Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 13 November at 13:00 – 15:00 - Trust Board Room, Gundulph Offices and via MS Teams

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	13:00	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 10 September 2024	Chair	3	13:05	Approve
2.2	Action Log		17		Note
3.	**Opening Matters**				
3.1	Chief Executive Update	Chief Executive	18	13:10	Note
3.2	Council of Governors Report – no update from August 2024	Lead Governor	Verbal	-	-
	Board Story Presentation				
3.3	Breast Feeding Story	Associate Director of Patient Experience	21	13:15	Note
4.	**Performance, Risk and Assurance**				
4.1	Trust Risk Register	Company Secretary	28	13:25	Assurance
	Board Assurance Framework				Assurance
4.2	Emergency Preparedness, Resilience and Response – Annual Assurance Rating	Chief Operating Officer	37	13:30	Assurance
4.3	Integrated Quality Performance Report **APPENDIX 1**	Chief Delivery Officer	41	13:35	Assurance
	~ WELLBEING BREAK – 5 minutes ~				
5.	**Board Assurance Reports**				
5.1	Quality Assurance Committee	CNO/CMO/Committee Chair	**To Follow**	13:50	Assurance
5.2	People Committee	Chief People Officer, Committee Chair	45	13:55	Assurance

5.3	Finance, Planning and Performance Committee	Chief Finance Officer, Committee Chair	49	14:00	Assurance
	6. Papers				
6.1	Finance Report (Month 6) **APPENDIX 2**	Chief Financial Officer, Chief Delivery Officer	54	14:05	Note
6.2	ED Recovery	Chief Delivery Officer	Verbal	14:15	Note
6.3	Maternity Services Reports: a) Claims, Complaints and Incidents - Triangulation b) CNST Compliance - Update c) Perinatal Culture Leadership d) Perinatal Quality Surveillance **APPENDICES 3, 4, 5, 6**	Director of Midwifery	56	14:25	Assurance
6.4	Kent and Medway NHS Strategy 2024/25 – 2029/30 **APPENDICES 7, 8, 9, 10**	Chief Delivery Officer	64	14:30	Approve
6.5	Strategy Review and Summary	Director of Strategy and Partnership	67	14:35	Note
6.6	In Patient Survey Results - Update	Associate Director of Patient Experience	79	14:40	Note
6.7	Medical Education Annual Report	Chief Medical Officer	104	14:45	Note
	7. Closing Matters				
7.1	Questions from the Council of Governors and Public	Chair	Verbal	14:50	Note
7.2	Escalations to the Council of Governors				
7.3	Any Other Business	Chair	Verbal	14:55	Note
7.4	Reflections				
7.5	Date and time of next meeting: Wednesday, 15 January 2024				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the Trust Board Meeting in Public

Tuesday, 10 September 2024 12:30 – 15:30

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

And via MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	John Goulston	Trust Chair
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Jayne Black	Chief Executive
	Jenny Chong	Non-Executive Director
	Leon Hinton	Chief People Officer
	Mojgan Sani	Non-Executive Director
	Nick Sinclair	Chief Operating Officer
	Paulette Lewis	Non-Executive Director
	Sarah Vaux	Chief Nursing Officer (Interim)
Attendees:	Emma Tench	Assistant Company Secretary (Minutes)
	Glynis Alexander	Director of Communications and Engagement.
	Hari Aggarwal	Governor
	Karen Fegan	Governor
	Lorna Gibson	Director at NHSE
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Paul Stephens	Trust Member (public)
	Sam Harrison	CQC Operations Manager

1. PRELIMINARY MATTERS

1.1 Chair's Introduction and Apologies

The Chair welcomed all present. Apologies for absence were noted as above Introductions were made. The following were highlighted:

a) Annual Members Meeting on 11 September 2024 at 6pm – all welcome.
b) Patient First Spotlight sessions every Thursday morning at 08:15, all are welcome. Session attended highlighting the hydration station for patients to aid a peaceful night's sleep.

1.2 **Quorum**
The meeting was confirmed as quorate.

1.3 **Declarations of Interest**
No additional declarations of interest to declare for this meeting.

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

2.1 The minutes of the meeting held on 24 July 2024 were **APPROVED** as a true and accurate record

2.2 **Action Log** – action log reviewed and updated; held under a separate cover.

3 Opening Matters

3.1 **Chief Executive Update**

Jayne Black presented the report in line with the paper submitted, highlighting the following key points:

a) Emergency Care Improvements – recording shortest ambulance handover in England this summer. Introduction of new model of care. Improvement in emergency department performance.
b) New Endoscopy Unit – now able to see approximately 400 patients extra a month.
c) Improved Patient Feedback – improvements in 27 areas from cancer patients compared to the previous year. Overall survey results are lower than when compared to other Trusts. A Patient First priority.
d) Wellbeing Improvements Recognised – achieved Platinum in the Healthy Workplace Programme provided by Medway Council.
e) Home Diabetes test for 'at risk' pregnant women.
f) Investing in a Greener Future – installing solar panels, replacing aging boilers with heat pumps, installing energy efficient LED lights and double glazing.
g) Nurses shortlisted for Nursing Times Award – congratulations to Learning Disability Nurses for being shortlisted.

The Board **NOTED** the report

3.2 **Council of Governors Report (August 2024)**

The report was taken as read, in the absence of the Lead Governor. The report includes the following key points:

a) The council were advised of the upcoming Lead Governor Elections with further information to be cascaded to Governors in due course. The Constitution to be refreshed to state a three-yearly election.
b) The council were invited to express their interest in observing committees and becoming a member of the Council of Governors Nominations and Renumerations Committee.
c) The council were given presentations from April Howard on Data Protection and Security, and Wayne Blowers on CQC Well-Led Preparations.
d) The Annual Report and Accounts were presented to the Council of Governors for the reporting period April 2023 to March 2024. The council noted the contents in preparation for submission to Parliament.
e) The Board wished David Brake a speedy recovery.

The Board were **ASSURED** by the report

3.3 **Governance Review – Board Delegations**

Matt Capper presented the report in line with the paper submitted, providing an update on Non-Executive Director designations and Board Committee membership to take account of the changes of the Chair and Non-Executive Directors in 2024, which were approved by the Council of Governors. The report includes the up to date position on Executive Director designations and Committee membership.

The Board is asked to approve:

a) The Non-Executive and Executive Director membership of committees as set out in section 4, Table 3 effective from 1 October 2024.
b) The changes to the Non-Executive directors' designations following the approval of the Council of Governors (see sections 5 and 6) covering;
    - The proposed appointment of deputy chairs to each Board Committee (see section 5, table 4)
    - The appointment of Jenny Chong as Senior Independent Director (SID)
    - The appointment of NED champions as detailed in section 6.2

The Board **APPROVED** the delegations subject to minor amendments, to be presented to the Council of Governors at their November 2024 meeting.

4. Performance, Risk and Assurance

4.1 **Trust Risk Register**

Sarah Vaux and Matt Capper presented the report in line with the paper submitted, providing the following key points:

a) 221 approved Risks with 25 scoring 15 and above.
b) 17 new risks added, 22 risks awaiting review, 16 risks awaiting approval.
c) 54 risk have been closed down.
d) 18 risks have had their score reduced since their last review
e) 2 risks have had their score increased since their last review
f) 8 risks have been rejected.
g) All Executives continue to review their risk profile monthly.
h) Supplementary documents have breakdown of risks – we will be working to separate risks form the issues, all will be reviewed for updates and actions.

<u>Check and Challenge</u>

i) Paulette Lewis: good to see improvements. How are risks reviewed and feedback recorded ensuring an improved narrative? Matt Capper: a tool to log and update ensuring triangulation has been added, you will see reiterations in coming reports.
j) The Chair: *issues* need to be separated from the risk register, these need to be recorded in the risk register until removed.

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

4.2 **Board Assurance Framework**

Matt Capper presented the report in line with the paper submitted providing the Board with assurance for the 18 strategic risk aligned to each of the Trust's True North Domains.

a) Outgoing version of the BAF, fully mapped through, will show closure section with full narrative and links back risks both operation and strategic.

<u>Check and Challenge</u>

b) Annyes Laheurte: will the new layout be reviewed at the Audit and Risk Committee?

Matt Capper: yes, on 12 September and then to Executives on 13 September.

The Board were **ASSURED** by the report

4.3 **Integrated Quality Performance Report**

Gavin MacDonald presented the report in line with the paper submitted. The report relates to Month 4 and provides the Board with an update performance against the Trusts Strategic Priorities:

a) The People domain continues to show the highest volume in metrics improving for Statistical Variance, the Patients domain shows the highest % of statistical improvement metrics (~58% of all metrics)
b) The Systems & Partnerships domain shows the highest number of variances that are statistically showing concern, with 41% of all metrics flagging
c) Both Quality and Sustainability domains show the majority of their metrics are not showing any significant statistical change and as such are showing common variation.
d) Overall, 69 metrics are now showing improved statistical variance (-2 from last month) against 34 which are showing concern (+2 from last month).
e) Key areas of improvement are identified with actions and mitigations being taken by operational teams which are contained in the report
f) Patients:

- Recommendations have reached 91.1%, highest to date. Response rate has doubled over 23/24 with a reduction in overall negative responses.
- Issues remain with patients trying to contact someone from their medical team in regards to appointments and results.
- FFT improvising position except emergency care who say a 1.9% decrease.
- Mixed sex breaches have significantly reduced.
- Complaints – remains stable, 31 cases at month end, 4 complaints re-opened, breached complaints improving at 6.7%, 1 upheld ombudsman case.

g) Quality:

- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality (SHMI) higher than expected
- Admissions for 'COPD & Bronchiectasis' remains a concern.
- Clinical incidents decreased by 41.6% compared to June.
- 98.9% of all incidents reported in low or no harm. 7 incidents in July caused moderate harm or above.
- 1 maternal death, not thought to be caused by omissions in care.
- Reduction in falls overall.

h) System and Partnership:

- Emergency care consistently over achieving.
- 61.16 overnight admissions per year to each bed, national average is 55.
- Delays in endoscopy contributing to poor RTT performance. On site mobile unit will add capacity.
- Collaborative booking process between the Trust and PPG will provide a further 200 units from September.
- ENT improved position.
- Rheumatology locum to provide additional clinics
- Cardiology outsourcing to provide weekend clinics.
- Cancer performance continues to be low in June, improvements in July.

i) People:

- Majority of leavers had stay conversations as part of new intention to leave process.
- Absence remains above target
- Successful recruitment to difficult to appoint roles.
- Improvements in nursing back fill rates

j) Sustainability:

- £0.5m adverse to plan, year to date, driven by industrial action.
- Efficiency programme identified £16.1m, with additional £2.5m of run rate efficiencies.
- Full year effect of budget out/income schemes is £18.3m
- Reduction of 144 Whole Time Equivalent (WTE) with at a remaining 256 to hit target
- Contractual assumptions not aligned.

Check and Challenge

k) Paulette Lewis: Reduction in full time equivalents, who does this relate to and what is the impact to staff and safety.
Gavin MacDonald: this relates to bank and agency reduction.
Jayne Black: we are getting staff into full time posts ensuring we are maintaining safety, making sure we are recruiting into post.

l) The Chair: regarding overnight admissions, what is in place to turn the dial.
Nick Sinclair: we are already more efficient than the national average, but still we are 40 beds short in summer and 100 beds short in winter.
The Chair: is this related to internal or external controls, in terms of new pathways.
Nick Sinclair: it's a mixture, some things we can do ourselves, admission avoidance is a focus, we will change our pathways and same day emergency care and mitigate our need for inpatient beds. Still significant work to address the size of community services to match our demand. We work with health and care partnership on community pathways, in its test phase.
Jayne Black: continued work with our partners is important. A pilot scheme was started with SECAmb in April 24 to direct patients, at source, to the correct pathway. The scheme will be reinstated in October 24.
Alison Davis: clinical pathways – we continue to drive innovation, ensuring patients don't stay in hospital longer than they need to. At forefront using national best practice guidance.

The Board were **ASSURED** by the report

5 Board Story Presentation
Physician Associates at Medway NHS Foundation Trust

Professor Hasib Ahmed delivered his presentation to the Board, highlighting the following key points:

a) Brief history and development of the role.
b) Supervision and scope of practice
c) Importance in the healthcare system
d) Value in secondary care

Check and Challenge

e) Jenny Chong: are patients aware they are interacting with a Physician Associate (PA)
Hasib Ahmed: yes, this must be made clear. This hasn't been happening consistently in primary care.

f) Jenny Chong: how do we monitor this.

Hasib Ahmed: secondary care is not the problem but have had recent issues in primary care. We have a handful of PA's at Medway who all know who they report to. If there is an issue they report to their supervisor.

g) Jenny Chong: – is the PA or Consultants name on the EPR
Hasib Ahmed: there is space to indicate both on the EPR.

h) Jenny Chong: there has been some media about PA's being paid more than Junior Doctors.
Hasib Ahmed: there has been a huge amount in the press regarding regulation by the GMC, this is yet to bottom out.

i) Alison Davis: PA and Clinical staff are supported by the GMC with no friction reported, staff continue to respect each other.

j) Jenny Chong: how do we compare to other Trusts, in terms of the amount of PA's at Medway.
Hasib Ahmed: we were way ahead but has now trailed off, we are now in the mid-range.

k) Gavin MacDonald: the PA's are highly trained individuals, what happens once they qualify, how does this fit in with the doctor programme.
Hasib Ahmed: in terms of progression, once the GMC comes on board there will be the same CPD as doctors. There will be formalisation. There will be opportunities to become the lead supervisor in their discipline.

l) Gary Lupton: how do we fund these posts and what is the ongoing training.
Hasib Ahmed: training needs to be formalised, need revalidation of CPD as medical workforce. Funding has been down to departments. Some funding taken from other posts that could not be filled. ED has been the most successful in the utilisation of PA's.

m) Paulette Lewis: whilst we are waiting for the GMC regulation how can you assure us of safety and how this is being managed.
Hasib Ahmed: the governance rests with the supervisor, who takes full responsibility for their PA. Legally all responsibility lies with the CMO.

n) Paulette Lewis: can PA's move onto to become doctors
Hasib Ahmed: no, if they want to become a Doctor they will need to start again at medical school.

The Board thanked Professor Hasib Ahmed and his team for the presentation.

6 Board Assurance Reports

6.1 Quality Assurance Committee

Alison Davis and Sarah Vaux presented the report in line with the paper submitted, highlighting the following key points:

a) The Quality and Safety Risk Register and BAF were received and discussed for content. The revised approach to BAF reporting was discussed. Members confirmed approval of risks and noted the reports.

b) The Maternity CQC Picker report including an update on the actions and the trajectory to complete the final few remaining. The Committee were assured by the report.

c) The Mortality Review and Action log. The trust has developed an improvement plan in response to the recommendations made in the report and the implementation at Trust and divisional level was discussed. The Committee noted the report

d) The Mortality and Morbidity Assurance and Escalation Report was discussed. The activity in relation to reviewing deaths wads outlined as well as the process for learning. The Committee noted the report.

e) The Quality Strategy Implementation Update which included progress against the key areas of focus which are either on track or completed. The Committee approved the report.

f) The Integrated Quality Performance Report was reviewed and the links to Trust's North and Strategic Objectives were discussed. The Committee noted the report

The Board were **ASSURED** by the report

6.2 **People Committee**

Leon Hinton and Jenny Chong presented the report in line with the paper submitted, highlighted the following key points:

a) Recommend to Board to approve the Medical Appraisal and Revalidation Annual Report.
b) Freedom to Speak Up items of concern to be highlighted with the assurance report.
c) Culture and impact on work place culture
d) StatMan training and how this is delivered.
e) Appraisals and quality of appraisals.
f) Scruitinising data from Violence and Aggression group.
g) People promise – live across the trust.

The Board were **ASSURED** by the report

6.3 **Finance, Planning and Performance Committee**

Alan Davis and Gary Lupton presented the report in line with the paper submitted providing the Board with the following highlights:

a) Efficiencies
b) Cash position and critical focus
c) Year-end forecast
d) Performance in ED and Endoscopy capacity.

The Board were **ASSURED** by the report

7 Board Papers

7.1 **Finance Report (Month 4)**

Alan Davis presented the report in line with the paper submitted, highlighting the following key points:

a) The Trust reports a deficit of £2.3m in month 4, and £12.2m year to date (YTD); the YTD performance is adverse to plan by £0.5m, mainly due to unbudgeted costs of £0.5m arising from industrial action.
b) The efficiency programme has under delivered by £0.4m against the YTD plan of £4.5m.
c) The capital position is underspent as at month 4 due to the timing of schemes being delivered (principally CDC leases being signed)/awaiting approval of the full current year programme.
d) Cash at the end of June was £9.6m. The Trust continues to draw down its deficit support funding – the cash position overall continues to be a concern and will require careful management and solutions. This could impact on performance against the Better Payment Practice Code to ensure we have sufficient monies to pay staff and creditors.

<u>Check and Challenge</u>

e) The Chair: with the underspend in Month 4, what is our confidence on capital allocation. Alan Davis: recently agreed additional schemes, plan to be finalised plan for uncommitted element. At this stage we are confident to deliver before 31 March. CDC at Rochester needs review for risk and alternatives.

Nick Sinclair: CDC Sheppey on track, CT will open next month. MRI is due on line in March 2025. Rochester CT is unlikely to be live before December 2024. Drawn up a potential plan tabled at execs for further scope to get CT running earlier at another venue.
Jayne Black: Rochester CDC – every opportunity needs to be taken, important we work through issues.

f) Gary Lupton: not seen a business case in some time, flat line capital budget. Diagnostic strategy - have we had an overarch of where we are.
Matt Capper: this is in the clinical strategy, taking lead from the national directive.
Alison Davis: there will not be a separate diagnostic strategy.

g) Gary Lupton: CT in terms of where they are, does this fit in with the strategy.
Nick Sinclair: yes, it fits in with whole imaging services and capital. Example, approved update of simple x-ray equipment. We are absolutely continuing to resolve Rochester solution. The relocation of the MRI, for the meantime, will mean immediate action for patients.

h) The Chair: an update on the Rochester CDC to be reviewed at FPPC. *Post meeting note: added to the FPPC agenda.*

i) The Chair: a need to find another £3m of mitigations. *Post meeting note: review of further £3m mitigations to be discussed at FPPC.*

The Board **NOTED** the report

7.2 **Financial Recovery Plan Report**

Alan Davis presented the report in line with the paper submitted providing the Board with the following key points:

a) The Trust is forecasting a draft *unmitigated* deficit of £38.6m, being £10.8m adverse to its control total of £27.8m. The Trust *must* identify mitigating actions to address this projected risk/overspend.

b) 21 different lines have been identified, with each unmitigated overspend assigned to an executive lead to ensure full understanding, agreement and mitigation of the pressure. An Executive lead Task and Finish Group has been establised, chaired by the Chair of the Finance, Planning and Performance Committee, to oversee this work.

<u>Check and Challenge</u>

c) The Chair: reduced run rate will feed into cost improvement programme for next year.

d) The Chair: forecast outturn – note thanks to Rob Cooper from NHSE for support.

e) Nick Sinclair: for assurance on a Friday 13 September there is a waste reducing check and challenge. When the numbers move they are reviewed with the NHSE support team. For awareness compared to last year, we are already looking at £13m recurrent into next year. We are in a much better place, but recognising the gap to close.

The Board **NOTED** the report

~The Board took a 10-minute wellbeing break~

7.3 **Maternity CNST Compliance Assurance Report**

Alison Herron presented the report in line with the paper submitted providing the Board with the following updates:

a) CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025

b) Anticipate declaring compliance with all 10 Safety Actions within the required reporting period.
c) Safety Action 8 currently off-track due to compliance figures <90% for some staff groups. This has been escalated appropriately and actions are in place to mitigate this risk. It is anticipated that compliance >90% will be achieved for all staff groups.
d) Monthly reporting via MNSCAG and reporting to each Trust Board until submission.
e) Review and presentation dates agreed with LMNS for key requirements prior to submission of compliance to MFT Trust Board in January 2025

The Board **NOTED** and were **ASSURED** by the report, specifically:

- NICU medical and Nursing staffing position
- NICU Nursing action plan
- Safety Action 9 - The Board Safety Champions support the perinatal quadrumvirate and meet with them monthly via MNSCAG.
- Safety Action 9 - Update on SCORE survey - Perinatal Leadership report progress and monitoring of actions.

7.4 **Perinatal Quality Surveillance Report**

Alison Herron presented the report in line with the paper submitted providing the Board with the following highlights:

a) Clinical Negligence Scheme for Trusts (CNST) Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9)
b) Monthly updates aligned with the minimum dataset of the PQSM are submitted monthly to QPSCC and QAC (within IQPR) along with a detailed report to every Trust Board.
c) The report provides quarterly oversight for Q1 2024/25 including the following:
    - Incidents – increase in number, 96% Maternity and 100% in Neonatal reported as no or low harm
    - Investigations – 1 Maternity and Newborn Safety Investigation (MNSI) referral made. 1 postpartum death maternal death in the community. Actions in place to address 3/4th degree tears.
    - Perinatal Mortality Review Tool (PMRT) – 9 MBRRACE (National Audit programme) reportable cases in Q1.
    - Risks – 13 risks in maternity and 2 in Neonatology.
    - Workforce/Staffing – remains a challenge.
    - Training – overall compliance increases to 92.63% for Maternity and Neonatal staff.
    - Staff and Service User Feedback – Overall improvement in Friends and Family Testing (FFT)
    - Safeguarding – improvements noted.

<u>Check and Challenge</u>

d) Paulette Lewis: in terms of diversity, around language and communication, it would be good to know about the language and delivery of communication.
Alison Herron: we have that information, not all is directly linked to actual language barriers but can refer to the terminology used, this information can be added to future reports.
e) Alison Davis: training compliance - what level of confidence is the trajectory.
Alison Herron: Assured we are on track to achieve, we have dates in place, with contingency to ensure this happens. Progress already made.

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

7.5 **Perinatal Cultural Leadership Report**

Alison Herron presented the report in line with the paper submitted providing the following:

a) Goal of the perinatal culture and leadership programme is to improve the safety and quality of care delivered to women, birthing people and babies by enabling those with specific responsibility for safety in maternity and neonatal units to understand the relationship between leadership, safety improvement and safety culture in order in enable change.
b) Three-year delivery plan committed to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024. This is now complete.
c) The QUAD completed the programme in April 2024.
d) The national network of Patient Safety Collaboratives (PSCs) have been commissioned to offer support to sustainably support the leadership capacity, capability and improvement relating to safety culture within maternity and neonatal units and as part of local systems, building on the progress made during Phases 1-3 of the Perinatal Culture Leadership Programme (PCLP).
e) Working closely with the PSCs to ensure that any ongoing support aligns with the principles of the PCLP and to identify any potential challenges or opportunities.
f) New QUAD has been shared with PSC and meeting arranged for August 2024.

<u>Check and Challenge</u>

g) The Chair: what difference has the cultural progress made.
Alison Herron: culture changes are continuous, I want to see the difference from last year to now and again next year; we are currently about quarter of the way there. Diversity has improved but a way to go, we would like to mirror out multi-cultural society. We are unpicking a lot with our data for each of our cultural beliefs.
Jayne Black: the cultural transformation piece can be used to build on what has been started.

The Board **NOTED** and were **ASSURED** by the report, specifically:

- Progress against the SCORE Survey Action plan

7.6 **Maternity Claims, Incidents, Complaints Triangulation Report**

Alison Herron presented the report in line with the paper submitted, providing the following key points:

a) NHSR Claims scorecard published annually in September with data for the previous 10 years.
b) MFT have had 55 Obstetric claims in the 10-year period from 2013/14 to 2022/23.
c) Of these claims, 11 are currently open with 1 incident ongoing. 43 have been closed, 20 of which have been settled with damages.
d) CNST Year 6 requires Trust Boards to have a quarterly oversight of obstetric claims data triangulated with data from incidents and complaints.
e) This report reviews the NHSR Claims scorecard along with incidents and complaints from 2023/2024 to provide thematic analysis and identify areas for improvement and areas where improvements have been made following past incidents and claims. The report will review under the following headings:
    - Yearly breakdown of claims by incident date and claims date.
    - Progress/status of current claims

- Review of claims outcomes against current MSNI/PSIRF/SI outcomes
- Review of claims against current datix incidents and complaints
- Review of claim closed with damages awarded with review of learning and current practice.

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

7.7 **Infected Blood Inquiry Report**

Alison Davis presented the report in line with the papers submitted, the report provides details of the letter released by Amanda Pritchard on 20 May 2024 to NHS Organisations regarding the Infected Blood Inquiry Report. As a result of the letter Medway NHS Foundation Trust have reviewed practices to ensure safety measures are in place, and compliance with all national standards.

Check and Challenge

a) Jenny Chong: in regards to tracking onto the EPNA are there issues with blood components.
Alison Davis: no issue to my knowledge.
b) Paulette Lewis: is this likely to happen again.
Alison Davis: unlikely with the processes in place.

The Board were **ASSURED** by the report

7.8 **Annual Reports**

7.8.1 **Safeguarding Annual Report**

Sarah Vaux presented the report in line with the paper submitted. The report includes:

a) Arrangements the Trust has in place to ensure that it complies with statutory safeguarding guidance, as well as to work collaboratively with multi agency partners and across the Medway and Swale and wider Kent and Medway system. In addition, the arrangements in place to support patients with Learning Disability are described.
b) Safeguarding activity undertaken staff to assist staff in meeting safeguarding duties and requirements. The report includes activity undertaken collaboratively under the Kent and Medway Safeguarding Board and Partnership arrangements, including publication of practice review.
c) Of note the challenge of responding to the needs of children and young people with mental health/ behavioural and emotional health concerns is identified.
d) During the year there has been a focus on training compliance and this remains a priority for the year ahead
e) The report was *approved* at the Quality Assurance Committee on 04 July 2024.

The Board **NOTED** the report

7.8.2 **Infection Prevention Control Annual Report**

Sarah Vaux presented the report in line with the paper submitted. The report provides the following:

a) Focus on the activities from 2023/24. The report measures IPC practices against the 10-criterion based on Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.
b) IPC team structure, detailing the training of the team. It also measures improvement against the IPC board assurance framework.

c) All of the organisms that form part of mandatory surveillance are included in the report and measures the Trusts position against thresholds, learning from Post Infection Reviews (PIR's) and the split of infections across Divisions, care groups and ward areas.
d) The report is inclusive of winter respiratory viruses, FIT testing, surgical site infection surveillance, link practitioners, decontamination, hospital cleanliness, commode audit outcomes, and estates work with the addition of the new simulation training created by the IPC team to support wards with repeated hospital acquired infections.
e) The report was *approved* at the Quality Assurance Committee on 04 July 2024

The Board **NOTED** the report

7.8.3 **Medical Appraisal and Revalidation Annual Report**

Alison Davis presented the report in line with papers submitted. The report provides:

a) A summary of previous actions, updates and new actions for the current Trust year.
b) Details the provision of resources to ensure that the appraisal and revalidation processes are conducted in a professionally safe way adhering to Responsible Officer (RO) regulations 2010 amended 2013
c) Details regarding medical appraisal compliance and a brief summary of revalidation recommendations for the 2023-2024 Trust year.
d) The report was *approved* at the People Committee on 31 July 2024
e) Thanks to colleagues for the support with this report.

Check and Challenge

f) Paulette Lewis: disproportionally groups are being reported. With international recruitment and looking at their curriculum there is a need to take time to understand. Would be good for us to look deeper. A look into the culture of the organisation and who individuals fit in.
Alison Davis: we have a programme in place to support. The coaching and training from the Cultural Transformation programme will address additional requirements.
g) Gavin MacDonald: lot of work on job planning, what is the relationship in appraisals and job planning.
Alison Davis: there needs to be a job plan to support the annual appraisal, the two have an overlap at each appraisal there is a statement to sign off part of the job plan.
h) Jenny Chong: with regards to the 'decision making group' investigation lean heavily towards BAME doctors, is wellbeing being considered with these investigations.
Alison Davis: every concern is raised, there was an initial review, the actual investigation was a very short process, wellbeing is always a consideration and supported.

The Board **APPROVED** the report

7.9 **Patient First Achievements**

Gavin Macdonald presented the report in line with the paper submitted, providing the Board with an overview of the Patient First Improvement and Operational Management System called Patient First. The report includes

- Examples of adoption and positive impacts across the organisation.
- The key achievements against priorities for the years 2022/23. 2023/24 and 2024 to date.

a) Each of the five True North (TN) strategic areas are profiled with a summary of our Ambition and Vision. It states the supporting Strategic Initiatives, Corporate Projects and other key linked activities, as well as our outcomes against our annual breakthrough objectives (BO).

b) Key achievements in each domain are evidenced.
c) Work is underway and due to complete in Q4 to developed the 2025/ 2028 Patient First Strategy which will set out how the organisation will further build on clinical and patient engagement with Patient First

Check and Challenge

d) Jayne Black: this is an opportunity to consider what to put into our strategy, next steps around this to be reviewed at the October SDR.

The Board were **ASSURED** by the report

7.10 **Quarter 1 – Learning from Deaths Report**

Alison Davis presented the report in line with the paper submitted. The following key points were highlighted:

a) A total of 13.3% of deaths were subject to Structured Judgement Review during July. No deaths were judged as avoidable but three deaths were referred to the Incident Review Group (IRG) for further investigation for poor care overall.
b) Issues with Do Not Attempt Resuscitation (DNAR) and Treatment Escalation Plan (TEP) forms raised.
c) Communication remains an issue.
d) Structured Judgement Review (SJR's) sent to Electronic Patient Records (ePR) have been an issue.
e) New process for SJR reviews.
f) Delays with MCCD remains an issue.
g) HMSR and SHMI remain higher than expected.
h) Further improvement work being progressed through the Mortality A3 refresh and the NICHE action plan including establishing a process for RIP validation of data

Check and Challenge

i) Gary Lupton: within our demographic, are there to flags in terms of respiratory.
Alison Davis: Dr Foster looks at HSMR, they have aligned a peer group indicating we are in the expected range.
j) Annyes Lahuerte: how do we consider outside factors.
Alison Davis: we need to ensure our coding is recorded accurately, there is always more to do.
k) The Chair: we are a significant outlier, a priority that we understand. With respiratory pathways a lot we can do quite quickly, we need to be clear on the projects and actions.
Jayne Black: important to use Patient First to drive issues through. Need to feedback to divisions and specialty meeting to be picked up urgently.

The Board **NOTED** the report

8. Closing Matters

8.1 **Questions from the Council of Governors and Public**

a) Paul Stephens: in regards to agenda item 4, 'end of life decisions not completed by the end of the day' what impact does this have on next of kin.

Alison Davis: end of life was picked up through the 'avoidable 2222 calls' Breakthrough Objective. The end of life team continues to make decisions during the day, however some are sadly unavoidable and have to be made out of hours.

b) Paul Stephens: in regards to the Quality KPI Scorecard with reference to falls, 29 stated as low harm, were the other falls more serious.
Sarah Vaux: recorded falls are either low or no harm, other percentages would relate to no harm falls.

8.2 **Escalations to the Council of Governors**
No escalations to make to the Council of Governors.

8.3 **Any Other Business**
Thank you to Chris Burton who leave us on 30 September; we will be welcoming Professor Jane Perry from Canterbury Christ Church University.

8.4 **Reflection**
Nothing to note for reflection at this meeting.

8.5 **Date of next meeting**
Wednesday, 13 November 2024

6.5 The meeting closed at 15:45

These minutes are agreed to be a correct record of the Board Meeting in PUBLIC of Medway NHS Foundation Trust held on Tuesday, 10 September 2024

Signed by Chair …….. Date ……

Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
24.07.24	**TB/002/2024**	Outcome of the meeting between the CMO and Rosie Chester to be updated to the Board November.	13.11.24 ~~10.09.24~~	Chief Medical Officer	**PROPOSE TO CLOSE** - update on agenda following meeting scheduled for Thursday, 19 September 2024 @ 11:00 on MS Teams	Green
24.07.24	**TB/004/2024**	Timing and refresh of system and partnership work with collaborative partners to be bought back to the Board for review.	13.11.24 ~~10.09.24~~	Director of Strategy and Partnership/Company Secretary	**REQUEST TO BE DEFERRED TO JANUARY 2025 MEETING** - System Partnership Away Day scheduled for 15.11.24	Amber
24.07.24	**TB/006/2024**	Feedback from NHS, regarding the Financial Recovery Plan to be shared with the Board in Private in August.	13.11.24 ~~10.09.24~~ ~~21.08.24~~	Chief Financial Officer	**PROPOSE TO CLOSE** - Item added to agenda. 10.09.24 - not yet received feedback.	Green

Chief Executive's report: November 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.

Annual Members' Meeting

My thanks to Trust members, stakeholders and colleagues who attended our Annual Members' Meeting on 11 September. We welcomed around 80 people in the hospital's restaurant and online to reflect on the achievements and challenges of the past year and to outline our plans for the year ahead.

Particular thanks to colleagues from surgery who spoke about the recent improvements they have made for our patients, including introducing day case hip and knee replacements and extending the use of robotic assisted surgery to more specialties, including gynaecology.

Visitors were also able to visit a number of stands promoting services within the hospital, such as our patient portal Patients Know Best, and find out how Patient First, our improvement programme, helps us focus on the right priorities to make the biggest difference for our patients.

Improving performance

Despite significant and ongoing pressure on the emergency pathway in recent months, I am pleased to report a sustained improvement in emergency department (ED) performance, which has consistently exceeded the national four-hour emergency care standard since March 2024, together with excellent ambulance turnaround times.

We continue to focus our efforts on reducing overcrowding in the department and ensuring patients can be admitted to a ward sooner, which are both impacted by the stubbornly high numbers of patients awaiting out of hospital care before they can be discharged.

Cancer care

We have also seen a tremendous improvement in waiting times for patients on the breast cancer pathway. Using the Patient First methodology to drive a focused piece of work to tackle long waits and poor patient experience, the national 28 Day Faster Diagnosis Standard (Breast) has dramatically improved – up from 19 and 20 per cent in June to 90 and 93 per cent in September. There has also been an overall improvement in the 28 Day Faster Diagnosis Standard for all cancers – up from 51 per cent in June to 78 per cent in September.

Improving patient feedback

One of our Patient First objectives is to increase the number of people giving feedback about their care through the Friends and Family Test (FFT), as well as increase the number who would recommend us as a place to be treated. This feedback is vital to helping us further improve patient care.

I am pleased to report that there has been a marked improvement since last October, when just 12.9 per cent of patients were responding to the test, and 88.2 per cent of those saying they would recommend our care. In September 2024, the response rate was up to 16.7 per cent, with a recommend rate of 92 per cent.

Feedback has improved in all areas, including ED where in September, 74 per cent of patients who responded gave feedback following a visit to the department would recommend the care, up from 65 per cent in January 2024.

We are committed to sustain this trend of improvement and exceed the national 95 per cent target, in all areas, as we currently are for inpatients.

Staff recognised in national awards

I am delighted that once again, colleagues here at Medway have been recognised for their innovations in clinical practice in key national awards.

Members of the Safeguarding Team were finalists in the 'Learning Disabilities Nursing' category at the recent Nursing Times Awards, recognised for their innovative work with theatre colleagues to introduce a ‘one stop shop’ service for patients with learning disabilities and autism who require medical procedures under a general anaesthetic.

In addition, an initiative that has reduced waiting times and improved outcomes for patients needing emergency surgery has been highly commended at this year’s HSJ Patient Safety Awards, which are designed to drive improvements in culture and quality across the NHS. Colleagues from our surgery and anaesthetics department were recognised in the ‘Urgent and Emergency Care Safety Initiative of the Year’ category.

A year of Patients Know Best

I am pleased to share the success of Patients Know Best, our online portal that makes it possible for patients to access their hospital appointments, clinic letters and discharge summaries in one handy place.

More than 163,000 people have registered for Patients Know Best with almost 107,000 patient letters read using the portal since it was launched last October. We’ve also sent nearly 200,000 appointment reminders through the portal, reducing the number of missed appointments.

We know from feedback that the portal is well received by our patients, particularly the speed with which they can access details of their upcoming appointments, so they no longer have to wait for letters to arrive by post.

Reducing the number of letters sent to patients has saved at least £70,000 in printing and postage costs, and saved more than 4,200kg of carbon emissions, helping us meet the commitments in our Green Plan.

I am delighted that the number of specialities using the portal to communicate with patients has grown over the last year, and will to continue to do so.

Patients Know Best is available through the NHS app, which also allows people to book and manage GP appointments, order repeat prescriptions and view their GP health record.

Ticketless parking coming soon

Preparations are underway to introduce a new ticketless payment system that will make it easier for our patients and visitors to pay to park at the hospital. Automatic Number Plate Recognition (ANPR) will be introduced before Christmas in Car Park 1 (multi story ground floor, opposite the main entrance) and Car Park 2 (opposite Green Zone entrance).

With ANPR, the car registration plate will be scanned on arrival at the car park and the barrier will automatically open. No ticket is required. Payment is made before leaving the car park by entering the registration plate into one of the pay stations located inside the hospital and in each car park. Payment will continue to be by cash, card or online.

Blue Badge holders and patients eligible for concessionary rates will continue to visit the Security Desk in the hospital's main entrance before returning to their vehicle. A member of the team will validate the parking using the registration plate.

"Life-saving" Medway nurse rescues man on street with CPR

Finally, I am very proud to lead this Trust as I am daily reminded of the lifesaving difference colleagues here make to the lives of our patients and their families. But it's not every day that a colleague helps to save someone's life while off-duty.

That's exactly what 25-year-old nurse Rachael Lewis did when she recently discovered 77-year-old returned airline pilot, Chris Mills, unresponsive and without a pulse on a road near to Chatham's Dockside Outlet shopping centre.

Rachael spent several minutes administering and overseeing cardiopulmonary resuscitation (CPR), helping to save his life following signs of cardiac arrest. Chris was then brought to the hospital to continue his recovery thanks to the ongoing care and support of staff. As Chris rightly said when he was recently reunited with Rachael here at the hospital – amazing just doesn't do justice to her lifesaving actions. I could not be prouder of Rachael and all the team involved in Chris's care.

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Story to Board – Breast Feeding		**Agenda Item**	3.3
Author	Nikki Lewis, Associate Director of Patient Experience			
Lead Executive Director	Chief Nursing Officer			
Executive Summary	This item highlights work to improve areas for staff or patients to breastfeed their baby following a staff experience on return from maternity leave.			
Proposal and/or key recommendation:	Nil			
Purpose of the report (tick box to indicate)	Assurance		Approval	
	Noting		Discussion	✓
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	N/A			
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:	N/A			
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:	Systems & Partnerships - Board Assurance Framework (excel spreadsheet)		
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.

Story to Board

Breastfeeding

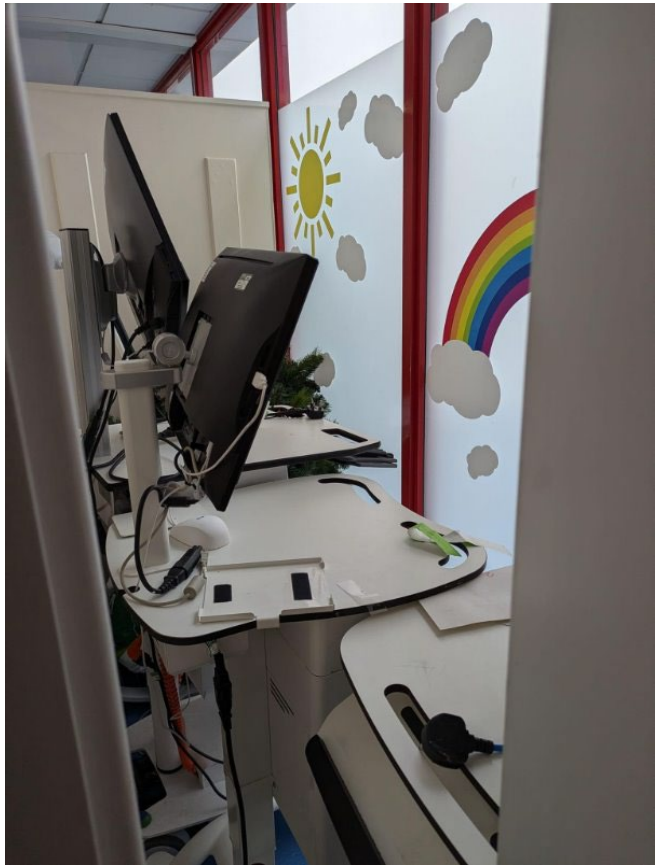
Alannah Jefferies, Radiographer and Patient at MFT

Nikki Lewis, Associate Director of Patient Experience

My Story

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

Room in SDEC



Improvements

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

PODS

- One idea we have had is to install ‘mum pods’ into 2 different spaces
- Potentially a booking system can be set up for staff
- Patients can use it when its vacant
- Accessible for pushchairs / wheelchairs
- Safe, clean, calm space for breast feeding / expressing
- Looking to get support from charity to fund the pods
- The group have discussed other opportunities to convert spaces if the pods cannot be fully funded
- The group will contribute to the updated SOP for staff and patients who need to breastfeed

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Corporate Risk Register and Board Assurance Framework (BAF)	**Agenda Item**	4.1
Author	Matthew Capper, Director of Strategy and Partnership/Company Secretary		
Lead Executive Director	Matthew Capper, Director of Strategy and Partnership/Company Secretary		

Executive Summary

The risk register and board assurance framework are intended to give the members of the Trust Board assurance as to the current position of the Trusts risks management system.

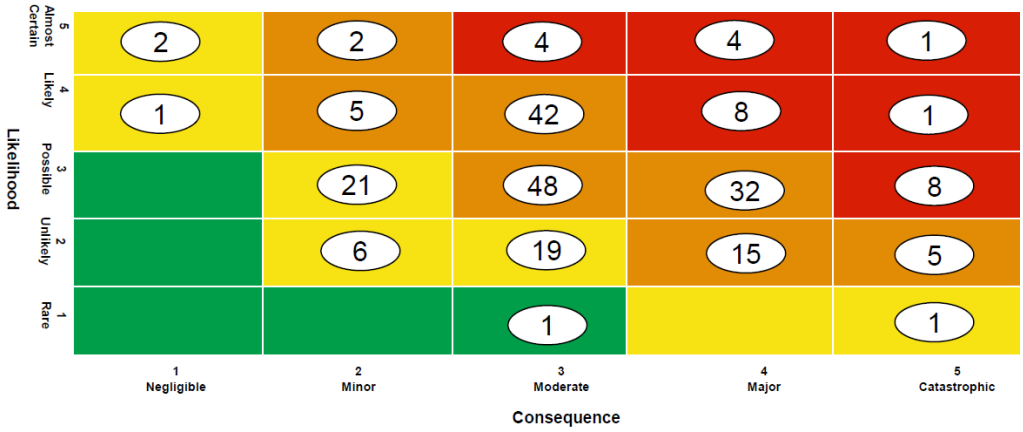
The regular maintenance and oversight of risk satisfies regulatory and statutory duties such as those overseen by the Care Quality Commission (CQC), Ofsted and Health and Safety Executive to implement effective risk management systems. It also reflects the NHS Foundation Trust Code of Governance, and the Compliance Framework.

Risk Register summary:
The Trust Risk Register has 226 approved risks in total with 26 risks scoring 15 and above (designated extreme risks).

There have been 37 new risks, of which

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

The heat map below summarises the total number of risks assigned to each rating.



The trusts risk register is being amended to stratify the risks from the issues. Of the previously identified 'extreme' risks with a rating of 20 and over all are now described as issues and recovery actions will be prioritised to recover these areas. These issues are as follows:

Issue ID	Issue Title	Issue Owner	Score
2060	Capital allocation less than requirement.	CFO	25
2083	Timely culling or destruction of medical records.	CMO	20
2056	ICB alignment of clinical income to services provided.	CFO	20
1856	Faulty TURBT and TURP sets due to age of equipment may result in harm to staff and patients.	COO	20
1711	Processing of personal data.	CMO	20
1133	Insufficient Midwifery Staffing impacting the ability to provide patient care.	CNO/COO	20

A review of the risk register has been completed and 10 risks were identified as being more than 12 months old and with no adjustment made to their rating. A full description of the treatment approach for these will be discussed at the Audit and Risk Committee but a summary of these items can be found in the table below:

Risk ID	Risk Title	Proposed treatment
1045	Breaching Deprivation of Liberty safeguards legislation resulting in patients being detained outside of the legal framework.	Remove (no longer relevant)
1025	Euroking maternity system not fit for purpose, impacting patient safety data quality, stat analysis, CNST and clinical info.	Refresh
1052	Inadequate MRI Capacity.	Refresh
1232	Patients that lack mental capacity leaving the hospital without the knowledge of staff are at risk of harm.	Remove (no longer relevant)
1044	Pandemic may impact delivery of service.	Remove (no longer relevant)
1162	Mass Casualty incident may result in inability to maintain elective activity.	Refresh
1165	Supply Chain Failure / Interruption may impact ability to maintain critical and non-critical functions.	Refresh
1113	A risk that the trust is using unlicensed medicines inappropriately.	Remove (no longer relevant)
1187	PHARMACY - there is a risk patients will not be able to receive their medication due to stock shortages.	Remove (no longer relevant)
1109	Training Needs Analysis is not in place that covers information governance (IG) and cyber security	Remove (no longer relevant)

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

Board Assurance Framework (BAF) summary:

The BAF is used to record and report the organisation's strategic objectives, risks, controls, and assurances to the board. The review and refresh of the trusts BAF has now been completed and the boards attention is drawn to the following changes:

BAF ID	Change
1,2,3,4,8	Sustainability strategic risks mapped to the FRP, IIP and the NOF 4 transition criteria.
9	Amended to focus to reflect a deteriorating performance.
11	Renewed to reflect revised Patient breakthrough objective focus.

For the October 2024 reporting period there have been two new strategic risks identified

- BAF 15 - New – reflecting both external instabilities as well as fragility of internal capital position.
- BAF 16 - New – reflecting strategic risks identified through business planning and winter planning.

Of the 16 strategic risks:

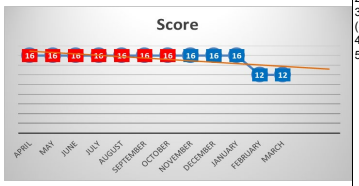
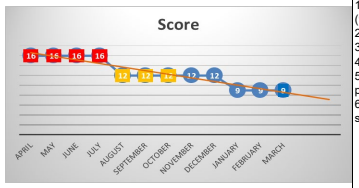
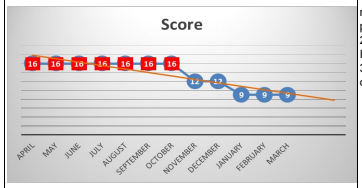
- 1 strategic risk is rated 25 (BAF 2)
- 0 strategic risks have been closed this month.
- 14 strategic risks have maintained their rating.
- 1 strategic risks has had its rating increased and is off trajectory to meet its target score (BAF 12). This is down to an amendment to the 65week waiting list recovery.

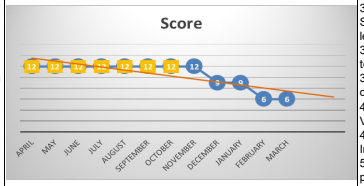
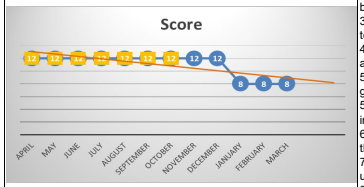
Proposal and/or key recommendation:	The Board are asked to note the report.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Risk and Compliance Sub-Committee Date 17 September 2024 Meeting: Executive Management Committee Date: 29 October 2024			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring:	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Contained within the Executive Summary.				
Resource implications:	None directly.				

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	Maintenance and oversight of risk is a regulatory and statutory duty overseen by the Care Quality Commission (CQC), Ofsted and Health & Safety Executive to implement effective risk management systems. It is also a criteria within the NHS Foundation Trust Code of Governance, and the Compliance Framework.		
Appendices:	Board Assurance Framework for October 2024		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Matthew Capper Job Title: Director of Strategy and Partnership (and Company Secretary) Email: m.capper@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.

MFT Board Assurance Framework **Oct-24**

ID	Patient First Domain	Lead Committee	Date Added	Full Description of Risk -	Initial Consequence	Initial Likelihood	Initial Risk Rating	Mitigation / controls	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Forecast	Actions Planned to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date	Exec Owner	Senior Manager Lead	Update position
BAF1	Sustainability	FPPC	Mar-24	There is a risk that the trust does not effectively manage its budgets/experiences unbudgeted cost pressures resulting in a risk to the deliver of the in year control total.	4	4	16	1. Robust budget setting 2. Weekly executive-led check and challenge sessions re efficiencies/mitigations 3. Access operational group 4. Budget statements/budget holder meetings 5. Full staffing of PMO 6. NHSE Improvement Director support and NHS Intensive Support team 7. Application of "Grip and Control" checklists, and "Core/Level 2-3-4" NHSE controls 8. Self-assessment and implementation of HFMA sustainability checklist 9. VCP and enhanced non-pay controls	4	4	16			1. Medical staffing project underway to deliver a roster solution. 1b. Reconciliation of budgets to rosters (Oct). 2. Budgets to be signed off by divisions (sept). 3. Approval of month end variance and forecasting SoP (Sept) 4. Escalation process/SOP (Oct) 5. Delivery of BAF 8 actions.	4	3	12	Mar-25	CFO	Paul Kimber	Oct 24 - 1. Recruitment of a roster specialist underway - appointment made. 1b. Reconciliation work underway, completion due end Q2. 2. All clinical divisions budgets signed off by division, some corporate budgets outstanding. 3. Document submitted to FPPC for approval (Sep) - feedback from NHSE was that they did not feel a formal/written document was required; however, this is recommended best practice per the HFMA self-assessment in recent years. Other system providers have been asked if they have a formalised procedure. 4. Discussed at Trust Exec due Oct. The latest forecast outturn indicates a risk to control total of up to £15.1m with full mitigations not yet identified.
BAF2	Sustainability	FPPC	Mar-24	ISSUE - The backlog maintenance report for the Trust indicates critical works that far exceed the in-year and even a multi-year allocation from system operational capital. The risk is that large parts of the estate will not be fit for use and therefore impact on the quality of care provided and impact the trusts ability to meet its other statutory and recovery objectives.	5	4	20	1. Completion of Trust prioritisation matrix, including risk register entries 2. Programme review and approval by Trust Executive each financial year 3. Proposal paper drafted setting out options to address findings of the 6-Facet survey 4. Submission of capital plans and requests via the system to secure minimum fair share of operating capital allocation 5. Application for additional capital funds where available, e.g. PDC, charity, grants, etc.	5	5	25			1a. Risk based prioritisation matrix produced and being used for the capital spend discussions. 1b. Explore strategic capital finance options with ICS and NHSE.(ongoing). 1c. Report findings of the 6-facet survey to ICS/NHSE Revised business planning links including establishment of dedicated group.	3	4	12	Dec-24	COO	Neil Mcelduff	Oct 24 - Revised 6-facet mitigation plan due Oct 24. Risk rating held at 25 until plan reviewed. CDC slippage in 2024/25 may give some headroom for additional projects in this financial year, however these monies will need to be brokered into 2025/26 to complete the CDC works.
BAF3	Sustainability	FPPC	Jun-23	A number of independent reports into the drivers of deficit at the Trust have identified the financial culture of the organisation as a contributory factor in the performance. Without addressing the culture the Trust may struggle to deliver its financial plans. Failure to address this as an issue could impact the Trust's exit from SOF4.	4	4	16	1. Budget holder meetings 2. Budget holder training (stat man) 3. Finance Training Policy 4. Mandatory objective in appraisal form 5. Sustainability work stream within Patient First 6. Communication via senior managers meetings and Trust Management Board 7. Compliance reporting to FPPC (as part of payables update) and to the Audit and Risk Committee. 8. Better Business Case trained staff. 9. Audit tracker	4	3	12			1. Add budget holder training to Stat and Man training list (90% target) 2. business planning ownership by divisions. 3. escalation process implemented (as BAF 1). 4. Core financial policy refresh and relaunch (from Oct). 5. Link through to the trust cultural transformation programme. 6. Divisional care group service involvement in future financial strategy and recovery and sustainability.	3	3	9	Mar-25	CFO	Exec	Sept 24 - 1. Trust Management Board review completed and approach supported. Budgets signed-off. 2. Roadmap to going to Trust Management Board and new Strategy, Performance and Planning Group has been established established. 3. as BAF 1 4. Draft being compiled, awaiting for revised procurement guidance. 5. At the scoping phase/Listening stage. 6. Linked to action 2.
BAF4	Sustainability	FPPC	Mar-24	Delivery of the Trust's financial strategy Without clear enablers, system and NHSE support and full alignment to the clinical strategy, this could be at risk. The Trust currently remains in SOF4	4	4	16	1. Patient First True North and governance 2. Trust Board approved Finance Strategy 3. Working alongside NHSE Intensive Support director 4. Trust IIP 5. ICS financial recovery work being undertaken (of which the Trust is engaged)	4	4	16			1. Implementation of KPMG financial improvement recommendations which includes a review of core financial policies. 2. Board approved financial strategy and IIP. Implementation of IIP and agree with ICB. 3. ICS producing a financial recovery plan which the trust will contribute to (Oct).	3	3	9	Mar-25	CFO	Paul Kimber	Oct 24 - Strategy, Planning and Performance Group has met and begun scrutinising NOF4 exit criteria and evidence. CFO has escalated unfunded services with commissioners. FRP reporting to FPPC from October meeting.

ID	Patient First Domain	Lead Committee	Date Added	Full Description of Risk -	Initial Consequence	Initial Likelihood	Initial Risk Rating	Mitigation / controls	Current Consequence	Current Likelihood	Current Risk Rating	Direction of Travel	Forecast	Actions Planned to reduce risk	Target Consequence	Target Likelihood	Target Risk Rating	Target date	Exec Owner	Senior Manager Lead	Update position
BAF5	People	People	Jul-24	There is a risk the Trust is unable to retain sufficient levels of staff to ensure safe staffing levels, which results in higher turnover and in turn higher than expected levels of recruitment.	4	3	12	1. NHS Long Term Workforce Plan and MFT People Strategy aligned to the Plan. 2. 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 pay bill. 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 development of nursing and midwifery and CSW staff 9. People Breakthrough Objective focussed on staff turnover in the first 24 months of employment	4	3	12			1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions. 2a. We are exploring robotic automation of the elements of the recruitment process with a view of outsourcing this process from another NHS organisation. (as update) 2b. We are supporting Trust's Medical Productivity Programme and an A3 methodology on Medical Recruitment. 2c. Review of the end to end medical recruitment process. 3a.Stay Conversations to be offered as an action as part of Staff Survey action planning (where staff indicated intention to leave the organisation). 3b. Develop Stay Conversations to be rolled out within the teams where turnover is higher than average. 3c. Continue to embed Intention to Resign process within the divisions. 4a.Intention to Resign process is going to be linked with the VCP process for vacant roles. 4b. Continue to promote Intention to Resign process and Exit Interviews through team huddles and HR BPs. 5. New approach to be explored with the system and new policy written. 6. Address staffing issues (FTEs and job roles) through the investment case.	4	2	8	Mar-25	CPO	Dominika Kimber	Oct 24 - Nb. adjusted target score based on consequence. 1. Action completed as no further IA identified. 2a. working with ICS on scaling people services. 2b. work continuing 2c. Review completed. 3a/b/c. Process is in place but poor take up at present. Looking at local scale issues. 4a/b. Action complete 5. Policy being drafted and will be united to People Committee in November.
BAF6	People	People		There is a risk that staff will not feel confident to raise concerns and that their concerns will be dealt with by the organisation. This may lead to worsening engagement levels and quality of patient care.	4	3	12	1. Strategy: People Strategy in place 2. 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. Communication routes well established in Trust 5. Freedom to speak up guardians are in place. 6. VBR in place Qualitative and quantitative values-based appraisal to continue to embed values into the Trust culture. 7. 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. 8. New Starter Survey project	4	3	12			1. Staff Compact to be reviewed and updated to include new / additional leadership behaviours. This links with the NHSE Behaviours Framework which is being developed. 2. In conjunction with colleagues in East Kent, review our management essentials offer and identify modules for development / collaborative work. This links with the NHSE Behaviours Framework & Management training which is being developed. 3. Design Stay Conversations which will be rolled out to the teams/departments as a proactive retention tool. 4. ICB New Starter Survey 2023 results need to be analysed and actions assigned to the respective teams. 5. MFT own New Starter Survey, replicating ICB survey is going to be launched. 5. Identify areas where completion falls below 90% and raise in care group/team meetings. 6. QA process to be rolled out. Feedback to be provided to the HR and OD Performance Group. 7. FTSU process has been reviewed. Policy needs to be updated and published. 8. Launch and promote Dignity at Work Advisors. 9. Communicate lessons and improvements implemented from staff feedback and concerns/grievances. Design a dedicated intranet page where these reports will be accessible.	4	2	8	Mar-25	CPO	Dominika Kimber	Oct 24 - 1. Still awaiting the national Behaviours Framework, The trust is developing examples of negative behaviours through engagement with staff and network reps. 2. Head of Wellbeing and Staff Experience & Head of OD are liaising with East Kent to progress. 3. The Trust is currently implementing the NHSEI Culture, Engagement and Leadership programme. 4. In depth analysis of the data is underway. A dedicated T&F Group has been established to discuss actions. 5. New Head of Wellbeing and Employee Experience will be taking this action forward. 9. Launched in July - completed 10. Refreshed Strategic Leadership Initiative (Leadership and Behaviours). New freedom to speak up service went live 30 sept, reviewing implementation.

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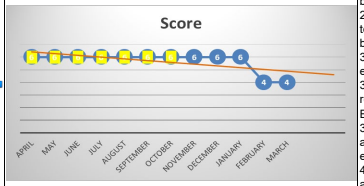
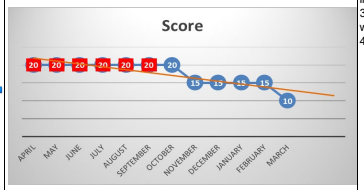
BAF7	People	People	Sep-23	Should the Trust fail to deliver its strategic objectives relating to EDI, there is a risk that our people will not be able to thrive at work and that the Trust will not meet its statutory obligations to its employees. This may lead to poor employee experience and negative impact on staff wellbeing, both at work and in general. IMPACT: Failure to meet the requirements of the Equality Act 2010; increase in staff turnover; increase recruitment and retention challenges; and therefore impact negatively on quality of patient care and experience.	2	3	6	1. Trust-wide culture, engagement and leadership programme to provide staff and leaders with skills to engage and retain staff. 2. Executive team and Trust Board have committed to EDI Objectives as part of their personal objectives (HIA1); although now signed off, work is required over 2024/25 to support delivery of those objectives 3. All forms of discrimination (including bullying and harassment) must be managed effectively and we need to understand what preventative/proactive measures can be taken. 4. Advice and signposting regarding concerns around discrimination (bullying and harassment) must be easily accessible and volunteer advisors must be competent and trained in their roles.	2	3	6			1a. Review of the People Strategic Initiative (Leadership and Behaviours) and implementation of the agreed actions. 1b. Development of Behaviours Framework (aligned with Trust Values, incorporating all existing tools referencing behaviours e.g. Compact, Our Leadership Way, Nolan Principles) 1c. Development of examples of negative staff behaviours to be included in the Behaviours Framework 2. Periodic meetings with Executive Team and whole board to support delivery of HIA1 Objectives that were agreed before 31 March 2024 3a. Anti-bullying and harassment group to be reviewed and re-established. 3b. Revised Bullying, Harassment, Discrimination and conflict resolution policy to be launched and communicated by the Exec (wider comms plan) 3c. New duty to protect staff from sexual harassment and actions relating to the Sexual Safety Charter will be embedded into Trust's policies and processes 4. Trained Dignity at Work Advisors will become available to advise staff. Ongoing support will be provided by the Head of EDI. 5. Cultural transformation programme.	2	2	4	Mar-25	CPO	Alister McClure	Oct 24 - 1.NHSE plan to develop a similar Framework - we are liaising with them. Consultation with staff networks initially, using examples of negative/uncivil behaviours recorded to Datix. 2. HIAs included in Exec appraisals. 3a. Anti-bullying and harassment group meeting monthly to triangulate information and seek assurance on action taken 3b/c. Bullying, Harassment, Discrimination and Conflict Resolution Policy reviewed and updated, including process maps and updates on sexual safety. Anti-Bullying and Harassment Group has refocused from data analysis to assurance on action; Policy changes on Sexual Safety and the prevention of sexual harassment and abuse have been made 4. Dignity at Work Advisors programme continues, with regular updates on policy changes and peer support. 5 – Equality Impact Assessment of Employee Relations and Organisational Development functions being designed. Cultural transformation Programme diagnostic phase has begun with baseline performance data.
BAF8	Sustainability	FPPC	Mar-24	The current finance and contract environment continues to support the trust not receiving appropriate recompense from the services delivered during the reporting period for example Ruby Ward.	4	4	16	1. Business planning / contract negotiations 2. Correspondence and meetings between provider and commissioner outlining issues and actions 3. Seek support from operational/clinical colleagues at the commissioner.	4	5	20			Oct 24 - 1. Contract review meetings to reach proposals for presentation to Boards. 2. Present cases to ICB (escalated to NHSE if necessary). 3. Regular reporting of Code and Capture into Finance Committee, Check and Challenge group and RSP oversight group	3	3	9	Mar-25	CFO	Paul Kimber	Oct 24 - 1. There remains a lack of consensus between Trust and commissioner in respect of commissioned services such as Ruby Ward. This issue is being escalated to the CEO and CFO of the ICB. 2. MFT CEO formally writing to the ICB (Oct) 3. Impact of funding being withheld is being included in the trusts FRP and forecasts. This will be circulated to the NHSE oversight group.
BAF9	Quality	QAC	Aug-24	SHMI and HSMR mortality indices show that Medway Foundation Trust are outside the expected range. There is a risk that patients maybe dying unnecessarily whilst at an inpatient at Medway Foundation Trust or within 30 days of discharge. (To be reviewed once Patient First Breakthrough objective is confirmed)	5	4	20	1. Avoidable #2222 breakthrough objective. 2. Depth of coding level. 3. Mortality Breakthrough Objective. 4. Admission pathway and medical model. 5. Learning from deaths process, End of life care pathway and data validation of deaths processes	5	4	20			1. Review of the emergency admission pathways / medical model with a focus on patients admitted with respiratory disease. 2. Further embedding of learning from deaths methodology including the SJR process to utilise skills of the MDT. 3. Improving identification of end of life and communication with patients and families regarding end of life care. 4. Continue to focus on data quality improvements.	5	2	10	Mar-25	CMO	James Alegbeleye	Sept 24 - 1. Avoidable #2222 breakthrough objective has significantly reduced the number of cardiac and peri arrest calls. This is now transferring to BAU. 2.. Following a review it is clear the depth of coding at the trust is better than the national level. 3. Mortality Breakthrough Objective established root causes and countermeasures identified. 4. new SJR process commenced - phase 1 02/09/24. 5. Focussed support for specialty morbidity and mortality meetings. 6. EoLC colleague has joined weekly BTO huddle. 7. Data quality reviews continuing. 8 The first medical model workshop was held in September. Further workshop planned to look at emergency pathways - 11 Oct. 24

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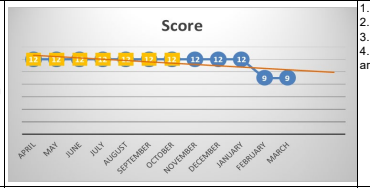
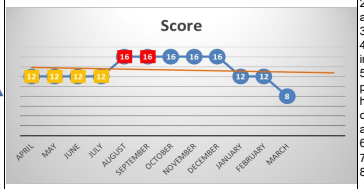
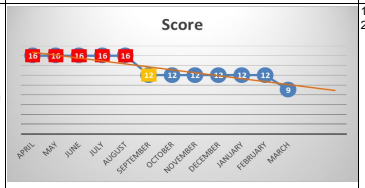
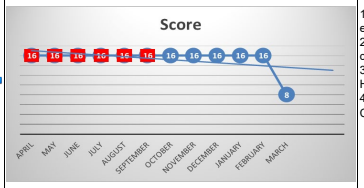
BAF11	Patient	QAC	Sep-24	There is a risk that patients and their families may not receive outstanding, compassionate care every time	4	3	12	1. Weekly FFT huddles to discuss top themes and trends from feedback 2. Divisional and Exec SDR to review the top contributors 3. Monitoring complaints against the trajectory for the quality priority and staff attitude	3	4	12			1. Fundamentals of care programme of work 2. The re-established ward accreditation programme 3. Internal assurance visit schedules 4. Bespoke education, training and intense support in clinical areas	3	3	9	Mar-25	CNO	Nikki Lewis	Oct 24 - 1. the programme continues to be rolled out and progress is being reported through the QPSSC. 2. The ward accreditation programme is underway with 6 wards having been assessed. One ward is close to achieving Gold. Additional support will be provided to those wards that have not reached the Bronze rating. 3. The schedule is being complied, IPC visits have taken place with guests from the ICB IPC team. A positive response was received. 4. Requirements are being reviewed.
BAF12	System & Partnership	FPPC, QAC	Jun-23	Lack of operational performance for example not meeting constitutional (e.g. RTT) measures has wide-ranging implications, affecting patient care, trust, finances, and overall NHS performance It's essential for trusts to address these issues promptly to maintain high-quality healthcare services.	4	3	12	1. Focused work through the HARIS group 2. Weekly RTT meeting including robust review of RTT process 3. Reports direct to COO 4. Monthly reporting to TMB Focus on clinical urgent and then long waits Patient P control in operation Use of ERF monies to support increased activity	4	4	16			1. Continuing to embed the Acute Medical Model 2. Reviewing the Full capacity protocol, opel triggers and actions 3. Embedding fit to sit/pulling next patients to wards 4. Reviewing existing protocols and processes to achieve improvements 5. Improving relationships with SECAmb and working in partnership has mitigated high numbers of ambulance handover delays increase in Virtual beds to 155 by end of Q4 currently av. 75 virtual beds for early supported discharge and admission avoidance 6. Single Point of Access pilot 7. Rota of Senior Operational staff on the shop floor 8. Safe Haven 24 hour mental health provision	4	2	8	Mar-25	COO	Divisional Directors	Awaiting update
BAF13	Systems & Partnership	EMC, FPPC	Jun-23	There is a risk that conflicting priorities, financial pressures and/or ineffective governance across the ICS results in negative impacts to Medway Foundation Trust's ability to deliver timely, appropriate access to acute care.	4	4	16	1. LAEDB - Oversight dashboard 2. Kent and Medway Integrated Care Board 3. Kent and Medway Integrated Care Partnership Joint Committee 4. Joint development of plans at ICS level 5. Kent CEOs Meeting 6. Trust-wide Flow and Discharge Corporate Project 7. Alignment of Trust, Primary Care, Community and other system partner plans with ICS and ICP plans	3	4	12			1. Review of LAEDB ToR, agenda and required reports. 2. review in-reach with clinical leads	3	3	9	Mar-25	CEO	Exec	Sept 24 - 1. Review underway. 2. SoP drafted. 3. Undertake benefit realisation for the Acute Medical Model. COMPLETE. 4. Full review of utilisation of community capacity is yet to begin.
BAF14	Systems & Partnership	EMC, FPPC, QAC	Jun-23	The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity. There is a risk that the increase in patients without a criteria to reside and the low discharge profile will reduce flow through the hospital and increase demand for bed capacity. This in turn impacts on the quality of care provided, increases length of stay and adds pressure to the financial sustainability of the trust.	4	4	16	1. Regular management meetings to monitor and support progress on improving discharge processes throughout the Trust. 2. Flow and Discharge Corporate project. 3. HCP Discharge Group, Efficiencies Group and LAEDB. 4. TeleTracking. 5. Virtual Ward initiatives	4	4	16			1. Create an operational plan that supports the closure of escalation beds. 2. Standardised LoS meetings with divisional care groups to challenge and escalate patients for MD. 3. Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS. 4. Board Round improvement as part of the reducing LoS CP.	4	2	8	Mar-25	COO	Tracey Stocker	Sep 24 - 1. Plan compiled and in operation. 2. Meetings in place and approach being deployed. 3. Action plan has been drawn up by the HCP discharge group, however, HCP have delayed the review of the pathways until Jan. All discharge related work through the HCP has been stopped pending HCP / ICB decisions on the Transfer of Care functions. this is due in Q2 of 24/25. 4. Work has commenced with 5 wards.

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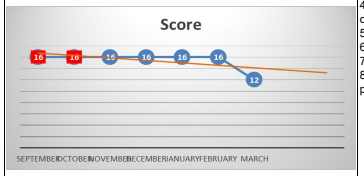
BAF15	Corporate	EMC	Sep-24	As the dependency on digital solutions increases to undertake trust business there is a risk that without continual investments and maintenance (including cyber security) that the trust will not be able to deliver on its core responsibilities and duties. The Trust operates its own internal data centres and servers for the majority of its IT systems and hosts and/or manages service arrangements with some suppliers. These are potential targets for cyber-attacks and/or cyber crime.	4	4	16	1. Digital and data (DDaT) strategy and implementation plan. 2. IT investment summary (business planning item) 3. Board level leadership and oversight (Chief Delivery Officer). 4. Annual maintenance programme. 5. Server upgrade programme. 6. Cyber security review findings and resultant action plan. 7. Links to national IT initiatives and programmes (e.g. CSOC).	4	4	16			1. Delivering the DDaT implementation plan. 2. Drafting an investment summary to be included in the trust business planning process. 3. Awareness raising and education on cyber security and associated IT risks. 4. Reviewing and producing a cyber strategy for Medway in collaboration with ICB. 5. Continuation of the server upgrades programme. 6. Implement the trusts ransome ware backup solution 7. Continuation of the trusts network refresh. 8. Continuation of the trusts digitisation of 'paper case notes' project.	4	3	12	Mar-25	CDO	Adrian Billington	Oct 24 - 1. DDat implementation underway and monitored monthly. Assurance reports produced. 2. Investment summary being drafted and due to be presented to FPPS in Nov 24 3. Cyber security training due Dec24 (board development day) 5. Server upgrade programme 50% completed. 6. Ransomware backup programme completed. 7. in line with national timeline the trust is linking all its windows devices to CSOC. 8. Paper case note project continuing to be implemented. The inpatient element is complete and the project is moving on the outpatient records.. 9. The trust has reviewed its cyber security arrangements and is producing a cyber strategy for Medway in collaboration with ICB - starting October 24.
BAF16	Systems & Partnership	EMC, FPPC, QAC	Sep-24	ISSUE - A lack of available beds within the trust will increase delays in emergency departments, cause patients to be placed on clinically inappropriate wards and increase the rate of hospital-acquired infections, while pressure on staff to free up beds could pose a risk to patient safety.	4	5	20	1. Trust Winter plan escalation actions	0	0	0	New		1. ED recovery action plan implementation	4	3	12		COO	Daren Palmer	Awaiting update

Meeting of theTrust Board
Wednesday, 13 November 2024

Title of Report	Assurance Report for Emergency Preparedness, Resilience and Response Group		**Agenda Item**	4.2
Author	Brian Williams, Head of Emergency Preparedness, Resilience and Response			
Lead Executive Director	Nick Sinclair, Chief Operating Officer			
Executive Summary	The Medway NHS Foundation Trust Emergency Preparedness, Resilience and Response group met in August 2024. This report provides an overall update on progress against the Emergency Preparedness, Resilience and Response Core Standards annual assurance improvements, the work plan for 2024 and current risks and threats.			
Proposal and/or key recommendation:	Note current Assurance and Business Continuity Network position			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Emergency Preparedness, Resilience and Response Group Date 13.09.24 Meeting: Risk and Compliance Sub-Committee Meeting Date: 17.09.24			
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
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe:	Effective: X	Caring:	Responsive: X	Well-Led:
Identified Risks, issues and mitigations:	Supply Chain – EES Infectious Disease – Mpox Measles			
Resource implications:	N/A			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	N/A			

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chair
EPRR Group	August 2024	Brian Williams

Number of attendees	Number of apologies	Quorate	
		Yes	No
9	22	x	

Declarations of Interest Made

Nil

Assurance received at the Group meeting

Annual EPRR Assurance Improvements plan

The Trust obtained 'Full Compliance' for 2023 having not done so for many years.
As such there is not an improvement plan required. The EPRR team at MFT are confident that we will be able to maintain our Fully Compliant status.

We have collated evidence against the Core Standards and have assessed ourselves again as **fully compliant.** We have also received the DEEP Dive evidence from our Digital/IT team for submission which is also fully compliant. This is to be submitted 02 September 2024

Decisions and Actions made by the Group

N/A

Highlights from sub-groups reporting into this group

The Trust Business Continuity Network is managed by the Head of EPRR in the absence of a Band 7. This network has an agreed Terms of Reference and aligns with the Trust's BCM Framework 2024.

The Service-level Business continuity plans tracker is held by Integrated Governance to ensure oversight of all service-level Business Continuity plans and details of state – ownership, in development, endorsed, published and socialised, exercised and review.

Trust BCP:

- Total BCP's across Trust – **83**
- Plans in date – **57 (68%)**
- Plans due for review in 3/12 – **24 (29%)**
- Plans overdue – **24 (32%)**

**Accurate as of 15/07/24*

This is now an element of the Senior EPRR Officer's work plan to maintain the Business Continuity Network to expedite progress with developing and reviewing these plans. It is being managed by the Head of EPRR until B7 role is again filled.

Items to come back to the Group

N/A

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

Item	Group, Subcommittee, Committee	Date
Nil		

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

The 2023 EPRR Work plan is available to the team, a substantive Head of EPRR is planned to be in place before April. The work plan is fully aligned to the NHS EPRR Core Standards expected for 2024

Items/risks/issues for escalation

1) EPRR Lessons Identified log

There were **32** Lessons Identified recommendations outstanding (Down from 36 03/23) on the log of which 6 were progress. We have **one outstanding action** related to IT/Cyber at this time This will be on the agenda for the group's next meeting as a priority. Follow ups will be made on this and appropriate escalation to Divisional Directorate.

2) EPRR Training

- The 2024 EPRR Training Prospectus is in circulation and has been advertised to all staff once this has been endorsed by the EPRR group and Senior Leadership team. The Training being offered is fully aligned to the NHS EPRR core standards assurance requirements and the Trust's Training needs analysis. The EPRR Training remains standalone and not integrated with ESR for access, recording competency or easily reportable data. This work has been authorised and will be in place end of 2024.

- Incident Commander Training

In line with the Training needs analysis included as part of the Trust SMoC and DoC Policy, all Senior Managers on Call and Directors on call should undertake this training before commencing in the On Call rotas. This has been satisfied. New Strategic and Tactical Command training is delivered as required. Consolidation of validation will follow.

- CBRN Training

The agreed standard of ensuring MFT have staff trained to respond to a CBRN incident, using a training package consistent with the SECAmb SORT / HART models. We run course internally monthly supported by ED. We are also looking to expand to include non-clinical staff for training.

ED have nominated a member link staff (awaiting 2nd) to ensure the CBRN cupboard and equipment is jointly audited and maintained with the MFT EPRR Team.

- Loggist Training

The Trust Loggist list has been updated. There are currently 18 staff trained across the Trust. There is a fully reviewed Training package available on the shared drive which can be informally delivered by the EPRR Officer. We are also sourcing train the trainer courses for the EPRR team.

3) EPRR Risk Register

The current EPRR risk Register will have full review in March. There are risks which require closing and possible new Risks which are not yet articulated.
This review will be informed by:

- the Kent Community Risk Register maintained by our Kent Resilience Forum (accessible via the KRF RD page)
- the Local Health Resilience Partnership EPRR Risk Register

Implications for the corporate risk register or Board Assurance Framework

Nil

Examples of outstanding practice or innovation

1) **EPRR Exercising and Debriefing sessions – Lessons Identified reports**
   EPRR currently in planning stages for a senior ops table top exercises at their request.
   A number of debriefs of IT and network incident are available.

2) **Partnership working and networking.**
   HM Coastguard and HM Coroner's Office.
   Operation Joinville – CBRN Exercise with London Ambulance Service and the Metropolitan Police.
   Operation Melville – K&M wide Evacuation exercise led by MFT and K&M EPRR teams.
   Medway Council including Table top attendance.
   LHRP and North West
   NHSE SE EPRR Conference.
   Supported facilitation of G4S Evacuation Exercise.

3) **Consultant/Junior Doctors IA**
   EPRR stood up the ICC in support of all of the Junior Doctors industrial action. Both Hot and Cold debriefs were facilitated and learning utilised in the planning for the upcoming IA.

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Integrated Quality and Performance Report for Month 5: 2024	**Agenda Item**	4.3
Author	Simon Bailey, Director of Business intelligence		
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer		
Executive Summary	This Report relates to the Month 5: 2024 and provides the Board with an update of performance against the Trusts Strategic Priorities. **Overall summary:** • The People domain continues to show the highest volume in metrics improving for Statistical Variance, (30), however the Patients domain shows the highest % of statistical improvement metrics (~61% of all metrics) • The Systems & Partnerships domain is showing the highest number of variances that are statistically showing concern, with 38% of all metrics flagging • Both Quality and Sustainability domains show that the majority of their metrics are not showing any significant statistical change and as such are showing common variation. • Overall, 69 metrics are now showing improved statistical variance (no change from last month) against 33 which are showing concern (-1 from last month). Key areas of improvement are identified with actions and mitigations being taken by operational teams which are contained in the report **Domain summary:** ***Patients*** • Overall positive experience of care has improved in the last 3 months and achieved 93.3% which is the highest achieved to date and 1.7% off target • During the weekly breakthrough huddles, overall experience of care has reached target of 95% 2 weeks consecutively • Inpatient FFT has reached 95.3% for the first time • Response rate has improved month on month in all areas • A reduction has been seen overall in the number of negative responses by theme however clinical treatment remains the highest contributor • Issues remain with patients reporting difficulties being able to contact someone from their medical team in regards to appointments / results. This information correlates with PALS enquiries • Patients report that waiting is negatively contributing to their experience, this is also in relation to discharge from hospital • An AI project is underway aimed at managing queries, re: appointments, more efficiently. This will directly contribute in the reduction of concerns ***Quality*** • 98.6% of all incidents reported resulted in low or no harm • 13 incidents in August caused moderate harm or above		

- Delays in diagnosing ENT cancer; delay in identification and treatment of sepsis; self-harming whilst an in-pt; 2 cat 2 PUs; missed C7 fracture; fall in ED resulting in head injury; delays in anticoagulation linked to a PE; possible missed opportunity to optimise in the 24hrs prior to surgery; given food that was not level 5 consistency
- Hospital Standardised Mortality Ratio (HSMR) for May 23- Apr 24 is 109.9 and 'higher than expected'
- SHMI for Apr 23 - Mar 24 is 1.19 and 'higher than expected'
- COPD & Bronchiectasis and Acute Bronchitis remains a consistent outlier for both indicators.
- For Respiratory diagnosis chapter, Medway have a statistically significantly higher than expected HSMR compared to all acute non-specialist trusts. Relative risk for patients admitted from the respiratory diagnosis chapter has notably increased over the last two years.
- 5.1% deaths subject to SJR. No avoidable deaths identified.
- The % of in-hospital deaths has increased and is notably higher now than in previous years.
- COPD & Bronchiectasis and Acute Bronchitis remain outlying diagnosis groups

System and Partnerships

- Emergency Care August total ED performance continues to be over 78% at 79.9%
- Trust achieved number 1 in the country for ambulance handover delays
- Non-admitted performance continues to rise for 4th consecutive month at 85.8% however Admitted performance remains low at 4.5%
- Patients waiting over 12 hours remains high at 12.9%
- Regarding RTT Performance, the mobile unit on site will open at the beginning of September and this alongside the increased support from PPG, will provide an additional 600 units each month – this with an improvement in the booking and validation processes will improve the performance within gastro and colorectal significantly. Cardiology are providing additional weekend clinics and try to eliminate 65 week waiters.
- Endoscopy capacity remains an issue however the new mobile unit will provide significant additional capacity to mitigate this. Cardiology workshop identified areas for improvement and options are being explored short term solution to try and eliminate 65 week waiters.
- Diagnostics demand and capacity work is underway with the support of the NHS England and will be completed in September. This will also include the reporting element of the service.

People

- The breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% with August 2024 reporting off target in month for a second month in a row. Overall metric shows a near 50% reduction in 12-months overall. The majority of leavers had stay conversations as part of the new intention to leave process; reasons for all have been reviewed by the divisional teams for learning and action.
- 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. ***Sustainability*** • The Trust reports a surplus of £10.9m in month 6 and a deficit of £3.2m year to date (YTD); this is adverse to plan by £1.9m. In-month the Trust has received £14.7m of deficit support funding and the control total has been adjusted accordingly; it has also received £0.5m of industrial action funding. • 2) The efficiency programme has under delivered by £0.6m against the YTD plan of £8.7m. • 3) The capital position is underspent as at month 6 due to the timing of schemes being delivered (principally CDC leases being signed). The CDC issues have now been resolved in principle but are expected to impact completion in 2024/25. The projects are under review to agree timescale/financial slippage into 2025/26. • 4) Cash at the end of September was £5.2m. The deficit support funding referenced above (£25.4m for the full year) is cash-backed and as such we shall cease further raw down of Public Dividend Capital as cash support.
Proposal and/or key recommendation:	The Board is asked to review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive Director to undertake.

Purpose of the report (tick box to indicate)

Assurance	X	Approval	
Noting	X	Discussion	

Committee/Group at which the paper has been submitted:	This has been requested in response to Trust Chair / NED feedback from regulatory preparations

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:	No recommendations being made. Summary position document for 2022-23 and 2023-24
Resource implications:	None
Sustainability and /or Public and patient engagement considerations:	This is a summary paper which states current position on delivery against planned priorities
Integrated Impact assessment:	N/A

Legal and Regulatory implications:	N/A – this is not a recommendations paper	
Appendices:	Summary paper only – Patient First in Action (two year review)	
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:	Gavin MacDonald (Chief Delivery Officer) gavin.macdonald3@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance X	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Meeting of the Board of Directors in Public
Wednesday, 13 November 2024

Title of Report	Assurance report – People Committee 26 September 2024			**Agenda Item**	5.2
Author	Leon Hinton, Chief People Officer				
Committee Chair	Jenny Chong, Chair of Committee/NED				
Executive Summary	Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.				
Proposal and/or key recommendation:	Not applicable				
Purpose of the report (tick box to indicate)	Assurance	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	People Committee, 26 September 2024				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Leon Hinton, leon.hinton@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
5	1	x	

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

None		

Items/risks/issues for escalation

Issues and or Risks to note: None
Reflection: (1) papers are of high quality with good discussions; (2) risk registers to be reviewed for correct ownership; (3) policies are of high standard; (4) how do we measure that we are positively changing our culture; (5) we must ensure high-quality in all of our data sources and reporting.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for August 2024. The Committee were **ASSURED** by the report: • True North (Staff Engagement) – [6.65, 0.02 improvement, 0.28 below target] third successive increase; however, ranked score has worsened with the Trust remaining in the further quartile for staff engagement nationally; • Breakthrough (turnover) – [1.4%, 0.4% improvement, off target], met business rules six out of nine months, specific issues in relation to AHP turnover has been escalated to the HaCP, a staff facilities audit to be commissioned; • Staff appraisal – [89.2%, -0.3% deterioration, 0.8% off target] progress remains poor, particular focus for corporate areas through fortnightly escalations; • Vacancy rate – [6.9%, 0.9% improvement, on target];	Assurance

• Voluntary turnover – [8.8%, +0.1% deterioration, 0.8% off target] holding position, signification improvements forecast with recruitment pipeline for nursing and midwifery in particular; • Staff fill rates – a review is currently being undertaken in relation to CHPPD calculation methodology; • Sickness absence – [4.7%, -0.3% improvement, 0.7% off target] improvement to long-term and short-term sickness with a seasonal pattern matching the wider system. OH business case submitted to support meeting target and improve health and wellbeing of staff; • StatMan – [89.6%, +0.4% improvement, on target].	
2. Employee Relations case work learning The Committee **NOTED** the update in relation to the lessons learnt from the national Michelle Cox case and actions completed which have included: improvements to several HR policies; equality impact assessments of all key HR processes; cultural competency training for the ER team (2025); ethnicity monitoring at the key stages of HR processes; changes to the way we approach allegations of discrimination and harassment; senior HR/EDI support to protected characteristics colleagues through processes and wider support.	Not Applicable
3. People Strategy 2024-2027 implementation plan and status update The Committee **NOTED** the update on the People Strategy implementation plan, the detailed actions underway and informed that there were no immediate barriers to implementation. No new risks nor issues were raised. In the future, the Committee is to receive a status update report evidencing impact on agreed KPIs. Of the 42 activities, 40 were green rated (from 38) out of 42 activities. The Committee reviewed the four pillars of i) Becoming an employer of choice; ii) growing our talent; iii) keeping our people thriving at work; iv) delivering new ways of working.	Not Applicable
4. Board Assurance Framework (BAF) and Risk Register The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items 3d, 3e and 3f. No changes were made to the scoring. The Committee discussed the risk register and requested review of the risk associated with workforce growth. The Committee were **ASSURED** and **NOTED** the report.	Assurance
5. Policies for approval The Committee **APPROVED** the following policies following comment: • Reasonable adjustments and modified duties policy; • Disability and Health Passport; • Employing staff in reservice forces procedure; • Medical staff annual leave policy; • Job planning policy; • Fit and Proper Persons policy (post-meeting).	Not Applicable
6. Medical Education Report The Committee received the Medical Education report including an update on the annual priorities for the service, an update on the current NHS England Kent, Surrey, Sussex quality visits and GMC survey responses; current and future expansion of postgraduate doctors and KMMS student numbers The Committee were **ASSURED** by the report.	Assurance

7. **Health Care Worker Vaccination Campaign** The Committee received the plan for the 2024/25 vaccination campaigns to a 65% flu uptake target. The plan included the communication plans, resourcing and peer vaccinator controls. The Committee **APPROVED** the report.	Not Applicable
8. HR and OD Performance The Committee were **ASSURED** of HR and OD performance against workplan.	Partial Assurance
9. Anti-Bullying and Harassment Group Assurance report The Committee received the assurance reports covering the periods since the last committee. The Group's approach, following improvements in triangulation, has moved into divisional/local actions supported by the group. The Committee were **ASSURED** by the report.	Assurance
10. People Promise update The Committee **NOTED** an update in to the People Promise Exemplar programme with ten of the twelve focus areas on track, work will commence on the NHS England behavioural framework in October 2024.	Assurance
11. Workforce Planning and Controls The Committee received an outline of the workforce controls in place assessed against the ICB best practice controls. 18 of the 24 were assessed as green, two red (due for implementation) and four amber (assessing the effectiveness of the control). The Committee **APPROVED** the return to the ICB.	Assurance

Meeting of the Trust Board in Public
Wednesday, 13 November 2024

Title of Report	Finance Planning and Performance Committee Assurance Report – 30 October 2024	**Agenda Item**	5.3
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. Effectiveness Survey Questions are drafted and will be sent to Gary to approve. Survey will be uploaded to the in-house IT system GATHR. Reporting will come to March 2025 Committee ready for the new financial year. The Committee does have comparable data from 2023-24. The Committee **NOTED** the reports.	Significant Assurance
2. Risk Register The reports for Sustainability and Systems and Partnership were reviewed. The minutes detail some important changes. Committee asked for some housekeeping on the register, including; reduction of duplication, transfer some risks to issues, add commentary and approve early risks from June 2024. Jayne Black will discuss with Matt Capper. The Committee **NOTED** the reports.	Partial Assurance
3. Board Assurance Framework (BAF) The Committee asked that the governance around quantity and quality of papers and triangulation of information is reviewed. Review how the risk rating aligns with the relevant section on the Integrated Improvement Plan (IIP). Reporting must be accurate. Jayne Black will discuss with Matt Capper. The Committee were **ASSURED**.	Partial Assurance

4. Finance Report M6 – including Aged Debt Briefing The Trust reports a surplus of £10.9m in month 6 and a deficit of £3.2m year to date (YTD); this is adverse to plan by £1.9m. In-month the Trust has received £14.7m of deficit support funding and the control total has been adjusted accordingly; it has also received £0.5m of industrial action funding. The efficiency programme has under delivered by £0.6m against the YTD plan of £8.7m. The Committee asked for information around the non-NHS Debt and asked for alignment to understand current position, mitigations, risk size and what is happening at the task and finish group. The Committee **NOTED** the report, with some gaps in assurance.	Partial Assurance
5. Financial Recovery Integrated Improvement Plan Evidence The Trust has a target to reduce its monthly deficit by the end of 2024/25 to £1.0m-£1.5m, and in 2025/26 to reduce this further to a monthly breakeven by the end of the year; this breakeven would be expected to be sustained in 2026/27 and beyond. The Committee noted there is a significant amount of work necessary to have document ready for the December Board meeting. The Committee asked for the submission timeline to be reviewed and aligned for FPPC, Trust Board and ICB. The Committee **NOTED** the report	Partial Assurance
6. Reducing Waste Programme The latest position on both the waste reduction efficiencies, operational efficiencies and run-rate improvement opportunities. The Committee asked for this information to be included in the financial recovery plan. The Committee **NOTED** the report.	Partial Assurance
7. Activity Report The report outlined key activity variances from plan, the drivers and the constitutional standards performance. The governance process for Activity will report to the new Strategy, Planning and Performance Group. The Committee **NOTED** the report.	Assurance
8. Business Planning 2025/26 The Director of Planning and Performance presented the report. Divisions are focused on job planning. The Committee asked for a review of the timeline for papers and planning for FPPC and Board. Need a summary giving the essence of the Business Plan for 2024/26 at December FPPC. The Committee **NOTED** the report.	Assurance

9. DDaT Strategy Implementation - Finance and Investment Forecast The report presented the finance and investment forecast to deliver against the Strategy implementation plan. The Trust needs to align with the rest of Kent and Medway – this should be considered in the capital plan and also internal/external investment. The Committee **APPROVED** the report.	Assurance
10. Recovery Support Programme - Transition Report and Supporting Evidence In preparation for the transition out of the National Recovery Support Programme in December 2024, the report provided progress against the six transition criteria formally known as exit criteria. The report presented some remaining areas where the evidence is to be finalised. The Committee **APPROVED** the report and self-assessment.	Assurance
11. Capture and Counting Programme 2024/25 The report detailed how the programme has been given a target income of £1.5m in 2024/25. Projects have been identified to deliver this value. Two schemes have upgraded since submission of the report. The Committee asked for consideration around what funding and resources would be of benefit to the Capture and Counting Programme for 2024/25, to assist delivery. The Committee **NOTED** the report.	Assurance
12. Terms of Reference (TOR) The following TOR were considered and approved by the Committee: 1) Green Sustainability Strategic Group 2) Strategy, Planning and Performance Group The Committee **APPROVED** the TORs with minor amends	Significant Assurance
13. Strategies to Reduce Estates Maintenance Backlog The Committee report detailed the overall backlog position identified in the 6-facet survey and as reported for ERIC Returns for the Trusts built assets is estimated to be £119m Gross. Critical infrastructure risk, issues that are needing some level of urgent or major repairs are in the sum of £56,3m Gross. The Committee **NOTED** the report.	Assurance

	14. Medical Productivity This report provides an overview of current progress of the Medical Productivity corporate project including job planning, clinical efficiency, recruitment and retention, and rostering. The Committee **NOTED** the report.	Assurance
	15. Integrated Quality Performance Report (IQPR) The Committee **NOTED** the report.	Assurance
	16. ADDITIONAL REPORT UNDER AOB: <u>Pembroke Ward Fire Safety Works - Electrical Safety Issues</u> Contractors entered Pembroke Ward as planned 21 October 2024. The backlog condition was unknown prior to this date however issues were anticipated. With ceilings removed, a series of electrical issues have been identified which present significant fire safety risk to the ward and occupants. This report is an options analysis for the Committee to consider. The Committee **RATIFIED** the decision made by the Executive Team. There were no matters of any other business.	Significant Assurance

Proposal and/or key recommendation:	None other than business as usual.			
Purpose of the report (tick box to indicate)	**Assurance**	**X**	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	The papers were submitted to the Finance, Performance and Planning Committee – 30 October 2024, this assurance report is a reflection of that meeting.			

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

Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Corporate Risk Register and Board Assurance Framework items.
Resource implications:	Individual resource considerations are provided at the Finance, Planning and Performance Committee
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the Finance, Planning and Performance Committee
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Finance, Planning and Performance Committee
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Finance, Planning and Performance Committee
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information or any enquires relating to this paper please contact:	Paul Kimber Deputy Director of Finance paul.kimber1@nhs.net

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Finance Report – Month 6	**Agenda Item**	6.1
Author	Dan Thompson, Finance Business Partner Cleo Chella, Associate Director Income & Contracts Isla Fraser, Financial Controller Paul Kimber, Deputy Chief Finance Officer		
Lead Executive Director	Alan Davies, Chief Finance Officer		
Executive Summary	• The Trust reports a surplus of £10.9m in month 6 and a deficit of £3.2m year to date (YTD); this is adverse to plan by £1.9m. In-month the Trust has received £14.2m of deficit support funding and the control total has been adjusted accordingly; it has also received £0.5m of industrial action funding. • The efficiency programme has under delivered by £0.6m against the YTD plan of £8.7m. • The capital position is underspent as at month 6 due to the timing of schemes being delivered (principally CDC leases being signed). The CDC issues have now been resolved in principle but are expected to impact completion in 2024/25. The projects are under review to agree timescale/financial slippage into 2025/26. • Cash at the end of September was £5.2m. The deficit support funding referenced above (£25.4m for the full year) is cash-backed and as such we shall cease further draw down of Public Dividend Capital as cash support.		
Proposal and/or key recommendation:	The committee is asked to note this report.		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	✓	Discussion	
Committee/Group submitted: **Date of Submission:**	Meeting: FPPC Date: 30 October 2024 The Trust Executive have been briefed on the financial performance.			

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. Careful cash management.
Resource implications:	The report sets out the financial resources /performance / position of the Trust

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

Meeting of the Trust Board in Public
Wednesday, 13 November 2024

Title of Report	**Maternity Claims, Incidents and Complaints Triangulation Report – Q2 2024-2025**		**Agenda Item**	6.3a
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery Ellen Salmon, Maternity compliance manager			
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer			
Executive Summary	• The report reviewed the claims scorecard for 2013-2023 alongside incidents and complaints for 2023/24. This included a review by ethnicity of service users. • The report also reviewed all claims to identify if they were known to the Trust. • For Incidents reviewed at CRIG in 2024 – 14.8% of incidents related to service users from Black backgrounds – compared to 9% of the 2023/24 birth rate. (17% of ATAIN cases and 20% of Postpartum haemorrhage - PPH) • For Complaints from 2023/24 – 15% (3) of complaints received were from Asian families compared to 6% of birth rate. No complaints were received from black families. • For Claims – 45/49 claims were able to be identified and Asian families accounted for 17.5% of claims from 2013-2023. 0 claims received from black families. • 39/45 claims were known to the Trust prior to the claim being issued. • 62.5% of these were investigated beyond the initial datix report with 25% being SIs, 15% MNSIs and 10% Patient Safety Case Review (prior to the SI framework) Actions identified: • Undertake a case review of current PPH for black ethnicities to identify any themes/learning. • Undertake a case review of ATAIN babies for black ethnicities with fetal wellbeing midwives/NICU ATAIN leads to identify any themes/learning. • Undertake a review of complaints and other service user feedback, including CQC Picker, to see if there is a broader theme from Asian families raising concerns regarding communication and care. • Share the above at future audit meeting, once completed. • Continue to do a deep dive of claims quarterly with new scorecard once released.			
Proposal and/or key recommendation:	Trust Board reporting to meet requirements of CNST year 6			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Committee/Group submitted:	• Maternity and Neonatal Safety Champion Assurance Group - 4 October 2024			

Date of Submission:	• QAC 7 November 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	N/A				
Resource implications:	N/A				
Sustainability and /or Public and patient engagement considerations:	N/A				
Integrated Impact assessment:	Has the quality and equality assessment been undertaken? **Yes**				
Legal and Regulatory implications:	Compliance with CNST Year 6				
Appendices:	N/A				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: Alison.herron2@nhs.net				
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance				There are significant gaps in assurance or actions
	Partial Assurance				There are gaps in assurance
	Assurance	X			Assurance minor improvements needed.
	Significant Assurance				There are no gaps in assurance
	Not Applicable				No assurance required.

Meeting of the Trust Board in Public
Wednesday, 13 November 2024

Title of Report	Maternity CNST 10 Safety Actions Compliance Update Report	**Agenda Item**	6.3b
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery Ellen Salmon, Maternity CNST & Compliance Manager		
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer		
Executive Summary	• CNST Year 6 Published 02 April 2024 with reporting period ending 30 November and submission due 03 March 2025 • Anticipate declaring compliance with all 10 Safety Actions within the required reporting period. • Safety Action 8 currently off-track due to compliance figures <90% for some staff groups. This has been escalated appropriately and actions are in place to mitigate this risk. It is anticipated that >90% compliance will be achieved for all staff groups, with booked trajectories for PROMPT (emergency skills training) and Fetal monitoring (CTG) training for obstetric medical teams to achieve >90% by 30 November 2024. • Anaesthetic colleagues significantly below 90% target for PROMPT at 74%, however education lead working with anaesthetic lead to book dates. • Drop in NBLS (New-born Life Support training) compliance in September for midwives (83%), MSWs (72.3%) and ANNP (67%) – all matrons and senior sisters contacted to support staff attendance. • Maternity compliance manager to closely monitor all of the above with education leads and escalate to DOM at earliest opportunity if compliance at risk. • Monthly reporting via MNSCAG and reporting to every Public Trust Board until submission. • Review and presentation date agreed with LMNS, 3 December 2024, to discuss and agree key requirements, prior to submission of compliance to MFT Trust Board in January 2025.		
Proposal and/or key recommendation:	Direct reporting to Trust Board from MNSCAG as per Corporate Governance Structure		

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

Committee/Group submitted: **Date of Submission:**	• Maternity and Neonatal Safety Champion Assurance Group – 04 October 2024 • QAC - 07 November 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People)	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: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	N/A				
Resource implications:	N/A				
Sustainability and /or Public and patient engagement considerations:	N/A				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	Compliance with CNST Year 6				
Appendices:	N/A				
Freedom of Information (FOI) status:	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.

Meeting of Trust Board
Wednesday, 13 November 2024

Title of Report	Perinatal Culture and Leadership Programme and SCORE Survey Report		**Agenda Item**	6.3c
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery			
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Office			
Executive Summary	• The national network of Patient Safety Collaboratives (PSCs) have been commissioned to offer support to sustainably support the leadership capacity, capability and improvement relating to safety culture within maternity and neonatal units and as part of local systems, building on the progress made during Phases 1-3 of the PCLP. • The quad will continue working closely with the PSCs to ensure that any ongoing support aligns with the principles of the PCLP and to identify any potential challenges or opportunities. • New QUAD has been shared with PSC and preliminary meeting held. Follow up face to face meeting to be arranged. • SCORE survey to be repeated in Autumn 2024, to include all of Women's, Children, Young People division. • 13 actions completed, 3 on track. 2 actions overdue and 1 action off track			
Proposal and/or key recommendation:	Trust Board reporting to meet requirements of CNST year 6			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Committee/Group submitted: **Date of Submission:**	• Maternity and Neonatal Safety Champion Assurance Group - 04 October 2024 • QAC - 07 November 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report			

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

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

Identified Risks, issues and mitigations:	N/A
Resource implications:	N/A

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	Compliance with CNST Year 6		
Appendices:	N/A		
Freedom of Information (FOI) status:	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.

Meeting of the Trust Board in Public
Wednesday, 13 November 2024

Title of Report	**Perinatal Quality Surveillance Quarterly Report, Q2 2024/25**	**Agenda Item**	6.3d
Author	Alison Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery		
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer		
Executive Summary	➢ CNST Year 6 continues the expectation that Trust Boards will receive quarterly reports on Perinatal Quality in line with the minimum data set of the Perinatal Quality Surveillance Model (PQSM). (Safety Action 1 and Safety Action 9) ➢ Monthly updates aligned with the minimum dataset of the PQSM are submitted monthly to QPSCC and QAC (within IQPR) along with a detailed report to every Trust Board. ➢ This report provides quarterly oversight for Q2 2024/25 and includes the following: ➢ Incidents - Increase in number of incidents reported in maternity this quarter = 454 (353 in Q1) with 4 incidents reported as Moderate Harm or above and NICU 42 reported (47 in Q1). ➢ 4 incidents moderate harm or above: ➢ Maternal death (MNSI) ➢ Unexpected Neonatal Admission, therapeutically cooled (MNSI) ➢ Intrauterine Death 38+6 following RFM (AAR) ➢ Neonatal Femur fracture at ELCS for breech presentation (ATAIN Review) ➢ Investigations – 3 MNSI investigations closed. 40 ATAIN (Avoiding term admissions to Neonatal unit) reviews, 39 CRIG (Clinical Incident review group) reviews, 1 AAR (After Action review) ➢ PMRT - 8 MBRRACE reportable cases in Q2. 38 actions open relating to PMRT - Communication and documentation being the most common themes. ➢ Risks - Currently 11 risks in maternity and 2 in Neonatology, with highest risk of 20 related to midwifery workforce challenges and 1 scored 15 relating to MIS. ➢ Workforce/Staffing - Midwifery staffing remains a challenge with contractual vacancy numbers remaining high across the quarter, plus high levels of maternity leave. Positive workforce retention rates, in particular with MSW's who were previously at risk group. Trajectory for midwives has been refreshed with a view to reach full establishment/rostered in post by end of May 2025. 3 RN's working on the postnatal ward are commencing the RM conversion course in September 24 ➢ Continuous service user feedback and coproduction work supported by MNVP. Positive FFT response rate 71% with a 95% recommend rate for month of September. ➢ Positive staff feedback within FFT free text and 10 MSW's received the highly regarded National CMO recognition awards and badges.		

Proposal and/or key recommendation:	Direct reporting to Trust Board from MNSCAG as per Corporate Governance Structure			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
Committee/Group submitted: **Date of Submission:**	• Maternity and Neonatal Safety Champion Assurance Group – 04 October 2024 • QAC 07 November 2024 - Reports noted and included as appendices within MNSCAG Assurance and Escalation Report			

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

Identified Risks, issues and mitigations:	N/A
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	Compliance with CNST Year 6
Appendices:	N/A
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: Alison.herron2@nhs.net

Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Board of Directors in Public
Wednesday, 13 November 2024

Title of Report	Kent and Medway NHS Strategy 2024/25 – 2029/30	**Agenda Item**	6.4
Author	Rachel Hewett, Director of System Strategy - ICB Rachel Otley, Director of System Strategy - ICB Matt Tee, Director of Communications and Engagement - ICB Natalie Davies, Chief of Staff - ICB		
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer		
Executive Summary	**Introduction** NHS provider organisations, primary care and NHS Kent and Medway have come together to produce our NHS Strategy 2024/25-2029/30. We know we can achieve more collectively, rather than individually, to meet the health needs of our population and this strategy outlines our ambition and vision for NHS services of the future. It does not replace our organisational strategies, nor does it seek to replicate the work of provider collaboratives or health and care partnerships. It recognises the challenges we can best address together and, unlike our Integrated Care Strategy, focuses only on healthcare services. This paper outlines the approach taken to developing the strategy and addresses key questions about its purpose. The strategy document describes the shared ambition, our strategic themes, goals and how we will work together in delivery to improve the health outcomes of our population. **Development** The NHS strategy development has taken a co-production approach. Executives from across NHS provider trusts and primary care leads have participated in a number of workshops over the last six months. These workshops agreed the continuous improvement approach, defined a shared ambition and then shared and discussed data to determine the focus of the strategy. Data came from a wide range of sources, for example PowerBI, our organisational reporting, Joint Strategic Needs Assessments, staff surveys, the GP patient survey, Office for Health Improvement and Disparities, Office of National Statistics, Fingertips, Public Health England, HES, Kent and Medway Cancer Alliance, and the Quality Outcomes Framework reporting. It compared Kent and Medway against other systems in the South East and nationally as well as within Kent and Medway. The critical success factors for delivery have also been a key topic of conversation throughout the strategy development. Initially an executive project group met weekly, supported by a weekly working group of continuous improvement experts from each of the organisations. These groups co-designed, delivered and facilitated the early workshops. Subsequently the Chief Executives as Senior Responsible Officers (SROs) for each of the themes and enablers, supported by a group of executives, further developed the key targets and early thinking on implementation plans. Some of the key questions that we addressed during the development phase are included as Appendix 1. **Continuous Improvement** A continuous improvement approach has been adopted for the development of the strategy. This aligns with NHS Impact and the journey all NHS trusts are		

	on in developing their improvement cultures. Whilst there are some differences in approaches between the organisations, we have sought to define a common language during our workshops and to utilise a common A3 methodology in determining our targets and delivery plans. The use of improvement methodology to a system strategy has been challenging and has required some flexibility in application. We have sought to apply the principles of the methodology to the work undertaken and this is work that will continue over the next phase. **The NHS Strategy** The NHS Strategy is attached as Appendix 2, with more detailed A3s in Appendix 3. These A3s describe the thinking and collective agreement to this point. It is recognised that the breakthrough objectives in particular will need further refinement as we move forward. The strategy explains why we need to work differently together, focusing on a 'left shift' to prevention and primary and community care. It defines the shared ambition for the NHS in Kent and Medway, confirms the adoption of the NHS values and sets our areas of focus, the strategic themes. For each theme it outlines the three to five-year targets and then initial 12 to 18-month breakthrough objectives. Since the improvement approach is an iterative process, these breakthrough objectives are still subject to development but we are committed to the overarching aims. Finally, the strategy describes how we will work together, focusing not just on the delivery architecture but also the culture and approach to continuous improvement.
Proposal and/or key recommendation:	The Board is asked to: • Note the co-production approach to the development and delivery of NHS Strategy. • Approve the NHS Strategy endorsing the direction of travel as described in the A3s.

Purpose of the report (tick box to indicate)	Assurance		**Approval**	**X**
	Noting	**X**	Discussion	
State reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	**Commercially Sensitive: X**	Exceptional Circumstances:

Committee/Group at which the paper has been submitted:	Strategy, Planning and Performance Group on 14 October 2024

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

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	**Well-Led: X**

Identified Risks, issues and mitigations:	Risks are covered in the paper

	Key risk is operational / delivery pressures impacting ability to allocate sufficient time and resource to deliver the strategy resulting in unsustainable services, poorer outcomes and an inability to meet future demand. Mitigated by CEO and exec leadership and delivery architecture embedded in existing programmes.	
Resource implications:	No new resources requested. Delivery plan to be developed.	
Sustainability and /or Public and patient engagement considerations:	Aligns with sustainability and green plan, recognizing that these also contribute to patient outcomes, sustainable services, an engaged workforce and financial sustainability. Short engagement survey completed during development stages. Further engagement to be completed as delivery plans are developed.	
Integrated Impact assessment:	Detailed in appendix 4	
Legal and Regulatory implications:	The strategy will assist the NHS in Kent and Medway meeting constitutional standards in the future.	
Appendices:	Appendix 1: Development FAQs Appendix 2: Kent and Medway NHS Strategy 2024/25 – 2029/30 Appendix 3: Strategic theme A3s and enabler proposals Appendix 4: Equality Impact Assessment	
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:	Gavin MacDonald, Chief Delivery Officer gavin.macdonald3@nhs.net Rachel Hewett, Director of System Strategy r.hewett1@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance **X**	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Strategy Roadmap		**Agenda Item**	6.5
Author	Maya Guthrie, Project Manager - Strategy and Partnerships			
Lead Executive Director	Matt Capper, Director of Strategy and Partnerships/Company Secretary			
Executive Summary	Please note updated Strategy Roadmap.			
Proposal and/or key recommendation:	For discussion please.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting		**Discussion**	**X**
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) X**	**Priority 3: (Patients) X**	**Priority 4: (Quality) X**	**Priority 5: (Systems) X**
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	**Effective: X**	**Caring: X**	**Responsive: X**	**Well-Led: X**

Identified Risks, issues and mitigations:	n/a
Resource implications:	n/a
Sustainability and /or Public and patient engagement considerations:	n/a
Integrated Impact assessment:	n/a
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		
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
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Strategy Review

Strategy & Partnerships

November 2024

Patient FIRST

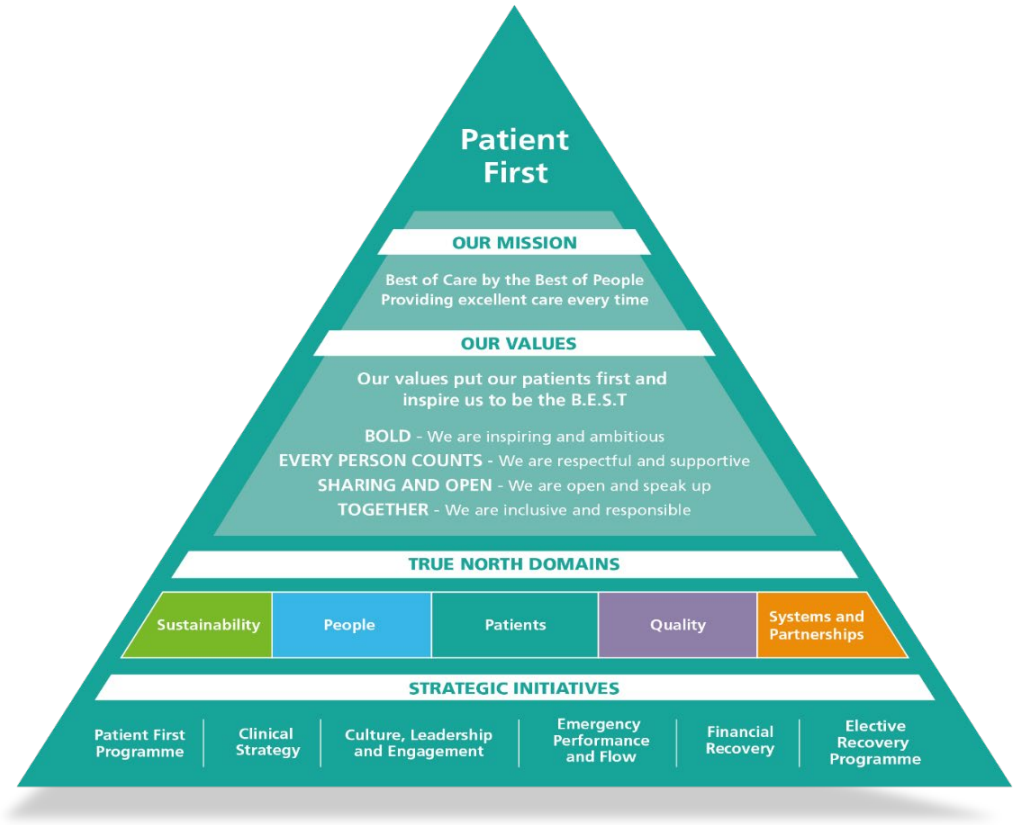
Patient First

Our overarching Trust strategy that highlights our core values of putting the patient first every time.

At Medway NHS Foundation Trust we are dedicated to putting our Patients First, at the heart of everything we do. Every time any of us interact with our patients, their families and carers, we should ensure our interactions are prompt and positive.

Our strategies will be firmly embedded in the Patient First improvement system, which confirms our commitment to ensuring that patient care and experience are our top priority. We do this by focusing on continual improvement, delivering the best of care by the best of people. All teams are central to delivering improvements and achieving our strategic direction, known as our True North and the delivery of our breakthrough objectives.

The Patient First Strategy has been published on Q-Pulse and can be found here. The refresh is currently underway.



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Roadmap

Patient FIRST

Approved Strategies

NHS Medway NHS Foundation Trust

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

Strategies in Progress

NHS Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '24	Feb '24	March '24	April '24	May '24	June '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24
Information Governance				Development of Strategy							Board Nov-24	
Infection Prevention and Control				Development of Strategy							Board Nov-24	
Patient Experience Refresh				Development of Strategy							Board Nov-24	
Freedom to Speak Up								Development of Strategy				Board Dec-24
Patient First Refresh								Development of Strategy				Board Dec-24
Estates and Facilities									Development of Strategy			
Green Plan Refresh										Development of Strategy		
Nursing, Midwifery and Allied Health Professionals										On Hold		

Approved Implementation Plans

NHS Medway NHS Foundation Trust

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

Implementation Plans in Progress

Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '24	Feb '24	March '24	April '24	May '24	June '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24
Information Governance								Development			Board Nov-24	
Freedom to Speak Up										Development		Board Dec-24

On Hold

Discussions are being had regarding the timeline to align with national priorities around the Nursing, Midwifery and Allied Health Professionals (NMAHP) strategy.

Accessibility

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

Strategy Template

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

Strategy Summaries

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

In Progress

In Progress

- **Clinical Strategy Implementation Plan**: The Strategy and Partnerships team have reached out to senior colleagues to capture the next required quarterly updates on their “Priorities and Ambitions”. This work will happen virtually and also face to face. This will be presented at November 2024 Trust Management Board.

- **Patient First Strategy Refresh:** The Strategy team are working closely with the Transformation Team to support the refresh, which has included composing and carrying out a questionnaire with staff to inform it, as well as attending key meetings with Transformation on the next key steps.

- **Trust Green Plan:** A key outcome of this 2021-2026 strategy was to produce a Transport Plan expanding on details committed to in the Green Plan. Estates and Facilities colleagues and the Strategy team are working on aligning this to existing strategies ready for approval. We are due to review and refresh the Green Plan in the next few months.

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

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	Inpatient Survey Results, CPES survey results and actions			**Agenda Item**	6.6
Author	Nikki Lewis, Associate Director of Patient Experience				
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Officer				
Executive Summary	Report outlines divisional actions based on the recent findings from the adult in-patient and cancer patient CQC surveys.				
Proposal and/or key recommendation:	Nil				
Purpose of the report (tick box to indicate)	Assurance		Approval		
	Noting	✓	Discussion	✓	
Committee/Group at which the paper has been submitted:	N/A				
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:	N/A				
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:	Systems and Partnerships - Board Assurance Framework				
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.

CQC Surveys

CPES and Adult In-Patient Action Plans

September 2024

Nikki Lewis, Associate Director of Patient Experience

NHS
Medway
NHS Foundation Trust

Cancer Experience Survey 2024

Cancer Patient Experience Survey (CPES)

Headlines

- The survey was undertaken by Picker on behalf of NHS England and it was overseen by a national Cancer Patient Experience Advisory Group.
- The survey was commissioned and managed by NHS England. The survey provider, Picker, is responsible for designing, running and analysing the survey.
- The 2023 survey involved 132 NHS Trusts. Out of 120k+ people, 63,428 people responded to the survey, yielding a national response rate of 52%, a 46% response rate for MFT

- The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2023.
- The fieldwork for the survey was undertaken between November 2023 and February 2024.
- The survey asks the patient questions across their whole journey, diagnosis, treatment and in patient stay

CPES – Demographics

Overall response rate

445 patients responded out of a total of 965 patients, resulting in a response rate of 46%.

	Sample size	Adjusted sample	Completed	Response rate
Overall response rate	1,021	965	445	46%
National	129,231	121,121	63,438	52%

Respondents by tumour group

	Number of respondents
Brain / CNS	0
Breast	111
Colorectal / LGT	45
Gynaecological	*
Haematological	52
Head and neck	9
Lung	33
Prostate	60
Sarcoma	0
Skin	0
Upper gastro	*
Urological	74
Other	53
Total	**445**

Respondents by survey type

	Number of respondents
Paper	362
Online	83
Phone	0
Translation service	0
Total	**445**

Respondents by ethnicity

	Number of respondents
White	
English / Welsh / Scottish / Northern Irish / British	367
Irish	8
Gypsy or Irish Traveller	*
Roma	*
Any other White background	7
Mixed / Multiple Ethnic Groups	
White and Black Caribbean	*
White and Black African	*
White and Asian	*
Any other Mixed / multiple ethnic background	*
Asian or Asian British	
Indian	*
Pakistani	*
Bangladeshi	*
Chinese	*
Any other Asian background	*
Black / African / Caribbean / Black British	
African	8
Caribbean	*
Any other Black / African / Caribbean background	*
Other Ethnicity	
Arab	*
Any other ethnic group	*
Not given	
Not given	40
Total	**445**

*indicates the count is not shown due to suppression

CPES – Scores

NHS Medway NHS Foundation Trust

Most Improved Scores

No	Question	2023 score	2022 score	2021 score	National score
Q12	Patient was told they could have a family member or carer or friend with them when told diagnosis	**81%**	**73%**	**64%**	**81%**
Q32	Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	**65%**	**60%**	**51%**	**70%**
Q43	Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	**80%**	**71%**	**66%**	**78%**

Benchmarked Score against national and previous years

YOUR OVERALL NHS CARE	Unadjusted scores						Case mix adjusted scores			National score
	2022 n	2022 score	2023 n	2023 score	Change 2022-2023	Change overall	2023 score	Lower expected range	Upper expected range	
Q56. The whole care team worked well together	431	86%	414	87%			87%	87%	93%	90%
Q57. Administration of care was very good or good	458	84%	431	83%			84%	83%	91%	87%
Q58. Cancer research opportunities were discussed with patient	275	33%	239	30%		▼	31%	34%	56%	45%
Q59. Patient's average rating of care scored from very poor to very good	443	8.7	423	8.7			8.7	8.7	9.1	8.9

Areas of improvement and focus

	Question	2023 Score	2022 score	2021 score	National score	Action / Improvement	Owner
Q21	Patient was definitely involved as much as they wanted to be in decisions about their treatment	75%	75%	77%	80%	To implement the ACCEND framework across all clinical areas to ensure nursing, AHP's and junior medical staff are provided with the relevant core clinical skills and knowledge to deliver high quality services to people affected by cancer.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q22	Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	78%	77%	70%	83%	To ensure that all communication clearly recommends that patients bring an accompanying family member or carer to appointments to help share the information.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q24	Patient was definitely able to have a discussion about their needs or concerns prior to treatment	67%	65%	70%	72%	Ensure all CNS Teams undertake an initial HNA and create a care plan to be followed and updated throughout their treatment pathway.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q34	Patient was always able to get help from ward staff when needed	66%	68%	75%	73%	To introduce cancer link nurses in the general wards with access to specialist advice and resources.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q35	Patient was always able to discuss worries and fears with hospital staff	53%	59%	66%	65%	To introduce cancer link nurses in the general wards with access to specialist advice and resources. To ensure site specific and AOS CNS teams undertake ward visits for patients admitted to hospital to ensure continuity of care.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q39	Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	73%	68%	70%	79%	Improvement in score from last year following introduction of Band 4 CSW from Social work team visiting GDU daily. Macmillan Information hub staffed for patients, family and carers attending the unit. Continue to encourage staff to utilise the Macmillan Information Hub and Quiet room as required to enable privacy for conversations.	Macmillan Lead Cancer Nurse & Patient Experience Team

Areas of improvement and focus

	Question	2023 Score	2022 score	2021 score	National score	Action / Improvement	Owner
Q41.2	Beforehand patient completely had enough understandable information about chemotherapy	79%	83%	83%	86%	Full review of patient information literature and accessible information. Regular monitoring of patient pre-chemotherapy assessments to ensure consistent approach to provision of education and information.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q42.2	Patient completely had enough understandable information about their response to chemotherapy	74%	-	-	81%	Ensure information is available to meet the needs of all patients including those whose primary language is not English, and those with neuro diverse or hidden disabilities.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q42.5	Patient completely had enough understandable information about their response to immunotherapy	67%	74%	-	81%	All patients on immunotherapy are now provided with alert information relating to their specific treatment. Education and training needs to be provided to all nursing staff across the cancer units, wards, ED and SDEC on the effects of immunotherapy treatment and cancer.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q48	Patient was definitely able to discuss options for managing the impact of any long-term side effects	44%	50%	50%	55%	All patients to have an end of treatment summary which will provide information and signposting for management of long term side effects. Encourage CNS site specific teams to hold information/education sessions for patients on how to manage long term psychological and physical side effects.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q55	Patient was given enough information about the possibility and signs of cancer coming back or spreading	49%	57%	56%	64%	All patients to have an end of treatment summary which will provide information and signposting for management of long term side effects. To ensure all patients are aware of the PIFU pathway, including identifying red flag symptoms for referral back into the service.	Macmillan Lead Cancer Nurse & Patient Experience Team
Q58	Cancer research opportunities were discussed with the Patient	30%	33%	44%	45%	Liaise with research teams across KMCA to ensure up to date research studies are available for discussion at MDT and with patients.	Macmillan Lead Cancer Nurse & Patient Experience Team

Adult In-Patient Survey 2024

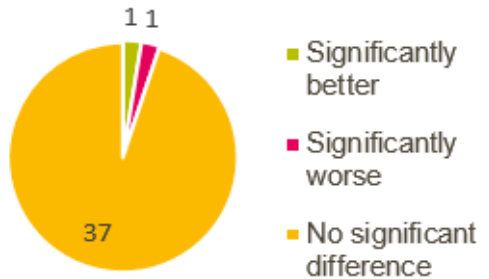
Adult Inpatient Survey

Headlines

- The Adult inpatient survey fieldwork was undertaken in late 2023.
- Patients are asked 50 questions in relation to their admission, stay, staff and discharge
- Medway NHS Foundation Trust's response rate was 38%
- The majority of respondents where white British and over the age of 66

1250	1170	38%	43%	35%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (445)	Average response rate for similar organisations	Your previous response rate

74% Q49. Rated overall experience as 7/10 or more	Historical comparison*
94% Q48. Treated with respect and dignity overall	
96% Q18. Had confidence and trust in the doctors	



Comparison with average*

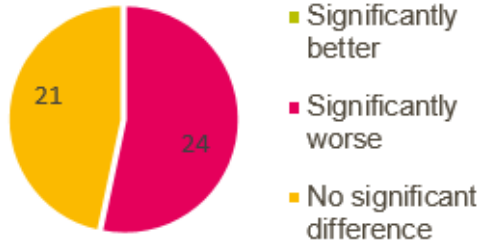
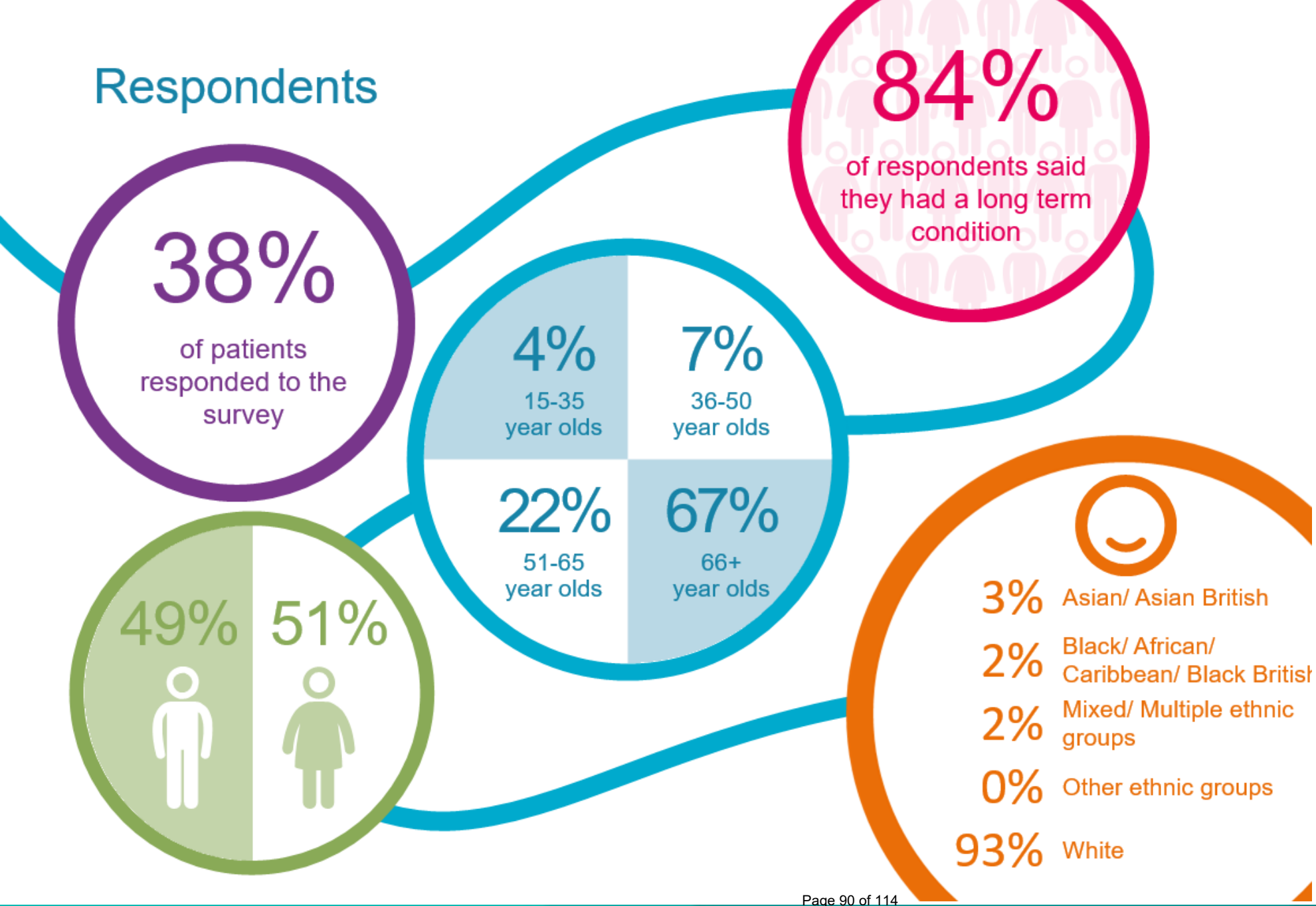


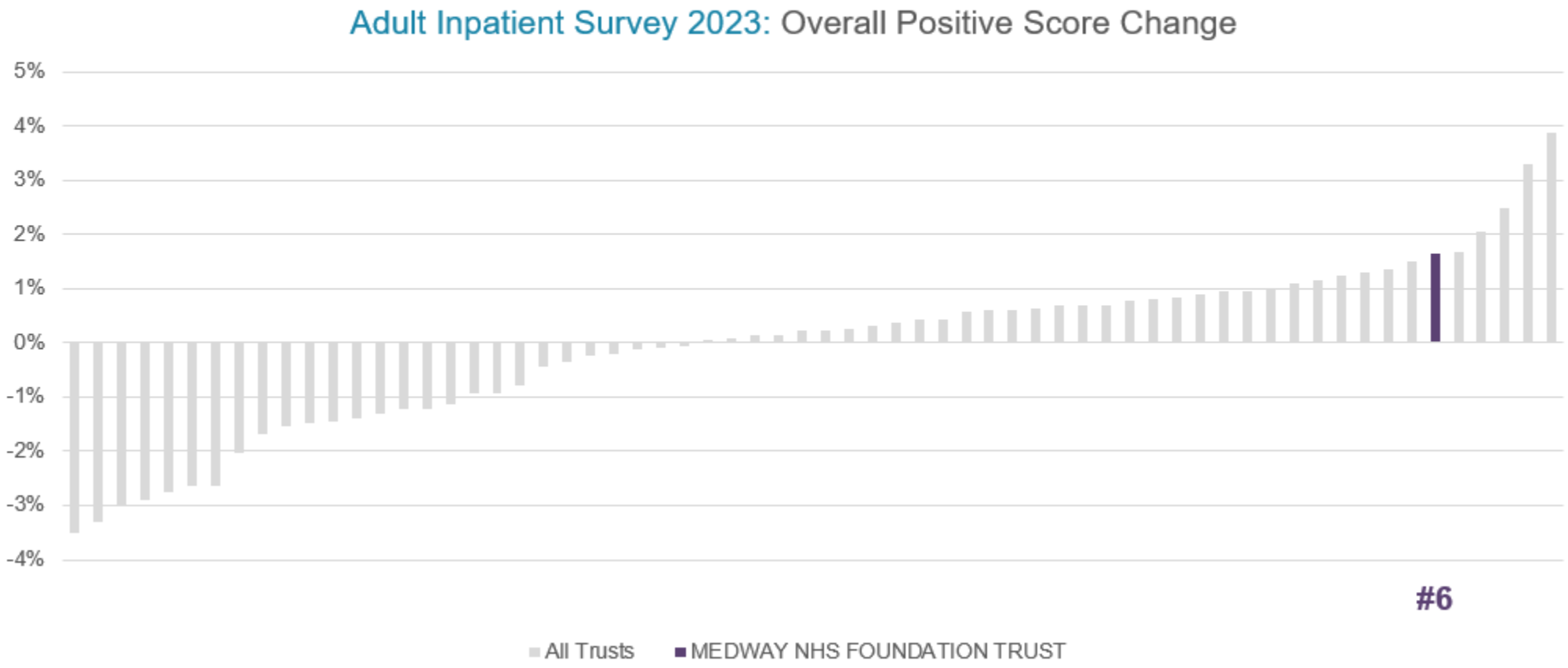
*Chart shows the number of questions that are better, worse, or show no significant difference

Respondents



League Table: historic positive score

The historical league table shows how your overall positive score change from the previous survey, and how this change compares to other organisations who ran the Adult Inpatient Survey 2023 with Picker.



Adult survey – scores

Most improved scores

No	Question	2023 score	2022 score	2021 score	National score
Q8	Staff explained reasons for changing wards at night	75.3%	66.2%	77.4%	80.9%
Q13	Hospital food was very or fairly good	68%	61.6%	63.6%	68.4%
Q14	Got enough help from staff to eat meals	80.2%	73.3%	80.6%	83.3%
Q49	Rated overall experience as 7/10 or more	74.0%	70.0%	71.7%	82.9%
Q50	Asked to give views on quality of care during stay	38.6%	6.4%	6.0%	35.1%

Bottom 4 scores

No	Question	2023 score	2022 score	2021 score	National score
Q8	Staff explained reasons for changing wards at night	75.3%	66.2%	77.4%	80.9%
Q2	Did not mind waiting as long as did for admission	59.6%	67.3%	68.5%	58.3%
Q37	Staff discussed need for additional equipment or home adaptation after discharge	80.3%	77.1%	82.7%	81.4%
Q46	Got enough support from health or social care professionals after discharge	79.6%	77.3%	72.7%	77.5%

Medicine and Emergency Care Division;
Actions

Areas of improvement and focus

	Question	%	Actions for improvement *i.e. in December 2023 we developed a leaflet to provide patients information to explain why they were waiting*
Q5	Did not have to wait too long to get to a bed on a ward	49%	There is a Trust wide flow and discharge Corporate plan in place being led by the Executive team
Q23	Always or sometimes enough nurses on duty	78%	Safer Staffing reviews have taken place for all wards and an establishment review will take place after the 2nd round of reviews which is commencing in October 2024
Q31	Existing individual needs taken into account	76%	Individualised care plans will be developed to ensure individual needs are taken into account
Q43	Staff told patient who to contact if worried after discharge	47%	Local contact details will be displayed on all wards with key contacts for patients should they have enquiries after discharge
Q50	Asked to give views on quality of care during stay	27%	There is a Trust wide True North objective in place and focus will remain on obtaining feedback via the Friends and Family Test (FFT)

Areas of improvement and focus

	Question	Actions for improvement *i.e. in December 2023 we developed a leaflet to provide patients information to explain why they were waiting*
Q40	Leaving hospital: Staff telling patients who to contact if worried about condition/treatment after leaving hospital	• There are plans to implement a Divisional structure where patients can contact identified staff should they have concerns after leaving hospital • Posters to be displayed on each ward outlining this information
Q5	Wait to get a bed: The wait to get a bed on a ward after arrival	• Continue to implement the Trust wide corporate project on Flow and Discharge
Q39	Leaving hospital: Patients being given information about what they should / should not do after they leave hospital	• Review and further develop an information booklet for discharge from hospital • Review individual/condition specific discharge leaflets for key clinical conditions • Review accessibility of information/signposting on wards
Q27	Talking about worries and fears: Patients feeling able to talk to staff about their worries and fears	• Work with staff in all areas to continue to engage with patients and discuss worries and fears • Signpost patients to the Call for Concern numbers
Q49	Overall experience: The patient's overall experience while in hospital	• Continue to focus of feedback from FFT and local ward action plans from feedback obtained

Next steps

Actions	Owner & Estimated Completion date/
Review and further develop the discharge from hospital leaflet	Heads of Nursing and Matrons December 2024
Review condition specific information held on the wards	Ward managers and Matrons December 2024
Develop a process for patients to be able to contact named individuals/roles to contact if they have concerns after leaving hospital	Heads of Nursing and Matrons November 2024

Surgery and Anaesthetics Division; Actions

Areas of improvement and focus

	Question	%	Actions for improvement *i.e. in December 2023 we developed a leaflet to provide patients information to explain why they were waiting*
Q5	Did not have to wait too long to get to a bed on a ward	50%	Making sure all patients are on teletracking, use of discharge lounge, discharge planning, board rounds attended by MDT, discharge facilitator in post to support timely discharge. Dedicated hip fracture ward which strives to keep a red bed at all times, second trauma and orthopaedic ward supporting the specialty, dedicated ring fenced elective orthopaedic elective inpatient and day surgery service.
Q23	Always or sometimes enough nurses on duty	81%	Safe staffing reviews undertaken every 6 months, matron/ward manager oversees staffing daily, a weekend and night plan sent to Site team, senior nurse cover weekends for staffing oversight. Significant reduction in vacancies over the last 12 months.
Q29	Staff helped control pain	89%	Acute pain service available Monday to Friday, out of hours anaesthetic cover to support, rolling programme of staff attending acute pain study day, daily review of patient feedback, pain scoring form is part of patient observations of physical parameters.
Q35	Felt involved in decisions about discharge from hospital	57%	Daily ward rounds by surgical teams, MDT involvement in board rounds.
Q36	Staff involved family or carers in discussions about leaving the hospital	45%	Family or carer are actively encouraged to speak to ward teams, clear sign posting for ‘who are we’ and ‘don’t take your troubles home’ encouraging visitors to seek information regarding their loved ones.

Areas of improvement and focus

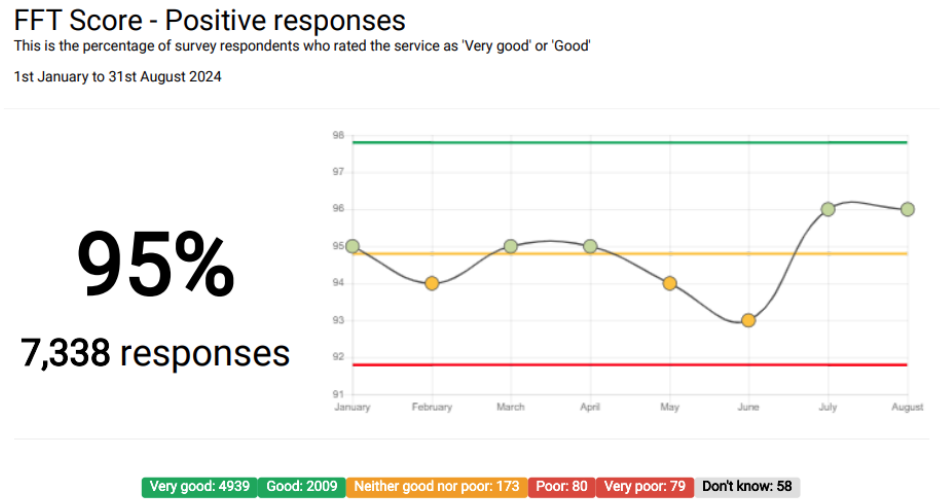
	Question	%	Actions for improvement *i.e. in December 2023 we developed a leaflet to provide patients information to explain why they were waiting*
Q10	Got enough help from staff to wash or keep clean	78%	Fundamentals of care, matron rounding, ward manager daily rounds, patient feedback, wards stock patient hygiene essentials
Q24	Staff did not contradict each other about care and treatment	55%	Specialty wards in place reducing the number of teams physically on the ward enabling nursing staff to attend ward round, FFT feedback re: communication regularly reviewed.
Q28	Given enough privacy when being examined or treated	97%	Dignity and privacy curtains in place, chaperones offered in SAU, GAU or as required
Q40	Understood information about what they should or should not do after leaving hospital	92%	Discharge advice is provided on the EDN including medicines instructions/advice, wound care and any important information.
Q38	Given enough notice about when discharge would be	78%	MDT board round well attended discussing often complex discharges and planning, large number of medically fit patients often awaiting pathway 1, 2 or 3 which become available at short notice.

Where Patient Experience could improve overall

Question	Actions for improvement *i.e. in December 2023 we developed a leaflet to provide patients information to explain why they were waiting*
Leaving hospital: Staff telling patients who to contact if worried about condition/treatment after leaving hospital	Follow up call in place for all elective patients from 24 hours after discharge, SAU offer a 72 hour re-attendance for patients if needed, Day Surgery have an out of hours elective phone for patients to call for advice.
Wait to get a bed: The wait to get a bed on a ward after arrival	Making sure all patients are on teletracking, use of discharge lounge, discharge planning, board rounds attended by MDT, discharge facilitator in post to support timely discharge.
Leaving hospital: Patients being given information about what they should / should not do after they leave hospital	Discharge advice is provided on the EDN including medicines instructions/advice, wound care and any important information.
Talking about worries and fears: Patients feeling able to talk to staff about their worries and fears	'Don't take your troubles with you' posters visible on the ward, matrons complete weekly documented bed by bed reports, ward managers complete daily bed by bed review, pastoral support available by chaplaincy team.
Overall experience: The patient's overall experience while in hospital	Friends and family feedback reviewed daily and discussed at divisional safety huddle and at daily ward huddles.

Next Steps;

Actions	Owner & Estimated Completion date/
'You said, we did' poster to be displayed in ward FFT boards to be updated monthly	Ward managers and matrons Monthly update
Patient information poster in bays explaining pain management	Ward managers 1st October 2024 to have posters up in all bays
Display 72 hour re-attendance poster in waiting rooms	Ward managers September 2024
'Don't take your troubles with you' poster to be displayed on all wards	Ward managers 30th September 2024

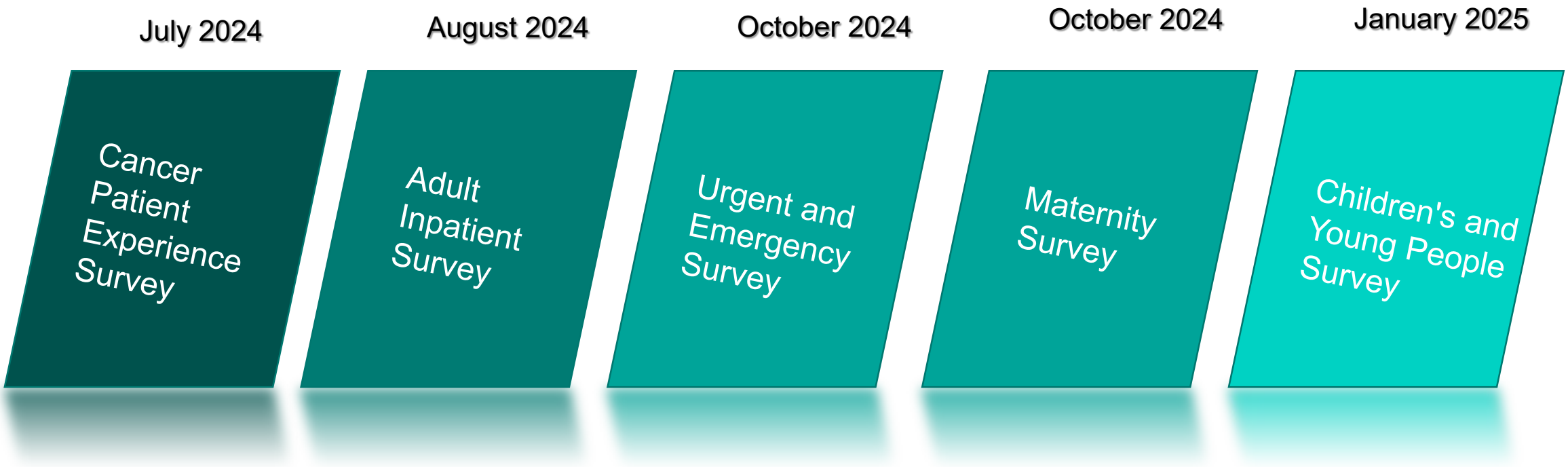


Corporate Nursing Team - Next steps

- As an organisation we have a responsibility to ensure the respondents to the CQC survey are representative of the population we serve.
- The field work for the survey is completed by Picker on behalf of MFT. Therefore, there is a need to promote the survey internally and Picker's approach to promoting this work
- The Head of Patient Experience alongside the Engagement team will lead on expanding the awareness of promoting this survey during the times of sampling.

- The Associate Director of Patient Experience has commenced a review of the services that Picker provide in comparison to companies who provide a similar service to identify any areas of improvement.
- The Associate Director of Patient Experience is working with the heads of service for patient experience and engagement at DGT and EKHUFT to focus on a system approach to issues that patients have raised to compare findings.
- With the findings of the system led approach, to link back into the ICB to improve services overall.

Surveys – publication dates



- MFT commission Picker to complete the field work and analysis, except the CPES survey
- Outcomes are sent to us ahead of the publication date under embargo, except the CPES survey
- NHSE lead on the CPES survey as opposed to the provider organisation

Meeting of the Trust Board
Wednesday, 13 November 2024

Title of Report	**Medical Education - Annual Report 2024**	**Agenda Item**	6.7
Author	Dr Janette Cansick, Director of Medical Education – stepped down Dr Ashike Choudhury, Director of Medical Education – September 2024 Carol Atkins, Head of Medical Education Services June Mossop-Toms, Medical Education Manager		
Lead Executive Director	Alison Davis, Chief Medical Officer		
Executive Summary	To inform/advise the Board of: 1. Introduction and the structure of Medical Education 2. Changes in Trainee Establishment including National Workforce Expansion and Redistribution Programmes 3. Finance 4. Impact of Industrial Action 5. Update on Quality Visit action plans 6. General Medical Council (GMC) 2024 surveys 7. Simulation Report 8. Undergraduate Report 9. Library Report MFT has one Director of Medical Education (DME) supported by one Deputy Director of Medical Education, Head of Medical Education Services and Medical Education Manager to oversee medical training, with educational leads within different training programmes and specialties to oversee localised delivery. Additionally the Director of Undergraduate Medical Education (DUME) oversees the delivery of undergraduate education and training, under the leadership of the DME. The DME is accountable to the Trust Chief Medical Officer and NHSE Workforce Training and Education (WTE) Directorate Kent Surrey Sussex (KSS) Postgraduate Dean. Medical Education is responsible for: Postgraduate medical training (for doctors in training posts) and some support for SAS doctors and Locally Employed Doctors; Undergraduate training (from two medical schools – Kings College Hospital (GKT) and Kent and Medway Medical School (KMMS); Simulation training; Knowledge and Library services; Physician Associate students; Pharmacy training. Our 2023/4 priorities have been: a. Driving quality improvement programmes in Paediatrics and General Surgery, in response to KSS Quality and GMC survey results. b. Establishing improved provision for International Medical Graduates, both trainees and Locally Employed Doctors. c. Expanding number of KMMS students on site – providing education and training as well as ensuring accommodation. d. In partnership with Service leads and operational colleagues, review of workforce requirements and opportunities for accommodating additional trainees (which will improve patient care) through expansion and redistribution of trainee posts nationally,		

	e. Strengthening the role of educators across the Trust through Community of Medway Medical Educators and enhanced provision of training opportunities and educational CPD workshops. f. Completion of the Education Centre refurbishment g. Education Fellow programme. h. Focusing on provision of multi-professional learning opportunities, through simulation, clinical librarians and Faculty of Education collaborative working.
Proposal and/or key recommendation:	The Board is requested to: 1) Receive an update on the current NHSE KSS Quality Visits and GMC Survey responses 2) Receive an update on current and possible future expansion of postgraduate doctors in training (trainee) establishment 3) Receive an update on expanding KMMS student numbers, along with ongoing GKT students. 4) Be aware of the risks and mitigations identified within Medical Education: a. Ongoing education and training quality concerns for Foundation trainees in General Surgery and Paediatrics; this is to be published imminently b. Recurrence of training concerns in Acute Internal Medicine c. Risk of burnout reported nationally for both trainees and trainers, particularly with concerns raised by trainers that time for training is impacted by other work pressures d. Trajectory to provide increase education, training and support to Locally Employed Doctors (including many International Medical Graduates) with no increased funding support.

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

Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: People Committee Date: 26/09/2024

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

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

Identified Risks, issues and mitigations:	Be aware of the risks and mitigations identified within Medical Education:

	Education and training quality concerns across Medicine, Surgery and General Paediatrics. Non improvement of GMC domains may lead to withdrawal of training posts. Reduction in IMT expansion in medicine. Accommodation requirements for additional medical students Service financial pressures leading to difficulty in incorporating additional training posts. Increased training lead and administration support requirements for support of Locally Employed Doctors.
Resource implications:	New NHSE KSS contracts with enhanced oversight of our budgets from them.
Sustainability and /or Public and patient engagement considerations:	Not applicable.
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ ✓ Not applicable
Legal and Regulatory implications:	NHS England Kent, Surrey and Sussex, Education Contract.
Appendices:	None
Freedom of Information (FOI) status:	Tick either: ☐ ✓ This paper is disclosable under the FOI Act ☐
For further information please contact:	Name: Dr Ashike Choudhury Job Title: Director of Medical Education Email: ashike.choudhury@nhs.net Name: Carol Atkins Job Title: Head of Medical Education Services Email: catkins@nhs.net

Please mark with 'X' - Reports require an assurance rating to guide the discussion:			
	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	✓	No assurance required.

1. Introduction and Structure of Medical Education at MFT

MFT, as a Local Education Provider (LEP), works with NHSE Kent Surrey Sussex (KSS) Deanery (within the Workforce Training and Education (WTE) Directorate of NHS England. MFT is contracted through the NHSE Education Funding Agreement and allocated budget to fund specific education and training and to meet strategic education and training objectives, for both undergraduate medical students and postgraduate doctors in training (PGDiTs). A broad range of education and training services are commissioned with the expectation of provision of high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust. MFT is expected to support national workforce priorities and those identified locally through KSS Deanery, and to make investment plans and decisions based on long-term workforce planning.

MFT has a duty to demonstrate that the quality of the education and training that we provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The expected outcome of quality placements and training is excellent patient care provided by competent, motivated and capable staff. Medical Education contributes to the NHSE Annual Self-Assessment Return for Placement Providers, overseen by the Chief People Officer.

The Director of Medical Education (DME) is responsible for managing the KSS Contract on behalf of their LEP, within the national guidelines set out by the GMC and the medical Royal Colleges, and the regional systems. This is under the oversight of the Executive Leadership of the Chief Medical Officer (CMO). KSS expects the quality of training to be maintained and improved in terms of: administrative support for PGME; clinical medical education; programmed activities and local course delivery; provision of library services and resources supporting IT access; provision of simulation facilities; and faculty development.

Additionally, PGME oversees the placements of the Undergraduate Medical Students from Kent and Medway Medical School (KMMS) and King's medical school (GKT). The Director of Undergraduate Medical Education (DUME) leads on this work, supported by the DME.

The senior education team, led by the DME, has recently written a five year Trust Medical Education strategy, with Operational Plan for the next one to two years.

Workforce

- Dr Janette Cansick finishes as DME mid September after nine years, and recruitment is underway, with interview planned for 16 September
- DME is dually accountable in the Trust to Alison Davis, Chief Medical Officer (CMO), and at NHSE WTE KSS to Prof.Jo Szram, Postgraduate Dean. DME meets with the CMO fortnightly 1:1 and weekly at the CMO Operational Meeting.
- Deputy DME Dr Ashike Choudhury
- DUME Dr Priya Krishnan
- Head of Medical Education Services (Carol Atkins) is responsible to the DME. She is supported by an operational Medical Education Manager (MEM, June Mossop-Toms) and administration team (including Postgraduate, Undergraduate, Simulation, Library services and Education Centre teams).
- Local Faculty Group (LFG) leads (College Tutors) in all clinical areas, Foundation Training Programme Directors (FTPD), Director of Undergraduate Medical Education (DUME) and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME.
- There are currently about 160 Educational Supervisors registered as GMC trainers
- Six Education Fellows
- In addition the quality of Pharmacy education and training is overseen by the DME.
- The Library and Knowledge Services reports to the DME and Head of Medical Education Services.

Nomenclature of Doctors

There is a move to change the term from 'junior doctors' to resident doctors, directed by the British Medical Association. However, this encompasses all doctors who are not SAS or Consultant grade. i.e. from Foundation Year 1 (pre-GMC registration) to final year Registrar (in process of applying for consultant jobs).

Postgraduate Doctors in Training (PGDiT) is used for doctors recruited into national training programs, and the term trainee is used interchangeably with PGDiT. All other resident doctors are 'Locally Employed Doctors' often known as Clinical Trust Fellows. A significant percentage of these are International Medical Graduates (IMGs). These doctors have their own education and training needs which is often overlooked. A recent Royal College of Physicians reports states that all doctors are 'doctors in training'. Significant work has been undertaken this year to increase the education and training for this group of doctors to align closer to what we provide for our trainees.

Educational Quality Governance

How the quality of medical education and training is monitored is crucial. In particular, providing clear mechanisms for and enabling trainees and students to voice any concern is vital, in order to have a continuous improvement methodology. In the GMC training survey, the three questions asked of trainees within the educational governance domain are: 1. Knowing how to raise a concern about education and training; 2. Confidence in knowing a concern would be addressed; 3. Confidence in knowing how to escalate a concern if it wasn't addressed. This scored favourably in the GMC training survey this year.

The formal feedback mechanisms we have in Trust for PGDiTs are:

- Voice of Postgraduate Doctors in Training
  - Trainee in Action groups in key areas of need (medicine, surgery, pharmacy)
  - Representatives at Specialty Local Faculty Groups (LFGs) and Local Academic Board (LAB)
  - Meetings with DME and CMO
  - PGDiT's forum (contract issues) – led by Guardian of Safe Working (GSW) - Dr Shrawan Agrawal.

- Local Faculty Groups (LFG, chaired by College Tutors) meet three times a year

- Local Academic Board (LAB) meets three times a year
  - reports from all areas of medical education, with joint learning
  - Simulation, Pharmacy and Library reports
  - All LFG leads summarise improvements and any concerns arising
  - Trainee Representatives provide feedback, including patient safety concerns
  - GMC survey results and KSS Quality visits are discussed.
  - All quality metrics are discussed.

2. Update on Trainee Establishment

1. Postgraduate Doctors in Training

   We have a total of 270 postgraduate doctors in training, of which 202 are tariff funded; 60 Trust funded; eight community F2 posts are 100% funded (without placement fee)

   The spread of posts is as follows

   Foundation Level – 56 F1 doctors; 55 F2

   GP Trainees – 64 – 38 placed in the hospital

Core Specialty Trainees – 61
Higher Specialty Trainees – 73

2. National Workforce and Redistribution and Expansion Programmes

In 2024/5 we are increasing our trainee establishment in the following areas:

- Medicine (IMT level) = IMT1 x 4
- Paediatrics = 2 higher
- Respiratory = 1 higher
- Endo & Diabetes = 1 higher
- Anaesthetics = 1 higher
- Haematology = 2 higher
- Obstetrics and Gynaecology – 1 higher

There has been ongoing work with operational colleagues to review workforce and identify areas where we can replace a Trust employed doctor with postgraduate doctor in training going forward.

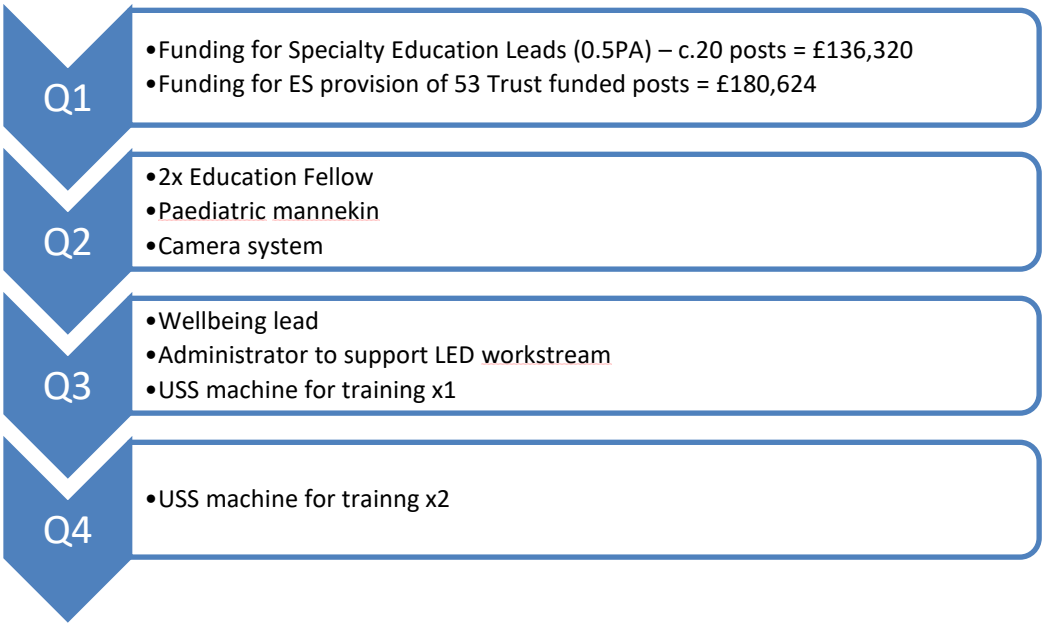
3. Chief Registrars
There has been a Chief Registrar in Medicine from October 2022 to March 2024. From October 2024 we will have two Chief Registrars, one in Medicine and one in Surgery. This is an exciting opportunity for drive in quality improvements across the specialties; projects such as Hospital at Night, deteriorating patient pathway with reduction of arrest calls, and improving handovers, have been supported by Chief Registrars. There will be enhanced opportunities for collaborative working across Education and Services, supporting significant improvements for trainee experience.

4. Medical Education Fellows
Six medical education fellows have started in Trust in August. They have specific spheres of work, including Undergraduate teaching, Foundation teaching, Simulation, Analysis and support for issues arising out of GMC training survey, Patient Experience.

3. Finance

Medical Education in MFT oversees the funding and quality for the training programmes and posts in a wide variety of specialties in the Trust and community. The DME carries direct responsibility for the financial management of the tariffs which cover funding for all direct costs involved in delivering medical education and training by the Trust. 20% is top-sliced by MFT. There is increasing oversight of expenditure by KSS, in particular for Undergraduate spend. A significant change in enhanced funding has been the removal of monies for DME/deputy DME time, but in place additional support funds for various workstreams.

In 2023/24 financial year, undergraduate tariff was fully utilised; however postgraduate tariff was underspent by approximately £450k; this was in recognition that the Education Centre upgrade, which was capital funded, was significantly for the benefit of our doctors in training so some tariff could be used. For the 2024/25 financial year it is planned for tariff to be fully used. In Quarter One, we agreed funding from tariff to departments for Specialty Education Leads and Supervisor provision for the Trust funded posts, providing a net gain to the Trust of about £317k.



4. Impact of Industrial Action

Industrial Action, both for 'junior doctors' and consultants, has significantly impacted education and training this year. This has been minimised as much as possible through enabling PGDiTs to focus on their competencies and through individual support from Educational Supervisors.

5. KSS Quality Visits

Due to concerns arising from the GMC National Training Survey in 2023 we received a Quality Intervention Visit in March 2024 to Foundation Programme in General Surgery and Urology, and Foundation and GP training programmes in General Paediatrics. Notably we were issued with one Immediate Mandatory Requirement (IMR) around Foundation doctors taking responsibility for the trauma bleep; this has been actioned and resolved. The consultant teams, with senior nursing and management colleagues, have accepted the feedback and are effectively engaging to establish positive change. There is a planned review visit planned on 1st November 2024.

In paediatrics, concerns and our actions to resolve include:

- Undermining concerns – implementation of multiprofessional buddy groups; civility training
- Lack of awareness of FTSU guardian – clarity at induction, posters in doctor's office
- Learning from incidents – trainees included in meetings, with encouragement to report incidents
- Difficulty in exception reporting – emphasised at Trust and local induction
- Clinical skills training – enhanced during in situ simulation sessions in first few weeks of placement
- Length of handovers – review of handover process to ensure PGDiTs can finish shifts on time

For urology, the visiting team heard very positive feedback from trainees. The urology consultants had already engaged very positively with the Medical Education team, and resolved previous concerns effectively. There are no actions.

In general surgery, concerns and our actions include:

- Discouragement from reporting and learning from incidents – already a change with good evidence of attendance
- Exception reporting – training and encouragement to use the reporting tool through induction
- Senior ward cover concerns – rota revised to include regular consultant led ward rounds
- Allocation of self development time – now included on rota
- Appropriate completion of assessments by supervisors – improved

On a positive note, the previous Quality action plan for Medicine has been closed. This is following intense collaborative working between Service leads and Education leads, with support from the CMO Office. The same approach is being undertaken with the current Quality action plan.

We have had two positive undergraduate visits – from Kent and Medway Medical School and GKT (Kings) Medical School. We were commended in many areas for both. The one significant change we have undertaken following the Visits has been to split the finances for Undergraduates, for enhanced accountability of spending.

6. GMC National Trainee Survey (NTS) 2024

National picture

Nationally the survey of trainees shows that, thanks to the hard work and dedication of trainers, trainees and education organisations, the quality of training across the UK remains high. 86% of trainees were positive about their clinical supervision, and 83% said the quality of their experience in their post was good or very good. There are some significant challenges outlined. Wellbeing remains a significant concern, with 21% trainees at high risk of burnout and over half describing their work as emotionally exhausting to a high or very high degree. As a contributor to this, 26% in secondary care posts reported their training to be adversely reported by rota gaps not being dealt with. Whilst the majority nationally report supportive workplaces, there are concerns regarding discriminatory and unprofessional behaviours being reported.

The survey of trainers shows that the majority (90%) enjoy their role but there are concerns around the time and support received for training, with 27% reporting insufficient time in their job plan, and 48% reporting not being able to use the designated time for training. Additionally half of trainers are measured to be at high or moderate risk of burnout.

Results for Medway

NB: White = interquartile range; Pink – bottom quartile range; Red = below outlier; Pale green = upper quartile range; Green – above outlier

We had two Patient Safety concerns raised through the GMC trainee survey. The first related to corridor care of patients in ED which has been resolved. The second was a variety of concerns relating to patient care on Sapphire Ward, including lack of continuity of care, variability in standard of care, lack of competence of Trust registrars in some procedures, and nursing documentation concerns. This was robustly investigated and measures have been put in place to rectify the corroborated issues.

There was a Bullying and Undermining concern raised in ED about the behaviour of an individual (unnamed) consultant and recruitment practice. The latter was investigated and not corroborated. Whilst the individual concern could not be directly addressed as no further information could be gained (GMC training survey is anonymous), actions include: CMO discussion with Clinical Director and Clinical Lead to set expectations; listening events for registrars across different specialties including ED; Civility Saves Lives and Active Bystander training available to all doctors.

Positives

Notably we have two departments which are outstanding on the trainee survey this year. Neonates has seven green flags and radiology seven green flags and one pale green flag.

A few areas have significantly improved compared to 2023 results.

Specialty	**2023**	**2024**
Paediatrics	7 red flags and 3 pink flags	1 green, 1 red, 5 pink flags
Urology	7 red flags	2 red flags
Cardiology	9 red flags	1 pink flag
Haematology		2 green flags
Emergency Medicine (GP)		3 green flags and 2 pale green

Areas of Concern

Each of these areas is being actively reviewed, reported on to the GMC, with action plans being implemented.

- General Surgery – ongoing from Visit in March (GMC training survey filled in at that time) – particularly concerning are red flags in Clinical Supervision Out of Hours and Teamwork
- Acute Internal Medicine – seven red flags and six pink flags
- Acute Common Care Stem (ACCS) – two red flags and nine pink flags – initial review relates this to the issues in Acute Internal Medicine
- Intensive Care Medicine – four red flags and seven pink flags
- Emergency Medicine – one red flag for Clinical Supervision

7. Simulation Report (Dr Manisha Shah, Gemma Dockrell)

The Simulation Department at Medway NHS Foundation Trust has continued to build on the progress made in previous years, enhancing patient safety through innovative simulation-based training. This year, the number of simulation sessions has increased from 460 to 510, and going forward will be supporting an increased number of Foundation trainees, medical students and IMTs. Our focus is to increase multidisciplinary team training at MFT.

Simway Hospital: In 2024, we ran an enhanced version of the Simway Hospital at the Canterbury Christ Church University (CCCU) Medway Campus. This project, designed for Foundation Year 1 (FY1) doctors, won first prize for Best Poster Presentation at the SimNet Conference ‘Sim4Safety’, and Best Presentation at the MedEd Leaders Conference. We are aiming to take this forward to enter the Parliamentary Awards and the HSJ Awards this year.
Other notable presentations this year include: Advancing Patient and Learner Safety; Establishing SOPs for In situ Simulation; and ‘What makes you qualified to do that ‘at SimNet Sim4Safety.

Strategic Developments and New Initiatives:

· International Medical Graduate (IMG) Foundation Programme: Collaborating with the Foundation medical education team to create an IMG support programme to align alongside the set mandatory elements.
· KMMS: Designing suitable simulation-based sessions, clinical skills sessions and reviewing to enhance the programme for both year 4 and in preparation for year 5 students

· Maternity Services Pilot Project: Medway NHS Foundation Trust (MFT) has been chosen as the first pilot site from Kent, Surrey, and Sussex (KSS) for an NHSE-funded project in collaboration with CCCU, aimed at improving maternity service outcomes through in-situ simulation.
· Surgical Induction Programme: The Simulation team has supported the Surgical Department in delivering simulation-based induction for FY1 doctors starting in August 2024. We are working towards delivering RCS accredited START course by December 2024.
· Medicine Induction Programme: The Simulation team has supported the Medicine Department in delivering simulation-based induction for all new doctors in the department leading to improvement in Induction score ratings to 4.6/5.
· IMG and LED: New developments from the RCOP report (2024) highlighting the requirements to support IMGs and LEDs in education, which will be discussed for development.
· IMT Skills and Simulation Training: Our Internal Medicine Training (IMT 1-3) skills and simulation training program is now fully established, providing essential hands-on experience for trainees. Introducing a new element of Pleural/NIV Day.
· Pharmacy Simulation Programme: The simulation Team support Pharmacy Trainees focusing on curriculum-based competencies, Human Factors and communication.
· Airway Competencies Project: The Simulation Department supported an anaesthetic trainee in delivering a project focused on airway competencies training for ART nurses as per their new curriculum.
· Human Factors and Ergonomics (HFE) Project: The in-situ simulation-based HFE project on Lister Ward, led by the simulation team, was successfully presented at the Grand Round on 19th July 2024.
· Human Factors and Ergonomics (HFE) Project: Simulation Team supported NICU in 'Human Error in Nicu' which was presented as a Spotlight Presentation.

Overall, it has been a productive year and we remain at the forefront of innovative training and patient safety initiatives.

8. Undergraduate Medical Education (Dr Priya Krishnan)

We have had a successful academic year which has incorporated two quality visits from KMMS and King's medical schools with really positive feedback. The visits noted the positive teaching culture and the high standards of teaching and supervision that undergraduate students receive at Medway. This has also been evidenced by the high student feedback scores across modules (year 4 feedback was the best in the region). Action points have included replacement of white goods in the accommodation, increased involvement of the undergraduate team with finance, out of hours contact and supervision, and evidencing teaching roles in clinicians' job plans.

The last academic year incorporated new KMMS year 4 students alongside existing year 3, and Kings year 4 and 5 students. The faculty has expanded to support these fourth year modules alongside additionally expanding the number of clinical and educational supervisors. We have worked with KMMS to appoint new year 5 leads and develop timetables for the next full cohort of KMMS students. We have also supported appointments of six new education fellows who will support undergraduate and postgraduate education including simulation and skills.

We are looking forward to similar successes in the forthcoming academic year with a newly expanded team and increased number of students. We expect a further visit from KMMS in November.

9. Knowledge and Library Services (Richard Pemberton)

The Knowledge and Library Service has had another successful year. The team have utilised the Trust's Patient First programme to continuously improve throughout the year. All the full time staff have completed the Patient First training and the team have installed an improvement board.
The improvements have included changes to physical space to create more study space for library readers, targeted work to meet the needs of more departments and process changes to improve team efficiency. The team were subject to a Quality Improvement Framework Visit by NHSE WTE. The report was glowing, it showed a significant improvement on the previous report from 2021. The NHSE WTE team particularly recognised the ongoing work of the KLS team and the support from the Trust to allow the team to flourish. The team was supported in the process by the CMO, DME, Head of Research and Innovation and the lead for Nurse Clinical Education.
Library use has increase on all major markers between August 2022-July 2023 and August 2023-July 2024 including:

- Book loans 19.64% up,
- Electronic resource enquiries (Clinical Decision Support Tools and eJournals) 26.31% up,
- Searches conducted up an incredible 212.22%.

Some of these searches have supported other teams to make significant savings for the Trust including changes to gas storage and a drug change by the Pharmacy team. A 2022 study found that there is a net economic benefit of £3.85 for every £1 invested where librarians summarise research evidence and examples of best practice, making it decision ready. The MFT librarians are working at search capacity. The Trust would need to invest in a further librarian if the service was to expand to working with every clinical department.