Public Trust Board Meeting

Wednesday, 24 July 2024 at 12:30 – 15:30 Trust Board Room, Gundulph Offices

Item	Subject	Presenter	Page	Time	Action
1.	**Preliminary Matters**				
1.1	Chair's Introduction and Apologies	Chair	Verbal	12:30	Note
1.2	Quorum				
1.3	Declarations of Interest				
2.	**Minutes of last meeting and Action Log**				
2.1	Minutes of 15 May 2024	Chair	3	12:35	Approve
2.2	Action Log – none for July 2024		-		-
2.3	Chief Executive Update	Chief Executive	12	12:40	Note
2.4	Council of Governors Report (May 2024)	Lead Governor	15	12:50	Assurance
2.5	Constitution Amendments 2024 (***Appendix in Appendices Pack***)	Company Secretary	18	12:55	Approve
3.	**Board Story Presentation**				
3.1	End of Life Care on Lister Ward – Dr Rosie Chester	Associate Director of Patient Experience	20	13:00	Note
4.	**Board Assurance Reports**				
4.1	Quality Assurance Committee (June and July 2024)	Chief Medical Officer, Chief Nursing Officer (Interim), Committee Chair	33, 37	13:20	Assurance
4.2	People Committee (May 2024)	Chief People Officer, Committee Chair	41	13:25	Assurance
4.3	Audit and Risk Committee (June 2024)	Company Secretary, Committee Chair	45	13:30	Assurance
4.4	Finance, Planning and Performance Committee (May and June 2024)	Chief Finance Officer, Committee Chair	49, 53	13:35	Assurance
5.	**Public Board Papers**				
5.1	Maternity Workforce Oversight Report (***Appendix in Appendices Pack***)	Chief Nursing Officer (Interim)	56	13:40	Assurance
5.2	Maternity CNST Compliance Assurance Report - Updates and Actions		58		Assurance
5.3	Learning from Deaths – Quarterly Update	Chief Medical Officer	Verbal	14:00	Assurance

5.4	Strategy Review and Summary	Director of Strategy and Partnerships	82	14:20	Note
~ WELLBEING BREAK - 10 minutes ~					
5.5	Finance Report (Month 2) (***Appendix in Appendices Pack***)	Chief Financial Officer	94	14:40	Note
5.6	Financial Recovery Plan Report –		96	14:45	Note
5.7	Annual Report and Accounts (***Appendix in Appendices Pack***)	Company Secretary/ Chief Financial Officer	99	14:50	Note
5.8	Health and Safety Annual Report (***Appendix in Appendices Pack***)	Chief Nursing Officer	101	15:00	Assure
6. Performance, Risk and Assurance					
6.1	Integrated Quality Performance Report – June 2024	All Executives	103	15:10	Note
6.2	Risk Register (***Appendix in Appendices Pack***)	Company Secretary	155	15:20	Note
6.3	Board Assurance Framework (***Appendix in Appendices Pack***)		157		Note
7. Closing Matters					
7.1	Questions from the Council of Governors and Public	Chair	Verbal	15:20	Note
7.2	Escalations to the Council of Governors				
7.3	Reflection				
7.4	Any Other Business				
7.5	Date and time of next meeting: Tuesday, 10 September 2024				

Key – Patient First Domains

Quality
Patients
People
Sustainability
System and Partnership

Minutes of the PUBLIC Trust Board Meeting

Wednesday, 15 May 2024 12:30-15:30

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

And on MS Teams

PRESENT		
	Name:	**Job Title:**
Members:	Mark Spragg	Chair (Acting)
	Alan Davies	Chief Financial Officer
	Alison Davis	Chief Medical Officer
	Gary Lupton	Non-Executive Director
	Gavin MacDonald	Chief Delivery Officer
	Jayne Black	Chief Executive
	Jenny Chong	Non-Executive Director
	Leon Hinton	Chief People Officer
	Nick Sinclair	Chief Operations Officer
	Sarah Vaux	Chief Nursing Officer (Interim)
Attendees:	Adrian Ward	Non-Executive Director (Non-voting)
	Alana Almond	Deputy Company Secretary (Minutes)
	Alison Herron	Director of Midwifery (Agenda Items - 5.1, 5.2 and 5.3)
	Chris Burton	Academic Non-Executive Director
	David Brake	Lead Governor
	Glynis Alexander	Director of Communications and Engagement
	Ian Frankcom	Health Solutions Partner – UK and Ireland
	Karen Fegan	Governor – Staff (left at 14:30)
	Lorna Gibson	Improvement Director – National Recovery Support Team, NHS England
	Martine Rowe	Governor
	Matt Capper	Director of Strategy and Partnerships/Company Secretary
Apologies:	Annyes Laheurte	Non-Executive Director
	Paulette Lewis	Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all to the meeting. Apologies were noted as above.

- *Welcome to the May meeting of the Board. Whether you are a member of staff, governor, local resident or visitor, thank you for taking the time to attend.*

- *Some of you may have been made aware of the unfortunate death of James Williams last Sunday – he was an ex Olympian an ex-athlete, a nice gentleman and a real supporter of Medway – we shall miss him a great deal.*

- *Today you will hear about progress at the hospital as well as some of the challenges we face. Sadly, due to the very nature of the work the NHS does, there are always going to be pressures, but as the saying goes, adversity is one of life's greatest teachers. And indeed, we have learnt so much which informs the very many improvement projects underway through our Patient First approach. Just how far we have come, and the high regard in which the hospital is held by the community, was recognised when the Trust was granted the Freedom of Medway. Medway Council bestowed the honour – previously reserved for military bodies – in tribute to our amazing staff, and it was a privilege to be able to celebrate the official presentation at a ceremony in Rochester last month.*

- *I am delighted that a number of colleagues were able to be part of that very special occasion – award winners, long serving staff and senior leaders were invited to the celebration along with local councillors and other stakeholders. Among colleagues invited were Jackie Matthews, a Clinical Sister on the Oliver Fisher Neonatal Unit, and Gill Marshall, a Children's Continuing Care Nurse Co-ordinator. The reason I single out these two colleagues is that for me they epitomise so much that's special about Medway Maritime Hospital. Jackie and Gill both trained as registered nurses at the hospital, and have been friends and colleagues since the day they met – and that was an impressive 40 years ago. It is the commitment, dedication, and sense of belonging that we hear about and see as we go around the hospital, that ensures everyone is pulling in the same direction, even when the going gets tough. To Jackie and Gill, and all our colleagues who share their values, I want to say thank you, you are greatly appreciated.*

- *This is a particularly poignant reminder for me as my own time on the Board is coming to an end. After seven years as a Non-Executive director, and most recently as Acting Chair, my term of office is completed and I will hand over to a new chair. This is therefore my last Board meeting, so I want to take a moment to thank all those colleagues within the Trust I have worked with during my time at Medway. I have seen so many examples of inspirational leadership, of courage, of perseverance and determination, and most importantly, of kindness and compassion. I will see many of you before I leave. I know I will see many of you again before I step down, but thank you for allowing me to play a small part in this hospital's amazing journey.*

1.2 **Quorum**

The meeting was confirmed to be quorate; at least one-third of the whole number of the voting Directors are present including at least one Executive Director and one Non-Executive Director.

1.3 **Declarations of Interest**

There were no declarations of interest against any agenda item.

2 Minutes of the last meeting, Action Log, Chief Executive and Council of Governors Updates

2.1 **Minutes of 06 March 2024**

The Minutes of the meeting held on 06 March 2024 were **APPROVED** as a true and accurate record.

2.2 **Action Log**

There were no actions for Board on the log. Action Log is held under separate cover

2.3 **Chief Executive Update**

Jayne Black presented the report for noting. The report included the following highlights:

a) Improving Emergency performance
b) Care Hub pilot underway
c) Ruby Ward opens
d) Surgery improvements
e) Maternity achieves safety actions for fifth year
f) Trust Clinical Strategy
g) National recognition for support programme for newly registered healthcare professionals.
h) Staff recognised with highest civic honour
i) Marking 25 years of maternity at Medway NHS Foundation Trust

Jayne thanked the Chair from the Trust, colleagues and personally from Jayne for his work at the Trust.

Check and Challenge

Mojgan – with the single point of access pilot in place in ED, are the team following up with the patients that there is no harm and that the care given has been appropriate. Nick – patients that do not come into the hospital will be cared for by community care providers. The pilot does follow up with the patients and the hub have the data for follow ups and outcome. The Trust is looking for funding for this to be made permanent.

The Board **NOTED** the report.

2.4 **Council of Governors Report for April 2024**

David Brake presented the report. The report is tendered by the Council of Governors, enabling escalations from the Governors to be directed to the Trust Board for review and comment. Upcoming key highlights included the recent Governor elections.

a) David wanted to record his personal thanks to Mark for all the help and support personally and extend thanks from the Council of Governors. They wished Mark the best for the future.
b) Governor Elections are complete and they will attend the next Council meeting on 22 May 2024.
c) Programme of public events is being prepared and this will encourage engagement and learning.
d) David was honoured to be part of the Freedom of Medway event, he is extremely proud of the Trust.

Check and Challenge

Chair – newly elected governors will start in June following elections. Chair thanked the Staff Governors for joining the Board meeting and the Lead Governor for his good wishes.

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

2.5 **Constitution – Review**

Matt Capper gave a verbal update for noting. It is part of the annual work plan to check the Constitution is fit for purpose. There have been changes in regard to the Chair/NEDs and best practice within tenure.

When complete the document will be submitted to the Board and the Council of Governors.

The Board **NOTED** the update.

3 Board Story Presentation

3.1 There was no Board story in May 2024.

4 Board Assurance Committee Updates

4.1 **Quality Assurance Committee**

Alison Davis and Sarah Vaux presented the report for the meeting held on 11 April 2024 and 02 May 2024.

a) Areas of risk identified are ongoing but there were no escalations to Board.
b) Sustained improvement in avoidable 2222 calls and ongoing work in terms of learning from deaths.

Check and Challenge

Jenny – the QAC Committee are seeing improvements, thanks to Alison and Sarah.

The Board was **ASSURED** and **NOTED** the reports.

4.2 **People Committee**

Leon Hinton presented the report for the meeting held on 15 March 2024.

a) There are no escalations to Board. The people strategy was scrutinised. Update on the Staff Survey results for 2023; there have been improvements but work to do.
b) KPIs will be picked up under the IQPR later in the Board meeting.
c) New BAF risks were discussed.

Check and Challenge

Chair - Staff appraisal rates were deteriorating but the Trust are monitoring – what is the progress?
Leon – there is a further decrease and it is lower where we should be, work to improve commenced. The appraisals are being done but there has been a delay in recording.

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

4.3 **Finance, Planning and Performance Committee (FPPC)**

Alan Davies and Gary Lupton presented the reports for the meetings held on 28 March 2024 and 25 April 2024.

There are no escalations to Board. There are items to discuss from Committee on the Board agenda.

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

5 Public Board Papers

5.1 **Perinatal Culture Leadership Report**

Alison Herron presented the report in line with the paper submitted, advising the aim 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.

The Board **NOTED** the update

5.2 **Perinatal Quality Surveillance Report**

Alison Herron presented the report, summarising the quarterly position:

a) 355 Maternity Incidents reported via Datix
b) 24 NICU incidents
c) 4 MSNI referrals
d) 79 MDT incident reviews at CRIG
e) 1 AAR case
f) 11 MBRRACE reportable cases in Q4
g) >98% compliance for Foetal Monitoring Training for all staff groups.
h) Overall mandatory training compliance increased to 86.76%
i) Improvements required in obstetric emergency training and some mandatory training topics.
j) 11 risks in maternity and 2 in neonatology – Midwifery workforce (20) and Maternity Information System (15)
k) Staff and Service user feedback, including launch of CQC Picker Survey 2024 and Co-production charter.
l) CNST Year 6 published 02 April 2024.

The Board **NOTED** the report.

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

Alison Herron presented the report highlighting a review of the claim's scorecard for the past ten years alongside current incidents and complaints:

a) 55 Claims from 2013-23
b) 15 SIS/PSIRF investigations from December 2022 to March 2024
c) Outcomes of claims and incidents reviewed.
d) Increased numbers of HIEs noted in Q4 incidents however no thematic or root cause correlations. Continue to monitor.

<u>Check and Challenge</u>

Jenny – great to see the Trust is at Phase 3, has there been any learning from Phases 1 and 2. How will the learning be communicated across the Trust? Alison H – the team do not want to be isolated so this has been picked up through QPSSC, in regard to wider sharing. Will discuss how this works with Sarah Vaux and Wayne Blowers. The Culture Survey is already Trust wide on GATHR.

Jayne – good news that the business case is progressing – what is the system proposing? Must make sure the right IT solution is in place. Alison H – there was a system wide group reviewing what is the best solution, currently the Trust use Badgernet. It is looking likely that this will continue to be used and the case is going through procurement process and options appraisal.

Jayne – great to see training in safeguarding improving, there are however still issues in resus training. Alison H – this is being monitored through management team, if there is non-attendance it is addressed.

Jayne – what about safeguarding in the community? Alison H – work is progressing in the community teams, a named midwife is attending meetings alongside a safeguarding lead.

Jayne – improvements are being seen in recruitment, can you inform the Board what mitigations are in place around risks in staffing issues? Alison H – there are high numbers of vacancies but good gap fill rates, revised bank rates, escalation processes in place up to high cost agency, also to on call, specialist midwives/senior sisters/matrons and above, community midwives on call.

These improvements are an outcome from the consultation in 2023. Escalations/risks will come through to Board from QAC.
Jayne – well done to the team for the incredible 'Virtual Ward' it is the first in the country. Alison H – it is working well to date, still need to build up as it is early days.
Gavin – there are some other IT solutions to discuss so will have the conversation with Alison H.
Alan – with the new bank rates and improved fill rate; does this give a risk and are there mitigations. Alison H – yes, it is a risk but will continue to discuss with the Executive team. Sarah – the team are assuring quality, maintaining safety but also focusing on costs.
Martina Rowe (Governor) – what are we doing about newly qualified students who refuse a job offer - an external query was raised by a potential candidate about the Trust's interviewing technique? Alison H – will discuss with Martina outside of Board. Leon – confirmed the Trust use value-based questions as a standard so will discuss with Alison H.

The Board **NOTED** the report.

5.4 **Emergency Preparedness, Resilience and Response - Policy**

Nick Sinclair presented the policy which ensures the Trust compliance with its duties as a category one responder organisation under the Civil Contingencies Act (2004). This enables the Trust to ensure effective arrangements are in place to deliver appropriate care to patients during an emergency or incident that disrupts normal service delivery.

This Policy outlines the roles, responsibilities and delivery of Emergency Preparedness, Resilience and Response (EPRR), to achieve organisational resilience in accordance with national legislation and local policies, guidance and frameworks

Check and Challenge
Gavin – could Nick add the standard around training and requirements – should there be a section on it? Nick – yes, this can be added for the next review.
Jenny – do the reports come to Board on a regular basis – when is this due? Matt - There is annual continuity information. These reports will come through to the ARC and assurance to Board.
Jenny – do we partner with other trusts – can we mutually support each other? Nick – there is an exercise diary and register. Recently there was a table top exercise on how to deal with a complete power outage. There are varying scales on exercises.
Mojgan – what are the key elements in regard to access to drugs/controlled drugs, would expect to see a section on roles and responsibilities, could the policy capture this? Nick – will take this away and check, but this will be in each departments business continuity planning.

The Board **APPROVED** the Policy

~ Wellbeing Break ~

5.5 **Finance Report**

Alan Davies presented the report, with the following highlights the following:

a) The Trust reports a position of £19.9m deficit reduced to £19.7m after adjusting for donated assets, this being an in-month improvement of £0.3m
b) The Trust delivered the Month 7 forecast position of £19.7m as agreed by the Executive Team with the Integrated Care Board.
c) Efficiency delivery to date includes £11.9m of out of budget schemes, and a further £1.9m of run-rate reductions, and £2.7m of cost avoidance schemes, reporting the total efficiency delivery of

£16.5m YTD. In addition to this there is a further £2.8m for capture and coding work from the ERF to increase income.

d) The final capital position breakeven as schemes were prioritised to utilise all funding available.
e) Cash is £8.5m adverse to plan due to the unplanned deficit position.
f) Bank and agency spend decrease in Month 1.
g) Delivered the capital target.
h) No criteria to reside – the Trust is about 100 beds short.

Check and Challenge

Gary – the FPP Committee have been discussing; what is the value of the 120 beds – could this be better spent in the health economy and share this across other providers?

Chair pointed out that capture and counting could be applied either to efficiencies or as income from ERF.

The Board **NOTED** the update.

5.6 **Annual Business Plan**

Gavin MacDonald and Alan Davies presented the plan providing the Board with an update on progress of all aspects of business planning and the Trust reaching the proposed activity, workforce and financial plans that are triangulated. The Executives undertook a rigorous check and challenge process with clinical divisions, including scrutiny of overspends and cost pressures. The financial plan remains a deficit of £29m. Further scrutiny of the overspends and cost pressures is due to be undertaken by Trust Executives before the final submission in June 2024.

Check and Challenge

Gary – the update on risks is useful and hoping for ongoing monitoring at FPPC, currently the position is more positive.

Gary - Capacity and demand gap – would be useful to understand this more. Could the table have the previous few years of plan and actual activity – so we can see the year on year growth. This will help us plan ahead and predict future activity levels based on historical growth. Jayne – yes.

Jayne – team are more confident in the control and mitigations now. Actions, processes and initiatives are put in to reduce amount of escalations.

Sarah – the reduction in bank work has been successful but with safety in mind – it has not compromised safety. It has been a quality and financial benefit.

Chair – well done for spending the capital.

The Board **APPROVED** the business plan.

5.8 **Green Plan – Review**

Nick Sinclair presented the report advising the Board in October 2020, the NHS became the world's first health service to commit to reaching carbon net zero. This commitment was made in response to the significant and escalating threat to health posed by climate change. The NHS has established a clear ambition along with two evidence-based targets:

a) Net zero by 2040 for the NHS Carbon Footprint
b) Net zero by 2045 for the NHS Carbon Footprint Plus

The Trust's formal Green Plan issued during 2020/21 provides an organisation-wide strategy that outlines the Trust's plan of action necessary to achieve the targets within the Greener NHS Net

Zero Programme. The Trust has received £25.9m in funding for various projects including replacing windows to reach carbon net zero.

Check and Challenge
Gary – fantastic news on the funds – patient experience will be improved with double glazed windows.
Chair – how much in addition to this will we need to spend to deliver the plans? Nick – sitting alongside the green plan is the Development and Control Plan but this will be monitored with funding streams to enable the Trust to develop the site to modern healthcare delivery.

The Board **NOTED** the plan.

6 Performance, Risk and Assurance

6.1 **Integrated Quality Performance Report – March 2024 (Refreshed)**

The Executives presented the report for noting on their True North Objectives.

a) Sarah Vaux, Chief Nursing Officer (Interim)
Highlighted the data in the report for: Friends and Family Test, improving staff behaviour to improve care and reduction in numbers for mixed sex accommodation (MSA).

b) Alison Davis, Chief Medical Officer
Highlighted the data in the report for: Mortality metrics, Learning from Deaths, Fractured Neck of Femur, EDN backlog.
Jayne – good news in regard to reduction in MSA, violence and aggression has decreased and the Board appreciate the good work around this. Sarah – it is a positive story and work is looking at accuracy and capture of data. Flow is improving is reducing the incidents. Violence, Aggression and Security group is now re-established. Uptake of security one day training has been excellent, high numbers of staff are engaging to give them the skills to intervene and prevent violent incidents. Alison – red and yellow card system links through to safeguarding and flags if patients are vulnerable.
Jayne – C-Diff numbers have increased; what work are we doing with this? Sarah – it is the cumulative total at year end, the Trust is not an outlier.
Chair – is there new IPC lead in place? Sarah – yes, Steph Gorman continues to support the ICP lead. Team is working effectively.
Mojgan – queried the SJR targets that have been listed in reports. Alison – the reports are almost finalised and will come through the governance process. The target may be slightly too high so the team must embed the SJR process. It is crucial to identify positive learning and how to share best practice; also where the learning opportunities are.
Chair – Board will do more work on SJR in the future – this was discussed at last weeks' Board Development session.

c) Nick Sinclair, Chief Operating Officer
Highlighted the data in the report for: Referral to Treatment, Ear Nose and Throat, Endoscopy, DM-01, Cancer Targets, Wait Times and Discharges.

d) Leon Hinton, Chief People Officer
Highlighted the data in the report for: Staff Survey results, Staff Leavers, Intention to Leave Process, KPI rating, Vacancy Rate, Voluntary Turnover, Appraisal Rate, StatMan Training, Bank and Agency Spend, Apprentices, Sickness Rates, EDI and Medical Education

e) Alan Davies, Chief Financial Officer
Covered highlights through the meeting and had nothing to add.

The Board **NOTED** the updates.

6.2 **Risk Register – Refresh Update**

Matt Capper, gave a verbal update for noting. The team are working through the refresh, how risks are reported and are integrated into the organisation. There has also been a review of the Risk and Assurance Group and its governance process. There will be quarterly reporting.

The Board **NOTED** the update.

6.3 **Board Assurance Framework (BAF) - Refresh**

Matt Capper, presented the refreshed BAF, this refresh process is ongoing. The refresh is about re-prioritising strategic risks. There is a focus on Patient First but overlaid with operational risks for clarity around each risk. Work is progressing. Matt will do the work on mapping.

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

7. Closing Matters

7.1 **Questions from the Public**

There were no questions received from the public.

7.2 **Risks Identified**

No new risks identified.

7.3 **Reflection**

This is chair's last board meeting having been a NED for a little over seven years. Jayne thanked Mark for his dedication to the Trust and wise counsel to her.

7.4 **Any Other Business**

Chair - Plea to the Executive team to remember that the hospital charity has funds to be spent for the benefit of patients and staff. There is formal process follow and Donna Law is awaiting requests.

Chair – the League of Friends have been incredibly generous and donate around three hundred and fifty thousand pounds to the Trust annually. They have given the Trust in excess of £5m over the years. As a charity they are required to spend, or at least allocate their profit by their year end of July 2024 and have asked us to give them a list of items we would like, for them to consider.

7.5 **Date of next meeting**

Wednesday, 17 July 2024

The meeting closed at 15:30

These minutes are agreed to be a correct record of the PUBLIC Trust Board Meeting of Medway NHS Foundation Trust held on Wednesday, 15 May 2024

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

Chief Executive's report: July 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.

Welcoming our new Trust Chair

I would like to formally welcome our new Trust Chair, John Goulston, who joined us on 1 June. John is an experienced chair and former chief executive in healthcare, who has led a range of NHS organisations in London and is also well-known in the Kent and Medway NHS system.

I would also like to thank Mark Spragg for all he has done for the Trust as a Non-Executive Director over the past seven years, and for taking on the role of Acting Chair more recently.

New Trust Governors

I would also like to welcome our recently elected Governors whose terms began this month.

- **Public Governors representing Medway** – Tina Rowe (re-elected), Carol O'Meara, Candice Penfold, Natasha Turner, Stephen Worth, Hari Aggarwal (re-elected), Anna Krzyzanowska and William Ruscoe.
- **Public Governors representing Swale** – Tess Fenn, Paul Riley, Jay Patel (re-elected) and Christine Palmer.
- **Staff Governors** – Donna Findlater, Matt Taiano, Yushreen Vadamootoo, Karen Fegan (re-elected) and Joy Onuoha.

Sincere thanks to our Staff and Public Governors who have recently completed their terms. Their contribution to ensuring that the views of our patients, public and colleagues are heard is sincerely appreciated.

Improving emergency performance

In recent months we have made many changes to improve how it feels to be in our care, particularly in our Emergency Department (ED).

We have made significant progress in reducing overcrowding in the department and waiting times for emergency care have improved significantly. In May, 78.4 per cent of patients attending ED were seen, treated, discharged or admitted within four hours, up from 65 per cent in December, and exceeding the national target for the third month.

This sustained progress is significant given the continued challenges with the flow of patients to out of hospital care, with a stubbornly high number of patients who are medically fit to leave our wards. We continue to work closely with our system partners to address this so that we can get more of our patients to the care they need sooner.

We have introduced a new acute and emergency medical model, a new same day emergency care service for frail patients, and in April we opened a new 32 bed ward for patients with serious breathing or heart conditions – all of which are helping to reduce delays and improve care.

More broadly, over the last year, we have seen improvements in the number of people recommending our care, particularly from inpatients, those having day operations and giving birth with us.

These improvements, driven by our Patient First priorities, are made possible by the ongoing commitment and efforts of our hard-working teams.

Using technology to release up time to care

Underpinning some of this progress is our bed management system, Teletracking, which provides real-time visibility of the beds available across the hospital. Staff operating the system from our Care Coordination Centre can see at a glance when a patient is waiting to be admitted, if beds are occupied, when beds need cleaning and are ready to be allocated, or have already been allocated, as well as when patients are due to be sent home. Since being introduced last September, the system is helping us move patients into beds on wards faster and releasing thousands of hours of nurse time to care for them.

Trust team shortlisted for national patient safety award

I am delighted that an initiative that has helped us reduce waiting times and improve outcomes for patients requiring emergency surgery has been shortlisted for the Urgent and Emergency Care Initiative of the Year at the annual HSJ Patient Safety Awards.

The initiative brought together teams involved in emergency surgery to identify and remove barriers that delayed patients' operations. As a result, the team has introduced a series of measures to help reduce delays and improve care, and we are seeing more patients through this specialist operating theatre, so they are getting the treatment they need sooner. Not only has this benefited our patients, which was our main focus, it has helped build staff morale and improve wellbeing. Using the theatre more efficiently also saves us almost £100,000 per year.

Unveiling our new pharmacy robot

A project to replace our dispensing robot in the hospital Pharmacy with a new and more technologically advanced machine has completed, thanks to £850,000 investment. The new robot, a tandem machine, named 'Bert' and 'Ernie', is more efficient, more reliable, and able to hold much more stock – about 20,000 packs of medications, increased from 12,000.

Top marks for cancer unit

I would like to acknowledge our Macmillan Cancer Care Unit for receiving an award for the services it provides to help support people living with cancer and their families. It achieved the Macmillan Quality Environment Mark after it scored five out of five following an assessment of Galton Day

Unit, inpatient services on Lawrence Ward, shared spaces, information resources and staff areas. The review also included feedback from both patients and staff. The report said the unit 'exceeded the level required to retain the Macmillan Quality Environment Mark and is to be congratulated on this achievement.'

New PALS Hub

I am pleased to report that our Patient Advice and Liaison Service (PALS) Team has opened a hub in the hospital main reception where patients and visitors can speak to the team face-to-face about any problems or concerns they may have about our services, if they have been unable to resolve after speaking to staff. This is just one of the many ways we are working to improve the patient experience by ensuring they, as well as their loved ones and carers, feel listened to, and any necessary actions are taken at the earliest opportunity, so they don't take their troubles home with them.

Marking a special anniversary

Earlier this month colleagues old and new, patients and relatives gathered for a special exhibition at the hospital to mark the 25th anniversary of maternity services and the Oliver Fisher Neonatal Unit transferring from All Saints Hospital in Chatham to Medway Maritime Hospital.

As well as displays of photos and memorabilia our midwives and neonatal nursing staff spent talking to patients and visitors about their work, advances in medicine and technology, and the different services we offer compared to what was available back in 1999. It is remarkable to consider how far services have come in that time.

Celebrating our Medway Stars

Finally, it is rare that we have the opportunity to bring staff together to acknowledge their excellent patient care which is why our Medway Star Awards ceremony, on 13 June, was a particularly special moment. Our Star Awards recognise and reward those who have gone the extra mile, or shown great passion and commitment to making our services the best they can be for our patients and colleagues.

The gala event, our first since before the pandemic, saw 11 awards presented, with nominations from staff and local people. It was an incredibly special evening, with colleagues who had been shortlisted sharing with very moving stories on video throughout the evening.

I could not have been prouder, and I know I speak for the whole Executive Team in saying it was a highlight of the past 12 months. We could clearly see evidence of how our Patient First programme is leading to improvements for patients, but these changes wouldn't happen without the commitment, compassion and drive of our staff.

The Meeting of the Public Trust Board
Wednesday, 24 July 2024

Meeting	Council of Governors Public Meeting – 22 May 2024		
Title of Report	**Assurance and Escalation Report**	Agenda Item	2.4
Lead Director	Matt Capper – Director of Strategy and Partnership and Company Secretary		
Report prepared by	Emma Tench – Assistant Company Secretary		
Report Approved by	Mark Spragg – Acting Chair		
Executive Summary	This report is tendered by the Council of Governors. The report enables escalations from the Council of Governors to be directed to the Trust Board for review and comment. The Council of Governors meeting covered the following items: • The council were presented with the final draft of the annual report and accounts and a period of question and answer took place before the council moved to approve both documents. The documents were escalated to the Audit and Risk Committee for ratification. • Patient engagement - Governors were given a presentation by the Associate Director of Patient Safety, on the process for raising complaints, Friends and Family Testing (FFT), enhanced care and the trusts dementia buddy service and an opportunity to ask questions and feedback issues that had been brought to their attention through their work as public and staff governors. • Governor elections – An update on the progress of the Governor elections was provided and a general discussion took place about the governor development programme for 2024/2025. • The council reflected on its recent decision with regards to the appointment of a new trust Chair and took the opportunity to thank Mark Spragg for his service as the Senior Independent Director and Interim Trust Chair. • The trust constitution refresh for 2024 was discussed and council members were advised that they would be sent draft amendments for comment, discussion and approval ahead of the trust Board in July. There were no items for escalation to the Board at the meeting held 22 May 2024.		
Recommendation/ Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	None			

Reports to committees will require an assurance rating to guide the Committee's discussion and aid key issues reporting to the Board	
The key headlines and levels of assurance are set out below:	
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

Meeting	Meeting Date	Group Chairs
Council of Governors	22.05.24	**Mark Spragg – Trust Chair** **David Brake – Lead Governor**

Number of attendees	Number of apologies	Quorate	
		Yes	No
10	7	x	

Declarations of Interest Made

No declarations of interest received against any agenda item.

Assurance received at the Group meeting

1) Governor were presented with the Annual Report/Accounts – the report was **APPROVED** by the council.
2) The Governors were assured that the elections were proceeding as planned and would be completed in line with the election roadmap shared at the previous meeting.

Key actions

Key actions from the meeting:

1) Head of PALS to be invited to the council meeting in November 2024 to provide an update on patient's complaints process and its current performance.
2) The council requested that a pre-meeting, led by the Lead Governor and independent of any members of the trust, be added before each Council of Governor meetings.

Highlights from sub-groups reporting into this group

- The Trust Finance, Planning and Performance Committee submitted the draft accounts for consideration by the council.

Items to come back to the Group

- An item describing a draft governor development programme for 2024/2025. – Next meeting

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

Item	Group, Subcommittee, Committee	Date
Annual Report and Accounts	Audit and Risk Committee	20 June 2024

Reports not received as per the annual workplan and action required

None
Items/risks/issues for escalation
None
Implications for the corporate risk register or Board Assurance Framework
None
Examples of outstanding practice or innovation
1) Governors and Executives extended their thanks and appreciation to Mark Spragg and the Governors who have come to the end of their term of office.

Meeting of the Trust Board
Wednesday, 24 July 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Constitution Review</td><td>Agenda Item</td><td>2.5</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">Matthew Capper, Director of Strategy and Partnership & Company Secretary</td></tr>
<tr><td>Executive Summary</td><td colspan="5">An NHS foundation trust's constitution is the central document which establishes the fundamental principles and processes the directors and council of governors of a foundation trust must follow.

The trust constitution follows the national model and the presence of a constitution is mandated by the requirements set out in Health and Care Act 2022. The annexes to the constitution provide the trust with an opportunity to set out how its board and council of governors will function and work together, these are referred to as the Standing Orders.

A constitution with inadequate or outdated provisions will result in difficulties when it comes to implementing change and making decisions. As it is a statutory and regulatory requirement our constitution is viewed by our regulators under the banner of "well led". It is therefore important that the constitution is regularly reviewed and updated to reflect best practice and reflect organisational practices.

The following amendments have been made to the trust constitution (V3.0):

• Section. 22.2.2
Number amended to reflect the current board composition.

• Section .24.7
Removal of the ability to reset tenure following a change in role. Now in line with best practice.

• Annex – 5, Section 2.8.1
Number amended to reflect the current board composition.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">The Board are asked to approve the amendments and adopt the amended Constitution.</td></tr>
<tr><td rowspan="2">Purpose of the report (Please mark with 'X' the box to indicate)</td><td>Assurance</td><td></td><td>Approval</td><td colspan="2">x</td></tr>
<tr><td>Noting</td><td></td><td>Discussion</td><td colspan="2"></td></tr>
<tr><td><u>Governance Process</u>: Committee/Group and Date of approval:</td><td colspan="5">Council of Governors approval via email – June 2024</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Please mark with 'X' 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>
</table>

	X				X
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: X
Identified Risks, issues and mitigations:	Amendments to any aspects of the constitution that cover the operation of the council of governors are required to be submitted to NHS England for approval. The amendments made to the document for approval do not make changes to the operation of the council of governors.				
Resource implications:	There are no resource implications to refreshing the constitution.				
Sustainability and /or Public and patient engagement considerations:	The revised constitution follows the national model template and meets the required equality tests. There are no green sustainability elements to this document. The engagement considerations have been achieved through the approvals process followed (see committee/group sign off route above).				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☒ Not applicable				
Legal and Regulatory implications:	The trust has an existing approved constitution so there is no legal implication with non-approval of this version as the amendments are not significant.				
Appendices:	Constitution Document (V3.0)				
Freedom of Information (FOI) status:	Tick either: ☒ This paper is disclosable under the FOI Act ☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.				
For further information please contact:	Name: Matt Capper Job Title: Director of Strategy and Partnership & Company Secretary Email: m.capper@nhs.net				

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

Meeting of the Trust Board
Wednesday, 24 July 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Patient Experience Story to Board</td><td>Agenda Item</td><td>3.1</td></tr>
<tr><td>Author</td><td colspan="5">Nikki Lewis, Associate Director of Patient Experience</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Sarah Vaux, Interim Chief Nursing Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">This report covers the experiences of Dr Rosie Chester with her mother on Lister ward in August 2023</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">A clear description of what the board/committee is being asked to agree/discuss/note.</td></tr>
<tr><td rowspan="2">Purpose of the report (Please mark with ‘X’ the box to indicate)</td><td>Assurance</td><td></td><td>Approval</td><td colspan="2"></td></tr>
<tr><td>Noting</td><td>x</td><td>Discussion</td><td colspan="2">x</td></tr>
<tr><td><u>Governance Process</u>:

Committee/Group and Date of Submission/approval:</td><td colspan="5">n/a</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">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)
x</td><td>Priority 4: (Quality)
x</td><td>Priority 5: (Systems)</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Please mark with ‘X’ the CQC domain the report aims to support:</td></tr>
<tr><td>Safe:</td><td>Effective:</td><td>Caring:
x</td><td>Responsive:
x</td><td>Well-Led:</td></tr>
<tr><td>Identified Risks, issues and mitigations:</td><td colspan="5">n/a</td></tr>
<tr><td>Resource implications:</td><td colspan="5">n/a</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="5">n/a</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="5">Please tick the correct box and provide required information.
Has the quality and equality assessment been undertaken?
☐ Yes (please attach the action plan to this paper)
☐ Not applicable</td></tr>
</table>

Legal and Regulatory implications:	n/a.		
Appendices:	Presentation of patient story		
Freedom of Information (FOI) status:	Tick either: ☐ This paper is disclosable under the FOI Act ☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.		
For further information please contact:	Name: Nicola Lewis Job Title: Associate Director of Patient Experience Email: nicola.lewis18@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable	x	No assurance required.

Patient Story to Board

Dr Rosie Chester,
BMBS MRCP PGDip Palliative Medicine

Nikki Lewis, Associate Director of Patient Experience

Mum - Christine Chester

A mother, wife and Nanny

- Mum was a rock chick at heart, which she passed onto me
- She had been battling with breast cancer for 14 years
- She had a great quality of life, right up until the last few weeks
- She loved her garden; that's where she is now….
- I trained at MFT as a junior doctor and have always been proud to work for and be associated with MFT
- I now work as a Consultant in Palliative Medicine at Wisdom Hospice, and in-reach into MFT

Admission

- Mum was still on active cancer treatment, but had been feeling poorly for a couple of weeks
- Tested positive for Covid and put her ‘feeling under the weather’ down to that over anything more sinister
- Went for pre-chemo bloods and was contacted in the afternoon to attend ED because her kidneys and LFTs were deranged
- Care received in ED was good; had her own room, nurses were attentive, medical team were good and visiting was open
- They felt with IVI she would improve – DNACPR discussed, but all in agreement she should remain for resuscitation
- Remained in ED because of lack of beds for nearly 48 hrs
- Moved overnight to Lister - NoK was not informed, mum had no means to contact us
- Was fed up and in a lot of pain
- Because she was so distressed and uncomfortable / in pain she found it difficult to concentrate and carry out normal activities

Lister Ward

- Brother attended in the morning – went to ED and found out she was moved. Went to Lister but told visiting wasn't until the afternoon
- They did let him in to say hello – he had travelled from London
- As she was Covid positive, she was in a side room in the ward with the door shut, and 'out of sight'
- Ward were militant in us using PPE, despite her being positive for 4 weeks and the guidance would suggest she no longer required to be isolated. I tried in vain to argue this
- Call bell wasn't in reach when I arrived. She was in tears in pain even though she had asked for pain relief an hour before, this hadn't been administered

Ward Care

- I tried to track down a nurse, and family members for the patient in bay opposite also required help.
- Took almost an hour for someone to come and attend to her and patient opposite
- The medication they brought mum was morphine, which is inappropriate for her medical condition (due to her poor kidney function)
- Exasperated, I said to just give it to her because I don't want her in pain any longer and I will watch her to make sure she doesn't stop breathing
- She should have had oxycodone but they didn't have this on the ward so they gave her morphine instead.
- I was concerned and wanted to speak with someone from the medical team but told there was no one to speak to
- This left me feeling angry, worried, anxious and frustrated

Ward care

- Following day I arrived at 2pm (earliest visiting) she was in tears, she had asked for pain relief but hadn't had any
- My dad had also had to clean up urine from her floor where her catheter had leaked and when he told a nurse they just threw a towel on the puddle, so he mopped up
- I felt I had no alternative but to contact my colleagues in the hospital palliative care team as it was a Friday afternoon, even though we didn't know she was palliative at this point. I needed her symptoms to be controlled.
- They came quickly and advised a syringe driver with Alfentanil and an anti-sickness drug. This would be standard practice for patients with significant pain in palliative care if they are in renal failure
- No alfentanil on the ward so one of the palliative care team ordered this from pharmacy and assisted the nurse with preparing the syringe driver as they were not familiar with this treatment on the ward
- I was then able to speak with the medical team as I was able to exert my position somewhat to be able to gain this information. I may not have had this opportunity if I were a lay person. I was taken to an office and spoke with the Consultant and Registrar.

Communication

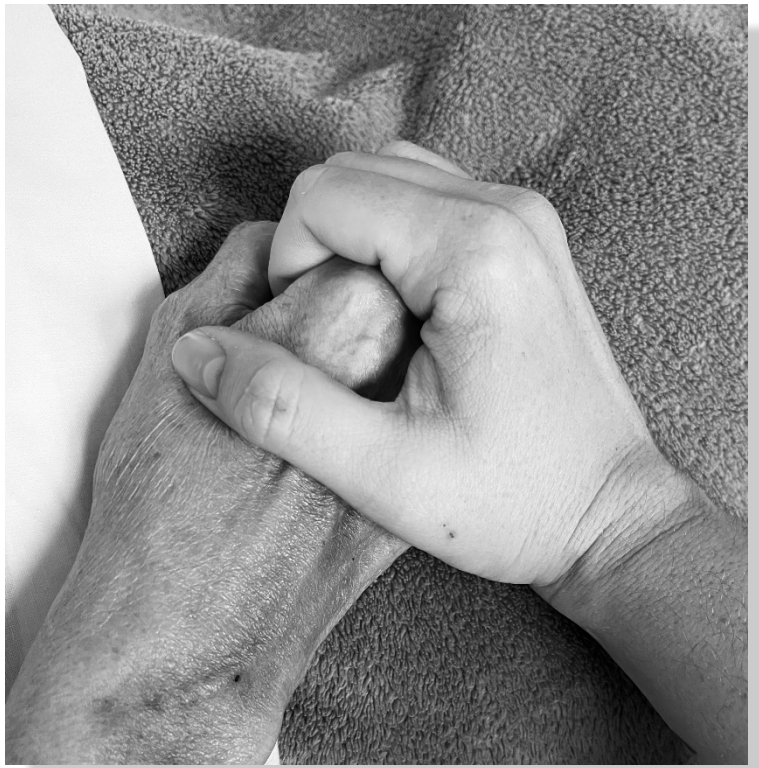
- The communication issues were significant
- Mum's information was shared with me in the first instance as opposed to mum herself, despite her still having capacity. Particularly around DNACPR and ceilings of care
- I felt this was because they were speaking to me as a medical colleague, not my mum's daughter
- I asked if they would go on to have these conversations with Mum which they assured me they would, but they didn't
- I was left to have those conversations with her on my own which was highly distressing for me, and has played a significant part in my subsequent grief

Communication

- 4 hours later when my brother arrived the syringe driver was still not in place, despite it having been prepared during my visit – it was put up during his visit, but this was clearly very delayed
- On the Saturday afternoon she became confused and agitated
- I found out from the Palliative Care Team she had been seen by ART and ICU overnight and a ceiling of treatment applied. This had not been communicated with us as a family.
- She was still in a lot of pain – writhing around in bed unable to get comfortable and only once did she receive top-up pain medication

Hospice

- I explored admitting her to the hospice, and for transparency I am one of the admitting consultants for the Wisdom hospice however I was not on call / the admitting consultant when my mum was referred – I was on leave from work
- No doctors available at MFT so I had a conversation with mum myself; no more they can do for you, you are going to die. I asked her, do you want to get out of here? Unsurprisingly she said yes please.
- Transferred to hospice the next day (Sunday)
- I was present with her at MFT from 8am to ensure a quick and smooth discharge
- Immediately on arrival at the hospice, she was made comfortable
- We went outside on the patio and felt the sun on her face
- She didn't wake up again. She passed away peacefully in the early hours of Tuesday morning, just over 24 hours after she was admitted to the hospice.



Final comments

- I was disappointed in the care my mum received at MFT, and seeing her cry in pain will forever be etched in my memory
- As a colleague, I was even more disappointed because I know for certain that it could have done better
- Working in the hospice, unfortunately mum's is not the only story where care was less than adequate
- Working hard with hospital palliative care and end-of-life teams to improve care and communication for patients like mum – still a long way to go, but I am proud of what we have achieved so far
- I will continue to strive for better PEOLC in MFT, in her legacy

Meeting of the Board of Directors in Public
Wednesday, 24 July 2024

Title of Report	Quality Assurance Committee – 06 June 2024	**Agenda Item**	4.1
Author	Alison Davis – Chief Medical Officer Sarah Vaux – Chief Nursing Officer		
Committee Chair	Paulette Lewis, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Risk Register – Quality and Safety The committee reviewed the risk register and discussed risks rated extreme including controls and mitigations. The Committee were **ASSURED** and **NOTED** the report	
2. Assurance and Escalation Reports from Quality Patient and Safety Sub-Committee (QPSSC) The Committee received the report and noted the areas reviewed within the subcommittee, this included assurance and escalation reports from its reporting assurance groups and noted the key items raised and the actions described to manage them: • Accessible information standards and work on-going. • IPC update. • Safeguarding report and noted on-going oversight of compliance against L3 safeguarding training. • Teletracking flagging visibility. • Oversight of incidents and trajectory for closure. • Work to strengthen oversight of NatSSIPPS. • Improvement work within ED. Closure of the ED escalation area.	

The committee requested further information the status of availability and quality of mattresses available to the organisation. A report has been requested to review by the committee. Praise received from a Governor whose mother was treated in Tennyson ward, CNO to pass onto staff. The Committee were **ASSURED** and **NOTED** the report	
• **Maternity BI-Annual Work Force Report** The committee received the report and noted: • Gaps in the clinical midwifery workforce are highlighted with mitigations in place. • Ongoing compliance with 1:1 care in labour and supernumerary coordinator. • Full' birthrate plus' conducted in 2023 with support from Trust to implement recommendations. • Good compliance with Fetal Monitoring training and Practical Obstetric Multi-Professional Training (PROMPT) for midwifery staff. MDT training under review. • Breaks review audit taking place. The report highlighted mitigations and planning for maternity wards, especially in relation to newly qualified midwives coming to the organisation in 2025. The Committee were **ASSURED** and **NOTED** the report	
3. Quality Account Sign-Off The Quality Account to be ratified by the ARC on 20 June, delegation of authority from the Trust Board. The Committee **APPROVED** the Quality Accounts.	
4. Annual Legal Report The Committee received the report which highlighting the Trust's performance in respect of legal matters including activity in legal matters including coronial matters and arrangements for disseminating learning from claims and other cases. The Committee **NOTED** the report.	
5. Clinical Audit Annual Report The committee reviewed the report for 2023/24, the report highlights the clinical audits carried out by the organisation, the	

	areas of improvement in Quality Priorities, and the NICE guidance guidelines assessed. The Committee **NOTED** the report.	
	6. Integrated Quality Performance Report (IQPR) The Committee reviewed the Quality and Patient elements of the IQPR. It reported on the quality and patient experience performance across all key performance indicators. Committee noted the triangulation with areas in the quality priorities, on-going MSA and mitigations in place. The Committee **NOTED** and **APPROVED** the report	
	7. Board Assurance Framework Reviewed in line with the report submitted The Committee were **ASSURED** and **APPROVED** the report.	

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:	Quality Assurance Committee – 06 June 2024				

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: ✓	Effective: ✓	Caring: ✓	Responsive: ✓	Well-Led: ✓
Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Board Assurance Framework item.				

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

Meeting of the Board of Directors in Public
Wednesday, 24 July 2024

Title of Report	Quality Assurance Committee – 04 July 2024	**Agenda Item**	4.1
Author	Alison Davis – Chief Medical Officer Sarah Vaux – Chief Nursing Officer		
Committee Chair	Paulette Lewis, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Risk Register – Quality and Safety The committee noted details of: • Endoscopy Unit update • Imaging Equipment • Midwifery Staffing • That the risk relating to the potential closure of SAU will be reduced due to the mitigations in place The Committee were **ASSURED** and **NOTED** the report	
2. Assurance and Escalation Reports from Quality Patient and Safety Sub-Committee (QPSSC) held 27 March 2024 The report highlighted a number of areas. The committee discussed the four months wait time for fitting ambulatory ECG monitors in cardiology, training for Adult Safeguarding and support from the integrated governance teams for the divisions. Further updates to provide assurance was requested at the next Committee meeting.	

The Committee were **ASSURED** the report	
3. Infection Prevention and Control (IPC) Annual Report The committee reviewed the annual report for Infection Prevention and Control. The committee noted Keats Ward as leading the way in simulation training. The Committee were **ASSURED** and **APPROVED** the report	
4. Maternity Safety Self-Assessment Tool Annual Update Report The committee noted that regular updates will be reflected in the maternity BAF which is reviewed monthly The Committee were **ASSURED** by the report.	
5. Annual Complaints Report The committee discussed the positive changes made to address attitudes of staff. The committee were informed of processes in place to ensure patient communication is improving. The Committee **APPROVED** the report.	
6. Clinical Review Process for Breast Surveillance This is a review requested by NHSE for a high-risk patient group. The committee requested an update on the report for the next QAC meeting. The Committee were **ASSURED** by the report.	
7. Learning from Deaths – Quarterly Report The committee requested future reports highlight how learning from deaths is being embedded and cascaded to staff. The Committee were **ASSURED** and **NOTED** the report	
8. Emergency Department (ED) Improvement Plan The committee requested an update to come to the next QAC meeting to give assurance on quality and safety to patients. The Committee were **ASSURED** and **APPROVED** the report	
9. Safeguarding Annual Report	

	The committee requested further information on the demographic of the community within future reports. The Committee were **ASSURED** and **APPROVED** the report	
	10. Research and Innovation Implementation Plan Update The Committee **APPROVED** the update the Plan Update.	
	11. Trust Prevent Policy The Committee **APPROVED** the policy	
	12. Integrated Quality Performance Report (IQPR) Reviewed in line with the report submitted. The Committee **NOTED** and **APPROVED** the report	
	13. Board Assurance Framework Reviewed in line with the report submitted, noting closure of 1B. The Committee were **ASSURED** and **APPROVED** the report.	

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:	Quality Assurance Committee – 04 July 2024			

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

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

Meeting of the Board of Directors in Public
Wednesday, 17 July 2024

Title of Report	Assurance report – People Committee 30 May 2024		**Agenda Item**	4.2
Author	Leon Hinton, Chief People Officer			
Committee Chair	Jenny Chong, Chair of Committee/NED			
Executive Summary	Assurance report to the Trust Board from the People Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	Not applicable			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
Committee/Group at which the paper has been submitted:	People Committee, 30 May 2024			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:			
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.			
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.			
Appendices:	None			
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act.			
For further information or any enquires relating to this paper please contact:	Leon Hinton, leon.hinton@nhs.net			
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions		
	Partial Assurance	There are gaps in assurance		
	Assurance	Assurance with minor improvements needed.		

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

ASSURANCE AND ESCALATION HIGHLIGHT REPORT

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

Declarations of Interest Made

Lorna Gibson, NHSE Improvement Director, at meeting for observation only.

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

Item	Group, Subcommittee, Committee	Date
None		

Reports not received as per the annual workplan and action required

Update in relation to European Paediatric Life Support StatMan compliance	July Committee	

Items/risks/issues for escalation

Issues and or Risks to note: (1) staff appraisals compliance to be checked; (2) Safeguarding Adults L3 and Moving/handling L3 StatMan remain significantly below target; (3)–Occupational Health resource capacity is impacting recruitment, reporting and staff experience, the business case is pending approval

Reflection: (1) Agenda time allocations to be reviewed (2) Content to be reviewed to ensure sufficient time for discussion into strategic issues including culture.

Implications for the corporate risk register or Board Assurance Framework

None recorded

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. IQPR The Committee reviewed the refreshed patient first version of the IQPR. It reported on the workforce performance across all key performance indicators for April 2024. The Committee were **ASSURED** by the report: • True North (Staff Engagement) – [6.65, 0.02 improvement, 0.28 below target] third successive increase; however, ranked score has worsened with the Trust remaining in the further quartile for staff engagement nationally; • Breakthrough (turnover) – [0.8%, 0.6% improvement, on target], now statistically improving SPC methodology; • Staff appraisal – [87.7%, -1.1% deterioration, 2.3% off target] progress remains low; backlog of appraisals to be recorded being resolved; • Vacancy rate – [5%, new financial year, on target] improvements continue for nursing, CSW and particularly strong pharmacy recruitment.	Assurance

• Voluntary turnover – [9%, -0.4% improvement, 1% 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) and now above target of CHPPD target of 9.5; • Sickness absence – [4.1%, -0.2% improvement, 0.1% off target] improvement to long-term sickness however variable short-term sickness. OH business case submitted to support meeting target and improve health and wellbeing of staff; • StatMan – [88.1%, +1.4% improvement, on target] strong improvement over target; improvements across the majority of areas including face-to-face. Particular work with moving and handling training to change delivery method to improve compliance and retain compliance to CSTF standards. This is also a national project to rationalise the increasing demands for StatMan training requirements for staff with the aim of improving standards whilst decrease the training time. An update was provided in relation to DBS compliance. An analysis was done on age profile for the Trust demonstrating a low potential risk for retirements significantly affecting the Trust's ability to maintain staffing levels and how the Trust mitigates risk for specific services through succession planning.	
2. People Strategy 2024-2027 implementation plan and status update The Committee **NOTED** the update on the People Strategy implementation plan, the detailed actions underway and informed that there were no immediate barriers to implementation. No new risks or issues were raised. In the future, the Committee is to receive a status update report evidencing impact on agreed KPIs. Of the 42 activities, 38 were green rated, four amber, and none were red rated. The Committee reviewed the four pillars of i) Becoming an employer of choice; ii) growing our talent; iii) keeping our people thriving at work; iv) delivering new ways of working.	Not Applicable
3. Board Assurance Framework (BAF) and Risk Register The Committee discussed the revised People BAF items, mitigations, actions and gaps in control for items 3d, 3e and 3f. No changes were made to the scoring. The Committee discussed the risk register and requested review of the risk associated with workforce growth. The Committee were **ASSURED** and **NOTED** the report.	Assurance
4. Policies for approval The Committee **APPROVED** the following policies following comment: • Secondment and acting-up policy; • DBS policy; • Equality impact assessment policy; • Conducting stay conversations – managers' guidance.	Not Applicable
5. Health and Wellbeing Guardian Assurance Report Q4 2023/24 The Committee received a report providing an update of the wellbeing dashboard metrics and a migration based on the new guidance; this reported against the newly updated 12 key responsibilities. Medway Fitness Hub continues to increase its membership. Pilates is now offered to staff members at discounted rates. The Committee were **ASSURED** by the report.	Assurance

6. **Anti-Bullying and Harassment Group** The Committee received a report in relation to bullying and harassment data from January 2023 to March 2024 triangulated with data from Datix, exit interviews, employee relations cases, dignity at work advisors, staff network chairs and the lead Freedom to Speak Up Guardian. The Committee will in future receive an assurance report. The report highlighted areas of concerns (location); professional group working concerns and actions to address the concerns. The Committee **NOTED** the report.	Partial Assurance
7. HR and OD Performance The Committee were **ASSURED** of HR and OD performance against workplan, including an improvement to recruitment time to hire and a reduction of annual agency spend by £0.25m.	Partial Assurance
8. People Promise Exemplar Programme The Committee **NOTED** the summary of the programme and the key actions the Trust was taking in preparedness for coordinating and embedding all aspects of the NHS People Promise to improve staff experience and retention following the award of one-year fixed funding from NHS England.	Not Applicable
9. 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. The Committee **NOTED** the report.	Assurance

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Audit and Risk Committee – Assurance Report Meetings held: 20 June and 04 July 2024	**Agenda Item**	4.3
Author	Emma Tench, Assistant Company Secretary		
Lead Executive Director	Matt Capper, Company Secretary & Director of Strategy and Partnership		
Executive Summary	The Audit and Risk Committee is a crucial component of an organisation's governance structure and is responsible for the following key roles: • Financial Reporting Oversight: • Audit Process • Internal Controls and Compliance • Auditor Appointment and Oversight • Regulatory Compliance In undertaking its financial reporting role the committee received delegated authority from the Board on 15th May 2024 to review and approve the annual trust accounts, the annual audit report and to approve any adjustments (if required) to the accounts made after the Board approval. This assurance report highlights the headline items discussed, key risks and items for escalation to the Board. The Audit and Risk Committee meeting of 4 July 2024 focused on the progress against the internal and external audit actions as well as discussing the planned developments for the Risk process. There were no risks or items identified for escalation to the Board.		
Proposal and/or key recommendation:	The Board are asked to note the assurances contained within the report.		

Purpose of the report (tick box to indicate)	**Assurance**	**X**	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 20 June 2024 (approved) and 04 July 2024.				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	**Priority 5: (Systems) X**
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	**Well-Led: X**

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:	Matt Capper – Director of Strategy and Partnership, & Company Secretary.		
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

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

Items/risks/issues for escalation

Issues and or Risks to note:

- No issues or risk noted at meetings

Reflection:

- Cyber and Third-Party Security to be reported to Committee
- New frameworks to be reviewed from July
- Meetings to be held quarterly (plus Annual Report meeting)

Implications for the corporate risk register or Board Assurance Framework
None reported at meetings

Key headlines – The reports were challenged by Committee Members, the answers received gave assurance unless noted below.	Assurance Level
1. **Board Assurance Framework** The Committee were assured the refreshed framework will bring additional mechanisms to assure controls remain effective. The Committee **NOTED** the report for the meeting held 20 June and 04 July	
2. Trust Risk Register The Committee requested updates on actions 15.36 for Estates. The Committee **NOTED** the report for the meeting held 04 July	
3. Integrated Quality Assurance Report (IQPR) The Committee **NOTED** the report for the meeting held 04 July	
4. Annual Report and Accounts The Committee **APPROVED** the Annual Report, for submission to Parliament after the general election and the state opening of parliament has been completed, for the meeting held 20 June.	
5. Quality Accounts The Committee **APPROVED** the Quality Accounts, for submission to Parliament as part of the Annual Report, for the meeting held 20 June.	
6. External/Internal Audit Report The Committee were presented with the following: • Audit finding Report – Grant Thornton • Auditors Annual Report – Grant Thornton • Data Security and Protection Toolkit Report - KPMG • Fit and Proper Persons Report – KPMG • Head of Internal Audit Opinion – KPMG • Internal Audit Plan for 2024/25 The Committee **NOTED** the reports, for the meeting held 20 June	
7. Internal / External Audit Action Tracker Update The Committee requested submission dates to be added to the tracker The Committee were **ASSURED** and **NOTED** the report, for the meeting held 04 July.	
8. Local Counter Fraud Report The Committee **NOTED** the report, for the meeting held 04 July.	

9. Financial Compliance The Committee agreed to add Single Tender Waivers as a standing agenda item, in line with approved governance route for RSM The Committee were **ASSURED** and **NOTED** the report, for the meeting held 04 July	
10. Health and Safety Report 2024/25 The Committee were **ASSURED** by the report, the report to be presented at Trust Board on 24 July 2024, for the meeting held 04 July.	

Meeting of the Board of Directors in Public
Wednesday, 24 July 2024

Title of Report	Finance Planning and Performance – 30 May 2024	**Agenda Item**	4.4
Author	Paul Kimber, Deputy Chief Financial Officer		
Committee Chair	Gary Lupton, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Tele Tracking – Benefits Analysis An update on the deployment of Tele Tracking was given by the COO. Members assured the run rate has been reduced due to the process. A request for information on limited resource in the BI team and if there is a need for realignment and priorities. The Committee **NOTED** the report	Assurance
2. Recovery Support Funding – Benefits Analysis Recovery support funding approved to the Trust, appointing an Efficiencies Director and Programme Director for Counting and Capture, the income covered 72% of their costs. The Committee **NOTED** the report	No assurance required
3. Workforce – Deep Dive Conversation Review of work undertaken to assess the headcount increase in the last 12 months/four years. The target reduction in temporary workforce and associated costs and the progress to date. The Committee **NOTED** the report	Partial Assurance
4. Finance Report M1 The Committee received the paper for Month 1/April 2024, reporting a deficit of £3.6m in month 1. Efficiency programme has under delivered by £0.3m. The capital position is adverse to plan,	Partial Assurance

awaiting approval of the current year programme. Cash at the end of April was £14.3m. The Committee **NOTED** the report, with some gaps in assurance.	
5. Efficiencies Programme Report 2024/25 Currently over 100 cost saving schemes identified with a value of £17.69m. Weekly Exec Check and Challenge continues to ensure transitioning identified opportunities into deliverable savings and mitigate any risks. The Committee **NOTED** the report.	Partial Assurance
6. Digital Data and Technology Strategy Progression The committee were given detailed updates on areas of risk, system wide projects and timelines/next steps. The committee requested a strategic overview report to the committee, including the investment report for the next 3-5 years. The Committee **NOTED** the report.	Partial Assurance
7. Analysis Report on Emergency Department Income and Expenditure The report will be reviewed in full at the June meeting. The Committee **NOTED** the deferral of the report.	No assurance required
8. Planning and Performance; Activity Report PODs showing over-performance against planned levels. Elective activity in consistent increase trend over both 19/20 and 22/23 positions. Non-elective inpatient activity is starting to see a consistent increase in trend. This work is being linked to GIRFT. The Committee were **ASSURED** by the report.	Assurance
9. Model Health Systems The presentation detailed surgery and anaesthetics efficiency schemes for 2024/25. The Committee **NOTED** the update.	Assurance
10. Pre-Submission report as part of 2023/24 National Cost Collection	Assurance

	The report detailed the plan and associated processes that are in place to successfully complete the mandated costing submission for 2023/24. The committee were **ASSURED** and **NOTED** the report.	
	11. Integrated Quality Performance Report (IQPR) The Committee **NOTED** the report.	Assurance
	12. Medical Productivity – Corporate Project Update The report included information on how to optimise productivity within the Trust corporate project. Overview of the current progress, future plans and areas of consideration. The committee **NOTED** the report	Partial Assurance
	13. Board Assurance Framework (BAF) The reports for Sustainability and Systems and Partnership were not presented pending the work to update the template. The Committee **NOTED** the update to the template.	Assurance
	14. Corporate Risk Register The reports for Sustainability and Systems and Partnership were reviewed The Committee were **ASSURED** and **NOTED** the reports.	Assurance

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:	Finance, Performance and Planning Committee – 30 May 2024			

Patient First Domain/True	Tick the priorities the report aims to support:				
	Priority 1:	Priority 2:	Priority 3:	Priority 4:	Priority 5:

North priorities (tick box to indicate):	(Sustainability) ✓	(People)	(Patients)	(Quality)	(Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective: ✓	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	All risk, issues and mitigations are referenced in the Board Assurance Framework item.				
Resource implications:	Individual resource considerations are provided at the Finance, Planning and Performance Committee				
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the Finance, Planning and Performance Committee				
Integrated Impact assessment:	Where applicable, individual considerations are provided at the Finance, Planning and Performance Committee				
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the Finance, Planning and Performance Committee				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Alan Davies, alan.davies@nhs.net				

Meeting of the Board of Directors in Public
Wednesday, 24 July 2024

Title of Report	Finance Planning and Performance – 25 June 2024	**Agenda Item**	4.4
Author	Paul Kimber, Deputy Chief Financial Officer		
Committee Chair	Gary Lupton, Non-Executive Director		
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions	
	Partial Assurance	There are gaps in assurance	
	Assurance	Assurance with minor improvements needed.	
	Significant Assurance	There are no gaps in assurance	
	Not Applicable	No assurance required.	

Key headline and assurance level

Key headline	Assurance Level
1. Financial Report Month 2 The committee requested additional information to quantify the level of risk, the value of risk and the mitigation. The Committee **NOTED** the report	Assurance
2. Activity Report The committee requested additional: • Overall summary on the headlines and what this means for income, to triangulate. • Return on investment and cashing up, what have the benefits been The committee **NOTED** the report	Assurance
3. Finalised Finance Plan – Operating Plan Resubmission The committee **APPROVED** the plan	Not applicable
4. RSP Integrated Improvement Plan The committee noted the plan was ratified at the Extraordinary Trust Board meeting on 27 June. Cited at Regional Oversight, to be submitted on 30 June. The Committee **APPROVED** the plan	Not applicable

	5. MCH Debt Update The Committee **NOTED** the update	Partial Assurance
	6. Reducing Waste Programme 2024/25 The committee requested additional information on corporate spend, the risks and mitigations for assurance. The Committee **NOTED** the report	Partial Assurance
	7. Integrated Quality Performance Report (IQPR) Systems and Partnerships, and Sustainability was reviewed by the committee. The Committee **NOTED** the update.	Assurance
	8. Board Assurance Framework (BAF) Systems and Partnerships, and Sustainability was reviewed by the committee. The Committee **NOTED** the report	Assurance
	9. Corporate Financial Risk Register The Committee **NOTED** the register.	Assurance

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:	Finance, Performance and Planning Committee – 27 June 2024			

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

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

Meeting of the Trust Board
Wednesday, 24 July 2024

<table>
<tr><td>Title of Report</td><td colspan="3">Maternity Workforce Bi-Annual Assurance Report</td><td>Agenda Item</td><td>5.1</td></tr>
<tr><td>Author</td><td colspan="5">Ali Herron, Director of Midwifery
Kate Harris, Associate Director of Midwifery</td></tr>
<tr><td>Lead Executive Director</td><td colspan="5">Sarah Vaux, Interim Chief Nursing Officer</td></tr>
<tr><td>Executive Summary</td><td colspan="5">• CNST Year 6 continues the requirement for a bi-annual midwifery workforce paper to be presented to Trust Board.
• 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 January 2024.
• Gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this.
• Vacancy remains high at 17.21 WTE. Trajectory in place and anticipate full establishment by May 2025 with graduation of displaced CCCU students from Surrey.
• Midwifery workforce risk (1133) remains the highest risk on the WCYP risk register at 20. This score has been agreed by the CNO and the risk now sits under the Safety domain.
• Ongoing compliance with 1:1 care in labour and supernumerary coordinator.
• Full Birth-rate plus conducted in 2023 and PID to support recommendations from this paper is in final draft.
• Good compliance with Fetal Monitoring training and PROMPT for midwifery staff.</td></tr>
<tr><td>Proposal and/or key recommendation:</td><td colspan="5">Board 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>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 submitted:

Date of Submission:</td><td colspan="5">Maternity and Neonatal Safety Champion Assurance Group – 3 May 2024

QPSSC – 23 May 2024

QAC – 6 June 2024</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">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)
X</td><td>Priority 4: (Quality)
X</td><td>Priority 5: (Systems)</td></tr>
</table>

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 6				
Appendices:	N/A				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email:Alison.herron2@nhs.net				
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance			There are significant gaps in assurance or actions	
	Partial Assurance			There are gaps in assurance	
	Assurance	X		Assurance minor improvements needed.	
	Significant Assurance			There are no gaps in assurance	
	Not Applicable			No assurance required.	

Meeting of the Trust Board
24 July 2024

Title of Report	CNST Year 6 Update Report		**Agenda Item**	5.2
Author	Ali Herron, Director of Midwifery Kate Harris, Associate Director of Midwifery Ellen Salmon, Maternity CNST & Compliance manager			
Lead Executive Director	Sarah Vaux, Interim Chief Nursing Office			
Executive Summary	• CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025 • On track to declare compliance with all Safety Actions. • Monthly reporting via MNSCAG and to Trust Board until submission. • Review and presentation dates agreed with LMNS for key requirements.			
Proposal and/or key recommendation:	Board Assurance			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
Committee/Group submitted: **Date of Submission:**	Maternity & Neonatal Safety Champion Assurance Group 7 June 2024 Women's Care Group 11 June 2024 QPSSC 24 June 2024 QAC 4 July 2024			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) 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	N/A

considerations:			
Integrated Impact assessment:	Has the quality and equality assessment been undertaken? N/A		
Legal and Regulatory implications:	Compliance with CNST Year 6		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Alison Herron Job Title: Director of Midwifery Email:Alison.herron2@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Maternity (and perinatal) Incentive Scheme – Year 6

Update report June 2024

Executive Summary

- CNST Year 6 Published 2 April 2024 with reporting period ending 30 November and submission due 3 March 2025
- On track to declare compliance with all Safety Actions.
- Monthly reporting via MNSCAG and to each Trust Board until submission.
- Review and presentation dates agreed with LMNS for key requirements.

CNST Year 6 Self-Assessment

True North	Safety Action	Description	May 2024
Quality	Safety Action 1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 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 (TC) services in place and undertaking quality improvement to minimise separation of parents 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 Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	

NHS Medway NHS Foundation Trust

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

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.

NHS Medway NHS Foundation Trust

Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?				**On track**
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
1.1	Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?	Bereavement Midwife	All eligible deaths reported within 7 working days. Additional reporter to be added to the system to mitigate LTS.	
1.2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Bereavement Midwife	Parents views sought for all cases and included in PMRT meeting.	
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Bereavement Midwife	Review of all eligible cases completed within 2 months.	
1.4	Were 60% of the reports published within 6 months of death?	Bereavement Midwife	Currently achieving >60% publication within 6 months despite 5 cases being published outside of this time. Change in process for neonatal PMRTs to ensure sign-off/publication within 2 weeks of PMRT meeting	
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	Bereavement Midwife	Quarterly reports to Trust Board in January & May, September, November 2024	
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Bereavement Midwife	Quarterly reports to MNSCAB Dec 2023, February, April, July, October 2024	

Key Messages:

- Currently meeting all reporting requirements for CNST year 6 with appropriate processes in place to maintain compliance.
- PMRT meetings well established and well attended by MDT and external stakeholders.
- Actions from PMRT reviews to be incorporated into central Action Log and PMRT cases to be added to incident spreadsheet to support thematic review in line with other incidents across the service.

Issues, Concerns, Gaps:

- 5 Neonatal cases breached 6 month publication requirement.
- Long-term sick in bereavement team reduced reporters to one.

Actions and Improvements:

- Process review for Neonatal team to ensure sign-off of reports on day of PMRT and publication within 2 weeks.
- Additional reported to be added to support lead bereavement midwife.
- Share learning from PMRT cases via Maternal Compass Governance Newsletter where required. .

True North: System & Partnership

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.

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?				On Track
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only 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 2024? Final data for July 2024 will be published during October 2024.	Digital Midwife	February 2024 scorecard showing pass for 11 out of 11 elements. Continue to monitor monthly and review of July data to ensure compliance.	
2.2	Did July's 2024 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)	Digital Midwife	February 2024 scorecard shows compliance with this requirement. Continue to monitor monthly and review of July data to ensure compliance.	

Key Messages:

- On Track to achieve compliance with Safety Action 2

Issues, Concerns, Gaps:

- EK planning update in June 2024.

Actions & Improvements:

- LMNS and Digital Midwife to review planned update and see if this can be delayed until August 2024 to mitigate the risk of impacting July 2024 data.

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.

Medway NHS Foundation Trust

NHS England

Organisation Name: MEDWAY NHS FOUNDATION TRUST

Reporting Period: February 2024

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	280			Passed
CQIMDQ14	325	350	92.9		Passed
CQIMDQ15	320	320	100.0		Passed
CQIMDQ16	285	320	89.1		Passed
CQIMDQ24	280	285	98.2		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	180	325	55.4	Passed
CQIMDQ08	325	325	100.0	Passed
CQIMDQ09	325	350	92.9	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	325	350	92.9		Passed
CQIMDQ11	150	325	46.2		Passed
CQIMDQ12	20	325	6.2		Passed
CQIMPPH	15	325		46	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	325	350	92.9		Passed
CQIMDQ22	320	320	100.0		Passed
CQIMDQ23	285	320	89.1		Passed
CQIMPreterm	30	315		101	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	325	350	92.9		Passed
CQIMDQ15	320	320	100.0		Passed
CQIMDQ16	285	320	89.1		Passed
CQIMDQ18	155	320	48.4		Passed
CQIMDQ20	5	140	3.6		Passed
CQIMTears	5	140			Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	325	350	92.9	Passed
CQIMDQ15	320	320	100.0	Passed
CQIMDQ16	285	320	89.1	Passed
CQIMDQ18	155	320	48.4	Passed
CQIMDQ26	320	320	100.0	Passed
CQIMDQ27	455	455	100.0	Passed
CQIMDQ28	225	455	49.5	Passed
CQIMVBAC	5	25	20.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	325	350	92.9	Passed
CQIMDQ31	325	325	100.0	Passed
CQIMDQ32	290	325	89.2	Passed
CQIMDQ33	325	325	100.0	Passed
CQIMDQ34	155	325	47.7	Passed
CQIMDQ36	325	325	100.0	Passed
CQIMDQ37	160	325	49.2	Passed
CQIMDQ38	320	325	98.5	Passed
CQIMDQ39	290	325	89.2	Passed
CQIMRobson01	10	45	22.2	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	55	70	78.6	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	40	45	88.9	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	455	350	130.0	Passed
CQIMDQ04	450	455	98.9	Passed
CQIMDQ05	70	450	15.6	Passed
CQIMSmokingBooking	70	450	15.6	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	320	325	98.5	Passed
CQIMSmokingDelivery	60	320	18.8	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	450	455	98.9	Passed

True North: Patients

Safety Action 3: Transitional Care and ATAIN
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

Medway NHS Foundation Trust

Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?				**On track**
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice 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.	Neonatal Clinical Lead	Guideline in place and ongoing audits of TC pathway being completed. Audit findings to be summarised in CNST reports.	
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.				
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	NICU Governance Lead/Fetal Wellbeing Midwives	RDS QI project identified. To be registered with Trust Quality Team and evidence of registration saved as evidence.	
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	NICU Governance Lead/Fetal Wellbeing Midwives	LMNS agreed dates for presenting provisional reports and an update report. (July and October to Neonatal Sub-Group)	

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 including Neonatal Consultant ATAIN Lead, NICU Governance Lead, Fetal Wellbeing leads and Obstetric Lead.
- Quarterly audits ongoing.
- All findings reported via MNSCAB and shared with the LMNS via Neonatal Subgroup.
- Action plan in place for findings from ATAIN reviews
- Respiratory Distress QI project identified.

Issues, Concerns, Gaps:

- Thematic review of Term reveal fluctuating risk/contributory factors for term admission.
- National and local reduction in steroid update following RCOG recommended counselling showing an increase in admission rates for babies born at 37 weeks.

Actions, & Improvements:

- Work commenced on RDS QI project.
- Further audit/review of admission rates prior to RCOG updated in counselling.
- Shift focus from steroids at 37 weeks to delivery at 38 weeks where clinically appropriate to prevent term admissions.
- Continue quarterly reporting.
- Share learning and QI project with LMNS.

ATAIN Action Plan CNST Year 6

Medway NHS Foundation Trust

Overdue	
On Target	
Near Completion	
Complete	

ATAIN Action Plan 2023/24

Action No.	Action Required	Update	Owner	Target Date	Current Position
1	Ongoing audit of term admission and caesarean section	ATAIN babies continue to be reviewed in weekly CRIG meeting. Caesarean section audit already being undertaken by obstetric team	SF/JR/HW	Ongoing quarterly audit	
2	Review of the RDS pathway for NICU	Meeting to take place between Neonatal governance lead and newly appointed neonatal consultant for ATAIN	AS/RM	01/06/2024	
3	Meet with the obstetric and intrapartum midwifery team to discuss use of antibiotic prophylaxis for prolonged rupture of membranes and antibiotic treatment of suspected chorioamnionitis	Meeting to take place between Fetal Wellbeing Team, Labour Ward Lead and Intrapartum Matron	SF/JR/HW/AC	01/06/2024	
4	Audit of ELCS and uptake of antenatal steroids	FWB have already collected data for 2023 deliveries, awaiting data from NICU colleagues to compare to admissions for RDS prior to the change in national guidance in 2019 for antenatal steroid counselling	SF/JR/HW/AC	01/06/2024	

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

Medway NHS Foundation Trust

Key Messages:

- The CNST criteria for employing short & long -term locum Doctors to be audited April to September.
- RCOG for compensatory rest post on –call is met and evidenced via rosters
- 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
- Consultant attendance monitored via weekly CRIG meeting for incidents meeting Must attend criteria and audited via bed state.
- 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 5.96WTE across all nursing bandings with 6 band 5s promoted to band 6.
- QIS currently 63% with trajectory to be 68% in September 2024.
- 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.

Neonatal Nursing Qualified in Speciality Action Plan

CNST Year 6

Overdue		
On Target		
Near Completion		
Complete		

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		
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		

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

NHS Medway NHS Foundation Trust

	Requirement	Lead	Actions/progress	On track
Obstetric 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 following an audit of 6 months activity :				
4.1	Locum currently works in their unit on the tier 2 or 3 rota?	Obstetric CD	To Audit from April to September 2024	
4.2	OR 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 Progrssion (ARCP)?	Obstetric CD	To Audit from April to September 2024	
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Obstetric CD	To Audit from April to September 2024	
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology.				
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Obstetric CD	No long-term locums in CNST Year 5 - to confirm for CNST year 6	
RCOG compensatory rest (not reportable in MIS year 6)				
4.5	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?	Obstetric CD	Appropriate compensatory rest process in place as reflected in rota.	
4.6	OR Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?	Obstetric CD	Appropriate compensatory rest process in place as reflected in rota.	
Consultant Attendance				
4.7	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 when a consultant is required to attend in person?	Women's MD	Ongoing audit via weekly CRIG meeting and bedstates. Reported monthly via MNSCAB.	
4.8	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?	Women's MD	Actions identified and learning disseminated across department.	
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Women's MD	Position reported to Trust Board via SIOR and CNST reports.	
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Women's MD	Position reported via MNSCAB which is attended by Board Level Safety Champions.	
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Women's MD	To be presented to LMNS September 2024	

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

NHS Medway NHS Foundation Trust

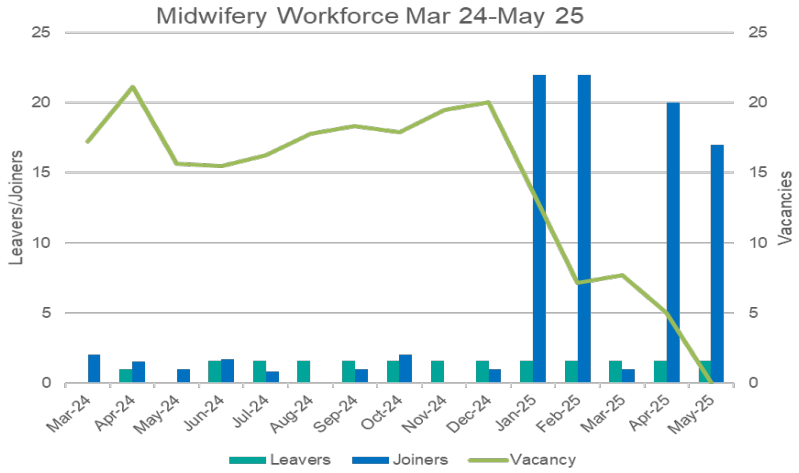
	Requirement	Lead	Actions/progress	Compliance status
Anaesthetic Workforce				
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to 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) - Representative month rota acceptable.	Obstetric Anaesthetic lead	This is reflected in the Anaesthetic	
Neonatal Medical Workforce				
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Neonatal CD	Neonatal Unit continues to meet BAPM standards for medical staffing.	
4.14	Is this formally recorded in Trust Board minutes?	Neonatal CD	To be included in CNST reporting to Trust Board with request to formally note in the minutes.	
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	Neonatal CD	N/A	
4.16	Was the above action plan shared with the LMNS?	Neonatal CD	N/A	
4.17	Was the above action plan shared with the ODN?	Neonatal CD	N/A	
Neonatal Nursing Workforce				
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	NICU Matron	QIS currently 63% action plan in place.	
4.19	Is this formally recorded in Trust Board minutes?	NICU Matron	To be included in CNST reporting to Trust Board with request to formally note in the minutes.	
4.20	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	NICU Matron	To be included in CNST reporting to Trust Board with request to formally agree action plan.	
4.21	Was the above action plan shared with the LMNS?	NICU Matron	To be presented to LMNS September 2024	
4.22	Was the above action plan shared with the ODN?	NICU Matron	To be shared with ODN following Trust Board sign-off	

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 reportingg schedule continues from CNST Year 5 with reports due to Trust Board July 2024 and January 2025.
- Birthrate Plus establishment review completed in July 2023. All recommended posts approved in 2024/25 business planning and recruitment underway
- 100% Compliance 1:1 Care in Labour.
- 100% Compliance with Supernumerary status of Delivery suite coordinator in line with CNST guidance.
- Acuity, staffing, vacancy, sickness, recruitment and retention reviewed monthly at MNSCAB and any matters for concern escalated via QPSCC and QAC to Trust Board.



		Aug 23-Apr 24								
Measure	Goal	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Midwife to Women Ratio - Funded	1:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25	01:25
Actual Worked ratio	1:25	01:33	01:34	01:31	01:32	01:33	01:33	01:34	1:30	1:31

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

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

Medway NHS Foundation Trust

Can you demonstrate an effective system of midwifery workforce planning to the required standard?				On Track
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Head of Midwifery	Bi-annual reporting schedule in place. Report to MNSCAB May 2024 and to trust Board July 2024.	
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.	Head of Midwifery	Birth rate Plus completed in 2023.	
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, 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. ● 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. ● 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.	Head of Midwifery	Included in Bi-annual workforce report to Trust Board.	
5.4	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 on duty **at the start of every shift.**	Head of Midwifery	Continue to maintain 100% compliance with Supernumerary. Audited via Bed state and Acuity Tool	
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Head of Midwifery	Continue to maintain 100% compliance with 1:1 care in labour. Captured via dashboard. EuroKing backcopy being corrected to ensure no false-negative returns.	
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.	Head of Midwifery	Continue to monitor monthly and action plan will be put in place if required.	

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

Medway NHS Foundation Trust

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

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

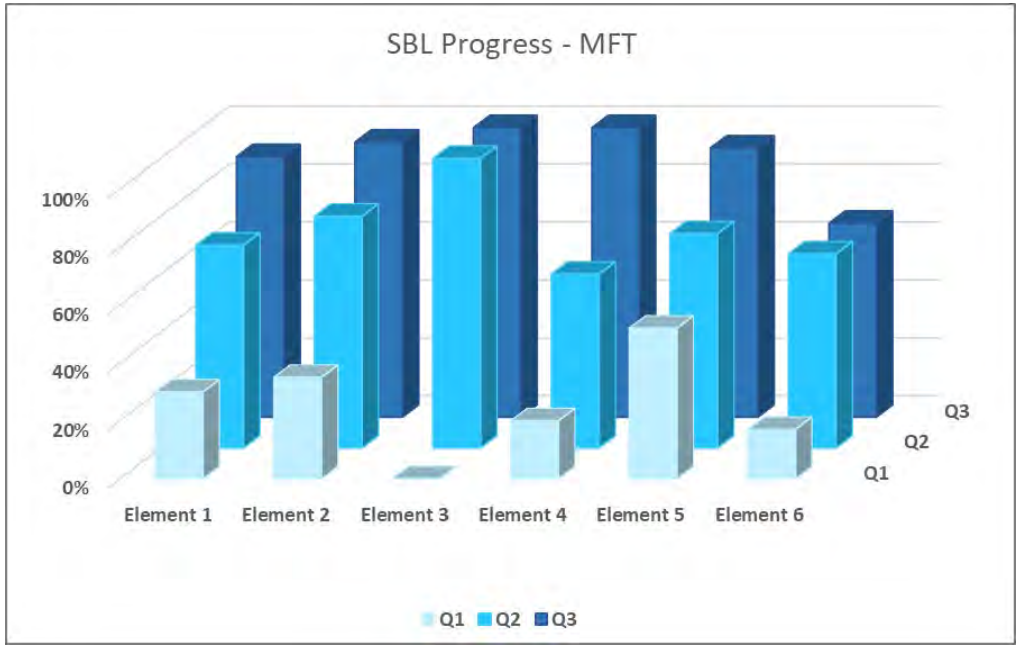
Saving Babies Lives Care Bundle v. 3 LMNS Validated Compliance May 2024

NHS Medway NHS Foundation Trust

Key Messages:

- Achieved 91% overall compliance across the 6 elements.
- All elements, with exception of element 6 are 90% or above.
- Complaint with CNST year 6 requirements which allows Trusts to declare compliance if <100% so long as targets and progress are agreed and reviewed with LMNS.
- Q4 Submission submitted to LMNS.
- 3 quarterly meetings to be held in CNST Year 6 period to meet requirements.
- Planned dates for learning and sharing forums with all Trusts in LMNS.
- Action plan in place to achieve 100% for all elements, with 11 actions on track and 23 completed.

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)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	90%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	89%	Partially implemented	93%
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	90%	Partially implemented	91%



True North: Quality

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
Goal: To reduce stillbirth

Medway NHS Foundation Trust

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?				On Track
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
6.1	Have you provided a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB ? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Director of Miwdifery	DOM to discuss sign-off with Executive Medical Director	
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Head of Midwifery	Quarterly discussions scheduled for July, October and December 2024 to meet CNST Year 6 requirements	
6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Head of Midwifery	Quarterly discussions scheduled for July, October and December 2024 to meet CNST Year 6 requirements	
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Head of Midwifery	Ongoing quarterly reporting for each element to include review of local themes and potential harms.	
6.5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Head of Midwifery	LMNS currently assessing Trust at 91% with improvement anticipated in Q4. To review trajectories in Q4 meeting in July 2024.	
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Head of Midwifery	Element leads to share at LMNS learning and sharing forums including Preterm optimisation in June 2024. Second planned date for sharing 8 August 2024.	

True North: Patients

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

Ambition Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

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

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.				**On track**
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	MNVP Lead/HOM	Evidence to be supplied via MNVP lead/LMNS	
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as**: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	Head of Midwifery	MNVP Lead currently attends Maternity and Neonatal Safety Champion Assurance Board. LMNS MNVP lead conducting review of meetings currently attended to take a system-wide approach.	
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Head of Midwifery	Evidence to be supplied via MNVP lead/LMNS	
7.4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	Head of Midwifery	MNVP report bi-monthly to MNSCAB and have open communication with HOM/DOM. MNVP feedback reported via PQSM in Trust Maternity SIOR monthly along with CNST reports and PQSM quarterly reports. To monitor and escalate if required.	
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan.	Head of Midwifery	Co-produced action plan from 2022 and 2023 survey in place and monitored via BAF	
7.6	Has progress on the coproduced action above been shared with Safety Champions?	Head of Midwifery	Maternity CQC survey is scheduled on the MNSCAB workplan where progress will be presented, along with monitoring via the BAF.	
7.7	Has progress on the coproduced action above been shared with the LMNS?	Head of Midwifery	Date to be confirmed to share progress with LMNS	

True North: People

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?
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 2023 – 30th November 2024)

PROMPT training

	Active Staff	Complaint	March 2024	May 2024
Midwives	178	161	90%	92%
MA & MSW	51	47	92%	90%
Theatre Nurses and ODNs	30	28	93%	87%
Obs Consultants	22	16	72%	45%
Obs SpR/SHO	34	29	85%	78%
Anaesthetic Consultant	7	5	75%	21%
Aneas. SpR/SHO	23	19	82%	82%

Neonatal Life Support Training

	December 2023	May 2024
Midwives	91%	91%
NICU Nurses	89%	94%
Neonatal Consultants	90%	92%
Neonatal doctors	94%	90%
ANNP	100%	100%

Key Messages:

- Compliant with 90% or more for all staff groups for fetal monitoring and NBLS training.
- Compliance for PROPT below 90% for all groups, with exception of MSWs and Midwives.

Issues, Concerns, Gaps:

- <90% for PROMPT training for most staff groups.
- Medical staff non-attendance due to DNA or removal from rota due to staffing issues
- Theatre staff unable to attend July & August.
- No obstetric faculty within PROMPT team currently.

Actions & Improvements:

- HOM to meet with obstetric CD to assign new obstetric PROMPT lead.
- PROMPT training sessions to be reallocated in rota and medical attendance to be supported by CD and Labour Ward Lead.
- 2 PROMPT sessions booked per month to support compliance. Adequate sessions available to support >90% compliance prior to CNST deadline.
- Continue to monitor compliance monthly and escalate any gaps in compliance as required to CD/HOM/MD/GM

Fetal Monitoring Training and Assessment

	Dec 2023	March 2024	May 2024
Midwives	100%	97.7%	98%
Obstetric Consultants	89%	100%	94%
Doctors in training	80%	100%	100%

True North: Quality

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

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.

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?				On Track
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?	Director of Midwifery	Reported monthly via Maternity SIOR and detailed quarterly reports in place.	
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Director of Midwifery	NED and Board Safety Champion quorate members of MNSCAB and monthly engagement sessions with staff booked for remained of year.	
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Director of Midwifery	Reported monthly via Maternity SIOR and included in Trust Board papers and detailed quarterly reports also presented to Trust Board. SIOR and Quarterly reports presented by DOM.	
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Director of Midwifery	All elements of PQSM included in SIOR and quarterly reports.	
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Director of Midwifery	Monthly submission of PQSM data to LMNS for review at quarterly LMNS Quality Committee.	
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Director of Midwifery	Engagement sessions, both virtual and in person arranged with NED and Board Level Safety Champion monthly. Ongoing since Year 5.	
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Director of Midwifery	Triangulation report scheduled for MNSCAB quarterly.	
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Director of Midwifery	Perinatal leadership team meet monthly with the Board Level Safety Champion and NED at MNSCAB meeting with clear lines of reporting to Trust Board. Will continue to report via CNST reports and request Trust Board to minute as required.	
9.9	Evidence in the Trust Board minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Director of Midwifery	SCORE survey reported and monitored via MNSCAB and progress against the action plan will be reported via CNST reports to Trust Board.	

True North: Quality

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

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 (PPQSM) with monthly reporting via MNSCAB and to every Trust Board.
- Detailed quarterly PQSM report to Trust Board to identify themes, trends and actions.
- 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 quadrumvirate
- 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 and action plan in place.
- Quad attended Perinatal Leadership Programme and quarterly reporting in place to MNSCAB.

Issues, Gaps Concerns:

- Themes and trends from datix currently not reported into Divisional Board.
- CDs have replaced MDs in perinatal quad. GM and HOM supporting transition.
- Front line Safety Champions have not been reviewed since changes in staff and roles.

Actions & Improvements :

- PQSM report to be presented to Divisional Board monthly.
- Neonatal to complete culture survey monthly.
- Repeat SCORE survey in Autumn 2024 for both maternity and neonatal.
- To continue to engage with the LMNS for regional shared learning and ensure reflective learning within MFT from other Trusts identified concerns/issues.
- GM and HOM working closely with Obstetric and Neonatal CD to continue work of perinatal leadership programme.
- Utilise Board Level Safety Champions to escalate risks and provide supportive challenge.
- HOM to review front line Safety Champions and ensure that they are reflective of the workforce and the service needs. Re-launch and reinvigorate Safety Champions across the unit so all staff understand importance of the role.

True North: Quality

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.

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 Resolution's Early Notification (EN) Scheme?				**On Track**
	Requirement	**Lead**	**Actions/progress**	**Compliance status**
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Risk Midwives	All eligible cases reported	
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Risk Midwives	All eligible cases reported	
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Risk Midwives	All eligible families have received appropriate information.	
10.4	Has 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.	Risk Midwives	All requirements regarding DOC have been completed.	
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Risk Midwives	Record to be presented to Trust Board via CNST reports.	
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Risk Midwives	Record to be presented to Trust Board via CNST reports.	
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Risk Midwives	Record to be presetned to Trust Board via CNST reports.	
10.8	Have you completed 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.	Risk Midwives	Appropriate field completed. To continue to monitor.	

Next Steps:

Medway NHS Foundation Trust

Actions and Next Steps:

- Monthly reporting to MNSCAG with Bi-monthly reporting to Trust Board until submission.
- Report to be submitted to QPSCC, QAC and Trust Board (July 2024)
- Continue to engage with LMNS CNST Peer Assurance Group
- Schedule reports to ensure local review, Trust Board Review and LMNS review takes place within the required timescales (many items required to be reported/completed by end of reporting period on 30 November 2024.
- Engage Safety Action leads to attend LMNS review meetings
- Collate evidence archive and make available to Executives via Shared Drive as per CNST Year 5.
- Review CNST Year 5 rebate with Dom, HOM, MD and GM to ensure effective and appropriate reinvestment to support maternity safety.

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Mid-Year Strategy Review		**Agenda Item**	5.4
Author	Lauren Pryor, Senior Project Manager Maya Guthrie, Project Manager			
Lead Executive Director	Matt Capper, Director of Strategy and Partnerships			
Executive Summary	The mid-year strategy review outlines the current and on-going status of the Strategy and Partnerships portfolio.			
Proposal and/or key recommendation:	Submitted for assurance.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Trust Board			

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

Identified Risks, issues and mitigations:	N/A
Resource implications:	N/A
Sustainability and /or Public and patient engagement considerations:	N/A
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*)

	☒ Not applicable (*please indicate why an equality assessment was not required)*		
Legal and Regulatory implications:	N/A		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information or any enquires relating to this paper please contact:	Matt Capper m.capper@nhs.net Toni Sheeran tonisheeran@nhs.net		
Reports require an assurance rating to guide the discussion:			
	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance	✓	There are no gaps in assurance
	Not Applicable		No assurance required.

NHS
Medway
NHS Foundation Trust

Strategy Review

Strategy & Partnerships

July 2024

Patient FIRST

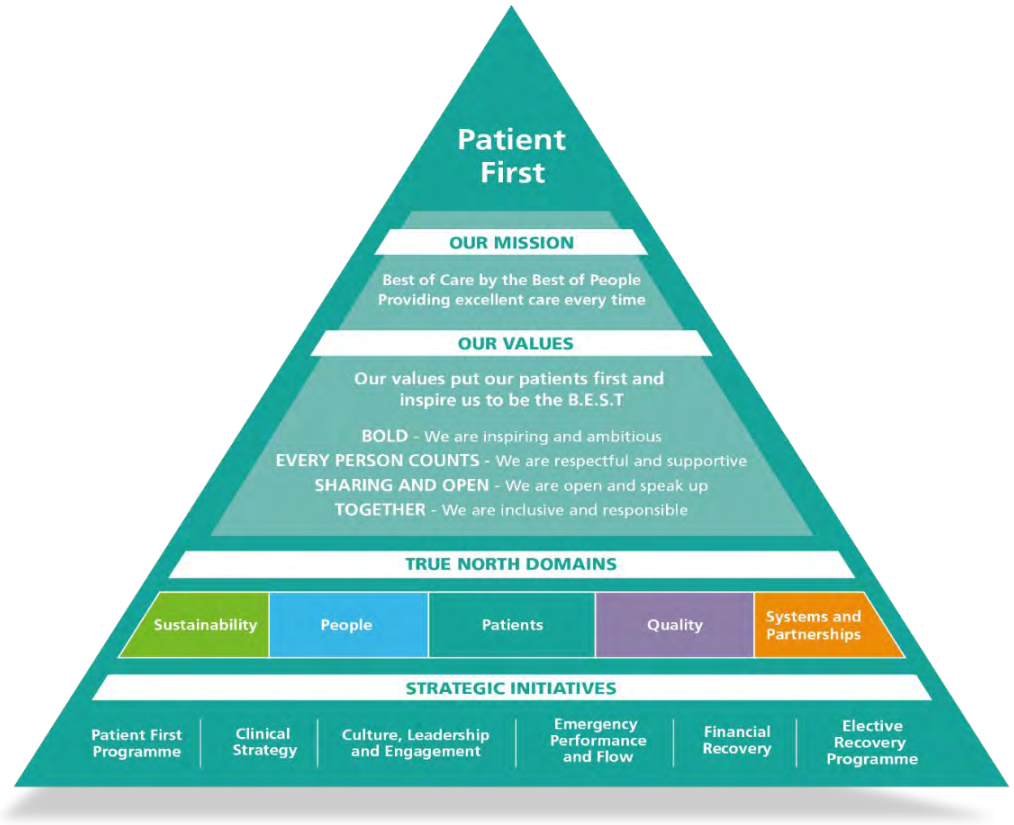
Patient First

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

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

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

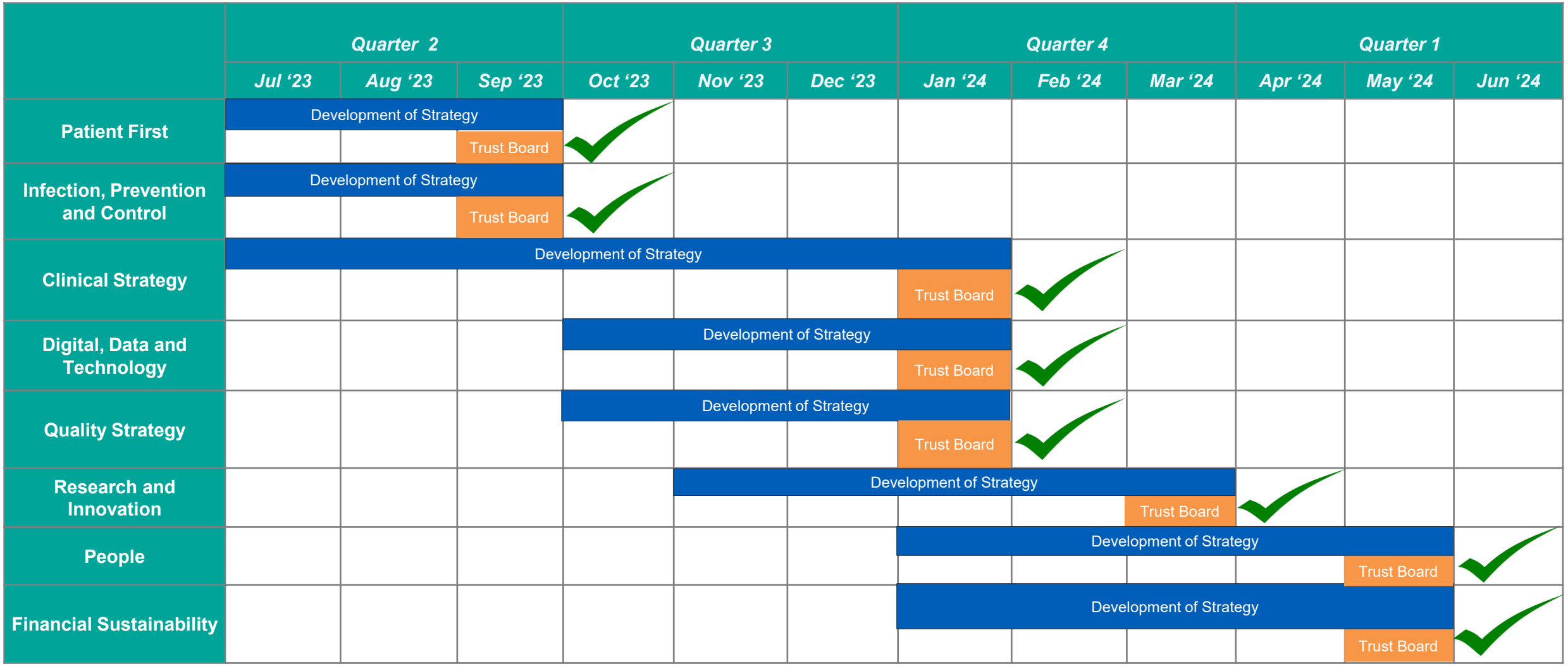
The Patient First Strategy has been published on Q-Pulse and can be found here.



Roadmap
- summary of progress

Approved Strategies

NHS Medway NHS Foundation Trust



Strategies in Progress

NHS Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '24	Feb '24	March '24	April '24	May '24	June '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24
Patient First Review & Refresh							Development of Strategy		Board Sept-24			
Information Governance				Development of Strategy						Board Oct-24		
Patient Experience Review & Refresh				Development of Strategy							Board Nov-24	

Implementation Plans

NHS Medway NHS Foundation Trust

	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
	Jan '24	Feb '24	March '24	April '24	May '24	June '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24
Clinical Strategy	Development				Trust Board	✓						
Digital, Data and Technology	Development				DDaT Group	✓						
Quality Strategy		Development			QAC	✓						
People				Development	People Committee	✓						
Research and Innovation				Development			TBA					
Financial Sustainability						Development	TBA					

What's next

The following strategies are due to start in the next quarter. Preparatory discussions are underway to finalise the their scope and supporting governance:

- Nursing Midwifery and Allied Health Professionals
- Freedom To Speak Up

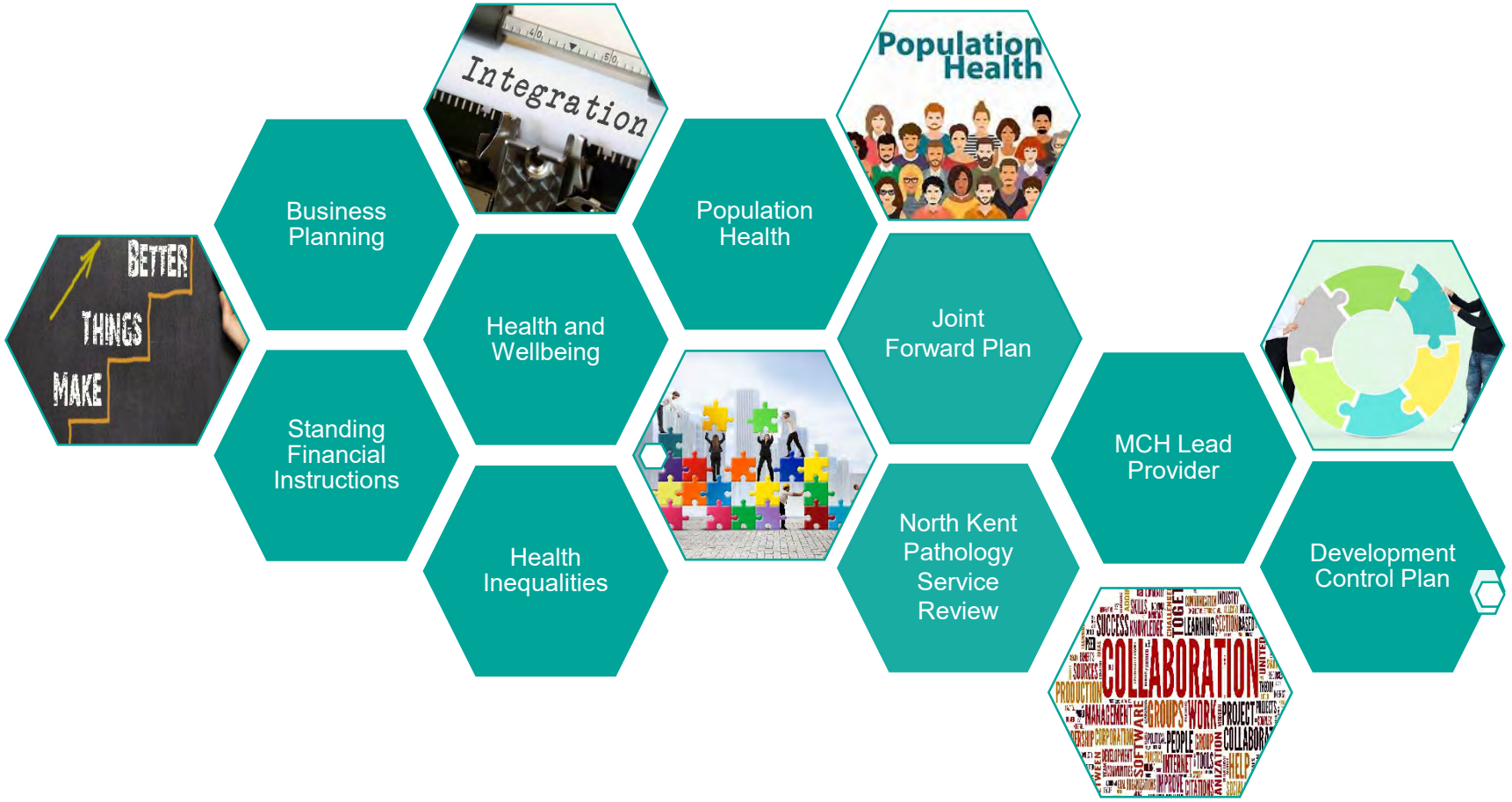
Accessibility

In line with the requirements set out in the accessibility regulations 2018 the Strategy and Partnerships team have adapted all of the strategic document templates to ensure they fully comply with the accessibility guidance.

Strategy Summaries

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

Partnerships



In Progress

In Progress

- **Information Governance Strategy**: There has been engagement with key stakeholders and a collaborative agreement of the team's ambitions and priorities. A draft strategy has been written and reviewed at Trust Information Governance Group (IGG) and been submitted to the Trust Risk and Compliance Assurance Sub Committee (RCASC). The Strategy is due to attend Board in October 2024.

- **Clinical Strategy Implementation Plan**: The Strategy and Partnerships team are meeting with senior colleagues to capture updates on a quarterly basis to be reported into Trust Management Board.

- **SFI's:** The next milestone is for the Strategy and Partnerships team to work with Procurement colleagues to finalise their entries following new legislation released and training undertaken.

- **Population Health:** The Strategy and Partnerships Team will be presenting the Clinical Strategy to the ICB Population Health Management Meeting in August 2024.

- **Estates and Facilities Strategy:** The strategy is bringing together multiple strands of work being done across the Trust to ensure the strategy is relevant, and fit for purpose. The Trust is in early stages of conversations with external stakeholders to meet national ambitions and ensure the Trust site is sustainable for the medium and long term future.

Meeting of the Public Trust Board
Wednesday, 24 July 2024

Title of Report	Finance Report – Month 2		**Agenda Item**	5.5
Author	Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director Income and Contracts Isla Fraser, Financial Controller			
Lead Executive Director	Paul Kimber, Acting Chief Finance Officer			
Executive Summary	1) The Trust reports a deficit of £3.3m in month 2, and £6.9m year to date (YTD); this is on plan. 2) The efficiency programme has under delivered by £0.5m against the YTD plan of £1.5m. 3) The capital position is underspent as at month 2 due to the timing of schemes being delivered/awaiting approval of the full current year programme. 4) Cash at the end of May was £6.2m.			
Proposal and/or key recommendation:	The Trust Board is asked to note this report.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	✓	Discussion	
Committee/Group submitted date:	Trust Executive have been briefed on the financial performance. FPPC – 25.06.24			
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*			
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*			
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	Non-delivery of the breakeven control total			
Resource implications:	The report sets out the financial resources /performance / position of the Trust			
Sustainability and /or Public and patient engagement considerations:	N/A			
Integrated Impact assessment:	Not applicable			
Legal and Regulatory implications:	Achieving breakeven is a statutory duty			

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

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Integrated Improvement Plan	**Agenda Item**	5.6
Author	Paul Kimber, Acting Chief Financial Officer		
Lead Executive Director	Paul Kimber, Acting Chief Financial Officer		
Executive Summary	The Trust has developed and submitted its Integrated Improvement Plan ("IIP") to the ICB and NHSE. The document sets out the manner by which it seeks to deliver financial improvement with no adverse impacts on quality, safety and performance. This is designed to allow the Trust to evidence delivery against the remaining exit criteria as part of the NHS Recovery Support Programme. The primary focus of the IIP is 2024/25 performance and we will need to keep this 'live' to ensure it dovetails into the Integrated Care System ("ICS") financial recovery. The IIP builds on work previously undertaken in 2022 as part of the Financial Recovery Plan at that time, together with incorporating subsequent reports and new conditions that are being experienced today. It identifies those key drivers of the financial deficit, including the comparatively low levels of primary care, and sets out the workstreams designed to tackle these. The key areas of focus for the Trust to deliver against the exit criteria are therefore: 1. Delivery of the 2024/25 plan 2. Development of a medium term financial plan alongside the ICS 3. Safe and sustainable clinical model 4. Affordable workforce plan 5. Transformation and efficiencies 6. Activity and income In order to support the above, there are a number of enabler workstreams: 1. Financial governance and control 2. Programme management office 3. Training and development 4. Trust and ICS collaboration 5. Digital The Trust will begin monthly reporting across a range of financial and non-financial metrics to evidence delivery of the above. The key and enabler workstreams have been fully mapped to the Financial Sustainability Strategy.		
Proposal and/or key recommendation:	The Trust Board is asked to note this report.		

<table>
<tr><td rowspan="2">Purpose of the report (Please mark with ‘X’ the box to indicate)</td><td>Assurance</td><td></td><td>Approval</td><td></td></tr>
<tr><td>Noting</td><td>X</td><td>Discussion</td><td></td></tr>
<tr><td><u>Governance Process</u>:

Committee/Group and Date of Submission/approval:</td><td colspan="4">Meeting: Finance, Planning and Performance Committee
Date: 25 June 2024

Meeting: Private Trust Board
Date: 27 June 2024

The Integrated Improvement Plan was approved at both of the above meetings.</td></tr>
<tr><td rowspan="2">Patient First Domain/True North priorities (tick box to indicate):</td><td colspan="5">Please mark with ‘X’ the priorities the report aims to support:</td></tr>
<tr><td>Priority 1: (Sustainability)
X</td><td>Priority 2: (People)
X</td><td>Priority 3: (Patients)
X</td><td>Priority 4: (Quality)
X</td><td>Priority 5: (Systems)
X</td></tr>
<tr><td rowspan="2">Relevant CQC Domain:</td><td colspan="5">Please mark with ‘X’ the 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>Identified Risks, issues and mitigations:</td><td colspan="4">Key risks to delivery of the exit criteria include but are not necessarily limited to:
Continued high proportion of ‘no criteria to reside’ patients
Capital allocations
Income/activity risks
Efficiency improvements</td></tr>
<tr><td>Resource implications:</td><td colspan="4">The plan seeks to ensure that we use our limited resources effectively. No additional resources are requested at this time.</td></tr>
<tr><td>Sustainability and /or Public and patient engagement considerations:</td><td colspan="4">N/A</td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="4">Please tick the correct box and provide required information.
Has the quality and equality assessment been undertaken?
☐ Yes (please attach the action plan to this paper)
☑ Not applicable</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="4">The Trust has a statutory duty to breakeven.</td></tr>
<tr><td>Appendices:</td><td colspan="4">None</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="4">Tick either:

☑ This paper is disclosable under the FOI Act

☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.</td></tr>
</table>

For further information please contact:	Name: Paul Kimber Job Title: Acting Chief Financial Officer Email: paul.kimber1@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board Meeting
Thursday, 20 June 2024

Title of Report	**Annual Report and Accounts**	**Agenda Item**	5.7
Author	Alana Marie Almond, Deputy Company Secretary		
Lead Executive Director	Matt Capper, Director of Strategy and Partnership/Company Secretary		
Executive Summary	The Annual Report and Accounts for Medway NHS Foundation Trust covering the reporting period of April 2023 to March 2024. The Annual Report is made up of a number of required elements, these include: Annual Accounts, Annual Quality Accounts, Assurance statements. The production of an Annual report is a statutory requirement and the document is audited by our external auditors for compliance against the criteria in the national NHS Foundation Trust Annual Reporting Manual. The Quality Account is submitted under separate cover at this meeting. Due to the general election, NHS foundation trusts will not be able to lay annual reports until after the State opening of Parliament on 17 July 2024. The timing of the summer recess is not currently known and cannot be determined until after 17 July.		
Proposal and/or key recommendation:	The Committee is asked to note the contents of the document in preparation for submission to Parliament.		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Trust Board (draft Annual Report) Date: 15 May 2024 Meeting: Audit and Risk Committee (Approval) Date: 20 June 2024			

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

Identified Risks, issues and mitigations:	It is a statutory requirement to produce Annual Accounts, Annual Quality Accounts, and Assurance statements. Therefore, non-adherence to this requirement will result in qualifications being level at the Trust and undertakings being issued by NHS England.		
Resource implications:	None		
Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	Not applicable		
Legal and Regulatory implications:	As per the Risks section		
Appendices:	Annual Report and Accounts 2023/24		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Matt Capper Job Title: Director of Partnership and Strategy/Company Secretary Email: m.capper@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	X	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Health and Safety Annual Report 2023/24			**Agenda Item**	5.8
Author	Adam Clark – Health and Safety Manager				
Lead Executive Director	Sarah Vaux; Interim Chief Nursing Officer				
Executive Summary	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 & 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. This is the fifth 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. Of the 12 objectives set for 2023/24, 10 were achieved, as set out in Section 4 of the report				
Proposal and/or key recommendation:	For Assurance to the Trust Board				
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance	✓	Approval		
	Noting		Discussion		
Committee/Group submitted and date:	ARC - 05 July 2024 HSSG – 05 May 2024				
Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: ✓	Effective: ✓	Caring:	Responsive: ✓	Well-Led: ✓
Identified Risks, issues and mitigations:	N/A – Summary report only				
Resource implications:	N/A				

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	Failure to comply with the Health and Safety at Work etc. Act 1974; the Regulatory Reform (Fire) Safety Order 2005; the Environmental Protection Act 1990 and the regulations that fall below them, could result in enforcement action, fines or imprisonment.		
Appendices:	N/A		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information please contact:	Name: Louise Furlong Job Title: Head of Quality and Safety Email: louise.furlong@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance	✓	There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

June - 2024

Patient FIRST

Executive Summary

Jayne Black
Chief Executive

True North

	Variation: Common	Variation: Improve	Variation: Concern	Assurance: Common	Assurance: Improve	Assurance: Concern
People	20	31	4	18	15	15
Systems & Partnerships	14	8	15	16	5	5
Quality	51	15	9	13	4	5
Patients	10	14	2	3	0	5
Sustainability	9	1	2	7	0	0

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

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

Key Messages

- The People domain continues to show the highest volume in metrics improving for Statistical Variance, and, proportionately, also shows the highest % of statistical improvement metrics (56% of all metrics)
- The Systems & Partnerships domain is showing the highest number of variances that are statistically showing concern, with 41% of all metrics flagging
- Both Quality and Sustainability domains show that the majority of their metrics are not showing any statistical improvement and as such are showing common variation.
- Overall, 71 metrics are now showing improved statistical variance (+5 from last month) against 32 which are showing concern (-2 from last month) in month.

Issues, Concerns & Gaps

ED & Flow - High level of NCTR patients still impacting on ability to increase discharges

Mortality - The number of observed deaths in Jan-24 was the highest in any month over the last year and whilst the number of expected deaths did also increase, it did not match the upward trend. The high value for Jan 24 reversed the Trusts improvement in overall HSMR.

Workforce - Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice

Finance - Delivery of cash-releasing savings, i.e. those which will reduce our actual current expenditure, are key to deliver the outturn and run-rate requirement. Additionally, delivery of the elective income targets in the Trust's plan must be met, including the full year effect of new capacity that has been introduced

Access - Endoscopy capacity remains an issue however the new mobile unit will provide significant additional capacity to mitigate this.

Actions & Improvements

Finance - Identification, development, implementation and delivery of the efficiencies/waste reduction programme, together with continued resilience in reducing worked WTEs (specifically bank and agency).

ED - Continuing design work with system partners for UTC model plus review of rota heat-map to identify hour by hour clinician allocation and potential redistribution to increase productivity during day hours

Patient Experience - The divisional and care group teams have begun drafting action plans against the new A3 objectives to reduce concerns raised by patients in relation to staff attitude

Mortality - Mortality A3 refresh in progress to look at root causes and countermeasures to address the higher than expected mortality indicators and improving the SJR process and outcomes.

People - Delivery of targeted improvement plan developed for the National Staff Engagement Score and governed by anti-bullying and harassment group, together with a review of the flexible-working recording/self-service.

Patients

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Complaints	5	5	0	4	0	1
FFT	13	19	3	7	0	11
PALS	3	2	2	1	0	0
Patient Experience	1	1	0	2	0	0
PHSO	4	3	0	1	0	0

Patient FIRST

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

Committees:
Quality Assurance Committee (QAC)

Patients

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

FFT

Total FFT Recommend %

Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	95.0%			89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%

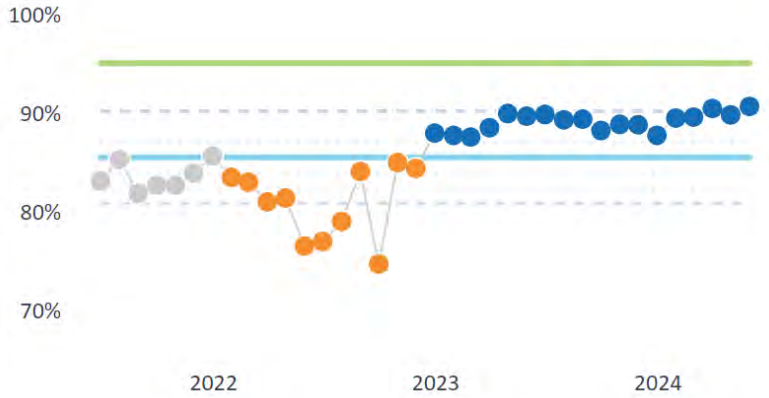
True North Domain: **Patients**

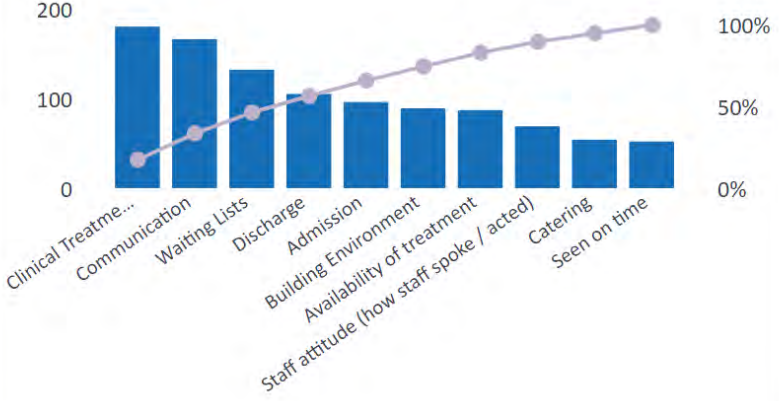
KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:

3	1	0	0	6





Key Messages

- The response rate target has been removed but added as a watch metric for all divisions for monitoring
- Overall the recommend rate has marginally improved in all areas
- The recommend target rate for the ED has been reduced from 95% to 85% which is based on average rates in other organisations
- BO huddles have moved to focusing on positive feedback as well as driving actions based on negative feedback. This is to ensure celebrations are captured

Issues, Concerns & Gaps

- Managing patient expectations and communication remain the top 2 contributors in negative patient feedback
- Further drive in this area is required in ED
- Patients are reporting difficulties being able to contact someone from their medical team in regards to appointments / results. This information correlates with PALS enquiries

Actions & Improvements

- The divisional and care group teams have begun drafting action plans against the new A3 objectives to reduce concerns raised by patients in relation to staff attitude
- Education / teaching sessions to be organised and facilitated by the patient experience team
- A working group has been set up to address the concerns with patient appointment letters, this work will be in collaboration with the Cancer and Core Clinical Services team who have identified this as an area of improvement. This will be supported by the Cancer Alliance as a national project.

Patients

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Patients	FFT			Inpatients FFT Recommend %	95.0%	H	F	Watch is red for 4 reporting periods	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%
				Emergency Care FFT Recommend %	85.0%		F	Watch is red for 4 reporting periods	64.7%	68.9%	71.6%	77.1%	70.2%	74.9%
				Outpatient FFT Recommend %	95.0%	H	F	Watch is red for 4 reporting periods	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%
	Patient Experience			Mixed Sex Accommodation Breaches	0		?	Watch is red for 4 reporting periods	486	278	90	110	108	89
	Complaints			Complaints Breached %	5.0%	L	F	Watch is red for 4 reporting periods	64.0%	62.5%	82.8%	61.5%	29.6%	29.6%

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Patients	FFT			Total FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%
				Total FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	12.3%	14.5%	13.9%	16.1%	15.1%	15.6%
				Inpatients FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%
				Inpatients FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	36.3%	41.2%	44.6%	51.6%	47.8%	51.6%
				Outpatient FFT Recommend %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%
				Outpatient FFT Response Rate %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	8.6%	9.9%	9.1%	9.8%	9.7%	9.6%
	Complaints			Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	19	25	29	26	23	27
				Complaints Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	81	86	90	88	65	51
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	64.0%	62.5%	82.8%	61.5%	29.6%	29.6%
	PALS			PALS Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	75	78	76	97	119	98
				PALS Converted to Complaints	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	1	0
	PHSO			PHSO Cases Closed - Partially Upheld	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Patients	PHSO			PHSO Cases Closed - Not Upheld	-		Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Patients

Key Messages

- MSA breaches have reduced slightly in the last reporting period as flow has improved slightly in ADL..

Issues, Concerns & Gaps

- The BI team are still unable to report MSA breaches reported by the ward on teletracking. The reporting of this data is reliant on the Associate Director of Patient Experience
- Patients who are waiting to step down from ICU / HDU continue to be one of the top contributors to MSA breaches
- Issues have been identified with the tagging of mixed sex breaches on the teletracking system

Actions & Improvements

- Actions and improvements are unchanged from the previous reporting period as the issues and concerns are not fully resolved. This has been escalated. We are awaiting the teletracking national team to resolve this.
- The issues with tagging patients in clinical areas has been escalated to the national team who are working on a solution

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Patients	FFT			Total FFT Recommend %	95.0%	H	F	89.8%	89.2%	89.3%	88.2%	88.8%	88.7%	87.7%	89.4%	89.5%	90.4%	89.7%	90.6%
				Total FFT Response Rate %	-	H		11.8%	12.0%	10.7%	12.8%	13.8%	11.9%	12.3%	14.5%	13.9%	16.1%	15.1%	15.6%
				Inpatients FFT Recommend %	95.0%	H	F	93.2%	93.5%	91.3%	90.7%	92.2%	93.3%	92.3%	94.2%	93.1%	93.2%	92.6%	93.3%
				Inpatients FFT Response Rate %	-	H		34.0%	33.6%	29.9%	36.9%	45.5%	38.3%	36.3%	41.2%	44.6%	51.6%	47.8%	51.6%
				Emergency Care FFT Recommend %	85.0%		F	75.2%	73.1%	74.8%	75.2%	67.9%	69.2%	64.7%	68.9%	71.6%	77.1%	70.2%	74.9%
				Emergency Care FFT Response Rate %	-	L		7.3%	8.4%	6.1%	9.8%	8.7%	7.5%	8.2%	9.9%	7.5%	10.1%	8.8%	9.1%
				Outpatient FFT Recommend %	95.0%	H	F	91.9%	91.6%	92.0%	91.1%	92.4%	91.9%	91.5%	91.9%	91.5%	91.3%	92.7%	92.6%
				Outpatient FFT Response Rate %	-	H		8.5%	8.2%	8.0%	8.4%	8.7%	7.5%	8.6%	9.9%	9.1%	9.8%	9.7%	9.6%
				Maternity FFT Recommend %	95.0%		?	82.3%	87.8%	92.5%	92.5%	90.5%	82.7%	88.5%	85.8%	88.8%	99.4%	96.5%	92.6%
				Maternity FFT Response Rate %	-			16.9%	31.5%	31.5%	33.5%	26.1%	14.5%	30.9%	38.7%	30.6%	49.1%	47.8%	39.1%
	Patient Experience			Mixed Sex Accommodation Breaches	0		?	147	83	109				486	278	90	110	108	89
	Complaints			Complaints	-	L		28	42	35	28	32	19	19	25	29	26	23	27
				Complaints Closed	-			58	45	52	35	38	30	22	20	25	28	46	41

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Patients	Complaints			Complaints Open - Month End	-	L		125	124	107	100	95	84	81	86	90	88	65	51
				Complaints Re-Opened	-			4	2	7	1	2	2	2	1	6	1	3	3
				Complaints Acknowledged Within 3 Working Days %	95.0%	H	?	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%	L	F	40.9%	57.5%	61.1%	38.9%	41.2%	42.4%	64.0%	62.5%	82.8%	61.5%	29.6%	29.6%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-	H		333	425	388	416	528	428	496	463	417	480	428	446
				PALS Closed	-			339	411	371	384	552	485	709	460	419	459	406	467
				PALS Open - Month End	-	L		303	317	334	365	344	287	75	78	76	97	119	98
				PALS Converted to Complaints	-	L		7	6	4	0	0	0	0	0	0	0	1	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			3	0	0	0	0	1	0	0	1	1	0	2
				PHSO Cases Closed - Partially Upheld	-	L		0	1	0	1	0	0	0	0	0	0	0	0
				PHSO Cases Closed - Upheld	-			0	0	0	0	0	0	0	1	0	0	0	0
				PHSO Cases Closed - Not Upheld	-	L		0	0	0	0	0	0	0	0	0	0	0	0
				PHSO Cases Closed - No Investigation Required	-			0	0	1	0	0	0	0	1	4	0	0	0

Quality

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

NHS Medway NHS Foundation Trust

Sarah Vaux
Chief Nursing Officer (Interim)

Alison Davis
Chief Medical Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Incident Management	16	14	6	11	2	8
Falls	10	1	0	6	1	0
IPC	6	3	0	2	1	0
Medicines	5	0	0	2	1	0
Mortality	17	1	3	12	1	3
Pressure Ulcer	6	0	1	1	1	0
Health & Safety	0	2	0	0	0	0
Legal & Information Governance	1	1	1	0	0	0
Maternity	16	0	0	2	0	2
Risk & Policy	4	0	0	0	0	0
Surgical	1	0	0	0	0	1
VTE	0	1	0	1	0	0

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

Committees:
Quality Assurance Committee (QAC)

Quality

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

Incident Management

Low or No Harm Incidents %

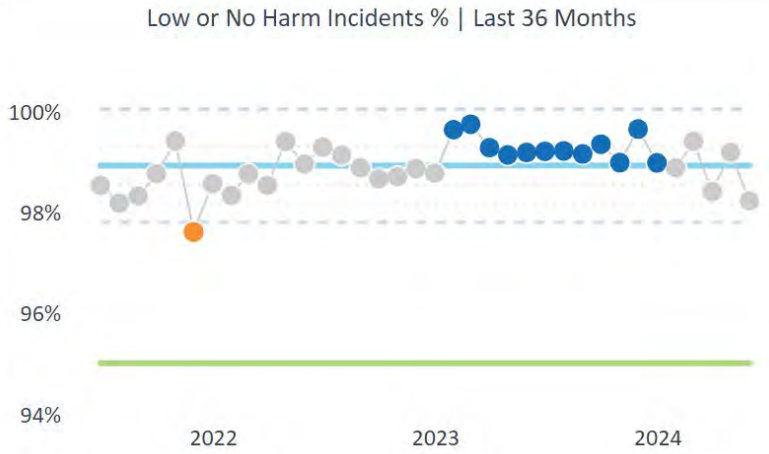
Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	95.0%		P	99.2%	99.2%	99.2%	99.3%	99.0%	99.6%	99.0%	98.9%	99.4%	98.4%	99.2%	98.2%

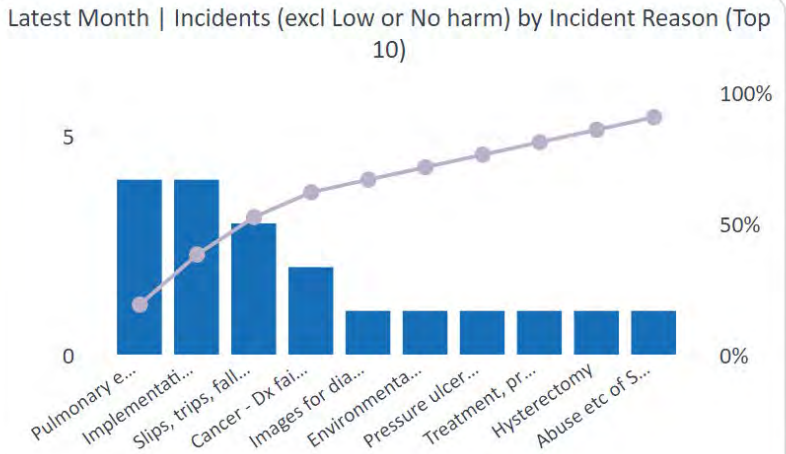
True North Domain: Quality

KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary: 9 | 0 | 5 | 3 | 3





Key Messages

- 98.3% of all incidents reported resulted in low or no harm.
- 15 incidents in June caused moderate harm or above.
- 13 Incidents caused moderate harm: 5 x PEs; CT Scan not completed and incorrect NEWS score; patient discharged with a severe burn; 3 Implementation of care issues; delayed diagnosis and cancer found; treatment delay of medications, nutrition and fluids; 1 fall.
- 1 Incident caused severe harm; incident during surgery requiring admission to ITU and plan for back to theatre.
- Diagnostic delay in reporting leading to potential harm (under investigation).

Issues, Concerns & Gaps

15 patients came to harm due to omissions in care: Safeguarding incident raised by the care home, NEWS scores not being recorded correctly resulting in a 2222 call, delay in SALT re-assessment, omission of critical medication

Actions & Improvements

- Improvement actions for falls and pressure ulcers being progressed in line with QIPs. Falls due to be refreshed in July.
- VTE Lead to investigate locally and highlight themes from all reported hospital acquired PE then set up an A3 quality improvement plan group.
- Thematic review into cancer PTL process to identify human procedural steps that present a human error risk.
- A business case is being developed to support the automated NEWS score recording and a NEWS Dashboard is being developed.
- Deteriorating patient dashboard will be launched at grand round on Friday 19th July.

Quality

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

Mortality

Crude Mortality Rate %

Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	1.30%			1.27%	1.31%	1.44%	1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%

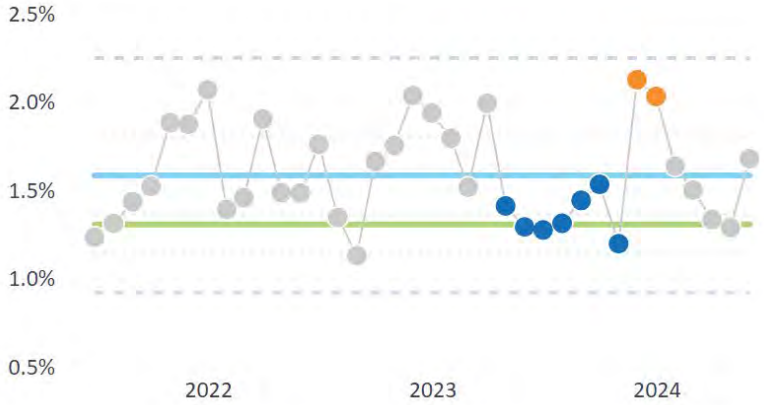
True North Domain: Quality

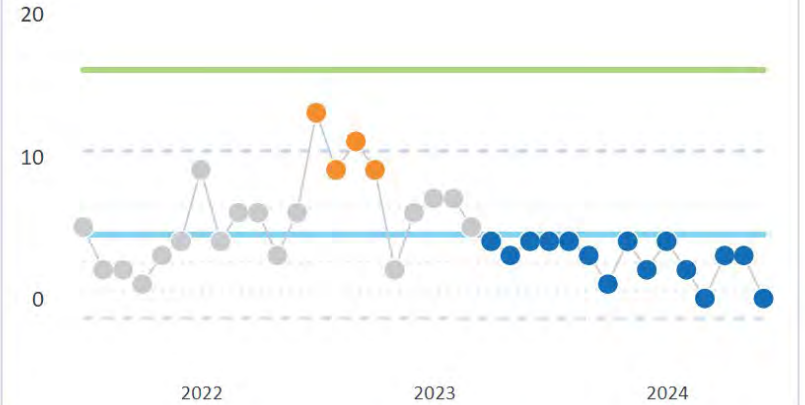
KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary:

	L	H	L	H
10	0	2	1	0





Key Messages

HSMR for Apr 23- March 24 is 113.7 and remains 'higher than expected' March 24 on a single month trend is the second time the value has been below 100.
SHMI for Feb 23- Jan 24 reports as 1.16 and 'higher than expected'.

10.4% deaths were subject to SJR review for Jun 24. 2 deaths were judged as possibly preventable and escalated to Patient Safety as potential incidents. One case is awaiting IRG presentation and the other case was declared a PSII

Issues, Concerns & Gaps

The number of observed deaths in Jan 24 was the highest in any month over the last year and whilst the number of expected deaths did also increase, it did not match the upward trend. The high value for Jan 24 reversed the Trusts improvement in overall HSMR.

For the most recent data up to March 24, the expected rate has continued to fall, despite the Trust being close to the median, or better than the national rate for metrics most associated with quality of documentation (coding).

Actions & Improvements

Quality of M&M reviews improving with some specialties highlighting issues and concerns with actions assigned. These cases are being highlighted to the MMSG.

Mortality A3 refresh in progress to look at root causes and countermeasures to address the higher than expected mortality indicators and improving the SJR process and outcomes.

Quality

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Incident Management			Clinical Incidents with Harm (Moderate and above)	0		?	Watch is red for 4 reporting periods	9	9	6	12	5	17
				Serious Incidents Responded to Within 60 Days %	95.0%		F	Watch is red for 4 reporting periods	56.3%	16.7%	50.0%	50.0%	0.0%	0.0%
				EDNs Completed Within 24hrs %	90.0%	H	F	Watch is red for 4 reporting periods	75.4%	78.5%	78.0%	77.5%	80.3%	78.4%
	Mortality			HSMR (All)	100	H	F	Watch is red for 4 reporting periods	113.50	113.15				
				SHMI	1	H	F	Watch is red for 4 reporting periods	1.16					
				Fractured NOF Within 36 Hours	92.0%		?	Watch is red for 4 reporting periods	71.4%	73.7%	60.0%	60.0%	51.5%	
				SJRs Completed %	25.0%		F	Watch is red for 4 reporting periods	6.5%	7.3%	6.8%	9.2%	4.5%	9.2%

Quality

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Incident Management			Serious Incidents	-	L	Special cause of improving nature or lower pressure due to (L)ower values	4	2	1	2	0	1
				Serious Incidents Open - Month End	-	L	Special cause of improving nature or lower pressure due to (L)ower values	28	28	20	17	15	9
				Serious Incidents Closed by ICB 1st Time %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	88.9%	50.0%	55.6%	100.0%	50.0%	100.0%
				Never Events	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				EDNs Completed Within 24hrs %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	75.4%	78.5%	78.0%	77.5%	80.3%	78.4%
	Falls			Falls Resulting in Death	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	IPC			MRSA Cases - Hospital Acquired	0	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0
	Mortality			Avoidable 2222 Calls	16	L	Special cause of improving nature or lower pressure due to (L)ower values	4	2	0	3	3	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	99.4%	99.2%	99.7%	99.1%	99.4%	99.5%
	Health & Safety			Resuscitation Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	82.2%	82.4%	83.8%	83.1%	83.0%	83.8%
				Mental Capacity Act Training Compliance %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	81.4%	81.7%	83.1%	84.0%	84.9%	85.1%
	Legal & Information Governance			Regulation 28 Reports	-	L	Special cause of improving nature or lower pressure due to (L)ower values	0	0	0	0	0	0

Quality

Key Messages

Falls
- The Throne Project continues- all toilets and bathrooms audited. Recommendations currently being grouped for action.
- The call bell element of the CRASH bundle has achieved over 90% target for the first time
- Working with staff in Emergency Department (ED) to improve falls prevention documentation and strategies following successful ED quality week

TVN
- Incidents remain static since the last reporting period. Overall, HAPU's have reduced significantly since the roll out of the QIP and intense support in clinical areas.

VTE
- VTE remains consistent with compliance and completion of the VTE assessment in most clinical areas

Issues, Concerns & Gaps

Falls
- Awaiting approval for Mandatory training and upload of e- learning for safe management and use of bedrails onto ESR.
- 102 inpatient falls in June- further analysis being undertaken to identify any themes and trends impacting on the overall increase in this reporting period.

TVN
- Issues remain with the delivery of pressure relieving mattresses, review report for execs in development.

VTE
- Issues with how prophylaxis is prescribed on EPMA. A request has been submitted to the EPR team to change how clinicians complete the VTE assessment and then go on to prescribe medication for thrombo-prophylaxis.

Actions & Improvements

Falls
- To complete the recruitment process within the falls team as agreed in business planning.

TVN
- To complete a full review of the mattress delivery project with E&F to ascertain its continuation.
- Roll out of the purpose T assessment, this is on trajectory in line with the roll out plan for clinical areas. However the change on EPR has stalled due to the EPR change freeze

VTE
- An A3 working group to be stood up to address the ongoing prescribing issues with prophylaxis medication to include clinical and EPR stakeholders.

Maternity

Key Messages

Perinatal Quality – Incidents: 0 incidents moderate harm or above for maternity or neonatal; 110 incidents reported in Maternity, 37 low harm; 4 relating to 3rd and 4th degree tears; 20 relating to PPH >1000mls (all no harm); 1 MSNI referral following forceps delivery. **Perinatal Quality – PMRT:** 2 MBRRACE reportable deaths- all reported within required timeframe; 2 Stillbirths (twins; 2 Maternity PMRT reviews – care graded AA. **Staffing:** Midwifery vacancy for June 2024- 18.20 WTE with 9.26 WTE awaiting start date; Maternity Leave – 11.64; Band 3 MSW vacancy; 4.93WTE with a further 4.36 awaiting start date; Successful recruitment to Patient Experience and EDI Role in June 2024; 5 band 2 MSWs successfully recruited to band 3 MSW positions. **Training:** Fetal Monitoring and NBLS training >90% for midwives and doctors in training; PROMPT Training >90% for midwives and MSWs <90% for Obstetric & Anaesthetic consultants & doctors in training and theatre staff; NBLS training >90% for NICU Nursing, NICU doctors in training and ANNP. 89% for midwives and 84% for neonatal consultants. **Listening to Women and Families – Service Users and MNVP:** Positive feedback received from family for midwives and student midwife who attended a home birth; Neurodivergent women and birthing people have feedback poor experiences within the service; Plan for "Whose Shoes" event in October 2024; Review of CQC Picker Survey Action plan for MNSCAG July 2024; Co-production of action plan following service user feedback from LMNS executive Board regarding scanning service at Trust within LMNS. **Staff Feedback**: Board Level Safety Champion Engagement Session held in month. Staff concerns included:Servicing and availability of Equipment from EME; The need for deputy senior sisters to support senior sister role and support succession planning; Staff raised concerns regarding release of bank shifts; Culture survey questions finalised and staff given opportunity to respond in Autumn 2024. **External:** No Regulation 28 notices, HSIB/NHSR/CQC requests for action; SBL Q4 evidence submitted in June 2024. Feedback meeting July 2024; Continue to progress actions to achieve compliance against CNST Year 6 10 Safety actions. Noted to be on track for all actions.

Issues, Concerns & Gaps

Perinatal Quality – Incidents: Additional Training required for staff regarding prevention, diagnosis and management of 3rd and 4th degree tears; PPH audit required; MSNI case following difficult delivery, concerns noted regarding handover of maternal care. **Perinatal Quality - PMRT:** Managing family expectations when bluebell room (bereavement room) is already occupied; Risk factors at 12/40 discussed. **Training:** PROMPT Training <90% for obstetric, anaesthetic doctors and theatre staff. Need to achieve 90% compliance by 30 November 2024 to declare compliance with CNST year 6; Safeguarding Adults and Children's level 3 <85%; Out of date neonatal staff to complete NBLS training; CNST updated requirements for first responders to births <34 weeks to have intermediate NLS. **Risk:** (1133) midwifery staffing remains highest risk – Score 20; New risk (2078) added regarding risk to providing timely fetal medicine scanning due to failing/out of date equipment. – Score 12; Risk (2061) regarding UKAS accreditation closed as waiver received. **Listening to Women and Families – Service Users and MNVP:** No antenatal information available for parents regarding TC; Gaps in support and accommodations provided for neuro-diverse service users identified from service user feedback; MNVP currently do not have capacity to attend all the meetings suggested by CNST Year 6. **Staff Feedback:** Need to relaunch frontline Safety Champions following changes in staff and leadership roles. **External:** Outstanding actions for SBL identified; Clarification from outcome/funding from business planning for dietician and nursing support for SBL pathway needed.

Actions & Improvements

Perinatal Quality – Incidents: 3rd and 4th degree audit presented at Audit meeting in June, along with proposal to change from STOMP to RCOG OASI Bundle. Relevant operational, procedural and training changes to be implemented. To be discussed via Labour Ward Forum and Care Group; MSNI case – discussion with clinicians who delivered baby and discuss at MDT theatre meeting. Support MSNI in investigation. **Perinatal Quality – PMRT:** Review risk assessment factors included at 12/40 review; Support families when bluebell is already occupied, including ensuring appropriate signage on door of delivery room and locating family away from other women in labour if possible; Bereavement team to communicate this feedback to staff via top5 and launch bereavement newsletter. **Staffing:** Successful recruitment to Patient Experience and EDI Midwife; Focus on retention and staff wellbeing; Culture Survey planned for Autumn 2024; Workforce Action plan refreshed for 2024/25. **Training**: Education lead to provide a trajectory to ensure booked sessions will be adequate to achieve >90%. Escalate to HOM/GM/MD as required to ensure target achieved; Review of Safeguarding training booking at Trust level to support capacity – now booked to 140% capacity and review of all bookings to ensure course booked is course mapped to; Reviewing first responders level of NLS training with NICU Nursing and Obstetric Education leads to provide assurance for CNST SA8. **Risk:** Continued reduction in delays on IOL pathway noted. Risk score to be reduced following 3 months consistent reduction in delays. **Listening to Women and Families – Service Users and MNVP:** Working party including MNVP lead, Service user and Mental Health midwives being established to review the pathway and resources available for neuro-diverse women and birthing people; LMNS MNVP lead reviewing funding, structure and working of MNVP to support additional capacity required; Action plan following LMNS Executive Board feedback to be coproduced with MNVP and Patient Experience Lead to ensure offering best care and experience for women, birthing people and families. **Staff Feedback:** Maternity Compass governance newsletter launched; "You Said, We Did" bulletin to be included in Friday News/Staff notice boards; Leaders to continue to be visible on unit, undertake monthly Teams Talks (HOM/DOM) and Safety Champion engagement sessions (NED/CNO); Findings of audits, including breaks audit, IOL and CS to be shared with staff; Actions from audit meetings now captured centrally.; Anonymous Safety Champion Feedback form to be launched alongside of poster and other staff comms to reinvigorate the role. **External:** Quarterly meetings with LMNS to be arranged to review targets and QI work for SBL.; CNST reporting to Trust Board commenced. Audit and collating of evidence commenced; Timelines for presentation to LMNS and Trust Board to meet requirements of CNST finalised.

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Incident Management			Low or No Harm Incidents %	95.0%		P	99.2%	99.2%	99.2%	99.3%	99.0%	99.6%	99.0%	98.9%	99.4%	98.4%	99.2%	98.2%
				Total Incidents Reported	-			1,505	1,650	1,766	1,984	2,155	1,686	1,366	1,337	1,329	1,191	1,228	1,179
				Clinical Incidents with Harm (Moderate and above)	0		?	8	10	8	11	16	6	9	9	6	12	5	17
				Incidents Open - Month End	-	H		1,261	1,340	1,691	2,156	2,413	2,979	2,771	2,735	2,773	2,726	1,616	1,659
				Incidents Overdue - Month End	-	H		184	218	388	479	701	1,141	1,653	1,772	1,733	1,797	653	727
				Serious Incidents	-	L		3	4	7	7	16	2	4	2	1	2	0	1
				Serious Incidents Closed	-			8	14	12	11	6	9	9	2	9	5	2	7
				Serious Incidents Open - Month End	-	L		49	40	35	30	40	33	28	28	20	17	15	9
				Serious Incidents Responded to Within 60 Days %	95.0%		F	40.0%	0.0%	40.0%	25.0%	33.3%	66.7%	56.3%	16.7%	50.0%	50.0%	0.0%	0.0%
				Serious Incidents Closed by ICB 1st Time %	-	H		62.5%	35.7%	75.0%	81.8%	100.0%	100.0%	88.9%	50.0%	55.6%	100.0%	50.0%	100.0%
				Never Events	0	L	?	0	0	0	0	1	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-	H		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				Duty of Candour Compliance Stage 2 %	-			50.0%	72.7%	66.7%	83.3%	100.0%	100.0%	71.4%	100.0%	92.3%	100.0%	100.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Incident Management			RIDDOR Incidents	-			4	5	4	2	0	0	4	4	2	2	2	0
				RIDDOR Compliance %	-			100.0%	40.0%	75.0%	0.0%	-	-	75.0%	50.0%	100.0%	100.0%	100.0%	-
				Health & Safety Incidents	-	H		107	118	118	96	108	85	119	151	115	128	96	86
				Sharps Injuries	-			15	14	10	6	12	10	7	17	8	5	10	9
				Violence & Aggression Incidents	-	H		141	109	136	127	138	176	193	252	173	203	166	174
				Assaults - Patient on Staff	-	H		58	63	75	55	64	60	64	99	78	108	70	76
				EDNs Completed Within 24hrs %	90.0%	H	F	72.9%	71.5%	74.2%	77.9%	77.6%	74.4%	75.4%	78.5%	78.0%	77.5%	80.3%	78.4%
	Falls			Low or No Harm Falls %	95.0%		?	97.1%	96.2%	97.8%	97.4%	95.9%	98.9%	100.0%	97.9%	100.0%	94.6%	98.8%	99.0%
				Falls - Total	-			69	78	92	78	74	88	77	94	80	74	85	102
				Falls - Low Harm	-			24	25	26	23	11	30	24	22	17	15	19	24
				Falls - Moderate Harm	-			1	2	0	2	1	0	0	0	0	2	1	1
				Falls - Severe Harm	0		?	1	1	2	0	1	1	0	2	0	2	0	0
				Falls Resulting in Death	0	L	?	0	0	0	0	1	0	0	0	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Falls			Falls per 1,000 Bed days	-			4.47	5.08	5.96	5	4.99	5.90	5.08	6.69	5.23	5.08	5.78	7.29
	Pressure Ulcer			Pressure Ulcers - Total (Reportable)	24		?	27	26	27	25	30	20	23	25	24	15	16	19
				Pressure Ulcers - Grade 2	-			9	5	5	3	6	3	5	8	5	8	8	6
				Pressure Ulcers - Grade 3	-	H		0	0	0	0	1	0	0	2	3	7	8	13
				Pressure Ulcers - Grade 4	-			1	0	0	3	1	2	0	0	0	0	0	0
				Pressure Ulcers per 1,000 Bed Days (Reportable)	-			1.75	1.69	1.75	1.60	2.03	1.34	1.52	1.78	1.57	1.03	1.09	1.36
	Medicines			Medicine Errors - Total	-			98	101	74	87	97	70	63	90	81	88	61	68
				Low or No Harm Medicine Errors %	95.0%		P	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	98.4%	100.0%
	IPC			IPC Incidents	-			30	54	41	56	39	53	35	45	50	38	54	31
				C-Diff Cases - Hospital Acquired Total	-			3	1	5	3	3	5	3	4	8	4	4	2
				C-Diff Cases - Hospital Acquired YTD (Cumulative)	33			24	25	30	33	36	41	44	48	56	4	8	10
				C-Diff Cases - Hospital Acquired (HOHA)	-			2	0	3	3	3	3	1	3	6	2	3	2
				E.coli Cases - Hospital Acquired	-			5	9	4	9	5	8	2	6	4	6	3	5

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	IPC			E.coli Cases - Hospital Acquired YTD (Cumulative)	73			19	28	32	41	46	54	56	62	66	6	9	14
				MRSA Cases - Hospital Acquired	0	L	?	0	0	0	1	1	0	0	0	0	0	0	0
				MSSA Cases - Hospital Acquired	-			2	1	2	4	3	1	4	3	2	4	1	0
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			14	15	17	21	24	25	29	32	34	4	5	5
	Mortality			Crude Mortality Rate %	1.30%		?	1.27%	1.31%	1.44%	1.53%	1.19%	2.12%	2.03%	1.63%	1.49%	1.33%	1.28%	1.67%
				Avoidable 2222 Calls – Cardiac Arrest	1		?	2	0	1	1	2	2	1	0	0	1	2	0
				Avoidable 2222 Calls – Peri-Arrests	3		?	2	4	2	0	2	0	3	2	0	1	1	0
				Avoidable 2222 Calls	16	L	P	4	4	3	1	4	2	4	2	0	3	3	0
				HSMR (All)	100	H	F	111.72	112	113.20	113.33	109.96	110.31	113.50	113.15				
				Expected Death Rate %	-			3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.6%				
				SHMI	1	H	F	1.12	1.13	1.16	1.15	1.13	1.14	1.16					
				Fractured NOF Within 36 Hours	92.0%		?	48.4%	76.7%	31.3%	52.1%	71.9%	50.0%	71.4%	73.7%	60.0%	60.0%	51.5%	
				Number of Deaths Reviewed via SJR	-			15	9	8	12	13	8	13	12	11	13	6	13
				SJRs Completed %	25.0%		F	11.3%	7.0%	6.3%	7.8%	9.7%	4.3%	6.5%	7.3%	6.8%	9.2%	4.5%	9.2%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Mortality			Total Number of Deaths Due to Failings in Care	-			0	0	0	0	0	0	1	0	0	1	0	0
				Number of LD Deaths Reviewed via SJR	-			1	0	1	1	1	0	1	1	1	1	2	0
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%	H	?	98.7%	99.4%	99.7%	98.9%	99.5%	99.0%	99.4%	99.2%	99.7%	99.1%	99.4%	99.5%
	Maternity			Caesarean Section %	-			48.2%	44.9%	47.3%	46.7%	51.6%	48.8%	49.6%	52.0%	44.2%	43.5%	44.2%	50.5%
				Elective C-Section %	-			16.4%	16.9%	22.0%	21.0%	21.5%	17.6%	19.8%	19.6%	19.2%	21.0%	17.2%	19.8%
				Emergency C-Section %	-			31.8%	28.0%	25.3%	25.6%	30.0%	31.2%	29.8%	32.3%	24.9%	22.5%	27.0%	30.7%
				PPH greater than 1000mls	-			35	56	30	39	49	54	35	44	41	37	45	37
				Total Number of Still Births Greater Than 24 weeks Gestation	-			1	1	2	2	3	0	1	3	0	0	3	2
				Neonatal Deaths	-			2	4	4	0	1	4	1	2	3	0	1	0
				Maternity Serious Incidents	-			2	0	0	0	0	1	2	2	1	0	0	0
				Maternity HSIB Referrals	-			1	0	0	0	0	1	2	2	1	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			1	0	0	0	1	1	1	1	0	0	0	0

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Quality	Risk & Policy			Risks Open - Low (Month End Snapshot)	-											6	4	6	4
				Risks Open - Moderate (Month End Snapshot)	-											55	57	55	50
				Risks Open - High (Month End Snapshot)	-											171	160	162	159
				Risks Open - Extreme (Month End Snapshot)	-											33	30	26	25
	Health & Safety			Resuscitation Training Compliance %	-	H		81.1%	78.6%	79.5%	81.3%	81.6%	81.2%	82.2%	82.4%	83.8%	83.1%	83.0%	83.8%
				Mental Capacity Act Training Compliance %	-	H		82.3%	81.3%	80.6%	80.3%	80.6%	81.5%	81.4%	81.7%	83.1%	84.0%	84.9%	85.1%
	Legal & Information Governance			Inquests Received	-	H		14	18	16	6	8	21	15	14	8	14	13	10
				Inquest Hearings	-			4	6	6	6	12	3	5	10	8	8	6	5
				Regulation 28 Reports	-	L		0	0	0	0	0	0	0	0	0	0	0	0

Systems & Partnerships

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

NHS Medway NHS Foundation Trust

Nick Sinclair

Chief Operating Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Access	23	10	25	26	8	13
Emergency Care	5	8	3	7	1	4

Operational Leads:

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

Committees:

Finance & Performance Committee

Systems & Partnerships

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

Access

RTT Incompletes Performance %

Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	54.0%	L	P	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.4%

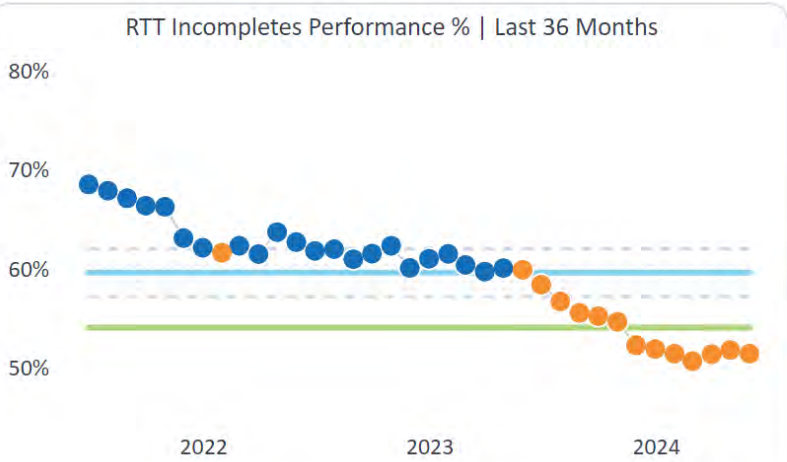
True North Domain: Systems & Partnerships

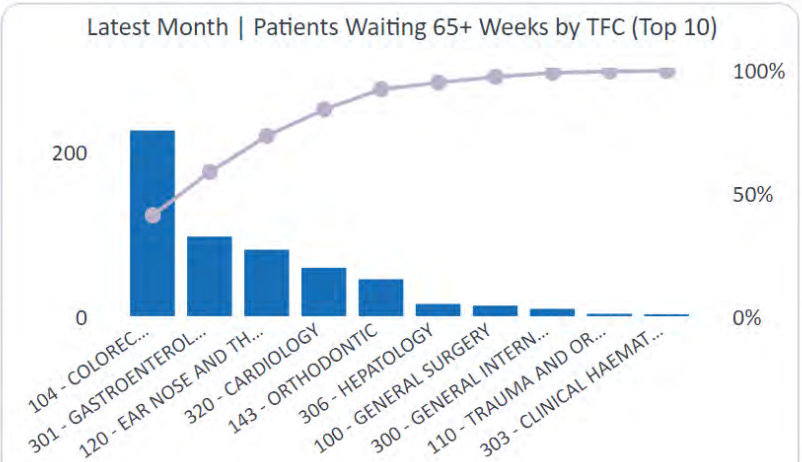
KPI Threshold: 54.0%

Sub Domain KPIs: 26

Variation Summary:

10	6	7	2	1





Key Messages

Ongoing delays with endoscopy contributing to poor performance within Gastro and colorectal – mobile unit will support improvement with additional 392 units of capacity. Due to be operational from 22nd August

ENT have improved their position and majority of over 65 week waits now have a TCI

Cardiology are exploring additional weekend clinics to reduce their delays and have a workshop booked for mid July

Issues, Concerns & Gaps

Endoscopy capacity remains an issue however the new mobile unit will provide significant additional capacity to mitigate this.

Diagnostics demand and capacity work is underway with the support of the NHS England. This will also include the reporting element of the service.

Actions & Improvements

Review of Endoscopy booking processes to be reviewed with support from NHSE and the endoscopy ICB lead

Review of cardiology service in a July workshop

Systems & Partnerships

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

Emergency Care

Total EC 4 Hour Performance %

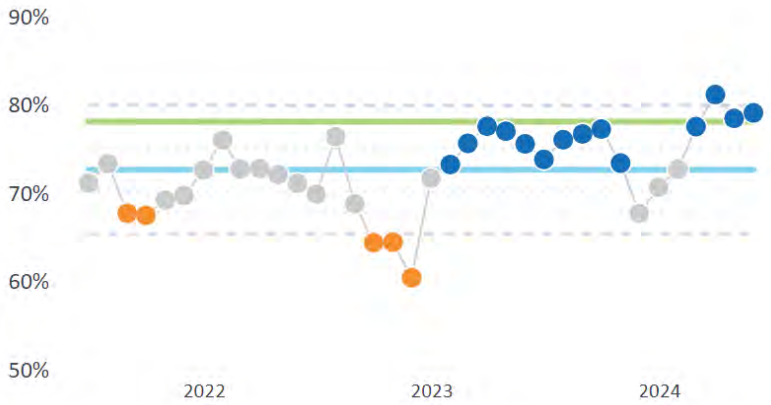
Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	78.0%			73.7%	75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%

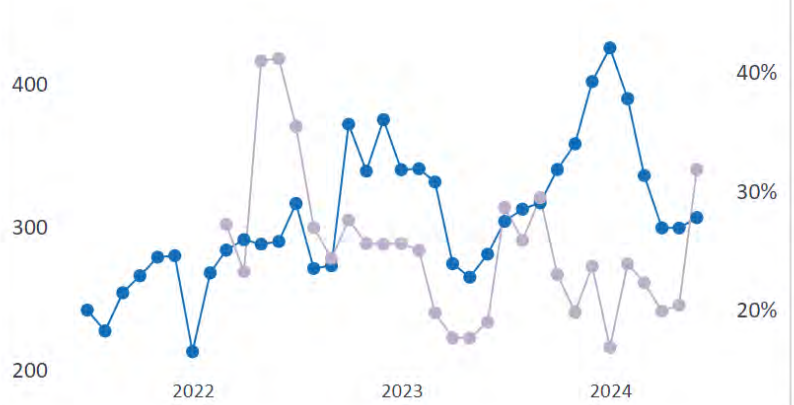
True North Domain: Systems & Partnerships

KPI Threshold: 78.0%

Sub Domain KPIs: 11

Variation Summary: 4 | 1 | 1 | 2 | 3





Key Messages

Currently over delivering on ED performance since April 2024

Work commenced with system partners to introduce full UTC at MFT acute site

Daily improvement huddles with ED team continuing daily with good representation from all staff groups

Rota heatmap now completed

Issues, Concerns & Gaps

SPOA has currently paused but work underway with all stakeholders to reinstate

High level of NCTR patients still impacting on ability to increase discharges

Actions & Improvements

Work underway to improve standardised inreach for main specialities (Gastro, Resp, Cardio) into ED and SDEC

Continuing design work with system partners for UTC model

Review of rota heatmap to identify hour by hour clinician allocation and potential redistribution to increase productivity during day hours

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Access			RTT 65+ Week Waiters	0	H	F	Driver is red for 2 reporting periods	257	286	235	284	404	552
				RTT 52 Week Breaches	1,250	H	P	Watch is red for 4 reporting periods	1,659	1,886	2,159	2,360	2,610	2,842
				OP Average Time to First Appointment (days)	60	H	F	Watch is red for 4 reporting periods	98.84	104.04	103.36	106.99	104.66	108.86
				Operations Cancelled by Hospital on Day	0		?	Watch is red for 4 reporting periods	15	7	10	16	18	15
				Urgent Operations Cancelled for 2nd Time	0		?	Watch is red for 4 reporting periods	0	2	1	2	5	1
				Cancer USC Performance %	93.0%	L	?	Watch is red for 4 reporting periods	84.9%	73.0%	72.8%	73.4%	70.1%	
				Cancer USC Performance - Breast Symptomatic %	93.0%	L	?	Watch is red for 4 reporting periods	58.4%	38.4%	4.2%	2.9%	0.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%		?	Watch is red for 4 reporting periods	81.3%	86.4%	92.6%	75.0%	94.6%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	Watch is red for 4 reporting periods	72.5%	68.1%	68.2%	67.4%	67.6%	
				Cancer 28 Day Faster Diagnosis %	77.0%	L	?	Watch is red for 4 reporting periods	63.1%	73.0%	66.0%	56.5%	53.7%	
				DM01 Performance %	73.1%	L	?	Watch is red for 4 reporting periods	59.5%	66.7%	66.9%	65.4%	67.1%	67.4%
	Emergency Care			Type 1 EC 4 Hour Performance %	75.0%	H	F	Watch is red for 4 reporting periods	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%
				Total EC 12 Hour Breaches	0	H	F	Watch is red for 4 reporting periods	953	798	798	521	588	618

Systems & Partnerships

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Emergency Care			Average Time in EC Department - Excl. Type 5 (mins)	240			Watch is red for 4 reporting periods	424.67	389.04	335.25	298.57	298.53	305.81
				Ambulance Handover Delays (> 60 mins)	0			Watch is red for 4 reporting periods	9	5	6	3	3	2

Systems & Partnerships

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Access			Outpatient DNA Rate %	10.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	6.3%	6.2%	6.2%	6.2%	6.3%	6.2%
				OP First to Follow Up Ratio	-	L	Special cause of improving nature or lower pressure due to (L)ower values	1.96	1.87	1.84	1.88	1.76	1.76
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	80.3%	72.2%	90.0%	71.4%	71.4%	
	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	75.7%	77.9%	83.0%	86.9%	84.0%	84.7%
				Type 1 EC 4 Hour Performance %	75.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%
				Ambulance Handover Delays (> 30 mins)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	161	90	103	67	49	73
				Ambulance Handover Delays (> 60 mins)	0	L	Special cause of improving nature or lower pressure due to (L)ower values	9	5	6	3	3	2

Access

Key Messages

Ongoing delays with endoscopy contributing to poor performance within Gastro and colorectal – mobile unit will support improvement with additional 392 units of capacity. Currently reviewing criteria of patients for the mobile unit to ensure that the additional capacity is used in an optimal fashion

ENT have improved their position and majority of over 65 week waits now have a TCI

Issues, Concerns & Gaps

Increase in number of patients over 78 weeks (18 – 7 booked) related to Endoscopy. Issues identified with data not being transferred from Endoscopy schedule to PAS therefore could be in a more positive position. This issue is bring resolved.

Endoscopy capacity remains an issue however new unit will provide significant additional capacity to mitigate this.

Diagnostics delays have led to a delay in reporting, this has now been mitigated by some planned additional capacity to support

Actions & Improvements

Endoscopy booking processes to be reviewed with support from NHSE and ICB endoscopy lead

Endo/PAS transition issues plan with team and BI

Cardiology service workshop planned for July 2024 – review potential outsourcing for one stop weekend clinics

Emergency Care

Key Messages

Currently over delivering on ED performance since April 2024

Work commenced with system partners to introduce full UTC at MFT acute site

Daily improvement huddles with ED team continuing daily with good representation from all staff groups

Rota heatmap now completed

Issues, Concerns & Gaps

SPOA has currently paused but work underway with all stakeholders to reinstate

High level of NCTR patients still impacting on ability to increase discharges

Actions & Improvements

Work underway to improve standardised in reach for main specialities (Gastro, Respiratory, Cardio) into ED and SDEC

Continuing design work with system partners for UTC model

Review of rota heatmap to identify hour by hour clinician allocation and potential redistribution to increase productivity during day hours

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Access			RTT Incompletes Performance %	54.0%	L	P	58.3%	56.6%	55.5%	55.2%	54.6%	52.2%	51.8%	51.4%	50.6%	51.3%	51.8%	51.4%
				RTT 65+ Week Waiters	0	H	F	101	176	220	246	217	237	257	286	235	284	404	552
				RTT 40+ Week Waiters	-	H		3,465	4,235	4,370	4,395	4,523	5,311	5,569	5,927	6,296	6,434	6,627	6,683
				RTT Waiting List Size	-	H		38,661	39,676	40,403	41,150	41,562	42,487	43,133	43,716	44,646	44,751	44,491	44,487
				RTT 52 Week Breaches	1,250	H	P	1,019	1,143	1,209	1,291	1,441	1,439	1,659	1,886	2,159	2,360	2,610	2,842
				OP Average Time to First Appointment (days)	60	H	F	91.78	88.39	96.13	98.44	98.54	94.83	98.84	104.04	103.36	106.99	104.66	108.86
				Outpatient DNA Rate %	10.0%	L	P	7.6%	7.4%	8.9%	7.5%	7.0%	7.5%	6.3%	6.2%	6.2%	6.2%	6.3%	6.2%
				OP First to Follow Up Ratio	-	L		1.99	2.05	1.99	2.03	1.89	1.95	1.96	1.87	1.84	1.88	1.76	1.76
				Operations Cancelled by Hospital on Day	0		?	11	5	14	9	20	12	15	7	10	16	18	15
				Cancelled Operations Not Rescheduled < 28 Days %	-			45.5%	80.0%	21.4%	22.2%	70.0%	75.0%	53.3%	42.9%	50.0%	50.0%	66.7%	53.3%
				Urgent Operations Cancelled for 2nd Time	0		?	2	0	2	1	3	2	0	2	1	2	5	1
				Day Case Rate %	-			85.6%	86.1%	85.5%	87.0%	85.9%	86.2%	87.9%	87.3%	86.1%	85.9%	85.2%	83.6%
				Average Elective Length of Stay (days)	3	H	?	2.46	2.60	2.74	3.32	3	2.79	2.54	2.55	3.20	2.92	3.45	2.81

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10	H	P	4.51	4.50	4.89	4.83	4.79	4.81	4.66	4.63	4.28	4.51	4.50	5.35
				104 Day Cancer Waits	-			13	12	10	17	17	7	13	12	14	16	9	
				Cancer USC Performance %	93.0%	L	?	94.3%	88.5%	93.4%	90.2%	85.8%	92.7%	84.9%	73.0%	72.8%	73.4%	70.1%	
				Cancer USC Performance - Breast Symptomatic %	93.0%	L	?	100.0%	41.7%	83.1%	80.0%	63.5%	69.4%	58.4%	38.4%	4.2%	2.9%	0.0%	
				Cancer 31 Day First Treatment Performance %	98.2%		?	99.3%	98.2%	98.8%	98.1%	93.6%	99.2%	97.0%	98.7%	98.4%	94.9%	98.1%	
				Cancer 31 Day Subsequent Treatments - Drugs %	100.0%		?	100.0%	100.0%	91.7%	97.5%	100.0%	100.0%	91.2%	100.0%	100.0%	90.5%	100.0%	
				Cancer 31 Day Subsequent Treatments - Surgery %	98.0%		?	100.0%	85.0%	95.0%	93.9%	93.8%	100.0%	81.3%	86.4%	92.6%	75.0%	94.6%	
				Cancer 62 Day Treatment - GP Refs %	85.1%	L	?	72.5%	74.8%	78.9%	65.6%	68.1%	79.0%	72.5%	68.1%	68.2%	67.4%	67.6%	
				Cancer 62 Day Treatment - Cons Upgrades %	75.0%	H	?	75.9%	76.7%	83.3%	81.3%	81.6%	78.4%	80.3%	72.2%	90.0%	71.4%	71.4%	
				Cancer 62 Day Treatment - Screening Refs %	92.7%		?	77.8%	87.5%	65.9%	72.4%	85.2%	74.1%	73.3%	47.6%	95.7%	77.6%	84.2%	
				Cancer 28 Day Faster Diagnosis %	77.0%	L	?	73.3%	74.0%	70.0%	66.6%	65.2%	69.8%	63.1%	73.0%	66.0%	56.5%	53.7%	
				Cancer 28 Day Faster Diagnosis Screening %	-			68.6%	66.1%	61.9%	68.5%	74.1%	76.7%	47.7%	79.3%	76.5%	72.2%	76.7%	
				DM01 Performance %	73.1%	L	?	65.1%	59.8%	61.6%	61.3%	62.1%	56.6%	59.5%	66.7%	66.9%	65.4%	67.1%	67.4%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	78.0%	H	?	73.7%	75.9%	76.6%	77.1%	73.3%	67.6%	70.6%	72.6%	77.4%	81.1%	78.4%	79.0%
				Total EC 4 Hour Performance - Non-Admitted %	85.0%	H	?	79.1%	81.8%	82.3%	82.6%	78.7%	73.8%	75.7%	77.9%	83.0%	86.9%	84.0%	84.7%
				IP Discharged Before Noon % (Inc transfers to ADL)	-	L		17.2%	17.4%	17.0%	16.8%	17.3%	15.0%	14.1%	14.3%	12.6%	12.7%	13.9%	12.2%
				Type 1 EC 4 Hour Performance %	75.0%	H	F	63.0%	64.2%	65.8%	65.2%	62.0%	52.9%	59.1%	63.5%	69.3%	69.5%	70.6%	68.8%
				Total EC 12 Hour Breaches	0	H	F	344	387	572	742	766	785	953	798	798	521	588	618
				Average Time in EC Department - Excl. Type 5 (mins)	240		F	303.22	311.69	316.19	339.48	357.44	401.08	424.67	389.04	335.25	298.57	298.53	305.81
				Number of ED Arrivals by Ambulance	-			3,007	2,978	3,009	3,107	3,137	3,167	3,281	2,956	3,173	2,981	2,993	2,869
				Ambulance Handover Delays (> 30 mins)	-	L		59	42	46	73	85	177	161	90	103	67	49	73
				Ambulance Handover Delays (> 60 mins)	0	L	?	1	2	3	1	3	10	9	5	6	3	3	2
				Bed Occupancy - NCTR % (G&A)	-			28.5%	25.8%	29.4%	22.9%	19.8%	23.6%	16.8%	23.8%	22.2%	19.8%	20.3%	31.7%
				30 Day Readmission Rate	13.0%		P	9.6%	9.1%	9.3%	10.1%	9.7%	10.1%	9.2%	10.0%	9.8%	10.0%	10.7%	8.1%

People

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

NHS Medway NHS Foundation Trust

Leon Hinton

Chief People Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
StatMan	9	22	4	10	15	10
Compliance	2	0	0	1	0	1
Diversity	1	1	0	0	0	0
Safe Staffing	0	8	0	5	0	1
Workforce	29	13	3	35	0	6

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

Committees:
People Committee

People

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

Workforce

National Staff Engagement Score

Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65

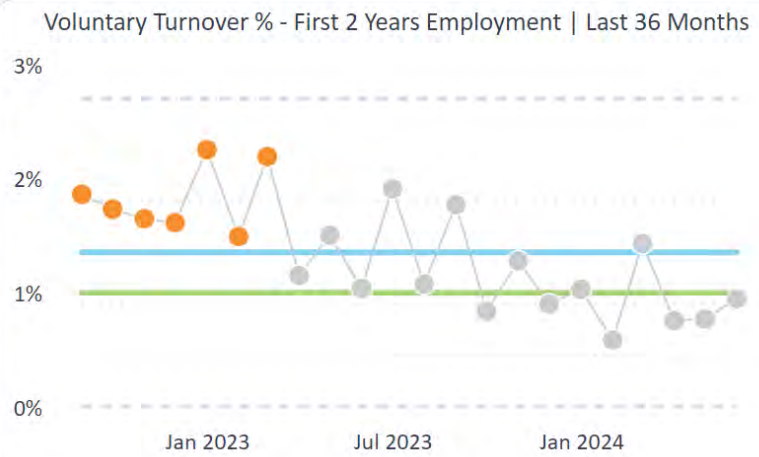
True North Domain: **People**

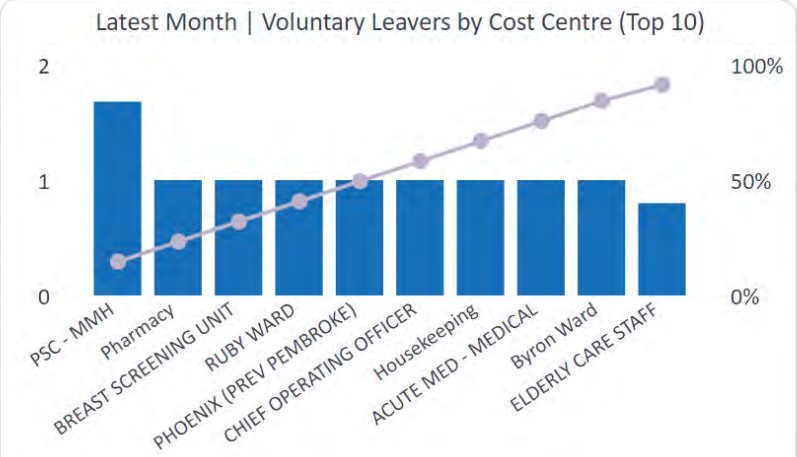
KPI Threshold: 6.93

Sub Domain KPIs: 16

Variation Summary:

9	0	0	4	3





Key Messages

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

The breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% with June 2024 continuing to report on-target. The new stay conversation processes and intention to leave process are now both live; however, with A3 in progress to improve take-up. A significant number of countermeasures have been enacted to address the turnover (improving trend over 12-months).

Issues, Concerns & Gaps

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

Actions & Improvements

- Delivery of targeted improvement plan developed and governed by anti-bullying and harassment group;
- Review of flexible-working recording/self-service;
- Ensuring that reasons for leaving are also captured prior to vacancy control process.

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	Workforce			Staff Appraisal Rate %	90.0%	H	F	Watch is red for 4 reporting periods	89.1%	88.9%	89.5%	89.3%	88.6%	87.8%
				Voluntary Turnover %	8.0%	L	F	Watch is red for 4 reporting periods	10.2%	9.7%	9.4%	9.1%	8.8%	8.7%
				Sickness Absence Rate - Total %	4.0%		?	Watch is red for 4 reporting periods	5.5%	4.9%	4.3%	4.4%	4.7%	5.0%
				Sickness Absence Rate - Short Term %	2.0%		?	Watch is red for 4 reporting periods	3.2%	2.5%	2.0%	2.2%	2.3%	2.6%
				Sickness Absence Rate - Long Term %	2.0%		?	Watch is red for 4 reporting periods	2.3%	2.5%	2.3%	2.2%	2.4%	2.4%
				Time to Hire - AfC	42		?	Watch is red for 4 reporting periods	88.10	60	66.10	61.10	55.30	47.90
	StatMan			StatMan: Moving and Handling L2 Compliance %	85.0%		F	Watch is red for 4 reporting periods	79.2%	78.9%	78.9%	79.6%	80.4%	79.9%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	L	F	Watch is red for 4 reporting periods	45.0%	44.5%	43.7%	43.4%	43.9%	46.7%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	?	Watch is red for 4 reporting periods	79.9%	77.6%	76.7%	77.2%	79.3%	80.5%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	76.4%	65.5%	74.1%	72.4%	68.3%	83.9%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	71.7%	71.2%	77.8%	77.3%	80.0%	81.4%

People

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	StatMan			StatMan: New Born Life Support Compliance %	85.0%		F	Watch is red for 4 reporting periods	73.4%	78.5%	82.9%	82.0%	80.2%	80.8%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	Watch is red for 4 reporting periods	79.3%	77.6%	79.1%	78.4%	78.4%	79.7%
	Compliance			DBS Compliance %	100.0%		F	Watch is red for 4 reporting periods	99.8%	99.7%	99.7%	99.7%	99.7%	99.7%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	Workforce			National Staff Engagement Score	6.93	H	Special cause of improving nature or lower pressure due to (H)igher values	6.65	6.65	6.65			
				Staff Appraisal Rate %	90.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	89.1%	88.9%	89.5%	89.3%	88.6%	87.8%
				Staff in Post (FTE)	-	H	Special cause of improving nature or lower pressure due to (H)igher values	4,956.95	5,003.08	5,031.78	5,040.46	5,034.33	5,034.96
				Staff Leavers (FTE)	-	L	Special cause of improving nature or lower pressure due to (L)ower values	39.76	35.66	53.55	37.79	42.58	39.81
				Vacancy Rate %	9.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	4.2%	3.4%	2.9%	8.1%	7.7%	7.7%
				Voluntary Turnover %	8.0%	L	Special cause of improving nature or lower pressure due to (L)ower values	10.2%	9.7%	9.4%	9.1%	8.8%	8.7%
				Agency Spend %	3.7%	L	Special cause of improving nature or lower pressure due to (L)ower values	2.0%	2.7%	1.1%	2.1%	2.4%	1.5%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	91.1%	91.6%	92.3%	95.1%	94.7%	94.6%
				Staff Fill Rate % (Total) - Registered Nurse	-	H	Special cause of improving nature or lower pressure due to (H)igher values	88.8%	90.0%	89.9%	91.7%	90.7%	90.1%
				Care Hours per Patient Day (CHPPD)	9.50	H	Special cause of improving nature or lower pressure due to (H)igher values	9.10	9.20	9.05	9.82	9.98	9.48
	Diversity			Diversity of Workforce %	-	H	Special cause of improving nature or lower pressure due to (H)igher values	40.3%	40.5%	40.8%	41.1%	41.5%	42.0%
	StatMan			StatMan Training Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	87.4%	87.9%	87.7%	88.1%	88.8%	89.0%
				StatMan: Conflict Resolution Compliance %	85.0%	H	Special cause of improving nature or lower pressure due to (H)igher values	93.5%	94.1%	94.5%	94.9%	95.2%	95.0%

People

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	StatMan			StatMan: EDI Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.4%	95.4%	95.4%	95.6%	95.9%	96.0%
				StatMan: Freedom to Speak Up Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	93.0%	93.6%	94.0%	94.3%	94.8%	95.4%
				StatMan: Freedom to Speak Up Compliance % - Managers	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	86.8%	87.2%	88.0%	89.1%	91.2%	92.7%
				StatMan: Health Safety and Welfare Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	89.3%	89.6%	89.2%	88.9%	88.9%	90.1%
				StatMan: Infection Prevention L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.3%	96.9%	97.5%	97.0%	97.1%	97.6%
				StatMan: Information Governance Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	90.4%	91.0%	90.8%	91.6%	91.8%	91.1%
				StatMan: Moving and Handling L1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	87.4%	89.0%	90.1%	91.4%	92.3%	93.1%
				StatMan: Basic Prevent Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	94.6%	96.0%	97.0%	97.1%	97.3%	97.6%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	95.8%	96.4%	97.3%	96.7%	96.9%	97.3%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	96.0%	96.4%	97.0%	96.6%	97.0%	97.4%
				StatMan: Advanced Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	74.5%	71.8%	75.2%	79.1%	83.7%	85.4%
				StatMan: Adult Basic Life Support Compliance %	85.0%		Special cause of improving nature or lower pressure due to (H)igher values	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%

People

Key Messages

- The Trust's breakthrough objective to reduce voluntary turnover for individuals with less than 24 months service remains on target for the month (met business rules for six out seven months), mirroring the continued improvement to the Trust's overall voluntary leaver rate (above target, improving).
- Industrial action occurred for Junior Doctors in June. Plans to address patient care and safety throughout were enacted through EPRR processes.
- The Trust remains compliant with NHS England framework agency rules (nil off framework) and reporting breaches and compliance with South East temporary staffing collaborative.
- Appraisals remain off target and deteriorating. Focus on the corporate areas performance (off track) is focus for July.
- The Trust held its main staff awards on 13 June to celebrate excellent values and quality.
- Improvement noted for medical staffing hire metrics with six of seven metrics now on target. Successful recruitment to difficult to appoint roles including consultant anaesthetists.

Issues, Concerns & Gaps

- Absence remains above target and deteriorating. Reasons for sickness show an significant increase for musculoskeletal-related absences (increased by 3%), cold/flu (increased by 0.7%) and pregnancy-related (+0.9%). Underlying reasons for particular increases to be reviewed for root cause.
- DBS role review continues with new DBS policy and extended group of staff requiring three year renewal.
- Significant increase in recruitment volume following approval of business cases and investments (and deterioration of hire times)

Actions & Improvements

- Initiating the culture programme addressing violence and aggression towards staff and EDI culture with key stakeholders.
- Enactment of the approved occupational health business case.
- Disability and Health Passport sent for consultation;
- Inclusion by Design (IBD) Training ready for delivery, 11 sessions between July 2024 and April 2025

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	Workforce			National Staff Engagement Score	6.93	H	F	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65	6.65			
				Voluntary Turnover % - First 2 Years Employment	1.00%		?	1.9%	1.1%	1.8%	0.8%	1.3%	0.9%	1.0%	0.6%	1.4%	0.8%	0.8%	0.9%
				Staff Appraisal Rate %	90.0%	H	F	91.5%	91.8%	90.1%	89.9%	89.8%	89.2%	89.1%	88.9%	89.5%	89.3%	88.6%	87.8%
				Staff in Post (FTE)	-	H		4,711.87	4,793.43	4,789.23	4,870.58	4,906.42	4,935.20	4,956.95	5,003.08	5,031.78	5,040.46	5,034.33	5,034.96
				Staff Leavers (FTE)	-	L		57.55	129.36	82.43	65.89	57.12	46.37	39.76	35.66	53.55	37.79	42.58	39.81
				Staff Starters (FTE)	-			72.79	164.09	102.71	133.28	78.48	45.43	86.30	68.08	46.99	53.41	21.66	34.84
				Vacancy Rate %	9.0%	L	?	6.7%	6.1%	5.5%	5.1%	5.2%	4.6%	4.2%	3.4%	2.9%	8.1%	7.7%	7.7%
				Voluntary Turnover %	8.0%	L	F	12.1%	11.4%	11.3%	10.9%	10.9%	10.7%	10.2%	9.7%	9.4%	9.1%	8.8%	8.7%
				Voluntary Turnover (ICS) %	-			1.1%	1.2%	1.4%	0.9%	1.2%	1.0%	0.8%	0.7%	1.0%	0.6%	0.8%	0.8%
				Sickness Absence Rate - Total %	4.0%		?	4.3%	4.7%	4.9%	4.9%	4.5%	5.1%	5.5%	4.9%	4.3%	4.4%	4.7%	5.0%
				Sickness Absence Rate - Short Term %	2.0%		?	1.9%	2.4%	2.7%	2.4%	2.2%	2.9%	3.2%	2.5%	2.0%	2.2%	2.3%	2.6%
				Sickness Absence Rate - Long Term %	2.0%		?	2.4%	2.3%	2.2%	2.5%	2.3%	2.2%	2.3%	2.5%	2.3%	2.2%	2.4%	2.4%
				Time to Hire - AfC	42		?	72.40	71.50	78.40	66.70	62.10	60.40	88.10	60	66.10	61.10	55.30	47.90

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	Workforce			Time to Hire - Medical	70			83.90	83.70	92	89.60	65.30	147.70	107	76	54.90	91.30	66.70	58.90
				Agency Spend %	3.7%	L		3.0%	2.9%	3.0%	2.6%	3.5%	2.7%	2.0%	2.7%	1.1%	2.1%	2.4%	1.5%
				Bank Spend %	10.0%			11.6%	13.8%	9.8%	12.2%	10.9%	11.0%	13.1%	11.7%	8.6%	11.1%	10.2%	10.3%
	Safe Staffing			Staff Fill Rate - Total %	85.0%	H		91.8%	90.5%	88.1%	89.5%	92.8%	90.0%	91.1%	91.6%	92.3%	95.1%	94.7%	94.6%
				Staff Fill Rate % (Total) - Registered Nurse	-	H		88.1%	86.3%	84.8%	87.7%	89.3%	88.2%	88.8%	90.0%	89.9%	91.7%	90.7%	90.1%
				Care Hours per Patient Day (CHPPD)	9.50	H	F	9.14	9.15	9.03	9.05	9.18	9.06	9.10	9.20	9.05	9.82	9.98	9.48
	Diversity			Diversity of Workforce %	-	H		-	-	38.6%	39.2%	39.7%	40.0%	40.3%	40.5%	40.8%	41.1%	41.5%	42.0%
				Diversity of Board %	-			-	-	16.7%	9.1%	18.2%	18.2%	18.2%	16.7%	16.7%	20.0%	18.2%	23.1%
	StatMan			StatMan Training Compliance %	85.0%	H		86.6%	83.7%	84.9%	86.1%	86.7%	87.5%	87.4%	87.9%	87.7%	88.1%	88.8%	89.0%
				StatMan: Conflict Resolution Compliance %	85.0%	H	P	92.4%	92.0%	92.4%	92.7%	93.5%	94.0%	93.5%	94.1%	94.5%	94.9%	95.2%	95.0%
				StatMan: EDI Compliance %	85.0%	H	P	94.3%	94.3%	94.2%	94.3%	95.0%	95.5%	95.4%	95.4%	95.4%	95.6%	95.9%	96.0%
				StatMan: Fire Safety Compliance %	85.0%			83.6%	83.7%	83.2%	83.1%	82.5%	82.1%	81.7%	82.9%	81.2%	84.2%	85.9%	84.5%
				StatMan: Freedom to Speak Up Compliance %	85.0%	H	P	85.5%	87.7%	89.5%	90.5%	91.7%	92.7%	93.0%	93.6%	94.0%	94.3%	94.8%	95.4%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	StatMan			StatMan: Freedom to Speak Up Compliance % - Managers	85.0%	H	?	87.2%	74.0%	76.6%	79.4%	82.4%	83.7%	86.8%	87.2%	88.0%	89.1%	91.2%	92.7%
				StatMan: Health Safety and Welfare Compliance %	85.0%	H	P	83.4%	90.2%	88.3%	86.7%	86.7%	89.8%	89.3%	89.6%	89.2%	88.9%	88.9%	90.1%
				StatMan: Infection Prevention L1 Compliance %	85.0%	H	P	93.9%	93.6%	93.9%	94.8%	95.8%	95.6%	96.3%	96.9%	97.5%	97.0%	97.1%	97.6%
				StatMan: Infection Prevention L2 Compliance %	85.0%		P	88.3%	87.1%	87.7%	89.1%	89.0%	89.6%	88.8%	88.7%	88.5%	89.7%	89.6%	89.1%
				StatMan: Information Governance Compliance %	85.0%	H	P	90.0%	89.7%	89.9%	90.8%	90.7%	90.9%	90.4%	91.0%	90.8%	91.6%	91.8%	91.1%
				StatMan: Moving and Handling L1 Compliance %	85.0%	H	?	90.5%	47.3%	66.6%	77.9%	83.2%	85.8%	87.4%	89.0%	90.1%	91.4%	92.3%	93.1%
				StatMan: Moving and Handling L2 Compliance %	85.0%		F	82.8%	83.9%	81.0%	80.6%	80.7%	81.2%	79.2%	78.9%	78.9%	79.6%	80.4%	79.9%
				StatMan: Moving and Handling L2 Compliance % - 2 Years	85.0%	L	F	51.1%	50.6%	48.0%	44.1%	44.9%	45.1%	45.0%	44.5%	43.7%	43.4%	43.9%	46.7%
				StatMan: Patient Safety L1 Compliance %	85.0%		P	92.2%	92.9%	93.5%	94.3%	94.5%	95.1%	95.3%	95.4%	88.6%	87.7%	90.3%	91.7%
				StatMan: Patient Safety L2 Compliance %	85.0%		?	80.0%	-	-	-	-	-	-	-	-	-	-	-
				StatMan: Basic Prevent Compliance %	85.0%	H	P	92.0%	92.3%	92.4%	93.7%	94.9%	96.1%	94.6%	96.0%	97.0%	97.1%	97.3%	97.6%
				StatMan: Prevent WRAP Compliance %	85.0%	L	P	91.2%	90.3%	88.1%	87.3%	87.3%	87.6%	86.9%	87.2%	87.8%	88.3%	89.1%	88.3%
				StatMan: Safeguarding Adults Level 1 Compliance %	85.0%	H	P	94.2%	93.6%	94.1%	94.0%	95.0%	96.0%	95.8%	96.4%	97.3%	96.7%	96.9%	97.3%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	StatMan			StatMan: Safeguarding Adults Level 2 Compliance %	85.0%		P	91.3%	91.6%	93.0%	93.1%	93.2%	94.0%	92.0%	91.8%	91.1%	91.3%	92.3%	92.5%
				StatMan: Safeguarding Adults Level 3 Compliance %	85.0%	H	F	24.7%	36.6%	43.6%	48.2%	54.5%	57.2%	59.6%	63.6%	66.9%	65.8%	66.3%	68.7%
				StatMan: Safeguarding Children Level 1 Compliance %	85.0%	H	P	91.9%	92.7%	93.4%	94.2%	94.6%	95.5%	96.0%	96.4%	97.0%	96.6%	97.0%	97.4%
				StatMan: Safeguarding Children Level 2 Compliance %	85.0%	L	P	89.9%	88.3%	88.0%	85.7%	84.6%	84.4%	82.8%	83.2%	82.9%	84.5%	86.0%	86.2%
				StatMan: Safeguarding Children Level 3 Compliance %	85.0%	L	?	83.2%	82.2%	80.8%	80.9%	82.0%	80.0%	79.9%	77.6%	76.7%	77.2%	79.3%	80.5%
				StatMan: Advanced Life Support Compliance %	85.0%	H	F	77.6%	71.8%	77.0%	77.7%	76.6%	74.5%	74.5%	71.8%	75.2%	79.1%	83.7%	85.4%
				StatMan: Adult Basic Life Support Compliance %	85.0%	H	F	80.8%	79.4%	81.4%	82.7%	82.4%	81.4%	82.0%	80.9%	82.1%	80.9%	81.1%	82.1%
				StatMan: Adult Immediate Life Support Compliance %	85.0%	H	F	78.9%	78.6%	75.8%	74.3%	74.4%	75.1%	76.3%	80.2%	80.2%	85.6%	83.0%	80.9%
				StatMan: Anaphylaxis Compliance %	85.0%	H	P	89.5%	83.2%	84.4%	87.7%	90.2%	90.1%	91.1%	91.8%	91.7%	90.3%	89.7%	89.9%
				StatMan: European Paediatric Advanced Life Support and Advanced Paediatric Life Support Compliance %	85.0%	H	F	83.3%	73.2%	72.7%	80.4%	81.8%	81.5%	76.4%	65.5%	74.1%	72.4%	68.3%	83.9%
				StatMan: Mental Health Liaison Service Compliance %	85.0%	H	F	72.3%	72.6%	69.5%	68.0%	66.3%	70.7%	71.7%	71.2%	77.8%	77.3%	80.0%	81.4%
				StatMan: New Born Life Support Compliance %	85.0%		F	74.7%	72.8%	73.4%	77.3%	77.5%	71.7%	73.4%	78.5%	82.9%	82.0%	80.2%	80.8%
				StatMan: Paediatric Basic Life Support Compliance %	85.0%	H	F	74.6%	74.0%	75.4%	77.7%	77.7%	78.2%	79.3%	77.6%	79.1%	78.4%	78.4%	79.7%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
People	StatMan			StatMan: Paediatric Immediate Life Support Compliance %	85.0%			75.9%	78.7%	72.2%	68.9%	64.1%	70.7%	76.1%	87.7%	83.4%	83.5%	84.1%	85.5%
	Compliance			Professional Registration Compliance %	100.0%					100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
				DBS Compliance %	100.0%					99.6%	99.7%	99.7%	99.8%	99.8%	99.7%	99.7%	99.7%	99.7%	99.7%

Sustainability

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

NHS Medway NHS Foundation Trust

Alan Davies

Chief Financial Officer

Patient FIRST

Sub Domain	Variation			Assurance		
	Common	Improve	Concern	Common	Improve	Concern
Financial Position	20	4	4	20	0	0

Operational Leads:

Paul Kimber - *Deputy Chief Financial Officer*

Committees:

Finance & Performance Committee

Audit & Risk Committee

Sustainability

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

Financial Position

Breakeven Revenue Budget (£)

Type	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	£0.00m			2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	2.76m	0.28m	-0.10m	0.08m

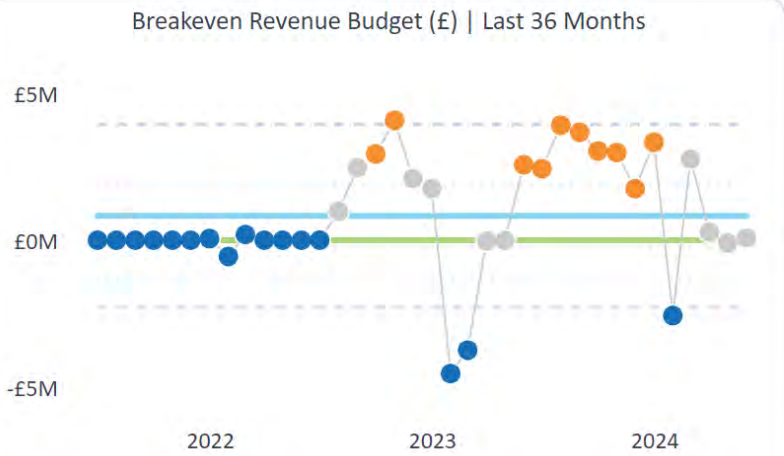
True North Domain: **Sustainability**

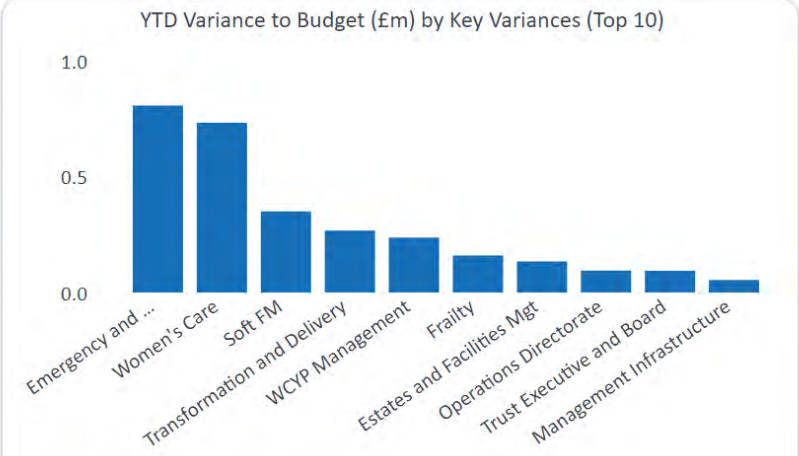
KPI Threshold: £0.00m

Sub Domain KPIs: 12

Variation Summary:

9	1	1	0	1





Key Messages

The Trust is reporting £0.5m adverse to plan for the year to date at Q1. This is driven by £0.6m of industrial action costs incurred in June. We await further guidance nationally on whether these will be funded, treated as an "allowable miss" or if the Trust will be expected to absorb the cost within plan.

Delivery of the financial plan in 2024/25 is critical to the Trust's exist from Oversight Framework level 4 / Recovery Support Programme.

Issues, Concerns & Gaps

Delivery of cash-releasing savings, i.e. those which will reduce our actual current expenditure, are key to deliver the outturn and run-rate requirement.

Delivery of the elective income targets in the Trust's plan must be met, including the full year effect of new capacity that has been introduced.

There are a number of contractual assumptions between the Trust and the commissioner that are not aligned and present a potential risk to the financial performance.

Actions & Improvements

Identification, development, implementation and delivery of the efficiencies/waste reduction programme.

To mitigate the above, continued resilience in reducing worked WTEs (specifically bank and agency).

Implementation of the Trust's Integrated Improvement Plan ("IIP") as part of RSP/Oversight.

Sustainability

KPI Warnings - Business Rules Triggered

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Patient First Business Rule Trigger	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Sustainability	Financial Position			Total Financial Overspend (£)	£0.00m			Driver is red for 2 reporting periods	6.32m	6.02m	19.01m	1.56m	0.61m	1.55m
				(Surplus) / Deficit (£)	£0.00m			Watch is red for 4 reporting periods	4.13m	-15.51m	2.47m	3.57m	3.33m	2.85m

Sustainability

KPI Improvements - Special Cause Variation

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	Improvement Description	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Sustainability	Financial Position			Actual Worked FTE	-		Special cause of improving nature or lower pressure due to (H)igher values	5,527.16	5,542.70	5,570.28	5,475	5,452.75	5,470.54

Sustainability

Key Messages

The Trust is reporting £0.5m adverse to plan for the year to date at Q1. This is driven by £0.6m of industrial action costs incurred in June. We await further guidance nationally on whether these will be funded, treated as an "allowable miss" or if the Trust will be expected to absorb the cost within plan.

Delivery of the financial plan in 2024/25 is critical to the Trust's exist from Oversight Framework level 4 / Recovery Support Programme.

Issues, Concerns & Gaps

Delivery of cash-releasing savings, i.e. those which will reduce our actual current expenditure, are key to deliver the outturn and run-rate requirement.

As a mitigation against non-delivery of the waste reduction programme the Trust is pursuing an operational efficiencies programme to reduce its worked FTEs (in the context of growth of almost 10% during 2023/24). There has been early success during April and May, although this has now plateaued in June.

Delivery of the elective income targets in the Trust's plan must be met, including the full year effect of new capacity that has been introduced.

There are a number of contractual assumptions between the Trust and the commissioner that are not aligned and present a potential risk to the financial performance.

Actions & Improvements

Identification, development, implementation and delivery of the efficiencies/waste reduction programme, specifically cash-releasing opportunities. In conjunction with this, pursue operational efficiency opportunities.

To mitigate the above, continued resilience in reducing worked WTEs (specifically bank and agency).

Implementation of the Trust's Integrated Improvement Plan ("IIP") as part of RSP/Oversight.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0.00m			2.43m	3.91m	3.67m	3.04m	2.98m	1.75m	3.33m	-2.56m	2.76m	0.28m	-0.10m	0.08m
				Total Financial Overspend (£)	£0.00m			4.56m	5.33m	4.83m	5.43m	5.17m	5.79m	6.32m	6.02m	19.01m	1.56m	0.61m	1.55m
				(Surplus) / Deficit (£)	£0.00m			3.42m	4.90m	4.66m	3.84m	3.78m	2.55m	4.13m	-15.51m	2.47m	3.57m	3.33m	2.85m
				Agency Spend (£)	-			0.75m	0.74m	0.80m	0.65m	0.88m	0.68m	0.54m	0.71m	0.42m	0.55m	0.61m	0.40m
				Income (£)	-			-36.16m	-35.35m	-36.35m	-35.74m	-36.63m	-39.02m	-38.07m	-56.72m	-52.27m	-37.37m	-37.52m	-37.02m
				Income (£) vs Budget	£0.00m			-1.83m	-1.02m	-0.58m	-1.18m	-2.07m	-4.45m	-3.49m	-8.38m	-16.46m	0.50m	0.33m	0.85m
				Total Pay Spend (£)	-			24.45m	25.75m	26.83m	25.24m	24.93m	25.00m	26.71m	25.99m	37.01m	25.67m	25.86m	26.29m
				Total Pay Spend (£) vs Budget	£0.00m			2.64m	4.04m	3.22m	3.25m	3.70m	3.17m	4.85m	4.10m	14.99m	-0.46m	-0.05m	0.56m
				Total Non-Pay Spend (£)	-			12.91m	12.52m	11.77m	12.22m	13.18m	14.42m	13.35m	13.09m	15.22m	12.96m	12.65m	11.48m
				Total Non-Pay Spend (£) vs Budget	£0.00m			1.53m	1.04m	0.74m	0.97m	1.17m	3.01m	1.95m	1.72m	3.85m	0.30m	-0.33m	-1.13m
				Actual Worked FTE	-			5,215.43	5,344.21	5,240.17	5,444.71	5,403.07	5,461.76	5,527.16	5,542.70	5,570.28	5,475	5,452.75	5,470.54
				Actual Worked FTE vs Budget	0			138.77	211.60	150.93	284.50	204.96	264.97	332.87	347.90	361.66	-27.32	-17.51	7.26

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Trust Risk Register		**Agenda Item**	6.2
Author	Louise Furlong; Head of Quality and Safety			
Lead Executive Director	Sarah Vaux; Chief Nursing Officer			
Executive Summary	The risk register report is intended to give the members of the Board assurance as to the current position of the Trusts risks management system. The report also responds to the regulatory and statutory duties such as those overseen by the Care Quality Commission (CQC), Ofsted and Health & Safety Executive to implement effective risk management systems. It also reflects the NHS Foundation Trust Code of Governance, and the Compliance Framework. The data provided in this report was current as of the 28th June 2024 The Trust Risk Register has 237 approved risks in total 25 risks are scoring 15 and above. 25 new risks added 22 risks have been closed down 16 risks have had the score reduced since their last review, 5 risks have had the score increased since their last review, and 9 risks have been rejected. The report highlights the reduction in review compliance, the lack of movement in risk scores, and the absence of actions being assigned in order to mitigate the risks.			
Proposal and/or key recommendation:	The Board is asked to note the content of the report.			
Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
Governance Process: **Committee/Group and Date of Submission/approval:**	Meeting: Risk & Compliance Sub-Committee Date: 16th July 2024			

Patient First Domain/True North priorities (tick box to indicate):	*Please mark with 'X' the priorities the report aims to support:*				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
Relevant CQC Domain:	*Please mark with 'X' the CQC domain the report aims to support:*				
	Safe: X	Effective: X	Caring: 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:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable		
Legal and Regulatory implications:	N/A		
Appendices:	Risk Register Report		
Freedom of Information (FOI) status:	Tick either: ☐ This paper is disclosable under the FOI Act ☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.		
For further information please contact:	Name: Louise Furlong Job Title: Head of Quality & Safety Email:louise.furlong@nhs.net		
Please mark with 'X' - Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance		Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Meeting of the Trust Board
Wednesday, 24 July 2024

Title of Report	Board Assurance Framework		**Agenda Item**	6.3
Author	Integrated Governance Practitioner			
Lead Executive Director	Chief Financial Officer, Sustainability Chief Medical Officer, Quality Chief Nursing Officer, Patient Chief Operating Officer, Systems & Partnerships Chief People Officer, People			
Executive Summary	The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through the Executive Board. The Board Assurance Framework (BAF) consists of 16 strategic risks aligned to each of the Trust's True North Domains.			
Proposal and/or key recommendation:	The Trust Board is asked to note the report for assurance and discussion.			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting	✓	Discussion	✓
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Audit & Risk Committee 4th July 2024			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability) ✓	Priority 2: (People) ✓	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:			
	Safe: ✓	Effective: ✓	Caring: ✓	Responsive:✓	Well-Led: ✓
Identified Risks, issues and mitigations:	As outlined in the relevant sections of the Board Assurance Framework.			
Resource implications:	N/A			

Sustainability and /or Public and patient engagement considerations:	N/A		
Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk.		
Appendices:	Board Assurance Framework (PDF)		
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act		
For further information or any enquires relating to this paper please contact:	Integrated Governance Team medwayft.integratedgovernance@nhs.net		
Reports require an assurance rating to guide the discussion:	No Assurance		There are significant gaps in assurance or actions
	Partial Assurance		There are gaps in assurance
	Assurance	✓	Assurance minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.