Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Wednesday, 14 May 2025 at 12:30 – 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	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest – Register	Company Secretary		12:32	Approve
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 12 March 2025	Chair		12:35	Approve
2.2	Action Log				Note
2.3	Constitution – Annual Review	Company Secretary	Verbal	12:40	Approve
2.4	Board and Committee Membership and Designations			12:45	Approve
3.	**Opening Matters**				
3.1	Chief Executive Update	Chief Executive		12:50	Note
3.2	Council of Governors Report	Lead Governor	Verbal	13:00	Assurance
	Board Story Presentation				
3.3	Staff Story: Neurodiversity with Matthew Taiano	Associate Director of Patient Experience		13:05	Note
4.	**Performance, Risk and Assurance**				
4.1	Risk and Issue Register and Board Assurance Framework	Company Secretary		13:20	Assurance
4.2	Quality Assurance Committee (Apr/May)	Chief Medical Officer Chief Nursing Officer Committee Chair		13:25	Assurance
4.3	People Committee (Mar)	Chief People Officer Committee Chair		13:30	Assurance
4.4	Finance, Planning and Performance Committee (Mar/Apr)	Chief Finance Officer Committee Chair		13:35	Assurance
4.5	Audit and Risk Committee (May)	Chief Finance Officer Committee Chair		13:40	Assurance
4.6	Integrated Quality Performance Report **APPENDIX 1**	Chief Delivery Officer	3	13:45	Assurance

Agenda

4.7	Finance Report (Month 12) **APPENDIX 2**	Chief Financial Officer (Interim)	58	13:50	Note
4.8	Improving Financial Governance Tracker **APPENDIX 3**	Chief Delivery Officer	63	14:05	Note
~ WELLBEING BREAK – 10 minutes at 14:10 ~					
5. Papers					
5.1	Patient First Strategy – Refresh **APPENDIX 4**	Chief Delivery Officer	82	14:20	Approve
5.2	2025/26 Business Planning – Progress Update	Chief Delivery Officer		14:25	Note
5.3	Emergency Preparedness, Resilience and Response – Policy **APPENDIX 5**	Chief Operating Officer	106	14:30	Note
5.4	Green Plan – Annual Review	Chief Operating Officer		14:35	
5.5	RCP Rheumatology **APPENDIX 6**	Chief Medical Officer	122	14:40	Approve
5.6	CQC Feedback Letter	Chief Nursing Officer (Interim)		14:45	Note
6. Closing Matters					
6.1	Questions from the Council of Governors and Public	Chair	Verbal	14:50	Note
6.2	Escalations to the Council of Governors				
6.3	Any Other Business				
6.4	Reflections				
6.5	Date and time of next meeting: Wednesday, 23 July 2025				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

NHS
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Integrated Quality & Performance Report

March - 2025

Patient FIRST

Executive Summary

Gavin MacDonald
Chief Delivery Officer

Our refreshed True North Domains

True North Domains describe our key goals, by which we know we would be providing excellent care in a sustainable way. We are proposing to refresh these to reflect our updated position:

Systems and Partnerships
92 per cent of patients treated within 18 weeks for Referral to Treatment (RTT) by March 2029

Patients
Achieve 95 per cent of patients having a positive experience

People
To have a highly engaged workforce across the organisation which will make us the employer of choice

Improving our performance to be in line with the National Emergency Care Standards with the emergency departments and our inpatient care areas for both adults and children

Quality
No avoidable harm or deaths, and for the Summary Hospital-level Mortality Indicator to be within the expected range

Sustainability
To reach a sustainable underlying breakeven revenue position by 2028/9

True North

	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
People	20	33	3	20	15	14
Quality	47	13	18	14	5	3
Systems & Partnerships	21	8	9	18	3	7
Patients	8	16	3	5	1	3
Sustainability	4	4	4	7	0	0

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

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

Executive Summary: True North Strategy and Supporting Breakthrough Objectives

NHS Medway NHS Foundation Trust

People

Ambition:

To be the employer of choice and have the most highly engaged staff within the NHS.

Vision:

We will have a highly-engaged workforce across the organisation which will make us the employer of choice.

We will recruit and keep the best people by having a culture of staff-led improvement and innovation.

Breakthrough Objective:

Reduction in the total number of reports relating to staff incivility & bullying or harassment reported by 50%.

Performance:

Type	BO	Key Performance Indicator	Threshold	V	A	Feb-25	Mar-25
		National Staff Engagement Score	6.93			6.74	
		Incivility Cases (Combined)	20			56	95

Patients

Ambition:

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

Vision:

Every time any of us interact with our patients, their families and carers, we should ensure our contacts are prompt and positive.

Breakthrough Objective:

To achieve a minimum of 95% positive experience of care in Outpatients and 80% for Emergency care services.

Performance:

Type	BO	Key Performance Indicator	Threshold	V	A	Mar-25
		Total FFT Recommend %	95.0%			90.5%
		Emergency Care FFT Recommend %	80.0%			73.7%
		Outpatient FFT Recommend %	95.0%			91.3%

Quality

Ambition:

Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have.

Vision:

To have no patients die when it could have been prevented. Medway NHS would like to bring the Trust in line within the lowest quartile of the Hospital Standardised Mortality Ratio (HSMR) funnel plot by 2025/26.

Breakthrough Objective:

Reduce the number of patients coming to avoidable harm & reduce avoidable deaths in hospital of patients admitted via the emergency pathway.

Performance:

Type	BO	Key Performance Indicator	Threshold	V	A	Mar-25
		Low or No Harm Incidents %	95.0%			99.3%
		Crude Mortality Rate %	1.30%			1.62%

Systems and Partnerships

Ambition:

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

Vision:

Medway NHS to have a stable bed occupancy of 92% by 2028.

Improved timely access for patients on the Referral to Treatment (RTT) pathway.

Breakthrough Objective:

60% of patients will have their RTT pathways complete < 18 weeks by March 2026;
To achieve a maximum 6% in Type 1, 12-hour length of stay (LoS) in ED.

Performance:

Type	BO	Key Performance Indicator	Threshold	V	A	Mar-25
		RTT Incompletes Performance %	54.0%			53.0%
		RTT 65+ Week Waiters	0			80

Type	BO	Key Performance Indicator	Threshold	V	A	Mar-25
		Total EC 4 Hour Performance %	80.0%			77.4%
		Type 1 LOS > 12 Hours in EC %	6.0%			13.2%

Sustainability

Ambition:

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

Vision:

For Medway NHS to reach a sustainable underlying breakeven position within the next 5 years (by 2028/29).

Breakthrough Objective:

Reduce our cost base by £27m to contribute towards a productive, safe, affordable workforce.

Performance:

Type	BO	Key Performance Indicator	Threshold	V	A	Mar-25
		Breakeven Revenue Budget (£)	£0.00m			1.37m
		Total Financial Overspend (£)	£0.00m			4.04m

Executive Summary: Strategic Initiatives

Culture, Leadership and Behaviours – SRO Leon Hinton, CPO

- Unconscious bias workshop for Board in March 2025.
- 190+ attended confidential listening services.
- 230 completed anonymous survey.
- Board personal development plans updated with inclusive leadership focus.
- Board agreed collective improvement action plan following self-assessment.
- Senior leaders to undertake self-assessment in coming months to review their cultural awareness, inclusion, diversity, diligence and competence.

Patient First Programme – SRO Gavin MacDonald, CDO

- Overall status amber.
- Strategy Deployment Workstreams re-instated.
- Current delays to Breakthrough Objective cascade to Divisions/Corporate.
- Workstream roadmap actions underway, expected to return to green rating in the next 2-4 weeks.

Clinical Strategy – SRO Alison Davis, CMO

- Launched in April 2024 following full service review to understand key ambitions and priorities over 3-5 years
- Currently undergoing a review and refresh due to go to Board in October 2025, working closely with specialty leads and linking in to annual business planning and capital programming work in line with our Patient First ethos.
- All specialties have achieved one or more of their Year 1 priorities.

Access and Flow Productivity – SRO Nick Sinclair, COO

- March Data shows performance of 77.82%, surpassing National target of 76%, with notable peaks of 85.09%.
- Efforts continue to optimise care pathways and enhance patient flow.
- Incomplete performance improved to 52.3%, and patients waiting over 65w decreased to 80 by the end of March 2025 post validation..
- April goal for zero patients waiting over 65 weeks.
- Fortnightly Tier 2 meetings remain in place to oversee Elective Performance.
- Two supportive Corporate Projects: Elective Reform and Reducing Length of Stay.

Digital, Data and Technology (DDaT) - SRO Gavin MacDonald, CDO

- DDaT Strategy launched January 2024
- Current review and refresh to publish this year, along with stand alone Cyber Strategy to support National best practice.

Financial Recovery Plan (FRP) – SRO Simon Wombwell, CFO

- Trust has delivered against accepted forecast outturn for 24/25 using additional non-recurrent measures.
- Focus on 25/26 and applying rigorous control over expenditure.
- Significant efficiency target of operating expenditure for 25/26.
- Business Planning has highlighted a number of cost pressures that could jeopardise delivery of the £15.m deficit control total.
- Currently developing medium term FRP.

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Executive Summary: Corporate Projects

Elective Reform, SRO Nick Sinclair, Chief Operating Officer

Key deliverables
- Review current clinic templates across all platforms.
- Review current utilisation of remote Patient Initiated Follow up appointment, advice & guidance and referral criteria.
- Develop new Patient Tracking List (PTL) Dashboard to support the validation of our PTL position.
- Maximise Clinical Diagnostic Centres opportunities.
- Optimise testing – Straight to test pathways and direct access referrals.
- Maximise the utilisation and functionality of the NHS App.

Previous 30 days focus
- Dashboard scoping and demo.
- Concise list established for reporting available from the data quality team for PTL management.
- Established Key Performance Indicators (KPIs) for each workstream.
- Continue to scope the detail of each.

Next 30 days focus
- Service teams to review dashboard and provide feedback/recommendations.
- Review of the PTL report by the service teams.
- KPIs finalised and agreed.
- Finalise the scope of all workstreams.

Reducing Length of Stay, SRO Lorna Gibson, Director of Efficiency, Productivity and Development

Key deliverables
- Rollout of new and improved board rounding across all wards.
- Streamline Electronic Discharge Notification (EDN) completion process to support medicine/dispensing efficiency.
- Enhancements to internal diagnostic requests and internal referral processes.
- Increase effective usage of Teletracking across the wards.
- Improve discharge process for all pathway 0 patients
- Enhanced Frailty Same Day Emergency Care..
- Development and utilisation of Criteria Led Discharge.

Previous 30 days focus
- Proactive patient management & Targeted Care workstream scope confirmed.
- Programme level KPIs agreed.
- Dashboard specification produced and working with Business Intelligence on the development.
- Implementing the new board rounding process in the Acute Medical Unit (AMU).

Next 30 days focus
- Workstream KPIs agreed.
- Dashboard drafted and shared with stakeholders for review.
- Review effectiveness of new board round processes in AMU and capture lessons learnt.
- Plan next wards to implement.

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Medical Productivity, SRO Alison Davis Chief Medical Officer

Key deliverables
- Validation of Team Job Plans.
- Approval of Team Job Plans.
- Development of individual Job Plans..
- Approval of Individual Job Plans.
- Development of Programmed Activity options Paper.
- Development of Rostering Options Paper.
- Recruitment & Retention A3.
- Development of Productivity Dashboard.

Previous 30 days focus
- Team Jobs plan reviews completed for 10 specialities.
- Rostering analysis and options developed – To be formally collated into an options paper.
- Productivity Dashboard scoped and specification approved – Data currently being pulled from various data sources.

Next 30 days focus
- Presentation of Team Job plans at consistency panels for sign off.
- Continue to schedule and complete team job plans.
- Recruitment and Retention A3 Session.
- Recruitment and Retention Workstream scoping – Agree Objective, Deliverables. KPIs and Risk.
- Draft dashboard developed and agreed.

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Integrated Quality & Performance Report Main Report

Patient FIRST

Patients

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
PALS	2	2	1	0	1	0
Complaints	2	3	1	1	0	1
FFT	2	7	1	3	0	2
Patient Experience	0	1	0	1	0	0
PHSO	2	3	0	0	0	0

Patient FIRST

Operational Leads:
Wayne Blowers - *Director of Quality & Patient Safety*
Nicola Lewis - *Associate Director of Patient Experience*

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	95.0%	H	F	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%

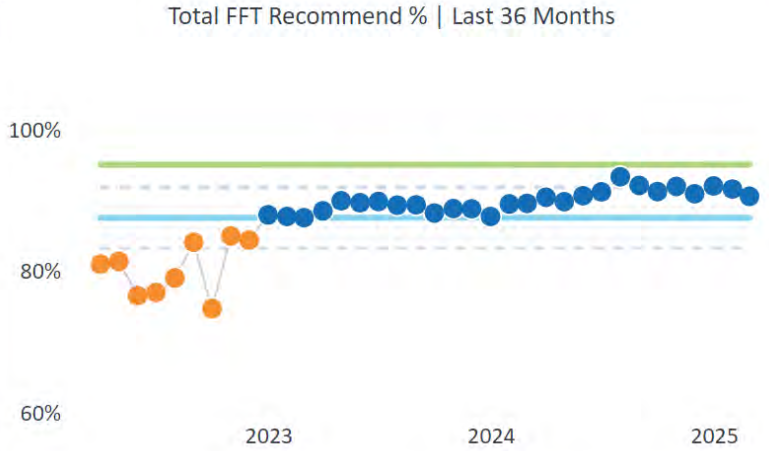
True North Domain: **Patients**

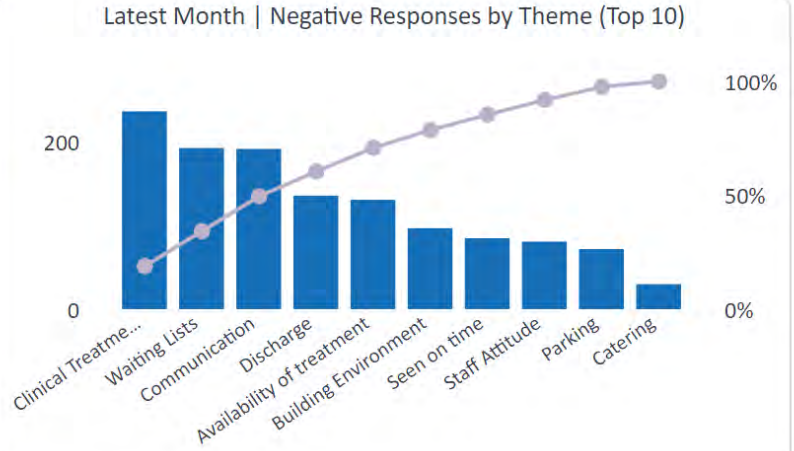
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

2	1	0	0	7





Key Messages

- Following the recent update and refresh of the TN A3, the approach and targets for achieving FFT has changed.
- ED and outpatients will continue to drive FFT overall positive experiences of care
- Inpatients and Maternity FFT will become watch metrics.
- E&F are driving their own improvements in regards to parking and patient catering

Issues, Concerns & Gaps

- The divisions are yet to identify the root causes and countermeasures as part of the A3 refresh
- Historically Outpatient data is reported within cancer and core clinical services, however outpatient clinics are hosted by multiple care groups

Actions & Improvements

- The group are to identify the countermeasures for the division through the catch ball process in the coming week that will drive their improvements
- The DDoNs will identify the correct outpatient clinics which are attributed to their division and develop countermeasures to drive the improvements required based on patient feedback

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patients	FFT			Emergency Care FFT Recommend %	80.0%			Driver is red for 2 reporting periods	72.8%	75.3%	71.1%	74.6%	75.3%	73.7%
				Outpatient FFT Recommend %	95.0%	H	F	Driver is red for 2 reporting periods	93.0%	93.1%	92.3%	93.3%	92.6%	91.3%
				Inpatients FFT Recommend %	95.0%	H		Watch is red for 4 reporting periods	93.9%	95.1%	94.7%	94.9%	94.9%	94.7%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L		Watch is red for 4 reporting periods	10	6	17	2	13	5
	Complaints			Complaints Breached %	5.0%	L	F	Watch is red for 4 reporting periods	20.0%	21.2%	16.7%	33.3%	20.0%	16.2%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%
				Outpatient FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.0%	93.1%	92.3%	93.3%	92.6%	91.3%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.9%	95.1%	94.7%	94.9%	94.9%	94.7%
				Maternity FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	96.5%	98.3%	97.3%	97.9%	94.5%	94.1%
				Total FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	15.2%	13.8%	12.8%	13.1%	13.1%	13.5%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	53.7%	49.4%	42.6%	42.9%	45.8%	48.5%
				Maternity FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	76.0%	70.1%	72.3%	71.8%	72.6%	40.0%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	Special cause of improving nature or lower pressure due to (L)ower values	10	6	17	2	13	5
	Complaints			Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	65	54	48	63	70	64
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	20.0%	21.2%	16.7%	33.3%	20.0%	16.2%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	89	99	97	95	84	77
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patients	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				PHSO Cases Closed - Upheld	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				PHSO Cases Closed - Not Upheld	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

Key Messages

- MSA breaches remain low with ICU and HDU the top contributors due to delays in stepping patients down to the ward.
- The Single Sex Policy has been circulated for comments and will be sent for ratification at May PEG
- 100% complaints acknowledged
- 0 PALS converted to complaints
- Complaint themes include, delays in medical care, concerns/delays regarding medication and pain relief, delays in diagnosis and treatment, general dissatisfaction with medical and nursing care and treatment, appropriateness of discharge.
- PALS themes include; lack of communication from departments and difficulties contacting relevant departments, queries and delays for outpatient appointments, obtaining test/scan results, medical and nursing care issues. 33 compliments received in PALS.
- No PHSO cases opened or closed / 0 complaints re-opened for ongoing investigation.

Issues, Concerns & Gaps

- There have been issues with some clinical areas understanding what constitutes a mixed sex breach.
- 16.2% of complaints breached KPI – 6 breached (Surgical Services 1, Spec Med 2, AEM 1, Women's Care 1, Children & Younger People 1). 5 complaints required outstanding comments or additional comments to be able to complete the complaint investigation and complete response. 1 complaint breached due to delays with divisional review and approval. Escalations were made to HON and Triumvirates in all Care Groups.
- High number of contacts and enquiries being received in the PALS department via walk-ins to the HUB, telephone calls and emails received.
- There is continued support offered to the main reception team when the reception desk is unattended. These enquiries are mainly for signposting and general information and therefore do not get registered.

Actions & Improvements

- Teaching and education sessions to be widely available for staff, these will commence in the ICU and HDU in early April 2025.
- Nursing staff on a surgical ward have collaborated with the Resuscitation Team to enhance staff knowledge on stroke awareness following an incident, further roll out of the awareness raising is planned.
- Confirmed escalation to staff on surgical wards; when relatives wish to receive a clinical update staff will inform the Senior Sister/Matron to facilitate a conversation with the Consultant/Registrar.
- Learning following an incident in maternity have led to updated guidance to ensure that a speculum examination is offered where appropriate (eg - in cases where there are symptoms that could indicate premature labour)

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patients	FFT			Total FFT Recommend %	95.0%	H	F	90.4%	89.7%	90.6%	91.1%	93.3%	92.0%	91.2%	91.9%	90.9%	92.0%	91.5%	90.5%
				Emergency Care FFT Recommend %	80.0%		?	77.1%	70.2%	74.9%	73.0%	79.9%	74.0%	72.8%	75.3%	71.1%	74.6%	75.3%	73.7%
				Outpatient FFT Recommend %	95.0%	H	F	91.3%	92.7%	92.6%	93.0%	94.7%	92.8%	93.0%	93.1%	92.3%	93.3%	92.6%	91.3%
				Inpatients FFT Recommend %	95.0%	H	?	93.2%	92.6%	93.3%	94.5%	95.3%	95.6%	93.9%	95.1%	94.7%	94.9%	94.9%	94.7%
				Maternity FFT Recommend %	95.0%	H	?	99.4%	96.5%	92.6%	88.0%	92.6%	94.8%	96.5%	98.3%	97.3%	97.9%	94.5%	94.1%
				Total FFT Response Rate %	-	H		16.3%	15.0%	15.2%	14.6%	16.1%	15.3%	15.2%	13.8%	12.8%	13.1%	13.1%	13.5%
				Emergency Care FFT Response Rate %	-	L		10.2%	8.4%	8.0%	7.5%	7.5%	6.6%	7.6%	7.5%	6.8%	7.5%	7.5%	7.7%
				Outpatient FFT Response Rate %	-			9.8%	9.7%	9.6%	9.8%	11.3%	10.6%	10.2%	9.4%	9.1%	9.6%	9.1%	9.4%
				Inpatients FFT Response Rate %	-	H		53.5%	49.3%	53.7%	55.3%	55.1%	54.5%	53.7%	49.4%	42.6%	42.9%	45.8%	48.5%
				Maternity FFT Response Rate %	-	H		49.2%	47.6%	39.1%	34.2%	42.3%	70.6%	76.0%	70.1%	72.3%	71.8%	72.6%	40.0%
	Patient Experience			Mixed Sex Accommodation Breaches	0	L	?	110	108	89	26	12	12	10	6	17	2	13	5
	Complaints			Complaints	-			28	23	26	21	30	22	43	19	20	37	36	27
				Complaints Closed	-	L		28	45	37	38	20	27	24	30	26	22	29	33
				Complaints Open - Month End	-	L		91	69	58	41	51	46	65	54	48	63	70	64

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Patients	Complaints			Complaints Re-Opened	-			1	3	1	4	1	4	10	2	2	1	7	0
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	59.3%	34.5%	21.4%	3.6%	0.0%	30.8%	20.0%	21.2%	16.7%	33.3%	20.0%	16.2%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			480	428	446	499	421	521	439	515	463	470	447	321
				PALS Closed	-			457	402	458	540	402	527	441	505	465	472	458	329
				PALS Open - Month End	-	L		105	131	119	78	97	91	89	99	97	95	84	77
				PALS Converted to Complaints	-	L		0	1	0	0	1	0	0	0	0	0	0	0
				PALS Re-Opened	47	H	P	41	47	30	33	18	56	19	34	30	20	27	20
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	L		1	0	2	2	2	0	0	0	0	0	0	0
				PHSO Cases Closed - Partially Upheld	-			0	0	0	0	0	0	1	1	1	0	0	0
				PHSO Cases Closed - Upheld	-	L		0	0	0	1	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			0	0	0	0	0	0	1	1	0	0	0	0

Quality

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
IPC	5	0	4	1	2	0
Incident Management	12	4	5	2	1	2
Medicines	2	0	0	0	1	0
Mortality	9	2	5	6	1	1
Falls	6	1	0	3	0	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	2	1	0	0	0	0
Maternity	7	0	1	0	0	0
Pressure Ulcer	2	0	3	1	0	0
Risk & Policy	2	2	0	0	0	0
VTE	0	1	0	1	0	0

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

Committees:
Quality Assurance Committee (QAC)

Quality

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

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	95.0%		P	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	99.1%	98.9%	98.7%	99.2%	99.3%

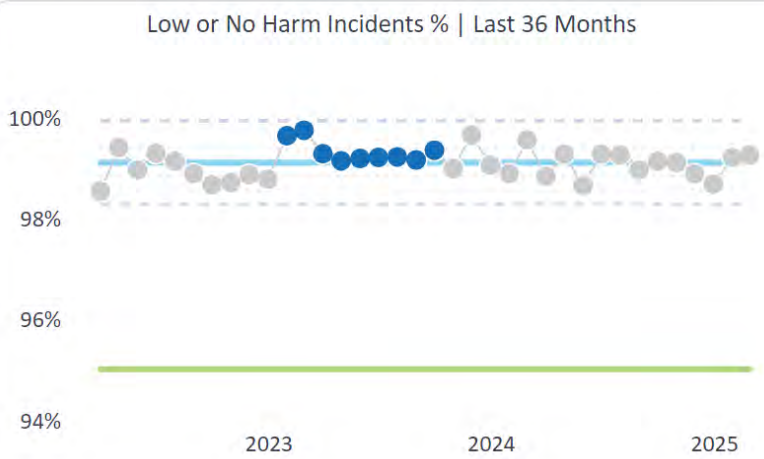
True North Domain: Quality

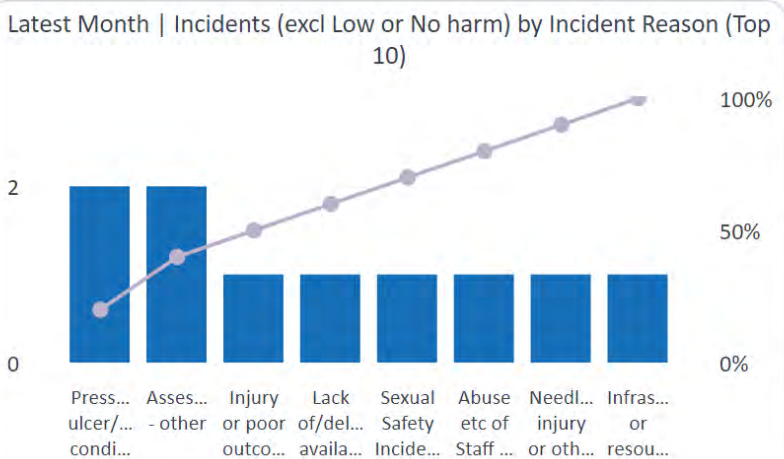
KPI Threshold: 95.0%

Sub Domain KPIs: 21

Variation Summary:

	L	H	L	H
12	0	5	0	4





Key Messages

- 99.2% of all incidents reported resulted in low or no harm.
- Clinical incidents with harm as moderate or above decreased in March.
- 5 incidents in March caused moderate harm or above: third degree tear; missed fractured NOF; 2 x Cat 4 PU; wrong infusion administered.

Issues, Concerns & Gaps

- Prompt recognition and diagnosis Cauda equina (harm to be validated)
- Available space within ED impacting physical (mobility) assessments being completed with suspected fracture.
- Early recognition and prevention of deterioration of pressure damage when admitted with developing PU.
- DKA pathway not being followed as per guidance

Actions & Improvements

- Enhanced TVN support for wards with turning and repositioning. Working with MCH to reduce PUs on arrival.
- A3 to commence to address histology issues between MFT and MTW.
- DKA working group set up to improve best practice in line with guidance.
- Therapies and ED to review requirement for mobility assessment
- Copy and Paste function removed from EPR.
- Process for updating TEP form communicated to resident doctors via teaching sessions, local ward induction and Trust induction.
- Sickle Cell Policy reviewed and updated. Formal teaching
- session for relevant staff on Sickle Cell. Enhanced pain management SOP created and shared with all relevant staff via MDT & MDMs.

Quality

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

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	1.30%			1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.52%	1.80%	2.32%	1.90%	1.64%

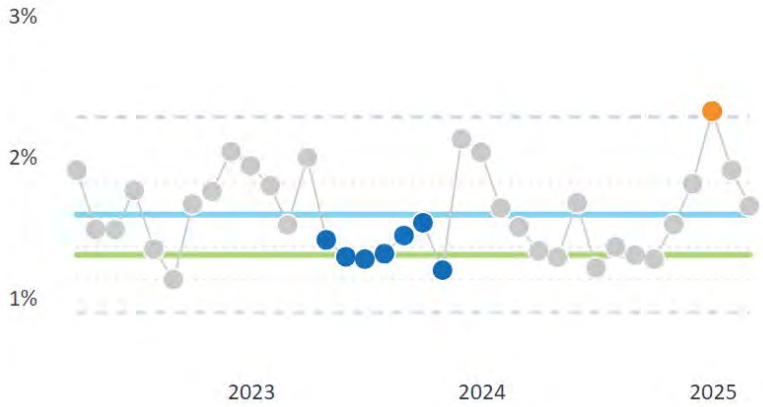
True North Domain: Quality

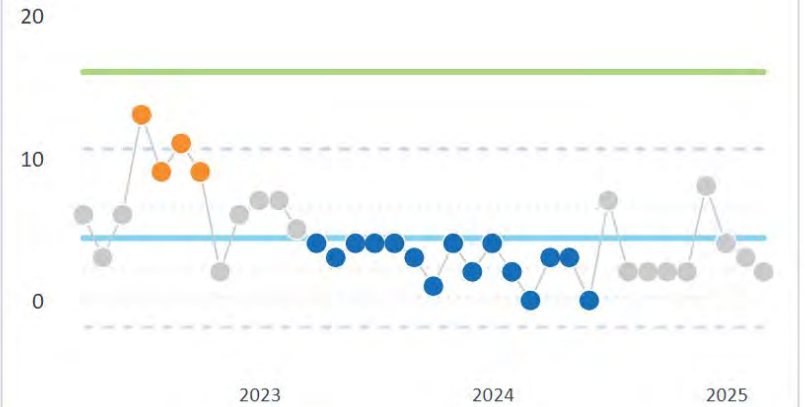
KPI Threshold: 1.30%

Sub Domain KPIs: 16

Variation Summary:

9	0	5	1	1





Key Messages

- HSMR+ for Nov 23- Oct 24 is 93.3 and 'as expected'. HSMR+ continues to remain stable for the Trust
- SHMI for Nov 23- Oct 24 is 1.20 and 'higher than expected'
- 14.8% deaths were subject to SJR with 1 avoidable death identified.
- 11 cases for stage 2 review following initial SJR review as potentially avoidable or overall care score graded as poor.
- 1 Case was escalated to a Patient Safety Incident Investigation (PSII) as an avoidable death.

Issues, Concerns & Gaps

- SJR completion has increased to 14.8% of deaths however is reliant upon clinical staff capacity to undertake reviews.
- SHMI continues to be higher than expected
- COPD remains an outlying diagnosis group for the Trust

Actions & Improvements

- A3 on SJR completion to achieve the 12.5% target has achieved target, work ongoing to ensure sustainability.
- Review of current SJR referral process to IRG/PSIRG for patients deaths more than likely due to problems in care. Focus on learning and actions.
- 1 SJR case identified the need for recommencing the joint ED and Critical Care M&M, excellent attendance (over 30 clinicians) with some well thought joint actions aimed at improving working between the teams for complex patients.
- MEOs & ME's planned return to site in April.

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0		F	Watch is red for 4 reporting periods	9	8	8	11	9	5
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	84.6%	85.3%	84.7%	82.9%	82.2%	82.9%
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	Watch is red for 4 reporting periods	31	17	26	34	39	30
	Mortality			SHMI (12m)	1	H	F	Watch is red for 4 reporting periods	1.20					
				Fractured NOF Within 36 Hours	92.0%		?	Watch is red for 4 reporting periods	66.6%	76.2%	83.3%	70.7%	60.9%	

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Incident Management			After Action Review (AAR) Closed	-	H	Special cause of improving nature or lower pressure due to (H)igher values	2	1	3	2	4	6
				Duty of Candour Compliance Stage 1 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	84.6%	85.3%	84.7%	82.9%	82.2%	82.9%
	Falls			Falls Resulting in Death	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Mortality			HSMR (12m)	100	L	Special cause of improving nature or lower pressure due to (L)ower values	97.68	99.61				
				Number of LD Deaths Reviewed via SJR	-	H	Special cause of improving nature or lower pressure due to (H)igher values	0	4	0	0	1	4
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	99.7%	99.8%	99.1%	98.9%	97.4%	94.4%
	Risk & Policy			Risks Open - Moderate (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	22	20	20	22	19	17
				Risks Open - High (Month End Snapshot)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	45	41	47	45	47	48
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	82.9%	84.2%	84.5%	84.0%	84.0%	83.7%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.3%	87.0%	86.9%	86.1%	86.0%	85.3%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

VTE - Overall compliance has fallen slightly this reporting period. S&A and CCCS have scored below 90% for completed VTE risk assessments within 24 hours; The number of HAT has reduced by 50% since January 2025
Falls - The number of falls reduced in the last reporting period, the falls that occurred were low/no harm; New integral falls alarms have been purchased and deployed in line with the mattress replacement programme.
HAPU - The number of HAPU has reduced in the last reporting period; Intensive support to be provided to Lawrence, Emerald, Phoenix and Kingfisher by TVN team (QIP 1.4); The replacement mattress project is underway and on trajectory for completion in late April 2025
FNOF-A total of 32 patients with hip fractures were admitted in March 2025. Of these 7 patients breached the 36 hours target, resulting in 71.42% compliance for timely surgery. Our performance in March 2025 was better than the Feb 2025 compliance rate of 60.9%. Four of the 32 patients breached due to insufficient theatre time and 3 patients required medical optimisation prior to surgery. Medway's KPI for prompt surgery (63%) remains above the national average of 58% on NHFD national audit database.

Issues, Concerns & Gaps

VTE - Paediatric areas since moving to EPR are scoring 0% for VTE assessments in patients over the age of 16 years; There has been delays in administering thromboprophylaxis to patients in the ED who have been provided a DTA; HAT data has not been officially reported on the IQPR due to data quality issues
Falls - There have been significant staffing challenges in the Falls team which has affected the trajectory of targets from the QIP.
HAPU - There has been a noticed increase in level of harm over the last quarter, this has been reflected similarly across the network and wider system.
FNOF – Availability of theatre slot remains a main challenge. To mitigate this we are doing lots of cases as TCI ambulatory trauma and day case trauma. However, often we have patients in groups of 4-5 admitted over a single 24 hour period, making the 36-hour target a challenge. Also, we are seeing patients who have significant co-morbidities and have acute medical issues that needs optimisation prior to surgery to reduce peri-operative mortality – this results in delayed surgery, but remains in the best interest of patients.

Actions & Improvements

VTE - VTE Team are working with the leads from Paediatrics and EPR team through the A3 group to improve the VTE risk assessment reporting overall. A hard stop will be introduced on the Paediatrics EPR to ensure completion; As part of the QI improvement in ED, a quality week will commence in ED in early May. Pop up teaching and information will be shared in relation to the administering of thromboprophylaxis and to identify any learning from a VTE perspective; The VTE lead is working with the BI team for a resolution to HAT data issues and reporting positive VTE scans. This should be complete in mid-may 2025. This will be reflected on the IQPR for assurance.
Falls - The Falls lead has successfully recruited into the vacant falls CNS posts. They will commence in role early April and early May 2025; The ADPE is supporting the falls lead with QIP trajectory actions to ensure divisional compliance.
HAPU - The TVN, quality team and PE team will be attending a system wide harm reduction summit in late April 2025 led by the ICB. This will be to share learning and identify and contributory factors within the system and local learning
FNOF- Extending the orthogeriatric service and care to NAFF patients has been a significant change in our pathway offering safe and equitable care. The e-trauma tag also is helping us identify these patients to ensure optimum care. We have created the anti-coagulation SOP to standardise care for patients on anti-coagulants and thereby reducing some of the breaches. The MDT approach with anaesthetist, orthopaedics and orthogeriatricians is helping us optimise medically unwell patients to ensure safe peri-operative care.

Maternity

Key Messages

- Perinatal Quality – Incidents March 2025: 1 Incidents in maternity rated Moderate harm or above; 0 new MNSI cases; 136 ↓ incidents reported in Maternity, 36 were graded Low harm; 31 ↑ relating to PPH >1000mls; 19 ↑ Incidents in NICU, 5 ↓ relating to medication. 2 graded as Low harm
- Perinatal Quality – PMRT – March 2025: Neonatal deaths – March 2025 (1 MBRRACE reportable for MFT) - 25+0 Extreme prematurity following placental abruption. (MBRRACE and PMRT); 24+1 Ex-utero transfer (MBRRACE reportable at birthing trust); 17+1 early neonatal death (CDOP only). Stillbirths March 2025 - 2 stillbirths, 25+4 , 31+3 (both likely placental abruption) (MBRRACE and PMRT)
- Training – March 2025: Rolling training dates for 2025 in place for Fetal Monitoring and PROMPT to maintain compliance with CNST. Trajectory to be monitored monthly along with compliance figures; Midwifery staff 86.5% complaint with Safeguarding Adults level 3.
- Staffing: 11.56 WTE Band 5/6 vacancy with good recruitment pipeline. Trajectory to have vacancy reduced to 2.43 WTE by June 2025.

Issues, Concerns & Gaps

- Perinatal Quality – Incidents March 2025: An ongoing audit of 3rd and 4th degree perineal tears is in progress, with continued efforts to enhance education for healthcare professionals in the detection and management of perineal trauma.
- Variability exists in the grading of harm severity at both local and national levels. Further work is needed to standardize assessment criteria to ensure consistency in incident classification
- Perinatal Quality - PMRT –March 2025: Disconnect between MBRRACE reportable and figures reported by BI. Parameters are not the same; 2 PMRT reviews held in March and areas for improvement included:
- Timeline of results not communicated to parents; Communication with parents throughout care and resus of baby; Documentation – aspects of care not recorded with sufficient clarity to give assurance that care and communication with parents was undertaken.
- Training – March 2025: Safeguarding Children's – Midwifery staff –84%; Medical Staff 83% (↑); Safeguarding Adults Medical Staff – 78% (↑);
- Staffing: Working with Universities to provide additional support to students as required and to discuss interview process.

Actions & Improvements

- Perinatal Quality – March 2025: OASI-2 was officially launched in February, with additional teaching integrated into mandatory training from January 2025. Training sessions will be delivered by our consultant team to enhance clinical competency in perineal trauma management; The IOL pathway continues to strengthen, with a particular focus on reducing delays in the system once induction has commenced. Ongoing efforts aim to streamline processes and improve patient flow; A comprehensive review of the Maternal Care Unit (MCU) and 'Call the Midwife' services is underway to optimize their utilization and enhance accessibility for maternity service users.
- Perinatal Quality – PMRT – March 2025: Publication of maternity patient information booklet to support communication of expectations; Neonatal Training Action plan for both documentation and communication to ensure all clinical care is documented in a timely fashion with checklist in place to support this; Consider aligning Trust Dashboard with MBRRACE reporting.
- Training – March 2025: OCSE training in obstetric emergencies delivered for student midwives; Student midwives requiring attendance at additional births to gain registration being mapped to intrapartum care to support this and support the recruitment pipeline.
- Staffing: 24 newly qualified band 5 midwives in preceptorship since January 2025. Will increase to 39 by April 2025; Action plan to be developed in response to Staff Survey results 2024; Lead midwife for IOL now in post substantively – to continue to work with patients and staff on further improvements to the pathway.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	98.8%	99.3%	98.6%	99.3%	99.2%	99.0%	99.1%	99.1%	98.9%	98.7%	99.2%	99.3%
				Total Incidents Reported	-			1,191	1,228	1,179	1,229	1,199	1,055	1,139	1,112	1,068	1,207	1,245	1,334
				Clinical Incidents with Harm (Moderate and above)	0		F	8	5	12	3	6	10	9	8	8	11	9	5
				Incidents Open - Month End	-			2,969	1,861	1,912	2,011	2,176	2,178	1,931	1,653	1,742	1,687	1,707	1,782
				Incidents Overdue - Month End	-	H		2,000	886	971	1,062	1,223	1,220	1,094	740	780	748	657	715
				Patient Safety Incident Investigations (PSII) Declared	-	H		2	0	1	0	0	0	2	0	0	1	1	1
				Patient Safety Incident Investigations (PSII) Closed	-			0	0	0	0	1	1	1	2	0	0	0	0
				Patient Safety Incident Investigations (PSII) Open - Month End	-	H		2	2	3	3	2	1	2	0	0	1	2	3
				After Action Review (AAR) Declared	-			1	5	3	2	0	4	0	7	2	6	5	1
				After Action Review (AAR) Closed	-	H		1	4	2	2	3	2	2	1	3	2	4	6
				After Action Review (AAR) Open - Month End	-	H		3	4	5	5	2	4	2	8	7	11	12	8
				Never Events	0		?	0	0	0	0	0	0	2	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Incident Management			Duty of Candour Compliance Stage 2 %	-			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				RIDDOR Incidents	-			2	2	0	1	0	3	3	3	1	0	1	0
				RIDDOR Compliance %	-			100.0%	100.0%	-	100.0%	-	100.0%	66.7%	100.0%	100.0%	-	100.0%	-
				Health & Safety Incidents	-			128	97	85	97	55	43	64	54	45	53	46	44
				Sharps Injuries	-			2	6	7	12	13	10	6	13	7	9	5	7
				EDNs Completed Within 24hrs %	90.0%			78.9%	81.6%	79.9%	83.0%	84.1%	82.6%	84.6%	85.3%	84.7%	82.9%	82.2%	82.9%
				Violence & Aggression Incidents	126			204	166	174	157	139	108	119	99	123	116	172	247
				Assaults - Patient on Staff	-			108	70	76	71	60	40	62	35	53	57	66	73
	Falls			Low or No Harm Falls %	95.0%			94.6%	98.8%	99.0%	100.0%	98.8%	97.8%	98.0%	100.0%	100.0%	98.2%	100.0%	100.0%
				Falls - Total	-			74	85	102	93	82	92	102	74	83	114	90	70
				Falls - Low Harm	-			15	18	21	29	21	29	33	27	21	34	35	30
				Falls - Moderate Harm	-			2	1	1	0	0	1	2	0	0	1	0	0
				Falls - Severe Harm	0			2	0	0	0	0	1	0	0	0	1	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Falls			Falls Resulting in Death	0	L	?	0	0	0	0	1	0	0	0	0	0	0	0
				Falls per 1,000 Bed days	-			-	-	-	-	-	-	-	-	-	-	-	-
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	15	16	19	19	23	22	31	17	26	34	39	30
				Pressure Ulcers - Grade 2	-	H		8	8	6	8	18	15	24	9	15	20	19	9
				Pressure Ulcers - Grade 3	-	H		7	8	13	10	4	7	6	7	11	13	18	19
				Pressure Ulcers - Grade 4	-	H		0	0	0	1	1	0	1	1	0	1	2	2
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			-	-	-	-	-	-	-	-	-	-	-	-
	Medicines			Medicine Errors - Total	-			88	61	68	99	94	68	89	92	78	75	70	99
				Low or No Harm Medicine Errors %	95.0%		P	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	98.6%	100.0%
	IPC			IPC Incidents	-	H		38	54	31	66	108	49	59	55	53	51	46	50
				C-Diff Cases - Hospital Acquired Total	-			4	4	2	4	7	11	5	6	5	6	4	6
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	53			4	8	10	14	21	32	37	43	48	54	58	64
				C-Diff Cases - Hospital Acquired (HOHA)	-			2	3	2	4	4	4	5	4	1	6	4	4

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	IPC			E.coli Cases - Hospital Acquired	-			6	3	5	6	9	2	5	8	2	2	7	4
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			6	9	14	20	29	31	36	44	46	48	55	59
				MRSA Cases - Hospital Acquired	0		?	0	0	0	0	0	0	0	0	2	0	0	0
				MSSA Cases - Hospital Acquired	-			4	1	0	0	3	4	1	1	3	2	4	1
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			4	5	5	5	8	12	13	14	17	19	23	24
	Mortality			Crude Mortality Rate %	1.30%		?	1.33%	1.28%	1.67%	1.21%	1.36%	1.30%	1.27%	1.52%	1.80%	2.32%	1.90%	1.64%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	1	2	0	2	0	0	0	0	2	1	1	1
				Avoidable 2222 Calls – Peri-Arrests	3		?	1	1	0	5	2	2	1	2	6	3	2	1
				Avoidable 2222 Calls	16		P	3	3	0	7	2	2	2	2	8	4	3	2
				HSMR (12m)	100	L	?	98.08	98.15	98.90	99.14	98.65	99.21	97.68	99.61				
				HSMR Expected Death Rate (12m)	-	H		5.1%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.3%				
				HSMR Expected Death Rate (Month)	-			4.9%	4.7%	5.6%	4.8%	5.5%	4.9%	4.7%	5.9%				
				SHMI (12m)	1	H	F	1.19	1.18	1.20	1.20	1.20	1.20	1.20					
				SHMI Expected Death Rate (12m)	-	H		3.0%	3.0%	3.0%	3.1%	3.1%	3.1%	3.1%					

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Mortality			SHMI Crude Death Rate (12m)	-			3.6%	3.5%	3.6%	3.7%	3.7%	3.7%	3.7%					
				Fractured NOF Within 36 Hours	92.0%			60.0%	51.5%	52.5%	56.5%	74.1%	66.6%	66.6%	76.2%	83.3%	70.7%	60.9%	
				Number of Deaths Reviewed via SJR	-			13	6	13	13	5	16	16	18	14	13	10	18
				SJRs Completed %	12.5%			9.3%	4.5%	9.3%	11.2%	4.1%	13.1%	12.1%	11.9%	9.4%	6.6%	7.2%	14.8%
				Total Number of Deaths Due to Failings in Care	-			1	0	0	0	0	0	0	0	1	1	0	2
				Number of LD Deaths Reviewed via SJR	-			1	2	0	1	0	0	0	4	0	0	1	4
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			99.1%	99.4%	99.5%	99.8%	99.0%	99.2%	99.7%	99.8%	99.1%	98.9%	97.4%	94.4%
	Maternity			Caesarean Section %	-			43.5%	44.2%	50.5%	42.5%	49.4%	49.2%	51.0%	48.6%	48.1%	46.5%	51.1%	45.1%
				Elective C-Section %	-			21.0%	17.2%	19.8%	17.3%	20.0%	19.4%	19.8%	19.4%	21.8%	19.8%	22.3%	21.2%
				Emergency C-Section %	-			22.5%	27.0%	30.7%	25.2%	29.4%	29.8%	31.1%	29.1%	26.3%	26.6%	28.7%	23.9%
				PPH greater than or equal to 1500mls	-			12	18	14	12	20	12	14	16	20	18	12	15
				Total Number of Still Births Greater Than 24 weeks Gestation	-			0	3	2	0	1	2	0	0	0	2	2	2

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Quality	Maternity			Neonatal Deaths	-			0	1	0	2	2	1	0	2	2	3	3	3
				Maternity and Newborn Safety Investigations (MNSI) Declared	-			0	0	0	0	0	0	1	0	0	2	1	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	1	1	1	0	0	1	0	0	0
	Risk & Policy			Risks Open - Low (Month End Snapshot)	-			3	5	4	1				1	1	1	1	3
				Risks Open - Moderate (Month End Snapshot)	-	L		41	38	32	33	24	23	22	20	20	22	19	17
				Risks Open - High (Month End Snapshot)	-	L		94	85	81	82	47	46	45	41	47	45	47	48
				Risks Open - Extreme (Month End Snapshot)	-			15	13	12	11	10	11	7	6	5	5	6	8
	Health & Safety			Resuscitation Training Compliance %	-	H		83.0%	83.1%	83.9%	83.6%	83.6%	82.9%	82.9%	84.2%	84.5%	84.0%	84.0%	83.7%
				Mental Capacity Act Training Compliance %	-	H		84.0%	84.9%	85.1%	85.6%	86.6%	85.5%	86.3%	87.0%	86.9%	86.1%	86.0%	85.3%
	Legal & Information Governance			Inquests Received	-			14	13	10	15	10	7	7	12	8	15	8	7
				Inquest Hearings	-			8	6	5	10	11	3	5	5	6	7	5	6
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

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

NHS Medway NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	15	4	8	15	2	4
Emergency Care	6	4	1	3	1	3

Operational Leads:
Stewart Nisbet - *Director, Surgery and Anaesthetics*
Nicola Cooper - *Director, Medicine and Emergency Care*
Sam Chapman - *Director, Cancer and Core Clinical Services*
Nadia Stevens - *Director, Women, Children and Young People*

Committees:
Finance & Performance Committee

Systems & Partnerships

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

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	54.0%	L	?	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%	49.9%	50.1%	51.0%	52.3%

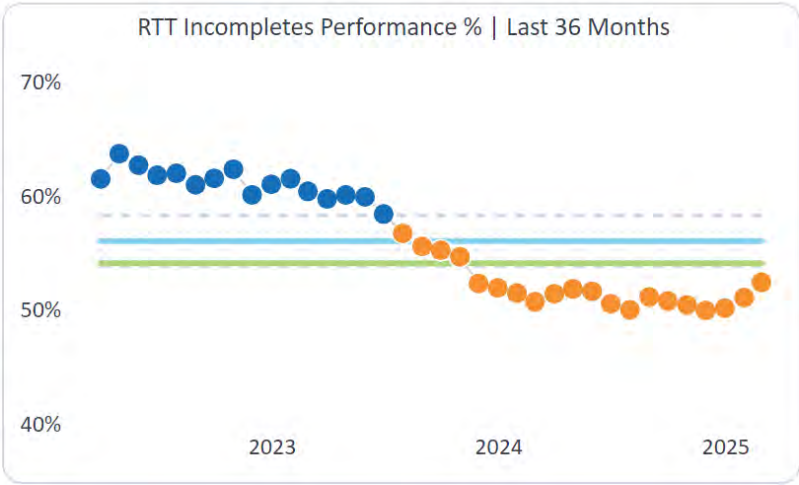
True North Domain: **Systems & Partnerships**

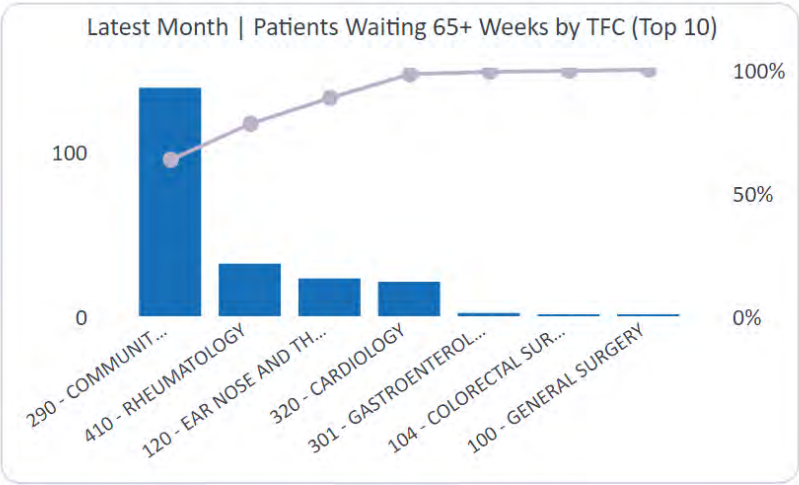
KPI Threshold: 54.0%

Sub Domain KPIs: 27

Variation Summary:

	L	H	L	H
15	2	6	2	2





Key Messages

- Incomplete performance was 52.3% for March which is the highest performance in the year.
- The number of patients waiting over 65 weeks at the end of March was 219 including Community Paediatrics (139). Community Paediatrics is excluded from RTT National reporting including the >65 week position. There as been a reduction of 98 patients waiting >65 weeks from previous month.
- Trajectory for end of April is 0 except for patient choice. Daily monitoring of patient pathways continues. Community Paediatrics are excluded.
- Fortnightly Tier 2 meetings still in place with NHSE and ICB to monitor elective performance and provide any necessary support

Issues, Concerns & Gaps

- No General Manager for Rheumatology and Neurology, out to advert closes 17 April 2025.
- Rheumatology capacity is reliant on consultant engagement for additional sessions and recruitment.

Actions & Improvements

- Ongoing discussions with KIMs for Rheumatology outpatient support, not part of spec com contract, awaiting confirmation of tariff.
- MTW have offered PTL validation support; patient cohorts agreed with MTW, awaiting system access.
- Intensive Support Team report received. Recommendations in relation to process and reporting to be included within Elective Reform work streams.
- Liaise with BI to remove Community Paediatrics from RTT reporting in IQPR.

Systems & Partnerships

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

Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	78.0%			81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%

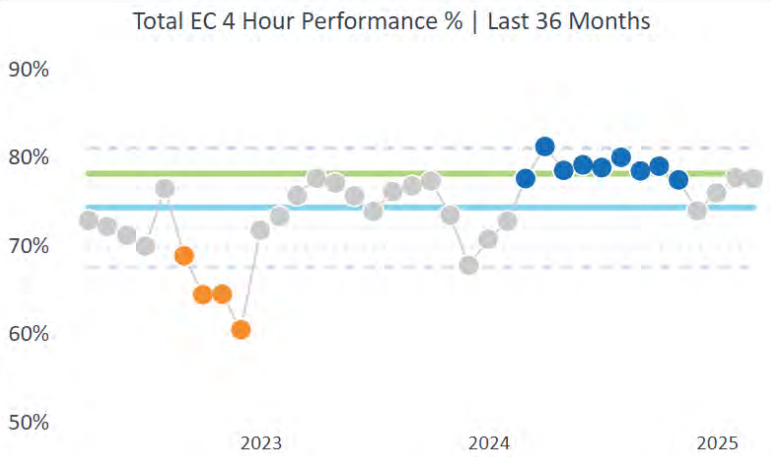
True North Domain: Systems & Partnerships

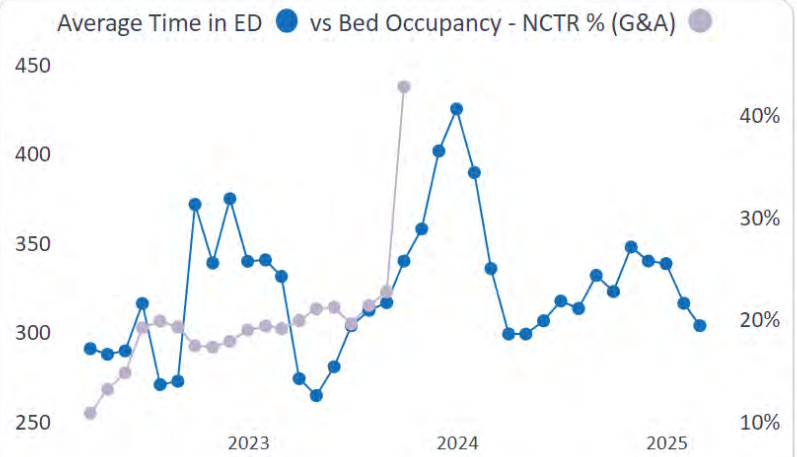
KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary:

6	0	1	3	1





Key Messages

March has been a good month for Emergency Department (ED) performance, meeting the national target of 76%. Performance averaged 77.82% for the month, with a high of 85.09%, and an impressive 7 days where performance reached the 80s. Only 6 days in the month fell below the national target, a reduction of one day compared to February.
There is ongoing focus around effective use of care pathways, including streaming to SDEC, FSDEC, MedOCC, and ensuring specialty appropriateness in order to drive performance and improve patient flow.
The department remains focused on continuous improvement—for both our patients and our staff.

Issues, Concerns & Gaps

Poor flow through CDU area. This is predominantly due to the inability to be able to staff this area with a registered nurse due to high number of patients and high acuity levels. With the capacity to staff CDU with a RN the department would be able to see more patients through the unit however. ED nursing to provide staffing when majors are not lodging and patient numbers are lower. The leadership team continue to work closely on the shop floor with staff to drive performance through use of pathways to other care providers, streaming to SDEC, FDEC, MedOCC and speciality appropriateness.
Work continues around ED breaches and live validations, the operational team are working hard to improve and sustain higher levels of this.

Actions & Improvements

SDEC streamed patients remains high at 503 for March.
Drive and improve the utilisation of CDU & plan workforce around this to ensure we are utilising 24 hours a day with RN and RMN support. March has seen a positive response to RMN support for the area to function smoothly, ED has seen a positive Trust response for staffing support across the Trust.
Ambulance handover remains one of the best in the region with the most ambulances taken in compared to any other Trust, this is a continued fantastic effort from the team and we strive to uphold these standards. MFT consistently sees more patients than any other Trust and still retains excellent handover standards.
Nursing funding has been established for 45 additional staff members.
Care group decline in sickness from 6% > 4%, following a 6 month incline in performance

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	H	F	Driver is red for 2 reporting periods	348	229	248	349	317	219
				RTT 52 Week Breaches	1,250	H	?	Watch is red for 4 reporting periods	2,265	2,118	1,938	2,021	2,005	1,979
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	111.21	116.61	107.62	118.50	121.51	120.09
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%		?	Watch is red for 4 reporting periods	97.3%	90.0%	94.7%	85.2%	96.4%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	Watch is red for 4 reporting periods	58.1%	65.0%	63.7%	55.9%	62.9%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	Watch is red for 4 reporting periods	28.6%	84.2%	70.0%	44.4%	69.6%	
				Cancer 28 Day Faster Diagnosis %	77.0%		?	Watch is red for 4 reporting periods	76.1%	71.7%	70.5%	68.4%	69.4%	
				Critical Care Discharge Delays > 4Hrs	7.1%		F	Watch is red for 4 reporting periods	69.5%	49.5%	67.3%	53.1%	53.5%	62.4%
	Emergency Care			Total EC 4 Hour Performance - Non-Admitted %	85.0%		?	Watch is red for 4 reporting periods	85.0%	82.2%	79.2%	81.5%	82.9%	83.2%
				Type 1 EC 4 Hour Performance %	75.0%		F	Watch is red for 4 reporting periods	67.8%	65.8%	58.3%	61.1%	64.7%	65.8%
				Total EC 12 Hour DTAs	0	H	F	Watch is red for 4 reporting periods	693	771	771	756	706	688
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	Watch is red for 4 reporting periods	322.42	347.30	339.45	338.01	315.81	303.29

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.0%	5.5%	6.4%	5.5%	5.2%	5.8%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.72	1.67	1.76	1.77	1.77	1.63
				Day Case Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	86.0%	87.5%	88.7%	86.2%	86.3%	87.1%
				DM01 Performance %	73.1%	H	Special cause of improving nature or lower pressure due to (H)igher values	72.3%	78.4%	78.3%	82.5%	87.4%	91.1%
	Emergency Care			IP Discharged Before Noon % (Inc transfers to ADL)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	20.6%	21.5%	17.6%	21.1%	20.0%	21.4%
				Ambulance Handover Delays (> 30 mins)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	77	76	145	137	86	77
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	2	6	10	8	1	0
				30 Day Readmission Rate	13.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	7.1%	7.4%	7.8%	7.4%	8.1%	7.9%

Access

Key Messages

- Incomplete performance was 52.3% for March which is the highest performance in the year.
- The number of patients waiting over 65 weeks at the end of March was 219 including Community Paediatrics (139). Community Paediatrics is excluded from RTT National reporting including the >65 week position. There as been a reduction of 98 patients waiting >65 weeks from previous month.
- Trajectory for end of April is 0 except for patient choice. Daily monitoring of patient pathways continues. Community Paediatrics are excluded.
- Fortnightly Tier 2 meetings still in place with NHSE and ICB to monitor elective performance and provide any necessary support.

Issues, Concerns & Gaps

- No General Manager for Rheumatology and Neurology, out to advert closes 17 April 2025.
- Rheumatology capacity is reliant on consultant engagement for additional sessions and recruitment

Actions & Improvements

- Ongoing discussions with KIMs for Rheumatology outpatient support, not part of spec com contract, awaiting confirmation of tariff.
- MTW have offered PTL validation support; patient cohorts agreed with MTW, awaiting system access.
- Intensive Support Team report received. Recommendations in relation to process and reporting to be included within Elective Reform work streams.
- Liaise with BI to remove Community Paediatrics from RTT reporting in IQPR.

Emergency Care

Key Messages

- Non-Admitted 4 Hour - Despite a 2 month dip through Dec > Jan , March has seen a continued positive incline at 77.8%. April is currently on target to exceed 76%.; Decrease LOS in the department with March achieving 3.8% which is the lowest in 5 months; Initial assessment continued increase achieved nearly overall 60% for March; Continued push for improvement of CDA utilisation with the aim of exceeding previous high numbers of ambulant patients via CDA; Development of SDEC, Single point of access Pathways via ED; Continue to implement no bedded patients in Area 3 to help create flow through Area 3 and relieve other area's of the department during sustained pressures; Continue to work towards implementation of HARIS initiatives covering High Intensity Users and reduction of Ambulance Conveyance; CDA has shown a decrease in patients showing 2974 from Feb 299.. We strive for continuous improvement and to exceed 300 patients streamed via CDU. Work on staffing is being undertaken to allow more patients via this area.

- Admitted 4 Hour - Continued improvement in utilisation of SDEC pathways, streaming to MedOCC, avoiding DTA's; Top breach reasons have shown a change and selection of reasons for breaches, granular work is being done to establish reasons and next steps; De-escalation and protection of recently escalated EAU and Discharge lounge, and embedding of escalation processes to improve flow.

Issues, Concerns & Gaps

- Non-Admitted 4 Hour - Type 3 performance: Sustained non admitted performance; Mental Health CDA utilisation; SDEC opening overnight, although a decline by 19 patients in March SDEC had 139 overnight stays. This is a decline.
- SDEC Emergency Pathway established pilot to reduce number of DTAs; Utilisation of Mental Health pathways, collaborative working with KMPT, exploring a dual role MHP/AMP; Granular review of breach data to identify areas of concern in the department, focusing on specific areas; Continuation of attention to ambulance handover.
- Drive on morale and incivilities within the Care Group.
- Security in ED PID to be started, drive for reduction of V&A cases in the department.
- System capacity; Staffing shortages and sickness.
- Finance capabilities to implement improvements.
- High acuity and increased attendances via ED.
- Industrial Action.
- Complete system outage planned may cause risk and compromise patient safety, robust plan to be implemented.

Actions & Improvements

- Partnership working with KMPT to fully utilise mental health pathways.
- Direct access to SDEC via SECAMB.
- SDEC emergency care pathway.
- Collaborative work with other specialities for streamlined pathways to appropriate patient care.
- Extension of 111 direct access booking times.
- Increase in workforce to maximise patient care and experience.
- System partnership working to address and understand support when acute Trust is at critical capacity.
- KMPT to review and address prolonged wait times for mental health patients i.e. awaiting admission.
- Go Live with NHSE for Front Door Model.

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	L	?	51.3%	51.8%	51.5%	50.5%	49.9%	51.1%	50.7%	50.4%	49.9%	50.1%	51.0%	52.3%
				RTT 65+ Week Waiters	0	H	F	284	404	549	630	542	390	348	229	248	349	317	219
				RTT 40+ Week Waiters	-	H		6,434	6,627	6,662	6,736	6,778	6,274	5,917	5,777	5,982	5,843	5,745	5,704
				RTT Waiting List Size	-	H		44,751	44,491	44,528	44,477	44,130	43,248	42,912	42,165	41,518	40,726	40,831	40,842
				RTT 52 Week Breaches	1,250	H	?	2,360	2,610	2,834	2,922	2,687	2,362	2,265	2,118	1,938	2,021	2,005	1,979
				OP Average Time to First Appointment (days)	60	H	F	107.64	105	109.35	104.30	109.03	117.62	111.21	116.61	107.62	118.50	121.51	120.09
				Outpatient DNA Rate %	10.0%	L	P	6.1%	6.3%	6.3%	6.3%	6.2%	6.2%	6.0%	5.5%	6.4%	5.5%	5.2%	5.8%
				OP First to Follow Up Ratio	-	L		1.80	1.68	1.69	1.74	1.64	1.75	1.72	1.67	1.76	1.77	1.77	1.63
				Operations Cancelled by Hospital on Day	13		?	13	11	10	15	18	11	12	15	8	17	10	4
				Urgent Operations Cancelled for 2nd Time	0		?	2	5	1	0	1	0	1	2	1	1	0	0
				Day Case Rate %	-	H		86.0%	85.5%	85.0%	84.4%	83.9%	86.5%	86.0%	87.5%	88.7%	86.2%	86.3%	87.1%
				Average Elective Length of Stay (days)	3		?	2.93	3.43	2.84	2.73	2.31	2.65	2.62	2.21	2.86	2.57	2.09	2.21
				Average Non-Elective Length of Stay (days)	10	H	P	4.51	4.50	5.38	6.06	6.11	6.16	6.46	6.61	6.31	6.43	6.59	6.43

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Systems & Partnerships	Access			104 Day Cancer Waits	-			16	9	17	17	14	12	16	21	9	18	11	
				Cancer USC Performance %	93.0%			73.4%	70.1%	68.7%	70.6%	72.7%	93.6%	96.2%	94.9%	94.0%	82.2%	82.4%	
				Cancer USC Performance - Breast Symptomatic %	93.0%			2.9%	0.0%	9.9%	9.7%	38.6%	84.6%	97.9%	95.2%	90.6%	56.0%	14.4%	
				Cancer 31 Day First Treatment Performance %	98.2%			94.9%	98.1%	97.2%	96.4%	96.2%	97.2%	93.5%	96.5%	100.0%	91.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%			90.5%	100.0%	100.0%	100.0%	100.0%	100.0%	97.3%	90.0%	94.7%	85.2%	96.4%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%			75.0%	94.6%	92.6%	96.4%	100.0%	93.9%	97.4%	100.0%	100.0%	97.3%	100.0%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	F	67.4%	67.6%	68.2%	67.7%	67.2%	64.3%	58.1%	65.0%	63.7%	55.9%	62.9%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%			71.4%	71.4%	81.6%	85.7%	79.2%	87.2%	82.4%	79.4%	67.9%	77.6%	82.0%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%			77.6%	84.2%	80.0%	84.6%	66.7%	90.6%	28.6%	84.2%	70.0%	44.4%	69.6%	
				Cancer 28 Day Faster Diagnosis %	77.0%			56.5%	53.7%	52.3%	67.9%	76.4%	76.5%	76.1%	71.7%	70.5%	68.4%	69.4%	
				Cancer 28 Day Faster Diagnosis Screening %	-			72.2%	76.7%	74.5%	62.9%	45.5%	68.1%	65.3%	66.4%	50.5%	31.2%	49.0%	
				DM01 Performance %	73.1%	H		65.4%	67.1%	67.4%	67.6%	63.6%	68.4%	72.3%	78.4%	78.3%	82.5%	87.4%	91.1%
				Critical Care Admission Delays > 4Hrs	6.2%			8.8%	2.8%	4.5%	7.2%	0.9%	2.5%	7.8%	7.8%	6.8%	7.6%	9.4%	4.0%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Systems & Partnerships	Access			Critical Care Discharge Delays > 4Hrs	7.1%		F	53.5%	57.7%	59.2%	57.3%	51.4%	52.4%	69.5%	49.5%	67.3%	53.1%	53.5%	62.4%
	Emergency Care			Total EC 4 Hour Performance %	78.0%		?	81.1%	78.4%	79.0%	78.7%	79.9%	78.3%	78.8%	77.3%	73.8%	75.8%	77.6%	77.4%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%		?	86.9%	84.0%	84.6%	84.1%	85.9%	83.9%	85.0%	82.2%	79.2%	81.5%	82.9%	83.2%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	H		12.7%	13.9%	12.1%	16.6%	17.1%	18.3%	20.6%	21.5%	17.6%	21.1%	20.0%	21.4%
				Type 1 EC 4 Hour Performance %	75.0%		F	69.5%	70.6%	68.8%	68.5%	67.6%	64.9%	67.8%	65.8%	58.3%	61.1%	64.7%	65.8%
				Total EC 12 Hour DTAs	0	H	F	521	587	618	663	576	644	693	771	771	756	706	688
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	298.60	298.55	305.98	317.06	312.84	331.38	322.42	347.30	339.45	338.01	315.81	303.29
				Number of ED Arrivals by Ambulance	-			2,981	2,993	2,869	2,919	2,820	2,887	3,020	3,051	3,248	3,210	2,722	3,021
				Ambulance Handover Delays (> 30 mins)	-	L		67	49	73	59	46	77	77	76	145	137	86	77
				Ambulance Handover Delays (> 60 mins)	0	L	?	3	3	2	2	1	5	2	6	10	8	1	0
				Bed Occupancy - NCTR % (G&A)	-			-	-	-	-	-	-	-	-	-	-	-	-
				30 Day Readmission Rate	13.0%	L	P	9.9%	10.4%	8.7%	8.5%	8.4%	7.4%	7.1%	7.4%	7.8%	7.4%	8.1%	7.9%

People

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

NHS Medway NHS Foundation Trust

Leon Hinton
Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	8	22	2	7	15	10
Compliance	1	1	0	1	0	1
Diversity	0	2	0	0	0	0
Safe Staffing	1	2	0	1	0	1
Workforce	10	6	1	11	0	2

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

Committees:
People Committee

People

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

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
	6.93	H	F	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74

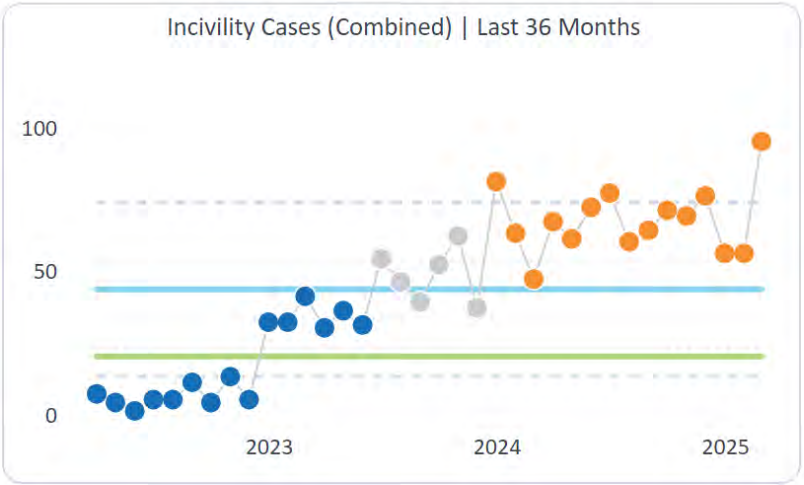
True North Domain: | People

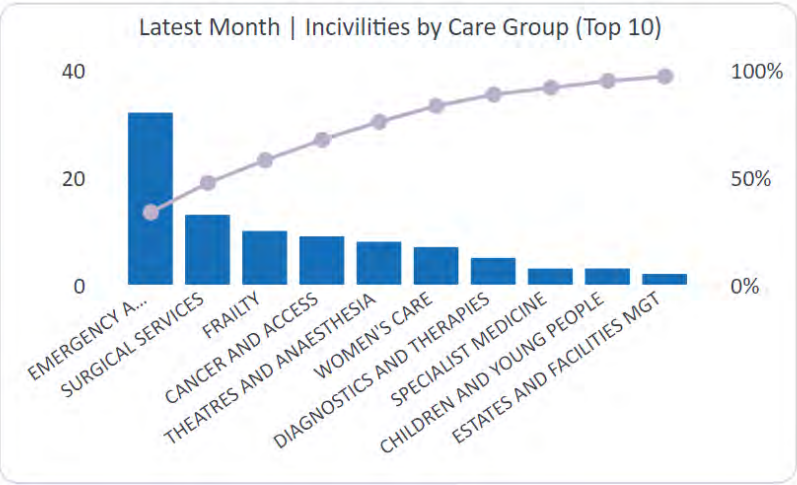
KPI Threshold: | 6.93

Sub Domain KPIs: | 17

Variation Summary:

	L	H	L	H
10	0	1	4	2





Key Messages

The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey. In March 2025, our staff engagement has improved (+0.09) moving the Trust into the next quartile.

As a weekly breakthrough objective with the aim of reducing reported incivilities by 50%, we are aiming to have concluded consolidation of all data source by March. The sensitivity of the family and friends test narrative has been improved (increasing the number of cases). A number of interventions have now been commissioned following triangulation to address incivilities in specific teams.

Issues, Concerns & Gaps

- Potential duplicate reporting of incivilities via multiple reporting routes;
- Sensitivity of narrative may overestimate the number of reported incivilities;
- Lack of confidence in reporting processes;
- Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice.

Actions & Improvements

- Catchball with divisions for a new breakthrough objective;
- Building into the reporting dashboard the additional sources;
- Continued development of the root causes via A3 methodology in tandem with refresh of the strategic objective for people.

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	Workforce			Incivility Cases (Combined)	20	H	?	Driver is red for 2 reporting periods	71	69	76	56	56	95
				Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%
				Sickness Absence Rate - Total %	4.0%		?	Watch is red for 4 reporting periods	5.3%	5.3%	5.3%	5.6%	5.1%	4.4%
				Sickness Absence Rate - Short Term %	2.0%		?	Watch is red for 4 reporting periods	2.5%	2.6%	2.7%	3.2%	2.7%	2.2%
				Sickness Absence Rate - Long Term %	2.0%		?	Watch is red for 4 reporting periods	2.8%	2.6%	2.6%	2.4%	2.5%	2.1%
				Time to Hire - AfC	42		?	Watch is red for 4 reporting periods	60	58.30	45.40	55.60	63.80	54.90
	Safe Staffing			Care Hours per Patient Day (CHPPD)	9.50	H	F	Watch is red for 4 reporting periods	8.71	8.55	8.62	8.58	8.80	8.97
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%		F	Watch is red for 4 reporting periods	80.7%	80.1%	79.4%	79.3%	78.3%	79.4%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	Watch is red for 4 reporting periods	50.6%	51.7%	51.5%	53.7%	54.6%	54.2%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	79.4%	81.3%	84.5%	84.8%	82.2%	82.0%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	81.9%	83.3%	81.8%	82.1%	79.1%	83.4%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	81.2%	82.3%	83.0%	81.8%	82.1%	81.2%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	78.3%	76.7%	77.6%	78.1%	77.9%	80.6%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	StatMan			StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	76.3%	77.3%	79.7%	82.2%	80.0%	80.3%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	81.2%	84.2%	82.1%	83.8%	83.6%	81.9%
				StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.5%	83.3%	82.5%	79.2%	76.1%	74.6%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	75.9%	77.5%	78.5%	78.2%	78.6%	77.3%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	Watch is red for 4 reporting periods	78.4%	81.4%	79.1%	77.2%	77.6%	84.1%
	Compliance			DBS Compliance %	100.0%		F	Watch is red for 4 reporting periods	99.0%	98.9%	99.5%	99.3%	99.5%	99.7%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	Workforce			National Staff Engagement Score	6.93	H	Special cause of improving nature or lower pressure due to (H)igher values	6.74	6.74	6.74	6.74	6.74	
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,115.87	5,128.28	5,145.13	5,152.03	5,177.64	5,203.60
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%
				Time to Hire - Medical	70	L	Special cause of improving nature or lower pressure due to (L)ower values	78	69.90	60.90	61.70	65.90	58.10
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	1.5%	1.4%	1.2%	0.9%	1.1%	0.6%
				Bank Spend %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	9.0%	8.2%	9.6%	9.9%	9.7%	6.6%
	Safe Staffing			Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	90.1%	96.1%	89.2%	88.6%	90.0%	92.5%
				Care Hours per Patient Day (CHPPD)	9.50	H	Special cause of improving nature or lower pressure due to (H)igher values	8.71	8.55	8.62	8.58	8.80	8.97
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	42.7%	43.0%	43.3%	43.3%	43.5%	43.7%
				Diversity of Board %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	30.8%	30.8%	30.8%	28.6%	28.6%	28.6%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	87.2%	87.5%	87.9%	88.9%	89.1%	89.1%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	95.0%	95.2%	95.1%	94.9%	94.9%	94.8%
				StatMan: EDI Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	96.1%	96.2%	96.2%	96.0%	96.1%	96.0%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	StatMan			StatMan: Fire Safety Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	85.7%	86.5%	87.7%	88.0%	87.8%	86.7%
				StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.0%	96.2%	96.5%	96.6%	96.7%	96.9%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.3%	94.2%	95.2%	94.8%	94.7%	95.8%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	92.4%	92.6%	92.7%	92.3%	91.8%	91.5%
				StatMan: Infection Prevention L2 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.1%	90.3%	90.3%	89.7%	89.6%	89.9%
				StatMan: Information Governance Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.7%	90.9%	91.9%	91.4%	91.5%	91.7%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.8%	95.1%	95.4%	95.6%	95.7%	95.6%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	50.6%	51.7%	51.5%	53.7%	54.6%	54.2%
				StatMan: Patient Safety L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	91.3%	92.0%	92.6%	93.3%	93.4%	93.6%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.1%	96.5%	96.7%	96.7%	97.1%	97.3%
				StatMan: Prevent WRAP Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.8%	90.2%	91.1%	90.5%	91.2%	91.6%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.8%	95.7%	95.7%	95.9%	94.4%	95.0%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	79.4%	81.3%	84.5%	84.8%	82.2%	82.0%

People

Key Messages

- The strategic objective to improve the staff engagement score, reported via the national staff survey, has improved to 6.74 (+0.09) moving the Trust to the third quartile. This remains off target (objective to move to the upper quartile). The results of the 2024 staff survey will be used to refresh the Trust's people domain strategic objective;
- Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative. Trust spend remains below the agency spend ceiling through 2024/25;
- Commissioned Mental Health First Adier (MHFA) training for 2025 + MHFA refresher training. Capacity for 74 new MHFAs + 44 refresher training;
- Developed the wellbeing calendar to incorporate further opportunities to promote women's health and men's health;
- Welcome Aboard – launch of Welcome Aboard new starter survey. New starters will be sent surveys at end of week 1, month 1, month 3, month 6 and month 12. Each survey focuses on the different stages of their onboarding, and each survey aligns to the different elements of the People Promise.

Issues, Concerns & Gaps

- Management essential planned twice each month and fully booked throughout 2025. This is now at capacity;
- Advanced Management essentials offered monthly and fully booked until January 2026. This is now at capacity;
- Organisational Development capacity to respond to commissioning requests for incivility countermeasure and need to develop proactive approach aligned to data and intel.

Actions & Improvements

- OD team to liaise with employee relations team to examine opportunities to address capacity issues through similar triage processes;
- Review of Induction Day 1 and development of a new starter handbook to commence in April;
- Review of changes to Day 3 with Subject Matter Experts scheduled for April.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	Workforce			National Staff Engagement Score	6.93	H	F	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	6.74	
				Incivility Cases (Combined)	20	H	?	67	61	72	77	60	64	71	69	76	56	56	95
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	0.8%	0.9%	1.0%	1.9%	1.6%	1.2%	1.1%	0.7%	0.8%	1.9%	1.0%	1.4%
				Staff Appraisal Rate %	90.0%		?	89.7%	89.2%	89.1%	90.1%	90.5%	89.8%	88.9%	88.8%	90.1%	90.0%	89.3%	88.3%
				Staff in Post (FTE)	-	H		5,037.19	5,029.95	5,027.75	5,030.82	5,091.89	5,066.16	5,115.87	5,128.28	5,145.13	5,152.03	5,177.64	5,203.60
				Staff Leavers (FTE)	-			37.79	44.65	42.21	62.65	145.58	67.67	70.68	49.26	39.32	48.84	43.72	54.27
				Staff Starters (FTE)	-			53.41	21.66	34.77	55.36	131.18	117.73	88.98	55.63	29.25	69.71	64.80	66.39
				Vacancy Rate %	9.0%		?	8.1%	7.8%	7.7%	7.8%	6.8%	7.3%	6.6%	6.5%	6.2%	7.2%	6.7%	6.2%
				Voluntary Turnover %	8.0%	L	F	9.1%	8.8%	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%
				Voluntary Turnover (ICS) %	-			0.6%	0.9%	0.9%	1.2%	1.4%	1.0%	0.9%	1.0%	0.7%	1.0%	0.7%	1.0%
				Sickness Absence Rate - Total %	4.0%		?	4.4%	4.7%	5.1%	5.0%	4.9%	5.3%	5.3%	5.3%	5.3%	5.6%	5.1%	4.4%
				Sickness Absence Rate - Short Term %	2.0%		?	2.2%	2.2%	2.4%	2.2%	1.8%	2.4%	2.5%	2.6%	2.7%	3.2%	2.7%	2.2%
				Sickness Absence Rate - Long Term %	2.0%		?	2.2%	2.5%	2.8%	2.8%	3.1%	2.9%	2.8%	2.6%	2.6%	2.4%	2.5%	2.1%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	Workforce			Time to Hire - AfC	42			61.10	55.30	47.90	54	55.90	56	60	58.30	45.40	55.60	63.80	54.90
				Time to Hire - Medical	70			91.30	66.70	58.90	42.60	86.50	51	78	69.90	60.90	61.70	65.90	58.10
				Agency Spend %	3.7%			2.1%	2.4%	1.5%	1.7%	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%	1.1%	0.6%
				Bank Spend %	10.0%			11.1%	10.2%	10.4%	12.1%	10.2%	10.5%	9.0%	8.2%	9.6%	9.9%	9.7%	6.6%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			96.6%	96.0%	96.0%	95.7%	87.3%	85.8%	85.4%	99.4%	85.9%	85.5%	87.4%	91.1%
				Staff Fill Rate % (Total) - Registered Nurse	-			93.0%	91.2%	90.6%	90.1%	89.6%	89.7%	90.1%	96.1%	89.2%	88.6%	90.0%	92.5%
				Care Hours per Patient Day (CHPPD)	9.50			9.26	9.28	8.84	8.47	8.57	8.51	8.71	8.55	8.62	8.58	8.80	8.97
	Diversity			Diversity of Workforce %	-			41.1%	41.5%	42.0%	42.0%	42.2%	42.2%	42.7%	43.0%	43.3%	43.3%	43.5%	43.7%
				Diversity of Board %	-			20.0%	18.2%	23.1%	21.4%	25.0%	25.0%	30.8%	30.8%	30.8%	28.6%	28.6%	28.6%
	StatMan			StatMan Training Compliance %	85.0%			88.1%	88.8%	89.0%	89.2%	89.6%	89.0%	87.2%	87.5%	87.9%	88.9%	89.1%	89.1%
				StatMan: Conflict Resolution Compliance %	85.0%			94.9%	95.2%	95.0%	95.0%	95.4%	94.9%	95.0%	95.2%	95.1%	94.9%	94.9%	94.8%
				StatMan: EDI Compliance %	85.0%			95.6%	95.9%	96.0%	95.9%	96.2%	95.8%	96.1%	96.2%	96.2%	96.0%	96.1%	96.0%
				StatMan: Fire Safety Compliance %	85.0%			84.2%	85.9%	84.5%	85.6%	84.5%	83.8%	85.7%	86.5%	87.7%	88.0%	87.8%	86.7%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	StatMan			StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	94.3%	94.8%	95.4%	95.4%	96.0%	95.9%	96.0%	96.2%	96.5%	96.6%	96.7%	96.9%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	89.1%	91.2%	92.7%	92.2%	93.4%	94.2%	94.3%	94.2%	95.2%	94.8%	94.7%	95.8%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	88.9%	88.9%	90.1%	90.8%	91.6%	91.1%	92.4%	92.6%	92.7%	92.3%	91.8%	91.5%
				StatMan: Infection Prevention L1 Compliance %	85.0%		P	97.0%	97.1%	97.6%	96.7%	96.1%	95.6%	96.0%	96.1%	96.1%	96.4%	95.2%	95.6%
				StatMan: Infection Prevention L2 Compliance %	85.0%	H	P	89.7%	89.6%	89.1%	88.6%	89.5%	88.9%	89.1%	90.3%	90.3%	89.7%	89.6%	89.9%
				StatMan: Information Governance Compliance %	85.0%	H	P	91.6%	91.8%	91.1%	89.9%	90.8%	90.3%	90.7%	90.9%	91.9%	91.4%	91.5%	91.7%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	91.4%	92.3%	93.1%	93.2%	94.2%	94.3%	94.8%	95.1%	95.4%	95.6%	95.7%	95.6%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	79.6%	80.4%	79.9%	79.8%	79.7%	79.8%	80.7%	80.1%	79.4%	79.3%	78.3%	79.4%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	H	F	43.4%	43.9%	46.7%	48.0%	49.7%	50.2%	50.6%	51.7%	51.5%	53.7%	54.6%	54.2%
				StatMan: Patient Safety L1 Compliance %	85.0%	H	P	87.7%	90.3%	91.7%	91.3%	91.7%	90.7%	91.3%	92.0%	92.6%	93.3%	93.4%	93.6%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	-	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	97.1%	97.3%	97.6%	96.0%	95.8%	95.6%	96.1%	96.5%	96.7%	96.7%	97.1%	97.3%
				StatMan: Prevent WRAP Compliance %	85.0%	H	P	88.3%	89.1%	88.3%	89.0%	89.7%	89.1%	89.8%	90.2%	91.1%	90.5%	91.2%	91.6%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	StatMan			StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	96.7%	96.9%	97.3%	96.2%	95.7%	95.3%	95.8%	95.7%	95.7%	95.9%	94.4%	95.0%
				StatMan: Safeguarding Adults Level 2 Compliance %	85.0%	L	P	91.3%	92.3%	92.5%	91.8%	91.8%	90.2%	87.9%	88.5%	89.0%	88.1%	88.9%	89.9%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	65.8%	66.3%	68.7%	72.6%	76.5%	76.6%	79.4%	81.3%	84.5%	84.8%	82.2%	82.0%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		P	96.6%	97.0%	97.4%	96.4%	96.3%	96.4%	96.5%	96.5%	94.6%	95.5%	95.0%	95.2%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	84.5%	86.0%	86.2%	87.2%	87.2%	85.8%	86.1%	86.2%	85.3%	85.7%	86.3%	86.1%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%		?	77.2%	79.3%	80.5%	81.9%	81.5%	80.7%	82.2%	84.2%	80.3%	81.7%	84.3%	85.4%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	79.1%	83.7%	85.4%	85.1%	83.9%	87.2%	81.9%	83.3%	81.8%	82.1%	79.1%	83.4%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	80.9%	81.1%	82.1%	81.9%	82.3%	81.0%	81.2%	82.3%	83.0%	81.8%	82.1%	81.2%
				StatMan: Adult Immediate Life Support Compliance %	85.0%		F	85.6%	83.0%	80.9%	80.5%	80.0%	78.6%	78.3%	76.7%	77.6%	78.1%	77.9%	80.6%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	90.3%	89.7%	89.9%	90.8%	91.7%	91.8%	92.1%	93.2%	93.1%	93.5%	94.1%	94.3%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	72.4%	68.3%	87.4%	85.9%	80.6%	83.0%	76.3%	77.3%	79.7%	82.2%	80.0%	80.3%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	76.5%	82.0%	82.6%	82.3%	81.1%	80.6%	81.2%	84.2%	82.1%	83.8%	83.6%	81.9%
				StatMan: New Born Life Support Compliance %	85.0%		F	82.0%	80.2%	80.8%	79.9%	78.7%	75.9%	79.5%	83.3%	82.5%	79.2%	76.1%	74.6%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	StatMan			StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	78.4%	78.4%	79.7%	78.0%	77.9%	77.5%	75.9%	77.5%	78.5%	78.2%	78.6%	77.3%
				StatMan: Paediatric Immediate Life Support Compliance %	85.0%		?	83.5%	84.1%	85.5%	85.9%	80.8%	77.7%	78.4%	81.4%	79.1%	77.2%	77.6%	84.1%
	Compliance			Professional Registration Compliance %	100.0%	H	?	100.0%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				DBS Compliance %	100.0%		F	99.8%	99.8%	99.8%	99.8%	99.4%	99.5%	99.0%	98.9%	99.5%	99.3%	99.5%	99.7%

Sustainability

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

NHS Medway NHS Foundation Trust

Simon Wombwell
Chief Finance Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	4	4	4	7	0	0

Operational Leads:
Paul Kimber - *Deputy Chief Finance Officer*

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

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

Financial Position

Breakeven Revenue Budget (£)

Type	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	£0.00m			-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m	-4.62m	1.39m

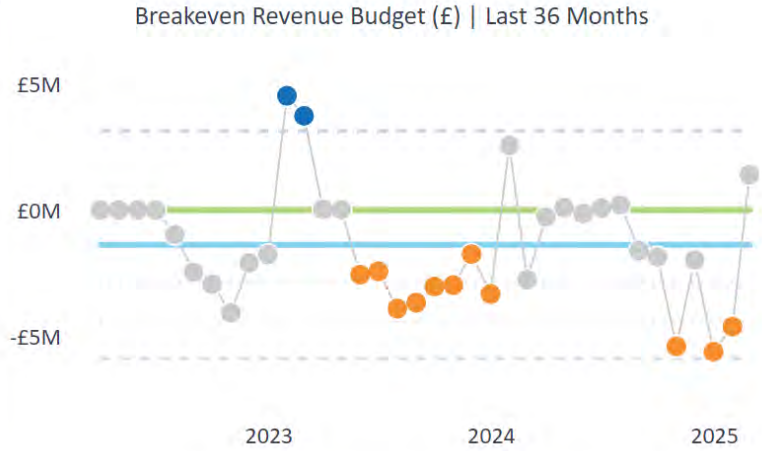
True North Domain: **Sustainability**

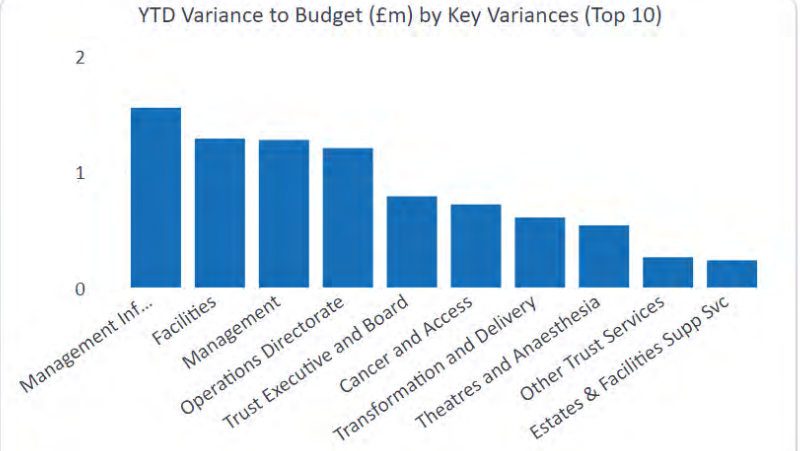
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

4	0	4	1	3





Key Messages

The Trust has delivered a deficit of £22.4m against a control total of £2.4m in 2024/25, i.e. £20.0m adverse.

This performance does represent a £0.5m improvement against the forecast, in line with national expectations.

Issues, Concerns & Gaps

The Trust utilised a further £3.5m of non-recurrent opportunities (in respect of the car park VAT reclaim) over and above the original forecast in order to deliver the year end performance.

The underlying run-rate of the Trust remains challenging and must be addressed as part of the 2025/26 performance.

Actions & Improvements

The Trust has a significant efficiency programme in 2025/26 of £45m (being ~£27m of internal schemes plus a further ~£18m of system schemes).

It is crucial that this is delivered:

1. In order to meet the deficit plan
2. In a cash-releasing nature (i.e. reduce current spending) to avoid the need for cash support (which is now being equated to an indication of failure of an organisation's leadership).

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	2.08m	6.22m	2.63m	3.00m	3.34m	3.36m
				Total Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	0.43m	3.81m	0.74m	1.68m	1.68m	19.47m
				Total Non-Pay Spend (£) vs Budget	£0.00m			Watch is red for 4 reporting periods	2.19m	1.45m	2.60m	1.46m	1.19m	1.96m

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sustainability	Financial Position			Agency Spend (£)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0.50m	0.42m	0.32m	0.26m	0.31m	0.30m
				Income (£)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	47.61m	41.37m	41.38m	39.35m	38.33m	63.01m
				Income (£) vs Budget	£0.00m	H	Special cause of improving nature or lower pressure due to (H)igher values	0.86m	-0.28m	0.18m	-1.73m	-1.55m	22.13m
				Actual Worked FTE	-	H	Special cause of improving nature or lower pressure due to (H)igher values	5,579.90	5,505.10	5,556.27	5,552.05	5,618.26	5,705.64

Sustainability

Key Messages

The Trust has delivered against its accepted forecast outturn for 2024/25, but had to deploy additional non-recurrent measures to do so.

It is vital that attention turns to 2025/26 and applying rigorous control over expenditure.

(NB the spikes seen in month 12 in respect of pay and income relate to pension scheme contributions funded by NHSE.)

Issues, Concerns & Gaps

The Trust has a significant efficiency target of operating expenditure) for 2025/26.

Divisional business planning has indicated a number of potential cost pressures that, if these materialise, could jeopardise the Trust's delivery of its £15.5m deficit control total.

Actions & Improvements

The Trust must take rapid action to change the way it provides services – clinical and non-clinical – in order to reduce current spending. This will be supported through the 'Reducing Waste Board' and the Sustainability Breakthrough Huddle.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			-0.28m	0.10m	-0.14m	0.07m	0.20m	-1.60m	-1.86m	-5.41m	-1.98m	-5.62m	-4.62m	1.39m
				Total Financial Overspend (£)	£0.00m			1.56m	0.61m	1.62m	1.37m	2.74m	3.87m	2.08m	6.22m	2.63m	3.00m	3.34m	3.36m
				(Surplus) / Deficit (£)	£0.00m			-3.57m	-3.33m	-2.85m	-2.31m	-1.81m	11.24m	-1.57m	-5.10m	-1.72m	-5.35m	-4.24m	3.50m
				Agency Spend (£)	-			0.55m	0.61m	0.40m	0.44m	0.50m	0.57m	0.50m	0.42m	0.32m	0.26m	0.31m	0.30m
				Income (£)	-			37.37m	37.52m	37.02m	39.81m	38.21m	52.45m	47.61m	41.37m	41.38m	39.35m	38.33m	63.01m
				Income (£) vs Budget	£0.00m			-0.50m	-0.33m	-0.85m	0.93m	1.27m	1.40m	0.86m	-0.28m	0.18m	-1.73m	-1.55m	22.13m
				Total Pay Spend (£)	-			25.67m	25.86m	26.29m	26.13m	26.22m	26.23m	32.75m	30.64m	27.20m	27.72m	27.70m	45.66m
				Total Pay Spend (£) vs Budget	£0.00m			-0.46m	-0.05m	0.76m	0.03m	2.64m	1.29m	0.43m	3.81m	0.74m	1.68m	1.68m	19.47m
				Total Non-Pay Spend (£)	-			12.96m	12.65m	11.48m	13.56m	11.91m	12.47m	14.29m	13.91m	15.04m	14.21m	12.64m	14.35m
				Total Non-Pay Spend (£) vs Budget	£0.00m			0.30m	-0.33m	-1.26m	0.91m	-1.06m	1.22m	2.19m	1.45m	2.60m	1.46m	1.19m	1.96m
				Actual Worked FTE	-			5,475	5,452.75	5,470.54	5,531.73	5,480.86	5,528.07	5,579.90	5,505.10	5,556.27	5,552.05	5,618.26	5,705.64
				Actual Worked FTE vs Budget	0			-27.32	-17.51	7.26	50.36	5.09	50.05	81.09	4.96	52.83	-1.98	60.59	142.28

Finance Report

For the period ending 31 March 2025 (M12)

Contents

The report that follows is as presented to the Finance, Planning and Performance Committee at its meeting on Thursday 24th April. The report was written at the time when the draft / unaudited accounts were still being compiled, i.e. pending completion of the full set of unaudited accounts. There is no change to the full year deficit position between this report and the draft / unaudited accounts (which were submitted in accordance with the national deadline), although some minor classification adjustments may have been applied between categories.

The detailed draft accounts will be subject to Trust governance, including review by the Audit and Risk Committee and External Auditors (Grant Thornton). Final adoption of the Accounts will be by the Trust Board and signed by the Trust's Accountable Officer, Jonathan Wade, Chief Executive Officer.

1. Executive Summary – Trust level

The financial results to March 2025 (Month 12) are set out below. This report describes the draft accounts position for 2024/25, pending any finalisation points and external audit. Performance is measured against the Plan agreed with NHSE, and the position against the £22.9m forecast I&E deficit (reported from M8).

£m	Budget	Actual	Var.	Commentary
Income and Expenditure (I&E) Surplus / (Deficit)				
In-month reported	2.1	3.5	1.4	The headline position for March is **£0.5m surplus**, resulting in a full year deficit of £22.4m; this being £20m adverse to the submitted plan of £2.4m. This is an improvement on the £22.9m deficit forecast previously reported.
Tech. adjustments	(2.3)	(2.9)	(0.6)	
In-month vs **plan**	**(0.2)**	**0.5**	**0.7**	The in-month favourable performance is, in the main, due to a series of one-off improvements, for example: a £3.5m car park VAT reclaim and a review of expenditure accruals judged as no longer required. Our accounts and estimates will be reviewed as part of the external audit process.
In-month vs **forecast**	**(0.5)**	**0.5**	**1.1**	
Full Year total	**(2.4)**	**(22.4)**	**(20.0)**	The overall deficit continues to reflect a mix of capacity and activity pressures driving spend levels, including maintaining our commitment to safe care, as well as income write-backs and some unfunded services.
Forecast outturn	**(22.9)**	**(22.4)**	**0.6**	
Efficiencies Programme				
In-month	2.1	2.0	(0.1)	The final efficiency programme position reports an adverse variance of £0.1m in-month and £1.3m at year end. Some further work to align the finance reporting and PMO data, we expect this number to rise once completed to allow for activities in the final weeks of the year.
YTD	21.5	20.2	(1.3)	
Cash				
Month / Year end (31 March 2025)	16.2	13.3	(2.9)	Our cash level shows an in-month increase of £1.9m in March, although this is still £2.9m adverse to our plan as a result of the adverse I&E deficit. Closing cash value is £13.3m. Whilst this is a positive position relative to the I&E deficit, this is expected to reduce early in the new year as the capital invoices for deliveries last month will be due for payment in April / May.
Capital				
Outturn				Capital Outturn is £25.9m, being £6.8m below plan as agreed with the ICB to balance the K&M system capital position. £6m slippage relates to CDC leases which were unable to complete in year; now committed to complete in Q2 to Q3 2025/26. Values are yet to be confirmed, but, optimistically, cost may be lower than the 2024/25 planned estimate. £0.4m of slippage relates to Endoscopy PDC - accepted as an underspend on behalf of K&M - this funding will be added to the MFT capital allocation in 2025/26.
Capex	26.7	25.9	(6.8)	
Leases	6.0	0	(6.0)	
Total	**32.7**	**25.9**	**(6.8)**	

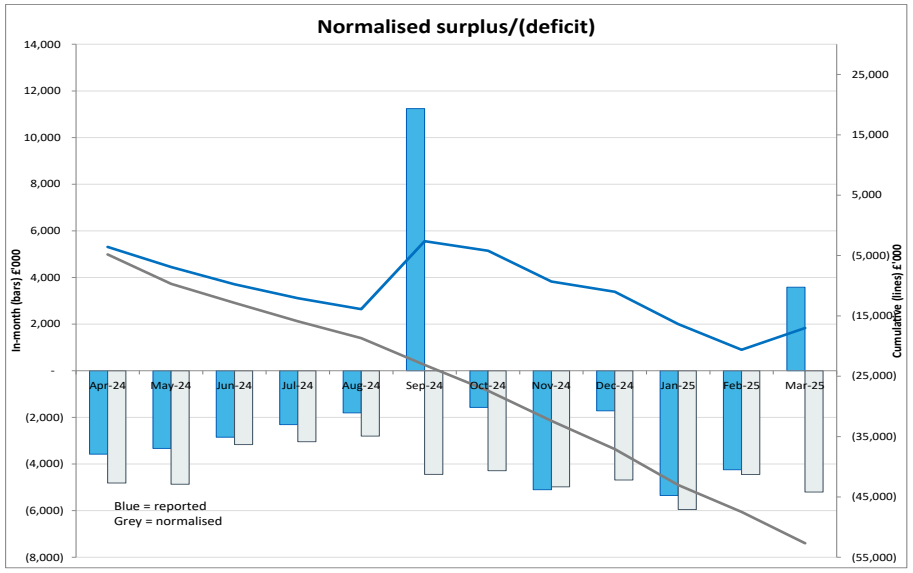
2. Income and Expenditure (I&E) vs Plan

£m	In-month			Year-to-date			Commentary
	Plan	Actual	Var.	Plan	Actual	Var.	
Clinical income	38.6	34.3	(4.2)	439.7	423.9	(15.8)	Clinical income remains adverse as a result of the planning assumptions in respect of Ruby Ward funding, endoscopy mobile unit capacity in H1 and high cost drugs overperformance from the ICB, as well as the impact of releasing prior year accruals. Other income is favourable principally due to unplanned receipt of education funds, estates & car parking income £3.5m, industrial action funding, radio-pharmacy services to other providers, and NHSE pension income (the £18m of cost is included in other pay).
High cost drugs	2.2	2.2	0.0	25.9	28.1	2.3	
Donated asset adj.	2.3	3.1	0.8	5.3	5.8	0.5	
Other income	0.1	8.4	8.3	26.3	43.4	17.1	
Pension income	0.0	18.0	18.0	0.0	18.0	18.0	
Total income	**43.2**	**66.1**	**22.9**	**497.2**	**519.2**	**22.0**	
Nursing	(10.9)	(12.7)	(1.8)	(130.0)	(134.9)	(5.0)	ED staffing to meet demand, MEC and S&A to meet demand/address patient acuity/fill rota gaps, enhanced care requirements, CIP shortfalls* and pay awards over and above national planning assumptions and year end A/L accrual increase are drivers of an adverse pay position. In-month medical position includes £0.7m accruals released as no longer required.
Medical	(9.0)	(8.0)	1.0	(108.0)	(107.4)	0.5	
Other	(6.3)	(7.4)	(1.1)	(78.1)	(88.1)	(12.0)	
Pension costs	0.0	(18.0)	(18.0)	0.0	(18.0)	(18.0)	
Total pay	**(26.2)**	**(46.0)**	**(19.8)**	**(316.0)**	**(348.4)**	**(32.4)**	
Clinical supplies	(4.9)	(5.6)	(0.7)	(59.1)	(63.2)	(4.1)	Primary drivers are consumable volumes to meet demand, inflation above plan, year-end stock adjustments transacted in March and under-delivery* of non-pay efficiency targets. **Note: some efficiencies recorded against CIP are cost avoidance and therefore not transacted in the ledger.* Reimbursable high cost drugs spend is offset by the income above.
Drugs	(1.2)	(1.2)	0.0	(13.8)	(14.9)	(1.1)	
High cost drugs	(2.2)	(2.3)	(0.1)	(25.9)	(28.2)	(2.3)	
Other	(4.1)	(5.3)	(1.2)	(50.1)	(53.2)	(3.1)	
Total non-pay	**(12.4)**	**(14.3)**	**(2.0)**	**(148.9)**	**(159.5)**	**(10.6)**	
EBITDA	**4.6**	**5.7**	**1.1**	**32.3**	**11.3**	**(21.0)**	
Non-operating exp.	(2.5)	(2.2)	(0.7)	(29.7)	(28.5)	1.2	The favourable variance arises due to a lower than planned PDC dividend and delayed capital spending generating lower depreciation charges.
Reported surplus/(deficit)	**2.1**	**3.5**	**1.4**	**2.7**	**(17.1)**	**(19.8)**	
Technical adjustments	(2.3)	(3.0)	(0.6)	(5.0)	(5.3)	(0.3)	Salix Grant (Decarbonisation Project) is reported in line with delivery profile, which differs slightly to the planned phasing.
Control total	**(0.2)**	**0.5**	**0.7**	**(2.4)**	**(22.4)**	**(20.0)**	The Year end position is **£22.4m deficit**, an improvement of £0.5m from February (Average £1.9m deficit per month).
Deficit Support Funding (incl. in Clinical Income)	(1.9)	(1.9)	-	(25.4)	(25.4)	-	
Performance against £27.8m deficit plan	**(2.1)**	**(1.4)**	**0.7**	**(27.8)**	**(47.8)**	**(20.0)**	After removing the non-recurrent Deficit Support Funding (DSF), this creates an underlying £47.8m deficit (Average £4m deficit per month).

3. Normalised performance

The table below adjusts the reported I&E position for technical and other non-recurrent adjustments to give a 'normalised' view of the financial position i.e. the position we would expect to report operating on a normal, ongoing basis.

£'000	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reported surplus/(deficit)	**(3,575)**	**(3,328)**	**(2,852)**	**(2,310)**	**(1,807)**	**11,241**	**(1,568)**	**(5,099)**	**(1,718)**	**(5,347)**	**(4,242)**	**3,585**
Technical adjustments	(15)	12	(173)	25	(178)	(275)	(267)	(475)	(1,188)	424	(200)	(3,032)
Control total surplus/(deficit)	**(3,590)**	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**10,966**	**(1,835)**	**(5,574)**	**(2,906)**	**(4,923)**	**(4,442)**	**553**
Deficit support funding	-	-	-	-	-	(14,247)	(1,973)	(1,776)	(2,306)	(2,191)	(989)	(1,948)
Control total surplus/(deficit) before deficit support funding	**(3,590)**	**(3,316)**	**(3,025)**	**(2,285)**	**(1,985)**	**(3,281)**	**(3,808)**	**(7,350)**	**(5,212)**	**(7,115)**	**(5,431)**	**(1,395)**
Normalisation adjustments:												
Covid - income	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(150)	(305)	(47)	(157)	(157)
Covid - incremental costs	-	1	3	-	-	1	-	1	-	(1)	(1)	3
Non-recurrent adjustments	(618)	(429)	(131)	(52)	(589)	(224)	537	320	833	1,214	1,140	(288)
Industrial action costs	-	-	447	130	-	-	-	-	-	-	-	-
Industrial action income	-	-	-	-	-	(542)	-	-	-	-	-	-
Annual leave accrual cost	-	-	-	-	(465)	-	-	-	-	-	-	147
Pension 9.4% Costs	-	-	-	-	-	-	-	-	-	-	-	17,984
Pension 9.4% Income	-	-	-	-	-	-	-	-	-	-	-	(17,984)
Pay Award	(1,267)	(1,268)	(1,268)	(1,267)	(949)	(1,205)	5,239	3,109	-	-	-	-
Pay Award Income	960	960	960	960	961	961	(6,103)	(906)	-	-	-	-
NHS Property Services Credit Note	-	(667)	-	-	-	-	-	-	-	-	-	-
Car Parking VAT - Claim Recognised												(3,508)
Additional Sessions Accrual	-	-	-	(379)	379	-	-	-	-	-	-	-
Recurrent surplus/(deficit)	**(4,815)**	**(4,869)**	**(3,164)**	**(3,043)**	**(2,800)**	**(4,441)**	**(4,285)**	**(4,976)**	**(4,683)**	**(5,949)**	**(4,449)**	**(5,198)**
Recurrent surplus/(deficit) - cumulative in-year	*(4,815)*	*(9,683)*	*(12,847)*	*(15,891)*	*(18,691)*	*(23,132)*	*(27,417)*	*(32,393)*	*(37,076)*	*(43,025)*	*(47,473)*	*(52,672)*



Commentary:

- The normalised/recurrent I&E position adjusts the headline, reported position for technical and one-off items e.g. income and spend relating to charitable donations and one-off impacts e.g. industrial action.
- The normalised reporting in-month I&E position (£5.2m) shows a deterioration in our in month recurrent deficit by £0.7m.
- As reported previously, the position throughout the year is caused by a combination of (i) under reporting of pay awards in earlier months and (ii) increased spending following increases in capacity e.g. CDCs, Ruby Ward, Endoscopy without a compensatory increase in our income.
- This indicates MFT carries a ~£52.7m underlying gap to deliver a sustainability in its finances, before assessment of cost pressures arising in 2025/26 e.g. CNST premium increases.

4. Conclusions

The Trust Board is asked to note the report and financial performance to March 2025 (the draft Year End position):

- £0.5m surplus in-month
- £22.4m deficit for the financial year.
- This represents a £20.0m adverse variance to the £2.4m deficit plan set at the beginning of the year.

I&E: the in-month performance was £1.1m better than forecast. Whilst this is positive, the reported position at M11 / February (YTD £22.9m deficit) required us achive break even or better to achieve our revised year end target and the manner in which this was achieved was through largely one-off measures. The notable inclusion of a £3.5m accrual for the recovery of VAT recovery on car park charges[1].

Whilst delivery of cost reductions and tight financial control remains crtitical, our activity performance (reported in income) has been disappointing in most months since December (exception is January), after a relatively strong autumn performance.

Further, as reported over recent months, the position for 2024/25 means a number of risks are carried into 2025/26 (risk value: ~£9m)

1. The North Kent Pathology Service (NKPS) charges for 2024/25 remain under dispute and could result in costs of ~£3.5m chargeable in 2025/26.
2. Medway Community Care (MCH) continue to dispute our charge for Triage services, whch could result in debtor write-offs of ~£1.5m in 2025/26.
3. The decision to allow Car Park VAT Recovery of £3.5m is currently under appeal by HMRC. If HMRC are successful, we would reverse this accrual.

Balance Sheet / SOFP: At the time of writing this Report, the Balance Sheet is still in the process of finalisation for the final accounts. Importantly, the Trust remains within its CDEL (capital plan).

Cash: At the year end the Trust remains cash positive, at £13.3m. A separate analysis of cash scenarios into 2025/26 is the subject of a separate paper to the April FPPC.

Simon Wombwell
Chief Finance Officer
April 2025

[1] Provision of car parking is linked to the provision of hospital services and medical care, the Trust is therefore deemed not a taxable person, and exempt “as a public authority” applying the concept of a “special legal regime” (Northumbria Healthcare NHS FT v HMRC).

Master Financial Governance Action Tracker V1.1

Theme: Trust Board and Board Governance

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status update	Status (%) 25	50	75	100	Supporting evidence
1	MPratt Report	Review financial reporting and forecasting to Board	Ensure concerns are escalated and debated at the Board, with firm recommendations for SMART actions Develop a “golden thread” anchoring actions to sustainable finances	CEO, Lead Executives, Non-Executive Chairs	28.03.25	Financial Report reviewed including additional presentation on YTD and forecast presented to FPPC and Board through Q4. Weekly update to Chair and FPPC Chair. Finance Report updated with I&E forecast, risks and opportunities explained. Finance update also provided to Senior Leaders Forum, with discussion. Further Review of Board Report format to be part of 25/26 finance team objectives.			■		M11 finance report Month 9 forecast for FPPC Supplementary financial report to the March Trust Board in private Finance report to senior managers meeting in January 2025
2	MPratt Report	Ensure the Board considers the most up-to-date financial position in public	Revise agenda planning; Ensure communications reflect actions to address issues; Circulate reports to Board members when the Board does not meet	Director of Strategy, partnerships and Company Secretary	28.02.25	The Board has and will continue to receive a monthly report on the trusts financial position as well as a forecast on financial performance.			■		See Public Board papers

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status update	Status (%) 25	50	75	100	Supporting evidence
3	MPratt Report	Review Board Assurance Framework (BAF) and corporate risks	Review BAF and corporate risks; Develop revised assessments and action plans	Director of Strategy, partnerships and Company Secretary	28.02.25	The review of the BAF has been completed and a revised version was presented to the Board in September 2024. The corporate risk and issues process were reviewed and amended in November 2024. Both the BAF and the risk and issues registers are submitted to Board and all committees on a monthly basis. The BAF is shared with the ICB on a quarterly basis.					Evidence submitted to internal audit review
4	MPratt Report	Improve the recording of check and challenge discussions	Ensure check and challenge exchanges at each Board and Committee meeting are captured with SMART actions and reporting timelines in action logs	Director of Productivity, Efficiency and Development.	28.02.25	The committee/board assurance template has been amended to prompt SMART actions. – December 24.					
5	MPratt Report	Strengthen Unitary Board financial awareness, roles and responsibilities	Consider commissioning a Board and Team development program	Board Chair, CEO	28.02.25	A Board development programme has been in operation for the 2024/25 reporting period and is being refreshed for the 2025/26 year. This action is reflected in the board annual work plan and the trusts standing orders.					

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status update	Status (%) 25	50	75	100	Supporting evidence
						Interim CFO presentation to Board development day Dec 2024. Two new NEDs starting tenure on 1 May 2025, both with strong financial backgrounds.					
6	MPratt Report	Improve budget-setting process	Implement revised processes to ensure the Board is fully sighted on budget-setting assumptions; Ensure mitigations to control risks are explicit and formally agreed	Board Chair, CEO, CFO	27.03.25	Process paper submitted to Board in November 24, update papers presented to Exec committee, FPPC and Board on a monthly basis. 25/26 budget baseline based on Outturn as a proxy to achieve budgets aligned with current spend levels. This is then reviewed further as part of the CIP process. Next step budget sign off process to be completed by 9th May 2025					Business Planning Board Assurance Process as in March FPP papers

Theme: Capacity and Capability

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update	Status %	Supporting Evidence
7	MPratt Report	Executive Team to reassess approach to change	Executive Team to reassess its appetite for change and risk to give greater emphasis, pace, and urgency to the actions needed to achieve financial sustainability	CEO	31.03.25	Needs further focus M1 2025 mitigations in place including: • Vacancy Panel Process • Clinical Posts Freeze • Non-corporate recruitment freeze • Weekly Sustainability Delivery Group stood up • Review of clinical divisions		Commenced Executive Weekly meetings and away day in March 2025
8	MPratt Report Anne Eden Meeting actions 20.01.25	Implement performance management arrangements	Consider and implement performance management arrangements demonstrating increased effectiveness in delivering financial control and sustainability	CFO	28.01.25	Financial Report deep dive into AP and AR presented to FPPC and ARC in February and March respectively. Budget setting process designed to improve budgets and support relevance of variances in both income and expenditure.		

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update	Status %	Supporting Evidence
9	MPratt Report	Interim CFO to reinvigorate the finance department	Act with pace and urgency to reinvigorate the finance department by setting clear expectations of professional standards; Hold team and colleagues to account for delivering agreed actions	CFO	Initiated and ongoing	First development session, including the whole team held on 26 March 2025, with a programme working with SE Finance Academy. Departmental objectives in draft, to be cascaded to individuals for 2025/26. Letter to all Senior Managers on improved financial stewardship requirements, circulated to Finance Senior Team.		14th February 2025 letter to all Executives and Members of Trust Management Board
10	Mpratt Report	Ensure sufficient financial business partner support	Ensure sufficient financial business partner support to divisions to promote improved financial control and business planning to deliver Trust financial sustainability	CFO	28.02.25	Agency FBP in place with internal acting up (following recent departure of the other agency FBP). NHSE independent review has initiated discussions on long term structures and work is underway to develop proposals. RSP funding (£100k) secured for first six months of 25/26.		
11	KPMG	Budget setting process starts too late and	Seek budget sign-offs prior to submission: budgets should be	CFO	31.03.25	Final decisions on 2025/26 budget requests / affordability being taken		Budged sign off document

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update	Status %	Supporting Evidence
		there are limited protocols to prepare budgets	submitted to the finance committee only after the budget holders agree on the draft budgets			before budget sign-off. Further refinements to process will continue to be made with support from Director of Planning / CDO.		
12	KPMG	Different Divisions use varied and inconsistent approaches when preparing budgets	Training for FBPs: we will consider the need for training sessions for FBPs, budget holders and divisional leads to support effective and efficient usage of existing system capabilities	CFO	31.03.25			Action set out in Finance Department Review Report
13	KPMG	Management reports are backwards looking and sub-optimal in length	Training for FBPs: we shall consider the structure of the financial management team and seek (further) investment in training and development; the purpose will be to shift management reports from being a 'scorekeeper' to predictive/prescriptive reports	CFO	31.12.24	Standard Operating Procedures to be developed as part of the Finance Team objectives, including standardised reporting templates to be used by all Divisions. As above, structures are under consideration and standardisation of work will be addressed through the NHSE independent review report.		

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update	Status %	Supporting Evidence
14	KPMG	Medical recruitment: time to hire and candidate withdrawals (pay)	Discussions with KCHFT to outsource recruitment transactional services to improve reporting and time to hire (using robotics) to be progressed	Chief People Officer	31.03.25	Progressing ICB have commissioned review of full system shared business opportunity for RPA transactional recruitment. Report due March 2025. Also workstream within Medical Productivity corporate project 24/25		
15	KPMG	Rota reviews (pay)	Following assessment of current rostering practices for ED Nursing, Anaesthetics doctors and Radiology against the 'nine' rules of good rostering this work should now be expanded to include other areas with evidence of rostering challenges and/or in-year budget overspends	Chief Operating Officer	31.03.25	Competed for nursing following full safe staffing review and rosters are managed within Healthroster rules. Ward Managers and Matrons review weekly with HoN and DDoN Monthly to ensure compliance. Medical rostering review is underway with a SME employeed. Demand and capacity review being completed and business case for a rostering system is being developed.		

Theme: Financial Controls

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update					Supporting Evidence
16	Mpratt Report / Grant Thornton	Task the interim CFO with improving understanding of financial recovery plan details	An updated Financial Recovery Plan (Financial Strategy) is to be written and agreed by Trust Board, ICB and NHSE. Consideration needs to be given to the outputs of the potential Group model linked to D&G.	CFO	31.03.25	FRP in draft. This will include a description of strategy and actions required to achieve sustainability. The process is expected to be iterative, involving ICB and NHSE, led by the MFT Board.	.				
17	Mpratt Report	Revise “Patients First” break-through objectives	Consider revising “Patients First” break-through objectives to encourage a focus on monthly run-rate against budget	CDO. CFO	28.02.25	True North updated. Breakthrough Objective recently agreed through catchball to align with 25/26 CIP target and indicative WTE target reduction/					
18	Mpratt Report	Revisit performance and action plans	Revisit performance and action plans to ensure that all outstanding action plans are owned and delivered; Revisit performance and action plans and benchmark them	CEO	28.02.25	Merger of several action planning into once tracker					Current document

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update					Supporting Evidence
			against best practices								
19	KPMG	Bottom up budgets prepared by the divisions do not align with the top-down funding available, due to lack of consensus on demand, activity and workforce levels	Budget setting has been created from outturn spend to align with the outturn activity, workforce and performance. The process to agree budgets has been iterated from this baseline, including an assessment of increased activity targets (to achieve national trajectory targets for RTT, Cancer and ED).	CDO	15.04.25	Approaching completion following sign off by Trust Board and submission to ICB and NHSE.					March 2025 signed of business plan submission
20	KPMG	Better alignment required between finance, activity and workforce data	Development of the digital infrastructure to ensure integration across multiple systems to minimise manual links and be able to generate bespoke reports	CDO	01.12.25	Progressing					
21	KPMG	Risk of incorrectly coded activities informing the block contract	Continue optimising coding opportunities: we are already	CDO	31.12.24	Programme of work completed for last year.					

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update					Supporting Evidence
			exploring where capture and counting of activity can be improved			New programme of work for 2025/26 being scoped.					
22	KPMG	Risk of high cost drugs claims not being adjusted regularly	Ensure demand and capacity modelling reflects accurate activity coding: we will ensure that the activity estimates resulting from the demand and capacity modelling exercise are mapped correctly to the appropriate codes, to inform the appropriate block contract with the ICB	CDO	31.12.24	Complete and being evaluated.					
23	KPMG	Standing financial instructions (SFIs) are not up to date	Update the SFIs to reflect new capital governance structure	CFO / CoSec	31.03.25	Revised SFIs drafted and due to be presented to May ARC.					
24	KPMG	Contract spend reductions (pay and non-pay)	The Trust will implement new controls and review of booking procedures from 1st Feb to provide more visibility, governance and controls for taxis	CFO	31.05.25	Process for spend on Taxis is under further review					.

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

Theme: Financial Recovery

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update		Supporting Evidence
26	Grant Thornton	Activity data used in service line reporting should be reviewed carefully for completeness	As gaps in budgeted activity are identified, the Trust should promptly make any relevant adjustments to activity data used by the costing team so that comparative exercises to monitor and understand cost are reliable and robust	CFO	31.12.24	Work has begun on the 24/25 National Cost Collection Index and will be addressed therein.		
27	NHS CFA	The Procurement, Finance and Pharmacy Teams will take part in a working group and report to the ARC to establish how all departments can contribute to ensure effective due diligence and contract management at the Trust	The Procurement, Finance and Pharmacy Teams will take part in a working group and report to the ARC to establish how all departments can contribute to ensure effective due diligence and contract management at the Trust	CFO / Chief Pharmacist	31.12.24	We have established the Atamis contract database and will develop contract management capability in line with the new Procurement Act. We will also need to create clarity between the role of Procurement and contract management i.e. to identify which department is best placed to be the contract owner/manager – this should not		

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update				Supporting Evidence
						automatically default to Procurement, who will not be close to supplier performance on a day-to-day basis.				
28	KPMG	CIP stretch targets are deemed unrealistic in some cases, and not managed in line with leading practice.	Explore transformational CIP schemes: given the Trust benchmarks well in Model Health Systems cost per WAU and reference index cost, we will explore transformational opportunities (e.g. rationalisation and transformation of back office functions, digital transformation opportunities, opportunities from increased collaboration and service transfers within the region and/or mergers). This will also include full engagement with the ICB/ICS.	Director of Productivity and Efficiency & Development	30.06.25	Options for CIP allocation were discussed at Execs, including allocation where there may be the greatest opportunity using MH data, but the decision taken was to allocate a 'blanket' approach ie equitably across all areas. Areas of productivity opportunity have been cross-checked with the NHSE opportunities pack and are linking in to business planning and Corporate schemes.	Due to scale of CIP				An updated CIP tracker is in development to capture efficiencies, productivity and corporate targets and delivery both internal and system-based, to be completed and fully live by the end of April. A pilot is also underway for 3 challenged services via an external supplier to support identification and approach to productivity.

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update					Supporting Evidence
36	KPMG	Medical recruitment: time to hire and candidate withdrawals (pay)	Explore opportunities with ICB for collaborative medical workforce planning and working i.e. medical staff work across Trusts to avoid duplication/ mitigate hard to fill posts	CMO	31.03.25	Completed. We are now withing national standards for recruitment guidelines. This continues to be moniotorted. We are looking for further opperunities to shorten the timeline by looking at time form resignation to taking up post.					
39	KPMG	Middle grade WTE growth (pay): FY20 to FY24 YTD M6	Reduced agency & bank spend across the clinical directorates through: •Detailed review each middle grade rota to confirm the number required for the rota and to test balance between funded training numbers and non-training (for service) roles. Non-training posts not required for rota compliance and safe service	CMO	28.02.25	Completed. New rostering role in place. Vacancies and session going through CEO VCP					JD VCP spreadsheet

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update					Supporting Evidence
			provision should be removed. •Improved rostering practices, particularly for those specialties with significant WTE growth •Job planning (aligned to demand & workforce capacity modelling) •Recruitment strategy actions for hard to recruit to posts, particularly in light of system partners competing for the same staff and offering incentives to fill vacancies covered by bank								
41	KPMG	Reducing emergency medical length of stay, total bed opportunity per year: 81-134 beds	Continued focus on long stay patients, maximising virtual wards and focus on flow and discharge related	COO	31.03.25	Ongoing discussions regarding LLoS with HCP partners. Ongoing community capacity concerns in discussion.					

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update		Supporting Evidence
			delays to reduce LoS Expedited discharge: discharge patients earlier in the day Reduce multiple ED attendances			Internal flow work continues with reduced LoS with nearly all specialities at National median. Average discharge time now at 14:34. Functioning Discharge Lounge and reduced escalation. Virtual Ward is consistently over capacity with all pathways agreed and embedded. High Intensity User programme in place and Community partners managing caseloads of patients in collaboration with Primary Care.		
42	KPMG	Contract spend reductions (pay and non-pay)	Consideration required on use of internal bank staff who may be instead booked at cheaper rates (as seen at other Trusts) Use of technological tools to avoid face to	CNO	31.03.25	The translation and interpretation service spec is complete and with the Procurement team. The tender process has commenced but we have been advised that the full tender process will complete in circa 12 -26 weeks.		This framework is published for PCN's however this applies to acute providers too.

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update		Supporting Evidence
			face bookings where appropriate and to track interpreters actual timesheets Implementation of a central booking team who may govern interpreters scheduling, authorise bookings and govern cancelled sessions Enhanced controls on invoice reconciliations and raising of purchase orders to ensure Trust not being overcharged / paying late payment charges			A standard operating procedure will be circulated once the provider has been commissioned to provide the services required. Finance Bp colleagues are on board and prepped to step in to assist with this process when ready. We are not able to utilise staff or volunteers for patient translation services due to legal obligations and the minimum level of training a translator / interpreter is required to have.		NHS England » Interpreting and translation in primary care
43	KPMG	We recommend that a formal Procurement Strategy or Policy	Creation of a Procurement Strategy to be added to Finance	CFO	31.10.25			Associate Director of Procurement to draft initial

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update		Supporting Evidence
		is created which includes: - References to fraud, bribery, corruption or the relevant legislations in the context of the procurement process, e.g. contract splitting. - The processes in place for single tender waivers (or reference to these processes in a separate document) - The consequences of staff failure to comply with procurement processes a section referencing associated policies including: Anti-Fraud, Bribery and Corruption; SFIs; Conflicts of Interest;	and Procurement team objectives and a completed document to be taken to FPPC by October 2025. To include clear references to collaboration at System level.					document for review by Executive before onward governance. Initial ideas and research started. Procurement Strategy

Rec. No.	Source Report	Recommendation	Improvement Action	Responsible Person/s	Expected Completion Date	Status Update		Supporting Evidence
		Disciplinary and Code of Conducts.						
44	Anne Eden meeting 20.01.25	Review RSP support and what is required	Scope out capacity and capability requirement to deliver RSP requirement 2025/26	CEO / CDO	01.05.25	Being collated in preparation for the RSP escalation meeting on 7th May 2025		

NHS
Medway
NHS Foundation Trust

PATIENT FIRST STRATEGY

Patient
FIRST

Patient First Strategy

Authors:	Chief Delivery Officer Director of Transformation Senior Strategy Development Officer
Document Owner	Chief Delivery Officer
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Document ID Number	STRCGR017
Implementation Date:	September 2023
Approved By:	
Date of Next Review:	May 2026

Document Control / History	
Revision No	**Reason for change**
V1.0	Approval of Strategy at Trust Board (September 2023)
V1.1-12	Annual review and refresh (October 2024)

Consultation
Trust Strategy Deployment Review
Trust Executive Group
Trust Board

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

Table of Contents

Foreword

Introducing our Patient First Strategy

It is with great pride that I am able to introduce the Trust's Patient First Strategy for the next three years; with pride because we can now speak of real successes that Patient First is bringing us.

Patient First redefines how we approach quality and continuous improvement. The improvement system provides us with a set of tools, behaviours and routines designed to deliver daily, continuous improvement and performance excellence.

This updated strategy outlines our continued commitment to Patient First in all areas of the hospital, providing opportunities for all involved in patient care, including the patient themselves, to get involved and help us drive improvement. We look forward to continuing this journey with you.

Jon Wade, Chief Executive

Patient First has undoubtedly made a remarkable difference since it was introduced in the Trust. We have seen fantastic improvements in our care of deteriorating patients, our ambulance hand-over times and waiting times for surgery, to name but a few. This strategy demonstrates our commitment to build on these achievements in the coming years, acknowledging we still have much more to do to get to where we want to be.

I am very proud that our progress on this improvement journey has turned heads, with partners and healthcare organisations across the country – and indeed the world – visiting us to see how we are implementing the improvement system to deliver results.

We will continue to turn the dial for long term transformational change, with our key themes (True North domains) of Quality, People, Patients, Systems and Partnerships and Sustainability underpinning everything we do.

Gavin MacDonald, Chief Delivery Officer

Introduction

At Medway NHS Foundation Trust, we are dedicated to putting our patients first, at the heart of everything we do. Every time we interact with our patients, their families and carers, we should ensure our interactions are prompt and positive. This requires both listening to the patient and working together with colleagues as a team to provide the right care, in the right place, at the right time.

The Patient First Improvement System (PFIS) is a tried and tested improvement methodology and management system recognised nationally for enabling the fast-paced delivery of sustainable and embedded change. The system is aligned with the operational excellence approach outlined by the NHS Impact Framework that helps us to articulate our Trust's core objectives using common language, improvement tools and techniques and a standardised approach. Our local system partners (and Trusts across England) have adopted similar continuous improvement methodologies within their Trusts. This helps provide consistent care across our local health system, as we share a commonality of language and approach to improvement. We work closely with our Health and Care Partnership and Integrated Care Board, attending various provider collaborative meetings and sharing best practice, which encompasses the essence of Patient First. Our Executive colleagues are active members within the Health and Care Partnership Executive team, ensuring our system working and transformation is embedded across all of Kent and Medway.

Strategic Context

Medway NHS Foundation Trust serves a population of more than 427,000 across Medway and Swale (Sittingbourne and the Isle of Sheppey). In 2024**,** we provided care for more than 185,000 patients in our Emergency Department and more than 85,000 inpatients on our wards. More than 445,000 outpatient appointments took place, and in our maternity care services, more than 4,400 babies were born in the hospital and community.

As an NHS Foundation Trust, we have a Council of 26 Public, Partner and Staff Governors with more than 6,000 public members. We employ over 5,700 staff and have over 800 bank staff, making us one of Medway's largest employers.

NHS Long Term Plan

In October 2024, the Department of Health and Social Care (DHSC) launched Change NHS, to engage nationally on the new 10 Year Health Plan for England. Whilst we await the full outcome of this consultation, we will continue to progress with the key deliverables from The NHS Long Term Plan (2019) which was developed by a variety of frontline health and care staff, patient groups and other experts. The Long Term plan helped to articulate the steps needed to make the NHS fit for the future. The longstanding aim is to prevent as much illness as possible and illness that cannot be prevented should, where possible, be treated in the community and primary care. If care is required from an acute hospital, the goal is treatment without having to stay as an inpatient. When people no longer need to be in hospital, they should receive good health and social care support to go home or return to their place of care.

The key priorities listed within the plan focus on:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well.

Staff across England within the NHS, worked with NHS England and highlighted the need to do things differently to achieve these priorities, focusing on:

- Giving patients and staff more control and encouraging collaborations and joint services to ensure we can meet the needs of our community
- Focusing on preventing illness and tackling health inequalities
- Ensuring adequate training for staff to improve recruitment and retention
- Embracing and utilising data and digital technology, and
- Reducing waste – ensuring taxpayers' investment avoids duplication and reducing expenditure where possible

The NHS Long Term Plan sets out a national path for transformation across health systems in England and our Patient First Strategy highlights how we are empowering our staff and implementing these changes at a local level. NHS England also published a delivery and continuous improvement review in April 2023, which outlined the need for each Trust in England to have an operational excellence model that focusses on quality and continuous improvement, like the new, single, shared NHS improvement approach - NHS Impact. The ongoing implementation of our operational excellence model, Patient First, illustrates our commitment to the one system approach to improvement. A holistic improvement system spanning our whole organisation, with an inch-wide, mile deep ethos ensures that we stay focused on the things that help us achieve our True North.

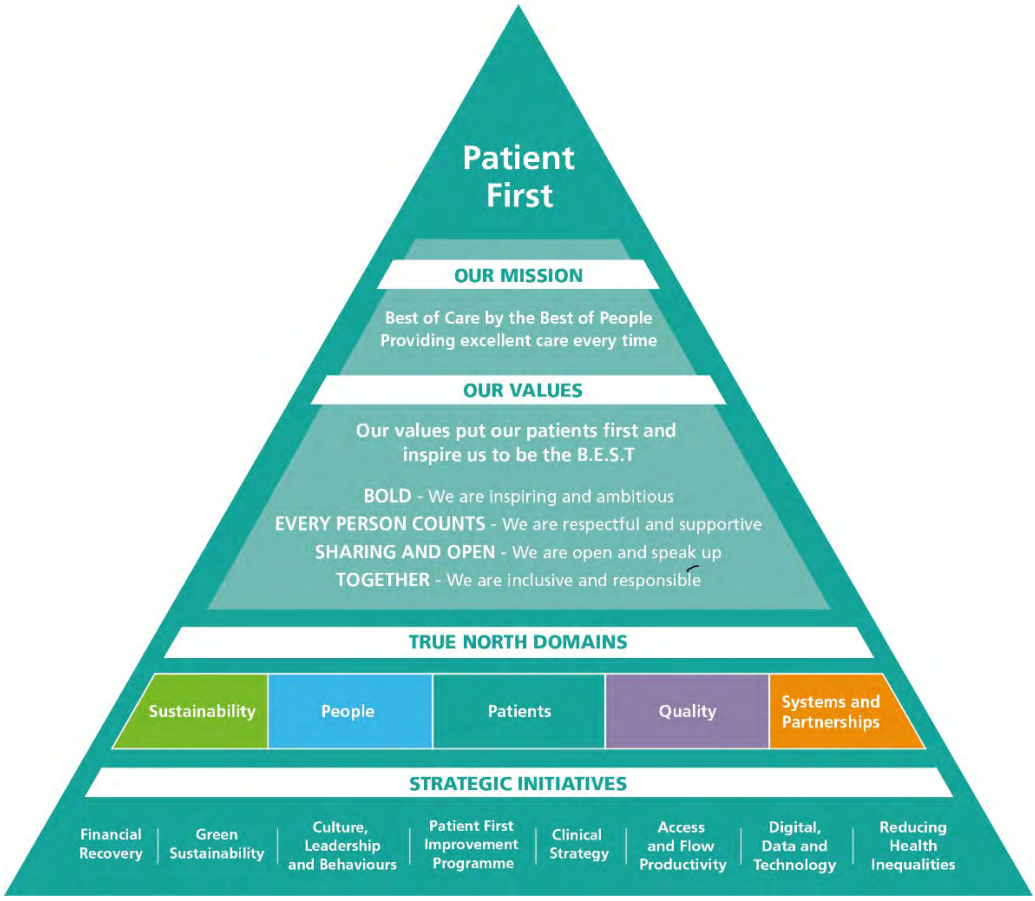
We look forward to updating this Strategy once the 10 Year Health Plan for England is formally published by the DHSC and ensure we continue to deliver optimal services to support the needs of our population.

Mission, Vision and Aspirations

Patient First is our structured approach and overarching strategy to empower and enable all staff to improve our services and meet the needs of our patients and local community. Our mission is to provide the “best of care by the best of people”, providing excellent care every time. By 2028, our vision is to deliver the best care outcomes through brilliant people, and be a leading partner within an integrated system of health and social care, providing a positive patient experience without boundaries.

The guiding principles of our Patient First improvement system build on our successes of the past, but bring greater clarity, structure and support so that we can make improvements that are more significant, and do so at pace. It focuses on fewer priorities, so that we concentrate on those that make the biggest difference to delivering better, more timely care for our patients. It will also help us address some of the long-standing issues that can affect patient care with a structure and tools to support us in identifying, developing and delivering the improvements needed. All teams are integral to delivering improvements.

‘Patient First’ is a combination of our mission, Trust Values, True North domains, supported by strategic initiatives, breakthrough objectives and corporate projects. In order to deliver these, a management system is in place, alongside a set of principles around culture, leadership, behaviours and communication.



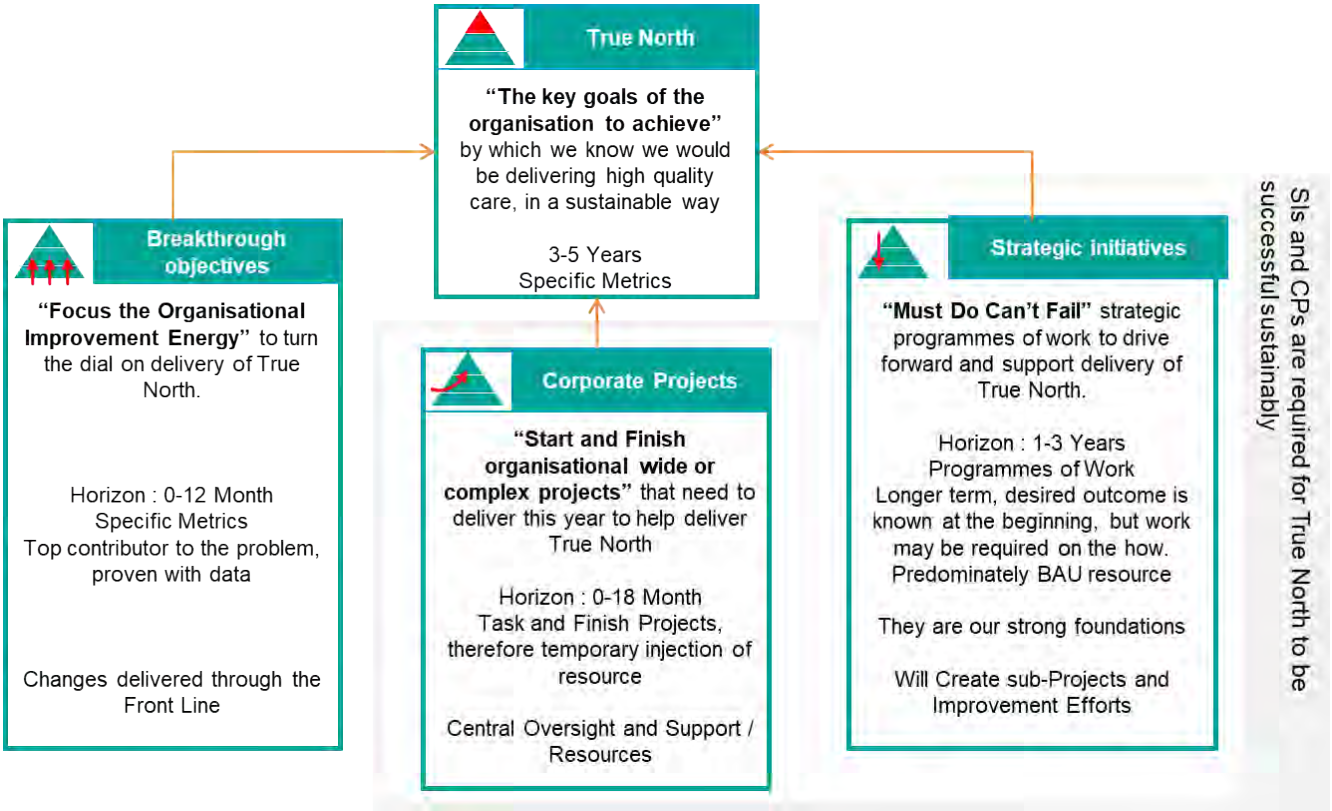
Building on this strategy 'triangle', our True North domains have the following ambitions and visions for 2025:

The Trust will continue to build a culture of continuous improvement by identifying and communicating our priorities. This ensures that all staff can align with the organisation's strategy and support its deployment to achieve against these shared priorities.

Methodology

Our Patient First 'triangle' demonstrates the golden thread of continuous improvement throughout the Trust. Our strategy is founded on an "inch-wide, mile deep" improvement approach. Data-driven methodology ensures the improvement effort is focused on the areas that make the biggest difference to help us progress towards our True North.

The delivery of our True North is achieved through a series of breakthrough objectives, corporate projects and strategic initiatives. The diagram below describes what each of these elements are, the desired outcome and the timeframes for delivery. These are reviewed on a yearly basis by the Trust Board, Divisional and Care Group leads.

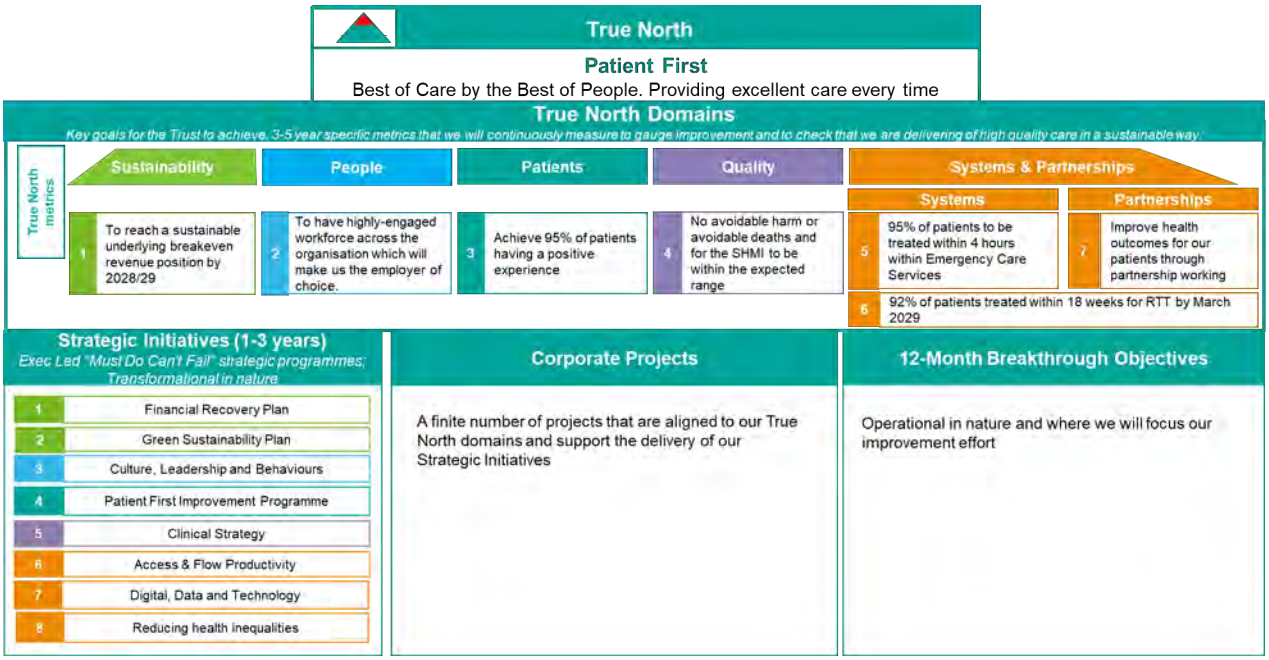


To deliver the Patient First Strategy we have developed a strategic framework which includes: Strategy deployment, an operational management system, centre of excellence through building internal capability, developing leadership behaviours, supported by transformational projects and providing an environment of open communication and engagement that values all staff within the organisation and their contributions.

Together, the components of our triangle will deliver initiatives to ensure that all patients receive the best of care by the best of people, every time. Key enabling strategies have been developed to support the strategic framework including; Clinical, People, Quality, Research and Innovation, Freedom to Speak Up, Information Governance, Infection, Prevention and Control and Patient Experience.

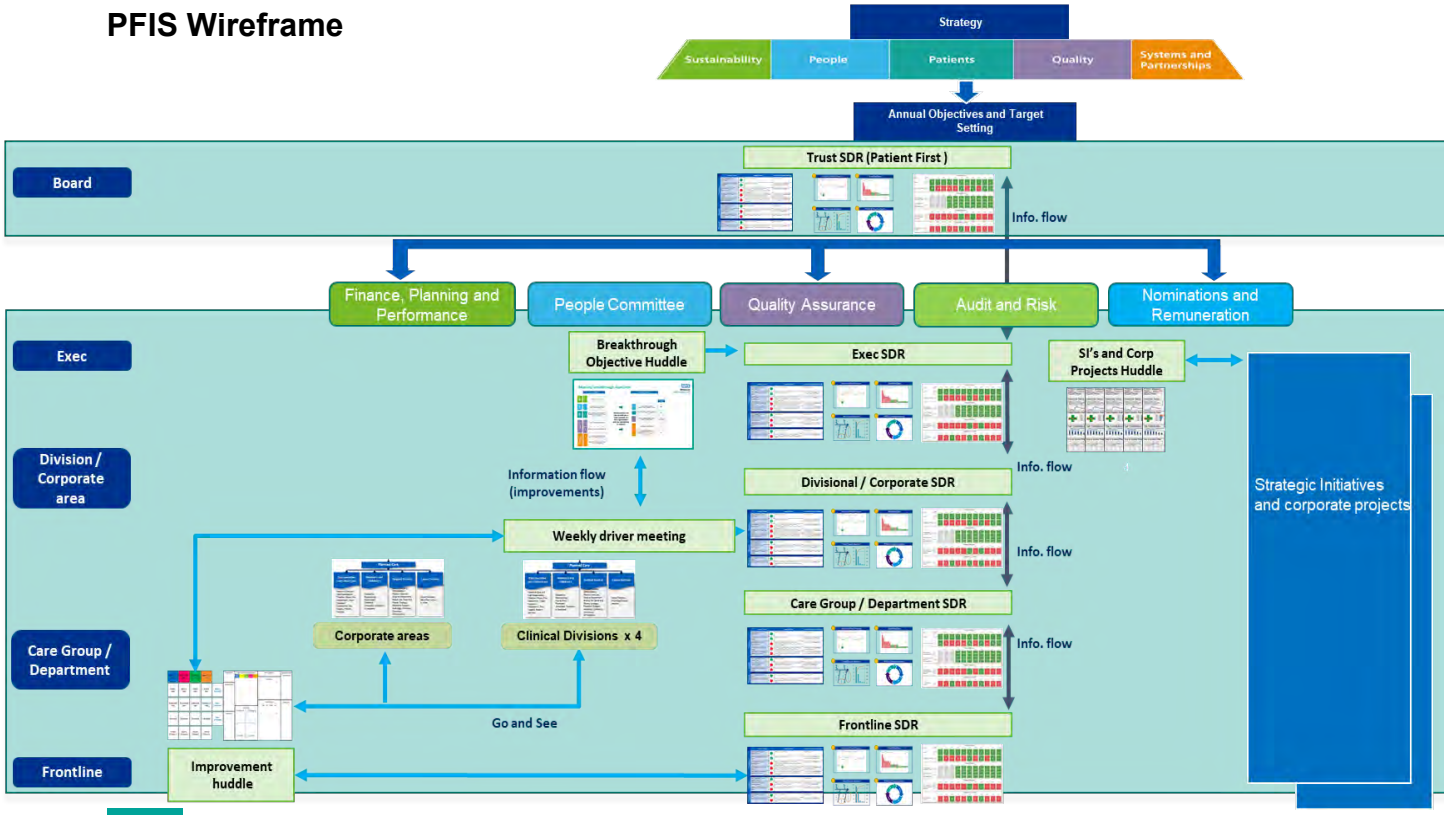
There are also supporting strategies that will align to each of our True North domains, such as Data, Digital and Technology Strategy and the Estates and Facilities Strategy.

The strategic planning framework of this approach is outlined below:



The strategic planning framework builds assurance from Ward to Board. In order to deliver this, the Patient First System provides performance and governance assurance through a daily to monthly drumbeat. This is supported by a standard work approach, which is a written set of step-by-step instructions for completing tasks using the best-known methods.

PFIS Wireframe



The above diagram shows how the daily improvement huddles feed all the way through to bi-monthly Trust Board. To establish the 'drumbeat', frontline colleague's complete daily improvement huddles, which focus on opportunities for improvement in their areas. These huddles link to weekly driver meetings across the various frontline teams. This information is then shared on a weekly basis at various Clinical Care Group and Departmental Driver Meetings onto the Divisional and Corporate Driver Meeting and through to the monthly SDR meetings. To complement this the breakthrough objectives are reviewed at individual weekly huddles, led by an Executive Lead.

This cadence provides a robust route for colleagues to share their success and highlight their risks, whilst still focusing on making improvements, as outlined below:

- **Daily Performance Huddle** – Daily huddle for frontline staff, focusing on drivers that have been cascaded to the department. Joining up frontline and divisional managers as one operating system.
- **Weekly Driver Meeting** – To review the Speciality/Divisions' drivers that contribute to achieving the strategy (uses the performance board to discuss each driver)
- **Monthly Strategy Deployment Review Meeting** – To review the Divisions scorecard, focusing on the progress of the driver and watch metrics (uses countermeasures summary or verbal update to present.

The Integrated Quality and Performance Report (IQPR) is a key document in ensuring that the board is sighted on areas of concern in relation to a range of internally and externally set Key Performance Indicators (KPIs). The IQPR is developed around the Trust's Patient First journey with centralised data direct from the Patient First scorecard collated into the Trust level pack. Each metric is present within the Patient First Dashboard that allows users to view full ward to board at Trust, Divisional / Corporate, Care Group / Department and Ward / Team level, displaying one single, consistent version.

Strategic Initiatives enable long-term transformational organisational sustainability. Even though these are longer term pieces of work, as the initiatives cut across multiple True North domains, they are reviewed and refreshed annually using the A3 thinking methodology, ensuring that countermeasures, risks, visions and goals are agreed, providing an early indication of Corporate Projects that may arise.

Corporate Projects

Corporate Projects are start and finish organisation-wide or complex projects expected to deliver within approximately 12-18 months and support True North priorities. These are usually aligned to Strategic Initiatives, or regulatory requirements. Corporate Projects are prioritised using a Strategic Filter at the monthly Strategy Deployment Review meeting. This ensures that the project is reviewed in terms of resourcing requirements, benefits expected and impact, and categorised as either Mission Critical, Important, Wait or Business as Usual.

Breakthrough Objectives

The delivery of the True North metrics are supported through the setting of annual Breakthrough Objectives. These breakthrough objectives are developed from the annual Strategic Planning review process which also includes a review of the True North domains.

These objectives are key “drivers” to support improvement in the areas of greatest opportunity.

Breakthrough objectives should:

- Be translatable to the frontline in a measurable and meaningful way
- Support us with engaging Trust-wide on Patient First
- Be objectives we can cascade to all wards and departments – so teams at every level can actively contribute to their achievement.

Key Achievements

Patients

2022/23

- Free meals introduced for parents and carers on children’s ward

2023/24

- Launch of the UK’s first Namaste Care Service in a hospital setting

2024/25

- Our Macmillan Cancer Unit has received a top award for the services it provides to help support people living with cancer and their families (2024)

Quality

2022-23

- Patient Safety Initiative Call 4 Concern launched in January 2023 in advance of NHS England’s commitment on the introduction of Martha’s Rule from April 2024

2023/24

- Publication of the Trust’s Clinical Strategy 2024-2027 following extensive engagement.
- Developing a Trust and ward level dashboard to support teams to identify and monitor a number of key things that help to improve the care of our unwell and deteriorating patients

2024/25

- The integration of the Treatment Escalation Plan (TEP) documentation into the Electronic Patient Record for all patients

Systems and Partnerships

2022-23

- Patient Initiated Follow-Up (PIFU) appointments putting patients in control of when they see a clinician as they can book an appointment when they need it most

2023/24

- New bed management system (2023) patients are being moved into beds on wards faster and thousands of hours have been freed up for nurses to care for them
- Opening of the Sheppey Frailty Unit in Sheppey Community Hospital (2023)

2024/25

- Medway achieved best performing trust for ambulance handovers in the country (2024)
- New cardio respiratory ward opening (2024) providing more than 30 new beds
- High Intensity Theatre (HIT) for Ear Nose and Throat, Surgical Team.

People

- Improvement in Staff Survey Results for most areas year on year.

2022/23

- The launch of "Career Conversation Clinics" by the Clinical workforce team providing colleagues with an opportunity to find about the exciting development opportunities available at Medway

2023/24

- National recognition by receiving the National Preceptorship Interim Quality mark for the support provided by the Trust to newly registered healthcare professionals. The Trust was awarded the "NHS Pastoral Care Quality Award in recognition of work done in international recruitment and the physical and emotional support we provide to overseas staff
- Introduction of the independent Freedom to Speak up Guardian Service
- Breakthrough Objective to reduce voluntary turnover within the first two years of employment shows a near 50% reduction in 12 months.

Sustainability

2022/23

- A fully substantive Corporate Project Management Office Team has been stood up to support the Reducing Waste Programme.

2023/24

- Weekly "Check and Challenge" meetings are now embedded, introducing a rigour and governance to support the financial management of the programme.

2024/25

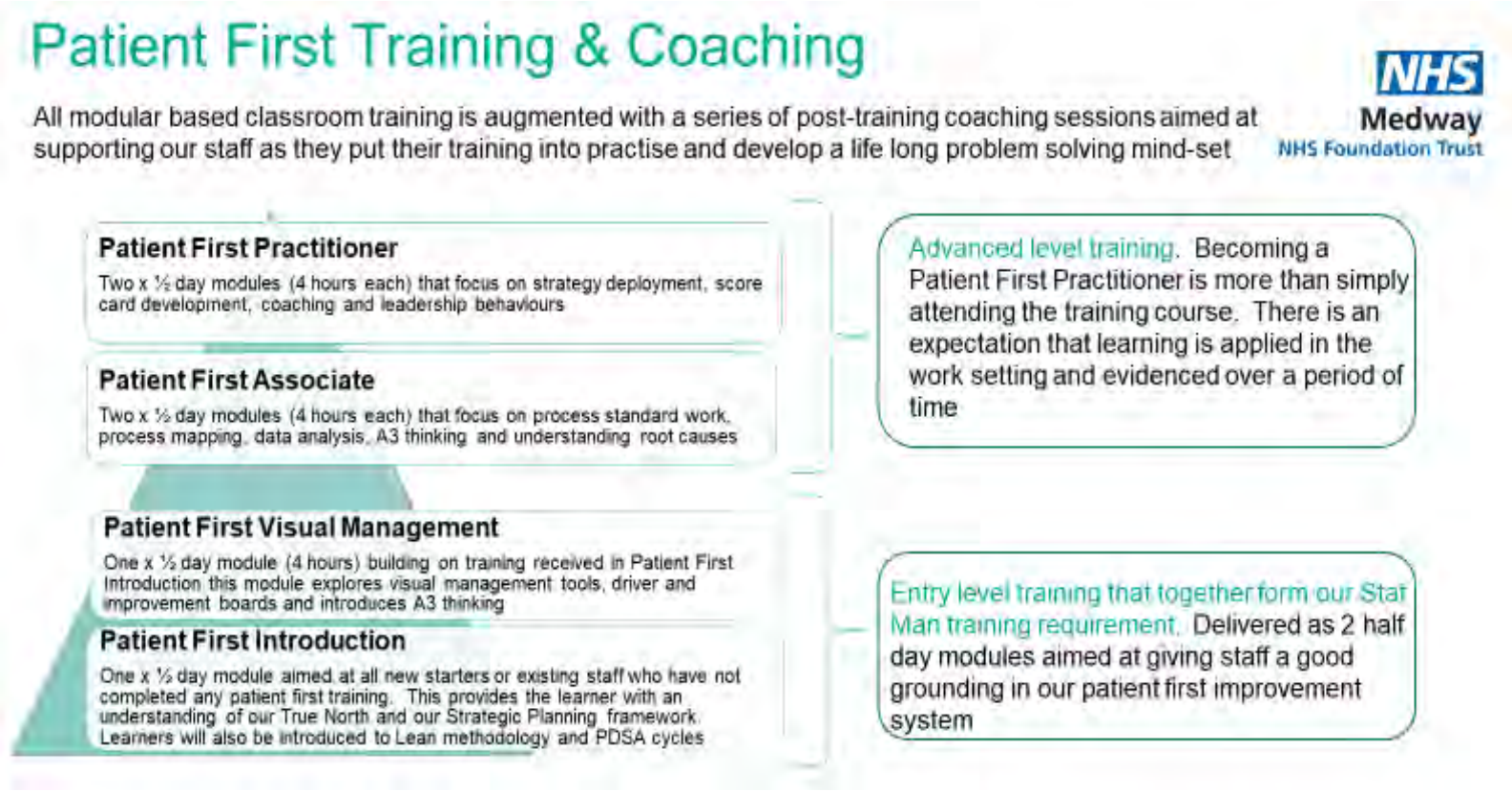
- Work progressed against the 2024/2025 programme of efficiency cuts, there has been notable progress in job planning, medical productivity, outpatients Artificial Intelligence, "Faculty Frontier" and other transformational schemes. The new programme of work is being finalised for 2025/26 currently.
- The Trust has put in to place, plans to invest in solar panel installation, replacement of boilers with modern heat pumps, installation of efficient LED lights and double glazing. This has been enabled by circa £26 million received in funding, allowing us to fulfil our commitment to be net zero by 2040.

We are proud of the improvement work we are undertaking together and stood up a weekly "spotlight" session in the main foyer of our hospital which has been showcasing improvements since November 2023. Every Thursday, Teams from across the hospital come and share an improvement that they have made, using Patient First principles, which has had a positive impact for our patients, their carers and families or for our staff. We proudly display photographs and short explanations of each improvement on the wall of our spotlight location; if you are ever in our hospital please stop by and take a look at the fantastic improvement work we are doing together.

Training and development in Patient First

In order to support our Patient First programme, our Transformation Team has a Trust-wide training programme, ensuring all colleagues are equipped with the right tools and knowledge to implement continuous improvement in their areas of work. All classroom-based training is augmented with a series of post-training coaching sessions aimed at supporting our staff as they put their training into practise and develop a lifelong problem solving mind-set.

The high- level overview of facilitated training is listed below:



We are also developing a digital training offer for all staff which will be available in 2025. The course content for the classroom training schedule follows the below structure:

Lesson	Level	Duration
Introduction 1 **StatMan**	Introduction	4 hours
Introduction 2 – Visual Management **StatMan**	Associate	4 hours

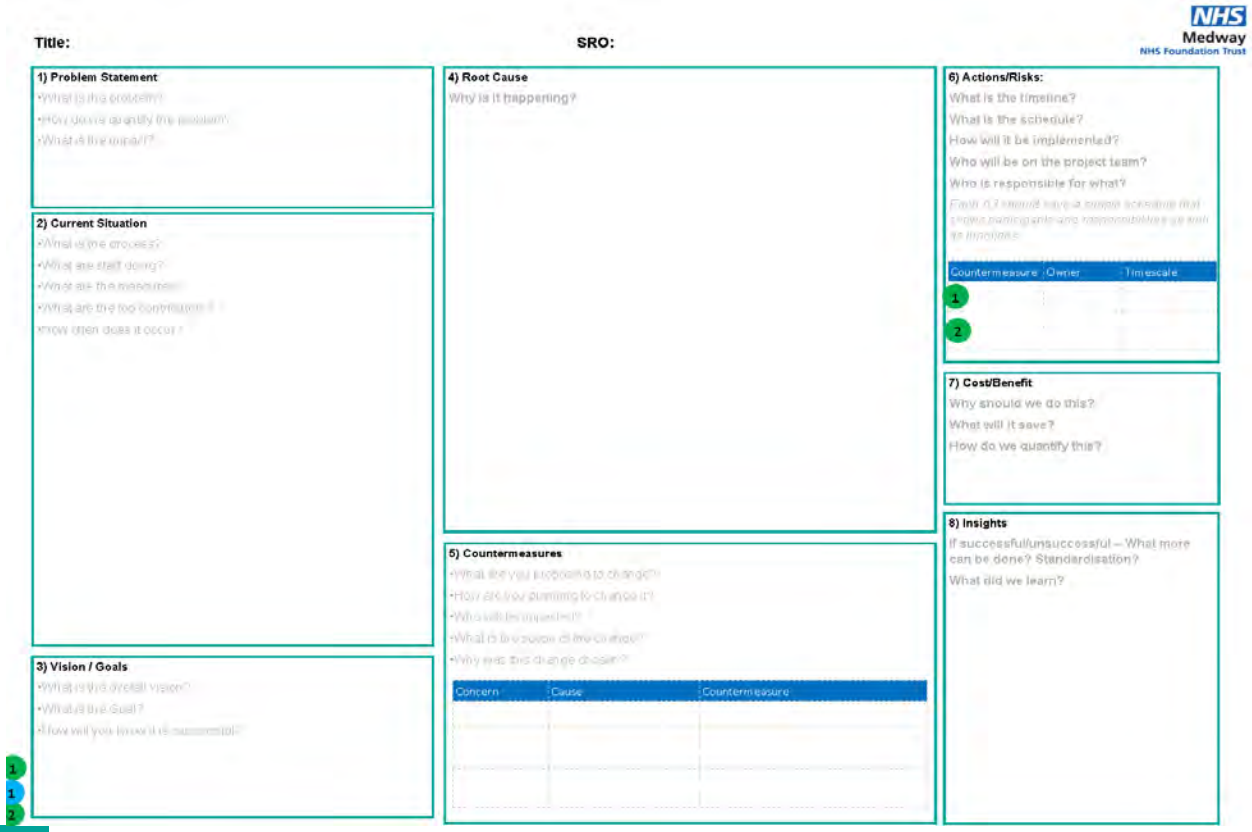
Associate 1 – Process mapping & Standard work	Associate	4 hours
Associate 2– A3 learning, data Analysis & root cause analysis	Associate	4 hours
Practitioner 1– Strategy deployment & Score card development	Practitioner	4 hours
Practitioner 2- Coaching & leadership behaviours	Practitioner	5 hours

Tools to support improvement

A range of tools are available to support staff in their development of continuous improvement. Each of the tools are essential to delivering our Patient First Strategy, and are explained below:

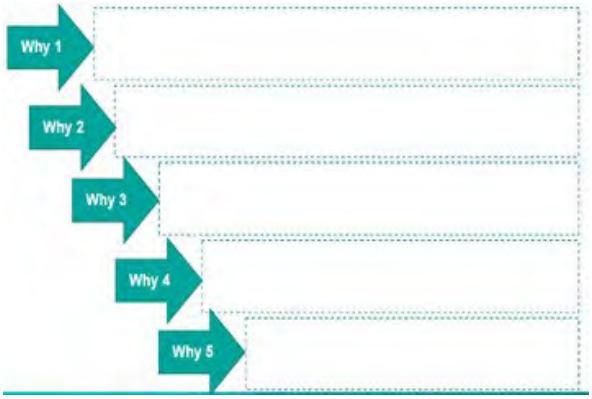
A3

A3 thinking follows a common structured problem-solving approach, using an A3 piece of paper, to ensure only relevant information is captured. The A3 format tells the whole story of the problem on one page, bringing together the analysis/root cause of the problem, its counter measures and an action plan.



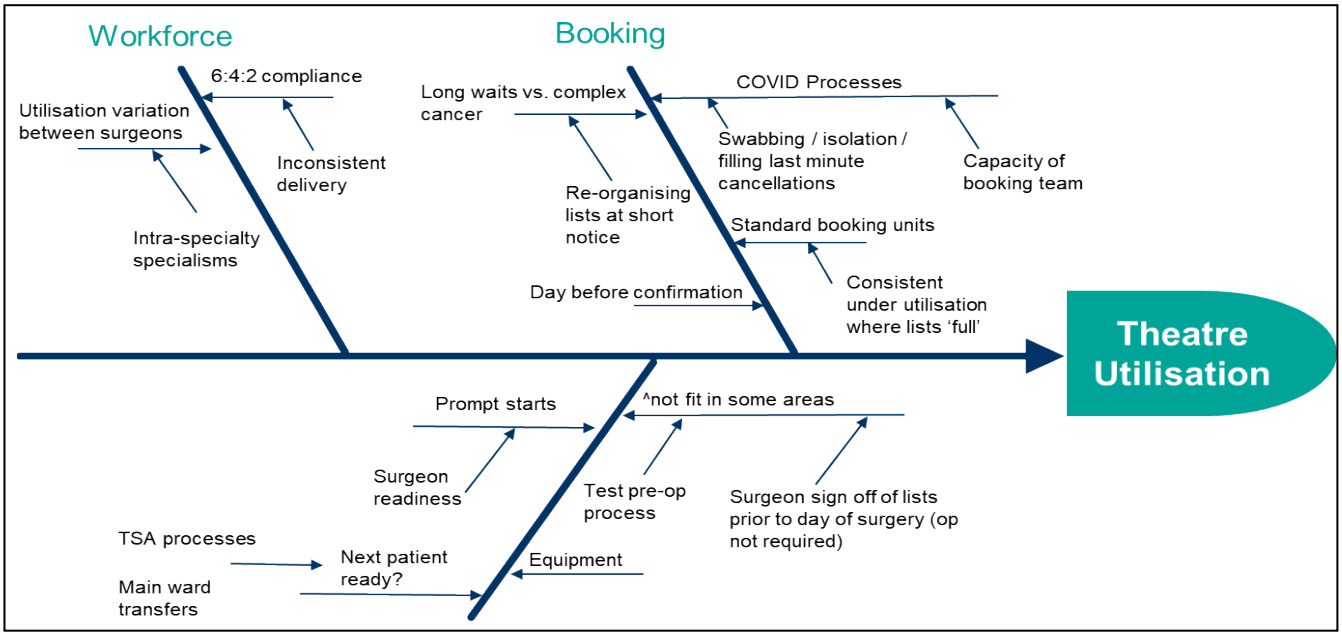
5 Whys

The 5 whys tool is the practice of asking “why” repeatedly whenever a problem is encountered in order to get beyond the obvious symptoms and discover the root cause. It is a really simple yet effective root cause analysis tool and encourages colleagues to stop and think before jumping to solutions when an issue arises.



Fishbone

The fishbone tool is a visual tool that uses a fish shaped diagram to model the possible root causes and troubleshoot possible solutions at the same time. It allows colleagues to view the problem visually in an order that will help to influence problem solving.



Leader Standard Work (LSW)

Our LSW sets out the standard expectations of a leader and associated management best practices. The execution of standard work ensures there is a tiered structure of accountability with appropriate escalation routes and touchpoints between the front line and management ensuring communication barriers are removed. The focus is on how we learn from behaviours and how and what we spend our time on.

Leader Standard Work		February 2022																								
			1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31	
Daily	**Time of Day**	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Executive Huddle																										
Weekly	**Day/time**																									
Strategic Initiative delivery meetings																										
Planning and coaching sessions with Deputies																										
Fortnightly	**Day/time**																									
Gemba																										
Monthly	**Day/time**																									
TLT Strategic Initiatives																										
TLT Trust Projects																										
TLT True North / Breakthrough Objectives / Scorecards																										
TLT Other times																										
Exec discursive time																										
Division PRMs																										
Board committments																										
Quarterly	**Day/time**																									
Annually	**Day/time**																									
Daily hours scheduled	TBD																									
Average Weekly Scheduled Hrs/day	TBD																									
Daily tasks scheduled	TBD																									
Daily tasks completed per standard	100%																									
Weekly % of tasks completed per std	100%																									

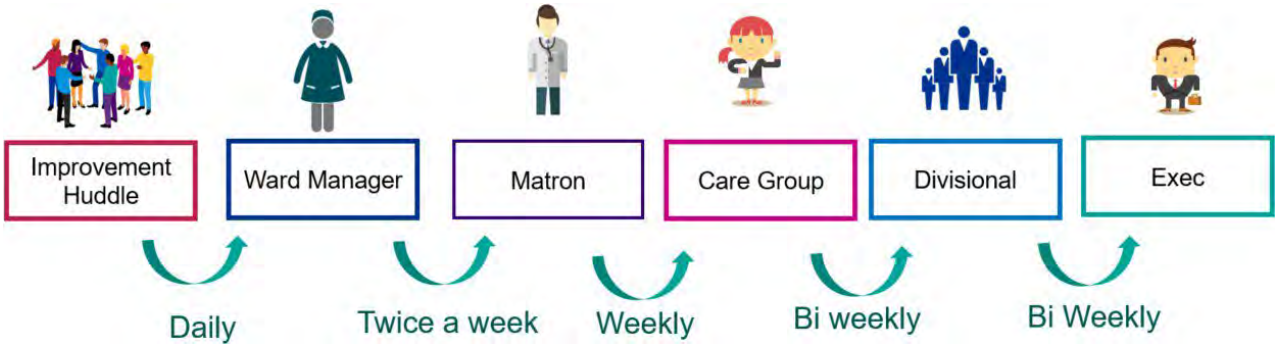
Standard Work

By creating a standard work template for processes, we are able to revisit and ensure compliance with our own standards. The Standard Work template describes and implements the best and most efficient way to complete a process, defined by leader standard work (as above), to set the expectations and management best practice. It allows colleagues to focus on how to undertake certain activities/tasks such as patient admissions, medication administration, patient registration and even site management processes.

#	Major steps	Details (if applicable)	Diagram, Workflow, Picture, Time ,Grid
1.	**Briefly review each lane on your team Performance Board.**		
1a .	Driver metric: ☐ Give brief overview of the driver metric	Driver metric: Remind staff of the team's driver metric. You may choose to mention: • Link to Breakthrough Objective • The problem statement • Current goal	
1b.	Historical data: ☐ Describe what the historical data shows ☐ Periodically ask for staff insights on the data	Historical data: Describe what the historical data shows. Periodically ask for staff insights on the data (huddle lead should make a judgement as to the frequency this is required, e.g. new starters to the team, introduction of a new driver metric or countermeasure, etc.) You may ask questions like: • What do you notice? • What might be causing this trend in the data? • What might we want to take a closer look at? • What is the top contributing reason that we are focussing on?	

Status Exchange

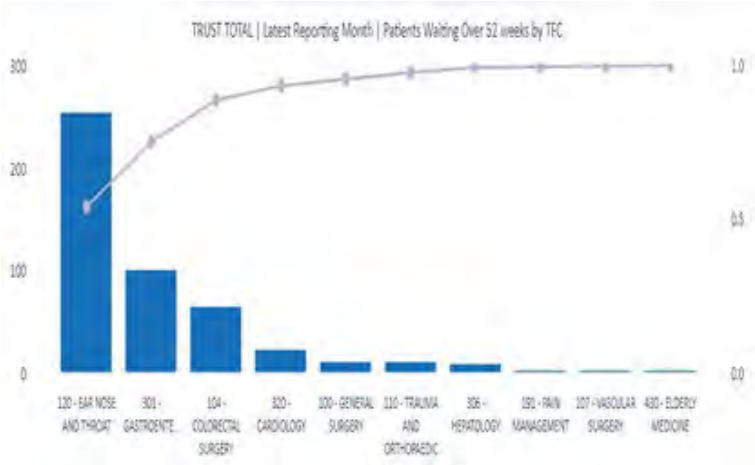
Status Exchange is an information and escalation flow conversation between team members and leaders to proactively reinforce strategic goals through focused questions, address biggest priorities of the day and supports leaders to spot developing trends and issues while providing mentoring and coaching for staff on a continual basis.



The questions within the Status Exchange template will differ from Executive colleagues to frontline colleagues, to ensure colleagues can ask the correct questions in order to provide assurance to Board Level. The Executive team use the status exchange at the weekly executive team meeting to ensure effective communication between each executive.

Pareto Chart

A Pareto chart is a fast way to identify significant contributing factors from the insignificant ones. It helps colleagues to determine which areas will have the most impact on affecting change and making improvements to the process. This determines where colleagues will and will not devote their time as a result of data analysis.



PDSA Cycles

PDSA stands for Plan, Do, Study, Act and allows colleagues to: Plan the change to be implemented, carry out the test of change, use before and after data to measure the change while reflecting on the impact and what was learnt, and finally to react to the insights gained and plan the next change cycle of full implementation.

GEMBA

Gemba is a Japanese term that translates to “the real place”. Managers and leaders on every level take regular walks where the work is done and where staff are making a difference for patients, and have the opportunity to ask questions in order to see where they can add value. Gemba’s connect management to frontline by observing, engaging and improving. Gemba walks can look for non-value-adding activities, get to know staff and show appreciation or to learn from an incident or new process. Executives, Non-Executives Directors (NEDs) and Senior Managers have so far focused on staff behaviour, winter planning and the use of clinical systems. An electronic template (using our Gathr software) is then completed to capture the feedback and any lessons learned or new improvement ideas to support our colleagues and ensure we are adding value.

Scorecard

The scorecard is a balanced set of Key Performance Indicators (KPIs) at Executive, Division/Corporate areas, Care Group, Specialty and Departmental/Service area level that have come directly from the True North metrics. The scorecard is made up of metrics that have been chosen for improvement and that are being monitored to ensure performance is maintained.

Scorecard Selection: TRUST TOTAL

Patient First Scorecard

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

KPI Scorecard

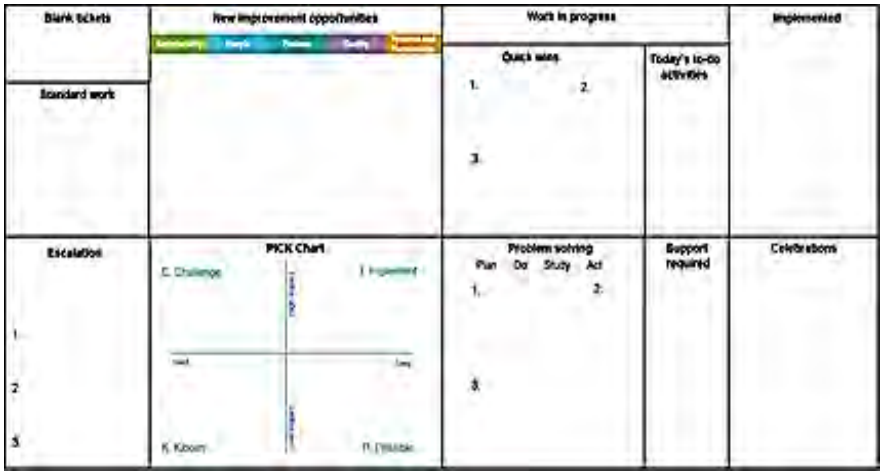
Business Rules Selection: All

KPI Type Selection:
(Click on the icons to show/hide)

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People	Workforce			Vacancy Rate %	9.0%			8.1%	7.8%	7.7%	7.8%	6.8%	7.3%	6.6%	6.5%	6.2%	7.2%	6.7%	6.2%
				Voluntary Turnover %	8.0%			9.1%	8.8%	8.7%	8.7%	9.0%	8.6%	8.7%	8.5%	8.2%	8.4%	8.4%	8.3%
				Voluntary Turnover (ICS) %	-			0.6%	0.9%	0.9%	1.2%	1.4%	1.0%	0.9%	1.0%	0.7%	1.0%	0.7%	1.0%
				Sickness Absence Rate - Total %	4.0%			4.4%	4.7%	5.1%	5.0%	4.9%	5.3%	5.3%	5.3%	5.3%	5.6%	5.1%	4.4%
				Sickness Absence Rate - Short Term %	2.0%			2.2%	2.2%	2.4%	2.2%	1.8%	2.4%	2.5%	2.6%	2.7%	3.2%	2.7%	2.2%
				Sickness Absence Rate - Long Term %	2.0%			2.2%	2.5%	2.8%	2.8%	3.1%	2.9%	2.8%	2.6%	2.6%	2.4%	2.5%	2.1%
				Time to Hire - AfC	42			61.10	55.30	47.90	54	55.90	56	60	58.30	45.40	55.60	63.80	54.90
				Time to Hire - Medical	70			91.30	66.70	58.90	42.60	86.50	51	78	69.90	60.90	61.70	65.90	58.10
				Agency Spend %	3.7%			2.1%	2.4%	1.5%	1.7%	1.9%	2.2%	1.5%	1.4%	1.2%	0.9%	1.1%	0.6%
				Bank Spend %	10.0%			11.1%	10.2%	10.4%	12.1%	10.2%	10.5%	9.0%	8.2%	9.6%	9.9%	9.7%	6.6%
	Safe Staffing			Staff Fill Rate - Total %	85.0%			96.6%	96.0%	96.0%	95.7%	87.3%	85.8%	85.4%	99.4%	85.9%	85.5%	87.4%	91.1%

Improvement Boards

Improvement Boards are a visual tool, used to track daily improvement activity. Improvement activities are identified when discussing the Driver Metric(s) on the performance board. Daily operational activities can be identified in huddles, morning handovers and ward rounds. Colleagues will then complete an improvement opportunity ticket, and place it on the board to review in the next meeting.



Performance Board

The performance board is a physical board that includes charts and graphs to document performance over time of the metrics that align with the strategic initiatives of the Trust. Typically, the board will also include a visual tracking system to collect, prioritise and track the implementation of improvement ideas.

Driver Metric	Driver Metric	Driver Metric	Driver Metric	Driver Metric	
Monthly data	Monthly data	Monthly data	Monthly data	Monthly data	Monthly Scorecard
Weekly/daily data	Weekly/daily data	Weekly/daily data	Weekly/daily data	Weekly/daily data	Other information
Top causes	Top causes	Top causes	Top causes	Top causes	A3
Actions (PDSA/A3)	Actions (PDSA/A3)	Actions (PDSA/A3)	Actions (PDSA/A3)	Actions (PDSA/A3)	

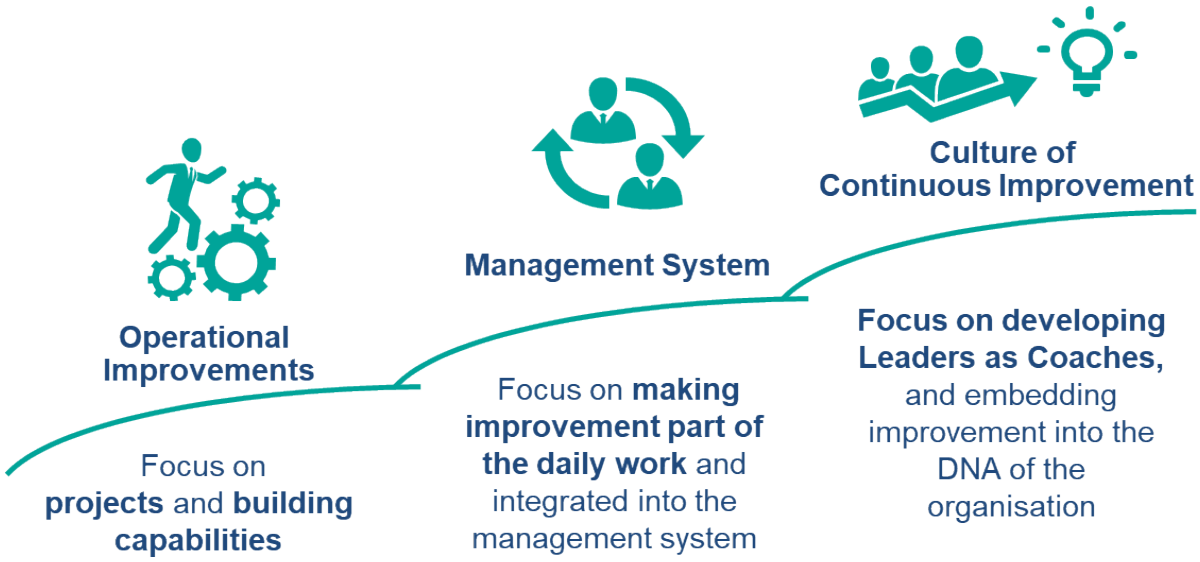
Leadership Behaviours

We know that the leadership behaviours we display have a significant impact on the culture of our organisation. It's something we feel very strongly about at Medway and as such we have used Patient First to develop a set of expectations around leadership behaviours that have been cascaded to all levels of leadership and management across our organisation, including our executive and non-executive directors.

The key principles that drive the right leadership behaviours are:

- Create value for our patients
- Create consistency of purpose
- Think systematically
- Assure quality at source
- Improve flow and pull
- Seek perfection
- Embrace scientific thinking
- Focus on process (not people)
- Respect every individual
- Lead with humility

Focusing on the leadership behaviours outlined above, this will help us develop our internal capability and sustain our Patient First improvement journey as demonstrated below:



Leadership training remains a key offer to support the leaders our Trust. The training focuses on helping leaders to deploy and embed the Patient First system locally and to develop a coaching style and relationship with their teams. development of personal development plans across all our leadership teams, including both Exec and Non-Exec members of our Board.

Engagement

In preparing our Patient First Strategy for the next three years it was vital to listen and take into account the thoughts of our staff at the Trust who are best placed to tell us what we do well and what we can do to improve. To inform our Patient First Strategy we:

1. Ran a dedicated Patient First conference in 2024, with more than 100 colleagues and partners focused on learning, success and improvement which received very positive feedback. A further event is planned for the Summer 2025

2. Implemented a questionnaire for staff members focused on hearing feedback around training, tools, methodology and how we can continue to engage with patients and the public
3. Socialised the Strategic Planning Framework through dedicated engagement events with staff, patients and their families, highlighting the changes we were proposing and the expected benefits

Questionnaire and Engagement Event Results

Our bespoke survey was shared with staff in April 2025 for their feedback on Patient First and the changes that had been proposed to the Strategic Planning Framework (SPF) for 2025/26. Staff were asked if they felt the changes would support the organisation more to deliver improvement and any challenges that may arise as a result of the changes. Staff were also asked to rate the impact they felt the changes may have on their role. In addition, a number of public engagement activities were undertaken to show patients, families and visitors what changes were being made and why.

Key feedback from the staff survey showed:

- Respondents were broadly equally split between clinical and non-clinical staff;
- 82 percent of respondents felt that some, or all, of the proposed changes to the SPF for 2025/26 could make Patient First more effective; 18 percent felt that there was more work to do to better engage with staff to understand the causes of longstanding issues within the organisation and to address needs of the local population.
- Approximately three-quarters of respondents did not foresee any challenges resulting from these changes but just over one quarter did. Those that identified challenges felt that they arose in the areas of engaging fully with staff, across all areas of the organisation and in addressing our improvement needs with the known resourcing constraints;

Feedback gathered from both the survey and the public engagement activities has been incorporated into our next steps and actions for the coming months ensuring staff continue to be supported to contribute to Patient First and use the tools and systems to deliver against our ambitious priorities for improving the health of patients and the engagement and support for our staff.

Next Steps

In our next set of Breakthrough Objectives (2025/26), our focus remains firmly on the True North Domains.

- Under **Sustainability,** we will build on foundations laid towards reaching a sustainable or recurrent break-even position by 2028/29.
- Focus will move towards staff engagement for **People**, as we work to improve staff experience, looking at why people choose to work here and what we can do to make this an even better place to work.
- Continue to focus on increasing number of **Patients**, who are reporting having a good experienced with us when receiving care
- **Quality** will focus on reducing avoidable harm and mortality by improving care,

learning from avoidable incidents and further improving our reporting and recording practices

- Under **Systems and Partnerships,** we will continue work to further reduce waits for elective care towards the 18-week target for treatment. We will work hard to manage our emergency care pathways to ensure patients do not wait for extended periods within our emergency department, specifically focussing on reducing 12 hour waits, to ensure patients receive care in the best place for their needs. We will expand the scope of work in this area to encompass engagement with partners across the wider Kent and Medway system to influence and support activities that reduce health inequalities. We will consider those who are impacted more significantly and may not have their health and wellbeing outcomes fully optimised due to wider determinants including deprivation and / or social exclusion.

By focusing on continuous improvement, and empowering our staff to make changes in their own areas of work, we will improve patients' outcomes and experiences whilst in our care. Applying Patient First principals will help to increase staff job satisfaction, through training and development and also providing a level of autonomy to allow our staff to lead on changes that will improve their areas.

NHS England has published a nationwide requirement for Trusts to have an operational excellence plan, which demonstrates the same values as the Patient First programme. Through the adoption and implementation of our Patient First Improvement System, the Trust has all the elements required for a successful improvement approach aligned to the NHS improvement standard. The ethos of our Patient First principles align to this recommendation from NHS England.

Our local system leaders are also committed to continuous improvement, which encourages better partnership working and ensures that we, as a system, are aligned to the needs of patients.

Actions for the next six months

- Engage with partners across the health and care system to determine opportunities to influence and improve access to services focussing on health inequalities and better outcomes for patient impacted by social exclusion or deprivation.
- Patient First Training continues to be adapted to provide the best learning outcomes for our staff.
- Following the successful implementation of Care Group and Divisional Strategy Deployment Reviews (SDRs), we are moving to engage and support delivery in both Frontline Clinical areas and further expanding our Corporate Teams.
- Agreeing the platform for our digital offering took longer than we had expected so the implementation of Digital Patient First including roll out of digital learning and masterclass offerings is expected to go live within the next three months.
- Further Trust Board Development, following the buddying of Non-Executive Directors and Executives to Gemba; further evolving the Trust Board SDR.

Actions beyond the next six months

- Regular yearly refresh and review of our relevant Breakthrough Objectives, ensuring

collaboration with the Health and Care Partnership, Provider Collaborative, other system partners, our colleagues and our patients
- Identify key opportunities where we can support or influence partners to support activities that will start to address areas of health inequalities across Medway and Swale
- Lead on the integration of continuous improvement approach across the local health and care system

At Medway, we understand how important putting our patients first is to their experience within our care and their clinical outcomes. We will be working closely with our Head of Engagement to ensure our patients, members and local governors have the opportunity to input into our priority areas for the annual refresh each and every year.

As well as enhanced engagement with our service users, we will also be driving the integration of the Patient First approach to our local health and system partners to ensure we are working together with the patient in mind.

Following the methodology, we will be data driven and continually review the impact we are having, and amend our approach to ensure the maximum improvements for our patients and population health.

References

Document	**Ref No**
References:	
Trust Associated Documents:	
Quality Strategy	
Digital, Data and Technology Strategy	
Research and Innovation Strategy	
People Strategy	
Clinical Strategy	
Freedom to Speak Up Strategy	
Information Governance Strategy	
Infection, Prevention and Control Strategy	
Patient Experience Strategy	

END OF DOCUMENT

Medway NHS Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

Policy Reference Number:	POLCOM045
Version Number:	10
Approving Committee/Group	Medway NHS Foundation Trust Board
Department / Category	Emergency Preparedness, Resilience and Response
Accountable Executive Lead	Nick Sinclair, Chief Operating Officer
Name of Author	Thomas Doherty, Head of Emergency Preparedness, Resilience and Response
Brief Outline of This Policy and Standard Operating Procedure	This Policy ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). This enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery.
Date Approved	31 June 23
Approved By	Senior Operations Group
Date Ratified	4 July 2023
Ratified By	Medway NHS Foundation Trust Board
Published Date (made live for use)	

Medway NHS Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

Review Date	4 July 2026
Target Audience	All staff

Key Principles of This Policy	
1.	Influence Employee Behaviour with Policy Communications
2.	To support delivery of Emergency Preparedness, Resilience and Response (EPRR).
3.	To provide consistency and coordination in cases of an incident/event.

This policy has been reviewed and is compliant with the most up to date Code of Practice and NICE Guidelines	
Title of Code of Practice	**NICE Reference Number (s)**

Document Control/History List			
Version No	**Date**	**Author**	**Reason and Summary of Change**
1.0			Detail the arrangements of the Trust in relation to the Local Health Resilience Partnership (LHRP) and Kent Resilience Forum (KRF).
2.0			Reference to include National Risk Register 2014
3.0			Change of Organisational leads.
4.0			Streamlined into Corporate Trust Policy for Board approval. Responsibilities of the Board and EPRR Group added. References to supporting documents added.
5.0			Change of author, owner, Accountable Executive and update of Trust Logo

6.0			Role and Responsibility of Non-Executive Director with EPRR Portfolio Trust Annual Report requirement
7.0	08/19		Revision of terminology in line with the NHS England EPRR Standards and update of roles in place.
8.0	07/20		Combination of EPRR and Business Continuity Policy into one document
9.0	06/21		Update to the structure of EPRR responsibilities.Section 4.1 update Board responsibilities to; *Ensuring they review annually and are satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its duties*
9.1	09/22		Complete sections review and update of content throughout. Updated EPRR staffing and governance structure and full content alignment to the updated EPRR Framework (2022). Includes reference to new NHS Minimum Occupation Standards and Trust Business Continuity Management System Framework (2022).
9.2	04/23		Change to organisation structure diagram. Review of content throughout. No additional changes made.
10	June 2023	Head of Emergency Preparedness, Resilience and Response	Format/Template update

POLICY ON A PAGE

1. Why do we need this Policy

Medway NHS Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.

2. What do I need to know	**3. Quality Standards**
Medway NHS Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.	Civil Contingencies Act 2004, NHS Act 2006 Health and Care Act 2022, NHS standard contract NHS Core Standards for EPRR (annual assurance) The NHS England EPRR Framework (2022) NHS England business continuity management framework (2013) in alignment with ISO 22301.
4. Understanding the Process	**5. Contact**
To prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario To have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience To ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities.	Tom Doherty – Head of EPRR Brian Williams – Senior EPRR Officer

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Medway NHS Foundation Trust Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

POLICY SECTION

1. Introduction

1.1. Medway NHS Foundation Trust has a legal duty to plan for and have capabilities to respond to and recover from, incidents and emergencies that could impact on the health, safety and security of staff, patients and visitors. This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks.

2. Policy Purpose

2.1. This Policy ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). In alignment with the legislations, policies and frameworks described in section 3.0, this enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery.

3. Policy Statement

3.1. EPRR supports the Trust Business and Strategy objectives by ensuring the continuous improvement and rolling programme of EPRR, to achieve organisational resilience and annual compliance with the 64 NHS EPRR core standards for Acute Trusts. The EPRR function is promulgated throughout the Trust by the EPRR team, who promote and the Trust's EPRR group to collaboratively develop and deliver a programme of Training and Exercising to ensure staff are familiar with EPRR best practice, internal response plans and resilience arrangements and know who to approach for tactical advice to support an effective response to an emergency or disruptive event, when required.

4. Related Policies

4.1. DOC771 - Mass Casualty Incident Plan

4.2. OTCOM008 - Chemical, Biological, Radiological and Nuclear Explosion (CBRNe) Plan

4.3. **Medway NHS Foundation Trust Incident Response Plan**

5. Glossary of Terms

5.1. Under section 1(1) of the CCA 2004 an 'emergency' is defined as:

"(a) an event or situation which threatens serious damage to human welfare in a place in the United Kingdom; (b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom; or (c) war, or terrorism, which threatens serious damage to the security of the United Kingdom".

Emergency preparedness: The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies.

Resilience: Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incidents and emergencies.

Response: Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery.

Incidents: For the NHS, incidents are defined as:
Business Continuity Incident – an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

Critical Incident – any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Major Incident – The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder. In the NHS this will cover any occurrence that presents serious threat

to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

6. References

6.1. The NHS England EPRR Framework (2022) NHS England business continuity management framework (2013) in alignment with ISO 22301

6.2. Civil Contingencies Act 2004

6.3. NHS Act 2006

6.4. Health and Care Act 2022, NHS standard contract

6.5. NHS Core Standards for EPRR (annual assurance)

7. Roles and Responsibilities

7.1. Trust Board

Whilst it is recognised that EPRR is a collective board level responsibility, a number of Non-Executive Directors bring skills and experience in crisis and incident management. Where this is the case, additional support to the AEO from a suitably experienced NED is recommended. This will be a decision for local Chairs and Chief Executive Officers (CEOs), in addition to:

- Approving the Trust's Corporate Policy for EPRR and Business Continuity.
- Reviewing and approving the annual reports to the Board, on Trust compliance with the NHS England EPRR Core standards and overview of EPRR annual activity.
- Understanding the statutory EPRR framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.
- Supporting the delegated responsibility of Strategic Command and Control during an incident, that requires such structures to be implemented.
- Ensuring that the organisation has sufficient and appropriate resource, to effectively discharge its EPRR duties.

7.2 Chief Executive

NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. Chief executives will be able to delegate this responsibility to a named director.

- Responsible for designating the responsibility of EPRR as a core part of the organisation's governance and operational delivery programmes
- Is aware of the factors within the organisation which could negatively impact on public protection within their health community as a result of a major incident
- Is aware of the Trust's legal duty to respond to and recover from a major incident, in parallel with continuing patient services
- Responsible for nominating an Accountable Emergency Officer

7.3 Accountable Emergency Officer

The Chief Operating Officer is the designated Executive for EPRR and often the delegated Accountable Emergency Officer who can delegate responsibilities below, to a deputy:

- Ensure the Trust has appropriate resources committed and funds available to the EPRR Function
- Plans and policies are in place to fulfil the requirements of the statutory framework
- Commitment from Senior Leadership towards their staff engagement with the programme of EPRR work
- Ensure the organisation is properly prepared and resourced to respond to a major incident
- Attend the Local Health Resilience Partnership Executive Group (no less than 75% of meetings)
- Provide EPRR reports to the Board no less frequently than annually and as a minimum, include an overview on;
    - Training and exercising undertaken by the organisation
    - High level EPRR risks and mitigations
    - Summary of any business continuity, critical incidents and major incidents
    - Summary of lessons identified from Incidents and exercises
    - The organisation's compliance position in relation to the latest NHS England EPRR Assurance process

7.4 Emergency Preparedness Resilience and Response Manager

- Ensure the Trust EPRR and Business Continuity Policy is effectively delivered in liaison and engagement with all relevant staff across the Trust
- Ensure all relevant response and resilience plans aligned to the EPRR Core standards and local risks, are developed in accordance to national and local guidance; are tested and accessible to staff

- Develop an annual EPRR Work Plan which is fully aligned with the NHS EPRR Core standards, the Trusts' Business strategy and is agreed by the Trust Board. The work plan will address: Training and exercise requirements for all staff, 'lessons learnt' process from incidents and exercises, Identification of risks to inform plan mitigations, Business Continuity Management in accordance with the Trust's Business Continuity Management System Framework (2022) and Identify outcomes of assurance and audit processes. The work plan must consider the LHRP and LRF work plans as appropriate.
- Mentor and provide leadership to staff in the EPRR team and support their personal development in delivering elements of the EPRR work plan.
- Represent the Trust at local resilience sub and partnership groups related to EPRR and the LRF, to input into the development of response plans, training and exercising
- Support the Accountable Emergency Officer in providing regular assurance to the Trust Board regarding the delivery of the EPRR work programme, aligned to the NHS EPRR Core Standards.
- Ensure the EPRR function, including all Training and Exercising, is delivered to a high standard, aligned with local risk registers and Minimum Occupational Standards for EPRR (england.nhs.uk) objectively to achieve organisational resilience.
- Provide regular training sessions for On Call staff to ensure resilience out of hours including access to personal log books, a contacts directory for internal and external stakeholders in an emergency and a list of trained Loggists to be called upon.

7.5 Divisional Directors, General Managers, Service leads and Heads of Department (Clinical and non-clinical)

- Commit to attending the EPRR group meetings to understand the engagement required from staff across each of the divisions and departments, with the EPRR team to achieve the annual work plan and programme of continuous improvement via Lessons Identified.
- Regularly input into the EPRR group to highlight risks and issues to continuity of service and organisational resilience and work collaboratively to mitigate these.
- Ensure that Business Impact assessments and business continuity plans are in place, have appropriate ownership in departments, are up to date and accessible
- Release staff to undertake Training and Exercises to develop and test EPRR Plans and for personal development, in compliance with the Trust EPRR Training needs analysis.

- Directors, General Managers and Heads of Department who are aligned to the Trust On Call rotas will comply with the agreed EPRR training programme for On Call staff, ensuring an up to date EPRR portfolio is kept and training attendance is recorded.
- Ensure that when 'On Call', they are accessible and are fit to carry out their duties at all times and have access to the required equipment, information and policies on ResilienceDirect and the staff intranet, including the Trust On Call protocol for SMoC and DoC staff.

7.6 On Call EPRR Duties – Senior Managers and Directors

In response to an emergency incident, which requires activation of an emergency plan, the Incident Coordination Centre and/or the command and control structure out of hours, the Senior Manager on Call and Director on call have a duty to assume the relative command positions. The SMoC will assume the role of the Tactical Commander and the DoC will assume the Strategic Commander. This policy permits those staff who have undertaken the Trust EPRR Incident Command Training module, the authority to act outside of their normal scope of duties in direct response to an evolving incident, in order to preserve life, ensure the safety and security of patients, staff and visitors, in keeping with the Trust's vision and values.

7.7 Communications Team

The Communications Team are responsible for regularly attending the EPRR Group, developing Incident Communication plans, being aware of the internal and external Incident alerting process and warning and informing civil protection duties under the CCA 2004.

Trust Communications staff will sit within Strategic and Tactical Command during an incident and ensure effective and timely communications to staff, patients, visitors and external stakeholders as appropriate.

7.8 ICT

The Head of IT will ensure that there is an effective Disaster Recovery Plan (Covering loss of physical assets and recovery with a recovery time objective), reviewed annually and is made available to staff in the Trust for awareness.

Ensure the Trust can demonstrate its resilience to Cyber Security threats with a Cyber resilience and response plan which is compliant with the Data protection and security toolkit and Kent LHRP Cyber Security standards, annually.

7.9 Estates and Facilities

All teams within this department will ensure the organisation has appropriate resilience plans, processes and resources in place to ensure continuity of utilities and accommodation provision for all areas of the Trust to operate safely.

8. Process for Monitoring Compliance and Effectiveness

8.1. All relevant response and resilience plans aligned to the EPRR Core standards and local risks, are developed in accordance to national and local guidance; are tested and accessible to staff.

8.2. Provide EPRR reports to the Board no less frequently than annually and as a minimum, include an overview on;

- Training and exercising undertaken by the organisation
- High level EPRR risks and mitigations
- Summary of any business continuity, critical incidents and major incidents
- Summary of lessons identified from Incidents and exercises
- The organisation's compliance position in relation to the latest NHS England EPRR Assurance process

8.3. The lessons identified from debriefing activities are vital to improving the way we respond to incidents. Inquests and inquiries focus heavily on previous lessons and responder organisations must be able to prove they have identified and shared learning to try to prevent future similar issues.

9. Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
EPRR Risk Register	EPRR Group – each meeting	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
EPRR and Business Continuity Policy review	Annually	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
Trust compliance with EPRR Core standards and overview of EPRR activity during the year	EPRR Group - Annually	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
EPRR work plan	EPRR Group – twice yearly	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	
Lessons Identified (from exercises and/or incidents)	EPRR Group – each meeting	EPRR Manager	AEO, RCAG, Risk and Audit Committee, Trust Board	

10. Equality Impact Assessment Statement and Tool

10.1. All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]". This is most easily achieved through an Equality Impact Assessment.

10.2. When developing or revising policies, programmes, projects, strategic decisions, the person responsible for that work and associated decisions must record and publish their assessment of impact against the protected characteristics, and the public sector equality duty, as described in the Equality Act 2010. They must also put in place systems to monitor and review those impacts.

10.3. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment.

10.4. The following Equality Impact Assessment Screening Tool is designed to help identify the key issues for each protected characteristic and element of the Public Sector Equality Duty. This is not the impact assessment, simply a tool to help identify potential impacts.

11. Completed Equality Impact Assessment Statement and Tool

Is there any evidence that some groups are affected differently? (use the screening below)					
Protected Characteristic	Could there be an adverse impact? Yes/No/ Unknown	Relevance None/Low/ Medium/High	Proportionality (likelihood of risk/impact)		Notes
			None/Low/ Med/High	+ve / -ve	
Age	NO	None	None		
Disability	NO	None	None		
Gender / Sex	NO	None	None		
Gender Identity	NO	None	None		
Race	NO	None	None		
Religion/Belief	NO	None	None		
Sexual Orientation	NO	None	None		
Pregnancy & Maternity	NO	None	None		
Marriage / Civil Partnership	NO	None	None		

Questions		
1	Does the proposal …	
a	• promote equality of opportunity?	N/A
b	• eliminate unlawful discrimination?	N/A
c	• good community relations?	N/A
d	• amount to illegal discrimination?	N/A
e	• create an inequality?	N/A
2	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? Is the impact of the case likely to be negative and if so can the impact be mitigated? Can we reduce the impact by taking different action: what alternatives are there to achieving the aim?	N/A

e recommendations								
No.	**Recommendation**	**Timeline**	**Lead**	**Update**	**RAG Rating**	**Owner**	**Update 11/2/2025**	**Action point Updated on 14/03/2025**
1	This report should be considered by the **Trust Boar**d, or relevant subcommittee and oversight of an action plan should be provided to a **Non-Executive Board member** to ensure these recommendations are completed	Immediate 0-3 Months	Jeremy Davis	This report and action plan will be discussed at Exec meeting w.c.30.09.24 and QAC w.c.07.10.24. Weekly meetings have been established w.c.14.10 to track progress against the plan.		**Nicola Cooper**		Regular meeting - weekly till Nov. Meetings need to continue
2	The Trust should review the cases highlighted to the Chief Medical Officer by the review team which require urgent follow up or review by the rheumatology team	Immediate 0-3 Months	Jeremy Davis	Complex patients have now all been seen by Internal Trust team- Dr Jilani and Dr Subasinghe. Patients have also been discussed in complex MDT. Patient will be followed up by Dr Adnan (new locum consultant).		**Amjad Jilani**		Complex patients have now all been seen by Internal Trust team- Dr Jilani and Dr Subasinghe. Patients have also been discussed in complex MDT. Patient will be followed up by Dr Adnan (new locum consultant). Group of complex cases highlighted by RCP - reviewed by Dr Jilani. No significant risks were noted. All patients were found to be safe.
3	The service should **stop its Point of Care ultrasonography** until the diagnostic images can be stored within an appropriate facility that will allow review and scrutiny and there are appropriate **governance arrangements** in place to maintain oversight.	Immediate 0-3 Months	Shrawan Agrawal Sanjay Suman	It is felt that an urgent risk assessment is required to decide if PoC ultrasound should stop completely, until images can be stored in appropriate facility. There are appropriate governance arrangements to maintain oversight and all colleagues undertaking PoC ultrasound have credentials reviewed to ensure they have had relevant training. Initial meeting took place with Radiology team and clinic leads in April regarding storage of POC ultrasounds in radiology but no progress as of yet. Conversation to be picked up now new General Manager in post.		**Kerrie Ford** **Amjad Jilani** **Sunari Subasinghe**	Numbers have been sent to Radiology and discussions had by AJ - fedback they are unable to store images for minimum of 3 months whilst they do some upgrades. AJ is able to do USS clinics - opportunity to look at income generation, KF to take forward.	Needs update. No POC ultrasound is being done currently. Numbers have been sent to Radiology and discussions had by AJ - fedback they are unable to store images for minimium of 3 months whilst they do some upgrades. AJ is able to do USS clinics - opportunity to look at income generation, KF to take forward. There are appropriate governance arrangements to maintain oversight and all colleagues undertaking PoC ultrasound have credentials reviewed to ensure they have had relevant training. Clarification needed from RCP if all clinicians can't use USS machine. Who will certify ?Dr Bilagi. Issue for TA US for Dartford inpatient. Waiting time for US in radiology department.
vice design								
No.	**Recommendation**	**Timeline**	**Lead**	**Update**	**Status**	**Owner**		

4	The Trust should review the national directive to improve **communication between primary and secondary care** without the need for formal clinic referral (using the **advice and guidance programme**). It must be delivered by motivated individuals who have appropriate time allocated within their job plan	Immediate 0-3 Months	Shrawan Agrawal Sanjay Suman	Advice and Guidance usage within Rheumatology to be looked into to determine correct was to implement. To form part of 25/26 job planning discussions. The form part of additional recruitment business case.		**Sri Sriranagn** **Kerrie Ford**	To feed into KF plan to have a locum cons/substantive with income outweighing the expenditure / RTT reduction / simaltaneous launch of A&G which is also income generating	Advice and guidance - Dr Srirangan will present in 2 weeks. Model (how to deliver it) Job plan 25/26 discussion - Further recruitments (income outweighing the expenditure / RTT reduction / simultaneous launch of A&G which is also income generating)
5	All referrals should be pooled and **triaged** following an agreed set of principles, which are consistently applied. This time should be identified within a job plan.	Short term 0-6 months	Shrawan Agrawal Sanjay Suman	Review of triage pathways and specialist clinics to be undertaken. Awaiting response from internal contracts team around what we are commissioned to provide as a Rheumatology service. Awaiting ICB response from Dan Coleman around GP Liaison and non-inflammatory pathways. Support required from CMO team (Robust training for non inflammatory conditions in case they miss the diagnosis) To form part of additional recruitment business case.		**Kerrie Ford**	This sits with Chris Williams - pathways were sent across. CW to look at extended scope of phsyio	Review of triage pathways and specialist clinics to be undertaken. (Currently MCH) Awaiting response from internal contracts team around what we are commissioned to provide as a Rheumatology service. KF to look into this and raise with Dan Coleman/Chris Williams. Awaiting ICB response from Dan Coleman around GP Liaison and non-inflammatory pathways. Support required from CMO team. To form part of additional recruitment business case.
6	The service should review its **GCA/Vasculitis clinical service** arrangements. The review team recommend that **two consultants within the department** lead on the responsibility of these patients to ensure a consistency of management.	Short term 0-6 months	Shrawan Agrawal	SOP is finalised for temporal artery biopsy for GCA and is now on Qpulse. Ultrasound SOP is still being worked on- to pick up with Gemma Wren on status		**Amjad Jilani** **Kerrie Ford**	To feed into plan to have a locum cons/substantive with income outwieght the expenditure & RTT reduction - KF	**North Fleet site** - GCA - Dr Jilani; (When Dr Jilani can start doing after governance issue) Vasculitis/CTD - Dr Adnan **Medway site** - GCA - new recruitment: Vasculitis/CTD - Dr Wijesooriya To feed into plan to have a locum cons/substantive with income outwieght the expenditure & RTT reduction - KF "SOP is finalised for temporal artery biopsy for GCA and is now on Qpulse. Ultrasound SOP is still being worked on- to pick up with Gemma Wren on status"

7	The Trust should invest in providing **Good clinical input into the Muscoskeletal (MSK) service triage** to further improve the patient experience and ensuring patients are directed towards the correct avenue of care.	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	Potential requirement for the Trust to invest in improved triage systems. To form part of 25/26 job planning discussions. To form part of additional recruitment business case.		**All**	To feed into plan to have a locum cons/substantive with income outwieght the expenditure & RTT reduction - KF	Potential requirement for the Trust to invest in improved triage systems. KF to pick up with IT. Meeting planned for 26th March. To form part of 25/26 job planning discussions. To form part of additional recruitment business case. Income outweight the expenditure & RTT reduction
8	The service should develop their Patient Initiated Follow Up **(PIFU)** provision to reduce the requirement for some patients taking up follow up appointment slots	Medium term 6-12 months	Shrawan Agrawal	The department reported a **1.16% PIFU rate for August 2024** and will continue to work towards identifying suitable patients.		**Kerrie ford** **Amjad Jilani**	AJ will use GIRFT recommendations to promote / KF to share information of Rheumatology specific examples to all team and monitor PIFU % each week . Will feed into B&G meetings	Monitor PIFU weekly. Dr Jilani to share information regarding increasing PIFU usage as the GIRFT lead. KF to map out process/pathway for PIFU use. PIFU for lomg term condition e.g. inflammatory arthritis is diefferent than PIFU in short term conditions. Part of monthly Rheumatology B&G meetings
9	The service should open discussions about restoring a **Temporal Artery Biopsy service**, if not within Vascular services, then within Ophthalmology	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	Biopsies undertaken by Vascular surgeons at East Kent MFT do not provide Vascular or Ophthalmology services. Access to Ophthalmology raised as a risk.		**KF/AJ**	To speak with AM RE: a sample of patients to check if the pathway has worked	Biopsies undertaken by Vascular surgeons at East Kent MFT do not provide Vascular or Ophthalmology services. Access to Ophthalmology raised as a risk.
10	The service should consider scope for r**educing the model of single consultant ownership of patients,** and where viable, run **disease-specific clinics**. This would help to reduce the risk of isolated working patterns and also **issues around inequity of workload between colleagues**. Any changes will need to be monitored and reviewed to ensure that they do not result in adverse longer waits for patients. Community engagement will also need to be maintained in a **hub and spoke model.**	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	To form part of additional recruitment business case. The department feel as though even with disease specific clinics there would be a requirement for individual consultant responsibility. CMO team to advise on clarification from RCP recommendation.		**KF / AJ**	To review during job planning discussions	To form part of additional recruitment business case. The department feel as though even with disease specific clinics there would be a requirement for individual consultant responsibility. CMO team to advise on clarification from RCP recommendation. Does not appear practical. CTD/Vasculitis clinic (MFT & North Fleet) - Dr Wijesooriya/Dr Adnan GCA clinic (North Fleet) - Dr Jilani ; Medway - new recruitment Axial SpA (North Fleet) - Dr Jilani; Medway - new recruitment

11	The service should introduce an o**pen and transparent** process to determine **job planning** schedules which involves all colleagues. One consideration is to have **team job planning.**	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	Team job planning has taken place for 24/25 with Dr Agrawal leading and was felt to have been beneficial. To remain part of process moving forward.				Job plan 2023/24 - done in team and then open and transparent way, full details. Some productivity concern. KF will get details, an improvement plan needed once reasons found.
12	The Trust should optimise the **IT performance** of a clinical facing infrastructure, as the current system is insufficient to ensure **smooth running of clinical services.**	Medium term 6-12 months	TBC	Trust wide issue for review.		**KF**	KF working with Project Management RE: implementation	Trust wide issue for review - slow wi-fi, EPR, Timeline. Electronic triage wc 24th March Dictation planned for Sep 2025. KF working with Project Management RE: implementation
13	The service should re-establish its **patient education sessions**, which is something that has not re-started post Covid-19 due to workforce capacity and room availability. These are very cost effective and efficient ways of imparting education leading to a reduction in patient contact. Their reinstatement should be seen as a priority.	Medium term 6-12 months	Shrawan Agrawal/ Alison Streatfield	**Educational leaflets by 'versus arthritis'** are usually given. Can be re-emphasised with every one, also some **links** can be re-shared with all clinicians to be shared with patients for education. To look into options for nursing team to run **monthly sessions**- to pick up with **Alison.**		**Alison Streatfield** **Sunari Subasinghe**	To speak with AS for input	To speak with AS for input - ?part of SPA or VCP
14	The service should review the purpose, structure and makeup of **all rheumatology MDTs** so that all members of the team are involved, including **nurses, therapists, and pathway coordinators**. **Relevant clinicians should be represented,** whose time is identified within their job plans, and at a **minimum the output of the MDT should be included in the notes or electronic patient record (EPR)** but **ideally a summary of the discussion. The gold standard would be to include membership, clinical concern, relevant discussion and with final decision-making clearly outlined with copies of correspondence sent to the patient, GP and relevant specialties.**	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	Current situation: Virtual Biologic MDT every 2 weeks ILD MDT every 4 weeks Radiology MDT every week SECARD MDT every 2 weeks Complex case Rheumatology MDT every 1 week Monthly business meeting for two hours RCP has separately recommended individual clinicians are responsible for presenting their cases. Need to decide whether this is for all MDT's including SECARD or whether SECARD is different and just the two named clinicians for those patients will present cases. There is a slight conflict in the RCP advice here so please discuss outcome decisions with Alison. It is also important that attendance logs are kept and non-attendance without good reason is challenged. It has now been included in everyone's job plan, through still clinics are not moved. Will need special complex case MDT code, clinician will do a letter accordingly about meeting and copy will be stored and shared with patients.		**Sunari Subasinghe** **Kerrie Ford** **All**	All of these MDT's take place / KF to liaise with NC RE: feasibility of charging ICB for undertaking	**Current situation: some on Wednesdays** Virtual Biologic MDT every 2 weeks ILD MDT every month Radiology MDT every week SECARD MDT every 2 weeks Complex case Rheumatology MDT every week Monthly business & Governance meeting for two hours Attendance logs to be kept Non-attendance without good reason is challenged. Now included in everyone's job plan, through still clinics are not moved. Will need special complex case MDT code, clinician will do a letter accordingly about meeting and copy will be stored and shared with patients. Need to charge from ICB - MDT (complex case Rheumatology MDT)

15	The service should review its **patient correspondence** provision as the current **typing pool** does not provide a good service. The current situation has high-cost consequences for the Trust through provision of **re-prescriptions whilst waiting for correspondence.**	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman/ Mark Bennett	Voice recognition go live imminent- Awaiting IT to confirm go live dates for Rheumatology		**KF**	KF working with Project Management RE: implementation	EPR/Dictation/electronic triage meeting. Electronic triage - wc 24th March Dictation planned for Sep 2025.
nd team working								Electronic triage wc 24th March
No.	**Recommendation**	**Timeline**	**Lead**	**Update**	**Status**	**Owner**		
16	The trust should revisit the business case for **additional consultant support/**capacity which **has been previously rejected.**	Short term 0-6 months	Nicola Cooper	To pick up current demand and capacity modelling. 12 month locum position in place as of 16/09/24 Service development plans to be looked at (requirement to be driven by data)		**Kerrie Ford**	KF now picking up where the business planning / case was paused. Updating figures / to submit for review and add to B planning slides for exec review.	Submitted for review by executive team - with Nicola Cooper awaiting response. 12 month locum position in place as of 16/09/24 (Though one consultant is not seeing any new patient since Nov. 2023). Two consultants droped one clinic each weekly. So **less number of clinics are running than Pre-RCP visit.** Service development plans to be looked at (requirement to be driven by data)
17	The service should review its **clinical workload for consultants,** with no colleagues asked to do more than five clinics a week. It is evident that the workforce cannot manage with current arrangements. **Unsustainable work load. Significant strees seen during interview with signs of burn out and an acceptance that patient safety was compromised.**	Short term 0-6 months	Shrawan Agrawal/ Sanjay Suman/ Mark Bennett	At present no consultants completing more than 5 clinics per week. New round of Job Planning to commence in October. To work alongside BI in understanding number of patients per individual consultant in order to work towards parity within the team.		**Kerrie Ford**	At present no consultants completing more than 5 clinics per week. New round of Job Planning to commence in October. To work alongside BI in understanding number of patients per individual consultant in order to work towards parity within the team.	At present no consultants completing more than 5 clinics per week. New round of Job Planning 2024-25. To work alongside BI with cleansing data in understanding number of patients per individual consultant in order to work towards **parity within the team, so that patient safety not compromised. KF collecting data on numbers, discharge rate, PIFU utilisation.**

18	The service should review its **clinical workload for nurse specialists,** with no colleagues asked to do more than five clinics a week. This will enable the team to provide additional essential support to the consultant body and patient care	Medium term 6-12 months	Alison Streatfield/ Mark Bennett	Previously completed CNS D+C modelling to be reviewed. CNS job planning to be formalised. CNS demand and capacity to be undertaken. Additional staff requests will be part of business case if identified through demand and capacity modelling. Nurses currently completing up to 6 clinics per week.		**Alison Streatfield** **Kerrie Ford**	To speak with AS for input	Needs two B7 and one Band8A nurse (ACP) - MTW model. CNS job planning to be formalised. CNS demand and capacity to be undertaken. Additional staff requests will be part of business case if identified through demand and capacity modelling. Nurses currently completing up to 6 clinics per week.
19	The Trust should invest in **more clinical nurse specialists** and invest in those nurses already in post. This will significantly improve the quality of care to patients and provide a network of safe management that is responsive to the needs of the population. Developing the nursing roles with the ability to **inject joints** and **prescribe common drugs** will require appropriate medical oversight which needs to be recognised within job plans.	Medium term 6-12 months	Alison Streatfield/ Vicky Watson	Previously completed CNS D+C modelling to be reviewed. Current situation- Two nurses are being supervised for joint injections. Trust wide Specialist Nurse Establishment review ongoing, meetings to commence in October. Trust wide project has commenced September 24 into the role of the ACP, which means development for Specialist Nurses to move forward with education- which will include nurse prescribing. Future planning for service is for ACP roles. Care Group will need to plan for future funding.		**Kerrie Ford** **Vicky Watson**	To speak with AS for input	Previously completed CNS D+C modelling to be reviewed. Current situation- One nurse can inject knee unsupervised, another is going to do soon. One nurse is working towards drug prescribing. Trust wide Specialist Nurse Establishment review ongoing, meetings to commence in October. Trust wide project has commenced September 24 into the role of the ACP (Advanced clinical practitioner), which means development for Specialist Nurses to move forward with education- which will include nurse prescribing. Future planning for service is for ACP roles. Care Group will need to plan for future funding.
ıance and audit								
No.	**Recommendation**	**Timeline**	**Lead**	**Update**	**Status**	**Owner**		
20	The Trust should review its **governance structure** to determine whether the current arrangements are sufficiently robust to identify and **investigate patient safety concerns** and whether there is sufficient responsiveness to implement relevant change.	Short term 0-6 months	Alison Streatfield	Following the review a governance lead was appointed- Dr Sunari Subasinge. Currently undertaking local reviews for Datix and complaints. She has also commenced 52 week harm reviews. Process in place but minimal completion due to Rheumatology workforce gaps.		**Kerrie Ford** **Sunari Subasinghe**	Ongoing work to complete 52 week harm reviews, as wait time grows we are still attempting to clear the backlog.	Following the review a governance lead was appointed- **Dr Sunari Subasinge.** Currently undertaking local reviews for Datix and complaints. She has also commenced **52 week harm reviews.** Process in place but minimal completion due to Rheumatology workforce gaps. KF awaiting response from quality assurance to review the back log and process.

21	The Trust needs to address the **lack of handover or training for individuals** who held **divisional governance roles.**	Medium term 6-12 months	TBC	Trust wide issue for review by patient safety team.		**Kerrie Ford**	Trust action	Trust wide issue for review by patient safety team.
22	The Trust should include audits within their governance arrangements. A key audit is the **National Early Inflammatory Arthritis Audit (NEIAA)**, but consideration should be given to rolling a**udits of GCA, Lupus, Sjogren's, Myositis etc.** All patients within the department should be included in these audits and all clinicians should be engaged in the relevant meetings. Additional separate governance arrangements at DVH with non-rheumatology experts should stop.	Medium term 6-12 months	TBC	The Trust is currently an outlier for the last 5 years in NEIAA (National early inflammatory arthritis audit), resulting in not being able to see patients with suspected early arthritis within national target timeframe (national target of starting treatment is 6 weeks, current waiting time to see patients at Medway is approx. 45 weeks, north fleet approx. 57 weeks). Previously the department had an admin assistant to help with NEIAA data entry, this will be explored as part of the upcoming business case.		**Sri Srirangan** **Kerrie Ford** **Amjad Jilani**	KF to check with consultants that these audits are being carried out	NEIAA - Trust is outlier for >5 yrs Audit on GCA, Lupus, Sjogren's, Myositis - keen to be done but only 0 month, need admin assitant for 3 and 12 months data NICE recommendation for EIA appointment - 3 weeks and for treatment 6 week Medway waiting time approx. 47 weeks Surrounding trust (East Kent/MTW) - 4 weeks Amjad Jilani - working on EIA proforma and service NEIAA data entry - 0/3/12 months (previously Rheumatology admin assistant) - no post now Data entry - 0 month has been done by some
Pharmacy								
No.	**Recommendation**	**Timeline**	**Lead**	**Update**	**Status**	**Owner**		
23	The service should invest in a suitable IT system that provides a **cost effective monitoring and prescribing of disease modifying arthritis drugs (DMARDS)**. It can be operated by an **administrative post with suitable support from nurses and physicians.**	Medium term 6-12 months	Steve Cook	Initial discussion with Steve Cook, although this sits under **Pharmacy** as an action this is more of a Trust wide piece of work, if required.		**Kerrie Ford** **Steve Cook**	Sitting with pharmacy	Sitting with pharmacy
24	The service should increase its **bi-monthly (every two months) virtual biologic clinics** to ensure the clinic can respond to demand. The service will need to ensure that there is appropriate oversight and audit of this service as indicated by national guidelines.	Medium term 6-12 months	Shrawan Agrawal/ Sanjay Suman	This clinic now runs fortnightly, with potential scope to increase to weekly with necessary recruitment.			All	This clinic now runs fortnightly, with potential scope to increase to weekly with necessary recruitment.

25	The Trust should consider either appointing a **high-cost drugs pharmacist** or ensuring that an **existing pharmacist** within the organisation has clear responsibility to provide oversight of the departmental bi**ologic drug use and spend, providing vital checks and balances towards appropriate prescription.** The role should also include oversight of specialist commissioned medication pathways and funding requests.	Long term 12-24 months	Steve Cook	To be explored as part of recruitment business case		**Kerrie Ford** **Steve Cook**	Sitting with pharmacy	Sitting with pharmacy