Agenda

NHS Medway NHS Foundation Trust

Public Trust Board Meeting

Wednesday, 06 March 2024 at 12:30 – 15:30 Trust Board Room, Gundulph Offices

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 17 January 2024	Chair	3	12:35	Approve
2.2	Action Log – none for March 2024		-		Discuss
2.3	Trust Board Workplan	Company Secretary	11	12:40	Approve
2.4	Chief Executive Update	Chief Executive	14	12:45	Note
2.5	Council of Governors Report	Lead Governor	17	12:50	Note
3.	**Board Story Presentation**				
3.1	Macmillan Nurses – Nicola Cooper, Cancer Service by Director of Operations (Cancer and Core Clinical Services)	Associate Director of Patient Experience	19	13:00	Note
4.	**Board Assurance Reports**				
4.1	Quality Assurance Committee Update (February 2024)	Chief Medical Officer, Interim Chief Nursing Officer, Committee Chair	33	13:20	Assurance
4.2	People Committee Update (January 2024)	Chief People Officer, Committee Chair	38	13:30	Assurance
4.3	Finance, Planning and Performance Committee Update (January 2024)	Chief Finance Officer, Committee Chair	42	13:40	Assurance
5.	**Public Board Papers**				
5.1	Violence and Aggression - Update	Interim Chief Nursing Officer	Verbal	13:50	Note
5.2	Perinatal Quality Surveillance Report	Director of Midwifery	45	14:00	Note
	~ WELLBEING BREAK - 15 minutes ~				
5.3	Finance Report (Month 9)	Chief Finance Officer	79	14:25	Note

5.4	Annual Accounts Review	Chief Finance Officer	99	14:40	Note
5.5	Annual Business Plan Checkpoint	Chief Operating Officer	Verbal	14:45	Note
5.6	Strategy Review and Summary	Director of Strategy and Partnerships	102	14:50	Note
5.7	Replacement of Interventional Radiology Machine	Nicola Cooper, Cancer Service by Director of Operations	111	14:55	Approve
6.	**Integrated Quality Performance Report (IQPR) and Board Assurance Framework (BAF)**				
6.1	IQPR – January 2024	All Executives	148	15:00	Note
6.2	Risk Register	Company Secretary	186	15:05	Note
6.3	Board Assurance Framework		216		Note
7.	**Closing Matters**				
7.1	Questions from the Public	Chair	Verbal	15:15	Note
7.2	Risks Identified				
7.3	Reflection				
7.4	Any Other Business				
7.5	Date and time of next meeting: Wednesday, 15 May 2024				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 17 January 2024 at 12:30 – 15:30

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

and Virtually on MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	Mark Spragg	Acting Chair
	Alan Davies	Chief Financial Officer
	Annyes Laheurte	Non-Executive Director
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Jayne Black	Chief Executive
	Leon Hinton	Chief People Officer
	Mojgan Sani	Non-Executive Director
	Nick Sinclair	Chief Operations Officer
	Paulette Lewis	Non-Executive Director (Virtual)
	Sarah Vaux	Chief Nursing Officer (Interim)
	Sue Mackenzie	Non-Executive Director
Attendees:	Adrian Ward	Non-Executive Director
	Alana Almond	Deputy Company Secretary (Minutes)
	Anan Shetty	Governor - Medway (Virtual)
	David Brake	Lead Governor (Virtual)
	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
	Jeremy Davis	Deputy Chief Medical Officer (Deputising for Alison Davis)
	Jignesh Patel	Governor - Swale (Virtual)
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Michael Taylor	Head of Strategic Relationships for Healthcare Business Solutions UK (Observing - Virtual)
	Paul Stephens	Member of the Public (Observing - Virtual)
Apologies:	Alison Davis	Chief Medical Officer

1 PRELIMINARY MATTERS

1.1 Chair's Welcome and Apologies

1) *Firstly, welcome to this first Board meeting of 2024, and happy New Year. The last time we held a formal Board meeting, at the beginning of November, the trees were still shaking off the last of their leaves, and Christmas was just a twinkle on the calendar.*

2) *We are now in the depths of winter – the NHS winter. The temperatures may only just be dipping below zero outside, but within the hospital we certainly know winter is here.*

3) *For many weeks now our Emergency Department has been experiencing seasonal pressures leading to longer waits than we would wish to see, and we know the pressure will not ease for some time.*

4) *There has also been a period of industrial action, and while we respect the rights of colleagues to take such action, it unfortunately, has an impact on patients whose appointments have had to be postponed, and for this I would like to apologise and thank our local population for their understanding.*

5) *However, in spite of the challenges the Trust faces, there is much to feel encouraged about: we are seeing improvements in a number of areas, and we constantly see colleagues innovating and transforming services to make the experience of patients better.*

6) *As I go around the hospital and talk to staff, I meet people who are not defeated or discouraged, even though they may be tired. They are determined and positive about the changes they can make, using our Patient First methodology.*

7) *Albert Einstein is quoted as saying: "It's not that I'm so smart, it's just that I stay with problems longer." You might say he was being rather modest there! But the quotation is a good one and relevant to our situation here in Medway. I see colleagues in all roles, and at all levels, determined to find solutions to problems, which gives me great confidence for the year ahead and, actually, I know these colleagues are pretty smart too!*

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Declarations of Interest

There were no declarations of interest against any agenda item.

2 MINUTES OF THE LAST MEETING AND ACTION LOG

2.1 The minutes of the meeting held on 08 November 2023 were **APPROVED** as a true and accurate record.

2.2 The Action Log was reviewed. There was no actions listed or outstanding. The log can be found under separate cover.

2.3 Chief Executive Update

Jayne Black presented to the Board the paper as submitted within the papers. Jayne echoed Chair's comments on the pressures the hospital is under and stated that SECAmb had commended the Trust on its efforts.

The Board **NOTED** the report

2.4 **Council of Governors Update**
David Brake gave a verbal update to the Board, highlighting the following items:

a) Engagements in the community and in the hospital; most feedback is positive and supportive. Seldom have they received negative reports.
b) Supported the Strategy Team with engagement events, asking community to give feedback.
c) Frailty Event attended by local community and healthcare providers.
d) Charity and Christmas Market was attended by Governors.
e) Focus for 2024; Governor Elections in March 2024, there will be engagement events throughout the first part of the year.

The Board **NOTED** the update.

3 Board Assurance Reports

3.1 Quality Assurance Committee Update (December 2023 and January 2024)
Paulette Lewis and Sarah Vaux updated the Board in line with the papers submitted, providing headlines from the Assurance Reports for the meetings held in December 2023 and January 2024.

Escalations to the Board

a) Chair; As a general comment, Committee Chairs and Executives should clarify on the assurance reports what the escalations are and to whom so as to separate them from points for future consideration by the Committee.
b) Chair; For example, Misidentification of blood samples is listed on the report, but is this a Board escalation? Jeremy; will review with Alison on her return all the escalations for Board and decide whether or not they need escalating to Board or will be considered further by the Committee.

The Board was **ASSURED** by the reports.

3.2 People Committee Update (November 2023)
Sue Mackenzie and Leon Hinton presented the report in line with paper submitted, providing headlines from the Assurance report for the meeting held in November 2023.

Escalations to the Board

a) DBS level review; ensuring the DBS checks meet compliance with the NHS Employment Standards in accordance to role requirement. Jayne; this is being picked up through Safe Staffing Review. Leon; will pick up alignment through general alignment and ledger.
b) Safe Staffing Review; historical issues associated with service development approval and funding/budget/commissioning.
c) New versions on BAF will be submitted to the People Committee next meeting.

The Board was **ASSURED** by the report submitted.

3.3 Finance, Planning and Performance Committee Update (November and December 2023)
Gary Lupton and Alan Davies presented the report in line with papers submitted, providing headlines from the Assurance reports for the meeting held in November and December 2023.

Escalations to the Board
There were no escalations to the Board

The Board was **ASSURED** by the reports submitted.

3.4 Audit and Risk Committee Update (December 2023)

Annyes Laheurte and Alan Davies presented the report in line with paper submitted, providing headlines from the Assurance report for the meeting held in December 2023.

Escalations to the Board

a) Need to review the approach to the Board Assurance Framework (BAF). Matt; this is in hand.
b) Fire Safety in Emergency Department. Nick; KFRS are assured that the risk is being appropriately managed, and assured that evacuation plans are sufficient. Daily checks by management to ensure there are no further significant risks that are not mitigated. All mitigations have been approved by KFRS.

The Board was **ASSURED** by the report submitted.

4 QUALITY

4.1 Health and Safety Annual Report

Sarah Vaux presented the report to the Board to note. The report covers 2023/24 and the objectives for the year 2024/25. The report was scrutinised by the Private Board on this day and is submitted to the Public Board for noting.

4.1.1 The objectives for 2023/24 will be delivered by March 2024 and reported to the Audit and Risk Committee.

The Board **NOTED** the update

4.2a Maternity CNST Compliance Year 5 Board Declaration Report

Sarah Vaux and Alison Herron presented the report to the Board to note the assurance report and its appendices and approve for the Trust to submit to NHSR a declaration of compliance against all 10 safety standards.

4.2.1 The report provided an update to the Trust Board on the Maternity Service's progress against compliance to the 10 Safety Actions for CNST Year 5. The report noted that maternity is declaring compliance with all 10 safety standards and our work has been subject to peer review.

Non-Executive Directors - Check and Challenge

a) Jenny; every summer the reports requirements increase. The work now addresses the cultural element and aligns with the Trust's Clinical Strategy. Board; noted
b) Gary; how does this link to the CNST premium, is there a reduction? Matt; this is entered into our overall indemnity but it does not reduce.
c) Annyes; as we are a tertiary centre, where does liability lie? Alison; it depends where the fault lies, it is an intensive tariff for care.
d) Chair; within the Safety actions queried the 'Pre-existing diabetes in pregnancy', BRAG report August to November red then January 2024 is green. Alison; informed the Board of the mitigations and actions that were put in place for the improvement in the BRAG and that she was assured the green rating in January is appropriate and that the previous red rating was probably too harsh.
e) Chair; thanked Alison and team for their work noting that this is a very significant piece of work in a very short timescale.

The Board **NOTED** and **APPROVED** the report

4.2b Maternity Workforce – Bi-Annual

Sarah Vaux and Alison Herron presented the report to the Board.

4.2.2 The report provided assurance to the Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels.

Non-Executive Directors - Check and Challenge

a) Gary; does this tie into the Safe Staffing review? Sarah; yes
b) Chair; current position with the students from Canterbury Christchurch University, were they transferred over to Surrey University? Alison; there is a bridging process now in place from Canterbury to Surrey, there is a process for the students now to come back to the Trust in placement. Third year students were impacted the most. They did come back to their placements in October 2023 and the team are working closely to build their confidence. LMNS are working with the Trust on students from other universities. The Trust will not catch up with "missing" qualifying students until, probably, January 2025.
c) Thanks from the Board to the team.

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

4.3 Patient Safety Incident Response Framework (PSIRF)

Sarah Vaux and Wayne Blowers presented the report to the Board to approve the plan and policy ahead of submission to the Kent and Medway ICB for final approval and agreement for transition to investigating incidents under the Patient Safety Incident Response Framework (PSIRF).

4.3.1 PSIRF will replace the existing 2015 Serious Incident Framework. The framework represents a shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS and is a key part of the NHS patient safety strategy. It is a positive step forward and has a focus on Patient First work.

4.3.2 The focus has come away from individual incidents and taking an overall view on matters so the training is embedding.

Non-Executive Directors - Check and Challenge

a) Jenny; Do all trusts have same way of reporting? Sarah and Wayne; All organisations are required to complete this as it is a national requirement. More focus will be on learning. Investigating is based on some mandatory investigating under the serious incident framework. NHSE ask what are organisations biggest risks and priorities, the Trust has considered this.
b) Jayne; for the team to consider – with the roll out of training, what is the training and how does it dovetail with the improvement training the Trust already gives. Sarah and Gavin; agreed
c) Chair; thanked Wayne and the team.

The Board **APPROVED** the plan and the policy.

****** The Board took a 10 minute Wellbeing Break ******

5 PATIENTS

There were no items

6 PEOPLE

There were no items

7 SUSTAINABILITY

7.1 Finance Report (Month 8)

Alan Davies presented the report for noting, the paper was taken as read.

7.1.1 The Trust reports a £30.1m deficit YTD, this being £18.5m adverse to the plan.

7.1.2 Efficiencies to date total £8.7m, this being £7.2m adverse to the plan. There are a further £0.6m of cost avoidance schemes, with the total efficiency delivery reporting £9.3m YTD.
7.1.3 The capital position is underspent by £7.8m due to delays in progress across the main major projects.
7.1.4 Cash is £14.4m adverse to plan, this is mainly due to the unplanned deficit. The Trust will need some extra cash in the next year.
7.1.5 Non-clinical recruitment freeze is in place currently.
7.1.6 Received KPMG Report in draft and Alan and Jayne have met with them. Report to be circulated once signed off and it deals with themes such as medical staff recruitment, rota reviews, review of medical middle grade pay, length of stay and contract management.
7.1.7 Key priority for the team is budget setting correctly for next year with greater engagement with budget holders. This way the teams can forecast properly.
7.1.8 £800k slippage from the Community Diagnostic Centres into next year, this will be monitored through the FPPC.

Non-Executive Directors - Check and Challenge

a) Chair; has the Trust borrowed more funds for this year? Alan; No
b) Gary; being more forward looking, there will be challenges for finance team about how we align. Governance controls were a focus. Can KPMG support us going forward? Jayne; yes there is a meeting with NHSE and RSP 18.01.24 and support will be discussed.
c) Annyes; can the Board see the KPMG report. Alan; yes will circulate once report is finalised.
d) Chair; what is current positions on negotiations for budget setting? Alan; still waiting for spending planning from NHSE expected in the next week.
e) Gary; how can the Trust integrate to improve care? Jayne; meeting with partners to discuss how to work differently (MTW and ICB).

The Board **NOTED** the report.

8 SYSTEMS AND PARTNERSHIP

There were no items

9 INTEGRATED QUALITY PERFORMANCE REPORT (IQPR) AND BOARD ASSURANCE FRAMEWORK (BAF)

9.1 Integrated Quality and Performance Report (IQPR)

The Executive Team presented the report in line with the papers submitted.

Sarah Vaux, Chief Nursing Officer (Interim)

The report was presented to Board for noting in regard to Patients and Incidents.

Non-Executive Directors - Check and Challenge

a) Jayne; what are the areas that are struggling? This is discussed at huddles. Sarah; this will be looked at in more detail and reported on.

Jeremy Davis, Deputy Chief Medical Officer

The report was presented to Board for noting with particular focus on Complaints, which is a risk area and PALS. Mortality was also discussed in line with the paper.

Non-Executive Directors – Check and Challenge

a) Chair; what extra help is needed to improve in the area of Incidents. Sarah; the improvements and actions already in place will improve and no additional staff are required. Training is increasing responses.

b) Jayne; PALS significant increase in their work load, how can this service can be managed in a different way? Sarah and Wayne; this is work in progress and being reviewed.
c) Jayne; Mixed Sex Accommodation – when will the team be able to report automatically on TeleTracking? Nick; no time scale but it will happen.
d) Jayne; ED Flow work. Nick; daily huddles around ED pressures. The areas of pressure are on wards not actually in the ED. Improvement work is ongoing.
e) Jayne; violence and aggression there are too many incidents in month. This will be picked up by the necessary committee. Sarah; chairs the Violence and Aggression group and it will be addressed.

Nick Sinclair, Chief Operating Officer
The report was presented to Board for noting in regard to RTT, DM01, Cancer, Wait Time, Access and Emergency Care. Nick explained the various triaging that takes place in ED to MedOCC and SDEC or to ED itself.

Leon Hinton, Chief People Officer
The report was presented to Board for noting in regard to workforce.

Non-Executive Directors - Check and Challenge

a) Chair; did the issue with pre-checks for international recruitment get sorted? Leon; yes this was dealt with. There have been dismissals in relation to qualification checks carried out more recently, arising out of fraudulent test results.

Alan Davies, Chief Finance Officer
This element was covered under Item 7.1.

The Board **NOTED** the Integrated Quality Performance Report

9.2 Board Assurance Framework (BAF)

The Executive Team presented the report in line with the papers submitted. Matt Capper as Company Secretary will lead on the BAF going forward. There will be a rapid review on the BAF initially for gap analysis. There will be a BAF refresh submitted to Board by March 2024. The BAF will be integrated with Patient First. There will be more definition between strategic and operational risks. Will ensure that the actions/mitigations are correct and are they in place, if risks are not moving what the Trust is doing about it.

Non-Executive Directors - Check and Challenge

a) Chair; Quality 2a - Lack of timely escalation and treatment of deteriorating patients, at meetings it has been celebrated that 2222 breakthrough has reached its target of 50% reduction. This appears to have had little impact on the risk rating. Why has the risk rating not reduced? Jeremy; there has been improvement but risk has not gone down aside from 25 to 15 in January 2023. Matt; the BAF review will address some of these rating issues with clarity around strategic and operational risk.

The Board **NOTED** the Board Assurance Framework

10 CLOSING MATTERS / BOARD BUSINESS

10.1 Risks Identified

No additional risks identified.

10.2 Reflection

Approved all of the reports that the Board have been asked to.

10.3 Any Other Business

a) There were no Questions from the Public

b) Jenny; discussed why the Trust has increased focus around Cyber Threat and Security. It is a concern for the Trust and the NHS as a whole. Alan; Cyber Fraud training is provided to colleagues.

10.4 Date of next meeting - Wednesday, 06 March 2024

The meeting closed at 15:20

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 17 January 2024

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

Trust Board Work Plan
Annual Work Plan 2024 - 2025

		2024				2025	
Item	**Lead**	**May**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**
Preliminary Standing Items							
Welcome and Apologies	Chair	X	X	X	X	X	X
Quorum		X	X	X	X	X	X
Declaration of Interest		X	X	X	X	X	X
Chairs Briefing (not inc. in papers)		X	X	X	X	X	X
Chief Executive Report	CE	X	X	X	X	X	X
Minutes of previous meeting	Chair	X	X	X	X	X	X
Matters arising and Action Log		X	X	X	X	X	X
Standing Items							
Board Assurance Framework	Company Secretary	X	X	X	X	X	X
Trust Risk Register	Company Secretary	X	X	X	X	X	X
Integrated Quality Assurance Report	Executives	X	X	X	X	X	X
Committee - Board Assurance Report	Lead Exec/ Committee Chair	X	X	X	X	X	X
Council of Governors Report	Lead Governor	X	X	X	X	X	X
Board Story (Clinical/Service or Patient)	Associate Director of Patient Experience	X	X	X	X	X	X
Statutory Papers							
Maternity Workforce Oversight Report	Chief Nursing Officer		X			X	
Maternity CNST Compliance Assurance Report – Updates and Actions			X	X	X	X	
Perinatal Quality Surveillance Report		X		X	X		X
Perinatal Culture Leadership Report		X		X	X		X
Claims, Incidents, Complaints Triangulation Report		X		X	X		X

Trust Board Work Plan
Annual Work Plan 2024 - 2025

NHS Medway NHS Foundation Trust

		2024				2025	
Item	**Lead**	**May**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**
Health and Safety Annual Report	Chief Nursing Officer					X	
Emergency Preparedness, Resilience and Response - Policy	Chief Operating Officer	X					
Emergency Preparedness, Resilience and Response - Annual Assurance Rating					X		
Governance Review: a) Committees b) Board c) Council of Governors d) Terms of Reference e) Work Plan f) Governance Structure	Company Secretary			X			
Medical Education Annual Report	Chief Medical Officer				X		
Safeguarding Annual Report	Chief Nursing Officer			X			
Data Security Protection Toolkit	Chief Delivery Officer			X			
Constitution Review	Company Secretary	X					
Trust Risk Policy					X		
Strategies (as and when required)							
Ratification of Policies: a) Trust Risk b) Risk Management Framework c) Freedom of Information d) Safeguarding Complaints e) Standards of Business Conduct f) Integrated Governance g) Health and Safety h) People		X					
Medical Appraisal and Revalidation Annual Report	Chief Medical Officer			X			

Trust Board Work Plan
Annual Work Plan 2024 - 2025

		2024				2025	
Item	**Lead**	**May**	**Jul**	**Sept**	**Nov**	**Jan**	**Mar**
League of Friends Annual Update	League of Friends				X		
Annual Business Plan Check Point	Chief Operating Officer						X
Annual Business Plan		X					
PLACE Assessment Action Plan (month TBC)	Chief Operating Officer						
Green Plan	Chief Executive	X					
Strategy Review and Summary	Director of Strategy and Partnerships		X		X		X
Finance Report	Chief Financial Officer	X	X	X	X	X	X
Standing Financial Instructions and SORD		X					
Annual Accounts – Review							X
Annual Report and Accounts			X				
Financial Efficiencies				X			
Closing Matters							
Questions from the Public	Chair	X	X	X	X	X	X
Risks Identified		X	X	X	X	X	X
Reflection		X	X	X	X	X	X
Any Other Business		X	X	X	X	X	X

Key – Patient First Domains

Quality
People
Patients
Systems and Partnerships
Sustainability

Chief Executive's Report - March 2024

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting. The Board is asked to note the content of this report.

Tackling Operational Pressures

I would like to thank staff for their continued efforts to safely care for our patients and continue to make every effort to improve flow though the hospital during what continues to be a very challenging winter.

Our four-hour emergency performance has remained broadly in line with the national average and we continue to turn ambulances around quickly. However, throughout this winter, we have consistently seen high numbers of patients waiting more than 12 hours to be admitted to a ward, as we continue to care for between 80 and 130 patients who no longer need our specialist acute care and are awaiting out-of-hospital support to continue their recovery.

We continue to work hard to improve flow through the hospital and the introduction of TeleTracking, our bed management system, is helping to turn beds around more quickly. Patients wear an electronic wristband during their hospital stay which on discharge, automatically updates teams managing our beds that a bed is ready to be prepared for the next patient.

For every patient whose wristband goes into the dropbox, their discharge happens two and a half hours earlier than through PAS, our patient administration system. This enables us to release hours of idle bed time back to us so our patients can be admitted into a bed much sooner, which is better for them, and for our incredibly busy Emergency Department.

A Year of Sheppey Frailty Unit

Our dedicated frailty unit, based at Sheppey Community Hospital in Minster, marked its first birthday in January. The unit is the first Trust facility offering access to the same levels of acute care, away from our main site at Medway Maritime Hospital in Gillingham.

Over the last year the team have care for and discharged around 600 patients, providing care closer to home for people for people in Sheppey, Sittingbourne and the surrounding areas. The unit is now a well-established and relied upon service for patients in Swale and we are proud of the excellent team we have built and all that has been achieved over the last year.

Patient Knows Best

Patients are able to access their own hospital appointments with the launch of a new online patient engagement portal Patients Know Best (PKB). The Trust joins three other trusts in Kent and Medway in offering the Patients Know Best portal which aims to support a smoother experience for patients, giving them a single handy place to access their appointment letters and make changes to their upcoming care.

Since the portal's launch in October 2023, 14,000 new registrations have been made with more than 124,000 people registered to access their healthcare through Patients Know Best across Medway.

People can use Patients Know Best to view appointments, appointment letters, discharge summaries and more, quickly registering through the NHS app or the dedicated Patients Know Best website for Medway. As the portal develops, patients will be able to view results letters from different specialities such as radiology and endoscopy.

The portal also supports our Green Plan by reducing the number of letters sent out, as patients will be able to quickly access appointment and clinical information digitally which minimises delays with a reduced carbon footprint.

Royal College of Anaesthetists Accreditation

Our Anaesthetic Department has received the prestigious Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) – demonstrating a commitment to patient safety and high-quality care.

Medway is just the second NHS Trust in Kent to be presented with the accreditation, which promotes quality improvement and the highest standards of anaesthetic service. To receive it, departments are expected to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership.

Care Quality Commission Maternity Survey

Results of the Care Quality Commission's annual maternity survey were published in February. A total of 164 people who gave birth in the care of our Trust rated their antenatal care, experience of labour and birth, and postnatal care, and I am pleased to say our positive responsive rate was better than the national average in a number of areas. We also saw a significant improvement in some areas.

The results included:

- 96 per cent were treated with kindness and compassion during labour and birth
- 95 per cent were provided with relevant information about feeding their baby
- 93 per cent had confidence and trust in staff during labour and birth
- 93 per cent were given enough support for mental health during pregnancy.

The survey also identified areas for improvement including aspects of postnatal care, which the service are working on, together with our local Maternity and Neonatal Voices Partnership. There is always much that we can learn from surveys like this as we strive to provide the best possible care for our patients.

Governor Elections

The Trust has a number of committed Governors coming to the end of their terms of office this summer with a total of 12 Public Governor seats available – eight in Medway and four in Swale. The nomination

stage opens on Friday 1 March and closes on Monday 18 March. Terms will begin on 01 July 2024, and last for three years.

Governors play a crucial role in our Trust and it is vital that we have a strong and dedicated team who can ensure that local people are represented. Anyone who is a member of the Trust can stand as a Governor for the constituency in which they live. We are seeking applications from people with an interest in learning more about the Trust and the local health system, and engaging with the local community and patients.

I would like to sincerely thank Governors who are approaching the end of their term for their valuable service.

League of Friends Donations

Sincere thanks to our partners at the Medway League of Friends for donating more than £81,000 to our hospital over the last year.

Thanks to funds raised by the charity's hospital café, shop and donations, they have contributed:

- £25,751 for 25 new infant resuscitators for our neonatal unit
- £16,082 for a new cooling unit for critical care
- £12,026 to buy new equipment for our cardio respiratory department and equipment library, including four new Fractional Exhaled Nitric Oxide (FeNo) devices, which are used to diagnose asthma by measuring your breath.
- £28,028 for a new bladder scanner for our urogynaecology clinic and two further scanners for our Equipment Library.

The Meeting of the Public Trust Board
Wednesday, 06 March 2024

Meeting	Council of Governors Public Meeting – 22 February 2024		
Title of Report	**Assurance and Escalation Report**	Agenda Item	2.5
Lead Director	Matt Capper – Director of Strategy and Partnership and Company Secretary		
Report prepared by	Emma Tench – Assistant Company Secretary		
Report Approved by	Mark Spragg – Acting Chair		
Executive Summary	This report is tendered by the Council of Governors. The report enables escalations from the Council of Governors to be directed to the Trust Board for review and comment. Key items from the meeting: 1) Update on Governor Elections 2) Membership and Events Survey Update 3) Use of NHS emails by Governors in line with GDPR		

Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	None			

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

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

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Council of Governors	22.02.24	**Mark Spragg – Trust Chair**

Number of attendees	Number of apologies	Quorate	
		Yes	No
10	4	x	

Declarations of Interest Made
No declarations of interest received against any agenda item

Assurance received at the Group meeting
1) Governors were taken through the various ways in which the Board gets assurance that the best of care is being delivered to patients and what happens when this goes wrong. 2) An introduction to PSIRF was given. 3) Governors invited to attend the Executive Improvement huddle in Gundulph (Tuesday at 08:30) to provide assurance of processes and mitigations in place throughout the organisation. 4) Governors invited to the Patient First 'Spot Light' session in the main entrance (Thursday at 08:15), providing assurance of development from different departments throughout the organisation.

Key actions
1) Estates to be contacted regarding non-blue badge holder parking in disabled bays. 2) Governors to encourage patients and families to report any below standard treatment to PALS to enable proper escalation and review and enhance learning. 3) All Governors to use their NHS email address, set up to be confirmed by Kim Willsea – Governor and Membership Officer.

Highlights from sub-groups reporting into this group
N/A

Items to come back to the Group
• Updates on implementation of Decision Time – platform for distribution of papers • Updates on NED and Chair recruitment process and NED appraisals.

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required
Risk training to be circulated via email to ensure compliance.

Items/risks/issues for escalation
None

Implications for the corporate risk register or Board Assurance Framework
None

Examples of outstanding practice or innovation
1) Governors congratulated the organisation on the 13-minute ambulance handover.

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Macmillan Cancer Services

Patient FIRST

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Medway
NHS Foundation Trust

Our six objectives to reach and improve the lives of everyone living with cancer

1. Everyone with cancer will know that they can turn to Macmillan from the moment they are diagnosed, and how we can help them.
2. Everyone with cancer will have a conversation about all their needs and concerns, and get the support that's right for them.
3. Everyone with cancer will have their vital needs met by high quality services.
4. We will inspire more people to give to Macmillan so we can continue to be there for people when they need us the most.
5. We will improve the key processes which support Macmillan to do its work as efficiently and effectively as possible.
6. We will reflect and represent the communities we serve in everything we do to support everyone living with cancer.


With heart


With strength


With ambition

MACMILLAN CANCER SUPPORT

Macmillan Cancer Care Unit

NHS Medway NHS Foundation Trust

- The Macmillan Cancer Care Unit is a welcoming and naturally lit environment which comprises of Lawrence Ward and Galton Day Unit. It is dedicated to supporting patients diagnosed with cancer and their families.
- Lawrence Ward is an inpatient facility; equipped with private rooms and bedded bays designed specifically for our haematology and oncology patients.
- The Galton Day Unit specialises in providing chemotherapy and other specialist oncology treatments. There is a Macmillan Information Centre to support patients, and a tranquil garden space is available to use by patients attending the unit and ward.
- We take a holistic, personalised approach to each patient, providing high quality clinical care and supporting patients and their families with advice and information. We signpost to a variety of services aimed at enhancing patients overall well-being according to their individual needs.
- Clinical support is delivered by consultant oncologists, haematologists and specialist nurses, working alongside a team of administrators and volunteers. The unit is supported by a wide range of Macmillan professionals such as clinical nurse specialists, cancer support workers, social worker, counsellors, dieticians, physiotherapists, occupational therapists, and pharmacists.
- The unit can be accessed from the main hospital corridor and Galton Day Unit also benefits from a dedicated exterior entrance and drop off point.

Macmillan Cancer Information Centre

NHS Medway NHS Foundation Trust

MACMILLAN CANCER SUPPORT

NHS Medway NHS Foundation Trust

Macmillan Support Line; offers physical, financial and emotional cancer support over the phone on

0808 808 0000, open 7 days a week, 8am-8pm

Medway Macmillan Information and Support Centre;

01634 976315

What support can Macmillan offer?

NHS Medway NHS Foundation Trust

Macmillan Buddy Service

- Free telephone buddy service.
- A volunteer buddy to listen, talk and support so no one has to face cancer alone.
- 12 weeks or more of support

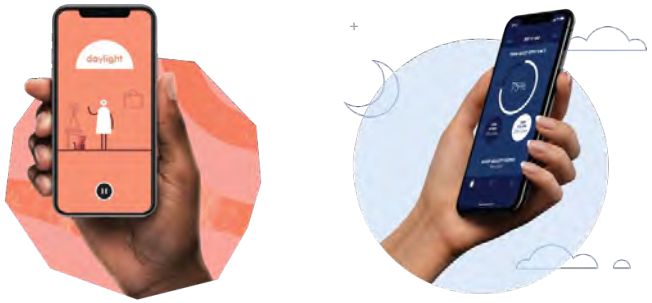
Macmillan Bupa Counselling

- Macmillan and Bupa are working in partnership to provide free counselling and emotional support
- Six free one-to-one counselling sessions with a qualified therapist (via phone or video call).
- Go to the Macmillan website to book a Bupa wellbeing assessment.

MACMILLAN CANCER SUPPORT

Macmillan & Big Health

- Macmillan and Big Health are working together cancer patients with instant access to free mental health support
- Sleepio; a sleep improvement programme (**sleepio.com/macmillan**)
- Daylight; management of anxiety and worry (**trydaylight.com/macmillan**)



MFT Macmillan CLINICAL Nurse specialist (CNS) Role

- First point of contact for patients
- Support patients and their families through their cancer journey with care and compassion
- Take a holistic approach to make sure that we provide support and information that is appropriate for each patient; whether that is physical, practical or psycho-social

MFT Macmillan CLINICAL Nurse specialist (CNS) Role

- Meet the patient with the Consultant when they attend clinic appointments

- Ensure that the patient fully understands their diagnosis, their treatment plan and the rationale for any further investigations

- Help them manage their diagnosis, through to treatment, recovery or palliative care

MFT Macmillan CLINICAL Nurse specialist (CNS) Role

Medway NHS Foundation Trust

- Support patients undergoing surgery and/or receiving oncology treatment; chemotherapy, hormone therapy, targeted therapy, immunotherapy and radiotherapy

- We ensure both the patient and their family are well supported and signpost them to other services whether in the community or in hospital

- We liaise and work collaboratively with multiple primary and secondary care teams, as well as other hospitals/organisations to ensure that patients receive the best possible care

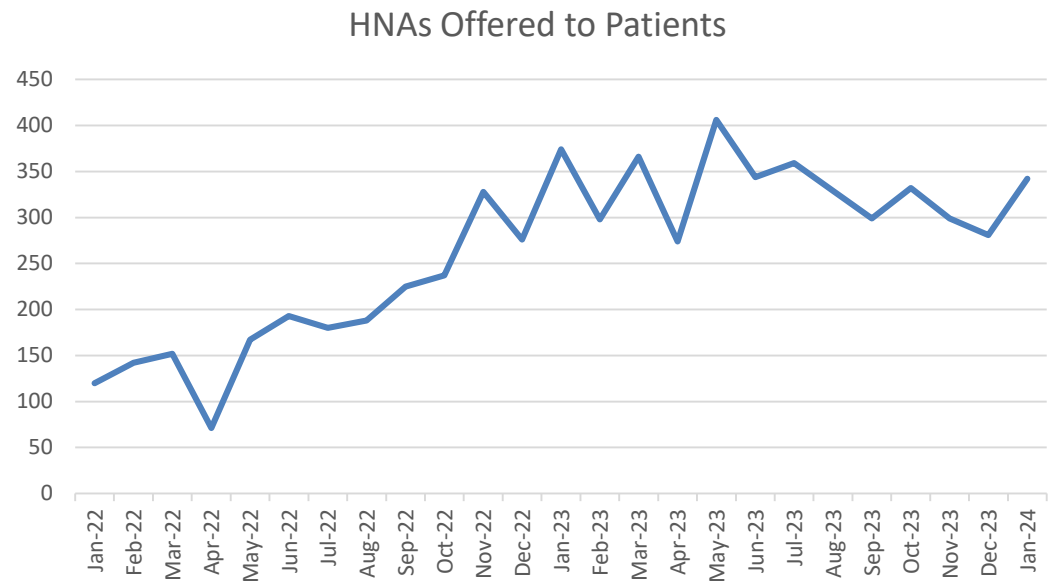
MFT Macmillan CLINICAL Nurse specialist (CNS) Role

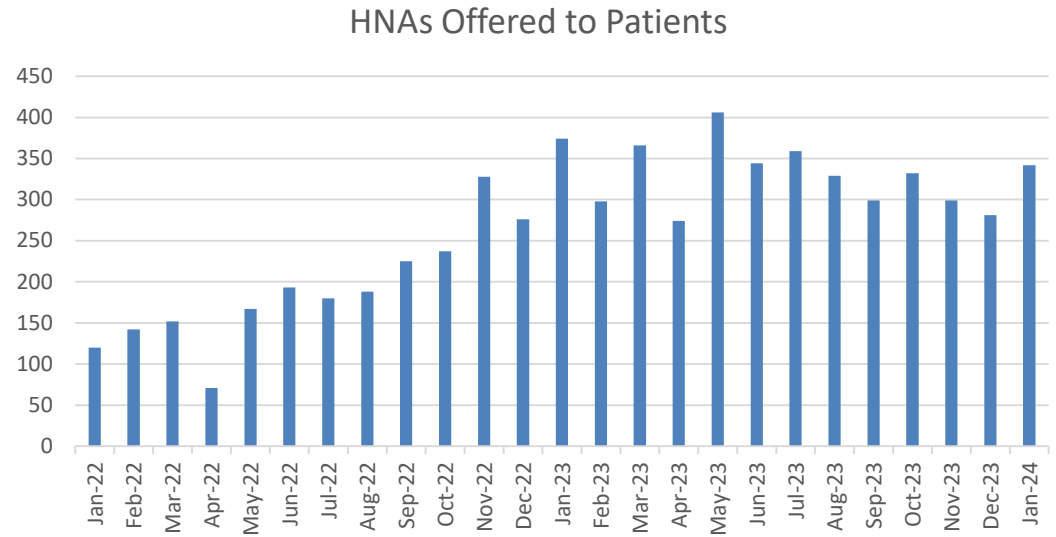
- Help empower patients to self-manage their care and treatment
- We are the patients advocate and will be their voice when they struggle to have one
- To ensure each patient has the right support, by the right person, at the right time
- Enable the patient to feel heard and included in their care when living with cancer

Holistic needs assessment

- The **HNA** is a structured method of identifying needs, and discussing and agreeing the best way to meet them from the person's perspective.
- It involves identifying and prioritising needs and then planning to address the prioritised needs.
- It offers a way to consider the multi-dimensional effect of cancer and its treatment. The HNA is a way to engage with the person and address their concerns and/or needs at the most appropriate times.
- Below graph shows the increase of HNAs offered to patients from 2022 to 2024

Row Labels	Count of NHS Number	Percentage Change from previous month
Jan-22	120	
Feb-22	142	18.33
Mar-22	152	7.04
Apr-22	71	-53.29
May-22	167	135.21
Jun-22	193	15.57
Jul-22	180	-6.74
Aug-22	188	4.44
Sep-22	225	19.68
Oct-22	237	5.33
Nov-22	328	38.40
Dec-22	276	-15.85
Jan-23	374	35.51
Feb-23	298	-20.32
Mar-23	366	22.82
Apr-23	274	-25.14
May-23	406	48.18
Jun-23	344	-15.27
Jul-23	359	4.36
Aug-23	329	-8.36
Sep-23	299	-9.12
Oct-23	332	11.04
Nov-23	299	-9.94
Dec-23	281	-6.02
Jan-24	342	21.71
Grand Total	**6582**	





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Macmillan Partnership Working

NHS Medway NHS Foundation Trust

- Collaborative working with Macmillan to review pathways, and service development for the CNS teams and support for Macmillan funded posts.

- Support provided by Macmillan to fund posts for 24 months to embed into services to support with the management and service development of the cancer CNSs with the exception of the Macmillan metastatic breast CNS post. This was a four year pump prime reducing percentage post to support the trust at a time of financial challenge and to meet the gap in service as there was no support for this group of patients.

- Access to Macmillan services for both CNS and patients. Macmillan provide a learning hub, grants for staff for innovation, conference's, wellbeing, along with patient grants and counselling services.

Workforce Development Macmillan Partnerships

NHS Medway NHS Foundation Trust

Macmillan	**Collaboration to add new and additional Macmillan workforce:** • CNS posts: Cancer Support Workers to assist each of the tumour-specific CNS teams by conducting holistic needs assessments etc. • Cancer nursing leadership support roles. • Manned information centre.
Macmillan Funded Posts	• Deputy Lead Cancer Nurse • AOS three CNS posts • Haematology CNS and CSW • Lung CNS • Metastatic Colorectal CNS and CSW • Counsellor
Workforce initiatives	• Oncology Breast, Uro-oncology, Metastatic Breast CNS and CSW funded posts.

Acute Oncology 7 day service project

Psychosocial support for cancer

Meeting of the Board of Directors in Public
Wednesday, 06 March 2024

Title of Report	Assurance report – Quality Assurance Committee 8 February 2024	**Agenda Item**	4.1
Author	Joanne Adams, Business Support Manager		
Committee Chair	Paulette Lewis, Chair of Committee/NED		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Integrated Quality and Performance Report (IQPR) The Committee reviewed the Quality and Patient elements of the IQPR. It reported on the quality and patient experience performance across all key performance indicators for January 2024. The main area of improvement was: • SHMI had fallen within the expected ten months to within the expected range. The Committee were **ASSURED** by the report	Assurance with minor gaps
2. Board Assurance Framework and Risk Register The Committee **NOTED** the quality, safety and patient experience BAF scores and the action progress against gaps. The Committee was requested to approve the closure of two strategic risks (1b and 1e) currently held on the Quality BAF. Approval was only given for risk 1e to be closed. The Committee **NOTED** the risk register for quality and safety and challenged the high percentage of risks (84%) that indicated no movement in their rating from the previous month. The following risks were discussed in detail: • Fragility of the Euroking maternity system and the lack of a record back copy facility leading to risk of overwritten	Assurance with minor gaps

information in patient records – the trust is working with system partners on a maternity digital system re-procurement for an alternative solution. • Failed or poor quality discharge increasing safeguarding risks. – CNO and COO reviewing discharge policy. Impact review to be carried out. The Committee were **ASSURED** by the report.	
3. Assurance and Escalation Report from Quality & Patient Safety Sub-Committee (QPSSC) The Committee reviewed the assurance and escalation report from its sub-committee and **NOTED** the key items raised and the actions described to manage them: • C.Diff and MRSA cases have breached the Trusts target score – this is a national picture and is under review. • Resus training numbers in surgery and anaesthetics are below the Trusts target – management will be through the divisional board and monitored directly by QPSSC. • Privacy and dignity arrangements in the emergency department during surge periods are being addressed by the Chief Nurse – actions to be completed by March 2024. • The performance trajectory for #2222 calls is improving (the total numbers are declining) and will continue to be monitored through the corporate project and SDR.	Partial assurance with gaps
4. National Clinical Audit and NICE 22/23 annual report The Committee received a report summarising the outputs from the National Clinical Audit the highlights were: • Successful delivery of clinical audits with 98% compliance. • A need to ensure recommended actions from audits are fully implemented. • The requirement to implement NICE guidance in a timely manner. The Committee **APPROVED** the report.	Significant assurance
5. Mental Health Support update The Committee **NOTED** the update report highlighting the actions taken so far to ensure safe management and plans for the future for providing mental health support to patients in need of mental health support. These actions include: • High Risk Mental Health Unit	Significant assurance

• Paediatric Mental Health Liaison Nurse for CHED • Menth Health Lead Nurse for the Trust • Physical changes to the car park. The Committee were **ASSURED** by the report	
6. Infection, Prevention and Control The Committee **NOTED** the root cause analysis report commissioned by the previous QAC to identify the keys infection, prevention and control risks. The key risks are: • Breaching of thresholds for C.Difficile and MRSA bacteraemia. • Not taking the learning from all infection reviews with common contributory factors. • Ineffective engagement of the Network and regional collaborative for both MRSA and C.Difficile.	Partial assurance with gaps
7. Anti-microbial Stewardship report The Committee were **ASSURED** by the update report which considered the updated antimicrobial guidelines, antimicrobial usage and delivery of CQUIN3. An area of risk to note is the Trust is an outlier in regards with antibiotic consumption in comparison with other acute Trusts in the South-East.	Partial assurance with gaps
8. Emergency Department (ED) Improvement Plan The Committee **NOTED** the progress made against the trust wide improvement plan which supports the flow through the hospital. Highlights from the discussion were: • Oversight of the plan is through the weekly executive meeting. • Links with the new clinical strategy to inform future work programmes that will enable the service to meet future demand and capacity challenges. • The imminent delivery of the refitted Ruby Ward. • The patient safety focused work with both internal and external staff and partners.	Significant assurance
9. Q3. Quality Governance Report The Committee reviewed the Q3 quality governance report and were assured by the progress described in the Q3 update report.	Partial assurance with gaps
10. Maternity Picker Survey	Partial assurance with gaps

	The committee **NOTED** the summary of the maternity survey, carried out by Picker in April and June 2023. The Committee were **ASSURED** by the report: • Feedback was less than 70% - measures to address this are included in the outcomes action plan. • Benchmarking has been undertaken with neighbouring organisations within the network. • The bottom five score and five most declined scores form the core of the outcomes action plan.	
	11. Research and Innovation Strategy The Committee reviewed the draft Research and innovation Strategy and **RECOMMENDED** that the draft strategy be submitted to the Trust Board for approval.	Significant assurance
	Decisions made: 1) Board Assurance Framework, closure of risk 1e.	
	Further Risks Identified: 1) None identified.	
	Escalations to the Board or other Committee: 1) None.	

Proposal and/or key recommendation:	• Research and Innovation Strategy to be submitted to the Trust Board with the recommendation to approve. – 6 March 2024.			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Quality Assurance Committee, 08 February 2024			

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

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

Meeting of the Board of Directors in Public
Wednesday, 06 March 2024

Title of Report	Assurance report – People Committee 25 January 2024	**Agenda Item**	4.2
Author	Leon Hinton, Chief People Officer		
Committee Chair	Sue Mackenzie, Chair of Committee/NED		

Key headline and assurance level

Key headline	Assurance Level
1. IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for December 2023. The Committee were **ASSURED** by the report: • True North (Staff Engagement) – update due Q4 2023/24; • Breakthrough (turnover) – [1%, 0.3% improvement, on target] on target for one-month; • Staff appraisal – [87.8%, -1.2% deterioration, 2.2% off target] fourth successive month below target, clinical divisions remain largely on target, corporates remain off target; • Vacancy rate – [2.8%, -0.6% improvement, on target] continues to improve with improvements to nursing, AHP and CSW vacancies and strong pipeline; international pharmacists now in pipeline. • Voluntary turnover – [10.6%, -0.2% improvement, 2.6% off target] continues to improve along with stability and reduced vacancies. No significant outliers to improving position by staff group. • Staff fill rates – improving position for achieving required staffing versus planned staffing and increased care hours per patient day (CHPPD) however below target of CHPPD target of 9.5; • Sickness absence – [4.9%, 0.1% deterioration, 0.9% off target] significant increase to sickness rate across the Trust. Reviewing whether sickness rate should move into the breakthrough objective due to deterioration; • StatMan – [87.4%, +0.7% improvement, on target] slight improvement over target; however, capacity and DNA issues continue particularly for classroom-based learning, fire, safeguarding/MCA and resus – capacity issues resolving through to March 2024 for safeguarding. • Employment standards –compliance work continues with the Head of Safeguarding.	Assurance

2. Board Assurance Framework and Risk Register The Committee **NOTED** the current BAF scores and the draft position of the new BAF items replacing the existing People BAF risks, action progress against gaps. The Committee **NOTED** the current people risk register which reported nine approved risks with one scoring over 15, all risks had been reviewed within timeframe.	Assurance
3. Violence and Aggression Report The Committee received the presented report providing a detailed overview of violence and aggression incidents against staff over 12-months. The report included actions to address the underreporting of incidents on datix versus security logs; however, this was improving. The yellow and red card system was discussed following ratification. Training for enhanced break-away had been sourced and bookings for training can now be made by staff. Body-worn camera had trialled since November 2023 with a survey being used to capture feedback and improve the cameras.	Partial Assurance
4. Bullying and Harassment Report The Committee received a report summarising learning actions for the Trust following a number of external employment cases to ensure the Trust's policies, systems and practices address and prevent issues identified in the external cases. The Committee **NOTED** the report. The Committee **APPROVED** the Trust's new Bullying, Harassment, Discrimination and Conflict Resolution policy.	Assurance
5. HR and OD Performance The Committee **NOTED** the HR and OD performance against workplan, including an improvement to recruitment time to hire and the review of DBS levels by role.	Assurance
6. Industrial Action The Committee **NOTED** an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff.	Assurance
7. Freedom to Speak Up Assurance Report (Q2, Q3 2023/24) The Committee were **ASSURED** of the Lead Freedom to Speak Up Guardian's assurance report for the two quarters. Freedom to	Partial Assurance

	speak up cases had increased for four successive quarters with corresponding increases to each of the reporting domains including a significant increase in anonymously raised concerns; a breakdown was included with associated learning and addressing actions. The report included learning from external cases and future actions resulting from the public inquiry into Lucy Letby.	
	8. Staff Survey Action Plan The Committee **NOTED** the progress of the 2022 staff survey action plan progress through 2023 in advance of the 2023 results.	Partial Assurance
	Decisions made: 1) The Committee approved the Trust's new Bullying, Harassment, Discrimination and Conflict Resolution policy subject to a separate easy reference guide being published separately.	
	Further Risks Identified: 1) None identified.	
	Escalations to the Board or other Committee: 1) None.	

Proposal and/or key recommendation:	Not applicable				
Purpose of the report (tick box to indicate)	Assurance	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	People Committee, 25 January 2024				

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

Identified Risks, issues and mitigations:	All risk, issues and mitigations are 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, leon.hinton@nhs.net

Meeting of the Board of Directors in Public
Wednesday, 06 March 2024

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

Key headline and assurance level

Key headline	Assurance Level
1. Finance Report M9 (inclusive of IQPR) The Committee received a report summarising the position of the Trust for Month 9. The Committee **NOTED** the report.	Partial assurance
2. Business Planning and Budget The Committee **NOTED** update.	Assurance
3. Efficiencies Programme Update 2023/24 The Committee were updated on the current position and progress with the Trust's planning process. The Committee **NOTED** the report	Partial assurance
4. Performance Report The Committee were provided with an update on the performance across the key business performance metrics of emergency demand, patient flow, referral to treatment, cancer and diagnostics performance. The Committee were **ASSURED** and **NOTED** the report	Assurance
5. Overseas Visitors Handbook - Policy The Committee **APPROVED** the update	No assurance required

	6. Medicines Efficiencies Programme – Quarterly Update The Committee **NOTED** the update from the Chief Pharmacist providing an overview of medicine expenditure.	Assurance
	7. Board Assurance Framework (BAF) The reports for Sustainability and Systems and Partnership were reviewed. The Committee were **ASSURED** and **NOTED** the reports. Risk 4a was **APPROVED** to close	Assurance
	8. Corporate Financial Risk Register The Sustainability and Systems and Partnership Risk Registers were reviewed by the Committee. The Committee **APPROVED** moving Risk 1025 to the Chief Delivery Officer Risk Register. The Committee were **ASSURED** and **NOTED** the reports.	Assurance
	Decisions made: 1) The Committee approved the closure of Risk 4a from the BAF. 2) The Committee approved the approved the Overseas Visitors Handbook update.	
	Further Risks Identified: • The risk to the financial forecast was noted by the Committee; work is ongoing to agree a forecast outturn. • The CNO was asked to flag any immediate safe staffing risks with the Committee accordingly. **Reflection:** The Chair commented on the value of having robust conversations on difficult topics	
	Escalations to the Board or other Committee: 1) None.	

Proposal and/or key recommendation:	Not applicable			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
Committee/Group at which the paper	Finance, Performance and Planning Committee – 25 January 2024			

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: ✓

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

Meeting of the Public Trust Board
Wednesday, 06 March 2024

Title of Report	Perinatal Quality Surveillance Quarterly Report		**Agenda Item**	5.2
Author	Alison Herron, Director of Midwifery Kate Harris, Head of Midwifery			
Lead Executive Director	Sarah Vaux, Interim Chief Nursing and Quality Officer			
Executive Summary	This report provides an update to the Trust Board on the Perinatal Surveillance Quarter 3 Data			
Proposal and/or key recommendation:	Approve the report and its assurance			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	X
	Noting		Discussion	
Committee/Group submitted:	a) Maternity and Neonatal Safety Champion Assurance Board - 08 February 2024 b) QPSSC – 29 February 2024			

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

Identified Risks, issues and mitigations:	Maternity Staffing remains the highest scoring risk on the Women's risk register (Risk ID Midwifery staffing ID 1134 Score= 20)
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	Compliance with CNST Year 5/6 and CQC standards
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act

For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Perinatal Surveillance – Quarterly Report Oct-Dec 2023

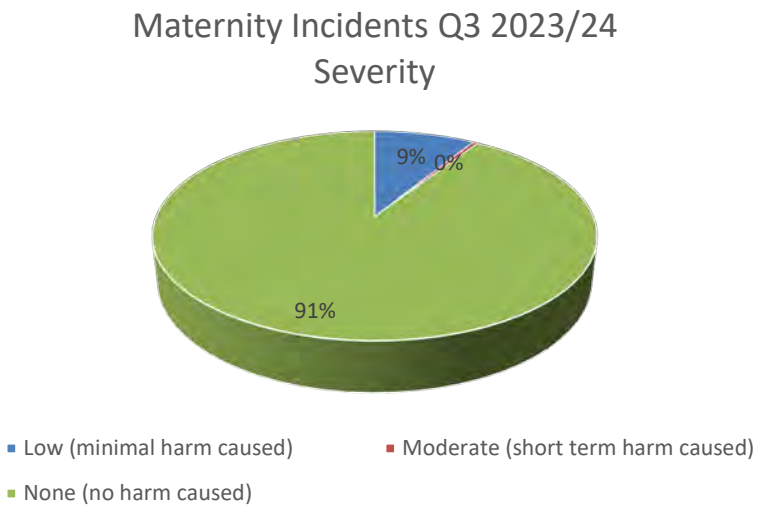
Alison Herron, Director of Midwifery
Kate Harris, Head of Midwifery

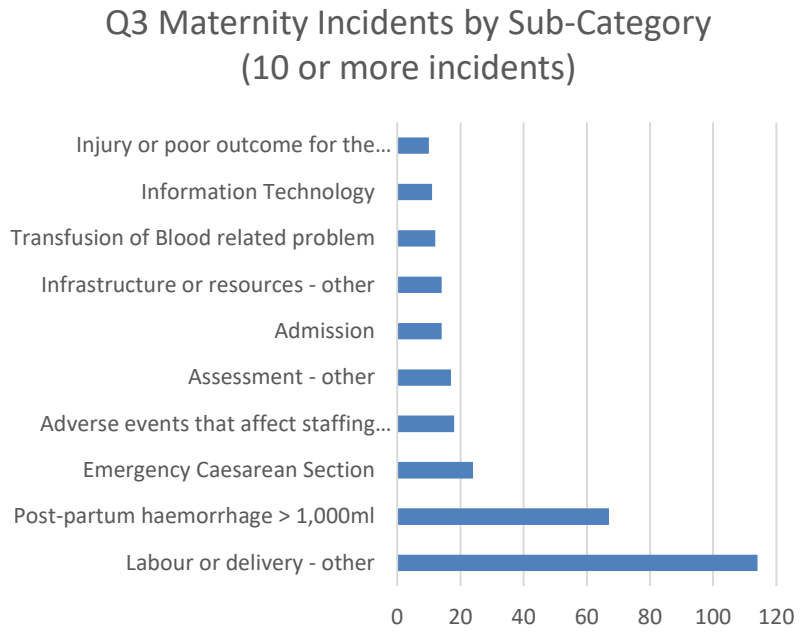
Incidents, investigations and PMRT

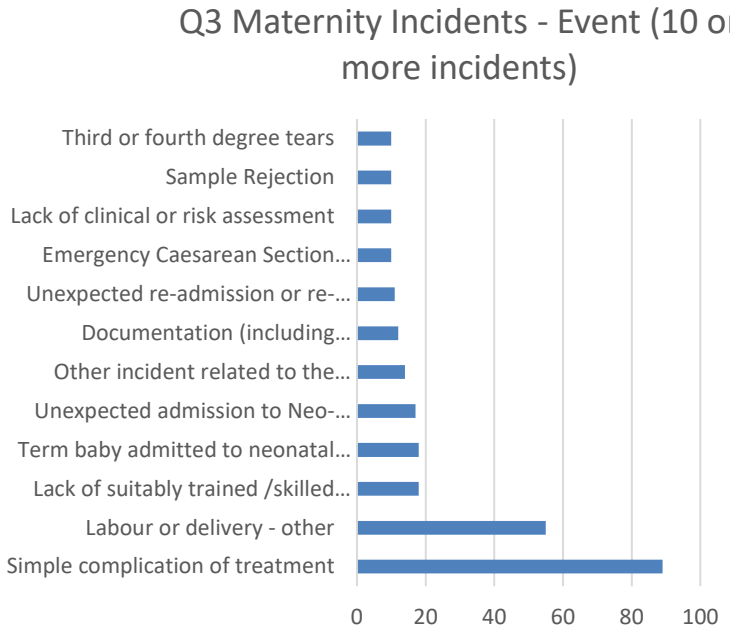
True North: Quality

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

NHS Medway NHS Foundation Trust







Key Messages:

- 458 incidents reported in Q3
- >99% of incidents reported are no or low harm.
- 2 incidents reported as Moderate Harm
  - 13L PPH – HLI
  - Cord Prolapse MSNI investigation

Top Three themes in maternity incidents for (sub-category) for Q3:

- Labour or Delivery (114)
- PPH > 1L (67)
- Emergency C-section (24)

Top 3 Maternity Incidents by event for Q3 :

- Simple complication of treatment (89)
- Labour & Delivery – other (55)
- Lack of suitably trained staff (18)
- Term baby admitted to neonatal Unit (18)

True North: Quality

Perinatal Surveillance Tool: Quarterly Report

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

NHS Medway NHS Foundation Trust

Issues, Concerns & Gaps:

- Need to ensure maternity and neonatal staff awareness of PSIRF and how this affects learning from incidents.
- Workforce continues to remain a challenge despite recruitment and retention activities. Remains highest risk on risk register ID 1134 Score= 20)

Actions & Improvements:

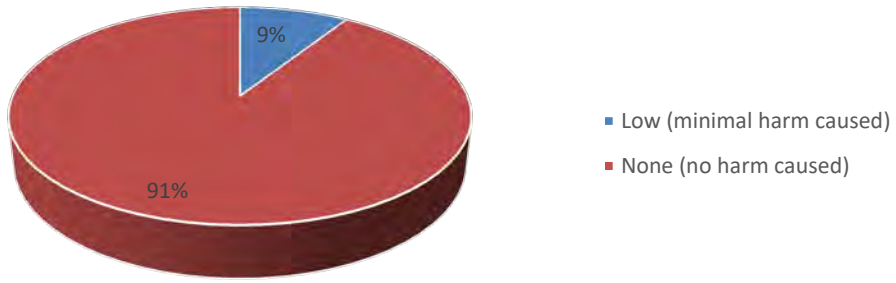
- Learning from datix and incident investigations, including MSNI cases to be incorporated into mandatory training in 2024.
- PSIRF is going live this year. Deadline for trusts: April 2024 to implement. Maternity Governance and Risk team to incorporate into mandatory training and produce some communication for staff. Continue to work with Trust Patient Safety Team to engage in roll out process.
- Reviewing all term admissions (ATAIN cases) with dedicated MDT meeting from 2024 as numbers for review not manageable in weekly CRIG meeting.
- All ATAIN cases reviewed and quarterly audit report presented to MNSCAB and MDT action plan in place.
- All PPHs >1500ml are reviewed at CRIG and actions and learning identified where required.
- Quality improvement project regarding PPH completed, with a change in practice from Oxytocin to Carbetocin for all women undergoing elective or emergency caesarean section under regional anaesthesia, excluding those with pre-eclampsia. Conclusions from audit show:
    - Carbetocin is superior to Oyxtocin in preventing major PPH (60% reduction in PPH rate >1000ml in audited sample)
    - Reduces the need for additional uterotonics
    - Reduces need for blood transfusion.
- Workforce action plan in place to support improved staffing, with focus work on recruitment and retention ongoing. Monthly reporting via MNSCAB.

True North: Quality

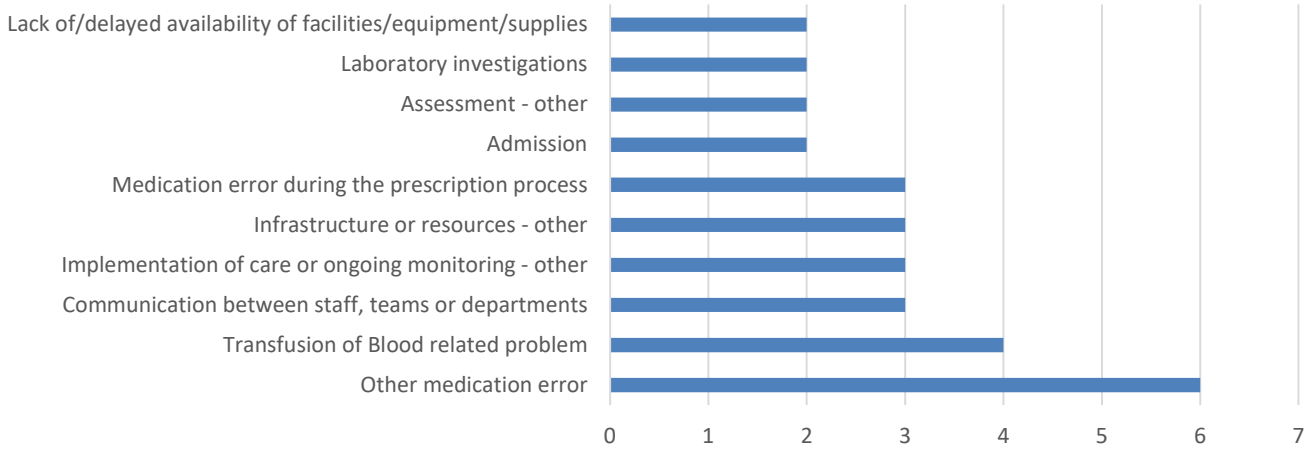
Perinatal Surveillance Tool: Quarterly Report
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight. **Goal:** To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust

NICU Incidents by Severity Q3 2023/24



NICU Incidents by Event Q3 2023/24
(2 or more reported)



Key Messages:

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

Actions and Improvements

- Medicines management team started meeting to address medication errors
- Nursing Governance Lead in Post December 2023.
- Re-establishment of human factors group

Top 3 NICU Incidents by event for Q3 :

- Other Medication error (6)
- Transfusion of blood related problem (4)
- Implementation of care or ongoing monitoring (3)
- Communication between teams/staff/departments (3)
- Infrastructure (3)
- Medication error during prescription process (3)

True North: Quality

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

NHS Medway NHS Foundation Trust

Key Messages:

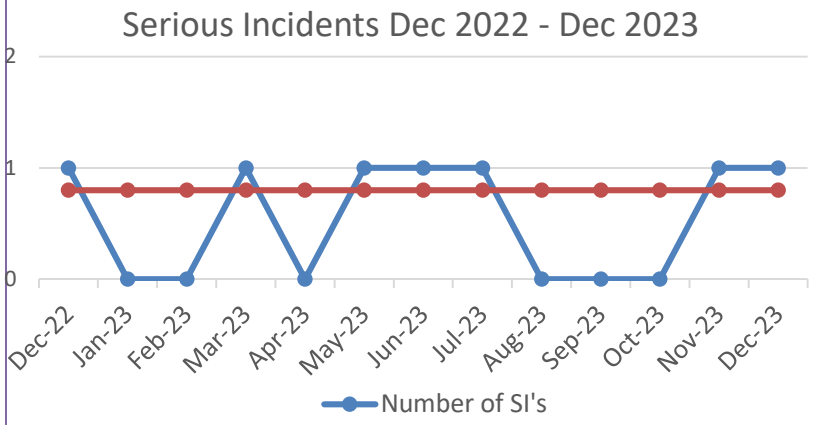
- 2 referrals to MSNI/SIs in Q3
  - Term Baby born in poor condition following an SVD on Delivery Suite
  - Baby born in poor condition following cord prolapse at home.
- 1 MSNI investigation closed in Q3
- 4 Actions from MSNI cases from Q1 and Q2 closed in Q3.

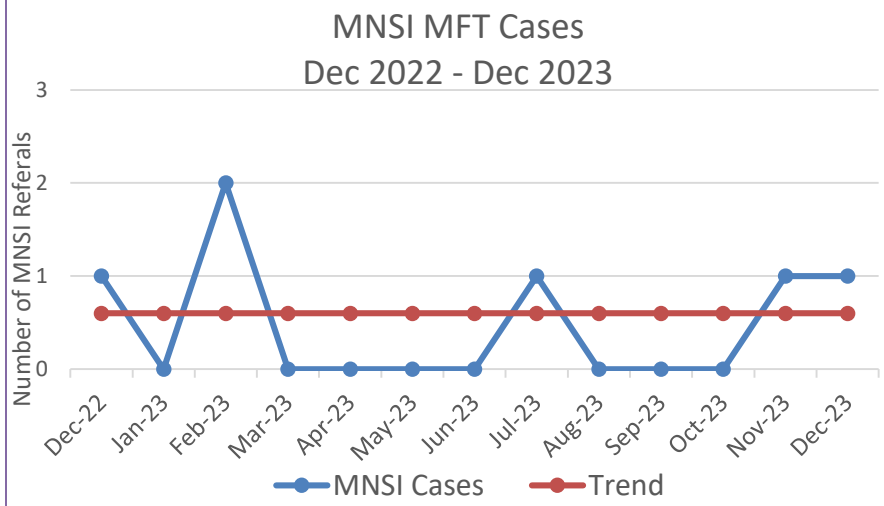
Issues, Concerns & Gaps:.

- Delays with accessing the different systems across the trust. Unable to send MNSI documentation with details of admissions across different departments.

Actions & Improvements:

- Risk team, Delivery Suite coordinators and obstetric triage staff to have access to Trust clinical systems outside maternity in order to be able to access patient records in emergency situations and for incident review.
- Immediate actions and learning from Q3 referrals:
  - No immediate actions from first referral.
  - Referral to SECAMB for reflective discussion with attending crew.
  - Referral to SECAMB legal around management of cord prolapse.
- Completed actions Q3:
  - Fetal monitoring training compliance closely monitored. Currently 100% for midwifery staff.
  - MCU now has dedicated registrar rostered for clinical reviews and on-call registrar responsible for clinical reviews in triage.
  - Antenatal guideline updated to ensure there is a robust BMI pathway.
  - Antenatal guideline aligned to national guidance.





True North: Quality

Perinatal Surveillance Tool Data Dec 2023 – Rapid Reviews (RR) and High Level Investigations (HLI)

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

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

NHS Medway NHS Foundation Trust

Key Messages :

- 99 cases reviewed at MDT CRIG meeting in Q3
- 10 rapid reviews completed in Q3
  - 2 HLI investigations in Q3
    - IUD 36+3
    - 13L PPH
  - 2 MSNI referrals
  - 3 cases for review at PMRT
- 1 HLI closed in Q3
- Coroner inquest scheduled for March 2024 for neonatal death from April 2023.

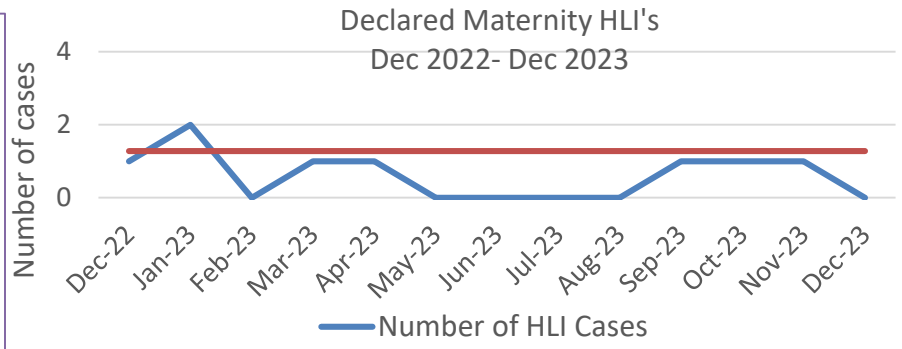
Issues, concerns, gaps:

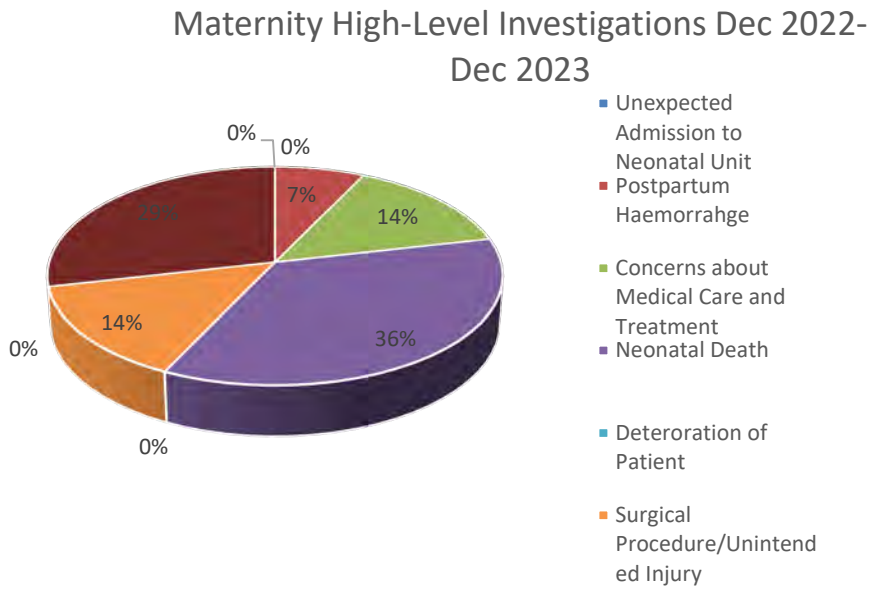
- Sharing actions before submission to SIRG to make sure they are SMART.
- Access to interpreting across the Trust being reviewed at Trust level. Maternity Services engaged in this process.

Actions and improvements

Ongoing actions from closed HLI in Q3. All actions in date and on target for completion.

- Improved skill and understanding in measuring of symphysis-fundal height (SFH), trust guidance and relevant referral pathways.
  - Staff training
  - Additional questions in EuroKing
  - Review clinical guidelines
- Review hypertension in pregnancy guideline
- Review Small for gestational age guideline
- Improved access to interpreting services
  - Engage in Trust-wide work to review interpreting services.
  - Ensure key staff have access to book interpreters and appropriate technology in place to support this.





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

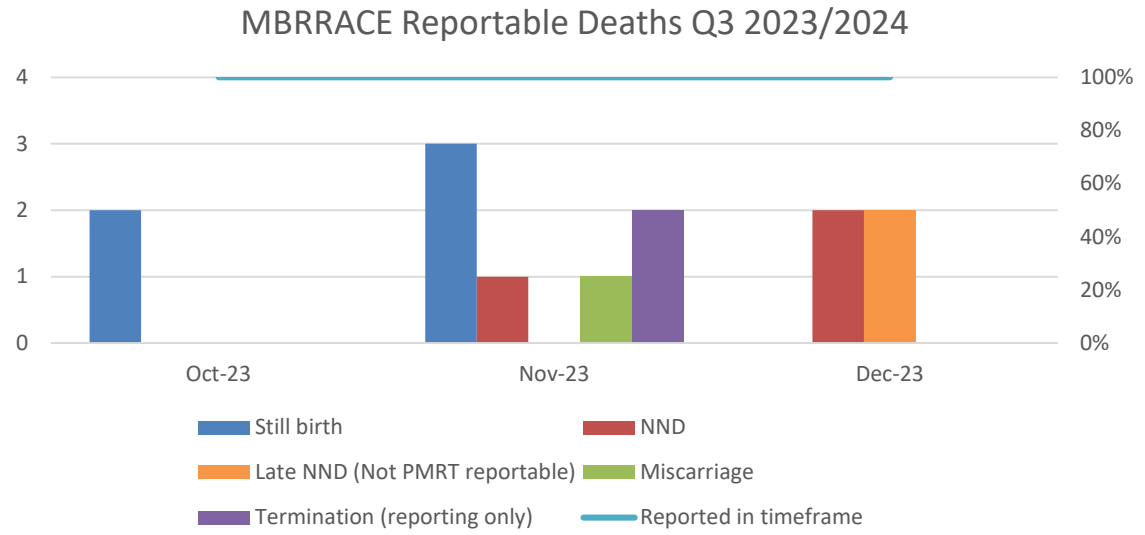
NHS Medway

Key Messages :

- 11 MBRRACE reportable cases in Q3.
- 2 Late Neonatal deaths
- All cases reported within CNST/MBRRACE timeframes
- 10 PMRT reviews completed in Q3. Key concern raised regarding communication.

Issues, Concerns, Gaps:

- Lack of standardised review process for late neonatal deaths.
- Difficulty in disseminating learning from cases widely in real time.
- Difficulty in engaging external medical stakeholders for review meetings
- Communication during antenatal, intrapartum and postnatal period flagged as a concern across a number of PMRT cases in quarter.



Case	Category	Gestation at birth	Initial Findings	Level of investigation	Immediate learning/Actions
1	Stillbirth	36+4/40	Unexplained	PMRT, HLI	Review call the midwife process
2	Stillbirth	39+1/40	Unexplained	PMRT	Care grading AA, no concerns
3	Stillbirth	36+4/40	Unexplained	PMRT	Care grading AA, no concerns
4	Stillbirth	30+0/40	Unexplained	PMRT	PMRT review Feb 2024
5	Stillbirth	40+4/40	Unexplained	PMRT	PMRT review Feb 2024
6	Termination	27/40	Fetal Abnormality	Notification only	N/A
7	Termination	22/40	Oligohydramnios	Notification only	N/A
8	Miscarriage	22+4/40	Triplet 1 following laser treatment	PMRT	Laser treatment at London Trust. Transfer of care to MFT following loss of triplet. PMRT due March 2024
9	Neonatal death	23/40	Prematurity	PMRT	Care graded B,A, A due to communication concerns raised regarding antenatal management
10	Neonatal death	26/40	Placental abruption/prematuirty	PMRT	No immediate care concerns raised. PMRT March 2024.
11	Neonatal death	23/40	Prematurity	PMRT	Born at neighbouring Trust. No immediate care concerns. PMRT March 2024.
12	Late Neonatal Death	40/40	HIE	PMRT, Referral to MSNI from neighbouring Trust	Care grading D, A, A Born at neighbouring Trust following placental abruption. Learning for other Trust regarding management of induction, monitoring of mother and fetal heart in labour.
13	Late Neonatal Death	40+4/40	HIE	PMRT, Referral to MSNI	Learning identified for SECAMB colleagues . Awaiting PMRT. Case referred to coroner.

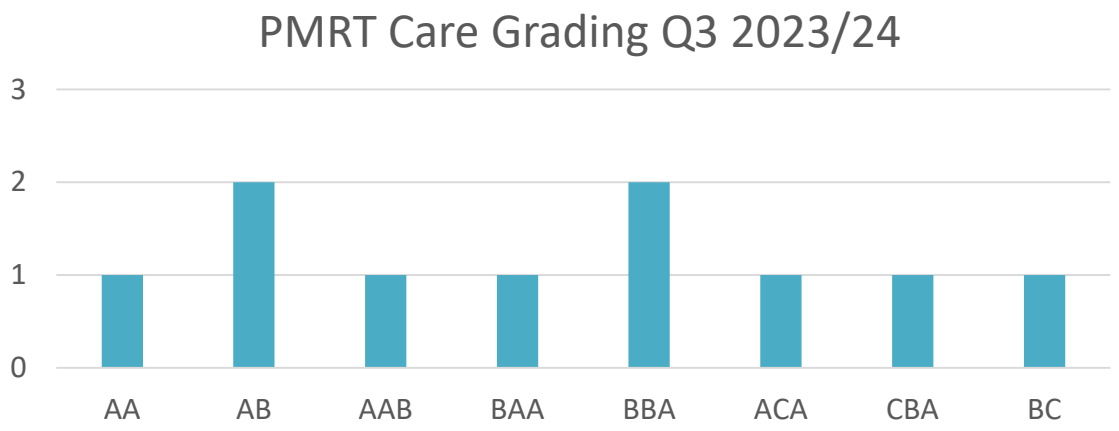
Perinatal Surveillance Tool Q3 2023/24 – Perinatal Mortality Review Tool
Ambition: To ensure Robust, transparent, multidisciplinary and patient centred review of all perinatal losses with external oversight
Goal: To ensure all eligible perinatal losses are reported to the required standard.

Medway NHS Foundation Trust

Actions & Improvements:

- Review and recruit alternative lay members for the group including additional bereaved parents.
- Remind Neonatal Staff to discuss PMRT and provide parents with written information prior to leaving the Neonatal Unit. This is being audited for the next 3 months
- There is continual improvement in the collaborative working between the Maternity and Neonatal Team regarding the PMRT reporting.
- Maintenance of PMRT spreadsheet for yearly themes including both Maternity and Neonatal reviews
- PMRT data to be reported to the wider Trust within all Mortality and Morbidity meetings
- Collation of all PMRT actions from 2023/24 and triangulation of PMRT action plan with Incidents and Service User feedback. To be incorporated into the BAF.
- Engagement with external medical colleagues to support attendance. Maternity PMRT meetings returned to Fridays to support wider attendance.
- Membership of PMRT meetings to be extended to doctors in training to support shared learning and wider dissemination throughout service.
- Following late neonatal death (at 4 months old) agreement between maternity and neonatal teams to use PMRT process to review these cases to promote consistent review, care grading and opportunities for learning for these cases.

Gradings of Care on PMRT Tool
A - The review group concluded that there were no issues with care identified up the point that the baby was born
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby



PMRT Case Reviews Q3 2023/24	Care grading	Reason for grading
1	BBA	Communication between Neonatal Unit and Delivery Suite
2	CBA	Issues for neighbouring Trust
3	AB	Separation of mum and baby following delivery
4	AA	No concerns
5	ACA	Resuscitation issues and no documented care plan
6	AAB	Maternal postnatal issues
7	BAA	Pre-delivery diagnosis not made
8	AB	Communication concerns
9	BC	Communication concerns
10	BBA	Communication concerns

Workforce – training and clinical safe staffing

Perinatal Surveillance Tool Q3 2023/24 – Training

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

Medway NHS Foundation Trust

Key Messages:

- CNST complaint with PROMPT and Fetal Monitoring Training as of 1st December with all groups >90%.
- CNST compliant with NBLS training as of 1st December with all groups >85%. Action plan in place for Neonatal Nursing to achieve >90%.
- Maintaining midwifery compliance across PROMPT and Fetal Monitoring training.
- Midwifery compliance for essential skills 90%

Issues, concerns, gaps:

- Compliance with PROMPT training fallen below 90% for obstetricians & anaesthetists
- Complaint with Fetal Monitoring training fallen below 90% for Consultants and doctors in training.
- Clinical needs prioritised over training resulting in non-attendance.

		MDT PROMPT	
Staff Group	# Active Staff	n	%
Midwives	178	161	90%
MA & MSW	51	47	92%
Theatre Nurses & ODP	30	28	93%
Obs Consultants	22	16	72%
Obs SpR/SHO	34	29	85%
Anaes. Consultants	7	5	75%
Anaes. SpR/SHO	23	19	82%
TOTAL	345	305	75%

Fetal Monitoring Training and Assessment	Compliance
Midwives	100%
Obstetric Consultants	89%
Doctors in training	80%

		Essential Skils	
Staff Group	# Active Staff	n	%
Midwives	178	161	90%
TOTAL	178	305	90%

Actions and improvements

- Insitu SIM programme relaunched in January 2024 with MDT attendance supported.
- SBAR to be included in PROMPT and essential skills.
- Capturing the doctors on their induction
- Ensuring all new starters have completed PROMPT within 3 months of starting
- Education team to flag with Service Manager and General Manager non-attendance by medical team to ensure rebooking. Midwifery non-attendance escalated to senior sister.
- Trajectory in place to achieve >90% by April 2024. All staff have PROMPT allocated to their rota.
- 2 consultants outstanding for Fetal monitoring training – booked for February 2024.
- 4 doctors in training outstanding – all booked onto training.

Perinatal Surveillance Tool Q3 2023/24 – Training

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

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

Medway NHS Foundation Trust

Key Messages:

- Overall compliance for Maternity and Neonatal Staff for mandatory training is 84.42%

Issues, concerns, gaps:

- Maternity and Neonatal staff compliance below Trust target across a number of training requirements.

Actions and improvements

- Mandatory training compliance to form part of appraisal process
- Senior sisters to identify individual staff needs and to roster attendance to support compliance.
- Those with significant lapse in training compliance to have 1:1 review with matrons/clinical supervisor.
- Band 6 research midwife to complete keyworker course in February 2024 to be able to undertake workplace assessments for moving and handling training.

Perinatal Surveillance Tool Q3 2023/24 – Workforce

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

Medway NHS Foundation Trust

Key Messages :

- Midwifery staffing remains a challenge with true vacancy rate increasing across the quarter.
- Long term sick and maternity leave also increased across the quarter.
- NICU nursing establishment increased and diluted Qualified in speciality figures. Currently 65% with action plan in place to achieve >70%.
- Positive midwifery workforce retention rates.

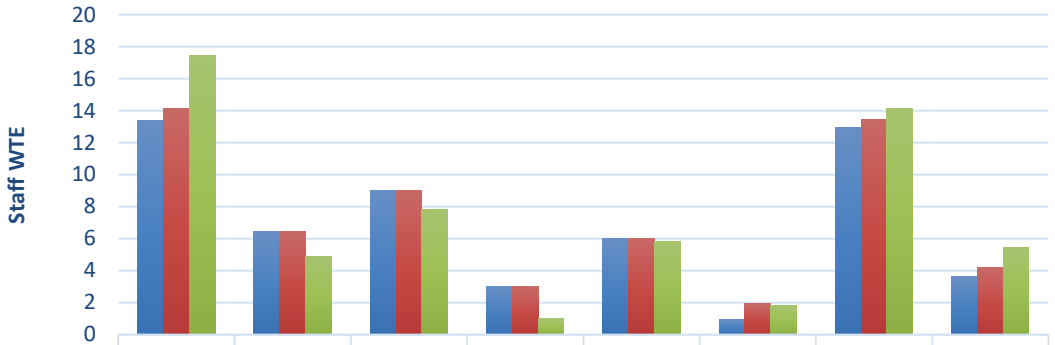
Issues, concerns, gaps:

- External funding for recruitment and retention midwife due to end in May 2024. Ongoing funding not confirmed. DOM escalated to Chief Midwifery Officer for South East.
- NICU workforce <70% QIS.
- Vacancy rate in midwifery staff continues to be a challenge.
- Shortfall in newly qualified midwives due to the impact of the displacement of CCCU students.
- Long-term sickness increased in quarter.

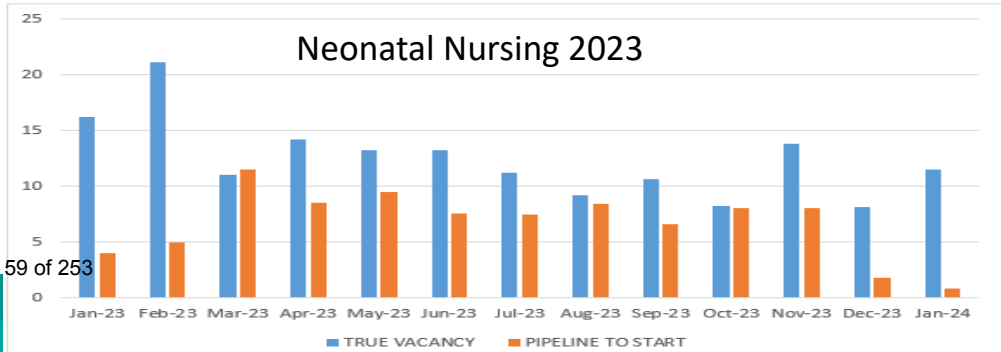
Actions and improvements

- Appropriate oversight and escalation of workforce concerns with Action plan in place.
- Working locally, regionally and internationally to support recruitment.
- Action plan in place for NICU Nursing QIS and Midwifery Workforce.6 due to qualify in September 2024
- Working to support wellbeing of staff to maintain good retention rates.
- Surrey University taken on CCCU students with anticipated graduation date of March 2025.
- Long-term sickness has been managed inline with Trust policy.

Midwifery Staffing Q3 2023/24



	True vacancy	Secondments	Recruited	Start dates agreed	Awaiting employment checks	Leavers	Maternity Leave	Average Long Term Sick across month
Oct-23	13.43	6.44	9	3	6	0.96	12.96	3.61
Nov-23	14.15	6.44	9	3	6	1.96	13.48	4.18
Dec-23	17.45	4.89	7.82	1	5.82	1.8	14.12	5.47



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

Perinatal Surveillance Tool Data Dec 2023 – Service User Feedback

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

Medway NHS Foundation Trust

Key Messages:

- Strong working relationship with Maternity and Neonatal Voices Partnership Lead who provides service user feedback and works to support multiple co-production streams across the service including:
  - Review of complaint responses
  - Review of audits
  - Production and review of virtual tour
  - Production of antenatal education videos for parents.
- Continue to seek ways to improve service user engagement.

Issues, concerns, gaps:

- Gaps identified from service user feedback when care provided across multiple Trusts. Working with colleagues at neighbouring Trusts to ensure improved communication and pathways.
- Ongoing challenges to engage with service users, particularly those from minority groups. Patient Experience and EDI midwife to support ongoing development of service user engagement.

Actions and improvements

- Virtual Unit tour video reviewed and re-shot in response to service user feedback who raised concerns that the previous virtual tour did not reflect the diversity of service users and staff.
- Visiting policy reviewed in direct response to service user feedback and visiting extended to siblings
- MNVP Lead to present formal update at MNSCAB meeting, to include updates on co-production and service user feedback.
- Patient stories to be added to MNSCAB work plan from March 2024.
- Personalised Care and Support Booklets now available in top 5 local languages.
- Patient Experience Midwife and Equality, Diversity and Inclusion Midwife included in business case for 2024 following birth rate plus recommendations.
- Plans for 15 Steps Challenge and "Who's Shoes' challenge in 2024.

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

NHS Medway NHS Foundation Trust

Key Messages:

- SCORE culture survey undertaken in November 2023
- Action plan developed by staff and monitored via BAF and shared with Board Level Safety Champions.
- Monthly Cultural intelligence survey undertaken monthly on Gather in conjunction with Board Level Safety Champion Engagement Sessions.
- Board Level Safety Champion engagement sessions continue providing staff an opportunity to raise concerns or celebrate good practice with Board Level Safety Champion and NED.
- Monthly Team Talks and Staff Forums in place for 2024.
- Appropriate processes in place for staff to raise and escalate concerns, both on shift, with managers and Freedom to Speak Up Guardian.

Issues, concerns, gaps:

- Further work to understand outcomes from quality improvement work and to share these with staff to support morale and readiness for change.
- Staffing shortages remains a concern and is highest risk on risk register. Ongoing workforce action plan in place and monthly review and escalation via MNSCAB.
- Need for improved community connectivity.
- Community premises.
- Concerns raised regarding MCU/Triage Capacity.

Actions and improvements

- 3 Professional Midwifery Advocates undertaken Cultural Coaches training and now have the skills to support and hold cultural conversations in additional to the external sessions. To support with further sessions and implementing actions from SCORE survey.
- Key areas for improvement identified:
    - Improvement readiness and local leadership
    - Burnout climate
    - Team work
    - Safety Climate Domain.
- Plan to conduct local SCORE survey in 6 months time to evaluate progress.
- Digital midwife working with IT to trial dongles
- Community connectivity being addressed to explore hard wiring connectivity and multi-network SIM
- To review contacts and community requirements
- Meeting with community matron to outline need
- MCU/Triage to be next patient first project. Pre-launch work underway and A3 to be held in Feb 2024.
- .

Maternity Risks

NHS Medway NHS Foundation Trust

Patient FIRST

Executive Summary – Risks

Currently 8 risks in maternity and 2 in Neonatology

Two risk with scores 15 to 20 (Maternity)

Highest risk related to midwifery workforce challenges

All mitigations and scores have been reviewed within required timeframes

Maternity Risks

NHS Medway NHS Foundation Trust

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Insufficient Midwifery Staffing impacting the ability to provide patient care.	Insufficient midwifery workforce to meet demand. • Inability to provide 1:1 care in labour. • Avoidable delays in the IOL pathway. • Poor patient experience. • Potential for adverse clinical outcome. • Poor staff morale and burnout. • Inability to implement continuity of carer in line with national directive.	Vacancy remains relatively static at 14 wte vacancy and 15 wte maternity leave. Covering some shifts with RN's rather than RM's.	Staff retention and international recruitment options Risk score has not changed despite recruitment and retention activity 24.1.24 Vacancy unchanged, continue to work with LMNS and locally to attract registrants. Mitigate with Birth Rate Plus PID to increase MSW establishment. PID with DOM for review.	12 (4x3)	20 (5x4)	20 (5x4) ⟺	04 (2x2)
Delays in Induction of Labour	The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff vacancies.	The A3 has been revised. Pilot project to commence 10 July whereby there will be an Induction of Labour pathway Consultant and Midwife Lead to manage IOL pathway in conjunction with Lead Obstetrician. Daily tracking audit.	There has been improvement in the IOL pathway with sustained improvement. Risk score reduced to reflect this Risk score has not changed, Nov has seen increase on No of women on IOL list each day, capacity issues IOL delays continue and are monitored through IOL QI project lead by consultant midwives. Risk assessments in place to ensure no harm.	12 (3x4)	12 (4x3)	12 (4x3) ⟺	04 (2x2)

Maternity Risks

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Potential failure to appropriately risk assess women in the community due to lack of experienced Midwives allocated to work within the community setting.	Due to current staffing concerns within the community setting, B5 and junior/inexperienced midwives are being allocated to work within the community teams. Due to the nature of community work it is difficult to provide close supervision/support to these midwives. Delay in assessment/escalation of clinical situation by junior midwife. Failure to appropriately risk assess women in the community due to lack of experience. Dissatisfaction of the midwife in her role in the community. Increased burden on established midwives within the team.	• Close contact with community team senior sister. • Provision of 'New Starter Pack'. • Supernumerary period of 1-2 weeks. Band 5 Midwives continue to work in the community setting with enhanced support due to high vacancies.	There is a lack of B6 Midwives to allocate to community working, due to high vacancy and maternity rate. Due to current vacancy rate we are not able to allocate B6 midwives to community setting only therefore risk will remain the same score until vacancy rate improves. No change in month. No harm noted. Mitigated through enhanced support.	09 (3x3)	09 (3x3)	09 (3x3) ⟺	06 (2x3)
Community Midwifery Premises	There is a lack of community office space for community midwifery teams which is causing disruption to the maternity provision. There is further risk of loss of premises and financial implications due to a lack of contracts for most of the community midwifery venues	• Working with contracts team to get SLA's in place • Still no hub for All Saints. Saxon Way clinics also being misplaced at end of August 2023. Conversations continue to take please with ICB and Space Utilisation group at MFT.	• Appropriate community space to be found and contracts for venues to be written. • Options being explored with Paul Mullane / CHP for All Saints Hub. Awaiting quote for premises at Lordswood Ongoing discussion with estates lead and GM	09 (3x3)	06 (2x3)	09 (2x3) ⟺	06 (2x3)
Unable to access patient records at community antenatal clinics	Digital connectivity support inadequate to provide safe clinical risk assessment and record keeping. No/limited access to critical clinical information.	• LMNS discussing Midwives being able to access hard wiring internet at all centres.	• Broadband permission or alternative connectivity confirmed for all centres in Phase 1. • Dongles approved and ordered, awaiting delivery. All teams will receive 2 each. • GovRoam tested and working in one centre yesterday. • New Guest WiFi setup created for 2 centres • Awaiting further feedback from users on GovRoam and new Guest WiFi setups • Risk increase on 8.12.23 due to dongles	12 (4x3)	06 (3x2)	09 (3x3) ↑	04 (2x2)

Maternity Risks

NHS Medway NHS Foundation Trust

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Inconsistent and inaccurate data being shared outside the organisation	Poor quality, completeness and availability of maternity data resulting in reduced efficiency and potential reputational damage	• Preventative measures include regular manual review of data, audit and data cleaning • Digital midwife ongoing working with BI to align front and back end system reporting • Weekly checking of data	Data anomalies continue to be an issue Recent meeting with Simon Bailey to highlight issues with data inaccuracies. Working with BI to understand the issue and then correct. Risk score will reduce once we see an improvement in data. Inaccurate data continues to be received by IQPR in January 2024. Manually rectified. Score remains unchanged.	06 (2x3)	06 (2x3)	06 (2x3) ⟺ ⟺	04 (2x2)
Movement of staff to support acuity on Delivery Suite creates red flags in other areas	Due to staffing shortfalls and high acuity Senior Sisters, community midwives and specialist midwives are being either redeployed or moved from their own roles to cover the deficit. This impacts negatively effective clinical leadership and clinical oversight of the maternity unit. Community midwives are working over the working time directive and staff morale is low.	The movement of staff across the unit has reduced following the implementation of the new on-call roster. However with the high vacancy and maternity factor score remains the same.	Staff retention and recruitment options Staff movement remains and supported with area orientation packs. No harm or incidents noted. Risk mitigated through orientation. No harm noted. Will remain until vacancy reduced.	09 (3x3)	06 (3x2)	06 (3x2) ⟺	04 (2x2)
Risk of harm to maternity staff whilst lone working	A proportion of maternity staff spends some or all of their working hours working alone. This creates risk when working in community hubs and when visiting families. They could be subject to violence and aggression and if taken unwell there is no-one else to alert or observe.	Lone worker devices Provide staff with conflict resolution training Provide staff with mobile phones Arrangements for maintaining contact at home births	Not every community midwife has a lone worker device Once all staff receive all lone worker devices risk will be closed.	04 (2x2)	04 (2x2)	04 (2x2)	04 (2x2)

Maternity Risks – awaiting DMB approval

Medway NHS Foundation Trust

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Delivery suite birthing beds in state of disrepair, inability to source parts may result in patient harm	5 birthing beds on the delivery suite are > 10 years old and in a state of disrepair. Potential of being unable to repair or obtain parts if required. Potential harm to patient if beds dysfunctioned.	• An equipment bid has been submitted to the Trust medical devices group. • Delivery beds are currently being serviced to highlight any existing issues. • Monitoring of any adverse outcomes or patient harm in relation to bed mechanics dysfunctioning	- Lack of funding to purchase replacement	12 (3x4)	New risk	12 (3x4) ⟺	02 (2x1)
Maternity Information System coming to end of contract	Euroking contract end date is 03 December 2025.	• Discussions with LMNS and Trust IT Directors re sourcing alternative system. • Scoping to be reviewed	PID being drafted – no change to risk score in month. Reviewed with CDO, Increase in risk score, waiting for capital budget to be confirmed in 24/25 to procure new system.	10 (5x2)	New risk	15 (5x2) ↑	04 (2x2)

NICU Risks

Risks

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Lack of available space in NICU for equipment storage	Equipment which is being used regularly in NICU is being stored in: 1. Corridors - equipment is covered and stored in corridors which pose an IPC and health and safety risk. 2. Bedroom 3 - equipment is currently stored in bedroom 3, meaning that a parent is unable to stay on site. Not meeting GIRFT recommendations. 3. NICU seminar room and impacting on team meetings and social distancing.	1. Store equipment in isolation room. 2. Cease using the NNU seminar room for meetings or staff breaks while clean equipment is in. 3. Equipment in corridors being covered. 4. Reduced NICU capacity is managed through network referrals and cot closure.	• Equipment stored in seminar has been section off, with the use of screens. Funding now approved for renovations of the seminar room to start – • 29/09/2023 Awaiting start date for the works to start • 26/10/2023 Weekly planning meetings arranged- to commence 27/10/2023. provisional start date for works is January 2024 • 17/11/23 Weekly planning meetings continue - Asbestos survey completed, Architect visit arranged. Storage cupboard clearance commenced. Provisional start date remains Jan 2024 • 15/12/2023 – Concerns flagged with electrical supply. May delay start of works. Weekly update meetings continue • 15/01/2024 – Works out to tender, Store rooms in seminar room cleared. Seminar room meetings cancelled in preparation for work.	9 (3x3)	8 (4X2) ⟷	8 (4x2)	04 (2x2)
Inability to provide nasogastric tube feeding for NICU graduates in the community setting	Currently we do not have the infrastructure and resources to enable short term NGT feeding at home as recommended by GIRFT. Inability to meet GIRFT standards. Increased LOS in hospital. Impact on patient flow in NICU.	This care is provided to babies as inpatients. Parents are supported to provide this care to their baby while they remain in hospital. Additional nurses added to NOAH work force to prepare for expansion in community role.	Guidelines are currently being written, plans for 'virtual wards' are underway NGT feeding at home / Virtual ward will commence on 29/01/2024	09 (3x3)	09 (3x3) ⟷	09 (3x3)	03 (3x1)

NHS
Medway
NHS Foundation Trust

Safeguarding Performance Report

Data through to December 2023

Patient
FIRST

SIOR - Safeguarding

Successful Deliverables

- Increase in compliance for safeguarding adult level 3 midwifery compliance
- All KPI's Met for Maternity Safeguarding this month
- Hospital Staff are now notifying maternity safeguarding team via email of known families with safeguarding involvement upon attendance

Next Steps

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

Identified Challenges

- Supervision for non-CP case holder compliance is low at present
- Ongoing difficulties with staff following the DNA pathway

Next Steps

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

Opportunities

- Implementation of antenatal toxicology testing

Next Steps

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

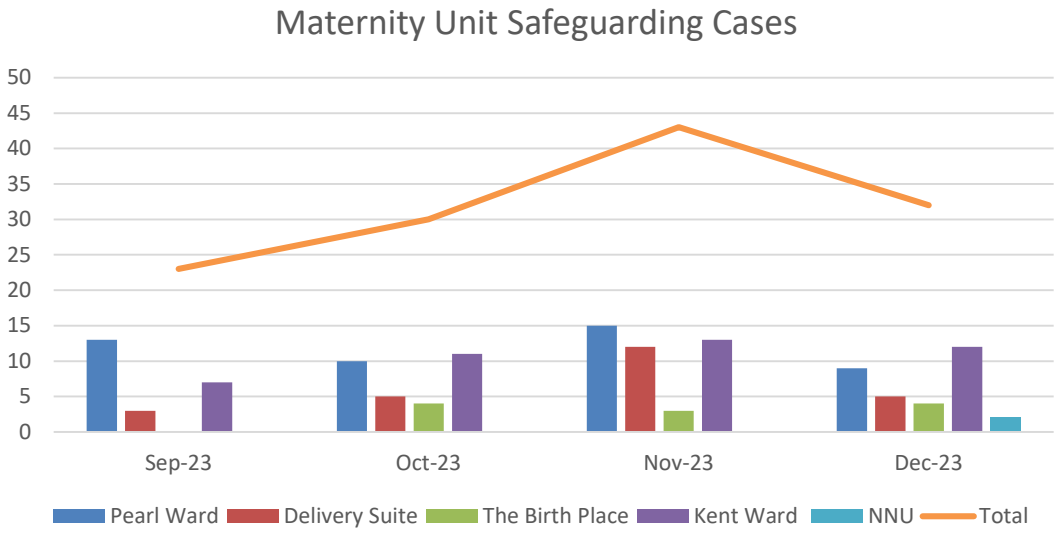
Risks

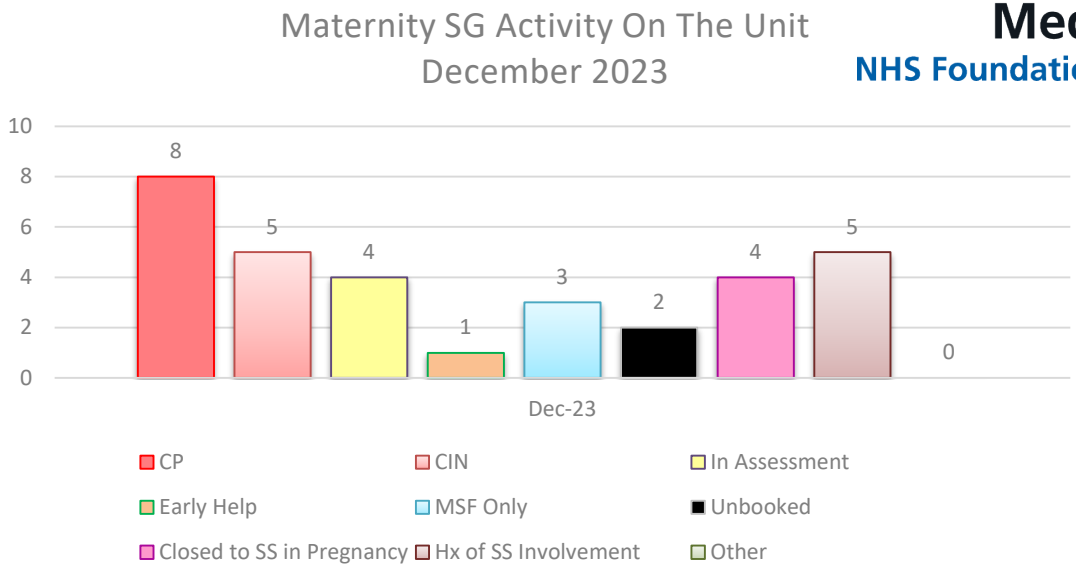
- Maternity staff are currently non-compliant for Adult Level 3 Safeguarding training

Next Steps

- Information has been sent to all staff to complete the Adults Level 3 Safeguarding training as a priority , full day face to face training now added to ESR
- Incentive opportunity shared with all Senior Sisters who reach 100% compliance first to keep up momentum of staff booking onto training
- Monthly compliance update sent to all Senior Sisters/ Matrons/ Head of Maternity for continued oversight and review

Safeguarding Related Incidents/ Activity – Maternity Unit





Key Messages:

- Maternity Safeguarding had oversight of 32 services users on the maternity wards in December.
- There has been 2 service users that have presented for care Unbooked
- 2 service users have absconded from the unit, one was antenatally with cannula remaining in situ and the second was postnatally with the baby
- There has been a total of 9 Pre Discharge Planning meeting facilitated
- Maternity Safeguarding has supported the neonatal unit with 2 babies under CP plans

Issues, Concerns & Gaps:

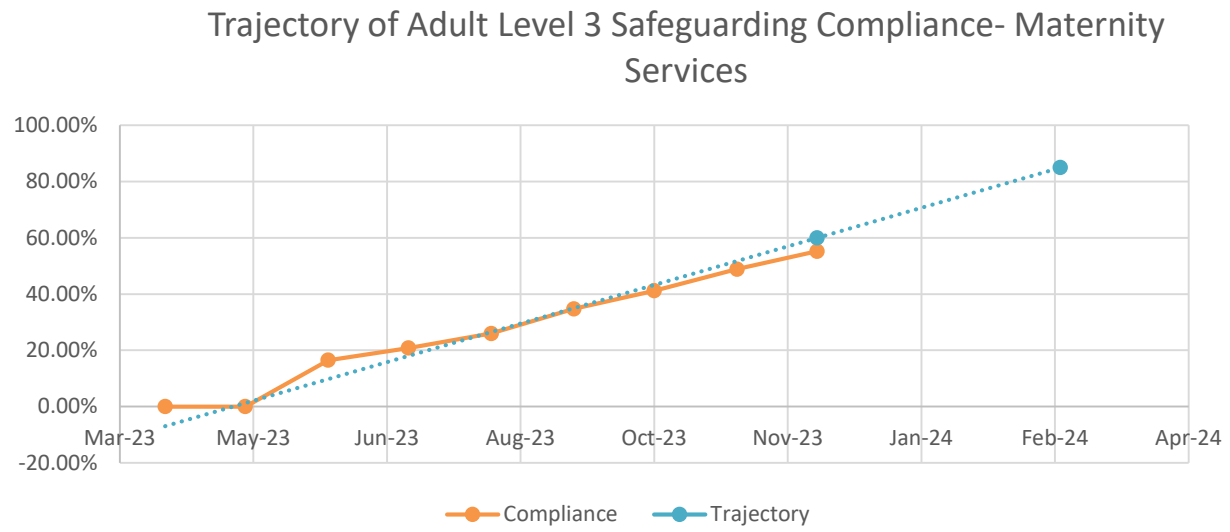
- Despite the increased security measures on the wards , 2 service users were able to abscond from the ward both with history or current safeguarding concerns
- There has been delays in pre discharge planning meetings being held due to social workers not following hospital processes- This is causing delays in discharge and bed blocking
- Maternity staff continue to not follow Unbooked/concealed pregnancy policy which is causing delays in safeguarding input

Actions & Improvements:

- Incidences of absconding patients have been datixed, follow up wellbeing checks completed, and appropriately escalated to ward managers and maternity safeguarding team. Ward Managers to review datix's and identify areas of improvement to reduce this risk in future
- Meeting arranged between Named Midwife for Safeguarding and leads in both Kent and Medway Social care to review pre discharge planning processes
- Unbooked Pregnancy guideline to be reviewed and increased communications of management to be shared with all staff

Safeguarding Training

Medway NHS Foundation Trust



Key Messages:

- Compliance for Adult Level 3 Safeguarding Training is increasing in maternity, however is below the expected trajectory for December 2023.
- Trajectory for compliance in maternity is for 60% compliance by December and 85% or above by March 2024

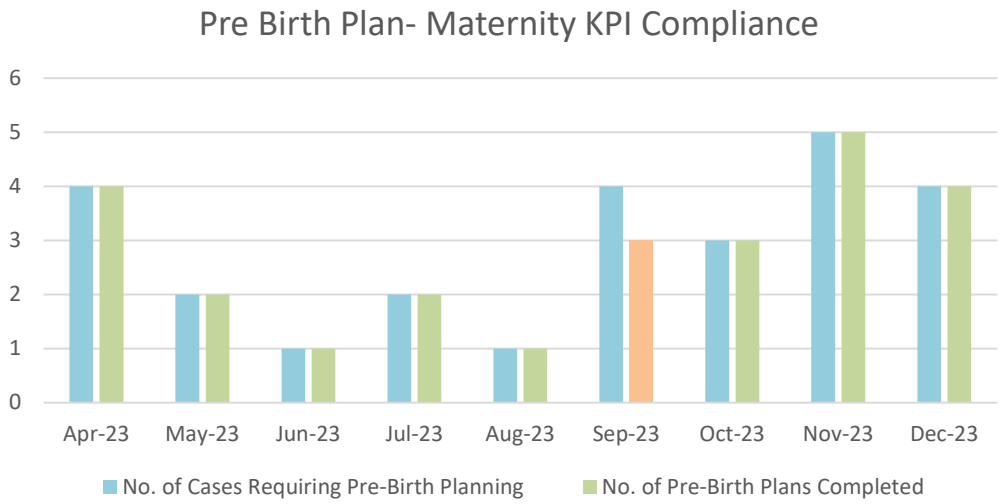
Issues, Concerns & Gaps:

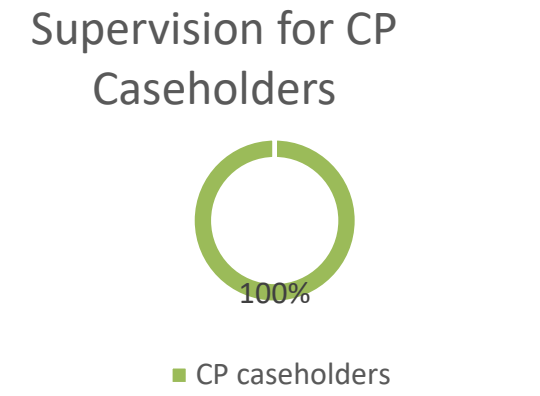
- High demand of staff requiring training but limited sessions to book onto due to Safeguarding Team capacity and staff not attending booked sessions

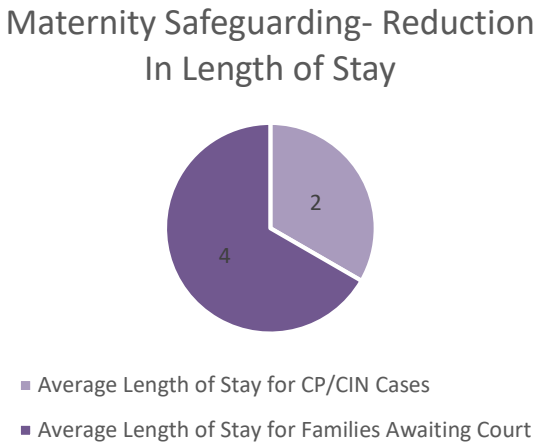
Actions & Improvements:

- Adults level 3 training : full day sessions are now being offered and have been added to ESR until March 2024. Once the session is completed staff will be compliant in Level 3 Adult Safeguarding, Prevent, Learning Disabilities and Mental Capacity training
- All Midwives and Doctors have been emailed and encouraged to book directly via ESR
- Ward managers/Senior sisters are being notified of staff that have booked but not attended training to manage on a 1:1 basis
- Monthly email updates sent to all Maternity Senior Sisters , Matrons , Head of Midwifery with current compliance, trajectory and list of staff who are and are not compliant

Safeguarding KPI Scorecard







Maternity Safeguarding KPI's include:

- 100% Pre Birth Planning for CP cases
- 100% Supervision for CP cases
- Reduction in Length of Stay for Safeguarding cases

Key Messages:

- We have achieved all KPI's in December 2023
- Reduction of length of stay remains an ongoing effort and relies on multi- agency working. Recent increased length of stay noted due to working with out of area local authorities where improved collaborative working is required. Meeting arranged with local authorities to streamline process.
- The data for Reduction of Length of Stay is from the 2021 audit completed. This is due for a re-audit at the end of 2023

NHS Medway NHS Foundation Trust

NICU Safeguarding Update

Data through to December 2023

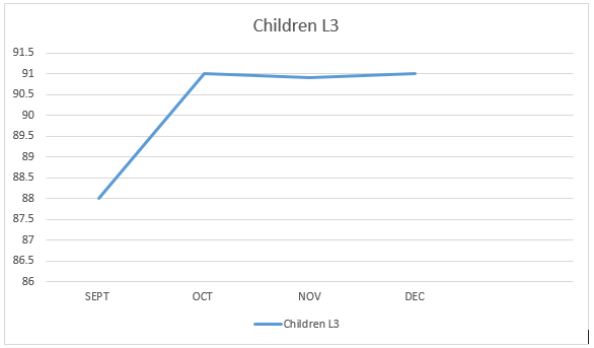
Patient FIRST

SIOR - Patients

Successful Deliverables

- 4 inpatients with safeguarding concerns (DEC)
- Safe guarding Level 3 staff statman compliance 90.91%
- Changed NIC handover –

online copy saved to ensure safeguarding is not missed



Next Steps

SG L3 compliance:
Sept 88%
Oct 91.01%
Nov 90.91%
Dec 90.91%

Identified Challenges

- Staff chased to ensure compliance – Deadlines sets
- Improved communication between NICUs within the Network is required to ensure seamless transfers of care
- To improve communication between Out of Area Hospitals/Outreach Teams
- NIC handover of SG concerns

Next Steps

- Reinstated the use of SHARED forms across MIC and NICU to prompt information sharing re: safeguarding and mental health issues
- Work with BadgerNet Leads to move all NICU Safeguarding documentation to BadgerNet so it will be paperless, and will then be more visual to all NICU staff for information sharing
- Online handover sheet to be created, safety netting handover process

Opportunities

- Staff compliance remains >90%
- New staff supported to complete mandatory training during their supernumery induction period
- Weekly meetings are face to face, ensuring positive information sharing
- Add safeguarding documentation to BadgerNet

Next Steps

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

Risks

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

Next Steps

- Ensure additional training opportunities – ensure new staff complete training during induction period
- Introduce a step by step flow chart for MIC to use when a mum has a history of drug miss use
- Transfer all safeguarding documentation on BadgerNet EPR
- Online handover sheet created – now in use

Perinatal Surveillance Next Steps

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

Meeting of the Board of Directors in Public
Wednesday, 06 March 2024

Title of Report	Finance Report – Month 9		**Agenda Item**	5.3
Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Matthew Chapman, Head of Financial Management Mark Pordage, Associate Director Income and Contracts Isla Fraser, Financial Controller			
Lead Executive Director	Alan Davies – Chief Finance Officer			
Executive Summary	a) The Trust reports a £32.6m deficit YTD, this being £20.2m adverse to the plan. b) Efficiency delivery to date total £8.8m with a further £0.9m of cost avoidance schemes; the total efficiency delivery reporting £9.8m YTD this being £9.0m adverse to plan. c) The capital position is underspent by £9.8m due to delays in progress across the main major projects including CDC, endoscopy, diagnostic equipment replacement and fire. d) Cash is £12.8m adverse to plan, this is £0.8m increase on the November cash balance.			
Proposal and/or key recommendation:	This report is provided for assurance			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	✓	Approval	
	Noting	✓	Discussion	
Committee/Group submitted:	25.01.24 - Finance, Performance and Planning Committee			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	Non-delivery of the breakeven control total			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			

Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	Achieving breakeven is a statutory duty		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alan Davies Job Title: Chief Finance Officer Email: Alan.Davies13@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance	X	There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Finance report

For the period ending 31 December 2023

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(798)	(2,548)	(1,750)	The Trust is reporting a £2.5m deficit for December, the overall position is a £32.6m deficit YTD, this being £20.2m adverse to plan. The main deficit variance to budget is due to overspending on medical staff (£13.6m), and nursing staff (£5.6m) as well as the unfound efficiencies to date (£9.0m); this is partially offset by the phasing of Central reserves into the position. £7.6m of the medical staff adverse variance relates to non-operational issues including industrial action £2.5m, unidentified stretch efficiency target £4.1m and pay award under funding £1.1m. The in-month deficit run-rate has improved by £1.2m; this is mainly due to £2.5m of additional funding for industrial action (£1.5m), winter pressures (£0.4m) and capital charges funding of (£1.2m, this being an in-month increase of £0.5m as month 8 included £0.7m). These benefits are partially offset by increased costs of £1.2m, caused by industrial action (£0.2m), winter pressures (£0.2m), credit loss provision (£0.3m) and estate maintenance (£0.3m). A revised forecast of £35.6m was agreed in November by the Executive Team and in discussion with the Integrated Care Board (ICB), although the system is tasked by NHSE with further improvement. The efficiency programme and further mitigations identified continue to be prioritised with a view to delivering the revised forecast.
Donated Asset Depreciation	22	26	4	
In-month total	**(776)**	**(2,522)**	**(1,746)**	
YTD total (adjusted)	**(12,384)**	**(32,608)**	**(20,224)**	

Efficiencies Programme				
In-month	2,744	1,536	(1,208)	The delivered efficiency programme totals £1.5m for December, this being £0.5m more than November; the increase relates to £0.3m MRI income and £0.2m patient flow at Amherst Court. The position is £9.0m adverse to plan YTD as some schemes have not delivered as expected; in addition to this further schemes to meet the stretch target have not been fully identified.
YTD	18,765	9,766	(8,999)	

1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	27,523	14,759	(12,764)	The Trust cash balance at 31 December was £14.8m; this is a £0.8m increase on November cash balance but still £12.8m less than plan due to the continued unplanned revenue deficits. All agreed PDC of £11.4m has been drawn to date, however only £4m has been spent against this sum. A Further £2-3m of PDC is expected to be drawn before year end, mainly for EPR. The M9 cash balance therefore includes £7.4m of capital funds which are yet to be spent over the remaining quarter. Pushing these suppliers/contracts to 30 day terms should allow the Trust to manage without emergency cash borrowing for the remainder of the year. However, borrowing will be required in April 2024 onwards unless contract payment profiles can be realigned with commissioners, which would push borrowing back to later in the year.
Capital				
In-month	2,886	884	(2,002)	The capital programme is currently 28% complete / £9.8m (55%) behind the year to date plan. This relates to the same projects previously highlighted (MRI, Gamma, CDC, Endoscopy) for which total slippage at year end is expected to be £4.2m. This will be offset by the over commitment agreed in the original plan (£0.2m), the prior year 'hangover' (£0.2m) Q3 approved slippage plan (£2.9m) and Ruby ward forecast overspend (£0.7m). Other key risks to the delivery of the plan are: - £1.2m MOU for EPR PDC funding has been confirmed but not yet been issued by NHSE - £2.3m Endoscopy PDC cannot be drawn in 23/24 as the project is not going ahead. An agreement with NHSE will be required to defer funding until 24/25 or utilise for other purposes. As the slippage has not yet been formally declared to NHSE due to options around mobile units being considered, the forecast is still currently to draw and spend the funding. - CDC project forecast assumes £1.8m of vesting will be possible.
YTD	17,987	8,235	(9,752)	
Annual Forecast	29,399	29,399	0	
Of which				
System Capital	13,423	13,423	0	
Donations	86	86	0	
PDC Capital	15,890	15,890	0	

2. Income and expenditure

£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	30,282	33,387	3,104	272,534	278,569	6,035
High cost drugs	2,030	2,457	427	18,271	19,867	1,595
Other income	2,255	3,140	885	20,297	24,875	4,578
Donated Asset Adjustment	-	39	39	-	80	80
Total income	**34,567**	**39,022**	**4,455**	**311,103**	**323,390**	**12,288**
Nursing	(9,448)	(10,192)	(745)	(84,149)	(89,791)	(5,642)
Medical	(6,517)	(8,073)	(1,556)	(61,056)	(74,650)	(13,594)
Other	(5,867)	(6,734)	(867)	(54,670)	(59,968)	(5,298)
Total pay	**(21,831)**	**(24,999)**	**(3,168)**	**(199,875)**	**(224,409)**	**(24,534)**
Clinical supplies	(3,770)	(5,588)	(1,819)	(35,817)	(42,379)	(6,562)
Drugs	(855)	(1,077)	(221)	(7,947)	(9,881)	(1,934)
High cost drugs	(2,041)	(2,318)	(277)	(18,372)	(19,864)	(1,492)
Other	(4,744)	(5,448)	(704)	(42,566)	(40,502)	2,064
Total non-pay	**(11,411)**	**(14,432)**	**(3,021)**	**(104,702)**	**(112,626)**	**(7,924)**
EBITDA	**1,325**	**(409)**	**(1,734)**	**6,525**	**(13,645)**	**(20,170)**
Depreciation	(1,508)	(1,504)	4	(13,571)	(13,733)	(162)
Donated asset adjustment	(22)	(26)	(4)	(199)	(116)	83
Net finance income/(cost)	96	80	(16)	863	1,078	216
PDC dividend	(689)	(689)	-	(6,201)	(6,493)	(292)
Gain/Loss on Disposal	-	-	-	-	19	19
Non-operating exp.	**(2,123)**	**(2,139)**	**(16)**	**(19,108)**	**(19,244)**	**(136)**
Reported surplus/(deficit)	**(798)**	**(2,548)**	**(1,750)**	**(12,583)**	**(32,889)**	**(20,306)**
Adj. to control total	**22**	**26**	**4**	**199**	**281**	**82**
Control total	**(776)**	**(2,522)**	**(1,746)**	**(12,384)**	**(32,608)**	**(20,224)**

1. The YTD clinical income reported position includes the full value of ERF funding and Community Diagnostics Centre (CDC) income; ERF activity is achieving planned levels. Due to medical staff industrial action the forecast of over performance is at risk for the remainder of the year.
2. The associated cost to the independent sector and additional consultant sessions to deliver this additional elective activity is £4.7m YTD, in-month increase £0.7m.
3. Other income YTD favourable variance includes catering income £0.2m, Ockenden funding £0.3m, international nurse recruitment £0.6m, high cost devices £0.9m and medical education £3.1m; this is offset by an under recovery for virtual wards income of £0.2m.
4. Pay adverse variance £24.5m YTD includes £4.0m efficiency stretch target, £6.3m unfunded cost pressures, £2.2m vacancy factor negative reserve, £2.5m industrial action costs and £4.6m unidentified efficiencies included specifically in the Medicine and Emergency Care division. The remaining variance of £4.9m includes £1.2m enhanced care costs, continued overspending driven by premium costs for temporary staff due to activity pressures, mainly in emergency care, and escalation capacity, as well as temporary staff cover for rota gaps from vacant posts and staff absences.
5. In-month total pay costs have increased by £0.1m since month 8, mainly due to the previous month improvement from the £0.2m release of additional sessions accruals, there are also £0.2m of medical industrial action in-month costs and a £0.1m reduction to agency staff spend.
6. To date, a benefit of £3.9m of the ERF non-pay reserve is offsetting some of the adverse variances from overspending and non-delivery of efficiencies.
7. The drugs adverse variance YTD includes £0.9m of costs being offset in the Other Income category.
8. Clinical supplies adverse variance includes £5.1m efficiency stretch target, £0.6m Amherst beds offset with income, £0.1m virtual wards, £0.2m medical equipment maintenance, and £0.4m theatre supplies. Other non-pay includes favourable variance from reserves held centrally, with £5.4m offsetting some of the unfound efficiencies.

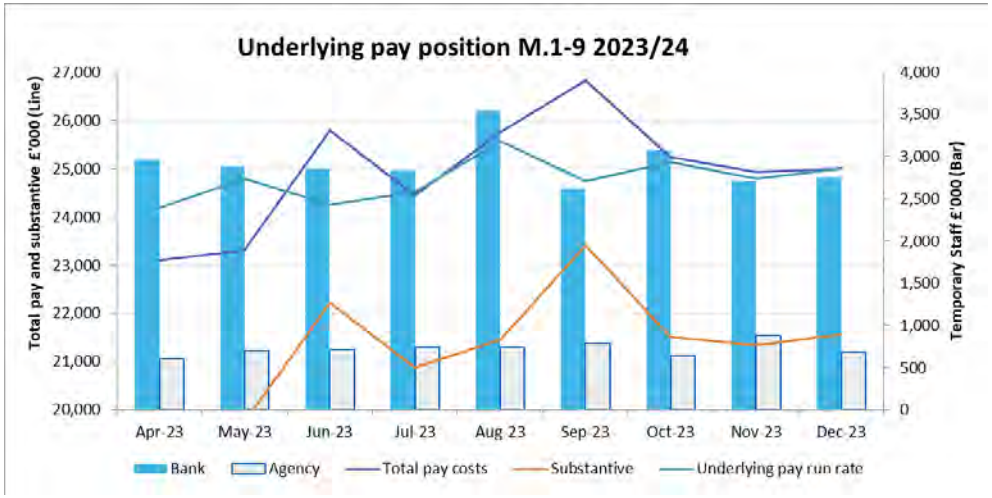
3. Trust level reconciliation of actual position to forecast

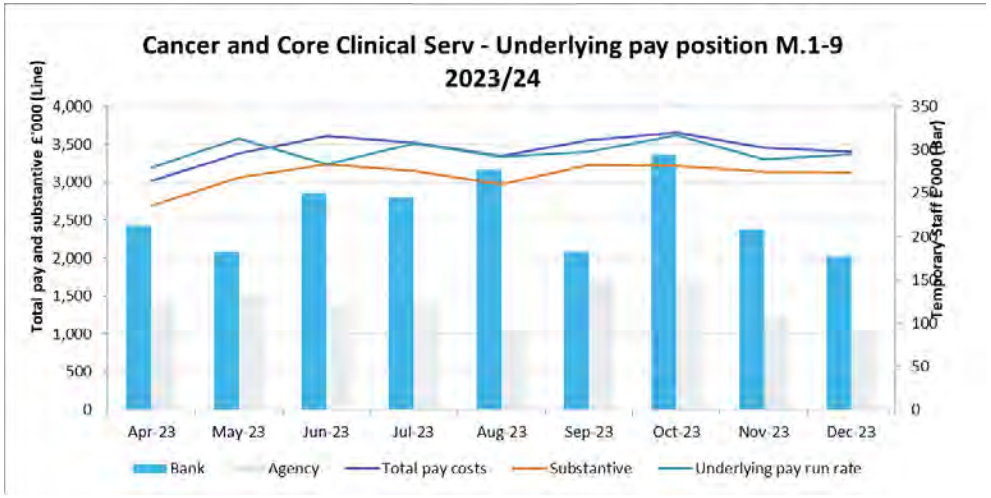
The forecast position approved by the Executive Team is an overall deficit for the year of £35.6m; this was presented at the November committee. The profiled deficit for December was £2.6m, which has been achieved, however this is mainly due to additional funding sources that were not known when the forecast was compiled. There is a risk if the current level of spend continues and mitigations are not realised, the Trust will not reach the £35.6m; this is under review using the actual results from December, along with including the impact of the additional financial controls and the KMPG conclusions from their report.

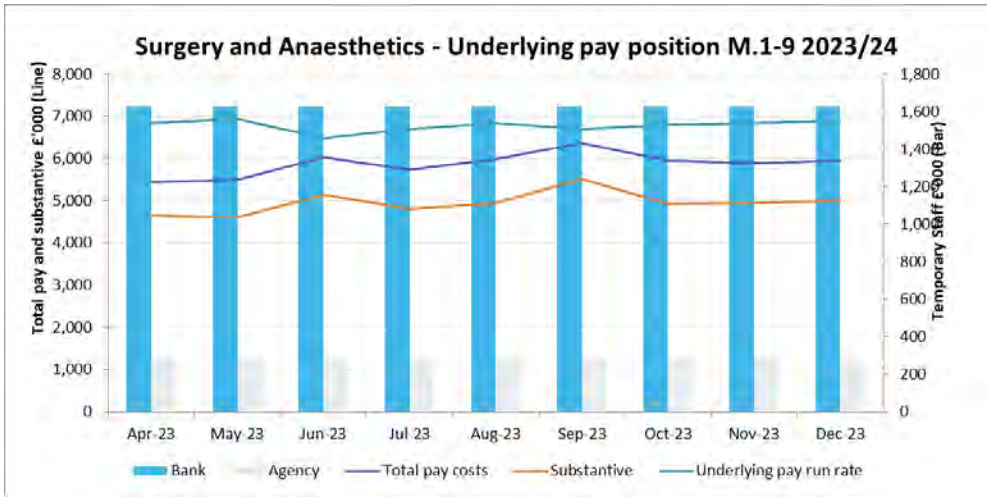
	In-month			
£m	Income £m	Expend £m	Net £m	Reasons for movement from forecast
Actual month 9 deficit	39.0	(41.6)	(2.6)	Reported position month 9
Forecast as at month 7	36.1	(38.7)	(2.6)	Profiled forecast for month 9 included within the £35.6m forecast outturn deficit
Favourable movement	**2.9**	**(2.9)**	**0.0**	**Overall in-month forecast position was achieved**
Represented by:				
Industrial action funding	1.5	0.0	1.5	Not assumed in forecast
Capital charges funding	0.9	0.0	0.9	£1.2m benefit in month less £0.3m assumed in forecast
Amhurst beds	0.6	(0.6)	0.0	Actual
Smoking cessation funding	0.1	0.0	0.1	Not assumed in forecast
Winter pressures	0.4	0.0	0.4	Winter pressure funding, staff costs increased by £0.1m due to the winter plan.
ERF forecast	(0.3)	0.0	(0.3)	Over delivery not achieved.
ERF improvement	(0.2)	0.0	(0.2)	Not included in the position (counting & capture benefits)
Cost of industrial action	0.0	(0.2)	(0.2)	Not assumed in forecast
Surgery & Anaesthetics	0.1	(0.8)	(0.7)	Industrial action costs £0.1m, medical substantive staff recruitment £0.1m with no reduction to temporary staff, increased nursing bank cost £0.1m mainly ICU, estimated ERF costs to deliver activity higher than forecast £0.3m, audiology non-pay £0.1m (matched by income), purchase of stock in theatres £0.1m.
Medicine & Emergency Care	0.1	(1.0)	(0.9)	Increased escalation capacity £0.1m, approved winter plan £0.1m, industrial action £0.2m, substantive medical recruitment £0.1m, efficiencies not as forecast (LOS) £0.3m,gastro waiting lists costs £0.1m, high cost devices £0.1m matched with income.
Cancer & Core Clinical Services	0.0	0.2	0.2	Lower cost of covering vacancies in Radiology and Pharmacy.
Women, Children & Younger People	0.0	(0.2)	(0.2)	Increase in drugs and clinical supplies driven by activity.
Corporate Services	0.1	(0.1)	(0.0)	Recovery support funding £0.1m, increased costs of work permits & e-allocate.
Estates & Faciltities	0.0	(0.3)	(0.3)	Estates maintenance £0.1m, other non-pay pressures for postage, taxis, linen, arriva bus contract.
Other / Central Adjustments	(0.2)	0.1	(0.1)	Credit loss provision mivement, plus smaller movements in central reserves.
Total	**2.9**	**(2.9)**	**0.0**	

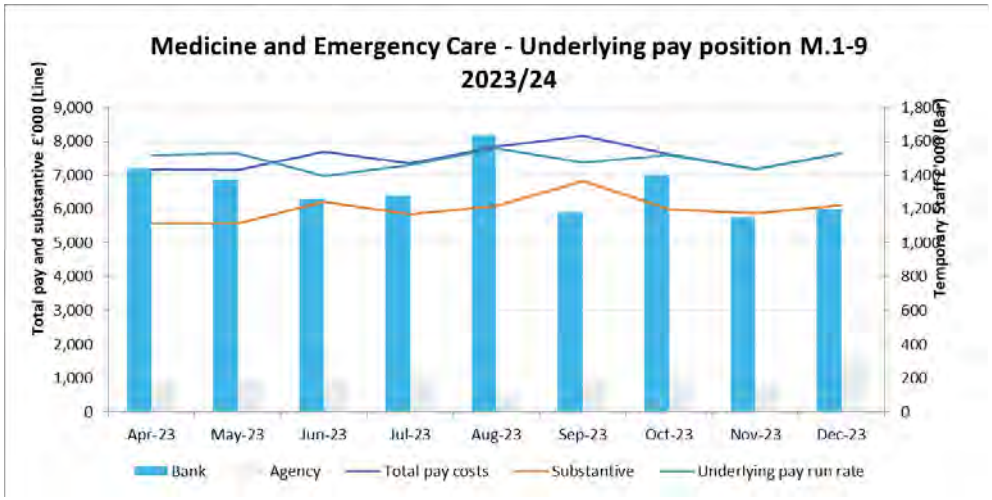
4. Pay

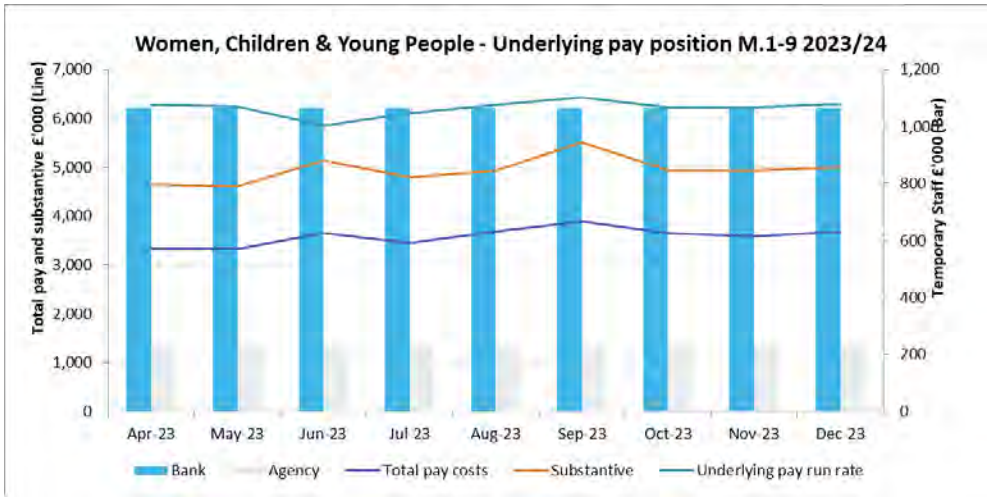
Pay is overspent by £24.5m YTD and is the leading cause of the Trust's adverse financial performance. Medical and nursing pay accounts for £19.2m of the overspend with a further £5.3m within the remaining other staff category. The charts below present the underlying pay position by division after removing non-recurrent items and phasing the back dated pay awards over the months to which the costs relate. The overall underlying pay position has remained relatively flat, but not at the reduced level required to deliver the forecast outturn.

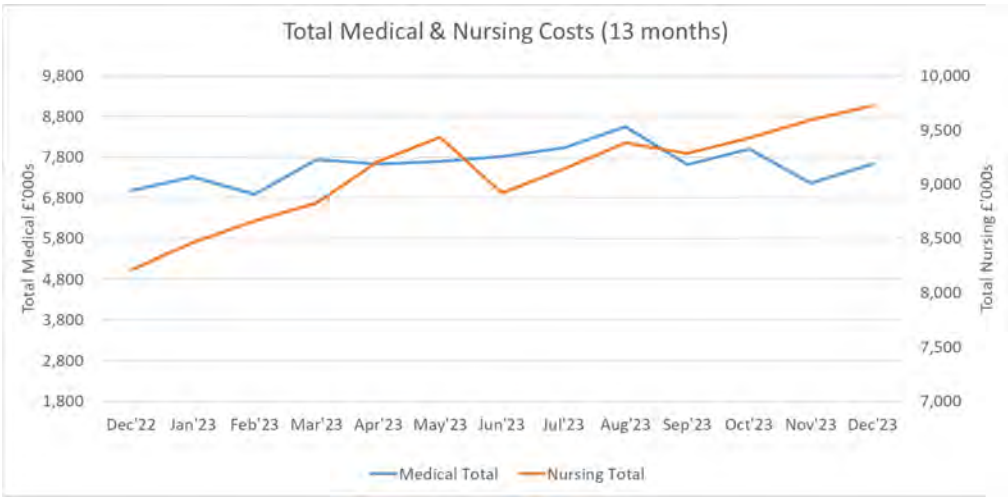












The key drivers of the deficit pay position along with the counter measures remain unchanged from month 7.

Drivers (summarised):

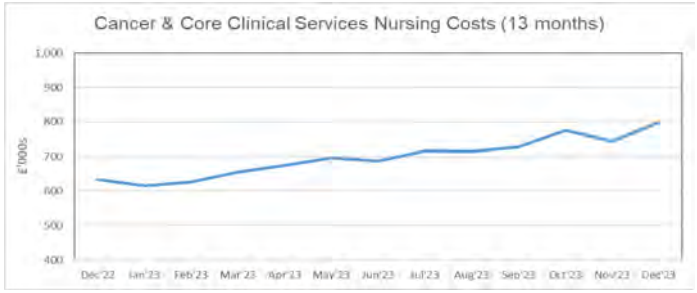
- Industrial action (£2.5m)
- Patient acuity/escalation (c.£2.0m)
- Medical pay award (£1.0m): gap between actual cost and funding uplift.
- Vacancies, rota gaps and backfill of vacant clinical posts, difficult-to-recruit positions, supernumerary nursing cover with a growing workforce.
- ERF / activity,
- Efficiencies (£4.3m): shortfall in delivery against the phased operating plan.

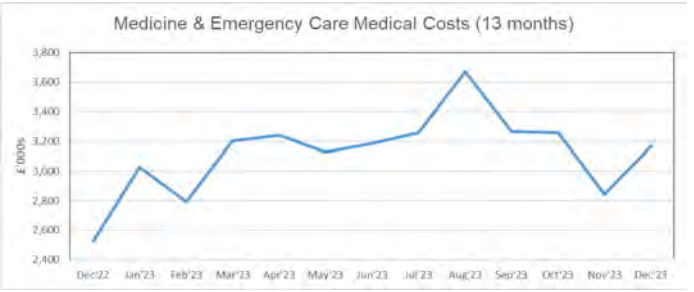
Counter measures (summarised)

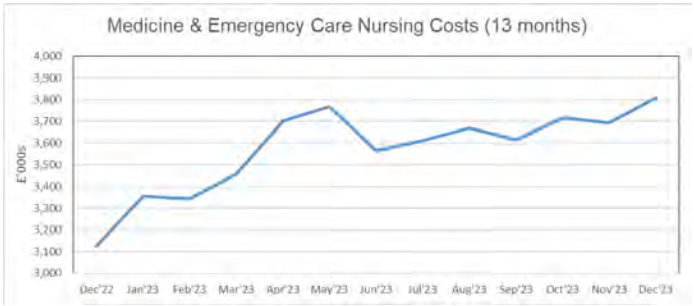
- Development of SHOs to registrar posts, consultation conclusion and implementation of GIM rota as well as new junior doctor block rota Implemented.
- Sickness absence management.
- Finalisation of job planning for 2024/25 will be completed by Q4, reduction in use of additional sessions to cover job plan, annual leave and on call.
- Options appraisal of a new medical rota systems
- Demand and capacity planning to completed in November and alignment with job plan
- Demand driven escalation capacity being managed through corporate projects
- Patients are assessed using a new enhanced care assessment tool. The assessment is now approved by the Divisional directors of nursing as additional control

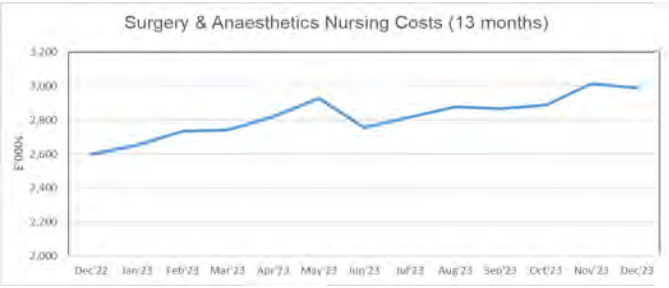
After phasing the backdated pay award over the financial year, the trend chart above shows medical staffing costs have remained the same in December as they were in April, the in-month increase is due to industrial action and the previous month including the non-recurrent benefit of £0.2m due to the release of an additional session accrual. Consistent to last month, nursing costs have increased by 6% in December from April from escalation capacity, enhanced care and activity pressures.

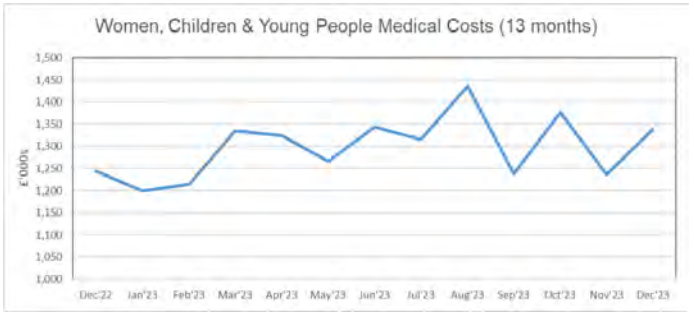
The following charts present the 13 month view of medical and nursing costs within the four clinical divisions.

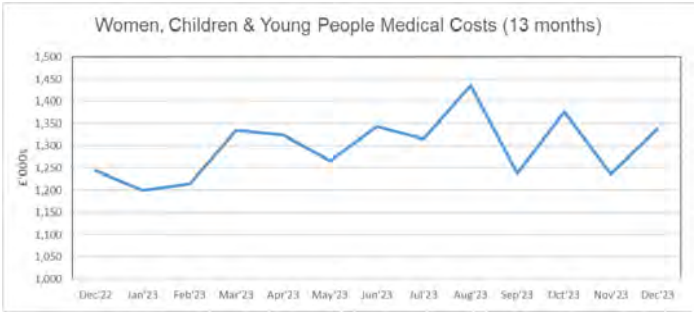












5. Clinical Income

Clinical Income by Commissioner	In Month Movement			YTD Month 09		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
NHS Kent and Medway ICB						
Fixed Income	20,586	20,586	-	179,859	179,859	-
ERF - Variable Income	5,132	5,132	-	50,225	50,225	-
Non-ERF Variable Income	2,181	2,273	92	21,011	21,854	843
Sub-Total	**27,899**	**27,991**	**92**	**251,095**	**251,938**	**843**
NHS England						
Fixed Income	3,203	3,203	-	28,924	28,924	-
ERF - Variable Income	442	442	-	3,881	3,881	-
Non-ERF Variable Income	254	666	412	2,291	3,314	1,024
Sub-Total	**3,900**	**4,312**	**412**	**35,096**	**36,120**	**1,024**
Other Contracted ICBs						
Fixed Income	113	113	-	990	990	-
ERF - Variable Income	53	53	-	491	491	-
Non-ERF Variable Income	14	14	(0)	145	143	(2)
Sub-Total	**181**	**181**	**(0)**	**1,627**	**1,624**	**(2)**
Non-Contracted K&M ICB	-	3,010	3,010	-	4,644	4,644
Non-Contracted ICB (LVA)	193	193	(0)	1,738	1,734	(4)
Other…	140	157	17	1,250	2,375	1,125
Grand Total	**32,313**	**35,843**	**3,531**	**290,806**	**298,436**	**7,630**

The table outlines clinical income for the Trust split by NHS contracted and non-contracted services as at month 9. The variance to plan YTD equates to £7.6m favourable. A summary of the key drivers are provided below:

- All ERF variable income is currently set to plan. Agreement of the final ERF targets with all commissioners is now complete. This accounts for the various changes introduced during the year to compensate for the impact of the industrial action and tariff changes published. A full YTD and retrospective adjustment will be applied in the next month's report to coincide with the local ICB and NHSE Regional decision to move forecasts at Month 10. A summary of the YTD actual ERF achievement is included in section 5a and includes the expected forecast achievement for the year.
- NHS Kent and Medway ICB is over-performing by £0.8m YTD which relates to High Cost Tariff excluded Devices (Insulin Pumps) and matches overspends in expenditure.
- High Cost Drugs are above plan (over-performance £1.6m YTD) which is mostly recoverable from NHSE as these costs are on a pass-through basis for Specialised Commissioning and offsets expenditure. HCDs are fixed with the ICB and is overspent YTD by £0.8m causing a cost pressure for the Trust, however the block HCDs within the NHSE contract is underspent by circa £0.7m and so marginally offsets the ICB cost pressure.
- Non-Contracted income from Kent & Medway ICB has a positive variance YTD for funding that was not planned at the beginning of the year, this relates to in-year allocations for Sheppey Frailty Unit (£0.5m), Capital Charges support (£2.0m), Winter Schemes (£0.4m), funding for the reinstated Diabetic Foot service (£0.3m) and national funding support for costs associated with the various Industrial Actions YTD (£1.5m).
- Contracts with the ICB and NHSE are expected to be signed shortly; the delay is due to the changes to ERF guidance and the need to calculate and agree the movement between the fixed and variable elements of the contracts. The final agreed values have been adjusted and reported in the Month 9 report.

5a. Elective Recovery Fund (ERF)

The Trust ERF over-achievement YTD is currently a small financial opportunity to the financial position of £0.043m, the full year forecast is expected to over-perform by £1.985m. Elective performance has been maintained during December and has resulted in a further improvement in ERF performance and for the first time this year is overachieving against the adjusted stretch target set. The forecast year end over-achievement has deteriorated by £0.5m due to a delay to the opening of the CDC mobile endoscopy capacity previously expected to be operating from January 2024, this may adversely impact delivery of the re-forecast £35.6m deficit submission (although the costs to run the unit are equally not being incurred) but has not been factored in to date.

	YTD ACTUAL PERIOD										FORECAST PERIOD			
Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Jan	Feb	Mar	FY Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adjusted Plan	**5,565**	**6,161**	**5,913**	**6,042**	**6,078**	**6,136**	**6,173**	**6,393**	**5,562**	**54,023**	**5,617**	**5,753**	**6,022**	**71,414**
Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Jan	Feb	Mar	FY Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Actual / Forecast	**4,802**	**5,903**	**6,142**	**6,029**	**6,163**	**6,081**	**6,264**	**6,942**	**5,769**	**54,095**	**6,047**	**6,122**	**6,122**	**72,386**
Re-Forecast Adjustments														
Additional Counting and Capture									0		395	420	467	**1,282**
NHSE and LVA ERF Zero Clawback	-27	-68	-108	23	-85	-40	-80	-29	385	-29	-116	-60	-62	**-268**
Adjusted Forecast Actual	**4,775**	**5,834**	**6,034**	**6,052**	**6,077**	**6,042**	**6,183**	**6,913**	**6,154**	**54,065**	**6,326**	**6,482**	**6,527**	**73,400**
Variance to Revised Plan	**-790**	**-327**	**121**	**10**	**0**	**-94**	**10**	**521**	**592**	**43**	**709**	**729**	**505**	**1,985**
% Achievement of Plan	*85.8%*	*94.7%*	*102.0%*	*100.2%*	*100.0%*	*98.5%*	*100.2%*	*108.1%*	*110.6%*	***100.1%***	*112.6%*	*112.7%*	*108.4%*	***102.8%***
2019/20 Baseline	4,920	5,317	5,979	5,410	5,249	5,298	5,296	5,822	4,679	**47,972**	5,408	5,926	5,701	**65,006**
Variance to Baseline	**-145**	**518**	**55**	**642**	**828**	**743**	**887**	**1,091**	**1,475**	**6,094**	**919**	**555**	**826**	**8,393**
% Variance to Baseline	*97.0%*	*109.7%*	*100.9%*	*111.9%*	*115.8%*	*114.0%*	*116.7%*	*118.7%*	*131.5%*	***112.7%***	*117.0%*	*109.4%*	*114.5%*	**112.9%**
Impact of Industrial Action	-640	0	-202	-937	-380	-227	-351	0	-314	**-3,051**	-366			**-3,417**

- National ERF guidance changes have been included for 2.3% Pay Award Uplift and accounts for both the Agenda for Change Pay Award (1.6%), the Medical Staffing Pay Award (0.7%) and a 4% ERF Target reduction for the various industrial actions impacted from April to October (which reduces the annual target by 4% in total, profiled equally across the year).
- Industrial action impact accounts for the previous action in April, June, July, August, September and October and an estimate for the future industrial action in December and January has been assumed in the forecast.
- Based on the Counting and Capture review completed to date, it is estimated that this will improve ERF performance by circa £1.2m which will include activity reported and backdated to April 2023. This is increasingly becoming a financial risk to the ERF forecast due to a lack of progress in implementing the changes to recording of the activity which is needed to realise the financial benefit in 2023/24; a Programme Board has now been established to oversee and monitor the changes and report on progress.
- The ERF forecast includes an adjustment for NHSE and Low Value Activity (LVA) due to the expected removal of clawback in H2 for under-achievement and that the NHSE Health & Justice contract and LVA will not be subject to variable payments for ERF.

6. Efficiency programme

Status £'000	Blue	Green	Amber	Red	Sub-total	Cross Cutting	Sub-total Identified	Over / (un-) identified	Plan Target	Cost reductions	Total Efficiencies
Planned care	88	1,358	0	0	1,446	3,471	4,917	(886)	5,803	276	5,193
UIC	0	150	0	0	150	4,330	4,480	(1,091)	5,571	3,535	8,015
E&F	251	1,420	0	0	1,671	0	1,671	396	1,275	0	1,671
Corporate	6	142	0	0	147	394	542	(809)	1,351	0	542
Central	0	555	0	0	555	3,000	3,555	3,555	0	0	3,555
Sub-total	**346**	**3,624**	**0**	**0**	**3,970**	**11,195**	**15,165**	**1,165**	**14,000**	**3,811**	**18,976**
Unidentified	0	0	0	0	0	0	0	(13,000)	13,000	0	0
Total	**346**	**3,624**	**0**	**0**	**3,970**	**11,195**	**15,165**	**(11,835)**	**27,000**	**3,811**	**18,976**
Month 8 position	*346*	*3,522*	*0*	*0*	*3,868*	*11,381*	*15,249*	*(11,751)*	*27,000*	*2,693*	*17,942*
Movement in-month	***0***	***102***	***0***	***0***	***102***	***(186)***	***(83)***	***(83)***	**0**	***1,118***	***1,034***

Cross cutting schemes BRAG status

Status £'000	Blue	Green	Amber	Red	Sub-total
Total	231	11,418	154	-	**11,804**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	2,744	1,536	(1,208)	18,765	9,766	(8,999)	27,000	15,701	(11,299)

Process

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

The delivered efficiency programme position for the year to date is £9.8m; this includes £6.6m from the cross cutting schemes, mainly for procurement £0.7m, clinical productivity in theatres £1.2m, patient flow length of stay reduction £0.7m, medical job planning £0.4m, interest received £0.2m, medicines management £0.7m, reduced staff sickness £0.3m and elective work efficiencies £2.3m. The total of identified "cash out" schemes remains at £15.2m, these are budgets being reduced to that value, with a further £3.8m of run-rate improvements in the form of cost reductions/avoidance or income generation.
The efficiency programme continues to be prioritised by the Executive Team along with support from the project management office (PMO). There are regular check & challenge meetings where all schemes are addressed or discussed in more detail with divisions, with specific feedback and actions requested as well as finalising of PIDs to be presented at the panel.

7. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
273,519	**Non-current assets**	**267,804**	**(5,715)**
6,375	Inventory	6,664	289
29,119	Trade and other receivables	27,550	(1,569)
34,742	Cash	14.759	(19,983)
70,206	**Current assets**	**48,973**	**(21,263)**
(953)	Borrowings	(312)	641
(50,315)	Trade and other payables	(44,201)	5,114
(1,320)	Other liabilities	(1,735)	(415)
(52,557)	**Current liabilities**	**(44,248)**	**5,340**
(1,952)	Borrowings	(1,781)	171
(1,031)	Other liabilities	(1,018)	13
(2,983)	**Non-current liabilities**	**(2,799)**	**184**
288,185	**Net assets employed**	**266,730**	**(21,455)**
475,198	Public dividend capital	486,632	11,434
(251,419)	Retained earnings	(284,308)	(32,889)
64,406	Revaluation reserve	64,406	0
288,185	**Total taxpayers' equity**	**266,730**	**(21,455)**

Key messages:

1. Non-current assets are £5.7m lower than year end, being the net impact of investment expenditure of £8.2m, £13.8m depreciation and £0.2m impairment.

2. In month 9 the Trust has net current assets of £4.8m; this is due to the impact of the cash management plan which has involved the drawdown of all PDC, reciprocal payments only to NHS creditors and pushing all creditors to the BPPC limit without contingency days.

3. Trade and other receivables are £27.6m (80% of average monthly income). Work is underway to recover debts as quickly as possible to aid the cash position, however there are a number of large longstanding disputes within the balance which will also involve settling creditor debt once finalised.

4. Cash has decreased by £20.0m since the start of the financial year due to the Trust deficit of £32.9m, partially offset by the drawdown of £11.4m PDC. An enhanced cash management plan has been implemented to ensure that borrowing is not required until FY 2024/25. Any borrowing from DHSC will be made via PDC, need approval from NHSE and will be at a cost of 3.5% p.a. interest.

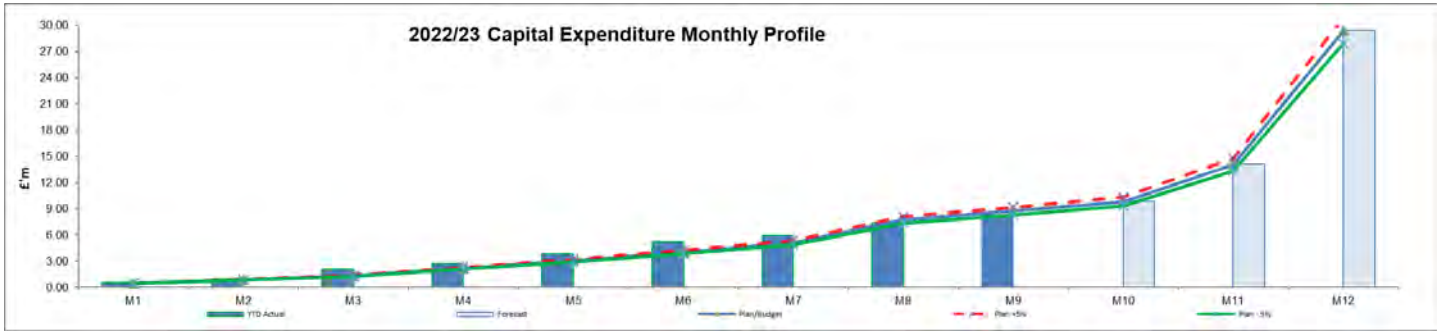
5. Trade and other payables are £44.2m (128% of average monthly expenditure). This balance has increased in line with the cash management plan but is still lower than the balance at 2022/23 year end as this included the pay award accrual.

6. Public Dividend Capital has increased by £11.4m, which relates to capital project funding for the CDC, Endoscopy, and Ruby. These funds are issued to the trust at PDC dividend borrowing rate of 3.5% so will therefore result in an additional £400k revenue cost, in part funded by NHSE.

8. 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	471	264	1,860	2,015	155	2,480	2,480	2,510	30	2,510	0	0
Routine Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire	104	39	(65)	938	510	(428)	972	1,251	1,250	(1)	1,250	0	0
Medical and Surgical Equipment Programme	406	99	(307)	3,653	656	(2,997)	5,150	4,871	3,971	(900)	3,971	0	0
IT	90	126	36	410	463	53	1,362	480	600	120	600	0	0
Service Developments	32	26	(6)	288	294	6	2,451	384	412	28	412	0	0
Total System Capital	**839**	**761**	**(78)**	**7,149**	**3,938**	**(3,211)**	**12,415**	**9,466**	**8,743**	**(723)**	**8,743**	**0**	**0**
IT - EPR	167	(47)	(214)	1,500	2,267	767	1,200	2,705	2,585	(120)	680	1,905	0
IT - PACS/RIS/IREFER	13	30	17	118	200	82	0	186	197	11	93	104	0
Endoscopy	377	21	(356)	3,394	501	(2,893)	2,300	4,525	2,300	(2,225)	0	2,300	0
CDC	547	(9)	(556)	4,923	977	(3,946)	6,564	8,622	7,780	(842)	1,008	7,614	0
Total Planned Additional Capital	**1,104**	**(5)**	**(1,109)**	**9,935**	**3,945**	**(5,990)**	**10,064**	**16,038**	**12,862**	**(3,176)**	**1,781**	**11,923**	**0**
Total Planned Capital	**1,943**	**756**	**(1,187)**	**17,084**	**7,883**	**(9,201)**	**22,479**	**25,504**	**21,605**	**(3,899)**	**10,524**	**11,923**	**0**
Cardio Village	1,000	44	(956)	1,000	112	(888)	0	3,854	4,580	726	1,126	3,854	0
IT- Paeds Adoption	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Hub	0	0	0	0	0	0	0	0	0	0	0	0	0
Cyber	7	0	(7)	7	0	(7)	83	83	83	0	0	83	0
RAAC	3	0	(3)	3	0	(3)	30	30	30	0	0	30	0
Donated Equipment - LOF	0	0	0	86	86	0	0	86	86	0	0	0	86
Total Additional Capex	**1,009**	**44**	**(965)**	**1,095**	**198**	**(897)**	**113**	**4,053**	**4,779**	**726**	**1,126**	**3,967**	**86**
Unplanned Expenditure*	0	37	37	0	209	209	0	0	212	212	212		
Approved Slippage schemes	0	47	47	0	51	51	0	2,927	2,907	(20)	2,907		
Total Capex	**2,952**	**884**	**(2,068)**	**18,179**	**8,341**	**(9,838)**	**22,592**	**32,484**	**29,503**	**(2,981)**	**14,769**	**15,890**	**86**
Slippage Target	(66)	0	66	(192)	(106)	86	0	(3,085)	(104)	2,981	(1,346)		
Total Capex	**2,886**	**884**	**(2,002)**	**17,987**	**8,235**	**(9,752)**	**22,592**	**29,399**	**29,399**	**0**	**13,423**	**15,890**	**86**



9. Capital (continued)

YTD Capital is £9,752k behind plan, mainly due to the following;

Project	YTD Budget £'000	YTD Actual £'000	YTD Var. £'000	23/24 Budget £'000	23/24 Fcst £'000	23/24 Var. £'000	23/24 Var. %	Narrative	Funded by
Endoscopy	169	0	(1,669)	2,225	0	(2,225)	(100%)	No change from M8 report Slippage is funding a plan of additional schemes approved in Q3.	Internal Funds
Endoscopy	1,725	501	(1,224)	2,300	501	(1,799) reported to NHSE as 0	(78%) reported to NHSE as 0%	No change from M8 report Slippage is not forecast internally as funding has not yet been drawn	PDC
CDC	4,923	977	(3,946)	8,622	7,780	(842) reported to NHSE as 0	(10%) reported to NHSE as 0%	After a full review overall the project is forecast to cost £3.8m more than the available funding for which a bid has been submitted to NHSE. However in 2023/24 the project is expected to underspend by £0.9m and the only way to defer that funding is for The Trust to utilise this on other projects and internally fund at the same level in 2024/25. This will therefore fund the increased costs of Ruby ward.	PDC
Gamma Camera	1,500	35	(1,465)	2,000	2,000	0	0%	No change from M8 report	£1m prior year system capital / current year internal funds
MRI Enabling	1,350	69	(1,281)	1,800	1,000	(800)	(44%)	No change from M8 report. Slippage is funding a plan of additional schemes approved in Q3.	Prior year PDC/current year internal funds
CR replacements	375	223	(150)	500	400	(100)	(20%)	No change from M8 report Slippage offsets original plan over commitment	Prior year PDC/current year internal funds
Fire urgency works	928	510	(428)	1,251	1,251	0	0%	No change from M8 report	Internal funds
Sub-total	**12,470**	**2,315**	**(10,155)**	**18,698**	**12,932**	**(5,766)** reported as **(2,125)**	**(31%)** reported as **(11%)**		

9. Capital (continued)

The following are overspent YTD or in forecast outturn

Project	YTD Budget £'000	YTD Actual £'000	YTD Var. £'000	2023/24 Budget £'000	2023/24 Forecast £'000	2023/24 Var. £'000	Var. %	Narrative	Funded by
Ruby Ward (Cardio Village)	1,000	95	(905)	3,854	4,580	726	19%	Separate report presented to Trust Executive 16/01/2024. To be funded from CDC PDC slippage	PDC
Courtyard lifts	1,110	1,291	181	1,480	1,480	0	0%	Previously forecast to overspend, costs brought back to budget.	Internal Funds
Harvey Ward	375	429	54	500	600	100	20%	Project will complete before 31st March but over budget due to additional requirements from service.	Internal Funds
EPR	1,500	2,267	767	2,705	2,585	120	4%	MOU yet to be receipted but previous documentation suggests funding will be £505k more than originally planned. £120k will be underspent to offset overspend expected on Teletracking as below	Internal Funds & £1,905k PDC
Teletracking	75	190	115	100	220	120	120%	Increased project management costs not factored in original case.	Internal Funds
PACS/RIS/Irefer	118	200	82	186	197	11	6%	MOU issued for an additional £28k of funding. Project ahead as ICB invoiced in advance for the year.	Internal Funds & £108k PDC
Unplanned Projects	0	208	179	0	212	212	100%	This overspend primarily relates to the Laundry ironer approved in March form 22/23 slippage, increased costs in relation to VAT and other issues.	Internal Funds
Sub-total	**4,178**	**4,680**	**502**	**8,825**	**9,874**	**1,049**	**12%**		

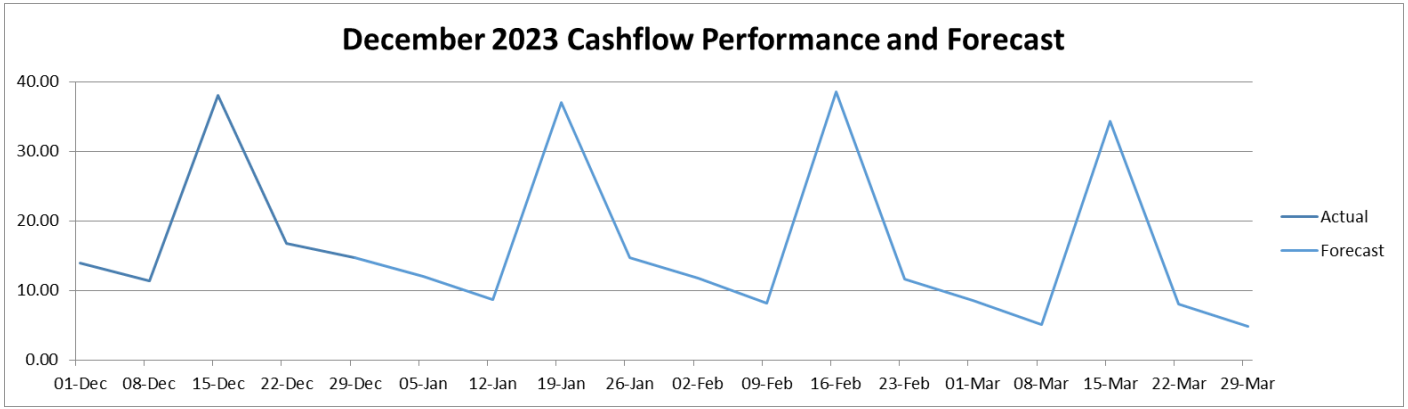
Overall the planned capital programme including new funding is budgeted at £29,339k and forecast at £25,336k, i.e. £4,003k underspent.

The following originally unplanned aspects bring the forecast to the required £29,339k

- Unplanned project expenditure £212k
- Original planning over commitment shortfall £158k
- Slippage plan £2,907k
- Ruby additional cost £726k

9. Cash

	Actual					Forecast												
£m	03/11/23	10/11/23	17/11/23	24/11/23	01/12/23	08/12/23	15/12/23	22/12/23	29/12/23	05/01/24	12/01/24	19/01/24	26/01/24	02/02/24	09/02/24	16/02/24	23/02/24	01/03/24
BANK BALANCE B/FWD	**14.71**	**13.39**	**10.47**	**39.26**	**15.94**	**13.95**	**11.30**	**39.36**	**18.51**	**14.22**	**11.48**	**8.16**	**36.74**	**14.48**	**11.02**	**8.60**	**37.95**	**11.08**
Receipts																		
NHS Contract Income	0.04	0.11	32.13	0.26	0.09	0.00	32.93	0.00	0.00	0.00	0.00	36.92	0.00	0.00	0.00	32.93	0.00	0.00
Other	0.55	0.21	0.37	0.32	0.78	0.17	0.68	0.63	0.15	0.20	0.33	0.64	0.63	0.25	0.33	0.65	0.25	0.63
Total receipts	**0.59**	**0.32**	**32.50**	**0.57**	**0.87**	**0.17**	**33.61**	**0.63**	**0.15**	**0.20**	**0.33**	**37.56**	**0.63**	**0.25**	**0.33**	**33.58**	**0.25**	**0.63**
Payments																		
Pay Expenditure (excl. Agency)	(0.44)	(0.45)	(3.86)	(19.38)	(0.41)	(0.46)	(0.44)	(23.22)	(0.44)	(0.44)	(0.44)	(3.97)	(19.69)	(0.47)	(0.44)	(0.44)	(23.22)	(0.47)
Non Pay Expenditure	(1.10)	(2.70)	(6.02)	(4.13)	(2.44)	(2.27)	(4.40)	(2.70)	(3.40)	(1.80)	(2.50)	(4.26)	(2.45)	(2.30)	(2.55)	(2.65)	(3.01)	(2.53)
Capital Expenditure	(0.36)	(0.11)	(0.07)	(0.38)	(0.02)	(0.09)	(0.71)	(0.60)	(0.60)	(0.70)	(0.70)	(0.75)	(0.75)	(0.95)	(0.95)	(1.15)	(0.89)	(0.77)
Total payments	**(1.91)**	**(3.25)**	**(9.96)**	**(23.89)**	**(2.87)**	**(2.81)**	**(5.55)**	**(26.52)**	**(4.44)**	**(2.94)**	**(3.64)**	**(8.98)**	**(22.89)**	**(3.72)**	**(3.94)**	**(4.24)**	**(27.12)**	**(3.77)**
Net Receipts/ (Payments)	**(1.31)**	**(2.93)**	**22.54**	**(23.32)**	**(2.00)**	**(2.64)**	**28.06**	**(25.89)**	**(4.29)**	**(2.74)**	**(3.31)**	**28.58**	**(22.26)**	**(3.47)**	**(3.61)**	**29.34**	**(26.87)**	**(3.14)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	6.33	0.00	0.00	0.00	0.00	5.03	0.00	0.00	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00
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
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**6.25**	**0.00**	**0.00**	**0.00**	**0.00**	**5.03**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.20**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**13.39**	**10.47**	**39.26**	**15.94**	**13.95**	**11.30**	**39.36**	**18.51**	**14.22**	**11.48**	**8.16**	**36.74**	**14.48**	**11.02**	**8.60**	**37.95**	**11.08**	**7.94**



Prior year end	£'000	Month end actual	Var.
34,742	Cash	14,759	(19,983)

The overall cash balance has increased by £0.8m in December.

£38.8m of cash was received in month
£32.4m NHS contract income for the month, £5m PDC funding and £1.4m cash receipts in relation to trading activities and settlement of prior period sales invoices.

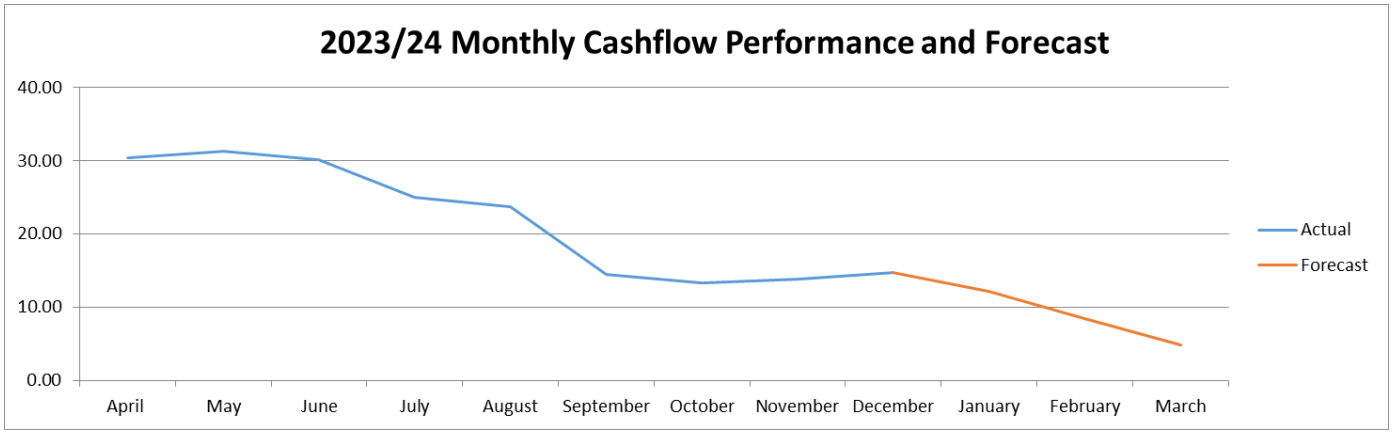
£38m of cash was paid out by the Trust in month
£13.7m (36%) in direct salary costs to substantive and bank employees
£10.5m (28%) employer costs to HMRC and NHS Pensions
£13.8m (36%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

9. Cash (continued)

Cash management is key for the remainder of 2023/24 to enable the Trust to fulfil its obligations without the need to borrow funds from NHSE/DHSC. Borrowing in this way costs 3.5% per annum interest and then becomes a permanent monthly need whilst the Trust runs at a deficit.
Based on mitigations and revised expenditure controls highlighted in the month 9 report the forecast cash flow for the remainder of the year is as below.

Monthly Forecast **w/e**

	Actual									Forecast		
£m	April	May	June	July	August	September	October	November	December	January	February	March
BANK BALANCE B/FWD	**34.65**	**30.40**	**31.25**	**30.13**	**24.98**	**23.66**	**14.43**	**13.36**	**13.84**	**14.69**	**12.14**	**8.45**
Receipts												
NHS Contract Income	33.44	33.85	43.34	37.91	32.46	33.67	38.26	32.54	32.42	36.80	32.71	36.41
Other	1.74	1.30	3.62	2.15	2.16	1.67	1.58	2.12	1.36	1.82	1.90	1.83
Total receipts	**35.17**	**35.15**	**46.96**	**40.06**	**34.62**	**35.35**	**39.83**	**34.66**	**33.78**	**38.62**	**34.62**	**38.24**
Payments												
Pay Expenditure (excl. Agency)	(22.77)	(22.49)	(29.23)	(27.54)	(23.80)	(25.82)	(25.39)	(24.51)	(24.18)	(24.85)	(25.00)	(24.56)
Non Pay Expenditure	(10.30)	(11.03)	(16.60)	(16.43)	(11.47)	(12.72)	(14.44)	(15.34)	(12.79)	(13.97)	(10.16)	(9.66)
Capital Expenditure	(6.36)	(0.71)	(2.25)	(1.23)	(0.67)	(1.27)	(1.07)	(0.57)	(0.99)	(2.88)	(4.34)	(3.64)
Total payments	**(39.42)**	**(34.23)**	**(48.08)**	**(45.20)**	**(35.94)**	**(39.81)**	**(40.90)**	**(40.42)**	**(37.96)**	**(41.71)**	**(39.50)**	**(37.86)**
Net Receipts/ (Payments)	**(4.25)**	**0.93**	**(1.12)**	**(5.14)**	**(1.32)**	**(4.47)**	**(1.07)**	**(5.76)**	**(4.19)**	**(3.08)**	**(4.89)**	**0.38**
Funding Flows												
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.08	0.00	6.33	5.03	0.53	1.20	0.45
Loan Repayment/Interest payable	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	(4.84)	0.00	0.00	0.00	0.00	0.00	(4.43)
Total Funding	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**(4.77)**	**0.00**	**6.25**	**5.03**	**0.53**	**1.20**	**(3.97)**
BANK BALANCE C/FWD	**30.40**	**31.25**	**30.13**	**24.98**	**23.66**	**14.43**	**13.36**	**13.84**	**14.69**	**12.14**	**8.45**	**4.85**



10. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is £2.5m deficit in-month and £32.6m deficit YTD; this being £20.3m adverse to the deficit plan position as agreed with the ICB and NHSE.

Work to deliver the counter measures and improved run-rate per the November forecast are underway and in the process of being fully tracked. KPMG have issued their draft financial recovery report aligned to this work.

With the recently announced industrial action the forecast is now at risk; we await further national guidance in response. In light of the IA and the M9 performance, the Trust is evaluating the risks to the £35.6m forecast deficit as well as the expected impact of the mitigations from the additional financial control measures and the countermeasures recommended in the KPMG report – an update will be provided at the FPPC meeting.

Alan Davies
Chief Financial Officer
January 2024

Meeting of the Trust Board
Wednesday, 06 March 2024

Title of Report	Annual Accounts Review		**Agenda Item**	5.4
Author	Paul Kimber, Deputy Chief Financial Officer			
Lead Executive Director	Alan Davies, Chief Financial Officer			
Executive Summary	The Trust is developing its workplan to deliver the annual report and accounts for the year ending 31 March 2024. The draft annual accounts are due to be submitted by noon on 24 April. The audited annual accounts and text of the annual report is due to be submitted by noon on 28 June. There are no changes in accounting standards or annual report contents to note.			
Proposal and/or key recommendation:	The Trust Board is asked to note the contents of this report.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
Committee/Group submitted:	N/A			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) X	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe:	Effective:	Caring:	Responsive:	Well-Led: X
Identified Risks, issues and mitigations:	The Trust is required to comply with the annual report and accounts submission dates, which typically focussed work and efforts to achieve.			
Resource implications:	Preparation of the annual report and accounts requires significant effort from a variety of staff.			
Sustainability and /or Public and patient engagement considerations:	The annual report considers these matters.			
Integrated Impact assessment:	Not applicable			

Legal and Regulatory implications:	Preparation of the annual report and accounts is a statutory requirement.		
Appendices:	None		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Paul Kimber		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	X	No assurance required.

1 Requirements

The Trust is preparing to prepare its annual report and accounts for the year ending 31 March 2024. The quality accounts are considered separately from this paper.

The financial accounts are the responsibility of the Finance Department and, at the time of writing, instructions are in the process of being issued to provide guidance to the wider Trust. This will include the requirement to undertake stock counts, receipting of orders, etc.

The Company Secretarial team are responsible for the coordination/preparation of the annual report; this incorporates the narrative from across the Trust about governance, developments, performance and outlooks.

2 Timetable

The key dates are noted below; the submission dates are in **bold** font.

Date	Detail
21 March	Last payment date between DHSC bodies for 2023/24, unless by prior agreement.
31 March	Year end
24 April (noon)	**Submission of draft accounts and national finance return.**
25 April	Grant Thornton (external auditors) being their year end audit.
20 June	Audit and Risk Committee to approve the annual report and accounts
28 June (noon)	**Submission of signed annual report and accounts together with auditor's reports**
TBC	Laying of annual report and accounts before Parliament

3 Key changes / points to note

Accounting standards

There are no new standards or policies changes to note.

Special payments

The approval and disclosure of special payments has been and continues to be an area of focus. Key responsibilities for the Trust are:

- All (non-contractual) severance payments require national approval before they are agreed or paid, regardless of value.
- All special payments above £95,000, plus any of any value that may be considered novel, contentious or repercussive, require additional approval before they are agreed or paid.

Local audit procurement

NHSE have reiterated their advice on good practice when seeking to procure external audit services, including allowing sufficient time. This is in light of a stagnant market that has left some organisations without an appointed external auditor.

The 2023/24 year end will be the fifth year of appointment of Grant Thornton and hence the Trust will be obliged to conduct a procurement exercise. A number of other organisations within the Ken and Medway system are in a similar position and hence we are exploring a coordinated procurement.

Meeting of the Trust Board
Wednesday, 06 March 2024

Title of Report	Strategy Review		**Agenda Item**	5.6
Author	Lauren Pryor, Senior Project Manager			
Lead Executive Director	Matt Capper, Director of Strategy and Partnerships			
Executive Summary	The Strategy Review highlights the current and on-going status of the Strategy and Partnership portfolio.			
Proposal and/or key recommendation:	Submitted for assurance.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group submitted:	N/A			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) ☐	Priority 2: (People) ☐	Priority 3: (Patients) ☐	Priority 4: (Quality) ☐	Priority 5: (Systems) ☐
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe: ☐	Effective: ☐	Caring: ☐	Responsive: ☐	Well-Led: ☐
Identified Risks, issues and mitigations:	N/A			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	Not applicable			
Legal and Regulatory implications:	N/A			
Appendices:	N/A			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act			
For further information please contact:	Name: Matt Capper Job Title: Director of Strategy and Partnerships Email: m.capper@nhs.net			

	Name: Toni Sheeran Job Title: Deputy Director of Strategy and Partnerships Email: tonisheeran@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	X	No assurance required.

NHS
Medway
NHS Foundation Trust

Strategy Review

Strategy & Partnerships

March 2024

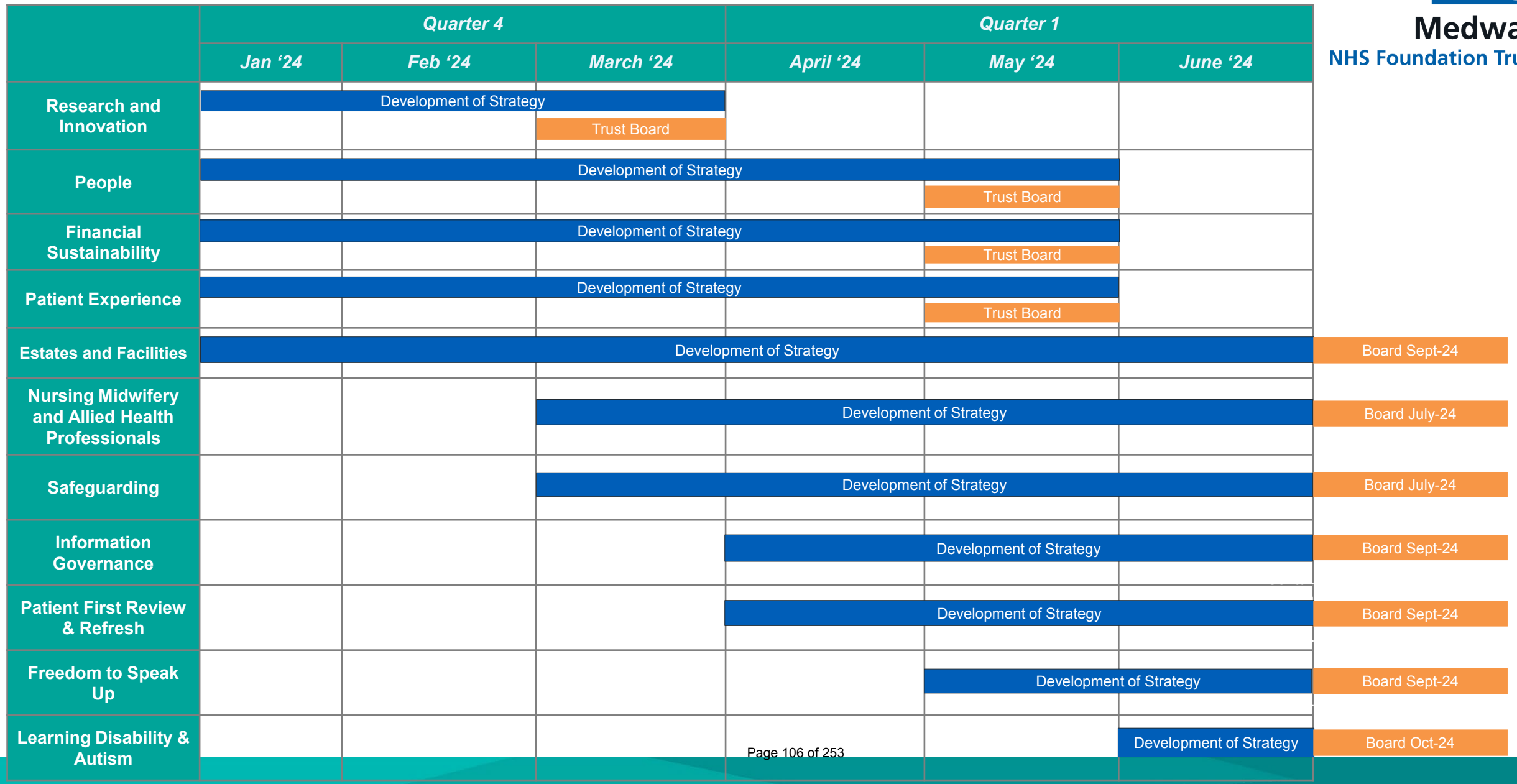
Patient FIRST

Approved Strategies

NHS Medway NHS Foundation Trust

	Quarter 2			Quarter 3			Quarter 4		
	Jul '23	Aug '23	Sep '23	Oct '23	Nov '23	Dec '23	Jan '24	Feb '24	Mar '24
Patient First	Development of Strategy		Trust Board	✓					
Infection, Prevention and Control	Development of Strategy		Trust Board	✓					
Clinical Strategy	Development of Strategy						Trust Board	✓	
Digital, Data and Technology				Development of Strategy			Trust Board	✓	
Quality Strategy				Development of Strategy			Trust Board	✓	

Strategy Roadmap 23/24



Reviews

Conversations are taking place with key leads and stakeholders to determine whether the below areas require a full strategy document or a policy.

- Cyber
- Procurement
- Dementia
- Medical Devices

Accessibility

The S&P team are working on newly approved strategies to include accessibility guidance. Selected strategies will have a fully accessible summary document on the Trust website, with the full strategy available upon request.

Strategy Template

A fully accessible strategy template with coaching and supporting questions/reminders is in progress to support the leads for strategies. This document will be available on Q-Pulse once approved.

Partnerships

Business Planning

Health and Wellbeing

Standing Financial Instructions

Health Inequalities

Population Health

Elective Hub

Joint Forward Plan

North Kent Pathology Service Review

MCH Lead Provider

In Progress

NHS Medway NHS Foundation Trust

Research and Innovation

We need to develop our research and innovation capability to improve outcomes, attract the best staff and increase the organisation profile. We will collaborate with local higher education institutions and local enterprise to support and develop our research and innovation ambitions.

- Well received at all governance with minimal amendments (Research and Innovation Governance Group (RIGG), Research Operational Group (ROG), Quality and Patient Safety Sub-Committee (QPSSC) and Clinical Effectiveness Oversight Group (CEOG))
- Submitted to Trust Board for March review/approval.

People

Our people are our biggest asset, and following the NHS Long Term Workforce Plan principles will be a key enabler to the success of our strategies and retaining our workforce to support the future innovations. We need to continue the development of our collaborative organisational culture. Our people will need to embrace new and different ways of working, including digital healthcare, working across organisational boundaries and working outside of the hospital walls.

- Engagement with key stakeholders and agreement of priorities within the team completed
- Draft written and reviews underway
- Review by People Committee in March 2024, with a view to submit to Trust Board May 2025

In Progress

NHS Medway NHS Foundation Trust

Financial Sustainability

The Trust is engaging on its Sustainability Strategy for the next five years, moving the Trust to a sustainable financial position. This strategy will define the way we move forwards with our financial recovery programme and give us an opportunity to position ourselves among the top performing Trusts in the country, and benchmark ourselves against national standards. To achieve this, we need to design a strategy which promotes efficiencies, delivers value for money and optimises quality and sustainability.

- Refreshing Standing Financial Instructions (SFI's) as they feed into the Strategy.
- Awaiting finalisation of business planning to inform the content of the Strategy.
- Due to be reviewed/approved at Finance, Planning and Performance Committee (FPPC) in April 2024 with a view to submit to May 2024 Trust Board.

Meeting of the Public Trust Board Meeting
Wednesday, 06 March 2024

Title of Report	Replacement of Interventional Radiology Machine	**Agenda Item**	5.7
Author	Nicola Cooper – Divisional Director of Operations		
Lead Executive Director	Alan Davies – Chief Finance Officer		
Executive Summary	This document is to seek investment of £1,958,000 to purchase a new Interventional Radiology (IR) Machine. This is to ensure that we maintain the IR service currently available by the trust, including the 24/7 on call aspect of the service. The machine in situ has had an End of life Certificate in place since 31st December 2020 and an End of Service Certificate in place since 31st December 2022. Owing to the age of the machine we are experiencing a growing number of faults and breakdowns and due to its age no new parts are available to address these issues. At present a second hand tube has been installed to replace the existing faulty equipment. Following the install of this part a defect is present causing serious issues with the imaging, this is most likely due to the replacement part. Working with a decreased field of view has the potential to increase imaging acquisitions required which will increase patient radiation dose and lengthen the procedure time. The Medical Physics team have stipulated all patients who are treated under these conditions must be reviewed to monitor their radiation dose due to the increased risk of continuing to work with a fault on the machine. We have been working to a six month deadline to replace the machine as working with the current restrictions should not be a long term solution due to the increased risks. The six months expires on the 01 March 2024, at which point the expectation from the Medical Physics team is the machine will no longer be utilised and they reserve the right to decommission the machine from use. Deploying a newer technology means faster acquisition times and extension of services including prostate embolization for cancer patients, thyroid ablations and expansion of Post-Partum Haemorrhage (PPH) service. This is only possible currently on a very limited scale and a newer faster machine would allow rapid growth and expansion of these services. The majority of these patients will be for cancer treatment and as such this will also assist with the Trust attaining faster diagnosis and treatment targets. The loss of the Interventional service would impact on the Trust reputation and have financial implications.		

	Without the service there would be patient safety risks as the patients would need to be transported for their emergency care, have open surgery with the associated increase in length of stay, day cases would have to be redirected to another provider and planned treatments would incur further delays. There would also be the difficulty of finding another provider that has capacity to take these patients. Without replacement there is not only a risk to the service but also the retention of the Radiologists. There is a known National shortage of Radiologists and as such it is imperative to retain the existing highly qualified staff that we have.
Proposal and/or key recommendation:	Seven options have been included in the Business Case presented to the Trusts Investment Group (TIG) and assessed against service needs. The only option that fully meets the service needs and allows for future service development as described in the Trusts clinical strategy is the purchase and install of a new permanent unit. Without agreement to replace the current machine the Medical Physics team will remove the equipment from operation resulting in loss of the service. If agreement is received a paper inclusive of time line will be prepared for the Medical Physics team in order to try and extend the use of existing machine until the new machine is available – likely to be 12 to 24 weeks Early allocation and release of funds is essential in order to gain this agreement.

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

Committee/Group submitted:	Finance, Planning and Performance Committee – 29.02.24 Trust Investment Group – 05.02.24 Exec Meeting – 27.02.24

Patient First Domain/True North priorities (tick box to indicate):

Please mark with 'X' the priorities the report aims to support:

Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
X		X	X	

Relevant CQC Domain:

Please mark with 'X' the CQC domain the report aims to support:

Safe:	Effective:	Caring:	Responsive:	Well-Led:
X	X	X	x	

Identified Risks, issues and mitigations:	The risk is total loss of the interventional service inclusive of the out of hour's emergency cover. This is on the risk register scoring a 20 (likelihood 5, Impact 5) This will result in the need for invasive surgeries or transport to alternative sites. This poses patient safety risks and issues with capacity for other sites to accept patients. Radiologists in this area are classified workers and as such non-compliance with annual dose limits will result in inability to continue to work. Given the

	increased doses being seen it is imperative the equipment is decommissioned and replaced as a matter of urgency.		
Resource implications:	Project requires capital outlay of funds (identified). There will be no requirement for increase in staffing over current establishment as confirmed in the finances within the case. No change to supporting services as the main increase in patients will be those treated as outpatients so no additional portering or bed allocation is needed.		
Sustainability and /or Public and patient engagement considerations:	One of the objectives of the Trust under Patient First is to reduce length of stay within the Trust and by optimising the least invasive techniques and cutting edge technologies this will be achievable. There will be reduction in reliance on high dependency beds and extended admission times as many cases can be completed as outpatients or day cases. Ensuring that facilities are available to offer the best possible outcome whilst reducing invasive requirements fits in with both sustainability and quality of care offered to patients. High quality equipment will also promote the department attracting the best staff to the area to work. This will assist with retention of staff and ensure we are the employer of choice in the Kent area. The development of this service, as described in the Trust's clinical strategy is dependent on having fit-for-purpose equipment		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	It is the employers responsibility under the Ionising Radiation Regulations 2017 to ensure all necessary steps are taken to restrict radiation exposure to employees and other persons. The current machine does not meet this requirement and should this machine continue to be used there is a possibility of sanctions or financial penalties from HSE once Medical Physic withdraw support of the machine.		
Appendices:	No appendices added but embedded quotes are available in full business case.		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Nicola Cooper Job Title: Divisional Director of Operations Email: nicola.cooper@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance	X	There are no gaps in assurance
	Not Applicable		No assurance required.

BUSINESS CASE KEY SUMMARY FOR THE PUBLIC TRUST BOARD

Guidance:

This document is to be used to provide the Trust Board with summary information about the investment proposal and the governance process that has been followed.

This is not intended to replace the executive summary of the business case or introduce new material that should be contained within the case itself.

This document should be included alongside the cover sheet for the meeting of the FPPC and Trust Board and in addition to the case itself. Responses to the matters below should be concise.

Query	Response
1. On what date was this case approved and at what group?	Trust Investment Group - 5th February Trust Board – 27th February Finance Planning and Performance – 29th February 2024
2. What is the proposal requesting?	This document is to seek investment of £1,958,000 to purchase a new Interventional Radiology (IR) Machine. This is to ensure that we maintain the IR service currently available at the trust, including the 24/7 on call.
3. What issue / risk does this resolve?	Risk Ref : 1363 End of Life Philips FD20 – likelihood 5 consequence 4 = 20
4. What is the feedback or points to escalate from the approving group? How have these been addressed?	TIG - Include Integrated Impact Assessment with the case. - Add any costs associated FPPC - TBA
5. What is the financial impact of the proposal? (NB – this should include capital, income and revenue costs.)	£1,958,000 capital funds for enabling works, purchase of the machine and installation inclusive of commissioning required. No additional costs as staffing already in budget.
6. Is the proposal part of the existing capital	The request is for capital funding from allocation in 24/25.

Query	Response
programme or revenue budget for the year? If not, how will this be funded?	
7. Where the proposal has a multi-year revenue impact, what discount / inflation rates have been used?	N/A
8. What supplier selection / procurement process has been applied?	Procurement have assisted with tender process and the award will be via Supplychain. Clinical evaluation has taken place and scored accordingly. The selected manufacturer will be asked to supply the project via turnkey option.
9. On what date was the impact assessment completed? Have circumstances changed since then?	10 / 02 /2024 – no change.

Cancer and Core Clinical Services Division

Business Case Replacement of Interventional Radiology Machine

Version 1

Document Control / History	
Version no.	**Reason for change**
1	First Draft

Further guidance can be found in the Trust's Business Case Policy, which can be found here: http://qpulse-drs.medway.nhs.uk/Corporate/Documents.svc/documents/active/attachment?number=POLCF022

Template version March 2021

Contents

1. Executive summary

This document is to seek investment of £1,958,000 (awaiting final enabling costs) to purchase a new Interventional Radiology (IR) Machine. This is to ensure that we maintain the IR service currently available by the trust, including the 24/7 on call.

1.1 Strategic case

The Trust Clinical Strategy for the next three, five and ten years will define the way the Trust moves forward. This includes strengthening services and optimising quality and sustainability.
Currently the Interventional service does not comply with this strategy compromising patient safety and experience and also the ability to develop the service to offer high quality diagnostics and treatments to the population of Medway and Swale.

Without replacement there will be both financial and reputation impacts to the Trust and delays to the patient diverging from the Trust True North of all patient referral to treatment pathways to be completed within 65 weeks.

1.2 Economic case

Options matrix has been completed and scored against required outcome.
Two options have been shortlisted but following on with further evaluation only one option remains which is full replacement inclusive of the associated enabling works costs.

1.3 Commercial case

The loss of the Interventional service would impact on the Trust reputation and have financial implications.
Without the service there would be patient safety risks as the patients would need to be transported for their emergency care, day cases would have to be redirected to another provider and planned treatments would incur further delays.

There would also be the difficulty of finding another provider that has capacity to take these patients as all systems in the local area are already at or very close to capacity.

1.4 Financial case

This will be a Capital investment request in order to maintain and develop the Interventional service. Procurement will ensure compliance with purchase.

1.5 Management case

Procurement will be responsible for purchase once clinical evaluation is complete.
Estates will liaise with the chosen provider and have regular project meetings with the same.
A lead from the clinical area will also be involved in this group.
The installation will be monitored against the pre-arranged time scales with accountability through review meetings reported back via Head of Imaging to the Divisional Director.
Over sight will be maintained by the Imaging Clinical Governance Group.

2. Strategic case

2.1 Service overview

Interventional Radiology (IR) is a sub-speciality of Radiology.

It uses Image guidance to perform procedures to diagnose and treat diseases using the least invasive techniques.

There is a 24/7 service, 365 days a year supporting fellow clinicians in offering patients the best of care. Out of hours Interventional Radiology service has an increasing role in the acute management of a variety of clinical emergencies including control of haemorrhage, renal and biliary obstruction

IR services enhance outcomes for patients receiving elective and non-elective care for many conditions. Interventional Radiology treats patients from all specialities throughout the Trust

including Oncology, Urology, Gynaecology, Vascular, General Surgery, Obstetrics, Gastroenterology and Trauma.

The benefits of Interventional procedures include:

- Minimally invasive
- Less Pain
- Shorter recovery time
- Shorter hospital stay
- Generally avoids patients having a general anaesthetic and open surgeries

IR provides high quality care and uses technology to achieve the best results.

This includes:

1. Vascular Intervention (Arterial) – procedures involving the arteries throughout the body such as angioplasty (balloon dilatation of narrowed blood vessels) or embolisation (blocking off blood vessels to tumours or when someone is bleeding internally).

2. Vascular Intervention (Venous) – procedures involving the veins such as inserting lines into veins, inserting filters to prevent clot travelling around the body (IVC filters) or using devices to suck clot out of blocked veins (thrombectomy).

3. Non-vascular Intervention – procedures not involving the blood vessels such as unblocking kidneys (nephrostomy) or the liver (PTC), or inserting feeding tubes into the stomach (RIG).

On average, the Interventional Radiology Department performs 1,500 procedures annually. This equates to approximately 125 a month, 35 a week and 6 procedures a day.

2.2 Service and Trust strategy and aims

The Trust Clinical Strategy for the next three, five and ten years will define the way the Trust moves forward. This includes strengthening services and optimising quality and sustainability whilst taking into account the changing health needs of the population we serve.

Ensuring that facilities are available to offer the best possible outcome whilst reducing invasive requirements fits in with both sustainability and quality of care offered to patients. High quality equipment will also promote the department attracting the best staff to the area to work. This will assist with retention of staff and ensure we are the employer of choice in the Kent area.
New procedures will be possible and assist with reduction of patients outsourced for their procedures. This not only gives a better patient experience but also ensures we provide outstanding, compassionate care for our patients and their families every time.

The Clinical Strategy will be firmly embedded in the Patient First improvement system which ensures that patient care and experience are the top priority.
One of the objectives of the Trust under Patient First is to reduce length of stay within the Trust and by optimising the least invasive techniques and cutting edge technologies this will be achievable. There will be reduction in reliance on high dependency beds and extended admission times as many cases can be completed as outpatients or day cases.

Despite the initial outlay of Capital for the machine and enabling works this project will ensure sustainability – high quality service through optimisation of resources. This is currently not possible with the limitations of the machine and also prevents branching out to newer procedures and attracting the enhanced tariff these will bring. Many of the auxiliary equipment used can be reclaimed via excluded devices but still receive a high tariff.

2.3 The case for change

Investing in a new machine will ensure procedures continue to comply with the Trust's Clinical Strategy of optimising quality and sustainability whilst taking into account the changing health needs of the population we serve. Loss of the service would also mean we do not achieve the Patient First strategy and not align with the true north domains set out within.

Not replacing the machine leaves the service in a compromised state as the likelihood of machine failure increases and it is a single point of failure. Medical Physics will also regularly assess the unit and have already stated they will not support the continued use without an agreed replacement plan.
Losing the service would significantly reduce patient treatment options, specifically patients awaiting ports for chemotherapy, increase patient waiting times and would mean the trust would be unable to provide 24/7 emergency cover to Accident and Emergency, Urology, Gastroenterology and Obstetrics.

2.3.1 Investment/spending objectives

In order to maintain the service we need a fully functional machine capable of utilising new technologies and reducing dose to the patients.
Newer technologies means faster acquisition times and extension of services including prostate embolization for cancer patients, thyroid ablations and expansion of Post-Partum Haemorrhage (PPH) service.

The current machine has deteriorating image quality and a number of caveats and restrictions have been put in place by Medical Physics with a time frame to stop using the current equipment completely.
Radiation dose to patients remains within the upper limit of safe however newer technologies have improved dose reduction software reducing dose to patients and to staff.
Due to the age of the current machine the software available is outdated and the system runs on Windows XP which also leaves the service vulnerable as should the host computer go down, there are no longer parts available for this system.

2.3.2 Existing arrangements

The machine in situ has had an End of life Certificate in place since 31st December 2020 and an End of Service Certificate in place since 31st December 2022.

At present- a replacement second hand tube has been installed to replace the existing faulty equipment. Following the install of the replacement tube, an obvious defect is present causing serious issues with the imaging, this is most likely due to the fact is it a second hand part. Unfortunately, due to the age of the machine and the fact the End of Service Certificate has been issued, we are no longer able to source new parts.

We are continuing to provide a 24/7 service, however we are working within the constraints of the medical physics caveats.

We are working with a decreased field of view, this has the potential to increase imaging acquisitions required which will increase patient radiation dose and lengthen the procedure time.

Medical Physics have stipulated all patients who are treated under these conditions must be reviewed to monitor their radiation dose due to the increased risk of continuing to work with a fault on the machine.

We have been given a 6 months period to replace the machine as working with the current restrictions should not be a long term solution due to the increased risks. The 6 months expires on the 1st March 2024, at which point the expectation from Medical Physics is the machine will no longer be utilised.

2.3.3 Business needs – current and future

The Trust continues to strive to accommodate both inpatient and outpatients awaiting procedures. By having a procedure in IR the patient avoids extended admission and far more invasive procedures. This saves the Trust money, reduces length of stay and more importantly gives the best possible outcome for the patients. Many referrals are made late in the patient pathway it is imperative that there are no further delays to planned and urgent procedures.
The machine is on the risk register scoring at 20.

Replacing the IR machine will not create any additional pressures on supporting services, both during the replacement and once normal service has resumed.

The replacement machine will enable the Interventional service to continue to provide the current service meaning no additional portering will be required. Currently, in order to maintain a prompt service and ensure maximum utilisation, often Interventional staff collect and return patients for handover purposes and this will continue.
Housekeeping services will remain as per the current requirements with daily cleans and only additional assistance for infective patients.
Support provided by the Estates department will not be expected to change so no additional costs are anticipated.

Prior to the commissioning of the room support will be required from the IPC team in the form of advice and sign off to use the room once compliance is achieved, no additional costs are anticipated.

During the install, additional support will be required from Medical Physics in order to ensure the room and machine are compliant with regulations and is safe to use. The Trust source these services from MTW Medical Physics and the cost of the additional support is included in the estimate for building works.

Following the replacement of the machine, the long term plan is to expand services within IR to offer patients the best care available. Expansion will most likely require additional support from services outside of imaging e.g. anaesthetic support however this will require a separate pathway plan and business case.

2.3.4 Potential scope and service requirements

This will be a turnkey project to ensure minimal as possible disruption to service.
The same provider would be responsible for removal, enabling works and installation of new machine.

2.3.5 Main benefits and risks

A new machine with state of the art technologies would allow for expansion of our non-vascular service. The Trust is working with Darenth to try and build a profile to be a hub and spoke model for all non-vascular work.
This would involve cross site working and allow the implementation of the newest procedures such as embolization's and ablations.
This is only possible currently on a very limited scale and a newer faster machine would allow rapid growth and expansion of these services. The majority of these patients will be for cancer treatment and as such this will also assist with the Trust attaining faster diagnosis and treatment targets.

There would be no scope for involvement of CDCs in this project as the service needs to be based at the acute site.

Without replacement there is not only a risk to the service but also the retention of the Radiologists. There is a known National shortage of Radiologists and as such it is imperative to retain the existing highly qualified staff that we have. Given the proximity of the Trust to the larger London sites there is already gaps in provision and as such we need to ensure the offer of state of the art machines in order to appear competitive to these other Trusts.

2.3.6 Constraints and dependencies

The replacement of the machine is dependent on capital funding. Availability of estates/building teams will also effect the progression of the project.
A project manager will be required to manage the install.

It is predicted the replacement will take up to 4 months, the impact on referring specialities during this period if the department was to close would be severe. In order to maintain a service and only cause minimal disruption, a portable c-arm can be utilised in the department.
There is a possibility of use of other areas in the Trust such as the fluoroscopy room but again this would be limited and assessed on a case per case basis. Not all rooms would be suitable for use in all cases.

3. Economic case

3.1 Critical success factors

The critical success factors are:

1. Provide a robust 24/7 Interventional Radiology service
2. The removal of imposed restrictions on the service by Medical Physics
3. Use the most up to date software to achieve quality imaging to diagnose and treat patients
4. Avoid initiating BCP due to equipment downtime
5. Utilise dose reduction software to efficiently image patients whilst keeping the radiation dose and screening time as low as reasonably possible
6. Have sufficient service support from engineers to be able to provide preventative maintenance and remedial works and for parts to be accessible to ensure fixes can be completed.

3.2 Long-listed options

The long list of options are as follows:

Option	Title	Description
1	Do nothing	As described in the strategic case above.
2	Outsource within the Vascular Network	Vascular day cases are currently performed at MMH. Cases could be shared out within the Vascular network, however each site already experiences demand pressures and capacity for these patients will be an obstacle. Patients would experience extended wait times for their procedures and delays in treatment.
3	Outsource to other Trusts/Private Sector	There are currently no Service Level agreements in place for transferring patients out to other Trust's/private sector. Several SLAs would need to be agreed to cover all patients referred from the different specialities.

		The Trust would incur the costs of sending out the patients. Patient safety and experience would be impacted negatively due to travel and delayed wait times.
4	Utilise a mobile imaging unit	A mobile unit would be a short term solution only whilst a new machine was installed in order to keep patient backlogs at a minimum. The limited capabilities of a mobile unit would require risk assessments for all procedures to justify whether they could be safely performed. It would be highly probable that certain procedures will not be possible on a mobile unit and arrangements for these patients to be transferred out would be required. Procedures most likely to be effected are post-partum haemorrhage, urology and GI bleeds. Detector sizes are much smaller than that of a static IR unit meaning image quality would be significantly impacted and the radiation dose received by the patient would be significantly increased. A risk assessment would be required to justify the use and Medical physics restrictions would most likely be imposed to a short time period only.
5	Patients will undergo alternative procedures e.g. Surgical alternatives	It is possible some patients could be treated in surgery as opposed to Interventional Radiology. This would require additional surgical support in the form or facilities and surgeons. Theatre capacity would be an obstacle. Many patients require interventional Radiology as they are unsuitable for surgical intervention due to ill health- for these patients this would not be feasible and they would need to be transferred to a supporting Trust or Interventional Radiology. Interventional Radiology is a much less invasive technique, and therefore requires less post procedural inpatient recovery time. A move to a surgical approach over IR would see an increase in inpatient recovery times, in a Trust that is already at full capacity.

6	Cease service	Losing the IR service would lead to patients being transferred out to receive treatment. Many procedures completed in IR are time sensitive to ensure the best outcome for the patient, transferring patients to other sites increases the risks and often negatively impacts the patient's outcome. Each speciality that refers into IR would have to be consulted on the change and risk assessments for each service would be required to highlight how each would be affected by the loss of IR. SLA's would be required with each centre providing IR services to MMH, and the Trust would incur the costs of sending out these patients on a case by case basis.
7	Replace with a permanent unit	A full service will resume with all imposed limitations removed by Medical Physics. A bespoke room would mean Radiology is able to support all the needs of the current referring services to include obstetrics, urology and GI bleeders. Dose reduction software will ensure patient safety and staff safety are at the forefront of the service. Improved image quality will mean patients are accessing the best possible care. A bespoke unit that fulfils all the needs of the service could provide scope to extend the service to become the centre of excellence for certain procedures and generate further income for the Trust.

Assessment:

1 – do nothing	✗ The service will continue to run with the current restrictions in place. The machine will remain out of service with the company so any further issues could cause abrupt downtime with no certainty of repair. With restrictions imposed by Medical Physics and a 6 month timeframe to rectify these, no change will result in the service being withdrawn from 1st March 2024.	✗ The current restrictions imposed by medical physics will remain in situ as no improvements will have been made to the unit.	✗ The software is out of date and unsupported by the supplier. Image quality is currently poor with restrictions imposed,	✗ There will be no changes to the frequency and duration of which the service has to go into BCP- the machine will remain end of life/end of service and sourcing parts will only become more difficult.	✗ No change will mean there will be no change to the dose given to the patient and also the increase in screening times due to poor image quality. In order to obtain sufficient imaging for diagnosis and treatment, it is often necessary to increase the dose rate to the patient.	✗ The current machine has been issued end of life and of service certificates. No change means there is no assurance that any fault can be fixed as parts cannot always be sourced. The service remains in a fragile state whereby, it is possible that a fault occurs that cannot be fix and the service will abruptly cease.
2 – Outsource within the Vascular Network	✗ Depending on capacity across the other Trust's in the Vascular network, it is possible that vascular patients could receive treatment elsewhere.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024.	✗ With the machine removed from service, the Trust will revert to a permanent state of BCP for Interventional Radiology services.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024

3 – Outsource to other Trusts/Private Sector	✗ There will be no onsite service for patients. Patients will have to be transferred out to other sites for treatment. Currently there are no SLA's in place and capacity elsewhere would be an obstacle.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024.	✗ With the machine removed from service, the Trust will revert to a permanent state of BCP for Interventional Radiology services.	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024	✗ Restrictions imposed mean that without a machine replacement plan, the service provided on site at MMH will no longer be available as of the 1st March 2024
4 – Utilise a mobile imaging unit	✓ Interventional Radiology will be able to maintain a limited service. A number of procedures will be possible on a portable, to include on call cases however a normal complete service will not resume and SLA's will be required to transfer out patients not suitable for imaging on a portable machine.	✗ Due to a reduction in the field of view (FOV) on a portable additional imaging would be required, increasing the screening time. This increase and reduction in FOV would mean additional reviews and any necessary restrictions would be adhered to.	✗ The utilisation of a portable machine will restrict practice as software currently utilised will not be available, e.g. CT rotation, XPER guide and saving table positions	✓ BCP would be avoided for a range of procedures however, would still be required for the procedures not possible on the portable.	✗ Dose to staff and patients would be a concern on a portable. The reduced FOV would increase screening time and dose to the patient. The lack of lead barriers would create concern amongst the staff group as these would not be available and would provide an environment like currently in situ. Staff would	✗ A loan machine would be covered under a service contract by the company providing it.

					require additional monitoring and as classified workers, if doses to the Consultants began to hit the threshold they would have to cease practice for a period of time.	
5 – Cease service	✗ All patients needing Interventional Radiology would require transfer out or alternative treatment if suitable. Demand on these services would increase and patient safety would be compromised as mostly patients are not suitable for alternative treatments and transferring them out can cause a delay with severe implications. Consultants would deskill and most likely seek work at other	✗ No longer applicable	✗ No longer applicable	✗ With the machine removed from service, the Trust will revert to a permanent state of BCP for Interventional Radiology services. All specialities that refer into Interventional Radiology will require BCP review.	✗ No longer applicable	✗ No longer applicable

	Trust's- this will have an implication on the General Radiology reporting service.					
6- Replace with a permanent unit	✓ A full IR service will continue. No referring specialities will be effected. Patients will remain on site and the Trust will be able to provide Interventional Radiology options to all patients.	✓ All restrictions will be lifted and normal service would resume.	✓ New equipment would provide the service with the most up to date software. This will improve patient safety and experience, reduce radiation dose to patients and staff and allow the service to expand where required.	✓ A new machine will improve reliability and reduce downtime due to machine fault. Remote access is available for these newer systems so the majority of issues will be fixed remotely without interruption to the service.	✓ Dose reduction software comes as standard on newer IR machines and will provide improved image quality whilst lowering the radiation dose to the patient and staff.	✓ In the event of any issues with new equipment, parts are guaranteed and engineers with the required experience are more readily available, making up time of newer machines about 98-99% regardless of the manufacturer.

3.3 Preferred way forward

Based on the above, the shortlisted options are:

- Option 1 – replace with a permanent unit
- Option 2 – utilise with a mobile imaging unit

The preferred way forward at this time is option 1.

3.4 Shortlisted options

3.4.1 Benefits and Risks appraisal

Strengths	**Weaknesses**
• Maintain a robust 24/7 Interventional Radiology Service • Capable of carrying out 100% of Interventional procedures currently performed at MMH • Improve patient downtime due to equipment failure • Ensure patient safety by using the most up to date technology • All Medical Physics restrictions will be removed • Reduce radiation dose to patients and staff using dose reduction software • Retain skilled staff • New equipment will be covered by a service contract and parts will be accessible • Remote dial in by engineers to proactively prevent faults and avoid disruption to the service	• Experience disruption for a 4 month period • Re-train staff to use new equipment
Opportunities	**Threats**
• Expand the service to include -Thyroid ablations -Post Partum Haemorrhage hub -Prostate embolisations • Attract staff to work at the Trust • Continue to take Radiology Registrar's • Increased activing and funding for the Trust as less downtime will occur • Utilise a portable unit to maintain a service during refurbishment/upgrade	• Capital funding availability • Building/estates support • Project manager support

3.4.5 Green sustainability

To meet the Trust Green Plan there is a need to be cost efficient, adopt newer technologies and reduce waste. There is also a need to reduce patients moving across sites and treat at source.
The only way to achieve this plan is to have bespoke facilities on site to allow care to be undertaken at site and remove the need for the patient to travel. Newer technologies will also allow for expansion of service again reducing the need for patients to travel and also reduce reliance on invasive surgeries which will reduce the consumables used whilst also reducing patient stay within the hospital.

3.4.6 Preferred option

The preferred option is to replace the existing machine with a new permanent machine. This is the only option that will meet all critical success factors.

There were 2 shortlisted options- one being a mobile unit. After further assessment of this option, it will not be a long term solution.

Whilst utilising a mobile unit will allow Interventional Radiology to maintain a limited service and avoid going into BCP, the machine will not have the capabilities to perform all procedures on it.

Utilising a mobile unit will mainly not meet the critical success factors to ensure restrictions imposed by Medical Physics are removed and treat patients using up to date software. This will mean image quality is compromised and patients will not be offered the best treatment available to them.

Most importantly, the mobile unit will not meet the critical success factor to reduce the radiation dose to the patient and staff. Patient safety will be compromised due to the setup of a mobile machine and the lack of lead protection surrounding it. The patients and staff present during procedures will be at higher risk in comparison to the current Interventional Radiology setup.

4. Commercial case

4.1 Procurement strategy and route

The procurement team will be involved to utilise Supply Chain in order to meet compliance. A statement of requirements will be completed in order for tenders to be received that are fit for purpose for this purchase.
Quotes for enabling works will be required in order to ensure the room is bought up to the correct spec. The project will aim to be turnkey, reducing waits between enabling work and installation of equipment as this will be done by the same company.
A clinical evaluation process will be required to include presentations by each company who has tendered. The same team of staff will attend each presentation and will form the team who will score each product. The evaluation process will include a representative from Procurement and Medical Physics.
A framework will be used to score all aspects of each product to identify which piece of equipment is the most suitable for the requirements of the department. The framework has been drafted and attached below.


Evaluation Scoring Criteria.xlsx

If required, site visits can be arranged for the evaluation team to see the equipment in use at neighbouring Trust's.

4.2 Service requirements and outputs

The machine and enabling works will be a one off fixed cost. A turnkey option will be required as per Estates request. The Estates team are involved and liaising with the chosen providers and completing the required Employers requirements.

The expectation will be a guaranteed 98% uptime with within 24 hour call out for the engineers.

The machine will be under warranty for the first 12 months and thereafter there will be an annual cost for the service contact that will comply with standard NHS terms and conditions.

4.3 Risk allocation

Risk category	Potential allocation		
	Trust	Supplier	Shared
Design risk			✓
Construction and development risk			✓
Transition and implementation risk			✓
Availability and performance risk			✓
Operating risk (including recruitment)	✓		
Variability of revenue risks	✓		
Termination risks	✓		
Technology and obsolescence risks			✓
Control risks	✓		
Residual value risks	✓		
Financing risks	✓		
Legislative risks	✓		
Other project risks	✓		

4.4 Charging mechanism

[Insert narrative here.]

4.5 Key contractual arrangements

Procurement will ensure purchasing compliance alongside clinical evaluation of each system.
Estates will engage with suppliers choice of contractor for enabling works ensuring compliance with regulations or accepting liability of any mitigations that are put in place.
RPA will be involved in procurement to ensure radiation safety and will be responsible for completing the requirement of the room to comply with Radiation legislation. Approval for the drawings will have to be achieved at design phase to allow for the project to proceed.
RPA will work with chosen supplier to commission the room and work through any anomalies as required through this process.
End user at Trust will sign off on completion and use.

4.6 Personnel implications

No change or implications as the staff would remain the same as this is a like for like change inclusive of on call and opening hours.
Additional Radiologist may be attracted to the new equipment offered as this is a nationally known shortage skill set. Given the Trust proximity to London we need to make the department attractive to work at.

4.7 Accountancy treatment

This will be a capital purchase and a turnkey project.
Any external funding opportunities will be explored but to date there is no allocation.

5. Financial case

Statement of requirements completed by the Radiology Department and submitted to procurement to go out to tender. Quotes that are fit for purpose have been received via Supply Chain from GE, Siemens and Philips. The quotes are ranging from £676k to £898k (the financial modelling uses the higher end costs for now).

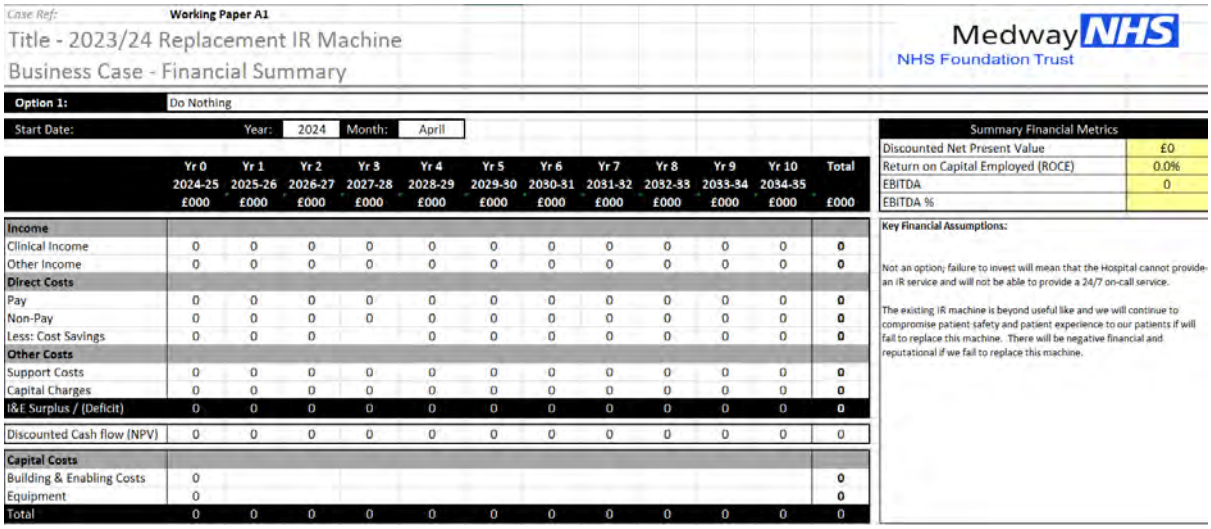
Clinical evaluation of the proposed machines will take place to identify the most appropriate machine for the requirements of the service via company presentations, Please see the quotes attached below.

Quote GE.xlsx Quote Philips.xlsx Quote Siemens.xlsx

There is also an estimated cost of up to £750k for enabling works to ensure the room is bough up to spec and made compliant with new legislation. The air handling costs are as yet unknown until a survey is completed so this figure may increase. There is also a need to include a 10% contingency within this cost.

There is potential for the new machine to generate further income- with improved image quality and more up to date software packages it would be possible to explore implementing new services that would generate further income.

- Updated software and image quality also has the potential to reduce procedure time
- No increase in staffing costs as will utilise existing staff.
- Capital funding is being requested for this proposal



Case Ref: Working Paper A1

Title - 2023/24 Replacement IR Machine

Business Case - Financial Summary

Medway NHS Foundation Trust

Option 1:	Do Nothing

Start Date: Year: 2024 Month: April

	Yr 0 2024-25 £000	Yr 1 2025-26 £000	Yr 2 2026-27 £000	Yr 3 2027-28 £000	Yr 4 2028-29 £000	Yr 5 2029-30 £000	Yr 6 2030-31 £000	Yr 7 2031-32 £000	Yr 8 2032-33 £000	Yr 9 2033-34 £000	Yr 10 2034-35 £000	Total £000
Income												
Clinical Income	0	0	0	0	0	0	0	0	0	0	0	0
Other Income	0	0	0	0	0	0	0	0	0	0	0	0
Direct Costs												
Pay	0	0	0	0	0	0	0	0	0	0	0	0
Non-Pay	0	0	0	0	0	0	0	0	0	0	0	0
Less: Cost Savings	0	0	0		0	0	0	0	0	0	0	0
Other Costs												
Support Costs	0	0	0	0	0	0	0	0	0	0	0	0
Capital Charges	0	0	0	0	0	0	0	0	0	0	0	0
I&E Surplus / (Deficit)	0	0	0	0	0	0	0	0	0	0	0	0
Discounted Cash flow (NPV)	0	0	0	0	0	0	0	0	0	0	0	0
Capital Costs												
Building & Enabling Costs	0											0
Equipment	0											0
Total	0	0	0	0	0	0	0	0	0	0	0	0

Summary Financial Metrics	
Discounted Net Present Value	£0
Return on Capital Employed (ROCE)	0.0%
EBITDA	0
EBITDA %	

Key Financial Assumptions:

Not an option; failure to invest will mean that the Hospital cannot provide an IR service and will not be able to provide a 24/7 on-call service.

The existing IR machine is beyond useful like and we will continue to compromise patient safety and patient experience to our patients if will fail to replace this machine. There will be negative financial and reputational if we fail to replace this machine.

Option 2:	Replace through the purchase a new IR machine (Preferred option)											
Start Date:		Year:	2024	Month:	April							

	Yr 0 2024-25 £000	Yr 1 2025-26 £000	Yr 2 2026-27 £000	Yr 3 2027-28 £000	Yr 4 2028-29 £000	Yr 5 2029-30 £000	Yr 6 2030-31 £000	Yr 7 2031-32 £000	Yr 8 2032-33 £000	Yr 9 2033-34 £000	Yr 10 2034-35 £000	Total £000
Income												
Clinical Income	0	0	0	0	0	0	0	0	0	0	0	**0**
Other Income	0	0	0	0	0	0	0	0	0	0	0	**0**
Direct Costs												
Pay	0	0	0	0	0	0	0	0	0	0	0	**0**
Non-Pay	0	0	0	0	0	0	0	0	0	0	0	**0**
Less: Cost Savings	0	0	0	0	0	0	0	0	0	0	0	**0**
Other Costs												
Support Costs	0	0	0	0	0	0	0	0	0	0	0	**0**
Capital Charges	-290	-286	-282	-275	-267	-259	-252	-244	-237	-229	-221	**-2,842**
I&E Surplus / (Deficit)	-290	-286	-282	-275	-267	-259	-252	-244	-237	-229	-221	**-2,842**
Discounted Cash flow (NPV)	-2,030	-276	-60	-52	-43	-35	-28	-21	-14	-8	-3	-2,571
Capital Costs												
Building & Enabling Costs	988											**988**
Equipment	970											**970**
Total	1,958	0	0	0	0	0	0	0	0	0	0	1,958

Summary Financial Metrics	
Discounted Net Present Value	-£2,571,195
Return on Investment	
EBITDA	0
EBITDA %	

Key Financial Assumptions:

This option provides additional opportunities:

- Expand the service to include
  - -Thyroid ablations
  - -Post Partum Haemorrhage hub
  - -Prostate embolisations
- Attract staff to work at the Trust
- Continue to take Radiology Registrar's
- Increased activing and funding for the Trust as less downtime will occur
- Utilise a portable unit to maintain a service during refurbishment/upgrade

Potential financial benefits will be highlighted and monitored as the project progresses - currently the financials assume no financial benefit or additional costs (there is a possibility that the maintenance of the new machine may be more expensive due to inflationary pressures.

Option 2 above is the preferred option, but clearly shows a negative NPV; this is a qualitative case and is more about maintaining our existing IR service and ensuring continued patient safety and quality.

Appendix 3 includes the financial model

This scheme requests funding/will be funded from the following sources:

Source	Capital £'000	Revenue £'000	Comments
Reallocation of existing budget			
Internally funded	£1,958		To be drawn down from Internal Capital funds
Externally funded			
Cost pressure / from Trust reserves			
Total	**£1,958**		

It is anticipated that the capital expenditure and completion of works will be incurred as follows (TBC):

Source £'000	Apr-24	May -24	Jun-24	Jul-24	Aug -24	Sep-24	Oct-24	Nov -24	Dec-24	Jan-25	Feb-25	Mar-25	After 1yr	Total
Exist. Budget														
Internal	£1,958													£1,958
External														
Press / reserves														
Total	**£1,958**													**£1,958**

6. Management case

6.1 Programme and/or project management governance arrangements

A project manager from the chosen supplier will be appointed and Estates have already allocated a project manager. There will be engagement from the Lead Radiographer and Nurse to ensure clinical and radiation compliance also.
Task and finish group between Estates and Imaging will be stepped up and weekly meetings pre, during and after the project will be put in place.
Imaging Governance will be kept appraised on the build and any required escalations will go to the Divisional Director.
All drawings prior to start will be signed off by Estates, RPA and Head of Imaging.

6.2 Use of specialist advisers

We are under contract with Radiation Protection Services based at Maidstone. The Medical Physics experts from this source will be used to sign of the drawings and then commission the machine.

Estates will engage all required external contractors including M&E, electrical surveys and designers. Estates will also be responsible for any require RAMS or similar.

The successful supplier will tender to companies and award accordingly following this tender process. MFT will have a single contract with the supplier and their own internal governance will oversee the enabling works provided by their chosen provider.

6.3 Change and contract management arrangements

Estates and Imaging will step up a task and finish group to monitor progress with regular meetings to measure against pre agreed time scales.
A project manager will be provided by Estates and the chosen provider to allow direct contact and correspondence.

Time scales slippage will managed contractually and incur pre agreed penalties if this extends beyond the acceptable limits.

A contingency of 10% has been put into the costs for unexpected issues that may be uncovered in the enabling works.

6.4 Benefits realisation arrangements

This will be a capital procurement with limited financial impact.

The benefit of a new machine and a reduction in downtime will see an increase in productivity and potential expansion of the service.
Pt experience will be improved as more procedures become available and there will be a reduction on the need for invasive surgeries and in doing so reduce the length of stay for these patients. At this time this is not able to be quantified but long term this can be reviewed and costed retrospectively.
Both numbers of patients seen and increase in revenue can be reviewed in comparison to current numbers once the service is up and running.

6.5 Risk management arrangements

Purchasing the machine poses a financial risk to the Trust as it will be a large capital spend, however the benefit of the spend will outweigh the risk of ceasing the service that will come with its own cost implications due to transferring out patients or prolonged inpatient stays due to alternative more invasive treatments.

The project will take the current Interventional Radiology room out of action during the period of install. This risk will be mitigated by displacing some procedures to other rooms within the Radiology Department and also by utilising a mobile unit to perform procedures on.

6.6 Post-implementation and evaluation arrangements

Retrospective audits to determine increase in patient numbers as well as the increase in variety of cases done will be possible.

Removal of restriction to use by medical physics will be lifted. Dose to patient will be at the low end of the spectrum as opposed to the high end which it currently sits.
Patient experience will be improved and there will be a measurable reduction to length of stay for patients who would have otherwise had open surgery requiring recovery time.

6.7 Contingency arrangements and plans

During the time the existing unit is out of operation there are several areas that will be utilised.
A mobile unit will be used in the second room which will allow most procedures to be completed.
The fluoroscopy room opposite the existing suite is also available for use although for limited cases due to the limitations of the room.
There is also a possibility of using the Cardiac suite out of hours but this is still in the stages of being discussed and as yet is not confirmed.
Use of other local providers is also being considered with talks underway with DVH for this to happen.

A turnkey project will minimise downtime.

7. Sign-off

Investment

Title	Name	Signed	Date
Investment lead	[X]		
Divisional leadership* / Corporate director	N Cooper Dr P Bilagi		
Finance Business Partner	A Patel		
Executive sponsor (where gross value exceed £50k)	[X] / n/a		

* For clinical divisions this must include the full divisional triumvirate/leadership.

Inter/dependency approvals

Function	Dependency (delete as applicable)	Name	Signed	Date
Capital accounting	Y/~~N~~			
Procurement	Y/~~N~~	D Small		
Workforce	~~Y~~/N			
IT	Y/~~N~~	P Butcher		
Facilities and estates	Y/~~N~~	B Edwards		
Infection prevention and control	Y/~~N~~	R Harford-Rothwell		
Pharmacy				
Therapies	~~Y~~/N			
Diagnostics and clinical support	Y/~~N~~	N Cooper		
Other care groups (please state which)	~~Y~~/N			
Other (please state)	Y/N			

Appendix 1 – Trust strategy

(Please tick which of the Trust's True North objectives this investment proposal addresses.)

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

(Please tick which of the CQC domains this investment proposal addresses.)

Safe	Effective	Caring	Responsive	Well-led
☒	☒	☐	☒	☐

Appendix 2 – Integrated impact assessment

The Trust's Integrated Impact Assessment must be completed and appended to this document.

The policy can be found here:

http://qpulse-drs.medway.nhs.uk/Corporate/Documents.svc/documents/active/attachment?number=POLCGR135

The assessment template can be found here:

Integrated Impact Assessment Template

Is the risk associated with this proposal included on the department risk register?
[Delete one]

Yes / No

If yes, please confirm the following information from the risk register:

Date risk raised	27/06/2022
Update date	12/12/2023
Risk owner	Lorraine Becconsall
Risk type	Clinical Performance and Medical Devices
Risk ref.	1363
Risk title	End of Life support of Philips FD20
Consequence score	4
Likelihood score	5
Total current risk score	20

Please complete the priority matrix below.

Assessment	Score	Strategy Fit (Including impact on sustainability)	Patient/Staff Safety/Care	Legal/Compliance	Contribution to Efficiencies	Risk Mitigation	Total
Assessed Score	1 to 5						0
Rationale	*NARRATIVE*						
Scoring Guidance	5	Clear evidence that the case delivers a specific and tangible element of the Trust's strategy	Clear evidence that the case delivers a specific and tangible improvement to patient safety	Clear evidence that the case is urgent and critical to meet a specific legal or regulatory requirement.	Over £100k a year, within 12 months of investment	Very high risk score (20 or above) as per Trust's Risk Matrix	Very high risk score (20 or above) as per Trust's Risk Matrix
	4	Clear evidence that the case directly drives a specific and tangible element of the Trust's strategy	Clear evidence that the case directly drives a specific and tangible improvement to patient safety/care	Clear evidence that the case is necessary to meet a specific legal or regulatory requirement.	£50k-£100k a year, within 12 months of investment	High risk score (15-20) as per Trust's Risk Matrix	High risk score (15-20) as per Trust's Risk Matrix
	3	Clear evidence that the case directly drives the delivery of the Trust's strategy	Clear evidence that the case directly drives the strategy on improving patient safety/care	Clear evidence that the case is recommended by legislation and regulations.	Less than £50k a year, within 12 months of investment	Medium risk score (9-14) as per Trust's Risk Matrix	Medium risk score (9-14) as per Trust's Risk Matrix
	2	Evidence that the case influences a specific part of the Trust's strategy	Evidence that the case influences a specific part of the strategy on improving patient safety/care	Evidence that the case contributes to achievement of a specific legal and regulatory requirement	Over £50k a year, more than 12 months after investment	Moderate risk score (4-8) as per Trust's Risk Matrix	Moderate risk score (4-8) as per Trust's Risk Matrix
	1	Evidence that the case influences the Trust's strategy	Evidence that the case influences improvements in patient care	Evidence that the case is desirable under regulations	Less than £50k a year, more than 12 months after investment	Low risk score (1-3) as per Trust's Risk Matrix	Low risk score (1-3) as per Trust's Risk Matrix
	0	No impact on delivering the Trust's Strategy	No impact on patient care improvements	No impact on legal or regulatory requirements	No savings/efficiencies	No risk, score 0	No risk, score 0
Weighting		**20%**	**25%**	**20%**	**10%**	**25%**	**100%**

Appendix 3 – Financial Case

Replacement IR machine Business Ca

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

January - 2024

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

Key Messages

- The Workforce sub-domain continues to show the highest volume in metrics improving for Statistical Variance (despite additional metrics included), with 6 areas of concern, however 6 of the metrics are failing against threshold

- The Access sub-domain has the highest number of variances that are statistically showing concern, with Incident Management and Financial Position domains also showing a high number of concerns

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

- Whilst the FFT sub-domain is showing the largest number of metrics not meeting the Assurance thresholds, 80% of them are showing consistent or improved variation

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

- Overall, 33 new metrics have been added since last month. 53 metrics are now showing improved statistical variance (+15 from last month) against 49 which are showing concern (+6 from last month) in month

True North	Sub Domain	Variation			Assurance		
			L	H L H	P	F	?
Patients	Complaints	2	4	0	0	1	1
	FFT	3	5	2	0	8	2
	PALS	3	1	0	0	0	0
	Patient Experience	0	0	1	0	0	1
	PHSO	3	1	0	0	0	0
People	Workforce	21	23	6	0	6	7
Quality	Falls	7	0	0	0	0	3
	Health & Safety	1	1	0	0	0	0
	Incident Management	7	6	7	1	3	1
	IPC	6	0	3	1	0	2
	Legal & Information Governance	0	1	2	0	0	0
	Maternity	7	0	2	0	0	0
	Medicines	2	0	0	1	0	0
	Mortality	7	2	4	1	3	4
	Pressure Ulcer	5	0	3	0	0	2
	Risk & Policy	5	0	1	0	0	0
	VTE	0	1	0	0	0	1
Sustainability	Financial Position	7	1	6	0	0	9
Systems & Partnerships	Access	13	4	9	2	5	12
	Emergency Care	5	3	3	1	4	3

Patients

Sarah Vaux
Chief Nursing Officer *(Interim)*

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

Committees:
Quality Assurance Committee (QAC)

NHS Medway NHS Foundation Trust

Patient FIRST

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	95.0%	H	F	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%

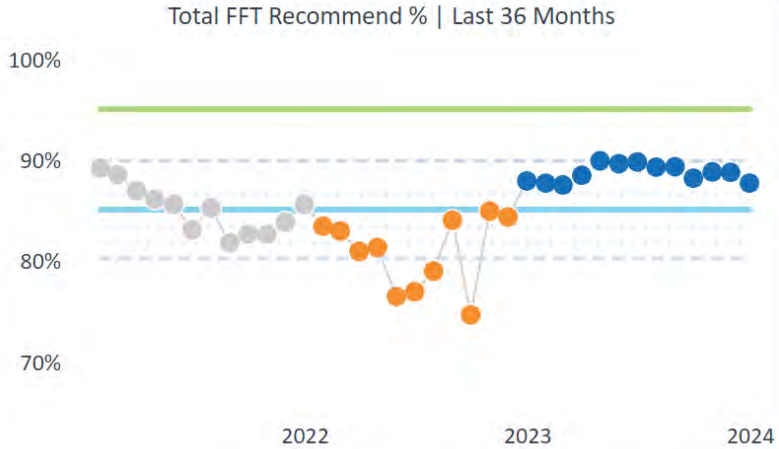
True North Domain: **Patients**

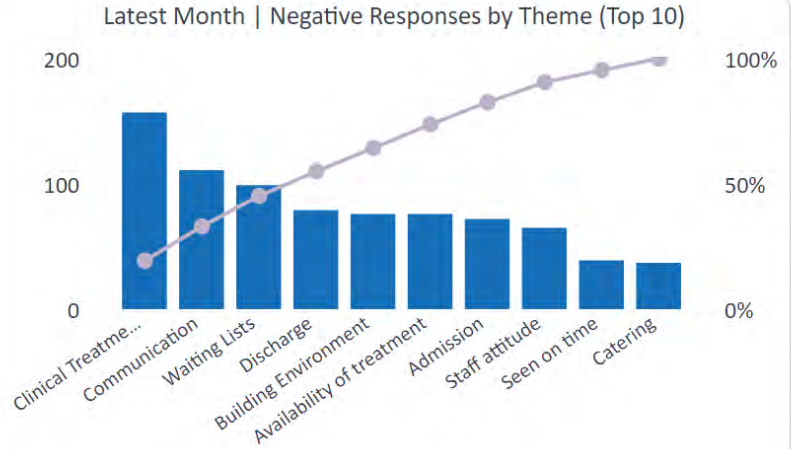
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

	L	H	L	H
3	2	0	0	5





Key Messages

- Overall response and recommend rate remains static for the last 3 months
- Emergency department recommend rate has dropped. This is likely to the ongoing operational flow challenges across the organisation.
- The top negative themes from patients.

Issues, Concerns & Gaps

- Emergency care and outpatient response rates remain low and continues to be a challenge.
- Emergency care demands and reduced patient flow out of ED continues to contribute to a reduced response rate and below expected recommend rate at 64.7%
- Data quality issues remain an issue since the merge into the new divisions.

Actions & Improvements

- Weekly breakthrough huddles continue to create appropriate counter measures weekly as indicated.
- Bespoke action plans have been developed for the ED and OPD to improve recommend and response rate. The ADPE will provide weekly support for the teams in their improvement journey.
- Data quality issues are being addressed with PMO, BI and the ADPE in relation to mapping all outpatient areas

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Patients	FFT			Total FFT Recommend %	95.0%	H	F	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%
				Total FFT Response Rate %	45.0%	H	F	10.1%	10.2%	9.7%	11.5%	11.8%	12.0%	12.2%	10.9%	13.0%	14.0%	12.0%	12.6%
				Inpatients FFT Recommend %	95.0%	H	F	89.1%	85.2%	85.5%	90.8%	92.5%	93.2%	93.5%	91.3%	90.7%	92.2%	93.3%	92.3%
				Inpatients FFT Response Rate %	45.0%	H	F	16.4%	17.9%	16.0%	25.9%	31.4%	33.0%	32.9%	29.1%	36.1%	43.6%	36.6%	34.9%
				Emergency Care FFT Recommend %	95.0%		F	73.5%	74.1%	83.1%	80.7%	75.3%	75.2%	73.1%	74.8%	75.2%	67.9%	69.2%	64.7%
				Emergency Care FFT Response Rate %	45.0%	L	F	7.6%	7.3%	7.6%	8.3%	7.1%	7.2%	8.2%	6.0%	9.6%	8.5%	7.3%	8.0%
				Outpatient FFT Recommend %	95.0%	H	F	91.1%	91.7%	91.4%	92.8%	92.2%	91.9%	91.6%	92.0%	91.1%	92.4%	91.9%	91.5%
				Outpatient FFT Response Rate %	45.0%		F	9.4%	8.9%	8.5%	8.9%	8.8%	8.8%	8.6%	8.3%	8.8%	9.0%	7.8%	9.0%
				Maternity FFT Recommend %	95.0%	L	?	92.5%	95.1%	95.6%	89.5%	83.8%	82.3%	87.8%	92.5%	92.5%	90.5%	82.7%	88.5%
				Maternity FFT Response Rate %	45.0%		?	22.3%	55.4%	32.3%	44.3%	35.1%	16.9%	31.3%	31.4%	33.3%	26.1%	14.4%	30.7%
	Patient Experience			Mixed Sex Accommodation Breaches	0	H	?	835	795	205	189	130	147	83	109				486
	Complaints			Complaints	-	L		53	44	32	24	23	28	42	35	28	33	19	19
				Complaints Closed	-			39	27	15	38	90	58	46	52	36	38	31	24

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Patients	Complaints			Complaints Open - Month End	-	L		201	219	236	222	155	125	123	106	98	94	82	77
				Complaints Re-Opened	-			4	6	0	0	9	4	2	7	1	2	2	2
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	96.2%	95.5%	100.0%	100.0%	95.7%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	73.9%	81.4%	83.7%	87.5%	58.1%	42.9%	57.5%	60.0%	37.1%	41.2%	40.6%	60.9%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			376	348	253	404	380	333	425	388	416	528	428	496
				PALS Closed	-			293	340	236	347	279	308	408	372	386	556	494	724
				PALS Open - Month End	-	L		200	208	226	283	386	411	429	445	473	448	382	154
				PALS Converted to Complaints	-			8	4	2	2	0	7	6	4	0	0	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			2	3	1	1	2	2	0	0	0	0	1	0
				PHSO Cases Closed - Partially Upheld	-			0	0	0	0	0	0	1	0	1	0	0	0
				PHSO Cases Closed - Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0

SIOR - Patients

Successful Deliverables

- Manual upload of MSA breaches was successful for January
- Complaints – Closed more complaints than opened 24 vs 19 in January for the 9th consecutive month.
- Complaints – Continued downward trend in total open complaints since April-23
- Complaints – 100% of complaints acknowledged within 3 working days
- PALS – closed more PALS than opened in month for third consecutive month
- PALS - continued downward turn in overall open PALS at month end

Next Steps

- A process map has been developed for staff to easily map what to do when an MSA breach may occur. This has been circulated to clinical colleagues for comments and will form part of the MSA policy.

Identified Challenges

- MSA reporting went live on 01/02/24. however there are still challenges with reporting justified breaches on teletracking.
- An increase in MSA breaches for January to be noted as the trust remains in OPEL 4 and escalated to Christina Rosetti and the discharge lounge.
- Complaints – unable to provide a complaint response within 25 working days for ~60% of complaints

Next Steps

- Reporting justified breaches has been escalated to the teletracking team, awaiting the dropdown box to be added on the platform. This should be resolved by early March 24.
- Christina Rosetti has now closed. All MSA breaches are still required to be escalated to the DoC despite the operational flow challenges.

Opportunities

- To move the MSA Project to BAU once the teletracking process has been established
- Complaints – pre-draft responses for breached complaints whilst awaiting comments which will enable faster response times for complainants
- PALS – better signposting and access direct to services negating the need for service users to raise a PALS concern as they cannot make contact with the service directly

Next Steps

N/A

Risks

- There is a lack of robustness in the management approach to MSA. This is reflected on the risk register which remains unchanged.
- Complaints – If turnaround times for comments from clinical teams are not received in a timely manner, then complaint responses will exceed the Trust's 25 working day KPI, leading to increased dissatisfaction from complainants

Next Steps

- The risk will be reduced once the teletracking process has been fully embedded. And the reporting issues resolved.

Quality

Sarah Vaux
Chief Nursing Officer
(Interim)

Alison Davis
Chief Medical Officer

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

Committees:
Quality Assurance Committee (QAC)

NHS Medway NHS Foundation Trust

Patient FIRST

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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	95.0%		P	99.6%	99.7%	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.3%	98.9%	99.4%	98.5%

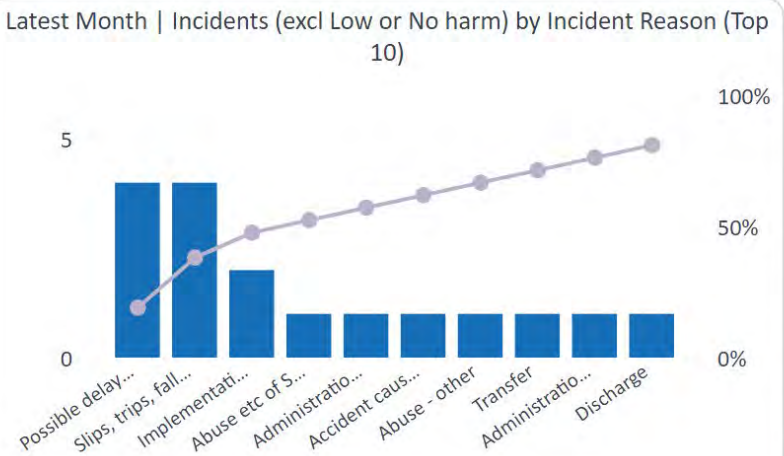
True North Domain: Quality

KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary:

	L	H	L	H
7	0	7	2	4



Key Messages

- There has been a significant drop in the number of incidents reported this month. The decrease in incidents reported for the last 2 months has coincided with the introduction of LFPSE.
- 12 hour breaches are no longer being reported due to the development of a new dashboard which provides all the data that will allow specialities to complete harm reviews as required.

Issues, Concerns & Gaps

- Further training is required to ensure staff are able to complete the LFPSE required questions.
- BI dashboard currently under construction so currently no data being captured on Datix.

Actions & Improvements

- A new training programme has been developed with adhoc sessions being provided by the PST.
- Once dashboard has been completed historic data can be reviewed by speciality teams for harm caused.

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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	1.30%			1.79%	1.51%	1.99%	1.41%	1.28%	1.29%	1.32%	1.45%	1.54%	1.18%	2.13%	2.01%

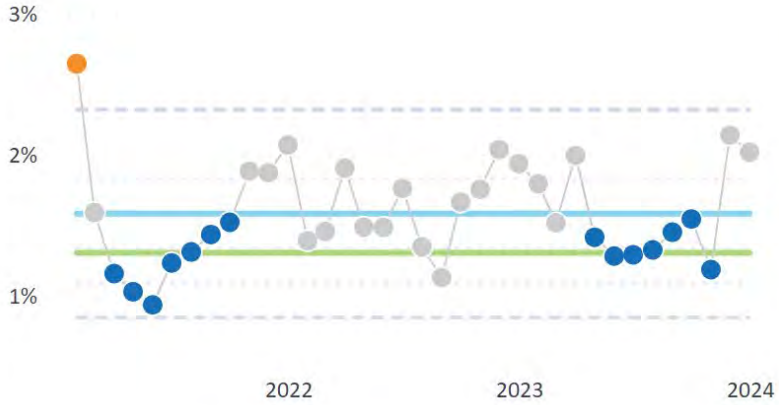
True North Domain: Quality

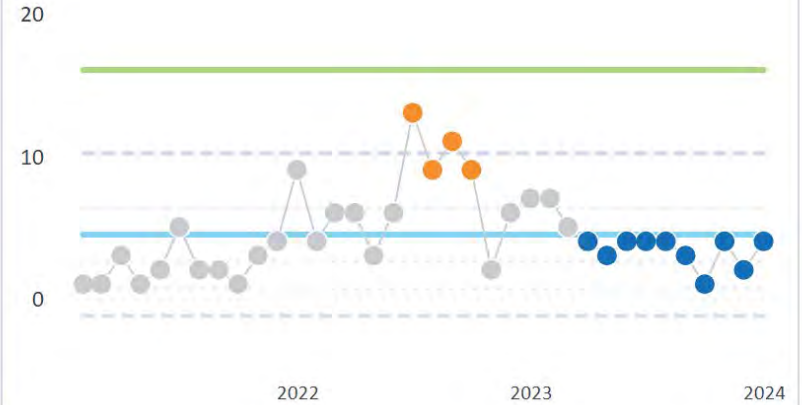
KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary:

7	0	4	1	1





Key Messages

- HMSR for Oct 22- Sept 23 is 109.67 and 'higher than expected'. This is a slight rise but a natural fluctuation in data. The trend would need to be repeated before being statistically significant.
- Expected rates of mortality continue to improve (two and half year high) but crude rates also continue to increase.
- Emergency weekend HSMR is 110.1 and 'within expected'
- Emergency weekday HSMR is 108.1 and 'higher than expected'
- SHMI for Sept 22- Aug 23 is 1.13 and 'higher than expected'- slight divergence noted between crude and expected rate causing the slight increase in SHMI.
- 6.6% of death were subject to SJRs with one case judged as potentially avoidable. This case was escalated to IRG and declared as a Serious Incident.
- The Learning Disability case was judged as definitely not avoidable. The case will be sent to LeDeR for review and was sent to Frailty for Speciality M&M discussion.

Issues, Concerns & Gaps

- SHMI has moved back into a 'higher than expected' value' and a further look into next months data issue indicates another rise in SHMI value driven by increased crude rates and decreased expected rates.
- Speciality M&M compliance has shown little improvements

Actions & Improvements

- The potential failing in care was escalated to the IRG and declared as an SI which is currently ongoing. Learnings will focus on staff training in pre assessment, processes to have blood results printed in full and risk assessment matrix to be made available at the time of pre-op assessment.
- Clinical Coding and Learning from Deaths are presenting at Speciality M&M meetings on the importance of documentation and the impact of coding, finance and mortality. Indicators.
- The new mortality newsletter which will share learning from SJRs and update the Trust on mortality and coding issues has been drafted, ready for sign of at the MMSG in February.
- B5 administration support now in post for the mortality team.
- The Trust is currently undergoing a review from NICHE into the Learning from Deaths process.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.6%	99.7%	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.3%	98.9%	99.4%	98.5%
				Total Incidents Reported	-	H		1,358	1,538	1,102	1,154	1,463	1,505	1,650	1,766	1,984	2,155	1,686	1,366
				Incidents with Harm (Moderate and above)	0	H	F	5	4	8	10	12	12	13	15	14	24	10	21
				Incidents Open - Month End	-	H		1,432	1,586	1,296	1,127	1,260	1,244	1,316	1,662	2,126	2,380	2,941	2,730
				Incidents Overdue - Month End	-	H		363	474	274	241	185	168	200	362	446	671	1,104	1,614
				Serious Incidents	-			11	10	2	8	4	3	4	7	7	16	2	4
				Serious Incidents Closed	-			2	9	10	9	11	8	14	12	11	6	9	9
				Serious Incidents Open - Month End	-	L		68	69	61	60	53	48	39	33	28	38	31	26
				Serious Incidents Responded to Within 60 Days %	95.0%		F	14.3%	22.2%	30.0%	14.3%	57.1%	40.0%	0.0%	40.0%	25.0%	33.3%	66.7%	56.3%
				Serious Incidents Closed by ICB 1st Time %	-	H		0.0%	11.1%	40.0%	44.4%	36.4%	62.5%	35.7%	75.0%	81.8%	100.0%	100.0%	88.9%
				Never Events	0	L	?	0	0	0	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		87.5%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-			100.0%	71.4%	0.0%		77.8%	50.0%	72.7%	66.7%	83.3%	100.0%	100.0%	71.4%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	Incident Management			RIDDOR Incidents	-	H		3	1	3	2	4	4	5	4	2	0	0	4
				RIDDOR Compliance %	-			100.0%	100.0%	66.7%	100.0%	75.0%	100.0%	40.0%	75.0%	0.0%	-	-	50.0%
				Health & Safety Incidents	-	H		31	19	25	17	19	107	118	118	96	108	80	119
				Sharps Injuries	-			7	8	8	11	8	15	14	10	6	12	10	7
				Violence & Aggression Incidents	-	H		54	60	74	83	155	141	109	136	127	138	176	193
				Assaults - Patient on Staff	-	H		27	36	41	44	71	58	63	75	55	64	60	64
				EDNs Completed Within 24hrs %	90.0%	H	F	69.5%	70.4%	70.0%	74.1%	74.7%	73.2%	72.7%	74.9%	78.8%	77.9%	74.3%	75.3%
	Falls			Low or No Harm Falls %	95.0%		?	95.5%	98.9%	96.4%	100.0%	100.0%	97.1%	96.2%	97.8%	97.4%	95.9%	98.9%	100.0%
				Falls - Total	-			89	90	84	61	71	69	78	92	78	74	88	77
				Falls - Low Harm	-			24	19	15	14	20	24	25	26	23	10	30	24
				Falls - Moderate Harm	-			4	0	0	0	0	1	2	0	2	1	0	0
				Falls - Severe Harm	0		?	0	1	3	0	0	1	1	2	0	1	1	0
				Falls Resulting in Death	0		?	0	0	0	0	0	0	0	0	0	1	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	Falls			Falls per 1,000 Bed days	-			6.33	5.88	5.67	3.98	4.81	4.47	5.08	5.96	4.99	4.97	5.86	5.05
	Pressure Ulcer			Pressure Ulcers - Total	-	H		51	38	33	30	37	43	41	41	44	46	40	33
				Pressure Ulcers - Grade 1	-	H		12	15	8	2	6	16	15	14	19	16	20	10
				Pressure Ulcers - Grade 2	-			11	6	5	10	3	9	5	5	3	6	3	5
				Pressure Ulcers - Grade 3	0		?	0	0	0	0	1	0	0	0	0	1	0	0
				Pressure Ulcers - Grade 4	0		?	0	0	0	1	0	1	0	0	3	1	2	0
				Pressure Ulcers - Unstageable	-			19	10	9	9	14	7	9	6	7	7	8	8
				Pressure Ulcers - Deep Tissue Injury	-			9	7	11	8	13	10	12	16	12	15	7	10
				Pressure Ulcers per 1,000 Bed Days	-	H		3.63	2.48	2.23	1.96	2.51	2.79	2.67	2.66	2.81	3.09	2.67	2.16
	Medicines			Medicine Errors - Total	-			66	87	71	72	82	98	101	74	87	97	70	63
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	100.0%	100.0%	98.6%	100.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	98.4%
	IPC			IPC Incidents	-			9	19	11	7	24	30	54	41	56	39	53	35
				C-Diff Cases - Hospital Acquired Total	-			1	4	7	6	8	3	1	5	3	3	5	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	33			42	46	7	13	21	24	25	30	33	36	41	44
				C-Diff Cases - Hospital Acquired (HOHA)	-			1	2	5	4	5	2	0	3	3	3	3	1
				E.coli Cases - Hospital Acquired	-			3	3	6	4	4	5	9	4	9	5	8	2
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			47	50	6	10	14	19	28	32	41	46	54	56
				MRSA Cases - Hospital Acquired	0		?	0	0	1	1	0	0	0	0	1	1	0	0
				MSSA Cases - Hospital Acquired	-			2	0	2	3	7	2	1	2	4	3	1	4
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			25	25	2	5	12	14	15	17	21	24	25	29
	Mortality			Crude Mortality Rate %	1.30%		?	1.79%	1.51%	1.99%	1.41%	1.28%	1.29%	1.32%	1.45%	1.54%	1.18%	2.13%	2.01%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	1	3	2	1	1	2	0	1	1	2	2	1
				Avoidable 2222 Calls – Peri-Arrests	3		?	6	2	2	2	3	2	4	2	0	2	0	3
				Avoidable 2222 Calls	16	L	P	7	5	4	3	4	4	4	3	1	4	2	4
				HSMR (All)	100	H	F	116.60	115.07	115.16	112.85	111.91	109.55	109.09	109.73				
				Expected Death Rate %	-	H		3.6%	3.7%	3.7%	3.8%	3.8%	3.8%	3.8%	3.9%				
				SHMI	1	H	F	1.14	1.14	1.14	1.15	1.14	1.12	1.13	1.16				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	Mortality			Fractured NOF Within 36 Hours	92.0%		?	56.1%	48.6%	67.6%	72.2%	56.0%	48.4%	76.7%	31.3%	52.1%	71.9%	50.0%	
				Number of Deaths Reviewed via SJR	-	H		13	8	8	11	14	15	9	8	12	13	8	13
				SJRs Completed %	25.0%		F	8.0%	5.1%	5.0%	8.5%	11.0%	11.2%	7.0%	6.3%	7.8%	9.8%	4.3%	6.6%
				Total Number of Deaths Due to Failings in Care	-	H		0	0	0	0	0	0	0	0	0	0	0	1
				Number of LD Deaths Reviewed via SJR	-			3	0	1	1	0	1	0	1	1	1	0	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	?	73.2%	80.6%	84.6%	88.4%	91.8%	98.2%	98.8%	99.5%	98.2%	98.7%	97.1%	98.1%
	Maternity			Caesarean Section %	-	H		52.5%	40.5%	49.3%	45.2%	50.8%	48.2%	44.9%	47.3%	46.7%	51.6%	48.8%	49.6%
				Elective C-Section %	-			22.7%	15.9%	17.2%	16.7%	20.8%	16.4%	16.9%	22.0%	21.0%	21.5%	17.6%	19.8%
				Emergency C-Section %	-			29.8%	24.7%	32.1%	28.6%	29.9%	31.8%	28.0%	25.3%	25.6%	30.0%	31.2%	29.8%
				PPH greater than 1000mls	-			35	34	40	35	44	35	56	30	39	49	54	35
				Total Number of Still Births Greater Than 24 weeks Gestation	-			1	1	3	0	2	1	1	2	2	3	0	1
				Neonatal Deaths	-			0	0	2	2	1	2	4	4	0	1	4	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Quality	Maternity			Maternity Serious Incidents	-			2	1	0	1	0	2	0	0	0	0	1	2
				Maternity HSIB Referrals	-			0	0	0	0	0	1	0	0	0	0	1	2
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			1	0	0	0	0	1	0	0	0	1	1	1
	Risk & Policy			Risks Approved	-			30	58	18	13	18	12	16	17	11	10	18	10
				Risks Approved - Low	-			0	0	0	0	0	0	0	0	0	0	0	1
				Risks Approved - Moderate	-			1	1	0	0	1	0	2	0	1	0	1	1
				Risks Approved - High	-			26	47	10	8	11	8	11	11	6	7	10	6
				Risks Approved - Extreme	-			3	10	8	5	6	4	3	6	4	3	7	2
				Risks Approved - Closed	-			3	1	6	33	24	3	6	14	12	17	3	9
	Health & Safety			Resuscitation Training Compliance %	-			79.1%	78.7%	79.4%	79.3%	80.9%	81.1%	78.6%	79.5%	81.3%	81.6%	81.2%	82.2%
				Mental Capacity Act Training Compliance %	-			81.0%	81.8%	81.9%	81.9%	83.1%	82.3%	81.3%	80.6%	80.3%	80.6%	81.5%	81.4%
	Legal & Information Governance			Inquests Received	-			8	10	0	5	3	14	18	16	6	8	21	14
				Inquest Hearings	-			3	1	2	4	3	3	5	6	6	13	3	7

Quality

KPI Scorecard

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

SIOR - Quality

Successful Deliverables

- The number of falls has reduced in January with no patients resulting in severe harm.
- Falls and TVN team have moved to PSIRF reporting which is working well and intensive support huddles on the wards continue.
- VTE compliance remains above target
- IPC – Working as part of Kent and Medway C.difficiles collaborative and NHSE regional MRSA collaborative to develop better understanding of the infections and increase. Trust is not an outlier.
- eDN programme - generation and transfer of eDN's moved to Flow & Discharge programme; and resolved issue with Area 8 activity

Next Steps

- To propose to increase the VTE nurse post from 0.6 WTE to 1.0 WTE though the business planning cycle, to decrease the risks raised on the register.
- Complete the deep dive for eDN pathways in SDEC & Sunderland Day Unit
- Confirm Divisional Governance tracking of eDN's
- Review the metric for eDN completion within 24 hours to identify optimal time to ensure early completion but resolve re-works. Also impacted by transfers within system where eDN completion pre-discharge is a requirement for social care to take patients in advance of planned discharge date

Identified Challenges

- Staffing in the falls team has been identified as an issue.
- The transfusion and thrombosis group commenced in November however there has not been a further date set, this has been documented on the risk register
- Falls and TVN equipment process has been a consistent challenge.
- New wound care guidance has been published nationally which is required to be implemented by April 2024.
- IPC – continue to acquire new Hospital infections however remain at only 3 avoidable C.difficiles out of the 44 cases
- eDN backlog review confirmed that the full backlog number (circa 30,000 records validated as unsent)

Next Steps

- The teams to contribute to the business planning cycle to look at capacity and demand within the team. this will identify any staffing gaps within the service.
- An A3 has commenced in line with the patient first methodology to identify the root causes for equipment issues. This is being led by the TVN, Falls and E&F teams.
- A roll out plan for the new wound care guidance is being drafted and will be shared in all forums.
- To support the VTE nurse to transition their work into the Transfusion and thrombosis group to a BAU position. The integrated governance team have offered support to get this started.
- eDN Backlog – agree process for clinical review and backlog closure

Opportunities

- New pressure ulcer guidance was published in January 2024.
- PSIRF – transition to new framework 1 February 2024 enabling greater opportunity to focus on learning and improvement rather than lengthy investigations
- IPC – Since IPC started to datix all Hospital infections the reporting numbers have remained at a consistent level. The previous low number meant IPC was not included in first roll out of PSIRF.

Next Steps

- TVN - the guidance will be reflected in local policy and shared with clinical teams by late February 2024
- IPC – Working and aligning with PSIRF for investigations. 1st draft QIP now refining actions before agreeing it with ICB to be part of phase 2 roll out.
- FNoF - The long term Ortho-geriatrician to support the medical care has been advertised and the job plan is currently under review by the surgical directorate

Risks

- VTE: Information from the VTE assessment is not being pulled through to PAS and being logged on a separate software system / There is no robust process for reporting positive VQ /
- 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.
- Clearance of eDN backlog will require additional resource as a cost

Next Steps

- To propose to increase the VTE nurse post from 0.6 WTE to 1.0 WTE though the business planning cycle, to decrease the risks raised on the register.
- TVN - A Task and finish group has commenced to remedy the equipment issues
- FNOF - Continue to look at ways of increasing theatre capacity and productivity; whilst also improving medical optimisation of patients

SIOR - Maternity

Successful Deliverables

Declared compliance with all 10 Safety actions of CNST Year 5.

- LMNS validated 74% compliance across all Saving Babies Lives Care Bundle v3 elements. Meets CNST requirements and on track to achieve full compliance in March 2024 (validated July 2024)
- All MBRRACE cases reported within required timeframes.
- Launch of MNVP/Service user co-produced virtual unit tour.
- Midwifery Safeguarding Adults Lvl 3 training now at 61% (previously incorrectly mapped for maternity staff)
- 0 incidents moderate harm or above.
- Board Level Safety Champion walkabout completed in month.

Next Steps

- Continue to progress identified actions to achieve full compliance with SBLv3 by March 2024.
- Prepare audits and evidence submission for Q3 SBLv3 in March 2024.
- Training trajectory in place for Adult Safeguarding Level 3 training – on track to achieve >85% compliance by March 2024.
- Continue to work with MNVP including 15 Steps Challenge and "Who's shoes" event in 2024.
- Staff feedback from walkabouts, including concerns regarding burnout, form part of action plan from SCORE survey.

Identified Challenges

- 2 MNSI referrals/Sis : 1st case – HIE grade 3 following unknown pregnancy, 2nd case HIE grade 3 following LSCS
- 2 MBRRACE reportable deaths in January 2024: 1 NND 20+1, 1 Stillbirth 25+1
- 1 Maternity PMRT meeting Jan 2024 : 1st Case – D, C due to parental concerns – HLI held following delivery
  - 2nd Case – D, C due to parental concerns – HLI held following delivery
- 1 Neonatal PMRT: 1st Case, D, A, A – baby delivered at neighbouring Trust and there is a robust action plan in place.
- 1 Coroner's case scheduled for March 2024.
- Staff training January 2024 : Obstetric Emergency 84% ,Fetal Monitoring –89%, NBLS – 80% - Data quality issue with NBLS on ESR

Next Steps

- PMRT cases reviewed in January both HLI with action plans in place. To work with Risk and Governance midwives to triangulate actions from PMRT and HLIs to ensure robust learning action plan in place.
- No immediate learning or actions from MNSI referrals. Supporting MNSI investigation process.
- Risk and Governance midwives continue to support staff prior to upcoming coroner's case.
- Medical staff out of date for Obstetric emergency and fetal monitoring training booked in upcoming months. Midwives >90%.
- NBLS data issues raised with ESR team.

Opportunities

- Weekly review of free text from FFT with HOM/Matrons/Senior Sisters – actions to be incorporated into service user feedback action plan on BAF.
- SCORE Culture survey (staff) results published and actions and recommendations from staff to form part of action plan. Shared with Board Level Safety Champion and NED. Re-survey in 6 months time.
- Service user engagement in training development via MNVP.
- 3 PMAS undertaken Culture Coaches training and now have the skills to support and hold cultural conversations in addition to external sessions. To support with further sessions and implementing actions from SCORE survey.

Next Steps

- Service user feedback to be incorporated into in-situ sims and education sessions.
- Ongoing work to triangulate service user feedback from all avenues, including complaints, incidents, claims, surveys and FFT to further develop and co-produce improvement plan.
- On back of SCORE survey conduct Breaks audit, identify barriers to breaks and develop action plan with target and trajectory for improvement.
- Relaunch "You Said, We Did" across the unit to allow staff to see the outcomes from actions.
- Continue with monthly "Teams Talk".

Risks

- Maternity Staffing remains the highest scoring risk on the Women's risk register (Risk ID Midwifery staffing ID 1134 Score= 20)
- Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info Risk ID 1025 Score =15)
- Induction of Labour has been identified as a significant red flag within the acuity tool (Risk ID delays in induction of labour ID 1131 Score reduced 12)

Next Steps

- Continue with recruitment and retention work, alongside business case for Birthrate Plus recommendations.
- Euroking to be standing agenda item at IGG meetings as agreed with DPO from October 2023 onwards until issue resolved. Reviewed with CDO, Increase in risk score to 15, waiting for capital budget to be confirmed in 24/25 to procure new system.
- Induction of Labour A3 QI project showing significant reductions in delays in IOL- consider reduction in risk score if reduction sustained.

Systems & Partnerships

Nick Sinclair
Chief Operating Officer

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

Committees:
Finance & Performance Committee

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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	92.0%	L	F	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%

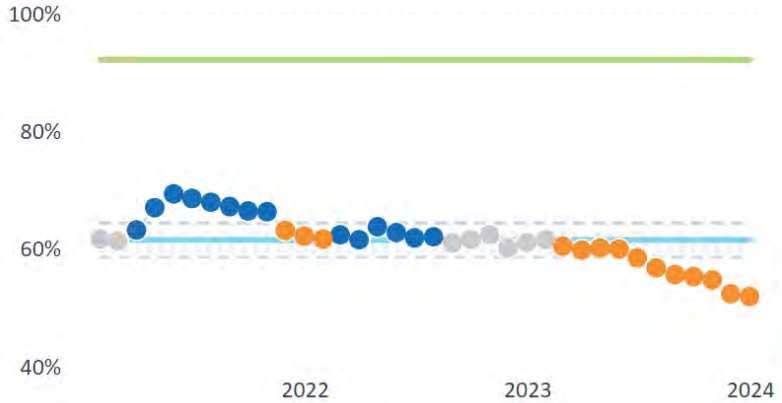
True North Domain: **Systems & Partnerships**

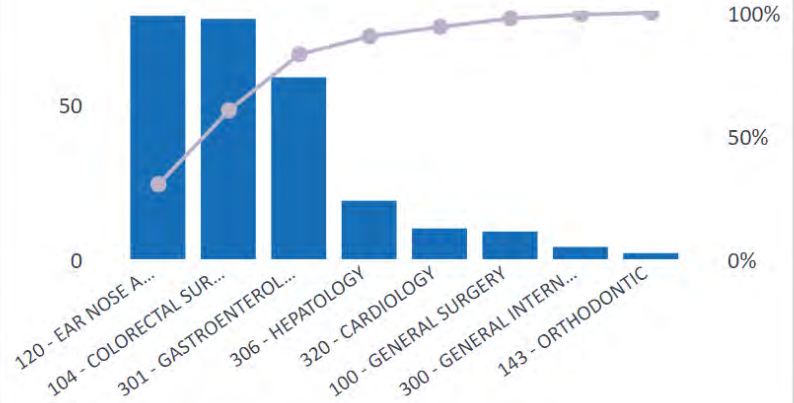
KPI Threshold: 92.0%

Sub Domain KPIs: 26

Variation Summary:

	L	H	L	H
13	2	7	2	2





Key Messages

Poor performance in RTT position, in part due to ongoing industrial action but also lacking assurance around robust validation – training pack in progress to support clinical and non clinical staff with PTL management

Lack of endoscopy capacity remains a driving force in poor RTT and cancer performance

Issues, Concerns & Gaps

RTT
Inability to clear 78 week waits in Gastro and Colorectal by end of March 24 due to lack of endoscopy capacity
Inability to view ENT patients at DVH
Cancer
Ongoing issues with backlog within LGI and UGI due to lack of endoscopy capacity

Actions & Improvements

RTT
New PTL process commencing first week of March
Training programme for clinical and non clinical staff for PTL management in development
Care Groups linked with long waiters asked to provide recovery plan and trajectory for all patients who will hit 78 weeks by the end of March
Cancer
Deep dive of each tumour site underway for 28 days underway starting with lung
Ongoing work with Tier 2 around sourcing Endo capacity

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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	76.0%			70.4%	72.7%	75.4%	74.8%	73.2%	71.2%	73.6%	74.6%	75.4%	71.0%	65.3%	68.3%

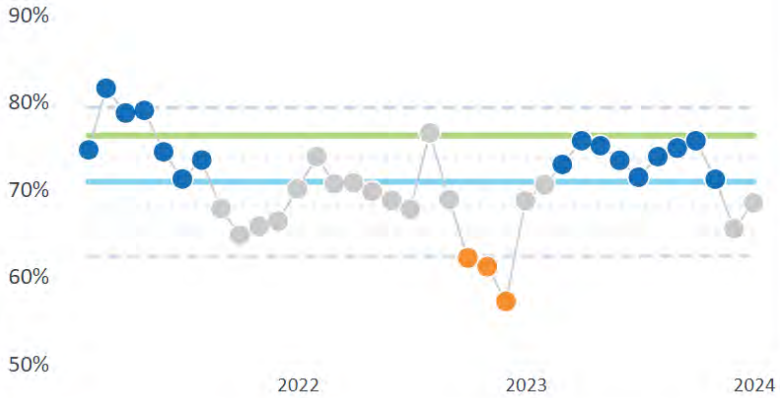
True North Domain: Systems & Partnerships

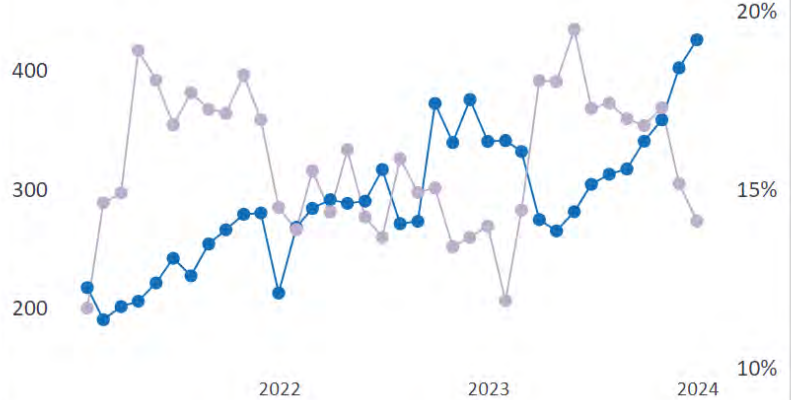
KPI Threshold: 76.0%

Sub Domain KPIs: 11

Variation Summary:

5	1	2	3	0





Key Messages

4 Hour performance has improved slightly in January to 68.3% but still remains challenged due to the high acuity and number of patients. Area 3 was frequently blocked which directly affects 4 hour performance due to the inability to assess patients.
Type 3 performance continues to be challenging and under utilisation of alternative pathways such as MEDOCC and SDEC.

Issues, Concerns & Gaps

Flow out of the acute floor continues to be challenged with corridor care and lodging of various areas within ED, frequently utilised. The utilisation of CDA has not been optimal due to the complexity of mental health patients.
The Trust have not yet achieved 40% of discharges by midday with a high number of medically fit patients occupying beds across the Trust.

Actions & Improvements

Review of speciality in-reach cover to target patients at the front door and reduce conversion rate of DTAs
Maintain utilisation of CDU & plan workforce around this to ensure we are utilising 24 hours a day with RN.
SPOA pathway to be launched in March to reduce unnecessary conveyances into ED, previous studies have shown a reduction of 60-70 conveyances per week once established

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Systems & Partnerships	Access			RTT Incompletes Performance %	92.0%	L	F	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%
				RTT 65+ Week Waiters	0	H	F	221	104	119	90	91	101	176	220	246	217	237	260
				RTT 40+ Week Waiters	-	H		2,569	2,726	3,083	3,236	3,139	3,465	4,235	4,370	4,395	4,523	5,311	5,602
				RTT Waiting List Size	-	H		35,991	36,835	36,659	37,018	37,847	38,661	39,676	40,403	41,150	41,562	42,487	43,225
				RTT 52 Week Breaches	0	H	F	560	471	581	820	877	1,019	1,143	1,209	1,291	1,441	1,439	1,675
				OP Average Time to First Appointment (days)	60	H	F	90.52	89.74	79.11	88.86	86.56	90.62	86.92	94.19	97.65	98.11	95.34	99.37
				Outpatient DNA Rate %	10.0%	L	P	7.5%	7.9%	7.8%	7.9%	8.2%	8.1%	7.9%	9.5%	8.0%	7.4%	7.9%	6.7%
				OP First to Follow Up Ratio	-	L		2.26	2.29	2.48	2.46	2.30	2.20	2.29	2.19	2.22	2.05	2.15	2.11
				Operations Cancelled by Hospital on Day	0		?	8	29	8	13	13	11	5	14	9	20	12	15
				Cancelled Operations Not Rescheduled < 28 Days %	-			25.0%	51.7%	37.5%	53.8%	7.7%	45.5%	80.0%	21.4%	22.2%	70.0%	75.0%	40.0%
				Urgent Operations Cancelled for 2nd Time	0		?	0	1	2	2	1	2	0	2	1	3	2	0
				Day Case Rate %	-	H		84.9%	84.9%	85.8%	85.5%	83.8%	85.5%	85.7%	85.3%	86.7%	85.8%	86.1%	87.1%
				Average Elective Length of Stay (days)	3	H	?	2.10	2.44	2.78	2.48	2.49	2.46	2.60	2.74	3.32	3	2.79	2.62

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10	H	P	4.56	4.56	4.93	4.57	4.63	4.51	4.50	4.89	4.83	4.79	4.81	4.73
				104 Day Cancer Waits	-			7	7	7	12	7	13	12	10	17	17	7	
				Cancer 2ww Performance %	93.0%		?	70.7%	80.9%	94.5%	94.9%	92.2%	94.3%	88.5%	93.4%	90.2%	85.8%	92.7%	
				Cancer 2ww Performance - Breast Symptomatic %	93.0%		?	6.9%	16.7%	93.6%	100.0%	83.3%	100.0%	41.7%	83.1%	80.0%	63.5%	69.4%	
				Cancer 31 Day First Treatment Performance %	96.0%		?	98.2%	100.0%	100.0%	98.8%	98.7%	99.3%	98.2%	98.8%	98.1%	93.6%	99.2%	
				Cancer 31 Day Subsequent Treatments - Drugs %	98.0%		?	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	97.5%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	94.0%		?	91.3%	100.0%	94.4%	91.3%	100.0%	100.0%	85.0%	95.0%	93.9%	93.8%	100.0%	
				Cancer 62 Day Treatment - GP Refs %	85.0%		?	85.6%	78.5%	79.2%	67.1%	71.4%	72.5%	74.8%	78.9%	65.6%	68.1%	79.0%	
				Cancer 62 Day Treatment - Cons Upgrades %	50.0%		?	61.1%	87.5%	77.8%	72.7%	34.4%	75.9%	76.7%	83.3%	81.3%	81.6%	78.4%	
				Cancer 62 Day Treatment - Screening Refs %	90.0%		?	72.7%	100.0%	88.9%	40.0%	70.0%	77.8%	87.5%	65.9%	72.4%	85.2%	74.1%	
				Cancer 28 Day Faster Diagnosis %	75.5%		?	75.3%	75.7%	77.6%	69.3%	72.4%	73.3%	74.0%	70.0%	66.6%	65.2%	69.8%	
				Cancer 28 Day Faster Diagnosis Screening %	-	H		81.8%	52.9%	78.6%	82.1%	55.8%	68.6%	66.1%	61.9%	68.5%	74.1%	76.7%	
				DM01 Performance %	99.0%	L	F	72.4%	72.2%	67.7%	65.5%	67.1%	65.1%	59.8%	61.6%	61.3%	62.1%	56.6%	59.5%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	76.0%		?	70.4%	72.7%	75.4%	74.8%	73.2%	71.2%	73.6%	74.6%	75.4%	71.0%	65.3%	68.3%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	L	?	76.7%	78.9%	82.4%	80.3%	79.2%	76.9%	79.8%	80.5%	81.2%	76.7%	71.8%	73.7%
				IP Discharged Before Noon % (Inc transfers to ADL)	40.0%		F	11.8%	14.4%	18.0%	18.0%	19.5%	17.2%	17.4%	16.9%	16.8%	17.3%	15.1%	14.1%
				Type 1 EC 4 Hour Performance %	75.0%		F	58.2%	58.2%	62.8%	64.8%	65.9%	63.0%	64.2%	65.8%	65.2%	62.0%	52.9%	59.1%
				Total EC 12 Hour Breaches	0	H	F	428	540	131	106	190	344	387	572	742	766	785	953
				Average Time in EC Department (mins)	200	H	F	340.05	330.79	273.57	264.10	280.22	303.24	311.69	316.19	339.50	357.44	401.08	424.67
				Number of ED Arrivals by Ambulance	-			2,704	2,915	2,929	3,048	2,777	3,007	2,978	3,009	3,107	3,142	3,167	3,281
				Ambulance Handover Delays (> 30 mins)	-	L		111	77	57	32	40	59	42	46	73	85	177	161
				Ambulance Handover Delays (> 60 mins)	0	L	?	5	3	2	2	3	1	2	3	1	3	10	9
				Medically Fit for Discharge Patients %	9.0%			-	-	-	-	-	-	-	-	-	-	-	-
				30 Day Readmission Rate	13.0%	L	P	9.7%	9.4%	10.0%	9.2%	10.0%	9.5%	9.1%	9.3%	10.1%	9.7%	10.3%	8.5%

SIOR - Access

Successful Deliverables

DM01
- All areas over 95% outside of Endoscopy

Cancer
- Maintenance of 28 FDS at around 70% despite ongoing issues with LGI and UGI due to endo capacity

Next Steps

Cancer
- Ongoing work with Tier 2 teams around cancer backlog – No potential support in the short term to improve this position. CEO has been in attendance at the Tier 2 meetings.
- Pathway reviews of all tumour sites (28 days) underway starting with lung

Identified Challenges

RTT
- Poor validation and processes around PTL management
- Still a number of patients waiting over 65 and 78 weeks
- Endoscopy capacity impacting colorectal, gastro and hepatology waits

Next Steps

RTT
- New PTL process commencing first week of March
- Training programme for clinical and non clinical staff for PTL management in development
- Care Groups linked with long waiters asked to provide recovery plan and trajectory for all patients who will hit 78 weeks by the end of March

Opportunities

RTT/Cancer
- Potential of increased mutual aid to support Endoscopy capacity is unlikely above current levels due to funding and logistical constraints. Therefore the Endoscopy situation is likely to continue for some time. We are continuing to explore the elective hub but may need to go back and consider other opportunities.

Next Steps

RTT/CANCER
- Continued discussion with ICB/National team

Risks

RTT
Clearing >78 weeks by end of March due to Endoscopy capacity
Cancer
28 days compliance

Next Steps

RTT
- Care Groups linked with long waiters asked to provide recovery plan and trajectory for all patients who will hit 78 weeks by the end of March

CANCER
- Deep dive of all cancer 28 day pathways starting with lung

SIOR - Emergency Care

Successful Deliverables

Non-Admitted 4 Hour

- Although our non-admitted performance is below threshold, we are still doing better performance wise looking at a yearly basis.
- CDA performance is also improved on the previous year.

Direct 111 Pathway

- The Direct 111 pathway has eliminated 111 breaches and subsequently reduced the number of DTAs

Next Steps

- Continued push for improvement of CDA utilisation
- Development of SDEC and Single point of access Pathways via ED.
- Continue to work towards implementation of HARIS initiatives covering High Intensity Users and reduction of Ambulance Conveyance
- De-escalation and protection of recently escalated EAU and Discharge lounge, and embedding of escalation processes to improve flow.

Identified Challenges

- Increased number of referrals and DTAs
- Type 3 performance.
- Sustained non admitted performance.
- Mental Health CDA utilisation.
- Acute floor flow – Lister & Sapphire have extended LOS due to medical outliers.

Next Steps

- AMU Emergency Pathway established pilot to reduce number of LOS
- Continue review of Mental Health pathways.
- Increase utilisation of streaming to Meddoc and alternative care pathways. Type 3 Performance recovery plan to be monitored through UEC Delivery Board.

Opportunities

- Partnership working with KMPT to fully utilise mental health pathways.
- Direct access to SDEC via SECAMB.
- SDEC emergency care pathway.
- Single point of access pathway to reduce unnecessary conveyances to ED
- Speciality in-reach

Next Steps

- Collaborative working with SECAMB, frailty and ED to design SPOA pathway to launch in March.
- Improved utilisation of Mental health pathways in collaboration with KMPT.
- Review of SDEC clinics – to be matched in line with avoidable DTA's.
- Embed speciality in-reach in job planning

Risks

- System capacity.
- High acuity and increased attendances via ED.
- Industrial Action.
- Ongoing increased demand continue overspend against budget

Next Steps

- System partnership working to address and understand support when acute Trust is at critical capacity.
- KMPT to review and address prolonged wait times for mental health patients i.e. awaiting admission.
- Launch pilot of SDEC emergency care, SPOA and HIU pathways.
- Review job plans of Speciality Doctors to provide in-reach

People

Leon Hinton
Chief People Officer

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

Committees:
People Committee

NHS Medway NHS Foundation Trust

Patient FIRST

People

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

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Feb-23	Mar-23
	6.93	H	F	6.63	6.63

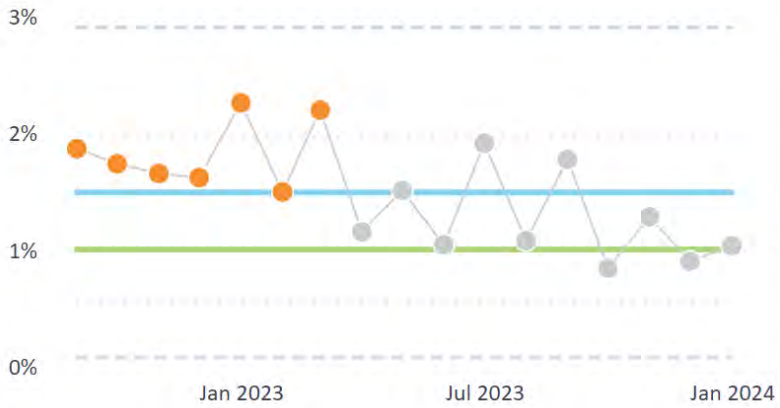
True North Domain: People

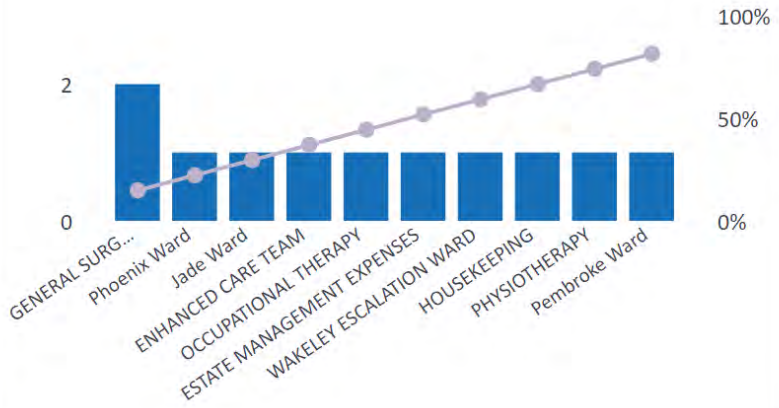
KPI Threshold: 6.93

Sub Domain KPIs: 50

Variation Summary:

	L	H	L	H
21	6	0	3	20





Key Messages

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

The new breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% is in operation with January 2024 reporting on-target (positive) than the monthly target (a positive direction over 12-months); the reports have now moved to the new divisions and will support a new level of details. The new stay conversation processes and intention to leave process are now both live; however, with low take up. A communication plan is being worked up with divisions to ensure the right processes are being followed for those intending to leave.

Issues, Concerns & Gaps

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

Actions & Improvements

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

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
People	Workforce			National Staff Engagement Score	6.93	H	F	6.63	6.63										
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.5%	2.2%	1.2%	1.5%	1.0%	1.9%	1.1%	1.8%	0.8%	1.3%	0.9%	1.0%
				Staff Appraisal Rate %	90.0%	H	F	90.7%	91.7%	92.3%	92.2%	92.3%	91.5%	91.7%	90.0%	89.6%	89.5%	88.6%	88.0%
				Staff in Post (FTE)	-	H		4,635.23	4,691.08	4,685.85	4,703.40	4,737.11	4,768.93	4,847.14	4,843.39	4,926.12	4,960.58	4,989.68	5,010.61
				Staff Leavers (FTE)	-			55.81	66.40	55.76	50.59	45.45	59.55	129.36	80.43	64.89	56.52	45.37	38.76
				Staff Starters (FTE)	-			71	87.72	66.93	80.02	59.85	74.79	164.08	102.71	133.28	78.48	45.43	77.83
				Vacancy Rate %	9.0%	L	?	7.6%	6.5%	7.5%	7.3%	6.3%	5.7%	5.1%	4.5%	4.0%	4.1%	3.6%	3.2%
				Voluntary Turnover %	8.0%	L	F	12.9%	12.5%	12.6%	12.5%	12.5%	12.0%	11.4%	11.2%	10.8%	10.8%	10.6%	10.1%
				Staff Fill Rate - Total %	85.0%	H	?	80.0%	82.2%	87.7%	89.9%	91.1%	91.8%	90.5%	88.1%	89.5%	92.8%	90.0%	91.1%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		78.3%	80.3%	86.0%	87.1%	88.4%	88.1%	86.3%	84.8%	87.7%	89.3%	88.2%	88.8%
				Care Hours per Patient Day (CHPPD)	9.50	H	F	8.53	8.52	9.14	9.21	9.27	9.14	9.15	9.03	9.05	9.16	9.01	9.05
				Sickness Absence Rate - Total %	4.0%		?	4.6%	4.6%	4.0%	4.0%	4.0%	4.3%	4.7%	4.9%	4.9%	4.4%	5.1%	5.2%
				Sickness Absence Rate - Short Term %	2.0%		?	2.4%	2.5%	2.1%	2.0%	1.8%	1.9%	2.4%	2.7%	2.4%	2.1%	2.9%	3.3%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
People	Workforce			Sickness Absence Rate - Long Term %	2.0%	L	?	2.2%	2.1%	1.9%	1.9%	2.1%	2.4%	2.3%	2.2%	2.5%	2.3%	2.1%	1.9%
				StatMan Training Compliance %	85.0%		?	84.8%	85.1%	85.5%	86.2%	87.4%	86.5%	83.7%	84.9%	86.0%	86.7%	87.4%	87.4%
				Professional Registration Compliance %	100.0%		F								100.0%	99.9%	99.9%	99.9%	99.9%
				DBS Compliance %	100.0%	L	F								99.3%	99.3%	99.3%	99.3%	98.1%
				StatMan: Conflict Resolution Compliance %	85.0%		P	92.0%	92.4%	92.3%	92.6%	93.5%	92.4%	92.0%	92.4%	92.7%	93.5%	94.0%	93.5%
				StatMan: EDI Compliance %	85.0%	H	P	94.8%	95.0%	94.6%	94.0%	95.2%	94.3%	94.3%	94.2%	94.3%	95.0%	95.5%	95.4%
				StatMan: Fire Safety Compliance %	85.0%		F	80.1%	80.6%	81.3%	81.5%	85.8%	83.6%	83.7%	83.2%	83.1%	82.5%	82.1%	81.7%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H	?	86.5%	87.2%	88.7%	89.4%	91.3%	85.5%	87.7%	89.5%	90.5%	91.7%	92.7%	93.0%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	80.7%	81.7%	83.5%	83.6%	84.9%	87.2%	74.0%	76.6%	79.4%	82.4%	83.7%	86.8%
				StatMan: Health Safety and Welfare Compliance %	85.0%		P	89.4%	89.4%	90.1%	89.1%	87.1%	83.4%	90.2%	88.3%	86.7%	86.7%	89.8%	89.3%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	95.9%	95.9%	95.4%	95.8%	96.1%	93.9%	93.6%	93.9%	94.8%	95.8%	95.6%	96.3%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	87.0%	88.1%	88.3%	88.9%	90.3%	88.3%	87.1%	87.7%	89.1%	89.0%	89.6%	88.8%
				StatMan: Information Governance Compliance %	85.0%	H	P	87.4%	88.2%	88.7%	89.0%	91.6%	90.0%	89.7%	89.9%	90.8%	90.7%	90.9%	90.4%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
People	Workforce			StatMan: Moving and Handling L1 Compliance %	85.0%		?	86.3%	86.7%	87.0%	87.6%	90.9%	90.6%	47.3%	66.6%	77.9%	83.2%	85.8%	87.4%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	80.0%	76.9%	78.7%	80.0%	81.3%	82.8%	83.9%	81.0%	80.6%	80.7%	81.2%	79.2%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	L	F	50.8%	48.7%	53.3%	53.5%	51.5%	51.1%	50.6%	48.0%	44.1%	44.9%	45.1%	45.0%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	88.3%	89.6%	90.5%	91.0%	93.0%	92.2%	92.9%	93.5%	94.3%	94.5%	95.1%	95.3%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	88.2%	88.9%	87.5%	93.3%	86.7%	80.0%	-	-	-	-	-	-
				Diversity of workforce %	-	H				38.2%	38.1%	38.4%	38.8%	38.9%	38.8%	39.4%	39.9%	40.2%	40.5%
				Diversity of Board %	-					8.3%	5.6%	5.6%	19.0%	19.0%	18.2%	14.3%	19.0%	19.0%	19.0%
				StatMan: Basic Prevent Compliance %	85.0%		P	94.1%	94.7%	94.9%	95.0%	94.3%	92.1%	92.3%	92.4%	93.7%	94.9%	96.1%	94.6%
				StatMan: Prevent WRAP Compliance %	85.0%	L	P	90.7%	90.8%	91.1%	90.8%	91.7%	91.2%	90.3%	88.1%	87.3%	87.3%	87.6%	86.9%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	90.9%	91.6%	91.8%	92.0%	93.7%	94.2%	93.6%	94.1%	94.0%	95.0%	96.0%	95.8%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%		P	91.7%	91.8%	91.5%	91.0%	91.9%	91.3%	91.6%	93.0%	93.1%	93.2%	94.0%	92.0%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	2.5%	2.8%	3.1%	12.5%	21.5%	24.7%	36.6%	43.6%	48.2%	54.5%	57.2%	59.6%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%	H	P	93.7%	94.8%	94.9%	94.8%	94.4%	92.0%	92.7%	93.4%	94.2%	94.6%	95.5%	96.0%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
People	Workforce			StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	90.3%	90.9%	90.5%	90.5%	90.7%	89.9%	88.3%	88.0%	85.7%	84.6%	84.4%	82.8%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	?	85.1%	84.4%	84.7%	83.0%	83.6%	83.2%	82.2%	80.8%	80.9%	82.0%	80.0%	79.9%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	67.3%	76.8%	81.7%	80.5%	79.6%	77.6%	71.8%	77.0%	77.7%	76.6%	74.5%	74.5%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	78.8%	79.3%	79.6%	79.2%	80.5%	80.8%	79.4%	81.4%	82.7%	82.4%	81.4%	82.0%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		F	75.3%	73.7%	74.9%	74.0%	76.0%	78.9%	78.6%	75.8%	74.3%	74.4%	75.1%	76.3%
				StatMan: Anaphylaxis Compliance %	85.0%	H	?	87.5%	87.9%	87.9%	88.2%	89.7%	89.5%	83.2%	84.4%	87.7%	90.2%	90.1%	91.1%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	55.9%	56.5%	60.7%	66.7%	78.6%	83.3%	73.2%	72.7%	80.4%	81.8%	81.5%	76.4%
				StatMan: Mental Health Liaison Service Compliance %	85.0%		F	68.5%	64.0%	69.7%	71.7%	71.1%	72.3%	72.6%	69.5%	68.0%	66.3%	70.7%	71.7%
				StatMan: New Born Life Support Compliance %	85.0%	L	F	82.2%	80.5%	80.4%	79.5%	79.0%	74.7%	72.8%	73.4%	77.3%	77.5%	71.7%	73.4%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	70.8%	67.8%	68.1%	68.8%	72.1%	74.6%	74.0%	75.4%	77.7%	77.7%	78.2%	79.3%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	78.2%	81.9%	77.9%	76.5%	80.0%	75.9%	78.7%	72.2%	68.9%	64.1%	70.7%	76.1%

SIOR - People

Successful Deliverables

- Trust remains below NHSE Trust agency target (<3.7% total paybill)
- Extended Equality and Inclusion Policy approved by EISG, awaiting approval from JSC in February
- Dignity at Work Advisors programme launched
- OH improvements with triaging being successful and seeing the Doctor for most within 20 days has been achieved and Pre-employments have been triaged, and appointments with nurses are being offered within 10 working days.

Next Steps

- Continuing development of resources and opportunities to support Dignity at Work Advisors and B&H Investigators
- Neurodiversity toolkit to be developed
- Positive Action practice guide/procedure or policy
- Board session on HIA1 and HIA generally
- Successful agreement of the SOP for HIV prophylaxis support following inoculation and contamination injuries we are now waiting for the MOA
- Measles outbreak lead to shortages of MMR vaccine – pharmacy has been able to get the vaccines and staff continue to be vaccinated

Identified Challenges

- Time to hire recruitment times increased with an expected improvement to be seen in March;
- Equality Delivery System (audit tool) assessment by 29 February
- The wellbeing hub has been found to be used in an unacceptable way. The wellbeing team are completing checks three times a week to ensure it stays available to all colleagues 24/7

Next Steps

- Inclusion by Design training launch by end February – to cover Recruitment and Retention, Reasonable Adjustment and Modified Duties, Cultural Competence, Equality Impact Assessment
- Task and finish group to assess against the EDS measures. The main challenge will be providing evidence from clinical practice. Fortunately, Trusts do not have to conduct a Trust-wide assessment. HR&OD elements are already assessed against the tool, from previous years assessments, and only need updating.

Opportunities

- Emergency Department (including CHED) junior rotas moving to the centralised Medical Rota Coordination Service – Rota Co-Ordinator started on 4th December 2023 commenced training
- Use of medical gender pay gap work to develop HIA3 Action Plan. (A3 now in progress)
- To work with the housekeeping team to look at the rota for cleaning to identify if time changes could work better and if anything can be done to reiterate to colleagues what is acceptable usage of the hub – New signs etc.

Next Steps

- Discuss Medical Pay Gap with CMO and develop A3 and task/finish group; expand pay gap reporting plan based on Workforce Intelligence dashboard

Risks

- Low level of Equality Impact Assessment in decision making
- Work is ongoing around matching jobs to the correct DBS classification to ensure employees have the correct DBS clearances
- Non adherence to the regional rate card (Nursing and Medical) by neighbouring Trust impacts our bank/agency fill rate
- Significant gaps in Occupational Health workforce. A business case has been submitted for review.

Next Steps

Undertaking audit/gap analysis on all HIAs, consolidating existing evidence, and producing action plan. Session with Trust Board Away Day.

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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
	£0	H	?	-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m

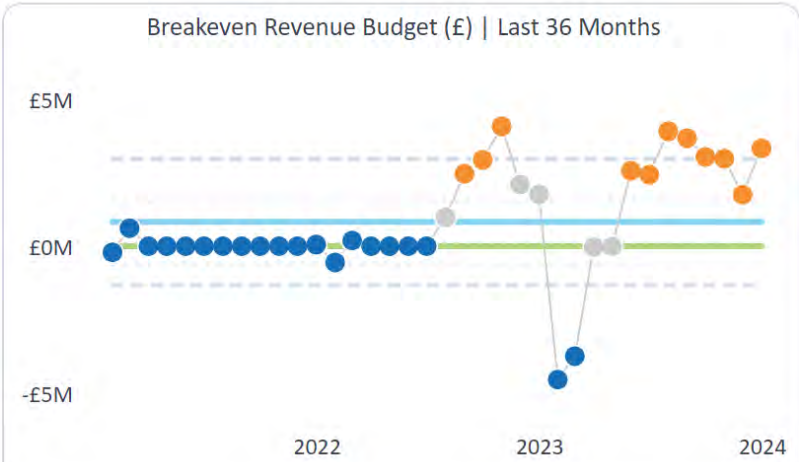
True North Domain: **Sustainability**

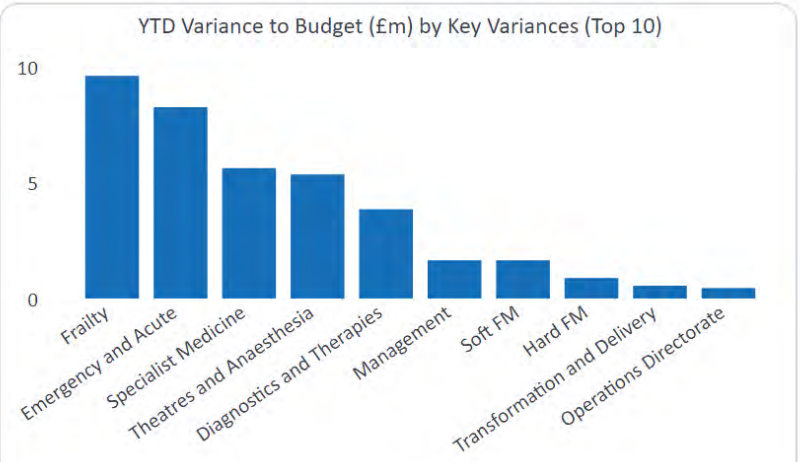
KPI Threshold: £0

Sub Domain KPIs: 14

Variation Summary:

7	0	6	0	1





Key Messages

The Trust reports a deficit of £4.1m in month 10 of 2023/24, after removing the allowable technical accounting for impairments and donated assets, the adjusted year to date deficit is £36.7m; this is £23.6m adverse to the YTD plan agreed with NHSE and ICB.
The in-month run-rate has deteriorated by £1.6m; this is mainly due to the previous month including year to date income adjustments for industrial action £1.5m and capital charges funding of £0.5m. The expenditure run-rate is £0.6m higher, predominantly due to higher industrial action costs for the 6 days in January compared to 3 days in December as well as increases to temporary staff during the Winter period.

Issues, Concerns & Gaps

The full value of contract income for ERF and Community Diagnostics Centre (CDC) has been included in the position; the ERF activity plans are over performing by £0.6m, this has been included in the January income position. There is a continued risk of CDC income clawback although until agreed with the ICB the full value of funding has been recognised. Of the £27m efficiencies target, £16.8m is forecast to delivery, this includes£4.6m of cost avoidance and run-rate reduction schemes.
The Trust has provided and agreed with the executive team a revised forecast of a £35.6m deficit, work continues to deliver this position.

Actions & Improvements

Implementation of mitigations/counter measures within divisions to control overspending on medical and nursing pay costs, via the Breakthrough Objective for Sustainability.

Further mitigating controls as highlighted in the KPMG report.

Continued monitoring of efficiency schemes development and implementation. Implementation of enhanced financial controls. Continued training to budget holders, as well as support with budget variance analysis

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0			-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m
				Total Financial Overspend (£)	£0			2.55m	12.72m	1.02m	1.31m	3.30m	4.56m	5.33m	4.83m	5.43m	5.17m	5.79m	6.32m
				Agency Spend %	3.7%			3.5%	1.9%	2.6%	3.0%	2.7%	3.0%	2.9%	3.0%	2.6%	3.5%	2.7%	2.0%
				Bank Spend %	10.0%			11.6%	7.8%	12.8%	12.4%	11.1%	11.6%	13.8%	9.8%	12.2%	10.9%	11.0%	13.1%
				(Surplus) / Deficit (£)	£0			-4.63m	-4.83m	2.46m	2.47m	4.82m	3.42m	4.90m	4.66m	3.84m	3.78m	2.55m	4.13m
				Agency Spend (£)	-			0.78m	0.80m	0.60m	0.70m	0.71m	0.75m	0.74m	0.80m	0.65m	0.88m	0.68m	0.54m
				Income (£)	-			-39.66m	-60.80m	-34.16m	-34.78m	-35.20m	-36.16m	-35.35m	-36.35m	-35.74m	-36.63m	-39.02m	-38.07m
				Income (£) vs Budget	£0			-7.35m	-27.50m	-0.24m	-0.89m	-0.02m	-1.83m	-1.02m	-0.58m	-1.18m	-2.07m	-4.45m	-3.49m
				Total Pay Spend (£)	-			22.54m	42.56m	23.10m	23.32m	25.79m	24.45m	25.75m	26.83m	25.24m	24.93m	25.00m	26.71m
				Total Pay Spend (£) vs Budget	£0			2.02m	22.13m	0.88m	1.12m	2.51m	2.64m	4.04m	3.22m	3.25m	3.70m	3.17m	4.86m
				Total Non-Pay Spend (£)	-			10.99m	11.03m	11.58m	11.70m	12.29m	12.91m	12.52m	11.77m	12.22m	13.18m	14.42m	13.35m
				Total Non-Pay Spend (£) vs Budget	£0			1.17m	1.13m	-0.47m	-0.35m	0.26m	1.53m	1.04m	0.74m	0.97m	1.17m	3.01m	1.94m
				Actual Worked FTE	-			5,102.29	5,227.19	5,127.10	5,174.36	5,229.67	5,215.43	5,344.21	5,240.17	5,444.71	5,403.07	5,461.76	5,527.16
				Actual Worked FTE vs Budget	0			68.30	192.45	43.79	82.68	156.70	138.77	211.60	150.93	284.50	204.96	264.97	332.87

SIOR - Sustainability

Successful Deliverables

Overperformance against the ERF plans, despite 6 days of medical industrial action in January.

Cash management strategies in place therefore the forecast position at 31st March looks sufficient. Revenue support loans will therefore not be required for 2023/24.

Next Steps

Submission of the further iterations of plans for 24/25 to the Integrated Care Board (ICB).

Identified Challenges

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

1. Delivery of the mitigated forecast financial position.
2. Management of medical and nursing pay costs, both of which are significantly overspent year to date.
3. Identification, development, implementation and delivery of the efficiencies programme..

Next Steps

Progress with the counter measures following the development of A3 documents for nursing and medical pay costs, as part of the 'control of overspending' breakthrough objective.

KPMG report and implementation of actions therein.

Winter pressures and increased use of escalation capacity, this includes the use of Christina Rossetti beds.

Opportunities

Business planning for 24/25 identifying gaps between service provision and anticipated income.

Enhanced financial controls as agreed by the Executive team, as well as further as highlighted and recommended in the KMPG report.

Next Steps

Further progress with working alongside the ICB in populating the long term financial plan.

Using demand and capacity modelling to inform business plans for 24/25.

Risks

Ongoing risks continue, including:

- Identification and delivery of the efficiency programme for 2023/24 as well as 2024/25..
- Medical staff industrial action impact of delivering ERF activity.
- Implementation of enhanced financial controls regarding recruitment, temporary staff spending, additional sessions, & non-pay costs.
- Reducing cash balance if deficit continues.

Next Steps

Ongoing monitoring and reporting of risks through to Execs and FPPC

Meeting of the Trust Board in Public
Wednesday, 06 March 2024

Title of Report	Trust Risk Register Report		**Agenda Item**	6.2
Author	Louise Furlong; Integrated Governance Manager and Interim Head of Health and Safety			
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer			
Executive Summary	The Trust risk register report is intended to give the members of the Board assurance as to the current position of the Trusts risks management system. The report also responds to the regulatory and statutory duties such as those overseen by the Care Quality Commission (CQC), Ofsted and Health & Safety Executive to implement effective risk management systems. It also reflects the NHS Foundation Trust Code of Governance, and the Compliance Framework. The data provided in this report was current as of the 01 January 2024. The report consists of 252 approved risks, 34 of which are 'extreme'. 79% of risks have been reviewed within the required timeframes. The report highlights the lack of movement in risk score over the previous month, and an extreme risks which is overdue for review.			
Proposal and/or key recommendation:	The Board is asked to **note** the contents of this report.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		**Approval**	
	Noting	**X**	**Discussion**	
Committee/Group and date submitted:	Meeting: Trust Executive SDR Date: 13 February 2024			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	**Priority 4: (Quality) X**	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe:	Effective:	Caring:	Responsive:	**Well-Led: X**
Identified Risks, issues and mitigations:	N/A			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	Not applicable			

Legal and Regulatory implications:	The report also responds to the regulatory and statutory duties such as those overseen by the Care Quality Commission (CQC), Ofsted and Health & Safety Executive to implement effective risk management systems		
Appendices:	Trust Risk Register Report – January 2024		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Louise Furlong Job Title: Integrated Governance Manager and Interim Head of Health and Safety Email: louise.furlong@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	**X**	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Trust Risk Register Report

Louise Furlong; Integrated Governance Manager

January 2024

Executive Summary

	Assurance
Risk Management	

The Trust Risk Register has 252 approved risks in total
34 risks are scoring 15 and above.

20 new risks added
29 risks are awaiting review, and
32 risks awaiting approval.

10 risks have been closed down
21 risks have had the score reduced since their last review,
3 risks have had the score increased since their last review, and
12 risks have been rejected.

All Executive Members have been invited to review each of their risk profiles on a monthly basis.

Full Assurance	Partial Assurance	Limited Assurance

SIOR - Risk Management

NHS Medway NHS Foundation Trust

Successful Deliverables

- 10 risks have been closed in January
- 79% of risks were reviewed within their required timeframe in January (Up from 71% in December)
- 74% of risks scoring 15+ have been reviewed within the required timeframe in January (Up from 53% in December)
- Risks have been realigned to the new clinical divisions and care groups
- All Care Groups have access to risk, incident, complaint and claim data via bespoke dashboards
- All Groups and Committees have now been added to DATIX, enabling risks to be aligned to the relevant group/committee responsible for onward monitoring

Risks Closed in January

1252 – Mortuary Private Ambulance
Rationale: *Replacement vehicle procured and delivered*

1582 - Proposed IHSS move of current operational service from Maidstone to Aylesham
Rationale*: IHSS Move now complete*

1642 - Lease of medical records facility expires 29th December 2023
Rationale: *New lease signed*

1687 - *Potential for Trust not to deliver against activity plan for 2023/24 which could jeopardise delivery of deficit control total.*
Rationale: *Elective target for 23/24 has now been met and all additional activity is profitable*

1709 *- Inability to back-fill positions within the facilities department from bank/agency establishment will impact delivery of service*
Rationale: recruitment to full establishment and bank has been completed. No agency being used for this task

1778 *- Potential for unauthorised access to be gained to Abigail's Place leading to safeguarding risk to deceased babies*
Rationale: *Lead midwife reviewed access control with trust lead to ensure appropriate management of access control*

1794 *- Cancellation of Theatre Sessions due to lack of anaesthetic cover*
Rationale*: Pay dispute resolved for SAS doctors*

1798 *- Non Compliant Critical Care Trainee Doctor rotas*
Rationale: *Trust deem rota to be compliant*

1835 *- Lack of funding for PKB Patient service centre coordinators*
Rationale: *Business case approved department in the process to recruit perm roles*

1870 *- Thera Trainer – Bemo bed cycle for Critical Care*
Rationale: *Thera Trainer – Bemo bed cycle for Critical Care has been obtained*

Risks Rejected in January

12 Risks were rejected in January

The number of rejected risks broken down by category are as below**:**

Risk Already Resolved - 0

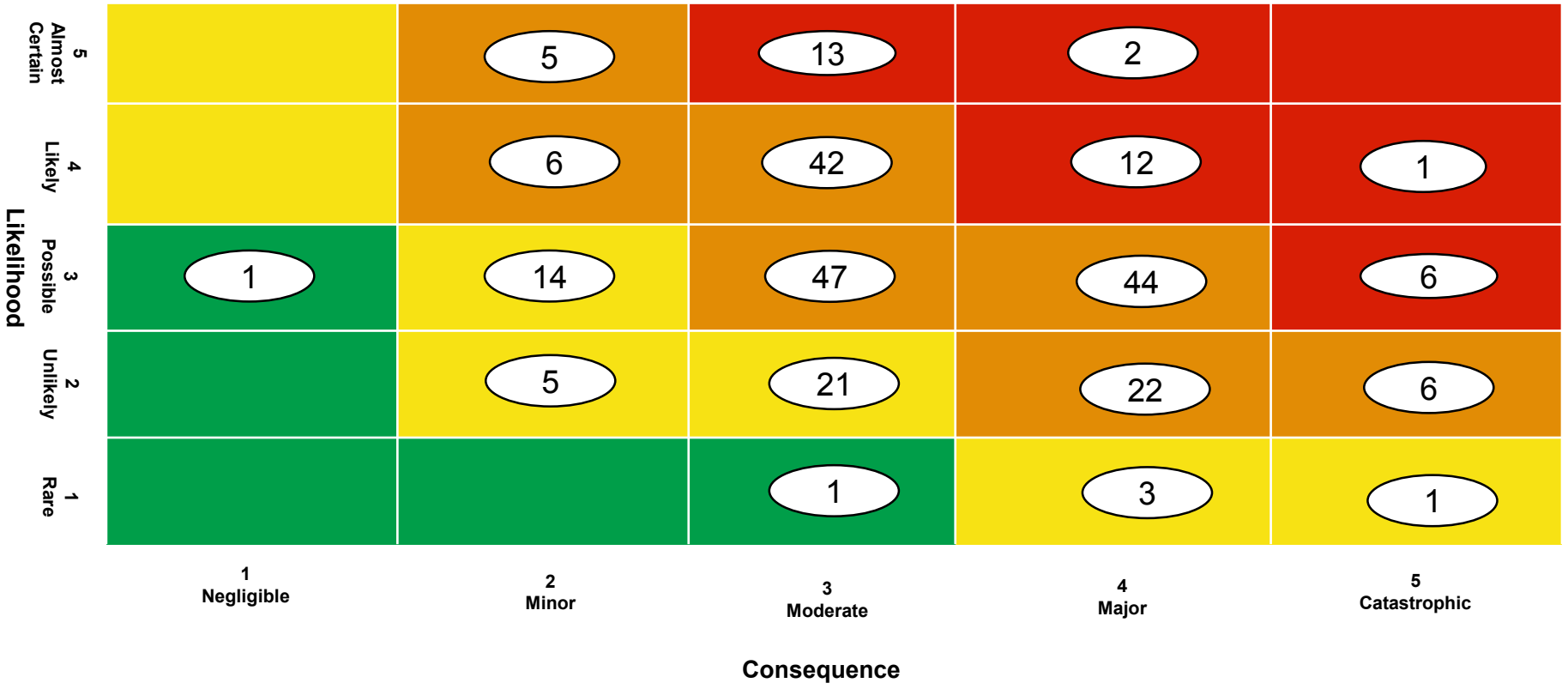
Incorrect Form Completed – 12

Duplication - 0

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

Trust Risk Register – Heat Map

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



Risks scoring 20

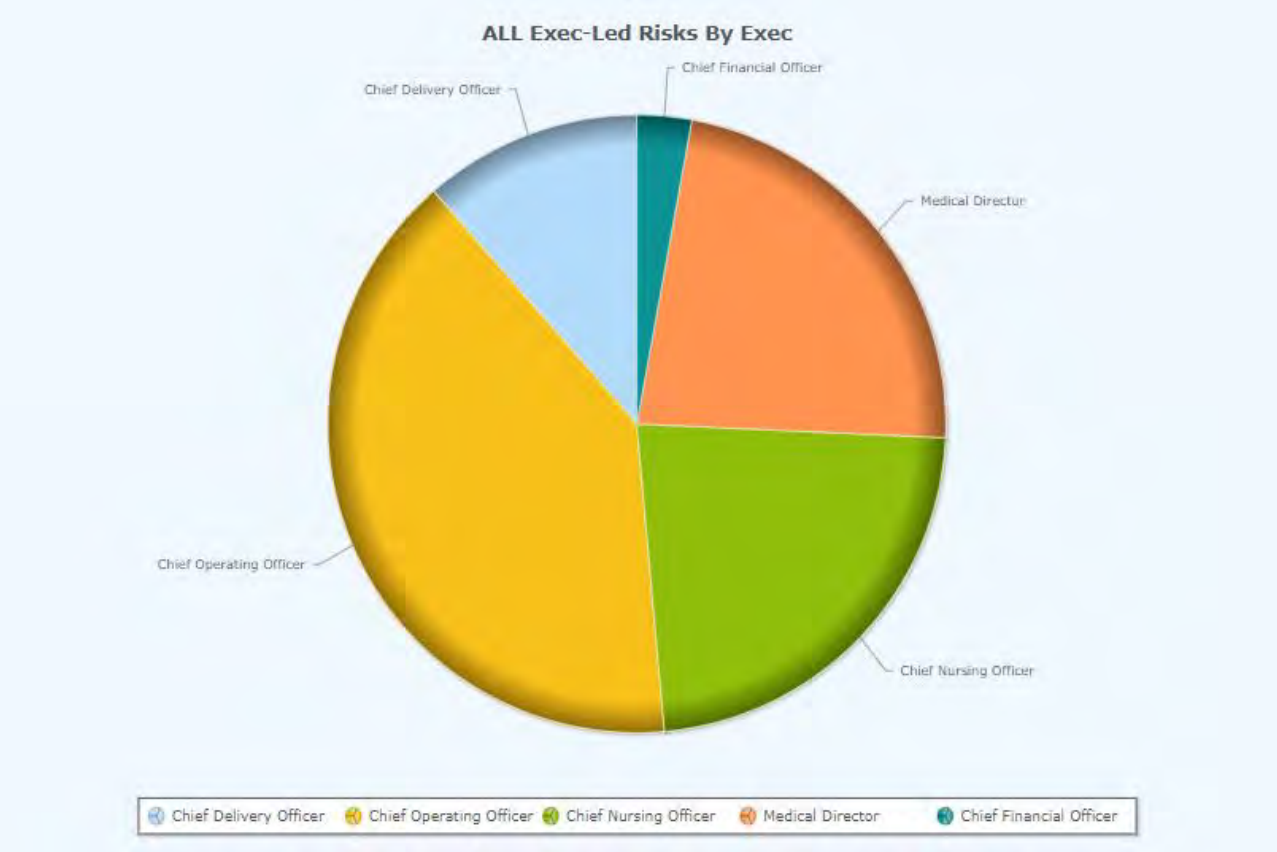
1133 - Insufficient Midwifery Staffing impacting the ability to provide patient care.

1502 - Non-Compliance to SAR & FOI Timeframes which gives rise to potential enforcement action and penalties

1711 - Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.

All other risk scoring 15+ are summarised in slides 9-23.

‘Extreme’ Risks by Executive



34 Risks scoring 15+

CDO – 4 (12%)

CFO – 1 (2%)

CMO – 7 (21%)

CNO – 8 (24%)

COO – 14 (41%)

CPO – 0 (0%)

CDO Risk Profile – 'Extreme' Risks (Risks scored 15+)

Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1025	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST & clinical info	A number of issues have been identified with Euroking maternity system, inclusive of: - Back-copying of answers and - Duplication of records caused by failed data migration (Sep 2020) These issues have resulted in no assurance of reporting output and may result in issues relating to patient safety, data quality, statistical analysis, CNST and clinical information. The impact may be financial implication by way of the ICO or harm to patients as a result of incorrect patient information being available.	- Manual data adjustments made to ensure MSDS is uploaded and local data reported. - Local data reconciliation being done to expose gaps occurring together with close working relationships between BI and Maternity. - Manual review and individual case file analysis underway	MNSCAB CGMB DMB IGG RCASC Euroking to be standing agenda item at IGG meetings as agreed with DPO from October 2023 onwards until issue resolved - Gone into capital planning for 24/25. Sited on risk through digital data and technology group.	- System supplier aware of insufficient mappings provided but are not acting on need. - Lack of funding to procure new system. - No reconciliation between System, System Reporting solution & automated Data Output. - EuroKing supplier will not provide mapping for fields, meaning it is extremely difficult to reconcile between data output and mappings done for Maternity Services Data Set (MSDS) process and output . - National risk identified by Another EuroKing Trust (Wrightington, Wigan and Leigh NHS FT, WWL) has identified a large scale issue where some answers in EuroKing have back-forward-copying of answers within workflows. These are at pregnancy level and in effect overwrites and/or complete empty fields in previous care episodes. This was in response to a concern raised and confirmed when the software supplier Magentus provided them with mapping of all questionnaires and the report was analysed. The Trust was alerted to this through the Digital Midwives EuroKing network. It is likely that this issue also exists within the Medway version of EuroKing and the full extent is yet to be fully assessed. Unable to fully ascertain the extent of the issue - Some legal records are overwritten or completed when none was there. The amendments and additions can be seen in the auditing software but may be misleading to the front end user. - The audit trail offers some insight to what has happened when data has back-copied but is not detailed enough to offer full clarity of where the amendments have pulled from.	5	3	15	—	On Track	Trude McLaren

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CDO Risk Profile – 'Extreme' Risks (Risks scored 15+)

Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1408	Emergency Bleep/Pager system reliability	Emergency pager/Bleep system is unreliable and has failed on multiple occasions in the 6months leading up to risk being raised. Emergency requests for critical clinical staff support teams has to reverted to the use of radios. The implementation of this plan is a manual distribution task.	Radio's used as back up option to replace the bleeps in the event of failure. Funding secured for Everbridge system, to go live Summer 24. Testing undertaken by existing supplier. Tightening up of process for twice daily test calls.	Pager system maintenance contractor to assess system and complete health check and carry out required replacement of components to improve reliability.	No sufficient number of radios to circulate in event of bleep failure. Existing telecomms contract expires in approx 18months, wider review of system to take place in anticipation of this	3	5	15	—	On Track	Adrian Billington
1645	Unsupported Server Operating Systems	The Trust is running outdated and unsupported operating systems on a number of servers that host clinical and administrative systems. The Trust has 6 servers utilising Server 2003R2, all of which have projects actively engaged in decommission/upgrade. The Trust has 121 servers running on Server 2008R2 operating system (approx. 35% of the Trust's total server estate). This OS has reached its end-of-support date. The Trust had up until January 2023 purchased extended support arrangements (ESU) from Microsoft, however the extended support period is no longer offered for further renewal. This means that Microsoft is no longer providing security updates or technical support for this operating system, which leaves the organization's servers vulnerable to security threats and software vulnerabilities.	- The Trust has invested in licensing and data centre hardware to enable the mitigation of these risks. - The ITPMO is actively running a project to review server operating systems and work associated with this mitigation. For all associated servers, the Trust intends to: - Upgrade to a Supported Operating System such as Server 2019 or newer. - Implement Security Measures such as firewall restrictions, intrusion detection and prevention systems, and utilise existing antivirus software to reduce the risk of a security breach. - Regular Vulnerability Scanning to identify any security vulnerabilities and to take appropriate remedial action. - Limit Access to these servers to limited authorized personnel only. - CDO taking paper to Board 13/09, proposal for further mitigation re servers -MMHMYSQL01 & MMHMYSQL02 – Chris & John – We need to give them a deadline to move everything off before power off - ongoing. -MMHPLICS01 – QlikView – Need control code from licence to migrate – -BI are planning on scrapping this in near future but no set date. -MMHPSI01 – Dart QSCAN - ongoing -Capital Allocation 23/24, project: 21/22-159 Cyber Security	The ITPMO will document the associated remediation plan and provide a schedule of works. Highlight reports and compliance to this plan will be provided at Project and Digital Board. Although this has not been requested yet. The Trust may need to report on this progress to NHSE in a similar way to how PC/Laptop OS migrations were reported	However significant technical issues with the supplier and the commissioning of this infrastructure has delayed dependent migration and upgrade works. Until the remediation works are completed, the Trust is at increased risk of: Cyber Security Risks: Since the operating system is no longer receiving security updates, any new security vulnerabilities discovered by hackers or cybercriminals will not be patched by Microsoft, leaving the organization's servers at risk of cyber attacks. Compliance Issues: The organization is in breach of compliance requirements of the DSPT and Cyber Essentials until at least 90% f servers are on supported operating systems. Business Disruption: Any security breaches or vulnerabilities discovered could result in business disruption and potential loss of data.	4	4	16	—	On Track	Craig Allen

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CDO Risk Profile – 'Extreme' Risks (Risks scored 15+)

Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1689	If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk.	The efficiencies target for 2023/24 is £27m / 6.6% of income, being significantly more than has been delivered before. The Trust has not identified the full value of efficiencies at the start of the financial year. If the trust does not deliver its efficiency programme then the financial performance against control total could be at risk.	• Approval panel for schemes > £50k gross value/impact. • Scrutiny and challenges at the Efficiencies Delivery Group. • Financial Improvement Director and Interim Chief Delivery Officer in place. • Strategy & Transformation team resources being redeployed to support this programme short term together with the appointment of a project manager externally (until the end of July 2023). • KPMG resource redeployed from Patient First to support development of workforce efficiency programme for 2023/24. • Long term proposal for a PMO is being discussed by executives. • Supported by / participants of the system productivity and efficiency group.	• Reporting to Efficiency Delivery Group and the Finance, Performance and Planning Committee (identified vs budget, delivered vs budget [in-month and YTD]). • External audit value for money procedures. • Internal audit procedures on a cyclical basis. • SOF reporting / meetings with NHSE, including leveraging knowledge and best practice from Intensive Support Team.	• Financial culture and awareness. • Capacity and use of benchmarking. • Increasingly unlikely to meet target as year end nears	5	3	15	▼	On Track	Gavin MacDonald

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CFO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1691	Potential for the Trust to have an unfunded cost pressure should the proposed harmonised bank rate be applied.	The ICB is seeking to harmonise the bank rates paid by all organisations within the system. The Trust currently has the lowest bank rates of all providers, with the proposal being that the harmonised rates would be above the current levels. If the rate harmonisation is applied the Trust, it would have an unfunded cost pressure, meaning that the Trust's financial performance against control total is at risk.	• The Trust currently controls its own bank rates. • The Trust participates in the ICB workforce groups and has voiced concerns. • Proposal put forward to Execs for MFT to meet MTW rates, which is the next lowest payer in the Kent to Midway system. - The proposal accepted by Exec following additional mitigations added to the proposal. This was verbally updated at FPPC on 24/08. Finance to support HR in further control mitigations against the partially mitigated financial risk. • Finance Committee held 28/09 agreed to freeze bank rate and review at a later date • Updated paper to be bought back to Execs next week, with a view for implementation for 24/25.	Reporting mechanisms • CPO's office • Trust Executive • People Committee • FPPC • System groups • South East Bank Collaborative	• No funding secured for increase in bank rates • Increase in bank rate would result in immediate cost pressure of circa £2million • Risk will remain apparent until agreement sought to build into 24/25 implementation	4	4	16	—	On Track	Dominika Kimber

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

N.B. Full details of all risks are available on the Trust Risk Register.

CMO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1433	Delayed Recording of Observations on Electronic Patient Record (EPR)	Delayed Recording of Observations on EPR due to insufficient access to computers or devices. Results in a delayed NEWS score calculation and alert for staff, leading to in a delay in staff recognising deterioration and calling for help this results in delayed responses to deteriorating patients due to staff inability to remember NEWS scores without the adequate tools.	Ward have been allocated on average 5 standard WOW - workstation on wheels. Any old laptop on wheels which may be working slow are replaced as necessary when staff report issue. IT resource audit carried out as part EPR deployment for EPR, EPM, and re audit for EPR Order Comms - investigation request and results. ART audit monitoring. All wards have copies of laminated NEWS charts for reference in the bedside folders. NEWS training is essential to role with yearly updates for clinical staff.	IT service desk reporting. Incident reporting. EPR Clinical Implementation Group. EPR programme will report an increase in requests for Laptop on Wheels, and seek a resolution for ward areas. NEWS audit report monthly GATHER report taken to Resus and Deteriorating Patient Group.	Staff work-around. Space restriction in ward areas. Competing priorities Inability to access the device. Transcribing to paper is a legacy practice. Wifi hot spots causing staff to record on paper Agency or bank staff unfamiliar with the system	4	4	16	–	Overdue	Emma Coutts
1502	Non-Compliance to SAR & FOI Timeframes	The Trust is currently non-compliant with the statutory timeframes due to significant backlogs for SARS & FOI with a risk of enforcement action and penalties	- Business Case approved by ICB - 4 posts on fixed term contracts (8months) - Assigned 1 individual to admin role daily to deal with phone calls and emails in order to minimise disruption to workload - Processes constantly monitored in order to make improvements at earliest opportunity. - Associate Director of Legal and Integrated Governance Manager to investigate actual SARs and FOI position ahead of next IGG on 5th February 2024	- Weekly reports to Director of Integrated Governance, Patient Safety & Quality - Reports onwards to CMO/Caldicott Guardian - Information Governance Meetings	- Lack of funding for the additional positions - fixed term positions likely to end soon - Requests for email information requires liaison with NHS Digital and adds to backlog - IG Meetings not routinely held. - Trust written to by ICO in regards to case not dealt with in a timely manner - Backlog circa 900 for SARS with approx 800 breached - Backlog circa 110 for FOIs with approx 70 breached - Actual SARS and FOI position unknown as tools available to Trust to extend timeframes may not have been utilised.	5	4	20	–	On Track	Anne Bailey

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

N.B. Full details of all risks are available on the Trust Risk Register.

CMO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1699	Failure to Provide Agreed Level of Imaging Cover To Theatres Due to Poor Quality Imaging Equipment	Imaging has an agreement with Theatres to provide 4 Radiographers and Image Intensifiers (II) each day Monday to Friday. Currently there are 4 fully functional II's on site. There is a 5th machine on site that has many restriction imposed on it due to poor image quality and Medical Physics have now advised for this to be removed from action for these same reasons. 2 of the 4 functioning machines are over 10 years old. Due to the age of the machines, equipment downtime is occurs often which causes capacity issues for theatres and sometimes delays to patients. Poor image quality on 2 of the machines means they cannot be used during spinal cases, this also impact allocations specifically if one of the 2 machines is experiencing a fault. As the 5th machine has now been advised to be removed, when an equipment fault occurs on one of the remaining machines, our available capacity falls to 3 and we are no longer able to achieve the agreement between Imaging and Theatres.	1. Staff are trained to optimise image quality 2. Weekly attendance at the planning meeting to allow best use of the limited resources and allocation of machines is completed based on the one that would work best for the case in question. 3. Ongoing staff training is in place and the nature of the issue is known to the surgeons and the Radiographers. 4. PID drafted, equipment bid submitted	- Planning meetings	1. Staff can only optimise image quality within limitations of machine 2. The only way this risk will be mitigated is to purchase additional equipment to replace that which is no longer usable. 3. Image quality of existing equipment poor 4. Equipment aging and been advised to take some out of use 5. Awaiting outcome of equipment bid 6. Awaiting confirmation as to capital slippage for 23/24 before submission of PID	5	3	15	–	Overdue	Lorraine Becconshall
1711	Trust may be in breach of Article 5 of GDPR as a result of breaching retention, archiving and disposal of leavers information.	The Trust processes around retention, archiving and disposal of personal information relating to members of staff who have left the Trust is not clear, and as such the Trust may be in breach of their regulatory duties - this may lead to financial and reputational damage to the Trust. This will relate to locally recorded personal information and local personal files, as well as official HR records (occupational health, payroll, employee relations, training records etc.) This is also relevant to subject access requests made for individuals for their personal information where it is not known the location of the personal information. This also needs to consider other means or processes of recording personal data such as DATIX system.	- Records held directly by HR are stored in electronic files	- information Governance Group - risk and compliance assurance sub-committee	- No retention, archiving of files - Very variable across Trust	5	4	20	–	Overdue	Anne Bailey

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CMO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1725	The ongoing and continuous increase in antimicrobial consumption	At MFT Access category (first line antibiotics) shows a downtrend while Watch category (second line broader spectrum antibiotics) shows an uptrend overall. These are negative developments considering that Standard Contract for 2023-24 as aligned to the UK AMR National Action Plan is to reduce consumption of Watch and Reserve antibiotics in hospitals by 10% from a 2017 baseline. An increased use of antimicrobials have an implication for increased cost, antimicrobial resistance and increased rates of C.difficiles and invasive fungal infection	- EPMA - Antimicrobial ward round - AMSG - Report to IPCSAG and QPSSC - Consumption report - ward clinical pharmacists have capability to review antimicrobial prescribing where there is cover - junior doctor training	- Reports presented to AMSG, IPCC - Antimicrobial point prevalence audit twelve monthly - Antimicrobial CQUIN	- Lack of audits due to start in July - Lack of antimicrobial pharmacist time - Antimicrobial pharmacist on sabbatical from Oct to Jan - Prescribing practice - Reduced microbiology consultant input due to capacity issues on a 10 PA job plan - lack of clinical pharmacist time on wards due to staffing shortages - lack of ownership across MDT for antimicrobial stewardship	4	4	16	–	Overdue	Paul Kitchen
1731	Backlog of patients awaiting review within Diabetes & Endocrine Service	As a result of consultant retirement in March 2022, clinic which was historically held off-site on a regular basis (twice weekly) is no longer taking place and is impacting patient safety within the Diabetes and Endocrine speciality.	Department have seen approximately 150 patients at the time new consultants were recruited into the team. Currently in the process of trying to accommodate these patients within regular clinics - concerns around timeframe in which patients can be seen	Continuously monitor the review list which is held within the department including all patients waiting to be seen.	Current capacity within the team affecting length of time for these patients to be seen in alternative clinic.	5	3	15	–	Overdue	Linda Stevens
1848	Obsolete Procedure Trollies	Procedure trollies are >10 years old and several are now obsolete and condemned. The number of trollies now in use have been reduced significantly which is impacting turnaround times in theatres and utilisation. There is a potential of patients being cancelled on the day if more trollies are condemned. Income will also be reduced in line with decreased productivity. There is also a potential of harm being caused to the patient should trolley fail to operate due to age. Also harm to staff due to additional moving and handling	- condemned trollies taken out of use - EME team review of current trollies in use - Equipment bid completed for new trollies - Using beds and chairs to move patients off of procedure trollies to continue with operating - Funding approved by Execs as part of capital slippage	- Weekly meeting with theatre lead - Risk Register and discussed at POCC Board meeting/Divisional meetings - Discussed at monthly medical devices meeting for new trollies	- new trollies required - equipment bid	5	3	15	–	Overdue	Sharon Kaur

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CNO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Controls	L	C	Current Score	In-month change	Review RAG	Operational Owner
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.	Insufficient midwifery workforce to meet demand. • Inability to provide 1:1 care in labour. • Avoidable delays in the IOL pathway. • Poor patient experience. • Potential for adverse clinical outcome. • Poor staff morale and burnout. • Inability to implement continuity of carer in line with national directive.	• Enhanced Bank Rates: encourage staff • Weekly workforce meeting with senior sisters • Rolling recruitment to fill vacancies • Current 26 WTE vacancies recruited to – due to start between September and December and will need supernumerary support. • Mitigate risk by movement of staff across the unit based on acuity and capacity. • Senior Sisters, specialist midwives and matrons working clinically to support ward staff • Regular HOM Briefing to staff and Board Level Safety Champions walk around to support staff. • Support staff for retention	• Daily and weekly monitoring and escalation where required • Supporting staff for retention	• Staff retention and international recruitment options • 2nd and 3rd year students will attend Surrey University and qualify in 2025	4	5	20	–	On Track	Kate Harris
1446	Multiple areas of non-compliance with H&S legislation	Following the undertaking of a H&S audit against the NHS Workplace Health & Safety Standards Audit (WHSSA) 2022 - the H&S Team have identified a number of areas where the Trust cannot demonstrate full compliance against the Health & Safety at Work Act 1974 and the Regulations that fall under it.	- Provision of competent advice to the Trust by way of having an appointed Head of Health & Safety and H&S team. - Progress updates monitored by way of improvement plan (BAF) - Departmental audits undertaken by H&S team - Local spot checks undertaken by departments - Incident reporting system available to all staff - External audits for various E&F functions by Authorised Engineers (AEs)	Assurance will be reported on via the below governance routes: - Health, Safety & Security Group - Risk Assurance and Compliance Group - Audit & Risk Committee Health & Safety reports published	- Completion of action plan not seen as a priority for those action owners sitting outside the H&S Team Interim management arrangements within E&F has led to actions lacking ownership - H&S Team not fully staffed.	4	4	16	–	On Track	Louise Furlong
1647	Mixed sex breach compliance data reporting	As a result of inconsistent data reporting by staff and business intelligence team for mixed sex breaches in clinical areas the trust is non-compliant with national standards. The impact is that the organisation is reporting a high number of mixed sex breaches each month. There are no robust assurances in place to mitigate the risk, the policy is outdated.	A3 deep dive, patient first methodology underway revision of the MSA policy review of processes with BI - validation - clinical teams	reports to be presented at PEG / QPSSc MSA data is monitored through the IQPR which goes to board	poor understanding of the root causes of the MSA reporting data outdated policy inconsistent policies for reporting MSA data	5	3	15	▲	On Track	Nikki Lewis
1666	The Trust has breached the zero tolerance for MRSA bacteraemias in 2023/24	The Trust has had 2 MRSA bacteraemias in April and May 2023. Both patients had had a positive colonisation of MRSA on routine screening and were not treated with decolonisation treatment which led to the bacteraemia. There is poor management of cannulas and understanding of the possibility of any patient with MRSA colonisation developing a bacteraemia. There is a risk that this could happen again in another ward which would led to external scrutiny.	MRSA screening audits weekly on wards Reviewing frequency of cannulation competency Period of increased incidence for both wards - simulation training for wards with bacteraemias - wards with 2 or more colonisations within a 28 day period are placed on a Period of Increased Incidence (PII) - IPC attendance at huddles for wards on PII - Simulation provided to wards on PII	- Reported monthly to IPCSAG. - Learning shared at cross divisional meeting, IPC operational group and at divisions - Deep dive completed in June with actions agreed by Divisional directors of nursing and director of midwifery	- MRSA screening compliance remains below 90% compliance. - at 4 cases in October - Documentation is main area reducing compliance - Wounds and cannula sites not being screened when should be	4	4	16	▲	Overdue	Steph Gorman

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CNO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Controls	L	C	Current Score	In-month change	Review RAG	Operational Owner
1667	The trust will not met the 23/24 thresholds set for alert organisms and have an increased number of hospital acquired infections	The Trust needs to meet the agreed 23/24 targets to minimise the numbers of healthcare associated infections for MRSA, C.difficiles, klebsiella, E.coli and Pseudomonas. Last year the Trust breached the threshold for both MRSA and C.difficile but was under trajectory for all other organisms. There is a possibility of returning to NHSE/I and ICB oversight if targets are breached and no mitigations are demonstrated.	- Performance of Hospital Acquired infections is measured monthly and reported to IPCSAG. - This is assessed against the national thresholds set (33) still which were reduced further in 23/24. - This is also reviewed at divisional and care group level and is reported to QPSSC and QAC. - Post infection reviews are completed looking at any lapses in care and avoidable harm. - C-Diff ward Rounds commenced 05/07/23 to review all inpatients with C-Diff and GDH - Benchmarking against other Trusts monthly (month in-hand) - Vast majority unavoidable - Will be part of network CDI collaborative	- Outcomes are discussed at IPC operational group and form part of the annual report. - IPCSAG - Divisional governance meetings - QPSSC and QAC - IPC Strategy to reduce the number	- Increased numbers of C.difficiles that are healthcare associated in April and May which mean the threshold is likely to be breached by September 23. - National Trend	4	4	16	▲	Overdue	Steph Gorman
1844	Poor management of sharps is leading to staff sustaining avoidable sharps injuries	As a result of the poor management of sharps devices, staff are sustaining sharps injuries which otherwise would be avoidable. The harm caused to staff is dependant on whether injury is sustained by clean or dirty sharps, but could lead to staff sustaining a blood-borne virus (BBV) and may result in legal implications for the Trust	• IPC training rolled out • H&S Keyworker event in October in collaboration with IPC to focus on safe management of sharps • Support requested from facilities colleagues to remind staff of correct waste streams • Sharps group now established and membership agreed, inaugural meeting due to be held Jan 2024	• HSSG • IPC Group • Incident monitoring by H&S • Incident analysis quarterly by H&S • Sharps Group	• Sharps injuries not always reported via DATIX with staff presenting to OH only • Sharps group not yet established • T&F group not able to get engagement	3	5	15	–	On Track	Louise Furlong
1906	DBS checks outstanding for Volunteers	Volunteers are not included in the centralised recruitment process at MFT. As a result Volunteers are recruited by the Voluntary services manager. there is little assurance that DBS checks are being completed adequately. there is no central oversight of these checks or referral to the safeguarding team	Volunteers were added to ESR, this was completed by the resource team in mid December 2023 volunteer recruitment has been halted until an appropriate mandatory training package has been agreed and can be provided to all volunteers. the current mandatory training provision that is available to paid staff is not appropriate for volunteers to undertake a full review of all training has commenced for current volunteers rechecking of DBS's commenced in September 2023 by the voluntary services manager	the recruitment team have successfully inputted all volunteer details onto the ESR system. therefore mandatory training could be accessed once agreed. the mandatory training package that is provided by e-lfh to be approved and agreed for use. this is to be approved at PEG	no central oversight of the DBS checks by recruitment team as the Voluntary services manager undertakes this task independently Voluntary services manager is on long term sick, there is no one to back fill her position leaving the service without a manager the service is not working in line with similar organisations and does not follow all national guidance in regards to mandatory training approval required at Execs to complete enhanced DBS checks for all volunteers	5	3	15	–	On Track	Nikki Lewis

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

CNO Risk Profile – 'Extreme' Risks (Risks scored 15+)

Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Controls	L	C	Current Score	In-month change	Review RAG	Operational Owner
1233	Safeguarding impact as a result of failed or poor quality discharges & lack of policy	There are a number of Statutory Safeguarding Adult reviews (section 44 of The Care Act) and safeguarding concerns raised against the Trust in relation to the impact of a poor discharge or failed discharge on the patient. The impact of this ranges from concern over poor communication, incorrect or insufficient medication, poor or no on going referrals, failure to recognise and / or escalate self neglect and failure to recognise a deterioration in the patients condition before they leave the Trust and thus discharge not aborted. Patients health on readmission can have significant impact on outcome and therefore Neglect has been substantiated against the Trust in a number of these cases. Failure to discharge a patient safely can impact negatively on the patients health and outcomes. This in turn can impact negatively on the Trust from our regulators and reputation and publicity.	- Director of Operations: Discharge - Transfer of care concern meetings. - Safeguarding alerts raised where discharge is implied as the cause of the neglect / act of omission are raised on Datix - daily attendance by therapies at Discharge meetings - IDT Team		- Different systems used by the IDT and Trust team - Lack of assurance that these concerns have been investigated and addressed -Trust discharge policy has been out of date for 2 years and is an outstanding assurance item and requirement for the Kent and Medway Safeguarding Adults Board 2022 Self Assessment Framework.	3	5	15	–	Overdue	Tracy Stocker

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

COO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1053	Risk of inability to provide adequate plain film service due to ageing equipment and increased downtime. Loss/interruption	Due to their age, the CR readers used in General Imaging to process x-rays are unreliable and very prone to breaking down. The age of the equipment also means sourcing parts for the machines is becoming increasingly difficult. There is a risk that these concerns could lead to potential delays in care	• Capacity going through the machine is regularly monitored and managed • Limited GP walk-in service • Inpatient x-ray room utilised to facilitate A&E patients and potentially some GP bookings • Sittingbourne and Sheppey hospitals can be utilised	• Imaging governance meeting • Diagnostic and Clinical support services governance meeting • Divisional governance Board	No CR reader has not been sourced	3	5	15	—	On Track	Lorraine Becconshall
1218	Emergency Department at Full Capacity	Inability to effectively manage patients and flow due to: demand exceeding capacity, high attendance rates, high conveyance rates by SECAmb, inadequate downstream capacity. Inpatient specialty Assessment Areas being utilized for capacity management resulting in patients attending ED rather than Assessment Areas in the first instance. Risk of sub optimal care provided to patients. Deteriorating patient recognition. Poor patient experience and Poor staff experience. Risk to KPIs around sepsis, ambulance handover times, infection control, pressure damage, falls, feedback and reputational risk.	2 hourly board rounds take place in ED with a focus on patient safety. Quality & safety rounds completed, escalation via SMOC and DOC out of hours, in hours head of capacity and flow. Streaming model implemented to identify appropriate care, transformation programme in place to support direct access to appropriate assessment areas. Implementation of Majors Lite. Flexible use of Majors cubicles, Rapid assessment unit established. To fully embed the patient flow policy to mitigate the requirement to activate the full hospital escalation protocol. 31.01.2020 - escalated to CCG to increase discharge profile and identify additional capacity. Review of Standard Operating Procedures (escalation SOP, Flow SOP and Medically Fit SOP) 18.12.2023 Last week we experienced one of the worst episodes of being full capacity. We declared business continuity. Clinics were cancelled consultants were diverted to see day 2 patients. The capacity of SMART team was raised. Two 1 hour meetings involving all departmental leads were conducted to heighten the awareness across the division.			4	4	16	—	On Track	Chris Parokkaran
1337	Lack of capacity within Endoscopy to reduce backlog and address cancer targets	Demand currently outweighs capacity within endoscopy for both 2week wait and 52week wait pathways. This may negatively impact patient outcomes, and have reputational impact for the Trust. Due to contractual issues with Practice Plus Group (PPG) there will be a period where there will be substantially reduced capacity for endoscopy provision for MFT.	Patient scheduling prioritisation on clinical need PPG contract now in place Additional insourcing via ERF funds on weekend with 18 week solutions Reworked PID to be submitted with 3 options appraisal to address the capacity gap. Outsourcing to PPG Surgical theatre lists are being used to support with clearing the patient backlog. Mutual aid from MTW due to commence early June Mutual aid from DVH, discussions to take place in early June	• Weekly review of number of patients sent to PPG • Attendance at cancer PTL meetings to ensure cancer patients are prioritised • Utilisation of capacity regularly reviewed • Compliance reported on via IQPR Patient First Dashboard	• Further capacity required via continued insourcing and additional outsourcing • Confirmation of feasibility of identified space of expansion of 2 rooms • Further risk of reduced capacity when gastro outsourcing begins	4	4	16	—	On Track	Linda Stevens

Not recorded on DATIX | ON TRACK – Risk reviewed within required timeframe | AT RISK – Risks due for review within 7days | OVERDUE – Risks exceeded review date

N.B. Full details of all risks are available on the Trust Risk Register.

COO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1373	Obsolete Fukuda Monitors which are used for monitoring vital signs	10 Fukuda Monitors in HDU are >10 years old therefore parts are now obsolete. Impact of risk Closure of HDU beds, Patient safety, Loss of data, manual input of data into Metavision.	• Equipment loan/shared from other areas not utlising them • Patient management • Criticial care support system: transfer	- Purchase of new Fukuda Monitors		5	3	15	—	On Track	Sharon Kaur
1417	Possible non-renewal of ARSAC licence for Nuclear Medicine due to aging equipment	The ARSAC licence due for renewal on 14th February 2024 is contingent on 2 actions being taken forward by the Trust Non-renewal of the ARSAC licence may impact the Trusts radio-pharmacy service, to all 7 Trusts to which is currently provides a service.	- escalated to Execs by SBAR - Head of Imaging liaised with Estates & Capital Project Team to try and identify funding - Equipment Specification agreed6 x	- Risk discussed and escalated via : - RPG/HSSG - Imaging Governance - Care Group	- Funding not agreed - PID cannot be submitted for capital funding unless reconfiguration agreed with Capital Projects Team	4	4	16	—	Overdue	Lorraine Becconshall
1452	Non-compliance with Ionising Radiation Regulations 2017 (IRR) within Nuclear Medicine	Multiple non-compliances with IRR-17 legislation may impact the Trusts ability to continue delivering a Nuclear Medicine Service. The department requires re-configuration in order to address all of the actions identified from the audit undertaken by Radiation Physics. Risk linked to: 1417.	-Action Plan being monitored via regular meetings, Radiation Protection Group and Health, Safety & Security Group -Berthold Hand & Foot monitor being trialled prior to purchase 09.02.23 Hand & Foot monitors have now been ordered. Plans are being looked at to redesign the department, this is in liaison with the installation of the new gamma camera. East Kent will be providing physicist cover 1 day per week going forwards.	- Progress against action plan reported via RPG and HSSG. - 27 actions closed	-There are shortfalls in the designation of areas and monitoring of these designated areas which poses a significant risk of regulatory non-compliance in this area	4	4	16	—	On Track	Sarah Lee
1491	Theatre lights non-repairable beyond end of 2023.	Risk that theatre operating lights may be non-repairable beyond the end of 2023 as a result of withdrawals of spare components. The quality of the theatre lighting is also currently inadequate. The combination of the above 2 factors give risk to potential patient safety risks. This could be caused by: - Prolonged operating time, - Poor vision in operation field, - Prolonged anaesthetic time, and - Possibility of surgery being ineffectively completed - Disruption to theatre operating lists	- Datix completed each time an issue with lighting arises and Neil Adams is listed as handler. - Issue raised with Estates as they occur. Out of hours this is raised via site or switchboard. - Reactive repairs when issues arise. - Portable lighting available. - Patient prioritisation where possible to allow small procedures to occur in theatres with most problematic lighting. - On high priority list for 22-23	- Log of issues reported via DATIX and also via Estates hotline during working hours. Risk discussed via: - POCC board - Divisional Meetings	- Site and switchboard may not communicate with relevant parties - Portable lighting only suitable for small procedures. - Patients cannot always be allocated dependant on lighting issues - You cannot purchase parts for these lights now due to the age therefore need replacing with new lights. - Consultant/s have threatened patient lists to be cancelled if issue not remedied. - Awaiting timeframes for completion	4	4	16	—	On Track	Paul Norman-Brown

COO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1656	Fire Safety	A fire on site could lead to: - Loss of life - Injury or harm to people, including patients, staff and visitors etc. - Loss or damage to buildings, infrastructure and equipment - Reputational damage - Impact on patient services/care - Financial impact Fire Safety is multi-faceted and as such, the risk score is impacted by - Detection - Compartmentation - Suppression - Emergency Lighting - Training - Management - Housekeeping (Site safety).	- Mandated annual fire safety training for all Trust employees - Optional annual fire warden training available to all Trust employees - In-house fire response service provided to attend all detector and call-point activations on a 24/7 basis - Departmental fire risk assessments - Annual inspection of all fire doors on site - Repair or replacement of fire doors as required - Fire safety team involved in planning stages of all capital projects - Weekly fire alarm tests undertaken - 5-day week presence from fire alarm engineers - New fire alarm being systematically installed - Fire damper inspections undertaken in March 2023 - All cladding replaced on-site post-grenfell. - Walkarounds undertaken by fire safety team to check controls - Capital allocation for 2023/24: Capital Project: Install Fire Compartmentation & Fire dampers Capital Project: 21/22-042 Replace Fire Doors Capital Project: 21/22-039 Replace Fire Alarm Capital Project: Emergency Lighting Replacement - ED misting system was requested after building works had commence however the build remains HBN compliant	- Competent person appointed for Fire - Monthly Fire Safety Group - Monthly Health, Safety & Security Group - Appointed Authorised Engineer (AE) for Fire - Annual Audit by AE - Annual Audit by Kent Fire and Rescue Service (KFRS) - Roles and Responsibilities of designated individuals recorded within the Corporate Fire Safety Policy	- Management: No methodology of dealing with smokers. - No consequence to rule-breakers. - ED Misting system cannot be commissioned whilst occupied and therefore will not function. - no smoking cessation group established.	3	5	15	–	On Track	Neil McElduff
1693	Chronic Pain Service - unable to meet elective activity target for 23/24	The elective activity target for the 23/24 has been set at 2852 patients. The service is unable to meet this target due to lack of theatre capacity and regular cancellation of outpatient clinics as consultants are required to cover elective theatre sessions due to lack of anaesthetic staffing. This in turn is delaying patients receiving treatment within the constitutional target.	- Weekend activity is scheduled for chronic pain procedures - Additional Clinics have been requested - Locum anaesthetists requested to support theatre activity - CPO is negotiating with Drs regarding T&Cs for additional sessions	- Monitoring of Planned Vs Actuals - Triaging of referrals to ensure urgent patients are scheduled in a timely manner (mainly routine patients) - Weekly review of anaesthetic rotas	- Lack of anaesthetic cover in theatres - dependant on uptake from consultants to cover additional activity	5	3	15	–	On Track	Sharon Kaur

Not recorded on DATIX	ON TRACK – Risk reviewed within required timeframe	AT RISK – Risks due for review within 7days	OVERDUE – Risks exceeded review date

N.B. Full details of all risks are available on the Trust Risk Register.

COO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1729	Lack of service provision for Breast Family History clinic	Following x2 Breast CNS resignation there are currently no competent CNSs to provide a Family History service at MFT. This has resulted in no provision for patient assessment and support for Family History referrals received into the Trust, which will lead to lack of screening and potential early diagnosis of breast cancer and poor patient experience.	The Breast Care Nurse is currently undertaking Family History training and competencies.	Care Group Board Divisional Board	Lack of financial resources to outsource the clinic to GSST to cover the service whilst training is undertaken by BCN.	5	3	15	▼	On Track	Louise Black
1839	High Radiation Doses at Sittingbourne Hospital	As a result of Medical Physics reviewing dose data to establish Diagnostic Reference levels (DRL's), it has been highlighted that patients are receiving higher doses of radiation when having x-rays at Sittingbourne Hospital. This is compared to National DRL's (for CR equipment) and compared to digital (DR) equipment.	Radiation Protection Supervisor is collecting DRL information and exposure indexes for the most routinely performed x-rays. This will help establish the relationship between dose and the diagnostic quality of radiographs.	Radiation physics are aware and currently investigating. The equipment is still producing diagnostic images, although these are over the recommended National DRL's and higher exposure factors are needed to produce the diagnostic images. Staff are aware and using the ALARP (As Low As Reasonable Practicable) principle to optimise doses as much as possible.	Until this equipment is replaced we cannot easily reduce the dose to patients, and therefore cannot reduce the risk score. CR equipment is gradually becoming obsolete which means finding parts and optimisation of equipment is difficult. The CR reader is on end of life.	5	3	15	—	On Track	Sarah Lee
1884	Blood Sampling and Labelling	Because of poor sample labelling there is a risk that there will be a transfusion never event, or untoward patient event due to the potential of wrong blood in tube. Current sample rejection rate for blood transfusion is 6.5% (national average 4.4%, regional 4.3%).	- BloodTrack PDAs used in sample labelling in Blood Transfusion which includes scanning of wristband, pre-sampling checklist -Blood Transfusion LIMS to check for historical records - 2 sample policy prior to issue of group specific blood	Quality Improvement Plan completed 5 workstreams identified: 1. review and update patient verification policy 2. Deliver QIP with assistance from PSG 3. A3 session being completed to reduce number of sample rejections and wrong blood in tube 4. PID for TP Assistant submitted , awaiting for approval 5. Comms drafted and submitted for approval to PSG for distribution to all staff regarding sample rejection and on how to avoid patient harm - QIP in ED, agreed plan to reduce sample rejections in ED due to persistent high number of sample rejections. Weekly catch up with ED team to discuss sample rejections, identify ED staff that need refresher training, drive cultural change through huddles, discussions,4Cs,etc -Agreed with ED Admin Service Manager to ask staff to confirm with patient/carer their details on wristband is correct before attaching wristband on patient; Practice of booking in patient before they arrive in hospital will now be stopped.	-SECAMB - requirement to standardise patient identification in the Emergency Operation Centre -Trust to review and update policy in patient verification -standardise wristband and PAS labels to include patient details -Provision of additional BloodTrack machines to clinical areas -Training compliance needs improvement -BloodTrack upgrade inc 'smart' fridge -provision of additional ED phlebotomy support -Blood Transfusion Order Comms -Teletracking to include hospital number of patient -function currently 'greyed out' -Blood Transfusion COnsent and TACO checklist on EPR -Data collection system to track and trend blood transfusion inc sample rejections,traceability,etc -TP Assistant and additional TP	3	5	15	—	On Track	Kathleen Sharp

N.B. Full details of all risks are available on the Trust Risk Register.

COO Risk Profile – 'Extreme' Risks (Risks scored 15+)

NHS Medway NHS Foundation Trust

Risk ID	Risk Title	Risk Description	Mitigations	Controls & Assurances	Gaps in Control	L	C	Current Score	In-month change	Review RAG	Operational Owner
1912	Unfunded Bed Turnaround Team	Unbudgeted expenditure to clean Trust wide discharge beds to meet requirements of Teletacking - the original scope of the project did not consider the bed cleaning, mattress integrity and bed making services which were originally undertaken by Clinical Teams. the risk is currently mitigated by using agency cleaning staff and an additional consumables supply is obtained via the Housekeeping, all of which is an unfunded cost pressure	Teletracking cleaning requirements are covered by agency staff. Teletracking Project Team is aware of the agency usage. Detailed report issued to Execs which awaits a response.	Agency booked/monitored in line with the National standards of cleanliness, by the Facilities Housekeeping Team. Any shortages are covered by the inhouse staff. Financial status reported monthly on Budget Statement.	Reliability on external agency Lack of continuity of having a consistent workforce Time required to train agency staff who may not stay in the job No assigned budget.	5	3	15	–	On Track	Mons Kalsi
1293	Closure of the SAU/Bedded leads to increased wait times in ED/delays to triage treatment etc. and impact patient experience	Closure of the SAU may lead to: 1. Patients stay in ED for long period of time 2. As patients are speciality patients they are often placed in the corridor to wait to be seen by the surgical teams, risk of patient deterioration 3. This causes additional pressure to ED and capacity in ED. 4. Delayed treatment 5. Staff welfare/wellbeing/morale 6. Patient feedback/FFT	- The aim is to get the 2 assessment rooms open as soon as possible so that waiting room suitable patients can go to SAU. - Any returners i.e. for scans etc are still seen in SAU whilst closed - Relocation of staff as required in order to support - FFT surveys/ monitor outputs - Not recent closures/ unit continues to function	- Divisional Risk Review Group - Care Group Board - Divisional Governance Board - PSG - QPSSC	- SAU needs to be ring fenced so it can continue to function - Staff availability in order to support - Medical outliers even when Trust is not in business continuity	5	3	15	–	On Track	Joss Hargan

Not recorded on DATIX	ON TRACK – Risk reviewed within required timeframe	AT RISK – Risks due for review within 7days	OVERDUE – Risks exceeded review date

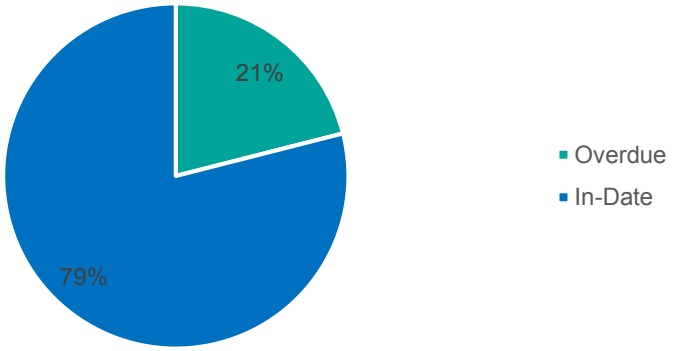
N.B. Full details of all risks are available on the Trust Risk Register.

Approved Risks

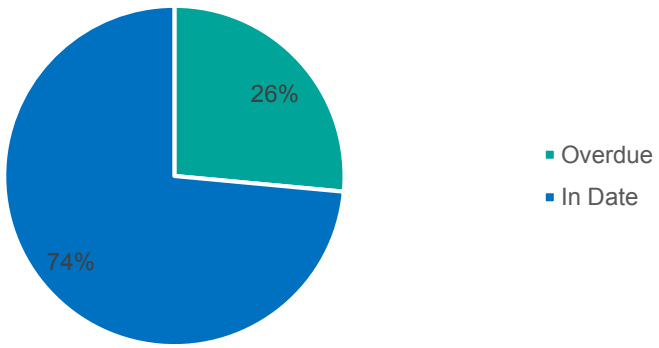
Of the 252 approved risks;
- 53 have breached their review date

Of the 34 ‘extreme risks’;
- 9 have breached their review date

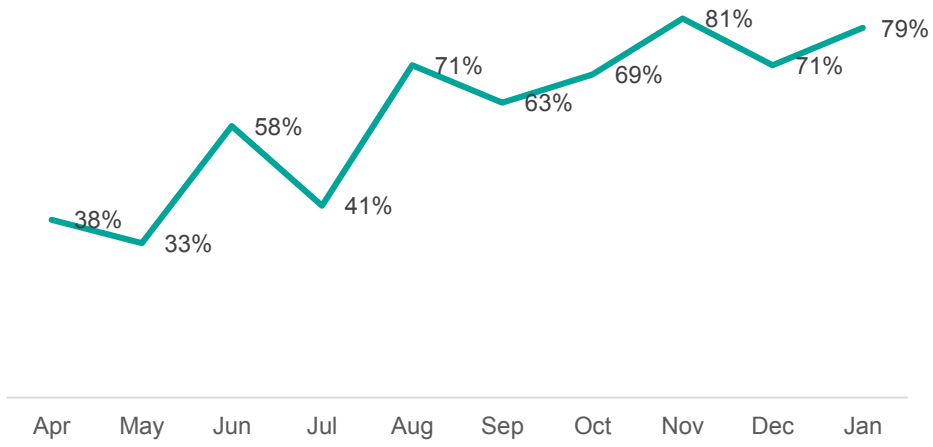
Risks by Review Status



'Extreme' Risks by Review Status



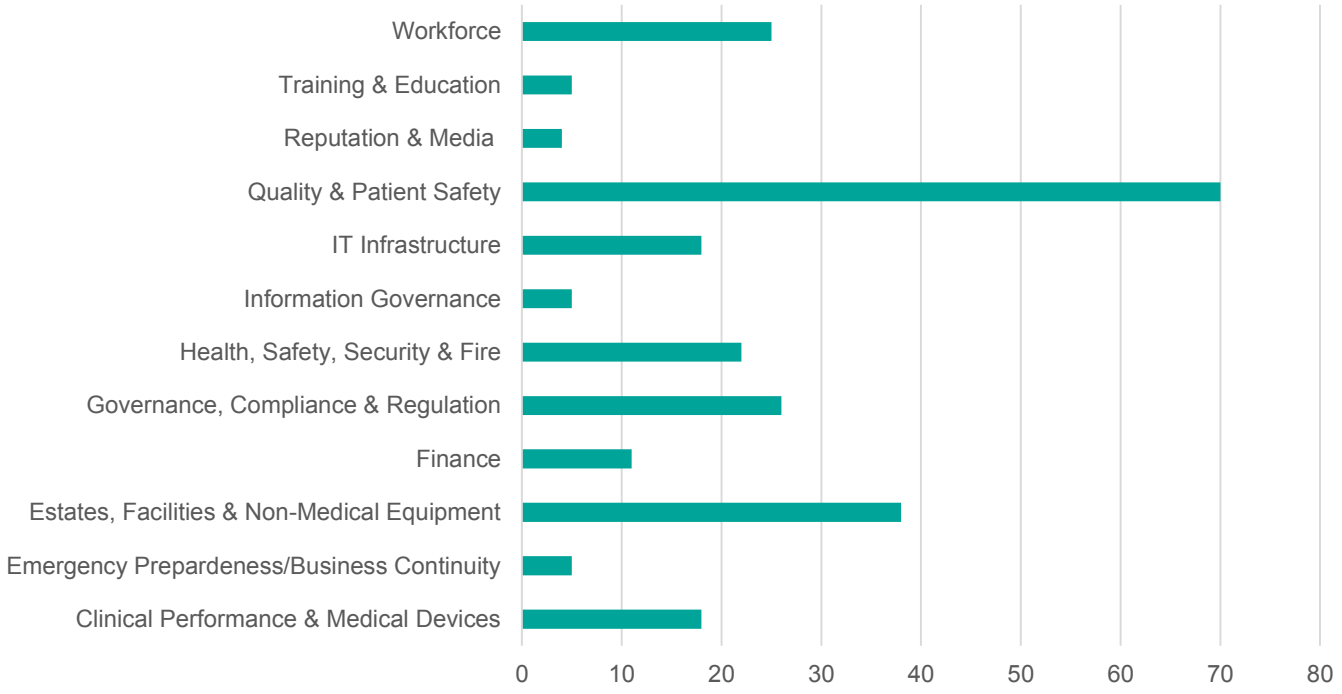
Review Rate by Month



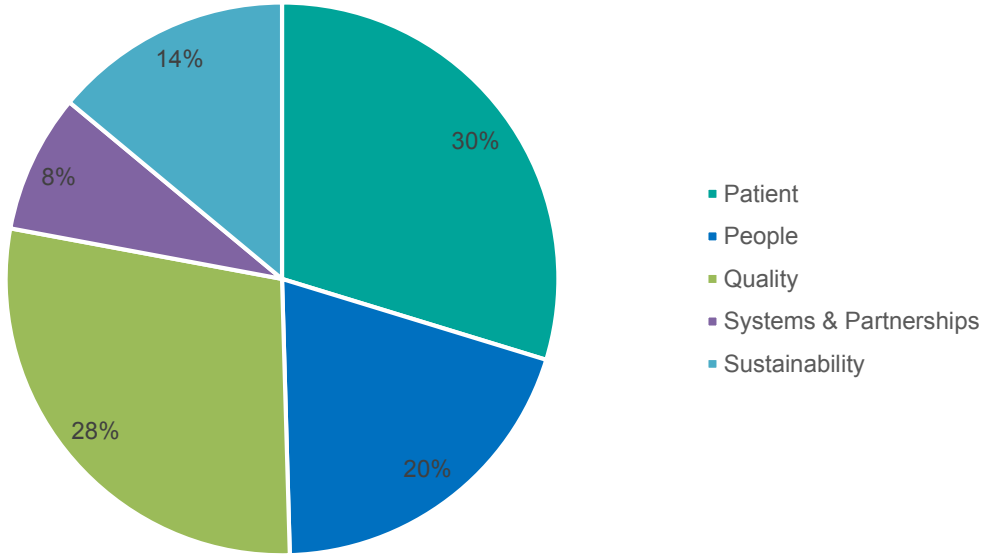
Approved Risks

NHS Medway NHS Foundation Trust

Risk Themes



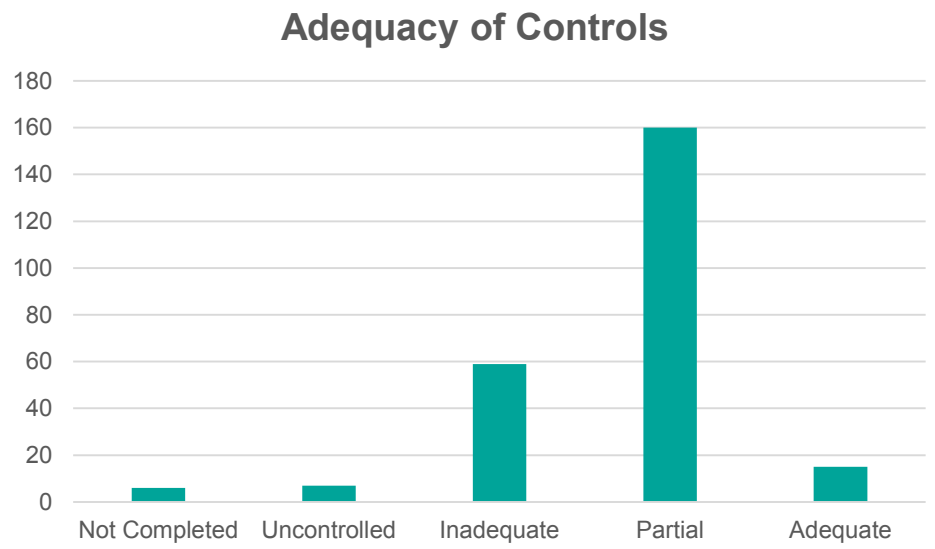
Approved risks by True North Domains

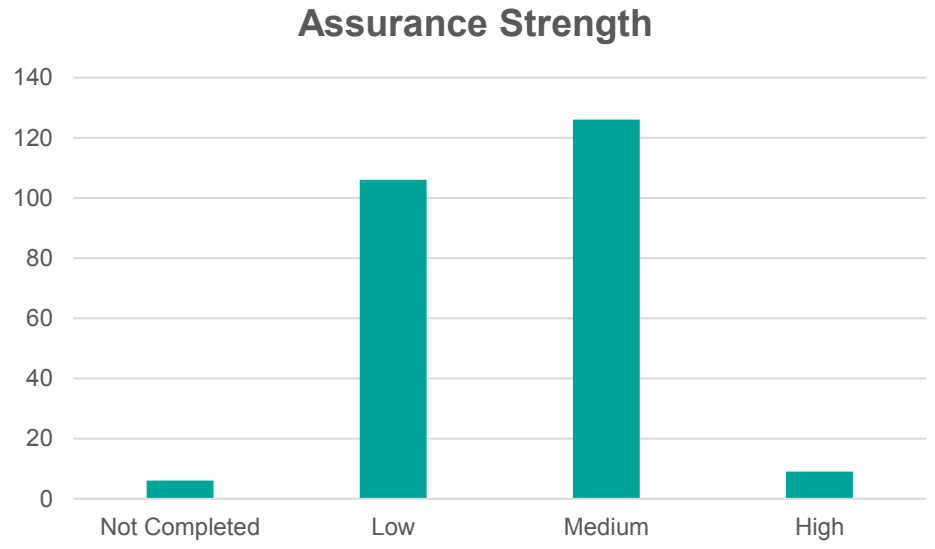


Approved Risks

Of the approved risks;

- The adequacy of controls for 89% of risks is either inadequate or partial
- The assurance strength of 94% of risks is Low or Medium
- There continues to be greater correlation between the adequacy of controls and level of assurance





Systems & Performance– Deep Dive

The Systems & Performance Risk Register has 0 approved risks in total

0 new risks added
0 risks are awaiting review, and
0 risks awaiting approval.

0 risks has been closed down
0 risks have been rejected.

Estates & Facilities– Deep Dive

The Estates & Facilities Risk Register has 53 approved risks in total
3 risks are scoring 15 and above

1 new risk added
3 risks are awaiting review, and
0 risks awaiting approval.

1 risks has been closed down
2 risks have had the score reduced from the previous month,
1 risk has had the score increased from the previous month and
0 risks have been rejected.

98% of E&F risks were reviewed within the required timeframe.

Oldest Risk: 28th November 2019

Action Required

Ref	Action	Owner	Date	Status
01	95% of approved risks to have been reviewed within timeframe	Risk Owners with oversight by IGT	31 July 23	Overdue. Review rate currently at 74%
02	Review of process for new risks to ensure they are approved in a timely way with 95% approved within 1 month of being raised	IGT	31 July 23	Process complete. 95% target not yet achieved
03	100% of approved risks are fully completed	Risk Owners with oversight by IGT	31 July 23	Complete
04	Quarterly reporting against Risk Management KPIs	IGT	31 July 23	Complete
05	Consolidate all EPR and EPMA Risks into 2 singular risks as agreed with MD and CNO. These 2 new risks should focus on functionality of the system and staff not following processes/using workarounds	Kerry O'Reilly with support from IGT	31 July 23	Overdue. Awaiting risk review meeting with CINO and Divisional Director of Nursing
06	Assign every risk to the 'group or committee' responsible for onward monitoring	IGT	31 July 23	Complete
07	Work with divisions to 'cascade' information relating to the difference between incidents and risk	IGT	31 Oct 23	Complete

Meeting of the Trust Board
Wednesday, 06 March 2024

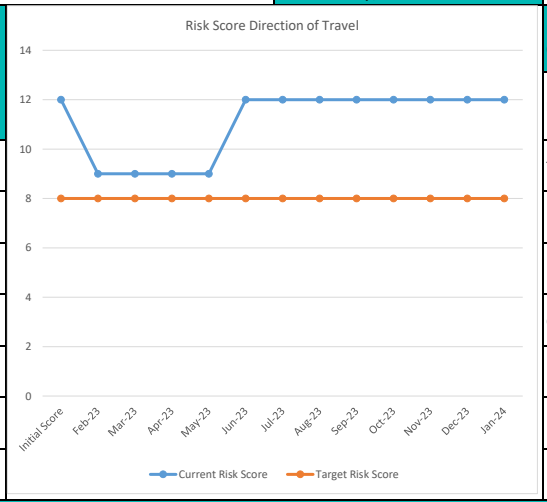
Title of Report	Board Assurance Framework		**Agenda Item**	6.3
Author	Integrated Governance Practitioner			
Lead Executive Director	Chief Financial Officer, Sustainability Chief Medical Officer, Quality Chief Nursing Officer, Patient Chief Operating Officer, Systems & Partnerships Chief People Officer, People			
Executive Summary	The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through the Executive Board. The Board Assurance Framework (BAF) consists of 19 strategic risks aligned to each of the Trust's True North Domains.			
Proposal and/or key recommendation:	The Trust Board is asked to **note** the report for assurance and discussion.			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting	✓	Discussion	✓
Committee/Group at which the paper has been submitted:	Risk and Compliance Assurance Sub-Committee 20 February 2024.			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) ✓	Priority 2: (People) ✓	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:			
	Safe: ✓	Effective: ✓	Caring: ✓	Responsive:✓	Well-Led: ✓
Identified Risks, issues and mitigations:	As outlined in the relevant sections of the Board Assurance Framework.			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	N/A			

Legal and Regulatory implications:	There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk.		
Appendices:	Board Assurance Framework (PDF)		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information or any enquires relating to this paper please contact:	Integrated Governance Team medwayft.integratedgovernance@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 minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

PATIENT BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	12.1%	10.8%	13.0%	14.4%	12.4%	12.6%	12.6%	
Inpatients FFT Response Rate	45.0%	32.2%	28.4%	35.4%	45.1%	42.2%	34.9%	36.4%	
Emergency Care FFT Response Rate	45.0%	8.1%	6.0%	9.5%	8.3%	7.2%	8.0%	7.9%	
Outpatient FFT Response Rate	45.0%	8.5%	8.3%	8.8%	9.5%	8.0%	9.0%	8.7%	
Maternity FFT Response Rate	45.0%	31.3%	31.4%	33.3%	26.3%	14.4%	30.7%	27.9%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

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

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

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

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

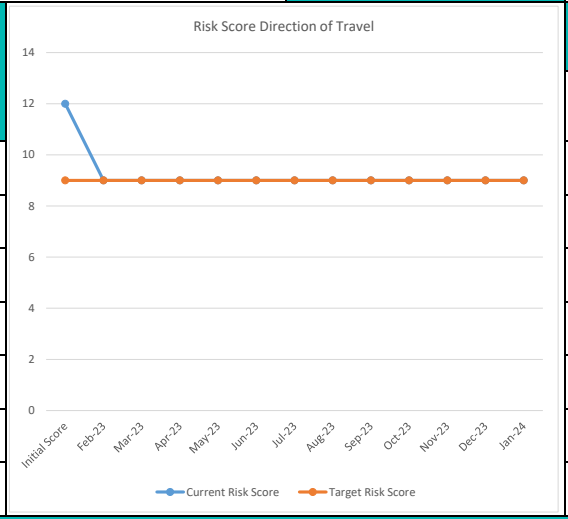
Date of Last Review:	15 January 2024
Date of Next Review:	15 February 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1b
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which cannot be used for benchmarking across the Trust
Relevant Group/Committee	Quality Assurance Committee

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Total FFT Response Rate	45.0%	12.1%	10.8%	13.0%	14.4%	12.4%	12.6%	12.6%	
Inpatients FFT Response Rate	45.0%	32.2%	28.4%	35.4%	45.1%	42.2%	34.9%	36.4%	
Emergency Care FFT Response Rate	45.0%	8.1%	6.0%	9.5%	8.3%	7.2%	8.0%	7.9%	
Outpatient FFT Response Rate	45.0%	8.5%	8.3%	8.8%	9.5%	8.0%	9.0%	8.7%	
Maternity FFT Response Rate	45.0%	31.3%	31.4%	33.3%	26.3%	14.4%	30.7%	27.9%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Original surveys approved by Senior teams based on NHSE guidance All survey requests to be approved via the Executive Team All survey changes actioned by Gather Team	Gather system and FFT feedback to benchmark the responses in each

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

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

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

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

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

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

Risk submitted to QAC for proposal of closure October 2023

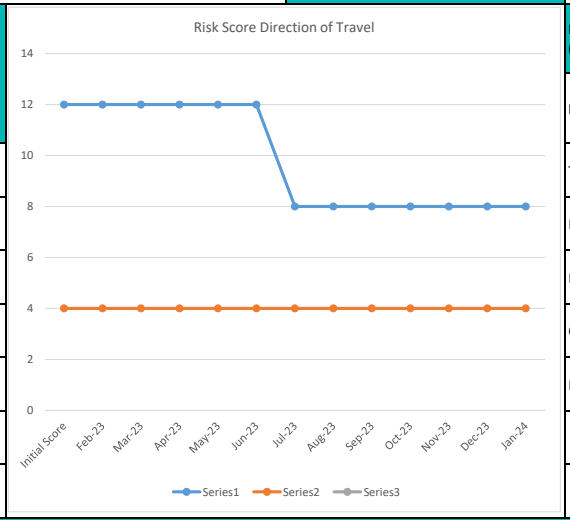
Date of Last Review:	15 January 2024
Date of Next Review:	15 February 2024

PATIENT BOARD ASSURANCE FRAMEWORK

Risk ID:	1c
Executive Owner	Chief Nursing Officer
Operational Owner	Nicola Lewis, Associate Director of Patient Experience
Primary Risk Grouping	Patient
CQC Domain	Responsive

Objective:	Providing outstanding, compassionate care for our patients and their families, every time.
Principal Risk Name & Description	Potential lack of delivery across other True North Domains could lead to patients not recommending our services as a place to receive care
Relevant Group/Committee	Quality Assurance Committee

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Total FFT Recommended Rate	95.0%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	88.7%	
Inpatients FFT Recommended Rate	95.0%	93.5%	91.3%	90.7%	92.2%	93.3%	92.3%	92.2%	
Emergency Care FFT Recommended Rate	95.0%	73.1%	74.8%	75.2%	67.9%	69.2%	64.7%	70.8%	
Outpatient FFT Recommended Rate	95.0%	91.6%	92.0%	91.1%	92.4%	91.9%	91.5%	91.8%	
Maternity FFT Recommended Rate	95.0%	87.8%	92.5%	92.5%	90.5%	82.7%	88.5%	89.1%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

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

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

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

Operational flow and processes in maternity have caused a reduction in recommend rate over the last 2 months.	Maternity teams to implement a deep dive / A3 into the issues surrounding induction of Labour	31/07/2024	On Track/Not Yet Due	Alison Herron, Director of Midwifery / Kate Harris, Head of Midwifery	This project will be running for 1 year
Staff attitude has been a theme from patient feedback, PALS and Complaints in maternity areas	A3 deep dive into issues surrounding staff attitude, with intentional rounding from senior staff out of hours	31/08/2023	Complete	Kate Harris, Head of Midwifery	Maternity A3 and action are complete 15/09/2023
Staff attitude has been a theme from patient feedback in inpatient areas	A3 deep dive discussions have commenced with further detail around actions and improvements will be collated with the CNO and team	30/11/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	the A3 for staff attitude to be shared at the PE Group / QPSSc and QAC
Staff attitude and concerns at night have been raised from patient on inpatient areas	A rota for senior staff support and visibility has been developed with the CNO. The approach to be approved at the next CNO meeting	30/09/2023	Complete	Nicola Lewis, Associate Director of Patient Experience	
Low recommend rate in OPD and ED	Clinicans in OPD to offer a reminder to patients complete the survey following their consultation. Actions are being collated in care group huddles to improve the FFT recommend rate, these are escalated	30/11/2023	Overdue	Outpatients / ED Team	to separate this into 2 separate actions to close this action. Please see below
Low recommend Rate in ED	to meet with the ED teams and join their huddles. Restart A3		Overdue	Kathy Ward (HoN) Kate Holmes (DDoN)	
Low recommend rate in OPD	• Engaging all clinicians in OPD to engage with FFT and remind patients to scan the QR code. • Review and refresh all FFT merchandise in OPD areas. • ADPE to attend the OPD patient experience meeting to promote the use of FFT. • New divisional structure commenced in late 2023, areas in OPD to be updated on Gather and refresh of the system to commence in the next reporting period		On Track/Not Yet Due	Chris O'Connell (Matron) Laura Potter (DDoN/AHP interim)	
Noise at Night	6. A full evalutation of the noise at night project to be completed	31/08/2023	Overdue	Divisional Directors of Nursing	15/01/2024 awaiting the evaluation report from DDoNs

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

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

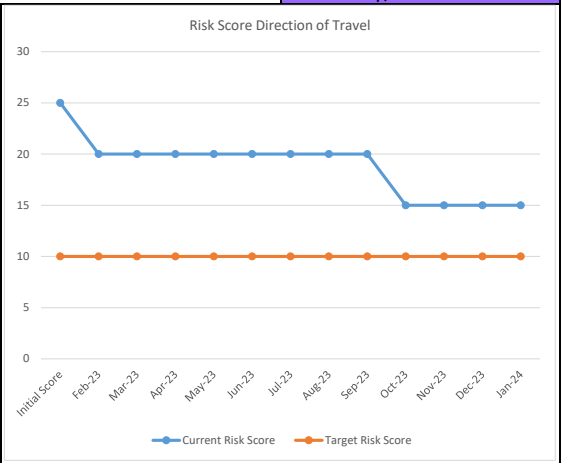
Risk rating has increased as actions are overdue and FFT recommend rate has not improved in OPD and ED, which decreases the overall receommend rate in the organisation

Date of Last Review:	15 January 2024
Date of Next Review:	15 February 2024

QUALITY BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Avoidable 2222 Calls - Total	16	4	3	1	4	2	4	3	
Avoidable 2222 Calls - Cardiac Arrest	1	0	1	1	2	2	1	1	
Avoidable 2222 Calls - Peri-Arrest	3	4	2	0	2	0	3	2	
ALS/BLS Training Compliance	85.0%	79.0%	80.0%	81.0%	80.0%	81.2%	81.0%	80.4%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

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

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

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

1a. Doctors not ALS/BLS Trained	1a. Improve ALS/BLS training compliance	22/05/2023	Overdue	Chief Medical Officer	YTD average only at 80%, target not yet achieved. **Work ongoing with action plan. Service Managers working with respective areas on compliance.** **BLS - 82.5%. KPMG Audit now received ans id being acted upon** **ALS - 73.2%** **ILS - 72.6%**
2a. EPR system needs optimisation	2a. Cardiac and pre-arrest proforma on to EPR	24/04/2024	On Track/Not Yet Due	Tamara Stephens, Sherwin Sinocruz	Ongoing SIM testing referral tool for escalation. **Re-design complete and awaiting electronic completion.**
2b. EPR system needs optimisation	2b. Electronic SBAR referral tool for escalation	24/04/2024	On Track/Not Yet Due	Emma Coutts	**This has been moved through to testing which will take place 08/02/2024 and will then be taken back to the EPR Board for approval.**
2c. EPR system needs optimisation	2c. ABG/Point of Care Testing integration with EPR	22/04/2024	On Track/Not Yet Due	Tamara Stevens, Kerry O'Reilly, Dilip Pillai	Awaiting Order Comms Switch on 04/2024
2d. EPR system needs optimisation	2d. Medicus ART clinical entry integration with EPR	31/03/2025	On Track/Not Yet Due	Dilip Pillai, Kerry O'Reilly, Emma Coutts, James Alegbeleye, Zohreen Amir	**There will be an integration cost involved of £6000 which has been reduced by £3000 if the trust can complete this integration along with the update that MEDICUS will be completing for us . To be confirmed if this can be sought from the critical care budget in line with the ICU IT Medicus costing. Update due 21/02/2024. MAy go through Stategic Filter? corporate project**
2e. EPR system needs optimisation	2e. **ReSPECT/DNACPR/TEP development + electronic integration with community ICS and Trust	01/09/2024	On Track/Not Yet Due	James Alegbeleye, Zohreen Amir, Dilip Pillai	Larger project, pending JaA work + recruiting next Darzi fellow. Discussions/review ongoing around content, electronic integration and whether there can be a single form across the community and Trust. N**ot yet complete, ongoing discussions. Pilot form to be tested. Update 13/03/2024**
2f. EPR system needs optimisation	2f. Rewrite of TEP form	30/06/2023	Complete	James Alegbeleye	See action ref 2e. **This has been marked as complete despite ongoing work as it is now included in action 2e.**
3a. Failure to escalate/escalate/gap in clinical plan: Gap in knowledge of SOP/Standard	3a. Targeted NEWS/Alert training to be mandatory for all staff	15/11/2023	Complete	Emma Coutts	Complete
3b. Failure to escalate/escalate/gap in clinical plan: NEWS not captured as per standards	3b. A3 on timeline for NEWS	01/09/2024	On Track/Not Yet Due	Jamie Moore, Kate Holmes, Emma Coutts	Three streams - i) Ensure Observations are undertaken as needed; ii) ward scores visible on whiteboards; iii) Streamline and automate processes for uploading results to EPR and acting upon these. Updates om all three by 06/03/2024
3c. Failure to escalate/escalate/gap in clinical plan: Lack of data, ownership, review delays	3c. Metavision critical care virtual ward for ITU outliers reintroduced - SOP to be written on referrals	08/11/2023	Complete	Rachel Krol	It has become clear that Metavision is not suitable for this and RaK is pursuing other options. Marked as complete as moved to BAU in critical care
3d. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3d. Tazocin PGD	08/11/2023	Complete	Emma Coutts, Rachel Krol, Godwin Simon	Upon review, this action is not required.

3e. Failure to escalate/escalate/gap in clinical plan: Delay in prescribing meds, lack of monitoring of high NEWS list	3e. Metraminol in ED, SOP to be implemented	08/11/2023	Complete	Emma Coutts, Godwin Simon	Marked as complete as moved to BAU
3f. Failure to escalate/escalate/gap in clinical plan: Board rounds and handover pilot	3f. Escalation on board rounds	08/11/2023	Complete	Jamie Moore, Kate Holmes, Dilip Pillai, Tracy Stocker	This is now BAU. Ongoing, trial on Harvey and Pembroke for ward handovers is now underway, using WOW's to share information amongst team.
3g. Patients leaving ICU/HDU do not always have an appropriate level; of consultant and other senior review, knowledge of patient, and escalation of care when transferred to a ward. Also concerns re admission handover and access to parent teams whilst on ICU	3g. Review of ICU pathway including admission, parent clinical team review whilst patient on ICU/HDU and medical and nursing handover arrangements when patient leaves ICU/HDU	13/03/2024	On Track/Not Yet Due	Chris Parokkaran, Rachel Krol, Howard Cottam	Had initial meeting. Ongoing discussions
4a. Failure of appropriate delivery of care, monitoring and escalation by specialist team whilst awaiting transfer, lack of ownership of patient care	4a. SRO led session to establish full root cause and key tests of change and engagement with wider stake holder group	31/03/2025	On Track/Not Yet Due	Howard Cottam	A3 completed. HoC workign with other DMD's re how to mitigate
5a. End of Life Decision being made at night rather than earlier in the day. End of Life decisions are often not prioritised and therefore, are not always completed by the end of the day.	5a. Discussed and agreed at QPSC that action is required but multi-disciplinary meeting needed and learning	24/04/2024	On Track/Not Yet Due	Emma Coutts	Weekly data to be provided. **Audit presentation to be reviewed at quality huddle on 21/02/2024.**
6a. Epilepsy following cardiac arrest - reduced awareness of time critical drugs	6a. Clarify status of non-avoidance of 2222 call - Review case of epileptic patient and clarify whether this was a non-avoidable 2222 call.	08/11/2023	Complete	Godwin Simon, Tamara Stephens, Emma Coutts, Rachel Krol	Missed dosage working group to look at report and identify ongoing actions to resolve issue. Drugs issues to be raised on risk register for both Divisions - JD to circulate list of time critical drugs to doctors for comment. Pharmacy students currently working on this list as a project supervised by Chief Pharmacist. **Action complete.**

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

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

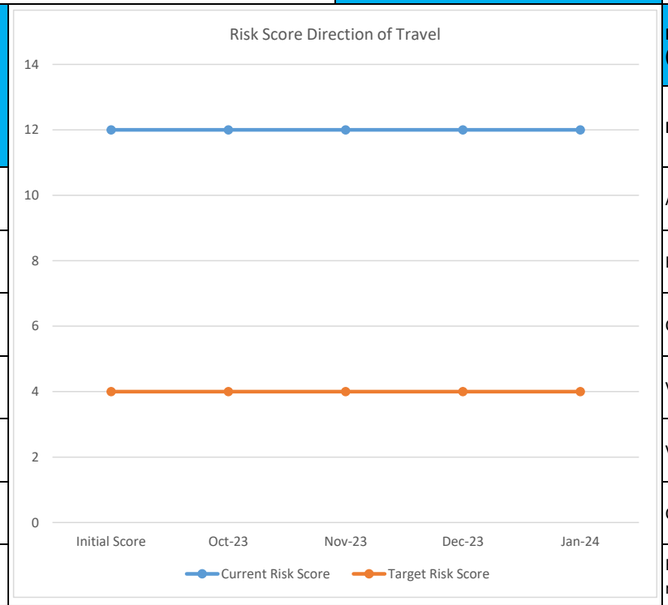
Investigations taken forward - new rota in place
Current status - Hospital at Night - working well

Date of Last Review:	14 February 2024
Date of Next Review:	14 March 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

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

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	
Risk Score at Last Review				
Current Risk Score	3	4	**12**	**N**
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Agency Spend	3.7%	2.6%	3.5%	2.7%	2.0%			2.7%	
HR KPI - Time to Hire (days)	42.0	66.7	61.2	60.4	88.0			69.1	
Care Hours Per Patient Day (CHPPD)	9.5	9.1	9.2	9	9.1			9.1	
Voluntary Turnover First 2 Years of Employment (in month)	1.0%	0.7%	1.0%	0.8%	0.6%			0.8%	
Voluntary Turnover (Annual)	8.0%	10.8%	10.8%	10.6%	10.1%			10.6%	
Contractual Vacancy Rate	9.0%	4.0%	4.1%	3.6%	3.2%			3.7%	
HR KPI - OH Pre-Employment Checks within 10 days of receipt	90.0%			73.0%				73.0%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

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

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Safe staffing levels for the periods of industrial action.	1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	This is an ongoing action for the periods of strike action.
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	2. We are exploring robotic automation of the elements of the recruitment process	31/03/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	3. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment.	31/03/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	New action
2. We need to improve our end to end recruitment and onboarding process. This includes time to hire (advert approval to unconditional offer) and candidate experience.	4. Review of the end to end medical recruitment process.	31/03/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	New action
3. We need to understand how we might improve our retention by preventing resignations.	5. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average.	29/02/2024	On Track/Not Yet Due	Lisa Webb, Associate Director OD	Progressing well
4. We need to improve our understanding of the reasons why staff leave clinical areas difficut to recruit to.	6. Continue to promote Intention to Leave process and Exit Interviews through team huddles and HR BPs.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	
5. Consider implementation of recruitment and retention premia for difficult to recruit and retain roles, including medics	7. New approach to be explored with the system and new policy written.	31/03/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Development of an ESR report to identify difficult to recruit areas.

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

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

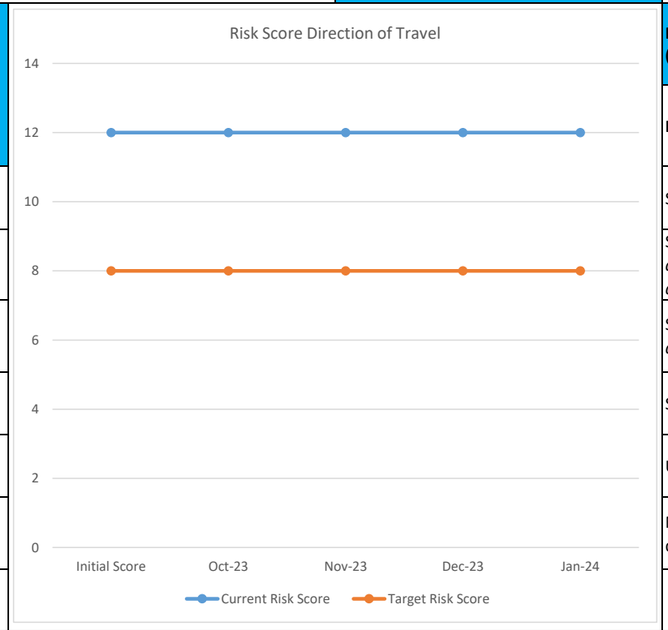
External labour market - addressed through annual skills demand profile through operational planning returns to ICB (education commissioning shortages) and continued international recruitment to address domestic skills shortage through ethical recruitment.
Our ability to retain staff through competitive rewards packages is limited due to the Trust's financial position and a natonally agreed rates of pay, therefore we plan to develop and promote Trust's Employee Value Proposition through the refreshed Employer Brand.

Date of Last Review:	14 February 2024
Date of Next Review:	14 March 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

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

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	3	4	**12**	
Risk Score at Last Review				
Current Risk Score	3	4	**12**	**N**
Target Risk Score	1	4	**4**	
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Medium			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
Staff Survey Engagement Score	6.93	6.63	6.63	6.63	6.63			6.63	
Staff Survey Question: *If I spoke up about something that concerned me, I am confident my organisation would address my concern*	48.0%	41.0%	41.0%	41.0%	41.0%			41.0%	2021,22 and 23 survey results are between 39% and 41%. National average is 47-48%
Staff Survey Question: *My organisation respects individual differences.*	70.0%	67.0%	67.0%	67.0%	67.0%			67.0%	2021 survey - 61.7%; 22 Survey - 65.7%, 23 Survey - 67%. National average 70%
Staff Appraisal Rate	90.0%	89.4%	89.0%	88.6%	88.0%			88.7%	
Uptake of Management Essentials Training		9	21	14				15	
New metric on incidents reported once we have sufficient data from the Anti-Bullying and Harassment Group									

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. We need to ensure that Leadership and Management behaviours make a clear link with staff engagement levels. This is part of the People Startegic Initiative.	1. Staff Compact to be reviewed and updated to include new / additional leadership behaviours.	31/03/2024	On Track/Not Yet Due	Lisa Webb	
2. Management essentials to be reviewed to identify gaps which deliver skills required to improve staff engagement levels. This is part of the People Strategic Initiative.	2. In conjunction with colleagues in East Kent, review our management essentials offer and identify modules for development / collaborative work.	29/02/2024	On Track/Not Yet Due	Lisa Webb	
3. Currently we have little data which could be used to improve staff retention e.g. reasons behind our high turnover of staff in the first two years of employment.	3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool.	29/02/2024	On Track/Not Yet Due	Lisa Webb	This work is under way.
4.We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	4. ICB New Starter Survey results need to be analised and actions assigned to the respective teams.	01/05/2024	On Track/Not Yet Due	Lisa Webb	In depth analysis of the data is underway. A dedicated T&F Group will be established to discuss actions.
4. We need to understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.	5. MFT own New Starter Survey, replicating ICB survey is going to be launched.	01/05/2024	On Track/Not Yet Due	Lisa Webb	
5.We need to see an increase in appraisal completion and ensure that the level is sustained.	5. Identify areas where completion falls below 90% and raise in care group/team meetings.	Ongoing	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	Action to be progressed by HR BPs.
6. We need to improve perception of appraisals and their addedd value, to improve engagement levels.	6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group.	29/02/2024	On Track/Not Yet Due	Lisa Webb	QA underway waiting for first iteration of data
7. Review Trust's Freedom to Speak Up Policy and process for comissioning investigations.	7. FTSU process has been reviewed. Policy needs to be updated and published.	31/01/2024	Complete	Katrina Ashton	
8. We need to provide staff with alternative ways of raising concerns with the organisation.	8. Launch and promote Dignity at Work Advisors.	31/01/2024	Complete	Dominika Kimber, Deputy Chief People Officer	
9. Improve staff confidence that the organisation listens to their concerns and implements improvements.	9. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accesible.	31/03/2024	On Track/Not Yet Due	Dominika Kimber, Deputy Chief People Officer	

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

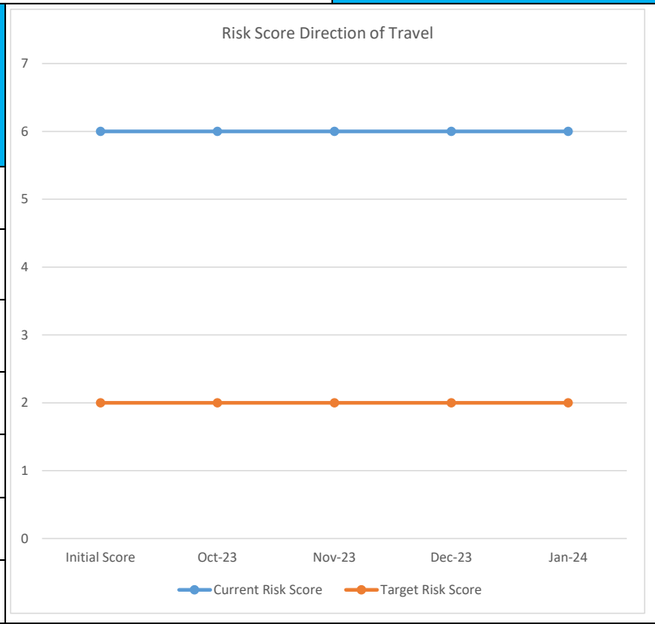
Additional Comments (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)
Factors which are external to the Trust and not in our control are likely to have a negative impact on staff engagement and morale (worstening financial situation, cost of living crisis, recession).

Date of Last Review:	14 February 2024
Date of Next Review:	14 March 2024

PEOPLE BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Average**	**Comments:**
WRES 5 and 6	29.0%	34.6% 31.9%	N/A	N/A	N/A				WRES 5 - % of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. WRES 6 - % of BAME staff experiencing
WRES 8	15.0%	18.3%	N/A	N/A	N/A				% of BAME staff responding to say they had personally experienced discrimination at work from managers, team leaders, or other colleagues
WDES 4a I and 4a ii	17; 27%	17.1% 29.5%	N/A	N/A	N/A				% of staff with a lon term illness experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months; and % of staff
WDES 4b	48.0%	51.4%	N/A	N/A	N/A				% of staff with a long term illness saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
WDES indicator 8 (Reasonable Adjustment)	70.0%	74.7%	N/A	N/A	N/A				% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
% BAME Staff at Band 8a and above (AFC)			N/A	N/A					This will need to be new monthly data request to Workforce Intelligence, and will need to be a comparison between Band 8a and All bands. Workforce request has been submitted.
AfC staff Gender Pay Gap	0.0%	1.9%	N/A	N/A	N/A				

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

To consider once we establish a baseline score; WRES and WDES are currently only assessed annually; periodic calculations could be made only for the quantifiable measures such as pay gaps.

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

Gaps in Controls (What additional controls and assurances should we seek?)	Mitigating Actions to Address Gaps (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff.	1. Review of the People Startegic Initiative (Leadership and Behaviours) and implementation of the agreed actions.	Ongoing	On Track/Not Yet Due	Dominika Kimber	
2. We need to ensure that our Executive team and Trust Board are equipped with EDI competencies. (NHSE requirement)	2. Development of Exec and Board EDI Competencies (NHS HIA1)	31/01/2024	Overdue	Alister McClure	
3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactve measures can be taken.	3a. Anti-bullying and harassment group to be reviewed and re-established.	31/01/2024	Complete	Dominika Kimber	
	3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan)	31/01/2024	Complete	Dominika Kimber	
4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI.	31/01/2024	Complete	Alister McClure	

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

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

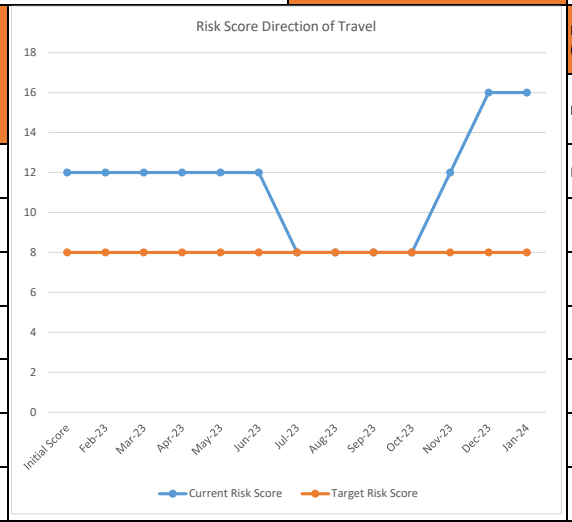
Poor adherance to the Trust values may lead to the worstening employee and patient experience with negative impacts on quality of care and patient safety and the Trust's reputation amongst the patients, their families, current and prospective employees.

Date of Last Review:	14 February 2024
Date of Next Review:	14 March 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
RTT Incomplete Performance	92.0%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	54.3%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

RTT postion fell in the last 3 months. The total number of patients over 65 weeks has increased largely due to endoscopy. The agreement to provide x1 extra endo room at DVH to support.

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

The trust had7 78 week breaches all of which relate to ENDO and x1 patient is within the ENT area.
A request has come from exec to complete an affordability chart on elective WLI which will be done in the next few weeks.

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

Weekly RTT meeting
Reports direct to COO
Monthly reporting to TMB
Focus on clinical urgent and then long waits
Patient P control in operation
Use of ERF monies to support increased activity
Breach validation plus clinical harm

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

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

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

1. There is a risk associated with the junior doctor strike which has increased the PTL resulting in a loss of appox. 1000 outpatients and 150 electives.	1				
2. Increase risks due to consultant strikes	2				
3	3				
4	4				

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

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

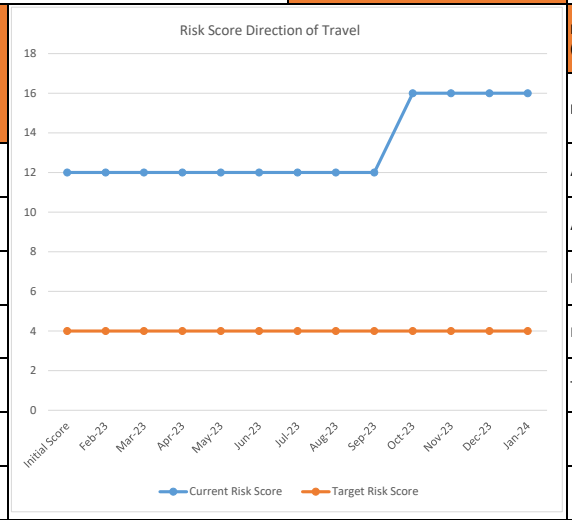
Trust has agreed to hit no 65 week breaches for next year.
Lack of ward and outpatient space currenlty. New Ward has been assigned which is due in August.
Increase in winter presentations may negatively impact RTT performance.

Date of Last Review:	19 February 2024
Date of Next Review:	14 March 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Average time in EC Dept (mins)	7	311.7	316.2	339.5	357.5	401.2	424.7	358.5	
Ambulance HO delays > 60mins	0	2	3	1	3	10	9	5	
ED 12 Hour Breaches	0	387	572	742	766	785	953	701	
IP Discharge Before Noon	40%	17.4%	17.0%	16.8%	17.3%	15.2%	14.1%	16.3%	
Total ED 4 Hour Performance	95%	73.6%	74.6%	75.4%	71.0%	65.6%	68.3%	71.4%	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Continuing to embed the Acute Medical Model Reviewing the Full capacity protocol, opel triggers and actions Embeding fit to sit/pulling next patients to wards Focused work through the HARIS group Reviewing existing protocols and processes to achieve improvements Improving relationships with SECAmb and working in partnership has mitigated high numbers of ambulance handover delays increace in Virtual beds to 155 by end of Q4 currently av. 75 virtual beds for early supported discharge and admission avoidance	Ongoing review of current systems and processes Breakthrough huddles weekly SDR score card reflecting performance Safer staffing huddles to support safe flow Care group SDRs currently being implemented

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

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

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

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

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

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

Date of Last Review:	19 February 2024
Date of Next Review:	14 March 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

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

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

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Total ED 12 Hour Breaches	0	387	572	742	766	785	953	701	
Total 4 hour performance	78%	73.6%	74.6%	75.4%	71.0%	65.6%	68.3%	71.4%	
>14 day LOS		364	358	337	349	403	424	373	Currently based on sum of 'Those discharged between 14 and 20 days' and 'Discharged 21 Days or Over'
#NCTR		18.2%	19.9%					19.1%	Due to the TT deployment BI are not able to supply figures from October.
Average wait to 1st OPA (days)	60	85.51	93.07	96.34	94.4	94.43	99.37	93.9	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

- LAEDB - Oversight dashboard
- Kent and Medway Integrated Care Board
- Kent and Medway Intregrated Care Partnership Joint Committee
- Joint development of plans at ICS level
- Kent CEOs Meeting
- Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans
- Trust-wide Flow and Discharge Corporate Project

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

- Dashboard capturing actions and unintended consequences on system partners
- Evidence attendance at ICS and ICP meetings
- Updated ICP and ICS risk register, reflecting input from system organisations
- Risk Report monthly
- Finance Committee report to Board
- Internal review and monitoring of access to care metrics with exec oversight

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

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

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

1. LAEDB Refresh, pulling together renewed dahsboard to capture actions and impact across all agreed system KPIs	1. Review of LAEDB ToR, agenda and required reports	31/08/2023	Complete	Chief Operating Officer	Extended due to AL in July.
2. Trajectory for Medocc Performance	2. To work with MEDOCC to agree trajectory for sustained improvements	31/08/2023	Overdue	Chief Operating Officer	Some incremental improvement seen but not yet sustained
3	3				
4	4				

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

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

- Sustained improvement in 4hr performance across Type 1 and non-admitted.
- NCTR has remained high over the last 2 months
- Average wait to 1st OPA has remained high over the last 2 months
'- Non-admitted flow is relatively stable but have experienced volatilty in Type 3 performance
- Community capacity has been difficult to fully utilise due to criteria and transport delays
- Average wait to 1st OPA has remained high over the last 2 months, with increase in referrals. Work has been done to implement referral rejection criteria in some areas but success slow due to large number of locum GPs in Kent and Medway region. This continue to present challenges

Date of Last Review:	19 February 2024
Date of Next Review:	14 March 2024

SYSTEMS & PARTNERSHIPS BOARD ASSURANCE FRAMEWORK

Risk ID:	4e	**Objective:**	Delivering timely, appropriate access to acute care as part of a wider integrated care system.
Executive Owner	Chief Operating Officer		
Operational Owner	Tracy Stocker, Director of Operations for Flow & Integration	**Principal Risk Name & Description**	There is a risk of financial impact if we are unable to increase flow and close escalation areas.
Primary Risk Grouping	Systems & Partnerships		
CQC Domain	Safe	**Relevant Group/Committee**	Trust Management Board / Finance, Planning & Performance Committee

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

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Average**	**Comments:**
Pre Noon Discharge - G&A Adult > 1 Day LoS (Including Transfer to ADL)	40%	17.4%	17.1%	16.8%	17.3%	15.2%	14.1%	16.3%	
Avg. Length of Stay - G&A Adult > 1 Day LoS	7	10.9	12.6	11.8	11.7	11.1	11.7	11.6	
Bed Occupancy - G&A Adult > 1 Day LoS	92%	92.4%	92.4%					92.4%	Due to the TT deployment BI are not able to supply figures from October.
NCTR at Midnight (count) - Month Average	80	63	72	78	119	100	106	89.7	
IP Discharges - - G&A Adult > 1 Day LoS (Including Transfer to ADL)		1826	1823	1823	1873	1834	1789	1828	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

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

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

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

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. An operational plan that supports the closure of escalations area's. Full collaboration with system partners in discharging patients that have no criteria to reside in an acute bed. Cultural change within clinical teams across the Trust. Training programme that emphasises golden standard discharge processes.	1. Both Divisions providing senior oversight of BR's to support discharge planning against EDD.	31/03/2023	Complete	Divisional Management Teams	New action to be agreed as part of the Corporate programme to improve flow and reduce LoS 16/02/24 Action complete, BR improvement within the new F&D corporate project. Asurance via 4th action below
2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MDT, Snr review	2. Each care group attends a LLoS meeting BiWeekly chared by6 DoOF&I	31/10/2023	Complete	Care Group Management Teams	update 20/11/23 these meeting are in diaries and LoS for all IP >14 days for CTR and NCTR
3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS	3. HaCP discharge group reviewing pathways via an action plan following the Vital Hub audit	31/10/2023	Overdue	Tracy Stocker, Director of Operations for Flow & Integration	action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. TS has discussed this with the COO and is writing a PID for a solution to this. 16/02/24 HACP decideing on plan to review, MFT waiting for HaCP exec decision.
4 Board Round improvement as part of the reducing LoS CP.	4. Re-embed SAFER, red2green and operationalise electronic BR's	31/12/2023	Overdue	Tracy Stocker, Director of Operations for Flow & Integration	Work with the care groups has started. Work with Sapphire and with Planned care ward commenced in early november 16/02/2024 Five wards have been supported with BR and escalation improvement. Further wards to be planned

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

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

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

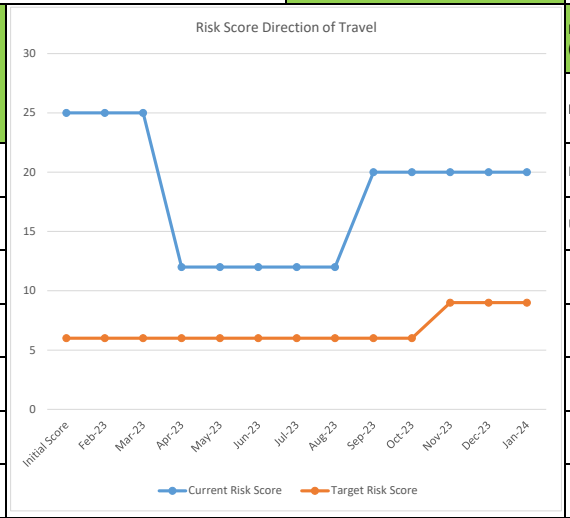
LoS efficiency work to support effective Board Rounds (sept '23), Virtual wards and the mobilisation of 41 beds at Amhurst Court in October will support the trust in reducing LoS across the acute wards. There is an element of concern with our partner organisations ability to meet the demand for PW 1-3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

Date of Last Review:	19 February 2024
Date of Next Review:	14 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD**	**Comments:**
Patient Flow and Discharge efficiency variance to plan (£m)	0	0.0	0.0	0.0	-0.5	-0.8	-0.6	0.0	
Unbudgeted cost of escalation capacity (£m)	0	0.2	0.3	0.1	0.1	0.2	0.3	1.1	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

The Trust closed escalation capacity in April 2023 that it had planned to keep open during Q1. However, it is acknowledged that the Trust has an estimated bed shortfall of c100 this winter.
The potential consequence at this time is considered to be 0.5% - 1% of annual budgets and hence is deemed "major" / 4, i.e. the unbudgeted cost this year is anticipated to be up to £4m based on YTD spend and a trend of increasing usage.
The likelihood is proposed as 5 based on current projections of a bed base that is almost 100 less than will be required this winter.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
"Patient Flow and Discharge" is a cross-cutting scheme within the efficiency programme. There is a SOP for opening escalation capacity. Site meetings held several times per day. Site director is in post. The Executive Team has agreed a de-escalation plan. Transfer of c40 patients to Amherst as part of community step down bed provision underway - need to ensure these are fully utilised. Implementation of Teletracking (digital bed management). Business case development for a ring-fenced elective hub.	Patient Flow and Discharge working group / corporate project team. Efficiencies Delivery Group oversight. Site meetings attended by clinical and operational staff, site office and execs. Medically fit/no criteria to reside patients are monitored daily. Medway and Swale Commissioning / Discharge Group meetings. Implementation of Teletracking at other NHS organisations.

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

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. Clarity between the drivers of escalation closure, split between activity volumes, admission rates and length of stay/patient flow improvements.	1. Capacity and capital planning meetings to proceed, including a plan for the development of an estates strategy upon approval of the clinical strategy.	30/09/2023	Overdue	Nick Sinclair, Chief Operating Officer	Estates strategy work is being launched, with support being implemented.
2	2. Plan and design the construction works associated with the UEC awarded funding for the Cardio-Respiratory village.	31/08/2023	Overdue	Nick Sinclair, Chief Operating Officer	Works ongoing - current timetable estimates handover in March 2024. Business case approved at Finance, Planning and Performance Committee in October 2023.
3	3. Development, approval and implementation of the winter plan.		On Track/Not Yet Due	Nick Sinclair, Chief Operating Officer	

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

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

Amherst step down community beds are open.
Support building regionally and nationally around proposals for an elective hub.

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

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

Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	Tar	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	YTD	Comments:
Identified vs planned schemes variance (£m)	-	- 13.0	- 12.6	- 10.0	- 11.8	- 11.8	12.2	12.2	
Actual vs planned performance variance (£m)	-	- 2.1	- 2.0	- 1.0	- 1.9	-1.2	-0.12	- 9.0	
Forecast variance (£m)	-	-	-	-	- 8.1	- 8.1	10.2	10.2	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

The target is significant and the gap between the value of schemes identified/forecast delivery and the target is greater than 1% of the Trust budget. The consequence score is therefore rated as "catastrophic" / 5.
Despite there being a pipeline of schemes still being worked through, there is an almost certain likelihood of slippage ad thus is rated as 5.

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

Gaps in Controls (What additional controls and assurances should we seek?)	Mitigating Actions to Address Gaps (What more should we do to address the gaps?)				
	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. Financial culture and awareness.					

2. Capacity and use of benchmarking.	2. Implementation of substantive PMO structure.	31/03/2024	On Track/Not Yet Due	Gavin MacDonald, Chief Delivery Officer	Interviews finish on the 17th January for support positions and the team will be in place for the new financial year. 8A Programme managers appointed, along with Band 7
	3. Permanent recruitment into PMO	31/03/2024	On Track/Not Yet Due	Gavin MacDonald, Chief Delivery Officer	Please see No.2 above.

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

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

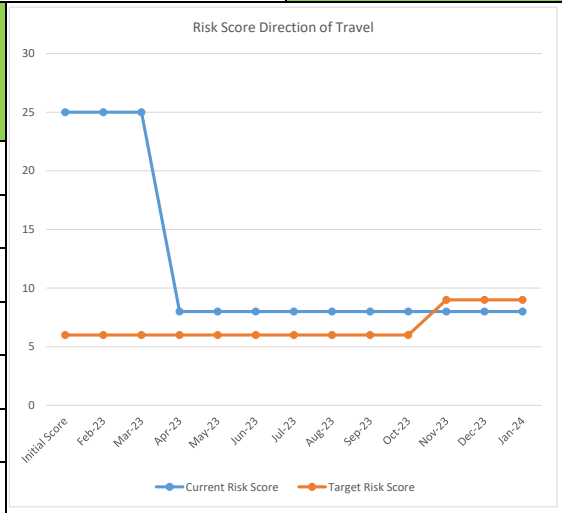
New governance process presented to EDG and to be implemented for 2024/25

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

Risk Rating & Analysis (▲, —, ▼, N)	**Likelihood**	**Consequence**	**Risk Score**	**Direction of Risk Score**
Initial Risk Score	5	5	**25**	
Risk Score at Last Review	4	2	**8**	—
Current Risk Score	4	2	**8**	—
Target Risk Score	3	3	**9**	—
Trust Risk Appetite	Appetite: Moderate Range: 9-15 Score (trigger level): 9			
Assurance Strength	Low			
Adequacy of Controls	Partial			



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD**	**Comments:**
Drugs variance to budget in-month (£m)	-	- 0.4	- 0.1	- 0.2	- 0.2	- 0.2	- 0.3	- 1.9	
Forecast variance to budget (£m)	-	-	- 2.6	- 2.0	- 2.0	- 2.0	- 2.1	- 2.1	

Context Summary
(Patient First problem statement, current situation)

During 2022/23 the Trust experienced significant overspends against its drugs budgets. This was added as a specific areas of concern as part of the Sustainability Breakthrough Objective huddle.
In 2023/24 the drugs budgets are overspent.

Rationale for Current Score

If the YTD overspend were to be extrapolated across the full year there would be an overspend of c£2.4m, being a little over 0.5% of the Trust's annual budget; however, given that £1m of the YTD adverse performance is driven by income-backed funding the consequence score is maintained as "minor" / 2.
On this same basis the likelihood score has been assessed as "likely" / 4, pending any necessary interventions.

Key Existing Controls (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
A medicines efficiency working group has been established and is meeting fortnightly. (with quarterly reporting to FPPC) Medicines efficiency is a cross-cutting efficiency scheme and has been approved through the panel for 2023/24. A medicines optimisation post has been agreed (including through the ICB double-lock process) to drive prescribing habit changes, drugs switches and other measures to deliver the efficiencies programme. The post was recruited to in October 2023.	Budget holder meetings. Sustainability Breakthrough Objective huddle. Efficiencies Delivery Group. Finance, Planning and Performance Committee reporting.

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

1. Detailed analysis of drugs spend and usage to understand reasons for changes in expenditure and introduce controls to limit and reduce medicine expenditure, where possible without impacting the quality and safety of patient care

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

Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Continued review of medicines use and expenditure, with ongoing implementation of schemes	Ongoing	On Track/Not Yet Due	Sharon Meehan	In progress - ongoing activity

2 Dedicated oversight of medicines usage and expenditure through detailed and automated analysis of data, linking to activity.	2. BI to develop a bespoke medicines usage and expenditure reporting tools (e.g. highlight top medicines expenditure in budgets, top changes in drug lines etc.)	01/09/2023	Overdue	John Brewer	In progress - estimated delivery by December
3. Monthly and quarterly medicines usage and expenditure reports required for care group oversight of medicines expenditure	3. BI to create a monthly and quarterly standardised medicines usage and expenditure report for commentary by care groups	01/09/2023	Overdue	John Brewer	In progress - estimated delivery by December

Trust Risk Register Aligned to Board Assurance Framework	1227: Pharmacy cold store temperature failure	Current Risk Score: (3x3 = 9)
	1067: JAC Invoice Processing	Current Risk Score: (3x3 = 9)
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

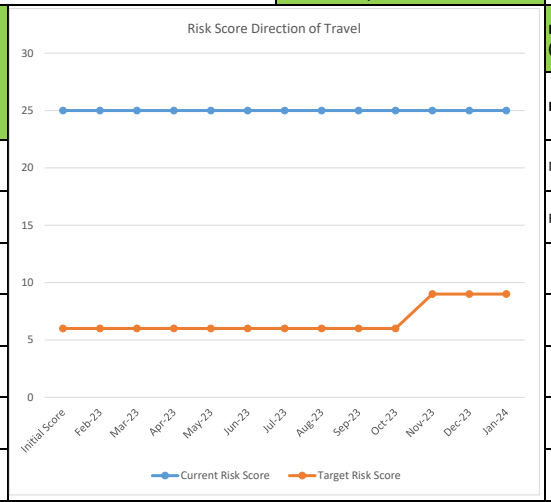
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD**	**Comments:**
Medical staff variance to budget in-month £m	-	- 2.7	- 1.4	- 2.0	- 1.2	-1.556	-2.7	- 13.6	The YTD adverse variance to plan includes costs associated with the industrial action, vacancies, ED pressures, weekend anaesthetics cover and cover for ENT and HDU, together with rotational doctor/GIM costs and unidentified efficiencies.
Forecast variance to budget £m	-	-	- 18.6	- 18.6	- 18.6	- 18.6	- 17.8	- 18.6	

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

Whilst efforts are being made to control the overspending of this pay group, the YTD results indicate a significant overspend. Should this continue the impact would be greater than 1% of the Trust's annual budget and hence would score as "catastrophic" / 5.
The likelihood has been retained at 5 given the historic overspend and this continuing in 2023/24.

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

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

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

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

1. Implementation of actions arising from finance huddle.	1. Complete job planning.	i) 31/08/2023 for "straight forward" rosters ii) 31/10/2023 for "less simple" rosters	Overdue	Alison Davis, Chief Medical Officer	Work paused during August due to annual leave and is now subject to completion of demand and capacity modelling. UPDATE At 01/02/24 progressing gain with a target end point of end March 2024. Is also part of medical productivity corporate project, SRO Ranjit Akolekar
2. Progression and implementation of medical efficiency cross-cutting scheme actions.	2. Recruitment plan development, particularly for hard to recruit to posts.	30/09/2023	Overdue	Leon Hinton, Chief People Officer	This is now one of the three parts of a corporate project supporting medical productivity. SRO Howard Cottam
3. Job planning is currently incomplete.	3. Identify and procure an appropriate rostering platform to ensure all specialties have rostered medical staffing. Internal audit review of adequacy of rostering processes and controls.	31/03/2024	On Track/Not Yet Due	Jeremy Davis, Deputy Chief Medical Officer	This is now one of the three parts of a corporate project supporting medical productivity. Initial A3 held. SRO Jeremy Davis
	4. Medical efficiencies is being stood up as Corporate Project. The govenrance and arrangements are to be put in place.	28/02/2024	On Track/Not Yet Due	Alison Davis, Chief Medical Officer	Medical efficiencies now known as Medical Productivity. 3 separate work streams - Rostering and Leave; Recruitment and Retention; Job Planning and Productivity (includes mandatory training, productive design of IT etc.) SRO's as above, Excec Owner Alison Davis

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

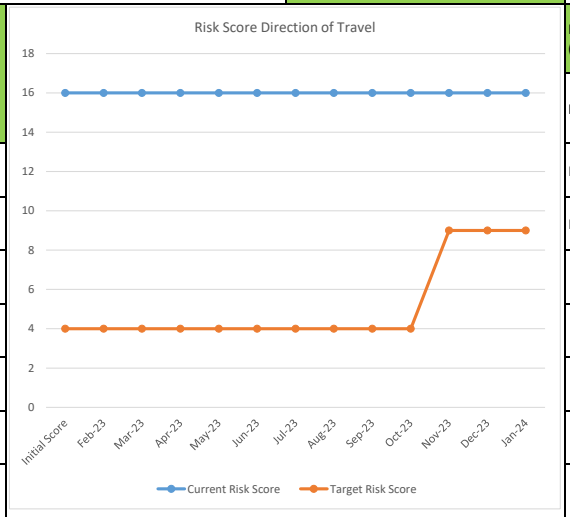
Additional Comments
(Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD**	**Comments:**
Number of lapsed budget holder training (no.)	0	86	86	81	76	79	74		
Number of lapsed budget holder training (%)	0%	45%	45%	42%	39%	39%	36%		

Context Summary
(Patient First problem statement, current situation)

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

Rationale for Current Score

Consequence: staffing and competence - moderate error(s) due to levels of competency (individual or team). Finance including claims: before utilisation of reserves the Trust is adverse by >1% of budget in clinical divisions. Statutory duty: low performance rating.
Likelihood: expected to occur at least weekly.

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

Budget holder meetings
Budget holder training (statman)
Finance Training Policy
Mandatory objective in appraisal form
Efficiencies as a corporate project
Control of overspending implementation as a breakthrough objective
Communication via senior managers meetings and Trust Management Board
Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee.
Better Business Case trained staff.

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

Previously performance review meetings - now Strategic Deployment Reviews.
Care group and divisional board meetings.
Budget holder meetings
Efficiency Delivery Group
Finance, Planning and Performance Committee
Trust Board
Oversight meetings
Internal audit

Gaps in Controls

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

(What additional controls and assurances should we seek?)	Action	Due Date	Action RAG	Action Lead	Progress Notes / Action Completion Date
1. The controls themselves should be sufficient if implemented wholly and fully. Non-adherence to the controls (and SFIs) to be considered.	1. 'Finance Business Partners to emphasise the requirement for budget holder training to relevant staff.	Ongoing	On Track/Not Yet Due	Finance Business Partners	There has been better attendance at recent training events.
2	2. Confirmation required for inclusion of budget holder training as part of statman	31/10/2023	Overdue	Leon Hinton, Chief People Officer	A full review of the statman programme is being undertaken to confirm.

Trust Risk Register Aligned to Board Assurance Framework	1722: Individuals could be open to a charge of Fraud or Bribery	Current Risk Score: (4x2 = 8)
	1724: Contract Management	Current Risk Score: (4x3 = 12)
		Current Risk Score:
		Current Risk Score:
		Current Risk Score:

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

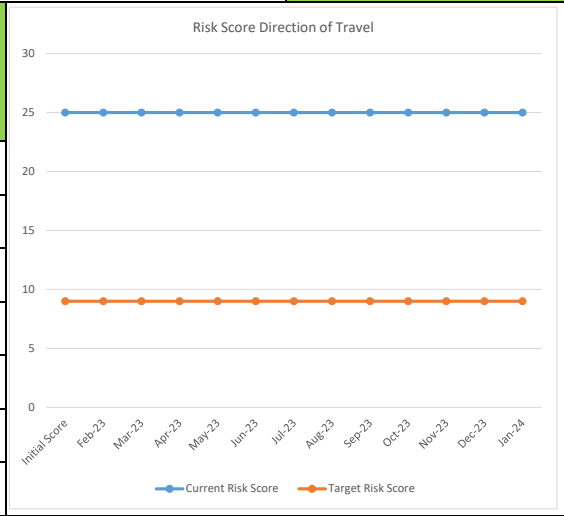
A wider leadership training programme is being explored at the Trust, which would require individuals to complete specified elements of financial training.
The recently completed KPMG report has highlighted some areas for improvement in financial governance, including budget setting, forecasting and financial engagement of budget holders - actions have been agreed and will be reported though FPPC going forward.

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024

SUSTAINABILITY BOARD ASSURANCE FRAMEWORK

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

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



Relevant Key Performance Metrics
(taken from Patient First Dashboard)

Indicator	**Tar**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD**	**Comments:**
Variance to control total	-	- 3.9	- 3.7	- 3.0	- 3.0	- 1.7	- 3.3	- 23.6	

Context Summary
(Patient First problem statement, current situation)

If there is insufficient financial awareness, management, control and oversight within the Trust it may lead to an inability to deliver the financial control total, leading to a reputational impact.
Under contracting arrangements the ICB must meet its control total; this equates to a £15m deficit for the Trust as submitted in the May plan. Given the YTD performance, inherent risks within the plan and current position on unidentified efficiencies and mitigations, there is significant uncertainty and a risk of the Trust not meetings its control total.
The Trust currently remains in SOF4.

Rationale for Current Score

Given the YTD performance the likelihood of non-delivery is "almost certain" / 5. The financial consequence, if extrapolated, is >1% of the annual Trust budget and is thus "catastrophic" / 5.
Reassurance will be required both in terms of in-year delivery and the plans to return to breakeven in 2024/25.

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

1. Rebasing of divisional plans through robust business planning/budget setting. 2. Seek additional monies from third parties to support initiatives and/or the underlying financial position, including the Charity, ICS and national funding sources. 3. Work with NHSE intensive support team. 4. Application of NHSE “Grip and Control” actions to limit spending, at least on a temporary basis. 5. PMO: a. Work with divisional teams to identify, develop, implement and track operational delivery and financial consequences of efficiency schemes. b. Delivery of efficiency showcase events. 6. Financial Training Policy and SOP, setting out the minimum levels of which staff awareness of financial matters and their responsibilities thereon. 7. Activity pressures monitored as follows: a. Daily review of emergency flow data to inform new actions & interventions. b. x3 times per day site / flow meetings. c. Patient First Programme work streams focused on improvements to: i. Discharge and Flow ii. Acute Care Transformation d. Public communication. e. HARIS, CDC and virtual wards projects 8. Breakthrough Objective on "control of overspending". 9. Enhanced VCP process and approval group. 10. NHSE 2023/24 controls spreadsheet and enhanced internal controls. 11. Application of safe staffing recommendations in budgets. 12. Drivers of deficit and Financial Recovery Plan	Monthly reporting and insight of actual v budget performance for review at care group boards, divisional boards, divisional SDRs, Finance, Planning and Performance Committee and the Trust Board. Internal accountability framework at programme level, i.e. budget holder meetings. Delivery of and attendance at training programmes for staff. Appraisals / objective setting Efficiency Delivery Group. NHSE intensive support team Internal audit Breakthrough huddle Oversight meetings with NHSE and ICB

Gaps in Controls (What additional controls and assurances should we seek?)	**Mitigating Actions to Address Gaps** (What more should we do to address the gaps?)				
	Action	**Due Date**	**Action RAG**	**Action Lead**	**Progress Notes / Action Completion Date**
1. Communication to and understanding of Trust staff to the financial issues and their resolution.	1. Undertake further FRP reset work.	30/09/2023	Overdue	Paul Kimber, Deputy Chief Financial Officer	LTFM document delayed due to ongoing ICS process.
2. Accountability/responsibility of budget holders.	2. Budget holder training	Ongoing	On Track/Not Yet Due	Finance Business Partners	See BAF entry 5e
	3. Implementation of enhanced financial controls, including action plan derived from KPMG report	28/02/2024	On Track/Not Yet Due	Alan Davies, Chief Financial Officer	

Trust Risk Register Aligned to Board Assurance Framework	
1237: Increase bank spend due to enhanced care requirements will lead to overspend against budget	Current Risk Score: (5x2 = 10)
1064: Debt Recovery - Non NHS Trade Debt	Current Risk Score: (2x2 = 4)
1065: Debt Recover - NHS Trade Debt	Current Risk Score: (2x2 = 4)
1688: Capital Allocation	Current Risk Score: (4x3 = 12)
1692: Inflation	Current Risk Score: (3x3 = 9)
1691: Potential for the Trust to have an unfunded cost pressure should the proposed harmonised bank rate be applied	Current Risk Score: (4x4 = 12)
1687: Potential for Trust not to deliver against activity plan for 2023/24 which could jeopardise delivery of deficit control total	Current Risk Score: (5x5 = 25)
1696: Data Quality may result in risk to patient safety and financial income loss	Current Risk Score: (4x3 = 12)
1861: Cash holdings depleting may result in Trust running out of cash	Current Risk Score: (3x4 = 12)

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

KPMG have provided the Trust with their report on financial improvmement, including further counter measures and mitigations.

Date of Last Review:	06 February 2024
Date of Next Review:	15 March 2024