Pay spend vs Budget
Sustainability	Financial Position		Total Non-Pay Spend (£)	Total Non-Pay Spend

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Sustainability	Financial Position		Total Non-Pay Spend (£) vs Budget	Total Non-Pay Spend vs Budget
Sustainability	Financial Position		Actual Worked FTE	Actual Worked FTE (Finance Ledger)
Sustainability	Financial Position		Actual Worked FTE vs Budget	Actual Worked FTE vs Budget (Finance Ledger)
Systems & Partnerships	Access		RTT Incompletes Performance %	The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for less than 18 weeks from referral.
Systems & Partnerships	Access		RTT 40+ Week Waiters	The number of patients on the RTT waiting list waiting 40 weeks or more at month end
Systems & Partnerships	Access		RTT Waiting List Size	RTT Waiting List Size
Systems & Partnerships	Access		RTT 52 Week Breaches	The number of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for over 52 weeks.
Systems & Partnerships	Access		OP Average Time to First Appointment (days)	OP Average Time to First Appointment (Days), excluding diagnostic imaging and ward attenders
Systems & Partnerships	Access		Outpatient DNA Rate %	The percentage patients failing to attend their Outpatient appointment (DNA - Did not Attend)
Systems & Partnerships	Access		OP First to Follow Up Ratio	Outpatient First Attendance to Follow Up Attendance Ratio
Systems & Partnerships	Access		Operations Cancelled by Hospital on Day	Operations Cancelled By Hospital on Day
Systems & Partnerships	Access		Cancelled Operations Not Rescheduled < 28 Days %	The Percentage of Cancelled Operations Not Rescheduled < 28 Days for Non-Clinical Reason
Systems & Partnerships	Access		Urgent Operations Cancelled for 2nd Time	Cancelled Urgent Procedure For 2nd Time For Non-Clinical Reason
Systems & Partnerships	Access		Day Case Rate %	Day Case % Rate - where National_POD = 'DC' / National_POD IN ('EL','DC')

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Systems & Partnerships	Access		Average Elective Length of Stay (days)	Average Elective (EL, DC, RDA) Length of Stay
Systems & Partnerships	Access		Average Non-Elective Length of Stay (days)	Average Non-Elective Length of Stay
Systems & Partnerships	Access		104 Day Cancer Waits	104 Day Cancer Waits
Systems & Partnerships	Access		Cancer 2ww Performance %	The proportion of patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral.
Systems & Partnerships	Access		Cancer 2ww Performance - Breast Symptomatic %	The proportion of Breast Symptomatic patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral.
Systems & Partnerships	Access		Cancer 31 Day First Treatment Performance %	The proportion of patients who had their first definitive treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 31 Day Subsequent Treatments - Drugs %	The proportion of patients who had their subsequent anti-cancer drug treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 31 Day Subsequent Treatments - Surgery %	The proportion of patients who had their subsequent surgical treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 62 Day Treatment - GP Refs %	The proportion of patients urgently referred by GPs/GDPs for suspected cancer and had first definitive treatment within 62 days from referral.
Systems & Partnerships	Access		Cancer 62 Day Treatment - Cons Upgrades %	The percentage of patients upgraded by a consultant for cancer and had first definitive treatment within 62 days from referral.
Systems & Partnerships	Access		Cancer 62 Day Treatment - Screening Refs %	The proportion of patients referred by the national screening programme and had first definitive treatment within 62 days from referral.
Systems & Partnerships	Access		Cancer 28 Faster Diagnosis %	The proportion of patients referred for suspected cancer that are informed if they do or do not have a cancer diagnosis within 28 days
Systems & Partnerships	Access		Cancer 28 Faster Diagnosis Screening %	Cancer 28 Faster Diagnosis Screening
Systems & Partnerships	Access		DM01 Performance %	The proportion of patients that are currently waiting for a diagnostic test for less than 6 weeks from referral.

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Systems & Partnerships	Emergency Care		Total EC 4 Hour Performance %	Percentage of patients treated within 4 in Emergency Care
Systems & Partnerships	Emergency Care		IP Discharged Before Noon % (Inc transfers to ADL)	Percentage of patients discharged from hospital before noon (between 06:00:00 and 11:59:59 - Including transfers to the discharge lounge before noon)
Systems & Partnerships	Emergency Care		Type 1 EC 4 Hour Performance %	Performance against the national 4 hour target (Type 1 departments only) - The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours
Systems & Partnerships	Emergency Care		Total EC 12 Hour Breaches	The number of patients with total LOS of greater than 12hrs in EC Department (Type 1 & 3 departments combined)
Systems & Partnerships	Emergency Care		Average Time in EC Department (mins)	Average Time in EC Department (Mins)
Systems & Partnerships	Emergency Care		Number of ED Arrivals by Ambulance	Number of ED Arrivals by Ambulance (Ambulance Handovers)
Systems & Partnerships	Emergency Care		Ambulance Handover Delays (> 30 mins)	The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 30 minutes.
Systems & Partnerships	Emergency Care		Ambulance Handover Delays (> 60 mins)	The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 60 minutes.
Systems & Partnerships	Emergency Care		Bed Occupancy - General & Acute %	The proportion of beds occupied at midnight (General and Acute beds only)
Systems & Partnerships	Emergency Care		Medically Fit for Discharge Patients %	% Medically Fit for Discharge (MFFD) Patients
Systems & Partnerships	Emergency Care		30 Day Readmission Rate	30 Day Readmission Rate

Meeting of the Trust Board
Wednesday, 12 July 2023

<table>
<tr><td>Title of Report</td><td colspan="3">Board Assurance Framework - Quarterly Update</td><td>Agenda Item</td><td>3.2</td></tr>
<tr><td>Author</td><td colspan="5">Claire Cowell, Integrated Governance Practitioner</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Evonne Hunt, Chief Nursing Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">There are 21 risks on the Board Assurance Framework as per the below overview.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">The Trust Board is asked to note the report for assurance and discussion and approve the action plan developed to address under performance and increase control and assurance.</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td>X</td><td>Approval</td><td colspan="2">X</td></tr>
<tr><td>Noting</td><td>X</td><td>Discussion</td><td colspan="2">X</td></tr>
<tr><td>(If appropriate) state reason for submission to Private section of Board:</td><td>Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td colspan="2">Exceptional Circumstances:</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">The Board Assurance Framework has been presented at the Audit and Risk Committee on 22 June 2023.</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick 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)</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</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">As outlined in the relevant sections of the BAF</td></tr>
<tr><td>Resource implications:</td><td colspan="5">N/A</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="5">N/A</td></tr>
</table>

Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk.		
Appendices:	Not applicable		
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:	Dan Rennie-Hale d.rennie-hale@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	**X**	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Objective	Risk No.	Risk Description	Current Score	Movement
Providing outstanding, compassionate care for our patients and their families, every time	Patient 1a	Low uptake as a result of patient feedback fatigue due to patients not being able to see the improvement being made from completing a survey makes	9	▬
	Patient 1b	Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which could lead to data variation which cannot be used for benchmarking across the Trust	9	▬
	Patient 1c	Potential lack of delivery across other True North Domains could lead to patients not recommending our services as a place to receive care	12	▬
	Patient 1d	Another Covid surge could lead to staff losing momentum in the delivery of the FFT breakthrough objective	6	▲
	Patient 1e	As other wards (aside from the initial 4 implementation wards) gain interest in Patient First roll out, there is a risk that they would commence development of their own patient feedback approach, outside of the Patient First frontline implementation programme. This could lead to data variation and identification of areas for improvement which are not linked back to the Patient First programme	6	▼
Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have	Quality 2a	Lack of timely escalation and treatment of deteriorating patients	20	▬
To be the employer of choice and have the most highly engaged staff within the NHS	People 3a	There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function.	16	▬
	People 3b	Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	12	▬
	People 3c	Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. IMPACT: This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	6	▬
Delivering timely, appropriate access to acute care as part of a wider integrated care system	Systems & Partnerships 4a	Not meeting the 104% target for the Elective Recovery Fund will provide further financial challenge. (Financial Value)	9	▬
	Systems & Partnerships 4b	Not meeting the RTT standards brings a risk to the quality of care we are providing our patients as well as their overall experience	12	▬

Objective	Risk No.	Risk Description	Current Score	Movement
	Systems & Partnerships 4c	Risk around lack of operational performance for example not meeting constitutional measures (new quality indicators)	12	▬
	Systems & Partnerships 4d	Shared quality of care and performance across the heath and Care Partnership may affect the Trusts quality and safety through increased ambulance handovers, patient acuity, mortality and admissions.	8	▬
	Systems & Partnerships 4e	There is a risk of financial impact if we are unable to increase flow and close escalation areas.	16	▬
Living within our means providing high quality services through optimising the use of our resources	Sustainability 5a	The cost of our escalation capacity raises a risk against our current overspend. If the Length of Stay efficiency cannot mitigate this, there will be a financial impact.	12	▼
	Sustainability 5b	Not delivering the Efficiencies Programme will impact Trust overspend and increase cost pressures Trust wide.	20	▬
	Sustainability 5c	Current spend on drugs Trust wide is a risk to reducing overspend due to overall overspend on drugs – there needs to be a focus on changes in prescribing habits.	8	▼
	Sustainability 5d	Mitigating against medical staffing (agency/locum/additional sessions) is a risk to overspend	25	▬
	Sustainability 5e	Living within our means providing high quality services through optimising the use of our resources	16	▬
	Sustainability 5f	Covid-19 income and expenditure	8	▼
	Sustainability 5g	Delivery of the control total and FRP	25	▬

Meeting of the Trust Board
Date: 12 July 2023

Title of Report	Quality Assurance Committee – Assurance Report	**Agenda Item**	4.1a
Prepared by:	Joanne Adams, Business Support Manager		
Approved by:	Paulette Lewis, Non Executive Director (Chair of QAC) Dan Rennie-Hale, Director of Integrated Governance, Quality and Patient Safety		
Lead Executive Director	Evonne Hunt, Chief Nursing Officer		
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee held on Wednesday 31 May 2023, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.		
Proposal and/or key recommendation:	The Committee approved the following papers for onward sharing with Trust Board: - Integrated Quality Performance Report (IQPR)		

Purpose of the report (tick box to indicate)				
	Assurance	√	Approval	
	Noting		Discussion	

(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:

Committee/Group at which the paper has been submitted:	

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: X**

Identified Risks, issues and mitigations:	NIL	
Resource implications:	NIL	
Sustainability and /or Public and patient engagement considerations:	NIL	
Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	NIL	
Appendices:	Not applicable	
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:	Evonne Hunt, Chief Nursing Officer evonne.hunt1@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.

Key headlines	**Assurance Level** **(use appropriate colour code as above)**
1. Assurance and Escalation report from Quality and Patient Safety Sub-Committee (QPSSC) The Committee received the Assurance and Escalation Report from the QPSSC, which took place on Monday, 22 May 2023. There were a number of items discussed at the QPSSC, which were included on the QAC agenda. The paper was taken as read and the Committee was **ASSURED** and **NOTED** the report.	Green
2. Integrated Quality Performance Report (IQPR)	Red/Amber

The committee received and discussed the integrated quality performance report (IQPR) in depth, with focus on the following areas:
• Friends and Family Test (FFT) the total recommend rates are as follows:
    o Maternity - remained above the 95% target in the last reporting period.
    o Outpatient and ED remains static since the last reporting period.
    o The feedback post-boxes in Main Reception have been removed. These have been replaced with posters with QR code for visitors to complete an electronic FFT. Future planning include stands with iPads so visitors can look at questions and check accuracy of contact detail.
• A project to 'reduce noise at night' has launched in both divisions at the end of May. The project was created as a response to an action linked directly from patient feedback as a reason for not recommending the hospital.
• SOP are completed for the Complaints team to standardise reporting and processes. This will ensure data accurately reflects the position.
• Duty of Candour is 100% compliant
• Violence and Aggression – there is an increase to the number of violence and aggression incidents and more focused work needs to be carried out to address this
• VTE Risk Assessment:
    o The VTE alert on EPMA and EPR is now live.
    o The newly recruited VTE Clinical Nurse specialist will commence in post at the end of June 2023. Key areas of focus will be education on responsibilities of the risk assessment.
    o Patients must complete their risk assessment within 24 hrs. EPR will not allow patients to progress further without this being completed.
• Improvements expected in Fracture NOF rates, when there are additional beds to support the pathway. This is a corporate project to support medical care and part of Getting It Right First Time (GIRFT).
• There are ongoing reductions in backlog (200 currently open), the responses to Serious Incidents are quicker and improvements are visible.
• The Committee was informed that there is an external review on data. The commission will include a review of roles and responsibilities.
 	
The Committee **NOTED** the report.	

3. Infection Prevention and Control update The committee received the infection prevention and control update which provide updates on:- **Commode Audit:** • Results - 89 commodes audited overall and result was 100% performance on condition and cleanliness. All replacement commodes will be in place by Summer 2023. **Draft Annual Programme:** The Committee received and discussed the draft annual IPC programme, the report once finalised will be signed off by the Trust Board. **IPC education framework gap analysis**: The trust has carried out a gap analysis against the NHSE IPC Education Framework	Green

that was published on 7th March 2023, this sets out how we design and deliver IPC education. The team have developed a new way of delivering training which was launched on Friday 19th May 2023 which received good feedback. Compliance with level 2 training is above 85% and the team are looking at staff groups for training and will be included in the medical induction training from August. **IPC BAF**: 97 actions from the 145 has been completed. The BAF is set out by the 10 criteria that we are required to report under the code of practice. The overdue actions are predominantly around environment, cleanliness and ventilation which are monitored by the infection, prevention and control committee and 4 actions relate to patient experience with issues around visiting, these are superseded with the recent changes to visiting times. The Committee were informed the Handwashing Audit is monitored on GATHER. The Hand Hygiene Audit has been 95% for the past four months, 64% of observations were with soap and water. The Committee **NOTED** the report.	
4. Human Tissue Authority Report The Committee received and discussed the human tissue authority (HTA) report which provided an update following an unannounced inspection by the HTA in October 2022. The unannounced inspection was triggered by a complaint relating to mortuary cleanliness and dignity of the deceased. The inspection is a visual inspection of the establishment and an oversight of key licence activities that includes interviews with members of staff and overview of documentation. The Committee were informed that there was no evidence to substantiate the allegations in the compliant. The inspectors complimented the staff on how prepared the trust was at the inspection. The trust received one minor short fall into standards relating to shrouding covering deceased. To address this the mortuary staff will ensure the full and appropriate covering of deceased at the daily identification check. This action was closed on 24th February 2023. The Committee congratulated the team on their work and **NOTED** the report.	Green
5. DNA training – A3 thinking The Committee received and discussed the DNA training A3 thinking which set out the successes, identified issues, current plans to address identified risks and countermeasures proposed. The Committee were informed that a StatMan Task and Finish Group has been established to address issues around StatMan compliance. Meetings will continue throughout the year to address the risks and improve the process as a countermeasure to high DNA statistics. The Committee were informed that a process for accurately mapping StatMan training is being developed and a review of current mapping of StatMan training is taking place. The process will be approved by Chief Nursing Officer and Chief People Officer and submitted to QPSSC then QAC. The Committee **NOTED** the report.	Green
6. Mixed Sex Accommodation (MSA)	Green

The Committee received and discussed the mixed sex accommodation paper which provided an update on the work taking place to reduce breaches and the trusts current position. The Committee were informed that the trust has looked at other trusts and how they record MSA. The trust will update its policy and process and will implement all patients will be cared for in a single sex accommodation all of the time with exceptions to the rule by approval of the Divisional Directors of Nursing where they will explore other opportunities. Only expected breaches are delays in stepping patients out of ICU. The Committee **NOTED** the report.	
7. Mortality update The Committee was advised the Trust's Standardised Hospital-level Mortality Indicator (SHMI) for the period spanning December 2021 - November 2022 is 1.13 and 'higher than expected' and the Trust's HSMR for the period of January 2022 - December 2022 is 115.7 and is showing 'higher than expected'. The Committee were informed that education around clinical documentation appears to have made a positive impact on the rates, as shown by the spike in December and January. Slight reduction in March 2023 mirrors the same drop in March 2022. There is a workstream as part of the Mortality Data Task and Finish Group, led by the COO, to address clinical coding issues over the next 3-5 weeks. Action Plan detailed in the report. All Structured Judgement Reviews (SJRs) are now referred and completed on Datix. Themes are much easier to identify. Ongoing work to improve this area further to avoid the ambiguous 'other' category. The Committee **NOTED** the report.	Green
8. C-section audit The Committee received a presentation on C-section audit which provided information and data in relation to the Caesarean Section audit completed in May 2023, covering a one year period of 2022-2023. The aim if for the Trust to be safe for mothers and babies. To do this the Trust will conduct continuous audit of statistics, reflections, shared learning and teaching. The Trust's annual figures in 2022 were slightly higher than neighbouring hospitals. The audit included benchmark comparisons of CS rates against other Trusts, deep dives and future workstream improvements, in addition to the Audit Programme for next 6-12 months. The Committee was asked to note the content of the slide for Highlighted the Hypoxic ischaemic encephalopathy (HIE). The Committee **NOTED** the report.	
9. Maternity CQC final report and 'should do' action plan	Green

The Committee received and discussed the Maternity CQC final report and 'should do' action plan. The CQC conducted an inspection of the trust's maternity service on 7th December 2022. The inspection was part of a national maternity inspection programme, spending time in all of the Maternity areas. The CQC published their final report for Medway Maternity Services on 28th April 2023 with an overall rating of GOOD, including maintaining GOOD for the two particular standards assessed for Safe and Well-led. No 'Must Do' Actions were identified within the published report, however six 'Should Do' actions were identified. An action plan has been developed to sustain the rating and driving towards 'Outstanding'. The Committee congratulated the team and **NOTED** the report.	
10. Draft quality account 2023/24 The Committee received the draft Quality Account 2023/24, to approve, ahead of minor final amendments and addition of statements from external stakeholders, before final ratification by the Audit and Risk Committee and Trust Board. There will be a full refresh on quality priorities so the details in the account may change slightly, additional information will be included on local audits and how the Trust changes the process on audits and the CQC ratings will be added; Maternity and ED The Quality account is to be published by 30th June 2023 The Committee **APPROVED** the report and were asked to send feedback to Dan Rennie-Hale by email.	Green
Risks and Escalations to Board The quality assurance committee informs the Board of the following matters: • StatMan Training: identifying priorities and QSPPC to add to the Risk Register. Update to come back to QAC once progress has been made.	

Trust Board – Wednesday, 12 July 2023

Meeting	Quality Assurance Committee			
Title of Report	**Assurance and Escalation Report for Quality Assurance Committee**		Agenda Item	4.1b
Lead Non-Executive Director	Paulette Lewis, Non-executive Director (Chair of QAC)			
Lead Executive Director	Evonne Hunt, Chief Nursing Officer Alison Davis, Chief Medical Officer			
Report prepared by	Joanne Adams, Business Support Manager			
Report Approved by	Paulette Lewis, Non-executive Director (Chair of QAC) Dan Rennie-Hale, Director of Integrated Governance, Quality and Patient Safety			
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee held of Tuesday, 27 June 2023, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.			
Proposal and/or key recommendation:	The Committee approved the following papers for onward sharing with Trust Board: a) Integrated Quality Performance Report (IQPR) b) IPC annual report and NHS standard contract c) Safe staffing establishment review d) Maternity workforce oversight report e) Patient/service story for Board f) Quality account			
Purpose of the report (tick box to indicate)	Assurance	√	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	N/A			

<table>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick 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) √</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led: X</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5">The committee identified the following matters to inform the Board:
None</td></tr>
<tr><td>Resource implications:</td><td colspan="5">NIL</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="5">NIL</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="5">NIL</td></tr>
<tr><td>Appendices:</td><td colspan="5">Key headlines and assurance level listed below.</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="5">This paper is disclosable under the FOI Act.</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="5">Evonne Hunt, Chief Nursing Officer
evonne.hunt1@nhs.net</td></tr>
<tr><td>Reports require an assurance rating to guide the discussion:</td><td colspan="3">Partial Assurance</td><td colspan="2">There are gaps in assurance</td></tr>
</table>

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Quality Assurance Committee (QAC)	27 June 2023	Paulette Lewis, NED

Number of attendees	Number of apologies	Quorate	
		Yes	No
16	6	x	

Declarations of Interest Made

There were no declarations of interest in relation to items on the agenda.

Assurance received at the Group meeting

(overview of key points/issues/matters on the agenda discussed at the Group meeting, including anywhere the group was unable to obtain assurance or there may be an adverse impact for the Trust (e.g. potential impact on: strategic progress, compliance or patient safety). Consider whether the agenda was fit for purpose – e.g. linked to the terms of reference and the work plan for that month)

Minutes of previous meeting and action log: key points of note:

- Minutes of the meeting held on 31 May 2023 were approved as an accurate record.
- Action log was updated with some actions remaining open.

Assurance and Escalation Report form Quality and Patient Safety Sub-Committee (QPSSC): Key points of note:
The Committee received the assurance and escalation report from QPSSC held on 22 June 2023 and were assured by the report which provided assurance on the items discussed at the meeting, decisions made and actions taken.

The Committee noted a number of items discussed at QPSSC were included on the QAC agenda.

Integrated Quality Performance Report (IQPR): Key points of note:
The Committee received and discussed the IQPR with particular discussion on the following metrics:

a) Friends and family test feedback (FFT) – response and recommend rates, work taking place to: reduce noise at night, assist the catering team to improve the provision and standard of food, ensure the Trust has the correct contact numbers for patients. Capturing FFT from specialist nurse teams not just inpatient wards and outpatient appointments.
b) Improved position with closure of backlog of complaints, this is due to collaborative working with the central team and divisions.
c) Mixed sex accommodation (MSA) ongoing piece of work with improvement made due to the closure of escalation areas.
d) Increase to the number of incidents relating to violence and aggression; however, this may be in part due to improved reporting processes.
e) Incidents - continue to have 98.9% low harm and clinical colleagues attending ICB serious incident closure panels to provide assurance and reassurance to ICB colleagues
f) Duty of candour 100% for Stage 1.
g) 19 C.diff cases since the beginning of the financial year against a threshold of 33; this is a national issue. Investigations show the cases were not avoidable.
h) Refreshing overdue policies.
i) Continued work on mortality SHMI an HSMR to bring the trust back to within the expected range. Additional structured judgement review training has been provided to clinicians

j) Medical examiners have identified allergy status not always completed and there have been incidents of patients been prescribed antibiotics they are allergic to.
k) #NOF pathway has improved.

The Committee expressed its concern over the number of incidents of violence and aggression and were informed of the focused work and measures in place to help to address the issues. These included; implementing the Red and Yellow card policy to warn patients and exclude them from the trust, posters displayed across the Trust informing patients and visitors of the trusts zero tolerance to violence and aggression.

The Committee asked to be kept informed on progress being made on the concerns.

Infection, prevention and control:
Annual report: Key points of note:
The Committee received and discussed the IPC annual report which provided a summary record of all activities relating to practices in IPC at the Trust during the period of April 2022 to March 2023.

The Committee were **ASSURED**.

NHS Standard Contract: Key points of note:

The Committee received the NHS IPC standard contract paper.

Medicines management and medicines safety audit: Key points of note:
The Committee received and discussed the medicines management and medicines safety audit which was carried out in April 2023. The audit identified only five wards were 85% compliant and were informed of the work taking place to improve compliance and improve fundamental nursing standards.

The Committee were concerned about TTO being left on the wards after a patient has been discharged and associated cost implications. The Committee has asked for details to be provided in the next report.

Safe staffing establishment review: Key points of note:
The Committee received and discussed the safe staffing establishment review which was conducted between April 2022 and September 2022.

The Committee had a robust discussion about the changes that have happened since the report was first produced with the closure of escalation wards, PAHU and deployment of staff back to their wards and departments.

The Committee were provided with assurance that twice daily safe staffing meetings are conducted with any red rated wards being escalated to the Chief Nursing Officer.

The Committee were informed that the next cycle of safe staffing establishment reviews has commenced and a report will be presented to QAC once finalised.

This paper is presented to Trust Board and People Committee.

Maternity workforce oversight report: Key points of note:
The Committee received and discussed the bi-annual maternity workforce oversight report that provides an update on staffing numbers, acuity, red flags and consultant staffing and daily workforce planning.

The Committee discussed the current challenges with vacancies and subsequent impact on induction to labour and actions taking place to recruit and fill shifts with bank staff.

The Committee were informed that the formal BirthRate Plus review has commenced with a preliminary report expected at the end of the month.

This paper is presented to Board.

Clinical effectiveness report: Key points of note:
The Committee received and discussed the clinical effectiveness report which provided and update on national, local and clinical audit activity, NICE guidance reviews, LoCSSIPs, safety alert updates and risks.

The Committee were informed that there has been poor attendance over the last six months at the Clinical Effectiveness and Outcomes Group (CEOG), the meetings are going to be held monthly clinicians have time allocated within their job plans to attend.

The Committed had a discussion about the number of outstanding NICE guidance, national and local and clinical audits and the processes and steps in place to improve compliance. The Committee expressed its concern with 26% compliance to NICE guidance and will escalate to Board.

The Committee will be provided with an update and improvement plan at the next QAC following approval at CEOG on 11 July.

Patient/service story for Board: Key points of note:

- Clinical/Staff Story going to Private Board will be an update from the mortality service.
- No Patient Story available for Public Board

This paper is presented to Board.

Falls update: Key points of note:
The Committee were provided with an update on falls:

a) Overall common cause variation, incidents verified with wards, 61 falls for May
b) Concern with equipment, 31 falls alarms retrieved they have been returned to company to be fixed. 16 cannot be replaced due to the insertion of the link into the alarm. This is on the risk register and training is need for staff on how to operate the falls alarms. Kerry will do an A3 about why the team are not being told about issues with equipment.
c) Documentation audit to be carried out on witnessed and unwitnessed falls,
d) Increase to the CRASH bundle compliance.
e) Tennyson ward 100% crash bundle last 6 months.
f) Can break data down to provide specifics on each ward to develop action plans.

Pressure ulcers update: Key points of note:
The Committee were provided with an update on hospital acquired pressure ulcers:-
a) 53 PU for the year, 30 in May, 29 low harm and 1 investigation.
b) Positive deliverables – increase support from the business intelligence team has improved the data on the scorecard and within Gather.
c) Working with NHSE on model hospital data
d) CQUIN is risk assessment and care planning, work is taking pace with BI for capturing quarter one audit.
e) Team now provide training at trust clinical induction.
f) A3 on clinical engineering will take place to look at issues with tracking of equipment.
g) Wound photography stored on ward devices; work is taking place to remove images stored on the devices and the SOP is being revised.

VTE update report: key points of note:
The Committee were provided with an update on falls:-
a) Data is showing special cause variation and the shift in data occurred moving to electronic system and work is taking place with the business intelligence team to align the system to pull the data sets.
b) Paediatrics are still using paper drug charts to record VTE assessments
c) New VTE nurse joins the trust today and will focus on VTE risk assessments and education.
d) There is a hard stop within EPR that will not allow medications to be prescribed unless a VTE risk assessment has been completed.
e) Work is taking place to improve the process of identify positive scans.

Draft quality account priorities 2023-24: key points of note:
The Committee received the quality account 2023/24 which now includes the quality priorities which are aligned to Patient First.

The Committee were informed that the Audit Committee has agreed and ratified the quality account.

The Committee agreed it was happy with the content of the report which will be signed off by the Chief Executive and Trust Chair, then published on 30 June 2023.

This paper is presented to Board.

Quality and Patient Safety Sub-Committee terms of reference and work plan: Key points of note:
The Committee **APPROVED** the Quality and Patient Safety Sub-Committee terms of reference and work plan

Quality Assurance Committee Terms of Reference: Key points of note:
The Committee discussed the revised terms and reference noting the cross reference to the national code of governance, membership and people who should be in attendance.

The Committee **APPROVED** the Quality Assurance Committee terms of reference.

Key actions

Actions to note:
a) The Committee to be kept informed on the work to address violence and aggression.

b) The Chief Pharmacist to include details of discharge medications left behind on wards and cost implications in the next medicines management and medicines safety audit report.
c) Director of Integrated Governance, Quality and Patient Safety to bring an updated position and improvement plans on clinical effectiveness to the next meeting.

Highlights from sub-groups reporting into this group

(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)

Assurance and Escalation Report form Quality and Patient Safety Sub-Committee (QPSSC): key points of note:
The Committee received the assurance and escalation report from QPSSC held on 22 June 2023 and were assured by the report which provided assurance on the items discussed at the meeting, decisions made and actions taken.

The Committee noted a number of items discussed at QPSSC were included on the QAC agenda

Items to come back to the Group

(Items the Group is keeping an eye on outside its routine business cycle)

- Updates on violence and aggression
- Trajectories and improvement plans on clinical effectiveness

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

Item	Group, Subcommittee, Committee	Date
Integrated quality performance report	Trust Board	12.07.23
IPC annual report and NHS standard contract	Trust Board	12.07.23
Safe staffing establishment review	Trust Board	12.07.23
Maternity workforce oversight report	Trust Board	12.07.23
Clinical/Staff story for Private Board	Trust Board	12.07.23
Quality account	Trust Board	12.07.23

Reports not received as per the annual work plan and action required

- n/a

Items/risks/issues for escalation

(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)

Issues and or Risks to note:
The committee raises the following matters to Board:

- **C.Diff and delay in isolation of patients;** there is work taking place with the change of the diarrhoea assessment and re-education to staff on timely sampling and timely isolation. However, isolation is sometimes impacted by the availability of a side room.
- **TTO being left on the wards after the patient has been discharge;** the Chief Pharmacist has been given an action to provide an update on the numbers of TTO left and cost implications in the next medicines management and medication safety audit report.
- **Open liquids with no expiry dates:** work is taking place to address medicines management on the wards and spot checks are taking place by Matrons. Works is also starting to look at fundamental standards of nursing, of which medicines management is a standard.

- **26% compliance with NICE guidance:** the clinical effectiveness and outcomes group is being re-established and has requested trajectories and improvement plans to be presented at the meeting on 11 July. QAC will receive and update at its July meeting.

Reflection:
- The conversation and discussions and participation were very good with some of the assurances coming through.

Any other business:
- There was no other business for discussion.

Implications for the corporate risk register or Board Assurance Framework
Risks that have remained at the same risk rating for a period of time are being reviewed by the relevant Executive lead. This review may will result in changes to the Trust risk register and board assurance framework.

Examples of outstanding practice or innovation
n/a

Meeting of the Trust Board
Wednesday, 12 July 2023

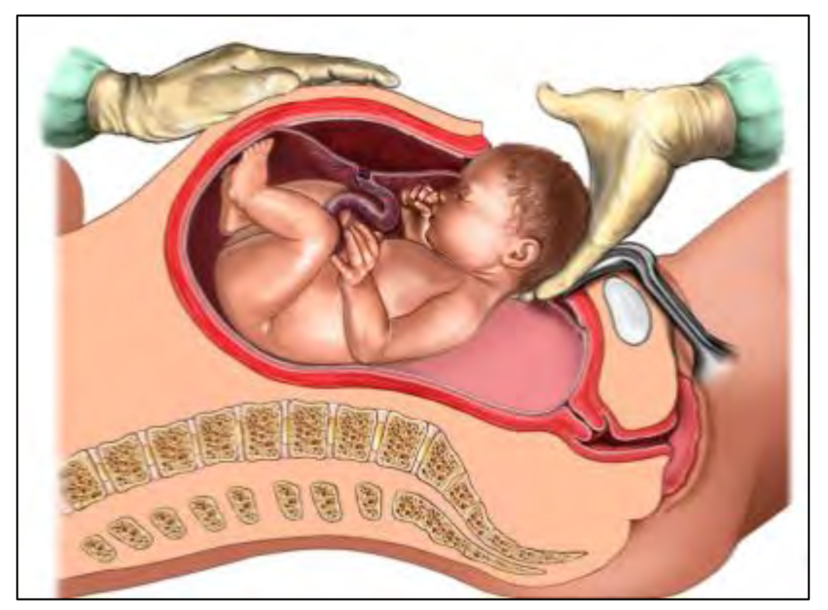
Title of Report	Caesarean Section Audit			Agenda Item	4.2
Author	Ranjit Akolekar, Consultant Obstetrician and Gynaecologist (Fetal Medicine) and Clinical Director for Women's Health				
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer Alison Davies, Chief Medical Officer				
Executive Summary	In July 2021, the Health and Social Care Committee Report regarding the Safety of Maternity Services in England recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. Maternity services should continually monitor safety and outcomes for mothers and babies with regular audit, and any recommendations and quality improvements implemented where required. This presentation provides information and data in relation to the Caesarean Section audit completed in May 2023, covering a one-year period of 2022 to 2023. The report includes detail on the: a) Annual figures 2022 with Medway NHS Foundation Trust being slightly higher than neighbouring hospitals b) A comparison of like for like hospitals which have a fetal medicine centre and a Level 3 neonatal unit – showing Medway NHS Foundation Trust is comparable with these trusts c) A deep dive into the maternal demographics, co-morbidities and obstetric factors for those having an outcome of a caesarean section birth d) A review of the Robson Criteria and Caesarean section e) HIE rates noted to be lower than national expected rates f) Recommendations for further deep dives and quality improvement work streams				
Proposal and/or key recommendation:	The Board is requested to NOTE the report				
Purpose of the report (tick box to indicate)	Assurance	X	Approval		
	Noting	X	Discussion		
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:	

<table>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Maternity and Neonatal Safety Champion Assurance Board 05.05.23
Quality and Patient Safety Sub-Committee 22.05.23
Quality Assurance Committee 31.05.23</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)</td><td>Priority 2: (People)</td><td>Priority 3: (Patients)
X</td><td>Priority 4: (Quality)
X</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:
X</td><td>Effective:
X</td><td>Caring:
X</td><td>Responsive:
X</td><td>Well-Led:
X</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Resource implications:</td><td colspan="5">No additional resource implications</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="5">The Trust is required to be compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendix 1 – Caesarean Section Audit Presentation 2022-2023</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="5">This paper is disclosable under the FOI Act</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="5">Ranjit Akolekar, Consultant Obstetrician and Clinical Director
ranjit.akolekar@nhs.net</td></tr>
<tr><td rowspan="5">Reports require an assurance rating to guide the discussion:</td><td colspan="2">No Assurance</td><td colspan="3">There are significant gaps in assurance or actions</td></tr>
<tr><td colspan="2">Partial Assurance</td><td colspan="3">There are gaps in assurance</td></tr>
<tr><td colspan="2">Assurance</td><td colspan="3">Assurance with minor improvements needed.</td></tr>
<tr><td colspan="2">Significant Assurance</td><td colspan="3">There are no gaps in assurance</td></tr>
<tr><td colspan="2">Not Applicable</td><td colspan="3">No assurance required.</td></tr>
</table>

Caesarean section audit – 2022-2023

Maternity and Neonatal safety Champion Assurance Board

5th May 2023



Caesarean section: National narrative

NHS England and NHS Improvement

Dear colleague,

Re: Use of caesarean section rates data

We write to you regarding The Health and Social Care Committee Report on The Safety of Maternity Services in England (July 2021), which recommended the following:

"It is deeply concerning that maternity units appear to have been penalised for high Caesarean Section rates. We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. NHS England and Improvement must write to all maternity units to ensure that they are aware of this change." (p.51, para.168)

NHS England and NHS Improvement accepted this recommendation in the government's response (September 2021).

Caesarean section: Public perception

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Health

NHS England drops limit on offering Caesarean births

1 day ago

21st February 2022

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Features

Caesarean section: Ockenden report

Ordered by the House of Commons to be printed on 10 December 2020

Table 1. Comparison of Caesarean section rates between The Shrewsbury and Telford Hospital NHS Trust, neighbouring Hospital Trusts, and the rates in England.

	The Shrewsbury and Telford Hospitals NHS Trust	University Hospitals of North Midlands NHST	Royal Wolverhampton Hospitals Trust	NHS Hospitals England
2006-2007	11.8%	24.3%	25.5%	24.2%
2007-2008	15.5%	23.5%	26.1%	24.6%
2008-2009	16.8%	24.1%	25.0%	24.6%
2009-2010	15.8%	25.6%	24.9%	24.8%
2010-2011	No data	-	-	-
2011-2012	14.9%	26.3%	25.9%	24.4%
2012-2013	16.3%	25.4%	25.4%	24.8%
2013-2014	16.3%	27.6%	27.9%	26.2%
2014-2015	16.3%	26.0%	28.0%	26.5%
2015-2016	19.5%	29.0%	28.2%	27.1%
2016-2017	20.8%	29.8%	26.6%	27.3%
2017-2018	21.0%	30.0%	28.0%	29.0%

(Data from NHS Maternity Statistics NHS Digital)

- *Review of stillbirths, hypoxic encephalopathy, neonatal deaths*
- *They were proud of their low CS rates*
- *“They didn’t like doing caesarean sections”*
- *There was a culture to keep the CS rates low*

Caesarean section: House of commons

Written evidence submitted by Caesarean Birth (EPE0023) – 3rd May 2021

- Evidence submission as part of UK Parliament Inquiry: Safety of maternity services in England, including Caesarean Birth's (MSE00351)
- Concerns remain about preventable adverse outcomes in England's maternity services, including stillbirths
- Maternity care policy often seeks to keep advances in medical intervention and science to a minimum
- Women must be informed about access to NHS Consultant-led care as they are informed about midwifery-led care
- **Safety** must now be our number 1 priority in maternity care and not increasing normal birth rates and reducing caesarean section rates

Caesarean section: What is safety?

What does safety mean?

Intrapartum Hypoxia / stillbirth

Hypoxic/neonatal Encephalopathy (HIE)

Are we doing CS for the right reasons?

Umbilical Cord Prolapse
Cephalopelvic Disproportion (CPD)
Fetal Malpresentation
Placenta Previa

Continuous audit of statistics / reflections / teaching / shared learning

Caesarean section audit – 2022-2023

- **Comparison of CS rates at Medway NHS Foundation Trust**
  - Benchmark against LMNS
  - Benchmark against National rates (Level 3 FMU / NNU hospitals)
- **Deep dive:**
  - Maternal demographics (Age, Weight, Ethnicity, Parity)
  - Co-morbidities: Medical disorders, Obstetric complications (PE, GH, OC)
  - Obstetric factors: Relationship with prematurity, fetal growth and IOL
  - Robson criteria and CS rates
- **Deep dive:**
  - Inter-relationships between different groups
  - Multivariate regression analysis
  - Calculator for fitness for labour
- **Future work streams and audit programme for next 6-12 months**

CS rates: Benchmarking with LMNS

	Caesarean section rates (%)
Medway	41.0
DVH	38.2
MTW	36.9
EKHUFT	38.5

CS rates: Benchmarking with peer hospitals (FMU / NICU)

Deep Dive: Maternal demographics and CS rates

Maternal age

	Caesarean section rates (%)
Age >40	27.3
Age <40	26.0

No difference

Body mass index

	Caesarean section rates (%)
BMI >40	37.8
BMI >35	31.6
BMI 18-25	23.8

↑sed CS with high BMI

Parity

	Caesarean section rates (%)
Nullip	37.9
Parity	17.5

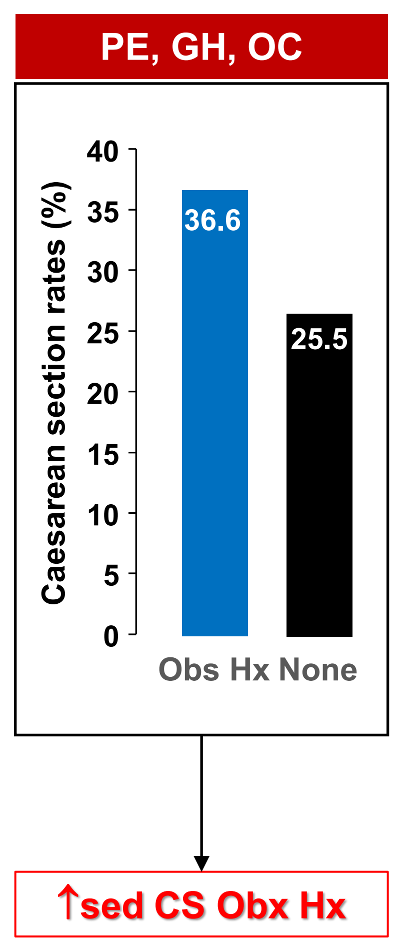
↑sed CS Nullip

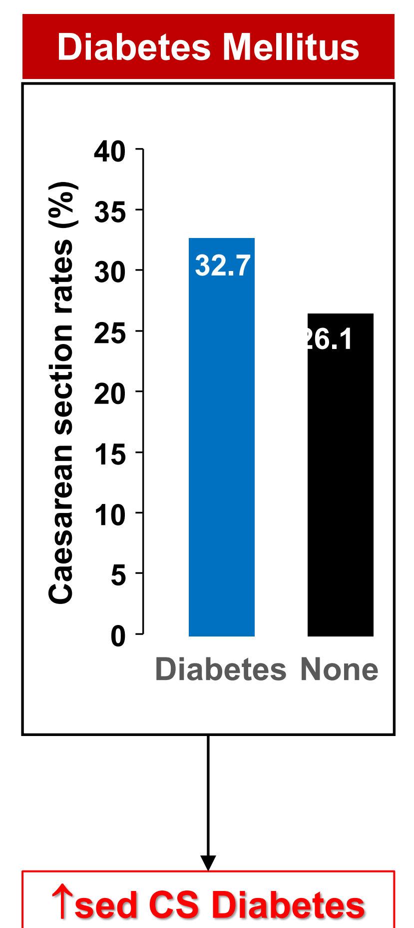
Racial / Family origin

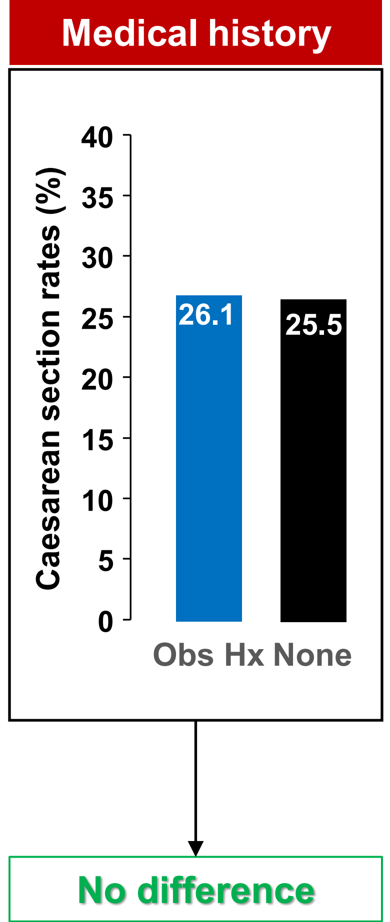
	Caesarean section rates (%)
Black /Asian	34.4
Other	25.6
White	25.1

↑sed CS in non-white

Deep dive: Obstetric factors and CS rates







Deep dive: Obstetric factors and CS rates

Relation with prematurity

Gestation	Caesarean section rates (%)
<32	66.7
<34	48.5
<37	42.1
>37	24.6

↑sed CS rate prematurity

Relation with fetal growth restriction

Group	Caesarean section rates (%)
SGA <3rd	37.3
SGA <5th	33.2
SGA <10th	30.4
Non-SGA	25.5

↑sed CS rate smaller babies

Onset of labour

Onset	Caesarean section rates (%)
IOL	35.1
Spont	22.4

↑sed CS IOL

Deep dive: Robson Criteria

GROUP 1

- Nulliparous women
- Singleton, ≥ 37 wks
- Spontaneous labour

GROUP 2

- Nulliparous women
- Singleton, ≥ 37 wks
- Induction of labour
- Elective CS (< labour)

GROUP 3

- Multiparous women
- Singleton, ≥ 37 wks
- Spontaneous labour
- No previous scar

GROUP 4

- Multiparous women
- Singleton, ≥ 37 wks
- No previous scar
- Induction of labour
- Elective CS (< labour)

GROUP 5

- Multiparous women
- Singleton, ≥ 37 wks
- Previous scar ≥ 1

GROUP 6

- Nulliparous women
- Breech presentation

GROUP 7

- Multiparous women
- Breech presentation
- All (+ uterine scar)

GROUP 8

- Multiple pregnancies
- All (+ uterine scar)

GROUP 9

- Singleton pregnancy
- Transverse / Oblique lie
- All (+ uterine scar)

GROUP 10

- Singleton pregnancy
- Gestation < 37 weeks
- All (+ uterine scar)

10

Deep dive: Robson criteria

Group	CS deliveries (N)	Total deliveries (N)	Group size (%)	Group CS rates (%)	Absolute contribution to CS rates (%)	Relative contribution to CS rates (%)
1	119	437	22.0%	27.2%	6.0%	15.0%
2	195	313	15.7%	62.3%	9.8%	24.6%
2a (induction)	114	232	11.7%	49.1%	5.7%	14.4%
2b (no labour)	81	81	4.1%	100.0%	4.1%	10.2%
3	19	497	25.0%	3.8%	1.0%	2.4%
4	67	225	11.3%	29.8%	3.4%	8.5%
4a (induction)	21	179	9.0%	11.7%	1.1%	2.7%
4b (no labour)	46	46	2.3%	100.0%	2.3%	5.8%
5	195	248	12.5%	78.6%	9.8%	24.6%
6	21	21	1.1%	100.0%	1.1%	2.7%
7	26	26	1.3%	100.0%	1.3%	3.3%
8	35	44	2.2%	79.5%	1.8%	4.4%
9	17	17	0.9%	100.0%	0.9%	2.1%
10	98	162	8.1%	60.5%	4.9%	12.4%
Total	**792**	**1990**	**100%**	**39.80%**	**39.80%**	**100%**

Deep dive: Robson criteria

Group	CS deliveries (N)	Total deliveries (N)	Group size (%)	Group CS rates (%)	Absolute contribution to CS rates (%)	Relative contribution to CS rates (%)
Nulliparous, > 37 wks, Spont labour			22.6%	30.5%	6.9%	16.7%
Nulliparous, > 37 wks, IOL + El CS			15.4%	69.7%	10.7%	26.0%
2a (induction)	289	518	10.5%	55.8%	5.9%	14.2%
2b (no labour)	239	239	4.8%	100%	4.8%	11.8%
3	58	1,156	23.4%	5.2%	1.2%	2.9%
4	133	549	11.1%	24.2%	2.7%	6.5%
4a (induction)	50	466	9.4%	10.7%	1.0%	2.5%
4b (no labour)	83	83	1.7%	100%	1.7%	4.1%
Multiparous, > 37 wks, Previous CS			14.5%	69.5%	10.1%	24.4%
6	75	75	1.5%	100%	1.5%	3.7%
7	54	58	1.2%	93.1%	1.1%	2.7%
8	68	86	1.7%	79.1%	1.4%	6.1%
9	15	15	0.3%	100%	0.3%	0.7%
10	209	406	8.2%	53.6%	4.2%	10.3%
Total	**1,976**	**4,932**	**100%**	**40.1%**	**40.1%**	**100%**

Hypoxic ischaemic encephalopathy (HIE)

Metric	National HIE rates	Expected (n)	Observed (n)	Observed rate
All HIE rates	5.14 per 1,000 livebirths	25.70 per year	**12 per year**	**2.47 per year**
Term HIE rates (> 37 weeks)	3.47 per 1,000 livebirths	17.35 per year	**11 per year**	**2.26 per year**
HIE 2/3 (moderate/severe)	2.81 per 1,000 livebirths	14.05 per year	**8 per year**	**1.65 per year**

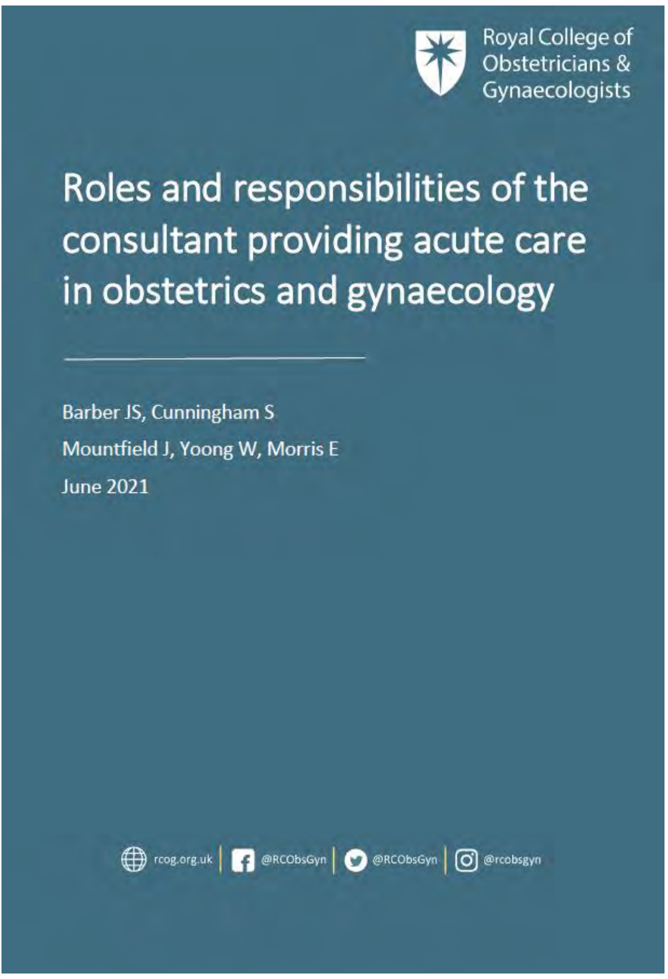
All HIE rates → **53% decrease**

Term HIE rates (> 37 weeks) → **37% decrease**

HIE 2/3 (moderate/severe) → **43% decrease**

Gale C, et al., Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database. Arch Dis Child Fetal Neonatal Ed 2018;103:F301–F306.

RCOG recommendations – June 2021:



Consultant MUST attend

- **High levels of activity:**
  - Second theatre open
  - Unit closure
- **Return to theatre**
- **Team debrief when requested**
- **Obstetric case requires HDT/ITU care**
- **Twin delivery < 30 weeks**
- **4th degree perineal tear**
- **Unexpected intrapartum stillbirth**
- **Eclampsia / Maternal collapse**
- **Post partum haemorrhage > 2L**
- **CS for following high-risk cases:**
  - Major placenta praevia
  - BMI > 50
  - Preterm delivery < 28 weeks

Are we collecting the right data

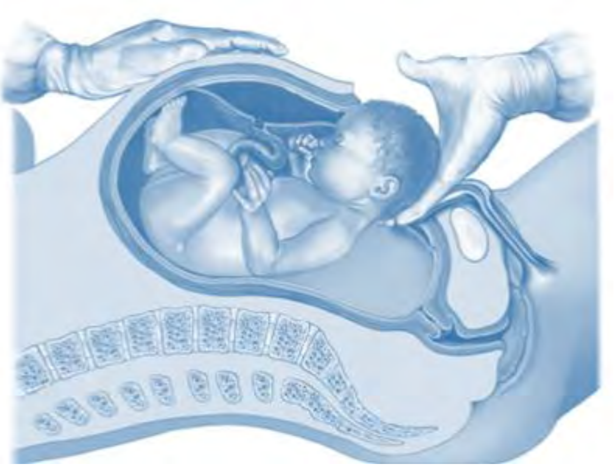
BMJ RESEARCH

Variation in rates of caesarean section among English NHS trusts after accounting for maternal and clinical risk: cross sectional study

Fiona Bragg, specialty registrar in public health,[1,2] David A Cromwell, senior lecturer,[1,4] Leroy C Edozien, consultant obstetrician and gynaecologist,[3] Ipek Gurol-Urganci, lecturer,[1,4] Tahir A Mahmood, vice president,[4] Allan Templeton, professor of obstetrics and gynaecology,[4] Jan H van der Meulen, professor of clinical epidemiology[1,4]

- **2-fold higher in mothers > 35 years of age**
- **1.5-fold higher in mothers of Afro-Caribbean race**
- **11-fold increased in parous pre CS**
- **5-fold increased in diabetes mellitus (type 1&2)**
- **35-fold increased in APH**
- **2-fold higher in prematurity**

- **CS rates depend on characteristics of population**
- **Comparing unadjusted CS rates is flawed and can lead to incorrect conclusions**
- **Hospital episode statistics have major weaknesses**
- **Significant proportion of data missing**
- **Use of emergency CS should be abandoned and replaced with Lucas / NCEPOD classification (NICE)**



Are we reporting the right statistics for Medway?

RESEARCH

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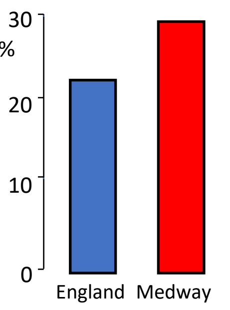
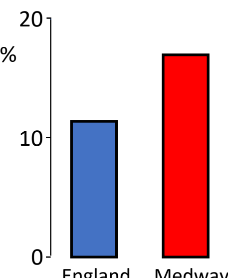
- CS rates depend on characteristics of population
- Comparing unadjusted CS rates is flawed and can lead to incorrect conclusions
- Hospital episode statistics have major weaknesses
- Significant proportion of data missing
- Use of emergency CS should be abandoned and replaced with Lucas / NCEPOD classification (NICE)

Index of Multiple Deprivation

Least deprived Medium Most deprived





Future work streams:

- Daily audit of Consultant presence for complex cases
- Daily audit of Emergency and Elective caesarean section
- Benchmarking of rates with LMNS
- Benchmarking of rates with national trusts (equal peer review)
- Robson criteria
- Data quality
- Dashboard metrics
- Presentation of paper to MNSCAB 7 days ahead of meeting

Questions?

Meeting of the Trust Board
Wednesday, 12 July 2023

Title of Report	Maternity Workforce Oversight Report		**Agenda Item**	4.3
Author	Alison Heron, Chief Medical Officer			
Lead Executive Director	Evonne Hunt, Chief Nursing Officer			
Executive Summary	This report provides the Board with a Maternity Workforce Oversight report in line with the requirements for Safety Action 5 for CNST Year 5.			
Proposal and/or key recommendation:	The Board is requested to NOTE the report			

Purpose of the report (tick box to indicate)	Assurance	**X**	Approval	
	Noting	**X**	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Maternity and Neonatal Safety Champion Assurance Board 24.05.23 Quality and Patient Safety Sub-Committee 22.06.23 Quality Assurance Committee 27.06.23			

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)** **X**	**Priority 4: (Quality)** **X**	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: **X**	**Effective:** **X**	**Caring:** **X**	**Responsive:** **X**	**Well-Led:** **X**

Identified Risks, issues and mitigations:	Not applicable
Resource implications:	No additional resource implications
Sustainability and /or Public and patient engagement considerations:	Not applicable

Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	Compliance with safety action 5 for CNST year 5	
Appendices:	Appendix 1 – Maternity Workforce Oversight Report	
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 Herron, Director of Midwifery alison.herron2@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.

Maternity Workforce Report

Alison Herron - Director of Midwifery

June 2023

Patient First

Patient First

OUR MISSION

Best of Care by the Best of People
Providing excellent care every time

OUR VALUES

Our values put our patients first and inspire us to be the B.E.S.T

BOLD - We are inspiring and ambitious
EVERY PERSON COUNTS - We are respectful and supportive
SHARING AND OPEN - We are open and speak up
TOGETHER - We are inclusive and responsible

TRUE NORTH DOMAINS

Sustainability	People	Patients	Quality	Systems and Partnerships

STRATEGIC INITIATIVES

Patient First Programme	Clinical Strategy	Culture, Leadership and Engagement	Emergency Performance and Flow	Financial Recovery	Elective Recovery Programme

SIOR - Patients

Successful Deliverables

100% of our 2022 B5 midwives remain in post

There is an effective system of midwifery workforce planning and monitoring of safe staffing levels

Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.

Formal Birth-rate Plus review is underway

Next Steps

Further enhance and review flexible working opportunities

Introduce yearly career MOT workshops to support personalised plans for all staff, ensuring both developmental and succession planning

Identified Challenges

The activity within maternity services is dynamic and can change rapidly

Frequent divert of the MLU

There was a steady decline in safe staffing over a number of months due to the significant vacancy rate and the sheer volume of unavailability the service was dealing with.

Next Steps

Updated escalation policy in place in line with the South East OPEL Framework

Registered nurses within the maternity setting has proven a positive experience for all; a full competency framework is being developed to support the safe development of this model.

Opportunities

The service will ensure an updated position following the Birthrate Plus review is available as soon as practically possible following the sharing of the report

Next Steps

It is anticipated that there will be a slight improvement in the acuity levels across the service from October 2023 with the commencement of the Greenwich University newly qualified midwives

The building blocks for MCoC will continue to be embedded in preparation for moving towards full implementation of the model in the future

Continue to join both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff workforce initiatives.

Risks

This maternity staffing report highlights frequency of maternity safer staffing red flags and the reasons for the red flags These red flags are triangulated with the Trust's incident reporting system Datix and assurance is gained from there being no link to patient harm.

As a service, Maternity also has a higher-than-average number of staff on maternity leave, year on year
Risk ID Midwifery staffing ID 1134 Score= 12

Next Steps

Midwifery staffing levels are proactively reviewed weekly as part of a 10-day forecast to determine planned staffing versus agreed establishment for each clinical area, including on calls.

A twice daily staffing huddle takes place which reviews the actual midwifery and support staffing and acuity levels to ensure a fast response with mitigating actions to address any highlighted staffing

Review Risk register entry scoring and mitigations

True North: People
Background to workforce report

Ambition: To provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
Goal: To provide an accurate account of the current workforce status

Background:
The NHSLA Maternity Incentive Scheme requires that MFT demonstrates an effective system of midwifery workforce planning to the required standard using the following standards prescribed within safety action 5 of the MIS:

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care
d	A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board

Issues, Concerns & Gaps:
- Activity in maternity is dynamic and can change rapidly
- Challenging quarter ensuring that there is adequate staffing in all areas
- Cross skilling of staff to ensure requisite skills and knowledge

Key Messages:
- The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
- This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
- The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in November 2022.
- Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- A clear breakdown of BirthRate Plus or equivalent calculations to demonstrate how the required establishment has been calculated is also included.

Actions & Improvements:
- Escalation policy updated in March 2023
- This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
- These red flags are now triangulated with the Trust's incident reporting system Datix and assurance is gained from there being no link to patient harm.

True North: People
Planned vs Actual Midwifery Staffing levels

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus
Goal: Outline the findings from the internal Birth-rate Plus review

		Month 2022/23						
Measure	Goal	Nov	Dec	Jan	Feb	Mar	April	May
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio	1:25	01.33	01:33	01:34	01:31	01:32	01:31	01:33

	Establishment	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	181.89	157.99	5.8	-18.10
MSW's Band 3	24.13	21.55	2.24	-0.4
Total	206.02	179.54	8.04	-17.7

Key Messages:

- The table presents the midwife to birth ratio which is determined by the number of births divided by the number of staff available each month.
- Based on the establishment, the mean midwife to birth ratio at MFT should be around 1:25 each month The current figures are being impacted by the increase in unavailability

Actions & Improvements:

- In order to support the workforce during this time of high unavailability and vacancy rates, the following measures have been introduced:
- Many specialist midwives have been job planned to work clinically which supports their clinical credibility in addition to the day-to-day workforce.
- The 7-day on call rota implemented March 23 is working well which, in conjunction with the on call manager which equates to managerial support being available to the clinical teams 24/7.
- Bank shifts remain incentivised for midwives to encourage pick up
- Midwifery Continuity of Carer remains suspended in line with the immediate and essential actions of the final Ockenden report. Further rollout will not take place until the service can support safe staffing on all shifts, and there is evidence that this is a sustained position. The building blocks for MCoC will continue to be embedded in preparation for moving towards full implementation of the model in the future

Issues, Concerns & Gaps:

- Need to prioritise women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway at the earliest opportunity
- A review of bank rates for midwives is required as they should be mapped to a specialist bank rate

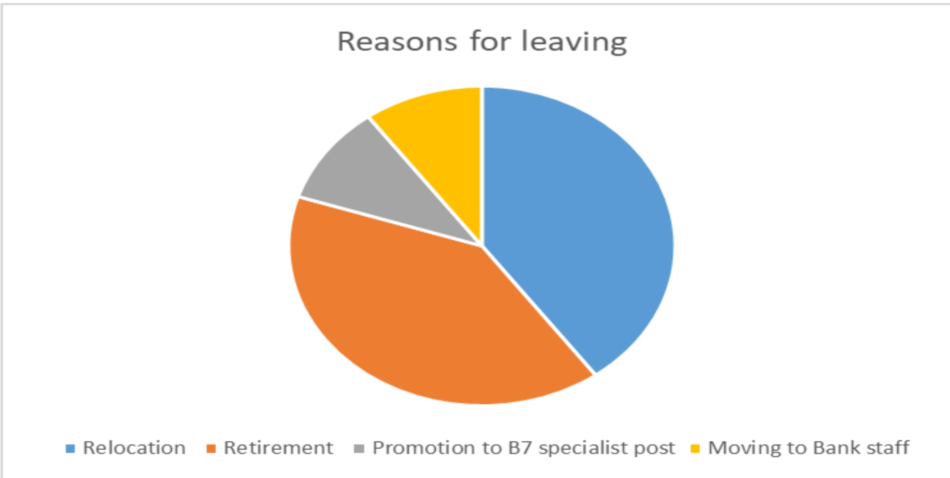
True North: People
Workforce Data March- May 23

Ambition: To ensure that we recruit and retain the required workforce to deliver safe, high quality care to our service users
Goal: To ensure that MFT is a great place to work by prioritising staff support and wellbeing

	Mar-23	April -23	May-23	June 23
True vacancy	13.29 WTE	14.9 WTE	20.46 WTE	18.10 WTE
Secondments	3.6 WTE on secondment into Band 7 roles	3.6 WTE on secondment into Band 7 roles	2.6 WTE on secondment into Band 7 roles	2.6 WTE on secondment into Band 7 roles
Pipeline	12.4 WTE recruited • 5 international midwives awaiting arrival • 11 B5/6 going through employment checks	6.00 WTE recruited • 4 WTE international midwives awaiting arrival • 4 WTE B5/6 going through employment checks	3.00 WTE recruited • 4 WTE international midwives awaiting arrival • 2 WTE B5/6 going through employment checks	3.00 WTE recruited 2 WTE international midwives have started and undergoing OSCEs 2 awaiting arrival
Leavers this month	1 leavers (0.95 WTE) moving to Trust nearer home	4 leavers (3.15 WTE) • 1 moved to B7 specialist post at another trust 2 moving to Trust nearer home 1 moving to flexibank for work/life balance	1 leaver (0.64 WTE) (retiring)	4 leavers (3.28 WTE) 3 retiring and returning on flexibank 1 relocation
Leavers expected over next 3 months				2 leavers expected within next 3 months 1 relocating to Australia 1 for research post
Maternity Leave	16 WTE	15 WTE	13 WTE	12.56 WTE (with further 8WTE pregnant)
Average Long Term Sick across month	4.25 WTE	0.8 WTE	1.55 WTE	3:04 WTE

Recruitment and Retention

Ambition: To ensure that we recruit and retain the required workforce to deliver safe, high quality care to our service users
Goal: To ensure that MFT is a great place to work by prioritising staff support and wellbeing



Key Messages:

- The maternity team continue to actively recruit new staff
- A number of recruitment drives have taken place in Spring 23, with varying degrees of success – none allowed us to fill all vacancies.
- 100% of our September 2022 B5 midwives remain in post which is testament to the commitment of the preceptorship midwife and the education team in supporting and ensuring a robust preceptorship package of support is in place.
- MFT are actively engaged with the local international midwifery recruitment programme and now have 3 international midwives in post
- The service is currently working with the HEE Midwifery Apprentice Programme and has 4 midwifery apprentices in post
- Representatives of MFT have joined both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff back to work

Issues, Concerns & Gaps:

- 100% of the Midwifery workforce are female and over 80% of child-bearing age so maternity leave will, at times, be disproportionately higher than other workforce groups
- The risk rating (ID 064) in relation to midwifery staffing is currently 12 with increasing challenges in achieving the required baseline staffing levels in the Obstetric Unit , Midwifery Led Unit and Community services.
- 2 leavers expected within next 3 months
  - 1 moving to research post
  - 1 relocating to Australia

Actions & Improvements:

- 7 day professional midwifery advocate service rolled out in 2023 to offer restorative supervision
- Band 7 midwife focussed on recruitment and retention with particular focus on supporting student midwives
- Monthly midwifery forum chaired by the DoM to encourage speaking up
- Monthly safety walk rounds by Safety Champions to talk to teams on shift
- Monthly Midwifery update for colleagues on progress around recruitment and actions taken as a result of the midwifery forum and safety walk-arounds

True North: People
Recruitment and Retention

Ambition: To ensure that we recruit and retain the required workforce to deliver safe, high quality care to our service users
Goal: To ensure that MFT is a great place to work by prioritising staff support and wellbeing

Key Messages:

- Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels has become more complex recently
- A formal BR+ assessment is underway. The service will ensure an updated position is available as soon as practically possible following the sharing of the report
- This paper highlights the additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service
- The report highlights that despite a challenging start to the year, the service now has improved oversight of staffing vacancies and oversight of safety metrics with a clear plan in place to address these. It also has a clear workforce plan that utilises a more diverse skill mix, which will enhance care provision and strengthen the clinical workforce

Actions & Improvements:

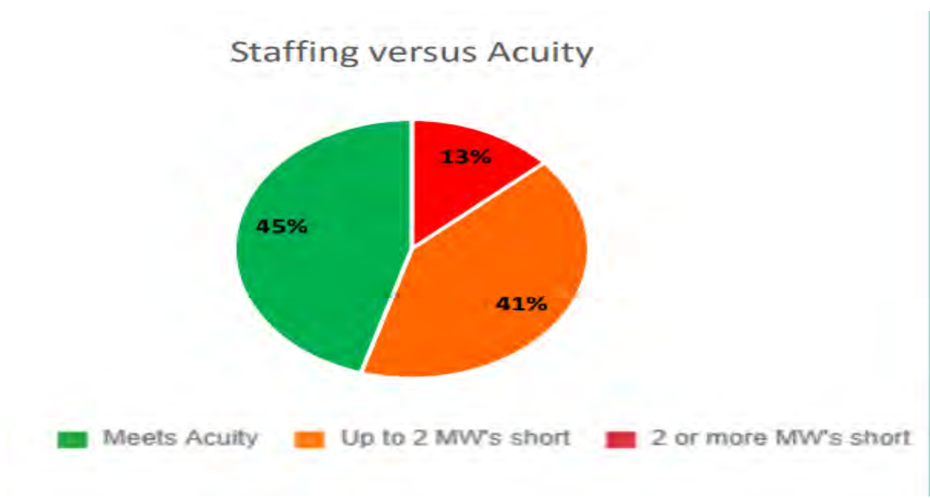
- Increased capacity for Greenwich midwifery students to help mitigate shortfall in qualified applicants in 2.5 years time from CCCU
- We are actively recruiting additional Registered Nurses, although awaiting NHSE response to RCM position statement

Issues, Concerns & Gaps:

- CCCU accreditation removed for all students April 23.
- Ensue that we continue to deliver the required support and wellbeing to support new starters and international midwives through their preceptorship period
- Challenge to maintain fully established workforce in light of national midwifery shortage.

True North: People
Birthrate Plus 4- hourly acuity tool

Ambition: To ensure adequate staffing resource to adequately meet need of women
Goal: To deliver safer maternity care as required by the CNST maternity incentive scheme



Key Messages:

- The pie chart shows Acuity RAG status for Jan- March 2023
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity. A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite data shows that for the periods when a data entry was made the unit was adequately staffed 45% of the time in this period. The unit recorded negative acuity 54% of the time. With 41% of 2 or more MW's short
- Assurance can be gained from the compliance rate for completion of the tool as it remains above 85% which is in accordance with the standard recommended by BR+

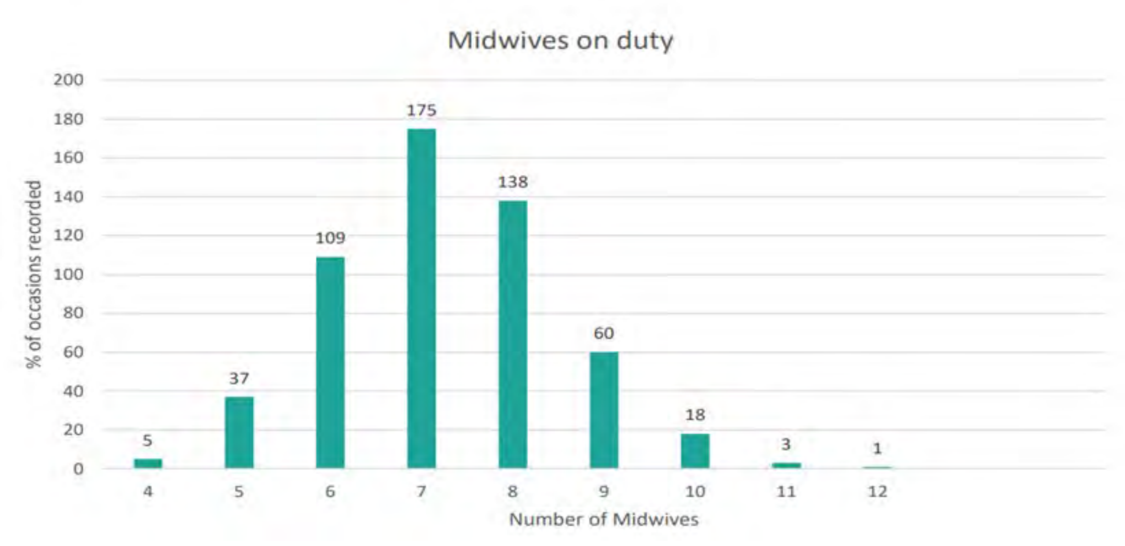
Issues, Concerns & Gaps:

- Staff are moved from other areas to mitigate against the risk of staffing shortfalls however this may create red flags in these areas

Actions & Improvements:

- The new web-based Birthrate Plus acuity tool was purchased by the Trust in 2022. Allowing for more detailed analysis of results and traffic light system that links to our escalation policy.
- The tool will further be rolled out in Q2 2023 on our antenatal and postnatal wards supporting proactive assessment of women on the ward and matching them against the staff available.

Acuity March- May 2023



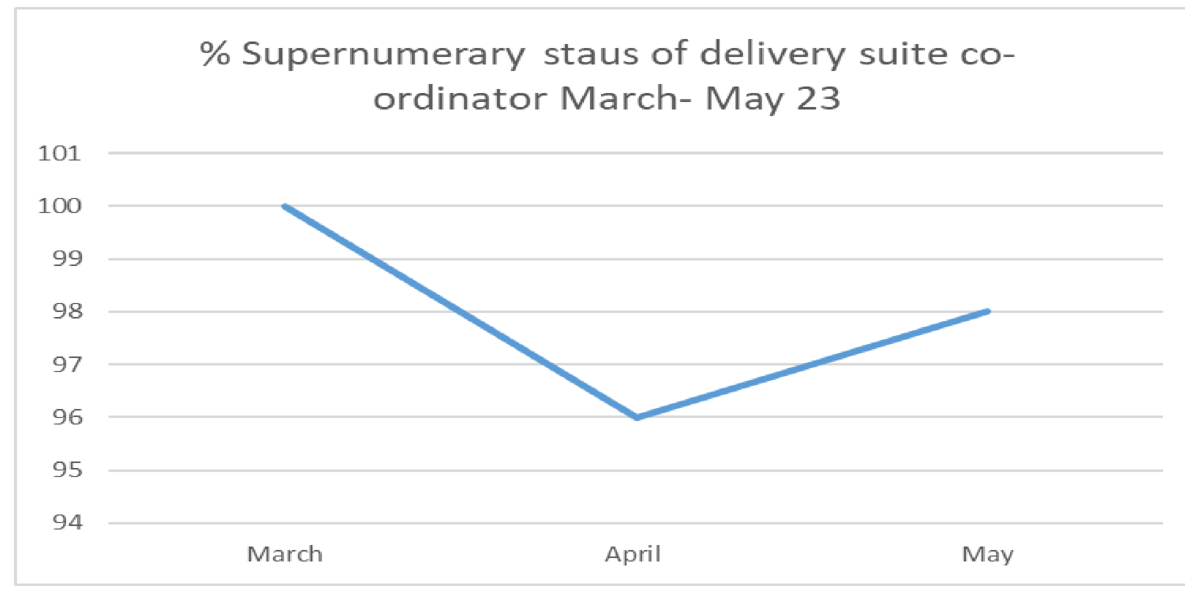
Key Messages:

- The bar chart demonstrates fluctuations in staffing over the 3 months reviewed (March- May 2023) with between 4 - 12 Midwives on duty on delivery suite with 7 being the most frequently recorded at 32% of times
- The categorisation of patients for the 3 month period is seen below, with the red indicating the most complex cases
- Actions are taken in line with the Escalation Policy to mitigate the risk to patient safety. This includes staff movement between areas, supernumerary staff within the numbers in addition to utilising the on-call team for short periods and sourcing additional staff at short notice.

Cat I	Cat II	Cat III	Cat IV	Cat V	Cat A2	PN Readmission	Cat PD1	Cat PD2	Cat PN	Cat A1	Cat X	IOL
102	177	450	347	502	263	13	195	315	141	183	109	24

True North: People
Delivery Suite Co-ordinator supernumerary status

Ambition: To ensure supernumerary status of the delivery suite co-ordinator.
Goal: To monitor compliance of supernumerary status and ensure there is an action plan in place of how the maternity service intends to achieve this .



Key Messages:

- Delivery suite supernumerary status is a core element of CNST Safety Action 5
- The twice daily bed state monitors the supernumerary status of the delivery suite co-ordinator to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary are also reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite.

Issues, Concerns & Gaps:

- MFT are not currently achieving delivery suite co-ordinator supernumerary status 100% of the time.

Actions & Improvements:

- To support mitigation of shortfalls the Trust has supported enhanced bank rates within maternity so far this financial year. This has had minimal positive impact.
- Data error identified on occasions and work ongoing to correct. Learning shared with all staff to prevent further error.

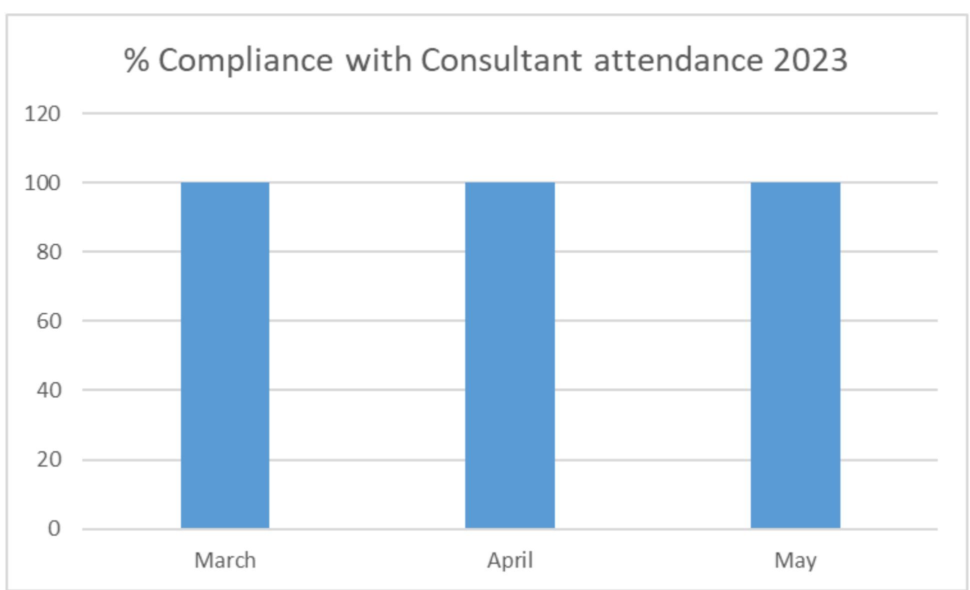
True North: People

NHS
Medway
NHS Foundation Trust

Clinical Workforce

Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care

Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard



Issues, Concerns & Gaps:

- NICU nursing workforce currently below 70% QIS requirement.

Key Messages:

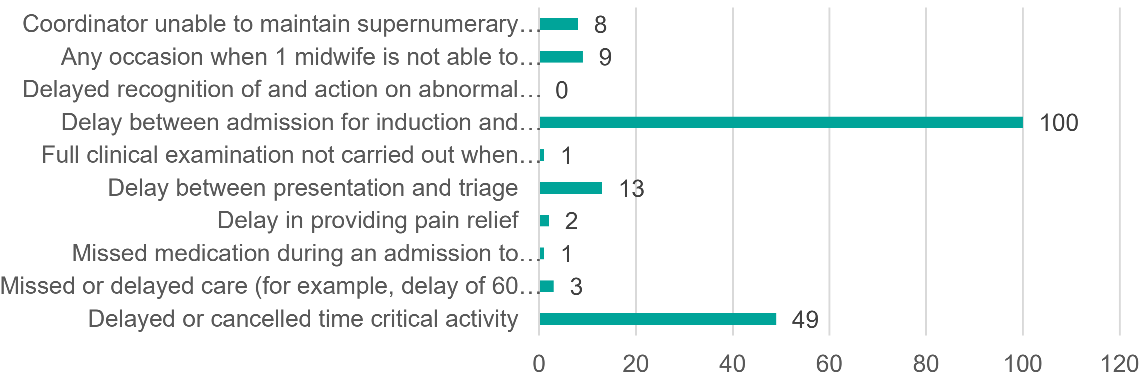
- There is 1 Obstetric Consultant Vacancy (resignation June) out to advert shortly and 0 in Neonatology
- Consultant Obstetrician establishment total of 20 = 12 substantive in post, plus 4 substantive Associate Specialist Consultants in post, 3 Locum Consultants (fixed term contracts) and 1 vacant.
- 1 X Specialist registrar leave since May 2023 and recruitment plan is in place for this post.
- Obstetric rota and SOP in place to support compliance with RCOG guidance for Obstetric Consultant roles and responsibilities.
- Audit of del suite consultant attendance 100% compliance for March- May 2023.
- NICU junior medical staffing compliant with BAPM requirements.
- NICU Nursing staff <70% Qualified in Speciality (QIS) due to increase in QIS establishment by 16 WTE. Further 5 new nurses currently in training, with a further 5 more planned to commence training in August– Action plan in place.

Actions & Improvements:

- Ongoing audit and monitoring at local level as well as presenting to Trust Board as per CNST requirements.
- Forecasted vacancies advertised at earliest opportunity

True North: People
NICE Red Flags

Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard



Issues, Concerns & Gaps:

- The highest number of red flags related to induction of labour (IOL) delays, totalling 54% of all red flags. Staff shortages across the unit have meant that women have been experiencing long delays in being able to be transferred to the delivery suite to progress their IOL.
- 13 (7%) of red flags related to women having a delay between presentation on the unit and being seen in obstetric triage and 9 (5%) red flags related to inability for 1 midwife to be able to provide continuous one-to-one care and support to a woman during established labour.

Key Messages:

- The National Institute for Health and Care Excellent (NICE NG4) have drawn up a list of 'Red Flag Events' for maternity units. In order to comply with national recommendations, maternity units need to demonstrate compliance regarding red flag monitoring and management. The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) also requires ongoing audit of maternity red flags
- A total of 186 Red Flags were reported across the maternity services March-May 2023.
- This is an increase of 64 against the previous reporting period
- The greatest number of Red Flags and which account for the majority of the Red Flag increases continues to be in relation to the delay between a pregnant person's admission for induction and the subsequent commencement of the process.
- The midwifery leadership team continue to review all incidents reported via Datix. During the reporting period there was one moderate harm incident involving a delay in the induction of labour process.

Actions & Improvements:

- An IOL working party and A3 is in progress to assist in reduction of red flags relating this this pathway
- An action plan to be developed to ensure appropriate escalation of red flags inline with the revised escalation guidance.

Action Plan

Objectives List of actions	Tasks What you need to do to achieve the action	Target Date	Owner	Current position	Actual Date
Review Flexible working opportunities	Survey staff feedback and suggestion Review and revise all JDs within care group Utlilise leavers interviews Include opportunities in all interviews	31/8/2023	RA/KH/SC	On target	
Introduce yearly career MOT workshops to support personalised plans for all staff, ensuring both developmental and succession planning	PMA to support facilitating workshops Diarise annual plan Incorporate and collate appraisal feedback	31/08/2023	KH	On target	
Update escalation policy in place in line with the South East OPEL Framework	Matron for intrapartum care to review and update	31/07/2023	AC	On target	
Increase registered nurse establishment in maternity	Advertise and appoint suitable candidates Develop a competency framework is being developed to support the safe development of this model.	31/08/23	KF	On target	date
Map the building blocks for MCoC in preparation for moving towards full implementation of the model in the future	Review and map our most vulnerable groups Consider how MCoC could be commenced in one team Produce recommendation report at MNSCAB	31/08/23	LP/ MK		
Triangulate red flag data with FFT, and datix	Review and appraise harm	31/07/23	KH	On target	
Review bank rates	Produce report and recommendation to People committee	31/07/2023	KH	Complete	
Review and Revise IOL A3	Work with transformation team and project lead to improve pathway Utilise staff and patient feedback to develop action plan	31/07/23	MK/ LP		

Meeting of the Trust Board
Wednesday, 12 July 2023

Title of Report	Maternity Care Quality Commission Inspection Outcome report and "Should Do" Action Plan		**Agenda Item**	4.3
Author	Alison Herron, Director of Midwifery			
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer			
Executive Summary	The CQC conducted an inspection of the Trust's maternity service on 07 December 2022. The inspection was part of a national maternity inspection programme, spending time in all of the Maternity areas. The CQC published its final report for Medway Maternity Services on 28 April 2023 with an overall rating of GOOD, including maintaining GOOD for the two particular standards assessed for Safe and Well-led. **Ratings** Safe – Good Well Led – Good No 'Must Do' Actions were identified within the published report; however, six 'Should Do' actions were identified. Action the trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services. This paper provides the committee with an update report on the detail from the maternity CQC published outcome report and the service action plan that has been developed in relation to the recommendation "should dos" within the report. This will be incorporated into the overarching maternity BAF Progress against the plan will be monitored via the Maternity and Neonatal Safety Champion Assurance Board Meetings and with the Trust Compliance team			
Proposal and/or key recommendation:	The Board is requested to NOTE the report			
Purpose of the report (tick box to indicate)	**Assurance**	X	Approval	
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Maternity and Neonatal Safety Champion Assurance Board 05/05/23 Quality and Patient Safety Sub-Committee 22/05/23 Quality Assurance Committee 31/05/23			

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)** X	**Priority 4: (Quality)** X	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: X	**Effective:** X	**Caring:** X	**Responsive:** X	**Well-Led:** X
Identified Risks, issues and mitigations:	Not applicable				
Resource implications:	No additional resource implications				
Sustainability and /or Public and patient engagement considerations:	Not applicable				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	The Trust is required to be compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.				
Appendices:	Appendix 1 - Maternity CQC Inspection Outcome report Appendix 2 - CQC “ should do” Action plan				
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 Herron, Director of Midwifery alison.herron2@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.			

Patient FIRST
Best of care Best of people

MFT Maternity CQC Inspection Outcome report and Should do Action Plan

Trust Public Board
July 2023

True North: Quality

MFT Formal CQC Inspection December 2022

Ambition: Ensure that all women and birthing people have access to safe, effective and personalised care

Goal: That the maternity service is safe, effective, responsive, well led and caring

- The CQC held an inspection of the trust's maternity service on 7 December 2022. The inspection was part of a national maternity inspection programme, spending time in all of the Maternity areas. The CQC have published their final report and the rating for the Trust Maternity services are overall GOOD.

Ratings		
Safe	Good	
Well Led	Good	

Examples of Key points within the report:

- Staff understood how to protect women, birthing people and babies from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however staff had not been trained to level 3 in adult safeguarding.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and acted upon women and birthing people at risk of deterioration.
- The service did not always have enough maternity staff. However, those working on the unit had the right qualifications, skills, and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff kept detailed records of women's and birthing people's care and treatment. Overall, records were clear, up to date, stored securely and easily available to all staff providing care.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

True North: Quality

Areas for improvement

No 'Must Do' Actions were identified in the published report, however six 'Should Do' actions were identified.

Action the trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust SHOULD take to improve are:

1. The service should have a process in place to ensure checks are made on necessary equipment in areas when the areas are not in use, to ensure they remain ready to use.
2. There should be sufficient CTG paper available and accessible to necessary staff at all times to ensure ongoing monitoring of babies when required.
3. The service should ensure, in line with trust policy, all indicated staff are trained to adult safeguarding level 3 and that staff are aware of how they can assess young women and birthing people at risk of child sexual exploitation.
4. The service should continue to improve staffing and recruitment to ensure a fully staffed service.
5. The service should follow its medication policies in the safe storage and monitoring of medicines and homely remedies.
6. The service should continue to develop an effective maternity-specific annual auditing programme.

Actions & Next steps:

- An action plan for the six 'should do' actions has been complied.
- Each 'should do; action will be reviewed, evidenced and compliance against each action will be tracked
- CQC Maternity Improvement Action plan monitoring meetings will be set up and support from the Central compliance team will be available.
- The action plan and progress against the plan will be monitored via the Maternity and Neonatal Safety Champion Assurance Board Meetings

Maternity Improvement Action Plan
As a result of the CQC visit 7 December 2022
V1

Ref No	Service	Trust wide	Action Description	What will be the final outcome? (include required KPIs or evidence of delivery)	Executive Lead	Directorate	Action/ Work stream Lead	Key milestones to be achieved	Start date	Due date	Revised due date	Completion date	RAG	RAG on revised due date
			Equipment											
1	Women's and Children's	X	The service should have a process in place to ensure checks are made on necessary equipment in areas when the areas are not in use, to ensure they remain ready to use.	Documents in place, staff awareness and understanding of the process and audits built into the yearly audit programme on the Gather system.	DOM	Planned Care	Frankie Whitehead Matron for Birthplace	Ward 'check in' 'check out' diversion/closure list (birthplace) Completion of all daily equipment check lists Audit of completeness and record of compliance to the check lists and re-audits Monitor through MNSCAB	01 May 2023	31 August 2023			On track	
2	Women's and Children's	X	There should be sufficient CTG paper available and accessible to necessary staff at all times to ensure ongoing monitoring of babies when required.	Monitoring and evidence of compliance	DOM	Planned Care	Alison Clarke Matron for Delivery Suite & MECU	Review the process for auditing and supplies of CTG paper Add 'no stock' of CTG paper to the trigger list for Maternity Datix CTG Paper is now added to the daily equipment check list for Delivery Suite and Theatres Audit of equipment check lists to see how many times on the audit there was no CTG paper available Monitor through MNSCAB	01 May 2023	31 July 2023			On track	
			Safeguarding											
3	Women's and Children's	X	The service should ensure, in line with trust policy, all indicated staff are trained to adult safeguarding level 3 and that staff are aware of how they can assess young women and birthing people at risk of child sexual exploitation.	Evidence that the staff are trained and target is achieved	DOM	Planned Care	Sorcha Magee/ Emma Feast Named Midwife for Safeguarding	Obtain baseline data on how many staff have now been trained for obstetrician midwives and MSWs Trajectory for all staff to complete - where we are and how to achieve compliance Education data Monitor through MNSCAB	01 May 2023	31 December 2023			On track	
			Staffing											
4	Women's and Children's	X	The service should continue to improve staffing and recruitment to ensure a fully staffed service.	Obtain a rolling trajectory to monitor and maintain staffing levels and reduce the vacancy rate to a safe staffing level. Engage in all the national programmes	DOM	Planned Care	Kate Harris Head of Midwifery	Evidence of the following: - Rolling recruitment - Return to practice recruitment - Part of midwifery apprenticeship programme and national returned to practice - Part of internal recruitment programme Trajectory/vacancy - Birth rate plus -Working with Universities to engage with the 18 month programme Monitor through MNSCAB	01 May 2023	31 December 2023			On track	
			Medication											
5	Women's and Children's	X	The service should follow its medication policies in the safe storage and monitoring of medicines and homely remedies.	Audits indicating compliance with Medicines Management	DOM	Planned Care	Karen Fegan Matron for inpatient and outpatient wards	Review SOP in relation to Medicines Management including storage of aromatherapy oils and update where necessary Review processes followed when the fridge alarms sound. Monitor that this process is followed correctly. Review results of departmental Medicines management audit Monitor through MNSCAB	01 May 2023	31 July 2023			On track	
			Auditing											
6	Women's and Children's	X	The service should continue to develop an effective maternity-specific annual auditing programme.	The development of the annual audit programme for maternity services is now complete. This was presented at MNSCAB on the 5th May 2023. Going forward this will be tracked through Midwifery Audit Committee meetings and Trust wide Audit Committee.	DOM	Planned Care	Aswini Balachandran/ Michelle Keeler	Information on staff rotas Copy of the annual audit programme Minutes of MNSCAB (5 May 2023) to evidence the discussion of the maternity service audit plan. Add Neonates audits to annual audit plan Monitor through MNSCAB	01 May 2023	31 May 2023			On track	

Meeting of the Board of Directors
Wednesday, 12 July 2023

<table>
<tr><td>Title of Report</td><td colspan="3">Data Security and Protection Toolkit Audit</td><td>Agenda Item</td><td>4.5</td></tr>
<tr><td>Author</td><td colspan="5">Paul Mullane, Head of Legal and Information Governance/Trust Data Protection Officer.
Anne Bailey, Information Governance Lead</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Alison Davis, Chief Medical Officer and Caldicott Guardian</td></tr>
<tr><td>Executive Summary</td><td colspan="5">a) This report gives an overview of performance relating to the 2022-23 Data Security and Protection Toolkit Audit.
b) The KPMG audit covered 13 assertions, relating to around 50 specific areas.
c) The assertions were graded more severely than in previous years, resulting in an Amber/Red rating.
d) There are eight areas where further work is required. Four were listed as medium risk, four as low risk.
e) There were no high risk areas of concern.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">The following report relates to the Data Security and Protection Toolkit audit carried out by KPMG for assurance and approval.</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td>X</td><td>Approval</td><td colspan="2">X</td></tr>
<tr><td>Noting</td><td></td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td>(If appropriate) state reason for submission to Private section of Board:</td><td>Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td colspan="2">Exceptional Circumstances:
X</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Information Governance Group
Risk Assurance Committee
Audit and Risk Assurance Committee</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick 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">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led:
X</td></tr>
</table>

Identified Risks, issues and mitigations:	The report makes up part of the Toolkit itself, so failure to accept would result in the audit not being accepted and the Trust failing that component.	
Resource implications:	No further resources are required.	
Sustainability and /or Public and patient engagement considerations:	A successful audit would result in increased public confidence and show that our security in both IT and Information Governance is at a high level.	
Integrated Impact assessment:	Not applicable (*please indicate why an equality assessment was not required)*	
Legal and Regulatory implications:	It is a requirement for the Trust to complete the full Data Security and Protection Toolkit annually. Part of this, is the audit, which covers around 50 mandatory assessments.	
Appendices:	Data Security Toolkit Audit Report	
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:	Paul Mullane, Head of Legal and Information Governance and Trust Data Protection Officer. p.mullane@nhs.net	
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 with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

1 Executive Overview

1.1 The following report will cover the Data Security and Protection Toolkit audit report by KPMG. The report has been supplied alongside this document.

1.2 Immediate action has been taken to develop action plans to address the areas identified below, for submission as part of the DSP Toolkit.

2 Overall Rating

Amber /Red

2.1 Following the release of the report put together by the independent auditors from KPMG, the Trust are rated as Amber/Red.

2.2 There are eight areas where an action plan was required, four as a medium risk and four low risk.

2.3 There are no high risk areas of concern.

2.4 Evidence was subjected to a higher level of interrogation compared to previous years.

2.5 Issues were raised last year, but not completely incorporated into day-to-day business. This would have mitigated some of the risks noted below.

3 Action Plans – Medium Risk

Amber /Red

3.1 Data security and protection training has not been completed in a timely manner for a proportion of new joiners. The Information Governance Lead carrying out an audit on Data Security Awareness training, highlighting any member of staff who is either out of date or has not completed a first assessment. Contact will be made within seven days and further weekly checks will be carried out.

3.2 A proportion of sampled user accounts of those no longer at the Trust had not been promptly disabled. The Standard Operating Procedure is being reviewed by the Head of IT and Information Governance Lead to ensure a timely removal of leavers by the end of June 2023. It will include suspension of accounts not active for 60 days, and removal after a year.

3.3 65% of the Trusts server estate is on supported versions of operated systems, which is below the 95% requirement. The Head of IT is producing a plan to meet the 95% target, by the end of September 2023.

3.4 Backups are not kept securely and separate from the Trust’s network (offline), or in a cloud service designed for this purpose. Evidence that a copy of backups is kept offline or in a cloud service designed to be separate from the Trust’s network is to be supplied by the Head of IT. A new service is being sourced, and will be in place by the end of September 2023.

4 Action Plans – Low Risk

Amber /Red

4.1 Log Retention Policy. There is no official log retention policy within the Trust, however it is covered in other documents. One policy should contain everything. A policy produced by the Information Governance Lead is due to be put forward at the next Information Governance Group by the end of June 2023.

4.2 Backup Procedure. There is no description for how backups should be restored within the Information Security Policy. The information needs to be added. The Head of IT is adding this information to the policy in order to resolve this risk by the end of June 2023.

4.3 A medical devices data security policy or procedure has not been formally documented at the Trust. A policy / process document should be in place covering how data security is assured during the full life cycle medical devices. The Head of Clinical Engineering has updated the document and passed it around for the appropriate committee to sign off when the policy update is due in September 2023.

4.4 The supplier list does not include contract durations. The Information Governance Lead is currently updating the document with the missing information. It will be completed by the end of June 2023.

5 Data Security and Protection Toolkit

Amber / Green

5.1 The full Toolkit submission for 2022-23 is continuing to progress and will be uploaded by the submission date of 30 June 2023.

6 Conclusion and Next Steps

6.1 The Board are given partial assurance and asked to APPROVE this report.

Data Security and Protection Toolkit

Medway NHS Foundation Trust

KPMG Governance Risk and Compliance Services

May 2023

Overall rating:	
	Significant assurance
	Significant assurance with minor improvement opportunities
>	Partial assurance with improvements required
	No assurance

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Detailed findings

Scope extract

Ratings definitions

Distribution list

For action:

Paul Mullane, Head of Information Governance & Legal Services, DPO

Anne Bailey, Information Governance Lead

Jennifer Berry, PMO Quality Manager

Craig Allen, Head of IT

Daniel Rennie-Hale, Director Integrated Governance

For Information:

Alison Davis, Chief Medical Officer (Executive Sponsor)

Audit and Risk Committee

Report status

Closing meeting: 19 April 2023

Draft report issued: 27 April 2023

Final report issued: 09 May 2023

Presented to Audit and Risk Committee: 22 June 2023

Executive summary

01

Conclusion

Our review followed the Data Security and Protection Toolkit (DSPT) Independent Assessment Framework and Guidance published by NHS Digital. We have reviewed 13 assertions across the 10 National Data Guardian Standards in the DSP Toolkit for Medway NHS Foundation Trust ('the Trust'). We provide an overall rating of 'partial assurance with improvements required' (**AMBER** - **RED**). This is not in line with management's anticipated assurance rating of 'significant assurance with minor improvement opportunities' and is driven by the need to improve the design of controls across a number of areas.

Whilst no high priority actions were raised within the review, five medium priority actions have been identified which are currently preventing the Trust from achieving compliance with the mandatory assertions. This includes controls which are 'quick wins' such as assigning action owners and timelines to the business continuity exercise outcomes and other actions which require a longer term and concentrated action plan to achieve compliance, for example, bringing the server estate up to 95% compliance with supported operating systems.

We observed good practice with regards to the DSPT submission through reporting to relevant groups and committees to support the assessment of compliance against toolkit assertions. The Trust Information Governance Group (IGG) has appropriate membership and oversight to assess compliance against assertions. Sub-assertions are assigned to responsible owners and are overseen and reviewed by the Head of Information Governance (IG) / Data Protection Officer (DPO). The return is reviewed and approved by the Head of IG / DPO as part of the final sign off.

As part of our audit programme for the DSP Toolkit review, we inspected a total of thirteen assertions from a total of 33 mandatory assertions. The DSPT self assessment must be submitted by 30 June 2023. At the point in time our review was conducted, we agreed with six of thirteen assertions as being complete (one of which has plans in place for the assertion to be complete by the submission deadline), we assessed five assertions as currently overstated, one assertion as currently understated and for the remaining assertion we agree with the Trust's assessment of being incomplete due to evidence being insufficient.

We assessed the level of confidence in the veracity of the DSP Toolkit self-assessment as per the NHS Strengthening Assurance Assessment Guide and provide a **medium** confidence level. We determined the overall National Data Guardian (NDG) standard classification risk rating to be **moderate** as no standards are rated as 'Unsatisfactory' and one or less are rated as 'Limited'. However, not all standards are rated as 'Substantial'.

Summary

Overall rating:	**Partial assurance with improvements required**	
Priority rating:	Control design	Operating effectiveness
High	-	-
Medium	1	3
Low	4	0

Acknowledgements

We would like to thank the following individuals for their contribution during this review:

- Paul Mullane, Head of Information Governance & Legal Services, DPO;
- Anne Bailey, Information Governance Lead;
- Jennifer Berry, PMO Quality Manager;
- Craig Allen, Head of IT; and
- Daniel Rennie-Hale, Director Integrated Governance.

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Executive Summary

Areas of good practice

- ✓ A suite of data security and protection policies are in place, which are reviewed and approved as appropriate.
- ✓ High strength password configurations, including the use of multi-factor authentication (MFA) for access to systems, are enforced.
- ✓ High severity CareCERT alerts are acknowledged and remediated within a suitable time frame.
- ✓ Data security protection incidents are logged and a root cause analysis conducted as a key part of lessons learned activities following an incident. This helps prevent similar incidents from occurring in the future or to be in a position to better manage them if they do occur.
- ✓ Network security management tools are in place, including the Fortigate firewall tool to monitor threats from websites. Microsoft Defender is also in use on endpoints to detect and report cyber events, which are reported to the IT team and a vulnerability detection system (Armis) is used on non-IT devices which scans for threats and vulnerabilities.
- ✓ The Trust uses the NCSC (National Cyber Security Centre) early alert service which helps to investigate cyber attacks on the network by notifying them of malicious activity that has been detected in information feeds. The Trust also uses the NCSC web check service which helps to identify and manage vulnerabilities in its publicly facing websites.
- ✓ Data is protected by using Transport Layer Security (TLS) encryption version 1.2 for email and browsers.

Out of scope

As part of the scope of this internal audit, our work was limited to a sample based review of controls as evidenced by the Trust's for its DSPT self-assessment. Our work did not include detailed testing of IT systems. This internal audit does not provide the Trust with complete assurance that its entire DSPT return provides a true and fair opinion (see Appendix A for in-scope assertions).

Summary of key findings

Area	Finding
Induction training	2.1 Data security and protection training has not been completed in a timely manner for a proportion of new joiners.
Leavers' user access removal	2.2 A proportion of sampled user accounts of those no longer at the Trust had not been promptly disabled.
Server estate	2.3 65% the Trust's server estate are on supported versions of operated systems, which is below the 95% requirement
Secure backups	2.4 Backups are not kept securely and separate from the Trust's network (offline), or in a cloud service designed for this purpose.
Log retention policy	2.5. There is no log retention policy at the Trust.
Backup procedure	2.6 The Trust's backup procedure does not include the steps needed to restore from backup.
Medical devices data security policy	2.7 A medical devices data security policy or procedure has not been formally documented at the Trust.
Supplier list	2.8 The supplier list does not include contract durations.

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Findings and management actions

02

2.1 Induction training (2.1.1)

Medium

Data security and protection training has not been completed in a timely manner for a proportion of new joiners.

As per the mandatory DSPT requirements for sub-assertion 2.1.1, new joiners must complete data security and data protection training a short time after joining the organisation.

Testing of sub-assertion 2.1.1 identified that 11.2% (95 out of 845) new joiners since April 2022 had not completed the mandatory data security and protection induction training at the time of the review (12 April 2023). This is an increased proportion compared to 2021/22. Therefore, the DSPT requirement had not been met.

Risk: Staff do not complete appropriate annual data security training and pass a mandatory test.

Agreed management action:

1. Action plan to ensure that staff whom are overdue to complete their induction training, complete this as a priority. Action plan to be approved at May IGG.
2. Enforce sanctions within HR policy where new joiners do not complete training within the required period.
3. Monthly review meeting to monitor training completion.

Evidence to confirm implementation:

1. Action plan created and approved by senior management, and is being implemented.
2. Enforcement of sanctions within HR policy.
3. Evidence that a monthly review meeting date has been set.

Responsible person/title:

Paul Mullane (Head of Information Governance & Legal Services, DPO) and Anne Bailey (Information Governance Lead)

Target date:

30 June 2023

2.2 – Leavers' user access removal (4.2.4)

Medium

A proportion of sampled user accounts of those no longer at the Trust had not been promptly disabled.

Former employees' accounts should be routinely and promptly removed or disabled from Active Directory (AD) domains and other user directories.

Sample testing of five former employees who left the Trust between June 2022 and March 2023 identified that four sampled leavers had an Active Directory account still enabled at the time of review (19 April 2023) although we did confirm they did not access Trust systems after their leave date). As such, their user account had not been promptly disabled and the DSPT assertion requirement had not been fully met.

Risk: Personal confidential data is not limited to staff who need it for their current role and access is not removed as soon as it is no longer required.

Agreed management action:

1. Procedure to identify leavers e.g. monthly check of leavers per ESR to confirm that access has been removed on a timely basis. SOP to be reviewed based on root cause analysis.

Evidence to confirm implementation:

1. Standard operating procedure to identify the method through which leavers will be identified.

Responsible person/title:

Paul Mullane (Head of Information Governance & Legal Services, DPO), Anne Bailey (Information Governance Lead) and Craig Allen (Head of IT)

Target date:

30 June 2023

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Findings and management actions

2.3 – Server estate (8.3.7)

Medium

65% the Trust's server estate are on supported versions of operated systems, which is below the 95% requirement.

95% of the server estate should be on supported versions of operating systems. 65% of the Trust's server estate are on supported version of operating systems. The DSPT requirement has not therefore been met. The Trust has recorded this risk in the risk register and is planning a project to mitigate this risk through decommissioning systems or migrating them to new server infrastructure.

Risk: There are unsupported operating systems, software and/or internet browsers used within the IT estate.

Agreed management action:

1. Project plan with clear actions with corresponding action owners and target timescales for implementation and clarity on where this will be reported through the governance structure.

Evidence to confirm implementation:

1. Project plan with corresponding action owners and target timescales for implementation reported through the governance structure.

Responsible person/title:

Craig Allen (Head of IT)

Target date:

30 September 2023

2.4 – Secure backups (7.3.6)

Medium

Backups are not kept securely and separate from the Trust's network (offline), or in a cloud service designed for this purpose.

Backups should be kept securely and separate from your network (offline), or in a cloud service designed for this purpose. Backups are not currently kept offline, securely and separate from the Trust's network, or in a cloud service designed for this purpose. As such, the DSPT assertion requirement had not been met.

The Trust are due to begin the planning process for implementing immutable online backups and is working with suppliers and NHSE for potential funding but this is unlikely to be delivered before June 2023.

Risk: The Trust is unable to effectively recover its key services. This leads to a greater likelihood that data is compromised.

Agreed management action:

1. Ensure that a copy of backups is kept offline or in a cloud service designed to be separate from the Trust's network.

Evidence to confirm implementation:

1. Evidence that a copy of backups is kept offline or in a cloud service designed to be separate from the Trust's network.

Responsible person/title:

Craig Allen (Head of IT)

Target date:

30 September 2023

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Findings and management actions

2.5 – Log retention policy (4.2.3)

Low

There is no log retention policy at the Trust.

It is essential that the Trust has a documented log retention policy in place, which outlines procedures for ensuring that logs are retained for a sufficient period (at least six months), managed securely, reviewed regularly and can be searched to identify malicious activity.

In practice, logs are retained for at least six months. However, there is no log retention policy in place at the Trust which explicitly stipulates the requirement that logs must be stored for a minimum of six months and how they can be reviewed regularly and searched to identify malicious activity. Therefore, the DSPT requirement had not been fully met

Risk: Staff are not clear on the minimum sufficient period of time logs should be held for and the process for managing and reviewing logs regularly. This could lead to delays in the identification of data security incidents or other forms of malicious activity.

Agreed management action:

1. Development of Log Retention Policy which clearly establishes which logs have to be retained, how long they ought to be retained for, and procedures for ensuring that they are managed securely and reviewed regularly. The policy should be appropriately approved at IGG, and made available to relevant members of staff.

Evidence to confirm implementation:

1. Log Retention Policy approved by IGG.

Responsible person/title:

Paul Mullane (Head of Information Governance & Legal Services, DPO) and Anne Bailey (Information Governance Lead)

Target date:

30 June 2023

2.6 – Backup procedure (7.3.4)

Low

The Trust's backup procedure does not include the steps needed to restore from backup.

The backup procedure should include the steps that would be taken if the organisation has to restore from backups.

However, the backup procedure within the Information Security Policy does not include the steps needed to restore from backup. Therefore, the DSPT assertion requirement had not been fully met.

Risk: Staff performing backups are not sufficiently clear on the steps required to restore from backup, limiting assurance that backups could be successfully restored following an incident or unplanned event.

Agreed management action:

1. Update the backup procedure within the Information Security Policy to include the steps that would be taken if the organisation has to restore from backup and ensure it is reviewed and approved by senior management.

Evidence to confirm implementation:

1. Updated backup procedure within the Information Security Policy.

Responsible person/title:

Craig Allen (Head of IT)

Target date:

30 June 2023

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Findings and management actions

2.7 – Medical devices data security policy (9.3.9)

Low

A medical devices data security policy or procedure has not been formally documented at the Trust.

A policy / process document should be in place covering how data security is assured during the full life cycle medical devices.

However, whilst only a small proportion of medical devices are connected to the network, there is no policy / process document which covers how the organisation assures data security during the full life cycle medical devices. Therefore, the DSPT assertion requirement had not been met. Action is set to be taken to include the required details in the Trust's Management of Reusable Medical Devices & Equipment Policy.

Risk: Staff are not clear on the controls in place for securing data for medical devices. Therefore, there is an increased risk that the Trust will be exposed to data security vulnerabilities.

Agreed management action:

1. Document how the organisation assures data security during the full life cycle of medical devices as part of a policy or procedure.

Evidence to confirm implementation:

1. Policy or procedure covering how the organisation assures data security during the full life cycle medical devices.

Responsible person/title:

Craig Adam (Head of IT) and Neil Adams (Head of Clinical Engineering)

Target date:

30 June 2023

2.8 – Supplier list (10.1.1)

Low

The supplier list does not include contract durations.

As per the mandatory requirements of sub-assertion 10.1.1, the Trust's supplier list should contain the duration of each of the supplier contracts. However, contract durations are not specified within the centralised list of suppliers.

Risk: IT suppliers are not held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

Agreed management action:

1. Update the supplier list to include the start and end date of each of the contracts with suppliers.

Evidence to confirm implementation:

1. Updated supplier list include the start and end date of each of the contracts with suppliers.

Responsible person/title:

Paul Mullane (Head of Information Governance & Legal Services, DPO) and Anne Bailey (Information Governance Lead) with IT support

Target date:

30 June 2023

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Detailed findings - internal governance structure

Governance

How the organisation is structured to assess compliance against assertions

- ✓ The Trust has an established Information Governance Group (IGG), which is chaired by the Caldicott Guardian, deputy chaired by the SIRO and attended by the Head of Legal Services and Information Governance (IG) who is the Data Protection Officer (DPO), Head of IT and others.
- ✓ IG work is coordinated by the Director of Integrated Governance, Quality and Patient Safety, who is nominated as the main administrator to work alongside the Head of ICT and Cyber Security Lead.
- ✓ All submissions are managed and assessed by the Head of IG before being marked as complete and discussed.

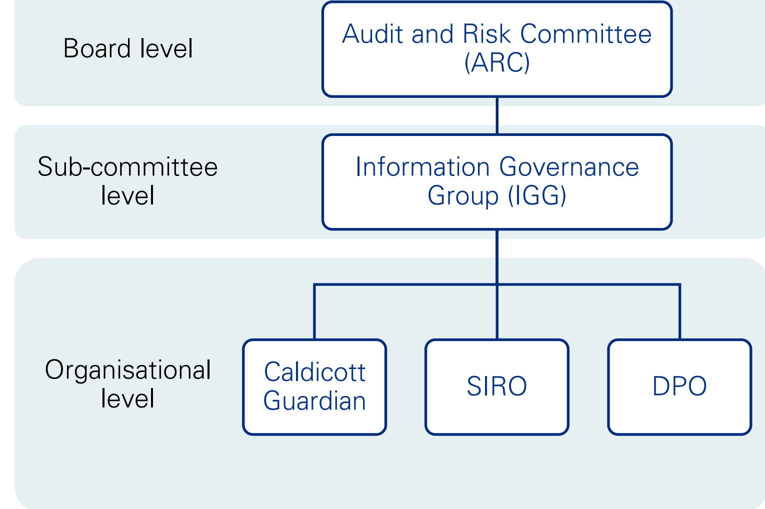
The method in which returns are made to the IG coordinator and evidenced

- ✓ Assertions are individually assigned to an owner based on their roles and responsibilities. The assertion owners identify any changes to requirements, and inform the Head of Legal Services and IG.
- ✓ Assertion owners submit evidence by email to the Head of Legal Services and IG who will verify the suitability before uploading it to the Toolkit.
- ✓ The Head of Legal Services and IG reviews evidence on an iterative basis as it is received from assertion owners, and is responsible for uploading the evidence directly to the Toolkit.

The method in which returns are validated, moderated and signed off for submission

- ✓ Evidence is reviewed iteratively by the Head of Legal Services and IG as it is received throughout the submission year.
- ✓ Prior to submission, there is a detailed review of all evidence obtained against self-assessed scores by the Head of Legal Services and IG. Once all the evidence has been obtained a final position is reported to the IGG along with the external assessment report and approval for submission is sought.
- ✓ The Director of Integrated Governance, Quality and Patient Safety performs the final sign-off and DSP Toolkit submission each year.

DSPT Hierarchy



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Detailed findings - summary of work undertaken and risks reviewed

Below we set out our assessment of the Trust's current scores for the sample of Toolkit assertions reviewed. We have based our assessment on the requirements set out within the NHS Digital Independent Assurance Framework, and indicated whether not, in our opinion, the Trust have met the in scope assertion.

Agree	Understated	Overstated	Agree but insufficient
From the evidence available we are able to agree with the Trust's self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our assessment that the Trust is performing at a level higher than recorded.	From the evidence available we are not able to agree the self-assessment as a reasonable assessment of current performance.	From the evidence provided it is our opinion the Trust has been accurate with its self-assessment, but it has not currently completed the mandatory assertion as required by NHS Digital.

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
1.3	Accountability and Governance in place for data protection and data security	1.3.1	Complete	Agree	✓ Key data security protection policies are approved and are up-to-date. ✓ Spot checks are undertaken to test compliance to data security and protection measures, most recently in the Fetal Medicine and SDEC. ✓ Clear lines of responsibility and accountability have been documented to named individuals responsible for data security and data protection including the SIRO, Head of IG, Caldicott Guardian and Head of IT. ✓ The data security risk register includes a risk description, owner, controls in place and a rating based on impact and likelihood. The Trust has identified their top three data security and protection risks. ✓ The Data Protection by Design and Default Policy includes guidance on privacy by design and default. ✓ The Trust's Data Protection Impact Assessment (DPIA) procedure embeds data protection in projects that require access to personal identifiable data. ✓ The Information Governance Group reports to the Risk Compliance and Assurance Group and Audit and Risk Committee on data security protection issues if necessary. The Trust has completed the mandatory sub-assertions.	**Agree**
		1.3.2	Complete	Agree		
		1.3.3	Complete	Agree		
		1.3.4	Complete	Agree		
		1.3.5	Complete	Agree		
		1.3.6	Complete	Agree		
		1.3.7	Complete	Agree		
		1.3.8	Complete	Agree		
		1.3.9	Complete	Agree		

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
2.1	Staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards	2.1.1	Complete	Overstated	✓ The Trust keeps a record of the mandatory Information Governance (IG) training completed. ✓ 95 out of 845 staff (11.2%) who joined from June 2022 had not completed the information governance security induction training. **(See Finding 2.1)** We are unable to state that the Trust has completed the mandatory sub-assertions.	**Overstated**
3.4	Leaders and board members receive suitable data protection and security training	3.4.1	Plan for completion by submission deadline	Agree	✓ Training requirements have been identified for senior members of staff with responsibility for data security and data protection including the SIRO, Caldicott Guardian and Head of IG. ✓ SIRO specific training is scheduled for April 2023. The Caldicott Guardian had received the required training. ✓ Training is scheduled for all Board members on 10 May 2023. The Trust is able to complete the mandatory sub-assertions.	**Agree**
		3.4.2	Plan for completion by submission deadline	Agree		
4.1	The organisation maintains a current record of staff and their roles	4.1.1	Complete	Agree	✓ The Trust keeps a maintains of all their staff members on the ESR system. ✓ The Trust do not allow systems without unique user credentials. The Trust has completed the mandatory sub-assertions.	**Agree**

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
4.2	The organisation assures good management and maintenance of identity and access control for its networks and information systems	4.2.1	Complete	Agree	✓ A user access audit was performed in November 2022. ✓ Logs on Avast antivirus (on endpoints) and on Fortianalyser (internet access monitoring) for over 6 months. • There is no log retention policy **(see finding 2.5).** • Four sampled leavers had an Active Directory account still enabled as of the time of review (**See finding 2.2)** We are unable to agree that the Trust has completed the mandatory sub-assertions.	**Overstated**
		4.2.3	Complete	Agree		
		4.2.4	Complete	Overstated		
4.5	You ensure your passwords are suitable for the information you are protecting	4.5.1	Complete	Agree	✓ Password guidance contains information on how to avoid choosing obvious and common passwords, not re-using passwords and where passwords must not be recorded. ✓ Account lockout is implemented after 5 invalid password attempts for 30 minutes. ✓ A password deny list is enforced as part of the Manage Engine AD Self Service Plus tool which is used to mitigate against password-guessing attacks. ✓ The Imprivata Single Sign On (SSO) solution is in place and enabled for access to Trust devices which uses multi-factor authentication (MFA). ✓ The Password Policy includes that highly privileged accounts should have passwords of high strength, infrastructure components shall be changed from default and password guidance on social media accounts. We are able to state that the Trust has completed the mandatory sub-assertions.	**Understated**
		4.5.2	Incomplete	Understated		
		4.5.3	Complete	Agree		
		4.5.4	Complete	Agree		

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Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
5.1	Process reviews are held at least once per year where data security is put at risk and following data security incidents	5.1.1	Complete	Agree	✓ The Cyber Resilience and Response Plan confirmed that it includes a mechanism for identifying the root cause of an incident as part of lessons learned exercises. ✓ Review of an incident confirmed root cause analysis had been undertaken and identified, along with steps taken to prevent similar incidents from occurring in the future. The Trust has completed the mandatory sub-assertions.	**Agree**
6.3	Known vulnerabilities are acted on based on advice from NHS Digital, and lessons are learned from previous incidents and near misses	6.3.1	Complete	Agree	✓ No data security incidents have occurred as a result of known vulnerabilities during the audit year. ✓ NHS CareCERT alert screenshots showed that the alerts were responded to within 48 hours. ✓ Avast anti-virus and Microsoft Defender ATP detect vulnerabilities on endpoints. Fortigate is also in use as a firewall solution to monitor threats from websites. There is a passive vulnerability detection system (Armis) used on non IT devices which scans for threats and vulnerabilities. ✓ There are no new digital services have been that are susceptible to fraud which have been implemented in the last 12 months. The Trust has completed the mandatory sub-assertions.	**Agree**
		6.3.2	Complete	Agree		
		6.3.3	Complete	Agree		
		6.3.4	Complete	Agree		

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
7.2	There is an effective test of the continuity plan and disaster recovery plan for data security incidents	7.2.1	Plan for completion by submission deadline	Agree	✓ A data security incident test is scheduled for the 7th June 2023 with outcomes due to be recorded. ✓ Actions from the business continuity test have been assigned to individuals, with defined timescales for each action to be implemented. We are able to agree that the Trust has completed the mandatory sub-assertions.	**Agree**
		7.2.2	Plan for completion by submission deadline	Agree		
7.3	You have the capability to enact your incident response plan, including effective limitation of impact on your essential service. During an incident, you have access to timely information on which to base your response decisions	7.3.1	Complete	Agree	✓ There is an incident response plan in place for data security and protection incidents. ✓ Staff responsible for data security incident response have completed specialist incident command training. ✓ Staff names, roles and contact details are clearly signposted for in the event of an emergency. Hard copies are located and accessible to staff within the hospital. • A backup procedure is in place, however, does not include steps needed to restore from backup. **(See finding 2.6).** ✓ Recovery Time Objectives (RTOs) and Recovery Point Objectives (RPOs) have been defined for an example key system (PAS). A backup restore was performed in January 2023. • There is a lack of offline and immutable backups at the Trust. **(See finding 2.4).** We are unable to agree that the Trust has completed the mandatory sub-assertions.	**Overstated**
		7.3.2	Complete	Agree		
		7.3.4	Complete	Overstated		
		7.3.4	Complete	Overstated		
		7.3.5	Complete	Agree		
		7.3.6	Complete	Overstated		

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
8.3	Supported systems are kept up-to-date with the latest security patches.	8.3.1	Complete	Agree	✓ The frequency and scope of patch management controls are documented and approved by the SIRO. ✓ Patches are automatically pushed to remote endpoints as soon as they are made available. ✓ Critical and high risk patches must be patched within 14 days. ✓ A sample of NHS CareCERT vulnerabilities had been managed and remediated within 14 days. ✓ There is regular reporting to Management on patch status through the Cyber Security reports to management. Where critical patches can not be deployed within 14 days, they are sent to the SIRO for assessment and risk acceptance where appropriate. ✓ The Trust uses the Microsoft Advanced Threat Protection (ATP) solution. • Whilst 98.1% of the desktop estate is on the latest supported versions of operating systems, 65% of the server estate is on the latest supported versions of operating systems which is below the required value of 95%. **(See finding 2.3).** ✓ The NCSC early warning service is in place at the Trust to notify of malicious network activity. We are unable to agree that the Trust is able to complete the mandatory sub-assertions.	**Agree but insufficient**
		8.3.2	Complete	Agree		
		8.3.3	Complete	Agree		
		8.3.3	Complete	Agree		
		8.3.4	Complete	Agree		
		8.3.5	Complete	Agree		
		8.3.6	Complete	Agree		
		8.3.7	Incomplete	Agree but insufficient		
		8.3.8	Complete	Agree		

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
9.3	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities	9.3.1	Complete	Agree	✓ Web applications are no longer to be developed in-house. ✓ The Fortigate 3000D web filter tool is used to prevent users from accessing potentially malicious websites. ✓ There is a documented and restricted list of individuals with authoritative access for both the internal and external DNS servers. ✓ There is a consolidated record of IP ranges across the Trust's network. The IP range record is manually reviewed on a quarterly basis (most recently in April 2023). ✓ NHS.net is used for email whereby TLS1.2 is implemented and TLS1.2 is also implemented for browsers. ✓ The National Cyber Security Centre (NCSC) Web Check service is used. ✓ A connected medical device register is maintained with device details, IP address, locations and whether network access is given. Network segmentation is in place for medical devices. • There is no policy detailing how data security is assured throughout the lifecycle of connected medical devices. There is no plan in place to ensure this is in place by the June submission deadline. **(See finding 2.7).** We are unable to agree that the Trust is able to complete the mandatory sub-assertions.	Overstated
		9.3.3	Complete	Agree		
		9.3.4	Complete	Agree		
		9.3.5	Complete	Agree		
		9.3.6	Complete	Agree		
		9.3.7	Complete	Agree		
		9.3.8	Complete	Agree		
		9.3.9	Plan for completion by submission deadline	Overstated		

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Appendix A

Detailed findings - summary of work undertaken and risks reviewed

Req. #	Description		Trust Assessment	KPMG Assessment	Comment	Overall Assessment
10.1	Systems which handle sensitive information or key operational services shall be protected from exploitation of known vulnerabilities	10.1.1	Complete	Overstated	• The supplier list includes name of contract, supplier name, details on the products, which suppliers process personal data, but not contract duration **(See finding 2.8).** We are unable to agree that the Trust has completed the mandatory sub-assertions.	**Overstated**

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Detailed findings - overall risk assurance rating and confidence level

The table below summarises our independent assessment of each DSS. The overall National Data Guardian (NDG) standard classification risk rating has been derived from an evaluation of the impact and likelihood of each in-scope assertion, from which we have assigned a point scoring in order to derive an overall assessment conclusion based on NHS digital guidance.

Standard Number	No. of Assertions Tested	Critical	High	Medium	Low	Standard Level Risk Rating	Overall Risk Assessment
One	**1**: 1.3	-	-	-	-	Substantial	Moderate
Two	**1**: 2.1	-	-	2.1	-	Moderate	
Three	**1**: 3.4	-	-	-	-	Substantial	
Four	**3**: 4.1, 4.2, 4.5	-	-	4.2	-	Moderate	
Five	**1**: 5.1	-	-	-	-	Substantial	
Six	**1**: 6.3	-	-	-	-	Substantial	
Seven	**2**: 7.2, 7.3	-	-	7.3	-	Moderate	
Eight	**1**: 8.3	-	-	8.3	-	Moderate	
Nine	**1**: 9.3	-	-	-	9.3	Substantial	
Ten	**1**: 10.1	-	-	-	10.1	Substantial	

* Note, as we agree that assertions 1.3, 3.4, 4.5, 5.1 and 6.3 have met the toolkit standard, they are considered not reportable and thus do not appear in our risk assessment table.

Risk Level

We have determined overall risk rating of the Trust’s data security and protection control environment, for the in-scope assessments as **Moderate.** Our assessment is based on NHS Digital guidance. The following NHS Digital definitions were used for aiding the decision of calculating the overall risk assessment for the Trust.

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Detailed findings - Data Security Standard (DSS) risk & confidence level

Overall risk rating across all in-scope standards	
Unsatisfactory	1 or more Standards is rated as 'Unsatisfactory'
Limited	No standards are rated as 'Unsatisfactory', but 2 or more are rated as 'Limited'
Moderate	There are no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards are rated as 'Substantial'.
Substantial	All of the standards are rated as 'Substantial'

Overall Confidence Level

The confidence-level in the veracity of the organisation's DSP Toolkit self-assessment submission has been determined by comparing our assessment findings against the self-assessment made by the Trust. The following NHS Digital definitions were used for aiding the decision of applying a confidence-level.

Level of deviation from the DSP Toolkit submission and assessment findings	Confidence level	Suggested Assurance level
High – the organisation's self-assessment against the Toolkit differs significantly from the Independent Assessment. For example, the organisation has declared as "Standards Met" or "Standards Exceeded" but the independent assessment has found individual National Data Guardian Standards as 'Unsatisfactory' and the overall rating is 'Unsatisfactory'.	**Low**	**Unsatisfactory OR Limited**
Medium - the organisation's self-assessment against the Toolkit differs somewhat from the Independent Assessment. For example, the Independent Assessor has exercised professional judgement in comparing the self-assessment to their independent assessment and there is a nontrivial deviation or discord between the two.	**Medium**	**Moderate**
Low - the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.	**High**	**Substantial**

We have determined the confidence level at the Trust as **Medium** and therefore, an **Moderate** level of assurance. The organisation's self-assessment against the Toolkit does differ from the Independent Assessment. See **Appendix B** for further detail on the Trust's assessment against our assessment findings for each of the in-scope assertions.

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Appendix A

Detailed findings - list of DSPT assertions tested

We have included below the assertions from the toolkit that we reviewed in detail as part of this review in green. These were the assertions as required by NHS Digital as part of the national DSPT audit requirements for 2022/23. All other assertions were not in scope for this review.

DSPT Audit Plan – Requirements for 2022/23					
1.1		4.3		8.2	
1.2		4.4		8.3	Supported systems are kept up-to-date with the latest security patches
1.3	Accountability and governance	4.5	You ensure your passwords are suitable for the information you are protecting	8.4	
1.4		5.1	Process reviews are held at least once per year	9.1	
2.1	Staff are supported in understanding their obligations	6.1		9.2	
3.1		6.2		9.3	Systems which handle sensitive information are protected
3.2		6.3	Known vulnerabilities are acted on based on advice from NHS Digital	9.4	
3.3		7.1		9.5	
3.4	Leaders and board members receive suitable data protection and security training	7.2	There is an effective test of the continuity plan and disaster recovery plan	9.6	
4.1	The organisation maintains a current record of staff and their roles	7.3	You have the capability to enact your incident response plan	10.1	Organisational suppliers, the products and services they deliver and the contract durations
4.2	The organisation assures good management and maintenance of identity and access control for it's networks and information systems	8.1		10.2	

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Appendix B

Scope extract

Background of the internal audit

Personal information is critical to the successful delivery of the objectives of Medway NHS Foundation Trust (the 'Trust'). Information systems and technology need to be robust, well maintained, and used effectively to protect the confidentiality, integrity, and availability of the personal information and data that is controlled, managed, and shared; and to minimise the risk of incidents affecting day-to-day operations, and provide the ability to provide high quality services. High-profile public sector personal data losses have brought data related issues into the public spotlight in recent years. As such, NHS Digital is taking data security and privacy extremely seriously in the need to protect patients and staff.

The Data Security and Protection Toolkit (DSPT) is NHS Digital primary tool for ensuring organisations working in healthcare with personal data are protecting their patient and staff information adequately. It forms part of NHS Digital's framework for assuring that organisations are implementing the 10 data security standards (published by the Department of Health and NHS England) and meeting their statutory obligations on data protection and data security. The results of the Trust's DSPT return also has wider implications because it is considered by the Care Quality Commission (CQC) as part of the 'well led' element of their inspections.

The DSPT contains a total of 33 assertions. The Trust, along with all NHS organisations, must demonstrate compliance with all mandatory DSPT assertions through the achievement of a 'pass mark' against each assertion by 30 June 2023. We have agreed with the Trust a risk based testing approach that involves us testing 13 of the 33 mandatory assertions this year. This is in line with the national testing requirements as suggested by NHS Digital for the 2022/23 DSPT audit programme. Details of the assertions to be tested this year are detailed within Appendix A.

A further requirement per NHS Digital guidance is to determine the level of confidence in the veracity of the DSPT self-assessment, as per the Strengthening Assurance Assessment Guide (refreshed for 2022/23 submission). Based on the self-assessment made by the Trust and our independent review of in-scope assertions, we will give the Trust a confidence level. See Appendix D for further information regarding confidence levels.

Scope of internal audit

The scope of the internal audit included consideration of:

- Internal governance processes supporting the DSPT self-assessment process including:
  - Defined roles and responsibilities for Data Security and Protection and how the organisation is structured to assess compliance against assertions;
  - How the DSPT evidence is submitted to the DSPT co-ordinator by relevant staff across the organisation;
  - How the DSPT evidence is validated by DSPT co-ordinators;
  - What types of evidence are used and how is it stored ahead of the submission; and
  - How the DSPT is signed off for submission.
- The scope of the internal audit covered each of the 13 mandatory assertions that NHS Digital require independent assurance over listed in Appendix A. Our approach will include sample testing of controls where appropriate.

Key risks identified

1	Evidence available to support the Trust's self assessment is inadequate.
2	Personal confidential data is not handled, stored and transmitted securely, whether in electronic or paper form.
3	Staff do not understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to handle information responsibly.
4	Staff do not complete appropriate annual data security training and pass a mandatory test.
5	Personal confidential data is not limited to staff who need it for their current role and access is not removed as soon as it is no longer required.
6	Processes are not reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.
7	Cyber attacks against services are not identified and resisted and CareCERT security advice is not responded to. Action is not taken immediately following a data breach or a near miss.

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Appendix B

Scope extract

	Key risks identified
8	Continuity plans are not in place to respond to threats to data security, including significant data breaches or near misses, and are not tested once a year as a minimum.
9	There are unsupported operating systems, software and/or internet browsers used within the IT estate.
10	A strategy is not in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials.
11	IT suppliers are not held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

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Appendix C

Ratings definitions

We have set out below the overall report grading criteria and priority ratings used to assess each individual finding.

Overall report rating	Definition
Significant assurance	The system is well designed and only minor low priority management actions have been identified related to its operation. Might be indicated by priority three only, or no management actions (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).
Significant assurance with minor improvement opportunities	The systems is generally well designed however minor improvements could be made and some exceptions in its operation have been identified. Might be indicated by one or more priority two management actions. (i.e. there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Partial assurance with improvements required	Both the design of the system and its effective operation need to be addressed by management. Might be indicated by one or more priority one, or a high number of priority two management actions that taken cumulatively suggest a weak control environment. (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
No assurance	The system has not been designed effectively and is not operating effectively. Audit work has been limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one management actions and fundamental design or operational weaknesses in the area under review. (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).

Finding priority rating	Definition
Low	Issues arising that would, if corrected, improve internal control in general but are not management actions which could improve the efficiency and / or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.
Medium	A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.
High	A significant weakness in the system or process which is putting you at serious risk of not achieving its strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any management action in this category would require immediate attention.

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This report has been prepared solely for Medway NHS Foundation Trust in accordance with the terms and conditions set out in our engagement letter. We do not accept or assume any liability or duty of care for any other purpose or to any other party. This report should not be disclosed to any third party, quoted or referred to without our prior written consent.

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Meeting of the Board of Directors

Title of Report	Board Assurance Report - People Committee, 25 May 2023	Agenda Item	5.1
Author	Leon Hinton, Chief People Officer		
Committee Chair	Sue Mackenzie, Chair of Committee/Non-Executive Director (NED)		
Key headline and assurance level			

Key headline	Assurance Level
1. IQPR and compliance report The Committee reviewed the refreshed Patient First version of the IQPR. It reported on the HR performance across all key performance indicators for April 2023. The Committee **NOTED** the report: a) An improvement to the staff engagement score (true north) from 6.56 to 6.63 (against target of 6.93) in conjunction with four-successive months of meeting the appraisal and wellbeing rate target of 90% (breakthrough objective); b) A consistently improving vacancy rate (4.9% against 9% target); c) A slightly improved voluntary turnover rate of 12.2% (however, above 8% target); d) An improving long-term sickness rate (1.8% against 2% target); short-term sickness remains above target (2.2% against 2% target). e) An above-target StatMan rate of 87.5% (against 85% target).	Partial Assurance
2. Equality and Culture Update The Committee received an update on the progress of the Equality action plan, which was also received by the Equality and Inclusion Steering Group. The Committee noted that one item relating to Positive Action is currently marked as amber. The Committee received for approval the Trust's anti-discrimination statement. The Committee requested the Statement to be taken for approval to the Executive and to be re-submitted to the Committee with a detailed implementation plan at the next meeting.	Partial Assurance
3. WDES and WRES Annual Report The Committee received an annual report for approval, in readiness for its publication by 30 May. Further analysis of the workforce data will be brought to the Equality Steering Group (in June) and the Action Plan will be brought to this Steering Group and the People Committee later in the year.	No assurance required

WRES indicator

Indicator 1: Workforce profile

- The main shift in the workforce profile is the development of Band 5 clinical staff into Band 6 roles; which has been improved BME representation at Band 6 (one of our long standing aims)

Indicator 2: Relative Likelihood of being appointed from shortlist.

- The report explains there is an issue about getting an accurate figure on this, as ESR has not picked up the ethnicity of a significant proportion of new starters. Approx. 480 entries may be incorrectly showing as 'unknown' and this figure will be investigated further.
- The relative likelihood figure (1.67) shown in the report is the worst case scenario. A rough estimate of the final likelihood is estimated to be between 1.0 and 1.3 – either of which is improvement on last year's figure of 1.52

Indicator 3: Relative likelihood of Entering Formal Disciplinary

- The relative likelihood of 1.06, illustrates that BAME staff are marginally more likely to be in disciplinary measures that White staff

Indicator 4: Relative likelihood of staff accessing Non-Mandatory Training.

- The data for this indicator shows that the performance on this indicator shows that 97.46% of BME staff and 97.46% of White staff accessed non-mandatory training. This creates a relative likelihood of uptake at 1.00. This compares to 1.05 in 2022.

Indicator 9: Board representation

- BME people remain under-represented on the Board and Exec; positive action is encouraged for upcoming recruitment

(Indicators 5-8 are not on the report; they are the staff survey results, and were reported in March)

WDES:

Indicator 1: Workforce Profile

- The proportion of disabled people in the workforce remains low at approximately 3%. Work to increase declaration rates is planned to launch in June.

Indicator 2: Relative likelihood of disabled people being appointed from shortlist

- This appears to indicate that disabled people are more likely to be appointed than non-disabled people; this could be an indicator that those disabled people who make it to shortlist are having an improved experience at interview/selection. However, the fact that there is small number of disabled people in the shortlist pool could be skewing the data (owing to an increased statistical margin of error).

Indicator 3: Relative likelihood of entering capability procedures (excluding sickness) • AT 1.94, this is a concerning issue. Disabled people being almost twice as likely as non-disabled people to enter capability procedures is the noticeable deterioration in either the WDES or the WRES, and will need to be a priority for the WDES/WRES Action Plan. Indicator 10: Board Representation. • Currently there are no Board members declared as disabled on ESR. As with the WRES, there is an opportunity for positive Action in forthcoming recruitment. As there is NO disabled representation on the Board/Exec, and few BAME or female members. The Committee **APPROVED** the report.	
4. People Strategy and Projects update The Committee received an update on the strategic projects for the HR and OD directorate. a) Of 64 activities, 4 activities are completed, 10 are delayed, 25 are marked as new activity and 25 are reported as progressing as planned. b) RAG rating of HR strategic activities reveals that 33 activities are rated as Green, 22 as Amber and 9 as Red. c) Update on the Culture and leadership project: milestones for completion in May and June include upskilling HR team on Just Learning Culture principles, incorporation of these principles into new manager's induction training and HR policies and development of Kindness into Action training. Risks and issues reported relate to the staffing issues within the OD and Wellbeing teams. d) Update on the Employee experience project: milestones for completion in May and June include A3 methodologies of the entire Recruitment and Onboarding process and on Flexible Working. Anti-bullying and Harassment Group will also scope out the review of information recorded to Datix. e) Update on the Talent management and succession planning project: milestones for completion in May and June include provision of work experience programme to accommodate age group 14 to 18 and provision of apprenticeships as part of the recruitment process f) Update on the Becoming employer of choice project: milestones for completion in May and June include A3 methodology on Management Essentials training and succession plans for all critical roles. The Committee **NOTED** the report.	No assurance required

5. HR Team Performance Report The Committee received a report from the HR and OD Performance Group, which provides assurance on the items discussed at the meeting, decisions made and actions taken. The Committee reviewed key points relating to HR Team's KPIs and discussed the following: • Percentage of disciplinary and grievance investigations completed within six weeks set is about 50% is set to improve as a consequence of the revised Disciplinary Policy and the Pre-Disciplinary Panel which will commission investigations, track their progress and remedy any delays e.g. through the allocation of additional resources. • Current time from referral to the OH service is much longer than our accepted KPI of 20 days. Team's current performance data indicates that all management referrals result in appointments outside this time (0% compliance with this KPI). This is due to an increase in management referrals and pre-employment checks, reflecting increased recruitment into CSW and nursing roles. The OH team has one B7 nurse vacancy and additional resource has been requested through this year's business plan. The Committee raised a concern about the resourcing issues experienced by the team. The Committee received highlight reports from Sub Groups and requested further information in relation to international recruitment and adherence to ethical recruitment guidelines.	Partial Assurance
6. Trust's preparedness for industrial action The Committee received an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff. Strike action occurred in January 2023 (Chartered Society of Physiotherapists), followed by 3 days strike action of Junior Doctors by the BMA from 13 to 15 March 2023 and 4 days strike from 11 to 14 April. Staff groups currently balloted include: • 897 nurses (RCN) • 98 consultants (BMA) • 1 consultant (British Dental Association) Further industrial action is expected between mid-June and end of December 2023. The Committee **NOTED** the report.	Assurance

<table>
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7. Wellbeing Guardian Assurance Report — Assurance

The Committee received an update on the end of Quarter 4, 2022/23 assurance report to the Non-Executive Director Wellbeing Guardian and Trust Board.

The 2022-23 National Health and Wellbeing Framework target of achieving 74% compliance (+5% on the previous year) has been surpassed by 0.5%. Compliance is now at 74.5% and the new target for 2023-24 has been set at 78% (+4%).

The Committee **NOTED** the report.

Decisions made:

1) Approval of WRES and WDES Annual Report

Further Risks Identified:

1) Resourcing issues affecting the performance of the Occupational Health team, potentially affecting health and wellbeing of staff and delaying recruitment process

Escalations to the Board or other Committee:

1) [People Sub-Committee] International recruitment adherence to ethical recruitment principles.

</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">Not applicable</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td colspan="2">Assurance</td><td>X</td><td>Approval</td><td></td></tr>
<tr><td colspan="2">Noting</td><td></td><td>Discussion</td><td></td></tr>
<tr><td>(If appropriate) state reason for submission to Private section of Board:</td><td colspan="2">Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td>Exceptional Circumstances:</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">People Committee, 25 May 2023</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)</td><td>Priority 2: (People)
X</td><td>Priority 3: (Patients)</td><td>Priority 4: (Quality)</td><td>Priority 5: (Systems)</td></tr>
</table>

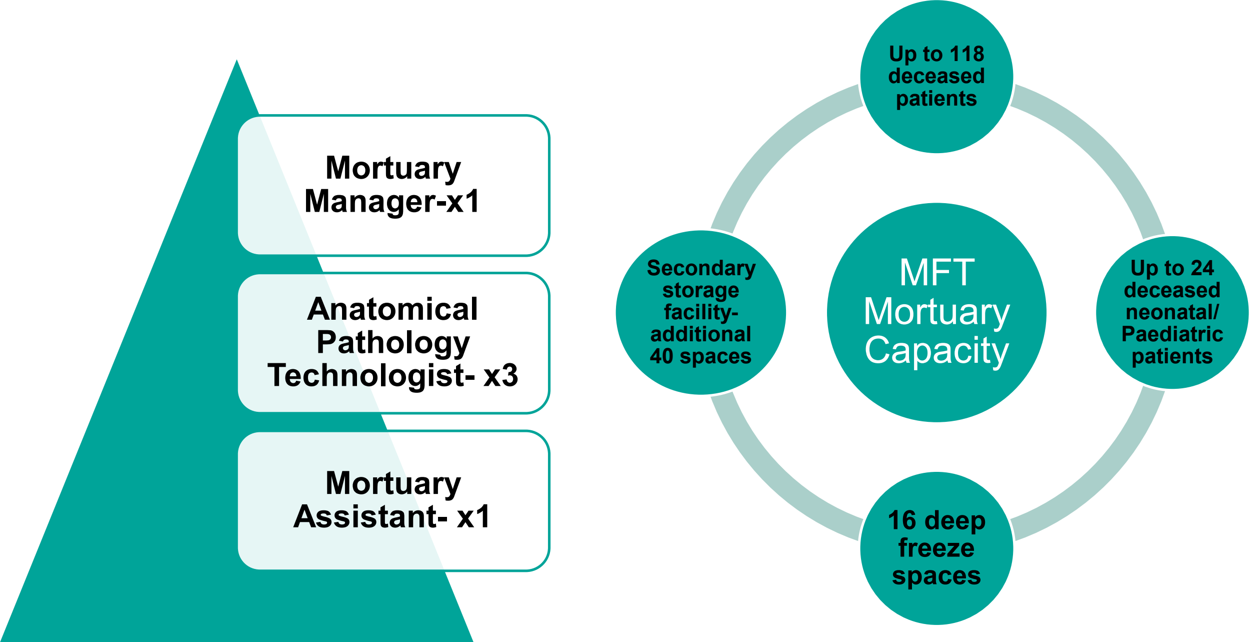
Patient FIRST

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	**Well-Led: X**
Identified Risks, issues and mitigations:	All risk, issues and mitigations are reference in the Board Assurance Framework item.				
Resource implications:	Individual resource considerations are provided at the People Committee.				
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the People Committee.				
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Leon Hinton, Chief People Officer leon.hinton@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			
	Not Applicable	No assurance required.			

Mortuary Department

Peter Basden - Anatomical Pathology Technologist

Mortuary Service



Key Messages:

- The mortuary at MFT is a HTA (Human Tissue Authority) regulated department
- The department is licensed to undertake post-mortem examinations, perform consented tissue retrievals and research donation (NHSBT and Queens brain bank)
- The department cares for MFT deceased patients. HMC community deaths and forensic cases on behalf of Kent Police covering the whole of Midkent and Medway
- The staff at MFT mortuary work extremely hard and are very proud of their department, this is evident through the positive and robust feedback received through the departments regulatory body at the last onsite inspection.

Issues, Concerns & Gaps:

- Decreased staffing level - Mortuary Manager currently on maternity leave. Duties are being covered by the team

Actions & Improvements:

- New flooring is being laid in the department
- A new private ambulance (with hydraulic lift?)

Successful Deliverables

- The department carries out between 1,200-1,600 post mortem examinations annually with up to 10 examinations carried out daily on behalf of HMC.
- Neonatal and paediatric post mortem examinations are carried out at Great Ormond street and St Thomas'.
- The department has a 24/7 On call service which is often utilised for urgent police investigations and consented tissue retrievals.
- 343 post mortem examinations carried out between March - May 2023
- Site B’s roof has been fully repaired

Identified Challenges

- Ensuring all staff are trained to use the Mortuary record system- EDEN- Porters have undertaken training- as paper record removed
- The removal of implantable devices

Opportunities

- Viewings and identification procedures are undertaken daily by Mortuary staff on behalf of HMC and Kent police.
- Hospital viewings are conducted by the MFT bereavement team.
- New flooring in the mortuary area is currently underway
- Collaborative working with other MFT services- Medical Examiner’s Office, the Bereavement Office and The End of Life Care Team

Risks

- Any concerns raised are addressed at the Mortuary’s monthly HTAC (Human Tissue Authority Committee), the Chief Medical Office and the Pathology Service Managers are present. (All meetings are minuted and action log updated)
- All mortuary practices and procedures are regulated by the HTA (Human Tissue Authority). The MFT Chief medical officer is the 'Designated Individual' (DI) for the trust and the mortuary has 4 'Persons designate' (PD) on the license. The HTA conduct onsite inspections to ensure that the department is operating within the remit of the license and HTA guidelines.

Meeting of the Trust Board
Date: 12 July 2023

Meeting	Finance, Planning and Performance Committee – May 2023		
Title of Report	**Assurance and Escalation Report**	Agenda Item	7.1a
Lead Director	Alan Davies, Chief Financial Officer Annyes Laheurte, Non-Executive Director/Chair of Committee		
Report prepared by	Elaine Adams, Business Support Manager – Finance		
Report Approved by	Alan Davies, Chief Financial Officer Paul Kimber, Deputy Chief Financial Officer Annyes Laheurte, Non-Executive Director/Chair of Committee		
Executive Summary	The enclosed report sets out the key discussions held at the Finance, Planning and Performance Committee in May 2023. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts, business planning update, endoscopy business case and committee terms of reference.		
Committees or Groups at which the paper has been submitted	n/a		
Resource Implications	n/a		
Legal Implications/ Regulatory Requirements	n/a		
Quality Impact Assessment	None		
Recommendation/ Actions required			

Approval	Assurance	Discussion	Noting
☐	☒	☐	☐

Appendices	

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

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

No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance

Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Finance, Performance and Planning Committee	25.05.23	Annyes Laheurte

Number of attendees	Number of apologies	Quorate	
		Yes	No
11	3	X	

Declarations of Interest Made

N/A

Assurance received at the Group meeting

(overview of key points/issues/matters on the agenda discussed at the Group meeting, including anywhere the group was unable to obtain assurance or there may be an adverse impact for the Trust (e.g. potential impact on: strategic progress, compliance or patient safety). Consider whether the agenda was fit for purpose – e.g. linked to the terms of reference and the work plan for that month)

Key actions

Business Assurance Framework and Risk Register

- The scores on the BAF and risk register were agreed. The medical staffing overspend amount was queried, the root cause and mitigations for this will be addressed in the finance breakthrough huddle. The ERF procedures for allocating funding are to be reviewed and strengthened.

Financial Performance

a) The Trust has reported a £2.5m deficit for month one in line with the plans.
b) The £15m planned deficit was profiled at £7.3m in Q1, the deficit will decrease with the onset of the benefit from the planned efficiency schemes in Q2.
c) Activity is behind plan in month one, due to industrial action and elective capacity is due to increase because of the additional elective ward and theatre in July.
d) The efficiency programme is in line with plan at £300k in month.
e) Capital expenditure for month one was £500k.
f) The nursing position overspend amount was queried, the root cause and mitigations for this will be addressed in the finance breakthrough huddle.

Performance report

a) The processes for elective operations are being reviewed. PIDs for the Theatre capacity will be reviewed and assessed on the prophet margins and which are clinically urgent so the best return on the ERF whilst maintaining clinically urgent cases can be assessed.
b) Activity for non-elective remained stable, with the exception of dropped attendances during the industrial action. The trajectory of 76% for the 4 hour performance was delivered for month 1. The 52 week is in a good position, the teams are reducing this.
c) ENT has been split into a specific issue and is a wider system problem.

d) DM01 is non-compliant driven by endoscopy. DVH has offered the Trust capacity to support the backlog reduction. MTW are offering the Trust more capacity at the weekends to support the RTT position.
e) Breast is in line with the plan. April's performance is 92%.

Capital Programme

a) The capital programme was submitted to the Execs. The report sets out the proposed programme for the system capital of £12.4m. The report includes a summary of the externally funded schemes, not all have been formally approved, part of which is the CDC programme amounting to £6.5m and the Cardiac Village bids submitted to NHSE/I for £11m of capital, one scheme has so far been approved.
b) Pembroke is the highest priority in terms of fire safety works.
c) All PIDs and business cases are to be worked up by the end of June.
d) The endoscopy business case is being progressed to be submitted to the Committee in July.
e) Increased external funding from NHSE is being looked into.

Progress against Efficiencies Programme

a) Work has been done to strengthen the governance around the Efficiencies Programme.
b) £13.7m has been identified against the £27m target. The milestone deliverables for this month are green.
c) £2.6m of the divisional schemes have been identified. Planned care has £5.9m target with £1.2m identified with ten schemes live. UIC has £5.9m target with £532k identified and three schemes live.
d) £11m of Cross Cutting themes have been identified. Focus has been put on the Cross Cutting themes. £270k was planned to deliver in month, £301k was delivered.
e) Outpatients and Theatres were put together in one scheme, these have now been separated and are individual schemes.
f) The Efficiency Programme and Corporate Central reserves have now been separated.

Financial Recovery Plan

a) The reports sets out the next steps in refreshing the Financial Recovery Plan, work that needs to be done to come out of SOF4. The final refresh will be submitted to the committee by the end of Q2. Progress updates will be given intermittently.
b) NHSE has given guidance and advise on how to exit SOF4. A number of individual documents will be compiled over the next few months to show progress.
c) This will be linked into the clinical strategy work and the underlying drivers of deficit.

Data Quality Review

a) There are three key issues around capture in some areas, the automation and visibility of data.
b) Governance is reflected in the data quality committee, the information governance and the data quality dashboard. Suggestions have been made to strengthen the data quality committee with further sub-committees.
c) An external review of the Trust's data quality is being considered. KPMG are assisting with this.

Corporate Governance Statement

a) This item relates to the Trust's operating licence and any conditions placed upon the Trust for any breaches. From 2015 the organisation had conditions and breach notifications placed on it, which resulted in undertakings covering areas such as clinical and performance issues, issues around training and compliance, items around leadership and finance issues.
b) This was reviewed in 2019/20 and reviews fed back to NHSE and NHSE/I who revised the undertakings and the breaches within the licencing conditions. The conditions were not removed. Some were softened. Pieces around safeguarding, infection prevention control and leadership questions around the make up of the board were done.

c) MFT approached NHSE for an update on the breaches and the assessment under the new approach. NHSE has confirmed MFT has been reviewed and with the exception of finance, the Trust is no longer in breach of conditions.
d) The monthly and quarterly reporting that the Trust now does is considered business as usual.
e) The NHSE position is being confirmed with solicitors to ensure that the reporting is accurate. Only the financial element will remain as an undertaking. In August/September this will be included into the SOF discussion and the breaches will be removed.
f) NHSE gave the Trust feedback which is being reviewed and the Trust's response will be brought to the Committee once it has been completed.

Fire Door order

- This paper was to approve the implementation of fire doors in Pembroke.
- The project was approved.

Breast Service Options

- The paper was discussed and approved at the Exec. Meeting. The outsourcing will continue until September. The Execs. supported option one. The excess capacity should be phased over a longer period.
- This will be represented with the phasing included.
- The committee agreed and approved to the end of September. The financials need to be clarified. Option nine – the result if nothing is to be done needs to be explained or removed.

Terms of Reference

- MCP stated that the ToR is linked to the Board of Governance work that is currently being done. This is looking at the entire governance structure and assuring that the accountabilities and decision making is aligned and compliant to the Patient First process.
- MCP will submit an entire piece that looks at the broader structure, i.e. schemes of delegation, work plans and the Terms of Reference.

Highlights from sub-groups reporting into this group

(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)

Items to come back to the Group

(Items the Group is keeping an eye on outside its routine business cycle)

Breast Service Options
Terms of Reference

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

Item	Group, Subcommittee, Committee	Date

Reports not received as per the annual workplan and action required

Items/risks/issues for escalation

(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)

Issues and or Risks to note:

Deep dives into the nursing position and the medical staffing overspend are to be done in the form of an A3 to be discussed at the breakthrough huddles. Reports will be submitted at the next FPPC in June.

Reflection:

Implications for the corporate risk register or Board Assurance Framework

Examples of outstanding practice or innovation

Meeting of the Trust Board
Date: 12 July 2023

Meeting	Finance, Planning and Performance Committee – June 2023		
Title of Report	**Assurance and Escalation Report**	Agenda Item	7.1b
Lead Director	Alan Davies, Chief Financial Officer Annyes Laheurte, Non-Executive Director/Chair of Committee		
Report prepared by	Elaine Adams, Business Support Manager - Finance		
Report Approved by	Alan Davies, Chief Financial Officer Paul Kimber, Deputy Chief Financial Officer Annyes Laheurte, Non-Executive Director/Chair of Committee		
Executive Summary	The enclosed report sets out the key discussions held at the Finance, Planning and Performance Committee. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts, business planning update, endoscopy business case and committee terms of reference.		
Committees or Groups at which the paper has been submitted	n/a		
Resource Implications	n/a		
Legal Implications/ Regulatory Requirements	n/a		
Quality Impact Assessment	None		
Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐ Noting ☐
Appendices			

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

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

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

Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Finance, Performance and Planning Committee	22.06.23	Annyes Laheurte

Number of attendees	Number of apologies	Quorate	
		Yes	No
12	3	X	

Declarations of Interest Made
N/A

Assurance received at the Group meeting
(overview of key points/issues/matters on the agenda discussed at the Group meeting, including anywhere the group was unable to obtain assurance or there may be an adverse impact for the Trust (e.g. potential impact on: strategic progress, compliance or patient safety). Consider whether the agenda was fit for purpose – e.g. linked to the terms of reference and the work plan for that month)

Key actions

Business Assurance Framework and Risk Register

- The scores on the BAF and risk register were agreed.
- Medical staffing remains an issue. 5F has now been removed as it relates to the Covid budget which is now small.

Financial Performance

a) The Trust has reported a £2.5m deficit for month two, in line with the plan, which is £4.9m year to date, in line with the plan.
b) The Efficiencies position year to date is £0.6m, marginally above plan.
c) The CDC programme has been agreed. All project plans and PIDs are to be submitted by the end of this month.
d) The biggest overspend is £2m for medical staffing seen in the first two months, this is mainly due to rotational doctors and staffing levels, the cost of covering vacancies, the impact of the industrial action and the impact of the elective activity, which is being mitigated by moving funding from the ERF reserve.
e) Industrial action has had a big impact on activity and income in month two. This will be quantified in month three to reflect the impact of the June industrial action.

Efficiencies Programme

a) £13.8m has been identified against the £27m target.
b) The PMO is now up and running. A portal is being set up where people can send in ideas to reduce waist as they come across them in their day to day work. The portal will go live next week.
c) Additional schemes have been worked up in the past week.

d) £141k in months one and two has been realised in medicines management, which results in the programme being £17k ahead of plan.
e) A further £12k has been approved in Estates & Facilities with another £805k being worked up and due to being submitted to panel. There is an additional Tele Tracking scheme supporting Length of Stay reduction worth £750k. There are additional divisional schemes amounting to under £50k. These additional schemes total £1.8m, £16m identified schemes in total. Other schemes are continuing to be worked up.
f) Discussions will be had with the commissioners around the value of block contracts in Unplanned Care.
g) Planned Care is being looked at to ensure that the Trust is capturing all the income.

Performance report

a) Non elective activity has returned to its highest point since December.
b) Ambulance handover performance remains good. The overall four hour performance dropped on the previous month to 74.5% for May, which is against a trajectory of 78%. Some of the drivers for this has been a lot of Mental Health presentations in the recent weeks, these are complex cases waiting for tier four and psychiatric beds for five days in the Emergency Department. KMPT is keen to work with MFT to help with mental health provision in the Emergency department. The clinical decision area has been implemented, patients that attend here are off the four hour clock.
c) MEDOC has had staffing issues which is causing them to have a higher sickness rate. MCH has been contacted to provide a plan that will enhance MEDOC's performance.
d) RTT have breached in the 52 week position in colorectal, gastro, ENT and rheumatology have the largest breaches, mainly due to cancellations during industrial action in April and June.
e) DM01 is nowhere near the trajectory due to endoscopy. There is an endoscopy paper that will support its recovery with support from DVH and MTW. Modular stand alone units are being brought in to aid reducing the backlog.
f) April performance for breast was 62%. MFT has been placed in Tier 2 for cancer performance. Bi weekly meetings with NHSE to discuss cancer performance recovery. A plan has been drawn up and will be submitted to NHSE next week, funding has been requested for modular units.

Financial Recovery Plan refresh

a) One paper is a follow up from last month's report. The second paper has more detailed review of the 2022/23 deficit.
b) The first paper now includes some drivers of deficit content. Financial and operational drivers were looked at. Some original drivers identified in the FRP still remain an issue.
c) The report next month will include the reconciliation of the current year operating plan back to what had been included in the long term financial model in the FRP.
d) A specific document on the efficiencies, strategic interventions and the clinical strategy around MCH, will be included in the September meeting.
e) Last month's paper has been shared with NHSE and the ICB, both have not shared any concerns. The papers presented today will also be shared with them.

Breast Service Options update

a) The paper has been enhanced from last month to answer some questions that were raised.
b) It has been explained why option one did not have a significant impact on activity. Option one included more support posts which are operational management and leadership development posts. There is an increased level of training flexibility so that the Trust could grow and sustain its own workforce.
c) The paper now explains why the Trust would not consider closing the service under option nine.
d) The paper was approved.

Automation in Medicines management – a vision for the future

a) Discussions have been had around pharmacy robots and what technology can do for pharmacy. Technology that is already available has been looked at.
b) The future for medicines management is to use closed loop medicines admin systems which are computer supported, using bar codes. This ensures that the right patient is given the right drug at the right time.
c) There are around 237m medication errors in the NHS annually, 54% are administration errors. MFT has 700-800 per year, administration errors account for 35% - 39%. The Trust can improve on this.
d) Patients medical records from their GP, what they are taking on admission and what medicines they are on when discharged are looked at by pharmacy staff. Their medicine plan is then drawn up from medicines in the medicine directory. Assessments are done before medicines are prescribed. The pharmacist insures that the most appropriate and cost effective medicines are then prescribed.
e) This will also work within an outpatient setting. Once a drug is prescribed the prescription will go to a pharmacy of the patient's choice, this is the EPS (Electronic Prescription Service)
f) 2,500 of Medway patients are treated in their own homes, currently this is done manually but can be done electronically going forward through the Bluetech system. This will be run through an automated drug cabinet, which will open the correct slot for the patients medication. Only authorised personnel can access the automated drug cabinet which will be done through fingerprints or a retinal scan. This secure storage can interface with the pharmacy systems, so that an accurate inventory of what has been used and what needs to be replenished can be kept. Information will be sent to the pharmacy robot who generates the order and replenishes the cabinet.
g) Controlled drugs are easier to apply with automated cabinets, checks etc completed by the cabinet.
h) Stock management for approval of drugs and electronic invoices are submitted.
i) The business case for this project is currently with EPR.

Elective Recovery report

a) The plan has been submitted to NHSE. The full ERF target for Inpatients, Outpatients, day case and Outpatient appointments needs to be met.
b) There are risks to the plan, such as industrial action and winter pressures, that have been mitigated through Harvey Ward coming on-line, Length of Stay reductions and Tele Tracking etc.
c) Recruitment plans are being worked on by HR in hard to recruit areas such as anaesthetics.
d) MFT has set a stretch target of 119% (33,455) against activity delivered in 2019/20, there is a gap of 2885k against the target. PIDs are being put together by each service area in Planned Care to detail the type of activity they want to put through the additional capacity. PIDs are being prioritised and approved. The cases with less clinical risk will be done in the additional sessions at the weekend.
e) The Trust is currently achieving the national productivity standard of 85%.

Highlights from sub-groups reporting into this group

(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)

Items to come back to the Group

(Items the Group is keeping an eye on outside its routine business cycle)

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

Item	Group, Subcommittee, Committee	Date

Reports not received as per the annual workplan and action required

Items/risks/issues for escalation

(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)

Issues and or Risks to note:

Further more detailed deep dives into the nursing position and the medical staffing overspend are to be done in the form of an A3 to be discussed at the breakthrough huddles. Reports will be submitted at the next FPPC in July.

Reflection:

Implications for the corporate risk register or Board Assurance Framework

Examples of outstanding practice or innovation

Meeting of the Board of Directors in Public
Wednesday, 12 July 2023

<table>
<tr><td>Title of Report</td><td colspan="3">Finance Report – Month 2</td><td>Agenda Item</td><td>7.2</td></tr>
<tr><td>Author</td><td colspan="5">Alan Davies, Chief Finance Officer
Matthew Chapman, Head of Financial Management
Cleo Chella, Associate Director Income and Contracts
Isla Fraser, Financial Controller</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Alan Davies – Chief Finance Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">a) The Trust reports a £2.5m deficit for month 2, this being per the plan for the month.
b) Activity performance is behind plan – due to the industrial action and mobilisation of resources – but no potential income impact of this is yet reflected in the results.
c) Efficiencies performed to plan at the Trust level, although this was predicated on the full year effect of schemes from 2022/23 rather than implementation of new schemes. The monthly target for the Trust begins to grow from realisation of new schemes from months 3 and 4.
d) There is a risk to delivery of the month 3 control total due to emerging pressures.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">The Trust Board is asked to NOTE this report</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td></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>(If appropriate) state reason for submission to Private section of Board:</td><td>Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td colspan="2">Exceptional Circumstances:</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Finance, Performance and Planning Committee</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td colspan="5">Priority 1: (Sustainability) ✓ | Priority 2: (People) | Priority 3: (Patients) | Priority 4: (Quality) | Priority 5: (Systems)</td></tr>
</table>

<table>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</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">Non-delivery of the breakeven control total</td></tr>
<tr><td>Resource implications:</td><td colspan="5">N/A</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="5">N/A</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="5">Achieving breakeven is a statutory duty</td></tr>
<tr><td>Appendices:</td><td colspan="5">N/A</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="5">This paper is disclosable under the FOI Act</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="5">Alan Davies – Chief Finance Officer
alan.Davies13@nhs.net</td></tr>
<tr><td rowspan="5">Reports require an assurance rating to guide the discussion:</td><td colspan="2">No Assurance</td><td colspan="3">There are significant gaps in assurance or actions</td></tr>
<tr><td colspan="2">Partial Assurance</td><td colspan="3">There are gaps in assurance</td></tr>
<tr><td colspan="2">Assurance</td><td colspan="3">Assurance with minor improvements needed.</td></tr>
<tr><td colspan="2">Significant Assurance</td><td colspan="3">There are no gaps in assurance</td></tr>
<tr><td colspan="2">Not Applicable</td><td colspan="3">No assurance required.</td></tr>
</table>

Finance report

For the period ending 31 May 2023

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1. Executive summary
2. Income and expenditure
3. Activity and income
4. Efficiencies programme
5. Balance sheet
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1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(2,483)	(2,473)	10	The Trust reports a £2,473k deficit position for May, decreasing to £2,451k after making the technical adjustments for donated assets. This position is £34k favourable year to date (YTD) to the financial plan agreed with the ICB and submitted to NHSE. The position also includes Elective Services Recovery Funding (ESRF) income of £2.6m YTD; there is a risk of repayment if ERF activity targets are not met. There is a concern that month 3 could realise an adverse financial performance; this arises due to an underlying run-rate that is adverse to plan and cannot be mitigated through central means, coupled with emerging risks.
Donated Asset Depreciation	32	22	(10)	
In-month total	**(2,451)**	**(2,451)**	**(0)**	
YTD total (adjusted)	**(4,922)**	**(4,888)**	**34**	
Efficiencies Programme				
In-month	271	299	28	The delivered efficiency programme position of £0.3m for May is slightly favourable to plan with delivery mainly from procurement savings, full year effect of 22/23 schemes and patient flow length of stay scheme in the Unplanned and Integrated Care division. The total savings plan target for the year is £27m.
YTD	541	600	59	
Cash				
Month end	32,461	31,333	(1,128)	Cash is 3% adverse to plan, this is a minor variance which raises no concern.
Capital				
In-month	1,877	400	(1,477)	Capital Funding available to the Trust at the start of 2023/24 was £22.6m, this consisted of: - £12.4m system capital. This is set by the system but self-funded by internal depreciation for the year, which is expected to be £18.4m. - £10.1m of PDC is already secured for the continuation of existing projects: EPR, CDC, Endoscopy and PACS/RIS Since Month 1 the ICB have confirmed that the £1m CDC underspend in 2022/23 will be brought into the Trust 2023/24 capital resource limit(CRL), increasing system capital to £13.4m, and the overall CRL to £23.6m Additional PDC bids for bed capacity, other IT schemes and diagnostic equipment have been submitted to the ICB/NHSE. Approval has been provisionally provided for the bed capacity bid although at a significantly reduced value; the Trust is liaising to confirm before official notification is provided and the CRL increased.
Forecast	23,563	23,563	0	
Of which				
System Capital	13,423	13,423	0	
Donations Capital	0	0	0	
PDC Capital	10,140	10,140	0	

2. Income and expenditure

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	29,492	30,012	519	58,985	59,678	693
High cost drugs	2,041	2,111	70	4,083	4,145	62
Other income	2,353	2,652	299	4,735	5,142	407
Donated Asset Adjustment	-	-	-	-	(29)	(29)
Total income	**33,887**	**34,775**	**889**	**67,803**	**68,936**	**1,133**
Nursing	(8,871)	(9,504)	(632)	(17,749)	(18,711)	(963)
Medical	(6,798)	(7,775)	(976)	(13,550)	(15,552)	(2,002)
Other	(6,526)	(6,038)	489	(13,122)	(12,157)	965
Total pay	**(22,196)**	**(23,316)**	**(1,119)**	**(44,421)**	**(46,420)**	**(2,000)**
Clinical supplies	(4,023)	(4,169)	(146)	(8,676)	(8,369)	307
Drugs	(937)	(1,112)	(176)	(1,873)	(2,130)	(257)
High cost drugs	(2,041)	(2,194)	(153)	(4,083)	(4,135)	(53)
Other	(5,049)	(4,229)	821	(9,470)	(8,654)	816
Total non-pay	**(12,050)**	**(11,704)**	**346**	**(24,102)**	**(23,287)**	**814**
EBITDA	**(360)**	**(244)**	**116**	**(720)**	**(772)**	**(52)**
Depreciation	(1,498)	(1,575)	(77)	(3,016)	(3,016)	-
Donated asset adjustment	(32)	(22)	10	(44)	(44)	-
Net finance income/(cost)	96	138	42	192	277	86
PDC dividend	(689)	(771)	(82)	(1,378)	(1,378)	-
Non-operating exp.	**(2,123)**	**(2,229)**	**(106)**	**(4,246)**	**(4,161)**	**86**
Reported surplus/(deficit)	**(2,483)**	**(2,473)**	**10**	**(4,966)**	**(4,932)**	**34**
Adj. to control total	32	22	(10)	44	44	0
Control total	**(2,451)**	**(2,451)**	**(0)**	**(4,922)**	**(4,888)**	**34**

1. The YTD clinical income includes Elective Services Recovery Fund ("ESRF") funding of £2.6m; this figure is reported on plan however there is a risk of repayment if agreed activity targets are not achieved in quarter 1.
2. The associated cost to the independent sector healthcare providers and additional consultant sessions to deliver ESRF activity is £1.0m YTD.
3. Other income includes recharges for pass through clinical supplies and drugs costs that are recorded in the relevant non-pay category. Also included are the NHS provider to provider contracts, car parking income, F&E retail income and medical education contribution to overheads.
4. Pay budgets are reporting a £1.1m adverse position in month and £2.0m YTD. The main drivers of the overspending continue to be premium costs for junior doctors to cover vacancies within the medical rota, temporary theatres staff, industrial action and non-delivery of the divisional efficiency programmes.
5. The recently announced pay award will be paid in June; it is estimated the cost will be £9.5m for the year and will fully utilise the pay inflation reserve; further funding from NHSE/ICB is anticipated. The cost estimate does not include any increase for medical staff. The non-consolidated and one off payments related to 2022/23 were accrued into that financial year along with funding.

3. Activity and Income

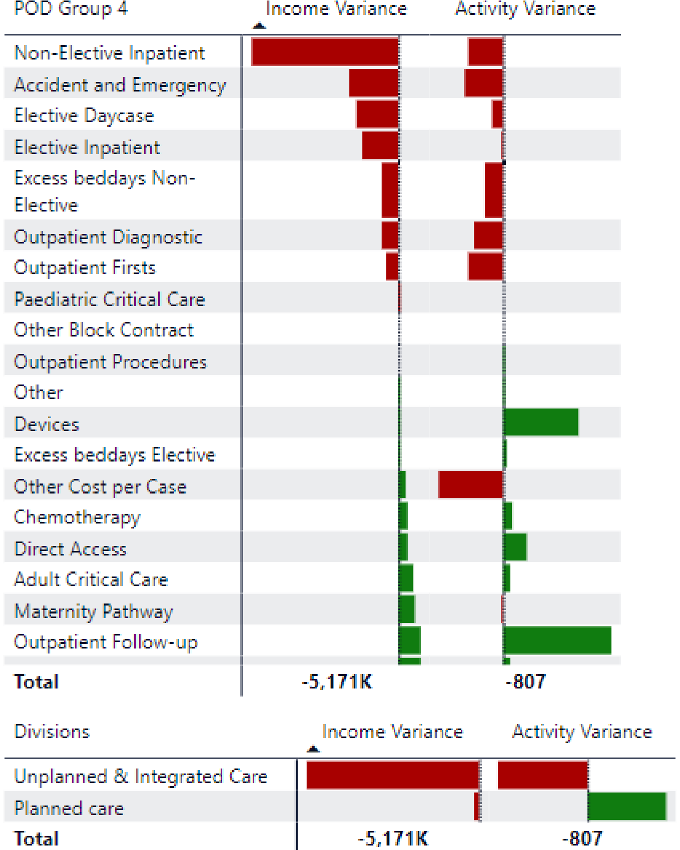
POD Group	Planned care YTD Plan £'000s	Planned care YTD Actual £'000s	Planned care YTD Variance £'000s	Unplanned & Integrated Care YTD Plan £'000s	Unplanned & Integrated Care YTD Actual £'000s	Unplanned & Integrated Care YTD Variance £'000s	Totals YTD Plan £'000s	Totals YTD Actual £'000s	Totals YTD Variance £'000s
Accident and Emergency	0	0	0	3,316	2,131	(1,185)	3,316	2,131	(1,185)
Adult Critical Care	1,461	1,810	349	0	0	0	1,461	1,810	349
Chemotherapy	218	362	144	6	69	63	224	431	207
Devices	55	0	(55)	384	476	92	439	476	37
Direct Access	113	176	63	1,764	1,911	147	1,877	2,087	210
Elective Daycase	3,150	2,261	(889)	1,138	1,019	(119)	4,288	3,280	(1,008)
Elective Inpatient	3,618	2,755	(863)	81	70	(11)	3,699	2,825	(874)
Excess beddays Elective	14	52	38	33	42	9	46	94	48
Excess beddays Non-Elective	286	426	139	863	333	(530)	1,149	758	(391)
High Cost Drugs	982	1,106	124	2,721	3,039	317	3,704	4,145	441
Maternity Pathway	1,392	1,813	421	0	0	0	1,392	1,813	421
Neonatal Critical Care	1,753	2,305	552	0	0	0	1,753	2,305	552
Non-Elective Inpatient	8,949	8,902	(47)	13,267	9,738	(3,529)	22,215	18,640	(3,575)
Other	51	60	9	24	23	(2)	75	82	7
Other Block Contract	279	279	0	277	277	0	555	555	0
Other Cost per Case	494	335	(159)	37	364	327	532	700	168
Outpatient Diagnostic	0	226	226	1,177	567	(610)	1,177	792	(385)
Outpatient Firsts	2,005	1,537	(468)	809	983	174	2,814	2,520	(294)
Outpatient Follow-up	903	1,275	372	1,132	1,305	173	2,035	2,580	545
Outpatient Procedures	1,250	1,256	6	99	94	(5)	1,348	1,350	2
Paediatric Critical Care	37	33	(4)	0	0	0	37	33	(4)
Total PbR Income	27,009	26,968	(42)	27,127	22,439	(4,688)	54,137	49,407	(4,730)
Block Adjustment K&M ICB							7,745	12,551	4,806
Block Adjustment SEL ICB							(51)	(69)	(19)
Block Adjustment Spec Comm							764	389	(375)
Block Adjustment NHSE Other							60	(14)	(74)
Block Adjustment LVA							(571)	(180)	391
Total Block Adjustments							**7,948**	**12,677**	**4,730**
Total Block Income							**62,084**	**62,084**	**(0)**

The table sets out the income and activity performance for the Trust at point of delivery ("POD") for the year to date as at month 2. The Trust is below plan by £4.7m overall, including HCD.

- All clinical income has been devolved to divisions based on activity plans priced using the NHS Payment System ("NHSPS") and local prices where applicable.
- The Trust has a benefit of £4.7m in its income position at M2 compared to the value of activity using the NHSPS.
- Planned Care division is £0.4m below plan, driven by underperformance in elective inpatients and in day cases, which is partly offset by over performance in both adult critical care and neonatal critical care. The underperformance is because additional sessions to deliver the ESRF target have not yet started.
- Unplanned care is £4.7m below plan, most of which is driven by non-elective underperformance (£3.6m) and A&E (£1.2m).

M2 Income and activity by POD (excl. HCD)

The underperformance in M2 for the SLA income based on national tariff is £5.2m (excluding high cost drugs). The underperformance is mostly driven by low activity in admitted patient care; this is explored further below.



POD Group 4	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Non-Elective Inpatient	£22,215K	£18,640K	-3,575K	9,513	7,146	-2,367
Accident and Emergency	£3,316K	£2,131K	-1,185K	17,548	14,899	-2,649
Elective Daycase	£4,288K	£3,280K	-1,008K	4,566	3,721	-845
Elective Inpatient	£3,699K	£2,825K	-874K	904	662	-242
Excess beddays Non-Elective	£1,149K	£758K	-391K	3,611	2,296	-1,315
Outpatient Diagnostic	£1,177K	£792K	-385K	9,816	7,796	-2,020
Outpatient Firsts	£2,814K	£2,520K	-294K	20,472	18,098	-2,374
Paediatric Critical Care	£37K	£33K	-4K	49	44	-5
Other Block Contract	£555K	£555K	0K	5,073	5,073	0
Outpatient Procedures	£1,348K	£1,350K	2K	6,429	6,470	41
Other	£75K	£82K	7K	591	649	58
Devices	£439K	£476K	37K	7,856	12,923	5,067
Excess beddays Elective	£46K	£94K	48K	131	275	144
Other Cost per Case	£532K	£700K	168K	10,948	6,571	-4,377
Chemotherapy	£224K	£431K	207K	1,348	1,965	617
Direct Access	£1,877K	£2,087K	210K	419,225	420,774	1,549
Adult Critical Care	£1,461K	£1,810K	349K	1,176	1,573	397
Maternity Pathway	£1,392K	£1,813K	421K	1,670	1,437	-233
Outpatient Follow-up	£2,035K	£2,580K	545K	23,595	30,865	7,270
Neonatal Critical Care	£1,753K	£2,305K	552K	1,748	2,225	477
Total	**£50,433K**	**£45,262K**	**-5,171K**	**546,269**	**545,462**	**-807**

Divisions	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Unplanned & Integrated Care	£24,406K	£19,401K	-5,005K	492,399	485,541	-6,858
Planned care	£26,027K	£25,861K	-166K	53,870	59,921	6,051
Total	**£50,433K**	**£45,262K**	**-5,171K**	**546,269**	**545,462**	**-807**

M2 Income and activity by POD (excl. HCD)

- Non-elective underperformance is £4m YTD at M2 including excess bed days. This is due to low activity delivery, lower than that delivered at the same time last year by 12%. Over 50% of the underperformance is driven by Geriatric medicine £2.6m and others include Diabetic Medicine £0.9m, Gastroenterology £0.9m and Respiratory £0.6m. There is offset by over performance in General Medicine of £2m
- Elective inpatients and day cases are £1.9m below plan, driven by low activity YTD at M2. Work to deliver the ESRF via additional sessions and insourcing is yet to commence but the activity plan assumed that this would begin in April.
- Outpatient income for first attendances is below plan by £0.3m, mainly driven by low activity in T&O £101k and Paediatrics £101k. This is linked to the ESRF comment above.
- ESRF performance is below the target YTD at M2 by £1.4m due to activity being below the plan. Under ESRF rules, this underperformance be clawed back by the ICB however this has not been reflected in the financial position at this stage. The performance is expected to improve as additional activity to deliver the target commences.
- Outpatient income for follow up attendances is above plan by £0.6m. This activity is paid as part of the fixed element and does not form part of ESRF. The expectation is to transfer resources to deliver more OP firsts and reduce the OP follow ups in year.
- Chemotherapy treatments are above the activity and financial plan of £0.2m at M2. This this is paid on cost and volume basis by NHSE as part of the variable element of the Aligned Payment and Incentive (“API”) contract.
- Direct access activity is above plan by £0.2m due to over performance in Cardiology. Direct Access Radiology, which is part of the variable element of the contract, is below plan £87k.
- Neonatal cot days are above plan and resulting in a favourable income of £0.5m at M2 and 341 days above plan.

4. Efficiency programme

Status £'000	Blue	Green	Amber	Red	Sub-total	Cross Cutting	Sub-total Identified	Over / (un-) identified	Plan Target	YTD Plan	YTD Delivery	Variance
Planned care	112	0	866	304	1,282	2,054	3,336	(2,467)	5,803	192	68	**(124)**
UIC	0	0	8	525	532	2,898	3,430	(2,141)	5,571	138	330	**192**
E&F	251	430	0	0	681	0	681	(594)	1,275	84	98	**14**
Corporate	6	57	77	0	140	123	264	(1,087)	1,351	43	38	**(5)**
Central	0	0	0	0	0	5,661	5,661	5,661	0	84	61	**(22)**
Sub-total	**369**	**487**	**951**	**829**	**2,636**	**10,736**	**13,372**	**(628)**	**14,000**	**541**	**596**	**55**
Stretch	0	0	0	0	0	450	450	450	0	0	0	**0**
Unidentified	0	0	0	0	0	0	0	(13,000)	13,000	0	0	**0**
Total	**369**	**487**	**951**	**829**	**2,636**	**11,186**	**13,822**	**(13,178)**	**27,000**	**541**	**596**	**55**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**271**	**299**	**28**	**542**	**599**	**57**	**27,000**	**27,000**	**-**

Process

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

The delivered efficiency programme position for the year is £0.6m; this includes £0.4m from the cross cutting schemes, mainly for procurement, and patient flow length of stay reduction.

The efficiency programme continues to be prioritised with more project management capacity being proposed and sourced. Services continue to identify and develop more schemes, some of which will be implemented over the first quarter of 2023/24, with the majority coming online from quarter 2.

5. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
273,519	**Non-current assets**	**271,405**	**(2,114)**
6,375	Inventory	6,425	50
29,089	Trade and other receivables	31,141	2,052
34,742	Cash	31,333	(3,409)
70,206	**Current assets**	**68,899**	**(1,307)**
(953)	Borrowings	(837)	116
(50,284)	Trade and other payables	(50,654)	(370)
(1,320)	Other liabilities	(2,641)	(1,321)
(52,557)	**Current liabilities**	**(54,132)**	**(1,575)**
(1,952)	Borrowings	(1,888)	64
(1,031)	Other liabilities	(1,031)	0
(2,983)	**Non-current liabilities**	**(2,919)**	**64**
288,185	**Net assets employed**	**283,253**	**(4,932)**
475,198	Public dividend capital	475,198	0
(251,419)	Retained earnings	(256,351)	(4,932)
64,406	Revaluation reserve	64,406	0
288,185	**Total taxpayers' equity**	**285,253**	**(4,932)**

Key messages:

1. Non-current assets are £2.1m lower than year end, being the net impact of investment expenditure of £0.9m and £3.0m depreciation.

2. Trade and other receivables are £31.1m (91% of average monthly income).
   Trade receivables are £13.5m (42%)*, which is a £3.2m improvement on the 2022/23 closing balance due to settlement of a large ICB debt. More than £9.8m (75%) is overdue for payment. A credit loss provision of £4.2m is held to offset 43% of this risk. The remaining balance is inter-NHS debt which is deemed to be risk free.*
   Prepayments are £3.7m (11.9%) this will unwind across the year.
   Income accruals are £17.4m (56%) £4.5m higher than the 2022/23 closing balance; this is due to the ICB underpaying on their contract YTD.

3. Cash has decreased by £3.4m due to the deficit.

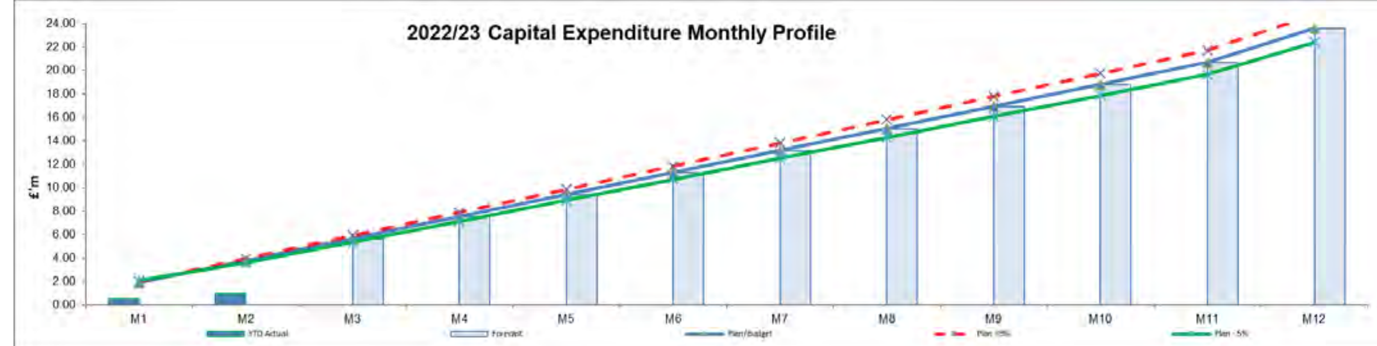
4. Trade and other payables are £50.6m (143% of average monthly expenditure).
   Trade payables are £18.3m (36%), which is a £0.6m improvement on the 2022/23 closing balance due to a higher than average level of capital payables at year due to late allocation of funds.
   In month 2 the Trust is compliant YTD with the Better Payment Practice Code (BPPC) target of 95%, the current rate is 95.1%.
   Pension, social security and other tax payables are £9.4m (19%) which is contractually one month in arrears.
   PDC Dividends payables are £1.8m (4%) DHSC collect dividends bi annually.
   Expenditure accruals, costs in the position without an invoice are £21.1m (42%), this balance has increased by £0.4m on the prior year end.

5. Other liabilities are £1.3m higher as a result of deferred income relating to the Q1 HEE income received in April.

6. Capital

2023/24 Capital Expenditure Update

£'000	In-month			Year To Date			Annual				Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	NHSE Reported Variance	Internal (system capital)	PDC	OTHER
Backlog Maintenance	207	(84)	(291)	413	134	(279)	2,480	2,480	2,480	0	2,480	0	0
Routine Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire	104	(91)	(195)	208	(79)	(287)	972	1,251	1,251	0	1,251	0	0
Medical and Surgical Equipment Programme	406	(120)	(526)	812	55	(757)	5,150	4,871	4,871	0	4,871	0	0
IT	47	51	4	94	64	(30)	1,362	562	562	0	562	0	0
Service Developments	217	0	(217)	435	0	(435)	2,451	2,609	2,609	0	2,451	0	0
Total System Capital	**981**	**(244)**	**(1,225)**	**1,962**	**174**	**(1,788)**	**12,415**	**11,773**	**11,773**	**0**	**11,615**	**0**	**0**
IT - EPR	167	279	112	333	57	(276)	1,200	2,000	2,000	0	800	1,200	0
IT - PACS/RIS	6	(3)	(9)	13	3	(10)	76	76	76	0	0	76	0
Endoscopy	192	0	(192)	383	(1)	(384)	2,300	2,300	2,300	0	0	2,300	0
CDC	547	468	(79)	1,094	486	(608)	6,564	7,572	7,572	0	1,008	6,564	0
Total Planned Additional Capital	**912**	**744**	**(168)**	**1,823**	**545**	**(1,278)**	**10,140**	**11,948**	**11,948**	**0**	**1,808**	**10,140**	**0**
Total Planned Capital	**1,893**	**500**	**(1,393)**	**3,785**	**719**	**(3,066)**	**22,555**	**23,721**	**23,721**	**0**	**13,423**	**10,140**	**0**
Cardio Village	0	0	0	0	0	0	0	0	0	0	0	0	0
IT- Paeds Adoption	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Additional Capex	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Unplanned Expenditure*	0	(21)	(21)	0	225	225	0	0	0	0	0	0	0
Slippage Target	(13)	(79)	(66)	(26)	0	26	0	(158)	(158)	0	0	0	0
Total Capex	**1,880**	**400**	**(1,480)**	**3,759**	**944**	**(2,815)**	**22,555**	**23,563**	**23,563**	**0**	**13,423**	**10,140**	**0**

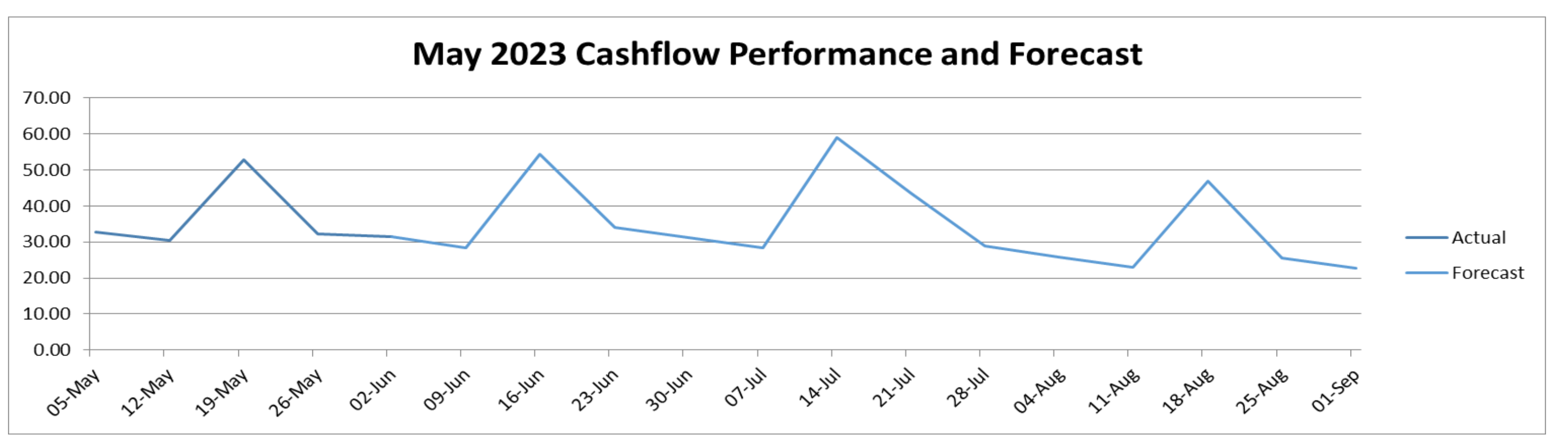


The capital programme at month 2 is 74% / £2.8m behind the NHSE submitted plan, which without detail was phased in equal 12ths. Since the submission, a detailed operational plan has been approved; this was delayed but is a significant improvement on the prior year timeline when the plan was not approved until month 6. This does mean project commencement was delayed resulting in the current slippage. Currently there are no indications that any agreed projects will not deliver and so the forecast is to deliver on plan for the year.

7. Cash

13 Week Forecast w/e

£m	Actual					Forecast												
	05/05/23	12/05/23	19/05/23	26/05/23	02/06/23	09/06/23	16/06/23	23/06/23	30/06/23	07/07/23	14/07/23	21/07/23	28/07/23	04/08/23	11/08/23	18/08/23	25/08/23	01/09/23
BANK BALANCE B/FWD	**30.40**	**32.71**	**30.39**	**52.75**	**32.29**	**31.43**	**28.52**	**54.53**	**33.96**	**31.30**	**28.38**	**58.95**	**43.57**	**28.91**	**25.94**	**23.03**	**46.98**	**25.70**
Receipts																		
NHS Contract Income	3.57	0.03	30.25	0.00	0.19	0.00	30.66	8.00	0.00	0.00	31.96	0.00	0.00	0.00	0.00	31.96	0.00	0.00
Other	0.18	0.16	0.36	0.29	0.76	0.31	0.38	0.40	0.58	0.31	3.64	0.40	0.58	0.25	0.31	0.53	0.58	0.25
Total receipts	**3.75**	**0.19**	**30.61**	**0.29**	**0.95**	**0.31**	**31.04**	**8.40**	**0.58**	**0.31**	**35.60**	**0.40**	**0.58**	**0.25**	**0.31**	**32.49**	**0.58**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(0.42)	(0.46)	(3.65)	(17.86)	(0.50)	(0.42)	(0.42)	(26.17)	(0.45)	(0.42)	(0.42)	(12.98)	(12.45)	(0.42)	(0.42)	(3.94)	(19.06)	(0.45)
Non Pay Expenditure	(0.97)	(1.99)	(4.36)	(2.49)	(1.28)	(2.51)	(4.41)	(2.60)	(2.60)	(2.60)	(4.41)	(2.60)	(2.60)	(2.60)	(2.60)	(4.41)	(2.60)	(2.60)
Capital Expenditure	(0.05)	(0.07)	(0.15)	(0.40)	(0.03)	(0.29)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)
Total payments	**(1.43)**	**(2.52)**	**(8.17)**	**(20.75)**	**(1.81)**	**(3.22)**	**(5.03)**	**(28.97)**	**(3.25)**	**(3.22)**	**(5.03)**	**(15.78)**	**(15.25)**	**(3.22)**	**(3.22)**	**(8.54)**	**(21.86)**	**(3.24)**
Net Receipts/ (Payments)	**2.32**	**(2.33)**	**22.44**	**(20.46)**	**(0.86)**	**(2.91)**	**26.01**	**(20.57)**	**(2.67)**	**(2.92)**	**30.57**	**(15.38)**	**(14.67)**	**(2.97)**	**(2.91)**	**23.95**	**(21.28)**	**(2.99)**
Funding Flows																		
Loan Repayment/Interest payable	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**32.71**	**30.39**	**52.75**	**32.29**	**31.43**	**28.52**	**54.53**	**33.96**	**31.30**	**28.38**	**58.95**	**43.57**	**28.91**	**25.94**	**23.03**	**46.98**	**25.70**	**22.71**



Prior year end	£'000	Month end actual	Var.
34,742	Cash	31,333	(3,409)

The overall cash balance has increased by £0.9m in May.

£35.2m of cash was received in month
£33.9m NHS contract income for the month, £1.3m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£34.3m of cash was paid out by the Trust in month
£13.0m (38%) in direct salary costs to substantive and bank employees.
£9.5m (28%) employer costs to HMRC and NHS Pensions
£11.8m (34%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

8. Risks and Forecast

The Trust will undertake full forecasting of its year end outturn from Q2. The key risks to delivery of the operating plan in 2023/24 and their mitigating actions are set out in full in the risk register; in summary these are as follows. (NB – a number of the risks are not quantified at this time as the range is variable and performance potentially volatile.)

Risk	£	Risk score	Mitigating actions
Delivery of the activity plan / ESRF.	TBC	25	• Fully costed plans to deliver target activity levels. • Approval of plans and release of budgeted ESRF reserve to deliver the work. • Monitoring and reporting mechanism
The Trust's capital proposals significantly exceed its allocation.	TBC	12	• Positive confirmation from care groups/divisions of completeness of 5-year capital programme as part of business planning. • Minimum twice yearly review of 5-year capital programme by stakeholders. • Projects on the 5-year capital programme to develop their PIDs/business cases to seek approval should funding become available at short notice.
Identification, development and delivery of the £27m efficiencies programme.	£13.2m (unidentified value)	20	• Sign off the 23/24 cross-cutting schemes at panel. • Progression of 23/24 divisional schemes through the approval panel. • Development of the pipeline / stretch schemes. • Agreement and implementation of the proposed PMO arrangements.
The Trust may not have sufficiently funded/budgeted bed capacity during the year/in winter.	TBC	12	• Capacity and capital planning meetings to proceed. • Follow up and respond to queries with NHSE following submission of UEC capacity funding bid. Implement capital projects thereafter if successful. • Further development and approval of the Patient Flow and Discharge project initiation document at panel. • Detailed plans and funding for step down beds to be developed and agreed.
The system is exploring harmonisation of bank rates, which would create an unfunded cost pressure for the Trust.	c£3m	16	• Resist rate increase within the system. • Quantify the unfunded pressure and seek monies from the system.
Cost inflation exceeds the tariff inflation provided for this purpose.	TBC	9	• Use of NHS Supply Chain as far as possible. • Robust contract renegotiation where expiring.

In addition to the above, there are emerging risks that may crystallise in June/month 3 that would cause the Trust to report an adverse financial performance if the underlying run-rate does not improve. These include:

- ESRF risk as previously outlined, should any underperformance monies need repayment. This risk is c£1.4m at month 2 and could grow.
- The Agenda for Change pay award for 2023/24 has not been accrued; on payment in month 3 this could give rise to a pressure of c£0.8m.
- There is a potential double count of CDC income; if this is the case the risk could be c£0.6m.
- Efficiency plans increase to an in-month target of almost £1m from c£0.3m.

9. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is £2.5m deficit in-month and £5.0m deficit YTD; this delivers the submitted plan position as agreed with the ICB and NHSE.

The efficiency programme has delivered £0.6m in-month and is slightly favourable to the plan, however further work is required to identify, develop and implement the schemes to deliver the full year target of £27m. Total ESRF income of £2.6m has been included, with £1.0m of costs incurred through use of the independent sector and additional consultant sessions.

There is a concern that month 3 could realise an adverse financial performance; this arises due to an underlying run-rate that is adverse to plan and cannot be mitigated through central means, coupled with emerging risks.

Alan Davies
Chief Financial Officer
June 2023

Meeting of the Trust Board of Directors
Wednesday, 12 July 2023

Title of Report	Trust Annual Report and Accounts 2022-23		**Agenda Item**	7.3
Author	Matthew Capper, Director of Strategy and Partnership/Company Secretary			
Lead Executive Director	Jayne Black, Chief Executive			
Executive Summary	This is the Annual Report for Medway NHS Foundation Trust covering the reporting period of April 2022 to March 2023. The Annual Report is made up of a number of required elements, these include - Annual Accounts, Annual Quality Accounts, Assurance statements. The production of an Annual report is a statutory requirement and the document is audited by our external auditors for compliance against the national Annual Report manual for Foundation Trust criteria.			
Proposal and/or key recommendation:	The Trust Board is asked to **NOTE/APPROVE** the contents of the document for final sign off.			
Purpose of the report (tick box to indicate)	Assurance		**Approval**	X
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	This paper has been presented and approved at the Audit and Risk Committee, before being presented to the Board for final sign-off.			

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:	Caring:	Responsive:	**Well-Led:** X

Identified Risks, issues and mitigations:	It is a statutory requirement to produce Annual Accounts, Annual Quality Accounts, and Assurance statements. Therefore, non-adherence to this requirement will result in qualifications being level at the Trust and undertakings being issued by NHS England.
Resource implications:	None
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	As Risks section
Appendices:	Trust Annual Report and Accounts 2022/2023 (word version)
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:	Matthew Capper, Director of Strategy and Partnership/Company Secretary m.capper@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.

Patient FIRST

Medway NHS Foundation Trust Annual Report and Accounts 2022/2023

Presented to Parliament pursuant to Schedule 7, Paragraph 25 (4) (a) of the National Health Service Act 2006

Forward from the Chief Executive and Chair

Chief Executive Overview

We are proud to be at the centre of our community and throughout 2022/23 our hard-working colleagues continued to serve the residents of Medway and Swale with great professionalism and compassion. I would like to thank them all for their outstanding commitment to providing care of the highest quality to our patients.

I would also like to take this opportunity to thank local our patients for their ongoing support. Thank you for your understanding when we had to make the very difficult decision to cancel appointments because of industrial action and for being patient when the waits for care were longer than we would have liked. Our staff continue to work very hard to reduce backlogs and ensure that you receive your appointment in a timely manner, and although we have had some success in doing so, we know there is still much more to do.

We know that receiving prompt emergency care is of vital importance to our community, which is why colleagues have been working hard to improve the responsiveness of our care. We have seen some good progress with our four-hour waiting times, but we want to ensure that we are able to deliver timely care every time, and that remains our focus.

We were delighted to improve the experience and outcome for some of our most vulnerable patients who arrive at our Emergency Department (ED), through our relaunched Accelerated Hip Fracture Pathway. The pathway was originally launched by our ED Team in 2016 with great success and received national praise due to its innovative approach and significant improvements. We were pleased to reintroduce this pathway and start offering the best possible care to our patients once again.
We also launched our new acute medical model at the Trust. The initiative is supported by NHS England and brings a new model to the Trust for patients with an acute medical need. As a result, we saw an immediate improvement in ambulance handover times.

We were delighted to see the hard work of our urgent and emergency care colleagues. Inspectors noted significant improvements since their previous inspection in December 2020 and rated the service as ‘Good’ overall. It had previously been rated as ‘Inadequate’.

In the report, inspectors commended staff for managing infection control risks, assessing risks to patients, and acting upon them. They praised the way care was planned to meet the needs of local people and individual patients. They also reported that staff felt respected, valued, and supported and that they were focused on the needs of patients receiving care.

Providing high-quality care for our cancer patients remains an important priority for the Trust and the fantastic work of our Cancer Services Team was recognised when they were named south east regional winner at the NHS Parliamentary Awards 2022 in the ‘Excellence in Healthcare’ category. The team scooped the award after being nominated by local MP Rehman Chishti, following significant improvements which saw the Trust achieve the national standard in four key areas of cancer care. Having timely access to imaging services is an important part of a patient’s healthcare journey and we were pleased to welcome a new MRI scanner to our site. The new mobile scanner helped patients get their diagnostic appointments quicker and reduced the number of people waiting for scans, which had increased since the COVID-19 pandemic.

We want to ensure that our care continues to be easily accessible for our communities and this year we were proud to open the Sheppey Frailty Unit. The unit, based in Sheppey Community Hospital, provides care to frail elderly patients closer to their homes in Swale. It also has the added advantage of freeing capacity within Medway Maritime Hospital enabling us to allocate further beds for planned operations and treatment.

This year we were proud to launch Patient First, our new, dynamic approach to providing excellent care, every time. Patient First helps us to improve the care and services we provide to the people of Medway and Swale by allowing us to target priorities that can have a big impact quickly. With this approach, we can deliver real and lasting change over time.

We are also continuing to work on the development of a Community Diagnostic Centre (CDC) with a hub at Sheppey Community Hospital, and a spoke site at Rochester Healthy Living Centre. Both sites will provide a range of new diagnostic services, including CT scans, MRIs, ECGs and x-rays, and will significantly improve the accessibility of these services to patients. Work is due begin in 2023 with new services being introduced over a two-year period, working towards achieving a seven-day, 12-hour-a-day service by 2025.

At Medway, we remain committed to embracing technology to improve care for our patients and the Trust took another step forward on its digital transformation journey when we went live with Electronic Prescribing and Medicines Administration (EPMA), and Electronic Discharge Notification (EDN) as part of our Sunrise Electronic Patient Records project.

The Emergency Department also went live with Sunrise. Once EPR is fully in place across the hospital, all information about a patient's medical history and treatment will be available electronically, on screen, at any location, at any time.

We also launched our new Single Sign-On (SSO) system. Previously some clinical staff had to use as many as 15 computer programmes when tending to a patient, with each requiring its own login details. As well as being time consuming, this required busy staff to remember multiple passwords or use the same one on multiple systems, potentially creating a cyber-security risk. As a result of the new system, the time spent logging into multiple computer systems has reduced significantly, meaning our clinicians are able to spend more time providing patient care.

Our colleagues continue to work hard to ensure that our hospital is financially sustainable; this means living within our means and providing high quality services by optimising the use of our resources. We take seriously our responsibility to get the very best value for the taxpayers of Medway and Swale. Most importantly, we know that by working more efficiently we can provide better and safer care for our patients.
Thank you for your ongoing support as we do our best to deliver the very best of care for local people.

Jayne Black
Chief Executive

Foreword from the Chair

This year has been a year like no other for our country and we were deeply saddened to hear of the death of Her Majesty Queen Elizabeth II. She served her country for 70 years and was an inspiration to so many people; her dedication to her role was second to none. Patients, colleagues, and visitors across the hospital joined more than seven billion people worldwide to watch her funeral.

It has also been a year of significant challenge for the NHS, and my thanks go to all our staff for their skill and compassion in caring for our population. It is important to me they are well supported in every aspect of their working lives.

Providing compassionate and dignified care is a cornerstone for us at Medway and I was proud that in the past year the Trust opened a new Changing Places toilet for people with significant learning and physical disabilities, making us the first acute Trust in Kent and Medway to offer such a facility. Changing Places toilets, which are larger than a standard wheelchair accessible toilet, are specially equipped to ensure those who are unable to use a toilet independently, can use the bathroom with dignity and hygienically.

We also introduced the Dandelion Scheme in our theatre department and recovery areas. The dandelion compassion sign is displayed when a person is expected to die in the next few hours or days, or when a person has just died. The aim is to promote dignity, respect and compassion at the end of life by encouraging a quiet atmosphere for the patient and their relatives at a very difficult time.

As an organisation we remain committed to delivering the highest quality of care to our patients and we have made a great deal of progress in achieving this. Of course, we will not rest on our laurels, and our Patient First programme, and the hard work of our staff, help us to drive improvement through every aspect of our care. There is more to do, and I am excited to see what the year ahead will bring.

I would like to extend my heartfelt gratitude to the League of Friends for their invaluable assistance over the past year. Our longstanding partnership with the Friends is of great importance to our Trust and their unwavering support, in conjunction with the contributions from the Oliver Fisher Trust and our own Trust Charity, has facilitated the purchase of essential items that have significantly benefited both our patients and staff.

I would also like to express my gratitude to our Trust governors for generously contributing their time to serve as a vital liaison between our organisation and the community we serve. Additionally, my sincere appreciation goes to our volunteers, whose kindness and dedication to our patients are indispensable when it comes to providing exceptional care. Without their selfless commitment, we would not be able to deliver the standard of care that we do.

I was very pleased to welcome Jayne Black who took on the role of Chief Executive in the past year. A nurse by background, Jayne has extensive leadership experience in acute, community and the wider healthcare system throughout her career, in a variety of roles, including Director of Operations, Deputy Chief Executive and Chief Operating Officer.

Finally, I would like to express my gratitude to our patients and their families for putting their confidence in us. We consider it a great privilege to serve our community, and we are keenly aware of the responsibility that comes with it.

Jo Palmer
Chair

Overview

Purpose and Activities

Medway NHS Foundation Trust is a public benefit corporation authorised under the National Health Service Act 2006. It is a single-site hospital based in Gillingham and serves a population of more than 427,000 across Medway and Swale.

We provide clinical services to more than half a million patients a year, including more than 180,000 ED attendances, more than 55,000 admissions, more than 360,000 outpatients' appointments and more than 4,500 babies born last year.

As an NHS Foundation Trust, we have 26 seats on the Council of Governors and more than 10,000 public members. We employ more than 4000 staff, making us one of Medway's largest employers. In addition, over 300 volunteers provide invaluable support across the League of Friends, Hospital Radio and the Voluntary Services Department.

The hospital is made up of two clinical divisions – Unplanned and Integrated Care and Planned Care – supported by corporate functions.

The Board of directors, led by Chairman Jo Palmer comprises five executive directors including Jayne Black, Chief Executive, and seven non-executive directors including the Chairman.

Brief History

Medway Maritime Hospital was originally a Royal Naval Hospital, opened by King Edward VII in 1905.

In 1961 the NHS acquired the hospital from the Navy. Buildings and facilities were modernised as part of a £1.5million modernisation scheme and the hospital reopened again as Medway Hospital in 1965. The hospital changed its name in 1999 to mark the start of a new era. The new name 'Medway Maritime Hospital' reflects the hospital's proud naval tradition.

Key Issues and Risks

The principal risks delivering the Trust's Strategic Objectives are recorded in detail in the Board Assurance Framework and the key operational risks are described in the corporate risk register, which are monitored by directorates and by the Executive Group.

A summary of significant risks within the Board Assurance Framework is included within the Annual Governance Statement.

Going Concern

Our going concern disclosure is detailed in the performance report.

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The accounts have been prepared on a going concern basis as we do not intend, nor consider that it will be necessary, to apply to the Secretary of State for the dissolution of the Trust with the transfer of the services to another entity in the foreseeable future.

Summary of Performance

The Trust did not achieve the national standard for the four hour performance target in 2022/23, finishing the year on 72.7% (all types). This was a 9% increase in performance from 2021/22 and only 3% below the national target. The Trust has achieved the national target several times in April 2023.

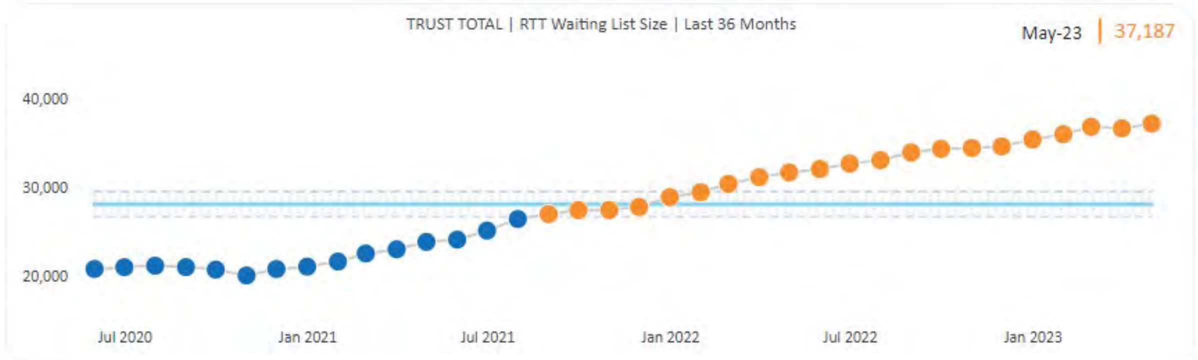
Key Performance Measures

The Trust formally agreed trajectories for the constitutional targets: Emergency Department, Referral to Treatment (RTT), Cancer and Diagnostic (known as DM01). These trajectories were based on demand and capacity work completed for all of the services using the NHS Improvement Tool.

The performance of these areas is monitored at all times and reported on a monthly basis in various different meetings internally and externally to the Trust.

Referral to Treatment (RTT)

The Trust did not meet the Referral to Treatment standard of 92%. We reported a year end position of 60.3%. The total waiting list size has steadily increased over the reporting period ending on 36,835 patients compared to 31,154 at the start of the year. The number of patients waiting more than 52 weeks for treatment is currently 475.



The Trust has identified a number of actions to address this underperformance, including:

- Addressing staffing issues in clinical areas with the largest waiting times and running additional clinics.
- Collaborating with system delivery partners to increase capacity, and
- Launching the patient initiated follow-up approach.

DM01

The Trusts performance against the Diagnostic Waiting Times and Activity standard (DM01) has been below the standard of 99% ending the year at 72.7%. Although factors such as capacity vs demand has impacted negatively on the DMO1 the principal reason is a significant increase in demand for diagnostic modalities including Echocardiography, Endoscopy and MRI. The Trust continues to utilise support from the Independent Sector to support the improvement plans for DM01.

Cancer

2022/23 Cancer Waiting Times Performance

The Trust reported an end of year compliance position of 80.9% against the national target of 93% for two-week waits (2WW) – all cancers, with the trust performing above the standard in seven of the twelve months of the reporting period. The Trust achieved this by continuing to work to the internal seven-day stretch target while also implementing new ways of working such as telephone and virtual clinics.

The Trust was compliant in two of the twelve months with the 93% operational standard for 2WW – breast symptomatic. The operational standard was not achieved for ten out of the twelve months as a result of patient choice and the breast service at the Trust unable to provide the required capacity to deal with the peaks and high level of demand for the service. The 2WW booking team now has access to real- time performance reports which allows issues to be escalated to service managers allowing 2WW breaches to be prevented before they occur.

The Trust has consistently met the 96% operational standard for 31-day for the full twelve months. Patients with a confirmed diagnosis of cancer are treated with the urgency required to ensure the trust

remains compliant against this Key Performance Indicator (KPI).

The Trust was compliant in eight of the twelve months with the 94% operational standard for 31 day subsequent treatment (surgery). This was achieved by continuing to work closely with the theatre and surgery teams to ensure that there was adequate capacity to prioritise treatments for patients with cancer. However, cases of national industrial action have impacted on our capacity and patient choice.

The Trust was compliant with the 98% operational standard 31-day waits for subsequent treatment (drug treatment) in nine out of twelve months. This represents a huge improvement in performance from the previous

The Trusts achievement of compliance with the operational standard of 85 per cent for 62 day waits from urgent GP referral continues to be maintained, and the role of cancer navigators, multidisciplinary team coordinators and other leadership and support staff in Cancer Services has again supported delivery of this

Emergency Care Standard

The year 2022/23 saw levels of attendance settling back to those experienced pre-pandemic. The Trust has continued to drive forward with improvements on a range of actions that ensure all parts of the hospital, and wider health and social care system, are able to respond to meet the emergency demand. In summary, these include:

- Closure of escalation areas to be used only during periods of extreme pressure.
- Safe access and initial assessment for patients conveyed by ambulance.
- Increase direct ambulance conveyance to Same Day Emergency Care (SDEC), Surgical Assessment Unit (SAU) and Frailty.
- Ensure that ED Internal Professional Standards are monitored and we are responsive to exceptional variation in activity.
- Validate Trust Internal Professional Standards in response to emergency referral and flow.
- Increase the number of patients who access zero Length of Stay clinical pathways across surgery, medicine and frailty.
- Minimise delays at every step of the ED journey.

Our dedicated, clinically-led Patient First programme gives us the tools and the confidence that we will deliver the required improvements in quality, performance and patient and staff experience.

Sustainability Report

Our carbon footprint

At Medway NHS Foundation Trust we continue to recognise that we are not only part of the NHS but that we play an integral role in the local community.

Sustainability means spending public money intelligently and responsibly, making efficient use of natural resources and taking our part in building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising costs of natural resources.

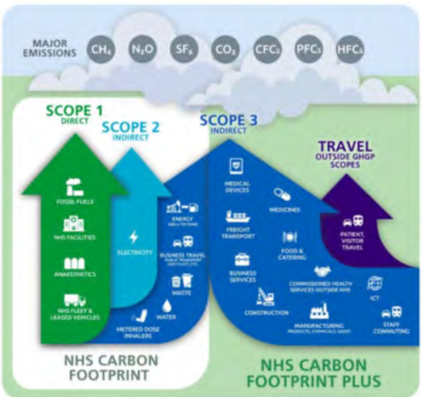
The Trust's formal Green Plan, first issued during 2020-21and updated annually, provides an organisation-wide strategy that outlines the Trust's plan of action that are necessary to achieve the targets within the Greener NHS Net Zero Programme.

Carbon Emissions

Carbon emissions are categorised into three scopes; scope 1 emissions (direct from owned resources), scope 2 emissions (indirect, through the generation of purchased energy) and scope 3 emissions (indirect, within the value chain). As the largest public sector emitter of carbon emissions, the NHS has a duty to respond to the targets for decarbonisation that are now embedded within law.

The Greener NHS National Programme published its strategy, 'Delivering a Net Zero NHS' in October 2020. The report set out trajectories and actions for the NHS to reach net zero carbon emissions by 2040 in relation to the emissions it controls directly, (**NHS Carbon Footprint targets**) and by 2045 for those emissions, it can only influence (**NHS Carbon Footprint Plus targets**).

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



In October 2022 the NHS became the first in the world to commit to delivering a net zero national health system. We continue to work hard to minimise our carbon footprint in line with the NHS commitments. These targets are:

The way this organisation can embed sustainability into its operation is to implement its Green Plan. Our Green Plan is endorsed by the Trust Board and supported by a dedicated Board sub-committee, as an organisation we acknowledge our responsibilities towards creating a sustainable future and have aligned our strategies with those priorities and ambitions of the United Nations Sustainable Development Goals (SDGs). Our organisation is starting to contribute to these SDGs at a local level.

Energy

During the most recent year, 22/23, the Trust spent a total of around £5.6m on Electricity and Gas which, in terms of cost alone, represents an increase of just over 101%. This movement in total costs is however made up of both an increase in the total volume of energy used, which accounts for 21% of the increased total costs, and increases in the unit price of energy which accounts for around 80% of the total increase in costs.

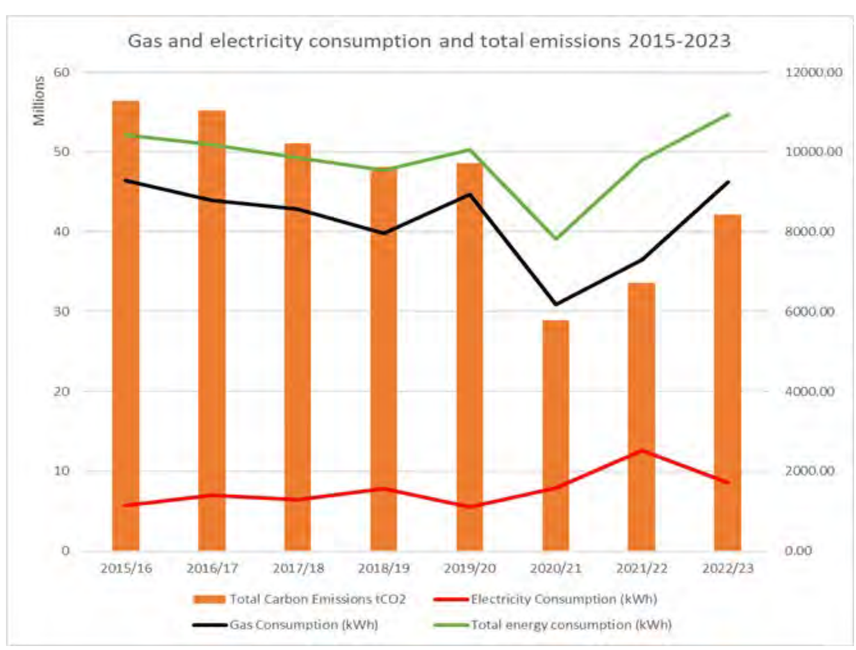
Energy Usage and Costs 21-22 to 22-23				
	Consumption		Costs	
	21-22	22-23	21-22	22-23
	KWH	KWH	£	£
Gas	36,491,997	46,214,831	874,698	3,300,348
Electricity	12,558,811	8,565,071	1,924,119	2,344,706
Total	**49,050,809**	**54,779,902**	**2,798,817**	**5,645,054**

The two principal factors causing these increases are as follows:

- Recovery from the COVID 19 Pandemic has seen significant increases in the level of operational activity on site and the return to site based work for many employees. These specific issues have had a direct impact upon the overall volume increases in energy consumption.
- International supply pressures upon gas and generated electricity have led directly to very significant increases in unit costs charged by suppliers.

Within our Green Plan we have also produced a Heat Decarbonisation Plan (HDP) that will enable the Trust to work towards a number of other NHS decarbonisation requirements. The HDP is a starting point for the Trust to plan how we intend to replace fossil fuel reliant heating systems with low carbon alternatives.

The Trust is committed to finding new and innovative ways to reduce both the cost and the volume of energy used and despite the turbulence of the past two years the emissions trend over the past eight years continues to show a medium to long term reduction as shown in the following graph.



As trust we are committed to reducing our environmental impact, and every action counts. Below are a few examples of the actions the Trust has undertaken in 2022/23:

- Anesthetic gases and measured dose inhalers.
  According to recent research, operating theatres are often three to six times more energy-intensive

than the rest of a hospital and are major contributors of waste. Anesthetic gases alone account for 2% of NHS emissions and 5% of a typical hospital's emissions. The NHS has committed to reducing greenhouse gas emissions from anesthetic gases and inhalers by both switching to alternative inhalers, and reducing the proportion of desflurane used in surgery to 2% or less by volume, across 2023/24, as a whole. The longer-term objective is the total elimination of desflurane and within this Trust Greener Edge recently undertook a nitrous oxide waste review. The Trust is currently awaiting the results of this review, which are expected to provide recommendations for rapid implementation via the action plans of a dedicated working group.

- Procurement processes
  This Trust has included a 10% social value weighting within the tender assessment process in order to reflect the potential supplier's impact upon local employment, the community, well-being and decarbonisation.
  Looking forward, from 1 April 2023, the NHS requires all suppliers of goods, services and works bidding new contracts above £5 million per annum to have a published Carbon Reduction Plan (CRP) in place, in line with the guidance published by the NHS.

- Waste
  Domestic waste recycling increased by 41% between 20/21 and 21/22 yielding a reduction in carbon emissions of 1.5 tonnes. We are still awaiting the figures for 22/23, however they are expected to show increased levels of recycling and reduction in emissions. This is a result of recent focus upon segregation of waste.
  Recycling posters have been reviewed and up-dated and the Trusts waste contractor held a waste roadshow in October 2022. This was a sustainability themed lunchtime event raising awareness with staff on environmental issues such as recycling.

- Catering
  Our Catering Team continues to recycle oil and food waste and introduced new recycling bins towards the end of the 2022/23 reporting year. The bins, funded by the League of Friends, have an additional aperture to allow food waste segregation and were rolled out as part of Global Recycling Day.
  From November 2022 to March 2023, the Catering Team actively reduced 88,125 items of plastic from the catering department. The Trust will be participating in the NHS England Pilot on measuring food waste. Collating spoilage and plate wastage to identify food waste reduction and avoidance opportunities.

- Walking Aids
  The nationally set target is that within the coming 5-year period 40% of all walking aids used will be refurbished. This Trust procures walking aids through an equipment loans scheme which promotes a circular economy approach through the return of equipment for refurbishment and reuse, helping the Trust to reduce our carbon emissions and meet the 40% national target. Further work to reduce emissions will include the inclusion of orthopaedic crutches. From November 2021 to March 2023, 467 items were returned to the Trust with 301 of those being recycled.

- Travel and Transport
  New Lease Car scheme
  The Trust launched a new car lease scheme in collaboration with Fleet Solutions in April 2023 limited to providing fully electric cars.
  Staff Transport
  We have created a Staff Transport Group. The work streams for this group include developing and promoting the Cycle to Work Scheme, the Season Ticket Loan Scheme and the Car Share Scheme.

- Air quality
  The Trust is in partnership with Medway Council regarding outdoor air quality monitoring. Medway Council will supply diffusion tubes to measure pollutant concentrations in the atmosphere.

Community Engagement, Human Rights and Anti bribery

Community Engagement

The Trust strives to undertake meaningful community engagement through actively informing, involving, and inviting feedback about our services. Involvement from our local community is essential in helping shape and influence decision making to improve services and our patient's experience. We encourage people to get involved and share their views, as this will help us have a better understanding of diverse health needs and what matters to patients, carers, the public, members, stakeholders and the wider community.

We will continue to share updates and opportunities to get involved by attending virtual and face-to-face meetings, community events, sharing information, and invitations to events with members and the community, providing updates on our website and through our bi-monthly Community Engagement newsletter.

In the last year, we have hosted and attended a variety of public events, including events focusing on Patient Experience, Improvement and Innovation, Improvements to our Emergency Department and frailty services.

One particular example of this is the work the Trust has undertaken with the Integrated Care Board and Medway and Swale Health and Care Partnership to identify ways of providing care closer to home for frail patients, and to create increased capacity in Medway Maritime Hospital to treat more elective patients.

Through this work a proposal to utilise vacant space in the Sheppey Community Hospital and creating a 22-bed frailty ward primarily for patients living in Swale, providing care closer to home for these patients.

Following a successful period of engagement with both our community and our staff the Sheppey facility was approved and was opened on 20 January 2023.

People, and Quality Priorities.

We also held our Annual Members' Meeting in October 2022.

The Trust actively participated in a plethora of engagement opportunities and our public governors have attended shopping and community centres, colleges, universities and events on our own premises. This included specifically engaging with residents from the Swale area about the opening of the Trusts new frailty ward within the Sheppey Community Hospital.

We plan to continue to build on our community engagement and provide opportunities to engage with the wider community groups in areas that are harder to reach. This will ensure that we continue to learn and discover the amazing work that is taking place in our local community, and ensure their voices are heard within the Trust.

Anti-bribery

During the reporting period, the Trust's local counter fraud services have been provided by KPMG. The Trusts Audit and Risk Committee approves an annual counter fraud work plan. It also receives a report at each meeting detailing cases of possible fraud and the outcome of any investigations. Progress in respect of proactive work and themed reviews is also reported. The Audit and Risk Committee monitors the implementation of any recommendations made by KPMG by way of a management action tracker.

The local counter fraud services team works closely with the internal audit team to consider how identified fraud risks can be addressed within the scope of their reviews and additional assurance can be provided through this route.

Throughout the year, KPMG raised awareness through a tailored combination of refreshing of

induction materials for the Trust, ad-hoc alerts to Trust staff and communications through events like Fraud Awareness Week. The counter fraud team brought two investigations forward from 2021/22 which were investigated and outcomes reported to the Audit and Risk Committee. No cases remain open.

Equality, diversity and human rights

Control measures are in place to ensure that the organisation's obligations under equality and human rights legislation are complied with. The Trust employs a Head of Equality and Inclusion to provide strategic and practical professional guidance and advice to the Trust.

The Trust's strategic approach to equality and diversity is managed through the Equality Delivery Scheme (EDS2). This is reviewed periodically, and the Equality Strategy will be refreshed in 2023. Additionally, the Trust publishes the results and action plans on mandatory equality metrics, such as the Gender Pay Gap and Workforce Race Equality Standard. These metrics enable the Trust to benchmark with other NHS organisations and partners, to produce and maintain action plans, and review and improve its performance for people with characteristics protected by the Equality Act 2010.

Training on Equality and Human Rights is mandatory for all staff, and management programmes have been developed to improve the Trust's leadership skills around equality, diversity and human rights. The Trust is committed to going beyond that which is mandated and makes equality and inclusion an integral part of everything it does for staff, patients and the local community.

Gender Pay Gap

In May 2022, the Trust published its gender pay gap and supporting statement for 2021/22, as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust's mean gender pay gap is 30 per cent and the median gender pay gap is 21.4 per cent. This is an improvement from the position in 2021. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. There is some evidence that this pattern is repeated in many other Trusts across the NHS, and relates to professional career paths.

The refreshed data for the 2022/23 reporting period is due in May 2023 and will be published on the Trusts website.

Overview of financial performance

Although on occasion the quality of the service we offer has not achieved the levels we have strived for, this has not been as a result of the removal of resource nor through a lack of willingness to ensure managers and clinicians have the manpower and equipment they need to provide those services. Choices have been made and will continue to be made as to how services might develop and change within the funding envelope and we will maintain our close relationships with local commissioners and the Integrated Care System/Board to ensure our patients receive the best care for the best value.

The accounts presented in this 2022/23 annual report show a deficit of £6.0 million; the performance against the Trust's control total is as per the table below.

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The accounts presented in this 2022/23 annual report show a deficit of £6.0 million; the performance against the Trust's control total is as per the table below:

	Plan £m	Actual £m	Variance £'000
Clinical income	357.8	397.4	39.6
Other income	34.8	34.8	5.3
Pay	(277.5)	(283.2)	(38.7)
Non-pay	(135.7)	(147.9)	(12.2)
Operating surplus	**7.1**	**1.1**	**6.0**
Non-operating expenses	(7.3)	(7.3)	0.0
Reported surplus/(deficit)	**(0.2)**	**(6.2)**	**(6.0)**
Net impairments	0.0	(0.1)	(0.1)
Donated Asset cost/income net	0.2	0.2	0.0
Impact of consumables from DHSC	0.0	0.1	0.1
Other adjustments	0.0	0.0	0.0
Control total	**0.0**	**6.0**	**6.0**

During the course of the financial year the Trust began to report an adverse performance. This principally arose from:

- Opening additional bed capacity that had not been budgeted due to demand and patient safety.
- Additional medical costs associated with that capacity, high levels of staff turnover coupled with vacancies, and a continued and unrelenting increase in activity.
- High drugs costs, linked both to the activity noted above and the sharp rise in inflation during the year.

In November 2022 NHSE released their “Protocol for changes to in-year revenue financial forecast”. This set out the process to follow in the event of a deterioration in the forecast compared to the annual plan. Due to the performance and continuing risks, the Trust worked with its system partners and NHSE to follow this process and declare the £6m deficit that was subsequently achieved.

Income

The majority of the Trust’s income is directly related to patient care from commissioning organisations such as Integrated Care Boards, CCGs and NHS England. Since 2020/21, this has been based on fixed income sums to cover historic contract levels, recognising that “ordinary” activity would be much reduced as a result of the Covid measures in place. The Integrated Care System did not ‘clawback’ or revert to an activity based income model for elective work.

Other operating income included: education and training funding; non-patient care or ‘hosted’ services to other organisations; car parking income; research and development funding, and; charitable constructions to expenditure.

An additional £8.2m income and expenditure was accounted for as non-recurrent clinical income in relation to the non-consolidated national pay award being considered at 31st March.

Expenditure

In 2022/23 the Trust is reporting increased costs of £27.1 million on pay: these arose from: £13.6 million on pay awards, £5.0m in respect of increases in social security (inclusive of the rate changes during the year) and directly paid pension contributions and £8.5 million to the additional staff in post to meet safer staffing and activity needs. Non-pay has increased by £10.5 million when compared to 2021/22; £3.7 million relates to higher depreciation charges (from investments made in the current and preceding financial year), £4.5 million on drugs costs (activity and inflation) and £2.1m on premises (maintenance, repairs and cleaning).

Capital expenditure plan

During the year, the Trust has invested £25.9 million in capital schemes in the areas shown below:

	£m
Estates and Site infrastructure	2.3
Fire Safety	2.5
Service Development	8.2
IT	6.5
Equipment	6.4
Total	**25.9**

The total investment is 15% higher than the previous year, mainly due to large externally funded projects approved by NHS England.

Some of the notable projects in the year have included:

- Development of community diagnostics hubs in Sheppey and Rochester, due to complete in 2023/24.
- Redevelopment of Endoscopy services
- Continuing implementation of an electronic patient records system
- Fire safety works

Cash flow and balance sheet

The balance sheet shows £288.2m of net assets at the end of the year, up from £260.0m of net assets at previous year end.

The Trust ended the year with £34.7 million cash in the bank; higher than originally planned due to late allocations of Public Dividend Capital and £0.8m unplanned bank income relating to interest rates rises.

Financial outlook

2023/24 will be another challenging year for the Trust. We have submitted a deficit plan for the year of £15.0 million, arising as a consequence of the continuation of those 2022/23 cost pressures.

From nationally collected data we know that in recent years the Trust has improved its efficiency position relative to Trusts up and down the country. This is represented by the chart below sourced from the national model health system data. The Trust's cost per 'weighted activity unit' has reduced each year from a high of £3,832 in 2016/17 to £3,377 in 2020/21 (the last available period).

It shows the Trust below the national median for its average costs yet historically it has had a significant deficit. The task as a health economy is to move our performance to comfortably within the top left hand quartile (better than average efficiency; surplus) while ensuring patients receive the care they deserve.

In conjunction with this improvement, the Trust has also experienced an improvement in its reference cost index. This again is a national measure to look at relative efficiency of organisations, with the baseline score of 100. With a score of 93 for 2021/22, the Trust is therefore operating at a lower comparative cost base.

To address this financial sustainability challenge, the Trust worked with system partners to produce a Financial Recovery Plan (“FRP”). The FRP set out the historic performance of the Trust, identified those key factors that had and continue to give rise to the Trust being in a loss-making position, the proposed mitigations to address these and long term financial modelling to assess the impacts. This did demonstrate that there was a route to financial sustainability for the Trust over the medium-term. However, performance and events during 2022/23 – including the rapid and significant inflationary rates – have meant that the Trust will revisit the work, the gaps that have developed and will reset those mitigations and strategic initiatives that will deliver this programme of work.

There remain a number of key risks to the overall 2023/24 plan, each of which are high on the agenda of the Board. Specifically:

- Delivery of activity in a capacity constrained hospital;
- Mitigation of cost pressures, including hyper-inflationary costs;
- Controlling expenditure in line with budgets;
- Delivery of a £27.0 million / 6.6% efficiency programme, ensuring no compromise on quality;
- Recruitment and retention of workforce to reduce reliance on premium cost temporary staff;
- Managing investments to a tight capital programme.

Overseas operations

The Trust does not have any overseas operations.

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2022/23.

Signed

Jayne Black
Chief Executive
[date]

Directors’ Report

Board of Directors

The following disclosures relate to the Trust’s governance arrangements and illustrate the application of the main and supporting principles of the NHS Foundation Trust Code of Governance (the Code). It is the responsibility of the board of directors to ensure that the Trust complies with the provisions of the code or, where it does not, to provide an explanation which justifies departure from the code in the particular circumstances.

The directors’ report has been prepared under direction issued by NHS England, the regulator for foundation trusts, and in accordance with the NHS Foundation Trust Annual Reporting Manual 2022/23.

The Trust Board

Medway NHS Foundation Trust is run by the board of directors. The board is responsible for overseeing the overall strategic and corporate direction of the Trust and ensures the delivery of the Trust’s goals and targets. It is also responsible for ensuring its obligations to regulators and stakeholders are met. Strategic priorities are set by the trust board annually. The risks to achieving these priorities are monitored through the board assurance framework, which provides the board with a systematic process of obtaining assurance to support the mitigation of risks. The Trust board leads the Trust and provides a framework of governance within which high quality, safe services are delivered to the residents of Medway and Swale.

Trust Board Governance

The board comprised a non-executive Chair, seven other non-executive directors, five voting executive directors, including the chief executive chief finance officer, chief nursing officer and chief medical officer. The Chair is responsible for leadership of the board of Directors and the Council of Governors and responsible for ensuring that the board and Council work together effectively. The senior independent director, who is also a non-executive director, provides a sounding-board for the Chair and serves as an intermediary for the other directors when necessary. They should be available to governors if they have concerns that contact through the normal channels has failed to resolve, or for which such contact is inappropriate. The senior independent director is also the deputy chairperson.

The non-executive directors scrutinise the performance of the executive team in meeting agreed goals and objectives and monitor performance. The executive directors are responsible for managing the day-to-day operational and financial performance of the Trust. The chief executive leads the executive team and is accountable to the board for the operational delivery of the Trust.

All voting board directors (executive and non- executive) have joint responsibility for board decisions, same legal responsibilities and collective responsibility for the performance of the Trust.

Together, the non-executive directors and executive directors bring a wide range of skills and experience to the Trust, such that the board achieves balance and completeness. The board meets monthly with bi-monthly development sessions.

All non-executive directors are eligible for appointment for two three-year terms of office, and in exceptional circumstances a further term of 12 months. The Chair and non-executive directors are appointed by the Council of Governors in accordance with the Trust’s Constitution.

The board has an approved Scheme of Delegation. The board delegates some of its powers to its committees, all of which have a non-executive chair. The arrangements for delegation are set out in the Trust’s Standing Orders and Scheme of Delegation. The Trust’s constitution and terms of reference of these committees and their specific powers are approved by the board of directors. The board committees are all assurance committees with the exception of the Nominations and Remuneration Committee.

Board Appointments and Leavers

Non-executive directors are appointed via a formal and transparent procedure, managed through the governors' nominations and remuneration committee, a sub-committee of the Council of Governors. This committee also advises the Council on the remuneration and terms and conditions of the non-executive directors.

The Council of Governors, advised by the Nominations Committee, appointed Paulette Lewis as a non-executive director for three years from 1st October 2022. The role was advertised.

Executive directors
The post of Chief Operating Officer was recruited to during the year. The role was publicly advertised and interviews were held by the Board's Nominations Committee.
At the time this report was produced, the Trust was recruiting two new non-executive directors to fill planned vacancies.

Decisions delegated to the Executive Group

The executive directors meet weekly and the meeting is chaired by the Chief Executive. Its purpose is to ensure that the objectives agreed by the board are delivered and to analyse the activity and performance of the Trust against the business plan to ensure that duties are appropriately delegated to the senior management team and actions monitored. It also ensures that the key information from external bodies is discussed, actions identified and messages disseminated appropriately across the organisation.

Statement about the balance, completeness and appropriateness of the board
The members of the trust board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. The skills portfolio of the directors, both executive and non-executive are balanced to ensure it meets the requirements of a NHS foundation trust.
The non-executive directors are considered to be independent in character and judgement and the board believes it has the correct balance in its composition to meet the requirements of a NHS foundation trust.

The Trust's constitution permits each term of office to be up to three years, to a maximum of seven years' service. Appointments and removals of non-executive directors are determined by the council of governors on the advice of the Nominations Committee.

The constitution was refreshed at the end of April 2023 to ensure it was fully compatible with the amendments to the Health and Care Act 2022 and the revised Code of Governance.

Directors of Medway NHS Foundation Trust 2022/23

Joanne Palmer
Chair – appointed 22 October 2020

Appointed as non-executive director 1 September 2015
Appointed as Senior Independent Director 22 December 2016
Appointed as Deputy Chair 1 April 2017 Acting Chair from 1 April to 21 October 2020
Term: first as Chair, ending 30 September 2023

Experience and Qualifications
Current role: Chief Operating Officer at BC&E
More than 30 years' experience in banking and financial services across a range of disciplines.
Member of the national committee for the Group's women's network, Breakthrough.

Membership of committees
- Trust Nominations and Remuneration Committee
- Finance Planning and Performance Committee
- Quality Assurance Committee

Mark Spragg
Non-Executive Director
Deputy Chairman and Senior Independent Director.

Appointed 1 April 2017
Term: second term commenced 1 April 2020 (extended for 12 months)

Experience and Qualifications
Qualified solicitor with more than 30 years' experience
Both a civil and criminal litigation specialist with expertise in the area of Financial Services.
Involved in a number of notable cases Involved in charity work.

Membership of committees
- Audit & Risk Committee (Chair)
- Finance, Planning and Performance Committee
- Trust Nominations and Remuneration Committee (Chair)
- Charitable Trustee

Adrian Ward
Non-Executive Director

Non-Executive Director for Freedom to Speak Up
Appointed 1 August 2017
Term: second, ending 31 July 2023

Experience and Qualifications
Practicing Veterinary Surgeon
Graduate of the Royal Veterinary College.
BSc (Hons) in Physiology from King's College, London.
Former Veterinary Advisor for pharmaceutical company - developed an interest in the development of antimicrobial resistance and the strategies that can be used to slow this process.
Case examiner for the Royal College of Veterinary Surgeons Preliminary Investigation Committee from 2015.
Chair, Fitness to Practice Panel for the Nursing and Midwifery Council from 2017
Member of the Institute of Chartered Accountants in England and Wales investigating Committee from 2018.
Promotes responsible antibiotic use and infection control strategies through his work with the Bella Moss Foundation.
Assists in development of educational resources for the veterinary profession as a volunteer for the British Small Animal Veterinary Association.

Membership of committees
- Quality Assurance Committee
- Health and Safety Strategy Committee Nominations and Remuneration Committee Charitable Trustee

Annyes Laheurte
Non-executive Director

Appointed 1 April 2021
Term: first, ending Mach 2024

Experience and Qualifications
Annyes has over 25 years' experience in financial reporting together with financial planning and analysis for international organisations.

Whilst working at Lloyd's of London, she focused on financial controls, process enhancements and safeguarding the Society's assets by mitigating operational risks.

Annyes is a Chartered Global Management Accountant (1991) and member of the Institute of Risk

Management (2007) and was awarded Specialist status (2009).

Membership of committees
Chair of Finance Planning and Performance Committee
Member of Audit & Risk Committee
Member of Nominations and Remuneration Committee
Charitable Trustee

Sue Mackenzie
Non-Executive Director
Appointed 1 April 2020
Term: second, ending 31 March 2026

Experience and Qualifications
Formerly Operations and Business Transformation Director for P&O Ferries. Operations Director at London Luton Airport
Career in the Army.
Chief Executive of the charity Cities in Schools (CiS),

Membership of committees
- Chair of People Committee
- Member of Nominations and Remuneration Committee
- Charitable Trustee

Paulette Lewis MBE
Non-Executive Director

Appointed November 2022.
Term: First, ending October 2025

Experience and Qualifications
Paulette has worked over 35 years in a variety of healthcare settings, gaining wide experience across acute and community services. She has held several senior/executive posts, including Director of Midwifery and Children Services, Executive Director Nursing and Director of the Pan London Maternity Service Review.

Paulette is a leadership and management consultant and has spent a great deal of her time mentoring and coaching individuals to help them reach their full potential.
In the year 2000, Paulette received a Silver Award for excellence in healthcare. In 2002, her charitable and leadership work was recognised by her receiving the European Social and Humanitarian award. In October 2022, Paulette received the Zenith Global Healthcare Award as special recognition for her global healthcare work. She was also a nominee for Nurse of The Year by The Jamaican Times UK Community Award in 2014.

Paulette was awarded an MBE in the Queen's Birthday Honours List in June 2014 for her work and contribution to nursing and charity work.

Non-voting Associate Non-Executives:

- Rama Thirunamachandran
- Jenny Chong

Jayne Black, Chief Executive

Experience and Qualifications
Jayne Black became the Trust's Chief Executive in August 2022. Jayne originally joined the Trust in November 2021 as Chief Operating Officer before becoming Interim Chief Executive in June 2022.

Jayne has considerable NHS leadership experience and is a trained nurse by background. She has worked across acute, community and the wider system throughout her career, in a variety of roles,

including Director of Operations, Deputy Chief Executive and Chief Operating Officer.

(01 April to 01 June 2022) Dr George Findley, Chief Executive

Experience and Qualifications
George was previously Deputy Chief Executive and Chief Medical Officer at University Hospitals Sussex NHS Foundation Trust, the trust formed following the merger of Western Sussex Hospitals with Brighton and Sussex University Hospitals.

During his seven years at Western Sussex George contributed to the Trust becoming the first non-specialist acute trust in the country to be rated ‘Outstanding’ in all the key inspection areas assessed by the Care Quality Commission. He was also part of the leadership team at Brighton during the period when the Trust exited special measures and climbed three inspection ratings to Outstanding for Caring and Good overall.

A specialist intensive care consultant, George is an experienced clinical leader at national and regional level, and a Fellow of the Health Foundation’s GenerationQ leadership develop and quality improvement programme.

Alan Davies
Chief Finance Officer

Experience and Qualifications
Alan joined the Trust in November 2020 and brings with him extensive Finance experience within the NHS, in Acute, CCG and Strategic settings. His last NHS role was as CFO for Luton CCG and prior to that was Deputy Finance Director at Barking Havering and Redbridge Hospitals.
He has a strong track record in improving financial performance and strengthening governance in NHS organisations in support of improving care for patients. Alan is a Fellow of the Chartered Association of Certified Accountants.

Leon Hinton
Chief People Officer

Experience and Qualifications
Leon brings a wealth of experience, having worked in a number of hospitals in the NHS over the past 17 years. He holds Chartered Fellow status with the Chartered Institute of Personnel and Development; a Master of Chemistry degree from the University of Warwick and postgraduate degrees in Human Resources Management (University of Wolverhampton) and Strategic Workforce Planning (University of West London).
Leon also holds financial accreditation and has studied with the Healthcare Finance Management Association.
Leon was an integral part of the leadership team at Great Ormond Street Hospital who won the national HPMA award in 2015 for improved HR capability. He is currently leading the work on the Trust’s refreshed People Strategy following the achievement of the regional CIPD award for HR team of the year in 2017.

Evonne Hunt
Chief Nursing Officer

Experience and Qualifications
Appointed October 2021 to the role of Chief Nursing Officer, Evonne has been a nurse for 24 years and has held director and senior leadership level positions in nursing, quality governance, patient safety, and risk management in acute, mental health and commissioning organisations in the NHS. She has also worked in the Department of Health and the independent and private healthcare sectors.

As Chief Nursing Officer, Evonne has board level responsibility for professional nursing, midwifery and allied health profession workforce to support the delivery of high quality compassionate care.

Evonne wanted to be a nurse since she was seven years old, heavily influenced by her mum who is a

nurse. She is extremely passionate about patient safety and experience, organisational culture and staff development and wellbeing.

Dr Alison Davis,
Chief Medical Officer (Caldicott Guardian)

Experience and Qualifications
Appointed January 2022, Alison started her clinical career as a paediatric ophthalmologist and has worked as a consultant at Moorfields Eye Hospital, St George's Hospital Tooting, Croydon University Hospital and as an honorary consultant at Great Ormond Street Hospital.

Recent clinical leadership experience includes deputy medical director at Moorfields and hospital medical director at Kent and Canterbury Hospital.

Trust Board meetings

The Trust board held a total of 7 public meetings between 1 April 2022 and 31 March 2023, and two development sessions. Trust board meetings normally are held in public, unless there is confidential or sensitive information to be discussed. This is detailed on the board agenda which is published, together with the meeting papers on the Trust's website.

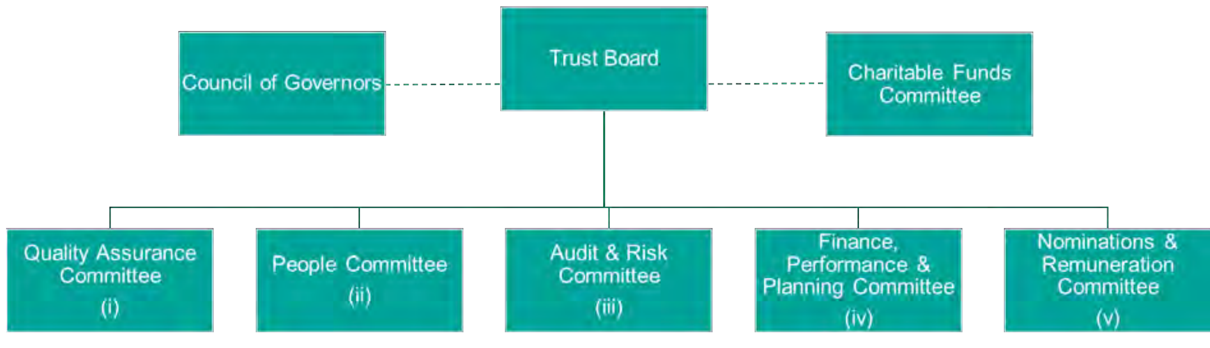
Director attendance at formal committee and public board meetings is detailed under: Attendance at Board of Directors and Committee meetings in 2022/23.

Development of working relationships with the Council of Governors

The Board of Directors and the Council of Governors have development/discussion sessions to examine particular areas of interest and concern. With the challenges facing the Trust, these sessions enable the views of both the Board of Directors and Council of Governors to be shared and are considered invaluable to all concerned.

Committees of the Trust board

The board delegates certain functions to committees that meet regularly. The board receives any amendments to committee terms of reference. Non-executive directors chair the board committees. Each committee reviews its own effectiveness annually; an up-to-date work programme, action log and terms of reference is maintained for each one. As part of the organisations implementation of the Patient First improvement methodology the trust has undertaken a review of its governance and has been aligning the committees Terms of Reference and work programmes to the new approach.



Committee structure

Audit & Risk Committee
The report of the Audit & Risk Committee is detailed separately as required by section C.3.9 of the NHS Foundation Trust Code of Governance.

Quality Assurance Committee
The Quality Assurance Committee is chaired by a non-executive director and has delegated authority from the Board to be assured that the appropriate structures, systems and processes are in place to manage quality and safety related matters, and that these are monitored appropriately. The committee ensures an integrated and coordinated approach to the development and monitoring of the quality metrics (patient safety, patient experience and clinical effectiveness) at a corporate level; it leads on the monitoring of quality systems within the Trust to ensure that quality is a key component of all activities within the Trust, and ensures compliance with regulatory requirements and best practice with patient safety, patient experience and clinical effectiveness.

The committee regularly receives assurance (where necessary seeks further guidance or actions) on serious incidents, safeguarding, infection prevention and control, complaints and other matters relating to the experience of our patients. The Committee also receives assurance from the Integrated Quality and Performance Report.

Outcomes from clinical audits are discussed at Committee meetings. The Committee provides a key issues report to the Board of Directors after every meeting on its activities.

The Committee met 12 times during 2022/23. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

Finance, Planning and Performance Committee
The Committee is chaired by a non-executive director and provides assurance that the Trust's strategy, financial forecasts, plans and operational performance are being considered in detail, and provides independent and objective assurance to the Trust Board regarding investments and significant contracts before their approval by the Trust Board.

The Committee provides a key issues report on its activities to the Board of Directors after every meeting. The Committee met 13 times during the year. Attendance is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

People Committee
Chaired by a non-executive director, this committee has strengthened the board's focus on key areas such as equalities, Freedom to Speak Up, staff well-being and recruitment. It has met 6 times in 2022/23.

Nominations and Remuneration Committee
The Nominations and Remuneration Committee (the Committee) is chaired by the Senior Independent Director and Deputy Chair. Its membership consists of the Trust's chair and non-executives. The committee is responsible for reviewing and making recommendations to the Trust board on the composition, balance, skill mix and succession planning of the Trust board, for determining the appointment of the executive directors, and monitoring the level and structure of other senior managers reporting directly to the chief executive.

It is responsible for reviewing the size, structure and composition of the board on an annual basis and makes recommendations to the board. Directors have individual appraisals and professional development reviews.

The committee met four times during the year. Attendance record is detailed under Attendance at Board of Directors and Committee meetings in 2022/23.

Attendance at Board of Directors and Committee meetings in 2022/23

		Trust Board and Committees						
Voting Members *(See Non-Executive Directors Biography and Committee structure for Chair of Committees)*	**Job Titles**	**Trust Board Private (7 formal meetings)**	**Trust Board (7 formal meetings)**	**Noms and Rems (4 meetings)**	**Audit and Risk (4 meetings)**	**Finance and Performance (11 meetings)**	**Quality Assurance (12 meetings)**	**People (6 meetings)**
Jo Palmer	**Chair**	7 of 7	7 of 7	4 of 4				4 of 6
Mark Spragg	**Senior Independent Director**	6 of 7	6 of 7	4 of 4	4 of 4	9 of 11		1 of 2
Sue Mackenzie	**Non-Executive Director**	4 of 7	4 of 7	4 of 4				6 of 6
Paulette Lewis	**Non-Executive Director**	2 of 2	2 of 2	1 of 1			4 of 4	
Adrian Ward	**Non-Executive Director**	6 of 7	6 of 7	4 of 4	3 of 4		9 of 12	
Annyes Laheurte	**Non-Executive Director**	7 of 7	7 of 7	4 of 4	4 of 4	11 of 11	5 of 8	3 of 6
Jenny Chong	**Associate Non-Executive Director**			4 of 4				
RamaThirunamachandran	**Academic Non-Executive Director**			2 of 4				
Tony Ullman	*Non-Executive Director*	2 of 3	2 of 3	2 of 2		0 of 11	4 of 4	1 of 2
Ewan Carmichael	*Non-Executive Director*	2 of 4	2 of 4	1 of 2			3 of 4	0 of 2
Jayne Black	**Chief Executive (from June 22)**	7 of 7	7 of 7			8 of 9		
Jayne Black	*Chief Operating Officer (until May 22)*					1 of 2		
Alan Davies	**Chief Finance Officer**	5 of 7	5 of 7		4 of 4	11 of 11		
Evonne Hunt	**Chief Nursing Officer**	6 of 7	6 of 7				9 of 12	
Alison Davis	**Chief Medical Officer**	6 of 7	6 of 7				9 of 12	
Leon Hinton	**Chief People Officer**	7 of 7	7 of 7	3 of 4				5 of 6
Sunny Chada	*Chief Operating Officer (from June 22 to Sept 22)*					3 of 3		
Mandy Woodley	*Chief Operating Officer (from Oct 22 to Dec 22)*	3 of 4	3 of 4			1 of 3		
Gavin Macdonald	*Chief Operating Officer (from Jan 23 to Apr 23)*	1 of 1	1 of 1			3 of 3		
Gary Lupton	*Director of Estates and Facilities (until May 22)*					2 of 2		
Richard Daniel	*Director of Estates and Facilities (from May 22 to Jan 23)*					4 of 7		
George Findlay	*Chief Executive (until May 22)*	1 of 2	1 of 2	1 of 1		0 of 2		
Paula Tinniswood	*Chief Strategy and Transformation Officer (until Sept 22)*					5 of 5		

Audit & Risk Committee Report

The Audit & Risk Committee's (the Committee) responsibilities and key areas discussed during 2022/23, whilst fulfilling these responsibilities, described in the table below:

<table>
<tr><th colspan="2">Principles of responsibility</th><th>Key areas discussed and reviewed by the committee during 2022/23</th></tr>
<tr><td rowspan="2">Review of the Trusts Risk Management Processes</td><td>Reviewing the Trust's internal financial controls, its compliance with national guidance for foundation trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems.</td><td rowspan="2">The outputs of the Trust's risk management processes
including reviews of:
• The Board Assurance Framework– the principal risks and uncertainties identified by the Trust's executive directors and movement in the impact and likelihood of these risks and assurances on controls.
• Work continuing on the Trust's risk management processes and risk reporting. Annual assessment of the effectiveness of internal control systems taking account of the findings from internal and external audit reports.
• Internal audit, counter fraud and external audit reports and updates.
• Interests, gifts, hospitality and sponsorship quarterly declarations.
• Losses and special payments
• Waivers of standing financial instructions</td></tr>
<tr><td>Reviewing the principal non-clinical risks and uncertainties of the business and associated annual report risk management disclosures. (Clinical risks are reviewed by the Quality Assurance Committee).</td></tr>
<tr><td rowspan="2">Financial Matters</td><td>Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance</td><td rowspan="2">• Annual report and financial statements, including the Head of Internal Audit Opinion, the Annual Governance Statement, the Annual Internal Audit Report, the Annual Counter Fraud Report and the External Audit Opinions on the Financial Accounts and recommended acceptance to the Trust Board.
• Key accounting policy judgements, including valuations.
• Impact of changes in financial reporting standards where relevant.
• Single tender waivers
• Losses and special payments</td></tr>
<tr><td>Review the annual report and financial statements before submission to the Board, to determine their objectivity, integrity and accuracy</td></tr>
<tr><td rowspan="2">External Audit</td><td>Monitoring and reviewing the external auditor's independence, objectivity and effectiveness.</td><td rowspan="2">• Basis for concluding that the Trust is a going concern.
• External auditor effectiveness and independence.
• External auditor reports on planning, a risk assessment, internal control and value for money reviews.
• External auditor recommendations for improving the financial systems or internal controls.
• Changes to Accounting Standards.</td></tr>
<tr><td>Developing and implementing policy
on the engagement of the external auditor to supply non audit services,
taking into account relevant ethical guidance.</td></tr>
</table>

Internal Audit	Monitoring and reviewing the effectiveness of the Trust's internal audit function that meets National Audit Office 2015 Code of Audit Practice and provides appropriate independent assurance to the Committee.	• High priority internal audit recommendations with progress report covering 18 months. • The internal audit reports discussed by the Committee included: • Payroll record management – Partial assurance with improvements • Risk Management – significant assurance with minor improvement opportunities • Business Continuity - significant assurance with minor improvement opportunities • Risk Maturity – assurance with improvements required • (mandatory audit of core financial systems) - Partial assurance with improvements required • Data Security Toolkit – Partial assurance with improvement required
	Satisfying itself that the Trust has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and reviewing the outcomes of work in these areas.	The reports identified recommendations for improvement that have been accepted by the executive directors. There have been regular reports and updates from the Local Counter Fraud Specialist throughout the year. This has included a review of the application of the Trust's Conflicts of Interest Policy.

Composition and meetings

The Committee is a non-executive committee of the Trust board, established in accordance with the Trust's constitution and has delegated authority to review the adequacy and effectiveness of our systems of internal control and our arrangements for risk management, control and governance processes to support our objectives.
Executive directors attend by invitation, and the Chief Executive and Chief Finance Officer are generally in attendance. Other executive directors and staff with specialist expertise attend by invitation.

The Committee met five times during the financial year.

Attendance at meetings

Non-executive directors (members)	Attendance at meetings
Mark Spragg (Chairman)	4/4
Annyes Laheurte	4/4
Adrian Ward	3/4

Code of Governance

Medway NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance (including the revised Code implemented in April 2023) on a comply or explain basis. In so far as the Board is aware, all possible steps have been taken to ensure that all relevant audit information has been disclosed in full to the auditors.

Effectiveness of the committee

The Committee reviews its effectiveness and impact annually using best practice guidance, and ensures that any matters arising from this review are addressed.

The Non-Executive Directors were satisfied that the Committee in 2022/23 had complied with its obligations and expectations as noted in its terms of reference, with steady progress being made on

improving processes, with further improvement required.

The Committee reviewed and approved its terms of reference in December 2022. The terms of reference were revised with changes to adhere to best practice and amendments to the Trusts approach to risk management. The Committee has also reviewed and approved its work plan for 2023/24.

The Committee also reviews the performance of its internal and external auditors' service against best practice criteria as detailed in the NHS Audit Committee Handbook.

External audit

The Council of Governors approved the appointment of Grant Thornton for a three-year term from 2019/20, with an option to extend for a further two years. This reporting period saw the last year of this appointment and the Trust is exploring the market to ascertain future options. This year's fee was £100,000. A separate fee is paid for work in connection with the hospital charity.

Their audit and non-audit fees are set, monitored and reviewed throughout the year and are included in the notes to the accounts.

Independence of external auditor

The Committee considered the independence of our external auditor undertaking non-audit work. No risks were identified in this respect, particularly in relation to self-review and familiarity. Our auditors will not be relying on any additional work undertaken when forming their opinion and we do not believe there to be a threat of familiarity.

Internal controls, internal audit and counter-fraud services

Internal audit services and counter fraud services are provided by KPMG. Internal audit cover financial and non-financial audits according to a risk-based plan agreed with the Audit & Risk Committee.

Counter fraud carry out reviews of areas at risk of fraud and investigate any reported frauds.

The audit plan of the internal auditors is risk- based, and the executive team works with the auditors to identify key risks to inform the audit plan. The Committee considers the links between the audit plan and the Board Assurance Framework. The Committee approves the internal audit plan and monitors the resources required for delivery.

During the year, the committee considers any proposed changes to the audit plan and monitors delivery against the plan approved at the start of the financial year.

The Head of Internal Audit Opinion 2022/23 was presented to the Audit & Risk Committee on 22 June for the period 1 April 2022 to 31 March 2023 an overall rating of ''Significant assurance with minor improvements" can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The Committee has reviewed the content of the annual report and accounts and taken as a whole:

a) It is fair, balanced and understandable and provides the necessary information for stakeholders to assess the Trust's performance
b) It is consistent with the annual governance statement, head of internal audit opinion and feedback received from the external auditors, and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately
c) It is appropriate to prepare the accounts on a going concern basis

The committee has approved the annual report and accounts under delegated authority from the board of directors.

Governors’ report

Council of Governors

The Council of Governors (the Council) is made up of elected and appointed governors who provide an important link between the Trust, local people and key stakeholder organisations. They share information and views that can influence and shape the way that services are provided by the Trust and they work together with the Board of Directors to ensure that the Trust delivers a high quality of healthcare within a strict framework of governance while achieving financial balance and planning for the future.

The Trust’s Constitution sets out the key responsibilities of the Council. Its general functions are to:

- Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- Represent the interests of the members of the Trust as a whole and the interests of the public.
- Appoint and, if appropriate, remove the Chairman and non-executive directors.
- Approve (or not) the appointment of any new chief executive.
- Decide on remuneration and allowances and other terms and conditions of office of the Chairman and non-executive directors.
- Receive the annual accounts, any report of the auditor, and the annual report at a general meeting of the Council of Governors.
- Appoint and, if appropriate, remove the foundation trust’s auditor.
- Approve ‘significant transactions’.
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution.
- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions.
- Approve amendments to the Trust’s constitution.

Membership of the Council of Governors

Members of the Trust, be they public or staff are all able to stand for election to the Council provided they are 16 years of age and are resident in the public constituency for which they are standing. Elected members of the Council are chosen by their constituency. The Council also includes appointed representatives from partner organisations and stakeholders from the local area to ensure a representation of views from the communities we serve.

The Chair of the Council is also the Chair of the Trust board, which promotes transparency and encourages the flow of information between the board and the Council.

The Council of Governors consists of 26 Governors and is composed of the following people:

Appointed Governors	Number
Local Authority (represented by a member of the Kent Health and Wellbeing Board)	1
Local Authority (represented by a member of the Medway Health and Wellbeing Board)	1
Local Authority – Swale Borough Council	1
University of Kent	1
Canterbury Christchurch University	1
University of Greenwich	1

Charity Representative (League of Friends)	1
Elected Governors (staff members)	**Number**
Staff Members	5
Elected Governors	**Number**
Medway	9
Swale	4
Rest of England and Wales	1

Public and Staff governors are elected for a maximum term of three years and are able to seek re-election for a further term.

Partner governors are nominated by their organisation and serve a term of office of three years. These governors can be replaced by their organisation during this time. An appointed governor is eligible for re-appointment at the end of their term.

Meetings of the Council of Governors

The Council held five ordinary meetings during 2022/23. Extraordinary meetings are also held from time to time when a decision is required outside of the normal schedule of meetings. For this reporting period two extraordinary meetings were held to review and approve the Trusts constitution.

Council of Governor members also attended the Trust annual general meeting in October 2022.

Individual attendance at Council meetings by governors and directors is detailed under Attendance at Council of Governors' meetings.

Lead Governor

The Council elects one of its members to be the Lead Governor who acts as the main point of contact for the Chair and Company Secretary, and between NHS England and the other governors, when communication is necessary.

The Lead Governor is responsible for communicating to the Chair any comments, observations or concerns expressed by governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business.

Cllr David Brake continued in the role as lead governor for the entire 2022/23 reporting period.

Committee of the Council of Governors

The Council has one committee, which is the Governors' Nominations and Remuneration Committee. The Committee has a number of responsibilities, including to review the remuneration of the non-executive directors each year; to be involved in the nomination process for all non-executive directors including the Chair; and to receive confirmation that appraisals have been carried out for the Chair and non-executive directors.

Membership

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. Members are invited to apply by completing a written or electronic application form.

Staff membership is available for staff members if they have a permanent contract, a 12-month or longer fixed term contract, have an honorary contract or are employed by the Trust although they may be working with other NHS organisations locally. Staff will automatically become Staff members unless they opt out.

In March 2023, the Trust had approximately 10,300 public members and 4,500 staff members giving a total of 14,800 members. The breakdown of our public membership by constituency is:

Constituency	Total
Medway	6,353
Swale	1,700
Rest of England and Wales	2,262
Membership total	10,315

As part of the Trusts “living with Covid” approach we moved to a hybrid approach of physical and online events and meetings. We held a series of events on including a members’ event considering the Trust’s Patient First programme and the Annual Members’ Meeting in October 2023 to name but a few.

Members received regular e-bulletins and received the Trust’s Special Edition News@Medway magazine by email which was also available on the Trust website.

The Trust’s membership strategy was reviewed by the Council of Governors in May 2022 and sets out how we attract, retain and engage with members. Our Community Engagement Officer and Governors held ‘Meet the Governor’ sessions in order to continue our engagement activity with our local community. This allowed us to share updates, support and encourage people to get involved and to form positive working relationship and a shared understanding of our community.

Through our engagement, we continued our efforts to establish our presence and strengthen networks and trust within the community.

Attendance at Public Council of Governors’ meetings

The information below outlines governors on the Council during 2022/23, together with their record of attendance.

	12/05/2022	11/08/2022	01/12/2022	09/02/2023	Total	Total (financial year 22-23)
George Findlay	Yes					
Jayne Black	Yes		Yes	Yes		3 out of 4
Partner Governors						
Cllr David Brake		Yes	Yes			**2 out of 4**
Susan Plummer	Yes	Yes	Yes			**3 out of 4**
Helen Belcher						**No attendance**
Claire Peppiatt-Wildman	Yes		Yes	Yes		**3 out of 4**

Cllr Angela Harrison		Yes		Yes		**2 out of 4**
Cllr John Wright	Yes	Yes	Yes			**3 out of 4**
Staff Governors						
Mohamed Mohamed	Yes		Yes	Yes		**3 out of 4**
Nithesh Mathai	Yes	Yes	Yes			**3 out of 4**
Lisa Marsh						**No attendance**
Vanessa Page		Yes	Yes	Yes		**3 out of 4**
Adebayo Da'Costa	Yes					**1 out of 4**
Medway Governors						
Penny Reid	Yes	Yes		Yes		**3 out of 4**
Diana Hill						**No attendance**
James Chespy	Yes					**1 out of 4**
Adrian Parsons		Yes	Yes	Yes		**3 out of 4**
Jacqui Hackwell	Yes	Yes		Yes		**3 out of 4**
Ian Chappell						**No attendance**
Timothy Newman		Yes	Yes			**2 out of 4**
Olaide Kazeem		Yes				**1 out of 4**
Martina Rowe						**No attendance**
Prof Anan Shetty		Yes	Yes			**2 out of 4**
Zoe Van Dyke	Yes	Yes	Yes			**3 out of 4**
Swale Governors						
Bill Sakaria						**No attendance**
Jennifer Oliphant		Yes				**1 out of 4**
Jay Patel		Yes	Yes	Yes		**3 out of 4**
David Nehra		Yes	Yes	Yes		3 out of 4
Rest of England & Wales Governor						
Rebecca Bellars		Yes	Yes			2 out of 4
Amran Hussain						**No attendance**
Non-Executive Directors						
Rama Thirunamachandran			Yes			**1 out of 4**
Ewan Carmichael	Yes					**1 out of 4**
Tony Ullman	Yes	Yes				**2 out of 4**
Joanne Palmer	Yes		Yes	Yes		**3 out of 4**
Mark Spragg	Yes	Yes	Yes	Yes		**4 out of 4**
Jenny Chong	Yes	Yes	Yes	Yes		**4 out of 4**
Sue Mackenzie						**No attendance**
Annyes Laheurte	Yes			Yes		**2 out of 4**

Paulette Lewis	Not in Post	Not in Post	Yes	Yes		**2 out of 4**
Adrian Ward						**No attendance**
Directors						
Glynis Alexander	Yes	Yes	Yes	Yes		**4 out of 4**
Paula Tinniswood	Yes					**1 out of 4**
Alison Davis	Yes			Yes		**2 out of 4**
David Sulch						**No attendance**
Leon Hinton	Yes	Yes	Yes	Yes		**4 out of 4**
Paul Kimber						**No attendance**
Gary Lupton	Yes	N/A	N/A	N/A		**1 out of 4**
Gurjhit Mahil						**No attendance**
David Seabrooke	Yes	N/A	N/A	N/A		**1 out of 4**
Alan Davies	Yes	Yes	Yes	Yes		**4 out of 4**
Liam Edwards						**No attendance**
Matt Capper	Not in post	Not in Post	Yes	Yes		**2 out of 4**
Evonne Hunt	Yes	Yes	Yes	Yes		**4 out of 4**

Director attendance at Public Council of Governors meetings 1 April 2022 to 31 March 2023

The Directors attend the meetings of the Council by invitation and to present routine assurance reports to the Council of Governors, in line with their duty to take steps to understand the views of governors and for the non-executive directors be held to account.

Dispute Resolution Process

In the event of disputes between the Council of Governors and the Board of Directors, the following Dispute Resolution Procedure shall apply:

1. In the first instance the Chair on the advice of the Company Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute.

2. If the Chair is unable to resolve the dispute the individual shall refer the dispute to the Company Secretary who shall appoint a joint special committee constituted as a committee of the Board of Directors and a committee of the Council of Governors, both comprising equal numbers, to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

3. If the recommendations (if any) of the joint special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

4. This dispute resolution procedure is set out in the Trust's Constitution which is available on the Trust's website.

Members may contact governors or Board members through the membership office by telephone on 01634 825292, by email to met-tr.members-medway@nhs.net, in writing to Membership Office, Gundulph, Medway Maritime Hospital, Medway NHS Foundation Trust, Windmill Road, Gillingham,

Kent, ME7 5NY, or through our website www.medway.nhs.uk

Disclosures

In setting its governance arrangements, the Trust has regard for the provisions of the NHS foundation trust code of governance 2014 (and the revised version implemented in April 2023) and other relevant guidance where provisions apply to the responsibilities of the Trust. The following section, together with the annual governance statement and corporate governance statement, explain how the Trust has applied the main and supporting principles of the code.

Principal activities of the Trust

Information on our principal activities, including performance management, financial management and risk, efficiency, employee information is outlined in the performance report.

Going Concern

The accounts have been produced on a “going concern” basis. Our going concern disclosure is detailed in the notes to the financial statements.

Directors' responsibilities

The directors acknowledge their responsibilities for the preparation of the financial statements.

Safeguarding external auditor independence

This is detailed under the Audit and Risk Committee section.

Off payroll engagements

Information about off-payroll engagements can be found below.

Transactions with related parties

Transactions with third parties are presented in the accounts. None of the other board members, the Foundation Trust's governors, or parties related to them have undertaken material transactions with the Trust.

Political Donations

There are no political donations to disclose.

Statement on better payment practice code (see note 17.1 of the accounts)

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust’s performance is set out below.

Note 17.1 Better Payment Practice Code

	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	58,897	129,566	61,357	136,657
Total non-NHS trade invoices paid within target	56,239	124,632	56,906	124,128
Percentage of non-NHS trade invoices paid within target	95.5%	96.2%	92.7%	90.8%
NHS Payables				
Total NHS trade invoices paid in the year	914	32,988	1,007	52,199
Total NHS trade invoices paid within target	801	31,696	689	47,406
Percentage of NHS trade invoices paid within target	87.6%	96.1%	68.4%	90.8%

The Better Payment Practice code requires that 95% of all valid invoices are paid by the due date or within 30 days of receipt of valid invoice, whichever is later.

NHS England well-led framework

The CQC Well Led inspections involve an assessment of:

- The leadership and governance at Trust board and executive team-level.
- The overall organisational vision and strategy.
- Organisation-wide governance, management, improvement; and
- Organisational culture and levels of engagement.

This draws on the CQC's wider knowledge of quality in the trust at all levels. Along with the implementation of Patient First, this methodology has formed the basis of the development programme for executive directors and informed the board development programme in 2022/23.

As part of their routine scheduled inspection programme, the CQC conducted a follow-up Well-led inspection of the Trust. The findings of this inspection were published in the summer 2022; the Trust received an improved rating of 'Good'.
The Trust has reviewed its position in relation to the enforcement undertakings agreed with NHS England – of 19 criteria, 17 have been discharged and work continues to close the remaining action points which all relate to the financial position of the Trust.

Stakeholder Relations

Over the past year we have been proactive in seeking the involvement of patients and public in the progress of the Trust and development of services, through workshops and focus groups and at events within the Trust.

The Trust's Chair and Chief Executive regularly meet key stakeholders to ensure they are kept informed about Trust progress and are able to support the involvement of the local community. Trust Executives also report to local authority scrutiny committees on a regular basis. Following the introduction of the Health and Care Act 22 the Trust is also a key partner in the Medway and Swale Health and Care Partnership and the Medway Health and wellbeing Board.

Patient Care

Please refer to the Quality Account published separately.

Fees and charges (income generation)

Please refer to the Annual Accounts.

Statement as to disclosure to auditors

Each individual who is a director at the date of approval of this report confirms that:

a) They consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
b) So far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.
c) They have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Medway NHS Foundation Trust's auditors are aware of that information.

The directors have taken all the steps that they ought to have taken as directors in order to do the things mentioned above, and:

a) Made such enquiries of his/her fellow directors and of the company's auditors for that
b) purpose; and
c) Taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.
d) All Board members have been assessed against the requirements of the fit and proper person test.

Income disclosures required by Section 43 of the NHS Act 2006

The Trust met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The bulk of our income is clinical income and it is unlikely that 'other income' will exceed clinical income for any reporting period.

Remuneration report

Annual Statement on remuneration

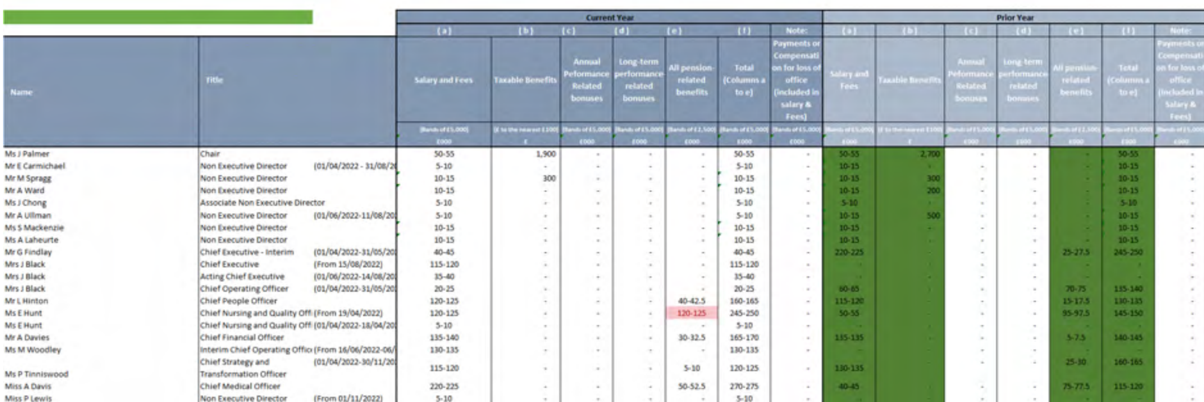
The Nominations and Remuneration Committee is a sub-committee of the Board, responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of the executive directors and all very senior manager appointments. Further details of the committee can be found within the Directors' Report section of this document. We have recruited on a substantive basis to senior leadership roles. Newly appointed executive directors have a notice period of six months.

Senior Managers Remuneration Policy

The Trust has a Senior Remuneration policy agreed by the Nominations and Remuneration Committee. The Trust recognises that in order to ensure optimum performance it is necessary to have a competitive pay and benefits structure. The objective of the Committee's strategy for the remuneration of executive directors and very senior managers is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources and strength and maintaining stability throughout the senior management team. Remuneration is therefore set and maintained to be competitive. The Nominations and Remuneration Committee reviews salaries each year. In 2022/23 the Nominations and Remuneration Committee considered and approved a recommendation for a consolidated cost of living award, for executives in their position on 1 April 2022.

Director salaries were within benchmarked salary ranges. When new appointments are made the salary is determined by reference to the NHS England and NHS Providers benchmarking of executive director salaries, current market rates and internal relativities with executive directors/very senior managers. The only non-cash elements of executive remuneration packages are pension-related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme, which applies to all NHS staff under the scheme.

The figures in the table below relate to the amounts received during the financial year. For 2022/23 there were no annual or long-term performance bonuses.



Name	Title		Current Year (a) Salary and Fees (Bands of £5,000) £000	(b) Taxable Benefits (£ to the nearest £100) £	(c) Annual Peformance Related bonuses (Bands of £5,000) £000	(d) Long-term performance related bonuses (Bands of £5,000) £000	(e) All pension-related benefits (Bands of £2,500) £000	(f) Total (Columns a to e) (Bands of £5,000) £000	Note: Payments or Compensation for loss of office (included in salary & Fees) (Bands of £5,000) £000	Prior Year (a) Salary and Fees (Bands of £5,000) £000	(b) Taxable Benefits (£ to the nearest £100) £	(c) Annual Peformance Related Bonuses (Bands of £5,000) £000	(d) Long-term performance related bonuses (Bands of £5,000) £000	(e) All pension-related benefits (Bands of £2,500) £000	(f) Total (Columns a to e) (Bands of £5,000) £000	Note: Payments or Compensation for loss of office (included in Salary & Fees) (Bands of £5,000) £000
Ms J Palmer	Chair		50-55	1,900	-	-	-	50-55	-	50-55	2,700	-	-	-	50-55	-
Mr E Carmichael	Non Executive Director	(01/04/2022 - 31/08/2	5-10	-	-	-	-	5-10	-	10-15	-	-	-	-	10-15	-
Mr M Spragg	Non Executive Director		10-15	300	-	-	-	10-15	-	10-15	300	-	-	-	10-15	-
Mr A Ward	Non Executive Director		10-15	-	-	-	-	10-15	-	10-15	200	-	-	-	10-15	-
Ms J Chong	Associate Non Executive Director		5-10	-	-	-	-	5-10	-	5-10	-	-	-	-	5-10	-
Mr A Ullman	Non Executive Director	(01/06/2022-11/08/20	5-10	-	-	-	-	5-10	-	10-15	500	-	-	-	10-15	-
Ms S Mackenzie	Non Executive Director		10-15	-	-	-	-	10-15	-	10-15	-	-	-	-	10-15	-
Ms A Laheurte	Non Executive Director		10-15	-	-	-	-	10-15	-	10-15	-	-	-	-	10-15	-
Mr G Findlay	Chief Executive - Interim	(01/04/2022-31/05/20	40-45	-	-	-	-	40-45	-	220-225	-	-	-	25-27.5	245-250	-
Mrs J Black	Chief Executive	(From 15/08/2022)	115-120	-	-	-	-	115-120	-	-	-	-	-	-	-	-
Mrs J Black	Acting Chief Executive	(01/06/2022-14/08/20	35-40	-	-	-	-	35-40	-	-	-	-	-	-	-	-
Mrs J Black	Chief Operating Officer	(01/04/2022-31/05/20	20-25	-	-	-	-	20-25	-	60-65	-	-	-	70-75	135-140	-
Mr L Hinton	Chief People Officer		120-125	-	-	-	40-42.5	160-165	-	115-120	-	-	-	15-17.5	130-135	-
Ms E Hunt	Chief Nursing and Quality Offi	(From 19/04/2022)	120-125	-	-	-	120-125	245-250	-	50-55	-	-	-	95-97.5	145-150	-
Ms E Hunt	Chief Nursing and Quality Offi	(01/04/2022-18/04/20	5-10	-	-	-	-	5-10	-	-	-	-	-	-	-	-
Mr A Davies	Chief Financial Officer		135-140	-	-	-	30-32.5	165-170	-	135-135	-	-	-	5-7.5	140-145	-
Ms M Woodley	Interim Chief Operating Offic	(From 16/06/2022-06/	130-135	-	-	-	-	130-135	-	-	-	-	-	-	-	-
Ms P Tinniswood	Chief Strategy and Transformation Officer	(01/04/2022-30/11/20	115-120	-	-	-	5-10	120-125	-	130-135	-	-	-	25-30	160-165	-
Miss A Davis	Chief Medical Officer		220-225	-	-	-	50-52.5	270-275	-	40-45	-	-	-	75-77.5	115-120	-
Miss P Lewis	Non Executive Director	(From 01/11/2022)	5-10	-	-	-	-	5-10	-	-	-	-	-	-	-	-

These figures have been audited.

Total Pension Entitlement

The table below excludes director who are paid via off-payroll arrangements, on another organisation's payroll and those who have drawn their pension. These figures have been audited.

		Current Year						
		(a)	(b)	(c)	(d)	(e)	(f)	(g)
Name	Title	Real Increase in pensions at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2023	Lump sum at pension age related to accrued pension at 31st March 2023	Cash Equivalent Transfer Value at 1st April 2022	Cash Equivalent Transfer Value at 31st March 2023	Real increase in Cash equivalent Transfer value
		(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000
Mr L Hinton	Chief People Officer	0-2.5	0-2.5	35-40	25-30	368	413	25
Ms P Tinniswood	Chief Strategy and Transformation Officer	0-2.5	0	5-10	0	89	112	5
Mr A Davies	Chief Financial Officer	2.5-5	0	55-60	160-165	-	41	21
Miss A Davis	Chief Medical Officer	2.5-5	0-2.5	75-80	155-160	1,454	1,592	67
Ms E Hunt	Chief Nursing and Quality Officer	5-7.5	0-2.5	25-30	45-50	353	416	34

Notes;
As Non-executive Directors do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive Directors
(e - g) A Cash Equivalent Transfer Value (CETV) is the actuarily assessed capital value of the pension scheme benefits accrued by a member at a particular point in time
The benefits values are the members accrued benefits and any allowable beneficiarys pension payable from the the scheme.
CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
(g) Real increase in CETV reflects the increase effectively funded by the employer. It takes account of the increase in accrued pension due to inflation,

Staff Costs

			2022/23	2021/22
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	215,439	1,109	**216,548**	**196,071**
Social security costs	24,252	-	**24,252**	**21,075**
Apprenticeship levy	1,067	-	**1,067**	**976**
Employer's contributions to NHS pension scheme	32,944	-	**32,944**	**30,289**
Pension cost - other	22	-	**22**	**14**
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	8,404	**8,404**	**7,688**
Total gross staff costs	**273,724**	**9,513**	**283,237**	**248,425**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**273,724**	**9,513**	**283,237**	**256,113**
Of which				
Costs capitalised as part of assets	-	-	-	-

These figures have been audited.

Expenses of Governors and Directors

The directors and governors receive reimbursement of travel and incidental expenses incurred as a result of their duties to the Trust, this is presented in the table below.

	Number in receipt of expenses 2022/23	Aggregate sum of expenses paid 2022/23	Aggregate sum of expenses paid 2021/22
Directors	9	4955.41	6502.9

Fair Pay Multiple

The table below provides the ratio between the highest paid Director in the trust and the median total remuneration of the whole workforce.

		Pay Multiplier	
		2021/22	2022/23
Band of Highest Paid Director	(£'000)	220-225	185-190*
Median Total Remuneration	(£'000)	26.0	27.0
	Ratio	8.7	7.0

* Amount adjusted from senior manager disclosure to reflect c.16% of cost is covered by NHS England

These figures have been audited.

Expenditure on consultancy

The Trust spent £1,738,000 on consultancy during 2022/23; this was a change of £1,198,000 compared to the previous year (2021/22) of £540,000. The increase is due to the support and roll out of the Trusts Patient First improvement methodology.

Jayne Black
Chief Executive
[date]

Staff report

The table below profiles the average worked full-time equivalent workforce across the organisation (including temporary staff) throughout 2022/23.

	Permanent	Other	2022/23 Total	2021/22 Total
	Number	Number	Number	Number
Medical and dental	762	9	771	704
Ambulance staff	-	-	-	-
Administration and estates	868	4	872	855
Healthcare assistants and other support staff	1,373	-	1,373	1,360
Nursing, midwifery and health visiting staff	1,410	31	1,441	1,378
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	438	17	455	458
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	**4,851**	**61**	**4,912**	**4,755**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

These figures have been audited.

Male and Female Employees

The table below profiles the voting Board Directors (Executive and non-executive) and other senior managers (by contractual full-time equivalent) on 31 March 2023.

	Voting Board Director	Other Senior Managers	All Staff
Female	3	30	3934
Male	4	17	1133
Total	7	47	5067

Sickness Absence Data

The table below sets out the Trust's sickness absence for 2022/23 compared with 2021/22. The overall sickness rate has increased over the last 12 months and equates to 18.00 average days sick per full-time employee. This has reduced from an average of 18.95 days in 2021/22.

The Trust is proactively managing sickness with improved reporting for managers, a policy to support and manage individuals with high sickness levels.
As part of keeping staff healthy and patient's safe, the Trust achieved a staff flu vaccination rate of over 75 per cent in 2022/23

Staff Group	2022/23	2021/22
Additional Professional, Scientific and Technical	4.81%	3.73%
Additional Clinical Services	7.13%	8.77%
Administrative and Clerical	4.03%	4.47%
Allied Health Professionals	3.46%	3.65%
Estates and Ancillary	7.41%	6.23%
Healthcare Scientists	2.12%	0.87%
Medical and Dental	2.15%	2.17%
Nursing and Midwifery Registered	5.29%	5.22%
Students	0.00%	0.00%

Staff policies

Staff policies and actions applied during the financial year
The Trust maintains policies and takes actions to enable the wellbeing, progression and development of staff. The relevant policies and operating procedures are set out in the table below. In addition the Trust consults regularly with the NHS Trade Unions on the review and application of policies; staff health and wellbeing; and organisational change.

Policies and Standard Operating Procedures:

Policy/SoP	How it supports the workforce	Renewal Date
Disability in Employment Policy	Enables the employment of disabled persons by ensuring due regard to their skills and abilities; this policy applies at recruitment and throughout employment, including, where appropriate, reasonable adjustments and adaptations. (see also the Attendance Management Policy)	October 2023
Attendance Management Policy and SOP	This policy is designed to support employees' attendance, and enable employees to remain in work/return to work after absence. The SOP includes the Trust's procedure for Assessment of Adjustment.	April 2025
Flexible Working Policy	This policy provides the framework for flexible working to be considered and applied fairly.	May 2025
Maternity Leave & Fertility Treatment policy	This is the framework to ensure correct and fair application of maternity-related entitlements, including maternity leave, keeping in touch and return to work.	November 2024
Shared Parental Leave Policy & Procedure	This is the framework to ensure correct and fair application of Shared parental leave entitlements, including leave, keeping in touch and return to work.	November 2025
Parent Leave Policy	This is the framework to ensure correct and fair application of entitlements for partners not already eligible for maternity leave.	November 2024
Adoption Leave Policy & Procedure	This is the framework to ensure correct and fair application of Adoption leave entitlements, including leave, keeping in touch and return to work.	November 2024
Dignity at Work Policy	This policy seeks to raise awareness of the expected standards of behavior in the workplace and the principles through which bullying and harassment will be eliminated and prevented.	Under review at time of publishing
Grievance Policy & Procedure	To set out the framework within which any concerns, problems or complaints raised by employees will be addressed and resolved in a fair, consistent and timely manner as near as possible to the point of origin, and in accordance with the principles of the ACAS Code of Practice and guidance.	Under review at time of publishing
Disciplinary Policy	The purpose of this policy and procedure is to encourage employees to achieve and maintain high standards of conduct and behavior in accordance with the requirements of the Trust and relevant professional codes of conduct.	Under review at time of publishing
Performance Management Policy & Procedure	To provide a standard framework to address issues of staff performance in a fair and consistent manner, so staff are aware of the level of performance expected from them.	November 2024
Employing Staff in the Reserve Forces	This is a new policy drawing together from other policies the Trust's commitment to staff who are members of the Reserve Forces, enabling them to be released for training and mobilisation.	December 2025

Apprenticeship Policy	This sets out the framework to enable the recruitment of apprentices at all levels (including internal development opportunities) and all ages.	October 2023
Organisational change policy	Where organisational changes are required, this policy aims to ensure consistency of practice, consultation where necessary and involvement of staff and Trade Unions in informing the outcome.	November 2024
Health and Safety Policy	This policy sets out the organisational framework to outline how the Trust achieves compliance with the Health and Safety at Work Act 1974 and associated regulations as required by law. It also ensures all Trust employees are aware of their individual role and responsibilities for health and safety within the organisation. Ensures robust systems are in place to report and investigate health and safety incidents in order to identify lessons learnt to be embedded in policy to support continuous improvement.	April 2025
Inclusion Policy	This policy sets out the Trust's commitment to the Equality Act 2010, and to NHS workforce standards (such as the Workforce Race Equality Standard)	June 2023
Freedom to Speak Up/Raising Concerns at Work/Whistleblowing Policy	This enables staff to be able to raise concerns at work safely, and for the Trust to respond to those concerns.	May 2025
Relationship between Medway NHS Foundation Trust and NHS Trade Unions Policy	This policy provides the framework for the NHS Trade Unions and Trust Managers to meet regularly to review: application of policies, staff wellbeing and organisational change	April 2023
Anti-Fraud, Bribery and Corruption Policy	The aim of the policy and procedure is to set out clearly for staff, the framework and controls in place for dealing with all forms of detected or suspected fraud, bribery and corruption.	March 2025

National NHS Staff Survey 2022

The NHS staff survey is a vital measure of the Trust's level of staff engagement, how staff are feeling, their morale and their experiences of working here. This is used by the Trust to listen and adapt to make improvements. The survey is conducted annually and compared against other NHS acute organisations and also against the Trust's own results from the previous year. This provides not only an opportunity to learn from our staff, but also how we compare to the national picture.
Since 2021, the Trust has improved in five of the seven themes; we are compassionate and inclusive; we each have a voice that counts; we are safe and healthy; we are always learning and we are a team. The score for we work flexibly remained static and the score for we are recognised and rewarded dropped by 0.1 points, mirroring the national picture. The Trust's People Strategy retains culture as a key delivery programme for the future. By continuing the embedding of our culture improvement programme in tandem with our staff survey action planning and implementation, values-based recruitment and continuous improvement methodologies – the Trust is committed to improving our staff experience which, in turn, will improve patient experience.

This year's Staff Survey response rate was 40 per cent, which is unchanged from 2021.

The survey is aligned with the seven People Promise element and in itself is critical to the promise that we each have a voice that counts. Employee voice is a fundamental enabler for employee engagement. Alignment of the survey with the People Promise elements began in 2021 therefore the 2022 results offers a two-year trend. This year eligibility was extended to active, in-house, bank only workers (staff who do not have a substantive or fixed term contract with the organisation). This is the first national data collection for bank only staff.

The seven People Promises:

The two themes, Staff Engagement and Staff Morale, are scored out of 10. The below table shows the People Promise themes for the Staff Survey.

The Staff Engagement score was 6.6 for 2022 and has increased by 0.1 since 2021. Our target as a Trust (our True North objective) is to move our staff engagement score to the upper quartile of national results by 2025, which is a score of 6.9.
The Staff Morale score was 5.6 for 2022 and has similarly improved by 0.1 since 2021.

The theme indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group (acute) are presented below.

People Promise	2021 score	2021 respondents	2022 score	2022 respondents
We are compassionate and inclusive	6.9	1839	7.0	1826
We are recognised and rewarded	5.7	1832	5.6	1817
We each have a voice that counts	6.4	1816	6.5	1803
We are safe and healthy	5.6	1818	5.7	1812
We are always learning	5.4	1736	5.5	1747
We work flexibly	5.9	1813	5.9	1804
We are a team	6.4	1829	6.6	1816
Themes				
Staff Engagement	6.5	1843	6.6	1826
Morale	5.5	1842	5.6	1826

Application of Modern Slavery Act

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero-tolerance approach to any form of modern slavery. The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

- People - Human resources policies provide processes and procedures to ensure that our employees and those employed in our supply chains are treated fairly at all times; these include:
  - Confirming the identities of all new employees and their right to work legally in the UK.
  - To have assurance from approved agencies that pre – employment clearance has been

obtained for agency staff and to safeguard against human trafficking.

- All staff appointed are subject to references, immigration and identity checks, this is to ensure staff have the legal right to work in the UK.
- The Trust has a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the recruitment selection process.

- Adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated, fairly and that pay, terms and conditions will comply with the latest legislation.
- The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers and also to comply with the relevant legislation. These are accessible on the intranet.
- The Trust is committed to creating and ensuring a non – discriminatory and respectful working environment for all staff, this is in line with its corporate social responsibilities.
- The Trust's Equality, Diversity and Inclusion, Grievance, Respect and Dignity at Work and Whistleblowing policies and procedures additionally give a platform for all employees the Freedom to Speak Up and to raise concerns about poor working practices.
- Ensuring appropriate mechanisms to regularly review and monitor progress on promoting and supporting diversity and inclusion within the Trust.
- All staff are required to undertake mandatory training in relation to diversity and inclusion and safeguarding.

- Whistleblowing (Freedom to Speak Up) – The Trust's Whistleblowing policy gives a platform for employees to raise concerns for further investigation and offers support to individuals that have suffered fiscal or professional detriment as a result of whistleblowing.
    - The Trust operates a Freedom to Speak Up, Raising Concerns at Work, so employees feel empowered to raise concerns around poor practices, health and safety or illegal activities which may bring harm to the Trust.

- Safeguarding – The Trust is committed to the principles setup in our safeguarding adults and children policies.
    - The Trust is compliant with Medway multiagency agreements.
    - Ensure clear safeguarding guidance so that employees, contractors, patients and the public are able to raise safeguarding concerns about how they are being treated or/ and about working practices at the Trust.

- Our approach to procurement and our supply chain includes:
    - Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes;
    - Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials;
    - Random requests that the main contractor provides details of its supply chain;
    - Ensuring invitation to tender documents contain a clause on human rights issues;
    - Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws;
    - Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery).
    - Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
    - Supplier adherence to our values: the Trust has zero tolerance to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.

Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our compulsory staff induction

training.

Trade Union Facility Time

Trade Union Facility Time disclosures

The Trust and recognised Trade Unions work through a partnership agreement to describe the partnership, processes and structures which are linked to our shared goals and objectives. The agreement outlines how we will work together to promote effective partnership regarding the workforce implications of delivering and developing the services we provide to our patients. In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017, we are required to produce an annual report detailing the facility time (the provision of time off from an employee's normal role to undertake Trade Union duties and activities when they are elected as a Trade Union representative); this information is provided below. The first publication year was 1 April 2017 to 31 March 2018 and the data must be published on or by 31 July every year thereafter.

Table1

Relevant union officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
19	16.84

Table2

Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	17
1-50%	2
51-99%	0
100%	0

Table3

Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£430.00
Provide the total pay bill	£242,425,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.00018%

Table4

Paid trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**51.81%**

Exit packages

Staff exit packages

Reporting of compensation schemes - exit packages 2022/23

		Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
		Number	Number	Number
Exit package cost band (including any special payment element)				
<£10,000		-	7	**7**
£10,000 - £25,000		-	1	**1**
£25,001 - 50,000		-	-	-
£50,001 - £100,000		-	1	**1**
£100,001 - £150,000		1	-	**1**
£150,001 - £200,000		-	-	-
>£200,000		-	-	-
Total number of exit packages by type		**1**	9	**10**
Total cost (£)		106,000	125,000	**231,000**

Reporting of compensation schemes - exit packages 2021/22

		Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
		Number	Number	Number
Exit package cost band (including any special payment element)				
<£10,000		-	3	**3**
£10,000 - £25,000		3	2	**5**
£25,001 - 50,000		1	2	**3**
£50,001 - £100,000		-	1	**1**
£100,001 - £150,000		1	-	**1**
£150,001 - £200,000		-	-	-
>£200,000		-	-	-
Total number of exit packages by type		**5**	8	**13**
Total resource cost (£)		£188,000	£220,000	**£408,000**

includes increase to amounts declared in 21/22 annual report following additional information provided by NHSEngland

Exit packages: other (non-compulsory) departure payments

	2022/23		2021/22	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	9	125	6	120
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	2	100
Total	**9**	**125**	**8**	**220**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

These figures have been audited.
2022/23

NHS Foundation Trust Code of Governance

Code of Governance

The NHS Foundation Trust Code of Governance was consulted on and updated for implementation in April 2023 (the Code) and brings together best practice from both the public and private sector in order to help NHS Foundation Trust Boards maintain good quality corporate governance. Although the Code is best practice advice, certain disclosures are required to be reported in the Trust's Annual Report, along with additional requirements as stated in the Annual Reporting Manual. The Trust's compliance is stated below with these requirements.

Code of Governance for NHS Foundation trusts - self assessment

Section	Provision	Comply/Explain
A2	**Provisions**	
A2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Comply
A2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaborative. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Comply
A2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Comply

A2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Comply
A2.5	In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	Comply
A2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply
A2.7	The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	Comply

A2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	Comply
A2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Comply
A2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	Comply
A2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Comply
B2	Provisions	
B2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply
B2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	Comply
B2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply

B2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Comply
B2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Comply
B2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: •has been an employee of the trust within the last two years. •has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust •has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme •has close family ties with any of the trust's advisers, directors or senior employees holds cross-directorships or has significant links with other directors through involvement with other companies or bodies •has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval). Is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Comply
B2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply
B2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time	Comply

B2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	Comply
B2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Comply
B2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Comply
B2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Comply
B2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	Comply
B2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Comply

B2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply
B2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Comply
B2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	Comply
C2	Provisions	
C2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply

C2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	Comply
C2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	Comply
C2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	Comply
C2.5	Open advertising and advice from NHS England’s Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Comply
C2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	Comply
C2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	Comply
C2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Comply

C2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Comply
C2.10	A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	Comply
C2.11	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	Comply
C2.12	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	Comply
C2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	Comply
C2.14	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	Comply
C3	For NHS trust board appointments	
C3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Comply
C4	Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts	

C4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Comply
C4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Comply
C4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Comply
C4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	Comply
C4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Comply
C4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Comply

C4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	Comply
C4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: Holding the non-executive directors individually and collectively to account for the performance of the board of directors communicating with their member constituencies and the public and transmitting their views to the board of directors contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	Comply
C4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	Comply
C4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	Comply
C4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Comply

C4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply
C4.13	The annual report should describe the work of the nominations committee(s), including: the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served the gender balance of senior management and their direct reports.	Comply
C5	Development, information and support	
C5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	

C5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	
C5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply
C5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Comply
C5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply
C5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Comply

C5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	Comply
C5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Comply
C5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required	Comply

C5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Comply
C5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Comply
C5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Comply

C5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Comply
C5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Comply
C5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Comply
C5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included. The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	Comply

C5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Comply
D2	Provisions	
D2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Comply

D2.2	The main roles and responsibilities of the audit committee should include: monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors reviewing and monitoring the external auditor's independence and objectivity reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.	Comply
D2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	Comply

D2.4	The annual report should include: the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Comply
D2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.	Comply
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Comply
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Comply

D2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Comply
D2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	Comply
E	**Remuneration**	

E2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Comply
E2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply
E2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Comply

E2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.	Comply
E2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Comply
E2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Comply

E2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	Comply
E2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	Comply
AB2.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.	Comply
AB2.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.	Comply
AB2.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	Comply

AB2.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Comply
AB2.5	The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.	Comply
AB2.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.	Comply
AB2.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Comply
AB2.8	The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.	Comply

AB2.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, e.g. clinical statistical data and operational data.	Comply
AB2.10	The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.	Comply
AB2.11	Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Comply
AB2.12	It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	Comply
AB2.13	The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.	Comply

AB2.14	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Comply
AB2.15	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Comply

NHS Oversight Framework

Oversight Framework

The NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at four themes: Quality, access and outcomes, Finance

and use of resources, Preventing ill health and reducing inequalities People, Leadership and capability

Based on information from these themes, providers are catagorised from one to four, where ‘four’ reflects providers receiving the most support, and ‘one’ reflects providers with maximum autonomy.

A Foundation Trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

The Trust was entered into enforcement undertakings in 2017 with the then NHS improvement. This position has been under review and a full progress review was undertaken in 2021. Although the category 4 status was not lifted from the trust, it was recognised that much progress had been made. Progress is reported through the year through regionally led oversight meetings. To date only the financial sustainability of the trust is listed on its ‘undertakings’ for breach of its license.

Statement of the chief executive's responsibilities as the accounting officer of Medway NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Medway NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Medway NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care

Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Jayne Black
Chief Executive

[Date]

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Medway NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Medway NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and for ensuring adherence to the guidance issued by NHS England, Department of Health and Social Care and the CQC in respect of governance.

However, the Chief Nursing Officer has had specifically defined responsibilities for leading on the management of risk throughout the Trust. Day to day management of risks is undertaken by operational management, who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly of all managers.

The Trust has an Integrated Risk Management Strategy and Policy in place which clearly sets out the accountability, reporting arrangements, identification, management for the control of risk, along with the risk management process of escalation and de-escalation to be followed. All relevant policies and procedures relating to risks are available to staff via the Trust intranet. The executive directors also monitor planned actions to mitigate risks and considers risks for inclusion in the corporate risk register or Board Assurance Framework. Risk management is a core component of the job descriptions of senior managers within the Trust.

The Trust's integrated quality and performance report is reviewed by all committees of the board and the Trust Board at each meeting. Deep dives are usually carried out for indicators where there is

sustained adverse performance. There are monthly performance improvement meetings between the group executive and the divisions to discuss areas of adverse performance as well as a dedicated risk review group which has representation from all areas of the trusts business.

The Trust learns from good practice through a range of mechanisms including clinical supervision and performance management, continuing professional development, clinical and process audit and application of evidence-based practice. At the heart of the Trust Risk Management framework is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate, changes will be made to the Trust's systems to enable this to happen.

The risk and control framework

The process starts with systematic identification of risks which are then evaluated, graded and either managed locally (with risk control measures identified and implemented to mitigate the potential for harm), or escalated for possible inclusion in the clinical or corporate risk registers. There are clear lines of accountability for the management of risks with an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/ de-escalation and challenge.

A risk management matrix with clear risk descriptors and tolerance levels is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and the Trust's appetite for risk is set within the boundaries of this risk evaluation. The Trust seeks to reduce risks to a level as low as reasonably practicable, however it is recognised that delivering healthcare carries inherent risks that can never be completely eradicated. The Trust recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes. The Board and its committees are aligned to assure that there is independent and strategic focus on risk and assurance.

A Patient Safety Group, chaired by the Director of Integrated Governance, Quality & Patient Safety meets monthly to ensure detailed scrutiny of, and learning from incidents, as well as the early identification of emerging themes and associated organisational risks.

During 2022/23 we embarked on a review of our corporate governance structures following the introduction of the trust wide Patient First continual improvement approach. Our arrangements provide the necessary support to deliver our operational priorities, improvement plans and strategic ambitions. This included a refreshed Executive structure to ensure optimal assurance and alignment to Board committees. A refreshed constitution and scheme of delegation was drafted and the organisation's clinical division structure was amended. The Trust Executive Team continues to reinforce the importance of clinical leadership and oversees a number of supporting sub-committees. The Board Assurance Framework sets out the principal risks to delivery strategic objectives and the key controls and assurances available to the Board on management of these significant areas of risk. The Board Assurance Framework also includes any Operational Risks, which may affect the achievement of the Trust's Patient First True North Domains escalated to the Board by the Executive.

At the end of the 2021/22 the Board Assurance Framework highlighted six areas where the Board has limited or partial assurance despite significant management attention:

- Lack of mitigating options against medical staffing (agency/locum/additional sessions) overspend (red 5x5 = 25), and
- There is a risk that the Trust may be unable to staff clinical and corporate areas to acceptable levels (red 4x4 = 16).
- Delivery of the control total and Financial Recovery Plan (red 5x5 = 25).
- Not delivering the Efficiencies Programme (red 4x5 = 20).
- The financial impact of non-closure of escalation areas (red 4x4 = 16).
- Internal financial governance controls, linked to efficiencies programme (red 4x4 =16)

Each year the Board completes a formal strategic risk review to identify new or continued principal risks which might threaten the achievement of the Trust's strategy and assigns them to a lead executive director. These risks are taken forward for the new financial year and overseen through the

Board Assurance Framework by the appropriate executive and Board committee.

For 2022/23, the Trust utilised many central control and assurance functions to ensure continued identification and evaluation of risk.

These included:
- Effective mechanisms in place to act upon national safety alerts and recommendations
- Our performance management framework, including an Integrated Quality and
- Performance Report across all aspects of the organisation.
- Analysis of patient experience, ward-level performance, incidents and complaints, monthly financial reporting and quality improvement activity
- Assurances provided through the work of the appropriate Risk and Assurance governance routes and reported to the Board and Committees.
- Learning from incidents and near misses and working with system partners to scrutinise response and actions.
- Risk assessments and analysis of risk registers and the Board Assurance Framework.
- Assurance from the Quality and Assurance Committee and the Audit and Risk Committee to the Board.
- Clinical audit, including national audits, audits arising from national guidance (for example from NICE), confidential enquiries and local audits related to patient safety and quality of care.
- Internal assurances through our internal audit activities and independent.
- External regulatory and assessment body inspections and reviews including the Care Quality Commission (CQC), Royal Colleges, Postgraduate Deanery, Information Commissioner's Office and Health and Safety Executive reports.
- Self-assessment against the compliance framework and CQC registration requirements, including well-led reviews.
- Freedom to speak up guardian and guardian of safe working hours (for doctors in training).

Quality governance arrangements

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year. The Chief Nursing Officer and the Chief Medical Officer are joint nominated Trust Executive Leads for the Quality Account. The quality priorities have been developed in consultation with a wide range of stakeholders; membership, patients, staff, board members. Delivery of the quality priorities will be monitored at the Quality Assurance Committee and by the Trust Board. You can read more about our priorities and developments in the Quality Account (published separately).

Our quality governance framework is built upon the principles described within the eight domains of NHS England and the CQC's well-led framework. Quality is deeply embedded in the Trust's overall Patient First strategy. Our refreshed organisational strategy was developed in liaison with staff, governors and wider partners and approved by the Board in July 2022. The strategy reinforces the vision, values and Patient First True North Domains. The Board actively engages in quality of care with patients, the public, staff and other relevant stakeholders through a number of different mechanisms and forums.

Quality targets are linked to divisions and quality governance is delegated to each one, with assurance reported to the Quality and Patient Safety sub-committee and ultimately the Quality and Assurance Committee. Each committee receives the monthly Integrated Quality and Performance Report, with up-to-date information on key quality, safety and performance indicators including patient safety, patient experience and clinical effectiveness. The Board receives the information bi-monthly.

The Trust's Scheme of Delegation details decisions reserved for the Board and its committees. This is being reviewed as part of the overall governance review. We are establishing four divisions that will provide world-class care to the diverse communities that we serve, and will be supported by our corporate services. These divisions are (from June 2023):

- Medicine & Emergency Care
- Surgery & Critical Care
- Women, Children & Young People
- Cancer & Core Clinical Services

Each division is the key building block of successfully delivering our core objectives and to ensure that strong clinical leadership remains at the heart of decision making at all levels of the Trust.
The governance arrangements underpinning the Trust operating model are kept under close review to ensure that issues and risks relating to quality of care are managed and where necessary escalated appropriately, and also to identify areas for improvement in executive or Board oversight of the performance of the divisions.

Assessing the quality of performance information

Our data-driven performance framework is used to monitor key performance indicators at corporate trust level, divisional and care group level, with a monthly Integrated Quality and Performance Reports collating trends and analysis for Committee and Board review and public scrutiny. A risk-based assessment of the data associated with key indicators helps determine the programme undertaken by the Trust's internal auditors and the quality of our information is also audited.

Assurance on compliance with the Health and Social Care Act 2008

The Trust is fully compliant with the registration requirements of the CQC. A range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. The Trust underwent a full assurance review with the CQC, providing assurance on our maternity services. The CQC carried out an unannounced inspection of our maternity services and awarded the trust a 'Good' rating. The Trust is currently rated:

Service	Date	Rating
Medical care (including older people's care)	30 July 2021	Requires improvement
Services for children & young people	30 July 2021	Requires improvement
Critical care	30 April 2020	Outstanding
Diagnostic imaging	26 July 2018	Requires improvement
End of life care	30 April 2020	Good
Maternity	28 April 2023	Good
Outpatients	26 July 2018	Good
Surgery	30 April 2020	Requires improvement
Urgent and emergency services	24 June 2022	Good

Managing risks to data security

All staff receive data security training as part of their corporate induction upon joining the Trust, with annual information governance and information security training mandated for all staff. Training requirements are supported by comprehensive policies and guidance to ensure access to relevant and up-to-date information.

An information asset owner (IAO), with responsibility for managing information risks, is named for each key information asset and is supported by specialist information security and information governance staff. Registers of information assets, flows and uses are maintained, reviewed and updated in year.

The Trust's annual Data Security and Protection Toolkit submission to NHS Digital on 30 June achieved an assessment of 'Partial Assurance with improvements required' rating.

The Trust is assessed for a level of confidence in the veracity of the DSP Toolkit self-assessment as per the NHS Strengthening Assurance Assessment Guide and our internal auditors felt our self-assessment provided a medium confidence level. The overall standard classification risk rating was described as moderate as no standards were rated as 'Unsatisfactory' and one or less are rated as 'Limited'. However, not all standards were rated as 'Substantial'.

An example of the areas where the Trust requires improvement are:

- Data security and protection training has not been completed in a timely manner for a proportion of new joiners
- A proportion of sampled user accounts of those no longer at the Trust had not been promptly disabled.
- Backups are not kept securely and separate from the Trust's network (offline), or in a cloud service designed for this purpose.

The Trust has compiled a recovery plan and these actions and their achievement will be tracked by the trusts internal audit tracker and will be overseen by the Audit and Risk Committee.

The Trust introduced a new electronic health record system during the reporting year and the programme continues to mature.

All information incidents and near misses are investigated and used as opportunities to improve processes and reduce risk. This is reinforced by information governance and information security awareness training that focuses on the need for safe processing and protection of personal and sensitive data.

As with all NHS organisations, we face continual challenges in balancing the delivery of high quality care with rising demand, rising acuity, rising rates of inflation and the need to increase both productivity and efficiency to meet challenging activity requirements.

Successful management of our risk management strategy and policy will be critical in enabling the Trust to do this in the future. We recognise that strategic and transformational change internally and across our local and system health economy will also be required to address any risks that we identify.

As we begin an era of 'living with COVID' we are acutely aware of the unique operational and strategic challenges to the Trust, most notably around workforce resilience, elective recovery and economic sustainability and uncertainty. These challenges are the same across the NHS and the country as a whole. This legacy has been, and will continue to be, felt across all our services and threaten the achievement of the Trust's objectives.

The same principal strategic risks for the organisation in 2022/23 will therefore be carried forward into 2023/24, but the effectiveness of their controls and sources assurance will need to continue to be assessed in light of the challenges facing the Trust and ongoing developments. A full review of these risks will be undertaken by the Board in 2023/24.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. Training is given to all staff at induction, including junior doctors, newly-appointed governance leads and newly-qualified nurses/midwives. The electronic incident reporting system gives feedback when an incident is investigated if the member of staff wishes to receive this. Staff are prompted by the incident reporting system to follow the ‘duty of candour’ process, with duty of candour information and training widely available.

All reported incidents are fully investigated to ensure the lessons are learnt and shared across the Trust. Any themes are identified, so that future recurrences can be prevented by coordinated work. The Trust has robust controls in place to manage the risk of nosocomial (hospital-acquired) infections. These controls are reviewed regularly by the Trust’s infection, prevention and control assurance group to ensure they remain fit for purpose.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Register of Interest

NHS Medway Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months as required by the Managing Conflicts of Interest in the NHS27 guidance.

The Trust Board reviews the register of interests at each meeting and requires all executive and non-executive directors to confirm their entries. A standing item is contained on all Board and Committee agenda’s which requires all senior staff, executive and non-executive directors to make known any interests in relation to the agenda.

A register of the directors’ interests is available to the public on the Trust’s website www.medway.nhs.uk or by contacting:

The Company Secretary,
Medway NHS Foundation Trust,
Medway Maritime Hospital,
Windmill Road,
Gillingham,
Kent
ME7 5NY.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

Green Plan

The foundation trust has undertaken risk assessments and has plans in place which take account of the ‘Delivering a Net Zero Health Service’ report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

EPRR

The Trust is a Category One responder under the Civil Contingencies Act (2004). Within the Act the Trust has specific statutory duties in relation to maintaining a resilient organisation that is able to work in partnership with other responders in response and recovery from major and business continuity incidents. In order to demonstrate compliance the Trust is aligned to the National Emergency

preparedness, Resilience and Response Framework (2015). NHS England nationally issues core standards against which each Trust undertakes a self-assessment and is then audited by its Commissioner. The Trust was awarded ‘Substantial Compliance’ by the Kent and Medway Integrated Care Board. This has been reported via the Local Health Resilience Partnership Executive Group for Kent and Medway to NHS England.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a range of processes to ensure resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of regular finance and efficiency programme reports to the executive group, the trust board and associated sub-committees.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has plans in place which take account of the ‘Delivering a Net Zero Health Service’ report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information governance

The table below breaks down the information breaches recorded on the Trusts DATIX reporting system for the 2022/23 reporting period. No incidents met the criteria required to report to the Information commissioners Officer (ICO).

Identifiable data lost in transit	Data disclosed in error such as emails sent to the wrong place, reports sent to the wrong patient	Non-secure disposal of paperwork	Unauthorised access to staff or patient information including sharing passwords or smartcards	Other IG/data security incident
7	33	6	1	12

Data quality and governance

The quality and assurance teams work closely with colleagues in the business intelligence team to ensure data provided to the Board is validated and accurate. Both teams have a variety of skills and expertise including analytics. This includes oversight by those with expertise in the relevant field; for example, the head of complaints would sign off any complaints data, ensure that correct processes have been applied to reporting the data from the system and that the data set is complete.

The quality and assurance teams collate data monthly from a variety of sources for the executive and trust management meetings and Integrated Quality and Performance Report. Primary sources include our local risk management system, which holds all incident, complaints, legal services, risks and safety alert databases.

A senior clinical analyst validates the data and issues the data packs monthly to the executive, which feeds into the Integrated Quality and Performance Report for data accuracy, validity and alignment. The Trust has a number of policies and protocols which describe the desired outcome or key performance indicator (KPI) which assists the Trust Board in determining if they are assured by the data they are receiving. For example, the Trust’s position relating to mortality outcomes is demonstrated by the Summary Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) which are benchmarked nationally to give Board members a clear picture of the Trust’s performance in this area.

A range of audits – internal and external – give assurance about the accuracy of data throughout the year. The Trust has a Quality and Patient Safety sub-committee where all data and information relating to quality of care and patient experience is reviewed. The Trust employs rigorous information

assurance processes in the production of the monthly Integrated Quality and Performance Report at both Clinical Group and Trust level, including local and Trust-wide validation of data and national benchmarking where available. The Integrated Quality and Performance Report is published as part of the Board papers and is available on the Trust's website.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Risk Committee and its sub-committees and groups and the Quality Assurance Committee and its sub-committees and groups, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. My review of the effectiveness of the system of internal control is informed by executives and managers within the organisation who have responsibility for the development and maintenance of the system of internal control and the assurance framework. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its objectives have been reviewed.

The Board Assurance Framework is framed in the context of the Trust's strategic objectives (Patient First) to ensure that focus is maintained on the delivery of agreed outcomes and the effective management of attendant risks. The internal auditors have confirmed that the Trust's Board Assurance Framework does reflect the Trust's key objectives and risks and is regularly reviewed by the Board. The Executive reviews the Board Assurance Framework on a monthly basis and the Trust Board reviews it on a quarterly basis, and the Audit and Risk Committee provides views on whether the Trust's risk management procedures are operating effectively.

The head of internal audit opinion for this year is 'significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The Board, through the executive directors, reviews risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety, patient experience, quality and workforce. The implementation of Patient First has strengthened this approach and enables the organisation to focus on addressing key issues as they arise in the most appropriate place.

The Audit and Risk Committee oversees the effectiveness of the Trust's overall risk management and internal control arrangement. On behalf of the Board, it independently reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. The Integrated Audit Committee regularly receives reports on internal control and risk management matters from the internal and external auditors. Concerns raised by the internal or external auditors have been considered by the executive team and the Audit and Risk Committee and have been addressed appropriately. For this reporting period, the Audit and Risk Committee 'in-housed' the role of tracking the implementation of auditor recommendations enabling a more streamlined and timely role out of improvements and a greater level of accountability for improvement.

The responsibility for compliance with the CQC essential standards is allocated to lead executive directors who are responsible for maintaining evidence of compliance. The Trust is addressing all areas of underperformance and non-compliance identified either through external inspections and patient and staff surveys, raised by stakeholders, including patients, staff, governors and others or identified by internal peer review.

The Trust has redesigned its governance systems and processes to both support the implementation of Patient First but also to strengthen decision making, accountability and quality.

Conclusion

I can confirm that no significant internal control issues have been identified.

Chief Executive
Date:

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Foreword to the accounts

Medway NHS Foundation Trust

These accounts, for the year ended 31 March 2023, have been prepared by Medway NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……………………………………………

Name **Jayne Black**
Job title **Chief Executive Officer**
Date

Report on the Audit of the Financial Statements

Independent auditor's report to the Council of Governors of Medway NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Medway NHS Foundation Trust (the 'Trust') for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, and the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act
2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice
(2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the
'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability

to continue as a going concern.
If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group
Accounting Manual 2022-23 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity
of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting
Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice
Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2022/23 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the
Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the directors

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2022/23, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit and Risk Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;

  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit and Risk Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraudulent expenditure recognition and significant accounting estimates. We determined that the principal risks were in relation to:
  - journal entries; and
  - revaluation of land and buildings.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and buildings valuations; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to valuation of land and buildings included within the accounts.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates; and
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation;
    - NHS England's rules and related guidance; and
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at:
www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in respect of the above matter except on 22 June 2023 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the Trust’s failure during 2022/23 to:

- develop plans to address its underlying deficit and to deliver required efficiency savings
- establish a dedicated programme management office to plan, deliver, monitor and report on efficiency schemes.

We recommended that the Trust prepare a medium-term financial plan which addresses its underlying deficit, develop comprehensive and achievable plans for delivering efficiency savings and establish a programme management office to deliver efficiency schemes.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor’s responsibilities for the review of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of ‘proper arrangements’. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor’s Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We certify that we have completed the audit of Medway NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act

2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Name: Darren J Wells

For and on behalf of Grant Thornton UK LLP, Local Auditor
London

Statement of Comprehensive Income

for the year ended 31 March 2023

		2022/23	2021/22
	Note	**£000**	**£000**
Operating income from patient care activities	3	397,443	370,315
Other operating income	4	34,801	30,160
Operating expenses	5	(431,097)	(393,469)
Operating surplus from continuing operations		**1,147**	**7,006**
Finance income	8	844	44
Finance expenses	9	(26)	(21)
PDC dividends payable	26	(8,168)	(6,976)
Net finance costs		**(7,350)**	**(6,953)**
Surplus/(Deficit) for the year		**(6,203)**	**53**
Other comprehensive Income/(Expense)			
Will not be reclassified to income and expenditure:			
Impairments	12	(2,200)	0
Revaluations	12	23,081	7,463
Total comprehensive Income/(expense) for the period		**14,678**	**7,516**

Statement of Financial Position

as at 31 March 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment	10	271,811	239,695
Right of use assets	13	928	0
Receivables	14	780	600
Total non-current assets		**273,519**	**240,295**
Current assets			
Inventories	15, 16	6,374	5,996
Receivables	14	29,086	13,889
Cash and cash equivalents	15, 16	34,742	33,455
Total current assets		**70,202**	**53,340**
Current liabilities			
Trade and other payables	17, 18	(50,285)	(28,147)
Borrowings	19	(953)	(136)
Provisions	20, 21	(519)	(763)
Other liabilities	17, 18	(800)	(1,353)
Total current liabilities		**(52,557)**	**(30,399)**
Total assets less current liabilities		**291,164**	**263,236**
Non-current liabilities			
Borrowings	19	(1,950)	(2,025)
Provisions	20, 21	(1,031)	(1,248)
Total non-current liabilities		**(2,981)**	**(3,273)**
Total assets employed		**288,183**	**259,963**

Financed by

Public dividend capital	475,198	461,656
Revaluation reserve	64,406	43,525
Income and expenditure reserve	(251,421)	(245,218)
Total taxpayers' equity	**288,183**	**259,963**

The notes on pages 7 to 41 form part of these accounts.

Signed	………………………..	………………………..
Name	**Jayne Black**	**Alan Davies**
Position	**Chief Executive Officer**	**Chief Finance Officer**
Date		

Statement of Changes in Equity for the year ended 31 March 2023

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2022 - brought forward	**461,656**	**43,525**	**(245,218)**	**259,963**
Surplus/(deficit) for the year	0	0	(6,203)	**(6,203)**
Net impairments	0	(2,200)	0	**(2,200)**
Revaluations - property, plant and equipment	0	23,081	0	**23,081**
Public dividend capital received	13,542	0	0	**13,542**
Taxpayers' equity at 31 March 2023	**475,198**	**64,406**	**(251,421)**	**288,183**

Statement of Changes in Equity for the year ended 31 March 2022

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021 - brought forward	**453,870**	**36,062**	**(245,271)**	**244,661**
Surplus/(deficit) for the year	0	0	53	**53**
Revaluations - property, plant and equipment	0	7,463	0	**7,463**
Public dividend capital received	7,786	0	0	**7,786**
Taxpayers' equity at 31 March 2022	**461,656**	**43,525**	**(245,218)**	**259,963**

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

for the year ended 31 March 2023

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,147	7,006
Non-cash income and expense:			
Depreciation and amortisation	5	15,634	11,914
Impairments and reversals	12	(42)	(78)
Income recognised in respect of capital donations (cash and non-cash)	4	(100)	(631)
(Increase)/decrease in receivables		(15,252)	2,083
(Increase)/decrease in inventories		(378)	966
Increase/(decrease) in trade and other payables		17,603	(762)
Increase/(decrease) in other liabilities		(553)	(6,231)
Increase/(decrease) in provisions		(445)	(657)
Net cash flows from / (used in) operating activities		**17,614**	**13,610**
Cash flows from investing activities			
Interest received		719	24
Purchase of property, plant and equipment and investment property		(21,366)	(30,858)
Receipt of cash donations to purchase capital assets		100	75
Net cash used in investing activities		**(20,547)**	**(30,759)**
Cash flows from financing activities			
Public dividend capital received		13,542	7,786
Movement in loans from the Department of Health and Social Care		(126)	(126)
Capital element of lease liability repayments		(956)	0
Interest on DHSC loans		(27)	(28)
Other interest (e.g. overdrafts)		(3)	(5)
Interest element of lease liability repayments		(14)	0
PDC dividend (paid)/refunded		(8,196)	(6,207)
Net cash generated from financing activities		**4,220**	**1,420**
Increase/(decrease) in cash and cash equivalents		**1,287**	**(15,729)**

	Note		
Cash and cash equivalents at 1 April - brought forward		**33,455**	**49,184**
Cash and cash equivalents at 31 March	15, 16	**34,742**	**33,455**

Notes to the accounts
For the year ended 31 March 2023

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office for National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.3.1 Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity. In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price. Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration. The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

Note 1.3.2 Revenue from Research Contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.3.3 NHS Injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.4 Other income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably
- The item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- costs form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Staff costs have also been capitalised where they arise directly from the construction or acquisition of specific property, plant or equipment.

The finance costs of bringing fixed assets into use are not capitalised.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is assessed on a case by case basis and is either capitalised as a tangible asset or expensed over the life of the licence.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.6.2 Measurement

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.
Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years. A yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In accordance with this policy the valuation undertaken on 2022/23 was therefore a desktop revaluation.
The valuation exercise was carried out in March 2023 with a valuation date of 31st March 2023

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when the assets are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment will be depreciated from the first quarter after the asset is deemed ready for use at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated economic lives. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment reclassified as 'Held for Sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other operating expenses'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.6.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min Years	Max Years
Buildings (set-up costs in new buildings)	3	10
Buildings & Dwellings	3	80
Plant & machinery	5	25
Transport (Vehicles)	7	7
Information technology	5	8
Furniture & fittings	7	10

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.8 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial assets and financial liabilities

Note 1.9.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.9.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust has developed a model for Non DHSC group bodies' contract and other receivables which assesses the liability by category and debtor type factoring in any known specifics to calculate the value of impairment.

This DHSC provides a guarantee of last resort against the debts of DHSC group bodies (excluding NHS charities); in accordance with the GAM these liabilities have been deemed risk free so no credit losses are calculated in relation to these liabilities.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.9.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.10 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.10.1 The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Operating Leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee
For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust’s incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

Note 1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 20 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.16 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.17 Critical judgements in applying accounting policies

Any judgements, apart from those involving estimations (see below) that management has made in the process of applying The NHS foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements are disclosed in the notes:

● Asset revaluation - See note 1.6.2
● Credit Loss Provision - See note 1.9.2 Financial Asset Impairments

Note 1.17.1 Sources of estimation uncertainty

There are no estimation uncertainties that could have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.19 Charitable Funds

The Trust is the corporate Trustee of Medway NHS Foundation Trust Charitable Fund – Registered Charity number 1051748. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

The NHS Foundation Trust has not consolidated the charitable funds as it is not deemed material to its accounts.

Note 1.20 Discontinued Operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.
There are no discontinued operations.

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 2 Operating segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely available and the cost to develop this information would be excessive.

Significant amounts of income are received from transactions with the Department of Health and other NHS bodies. Disclosure of all material transactions with related parties is included in note 28 to these financial statements. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	**2022/23**	**2021/22**
	£000	**£000**
Aligned payment & incentive (API) contract income / system block income	335,440	325,238
High cost drugs income from commissioners	24,680	22,360
Other NHS clinical income	6,689	7,217
Private patient income	0	93
Elective recovery fund[1]	10,771	4,555
Agenda for change pay award central funding[2]	8,266	0
Additional pension contribution central funding[3]	10,036	9,205
Other clinical income	1,561	1,647
Total income from activities	**397,443**	**370,315**

[1]Elective recovery fund has been incorporated into the block contract income in 2022/23.

[2]Proposed settlement for national pay dispute as advised and funded by NHS England.

[3]The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2022/23**	**2021/22**
	£000	**£000**
NHS England	61,486	48,473
Clinical commissioning groups *(demised 01/07/2022)*	76,547	319,399
Integrated care boards *(commenced 01/07/2022)*	256,711	0
Other NHS Providers	1,138	700
Non NHS: private patients	2	93
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	372	594
Injury cost recovery scheme	1,173	829
Non NHS: other	14	227
Total income from activities	**397,443**	**370,315**

Injury Cost Recovery income is subject to a credit loss allowance of 24.86% (2021/22: 23.76%) to reflect expected rates of collection.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2022/23	**2021/22**
	£000	**£000**
Income recognised this year	372	594
Cash payments received in-year	136	110
Amounts added to provision for impairment of receivables	468	730
Amounts written off in-year	197	59

Note 4 Other operating income

	2022/23	2021/22
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	1,309	1,401
Education and training (excluding notional apprenticeship levy income)	13,544	12,054
Non-patient care services to other bodies	7,866	4,790
Reimbursements and top up funding	0	748
Income in respect of employee benefits accounted on a gross basis	133	1,469
Other contract income	10,474	7,200
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	148	155
Receipt of capital grants, donations and assets	100	631
Charitable and other contributions to expenditure	1,227	1,712
Total other operating income	**34,801**	**30,160**

	2022/23	**2021/22**
Other Income includes:	**£000**	£000
Car Parking income	**1,478**	957
Catering	**708**	666
Pharmacy sales	**168**	136
Staff accommodation rental	**579**	491
Non-clinical services recharged to other bodies	**285**	235
Crèche services	**344**	316
Clinical tests	**2,221**	1,812
Clinical excellence awards	**172**	138
Other income not already covered (recognised under IFRS 15)	**4,519**	2,449
	10,474	7,200

Note 5 Operating expenses

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	13,614	13,327
Purchase of healthcare from non-NHS and non-DHSC bodies	1,715	1,364
Staff and executive directors costs [1]	276,332	249,934
Remuneration of non-executive directors	141	152
Supplies and services - clinical (excluding drugs costs)	34,158	35,114
Supplies and services - general	9,273	8,733
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	37,327	32,811
Inventories written down	10	8
Consultancy costs	1,738	540
Establishment	2,404	1,322
Premises	11,517	9,384
Transport (including patient travel)	1,285	1,048
Depreciation on property, plant and equipment and right of use assets	15,634	11,914
Impairments net of (reversals)	(42)	(78)
Movement in credit loss allowance: contract receivables / contract assets[2]	(375)	848
Increase/(decrease) in other provisions	(304)	(329)
Change in provisions discount rate(s)	(149)	26
Audit fees payable to the external auditor		
audit services- statutory audit	131	74
other auditor remuneration[3]	0	0
Internal audit costs	131	151
Clinical negligence	16,003	15,562
Legal fees	99	242
Insurance	239	212
Research and development	1,243	1,232
Education and training	7,415	6,629
Operating lease expenditure -comparative	0	643
Operating lease expenditure -short term	137	0
Redundancy	0	168
Car parking & security	277	329
Hospitality	19	8
Losses, ex gratia & special payments[4]	412	321
Other services, e.g. external payroll	392	340
Other	321	1,440
Total	**431,097**	**393,469**

[1] Staff and Executive Directors costs - excluded from this are Research and Development costs, Non Executives costs and Education and Training costs, as they are reported separately. This includes £10,036k (2021/22 £9,205k) relating to 6.3% pensions increase paid directly by Department of Health.

[2] Net movement in credit losses. Credit risk is only associated with Non NHS receivables.

[3] Not disclosed in the accounts are other audit Fees of £2.5k for the Independent Examination of Medway Foundation Trust Charitable Fund note 1.19.

[4] Excludes £10k stock write down detailed in separate line -see note 23.

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2021/22: £2,000k).

Note 6 Employee benefits

	2022/23	2021/22
	£000	£000
Salaries and wages	216,548	196,071
Social security costs	24,252	21,075
Apprenticeship levy	1,067	976
Employer's contributions to NHS pensions	22,908	21,084
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	10,036	9,205
Pension cost - other	22	14
Temporary staff (including agency)	8,404	7,688
Total gross staff costs	**283,237**	**256,113**

Note 6.1 Directors remuneration and other benefits

	2022/23	2021/22
	£000	£000
Directors Remuneration	1,182	1,589
Social Security Costs	130	214
Employer contributions to NHS Pension scheme	87	112
Total remuneration	**1,399**	**1,915**

5 Directors are accruing pension benefits under the NHS Pension defined benefit scheme (2021/22; 11)

Note 6.2 Retirements due to ill-health

During 2022/23 there were 3 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements are £276k (£433k in 2021/22).

Please Note: In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead.

Note 7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) Alternative pension scheme

For those employees who do not have access to the NHS pensions scheme but who are otherwise classified as employees with an entitlement to automatic enrolment in an appropriate pension the Trust has put in place an alternative workplace pension scheme. This scheme is administered by NEST (National Employment Savings Trust) and is a defined contribution pension scheme. The total contribution costs for this scheme for the financial year 2022/23 amount to £22k (2021/22: £14k).

Note 8 Finance income

Finance income represents interest received on assets and investments in the period.

	2022/23	2021/22
	£000	£000
Interest on bank accounts	844	44
Total finance income	**844**	**44**

Note 9 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2022/23	2021/22
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	26	27
Finance leases	13	0
Interest on late payment of commercial debt	3	5
Total interest expense	**42**	**32**
Unwinding of discount on provisions	(16)	(11)
Total finance costs	**26**	**21**

Note 9.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2022/23	2021/22
	£000	£000
Amounts included within interest payable arising from claims under this legislation	3	5

Note 10 Property, plant and equipment

Note 10.1 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2022 - brought forward	**7,542**	**175,559**	**4,783**	**16,077**	**51,273**	**86**	**34,829**	**2,579**	**292,728**
Additions	0	2,288	0	18,335	342	0	4,964	0	**25,929**
Impairments	(58)	(2,218)	0	0	0	0	0	0	**(2,276)**
Reversals of impairments	0	118	0	0	0	0	0	0	**118**
Revaluations	513	13,964	1,050	0	0	0	0	0	**15,527**
Reclassifications	0	6,957	0	(15,543)	979	0	7,607	0	**0**
Valuation/ gross cost at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**52,594**	**86**	**47,400**	**2,579**	**332,026**
Accumulated depreciation at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**32,700**	**85**	**18,005**	**2,243**	**53,033**
Provided during the year	0	7,294	260	0	3,567	1	3,532	83	**14,736**
Revaluations	0	(7,294)	(260)	0	0	0	0	0	**(7,554)**
Accumulated depreciation at 31	**0**	**0**	**0**	**0**	**36,267**	**86**	**21,537**	**2,326**	**60,215**

March 2023									
Net book value at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**16,327**	**0**	**25,863**	**253**	**271,811**
Net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**

Note 10.2 Property, plant and equipment - 2021/22

	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2021 - brought forward	**7,308**	**161,743**	**4,824**	**22,116**	**43,935**	**86**	**26,135**	**2,579**	**268,726**
Additions*	0	0	0	22,130	140	0	507	0	**22,777**
Reversals of impairments	0	78	0	0	0	0	0	0	**78**
Revaluations	234	1,126	(213)	0	0	0	0	0	**1,147**
Reclassifications	0	12,612	172	(28,169)	7,198	0	8,187	0	**0**
Valuation/ gross cost at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**51,273**	**86**	**34,829**	**2,579**	**292,728**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**0**	**0**	**0**	**29,294**	**84**	**15,926**	**2,131**	**47,435**
Provided during the year	0	6,066	250	0	3,406	1	2,079	112	**11,914**
Revaluations	0	(6,066)	(250)	0	0	0	0	0	**(6,316)**

Accumulated depreciation at 31 March 2022	**0**	**0**	**0**	**0**	**32,700**	**85**	**18,005**	**2,243**	**53,033**
Net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**
Net book value at 31 March 2021	**7,308**	**161,743**	**4,824**	**22,116**	**14,641**	**2**	**10,209**	**448**	**221,291**

Note 10.3 Property, plant and equipment financing- 2022/23

	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Owned - purchased	7,997	196,668	5,833	18,869	15,058	0	25,863	242	270,531
Owned - donated/granted	0	0	0	0	1,269	0	0	11	**1,280**
Total net book value at 31 March 2023	**7,997**	**196,668**	**5,833**	**18,869**	**16,327**	**0**	**25,863**	**253**	**271,811**

Note 10.4 Property, plant and equipment financing- 2021/22

	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Restated Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Owned - purchased	7,542	175,559	4,783	16,077	17,019	1	16,824	321	238,126

Owned - donated/granted	0	0	0	0	1,554	0	0	15	1,569
Total net book value at 31 March 2022	**7,542**	**175,559**	**4,783**	**16,077**	**18,573**	**1**	**16,824**	**336**	**239,695**

Note 11 Donations of property, plant and equipment

Note 11.1 Donations

Donations	2022/23 £000	2021/22 £000
Additions - donations of physical assets (non-cash)	0	556
Additions - assets purchased from cash donations/grants	100	75
Total Donations	**100**	**631**

Note 12 Revaluations and impairments of property, plant and equipment

The date of the latest valuation of land, buildings and dwellings was 31 March 2023. The valuation was carried out by an externally appointed independent RICS qualified valuer. Land and non-specialised buildings have been valued at market value for existing use and specialised buildings at depreciated replacement cost on a modern equivalent asset basis. See note 1.8.2 for more detail. Information on the economic life of property, plant and equipment is included in the accounting policies.

The overall impact of the valuation exercise was an increase of £20,923k, £23,081k revaluation net of £2,158k impairments.

Note 12.1 Revaluations

Changes in market price	2022/23 £000	2021/22 £000
Land	513	234
Buildings including dwellings	22,568	7,229
Total Revaluations	**23,081**	**7,463**

Note 12.2 Impairments

In 2022/23 net impairment reversals of £42k have occurred as result of a full revaluation of The Trust estate, this includes;

	2022/23 £000	2021/22 £000
Impairments charged to revaluation reserve	**2,200**	**0**
Impairments charged to operating expenditure	76	0
Impairment reversals credited to operating expenditure	(118)	(78)
Net impairment reversal credited to operating expenditure	**(42)**	**(78)**
Total Net Impairments	**2,158**	**(78)**

Note 13 Inventories

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**0**	**0**
IFRS 16 implementation - adjustments for existing operating leases / subleases	1,618	208	0	0	0	1,826
Valuation/gross cost at 31 March 2023	**1,618**	**208**	**0**	**0**	**0**	**1,826**
Accumulated depreciation at 1 April 2022 - brought forward	**0**	**0**	**0**	**0**	**0**	**0**
Provided during the year	779	119	0	0	0	898
Accumulated depreciation at 31 March 2023	**779**	**119**	**0**	**0**	**0**	**898**
Net book value at 31 March 2023	**839**	**89**	**0**	**0**	**0**	**928**

	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**980**
Impact of discounting at the incremental borrowing rate	
IAS 17 operating lease commitment discounted at incremental borrowing rate	**977**
Less:	
Commitments for short term leases	(5)
Commitments for leases of low value assets	(7)
Other adjustments:	
Other adjustments[1]	861
Total lease liabilities under IFRS 16 as at 1 April 2022	**1,826**

[1]correction of immaterial prior period error in IAS 17 disclosure (£114k) and contracts reassessed as containing a lease on transition (£975k)

Note 14 Trade and Other Receivables

	2022/23	2021/22
	£000	£000
Current		
Contract receivables[1]	29,131	15,092
Allowance for impaired contract receivables / assets	(4,088)	(4,861)
Prepayments (non-PFI)	2,975	2,687
Interest receivable	145	20
VAT receivable	529	594
Clinician pension tax provision reimbursement funding from NHSE	4	23
Other receivables	390	334
Total current trade and other receivables	**29,086**	**13,889**
Non-current		
Contract receivables[1]	462	369
Allowance for impaired contract receivables / assets	(115)	(88)
Clinician pension tax provision reimbursement funding from NHSE	433	319
Total non-current trade and other receivables	**780**	**600**
Of which receivables from NHS and DHSC group bodies:		
Current	21,949	8,303
Non-current	433	319

[1]Contract receivables includes invoiced £16,272k (2021/22 £10,775k) and unvoiced accruals of £12,859k (2021/22 £4,317k), overall increase of £14,039k relates to NHSE funding for the proposed national pay deal and ICB annual funding relating to various projects i.e. step down beds, community diagnostics, virtual wards

Allowances for Credit Losses

	Contract receivables and contract assets	
	2022/23	2021/22
	£000	£000
Allowances as at 1 April - brought forward	**4,949**	**5,225**
New allowances arising	1,302	2,186
Reversals of allowances	(1,677)	(1,338)
Utilisation of allowances	(371)	(1,124)
Allowances as at 31 Mar	**4,203**	**4,949**
Loss recognised in expenditure	**(375)**	**848**

*The Impairment allowance relates to £3,681k Non NHS (2021/22 £4,524k) and £522k Injury Cost Recovery Scheme (2021/22 £425k)) receivables only. Intra Group receivables are deemed to be risk free as they are backed by a guarantee from the Department of Health and Social Care.

Note 15 Inventories

	2022/23	2021/22
	£000	£000
Drugs	1,756	1,664
Consumables	4,619	4,332
Total inventories	**6,375**	**5,996**
of which:		
Held at lower of cost and NRV	6,375	5,996

Inventories recognised in expenses for the year were £71,485k (2021/22: £67,453k)

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £940k of items purchased by DHSC (2021/22 £1,003k)

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 16 Cash and Cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2022/23	2021/22
	£000	£000
At 1 April	**33,455**	**49,184**
Net change in year	1,287	(15,729)
At 31 March	**34,742**	**33,455**
Broken down into:		
Cash at commercial banks and in hand	79	364
Cash with the Government Banking Service	34,663	33,091
Total cash and cash equivalents as in Statement of Financial Position	**34,742**	**33,455**

Note 17 Trade and Other Payables

	2022/23 £000	2021/22 £000
Current		
Trade payables[1]	13,024	7,785
Capital payables[2]	9,794	5,231
Accruals	16,723	14,460
Social security costs[1]	3,271	0
Other taxes payable[1]	3,370	0
PDC dividend payable	417	445
Pensions contributions payable[1]	3,122	1
Other payables	564	225
Total current trade and other payables	**50,285**	**28,147**
Of which payables from NHS and DHSC group bodies:		
Current	7,545	5,703

[1] In 2022/23 Trust returned to making payments to suppliers, HMRC and Pensions within contractual terms i.e. within 30 days/1 month in arrears, during COVID payments were made early, on approval.

[2]Includes £3,995k of capital accruals (2021/22 £3,649k)

Note 18 Better Payment Practice Code

	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	58,897	129,566	61,357	136,657
Total non-NHS trade invoices paid within target	56,239	124,632	56,906	124,128
Percentage of non-NHS trade invoices paid within target	95.5%	96.2%	92.7%	90.8%
NHS Payables				
Total NHS trade invoices paid in the year	914	32,988	1,007	52,199
Total NHS trade invoices paid within target	801	31,696	689	47,406
Percentage of NHS trade invoices paid within target	87.6%	96.1%	68.4%	90.8%

The Better Payment Practice code requires that 95% of all valid invoices are paid by the due date or within 30 days of receipt of valid invoice, whichever is later.

Other Liabilities

	2022/23 £000	2021/22 £000
Current		
Deferred income: contract liabilities	800	1,353
Total other current liabilities	**800**	**1,353**

Note 19 Borrowings

	2022/23	2021/22
	£000	£000
Current		
Capital Loans from the Department of Health and Social Care	136	136
Lease liabilities	817	0
Total current borrowings	**953**	**136**
Non-current		
Capital Loans from the Department of Health and Social Care	1,898	2,025
Lease liabilities	52	0
Total non-current borrowings	**1,950**	**2,025**
Total borrowings	**2,903**	**2,161**

*Includes £23k (2021/22 £10k) of interest payable in accordance with IFRS9.

Reconciliation of liabilities arising from financing activities"

	TOTAL	DHSC Loans	Lease Liabilities
	£000	£000	£000
Carrying value at 1 April 2022	**2,161**	**2,161**	**0**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,082)	(126)	(956)
Financing cash flows - payments of interest	(41)	(27)	(14)
Non-cash movements:			
Impact of implementing IFRS 16 on 1 April 2022	1,826	0	1,826
Application of effective interest rate (interest charge arising in year)	39	26	13
Carrying value at 31 March 2023	**2,903**	**2,034**	**869**

	TOTAL	DHSC Loans	Lease Liabilities
	£000	£000	£000
Carrying value at 1 April 2021	**2,288**	**2,288**	**0**
Cash movements:			
Financing cash flows - payments and receipts of principal	(126)	(126)	0
Financing cash flows - payments of interest	(28)	(28)	0
Non-cash movements:			
Application of effective interest rate (interest charge arising in year)	27	27	0
Carrying value at 31 March 2022	**2,161**	**2,161**	**0**

Note 20 Provisions for liabilities and charges

	Pensions relating to staff	Legal claims	Other	Total
	£000	**£000**	**£000**	**£000**
At 1 April 2022	**1,364**	**66**	**581**	**2,011**
Transfers by absorption	0	0	0	**0**
Change in the discount rate	(546)	0	0	**(546)**
Arising during the year	521	156	0	**677**
Utilised during the year	(84)	(3)	0	**(87)**
Reversed unused	(129)	(43)	(317)	**(489)**
Unwinding of discount	(16)	0	0	**(16)**
At 31 March 2023	**1,110**	**176**	**264**	**1,550**
Expected timing of cash flows:				
- not later than one year;	79	176	264	**519**
- later than one year and not later than five years	481	0	0	**481**
- later than five years.	550	0	0	**550**
Total	**1,110**	**176**	**264**	**1,550**

The provision for pensions relating to staff reflects the liabilities due to early retirements prior to 6 March 1995. The legal claims provision reflects liabilities arising from Public and Employee Liability claims.
Other provisions are for dilapidations and onerous contracts.

	Pensions relating to staff	Legal claims	Other	Total
	£000	**£000**	**£000**	**£000**
At 1 April 2021	**1,518**	**225**	**936**	**2,679**
Change in the discount rate	26	0	0	**26**
Arising during the year	75	33	0	**108**
Utilised during the year	(92)	(133)	0	**(225)**
Reversed unused	(152)	(59)	(355)	**(566)**
Unwinding of discount	(11)	0	0	**(11)**
At 31 March 2022	**1,364**	**66**	**581**	**2,011**
Expected timing of cash flows:				
- not later than one year	116	66	581	**763**
- later than one year and not later than five years	476	0	0	**476**
- later than five years.	772	0	0	**772**
Total	**1,364**	**66**	**581**	**2,011**

Clinical negligence liabilities

At 31 March 2023, £213,444k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Medway NHS Foundation Trust (31 March 2022: £321,264k).

Note 21 Contingent assets and liabilities

	2022/23	2021/22
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(31)	(46)
Gross value of contingent liabilities	**(31)**	**(46)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(31)**	**(46)**
Net value of contingent assets	0	**0**

Note 22 Financial instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest-rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. The only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

Credit risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligations with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payments by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security. The Trust’s maximum exposures to credit risk at 31 March 2023 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's net operating costs are incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust received such contract income in accordance with Block contracts agreed with Commissioners and receives cash each month based on that contract.
Financial shortfalls incurred in day to day activities are financed by revenue support loans received from the Department of Health.

The Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust can borrow from the Department of Health and commercially to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore, exposed to significant liquidity risks in this area.

Note 22.1 Carrying values of financial assets

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2023		
Trade and other receivables excluding non-financial assets	26,358	**26,358**
Cash and cash equivalents at bank and in hand	34,742	**34,742**
Total at 31 March 2023	**61,100**	**61,100**

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2022		
Trade and other receivables excluding non-financial assets	11,208	11,208

Cash and cash equivalents at bank and in hand	33,455	33,455
Total at 31 March 2022	44,663	44,663

Note 22.2 Carrying value of financial liabilities

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2023		
Loans from the Department of Health and Social Care	2,034	2,034
Obligations under finance leases	869	869
Trade and other payables excluding non-financial liabilities	43,226	43,226
Provisions under contract	877	877
Total at 31 March 2023	47,006	47,006

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2022		
Loans from the Department of Health and Social Care	2,161	2,161
Trade and other payables excluding non-financial liabilities	27,446	27,446
Provisions under contract	989	989
Total at 31 March 2022	**30,596**	30,596

Note 22.3 Maturity of financial liabilities

	2022/23	2021/22
	£000	£000
In one year or less	45,070	28,280
In more than one year but not more than five years	802	815
In more than five years	1,527	1,616
Total	**47,399**	**30,711**

Note 22.4 Fair values of financial assets and liabilities

All financial assets and liabilities are held at book value which is deemed to be a reasonable approximation of fair value

Note 23 Losses and special payments"

	2022/23		2021/22 Restated	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Fruitless payments	1	10	1	8
Bad debts and claims abandoned	31	211	9	61
Stores losses and damage to property	12	171	14	217
Total losses	**44**	**392**	**24**	**286**
Special payments				
Ex-gratia payments	19	30	23	63
Special severance payments[1]	0	0	2	100
Extra-statutory and extra-regulatory payments	1	0	0	0
Total special payments	**20**	**30**	**25**	**163**
Total losses and special payments	**64**	**422**	**49**	**449**

[1] 2021/22 restated, nil previously reported

Note 24 Gifts

No gifts of more than £300,000 have been declared in 2022/23 (£0k 2021/22).

Note 25 Third party assets

The Trust held £0k cash at bank and in hand at 31 March 2023 (£0k at 31 March 2022) which relates to monies held on behalf of patients.

Note 26 Public Dividend Capital payable

The Trust is required to demonstrate that the PDC dividend payable is in line with the actual rate of 3.5% of average relevant net assets. £8,168K is payable this year (£6,976k 2021/22)

Note 27 Capital commitments

There are capital commitments in 2022/23 totalling £6,208k to report (£7,163k in 21/22).

Note 28 Related parties

The Medway NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health and Social Care.

The Department of Health and Social Care is the parent department of the Medway NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS England
Clinical Commissioning Groups/Integrated Care Boards
NHS Trusts and NHS Foundation Trusts
NHS Arm's Length Bodies
Health Education England

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures so no further detail of transactions will be disclosed

There are no prior year balances 2021/22 to disclose

Note 29 Events after the reporting date

There are currently no events after the reporting date

Meeting of the Trust Board
Wednesday, 12 July 2023

Title of Report	Audit and Risk Committee – Assurance Report 22 June 2023		Agenda Item	8.1
Author	Matthew Capper, Company Secretary			
Lead Executive Director	Jayne Black, Chief Executive, Mark Spragg, Independent Member			
Executive Summary	Assurance report to the Trust Board from the Audit and Risk Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	N/A			
Purpose of the report (tick box to indicate)	**Assurance**	✓	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Minutes from the Audit and Risk Committee approved at the Committee.			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	**Priority 5: (Systems)** ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	**Well-Led:** ✓
Identified Risks, issues and mitigations:	NIL				
Resource implications:	NIL				
Sustainability and /or Public and patient engagement considerations:	NIL				

Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	NIL	
Appendices:	Key headlines and assurance level listed below.	
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:	Matthew Capper, Company Secretary and Director of Strategy and Partnership	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Key headlines	Assurance Level
1. Annual Report and Accounts The Committee received the Annual Report and Accounts for approval, delegated by the Trust Board. The Annual Accounts and Report and Letter of Representation were APPROVED by the Committee for the period April 2022 to March 2023.	
2. Quality Accounts The Committee received the Quality Report for period April 2022 to March 2023. The external auditor review of the Quality Accounts was not required this year. The Committee APPROVED the recommendation that the quality account meets the statutory requirements for data inclusion and submission following an internal review and assurance process which was presented as part of the account. The Quality Accounts were sent to NEDs for final approval, via email, on 26 June 2023 (approval expected by 29 June).	

3. Internal Audit The Committee reviewed the following areas of the Internal Audit: a) DSP Toolkit - due for submission 30 June 2023 b) Health and Safety Governance – Fire Safety report to come to the next Committee meeting in August 2023 c) Internal Audit Progress Report d) Internal Audit Annual Report e) Internal Audit Action Plan – APPROVED by Committee Safe Staffing Level report to be brought to the next Committee meeting, showing reviews pending taken/taking place.	
4. Audit Action Tracker The Committee reviewed the Audit Action Tracker and approved 'proposed to close' actions. New actions to be added to the Tracker including External Audit Actions	
5. External audit report The Committee reviewed the External Audit Update providing the Auditors Annual report and findings for year ending 31 March 2023. The Committee APPROVED the report and findings.	
6. Counter Fraud The Committee reviewed the papers and approved the Counter Fraud Work Plan for 2023/24	
7. Board Assurance Framework The Committee received an update on the work undertaken on the 21 risks. The Committee noted the report for assurance and discussion, and approved the action plan developed to address under performance and increase control and assurance.	

Meeting of the Trust Board
Wednesday, 12 July 2023

Title of Report	Kent and Medway Pathology Network Collaboration Agreement	Agenda Item	8.2
Author	DAC Beachcroft LLP drafted the Collaboration Agreement with input from KMPN Board members, ICB Corporate Director and KMPN PMO Team.		
Lead Executive Director	Nick Sinclair, Chief Operating Officer (SRO)		
Executive Summary	Formation of The Kent and Medway Pathology Network (KMPN) and the pathology transformation programme has been endorsed by all of the Trust Boards as part of the NHSE Pathology network journey. KMPN is one of two acute Trust diagnostic networks in Kent and Medway (K&M), the other being the Kent and Medway Imaging Network (KMIN). KMPN is a jointly owned programme with all K&M pathology providers represented at Board level as members of the Network Board. Whilst pathology is provided at acute Trust level, the majority users of the service, for blood sciences at least, are outside the acute sector and sit in primary and community care. The pathology network/programme is supported and partially funded (on a non-recurrent basis) by NHSE and the ICB and the funding currently held on behalf of providers by the Integrated Care Board (ICB). KMPN is one of over 20 similar networks across England who are all are seeking to future proof pathology services in the face of rising demand and increasingly scarce resources, staff in particular. The intention of the KMPN is the same, based on a single management structure moving to a single service in the next few years. The ambition is that the single service will be stronger than the sum of its parts allowing KMPN providers to meet anticipated future demands in pathology safely and effectiveness. The move towards a single service provided by KMPN began with progression of enabling projects in the last few years: a single Laboratory Management System (LIMS) - FBC currently being implemented, and Managed Equipment Service (MES) - OBC currently out to tender to enable the production of the FBC. The business cases for these projects have been approved by; the KMPN Board, Trusts Boards and ICB Board. KMPN has proceeded to make two successful appointments into the roles of clinical director (CD) (Dr Supriya Joshi) and managing director (MD) (Ms Francesca Trundle). As executive leads, they will take forward the next steps to network maturity with changes needed over the coming years. The Collaboration Agreement (CA) is a document prepared on behalf of the members of KMPN and sets out the basis for this approach, giving the CD and MD authority to take up single management responsibility for KMPN and make recommendations to the Network Board. The CA has been drawn up by solicitors (DAC Beachcroft LLP) appointed in agreement with, and acting in the		

joint interests, on behalf of all four provider Trusts to ensure their interests are equally protected and that appropriate mechanisms exist for governance generally and with respect to moving forward by way of agreement via use of the change control procedure. The CA includes the terms of reference for the pathology Network Board and pathology network executive committee in the schedules that explain the relationship between the groups mentioned above. Once the CA has been approved then KMPN can move forwards in fully defining the scope of the single service alongside the agreed changes already in motion, including agreeing the future model of governance of a single service. Points to note:

a) The pathology network team is funded on behalf of all K&M providers via the Trusts. The LIMS implementation team is mainly funded by a four year non-recurrent contribution by the ICB. Each Trust has had finance team representation on the network governance and legal steering group, the CA does not in itself commit additional funding to the programme.
b) The CA requires the approval of all Trust Boards to give it authority, the NKPS Board effectively grants its approval via Trust Boards of Dartford and Gravesham NHS Trust and Medway Maritime NHS Foundation Trust.
c) The CA does not change the responsibility of each organisation (in the case of DGT and MFT this is merged as NKPS) for the safe delivery of services as is currently the case, in other words, there are no changes to the service received by patients, how that is delivered by our staff and who manages issues if anything goes wrong.
d) The engagement and management of staff across the network and the CA has been shared and agreed with HR business partners and Chief People Officers from each organisation and staff have been and will be briefed of the network intentions and changes.
e) As the programme progresses with its various phases of transformation such as LIMS, MES etc then the network Board will be responsible for ensuring changes are agreed, clinically led and conducted safely and effectively.
f) The CA allows the KMPN Board to make decisions going forwards without the need to consultant individual Trust Boards on each detail.
g) The programme draws on senior staff in each organisation and whilst backfill of the time required has been offered and taken up, individual services should note this does inevitably create some distraction from the day to day challenges of running a service.
h) At each Trust the SRO (Nick Sinclair, COO) is responsible for bringing back the network intentions (such as this CA) from the KMPN Board to the Trust Board, and taking individual Trust approval and concerns from the Trust Board to the KMPN Board, at points when required.
i) The data protection clauses in the Collaboration Agreement are relatively light-touch. This is because: (i) the Parties are independent Data Controllers, and are therefore separately responsible for discharging their own obligations under the UK GDPR; (ii) the Parties do not share liability under the UK GDPR as they otherwise would have if they were Joint Controllers or Controllers or they processed personal data on each other's behalf; and (iii) the personal data that may be shared under the Collaboration Agreement does not include patient-level data, and it will be limited to personal data that arises in the context of budgeting/ financial

<table>
<tr><td></td><td colspan="5">information. However, if there is a material change to either the nature or volume of personal data being shared under the Collaboration Agreement these clauses will need to be reviewed, and it may be that a Data Sharing Agreement will need to be drafted.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">The ask of the pathology transformation Board for Kent and Medway is that the Board APPROVES this Collaboration Agreement. To allow the establishment of a single management framework with delegated authority; and carry out the next steps as described in the Collaboration Agreement in order for the network to continue to mature to a single service to honour the signed intent of all providers across Kent and Medway.

Approve for the Chief Executive (Jayne Black) to sign the agreement</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td></td><td>Approval</td><td colspan="2">X</td></tr>
<tr><td>Noting</td><td></td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td>(If appropriate) state reason for submission to Private section of Board:</td><td>Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td colspan="2">Exceptional Circumstances:</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Reviewed by:
a) MFT Executive Management Committee 11.07.23
b) MFT Finance Committee FBC LIMS 20.05.21
c) KMPN Governance and Legal Steering Group (responsible for commissioning the agreement).
d) Kent and Medway Pathology Network Board, approved a draft on 11 May 2023 and the final version on 08 June 2023.</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)
X</td><td>Priority 2: (People)</td><td>Priority 3: (Patients)
X</td><td>Priority 4: (Quality)
X</td><td>Priority 5: (Systems)
X</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led:
X</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5"></td></tr>
<tr><td>Resource implications:</td><td colspan="5">There is no change proposed in this agreement to the current contribution made by the Trust to the operation of KMPN</td></tr>
</table>

Sustainability and /or Public and patient engagement considerations:	A key objective of the KMPN is the provision of a sustainable service. This agreement is an enabler to allow the network to move to a 'mature' status. This agreement does not change the current provision of services, therefore there has been no requirement to engage with the public or patients.	
Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	This is a legally binding agreement that has been drafted by a firm of solicitors on behalf of the four KMPN Member service provider Trusts.	
Appendices:	KMPN Collaboration Agreement - DACB v8 - DACB FINAL (30.05.23)(4135177.5) 2	
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:	Ada Foreman, KMPN Finance Lead Ada.foreman@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.

DAC BEACHCROFT

Dated 2023

(1) EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

(2) MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

(3) DARTFORD AND GRAVESHAM NHS TRUST

(4) MEDWAY NHS FOUNDATION TRUST

Kent and Medway Pathology Network Collaboration Agreement

DAC Beachcroft LLP
The Walbrook Building 25 Walbrook London EC4N 8AF UK
tel: +44 (0) 20 7242 1011 fax: +44 (0) 20 7831 6630
DX 45 London/Chancery LN

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Draft

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THIS AGREEMENT is made the .... day of 2023

BETWEEN:

(1) **EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST** of Kent and Canterbury Hospital, Canterbury, Kent, CT1 3NG (**"EKHUFT"**)

(2) **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST** of Maidstone Hospital, Hermitage Lane, Maidstone, Kent, ME16 9QQ ("**MTW**")

(3) **DARTFORD AND GRAVESHAM NHS TRUST** of Darent Valley Hospital, Darenth Wood Road, Dartford, Kent, DA2 8DA ("**DGT**"); and

(4) **MEDWAY NHS FOUNDATION TRUST of** Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY ("**MFT**").

together, "the Trusts" or "Kent and Medway Pathology Network ("KMPN")"

BACKGROUND:

(A) The Kent and Medway Pathology Network ("**KMPN**") (also known as "**South 8**") is comprised of the four acute Trusts who are Parties to this Agreement and is one of 29 networks proposed by NHS England ("**NHSE**") to improve the efficiency and operational consistency of pathology services in England.

(B) KMPN operates as a collaborative partnership governed by the Kent and Medway Pathology Network Board with executive and clinical representation from each Trust. It currently collaborates pursuant to a Vision Document which details how the Parties work together in terms of procuring certain services, management and governance of KMPN, commercial principles, workforce and organisational development and was approved on 11 September 2020 ("**Vision Document**"). The KMPN Trusts have also entered into a legally binding LIMS Collaboration Agreement to specifically govern their collaboration with respect to the LIMS Contract.

(C) KMPN now wishes to further formalise its collaborative arrangements via this Agreement which will replace the Vision Document. The Parties recognise that NHSE's maturity roadmap for pathology networks provides a robust plan both for the immediate and long term future and this Agreement is intended to govern working together in the short to medium term and enable the introduction of any required changes for the long term requirements. At the date of this Agreement, it is recognised that the existing pathology services operate under their individual management structures and it is the intention of the Parties to move to a single management structure. All changes to this Agreement, including any in relation to the on-going establishment of a single management structure and move towards a single service will be agreed via the Change Control Procedure. In addition, the Parties recognise that they have collaboratively procured the LIMS Contract and it is recognised that KMPN will also undertake a collaborative procurement for a managed equipment service (MES), the detail of which will be agreed via the Change Control Procedure.

(D) This Agreement covers the start of the journey of the KMPN from "emerging" to "maturing". This will see the Network develop from a single management structure to single overall service provision. The detailed actions to become a mature network are identified in the KMPN maturity matrix however the key areas for development on this journey are:-

- accountability for clinical quality management, clinical governance, risk and Clinical Safety (i.e. the NHSE mandated role for introduction of new or revised electronic systems within the NHS).

- To fully implement the pathology single management structure under the CD and MD

- To finalise the services in Scope for KMPN particularly with how the mortuary, IT, phlebotomy and POCT is delivered and managed
- Implement workforce strategy to address recruitment and retention issues,
- Implement single quality strategy and monitoring process across the network
- Develop network five year clinical strategy
- To finalise the risk sharing profile in respect of any surplus/deficit in the annual pathology services budgets.

NOW IT IS HEREBY AGREED as follows:

1. **DEFINITIONS**

1.1 In this Agreement, the words and expressions defined in Schedule 1 shall have the meanings attached thereto.

1.2 This Agreement shall be interpreted in accordance with the following provisions unless the context requires a different meaning:

1.2.1 unless otherwise specified, references to Clauses and Schedules are to the Clauses of and Schedules to this Agreement;

1.2.2 the Schedules to this Agreement are an integral part of this Agreement and any reference to this Agreement includes a reference to the Schedules; and

1.2.3 where the context requires, words importing the singular shall be construed as importing the plural and vice versa and words importing the masculine shall be construed as importing the feminine or the neuter or vice versa.

1.3 In relation to any conflict and/or inconsistency relating to the provisions of this Agreement, the following shall apply:

1.3.1 for any conflict and/or inconsistency between the Clauses and the Schedules to this Agreement, the Clauses shall take precedence;

1.3.2 for any conflict and/or inconsistency between the Schedules, the following order of precedence shall apply:

(a) Schedule 1 (Definitions);

(b) Schedule 2 (Collaboration Requirements) and Schedule 3 (Network Costs); and

(c) any other Schedules and their Annexes.

2. **LEGAL STATUS AND PURPOSE OF THIS AGREEMENT**

2.1 This Agreement sets out the Parties' intentions to work together during the Term. The Parties agree there are a number of key objectives for KMPN:

2.1.1 continuing the delivery of clinically and financially sustainable Pathology Services whilst moving towards the creation of a single service under a single management structure for the Pathology Services (via the Change Control Procedure) based on strong, viable service provision that is clinically led, standardised, innovative and creative;

2.1.2 continuing the delivery of a high-quality diagnostic service for the local health economy across primary, secondary and tertiary providers that continually improves the patient experience and outcomes;

2.1.3 continuing the development of a valued and involved workforce;

2.1.4 continuing the transformation of service models to deliver technological change, increasing efficiency and maximising staff potential whilst meeting the needs of client trusts and commissioners;

2.1.5 continuing the management and development of KMPN in a creative and competent manner;

2.1.6 working together in a cooperative and constructive manner, with integrity, honesty and transparency to fulfil their individual and shared responsibilities to deliver the aims of KMPN;

2.1.7 sharing of data e.g. financial, workforce, performance, operational risks, activity and quality, on an open book basis to enable comparison and allow trends and areas for improvement to be identified;

2.1.8 devising strategies for quantifying and sharing benefit and risk which support financial sustainability and ensure that they are delivered to the satisfaction of all Parties;

2.1.9 adopting policies which build and sustain a stable, strong, and vibrant pathology workforce, identifying opportunity for development, training and specialization and providing mutual support;

2.1.10 identifying and implementing strategies for reconfiguration and consolidation of services as opportunity arises and where demonstrably supported by business modelling following assessment of local needs as a means of delivering improved stability, quality and efficiency;

2.1.11 where outsourcing of testing is necessary, prioritise clinically appropriate solutions using laboratory services within KMPN where possible as a means of supporting high quality, consistent patient care aligned with existing referral pathways;

2.1.12 working positively but non-competitively with each other and with regional healthcare organisations to maximise opportunities for collaboration in the development of local and regional diagnostic services such as community diagnostic centres;

2.1.13 ensure that inter Kent providers are not bidding against each other or offering services to other organisations that are already provided within the KMPN. Any bids for new markets or existing contracts coming to an end and new tenders going forwards will be discussed as part of the KMPN business and agree the best placed provider to bid and the best configuration to meet the needs of the tender.

2.1.14 collaborating on joint procurement initiatives, including coordinating bids for funding, managing awards made to KMPN and supporting business case development

2.1.15 identifying opportunities for pioneering new technologies for the benefit of patient care;

2.1.16 promoting the use of strategies which drive operational consistency and reduce unwarranted variation across all KMPN workstreams, aiming for

harmonization of laboratory processes and systems, unified adoption of national standards, and equitable service provision across the South 8 geography; and

2.1.17 aiming to reach consensus on key decisions of KMPN direction and strategy, seeking to resolve in good faith any disagreements in line with the principles and values described in this Agreement and, where this fails, to work within the dispute resolution framework to resolve any issues which cannot otherwise be settled

2.2 In addition to Clause 2.1, this Agreement clearly sets out the obligations of each Party to KMPN in relation to achieving the Key Deliverables, Governance and Management Structure, Network Costs, Risk and Benefit Sharing, types of Pathology Services and fulfilling any other commitments required in relation to the during the Term.

2.3 The Parties acknowledge that this Agreement is between NHS Foundation Trusts and NHS Trusts. It is not an NHS Contract for the purposes of section 9 of the National Health Service Act 2006 and is intended to be legally binding between the Parties.

2.4 The Parties confirm to each other that they have and will continue to have all relevant and necessary authority and permissions to enter into this Agreement and that each Party has obtained approval in accordance with its internal governance arrangements to enter into this Agreement.

3. TERM AND KEY DELIVERABLES

3.1 This Agreement will commence on the date of execution and shall continue for the Term unless terminated earlier in accordance with this Agreement.

3.2 The Parties may agree to extend the Term of this Agreement, and such extension must be agreed in writing and executed by the Parties' respective authorised signatories.

3.3 This Agreement will govern the achievement of certain Key Deliverables to be achieved during the course of 2023 and 2024 including:

3.3.1 the move towards a single, overall management structure for the three existing Pathology Services which shall be agreed via the Change Control Procedure to the extent not included at the date of signature of this Agreement;

3.3.2 the procurement and collaboration requirements in relation to the MES pursuant to the MES Procurement Strategy (as the same may be updated from time to time and incorporated into this Agreement via the Change Control Procedure as the MES procurement develops);

3.3.3 the management and implementation of the LIMS Contract to the extent not already covered by the LIMS Collaboration Agreement;

3.3.4 Specifically, but not limited to, during the first 6 (six) months from the date of this Agreement:

(a) Finalisation of terms and conditions relating to work force management;

(b) Finalising governance structure below the executive level;

(c) Confirmation as to whether Medical and Transfusion practitioners are to be treated as Network staff or remain with their provider Trusts;

(d) Agreeing a quality & governance process for KMPN. This will include a full review of accreditation status to ISO 15189 of laboratories, examination procedures and tests. For those not currently accredited to ISO15189 a governance strategy will be agreed.

(e) Confirming and/or agreeing financial apportionments and responsibilities in accordance with financial principles in Schedule 2 Part 3;

(f) Agreeing collaboration strategy for point of care testing (PoCT), transport, phlebotomy and mortuary requirements which are currently not in Scope of this Agreement; and

3.3.5 any other general collaboration provisions as detailed herein.

4. GOVERNANCE AND MANAGEMENT STRUCTURE

4.1 The Parties have established a Kent and Medway Pathology Network Board with representation from each Party. The Kent and Medway Pathology Network Board is responsible for formal decision making and making proposals to the individual Trusts' Boards when applicable.

4.2 The Kent and Medway Pathology Network Board is supported by the Kent and Medway Pathology Network Executive Team which is responsible for operational decisions with respect to LIMS, MES and any other KMPN projects as well as the operation of the KMPN. The Kent and Medway Pathology Network Executive Team will make recommendations to the Kent and Medway Pathology Network Board and meetings will be chaired by the KMPN Clinical Director.

4.3 The KMPN Clinical Director report to and is accountable to the Kent and Medway Pathology Network Board. The Managing Director reports to the KMPN Clinical Director and the two roles are responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Managing Director has line management responsibility for the Pathology Services senior leaders for the part of their role identified for activities of Kent and Medway Pathology Network. The KMPN Clinical Director has a dotted line relationship with the Trust pathology clinical directors and transitional network clinical and quality lead as detailed in Schedule 2.

4.4 The Kent and Medway Pathology Network Executive Team is supported by the LIMS Project Steering Group, MES Project Steering Group, Workforce Steering Group and Governance and Legal Steering Group.

4.5 The KMPN Clinical Director will coordinate the transformation programme on behalf of the Kent and Medway Pathology Network Board .

4.6 Each Party shall fully support the Kent and Medway Pathology Network Board and perform their respective roles in relation to the Governance structure which is set out in Part 2 Schedule 2 (Collaboration's Requirements) including:

4.6.1 participation in decision making process via each representative's delegated authority in a timely and appropriate manner in line with the Kent and Medway Pathology Network Board's and/or Kent and Medway Pathology Network Executive Team's and/or any Steering Group's requirements;

4.6.2 communications with the KMPN Clinical Director, the KMPN Managing Director, Kent and Medway Pathology Network Board's and/or KMPN Executive Team and/or any Steering Group and providing input to each Party's approval processes proactively (to the extent reasonably required) and as and when reasonably requested; and

4.6.3 use of reasonable endeavours to co-operate with and provide assistance to each Party as requested by the Kent and Medway Pathology Network Board and/or KMPN Executive and/or any Steering Group.

4.7 The Parties hereby agree that Kent and Medway Pathology Network Board brings together expertise from across the Parties, with executive, clinical, and operational representatives acting under the delegated authority of Trust Boards to make recommendations on all issues relating to KMPN activity.

4.8 Additional attendees for specific agenda items and leads of individual work-streams may also be invited but do not have decision making power.

4.9 The Kent and Medway Pathology Network Board will provide strategic oversight and guidance for the successful delivery of the individual projects within its programme, supporting solutions which are in the best interests of KMPN.

4.10 The Kent and Medway Pathology Network Board will assist with conflict resolution as requested and provides targeted intervention where needed should progress towards shared milestones fall outside agreed tolerances.

4.11 The Kent and Medway Pathology Network Board has delegated authority from Trust Boards for the direction and management of these projects and to make decisions on policies and work programmes aligned with the agreed principles of KMPN (including any KMPN reconfiguration), including the management of operational and financial risk within agreed tolerances pursuant to the terms of this Agreement. This includes direct budget responsibility for PMO/KMPN costs, the management of external infrastructure funding awarded for dedicated management posts and project resource, and the line management of staff appointed to any such positions. It also includes decisions on moving any location for the performance of any tests. Organisations should not independently develop pathology tests already being provided by another organisation within KMPN. Where there is considered to be a clinical requirement to do so (e.g. due to turnaround time demands), this should be given due consideration through a formal change control process under this Agreement.

4.12 The Kent and Medway Pathology Network Board will be responsible for decisions relating to pathology tests including but not limited to:

4.12.1 decisions on moving any location for the performance of any tests;

4.12.2 notwithstanding that the Parties to this Agreement agree that no individual Party should independently develop pathology tests that are already being provided by another organisation within KMPN, the Parties agree that where there is considered to be a clinical requirement to do so (e.g. due to turnaround time demands) this will be reviewed and assessed by the Kent and Medway Pathology Network Board with any agreement documented via the Change Control Procedure;

4.12.3 agreeing strategies for the on-going provision and/or provision of new services to private/non-NHS providers in good faith with respect to the overall objectives of KMPN.

4.13 Decisions which are (or are perceived to be) out-with the agreed principles of KMPN may be referred to Trust Boards by any Party.

4.14 All significant investment by an individual Party will require Trust Board approval through standard governance processes appropriate to the scale of the proposal.

4.15 In the event that a disagreement arises that cannot be resolved through informal discussion a description of the disagreement should be submitted in writing by the aggrieved Party to KMPN, clearly and concisely setting out the nature of the dispute.

Executive representatives of the Kent and Medway Pathology Network Board shall meet within ten (10) Working Days of notice of the dispute being submitted at a meeting convened for the purpose of attempting to resolve it. Failing resolution, the procedure set out in Clause 21 of this Agreement shall be followed.

4.16 The Kent and Medway Pathology Network Board will produce an annual report documenting achievements, key recommendations and plans for the year ahead. The report shall evaluate the financial benefit to all Parties and make a comparative assessment of quality data, including detail on how improvement will be supported.

4.17 The annual report will be submitted to the Trust Board of each Party for review and information.

4.18 An annual meeting will be held to share progress and future plans with pathology teams and other stakeholders across all Parties and associated organisations.

Host and Hosting Obligations

4.19 The Parties hereby agree to the appointment of Maidstone and Tunbridge Wells NHS Trust as the Host Trust for the purposes set out in this Agreement. The Parties may agree to change the Host Trust by agreement between themselves. Each Party agrees that the Staff identified in Schedule 10 shall be employed by the Host Trust in accordance with this Agreement (including any Changes agreed pursuant to it).

4.20 Not used.

4.21 Subject to 4.22, the Host Trust shall carry out the Hosting Obligations in accordance with the Hosting Standards.

4.22 The Host Trust shall not be obliged to carry out or perform any act (or omission) that it reasonably considers:

4.22.1 would conflict with the legislation, regulations, the Host Trust's constitutional documents, the standing orders and standing financial instructions governing the Host Trust from time to time; or

4.22.2 would put the Host Trust's business or assets or reputation at risk.

4.23 There are no costs to be recovered in fulfilling the Hosting Obligations:

4.24 The Host Trust shall remain in place until the expiry or early termination of this Agreement UNLESS:

4.24.1 it serves not less than six (6) months' written notice [(such notice not to be served within the first twenty-four (24) months of the initial Term)] to the Kent and Medway Pathology Network Board that it wishes to resign as Host Trust; or

4.24.2 it serves notice to exit its participation from this Agreement in accordance with Clause 9.1.

4.25 During the term of the Agreement and for a period of twenty-one (21) years thereafter, the Host Trust shall (at the cost of KMPN) maintain in force insurance (or membership of a NHS Resolution risk sharing scheme) in respect of:

4.25.1 employers' liability to cover such heads of liability as may arise under or in connection with the Agreement and the provision of the Pathology Services;

4.25.2 any other insurance as the Parties may agree to incorporate pursuant to the Change Control Procedure.

4.26 The Host Trust shall, on a Party's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium in respect of each insurance.

4.27 For the avoidance of doubt, KMPN, acting through the Host Trust, shall attempt to mitigate its liabilities. Where the Kent and Medway Pathology Network Board considers it appropriate, the Parties acknowledge and confirm that where liability arises for which KMPN has insurance, they shall procure that KMPN shall seek to recover any losses from the relevant insurances rather than utilising the indemnities contained in this Agreement as a first recourse.

5. RESOURCE PROVISION AND NETWORK COSTS

5.1 Each Party commits to funding its share of the Network Costs including providing the resources required to ensure that the Host Trust's obligations under this Agreement and any payment obligations (as defined in any formal contracts) are met.

5.2 The Host Trust shall bill the Network Costs in accordance with the provisions set out in Schedule 3.

5.3 Any other costs relating to this Agreement shall be borne by each Party as they are incurred unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by all Parties. For the avoidance of doubt, such costs may include, but not be limited to, attendance at meetings and costs with complying with and/or performing in any relevant contract as agreed by the Parties or any other responsibilities defined in any other document agreed by the Parties.

6. REVIEW AND AUDIT OF THE COLLABORATION AGREEMENT

6.1 This Agreement shall be reviewed periodically and at least annually by the Kent and Medway Pathology Network Board.

6.2 The purpose of each review undertaken pursuant to Clause 6.1 is to ensure that the arrangements detailed within this Agreement are operating as envisaged and that each Party can raise any issues through the Kent and Medway Pathology Network Executive Team .

6.3 The Parties recognise and agree that this Agreement will require updating and amendments during its Term to reflect any Services that KMPN procures and any further contracts that any of the Trusts enter into, for example, in connection with the MES. All Parties shall act reasonably and in good faith in relation to required updates and amendments to reflect such requirements. Changes will be documents via the Change Control Process detailed in schedule 4.

7. RESPONSIBILITIES AND RISK AND BENEFIT SHARE

7.1 Each Party covenants with the other Parties that, for so long as it remains a Party or until the termination of this Agreement, it will:

7.1.1 at all times act in good faith towards the other Parties;

7.1.2 act in a timely manner (including by paying any costs within thirty (30) days of production of a valid invoice);

7.1.3 generally do all things necessary, to give effect to the terms of this Agreement;

7.1.4 take all reasonable steps to ensure, so far as it is able, that any meeting of the Kent and Medway Pathology Network Executive Team has the necessary quorum throughout;

7.1.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs; and

7.1.6 adhere to statutory requirements and best practice.

7.2 Each Party shall:

7.2.1 maintain accurate and complete:

(a) accounting and other financial records for each year in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom in relation to this Agreement;

(b) statements and records of all transactions for this Agreement

and make these available on request to any Party (subject to the provision of reasonable notice);

7.2.2 promptly notify the Kent and Medway Pathology Network Executive Team and Kent and Medway Pathology Network Board of any liabilities which it considers it is entitled to seek indemnity protection or reimbursement from the other Parties under this Agreement such notice to include:

(a) the quantum and nature of such liability;

(b) details of the circumstances causing such liability;

(c) any steps it has taken to minimise such liability; and

(d) other details regarding the liability, including details of any litigation.

7.3 The Parties to this Agreement agree to adhere to the Risk and Benefit Share as set out in Schedule 2 Part 3.

8. LIABILITY

8.1 No Party limits its liability for:

8.1.1 death or personal injury caused by its negligence;

8.1.2 fraudulent misrepresentation; or

8.1.3 any other liability which cannot be excluded or limited by Applicable Law.

8.2 Subject to Clause 8.4, each Party to this Agreement is liable for their own acts and omissions in connection with their own Pathology Services, any breach of this Agreement and/or any negligent or deliberate act or omission in connection with their own Pathology Services and/or this Agreement. Accordingly, to the extent that one Party's breach and/or negligence and/or wilful act or omission, either, in relation to their own Pathology Services and/or this Agreement causes another Party under this Agreement to suffer any loss, that former Party shall fully indemnity the Party who has suffered such loss.

8.3 No Party shall be liable under Clause 8.2 to the extent that the costs are already covered in the Network Costs.

8.4 No Party shall be liable for any Indirect Losses unless otherwise agreed in writing by the Parties.

9. TERMINATION

9.1 This Agreement shall terminate when all Parties agree to its termination. In addition, a Party may serve notice to terminate its participation in this Agreement upon giving twelve (12) months' notice to the Kent and Medway Pathology Network Board, subject to such notice only being permissible to be exercised after the expiry of the Transformation Programme.

9.2 A Party shall cease to be a Party to this Agreement if:

9.2.1 they commit a material breach of this Agreement or any contract that the Parties have entered into and (if such breach is remediable) fails to remedy that breach within a period of thirty (30) days after being notified in writing to do so by the Kent and Medway Executive Team; or

9.2.2 they are expelled by a resolution of the Kent and Medway Pathology Network Board where:

(a) the Party in default commits an Prohibited Act which is relevant to or connected with this Agreement; or

(b) the Party in default causes significant reputational damage to any other Party due to a material breach (whether or not capable of remedy),

9.2.3 they cease to exist in the form in which they existed when they are admitted as a Party to this Agreement, provided that this Clause 9.2.3 shall not apply to the extent that a relevant procedure is entered into for the purpose of a statutory reorganisation (where applicable) where the amalgamated, reconstructed or merged party agrees to adhere to this Agreement,

then the other Parties shall be entitled to immediately terminate the relevant Party's participation in the Agreement by joint written notice.

9.3 If notice is served pursuant to Clauses 9.1 or in the event a Party is expelled in accordance with Clause 9.2, then the Party that is in default or that wishes to withdraw or otherwise leave the Agreement shall pay any outstanding proportion of the Network Costs and any other costs directly arising pursuant to Clause 8. The Parties recognise that the Network Costs may accrue throughout the entire Term as well as on termination or expiry of this Agreement and any Party liable to pay such costs shall be notified of any final outstanding payments upon completion of the Term or as soon as practical thereafter.

9.4 The Parties recognise their continuing responsibilities in relation the performance of functions and liabilities under this Agreement. This liability extends, insofar as is required beyond expiry or termination of this Agreement.

10. CONSEQUENCES OF TERMINATION

10.1 Upon expiry or earlier termination of this Agreement, the Parties shall co-operate fully in achieving an orderly and efficient conclusion of the arrangements under this Agreement.

10.2 On termination of this Agreement, the following Clauses shall continue in force: Clause 7 (Responsibilities), Clause 8 (Liability,) Clause 9 (Termination), Clause 10 (Consequence of Termination), Clause 11 (Confidentiality), Clause 12 (Information and Sharing of Data), Clause 13 (Data Protection), Clause 14 (Bribery and Corruption), Clause 21 (Dispute Resolution), Clause 23 (Status of Agreement), Schedule 1 (Definitions) and Schedule 3 (Network Costs).

10.3 Termination of this Agreement shall not affect any rights, remedies, obligations or liabilities of the Parties that have accrued up to the date of termination.

10.4 Each Party shall act reasonably and in good faith with regards to mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Party to do so.

11. **CONFIDENTIALITY**

11.1 Each Party:

11.1.1 shall treat all Confidential Information belonging to any other Party or this Agreement as confidential and safeguard it accordingly; and

11.1.2 shall not disclose any Confidential Information belonging to any other Party or this Agreement to any other person without the prior written consent of that Party, except to such persons and to such extent as may be necessary for the performance of this Agreement or except where disclosure is otherwise expressly permitted by the provisions of this Agreement including Applicable Law.

11.2 Each Party shall take all necessary precautions to ensure that all Confidential Information obtained from any other Party under or in connection with this Agreement:

11.2.1 is given only to such of the employees and professional advisers or consultants engaged to advise it in connection with this Agreement and as is strictly necessary for the performance of this Agreement;

11.2.2 is, if it is Special Category Data or Personal Data, kept secure in accordance with the requirements of the Data Protection Legislation and only used in accordance with the disclosing Party's instructions;

11.2.3 is treated as confidential and not disclosed (without written prior consent) or used by any employees or professional advisers or consultants otherwise than for the purposes of performing its obligations under this Agreement.

11.3 The provisions of Clauses 11.1 to 11.3 (inclusive) shall not apply to any Confidential Information received by one Party from the other which:

11.3.1 is or becomes public knowledge (otherwise than by breach of this Clause 11 or through act of default on the part of the receiving Party or the receiving Party's agents or employees);

11.3.2 the receiving Party lawfully obtained from a Third Party who:

(a) lawfully acquired it;

(b) did not derive it directly or indirectly from the disclosing Party; and

(c) is under no obligation restricting its disclosure;

11.3.3 must be disclosed pursuant to a statutory, legal or parliamentary obligation placed upon the Party making the disclosure, including any requirements for disclosure pursuant to Clause 12 (FOIA), or otherwise in accordance with a court order, or the recommendation, notice or decision of a competent authority.

11.4 On termination of this Agreement or the participation of a Party, each Party (or in the event that the Agreement is terminated in relation to one Party, that Party) shall:

11.4.1 destroy or return to the other Parties, as applicable, all documents and materials (and any copies) containing, reflecting, incorporating or based on the other Parties' Confidential Information;

11.4.2 erase all Confidential Information belonging to the other Parties from computer and communications systems and devices used by it, including such systems and data storage services provided by Third Parties (to the extent technically and legally practicable); and

11.4.3 certify in writing to the other Parties that it has complied with the requirements of this Clause provided that a recipient Party may retain documents and materials containing, reflecting, incorporating or based on the Confidential Information of the other Parties to the extent required by Applicable Laws or any applicable governmental or regulatory authority.

11.5 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information.

11.6 The Parties agree that the provisions of this Clause 11 shall continue following expiry or termination for any reason of this Agreement for a period of three (3) years.

12. INFORMATION GOVERNANCE AND SHARING OF DATA

12.1 The Parties acknowledge that they are subject to the requirements of the FOIA, the EIRs and the Data Protection Legislation and the Parties shall assist and co-operate with each other to enable them to comply with these requirements.

12.2 The Parties shall procure that any of their agreed sub-contractors shall:

12.2.1 transfer any Request for Information to the relevant Party which is the subject of the Request for Information (the "**Disclosing Party**") as the case may be as soon as practicable after receipt and in any event within two (2) Working Days of receiving that Request for Information;

12.2.2 provide the Disclosing Party with a copy of all Information in its possession or power in the form that the Disclosing Party requires soon as practicable and in any event within five (5) Working Days (or such other period as the Disclosing Party may specify) of the Disclosing Party requesting that Information; and

12.2.3 provide all necessary assistance as reasonably requested by the Disclosing Party to enable it to respond to a Request for Information within the time for compliance set out in the FOIA and regulation 5 of the EIRs.

12.3 Each Party shall maintain an adequate records management system to enable it to retrieve the Information within the time limits prescribed in the FOIA and/or EIRs as applicable.

12.4 In considering whether Information is exempt from disclosure, the Disclosing Party shall reasonably consider the nature of such Information and in particular whether any information has been identified by the other Party as being commercially sensitive; however, for the avoidance of doubt, the Disclosing Party shall be responsible for determining in its absolute discretion whether the Information should be disclosed in response to a Request for Information.

12.5 Each Party acknowledges that the other Parties may, acting in accordance with the Secretary of State for Constitutional Affairs' Code of Practice on the discharge of public authorities' functions under Part 1 of FOIA (issued under section 45 of the FOIA, November 2004), be obliged under the FOIA or the EIR to disclose Information:

12.5.1 without consulting with the other Parties, or

12.5.2 following consultation with the other Parties and having taken their views into account.

12.6 The Disclosing Party agrees to keep the other Party fully informed of any FOIA requests received and processed in relation to this Agreement.

12.7 The Parties shall ensure that all Information produced in the course of this Agreement or relating to this Agreement is retained for disclosure and each Party shall permit the other to inspect such Information and documents and records containing such Information as that other Party may reasonably request from time to time.

12.8 It is agreed that the Kent and Medway Network Executive Team minutes and/or any other relevant documentation may contain commercially sensitive information, and that the Disclosing Party shall, where reasonably practicable and appropriate, seek the other Parties' opinion on whether such information is exempt from disclosure in accordance with the provisions of the FOIA or the EIRs save that the decision on disclosure shall remain the sole responsibility of the Disclosing Party.

12.9 Any costs charged for FOIA requests will be split proportionately between the Parties.

13. DATA PROTECTION

13.1 The Parties acknowledge that for the purposes of Data Protection Legislation, they are each independent Data Controllers in relation to the Contract Data.

13.2 The Parties agree to share Contract Data with each other to the extent necessary and proportionate to fulfil the purpose of this Agreement as identified by clause 2.1, and to meet their respective obligations as described by clause 2.2 (together the "**Purpose**").

13.3 Each Party shall comply with the Data Protection Legislation. Without prejudice to the foregoing, the Parties acknowledge that when one Party (the "**Data Discloser**") shares Contract Data with one or more Parties (the "**Data Receiver**"):

13.3.1 the Data Discloser will ensure it has a lawful basis for sharing the Contract Data under Data Protection Legislation;

13.3.2 the Data Discloser shall ensure it has provided clear and sufficient information to the Data Subjects as required by Data Protection Legislation;

13.3.3 the Data Receiver shall not Process the Contract Data in any way which is unrelated to or incompatible with the Purpose; and

13.3.4 for the avoidance of doubt, each Party shall ensure that it has lawful basis for Processing Contract Data at all times throughout the Term of this Agreement.

13.4 The Parties agree not to transfer, share or otherwise Process Contract Data outside of the UK.

13.5 Upon termination or earlier expiry of the Agreement for whatever reason, at the election of the Data Discloser, the Data Receiver shall either securely delete or return all Contract Data to the Data Discloser. If required by law to retain a copy, the Data Receiver shall inform the Data Discloser what it is retaining and the legal reason why it needs to be retained.

13.6 The Parties agree to use all reasonable efforts to assist each other with complying with the Data Protection Legislation. This includes (but is not limited to) the Parties providing each other with such assistance as is reasonably required to enable each other to

comply with any Subject Rights Requests within the time limits imposed by Data Protection Legislation.

14. **BRIBERY AND CORRUPTION**

14.1 The Parties must not commit any Prohibited Act.

14.2 Each Party warrants that in entering into this Agreement it has not committed any Prohibited Act and further represents and warrants it will, during the term of this Agreement (and procure that its employees, agents and contractors) not commit a Prohibited Act and will, comply with the Bribery Act 2010 and associated guidance published by the Secretary of State for Justice under the Bribery Act 2010 and all other Applicable Law in relation to bribery or corruption (the "**Bribery Laws**"). For the avoidance of doubt, any obligation to comply with (or to avoid any breach or contravention of) the Bribery Laws shall be deemed to include an obligation to avoid any act or omission that would constitute an offence under the Bribery Act 2010 if done or made by a person with a close connection with the United Kingdom (as defined in that Act) or if done or made in the United Kingdom.

14.3 Each Party further warrants that it has in place adequate procedures to prevent bribery and corruption, as contemplated by section 7 of the Bribery Act 2010, including an anti-corruption and bribery policy.

14.4 Each Party shall:

14.4.1 if requested, provide the Host Trust with any reasonable assistance, at the relevant Party's cost, to enable the Host Trust to perform any activity required by any relevant government or agency in any relevant jurisdiction for the purpose of compliance with the Bribery Act 2010; and

14.4.2 within fourteen (14) Working Days of the Commencement Date, and annually thereafter, certify to MTW in writing (such certification to be signed by an officer of the relevant Party) compliance with this Clause 14 by the relevant Party and all persons associated with it or other persons who are supplying goods or services in connection with this Agreement. For the avoidance of doubt, each Party shall provide such supporting evidence of compliance as the Host Trust may reasonably request.

14.5 If any breach of this Clause 14 is suspected or known, the relevant Party must notify the Host Trust immediately.

14.6 The Host Trust may expel any Party who is found in breach of this Clause 14 provided the Party is question is provided with a termination notice stating:

14.6.1 the nature of the breach;

14.6.2 the identity of the party whom the Host Trust believes as committed the breach; and

14.6.3 the date on which this Agreement will terminate.

14.7 Any termination under this Clause 14 will be without prejudice to any right or remedy which has already accrued or subsequently accrues to the Host Trust.

15. **EQUALITY ACT**

15.1 Each Party shall not unlawfully discriminate within the meaning and scope of the provisions of the Equality Act 2010 or any statutory modification or re-enactment of that Act or analogous legislation which has been, or may be, enacted from time to time relating to discrimination in employment or discrimination in the delivery of public services.

15.2 Each Party shall take all reasonable steps to secure that all their servants, employees or agents do not unlawfully discriminate as set out in Clause 15.1.

16. SUB-CONTRACTING AND ASSIGNMENT

16.1 No Party shall be entitled to sub-contract or assign its rights or obligations under this Agreement without the consent of each of the other Parties, such consent not to be unreasonably withheld or delayed unless such assignment, sub-contracting, novation or transfer is to a statutory successor in which case no consent shall be required.

16.2 At their own expense, the Parties shall promptly execute and deliver such documents and perform such acts as may reasonably be required for the purpose of giving full effect to this Clause 16.

17. INTELLECTUAL PROPERTY RIGHTS

17.1 All existing Intellectual Property of each Party that is used by the Parties in connection with this Agreement shall remain the exclusive property of the Party that owned such Intellectual Property on the commencement of this Agreement. Each Party hereby grants to each other a non-exclusive, royalty free licence to use any such existing Intellectual Property solely for the purposes of participating in the Procurement Process.

17.2 Any Intellectual Property created by a Party as part of or arising out of the Procurement Process shall belong to the Party who created it (the "**Owning Party**"). The Owning Party hereby grants to the other Parties a non-exclusive, royalty free licence to use any such new Intellectual Property for the purposes of collaborating in the Procurement Process.

17.3 The Parties will jointly own any jointly developed Intellectual Property arising out of the Procurement Process and no Party will be entitled to independently use such Intellectual Property other than in conjunction with the Procurement Process without the written consent of the other Parties.

17.4 Any dispute as to the ownership of any Intellectual Property shall be determined in accordance with Clause 21 (Dispute Resolution Procedure).]

18. ADHERENCE TO THIS AGREEMENT

18.1 In the event that a New Party wishes to join this Agreement, the New Party shall enter into a deed of adherence in the form set out in Schedule 11;

18.2 In the event that a New Party wishes to join this Agreement without any relevant contract for LIMS, the Parties shall agree such provisions via the Change Control Procedure.

19. VARIATIONS

19.1 Variations to this Agreement may be initiated by any Party by issuing a Change Control Note to the Kent and Medway Pathology Network Board by using the procedure set out in Schedule 4.

19.2 The Parties to this Agreement agree and acknowledge at the date of its signature that a number of changes will be required during the term of this Agreement. Such changes may include (but are not limited to):

19.2.1 Financial arrangement including levels of base costs and contributions to indirect costs;

19.2.2 impact of service change and reconfigurations (for example due to national mandates and/or centralised procurements) and changes relating to space utilisation;

19.2.3 The ICS collaborative bank (when it is in place) will manage bank requests on behalf of the KMPN;

19.2.4 A standard placement agreement is signed by each Trust in the KMPN and a university avoiding the need for individual honorary contracts (by June 2023);

19.2.5 Organisations should work to ensure equivalence of pay and conditions for roles across KMPN. Whenever a post is advertised, or an internal restructuring of a role is being considered, assurance should be sought from the workforce lead that the job description and banding are commensurate with those in other network organisations. Where a need to deviate from this position is considered necessary, this should be the subject of a Change Control Process under this Agreement.

20. NOTICES

20.1 Any notice required to be given under this Agreement may be delivered personally or sent by first class post, courier or transmitted by email to the Chief Executive (or equivalent) of each other Party at the address given at the beginning of this Agreement, or such other addresses as may be notified in accordance with this Clause 20 from time to time.

20.2 Any notice so sent shall be deemed to have been duly given if sent by (i) personal delivery or courier - on delivery at the address of the relevant Party; or (ii) prepaid first class post – five (5) days after the date of posting when able to be read as received on recipient's email server.

20.3 This Clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

21. DISPUTE RESOLUTION PROCEDURE

21.1 In the event of any dispute arising in relation to this Agreement ("**Dispute**"), the matter shall first be considered by the Kent and Medway Pathology Network Executive Team. In the event that the Kent and Medway Pathology Network Executive Team is not able to resolve the dispute within ten (10) Working Days of the matter arising, the Kent and Medway Pathology Network Executive Team . shall escalate the matter by referring it to the Kent and Medway Pathology Network Board

21.2 In the event that the Parties are unable to settle the dispute within ten (10) Working Days of referral to the Kent and Medway Pathology Network Board detailed in Clause 21.1, they shall within five (5) Working Days after the end of that negotiation period submit the dispute to an Expert in accordance with the process set out below.

21.3 An Expert is a person appointed in accordance with this Clause to resolve a dispute arising under this Agreement.

21.4 The Parties shall agree on the appointment of an independent Expert and shall agree with the Expert the terms of their appointment.

21.5 If the Parties are unable to agree on an Expert or the terms of their appointment within seven (7) days of either Party serving details of a suggested expert on the other, any Party shall then be entitled to request The Academy of Experts to appoint an Expert of repute with international experience in the subject matter of the dispute and for The Academy of Experts to agree with the Expert the terms of appointment.

21.6 The Expert is required to prepare a written decision including reasons and give notice (including a copy) of the decision to the Parties within a maximum of three months of the matter being referred to the Expert.

21.7 If the Expert dies or becomes unwilling or incapable of acting, or does not deliver the decision within the time required by this Clause then:

21.7.1 the Parties may agree or may apply to The Academy of Experts to discharge the Expert; and

21.7.2 the Parties may proceed to appoint a replacement Expert in accordance with this Clause 21 which shall apply to the replacement Expert as if they were the first Expert to be appointed.

21.8 All matters under this Clause must be conducted, and the Expert's decision shall be written, in the English language.

21.9 The Parties are entitled to make submissions to the Expert including oral submissions and will provide (or procure that others provide) the Expert with such assistance and documents as the Expert reasonably requires for the purpose of reaching a decision.

21.10 Each Party shall with reasonable promptness supply each other with all information and give each other access to all documentation and personnel and/or things as the other Party may reasonably require to make a submission under this Clause.

21.11 The Expert shall act as an expert and not as an arbitrator. The Expert shall determine the dispute arising under this Agreement which may include any issue involving the interpretation of any provision of this Agreement, their jurisdiction to determine the matters and issues referred to them and/or their terms of reference. The Expert may award interest as part of their decision. The Expert's written decision on the matters referred to them shall be final and binding on the Parties in the absence of manifest error or fraud.

21.12 The Expert may direct that any legal costs and expenses incurred by a Party in respect of the determination shall be paid by another Party to the determination on the general principle that costs should follow the event, except where it appears to the Expert that, in the circumstances, this is not appropriate in relation to the whole or part of such costs. The Expert's fees and any costs properly incurred by them in arriving at their determination (including any fees and costs of any advisers appointed by the Expert) shall be borne by the Parties in the proportions set out at Schedule 3 to this Agreement.

21.13 All matters concerning the process and result of the determination by the Expert shall be kept confidential among the Parties and the Expert.

21.14 Each Party shall act reasonably and co-operate to give effect to the provisions of this Clause and otherwise do nothing to hinder or prevent the Expert from reaching their determination.

21.15 The Expert shall have no liability to the Parties for an act or omission in relation to this appointment; save in the case of bad faith.

21.16 Nothing in this Agreement shall prevent a Party seeking from any court any interim or provisional relief that may be necessary to protect the rights or property of that Party or the security of Confidential Information, pending resolution of the relevant dispute in accordance with the process set out in this Clause 21.

22. GENERAL

22.1 No variation of this Agreement shall be effective unless it is in writing and signed by each Party.

22.2 Failure of any Party to enforce or exercise, at any time or for any period, any term of this Agreement does not constitute, and shall not be construed as, a waiver of any term and shall not affect the right to enforce such term, or any other term contained in this Agreement, at a later date.

22.3 Nothing in this Agreement shall constitute, or be deemed to constitute, a legal partnership between the Parties, or shall constitute any Party as the agent, employee or representative of the other(s).

22.4 The Parties hereby agree that this Agreement shall be binding on any successors in title.

22.5 No one other than a party to this Agreement, their successors and/or permitted assignees, shall have any right to enforce any of its terms whether by virtue of the Contracts (Rights of Third Parties) Act 1999 or otherwise.

22.6 If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and the Parties shall work together to agree a variation to this Agreement to ensure their continuation and achieve so far as possible their original intent. In the event that the Parties cannot agree an appropriate variation, any Party may terminate its participation from this Agreement with immediate effect.

22.7 No publicity or advertising regarding the relationship between the Parties concerning the Procurement Process, the LIMS Contract or this Agreement shall be released by any Party without the prior written approval of the other Party, which shall not be unreasonably withheld.

22.8 The Parties shall do and execute all such further acts and things as are reasonably required to give full effect to the rights given and the matters contemplated by this Agreement.

22.9 This Agreement may be executed and delivered in any number of counterparts, each of which is an original and which, together, have the same effect as if each Party had signed the same document.

22.10 This Agreement constitutes the entire agreement and understanding between the Parties with respect to the subject matter of this Agreement and supersedes any prior agreement, understanding or arrangement between the Parties with respect to the subject matter of this Agreement, whether oral or in writing.

23. STATUS OF AGREEMENT

This Agreement is governed in accordance with this Clause 23.

23.1 This Agreement and any dispute or claim arising out of, or in connection with, it, its subject matter or formation (including non-contractual disputes or claims) shall be governed by, and construed in accordance with, the laws of England.

23.2 The Parties irrevocably agree that the Courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

Definitions

Agreement	means this agreement, including its Schedules;
Applicable Laws	all laws, rules, regulations, codes of practice, research governance or ethical guidelines or other requirements of regulatory authorities, as amended from time to time;
Board(s)	means the executive board of any of the Trusts as the context so requires;
Bribery Laws	has the meaning set out in Clause 14;
Business Plan	means the annual business plan for KMPN prepared by Kent and Medway Pathology Network Executive Team and approved by the Kent and Medway Pathology Network Board in accordance with Schedule 9;
Change	means an amendment to any term or Schedule under this Agreement or any other contract entered into by the Parties (and agreed to be governed by this Agreement) pursuant to Schedule 4;
Change Control Note or "CCN"	means the written record of any Change agreed or to be agreed by the Parties pursuant to the Change Control Procedure as set out in Schedule 4;
Change Control Procedure	
Commissioner	the Information Commissioner (see Article 4(A3), UK GDPR and section 114, DPA 2018);
Confidential Information	means information, the disclosure of which would constitute an actionable breach of confidence, which has either been designated as confidential by a Party in writing or that ought to be considered as confidential (however it is conveyed or on whatever media it is stored), including commercially sensitive information, information which relates to the finances, business, affairs, properties, assets, trading practices, goods/services, developments, trade secrets, Intellectual Property rights, know-how, employees and other workers, customers and suppliers of a Party and all Personal Data and Sensitive Personal Data.;
Contract Data	means the management, performance and administrative data that may be collected, Processed and shared by the Parties under or in connection with this Agreement, which the Parties acknowledge includes Personal Data;
Data Controller	has the meaning given in the Data Protection Legislation;
Data Processor	has the meaning given in the Data Protection Legislation;
Data Protection Legislation	all applicable data protection and privacy legislation in force from time to time in the UK including without limitation the UK GDPR; the Data

	Protection Act 2018 (and regulations made thereunder) (**DPA 2018**); the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended; all other legislation and regulatory requirements in force from time to time which apply to a Party relating to the use of Personal Data (including, without limitation, the privacy of electronic communications); and the guidance and codes of practice issued by the Commissioner or other relevant regulatory authority and which are applicable to a Party
Data Subject	has the meaning given in the Data Protection Legislation;
Direct Losses	means amounts recoverable under Clause 8.3 or any Network Costs, excluding Indirect Losses;
Dispute Resolution Procedure	means the procedure set out in Clause 21 of this Agreement;
EIRs	means the Environmental Information Regulations 2004 together with any code of practice made pursuant to those Regulations and any related guidance issued by the Secretary of State for the Department for Environment, Food and Rural Affairs, the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Financial Year	means a financial accounting period of twelve (12) months ending on 31 March but, in the first year in which this Agreement is signed means the period starting on the date of signature and ending on 31 March;
FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in the Interpretation Act 1978), but excluding the EIRs, as amended modified or re-enacted from time to time, together with all codes of practice made pursuant to that Act or pursuant to that subordinate legislation from time to time, and together with any related guidance issued by the Information Commissioner or the Secretary of State for the Department of Constitutional Affairs;
Governance and Legal Group	means the group of that name reporting into the Kent and Medway Pathology Network Executive Team ;
Governance and Management Structure	means the KMPN governance and management structure set out in Part 2 of Schedule 2 (Collaboration's Requirements) as the same may be amended and updated from time to time pursuant to this Agreement;
Host Trust	means Maidstone and Tunbridge Wells NHS Trust as the contracting party under this Agreement on behalf of the KMPN;
Hosting Obligations	means those obligations set out in Schedule 5;
Hosting Standards	means those standards set out in Schedule 5;
Indirect Losses	means any loss of profits, loss of business or loss of business opportunity (whether such losses arise directly or indirectly) and any other consequential or indirect loss of any nature, but excluding Direct Losses;
Information	shall have the meaning given under section 84 of the Freedom of Information Act 2000 including but not limited to environmental information as defined in regulation 2 of the EIRs and Personal Data

	and data as defined in the Data Protection Legislation;
Intellectual Property	means any patents, rights to inventions, registered designs, copyright and related rights, database rights, design rights, topography rights, trademarks, service marks, trade names and domain names, trade secrets, rights in unpatented know-how, rights of confidence and any other intellectual or industrial property rights of any nature, including all applications (or rights to apply) for and renewals or extensions of such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world;
Kent and Medway Pathology Network Board	means the Kent and Medway pathology network's board or such other group that replaces it from time to time.
Kent and Medway Pathology Network Executive Team	means the Kent and Medway pathology network's management team or such other group that replaces it from time to time.
Key Deliverables	means the deliverables set out in Clause 3 and as more particularly described in Part 1 of Schedule 2 (Collaboration's Requirements);
KMPN	means the Kent and Medway Pathology Network;
LIMS Collaboration Agreement	means the collaboration agreement entered into by the Parties for the LIMS Contract;
LIMS Contract	means the contract for the provision of a pathology laboratory information management system entered into by EKHUFT with CliniSys ;
MES Contract	means the managed services contract to be procured by KMPN pursuant to the MES Procurement Strategy for the standardisation of analysers to improve quality and commercial outcomes of KMPN and for which further agreed provisions shall be included in this Agreement via the Change Control Procedure;
MES Procurement Strategy	means the MES Procurement Strategy v1.1 approved by the MES Steering Group on 21st September 2022 along with the paper called "September 2022 MES Project and Pathology Programme Delays noted at the meeting of the PNCOC and Transformation Board on 6th October 2022 and 13th October 2022 respectively;
MES Provider	means the supplier that enters into the MES Contract;
MES Steering Group	means the group of that name set up for the MES and reporting into the Kent and Medway Pathology Network Board;
Network Costs	means the KMPN management costs payable under or in connection with this Agreement, as apportioned between the parties as set out in more detail in Schedule 3 or as determined in accordance with Clause 8 of this Agreement and any other costs that are agreed to be incorporated via the Change Control Procedure;
NKPS	means the North Kent Pathology Service which is formed by DGT and MFT;
New Party	means a party who joins this Agreement pursuant to Clause 18;

Party(ies)	means each and any or all (as the context so requires) of the Parties listed at the start of this Agreement and any additional entities that become a party to this Agreement;
Personal Data	has the meaning given in the Data Protection Legislation;
Processing	has the meaning given in the Data Protection Legislation;
Personal Data	has the meaning given in the Data Protection Legislation;
Pathology Services	means the three independent pathology services that are provided by (1) NKPS at Darent Valley Hospital and Medway Maritime Hospital; (2) EKUHFT at William Harvey, Queen Elizabeth Queen Mother and Kent and Canterbury Hospital; and (3) MTW at Maidstone Hospital and Pembury Hospital;
Pathology Services senior leader (s) and Clinical Director(s)	means the relevant role of lead manager at any of the three Pathology Services;
Request for Information	shall have the meaning set out in FOIA;
Risk and Benefit Share	means the provisions relating to the same set out in Part 3 of Schedule 2 (Collaboration's Requirements);
Special Category Data	has the meaning given in the Data Protection Legislation;
Staff	means the staff that are employed by the Host Trust;
Steering Group(s)	means any or all of the transformation programme steering groups; LIMS Steering Group, MES Steering Group. Workforce Steering group, digital diagnostic steering group and Governance and Legal Steering Group as the context so requires;
Term	31st March 2038 unless terminated earlier in accordance with Clause 9 (Termination), or extended in accordance with Clause 3.2 (Term);
Terms of Reference	means the terms of reference that govern the set-up, management, roles and responsibilities of the Kent and Medway Pathology Network Board and the Kent and Medway Pathology Network Executive Team (as updated from time to time), copies of which (as at the date of this Agreement) are set out in Part 2 of Schedule 2 (Collaboration's Requirements);
Transformation Programme	means the programme detailing the planned transformation activities that KMPN shall implement via this Agreement, a copy of which is set out in Schedule 2 (Collaboration's Requirements);
UK GDPR	has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the DPA 2018;
Working Day	means any day other than a Saturday, a Sunday, Christmas Day, Good Friday or a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in any part of the United Kingdom and "**Working Days**" shall be construed accordingly.

SCHEDULE 2

Collaboration's Requirement

Part 1

KEY DELIVERABLES

The MES procurement phase of the project will conclude with an identical contract that all pathology services in the network (or individual Trusts) will enter into with a single MES Provider. The MES Provider will supply pathology services across all of the Trusts' sites and all specialities, for example a centralised inventory management solution, a specimen management and tracking solution and an Internal Quality Control solution. The MES Provider will also supply the biochemistry solution including tracked automation but it will sub-contract key elements of the MES Contract to third-party providers following a series of mini competitions, run by the MES Provider. Subject matter experts from the various disciplines will be directly involved in the assessment of bids as part of these mini competitions. The estimated launch date for the initial tender to select the MES Provider is early March 2023 and the total MES procurement phase of the MES project is expected to last around 12 months, with the initial stage taking around 7 months. Following the completion of the MES procurement phase, the MES Full Business Case (FBC) will be finalised and submitted for approval to the various governance Trust groups and NHSE, following which the MES Contract with the MES Provider will be finalised and signed.

A network SLA has been put in place with the main provider of outsources testing. When the needs arises the remaining small contracts will be held at Trust level will be procured/renewed on a network basis.

The LIMS Collaboration Agreement is separate to this Agreement. It covers the LIMS Contract and includes the following deliverables; -

- It provides legal protection for EKHUFT as they have entered into a legally binding commercial contract with CliniSys and are hosting the service on behalf of all Trusts in the KMPN;
- It is a legally binding agreement between all Trusts in the KMPN. All Trusts are bound by the agreement to pay an agreed share of the annual service costs and all other costs as they arise, e.g. delay payment penalties;
- It provides protection to all remaining Trusts should one or more Trust wish to stop using the LIMS system;
- It includes a provision for new Trusts joining at a future date; and
- It describes how the LIMS Contract will be governed.

COLLABORATIVE APPROACH AND CONFLICTS MANAGEMENT

1. The Trusts shall work collaboratively and in good faith during the Term in accordance with the provisions of this Agreement. The Trusts expressly recognise that the MES is intended to confer mutual benefits on all Trusts, and the Procurement Process and MES Contract(s) shall reflect this intention, in particular (but not limited to):

    1.1 standardising specifications across Trusts;

    1.2 rationalising and reducing supply-base for similar products/services, leveraging spend wherever possible;

    1.3 ensuring robust clinical evaluations that support the principles at Paragraphs 1.1 and 1.2;

    1.4 influencing behavioural change throughout the supply chain, reducing cost and removing process variation;

1.5 applying category management;

1.6 identifying and mitigating supply chain risk;

1.7 ensuring evidence based decision making;

1.8 procuring leaner requisition to pay processes;

1.9 ensuring focus on execution and project delivery; and

1.10 identifying strategic partners to achieve the outcomes listed at Paragraphs 1.1 to 1.10.

2. The Trusts have selected common Selected Suppliers for all Trusts by virtue of the application of the Contract Award Criteria. Each Trust has and shall continue to participate in the Evaluation Process as required by the Kent and Medway Pathology Network Board . The Procurement Process has and shall continue to be constructed so as to protect the Trusts from an outcome that puts any Trust in a worse position to its current contract(s).

3. Decisions made by the Kent and Medway Pathology Network Board in line with the application of the Terms of Reference shall be ratified by each individual Trust in accordance with Schedule 2 Part 2.

4. The Trusts shall keep each other fully informed of any issues and/or conflicts (or potential issues and/or conflicts) arising from, in relation to or connected to this Agreement and/or the Procurement Process and/or their Contracts that may have any material adverse impact on any Trust or a material adverse effect on the ability of the Trust to comply with the provisions of this Agreement and/or the provisions of their Contracts and/or participate in the Procurement Process. Each Trust shall act reasonably and in good faith with regards to escalating and mitigating any adverse consequences on each other to the extent it is reasonable and within the control of each Trust to do so.

5. The Trusts recognise that mutual benefit will be derived from a collaborative approach to management of their Contracts with respect to (but not limited to) the following:

5.1 system efficiency and resilience;

5.2 benchmark and performance data review;

5.3 cross-organisational operational delivery;

5.4 shared learning and cross organisational responsibilities;

5.5 escalation of issues and disputes with Selected Supplier;

5.6 cross organisational implementation and transition;

5.7 benefits realisation assessment;

5.8 innovation and technology assessments;

5.9 continuous improvement initiatives;

5.10 collaborative contract management;

5.11 business continuity;

5.12 management of adverse impacts on individual Contracts and subsequent cross organisational impacts (e.g. delays); and

5.13 price changes, extensions and change control.

6. Each Trust shall immediately give written notice to the other Trusts and the Network Board of any actual, threatened or suspected procurement challenge and/or other legal action in connection with a Contract of which it becomes aware.

7. The Parties will co-operate with each other in good faith and will take all reasonable action as is necessary for the efficient transmission of information and instructions and to enable the Parties to derive the full benefit of this Agreement and Contracts.

8. Parties will not enter into unilateral contract negotiations with the single MES provider or any other pathology equipment provider, all contract negotiations must be undertaken via a unified KMPN process

Part 2

GOVERNANCE AND CONTRACT MANAGEMENT

A. Terms of Reference for the Kent and Medway Pathology Network Board and Kent and Medway Pathology Network Executive Team

TERMS OF REFERENCE

KENT AND MEDWAY PATHOLOGY NETWORK BOARD

1. **Constitution**

Kent and Medway Pathology Network Board has delegated authority from its partner organisations to develop and deliver the pathology network services as set out in the network collaboration agreement.

The network board aims to reach consensus on key decisions of KMPN direction and strategy, seeking to resolve in good faith any disagreements in line with the principles and values described in the network collaboration agreement and, where this fails, to work within the dispute resolution framework to resolve any issues which cannot otherwise be settled.

With respect to representatives on the Kent and Medway Pathology Network Board, it is recognised and agreed that only the Parties to this Agreement shall have voting rights and be able to ratify/veto decisions of the Board. Any non-provider representatives on the Board are non-voting members and are not able to ratify or veto Board decisions.

2. **Scope**

To provide leadership oversight of Kent & Medway Pathology Network direction, strategy and operations.

3. **Aims, Functions and Objectives**

The role of the network board is:-

- Holding the Pathology Network Clinical Director and their leadership team to account for development and delivery of pathology services including risk and issue management.
- Ensuring the vision for the pathology network and the goal, strategic objectives and key requirements are met in the development of the pathology network.
- Approval of business cases for recommendation to the partner organisations.
- The Kent and Medways Pathology Network Board will produce an annual report documenting achievements, key recommendations and plans for the year ahead. The report shall evaluate the financial benefit to all Parties and make a comparative assessment of quality data, including detail on how improvement will be supported.
- The annual report will be submitted to the Trust Board of each Party for review and information.
- An annual meeting will be held to share progress and future plans with pathology teams and other stakeholders across all Parties and associated organisations

- Engage and consult with key stakeholders, including patients, pathology staff, pathology service users, ICBs and NHSE .to ensure network delivery meets their needs.

4. **Membership**

Position	Role on the Network Board
Chair (Senior Responsible Officer)	• Ultimately responsible for the programme of network development and delivery • Ensures network is focused on achieving its objectives and forecast benefits. • Engages with acute Trust CEOs and ICB executive to ensure their collective views are represented. • Holds the KMPN Clinical Director to account to deliver their objectives. • Holds network board members to account for their role as outlined below. • Chairs network board meetings ensuring members are enabled to fulfil their role and that ways of working are supported.
Acute Trust Executive SROs	• Represent their Trust executive colleagues on the network board and make decisions/recommendations on their behalf • Engage with executive and other senior colleagues to ensure socialisation of draft business plans and business cases and feedback to the network board in advance of the formal approvals process • Present applicable documents to Trust Boards and pre-board committees for approval
Acute Trust clinical representatives	• Represent their Trust clinical colleagues on the Network board and make recommendations on their behalf • Engage with clinical colleagues to ensure network plans are in line with Trust needs and that Trust needs are met by the pathology network
Primary Care Clinical Representative	• Represent their primary clinical colleagues on the Programme Board and make recommendations on their behalf • Engage with primary care clinical colleagues to ensure network plans are in line with primary care needs and that primary care needs are met by the pathology network
ICB Representative	• Represent and engage with ICB executive colleagues • Ensure network direction and strategic objectives are aligned with the strategic objectives of the ICB.

Position	Role on the Network Board
	• Review business plans and business cases as part of the governance and approval processes
Pathology Network Clinical Director	• Accountable to the SRO and network board for delivery of the network transformation projects and services. • Holds the managing director and senior network leadership team to account for delivery of their objectives. • Ensures network development and delivery aligns with the requirements of the NHSE maturity matrix. • Ensures that the network is well managed and delivers value for money. • Ensures agenda and papers support the achievement of network objectives and are developed through steering group/s and network leadership team as appropriate. • Ensures network direction and strategic objectives meet patient safety and quality requirements • Represents discipline clinical leads • Ensures engagement of network board members and Clinical Advisory Group members outside of meetings in order to make the best use of meeting time. • Engages with other pathology network clinical directors and NHSE diagnostics leads
Network Managing Director	• Leads on the day to day delivery of network projects and the transition to full operational management single service. • Facilitates the flow of information to and from the network Board and network senior leadership team. • Escalates risks and issues as required to the network Clinical Director and the network board. • Ensures the network is appropriately resourced • Provides support to and deputises for the network Clinical Director
Pathology network senior leaders	• Represents pathology services from an operational leadership perspective. • Ensures documents for approval meet operational requirements • Engages with operational colleagues in other disciplines across the network • Reports regularly and by exception on operational activity, risks and issues

Position	Role on the Network Board
Pathology Network (interim) Finance Director	• Reporting financial risks and concerns to the network Board. • Link to ICB strategic and capital planning leads. • Supports the network Board in setting and monitoring annual and multi-year budgets. • Supporting the financial aspects of business plans and business case. • Supports the realisation of cash-releasing benefits.
Pathology Network (interim) Workforce, education & network development Director	• Reporting workforce risks and concerns to the network Board. • Supports the network Board in ways of working and board development. • Supporting the workforce, education and network development aspects of business plans and business cases. • Supports the realisation of non-cash-releasing and qualitative benefits.
Pathology Network (interim) Digital director	• Reporting risks and concerns relating to digital transformation to the network Board. • Supporting the digital aspects of business plans and business cases. • Supports the realisation of benefits associated with digital transformation.
Pathology Network (interim) procurement director	• Reporting procurement risks and concerns to the network Board. • Supports the network Board in ways of working and board development. • Supporting the procurement aspects of business plans and business cases. • Supports the realisation of benefits associated with procurement.
NHSE South of England Diagnostics lead	• Feeds in learning from other networks and guidance from regional and national NHSE • Critical friend ensuring documents meet NHSE requirements
Non-executive director	• Supports the chair in holding the network board to account • Brings own expertise and experience to the network board • Engages with relevant stakeholders to ensure their collective views are represented.

Position	Role on the Network Board
	• Deputises for the Chair at network board meetings, ensuring members are enabled to fulfil their role and that ways of working are supported.

Additional attendees for specific agenda items and leads of individual workstreams may also be invited but do not have decision making power.

5. **Quoracy**

The network Board will be quorate with the chair, and an executive lead, clinical representative or nominated deputy from each trust and ICB; and the network clinical director or managing director.

Members are asked to nominate a regular deputy and to ensure they can attend in their absence and are suitably prepared for the meeting.

Where a network board meeting is not quorate, any decision or recommendation to trust boards will be unable to be agreed and will be carried forward to the next meeting. Where carrying forward to the next meeting would impact on the critical path of a project or network delivery, SRO approval will be sought by email/telephone by the network clinical director or managing director.

6. **Frequency of meetings**

Meetings will be held monthly for 2 hours.

7. **Reporting**

The network Board will report into the ICB committee as directed by the ICB. Trust SROs are expected to keep their Trust board updated regularly and by exception.

8. **Admin Support**

Admin support for Programme Board meetings will be provided from the network team.

9. **Ways of Working**

Ways of Working in Meetings and in the workplace

- Respect for each board member; as it is one team delivering the network.
- If unable to attend a meeting, then advise the meeting co-ordinator in advance
- Be appreciative – focus on what's going well first.
- Honesty and transparency (NB exception for commercially sensitive information)
- Giving timely feedback, both positive and constructive, to individuals
- Asking for advice and help when you need it
- Open to all ideas, critique and challenge
- Escalate issues to project team rather than outside the programme governance
- Everything is a learning opportunity
- Involve teams at all stages

- Respect work/life balance
- Call rather than email more
- Value our diversity

10. **Meetings governance**

- Terms of reference agreed by members within first two months of meetings being held
- Agree meeting dates well in advance and avoid changing them
- Meetings should start at the planned time; it respects members who have arrived in a timely manner.
- Papers are sent out at least 3 working days in advance of the meeting
- Larger documents such as business cases should be sent out with a minimum of 5 days in advance
- Meeting notes are issued, within 3 working days after the meeting is held
- Respect for each team member and not interrupting the contributor
- Time to reflect on
- Summarise actions and agree escalation to project team and stakeholder communications - what is shared and how

TERMS OF REFERENCE

KENT AND MEDWAY PATHOLOGY NETWORK EXECUTIVE TEAM

1. **Constitution**

Kent and Medway Pathology Executive Team has delegated responsibility from the Kent and Medway Pathology Network Board to plan, develop, deliver and report on the pathology network projects as set out in the network collaboration agreement towards a maturing network by March 2025.

2. **Scope**

The Kent and Medway Pathology Executive Team will lead and manage the delivery of network programme and projects within an overall framework of the NHSE maturity matrix. It will provide a forum for structured discussions on the local and national issues facing the Pathology Network. It aims to support each of the Trusts covered in the collaboration agreement in meeting their objectives by discussing and agreeing the implementation of service improvements across the network and by ensuring the network services are clinically, operationally and financially effective and meets the needs of its users.

3. **Aims, Functions and Objectives**

3.1 To manage the delivery and monitoring of the NHSE maturity action plan towards a maturing network by March 2025.

3.2 To hold project steering groups to account for the delivery of project milestones, supporting across the programme where required.

3.3 To receive and discuss current data on activity, quality, performance and workforce.

3.4 To develop a strategy for future service provision aimed at meeting the needs of service users in an efficient and cost effective manner.

3.5 To receive communications from both within and outside the Trusts in order to inform members of developments both locally and nationally.

3.6 To discuss the financial position of Pathology in each Trust and across the network, highlight any areas of budget pressure, and discuss remedial action.

3.7 To keep an up to date risk and issue log to include those which may impact on service provision as well as on network project delivery.

3.8 To develop and discuss management of implementation of any agreed changes at an operational level.

3.9 To review research and development opportunities.

3.10 To discuss the strategic position of the Trusts and ICS and how this will impact on Pathology.

3.11 To ensure effective communications and engagement with internal and external stakeholders

3.12 To ensure network values and behaviours underpin all network activities

3.13 To receive minutes from steering groups and the clinical advisory committee

4. **Membership**

Position	Role on the Pathology Executive Team
Chair (Network Clinical Director)	• Ensures network development and delivery aligns with the requirements of the NHSE maturity matrix. • Ensures that the network is well managed and delivers value for money. • Ensures network direction and strategic objectives meet patient safety and quality requirements • Engages with transitional speciality leads to ensure their views are represented. • Holds the Managing Director to account to deliver their objectives. • Holds executive team members to account for their role as outlined below. • Chairs executive team meetings ensuring members are enabled to fulfil their role and that ways of working are supported.
Network Managing Director	• Leads on the day to day delivery of network services. • Facilitates the flow of information to and from the Pathology Executive Team, steering groups and CAC. • Escalates risks and issues as required • Ensures agenda and papers support the achievement of network objectives and are developed through steering group/s and CAC as appropriate. • Ensures the network is appropriately resourced • Provides support to and deputises for the network Clinical Director
Pathology Network (interim) Finance Director	• Reporting financial risks and concerns to the Executive Team. • Link to ICB strategic and capital planning leads. • Supports the Executive Team in setting and monitoring annual and multi-year budgets. • Supporting the financial aspects of business plans and business case. • Supports the realisation of cash-releasing benefits.
Pathology Network (interim) Workforce, education & network development Director	• Reporting workforce risks and concerns to the Executive Team • Supports the Executive Team in ways of working and team development.

Position	Role on the Pathology Executive Team
	• Supports the chair of the workforce, education and network development steering group to deliver the workforce strategy • Supports the workforce, education and network development aspects of business plans and business cases. • Supports the realisation of non-cash-releasing and qualitative benefits. • Provides people management expertise in matters relating to network development, resourcing, career development and talent management
Pathology Network (interim) Digital director	• Reporting risks and concerns relating to digital transformation to the executive team. • Supporting the digital aspects of business plans and business cases. • Supports the chair of the digital steering group to deliver agreed pathology digital projects • Supports the realisation of benefits associated with digital transformation.
Pathology Network (interim) procurement director	• Reporting procurement risks and concerns to the executive team. • Supporting the procurement aspects of business plans and business cases. • Supports the realisation of benefits associated with procurement.
Pathology Services senior leaders	• Leads on agreed network projects within their identified and protected network time • Represents pathology services within their Trust/s from an operational perspective • Engages with operational colleagues in own Trust/s and across the ICP system • Represents all pathology disciplines in their service. • Ensures documents for approval meet operational requirements
Pathology Clinical Directors	• Represents their pathology service on the Programme Board from a clinical leadership perspective. • Ensures documents for approval meet patient safety and quality requirements • Engages with clinical colleagues in own Trust/s and across the ICP system • Represents all pathology disciplines in their service.

Position	Role on the Pathology Executive Team
Project Directors (LIMS and MES)	• Responsible for day to day project delivery • Reporting risks and concerns to the Executive Team • Reports on business case development and presents for approval • Supports steering group chair for ensuring delivery of aspects of project delivery
Steering group chairs (may also hold another role as above)	• Accountable for project delivery • Holds steering group members to account for aspects of project delivery
Programme support manager	• Ensures meetings are scheduled and papers are presented professionally and timely • Ensures appropriate minute taking and minutes reviewed by chair before circulating

Additional attendees for specific agenda items and leads of individual workstreams may also be invited but do not have decision making power.

5. **Quoracy**

The Pathology Executive Team will be quorate with the chair, a clinical director or pathology service senior leader or nominated deputy from each trust; and one other network director.

Members are asked to nominate a regular deputy and to ensure they can attend in their absence and are suitably prepared for the meeting.

Where a executive team meeting is not quorate, any decision or recommendation to the network board will be unable to be agreed and will be carried forward to the next meeting. Where carrying forward to the next meeting would impact on the critical path of a project or network delivery, member approval will be sought by email/telephone by the network clinical director or managing director.

6. **Frequency of meetings**

Meetings will be held monthly for 2 hours.

7. **Reporting**

The Pathology Executive Team will report into the Pathology Network Board.

8. **Admin Support**

Admin support for executive team meetings will be provided from the network team.

9. **Ways of Working**

Ways of Working in Meetings and in the workplace

- Respect for each board member; as it is one team delivering the network.
- If unable to attend a meeting, then advise the meeting co-ordinator in advance

- Be appreciative – focus on what's going well first.
- Honesty and transparency (NB exception for commercially sensitive information)
- Giving timely feedback, both positive and constructive, to individuals
- Asking for advice and help when you need it
- Open to all ideas, critique and challenge
- Escalate issues to project team rather than outside the programme governance
- Everything is a learning opportunity
- Involve teams at all stages
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- Respect for each team member and not interrupting the contributor
- Time to reflect on
- Summarise actions and agree escalation to project team and stakeholder communications - what is shared and how

B Job Descriptions for the Network Clinical Director and the Network Managing Director

JOB TITLE: Kent and Medway Pathology Network Clinical Director

BAND: Consultant plus Responsibility Allowance or Band 9 for clinical scientist

CARE GROUP: Kent and Medway Pathology Network (KMPN) hosted by Finance

DEPARTMENT: Kent and Medway Pathology Network

HOURS OF WORK: 0.6wte/6 PA

RESPONSIBLE TO: KMPN Board SRO

ACCOUNTABLE TO: KMPN Board SRO/Professionally accountable to employing Trust Chief Medical Officer

BASE: Clinical base with visits to other K&M hospital sites

Please note: The network Clinical Director role will be appointed for a period of 3 years subject to satisfactory performance and will be given a separate Contract of Employment in respect of the Clinical Director duties. The job description will be reviewed on an annual basis in line with the progression of the network. Subject to mutual agreement this Contract may be extended for a further period up to a maximum of six years.

Additional clinical PAs will be available for external candidates at one of more of the network sites.

JOB PURPOSE:

The post holder will be responsible for providing high-level strategic and clinical leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Clinical Director will be accountable to the Network Board SRO and clinically accountable to the Chief Medical Officer at their employing Trust.

KEY RESULT AREAS:

- The Clinical Director will be responsible for providing the necessary strategic direction, leadership and vision, to enable KMPN to meet its vision and objectives towards a maturing network by 2025 and will have a key role in the provision and development of services.
- The Clinical Director will be accountable to the Network Board for the clinical, scientific, operational and financial performance of KMPN, delegating aspects of these functions as appropriate.
- The Clinical Director will be supported by and work in close partnership with a Managing Director, accountable to the Clinical Director.
- The Clinical Director will be professionally accountable to the employing Trust CMO, who will provide support, where appropriate, to ensure that the Clinical Director delivers his/her responsibilities with regard to Clinical Governance.
- The Clinical Director will be responsible for ensuring that systems and processes are in place to effectively manage the Clinical Governance and Patient Safety within the Network.
- The Clinical Director ensures ensuring that systems and processes are in place to effectively manage network values and behaviours underpinning the strategic and operational development of the network including effective staff engagement and involvement of the KMPN Pathology workforce.

RESPONSIBILITY:

- Provide strategic direction for the development of service strategy, to enable the delivery of services within the network.
- Chair the Network Executive leadership team and Clinical Advisory Committee, making decisions according to delegated authority and recommending a course of action to the KMPN Board.
- Oversee the implementation of a comprehensive programme of quality improvement activity and patient safety by ensuring PQAD implementation and monitoring, a Clinical Audit programme in place, and that practice is based on evidence.
- Promote a culture of inquiry and research in the network,
- Ensure that risk is properly managed within the Network, ensuring a positive culture of learning from success and that serious incidents (SIs), adverse events and complaints are properly and comprehensively responded to in line with the Patient Safety Incident Reporting Framework.
- Ensure that clinical standards, GIRFT and NICE recommendations are implemented as appropriate by the Services
- Lead the development and implementation of Key Assurance Indicators
- In line with the network maturity matrix action plan, develop an agreed Business Plan which reflects quality and efficiency targets. agreed with the requesting services according to local pathways.
- Ensure the proper allocation and utilisation of resources necessary to meet the objectives and targets contained in the collaboration agreement once implemented, in relation to quality, volume and cost.
- Ensure equality of access to pathology services and maintain safety across Kent and Medway working with Trust medical directors.
- In collaboration with the Trust clinical directors, ensure that all Medical and Clinical Scientist staff within KMPN Pathology operate within clear lines of responsibility and accountability.
- Once appointed, agree with each transitional discipline lead within the Network, the arrangement of their network role within their annual job plans.
- Assurance that all staff have an annual appraisal in accordance with Trust policy and meets revalidation and professional registration requirements.
- Ensure that there is appropriate provision for Continuing Professional Development for all staff in the Network.
- Ensure that all targets set by external regulators are understood and met.
- Engage in succession planning, with particular reference to the identification and development of colleagues with an interest in clinical management.
- Develop and implement with the Trust clinical directors a transition from Trust clinical leadership to network clinical leadership ready for the next network phase.
- Agree with the network board annual objectives for KMPN and setting annual objectives for other staff as appropriate.
- To help define and implement a network way of working; support this and model its values and champion the evolution of the network

- Represent KMPN at relevant ICB forums and with external agencies.
- Ensure that a "Duty of Candour" is maintained with services users/carers at all time.
- Ensure services are able to be delivered safely and in accordance with the requirements of the Health and Social Care Act, including monitoring the quality and safety at each site of responsibility, identifying breaches, escalating them and acting on them as soon as possible.
- Be responsible for ensuring a regular process of review is in place to detect incidents that indicate adverse quality of care, and triangulate.
- The clinical director will act as the line manager for the network managing director and the transitional quality lead in the network part of their role
- The clinical director will operate a matrix management with dotted lines to and from the individual Trust pathology clinical directors and transitional discipline clinical leads and quality lead
- The programme management team (PMO) reports to the managing director and, as a team, support the clinical director through agreed delegated responsibilities.

The Clinical Director, Managing Director, pathology senior leaders and Finance Director for KMPN will agree an annual budget for the network PMO and projects with the network board and member organisations. They will be responsible for the effective and efficient use of that budget to deliver the agreed network projects.

ENVIRONMENT:

Working Conditions: Some working at home with some travel to other hospital laboratories and meeting venues.

Travel as required to meet the requirements of the role across Kent & Medway.

Physical Effort: Frequent screen and keyboard work with virtual meetings. Some driving to acute hospital sites.

Mental Effort: Significant concentration, problem-solving and project management.

Working under pressure to meet project key milestones - a flexible approach to work patterns is required.

Emotional Effort: Managing conflicting priorities and resistance to change. Manage multidisciplinary relationships across multiple organisations, regularly dealing with contentious issues.

JOB SUMMARY:

The post holder will be responsible for providing high-level strategic and clinical leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The Clinical Director will be accountable to the Network Board SRO and clinically accountable to the Chief Medical Officer at their employing Trust.

COMMUNICATIONS AND WORKING RELATIONSHIPS:

Internal	Pathology clinical directors and leads across Kent and Medway Clinical chiefs and leads across disciplines across Kent and Medway Pathology staff Pathology Network PMO and board members Staff within multiple project workstreams

Other NHS	ICB Primary Care NHSE Other pathology networks Other staff in network Trusts
External to NHS	RCPath IBMS Patients and public

- To maintain credibility with all key players within the network, fostering a culture of collaboration for the delivery of equitable, high quality care. At times this will include acting as an 'honest broker' reconciling conflicting views and interests.
- To foster and promote a culture of clinical engagement and influence ensuring the network is clinically led
- To support and help maintain the network structures that supports widespread multidisciplinary involvement including medical, clinical scientists, biomedical scientists, support staff and managers
- Enabling patient and public involvement
- To act as a champion for patients and their interests and support the appropriate involvement of the public and patients in the development of network programmes and decision-making
- Promoting equality and reducing inequalities
- Establish and maintain collaborative working relationships with all partners and commissioners.
- To effectively engage with other clinical networks where synergies exist around the achievement of outcome ambitions and integrated care pathways
- To engage and develop collaborations for quality improvement across the network, for the realisation of equitable access to quality care and the achievement of outcome ambitions for patients
- To work with other structures, including Academic Health Science Networks aligning innovation, education, informatics, and quality improvement
- To work with national level bodies ensuring alignment of policy and service transformation for patients
- Regularly meet with clinical and non-clinical staff to ensure they remain engaged in the vision for delivering excellence in all we do.
- Establish and maintain effective internal and external communication
- Articulate strategic, clinical and professional issues, including KMPN vision and strategy, to meet the needs of a diverse audience.

STANDARDS OF BUSINESS CONDUCT:

The post holder will be required to comply with the Trust's Standing Orders and Standing Financial Instructions and at all times, deal honestly with the Trust, with colleagues and all those who have dealings with the Trust including patients, relatives and suppliers.

HEALTH AND SAFETY:

The post holder will be required to observe local Health and Safety arrangements and take reasonable care of him/herself and persons that may be affected by his/her work.

SAFEGUARDING:

All staff have a duty to identify, report and record incidents of potential or actual abuse. This statement applies whether the victim is an adult or child. All queries will be addressed by the Trust Safeguarding Team.

PERFORMANCE REVIEW:

This job description will be used as a basis for individual performance review between the post holder and the Manager.

The job description covers only the key result areas, and as such does not intend to provide a comprehensive list of objectives. Specific objectives will be reviewed each April, and may develop to meet the changing needs of the service.

The post holder will need to take due account, in the way they achieve the key result areas of Trust policies and procedures.

The Trust aims to maintain the goodwill and confidence of its own staff service and users and the general public. To assist in achieving the objective it is essential that at all times, employees carry out their duties in a courteous and sympathetic manner.

The post holder will carry out their duties in accordance with the Trust Equal Opportunities Policy respecting the differing backgrounds of colleagues and clients.

CONTINUOUS IMPROVEMENT:

The Kent and Medway NHS and Social Care Partnership Trust has adopted a strategy for Continuous Improvement and all members of staff employed by the Trust are expected to play an active role in development and improving services to the benefit of patients.

THE TRUST'S MISSION STATEMENT:

To put patients first by providing community based, high quality and responsive healthcare services, delivered by well trained and supported staff who work with relatives, carers and other agencies in the best interests of patients.

STATEMENT OF THE TRUST'S AIMS AND VALUES:

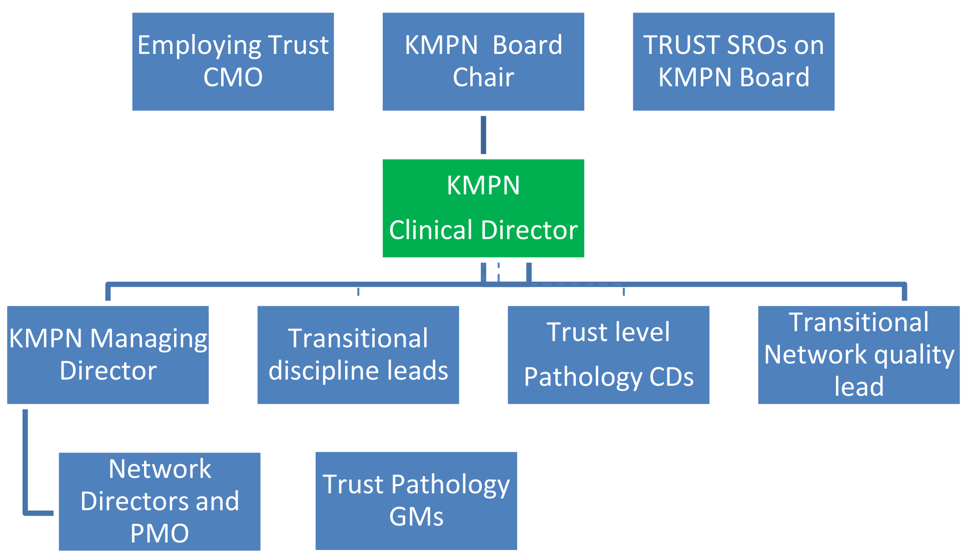
- To remain patient focused at all times by providing high quality and responsive healthcare services in hospitals and the community.
- To work closely with patients, their families, carer groups, local communities and other organisations ensuring care is co-ordinated.
- To respect and develop every member of staff by encouraging and supporting them in their personal and professional development and by valuing their input through recognition and individual reviews.

- To be innovative and proactive by encouraging staff to initiate new ideas in working practices and ensuring a process and continuous improvement in the way services are provided.
- To provide best practice and value-for-money by reviewing and evaluating services and sharing information internally and externally.

CONFIDENTIALITY:

The Kent and Medway NHS and Social Care Partnership Trust employees are required to ensure that information about patients is safeguarded to maintain confidentiality and is kept securely in accordance with NHS requirements of 1999. (The Caldicott Committee's Report on the review of patient-identifiable information 1997, & HSC/1999/012). This means that patient information can only be passed to someone else if it contributes to the provision of care or the effective management of health care services within the Trust.

ORGANISATION CHART:



Person Specification

Knowledge, Skills, Training and Experience

	Essential	**Desirable**
Training, Qualifications and Registration	▪ FRCPath ▪ Employed at consultant level ▪ Experience of Senior Management ▪ Evidence of continuous professional and leadership development ▪ GMC or HCPC registered	• Leadership qualification
Experience	▪ Clinical leadership roles in Pathology ▪ Credible to medical and other clinical and scientific colleagues	▪ Experience as clinical director or clinical lead

	Essential	Desirable
	▪ Experience of partnership working and amalgamating services across hospitals ▪ Experience working in acute hospital settings within Pathology services. ▪ Experience of leading complex change	
Knowledge and Skills	▪ Excellent leadership skills and the ability to build and motivate high performing teams ▪ Highly developed interpersonal skills, negotiation, conflict management, feedback, partnership working, and coaching skills ▪ Expert understanding of specialist healthcare science activities and management knowledge acquired through higher specialist training ▪ Strategic system-level thinker and ability to implement and embed system-level strategy successfully ▪ Implementation of different options on the effectiveness of the network as a whole ▪ Sensitive to clinical and political demands. ▪ Able to analyse and interpret highly complex information in a variety of formats ▪ Able to analyse situations and facilitate creative solutions using a collaborative team approach ▪ Knowledge of evidence-based policy making and NHS governance ▪ A good understanding of how to use data and financial incentives to improve quality and productivity ▪ To have a good understanding of integrated models of care across primary, secondary, tertiary and community care and appreciation of NHS contracting processes ▪ The ability to build excellent collaborative networks ▪ The ability to deal with ambiguity and complexity ▪ Able to assimilate complex and lengthy information and make decisions in an ambiguous and fast-moving environment ▪ Ability to communicate with stakeholders and the media, and convey complex messages to different recipient groups.	• Commercially focused within a healthcare setting • Proven ability in basic or translational clinical research

	Essential	Desirable
	▪ Able to develop effective and mutually supportive relationships with key partners within and without organisations ▪ Strong intellectual, strategic, and systemic thinking skills, with the ability to think creatively and laterally to achieve outcomes ▪ Able to make decisions confidently and consistently	

JOB DESCRIPTION

JOB TITLE: Managing Director

BAND: Agenda for Change Band 9

ACCOUNTABLE TO: KMPN Clinical Director

RESPONSIBLE TO: KMPN Clinical Director

TEAM NAME: Kent and Medway Pathology Network (KMPN)

BASE: Magnitude House as official base but work from Kent House and home with visits to other K&M hospital sites

CARE GROUP: KMPN hosted by Finance

SETTING (Inpatient, Community, etc.): Hospital laboratories

HOURS: 37.5h/week

The KMPN Managing Director is a new role developed to support the clinical director in leading through transformation to a maturing network and beyond.

KMPN is made up of seven laboratories across three pathology services in four acute Trusts – East Kent Hospitals University NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust and North Kent Pathology Services (hosted by Dartford and Gravesham NHS Trust and providing services to Medway Foundation Trust). The network provides services to a population of nearly 2 million in the Kent and Medway CCG/ICS area and into East Sussex, including direct access to all GP practices. There are nearly 800 staff working in pathology in Kent and Medway and the total pathology budget across all the services is over £50m.

Pathology services are currently structured as follows:

- Darent Valley Hospital at Dartford provided by Dartford and Gravesend NHS Trust operates a hub site for hot and cold work under North Kent Pathology Service (NKPS).
- Medway Maritime Hospital at Gillingham provided by NKPS operates as an Essential Service Laboratory (ESL) as well as Andrology and Foetal Medicine Unit screening.
- Queen Elizabeth Queen Mother Hospital at Margate provided by East Kent Hospitals University NHS Foundation Trust (EKHUFT) operates a traditional ESL with some blood film work.
- Kent and Canterbury Hospital at Canterbury provided by EKHUFT operates an ESL with some specialised testing and haemophilia, haemostasis and thrombosis services.

- William Harvey Hospital at Ashford provided by EKHUFT provides hot and cold pathology services including full pathology support to the Kent Cancer Centre. East Kent also conducts the majority of immunology work for the region.
- Maidstone Hospital provided by Maidstone and Tunbridge Wells NHS Trust (MTW) operates a full hot and cold laboratory with Blood Sciences, Microbiology and Cellular Pathology. In addition, Cellular Pathology provides the Histology and Cytology services for MFT and DGT. The regional Kent Cancer Centre is located and serviced by Pathology here.
- Pembury Hospital at Tunbridge Wells provided by MTW operates an ESL with average activity in excess of that at Maidstone hospital.

JOB PURPOSE:

The post holder will be responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The job description will be reviewed for the next phase of the network journey. The Managing Director will be accountable to the Network Clinical Director.

KEY RESULT AREAS:

- The Managing Director will be responsible for providing the necessary strategic direction, leadership and vision, to enable KMPN to meet its vision and objectives towards a maturing network by 2025 and will have a key role in the provision and development of services.
- The Managing Director will be accountable to the Clinical Director for the operational and financial performance of KMPN.
- The Managing Director will be supported by and work in close partnership with network directors, project directors and Trust pathology general managers.
- The Managing Director will be responsible for delivery of operational performance and within the Network.
- The Managing Director ensures that network values and behaviours underpin the strategic and operational development of the network including effective staff engagement and involvement of the KMPN Pathology workforce.

Leadership Responsibility

- Provide strategic and operational leadership for the development of network strategy, to enable the delivery of services within the network.
- Responsible for delivery of the NHSE maturity matrix action plan towards a maturing network by March 2025.
- Lead the development and implementation of Key Performance Indicators
- Develop and deliver the single LIMS and procurement of the single set of MSC contracts.
- Ensure appropriate agreements, systems and processes are in place to enable the
- implementation of the network plans in the partner organisations following the terms of the collaboration agreement;
- Avoid the destabilisation of business as usual operations, including activity, quality, safety and accreditation;
- Oversight of the work with the steering group chairs, project leads and programme team and to ensure the network plans are integrated with the overall strategy; ensuring synergy between strategy milestones and objectives;

- In line with the network maturity matrix action plan, develop an agreed Business Plan which reflects quality and efficiency targets. agreed with the requesting services according to local pathways
- Act as the budget holder for the programme and delegated project and service budgets, ensuring the proper allocation and utilisation of resources necessary to meet objectives and targets, in relation to quality, volume and cost.
- Ensure equality of access to pathology services and maintain performance across Kent and Medway working with Trust pathology teams.
- Ensure that all targets set by external regulators are understood and met.
- Engage in succession planning, with particular reference to the identification and development of colleagues with an interest in leadership and management.
- Develop and implement with the Trust general managers a transition from Trust leadership to network leadership ready for the next network phase.
- Translate KMPN annual objectives into team and individual objectives.
- Lead the planning and design of the projects to meet the vision and strategic direction;
- Manage the activities necessary to ensure delivery of a transformational strategy;
- Responsibility for the overall planning of the strategy and for providing vision and strategic direction to the team;
- To help define and implement a network way of working; support this and model its values and champion the evolution of the network.
- Coaching and supporting the network team and steering group chairs.
- Represent KMPN at relevant ICB forums and with external agencies.

Management Responsibility

- The managing director will act as the line manager for the network directors and project directors and is the day to day lead for the PMO
- The Trust pathology general managers will report to the managing director for their network role as agreed by Trust boards
- Managing, monitoring and reporting on benefits realisation management, tracking the progress and ensuring that the intended benefits are achieved with outcomes maximised;
- Provide and receive highly complex, sensitive and contentious information, including presenting information about projects and dependencies to a wide range of internal and external stakeholders in formal settings.
- Defining and implementing business processes that support the functions of the network;
- Define and manage the governance processes of the network;
- Proposes changes to and making recommendations for the programme and projects as appropriate;
- Contribute to the review and development of existing programme and project information management systems and contribute to the development of an integrated approach to project management;
- Lead the implementation of the programme and projects outputs to achieve the desired benefits;
- Motivate, challenge and inspire staff throughout the network to role model leadership and network values
- Ensure plans are in place to develop the network support and wider project teams including

talent management and succession planning;

- Provide and receive highly complex, sensitive and contentious information, including presenting information about the programme and dependencies involving a wide range of stakeholders in formal settings: therefore, the post holder must have the ability to deal with resulting potentially challenging situations;
- Ensure the learning from research and development activities is effectively shared across the network.

Financial Responsibilities

- The Clinical Director, Managing Director, General Managers and Finance Director for KMPN will agree an annual budget for the network PMO and projects with the network board and member organisations. They will be responsible for the effective and efficient use of that budget to deliver the agreed network projects.
- Responsibility for providing guidance and management on the procurement of identified products, equipment, services and facilities for the network, to execute required services – from defining requirements, developing specification, developing bid evaluation methodology,
- Act in a way that is compliant with Standing Orders and Standing Financial Instructions of the relevant organisations in the discharge of budget management responsibilities;
- Constantly strive for value for money and greater efficiency in the use of these budgets and to ensure that they operate in recurrent financial balance year on year.

ENVIRONMENT:

- Working Conditions: Some working at home with some travel to other hospital laboratories and meeting venues.
- Travel as required to meet the requirements of the role across Kent & Medway.
- Physical Effort: Frequent screen and keyboard work with virtual meetings. Some driving to acute hospital sites.
- Mental Effort: Significant concentration, problem-solving and project management.
- Working under pressure to meet project key milestones - a flexible approach to work patterns is required.
- Emotional Effort: Managing conflicting priorities and resistance to change. Manage multidisciplinary relationships across multiple organisations, regularly dealing with contentious issues.

JOB SUMMARY:

The post holder will be responsible for providing strategic and operational leadership to ensure that KMPN provides high quality patient care and achieves its transformation objectives towards a maturing network by March 2025. The job description will be reviewed for the next phase of the network journey. The Managing Director will be accountable to the Network Clinical Director.

COMMUNICATIONS AND WORKING RELATIONSHIPS:

Internal	• Pathology leads across Kent and Medway • Service leads across disciplines across Kent and Medway • Leadership teams in partner organisations • Pathology staff • Pathology Network PMO and board members • Staff within multiple project workstreams
Other NHS	• ICB • Primary Care • NHSE • Other pathology networks
External to NHS	• RCPath • IBMS • Suppliers • Patients and public

- Operate effectively in a flexible and demanding environment and proactively engage with stakeholders.
- Communicate, proactively, build good working relationships and provide information and advice to a wide range of internal and external stakeholders on a range of business sensitive issues.
- Lead as an expert; integrating systems and managing effective working relationships with the appropriate stakeholders.
- Drive and challenge each key working relationship to innovate and drive reform to achieve agreed objectives.
- Provide and receive highly complex, sensitive and contentious information, including
- presenting information about projects and dependencies to a wide range of internal and
- external stakeholders in formal settings.
- Manage potentially aggressive and/or antagonistic situations with staff and stakeholders
- within change programmes for successful outcomes.
- Deal with complex and conflicting subject matter problems or in day today work load in workshops, meetings, one to one communications and other events, comprising various parts of the business.
- Nurtures key relationships with senior and high-profile individuals and responsible for the maintenance of networks.
- Employ effective communication, negotiation and influencing skills to enable stakeholder relationships to deliver objectives
- Internal leaders and staff to gain input to the development of systems, processes and

- activities.
- Represent the network in sensitive and political situations, delivering difficult messages where required to high-level audiences.

STANDARDS OF BUSINESS CONDUCT:

The post holder will be required to comply with the Trust's Standing Orders and Standing Financial Instructions and at all times, deal honestly with the Trust, with colleagues and all those who have dealings with the Trust including patients, relatives and suppliers.

HEALTH AND SAFETY:

The post holder will be required to observe local Health and Safety arrangements and take reasonable care of him/herself and persons that may be affected by his/her work.

SAFEGUARDING:

All staff have a duty to identify, report and record incidents of potential or actual abuse. This statement applies whether the victim is an adult or child. All queries will be addressed by the Trust Safeguarding Team.

PERFORMANCE REVIEW:

- This job description will be used as a basis for individual performance review between the post holder and the Manager.
- The job description covers only the key result areas, and as such does not intend to provide a comprehensive list of objectives. Specific objectives will be reviewed each April, and may develop to meet the changing needs of the service.
- The post holder will need to take due account, in the way they achieve the key result areas of Trust policies and procedures.
- The Trust aims to maintain the goodwill and confidence of its own staff service and users and the general public. To assist in achieving the objective it is essential that at all times, employees carry out their duties in a courteous and sympathetic manner.
- The post holder will carry out their duties in accordance with the Trust Equal Opportunities Policy respecting the differing backgrounds of colleagues and clients.

CONTINUOUS IMPROVEMENT:

The Kent and Medway NHS and Social Care Partnership Trust has adopted a strategy for Continuous Improvement and all members of staff employed by the Trust are expected to play an active role in development and improving services to the benefit of patients.

THE TRUST'S MISSION STATEMENT:

To put patients first by providing community based, high quality and responsive healthcare services, delivered by well trained and supported staff who work with relatives, carers and other agencies in the best interests of patients.

STATEMENT OF THE TRUST'S AIMS AND VALUES:

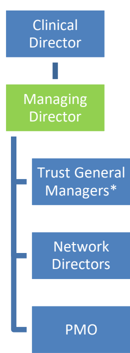
- To remain patient focused at all times by providing high quality and responsive healthcare services in hospitals and the community.
- To work closely with patients, their families, carer groups, local communities and other organisations ensuring care is co-ordinated.

- To respect and develop every member of staff by encouraging and supporting them in their personal and professional development and by valuing their input through recognition and individual reviews.
- To be innovative and proactive by encouraging staff to initiate new ideas in working practices and ensuring a process and continuous improvement in the way services are provided.
- To provide best practice and value-for-money by reviewing and evaluating services and sharing information internally and externally.

CONFIDENTIALITY:

The Kent and Medway NHS and Social Care Partnership Trust employees are required to ensure that information about patients is safeguarded to maintain confidentiality and is kept securely in accordance with NHS requirements of 1999. (The Caldicott Committee's Report on the review of patient-identifiable information 1997, & HSC/1999/012). This means that patient information can only be passed to someone else if it contributes to the provision of care or the effective management of health care services within the Trust.

ORGANISATION CHART:



*the GMs will report to the MD for the part of their role identified for network activities

PERSON SPECIFICATION

JOB TITLE: KMPN Managing Director

KNOWLEDGE, SKILLS TRAINING AND EXPERIENCE:

	Essential	**Desirable**
Training and Qualifications	▪ Educated to master's level in relevant ▪ subject or equivalent level of experience of working at a similar level in specialist area ▪ Post graduate management/leadership ▪ qualification or relevant experience ▪ Evidence of Continued Professional Development	▪ Masters level understanding of Pathology Scientific Disciplines

	Essential	Desirable
Experience	▪ Proven and significant leadership ▪ experience ▪ Significant management experience at senior level in the NHS ▪ Experience of leading transformational change in clinical services ▪ Proven experience of leading and ▪ delivering complex change and strategy development programmes in a politically sensitive and complex environment ▪ Experience of 'leading when you're not in charge' across multiple organisations ▪ Significant experience and understanding of programme and project management methodologies ▪ Extensive experience of delivering presentations to large groups of stakeholders in often pressured and politically sensitive environments ▪ Experience of managing and prioritising a large budget ▪ Experience of creating a new team and motivating and inspiring staff to work together to achieve a common objective	▪ Experience of leading transformational change in pathology services
Knowledge and Skills	▪ Dynamic personality and the ability to build trusted stakeholder relationships and wide support networks in a political context like the NHS in Kent and Medway ▪ Leadership, vision, strategic thinking and planning with highly developed political skills ▪ Ability to make decisions autonomously, when required, on ▪ difficult issues ▪ Ability to diffuse volatile, emotive or ▪ antagonistic situations ▪ Ability to resolve complex problems ▪ through win/win approach ▪ Openness and championing new ways of working including digital innovations ▪ Ability to strategically plan, ensuring ▪ continuity between Strategy and ▪ operational delivery plans	

	Essential	Desirable
	▪ Ability to identify, evaluate and support continuous development of services ▪ Demonstrated capability in matrix ▪ management and leadership ▪ Ability to analyse highly complex issues where material is conflicting and drawn from multiple sources ▪ Demonstrated capability to act upon ▪ incomplete information, using experience to make inferences and decision making ▪ Ability to analyse numerical and written data, assess options and draw appropriate conclusions ▪ Ability to provide informative reporting on finances and impact to Boards ▪ Demonstrated capability to plan over short, medium and long-term timeframes and adjust plans and resource requirements accordingly ▪ Ability to manage own workload and ▪ make informed decisions in the absence of required information, working to tight and often changing timescales ▪ Ability to delegate effectively ▪ Ability to work effectively between ▪ strategic and operational activities where required ▪ Working knowledge of Microsoft Office with intermediate keyboard skills ▪ Ability to promote equality of opportunity and good working relationships in employment and service delivery.	
Approach to Values	▪ Ability to maintain and communicate optimism in a challenging environment ▪ Team worker ▪ Self-motivated, able to work proactively ▪ Able to demonstrate drive and commitment ▪ Clear focus on improved efficiency and service improvement ▪ Ability to prioritise conflicting demands ▪ Personal resilience and confidence ▪ Effective motivator with strong influencing skills and personal credibility	

	Essential	**Desirable**
	▪ Focused on delivering objectives and improvements to patient services ▪ Demonstrable commitment to and focus on quality, promotes high standards to consistently improve patient outcomes ▪ Values diversity and difference, operates with integrity and openness ▪ Uses evidence to make improvements, seeks out innovation ▪ Actively develops themselves and others	
Other	▪ Ability to travel across Kent and Medway	

PART 3

RISK AND BENEFIT SHARE

Financial principles

ISSUE	Commencement	To be revised during 2023/2024
Start Budget	Included 'as -is' Direct cost. Initial budget set as per Trust budget setting methodology. In year from 23/24 to be managed as a total so any under/overspend contained within the total. i.e., Trusts to match outturn to budget each month and KMPN Board will provide a report to Trusts for inclusion in forecasts	Budgets to be set on the same assumptions. All direct costs to be included for services within Scope
CIPs	3% p.a. Programme savings net of any required investment to support delivery of CIP. i.e., not additional Evidence efficiency via benchmarking to be used to identify the level of efficiency required. E.g., use of Model hospital and GIRFT. Annual planning to provide assurance of relevant level of efficiency against benchmarking and level of self-funded transformation costs.	Clause to enable agreement of some additional CIP if financial position of Trusts requires more than uplift CIP
Inter Trust billing	No change	Current process is slow and causes aged debt therefore whole process to be overhauled and simplified.
Transfer of tests between Trusts	Costs to be at marginal rate	Need to restart the repatriation work as part of the TOM review. Agree process for test transfer
Repatriation of tests	Tests repatriated between members approved by all members. Financial impact to be equitable between all affected members.	Formal change control process for all test changes to be agreed.
Financial Transactions	Full disclosure by members at transaction level to KMPN for spend and WTE	Single Staff and skill mix changes procedure to be agreed
Planning	Setting the baseline budget to be within the system planning timeline	Have agreed process on planning in a timely fashion to enable decision making

Risk Share

The Parties agree the risk sharing profile set out in the table below subject to any agreed changes via the Change Control Procedure. With respect to the MES Contract, any savings will be recovered by the relevant Trust benefitting from such savings and the MES Contract shall be procured in accordance with the MES Procurement Strategy.

	MTW	EKHFT	NKPS
Network Costs	25%	25%	50%
LIMS	33%	34%	33%
MES	As incurred	As incurred	As incurred
Outturn	The Parties will finalise the risk sharing profile in respect of any surplus/deficit in the budget as part of the arrangements for the establishment of a single management structure and move towards a single service (as described in Recital (C) and (D) of this Agreement).		

PART 4

WORKFORCE AND ORGANISATION DEVELOPMENT

- Development of a Network staff bank to enable - Network staff to work across the Network sites & to support /enable development opportunities using K&M staff seamless Pass-Porting scheme
- Kent &Medway Network combined procurement process for apprenticeship & University recruitment
- Freedom to develop and agree standard job descriptions and job banding – irrespective of, however observing and working within sovereign organisations
- Combined recruitment events for established roles, independent employing organisations to alternate responsibility for hosting the events whilst autonomous organisations maintain constitutional employment rights
- Network process for combined bids for education funding
- Collaborative approach for the process of developing & training Clinical Scientists within the sovereign organisations across the Network
- Collaborative approach to HEE pathways for STP/HSST training &funding (as a precursor to joint accreditation)
- Open, transparent and inclusive approach to network development and design in partnership with staff and staff representatives

Workforce Schedule

1. Development opportunities through shadowing or working on other sites will be agreed through individual staff appraisal and personal development plans.

   Staff will be enabled through the K&M staff passporting scheme to work on other sites when mutually agreed as a development opportunity or part of a training programme.
   In an exceptional circumstance, e.g. pandemic, when business continuity, staff may be required to work on another site in accordance with the current emergency planning guidance.

2. Apprenticeships

   The network education leads group in conjunction with operational leads from each Trust develops an annual apprenticeship plan to meet workforce needs and presents to the workforce steering group for oversight. One of the partner Trusts tenders and manages apprenticeship contracts on behalf of the network. The apprenticeship levy offsets the cost of the apprenticeships at a sum agreed by each Trust and the network.

3. University students

   The network education leads group develops an annual student placement plan to meet workforce needs and presents to the workforce steering group for approval. The network education and training team including Trust education leads develop and maintain relationships with university leads and negotiate a number of placements each year based on the needs of the network. Students are recruited through a joint selection process including all disciplines on all sites with all university partners.

   All new network role design and recruitment to use standard job descriptions, tailored to individual service or discipline requirements. The standard job descriptions will incorporate key requirements of each employing organisation relevant to the pay band.

4. New network role job descriptions requiring job evaluation will be drafted by relevant managers with HRBP support and evaluated once by a panel comprising HR reps and staff side reps from within each employing Trust.

   Where similar jobs are currently banded differently between organisations, the HRBPs will review the job descriptions and submit a standard job description for job evaluation to a panel comprising HR reps and staff side reps from each employing Trust. For this iteration of the agreement, roles undergoing such harmonisation will be limited to pathology-specific roles e.g. laboratory assistant, pathology quality lead, to avoid impact on other professions outside of pathology.

   Funding of new or re-evaluated posts will depend on Trust affordability.

5. Combined recruitment events for roles where there are aligned Job Descriptions in scientific and administration posts, that are challenging to recruit into across the independent employing organisations.

   The Pathology Services across the Network would agree to alternate responsibility for hosting the events in collaboration with their recruitment team whilst autonomous organisations maintain constitutional employment rights.

   Candidates will be asked to express a preference for work base at the event and the post-recruitment process will include matching candidates to Trusts.

6. Network goals and plans will be fed into the Trust workforce plans to ensure that Trust workforce plans align with network direction and projects.

   Trust goals and plans will be fed into the network workforce plans to ensure that network workforce plans align with Trust direction

   Recruitment at band 8b and above leadership roles and B7 and above non-scientific roles e.g. quality, education, to be considered and validated by the workforce steering group.

7. Talent management process aligned to workforce plan and succession planning managed by the pathology leadership and facilitated by the Workforce Project Director and Practice Educator.

   Career development workshops for individuals and managers facilitated by the PMO and education leads.

   Interactive career development resources on NHS Futures and/or network website.

   The talent management process will link to Trust career development and talent management where career ambitions extend beyond pathology.

8. A single education and training plan for the network to support workforce plans.

   The education and training plan is costed by the PMO and submitted to the ICB People and OD team/HEE for annual funding round and any ad-hoc in year funding.

   The education and training plan is updated mid-year.

   Internal Trust budgets for education and training are devolved to the network on a per capita basis.

9. The network values include principles of an open, transparent and inclusive approach. The network PMO is responsible for a robust communications strategy.

   Communications are two-way between the network leadership and network staff.

   All pathology staff are briefed on network developments via monthly bulletins and lab visits.

A network website and social media accounts are kept updated on a weekly basis.

Questions and ideas from pathology staff are logged and used to develop a frequently asked questions page.

Pathology staff are encouraged and enabled by their managers to take part and be involved in network developments including focus and working groups, act as change champions, education and training events and conferences.

A joint management and staff partnership group will meet quarterly or as required to consider proposed network developments and any impact on staff, in liaison with pathology staff and Trust HRBPs.

PART 5

TRANSFORMATION PROGRAMME

PROJECT	Milestone	v0.2 of the Procurement Strategy Document
Service Change business case		
	FBC complete	30/09/2027
MES (MSC) business case		
	Select MES Primary Provider (PP)	24/05/2023
	MES procurement against the specs	30/04/2024
	MES specifications x8 (run by PP)	27/06/2024
	FBC complete - pre check and challenge	01/09/2024
	Contract award (all contracts)	01/04/2025
Governance		
	MES (MSC) FBC approved by Programme Board	01/10/2024
	MSC FBC approved by Trust Boards	01/11/2024
	MSC FBC approved by NHSEI	01/03/2025
	SC FBC approved by Programme Board	15/09/2027
	SC FBC approved by Trust Boards	31/12/2027
Implementation		
	Go live site 1 LIMS	20/08/2024
	Go live sites 2 LIMS	13/11/2024
	Go live sites 3 LIMS	06/01/2025
	LIMS Project Closed	31/05/2025
	Commence MES (MSC) – MTW	12/09/2024
	Complete MES (MSC) MTW	15/12/2025
	Commence MES (MSC) – EKHUFT	16/12/2025
	Complete MES (MSC) EKHUFT	23/03/2027
	Commence MES (MSC) – NKPS	24/03/2027

PROJECT	Milestone	v0.2 of the Procurement Strategy Document
	Complete MES (MSC) NKPS	17/03/2028
	Commence service change	01/04/2028
	Commence transfer to new GP order comms	TBC
	Complete transfer to new GP Order Comms	TBC
	Commence transfer to new Community Order Comms	TBC
	Complete transfer to new Community Order Comms	TBC
	Programme Closed	30/10/2034

SCHEDULE 3

Network Costs

1. **Network Costs**

1.1 KMPN management posts

1.2 Education and work force post non recurring each Contract Year

1.3 Management Posts

POST	BAND	WTE	£'000
Managing Director	9	1.00	141
Clinical Director		0.60	84
Workforce and OD lead	8D	0.80	94
Finance Lead	8D	0.50	59
IT Lead	8D	1.00	102
Programme support	5	1.00	34
Procurement lead	8A	1.00	61
Non-pay			10
			583
Practice Educator	8B		36
Total			619

NB the functions of a number of these posts are covered by PMO staff. As the network develops from a 'developing' network to a 'mature' network, formal appointment will be made to these posts.

2. **Project costs**

	23/24	24/25
	£'000	**£'000**
MES - Project		
MES – project Director	94	94
MES legal fees	68	
MES - Estates lead	53	
MES - PM implementation	0	99
Contingency	10	10
	882	821
LIMS implementation costs	3,044	2,119
LIMS Contingency	73	61
Workforce strategy - HRBPs	16	0

	23/24	24/25
	£'000	£'000
Workforce strategy – Practice Educators	86	0

3. **Funding sources**

	21/22	22/23	23/24	24/25
	£'000	£'000	£'000	£'000
Funding source				
Roll over funding from Acute Trusts	289	695	695	695
Send away saving	57.5	115	115	115
MES extension savings	596	596	596	596
CCG/ICB contribution	569	1,229	1,642	1,150
MES savings		0	0	94
NHSEI non recurrent contribution		235	235	0
	1,512	**2,870**	**3,283**	**2,650**

The ICB approved the LIMS FBC in which it to invest in the Network for four years to deliver the projects.

NHSE has agreed to contribute to Network costs for two years.

4. **Summary hosted Network/PMO costs**

	23/24	24/25
FUNDING	£'000	£'000
STP Base funding	695	695
Send away saving	115	115
MES extension savings	596	596
MES single contract savings	-	94
ICB contribution	1,642	1,150
ICB rephasing	818	351
NHSEI non recurrent contribution	235	-
	4,101	**3,001**
EXPENDITURE		
PMO	657	619
MES Project	225	202
LIMS	3,117	2,180
Workforce Strategy	102	-
	4,101	**3,001**

5. The Trusts have baseline budgets to deliver the services provided by the KMPN

Baseline BUDGETS

The Parties acknowledge and agree that the baseline budgets set out in this section is for information purposes only, and will be revised and agreed in accordance with the financial principles set out in Part 3 of Schedule 2.

NKPS 18/19	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	960	4,299	318	2,336	524	8,437
NON PAY	13	4,142	3,809	852	9,115	17,931
GROSS COST	**973**	**8,441**	**4,127**	**3,188**	**9,639**	**26,368**
INCOME	0	(7,762)	0	0	(1,105)	(8,867)
NET COST	**973**	**679**	**4,127**	**3,188**	**8,534**	**17,501**

MTW 18/19	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000
PAY	4,636	5,194	1,683	303	11,817
NON PAY	6,968	1,760	1,549	3,944	14,222
GROSS COST	**11,604**	**6,955**	**3,232**	**4,247**	**26,039**
INCOME	(7,291)	(945)	(1,200)	(6,199)	(15,635)
NET COST	**4,313**	**6,010**	**2,032**	**(1,952)**	**10,404**

EKHUFT 18/19	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	1,222	4,580	4,715	2,220	330	13,067
NON PAY	2	7,943	1,175	1,958	3,232	14,311
GROSS COST	**1,224**	**12,523**	**5,891**	**4,178**	**3,562**	**27,377**
INCOME	0	(7,565)	(889)	(1,142)	(2,114)	(11,710)
NET COST	**1,224**	**4,958**	**5,002**	**3,036**	**1,448**	**15,667**

KMPN	Reception	Blood sciences	Cellular	Micro	Other	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000
PAY	2,182	13,515	10,227	6,239	1,157	33,320
NON PAY	15	19,053	6,745	4,359	16,291	46,463
GROSS COST	2,197	32,568	16,972	10,598	17,448	79,784
INCOME	0	(22,618)	(1,834)	(2,342)	(9,418)	(36,212)
NET COST	**2,197**	**9,950**	**15,138**	**8,256**	**8,030**	43,572

Baseline Activity -18/19

ACTIVITY - NKPS	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	4,226,654	77,948	314,276	4,618,878
Direct Access - tests	103,380	77,948		181,328
Acute- requests	5,499,741	0	626,868	6,126,609
Acute - tests	130,695	0	0	130,695
NB Excludes MFT blood transfusion				

ACTIVITY - MTW	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	919,669	83,039	162,468	1,165,176
Direct Access - tests	4,229,503	89,842	897,212	5,216,557
Acute- requests	745,768	68,030	414,662	1,228,460
Acute - tests	3,739,066	328,233	833,135	4,900,434

ACTIVITY - EKHUFT	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	1,207,533	39,516	167,450	1,414,499
Direct Access - tests	4,837,563	52,159	212,872	5,102,594
Acute- requests	1,439,177	52,368	367,972	1,859,517
Acute - tests	5,809,532	256,669	474,663	6,540,864

ACTIVITY - KMPN	**Blood sciences**	**Cellular**	**Micro**	**TOTAL**
Direct Access - requests	6,353,856	200,503	644,194	7,198,553
Direct Access - tests	9,170,446	219,949	1,110,084	10,500,479
Acute- requests	7,684,686	120,398	1,409,502	9,214,586
Acute - tests	9,679,293	584,902	1,307,798	11,571,993

SCHEDULE 4
Contract Change Requests

1. **Purpose**

1.1 This Schedule sets out the procedure for dealing with Changes, including:

1.1.1 the rights of the Parties to request a Change;

1.1.2 the rights of the Parties to approve or reject a proposed Change;

1.1.3 the apportionment of costs incurred by the Parties in compliance with this Schedule; and

1.1.4 the form of any authorised Change.

1.2 Subject to Paragraph 1.1.4, a Change will not be effective until a relevant Change Control Note has been signed by the authorised representatives of Parties.

1.3 A Change Control Note will be in the form set out at the end of this Schedule.

2. **Requesting a Change**

A Party may submit a written request for Change to the other Parties via the Kent and Medway Pathology Network Executive Team .

2.1 Where a Party wishes to request for Change, it will prepare a Change Control Note and use all reasonable endeavors to provide as much information as possible to the Kent and Medway Pathology Network Executive Team in relation to the requested Change. The relevant Party will submit the Change Control Note to the Kent and Medway Pathology Executive Team .

2.2 If the Network Executive Team and/or Pathology Network Clinical and Operational Committee considers that it requires further information in order to consider the proposed Change, it will notify the relevant party within ten (10) Working Days of receipt of the request. Such notification must detail the further information required. The relevant Party will provide the further information and present it to the Kent and Medway Pathology Network Executive Team within ten (10) Working Days of receipt of the notification for further information.

3. **Consideration of requested Changes**

3.1 The Kent and Medway Pathology Network Executive Team will consider all requested Changes requested under Paragraph 2 of this Schedule and make recommendations to the Network Board .

3.2 The Kent and Medway Pathology Network's Executive Team's recommendation will include a risk score based on the following risk matrix:

Score	Description	Examples
5	Very high	Major impact on this Agreement, the collaboration/any relevant KMPN contracts and/or patients Major disruption to the collaboration/ KMPN contracts. Major financial impact

Score	Description	Examples
4	High	Significant impact on this Agreement, the collaboration/KMPN contracts and/or patients Extensive disruption to the collaboration/KMPN contracts Significant financial impact
3	Medium	Requested Change is unlikely to have any significant impact but Changes to be considered in relation to effect on patients and financial consequences
2	Low	Minor impact on this Agreement, the collaboration/KMPN contracts Minor or no disruption to the collaboration/KMPN contracts Minor or no financial impact
1	Very low	Insignificant impact on this Agreement, the collaboration/KMPN contracts No disruption to the collaboration/KMPN contracts No financial impact

4. **Approval of Changes by the Kent and Medway Pathology Network Board**

4.1 If the Change is approved by the Kent and Medway Pathology Network Board, the Change Control Note shall be signed by all Parties whereupon it shall become effective.

5. **Costs of Changes**

5.1 Each Party will bear its own costs in relation to compliance with this Change Control Procedure.

CHANGE CONTROL NOTE TEMPLATE

<table>
<tr><td colspan="2">CR Number:</td><td colspan="2">Title:</td><td colspan="2">Type of Change: [Contract / Operational] Change</td></tr>
<tr><td colspan="3">Contract:</td><td colspan="3">Required by Date:</td></tr>
<tr><td>Action:</td><td colspan="3">Name:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="3">Raised By:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Area(s) Impacted (Optional Field):</td><td colspan="3"></td></tr>
<tr><td colspan="3">Assigned for Impact Assessment By:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Assigned for Impact Assessment To:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Supplier Reference Number:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Full Description of Requested Contract Change:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Details of any Proposed Alternative Scenarios:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Reasons for and Benefits and Disadvantages of the Requested Contract Change:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Signature of Requesting Change Owner:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Date of Request:</td><td colspan="3"></td></tr>
</table>

SCHEDULE 5

Hosting Obligations and Hosting Standards

Part 1 - General Obligations

Subject to the timeframes set out in the Transformation Programme the Host shall:

1. employ all the relevant staff of KMPN and provide the human resources and employment support as described in Schedule 10;

2. in all matters regarding legal personality act on behalf of the KMPN, including, without limitation, entering into all contracts, agreement and arrangements in relation to the KMPN if agreed by the Parties;

3. be responsible for all regulatory matters such as:

   3.1 registration with the Care Quality Commission (or its successor body);

   3.2 registration with the Medicines and Healthcare products Regulatory Agency (or its successor body);

   3.3 registration with the Human Tissue Authority and accreditation with the UK Accreditation Service (UKAS).

   3.4 meeting the requirements of NHSE and any relevant ICBs and any other commissioning organisations;

4. set up separate accounting records in relation to the KMPN;

5. prepare financial reports and account for the KMPN in accordance with the agreed accounting principles;

6. supply each Party with the financial and other information necessary to keep the party informed about how effectively the business of the KMPN is performing and in particular shall supply each Party with:

   6.1 a copy of each year's Business Plan for approval in accordance with Clause 8.4;

   6.2 monthly income and expenditure accounts of the KMPN to be supplied within fifteen (15) Working Days of the end of the month to which they relate (the first Working Day being the first Working Day of the following month) and the accounts shall include activity report, a surplus and loss account, a balance sheet and a cashflow statement;

7. provide and monitor the provision of the Pathology Services to the Customers and operate the KMPN as the legal host on behalf of the Parties in accordance with the decisions of and directions of the Kent and Medway Pathology Network Board; and

8. perform the Hosting Obligations to the Hosting Standards (as applicable).

Part 2 - Hosting Standards

1. In its performance of the Hosting Obligations, the Host Trust shall:

   1.1 comply with all instructions of the Kent and Medway Pathology Network Board in relation to the operation and management of KMPN;

   1.2 perform the Hosting Obligations with the best care, skill and diligence in accordance with best practice in the supplier's industry, profession or trade;

   1.3 use personnel who are suitably skilled and experienced to perform tasks assigned to them, and in sufficient number to ensure that the Hosting Obligations are fulfilled in accordance with this Agreement;

   1.4 ensure that the Hosting Obligations conform with all descriptions and specifications set out in any reasonable written specification provided by the Kent and Medway Pathology Network Board;

   1.5 provide all equipment, tools and vehicles and such other items as are required to perform the relevant Hosting Obligations;

   1.6 use the best value goods, materials, standards and techniques, and ensure that all goods and materials supplied and used will be free from defects in workmanship, installation and design;

   1.7 obtain and at all times maintain all necessary licences and consents, and comply with all applicable laws and regulations, in respect of the Hosting Obligations;

   1.8 observe all health and safety rules and regulations and any other security requirements that apply at any of the premises from which the Pathology Services or the Hosting Obligations are provided; and

   1.9 not do or omit to do anything which may cause any Party to lose any licence, authority, consent or permission on which it relies for the purposes of conducting its business.

2. With the prior written consent of the Kent and Medway Pathology Network Board, the Host may sub-contract the provision of the Hosting Obligations to a Third Party, provided that such sub-contract contains obligations upon the sub-contractor which require it to provide the relevant obligation to the same (or a higher) standard to that set out in this Agreement.

Part 3 - Payment for Hosting Obligations

At the date of this Agreement no charges are payable to the Host Trust for the Hosting Obligations unless the Parties otherwise agree pursuant to the Change Control Procedure.

SCHEDULE 6

NOT USED

SCHEDULE 7

Intellectual Property Agreement

Kent and Medway Pathology Network

Collaboration agreement

(Arrangements for intellectual property (IP) and relationships with Third Parties)

Status	Draft
Version	0.3
Author	John Stedman
Date	25/2/2021

Document Control

Review, Approval and Distribution

Group	Version	Date	Review	Approve	Distribute
Legal and Governance Steering Group.	0.2	25/2/21	X	X	
Pathology Programme Team	0.3	4/3/21	X	X	
Pathology Programme Board	0.4	11/3/21	X	X	X

Change history

Version	Date	Author/editor	Details of change
0.1	25/1/2021	J Stedman	First draft
0.2	29/1/2021	J Stedman	Updated after discussion with A Price and A Foreman
0.3	25/2/2021	J Stedman	Updated after Legal and Governance Steering Group review: title and clause 1.5 amended, new clauses 5.3 and 8.2 added
0.4	11/3/21	J Stedman	Updated after Programme Board to include new clause 7.11 to clarify disclosure of IP.

This Agreement is made on the day of 2021 between:

(A) East Kent Hospitals University NHS Foundation Trust;

(B) Maidstone and Tunbridge Wells NHS Trust;

(C) North Kent Pathology Service (i.e. the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust.)

1. **Background**

1.1 The Parties have agreed the Network Agreement (i.e. *Vison for the Kent and Medway Pathology Service* version 0.9, 6th October 2020) to enable them to work together across Kent and Medway.

1.2 The Parties have agreed to implement a single laboratory information system (LIMS) and managed services contract (MSC).

1.3 The Parties have agreed to appoint a Director of Pathology Transformation who will work with teams and services to design and implement service changes which benefit the whole network.

1.4 The Parties wish to establish an agreement to govern their respective rights and obligations in relation to activity that may generate intellectual property.

1.5 This agreement supports the collaborative working of the Parties and in particular how intellectual property is managed and relationships with Third Parties.

2. **Definitions and interpretation**

The following words and phrases shall have the meanings set out below unless the context requires otherwise:

Agreement	means this non-binding agreement.
Background IP	means intellectual property generated before the Commencement Date.
Commencement Date	means the date on which the Programme Board approve this Agreement.
Confidential Information	means a. information relating to the business affairs, finances or commercial interests of the disclosing Party or of a Third Party to which the disclosing Party has lawful access which is disclosed to the other Party pursuant to this Agreement in whatever form; and/or b. know-how which shall mean any and all technical and other information which is not in the public domain, including information comprising or relating to concepts, discoveries, data designs, formulae, ideas, information relating to material, inventions, methods, models, assays, research plans, procedures, designs for experiments and tests and results of experimentation and tests (including results of research or development), processes (including manufacturing processes, specifications and techniques), laboratory records/quality control data, case report forms, data analyses, reports or summaries and information

	containing submissions to and information from any ethics and regulatory authorities introduced to or made accessible by one Party to another; and/or c. such other written information whether provided in printed, hand-written, electronic or any other form of sensory recognition, that the disclosing Party deems confidential and which is provided to the other Party in writing and marked "Confidential" or which is the subject of oral discussions which will be summarised in any form and agreed by the Parties within thirty days after each discussion, such summaries also to be marked "Confidential" d. save that this definition shall not include any disclosed matter which: i. can be shown to have already been in the possession of the recipient by legitimate means other than under the operation of this Agreement, prior to disclosure; or ii. can be shown to have been independently developed or acquired by the recipient without any breach of confidence or any infringement of Third Party rights; or iii. is or becomes in the public domain other than through breach of this Agreement.
Costs	means any costs incurred by the Parties when Network IP may be generated and attributable to the subject matter of this Agreement.
Collaborative Activity	means any activity where two or more of the Parties work together on an activity that may be novel and has the potential to generate intellectual property.
IP (intellectual property)	means all inventions, improvements and/or discoveries including without limitation all utility models, registered and unregistered designs, registered and unregistered trademarks, topography, data including diagnostic results, diagnostic performance data, and patient related data, databases, computer software, know-how, technical and confidential information, trade and business names and goodwill, processes and methodology (whether or not all of the same are registered) and anything analogous to any of the foregoing in any part of the world.
IP Advisor	means NHS Innovations South East.
NHS Data Principles	means a) Guidance: A guide to good practice for digital and data-driven health technologies i) https://www.gov.uk/government/publications/code-of-conduct-for-data-driven-health-and-care-technology/initial-code-of-conduct-for-data-driven-health-and-care-technology#define-the-commercial-strategy b) Guidance: Creating the right framework to realise the benefits for patients and the NHS where data underpins

	innovation i) https://www.gov.uk/government/publications/creating-the-right-framework-to-realise-the-benefits-of-health-data/creating-the-right-framework-to-realise-the-benefits-for-patients-and-the-nhs-where-data-underpins-innovation
Network Agreement	means the *Vison for the Kent and Medway Pathology Service* document (version 0.9, 6th October 2020) that was agreed by the Parties on 15th October 2020.
Network IP	means all IP arising from Collaborative Activity and all IP arising from activity undertaken by a Party within the Scope of this Agreement.
Party	means either North Kent Pathology Service (i.e., the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust) or East Kent Hospitals University NHS Foundation Trust or Maidstone and Tunbridge Wells NHS Trust and 'Parties' shall mean North Kent Pathology Service (i.e., the joint venture pathology service of Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust) and East Kent Hospitals University NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust;
Programme Board	means the Programme Board defined by the Network Agreement
Revenue	Means revenue arising for the commercial exploitation of Network IP
Revenue Share	means the sum remaining when the Costs have been deducted from the Revenue in the relevant Accounting Period.
Scope	means pathology services undertaken within any of the Parties laboratories and includes biochemistry, haematology, blood transfusion, haemophilia and coagulation, microbiology, cellular pathology, immunology. Services provided outside of laboratories are point of care testing, phlebotomy (EKHUFT and MTW only) and mortuary (not MFT) performed by their employees or commissioned or contracted by the Parties to a Third Party or any activity in support of pathology services e.g. IT products and services.
Third Party	means any other organisation or individual not a Party to this agreement.

3. **Term**

This Agreement shall come into force on the Commencement Date and continue in perpetuity.

4. **Collaboration**

4.1 The Parties will collaborate on activities that benefit the Kent and Medway Pathology Network and are in accordance with the Network Agreement.

4.2 Examples of Collaborative Activity include improvement activity, benchmarking, clinical validation of a diagnostic using NHS samples for a Third Party, the development of a

new diagnostic, the application of a diagnostic to a new disease or condition, the provision of data from NHS samples to a Third Party, the development of new or improved methodologies or processes. This list is non-exhaustive and other Collaborative Activity may give rise to IP that needs to be evaluated for its potential to be disseminated or commercialised.

4.3 The Parties will agree on a lead Party to engage and contract with a Third Party for commissioned activity on behalf of the Network.

4.4 If a Third Party is funding the Collaborative Activity, for example clinical validation of a diagnostic, then the Parties will agree how the funding and activity is apportioned between them in accordance with the Network Agreement and seek guidance from the IP Advisor on IP management.

4.5 If the Third Party is a commercial organisation then the price of undertaking the activity will be determined in advance by the Parties and will be based on commercial pricing.

4.6 Alternative mechanisms to fund Collaborative Activity that benefits Third Parties can be agreed by the Parties and may require the IP Advisor to advise.

4.7 If additional funding is necessary to undertake Collaborative Activity, then this will be agreed by the Programme Board and the Costs shared in alignment with the Network Agreement.

5. Intellectual Property

5.1 Network IP will be jointly held by the Parties.

5.2 If formal legal protection is required for Network IP, then either a lead Party will take on the legal protection activity required or the legal owner of the IP will be identified and they will undertake the protection activity required on behalf of the Parties.

5.3 The benefits arising from any Network IP asset will be shared jointly by the Parties in accordance with the Network Agreement.

5.4 The Costs of legal protection of the Network IP will be borne by the Parties in accordance with the Network Agreement.

5.5 Each Party shall promptly disclose to the other(s) all arising Intellectual Property generated by it and each Party shall co-operate, where required, in relation to the preparation and prosecution of patent applications and any other formal legal protection relating to Network IP as appropriate.

5.6 Each Party hereby grants to each other Party an irrevocable, non-transferable, royalty-free right to use all Network IP for clinical and research purposes, including research projects funded or commissioned by a Third Party provided that the Third Party does not gain or claim any commercial or exploitable rights to such Network IP.

5.7 All Background IP remains the property of the Party that generated it. No Party will make any representation or do any act which may be taken to indicate that it has any right, title or interest in or to the ownership or use of any of the Background Intellectual Property of the other Parties except under the terms of this Agreement. Each Party acknowledges and confirms that nothing contained in this Agreement shall give it any right, title or interest in or to the Background Intellectual Property of any other Party save as granted by this Agreement.

5.8 Each Party grants the others a royalty-free, non-exclusive licence to use its Background Intellectual Property for the sole purpose of participating in the Network Agreement. No Party may grant any sub-licence over or in respect of the other's Background Intellectual Property.

6. Commercialisation

6.1 The Programme Board will review opportunities for the commercialisation of Network IP and agree whether pursued or not with advice from the IP Advisor.

6.2 The Revenue Share arising from commercialisation of Network IP shall be shared between the Parties based on the same proportion as the shares within the Network Agreement.

6.3 If the Parties generate Network IP that does not have the potential to be commercialised but which has value to the NHS and patients in producing one or more non-commercial benefits, then the Parties will seek advice from the IP Advisor on how best to disseminate and exploit the Network IP to achieve those benefits. The non-commercial benefits may include one or more of the following: efficiencies, cost savings, kudos for the Parties and or the Network, and improved patient outcomes.

6.4 The IP Advisor will provide advice on appropriateness and methods of IP protection and methods of IP exploitation or dissemination if the Network IP is not suitable to be commercialised.

6.5 The Parties will comply with the NHS Data Principles when commercialising Network IP or exploiting Network IP that is not commercialised.

7. Confidentiality

Each Party undertakes:

7.1 to maintain Confidential Information in strict confidence save where ordered to disclose same by a competent court of law or other empowered tribunal or authority; and

7.2 to inform the other Party promptly where disclosure has been ordered as envisaged in Clause 7.1 above; and

7.3 to keep securely Confidential Information such that only persons under the obligations of confidence similar to those contained in this Agreement have access to or custody of the Confidential Information and otherwise to protect the same with no less care than they apply to their own confidential information; and

7.4 to use the Confidential Information it receives from the other Party only for the purpose for which it was disclosed. Neither Party shall use such Confidential Information for any other purpose, either for itself or for any Third Party; and

7.5 not to copy or reproduce the Confidential Information or make any record or re-formatting of it save as is reasonably necessary for the performance of its obligations under this Agreement; and

7.6 to return or destroy all copies of the Confidential Information including but without limitation to copies in written or electronic form, either on the request of the disclosing Party or on the expiry or termination of this Agreement; and

7.7 to keep confidential the terms and conditions of this Agreement; and

7.8 to ensure that all its employees, contractors, consultants and advisors are aware of the confidential nature of the Confidential Information and the obligations under this Agreement and shall accept responsibility for each of them as if their activities in relation to the Confidential Information were carried out by that Party itself.

7.9 The Parties agree that any Confidential Information released prior to the execution of this Agreement shall be deemed to have been delivered hereunder and shall be subject to the terms of this Agreement.

7.10 The Parties agree that any Confidential Information disclosed pursuant to this Agreement shall remain confidential for a period of five years following the termination of this Agreement.

7.11 Each Parties organisational management processes and Intellectual Property Policy will govern its own staff's compliance to ensure intellectual property that has potential commercial value is not disclosed and value subsequently destroyed.

8. **Publications**

8.1 Each Party will use all reasonable endeavours to submit material intended for publication, that may relate to the collaboration or a pathology innovation, to the other Parties in writing not less than 30 (thirty) days in advance of the submission for publication. The publishing Party may be required to delay submission for publication if in any other Party's opinion such delay is necessary in order for that other Party to seek patent or similar protection for material in respect of which it is entitled to seek protection, or to modify the publication in order to protect Confidential Information. A delay imposed on submission for publication as a result of a requirement made by the other Party shall not last longer than is absolutely necessary to seek the required protection; and therefore shall not exceed 3 (three) months from the date of receipt of the material by such Party, although the publishing Party will not unreasonably refuse a request from the other Party for additional delay in the event that property rights would otherwise be lost. Notification of the requirement for delay in submission for publication must be received by the publishing Party within 30 (thirty) days after the receipt of the material by the other Party, failing which the publishing Party shall be free to assume that the other Party has no objection to the proposed publication.

8.2 Where one or more Parties, but not all Parties, are involved in a collaboration that gives rise to a publication or other non-financial benefit, then consideration will be given to recognising those Parties in the publication or other non-financial benefit not involved in the Collaborative Activity who may have had to forgo involvement for any reason. E.g. one or more Parties but not all Parties bid for a piece of collaborative work, and it is not possible for all Parties to bid and participate.

9. **Third Parties**

9.1 When a Third Party approaches a Party or the Parties with an opportunity to undertake an innovative activity or project within the Scope of this Agreement, then the opportunity will be disclosed to the other Parties and the Programme Board will review the opportunity and decide whether to pursue or not.

9.2 If the Third Party is a commercial organisation, then the opportunity will be costed on a commercial basis to generate a Revenue Share for the Parties. The IP Advisor will provide advice on the commercial costing and alternative approaches the Parties may adopt, particularly if IP may generated, to ensure Costs are recovered and that the arrangement is beneficial to the Parties.

9.3 If the Third Party is a non-commercial organisation, then the opportunity will be costed to ensure Costs are recovered and that there is a benefit to the Parties of undertaking the opportunity. The IP Advisor will advise on appropriate mechanisms for the Parties to realise benefits from the opportunity.

SCHEDULE 8

Business Plan

1. **BUSINESS PLAN**

1.1 The Business Plan is an annual business plan for KMPN prepared by the Kent and Medway Pathology Network Executive Team and approved by the Kent and Medway Pathology Network Board in accordance with this Schedule 9.

1.2 The Business Plan shall be:

(a) the investment plan presented to Parties' boards; and

(b) the investment update papers, headed as such and presented to the Parties' boards, prior to the Commencement Date. The investment update papers show:

(i) A plan showing proposed activity volumes, planned prices and outline income and expenditure for the forthcoming Financial Year;

(ii) A detailed operating budget for the coming twelve months including a monthly projected income and expenditure account;

(iii) an investment plan for the coming twelve months (including Capital Expenditure requirements); and

(iv) details of the surplus (if any) to be retained by KMPN,

and shall be deemed adopted by the Kent and Medway Pathology Network Board at the date of signature of this Agreement.

1.3 For each Business Plan, the Parties shall procure (though the Kent and Medway Pathology Network Board) that such Business Plan shall include (without limitation) in relation to the Financial Year to which it relates:

(a) a financial report including an analysis of the estimated results of KMPN for the previous Financial Year compared with the Business Plan for that year, identifying variations in sales revenues, costs and other material items;

(b) a management report including business objectives for the Financial Year;

(c) a brief strategic review for the forthcoming five (5) Financial Years (the first two (2) Financial Years in detail, the remaining three (3) in outline);

(d) A plan showing planned activity volumes, planned prices and outline income and expenditure for the forthcoming five (5) years (the first two (2) years in detail, the remaining three (3) in outline);

(e) A detailed operating budget for the coming twenty four (24) months including a monthly projected income and expenditure account;

(f) an investment plan for the coming twenty four (24) months (including Capital Expenditure requirements) and balance sheet forecast;

(g) a cashflow statement giving:

i. an estimate of the working capital requirements; and

ii. an indication of the amount (if any) that it is considered prudent to retain, for the purpose of meeting those working capital requirements, from the surplus of the previous Financial Year that is available for distribution to the Parties;

(h) details of the surplus (if any) to be retained by KMPN;

(i) details of any additional call on Parties for working capital funding required as a result of deficit;

(j) an appraisal of the feasibility of Incorporating KMPN; and

(k) an assessment of the potential impact (including any material adverse financial impact or consequences) that KMPN plans for Pathology Services may have on the business of the Parties in the Financial Year in question.

1.4 A Business Plan (other than for the first Financial Year) shall be prepared by Kent and Medway Pathology Network Executive Team so that:

(a) the draft is available at least twelve weeks before the first Working Day of the Financial Year to which the plan relates; and

(b) the final version is available at least four weeks before the first Working Day of the Financial Year to which the plan relates.

1.5 The Business Plan is to be approved and adopted by the Kent and Medway Pathology Network Board before 1 April of the Financial Year to which it applies.

1.6 To the extent that a Business Plan is not approved and adopted in any Financial Year, the Business Plan for the preceding Financial Year shall be rolled forward, subject to updating the costs detailed in such Business Plan to reflect indexation by reference to national NHS guidance.

SCHEDULE 9

Premises

Terms and Conditions relating to the Premises

The Parties agree and acknowledge that any Premises issues shall be addressed and agreed via the Change Control Procedure

SCHEDULE 10

Staff

Network Team

POST	BAND	WTE
KMPN Managing Director	9	1.00
KMPN Clinical lead		0.60
KMPN Workforce and OD lead	8D	0.80
KMPN Finance Lead	8D	0.50
KMPN IT Lead	8D	1.00
KMPN Programme support	5	1.00
KMPN Procurement lead	8A	1.00

PMO Team

MES Project

Project manager MES	8D	0.80

Any staff required for implementation as approved by the MES FBC

LIMS Project

Project Director	8d	1.00
Junior Project Manager	8b	1.00
Analyser & Integration PM	7	1.00
Pathology reporting PM	7	1.00
Data Migration PM	7	1.00
Integration specialist (Data Architect)	7	1.00
Business Change Manager	8a	1.00
Business Change analysts	6	4.6
APEX specialist	8b	0.40
MLA data migration	3	1.00
MLAs training	3	12.00
Test Manager	7	1.00
Testers	5	8.00
Training manager	7	1.00
Digital (LIMS) System Manager	8b	1.00
Project Support Office	5	1.00
All approved recharges for backfill	various	N/A

Workforce Team

HR BP	**8A**	**0.30**
Education and training co-ordinators	**8A**	**0.64**
Practice Educator	**8B**	**0.72**

N.B the education posts are funded non-recurrently by HEE and will be reassessed annually.

SCHEDULE 11
Deed of Adherence

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Dated…………………………………………..

(1) **[INSERT FULL LEGAL NAME OF NEW PARTY]**

- and -

(2) **Existing Parties**

DEED OF ADHERENCE TO THE PATHOLOGY COLLABORATION AGREEMENT

THIS DEED OF ADHERENCE is made on [*INSERT DATE OF FINAL SIGNATURE]*

PARTIES

(1) [*INSERT FULL LEGAL NAME OF NEW PARTY*] of [*INSERT REGISTERED OFFICE ADDRESS*] (**New Party**), and

(2) The parties whose names and addresses are set out in Schedule 1 (**Existing Parties**).

RECITALS:

A This deed is supplemental to, and is entered into in accordance with, the Collaboration Agreement.

B The New Party wishes to be admitted as a partner.

C The Existing Parties have resolved to admit the New Party as a partner with effect from the Admission Date on the terms of this deed.

THE PARTIES AGREE:

1. **Definitions and interpretation**

1.1 The definitions and rules of interpretation in the Collaboration Agreement shall apply in this deed except where expressly stated to the contrary and the following expressions shall have the following meanings:

Admission Date	[*INSERT DATE*];
Existing Parties	means the parties whose names and addresses are set out in Schedule 1;
Collaboration Agreement	Pathology Collaboration Agreement dated [INSERT DATE], and made between the Existing Parties, as amended from time to time.

2. **Admission of New Party**

2.1 The New Party shall become a partner as from the Admission Date.

2.2 The New Party hereby covenants with each Existing Party who is a party to the Collaboration Agreement from time to time to observe, perform and be bound by all of the terms of the Collaboration Agreement which are capable of applying to the New Party and which have not been performed at the date hereof.

2.3 The New Party shall agree to contribute £[INSERT AMOUNT IN FIGURES] ([INSERT AMOUNT IN WORDS]) on or before the Admission Date every year in respect of the Network Costs.

3. **General**

3.1 This agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this agreement.

3.2 This deed may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

3.3 This deed and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England.

3.4 Each party irrevocably agrees that the courts of England shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this deed or its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1

The Existing Parties

Name	**Address**
[*insert*]	[*insert*]
[*insert*]	[*insert*]

EXECUTED AS A DEED by the parties on the date first set out on page 1.

Executed as a deed by
....

for and on behalf of **[INSERT NAME OF NEW PARTY]**

....
(Signature)

....
(Date)

In the presence of:

Signature ....

Name ....

Address
....
....
....
....

Occupation ....

Executed as a deed by
....

for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....
(Signature)

....
(Date)

In the presence of:

Signature ....

Name ....

Address
....
....
....
....

Occupation ....

Executed as a deed by
....

....
(Signature)

for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....

(Date)

In the presence of:

Signature ....

Name ....

Address

....

....

....

....

Occupation ....

Executed as a deed by

...

....

(Signature)

for and on behalf of **[INSERT NAME OF EXISTING PARTY]**

....

(Date)

In the presence of:

Signature ....

Name ....

Address

....

....

....

....

Occupation ....

SIGNATURE PAGE

SIGNED by ....
(Signature)

(Role) ……………………………………..
....
for and on behalf of **EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST**
(Date)

SIGNED by ....
(Signature)

(Role) ……………………………………..
....
for and on behalf of **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST**
(Date)

SIGNED by ....
(Signature)

(Role) ……………………………………..
....
for and on behalf of **DARTFORD AND GRAVESHAM NHS TRUST**
(Date)

SIGNED by ....
(Signature)

(Role) ……………………………………..
for and on behalf of **MEDWAY NHS FOUNDATION TRUST**
....
(Date)