Agenda

Public Trust Board Meeting

Wednesday, 17 January 2024 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 08 November 2023	Chair	3	12:35	Approve
2.2	Action Log – No actions for Nov '23		-		Discuss
2.3	Chief Executive Update	Chief Executive	11	12:40	Note
2.4	Council of Governors Update	Lead Governor	Verbal	12:50	Note
3.	**Board Assurance Reports**				
3.1	Quality Assurance Committee Update (December 2023 and January 2024)	Chief Medical Officer, Chief Nursing Officer, Committee Chair	13 17	13:10	Assurance
3.2	People Committee Update (November 2023)	Chief People Officer, Committee Chair	20	13:20	Assurance
3.3	Finance, Planning and Performance Committee Update (November and December 2023)	Chief Finance Officer, Committee Chair	25 29	13:30	Assurance
3.4	Audit and Risk Committee Update (December 2023)	Chief Finance Officer, Committee Chair	32	13:40	Assurance
4.	**QUALITY**				
4.1	Health and Safety Annual Report	Chief Operating Officer	35	13:50	Approve
4.2	a) Maternity CNST Compliance Assurance Report b) Maternity Workforce – Bi-Annual	Director of Midwifery/ Chief Nursing Officer	65 126	13:55	Note
4.3	Patient Safety Incident Response Framework (PSIRF)	Chief Nursing Officer	146	14:10	Approve
	~ WELLBEING BREAK - 15 minutes ~				
5.	**PATIENTS**				
5.1	No items	-	-	-	-
6.	**PEOPLE**				
6.1	No items	-	-	-	-

Agenda

7.	**SUSTAINABILITY**				
7.1	Finance Report (Month 8)	Chief Finance Officer	254	14:35	Note
8.	**SYSTEMS AND PARTNERSHIP**				
8.1	No items	-	-	-	-
9.	**Integrated Quality Performance Report (IQPR) and Board Assurance Framework (BAF)**				
9.1	IQPR	All Executives	274	14:50	Note
9.2	BAF		310		Note/ Approve
10.	**CLOSING MATTERS**				
10.1	Risks Identified	Chair	Verbal	15:15	Note
10.2	Reflection				
10.3	Any Other Business				
10.4	Date and time of next meeting: Wednesday, 06 March 2024				

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 08 November 2023 12:30 – 15:30

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

and Virtually on MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	Mark Spragg	Trust Chair
	Adrian Ward	Associate Non-Executive Director
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Evonne Hunt	Chief Nursing Officer
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Jayne Black	Chief Executive
	Jenny Chong	Associate Non-Executive Director
	Leon Hinton	Chief People Officer
	Mojgan Sani	Non-Executive Director
	Nick Sinclair	Chief Operations Officer
	Paulette Lewis	Non-Executive Director
Attendees:	Abby King	Deputy Director of Communications
	Alana Almond	Deputy Company Secretary (Minutes)
	David Brake	Lead Governor
	David Sulch	Consultant Stroke Physician, Dartford and Gravesham NHST
	Glynis Alexander	Director of Communications and Engagement
	Janet Harsent	League of Friends
	Jignesh Patel	Governor - Swale
	Marion Cogger	League of Friends
	Martina Rowe	Governor - Medway
	Matt Capper	Company Secretary/Director of Strategy and Partnership
	Michael Taylor	Healthcare Business Solutions
	Paul Stephens	Member of the Public
	Thais Ferrari	North Kent Pathology Service

DRAFT

Best of care
Best of people

	Thomas Vellender	Healthcare Business Solutions
	Vanessa Page	Governor- Staff
Apologies:	Sue Mackenzie	Non-Executive Director

1 PRELIMINARY MATTERS

1.1 **Chair's Welcome and Apologies**

1) Firstly, thank you for joining us for this Trust Board meeting today. I am delighted to be chairing this meeting today, my first as Interim Chair, following the departure of our Chair Jo Palmer, who has left Medway to take up an exciting professional opportunity in New York. I am sure you will all want to join me in thanking Jo for all she did for the Trust, and for our local community, during her time as Chair. She will be a hard act to follow, but I will do my best!

2) Welcome to you all, and in particular to Janet Harsent and Marion Cogger from the League of Friends, a group of dedicated volunteers who are very much valued by us all. Janet and Marion will provide us with the League's annual update on the support they have given the Trust over the past year. We see the League of Friends' contribution all around us in the hospital, through new medical equipment purchased with the money they have raised, through Hospital Radio, and in the shop, café and kiosk that provide such an important service for patients and visitors.

3) Only last week I was pleased to be invited to the official opening of their new shop and café in our main entrance – I know how much hard work and planning went into creating the lovely new facilities, so thank you for your commitment to see that project through to conclusion.

4) A special welcome too, to Lyn Gallimore who will be sharing with us her experience following a hip replacement. Lyn is well respected for the roles she has had representing the patient voice in healthcare, including for a number of years as a Trust Public Governor for Swale.

5) I am taking over this role as we approach winter – always a time of great challenge for the hospital. We never know exactly how big that challenge is going to be, but close monitoring, projections and close working with partner organisations ensure we are well-prepared to manage demand and deliver safe care for patients through the busiest months and while we anticipate challenges, it is also good to see that in many respects the hospital is improving, with our Patient First programme having a positive impact across the hospital. You will hear more about the Trust's performance and successes in Jayne's report and other presentations today.

6) Finally, I would like to thank patients, visitors, colleagues, and our local community for all the support you give the Trust, whether that is by sharing positive experiences, feeding back on how we can improve further, attending our engagement events or fundraising for us – it all makes a tremendous difference and we appreciate all you do.

1.2 **Quorum**

The meeting was confirmed to be quorate.

1.3 **Declarations of Interest**

There were no declarations of interest against any agenda item.

2 MINUTES OF THE LAST MEETING AND ACTION LOG

2.1 The minutes of the meeting held on 13 September 2023 were **APPROVED** as a true and accurate record.

The NEDs requested that the minutes captured 'check and challenge' and it was agreed that these would be more fully minuted going forward, while also capturing salient points of reporting.

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

2.3 **Chief Executive Update**
Jayne Black updated the Board in line with the paper submitted which was taken as read.

The Board **NOTED** the report

2.4 **League of Friends Annual Update**
Janet Harsent and Marion Cogger delivered the presentation on the Medway League of Friends. The paper was taken as read.

1) The presentation detailed information on the gift shops, provision of refreshments, fundraising and where the funds are spent across the hospital, and the Hospital Radio which is self-funding. There are 151 volunteers at present, including student volunteers. The League of Friends has made donations of £5,221,011 since 1995 for which we are very grateful.

The Board **NOTED** the update and gave its sincere thanks to the League of Friends for their hard work and donations.

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

1) Thanked the League of Friends
2) Congratulated Chair on his appointment and thanks again to Jo Palmer.
3) Congratulated the Trust for being awarded the Freedom of Medway, the highest civic honour.
4) Governor engagement events detailed through September and October including; Freshers Week, Trust Annual Members' Meeting, PLACE Assessment and Next Members' Meeting upcoming.

The Board **NOTED** the update.

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

3.1 **Integrated Quality and Performance Report (IQPR)**
The Executive Team presented the report in line with the papers submitted.

Evonne Hunt, Chief Nursing Officer
A full refresh of all Friends and Family Test surveys has been completed with the addition of the same day FFT survey. The top three themes and trends reported by patients remain the same as the last reporting period; wait time, staff attitude etc. Complaints were noted and the impact of industrial action. PALS, Mixed Sex breaches and the impacts on these. Incident reporting, 95% are low or no harm. The BI team and Quality team are working on how data is pulled through, some of the data has been reported at zero which is inaccurate. IPC data was detailed.

Non-Executive Directors - Check and Challenge

a) It would be helpful to see the Duty of Candour compliance data in the report.
b) What happens to feedback received from patients? Does the Trust respond to comment? *Not directly as the surveys are anonymous.*
c) Can the Trust do some communications to patients following surveys, to show the Trust is listening and responding to feedback? *Yes, and will also be picked up through strategic initiatives.*
d) It would be helpful to have a report submitted to QAC in regard to Antimicrobial Prescribing and Stewardship and the duration of antibiotics prescription.
   ACTION TO QUALITY ASSURANCE COMMITTEE – report to be submitted to the QAC and then onward assurance to the Board through the Committee Assurance report. *Action submitted to QAC 14.11.23*

Alison Davis, Chief Medical Officer

HSMR for June 2022 to May 2023 is 110.7 and 'higher than expected' though an improvement in overall HSMR. HSMR for May 2023 has returned to the 'within expected' limit, driven by the observed deaths significantly dropping to lower than the expected deaths for the second time this year.
SHMI for May 2022 to April 2023 is 1.14 and 'higher than expected'.
Emergency Weekend HSMR has made a significant improvement. Any slight improvement next month will likely see this metric return to 'as expected' values.
Fracture Neck of Femur; lack of theatre space still remains the main factor and medically unfit patients is the secondary factor for not achieving the 36 hours operating target.

Non-Executive Directors – Check and Challenge

a) There are gaps in coding; does the Trust use Dr Foster for reporting, and when can targets be achieved?
b) Good to see weekend mortality rate improvements - have we more insight as to why there were more deaths at the weekend? Alison replied that we do not but data is probably now more accurate.
c) Resus training compliance, more work is needed on this. *Will be addressed through 2222 work*

Nick Sinclair, Chief Operating Officer

Unfortunately, in September 2023 the number of patients waiting longer than 52 weeks has increased to 1,219 (August number is 1,153). Key drivers for the increase are capacity in ENT and Endoscopy and the impact of Industrial Action on Theatres and Outpatients.
Modular units to be placed at CDC locations to assist with this (additional 392 available slots).
Mutual aid support has started improvements and patients are accepting appointments at Darent and MTW at weekends. The Did Not Attend rate has increased.
ENT remains the primary concern for 52 and 78 week risk. There are plans in place to manage the backlog and to move to a sustainable position in 2024. There is an improving position for cancer services. Cancer is an improving position.
The average waiting time in ED and number of 12 hour breaches are both increasing.

Non-Executive Directors – Check and Challenge

a) Would like a report submitted to FPPC on 12 Hour Delays in ED
   ACTION TO FINANCE PLANNING AND PERFORMANCE COMMITTEE – *Action submitted to FPPC 14.11.23*
b) Would like to see more work to be done around flow and bed occupancy

Leon Hinton, Chief People Officer
Overall, the turnover rate for the entire Trust has continued to decrease. This is a trend since the start of the calendar year and the hope is for that metric to start to move into the blue for positive variance inwards. The turnover for less than two years, has varied up and down. It has marginally improved, but hopeful for more to come. Team are building upon the 'intention to leave' process, predicted completion by mid-November 2023. Continued improvements on vacancy rate which is now at 4.2% and is the lowest vacancy rate the Trust has had in six years. The team is working on staff bank spend, with a line by line review to understand current position.

The sickness absence rate has been spiking, particularly since August and September 2023. This is purely due to Covid-19.

Training compliance rates are monitored through the People Committee. Some areas of concern are: resuscitation training, fire safety training and moving and handling training.

Non-Executive Directors - Check and Challenge
a) Are we seeing improvements in weekend handover; 4a – looks like risk score is 6 and target?
b) Does the team need any support from the Board on appraisal rates which have dropped from 90 to 89.4?
c) Would like more information on international recruitment, exit surveys/interviews. *This is being addressed at the People Committee.*

Alan Davies, Chief Financial Officer
This update was combined with Agenda Item 7.2

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

3.2 **BAF**
The Executive Team presented the report in line with the papers submitted.
The Board Assurance Framework (BAF) consists of 20 strategic risks aligned to each of the Trust's True North domains. There are a number of risks that have seen no movement for six months or more. Eleven of the 20 strategic risks have had no movement in the last six months. This has been escalated to each of the relevant Executives and Operational risk owners, alongside being escalated via the Risk and Compliance Assurance Sub-Committee and onward to Audit and Risk Committee. Support sessions have been delivered by the Integrated Governance Team to several operational risk owners to enable a better understanding of the actions required to manage the risks effectively.

Non-Executive Directors - Check and Challenge
a) Are we seeing improvements in weekend handover; 4a – looks like risk score is 6 and target is 6, this has been same since July 2023; will this have an impact on risk levels and the same for RTT; there does not seem to be any actions for 4a/b/c what are they?
b) There are many 'red' mitigating actions and they should be dealt with as a matter of urgency. The Executive Team took these comments away.

The Board **NOTED** the Board Assurance Framework

5 **PATIENTS**
[In the interest of time this agenda item was moved ahead of schedule]
5.1 Patient Story - Hip Replacement
Nikki Lewis and Lyn Gallimore delivered the presentation, with some highlights for the Board including; Lyn's hospital admission, theatres and recovery, ward care and points for improvement

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Overall, the care that Lyn received was a relaxed and pleasant experience. The Board thanked Lyn for her story and feedback. The Chair was pleased that Lyn had a positive experience and appreciated her constructive observations. The Board acknowledged Lyn's suggestions with some being work in progress within the hospital. Small improvements make a big difference and the Board gave Lyn assurance that her feedback will be addressed and that a difference will be seen.

The Board **NOTED** the Patient Story.

[Board took a wellbeing break]

4 QUALITY

4.1 Quality Assurance Committee Update (September and November 2023)

Paulette Lewis and Evonne Hunt updated the Board in line with the papers submitted, providing headlines from the Assurance Reports for the meetings held on 27 September and 02 November 2023.

Escalations to the Board

a) HSMR Data was identified as a risk.
b) 33% safeguarding training compliance.
c) Quality Strategy expected to be presented at Trust Board in January 2024.
d) Falls and Pressure Ulcer data
e) Safeguarding Training compliance
f) Research and Innovation Annual Report to be presented at Trust Board in January 2024.

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

4.2 **EPRR Assurance**

Nick Sinclair presented the report in line with the submitted paper. It provided the Board with an update of progress of the EPRR work plan 2022/23 and an overview and understanding of Trust compliance with the 2023 NHS EPRR Core Standards assurance.

a) Last year the Trust's EPRR assurance achieved 'partial compliance' and were 'non complaint' within CBRN training and assurance. This resulted in a "Partial Compliant" assurance in line with the NHS England Framework. Unfortunately, the Trust was the only Trust in Kent and Medway to be given an area of 'non-compliance'.
b) The Trust recently submitted EPRR assurance and self-assessed against the framework and achieved "Full Compliance" across all areas of the given framework. This will be the first year in quite some time that the Trust has submitted a fully complaint assurance, which is a really positive reflection on the Trust.

The Board **APPROVED** the report.

4.3 **Medical Education Annual Report**

Alison Davis presented the report in line with the submitted paper.

Non-Executive Directors - Check and Challenge

a) Overall training satisfaction rate has dropped in one year which is disappointing, considering the level of capital spend. How is the Trust going to deal with recovery? *The governance around this work is through the People Committee and taken away by the Executives.*

The Board **NOTED** the report

DRAFT

6 PEOPLE

6.1 People Committee Update (September 2023)

Sue Mackenzie and Leon Hinton presented the report in line with paper submitted, providing headlines from the Assurance report for the meeting held on 28 September 2023

Escalations to the Board

a) Bullying and Harassment report required to Committee.
b) Safe Staffing Nursing Establishment Review report required to Committee.

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

7 SUSTAINABILITY

7.1 Finance, Planning and Performance Committee Update (September and October 2023)

Annyes Laheurte presented the report in line with paper submitted, providing headlines from the Assurance report for the meetings held 28 September and 26 October 2023. The report was taken as read.

Escalations to Board

a) Risk 5b 'Delivery of the efficiency programme' to be escalated. Risk rating 20 to 25 reflecting the passage of time and delivering the full £27m.
b) Risk 5a grading on BAF increased to 25
c) Finance Report M6 – Add CDC slippage to Corporate Risk Register
d) Finance Report M6 – Add support required to fund the cash position to Corporate Risk Register.

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

7.2 Finance Report (Month 6)

Alan Davies presented the report in line with the paper submitted. Alan highlighted a number of items from the report including a £22.7million deficit for month six, being £12.6million adverse to the plan. The monthly deficit target for the Trust is £1million per month for the remainder of the year. Efficiencies to data total £5.5million, being £5.5million adverse to the plan.

Non-Executive Directors - Check and Challenge

a) Can the Trust offer budget holder training, there should be focus on this for the future for improvements. *This is in hand and will be driven forward.*
b) Efficiencies Programme; are all the targets equal and how much is Model Hospital driven? Explained that Model Hospital is always used as is GIRFT.
c) The team should align the capital spend alongside the Trust risk register. Acknowledged by the Executive.

The Board **NOTED** the report.

8 SYSTEMS AND PARTNERSHIP

8.1 Mid-Year Strategy Review

Matt Capper presented the report in line with the paper submitted.

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

9. ITEMS DEFERRED/NOT RECEIVED

9.1 Patient Led Assessment of the Care Environment (PLACE) – Transfer of responsibility from CFO to COO, to submit in January 2024. Deferred from September and November 2023.

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[Post meeting note – date has been amended to March 2024 Board]

10 CLOSING MATTERS / BOARD BUSINESS

10.1 Reflection

Add 'Risks Identified' to the Board agendas.

10.2 Questions from the Public

There were no questions received. A few comments had been made during the meeting on the MS Teams chat function and were dealt with by the Company Secretary.

10.3 Any Other Business

ACTION FOR THE COMPANY SECRETARIAT

a) Committee Assurance reports should contain the meeting either embedded or another solution found.
b) Separate the actions for Committees and escalations to Board on assurance reports

10.4 Date of next meeting

The next formal Board meeting will be on Wednesday, 17 January 2024

The meeting closed at 15:47

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 08 November 2023

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

DRAFT

Chief Executive's Report – January 2024

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

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

Addressing operational pressures

We have seen a sustained period of very high numbers of patients and ambulances attending our Emergency Department, more than is usual at this time of year. In addition, at any given time we are caring for around 120 patients who well enough to leave our hospital but who are awaiting out-of-hospital support to continue their recovery.

As a result, patients are waiting longer than we would like to be admitted to a ward. I am sorry for the impact this is having on our patients and their relatives. I want to pay tribute to the significant efforts by colleagues across our Trust, and our health and care partners across the system, to safely care for our patients during this time of significant pressure.

Development of a cardio respiratory village

Work is underway on a new 32 bed cardio-respiratory village, including a new cardiac catheterisation laboratory, which is due to open in the hospital soon. This newly renovated area will help us to ensure that patients are treated more quickly this winter and beyond and has been made possible thanks to national funding awarded to us to support the recovery of urgent and emergency care services.

Industrial action

Junior doctor colleagues across the country took part in industrial action recently – for three days in December and six days at the start of the New Year. As with previous periods of industrial action, where necessary we rescheduled appointments and procedures and have rebooked patients as soon as possible.

For those colleagues who have voted to strike, I recognise that was not a decision taken lightly and respect their right to take action.

High intensity theatre lists

Our ear, nose and throat (ENT) surgical team has introduced high intensity theatre (HIT) lists to cut waiting times for our young patients needing their tonsils and adenoids removed. HIT lists help to cut waiting times and safely reduce the backlog for non-emergency surgery caused by the pandemic by focusing on just one type of routine surgical procedure and minimising surgeon down-time so they can operate on more patients. ENT surgery, particularly tonsillectomies, make up the bulk of our paediatric waiting list and HIT lists help reduce the number of children waiting to have their tonsils and adenoids removed.

Pharmacy robot renovation

Our pharmacy department is undergoing an exciting transformation which will lead to improved service for our patients and play a key role in the digital transformation of our hospital services. Work to replace our dispensing robot with a new and more technologically advanced robot is complete. This includes a new faster conveyer system, which will reduce any delays in medication being delivered. A new out-of-hours robot supply room has been built which will enable the on-call pharmacist to remotely supply medication out of hours. The final phase of the work, which is near completion, is the installation of the new inventory management software system which will give us better oversight of our pharmacy stock.

Patient First Spotlight

As part of our Patient First improvement journey we have introduced a new weekly improvement huddle which is held in the hospital's main entrance every Thursday morning. The Patient First Spotlight provides staff from across the Trust with the opportunity to share their Patient First improvements with colleagues and is open to members of the public.

Colleagues from critical care, the Emergency Department, surgery and therapies, among others, have spoken with pride about the work they are doing to put patients first.

Organ donation memorial

Last month our Organ and Tissue Donation Committee welcomed the families of 17 organ and tissue donors to a private ceremony during which their loved ones' names were unveiled on the Hero Wall Memorial in the atrium. We are extremely fortunate to have the Hero Wall Memorial here at Medway. This very special memorial honours those who gave the gift of life to many others after their death.

Meals for parents and carers

I am pleased to report that we have introduced free food for parents and carers staying with their child while they're on Dolphin Ward, our children's ward. The scheme was introduced by a colleague in the service who discovered that some parents and carers had not eaten, or were waiting for a partner, relative or friend to bring food in, as they could not afford to purchase a meal.

Thanks to the Catering Team, a breakfast, lunch and dinner menu has been introduced and is well received. This initiative demonstrates that we take the health and wellbeing of our parents and carers just as seriously as their child's and are proud to serve our local community.

Liver service accreditation

I am pleased to share the news that the Trust's Hepatology Service has attained the Improving Quality in Liver Services (IQILS) registration. This achievement, supported by the Royal College of Physicians, confirms our liver services work is of a high quality, and is tailored to the needs of our patients, putting them at the heart of the service. Colleagues from the Hepatology Team who have put so much effort and dedication into gaining this accreditation over the last 18 months.

Meeting of the Trust Board in Public
Wednesday, 17 January 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Quality Assurance Committee – Assurance Report
07 December 2023</td><td>Agenda Item</td><td>3.1</td></tr>
<tr><td>Author</td><td colspan="5">Emma Tench, Assistant Company Secretary</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Alison Davis, Chief Medical Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">Assurance report to the Trust Board from the Quality Assurance Committee, ensuring all nominated authorities have been reviewed and approved.
The report includes key headlines from the Committee.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">N/A</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">Minutes from the Quality Assurance Committee to be approved at the Committee on 09 January 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>Integrated Impact assessment:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="5">NIL</td></tr>
<tr><td>Appendices:</td><td colspan="5">Key headlines and assurance level listed below.</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="5">This paper is disclosable under the FOI Act.</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="5">Alison Davis, Chief Medical Officer: alison.davis20@nhs.net</td></tr>
</table>

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
6	8	x	

Declarations of Interest Made

None

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

Item	Group, Subcommittee, Committee	Date

Reports not received as per the annual workplan and action required

Anti-Microbial Stewardship	Deferred to Jan 2024	Agreed by CNO/CoSec
Safeguarding Update Report	Deferred to Jan 2024	Agreed by CNO/CoSec
Enhanced Care (including Dementia and Delirium)	Deferred to Jan 2024	Agreed by CNO/CoSec
End of Life Care Update Report	Deferred to Jan 2024	Did not go to QPSSC
Mental Health Update Report	Deferred to Jan 2024	Did not go to QPSSC
Clinical and Patient Story for Board	Deferred to Jan 2024	Did not go to QPSSC
Medical Examiners Activity Update	Deferred to Jan 2024	Did not go to QPSSC
MBRRACE Report	To go back through governance	
Infection Prevention and Control Update	Deferred to Jan 2024	Director not present at meeting to deliver the report. Ongoing report to include root cause analysis and details on progress of actions.

Items/risks/issues for escalation

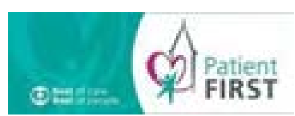
Issues and or Risks to note:
- Issues with Beepers for Resus.
- Risk with Pressure ulcers and falls.
- DBS certification levels for staff

Reflection:
- The Chair commented on full discussions on important topics.
- The Chair commented on the streamlining of QPSSC and QAC meetings working towards improvements for 2024.

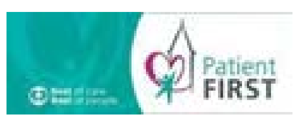
Implications for the corporate risk register or Board Assurance Framework

None recorded

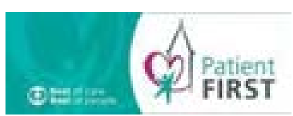
Key headlines	Assurance Level
1. Integrated Quality Performance Report (IQPR) The report was challenged by Committee Members, the answers received in regards to challenges gave Members assurance.	



Further assurance requested: • Migrated data to tele-tracking was requested. • Critical Medication including gaps, progress and training. The Committee were **ASSURED** and **NOTED** the report.	
2. Assurance and Escalation Report from Quality and Patient Safety Sub-Committee (QPSSC) held 29 November 2023 Further assurance requested for: • Updated template and training on Assurance Report writing. The Committee were **ASSURED** by the report, the decision made and the actions taken.	
3. Medicines Management Assurance Report Committee Members challenged the report, suggesting the organisation has divisional Lead Pharmacists. The Committee were **ASSURED** the report.	
4. Safe Staffing Establishment Review Report Further assurance requested for: • Outcomes for Morbidity and Induction of Labour The Committee were **ASSURED** and **APPROVED** the report.	
5. Clinical Negligence Scheme for Trusts (CNST) Compliance Update Report The Committee were **ASSURED** and **APPROVED** the report,	
6. Perinatal Quality Surveillance Quarterly Report Further assurance requested for: • 'Closed Maternity' diversion reasons to be added to the report. The Committee were **ASSURED** and **APPROVED** the report.	
7. Violence and Aggression Report The Committee **NOTED** the report	
8. Patient Experience – Report and Strategy The Committee were **ASSURED** by the report	
9. Venous Thromboembolism (VTE) – Update Report The Committee were **ASSURED** by the report	
10. Mortality and Morbidity and Learning from Death Report The Committee were **ASSURED** by the report	
11. Resuscitation Update Report Further assurance requested for: • Beeper issues within the hospital, assurance that this has been rectified.	



The Committee were **ASSURED** and **NOTED** the report	
12. Organ and Tissue Donation Annual Report The Committee **NOTED** the report	
13. Board Assurance Framework (BAF) for Quality and Patients The Committee were **ASSURED** and **NOTED** the report	
14. Risk Register – Quality and Safety The Committee requested more time to review and approve the register.	



Meeting of the Trust Board in Public
Wednesday, 17 January 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Quality Assurance Committee – Assurance Report 09 January 2024</td><td>Agenda Item</td><td>3.1</td></tr>
<tr><td>Author</td><td colspan="5">Emma Tench, Assistant Company Secretary</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Alison Davis, Chief Medical Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">Assurance report to the Trust Board from the Quality Assurance Committee, ensuring all nominated authorities have been reviewed and approved.
The report includes key headlines from the Committee.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">N/A</td></tr>
<tr><td rowspan="2">Purpose of the report (tick box to indicate)</td><td>Assurance</td><td>X</td><td>Approval</td><td colspan="2"></td></tr>
<tr><td>Noting</td><td></td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td>(If appropriate) state reason for submission to Private section of Board:</td><td>Patient Confidentiality:</td><td>Staff Confidentiality:</td><td>Commercially Sensitive:</td><td colspan="2">Exceptional Circumstances:</td></tr>
<tr><td>Committee/Group at which the paper has been submitted:</td><td colspan="5">Minutes from the Quality Assurance Committee to be approved at the Committee on 08 February 2024.</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Tick the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability) X</td><td>Priority 2: (People)</td><td>Priority 3: (Patients)</td><td>Priority 4: (Quality)</td><td>Priority 5: (Systems) X</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led: X</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="5">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="5">NIL</td></tr>
<tr><td>Appendices:</td><td colspan="5">Key headlines and assurance level listed below.</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="5">This paper is disclosable under the FOI Act.</td></tr>
</table>

For further information or any enquires relating to this paper please contact:	Alison Davis, Chief Medical Officer alison.davis20@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	4	x	

Declarations of Interest Made
None

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

Reports not received as per the annual workplan and action required

Anti-Microbial Stewardship	Deferred to Feb 2024	Agreed by CNO/CoSec
Safeguarding Update Report	Deferred to Feb 2024	Agreed by CNO/CoSec
Enhanced Care (including Dementia and Delirium)	Deferred to Feb 2024	Agreed by CNO/CoSec
End of Life Care Update Report	Deferred to Feb 2024	
Mental Health Update Report	Deferred to Feb 2024	
Clinical and Patient Story for Board	Deferred to Feb 2024	
Medical Examiners Activity Update	Deferred to Feb 2024	

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:

- Misidentification of blood samples

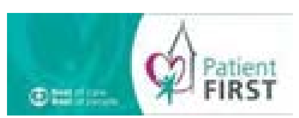
Reflection:

- The Chair commented on full discussions on important topics.
- The Chair commented on the extensive work being carried out by Executives
- The CEO highlighted a need for reporting of work in ED and the number of patients in beds that needs to be reviewed at QAC.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines	Assurance Level
1. Update of Terms of Reference The updates were highlighted by the Company Secretary, reviewed in order to tighten meeting operations. The Committee were **APPROVED** the Terms of Reference.	
2. Risk Register – Quality and Safety • Future Risk Register reports to be aligned to high Risks for review by the Committee. • The Committee Members requested information aligned to the IQPR The Committee **NOTED** the report	
3. Assurance and Escalation Report from Quality Patient and Safety Sub-Committee held 20 December 2023 • The Committee Members requested the following to be added to the Assurance Reports: o Key actions to have named responsibility o Timelines o Visual representation from each division in line with NICE guidance. The Committee were **ASSURED** the report.	
4. ICB Infection Prevention and Control Surveillance Visit The Committee were **NOTED** the report.	
5. CNST Compliance Report The Committee were **ASSURED** and **APPROVED** the report for Trust Board.	
6. Bi-Annual Staffing Report The Committee were **ASSURED** and **APPROVED** the report for Trust Board	
7. Quality Impact Assessment Policy and Standard Operating Procedure The Committee **APPROVED** the Policy and SOP	
8. Integrated Quality Performance Report (IQPR) • The CEO advised NEDs that the SDR triangulation with the IQPR will identify mechanisms and progression. The Committee **NOTED** the report	
9. Board Assurance Framework The Committee **NOTED** the report	



Meeting of the Trust Board in Public
Wednesday, 17 January 2024

<table>
<tr><td>Title of Report</td><td>Assurance Report – People Committee 30 November 2023</td><td>Agenda Item</td><td>3.2</td></tr>
<tr><td>Author</td><td colspan="3">Leon Hinton, Chief People Officer</td></tr>
<tr><td>Committee Chair</td><td colspan="3">Sue Mackenzie, Chair of Committee/NED</td></tr>
<tr><td>Key headline and assurance level</td><td colspan="3">
<table>
<tr><th>Key headline</th><th>Assurance Level</th></tr>
<tr><td>1. IQPR
The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for October 2023. The Committee were ASSURED by the report:
• True North (Staff Engagement) – update due Q4 2023/24;
• Breakthrough (turnover) – [0.8%, 1% improvement, on target] first time target has been met for the Trust (<1% in-month);
• Staff appraisal – [88.8%, -0.9% deterioration, 1.2% off target] second successive month below target, clinical divisions remain largely on target, corporates remain off target;
• Vacancy rate – [4%, -0.4% improvement, on target] continues to improve with improvements to nursing, AHP and CSW vacancies and strong pipeline; international pharmacists now in pipeline.
• Voluntary turnover – [10.8%, -0.5% improvement, 2.8% off target] continues to improve along with stability and reduced vacancies. No significant outliers to improving position by staff group.
• Staff fill rates – improving position for achieving required staffing versus planned staffing and increased care hours per patient day (CHPPD) however below target of CHPPD target of 9.5;
• Sickness absence – [4.8%, -0.2% improvement, 0.8% off target] continued escalated sickness since August predominantly due to covid sickness.
• StatMan – [85.9%, +1.1% improvement, on target] slight improvement over target; however, capacity and DNA issues continue particularly for classroom-based learning, fire, safeguarding/MCA and resus – capacity issues resolving through to March 2024 for safeguarding.
• Employment standards – professional registration remains on target, DBS compliance work continues with refresh of role-based requirement.</td><td>Assurance</td></tr>
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</td></tr>
</table>

2. Board Assurance Framework The Committee **NOTED** the current BAF scores, action progress against gaps.	Assurance
3. Safe Staffing Nursing Establishment Review The Committee received the report providing a high-level overview of the biannual 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 **APPROVED** the report following additional information in relation to addressing new services/expansion of services. The Committee addressed triangulation of red flags, incidents and current staffing.	Assurance
4. People Strategy and Projects Update The Committee received an update report including highlights from the four People Projects and alignment to the NHS People Promise deliverables. The Committee **NOTED** the report.	Assurance
5. HR and OD Performance The Committee were **ASSURED** of HR and OD performance against workplan, including an improvement to recruitment time to hire and the review of DBS levels by role.	Assurance
6. Industrial Action The Committee **NOTED** an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff.	Assurance
7. Modern Slavery and Human Trafficking Statement The Committee **APPROVED** the statement for publication highlighting the statement for the financial year 2023/24 advising no reports received from the staff, the public, or law enforcement agencies to indicate that modern slavery or human trafficking practices have been identified through supply chain, safeguarding, employee relations or resourcing.	Significant Assurance
8. Wellbeing Guardian Assurance Report The Committee were **ASSURED** by the quarter two 2023/24 assurance report. The report provided an overview of the changes to the Wellbeing Guardian guidance and key actions to	Assurance

ensure their implementation. The Committee was informed that the Kent and Medway Talking Wellness service had now formally closed with a move back to GP referral model for psychosocial interventions and support.	
9. Gender Pay Gap update The Committee received a verbal update in relation to work addressing the gender pay gap including an A3 approach to understanding pay difference particularly in medical and dental through the Women's network.	Not required
10. WRES and WDES Update The Committee received an update in relation to key indicators from the Workforce Equality Standards for Race and Disability (WRES and WDES) and the associated action plan. The actions will be added to the broader equality delivery plan in the future People Strategy. The Committee **APPROVED** the action plan for publication.	Partial Assurance
11. NHS England Self-Assessment for Placement Providers The Committee reviewed the amalgamated self-assessments from the various education supervisions across the Trust (medical education, nursing education, allied health professional education, pharmacy education and general education). A faculty approach is taken to address the gaps in the self-assessment for placement supervisors locally. The Committee reviewed examples of initiative and good practice; and the thematic groups of actions to address to meet the standards. The Committee **APPROVED** the self-assessment for submission.	Partial Assurance
12. Guardian of Safe Working Report The Committee reviewed the paper submitted highlighting the annual activities, discussions and outcomes; including benchmarking against other Trusts, how the Trust has improved feedback loop to staff about how issues are addressed. The report provided assurance of compliance with the contract. The Committee **NOTED** the report.	Not applicable
Decisions made: 1) Approval of the Modern Slavery and Human Trafficking 2023/24 statement for publication.	
Further Risks Identified: 1) None identified.	
Escalations to the Board or other Committee:	

	1) DBS level review – ensuring the DBS checks meet compliance with the NHS Employment Standards in accordance to role requirement. 2) Safe staffing review - historical issues associated with service development approval and funding/budget/commissioning
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, 30 November 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)

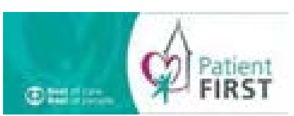
<table>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="6">Tick CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td colspan="2">Well-Led: ✓</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="6">All risk, issues and mitigations are reference in the Board Assurance Framework item.</td></tr>
<tr><td>Resource implications:</td><td colspan="6">Individual resource considerations are provided at the People Committee.</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="6">Individual considerations are provided at the People Committee.</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="6">Where applicable, Individual considerations are provided at the People Committee.</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="6">Individual legal and regulatory implications are provided at the People Committee.</td></tr>
<tr><td>Appendices:</td><td colspan="6">None</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="6">This paper is disclosable under the FOI Act</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="6">Leon Hinton, leon.hinton@nhs.net</td></tr>
<tr><td rowspan="5">Reports require an assurance rating to guide the discussion:</td><td colspan="3">No Assurance</td><td colspan="3">There are significant gaps in assurance or actions</td></tr>
<tr><td colspan="3">Partial Assurance</td><td colspan="3">There are gaps in assurance</td></tr>
<tr><td colspan="3">Assurance</td><td colspan="3">Assurance with minor improvements needed.</td></tr>
<tr><td colspan="3">Significant Assurance</td><td colspan="3">There are no gaps in assurance</td></tr>
<tr><td colspan="3">Not Applicable</td><td colspan="3">No assurance required.</td></tr>
</table>

Meeting of the Trust Board in Public
Wednesday, 17 January 2024

Title of Report	Finance Planning and Performance – Assurance Report, 30 November 2023		**Agenda Item**	3.3a
Author	Emma Tench, Assistant Company Secretary			
Lead Executive Director	Alan Davies, Chief Financial Officer			
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	N/A			
Purpose of the report (tick box to indicate)	**Assurance**	✓	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	Minutes from the Finance Planning and Performance Committee were approved at the Committee on 21 December 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:** ✓

Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	NIL	
Appendices:	Key headlines and assurance level listed below.	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.	
For further information or any enquires relating to this paper please contact:	Alan Davies, Chief Financial Officer.	
	No Assurance	There are significant gaps in assurance or actions



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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
		Yes	No
4	2	x	

Declarations of Interest Made
None

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

Reports not received as per the annual workplan and action required	
National Cost Collection	Deferred to December - meeting due to changes in NHSE submission - CFO
PID – ENT Increased Resource	Deferred to December – needs to follow governance process - CMO
Medical Staffing	Deferred to December - Report not approved by submission by CMO - verbal update and report to be submitted next meeting - CMO
Digital Health Records	Deferred to December – needs to follow governance process - CDO

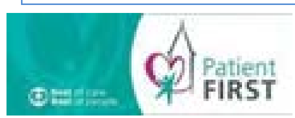
Items/risks/issues for escalation

Issues and or Risks to note: None
Reflection:
Chair request for detailed Executive Summary on cover sheets. Less requirement for lengthy reports if this is right. There have been good discussions on important areas today.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. **Board Assurance Framework – Systems and Partnership** The Committee were **ASSURED** and **NOTED** the report.	
Corporate Financial Risk Register - Sustainability	



The Committee **NOTED** the report.	
3. Integrated Quality Assurance Report (IQPR) – Systems and Partnership The Committee **NOTED** the report.	
4. IQPR – Sustainability The Committee **NOTED** the report.	
5. Twelve Hour Delays in Emergency Department **Further assurance required for:** • Expansion on conversation around delays in ED • Pressure points within the hospital • Bed capacity at Amherst • Procurement of further beds off site. The Committee **NOTED** the report,	
6. Aged Debt Briefing **Further assurance requested for:** • Provision against MCH debt not being paid. • ICS funding, end date and process • End date for MCH debt. Three to six months agreed. • Further updates to come to each FPPC meeting The Committee **NOTED** the report.	
7. Finance Report M7 **Further assurance requested for:** • Interest rates the Trust will pay back • Nursing and Medical payment breakdowns to be included in all future reports The Committee **NOTED** the report	
8. Financial Risk, Mitigations and Forecast The Committee **NOTED** the report	
9. Medical Staffing **Further assurance requested for:** • The A3 captures the overall position including actions, timelines, countermeasures and improvements. • Medical Staffing to be added to December 2023 The Committee were **ASSURED** by the report	
10. Business Planning The Committee **NOTED** the report	

11. Efficiencies Programme – Counting and Capture Programme The Committee **NOTED** the report	
12. Investment Governance and Business Case Policy The Committee **APPROVED** the report	
13. Theatre Robot Programme The Committee **APPROVED** the Business Case	
14. Digital Health Records The Committee **APPROVED** the Business Case subject to double lock approval	
15. Digital Dictation The Committee **APPROVED** the Business Case	

Meeting of the Trust Board
Wednesday, 17 January 2024

Title of Report	Finance Planning and Performance – Assurance Report, 21 December 2023			Agenda Item	3.3b
Author	Emma Tench, Assistant Company Secretary				
Lead Executive Director	Alan Davies, Chief Financial Officer				
Executive Summary	Assurance report to the Trust Board from the Finance, Planning and Performance Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.				
Proposal and/or key recommendation:	N/A				
Purpose of the report (tick box to indicate)	**Assurance**	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	Minutes from the Finance Planning and Performance Committee to be approved at the Committee on 25 January 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:** ✓
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	NIL				
Appendices:	Key headlines and assurance level listed below.				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Alan Davies, Chief Financial Officer.				
Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions		
	Partial Assurance		There are gaps in assurance		

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Member Attendees	Number of apologies	Quorate	
4	1	Yes	No
		x	

Declarations of Interest Made
None

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

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

Financial Recovery Plan Refresh	No progress has been made by the system since the last meeting on the financial modelling.
PID – ENT Increased Resource	CFO removed
Benefits Analysis on Teletracking	Deferred to March 2024 by Chair (COO)
Endoscopy – Immediate Capacity	Deferred to January 2024 – not been to Exec. (COO)
National Cost Collection	Deferred to January 2024

Items/risks/issues for escalation

Issues and or Risks to note: None

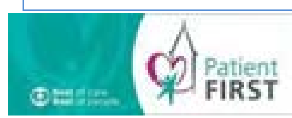
Reflection:

- Robust discussions with focus on key issues.
- More staff in post, a need to strengthen governance and controls.
- Positive steps for understanding, but a need for realistic timelines.
- Year-end targets are ambitious with head start on SIPS for next year.
- Timeline and ownerships with actions, being brave about resource required. A proposal in how we can invest in this.

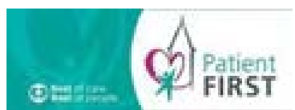
Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1.Finance Report – Month 8 (inclusive of IQPR and Sustainability Report) The Committee **NOTED** the report	
2. Medical Workforce – Deep Dive **Further assurance required for:**	



• Recruitment Governance Controls to be reported at the February 2024 Committee meeting. • Countermeasures and timelines to be added to future reports. The Committee **NOTED** the report.	
3. Efficiencies Programme 2023/24 **Further assurance required for:** • Excess bed day data to get traction on the system and drive forward The Committee **NOTED** the report.	
4. Performance Report (inclusive of IQPR Systems and Partnership) The Committee were **ASSURED** and **NOTED** the report.	
5. Draft Digital and Data Strategy The Committee **APPROVED** the report.	
6. Board Assurance Framework **Further assurance required for:** • Risk management and assurance that processes in place are working efficiently – a focus for Audit and Risk Committee. The Committee **APPROVED** the report.	
7. Corporate Financial Risk Register The Committee **APPROVED** the report	



Meeting of the Trust Board
Wednesday, 17 January 2024

Title of Report	Audit and Risk Committee – Assurance Report, 14 December 2023.			**Agenda Item**	3.4
Author	Emma Tench, Assistant Company Secretary				
Lead Executive Director	Alan Davies, Chief Financial Officer				
Executive Summary	Assurance report to the Trust Board from the Audit and Risk Committee, ensuring all nominated authorities have been reviewed and approved. The report includes headlines, items for escalation and key risks from the Committee.				
Proposal and/or key recommendation:	N/A				
Purpose of the report (tick box to indicate)	**Assurance**	✓	Approval		
	Noting		Discussion		
Committee/Group at which the paper has been submitted:	Minutes from the Audit and Risk Committee were approved at the Committee on 14 March 2024.				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	**Priority 5: (Systems)** ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	**Well-Led:** ✓
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	NIL				
Appendices:	Key headlines and assurance level listed below.				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.				
For further information or any enquires relating to this paper please contact:	Alan Davies, Chief Financial Officer.				
Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions		
	Partial Assurance		There are gaps in assurance		

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

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Number of Members	Number of apologies	Quorate	
		Yes	No
4	1	x	

Declarations of Interest Made
None tendered

Items referred to another Group, Subcommittee and or Committee for decision or action		
Item	Group, Subcommittee, Committee	Date
Fire Safety in Emergency Department	Executive Management Committee	19/12/2023
Resuscitation training – governance	QPSS Committee	20/12/2023
Annual Audit and Report timetable	FPP Committee	21/12/2023

Reports not received as per the annual work plan and action required		
Health and Safety Annual Report	Deferred to March 2024	HSSG on 15.12.24 RSCAG on 21.12.24
Standing Financial Instructions - Update	Deferred to March 2024	Not been reviewed by Stakeholders or Execs
Losses and Special Payment Policy	Deferred to March 2024	Not been reviewed by Stakeholders or Execs

Items/risks/issues for escalation

Issues and or Risks to note:

- Emergency Department overcrowding impacting on fire exit egress – emerging risk.

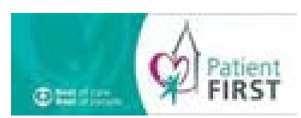
Reflection:

- Risk management process review for both operational and strategic risk is needed – workshop proposed to accelerate the review.

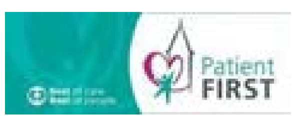
Implications for the corporate risk register or Board Assurance Framework

- Emergency Department overcrowding impacting on fire exit egress – emerging risk. Link to current Fire risks on the corporate risk register.

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. **Board Assurance Framework** **Further assurance required for:** • Risk management framework, workshop planned to initiate a review. This will include:	



• Risk Ratings • Mapping for Strategic and Operational Risks • Effectiveness of Controls in place to manage risks • Alignment to Patient First • Risk linked to SOF4 • Strategic risk For all Patient First Domains The Committee **NOTED** the report and supported the establishment of a workshop.	
2. Assurance and Escalation Report from Risk and Compliance Assurance Sub-Committee The Committee **NOTED** the report.	
3. Mortality Deep Dive The Committee were **ASSURED** by the report.	
4. Kent Fire and Rescue Service – Three Yearly Inspection Report **Additional items were raised in relation to fire safety and further assurance is required for:** • Overcrowding in ED creating a fire risk • Review of fire risk once new lift installation is completed. The Committee **NOTED** the report.	
5. Internal / External Audit Tracker Update The Committee **NOTED** the report,	
6. External Audit Report The Committee **NOTED** the report.	
7. Internal Audit Report **Further assurance requested for:** • PSIRF Audit timing to be reviewed in the New Year. The timetable will be circulated to FPP Committee The Committee **NOTED** the report	
8. Local Counter Fraud Plan **Further assurance requested for:** • Data to show when majority of waivers come through. • Trend of retrospective waivers The Committee **NOTED** the report	
9. Financial Compliance The Committee were **ASSURED** and **NOTED** the report	



Meeting of the Trust Board in Private
Wednesday, 17 January 2024

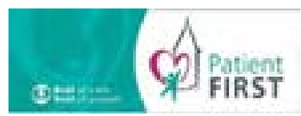
<table>
<tr><td>Title of Report</td><td colspan="2">2022/23 Health and Safety Annual Report</td><td>Agenda Item</td><td>3.5</td></tr>
<tr><td>Author</td><td colspan="4">Louise Furlong; Integrated Governance Manager and Interim Head of Health and Safety</td></tr>
<tr><td>Lead Executive Director</td><td colspan="4">Chief Nursing Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="4">The purpose of this report is to provide assurance on compliance with legislation and Trust policies to the Trust Board.
Included within the report is statistical analysis and key information regarding Health and Safety (H&S) activity, audit programme and progress, training compliance, reported incidents, RIDDOR and investigation outcomes across MFT, together with monitoring and responding to the health and safety needs of the Trust.

Of the 9 objectives set for 2022/23 only 4 were achieved, as set out in Section 4 of the report.
The Trust continues be under an improvement notice from the HSE as set out in Section 8 of the report.
Both the gaps in achieving objectives and the ongoing improvement notice inform the objectives of 2023/24.

This is the fourth Health and Safety annual report produced. The report and purpose of it conforms to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="4">The Board is asked to note the content of the report, and based on its content, The Board are asked to approve the 12 Objectives set for the current year (2023/24) six of which have already been completed with the remaining six on-track for completion by year-end.
The 6 completed objectives are:
1. Completion of the recruitment programme to bring the Health and Safety Team up to establishment.
6. To establish a formal sharps working group with accountability to the Health, Safety & Security Group, in order to ensure robust governance and monitoring arrangements in place.
7. To review and update the Health & Safety policy and associated SOPs and to consolidate into a 'Handbook'.
8. To recommence Health & Safety Keyworker sessions in order that departments have access to H&S advise at support at source.
9. To undertake a gap analysis against the National Back Exchange Standards and to redesign Moving & Handling training provision against the standards, with a plan to be fully aligned within the next 2years.
12. To work with the Integrated Governance Team to re-design the DATIX incident investigation for sharps, allowing better analysis of data, to understand hot-spots and trends.</td></tr>
<tr><td></td><td>Assurance</td><td>X</td><td>Approval</td><td>X</td></tr>
</table>

Patient FIRST

<table>
<tr><td>Purpose of the report (Please mark with ‘X’ the box to indicate)</td><td>Noting</td><td colspan="2">X</td><td colspan="2">Discussion</td><td></td></tr>
<tr><td>Committee/Group and date submitted:</td><td colspan="6">Meeting: Health, Safety and Security Group
Date: 05 December 2023</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="6">Please mark with ‘X’ the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)</td><td colspan="2">Priority 2: (People)
X</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="6">Please mark with ‘X’ the CQC domain the report aims to support:</td></tr>
<tr><td>Safe:
X</td><td colspan="2">Effective:</td><td>Caring:</td><td>Responsive:</td><td>Well-Led:</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="6">All areas of non-compliance noted throughout the report have already been reflected in the Trust Risk Register.</td></tr>
<tr><td>Resource implications:</td><td colspan="6">N/A</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="6">N/A</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="6">Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="6">Failure to effectively manage H&S could lead to prosecution by the HSE under the Health and Safety at Work Etc. Act 1974 and the regulations that fall under it.</td></tr>
<tr><td>Appendices:</td><td colspan="6">2022/23 Health and Safety Annual Report</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="6">This paper is disclosable under the FOI Act</td></tr>
<tr><td>For further information please contact:</td><td colspan="6">Name: Louise Furlong
Job Title: Integrated Governance Manager and Interim Head of Health and Safety
Email: louise.furlong@nhs.net</td></tr>
<tr><td rowspan="5">Please mark with ‘X’ - Reports require an assurance rating to guide the discussion:</td><td colspan="2">No Assurance</td><td></td><td colspan="3">There are significant gaps in assurance or actions</td></tr>
<tr><td colspan="2">Partial Assurance</td><td></td><td colspan="3">There are gaps in assurance</td></tr>
<tr><td colspan="2">Assurance</td><td>X</td><td colspan="3">Assurance minor improvements needed.</td></tr>
<tr><td colspan="2">Significant Assurance</td><td></td><td colspan="3">There are no gaps in assurance</td></tr>
<tr><td colspan="2">Not Applicable</td><td></td><td colspan="3">No assurance required.</td></tr>
</table>



Health and Safety Annual Report 2022/23

Louise Furlong
Integrated Governance Manager and Interim Head of Health and Safety

1 Executive Summary

1.1 The purpose of this report is to provide assurance on compliance with legislation and Trust policies to the Health, Safety and Security Group and the Trust Board. Included within the report is statistical analysis and key information regarding Health & Safety (H&S) activity, audit programme and progress, training compliance, reported incidents, RIDDOR and investigation outcomes across MFT, together with monitoring and responding to the health and safety needs of the Trust.

1.2 This is the fourth Health and Safety annual report produced. The report and purpose of it conforms to the Trust's Health and Safety Policy, Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996.

2 Introduction

2.1 The Health & Safety annual report covers the period 1st April 2022 to 31st March 2023. The report outlines key developments and the work that has been undertaken during this reporting period, and is an opportunity to consider work planned, and the objectives for the year ahead.

2.2 It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the Trust premises and during Trust activities to:

- Comply with health and safety legislation;
- Implement health and safety arrangements;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies;
- Develop partnership working and to ensure health and safety arrangements are maintained for all
- To ensure that the health and safety agenda is not only embedded, but embraced throughout the Trust using a variety of monitoring methods.

3 Overview of Legal Compliance

3.1 The table below outlines the main health & safety legislation and identifies the reactive and proactive work that the Trust has carried out in order to ensure compliance.

Legislation	Description of Actions/Level of Compliance	
Health & Safety at Work Act 1974	1. Version 11 of the Corporate Health & Safety Policy published 2. Competent persons in place to provide advice. 3. Health, Safety & Security Group held monthly	
Management of Health & Safety at Work Regulations 1999	1. Annual H&S Audit programme not completed 2.Annual H&S Work plan	
Manual Handling Operations Regulations 1992	1. Training delivered by competent person 2. Training not aligned to National Back Exchange Standards 3. Outstanding actions for Manual Handling on HSE action plan	
Display Screen Equipment Regulations 1992	1. DSE SOP and accompanying self-assessment tool updated. 2. Health & Safety Team conduct 1:1 assessments and provide advice on request	
Personal Protective Equipment Regulations 2022	1.PPE SOP updated to reflect the additional employer responsibilities to limb (b) workers	
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	1. Investigations have been implemented for all RIDDOR incidents and the findings are shared with the Health, Safety & Security Group.	

	2. RIDDOR reporting compliance not 100% 3. Enforcement notice received from HSE	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	1. Terms of reference have been reviewed for the Health, Safety & Security Group. 2. H&S Policy has been updated 3. H&S Trade union H&S Reps in place 4. Health and Safety Committee is well attended by Managers, Trust Competent Persons and TU safety reps. 5. Reports received on audits, action plan progress, KPIs and risk register 6. Health, Safety & Security Group acts as consultative committee for H&S policies	✓
Control of Substances Hazardous to Health 2002	1.COSHH audits completed weekly by departments 2. Adhoc spot checks completed by Health & Safety Team 3. H&S engage with departments as requested for product selection and risk assessment.	✓

4 2022/23 Health & Safety Objective Update

4.1 The achievement of the primary health and safety objectives for the year 2022/2023 are summarised below:

No.	Objective	What was achieved	
1.	Successful completion of the Health & Safety audit programme in order to identify key themes and trends to inform the work-plan of 2023/24	34% of audit programme delivered against plan.	✗
2.	To close-out the action plan for HSE	60% of the HSE action plan completed.	✗
3.	To continue the provision of Moving & Handling training, with a focus being on role-specific training.	Moving & Handling training provision continued to be delivered however compliance not achieved. Level 1 – 87% year end Level 2 – 77% year end Level 3 – 51% year end	✗
4.	To work in collaboration with the Patient Safety team to ensure a fit-for purpose incident reporting system is in place, and that staff are provided information, instruction and training on how to report incidents, and how to investigate incidents, in addition to educating staff around the requirements under RIDDOR, including the need to report on-time.	H&S Incidents continued to be reported via the incident reporting system DATIX. Daily cleanse undertaken by the Health & Safety team. RIDDOR SOP0377 updated to include flowcharts for staff to follow when making a decision on RIDDOR categorisation.	✓

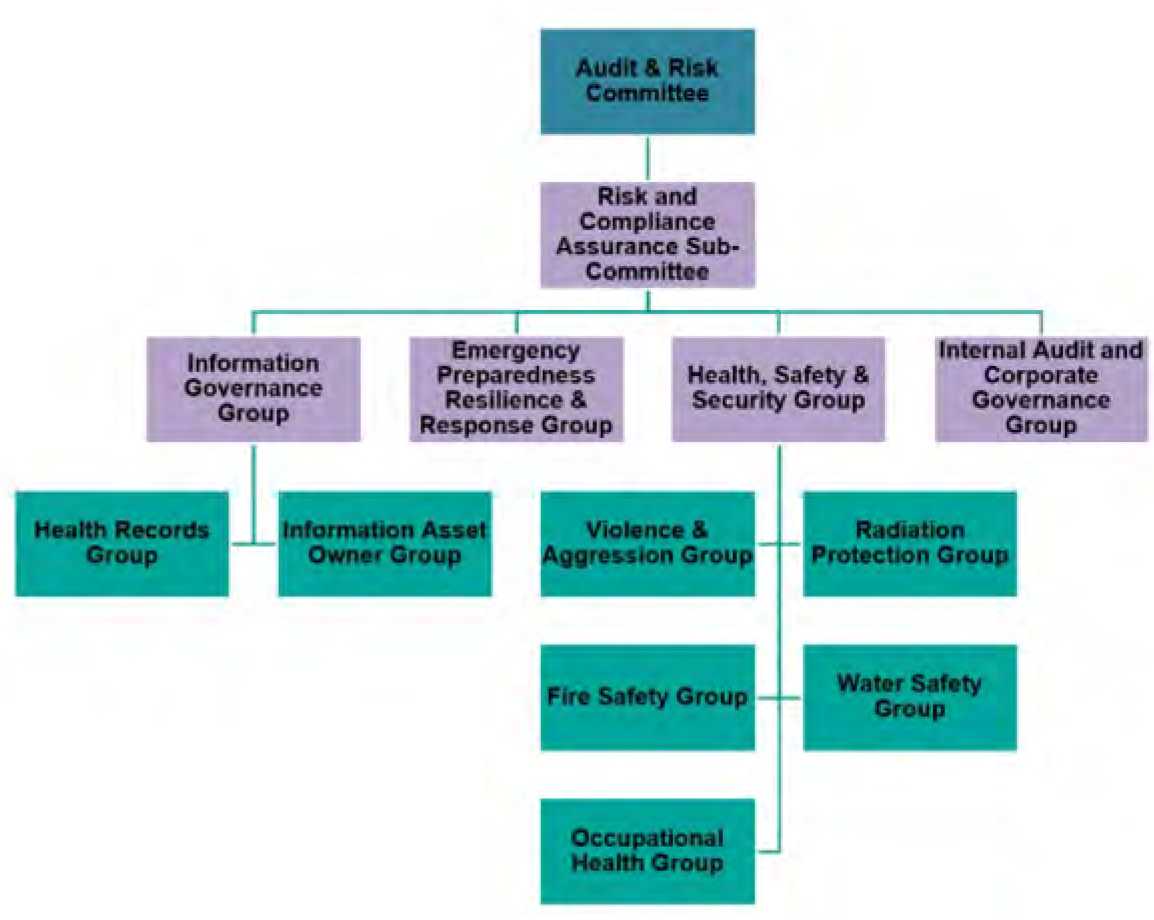
5.	To continue collaborative working with the Trust Legal team to defend both employer liability and public liability claims and to draw out key themes.	Health & Safety team respond to queries by the Trusts legal team on an adhoc basis. H&S team advise Legal of potential claims identified by way of incident investigation and ensure documents available	✓
6.	To engage with patient safety team regarding the integration of Health & Safety audits into the Trust data collection system (Gthr).	Health & Safety audits built into Gthr.	✓
7.	To identify the number and designation of limb (b) workers they employ in order to ensure that there is no difference in the way PPE is provided as defined by PPER 2022.	Action complete and PPE SOP0738 updated to reflect the changes to legislation.	✓
8.	To continue collaborative working with both the Infection, prevention and control, and occupational health teams to consolidate and risk assess various sharps items used across the Trust.	Sharps working group established and met weekly. Governance strengthened around sharps management but action to consolidate number of devices used and to risk assess not completed.	✗
9.	To investigate and identify a software solution, in order to enable effective management and distribution of risk assessments within the Trust.	Action placed on hold whilst wider Quality team consultation underway. Upon conclusion of the consultation, the systems review will now look at all QMS and sits outside the remit of the H&S Team	✗

5 Governance Arrangements

5.1 The Director with delegated responsibility for Health & Safety within the Trust is the Chief Nursing Officer.

5.2 The Health, Safety & Security Group is established on the authority of the Risk, Compliance and Assurance Sub-Committee to assist the Trust Board in fulfilling its responsibilities in relation to the Health and Safety at Work. It will fulfil its purpose by having responsibility for:

- Oversight of the systems and controls governing fire, security and health & safety, reviewing key performance indicators to assess their adequacy and identifying where improvements need to be made.
- Establishing and maintaining standards of health and safety and welfare in keeping with legal requirement and in accordance with Trust policy.
- Providing the Trust with an overarching view of health and safety and to provide assurance that non-clinical risks are effectively manage on behalf of the Trust.



5.3 The Health, Safety & Security Group has 5 established sub-groups, from which assurance and escalation reports are received, these include:

1. Violence & Aggression Group
2. Radiation Protection Group
3. Fire Safety Group
4. Water Safety Group
5. Occupational Health Group

5.4 In addition to receiving reports from established sub-groups, the Health, Safety & Security Group also receives regular reports on topics including:

1. Estates & Facilities compliance (including waste management)
2. Employer liability and public liability claims
3. Wellbeing reports
4. Infection prevention & control
5. PLACE

6 Competent Health & Safety Advice

6.1 The Health and Safety Team reports to the Director of Integrated Governance, Quality & Patient Safety.

The Health and Safety Team formed part of the wider Quality Team consultation in November 2022, and now consists of:

- Head of Health, Safety & Compliance
- One Health and Safety Lead (Vacant)
- One Moving & Handling Lead
- Two Health and Safety Officers (1 post vacant – awaiting start date)
- One Health & Safety Administrator (Vacant – awaiting start date)

6.2 Regulation 7 of the Management of Health and Safety at Work Regulations 1999 requires organisations to have competent health and safety advice. The organisation has many health and safety risks and regulations that are managed across the organisation. These risks have

are monitored through the Health, Safety & Security Group, or other appropriate monitoring arrangements.

6.3 The Health and Safety Team are responsible for advising and guiding the Trust to ensure that it is meeting, or working towards meeting, its legislative requirements. They also provide health and safety competent advice either verbally, via email or as part of an inspection/audit.

6.4 During this period 330 Datix incidents were monitored by the H&S Team with H&S advice given in all incidents.

6.5 In January 2023 the workplace exposure limit nitrous oxide was exceeded for staff working in the Delivery Suite. The H&S Team gave advice to the Estates & Facilities and Maternity Departments and completed the COSHH (risk) Assessment for the area. Ventilation of the area and scavenging machines were inspected to ensure efficiency, with personal monitoring to be repeated for staff working in that environment.

7 Policies

7.1 The following policies and standard operating procedures (SOPs) were consulted on and approved by the members of the Health, Safety & Security Group

- POLCS025; COSHH policy
- SOP0394; COSHH Procedure
- SOP0186; Risk Assessment Procedure
- SOP-MMH-DIR-001; Procedure for Dose Monitoring and Control of Staff Who Come into Contact with Ionising Radiation
- SOP0639; Display Screen Equipment (DSE)
- POLCS004; First Aid Policy
- POLCS005; Corporate Health & Safety Policy
- SOP0377; RIDDOR SOP
- POLCS008; Moving & Handling Policy
- SOP005, SOP0112 and SOP0113; Moving & Handling SOPs
- SOP0403; Security self-assessment SOP
- OTCS078; Security self-assessment
- POLCS032; Sanctions & Redress Policy
- Policy for Undertaking a Personal Search & Property

8 Enforcement Notices and Improvement Plans

8.1 The Health & Safety Executive (HSE) is the regulatory body for Health & Safety legislation for all organisations across the UK. The Trust received an improvement notice from the HSE on 23rd May 2022. The notice stated that the Trust was in material breach of Section 2(1) and 3(1) of the Health and Safety at Work Etc. Act 1974 (the Act) and Regulations 3(1) & 5(1) of the Management of Health and Safety at Work Regulations 1999 (the Management Regulations).

8.2 The notice followed two planned visits from HSE inspectors on 6th October 2021 (over 3 days) and 25th March 2022. The initial visit was part of a programme of inspections of hospitals to explore three key risk areas, violence and aggression, manual handling and Covid-19. The Principal HSE Inspector gave written feedback in February 2022. A subsequent visit in March 2022 found there had been insufficient progress against the initial observations.

8.3 The breaches related to the identification of and management of manual handling, and violence and aggression risks to staff and patients and these resulted in an action plan to address the issues, referred to as the HSE Board Assurance Framework. The action plan is reported on at the Health, Safety and Security Group. At time of reporting the action plan is 60% complete, with a number of actions overdue, that require completion as soon as practicable.

8.4 Following the notification it was agreed that the Trust should audit itself against the NHS Employers Workplace Health and Safety Standards. A separate action plan was created in line with the audit findings, referred to as the H&S Board Assurance Framework. At the time of reporting the action plan is 54% complete, 38% of actions overdue, and therefore requiring significant work to bring the action plan to a close.

8.5 The Trust was subject to a further improvement notice from the HSE in November 2022. The improvement notice related the late reporting of dangerous occurrences within the timeframes as defined in the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The Trust responded to the letter, identifying it was aware of the late reports, was monitoring them through its governance structure and was working towards improving its reporting compliance. Following the Trust's assurances, the improvement notice was lifted.

9 Changes to Legislation

9.1 The Health & Safety team is responsible for communicating any relevant legislative changes to the Trust Board and staff via the approved governance routes.

9.2 The Health and Safety Executive (HSE) is committed to helping business and other stakeholders adapt to changes in occupational health and safety law and practice in line with Government policy on 'Common Commencement Dates' which are:

- 6th April (the start of the tax year); and
- 1 October.

9.3 On 6 April 2022 the Personal Protective Equipment at Work (Amendment) Regulations 2022 (PPER 2022) came into force. They amend the 1992 Regulations (PPER 1992). The regulations extend an employer's duties to 'limb-workers' so that they matched those they have for their own direct employees. In essence, PPE should be provided, maintained and limb workers trained in its correct use.

A review was undertaken and the relevant standard operating procedure was updated accordingly.

9.4 The Retained EU Law (Revocation and Reform) Act 2023 has the potential to impact on the health and safety regulations which were derived from Europe. This will not affect the primary legislation that is the Health and Safety at Work etc. Act.
At present, there is no clear guidance on how or when changes to regulations will take place.

9.5 The Health & Safety team continue to monitor upcoming legislative changes in order to ensure the Trust remains compliant. Any changes to legislation will be escalated via the Health & Safety governance route.

10 Incident Reporting

10.1 Health and Safety Incidents are reported via the incident management system; Datix. The graphs outline the health and safety incidents from April 2022 to March 2023.

10.2 In 2022/23 there were 330 H&S incidents in this period, with only 35 near miss incidents. More work is required to increase reporting of these incidents as they are opportunities to prevent further H&S incidents and a key indicator of a positive health and safety culture.

Figure 1; Health & Safety Incidents by Month

10.3 Of the 14,900 incidents reported on Datix in the year, only 30 related to health and safety. This equates to 2.21% of all incidents.

10.4 The Trust uses the Datix system to act as its digital 'accident book'. The accident book is an essential document for employers and employees, who are required by law to record and report details of specified work-related injuries and incidents. It enables organisations to comply with legal requirements under social security and health and safety legislation, including Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements.

10.5 Historically, reporting of health and safety incidents via Datix has been poor, with a lack of awareness of the importance of reporting incidents, and anecdotal feedback from staff citing inadequate locations and time consuming processes as reasons for not reporting. The Patient Safety team has worked on improving the system by making it easier to log incidents, and creating additional categories to help identify incident types, including health and safety and potential RIDDOR incidents, more readily. In addition, daily data cleanses by both the Health & Safety and Patient Safety teams are identifying incidents where there is a health and safety dimension – for instance, a staff member receiving an injury whilst preventing a patient fall would be missed if it was only considered as a 'patient fall' incident.

10.6 Verbal feedback provided by the HSE during their visit in March 2022 was critical of the existing incident reporting system; specifically that the current set-up of the incident reporting

system utilised by the Trust, lends itself to patient-centric incident reporting, and is less suitable for staff-centric incidents.

10.7 The Health & Safety team continues to work alongside the Patient Safety team to continually review the incident reporting system to ensure it is fit for purpose and to promote its correct use through various routes, including training and attendance at meetings.

10.8 The following data provides a breakdown of the type and cause of health and safety related incidents that have been reported in 2022/23. Last year's figures are included for comparison.

Figure 2; H&S Incidents by Type

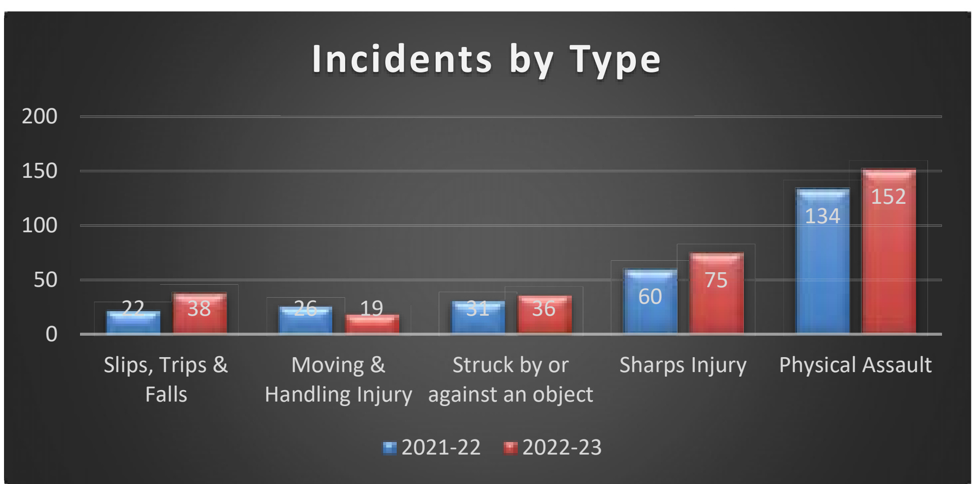
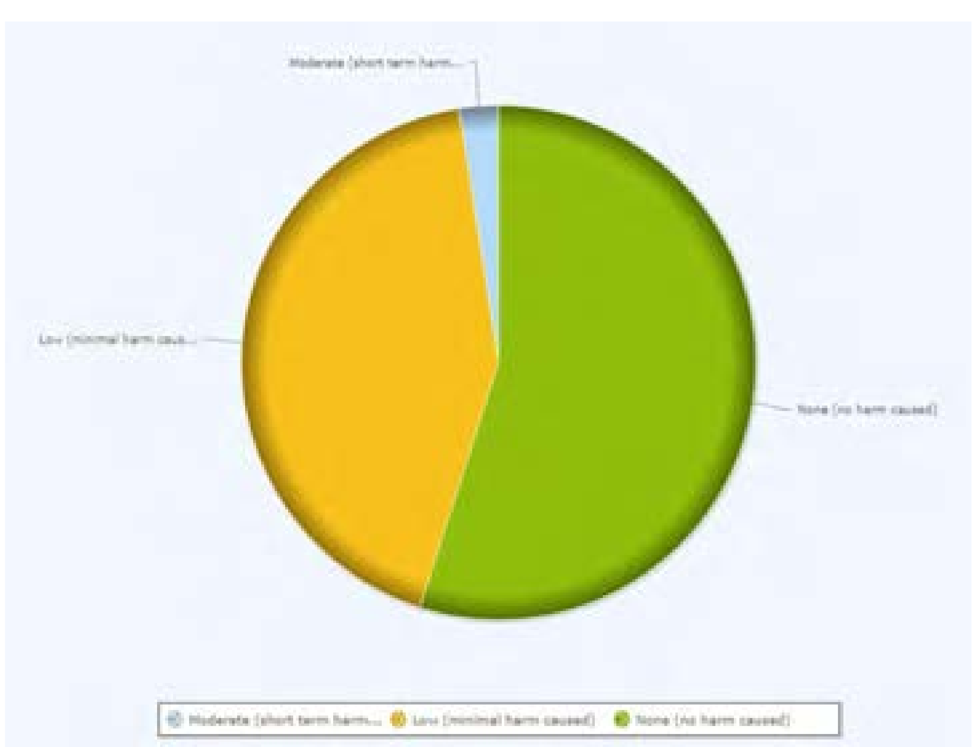


Figure 3; H&S Incidents by Harm Level



10.9 The top two sub categories of incidents have not changed since the last annual report; they remain physical assaults (see section 14) and injury from sharps.

10.10 Managers investigate incidents, supported by specialists when required, and any trends are reported to the Health, Safety & Security Group. Any learning is incorporated into H&S audits, advice and training. Only 2.4% of incidents were moderate harm; 97.6% being low and no harm.

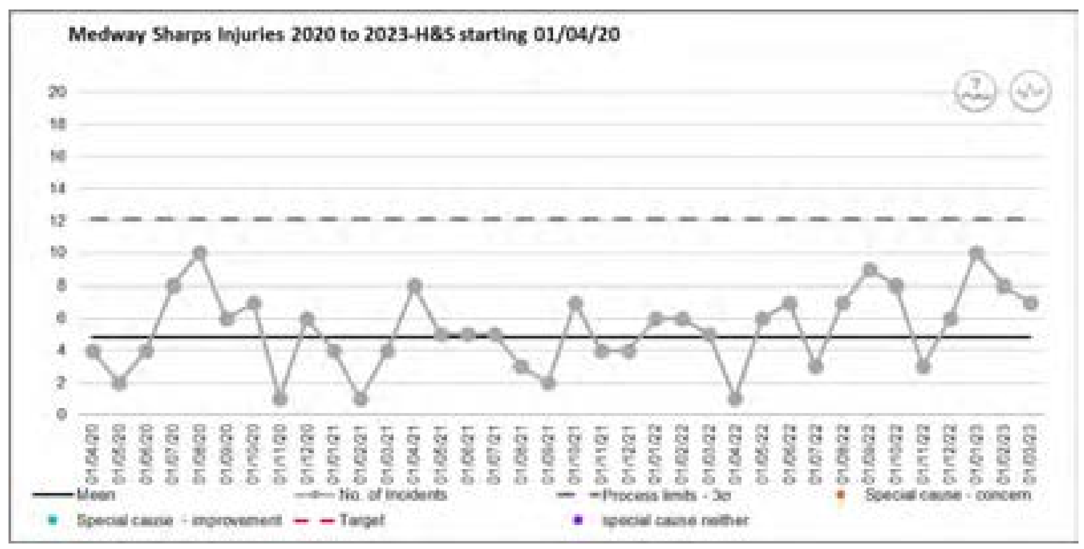
11 Sharps Safety

11.1 Injuries caused by sharps devices continue to be one of the categories with the highest number of incidents in the year.

11.2 Measures to avoid occupational exposure to blood borne viruses including prevention of sharps injuries must include; the safe handling and disposal of sharps. This includes the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff. This is a requirement of the 'Code of Practice on the prevention & control of infections' and 'Sharps Instruments in Healthcare Regulations 2013'.

11.3 There needs to be greater analysis of data in order to inform where the H&S and IPC resources should be focused, and therefore this will be a key priority for 2023/24.

Figure 4; Sharps injuries by month



11.4 Sharps and contamination injuries are a significant risk in healthcare settings, and the topic is a current area of interest for the HSE who have included it in their current hospital inspection programme.

11.5 The Health & Safety team have been working in collaboration with the Infection, Prevention & Control (IPC) team to review the number and types of sharps used across the Trust, with an aim to both streamline the number of devices (circa 6000) used, whilst ensuring the Trust is compliant with the Health & Safety (Sharps Instruments in Healthcare) Regulations 2013. Departments have been asked to review their unsafe sharps and move to safer alternatives or present risk assessments to the Sharps Working Group for decision.

11.6 The move to using safer sharps, and ensuring risk assessments are in place for non-safe sharps, are part of the process of reducing the frequency of sharps injuries. However, training and supervision is of equal importance as the safer sharp alternatives, are only safer if used correctly, and staff follow the correct procedures when disposing of them.

12 Slips, Trips & Falls

12.1 Slips, trips and falls of staff of other users of the site (excluding patients) are the third highest occurring incident type

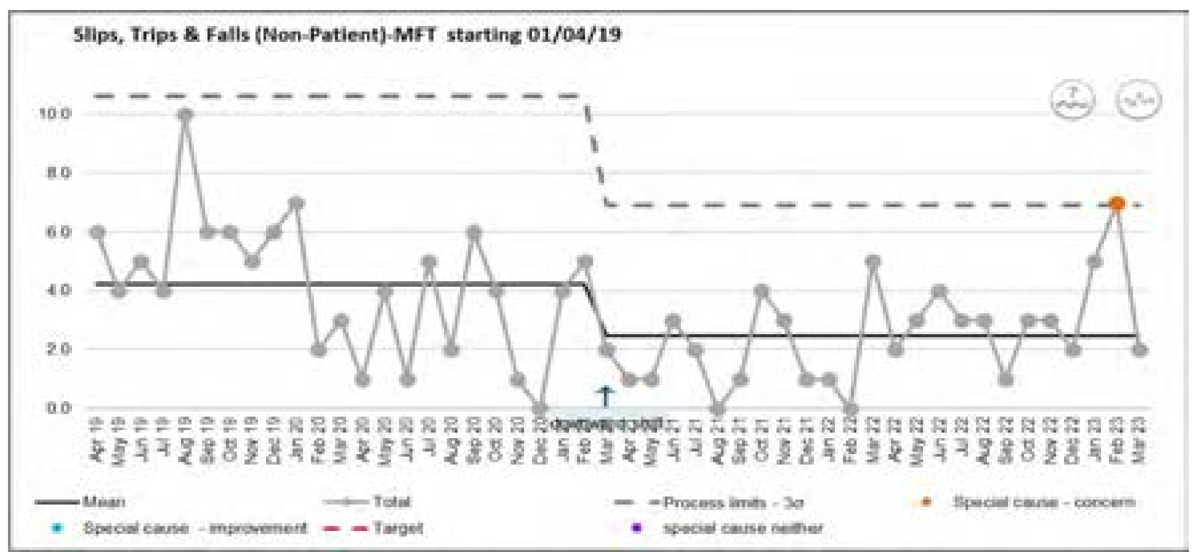
12.2 Slips trips and falls are one of the three main causes of RIDDOR reports due to the potential for fractures or prolonged absences from work.

12.3 An analysis of the 2022/23 incidents identified three primary causes of slips trips and falls:

1. Tripping over an object (24%) – this relates to the tidiness of workspaces and ward areas. Injuries occur from tripping over boxes, furniture and other obstructions in the working environment.
2. Falls from chairs (18%) – this relates primarily to chairs which move as people go to sit on them. This is attributed to incorrect castor specifications for the flooring. The use of computers on wheels in ward areas may be a factor in that more staff are working at computers in the wards as opposed to offices.
3. Slipping on wet/slippery surfaces (13%) – this includes both wet and dusty environments due to cleaning or maintenance work, as well as areas that become slippery due to inclement weather.

Figure 5; Slips, Trips & Falls by year

Figure 6; Slips, Trips & Falls by month



12.4 The other causes include staff illness, and a variety of different trips such as ice and snow and trips over small areas of damage to flooring or the external paths. This can be seen in the SPC chart for February 2023, when there was a special cause for concern but not attributable to a primary cause such as the weather.

12.5 There have been improvements made across the site with flooring repairs and replacements being undertaken and resurfacing works. However, there is no formalised process for undertaking routine risk assessments across the site so a standard operating procedure needs to be implemented to routinely review common areas of the site for potential hazards.

Individual teams remain responsible for keeping their work area tidy and reporting faults to the Estates Hotline.

12.6 IPC and H&S audits flag work areas that are cluttered and pose trip hazards. The Health & Safety team have worked with the Procurement Department on ensuring that chair castors are specified for the type of flooring they will be used on, and H&S audits include checking existing chair castors. Each incident is reviewed by the H&S team to ensure the handler has undertaken remedial measures to prevent a recurrence.

13 Moving & Handling

13.1 Moving & Handling matters at MFT are overseen by the Health & Safety Team, Specifically by the Trusts Moving & Handling Lead.

13.2 The Moving & Handling function have a designated training room from which all training is delivered.

13.3 The Moving & Handling Lead is responsible for investigating all incidents that include a factor of manual handling, alongside providing advice and guidance on equipment provision.

13.4 Nineteen (19) Moving and Handling incidents were reported in 2022-23, a decrease of seven (7) from the previous year. Due to their severity, five (5) of the incidents met a requirement to be reported to the HSE under the RIDDOR regulations (see section 14 below).

Figure 7; Moving & Handling Incidents by Year

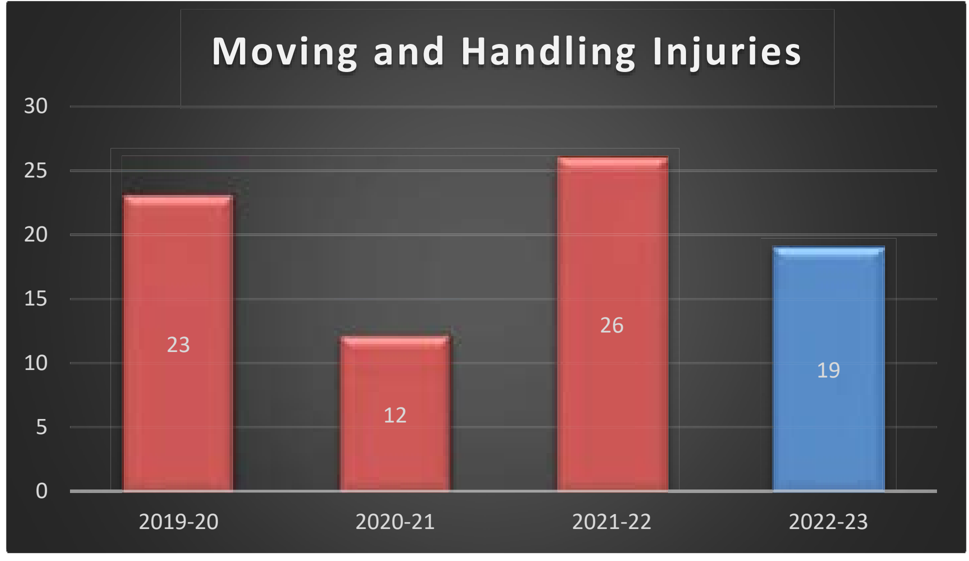


Figure 8; Moving & Handling Incidents by month

13.5 Moving and handling is recognised as a significant risk within healthcare settings. The challenges for safely moving patients without risk of injury to staff relate to ensuring that the staff are trained in correct moving and handling techniques, and have access to appropriate equipment for the task. Moving and handling risks also extend to non-patient moving and handling activities, as the hospital is reliant on the movement of significant quantities of waste, laundry, consumables and equipment in and around the site. The level of risk is reflected in the number of moving and handling related RIDDOR incidents reported by the Trust in 2022/23, putting moving and handling at joint highest, with five incidents.

13.6 Causes of injuries in 2022/23 vary and are seen across a range of activities, including moving inanimate loads around the building, assisting patients as the stand or walk and undertaking routine activities such as changing mattresses or moving beds around the hospital. Key to preventing moving and handling injuries is ensuring staff are fit to perform the task, that they have been trained and have the right equipment and follow the correct process. Training and observing staff in the workplace is also essential in ensuring good practice, as staff will not always follow their training within a busy work environment.

14 Security (Violence & Aggression)

14.1 During the year, the Security Management Specialist has carried out security risk assessments, violence and aggression risk assessments and made recommendations to clinical staff and Estates and Facilities Department where changes can be made to the

environment and alterations to the premises.

The Security Management Specialist continues to attend multi-disciplinary meetings and advise multiple staff groups on Violence and Aggression, crime reduction and lone working.

14.2 There has been a total of one-hundred and fifty-two (152) physical assaults in 2022-23, an increase of eighteen (18) from the previous year, still remaining one of the highest occurring incident categories reported via DATIX.

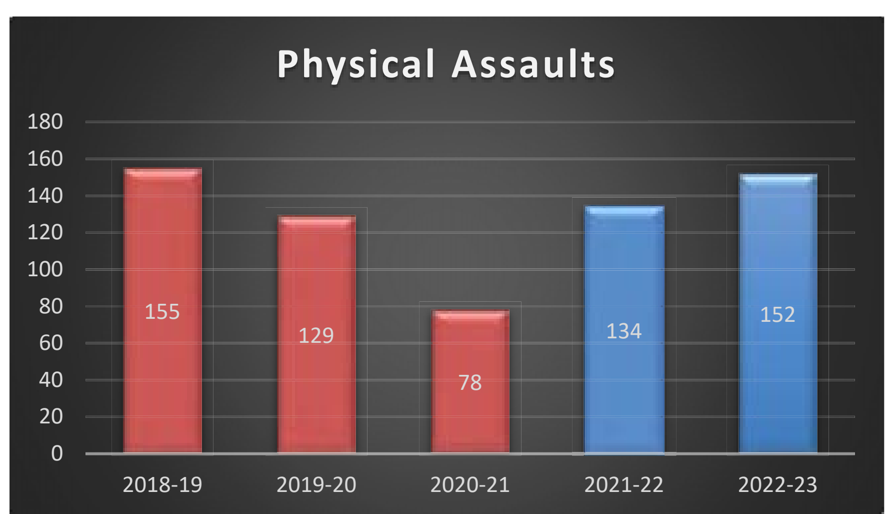
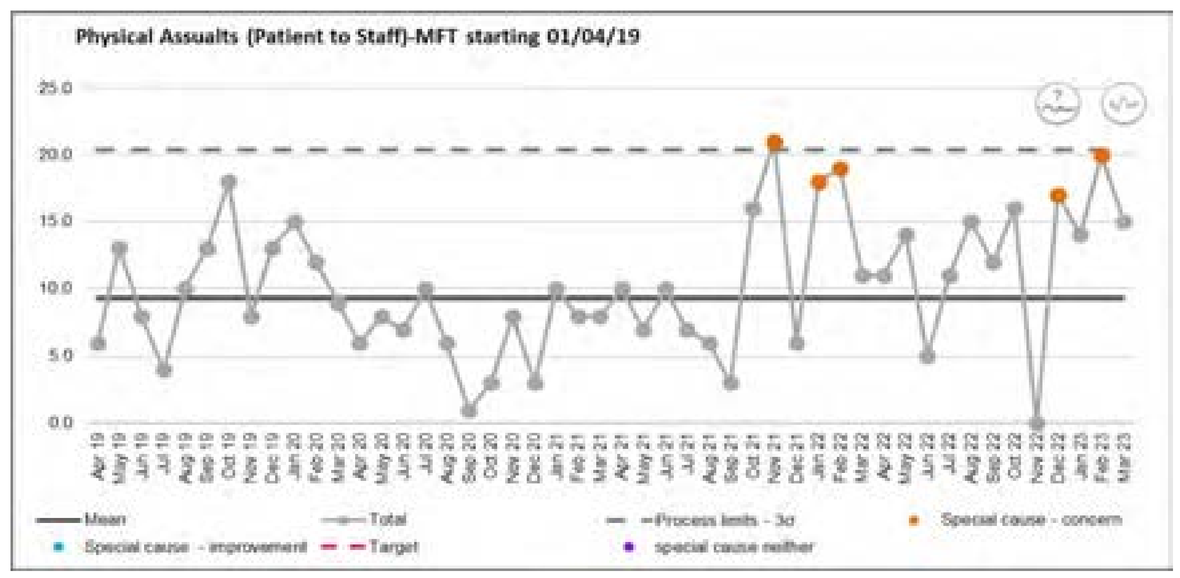


Figure 4; Total physical assaults by year SPC chart



14.3 Violence and aggression is an area of special interest to the HSE following their visit to the Trust in March 2022.

14.4 Physical assaults are the most reported incident type in 2022/23 with a 13.4% increase in comparison to the previous year. Physical assaults are one of the three main causes of RIDDOR reports.

14.5 The Security Violence and Aggression Group has undertaken a more in depth review of each incident to identify causative factors (clinical and non-clinical) in order to develop targeted controls to manage the risks in each area.

14.6 The Prevention and Management of Violence and Aggression (PMVA) training is available to staff in higher risk areas and the Security Manager is working with departments, such as the Emergency Department, to identify targeted strategies to manage violence and aggression, as well ensuring that the Sanctions and Redress Policy is applied to patients who physically or verbally assault staff.

14.7 Following an assault, staff are advised to attend A&E for assessment and treatment. They are also encouraged to attend Occupational Health where support and further guidance is offered, and to report the assault to the Police. The Security Manager is there to support staff who are part of a criminal case, and he meets regularly with an allocated Inspector from Medway Police to discuss criminal activity at the hospital. At present no staff assaults from 2022/23 have resulted in a criminal prosecution and there appears to be a reluctance for staff to go through this process.

14.8 The Trust remains committed to the delivery of a secure environment for those who use or work in the Trust so that the highest possible standard of care can be delivered; to this end security remains a key priority within the development and delivery of health services. In response to the HSE's improvement notice the Trust has increased the capacity of the in-house security team from eight whole time equivalent to sixteen and is exploring the use of body cameras in clinical areas where violence and aggression are prevalent. The Violence and Aggression Reduction Group will continue to work to reduce the number of physical and verbal assaults across the Trust.

15 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

15.1 Under RIDDOR, certain work place accidents, incidents, ill-health and certain near miss events must be recorded. Depending on the severity and nature of the injury, the Trust has a legal duty to report this data to the Health and Safety Executive.

15.2 Twenty-two (22) RIDDOR reportable incidents occurred within the Trust in 2022/23, all of the events concerned staff. This is a reduction of six (6) from last year, however still well above

trusts of similar size and composition, which tend to report about a third of that number.

Figure 9; RIDDOR submissions by Year

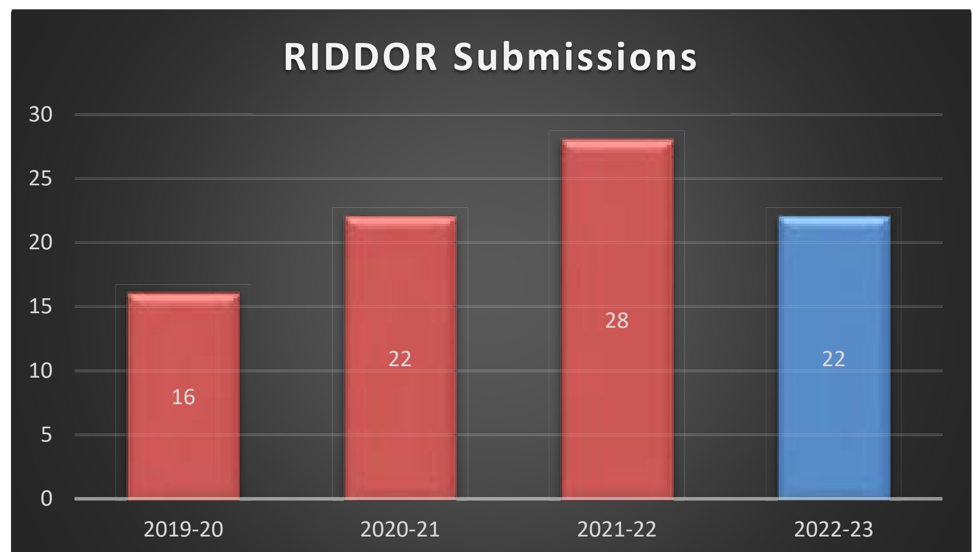
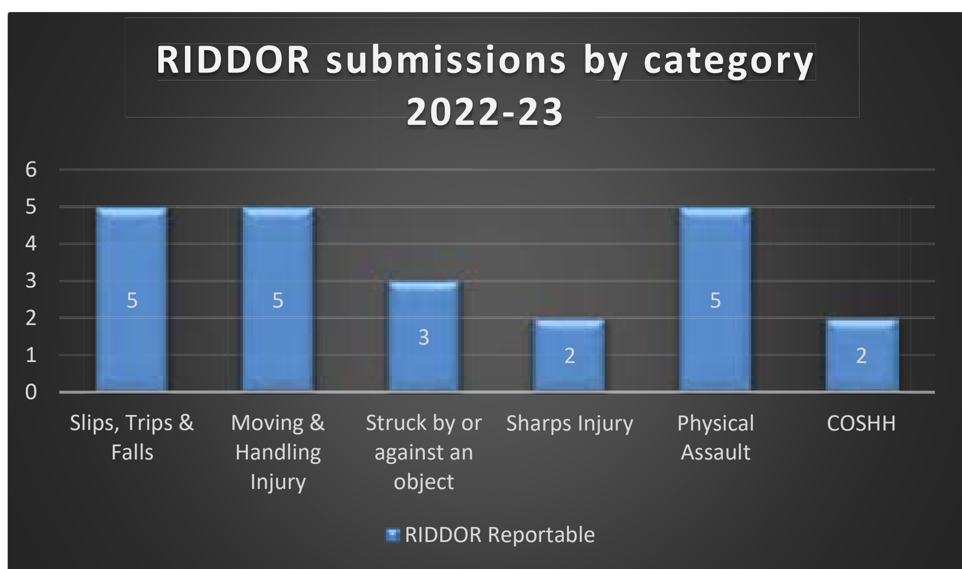


Figure 10; RIDDOR Submission by Incident Type



15.3 The Trust has historically performed poorly when reporting RIDDOR incidents within the regulatory timescales. This year saw a compliance rate of 68%, which is similar to previous years. Late or non-reporting of incidents by staff and managers is the main cause as this prevents the H&S team from flagging potential RIDDOR incidents early and ensuring an investigation is undertaken before determining if an incident is reportable.

15.4 An A3 thinking exercise has been completed to improve the RIDDOR compliance rate. This has seen the introduction of a daily cleanse by the Health & Safety Team to detect potential

qualifying incidents, and although RIDDOR reporting is covered within the statutory and mandatory health and safety training package, the message is being reinforced at induction sessions and at other opportunities such as in IPC and Occupational Health training sessions.

15.5 The top three areas for RIDDOR reportable injuries remain the same as 2021/22; slips, trips and falls, moving and handling and physical assault.

15.6 The Trust needs to improve its compliance with RIDDOR by ensuring staff and managers' report all incidents in a timely manner and flag those within Datix which may become RIDDOR reportable at the earliest opportunity. This will be achieved though staff training and awareness programs which are refreshed on an appropriate timescale.

15.7 All RIDDOR incidents reflect a level of harm that is impactful on the individual as well as the organisation. The Trust must set an ambitious target to reduce the number of these incidents to as low as is reasonably practicable and certainly within line with similar organisations which would mean only seven RIDDOR incidents or less per. year.

15.8 The annual work plans need to focus on the high risk areas within the Trust and ensure there are sufficient resources in place to progress improvements quickly.

16 Face Fit Testing (FFT)

16.1 The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 require employers to provide and maintain a safe working environment so far as reasonably practicable. The use of respiratory protective equipment is outlined in HSG 53 and is also contained in other regulations such as COSHH Regulations 2002; Control of Asbestos Regulations 2012; Control of Lead at Work Regulations 2002; Ionising Radiation Regulations 1999 and Confined Spaces Regulations 1997. An Approved Codes of Practice supports all these regulations.

16.2 In June 2021, the Department of Health and Social Care (DHSC) developed five resilience principles:

1. All FFP3 users should be fit tested and using two different masks (ideally three);
2. FFP3 users should interchangeably wear the masks they are fitted to;
3. Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type of FFP3;

4. Frontline stocks will be managed at no more than 7-10 days per SKU; and
5. Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter.

16.3 These face fit testing principles have been adopted by the Trust and are a mandatory requirement. These principles have also been incorporated into the MFT Fit testing programme and arrangements.

17 Training

17.1 Mandated Health & Safety training within the Trust currently consists of 2 levels of training:

1. **Health, Safety and Welfare**; completed at induction with a renewal period of 3 years. Training is available via a national e-learning package.
2. **COSHH Awareness;** completed at induction with a renewal period of 3 years. Training is available via an e-learning package. This is linked with Health, Safety & Welfare module, and requires completion in order for an individual's HS&W compliance to be updated.

17.2 Mandated Moving & Handling training within the Trust currently consists of 3 levels of training:

1. **M&H Level 1 (theory);** completed at induction by all staff, renewal every 2 years, available as e-learning module of face to face
2. **M&H Level 2**, is a practical session for all clinicians and non-clinical roles where manual handling is required, such as portering. Renewal every 2 years, face to face only.
3. **M&H Level 3**, is a practical session for Doctors only with a renewal period of 3 years.

17.3 The compliance rate for individual departments is set at 85% across all statutory and mandatory subject areas by the Trusts organisational development team.

17.4 Compliance levels at the end of the year for Health, Safety & Welfare, and Moving and Handling Level 1 were above 85%. Moving and Handling Level 1 training did fall below 85% in June, July and August of 2022.

17.5 Compliance levels for Moving and Handling Levels 2 and 3 were well below the target 85% score at the end of 2022/23 and this issue persists into the current financial year. Training capacity is limited by the number of competent staff in the Health and Safety Team who can provide moving and handling training and sickness absence has impacted on the number of sessions available. A recovery plan is being developed to address this.

17.6 In addition to statutory and mandatory training, additional training is required to be undertaken by staff who use ladders as part of their daily job. The requirements for ladder safety training are set out by the Working at Height Policy.

- Level 1 Ladder Safety Training (E-learning module via ESR) – renewed every 3 years.
- Level 2 Ladder and Step-ladder User Training (1/2 day face to face session) – renewed every 5 years.

Level 2 training is only required to be undertaken by staff who undertake working at height for the purpose of activities such as maintenance (I.e. Estates staff). All other staff required to work at height, should complete Level 1 training. The compliance levels for Level 1 training and reported on monthly by the Workforce Team. Records of compliance for Level 2 training should be held by the individual department in which the individual works.

Table 1; Training Compliance

Training	2019/20	2020/21	2021/22	2022/23
Health & Safety & Welfare (Inc. COSHH)	94%	89%	90%	89%
Moving & Handling Level 1	96%	89%	90%	87%
Moving & Handling Level 2	---	77%	83%	77%
Moving & Handling Level 3 (Doctors)	---	64%	68	51%
Ladder Safety Training	22%	38%	69%	65%

17.7 Compliance rates continue to fall below the target figure of 85%, this is likely due to the fact Ladder Awareness training is not mandated on employees ESR profiles. Without mandating key safety subjects, compliance is likely to remain low. The Health and Safety Audit looks at ladder training in each department, and this will enable a better understanding about whether the Level 1 training is required and whether it is being provided in the most appropriate way.

17.8 The Health & Safety Team also facilitates 1-day emergency first-aid training for departments who have identified via a risk assessment, that first aid provision is required. The nominal target for the Trust is one hundred and fifty (150), although this needs to be reviewed against the actual risk assessment for each area. There are currently (47) first-aiders, although

registered nurses can also fulfil the role. The locations of the first-aiders will be dependent on the risk level of individual departments.

17.9 Other departmental-specific safety training such as confined space, radiation safety etc. is currently arranged and managed locally at departmental level, and as such, the Health & Safety team does not have a broad-picture of compliance across all aspects.

18 Audit

18.1 Auditing is a key function of the Health & Safety Team, and is supported by the Management of Health & Safety at Work Regulations 1999, HSG65 (Plan, Do, Check, Act) and is a core component of the Trusts Health & Safety Management Arrangements.

18.2 During the Covid pandemic, the Health & Safety audit programme was placed on hold. The audit programme was re-visited for 2022/23, with the intention to audit all Trust departments before year-end.

18.3 The order of audits was based on the risk-profile of each department, with departments being given a priority level of 1-4. 1 being highest priority and 4 being the lowest priority. E.g. Inpatient wards have been issued a level 1 priority.

18.4 Due to staffing levels within the Health & Safety team, the audit programme had to be revised to focus on the priority 1 areas only with the remaining areas to be reprogrammed once the vacancies have been filled. 34% of audits were completed against plan.

18.5 The audits are now completed using Gthr (a data collection and analysis tool) to make the process more efficient.

18.6 In the meantime, departments are required to undertake local audits and inspections on a regular basis, on matters pertinent to health & safety, inclusive of:

- Window restrictor checks - conducted weekly
- COSHH (Control of substances hazardous to health) checks – completed weekly
- Workplace Inspections – Completed quarterly

These audits are currently completed by either the Health & Safety Keyworker or the departmental manager, with copies of audits shared via email, and data recorded in a spreadsheet.

18.7 In order to improve efficiency of completing the audits, and to enable data analytics, there is intention for the current suite of local audit tools to be integrated into Gthr.

Table 2; Audit Compliance by Division

Audit Area	Estates & Facilities	Corporate	Planned Care	Unplanned & Integrated Care	Trust
A. Health & Safety Policy	--	--	72%	63%	68%
B. Risk Assessments	--	--	41%	55%	48%
C. General Environment	--	--	86%	84%	86%
D. Display Screen Equipment	--	--	82%	82%	82%
E. First Aid	--	--	67%	63%	66%
F. Water Management	--	--	75%	100%	83%
G. COSHH	--	--	77%	78%	79%
H. Incident Management	--	--	81%	85%	83%
I. Electricity at Work	--	--	92%	99%	95%
J. Ladders & Platforms	--	--	39%	34%	35%
K. Waste Management	--	--	92%	100%	96%
L. Medical Gases	--	--	88%	44%	67%
M. Welfare	--	--	88%	79%	84%
N. Sharps	--	--	100%	97%	99%
O. Lone Working	--	--	78%	100%	82%
P. Training	--	--	71%	63%	69%
Overall	--	--	76%	76%	76%

19 Risk Assessments

19.1 The Health & Safety Team support the completion of risk assessments as required. Risk assessments have been completed for a variety of teams throughout the year, for departments including:

1. Housekeeping
2. Work Experience
3. Community Nursing
4. ED
5. Transport & Waste

19.2 The management on control measures from such risk assessments sit under ownership of the departmental manager.

19.3 In addition, several risk assessment pro-formas with associated guidance notes are available for staff to complete as required, including:

1. General Risk Assessment
2. COSHH Risk Assessment

3. Display Screen Equipment Self-Assessment
4. First Aid Needs Assessment
5. Lone Worker Risk Assessment
6. New and Expectant Mothers Risk Assessment

20 Conclusion

20.1 Improvements in health and safety are on-going across the Trust. The Health & Safety Team are working with the Trust's Clinical Divisions to increase compliance of local audits. Improvements in this area will show a greater level of legal compliance generally across the Trust.

20.2 Both the audit programmes and incident reporting are fundamental to the Trust being able to identify, analyse and address its high-risk areas. This relies on the involvement of all staff and managers and the Health & Safety Team are working Trust-wide to deliver on this. Reconfigurations made to Datix continues to improve the efficiency of reporting for staff and should also improve the follow up and investigation of incidents by managers.

20.3 Recruiting to vacancies in the Health & Safety Team will ensure the work plan for 2023/24 can be delivered. The 2023/2024 objectives document the key pieces of work required to improve upon the identified issues and forms the work plans for various departments within the Trust. Progress against these objectives will be reviewed at MFT Health, Safety & Security Group and forwarded to the Board for information.

21 Health & Safety Objectives 2023/24

21.1 The key objectives for the Health & Safety team for 2023/24 are set out below.

1. Completion of the recruitment programme to bring the Health and Safety Team up to establishment.
2. Successful completion of the Health & Safety audit programme in order to identify key themes and trends to inform the work-plan of 2023/24 and 24/25
3. To close-out the action plan for HSE BAF
4. To close out the action plan for H&S BAF (Workplace Health & Safety Standards Audit)

5. To expand the H&S metrics to include both leading and lagging indicators and to integrate these into the IQPR in order to improve data assurance.
6. To establish a formal sharps working group with accountability to the Health, Safety & Security Group, in order to ensure robust governance and monitoring arrangements in place.
7. To review and update the Health & Safety policy and associated SOPs and to consolidate into a ‘Handbook’.
8. To recommence Health & Safety Keyworker sessions in order that departments have access to H&S advise at support at source.
9. To undertake a gap analysis against the National Back Exchange Standards and to redesign Moving & Handling training provision against the standards, with a plan to be fully aligned within the next 2years.
10. To continue the provision of Moving & Handling training, with a focus being on role-specific training based on risk assessment.
11. To work to increase near miss incident reporting to demonstrate positive H&S culture.
12. To work with the Integrated Governance Team to re-design the DATIX incident investigation for sharps, allowing better analysis of data, to understand hot-spots and trends.

Meeting of the Public Trust Board
Wednesday, 17 January 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Maternity CNST Compliance Year 5 Board Declaration Report</td><td>Agenda Item</td><td>4.2a</td></tr>
<tr><td>Author</td><td colspan="5">Alison Herron, Director of Midwifery
Kate Harris, Head of Midwifery</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Sarah Vaux, Interim Chief Nursing and Quality Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">This report provides an update to the Trust Board on the Maternity Service's progress against compliance to the 10 Safety Actions for CNST Year 5. The report notes that maternity is declaring compliance for all 10 safety standards.

The report includes three appendices that form part of the submission and are to be noted by the Trust Board in order to submit declaration of full compliance to NHSR:

1) Claims Incidents and Complaints Triangulation Report: December 2023
2) Perinatal Culture Leadership Programme and Score Survey Report
3) Training Needs Analysis (TNA) 2023

CNST Year 5 has run from 30 May 2023 with declaration submission due to NHSR on 01 February 2024

Progress against compliance has been monitored via the Maternity and Neonatal Safety Champion Assurance Board (MNSCAB), which has reported to QPSCC, QAC and Trust Board.

The Maternity Service has worked closely with the LMNS via the peer assurance process to support achieving compliance.

The LMNS visited MFT on 28 November 2023 to review the declared position and evidence for all 10 Safety Actions and supported the service's intention to declare compliance with all 10 Safety Actions.

Trust Board is asked to note the assurance report and its appendices and approve for the Trust to submit to NHSR a declaration of compliance against all 10 safety standards

Once approved by Trust Board, the Board Level Declaration form needs to be signed by the CEO and the Chair of the ICB before Trust submission to NHSR by 12:00 on 01 February 2024.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">Trust Board is asked to note the assurance report and its appendices and approve for the Trust to submit to NHSR a declaration of compliance against all 10 safety standards</td></tr>
<tr><td rowspan="2">Purpose of the report (Please mark with 'X' the box to indicate)</td><td>Assurance</td><td>X</td><td>Approval</td><td colspan="2">X</td></tr>
<tr><td>Noting</td><td>X</td><td>Discussion</td><td colspan="2"></td></tr>
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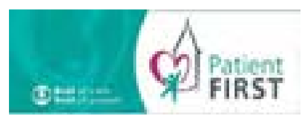
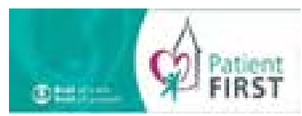


Committee/Group date submitted:	Maternity and Neonatal Safety Champion Assurance Group - 08.12.23 QPSSC - 20.12.23 Quality Assurance Committee - 09.01.24
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:* Priority 1: (Sustainability) **Priority 2: (People)** X **Priority 3: (Patients)** X **Priority 4: (Quality)** X Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:* **Safe:** X **Effective:** X **Caring:** X **Responsive:** X **Well-Led:** X
Identified Risks, issues and mitigations:	N/A
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	N/A
Legal and Regulatory implications:	Compliance with CNST Year 5
Appendices:	**Appendix 1**: Claims Incidents and Complaints Triangulation Report – Dec' 23 **Appendix 2**: Perinatal Culture Leadership Programme and Score Survey Report **Appendix 3**: Training Needs Analysis (TNA)
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: alison.herron2@nhs.net

Please mark with 'X' - Reports require an assurance rating to guide the discussion:

Rating	X	Description
No Assurance		There are significant gaps in assurance or actions
Partial Assurance		There are gaps in assurance
Assurance		Assurance minor improvements needed.
Significant Assurance	X	There are no gaps in assurance
Not Applicable		No assurance required.



CNST Year 5
Board Declaration Presentation

January 2024

Executive Summary

- CNST Year 5 has run from 30 May 2023 with submission due on 1 February 2024
- Progress against compliance has been monitored via the Maternity and Neonatal Safety Champion Assurance Board (MNSCAB), which has reported to QPSCC, QAC and in turn Trust Board.
- The Maternity Service has worked closely with the LMNS via the peer assurance process to support achieving compliance.
- The LMNS visited MFT on 28 November 2023 to review the declared position and evidence for all 10 Safety Actions and supported the service's intention to declare compliance with all 10 Safety Actions.
- The Maternity Service is declaring compliance with all 10 Safety Actions for CNST Year 5.
- The Board is asked to review the evidence detailed in the report and linked within the slides.
- Once approved by Board, the Board Level Declaration form needs to be signed by the CEO and the Chair of the ICB before submission to NHSR by 12 noon on 1 February 2024.

CNST Year 5 Self-Assessment

True North	Safety Action	Description	BRAG – August 2023	BRAG Sept 2023	BRAG Nov 2023	BRAG Jan 2024
Quality	Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard				
Systems + Partnership	Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?				
Patients	Safety Action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?				
People	Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?				
People	Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?				
Quality	Safety Action 6	Can you demonstrate that you are on track to compliance with all the elements of saving Babies' Lives Care Bundle Version Three?				
Patients	Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users				
People	Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?				
Quality	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?				
Quality	Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (*Known as Maternity and Newborn /safety Investigations Special Health Authority (MNSI) from October 2023*) and to NHS Resolutions Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?				

Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in 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 plans are being put in place to mitigate any delay
On Track	Action is on track with progress noted and on trajectory

True North: Quality

Complete

Safety Action 1 Evidence

Safety Action 1: PMRT
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.

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Key Messages:

- All reporting, surveillance and publishing requirements met for CNST year 5.
- MBRRACE generated database confirms compliance.
- Monthly Maternity PMRT meetings are held. Meetings include Multidisciplinary members with external representation by qualified Medical and Midwifery staffing and also Lay members.
- All perinatal deaths reported monthly to MNSCAB and to each Trust Board in line with Perinatal Surveillance Model.
- All actions identified have been reported to Trust Board.
- All action against PMRT action plan have been completed for CNST year 5.

Next Steps:

- Continue to report all eligible cases within the required timeframes.
- Continue MDT reviews of all PMRT cases and ensure that the parents views and questions are considered.
- Work with Clinical Governance Midwives to triangulate actions from PMRT with SI/HSIB/HLI/parent feedback to ensure robust triangulation of actions and learning.

Complete

True North: System & Partnership

Safety Action 2 Evidence

Safety Action 2: MSDS

Ambition: Ensuring data submitted as part of Maternity System Data Set is robust and accurate

Goal: To ensure accurate data input and correct data mapping to achieve compliance with Safety Action 2.

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Key Messages:

- 11/11 CQIMs have passed data quality (NHSE July Final Scorecard published 26.10.23)
- 100% of women booked in July have a valid ethnic category
- >5% of women placed on a MCOC pathway has valid CoC pathway indicator completed in July (97.8%)
- >5% of women placed on a MCOC pathway has Team and Lead Professional Completed in July (100%)
- The Trust made a successful final submission for July's data 29th August
- The Trust has 2 MSDS submitters and a 3rd undergoing approval

Next Steps:

- Focus on staff training to reduce service user errors.
- Review and update Trust ESR training in line with supplier advice.
- Continue local and national engagement to identify extent of backcopy data quality/risk impact and work with system supplier for a plan forward.
- Multidisciplinary work to commence in Trust to improve Dashboard.

True North: Patients

Complete

Safety Action 3 Evidence

NHS Medway NHS Foundation Trust

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?
Ambition: Review the provision of transitional care pathway and ATAIN data to ensure admissions to NNU are unavoidable
Goal: To reduce unnecessary separation of mothers and babies

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: • Neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Key Messages:

- Transitional Care (TC) service established since 2017.
- Neonatal team involved in decision making and care planning for all babies in TC.
- All term admissions to Neonatal Unit reviewed by an MDT and quarterly audits ongoing.
- All findings reported via MNSCAB and shared with the LMNS.
- Action plan in place for findings from ATAIN reviews approved via MNSCAB and included for Trust Board sign-off.

Next Steps:

- Continue to strengthen MDT review of all ATAIN cases.
- Work with LMNS and ODN to share learning from ATAIN reviews.

ATAIN Action Plan CNST Year 5

ATAIN Action Plan 2023-24

Overdue	
On Target	
Near Completion	
Complete	

Action No.	Action Required	Update	Owner	Target Date	Current Position
1	Re-establish dedicated MDT review meeting for all ATAIN cases.	ATAIN meeting has been confirmed, awaiting start date/time and location	Intrapartum Matron	30/12/2023	
2	Ongoing audit of term admissions and caesarean section	Dashboard has been changed to BI. Data collection is ongoing	Labour Ward Lead	30/01/2024	
3	Develop a SOP for ATAIN reviews to include agreement on local triggers to initiate deep diver review including overall numbers of admissions and admissions for specific conditions.	This will be actioned at the first ATAIN meeting	Maternity/NICU ATAIN leads	30/12/2023	
4	Review steroid administration for category 3 caesarean sections at CRIG meeting and agree best practice for documentation of discussions and decisions made by the mother and cascade to staff.	FWB team have met with the Labour Ward Lead. ATAIN data will be presented at Obstetric Audit meeting in January to discuss with the consultant team	SF	30/01/2024	
5	Review breastfeeding support for mothers for whom English is not their first language and for those living in areas of deprivation to ensure there is appropriate information and resources available.	FWB have met with the Infant Feeding Lead. Data collection for all readmissions for 2023 will be completed in January. All data will then be audited by the FWB team for themes. Literature and information provided to mothers has been confirmed in all languages (UNICEF)	SF/HC	30/01/2024	

Complete

True North: People

Safety Action 4 Evidence

Safety Action 4: Clinical Workforce

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

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	No
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	Yes
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	N/A
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A

Complete

True North: People

Safety Action 4 Evidence

NHS Medway NHS Foundation Trust

Safety Action 4: Clinical Workforce

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

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

Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	Yes
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	N/A
Was the agreed action plan shared with:		
16	LMNS?	N/A
17	ODN?	N/A
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	No
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
20	LMNS?	Yes
21	ODN?	Yes

True North: People

NHS Medway NHS Foundation Trust

Safety Action 4: Clinical Workforce

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

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

Key Messages:

- The CNST criteria is audited and met for employing short & long -term locum Doctors
- RCOG for compensatory rest post on –call is met and evidenced via rosters
- Recruitment continues to fill vacancies in both Obstetric and neonatal clinical workforce.
- Assurance of Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility for short-term locums
- RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours adhered to
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day – evidenced via rotas.
- Compliant with BAPM standards for Neonatal Medical Staffing with three tier rota in place – evidenced via rotas.
- NICU Nurse vacancy rate has reduced from 20 (JULY 2022) – 6.28 (OCT 2023)
- Due to establishment increase, QIS Trained staff reduced from 70.9% in September to 65% in October.
- Action plan in place to achieve QIS demonstrating progress since CNST year 4. Key actions of annual rolling training programme for band 5 staff to achieve QIS in place as well as robust recruitment process in place. Currently 0 band 5 vacancies and 7WTE band 6 (following 16WTE added to establishment in 2022).

Neonatal Nursing Qualified in Speciality Action Plan

CNST Year 5

Key	Colour
Overdue	Red
On Target	Green
Near Completion	Amber
Complete	Blue

Action No.	Action Required	Update	Owner	Target Date	Completion Date	Current Position
1	Support staff to complete specialty course to support achieving > 70% QIS by September 2024.	6 staff due to qualify September 2022 = 64.5% QIS 5 due to start course in September 2022 – qualify September 2023 = 66.63% 6 staff qualifying in September 2023 = 70.9% 6 more staff commenced training Sept 2023 **October 2023** **Staff base increased – Oct 2023 QIS currently 65%**.	NICU Matron	01/09/2024		Green
2	Recruit Additional QIS staff.	Continue recruitment and retention payments for QIS staff to recruit to additionally funded posts (16 WTE new QIS posts funded by network – 3 recruited to) Rolling advertisement in place for QIS Band 6. Education team increased to provided additional support induction and supervision for new staff **October 2023** **Current band 6 Vacancy now 7 WTE.** **Rolling advertisement in place for QIS Band 6.**	NICU Matron	01/09/2024		Green
3	Recruit to Band 5 vacancy	Ensure band 5 vacancies are advertised and recruited to in a timely way to optimise staffing. Advertised to ensure newly qualified student nurses are eligible to apply. Current band 5 vacancy 1 WTE **Oct 2023 – current band 5 vacancy 0**	NICU Matron	30/09/2023	30/09/2023	Blue
4	Workforce Review	Establishment review including Dinning tool which takes into consideration acuity and cot days in individual neonatal units. **Sept 2023 Workforce review completed.**	NICU Matron	30/09/2023	30/09/2023	Blue

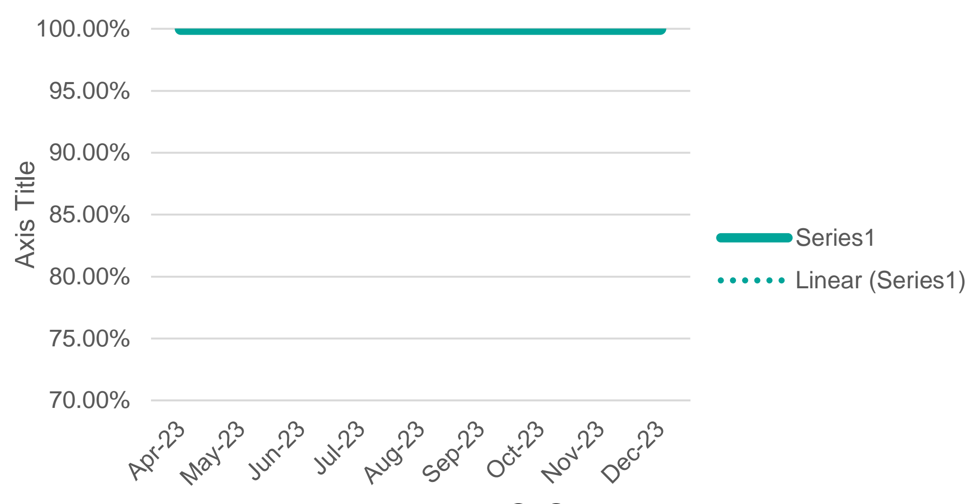
True North: People

Safety Action 4: Clinical Workforce

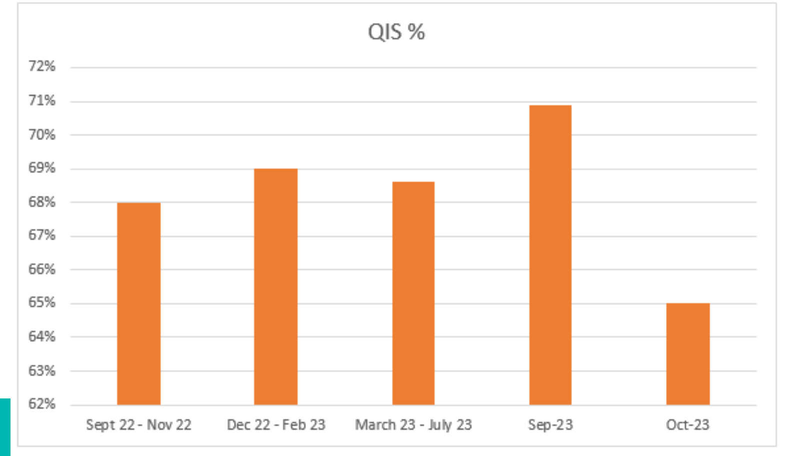
Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care

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

Consultant Attendance against RCOG guidelines



Neonatal Nursing QIS%



Obstetric Short-term locum audit

Locum	Date substantive employment at MFT ended.	Grade worked at MFT	Short term locum passport completed	RCOG Certificate of Eligibility for Locums	Meets RCOG/CNST requirements
CA	Oct-19	Registrar	N/A	N/A	Y
LK	Oct-19	Registrar	N/A	N/A	Y
MO	Oct-19	Registrar	N/A	N/A	Y
NS	Oct-22	Registrar	N/A	N/A	Y
CW	Oct-19	SHO	Yes	Yes	Y

Anaesthetic Obstetric on Call Audit

Anaesthetic Obstetric on call	Morning	Afternoon	Evenining	Night	Consultant Oncall	CNST Compliant
May	100%	100%	100%	100%	100%	Y
June	100%	100%	100%	100%	100%	Y
July	100%	100%	100%	100%	100%	Y
August	100%	100%	100%	100%	100%	Y
September	100%	100%	100%	100%	100%	Y
October	100%	100%	100%	100%	100%	Y
November	100%	100%	100%	100%	100%	Y

Neonatal Medical Staffing – December 2023

Neonatal Unit Activity	
Activity FY 21/22 (HRG 2016)	
ICU (XA01Z)	1663
HDU (XA02Z)	2188
SCBU (XA03Z)	3051

	BAPM standard	Description	Assuming all budgeted posts are fully recruited to (including Deanery or Trust funded); is the unit compliant with BAPM standard?
Standards for all NICUs	All tiers separate rota compliance	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff at all times	Compliant
	Tier 1 separate rota compliance 24/7	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care	Compliant
	Tier 2 separate rota compliance 24/7	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport)	Compliant
	Tier 3 separate rota compliance 24/7	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit	Compliant
	Tier 3 presence on the unit	Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)	Compliant

True North: People

Complete

Safety Action 5 Evidence

Safety Action 5: Midwifery Workforce
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	Yes
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	N/A
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	N/A
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

True North: People

Safety Action 5: Midwifery Workforce
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Key Messages

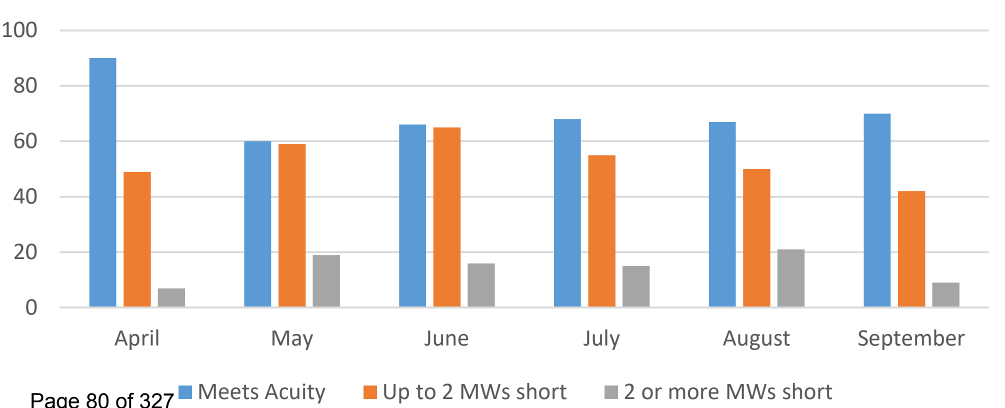
- Bi-annual Midwifery workforce oversight report presented to Trust Board (July 2023 and January 2024).
- Birthrate Plus establishment review completed in July 2023. Business case to support recommendations being prepared.
- 100% Compliance 1:1 Care in Labour.
- 100% Compliance with Supernumerary status of Delivery suite coordinator in line with CNST guidance. Reviewed and approved by LMNS.
- Acuity, staffing, vacancy, sickness, recruitment and retention reviewed monthly at MNSCAB and any matters for concern escalated via QPSCC and QAC to Trust Board.

2023	Compliance with 1:1 Care in Labour
May	100%
June	100%
July	100%
August	100%
September	100%
October	100%
November	100%
December	100%

2023	Compliance with Supernumerary status of Coordinator as per CNST guidance
May	100%
June	100%
July	100%
August	100%
September	100%
October	100%
November	100%
December	100%

Birth Rate Plus 2023 Findings

% uplift	Skill mix %	RMs	MSWs	Variance
22%	Current 94.5 / 4.5	-8.60	-0.50	-9.10
	90 / 10	0.75	-9.85	--9.10
25%	Current 94.5 / 4.5	-14.81	-0.85	-15.66
	90 / 10	-5.15	-10.51	-15.66



CNST Year 5
Elements within Safety Action 6
Saving Babies Lives Care Bundle 3

True North	Elements within Safety Action 6	Description	BRAG – August 2023	BRAG Sept 2023	BRAG Nov 2023	BRAG Jan 2024
Quality	Element 1	Reducing smoking in pregnancy	Green	Green	Green	Green
	Element 2	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction	Green	Green	Green	Green
	Element 3	Raising awareness of reduced fetal movement	Green	Green	Green	Green
	Element 4	Effective fetal monitoring during labour	Green	Green	Green	Green
	Element 5	Reducing preterm births	Green	Green	Green	Green
	Element 6	Management of pre-existing Diabetes in Pregnancy	Red	Red	Red	Green

Status	Definition
Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in 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 plans are being put in place to mitigate any delay
On Track	Action is on track with progress noted and on trajectory

Complete

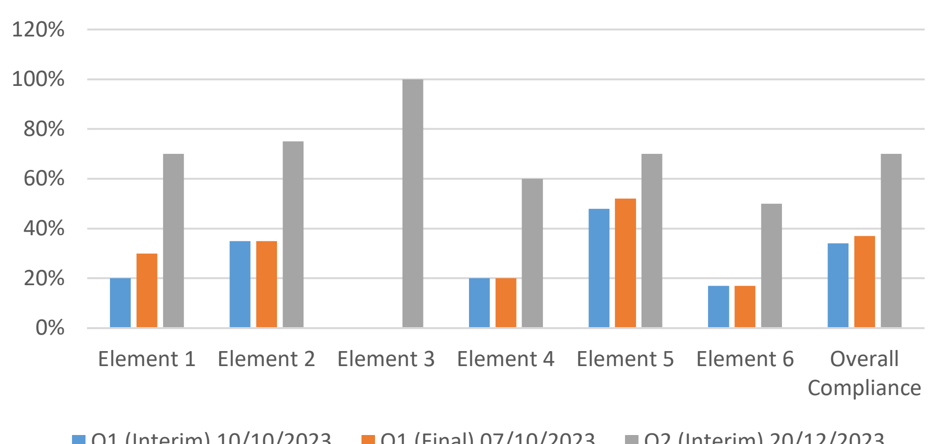
True North: Quality

Safety Action 6 Evidence

Safety Action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives care bundle Version 3?
Ambition: On track to fully implement all 6 elements of SBLv3 by March 2024
Goal: To reduce stillbirth

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Saving Babies Lives Care Bundle v. 3 LMNS Validated Compliance Dec 2023



Key Messages:

- CNST requires that Trusts achieve 70% overall and a minimum of 50% for each individual element to be complaint.
- Significant work undertaken by specialist midwives to improve compliance with the SBL interventions.
- LMNS validated compliance for Q1 was 37%. Q2 compliance has been assessed at 70% overall which meets the requirements for CNST year 5.
- Work continues to improve audit compliance, pathways for complex diabetic patients and ensure guidelines meet the intervention requirements.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	75%	Partially implemented	75%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	78%	Partially implemented	70%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	76%	Partially implemented	70%	CNST Met

SBL LMNS Validated Actions

Element	Key actions required to meet recommended standard	Target date	BRAG
Element 1	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories	Mar-23	
Element 2	Focus required on quality improvement initiatives to meet the required standard.	Mar-23	
Element 3	Fully meets standard - continue with regular monitoring of implementation.	Mar-23	
Element 4	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories	Mar-23	
Element 5	Evidence not in place - improvement required	Mar-23	
	Focus required on quality improvement initiatives to meet the required standard.	Mar-23	
	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories	Mar-23	
Element 6	Focus required on quality improvement initiatives to meet the required standard.	Mar-23	
	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories	Mar-23	

Next Steps:

- Trajectory in place to be fully implemented with all elements by March 2024 with action plans in place to meet the outstanding interventions of element.
- Continue to engage with LMNS validation process and peer support to ensure compliance.
- Continue to audit against required standards.
- Ensure all relevant guidelines are in place and audits are completed against these.
- Implement fetal fibronectin (qfFN) measurements once available (national shortage) and audit compliance against SOP.
- Continue to monitor staffing position against MCoC ambition.
- Prepare a business case to extend diabetes service to include dietician and diabetic nurse.
- Agree pathways for complex diabetic patients to maternal medicine centre.

True North: Patients

Safety Action 7 Evidence

Safety Action 7: Maternity & Neonatal Voices Partnership (MNVP)

Ambition: Ensuring that the voices of women, birthing people and their families are heard within the service and that service users are involved in coproducing maternity services.

Goal: Mechanisms in place for gathering service user feedback, and work with service users, through the MVNP to coproduce local maternity services.

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Key Messages:

- Funded user led Maternity and Neonatal Voices Partnership is in place
- Action plan based on 2022 and 2023 CQC survey free-text co-produced with MNVP lead, presented at Patient Experience Group and monitored via Maternity BAF.
- Work ongoing to strengthen service user engagement and to use service user feedback to support service and quality improvement work.

True North: People

Safety Action 8 Evidence

NHS
Medway
NHS Foundation Trust

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? Relevant time period 12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme.

Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2022 – 1st Dec 2023)

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes

Key Messages:

- Training plan in place which has implemented v2 of core competency framework. This has been shared and agreed by the Quad and LMNS. Requires Trust Board approval prior to submission.
- Training is delivered and received as an MDT and draws on service user feedback and local incidents, audits and investigation reports.
- Physiological Fetal Monitoring training rolled out in January 2023 and all staff trained and compliant in this.

Next Steps:

- Trust Board requested to approve Maternity Training Plan Trust Board requested to approve action plan for Neonatal Nursing NBLS training.

True North: People

NHS
Medway
NHS Foundation Trust

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? Relevant time period 12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme.

Ambition: All staff to attend Annual MDT Training, including obstetric emergency training in line with the Core Competency Framework.
Goal: >90% of all staff groups to have attended the relevant training with the CNST reporting period (1ST Dec 2022 – 1st Dec 2023)

Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes
14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	Yes
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	Yes

Training Compliance 1 December 2023

Obstetric Emergency Training 1 December 2023	
Staff	**%**
Midwives	97%
MSW	93%
Theatres	91%
Obstetric Cons	95%
Reg/SHO	92%
Anaes Cons	92%
Anaes Reg/Sho	95%

Fetal Monitoring Training and Assessment 1 December 2023	
Staff	**%**
Midwives	98%
Obstetric Consultants	100%
Obstetric Reg/SHO	100%

Neonatal Life Support Training 1 December 2023	
Staff	**%**
Midwives	91%
NICU Nurses	89%
Neonatal Consultants	90%
Neonatal doctors	94%
ANNP	100%

Key Messages:

- > 90% compliance for all staff groups for all training with the exception of Neonatal Nursing which was 89% on 1 December 2023.
- Action plan in place to achieve >90% compliance within 90 days of MIS submission. Trust Board requested to approve plan.

Neonatal Nursing Neonatal Basic Life Support Training
CNST Year 5 Action Plan

Overdue		(red)
On Target		(green)
Near Completion		(amber)
Complete		(blue)

Action No.	01-Dec-23	Action Required	Update	Owner	Target Date	Completion Date	Current Position
1	89% NICU Nurses compliant with annual NBLS training.	NICU Education lead to ensure all staff are booked onto NBLS training course at earliest opportunity.	22/12/23 13 staff currently non-complaint with NBLS training. To be booked on by February 2024.	NICU education Lead	28/02/2024		
2	20 NICU nurses NBLS compliance due to expire within next 90 Days.	NICU Education lead to review staff whose NBLS training is due to expire in next 90 days and ensure staff are booked onto training course before expiration date.		NICU education Lead	30/03/2024		

True North: Quality

Complete

Safety Action 9 Evidence

SafetyAction 9: Safety Champion

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.

Goal: Ensure there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

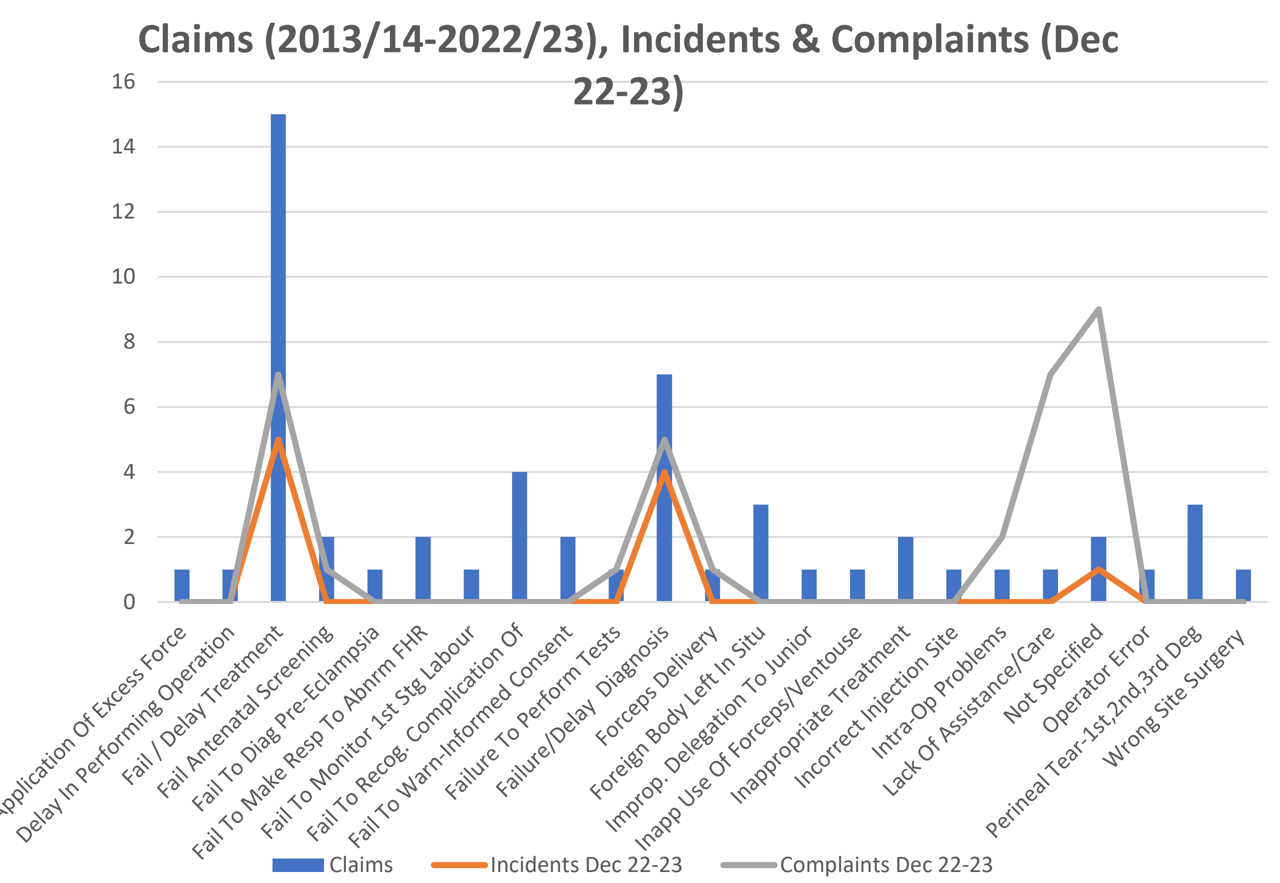
True North: Quality

Safety Action 9: Safety Champion

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.
Goal: Ensure there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.

Key Messages:

- The Trust has embedded the perinatal quality surveillance model with monthly reporting via MNSCAB and to every Trust Board.
- Concerns raised by staff, service users and safety intelligence are reflected through MNSCAB and up to trust Board
- The Board Safety Champions support the perinatal quadrumvirante
- A Non-executive director (NED) is working with the Board safety champion
- The Trust Claims scorecard is triangulated against incidents and complaints and this is reported via MNSCAB and onwards to Trust Board.
- SCORE Survey Completed.
- Quad attended Perinatal Leadership Programme and report via MNSCAB. Formal report on progress to Trust Board in January 2024.



Next Steps:

- To review the presentation of Perinatal Surveillance data at Trust Board to ensure effective reporting and improved oversight and assurance.
- Continue to work with Trust PSIRF leads to implement PSIRF in Maternity.
- Continue to work with LMNS in line with Perinatal Surveillance model to ensure system-wide learning and collaboration.

True North: Quality

Complete

Safety Action 10 Evidence

Medway NHS Foundation Trust

Safety Action 10: MNSI and NHSR EN reporting

Ambition: Ensure all eligible cases are investigated to the highest standard and receive appropriate external review.
Goal: Ensure all eligible cases are reported to Maternity and Neonatal Safety Investigation (MNSI) and NHSR's Early notification scheme.

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

Key Messages:

- 100% eligible cases reported to MNSI and NHSR (EN).
- 100% compliant of stage 1 Duty of Candour.
- All families referred to MNSI receive information on the role of HSIB and NHSR (EN)

Date of incident	NHS ER Date Sent	Datix WEB Ref	HSIB/MSNI Notified Date	HSIB/MSNI Number	Family Information leaflet given	DoC	Verbal Duty of Candour
05/12/2022	07/12/2022	126682	07/12/2022	MI-019029	07/12/2022	Y	06/12/2022
12/12/2022	N/A	131083	N/A	MI-025926	N/A	Y	N/A
15/12/2022	20/12/2022	127281	20/12/2022	MI-022329	19/12/2022	Y	20/12/2022
13/02/2023	15/02/2023	130000	15/02/2023	Rejected	15/02/2023	Y	15/02/2023
12/02/2023	15/02/2023	130070	15/02/2023	Rejected	15/02/2023	Y	15/02/2023
12/07/2023	17/07/2023	136628	17/07/2023	MI-029886	13/07/2023	Y	13/07/2022
28/11/2023	29/11/2023	144899	29/11/2023	MI-036546	29/11/2023	Y	28/11/2023

Board Declaration – 1 February 2024

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
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?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Maternity Claims Scorecard: Thematic Review 2023

Overview

- NHSR Claims scorecard published annually in September with data for the previous 10 years.
- MFT have had 55 Obstetric claims in the 10 year period from 2013/14 to 2022/23.
- Of these claims, 11 are currently open with 1 incident ongoing. 43 have been closed, 20 of which have been settled with damages.
- CNST Year 5 requires Trust Boards to have an oversight of obstetric claims data triangulated with data from incidents and complaints.
- This report reviews the NHSR Claims scorecard along with incidents and complaints from 2023 to provide thematic analysis and identify areas for improvement and areas where improvements have been made following past incidents and claims.
- Nationally, obstetrics account for 13% of all claims (volume) and 64% of the value of all claims paid.
- At MFT, Obstetrics account for 12% of claims volume and 41% of claims value.
- The highest volume and value of obstetric claims for MFT relate to failed or delayed treatment including retained placenta/membranes and cases of shoulder dystocia.

Incidents

Claims 2013/14 to 2022/23 & Dec 22-Dec 23 SIS and MNSI Investigations

16
14
12
10
8
6
4
2
0

Application Of Excess Force
Delay In Performing Operation
Fail / Delay Treatment
Fail Antenatal Screening
Fail To Diag Pre-Eclampsia
Fail To Make Resp To Abnrm FHR
Fail To Monitor 1st Stg Labour
Fail To Recog. Complication Of
Fail To Warn-Informed Consent
Failure To Perform Tests
Failure/Delay Diagnosis
Forceps Delivery
Foreign Body Left In Situ
Improp. Delegation To Junior
Inapp Use Of Forceps/Ventouse
Inappropriate Treatment
Incorrect Injection Site
Intra-Op Problems
Lack Of Assistance/Care
Not Specified
Operator Error
Perineal Tear-1st,2nd,3rd Deg
Wrong Site Surgery

Claims
Dec 22 Dec 23 Incidents

- 10 Serious incidents and MNSI cases between December 2022-23.
- 5 cases related to failure/delay in treatment and 4 related to failure/delay in diagnosis (failure to recognise deterioration).
- 1 case was escalated due to family concerns and listed as not-specified.
- Incidents for Dec 22 to December 23 are in line with highest causes for claims in past 10 years.
- 7 out of 10 incidents related to babies requiring additional care after birth including admission to Neonatal Unit and therapeutic cooling.
- 3 incidents related complications with the mother including limb ischemia following CS, post-natal anaphylaxis and PPH.

Complaints

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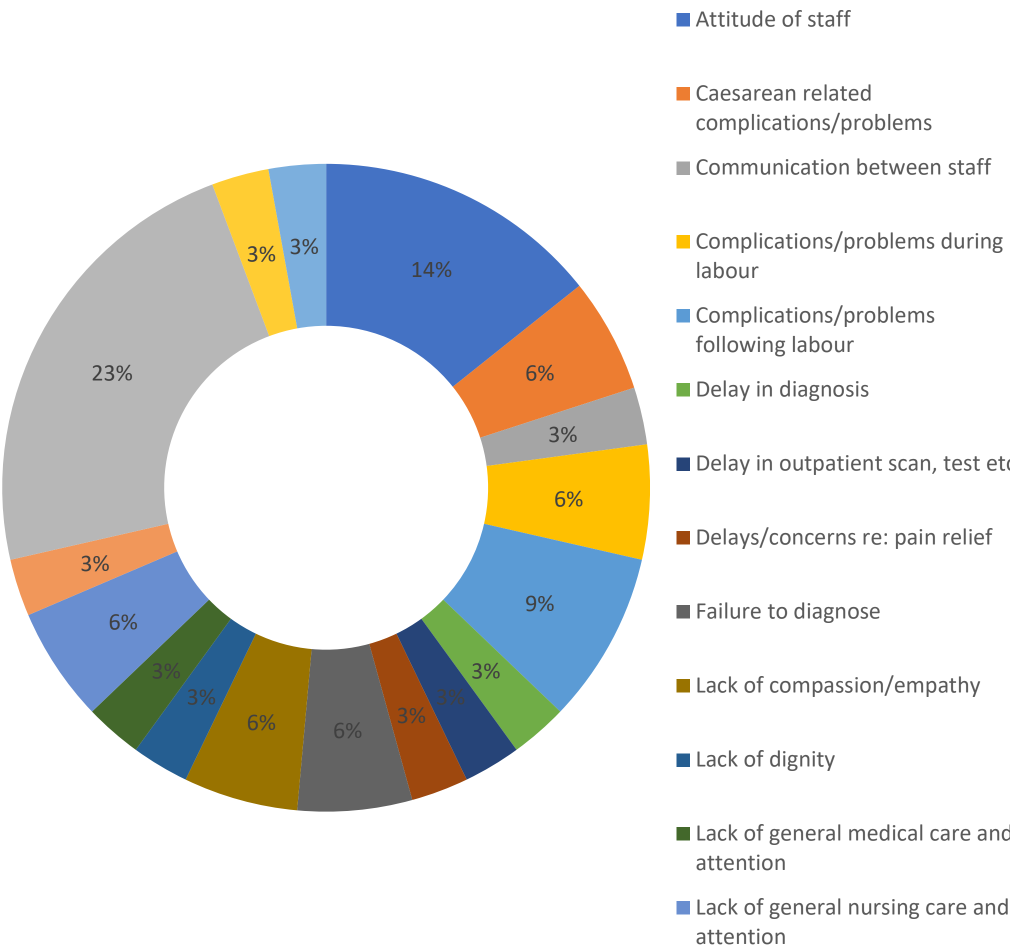
Obstetric and Maternity Complaints Dec 22-Dec 23



- 33 complaints received from December 22-Dec 23
- 8 (28%) Unsatisfied with treatment given, 5 (14%) attitude of staff.
- Mapping against the Claims for the past 10 years again shows that failure/delay in treatment or diagnosis accounts for 11 of the total complaints.
- Unlike claims, lack of assistance and care accounts for 7 complaints over the year opposed to 1 claim in the 10 year period.
- 9 complaints have been coded as “not specified” as these related to attitude of staff or communication and did not align with any other claim category.

Claims (2013/14-2022/23), Incidents & Complaints (Dec 22-23)

Findings

- Reviewing the repeated claims of shoulder dystocia and retained placenta/membranes identified on the scorecard it is reassuring that there have been no complaints or incidents relating to either of these in the period Dec 22-23.
- There is a robust process in place to review all stillbirths, unexpected neonatal admissions, including those admitted due to HIE requiring cooling, and neonatal deaths (MNSI, PMRT)
- Failure/delay to treat and diagnose remains the highest category across claims, incidents and complaints:
  - Quality improvement work relating to induction of labour is already underway to reduce delays for women on the induction of labour pathway.
  - Guidelines and pathways are constantly being reviewed to ensure the appropriate diagnostic and treatment pathways are in place.
  - Obstetric and Maternity Emergency training is a robust programme and incorporates learning from incidents, complaints and service user feedback. The programme also includes insitu simulation to support staff in recognising and escalating emergencies within the clinical environment which will be strengthened throughout 2024.

Next steps

- Work with NHSR to review coding errors – 3 ectopic claims miscoded to obstetrics and 2 stillbirths incorrectly coded as “loss of baby”. Potentially affecting premium.
- Work with Trust PSIRF leads to code incidents and complaints to help with thematic analysis and interpretation.
- Continue to monitor claims, incidents and complaints along with service user feedback to develop and co-produce with MNVP a robust improvement plan.
- Quarterly presentation to MNSCAB and Trust Board.
- Next report to review outcomes from claims against incidents and complaints.

Perinatal Culture and leadership Programme (PCLP) & SCORE survey

January 2024

Executive Summary

- Goal of the perinatal culture and leadership programme is to improve the safety and quality of care delivered to women, birthing people and babies by enabling those with specific responsibility for safety in maternity and neonatal units to understand the relationship between leadership, safety improvement and safety culture in order in enable change.
- Commitment of the Three year delivery plan to provide the perinatal culture and leadership programme to all maternity and neonatal quadrumvirates by April 2024.
- Included diagnosis of local culture (SCORE survey) and provided practical support to nurture culture and leadership
- Intended to support provision of a deeper understanding at trust board level of the support required for safe and personalised maternity and neonatal services including exploring:
  - psychological safety
  - accountability and negotiation
  - continuous learning
  - reliability
  - transparency
  - quality improvement methodology and measurement

Phase 1- Quad leadership development

Medway NHS Foundation Trust

Content

- 3 face to face modules and 4 action learning sets.
- 360 degree feedback.

Learning

- Individual reflection
- Support and challenge from peers
- A chance to find creative ways to bring about change
- A chance to test beliefs and assumptions and learn what works
- A safe environment to explore new ways of thinking and doing
- Personal, as well as professional, learning and development
- Insight into how others achieve different solutions
- A chance to progress new opportunities and develop new ideas.

Phase 2- Culture Survey

Interpreting and Using
Your SCORE Survey Results

Content

- 4 month process
- Identified local champions to support culture survey
- Mapping
- Go live with survey
- 6 week 'live' period
- Results

Learning

- Provided insight from clinical and non-clinical colleagues regarding what it feels like to work in maternity and neonatology
- Provided data to have useful conversations
- Encouraged participation of staff
- Developed transition to appreciative conversations that would otherwise be difficult to engage in.

Content

- 4-5 month process
- Quad development sessions
- Team conversations
- Improvement Planning

Learning

- How our leadership behaviours are perceived by colleagues
- Take action to improve the weaker areas.
- Designed a leadership strategy
- Focus on a small number of objectives that are achievable

Our Quad team purpose statement

Our team inspires our staff to deliver outstanding care to our families through promotion of a safe culture/ collaboration and innovation.

Our Quad collective vision

For our families to have a positive experience by being provided with safer, clinically effective care.

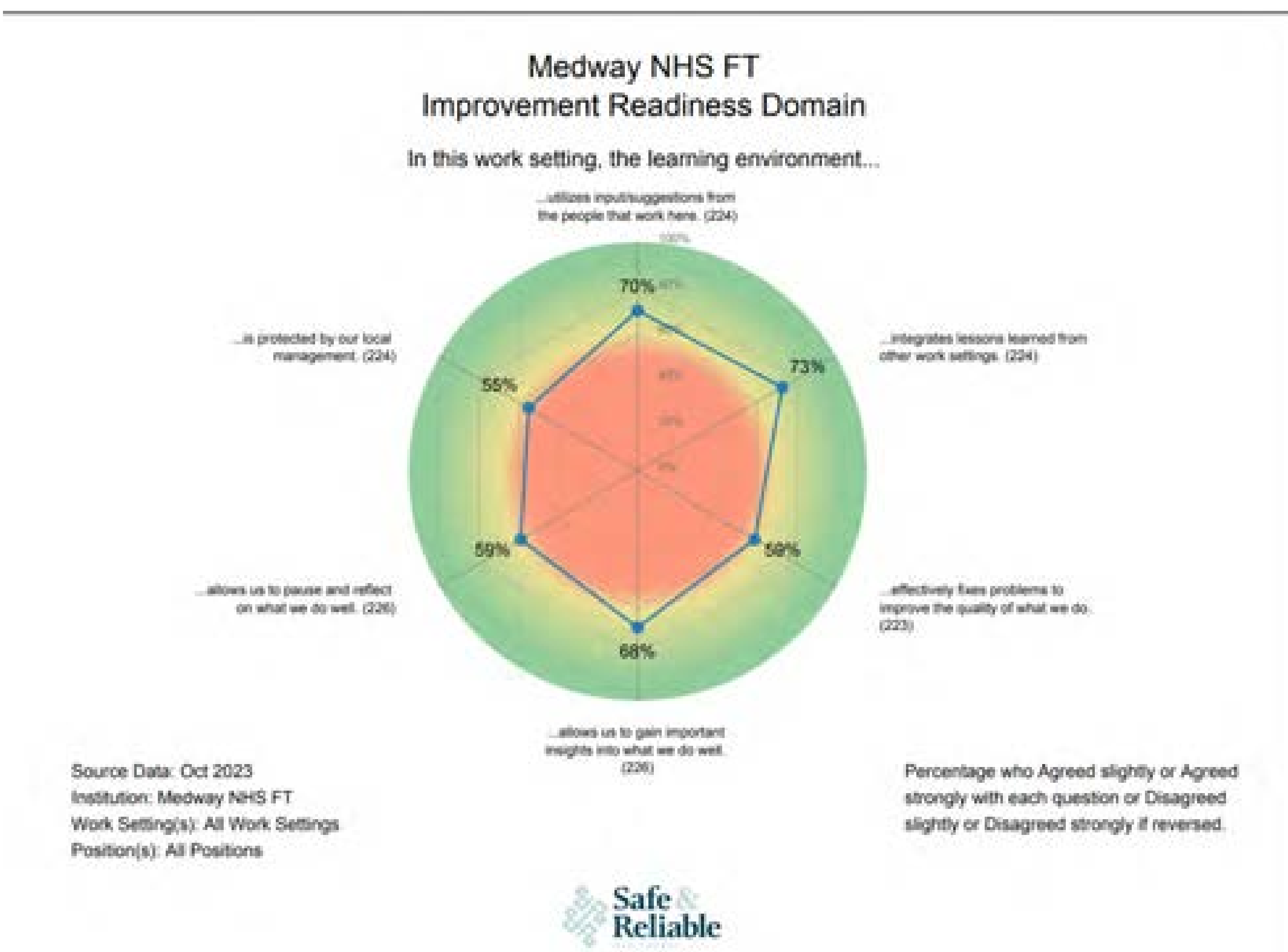
SCORE Survey- Improvement Readiness 2023

Key Messages:

- Survey period October 2023
- 9 work settings
- 45% response rate
- Integrated safety culture, local leadership, learning systems, resilience / burnout and work-life balance
- Improvement readiness score was 53% which identified an opportunity to improve how defects are identified and acted upon

Next Steps:

- Focus on staff feeling safe to speak up and know that their suggestions have been acted upon
- Visible closing of loop implemented (You said/ we did)
- Utilise safety champion walkabout to celebrate excellence and share learning.
- Created an agenda item for huddle for staff to highlight effective practice so it is not just about acuity.
- Work to develop annual safety conference to highlight best practice and processes that made great care possible
- Staff asked the ‘easy to fix’ frustrations that allowed quick fix (ie cupboard lighting)
- Provide an opportunity for staff to become involved and lead improvement activities



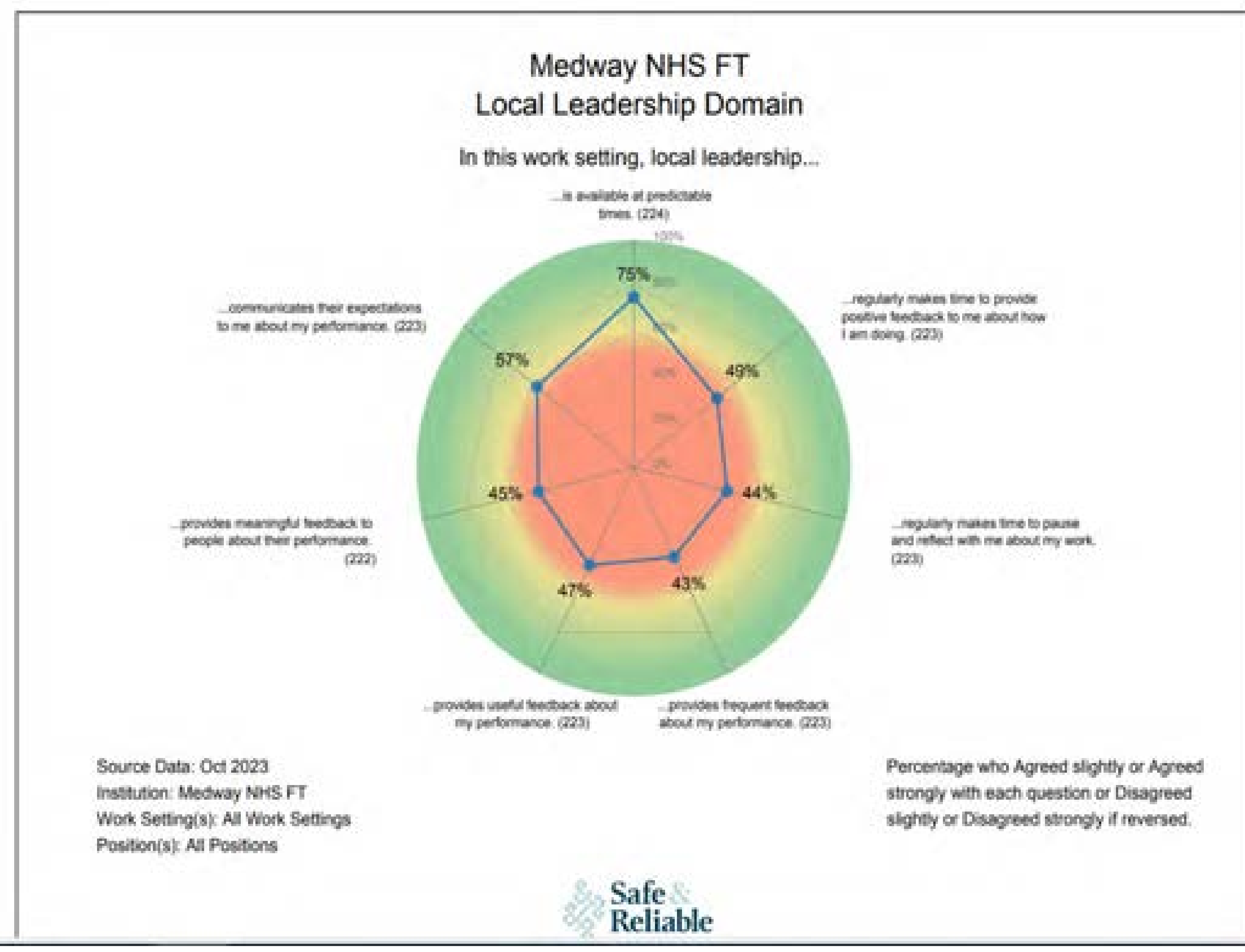
SCORE Survey- Local leadership 2023

Key Messages:

- The local leadership domain focuses on the activities that the leaders perform to increase psychological safety
- Psychological safety is
  Comfort asking questions, receiving feedback and being respectfully critical or willingness to suggest innovation.
  Staff not characterising interactions with their leader as judgemental.

Next Steps:

- Set goals / expectations about availability of leadership team to frontline staff
- Review number of meetings attended to ensure leaders are present in the work setting
- Diarise meeting free time to support visibility/ walk about.
- Use 360 degree feedback during coaching sessions
- Ensure regular 1:1s with
- Visible closing of loop implemented (You said/ we did)
- Utilise safety champion walkabout to celebrate excellence and share learning.
- Created an agenda item for huddle for staff to highlight effective practice
- Work to develop annual safety conference to highlight best practice and processes that made great care possible.



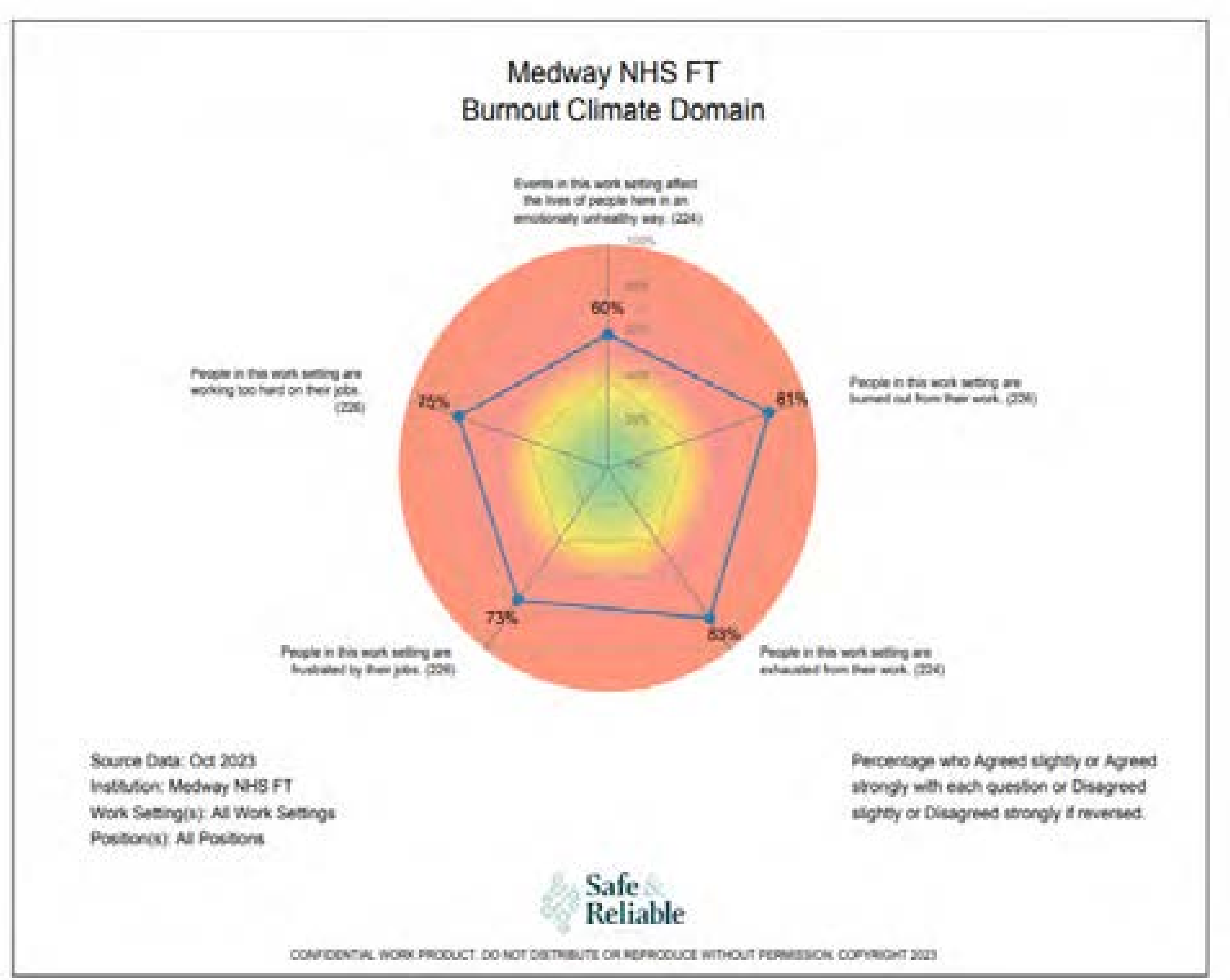
SCORE Survey- Burnout Climate 2023

Key Messages:

- The SCORE survey has two Burnout domains that give different perspectives. One set of questions pertains to how respondents perceive others around them, the other relates to how respondents perceive themselves
- Work–life balance, closely linked to Burnout, reflects the balance between professional, job related demands and maintaining a healthy personal lifestyle.

Next Steps:

- Celebrate success
- Measure the current state of affairs regarding meals and breaks and set a goal to improve it by X% through improved scheduling of breaks
- Enhance 're-briefs' to reallocate responsibilities dependant on current workload
- Focus on IT connectivity improvement
- Complete Maternity Care Unit/ Obstetric triage review by Q1 2024/25.



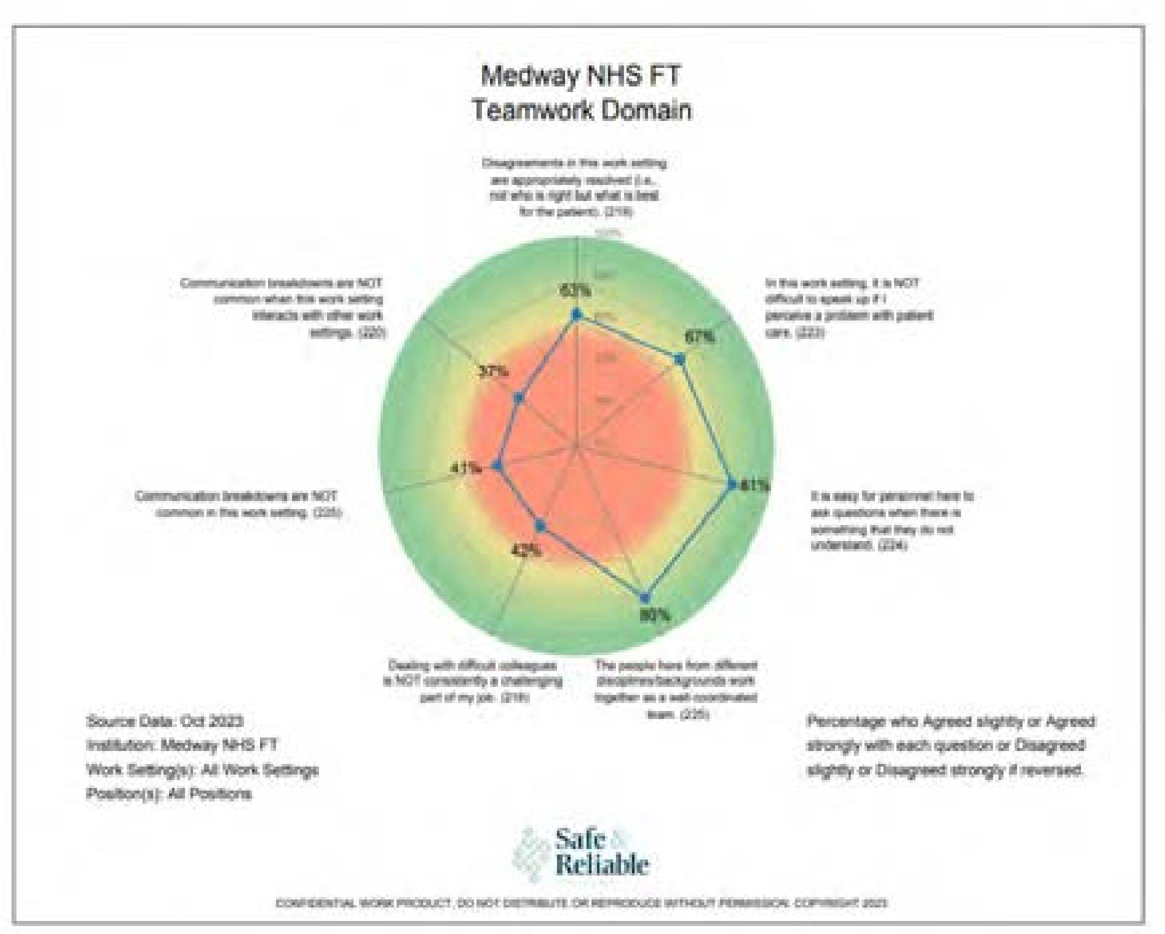
SCORE Survey- Teamwork 2023

Key Messages:

- The teamwork domain evaluates different aspects of culture that together characterize how teams work together.
- The items in this domain evaluate communication, difficult colleagues, psychological safety, and coordination of disciplines
- The challenge in this domain is that there are very few single actions that will target and improve all the items in this domain.
- When teamwork climate is low, employees may feel that their co-workers are not cooperative, that their voices are not heard by management, that their efforts are not supported, or that communication is not robust.

Next Steps:

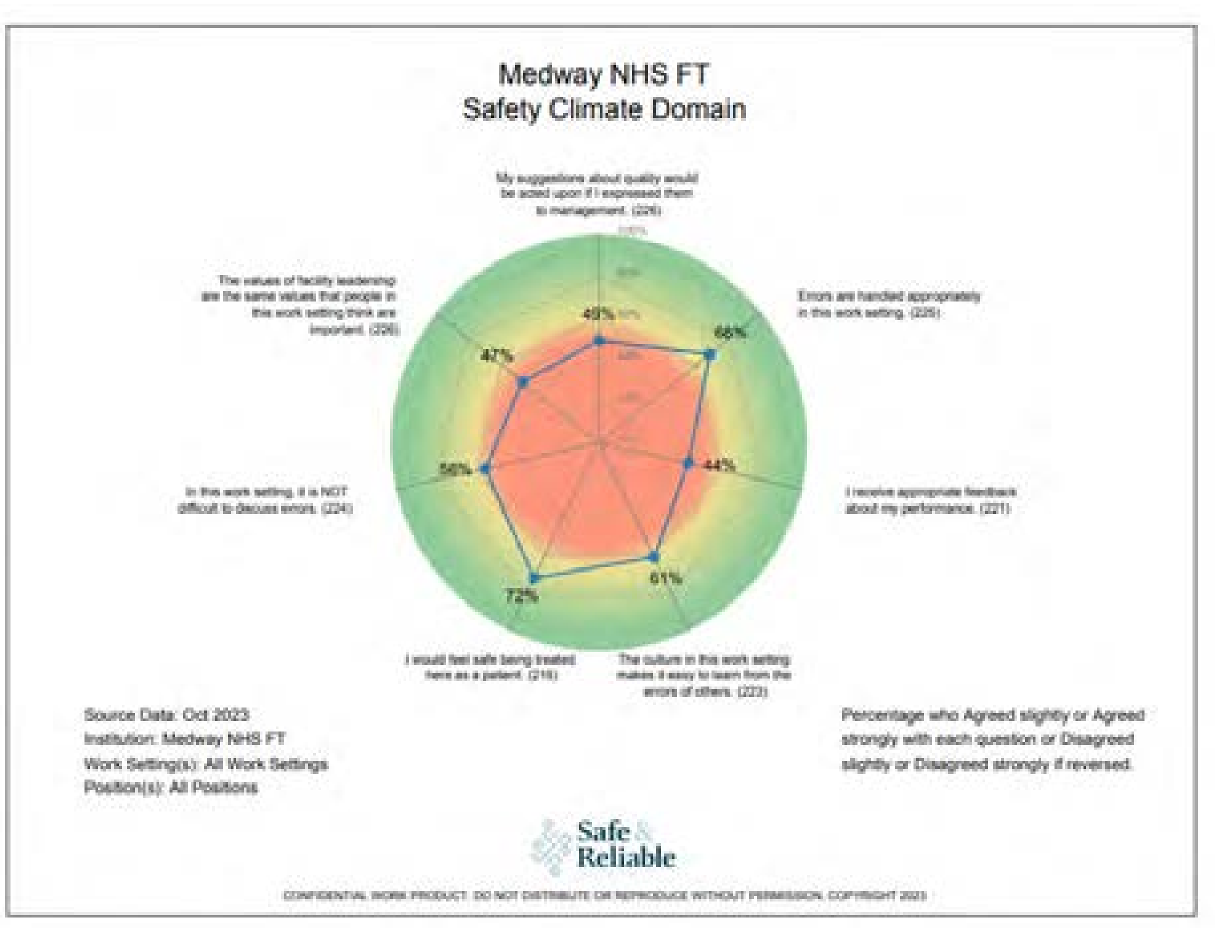
- Embed standardised SBAR communication
- Explore situations where communication breakdowns are common and focus on improvement in these areas
- Reiterate and display Trust values and expectations about behaviours that are acceptable
- Ensure QUAD are visible and setting a positive tone
- Ensure full attendance and individual team member participation at huddle



SCORE Survey- Safety Climate Domain 2023

Key Messages:

- Safety Climate scores predict clinical outcomes and tend to correlate closely with Teamwork Climate scores.
- When respondents report a low safety climate, they don't perceive a real dedication to safety in their work setting.
- Safety climate is significantly related to both employee safety (e.g., needlesticks, back injuries)



Next Steps:

- Embed visible learning boards
- Take near miss cases to CRIG
- Each staff meeting should begin with a description of a near miss or a ‘good catch’.
- Monthly newsletter to include special case highlights
- Embed SIM into practice weekly with QUAD attendance where possible.

NED/Safety Champion Feedback & Next Steps

- NED stressed importance of supporting the workforce as our best resource. Concerned about burnout culture.
- NED pleased that staff have had opportunity to raise concerns both on shift, with mangers and that there was an appropriate escalation process in place for staff to raise concerns, including the Freedom to Speak up Guardian.
- NED keen to understand outcomes from quality improvement work and to share these with staff to support morale and readiness for change.
- All identified actions to be captured on Maternity BAF and shared and monitored with QUAD and Safety Champions via the Maternity and Neonatal Safety Champion Assurance Board.
- Full report to be presented at Trust Board.
- Continued reporting via MNSCAB with Safety Champion escalation of concerns or support needed to Trust Board.

Guideline
Maternity Mandatory Specialist Training Policy
(Including Simulations skills and Training Needs Analysis)

1, Relevant to:

All clinical staff working within the Medway NHS Foundation Trust Maternity Service - employed on a substantive contract.

Compliance with this policy is applicable to both the individual's Professional Code of Conduct and their contract of employment.

2. Purpose of Guidance:

Medway NHS Foundation Trust recognises its staff as a valuable asset, without whose skills, knowledge, support and commitment it would be impossible to provide high quality care. The Trust accepts that it has a legal, ethical and moral obligation to ensure that its employees are safe and competent, with the appropriate knowledge and skills to ensure the delivery of high standard care and a positive patient experience.

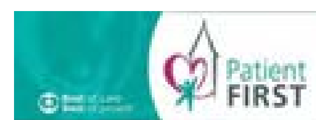
In order to minimise risk to both patients and staff, all clinical staff are required to attend the relevant mandatory specialist training as laid out in the Training Needs Analysis (TNA) to support attainment and retention of their knowledge and skills. Compliance to this TNA allows the Maternity Services to provide evidence of safe practice and risk minimisation to all relevant quality assurance bodies.

The aim of this guideline is to ensure that there is clear guidance surrounding the three primary drivers:

- Insight – drawing insight from multiple sources of information including policy and national recommendations
- Involvement – to give staff the skills and support they need.
- Improvements – to increase quality and safety in key areas by improving design, planning and provision of robust training and education to all maternity staff.

In addition, the aim of this guideline is to ensure that there is a thorough process set out for the provision of mandatory specialist training and ensure that:

- The Maternity Service meet and evidence their mandatory specialist training requirements on an ongoing basis and monitor effectiveness of provision.
- There is clarity of requirements and standards across the Maternity Services including the role of managers, individuals, and subject specialists/leads.
- The range of learning and development activities is continually updated developed and promoted in accordance with publications and Independent reviews such as Saving Babies Lives Guidance, CNST core competency framework and Ockenden review.



3. DEFINITIONS

Simulation Skills Drills/PROMPT

These drills and PROMPT are specific to management of emergencies around childbirth, with a focus on recent SIs and thematic analysis from the trust.

Mandatory Specialist Training

Training sessions that are specific to particular staff groups and disciplines. It includes classroom based learning, e-learning, skills drills and assessment of learning, with a focus on recent SIs and thematic analysis from the trust.

Training needs analysis (TNA)

An analysis usually presented in the form of a spreadsheet or table, which identifies the mandatory specialist training, required within a service. This analysis will also include the frequency each training subject should be complete and what staff group for which it is applicable. The Training Needs Analysis Matrix can be found here -

Maternity Mandatory Specialist Training Ma

Permanent staff

All staff directly employed under a contract of employment with the organization, including medical staff in training. All permanent staff and rotation Doctors must complete all relevant training outlined in the TNA Matrix (see above)

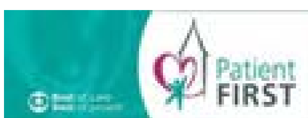
Bank staff

All regular bank staff are invited to attend all mandatory training and expected to maintain compliance with all training included within the TNA matrix

4. Roles and Responsibilities

Maternity Education Team are responsible for:

- Co-coordinating and facilitating a yearly TNA.



- Co-ordination, design and delivery of mandatory specialist training alongside obstetric and anesthetic leads.
- Booking Midwives and MSW's onto mandatory specialist training sessions and liaising with obstetric and anesthetic leads for MDT scheduling.
- Recording attendance on a training database.
- Rescheduling non-attendance or providing a suitable virtual alterative.
- Producing ad-hoc training data on request from line managers.

Specialist Training Leads.

Training Leads for each topic are responsible for:

- Resourcing and delivering the training and/or providing a deputy.
- Ensuring that training delivered supports national guidance and Trust policy based on best practice, incorporating any updates on policy and practice.
- Undertaking and evidencing continuing professional development (CPD) in relation to their subject(s) and skills as a learning and development practitioner.

Divisional Managers/Senior Sisters

Divisional managers/Senior Sisters will be responsible for ensuring that:

- Staff are released to attend mandatory specialist training during their normal working hours. If training is only available on days outside of normal working hours, the expectation is that arrangements are made to ensure attendance with sufficient notice.
- All staff requesting to attend 'external' training events have attended the relevant mandatory specialist and Trust training for their role in accordance with the TNA prior to submission of application.
- All training is undertaken within the timescales prescribed in this document.
- Line managers/appraisers to monitor individual compliance with ESR training.
- They review attendance and hold staff to account if they have not attended mandatory specialist training. Should any individual persistently not meet their mandatory specialist training requirements, having been provided every opportunity to do so in terms of guidance of what is required and time to attend, then the manager will take disciplinary action in line with the Trust Disciplinary procedures. Equally, managers who fail to release staff to attend mandatory specialist training sessions may be subject to disciplinary action in line with the Trust Disciplinary procedures.

This commitment must be integrated throughout the Maternity Service at all levels, and clinical staff are contractually obliged to attend all relevant mandatory specialists training according to their role and position and managers must release staff to attend.

Once study leave has been approved by the manager for an individual to attend mandatory specialist training, this shall then be deemed as 'protected time'.

Individuals

It is the responsibility of individuals to:

- Undertake the mandatory specialist training requirements for their role within the timescales outlined in this document and the TNA.
- Advise their manager and the education team if they are unable to attend a mandatory specialist training session, ensuring that it is rescheduled.
- Completing any pre-reading or virtual content within the timescales given.
- Apply the skills and knowledge from mandatory specialist training in the work place.
- Monitor ESR training compliance and ensure attendance/completing required training is undertaken in a timely manner.

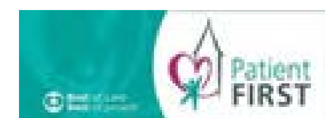
5. Guidance to Follow:

Mandatory Specialist Training (including Simulation Skills Drills)

Not all mandatory training is required by all staff. The TNA Matrix outlines which grade of staff should attend which mandatory training and the frequency of attendance. (see TNA Matrix). The Training Matrix includes 'tabs' for all available training and 'tabs' for individual staff groups and their required training.

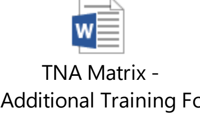
Mandatory training includes:

• Saving Babies Lives Care Bundle
  o Smoke free pregnancy
  o Monitoring fetal growth
  o Pre-term birth
  o Fetal monitoring
  o Fetal movements
• Fetal Surveillance
	• Local Learning – training targeted at local learning
	• Equity
	  o Cultural competency
	  o Conflict resolution
	• NIPE
	• MSW training



◦ Fetal surveillance in labour ◦ Gap and grow training • Personalised Care ◦ Informed choice ◦ Maternal mental health ◦ Safeguarding ◦ Bereavement • Baby Friendly Initiative – Infant feeding and BFI • Core Module 5 ◦ Care during labour and the immediate postnatal period ◦ Maternity critical care - MECU • Resuscitation ◦ Adult and Neonatal • Covid Compliance • Essential Midwifery Training ◦ Physiological birth ◦ Diabetes ◦ Research ◦ Supporting students in clinical practice ◦ Screening	• Equipment training • Medicines Management ◦ Drug assessment ◦ Medicines management ◦ VTE ◦ PGD • Aseptic Technique • ESR Learning ◦ Anaphylaxis ◦ Blood collection ◦ Blood sampling assessment ◦ Blood transfusion assessment ◦ COSHH awareness ◦ Female genital mutilation ◦ Health, Safety and welfare level 1 ◦ Infection prevention and control level 2 ◦ Information governance ◦ Mental capacity ◦ Moving and handling ◦ Patient safety ◦ Preventing radicalization – awareness of prevent

It is all Specialist Midwives/Lead Midwives' responsibility to ensure the TNA matrix remains relevant and up to date. If amendments are required, please complete the form below to describe the necessary changes and send to medwayft.maternityedteam@nhs.net so the Maternity Education Team can add to the matrix in a timely manner.



Emergency simulation skills drills/PROMPT

Multidisciplinary skills drills training sessions for managing emergency situations that may arise in a maternity setting allow all clinical staff to know and understand their specific roles and responsibilities in an emergency. Midwives, support workers, obstetric, anesthetic and other staff training together enables efficient and safe multidisciplinary team working to be created and practiced. A structured MDT debrief feedback to the teams will be conducted during the training session that incorporates discussing on human factors that arise with the scenarios.

The following simulation skills drills training sessions have been identified as mandatory. Identified staff must attend **ANNUALLY**. Although roles and responsibilities will differ for support workers, it is important that they are included in training sessions in order that they understand their important roles in emergency situations.

Skills Drills Training includes:

- Cord Prolapse
- Shoulder Dystocia
- Vaginal Breech
- Antepartum & Postpartum Hemorrhage
- Eclampsia
- Early Recognition of Severely Ill Pregnant Women
- Specific training for COVID-19

In addition, midwives, maternity support workers, obstetric staff and anesthetic staff that cover the obstetric rota must have annual basic maternal and neonatal resuscitation training.

Training is delivered by a multidisciplinary team of in-house trainers, which include;

- the midwifery education team
- a member of the Trust Resus Team

Lessons learnt from clinical incidents, complaints or SI's

Where there has been learning from any of the above, this will be presented at the relevant forum such as audit and perinatal meetings, before additions or amendments to the training programs are made.

All staff will be invited to weekly datix meetings, and learning from these, rapid review HSIB investigations and S.I's will be shared via various platforms including Fridays News, Huddles, in-situ simulation and mandatory training updates.

Results from audits

Any identified leaning from incidents/near misses/audit/feedback will be incorporated into training and simulations. It may only need to be presented at ward/audit meetings or highlighted through the newsletter. Staff are encouraged to join trust audit meetings to keep up to date with results of trust audits.

During the COVID-19 pandemic, it has been necessary to develop virtual screening packages as well as e-learning training packages, in order to meet social distancing requirements. The sessions will be recorded on the Training database and attendance kept in the same format as mandatory training, which is stored on the department electronic shared drive.

Review of Training Needs Analysis

The TNA process will involve a systematic review of all mandatory specialist training, covering the various staff groups in Maternity Services and will be undertaken annually by the Midwifery Education Team. Specialists/Lead Midwives will meet annually with the Midwifery Education Team in October to identify thematic training needs that are individual to the trust. These will be reflected in the TNA matrix and will be the following years' program.

However, where there is significant change to the required training, for example due to a change in frequency, national guidance or following from results of an audit/incident/claim/complaint, the Lead Education Midwife and Lead Consultant for training will be required to ensure that this change is fully resourced in terms of equipment, manpower etc.

The Lead Education Midwife will coordinate the TNA, and will present any findings/recommendation/updates to the Women's Health Directorate Governance Group for approval, along with the training plan to meet the identified training needs on an annual basis.

Training plan – delivering the training and updates

As a result of the TNA, the Lead Education midwife will produce a training plan giving details of the essential midwifery training sessions. They will coordinate with the training leads to ensure that the training is delivered along with the required attendance to ensure

that sufficient training interventions are scheduled to meet the requirements for each staff group. The contents of the sessions are outlined in the Training plan (see below) and will be updated on an annual basis and runs January-December.

Schedule of Mandatory Specialist Training Sessions

The training year begins in January and ends at the end of December, and all training dates will be available at the beginning of the year, and populated via departmental newsletters & directly to the various discipline leads for maternity, obstetrics, anesthetics, obstetric theatres and neonatal teams. The training dates will also be available on notice boards in all maternity clinical areas and circulated to all Senior Sisters & Band 7 lead midwives, Directorate managers, designated Obstetric, Neonatal and Anesthetist Consultants coordinators.

Expected Level of Attendance

The Maternity service will aim to achieve a compliance of 90% attendance rate across all identified staff groups for skills drills and neonatal and adult resuscitation, and 90% across all identified staff groups the remainder of the mandatory specialist training and within the specified timeframe as identified by the TNA.

Staff on maternity leave, long-term sickness, unpaid leave, or other, are **NOT** included in the specialist training. Training needs will be discussed with their line manager on returning to work.

Attendance at Training

- **Midwives and support workers**

All substantive Midwives & Clinical Maternity Support workers will be allocated dates to attend the specialist training sessions by the Maternity Education team or the line manager. These dates will be appropriately allocated directly onto the electronic roster system by the team to ensure that the members of staff attends the training once a year.

- **Doctors**

A schedule of all mandatory specialists training will be circulated to the appropriate administrative coordinator for all grades of obstetric, anesthetists, neonatal consultants via the Lead consultant for training. The clinical tutor & the lead consultant for training will advise the Maternity Education Team of which doctors will be attending each training session.

Log of attendance

Accurate recording of mandatory training records is essential as it provides the evidence of compliance required by external and internal assessors.

The Maternity Education Team will maintain a log of all maternity and obstetric staff attendance for all mandatory sessions (not including those on ESR – as this is down to the individual and line manager to monitor and maintain compliance). All staff are required to sign a record of attendance for both morning and afternoon sessions. If the session is a virtual session then participants will report their attendance at the beginning of the session, which will be recorded on the designated database.

A record of the Doctors who attend the PROMPT, the simulation skills session, will be stored on an electronic database, which can be accessed on the shared drive.

Adult and neonatal resuscitation practical sessions will be provided within the department by the Maternity Education team. A record of attendance will be recorded on the department database & Trust electronic record system ESR.

Coordinating Training Records

Attendance will be recorded on the live Directorate databases by the Maternity Education Team within **three weeks** of the session. These databases are stored electronically on the directorate shared drive.

An attendance summary will be completed by the by the Maternity Education Team midwife.

6. Implications of non-attendance on mandatory training sessions

The Maternity Education Team will notify all substantive staff and their line managers who **DO NOT** attend mandatory training via e-mail and they will be booked to attend the next available session. This date will be added directly onto the electronic roster system, which will notify the staff member by email when the date has been approved.

Attendance at mandatory training sessions is a **CONTRACTUAL REQUIREMENT.** Should any individual not meet their mandatory specialist training requirements, or fail to attend after the third occasion, having been provided every opportunity to do so in terms of guidance of what is required, time to attend etc. this will be reported Head of Midwifery and

disciplinary action in line with the Trust Disciplinary procedures will take place. Equally, **managers who fail to release staff** to attend mandatory specialist training sessions may be subject to **disciplinary action in line with the Trust Disciplinary procedures.**

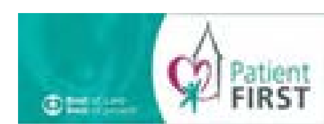
When there is non-attendance to mandatory training within permanent medical staff, this will be escalated to the appropriate line manager for further management.

7. Useful Contacts:

Lead Education Midwife – Jenna Thompson – jenna.tompson@nhs.net
Midwifery Education Team - medwayft.maternityedteam@nhs.net

8. Monitoring the Process:

What will be monitored	How/Method	Frequency	Lead	Reporting to	Deficiencies / gaps recommendations and actions
Guideline	Review document	Every three years	Author	Women's Health Policy and Procedures Committee	Amend policy and send out for consultation
Training Needs Analysis (TNA) Staff Group •Frequency of training and updates •Topics covered	TNA template sent to Consultants and training leads for input	Annually	**Lead Education Midwife**	Women's Health Directorate Governance Group.	Training programs to be circulated annually
Learning from incidents etc.	Attendance of relevant staff groups Training programs	Ad hoc	**Maternity Education Team**	Women's Health Directorate Governance Group.	Minutes of the Women's Health Directorate Governance Group will reflect the outcome actions to be acted upon



What will be monitored	How/Method	Frequency	Lead	Reporting to	Deficiencies / gaps recommendations and actions
Report outlining by staff groups the level of Attendance Cancellations DNA's At skills drills and other mandatory specialist training sessions	Review of database	Six monthly	**Maternity Education Team**	Women's Health Directorate Governance	Women's Health Directorate Governance
Follow-up of Non Attendance	Review of database	Six monthly	**Maternity Education Team**	Women's Program Governance meeting	Women's Program meeting
Co-ordination of training records	Review of database	Six monthly	**Lead Education Midwife.**	Women's Program Governance meeting	

9. Reference Material & Associated Documents:

NMC Quality Assurance Framework for Nursing and Midwifery Education (2017 updated).

FIGO Consensus Guidelines on Intrapartum Monitoring, 2015. Safe Motherhood & New-born Health Committee: Diogo Ayres-de-Campus

Better Births-improving outcomes of maternity services in England: A 5year forward view of maternity care, 2016

NHS Resolutions-Midwifery Incentive Scheme-Year 3 revised safety actions (updated 30 September 2020). Safety Action 8

Guideline
Maternity Mandatory Specialist Training Policy
(Including Simulations skills and Training Needs Analysis)

NHS England- Saving Babies' Lives –Version Two –a care bundle for reducing perinatal mortality 2019

MBRACE-UK

RCOA- 2018 Care of the critically ill woman in childbirth; enhanced maternal care

Refreshed links
PROCHR006 - Statutory and Mandatory Training Policy (1 attachment).
SOP0570 - Statutory and Mandatory Training (StatMan) Procedure (1 attachment)

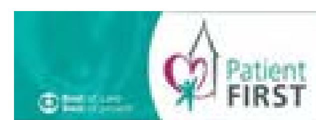
Old links
Maternity Mandatory Specialist Training Plan
Maternity Mandatory Specialist Training Matrix

10. Revision History

Revision No	Date	Reason for change
4	01.08.2023	To bring in line with Core Competency Framework

Guideline Reference Number:	GUDNM078
Version Number:	5
Approving Committee/Group	Planned Care
Department / Category	Maternity
Accountable Executive Lead	
Author's Job title	Lead for Maternity Education
Brief Outline of This Guideline	Training needs analysis for maternity education

Date Approved	
Approved By	
Date Ratified	
Ratified By	

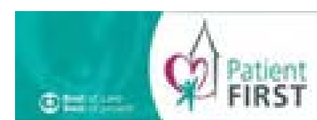


Guideline
Maternity Mandatory Specialist Training Policy
(Including Simulations skills and Training Needs Analysis)

Published Date (made live for use)	
Review Date	
Target Audience	All staff within Maternity

This Guideline has been reviewed and is compliant with the most up to date Code of Practice and NICE Guidelines	
Title of Code of Practice	**NICE Reference Number (s)**
Core Competency Framework Version Two	N/A
CNST Year 5	

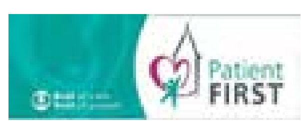
Document Control/History List			
Version No	**Date**	**Author's Job Title**	**Reason and Summary of Change**
5	Oct 2022	Lead for maternity Education	Changed in 2023 due to changes in national guidance of the Core competency Framework



Meeting of the Public Trust Board
Wednesday, 17 January 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Bi-Annual Maternity Workforce Report</td><td>Agenda Item</td><td colspan="2">4.2a</td></tr>
<tr><td>Author</td><td colspan="6">Alison Herron, Director of Midwifery
Kate Harris, Head of Midwifery</td></tr>
<tr><td>Lead Executive Director</td><td colspan="6">Sarah Vaux, Interim Chief Nursing and Quality Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="6">1) The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels.
2) The report highlights the frequency of maternity safer staffing red flags and the reasons for these.
3) It provides an accurate account of the current workforce status and includes an update from recommendations within the previous paper presented to Trust Board in August 2023.
4) Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
5) It gives a breakdown of the outcome of the formal BirthRate Plus staffing report or equivalent calculations to demonstrate how the required establishment has been calculated.
6) It shows compliance with 1:1 care in labour, supernumerary status of the labour ward co-ordinator and obstetric cover.
7) It highlights the areas of training in maternity with percentages of compliance plus the areas of training that require improvement</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="6">Approve the report and give assurance</td></tr>
<tr><td rowspan="2">Purpose of the report (Please mark with ‘X’ the box to indicate)</td><td>Assurance</td><td>X</td><td colspan="2">Approval</td><td colspan="2">X</td></tr>
<tr><td>Noting</td><td></td><td colspan="2">Discussion</td><td colspan="2"></td></tr>
<tr><td>Committee/Group date submitted:</td><td colspan="6">Maternity and Neonatal Safety Champion Assurance Group - 08.12.23
QPSSC - 20.12.23
Quality Assurance Committee - 09.01.24</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="6">Please mark with ‘X’ the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)</td><td>Priority 2: (People)
X</td><td>Priority 3: (Patients)</td><td>Priority 4: (Quality)
X</td><td colspan="2">Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="6">Please mark with ‘X’ the CQC domain the report aims to support:</td></tr>
<tr><td>Safe:
X</td><td>Effective:</td><td>Caring:</td><td>Responsive:</td><td colspan="2">Well-Led:
X</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="6">Maternity Staffing remains the highest scoring risk on the Women’s risk register (Risk ID Midwifery staffing ID 1134 Score= 20)</td></tr>
<tr><td>Resource implications:</td><td colspan="6">Business case to be written in line with the outcome of the formal Birthrate plus staffing review</td></tr>
</table>

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	Compliance with CNST Year 5		
Appendices:	None		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email: alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	**X**	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.



Bi-Annual Maternity Workforce Report3

Trust Board

17 January 2024

SIOR - Patients

Successful Deliverables

Second Maternity Workforce report to be presented to Trust Board as part of compliance with CNST year 5.
Improved triangulation between cultural improvement work, workforce data, red flags and patient feedback.
Birth Rate Plus completed in July 2023.
100% compliance with 1:1 care in labour and Supernumerary status of Delivery Suite Coordinator

Next Steps

Business case to be presented to Divisional Board February 2024.
Continue to monitor standards inline with CNST requirements.
Next maternity Board report for workforce due to Trust Board January 2024 and July 2024.

Identified Challenges

Birth rate plus identified a shortfall of 9WTE band 3 MSWs and 4WTE specialist midwives.
Midwifery vacancy remains relatively static despite recruitment activity.
Additional training requirements for CNST year 5 and Saving Babies Lives Care Bundle V3.
Unable to commence Continuity of Carer due to workforce challenges.

Next Steps

Consider increasing uplift to meet needs of training requirements.
Continue to monitor workforce for when establishment allows for safe roll out of MCoC in line with national directive.

Opportunities

Opportunity to improve compliance with training across all staff groups.
ESR to ensure correct mapping of maternity staff to level 3 safeguarding training.
Continue to triangulate staff, service user and workforce data to support ongoing service improvements.
Introduce yearly career MOT workshops to support personalised plans for all staff, ensuring both developmental and succession planning

Next Steps

Senior sisters and medical director to identify individual staff members with gaps in mandatory training and develop targets to achieve full compliance with all statutory requirements.

Risks

Maternity Staffing remains the highest scoring risk on the Women's risk register (Risk ID Midwifery staffing ID 1134 Score= 20)
Induction of Labour has been identified as a significant red flag
Withdrawal of CCCU midwifery programme – 18WTE students
Level 3 Safeguarding Training Compliance added to risk register, awaiting care group approval.

Next Steps

Work with Surrey University to support the displaced students who are now on placement at MFT – to qualify in Mar/April 2025

True North: People
Background to workforce report

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

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

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

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

Key Messages:
- The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels
- This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags
- The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented to Trust Board in August 2023.
- Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
- A clear breakdown of BirthRate Plus or equivalent calculations to demonstrate how the required establishment has been calculated is also included.

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

True North: People

Safety Action 5: Midwifery Workforce BIRTHRATE PLUS JULY 2023
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

Key Messages:

- MFT currently funds 212.57WTE clinical maternity staff (Bands 3-7), or which 196.91WTE are registrants
- Birthrate Plus (BR+) is a framework for maternity workforce planning and strategic decision-making
- The Birthrate Plus workforce tool was conducted in July 2023 and identified a shortfall in workforce to meet the recommended ratio of 1:25.

BirthRate Plus Methodology:

Birthrate Plus® is an evidence-based methodology based on national standards – in particular one-to-one care from a midwife for a woman during labour and delivery, together with the care of the new-born infant(s). It supports maternity services to identify the staffing they need to provide safe care. The methodology is sensitive to local factors, such as case mix and has been in use for over thirty years.

The methodology is based on research published in peer reviewed journals [1] and has been described as the 'gold standard' for maternity workforce planning [2]. The methodology was reviewed as part of the post Francis Inquiry safe staffing programme of work led by NHS England. In June 2016 Birthrate Plus® was endorsed by the National Institute for Clinical Excellence (NICE) following a review of the methodology against NICE guidelines on safe midwifery staffing for maternity settings. NICE noted that the resource encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline.

Birthrate Plus® doesn't specify or allocate a set number of hours per midwife for training and we would look to national policy or guidance to specify this.

There is information available nationally stating the specific components of training that each midwife should complete but there is currently no guidance available nationally which specifies the amount of training time each midwife should receive to complete this training.

However, each Trust has a locally agreed uplift to cover training, annual leave, sickness etc which ranges from 18-25% and this is included in the Birthrate Plus calculations.

True North: People

Safety Action 5: Midwifery Workforce BIRTHRATE PLUS JULY 2023
Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care
Goal: Ensure Midwifery workforce meets the required standard

% uplift	Skill mix %	RMs	MSWs	Variance
22%	Current 94.5 / 4.5	-8.60	-0.50	-9.10
	90 / 10	0.75	-9.85	--9.10
25%	Current 94.5 / 4.5	-14.81	-0.85	-15.66
	90 / 10	-5.15	-10.51	-15.66

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
2022/23	4.1	9.8	12.9	25.2	48.0
	26.8%			73.2%	
2018	38.0%			62.0%	

Key Messages:

- MFT currently funds 212.57WTE clinical maternity staff (Bands 3-7), or which 196.91WTE are registrants
- The Birthrate Plus workforce tool was conducted in July 2023 and identified a shortfall in workforce to meet the recommended ratio of 1:25.
- Based on the current 22% uplift this review identifies a short fall of 9.10WTE clinical roles and 4.18WTE non-clinical roles to achieve recommended staffing ratios
- The complexity of women has changed significantly since our last Birthrate plus review with the highest complexity of cases (category IV and V) rising from 62%- to 73%
- The long-term sickness rate for November 2023 is 5.92WTE

Issues, Concerns & Gaps:

- The service currently has a vacancy 14.15WTE
- Maternity leave is currently 13.8 WTE which is not factored into the 22% uplift and so unfunded
- Gaps are attempted to be covered with bank and agency with varying degree of success
- The annual turnover factor is 9.03% which is lower than the Trust overall turnover (14.4%) and is impacted by the number of midwives who have retired.
- CNST Year 5 has a significantly increased requirement on maternity training. Therefore the Birth-rate plus report also includes a 25% uplift evaluation

Actions & Improvements:

- A business case will be written to support the request for additional workforce budget to support Medway maternity in achieving the national agenda for maternity
- Work actively and in partnership with recruitment to maximise recruitment opportunities
- Continue to participate in International recruitment, Return to practice and retire and return

True North: People
Planned vs Actual Midwifery Staffing levels

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

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

		Month 2023						
Measure	Goal	April	May	Jun	July	Aug	Sept	Oct
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio	1:25	01.33	01:33	01:34	01:31	01:32	01:31	01:33

	Establishment	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	181.89	160.02	9.00	-12.87
MSW's Band 3	24.13	20.21	3.92	0
Total	206.02	180.23	12.92	-12.87

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

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 supported to work clinically which affects their specialist roles.
- 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 and agency support
- 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

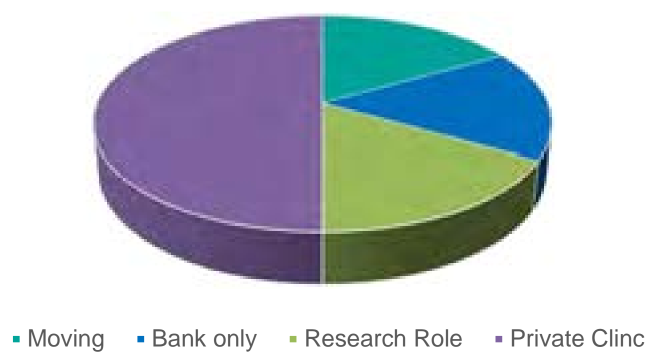
True North: People
Workforce Data Q4

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

	Sept-23	Oct-23	Nov-23
True vacancy	14.07 WTE	13.43 WTE	14.15 WTE
Secondments	4.08 WTE on secondment into Band 7 roles	6.44 WTE on secondment into other roles	6.44 WTE on secondment into other roles
Pipeline	**8.80 WTE recruited** 6.8 WTE B6 going through employment checks 2 WTE B5 Nurses going through employment checks	**9.00 WTE recruited** 2.0 WTE B6 with start dates Nov/Jan 1.0 WTE B5 with start date Nov 6.0 WTE B5 going through employment checks	**9.00 WTE recruited** 2.0 WTE B6 with start dates Dec/Jan 1.0 WTE B5 with start date Nov 6.0 WTE B5 going through employment checks
Leavers this month	**3 leavers (2.00) WTE)** - 1 moved to Trust nearer home - 1 moved to bank only - 1 moved to Research	**1 leavers (0.96) WTE)** - 1 moved to private clinic	**2 leavers (1.96) WTE)** - Both moved to private clinics
Leavers expected over next 3 months	**2 leavers expected within next 3 months** - 1 moving for promotion in another trust - 1 moving to bank only	**3 leavers expected within next 3 months** - all leaving for private clinics	**3 leavers expected within next 3 months** - 1 coming to contract end - 1 going travelling - 1 moving to bank only
Maternity Leave	14.40 WTE	12.96 WTE	13.48 WTE
Average Long Term Sick across month	5.1 WTE (covid rise noted)	3.61 WTE	5.92 WTE

Recruitment and Retention

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



Key Messages:

- The maternity team continue to actively recruit new staff
- A number of recruitment drives have taken place in Autumn 2023, with varying degrees of success – none allowed us to fill all vacancies.
- MFT are actively engaged with the local international midwifery recruitment programme and now have 5 international midwives in post
- The service is currently working with the HEE Midwifery Apprentice Programme and has 4 midwifery apprentices in post
- Representatives of MFT have joined both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff back to work

Issues, Concerns & Gaps:

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

- 1 contract coming to end
- 1 travelling
- 1 moving to bank only

Actions & Improvements:

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

True North: People
Recruitment and Retention

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

Key Messages:

- Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases; maintaining safe staffing levels has become more complex recently
- A formal BR+ assessment has been completed. An updated position was provided to the Maternity Board in August 2023
- This paper highlights the additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance.
- A clear and robust escalation policy is in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored. Early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service
- The service has a clear workforce plan, however implementation of the plan remains challenging due to national midwifery shortage.

Actions & Improvements:

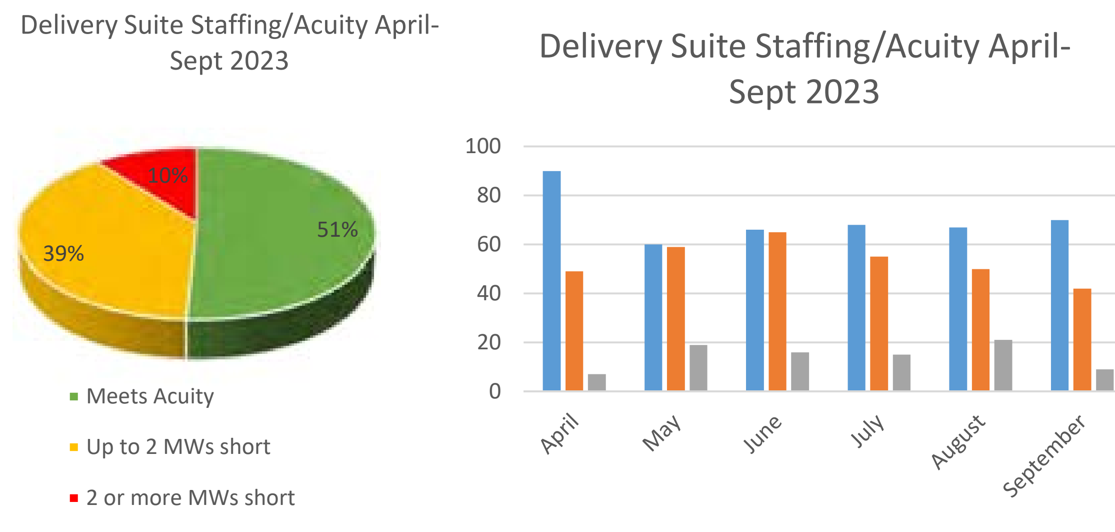
- Increased capacity for Greenwich midwifery students to help mitigate shortfall in qualified applicants from Surrey until April 2025 .
- We are actively recruiting additional Registered Nurses, although awaiting NHSE response to RCM position statement.
- Work with HEIs to ensure a continued pipeline of midwifery graduates despite removal of programme at local university.

Issues, Concerns & Gaps:

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

True North: People
Birthrate Plus 4- hourly acuity tool

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



Meets Acuity Up to 2 MWs short 2 or more MWs short

Issues, Concerns & Gaps:

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

Key Messages:

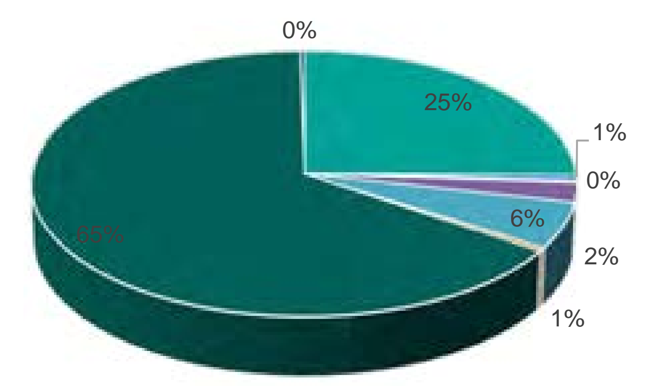
- The pie chart shows Acuity RAG status for April to September 2023.
- The Intrapartum tool currently uses Red, Amber, and Green as determinants of acuity. A target of 85% for Green, when there is an adequate number of midwives available to provide the clinical care required by the women depending upon their needs, is considered to be appropriate
- The Delivery Suite data shows that for the periods when a data entry was made the unit was adequately staffed 51% of the time in this period which is an increase from 45% in last reporting period. The unit recorded negative acuity 49% of the time. With 10% of 2 or more MW's short
- Compliance with the rate for completion of the tool has fallen to 75% which is in below the 85% standard recommended by BR+. This has been addressed with the coordinators and an improvement is expected in the next quarter.

Actions & Improvements:

- The new web-based Birthrate Plus acuity tool has been purchased by the Trust and will be rolled out in 2024. This will allow for more detailed analysis of results and traffic light system that links to our escalation policy.
- The tool will further be rolled out in Q4 2023/24 on our antenatal and postnatal wards supporting proactive assessment of women on the ward and matching them against the staff available.

True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

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



Key Messages:

- Red flags are recorded every 4 hours by the delivery suite coordinator on the birth-rate plus acuity tool. The same red flag may be recorded multiple times per shift (eg. Delay in induction of labour).
- The pie chart shows that 65% of red flags recorded from April to September were relating to delays in induction of labour.
- 25% of red flags relate to delay or cancelled time critical actives.
- 6% indicated a delay between presentation and triage and 2% indicated a delay in pain relief.

Actions & Improvements:

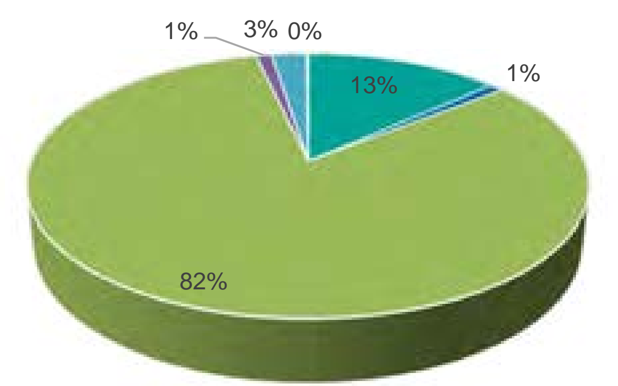
- To mitigate and resolve red flags and negative activity the coordinator records the following categories of action:
  - Staffing Actions
  - Clinical Actions
  - Management actions.
- Details of these actions are included on the next slide.

Issues, Concerns & Gaps:

- Staffing factors also contribute to red flags and poor acuity with inability to fill vacant shifts accounting for 64% of staffing factors in the reporting period.
- Delay in providing pain relief was also raised in the 2023 picker survey and will form part of this action plan.

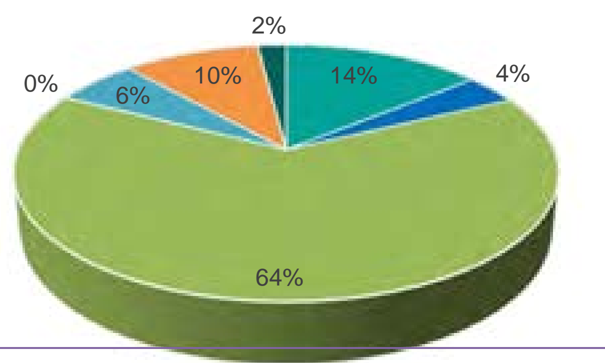
True North: People
Birthrate Plus 4- hourly acuity tool – Red Flags

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



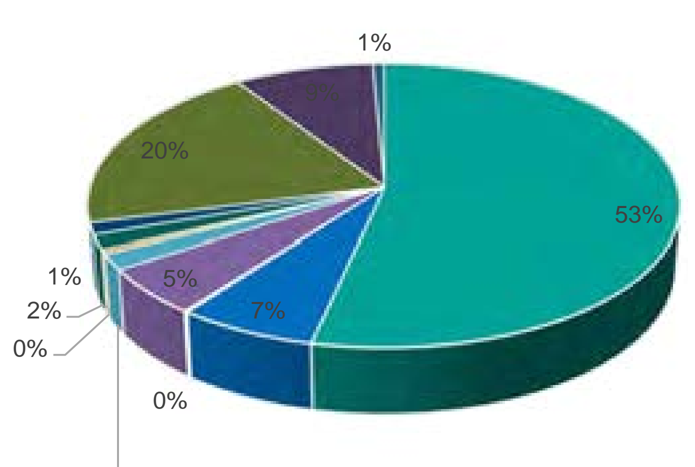
- Decline in-utero transfer
- Delay in accepting transfers
- Delay in commencing IOL (as per Trust Guidance
- Delay/Cancel planned procedure
- Delay in transfer of cases to theatre
- Delay in Elective LSCS >24 Hours

Staffing Factors Apr-Sept 23



- Unexpected midwife absence / sickness
- Unexpected support staff absence
- Unable to fill vacant shifts
- Midwife on transfer duties
- Midwife redeployed to other area

Management Actions Taken Apr-Sept 23



- Redeploy staff internally
- Redeploy staff from community
- Redeploy staff from training
- Staff unable to take allocated breaks
- Staff working beyond rostered hours
- Specialist midwife working clinically
- Manager/Matron working clinically
- Staff sourced from bank/agency
- Utilise oncall midwife

Key Messages:

- Delay in IOL accounts fro 82% of clinical actions taken which aligns with the red flags raised for IOL delays.
- Decline in-utero transfer accounts for 13% of clinical actions taken between April and September 2023, this is to ensure safety of patients already admitted into our maternity service.
- 53% of management actions taken were to redeploy staff across the unit and 20% saw the utilisation of the on-call midwife which is reflective of the on-call review document completed in August 2023.

Issues, Concerns & Gaps:

- Inability to take staff breaks is reflective of cultural improvement survey and will form part of our action plan for improving staff experience.

True North: People
Delivery Suite Co-ordinator supernumerary status

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

2023	Compliance with 1:1 Care in Labour
May	100%
June	100%
July	100%
August	100%
September	100%
October	100%
November	100%

2023	Compliance with Supernumerary status of Coordinator as per CNST guidance
May	100%
June	100%
July	100%
August	100%
September	100%
October	100%
November	100%

Key Messages:

- Delivery suite supernumerary status is a core element of CNST Safety Action 5
- The twice daily bed state monitors the supernumerary status of the delivery suite co-ordinator to ensure that they have oversight of all activity within the service.
- If there is an occasion where the delivery suite co-ordinator does not have supernumerary status, this is escalated to the Midwifery Manager on call
- All occasions of coordinator not supernumerary have been reviewed, and these are very brief periods of caring for postnatal women whilst waiting for staff to mobilise to delivery suite, and therefore meet the requirements of CNST allowing the service to declare 100% compliance with supernumerary status.

Actions & Improvements:

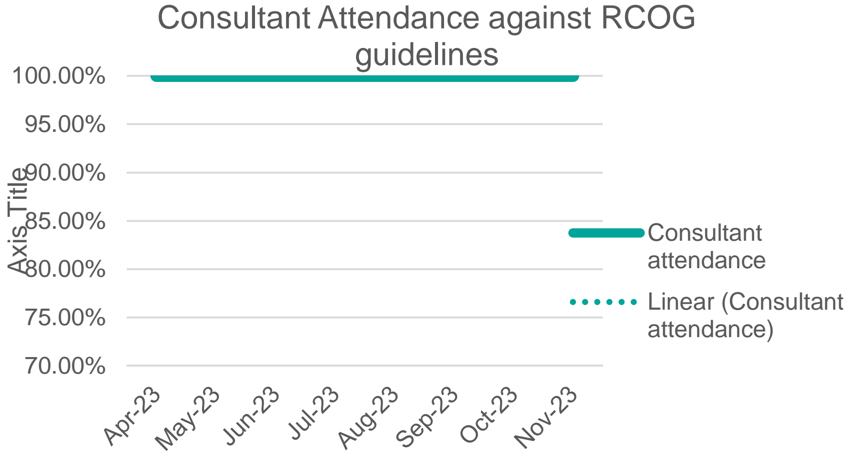
- Data error identified on occasions and work ongoing to correct. Learning shared with all staff to prevent further error.
- Continue to monitor compliance with CNST standards.

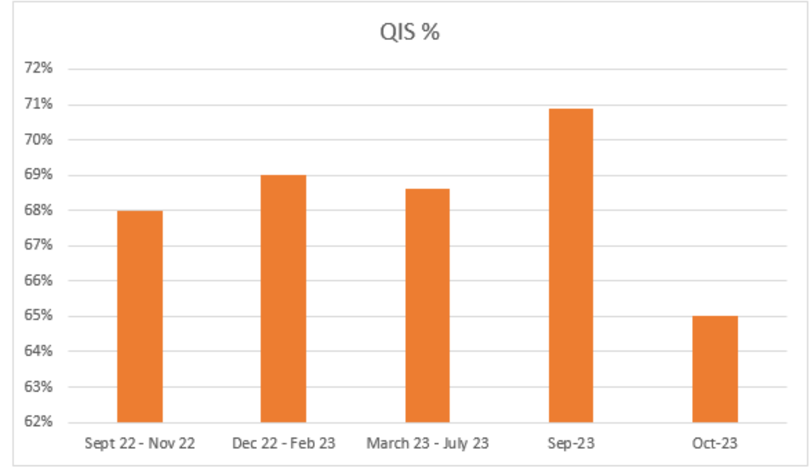
True North: People

Clinical Workforce

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

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





Key Messages:

- There are no current medical vacancies in Obstetrics and Neonatology
- Obstetric rota and SOP in place to support compliance with RCOG guidance for Obstetric Consultant roles and responsibilities.
- Audit of consultant attendance 100% compliance for April to September 2023
- NICU junior medical staffing compliant with BAPM requirements.
- Due to establishment increase, QIS Trained staff reduced from 70.9% in September to 65% in October.
- Action plan in place to achieve QIS demonstrating progress since CNST year 4. Key actions of annual rolling training programme for band 5 staff to achieve QIS in place as well as robust recruitment process in place. Currently 0 band 5 vacancies and 7WTE band 6 (following 16WTE added to establishment in 2022).

Actions & Improvements:

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

Issues, Concerns & Gaps:

- NICU nursing workforce currently below 70% QIS requirement.

True North: People
Mandatory Training - Midwifery

Key Messages:

- >90% for 7 mandatory training requirements.
- Maternity staff recently required to undertake level 3 safeguarding adults training and staff are on an appropriate trajectory to achieve this by March 2024.
- 8 subjects below 90% requirement for compliance.
- Targeted interventions by line managers to support training compliance.