Agenda

Public Trust Board Meeting

Wednesday, 13 September 2023 at 12:30 – 15:30 Trust Boardroom and via MS Teams

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 12 July 2023	Chair	3	12:32	Approve
2.2	Action Log		12		Discuss
2.3	Chief Executive Update	Chief Executive	13	12:35	Note
2.4	Council of Governors Update	Lead Governor	Verbal	12:40	
3.	**Integrated Quality Performance Report (IQPR) and Board Assurance Framework (BAF)**				
3.1	IQPR	All Executives	16	12:45	Note
3.2	BAF		Not in pack		Note/ Approve
4.	**QUALITY**				
4.1	Quality Assurance Committee Update (July and August 2023)	Chief Nursing Officer, Chief Medical Officer, NED	69	13:05	Assure
4.2	Perinatal Quality Surveillance Quarterly Report	Division Director of Midwifery	79	13:15	Approve
4.3	Patient First Strategy	Chief Delivery Officer	81	13:30	Approve
4.4	Infection Prevention Control Strategy	Chief Nursing Officer	110	14:00	Approve
	WELLBEING BREAK				
5.	**PATIENTS**				
	No reports this meeting				
6.	**PEOPLE**				
6.1	People Committee Update (July 2023)	Chief People Officer, NED	124	14:20	Assure
7.	**SUSTAINABILITY**				

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7.1	Finance, Planning and Performance Committee Update (July and August 2023)	Chief Finance Officer, NED	129	14:30	Assure
7.2	Finance Report (Month 4)	Chief Finance Officer	140	14:40	Note
7.3	Financial Efficiencies – Current Position	Chief Delivery Officer	156	14:50	Note
	WELLBEING BREAK				
8.	**SYSTEMS AND PARTNERSHIP**				
8.1	Audit and Risk Committee Update (September 2023) to follow 07.09.23	Chief Financial Officer, NED	Paper to follow	15:00	Assure
9.	**CLOSING MATTERS / BOARD BUSINESS**				
9.1	Reflection	Chair	Verbal	15:10	Discuss
9.2	Any Other Business				Note
9.3	Date and time of next meeting: 08 November 2023				

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 12 July 2023 12:30 – 15:30

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

Or Virtually on MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	Jo Palmer	Trust Chair
	Adrian Ward	Non-Executive Director
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Evonne Hunt	Chief Nursing Officer
	Gavin Macdonald	Chief Delivery Officer
	Glynis Alexander	Director of Communications and Engagement
	Jayne Black	Chief Executive Officer
	Jenny Chong	Associate Non-Executive Director
	Leon Hinton	Chief People Officer
	Mark Spragg	Non-Executive Director
	Nick Sinclair	Chief Operating Officer
	Paulette Lewis	Non-Executive Director
	Rama Thirunamachandran	Academic Non-Executive Director (Left at 13:30)
	Sue Mackenzie	Non-Executive Director
Attendees:	Alana Almond	Deputy Company Secretary (Minutes)
	Anan Shetty	Governor
	David Brake	Lead Governor
	Gignesh Patel	Staff Governor
	Jennifer Oliphant	Governor
	Kate Harris	Head of Midwifery and Nursing (Agenda Item 4.3)
	Latifat Awotedu	Quality Improvement Lead (Observing)
	Matt Capper	Director of Strategy and Partnership/Company Secretary
	Nikki Lewis	Associate Director of Patient Experience (Agenda Item 6.1)
	Peri McGhee	Anatomical Pathology Technologist (Agenda Item 6.1)
	Ranjit Akolekar	Consultant Obstetrician and Gynaecologist (Agenda Item 4.2)
Apologies:	Annyes Laheurte	Non-Executive Director

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1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present. Additional attendees joined the meeting for their agenda item only, as recorded above. Apologies for absence were noted as recorded above.

a) Chair updated the Board and thanked everyone for joining the meeting. Chair thanked colleagues who have continued to work with passion and dedication for patients during the summer months, often in very hot and challenging conditions – particularly last month (June 2023) which was recorded as the hottest June on record in Britain.
b) This month saw the Trust and the nation come together to mark the landmark 75th anniversary of the NHS (Wednesday 5 July 2023). Since its birth in 1948, the NHS has become a symbol of hope, compassion, and resilience; it remains a pillar of British society and is recognised globally for its achievements
c) Medway Maritime Hospital has provided NHS care since 1961 (previously it was a naval hospital), and it is incredibly proud to be at the heart of the community in Medway and Swale for so many years. The Trust owes so much of its history and success to the fantastic and hardworking colleagues who represent the organisation.
d) To say thank you, the Trust hosted a special 'NHS birthday lunch' for colleagues on the day of the anniversary. More than 1,150 colleagues were able to attend. Thank you to the team for putting on the event, notably the Catering Department, for working so hard. Patients were also involved in the celebrations, receiving a special cupcake to mark the birthday.
e) During the anniversary week we were proud to see colleagues representing the Trust at special services at Rochester Cathedral and Westminster Abbey, while you may have noticed the Trust's iconic Clock Tower and other landmarks lit up in NHS blue.
f) The celebrations helped to showcase the very best of Medway and the NHS – thanks once again to all our colleagues who continue to provide brilliant care every day and who will continue to do so for years to come.

1.2 Quorum

The meeting was confirmed to be quorate.

1.3 Declarations of Interest

There were no declarations of interest.

2 Minutes of the Last Meeting, Action Log and Updates

2.1 The minutes of the meeting held on 10 May 2023 were **APPROVED** as a true and accurate record.

a) Glynis Alexander attended May Board meetings – amendment to the minutes will be made.

2.2 The Action Log was reviewed and updated accordingly, the Action Log can be found under separate cover.

2.3 Chief Executive Update

Jayne Black, Chief Executive updated the Board on the current position within the Trust.

a) Highlighted, the strikes and asked the community to use GP/111 as an alternative to support the Trust, reducing pressures on the hospital.
b) Chair added thanks to the Trust Volunteers and to Raymond Chishti who hosted the recent Volunteer Awards, the Trust is so thankful to have support from local MPs.

The Board **NOTED** the update

2.4 Council of Governors Update

David Brake, Lead Governor gave a verbal update to the Board on the Council of Governors. With following highlights:

a) May and June were busy months for the Council and their engagement duties. Governors have attended many local events including; Kent Dementia Event, Recruitment Fair at Sheppey Frailty Unit, Armed Forces Day and Mid Kent College.
b) The College was useful for engagement with the younger community; ten students signed up from the College. The Council will continue to engage with the younger population to assist with membership.
c) The Council plans to attend; Medway and Swale Pride, Patient First Anniversary and Summer Fayre at the Trust.
d) The AGM will be a hybrid event on 27 September 2023.
e) David recently had an unfortunate accident and was treated in the Trust; he wanted to extend his gratitude to the team in the Emergency Department. He felt like he was 'Patient First', he asked Jayne Black to pass on his thanks for a positive experience.

The Board NOTED the update

3 Integrated Quality Performance Report (IQPR) and Board Assurance Framework (BAF)

3.1 IPQR - The Executives presented the report to the Board for noting.

Patients - Alison Davis

1) Mortality SHMI for the period of Jan 22 to Dec 22 is 113.60 and 'higher than expected'
2) Mortality HSMR for Feb 22-Jan 23 is 114.5 lower than previous month and 'higher than expected' (rolling 12 months). The Board will continue to monitor the HSMR/SHMI rates.
3) Medical Examiner has no concerns. There are currently no new Diagnostic group of concern, except the previous seven diagnosis groups reported with "higher-than-expected" deaths where deep dives have either been completed or are underway. No failing in care have been identified.
4) Task and Finish Group is held weekly to address 11 key areas of focus for immediate actions to improve the mortality data including clinical documentation and coding of deaths, resources for reviews of all death data within specialties, improved care of our deteriorating patients. The issue is with capturing data and not harm to patients.
5) Mandating the process that any patient who does not have a completed VTE assessment on EPR cannot be accepted into theatre.
6) FNoF - in May 2023, 36 patients were admitted with Fracture NOF, 26 patients had surgery within 36hrs, with compliance at 72%.

Quality and Patients – Evonne Hunt

1) The total response rate for FFT Trust wide has marginally improved month on month. The inpatient recommend and response rate has improved overall in the last reporting period.
2) There has been a consistent reduction in Mixed Sex Breaches across the organisation in the last two months; this has been as a result of the deep dive/A3 work that commenced and a wider engagement in weekly meetings to validate the data process.
3) Complaints remains a challenging area, the backlog being addressed, no indication of an increase in cases and 46 complaints closed in month (highest since July 2022). Themes are emerging and the team are working with front line colleagues to address any issues.
4) Infection Control Annual Report was approved by the Private Board 12 July 2023.
5) The Board enquired why there is no downward trend with the Violence and Aggression rates. The increase in this report is due to the Security team entering their results on a

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second system, their results are now entered on to Datix and this is a true reflection of the data. Work progressing to decrease numbers and a report will be submitted to the Audit and Risk and Quality Assurance Committees for monitoring data.
6) The Board thanked Evonne and the team for progress and improvements being made.

Systems and Partnerships – Nick Sinclair
1) The Board raised an error on Page 37 of the pack; Cancer 28 Faster Diagnosis % for April 2023 should not read 340.1%, Nick Sinclair would correct the paper as this has been submitted in error.
2) RTT continues to be a priority for the Trust. Treating all patients within 40 weeks is one of the Trusts key breakthrough objectives in the Patient First programme.
3) In May 2023 the number of patients waiting longer than 52 weeks has increased (April 591 to May 820)
4) ENT remains the primary concern for 52 and 78 week risk. Plans being developed to manage backlog and to move to a sustainable position. These numbers include figures around cancellations due to strike action. The aim is to have all diagnostic services in one place to reduce wait times and delays in diagnosis. Increased support from other Trusts and to include mobile units will assist with diagnostic capacity. Each strike action gives concern on waiting lists.
5) Total 4 hour performance deteriorated from September 2022 to mid-December 2022. It stabilised throughout January 2023and has achieved consistent incremental improvement since.
6) The Board thanked Nick and the team for ongoing improvements.

People – Leon Hinton
1) The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey. Both clinical divisions are reporting over 90% compliance.
2) Continuation of appraisal KPI breakthrough objective being met (>90%); however, a dip to 91.5% (five months being met, six required to meet business rules).
   New draft breakthrough objective has been identified through True North refresh.
3) During May the sickness rates overall was 3.98% which was an improvement with long term sickness improving 2.13% and short term sickness also improving.

Sustainability – Alan Davies
1) The Trust reports a deficit of £2.5m in month 2 of 2023/24 and year to date deficit of £5.0m; this is against a plan of the same value. The Trust is currently in SOF4 and must demonstrate delivery against its financial targets.
2) As well as Medical pay costs, management of nursing staff overspending is being added to the 'control of overspending' breakthrough objective. A new breakthrough objective for 'efficiencies' is being established. Further development, approval and implementation of efficiency schemes continues. The Trust has a stretching efficiencies target for the year, set at £27m / 6.6% of income. The value of efficiencies identified to date is £13.8m with a number of opportunities still in the pipeline. This will be reviewed at FPPC in July 2023.
3) The strikes are having a financial impact on overspend in June and July and is recognised nationally.

The Board **NOTED** the report

3.2 BAF - The Executives presented the report to the Board for noting and approval.

a) There are 21 strategic risks and are broken down by True North Domains. The overview was highlighted as per the papers. All BAF risks have mitigating actions against them.
b) The BAF is currently being refreshed and the Quality team will work with the Executive Leads to ensure this is completed.
c) Risk 2a - Lack of timely escalation and treatment of deteriorating patients; the Board was given assurance that this is being mitigated by additional learning being shared with teams.
d) EDI will be moved into a separate BAF.

The Board **NOTED** and **APPROVED** the document.

4 Quality

4.1 Quality Assurance Committee Update (May and June 2023)
Paulette Lewis, NED/Committee Chair presented to the Board for assurance.

The Board was **ASSURED** by the reports

4.2 Maternity Reports:
a) Caesarean Section Audit
Ranjit Akolekar, Consultant Obstetrician and Gynaecologist, presented to the Board for noting. Key highlights were given as follows:

a) In July 2021, the Health and Social Care Committee Report regarding the Safety of Maternity Services in England recommended an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently.
b) Maternity services should continually monitor safety and outcomes for mothers and babies with regular audit, and any recommendations and quality improvements implemented where required.
c) The presentation provided information and data in relation to the Caesarean Section audit completed in May 2023, covering a one-year period of 2022 to 2023.

The report included detail on the:
1) Annual figures 2022 with Medway NHS Foundation Trust being slightly higher than neighbouring hospitals
2) A comparison of like for like hospitals which have a fetal medicine centre and a Level 3 neonatal unit – showing Medway NHS Foundation Trust is comparable with these trusts
3) A deep dive into the maternal demographics, co-morbidities and obstetric factors for those having an outcome of a caesarean section birth. The deep dive objective was to ensure that the Trust is safe and causing no harm.
4) A review of the Robson Criteria and Caesarean section
5) Hypoxic ischaemic encephalopathy (HIE) rates noted to be lower than national expected rates.
6) Recommendations for further deep dives, using previous learning and experience from Chief Nursing Officers and quality improvement work streams

Chair was assured by the report and took comfort seeing the benchmarking against other comparable Trusts.

The Board **NOTED** the report.

4.3 Maternity Reports:
a) Maternity Workforce Report

Kate Harris, Head of Midwifery and Nursing, presented to the Board for noting. Key highlights given as follows:

a) The Board was provided with a Maternity Workforce Oversight report in line with the requirements for Safety Action 5 for CNST Year 5.
b) The team have been relatively successful within international recruitment and interest from other nurses within the Trust to transfer.
c) Bank staff are important in midwifery staffing levels, HR are aware of issues and working on solutions across the system.

The Board **NOTED** the report.

b) CQC Outcome and Action Plan
Kate Harris, Head of Midwifery and Nursing, presented to the Board for noting. Key highlights were given as follows:

a) The CQC conducted an inspection of the Trust's maternity service on 07 December 2022. The inspection was part of a national maternity inspection programme, spending time in all of the Maternity areas.
b) The CQC published its final report for Medway Maternity Services on 28 April 2023 with an overall rating of GOOD, including maintaining GOOD for the two particular standards assessed for Safe and Well-led. The Team now work towards reaching OUTSTANDING.
c) No 'Must Do' Actions were identified within the published report; however, six 'Should Do' actions were identified.

Chair thanked the team and stated that the Board are proud of the teams achievements.

The Board **NOTED** the report.

4.4 Data Security Tool Kit - KPMG Audit 2023
Alison Davis, Chief Medical Officer presented to the Board for assurance (partial assurance given) and approval. The Audit is complete, the paper was taken as read but the following was highlighted:

a) The audit found eight areas where further work is required. Some of the actions are not due until September 2023. A clear structure is being implemented for Information Governance.
b) The Board asked for Action Nos. 3.3 and 3.4 deadlines to be brought forward earlier than September 2023, although the actions are listed as 'Medium' they are important actions involving servers and backups so should be expedited. The Head of IT is on long term sick leave but the Director of IT can assist with delivery of these actions.
c) Actions due for the end of June 2023 are completed.

ACTION NO: PRIV/TB/009/23: Expedite action delivery deadlines with Adrian Billington and Michael Beckett in the absence of Craig Hall

The Board was **PARTIALLY ASSURED** and **APPROVED** the report and asked for an update to September Board.

5 People

5.1 People Committee Update (May)
Leon Hinton, Chief People Officer, Sue Mackenzie, NED/Committee Chair, presented to the Board for assurance.

a) Report on International Recruitment will be submitted to the People Committee end July 2023.
b) WRES and WDES Annual Report was submitted 30 May 2023; there has been a significant improvement on last years report and data but still a long way to go. Action Plan to address this will be submitted to the People Committee later in the year.
c) Resourcing issues affecting the performance of the Occupational Health team have been addressed with the recruitment to two vacancies. A further business case is being submitted to further assist. This will reduce the risk of potentially affecting health and wellbeing of staff and delaying recruitment processes.
d) Chair commented on the Board EDI Representation, the diversity of the group is wide ranging when encompassing all members, not just voting members. The diversity of the Board is strengthened by the recent appointment of two new NEDs. NHSE are aware of this.
e) The Board were encouraged to declare on visible and non-visible disabilities.

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

6 Patients

6.1 Clinical/Staff Story: Mortuary Service Update
Peri McGhee, Anatomical Pathology Technologist, presented to the Board on the Mortuary Department for noting.

a) The department carries out between 1,200-1,600 post mortem examinations annually with up to 10 examinations carried out daily on behalf of HMC.
b) The mortuary at MFT is a HTA (Human Tissue Authority) regulated department. The department is licensed to undertake post-mortem examinations, perform consented tissue retrievals and research donation (NHSBT and Queens Brain Bank). Following an unannounced visit by the HTA, they provided positive feedback and found nothing negative to report.
c) Collaborative working with other MFT services-Medical Examiner's Office, the Bereavement Office and The End of Life Care Team
d) The team also work closely with Kent Police
e) The Trust Mortuary provides learning to other Trusts.
f) Actions and Improvements included; New flooring laid in the department, new CCTV system installed, new access system and increased security, new private ambulance and improved training for porters

Chair stated it is a credit to the team how patients are treated with such care and dignity. The Board gave its thanks to the team and for the service as a whole.

The Board **NOTED** the presentation.

7 Sustainability

7.1 Finance, Planning and Performance Committee Update (May and June 2023)
Alan Davies, Chief Financial Officer, presented to the Board for assurance.

a) Deep dives into the nursing position and the medical staffing overspend are to be done in the form of an A3 to be discussed at the breakthrough huddles. Reports will be submitted at the FPPC for monitoring.
b) The Automation within the Pharmacy department is worth noting, as it is good for the Trust's future.

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c) Would be beneficial for the Committee to focus more on performance and activity.
d) Progress against Efficiencies Programme; work continues to strengthen the governance around the Efficiencies Programme. £13.7m has been identified against the £27m target. The milestone deliverables for this month are green. It is going to be extremely challenging to be able to hit the £27m target but work is bring driven forward. There are programmes of work still being processed through the system so the Trust awaits final figures.

e) **ACTION NO: PRIV/TB/010/23:** Financial Efficiencies - bring updated position on programme and savings to September Board, following submission to EMB w/c 17.07.23

The Board was **ASSURED** by the reports

7.2 Finance Report (Month 2)
Alan Davies, Chief Financial Officer, presented to the Board for noting.

The Board **NOTED** the report.

7.3 Trust Annual Report and Accounts 2022/23
Alan Davies, Chief Financial Officer presented to the Board for noting and approval.

a) Audit and Risk Committee have delegated authority from the Board to approve the Annual Report and Accounts and did so on 22 June 2023. In addition to this the Trust Chair, Chief Executive and Chief Finance Officer have signed.
b) There is a clean Audit Opinion on the Trust's accounts.
c) The Board suggested that the Trust Volunteers are mentioned in the Annual Report and at this year's AGM the Chair will give them a special mention.
d) The Board expressed its gratitude to all involved with the report and to do so on time.
The Board **APPROVED** the report and accounts retrospectively.

8 Systems and Partnerships

8.1 Audit and Risk Committee Update (June)
Alan Davies, Chief Financial Officer, Mark Spragg, NED/Committee Chair presented to the Board for assurance.

a) The Committee received the Annual Report and Accounts for approval, delegated by the Trust Board. The Annual Accounts and Report and Letter of Representation were APPROVED by the Committee for the period April 2022 to March 2023.
b) Head of Internal Audit is the same as last year.
c) Local Counter Fraud gave the Trust a 'Green' rating on all domains which is an improvement on last year.

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

8.2 Kent and Medway Pathology Network Collaboration Agreement
Nick Sinclair, Chief Operating Officer, presented to the Board for approval. The paper detailed an updated position and was taken as read.

a) Over the next year the Trust must ensure how this collaboration is mapped out with partners and how this reports into the Board – this will be completed by September 2023.

The Board **APPROVED** the agreement and agreed for it to be signed by the Chief Executive.

9 Closing Matters

9.1 There were no Questions from the Public

9.2 Reflection

9.3 Any Other Business

a) Chair congratulated Gavin Macdonald who has been appointed as Chief Delivery Officer.

9.4 Date and time of next meeting
The next formal Board meeting will be on 13 September 2023

The meeting closed at 14:40

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 12 July 2023

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

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Public Trust Board
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
01.02.2023	TB/005/2023	Timely data availbility for Committees and sub-committees	13.09.23 ~~29.03.23~~	Evonne Hunt, Chief Nursing Officer	**PROPOSE TO CLOSE** - CNO/CoSec in discussion with BI to design Data Query Template for each committee and sub-committee 12.07.23 - Update at September Board	Green

Chief Executive's Report – September 2023

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

The Board is asked to note the content of this report.

Industrial action

Junior doctor and consultant colleagues across the country took part in further industrial action in recent weeks; we would like to apologise to patients who had their appointments re-scheduled as a result. We are continuing to work hard to ensure we have robust plans in place to minimise the impact to patients of further periods of industrial action.

Trust highly commended for gynaecology training

The Trust has been recognised for the first time by the Royal College of Obstetricians and Gynaecologists for its work in gynaecology training through its Training Evaluation Form scheme. To have received great feedback from our trainees and placed in the top 10 performing units across the country shows the hard work and commitment from our Gynaecology Team in making sure we can offer the best training to our people and make Medway a great place to work.

Nursing Times Awards

Congratulations to the Research Team who have been shortlisted in the Nursing Times Awards for their entry 'Under-served lung research from Medway NHS Foundation Trust' in the Clinical Research Nursing category.
Congratulations also to acute and emergency medicine colleagues who have been shortlisted for their entry 'Acute and emergency medicine strategic collaboration to maximise community safety' in the Patient Safety improvement category. This is for the launch of the Acute Medical Model last autumn and all the associated improvements, notably our sustained reduction in ambulance handover times. The winners will be announced at a special awards ceremony in London on Wednesday 25 October.

Pharmacy Team shortlisted

I'm delighted to see our pharmacy colleagues receive some well-deserved national recognition after being shortlisted in the 'Medicines, Pharmacy and Prescribing Initiative of the Year' category at the HSJ Awards 2023. They have been shortlisted for the implementation of an innovative electronic prescribing and administration system that enables clinical pharmacists working remotely to screen discharge prescriptions for inpatients, improving the timely supply of medicines and contributing to better care for patients. The awards ceremony will take place on 16 November.

Welcoming special visitors to the Trust

We were delighted to welcome Professor Stephen Powis, the Medical Director of NHS England, on a special visit to Medway to meet some of our award-winning staff and hear about the major improvements we have made, including reducing avoidable cardiac arrest (2222) calls as a part of our Patient First strategy.

Prof Powis, who was joined on the visit by Kate Langford, Chief Medical Officer of NHS Kent and Medway Integrated Care Board visited a number of our clinical areas including Lister Ward and the Emergency Department. I was very proud to hear Prof Powis speak so encouragingly about all the ''excellent progress'' we have made, particularly across urgent and emergency care in relation to our 2222 work and ambulance handover improvements. He also thanked colleagues for all the

efforts they made last winter in the face of unprecedented pressure and spoke about the NHS Long Term Workforce Plan after it was published recently by NHE England.

We were also honoured to welcome Dr Vin Diwakar, Medical Director for Transformation and Secondary Care at NHS England. His role provides clinical leadership to improvement and transformation programmes including those which use improvement science, technology, digital, and data. Dr Diwakar heard about Patient First and was able to attend a ward huddle. He also had the opportunity to learn more about the clinical strategy, the education and training we provide to our medical doctors, virtual wards, frailty, and imaging areas and see our Da Vinci robot in action. He was incredibly impressed by what he saw, and I was delighted to hear his positive feedback about the work we are doing.

Publication of the 2022 Urgent and Emergency Care Survey

Last month the Care Quality Commission published the results of the 2022 Urgent and Emergency Care Survey which captured the views of people aged 16 and over who used Type 1 (major A&E) and Type 3 (Urgent Care Centre) urgent and emergency care services at one of 122 acute NHS Trusts in England during September 2022.

From our results, it was encouraging to see that most of the questions (39 out of 59) were answered positively, and that our response rate of 22 per cent was in line with other organisations. Notably, we saw positive and improved feedback from patients on being able to get food and drink while waiting; having enough privacy when discussing their condition with clinicians; staff helping with communication needs; waiting under four hours to be examined by a doctor/nurse; and having enough information to care for their condition at home.

This excellent feedback is a testament to the efforts of colleagues across Urgent and Emergency care who have worked so brilliantly in the last year to make significant improvements for our patients. This includes the launch of our Acute Medical Model which has transformed our ambulance handover performance and our award-winning project to better recognise deteriorating patients and reduce avoidable 2222 calls.

Elsewhere, we can see from the survey that there are some areas that can be improved, such as patients waiting 12 hours or more, patients being informed of waiting times within the department, and making sure areas are consistently kept clean and tidy. I'm pleased to say that we have already identified and begun working on several key actions to tackle these requirements and help enhance performance in these areas.

Trust chosen to offer specialist critical care training to midwives across the south east

I'm pleased to reveal that more than £75,000 has been awarded to the Trust to facilitate specialist training for midwives so they can provide critical care support to pregnant people who become unwell during pregnancy, labour and the postnatal period while on a maternity unit.

Health Education England (HEE), now a part of NHS England (NHSE), awarded the funding to us after we were selected from a number of NHS organisations across the country to deliver the Maternity Enhanced Care Unit course (MECU).

It aims to upskill midwives working in hospitals and birthing centres so they can continue to care for pregnant people who become severely unwell with medical, surgical or obstetric problems during pregnancy. Without this training, they would be cared for in a critical care unit.

The funding will be used to train up to 200 midwives from across the south east with the Trust hosting and delivering the programme.

Medway Charter

Last month we joined forces with other organisations to sign an agreement that will help drive social and economic change in the area. The One Medway Charter, signed by eight organisations, including Medway Council, the three universities at Medway, Mid-Kent College, our Trust, and the Chatham Historic Dockyard Trust, commits the organisations to work together to exploit opportunities and address challenges in priority areas including: Business and the Economy, Education and Skills, Health and Wellbeing, Sustainability and the Environment, and Arts and

Culture. It is the first time all these organisations have come together with a shared vision and objectives.
The charter builds on recent successes for Medway including securing funding of £14.5million from central Government under the Levelling Up Fund for projects that will reinforce the area's growing reputation as a regional creative and cultural hub and one that will attract significant additional investment for the local economy.
This is an important moment for Medway and an opportunity for real transformation in the area; I was very proud to be the authorised signatory for the Trust.

Congratulations to our Communications Team!
Congratulations to colleagues in our Communications Team who have been shortlisted in the Healthcare/Wellbeing Category of the 2023 Chartered Institute of Public Relations (CIPR) regional Pride Awards. They have been shortlisted for their work to promote SMART wards at the Trust and are the only NHS communications team to feature in the Channel Islands and South of England regional shortlist.

Summer Fun Day raises more than £650
Our Summer Fun Day returned this year and was a fantastic event for our community. In total £661.74 was raised including £131.15 from the research team's tombola. The money raised will be used to benefit patients and staff. A big thank you to all those involved in organising the event and to everyone who came along to support.

Annual Members' Meeting
Members of the public are invited to the Trust's Annual Members' Meeting on Wednesday 27 September 2023. This is an opportunity to find out what has happened at the hospital over the past year and our plans for the year ahead. You will hear about the improvements that have been made and also about early successes from our improvement programme, Patient First, which has been in place for just over a year, with a phased roll-out continuing.
Our featured speaker will be Arangham Lingham, Darzi Fellow and Orthopaedic Registrar, on the subject of 'Avoidable Cardiac Arrest Calls and Creating a Learning Culture with Patient First.' He will be speaking about the multi-disciplinary team's success in reducing the number of avoidable cardiac arrest calls from an average of five a month to just one.
The meeting takes place in the hospital restaurant, Below Deck Dining (Level One, Purple Zone), at 6pm on Wednesday 27 September.

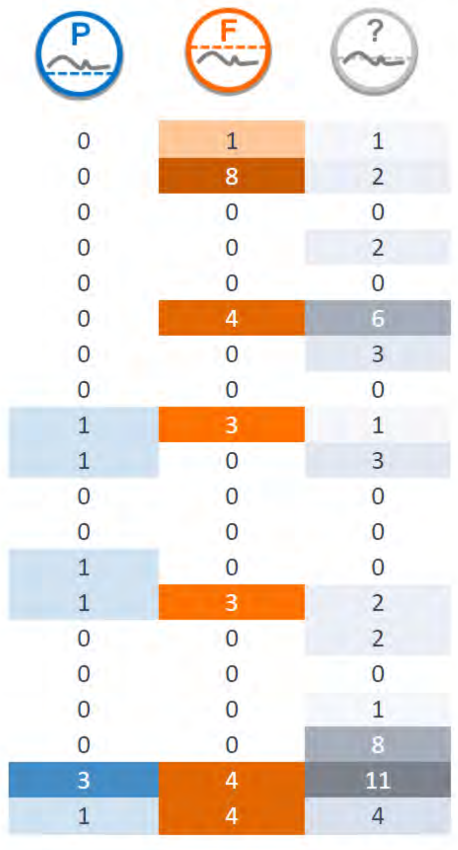
Communicating with colleagues and the community
The graphic below gives a flavour of some of the work we have done to communicate with our staff and community over the last month.

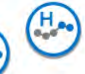
Integrated Quality & Performance Report

July - 2023

Executive Summary

Jayne Black
Chief Executive



True North	Sub Domain	Variation			Assurance		
			 L H	L H	P	F	?
Patients	Complaints	5	1	0	0	1	1
	FFT	4	4	2	0	8	2
	PALS	1	0	3	0	0	0
	Patient Experience	2	0	0	0	0	2
	PHSO	2	1	1	0	0	0
People	Workforce	5	9	0	0	4	6
Quality	Falls	6	1	0	0	0	3
	Health & Safety	1	1	0	0	0	0
	Incident Management	6	9	5	1	3	1
	IPC	8	2	0	1	0	3
	Legal & Information Governance	1	2	0	0	0	0
	Maternity	7	1	1	0	0	0
	Medicines	2	0	0	1	0	0
	Mortality	5	4	2	1	3	2
	Pressure Ulcer	4	0	4	0	0	2
	Risk & Policy	5	0	1	0	0	0
	VTE	1	0	0	0	0	1
Sustainability	Financial Position	7	1	5	0	0	8
Systems & Partnerships	Access	14	3	8	3	4	11
	Emergency Care	5	3	3	1	4	4

Patients

Evonne Hunt
Chief Nursing Officer

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

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

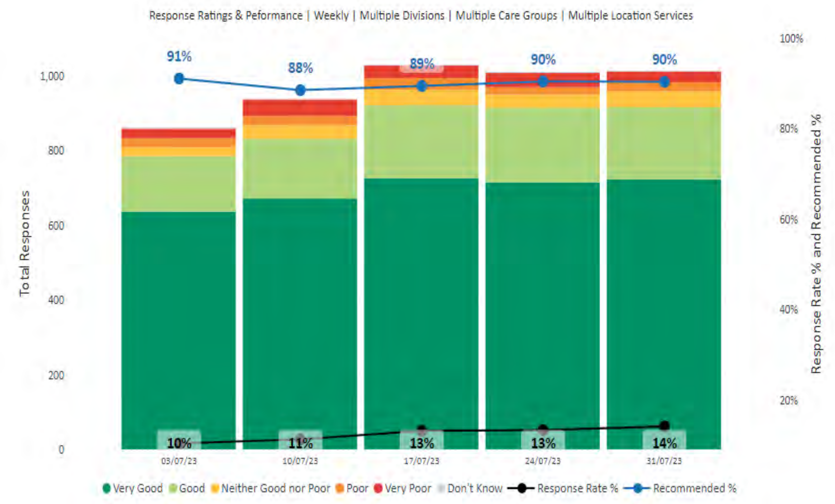
Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	95.0%	H	F	78.9%	84.0%	74.6%	84.9%	84.3%	87.9%	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%

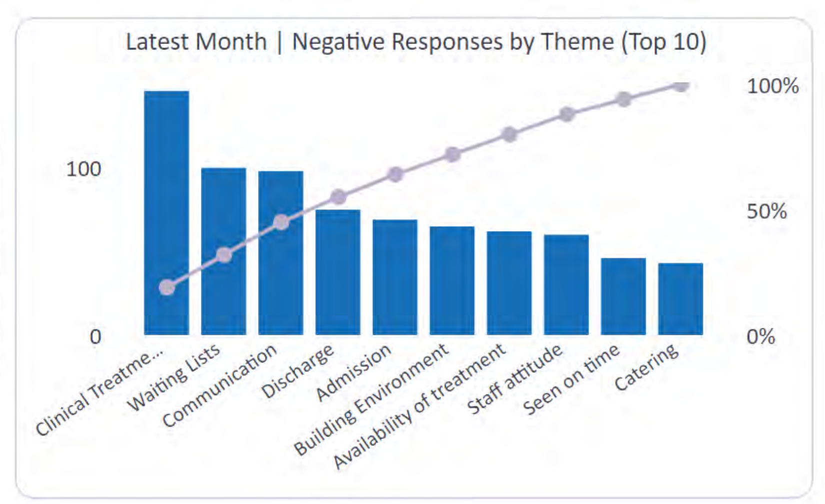
True North Domain: **Patients**

KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary: 4 | 2 | 0 | 0 | 4





Key Messages

- The FFT survey refresh is complete. These will be published in early Sept 2023
- A deep dive A3 has been developed to ascertain the top contributors associated with Staff attitude; to highlight key areas and key times to provide focus for the divisions.
- The Maternity induction of labour A3 has been approved as a quality metric for the division. This will steer the actions required improving the patient pathway and improving the Maternity FFT recommend rate

Issues, Concerns & Gaps

- Clinical treatment is a predominant theme emerging from patients. This relates to ward moves, access to treatment and waiting times. These have been attributed to the recent operational challenges.
- Staff attitude remains a top theme in patient feedback.
- Concerns with the induction of labour pathway in maternity.

Actions & Improvements

- For the divisional teams to create a robust process to communicate any delays in treatment within their departments to manage patients expectations
- To include the ward managers and matrons in the A3 project around staff attitude
- A night shift / twilight senior support has commenced in both divisions, with the aim to include the HoN's, DDoN's and senior nursing leads from September
- Actions from the maternity A3 deep dive for the induction of labour pathway in maternity areas continues.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Patients	FFT			Total FFT Recommend %	95.0%			78.9%	84.0%	74.6%	84.9%	84.3%	87.9%	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%
				Total FFT Response Rate %	45.0%			10.4%	9.5%	11.2%	8.1%	10.6%	9.8%	9.8%	9.9%	9.3%	11.1%	11.4%	11.9%
				Inpatients FFT Recommend %	95.0%			75.6%	75.6%	70.3%	90.7%	86.0%	87.6%	89.1%	85.5%	85.7%	90.7%	92.4%	93.2%
				Inpatients FFT Response Rate %	45.0%			19.3%	15.8%	18.8%	10.3%	14.7%	14.4%	15.6%	17.0%	15.2%	24.4%	30.4%	33.9%
				Emergency Care FFT Recommend %	95.0%			52.6%	70.9%	61.3%	66.8%	67.3%	75.7%	73.5%	73.7%	82.9%	81.1%	76.1%	75.6%
				Emergency Care FFT Response Rate %	45.0%			15.0%	12.3%	12.7%	8.4%	9.0%	8.0%	7.4%	7.2%	7.4%	8.3%	7.0%	6.7%
				Outpatient FFT Recommend %	95.0%			88.9%	88.5%	89.7%	90.0%	90.3%	91.4%	91.1%	91.7%	91.4%	92.8%	92.2%	91.9%
				Outpatient FFT Response Rate %	45.0%			8.1%	8.0%	8.5%	7.5%	10.5%	9.1%	9.2%	8.6%	8.2%	8.6%	8.6%	8.9%
				Maternity FFT Recommend %	95.0%			100.0%	100.0%	95.0%	88.2%	55.6%	97.3%	92.5%	95.1%	95.6%	89.5%	83.8%	82.3%
				Maternity FFT Response Rate %	45.0%			27.1%	28.7%	10.8%	4.3%	2.4%	31.7%	22.3%	55.4%	32.9%	44.3%	35.7%	17.2%
	Patient Experience			Mixed Sex Accommodation (MSA) Compliance %	0.0%			0.8%	0.8%	1.2%	2.0%	2.0%	2.1%	5.1%	4.3%	1.2%	1.1%	0.8%	0.8%
				Mixed Sex Accommodation Breaches	0			140	139	211	346	348	389	835	795	205	189	130	147
	Complaints			Complaints	-			49	39	50	37	37	33	52	44	32	24	23	28

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Patients	Complaints			Complaints Closed	-			26	34	25	20	21	43	39	29	15	40	92	63
				Complaints Open - Month End	-	L		131	136	161	178	194	184	198	214	231	215	146	111
				Complaints Re-Opened	-			0	1	0	8	0	2	3	6	0	0	7	2
				Complaints Acknowledged Within 3 Working Days %	95.0%		?	95.9%	100.0%	92.0%	94.6%	94.6%	90.9%	96.2%	95.5%	100.0%	100.0%	95.7%	100.0%
				Complaints Breached %	5.0%		F	53.1%	67.5%	69.2%	80.0%	75.0%	73.0%	77.3%	82.5%	82.9%	88.6%	58.6%	45.0%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			467	406	469	507	367	432	377	346	251	403	380	247
				PALS Closed	-	L		433	1,811	451	478	345	357	258	256	188	277	258	198
				PALS Open - Month End	-	H		1,423	18	36	65	87	163	282	372	435	561	683	732
				PALS Converted to Complaints	-	H		6	3	2	1	6	4	8	4	2	2	0	7
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-	H		0	1	1	1	0	1	2	3	1	1	2	2
				PHSO Cases Closed - Partially Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	1	0	0	0	0	0	0	0	0

SIOR - Patients

Successful Deliverables

- 63 complaints closed in month reducing total of open complaints to 111.
- Lowest complaints breached within 25 working days position in 12 months
- Oldest complaint response from Oct 22 (10 months), [oldest response in April 23 was 2+ years]
- Sustained reduction in MSA breaches trust wide. A marginal increase in reported MSA breaches in the last reporting period.
- The site report reflects the daily Trust wide position for MSA
- Any potential breaches are required to be authorised by the DoC on call

Next Steps

- Continue phase 2 of complaints recovery plan over August before moving to phase 3 in September
- To cross reference the site report MSA data with the monthly validation position to ensure accuracy in the Business Intelligence software reporting going forward.

Identified Challenges

- PALS open at month end rising and only 198 closed in month. Seven PALS converted to formal complaints in July
- The validation process for MSA is still reliant on staff engagement and manual removal.
- The approval and validation process remains inconsistent

Next Steps

- Reduce number of open PALs
- MSA reporting at MFT is in line with other organisations, however the process is unclear for reporting MSA breaches once tele-tracking is in place, as this will replace the current process that is captured on Extra-Med. This process is to be mapped and reflected in the SOP once approved.

Opportunities

- Eliminating backlog of complaints will enable better theming of current complaint issues and targeted improvement work
- To understand the timeline for the implementation of tele-tracking and how MSA breaches will be monitored and reported.
- To commence work with the EDI lead to reflect the care needs of patients who are transgender and non-binary when considering MSA. This work was due to commence in July 2023 but has been delayed due to operational pressures

Next Steps

- Learning and improvements from current complaints themes
- To review local and national policy in relation to the EDI work that has been demonstrated for patients who identify as trans or non-binary and reflect this into MFT daily practice by means of clinical induction

Risks

- Four complainants from October 2022 are still awaiting a response and growing number of PALS concerns not been closed
- Failing to learn from complaints relating to communication – remains the number one theme
- There is a lack of robustness in the management approach to MSA. This is reflected on the risk register as a score of 12.

Next Steps

- Reduce PALS contacts as unable to obtain clinical appointment information
- To review the MSA risk as per the trajectory

Quality

Evonne Hunt
Chief Nursing Officer

Alison Davis
Chief Medical Officer

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

Committees:
Quality Assurance Committee (QAC)

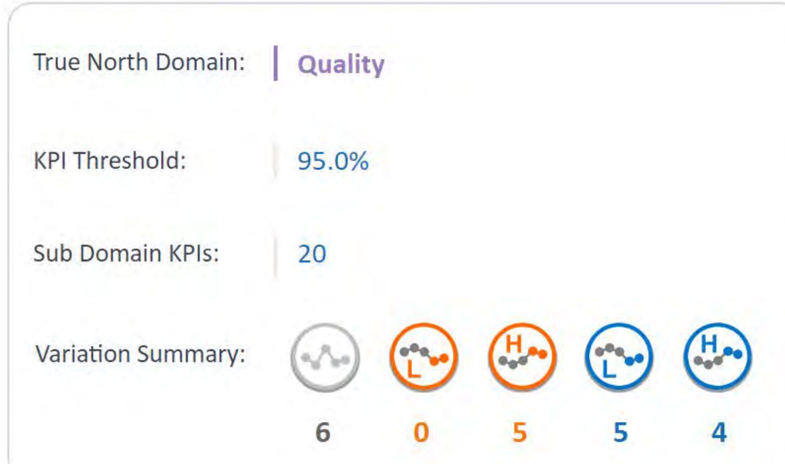
Quality

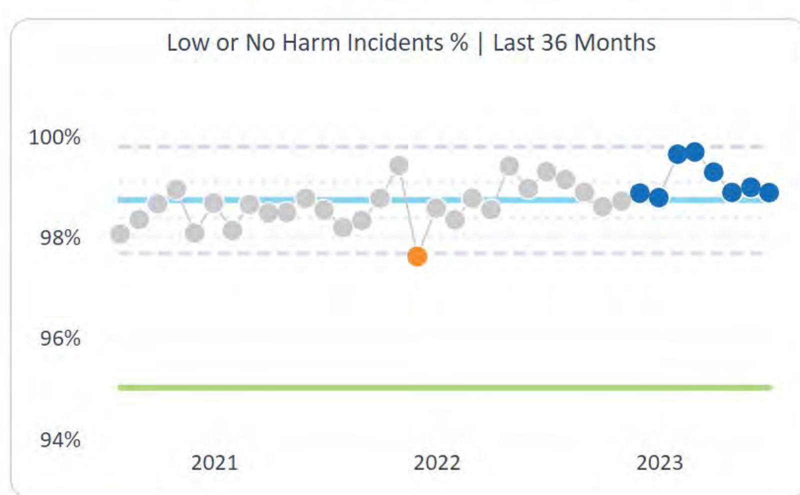
Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

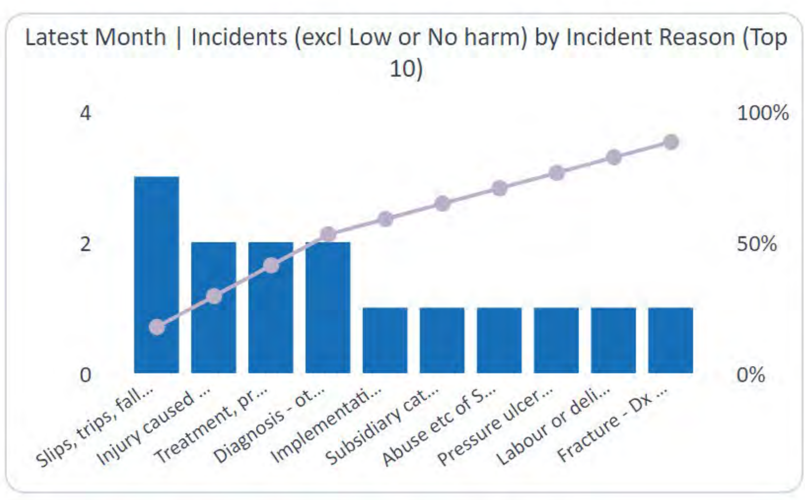
Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	95.0%			99.1%	98.9%	98.6%	98.7%	98.9%	98.8%	99.6%	99.7%	99.3%	98.9%	99.0%	98.9%







Key Messages

- Low and no harm incidents remain above 95% KPI threshold. Last eight data points achieving over 98%. Moderate and above harm incidents remain consistently less than 1% of total incidents reported.
- Incidents overdue a review at a six month low
- PSIRF transition end of October
- BI dashboards available at divisional level for assurance reporting.

Issues, Concerns & Gaps

- ~20% of all moderate and above incidents relate to patient falls.
- The PSIRF project requires multiple work-streams including involving patients in patient safety, revisions of the incident management policy and collaboration with the ICB which could impact on October transition date.
- High number of H&S incidents – intelligence is that these are as a result of improved reporting

Actions & Improvements

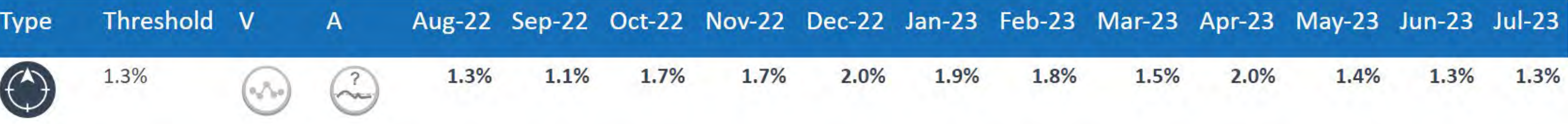
- Roll out of Falls and Pressure Ulcer quality improvement plans to embed improvement across the trust
- Strengthen and streamline IRG and SIRG processes to ensure that the right cases are presented and declared

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

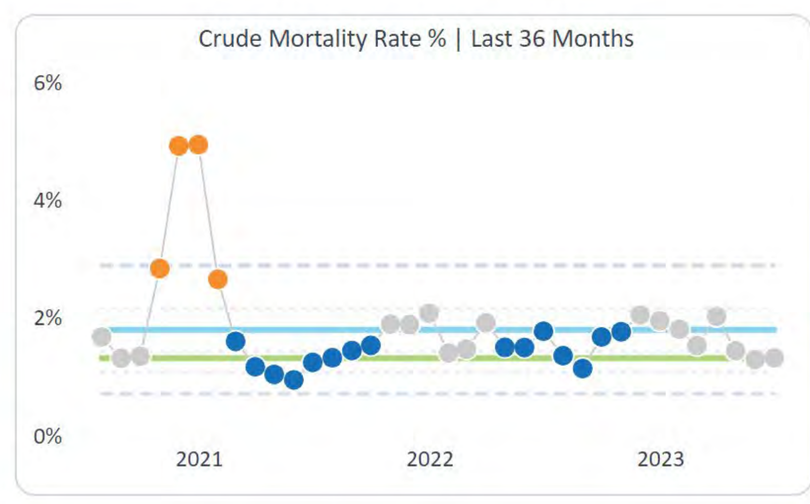
True North Domain: | **Quality**

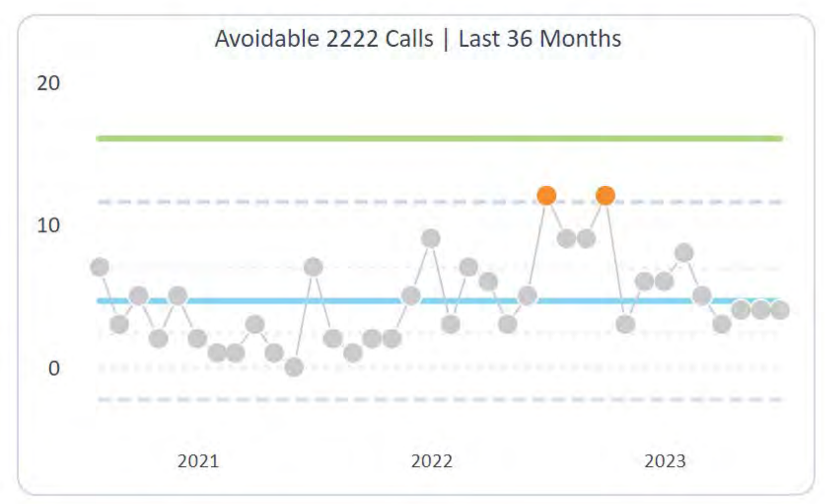
KPI Threshold: 1.3%

Sub Domain KPIs: 11

Variation Summary:

5	0	2	1	3





Key Messages

- Rolling 12 month HSMR for Apr 22- Mar 23 is 112.9 and 'higher than expected'
- Single month HSMR for Mar 23 is 83.7 and 'as expected'
- SHMI for Mar 22- Feb 23 is 1.14 and 'higher than expected'.
- 14% of deaths for July were subject to Structured Judgement Reviews- five cases were escalated for IRG : one Serious Incident declared, one rapid review, one due to be presented at IRG this week, two for extended rapid review (one subsequently closed).
- There are only a few remaining deep dives from the last category of outlying diagnosis group 'other nutritional and Endocrine metabolic disorders'. All other deep dives returned. two potential failings in care identified out of a total of 58 reviews carried out in the last few months across a number of different diagnosis groups and speciality teams. Both cases have been escalated to IRG for rapid review. Results pending.

Issues, Concerns & Gaps

- SHMI has had slight deteriorations over the course of the past few months and drivers for this remain unclear.
- Trajectory set for SJR completion of 25% deaths means additional resources to facilitate reviews, additional training for more reviews and focus on learning from actions and improvements from reviews becomes further challenging.
- Further education needed for clinicians completing deep dives to address the coding reviews around the firs Finished Consultant Episode and to confirm what the main condition being treated was in order for coding to rectify any errors.
- Incorrect consultants listed on PAS and issues with first finished consultant episode- work around this ongoing.

Actions & Improvements

- HSMR for Mar 2023 is the best performing month for some considerable time, driven by the significant increase in expected rate of death.
- Improvements seen this month across a number of different trend in coding: rates of non-elective palliative care is now comparable to the national rate. HSMR palliative activity continues to report as a six month high, deaths are reporting at a 12 months high indicating reporting in this area has significantly improved.
- Medical Examiners to identify any deaths identified in SHMI outlier groups for SJR.
- Deep dive escalation SOP has really improved the turn around for clinical reviews completed for outlying diagnoses groups. Only one group remaining.
- 7/11 actions completed from the Task and Finish Group
- Mortality Dashboard breaking down SHMI data now available

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	Incident Management			Low or No Harm Incidents %	95.0%			99.1%	98.9%	98.6%	98.7%	98.9%	98.8%	99.6%	99.7%	99.3%	98.9%	99.0%	98.9%
				Total Incidents Reported	-			1,029	1,157	1,489	1,311	1,405	1,464	1,358	1,538	1,102	1,154	1,463	1,505
				Incidents with Harm (Moderate and above)	0			9	13	21	17	16	18	5	5	8	13	15	17
				Incidents Open - Month End	-			767	913	1,149	1,091	1,137	1,614	1,432	1,585	1,289	1,118	1,248	1,215
				Incidents Overdue - Month End	-			46	64	60	69	94	128	364	475	270	235	176	156
				Serious Incidents	-			7	7	9	15	9	8	11	10	2	8	4	3
				Serious Incidents Closed	-			6	3	5	5	11	9	2	9	10	9	11	8
				Serious Incidents Open - Month End	-			44	48	51	61	59	58	67	68	60	59	52	47
				Serious Incidents Responded to Within 60 Days %	95.0%			20.0%	0.0%	0.0%	25.0%	37.5%	44.4%	15.4%	22.2%	30.0%	7.1%	42.9%	0.0%
				Serious Incidents Closed by ICB 1st Time %	-			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	40.0%	44.4%	36.4%	50.0%
				Never Events	0			1	1	0	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			50.0%	55.6%	94.7%	92.3%	90.9%	71.4%	87.5%	75.0%	50.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-			80.0%	75.0%	100.0%	20.0%	42.9%	66.7%	0.0%	14.3%	0.0%	18.2%	23.1%	20.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	Incident Management			RIDDOR Incidents	-			0	0	1	0	1	4	4	1	3	2	4	4
				RIDDOR Compliance %	-			-	-	100.0%	-	100.0%	100.0%	75.0%	100.0%	66.7%	100.0%	75.0%	100.0%
				Health & Safety Incidents	-			28	5	4	10	43	38	32	20	25	18	19	112
				Sharps Injuries	-			7	9	8	3	6	10	7	8	8	11	8	15
				Violence & Aggression Incidents	-			40	56	57	45	45	56	54	60	74	83	155	141
				Assaults - Patient on Staff	-			16	15	36	11	24	23	27	36	41	44	71	58
				EDNs Completed Within 24hrs %	90.0%			70.1%	67.2%	53.7%	59.5%	67.0%	68.7%	69.5%	70.5%	70.8%	75.4%	76.1%	70.0%
	Falls			Low or No Harm Falls %	95.0%			100.0%	94.7%	98.0%	91.6%	96.9%	98.2%	95.5%	98.9%	96.4%	100.0%	98.6%	97.1%
				Falls - Total	-			82	76	100	95	96	111	89	90	84	61	71	69
				Falls - Low Harm	-			25	26	26	18	23	23	24	19	15	14	20	25
				Falls - Moderate Harm	-			0	2	1	5	2	1	4	0	0	0	0	1
				Falls - Severe Harm	0			0	2	1	2	1	1	0	1	3	0	1	1
				Falls Resulting in Death	0			0	0	0	1	0	0	0	0	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	Falls			Falls per 1,000 Bed days	-			5.55	5.28	6.58	6.44	6.24	6.97	6.35	5.89	6.34	4.45	5.39	4.98
	Pressure Ulcer			Pressure Ulcers - Total	-			18	23	25	45	28	36	51	38	33	30	37	43
				Pressure Ulcers - Grade 1	-			0	0	0	0	0	7	12	15	8	2	6	16
				Pressure Ulcers - Grade 2	-			6	6	5	14	6	5	11	6	5	10	3	9
				Pressure Ulcers - Grade 3	0			1	0	0	0	0	0	0	0	0	0	1	0
				Pressure Ulcers - Grade 4	0			0	0	2	1	0	0	0	0	0	1	0	0
				Pressure Ulcers - Unstageable	-			4	10	12	15	11	12	19	10	9	9	14	8
				Pressure Ulcers - Deep Tissue Injury	-			7	7	6	15	11	12	9	7	11	8	13	10
				Pressure Ulcers per 1,000 Bed Days	-			1.22	1.60	1.65	3.05	1.82	2.26	3.64	2.49	2.49	2.19	2.81	3.10
	Medicines			Medicine Errors - Total	-			68	77	98	83	64	73	66	87	71	72	82	98
				Low or No Harm Medicine Errors %	95.0%			100.0%	100.0%	100.0%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	99.0%
	IPC			IPC Incidents	-			23	42	26	15	21	22	9	19	11	7	24	30
				C-Diff Cases - Hospital Acquired Total	-			3	5	3	6	6	3	1	4	7	6	8	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	35			18	23	26	32	38	41	42	46	7	13	21	24
				C-Diff Cases - Hospital Acquired (HOHA)	-			3	5	3	5	2	2	1	2	5	4	5	2
				E.coli Cases - Hospital Acquired	-			4	6	2	2	3	5	3	3	6	4	4	5
				E.coli Cases - Hospital Acquired YTD (Cumulative)	77			26	32	34	36	39	44	47	50	6	10	14	19
				MRSA Cases - Hospital Acquired	0		?	0	0	0	0	0	0	0	0	1	1	0	0
				MSSA Cases - Hospital Acquired	-			2	3	1	3	6	0	2	0	2	3	7	2
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			10	13	14	17	23	23	25	25	2	5	12	14
				Covid-19 Diagnosed - Total	0	L	?	135	105	226	57	137	97	153	192	107	25	49	41
	Mortality			Crude Mortality Rate %	1.3%		?	1.3%	1.1%	1.7%	1.7%	2.0%	1.9%	1.8%	1.5%	2.0%	1.4%	1.3%	1.3%
				Avoidable 2222 Calls	16		P	9	9	12	3	6	6	8	5	3	4	4	4
				HSMR (All)	100	H	F	113.43	114.33	114.95	115.79	115.77	113.98	114.33	112.92				
				Expected Death Rate %	-	L		3.6%	3.6%	3.6%	3.6%	3.6%	3.7%	3.7%	3.8%				
				SHMI	1	H	F	1.12	1.11	1.13	1.13	1.14	1.13	1.14					
				Fractured NOF Within 36 Hours	92.0%		?	71.9%	55.0%	79.3%	73.0%	73.7%	83.3%	56.1%	48.6%	67.6%	72.2%	56.0%	

Quality
KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	Mortality			Number of Deaths Reviewed via SJR	-			10	9	20	14	9	19	13	8	8	11	14	15
				SJRs Completed %	25.0%			8.1%	8.4%	13.2%	8.7%	4.7%	10.8%	8.1%	5.2%	5.0%	8.5%	11.2%	11.3%
				Total Number of Deaths Due to Failings in Care	-			0	0	1	0	0	2	0	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	1	1	0	0	1	3	0	1	1	0	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			92.7%	87.9%	72.3%	94.1%	82.6%	73.7%	73.2%	80.6%	84.6%	88.4%	91.7%	98.0%
	Maternity			Caesarean Section %	-			45.6%	45.8%	50.4%	53.3%	50.1%	44.6%	52.5%	40.5%	49.3%	45.2%	50.8%	48.2%
				Elective C-Section %	-			18.5%	18.2%	17.2%	19.3%	19.1%	17.6%	22.7%	15.9%	17.2%	16.7%	20.8%	16.4%
				Emergency C-Section %	-			27.1%	27.6%	33.2%	34.0%	31.1%	27.0%	29.8%	24.7%	32.1%	28.6%	29.9%	31.8%
				PPH greater than 1000mls	-			40	35	46	47	36	52	35	34	40	35	44	35
				Total Number of Still Births Greater Than 24 weeks Gestation	-			0	0	0	0	0	0	0	0	0	0	0	0
				Neonatal Deaths	-			1	3	1	0	1	1	0	0	2	2	0	2
				Maternity Serious Incidents	-			1	1	1	1	0	2	2	1	0	1	0	2

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Quality	Maternity			Maternity HSIB Referrals	-			0	0	0	0	0	1	0	0	0	0	0	1
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			0	0	0	0	2	0	1	0	0	0	0	1
	Risk & Policy			Risks Approved	-			7	8	7	10	7	16	31	60	21	8	10	7
				Risks Approved - Low	-			1	0	0	0	0	0	0	0	1	0	0	0
				Risks Approved - Moderate	-			0	2	0	1	1	1	1	1	0	0	0	0
				Risks Approved - High	-			3	3	2	6	3	11	27	48	12	4	7	4
				Risks Approved - Extreme	-			3	3	5	3	3	4	3	11	8	4	3	3
				Risks Approved - Closed	-			0	0	0	1	0	1	3	1	6	33	25	3
	Health & Safety			Resuscitation Training Compliance %	-			75.9%	76.3%	76.1%	78.3%	78.6%	79.4%	79.1%	78.7%	79.4%	79.3%	80.9%	81.1%
				Mental Capacity Act Training Compliance %	-			81.8%	81.4%	80.5%	79.8%	79.9%	80.1%	81.0%	81.9%	81.9%	81.9%	83.1%	82.3%
	Legal & Information Governance			Inquests Received	-			9	7	7	6	8	7	8	10	0	0	0	0
				Inquest Hearings	-			4	9	4	8	4	5	3	2	4	6	3	1
				Regulation 28 Reports	-			0	0	0	1	0	0	0	0	0	0	0	0

SIOR - Quality

Successful Deliverables

- Open serious incidents below 50 for first time since Sept-22 and 50% of SIs closed by ICB first time [highest closure in 12 months]
- HSMR at 112 and 11.3% of deaths reviewed by SJR
- IPC team moved to notifying wards of hospital acquired infections via Datix instead of emails and this has shown in an increase in IPC incidents.
- IPC team and microbiology started weekly C.difficiles ward round reviewing treatment of all patients in hospital with C.difficiles and GDH which has lead to a reduction in month of cases.
- COVID numbers remaining in single figures for three months with no outbreaks
- VTE: VTE Specialist Nurse recruitment is now in post & VTE risk assessments up to 98% complete
- VTE assessment on admission is mandatory

Next Steps

- Continue to reduce open SIs in line with improvement trajectory ready for PSIRF launch in October 2023
- Continue work with C.difficiles ward round and present results and impact to AMSG
- Continue to follow national guidance for COVID

Identified Challenges

- Rise in deep tissue injuries, IPC and medicine errors reported in July
- Total number of C.difficiles cases are at 24 against a threshold of 33 with a possibility to breach threshold by September 2023
- Trust has breached zero tolerance for MRSA bacteraemia
- VTE continues to be reported on safer sleep. No robust process to report VTE positive radiology scans post discharge
- There are identified challenges with the deployment, maintenance and distribution of mattresses and falls equipment

Next Steps

- To be part of Kent and Medway network collaborative on reducing C.difficiles in September 2023
- To continue using period of increased incidence monitoring for areas with more than two MRSA colonisations to identify gaps
- Radiology to develop the process for regular reporting of Positive radiology scans

Opportunities

- Themed learning coming from SI investigations enabling targeted improvement work
- QIPs for falls, Pressure ulcers, deteriorating patients, safeguarding to drive improvement work
- Greater divisional assurance via divisional BI reports
- Working with ICB and NHSE to decide if opportunity to offer both COVID booster and flu vaccinations to high risk inpatients over winter period
- For falls, VTE, TVN teams to be included as part of mandatory training on clinical induction

Next Steps

- Publish QIPs and thematic learning reports and actions/thematic reviews
- Meeting pharmacy to review and discuss the feasibility
- VTE: Radiology teams to inform the process for reporting a positive VQ/Doppler/CTPA scan to the VTE nurse specialist and develop a SOP / To include the next steps required to progress the hard stop for VTE assessments during the weekly VTE A3 group / The teams are working with the Deputy Chief nurse to include training for VTE, Falls and TVN as part of the clinical induction working group

Risks

- Increasing rate of Pressure Ulcers per 1,000 bed days
- Possibility of breaching the 2023/24 thresholds for MRSA and C.difficile - 1,667
- The Trust has breached the zero tolerance for MRSA bacteraemia in 2023/24 – 1,666
- Mattresses and falls equipment failures are not being escalated to the specialist teams which results in their disposal. There is no process within the clinical engineering team to monitor and track equipment appropriately. This has been added to the risk register.
- Photos of pressure damage that is used to refer to the TVN team have been stored on electronic devices / not deleted. This is in breach of information governance guidance.
- VTE: Information from the VTE assessment is not being pulled through to PAS and being logged on a separate software system / There is no robust process for reporting positive VQ.

Next Steps

- Review and procurement of Quality Management System to integrate quality areas across the Trust.
- A SOP was developed for TVN photography in 2021. All staff to follow the SOP and to delete photos / patient identifiable information on electronic devices when referring to the TVN, the team have sent out comms to all staff as a reminder. A digital solution has been identified to mitigate the risk for the TVN team and an overall policy is required for medical photography across the organisation.

SIOR - Maternity

Successful Deliverables

- No overdue SIs currently in maternity
- MFT Maintains 100% compliance to report all eligible cases to HSIB and NHSR EN
- Caesarean section audit presented at Trust Board in July 23
- Nine Rapid Reviews submitted in July 23 and presented to IRG.
- One recommendations for HLI accepted at IRG
- Rates of PPH (postpartum haemorrhage) reduced, especially PPH >1000mls

Next Steps

- Caesarean section round table planned September 23
- Working with HSIB colleagues to support smooth transition for future investigation process when HSIB incorporated within CQC in September 23
- Carbetocin (PPH) trial results to be presented at maternity Audit meeting in September 23

Identified Challenges

- Two neonatal deaths in July 23. One ex-utero from DVH. One MFT patient (41+4, delivered quickly on admission with no sign of life, meconium aspiration, resuscitation, HIE 3 - baby cooled but sadly did not survive)
- One HSIB referral (same case as MFT neonatal death patient above)
- BI data discrepancies remain. Caesarean section and PPH rates accurate but stillbirth and SI data incorrect (see below risk section for correct figures)

Next Steps

- MFT to present MBBRACE summary to MNSCAB and LMNS in September 2023
- Maternity Dashboard and BI data improvement work underway with digital midwife and BI team

Opportunities

- Working with colleagues regionally and locally to ensure PSIRF in maternity is considered and included within Trust transition
- Working with MNVP to ensure service users perspective and collaboration is embedded into investigations
- Hospital on call review completed as part of HSIB recommendation and will be shared with staff following HR BP approval
- Consultant Midwife has developed proposal together with MNVP focusing on BAME groups (where outcomes are known to be poorer) (MBBRACE 2022)

Next Steps

- In-situ training for all staff groups as part of CNST year five to incorporate learning from case reviews and form part of action plans for SI/HLI
- Padlets updated to ensure real time sharing of HSIB reports and recommendations

Risks

- SI data incorrect - One Maternity SI in July 23
- Stillbirth data incorrect – One in July 23
- Data inaccuracies added to Risk register (ID3521, Score =9)
- Induction of labour pathway remains on risk register (Score =12 ID2362)

Next Steps

- Pilot pathway for reducing delays in induction of labour underway and demonstrating improvements in patient experience. Consultant midwife working with BI to extract data.
- Reducing delays in induction of labour approved a divisional quality driver metric
- BI data improvement work underway with digital midwife and BI team

Systems & Partnerships

Nick Sinclair
Chief Operating Officer

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

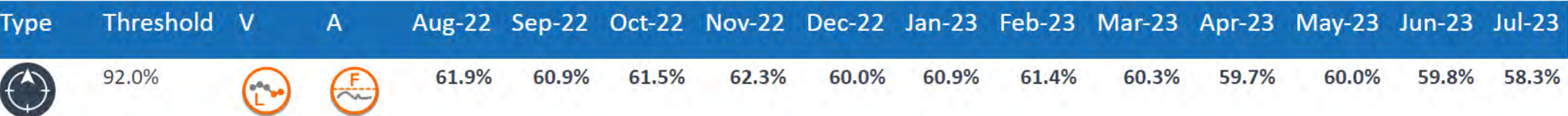
Committees:
Finance & Performance Committee

Systems & Partnerships

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

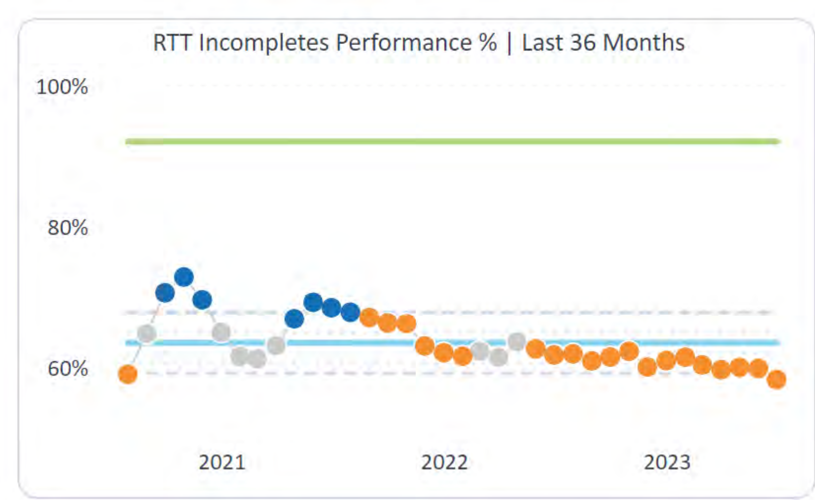
Access

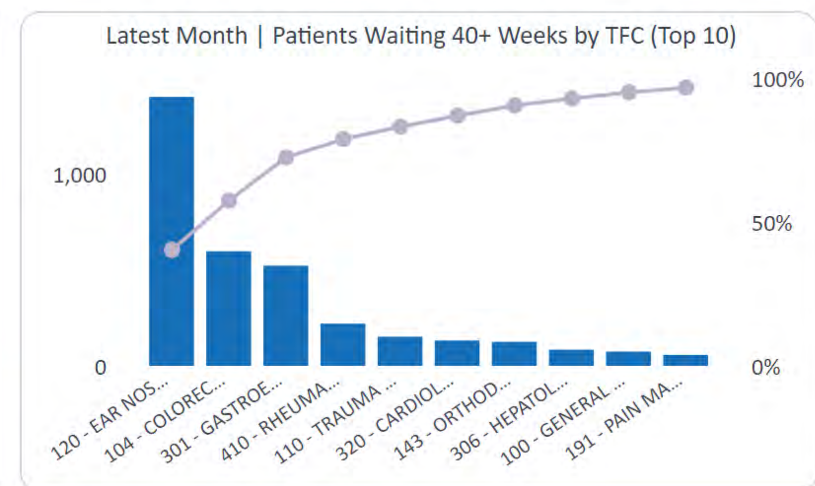
RTT Incompletes Performance %



Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	92.0%			61.9%	60.9%	61.5%	62.3%	60.0%	60.9%	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%

True North Domain:	Systems & Partnerships
KPI Threshold:	92.0%
Sub Domain KPIs:	25
Variation Summary:	14, 3, 5, 1, 2





Key Messages

- RTT continues to be a priority for the Trust. Treating all patients within 40 weeks is one of the Trusts key breakthrough objectives in the Patient First programme
- In July 2023 the number of patients waiting longer than 52 weeks has increased (June 870 to July 1,019). Key drivers for the increase are capacity in ENT and Endoscopy and the impact of Industrial Action

Issues, Concerns & Gaps

- ENT remains the primary concern for 52 and 78 week risk. Plans in place to manage backlog and to move to a sustainable position in 2024
- Diagnostic capacity in Endoscopy and Echocardiography are delaying diagnosis and treatment times. Plans in place to mitigate these issue in the next quarter.

Actions & Improvements

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

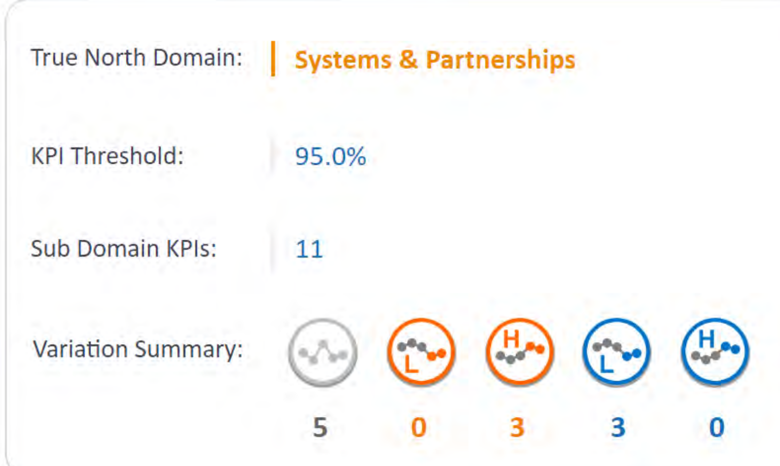
Systems & Partnerships

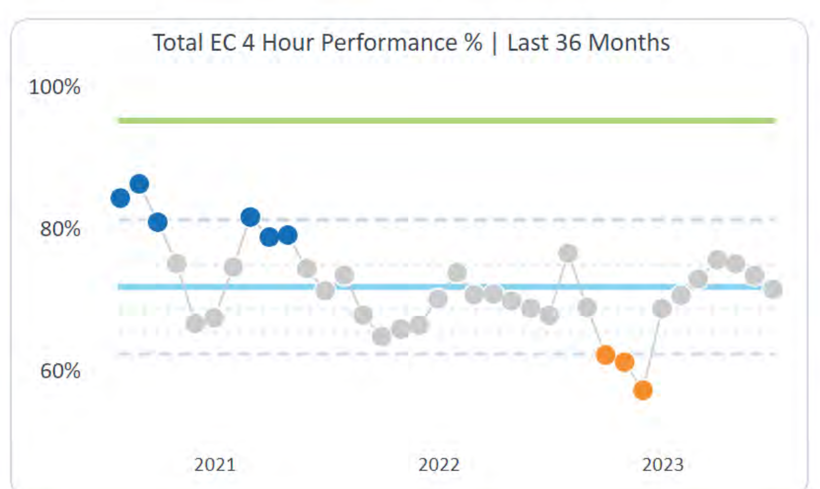
Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

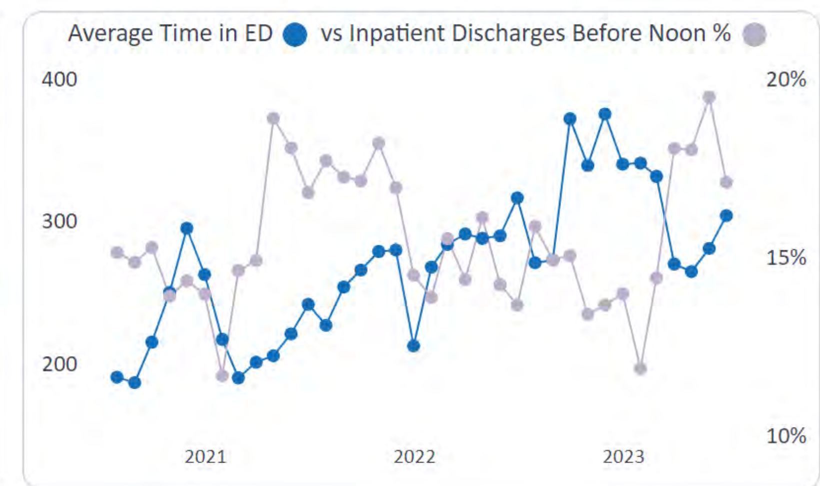
Emergency Care

Total EC 4 Hour Performance %

Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	95.0%		F	76.3%	68.7%	62.0%	61.0%	57.0%	68.5%	70.4%	72.7%	75.4%	74.8%	73.2%	71.2%



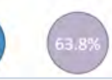




Key Messages

Total four hour performance deteriorated from Sept 2022 to mid Dec 2022. It stabilised throughout January and has achieved incremental improvement since 07/01/23. April saw the highest average total four hour performance at 75.5%, in more than 12 months. May saw a small dip to 74.5% but both Type 1 and Non-admitted performance have seen consistent and sustained improvements, with June seeing the highest Type 1 performance in the last 12 months at 65.9%, and reaching highs of 72.65% at times in July. Type 3 performance continues to be volatile, with operational plans in place to tackle this.

Latest Month	Latest Week	Yesterday
July-23	07/08/2023	14/08/2023
63.0%	63.8%	71.1%



Issues, Concerns & Gaps

- Flow out of the acute floor continues to be a key contributor, with the Trust not yet achieving 40% of discharges by midday, caring for large numbers of medically fit for discharge patients, and caring for a number of mental health patients waiting placement
- We continue to experience challenges at Medocc, with Type 3 performance being poorer in recent months (down to 82.3% for July, from 90.3% in Jan and 91.3% in April).

KPI Drilldowns Select KPI: Type 3 EC 4 Hour Performance %

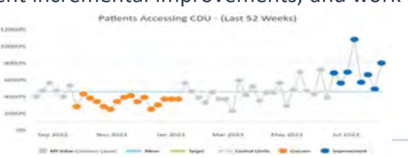
Overall KPI Performance: *Last 12 Months* Variation: Assurance:

Target	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
95.0%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	90.3%	85.6%	90.3%	91.3%	87.6%	[illegible]	[illegible]

Actions & Improvements

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

1. Refreshed CDU pathway live and improving in utilisation, with the greatest numbers in CDU in July (322), further up from 242 in June.
2. Next steps are to continue working with Medocc to improve flow management and sustain recent incremental improvements, and work with SECAmb to increase conveyance to Medocc pathways.



Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Systems & Partnerships	Access			RTT Incompletes Performance %	92.0%			61.9%	60.9%	61.5%	62.3%	60.0%	60.9%	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%
				RTT 40+ Week Waiters	-			2,175	2,135	1,935	1,930	2,258	2,370	2,569	2,726	3,083	3,236	3,139	3,480
				RTT Waiting List Size	-			33,076	33,936	34,347	34,433	34,615	35,403	35,991	36,835	36,659	37,018	37,847	38,714
				RTT 52 Week Breaches	0			383	422	504	567	603	590	560	471	581	820	877	1,020
				OP Average Time to First Appointment (days)	60			91.11	86.15	88.11	92.72	85.14	86.72	89.02	87.86	77.62	87.25	85.08	89.33
				Outpatient DNA Rate %	10.0%			7.7%	7.7%	7.8%	7.5%	8.6%	7.3%	7.1%	7.4%	7.2%	7.5%	7.6%	7.4%
				OP First to Follow Up Ratio	-			1.93	1.96	1.83	1.81	1.85	1.95	1.82	1.82	1.93	1.97	1.86	1.51
				Operations Cancelled by Hospital on Day	0			3	13	10	18	19	10	8	29	8	13	13	12
				Cancelled Operations Not Rescheduled < 28 Days %	-			33.3%	84.6%	60.0%	33.3%	36.8%	30.0%	25.0%	51.7%	37.5%	53.8%	7.7%	25.0%
				Urgent Operations Cancelled for 2nd Time	0			2	1	0	0	2	1	0	1	2	2	1	2
				Day Case Rate %	-			85.0%	84.7%	85.1%	84.8%	84.8%	85.7%	84.9%	84.4%	85.0%	84.9%	83.4%	84.7%
				Average Elective Length of Stay (days)	3			0.39	0.30	0.33	0.38	0.32	0.29	0.29	0.33	0.35	0.31	0.36	0.33
				Average Non-Elective Length of Stay (days)	10			4.75	4.48	4.71	4.64	4.59	4.76	4.56	4.57	4.94	4.58	4.65	4.56

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Systems & Partnerships	Access			104 Day Cancer Waits	-			5	7	4	5	3	11	4	5	6	9	4	
				Cancer 2ww Performance %	93.0%			93.2%	95.4%	93.3%	89.6%	92.8%	84.6%	70.7%	80.9%	94.5%	94.8%	92.2%	
				Cancer 2ww Performance - Breast Symptomatic %	93.0%			88.1%	85.7%	80.0%	74.3%	68.1%	44.4%	6.9%	16.7%	93.6%	100.0%	83.3%	
				Cancer 31 Day First Treatment Performance %	96.0%			96.7%	98.2%	96.4%	98.1%	98.2%	100.0%	98.2%	100.0%	100.0%	98.8%	98.7%	
				Cancer 31 Day Subsequent Treatments - Drugs %	98.0%			100.0%	93.3%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	94.0%			95.7%	90.9%	100.0%	89.5%	96.6%	88.9%	91.3%	100.0%	93.8%	91.3%	100.0%	
				Cancer 62 Day Treatment - GP Refs %	85.0%			82.5%	85.6%	85.0%	80.6%	84.8%	71.9%	85.6%	79.0%	80.1%	68.5%	72.7%	
				Cancer 62 Day Treatment - Cons Upgrades %	50.0%			61.3%	76.2%	76.7%	80.0%	76.2%	66.7%	75.0%	87.5%	77.8%	72.7%	37.5%	
				Cancer 62 Day Treatment - Screening Refs %	90.0%			90.0%	88.0%	75.0%	90.9%	66.7%	75.9%	72.7%	100.0%	88.9%	40.0%	90.0%	
				Cancer 28 Faster Diagnosis %	75.5%			77.4%	74.5%	71.5%	71.8%	62.4%	61.2%	75.3%	75.7%	77.5%	69.2%	72.3%	
				Cancer 28 Faster Diagnosis Screening %	-			45.3%	24.2%	40.0%	60.5%	56.3%	73.9%	86.2%	54.5%	81.8%	88.5%	56.4%	
				DM01 Performance %	99.0%			68.7%	73.2%	79.1%	79.3%	74.7%	71.1%	72.4%	72.2%	67.7%	65.5%	67.1%	65.1%
	Emergency Care			Total EC 4 Hour Performance %	95.0%			76.3%	68.7%	62.0%	61.0%	57.0%	68.5%	70.4%	72.7%	75.4%	74.8%	73.2%	71.2%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Systems & Partnerships	Emergency Care			IP Discharged Before Noon % (Inc transfers to ADL)	40.0%		F	15.8%	14.9%	15.0%	13.4%	13.6%	13.9%	11.8%	14.4%	18.0%	18.0%	19.5%	17.1%
				Type 1 EC 4 Hour Performance %	75.0%		F	57.3%	54.3%	45.5%	48.3%	46.5%	52.1%	58.2%	58.2%	62.8%	64.8%	65.9%	63.0%
				Total EC 12 Hour Breaches	0	H	?	148	166	420	263	560	422	428	540	131	106	190	344
				Average Time in EC Department (mins)	200		F	270.23	272.14	371.19	338.40	374.41	339.30	340.03	330.75	269.32	264.06	280.25	303.24
				Number of ED Arrivals by Ambulance	-			2,963	2,922	2,940	2,350	2,984	2,896	2,704	2,915	2,929	3,048	2,777	3,007
				Ambulance Handover Delays (> 30 mins)	-	L		446	512	679	150	277	103	111	77	57	32	40	59
				Ambulance Handover Delays (> 60 mins)	0	L	?	151	242	304	10	37	8	5	3	2	2	3	1
				Bed Occupancy - General & Acute %	92.0%	H	P	91.2%	91.4%	92.4%	91.7%	91.8%	92.0%	93.8%	93.3%	90.3%	89.8%	89.5%	90.4%
				Medically Fit for Discharge Patients %	9.0%	H	?	10.2%	10.0%	9.3%	9.9%	10.0%	10.1%	8.6%	9.4%	9.5%	9.4%	9.6%	9.5%
				30 Day Readmission Rate	13.0%	L	?	10.1%	10.0%	8.5%	8.4%	9.3%	9.6%	9.7%	9.3%	10.0%	9.2%	10.3%	8.8%

SIOR - Access

Successful Deliverables

RTT
- Additional outpatient activity ongoing for Gastroenterology
- Patient Initiated Follow-up (PIFU) relaunched with ENT, T&O, Urology, Gynae, paediatrics and Neurology
- ENT task and finish group continues to work on additional capacity plans to manage backlog

DM01
- Plans for additional Endoscopy capacity through mutual aid are being progressed

Cancer
- Achieved 31d cancer performance for July (unvalidated)

Next Steps

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

Cancer
- Increase performance for all targets – mostly an issue due to UGI/LGI

Identified Challenges

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

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

Cancer
- Currently under Tier 2 measures for backlog performance (UGI/LGI related to endoscopy capacity)
- Breast Radiology capacity low in August due to Consultant IA and Annual Leave – working on plan for additional sessions to recover 2 ww position

Next Steps

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

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

Cancer
- Medium term solution for Endoscopy capacity awaiting approval at TIG. Continue with fortnightly Tier 2 meetings with NHSE/ICB
- Continue on plan for increase in Breast Radiology capacity to mitigate reduction in slots.

Opportunities

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

DM01
- MTW and DGT offering weekend capacity for Endoscopy.

Cancer
- Increase Endoscopy Capacity with mobile unit – increased capacity will bring waiting times down and increase performance for UGI/LGI.

Next Steps

RTT
- Follow-up with ICB for potential ENT capacity

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

Cancer
- Await approval for medium term plan for additional endoscopy capacity

Risks

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

Cancer
- Ability to hit targets due to the UGI/LGI Performance for all targets

Next Steps

RTT
- DGT ENT contract discussions have taken place. A new SLA is being developed.

Cancer
- Await approval for medium term plan for additional endoscopy capacity.

SIOR - Emergency Care

Successful Deliverables

Non-Admitted 4 Hour

- Sustained improvements in non-admitted performance, with a recent dip in overall 4 hour performance due to volatility in Type 3 performance and impact from Industrial action. Sustained improvement in Type 1 performance in >12 mnths achieved in June (65.9%), despite continued high attendances, significant improvement in utilisation of CDU pathway, with highest numbers (322) since July 2022.

Admitted 4 Hour

- Improved performance with July highest in over 12 months (11.7%)

Next Steps

- Achieve further incremental improvement through increased utilisation of CDU pathways for ambulant patients requiring observations
- Expansion of service provision for patients requiring lower acuity mental health input with increased hours from Oct, allowing further utilisation of CDU capacity

Admitted 4 Hour

- De-escalation and protection of recently escalated EAU and Discharge lounge, and embedding of escalation processes to improve flow through for admitted patients. There has been ad-hoc escalation into these areas through June and July.

Identified Challenges

Non-Admitted 4 Hour

- Type 3 performance
- SECAmb to Medocc Conveyance
- Volume of mental health attendances

Admitted 4 Hour

- Flow from acute floor to admitted wards
- MFFD Numbers / difficulty achieving 100% utilisation of community capacity

Next Steps

- Work with Medocc to change operational model to manage demand more appropriately with booked appointments
- Monitoring of recovery trajectory from MCH
- Project with SECAmb focussing on conveyance direct to Medocc, focussing initially on abdominal pain pathway
- Utilisation and expansion of “Safe Haven” for lower acuity mental health attendances opened in July.
- De-escalation of Lister, EAU, and improvement of utilisation of RACE clinics
- Pilot project within Cardiology to progress hot clinic pathway – capacity scoping in July, agreed project scope August

Opportunities

- Mental health pathways, enabling CDU to be more fully utilised
- Collaborative working with SECAmb to reduce direct conveyances to ED.
- A-Ted pathways, including M-TED and F-TED (Mental health and Frailty alternatives to ED).
- De-escalation allowing Refer and Move work-stream, and achievement of short stay acute ward.

Next Steps

- Improved utilisation and expansion of provision of Safe Haven, August meeting regarding closer working with KMPT for patients waiting inpatient mental health placement
- Scoping conveyance opportunities with SECAmb to address the 10-13% attendances that get streamed immediately to Medocc
- Progress on work streams focussing on ATED including hot clinics and in-reach increase, alternatives to ED for frailty patients and mental health patients.
- De-escalation allowing Refer and Move work-stream, and achievement of short stay acute ward.

Risks

Overall

- System capacity – ICB/Community/Medocc/Mental Health
- Operational capacity to enact change and improvements, competing priorities
- Availability of funding for capital changes, and invest to save models
- Acuity and volume of attendances
- Ongoing industrial action

Next Steps

Overall

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

People

Leon Hinton
Chief People Officer

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

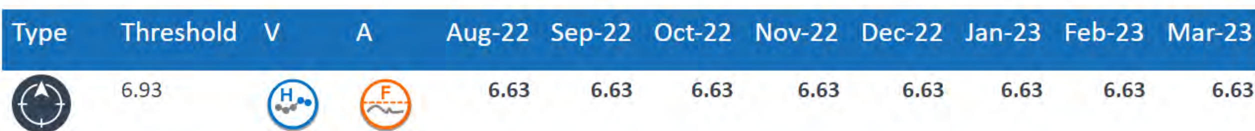
Committees:
People Committee

People

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

Workforce

National Staff Engagement Score



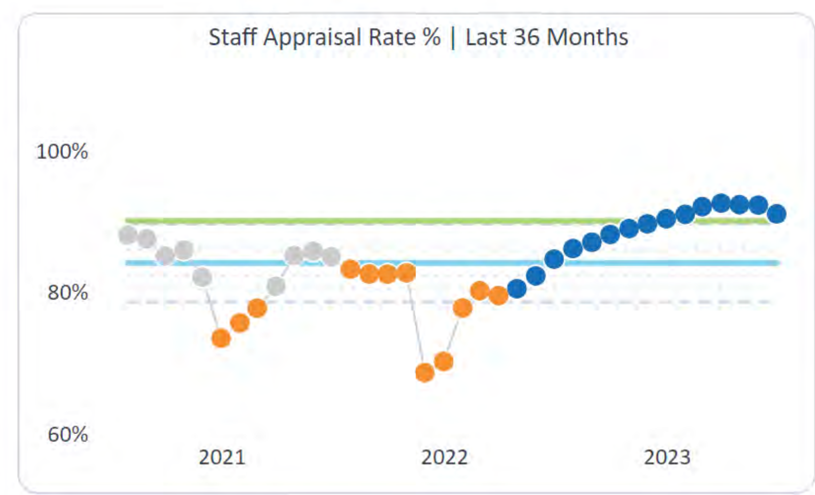
Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	6.93	H	F	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63

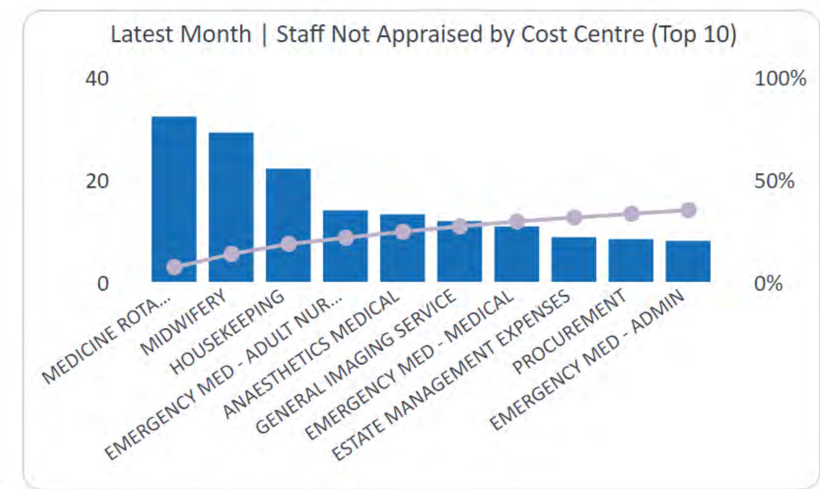
True North Domain: People

KPI Threshold: 6.93

Sub Domain KPIs: 14

Variation Summary: 5 | 0 | 0 | 4 | 5





Key Messages

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

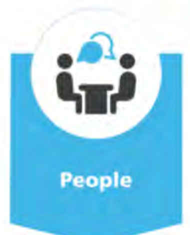
The new breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% is now in operation.

Issues, Concerns & Gaps

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

Actions & Improvements

- Intention to leave process to be finalised and implemented in September 23;
- Delivery of improvement plan developed and governed by anti-bullying and harassment group;
- Breakthrough huddle pack to be improved to ensure divisions have quality stratified data.



People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
People	Workforce			National Staff Engagement Score	6.93			6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63				
				Staff Appraisal Rate %	90.0%			86.1%	87.1%	88.2%	88.8%	89.5%	90.3%	91.2%	92.2%	92.7%	92.1%	92.1%	90.9%
				Staff in Post (FTE)	-			4,487.81	4,490.41	4,540.73	4,563.17	4,599.46	4,617.05	4,635.23	4,690.24	4,686.04	4,703.54	4,736.77	4,768.78
				Staff Leavers (FTE)	-			164.34	89.08	78.57	52.76	58.66	63.97	55.81	66.40	55.76	50.59	45.45	49.69
				Staff Starters (FTE)	-			190.18	82.31	113.06	80.43	46.69	94.05	71	87.72	66.93	80.02	59.85	74.59
				Vacancy Rate %	9.0%			10.4%	10.3%	9.9%	9.1%	7.9%	8.2%	7.2%	7.1%	6.9%	7.1%	6.2%	5.1%
				Voluntary Turnover %	8.0%			12.3%	12.5%	12.1%	11.7%	11.6%	12.0%	11.9%	11.6%	11.6%	11.4%	11.4%	10.9%
				Staff Fill Rate - Total %	85.0%			79.7%	81.3%	79.0%	80.6%	78.6%	78.2%	80.0%	82.2%	87.7%	89.9%	91.1%	91.8%
				Staff Fill Rate % (Total) - Registered Nurse	-			77.7%	79.7%	79.4%	79.6%	78.2%	76.5%	78.3%	80.3%	86.0%	87.1%	88.4%	88.1%
				Care Hours per Patient Day (CHPPD)	9.50			8.25	7.98	7.56	7.76	8.03	8.10	8.53	8.52	9.14	9.21	9.26	9.11
				Sickness Absence Rate - Total %	4.0%			4.4%	4.4%	4.9%	4.7%	5.3%	4.8%	4.6%	4.5%	4.0%	4.0%	3.8%	4.2%
				Sickness Absence Rate - Short Term %	2.0%			2.3%	2.5%	2.9%	2.5%	3.2%	2.5%	2.4%	2.5%	2.1%	2.1%	1.8%	2.1%
				Sickness Absence Rate - Long Term %	2.0%			2.2%	1.9%	2.0%	2.2%	2.1%	2.4%	2.2%	2.0%	1.9%	1.9%	2.1%	2.1%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
People	Workforce			StatMan Training Compliance %	85.0%		P	**85.9%**	**86.4%**	**86.4%**	**86.8%**	**86.6%**	**87.1%**	**86.8%**	**87.1%**	**87.7%**	**87.8%**	**88.6%**	**87.7%**

SIOR - People

Successful Deliverables

- Completion of aspiring development programme for Band 5 nurses (BAME and women focus) exceeding the target with 40 individuals completing the programme.
- Continued compliance with agency spend target;
- General internal medicine junior block roster now in place;
- Collaborative working with ITU/HDU has significantly reduced agency usage with better bank utilisation

Next Steps

- Step-by-step review of the international recruitment process to improve and streamline the process for a better experience for our new staff;
- Review of Trust bank rate arrangements.

Identified Challenges

- Continued high use of agency consultants following significant increase in 2023/24. Fortnightly planning meetings ongoing to ensure a plan is in place for each and every vacancy.

Next Steps

- Continued high use of agency consultants following significant increase in 2023/24. Fortnightly planning meetings ongoing to ensure a plan is in place for each and every vacancy.
- Reasonable Adjustment Task and Finish Group, to produce a Procedural Appendix, agree correct escalation routes, and consistency in decisions (including costs)

Opportunities

- Neurodiversity Toolkit – work is starting across ICS partners to share in the development of resources. This matches an ambition in our own EDI action plan.
- Emergency Department (including CHED) junior rotas moving to the centralised Medical Rota Coordination Service.
- Commencing international recruitment of pharmacists.

Next Steps

- Enact the new ED rosters within the centralised service.

Risks

- Non-adherence to the regional rate card (Nursing and Medical) by neighbouring Trust impacts our bank/agency fill rate

Next Steps

- Paper to FPPC confirming bank rate mitigations.

Sustainability

Alan Davies
Chief Financial Officer

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

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

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

Financial Position

Breakeven Revenue Budget (£)

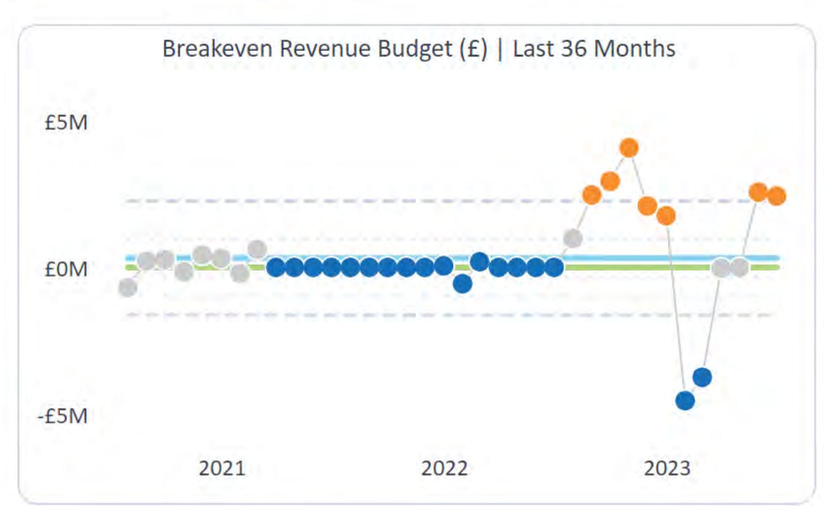
Type	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
	£0			0.98m	2.46m	2.94m	4.08m	2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m

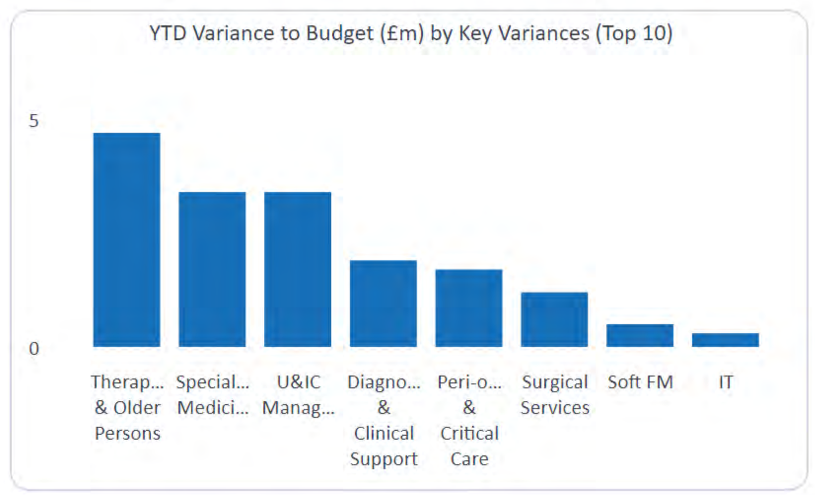
True North Domain: **Sustainability**

KPI Threshold: £0

Sub Domain KPIs: 13

Variation Summary: 7, 0, 5, 0, 1





Key Messages

The Trust reports a deficit of £3.4m in month 4 of 2023/24 and year to date deficit of £13.1m; this is £5.0m adverse to the YTD plan agreed with NHSE and ICB. The in-month income & expenditure position of £3.4m is in line with the average run-rate of the first quarter (£3.3m), however the planned deficit has reduced to £1.0m in July - from £2.3m in June – as a result of the efficiencies programme phasing.

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

Issues, Concerns & Gaps

The full value of ESRF income has been included in the position £5.3m, as well as Community Diagnostics Centre (CDC) income of £3.2m; there is a risk of partial repayment for both of these income sources as planned activity levels are not being delivered. Further confirmation of this is being worked through with the ICB as well as the impact on activity of industrial action. Of the £27m stretched efficiencies target, at the time of writing £16.5m had been identified for the year with more opportunities being presented to the delivery panel. In month 4, the efficiency plan increased to an in-month target of £3m from £0.9m.
Medical and nursing pay continue to be the primary areas of overspending.

Actions & Improvements

Implementation of mitigations within divisions to control overspending on medical and nursing pay costs.

Further development, approval and implementation of efficiency schemes continues.

Continued training to budget holders, as well as support with budget variance analysis.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0			0.98m	2.46m	2.94m	4.08m	2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m
				Agency Spend %	3.7%			3.5%	3.0%	3.1%	3.1%	2.8%	2.5%	3.5%	1.9%	2.6%	3.0%	2.7%	3.0%
				Bank Spend %	10.0%			13.4%	10.2%	11.9%	12.2%	11.2%	12.7%	11.6%	7.8%	12.8%	12.4%	11.1%	11.6%
				(Surplus) / Deficit (£)	£0			1.19m	1.65m	3.04m	4.18m	2.20m	1.76m	-4.63m	-4.83m	2.46m	2.47m	4.82m	3.42m
				Agency Spend (£)	-			0.77m	0.76m	0.71m	0.70m	0.63m	0.56m	0.78m	0.80m	0.60m	0.70m	0.71m	0.75m
				Income (£)	-			-32.62m	-35.65m	-32.64m	-33.03m	-34.20m	-34.37m	-39.66m	-60.80m	-34.16m	-34.78m	-35.20m	-36.16m
				Income (£) vs Budget	£0			-0.42m	-3.26m	-0.41m	-0.69m	-1.93m	-1.65m	-7.35m	-27.50m	-0.24m	-0.89m	-0.02m	-1.83m
				Total Pay Spend (£)	-			21.91m	25.22m	22.74m	22.74m	22.26m	22.69m	22.54m	42.56m	23.10m	23.32m	25.79m	24.45m
				Total Pay Spend (£) vs Budget	£0			1.49m	2.42m	2.28m	2.22m	1.78m	1.85m	2.02m	22.13m	0.88m	1.12m	2.51m	2.92m
				Total Non-Pay Spend (£)	-			10.03m	10.23m	11.19m	12.65m	12.32m	11.14m	10.99m	11.03m	11.58m	11.70m	12.29m	12.91m
				Total Non-Pay Spend (£) vs Budget	£0			-0.08m	3.32m	1.20m	2.61m	2.30m	1.13m	1.17m	1.13m	-0.47m	-0.35m	0.26m	1.25m
				Actual Worked FTE	-			4,935.05	4,911.91	4,952.63	5,017.52	5,001.50	4,999.98	5,102.29	5,227.19	5,127.10	5,174.36	5,229.67	5,215.43
				Actual Worked FTE vs Budget	0			-91.70	-111.65	-70.95	-5.15	-31.02	-38.51	68.30	192.45	43.79	82.68	156.70	138.77

SIOR - Sustainability

Successful Deliverables

The identified efficiencies for the year has increased by £1.6m to £16.6m, this is mainly due to a contribution from the ESRF income by delivering activity levels at less than cost reserves. The PMO and Finance teams continue to further progress schemes and support the divisions to deliver services in a more efficient way for the benefit of the patients.

Financial recovery plan (FRP) refresh document continues and will be provided to the FPPC in line with the schedule.

Next Steps

Most of the budgets have been signed off by budget holder with a small amount remaining to be completed, mainly due to service pressures or staff on annual leave. Budget Holder training is being delivered and the number of budget holders trained is increasing.

Using the patient first methodology the breakthrough objectives refresh are advancing and catch-ball meetings have taken place with ongoing scheduled follow up sessions. In addition, the focus on the identification and delivery of the efficiency programme for 2023/24 continues.

Identified Challenges

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

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

Next Steps

1. Delivery of the additional activity scoped by the Theatres and Outpatients efficiencies programme and as funded from ESRF reserves.
2. Recruit staff to the Community Diagnostics Centres with a view to delivering activity and reducing patient waiting lists.
3. Implementation of the counter measures following the development of A3 documents for nursing and medical pay costs, as part of the 'control of overspending' breakthrough objective.
4. Further development, approval and implementation of efficiency schemes in the pipeline.

Opportunities

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

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

The Trust is in the process of agreeing the implementation of enhanced financial controls

Next Steps

Development and approval of efficiency pipeline plans to bring into the programme.
Progress with working alongside the ICB in populating the medium term financial plan. This is expected to contribute towards the efficiency programme, and although another model has been issued in scheduled to be published by the end of September
Agree the operationalisation of enhanced financial controls and implement.

Risks

Ongoing risks continue, including:

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

Next Steps

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

Useful Information

Patient First

Patient First

OUR MISSION

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

OUR VALUES

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

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

TRUE NORTH DOMAINS

Sustainability	People	Patients	Quality	Systems and Partnerships

STRATEGIC INITIATIVES

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

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

Patient First - Guidance

Patient First - Metric Types

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

RAG Status & Thresholds

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

Patient First - Business Rules

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

Patient First - Guidance

NHSI 'Plot the Dots' Guidance

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

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

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

KPI Glossary

Future Developments

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

KPI Glossary

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

KPI Glossary

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

KPI Glossary

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

KPI Glossary

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

KPI Glossary

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

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	IPC		C-Diff Cases - Hospital Acquired Total	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated & Community Onset Hospital Associated)
Quality	IPC		C-Diff Cases - Hospital Acquired YTD (Cumulative)	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated & Community Onset Hospital Associated) YTD cumulative position
Quality	IPC		C-Diff Cases - Hospital Acquired (HOHA)	The number of Clostridium Difficile (C-Diff) cases - Hospital Acquired (Hospital Onset Hospital Associated)
Quality	IPC		E.coli Cases - Hospital Acquired	The number of E.coli cases - Hospital Acquired (Blood Culture Only)
Quality	IPC		E.coli Cases - Hospital Acquired YTD (Cumulative)	The number of E.coli cases - Hospital Acquired (Blood Culture Only) YTD cumulative position
Quality	IPC		MRSA Cases - Hospital Acquired	The number of MRSA cases - Hospital Acquired (Blood Culture Only)
Quality	IPC		MSSA Cases - Hospital Acquired	The number of MSSA cases - Hospital Acquired
Quality	IPC		MSSA Cases - Hospital Acquired YTD (Cumulative)	The number of MSSA cases - Hospital Acquired YTD Cumulative
Quality	IPC		Covid-19 Diagnosed - Total	The number of Covid-19 Inpatients
Quality	Legal & Information Governance		Inquests Received	Number of Inquests Received
Quality	Legal & Information Governance		Inquest Hearings	Number of Inquest Hearings Attended
Quality	Legal & Information Governance		Regulation 28 Reports	Number of Regulation 28 Reports
Quality	Maternity		Caesarean Section %	The percentage of total deliveries where a Caesarean Section was performed
Quality	Maternity		Elective C-Section %	The percentage of total deliveries where an Elective Caesarean Section was performed

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Maternity		Emergency C-Section %	The percentage of total deliveries where an Emergency Caesarean Section was performed
Quality	Maternity		PPH greater than 1000mls	The number of deliveries where PPH was greater than 1000ml
Quality	Maternity		Total Number of Still Births Greater Than 24 weeks Gestation	The total number of still births greater than the 24 weeks gestation period
Quality	Maternity		Neonatal Deaths	The total number of neonatal deaths less than 28 days prior to birth
Quality	Maternity		Maternity Serious Incidents	The total number of maternity related serious incidents recorded on Datix
Quality	Maternity		Maternity HSIB Referrals	The total number of HSIB (Health Safety Investigation Branch) referrals recorded on Datix
Quality	Maternity		Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3
Quality	Medicines		Medicine Errors - Total	The total number of medicine errors recorded on Datix
Quality	Medicines		Low or No Harm Medicine Errors %	The percentage of medicine errors recorded on Datix with either Low or No Harm recorded
Quality	Mortality		Crude Mortality Rate %	Crude Mortality Rate
Quality	Mortality		Avoidable 2222 Calls	The number of avoidable 2222 calls
Quality	Mortality		HSMR (All)	HSMR (All)
Quality	Mortality		Expected Death Rate %	Expected Death Rate as calculated within Dr Foster
Quality	Mortality		SHMI	Summary Hospital-level Mortality Indicator (SHMI)

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Mortality		Fractured NOF Within 36 Hours	Fractured NOF Within 36 Hours
Quality	Mortality		Number of Deaths Reviewed via SJR	Total SJR's completed in month irrelevant of when the death occurred
Quality	Mortality		SJRs Completed %	Total SJR's completed in month as a percentage of total deaths in month
Quality	Mortality		Total Number of Deaths Due to Failings in Care	Total SJR's completed with an outcome suggesting failings in care
Quality	Mortality		Number of LD Deaths Reviewed via SJR	Total SJR's completed in month irrelevant of when the LD death occurred
Quality	Mortality		Total Number of LD Deaths Due to Failings in Care	Total SJR's completed with an outcome suggesting failings in care - LD deaths only
Quality	Pressure Ulcer		Pressure Ulcers - Total	The total number of Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 1	The total number of Grade 1 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 2	The total number of Grade 2 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 3	The total number of Grade 3 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Grade 4	The total number of Grade 4 Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Unstageable	The total number of Unstageable Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers - Deep Tissue Injury	The total number of Deep Tissue Injury (DTI) Pressure Ulcers recorded on Datix
Quality	Pressure Ulcer		Pressure Ulcers per 1,000 Bed Days	The total number of Pressure Ulcers per 1,000 bed days

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Quality	Risk & Policy		Risks Approved	Total number of new approved risks added to the register according to the “Risk Approved Date”
Quality	Risk & Policy		Risks Approved - Low	Total number of new risks added to the register where the risk review score is between 1 and 3 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Moderate	Total number of new risks added to the register where the risk review score is between 4 and 6 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - High	Total number of new risks added to the register where the risk review score is between 8 and 12 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Extreme	Total number of new risks added to the register where the risk review score is between 15 and 25 (uses current score but if no current score then uses the initial score)
Quality	Risk & Policy		Risks Approved - Closed	Total number of risks closed in the month according to the “Closed date”
Quality	VTE		VTE Risk Assessment Completed %	The proportion of patients risk-assessed for Venous Thromboembolism (VTE)
Sustainability	Financial Position		Breakeven Revenue Budget (£)	Breakeven Revenue Budget Position
Sustainability	Financial Position		Agency Spend %	Percentage of total spend with regards to Agency staff
Sustainability	Financial Position		Bank Spend %	Percentage of total spend with regards to Bank staff
Sustainability	Financial Position		(Surplus) / Deficit (£)	(Surplus) / Deficit
Sustainability	Financial Position		Agency Spend (£)	Agency Spend £ (Finance Ledger)
Sustainability	Financial Position		Income (£)	Income £ (Finance Ledger)
Sustainability	Financial Position		Income (£) vs Budget	Income £ (Finance Ledger) vs Budget

KPI Glossary

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

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Systems & Partnerships	Access		Cancelled Operations Not Rescheduled < 28 Days %	The Percentage of Cancelled Operations Not Rescheduled < 28 Days for Non-Clinical Reason
Systems & Partnerships	Access		Urgent Operations Cancelled for 2nd Time	Cancelled Urgent Procedure For 2nd Time For Non-Clinical Reason
Systems & Partnerships	Access		Day Case Rate %	Day Case % Rate - where National_POD = 'DC' / National_POD IN ('EL','DC)
Systems & Partnerships	Access		Average Elective Length of Stay (days)	Average Elective (EL, DC, RDA) Length of Stay
Systems & Partnerships	Access		Average Non-Elective Length of Stay (days)	Average Non-Elective Length of Stay
Systems & Partnerships	Access		104 Day Cancer Waits	104 Day Cancer Waits
Systems & Partnerships	Access		Cancer 2ww Performance %	The proportion of patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral.
Systems & Partnerships	Access		Cancer 2ww Performance - Breast Symptomatic %	The proportion of Breast Symptomatic patients urgently referred by GPs/GDPs for suspected cancer and first seen within 14 days from referral.
Systems & Partnerships	Access		Cancer 31 Day First Treatment Performance %	The proportion of patients who had their first definitive treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 31 Day Subsequent Treatments - Drugs %	The proportion of patients who had their subsequent anti-cancer drug treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 31 Day Subsequent Treatments - Surgery %	The proportion of patients who had their subsequent surgical treatment within 31 days from their decision to treat.
Systems & Partnerships	Access		Cancer 62 Day Treatment - GP Refs %	The proportion of patients urgently referred by GPs/GDPs for suspected cancer and had first definitive treatment within 62 days from referral.
Systems & Partnerships	Access		Cancer 62 Day Treatment - Cons Upgrades %	The percentage of patients upgraded by a consultant for cancer and had first definitive treatment within 62 days from referral.
Systems & Partnerships	Access		Cancer 62 Day Treatment - Screening Refs %	The proportion of patients referred by the national screening programme and had first definitive treatment within 62 days from referral.

KPI Glossary

True North Domain	Sub Domain	Type	Key Performance Indicator	KPI Description
Systems & Partnerships	Access		Cancer 28 Faster Diagnosis %	The proportion of patients referred for suspected cancer that are informed if they do or do not have a cancer diagnosis within 28 days
Systems & Partnerships	Access		Cancer 28 Faster Diagnosis Screening %	Cancer 28 Faster Diagnosis Screening
Systems & Partnerships	Access		DM01 Performance %	The proportion of patients that are currently waiting for a diagnostic test for less than 6 weeks from referral.
Systems & Partnerships	Emergency Care		Total EC 4 Hour Performance %	Performance against the national 4 hour target (Type 1 & 3 departments combined) - The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours - (Actual submitted peformance positon)
Systems & Partnerships	Emergency Care		IP Discharged Before Noon % (Inc transfers to ADL)	Percentage of patients discharged from hospital before noon (between 06:00:00 and 11:59:59 - Including transfers to the discharge lounge before noon)
Systems & Partnerships	Emergency Care		Type 1 EC 4 Hour Performance %	Performance against the national 4 hour target (Type 1 departments only) - The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours - (Actual submitted peformance positon)
Systems & Partnerships	Emergency Care		Total EC 12 Hour Breaches	The number of patients with total LOS of greater than 12hrs in EC Department (Type 1 & 3 departments combined)
Systems & Partnerships	Emergency Care		Average Time in EC Department (mins)	Average Time in EC Department (Mins)
Systems & Partnerships	Emergency Care		Number of ED Arrivals by Ambulance	Number of ED Arrivals by Ambulance (Ambulance Handovers)
Systems & Partnerships	Emergency Care		Ambulance Handover Delays (> 30 mins)	The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 30 minutes.
Systems & Partnerships	Emergency Care		Ambulance Handover Delays (> 60 mins)	The number of patients arriving at Accident & Emergency (A&E) by emergency ambulance that was handed over to A&E staff in over 60 minutes.
Systems & Partnerships	Emergency Care		Bed Occupancy - General & Acute %	The proportion of beds occupied at midnight (General and Acute beds only)
Systems & Partnerships	Emergency Care		Medically Fit for Discharge Patients %	% Medically Fit for Discharge (MFFD) Patients
Systems & Partnerships	Emergency Care		30 Day Readmission Rate	30 Day Readmission Rate

Trust Board in Public
Date: Wednesday, 13 September 2023

Meeting	Quality Assurance Committee held on 26 July 2023		
Title of Report	**Assurance and Escalation Report from Quality Assurance Committee**	Agenda Item	**4.1**
Lead Non-Executive Director	Paulette Lewis, Non-Executive Director (Committee Chair)		
Lead Executive Director	Evonne Hunt, Chief Nursing Officer Alison Davis, Chief Medical Officer		
Report prepared by	Joanne Adams, Business Support Manager		
Report Approved by	Paulette Lewis, Non-Executive Director (Chair of QAC) Wayne Blowers, Deputy Director of Integrated Governance, Quality & Patient Safety		
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee held of Wednesday 26 July 2023, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.		
Proposal and/or key recommendations	The Committee approved the following papers for onward sharing with Trust Board: • Integrated Quality Performance Report (IQPR) • Perinatal Quality Surveillance		

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

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

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

Identified Risks, issues and mitigations:	The committee identified the following matters to inform the Board: 1) Safeguarding level 3 training; the safeguarding team are providing additional training sessions.

	2) End of life care dealing with deaths; the team are providing training to staff of having difficult conversations and breaking bad news. 3) Euroking data issue; national issue with incorrect data and has been presented to the executive team. No safety or harms identified. The trust is looking for a good digital system for maternity. 4) Increase of violence and aggression incidents; violence and aggression steering group has been set up to support implementation of zero tolerance to violence and aggressions to staff. **5)** Paediatric mental health patients; shortage of tier 4 mental health beds for paediatric patients, this is a national issue.
Resource implications:	NIL
Sustainability and /or Public and patient engagement considerations:	NIL
Integrated Impact assessment:	Not applicable
Legal and Regulatory implications:	NIL
Appendices:	Key headlines and assurance level listed below.
Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act.
For further information or any enquires relating to this paper please contact:	Evonne Hunt, Chief Nursing Officer evonne.hunt1@nhs.net
Reports require an assurance rating to guide the discussion:	Partial Assurance | There are gaps in assurance

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Quality Assurance Committee (QAC)	26 July 2023	Paulette Lewis, Non-Executive Director

Number of attendees	Number of apologies	Quorate	
		Yes	No
17	5	x	

Declarations of Interest Made

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

Assurance received at the Group meeting

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

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

- Minutes of the meeting held on 27 June 2023 were approved as an accurate record.
- Action log was updated with some actions remaining open.

Assurance and Escalation Report from Quality and Patient Safety Sub-Committee (21 July 2023): key points of note:

- Integrated Quality Performance Report (IQPR) was discussed in depth
- Patient experience of patients with mental health and Health and Safety report were discussed, both reports will be shared with QAC.
- Progress has been made updating out of date policies and documentation.
- Robust discussion about the increase of reported incidents relating to violence and aggression and actions taking place to implement zero tolerance of violence and aggression to staff.
- Good papers and discussion at the meeting.

Integrated Quality Performance Report (IQPR): key points of note:

- Friends and Family Test (FFT)
- Mixed sex accommodation breaches (MSA)
- Complaints
- Mortality, Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)
- Incidents relating to violence and aggression.
- Pressure ulcers
- Infection Prevention and Control
- Maternity
- VTE

QAC noted that staff attitude and compassionate care has been highlighted across multiple areas for patient feedback and were informed of the work taking place to address this.

Quarter one report – Quality Governance – patient safety, mortality and learning from deaths: key points of note:

- No 'never' events within quarter one
- Decrease to SI's and closed some of the backlog
- SI's are being monitored centrally with a trajectory in place to decrease the backlog.
- Increase to incident reporting following a slight decrease which was aligned to a decrease in reporting of 12 hour breaches in ED. Increase to pressure ulcers.

- Rapid reviews have remained static
- Duty of candour is 100%
- Level one patient safety training is at 94%, there is no national trajectory in place. MFT took the decision to make this training mandatory for staff.
- Concern relating to 40 additional mandatory questions in Datix, looking to streamline the MFT questions to keep the form user friendly.
- Work has been taking place on the implementation of PSIRF with training and communication to staff and driving the patient safety incident response plan across the trust.
- Data from SJR's is showing themes and trends and deep dives are taking place on the outline diagnosis groups and these are monitored by MSG.
- There is a new clinical learning from deaths lead who will help with sharing the learning from SJR and improving the SJR process.

Quarter one report – Quality Governance – quality assurance and compliance: quality and clinical effectiveness: key points of note:

- Six internal assurance visits were undertaken and action plans developed for each of those areas. Action plans need to be presented at Risk and Compliance Group.
- Ward accreditation process has been reviewed and ward assurance visits will recommence at the end of July. Four wards have been nominated and have been asked to complete a self-assessment.
- Quality account was successfully delivered and published on the trust website.
- Have received notification from national joint registry for data provider award for 2023.
- 73 NICE guidance reviews outstanding at the end of quarter one.
- There are 79 national audits the trust is participating in, 43 of those published in 2022/23 require review and 11 reports were reviewed in quarter one.
- There are 146 local audits in progress, 52 new local audits were registered in the first quarter and 22 of those being fully completed in the quarter. 68 audits have been finished and need to be presented in the divisions for closure.

Quarter one report – Quality Governance – CQUINs: key points of note:

- CQUIN 6 – monthly data for April is the maximum target we have achieve which puts the trust in the top third in the country.
- CQUIN 3 – achieved 43%, the lower the better on this CQUIN (40% target).
- CQUIN 5 – is about frailty, of the sample set 100% received a clinical frailty score. The CQUIN then sets out anyone with a clinical frailty score over six has a comprehensive geriatric assessment or referral to a clinical frailty service. The trust does not have that pathway and a working group will be set up to look at part 2 of this CQUIN.
- CQUIN 12 - six hour risk assessment of pressure ulcer is not being completed in some of our assessment units.
- CQUIN 2 – eating, drinking and mobilising after surgery is challenging due to ability to capture data and work is taking place with therapy team to help identify resource.

Quarter one report – Quality Governance – CQC information: key points of note:

- Four CQC information requests in quarter one. Three related to safeguarding concerns and one related to linen, hot water and staffing on the elderly care frailty wards.
- All requests were responded to in the timeframe and have been closed by the CQC.

QAC noted the concerns relating to discharges have been transferred over to the discharge team.

Quarter one report – Quality Governance – PALS and complaints: key points of note:

- Stabilised complaints process, concluded phase 1 of the 3 phase recovery plan. All targets met in phase one. Phase 2 is to the end of August - sustaining and building on the current position.
- Focus will also be to supporting PALS team on the closing of the loop on PALS concerns and early resolution working with patient experience and 'don't take your troubles home'.

- From 01 August the PALs office will relocate to the main entrance where staff will be proactive in approaching patients and visitors, staff will also be working proactively on the wards.

QAC noted the good progress and thanked the central team and divisions for their hard work in closing the backlog of complaints.

New IPC BAF gap analysis and proposed improvement plan: key points of note:
- The new IPC BAF and gap analysis report is a consolidation of existing BAF and newly published requirements.
- There are 113 actions of which 96 are new actions.
- Changes are specifically around systems for management of IPC, understanding cross transmission using transmission based precautions.
- Meetings have taken place with key stakeholders to make sure the actions make improvements.

QAC thanked the Associate Director of Infection Prevention and Control for her continued focus, stating it is a pleasure to read the reports and see the progress that has been made on infection prevention and control.

End of Life Quarter One report: key points of note:
- QAC received and discussed the quarter one End of Life Care report which set out the activity of the End of Life Care, Palliative Care and Namaste Care practitioner for the reporting period of April to June 2023.
- The service has seen an increase to referrals.
- Namaste Care service has received fantastic feedback from families and patients since implementation in February.
- There is a focus on providing education and training to staff on having difficult conversations and breaking bad news with families.

CQC UEC survey report (EMBARGOED NOT FOR SHARING EXTERNALLY): key points of note:
- QAC received and discussed the CQC UEC survey report acknowledging the report is embargoed and will not be published until 25 July 2023.
- QAC were advised that there are a number of improvements and areas of focus that the trust is already working on.

Perinatal Quality Surveillance Quarterly Report: key points of note:
- QAC received and discussed the perinatal quality surveillance quarterly report.
- There is an improving position against safeguarding level 3 training.
- Ockenden 1 and 2 are now closed.
- Improvement to postpartum haemorrhage pathway since the introduction of a drug to reduce bleeding.
- Staffing levels remain a challenge due to maternity leave and year 2 and 3 students from CCU, the ICB are working on a preferred pathway for the students.
- Issue with accuracy of data within Euroking

This paper is presented to Board.

Draft Quality Strategy Update Report: key points of note:
- QAC received and discussed the draft quality strategy update which provides an overview briefing of the Quality Strategy 2023/24-27 and outlines;
    - The principles to be included
    - Suggested priorities/actions
    - Next steps
- The briefing is designed to seek comment and agreement whilst the full Strategy document is developed for approval in September.

Key actions

- No actions identified.

Highlights from sub-groups reporting into this group *(Short description of any key successes / risks highlighted by the sub-groups. Outline any key projects delegated, e.g. task and finish exercises on a specific issue)*
Assurance and escalation report from Quality and Patient Safety Sub-Committee
Items to come back to the Group *(Items the Group is keeping an eye on outside its routine business cycle)*
n/a

Items referred to another Group, Subcommittee and or Committee for decision or action		
Item	**Group, Subcommittee, Committee**	**Date**
• Integrated Quality Performance Report (IQPR) • Perinatal Quality Surveillance Quarterly Report	Trust Board Trust Board	13.09.23 13.09.23

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

n/a

Items/risks/issues for escalation

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

Issues and or Risks to note:

- QAC agreed to inform Trust Board of the following matters and mitigating actions:
    - Safeguarding level 3 training; the safeguarding team are providing additional training sessions.
    - End of life care dealing with deaths; the team are providing training to staff of having difficult conversations and breaking bad news.
    - Euroking data issue; national issue with incorrect data and has been presented to the executive team. No safety or harms identified. The trust is looking for a good digital system for maternity.
    - Increase of violence and aggression incidents; violence and aggression steering group has been set up to support implementation of zero tolerance to violence and aggressions to staff.
    - Paediatric mental health patients; shortage of tier 4 mental health beds for paediatric patients, this is a national issue.

Reflection:

- Lots of good work and progress happening. Good discussions at the meeting.

Any other business:

- There was no other business for discussion.

Implications for the corporate risk register or Board Assurance Framework

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

Examples of outstanding practice or innovation

n/a

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Meeting	Quality Assurance Committee				
Title of Report	**Assurance and Escalation Report**		Agenda Item	4.1	
Lead Director	Evonne Hunt, Chief Nursing Officer				
Report prepared by	Alana Marie Almond, Deputy Company Secretary				
Report Approved by	Paulette Lewis, Committee Chair Evonne Hunt, Chief Nursing Officer				
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee held of Wednesday 30 August 2023, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.				
Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☒	
Appendices	None				
Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board					
The key headlines and levels of assurance are set out below:					
Partial assurance	Amber/ Red - there are gaps in assurance				

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Quality Assurance Committee	30.08.23	**Paulette Lewis**

Number of attendees	Number of apologies	Quorate	
		Yes	No
18	4	X	

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

Assurance received at the Group meeting

Assurance and Escalation Report - Quality and Patient Safety Sub-Committee (QPSSC)

a) Pressure ulcers – enquiry on category one and two pressure ulcers and why there has been an increase in the data; advised data now includes category one data, which was not included previously, although this is not a national requirement the data will highlight any issues that need to discussed with suppliers. A review has resulted in the removal of condemned mattresses.

b) Historical pressure ulcer conversations - advised of work with the Patient Safety Incident Response Framework (PSIRF) reviewing the investigation process, in line with NHSE guidelines. A Quality Improvement Plan will come to the next QAC for sign off in addition to QPSSC and ICB. The plan will cease standard investigations, instead focusing on improvements. Category four ulcers will still be investigated.

c) Sample rejection – Training Issues; advised the lab are responding to issues in real time, once the full remit is understood a full report will come to the next QPSSC.

d) Planned Care - advised the division are looking at making assumptions with patients, eg: patients with hip fractures, high impact interventions will be put into place and monitored weekly. Care providers will be included in feedback regarding outcomes from the Quality Improvement Plan.
The Committee was **ASSURED** and the report was **APPROVED**.

Integrated Quality Performance Report (IQPR) – Patients and Quality

a) Mortality – Trust Chair and CMO have met to further discuss mortality and the work with the Medical Examiner. The mortality data is on a rolling twelve month cycle, with an historical three month lag. Data from September 2023 should see an improving trend.

b) Mixed Sex Accommodation - addressing mixed sex ward breaches; critical care teams have been liaising with site teams at every touch point within the patients hospital stay. Divisional Matrons are in place to ensure the wards have everything required. Strengthening communications has been a focus.

c) Maternity Recommendation Rates – there has been a decrease over the last three months. The Family and Friends Test (FFT) for Maternity recommendation response rate fell due to delays in induction of labour, next month will see the return to 100% recommended rate. FFT communications are improving week on week, with further actions in place to ensure improvements. Themes from FFT have been triangulated, these will be reviewed in the report to come to QPSSC and QAC. Through the Patient First Breakthrough Objectives stratified data needs to be understood. Executives will review this through their GEMBA visits.
The Committee **NOTED** the report.

Infection Prevention and Control (IPC) Strategy

a) The Committee was presented with the Trusts new strategy for the next three years, highlighting visions and aspirations for providing high quality care to patients, reducing harm and healthcare associated infections.
The Committee **APPROVED** the report

Allied Health Professionals (AHP) Activity Update

a) Work around the workforce review will be continuously monitored.
The Committee was **ASSURED** and the report was **NOTED**

Patient/Service Story for Trust Board

a) The Committee discussed the Improvement Actions and how they will be monitored for assurance. Issues with escalation and communication are improving, as seen with avoidable 2222 calls. Communication remains an area of focus for all levels of staff to embed into everyday practices.

b) The Committee raised the distressing contents of the Cesary Patient Story; communication is highlighted as an issue that needs addressing. Junior members of staff do not feel empowered, there should be a

culture of allowing staff to have a voice and be able to take accountability of their patients. More work to be done to encourage staff to speak up and know they will be heard. There needs to be a change in culture.

c) Since the Cesary incident ‘Call for Concern’ has been implemented, to discuss immediate concerns and rapid review. Staff are being familiarised with the international ‘Early Warning Score’ and their set of parameters. All actions will be reviewed through divisional monitoring.
The Committee **APPROVED** the report

Complaints Annual Report

a) In how the complaints process is handled, a Patient First A3 approach was not taken, there was a recentralisation and change of process with clear issues, implementing a three stage recovery plan. However an A3 approach is being taken for Patient Advice and Liaison Service (PALS). The process will be triangulated.
The Committee **APPROVED** the report

Falls and VTE Update Report – June 2023

a) Committee enquired about the 21% of incidents that are happening on a Thursday and were advised work continues on the themes, including a focus on Thursdays and out of hour’s incidents. A deep dive is taking place into ‘unwitnessed falls’. The outcome of the review will be brought to QPSSC and QAC.
The Committee **NOTED** the report

Pressure Ulcers Review Update Report

a) Update on pressure ulcer activity for the month of June 2023.
The Committee **NOTED** the report

Adult In-patient Survey Results

a) Committee discussed the disappointing results, highlighting work that still needs to take place before the next survey in January 2024, which will reflect the national survey questions. Patient First methodology will continue to encourage a sustainable change.
The Committee **NOTED** the report

Resuscitation Update Report

a) The Committee discussed the need for a robust plan to be put into place, including identify gaps in mandatory training, and holding individuals to account.
The Committee **NOTED** the report

CQC Action Plan Update

a) The Committee was presented a paper, highlighting a monthly review of the plan.
The Committee **NOTED** the report

Key actions

- **QAC/312/23** - Executives to review the Cesary Story and address how a culture change will be addressed across the organisation.
- **QAC/313/23** - Fall and VTE Deep Dive on unwitnessed falls
- **QAC/314/23** - Names of those employees (within Resus) who have not completed mandatory training to be sent to Evonne Hunt, information to be shared with the People Committee.

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

Assurance and escalation report from Quality and Patient Safety Sub-Committee

Items to come back to the Group *(Items the Group is keeping an eye on outside its routine business cycle)*		
None		
Items referred to another Group, Subcommittee and or Committee for decision or action		
Item	**Group, Subcommittee, Committee**	**Date**
Integrated Quality Performance Report (IQPR)	Trust Board in Public	13.09.23
Perinatal Quality Surveillance Quarterly Report	Trust Board in Public	13.09.23
Infection Prevention Control Strategy	Trust Board in Public	13.09.23
Patient Story for Trust Board – Cesary Family	Trust Board in Private	13.09.23
Reports not received as per the annual work plan and action required		
N/A		

Items/risks/issues for escalation

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

Issues and or Risks to note to ensure these areas are reviewed and appropriate actions are put into place to improve the safety and quality for patients:

1) Bleeper system for Resus
2) Communication and culture, hospital wide.
3) Resus mandatory training.
4) Safeguarding Children Level 3 Training compliance – escalation from Safeguarding Strategic Group

Reflection:

The Chair commented on the positive robust discussions during the meeting.

Any other business:

Committee members to complete the Gather Self-Assessment Survey at their earliest convenience.

Implications for the corporate risk register or Board Assurance Framework

None

Examples of outstanding practice or innovation

None

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Title of Report	Perinatal Quality Surveillance Quarterly Report			**Agenda Item**	4.2
Author	Alison Herron, Director of Midwifery				
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer				
Executive Summary	This report provides an update and assurance to the Trust Board on the quarterly Perinatal Quality Surveillance Data.				
Proposal and/or key recommendation:	The committee is requested to NOTE the assurance and report.				
Purpose of the report (tick box to indicate)	**Assurance**	**X**	Approval		
	Noting	**X**	**Discussion**	**X**	
Committee/Group at which the paper has been submitted:	Maternity and Neonatal Safety Champion Assurance Board 07.07.23 Quality and Patient Safety Sub-Committee 20.07.23 Quality Assurance Committee 26.07.23				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	**Priority 3: (Patients)** **X**	**Priority 4: (Quality)** **X**	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: **X**	**Effective:** **X**	**Caring:** **X**	**Responsive:** **X**	**Well-Led:** **X**
Identified Risks, issues and mitigations:	Not applicable				
Resource implications:	No additional resource implications				
Sustainability and /or Public and patient engagement considerations:	Not applicable				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	Compliance with Ockenden and CNST				
Appendices:	Appendix 1: Perinatal Quality Surveillance Quarterly Report				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				

<table>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="2">Alison Herron, Director of Midwifery
alison.herron2@nhs.net</td></tr>
<tr><td rowspan="5">Reports require an assurance rating to guide the discussion:</td><td>No Assurance</td><td>There are significant gaps in assurance or actions</td></tr>
<tr><td>Partial Assurance</td><td>There are gaps in assurance</td></tr>
<tr><td>Assurance</td><td>Assurance with minor improvements needed.</td></tr>
<tr><td>Significant Assurance</td><td>There are no gaps in assurance</td></tr>
<tr><td>Not Applicable</td><td>No assurance required.</td></tr>
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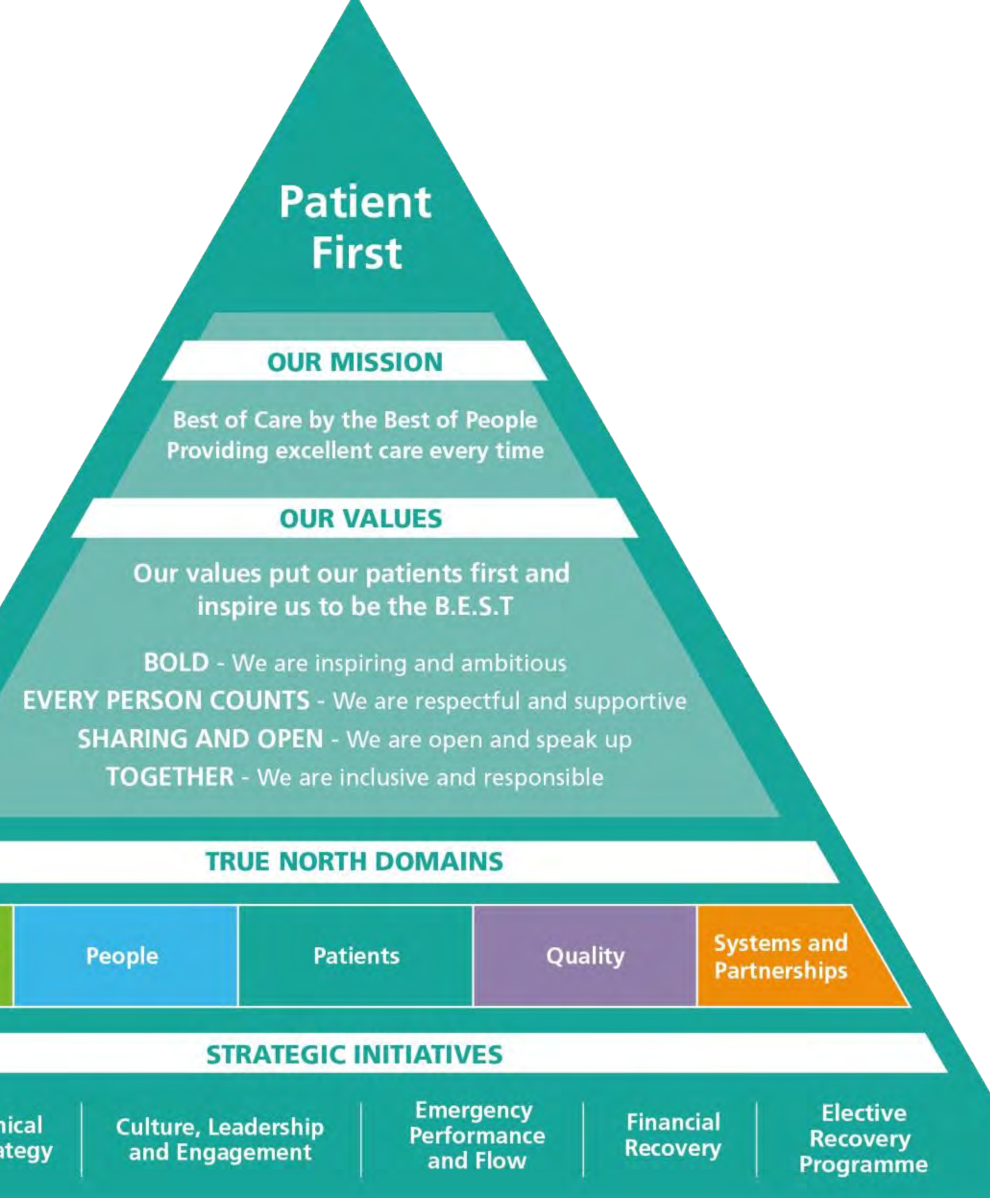
Perinatal Quality Surveillance Quarterly Report

Trust Board September 2023

Alison Herron – Director of Midwifery

Patient First



Incidents, complaints and risks

SIOR - Quality

Successful Deliverables

- Complaint and on target with All Safety Actions compliant with SI submissions
- No HSIB referrals in June 2023
- No current breaches in action plans
- 2 MBRRACE cases reported within mandatory timeframe

Next Steps

- Support from the Risk Midwives gathering statements & guidance.
- Continue to ensure timely management of actions and supporting staff with collecting evidence and sharing recommendations to all staff.

Identified Challenges

- CNST Year 5 has highlighted additional training requirements for all staff groups this year
- 2 complaints received in June 2023
- HSIB have been asked by the ICB to incorporate the retained SWAB into the review of a shared case with DVH.
- Including family's voice into investigation reports

Next Steps

- Revise TNA to reflect additional training needs and review how we can action
- Improve the sharing trends and patterns of complaints and ensure this feeds into mandatory training
- Improve direct communication with the family

Opportunities

- Caesarean section round table planned for August 2023
- Continuous work with an MDT compliance attendance at CRIG
- Complete benchmarking for 3 year delivery plan
- Commence CNST 10 safety action reporting into August MNSCAB

Next Steps

- Streamlined pathway with the digital midwife in having a more robust system with communicating incident's
- Work with CD to ensure job planning reflective of CRIG TOR requirements
- Work with compliance manager to ensure BAF is up to date and reflective of new work streams

Risks

- 0 declared Serious Incidents in June 2023
- Data issues re HIE rate/maternity SI's within IQPR for compliance with Monthly Board reporting for Ockenden/CNST. To be added to Risk register no ID as yet as awaiting July DMB
- Inquest found Trust failings that reflected those identified in Trust SI and HSIB report. National PFD given which the Trust is supporting with additional information to support the coroners report to NHS England
- Euroking back copying issue identified- awaiting addition to risk register after July DMB
- 1 stillbirth in June 2023

Next Steps

- Ongoing work with BI when using Datix data. Reviewing the quality of the data collection
- IOL stakeholder group held on 3.7.23 and priority actions developed
- Work with Euroking team, Trust and regional IT leads to understand impact and risk to patient/ Trust

True North: Quality

NHS
Medway
NHS Foundation Trust

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

Key Messages:

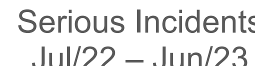
- From May – June 2023 there was 1 declared Serious Incident from the 8 Rapid reviewed presented at IRG.
- Incident Summary: Limb ischaemia due to femoral artery clot post elective caesarean section and subtotal hysterectomy. Mother transferred to Kent and Canterbury Hospital requiring right leg embolectomy and fasciotomy.

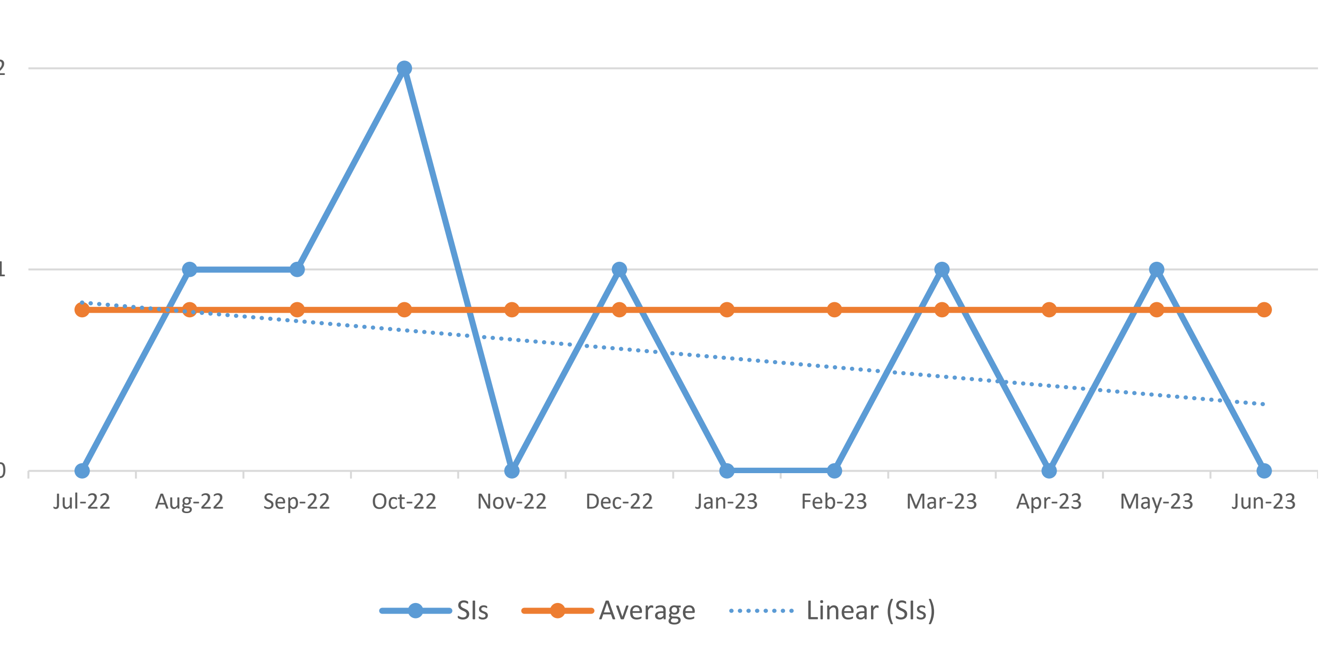
Actions & Improvements:

- Maternity are currently compliant and on target with SI submissions.
- Working better with introducing a robust system to share actions plans with leads from higher investigations.

Issues, Concerns & Gaps:

- ICB have asked HSIB to extend their investigation to review the potential never event (Retained swab).
- The trust undertook a Rapid Review presented at IRG. Did not find any concerns with care but, continue to support investigation.





True North: Quality

Perinatal Surveillance Tool Data Quarter May – June 2023 – Healthcare Safety Investigation Branch (HSIB)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight. **Goal:** To ensure all eligible perinatal losses are reported to the required standard.

Key Messages:

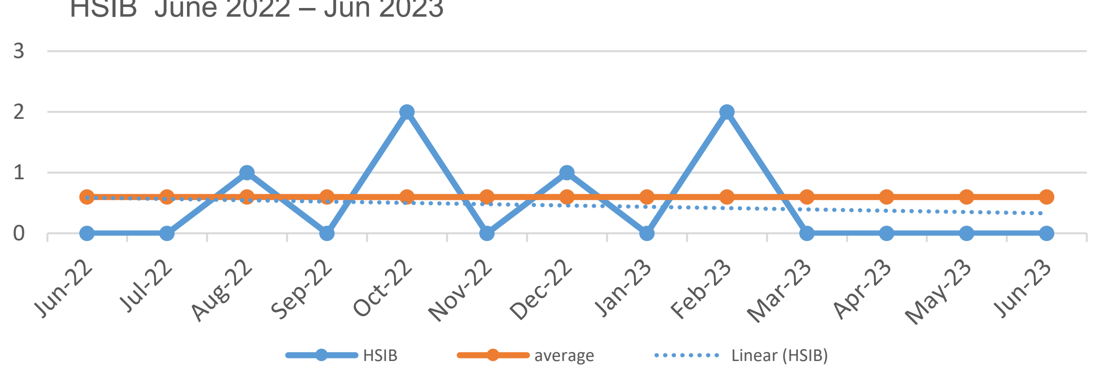
- 0 HSIB Referrals made in May – June 2023
- MFT Continue to maintain100% compliance to report all eligible cases to HSIB and NHSR EN
- The trust have received 2 Final HSIB reports which has been shared personally with staff involved and via our shared learning portal (Friday News) Action Plans created and distributed to leads. No current breaches in completing the action plans.
- The trust is supporting HSIB with a case when maternity was on divert to DVH. A mother presented with an IUD.

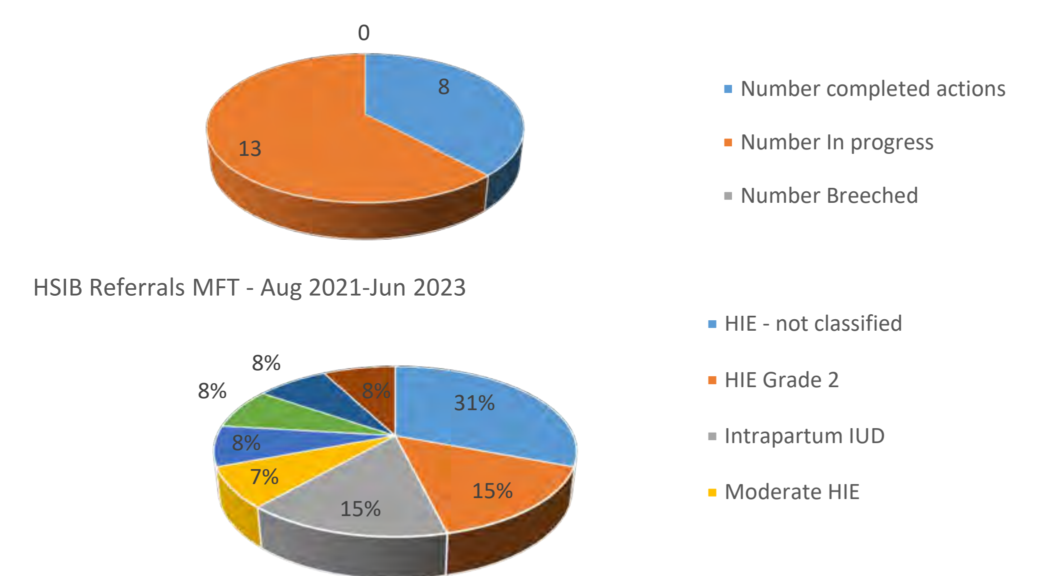
Actions & Improvements:

- Action's meeting with key maternity leads to improve the distribution of safety recommendations from HSIB.
- To encourage the timely management of actions and supporting staff with collecting evidence and sharing recommendations to all staff.

Issues, Concerns & Gaps:

- The Inquest concluded found no neglect by the trust. Identified trust failings which were identified in the HSIB and Trust HLI report. National PFD given which the trust is supporting with additional information to support the coroners report to NHS England.

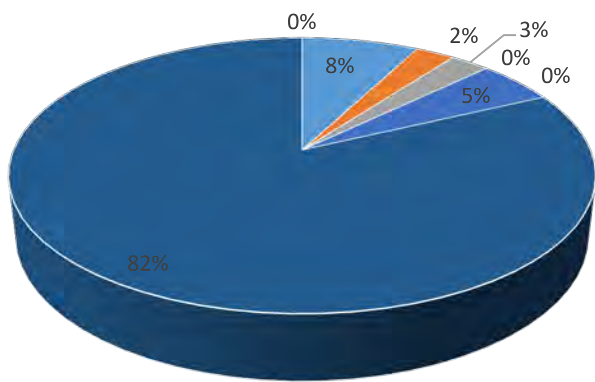




True North: Quality

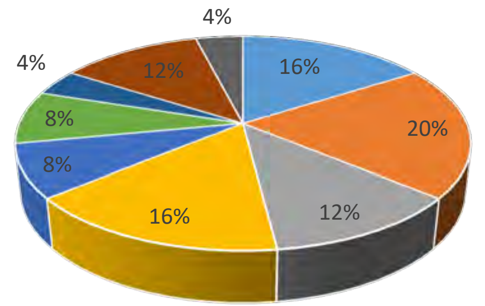
Perinatal Surveillance Tool Data May – June 2023 – Rapid Reviews (RR) and High Level Investigations (HLI)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

NHS Medway NHS Foundation Trust



- Unexpected Admission to NNU
- Post Partum Haemoraghe
- Neonatal Death
- Intrauterine death
- Delay in diagnosis
- Concerns about Care and treatment
- ATAIN
- Unit on Divert

Maternity and Neonatal High-Level Investigations
July 21- June 23



- Unexpected Admission to Neonatal Unit
- Postpartum Haemorrahge
- Concerns about Medical Care and Treatment
- Neonatal Death
- Deteroration of Patient
- Surgical Procedure/Unintended Injury
- Unexpected readmission/reattendance
- Intrauterine death
- Concerns about Nursing Care and Treatment

Key Messages:

- 5 Open HLI's, On target with current deadlines with the support from the Risk Midwives gathering statements & guidance.
- 1 SWARM undertaken in May-June.
  - Baby born in poor condition at 34+1 by category 1 LSCS. Baby admitted to NICU, sadly passed away a few days later. Referred to coroner's.

Actions & Improvements:

- Improvement of sharing draft HLI Reports with staff involved in the incident to conduct an accuracy of accounts following a SWARM.
- All HLI's will be presented at CRIG prior to going to SIRG to create a open culture of the recommended actions which will assist with a more SMART plan.
- Liaise with families to ensure their voices are heard.

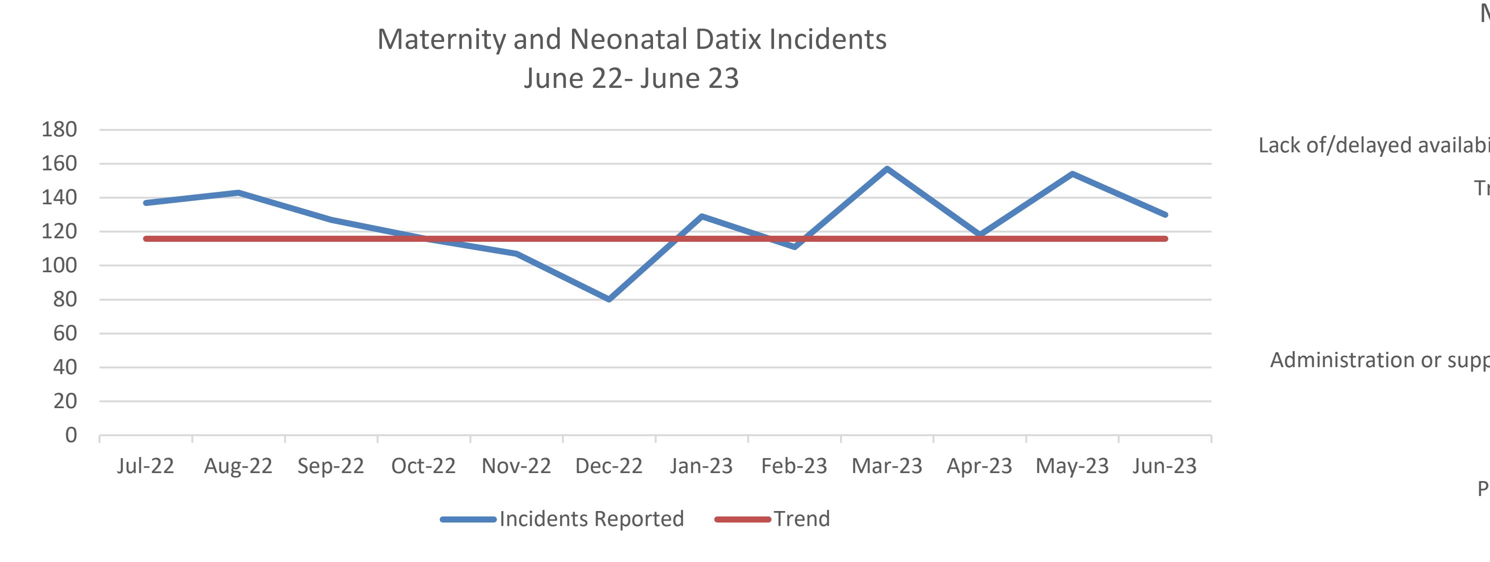
Issues, Concerns & Gaps:

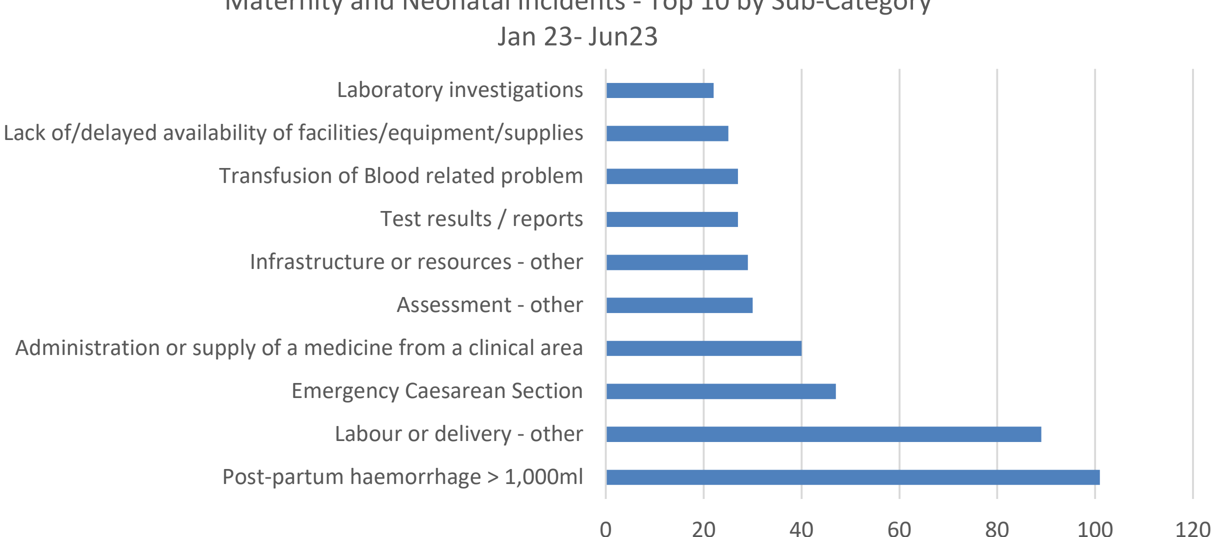
- Potential pre-inquest, Statements being prepared and will be sent to the coroner, to read. Trust has an ongoing HLI for this incident.

True North: Quality

Perinatal Surveillance Tool Data Quarter May – June 2023 – Datix

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





Key Messages: Datix themes – Q1 2023

- PPH & Labour or Delivery were the leading Sub-category's reported in Q1.
- Our key theme was unexpected term admissions to NICU. These were all reviewed at CRIG. Ongoing audit undertaken by fetal wellbeing team.
- Assurance of gathering data from incident's, staff reminded at top 5 huddle and mandatory training to complete Datix's. Trigger List circulated via Padlet & Friday News.

Actions & Improvements:

- Risk & Governance Snapshot poster published in May and shared with staff in the hospital and community settings.
- Improved communication for Datix's via Friday news. Streamlined pathway with the digital midwife in having a more robust system with communicating incident's

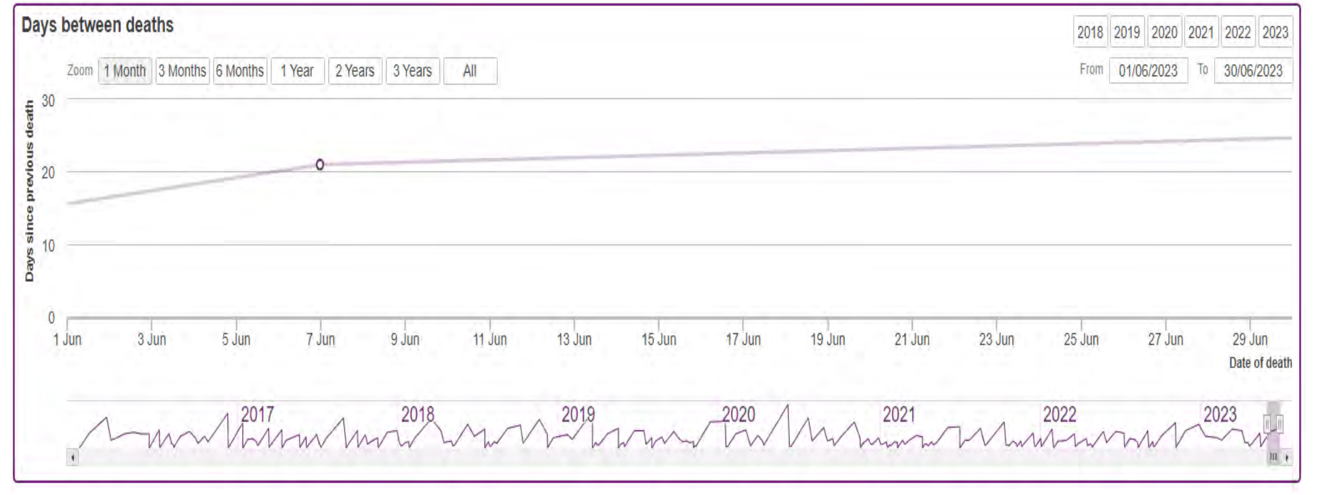
Issues, Concerns & Gaps:

- Continuous work with an MDT compliance of Obstetric attendance at CRIG. Ongoing project to review to support the attendance of Obstetrician's.
- Ongoing work with BI when using Datix data. Reviewing the quality of the data collection.

True North: Quality

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

MBRRACE REPORTABLE DEATHS June 2023



Key Messages:

2 Mbrrace reportable death in June 2023
1 stillbirth 1 of a set of twins – reported at day 0
1 Termination of pregnancy over 24 weeks – reported at 0 days
Notification only required will not require PMRT review
1 Maternity PMRT meeting discussed 2 cases
Care graded at A,A
Parents questions were answered at PMRT and will be sent to them in the report once published
No concerns of care.
Care graded as B,A
This was an SI and will be fed back to the parents once complete
3 PMRT reports signed off

Issues, Concerns & Gaps: same issues as March 2023

Issues raised by PMRT – Transfer of baby for PM. We have an SLA in place with GOSH for perinatal post mortem so no action required
Parents not offered to take baby home – As baby was for post mortem the baby needs to remain in licenced premises. No action required
Telephone conversations not recorded on electronic notes – action plan in place

Actions & Improvements:

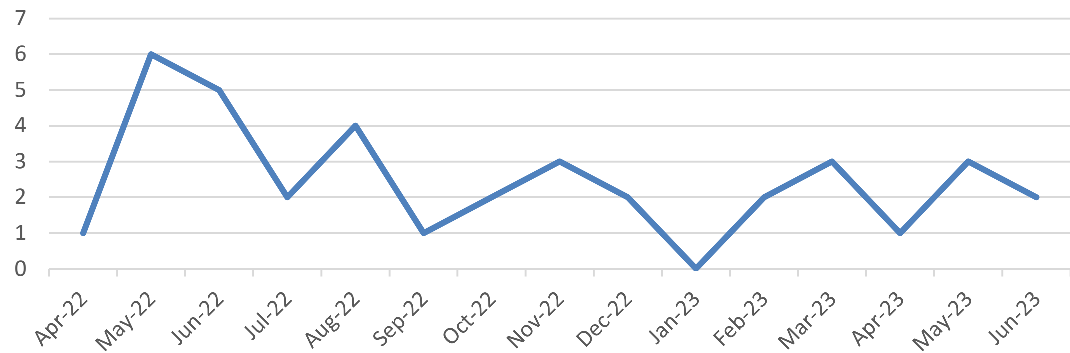
Complete action plan to ensure all telephone conversations are recorded on Euroking

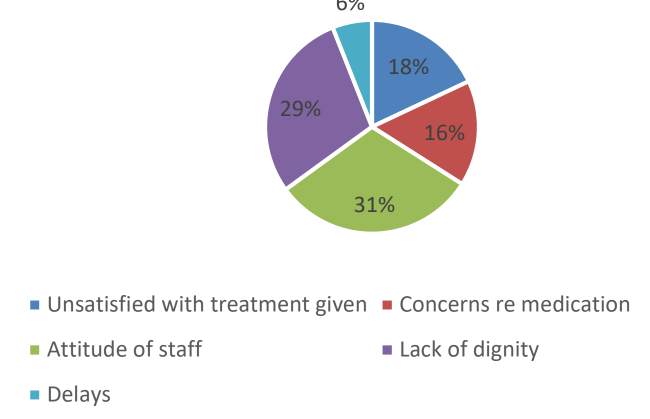
True North: Quality

Perinatal Surveillance Tool Data– Complaints

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

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





Key Messages:

- 6 complaints received in Q1 2023.
- Poor staff attitude noted within as themes
- Complaints are shared at team meetings and via staff comms
- All complaints are contacted at first instance via telephone call
- Of the six complaints recorded in Q1– one had breached its response rate due to multi HCP responses being collated
- Individual reflective conversations are being held with named staff . Named PMA support utilised for this

Actions & Improvements:

- Triangulation with FFT noted especially in relation to delays in the induction pathway
- Engaging leaders to respond to their own complaints
- Trends and patterns feed into mandatory training
- Ongoing work to support patients to be better informed to make choices and personalise care
- Ongoing triangulation with other avenues of patient feedback particularly via the MNVP.

Risks

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Trust unable to manage midwifery vacancies using CCCU students, impacting the workforce required to provide patient care.	In September 2022 CCCU were unable to take year 1 students due to negative feedback relating to both educational and practice placement issues. In February 2023 students were removed from William Harvey Hospital due to ongoing concerns and there was further scrutiny from HEE and NMC regarding student experience at MFT.	MFT are working with CCCU to support them with their action plan for submission to the NMC with a view to them being reaccredited as Midwifery education providers in April 2023.	• Information not forthcoming/confirmed as to what university will be taking responsibility for 2nd and 3rd year students • Only CCCU and a limited number of Greenwich students are currently appointed to MFT	12 (4x3)	06 (2x3)	20 (4x5) ↑	08 (4x2)
Insufficient Midwifery Staffing	Insufficient midwifery workforce to meet demand.	Position slightly improved 16 wte vacancy and 13 wte maternity leave. Covering some shifts with RN's rather than RM's. Engaging with International recruitment, we now have 5 International Midwives in pipeline. Confirmation has been received from CCCU advising that our University intake will not be until 2024.	Staff retention and international recruitment options	12 (4x3)	12 (3x4)	20 (5x4) ↑	04 (5x2)
Delays in Induction of Labour	The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff vacancies.	The A3 has been revised. Pilot project to commence 10 July whereby there will be an Induction of Labour pathway Consultant and Midwife Lead to manage IOL pathway in conjunction with Lead Obstetrician. Daily tracking audit.	Full establishment required Capacity demand and flow review required	12 (3x4)	15 (5x3)	16 (4x4) ↑	04 (4x2)

Risks

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Breach of COSHH Regulations in Delivery Suite as a result of Nitrous Oxide Workplace Exposure Limit (WEL) being breached.	Personal sampling undertaken between 17th and 19th January 2023 has identified a single staff member who exceeded the Workplace Exposure Limit (WEL) for Nitrous Oxide. Several other staff members dosimetry reports were close to the WEL. The report makes several recommendations for the Trust to take forwards in order to mitigate the risk.	• Ventilation subject to annual audit by Trust authorised engineer • Scavenger units in situ in delivery suite rooms	• No ventilation group currently in place. This should report via IPC and Medical gas Group • AE audit findings not shared more widely outside E&F • H&S Team not fully recruited to	09 (3x3)	n/a	09 (3x3) ⟺	03 (3x1)
Potential failure to appropriately risk assess women in the community due to lack of experienced Midwives allocated to work within the community setting.	Due to current staffing concerns within the community setting, B5 and junior/inexperienced midwives are being allocated to work within the community teams. Due to the nature of community work it is difficult to provide close supervision/support to these midwives. Delay in assessment/escalation of clinical situation by junior midwife. Failure to appropriately risk assess women in the community due to lack of experience. Dissatisfaction of the midwife in her role in the community. Increased burden on established midwives within the team.	• Close contact with community team senior sister. • Provision of 'New Starter Pack'. • Supernumerary period of 1-2 weeks. Band 5 Midwives continue to work in the community setting with enhanced support due to high vacancies.	There is a lack of B6 Midwives to allocate to community working, due to high vacancy and maternity rate.	09 (3x3)	09 (3x3)	09 (3x3) ⟺	06 (3x2)
Movement of staff to support acuity on Delivery Suite creates red flags in other areas	Due to staffing shortfalls and high acuity Senior Sisters, community midwives and specialist midwives are being either redeployed or moved from their own roles to cover the deficit. This impacts negatively effective clinical leadership and clinical oversight of the maternity unit. Community midwives are working over the working time directive and staff morale is low.	The movement of staff across the unit has reduced following the implementation of the new on-call roster. However with the high vacancy and maternity factor score remains the same.	Staff retention and recruitment options	09 (3x3)	09 (3x3)	09 (3x3) ⟺	04 (3x2)

Risks

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)	Previous Month Score (C x L)	Current Score (C x L)	Target Score (C x L)
Unable to access patient records at community antenatal clinics	Digital connectivity support inadequate to provide safe clinical risk assessment and record keeping. No/limited access to critical clinical information.	• LMNS discussing Midwives being able to access hard wiring internet at all centres.	IT support to provide consistent connectivity in all community settings	12 (4x3)	09 (3x3)	09 (4x3) ⟺	04 (3x4)
Community Midwifery Premises	There is a lack of community office space for community midwifery teams which is causing disruption to the maternity provision. There is further risk of loss of premises and financial implications due to a lack of contracts for most of the community midwifery venues	• Working with contracts team to get SLA's in place • Still no hub for All Saints. Saxon Way clinics also being misplaced at end of August 2023. Conversations continue to take please with ICB and Space Utilisation group at MFT.	• Appropriate community space to be found and contracts for venues to be written.	09 (3x3)	06 (2x3)	06 (2x3) ⟺	04 (2x2)

New risks to be added -

Risk Title	Description	Mitigations	Gaps in controls and assurances	Initial Score (C x L)
Inconsistent and inaccurate data being shared outside the organisation	Poor quality, completeness and availability of maternity data resulting in reduced efficiency and potential reputational damage	• Preventative measures include regular manual review of data, audit and data cleaning • Digital midwife ongoing working with BI to align front and back end system reporting • Weekly checking of data	Data anomalies continue to be an issue	06 (2x3)
Issues with Euroking back-copying a numbers of answers affecting data quality, statistical analysis, CNST, clinical information accuracy and data used to inform patients.	Another EuroKing Trust (Wrightington, Wigan and Leigh NHS FT, WWL) has identified a large scale issue where some answers in EuroKing have back-forward-copying of answers within workflows. These are at **pregnancy level** and in effect overwrites and/or complete empty fields in previous care episodes. This was in response to a concern raised and confirmed when the software supplier Magentus provided them with mapping of all questionnaires and the report was analysed. The Trust was alerted to this through the Digital Midwives EuroKing network. Some legal records are overwritten or completed when none was there. The amendments and additions can be seen in the auditing software but may be misleading to the front end user. The audit trail offers some insight to what has happened when data has back-copied but is not detailed enough to offer full clarity of where the amendments have pulled from. It is likely that this issue also exists within the Medway version of EuroKing and the full extent is yet to be fully assessed.	Senior discussion including the Trust CNIO, IT Lead, HOM and DOM Assessment of the questions known/suspected to be affected and evaluate for controls available now, i.e. question amendment, staff education, system configuration.	• Further analysis of the workflows when fully received will guide the next wider steps.	To be established

Safeguarding

SIOR - Patients

Successful Deliverables

- 100% Supervision is being provided to all CP case holders
- Pre birth planning remains consistently high for CP cases, 100% achieved for May
- Senior Sister in post for Team Connect to provide additional support and day to day oversight of the teams activities
- Additional Training is being provided to Team Connect to improve practice and develop further safeguarding knowledge and skills

Next Steps

- Continued close working between the Named Midwife for Safeguarding and the Senior Sister for Team Connect, to ensure clarity in roles and ensure robust safeguarding practices are implemented
- Audit on length of stay to be completed by the end of 2023 to compare against the last audit in 2021

Identified Challenges

- New staff in all maternity areas lacking in confidence and experience of managing safeguarding cases in both the hospital and community settings
- High demand on service in all areas, safeguarding is not seen as part of the holistic care provided
- Safeguarding maternity team changes is causing confusion amongst staff of who to escalate concerns to
- Due to increased demands on the Named Midwife for Safeguarding, it is becoming more challenging to be physically visible to staff due to competing demands

Next Steps

- Drop in supervision sessions as well as 1:1 and group supervision is being offered to all staff for additional support
- Named Midwife for Safeguarding is putting the responsibility of safeguarding back onto the allocated midwives with long armed support, this is to encourage a culture of safeguarding being everybody's responsibility and to increase individual confidence and competence in safeguarding practices
- Alternate methods of visibility is being used such as regular telephone ward rounds and teams meetings
- Operational support to be provided to the Named Midwife for Safeguarding
- Roles and responsibilities have been added to the Essential Skills Mandatory Training

Opportunities

- Developing service to better support Teenagers and Young people during pregnancy and postnatally
- Implementation of antenatal toxicology testing
- Improvement in the implementation of the DNA pathway in maternity

Next Steps

- Meeting arranged with Senior Sister for Team Connect and Named Midwife for Safeguarding to discuss implementation and logistics of new proposed Young People Maternity Pathway
- Complete PID for antenatal toxicology
- Distribute new DNA policy and checklist to all staff now that team training has been completed

Risks

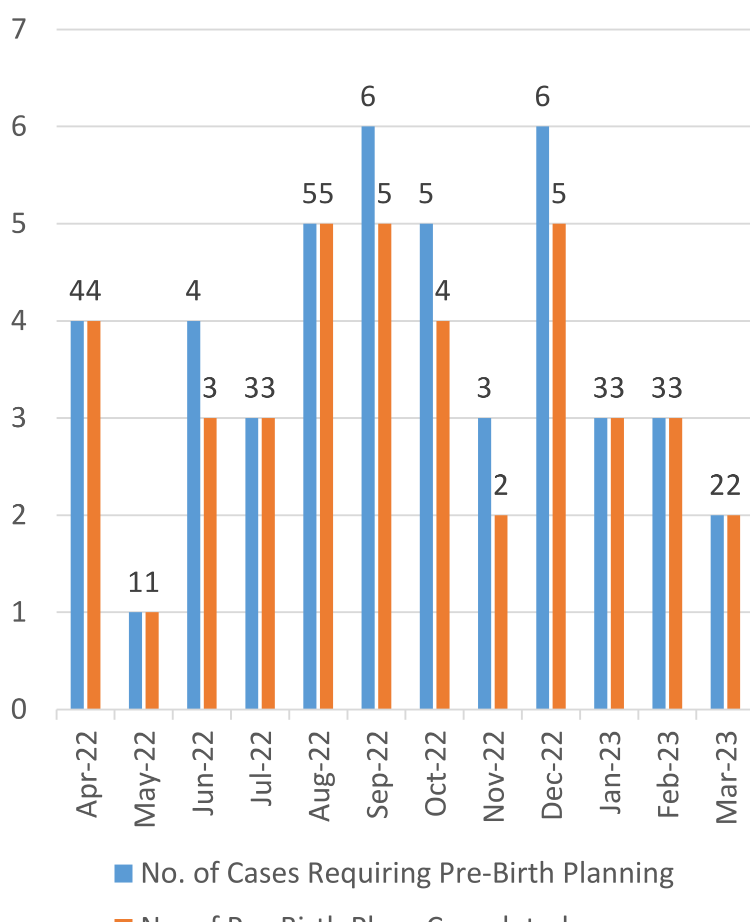
- There is a significant increase of maternity safeguarding activity which is adding to the continually increasing strategical aspects of the Named Midwife for Safeguarding role- this is not sustainable and increases risk of oversight and near misses
- Maternity staff are currently non-compliant for Adult Level 3 Safeguarding training

Next Steps

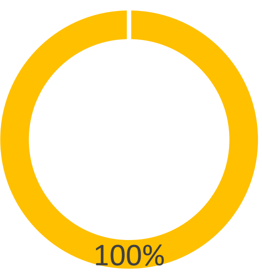
- Following a successful interview a Deputy Named Midwife for Safeguarding is to commence this secondment role in August 2023. This is to support with operational aspects of the role, cover in periods of absences of the Named Midwife for Safeguarding; and develop succession planning
- Information has been sent to all staff to complete the Adults Level 3 Safeguarding training as a priority
- Head of Safeguarding working closely with Workforce to rectify issues with STATMAN reporting of compliance

Safeguarding KPI Scorecard

Pre Birth Plans 2022/23

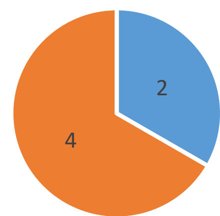


Supervision for CP Caseholders



CP caseholders

Maternity Safeguarding- Reduction In Length of Stay



Average Length of Stay for CP/CIN Cases

Average Length of Stay for Families Awaiting Court

Maternity Safeguarding KPI's include:

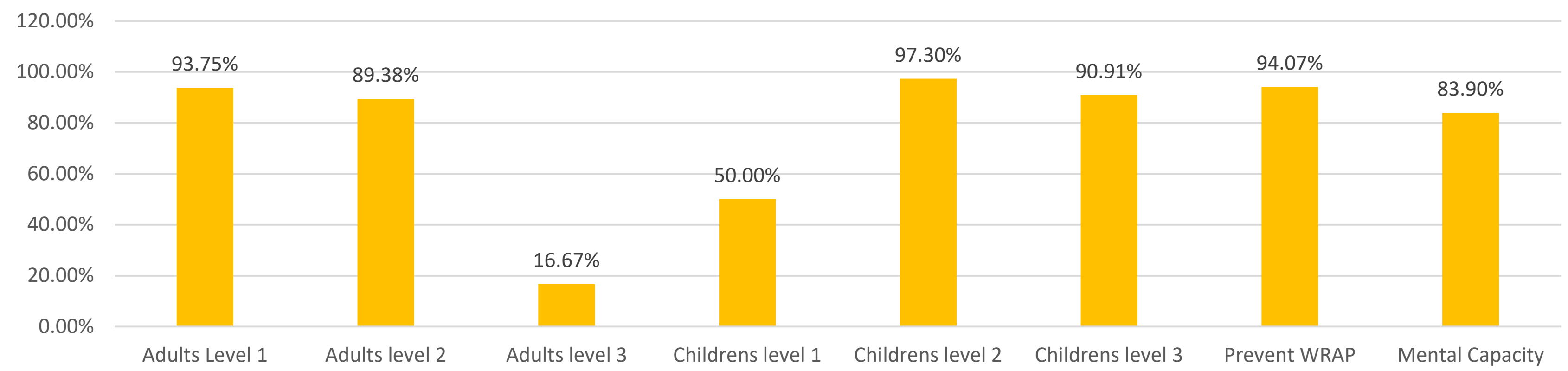
- 100% Pre Birth Planning for CP cases
- 100% Supervision for CP cases
- Reduction in Length of Stay for Safeguarding cases

Key Messages:

- We have achieved the KPI's for CP Supervision and Reduction of length of stay
- 100% of Pre Birth Plans not achieved, this is largely due to delivery prior to 36 weeks gestation. There are 2 within the last year that were not completed due to professional oversight of new member to Team Connect. Additional supervision provided and 1:1 conversations around the importance of robust planning completed
- The data for Reduction of Length of Stay is from the 2021 audit completed. This is due for a re-audit at the end of 2023

True North: Patients

Safeguarding -
Ambition: Excellent outcomes, ensuring no patient comes to harm with no adverse outcome
Goal: Protect others from abuse harm and neglect.

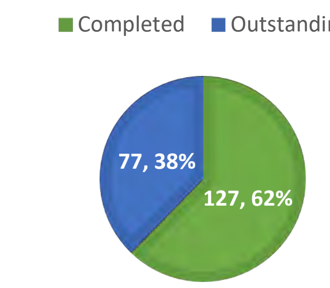


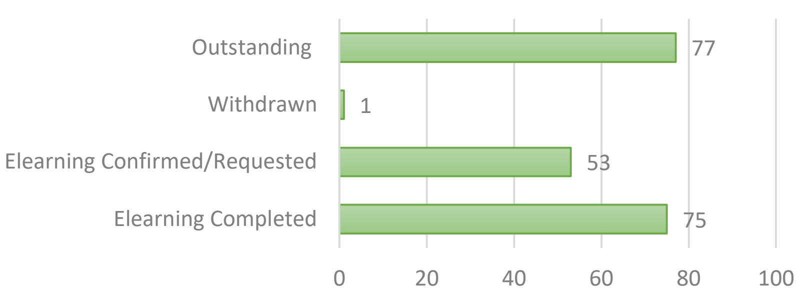
Key Messages:
- Under compliance with MCA training at present in Maternity
- Overall good compliance with safeguarding training with all other areas above the recommendation of 85%

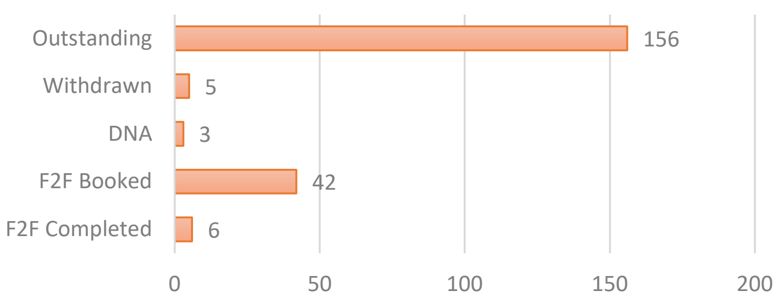
Issues, Concerns & Gaps:
- Maternity have historically not been mapped to Adults Level 3 SG training which was identified by the recent CQC visit as a concern
- Improvement in MCA training compliance is required
- There has been a decrease in the compliance for Level 3 Childrens Safeguarding Training, even though it remains above the 85% threshold

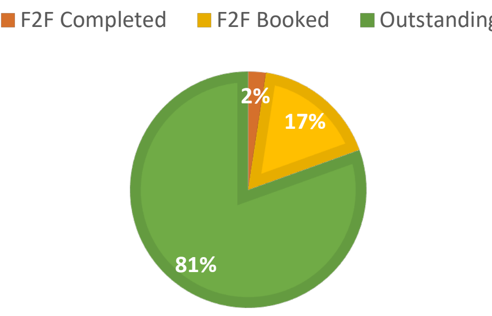
Actions & Improvements:
- All staff have been sent step by step guides on how to complete Adults Level 3 SG training. A large proportion of staff have completed the e-learning element of training
- Head of Safeguarding is liaising directly with Workforce to ensure accurate reporting and data is available
- MCA lead is facilitating bespoke sessions every month to Maternity to improve compliance. Direct emails have been sent to all of those who are non compliant encouraging them to book onto a session. Matrons and Senior Sister are aware of non-compliance and are having oversight of individual members of staff completing this and support time for them to attend training
- Children’s Level 3 SG training has returned to full day face to face training which will be provided jointly between the Named Midwife for Safeguarding and the Named Professional for Children’s Safeguarding to allow cross cover and MDT education

Safeguarding Training







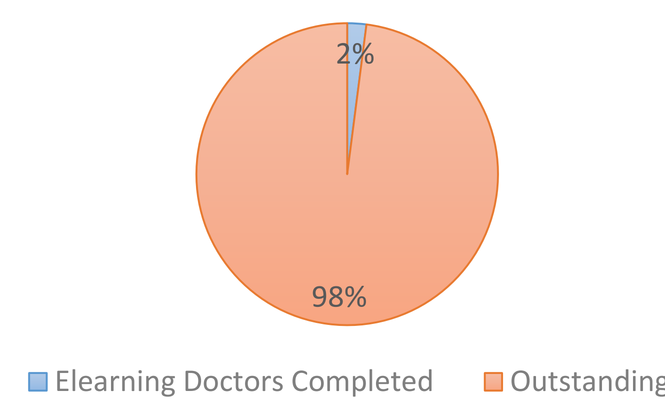


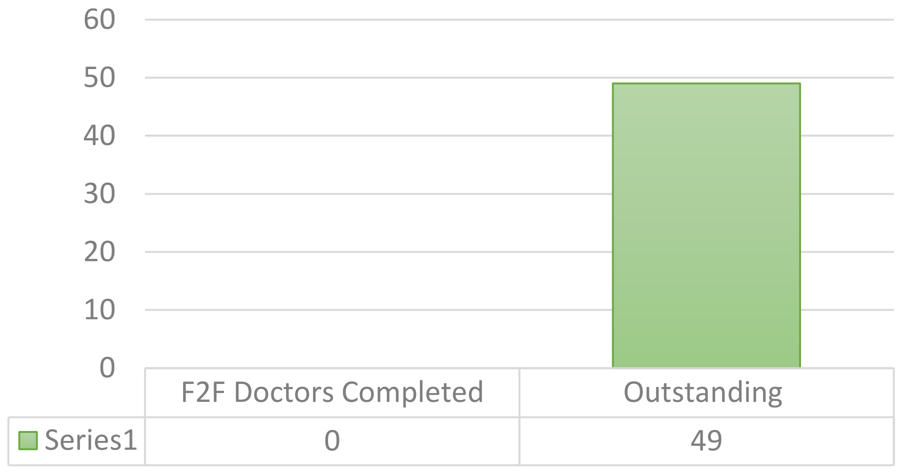
Key Messages:
- 62 % of Midwives have completed the elearning element of Adults LV 3 SG training
- 6 Midwives in total have completed both the Elearning and F2F elements of training which is 2% of the total midwives
- 42 Midwives have booked onto training but need to attend
- Once those booked on attend the training , this will leave 81% of midwives requiring to book and complete training

Issues, Concerns & Gaps:
- Although it is positive that 62% of midwives have completed the e-learning element of training, the expectation was for 100% of midwives to complete this by the 1st May 2023
- F2F sessions have had limited availability to book onto due to high demand which has caused delays for midwives to attend

Actions & Improvements:
- Full day sessions have been added onto ESR for combined Adults lv3/ LD/ MCA/ Prevent training. This will eliminate the need for the elearning aspect of training and overall save time and improve compliance
- To re email all senior sisters and copy in Matrons to ensure their teams are completing training and allocated protected time to do so

Safeguarding Training





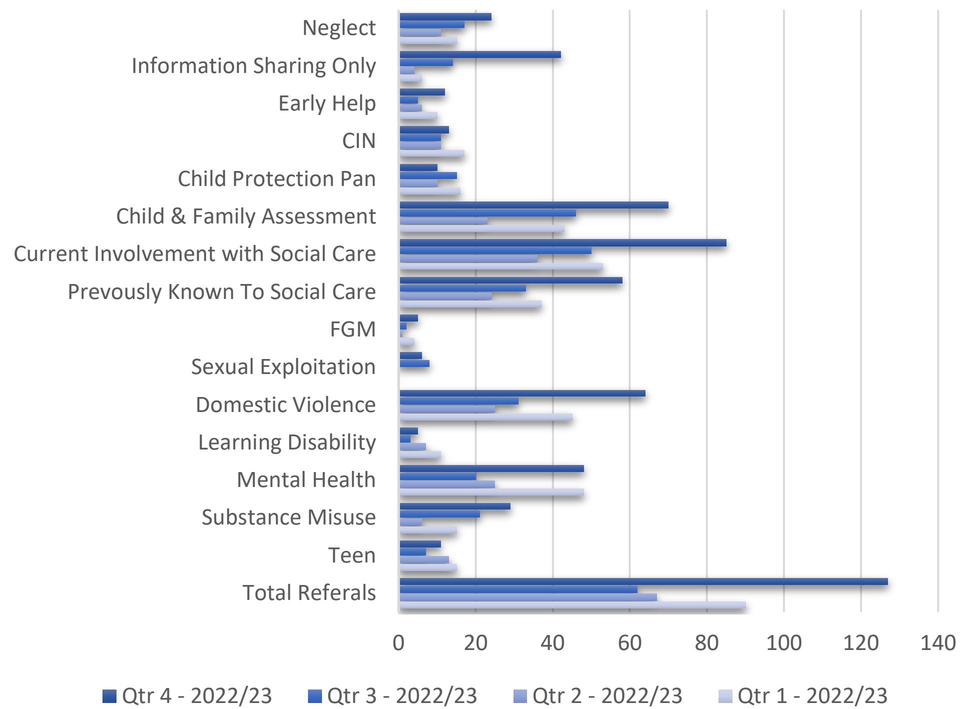
Key Messages:
- 0% of the Obstetric Doctor team are fully compliant with Adult Level 3 Safeguarding Training
- 1 Doctor has completed the elearning element of training

Issues, Concerns & Gaps:
- The obstetric team have voiced that they were unable to access the elearning, or had limited access to this
- Concern that the current perception of completing this training for doctors is deemed low priority or not required

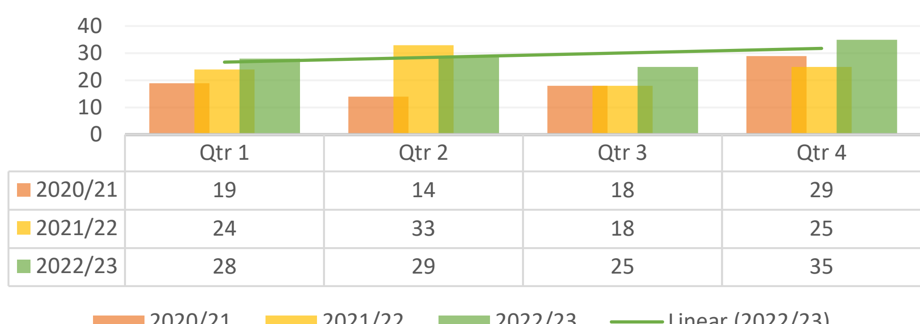
Actions & Improvements:
- Discussed in Labour Ward Forum and Managers that all patient facing clinical members of staff must be compliant in this training, including the obstetric teams
- Emails with details instructions to all doctors have been re sent
- 1:1 Teams meetings and email support has been provided to the obstetric team when requested which has been provided by Named Midwife for Safeguarding
- To seek support from senior management and the education team to further support compliance in this area

Maternity Activity

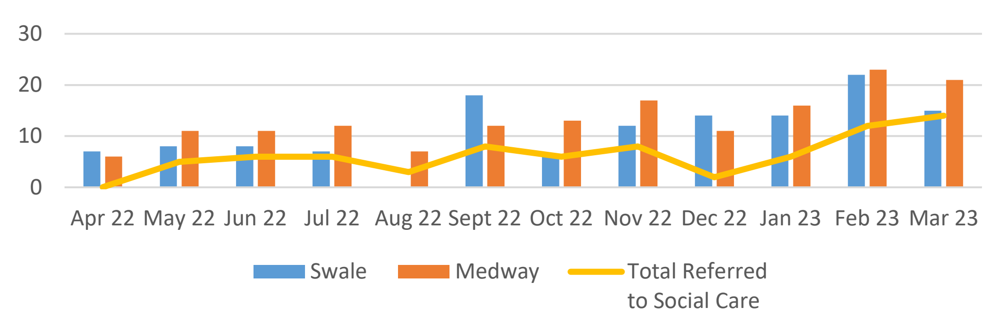
Risks/Concerns Identified on MSF



MASH Requests - Quarterly Data



Hub Referrals & Outcomes 2022/23



Key Messages:

- 346 MSF's were raised in 2022/2023, in comparison to 296 raised in 2021/2022, which is a 16.89% increase
- Main concerns raised were Current Involvement with Social Care and Domestic Abuse
- Upward trajectory in MASH requests needing to be completed, with an overall increase of 46.25% since the year 2020/21 to now
- 191 HUB referrals were heard in 2022/23- there has been a gradual increase in the amount of HUB referrals received which also correlates to the increase in social care referrals required

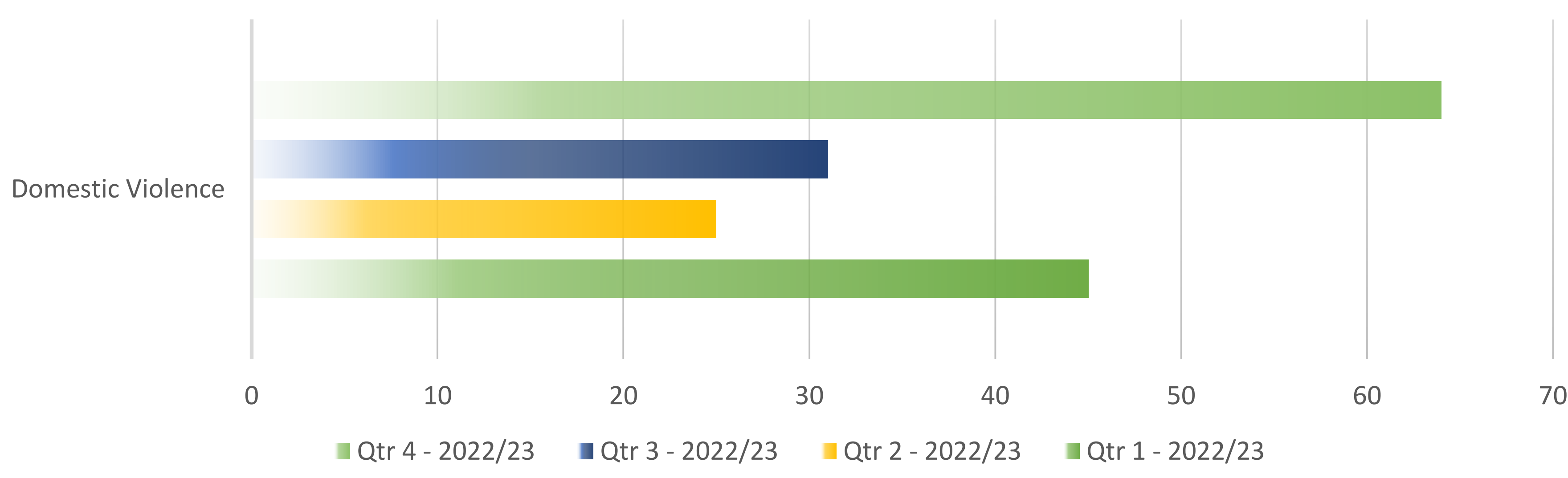
Issues, Concerns & Gaps:

- MASH comes with a set time frame to complete and return, the continued increase in requests could make it challenging to return within the time given which will delay decision making and safety planning
- Overall increase in maternity safeguarding activity is adding to the already heavy workload of the Named Midwife for Safeguarding meaning deadlines are often not being met
- The amount of families with safeguarding concerns are steadily increasing making it more challenging to have robust oversight of the safeguarding care being provided

Actions & Improvements:

- Successful applicant for the Secondment of Deputy Named Midwife for Safeguarding to start in August 2023, this is to provide cover in period of absence, support in the operational aspects of maternity safeguarding, support for the Named Midwife for Safeguarding, and to improve succession planning
- Team Connect are providing additional support in the interim to allow the Named Midwife to focus on the strategical aspects of the role
- Team Connect to provide supervision to community teams to increase oversight of safeguarding practices
- Increased supervision for Team Connect
- Teaching and support to maternity teams from Named Midwife for Safeguarding to improve confidence and competence in safeguarding practices for the long term goal of staff being less reliant on the safeguarding team for step by step guidance

Domestic Abuse



Key Messages:

- In total across 2022- 2023 we have had 165 families identified with Domestic Abuse as a concern; in quarter four alone 64 families were identified
- We have an average of 41 families per quarter with high risk domestic abuse concerns under maternity care
- Medway/Swale remain the second highest area for Domestic abuse in England and Wales

Issues, Concerns & Gaps:

- We rely heavily on self disclosure in Maternity services, and this data is only what is known to us at the time. There is a potential for a lot more families having domestic abuse as a concern that we are not aware of
- Safe enquiry is becoming more difficult in the maternity setting, Safe enquiry requires dedicated time and opportunity to complete. With the high pressures in all areas and low acuity we are missing opportunities for further enquiry
- We have seen an increase in Band 5 midwives in the community setting in 22/23, these midwives particularly tend to lack confidence in safeguard practices and need additional support from more experienced staff members

Actions & Improvements:

- Domestic abuse is included in the Level 3 Children's Safeguarding training for all midwives to keep up to date with current practice
- Professional curiosity is included in the Essential Skills Mandatory training and within this are discussions around Domestic Abuse and safe enquiry
- Collaborative working between Named Midwife for Safeguarding and HIDVA's to provide bespoke training to individual teams within Maternity . This will have a specific focus on how to be creative with safe enquiry, language to use/ rephrasing questions, building fast and trusting professional relationships.

Maternity Safeguarding: Governance Update

Key Messages:
Recent CQC visit Maternity Service received a : Good Rating overall
Childrens Level 3 Safeguarding training compliance for maternity remains high, this is hoped to continue by returning to face to face full day training
Achieving compliance in Maternity for Adults Level 3 safeguarding training remains challenging, however progress is being made in this area
DNA Audit has been delayed due to competing demands, however the new DNA Policy and amended checklist should be more user friendly with the aim to improve practice in this area
Improved Teenage pregnancy pathway recommendation from recent SI has been acknowledged and progress is being made with implementing changes to the service
The Named Midwife for Safeguarding role continues to expand and become increasingly strategic, this has been acknowledged and additional support in the form of a seconded Deputy Named Midwife is being provided from August 2023, this will be reviewed in January 2024.
Rebuilding a culture of safeguarding is everybody's responsibility is a high priority in maternity safeguarding at present
Domestic Abuse remains a high risk area in maternity, combined working between the Named Midwife for Safeguarding and HIDVA's is ongoing to provide additional training and support to staff. This is to be implemented to support service users better and encourage confidence in practice for staff

Continuity of Carer

SIOR

Successful Deliverables

- Decision made to extend retraction of MCoC

Next Steps

- Continue to work with regional and national system to ensure MCoC remains a priority when this can be safely deployed

Identified Challenges

- Midwifery staffing predictions indicate that midwifery staffing numbers are not due to improve by end Q2
- Lack of consistent access to physical spaces for clinical practice in the community and costs associated with this
- Potential for increasing work load, poor work-life balance, financial disadvantages and stress among midwives
- Discussions and plans will be agreed with the Trust HR and Trade Union representatives as part of our implementation plan.
- Close operational monitoring will be required to ensure that all clinical areas are appropriately staffed and not adversely affected by MCoC

Next Steps

- Continue active recruitment initiatives and explore wider opportunities with NHSE/ LMNS workforce leads

Opportunities

- The Birthrate plus staffing formal audit outcome (being undertaken in Spring 23) will be used to support a skill mix review and explore any MCoC opportunites

Next Steps

- While developing and implementing our plans, the Trust will engage with all maternity staff, Maternity & Neonatal Voices Partnerships and clinicians. Plans for rollout of improved provisions will be co-produced with the diverse communities that will be receiving them.

Risks

- Continuity of Carer National target has been retracted until safe staffing numbers are in place
- Trajectory for Continuity of Carer teams in place for 2023-2024 with LMNS/ICB request to have 1 team in place by end of Q2 2023 if safe staffing in place.
- Midwife staffing levels remain challenging and implementing a COC team by Q2 2023 is currently not achievable.
- Consultant midwives are undertaking a scoping exercise focused on improving the current provision at Medway Maternity for women from Black, Asian and mixed ethnicity backgrounds, where outcomes have been significantly poorer than among white women (MBRRACE 2022).

Next Steps

- Recruitment plans will be aligned to the workforce data, quality impact assessment and implementation options.
- Consultant Midwives are currently using Patient First A3 thinking to support the process

True North: Patients

Continuity of Care (CoC):

Ambition: To offer a Continuity of Carer model for all pregnant people

Goal: To ensure safer care based on a relationship of mutual trust and respect between pregnant people and their midwives

Key Messages:

- Continuity of Carer National target has been retracted until safe staffing numbers are in place
- Trajectory for Continuity of Carer teams in place for 2023-2024 with LMNS/ICB request to have 1 team in place by end of Q2 2023 if safe staffing in place.
- Midwife staffing levels remain challenging and implementing a COC team by Q2 2023 is currently not achievable.
- Consultant midwives are undertaking a scoping exercise focused on improving the current provision at Medway Maternity for women from Black, Asian and mixed ethnicity backgrounds, where outcomes have been significantly poorer than among white women (MBRRACE 2022).

Issues, Concerns & Gaps:

- Midwifery staffing predictions indicate that midwifery staffing numbers are not due to improve by end Q2
- Lack of consistent access to physical spaces for clinical practice in the community and costs associated with this
- Potential for increasing work load, poor work-life balance, financial disadvantages and stress among midwives
- Discussions and plans will be agreed with the Trust HR and Trade Union representatives as part of our implementation plan.
- Close operational monitoring will be required to ensure that all clinical areas are appropriately staffed and not adversely affected by MCoC

Actions & Improvements:

- The Birthrate plus staffing formal audit outcome (being undertaken in Spring 23) will be used to support a skill mix review
- While developing and implementing our plans, the Trust will engage with all maternity staff, Maternity Voices Partnerships and clinicians. Plans for rollout of improved provisions will be co-produced with the diverse communities that will be receiving them.
- The SOP requires an update to reflect our current position and trajectory.
- Recruitment plans will be aligned to the workforce data, quality impact assessment and implementation options.
- Consultant Midwives are currently using Patient First A3 thinking to support the process

Feedback- March- June 2023
- Service users
- Staff
- Students

NHS
Medway
NHS Foundation Trust

SIOR

Successful Deliverables

- FFT rate 48%
- Company identified to create revised virtual tour video
- 2 x awards for Maternity from national team received
- Staff cultural survey designed by maternity being rolled out in all wards.

Next Steps

- Continue to promote FFT in all areas
- Procure additional tablets

Identified Challenges

- Decline in recommended rate reflective of IOL delays
- Feedback received re temperature on ward areas
- CCCU students remain displaced

Next Steps

- Continue with quality improvement work around IOL
- Working with HEIs/ LMNS to ensure smooth transition for students once HEIs confirmed.

Opportunities

- To reinstate physical tours
- To improve work/life balance opportunities for staff

Next Steps

- Work with MNVP to ensure tours is service user designed
- Increased scrutiny by Matrons of rosters

Risks

- Need to monitor changes and ensure no service user experience adversely affected .
- Consider choose and book for ANC
- Sustaining opening of MLU
- Review of partner chairs and order as necessary
- Review or air cooling opportunities with estates team

Next Steps

- Recruitment plans will be aligned to the workforce data, quality impact assessment and implementation options.
- Consultant Midwives are currently using Patient First A3 thinking to support the process

True North - Patients

Ambition: To maintain a robust partnership between Trust and our Service Users that works to review and contribute to the development of maternity services

Goal: Ensure the voice of all services users is being heard

Key Messages:

- FFT response rate for maternity in May 48%
- Decline in recommended rate, narrative reflective of IOL experience
- 4 areas for improvement noted from FFT feedback
- Communication
- Estates and facilities
- Managing patient experience in relation to IOL delays
- **MNVP feedback highlights**
- Need to update virtual tour online
- Need to reinstate physical tours
- Communication
- Compassionate conversations

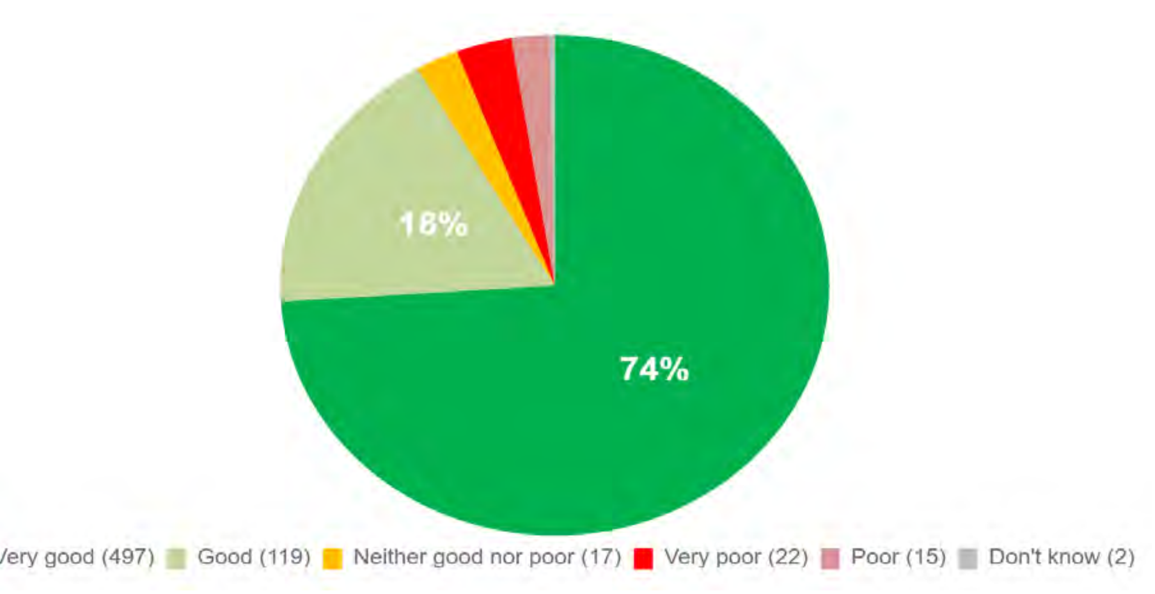
Issues, Concerns & Gaps:

- Need to monitor changes and ensure no service user experience adversely affected .
- Consider choose and book for ANC
- Sustaining opening of MLU
- Review of partner chairs and order as necessary
- Review or air cooling opportunities with estates team

Actions & Improvements:

- Feedback added to BAF
- IOL working group underway
- Share monthly with staff at team talks/ team meetings and via Fridays news
- Ongoing FFT feedback at huddle
- Added FFT posters to above beds

Maternity Friends and Family Test Results 1st January to 30th June 2023
672 responses in total



True North: People

Staff & Student Feedback -
Ambition: To identify issues affecting the internal environment and find solutions
Goal: To nurture positive contribution and engagement from the workforce

Key Messages:

- Staff feedback has been reflective of ongoing workforce challenges
- Staff have shared concerns regarding work/ life balance of rosters
- Noted deterioration in CCCU students morale
- The cultural improvement plan has been shared with the staff
- Team talks, Fridays news and closed social media groups are all utilised as engagement and update platforms for staff.
- Snapshot cultural survey undertaken prior to safety champs walkabout

Actions & Improvements:

- Senior team – increased scrutiny of rosters prior to release
- Staffing establishment posters displayed and shared at team meetings
- Current year 3 Greenwich students interviewed
- 2 x #marvellous awards won by the team and shared with comms

STUDENT TEACHING SESSIONS

Facilitated by Maternity Education Team

- Obstetric Emergencies
- Interview Prep
- Medicines Management
- Documentation Support
- Fetal Wellbeing

0900-1400

26th May 2023
2nd June 2023
21st July 2023
4th August 2023

Staff Cultural Survey Q1 2023/24

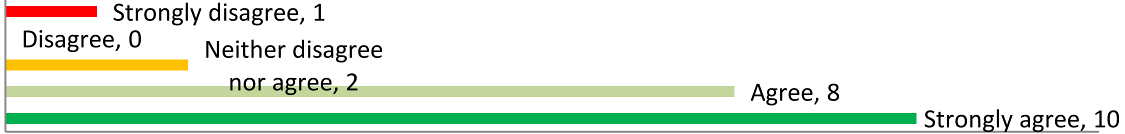
Staff & Student Feedback -

Ambition: To identify issues affecting the internal environment and find solutions

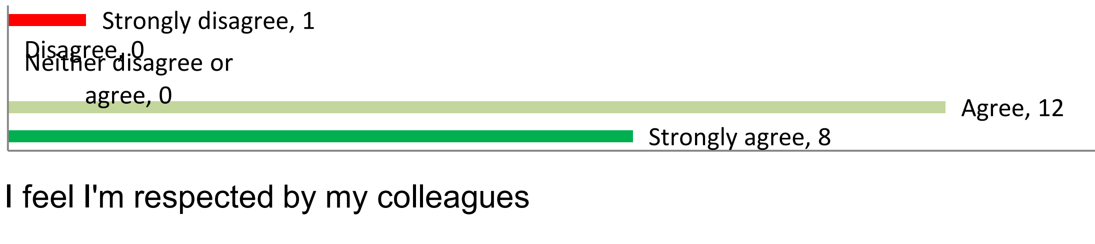
Goal: To nurture positive contribution and engagement from the workforce

Members of my team never reject others for being different and nobody is left out

A year from now I still expect to be working for this organisation



My team treats each other with respect



I feel I'm respected by my colleagues

Strongly disagree, 1
Disagree, 0
Neither disagree nor agree, 2
Agree, 12
Strongly Agree, 6

Key Messages:

- The cultural survey is a valuable real time snapshot of staff reflections
- It is utilised as part of Board safety champion walkabout
- It will also be utilised as part of the staff experience improvement work in relation to the staff survey
- Feeds into the QUAD perinatal culture survey and SCORE survey work

Issues, Concerns & Gaps:

- Unable to identify individual respondents and therefore negative comments need to be taken forwardd collectively and feed into cultural improvement plan on BAF

Actions & Improvements:

- Further develop staff listening events to improve attendance and opportunity for feedback
- Develop improvement plan that is shared with team
- Work with FTSU Guardian to ensure feedback is shared with the care group
- Roll out snapshot survey into NICU
- Include students and Wider MDT into snapshot survey

Ockenden Update

Ockenden 1 Self-Assessment June 2023

True North	Immediate and Essential Action	RAG Jan 23	RAG Mar 23	RAG Jun 23	Comments	Target Date
Quality	**IEA 1: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMNS) oversight**				All requirements of Ockenden met. To work with DOM to improve Board Reporting in line with Patient First methodology.	NA
Patients	**IEA 2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.**				NED now member of MVP meeting and additional quarterly meetings arranged with MVP/NED and HOM/DOM.. Continue to monitor MVP co-production/engagement via CNST Year 4 Safety Action 7	NA
People	**IEA3: Staff Training and Working Together: Staff who work together must train together**				All staff groups >90% compliant for MDT PROMPT and NBLS training Consultant AM and PM ward rounds continue. Audit ongoing PCSP staff training commenced Feb 2023 Ongoing monitoring of compliance	NA
Quality	**IEA4: Managing Complex Pregnancy: There must be robust pathways in place for managing women with complex pregnancies**				Local maternal medicine SOP now in place. Working with LMNS to develop regional maternal medicine centre. Consultant Midwife recruited Maternal Medicine Midwife post recruited to aternal medicine not recruited to. JD revised and recruitment recommenced	NA
Quality	**IEA5: Risk Assessment Throughout Pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway**				Risk assessment guideline now live on QPulse and compliant for Ockenden PCSP eLearning added to PROMPT pre-course training, to capture MDT compliance Risk assessment at every contact audit completed – action plan developed with recommendations LMNS-wide, Personalised Care and Support plans (PSCP) developed and launched February 2023.	NA

Ockenden 1 -Self-Assessment June 2023

True North	Immediate and Essential Action	RAG Jan 23	RAG Mar 23	RAG Jun 23	Comments	Target Date
Quality	**IEA6: Monitoring Fetal Wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**				Appropriate fetal wellbeing leads in post (1.4 WTE midwives and obstetric lead). Trajectory of 100% compliance in new Physiological Fetal Monitoring by end of January 2023	NA
Patients	**IEA7: Informed Consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery**				Action plan in place following MVP website review. LMNS PSCP will also support closing this action when implemented in January 2023. Maternal request audit commenced looking at documentation in intrapartum period when women choosing caesarean section	NA
People	**Workforce**				All recommendations of Birthrate Plus review 2020 recruited to	NA
Quality	**NICE Guidance in Maternity**				Process in place to monitor and review new NICE guidelines and ensure local guidance is appropriate and in date. Conditional formatting added to spreadsheet to ease alert of when guidelines are due for renewal or out of date. Consultant midwife post to lead on guidelines	NA

Complete	Action has been completed and there is robust evidence to support that the action has been completed and where relevant, embedded practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address
Off track with actions to deliver	Action is off track and plan are being put in place to mitigate any delay
On track	Action is on track with progress noted and on trajectory

Ockenden 2 – Self-Assessment June 2023

True North	Immediate and Essential Action	RAG Jan 23	RAG Mar 23	RAG Jun 23	Comments	Target date	Revised Target
Systems and Partnership	IEA 1: Workforce Planning and Sustainability : Financing a Safe Maternity Workforce				Workforce report for 2022 completed presented to Trust Board in Oct '22. Funding for full external BR+ workforce review received and commenced March 2023. Workforce report to go to June Board	Aug 2022	April 2023
Sustainability	IEA1: Workforce Planning and Sustainability: Training				Induction and preceptorship package strengthened. Community Induction pack approved and development of similar packs for all areas completed – including role/band specific information. PMA developing progression packages for staff to support advanced decision-making. Engagement and alignment of practices for AHPs Trust wide	Dec 2022	April 2023
People	IEA2: Safe Staffing				Enhanced Maternity Escalation plan now in place (June 2022). Formal mentorship programme for senior midwives ongoing.	NA	N/A
Quality	IEA3: Escalation and Accountability				Conflict of clinical opinion policy created to support psychological safety amongst the workforce. Elements have been incorporated into new fetal monitoring training package which was launched Jan 2023.	Nov 2022	April 2023
Quality	IEA4: Clinical Governance Leadership				NHSEI self-assessment refreshed and reported to Board Aug 2022. Kirkup EKHUFT report published – awaiting update from national team. Formalise clinical responsibility for guidelines.	NA	N/A
Quality	IEA5: Clinical Governance – Incident investigations and complaints				New CRIG MDT meeting in place and embedded. Continue to strengthen triangulation from clinical incidents and shared learning.	NA	N/A

Ockenden 2 – Self-Assessment June 2023

True North	Immediate and Essential Action	RAG Jan 22	RAG Mar 23	RAG May 23	RAG Jun 23	Comments	Target date	Revised Target
Quality	IEA6: Learning from Maternal Deaths					Maternal death guideline completed including relevant checklists updated – for sign off at LWF. Awaiting national guidance on the allocation of maternal cases to expert pathologist in maternal physiology.	Aug 2022	April 2023
People	IEA7: Multidisciplinary Training					Updated TNA approved in line with core competency framework – now live on QPulse. LMNS training review process established. Simulation sessions across the unit reinstated and closely monitor training compliance.	NA	N/A
Systems and Partnershi p s	IEA8: Complex Antenatal Care					Review pre-conception care with Primary Care. Case note audit to confirm compliance with guidance for diabetes and hypertension. Link made with ICB GP lead	Dec 2022	April 2023
Quality	IEA9: Preterm Birth					Preterm birth guidelines completed and awaiting sign off. “Prem7” antenatal optimisation bundle Quality Improvement project launched in October 2022 with ongoing audit throughout the project.	NA	N/A
Quality	IEA10: Labour and Birth					Development of Midwifery Led Unit operational risk assessment tool complete and new senior sister in post	N//A	N/A

Ockenden 2 – Self-Assessment June 2023

True North	Immediate and Essential Action	RAG Jan 23	RAG Mar 23	RAG May 23	RAG Jun 23	Comments	Target date	Revised Target
Patients	IEA11: Obstetric Anaesthesia					Postnatal anaesthetic follow-up for women and birthing people embedded and local guidelines for anaesthetics reviewed.	Dec 2022	April 2023
Quality	IEA12: Postnatal Care					Audit confirms compliance with consultant ward rounds and review of postnatal readmissions (commenced)	NA	N/A
Patients	IEA13: Bereavement Care					Current workforce covering 7 days where possible. Bereavement champions being identified who will attend additional training to support them in their role	Nov 2022	April 2023
Quality	IEA14: Neonatal Care					Audit to confirm compliance with ODN requirements including born in appropriate location, outcomes of in-utero transfers.	Dec 2022	May 2023
Patients	IEA15: Supporting Families					THRIVE midwife to support women with perinatal trauma commences in Nov. Audit confirms compliance with mental health pathways	NA	NA

Key	Description
Complete	Action has been completed and there is robust evidence to support that the action has been completed and where relevant, embedded practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address
Off track with actions to deliver	Action is off track and plan are being put in place to mitigate any delay
On track	Action is on track with progress noted and on trajectory

CNST UPDATE

CNST

Successful Deliverables

Maternity Incentive Scheme Year 5 received by the Trust.
Year 5 deliverables added to Maternity BAF
Technical data being reviewed by relevant leads
CNST & Compliance Manager engaged in the LMNS working group for year 5 CNST

Next Steps

Meetings are in the process of being scheduled with relevant staff , discussions are taking place in regard to this years scheme requirements for compliance and what is essential to achieve all ten safety actions.
To commence monthly reporting of BRAG status and identification of any risks from August MNSCAB.

Identified Challenges

Euro king Maternity System – data quality
Challenge with recruiting Obstetric medical workforce due to national shortage

Next Steps

To continue to work with BI and Euro king to ensure data accuracy
Ensure locums meet the required RCOG requirements

Opportunities

Opportunity to deliver on the CNST Year 5, ten maternity safety actions. Enabling CNST incentive to support safety improvements within the care group..
Explore opportunity to support increased commitment from MNVP

Next Steps

Map funding received from Year 4 and develop business plan for service development.
Understand financial implication of MNVP support

Risks

Increased training requirements for all staff groups
Releasing staff to complete mandatory training in view of vacancy rate

Next Steps

Review TNA to ensure it incorporates all revised elements
Consider increase in mandatory training uplift to support increased requirements

CNST - Table comparing CNST year 4 and year 5

Commentary highlighted in red indicates a change in wording

	CNST Year 4	CNST Year 5
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Safety Action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Safety Action 4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	Can you demonstrate an effective system of clinical* workforce planning to the required standard?
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
Safety Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Listen to women, parents and families using maternity and neonatal services and coproduce services with users
Safety Action 8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? 10 A local training plan is in place, 2) the plan has been agreed, 3) the plan is developed
Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

Saving Babies Lives Care Bundle

True North: Quality

Safety Action 6: Saving Babies Lives Care Bundle v2 (SBLCB)
Ambition: Support positive clinical outcomes through compliance with SBLCBv2 requirements.
Goal: Ensure compliance with all 5 Elements of SBLCB v3

Elements of the Saving Babies Lives Care Bundle	
Element 1	Reducing smoking in pregnancy
Element 2	Fetal Growth, Risk assessment, surveillance and management
Element 3	Raising awareness of reduced fetal movement
Element 4	Effective fetal monitoring during labour
Element 5	Reducing preterm births and optimising perinatal care
Element 6	Management of pre-existing Diabetes in Pregnancy

Key Messages:

- Currently achieving compliance for booking CO monitoring
- FGR audit to be completed indentifying detection rate of babies under
- Obstetric lead and fetal wellbeing midwives in post.
- Compliant with Birth in Appropriate Location due to level 3 neonatal unit.
- Compliant with administration of magnesium sulphate <30 weeks (>90%) excluding imminent deliveries
- Prep for Prem pathway in place .

Actions & Improvements:

- Action plan for implementation of SBLCB version 3 in progress.
- Additional scanning at 40 being reviewed and business case underway
- Continue working with Maternity Information System to improve reporting and data mapping for Smoking/CO monitoring as per SA 2.
- Smoking and CO monitoring now reporting via MSDS.
- Intrapartum antibiotics for preterm labour now part of SBLCB v3, fetal wellbeing midwives linking with digitial midwife to ensure this is added to the MIS.

Issues, Concerns & Gaps: .

- Intrapartum antibiotics for preterm birth data not being input onto badgernet.
- Continue to monitor compliance of Smoking and CO monitoring manually and cross reference with MSDS, until confident historical mapping errors from Maternity Information System are fixed

Maternity Dashboard Update

Measure	Goal	Red Flag	Apr-23	May-23	Total	•	RAG
Total Deliveries			350	378	728	YTD	NA
Hospital Deliveries %			97	99	98	AV%	NA
TBP Deliveries %			7	8	8	AV%	NA
Home Deliveries %			2.80%	1.10%	1.95%	AV%	NA
BBA's			2	2	71	YTD	
Water Births %			2.50%	3.20%	2.85%	AV%	
Number of SVDs			157	178	335		
% Unassisted Vaginal Deliveries	>50%	<45%	50.40%	47.10%	48.75%	AV%	
Total Instrumental Births %	<10%	>12%	6.90%	7.40%	7.15%	AV%	
% Induction of Labour	<25%	>30%	25.50%	23.30%	24.40%	AV%	
%C-Section (Elective)	<15%	>18%	17.20%	16.70%	16.95%	AV%	
%C-Section (Emergency)	<30%	>30%	32.10%	28.60%	30.35%	AV%	
Total rate % (Elective & Emergency)			49.30%	47.20%	48.25%	AV%	
Number of cases of meconium aspiration			1	0	1	YTD	
Term Baby Admits to SCBU/NICU	<4%	>5%	2.50%	2.10%	2.30%	YTD	
Intrapartum Still Births (>24/40)	0	>0	0	0	0	YTD	
Antepartum stillbirths (>24/40)	4 per 1000 births	>4 per 1000 births	3	0	3	YTD	
Term neonatal deaths < 7 days			1	0	1	YTD	
Number of cases of hypoxic encephalopathy grades 2&3	0	2	0	0	0	YTD	
Number of SIs			0	1	1	YTD	
PPH 1000-2499ml			40	35	75	YTD	
PPH>2500mls	0	2	3	3	6	YTD	
% Breast Feeding at delivery	>70%	<65%	66.50%	62.70%	64.60%	AV%	
% Smoking at Delivery	<10%	>12%	11.40%	11.90%	11.65%	AV%	

True North: Quality

Maternity Dashboard

Ambition: The Maternity Dashboard provides a monthly overview of the Maternity Directorate performance against a defined set of targets against key performance targets and safety indicators.

Goal: To review data against peers, local and national standards

Key Messages:

- The number of spontaneous vaginal deliveries (SVDs) for November was lower than expected range, at 56%. All place of birth choices were available during this period of time
- The number of unexpected admission was slightly higher this month. All babies admitted to NICU were reviewed. The common cause for admission was respiratory issues. There were no incidences of HIE 2 or 3
- The number of caesarean sections (CS) higher than the expected range. This is connected to the low SVD rate. The Clinical Director presented the Caesarean Section audit to Trust Board in June 2023 and round table meeting with key stakeholders is scheduled for July 2023. The leads will be conducting quarterly audits on a number of clinical topics including indication for CS, and any themes that emerge will be managed accordingly as part of the Quality Improvement work of the care group
- There was an increase in the number of cases of Shoulder Dystocia (an obstetric emergency with difficulty in delivering a baby's shoulders and body). Despite this increase, none of the babies born with Shoulder Dystocia had to be transferred to the neonatal unit.

Issues, Concerns & Gaps:

- No LMNS dashboard available since March 23 due to data quality issues
- Data quality risk (ID pending -Score 6) approved at care group in June and will go to DMB in July. For approval and adding.

Actions & Improvements:

- Once the LMNS dashboard is recommenced this will be shared at MNSCAB
- Work ongoing with BI to redesign the maternity dashboard and improve data quality.
- IOL working group underway
- Caesarean section round table July 2023

Maternity Workforce Report

SIOR - Patients

Successful Deliverables

100% of our 2022 B5 midwives remain in post

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

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

Formal Birth-rate Plus review is underway

Next Steps

Further enhance and review flexible working opportunities

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

Identified Challenges

The activity within maternity services is dynamic and can change rapidly

Divert of the MLU (although this is reducing)

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

Next Steps

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

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

Opportunities

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

Next Steps

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

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

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

Risks

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

As a service, Maternity also has a higher-than-average number of staff on maternity leave, year on year

Risk ID Midwifery staffing ID 1134 Score= 16 (increased in June 23)

Next Steps

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

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

True North: People
Planned vs Actual Midwifery Staffing levels- June 2023

Ambition: Achieving safe and appropriate midwifery staffing through implementation of Birth Rate Plus

Goal: Outline the findings from the internal Birth-rate Plus review

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

	Establishment	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	181.89	154.74	9.80	-14.49
MSW's Band 3	24.13	21.49	2.24	-0.40
Total	206.02	182.66	5.55	-14.89

Key Messages:

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

Actions & Improvements:

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

Issues, Concerns & Gaps:

- Need to prioritise women most likely to experience poorer outcomes, including by ensuring most women from Black, Asian and Mixed ethnicity backgrounds and also those from the most deprived areas are placed on a MCoC pathway at the earliest opportunity

True North: People
Workforce Data April – June 2023

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

	April-23	May-23	June-23	Projected July 23
True vacancy	20.46 WTE	16.78 WTE	18.10 WTE	14.49 WTE
Secondments	1.6 WTE on secondment into Band 7 roles	1.6 WTE on secondment into Band 7 roles	2.09 WTE on secondment into Band 7 roles	1.6 WTE on secondment into Band 7 roles
Pipeline	**3.00 WTE recruited** 2 WTE international midwives awaiting arrival 1 WTE B6 going through employment checks	**8.00 WTE recruited** 1 WTE international midwives awaiting arrival 7 WTE B5/6 going through employment checks	**5.80 WTE recruited** 0 WTE international midwives awaiting arrival 5.8 WTE B5/6 going through employment checks	**9.80 WTE recruited** 1 WTE international midwives awaiting arrival 5.8 WTE B6 going through employment checks 3 WTE B% Nurses going through employment checks
Leavers this month	**4 leavers (3.28 WTE)** 3 retiring and returning on flexibank 1 moving to Trust nearer home	**4 leavers (2.76 WTE)** 1 relocated to Australia 1 moved to Trust nearer home 1 moved to NICU 1 retired	**1 leavers (0.96 WTE)** - moving to fertility clinic	**1 leavers (0.45) WTE)** - Relocating to Australia
Leavers expected over next 3 months	**2 leavers expected within next 3 months** 1 moving to Trust nearer home 1 relocating to Australia	**2 leavers expected within next 3 months** 1 moving to a fertility clinic 1 relocating to Australia	**1 leaver expected within next 3 months** - relocating to Australia	**3 leavers expected within next 3 months** 1 moving to Trust nearer home 1 moving to bank only 1 moving to Research
Maternity Leave	13.75 WTE	12.56 WTE	12.56 WTE	14.36 WTE
Average Long Term Sick across month	2.38 WTE	3.55 WTE	3.69 WTE	0.64 WTE

Action Plan

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

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Title of Report	Patient First Strategy			**Agenda Item**	4.3
Author	Toni Sheeran, Deputy Director of Strategy and Partnerships				
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer				
Executive Summary	Patient First is our Trust Strategy. It is our True North, which describes our shared purpose to put our patients first by providing the best of care through the best of people providing excellent care, every time. The Patient First improvement system provides us with a set of tools, behaviours and routines designed to deliver daily, continuous improvement and performance excellence. Patient First helps us clearly define what our key priorities are and supports us to focus on the things that matter most and make the biggest difference to the care we provide. We will need to draw on our staff expertise and experience, about the improvements they want to make in their own areas of work that align with these priorities. The Patient First Strategy is an internal document outlining our commitment to the Patient First Improvement system and ethos, explaining the journey so far and our next steps for the future. Upon approval of this internal document, an external facing document will be co-created with Strategy and Communications colleagues, using Medway and Patient First branding/design and in an easy-read accessible document.				
Proposal and/or key recommendation:	This Strategy is submitted for Board approval.				
Purpose of the report (tick box to indicate)	Assurance		**Approval**	**X**	
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	Executive SDR Executive Group				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	**Priority 2: (People)** ✓	**Priority 3: (Patients)** ✓	**Priority 4: (Quality)** ✓	**Priority 5: (Systems)** ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: ✓	**Effective:** ✓	**Caring:** ✓	**Responsive:** ✓	**Well-Led:** ✓

Identified Risks, issues and mitigations:	N/A		
Resource implications:	N/A		
Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	The strategy outlines our compliance with NHS England's guidance regarding an operational excellence model.		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information or any enquires relating to this paper please contact:	Gavin MacDonald gavin.macdonald3@nhs.net Toni Sheeran tonisheeran@nhs.net		
Reports require an assurance rating to guide the discussion:	Insert Tick		
	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance	✓	There are no gaps in assurance
	Not Applicable		No assurance required.

Patient First Strategy

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Patient First Strategy

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

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Foreword

Introducing our Patient First Strategy

I am delighted to be able to introduce the Trust's Patient First Strategy for the next year. It is a pivotal moment for us as we are one year into our Patient First journey, and redefining how we approach quality and continuous improvement to provide the best possible healthcare services for the people of Medway and Swale in the future.

Patient First is our Trust Strategy. It is our True North, which describes our shared purpose to put our patients first by providing the best of care through the best of people providing excellent care, every time.

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

Patient First helps us clearly define what our key priorities are and supports us to focus on the things that matter most and make the biggest difference to the care we provide. We will need to draw on our staff expertise and experience, about the improvements they want to make in their own areas of work that align with these priorities.

Jayne Black, Chief Executive

Patient First is our ethos; it is how we do things at Medway NHS Foundation Trust and supports us with delivering high quality care in a sustainable way. After the first year of implementation, we continue to build on our successes and have taken lessons from the first year to inform our new Patient First strategy for the next year, underpinned with a set of values and behaviours against which we hold ourselves to account.

The True North ambitions for quality, people, patients systems and partnerships and sustainability give us the relentless focus on continuous improvement to improve experiences and outcomes for our patients and staff.

Gavin MacDonald, Chief Delivery Officer

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Patient First Strategy

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 is a tried and tested improvement methodology and management system recognised by NHS England for enabling the fast-paced delivery of sustainable and embedded change. It provides a framework that helps us to articulate our Trust's core objectives using common language, improvement tools and techniques as well as 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

About the Trust

Medway NHS Foundation Trust serves a population of more than 424,000 across Medway and Swale (Sittingbourne and the Isle of Sheppey). In 2022, we provided care for more than 125,000 patients in our Emergency Department and more than 88,000 inpatients on our wards. More than 278,000 outpatient appointments took place, and in our maternity care services, more than 5,000 babies were born in the hospital and community.

As an NHS Foundation Trust, we have a 26-strong Council of Governors with more than 10,000 public members. We employ 4,400 staff, making us one of Medway's largest employers.

NHS Long Term Plan

The NHS Long Term Plan (2019) was developed by a variety of frontline health and care staff, patient groups and other experts. This 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. 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 wherever possible. When people no longer need to be in hospital, they should then 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:

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- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems, and
- 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 that NHS England is asking for. 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.

Mission, vision and aspirations

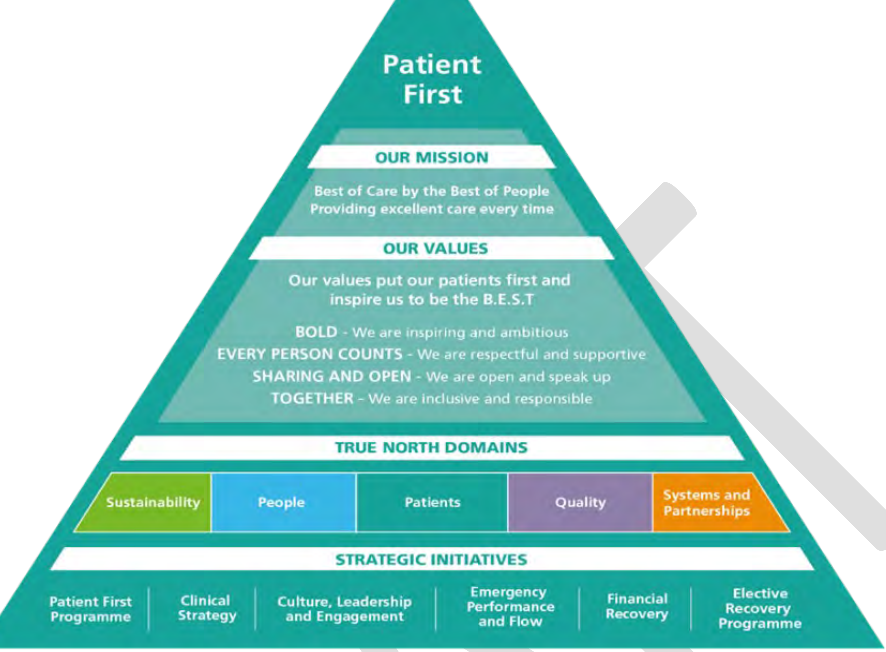
Patient First is our structured approach and overarching strategy to empower and enable all staff to improve our services and meet the needs of our patients and local community. Our mission is to provide the "best of care by the best of people", providing excellent care every time. By 2028, our vision 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 patient experience without boundaries.

Patient First highlights our core commitment to putting the patient first every time. We do this by focusing on continuous improvement, delivering the best of care through the best of people. The Trust's values underpin everything we do and we all work to these values in the delivery of safe, consistent and high quality patient care.

The guiding principles of the Patient First programme build on our successes of the past, but bring greater clarity, structure and support so that we can make improvements that are more significant, 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 Strategy

‘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 leadership behaviours.



Building on this strategy ‘triangle’, our True North domains have the following ambitions and visions:

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 interactions are prompt and positive.

Ambition:

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

Visions:

Timely care in the right place at the right time.

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

Ambition:

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

Vision:

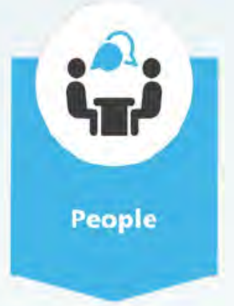
To reach a sustainable or recurrent break-even position by 2027/8.

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.



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.

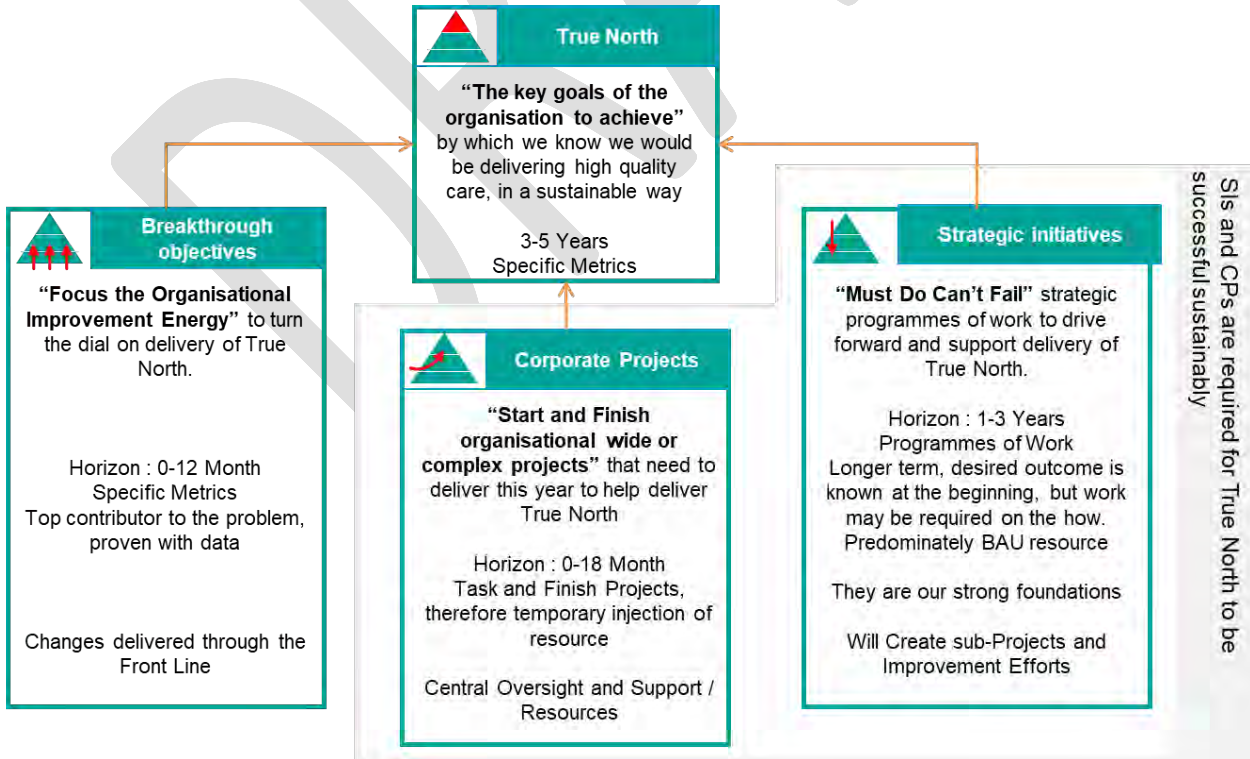
Patient First Strategy

We are currently reviewing our Trust values, to ensure full alignment with Patient First. Whilst we know that we aspire to be the B.E.S.T (bold, every person counts, sharing and open and together) – we have grown exponentially as a Trust over the past year by implementing continuous improvement and empowering our staff, and feel this should be reflected. An initiative to refresh our values began in June 2023 and is being led by the Chief Delivery Officer through an A3 process, while we continue to embed the well-established values.

The Trust will continue to create and build a culture of continuous improvement by identifying and communicating a set of priorities. This ensures that all staff can align with the organisation's strategy deployment and understand their contribution to achieving the strategy.

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 reach our True North. These are breakthrough objectives, corporate projects and strategic initiatives. The diagram below describes what each area is, the desired outcome and the timeframes for delivery. These are reviewed on a yearly basis by the Trust Board, Divisional and Care Group leads. This has been completed in May 2023 and will continue to be reviewed through the Trust Board and Executive strategic deployment reviews.



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Patient First Strategy

To deliver the Patient First Strategy and continuous improvement 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 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 will be developed to support the strategic framework. These include; Clinical Strategy, People Strategy, Patient Experience Strategy, Quality Strategy and Financial Sustainability Strategy. There are also supporting strategies that will align to each of our True North domains, such as Data and Digital Strategy and the Estates and Facilities Strategy.

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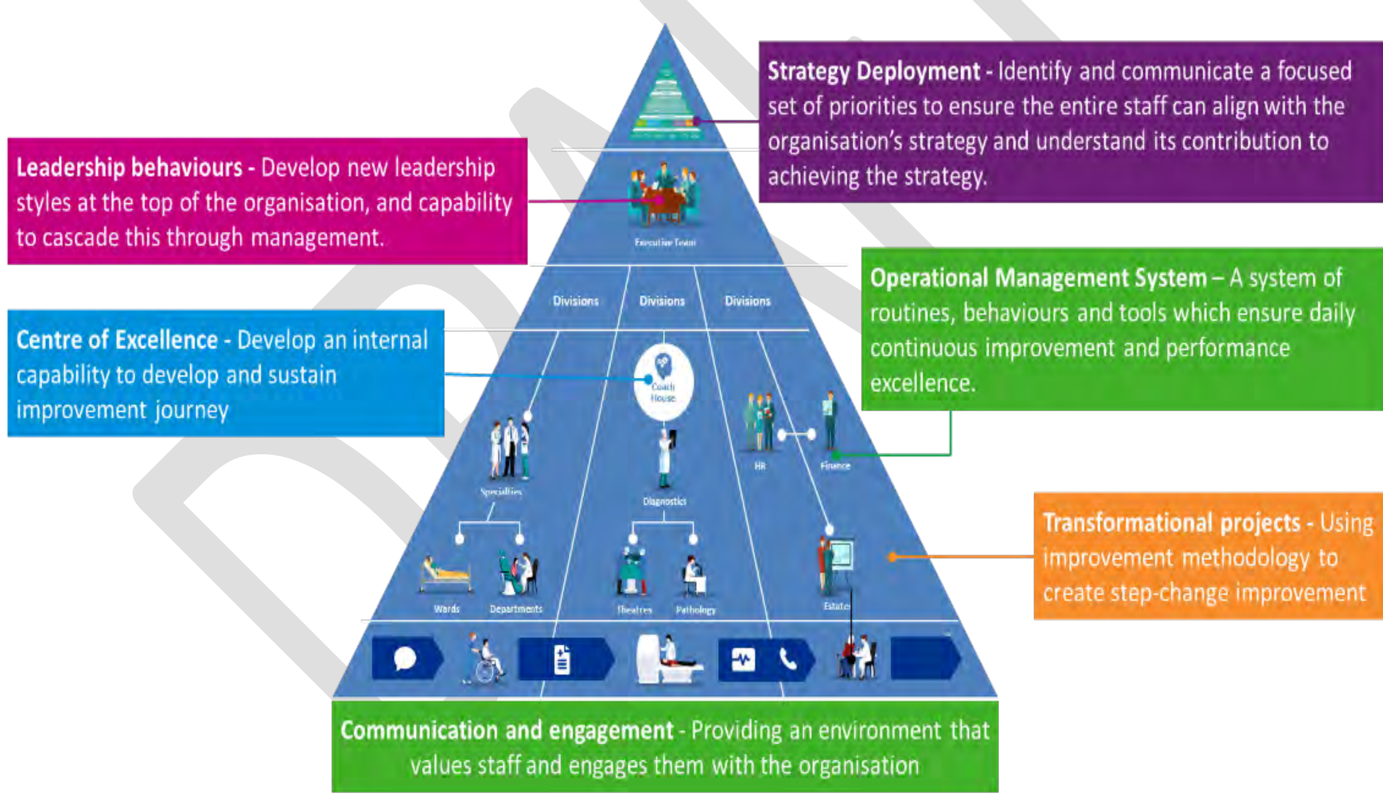
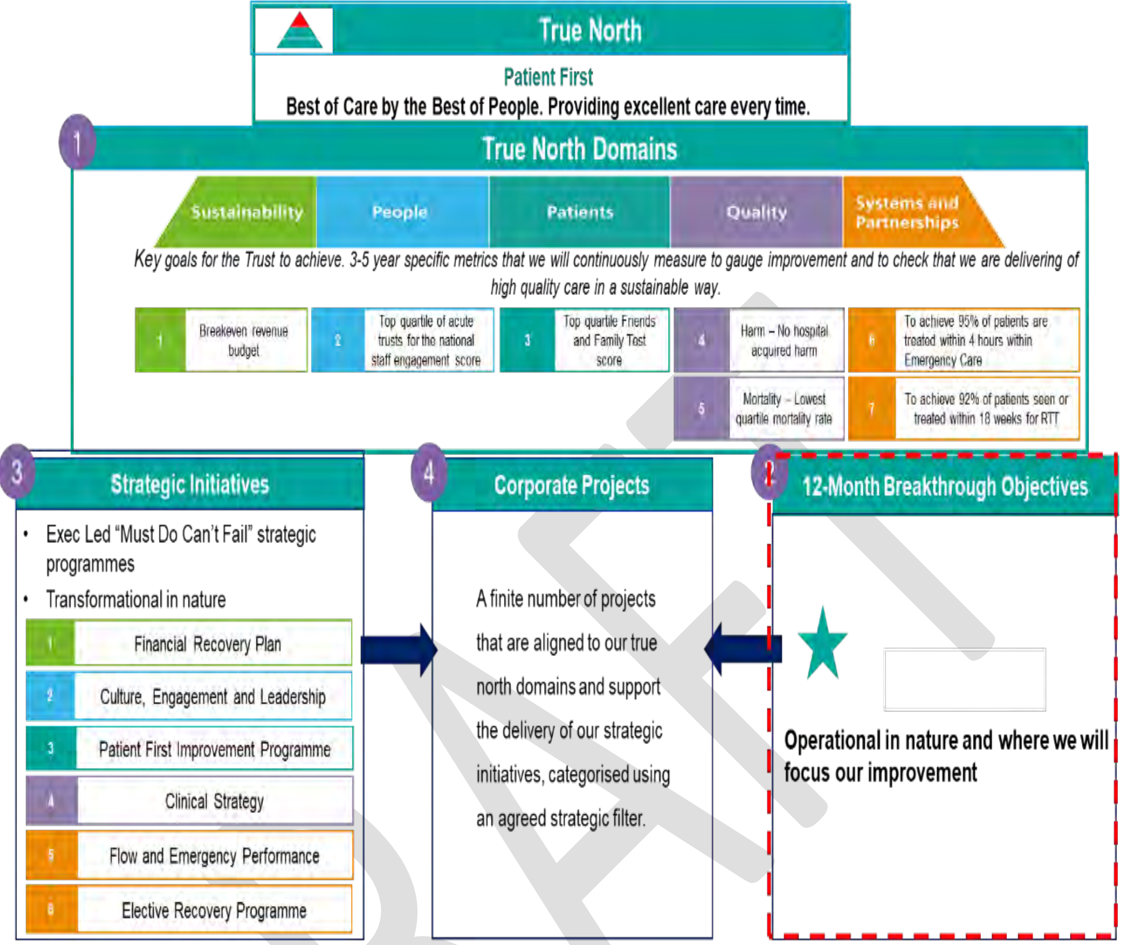


The strategic planning framework of this approach is outlined below:



The strategic planning framework builds assurance from Ward to Board. In order to deliver this the Patient First Improvement System (PFIS) 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 a task using the best-known methods.

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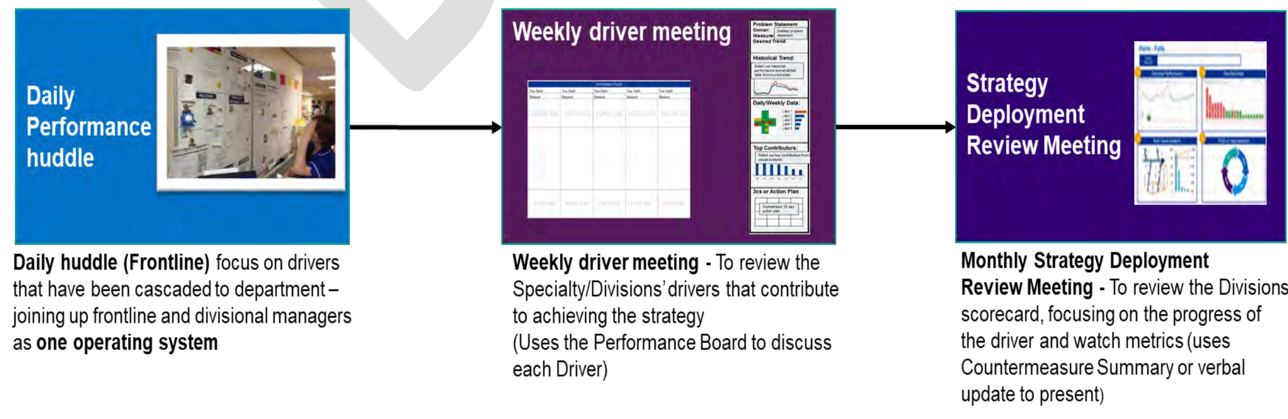
PFIS Wireframe

Strategy
Sustainability | People | Patients | Quality | Systems and Partnerships
Annual Objectives and Target Setting
Finance, Planning and Performance | People Committee | Quality Assurance | Audit and Risk | Nominations and Remuneration

Exec | Division | Care group | Frontline
Breakthrough Objective Huddle
Exec SDR (TMB)
SI's and Corp Projects Huddle
Strategic Initiatives and corporate projects
Information flow (improvements)
Divisional SDR
Info. flow
Weekly driver meeting
PC | UIC
Care Group SDR
Go and See
Frontline SDR
Daily huddle

The above diagram shows how the daily improvement huddles feed in to the monthly Executive Strategy Deployment Review (SDR) meetings and the bi-monthly Trust Board. To establish the 'drumbeat', our Frontline colleagues complete daily improvement huddles, which focus on opportunities for improvement in their areas that link through to the Trust breakthrough objectives. This information is then shared on a weekly basis at the Care Group Driver Meeting, the Divisional Driver Meeting and through to the monthly Divisional and Trust wide SDR meetings. To complement this the breakthrough objectives are reviewed at individual weekly huddles, led by an Executive Senior Responsible Officer (SRO).

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 huddle (Frontline) focus on drivers that have been cascaded to department – joining up frontline and divisional managers as **one operating system**

Weekly driver meeting - To review the Specialty/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 Countermeasure Summary or verbal update to present)

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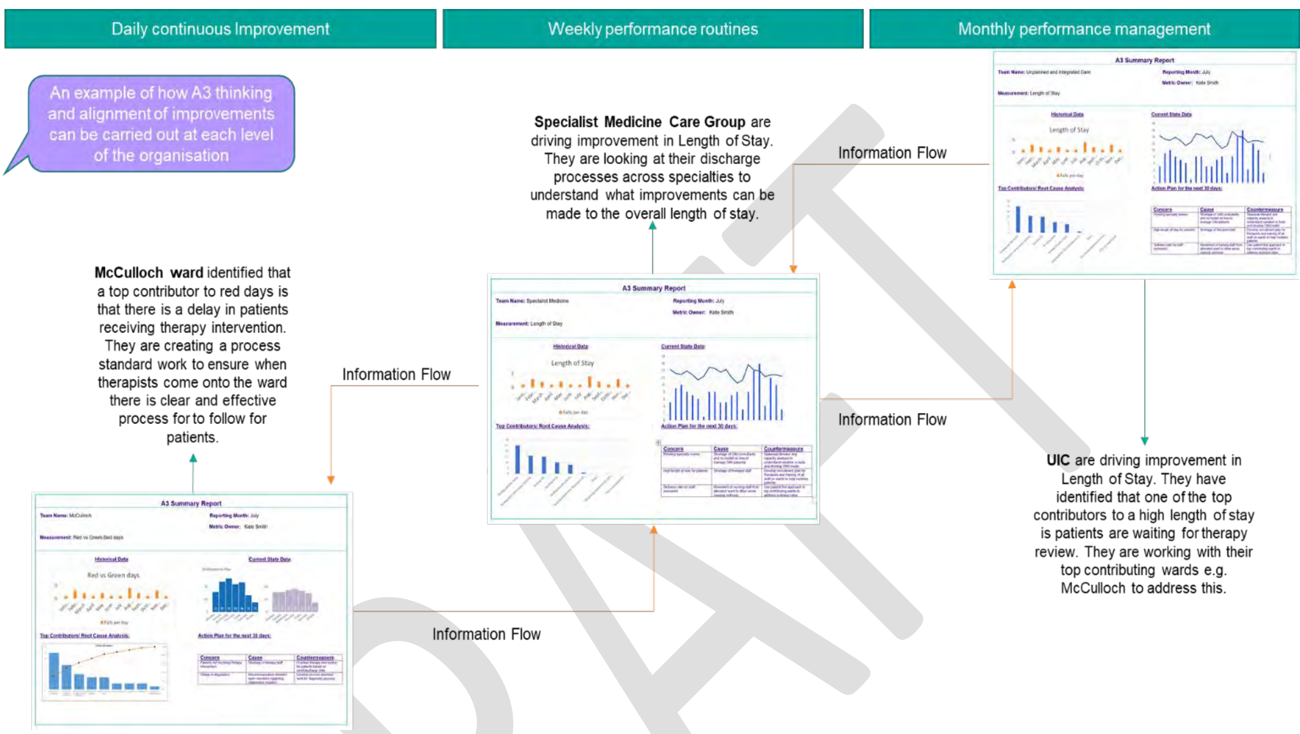
The data in the graphic below is taken from our Patient First Performance Dashboards. This outlines each area of work against our Trust-wide targets, which equates to daily improvements leading to large-scale change. The example below shows how the Trust is reducing length of stay for our patients. These dashboards are available for all staff, so they are able to review their progress.



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The Integrated Quality and Performance Report (IQPR) is a key document in ensuring that the board is sighted on key areas of concern in relation to a range of internally and externally set Key Performance Indicators (KPIs). The IQPR is newly 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, Care Group and Ward level, displaying one single, consistent version.

Strategic Initiatives enable long-term transformational organisational sustainability. 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 organisational wide or complex projects that need to deliver within 12-18 months to help deliver True North and are a product of alignment to Strategic Initiatives, Breakthrough Objectives or regulatory requirements. Corporate Projects are reviewed through the Strategic Filter by Executive colleagues at the monthly

Patient First Strategy

Strategy Deployment Review meeting to enable the project to be categorised as either Mission Critical, Important, Wait or Business as Usual with a review of resourcing aligned and requested. Trusts Corporate Projects are:

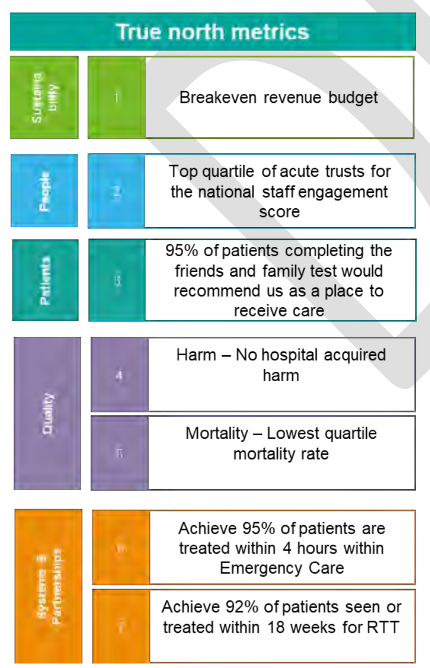
Mission Critical
CQC Well-Led
EDN Backlog
Efficiencies Programme Flow and Discharge Outpatient Optimisation Theatres Optimisation
Endoscopy Additional Capacity
Patient Safety Incident Response Framework
Sharps
VTE Pathway

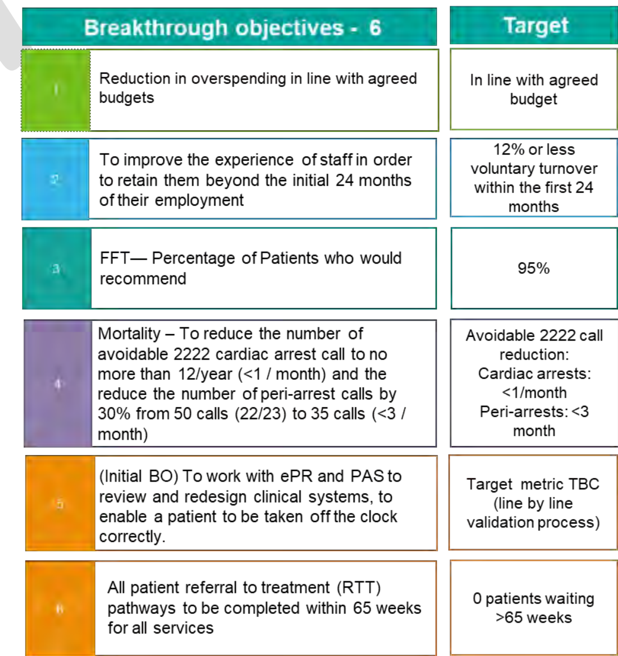
Important
Cauda Equina Pathway
Deteriorating Patient Dashboard
Neck of Femur Fracture Pathway

Breakthrough objectives

Our priorities are identified for each of our True North domains by setting a Breakthrough Objective. These breakthrough objectives are reviewed on an annual basis. Breakthrough objectives should:

- Be translatable to the frontline in a measureable and meaningful way
- Support us with engaging Trust-wide on Patient First
- Be objectives we can cascade to wards and departments – so teams at every level can be actively involved in making progress.





Patient First Strategy

Achievements in 2022/2023 were:

- **Systems and Partnerships** - Success from the Neurology Department where the team managed to reduce 40-week Referral to Treatment (RTT) waits for first appointments from 374 patients in August 2022, to two patients in the week beginning 16 January 2023.
  Waiting times for a first Cardiology appointment fell dramatically in six months, from an average of 64 weeks in October 2022, to 39 weeks by the end of April 2023.
- **Patients** FFT improvements - A pilot designed to help inpatients get a better night's sleep during their stay rolled out on four wards.
- **Sustainability**- Over the last financial year the Trust-wide efficiency programme was launched to optimise the use of medicines and realise savings through the rationalisation of medicine use. Pharmacy colleagues have identified £1 million savings.
- **Quality**- Colleagues recorded a sustained reduction in avoidable cardiac arrest calls across acute and emergency care from an average of five calls per month to just one.
- **People**- The Appraisals target was achieved and has continued to be met for the sixth consecutive month in July 2023

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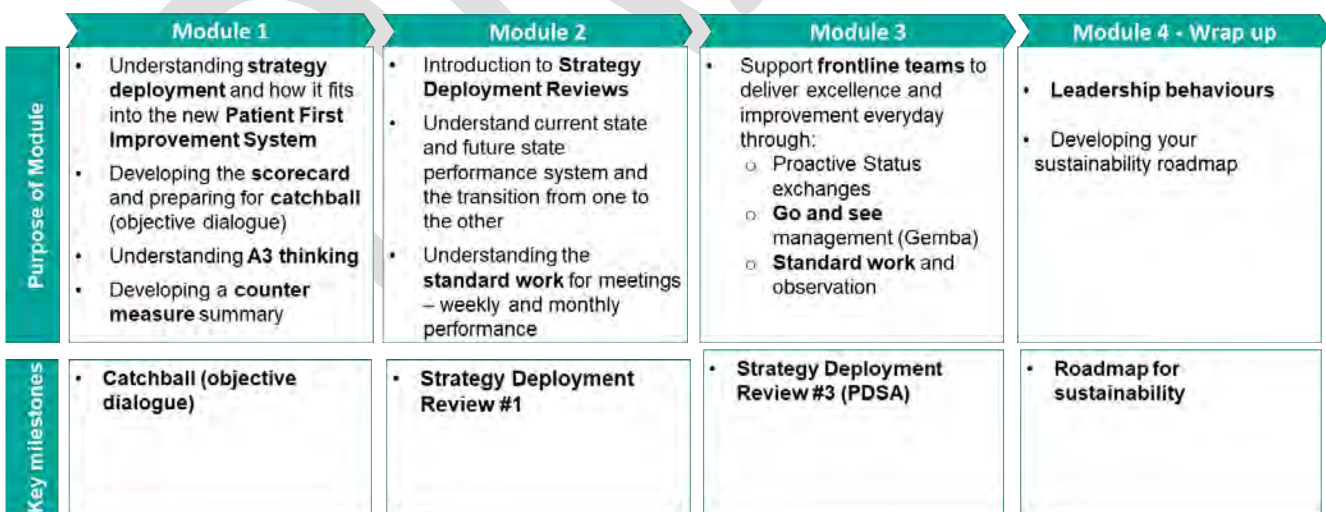
Training and development in Patient First

In order to support the Patient First programme, our Transformation Team has begun 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. The high-level overview of facilitated training is listed below



	Module 1	Module 2	Module 3	Module 4 - Wrap up
Purpose of Module	• Understanding **strategy deployment** and how it fits into the new **Patient First Improvement System** • Developing the **scorecard** and preparing for **catchball** (objective dialogue) • Understanding **A3 thinking** • Developing a **counter measure** summary	• Introduction to **Strategy Deployment Reviews** • Understand current state and future state performance system and the transition from one to the other • Understanding the **standard work** for meetings – weekly and monthly performance	• Support **frontline teams** to deliver excellence and improvement everyday through: ○ Proactive Status exchanges ○ **Go and see** management (Gemba) ○ **Standard work** and observation	• **Leadership behaviours** • Developing your sustainability roadmap
Key milestones	• **Catchball (objective dialogue)**	• **Strategy Deployment Review #1**	• **Strategy Deployment Review #3 (PDSA)**	• **Roadmap for sustainability**

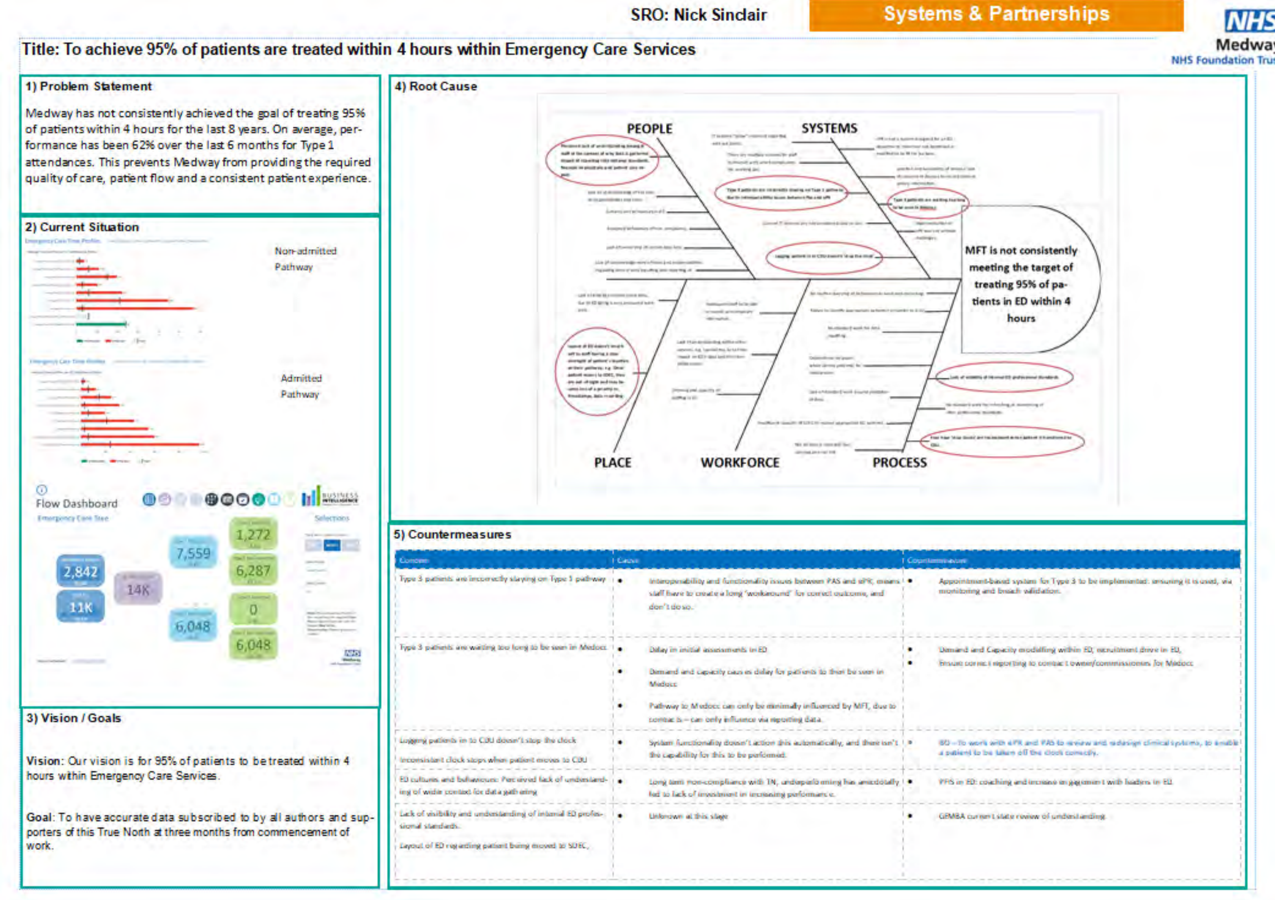
Further to the above, there is a digital training offer for all staff beginning in 2023, which will allow online training for appropriate elements of the course.

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:

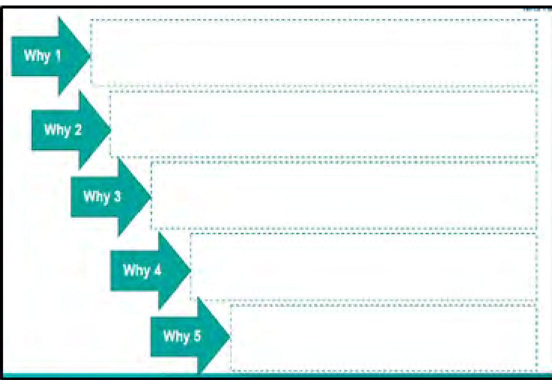
A3

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.



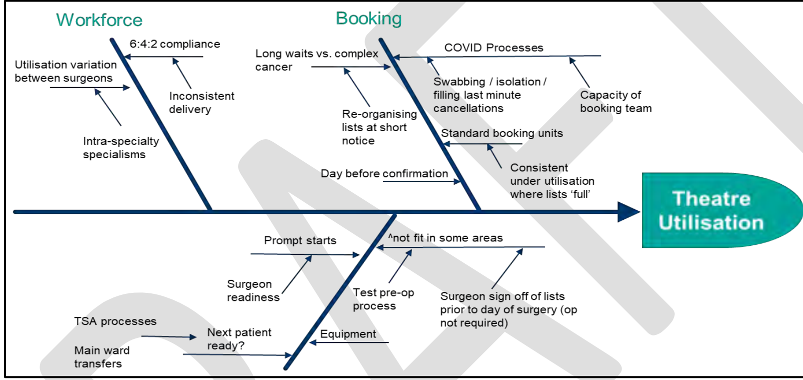
5 Whys

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.

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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%																									

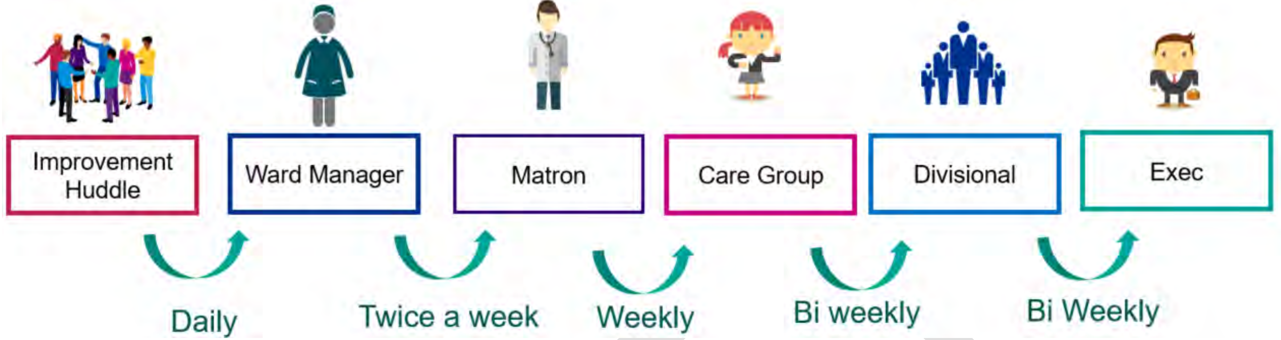
Standard Work

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. Below is an example as used by the Executive team:

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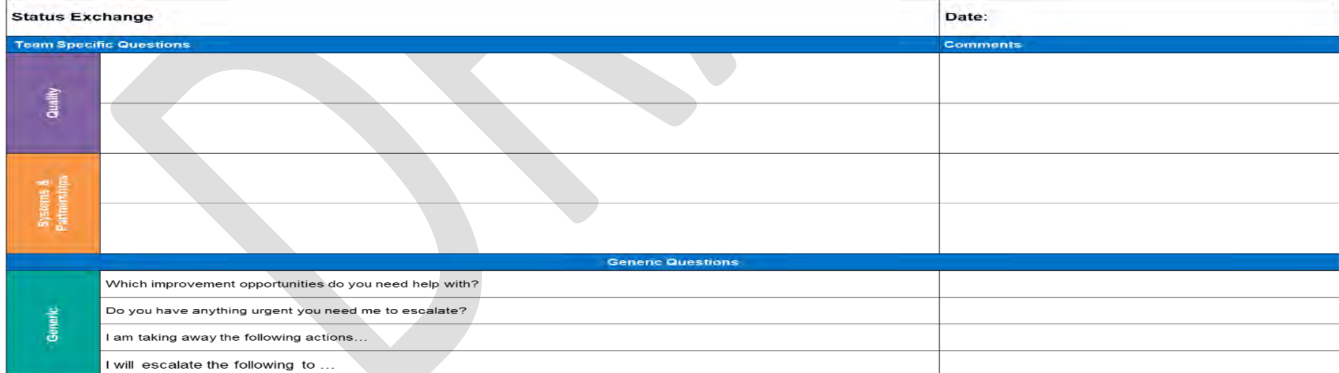
Example of status exchange



Status Exchange		Date:
Team Specific Questions		Comments
Quality		
Systems & Partnerships		
Generic Questions		
Generic	Which improvement opportunities do you need help with?	
	Do you have anything urgent you need me to escalate?	
	I am taking away the following actions…	
	I will escalate the following to …	

Status Exchange		Date
Team Specific Questions		Comments
Sustainability		
People		
Patients		

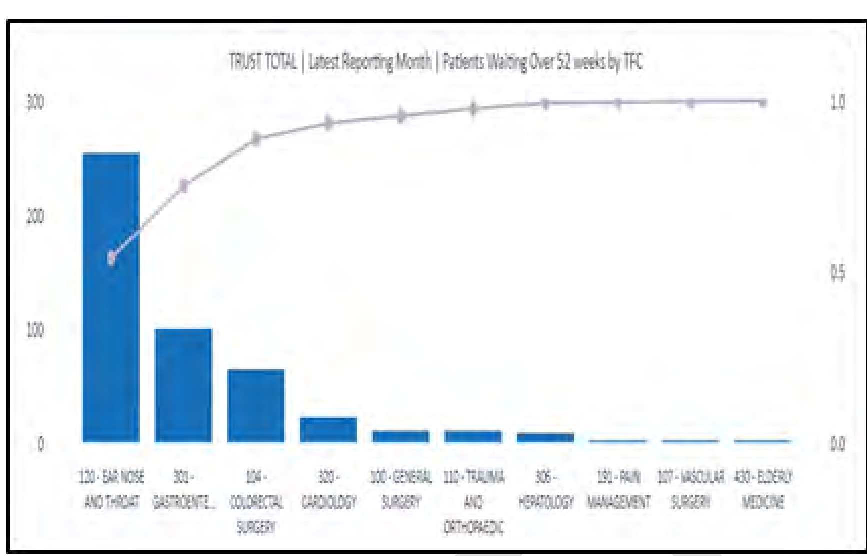
Delivery against the strategic planning framework that aligns to your Portfolio	
Breakthrough Objectives	
Strategic Initiatives	
Corporate Projects	

Portfolio specific reporting and issues that require planning	
CQC / NHSi / ICB matters	
Preparation for Board, committees, etc	
Current Matters	

Portfolio specific reporting and issues that require planning	
Reviewing the deputy's Personal A3	
Leader standard work adherence	
Coaching development	

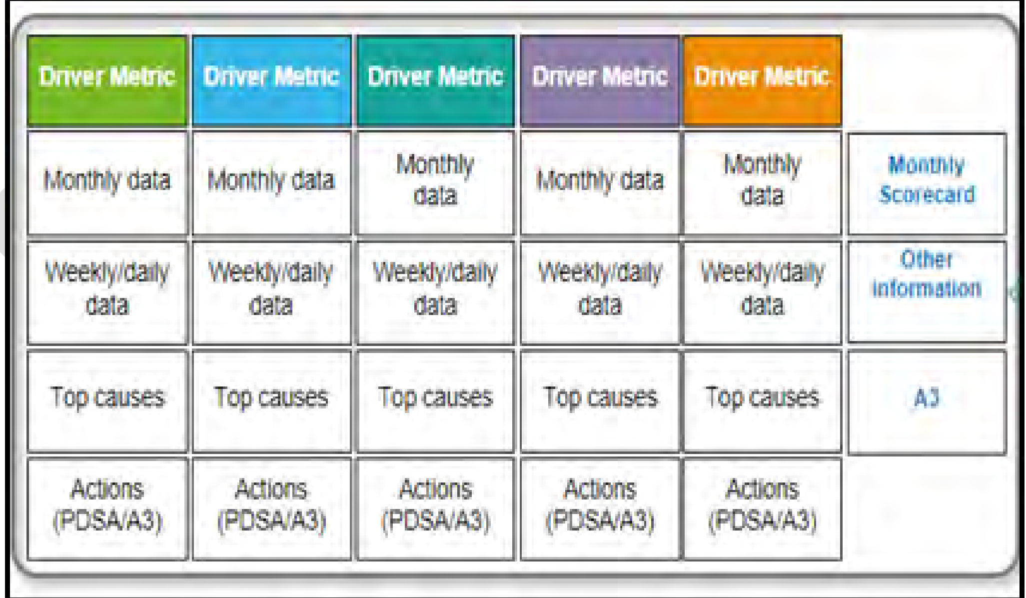
Pareto Chart

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.



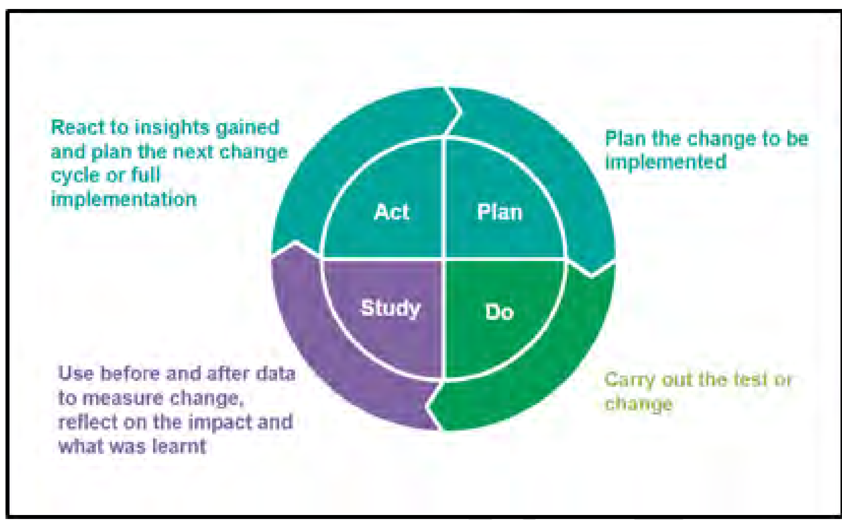
Performance Board

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.



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.



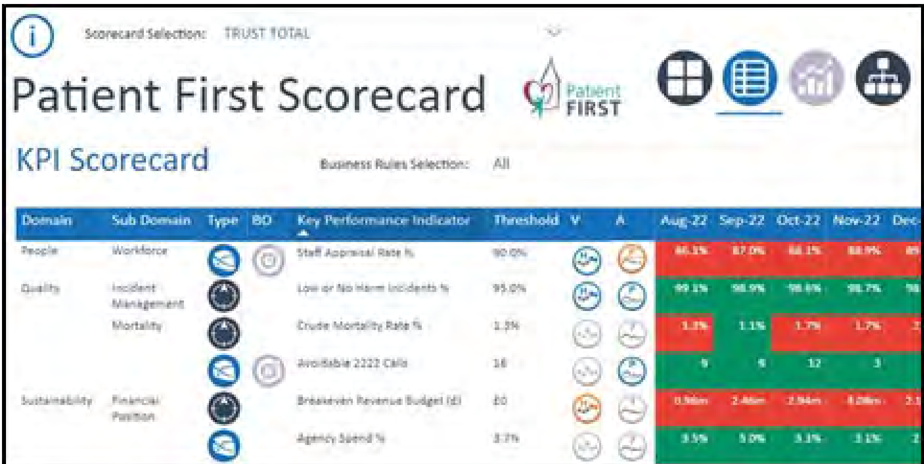
GEMBA

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. GEMBAs 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 DATIX software. A template 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

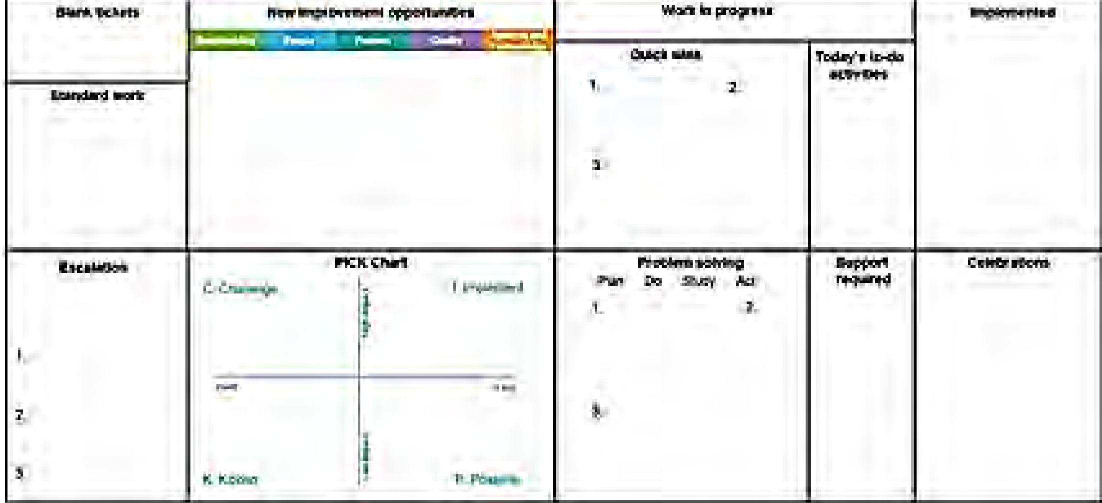
have come directly from the True North metrics. The scorecard is made up of metrics that have been chosen for improvement and that are being monitored to ensure performance is maintained.



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.

Example Improvement Board



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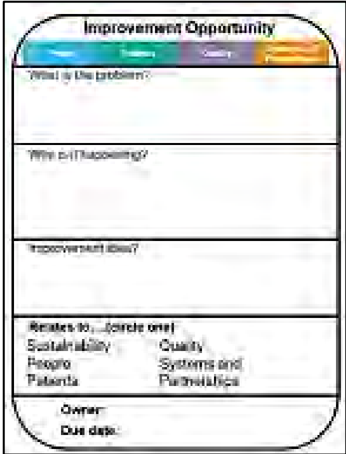
Example Improvement Ticket



Improvement Opportunity

Relates to....(circle one)

Sustainability | Quality
People | Systems and
Patients | Partnerships

Owner:

Due date:

Leadership behaviours

A key enabler to support this is a set of leadership behaviours, developed by the Executive team to enable capability to be cascaded through management teams and through the organisation. We have implemented these behaviours through Board Development, which has cascaded down to our leadership teams across the Trust. This “top down” approach has complemented the “bottom up” approach of continuous improvement by ensuring our senior colleagues are trained and able to support their staff on this journey.

The key principles that drive the right leadership behaviours are:

- Create value for our patient’s
- 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

By focusing on our leadership behaviours as demonstrated above, we can develop our internal capability and sustain our Patient First improvement journey as demonstrated below:

Patient First Strategy

Operational Improvements

Focus on **projects** and **building capabilities**

Management System

Focus on **making improvement part of the daily work** and integrated into the management system

Culture of Continuous Improvement

Focus on developing Leaders as Coaches, and embedding improvement into the DNA of the organisation

Over the past year, leadership training has been a part of the modules for Executives, divisional and care group leads. This has been an important part of establishing the Patient First strategy, to ensure all staff have senior support to make changes and to develop a coaching style and relationship.

Next Steps

In our second set of Breakthrough Objectives (2023/24), 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 retention for **People**, as our staff turnover is higher than we would like. We will work to improve staff experience, looking at why people choose to work here and why they choose to leave.
- Continue to focus on increasing number of **Patients**, who would recommend us as a place to receive care
- **Quality** will focus on reducing mortality figures by improving care further and improving medical coding practices
- Under **Systems and Partnerships,** we will work towards the 65-week target for treatment. We will work hard to identify where barriers occur to ensure out patients are treated within the timeframes they expect and deserve.

By focusing on continuous improvement, and empowering our staff to make changes in their own areas of work, we will improve patient outcomes and experiences while in our care. This means that patients will have a better experience while receiving care. Patient First will increase staff job satisfaction, through training and development and also providing a level of autonomy to allow them to lead on changes that will improve their areas.

DRAFT

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.

Building a Shared Purpose and Vision
Our workforce, trainees and learners understand the direction and strategy of the organisation/system, enabling an ongoing focus on quality, responsiveness & continued learning

Building Improvement Capability
All our people (workforce, trainees and learners) have access to improvement training and support, whether embedding within the organisation/system or via a partner collaboration

Developing Leadership Behaviours for Improvement
A focus on instilling behaviours that enable improvement throughout the organisation and systems, role modelled consistently by our Board & Executives

Investing in Culture & People
Clear and supported ways of working, through which all staff are encouraged to lead improvements

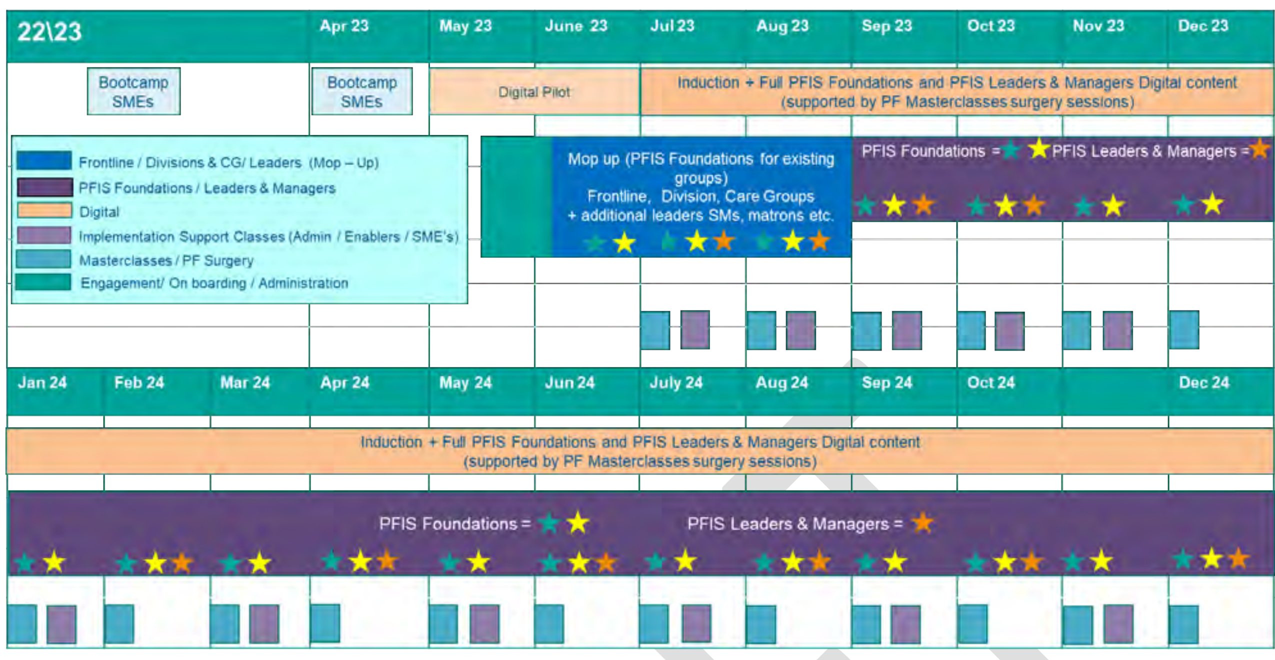
Embedding Quality Management System
Embedding approaches to assurance, improvement and planning that coordinate activities to meet patient, policy and regulatory requirements through improved operational excellence

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.

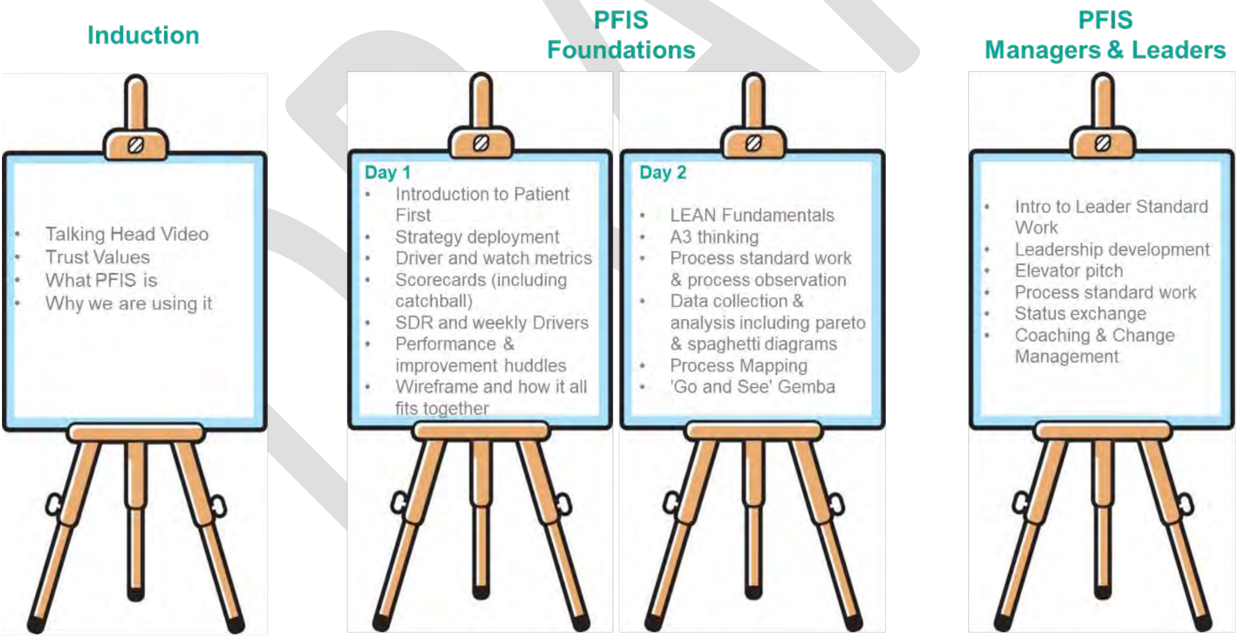
Actions for the next six months

- Patient First Training (Foundations and Leaders and Managers) continues from September 2023, introducing Care Group and Divisional Strategy Deployment Reviews (SDR's).
- Implementation of Digital Patient First including roll out of digital learning and masterclass offerings.
- Trust Board Development, including buddying Non-Executive Directors and Executives to Gemba; continuing development of the Trust Board SDR.

Our training roadmap for the next year is highlighted below:



The course content for the above training schedule follows the below structure:



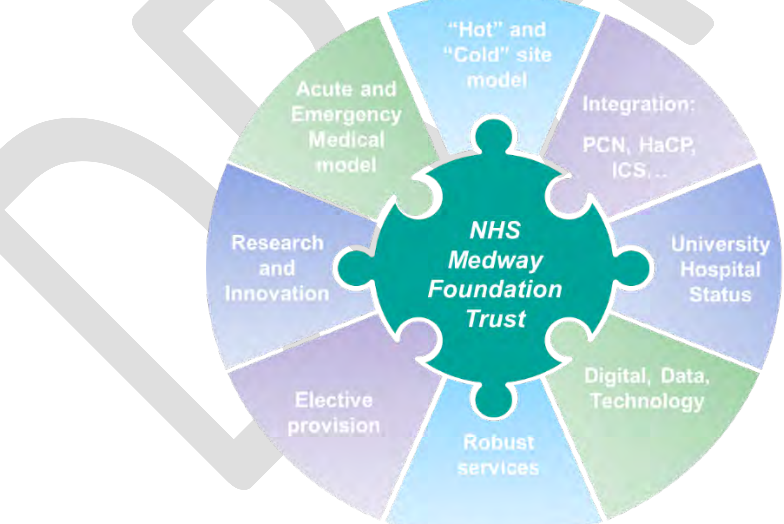
Actions beyond the next six months

- Commence refresh and review of our Breakthrough Objectives, by collaborating with the Health and Care Partnership, our colleagues and patients
- Review of impact on health inequalities and population health management across Medway and Swale
- Lead on the integration of continuous improvement approach across the local health and care system
- Appoint a clinician within the Transformation Team, to continue being a clinically led organisation

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 amending our approach to ensure the maximum improvements for our patients and population health. Our Clinical Strategy has been drafted using the Patient First principles, and focusses on large transformational change for our Trust's clinical services as listed below:



Following the publication of our Clinical Strategy in 2023, we will focus on our People and Quality strategies, which will also align to our Patient First Strategy.

References

Document	Ref No
References:	

Trust Associated Documents:	
Quality Strategy	People Strategy
Clinical Strategy	Nursing, Midwifery and Allied Health Profession Strategy
Digital Strategy	Equality, Diversity and Inclusion Strategy
Estates and Facilities Strategy	Health and Safety Strategy
Research and Innovation Strategy	Staff Health and Wellbeing Strategy

END OF DOCUMENT

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Title of Report	Infection Prevention and Control Strategy			**Agenda Item**	4.4
Author	Steph Gorman – Associate Director of Infection Prevention and Control				
Lead Executive Director	Evonne Hunt – Chief Nursing Officer and Director of Infection Prevention and Control				
Executive Summary	This report is being presented to the Trust Board to introduce the trusts new Infection Prevention and Control (IPC) Strategy for the next three years, highlighting our visions and aspirations for providing high quality care to our patients, reducing harm and Healthcare Associated Infections (HAI's). This strategy will support the Trust's philosophy of Patient First, delivering on the following two key True North Domains: • Quality: Excellent outcomes, ensuring no patient comes to harm • Patients: Providing outstanding, compassionate care for our patients and their families It has been compiled with our local system partners, to ensure we are all working collaboratively for the best outcomes for our patients. Following the Trust's strategy, Patient First, we will implement our lessons learned from the Covid-19 pandemic, using tools, behaviours and routines designed to deliver daily, continuous improvement and performance excellence.				
Proposal and/or key recommendation:	Review and discussion				
Purpose of the report (tick box to indicate)	Assurance		**Approval**	√	
	Noting		**Discussion**	√	
Committee/Group at which the paper has been submitted:	This strategy has been presented at IPC Strategic Assurance Group, Quality and patient Safety Sub-Committee and Quality assurance Group				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	**Priority 3: (Patients) √**	**Priority 4: (Quality) √**	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: √	**Effective: √**	**Caring: √**	**Responsive: √**	Well-Led:
Identified Risks, issues and mitigations:	N/A				

Best of care Best of people Patient FIRST

Resource implications:	N/A		
Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	The Trust is required to be compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.		
Appendices:	None		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information or any enquires relating to this paper please contact:	Steph Gorman, Associate Director Infection Prevention and Control		
Reports require an assurance rating to guide the discussion:			
	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	√	No assurance required.

Infection Prevention and Control Strategy

Author:	Stephanie Gorman
Document Owner	Evonne Hunt
Revision No:	v0.8
Document ID Number	TBC
Approved By:	Trust Board - 13 September 2023
Implementation Date:	September 2023
Date of Next Review:	September 2026

IPC Strategy

Document Control / History	
Revision No	**Reason for change**

Consultation
Infection Prevention and Control Strategic Assurance Group (IPCSAG)
Quality and Patient Safety Sub-Committee (QPSSC)
Quality Assurance Committee (QAC)
Trust Executive Group
Trust Board

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

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1. Foreword

I am really thankful for the ongoing commitment and dedication of the Trust's Infection Prevention and Control Team, playing a key role in maintaining our services and keeping our staff and patients safe.

Infection Prevention and Control remains a key area for Medway NHS Foundation Trust in making sure the risk and harm to patients is minimised, to ensure infection control continues to be everyone's business and that infection prevention and control measures continue to be embedded in everyday practice across the Trust.

I am delighted to introduce you to our Infection Prevention and Control Strategy for the next three years, highlighting our vision and aspirations for providing high quality care to our patients, reducing harm and healthcare associated infections. This strategy will support the Trust's philosophy of Patient First, delivering on the following two key True North Domains:

- Quality: Excellent outcomes, ensuring no patient comes to harm, and
- Patients: Providing outstanding, compassionate care for our patients and their families.

It has been produced with our local system partners, to ensure we are all working collaboratively for the best outcomes for our patients.

As part of our Trust's strategy, Patient First, we will implement lessons learned from the COVID-19 pandemic, using tools, behaviours and routines designed to deliver daily, continuous improvement and performance excellence.

Evonne Hunt, Chief Nursing Officer

2. Introduction

1.1 At Medway NHS Foundation Trust we are dedicated to putting our patients first, at the heart of everything we do. Medway NHS Foundation Trust has improved the standards for Infection Prevention and Control (IPC) and is now in a position to devise a strategy for continued improvement. We have a strong internal IPC Team who work closely with our colleagues across the Trust to support and push the IPC agenda.

1.2 The COVID-19 pandemic has shown that effective infection prevention and control is a crucial component of outstanding health care. This three-year strategy will support recovery from the pandemic, looking to the future, and will link with the Kent and Medway Integrated Care System (ICS) and Medway and Swale Health and Care Partnership (HaCP) to enable cross system and partnership working ensuring early recognition and prevention of emerging infectious disease threats as well as sharing of best practice and innovative ideas for management of existing infections.

1.3 The IPC workforce continues to be proactive, resilient, innovative and competent in order to protect our patients, visitors and staff from emerging infection control threats. The workforce continues to receive the support, resources and professional development they need to deliver the service now and in the future.

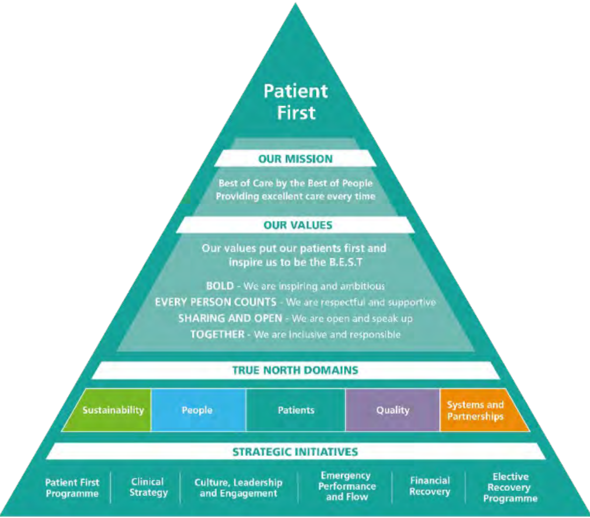
1.4 This IPC Strategy, along with the different initiatives arising from it, will enable us to embed important and substantial improvements in the quality of our patients' care at Medway and to ensure patients are kept safe from avoidable harms as a result of acquiring preventable infections. Our strategy is a critical part of providing outstanding services that meet the expectations of our patients, families and carers.

1.5 This strategy has been created to address our key priorities, while aligning with the Kent and Medway IPC Strategy, and with a focus on system working to improve outcomes for our patients across the local health and care system.

2 Core values

2.1 The Trust has worked closely with our local Integrated Care System and Health and Care Partnership to align our aspirations for improving IPC across Kent, , not just Medway NHS Foundation Trust. This strategy aims to build on the successes and learning gained over the years as well as build and increase our partnership working to improve our patients' journey.

2.2 The Trust's values underpin everything we do, and we expect our staff to work to these values in the delivery of safe, consistent and high quality patient care. The guiding principles of our overarching Patient First Strategy focus on continuous improvement. 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, and data driven methodology that ensures the improvement effort is focused on the areas that make the biggest difference to help us reach our True North.



2.3 The IPC Strategy aligns to our True North Domain of Quality, ensuring that we are providing high quality care to improve outcomes and reduce harm. Further to this, there are a number of relevant strategies and policies Trust-wide that link into the IPC Strategy, (such as the Patient Experience Strategy and Quality Strategy) some of which are listed below in Section 7. Together, our strategies will deliver a number of initiatives to ensure that all patients receive high quality care resulting in improved outcomes for patients.

3 Mission, vision and aspirations

3.1 Here at Medway, we are dedicated to putting our patients first by continually improving. All staff are responsible for good IPC practices and challenging those practices when not met. Keeping our patients safe from harm is everyone's business.

3.2 We know that there is a lot of work to be done to improve our IPC practices and recover from the COVID-19 pandemic, and this strategy will make sure that we:

- 3.2.1 Reduce the risk of healthcare associated infections for our patients
- 3.2.2 Work closely with our local system provider to ensure the needs of our patients across all of Kent and Medway are met
- 3.2.3 Ensure we continually improve IPC practices, including value for money, and
- 3.2.4 Embed learning and training to all staff so that IPC is everyone's business.

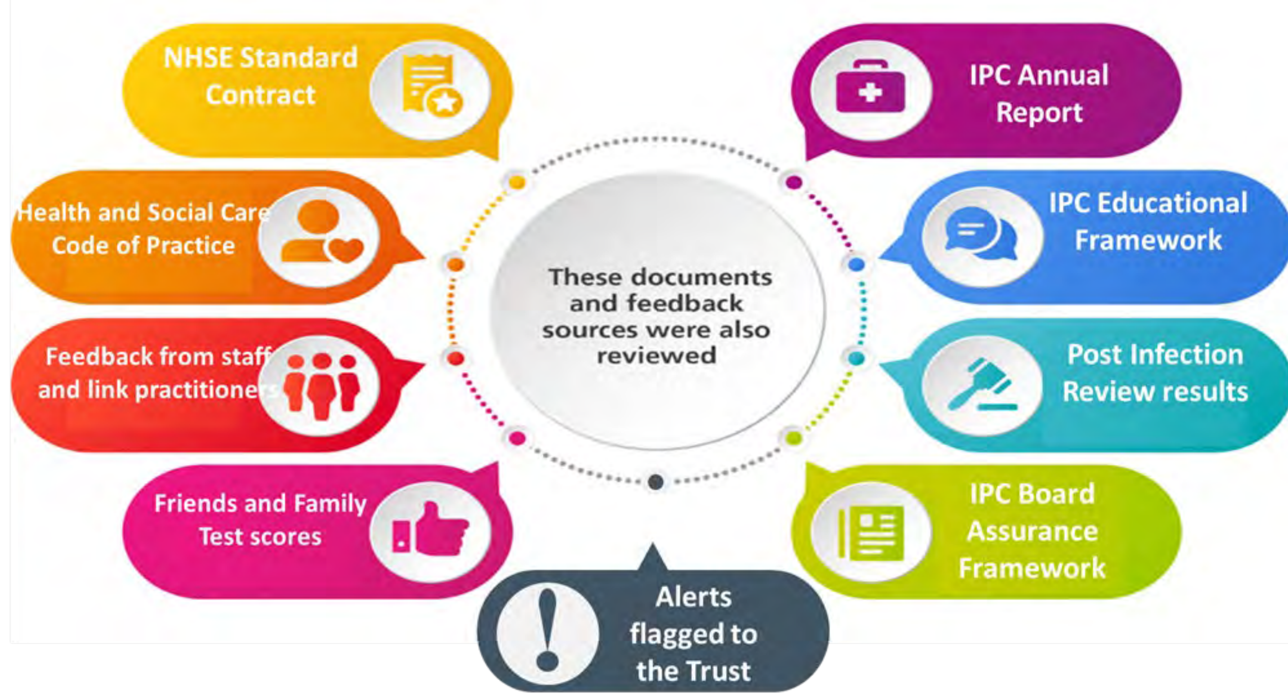
3.3 The IPC Strategy is the Trust's structured approach and overarching plan to enhance our IPC practices to improve our patients' quality of care. In order to do this, we are ensuring we are aware of, can meet and deliver the level of IPC patients would expect whilst in our care.

3.4 By implementing this strategy and the delivery plan that underpins it, our vision is to be recognised as an outstanding and innovative Trust by working collaboratively across the system providing a patient-centred, adaptable approach to empower all staff to deliver effective IPC to our patients.

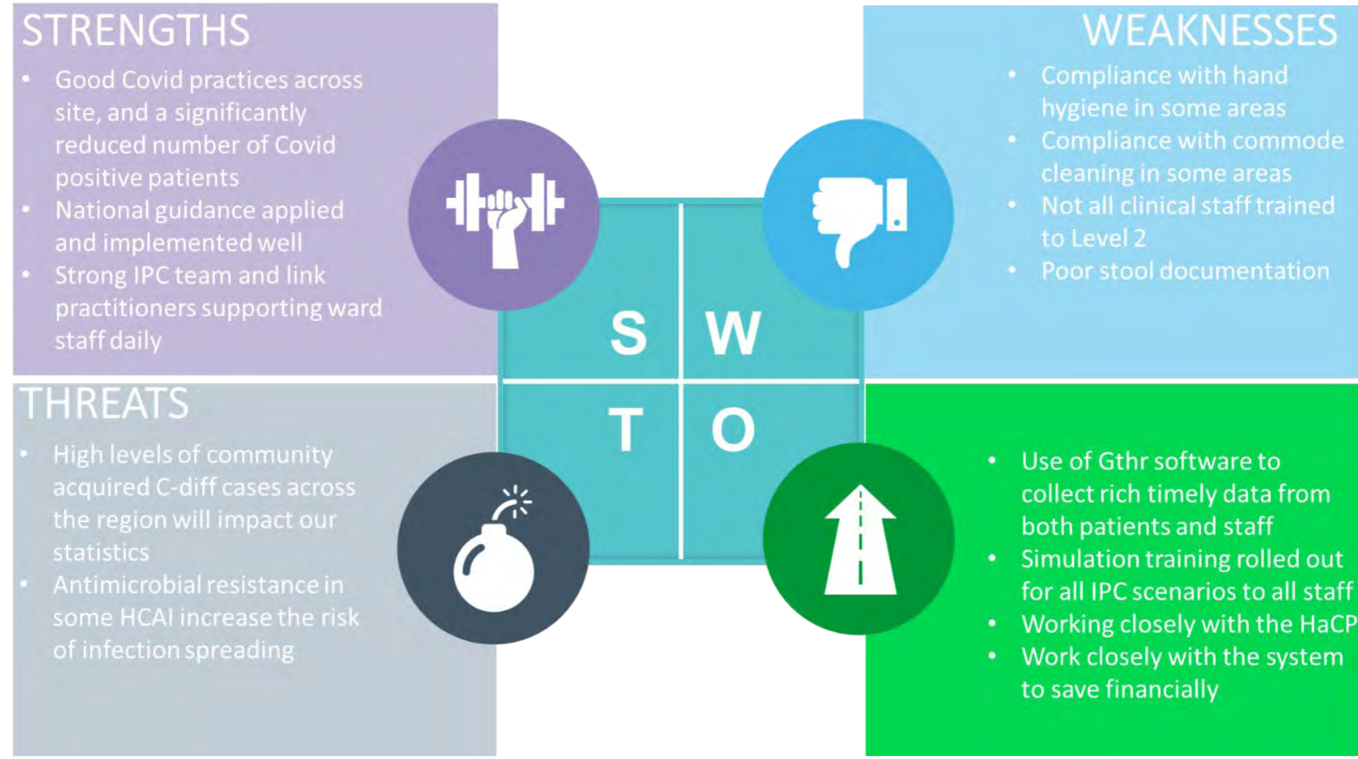
4 SWOT analysis

4.1 In preparation for this strategy, we worked closely with our local system partners to create a strategy that is fit for purpose for all Kent and Medway healthcare and our community.

4.2 In addition to to our engagement events, we also reviewed a number of feedback resources as outlined below.



4.3 From our engagement and continuous improvement approach, we have highlighted the following strengths, weaknesses, opportunities and threats to our infection prevention and control :



4.4 From the opportunities that were highlighted, we have already begun to implement change to improve our IPC practices. These changes include:

- Working with the Antimicrobial Stewardship Group to ensure antimicrobial stewardship remains a top priority
- Monthly IPC Oversight Group, Gthr and Post Infection Review (PIR) learning discussions led by Head of Nursing and IPC colleagues
- Trust-wide commode audits and engagement with staff and patients regarding the best new style to implement across the Trust
- Review of cleaning products and trial of new sporicidal wipes to reduce risk of infection
- A new diarrhoea assessment tool developed and launched to help support staff to identify patients with a possible Healthcare Associated Infection
- IPC teaching sessions during ward huddles.

5 Objectives and results

5.1 The six themes and principles that emerged as priority areas to improve our infection prevention and control over the next three years are:

5.1.1 **One system:** Working closely with our Health and Care Partnership and community healthcare to ensure consistent and clear priorities across Kent and Medway for IPC

5.1.2 **Reducing Healthcare Associated Infections (HCAIs):** to keep our patients safe from harm

5.1.3 **Provide safe services:** to increase patient experience and improve patient outcomes

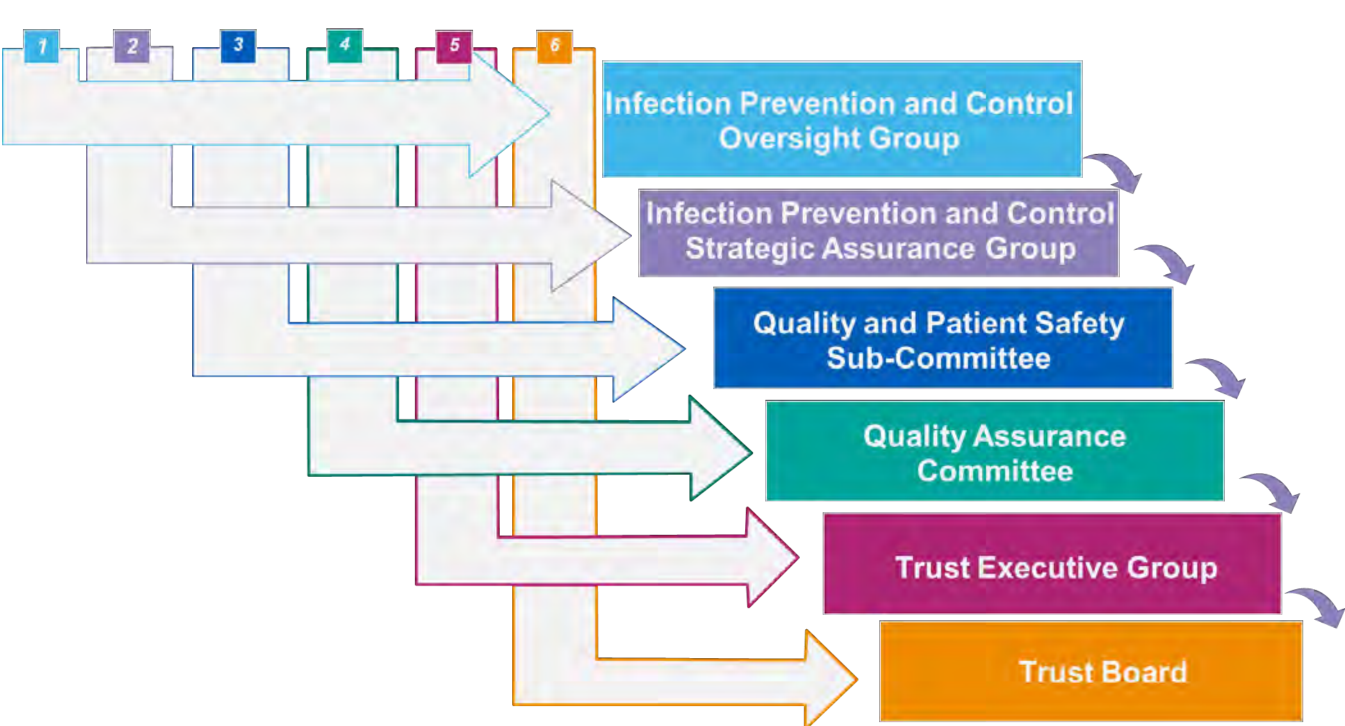
5.1.4 **Shared learning and continuous quality improvement:** to ensure we are able to provide an excellent service and continually improve our patients journeys

5.1.5 **Skilled, response and resilient workforce:** to ensure our patients receive the best of care by the best of people, focussing on developing and nurturing our staff and building a network of support

5.1.6 **Managing resources:** to ensure we are providing the best value for money, reviewing our procurement opportunities and sharing training opportunities across the system to reduce the cost for Kent and Medway,

6 Metrics and Key Performance Indicators

6.1 For this strategy to be meaningful for our patients, the implementation must be measured on its delivery. A detailed delivery plan has been developed, which sets out the key activities, success measures and timescales to achieve our aims. The plan will be continually reviewed, responding to new and emerging priorities as well as assuring delivery of the below Key Performance Indicators (KPIs) by September 2026. The KPIs will be monitored through a robust governance route, including the Strategic Assurance Group and Quality Assurance Committee as demonstrated below:



6.2 **Reduction in Healthcare Associated Infections (HCAI)**

6.2.1 All staff across the organisation must work together to ensure we can reduce our avoidable HCAIs (including Surgical Site Infections (SSIs), Catheter Associated Urinary Tract Infection (CAUTI), Blood Stream Infection (BSI) and Hospital Acquired Pneumonia (HAP)

Data on all HCAIs is already gathered. The aim by the end of the financial year is to create a central dashboard to include SSI, CAUTI and HAP instances in IQPR. To realise this, the IPC team will gain permissions to access CAUTI and HAP, then work with the Trust Business Intelligence team to present the data.

6.2.2 Five per cent reduction in mandatory reported Blood Stream Infections and 10 per cent reduction in Colorectal SSIs by 2024/25.

Root Cause Analysis exercises have been carried out into HA, BSI/SSIs, to identify lapses. Individual patients are now seen by IPC colleagues, who have had BSI/SSIs to further identify lapses in care. The aspiration is to put in to place targeted simulation training to address these lapses. This is captured in annual reports, as well as monthly to the IPC Assurance Group. Continuous audit and monitoring and training on catheters and cannulas will occur, as well as monitoring and audit of wound care in SSI cases.

6.2.3 Ten per cent reduction in all HCAIs by 2025/26.

Improving and increasing antimicrobial stewardship ward rounds and

C.difficile ward rounds. Continuing to build on training packages. The value of this increased number of ward rounds versus the number of infections reported, will be reported, and audited.

6.3 Provide safe services to improve quality of patient experience and outcomes

6.3.1 Implement national IPC guidance and Board Assurance Framework to ensure colleagues across the Trust are educated in IPC practices and work closely with their link practitioners.

An IPC improvement plan is in place to provide surety, and is reported through governance up to Board level.

This year, there will be a Link Practitioner showcase event. Link Practitioners will share what they have learnt to improve their workplace, and there will be awards distributed. This will increase wider Trust's awareness and value of Link Practitioners.

6.3.2 A continued compliance of above 90 per cent of staff trained in both level one and level two training in 2023/24, with an aspiration of a compliance of above 95 per cent of staff trained in IPC in 2024/25.

IPC is reverting to face to face and scenario based training after a period of being online only. It will be offered five days a week, with a view to moving to weekends too. It will be monitored by staff group, and reported monthly to Divisional leads to escalate their mainly Level two compliance.

6.3.3 Seventy-five per cent attendance of the 88 link practitioners at link sessions by April 2024
Link practitioners are required to attend at least three out of four meetings per year. Currently Medway NHS Foundation Trust colleagues are not compliant.

It is now required that ward managers and Matrons read Link Practitioner contracts, be aware of what's required of them, and to then sign a memorandum-of-understanding themselves. Lack of attendance will be reported to ward managers and Matrons, then if required, escalated to the Head of Nursing (HoN).

6.4 Ensure shared learning for continuous quality improvement

6.4.1 Work closely with colleagues and system partners to learn and improve, develop a standardised approach to Patient Safety Incident Review Framework and use A3 methodology to review root causes to current issues.

Early conversations with the Transformation team to initiate Patient First Improvement System (PFIS) for IPC colleagues to then disseminate. To complete Patient First training by December 2023.

6.4.2 Present A3 findings and compliance with patient Safety incident Response Framework (PSIRF) at IPCSAG on a quarterly basis, by December 2023.

Training to happen with Patient Safety team to access the Patient Safety Incident Response Framework (PSIRF).

6.5 Build a skilled, responsive and resilient workforce

6.5.1 Source and implement leadership courses (including MSc courses) for IPC nurses. Ongoing.

Obtaining an MSc in IPC will build a team of experts. This will enable them to support, and be empowered to challenge practices, improve leadership behaviours. The goal is to enrol a member of staff into the MSc programme every September.

6.5.2 To have 100 per cent of IPC team to all become qualified FIT-testers to further support the Trust's management of emerging infection threats.

After training, staff will provide a robust FIT-testing service, and then train colleagues to carry out FIT-testing in their workplace.

6.6 Manage resources to gain best value for money

6.6.1 Work closely with Procurement to ensure we continue to monitor and trial new products to support our efficiencies targets and collaborate with system partners.

In the Kent and Medway IPC leadership forum, agreement was made to all purchase the same wipes – different to current ones – and Procurement is engaged.

Procurement is already a core member of IPC meetings, and works closely to develop further IPC-related groups, to make the process more efficient.

7 References

Document	**Ref No**
References:	
NHS England Standard Contract	IPC Board Assurance Framework
IPC Improvement Plan	Post infection reviews
IPC Annual Report	Health and Social Care Act 2008
IPC Educational Framework	Code of Practice on the prevention and control of infections and related guidance (DH 2002)
NHS Outcomes Framework	ICS Quality Oversight Framework
Trust Associated Documents:	
Patient First Strategy	People Strategy
Clinical Strategy	Equality, Diversity and Inclusion Strategy
Quality Strategy	End of Life Care Policy
Digital Strategy	Health and Safety Strategy
Dementia Strategy	Learning Disability Strategy
Estates and Facilities Strategy	Maternity Safety Strategy

Research and Innovation Strategy	Data Quality and Assurance Strategy
Staff Health and Wellbeing Strategy	

END OF DOCUMENT

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Title of Report	Assurance report – People Committee 27 July 2023	Agenda Item	6.1
Author	Leon Hinton, Chief People Officer		
Committee Chair	Sue Mackenzie, Chair of Committee/NED		

Key headline and assurance level

1. Safe Staffing Nursing Establishment Review The Committee received the report providing a high-level overview of the bi-annual review of nursing staff levels across inpatient adult and paediatric wards. The report included an assessment of acuity and dependency, methodology, temporary staffing utilisation, staff management, vacancies, staff wellbeing and recommendation. The Committee requested further assurances to understanding the drivers to increased acuity with input from community. The Committee, whilst requesting additional analysis and root cause, recognises that daily safe staffing reviews continue to ensure patient safety.	Partial Assurance
2. Nursery compliance report The Committee received an update report including a schedule of learning events for the staff nursery following the 'good' Ofsted inspection in January 2023. The Committee **NOTED** the report.	Assurance
3. Freedom to Speak Up Lead Guardian's report – Q4 2022/23 and Q1 2023/24 The Committee received the Q4 and Q1 report from the lead guardian including the National Guardian's Office toolkit for developing a speaking up culture and the NGO's annual report, findings and a comparative review to the Trust's own speaking up routes. Over quarter 4, the number of cases had decreased; however, one case was reported as suffering detriment. Over the first quarter, the number of cases had risen sharply. The report detailed themes, lessons learnt from cases and triangulation with other indicators. The Committee **NOTED** the report.	Assurance
4. Wellbeing Guardian Assurance Report The Committee received a report updating the progress made against the national health and wellbeing framework. This included the Talking Wellness service closure following withdrawal of	Assurance

national funding for the system; however, the Trust's Employee Assistance Programme continues and further avenues are being explored to address the gap. The Committee **NOTED** the report.	
5. 2022 Staff survey action plans The Committee received a report updating the progress to date with developing and implementing local action plans responding to items raised within the 2022 national staff survey. The Committee **NOTED** the action plans.	Assurance
6. HR Team Performance Report and People Project updates The Committee received a report from the HR and OD Performance Group which provides assurance on the items discussed at the meeting, decisions made and actions taken. The Committee reviewed key points relating to HR Team's KPIs and discussed the following: • Current time from referral to the OH service is longer than our KPI of 20 days. However, new team members were starting through August and September; • Successful clinical support worker open day with over 33 offers being made. The Committee received an additional report concerning the code of practice for ethical international recruitment and received assurance the Trust's current and future plans were in line with the code of practice. The Committee **NOTED** the report and project updates.	Partial Assurance
7. MFT Institute of leadership and management centre update report The Committee received an update that there were no current learners at this time. The Trust is recruiting for cohorts for the level 3 award (19 applicants) and apprenticeship level 3 business admin programme (five applicants). A quality improvement plan is in place. The Committee **NOTED** the status of the centre.	Assurance
8. Trust's preparedness for industrial action The Committee received an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations,	Assurance

tactical command group structure, redeployment, national EPRR exercises and communicating with staff. The following strike action occurred: • Junior Doctors – 7am 14th – 7am 17th June; • Junior Doctors - 7am 13th -7 am 18th July; • Consultants 7am 20th - 7am 22nd July. Further industrial action (junior doctor, consultant and dentists) is expected in August and ongoing. The Committee **NOTED** the report.	
9. IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the HR performance across all key performance indicators for June 2023. The Committee **NOTED** the report: • The breakthrough objective of 90% wellbeing check and appraisal had been met for six-successive months. A new breakthrough objective has been agreed relating to reducing voluntary turnover within the first two years of employment; • A consistently improving vacancy rate (5.19%, down from 7.2%); • An improving long-term sickness rate (1.9% against 2% target); short-term sickness is on target (2%). An above-target StatMan rate of 88.7% (against 85% target); however some face-to-face courses remain below the standard.	Assurance
10. International recruitment pastoral quality charter The Committee **APPROVED** the international nurses' pastoral care charter which highlights how nurses will be supported on an ongoing basis for their move to the Trust.	Significant Assurance
11. Medical appraisal and revalidation annual report 2023 The Committee received the medical appraisal and revalidation annual report 2023 with the following highlights: • Of the 455 doctors due an appraisal, 94% completed their appraisal, 23 had approved missed appraisals, two had unapproved or missed appraisals (appropriate next steps have been taken); • 81 revalidation recommendations were sent to the GMC, 15 deferral recommendations were sent. The Committee **APPROVED** the statement of compliance.	Significant Assurance

	Decisions made: 1) Approval of the international recruitment pastoral quality charter; 2) Approval of the statement of compliance as part of the medical appraisal and revalidation annual report 2023. **Further Risks Identified:** 1) None identified. **Escalations to the Board or other Committee:** 1) [People Sub-Committee] NHSE bullying and harassment case report to be presented to the Board. 2) [People Sub-Committee] Report for leaving reasons including bullying and harassment.
Proposal and/or key recommendation:	Not applicable

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

Committee/Group at which the paper has been submitted:	People Committee, 27 July 2023

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

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

Identified Risks, issues and mitigations:	All risk, issues and mitigations are reference in the Board Assurance Framework item.
Resource implications:	Individual resource considerations are provided at the People Committee.

Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the People Committee.
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information or any enquires relating to this paper please contact:	Leon Hinton, Chief People Officer leon.hinton@nhs.net

Meeting of the Trust Board in Public
Date: 13 September 2023

Meeting	Finance Planning and Performance Committee – July 2023				
Title of Report	**Assurance and Escalation Report**		Agenda Item	7.1	
Lead Director	Annyes Laheurte, Non-Executive Director/Committee Chair				
Report prepared by	Elaine Adams, Business Support Manager				
Report Approved by	Alan Davies, Chief Financial Officer Paul Kimber, Deputy Chief Financial Officer Annyes Laheurte, Non-Executive Director				
Executive Summary	The enclosed report sets out the key discussions held at the Finance, Planning and Performance Committee. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts, financial recovery update, national cost collection pre submission report, Model Hospital, medicines efficiency update, breakthrough objective – control of overspending and committee terms of reference. The key risk is the adverse finance performance against the control total in month three, if not addressed could have an adverse impact on the Trust's exit from SOF4.				
Committees or Groups at which the paper has been submitted	n/a				
Resource Implications	n/a				
Legal Implications/ Regulatory Requirements	n/a				
Quality Impact Assessment	none				
Recommendation/ Actions required					
	Approval ☐	**Assurance** ☒	Discussion ☐	Noting ☐	
Appendices					
Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board					
The key headlines and levels of assurance are set out below:					
No assurance	Red - there are significant gaps in assurance and we are not assured as to				

	the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Finance, Performance and Planning Committee	27/07/2023	Annyes Laheurte

Number of attendees	Number of apologies	Quorate	
		Yes	No
13	2	X	

Declarations of Interest Made

N/A

Assurance received at the Group meeting

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

Business Assurance Framework and Corporate Risk Register

- Governance around BAF has been tightened, every section of the BAF will be updated on a monthly basis. This month has had no changes to the BAF or Corporate risk register scores. The scores on the BAF and risk register were **agreed.**
- Concerns around medical staffing and the efficiency programme remain.
- Elective services on the risk register will be adjusted to reflect the impact of industrial action.

Financial Performance

- The Trust has reported a £2.5m adverse position in month and year to date. The identified drivers for this are the medical overspend at £3m, of which £1m was due to April and June's industrial actions. Nursing accounts for £1.5m, which is due to premium costs paid related to vacancies.
- Efficiencies is reporting £1.5m delivery against plan. The target for month four is £3m a rise from £1m in month three, if there is no change in the run rate and expenditure the budget position would see a further adverse position in month four.
- Capital work is progressing and is working to plan, the adverse position seen is due to the plan phasing. There are no indications of any risk to delivering the full capital programme.
- The key risk is the adverse finance performance against the control total in month three, if not corrected it will put the Trust's exit from SOF4 at risk. Tighter financial controls are being discussed to reduce the risk.
- The system position is £10.6m adverse in month three. Medway is operating within its agency control limits currently and is meeting the national 2.7% target.

Breakthrough Objective – Control of overspending

- The focus of this breakthrough objective is medical and nursing overspend. Countermeasures have been employed to address the premium rate spend on cost of cover etc. A number of

- countermeasures are in place ready to start, such as the junior doctor rotation that will commence in August.
- Some benefits from the countermeasures are expected to crystallise from August.

Efficiencies Programme

- The overall RAG rating for June is red.
- £14.7m has been identified against the £27m target. £7.6m are currently delivering. £7m have been through panel and are about to be implemented. There are £10.2m worth of schemes currently being worked up bringing the total to £25m, this is £2m short of the target. The aim is to have identified £27m worth of schemes before the next EDG meeting in three weeks time.
- Work is being done around counting and coding which has been estimated at £5.1m.

Performance report

- Type one performance in ED is 66%, the highest level in twelve months. KCHT are delivering 100% performance in type three, consistently against four hours. MEDOC has been volatile with some days performance being 40%.
- Mental health presentations continue to be high. Discussions are taking place with KMPT to review how the Trust can work more collaboratively with them.
- RTT remains an issue. June's 52 week waits increased to 877. 4,218 outpatient appointments and 474 elective appointments had to be rescheduled due to industrial actions. Ongoing weekend work is looked at to address the backlogs.
- Work is being done collaboratively to improve the ENT service across the system.
- Due to capacity issues in Endoscopy, the Trust has been placed in Tier two for cancer performance. Fortnightly meetings with NHSE take place to provide assurance on performance recovery. Sustainable capacity is required which is being considered through the Endoscopy Business case.

Financial Recovery Plan refresh

- NHSE have released a control spreadsheet for 2023/24 which sets out the minimum requirements expected from organisations controls, commensurate with the financial risk of the organisation. The Trust has completed a self-assessment against the controls and will be increasing controls accordingly. The System will need to produce medium term financial plans that the Trust is linked to and the Trust's long term financial plan will be consistent with this. The System report is due at the end of September.
- A review of the establishment growth from pre-pandemic to today will need to be carried out. Organisations have received requirements and scope for this piece of work, the Trust has begun this work and will need to report back to the ICB and NHSE by mid-August. This paper will be brought to this Committee in August.

National Cost Collection 2022/23 Pre submission report

- This paper sets out the process and timetable that is being adopted for the submission of national cost collection. This will ultimately feed into the Model Health System data.
- Templates are being pre-populated. Costing and SLR accountants are working closely with the Efficiencies PMO. The hospital system information is being updated with the latest 2022/23 data. This will be used to highlight potential efficiencies to the service teams.
- The paper was **approved**.

Model Hospital

- An update from the latest Model Health System data, the 2021/22 National Collection Data was presented.
- The Trust continues to be more efficient relative to other Trusts, as measured by average cost per weighted activity unit (WAU) and is now in the top quartile of Trusts in the country by this

measure (ranking 22nd). Nevertheless, there remain specific areas for significant improvement, which will be followed through via the Efficiencies Programme. Also, given the Trust remains in a significant revenue deficit despite this improvement, this points more towards optimisation of income, including through improved data counting as capture, as an increasing solution of the underlying deficit.

- CNST continues to be an outlier, this is being looked at as part of the PMO work that is being undertaken.
- The “Distance to Target” model is being looked into to ensure that the Trust is receiving the correct compensation for the population that it covers.

Medicines Efficiency Programme, quarterly update

- In tariff medicines expenditure is increasing at a significantly lower rate than last year, it increased at 5.9% in quarter one for 2023/24 against a 16.7% increase last year. This is still rising but is being controlled as much as possible.
- There are external inflationary pressures, one supplier has imposed a blanket 8.5% increase on all medicines, and drug shortages that adversely impact the rate of expenditure increase.
- £1m medicine efficiencies were delivered last year over 13 schemes. A further 40 schemes were scoped during the year which are in the process of being implemented now.
- A target of £758k has been set for 2023/2024. 22 schemes have delivered this quarter worth £186k. Work streams are in place to deliver as planned.
- Key aims for this year are:

1. Warehousing of data and development of central medicines.
2. To develop an automated medicine efficiency tracking tool, with the aid of BI.
3. Increase the education and training of staff within the organisation.
4. To expand on the horizon scanning exercise.
5. Ongoing identification, implementation and tracking of efficiencies.

Terms of Reference

- Terms of Reference have been brought into line with the revision of the broader governance across the whole of the organisation.
- Some amendments were requested and MC will update for approval at the next FPPC.

Key actions

1. PK to review the “Distance to Target” model and ensure that the Trust is receiving the correct amount of compensation for the population that it serves, and liaise with the ICB accordingly.
2. AD and PK to review the out of area commissioning for specialist medicine to see if it can be repatriated to give the Trust a financial benefit.

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

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

Terms of Reference – Company Secretary

Items referred to another Group, Subcommittee and or Committee for decision or action		
Item	**Group, Subcommittee, Committee**	**Date**
N/A		

Reports not received as per the annual workplan and action required
N/A

Items/risks/issues for escalation *(Describe the reason for the item being escalated, where it has been escalated to and what action the group needs to take as a result. This may be include for example outstanding action where limited progress has been made)*
Issues and or Risks to note: **Reflection:**

Implications for the corporate risk register or Board Assurance Framework
Governance around BAF has been tightened, every section of the BAF will be updated on a monthly basis.

Examples of outstanding practice or innovation
N/A

Meeting of the Trust Board
Date: 07 September 2023

Meeting			
Title of Report	**Assurance and Escalation Report**	Agenda Item	7.2
Lead Director	Alan Davies, Chief Financial Officer Annyes Laheurte, Non-Executive Director		
Report prepared by	Elaine Adams, Business Support Manager - Finance		
Report Approved by	Alan Davies, Chief Financial Officer Paul Kimber, Deputy Chief Financial Officer Annyes Laheurte, Non-Executive Director		
Executive Summary	The enclosed report sets out the key discussions held at the Finance, Planning and Performance Report. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts, financial recovery update, harmonising of bank rates and national cost collection pre submission report.		
Committees or Groups at which the paper has been submitted	n/a		
Resource Implications	n/a		
Legal Implications/ Regulatory Requirements	n/a		
Quality Impact Assessment	none		
Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐ / Noting ☐
Appendices			

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

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

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Finance, Performance and Planning Committee	24/08/2023	Annyes Laheurte

Number of attendees	Number of apologies	Quorate	
		Yes	No
14	5	X	

Declarations of Interest Made
N/A

Assurance received at the Group meeting

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

Business Assurance Framework and Risk Register

- There have been no changes to the BAF or risk register scores. The scores on the BAF and risk register were agreed.
- Concerns around medical staffing and the efficiency programme remain. Mitigations are being put in place to address this issue.
- Elective services on the risk register will be adjusted to reflect the impact of industrial action. The Trust is currently achieving 106%.

Financial Performance

- Month four is reporting a £13m deficit year to date, which is £5m adverse to plan. Month four has an in-month deficit of £3.4m against a £1m deficit target. The Trust is £2m behind the ESRF income target but is still accruing to plan. The main expenditure variances are the medical and nursing staff costs which are being addressed in the breakthrough meetings.
- Nursing costs are primarily due to the impact of enhanced/specialling care. Controls are being implemented to alleviate this. Bank and agency costs along with bed escalation bed pressures are being reviewed.
- Capital is £4.8m behind the profile plan due to the phasing of some major schemes such as the CDCs. Endoscopy is a risk due to slippage in the rebuild scheme. An interim modular solution will be used with support from ICB.
- The Trust is £3m behind the income plan for activity which is mainly due to non-elective and A&E. There is some risk with the CDC income which the Trust is working through with ICP.

Efficiencies Programme

- The overall RAG rating for July is red.
- Progress is being made with what is currently being delivered and the schemes that have been identified.
- Just under £17m schemes have been identified against a £27m target. Schemes currently being delivered are £10m are currently being delivered. The Trust has a gap of £10m, £8.5m worth of additional schemes should be going through the panel this month that will be phased in Q3 and Q4, some schemes will run into next year, for example around IT and AI. The schemes total £25m which is £2m short of the total target.
- £1m from the counting and capture work has contributed to this.

Capture and Counting Programme

- The improvement of Capture and Counting will have a positive impact in the recording of clinical activity.
- The initial focus is to concentrate on things that will make a difference to the efficiency target.
- Areas that are not being correctly funded, or not funded at all will be highlighted once the data is accurate.
- Dashboards are to be set up to easily depict data at a glance which will enable the users to spot when things are wrong. A proposal of how to introduce this to the organisation stage by stage will be produced in October/November.
- Income and costs will be clearer once the data is accurate.
- The improved data can highlight areas that money can be spent on that would produce a good patient outcome and a good economic value
- Negotiations for next year can be carried out when the data is present.
- An update of the Capture and Counting Programme will be submitted to the FPPC in November.

Performance report

- The non-elective pressures continue to be high throughout July.
- The ambulance handovers have improved. The average ambulance handover is currently twelve minutes.
- The Trust's ED performance is around 71%/72%. The Trust is continuing to work towards 76%. 76%-78% is regularly reached throughout the week and at weekends. Type one is 65/66%.
- The 52 week position has increased from 870 to over 1,000 patients, the rise is mainly due to industrial action. Plans are in place to reduce the 52 week list.
- Plans are in place to recover diagnostics, the main problem being endoscopy, which NHSE is supporting the Trust with. DVH is now aiding the Trust with taking some patients so that the backlog is reduced. A modular build to place into the unit is being reviewed to increase the Trust's capacity by 400 patients per month. Clinical triage has been introduced.
- The cancer performance for July remains consistent. Waiting lists are continually being validated.
- RTT remains a priority. The aim is to treat all patients within 40 weeks. The Trust is at 65 weeks in some areas such as ENT, the Patient First methodology is being used to address this.
- Data quality has improved, allowing the Trust to validate the information produced with the clinicians in the ED in real time. The improvement in performance is being monitored.

- Type three performance is not consistent. The Trust is working with MedOCC to obtain stability around this.
- Issues in CDU have been reviewed. Safe Haven is now on site. Mental health patients are now directed to Safe Haven which allows CDU to be used for the correct purpose. The CDU pathway has now been refreshed. The patients being seen have risen from 242 in June to 322 in July. It is planned to fully maximise CDU during the winter pressures.
- Teletracking is due to be implemented within the next few weeks, which is anticipated to improve the Trust's admitted performance. The risk ratings in the BAF and the corporate risk register will be expected to benefit from the implementation of Teletracking, the expected benefits from discharge before noon and bed resources etc. should be reported.
- Performance is being monitored through SDRs. Patient First methodology is being used at care group level.
- The Trust was second nationally last week with regards to the ambulance handover.
- NHSE has asked the Trust to validate it to twelve weeks. Currently the Trust validates to 36 weeks.
- Work is being done to finalise the winter plan which will be submitted to the September board.
- The Trusts' procedures with regards to "freedom to speak up" should be discussed at the next Private Board in light of the Lucy Letby situation.

Financial Recovery Plan refresh

- This paper has been updated since last month following further work and further review.
- The draft reconciliation of establishment growth have been completed from 2019/20 up until the beginning of 2023/24.
- The Trust has grown in some areas. The Trust's budgeted establishment has seen an approximate 500 whole time growth in workforce, which is 11%. It is being assessed if the Trust is getting value for money in the workforce, considering the activity has barely changed since 2019/20. Activity is now growing. Efficiencies from the workforce investments will be reviewed, quality as well as activity will be assessed and reviewed with the operational teams and a further update will then be submitted to this group.
- The introduction of enhanced controls is shown as a way to tighten the financial processes.
- Further detail is being implemented around the additional controls that are in line with the level four controls. Reviews will be done of all agency and vacant posts, with further controls around areas such as consulting, outsourcing and enhanced care. Pending the outcome of the review, a non-clinical staff freeze may occur.
- Temporary staffing will be reported weekly along with a future six month forecast.
- The Trust is tasked with achieving financial sustainability but will need to consider the quality of patient care as a priority along with the financial implications. Clearing the patient backlog along with costs involved needs to be analysed together to reach the correct decision on what path to take.

Harmonising of Bank Rates

- The Trust has a history of strong controls on bank and temporary staffing usage.
- Negotiations are done centrally which has led to a £40m reduction in agency usage per year since 2016.
- The bank has been split between nursing grades and non-nursing grades.
- Historically, the Trust has been a high payer of bank rates, other organisations have harmonised with the Trust. Due to the lack of the system approach, bank rates are now paid at the national living wage.

- The bank consists of 80% of the Trust's employees who work beyond their contractual hours. The remaining 20% are bank-only contracts.
- A proposal is being put forward to harmonise between nursing and non-nursing rates. The move to the next lowest rate within the system, which is MTW and Kent Community Trust, is being pursued.
- If the rates were to be implemented immediately, the unmitigated cost, based on the 2022/23 usage, would be an extra cost of £3,557,000 mitigated to the Trust.
- Cost neutral bank rates for non-safe staffing roster cover requests have been ensured, saving £374k. This approach will encourage substantive recruitment as opposed to using temporary staff.
- Long-term bank and agency positions are reviewed weekly and a plan put in place to recruit substantively for these positions. Some positions cannot be filled due to labour market constraints.
- Currently, the Trust is a aiming to achieve 84% of the total workforce being substantive. The future aim is for 90%, 7.5% bank and 2.5% agency.
- Recruiting has been reviewed to ensure that the process is handled in a timely manner.
- After mitigation, the base rate should be reduced from £3,557,000 t £2,053,000. Further work needs to be done on mitigation which will be implemented on the 1st of September or the 1st of October, this needs to be aligned with financial controls.
- Budgets are funded based on a substantive agenda for change pay rates. Further strengthening of controls are needed to ensure that the utilisation of bank is managed within the funded pay budgets and to ensure that the £2.5m deficit is not added to the bottom line.
- The work will be completed and presented to the FPPC next month.

National Cost Collection 2022/23 Pre submission report

- The Trust has an index of 95, which is 5% below the national mean compared with the expected costs, based on national average costs, that have been applied to the Trust's case mix.
- The value is £18m below what the expected costs would be.
- The report sets out the details behind this. Some specialities have opportunities that are outliers, work is being done to understand why this is. Opportunities for cost reduction are to be identified when it is scrutinised as speciality level.
- This report shows that how the Trust resolves the underlying deficit is more related to income than cost reduction.
- The Trust has moved from 44th to 20th in terms of lowest average costs.
- The work that is being done on the capture and counting programme will have an impact on these figures.

Key actions

1. Chief Financial Officer to submit a full report on the forecast outturn at the next FPPC meeting in September.
2. Chief Financial Officer will bring back a full report on the Endoscopy business case to the next meeting.
3. Capture and Counting update to be added to the workplan for November.
4. Chief Executive Officer to liaise with Chief Operating Officer regarding the winter plan and confirm when the plan will be ready to submit to the board.
5. Chief Operating Officer to review the NHSE request to validate up to twelve weeks from 36.
6. Business Support Manager to notify the Co. Secretaries' that the Trusts' procedures with regards to "freedom to speak up" should be discussed at the next Private Board in light of the Lucy Letby situation.

7. Chief Financial Officer to give a further update on the workforce growth at the September FPPC.
8. Business Support Manager to inform the Co. Secretaries and LH that the People Committee review the implications of the harmonising of bank rates on potential wellbeing and staff issues.

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

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

Terms of Reference

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

Item	Group, Subcommittee, Committee	Date
N/A		

Reports not received as per the annual workplan and action required

N/A

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

Issues and or Risks to note:

Reflection:

Implications for the corporate risk register or Board Assurance Framework

Examples of outstanding practice or innovation

Meeting of the Board of Directors in Public
Wednesday, 13 September 2023

<table>
<tr><td>Title of Report</td><td colspan="3">Finance Report – Month 4</td><td>Agenda Item</td><td>7.2</td></tr>
<tr><td>Author</td><td colspan="5">Alan Davies, Chief Finance Officer
Paul Kimber, Deputy Chief Finance Officer
Matthew Chapman, Head of Financial Management
Isla Fraser, Financial Controller</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Alan Davies – Chief Finance Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">The Trust reports a £13.1m deficit for month 4, this being £5.0m adverse to the plan.
The monthly deficit target for the Trust is £1m per month for the remainder of the year.
Efficiencies to date total £3.4m this being £1.1m adverse to plan.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">This report is provided for assurance</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td>✓</td><td>Approval</td><td colspan="2"></td></tr>
<tr><td>Noting</td><td>✓</td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Finance, Performance and Planning Committee – 24 August 2023</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)
✓</td><td>Priority 2: (People)</td><td>Priority 3: (Patients)</td><td>Priority 4: (Quality)</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led:
✓</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5">Non-delivery of the breakeven control total</td></tr>
<tr><td>Resource implications:</td><td colspan="5">N/A</td></tr>
</table>

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

Finance report

For the period ending 31 July 2023

Contents

1. Executive summary
2. Income and expenditure
3. Activity and income
4. Efficiencies programme
5. Balance sheet
6. Capital
7. Cash
8. Risks and forecast
9. Conclusions

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(988)	(3,418)	(2,430)	The Trust is reporting a £3.4m deficit for July and £13.1m year to date (YTD), this position is £5.0m adverse to plan. The YTD position includes Elective Services Recovery Funding (ESRF) income of £5.3m and Community Diagnostics Centre (CDC) income of £3.2m; there is a risk of a partial repayment for both of these income sources as planned activity levels are not being fully delivered, this has been estimated to date as £2.0m for ESRF and £2.7m for CDC. It has been agreed with NHSE and the Kent & Medway Integrated Care Board (ICB) to report ESRF income on plan irrespective of possible under / over performance at this stage. The main deficit variances to budget are due to medical and nursing staff overspending as well as the unfound efficiencies to date of £2.1m. Medical staff industrial action has impacted adversely on services delivering ESRF activity; in additional to this there is a requirement for temporary staff to cover medical vacancies and operational pressures in emergency care, as well as ongoing nurse recruitment issues requiring agency staff cover at a premium cost. Beds pressures continue in Unplanned Care Divisions on McCulloch Ward as well as Emerald assessment unit and short stay beds. Using patient first methodology, an A3 breakthrough objective approach has been implemented identifying these drivers and agreeing mitigating actions. The planned deficit reduces to £1.0m in July, this is a reduction from the £2.4m per month in the first quarter due to the efficiency plan phasing; as the efficiencies are not delivering as planned the in-month run rate deficit is £3.4m which is broadly in line with the average of the first quarter at £3.3m.
Donated Asset Depreciation	22	22	(0)	
In-month total	**(966)**	**(3,396)**	**(2,430)**	
YTD total (adjusted)	**(8,119)**	**(13,081)**	**(4,962)**	
Efficiencies Programme				
In-month	3,014	1,799	(1,215)	The delivered efficiency programme totals £1.8m for July, this is £1.2m adverse to plan as some of the cross cutting themes are not delivering, in addition to schemes not being identified as required to meet the stretch target. The total savings plan target for the year is £27m, this is a £14m original target which has been allocated to all divisions, with an additional £13m stretch target that is held centrally.
YTD	4,505	3,395	(1,110)	
Cash				
Month end	31,552	29,000	(2,552)	Cash is £2.6m adverse to plan in line with the unplanned in month deficit.

Capital				
In-month YTD	1,877 7,509	682 2,727	(1,195) (4,782)	YTD underspend of £4.8m is due to delays in progress across the main major projects; Endoscopy, CDC, fire works and diagnostic equipment replacement. All reliant on the approval of PIDS and outside contractors being appointed to commence.
Annual Forecast *Of which* System Capital Donations Capital PDC Capital	28,359 13,423 86 14,850	28,359 13,423 86 14,850	0 0 0 0	Since Month 3 • £0.1m donation funding has been agreed for priority equipment replacement. • Strategic outline for an 'elective hub' has been developed ready for submission for an 'in principle agreement' from NHSE before a full business case is drawn up. This would cost approx. £25m in capital to develop and would need to be ready to start in 2024/25.

2. Income and expenditure

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	29,929	30,517	588	119,715	121,168	1,453
High cost drugs	2,030	2,388	358	8,121	8,553	432
Other income	2,367	3,250	883	9,469	10,596	1,127
Donated Asset Adjustment	-	-	-	-	(26)	(26)
Total income	**34,326**	**36,156**	**1,830**	**137,305**	**140,291**	**2,986**
Nursing	(9,188)	(9,707)	(519)	(37,158)	(39,124)	(1,966)
Medical	(6,040)	(8,088)	(2,048)	(26,246)	(31,523)	(5,277)
Other	(6,306)	(6,659)	(354)	(25,827)	(26,018)	(191)
Total pay	**(21,534)**	**(24,454)**	**(2,920)**	**(89,231)**	**(96,665)**	**(7,434)**
Clinical supplies	(4,042)	(5,006)	(964)	(16,998)	(18,012)	(1,014)
Drugs	(863)	(1,223)	(360)	(3,659)	(4,329)	(670)
High cost drugs	(2,041)	(2,388)	(347)	(8,165)	(8,553)	(388)
Other	(4,710)	(4,294)	417	(18,967)	(17,599)	1,368
Total non-pay	**(11,657)**	**(12,912)**	**(1,255)**	**(47,789)**	**(48,493)**	**(704)**
EBITDA	**1,135**	**(1,210)**	**(2,345)**	**286**	**(4,867)**	**(5,152)**
Depreciation	(1,508)	(1,508)	(0)	(6,032)	(6,032)	(0)
Donated asset adjustment	(22)	(22)	0	(88)	(88)	0
Net finance income/(cost)	96	11	(85)	383	574	190
PDC dividend	(689)	(689)	0	(2,756)	(2,756)	0
Non-operating exp.	**(2,123)**	**(2,208)**	**(85)**	**(8,493)**	**(8,302)**	**190**
Reported surplus/(deficit)	**(988)**	**(3,418)**	**(2,430)**	**(8,207)**	**(13,169)**	**(4,962)**
Adj. to control total	22	22	-	88	88	-
Control total	**(966)**	**(3,396)**	**(2,430)**	**(8,119)**	**(13,081)**	**(4,962)**

1. The YTD clinical income includes Elective Services Recovery Fund ("ESRF") funding of £5.3m; this figure is reported on plan, the risk of repayment if agreed activity targets are not achieved has increased by £0.2m from month 3 to £2.2m. The associated cost to the independent sector and additional consultant sessions to deliver ESRF activity is £2.2m YTD.
2. Delivery of ESRF activity targets has been impacted by medical staff industrial action. The Trust has received a national notification that activity targets will be adjusted down to 107% from 109%, this will be discussed further with the ICB.
3. Other income YTD favourable variance includes recharges for pass through drugs costs £0.3m and £1.0m medical education income above plan.
4. The adverse pay position continues to be premium costs for medical and nursing staff cover vacancies, activity pressures, industrial action cover, 1:1 nursing.
5. The drugs adverse variance YTD is due to activity pressures mainly in acute and emergency medicine and ESRF as well as insulin pumps expenditure of £0.3m that has been treated as a pass-through costs and offset in the Other Income category.
6. Clinical Supplies adverse variance YTD is due to maintenance contracts £0.2m, 2nd MRI scanner and activity pressures in Unplanned Care Division totalling £1.1m, theatres and prosthetic stock purchases £0.4m. To date, £2.2m of the ESRF expenditure reserve has been issued to divisions to cover additional costs of delivering activity. A further benefit of £3.0m of the reserve is included to offset some of the adverse variances from overspending and non-delivery of the efficiency targets of £2.7m.
7. The favourable variance in other non-pay is from the reserves held centrally included in the position.

3. Activity and Income

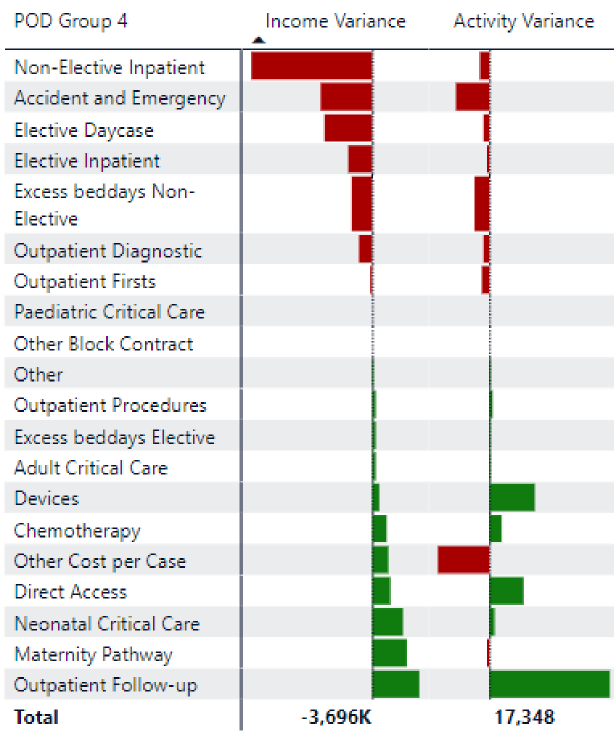
POD Group	Planned care YTD Plan £'000s	Planned care YTD Actual £'000s	Planned care YTD Variance £'000s	Unplanned & Integrated Care YTD Plan £'000s	Unplanned & Integrated Care YTD Actual £'000s	Unplanned & Integrated Care YTD Variance £'000s	Totals YTD Plan £'000s	Totals YTD Actual £'000s	Totals YTD Variance £'000s
Accident and Emergency	0	0	0	6,832	5,050	(1,781)	6,832	5,050	(1,781)
Adult Critical Care	3,152	3,092	(60)	0	181	181	3,152	3,273	121
Chemotherapy	437	834	396	13	87	74	450	921	470
Devices	115	85	(30)	805	1,029	223	920	1,114	194
Direct Access	202	392	190	3,548	3,942	394	3,751	4,334	583
Elective Daycase	6,484	4,894	(1,590)	2,233	2,216	(17)	8,717	7,110	(1,607)
Elective Inpatient	7,167	6,284	(883)	148	181	33	7,315	6,465	(850)
Excess beddays Elective	47	149	101	48	64	15	95	212	117
Excess beddays Non-Elective	636	998	362	1,757	702	(1,055)	2,394	1,700	(693)
High Cost Drugs	2,079	2,336	257	5,714	6,217	504	7,793	8,553	760
Maternity Pathway	2,723	3,845	1,121	0	0	0	2,723	3,845	1,121
Neonatal Critical Care	3,076	4,119	1,043	0	0	0	3,076	4,119	1,043
Non-Elective Inpatient	18,130	18,775	645	25,947	21,190	(4,757)	44,077	39,966	(4,111)
Other	85	118	33	52	49	(2)	136	167	31
Other Block Contract	578	578	0	570	570	0	1,148	1,148	0
Other Cost per Case	1,003	728	(274)	69	843	774	1,072	1,572	500
Outpatient Diagnostic	0	570	570	2,301	1,267	(1,034)	2,301	1,837	(464)
Outpatient Firsts	4,032	3,547	(484)	1,629	2,037	407	5,661	5,584	(77)
Outpatient Follow-up	1,815	2,707	892	2,099	2,806	707	3,914	5,513	1,599
Outpatient Procedures	2,621	2,744	123	213	200	(13)	2,833	2,944	111
Paediatric Critical Care	70	67	(2)	0	0	0	70	67	(2)
Total PbR Income	54,452	56,862	2,411	53,978	48,632	(5,346)	108,429	105,494	(2,935)
Block Adjustment K&M ICB							16,906	20,257	3,351
Block Adjustment SEL ICB							(123)	(164)	(41)
Block Adjustment Spec Comm							1,647	752	(895)
Block Adjustment NHSE Other							102	(69)	(171)
Block Adjustment LVA							(1,122)	(430)	691
Total Block Adjustments							**17,410**	**20,346**	**2,935**
Total Block Income							**125,840**	**125,840**	**0**

The table sets out the income and activity performance for the Trust at point of delivery ("POD") for the year to date as at month 4. The Trust is below plan by £2.9m overall (includes High Cost Drugs) resulting in a benefit to the block.

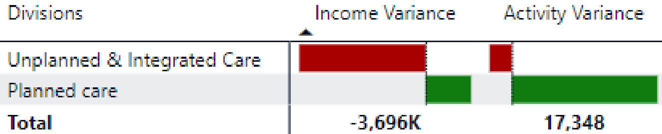
- Planned Care division is £2.4m above plan, driven by over performance in outpatient follow-ups, neonatal critical care and maternity pathway. Unfortunately these are within the fixed element (block) of the contract and represents no benefit to the Trust by the way of additional income. The over performance is offset by the underperformance in Elective Service Recovery Fund (ESRF) PODs in elective day cases, elective inpatients and outpatient firsts. Further details are described below.
- Unplanned care is £5.3m below plan, most of which is driven by non-elective underperformance (£4.8m) and A&E (£1.8m).
- The income lost due to industrial action is estimated to be £1.9m with £1.8m related to ERF. Further details are described below.
- There is a possible risk of clawback of £2.7m in CDC funding due to delays in opening both the Rochester and Sheppey sites. The Trust is seeking clarification on the probability of the clawback.

M4 Income and activity by POD (excl. HCD)

The underperformance in M4 for the SLA income based on national tariff is £3.7m excluding high cost drugs. This is an improvement from M3 of £0.5m mainly due to late coding of non-elective activity. The benefit from high cost drugs is £0.8m resulting in an overall under performance of £2.9m. The underperformance is mostly driven by low activity in admitted patient care; this is explored further below.



POD Group 4	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Non-Elective Inpatient	£44,077K	£39,966K	-4,111K	19,031	17,659	-1,372
Accident and Emergency	£6,832K	£5,050K	-1,781K	36,152	30,757	-5,395
Elective Daycase	£8,717K	£7,110K	-1,607K	9,157	8,307	-850
Elective Inpatient	£7,315K	£6,465K	-850K	1,816	1,626	-190
Excess beddays Non-Elective	£2,394K	£1,700K	-693K	7,456	5,155	-2,301
Outpatient Diagnostic	£2,301K	£1,837K	-464K	19,301	18,505	-796
Outpatient Firsts	£5,661K	£5,584K	-77K	41,261	40,282	-979
Paediatric Critical Care	£70K	£67K	-2K	93	90	-3
Other Block Contract	£1,148K	£1,148K	0K	10,146	10,146	0
Other	£136K	£167K	31K	1,078	1,311	233
Outpatient Procedures	£2,833K	£2,944K	111K	13,613	14,200	587
Excess beddays Elective	£95K	£212K	117K	266	632	366
Adult Critical Care	£3,152K	£3,273K	121K	2,536	2,790	254
Devices	£920K	£1,114K	194K	17,748	25,166	7,418
Chemotherapy	£450K	£921K	470K	2,704	4,977	2,273
Other Cost per Case	£1,072K	£1,572K	500K	21,860	13,708	-8,152
Direct Access	£3,751K	£4,334K	583K	838,370	844,176	5,806
Neonatal Critical Care	£3,076K	£4,119K	1,043K	3,096	4,059	963
Maternity Pathway	£2,723K	£3,845K	1,121K	3,327	3,112	-215
Outpatient Follow-up	£3,914K	£5,513K	1,599K	45,423	65,125	19,702
Total	**£100,637K**	**£96,941K**	**-3,696K**	**1,094,434**	**1,111,782**	**17,348**



Divisions	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Unplanned & Integrated Care	£48,264K	£42,414K	-5,850K	986,222	983,086	-3,136
Planned care	£52,372K	£54,526K	2,154K	108,212	128,696	20,484
Total	**£100,637K**	**£96,941K**	**-3,696K**	**1,094,434**	**1,111,782**	**17,348**

M4 Income and activity by POD (excl. HCD)

- Non-elective underperformance is £4.8m YTD at M4 including excess bed days. The underperformance is driven by Geriatric medicine of £4.3m. This is due to the ambitious planned growth in non-elective activity of 28% compared to 2019/20 and 44% compared to 2022/23. Other under performances include Diabetic Medicine of £1.3m, Gastroenterology of £1.4m and Respiratory of £1.2m. These specialties are similarly driven by ambitious planned growth. General Medicine is showing an over performance of £4.4m and based on the Model Hospital work done by the Costing Team indicates the over performance is mainly driven by patients with co-morbidity.
- Elective inpatients and day cases are £2.3m YTD below plan, driven by low activity and industrial action. Work to deliver the ESRF via additional sessions and insourcing has commenced and Harvey ward and Theatre 5 is expected to open in September. The activity plan assumed that this would begin in April. The impact of the Industrial action on elective inpatient and day cases is estimated to be £1.5m YTD.
- Outpatient income for first attendances is below plan by less than £0.1m, mainly driven by reduced activity in Paediatrics £147k and ENT of £94k offset by Gastroenterology of £252k and Neurology £158k. The impact of the industrial action is estimated to be £330k.
- ESRF performance is below the target YTD at M4 by £2.2m due to activity being below the plan. Under current ESRF rules this is expected to be clawed back however due to industrial action it has been agreed with NHSE and the Kent & Medway Integrated Care Board (ICB) to report on plan irrespective of possible under / over performance and thus has not been reflected in the financial position at this stage. The following table shows the current performance of ESRF of 91% against the ICB target of 112% ICB. The line below the table shows the Trust's performance against the recorded activity in 19/20 and is performing above the levels as 19/20 in May and June, but below in April and July.

Month	April	May	June	July	Total
Day Cases	73%	87%	87%	81%	**82%**
Elective Inpatient	81%	92%	104%	83%	**90%**
OPFA	92%	94%	107%	101%	**99%**
OPPROC	114%	109%	109%	86%	**105%**
Total	**84%**	**93%**	**99%**	**87%**	**91%**
Performance % against 19/20	**91%**	**104%**	**109%**	**97%**	**100%**

- Outpatient income for follow up attendances is above plan by £1.6m. This activity is paid as part of the fixed element and does not form part of ESRF.
- Chemotherapy treatments are above the activity and financial plan of £0.5m at M4. The improvement is mainly attributed to improved utilisation through the addition of specialist chemo agency nursing to dispense treatments. The activity is paid on a cost and volume basis by NHSE as part of the variable element of the Aligned Payment and Incentive ("API") contract.
- Direct access activity is above plan by £0.6m due to over performance in Cardio-Respiratory. Direct Access Radiology, which is part of the variable element of the contract and is below plan by £86k.
- Neonatal cot days are above plan and resulting in a favourable income of £1.0m at M4 and 963 days above plan. 328 cot days of £0.5m are related to patients yet to be discharged at the end of July. The remaining favourable movement was mainly due to additional activity on patients exhibiting higher acuity.

4. Efficiency programme

Status £'000	Blue	Green	Amber	Red	Sub-total	Cross Cutting	Sub-total Identified	Over / (un-) identified	Plan Target
Planned care	88	518	650	5	1,262	3,367	4,629	(1,174)	5,803
UIC	0	47	0	45	91	3,241	3,332	(2,239)	5,571
E&F	251	673	0	0	925	0	925	(350)	1,275
Corporate	6	134	0	0	140	394	535	(816)	1,351
Central	0	94	0	0	94	4,033	4,127	4,127	0
Sub-total	**346**	**1,467**	**650**	**49**	**2,512**	**11,035**	**13,547**	**(453)**	**14,000**
Unidentified	0	0	0	0	0	0	0	(13,000)	13,000
Total	**346**	**1,467**	**650**	**49**	**2,512**	**11,035**	**13,547**	**(13,453)**	**27,000**
Month 3 position	*369*	*1,273*	*951*	*829*	*3,422*	*11,280*	*14,702*	*(12,298)*	*27,000*
Movement in-month	***(23)***	***194***	***(301)***	***(780)***	***(910)***	***(245)***	***(1,155)***	***(1,155)***	***0***

Status £'000	YTD Plan	YTD Delivery	Variance
Planned care	981	419	**(561)**
UIC	1,021	812	**(208)**
E&F	168	464	**296**
Corporate	138	138	**(0)**
Central	922	1,562	**640**
Sub-total	**3,229**	**3,395**	**167**
Unidentified	1,276	0	**(1,276)**
Total	**4,505**	**3,395**	**(1,110)**
Month 3 position	*1,490*	*1,596*	***106***
Movement in-month	***3,015***	***1,799***	***(1,216)***

Cross cutting schemes BRAG status

Status £'000	Blue	Green	Amber	Red	Sub-total
Total	231	10,504	0	300	**11,035**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**3,014**	**1,799**	**(1,215)**	**4,505**	**3,395**	**(1,110)**	**27,000**	**12,443**	**(14,557)**

Process

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

The delivered efficiency programme position for the year to date is £3.4m; this includes £2.6m from the cross cutting schemes, mainly for procurement, patient flow length of stay reduction £0.5m, clinical productivity in theatres £0.3m, medical job planning £0.2m, interest received £0.2m, medicines management and elective work efficiencies.

The efficiency programme continues to be prioritised with more project management office (PMO) capacity being proposed and sourced. The Executive Team have held a check & challenge meeting where all schemes were addressed or discussed in more detail with divisions. Specific feedback and actions has been requested within a set timetable for response, as well as finalising of PIDs to be presented at the panel.

5. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
273,519	**Non-current assets**	**270,124**	**(3,395)**
6,375	Inventory	6,187	(188)
29,089	Trade and other receivables	21,342	(7,747)
34,742	Cash	29,000	(5,742)
70,206	**Current assets**	**56,529**	**(13,677)**
(953)	Borrowings	(679)	274
(50,284)	Trade and other payables	(42,396)	7,888
(1,320)	Other liabilities	(5,643)	(4,323)
(52,557)	**Current liabilities**	**(48,718)**	**3,839**
(1,952)	Borrowings	(1,888)	64
(1,031)	Other liabilities	(1,031)	0
(2,983)	**Non-current liabilities**	**(2,919)**	**64**
288,185	**Net assets employed**	**275,016**	**(13,169)**
475,198	Public dividend capital	475,198	0
(251,419)	Retained earnings	(264,588)	(13,169)
64,406	Revaluation reserve	64,406	0
288,185	**Total taxpayers' equity**	**275,016**	**(13,169)**

Key messages:

1. Non-current assets are £3.4m lower than year end, being the net impact of investment expenditure of £2.7m and £6.1m depreciation.

2. Trade and other receivables are £21m (61% of average monthly income).

3. Cash has decreased by £5.7m mainly due to Trust pay expenditure being higher than expected YTD.

4. Trade and other payables are £42.4m (123% of average monthly expenditure), £7.9m improvement on the year-end balance due to the net impact of the pay deal and settlement of March capital creditors.

5. Other liabilities are £4.3m higher as a result of deferred income relating to advance payment of HEE Income paid quarterly in advance.

6. Capital

2023/24 Capital Expenditure Update

£'000	In-month			Year To Date			Annual				Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	NHSE Reported Variance	Internal (system capital)	PDC	OTHER
Backlog Maintenance	207	435	228	827	799	(28)	2,480	2,480	2,480	0	2,480	0	0
Routine Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire	104	111	7	417	48	(369)	972	1,251	1,251	0	1,251	0	0
Medical and Surgical Equipment Programme	406	11	(395)	1,624	361	(1,263)	5,150	4,871	4,671	(200)	4,871	0	0
IT	47	(118)	(165)	187	(51)	(238)	1,362	562	563	1	562	0	0
Service Developments	217	78	(139)	870	78	(792)	2,451	2,609	2,609	0	2,609	0	0
Total System Capital	**981**	**517**	**(464)**	**3,925**	**1,235**	**(2,690)**	**12,415**	**11,773**	**11,574**	**(199)**	**11,773**	**0**	**0**
IT - EPR	167	198	31	667	506	(161)	1,200	2,000	2,000	0	800	1,200	0
IT - PACS/RIS/IREFER	6	(11)	(17)	25	76	51	0	76	76	0	0	76	0
Endoscopy	192	(2)	(194)	767	(2)	(769)	2,300	2,300	2,300	0	0	2,300	0
CDC	547	12	(535)	2,188	730	(1,458)	6,564	8,428	8,428	0	1,008	7,420	0
Total Planned Additional Capital	**912**	**197**	**(715)**	**3,647**	**1,310**	**(2,337)**	**10,064**	**12,804**	**12,804**	**0**	**1,808**	**10,996**	**0**
Total Planned Capital	**1,893**	**714**	**(1,179)**	**7,572**	**2,545**	**(5,027)**	**22,479**	**24,577**	**24,378**	**(199)**	**13,581**	**10,996**	**0**
Cardio Village	0	0	0	0	0	0	0	3,854	3,854	0	0	3,854	0
IT- Paeds Adoption	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Hub	0	0	0	0	0	0	0	0	0	0	0	0	0
Donated Equipment - LOF	0	0	0	0	0	0	0	86	86	0	0	0	86
Total Additional Capex	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,940**	**3,940**	**0**	**0**	**3,854**	**86**
Unplanned Expenditure*	0	74	74	0	288	288	0	0	288	288			
Slippage Target	(16)	(106)	(90)	(63)	(106)	(43)	0	(158)	(247)	(89)	(158)		
Total Capex	**1,877**	**682**	**(1,195)**	**7,509**	**2,727**	**(4,782)**	**22,479**	**28,359**	**28,359**	**0**	**13,423**	**14,850**	**86**

2023/24 Capital Expenditure Monthly Profile

The total 2023/24 capital investment for the Trust is forecast at £28,359k funded by;

- £13,423k of system capital, £12,415 ICB allocation and £1,008k of unspent PDC brought forward from 2022/23. The ICB allocation is funded from the Trusts internal depreciation.
- £14,850k PDC, additional funding from the Department of Health with a PDC dividend repayment rate of 3.5% per annum (£424k). This is similar to a loan interest charge and will impact the Trust I&E position.
- £86k charitable donations, Equipment bids of £130k were submitted to and agreed by League of Friends for funding, £86k towards capital equipment, £44k towards revenue purchases, all expected to be delivered in August.

Capital continued

YTD Capital is £4,782k behind plan, mainly due to large projects which were phased over 12 months which are yet to start;

Project	YTD Budget	YTD Actual	YTD Slippage	2023/24 Budget	2023/24 Forecast	Narrative	Funded by
	£'000	£'000	£'000	£'000	£'000		
Endoscopy	1508	(2)	(1,510)	4,525	4,525	Project budgeted to start in April and continue through 2023/24. However, the initial design of the development within the business case was deemed unsuitable by building contractors. £0.5m redesign budget has been allocated to complete a revised business case. This is likely to delay the start of any works until Q4 or beyond. A review is underway to estimate realistic timescales and realignment of funds should it be necessary	PDC & internal funds
CDC	2,188	730	(1,547)	8,428	8,428	Building works are being managed by NHS Property services and Community Health Partnerships, delays have occurred due to planning applications requiring approval before works can start. Rochester outcome is expected by end of August, Sheppey approval may not be received until October. The aim is still to complete by 31st March 2025.	PDC
Gamma Camera	667	0	(667)	2,000	2,000	Camera has been sourced, before it can be purchased enabling works need to be fully scoped and approved by Trust Investment Group (TIG). Completion by year end is a priority for the Trust and patients due to the age of equipment being replaced.	£1m prior year system capital/current year internal funds
MRI Enabling	600	67	(533)	1,800	1,600	MRI was purchased in 2022/23 with PDC funds and is currently in storage at an additional cost to the trust. Enabling works are being scoped by the supplier with the Trust for TIG approval in the next month. Completion by December is expected.	prior year PDC/current year internal funds
Pharmacy Robot	167	11	(156)	500	500	Installation of the equipment purchased in 2022/23 requires a service decant which is in planning stages. Once agreed the installation can happen over a number of weeks. Expected completion before December.	internal funds
Fire urgency works	417	48	(369)	1,251	1,251	Due to the reduced level of funding Estates have reviewed fire priorities before work could commence. This is now complete and work is due to commence in July and continue through to December.	internal funds

There are no planned projects currently forecast to overspend, however to date £288k of unplanned spend has occurred in relation to prior year project completion. The detailed plan was approved with an over commitment of £158k, in the forecast this balance has increased to £247k which is therefore the slippage needed across the programme to achieve our CRL.

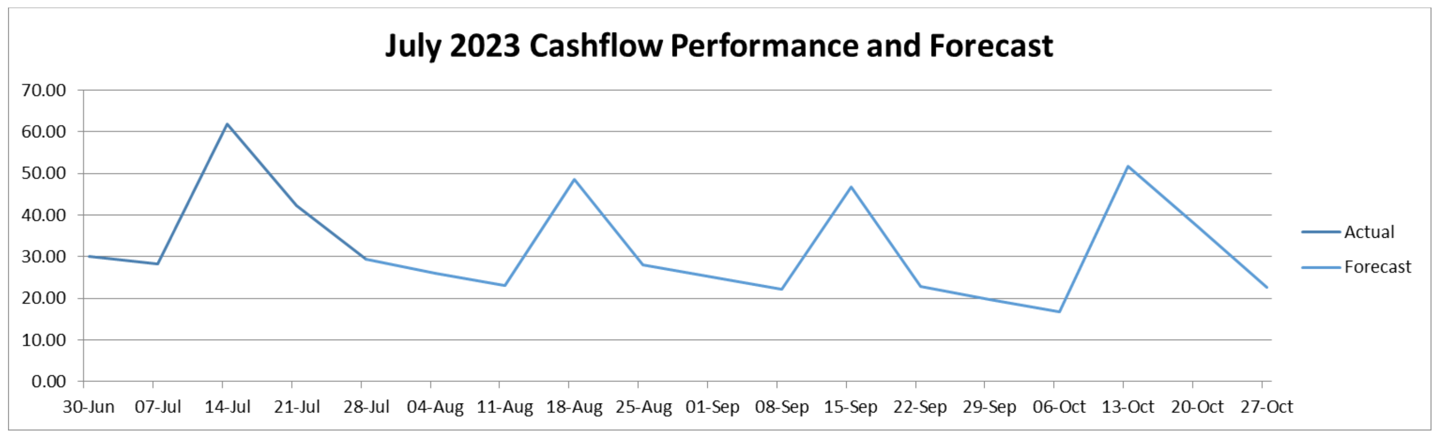
There is one new project in the pipeline for 2023/24 for the development of an Elective Hub, this is still in a scoping and approval stage with NHSE but could be in the region of £25m+ capital with an immediate current year delivery timeframe.

7. Cash

13 Week Forecast

w/e

£m	Actual					Forecast												
	30/06/23	07/07/23	14/07/23	21/07/23	28/07/23	04/08/23	11/08/23	18/08/23	25/08/23	01/09/23	08/09/23	15/09/23	22/09/23	29/09/23	06/10/23	13/10/23	20/10/23	27/10/23
BANK BALANCE B/FWD	**36.90**	**30.13**	**28.22**	**61.95**	**42.22**	**29.46**	**25.93**	**23.04**	**48.68**	**28.02**	**25.03**	**22.14**	**46.74**	**22.74**	**19.75**	**16.85**	**51.81**	**37.37**
Receipts																		
NHS Contract Income	0.00	0.11	36.41	0.00	1.60	0.00	0.00	33.48	0.20	0.00	0.00	33.48	0.20	0.00	0.00	37.47	0.50	0.00
Other	0.64	0.22	0.57	0.33	0.54	0.24	0.33	0.70	0.71	0.38	0.33	0.70	0.68	0.25	0.33	0.70	0.25	0.25
Total receipts	**0.64**	**0.32**	**36.97**	**0.33**	**2.14**	**0.24**	**0.33**	**34.18**	**0.91**	**0.38**	**0.33**	**34.18**	**0.88**	**0.25**	**0.33**	**38.17**	**0.75**	**0.25**
Payments																		
Pay Expenditure (excl. Agency)	(0.46)	(0.44)	(0.42)	(14.52)	(12.15)	(0.43)	(0.42)	(3.94)	(18.77)	(0.45)	(0.42)	(0.42)	(22.28)	(0.45)	(0.42)	(0.42)	(10.58)	(12.12)
Non Pay Expenditure	(5.13)	(1.66)	(2.56)	(5.49)	(2.54)	(3.05)	(2.60)	(4.41)	(2.60)	(2.80)	(2.60)	(4.41)	(2.40)	(2.60)	(2.60)	(2.60)	(4.41)	(2.60)
Capital Expenditure	(1.82)	(0.13)	(0.26)	(0.05)	(0.21)	(0.29)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)	(0.20)
Total payments	**(7.41)**	**(2.23)**	**(3.24)**	**(20.06)**	**(14.90)**	**(3.77)**	**(3.22)**	**(8.54)**	**(21.57)**	**(3.45)**	**(3.22)**	**(5.03)**	**(24.88)**	**(3.25)**	**(3.22)**	**(3.22)**	**(15.19)**	**(14.92)**
Net Receipts/ (Payments)	**(6.77)**	**(1.91)**	**33.73**	**(19.73)**	**(12.76)**	**(3.53)**	**(2.89)**	**25.64**	**(20.66)**	**(3.07)**	**(2.89)**	**29.16**	**(24.00)**	**(3.00)**	**(2.89)**	**34.95**	**(14.44)**	**(14.67)**
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(4.55)	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.08**	**0.00**	**(4.55)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**30.13**	**28.22**	**61.95**	**42.22**	**29.46**	**25.93**	**23.04**	**48.68**	**28.02**	**25.03**	**22.14**	**46.74**	**22.74**	**19.75**	**16.85**	**51.81**	**37.37**	**22.70**



Prior year end	£'000	Month end actual	Var.
34,742	Cash	29,000	(5,742)

The overall cash balance has decreased by £1.0m in July.

£40.0m of cash was received in month
£38.0m NHS contract income for the month, £2.0m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£41.0m of cash was paid out by the Trust in month
£13.5m (33%) in direct salary costs to substantive and bank employees
£14.1m (24%) employer costs to HMRC and NHS Pensions which included contributions relating to the 2023/4 pay award and non-consolidated pay award for 2022/23
£13.4m (33%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

8. Risks and Forecast

A detailed forecast at cost centre level has been estimated and will be worked through with services to establish mitigations and action plans to address adverse variances to budget. The key risks to delivery of the operating plan in 2023/24 and their mitigating actions are set out in full in the risk register; in summary these are as follows. (NB – a number of the risks are not quantified at this time as the range is variable and performance potentially volatile.)

Risk	£	Risk score	Mitigating actions
Delivery of the activity plan / ESRF.	TBC	25	• Fully costed plans to deliver target activity levels. • Approval of plans and release of budgeted ESRF reserve to deliver the work. • Monitoring and reporting mechanism
The Trust's capital proposals significantly exceed its allocation.	TBC	12	• Positive confirmation from care groups/divisions of completeness of 5-year capital programme as part of business planning. • Minimum twice yearly review of 5-year capital programme by stakeholders. • Projects on the 5-year capital programme to develop their PIDs/business cases to seek approval should funding become available at short notice.
Identification, development and delivery of the £27m efficiencies programme.	£17.5m (forecast variance vs £27m target)	20	• Sign off the 23/24 cross-cutting schemes at panel. • Progression of 23/24 divisional schemes through the approval panel. • Development of the pipeline / stretch schemes. • Check & challenge meetings with divisions and the Executive Team.
The Trust may not have sufficiently funded/budgeted bed capacity during the year/in winter.	TBC	12	• Capacity and capital planning meetings to proceed. • Follow up and respond to queries with NHSE following submission of UEC capacity funding bid. Implement capital projects thereafter if successful. • Further development and approval of the Patient Flow and Discharge project initiation document at panel. • Detailed plans and funding for step down beds to be developed and agreed.
The system is exploring harmonisation of bank rates, which would create an unfunded cost pressure for the Trust.	c£3m	16	• Resist rate increase within the system. • Quantify the unfunded pressure and seek monies from the system.
Medical and nursing staff continue to overspend.	£7.2m (YTD value)	25	• Breakthrough objective to control overspending and identify cause. • Divisions to implement mitigating actions.
Cost inflation exceeds the tariff inflation provided for this purpose.	TBC	9	• Use of NHS Supply Chain as far as possible. • Robust contract renegotiation where expiring.

In addition to the above, further risks may crystallise in August that would cause a higher adverse position to plan, these include:

- ESRF risk as previously outlined, should any underperformance monies need repayment. This risk remains at £2m at the end of month 4.
- Controls to reduce the underlying run-rate are impacted by other service pressures such as activity demand and further medical strike action.

9. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is £3.4m deficit in-month and £13.2m deficit YTD; this being £5.0m adverse to the deficit plan position as agreed with the ICB and NHSE.

This month's run-rate of £3.4m is broadly in line with the average run-rate for the first 3 months of £3.3m, although July includes a £0.9m non-recurrent benefit from high cost drugs income disputes that have been resolved. The planned deficit for month 4 and the remainder of the year is c.£1m per month, this reflects the impact from the phasing of the efficiency programme.

To address the reported adverse position, the financial recovery plan (FRP) is drawing on the outcomes and actions from the breakthrough huddles and A3 work to mitigate overspending areas associated with medical and nursing staff. The efficiency programme is being supported by the recently established PMO team and recent check & challenge meetings with all services and appropriate managers. Budget holders are being offered training and support from the Finance Department, as well as this, the executive team continues to implement actions to further control spend such as vacancy control panels, as well as drive the efficiency programmes and negotiate more income with the Integrated Care Board.

Alan Davies
Chief Financial Officer
August 2023

Meeting of the Trust Board in Public
Wednesday, 13 September 2023

Title of Report	Progress with the 2023/24 Efficiencies Programme	**Agenda Item**	7.3
Author	Charlene Hogg, acting Programme Management Office Manager (PMO)		
Lead Executive Director	Gavin MacDonald, Chief Delivery Officer		
Executive Summary	There has been good progress with the 2023/24 efficiencies programme, including some enhanced governance arrangements. Against the £27m target, just under £17m has been identified, phased and delivering. In addition there are schemes to the value £8.5m going though approval panel by the end of August 2023. This will total £25m identified by the end of this August 2023. The Trust is already delivering in excess of what was delivered in last year's efficiencies programme. Work has progressed to ensure accurate capture and counting of activity which has identified efficiencies to the value of £10.6m of which £1m is in year 1, non-block.		
Proposal and/or key recommendation:	To provide noting and assurance on progress.		

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

Committee/Group at which the paper has been submitted:	Finance, Planning and Performance Committee in August 2023				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People)	Priority 3: (Patients)	**Priority 4: (Quality) X**	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	**Effective: X**	Caring:	Responsive:	**Well-Led: X**
Identified Risks, issues and mitigations:	Impact of diversions of operational teams efforts towards other issues because of industrial action				
Resource implications:	Substantive Funding on the PMO structure				

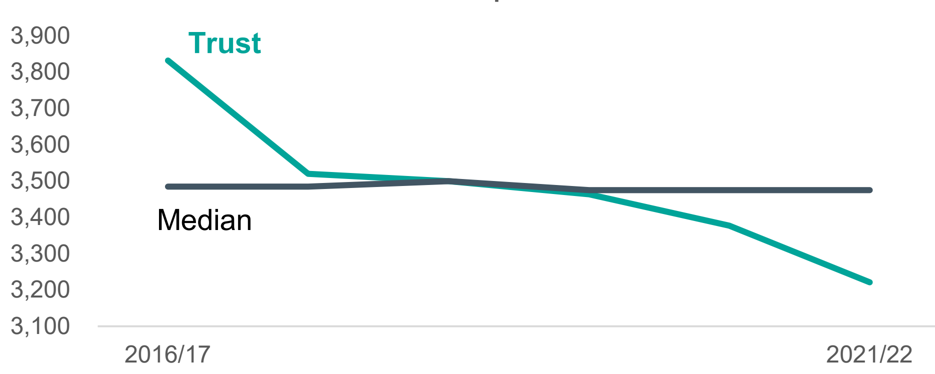
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	Not applicable. As part of the efficiencies programme, all efficiencies schemes have an integrated impact assessment completed.
Legal and Regulatory implications:	NHS Act, License Conditions
Appendices:	None
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information or any enquires relating to this paper please contact:	Gavin MacDonald, Chief Delivery Officer Gavin.macdonald3@nhs.net

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

Efficiencies Programme Update

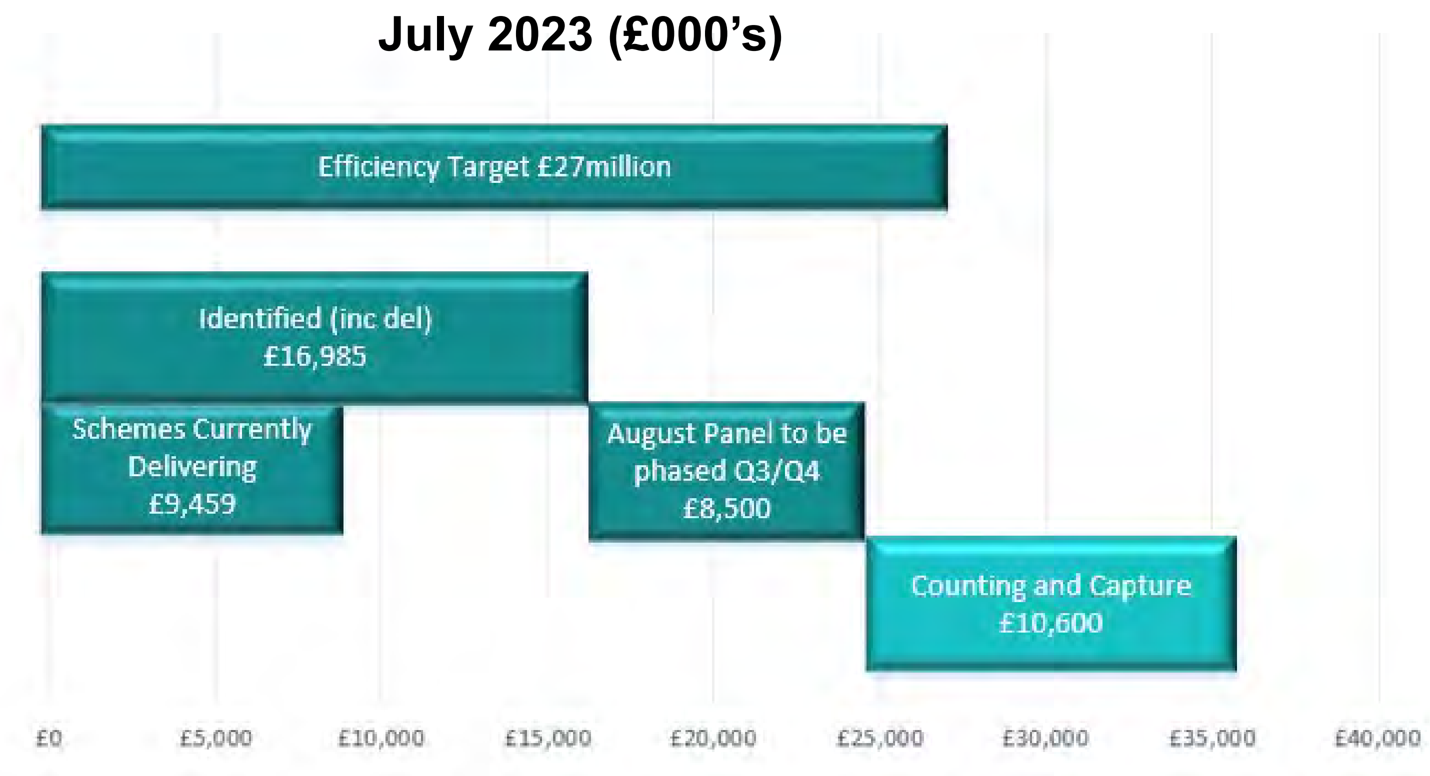
NHS
Medway
NHS Foundation Trust

- Following the recent Model Health Systems update for the 2021/22 National Cost Collection data, the Trust has shown continued improvement in its cost per WAU and is now in the top quartile.
- The Trust was the 20th most efficient acute Trust in England, which is an improvement from 2020/21 when the Trust was 44th. In the top chart opposite, Dartford and Gravesham NHS Trust are 17th (£3,181), East Kent Hospitals University NHS Foundation Trust are 49th (£3,462) and Maidstone and Tunbridge Wells NHS Trust are 81st (£3,663).
- Whilst cost efficiency opportunities remain, these are becoming harder to realise.
- We are applying equal focus to income opportunities, including those areas where the Trust may not be capturing activity, comorbidities and tariff differentials – see next slide.



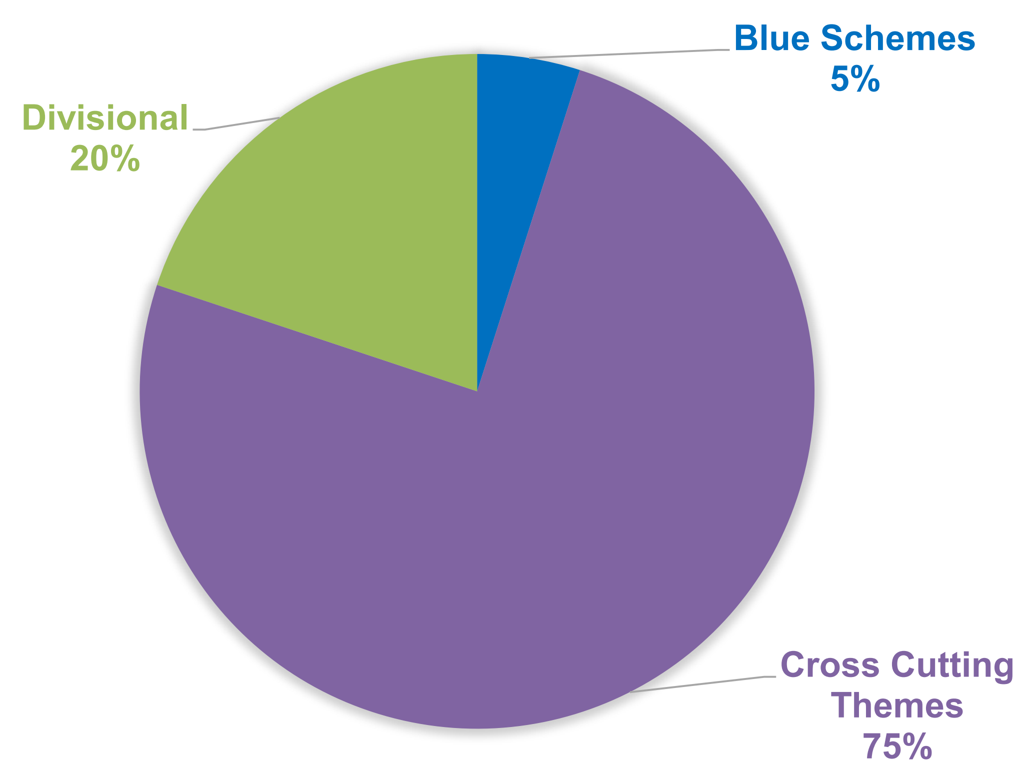
Efficiencies: Current Position

July 2023 (£000's)



- Delivery for this year already exceeds the total deliver for 2022/23
- There are currently schemes going through August PID Panel to be phased for Q3/Q4 which will be reflected in the September position statement
- Subject to approval, the value of schemes identified will be £24.5M by the end of August
- Further schemes being identified to support the additional £1.5M

Current Situation Schemes Delivering



Efficiency Programme	Current Delivery
Month 1 Delivery	£301,029
Month 2 Delivery	£298,750
Month 3 Delivery	£996,596
Month 4 Delivery	£815,514
Month 5 (Forecast)	£686,234
Month 6 (Forecast)	£735,496
Month 7 (Forecast)	£716,694
Month 8 (Forecast)	£901,412
Month 9 (Forecast)	£912,912
Month 10 (Forecast)	£1,024,836
Month 11 (Forecast)	£1,034,836
Month 12 (Forecast)	£1,035,336
Sub-total	**£9,459,645**
One Off Delievry (eg Rates)	£125,000
Total	**£9,584,645**

Efficiencies Programme Summary

	Milestones due for completion in the current reporting month	Date of completion	RAG
1	There has been good progress with the efficiencies programme. Against the £27m target, just under £17m has been identified, phased and delivering. In addition there are schemes to the value £8.5m going though approval panel this month to be phased in Q3/4 which will total £25m identified by the end of this month. We are already delivering in excess of what was delivered in last years efficiencies programme. Work has progressed to ensure accurate capture and counting of activity which has identified efficiencies to the value of £10.6m of which £1m is in year 1, non-block.	31/07/2023	
2	Business case for substantive PMO written. Approved by executive team and is now going through the triple lock process with NHSE. Funding for the interim PMO secured	31/07/2023	
3	Efficiency workshops with Divisional colleagues to source further opportunities with radical and dramatic approach to the programme scheduled with ongoing weekly cadence	31/07/2023	

	Milestones due next month	RAG
1	PID's currently in development to Panel by the end of August/first week in September. These are currently valued at £8.5M	
2	PMO to provide intensive support for all identified schemes that are not currently in delivery phase to expedite position. Take stock of deliverables for FY23/24 and begin scoping opportunities for FY 24/25	
3	Job planning and demand & capacity work to be completed by the end of August to inform further financial opportunities that could be exploited (specifically job planning) to add to the programme	

Efficiencies Programme	
Date	16/08/2023
Exec Lead	Gavin MacDonald
SRO	Steve Reipond
Reporting Month	July 23
Overall Project RAG	X

RAG justification

- Organisation reputational damage – Programme does not contain sufficient value to meet stretch target of £27m
- Impact on delivery for 23/24, failure to start some schemes has had a roll on effect on target this year.
- Schemes currently delivering will yield an estimated £17 million FYE.

Notable Celebrations

- *An additional £8.5M identified for the programme – currently sitting @ £25.4M (excluding C@C)*
- *Counting and Capture has identified £11M*

Efficiencies Programme Summary

	Risks	RAG
1	Delays to starting dates of key work streams results in under delivery of scheme value. Check and challenge held to mitigate blockers	
2	Impact of diversions of efforts towards other issues i.e. BC/Strike action	

	Issues	RAG
1	Delays to starting dates of key work streams results in under delivery of scheme value. Check and challenge held to mitigate blockers	
2	Key estates work for theatre 5 to come online delayed which will impact on scheme delivery. Harvey Ward now confirmed to open WC 21.08.2023	
3	Capacity of divisional teams in work up of delivery of projects	

Efficiencies Programme			
Date	16/08/2023		
Exec Lead	Gavin MacDonald		
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RAG justification

- Organisation reputational damage – Programme does not contain sufficient value to meet stretch target of £27m
- Impact on delivery for 23/24, failure to start some schemes has had a roll on effect on target this year.
- Schemes currently delivering will yield an estimated £17 million FYE.

Notable Celebrations

- *An additional £8.5M identified for the programme pipelined for panel – currently sitting @ £25.4M (excluding Counting and Capture)*
- *Counting and Capture has identified £11M*

Plan vs Actual

Trust

In-month £'000 (Bars): 3,500 3,000 2,500 2,000 1,500 1,000 500 0

Cumulative £'000 (Lines): 30,000 25,000 20,000 15,000 10,000 5,000 0

Mth 1 Mth 2 Mth 3 Mth 4 Mth 5 Mth 6 Mth 7 Mth 8 Mth 9 Mth 10 Mth 11 Mth 12

Plan | Ideintified | Actual / Fcast delivery
Cumulative Plan | Cumulative Ideintified | Cumulative actual/fcast

- The Trust reported a delivery of £2,411,889 YTD for July 2023.
- There was a significant incline in the planned target from Month 4 to £3million (Initially set at £300k for M1 and M2, £900k for M3)
- Delivery is currently £2,112,000 adverse to plan
- Different phasing methodology to be applied for FY24/25

Other Financial Opportunities

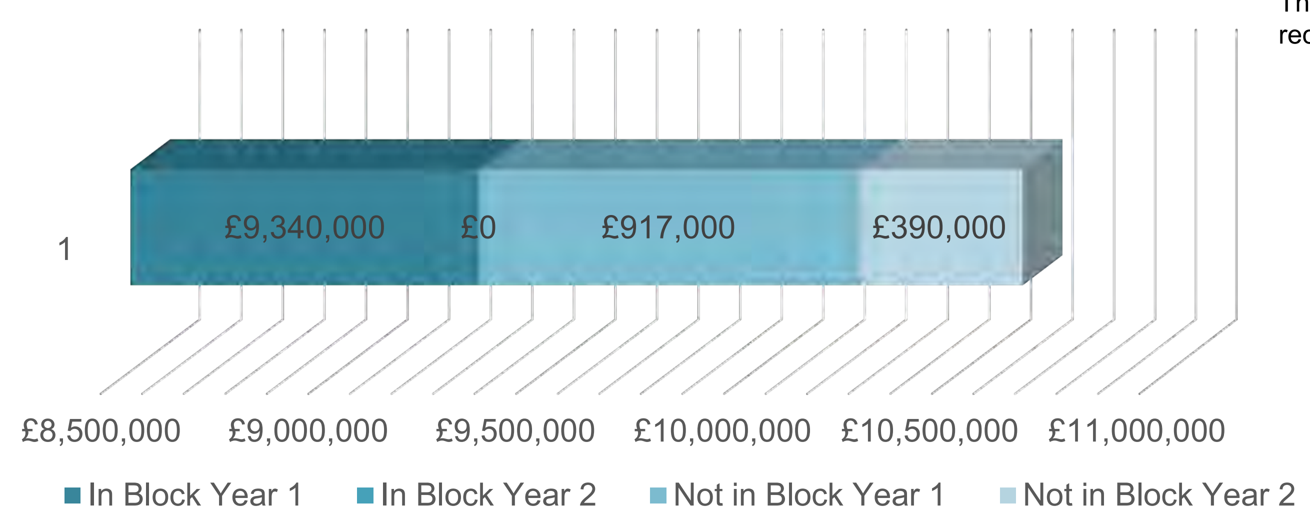
As PMO gains grip on the current situation, further opportunities are being recognised above and beyond cash out budgetary savings.

This programme will capture benefits and profits in associated areas:

- Counting and capture
- Income generation
- Overspend Reduction
- Consolidation
- Contract and SLA negotiation
- Contracts and Assets

Care Group	Scheme Name	Identified Opportunity	Rationale
UIC Management	Rotational Doctors	£746,280	This scheme absolutely demonstrates the values that we aspire to as a Trust and is a fantastic reduction in overspend.
Cross Cutting Theme	Counting and Coding	£11,000,000	Discovery work continues to identify revenue opportunities being missed due to the insufficient recording of information and relevant data capture. There are also services being provided by the Trust that have not been commissioned. This work will support future negotiations with commissioners to ensure activity is properly reflected and appropriately funded.

Counting and Capture Update



Approach

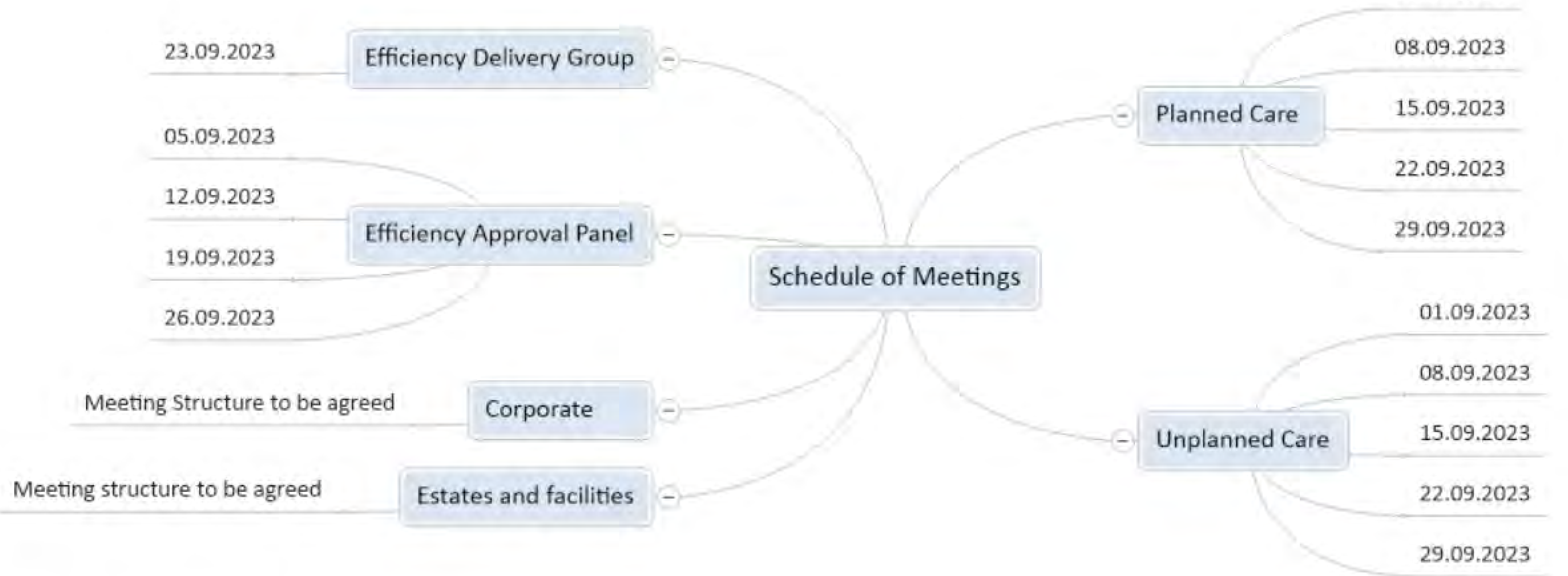
There are a range of factors which have combined and led to an examination of key areas where recording of clinical activity is not as it should be in MFT. These are:

- The identification of higher than expected mortality levels in the Trust
- A lack of correlation between public health, ill health and demographic information on the population of Medway and that which is recorded in the hospital activity data and in systems
- The review of some of the productivity opportunities identified against the actual activity in MFT which do not correlate well
- A higher than expected range of CNST costs for MFT, potentially reflecting a higher number of successful claims against MFT
- A notified low level of trauma recording to the Trauma Network compared to other Trusts
- The gaps in interoperability between the range of clinical systems being used across the Trust and therefore the lack of completeness of records on PAS (PAS not consistently used as main recording system)
- The significant deficit financial position of the organization despite an improving efficiency position in model hospital
- The inability to identify correlating recorded activity on PAS for other costs, ie the dispensing of medication to named patients
- Identified lack of knowledge about how the income and cost base should balance and contract arrangements applying to individual contract areas

Next Steps September 2023

The PMO will now be focusing on transition from discovery to delivery phase.

August 2023	PMO to offer intensive support to the wider organisation with writing PIDs and increasing overall scope of the programme
September 2023	PMO to focus on GIRFT and further faster initiatives to explore opportunities
September 2023	Begin scoping 24/25 efficiencies programme as part of the business planning cycle



Schedule of Events

Date/Month		Meeting/Schedule
29th August		PID Panel (weekly ongoing)
31st August		Extraordinary PID Panel
31st August		PMO/Finance Tracker rationalisation workshop
14th September		Check and Challenge event (monthly ongoing)
21st September		EDG
28th September		FPPC
19th October		EDG
26th October		FPPC
October TBC		ICB/ NHS England Oversight meeting
November TBC		Recovery Support Programme exit meeting